1 First in a series of Turning Point resources on Leadership development

Collaborative Leadership and Health

A Review of the Literature

from the Leadership Development
National Excellence Collaborative

TurningPoint

Collaborating for a New Century in Public Health

Acknowledgements

This collaborative leadership literature review was conducted under the auspices of the Turning Point Leadership Development National Excellence Collaborative, one of five national collaboratives working to strengthen and transform public health as part of the Turning Point Initiative. Seven states and three natonal partners patrticipated in this project: ASTHO, the Centers for Disease Control and Prevention, Colorado, Louisiana, Minnesota, NACCHO, Nebraska, Oklahoma, South Carolina, and Virginia.

The collaborative would like to recognize the four authors and their staff, from the University of Denver, for the depth of interest and knowledge they brought to the project to ensure the quality of this valuable resource for the public health community. We would also like to thank the Robert Wood Johnson Foundation for their financial support of this endeavor.

Research began in January 2001, and the final text for this collaborative leadership literature review was approved in November 2001.

Table of Contents

Introduction: The Literature Reviewed

The search for relevant literature on collaborative leadership centered on the following key terms:

Collaborative Leadership
Leadership Development
Leadership Capacities/Competencies/Skills
Leadership Assessment/Measurement
Leadership in Public Health
Leadership/Teams in Public Health

These terms were searched in the following databases. Relevant citations were obtained from the above databases in the quantities given in parentheses for each database:

ABI/Inform (10, 060)
Academic Universe/Medical (250)
Communication Abstracts (11)
ERIC (16,439)
Expanded Academics/Health Reference Center (22)
Medline (1835)
Periodical Abstracts (2449)
PsychInfo (63)
SocWork Abstracts (129)
WorldCat (6065)

The search covered 1985 to the present, on the assumption that any relevant literature prior to 1985 would be cited in a more recent work if it remained vital.

The basic process involved in selecting the items which comprise the literature reviewed was threefold: 1) All of the titles corresponding to the numbers given above were read. 2) Abstracts were obtained for any titles which promised to yield relevant content. 3) Full copies were obtained for any abstract which suggested that the item was likely to provide information specific to the key stions addressed by this literature review:

- What is the nature of collaborative leadership?
- Is there any systematic relationship between collaborative leadership and health outcomes?
- What skills, competencies and capacities are associated with collaborative leadership?
- What conditions promote or inhibit the success of collaborative leadership?
- What best practices are associated with collaborative leadership?
- What leadership development strategies are available, effective, and appropriate or collaborative leadership?
- What collaborative technologies should be recommended to enhance the development of collaborative leadership?

In addition to the systematic search of the above databases, the literature review includes sources known to the research team, four academically-based specialists in leadership and/or communication.

A search of websites produced the following hits for the key terms listed above:

Google (194,000 for just "collaborative leadership in public health")
MSN (40,410)
Northern Light (61,701)

Given these numbers and the process we employed for selecting relevant sources, we concluded that it would be impossible to summarize the information contained in these websites. A random sample of 200 websites produced, under closer examination, no information relevant to the questions listed above, that had not already been reported in the published literature.

Section 1: Leadership And Health Outcomes

Introduction

The first objective of this literature review was to determine what claims, if any, can be made that collaborative leadership affect health outcomes. One source provided an interesting point of departure for that question.

In summarizing the work of the Carnegie Commission on Preventing Deadly Conflict, a commission which involved world leaders such as Gorbachev, Carter, G. Bush, Boetros-Ghali, and Tutu, and which focused on what is arguably the most serious problem that confronts us as a people on this planet, the authors state, "…we have few firm empirical data on which sorts of leaders undertake preventive action, when and why they do so, and which leadership strategies and decision-making processes work best and under what sorts of conditions, domestic as well as international." (Hamburg, George, and Ballentine, 1999, p. 972).

What kinds of leadership lead to what consequences, under what circumstances and in which context is among the most complex and difficult puzzles challenging the development of reliable knowledge, scientific or otherwise. This may be why few scientists or scholars systematically study that question, however interesting and important it may be.

Perhaps even more informative is the fact that Carnegie Commission on Preventing Deadly Conflict relied considerably on the model of preventive medicine for an understanding of leadership. "A useful analogy is offered by recent developments in public health. Here, leadership in science, medicine, and government has helped to dramatically reduce the incidence of many incurable diseases through preventive measures such as immunization and education about the benefit of diet, exercise, and not smoking" (p. 972). That leadership in public health has substantially affected health outcomes is recognized beyond the health profession. Just one source of leadership, that provided by government, and its impact on public health from the late 18th century to the present has been summarized by Boufford (1999).

Two conclusions we reached early in conducting this literature review:

1. No one questions the importance of leadership in influencing health outcomes.
2. Very few people have systematically examined the relationship between leadership and health outcomes. The research which we found, specifically as it relates to collaborative forms of leadership, is reviewed in this section.

Relevant Research Categorized

Research on the relationship of collaborative leadership to health outcomes seems to fit three patterns. First, there is research that is "quasi-experimental" in nature. This research, though obviously incapable of manipulating leadership factors the way variables are manipulated in laboratory experiments, nevertheless attempts to systematically examine the various kinds of leadership received by different populations and subsequent differences in health outcomes experienced among those populations. Second, there is research which examines co-variations. That is, without "experimenting", some research examines the natural variations in leadership (or closely related factors) across a number of cases or locations, and asks whether health-related outcomes vary systematically with the differences in leadership. Third, some research reports case studies. Discoveries that arise from the in-depth analyses of individual cases, organizations, programs, initiatives, were considered relevant if the discoveries involved aspects of collaborative leadership.

Quasi-Experimental Research

Few items of published research were found in this category. However, those few are worth highlighting. The WHO European Collaborative Trial in the prevention of coronary heart disease was conducted in five countries: Belgium, Italy, Poland, the U.K., and Spain. Sixty-three thousand, seven hundred thirty-two (63,732) men in 80 factories comprises the study group, with factories matched in pairs and then randomly assigned to intervention and control conditions. The interventions included dietary advice, smoking cessation, weight loss, daily exercise, and drug treatment of hypertension. The outcomes assessed included fatal coronary heart disease, total coronary heart disease (fatal coronary heart disease plus non-fatal myocardial infarction), and total mortality. Intervention was associated with reductions in all the major outcomes assessed. And, of course, the WHO Trial led to other similar projects in the U.S.A. and abroad. This line of research is summarized by Gyarfas (1992).

