

## V. Summary and Discussion

When PHLI was founded in 1990, it represented a significant commitment by the CDC to improve public health infrastructure following the influential 1988 Institute of Medicine report, The Future of Public Health, which called for major improvements in the practice of public health in the United States. The program’s “theory of action” or “logic model,” if you will, was that strengthening individual leaders and building a network of leaders would help the field because by acting individually and (more importantly) together, these leaders could strengthen the nation’s public health infrastructure and systems.

We now briefly review what this study has found about whether this program logic was actually achieved over the past 15 years. *The overall answer is that the program had very considerable success in developing leaders, building networks, and improving public health infrastructure and systems.* Moreover, wider programs and movements are in place that are sustainably building on the core successes of PHLI, such as the large accreditation movement, the widespread state and regional leadership development programs, and the movement to define a fully functional state health department underway through ASTHO.

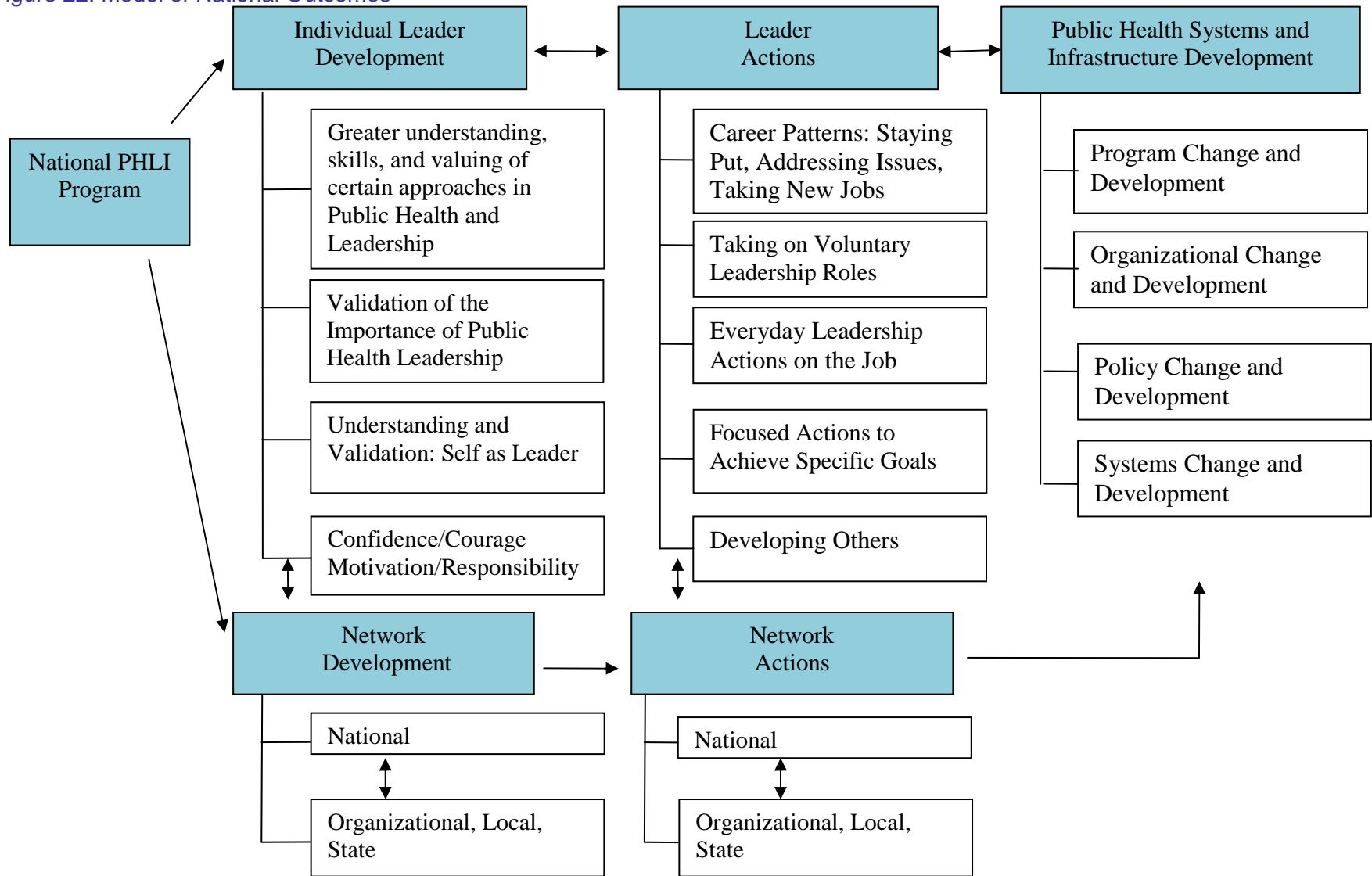
Figure 22, also presented earlier as Figure 6, summarizes study findings and their relationships with one another.

