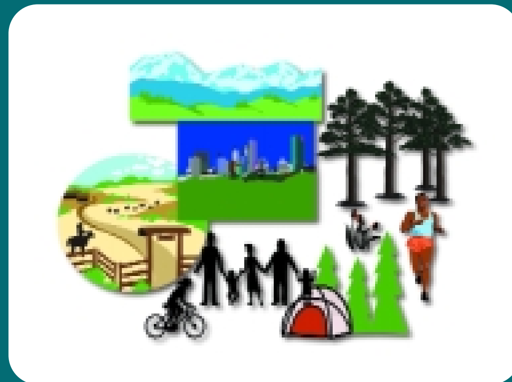
STRATEGIC PLANNING PHASE:

RECOMMENDATIONS FOR LEADERSHIP DEVELOPMENT WITHIN THE PUBLIC HEALTH FIELD AND COMMUNITY PARTNERS

TURNING POINT INITIATIVE



Colorado's

Public Health

Improvement Plan

Colorado Public Health Improvement Plan
Colorado Turning Point Initiative
August 2001

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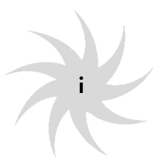


Background

ALMOST 14 YEARS AFTER THE PUBLICATION of the breakthrough report *The Future of Public Health* by the Institute of Medicine (IOM), some would contend that the U.S. public health system today is not much closer to realizing the goals of the IOM study than it was in 1988. While there have been public health achievements since then, new and more complex challenges have presented themselves. Among these new challenges are an increasingly diverse political constituency, the resurgence and spread of drug-resistant strains of disease-causing microbes, global transmission of new and emerging diseases, the threat of bioterrorism, decreased funding for public health programs and infrastructure, reduced health insurance coverage and overall access to health care, and health disparities. All of these issues present overwhelming challenges to safeguarding the future health of the public.

In the summer of 1999, the Colorado Department of Public Health and Environment (CDPHE) received a Turning Point strategic planning grant from the Robert Wood Johnson Foundation. The purpose of the grant was to facilitate a collaborative process to assess the health of Colorado residents, examine public health systems in Colorado, and then create a state public health improvement plan. This document is one product of that work. Colorado is one of 21 states participating in the National Turning Point Initiative and is guided by the overriding mission to transform and strengthen the public health system to make the system more effective, more community-based, and more collaborative.

A steering committee carried out the strategic planning process with input from workgroups. In examining health status and health systems within Colorado, it became clear that while Colorado is a relatively healthy state, there are still barriers that prevent optimal health for the general population, and there are specific population groups that are disproportionately impacted by disease, disability, and death, especially minority communities. In looking toward the future, public health is likely to face challenges never before seen, where a strong public health infrastructure and visionary leaders will be critical to maintaining the health of Colorado residents. Through its assessment, the Turning Point Steering Committee determined that many groups in Colorado have a difficult time accessing health care. This is due in part to a lack of insurance coverage and the fact that many rural areas in Colorado have been federally designated as Health Professional Shortage Areas. In terms of public health infrastructure, funding constraints currently prevent expanding the workforce, increasing information and data systems capacity, and enhancing organizational capacity, especially in local agencies.

Through its public health systems assessment, the steering committee determined that the key strategies for improving health status in Colorado include:

- Increasing the capacity of public health and environmental agencies
- Increasing the capacity to conduct population-based health status assessment
- Assuring access to quality health care
- Assuring access to insurance coverage
- Eliminating health disparities
- Promoting leadership development within the public health field and community partners

Beyond the steering committee and workgroups, the Turning Point Initiative used key informants, a review of the literature, and national and state data to examine each key strategy area. In this document, a national perspective will be included, as these key strategy areas are not unique to Colorado. This planning process was conducted by a diverse set of partners, many of whom are not from governmental public health agencies. The Colorado Turning Point Initiative believes that maintaining and improving the public's health requires partnerships with many different sectors and communities. This plan is meant to be carried out in collaboration and should be used as a guide. We believe that any person, community, or entity can take a leadership role in mobilizing partners around the recommendations in this plan, and we invite this participation in maintaining the health of our state.

Data Issues

This document attempts to provide the latest data available; however, data availability varies by year depending on the data source. In most cases, 1999 is the most recent year for available data. When 1999 data is not yet available, earlier data will be presented.

In preparing this plan, guidance was sought from the *Healthy People 2010* document, which will be referenced often. *Healthy People 2010* is a set of national health objectives to be achieved over the first decade of the 21st century. The objectives were developed by a consortium of partners, led by the U.S Department of Health and Human Services.