Important discoveries emerged from this research, including the following: "Preventive services are enhanced through the use of community organization which mobilizes a community's energies and resources to define and address a problem in a way that promotes local ownership and generates increasing effect over time." (p. 227). This research was a relatively early demonstration of the close relationship between health outcomes and collaborative processes in community-based intervention.

The second study is not technically quasi-experimental. It is presented here because, even though the methods are quite different from those employed in the first study, the very careful investigation of the phenomenon makes it similarly noteworthy. This research is reported by Kar, Pascual and Chickering (1999). This research reports analyses, along with meta-analytic statistical comparisons, of 40 case studies, collected from sources around the world, in which women and mothers were involved in social action and health promotion movements. The search for relevant case studies, the selection of specific cases, and the analyses performed on the cases make this research especially noteworthy. For our present purposes, the following discoveries are highlighted:

1. Many of the cases represent dramatic and substantial improvements in quality of life and health status for women and mothers, even those who were extremely poor and severely disempowered.

2. Leadership is a key explanatory variable in the success of these cases.

3. About half of the cases involved leadership development for enhancing individual capacities.

4. Half of the cases involved collaborative processes (partnerships, associations, cooperatives, and coalitions) for supporting grassroots initiatives, even if the grassroots movement employed confrontational strategies in pursuing its goals.

These are several studies worth considering early in this review because of the high confidence that can be placed in the conclusions reached by the researchers. They are big, broad studies that point to the importance of leadership in general, and collaborative leadership principles in particular, in promoting health outcomes. A second category of research allows us to narrow our focus somewhat.

Research Examining Co-variations

Research on leadership, especially social-scientific research, typically examines samples from given populations (people-organizations-communities) in order to explore correlations among variables. In our case, we want to know whether certain leadership behaviors or practices are systematically related to health outcomes.

Zimmerman et al. (1993) compared nine ICUs (one medical, two surgical, six medical-surgical) at five teaching and four non-teaching hospitals. They sampled 3,672 ICU admissions, 316 nurses, and 202 physicians. They measured ICU effectiveness by a ratio of actual/predicted hospital death rate and ICU efficiency by a ratio of actual/predicted length of stay. A wide variety of structural and organizational information failed to show any systematic relationship with ICU effectiveness or efficiency. However, on-site observations and analyses, performed by a four member investigative team which was unaware of each unit's performance rankings, resulted in the discovery of systematic relationships. For example, leadership differences existed between the high and low performing units. The effective leadership came from a variety of sources, ICU nurse manager, medical director, staff nurses, other physicians associated with the unit. This leadership included "a support approach that encouraged input and suggestions", "a caring, supportive environment for patients and staff", "effective nurse managers stress the importance of multidisciplinary collaboration, especially a collaborative relationship with the medical director characterized by mutual respect, informality, and joint participation in management decisions", and finally, "the ability to directly address issues in a collaborative fashion…"

Given the present nursing shortage, it might be argued that the quality of health care delivered by an institution is at least partially associated with the institution's ability to retain nurses. Taunton et al. (1997) examined the effects of leadership on staff registered nurse retention. These researchers studied four large acute care hospitals in a mid-western metropolitan area, sampling 95 middle managers and 11,071 staff registered nurses. A wide variety of measures and a sophisticated analysis, causal modeling, allowed the researchers to draw a comprehensive and detailed picture of retention in their sample. Of particular interest to us is the discovery that "manager leadership behaviors emerged as the target for intervention most likely to improve retention of hospital staff nurse" (p. 218). An important contributor to retention is the leadership behavior of managers, as reflected in valuing input, support for personal development, creating decision making opportunities, etc.

Groups of people who work well together are able to provide higher quality service to their clients. This claim has been substantiated in health care, particu-

larly among psychiatric rehabilitation teams (Corrigan & Giffort, 1998; Corrigan & McCracken, 1997, 1999). The role that leadership plays in the delivery of quality service or care is not simple or direct.

> To illustrate this emphasis on relationships, consider one of the better empirical studies of leadership we have encountered in the last several years. [Littlepage, et al, 1999]. A group of psychologists studied 1,264 members of 112 teams in the aerospace industry. Using a variety of measurements and some very sophisticated analyses, this research demonstrated that there were two very clear ways in which leaders influenced a group or team's performance.
>
> First, the leader could directly affect certain group process variables, such as a collaborative (open and supportive) climate. These group process variables, in turn, led directly to heightened group or team performance. In other words, leadership was effective to the extent that it created circumstances or conditions that allowed the group or team to succeed. The leadership variables didn't correlate directly with group or team performance, but instead correlated directly with the group process variables, which in turn predicted group performance.
>
> Second, leadership led to "group potency," the group's confidence in itself and its ability to achieve the goal. These potency variables enhanced group performance directly, as well as indirectly by positively influencing the group process variables described earlier. Either way, leadership can influence performance by enhancing the confidence that is felt in the group or team (Lafasto & Larson, 2001, p. 148).

Consider, then one other health outcome that has been linked in the research literature with leadership. Luz & Green (1997) completed an extensive literature review on absenteeism, sickness from work. Among factors associated with various forms of absenteeism was "quality of the leadership…". The ways in which leadership indirectly influences health outcomes are probably endless.

Case Studies

By far the most common form taken by reports of relationships between collaborative leadership and health outcomes is the case study. These are published reports of individual programs, initiatives, events. Emerging disciplines or new fields of knowledge tend to rely heavily on case studies for the discovery of patterns and relationships. In the case of leadership research, this is true in all contexts. It seems true also when considering leadership in the context of health. The following case studies, taken cumulatively, strongly reinforce the conclusion that relationships exist between collaborative leadership and health outcomes.

The Appalachia Leadership Initiative on Cancer (ALIC) began in 1992. Started by the National Cancer Institute, the goals of this initiative were to reduce cancer incidence and mortality, increase early diagnosis, and increase cancer survival within the Appalachian region. Four universities initiated projects covering 11 of the 13 Appalachian states. These projects focused on rural, medically underserved communities. All four projects adopted a focus on breast and cervical cancer. All four projects followed strategies of developing community-based coalitions at the county level.

