

**Public Health Leadership Development Summit
Executive Summary ♦ Summit Proceedings**

**Aberdeen Woods Conference Center
December 5, 2006**



**PUBLIC HEALTH
LEADERSHIP
SOCIETY**

Public Health Leadership Development Summit

Letter from the PHLS Executive Board
January 31, 2007



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Public Health Stakeholders:

The Public Health Leadership Society (PHLS) is pleased to release the *Proceedings of the Public Health Leadership Development Summit* for public comment. We would like to extend an invitation to public health stakeholders to comment on the proceedings on the PHLS website, www.phls.org

With the support of the Center for Disease Control and Prevention (CDC), PHLS successfully convened a select group of public health stakeholders to discuss leadership and workforce development on December 5th, 2006 in Atlanta, GA. The Public Health Leadership Development Summit was part of CDC's year-long efforts to focus on public health leadership development for the future.

Since the Summit, participants and others have expressed their interest for involvement in the larger process of advancing leadership and workforce development. We encourage stakeholders to post their comments and ideas on the PHLS website. Comments will be made available to CDC for consideration as they press on with the agenda for public health leadership nationally.

PHLS is committed to continuing the dialogue and study of public health leadership. With comments and support from the workforce, we hope to ensure the future of public health leadership and workforce development.

Sincerely,

Patricia Nolan, MD, MPH
Chair
Public Health Leadership Society

Joseph Kimbrell, MA, LCSW
Executive Director
Public Health Leadership Society

PHLS Leadership Development Summit

◆ Executive Summary ◆

Aberdeen Woods Conference Center

December 5, 2006

The Public Health Leadership Society, with support from the Centers for Disease Control and Prevention (CDC), convened a select group of stakeholders from academia, the private sector, and the federal, state, and local levels of government to discuss the future directions for leadership and workforce development. Leadership programs have made a substantial impact on the strength of the public health system for over a decade, and a review of past accomplishments as well as future prospects is timely.

The forum was opened by Dr. Stephanie Bailey and Dr. Steve Thacker from the Centers for Disease Control and Prevention, Dr. James Marks from the Robert Wood Johnson Foundation, and Phil Jacobs of BellSouth Community Technologies. The speakers cited leadership as a strategic imperative both for their own organizations and for the field at large. Dr. Thacker referred to the Summit as a renewal and an opportunity to discover what we need, how to get it, and the barriers to achieving what is needed. Phil Jacobs affirmed the importance of investing in leadership in the private sector and the public sector. He stated that BellSouth sees results on a daily basis from the investment that they make in identifying and training leaders. Dr. Marks spoke to the need for public health leadership development as an underpinning for public health effectiveness.

"THERE IS A NEED FOR PUBLIC HEALTH LEADERSHIP DEVELOPMENT AS AN UNDERPINNING FOR PUBLIC HEALTH EFFECTIVENESS."

- Dr. James Marks, Senior Vice president and Director of the Health Group, Robert Wood Johnson Foundation

Dr. Ron Davis, President-elect of the American Medical Association, chaired the event and listed the objectives of the Summit. These were to:

1. Identify and articulate a general direction and framework for leadership development for the public health workforce.
2. Identify the importance and priority of investments for public health leadership development.
3. Launch the study of public health leadership development and make a commitment to support stakeholders and funders to ensure an effective and useful process.
4. Identify the methods to communicate and disseminate the deliberations of the Public Health Leadership Development Summit.

Participants divided into workgroups to explore opportunities for advancing leadership in public health. They noted the challenges facing contemporary leaders, and the current climate of systemic change and evolving workforce composition. They observed that the current fabric of leadership development in public health is both historic and a logical evolution. Participants noted that if we did not have our current leadership programs in public health at the national, regional and state levels, we would have to create them. Their intrinsic value is that apparent.

