

# LEADERSHIP IN PUBLIC HEALTH

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# Leadership in Public Health - Introduction

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Throughout the centuries, public health practice has been driven by such outstanding leaders as Gottfried Wilhelm von Leibniz, John Graunt, Thomas Sydenham, Edwin Chadwick, Lemuel Shattuck, William Farr, Hermann Biggs, Alexander Langmuir, John Knowles, Tom Balderson, and more recently, Bill Foege and others at the national level and schools of public health, as well as state and local health departments. Yet, in 1988, the Institute of Medicine (IOM) articulated a crisis in public health in this country, including the absence of leadership, in addressing the challenges facing the nation in the new century. The public health community responded, and a key part of that response was establishment of the National Public Health Leadership Institute (NPHLI) in 1990, with funds from the Centers for Disease Control (CDC), to empower national leaders to fulfill their roles more effectively. In this issue of *Leadership in Public Health*, the contributors trace the history of a movement generated by IOM, report the activities that have spun off directly from that initial investment, update the progress made in the field, and articulate the new challenges the nation and the public health community face in the new century.

Rowitz provides a concise overview of the history of public health leadership development since the 1988 IOM report, including the National Public Health Leadership Development Network that was created by NPHLI graduates, establishment of state and regional leadership institutes modeled on NPHLI, and the Public Health Leadership Society. Rowitz then writes about the need for lifelong learning to address new problems and seek new solutions. He emphasizes the continuing leadership role of CDC and calls for development of a consortium of professional organizations engaged in public health leadership, including not only those mentioned here with a primary interest in leadership development but also the major organizations in public health practice (e.g., the Association of State and Territorial Health Officials, the National Association of City and County Health Officials, and the National Association of Local Boards of Health). A white paper written by Rowin et al. outlines specific elements of a design for leadership development for public health.

Baker et al. describe the first 15 years of NPHLI and the lessons learned since 1990: the importance of quality in learning, the fundamentally essential role of relationships among leaders, the need for continuous learning, and the need for leadership in this field (i.e., leadership on leadership). Umble et al. then reported on a rigorous evaluation of NPHLI, focusing on the simultaneous development of individual leaders and the complementary leadership networks that were formed by those leaders. They conclude that both areas have proven valuable and both need

enhancement to address ongoing and future challenges. The need for continuous evaluation was another conclusion of that report.

In early 2006, the Public Health Leadership Society (PHLS), a national program committed to supporting leadership development and diversity within the public health system, launched a year-long CDC study of public health leadership development. In December 2006, PHLS, with support from CDC, convened a select group of public health stakeholders for a national summit on public health leadership development. Theilen and the PHLS Summit Committee report on the outcomes of PHLS-hosted meeting. Ron Davis, President of the American Medical Association and chair of the summit summarized eight key recommendations from that summit.

1. Expand links on the basis of networks, partnerships, and systems thinking.
2. Develop evaluation metrics to assess return on investment.
3. Emphasize preparedness for intentionally created and natural disasters.
4. Use the tools of adult education, especially experiential learning.
5. Ensure succession planning.
6. Keep our eyes on the target - healthy people and healthy populations.
7. Use new knowledge, tools, and technologies.
8. Identify, enroll, and develop new leaders.

In August 2007, the Harvard School of Public Health and CDC jointly sponsored a Public Health Leadership Dialogue, a workshop that followed up on the summit's recommendations. As reported by Thacker and Marcus, workshop participants discussed a strategy for public health leadership development and the need for an explicit framework and system of partnerships as part of such a strategy. Four thematic areas emerged from that discussion.

1. Redefine the scope of public health leadership on the basis of emerging challenges and changing roles.
2. Build capacity in vision (strategy), operations, and logistics.
3. Build systems to enhance future leadership capacity.
4. Measure the impact of these efforts.