We begin our case discussions with this particular project for several reasons. First, it implies a recognition of the issues raised at the University of Denver Conference on the Turning Point Initiative. The ALIC initiative was planned with sufficient time and resources to allow reasonable expectations for achieving

change in the communities involved. And the project was initiated by creating collaborative relationships and sustained by developing collaborative coalitions, mostly outside the traditional infrastructures of public health. Since the project is long term, as of February, 2001 (Friedell et al, 2001) no morbidity or mortality results were available. However, the activities performed by the 63 counties through this initiative may be presumed to have created conditions for increased community awareness and early detection. Through mid 1997 the county coalitions were responsible for 111 breast and cervical screening programs, 35 screening programs for other cancers, 61 health fairs, 103 media activities, 47 grant proposals, 27 programs targeted specifically at health professionals, 500 presentations and outreach activities to increase cancer awareness, and approximately 300 presentations and activities to promote coalition activities. One summary of the project states, "The preliminary results from ALIC suggests that capacity, defined as a greater degree of interconnectedness between entities as they coordinate efforts for planned action, has been enhanced in the Appalachian cancer control system" (Friedell et al, 2001, p. 19).

Given sufficient time perspective, it's possible to see the long-term results of collaborative initiatives. For example, one can see, in graphic representations, the systematic decline in infant mortality rates in Boston in the ten years following the 1985 creation of a task force addressing increases in IMRs among communities of color (Rorie, Richardson, & Gardner, 1998).

Similar concrete or tangible changes in health outcomes have been attributed to other collaborative initiatives. For example, 28 health care organizations formed a structured collaborative effort to safely reduce their cesarean delivery rates in pursuit of a Healthy People 2000 goal of a cesarean delivery rate below 15% by the year 2000. As of 1998, 15% of the organizations had reduced cesarean delivery rates by 30% or more and 50% of the organizations had achieved reductions between 10 and 30% (Flamm, Berwick, & Kabcenell, 1998).

In a 3-year collaborative effort sustained by pediatric nursing at the University of Iowa Hospitals and Clinics specific improvements were documented in ongoing intravenous site assessment, extent of infiltration and estimated infiltration volume assessment, physician notification of infiltrations, documentation of severity, and compliance with guidelines and use of antidotes (Montgomery & Budreau, 1996).

Furthermore, specific improvements in cardiovascular outcomes have been attributed to collaborative initiatives:

- The average in-hospital mortality associated with CABG surgery for a region was attributed to the collaborative efforts of the Northern New England Cardiovascular Disease Study Group (Malenka & O'Connor, 1995).
- Improvements in physical, emotional, and anginal-specific health status after by-pass surgery are attributed to the collaborative leadership of a physician-led organization in Washington State (Goss et al., 2000).
- Decreases in length of stay and cost accompanied by increases in patient satisfaction to a level of about 95% were attributed to a collaborative initiative involving representatives of all personnel involved in cardiac care and the surgical faculty of a Boston hospital (Cohn, Rosborough, & Fernandez, 1997).

In what is described as an ongoing collaborative partnership between business, hospitals, and physicians, the Cleveland Health Quality Choice (CHQC) has documented "improved outcomes in all measured spheres over a 4-year period." Its success was attributed to leadership and shared vision (Sirio & Harper, 1996). And even more wide ranging results are reported in an ERIC document that

includes profiles of successful urban maternal and child health programs from over 90 cities in the U.S. (Peck, 1994).

There are a great many case studies in the literature we reviewed. Some of these case studies have been integrated into other sections of this report, such as best practices. The vast majority of these case studies are relatively straightforward descriptions of programs. That is, they describe what was done in a collaborative initiative, but the description does not include systematic evaluation of health outcomes attributed to the initiative. Nevertheless, several case studies were found which our team felt should be brought to your attention. One case was included because it contains descriptions or outlines of activities that are used by community leadership and support organizations to facilitate the process of community empowerment (Fawcett et al, 1995). The second case is highlighted because it involves a leadership development initiative that began as a seminar-driven program and evolved as a more action-based program situated in the communities (Crystal, 1995). This seemed to us consistent with what had emerged from the proceedings of the conference at the University of Denver.

Summary

The foregoing represents what we discovered about leadership and health outcomes in the literature we reviewed. Clearly, there is reason to believe that collaborative forms of leadership are good strategies for promoting health outcomes, especially in community-based efforts. Practically speaking, we might conclude that public health practice has experienced, and continues to experience, the changes that are occurring at a broader level.

> For the last fifteen years, social scientists and observers of contemporary life have been commenting on a dramatic change in the way we do business in both the public and private sectors. The change that has attracted so much attention and commentary is a significant increase in team work and collaborative efforts: people with different views and perspectives coming together, putting aside their narrow self-interests, and discussing issues openly and supportively in an attempt to solve a larger problem or achieve a broader goal (Lafasto & Larson, 2001, p. XVII).

Section 2: Skills, Competencies, and Capacities

Introduction

In the complex discussion of the making of a leader, identification of skills, competencies and capacities abound. The literature overwhelms the researcher with endless lists of both the knowledge and the performance skills of an effective leader. It is the purpose of this section to distill into some reasonable framework of terms, not just the most current and commonly held expectations for leaders skills, competencies and capacities, but also the unusual, perhaps least talked about and least researched aspects of this aspect of leadership.

It may be helpful at this point to step back from the question of skills, competencies and capacities and recall the shift that has occurred in our collective understanding of leadership through the past century. This shift has most notably given rise to a changing leadership skill set over time. Earlier discussions on leadership focused on the individual, his or her characteristics and traits that were often thought to be hereditary (Galton, 1869). This "Great Man Theory" approached leadership capacities as innate, fixed and cross-contextual. Skills and competencies as learned activities were disregarded. Instead, they were thought to be anchored in some internal personality or genetic set with which one was born. Vestiges of this theory are still apparent in some discussions of capacities today as words such as "traits" and "native trait" (Kirkpatrick & Locke, 1991; Schwartz & Pogge, 2000) surface. They are reinforced by the referencing of the age old question, 'Are leaders made or born?' (Kouzes & Posner, 1995; Rifkin, 1996; Avolio, 1999). Clearly though, this earlier understanding of leadership focused on the leader as solitary actor, as if the followers or context had no role in the leadership situation.