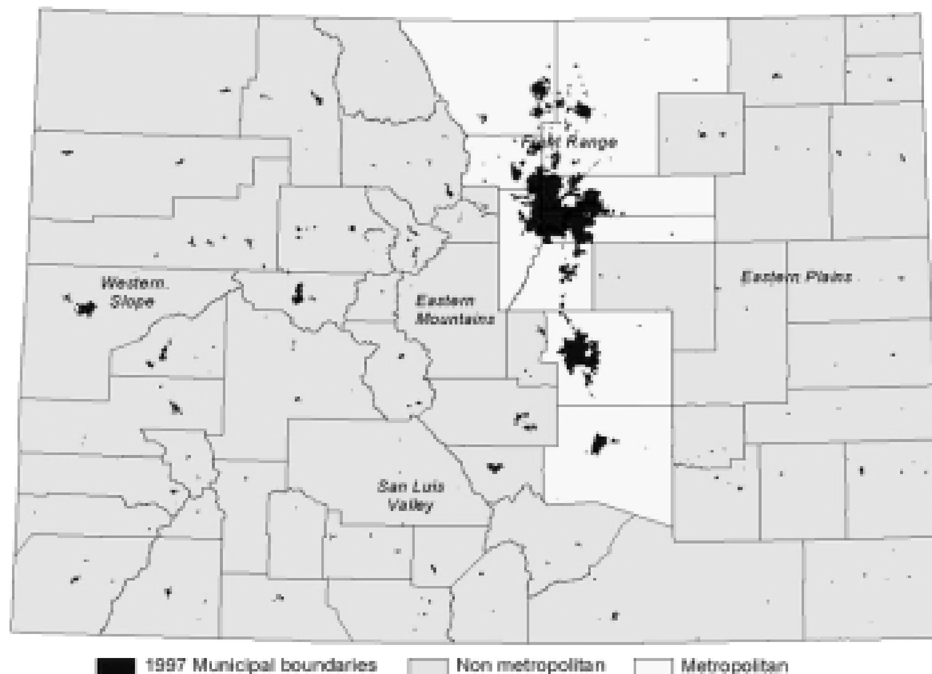
Colorado Turning Point also wishes to recognize the difficult issue of using labels when discussing race and ethnicity. It is hard to gain a consensus on the preference of categories such as "people of color/minority," "American Indian/Native American," "African American/black," "Hispanic/ Latino(a)," and "Caucasian/white." We acknowledge that not everyone identifies himself or herself with these categories, and we very much respect the importance of cultural differences in how communities prefer to be defined.

Finally, in accordance with the Centers for Disease Control and Prevention, Colorado Turning Point also recognizes that race and ethnicity are social constructs representing distinct histories and cultures of groups within the United States and that they are not valid biological or genetic categories.

Profile of Colorado

Colorado's population is young, healthy, rapidly growing, and increasingly wealthy, relative to national averages. With a population of approximately 4.3 million, Colorado is home to only 1.5 percent of the United State's population. Colorado's population density is 39.2 persons per square mile compared to the rest of the nation at 77.1.[1] Colorado is a geographically large state with 80 percent of its residents living in 10 metropolitan counties on the east side of the Rocky Mountains. This region is known as the Front Range. The remaining 20 percent of residents are scattered throughout the mountains, eastern plains, and western plains of the state (Figure 1). Colorado consists of 63 counties, 29 of which are considered rural and 23 are considered frontier (less than 6 people per square mile).[2,3] In November of 2001, Broomfield will become Colorado's sixty-fourth county.

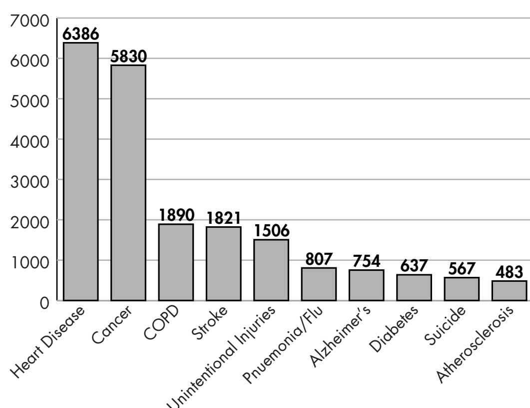
Figure 1: Metropolitan and Rural Regions of Colorado



Health Status

Colorado, by any number of measures, is a healthy state. In 1999, Colorado's age-adjusted death rate for all causes was 801.2 per 100,000 persons, well below the national rate of 881.9.[4] Colorado's death rate has remained lower than the U.S. rate for the past 16 years.[5] The fact that this rate has been adjusted for age indicates that the difference between Colorado and U.S. death rates is not due to Colorado's relatively younger population. Many of Colorado's health indicators are better than national health indicators, including leading causes of death. Colorado's death rates are lower than national death rates for chronic disease such as heart disease, cancer, stroke, and diabetes.[6] Leading causes of death in Colorado are displayed in Figure 2.

Figure 2: Leading Causes of Death, Colorado 1999



Colorado Department of Public Health and Environment, Health Statistics Section, *Colorado Vital Statistics,1999*. Denver, CO: June 2001.

