Collaborative Leadership State and Local Reactor Panel

Proceedings of a Conference on Collaborative Leadership

Sponsored by the
Leadership Development
National Excellence Collaborative

TurningPoint
Collaborating for a New Century in Public Health

Acknowledgements

The membership of the Turning Point Leadership Development National Excellence Collaborative includes individuals representing the following national organizations and state public health systems:

the Association of State and Territorial Health Officials (ASTHO), the Centers for Disease Control and Prevention (CDC), the National Association of City and County Health Officials (NACCHO), Nebraska, the National Public Health Leadership Development Network, Colorado, Louisiana, Minnesota, Oklahoma, South Carolina, and Virginia.

The Collaborative's members wish to thank those who served on the State/Local Reactor Panel described in this document and who shared their insights on collaborative leadership. They also extend their thanks to Lee Kingsbury of the Minnesota Department of Health for providing a starting point for the discussion and to Darvin Ayre of Ayre Associates for his deft facilitation of the dialogue.

The Collaborative also appreciates the support of the Robert Wood Johnson Foundation in accomplishing its mission of increasing collaborative leadership capacity across sectors and at all levels of public health organizations.

The Reactor Panel was held in Scottsdale, Arizona, on May 1, 2002.

A complete transcript of the panel discussion may be found on the Web at www.turningpointprogram.org or www.collaborativeleadership.org.

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Executive Summary

By Darvin Ayre

This executive summary is a discussion and overview of the proceedings of a panel discussion held at the Millennium Ranch Resort on May 1, 2002, in Scottsdale, Arizona. Twelve panelists, representing a mix of accomplished public health practitioners, academicians, developers of leadership training and administrators (see attachment for biographical information), were convened by the Turning Point Leadership Development National Excellence Collaborative. The purpose of the panel was to continue building understanding and knowledge of Collaborative Leadership as it applies to specific challenges and opportunities in the field of public health. The Panel addressed four questions that emerged from a previous expert panel session that was facilitated in Denver, Colorado on April 6,2001, by Dr. Carl Larson.

Questions

- How is collaborative leadership practiced at the federal, state, and local level? Is the skill set the same? If not, what are the differences?
- How is the practice of collaborative leadership approached by the individuals and organizations that are present?
- How can collaborative leadership be incorporated into "traditional" accredited training programs (e.g., leadership development institutes and schools of public health) in order to be integrated into organizational cultures at the local, state and federal levels?
- What are the best approaches to moving the content of the Turning Point Leadershipship Development National Excellence Collaborative's work into circulation and acceptance?

The following highlights represent almost 100 pages of transcript, reflecting a 3 1/2 hour panel discussion. As facilitator and moderator for the panel, my role was to help frame the four questions and provide reference points for the panelists. This Executive Summary captures key recurring themes, thought-provoking comments, and lessons that can be applied elsewhere.

Should the reader be interested, considerable information on collaborative leadership within the full transcript is available at www.turningpointprogram.org and at www.collaborativeleadership.org. Whether one is a serious student of leadership, a public health practitioner, or a civic-minded bystander interested in how things get done when diverse people, organizations and interests come together, these proceedings offer many insights into how critical public health work is currently being accomplished.

First, a working definition of a collaborative leader:

> **A collaborative leader is one who engages others by working together, convening appropriate stakeholders, and facilitating and sustaining their interactions.**

Key Themes

Though there were many interesting directions our conversations took with twelve panelists and four questions, there were key themes that emerged.

- **Proximity = Greater Accountability.**

There was agreement among panelists that both collaboration and collaborative leadership were more apparent at the local level. Part of this stems from the day-to-day reality of being closer to the shared issues and concerns of a neighborhood, community or region and part stems from the level of accountability that is required when working together in a collaboration at the local level.

When, as one participant put it, "I tell somebody at a community meeting that I'm going to do thus and such, there is a darn good chance I'm going to run into them at the grocery store and probably our kids go to school together… and so you end up being real accountable to the people that you run with."

In contrast, she went on to say, "In my work in public health, I have had some wonderful federal partners who go above and beyond the call of duty, but I know there are some that don't necessarily feel the accountability, because you aren't going to run into them again… there isn't that interaction on a frequent enough basis to really develop that trust and relationship, to feel like they're going to be accountable later on for what they say or do."

These concepts were supported by another participant who talked about the "human-ness" inherent in working at the local level. "I think we have the benefit in the local community of dealing with the people who experience gaps in health care or have other kinds of problems that we can put our resources together to respond. So they're always there for us to see what happened and they're always there to ask us why things aren't working well."

Though some panelists cited examples of greater collaboration and cooperation being initiated at the federal level (some due to September 11th), one panelist offered, "I'm not sure it'll ever be natural at the federal level. The extent to which you're connected to your stakeholders, and at the federal level, it's very difficult to be connected to your stakeholder, the closer they are to you… those connections, the tighter those are, the more natural it is to be collaborative."

- **Collaboration is absolutely vital to the work of public health.**

Several panelists raised the issue of how absolutely necessary it was for collaboration to occur, given the complexity of public health issues (e.g., health disparities, a coordinated response to bioterrorism, etc.) and the need for systems thinking.

One participant stated, "You're not going to do it in silos. You're not going to get at the issues plaguing society if we don't come together and be more efficient in our communication and in our efforts and where our dollars go."

Many agreed that while it may indeed be more difficult for collaboration to occur at the federal level, and the practice of collaboration may vary between local, state and federal levels, the principles were the same.

From a panelist who had interviewed several colleagues working at the federal, state and local levels, we heard, "Unanimously, folks told me that collaborative leadership is collaborative leadership. The skill set is the same. The question is how is it practiced? It varies. How does it vary?... Here's a conglomerate of their responses: it varies according to institutional memory, so what people have seen

and what they're used to is something that is modeled for them… And it's what people practice and also to the extent that it's modeled by the person at the very top. If collaboration is practiced at the very top, then other people fall into line that way."

▪ People define collaboration differently, depending on their experiences and roles.

Panelists described the work they and others do in being collaborative leaders. At times these descriptions varied, some felt, due to their perspectives and experiences. One panelist said, "I don't see much (collaborative leadership) at the federal level and often this kind of leadership isn't at the state level either." She went on to describe her work with 39 partnerships and 14 health jurisdictions. "Many would call themselves collaborative leaders, but boy, are they finding out what that's all about. They're having to listen in ways they've never had to listen before. This issue of respect and trust, it's not something you build in a classroom situation. It happens on a day-to-day basis. Testing consistency, testing focus, community folks aim high."

She went on to say, "Collaboration is really hard… the decision-making process is hard. It is hard to be inclusive. It is hard to support participation. It is difficult resource-wise and time-wise to foster the kind of development that all individuals need. It is very difficult to step outside of being one collaborative leader and recognize that you need multiple centers of leadership. Collaborative leaders, as good as they are, who get up there and do it alone burn out. And they leave huge gaping holes when they leave, by the way, that are very difficult to fill… It's called renewable leadership. You've got to be in the process of constantly developing, constantly bringing along new leaders as you move through the years that it will take to do what it is that you're trying to do."

Another panelist, though agreeing that the federal government often fails at getting connected at the community level, felt they (as a federal government entity) had been fairly productive at creating partnerships with professional associations and private foundations. He said, "Virtually everything we do in our division and in public health practice is done with others, whether that be the development of performance standards or leadership development work."

Following these comments, one panelist suggested that partnerships and collaboration can be very different animals, depending on who is providing the majority of the funds. He responded saying that "Often the federal government has funding, and that, in my opinion, sets a different power base in terms of how collaboration actually occurs, and I think that in those sorts of situations it's even more difficult to have a true collaborative. People have to work a lot harder to build consensus."

▪ Different situations require different styles of leadership.

It was also acknowledged that collaborative leadership wasn't the best leadership style to use in every situation. Indeed, panelists suggested that a dictatorial style of leadership might be advantageous in the case of a severe disease outbreak, leadership through making personal decisions after asking the opinions of others might be appropriate when monitoring the scientific results of a community screening, and a collaborative style of leadership is best used to mobilize a community for shared action around community activities. Leaders need to be prepared to use an array of leadership styles that fit given situations. One panelist challenged participants not to get caught in stereotyping leadership styles among people or organizations at the federal, state or local level. He noted, "The ques-

tion sets us up to force artificial distinctions and to reinforce stereotypes that we may bring with us… The more interesting question to ask: Are there opportunities for collaborative leadership to be practiced, and how might the outcomes be different if, in fact, the collaborative style were used where it is an appropriate style? At all levels of government, the basic idea behind government is as a public function, and I think, in the area of public function, disagreement, opportunities for disagreement, and opportunities for sharing philosophy would be very different."

The speaker went on to say that, given the kinds of improved health outcomes for the public that we desire as public health organizations, we need to have good public processes that make people feel like they are part of what's going on and not victims of solutions that are imposed. "At all levels of government," he said, "there are many more opportunities for collaborative leadership, for the skills and capacities of collaborative leadership, than we recognize. But historically, the training we receive, the role models that are in front of us, the experience we get in our systems, whether they be federal, state or local, are ones that present zero-sum games to us constantly. These (experiences) drive us to, in many cases, styles of leadership which are less than collaborative and which don't seek to share what we have."

There were related comments from other panelists during the first half of our discussion that echoed this need for stronger public processes and collaborative skills that could assist any size of community or grouping of organizations and interests in being more successful in tackling challenges together. Additionally, there was broad agreement that much work has yet to be done to ensure that there is a greater integration and sharing of learning between the federal, state and local levels.

One panelist stated, "There's not an integrated, collaborative approach across those levels, and I think we're challenged to think about examples when that has worked well, or real opportunities and mechanisms where we could have that happen in a more usual kind of way. There's a real divide… and no wisdom shared across levels (i.e., federal, state and local)."

■ It is important to build relationships and continually nurture them.

A key theme that emerged during the first half of our discussion was that of the importance of building collaborative relationships and continually nurturing them.

One example was shared by a panelist, saying, "I think we're a lot more alike than we are different (referencing federal, state and local levels), in terms of the different ways collaboration is practiced. One of the things that I've heard talked about here and mentioned several times is the importance of relationships. Those relationships are really the foundation of anything that we hope to be able to achieve, and part of collaboration is trust, and that's an essential ingredient. You don't develop that in a one-shot deal. You can't go somewhere and say, 'I want to collaborate with you today.'… The best time to make a friend is before you need one. You can't really wait until you need something from somebody to go to them and say, 'Hey, I think you have something that I need in order to succeed.' "

Many more comments followed this and pointed towards the importance of proactively developing a web or network of interconnectedness and what those relationships allowed people and organizations to accomplish well beyond the initial collaboration. Often these relationships enabled people (and their organiza-

tions) to accomplish things their individual and organizational capacities or levels of influence couldn't.

One panelist offered, "You use your partnerships to help you move into different arenas and different strategies for accomplishing things. Whether you had the skill at the beginning or not, you knew where to go and (the) partner to help you get those skill sets."

Another panelist described being able to find a more credible voice through one of their partners, someone else who could "carry the water" for them. In this case, they were interested in establishing an alternative government structure to improve community health. The partner was a hospital and healthcare association with whom they had worked before. This relationship proved particularly meaningful because "They (members of the association) were the ones who took this issue forward to the key members of the joint rules committee in both Houses. They're the ones that went to the chairmen of those committees and said 'This is important to do and this is why.' And it was much more effective than if we'd gone there and said 'Hey, we want to do this.' "

▪ Collaboration is unpredictable.

A key theme that emerged multiple times throughout our conversation was the unpredictable nature of collaboration. As we heard in several panelists' examples and comments, one cannot always predict the specific outcomes of a change effort, or from where the resources, relationships or impetus for change will come. This rather trial-and-error, experientially-driven nature of collaboration and collaborative leadership is not often readily accepted by those leaders accustomed to controlling outcomes or those accustomed to working in a highly predictable environment.

Collaboration, by its very nature, tends toward disorder at times and a lack of central control by any one entity. Additionally, given the emergent nature and understanding of collaborative practices, there has been little research on how it works or where it works best.

Several panelists offered a number of examples that suggested how they and their organizations had benefited from collaboration and the practice of collaborative leadership. A few of these examples illustrate the heuristic nature of collaboration.

Minnesota Family Services Collaborative

A family services collaborative was designed conceptually to bring together different sectors that had to work with family and children services in order to reduce competitiveness among service providers and look for more creative ways of solving problems. Individual family service collaboratives, now spread throughout the state, are very different from one another.

A panelist stated that, "They really reflect whatever the local community needs, but out of that, we came to first identifying high-priority, difficult problems that were hard to deal with. And now, as things have moved along over several years, we're getting much more futuristic in terms of looking at what could happen here with the partnerships we've developed."

Anthrax Contamination

This example relates how the state of Virginia, an area impacted by anthrax attacks, was able to maintain public health funding in the midst of major state budget cutbacks. Our panelist related, "When our medical society and stakeholders saw how stretched thin we were in terms of responding to that (anthrax contamination), they came forward in op/ed pieces in the newspaper… and the

medical society actually made appropriate funding (in protecting public health agencies from budget cuts) their number one legislative priority this past year. It's that kind of success story I think that we need to be able to tell as a way to explain to people how and why collaboration works."

Tobacco Control Legislation

In another example, a county health department, several community non-profit organizations, other agencies, and some citizens came together over a two-year period to promote regulations that could restrict the locations where tobacco could be sold or used. Though the tobacco industry fought to defeat this community generated effort, the collaborating partners were successful in getting the county board to adopt the regulations restricting tobacco product sales.

As our panelist noted, "I think the ultimate lessons out of that were (that) the most effective processes are ones in which people begin to identify the resources that each can bring. They share the resources that each has. They understand where their interest in something overlaps. They discard the areas where there may be differences that could pull them apart. They decide to focus on something specific, and then they work over time toward this very specific outcome."

"It's another illustration," he added, "of how one doesn't necessarily know how things are going to go and what one learns through work with other people are the strengths and the skills that others can bring to a collaboration."

Other examples from this panel discussion and found in the full transcript include:

- A collaboration among health systems, health departments and research institutions to begin advocating for access to medical information that will help them in their work.
- How a large metro area's public health department saw their community of supporters (including faith-based, business and entertainment representatives) step forward to advocate for not cutting $4 million from the public health department's budget.
- Two compelling stories that describe what happens when youth are an integral part of important decision-making conversations.

▪ Engage the skeptics.

Panelists offered several pointers on how they'd been successful in engaging so-called "skeptics." The skeptics they described included individuals who were heads of organizations and groups of scientists steeped in research and evaluation.

- Get people involved in the process of collaboration in some small way. They must be able to experience how it works and see the benefits for themselves.
- Help people identify the common values that will drive the work long term and also provide the "glue" to be successful over time.
- Do the "under-the-radar" work of building relationships and the champions that will help move the work forward.
- Build the support and infrastructure that enables those with special skills or knowledge (e.g. scientists) to apply that skill as participants in a collaborative process toward improving community health outcomes.

- Understand what the "skeptic" cares about. Identify their interests and provide ways to show how the collaborative process is likely to ultimately support their interests as well. Be clear, however, that they (or anyone else) cannot divert the collaborative process to meet their own agendas. Help them see the negative consequences of trying to do so.

Panelists also recognized that one must not ignore the need to sometimes provide evidence to others that the collaborative process is a valuable one… There is an emerging body of evidence, in the fields of education and public safety for example, that suggest that there is value to collaboration and collaborative leadership. At times this academic literature is helpful in making the case for the value of a collaborative approach to problem solving.

As one panelist states, "I think we have a responsibility to produce this kind of data. I don't think it's impossible and that we should shrink from the challenge of being able to do some basic research and produce quantifiable data that this (collaborative leadership/ collaboration) does make a difference."

▪ Develop and integrate the skills of collaboration and collaborative leadership.

Later in the discussion panelists were asked "What must we do to raise a new generation of people with the kind of skills who will naturally be inclined to work more collaboratively?" Prior to discussing specific strategies, panelists stated that recent shifts toward collaboration were in large part due to foundation and government initiatives that have funded collaborative planning and implementation efforts. These efforts to reduce duplication of services and work toward systematic change have already helped seed the ground for collaborative leadership and action. One panelist suggested, for example, that if the National Institutes of Health would commit 5% of its budget to the science of collaboration (i.e. understanding the conditions under which it works and doesn't), we would soon know a lot more about it and quickly have a constituency that was both clear on the value of collaboration and inclined to practice it regularly.

Panelists also talked about how to incorporate collaborative leadership skill building into traditional accredited training programs.

The following is a summary of strategies that panelists described as they discussed ways for building skills and interests in collaboration and collaborative leadership. In the course of discussion it became clear that we also need to address non-traditional strategies for learning since many public health workers do not come from formal, institutional training settings.

- **Integrate leadership as core competency.** Make leadership training a part of traditional public health and other health related curricula. Storytelling and case studies, for example, can be used as methodologies that work well in teaching leadership.
- **Develop teaming skills.** Integrate teamwork instruction into training curricula. Corporate America has led the way in this direction as they've built interdisciplinary teams of scientists and engineers at the cutting edge of the genomic, proteomic and information revolutions.
- **Observe leaders.** Create environments where students can observe leaders, reflect on what they observe, and receive mentoring in their own leadership development.