Dr. Ron Davis summarized the day's work on defining a leadership framework (Objective One):

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◆ Executive Summary *(continued)* ◆

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- ◆ Linkages are needed, including networking, partnership, and systems thinking
- ◆ Evaluations can define progress to date, develop a science of leadership development, create metrics, and define return on investments (ROI)
- ◆ Advocacy is key; requiring communications, policy and legislative skills
- ◆ Disaster and large-scale challenge preparation requires planning, response and crisis management skills and knowledge
- ◆ Experiential learning for public health practitioners requires intensive and meaningful training
- ◆ Resources are needed for public health and for developing leaders
- ◆ Succession planning avoids interruption in services, gaps in expertise, and poor disaster response.
- ◆ Healthy people and populations are the over-arching goals
- ◆ Integration of information technology, such as the internet, electronic health records and personal health records, is a key factor for change
- ◆ Potential leaders need to be identified, enrolled and developed

The speakers and participants articulated the importance and priority of leadership development investments (Objective 2).

The importance and value of leadership skills in public health was affirmed throughout the Summit. Leadership is too important to be “owned” by any one organization or sector. All of the Summit participants need to celebrate their successes, embrace the need to keep a strong network of leadership development, and reflect critically on the significance of their work after more than a decade of sustained investment. Leadership for leadership development must continue to come from many quarters, or fragile gains of the past may be eroded. It is far too important for public health in any of the stakeholder groups to abdicate their role.

The Summit is part of efforts by the CDC (Objective 3) to focus on leadership development both at CDC and for the larger public health workforce. Bearing Point Inc., a contractor for CDC, will focus their work on internal leadership development at CDC. The resulting framework might also serve as a guide for state and local public health agencies.

The Summit highlighted the need for a complementary examination of the system for leadership development beyond the CDC. The Public Health Leadership Society, the National Public Health Leadership Development Network, and other groups identified both the need and desire to have a period of review and reflection for all the leadership programs to provide guidance for improvement and to respond to the many challenges facing our workforce. This review must also examine the fragility of funding and support for many of our key programs.

The Public Health Leadership Society has posted the full proceedings of the Summit on its web site with an

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encouragement to comment on this critical topic. PHLs will continue to work with all the partners on ways to continue to enhance the field of leadership development.

◆ INTRODUCTION

The Centers for Disease Control and Prevention (CDC) provided support to the Public Health Leadership Society to convene a select group of stakeholders from academia, the private sector, and the federal, state, and local levels of government to discuss the future directions for leadership and workforce development. The Summit is part of a larger process of advancing leadership and workforce development within the field of public health. Leadership programs have made an impact on the public health community for over a decade, and a renewed look at the overall system for leadership development is timely.

◆ OPENING SESSIONS: EXPLORING OUR CHARGE

Dr. Stephanie Bailey, *Chief for Public Health Practice at CDC*, opened the forum with a welcome and introductions of the morning speakers.

Dr. Ron Davis, *President-elect of the American Medical Association*, cited four objectives for the Summit. These were to:

1. Identify and articulate a general direction and framework for leadership development for the public health workforce.
2. Identify the importance and priority of investments for public health leadership development.
3. Successfully launch the study of public health leadership development and make the commitment to support stakeholders and funders by providing input as needed to ensure an effective and useful process.
4. Identify the methods to communicate and disseminate the deliberations of the Public Health Leadership Development Summit.

Dr. Davis stressed that when we talk about the study of public health leadership development we recognize that this is a new era in public health. We are hoping for good ideas and solutions. We will want to communicate and act on the report that we develop in this meeting.

“LEADERSHIP IS ONE OF THE STRATEGIC IMPERATIVES FOR CDC.”

- Dr. Steve Thacker,
Centers for Disease Control and Prevention

Dr. Steve Thacker, *Director for the Office of Workforce and Career Development at CDC*, noted that leadership is one of the strategic imperatives for CDC. We should take advantage of this session as an opportunity to look

at what we should be doing in the coming years. This is more of a renewal than a beginning, an opportunity to discover what we need, how to get it, and some of the barriers to achieving what is needed. He charged the participants to think big and to challenge all of us.