From a public health perspective, Colorado has much in its favor. In 1998, the state was declared the third healthiest in the nation. When considering *Healthy People 2000* national health objectives, Colorado exceeded or was close to meeting objectives on such preventive indicators as mammograms and pap smears for women over age 50, reducing a number of infectious diseases such as HIV and gonorrhea, reducing births among teens, and reducing infant deaths.[7,8]

According to 1998 data, the latest data available nationally, Colorado does have a few health indicators that are poorer than the national average, including the death rates from chronic obstructive pulmonary disease, unintentional injuries, suicide, atherosclerosis, and Alzheimer's disease. Also, Colorado residents failed to meet the *Healthy People 2000* national health objectives for physical inactivity, smoking, and cholesterol screening.[9]

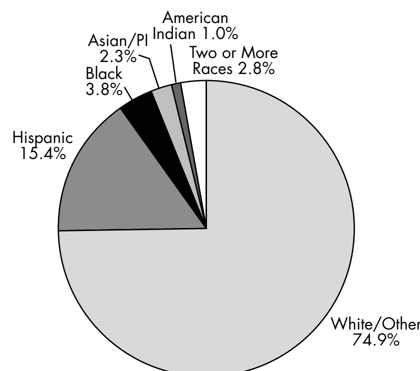
Demographics

In terms of racial and ethnic composition, minority groups account for 25.3 percent of Colorado's general population, and the number is increasing. The percentage of minorities in Colorado has increased over the past decade, mostly due to a nearly 33 percent increase in the number of Hispanics between 1990 and 2000. Population figures are provided in Figure 3. (Percentages do not add to 100 due to rounding.)[10]

Colorado's racial and ethnic composition differs from the national composition in that: the number of Hispanics in Colorado is higher, the number of Asian/Pacific Islanders is lower, and the number of blacks is significantly lower than national numbers. The number of American Indians in Colorado is proportionately similar to the rest of the nation.[11]

In 1999, Colorado's male to female ratio was 49.6 to 50.4. The median age was 35.7. The percentage of the population over age 65 was 10.1 compared to 12.7 percent nationally, and the percentage of the population over age 85 was 1.2 compared to 1.5 percent nationally.[12]

Figure 3: Colorado's Population by Race/Ethnicity, 2000



Source: Colorado Division of Local Government, "Table 3A: Census 2000 Counts of Colorado County Population by Race/Ethnicity and Hispanic Origin," *U.S. Census Bureau: Census 2000 Counts of Colorado Population*, Denver, April 13, 2001.

Poverty

In Colorado, the percentage of people living in poverty has been decreasing since the early 1990s and is below the national rate. In 1999, 8.3 percent of the Colorado population was below the federal poverty level, compared to 11.8 percent nationally. The difference is even more significant for children; 11.2 percent of school-age children in Colorado are below the federal poverty level versus 15.89 percent nationally.[13]

Education

The level of educational attainment for Coloradans is relatively high compared to U.S. average levels. In 1999, 90.4 percent of the population had a high school degree compared to 83.4 percent nationally. Also, 38.7 percent had at least a bachelor's degree, compared to 25.2 percent nationally.[14]

Notes

1. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Colorado 2001, State Health Profile* (Atlanta, Ga.).

2. Colorado Rural Health Center, *Colorado Rural Health Plan: Submitted for Colorado's Participation in the Medicare Rural Hospital Flexibility Program* (Denver, January 1999).

3. Colorado Rural Health Center, *Colorado Rural, Frontier, and Urban Counties, 2000 Census* (Denver, 2001).

4. Colorado Department of Public Health and Environment, Health Statistics Section, *Colorado Vital Statistics, 1999* (Denver, June 2001).

5. Colorado Department of Public Health and Environment, Health Statistics Section, *Colorado Vital Statistics, 1998* (Denver, March 1999).

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7. U.S Department of Health and Human Services, Centers for Disease Control and Prevention, *Colorado 2000 State Health Profile* (Atlanta, Ga.: 2000).

8. U.S. Department of Health and Human Services, Public Health Service, *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* (Washington, D.C.: U.S Government Printing Office, 1991), No. PHS 91-50212.

9. Colorado Department of Public Health and Environment, Health Statistics Section, *Colorado's Progress Toward Year 2000 Objectives,* Brief No. 26 (November 1998).

10. Colorado Division of Local Government, "Table 3A: Census 2000 Counts of Colorado County Population by Race/Ethnicity and Hispanic Origin," *U.S. Census Bureau: Census 2000 Counts of Colorado Population,* (Denver, April 13, 2001).

11. U.S. Department of Health and Human Services, *Colorado 2000 State Health Profile.*

12. U.S. Department of Health and Human Services, *Colorado 2001 State Health Profile.*

13. Ibid.

14. Ibid.

KEY STRATEGY:

Promote Leadership Development for the Public Health Field and Community Partners

Executive Summary

Purpose

The public health field is at a crossroads in terms of defining its role as it moves from direct service provider to population-based services. This, coupled with emerging public health challenges that have never before been seen, has created an urgent need for leadership in the public health field. However, it has become clear that public health professionals cannot do it alone. As we learned from the AIDS epidemic, leadership within communities is also needed to solve the complex problems that exist today while preparing for the challenges of tomorrow. The Colorado Turning Point Initiative has identified leadership development as a key strategy for eliminating health disparities, improving the health status of Coloradans, and ensuring health in the future.