- **Build new leadership paradigms.** Continue building a new paradigm of leadership that includes collaboration and collaborative leadership. We know that not every public health worker comes to us from an accredited training program. We need to develop a new mindset with new values and principles where we can, over time, both define and build the skill sets necessary to change the way we work. This will eventually create a collaborative leadership knowledge base that is part and parcel of the mainstream.
- **Practice.** Make opportunities available for students to work in the trenches with communities around real issues. This can bring home the lessons of what public health is about and how collaboration works.
- **Focus on community ownership.** Encourage people in your own public health organizations and training programs to practice collaborative leadership through working in groups on the problems to which they are closest. Help them find the opportunities for problem-solving that develop ownership of problems and their solutions.
- **"Incentivize" change.** Create incentives for effective problem solving. Give people opportunities to identify challenges that they can address (individually or as teams). Provide the support, infrastructure and other resources, including funds, that will encourage innovation and ownership.
- **Disseminate client/community-centric strategies.** Identify and disseminate strategies to close the gap in understanding between how we lead and learn from the top down and how we lead and learn from the bottom up. As one panelist stated, "How do we ensure that we are truly client-centered and that we're able to lead and create change alongside members of our communities and our constituencies?"

Panelists also addressed the issues associated with life-long learning, again recognizing that few public health professionals arrive through traditional or institutional channels and that given the pace of new knowledge creation, it is unrealistic to expect that our institutions and training venues will meet all the needs for professional development. A few tactics and strategies were identified.

Budgets. Build "learning" into your budgets over time. Plan for it. Build it into grant applications and look for ways to get training to your people. Trust that they can choose the right training to fit their professional need.

On-the-job training. Provide resources such as CD-roms and printed materials from public health organizations and agencies as well as mentoring and training by other public health professionals.

Measurements. "What gets measured gets done." Further promote the development of knowledge and practice of collaboration by ensuring that we assess how collaborative leadership is being done in federally funded programs. Include evaluation questions on every Request for Proposals (RFP) that make this type of assessment the norm. Also, consider building a tool specific to public health that aids people and organizations in measuring their capacity for and practice of collaboration and collaborative leadership.

Credentials and Certifications. Consider mandating credentialing and certification requirements for public health officials. This is a complex issue fraught with varieties of strong opinions and is currently under discussion among numerous public health institutions.

Curricula for Certification. Build a core curriculum that will help public health professionals know the basics of public health.

Standards and Practices dissemination. Identify standards and practices of a high performing health department and disseminate them. This could dovetail with the work currently being done by the CDC's Public Health Practice Program Office.

Community- focused learning. Create increased opportunities for MPH graduate students to do their academic study, research, and thesis work on emerging issues at the community level. Immerse them in communities and have their work be informed by the challenges they see and experience.

Core competencies. Make use of the core public health competencies articulated by the Council on Linkages in Public Health and build curriculum focused on building these competencies. These discussions are currently underway for accredited institutions.

What next?

How do we move forward the concepts and findings of the Turning Point Leadership Development National Excellence Collaborative so that they are integrated into public health practice and systems?

We closed our session by asking panelists and audience members how the work of collaborative leadership could best be moved forward. Described below are several of the suggestions given for broadening the use and application of collaborative leadership concepts and skills.

- Create new incentives for people to work more collaboratively. Influence funders to require evidence of collaboration or collaborative processes that will be employed in project/program proposals.
- Create a compelling vision of collaborative leadership and describe related vignettes. Offer case studies that show people what can be done when things go wrong, when resources dry up, or when unexpected challenges arise. Direct people to tools that help guide the process (e.g., MAPP & 360° evaluations on personal collaborative leadership).
- Help public health professionals understand that collaboration and collaborative leadership are a part of the job and that systems must support this. This can be done by promoting some of the many strategies discussed.
- Model the behavior and practice of collaboration and collaborative leadership. And tell the story of how it works.
- Address the issue of diversity within collaborations and in the practice of collaborative leadership. If we want to have a greater impact in the communities and among the constituencies we serve, we must more accurately reflect diverse voices and perspectives.
- Continue to promote the value of collaboration and the building of relationships locally. If our communities come to value public health and see their potential role in it, we may all benefit from broader investment and participation in improving the health in our communities.

Intriguing and unanswered questions

- Do leaders at the federal, state and local levels have the same understanding of or expectations for what collaborations and collaborative leadership should look like in practice? Is there agreement on the attitudes, behaviors and practices that collaborations and collaborative leaders hold in common in these different sectors?

- If collaboration occurs less naturally at the state and federal levels, is there a common framework that can give direction and focus to collaborations or skill sets that collaborative leaders can use to be more effective?
- How effective is a collaboration model at addressing issues of health disparity, and the racism that can be associated with health disparities? How is power truly shared in the context of these dramatic differences?

The study of collaboration and collaborative leadership is a new and exciting avenue for understanding how we can do the important work of public health through broader participation, investment, and creative thinking. It goes without saying that this summary is by no means the "be all and end all" of this conversation. Our panelists and audience members brought years of varied experiences to this discussion. I urge readers to take the time to review the full transcript of this dialogue to experience the nuances and insights of these public health leaders and this rich discussion. (See www.collaborativeleadership.org)

State and Local Reactor Panel Members

Darvin Ayre, facilitator

A consultant, facilitator, and trainer focusing his work in the areas of facilitative leadership, change processes, and community and organizational development. He has consulted and taught in a variety of private, public, and nonprofit environments throughout the U.S., Australia, New Zealand, Hong Kong, the Czech and Slovak Republics, Poland, Ukraine, South Africa, and the former Soviet Union.

Stephanie Bailey, M.D., M.S.H.S.A.

Acting Director for the Division of Public Health Practice at Meharry Medical College. She is a past president of NACCHO. Dr. Bailey also serves as Senior Consultant to the Public Health Practice and Program Office, CDC, for local public health practice. She previously worked at the Metro Nashville Public Health Department as Director of Health.

Mark Becker, Ph.D.

Dean of the University of Minnesota School of Public Health. He formerly served as Associate Dean for Academic Affairs and Professor of Biostatistics at the University of Michigan School of Public Health. Dr. Becker was elected a Fellow of the American Statistical Association in 1999. He has also been Principal Investigator on statistical methods research grants through the National Institutes of Health and the National Science Foundation.

Maria Campbell Casey, M.A., M.Ed.

Executive Director of the Partnership for the Public's Health, a collaborative venture of the California Endowment and the Public Health Institute. She is the past President of the Oakland-based Urban Strategies Council and former Director of the Community Building Support Center. Ms. Casey was a founding board member of the National Community Building Network, and currently serves on the boards of the Bay Area Mentoring Center and East Bay Perinatal Council.

Steve Frederick, M.P.A.

Team Leader of the Leadership and Management Development Program in the State and Community Services Branch of the Division of Public Health Systems Development and Research, in the Public Health Practice Program Office at the Centers for Disease Control and Prevention in Atlanta, Georgia. He also serves as the CDC Project Officer for the National Public Health Leadership Institute and the Management Academy for Public Health.

Denise Hase

Executive Director of the Northeast Colorado Health Department. She has served on the NACCHO Board of Directors as well as on NACCHO's Information Technology committee and Bioterrorism committee. Mrs. Hase is a founding member of the Colorado Association of Local Public Health Leaders. She has also served on the Colorado Turning Point Steering Committee.

Kathy Kennedy

Director of the Regional Institute for Health and Environmental Leadership in the Rocky Mountains. Dr. Kennedy is an Associate Clinical Professor of Preventive Medicine at the University of Colorado Health Sciences Center and a public health scientist who has conducted numerous studies in reproductive health. Her research has been concentrated in Mexico, Egypt, Pakistan, and the Philippines. Dr. Kennedy works as an advisor to the WHO Human Reproduction Programme in Geneva, Switzerland, and represents the National Public Health Leadership Development Network, an association of programs that do public health leadership training.

Lee Kingsbury

Minnesota Turning Point Project Coordinator. Ms. Kingsbury serves on the National Turning Point Leadership Collaborative and has worked in various capacities for state and local public health agencies for over 25 years. Currently, she supervises governance, policy development and planning activities in the Office of Public Health Practice at the Minnesota Department of Health.

Jeffrey L. Lake, M.S.

Associate Commissioner for Community Health Services for the Virginia Department of Health, and the statewide co-liaison for the Turning Point Initiative in Virginia. He is a member of the Advisory Board of the Management Academy for Public Health at the University of North Carolina – Chapel Hill, and is the current Chairman of the National Network of Public Health Institutes.

Robert M. Pestronk, M.P.H., candidate Dr.P.H.

Health Officer/Director of the Genesee County Health Department in Flint, Michigan, and member of the National Advisory Committee for the Turning Point Initiative. He is a past board member of NACCHO and past president of the Michigan Health Officers Association. Mr. Pestronk serves on the Board of the Greater Flint Health Coalition.

Harrison Spencer, M.D., M.P.H., D.T.M.&H.

President of the Association of Schools of Public Health. He is a former Dean at the London School of Hygiene and Tropical Medicine and at the Tulane School of Public Health and Tropical Medicine. Dr. Spencer has been elected a Fellow of the American College of Physicians and the American College of Preventive Medicine.

David P. Steffen, M.P.H., M.S.N., Dr.P.H.

Director of the National Public Health Leadership Institute at the University of North Carolina Chapel Hill. Previously served as the District Public Health Director for the State of New Mexico Public Health Division District III, encompassing the southwest quadrant of the state. He has worked as a family nurse practitioner and served in the Peace Corps in Morocco from 1977 to 1980.

Mary Wellik, B.S.N., M.P.H.

Director of Public Health in Olmsted County, Minnesota, and a member of Minnesota's Public Health Turning Point Initiative. She is also a member of the Minnesota Health Improvement Partnership, and was one of Minnesota's Tobacco Endowment Advisors. Ms. Wellik led the development of the Olmsted County Multicultural Healthcare Alliance and is currently co-chair of the Minnesota's Local Public Health Association Legislative Committee.

State and Local Reactor Panel

LEE KINGSBURY: I'm Lee Kingsbury, a member of the Leadership Development National Excellence Collaborative. I'd like to welcome you to a fabulous program. We're excited about what we're going to hear and learn this afternoon. I'd like to begin the meeting by asking the state and local reactor panel members to briefly introduce themselves.

STEVE FREDERICK: Thank you. I'm Steve Frederick. I'm with the Public Health Practice Program office at the Centers for Disease Control and Prevention in Atlanta, Georgia, and I'm responsible for all of our work with leadership and management development.

DAVID STEFFEN: Good afternoon, I'm David Steffen. I'm the Director of the National Public Health Leadership Institute at the University of North Carolina Chapel Hill. I've been doing that for about a year and half. And before that my background was as Regional Public Health Department Director in New Mexico, Southwest quadrant of New Mexico, bordering Arizona, so this is a bit of a homecoming for me.

KATHY KENNEDY: Hi, my name is Kathy Kennedy. I'm here today to represent the National Public Health Leadership Development Network, which is an association of programs that do public health leadership training. I also am the Director of the Regional Institute for Health and Environmental Leadership in the Rocky Mountains; that's Wyoming, Colorado, New Mexico, and Utah.

JEFF LAKE: Good afternoon. My name is Jeff Lake. I'm the Associate State Health Commissioner for the Commonwealth of Virginia, and I'm here today as the statewide co-liaison for our Turning Point Partnership in Virginia.

MARY WELLIK: Good afternoon. I'm Mary Wellik. I'm a Public Health Director for Olmsted County in Southeast Minnesota, and I'm a member of Minnesota's Public Health Turning Point Initiative.

STEPHANIE BAILEY: My name is Stephanie Bailey and I direct a team of public health professionals. I facilitate that team in Nashville, Tennessee; 565,000 people, and I'm very active in NACCHO and some other things.

HARRISON SPENCER: I'm Harrison Spencer. I'm the full-time President of the Association of Schools of Public Health. Before I started this position a year and a half ago, I was Dean at two schools for public health, the London School of Hygiene and Tropical Medicine, and before that the Tulane School of Public Health and Tropical Medicine.

DENISE HASE: Hello, I'm Denise Hase and I'm the Director of the Northeast Colorado Health Department. I also served on the Colorado Turning Point Steering Committee and I'm involved in a couple of other things.

MARK BECKER: Hi, my name is Mark Becker and I am the Dean of the School of Public Health at the University of Minnesota.

BOBBY PESTRONK: Bobby Pestronk, the Health Officer in Genesee County, Michigan, and member of the National Advisory Committee for the Turning Point Initiative.

MARIA CASEY: Good afternoon. Maria Casey, Executive Director of the Partnership for the Publics Health, which is a collaborative venture of the California Endowment and the Public Health Institute. I am also former Director of the National Community Building Support Center.

DARVIN AYRE: And my name is Darvin Ayre with Community Initiatives, and I'll be your moderator and facilitator this afternoon.

LEE KINGSBURY: Thank you, everyone. As you can see, we have convened a very rich panel of reactors for you this afternoon. And before we get started, I thought that I would talk a little bit about who we are and why we're here today. We're here clearly to talk about leadership and in particular the nature of collaborative leadership and the differences or similarities in how collaborative leadership gets played out at the different levels, local, state, and national levels.

I was thinking this morning as I woke up that it was going to be such a great afternoon because every single person in this room is a leader. And what we have heard from the experts over the last year or so is that the 80/20 rule applies to collaborative leadership: in about 80% of the situations in public health, our collaborative leadership skills operate those other things that we need to bring out of our "leadership toolbox" and I thought, this is going to be our opportunity to really learn and to take an afternoon to think about what are those skills, what are those styles, what are those approaches and how can we apply them to our work.

Just to give you a quick overview, the National Turning Point Program was conceived by Robert Wood Johnson and W. K. Kellogg foundations to really strengthen and transform public health for the 21st Century. Early experiences in the community and state partnerships led them to be interested in five overarching themes. They include performance management, information technology, social marketing, public health statute modernization or public health laws, and leadership development.

The leadership development collaborative was funded with a number of members, seven states, and we have three active national members, as well. The states include Colorado, Louisiana, Nebraska, Oklahoma, South Carolina, our lead and hard-working state of Virginia; the national folks are from ASTHO, the Association Of State and Territorial Health Officers; the NACCHO, National Association of City and County Health Officers; and the Centers for Disease Control and Prevention, and of course, the great State of Minnesota.

We've been working for the last couple of years asking ourselves a number of questions to try and deepen our understanding about leadership development, particularly in this growing, complex world that we're operating in. What is collaborative leadership? What are the skills that people need in order to be good collaborative leaders? Where do people gain these skills? Can you even train for these skills? What are the experts saying about what leaders today need and what are practitioners thinking and wanting? So we've commissioned a pretty extensive literature search and published that.

We convened just a year ago national key leaders to talk about the questions that I just mentioned. That was an incredibly rich experience for us, a very powerful learning experience. Out of that and some assessment surveys that we've done with folks in our seven states, we are about to embark on translating some of what we've been learning into training tools.

What we want to do today is to imagine what the leadership needs are. And leadership, and particularly collaborative leadership, is a fairly abstract concept and clearly we've struggled with that. The national program office staff provided us with some work by Crislip and Larson that we really gravitated to. They said

that if you bring the appropriate people together in constructive ways, and you provide them with good information, they will create authentic visions and strategies for adjusting the shared concerns of the organizations in which they work or the communities in which they live.

They went on to define collaborative leadership. A collaborative leader is one who engages others by working together, convening appropriate stakeholders, and facilitating and sustaining their interactions. So we've been doing a lot of thinking, talking, listening over the last couple of years and one of the questions that keeps coming up is, so what's the difference? Is there a difference between the kind of leadership development that we're familiar with and collaborative leadership?

So I have put together a handout quickly this week to try and lay out some of the things that we have been struggling with and thinking about this leadership development toolbox and what are those skills and competencies that we're talking about and how do they differ from what we've traditionally thought about as leadership development. So very quickly, you can see there are a couple of columns here for general leaders. We often operate in top-down structures, vertical, horizontal, or hierarchical relationships of influence. In collaborative leadership, what we've been contrasting that top-down structure with is horizontal power sharing, self-governing groups, trusting, learning to trust that the group is going to make the best possible decisions. We tend to think or practice in a world where decisions get made by a few people versus broad participation in decision-making, the ability to maximize the talents and resources to bring out the best in other folks. We think we need the ability to take some unilateral action at times to get things done, rather than thinking about the ability to guide and coordinate the decision making processes, putting others' needs first and above the needs and interests that we have and to be able to gracefully change direction when that's needed.

We've seen in more general leadership or thought about it in the past, it's sort of the old world, new world. We've had some articles that focus on winning or shifting the balance of power versus focusing on building relationships, and we heard from practitioners across the country, that what collaborative leadership is about is building relationships and that trust, the ability to establish trust and have trust in others and take the time. It's very inefficient in the beginning to take the time to establish that trust.

I'm not going to go through all of these because I want to get to our leaders, but you can see where we're going with this thinking. I just want to mention the difference between charismatic and visionary. Visionary or vision and shared visions were words that people used in our interviews, that a collaborative leader is one who has that skill to develop a shared vision that moves people beyond their current thinking and their current practice. They described it as clarity of purpose and a commitment, almost a passionate commitment that transcends the self.