### **Domain 1. Individual Leader Development**

We asked graduates to rate PHLI’s long-term influence on their leadership; 36% chose “large” while 43% chose “moderate”, 18% chose “small” and 2% chose “no influence.” The majority reported that PHLI had strengthened their understanding and skills related to leading public health agencies and communities. The majority also reported that PHLI had strengthened their interest in deepening their involvement with leadership efforts at the national, state, local, and organizational levels, and their commitment to staying in public health work.

In addition, the majority reported that PHLI strengthened their self-awareness as a leader, sense of importance and belonging to the national cadre of leaders in public health, professional network of people they can contact for ideas about how to handle their leadership challenges, and confidence and courage to take on leadership responsibilities.

Figure 22. Model of National Outcomes



Interview themes and hundreds of survey comments reinforced and explained these changes.

While some of the benefits that learners perceived to be quite valuable may seem “soft” and rather unimportant to a number of readers, they are in direct support of more recent and holistic concepts of competence. “Competence is not to be synonymous with skill. A competence is defined as the ability to successfully meet complex demands in a particular context. Its manifestation, competent performance, depends on the mobilization of knowledge, cognitive and practical skills, as well as social and behavioral components such as attitudes, emotions, values, and motivations. This holistic notion of competence is not reducible to one cognitive dimension” (Hakkarainen et al., 2004, p. 16).

These findings about scholars’ perceptions of important gains from PHLI remind us that leaders are not “machines” in need only of new practical skills, but complex personalities in search of a role and mission, vision, courage and encouragement, validation and confidence, and companions for the journey.

### **Domain 2. Leader Actions: Career-Related Outcomes and Voluntary Leadership Positions Taken**

The great majority – 87% - of survey respondents were still working in public health. About 20% of all PHLI graduates have now retired, but nearly all of them had remained in public health until they retired.

Main foci for graduates’ daily work after graduation included general organizational leadership in governmental agencies, community public health development, bioterrorism and preparedness, policy development and advocacy, and workforce development (both general and leadership development). Other fairly common foci included non-profit leadership, epidemiology, chronic disease, healthcare leadership, and infectious disease.

About 52% had stayed in the same organization and position since graduation – which interviewees attributed to commitment to a place rather than any form of stagnation. About 19% percent said that PHLI had helped them attain new jobs by increasing their skills, confidence, interest, networks, or by impressing the employer that the scholar had attended. Jobs that PHLI helped scholars attain often included federal bureau or division chief and state or local health officer, deputy, or division chief.

About 81% had taken on additional “voluntary” leadership roles that were not required by their jobs, such as task forces, boards, professional associations, and informal advocacy; 54% had taken on such roles *and* responded that PHLI had played some role in their doing so, mainly by increasing their confidence, interest in the work, skills, and networks.

Examples of voluntary roles scholars had taken on with PHLI’s influence included, at the national level, serving on boards and committees with NACCHO, ASTHO, NLN, PHLS, APHA, and other associations. At the state level, roles commonly included serving on

boards with a state public health association or state association of city and county health agencies. At the local level, many worked with community-level task forces and boards. The great majority of scholars responded that PHLI had made “some” or a “great” contribution to the leadership actions that they took when they assumed these voluntary roles.

### **Domain 3. Public Health Leadership Network Development and Network Actions**

When asked to “explain in some detail one of the most important influences that PHLI has had on your leadership,” over 80 scholars (24% of the respondents who answered this question) cited gaining improved and valuable network connections.

The most commonly cited benefits of these connections included enhanced overall understanding of public health leadership’s roles and goals; long-term professional knowledge-sharing; social support for taking action – such as ideas, encouragement, and good examples set by others; and being introduced to opportunities for formal collaborative work, such as with NACCHO or a State Public Health Association. In addition, many described how these collaborations had led to specific improvements in organizations, programs, policies, and “systems” at organizational, community, and state-levels.

Forty-five percent had sought “wise counsel” from another PHLI graduate in the past two years, while 55% had collaborated with other PHLI graduates on projects or activities. Formal network activities that emerged from PHLI included the PHLIS, the NLN, and State and Regional PHLI’s.

### **Domain 4. Public Health Systems and Infrastructure Development**

- 40% reported having observed a policy (law) change that PHLI graduates influenced directly or indirectly
- 60% reported having observed a program change that PHLI graduates influenced directly or indirectly
- 66% reported having observed an organizational change that PHLI graduates influenced directly or indirectly
- 67% reported having observed a systems change that PHLI graduates influenced directly or indirectly

Hundreds of respondents gave detailed descriptions of these changes. Many scholars described specific changes they *personally* had initiated, or which their team had initiated through the *applied team project* component of the program. A large number of others explained that a *group* or “*critical mass*” of PHLI graduates had accumulated over time within a state or federal agency, jurisdiction, or association (such as NACCHO) and collaborated to shape a new initiative.