Bobby Milstein, *Summit facilitator*, reviewed the agenda and cited the challenge of achieving our outcomes in one day. He asked for participant expectations. Feedback included discussion on whether there is a common definition of leadership and what are the right structures for new leadership. Participants shared some experiences with using outside experts for employee development and to assess leadership potential of employees and managers. The question of whether leaders are born or trained or both was raised. Issues of evaluation, sustainability, value of leadership, the role of networking and management versus leadership training and competences were all discussed. One participant noted that “bad management is a public health risk factor.” Another participant reminded the group that leadership is nested within the culture of an organization.

◆ DEVELOPING LEADERS IN PUBLIC HEALTH AGENCIES AND BEYOND

Phil Jacobs, *President of BellSouth Community Technologies and Chair of the Board of Directors for the CDC Foundation*, addressed the topic of *Developing Leaders in Public Health Agencies and Beyond*. Mr. Jacobs spoke of his respect for people in public health and their commitment to public health. He also noted that there is a growing appreciation of what public health does. Public health sets an example for business of doing the right thing. BellSouth has developed and used simulated exercises for their leadership. These simulations

“BENEFITS FROM INVESTING IN THE WORKFORCE CANNOT BE EASILY QUANTIFIED, BUT WE SEE THE RESULTS EVERY DAY AT BELL SOUTH.”

- Phil Jacobs, *President of BellSouth Community Technologies and Chair of the Board of Directors for the CDC Foundation*

are characterized by compressed timelines, immediate feedback, and crisis management. During the exercises, cross-disciplinary and cross-departmental communications and interactions are critical. As a public service, BellSouth has modified these simulations for use by area school districts and superintendents.

Some leadership qualities can be learned; some are possessed by the individual.

Leadership training cannot change everyone into a leader. Investing in leadership training and identifying new leaders is part of their succession process, which BellSouth takes very seriously. Every manager has to assess the talent of the staff. A 360 degree evaluation is done for all employees. The top 10% are identified as emerging leaders. Each key position must have a designated backup. Staff are taught priority-setting, decision-making, crisis management and undertake an objective leadership assessment.

BellSouth believes that the stronger we can make our communities, the stronger we are as a people. There is a return back to corporate America when a community is healthy. Much of the talent is homegrown at BellSouth; community investments help keep the company from being isolated. Staff are encouraged to invest in communities and volunteer personally.

BellSouth had a plan and was ready for disasters when the hurricanes of 2005 hit their service area. They had an emergency operations center structure in place. Command and control decision-making changes during a crisis. The roles quickly alter when you take your position as part of a team in a disaster. Their work with simulations made them more effective and able to function quickly to support their service area. Mr. Jacobs

noted the need for a dedicated crisis facility, communications support, and a management structure that provides metrics to be reported at regular times during a crisis. There needs to be a way to quickly reach all staff during a crisis when the usual methods don't work. They had a call in system in place.

Mr. Jacobs stated that the benefits from investing in the workforce cannot be easily quantified, but they see the results every day at BellSouth. Much of the "proof" is largely experiential, but the common denominator is evident in the quality of the people, their performance under changing conditions, and their involvement in their communities.

◆ **SNAPSHOT OF THE CURRENT SYSTEM FOR LEADERSHIP DEVELOPMENT**

Joe Kimbrell, *CEO of the Louisiana Public Health Institute*, reminded the participants of the composition of the workforce with an average age in the late forties. Up to 50% of the workforce may be eligible for retirement in a few years. The workforce is large, estimated at 500,000. The number of graduates from the accredited schools of public health is only 6399 annually.

He reviewed the landmarks of public health leadership development, starting with the Institute of Medicine report of 1988, followed by the development of the Public Health Leadership Institute in 1991, and 22 state and regional leadership programs over the next decade. Other key developments include the creation of the Public Health Leadership Society, the National Public Health Leadership Development Network, the State Health Leadership Initiative, and CDC leadership program.