Problem

Almost 14 years after the publication of the breakthrough report *The Future of Public Health* by the Institute of Medicine (IOM), some would contend that the U.S. public health system today is not much closer to realizing the goals of the IOM study than it was in 1988. While there have been public health achievements since then, new and more complex challenges have presented themselves. Among these new challenges are an increasingly diverse political constituency, the resurgence and spread of drug-resistant strains of disease-causing microbes, global transmission of new and emerging diseases, the threat of bioterrorism, decreased funding for public health programs and infrastructure, reduced health insurance coverage, and health disparities. All of these issues present overwhelming challenges to safeguarding the future health of the public.

Findings

Now, perhaps more than ever, there is a need for courageous, creative, impassioned leadership in the public health field, in addition to community partners. This is especially important in marginalized communities that have historically been disenfranchised. To this end, a full range of leadership skills need to be developed in diverse persons. Public health professionals must be participants in political processes and policy development in order to assure that the public health infrastructure is strengthened. They also need to be able to create a vision of what a healthy community looks like and then act to realize the vision in collaboration with community partners.

The leaders of tomorrow must not be left to chance but should instead be identified and cultivated through training and mentorship. This need becomes even more evident considering the new challenges facing public health and communities. Due to the complexity of these challenges, problem solving will require collaborative leadership skills—that is, the ability to facilitate many constituents or stakeholders to define the problem and then create and implement solutions.

Colorado Analysis

In addition to enhancing the leadership skills and approaches of current leaders, it is clear that there is a critical requirement to develop new leaders, thereby increasing the number of people who can engage others in resolving problems and in focusing the necessary commitment. There are several formal leadership training programs in Colorado. The Colorado Regional Institute for Health and Environmental Leadership is a yearlong program that targets the public, environmental, and health care fields. The Lundy Foundation's Leadership Challenge provides formal training to the gay and lesbian community. Leadership Denver is a formal program operated through the Denver Civic League. A strong influence on some of Colorado's leadership development programs has been the model developed by nontraditional community-based lay leadership. For example, the nationally recognized group Act Up mobilized the gay community and then influenced U.S. policymakers and the health care system to acknowledge the AIDS crisis and to target resources. The organization fundamentally changed U.S. public health practices.

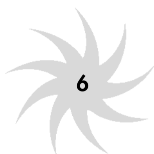
Many experts also agree that formal training is not always necessary. Professionals in the field of collaborative leadership believe that mentoring and providing opportunities of authority for potential leaders facilitates the development of new leaders. There may be opportunities for Colorado to create more formal mentoring networks.

Recommendations

The Colorado Turning Point Initiative outlines several recommendations to enhance leadership development within Colorado's public health field. First, the committee recognizes the value of recognized leaders identifying and cultivating emerging leaders. This need can be met informally or by the support of formal training for the emerging leader. Also, formal mentoring programs could be developed that utilize established leaders and Regional Leadership Institute graduates. Leadership development should be included in all workforce development plans and incorporated into individual employees' professional development plans.

The Initiative also advocates recognizing collaborative leadership as a vital public health strategy. To this end, the public health field should facilitate the development of pubic health advocates in diverse communities, either through the support of formal training, creating leadership opportunities, or establishing mentor relationships. The Initiative also recognizes the difficulty in making leadership development available to rural communities and rural public health agencies. Technical assistance should be offered or training made available at statewide meetings and conferences.

Additionally, it is strongly recommended that public health leaders become a more integral part of the political process, such as running for public office. This creates advocates for public health policies and increased infrastructure firsthand. And last, to enhance all the leadership development recommendations mentioned thus far, Colorado Turning Point recommends that public health in Colorado adopt the National Association of City and County Health Officials' *Principles of Collaboration*.



Leadership Development

Almost 14 years after the publication of the Institute of Medicine's (IOM) breakthrough treatise, "The Future of Public Health," many would contend that the U.S. public health system now is not much closer to realizing the goals of the IOM study than it was in 1988. While numerous public health achievements have taken place since then—the increased surveillance of communicable diseases, for example—new and more complex challenges have presented themselves. An increasingly diverse political constituency, hybrid strains of antibiotic-resistant infections thought to have been eradicated a generation ago, global transmission of new and emerging diseases, bioterrorism, and decreased funding for public health programs, seem to present overwhelming challenges to safeguarding the health of the public. Reduced access to health insurance and health care services along with health disparities magnifies the challenge.[1] Now, perhaps more than ever, there is a need for courageous, creative, impassioned leadership in public health.