So just to begin to get you thinking about where we've been moving (not that these are you do this or you do that), these are skills that we use depending on what the situations are. We've been struggling with what are the set of skills that are needed and I've put them into hard skills and soft skills or soft capacities because there are the traditional managing conflict productively, alternative decision making, communication skills, particularly non-traditional ways of communicating and discovery of shared meaning between people, systems thinking, those kinds of things. But also we've heard from people about the soft kinds of capacities: maturity, personal maturity. Some people have even said, "you know, you've got to be over 40." I liked that one. Balance. Humor. People described these leaders as leading with heart, having ego control, a strong sense

of ethics, and self-knowledge, the ability to reflect.

So we've also heard some things about what kinds of training strategies could be used to develop this kind of leadership, and the literature has told us that some of the best training programs utilize several different forms: action and experience, reflection, coaching and mentoring, and conceptual understanding. They use some combination of those kinds of things.

A year ago we convened an expert panel and it was an incredibly powerful experience for those of us that were participating in that and listening to it, but afterwards we thought, it isn't enough to just look at and talk about defining collaborative leadership and the skills of collaborative leadership. We need to know more about how those things get played out and practiced at state, local and federal levels. So I expect that we're going to have as rich an experience today, and let's begin. I'll turn it over to Darvin.

DARVIN AYRE: Great. Thank you, Lee, for that introduction. Again, my name is Darvin Ayre and I hail from Boulder, Colorado. And it was really refreshing to come here and realize that there are a lot of other Coloradoans here, but also that it's a lot warmer here because this time of year in Colorado, we're as likely to have snow as anything else on a spring day. But what I'd like to do is just frame today's conversation a little bit, talk about a couple of our objectives, frame the questions themselves, but also talk about the structure of our interaction today as well. And starting with that, what I'd just like to acknowledge is that we're going to take some time with welcome and introductions. We're going to go over the objectives and agenda and structure and then our framework for today is really to offer an opportunity for our panelists who have traveled from far and wide, and near probably in some cases, to comment on some of these questions that we frame, some of which are based on last year's conversation, some of which are new. And then from that, also invite the audience to participate in this conversation. And we're hoping that by three hours from now we'll be able to find a strength of interaction between the two, between the audience and the panelists.

Let me go through those real quickly. We're going to spend about an hour and a half on the first couple of questions, and those questions are: How is collaborative leadership practiced at the federal, state, and local levels? Is the skill set the same? Are there differences and if so, what are those differences? The second part of that framework would be: How is the practice of collaborative leadership approached in the individuals and the organizations present? That's all of you here as panelists, but I'm sure there's going to be opportunities for you as audience members to lend your two cents as well.

We'll take a break somewhere about an hour and a half into today's conversation. We'll probably take about a 10 or 15 minute break and then we'll come back and get into the next piece, which would be: How can leadership and collaborative leadership be incorporated in traditional accredited training programs, whether those are leadership development institutes like David runs or, say, schools of public health in order to be integrated into an organization's culture at local, state and federal level?

After that, we'll also take some time, probably not as much time but about a half hour, to ask the final question, which is: What are the best approaches to moving the context of the collaborative's work into circulation and acceptance? Now that we have this kind of content, that we're developing this content as a group, as a collaborative, what do we do with it? It's a "so what" and "now what" kind of a question. And we'll also then close with an evaluation.

Now, before we jump into this, I want to talk a little bit more about the structure. We've had people traveling from far and wide and we want to make sure that everybody has a chance to talk today, so I'm going to ask us to keep our comments really targeted to the questions. We're not going to create an artificial structure where audience members cannot talk. We want you to be able to say – if there's something really pressing, whether it's a question of clarification or incisive question that you think will help bump up the conversation, I would ask you to stand and we have somebody that can run a traveling mike around and have you ask that question. Fair enough? Okay.

Now before we get started, I was really intrigued by Lee's page here. I was telling her, you know, people are going to think I paid you to hand this out and –

LEE KINGSBURY: You can still do that.

DARVIN AYRE: I can still do that – thank you very much. But I want to tell you a story, because I am finding the whole distinction between leadership and collaborative leadership to be somewhat artificial, and I think many of us do. My story goes like this. I have had the pleasure of doing change work and particularly work with groups of leaders and teams in companies of all sizes, but also communities of all sizes. I've had the great opportunity to work with Healthy Community's initiatives over the last 10 to 12 years all around the U.S. And I had this great experience of working in a small South Carolina community for about four years, and I first went there in '96.

And just to give you a little bit of background here, this was a community that was about 55 percent African-American and about 45 percent white. This community is made up of several smaller communities, about two or three or four thousand, each of these communities, and wonderful people but also faced with some big issues: industries that were fading. The timber industry wasn't as strong as usual, it goes through cycles. There were other industries that were coming and going in the community. There are issues around education and where there were fair and equitable distribution of resources. There are lots of issues that any small rural community might be faced with anywhere in the U.S.

And over a period of nine months, we convened this community with about three or four hundred people being represented – representing, about 18 thousand people around the county, so it was a pretty good turnout. And we would go through a facilitative process that I helped them design and would have these conversations around where are we now, where do we want to go, what are the pressing issues, and in the final session – this was about the fifth session – there were about three hundred people in the room. We were getting to the point where we were trying to identify the key issues that we want to move forward as a community. We were using the collaborative leadership model where everybody could participate. It wasn't restricted. There was the standard conversation around education disparity and there was the conversation around economic development and what are we going to do, because this is a depressed area economically.

And about 30 minutes into the conversation, a young African-American woman stood up, about 15 years old, she went to a local high school, and I'll never forget the moment. She just looked around the room and she said, "You know what? Yes, it's important that there are problems in our education system that must be addressed, and yes, at the root of it is economic development. But I just have to say that part of the reason that this community doesn't function as well as it could is because as blacks and whites, we don't work together. We don't talk together. We don't worship together. There are a lot of things we don't do together."

You could have heard a pin drop in that room. You could have heard a pin drop. It was dead silent for about two minutes and then a middle-aged fellow, an attorney in town, got up and said, he said, "You know what? This is the first time in my 40 years in this community that somebody's had the gumption and the honesty to say just what is really going on in our community."

And as a result of that conversation, that community has gone on to build several different strategies and opportunities for people of different backgrounds, races, economic backgrounds, whatever it is, to come together and have conversations around what's important to them as a community.

Now, I bring this up to recognize that collaboration is that opportunity for new voices and new faces to participate in decision making in our communities, or in our organizations for that matter. And so yes, I do think our distinction around leadership and collaborative leadership is a false one, if you will. They work hand-in-hand to get the job done whatever that job might be.

Let's jump into our conversation today, and the first question being: How is collaborative leadership practiced at the federal, state, and local levels? Is the skill set the same across all those three levels? Maybe yes, maybe no, and if it is different, how is it different? And I'd like to open that question up to our panelists. Anybody ready to jump in?

STEPHANIE BAILEY: I'll start. I think over the last two to three years, there may have been an increasing urge to do more collaborative leadership, to be more collaborative at the federal level, but if you would ask me directly is there – there is not at the federal level. It is increasing at the state level, and it's been practiced for a long time at the local level. And the difference – I think the principles are the same. It's like if you have principles in anything, the principles are the same, meaning that the skill sets of collaboration are the same. You need to be able to practice it at the federal level, not only horizontally, but vertically. At the state level, not only horizontally, but vertically, and at the local level the same way. So the skill sets are not different, but I think there's a long way to go for it to be universally practiced, you know, at those levels.

DENISE HASE: I'll just jump in real quickly; just add to what Stephanie said. I think some of the reason that federal – there's a difference in the federal has to do with the fact of accountability. And I come from a rural part of Colorado, and so when I tell somebody at a community meeting that I am going to do thus and such, there is a darn good chance I'm going to run into them at the grocery store and probably our kids go to school together and a number of other things, and so you end up being real accountable to the people that you run with. And I have, in my work in public health, have had some wonderful federal partners who go above and beyond the call of duty, but I know there are some that don't necessarily feel the accountability, because you aren't going to run into them necessarily again and they can tell you they're going to do something, but there really isn't that interaction on a frequent enough basis to really develop that trust and relationship to feel like they're going to be accountable later on for what they do.

STEPHANIE BAILEY: In this day of bioterrorism, I have witnessed Congress begin to cause the federal level to talk more across departmental lines. When I did have the opportunity to testify for the Senate subcommittee, the Chair of the Committee would ask, "Well, Department of Justice, Department of Defense, Department of Health, are you all not talking together?" So there are forces that are causing collaboration; but, I think it'll take a longer time before it will become a natural thing at the level of the federal government.

MARY WELLIK: I'd make some comments about just the humanness of dealing with things on a collaborative level. I think we have the benefit in the local com-

munity of dealing with the people who experience gaps in health care or have other kinds of problems that we can put our resources together to respond to and so they're always there for us to see what happened and they're always there to ask us why things aren't working well. So if we keep the stratified level of leadership, it's pretty evident to those of us that are in leadership positions that we're not delivering in a way that is most effective. Whereas, if we're working with people in our communities, we can all feel the difference. We can sense that it's really building our community together.

MARK BECKER: Yes, I am not sure that collaborative leadership will ever be natural at the federal level. I think the issue that we're touching on is the extent to which you are connected to your stakeholders, and at the federal level it is very difficult to be connected to your stakeholders. The closer stakeholders are to one another, the tighter the connections and the more natural it is to be collaborative, to be connected in leadership. I believe it is extraordinarily difficult to sustain collaborative leadership when doing so requires crossing great geographic boundaries or bridging organizations with major cultural differences.

STEPHANIE BAILEY: I think the point I want to make is that to get at the issues that are really plaguing society today requires that you be collaborative. I mean it's just a strategy that you have to use in order to get it, whether it's health equity, disparities or whatever you want to call it, and the dollars that come down to help influence or make the difference in communities. You're not going to do it in silos and with the way you have it stratified by levels. You're not going to get at the issues that are plaguing society if we don't come together and be more efficient in our communication and in our efforts and usage of our dollars.

MARIA CASEY: I agree that it may be more difficult at the federal level, but I think that the principles still apply at the federal level. I support what you're saying, Stephanie, but certainly if you're going to engage in systems thinking, if you're going to be broader in terms of your picture of where public health needs to go, then it calls for a different kind of a leader, the kind of leader that I don't see very much of at the federal level and often this kind of leadership is not at the state level either. I have to say that coming from a context where we're working in 39 different partnerships and 14 health jurisdictions throughout California, we're really putting these concepts to the test, if you will. I think we have any number of leaders from diverse sectors in the community as well as government who would call themselves collaborative leaders, but boy are they finding out what that's all about. They are listening in ways that they've never had to listen before. The issues of respect and trust are not things that you build in a classroom situation. It happens when you're interacting with people on a day-to-day basis. Testing the consistency, testing focus, community folks aim high. They're asking their government partners to get there with them, to be where they are in terms of the things that matter to them. There is no panacea. There is no one person. We all know there is no silver bullet approach. And so collaboration is really hard. I actually had a lot of fun thinking about this and thinking about how much of a collaborative leader I am. And I will say that I'm trying to live it inside of my organization as well as outside with my various partners in the community, and it is hard. The decision-making process is hard. It is hard to be inclusive. It is hard to support participation. It is difficult resource-wise and time-wise to foster the kind of development that all individuals need. It is very difficult to step outside of being one collaborative leader and recognize that you need multiple centers of leadership. You can't do it alone. Collaborative leaders, as good as they may be, who get up there and do it alone burn out. And they leave huge gaping holes when they leave, by the way, that are very difficult to fill. So a really important part of being a collaborative leader is bringing along other leaders. It's called renewable leadership. You've got to be in the process of constantly developing,

constantly bringing along new leaders as you move through the years that it will take to do what it is that you're trying to do.

STEVE FREDERICK: Stephanie, thank you for getting us started off on such an –

STEPHANIE BAILEY: My pleasure.

STEVE FREDERICK: – energizing note. I think I agree with your basic premise, that the federal government doesn't do as good a job as possible at collaborating, particularly down to the community level. However, I think we do a decent job of partnering, and maybe there is a fundamental difference or maybe there isn't between partnership and collaboration. We talked a little bit about that in our meeting this morning.

I know in the public health practice program office all of our work is done in partnership with others. We work with schools of public health. We work with the professional associations. We work with private foundations. Virtually everything we do in our division and in public health practice is done with others, whether it's the development of performance standards, whether it's the leadership development work, we work episodically, and we work on developing long-term relationships. However, I think where we fail is to get down to the community level and work with people that are at the grass roots level. That's where we need to do a better job.

HARRISON SPENCER: You know there are certain examples of leadership where collaboration doesn't work as well as in other situations. An example might be a military campaign. But in the long run, there are very few instances where, in fact, building a consensus doesn't result in a much more effective program. Issues such as accountability and the fact that achieving consensus is more difficult are reasons, I think, why people don't practice collaborative leadership as much as they could. Sometimes you have to be forced into it, and then the accountability means that you realize that this is the most effective way to achieve the goals that you are looking for. Since the purpose of a panel is to get some debate going, I would maintain that a partnership can be very different from collaboration. Often the federal government has funding, and that, in my opinion, sets a different power base in terms of how collaboration actually occurs. It is my belief that in those sorts of situations sometimes it's even more difficult to have a true collaboration – in other words, where there's an unequal sense of power, whether it's financial or any other way, those that have the power, however you're defining that, have to work a lot harder to build consensus.

STEPHANIE BAILEY: I just had a follow-up comment to something you said. I don't think collaborative leadership is the one way to do or accomplish everything. If you embrace the essential services and you break down the essential services of public health practice and you look at the collective competencies that are needed to either mobilize, prevent, investigate, monitor or link or research, any of those broken down to an array of competencies will require any degree of a trust, of any of the things we're talking about under the guides of collaborative leadership. At some point, I will have to be a dictator when it comes to epidemics. In order to monitor, I will have to exert some other skill set. However, when I'm talking about mobilizing the community, to identify the problems; and/or to solve them; or linking at-risk persons to services; accessing quality services; or doing research (any of the essential services); you are talking about, at any given time, different styles of leadership. And this particular one, collaborative leadership, has a lot of potential of moving us in a different direction to affect change in our communities.

BOBBY PESTRONK: The question encourages artificial distinctions and reinforces stereotypes that many of us carry. To say that the federal government operates

one particular way, to say that the state governments operate a particular way, to say the local governments operate a particular way is like saying all African-Americans act this way, or all European-Americans function that way. The more interesting questions to ask are: Are there opportunities for collaborative leadership to be practiced at all levels of government? How might outcomes be different if, in fact, collaborative leadership styles were used at appropriate times? Government is meant to be a public process. Public processes at all levels of government are ripe for disagreement: in principle, perspective, and philosophy. In the case of governmental public health organizations, the outcome we seek is a healthier public. The means to achieve that outcome are varied and controversial; differences in opinion are vast. Good public outcomes, ones that will last for a period of time, require a good public process. People must feel that they are part of what's going on; that a resolution is not being imposed upon them. At all levels of government there are many more opportunities for collaborative leadership, for the use of collaborative leadership, for the skills and capacities of collaborative leadership than we recognize. But historically the training we receive, the role models that are in front of us, the experience that we get in our systems, whether they are federal, state or local, are constantly ones that present zero-sum games. This game encourages us to be less than collaborative. We don't seek to share what we have. We seek to receive more for ourselves than for other organizations.

DARVIN AYRE: I would like to interject just a second here. While we get Pam's question for the panelists, if I could ask you to think a little bit about collaborative efforts at the federal or state level, because I – at least so far, we've heard mostly that it's happening more at a local level or maybe the conditions are riper for it because you are closer to your stakeholder, but if you could cite specific examples of change efforts at the federal or state level you think are successful in their collaborative model or the way they've gone about that work, it would be great to hear those stories. Pam?

PAM GILLAM: Dr. Bailey, I just want to go back to your point about yes, there are different types of leadership, and they have to be used in different situations. But would you agree – and I think Bobby kind of hit on this a little bit – wouldn't you agree in a situation in terms of, for instance, emergency preparedness that decisions can be made as a collaborative and then when it's your – when you come up as dictator and have to make a decision, you can make decisions based on what that collaborative, in terms of emergency preparedness, for example, how to handle those situations as dictator?

STEPHANIE BAILEY: I do agree with that. The basic premise of that as far as the domestic preparedness is founded in community planning and getting together with OEM and getting together with police and getting together with EMS and making sure we know who's on first and what's on second, when it comes to biological, chemical, nuclear or disasters in general and learn the incident command system. So once you have that established then yes, you can. You know your role. Everyone respects and knows your role, so this has caused different kinds of opportunities in collaborative leadership that is more beneficial to the communities out there. So yes, I agree.

DARVIN AYRE: I just want to open up to other panelists as well, because we've heard from about five or six people. Are there other thoughts, other comments about this question around differences or similarities amongst the federal, state, and local levels? Kathy?

KATHY KENNEDY: You all know my opinions because I was here a year ago with you. I had the privilege of talking to you then, so in preparation for coming here, I knew that I shouldn't just tell you my views again. So I contacted people in our national network for public health leadership development, our immediate past

Chair, our new Chair who just changed office about five days ago, and also about 15 people who work on this federal level, the state level, and the local level, and they gave me an abundance of information. I have eight pages of quotes and some of them are pretty insightful, if you ever want quotes from these people. But one in particular, a fellow who works on the federal level says that skills in collaborative leadership need to be stronger on the federal level because of a consistently higher degree of skepticism shown by the public toward the feds compared with state and locals.