Lee Thielen, *Executive Director, CALPHO and the Public Health Alliance of Colorado*, noted the common threads that were reflected in the four papers that were included in the summit materials. These included:

- ◆ A belief that leadership is integral to public health practice.
- ◆ An articulated need for a partnership of multiple players to provide leadership training.
- ◆ Recognition that leadership needs keep evolving.
- ◆ Leadership training and development takes many forms, including coaching, mentoring, certification, and credentialing.
- ◆ Leadership means playing outside of your comfort zone, requiring courage, imagination, curiosity, crossing organizational lines and empathy for the cultures of other organizations.

We need leadership skills because what public health does is so important. Some of the illustrative goals that were identified for the Summit, show the need for public health leadership development; the goals are:

- ◆ To develop and improve the public health system.
- ◆ To mobilize public and private partnerships to promote health and safety in communities.
- ◆ To communicate public health to fellow citizens in ways that build trust and collaboration.
- ◆ To provide guidance, direction and momentum across organizational lines to respond to unanticipated threats.

◆ **WORKGROUPS AND DISCUSSION OF THE OPENING SESSIONS**

The participants discussed the concepts presented by the speakers and added their own observations:

- ◆ Connectedness in the system of leadership development has been evolving, but not according to a defined design. The elements of the system have accumulated incrementally over time.
- ◆ There is a need to identify the overall structure of the system for leadership development.
- ◆ There is logic to the connections and order of the components of leadership development, but there is no clear understanding of the building blocks of the system.
- ◆ A comprehensive approach is needed that recognizes that leadership comes from many levels and often from the technical professions, but must not be limited to those with special training. Ultimately, more ordinary citizens must become leaders for protecting the public's health.
- ◆ The schools of public health are producing many graduates, but we still have a paucity of leaders. Why?
- ◆ Fragility, concerns about sustainability and instability are part of the current dynamics in leadership development programs.
- ◆ Management training and leadership training are different, but also have some commonalities. Both are needed.
- ◆ Mentoring and public health advocacy are needed in leadership development.
- ◆ Metrics are needed to show the results of leadership development.

The participants broke into workgroups to list the major challenges that might be anticipated for public health in the next 10 years. The groups were asked to note those with the most far-reaching implications for leaders and for the current system of leadership development.

Challenges:

Some of the challenges noted included: health disparities, burden of illness, eroding confidence in public health, emerging information technologies, interconnectedness of the sectors, and many other challenges of the public health system.

Others included the move toward individual control over health decisions, changing demographics, obesity, and disaster preparedness, including another event with the force of 9/11. In addition, funding and the competition for scarce resources, the intersection of medicine/public health/ and consumerism, globalization, and the need to harness other voices in support of public health work were noted.

These challenges create the need for:

- ◆ Systems thinkers
- ◆ Ability to work across organizations
- ◆ Adaptive leaders
- ◆ Strong advocates
- ◆ Bold/wise/calculating risk takers
- ◆ Capacity for thoughtful and strong judgments
- ◆ Commitment to values and passion for public health

◆ A VISION OF PUBLIC HEALTH LEADERSHIP FROM THE ROBERT WOOD JOHNSON FOUNDATION

James Marks, *Senior Vice President and Director of the Health Group, RWJF*, noted that RWJF supports social

change for health, recognizing the primacy that the public health system, with the state and the local public health agencies at the core, has in making our communities healthy places to live, work and play. He stated that RWJF is very concerned about the future of the public health system and concerned that public health agencies are losing ground.

The Foundation is involved in promoting healthcare quality as well as population-based public health policy, issues of accountability and accreditation, and developing high leverage tools and strategies such as information technology and public health laws. They have looked at health services research to see what is comparable in public health. It appears that little has been done. RWJF is also interested in engaging in the public health field in advocacy for policies that improve health. RWJF has had experience and success in tobacco policy change and expects to use similar strategies in advancing other public health priorities, such as improving public health preparedness and obesity. There is a sense of urgency around chronic disease. For example, 25% of the increase in health care costs since 1987 is due to obesity.