During the past 20 years, society has transitioned from industrial types of organizations to information-based organizations. The emergence of technology and knowledge are now very important commodities. As society has evolved, so has the public health field, which is in the midst of a transition from provider of last resort, to provider of essential services and core public health functions. The field of public health is at a crossroads and seeking to redefine its mission and role in society; to restore vitality to some of its institutions; and to invigorate its professional workforce.[2]

These challenges will require leadership within the public health and environmental fields in order to manage these changes and provide for the needed infrastructure. To this end, a full range of leadership skills will need to be developed. Public health and environmental health professionals will need to be participants in political and policy development. They must create a vision of what a healthy community looks like and then to act in order to realize this vision. They will need to share leadership roles with community partners, as collaboratives form to address complex community health issues.[3]

The Colorado Turning Point Steering Committee has identified leadership development within the public health field, and its community partners, as a key strategy for enhancing and assuring the future health of the citizens of Colorado.

The Changing Role of Public Health

From the 1840s to the 1940s, public health had six basic functions: the collection of vital statistics, sanitation, communicable disease control, the provision of maternal and child health programs, health education, and the provision of laboratory services. Between 1940 and 1980, several other functions were added, including the development and provision of personal health services.[4] The 1988 Institute of Medicine Report, *The Future of Public Health*, called for a paradigm shift, describing essential services and the core public health functions of Assessment, Policy Development, and Assurance.[5]

According to the book *Public Health Leadership* by Louis Rowitz, public health infrastructure may be strengthened by utilizing the core functions of public health and its essential services as a guide to changes that should occur. The future of public health will be determined by the way in which core functions are carried out and essential services provided. Public health leaders must evaluate the health status of the population, evaluate the capacity of the community to address its health priorities and implement preventive measures to reduce the impact of or even avoid public health crises. Leaders must not rely on the current assurance models (service interventions) but must implement new assurance models built on an integrated system of service and program delivery.[6]

The Credibility of Public Health

Researchers who have investigated the advances in clinical medicine over the past 50 years, estimate that only five of the 30 years of increased life expectancy can be tied to clinical breakthroughs. Most of the increase in life expectancy is instead due to changes in public health policy. If society continues to invest in the public health system

substantial financial savings will accrue. It is the public health system that prevents epidemics; protects the environment, workplaces, food and water; promotes healthy behavior; monitors the health status of the population; mobilizes communities; responds to disasters; assures the quality and accessibility of medical care; reaches out to high risk and disenfranchised communities; performs research to develop new insights and innovative solutions; and leads the development of sound health policy and planning.[7]

With new challenges emerging in the public health field infrastructure needs to grow in order to continue to assure a healthy state and nation. However, barriers stand in the way of needed infrastructure, impediments such as the public not understanding the role of public health and legislators not perceiving the value of public health. For many, public health has become incorrectly synonymous with medicine for poor people. Compounding the dilemma is a widespread complacency about disease, a growing antagonism toward traditional medicine and its providers, and a skepticism, if not outright fearfulness, about immunization programs, the backbone of public health successes of the last 50 years.

According to Laurie Garrett in her book, *Betrayal of Trust, the Collapse of Global Public Health*:

> Public health is a negative. When it is at its best, nothing happens: there are no epidemics, children are immunized, the air is breathable, food and water are safe to consume, the citizens are well-informed regarding personal habits that affect their health, factories obey worker safety standards, (and) there is little class-based disparities in disease or life expectancy.

She argues that in the absence of the failure of public health, politicians faced with budgetary cuts may feel justified in cutting public health programs.[8]

Nationally, governmental public health budgets were reduced 25% between 1981 and 1993.[9] Additionally, public health agencies and professionals are experiencing an identity crisis due to recent changes in roles and responsibilities. Many human service fields struggle with issues of credibility simply due to the fact that the public often doesn't understand the nature of services provided. It will take public health leaders and its partners to market the value of public health and assure that its infrastructure is strengthened.[10]

Public Health Leadership Defined

The literature on public health and leadership emphasizes the importance of acknowledging that visionary, inspiring leaders are critical to driving change in public health. Leaders bring hope and vision and have the ability to find solutions for the challenges that face the field of public health.[11] Public health leaders must take on many roles including that of visionary, advocate, change agent, convener, policymaker and bridge builder. This is often carried out in varying political and social environments where individual rights or moral issues may conflict with the most efficient ways of keeping populations safe and healthy; the leader must strike a careful balance. Needle exchange programs to prevent the spread of HIV, and helmet laws are two examples of this. One is reminded of the old maxim that "If you are not involved in controversy, you are probably not practicing public health."