And then another related comment, because of politics, it's very easy for collaborative processes to be dismissed as forums for special interests. So this is a good thing to ask these people those kinds of questions. I think it's very insightful that it may be harder to be collaborative in some cases on a federal level than on a state and the local level. Conversely, I heard almost unanimously from folks who work on the local level that: Is there another way to operate? I mean, this is all, perhaps because they're the most resource-strapped of all.

And I also want to echo Bobby's comments that actually maybe we're asking the wrong question, because how is collaborative leadership practiced on these various levels and is it different? Unanimously, folks told me collaborative leadership is collaborative leadership. The skill set is the same. The question is: How is it practiced? It varies. And so the question would be: It varies with what? How does it vary? What are the circumstances that make it work in one circumstance or another versus another? And here's a conglomerate of their responses. It varies according to institutional memory, so what people have seen and what they're used to is something that is modeled for them and what people practice and also to the extent that it's modeled by the person at the very top. If collaboration is practiced at the very top, then other people often fall into line that way. It varies according to the will, skill, and energy of the individual person and also by circumstances.

FEMALE: I'll just jump in real quick with a very timely example of the federal government making huge effort at being collaborative, and the jury's out right now on if it's successful, so I can't tell you if it's going to have worked or not, but the whole supplemental funding for bioterrorism preparedness, there was – the words collaborative were in all of that RFP document many, many times and they had to show meaningful collaboration between the state and the local, and that's why I say the jury's out, because I only know my state and there was even differences of opinion on whether that was meaningful or not. But it is a very timely one that the federal government realized it was important and put it in writing of tell us, states, how you're collaborating with the local, so.

STEPHANIE BAILEY: And let me just say, CDC had played a big role in that, and I think you've seen over the last years CDC becoming very much collaborative oriented, and I can't say enough. PHPPO has taken the leadership in that. NACCHO and ASTHO, the collaboration between the states and the locals, particularly in the organizational piece, created the principles of collaboration and that has been approved by both the board of ASTHO and the board of NACCHO and used in many states so that states can collaborate with some equity with their local partners. So there are those kinds of efforts that are out there and are working very, very well.

MARY WELLIK: I'd just like to comment that I think that that's really one of our great opportunities, that at the federal, state and local level as our Turning Point leadership collaborative has worked on this issue, it's been evident that a lot of the collaborative leadership occurs at the local level, but the resources to develop that and the framework within which we can deliver programs and services and do things that will have some sustainability really is dependent on whether states and the federal government help us to do that with the resources that come to

local communities and how it comes and what the expectation is. So I really think we should be looking at the long-term outcome. As Bobby had said, what do we want to achieve here and how do we partner together to make that happen? And maybe we partner together to make it possible for local leaders, whether they're governmental or community leaders, to be able to do those things in places where that's most appropriate, but get that sustainability in place as well.

JIM DALE: Jim Dale, Jefferson County. The discussion about collaborative leadership makes me think about three issues, and those issues are perception, situations, and complexity. And within the perception, the issue would be, to me – "Perception equals reality," to quote Vince Gabello, and perception can be based on emotion or politics or rational, and public health people try to be rational. So that's one issue as we deal with, leadership. The other thing is situation, and a friend of mine worked for a two-star general named Dothel (spelling), Fred Dothel, the DOT kit fame, and General Dothel, Dr. Dothel said, "Where you are is where you sit." And having sit at the local level and the inspection level and at the policy level, your perceptions are a lot different.

And lastly, on complexity, the Santa Fe group talked about complexity being the interface of chaos and order and that's where things happen, and I think that you almost have to have a crisis develop (bioterrorism) to make something happen. You almost have to drive crisis to get change. So I think that situational leadership is the key. And as I look down this list I say, oh, I sit in the middle a lot of times, after I try to create trust and credibility, so ask comments on that.

DAVID STEFFEN: Just a couple comments on the federal or multilevel approach. A couple of phrases come into my mind when listening to this dialogue – six degrees of separation, and also the other, Tip O'Neil's comment, "All politics are local," and, likewise, all public health is local, and I think both of those statements talk about the relationship piece and how difficult – I think someone mentioned also this – distance can be. And really, leadership is about those relationships, about the meaning that gets developed in looking at people, concepts, and things in relationship to each other.

[End Side A, Tape 1; Begin Side B]

From my experience as a local health director working on border health issues in the US-Mexico region, it was very valuable for us to have federal health officials from CDC, HRSA and EPA come to the border so they could learn about us and our situation and we could learn about them and develop a positive relationship. It was a good example of people coming together. And, we made a lot of trips from the border to Washington, but there were also some local examples of HRSA under Claude Fox, Joe Baldi establishing a unified HRSA border working group. We talk about the horizontal integration of multiple levels of federal agencies that have a relationship to the border and at least doing that coordination internal to, for example, HRSA, in coming down and at least having one central point to discuss issues has been very valuable.

On the flip side of that, there has to have been – has to be some accountability managed by the local folks, and the establishment of the Border Health Commission across the 2,000-mile U.S./Mexico border has convened a central point from which those border states can relate with the federal government. And so when in some ways you make it simpler. It's not so much that people don't want to do that, but sometimes all that separation, all those people, all that complexity is difficult. If you can find points where people can kind of focus and come together and point and work together that helps.

One other comment I just have to make is about public health leadership being about values, very value-based, and sometimes somewhat different than other

values. We talk about the collaboration piece and in many ways a lot of the model that we have in this country is very much individualistic, competition-based. But I think as you talk about collaborative leadership from a Turning Point perspective, you have to talk about values. You have to talk about the difference in values. You have to talk about where you are coming from. That's part of that personal relationship development, too. For example, I really think that public health collaborative leadership grows out of the values of public health in terms of community is client, valuing primary prevention, social justice as the philosophy of public health and defining that in some sense, oftentimes defined as an equal floor of minimum opportunity from which to achieve one's dreams. But I think we need to do those sorts of things in terms of making those values clear because they're oftentimes somewhat different from folks – other folks. And then at some point, even while we have different values, I think where we come together in a collaborative process is around issues where everybody can agree there's an ethical or a moral reason to change. Where there is that urgency to change things.

Another thing I just want to talk to, also related to values are certain points in the Turning Point documents that talked about justifying things from a cost-effectiveness basis. We have to make sure this cost-benefit analysis is done and thereby show that collaborative leadership makes sense because through it we can get efficient health outcomes and, therefore, it's justified from an economic basis. However, you don't have to do that all the time. Sometimes you do something just because it's right. It's just ethical. It's the way you do things in a civic democracy. It's the way you do things from a public health perspective, and it doesn't have to be cost effective. So I just want to also mention to people that don't always feel you have to justify things on that cost benefit, cost-effectiveness basis. Sometimes that's really a tautology that you don't want to get into.

JEFF LAKE: It takes a lot more lead time to initiate projects in the public sector than in the community. The challenge is that because political leadership changes every four years or every six years, it's difficult to be able to sustain these initiatives. Don't get me wrong – our elected officials and our top leaders in our organizations are absolutely essential to promote these kinds of efforts. It's just that there's a lot more continuity in a community and the community may tire from dealing with new leaders every couple of years. So it seems to me that one of the things that we need to do is to work at stabilizing leadership. There's a certain amount of turnover that's going to occur just because of the nature of our elected officials, but we need to cultivate, the level below our elected officials and really focus on that layer of our organizations because that's where the institutional memory really resides. And it doesn't matter where you work, local, state or federal, that continuity and understanding and sort of buy-in from the folks who are going to be here yesterday, today and tomorrow, I think is really an important ingredient. And I think Bobby, you're right. It sets up some artificial distinctions. I think we're a lot more alike than we are different in terms of the different levels at which collaboration is practiced, and one of the things that I've heard talked about here and mentioned several times is the importance of relationships. Those relationships are really the foundation of anything that we hope to be able to achieve, and part of collaboration is trust, and that's an essential ingredient. You don't develop that in a one-shot deal. You can't go somewhere and say, "I want to collaborate with you today." You really need to look for those natural opportunities that we all have in our daily lives, to think about how what we're working on in terms of community health improvement, how another person can relate to that or another sector, and oftentimes we overlook potential partners. And as I'm frequently known to say, the best time to make a friend is before you need one. You really can't wait until you need something from somebody to go to them and say, "Hey, I think you have something that I need in order to succeed." That's got

to come naturally, it's got to be developed over time, and that's why I think the level below our elected and appointed officials is key, but it's really important to look at that layer into the organization that's going to be around.

STEPHANIE BAILEY: And Jeff, to even take it down further, the ones who we're training – our opening speaker mentioned greater than 40, but when I look at Pam and Jeff and I see younger – to be potential leaders is changing the entire culture and the way we do things altogether. So Pam and Jeff, go for it.

DARVIN AYRE: Mark, I'd like just to interject something here because you reminded of some commentary that I was reading from last year's session, which acknowledges this challenge of we normally think of leadership as being something that's leading downward. I think there was a conversation last year, although I wasn't present for that conversation, about how do we lead upward. And if I think about that layer that you're referencing, I do think leadership does come from below and it can, but have you seen instances of where that's happened and if not – or how does that happen effectively? Have you experienced it yourselves? Have you been able to impact those above in roles of leadership around collaboration or being more collaborative?

MARK BECKER: Well, yes, and to echo something that Jeff has said, it really comes down to something very simple: "just showing up." If the time when the collaboration is going to be built is when you must work together, meaning you do not have a prior history of working together, leading collaboratively is going to be extraordinarily difficult. If you have not shown up for prior meetings or events with "those people," whoever "they" are, when you have had that opportunity, and clearly we're all busy, then you have missed the all-important opportunity to establish the trust that is so essential to successful collaboration. Each of us has many stakeholders. We can't be at everything all the time, but to establish the basis for collaboration you have to just show up when the opportunity presents itself. You have to make a point of going to some meetings even when you do not have a specific goal or objective in mind for that particular meeting. Because when the time comes that your stakeholders need you, or you need them, the relationship and the trust need to be in place. You already have to have the credibility with one another. Your collaborators have to know who you are and they need to know that if you say you're going to do something you'll do it. Simply put, you just need to show up. That gets you, I believe, 80 to 90 percent of the way there in being able to collaborate effectively.

STEVE FREDERICK: Yeah, I think another aspect of the effective collaboration – and I think collaboration's very similar to building effective teams; there are certain characteristics of effective teams and effective collaborations and they're similar – is to make sure you not only have a diverse group of folks represented at the table, but that you have diversity of ideas and thoughts. So many times in our collaborations we see the usual cast of suspects around the room, and I think it's important that we really seek out those who have opinions that differ from those that we hold. That's an area where we do have a job.

DARVIN AYRE: And maybe going back to that notion that Maria brought up about renewable leadership, how do we make sure that we're always investing in renewing? Kathy, you had a comment.

KATHY KENNEDY: I wanted to agree entirely with Mark about the importance of showing up and doing what you say you will do, but I actually think that Jeff's point is even stronger, which is not just showing up, but creating an excuse, creating an occasion, creating a relationship, not just reacting when you're invited or when you need to show up. The analogy is of any kind of a web, a network being interconnected. The more connections there are the stronger that net would be.

If there are just a couple of relationships, it's not anywhere near as strong; but being proactive, as Jeff was saying, to create those opportunities is leadership.

DARVIN AYRE: So I hear us talking about the power of social capital, those levels of relationships and webs that are formed and we often don't recognize what they can do to support us at some future date, but they're there if we consciously build them.

JEFF LAKE: I guess one of the things that I'd like to follow up on, a comment that David made earlier is that it's true that we all have to be cognizant of what our values are and hold true to those in terms of being credible which is part of one of the underpinnings of being a collaborative leader. But one of the things that I think is missing from the dialogue and from the perception is how others see us. We don't typically – we're really good at sort of describing how we see ourselves and what our value set is. We're really good at how we perceive somebody else. What we're not really very competent is understanding how other people see themselves and understanding how other people see us. And in terms of being an effective collaborative leader, all four pieces of that puzzle have to be present in order to really fully understand what – where different folks are coming from in the way that we approach and listen for what the issue really is. We may think we know what the solution is, but again, as I'm one to say, we have two ears and one mouth and it behooves us to use them proportionately.

HARRISON SPENCER: One can reflect on how to convince people that this is a very positive way to approach leadership. If you've ever been involved in a collaborative approach, you know that it's a lot harder but that in fact at the end of the day it really works, and it may be the only approach that is sustainable in the long run. The complexity of public health problems requires collaboration to even begin to solve them. No matter how one feels about collaborative leadership, the fact is how can you even begin to remotely approach solving complex public health issues without having the stakeholders and the diverse groups involved sitting around the table. I don't think people really understand the power of the approach until they try it. The importance of the input from diverse groups in dealing with the complex public health problems we face is so obvious, it makes little sense not to try and build consensus.

BOBBY PESTRONK: Our public –

BOBBY PESTRONK: Our formal public systems for dealing with complex problems are basically non-collaborative. A most basic American right is the right to vote. And yet, that process itself is non-collaborative. The advocacy process for convincing people that they ought to take a certain view, or ought to vote a certain way, is not typically designed as a collaborative process. It's a process of controversy.

One of the things that we might do over time is to identify collaborative styles that could be used in place of some of the non-collaborative ones we now use. We could demonstrate in situations of controversy, as well as in situations where there is likely to be more time to deal with something in a more collaborative way, whether there are other styles, other public forms of decision making, that could involve large groups of people more effectively and collaboratively in decision making. Darvin gave us an illustration at the beginning of the session about a community of eighteen thousand. That's a small town, the size of the largest American cities in 1714. My county in 2002 is a community of 430,000 people. What collaborative style works in a community that large? What about a community of one million or ten million people? Do we have those styles? Do we have formal collaborative processes to use?

STEPHANIE BAILEY: And I would take that just a bit further. The processes and the styles that would allow the kind of collaboration within levels is not as well integrated. I think we're really challenged to think about examples where between levels has worked well, or real opportunities and mechanisms that we could have that happen in a more usual kind of way. There's a real divide. The wisdom that's happening at the local level doesn't really reach, I think, or connect with the collaborative approach at the federal level in a way that's helpful to us all.

MARY WELLIK: I think one of the things that would help that would be to have some real intentional practice around getting there, teaching ourselves to go through a collaborative process and selecting some people to help lead that across different levels of government. Because when I look at what happens in a local community, I'm thinking of collaboratives that have evolved in my community, the difficulty is often spanning between the education system and the governmental public health system and the business sector, and when we do those things we build capacity so that the next problem that's tougher, we can call on those same people to help us leverage something happening. I've noticed particularly in my community that we involve young people, K-12 young students, much more frequently in decision making now, not just about specific issues related to them but about the community in general, and that has really evolved from learning how to do that and learning how to reach into the community of young people and having them feel that, you know, if I say something here it's really going to make a difference. And one of the great payoffs to that has been the development of a master action plan for youth, which is county-wide, five communities, really looking at what do we want youth services and supports to be in the future as opposed to just dealing with all the problems that are out there. And recently a couple of kids went to a local city council proposing sidewalk improvements, which seems like kind of a strange things for kids to get at, but basically they're saying we can't get to each other's homes, we can't spend a lot of time after school or in the evening because it's dangerous to be out and around, so it limits our being able to be with each other. But they went to their city council and made this pitch instead of their parents and the city council was pretty impressed and really talked to these kids about what their role as elected officials was and responding to them. And it was a wonderful dialogue between young people and their elected officials and just learning what their whole process would be.

DARVIN AYRE: Did they get the sidewalks?

MARY WELLIK: They're on their way. It's amazing. It's on the city's plan. We just can't believe it.

STEPHANIE BAILEY: Mary, I'd like to ask or I think your first part was saying you had to learn how to go and talk with the kindergarteners, but I'm thinking that your relationship already with the Board of Education allowed you to say to them, how do you go and talk to them, and that's what collaboration is all about. You use your partnerships to help you move into different arenas and adopt different strategies for accomplishing things. Whether you had the skill at the beginning or not, you knew where to go and partner for help in obtaining those skill sets.

MARY WELLIK: In fact, early on a number of things have evolved out of a family services collaborative, which is something that we have in many communities in Minnesota and it was really designed conceptually to bring together different sectors that had to work with family and children services, reduce competitiveness, look for creativity, look for different ways of solving problems, and these collaboratives in different parts of the state are very different from each other. They really reflect whatever the local community needs, but out of that, we came to first identifying high-priority, difficult problems that were hard to deal with. And now as things have moved along over several years, we're getting much more

futuristic in terms of looking at what could happen here with the partnerships we've developed. So you're right, Stephanie.

JEFF LAKE: One of the other things that we have to be prepared to do is to really understand that we're not necessarily the most effective voice, and that's picking up on something that you said, Mary. Frequently, it's much more effective for one of the other sectors with which we work in collaboration to basically carry the water for us on a particular issue, whether it's with a group of elected officials or decision makers in an organization or in a partnership or in a community, having someone else, whether it's a school teacher or a Rabbi or a business owner, coming forward and saying this is an important issue and an important project and it's important to me because… When we advocate for something in which we have a vested interest, we tend to be seen as feathering our own nests. Part of the power of collaboration is having those other voices tell your story. And you know, specifically, Darvin, in response to an example in Virginia, we were interested in establishing an alternative government structure to improve community health, and we turned to one of our partners, the Hospital and Healthcare Association, who worked with us in Turning Point from the beginning. They were the ones who took this issue forward to the key members of the joint rules committee in both houses. They're the ones that went to the chairmen of those committees and said "This is important to do and this is why." And it was much more effective than if we'd gone there and said "Hey, we want to do this."