During the post-war industrial renaissance of the 1940's through the 1960's, the emphasis in leadership studies was on behavior. Both what the leader did as well as the leader's effect on other's behavior became important (Bryman, 1992). The skill set emphasis was on efficiency, management and control in order to produce. Discussion of skills and competencies reflected a more modernistic or behavioristic approach, in which the leaders held sharply different roles and performances of behavior than their followers (Hollander & Offermann, 1990). Often those roles were anchored in power or hierarchy.

As the post-industrial or so-called post-modern era has settled in among us, the role of the leader has changed. The homogenous situation of the past, with its concurrent understanding of leadership-followership as an activity of compliance, has been shattered. Today's world is marked by chaos more than not. Rapid technological advancements have not only increased communication, they have complicated communication. The same could be said in almost every aspect of life. Complexity and chaos, advancements and disintegration mark the organizational climate in almost every sector and as such call for changes in leadership skills, competencies and capacities (Denis et al., 1996). Not only have we shifted from a view of leader as sole or unitary actor to a team or community centered view of leadership (Dentico, 1999), but the social and economic times of most organizations have produced a demand for skills and abilities that are as complex as the situations in which they are found. The rapid change has moved leadership

from a hierarchical model of leadership into collaborative models (Kanter, 1989; Chrislip & Larson, 1994.) Leadership is no longer viewed as one-dimensional and is even seen more as a process of developing, using a variety of skills and competencies rather than a position or role (Avolio, 1999).

Definitions

With this new leadership that is adaptable or situational to the changing forces of today's world (Ross, 1992), we are presented with new definitions and challenges in understanding leadership skills, competencies or capacities. Cognitive theorists would suggest that inherent in the notion of skills or competencies are a combination of learning about something and the learning to do something. Knowledge conjoined with performance based on that knowledge develops skill or capacity. Leadership literature often confuses these two interdependent aspects of skills and competencies, developing lists of skills as knowledge at times and skills as performative action at times. Clearly both need to be considered in formulating a full understanding of leadership. We will consider both of these aspects in the breadth of lists being suggested from many directions.

In addition, some managerial and leadership literature uses the terms manager and leader interchangeably when speaking of skills (Perce, 1998; Schwartz & Pogge, 2000). Managerial skills seen as a subset of leadership skills and capacities may help to clarify this confusion. Management as "producing predictability and order" through various skills versus leadership as stimulating "change through the motivation and alignment of people with an established direction" (Schwartz & Pogge, 2000, p.466) provides another helpful distinction. A survey of 166 various manager positions and subordinates within technical field of work projects found that team process or leadership skills were the most lacking (Donnelly & Kezsbom, 1994). It was concluded that most managers, when trained through "traditional management and professional training" (p.6) are unprepared to meet the leadership skill demands of today's sophisticated marketplace. Because of this inter-reliance in skills, both notions of leadership and management will be considered in the literature and research review following.

Leadership Competency Frameworks

In Wilson, O'Hare and Shipper's (1990) examination of leadership research and literature, they suggest that leadership and its dependent skills and abilities work within a larger context of organizational roles. These roles are often ignored when leadership characteristics or competencies are identified. This useful approach to leadership acknowledges three elements: leaders exert influence; others accept that influence; and change or performance is produced.

In Yukl, Wall and Lepsinger's (1990) questionare based research of managers, a list of skills or behaviors effective leader managers utilize was formulated. That list included eleven items:

1. Informing
2. Consulting and Delegating
3. Planning and Organizing
4. Problem Solving
5. Clarifying Roles and Objectives
6. Monitoring Operations and Environment
7. Motivating
8. Recognizing and Rewarding

9. Supporting and Mentoring
10. Managing Conflict and Team Building
12. Networking

(Yukl, Wall, & Lepsinger, 1990, p. 227)

Another shorter list was generated by the research of Kouzes and Posner conducted on over a thousand managers through a personal best survey, case studies and interviews. Their list suggests that effective leaders display competencies in:

- Challenging the Process
- Inspiring a Shared Vision
- Enabling Others to Act
- Modeling the Way
- Encouraging the Heart

(Kouzes & Posner, 1990, p. 207)

In yet another leadership measurement oriented work conducted by Yammarino and Bass among 186 naval officers (1990, p. 159), four transformational leadership items or competencies and four transactional leadership items were developed as common to effective leadership:

Transformational Leadership Items and Examples

1. Charisma: "I am ready to trust him/her to overcome any obstacle."
2. Individualized Consideration: "Gives personal attention to me when necessary."
3. Intellectual Stimulation: "Shows me how to think about problems in new ways."
4. Inspirational Leadership: "Provides vision of what lies ahead."

Transactional Leadership Items and Examples

1. Contingent Promises: "Talks about special commendations and promotions for good work."
2. Contingent Rewards: "Personally pays me a compliment when I do good work."
3. Active Management-by-Exception: "Would reprimand me if my work were below standard."
4. Passive Management-by-exception: "Shows he/she is a firm believer in 'if it ain't broke, don't fix it'."

(Yammarino & Bass, 1990, p. 159)

These characteristics were used as selection criteria for leaders and were positively correlated with ratings of officers as effective leaders.

Survey data was collected from 283 leaders involved in engineering-focused project work to discern common effective leadership characteristics or abilities needed in organizations experiencing fierce competition, fluctuating markets and burgeoning technologies (Donelly & Kezsbom, 1994). Using a definition of competency as "an augmentable quality of leadership that appears to be a personality construct but is capable of modification via skills awareness and development (p.36)," eight competencies surfaced. These competencies were viewed as crucial in cross-functional team work: analytical, collaborative, communication, entrepreneurial, initiative, integrative, interpersonal, and managerial.

One conceptual framework distills leadership capacities into two dimensions providing an axiomatic "Leadership Grid" profiling concern for people against concern for production (Blake & McCanse, 1991). This conceptualization takes into account that all leadership activity is influenced by either a concern for people or concern for the "bottom line." In fact, the need for task skills and relationship skills may be constant forces at work in any leadership situation at any given time.