Public health leaders are concerned with excellence in public health. They act as role models for emerging public health leaders. They develop benchmarks for best practices. They work with the leaders of other organizations to develop a comprehensive, integrative approach to improving public health in the community.[12]

Training of Leaders Critical to Public Health

The 1988 Institute of Medicine report, *The Future of Public Health,* argued that the creation of effective leaders must not be left to chance. The report stated the concern that schools of public health were not teaching the necessary leadership courses. The report recognized that leaders would need training not only in public health specialties but in all management techniques and tools. Leaders must know how to work across organizations and cultures and how to integrate organizational activities into the communities they serve.[13] As a consequence of this report and through the support of the Public Health Program Office at the Centers for Disease Control and Prevention, a National Public Health Leadership Institute and a number of state-based or regional leadership institutes have been developed. Many of these institutes are a collaboration of a school of public

health and a state health agency. Progress in leadership development was noted in the1996 Institute of Medicine report entitled *Healthy Communities: New Partnerships for the Future of Pubic Health*. The report emphasized that leadership development must continue and that building and strengthening the infrastructure of public health would require strong and effective leaders.[14]

Leadership Development In Colorado

As a part of the national network of public health leadership institutes, Colorado developed its Regional Institute for Health and Environmental Leadership in 1998. The Institute is a collaboration of the University of Denver, the University of Colorado Health Sciences Center, the Colorado Department of Public Health and Environment, the Rose Community Foundation and the Centers for Disease Control and Prevention. The objectives of the program are “to augment the leadership skills of the participants, to broaden the view of the health and environmental system, and to encourage collaboration across the sectors of the system, broadly defined.” Up to 40 Fellows participate in a yearlong experience. The development of collaborative leadership skills is also a key component.[15] In addition to Colorado’s program, Yale and Harvard Universities, and the University of Maryland are also recognized for quality leadership programs in the public health arena.

Other local leadership programs include the Lundy Foundation’s Leadership Challenge, which has successfully developed leadership in marginalized communities using the American Leadership Forum as a template.[16] Leadership Denver through the Denver Civic League and the Denver Minority Leadership Program are additional examples.[17]

Leadership development does not necessarily require formal training. In a recent meeting in Denver, Colorado, a panel of experts in the field of collaborative leadership agreed that many leaders develop as the result of having a mentor and being given opportunities where they are empowered to lead. This is a model of leaders developing leaders.[18]

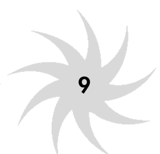
In addition to enhancing the leadership skills and approaches of current leaders, it is clear that there is a critical requirement to develop new leaders, thereby increasing the number of people who can engage others in resolving problems and in focusing the necessary commitment. Recognition of the need to cultivate a grass roots leadership is also vital in reconciling differences and being sufficiently representative of the diversity of interests within the public health and health care sectors. The effectiveness of these social changes will be measured when health conditions are altered in such a way that all are somehow better off. Successful engagement in this process can empower citizenry and bridge the schism between the public health and private care sectors.[19]

Leadership Practices

What practices make a leader successful? Jim Kouzes and Barry Posner have developed five fundamental practices derived from research-based case analysis and survey questionnaires spanning eleven years of study, which include a database of 10,000 leaders. These are the practices taught at Colorado’s Regional Institute for Health and Environmental Leadership. The five practices include the following and will be described below:

- Challenging the process
- Inspiring a shared vision
- Enabling others to act
- Modeling the way
- Encouraging the heart

1. Challenging the Process: Leaders venture out to seek and accept challenges as opposed to waiting for things to happen to them. They are pioneers, willing to take risks, experiment, and innovate. Courage is a common characteristic in leaders who challenge the process.[20]
2. Inspiring a Shared Vision: Creating a vision involves imagining what could be. The leader has an absolute and total personal belief in their picture of the future and is confident in their abilities to make extraordinary things happen. The visionary must enlist people with similar interests by convincing them of the possibility to realize the vision. The shared vision is required because a person without a constituency is not a leader, and a constituency without a leader will not progress.[21]



3. Enabling Others to Act: Leaders recognize that grand dreams don't become significant through the action of a single leader. Leadership is a team effort. Exemplary leaders enlist support and assistance from all stakeholders invested in the vision. Leaders involve those who will be effected by the vision and make it possible for these people to do good work. Leaders work to make their constituencies feel strong, capable, and committed.[22]
4. Modeling the Way: Titles are granted but it is behavior that earns respect. Leaders go first and set an example and build commitment through simple, daily acts that create process and momentum. To model effectively, leaders must be clear about their guiding principles.[23]
5. Encouraging the Heart: To take on a vision is long and arduous work. People become exhausted and disenchanted. Leaders encourage the hearts of their constituents to carry on. Encouragement can come from dramatic gestures or simple actions. It is part of the leaders job to show people that they can win.[24]

Leadership Case Study

The AIDS epidemic of the last 20 years offers an enlightening and inspiring case study of public health leadership. Ironically, this leadership came from sectors outside of traditional public health organizations and the mainstream medical establishment. It was a community-based lay leadership, most identifiable through organizations like Act Up. These individuals, these non-traditional leaders, galvanized, invigorated and emboldened not only the gay community, but U.S. policy makers and the health care system, to acknowledge the AIDS crisis and to target resources toward research. Act Up accelerated the FDA drug approval process and invented the phenomenon of "patient empowerment."[25]

Act Up was politically savvy, expert at manipulating the media, and adroit at devising unconventional and provocative marketing campaigns (so called "guerrilla marketing") to both raise public awareness about the disease and to educate individuals about avoiding infection. The organization fundamentally changed American public health practices; it taught other groups focusing on specific diseases how to "successfully hector the government for access to new treatments and services."