Two presentations at the dialogue meeting combined a response to concerns discussed at both the December summit and the August dialogue. The first by Marcus et al. described the elements of meta-leadership, a concept that evolved in response to national preparedness efforts and that has relevance to all of public health. Marcus described five dimensions of meta-leadership. The first dimension calls for self-awareness of the person

as a leader. The second dimension is the situation that calls for a response and the need for the leader to adapt to changing situations. The leader also has responsibility for leading in his or her area of authority, supporting staff in that area. Next, the leader must lead upward by knowing the boss' needs and priorities. Finally, an essential dimension of leadership crosses systems and communities.

The last paper in this issue was also presented at the dialogue meeting; it describes a newly articulated leadership development initiative at CDC, the Initiative for Leadership Enhancement and Development (I LEAD).

Jarvis et al. outline a systematic and comprehensive competency-based approach to leadership development that uses training, work experience, coaching, and mentoring to integrate leadership development and succession planning into an overall talent management approach.

As guest editors, we believe that the collection of these papers offers an exciting look at approaches to address the leadership challenge in the opening decade of a new century. Working together, we can build on the experiences of the past two decades to prepare the public health system for the leadership challenges that this country faces in the coming years.

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# Public Health Leadership Dialogue: Summary of a Workshop

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**Note:** The findings and conclusions in this report are those of the author(s) and do not necessarily represent the views of the Centers for Disease Control and Prevention.

With support from the Centers for Disease Control and Prevention (CDC), the Public Health Leadership Society convened a summit in December 2006 to address leadership and workforce development (<http://www.phls.org>). The purpose of this meeting was to discuss a comprehensive strategy for public health leadership development and a framework and system of partnerships for building a new cohort of leaders. These partnerships would leverage a core set of competencies applicable to the spectrum of public health practice. Speakers and participants at the summit expressed concerns regarding changes in the workforce, including new requirements for training professionals, as well as the anticipated wave of impending retirements affecting all disciplines in the public health system.

Development of such a comprehensive strategy requires agencies to share a vision of just what such a leadership career development ladder might comprise and how it can serve to promote performance excellence at all levels of the public health system. With a clear and well-delineated frame of reference, trained leaders can be more intentional and efficient in developing career goals and pathways for their areas of responsibility. The leadership framework should be both visionary and pragmatic but address far-reaching capacity building that spans the range of public health agencies and functions. The framework should also address the critical concerns of identifying, recruiting, training, assessing, retaining, and advancing future public health leaders.

In August 2007, as a follow-up to the December 2006 summit, CDC and the Harvard School of Public Health convened a working group to further delineate the leadership framework. The discussion focused on four thematic areas pertinent to public health leadership development: definitions, needs assessment, program development, and evaluation. This paper reports on the discussion of that meeting and includes recommendations for next steps.

## ***Theme One: Defining and Redefining the Scope of Public Health Leadership - Past, Present, and Future***

The terrorist attacks of September 11, 2001, and the subsequent anthrax incidents prompted a period of rethinking and change in regard to the role of public health, its infrastructure, and the scope and nature of public health responsibilities. In parallel fashion, those events also led to a reassessment of public health leadership competencies. Interest in this topic was raised further by the prominent and competent national role of public health leaders in addressing the SARS threat and recognition that in the event of pandemic influenza, public health leaders in states and localities throughout the country would be faced with similar high-performance expectations.

In light of these recent headlining public health events, participants noted other more subtle, yet equally important, developments. Interest continues in how public health practice can have a more decisive impact on urgent or ongoing health threats — tobacco cessation, obesity, and injury prevention among them. The field's higher profile in relation to the headline topics provides an opportunity to create broader reach on other public health concerns. However, greater attention also raises expectations; indeed, public health has come under increased scrutiny as funding and responsibilities have expanded. External trends also create opportunities. Globalization requires national public health leaders to assume a more international perspective. Pandemic influenza has raised awareness among the general population of these global links and how they can affect domestic health. What each of these factors has in common is the leadership equation — seizing the moment and maximizing the opportunities rests on leadership capacity and performance.

In this context, three critical questions arise.

**Scope of practice:** What are the boundaries of public health practice and how do changes affect what leaders must know and do?