Public Health Leadership Competency Frameworks

In specific literature pertaining to public health or health leadership competencies, several lists of competencies emerge. In a national survey of 524 public health nursing leaders, four areas of competencies were identified as needed for the challenges of today's world of health services: 1) political competencies which included politics, policy making and implementation and communication; 2) business acumen which included business, marketing and fiscal marketing; 3) program leadership which included evaluation and application of epidemiologic and research principles to health promotion programs, planning and implementation; and 4) management capacities which include problem solving, staffing issues and interdisciplinary team functioning (Misener et al., 1997, pp. 52-58).

In a survey of thirty-eight health leadership officers using 78 identified knowledge, skills, and abilities that a new health officer might require, five competence areas were suggested: 1) public image or skills related to working with the community; 2) policy development and program planning; 3) interpersonal skills; 4) agency management; and 5) legal issues. The study recommended adjustments be made through schools of medicine or public health to develop these skills as well as in current public health organization staff development programs (Liang, Renard, Robinson & Richards, 1993).

The Healthcare Forum conducted a national study to identify competencies to bridge leadership gaps for 21st century healthcare organizations ("Bridging the leadership", 1992). With no noticeable differences by respondent type and region the nearly 400 respondents confirmed six transformational leadership competencies and values as:

1. Mastering Change: (the capacity) to help organizations view change as an opportunity for new alternatives and calculated risk-taking
2. Systems Thinking: (the capacity) to understand inter-relationships and patterns in solving complex problems
3. Shared Vision: (the capacity) to craft a collective organizational vision of the future
4. Continuous Quality Improvement: (the capacity) to engender a never-satisfied attitude, which supports an on-going process to improve clinical and service outcomes
5. Redefining Healthcare: (the capacity) to focus on healing, changing lifestyles and the holistic interplay of mind, body, spirit
6. Serving Public/Community: (the capacity) to weld social mission to organizational goals, objectives and actions (p. 54-56).

The report went on to expose leadership capacities in mastering change, systems thinking and continuous quality improvement as posing the greatest gap between current practices and future needs.

The above list also dove-tailed with another discussion conducted during a Health Resources and Services Administration forum that focused on broad competencies of public health administrators as seen by public health practitio-

ners and faculty (Bureau of Health Professions, 1991). Ten areas of competency emerged, including policy analysis-strategic planning, communication skills, team leadership, financial management, human resource management, program planning and administration, organizational management-position, cultural competency, basic health sciences and political analysis. These ten competencies are reaffirmed as they appear in various forms throughout the literature.

Perhaps one of the most recent and well-respected approaches to leadership in the public health realm is the Leadership Competency Framework, formulated by the collaborative entities within the National Public Health Leadership Development Network (NLN) (Wright et al., 2000). This consortium of institutions, through reviews of current literature and several existing health leadership competency frameworks, sought to develop a comprehensive framework that would provide direction for public health leadership curriculum design and subsequent evaluative processes. Ultimately this framework was intended to provide standards for professional development and measurement of performance of leadership and consequent services for public health. Four leadership practice categories with corresponding competencies were articulated as:

1. Transformation—Public health needs and priorities require leaders to engage in systems thinking, including analytical and critical thinking processes, visioning of potential futures, strategic and tactical assessment, and communication and change dynamics.
2. Legislation and politics—The field of public health requires leaders to have the competence to facilitate, negotiate, and collaborate in an increasingly competitive and contentious political environment.
3. Transorganization—The complexity of major public health problems extends beyond the scope of any single stakeholder group, community unit, profession or discipline, organization, or government unit, thus requiring leaders with the skills to be effective beyond their organizational boundaries.
4. Team and group dynamics—Effective communication and practice are accomplished by leaders through building team work group capacity and capability (Wright et al., 2000, p. 1204).

Within each of the four competency focused categories, there are extensive lists of specific skills and capacities that give depth to each category.

Another public health competencies framework that must be considered is that developed by Sorenson, Bialek and Steele. Universal competencies in public health were identified in six areas: Analytical Skills; Communication Skills, Policy Development/Program Planning Skills, Cultural Skills, Basic Public Health Sciences Skills, and Financial Planning and Management Skills. Within each sphere, particular related competencies flesh out the depth of expectations of the leader. Each of these, along with those from the other frameworks, will be integrated when appropriate into the competency specific discussion following.

Clearly, the approaches to identifying and measuring skills and competencies relevant to effective leadership results in various categorization of capacities. Some authors have tried to reconcile these lists by matching them, with little satisfaction (Clark & Clark, 1990). Perhaps instead, we ought to consider them as helpful angles of approach to a multi-faceted context of similar entities. If greater responsiveness and flexibility in leadership applications are as sorely needed as some suggest (Kanter, 1989; Donelly & Kezsbom, 1994) using a variety of approaches to competencies may be more useful than trying to distill all leadership activity into a set of fixed skills. With that in mind, let us consider some of the more commonly cited skills, competencies and capacities that emerge from the literature.

Specific Leadership Skills, Competencies and Capacities

Building Vision

Probably the most notable commonality in leadership competency literature is that of vision production. Kouzes and Posner call this the "capacity to envision the future by mastering the essentials of "*Imagining the ideal and *Intuiting the future" (1995, p. 94). Visionary leadership is seen as future focused. It involves possibility and hopeful thinking which expands the boundaries of past or current thinking. It implies a movement "beyond current mental boundaries" ("Bridging the leadership", 1992). Not only does it move beyond current thinking and practice, it understands the obstacles embedded in current contexts that call for new vision.

While some would suggest that leaders must provide vision for something which is determinable, 'getting from here to there' and 'doing what needs to be done' (Bennis & Nanus, 1985; Guarriello, 1996) rather than something not yet known, it is clear that vision involves aligning resources in a direction. This often takes the form of mission or goal statements. Edward O'Neil posits that healthcare visioning requires competencies in "focusing on the future, founding the vision on core values, making the vision genuinely creative and aligning efforts in implementing the vision" (Gilkey, 1999, p. 272). This agrees with other approaches that imply a collective nature about vision building, the creative process required of the leader, the rhetorical skills involved with vision sharing, decision making efforts and the implementation of vision (Kotter, 1990; "Bridging the leadership, 1992; Wright et al., 2000). In relation to vision formation, Bryman suggests four other leadership related skills needed: communicating the vision, organizational empowerment of the vision, the ability to align the organizational culture with the vision and nurturing trust as change is implemented (1992, pp. 146-147).