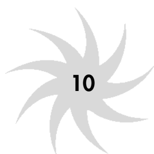
> The AIDS walk begot breast cancer walks, and public parades for other illnesses are now as much a rite of spring in Central Park as softball and Shakespeare. And while few groups staged the 'die-ins' favored by Act Up that tied up Holland Tunnel traffic and turned Grand Central into a macabre rush-hour graveyard of the living, many emulated the strategy.[26]

In the apparently inhospitable political climate of the 1980's, AIDS activists acquired political power, raised public awareness and sympathy, and garnered massive governmental and private sector resources to combat the epidemic.

The originality and power of AIDS fits the model of Kouzes' and Posner's five fundamental leadership practices.[27] The gay community's advocacy and perseverance *challenged the process* of the traditional health care delivery system, and *inspired a shared vision* in the AIDS community to minimize the disease's devastation if not to find a cure. Additionally, it *enabled others to act*, not just those with AIDS or at risk for contracting the virus; it created the paradigm for patients to be knowledgeable about their illnesses and to take initiative in their recovery. Finally, AIDS activism *modeled the way* for all patients and all diseases, and was an *impassioned movement*.

Leadership Types

Many times, organizations are guided by traditional models of leadership dependent on the power of the authority or the position. These types of leaders are appropriate in many situations. In times of distress, we turn to authority. We place our hopes and frustrations upon those with presumed knowledge, wisdom, and skill. Both in organizations and in politics, we look generally to our authorities for direction, protection, and order. Direction may take the form of vision, goals, strategy, and technique. Authority as it relates to these challenges is enormously productive if the authority is a credible leader. Sometimes, larger, more complex problems demand the involvement of many constituents or stakeholders in defining the problems and in creating and implementing solutions. The problems are too big for one group or person to solve alone. These types of situations call for collaborative leadership.[28]



To distinguish when the appropriate leadership type is required, Ronald Heifetz has proposed model based on types of problems. He labels these problems as Type I, Type II, and Type III. Type I problems are readily definable and have solutions; what is then needed is an expert or authority figure it out or to fix it. For example, a broken leg is easily diagnosed and treated by an orthopedic doctor. A more traditional style of leadership is needed for Type I problems.[29]

Type II problems are clearly defined but the solution is either unclear or requires action and thought on the part of those affected. This type of problem cannot be fixed solely by the expert. For example, a patient's heart problem cannot simply be cured by the doctor, instead the patient must alter his behavior and take the lead in assuring his own health, guided by the doctor. A public health example could involve air pollution where sources of pollution are known but there is little agreement about who is responsible and what solutions are appropriate. Many people may have to change behavior or take specific actions to implement a solution. Getting agreement on the solution to a Type II problem is often difficult.[30]

A Type III problem is the most complex, and many leadership development experts argue, the most common seen in public health. With a Type III problem, neither the problem nor the solution is definable, and usually, neither the problem nor the solution is agreed upon. Examples of these complex problems include teen pregnancy, crime, suicide, violence, and drug abuse. The war on drugs is a great example: is the problem a supply or demand issue? Is poverty the problem? Why are some communities more affected than others? There is no agreement on the problem, which makes the solutions unclear as well. Is the solution the "War on Drugs" or a "Just Say No" campaign?[31]

Most challenges faced by communities are Type II and Type III problems. These problems demand the involvement of many constituents or stakeholders in defining the problems and in creating and implementing solutions. The problems are too big for one group to solve alone.

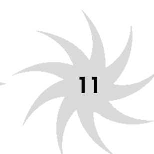
Collaborative Leadership

Leaders and citizens in this country's cities and regions face unprecedented challenges in addressing public problems of shared concern. As the complexity of US society has increased, traditional forms of leadership have become ineffective in solving complex problems.[32] Currently, across the county, citizens and civic leaders are addressing complex public issues in collaborative ways. They are taking new leadership roles that produce new visions and strategies for meeting public needs and creating a new civic culture. By creating approaches to help diverse citizens with disparate interests interact, they find ways to meet the broader needs of the community. In spite of cultural, geographic and circumstantial differences, political challenges are remarkably similar. "What makes leadership difficult in one area is the same in other areas. Traditional forms of civic and political leadership have failed to cope with these challenges."[33]

Characteristics of Collaborative Leaders

Typically, collaborative leaders usually have no explicit authority or power; leadership is a group process among peers. Collaborative efforts engage numerous sectors resulting in more diversity in terms of beliefs, values, knowledge and experience. Collaborative efforts attempt to address complex problems where the causes and solutions may be unclear. Collaborative leadership requires leaders to rely on the group work as their guide. Once the leader has inspired a shared vision, their task is to ensure that the process has integrity, is constructive and leads to results. The answers must emerge from the interaction of the stakeholders. Once this occurs, individual organizations are well positioned to reap the benefits of expanded thinking.[34]