Very frequently, graduates collaborated *with one another* to lead *others* through a collaborative process which led to infrastructure and systems improvements – such as leading a community public health system through a MAPP process, or leading an organization through a participatory strategic planning process that engaged a wider group of stakeholders than had previously been included.

A general historical pattern emerged from the data: a group of “thought leaders” met at PHLI and worked together to reconceptualize how public health systems should be structured and should function, and also how public health leaders should work to improve them. This highly influential group of graduates worked with others in senior positions nationally, and through associations such as NACCHO, ASTHO, PHLS, and NALBOH, to devise and disseminate new tools to help state and local governments define and improve public health infrastructure and systems. These tools included but were not limited to the Essential Services, Performance Standards, agency accreditation systems, APEXPH and MAPP, the Code of Ethics, and state and regional public health leadership development institutes.

Many PHLI graduates working at national, state, and local levels followed the lead of the early thought leaders by further refining these tools and ideas, and leading national, state, and local implementation of them. Other scholars made diverse other improvements.

### **Domain 5. PHLI and the Future Direction of Public Health Leadership Development in the United States**

Graduates made these observations and recommendations:

- Individual leader development and network development are important synergistic efforts that have helped to create a common public health framework and a fertile ground for diffusion of innovation
- Offer a continuum of “cutting edge” or forward-looking development opportunities including a national institute as well as continuing education and informal development activities to build a culture of lifelong learning and to sustain vibrant networks
- Consider how to support a more integrated and coordinated system of leadership development at the national and state levels
- Consider strategies to strengthen networks beyond the current methods, including enhanced connections to support succession planning and to facilitate opportunities to work on issues of national importance
- Build in an on-going evaluation system, focusing on both process and outcome measures
- Adequate and on-going funding is needed in order to support innovative programming and to enhance the existing leadership development foundation

## **Leader Development and Network Development: Warp and Woof**

In PHLI, leader and network development were simultaneous, mutually supportive, and parts of one another. We might say that they were “warp and woof”, essential parts of the same woven cloth, or a virtuous cycle. Either one without the other would have been less effective.

All of the personal gains that leaders made in PHLI helped them become interested, knowledgeable, skilled, and confident network members. Likewise, being part of a network of trusted colleagues at the vanguard of public health leadership promoted confidence and courage, inspired graduates to imitate their peers and network colleagues, and taught them much more than they could learn in a classroom setting.

This study’s observations of the complementary but distinct roles of “leader development” and “leadership network development” reflect wider discussions in the literature. For example, some scholars recently have used “leader development” to refer to initiatives designed primarily to develop individual leaders’ capabilities, and reserve “leadership development” for efforts to develop networks of leaders who can work together (Day, 2003). That conception of “leadership development” is becoming more prominent as the concepts of “collaborative” or “shared” leadership have gained favor for use in complex multi-party settings (Chrislip and Larson, 1994, Huxham & Vangen, 2000).

This understanding of individual leader and network development as warp and woof also fits very closely with research that shows relationships between individual and organizational innovation and performance and characteristics of leaders’ network positions, network ties, and network structures (Uzzi, 1997; Cross, Borgati, & Parker, 2002; Abrams et al., 2003; Cross & Cummings, 2004; Balkundi & Kilduff, 2005; Johnson-Cramer, Parise, & Cross, 2007). It also fits with theories of workplace learning that locate learning primarily within work and as a result of participating in communities of practice, rather than as primarily separate from work (Brown & Duguid, 2000; Wenger, McDermott, & Snyder, 2002).

It also fits well with models of collective expertise being discussed in current scientific literature about competence, expertise, knowledge creation and management, professional development, and professional performance. “The expertise needed in the knowledge society cannot be understood by referring only to a sum of individual cognitive competencies, but also to joint or shared competence manifest in the dynamic functioning of communities and networks of experts and professionals as well as supporting tools and instruments” (Hakkarainen et al., 2004, p. 8).

## **Visions for the Future Direction of Public Health Leadership Development in the United States**

The data and recommendations from graduates and key informants summarized above endorse the program's historic emphases on both leader and network development, and offer ways to strengthen both.

Future versions of PHLI should integrate “leader development” and “leadership network development” tightly with one another and with applied leadership work on issues of importance to agencies and systems. Such applied work can be quite valuable for both leadership learning and network development during the program itself. In addition, the long-term collaborations that emerge from PHLI can and should be nurtured. This study found that they can have significant impacts.