We need to look at system-wide issues in public health and their implications for leadership development. Public health is a cottage industry with few formal links. We don't have an integrated system but rather an array of independent "boutiques." Frequent turnover of leadership adds to the challenges.

We need influential voices outside of formal public health agencies to support and advocate for the work we do. Public health is not just a governmental responsibility.

He stated that we need to design a leadership system to respond to a public that expects more. Trust in government is declining generally. The lack of a background in public health in top state officials also needs to be addressed.

The heads of public health organizations need to be good at identifying new leaders. They also need to build bridges with key partners in the public health system, including health care organizations, community organizations, businesses, policy makers and the media. These bridges need to be built early, refreshed often, and have others recognize them.

He cited the need for integrity, energy and intelligence in our leaders. Integrity is most important of all. He noted that some characteristics of leadership are indeed those with which leaders were born. That challenges us to identify leaders with innate potential. Leaders also need the training and skills development to bring out those characteristics. We need to identify our potential stars early, train them well and require them to think of the bigger picture. Building networks and relationships are important elements of what leadership development should entail.

We need to be critical about what we do regarding public health leadership development, constantly improving and adjusting to meet needs. We need to do a good job in showing where past investments in leadership have led to important advances.

◆ **DEFINING PROMISING DIRECTIONS, WORKGROUP REPORTS AND CONCLUSIONS**

The participants voiced many reactions to the conversation about a framework for leadership development. Some noted the need to declare an emergency of public health leadership while others felt that we are using leadership as a substitute for what public health should do and be. Some of the participants were comfortable with the vision that leadership is about improved health, while others cited a need to have

a more narrowly defined vision of the purpose of leadership development. Participants saw the many accomplishments to date through the partnerships with state and local efforts and CDC. The issue can be framed as an asset model due to all the accomplishments over the last 15 years.

There is a tension between the uncertainties of sustainability of the current leadership strategies and programs, and the desire to build on current and past successes. The desire to develop a three level system that recognizes the different needs of the workforce at the levels of entry, mid-level and state and local director positions was articulated. An acceleration of the pool of leadership is seen as critical. The need for measures and evaluation of all programs was cited, along with an acknowledgement of how difficult that sort of inquiry may be.

The Bearing Point Group will look at CDC leadership programs over the next year. Participants offered to assist by providing input, information, and consultation to the study team.

Dr. Davis solicited information from the participants about new ventures in public health leadership. There are initiatives in California, at NPHLI with a year of review and renewal, with a combined NACCHO/RWJF anticipated initiative for local public health agency officials, with the Kansas Health Foundation, the Partnership for Prevention, and efforts in North Carolina with emerging leaders.

Dr. Ron Davis summarized the day's work:

Framework for Leadership Development

- ◆ Linkages are needed, including networking, partnership, and systems thinking
- ◆ Evaluations can define progress to date, develop a science of leadership development, create metrics, and define return on investments (ROI)
- ◆ Advocacy is key; requiring communications, policy and legislative skills
- ◆ Disaster and large-scale challenge preparation requires planning, response and crisis management skills and knowledge
- ◆ Experiential learning for public health practitioners requires intensive and meaningful training
- ◆ Resources are needed for public health and for developing leaders
- ◆ Succession planning avoids interruption in services, gaps in expertise, and poor disaster response.
- ◆ Healthy people and populations are the over-arching goals
- ◆ Integration of information technology, such as the internet, electronic health records and personal health records, is a key factor for change
- ◆ Potential leaders need to be identified, enrolled and developed

◆ COMMUNICATIONS FOR THE SUMMIT

The Summit Proceedings and related presentations will be shared with all the participants and posted on the Public Health Leadership Society's website, www.phls.org. A mechanism will be established to accept commentary and exchange dialogue on the topic. Participants will be advised on any future opportunities to add to the discussion.

◆ SUMMIT PLANNING COMMITTEE

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◆ ACKNOWLEDGMENTS

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