And I think the other example recently that we've experienced in Virginia is that we were an affected state in terms of anthrax contamination of the mail. When our medical society and when other stakeholders saw how stretched thin we were in terms of responding to that threat, they came forward in op/ed pieces in the newspaper advocating for protecting public health from cuts despite a multibillion dollar, with a B, shortfall in our state. The Medical Society made that their number one legislative priority this past year. And it's that kind of success story I think that we need to be able to tell as a way to explain to people how and why collaboration works. It's great for us to talk about it, but we need more of those examples. And it's messy work and it's not anything that's linear and you know, it's not everything that we collaborate on comes to fruition.

MARK BECKER: I can give you another example. In Minnesota we have very strict data privacy laws, much stricter than the federal laws that will go into effect next spring, at least in certain ways. These laws impinge on our ability in the university to do research, as well as on the ability of health departments and other relevant organizations to meet their respective missions. So we (the University) convened a series of meetings with the Minnesota Department of Health and various other interested parties, to discuss our respective issues and challenges. Some parties came to the table on a regular basis, and others were kept informed through written communications. For the longest time it felt like we weren't going to get anywhere; an obvious direction for initiating change was not emerging. Then, all of a sudden a health system that actually wasn't at that table with us, but found out what we were up to, engaged our group in a collaboration that was able very quickly to effectively lobby key members of the legislature to propose revisions in the relevant law for discussion in this legislative session. Those revisions are not likely to be enacted in this session, but you don't know where this type of process is going to go. It was having that collaboration, the dialogue around a shared interest that allowed us to very quickly engage in a potentially highly productive partnership. You know, when multiple parties with a shared interested, collaboration happens, it works, but it is not predictable. You don't control it. When we started meetings with our stakeholders we did not know exactly how the collaboration was going to evolve or where we were going to go with it. That was a lot of what we kept talking about. "How are we going to make this happen? Who's going to carry the ball? Who has the access to the key

member of the House or the Senate to get that piece of legislation entered and moved to discussion?" You don't necessarily know where you are going when you start down the road, and that's the beauty of it, because through small changes and adjustments collaboration works without being able to know how it's going to work.

BOBBY PESTRONK: We have tobacco control regulations in Genesee County which restrict where tobacco can be used and which also license every vendor of tobacco in the county. They are another illustration of how one doesn't necessarily know how things are going to turn out when one starts a process and of what one learns through work with other people about the strengths and the skills that others can bring to a collaboration. And it points I think, Jeff, to what you discussed earlier. When representatives from the health department first came forward to the local board to describe tobacco related disease in Genesee County and to present a rational case for tobacco control regulations, the first response from the board was: "Well, of course that's what you think as the local health department. You would be arguing for this. But this is a very controversial issue." There is a lot of money changing hands in the political process. It becomes very difficult to track interest on the part of elected officials. What we discovered after we proposed the regulations and it became a public process was that there were many individuals in the community who had no idea that county boards of commissioners may serve as a legislature to adopt regulations, which proscribe or encourage certain behavior in the community, under the authority of the health department.

We became aware, too, of the ability of other groups besides people in the health department to influence the policy process by making calls to elected officials to help them understand the legislative process and to see how they could make use of the legislative process in their own local community. The first time regulations were proposed to the board, they were voted down. Yet, there was an interest in the health department and among community groups in continuing to try to adopt these. The board of health, too, was convinced that they should bring the regulations back before the county board. In essence, the folks in the community and several nonprofit organizations organized themselves into a public lobbying campaign. They organized themselves by county commission district. Members of their organization who resided in a particular part of the county called their particular commissioner and made real to them the interests of their constituency in the regulations.

The ultimate lessons out of that were that the most effective public processes are ones in which people begin to identify the resources that each partner can bring, in which resources are shared, in which partners recognize where their interests overlap. They discard the areas where there may be differences which could pull them apart. They decide to focus on something specific, and then they work over time towards this very specific outcome. In our case ultimately, despite lots of money by the tobacco industry (and whose representatives appeared at all the hearings), the board adopted the regulations. Another lesson is that collaborative processes may have bottom-up processes and top-down components. What we're really talking about is recognizing that both of those components are often very useful to achieve the outcomes that we desire with respect to the public's health.

DARVIN AYRE: And it may have more to do with harnessing those powers amongst all. Stephanie, you had a comment.

STEPHANIE BAILEY: Just a quick one and it is about harnessing powers, and I think there are many community stories like this that you will hear and here is just one quick one. During the time that my budget was being cut as a health department, I guess seven years in a row, we had to adopt a different way of

doing public health's work. We did this by getting out in the community and creating the partnerships. About the sixth year of cuts, when the mayor revealed that the health department budget was about to be cut, I started getting calls from my community leaders: the faith based, the business, etc. saying, "Stephanie, this is not your battle." They went before council and protested that the budget should not be cut, and resultantly, the council did put money back in my budget. Of course, it wasn't between my mayor and me, but you know, that's the democratic process and it works well and it is all about relationships and building those relationships before you need them, before you need them.

DARVIN AYRE: Folks, I just want to do a quick time check. We had planned on doing a break in about 25 minutes from now and I just know it's post lunch, so I just want to do a quick check to see if we need to take a 10-minute break right now. Would that be helpful? Jeff's going no.

JEFF WILSON: The break's not here.

DARVIN AYRE [ph]: The break's not here, so we're waiting – I'll tell you what, we can take two and I'm just going to suggest that we do that because I see a lot of heads nodding yes. If that works for folks? Take a quick 10-minute bio-break, if you would. Bathrooms are around the corner. And then we'll take another break then when the break food comes.

LEE KINGSBURY: Yeah.

DARVIN AYRE: If that works. Okay – oh, before we go, folks, one thing. I want you to think about questions you're going to wish you would have asked during your quick break? Because we have this resource here today. Thank you.

[Break]

DARVIN AYRE: We would like to continue on in our conversation. I have a question for the panelists in just a second. What I'd like to do is open it up for our audience. There may be questions that are pressing from before break that you were wanting to ask. Let's go right here.

BUD NICOLA: Hi, Bud Nicola from the National Program office. In a conversation earlier with a colleague from a state I won't mention, an issue came up that's a little different than the track we've been on, and that is this is a room full of leaders who are used to seeing the long-term results of collaboration and who are real believers. In fact, the whole room is full of people who've had some experience with this very messy stuff; and I think everybody admits, it's very messy. In dealing with agencies in, well at CDC I dealt with an agency that was full of scientists who say "Well, where is the evidence, where is the scientific evidence that this stuff is effective, and show me why I should use this." One of the questions is, how do you create a culture in an organization that understands what the long-term power of this is? And this is an issue I've heard repeated at the state level and at the local level.

HARRISON SPENCER: I was dean in the London School in the U.K. The British don't like to change very much. They believe that in this country we often change too much. One of the ways they used to prevent change was to require extreme justification for every change and engagement in debate on possible consequences. This approach made even small changes difficult. Again, I'm so convinced that the way to have people learn about collaborative leadership is to get them involved in situations where they see that it works and also really, that it's the only approach to sustainability. If you do not have the stakeholders fully involved, any effort is going to break down in the long run.

DARVIN AYRE: So Harrison, if I can go back to you a second. Is there anything that you specifically did with those colleagues in London? You know, how did you

push, because it sounds like you did not want to get into a debate with them, but how did you still get them to see the value?

HARRISON SPENCER: As strategic issues became evident, I tried to find different ways within a collaborative framework to develop them. My plan was to get people involved in the approach, to live it and see whether they thought it made sense. The plan was to debate as little as possible and to try the approach as much as possible. Later I could point out the principles and why I thought they had been useful.

DARVIN AYRE: So I'm curious there, did you ask them to suspend their disbelief?

HARRISON SPENCER: I think maybe that is another panel discussion, thank you.

MARY WELLIK: I can speak to that. My local community is home to the Mayo Clinic, which is a huge organization, world renowned healthcare and research institution full of scientists and physicians who have so much to offer our community. We're very focused on their work and the work of the many other local organizations that have valuable assets and resources. I think to make collaboration work, we first have to look at what we value for our communities. That means if I really think that something needs to happen in our community that would enhance the public health of our community – For example, my community is currently developing a low-income dental clinic through a collaborative approach. I have to really believe myself that it's going to happen. I have to commit to the personal time and energy it will involve. It's going to take a long time as I have to get into those institutions, whether it be the dental society or the Mayo Clinic or the local government or the business community, and I have to look for people who are amenable to change over a long period of time. To me, a long period of time is probably three to five years on larger local issues. Then I just start laying the groundwork, first of all around the assessment data to make sure that people really understand that there is a valid issue, looking for the people who will respond to that and who respond at a social justice level or the level that says to me that they will become a champion as well; starting to build those champions in different organizations and institutions. Over time, starting to move ahead to lay the groundwork, it is essential to know that you can't do it unless you have the stakeholders on board, but you can do a lot of under-the-radar work that helps them to get on board. As that happens, and as partners emerge that adopt a collaborative way of doing things, know enough to back off and let them lead their own organization forward and keep watching, because sometimes people want something to happen, but they get tired or they just get to the point where they get too busy with something else. So you have to constantly be monitoring to make sure that all of the "little ducks" line up in order for you eventually to get to the point where the initiative gets above the radar. Then it becomes a collaborative, joint effort.

DARVIN AYRE: It sounds like there's a lot of commentary here to support that, but I want to go with Stephanie.

STEPHANIE BAILEY: I was going to say about this in particular, big organizations like CDC and HRSA where there is within the larger organization concentration on an issue, a thing, or disease, the leadership plays an important role in establishing how you collaborate. I think that's a big thing. They provide the opportunity for persons to take their scientific skills and benefit the community by capturing emerging knowledge. There are enough stories that have been out there for a while that I think putting the science to those community efforts is a logical next step. I think we have seen some examples of that in the past decade from the CDC.

DARVIN AYRE: So Stephanie, what I'm hearing you say there is framing, helping

frame the situation a way where they can take their knowledge and use it –

STEPHANIE BAILEY: That's right.

DARVIN AYRE: – in a different way or see it, their knowledge, in a different way.

STEPHANIE BAILEY: As Mary said, what does a scientist ultimately want to affect? And then submit that here's a way you can take your scientific knowledge and get to the same result, but you're using your skills as well in a different way.

JEFF LAKE: Yeah, one of the components of Bud's question was how do you convince a skeptic, and that's really an excellent question, Bud, and I wish I had an excellent answer for you. I think part of what the challenge in talking to a skeptic is to understand what that person cares about and to basically, connect the dots for that person in terms of what they care about and how the collaborative process can play into that. For a senior level decision maker who wants to avoid surprises, you know, you say to him, "Look, I can't predict what's going to come out of this collaborative process", and that's anathema to many people who are in positions of power because they want to control the outcome. You have to tell them, "I can't predict what's going to happen", but that the collaborative process is going to give a lot of insight into where people are coming from and what issues are out there so it's less likely to result in surprises, unanticipated surprises down the pike, and so I'd sort of frame it in a strategic way. At the same time I think it's important to tell folks that doesn't mean you can manipulate the collaborative process and that any attempt to do so is going to make it a lot worse for the decision maker than not knowing, because then you get both the issues of mistrust as well as people are going to clam up and you're not going to get the natural benefit of what that dialogue would have produced.

BOBBY PESTRONK: I think one has to assess who the skeptic is and what the skeptic believes and whether there are ways to incent the skeptic to believe something different. And I think one has to ask whether it's worth spending the time trying to convince the skeptic or whether there are ways to raise a new generation of people with bench skills who will be naturally inclined to work in a more collaborative fashion. I think that if one went back ten years ago and looked for discussions about collaborative leadership, looked for evidence of work between the bench and the trench – one would be hard pressed to find many examples of it, at least ones where people would raise themselves to a visible level and say, "We are working this way." But what has happened over time is that some leadership has been demonstrated by foundation funders and by some governmental agencies to place money behind collaborative styles, processes, and methods. This has encouraged their use and the publicity about them. In our culture, one can choose to act a certain way because it's important to the heart or because it is consistent with personal values. But we are fundamentally a market-based economy and more people, many people, including those who have the bench skills, will migrate to an area of practice or research if there is funding behind it. They will ask: Is there a future doing research in this area? Is there money to support my work in this area? If five percent of the NIH's budget were committed by leaders to developing the science for collaborative practice, for understanding the conditions under which collaboration works and where it doesn't, and to expose people to what is learned, not only would a generation of new researchers and practitioners be exposed to a new area and set of findings, we would know a lot more than we presently do. We wouldn't have to convince the skeptics. We'd, in fact, have a constituency that was used to practicing and using the methods of science in a new way including how to work collaboratively. We see it in evaluation, I think. One used to see evaluators coming into a community and judging whether results were obtained. Now, because of new ways of thinking and support for a new way of practice, and because the results are better, evaluators are coming into communities and saying, I don't really want to

sit back and judge. I actually want to be part of the process. I want to share what I know as well as look at what's going on. So I think I'd spend less time trying to convince the skeptics and I'd spend more time trying to figure out how to draw new people into learning, investigating, and practicing new ways of business. What's the educational process that could be used to do that? What are the funding streams that might attract people in, and what could we look forward to ten years from now if, in fact, we could create the conditions that would generate that sort of collaborative process? Why waste our time on the skeptics?

MARIA CASEY: I want to build on what you were saying, Bobby. With the partnership, we are paying very close attention to attempts to uncover what's happening well that people on the ground don't realize is happening well. They're actually doing policy and systems change, collaborative leadership is working. There's a lot of development going on, a lot of cooperation going on and traditionally, I think that the kinds of things that are happening well have been difficult to lift up in your typical evaluation. And so we're trying something not so new, but we may be trying it a little differently. We're rolling out a participatory evaluation model where we have local evaluators in each of the 14 jurisdictions that we're funding and they in part were selected by the grantees. So these are local people and what they voiced was: we want them to know us and know something about the complexity of the conditions where we're trying to have some success. And again, they work with the partners in coming up with the indicators as a part of their strategic planning process. They work with them in coming up with a local evaluation plan. They do the surveys. They do some of the regular kinds of tools that are used in participatory evaluation, but we have an additional step in the process where the results of a case study, for example, go back to the group. They take a look at it and say well, this isn't so, and we have a bit of deliberation going on. And I just have to say, there's this line between credible evaluation or research and that which is deemed not credible, and we're really walking that line and we're trying really hard not to tip over, but we find that the traditional means have not benefited this arena well. It is so difficult to lift up with some credible evidence the kinds of things that might turn skeptics around so we're, going to step out on a limb and try this new approach, and we'll all see what comes out of it.

STEVE FREDERICK: Bud, I think the issue you raised is a broader question than just measuring the success and producing data about the effects of collaborative leadership. It really gets the whole issue of leadership development, in general. Is this something that's effective and does it have any influence on individual development, organizational development, and ultimately on the health status? I think there's a lot of qualitative data out there. There's a lot of anecdotal information not only in public health, but in some of the work that's being done in other public sectors like education and public safety and in other fields that there is a value to collaboration and collaborative leadership. Nevertheless, I think we have a responsibility to produce some of this kind of data. I don't think it's impossible and we shouldn't shrink from the challenge of being able to do some basic research and produce quantifiable data that this does make a difference. And so I think we should bear some of the burden for that.