As the challenges of new public health landscapes involving globalization, financial strain, shifting power bases, and serious demands on an already stressed system present themselves, visionary leadership will be in high demand. Determining which values and purposes to preserve and which to change will be yet another navigational tool required by the health care leader. This gives rise to two other competencies: the capacity to manage change and collaborate.

Managing Change

Crisis and change have been present in the field of public health for a long time (Misener et al., 1997). The specificity and complexity of the challenges however has heightened, posing new types of health care management issues (O'Leary & O'Leary, 1999). Leader's' capacities to be "proactive, dedicated and politically astute" (p. 4) through impending changes will be crucial for success. The capacity to anticipate change and its confluent elements can strengthen one's position to form the future, thus lessening the danger of failure. Change often creates ambiguous situations as well as clouded goals, structures and lines of authority. In a case study looking at the process of change in a Canadian hospital, five propositions (P1-P5) were summarized that suggest leadership strategies, understanding and competencies to plot a course through the change process:

P1: Substantive change under ambiguity requires collaboration: more specifically the formation of a tightly knit group of actors that can perform specialized differentiated, and complementary roles in moving the organization in desired direction.

P2: Strategic change under ambiguities is likely to proceed in a cyclical pattern in which periods of substantive change alternate with periods of political realignment.

P3: Collective leadership roles are constructed and reconstructed over time through the credibility of enhancing and credibility draining consequences of various organizational tactics.

P4: Under ambiguity leaders may build influence and momentum for change through symbolic management tactics in which openings in the environment are identified and reinterpreted as strategic opportunities.

P5: Under ambiguity the tactics associated with the implementation of substantive strategic change tend to undermine leader's political positions, threatening the stability of leadership role constellations and slowing momentum for change (Denis, Langley, & Cazale, 1996, pp. 686-690).

Becoming an effective change agent then requires a constellation of skills that include but are not limited to analytical skills, ability to share leadership roles and problem solving processes, critical thinking, systems understanding, consensus and credibility building, collaborative inquiry, risk calculation and risk taking (Kanter, 1989; Wright et al, 2000; Denis, Langley & Cazale, 1996; O'Leary & O'Leary, 1999). Kotter suggests that leadership "is about coping with change" (1990, p. 103) and as such requires the energizing of behavior to move through inevitable barriers. In the health care services world of change this cannot be done without a sustaining vision, an understanding of the processes of change and collaborative processes (Kent & Graber, 1996).

Collaboration Competencies

An articulated assumption and finding in much of the literature regarding vision formation and management of change is the capacity for collaboration. Leaders in all spheres are being required to think and work across boundaries (Kanter, 1989; Liang et al., 1993; Himmelman & Nevarez, 1998; Chrislip & Larson, 1994) both to build collaborative visions and accomplish those visions together through joint goal setting and active pursuit of those goals. If collaboration is based on the belief that "if you bring the appropriate people together in constructive ways with good information, they will create authentic visions and strategies for addressing the shared concerns of the organization or community" (Chrislip & Larson, 1994, p. 14), then leadership practices or competencies to do this will be crucial. In their study of over fifty cases of collaborative efforts across many spheres of work, "strong leadership of the process" (1994, p. 53) was cited as a key to success. The kinds of skills called upon in this process included:

> Keeping stakeholders at the table through periods of frustration and skepticism, acknowledging small successes along the way, helping stakeholders negotiate difficult points, and enforcing group norms and ground rules (p. 53).

Franklin and Streeter (1995) conducted an overview of the process required in various approaches to linking public schools with human service agencies. Five approaches emerged that moved from least collaborative to more collaborative: "informal relations" to "coordination" to "partnerships" to "collaboration" to "integration". Each approach necessitated more complex leadership skills with increasing impact on the broader constituencies as collaboration increased.

Securing commitment, in-depth planning, training and educating one another, and sharing resources all shifted the power structures of traditional hierarchies. The Center for Creative Leadership contends that collaborative inquiry requires the capacity to "organize, sustain and participate in a broad collective effort on difficult challenges" (1999).

Collaboration demands a leadership capacity to shift from these vertical or hierarchical relationships of influence to horizontal power sharing (Kanter, 1989; Gustafson, 1997; Avery, 1999). In a survey of 100 healthcare executive leaders compared to a database of 7,000 executives in other fields around the world, consensus leadership in health care is on the rise (Lentz, 1999). Empowerment and power sharing are central to collaborative work. Not only is power generated and shared among participants within the collaboration, but influence is generated over larger spheres in a community, giving collaborations larger capacities for change (Fawcett et al 1995). With this shift in power comes a need for "the ability to step into other people's shoes and appreciate their goals" (p. 89). This involves the capacity to trust others' perspectives and have confidence in others' competencies to perform within the collaboration (Bryman, 1992; Schwartz & Podge, 2000). This perspective-taking skill is crucial to collaborative vision building, goal pursuit and service provision (Beckham, 1991; Hacker & Wessel, 1998; O'Leary & O'Leary, 1999).

In a study on collaboration between school principals and special education directors as they cared for special needs students, collaboration called upon a variety of perspective-taking skills (Lehner, 1993). These skills included sharing information through conferencing, trust development through team building, building consensus and consultation or seeking others' perspectives and expertise. Cooperative and interorganizational alliances are being called for like never before in health services (Zukerman, Kaluzny, and Ricketts, 1995; Linial, 1995). To strategically achieve their purposes, agencies and organizations need leaders with capacities to forge new partnerships between diverse constellations, built on shared commitment including vision, knowledge not only in the field of expertise, such as health, but of the community at large and competencies that will achieve what could not be achieved alone (Fawcett et al, 1995; Denis, Langley & Cazale, 1996). At the core of these collaborative competencies is another set of skills, that of communication.

Communication Competencies

As the complexities of issues being addressed increase, so do the requirements for communication (Kouzes & Posner, 1995). Not only are face-to face interactions increased in the new world of collaboration, but the need for diverse communicational skills of its leaders, from writing to public speaking to group dialogue to interpersonal communication. In a study of fifty-five state and territorial health officers, twelve knowledge, skills and abilities (KSA's) were identified as crucial for public health leadership (Liang et al., 1988). Presented in the form of statements, these skills included the ability to articulate the mission and goals both publically and privately, presenting and defending a position, effective use of public media, writing, and explaining/presenting budgets or other knowledge related content.