Arthur Himmelman, author of "Collaborating for A Change: Definitions, Decision-Making, Roles and a Collaboration Process Guide," has written that there is an increased incidence of public, private, and nonprofit institutions and organizations working together in coalitions with communities, neighborhoods, and constituencies.[35] Their interactions are defined as networking, coordinating, cooperating, or collaborating. These levels of interaction for a common purpose can be viewed on a continuum and organizations must decide the



appropriate choice about their working relationships and their level of commitment. Unlike other organizations, public health has a greater commitment as an advocate for all individuals, demonstrated by a collaborative and ethical framework, bringing a new approach to complex issues.[36] Himmelman identified several reasons for creating multi-sector collaboration in communities. As legislation requires services without providing adequate dollars for implementation, there is a need for developing other ways for communities to cope with such responsibilities. He also noted that local collaborative initiatives should not be considered an alternative to greater governmental support, but rather as strategic and valuable contributions to partnerships that enhance that support. Himmelman's rationale for collaboration included utilizing a diversity of individuals and organizations; inclusiveness of broad community interests and concerns; "pooled" resources to meet the financial, physical and human resource demands; demonstration of successful collaborative models; and finally the potential power of the collective coalition to effect change.[37]

A number of studies conducted by the Institute of Medicine have examined the role of public health agencies in relation to community-focused activities and the improvement of health within entire communities. No complete working model of this strategic initiative will emerge quickly or easily, in particular the emergence of partnerships to improve the health of communities. Investing in a process that mobilizes expertise and strategic action from a variety of community members, as well as state and organizational entities, offers us the best possibilities to substantially improve community and public health. Collaborative leadership holds an important key to the sustainability of those proposed projects and programs launched to implement other recommendations in this report. It appears to be a powerful means of achieving the stated goals of programs and to go beyond the tangible outcomes, and to enhance the potential for improvements and changes in other areas by creating robust partnerships. Educating, mentoring and providing opportunities for successful experience adds to the cadre of leadership necessary to continue thinking beyond limitations and into the realm of all that is possible when committed, passionate people learn to lead others.

Through increased infrastructure in the area of collaborative leadership development, recognized, experienced leaders will find access to and value in learning new approaches to leadership and in making concerted efforts to bring together all the parties who have solutions and answers. Additionally, the next generation of leaders will benefit from a development program that increases personal effectiveness as managers and as leaders. It is this belief in the need for leadership development that Colorado Turning Point issues this report.

Summary

A review of the literature has revealed that there are a number of theoretical models for successful leadership. Through increased infrastructure in the area of collaborative leadership development, recognized, experienced leaders will find access to and value in learning new approaches to leadership. However, as has been seen with AIDS advocacy and leadership of the last 20 years, successful, courageous, innovative leadership transcends theoretical frameworks and conventional, acceptable notions of problem solving. Leaders can create political consensus, envision solutions to complex problems, and raise capital, both human and financial. Politics is the art of the possible, and political will can ignite passions, spur awareness and embolden leaders not yet known to solve the public health problems of this century.

Recommendations

The following recommendations were derived from a focus group of Turning Point Steering Committee Members and representatives from the Regional Institute for Health and Environmental Leadership

Public and Environmental Health Fields

- Establish mentoring programs based on best practices to guide the building of networks, and to teach skills based on the wisdom of experienced leaders
- Recognize collaborative leadership as a vital public health strategy and introduce the concepts to lawmakers, policy level decision makers, and elected and appointed officials

- Provide technical assistance to small, rural communities and rural health agencies to aid in their leadership development efforts.
- Build a workforce development plan focusing on leadership development
- Link national level leadership development activities to the state and local level
- Adopt NACCHO's (National Association of City and County Health Officials) Principles of Collaboration

Public and Environmental Health Leaders

- Current leaders should recognize emerging leaders and support their leadership development through formal training and mentoring
- Leaders should run for public office to influence policies that will benefit the field and society as a whole
- Supervisors should facilitate the inclusion of leadership development in individual employee plans for professional development.

Public Health and its Partners

- Broaden collaborative initiatives to include others with the same problems or issues
- Recruit leaders who model collaborative characteristics and qualities to assist in workforce development of leadership skills
- Convene summits or conferences to bring people together to learn about collaboration, begin to build networks and begin collaborative processes
- Develop leadership programs for communities with health disparities or promote and support the attendance of community members in leadership programs

Leadership Development Programs

- Provide academic credit, recognition, and/or certification
- Coordinate Regional Institute graduates to as mentors for developing leadership skills within the public health workforce and with community partners

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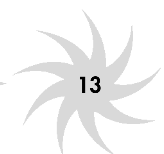

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