MARK BECKER: I want to take the question, follow up on what Steve said, and what Bobby and Maria said immediately before that, and change the question a little bit – take it away from changing the skeptic and go to the question of how do we get collaborative leadership into education. How do we prepare the next generation of public health professionals so that they are able, or better enabled, or better prepared to work in this way? First, responding to an earlier comment, I want to point out that the laboratory scientists are changing a lot in the ways they work, and much has changed in the ways that laboratory scientists are trained. I'm not a laboratory scientist, nor am I going to speak for them. But I do know

that the interdisciplinary nature of laboratory science is hugely different today than what it was, say, ten years ago. At the cutting edge of the genomic and proteomic revolution there is a lot of work being done in teams, and those teams draw together many individuals with very different skill sets. Our colleagues in the lab sciences are well into issues and questions where no one person alone has the skill set to make significant progress, so the next generation of bench scientists is being trained in a highly collaborative model and hence should be well prepared to participate in collaborative leadership. They'll be prepared to work in teams. Which is where I want to go with what we can do in education. I don't pretend to have all the answers, but how we get collaborative leadership into curriculum was something I thought about on the plane out here. I anticipated that, as an academic, I was going to have to say something about this particular question. Leadership training, if you will, is something that I would not designate as a separate course in the curriculum, I would prefer to integrate it across the curriculum. All of us have different styles of learning, and some styles work better for some situations than for others. I think one particular device that works very well in leadership training is story telling, and stories can be woven through and across the curriculum. People tend to remember stories better than they remember facts and figures. So you can work stories into the curriculum in the appropriate places, as examples, without even having to draw too much attention to the fact that you're teaching people about the success of collaboration, working together. You can also program working in teams into the curriculum – this is something that has been happening in schools of public health for some time now. Teamwork training, building that experience of working with other people and having to communicate your ideas and get the clarity of what the problem is out on the table, is critical. So, that's another part we can integrate across the curriculum. The piece I have struggled with in looking at the question was the role of mentoring. There are mentoring programs and systems in schools of public health, but it is impossible to guarantee that you provide a perfect mentoring experience for each and every student. When I think back on my own experiences it is difficult to pin down precisely how and when mentoring was important or effective. Mentoring is important, but the nonlinear nature of mentoring makes it difficult to predict or understand. And, you know, much of what I do remember from past experiences are stories of or from my mentors. I've tried to read books on leadership, and the ones that are abstract I usually don't get more than ten pages into and that's the end of it. The storybooks are good, especially the ones with pictures. I like board books. [Laughter] But, really, a lot of what I've found useful in my own life is observing leaders. This can take the form of everything from learning lessons by reading biographies of famous people that have done great things to observing people I've worked for or with. If you actively engage in observing, not just watching, but actually observing closely and thinking about what you have observed, you can develop leadership knowledge and expertise that well exceeds what you will find in books on leadership. How do you teach people to observe? That's a tough question. But perhaps, it is our responsibility to live the leadership models we want to teach. What you can do for the skeptic and for the students is to enable those who want to be collaborative leaders by showing them by actions that collaborative leadership can and does work. For example, in my own position, there have been times where colleagues have come to me and said, "We never thought that (action, program, etc…) would happen. We gave up trying years ago." In those cases the key to making progress where none had been made before was collaboration. I found people who cared and could make things happen when empowered by working with others who cared. I can't come in and do it top-down. You can enable other people to produce results – and you must produce results. I don't know how much data you have to produce, but results are important to the stories (that we tell), and in the leadership business stories can be much more powerful than data. You should not, must not, ignore data - there will be times and people that

will require data, but stories are what are motivational and what are remembered.

DARVIN AYRE: Thank you. I just want to acknowledge that there may be other questions in the audience for folks that you were hanging onto around break time. Are there any of those who want to surface at this point? Jim, did you have one? No? Anybody else? Okay. Yeah, right here. If we could catch right up here in the front row. Thank you. Go ahead, Bobby, while we're waiting.

BOBBY PESTRONK: Was there a question? Okay. The challenge is to produce our own myth. When you asked the question, Bud, the image that came to my mind was the Wizard of Oz. It's the scene where Toto walks into the chamber where the big head is, puffing and smoking and doing wizardry. Dorothy follows behind and watches as Toto pulls the curtain back and to reveal a regular old guy pulling the levers and creating the myth of competence and wizardry. When I'm challenged by the skeptics, I try to keep that image in mind. I recall that half of what is practiced by those who are the supposed experts in the field has never been subject to the same kind of evidence-based research and justification that is being demanded of those of us who are seeking a different world. And I think that part of the trick of training people to survive the skeptics whom they encounter is to give them stories and give them stories, the images and examples to help them understand that a world of myth surrounds those who are in leadership, that the results we seek but don't obtain are the result of some of those myths. It is our job to create another world of myth (and fact). Perhaps one that is based upon other principles and values.

FEMALE: Yes. I just wanted to ask, a lot of what we hear with leadership talks about how to train the people at the top in order to do leadership in different ways, and then I've heard about how to put it into academic programs for those that are coming out, but we have a large group of people that come into public health by different routes. So in order for collaborative leadership to work, I feel like it needs to be part of every public professional's and public health worker's sort of paradigm shift on how they do their job. I just wanted to ask, how do we get this to the rank and file public health worker so that we actually have a collaborative organization?

HARRISON SPENCER: It's not exactly answering your question, but my sense is, as I read the background material, that people who have tried collaborative leadership find that it works for them and they become very passionate about it as a way to do things, because they also find that not doing it this way doesn't work as well. I think it needs to move from a mindset to a skill set in a sense. We can teach people to do this better by defining the skills and competencies needed. Whether it is in an academic environment or whether it's in health agencies or wherever it is, you need to define the skills, the kinds of things that people need to reflect on in order to achieve collaboration and consensus. I think the real problem is that actual experience and observing, and the availability of mentoring are critical elements. One can understand the skills and the competencies needed, but you really can't practice them unless you somehow put them together in a very creative way. So, maybe it's just because of my academic roots, but I believe this concept can be translated into things that can be taught. I think experience is also a very important component and I think you can do research to help define the critical elements. One important question for me is how to shorten the time frame in which things happen. Schools of public health focus on practice in the academic environment, practice in research, practice in education, and practice in service. To translate collaborative leadership into skills and competencies that can be taught and learned requires a partnership between people who are actually doing and academic professionals. It also requires experience. So I think you need to move it more into the mainstream and begin

to think about it as a discipline or an academic issue. Then you can apply those skills and competencies in different ways at different levels, in a rigorous way.

MARIA CASEY: I just want to lift up as well the practice part of what must happen in academic arenas, and certainly this harkens back to where several of us worked with the Kellogg-based, community-based public health initiative, and one of the things we were pushing for in the academic arena and schools of public health was lifting up practice as an important part of what goes on, and we haven't won that battle yet, I know. However, just last week I made the last couple of a round of 39 site visits, and sometimes you just have the most wonderful experience when you get to the end, because I had a public health nurse that I met with, and she was literally exuberant. She was just thrilled because, she said, "I finally got it. I finally figured out what community-based public health is all about and now I really understand why I'm in public health." And this enthusiasm came out of a year and a half of working with a community group. And the lesson she had learned and now was communicating to everyone else, getting a lot of other people excited about it, and I should say that with the Los Angeles Health Department, we really are working with them at this point to provide training across the board. They are divided into eight service planning areas, and we're going to be helping them to provide training across the board in doing community-based public health to all of their nurses. And I think that's phenomenal; I think it's wonderful. Because I think you make your road by walking it, you don't make your road by talking it, and some things you just have to get out there and do, and sometimes you're running and fire is at your butt. But that's the way you learn. So again, I want to lift up the practice. It's so important.

JEFF LAKE: I think one of the strategies that we can all use with staff is to ask them to solve the problems that they're seeing. Because by coming together and trying to negotiate and figure out how to get the problems solved, they begin to practice some of the things that we're talking about. And it's got to be a problem that's important to them. The question about how paradigm change occurs is usually explained by the analogy that when there are so many problems that build up that you put up on the shelf because you can't solve them with the current paradigm, that those problems become so the weight becomes more than that shelf can bear, that's when you tend to get your paradigm changed. And so empowering staff and expecting staff to basically take responsibility for addressing challenges and problems that you see in doing their jobs, because they know the most about the work, is one strategy and I think can be fruitful.

STEPHANIE BAILEY: A couple of things, several things we did started with basic baby steps. Know your internal resources. So we have stressed for the last umpteen years, you need to know the internal resources in order to be able to say how they can affect and help you do your work. Another baby step, as you become a learning-ful organization and you allow more and more of your staff to go for training, whether it's a course – whether it's an update for your family nurse practitioner or whatever it is, have them come back and identify who else needs to know this information and then allow them to do oral presentations. It's skills-building. Another thing is, create initiatives through which staff can solve a problem, an issue or improve a process. In one of our initiatives we required that they partner with another division within the health department. Baby steps: starting with some small skill sets that lead to greater confidence and greater capacity. Use every opportunity to increase skill sets for everyone in the organization, because at any time we see our staff as "public health workers uniting the community for a healthier tomorrow."

DARVIN AYRE: Folks, I want to do a quick break here for a second, not leaving the room, mind you, but I just need to recognize that we have our feet in two different worlds right now around questions, and I want to make a choice here as a

group and decide to leave one set behind and move on to the next. Mark got us started off on the question around how do we make sure that we get this into institutional trainings and opportunities for people out there at whatever level in public health. I want to recognize, though, we are also talking about practice, specific practice, that each of us has utilized in our particular organizations in addressing some the barriers we've run into around collaboration, and before we leave that I just want to ask that question one more time. If you think about some of the commentary that came from last year, for example, here are some of the things that they talked about last year. Here are some competencies identified across all levels, whether they be state, federal, or local. They said, we see the core competencies as being conflict management, management of change, perspective taking, taking that time to reflect and what's the perspectives that are out here in my world. Promoting dialogue, setting clear direction, expressing clear values that everybody connects with. If you thing about those kind of core competencies and some of the other ones we've spoken of today, things like clarity around values, seeing commonalities, envisioning and mobilizing, can you place yourselves in any of those kind of competencies or skill sets, and how did they help you get through certain barriers. Do we have any stories around specifics before we move on to this other question?

[MALE]: Not a specific story, but I read the summary of last April's report on the plane, and before I read it I'd actually written down some notes to myself, sort of trying to figure out what I might have to contribute here, and I had actually written about clarity. And then I read about clarity, and I think it's more than clarity of values. I think in the cases – if I've ever been successful in collaborative relationships, and I hope I have, I think it's being clear about what I'm hoping to get out of the relationship, out of the partnership. So it's not just values, it's clarity of mission and goals. When I go into the room with people from a variety of different organizations, we're all there and we may have overlapping interests, we may have overlapping goals, but we need to be clear on why it is we're here working together on this. Because so often the approach is to go it alone. So I think values are important, but I think results are important, too, and you've got to be clear on what the result is that you're after and that everybody is able to do that. And to be able to speak clearly and succinctly about why it is you're at the table with everyone else.

MARY WELLIK: I think one of the issues around clarity of values is that you accept the other people around you in terms of why they're at the table. And a lot of times the barrier occurs over perceived differences as opposed to what the values lead you to in terms of wanting an outcome. I'll use the example of this dental clinic I mentioned earlier. Many times over the last 20 years we've addressed this issue in our community and many communities across the country. Typically what happens is that the dentists have an attitude that they aren't being heard and the governmental people have an attitude that we're offering resources and you're not taking advantage of them. Other people get involved in the same ways, having some barrier that doesn't allow them to move ahead towards solving the problem. Getting our local group to move beyond that meant focusing on our commitment to getting essential dental services to people who didn't have them, period. Do you really feel that they have a right to them or not? Most people assumed that there were people who didn't feel they had a right to them. When we got down to saying yes, we think these people have a right to dental services… just like all of us sitting around this table who have dental care. Where is the barrier to getting it accomplished? We helped each other work through a lot of misperceptions about each other. But it took a fair amount of reflection to get past the assumptions that we all had about each other, and that's something we haven't talked about a lot here. Collaborative leadership means that you have to do some things differently and you have to let go of some things. And in order to

do that, I think you need to reflect on what is it about myself and these people around the table that has to change, and how can we do that.

JEFF LAKE: Well, a recent example which reinforced for me the value of collaboration was I had a really difficult management issue that came up around the operation of some of our pharmacy services in our local health departments. And my concern was, and a barrier that initially kept me from approaching it as a problem that could really benefit from collaboration and my sort of approaching it that way, was my concern about the exposure that I'd have from the liability that would flow from talking about this problem. It was an issue where we were out of compliance with a contract that threatened the whole state's participation in that initiative. And what I decided what that if we simply took a traditional approach when we find a problem and said, that's not what you're supposed to do; flip the switch, turn it off, is there would have been a lot of disruption in the community. And so what I did was bring not only the public health officials in that community together but I also worked with voluntary organizations to learn about alternatives to the current arrangement, and then tried to create enough time and, you know, Harrison, you talked about the need to somehow compress this. And this was the situation in which, because of the potential liability, I needed a timely solution and I couldn't let it play out naturally over a year as the local director had requested. And so I relied on the relationships that had developed over the years to try and promote a solution that would both and limit our liability, but would also prevent there from being a major disruption in service delivery in that community. And I think we're on our way to a satisfactory resolution of that.

MARIA CASEY: It's just a brief comment, and it's that adaptive leadership is collaborative leadership as well. I think that a collaborative leader really has to know when they need to share the responsibility. And they're not omnipotent; they can't do everything. They don't have all of the skills. I think it's really important to know when someone else in the room needs to step in and help share the leadership role.

JIM DALE: Yeah. Question and comment, really. It's on building and on leadership training, and that is values, reflection, bioterrorism, continuing threads. And values is, do we value ourselves being a learning organization. So if people say I want to lead a learning organization, then we rescind you and we look at that. And then we say reflection, "Well, we don't have time for reflection because we count beads. We deliver services." And what do I mean? Well, I look in bioterrorism at first responders, and I look at police and I look at fire, and my house hasn't been robbed or burnt down, but they spend 20, 30, 40 percent of their time training, and in public health, do we do lifelong learning? No, we say deliver services, deliver services, deliver services. And so it's – I guess I'd like to have some comments on how we talk to our elected officials, our boards of health and train on – we need to train in lifelong learning.

BOBBY PESTRONK: Well, I think the answer to that depends upon one's individual community. How we did that in Genesee County was to over time simply build training funds into our budget. When I arrived there was $1,600 in the budget for training for a 150-person organization. And over time, what we began to realize was there was no way to inject new thought into the organization with that budget. It wasn't enough for me to suggest or demand new ways of doing business. If I say, "People, I believe this", they say, "Well, you know, that's just Bobby, he's just the head of the organization." One has to come from 50 miles away in order to be an expert because we couldn't possibly have a local expert. Slowly over a period of time I simply added training funding to the line items throughout the organization; in the line items that first-line supervisors, would have control of. And every time we wrote a grant proposal, we included in the grant proposal money for training. And every time we got a grant, we made sure

that we spent the money for that, and over time we began to accrue the resources within the organization that would now allow us to send people off to learn something new and get new ideas. Now, I have to say the most challenging thing is to figure out whether the things that people want training on are the ones that will return some value to the organization. But I think part of the trick is to have faith in the staff who are making these decisions about the things they need to learn; to allow them to feel that they will seek valuable training opportunities and that the sessions that they seek to go to will, if scrutinized, will be relevant and valuable. And to occasionally deny a request which is out of bounds. So I think within one's organization where one has some control over resources or where one can build control, it is important to take the step as a leader to say, let's build some resources into the organization. In other places, it may not be possible to take that risk or one may not have the opportunity for that.

[Male]: Well, he just left so I didn't know if he was – didn't think that I was going to (inaudible) question.

DARVIN AYRE: We need you to stay closer to your microphone.

[Male]: Yeah. Because I'd like – maybe I'll try to say this to him after he comes back, but this is an interesting issue, the whole issue of training and education, because I don't think that the recipients of this, or the providers of this, which, by the way, are not just schools of public health but are public health leadership institutes, community college and so forth. I'm not quite sure that there's been a coming together of the need, for example, for state and local health agencies in terms of continuing education in some very formal way. The reason that I think that's important, because he said, well, how do I go to my local officials. And I think if you had a national paragon that emphasized the importance of that, this is a particularly good time for this to occur. And I don't think we've had those kind of dialogues and I think we, at the schools of public health, are certainly equally to blame with anyone else, but I think this may be a real good time to do that and to set – so it's not just about what can I do given existing situations, but stepping back to a, you know, how about getting the stakeholders together and sort of say, this is something we really need and certainly something we'd like to provide, because there's something in it for us as well, and there's something probably in it for community colleges or accredited programs, leadership institutes. I mean, you can make a whole list of these in terms of coming together, so I think it's a great example of how this sort of a process might really serve some real ends and not necessarily in a huge time frame.

DARVIN AYRE: Well, and what I'd like to acknowledge, I think we're making the transition now to that question around how do we institutionalize collaborative leadership/leadership training and to make sure it gets integrated into the culture, whether that's the culture in communities or in educational institutions, wherever we might find that. And I want to go back to Kathy, and then I know that Mark had a comment, and also Denise and David.

KATHY KENNEDY: As we make this transition, it reflects Rosemarie's original question that Jim actually amplified. So how do we get this training to local health departments? I couldn't agree more that leadership training should be part of the curriculum in schools of public health, because people tend to believe what they learn in school. As a matter of fact, in medicine it has almost become a problem, because the field changes so quickly that what you learned five years ago may not be true today. But yet we hang on to what our teachers told us. In fact, I think it was Einstein who said the hardest thing he had to learn was that his teachers weren't always correct. Well, in this case the knowledge goes ahead. For example, if all MPH students learned the principles of collaborative leadership, first of all, they would start to think that it was part of their role as public health practitioners, that this had something to do with what they're

supposed to do every day. So I couldn't agree more that it should be part of the curriculum. But as we know, most people who work in public health don't have MPHs or don't ever train in public health. So have you tried to hire somebody recently whom you didn't have to train to do whatever? It's just very difficult. So on-the-job training has got to be part of what we do, especially in public health, since we know most of the people who serve in the public section in health aren't trained in public health. So some local health departments in Colorado have their own Public Health 101 courses and by the time you're there for three months you have to go through the course, a CD-ROM course or whatever it might be. Well, brilliantly, this collaborative will be producing some materials, probably on collaborative leadership. By the time you're in our department six months, you need to take this curriculum on collaborative leadership as well. And then the rest of us in the Mafia on this corner can kick in with formal leadership training programs that are either brief or long or whatever. And to me, that is for a person who is more experienced and has a state of readiness. And usually it's because they've reached a certain level of frustration and they want to think differently and learn how to do things differently. But that's yet another point. One final point is that it's wonderful to incorporate training funds into your budget, in whatever creative way you can do that. And as we know, travel and training are the first things to get cut; therefore, they always get cut because everything gets cut every year. But there are things that we can do to train or cultivate leadership in our organizations that are not very expensive. And this goes back to Mark's earlier comment about observing. So we need to model the behavior that we want to cultivate. We can set up mentorships within health departments or we can allow people who work in our health departments to mentor with other people in the community. Hey, I think there are a couple of win-wins going on in a situation like that. Oprah Winfrey made book clubs really popular in this country, and if a senior person in a health department or in a community led a leadership book club – this year we're going to choose two books on leadership. We're going to study Senge this year. Okay? In fact, invite some people in the community if you like, but even if it's just within your own house, who wants to join the assistant director of the department and help choose what those two books are going to be? And then people start sharing a language about – what does that cost? It costs the time of the people. And that's where our decisions, as leaders of health departments, in terms of how we let our people spend their time, can enhance leadership training. Getting right back to the people we really care about.