In a study focused on leadership relationships between general practitioners (GP's) and community psychiatric nurses (CPN's) and social workers, GP's did not initiate communication as often as the other two professionals but expected others to initiate with them (Sheppard, 1992). With the challenging venue of collaboration, communication of information between professions was seen as crucial to the care provided. The capacity to understand various styles and

expectations for communication between professions will allow leaders to find ways to overcome inherent obstacles.

Both the broader leadership literature and health focused literature calls for a wide array of communicational competencies and capacities needed. These range from making one's intentions and positions clearly known (Guarriello, 1996), to consistency in what is communicated (Beckham, 1998), to surfacing, managing and negotiating conflict through communication (Greene, 1998; Kazemek, 1994), to giving feedback and encouragement (Kouzes & Posner, 1995; Davidhizar & Shearer, 1997), to persuasion (Farrell & Robbins, 1993) to creating meaning and understanding or sense-making (Kent, Johnson & Graber, 1996; "Research pinpoints", 1999) to writing and reporting (Donelly & Kezsbom, 1994), reflective listening (Kent, Johnson, & Graber, 1996; Phillips, 1998) to interpersonal relating (Doody, 2000; Donelly & Kezsbom, 1994) to facilitation skills (Farrell & Robbins, 1993). Many of these skills and competencies are embedded in the Public Health Leadership Competency Framework developed by the National Health Leadership Network (Wright et al., 2000).

Team/Group Leadership Skills

In systems that rely on one another for production or delivery of services, groups or teams are often at its core. Group or team leadership skills and competencies are seen as one of the keys to success of a team (Beck & Yeager, 1996). While there are many other factors that contribute to making a team highly effective (LaFasto and Larson, 1989), leadership is certainly one of the more important factors.

A foundational knowledge about teams is crucial for team leadership. Knowledge about group culture, process dynamics and structures, and change dynamics are important for skill development in team leadership (Lord & Engle, 1996). Having a capacity to think from a team-based focus for operation as opposed to individual centered focus is key (Misener et al., 1997; Beck & Yeager, 1996). Beck and Yaeger suggest the capacities of clarifying goals, strategies and roles to accomplish goals are important in the team leadership process (1996). It is clear that identifying team oriented structures and creating a vision to work together is fundamental for team effectiveness (Wright et al, 2000; LaFasto and Larson, 1989).

Many of the skills required for collaborative efforts appear in the team literature, albeit more focused on facilitative leadership skills. Facilitation skills seem the most common thread. In the edited work on team facilitation by Frey (1995), competencies in leading group problem solving, decision-making, constructive dialogue and conflict resolution, and empowerment strategies expand the list. Facilitation skills tie communication back into the equation and we find a loop between team leadership skills, collaboration skills and communication skills that blur the categories.

In the current literature focused on facilitation and the work of facilitators, there is a wide categorization of roles, tasks, skills and characteristics identified. The facilitator as one who "helps assure a high quality conversation about issues that matter" (Rough, 1997, p.138) is required to develop a variety of skills. Some suggest that these skills are more internal, involving self awareness, role understanding, and analytical or thinking skills (Warehay, 1992), while others focus on external and communicational skills related to keeping ground rules, negotiating conflict, and clarifying tasks (Jones et al., 1995). Still others suggest logistical skills such as agenda development, room set-up and reporting that are necessary in the skill-set of a facilitator (Burns, 1995; Niederman, 1999; and Smith, 2000).

Management Competencies

In many of the frameworks cited for leadership competencies, management skills surface. As suggested earlier, distinctions are made between leadership and management, by authors such as Kotter stating that "management is about coping with complexity" and "leadership is about coping with change" (1990, p. 104). However the distinctions are made, management skills are seen as complimentary to leadership capacities (Kotter, 1990; Zaleznik, 1992; Donelly & Kezsbom,1994; Farrell & Robbins, 1993; Guarriello, 1996).

The leadership competency most cited in the area of management includes systems thinking (Kotter, 1990; Donelly & Kezsbom, 1994; Guarriello, 1996). Systems thinking is the ability to order ideas and patterns while understanding their influences and inter-relatedness ("Bridging the leadership", 1992). Strongly related to the skill set of managing change, this capacity allows leaders to see the bigger picture and structures of organizations or interorganization processes. It allows a leader to understand how changing one part can affect another.

Another set of management skills cited is that of organization. Not only organizing ideas and resources but people with whom you need to work (Zaleznik, 1992; Guarriello, 1996; Greene, 1998; Guthrie, 1999). Sometimes the management of people can be problematic for leaders because of resistant forces within the group itself, such as physicians. Guthrie (1999, p. 4) quipped that "physician leadership" is an oxymoron, while also admitting that mobilizing and managing such professionals could notably reform present healthcare delivery. In the area of managing ideas and resources, competencies include, but are not limited to assessing, planning, organizing, budgeting, controlling, allocating, monitoring and evaluating (Donnelly & Kezsbom, 1994; Misener et al., 1997; Doody, 2000). At times these skills will require the capacity to manage through new informational systems and technological resources (Misener et al., 1997).

Political/Legal Competencies

The complexities of inter-agency alliances and collaborations, particularly in the public or civic realm, call for competencies based on political understanding (Fawcett et al., 1995). In the Public Health Leadership Competency Framework (Wright et al., 2000), these competencies include an understanding of political and legislative processes and operations on the federal, state and local levels. The above discussion of collaboration is then further defined and focused for us as competencies in advocacy, community organizing, community education and marketing are called forth. Fawcett et al. (1995) remind us that leadership in this public and community realm requires a certain process of community empowerment. Finding, involving and sustaining stakeholders through the various levels of the community and the institutions with which serve it is no small capacity (Fawcett et al., 1995; Lyons, 1999; Wright, 2000).

In addition to understanding and developing skills in the political, often legislative arena of human services, public health leaders are also being called upon to understand the legal and regulatory issues that govern healthcare (Doody, 2000). Financial and operational procedures need to be understood with an ability to oversee or manage the ever-increasing complexities and challenges of today's healthcare environment (Singleton, 1997; Henley, 2000). In a day when cost-management, government mandates, future forecasting and joint-venture structuring are influencing the landscape of public health service, leaders will need the capacities to take in these changing forces and develop skills that analyze and apply new understanding to policy and services (Hudak, Brooke, Finstuen & Riley, 1993; Henley, 2000; Kowalski, 2000).