MARK BECKER: I think the question of lifelong learning is important, and Kathy's already said a lot of it can take place on the job as being part of the culture. But the roles of formal education, CDC, public health institutes, state initiatives, etc., are all important. In academia we're grappling with understanding and articulating our own roles in lifelong learning right now. Lifelong learning is a key buzz term in universities, and lifelong learning is being talked about in many fields, not just public health. We realize today that much of what we teach is at least partially obsolete in five years, and that is true in just about all fields of study. The pace of change and the rapidity with which we can integrate and disseminate new information is so much greater today. So, lifelong learning is central to all areas of study in universities. I can tell you a little bit about what we're doing at Minnesota. We're not at the front of the curve, but we're far from being at the back of the curve either. We have created a center for public health education and outreach that has lifelong learning in public health as its mission. We're just getting started, looking at different models, and one of the models we're deploying for the people that may be out there working in the trenches – folks that don't have either the time or the resources to go to school full time – is a general public health certificate delivered entirely through online courses, a fifteen credit hour certificate based on our core curriculum. This is new territory for us. We're still learning a lot about what works and what doesn't work in online environments,

but our overall experience so far has been extraordinarily positive. I want to come back to the clarity of mission piece for a minute. This conversation about practice in schools of public health and education and lifelong learning, well, this must be a collaborative process. It has been so far and we're not finished. Achieving and understanding clarity of mission is critically important. Sometimes I have to sit down with stakeholders and say, I have a budget just like the rest of you, and this is what I get and this is what I'm supposed to do with it, and you're asking me to do all of this other stuff (e.g., some specific form of public health practice), and you might think that's my mission, but nobody's given me a budget to do that. Or, what am I not going to do, and what do you want me to get rid of. This type of conversation takes place all the time. It is recognized that the lifelong learning piece is important. The questions are: "how can we do it, how do we pay for it, and who should be doing it?" There's turf here. Universities are not the only people interested in providing lifelong learning opportunities. There are associations that want to do it, and there are agencies within governments that want to do it, whether they be local, state, or national. There is a lot to be worked out here. I think one of the goals has to be – and I think part of the answer is, we're all going to do it, but we have to be clear about who does what. And this brings us back to the importance of clarity of mission for all of our organizations. You know, there are certain things that we can probably do better than some other folks. There are other things that we just shouldn't be doing. And that's where we have to get to, is working those issues out.

DARVIN AYRE: I know we have Denise and David and Steve that had comments, and I know we have another question in the audience here, so let's –

DENISE HASE: Sure. Thank you. You know, we started this afternoon with, you know, how is it different on the federal, state, and local level, and I think this question also has a role for all those different levels as well. The idea I had on the plane – we all decided that you have to have a plane ride.

MARK BECKER: That's where you get all the work done.

DENISE HASE: Thinking about this stuff, but the idea I had on the plane this morning was, if we – we all could take a role in this, and somehow if it could become one of the standard questions on some of those federal funding plans of how is collaborative leadership carried out in this program. So then that goes down to the states, and then you know what the states do, they ask all the locals, how the hell are you going to carry out collaborative leadership in HIV or maternal and child health or water quality or whatever it is. I think we start – and there'll be some people have to look up the words, and that's all right, that's learning. And so I think there are ways that we could start getting that into the plan. There are also a bazillion – that's not a technical term, but there is a dang lot of assessments going on right now in public health, and there are quite a few of them that include leadership. I was sitting here thinking, dang, I wished I'd looked, do they have collaborative leadership. I don't know if there's the word collaborative, but there's a lot of – one of the things that they ask is about leadership. So there's lots of public health assessment tools going on right now. And I am confident that there is some human being in this room that would have some influence on, oh, God, could we add a question about collaborative leadership, and then you know what? In that assessment out pops this and they're like, oh, I'll be dang. I want to talk a little separately about training. And I don't know if this is just a Colorado phenomenon or if it is happening across the nation, but there is a real backlash I am hearing very loud and clear of it costs more than just registration and travel to send people to training. And don't you be just thinking that by putting in the registration and travel you have covered their time costs because, you know what, WIC ain't going to pay them to go to no collaborative leadership training or Family Planning ain't going to pay them to go to no – so I don't know,

that's just something I want to throw out there. There's a big phenomenon in Colorado about it costs salary and fringe benefits to go to training and I hear – I see Alaska going yeah, that's a big issue. So I think that's something for people to think about, too.

DAVID STEFFEN: I just wanted to pick up on a little of what Denise said but going back more to what Maria said regarding adaptive leadership and what the roles might be. I think the rallying cry for public health performance standards was what gets measured gets done. I think it's the same around collaborative leadership. And even going back to your question around public health, people being trained, when I was in public health school there was very little talk of collaborative leadership, about public health values, community as client. Those pieces just aren't there. Just wanted to share what we are using as our sentinel text, our foundational texts for the National Public Health Leadership Institute. We have two. One is by Ronald Heifetz, *Leadership without Easy Answers,* and that's pretty thick reading. And luckily he's just come out with a new book which is much more readable, along with Marty Linsky, *Leadership on the Line*, which is excellent and actually has Mary Selecky in there as a public health leadership example, which is just fantastic and I think we'll go to that as a sentinel text. And also *The Deep Blue Sea*, by Wilfred Drath. In these books they outline the real three levels of leadership, and really only the third level probably is the collaborative leadership, and I'd really recommend the Leadership Collaborative focus on that third level of leadership and what they do. And just real quickly, these levels are lined up by what kind of problem it is and what kind of solution they demand. Level one is simple; problem is defined, solution is defined. Expert solves it. That's where the personal dominance level of leadership, or management, is really used. Second level, it's fairly clear, too, a problem is defined but the solution isn't. And so you get the people together and it's kind of an interrelational, a little bit of an interpersonal power influence thing in terms of how you come to select the particular solution. But the third level is where things are really happening in terms of public health leadership. These are the tough problems: urban sprawl, substance abuse, health care reform. Everybody thinks health care reform is a technical issue, a technical problem. If it were a technical problem it would have been solved a long time ago. It's a values issue. It's an ethical issue. It's an issue of what do we want to do. It's kind of like what you mentioned about the dental clinic, and it's not always that direct, you had to come through an evolution of values, I would think. If you'd come into that room the first day and said is dental health a right, I don't think everybody would have said yes. There was that level of leadership involved in there, that evolution of values, of learning, of progressing together, of coming to a higher order of thinking and dialogue that almost has a certain amount of higher value, almost a certain amount of love and empathy that's involved, and that has to be there. Now, getting back to the point of what gets measured gets done. All of our assessment tools, we have a Center for Creative Leadership kind of management-based assessment tool. It's a business model. Public health leadership and the assessment tools that we also need for that are different. And I don't know of a good one yet. And this is one thing the Collaborative could really help us with, is getting one which measures, even on a 360 type of basis, how well you are focusing on and practicing collaborative leadership at that third level that Heifetz and Drath talk about. Because I don't see it's out there. I asked at the NLN (National Public Health Leadership Development) annual meeting and there isn't one. That would be something that would really drive us and drive public health practice, and it could be used at that level. And I think the IOM report that's coming out June and July is certainly going to talk about credentialing individuals, accrediting agencies, and performance standards in a local public health system. It's going to talk about some key partners, like media, health care, nonprofits, and I mean, how are we going to collaborate with each of them? We're going to need that sort of tool to see if we really are making

that kind of collaboration to solve those difficult problems in public health, and that's where I think we really need to be focusing as collaborative public health leaders.

STEVE FREDERICK: This conversation has taken on a life of its own. I want to go back, actually, back to the future. The question that was originally asked, I guess about 20 minutes ago, was how do you make leadership development a lifelong process? And I think Kathy did an excellent job of talking about how you can make that occur and what resources are out there and what additional resources we need. The other part of the question is the why should that happen? And I think what we need to do is to create some disincentives to insure that it does happen. And I'm thinking of a few things, and maybe I'll open this up. It may be a can of worms; it may be a little controversial. But, you know, some of the things we can do are advocate for credentialing and certification requirements for public health officials at all levels and mandate that people receive this kind of training. So put the burden on the local health department to send their folks to receive this kind of training. The other think that may be less intrusive is to incorporate some of these into the performance standards work that Paul Halverson and CDC and PHPPO is doing so that these are highlighted as an expectation that high performing health departments, state and local level, will send their folks away for training. We need to create some kind of disincentive system so that people have to do this. Because if we just let people do it on their own, I don't think it's going to occur.

[Female]: Well, this isn't going to speak to your credentialing issue, but it goes along sort of with lifelong learning and what Kathy brought up a little bit ago, and that is it – something strikes me that pieces of this have come up through the afternoon. Earlier, Darvin, before the break you said can you lead upward. And at the same time we've been talking about a lot of our leadership training, leadership programs come out of academic centers, out of federally funded or supported public health leadership institutes, etc., so on the one hand the structures are pretty high up, and on the other hand we've been talking about some of us can, when we really reflect on it, some of our most profound experiences in collaborative leadership came from the ground up. And Mary, you talked about the kids who came to the community meeting and sort of impacted the whole meeting around their interest in the sidewalk issue. And in terms of stories, I think one of my most memorable moments was years ago I was involved with an environmental justice youth coalition of kids, youth in East Baltimore. And a grant came up out of the National Institute for Environment Health Sciences, so myself and two youths and this environmental scientist went to Research Triangle Park and went to the application meeting for this application and for this grant. And there were all these scientists in the room and the scientists were all asking questions about this grant that required community groups to be involved. And the scientists were asking questions about, well, how do we get these community groups to see that lead is the issue in their community. Or how do we make these community groups see that this is the problem. And this 16-year-old girl from our group stood up and said to this guy who was at the NIHS, said, I don't understand what these people are talking about; I thought this was all about what we in the community thought was the problem. And it – the whole group still remembers that today, and that was years and years ago. And that was – I've never forgotten that moment, and that had a very profound effect on me. So my point here is how do we identify intentional ways of bridging that gap between some of these very profound experiences of how we can be led upward with these structures that really provide us training through these umbrella, larger, higher up organizations, and how do we make that gap occur? Kathy, you've spoken to it a little bit, and I think we've touched on it with regard to really centering on those practices being observant, not just observant of other leaders

and bosses but of our community.

DARVIN AYRE: Well, let me just do a quick question here. I know that Mary and Jeff were holding comments. Could your comments respond –

JEFF LAKE: Yes.

DARVIN AYRE: – to that question, too?

JEFF LAKE: Yes. When we think about educational opportunities, when we think about teaching, and modeling collaborative leadership, a piece that's often missing is that we tend to involve the usual suspects and not to be reaching out to individuals from other sectors. And individuals who may have different points of view about how collaborative leadership is carried out. And I think we are more likely to consult others before there's a lot of formal training in a profession. And when we get them into our formal programs we sort of say, you know, well, you got to do it this way, and some of that sort of spontaneity and some of that sort of natural approach fizzles out. And so I think part of the answer is that we have to figure out a way to involve, whether it's voluntary organizations such as the Girl Scouts or somebody from the Chamber of Commerce or other sorts of organizations. Part of what I think made the session that we had last year so rich in terms of its product was that we had people there from very different walks of life and very different points of view. And we have to figure out how to institutionalize this practice, to make it seem natural. The other thing is we also need to influence the institutions that help shape our future leaders in public health. And basically, if we want to do that we have to figure out who they listen to. You know, when we say that we're going to have a credentialing process, that means the graduates of these institutions that are turned out have to be prepared to meet those requirements. And in terms of who institutions listen to, it's the people who hire their graduates. And so, you know, shaping the expectation about what graduates need to be prepared to do and, you know, basically having students who have those skills be successful helps feed into the pipeline in those institutions and helps reinforce the need to do that. Having said that, I do know enough about academic institutions to know how much I don't know. But I do know that there's a tremendous competition for curriculum. We had an idea in Virginia about how do we influence medical schools to teach more about community health and population health. Well, somebody who was really supportive of what we did was very frustrated with us. He said, "What do you want us to do, reduce the number of hours of instructional time devoted to teaching cardiology"? And so, you know, that's the challenge that I think we face in terms of moving these kinds of issues into the institutions that produce our future leaders.

DARVIN AYRE: The amount of time is finite. Mary and Stephanie?

MARY WELLIK: I'd like to go back to the discussion we had about bringing collaborative leadership from the bottom up and involving your public health staff and involving the community. When you really have an intractable problem in the community that's broad and involving a lot of sectors, I have seen the "bottom up" being the development of a core of people who want to tackle that problem and initiate that effort. There is a value in bringing together a lot of partners in the community to just learn about process especially when they are faced with a big problem.

In my community, we had a consensus training institute for 60 community leaders that involved 75 hours over a year's time and practicums on the part of all these people. This involved everyone from city council, county board, mayor, school superintendent, and people from our many minority communities. The training revolved around the fact that we had a very difficult problem to deal with, people want to find an answer, and there was a core of people that got us to

believe that this is part of the answer. I think sometimes when you have a problem, it's important for some of us to step back and say, how can we use this problem to enhance our community's capacity? I think in public health it's an opportunity we don't take often enough. Maybe the first step is internal, and that is using your skilled staff to help your other staff learn some collaborative leadership skills. Give them opportunities to do that. But also to take that up through your elected officials and encourage them and other people in the governmental role in your local community to get together and learn something about collaborative leadership with each other, bringing in those people that they might influence. I can see that with the modules and the kinds of things that our collaborative leadership group is putting together that that might be more sellable. It would have some validity just based in the work that's been done.

STEPHANIE BAILEY: As far as internal training goes, many of us have the good old public health nurse who's been there, and has a lot of experiential experience. You have your terminal degrees, and your master's level persons, whether it's an MPH or whatever. And what we have done is taken those persons to be faculty for what we have created and called Lentz University. Lentz is our administrative building. The curriculum takes all staff through the basics of public health, teaching Public Health 101 by statistics, epidemiology, etc. resulting in a certificate. It also has in it public health dilemmas, where you relate what each person's daily job aspect and task is to a particular community problem. This takes us to another level as well. There are a lot of coalitions in communities that have emerging questions and emerging things to be answered. You take your students preparing for their Master's, immerse them in the community and let them create their theses from emerging problems and issues. We have the opportunity to develop with two academic centers, medical schools in Nashville, Vanderbilt and Meharry, using the health department as the foundation, a division of public health practice conferring a Master's in Public Health degree. So there's a sense that you're capturing new knowledge and you're also creating the collaboration in order to lead to perhaps, sustainable solutions towards solving real problems. The other piece I want to just share real quickly is within the health department, you create opportunities for staff to go to school or to increase their learning opportunity. If accreditation comes, Davison County will be ready to take that test. Our doing formal training is futuristic, getting my staff ready and affording us the use of the skills we need right now in order to solve problems for our community.

BOBBY PESTRONK: I wonder, Mark and Harrison, how would one introduce into accredited schools of public health the kind of leadership curriculum that has been talked about today? How could it be made a part of the materials that we all would read as students? What steps would need to be taken to either lead schools of public health in that direction, to require them through accreditation to offer those, or to just create the conditions in which they might naturally move that way? You both are leaders in schools of public health or in associations of schools of public health. Is this too steep a challenge or is this one that is realistic? How would this happen?

MARK BECKER: Actually, it's on the radar screen right now. I guess I'll go first. All schools accredited by the Council on Education and Public Health must satisfy a series of criteria, including some on academic programs, in order to be accredited. And we're in a period right now where CEPH is receiving commentary or suggestions for revisions to the criteria. The accredited schools, represented by ASPH, and other sectors of public health, such as the Council on Linkages, are recommending a move towards competency-based education. Leadership is one of the competency areas being recommended, so we're going down that road. Now, in terms of the extent to which the collaborative sort of modules, etc., will integrate into curriculum, we're not to that stage yet. We're just getting to the

page where competencies in certain areas are part of the educational core curriculum. For those of you that aren't familiar with the current criteria, the current criteria, for all practical purposes, stipulate that the curriculum must include courses that cover five areas basic to public health. And so we're trying to move away from a course-based model and move to a more competency-based education. We need to identify the core areas of competency, as well as the core areas of knowledge. Leadership has been one of those competency areas in all of the discussions that I am familiar with. How we're going to do competency-based education at each individual school is not resolved yet, and what the specific competencies are is not resolved yet, but we're on the road.

HARRISON SPENCER: Again, you could spend a long time on that question. One thing I really like about this is I think collaborative leadership is not just useful in state and local health agencies, for example. It's my sense that this is an important principle for a wide range of "public health practice." And one of the realities of our schools now is that our students pursue a wide range of careers. Secondly, I don't think we've had enough dialogue and interaction between people that are hiring our graduates, including, particularly, yourselves and faculty from the schools of public health. We need much more understanding from faculty and deans about your needs and what you'd like to see happen. It's often done too much at a distance. And I'm with Mark, I think the way to do this is to move to competency-based education. Thus, anytime anybody says credentialing, I listen because I think that's going to be really helpful in assuring competency. It is not enough for somebody to take a course in vital statistics or management or whatever; we should know what competencies we expect them to learn. Competency-based education is really going to change how we teach and assess. Competency-based education makes sense because it is relevant, not just for people that are going to work in state and local health agencies, but for many careers, foundations, the federal government, international agencies, to name a few.

MARK BECKER: I'd say, having chaired an ASPH subcommittee that has drafted a recommendation in this area, there's a lot of interest across many schools. We don't have a prescription for what every school will do. There's flexibility for different models of implementation, but I believe there is wide recognition on the part of many that we need to be more deliberate in designing curriculum. I could go on for hours about how curriculum has actually evolved, rather than been designed from first principles, over centuries, at least it feels like centuries at times. As we make the move to competency-based education we need to avoid the trap of creating courses around competencies, and instead weave the competencies into core knowledge area courses. That is, the competencies need to be integrated across the curriculum, not segmented out. There are opportunities to get concepts, like leadership skills or communication skills, another competency area, quite naturally integrated across courses. For example, a number of universities have replaced undergraduate composition requirements with so-called writing across the curriculum requirements – substantive courses in areas like political science and philosophy courses that have substantial writing components. Well, – and it's not rocket science – we can do the same things with communication, leadership, and various other competency areas in our public health core curriculum. Now's the time to be reflective on the qualities of a leader as we, hopefully, go through this sea change in how we structure curriculum. It is going to be interesting.

DARVIN AYRE: Folks, I want to acknowledge that we have about 20 minutes in our timeframe left today, and we have one more question, which is to be reflective a little bit and ask ourselves, how do we take the knowledge base from today's conversation from last year and what do the implications say for the collaborative's work? How can we move this work forward most effectively? And

I know that Kathy's been very patient, do you have a comment before we move to that last question? Because I know you've been holding here for a few minutes.

[FEMALE]: Maybe sort of a transitional kind of question. In our regional leadership institute, we've had a small number of academics in the program every year, so it's just a sort of an additional way to inform how does one go about inserting leadership into the curriculum. And the National Leadership Collaborative also has published leadership competencies, so there's already a conceptual framework for doing competency-based training in leadership. Having said that, I'm here to represent a group of people who are zealous about leadership training, and their view is just do it, don't wait for the Council on Accreditation for Education and Public Health. Now, okay, that's easy for zealots to say, knowing that curriculum is a zero-sum game. You've only got so many captive hours.

MARK BECKER: Actually, there are many groups that have their own ideas on what the core competencies are, or should be, and when you put them all together it's about that high (hands indicate a stack of paper several feet tall). And one of the observations that I have from looking at a number of the competency projects is that none of us at any of these tables has all the competencies being listed in our own skill and experience sets, and yet it is suggested that we're going to require demonstrated competency on the part every one of our graduates. There remains much work to be done in refining the proposed sets of competencies down to a more realistic beginning set.

DARVIN AYRE: Folks, I want to make this transition into our last question, and that question is, What are the best approaches to moving the content of the collaborative's work into circulations and acceptance? And I'd like to open it broadly up and not suggest that only panelists will make the initial commentary, but I want to open this question up to all of us. How do we move this work forward?

[FEMALE]: I just want to underscore a point that Denise made, that groups like CDC and HERSA can require evidence of using a collaborative process in their proposals for projects and also in their evaluation schemes, and if you want to affect how people do their business, you affect how they get their money.

DAVID STEFFEN: Just a couple of things that I hope the collaborative could do, and I imagine they could do that for schools of public health as well. One is just creating a compelling vision of collaborative leadership. Those vignettes I think that you're talking about fill that very much. I think also, at the same time, a realistic version of collaborative leadership and community needs to be conveyed. Collaborative leadership can be somewhat of a pie in the sky, kumbaya type of thing, so I think some case studies that talk about when you get to those sticking points, when you have your first conflict, when some people drop out of the coalition, when money gets short. When those things happen, some case studies that really say, how do you get over these and go to the next level. I think those are the types of things that would be very, very valuable for folks. And the third thing is tools. You know, you value it, there are some things that you know you have to get over, but what are you going to use? What are you going to take away from that? Some real concrete tools in a generic kind of sense – perhaps MAPP is one of those tools; perhaps there are some other tools that you might have that people could actually utilize. Again, and I'll go ahead and put in my two cents worth for the development of that assessment tool, that 360 assessment tool, that people could use as a personal reflection and personal collaborative leadership development plan that they might develop for themselves, and their public health system would be very valuable, too. So those three things would be very valuable.

[FEMALE]: I want to mention, and it sort of relates to Denise's comment, too – I'm also from Colorado – but I think that one of the best things that can happen is that if this whole concept is integrated into the thought that it is an individual's responsibility that works in public health, that this becomes part of how they do their job. And Denise's comment about some of the Colorado public health leaders that are concerned because if there's offered a scholarship for training for their staff they're still going to have to pay for the time off. I can relate it to my original profession that I started out with was laboratory medical technologist. We started in Colorado, Colorado Association of Continuing Medical Laboratory Education. We were criticized for that, because what we were told was, you offer this education, we in the labs are going to have to pay for people to take the time off. But guess what? It was so valuable that the professionals in the laboratory – I'm going to call them professionals – did it on their days off, they arranged for people to work for them. And until we integrate this concept into how we all do our work every day, I don't think it's going to work. And there's going to constantly be coming up the issue, I don't want to pay for this. So it has to be an individual focus.

[FEMALE]: Maybe two short comments, and that is, of course, the behavior has to start with us. So we have to model the behavior, and if – it's sort of easier said than done, especially if you work in a government agency, because you start to figure out that when you want to join a collaborative and you want to offer things, not only your expertise but also part of your budget to chip in – which really is what collaboration is about, it's about sharing resources – there are a lot of barriers, especially within state government, as to you sharing your money or giving your money to a common group that has a common purpose. So there are challenges there, but at least if it's something you're practicing, not only are you modeling for the public health community or people you work with or people that you supervise, but you're also able, I think, to have a better understanding of the barriers and push for some of the changes.

[MALE]: I'd like to echo that. I think you model it and if you're in a position to, when it's successful, is talk it up. We do a number of publications, many of you do, and those are the good stories to highlight. Those are the ones to put on the front page. Those are the ones to put the nice pictures with. So you model it and then you find ways, whether you want to say market it, celebrate it, whatever, but you share it with others often. That's what advertising does, you know, same message. Give the message over and over again. Because you might get tired of telling the story, but as you tell the story, you're probably telling somebody who's never heard it before, unless you just sit in the office and tell the same person the story every day. They don't want to hear that.

DARVIN AYRE: Other ways that we can move the work of the collaborative forward? Any breakthrough strategies?

[FEMALE]: I mentioned that I'm rather new, so there's things that I still don't know, so if I step on toes and say something that maybe I don't know, it's okay, forgive me, you can always straighten me out later.

[FEMALE]: I'll take credit for it.

[FEMALE]: In order to broaden the collaborative and continue to have its work reach many different sectors, it would seem to me that there needs to be more diversity, and I haven't seen that yet. I'm quite surprised about that, considering we're talking about public health, and I would think that there are a lot more variety of people in public health than what I've seen so far. So that's just – I guess I throw out even as a question, is there more diversity than what I see in the room and maybe what I've even seen in my workplace, or is that something we need to work on?

MARY WELLIK: I can comment on that a little bit. My community's a little bit unusual because it attracts a lot of people from different countries or refugees and immigrants, so this is a community of about – the city is about 80,000 people and our local school district has 60 different languages in it. So many different cultural backgrounds, people of different cultural backgrounds who have always lived there, people who are immigrants, people who are refugees. To incorporate and respond to those cultural differences is really a challenge for those of us who have grown up in a homogeneous cultural experience. We really struggled with that for about 15 years or so. In the process we've tried a lot of different things. We've just started asking each of these different cultural groups to teach us about their culture. We've done things as simple as sharing food. We've found ways to create some contract money so that we can bring people on and give them positions where they can help people in their own community learn to use health resources that are in our community. And in the process, I've seen my staff and my department really get much more comfortable just with each other, asking each other questions, being more open about those cultural differences. It really takes a lot of energy and effort, although there's a big payoff. It's not the kind of thing that you really see on a balance, so you have to be constantly advocating around this kind of thing. The downside of it is that many of our systems require competencies in things that are based in my kind of cultural background, language skills, things of that nature. And it's very hard to give people jobs that get them into the systems where we need them to help us change. And so that's the thing we're constantly working on. How do we get people's voices in the room but also give them the jobs that are going to influence making those changes happen. And I guess I just have to say again, it's a slow process. We have Somalians, Bosnians, people from Mexico and South America, Hispanic people, Russians, we have all kinds of folks sitting around a table together saying there's some collective things that we can do together here that are working.

MARK BECKER: I think the answer to your question is "yes, we need to work on this." And actually, there are three pieces that we should be focused on. One is recruiting a more diverse student body. I come from the same state as Mary. Minnesota, though not widely recognized as such, is incredibly rich and diverse, especially with recent immigrants. Second, making sure that we, whether we is where they work or where they're educated, have an environment where everybody feels comfortable, that nobody is made to feel uncomfortable because they're different. And thirdly, we should focus on cultural competencies, so that all of our students are educated to be more aware, more knowledgeable, more competent in working across cultures, because that's the world today. So the answer is yes, we need to work on this, we have several areas to work on, and in our schools of public health we're endeavoring to do so.

MARY WELLIK: I'd just add that one thing that's helped us is that foundations are very interested in this arena. And we've really gone out looking to foundation funding for some of the programs that we've used to get this done.

BOBBY PESTRONK: Folks in our community have told us that one of the things we need to do is to open up some discussion about racism in our community, in the nation, and the extent to which that is really influencing the nature of the culture that we have and accounts for a good portion of the difficulty we have addressing bring people into the workplace, having people feel comfortable in the environment that we produce. Because there is a huge – we have in this country built many organizations and institutions under the assumptions that people will come, but they don't for reasons that we have not in our communities explored. They don't come because there is, in communities where there are different races, the races don't talk to one another, they don't understand their perception of each other, and they fail to get to the bottom of what folks in our community

tell us accounts for the disparities that exist. We're not yet focused on the root causes for these disparities; we're focused somewhere else right now. And I think the lessons our of our community right now are to open up some of these very difficult conversations, exploring how people feel and think about one another, what their perceptions about each other are, and getting people comfortable around that conversation as a starting point for really making some of the changes that may be necessary in our organizations.

HARRISON SPENCER: We have an agenda for diversity, too. When I say an agenda, it's an association-wide strategy on diversity led by the chair of our executive committee, Dean Susan Scrimshaw from the University of Illinois at Chicago School of Public Health. There are three elements. One is to increase the diversity of the faculty and students in schools of public health. Secondly, we have begun a new initiative to develop linkages with the historical black colleges and universities. We've been working very actively with minority health professions organizations and with the black caucus of Congress. However, the issue that I think is one of the most important public health problems for this decade is disparities in health. We usually think of the causes of health disparities as poverty and lack of education resulting in poorer access to appropriate medical care. The recent IOM report however, suggests that it is not that simple. Even at the same level of income and the same level of education, you still have health disparities in populations. And I think one of the most important things we can do to change this and to solve the problem is to require a very multidisciplinary approach with the input of many, diverse groups. And that's one of the goals we have: to improve this completely unacceptable reality of our healthcare system.

DAVID STEFFEN: Well, I'd just like to comment and say, you're right, thanks on that, and also thanks in terms of one of the competencies that I think is part of collaborative leadership that was mentioned a couple of times that we shouldn't forget, by youth oftentimes, by religious groups, and by elderly, and that's courage, you know, to speak out and say what's right. I think your comment is not unrelated to what we're talking about here today. A lot of times I think in public health the scientific version of public health in which we feel there are technical solutions to every problem, collaborative leadership is not valued, and I think the diverse individuals that are better at and are appreciative of that collaborative leadership process are not involved as much. So I think by pushing collaborative leadership, I think we will get a more diverse public health leadership force as well. A final thing that your comment occasions very definitely for me, and we were having a conversation about that, is the collaborative might be able to help us with another area of competence. One area that we just have not – and Steve and I have had discussions on this, too – one area of leadership curriculum that we've not been successful at getting at, at least as far as I know, is the cultural competence piece. Nobody has something that they feel good about, that's comfortable, that works, and no one's – I think one of the dangers we have is that people aren't going to feel comfortable being uncomfortable until they make it comfortable, if you follow my drift on that, and so we avoid it at this point. And so I think we need a push for that, and that's something that is key to collaborative leadership to get that done.

STEPHANIE BAILEY: However, I'm going to require the same competencies around collaborative leadership no matter what your color, if you're working in public health. Those competencies should be there whether you look like me or you do not look like me. If you're doing collaborative leadership and if you're about community, then you should have those skills and you should be competent at doing them. And I need to go.

DARVIN AYRE: Thank you, Stephanie. I know you have to catch a plane, so thank you for being here today. We have time for another question or comment on how

we move this work forward.

[MALE]: We've got three issues real quickly. Relationships, values, and dollars. If our communities value public health and population health, then they'd be willing to spend local dollars, and we're not spending local dollars. Most places are getting 90 percent from the feds. And so relationships could drive changes in values if we push for those relationships that would drive collaborative leadership. So to me, when we really feel strongly at the local level about public health and population health and health of our communities, then we'll reach deep in our pockets and spend some more and quit relying on the feds all the time. We always gripe about unfunded mandates, but maybe that's because we don't – aren't willing to look at the mirror and to develop people – get people out to vote for the right things.

DARVIN AYRE: Thank you. Folks, we're going to need to close for the day, but I want to do a quick evaluation that's public for all of us right now. I think that Jeff may have a written one. Is that later? In the collaboratives packet. We just want to do a quick plus Delta, if you will, and this is just to help us get a sense of what went well today and what we could do more or less of next time. What worked well today in this conversation? Just put it right out there and I'll try to capture it here. Things that worked well today. Anything about the format, the room.

[MALE]: Everybody that commented. I mean, I think all the panelists really were engaged in the comments.

DARVIN AYRE: Great. What else? [Inaudible] What else? Anything else?

[MALE]: The passion of the panelists.

DARVIN AYRE: The passion of the panelists. Great.

[FEMALE]: The panelists really spoke from their perspectives, their place in the industry.

DARVIN AYRE: Thank you.

[MALE]: Interaction with the audience.

DARVIN AYRE: Anything else?

[FEMALE]: Those were new ideas that people were suggesting.

DARVIN AYRE: New ideas?

[FEMALE]: We hadn't taken about [inaudible].

DARVIN AYRE: Some new ideas emerged.

[FEMALE]: Some new suggestions of action [inaudible]

DARVIN AYRE: Some action suggestions. What else? Anything else? Things that worked well today.

[FEMALE]: The room set-up.

DARVIN AYRE: The room set-up.

[FEMALE]: Nice [inaudible].

DARVIN AYRE: Okay.

[FEMALE]: I think the – I don't know who all, but I believe it was Jeff and probably some of his staff, did a nice job of having the panelists prepared with some background information and some –

[FEMALE]: We had some plane reading and so we were ready.

DARVIN AYRE: Well prepared. Anything else? Things that worked well? [Inaudible] Good – food is always a great way to do collaborative and conversation about collaborations. Anything else? Let's make a quick transition, then. Things we do more or less of next time. Things we would change to get more out of a day like today.

[FEMALE]: We think [inaudible] collaborative [inaudible].

DARVIN AYRE: The collaborative. Anything else?

[MALE]: We may have tried to pack too many questions into the time frame. I don't know if the panelists felt that at all.

[MALE]: As a panelist, it was sometimes difficult to know what question we were addressing. What did you want us to be talking about at this particular moment. Felt as though we were grazing across a whole pasture rather than a particular place.

DARVIN AYRE: Great. Thank you. Maria?

MARIA CASEY: It was a bit long to be sitting here.

DARVIN AYRE: Okay.

MARIA CASEY: When you're a panelist and you're being videoed, you don't feel like you can get up and sort of just stand up behind your chair, but I felt like I wanted to do that.

DARVIN AYRE: Thank you for that. Anything else? More of, less of. Yes?

[MALE]: Other diverging views. People hold opposing views [inaudible].

[FEMALE]: So we can have a debate.

[MALE PANELIST]: I think that's a good point.

DARVIN AYRE: Great. Thank you. Anything else?

[MALE]: Examples from other sectors as well.

DARVIN AYRE: Examples from other sectors.

[MALE PANELIST]: I think the first question was a tough one to start with. Might have started with the second question, speaking from our experience, and then go to the second one.

DARVIN AYRE: Great. Thank you. Folks, our time is up today. Thank you again for your participation, panelists and audience. Thank you very much.

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Collaborating for a New Century in Public Health

Turning Point is funded by:
THE ROBERT WOOD JOHNSON FOUNDATION®

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