Further Considerations for Leadership Capacities

In "Beware of the 'ego triangle'", Kazemek (1994) warns leaders of personal obstacles brought into the public domain, particularly in healthcare mergers. He suggests that leadership issues need to be addressed in order to expedite change, cooperation and collaboration. This capacity to step-aside is one of the more rare abilities suggested in the literature (Kazemek, 1994; Naughton, 1997). In addition to this more aesthetic personal aspect of leading, cultivating a capacity to learn surfaced (Chiaramonte & Mills, 1993; Cashman & Reisbert, 1994; Hart, 1995; "Research pinpoints", 1999). This capacity involves multifarious skills including self-reflection, self-knowledge, and an attitude or willingness to learn. In a survey conducted by Bennis and Nanus (1985) on 90 leaders regarding personal qualities they thought were required to lead their organizations it was found that the leaders,

> never mentioned charisma, or dressing for success, or time management, or any of the other glib formulas that pass for wisdom in the popular press. Instead, they talked about persistence and self-knowledge; about willingness to take risks and accept losses; about commitment, consistency and challenge. But, above all, they talked about learning (p. 187).

Naughton (1997) suggested twelve renewal tools for leadership, of which the capacity to set goals for personal development and learning was one. Hern (1997) encourages leaders to think of renewal not only for their organization but personal and professional life. Hotko and Van Dyke (1998) suggest that peer reviews when done well provide a rich source for personal reflection and evaluation. All of these notions are meant to nurture the capacity to learn, the ability to self-reflect and the capacity to be held accountable.

Two more aspects of leadership capacities are worth noting: spirituality and humor. The first concerns spirituality. In a study of leaders in Catholic healthcare services (McEnroe, 1995), faith or finding a larger purpose coupled with "finding meaning in the events of everyday life" (p. 6) was seen as a factor of strong leadership capacities. Aesthetic purpose, passion, credo or belief is seen by some as an anchoring capacity in leadership (Bryman, 1992; McEnroe, 1995; Naughton, 1997; "Research pinpoints", 1999). The second capacity concerns humor. Some have noted that humor not only reduces stress in the work place, but can also serve to explain and motivate when used effectively (Davis & Kleiner, 1989). 'Play' as another form of humor not only aids in team building, but can be useful in training, dream-casting, scenario building and teasing out the complexities of an issue or problem (Dentico, 1999).

Summary

"The new workplace actually requires us to keep all of our old skills- and then add to them" (Avery, 1999). The growing list of skills, competencies and capacities required of leaders, particularly in the public health realm, can be overwhelming (Ross, 1992). Do we expect too much? The question itself turns us back to a critical capacity for leadership today: collaboration. With the shared knowledge, skills and capacities of many leaders, as suggested by Ross (1992), an optimistic view is possible.

Section 3: Best Practices

Introduction

Best practices are the active behaviors of successful leaders of collaborations. To identify best practices, we looked at articles focusing on a wide variety of venues, including public health agencies, a collaboration among 40 northern New England hospitals, k-12 education and higher education, the politics of health care reform, social change coalitions in metropolitan New York and New Jersey, and a number of non-profit agencies.

Characteristics of Successful Collaboration

Two studies (Mizrahi & Rosenthal, 2001; Bland et al., 1999) report definitions of successful collaboration. As a beginning point, these studies provide feedback that at a gross level point to best practices for collaboration facilitators. A literature review conducted by Bland et al. (1999) indicated the following *set of processes and perceptions* would *predict* successful collaboration:

The opportunity to participate in decision making
The opportunity to influence decision making
The quantity of information exchanged
The quality of information exchanged
The handling of conflict
The sharing of vision and values
The satisfaction with the project
The commitment to the project (p. 1229)

Mizrahi & Rosenthal (2001) interviewed seventy past and current organizers and leaders of coalitions in focus groups, about their varying definitions of success in collaborations. The following dimensions were reported:

Achieving the goal
Gaining recognition from (social change) target
Gaining community support
Gaining new consciousness of issues
Creating lasting networks
Attaining longevity
Acquiring new skills

Approaching the issue of success definition another way, Mizrahi & Rosenthal (2001) asked coalition leaders to rank a list of internal and external elements. Internal factors are defined as those that *relate to the coalition's ability to sustain participation and maintain the effort and structure*. The internal elements that ranked high were: *relate process, structure, strategies, resources, decision making, commitment and leadership*. The following dimensions were significant:

Commitment to goal/cause/issue
Competent leadership(to be further defined)

Commitment to coalition unity/work
Equitable decision-making structure/process
Mutual respect/tolerance (p. 67).

Competent Leadership

Mizrahi & Rosenthal (2001) state *that competent leadership was the factor most often identified with coalition success* in their study. Characteristics chosen by coalition leaders that they determined important for successful leadership were associated with specific knowledge, skills and values. Respondents placed particular emphasis on: skills of facilitation and negotiation, including looking for commonalities (among coalition members); commitment and persistence; persuasiveness and credibility; strategic/political skills and trustworthiness.

According to this study, successful coalition leaders *recognize the critical need for coalition members to build personal relationships*, and assist them in doing so. Demonstrating respect for others, a willingness to share, and modesty are also mentioned.

In an insightful article that describes the processes and leadership involved in successful collaborations for health care reform in seven states, outstanding characteristics of the key *entrepreneurial* leaders 1are described (Paul-Shaheen, 1998). According to the author, entrepreneurial leaders are those who introduce innovation to society. Personal qualities include:

having a passion for change; being a political pragmatist; holding key positions of power; understanding the health care issues involved in the debate; and being a master of political process. These characteristics are seen as *a powerful counterweight to both the structural inertia built into legislative process and to the influence of special interest groups opposed to health care reform.* The author notes in quoting Mary Jo O'Brien of Minnesota, that these successful leaders never acted alone, and are *often the ones who carefully follow the process and preside over all the details; they often provide guidance and direction without visibility; and they serve as gobetweens and information gatherers and are often the "glue" that keeps the process going.*

In the literature review by Bland et al (1999), written to investigate a university-community collaborations, sixteen behaviors of effective leaders were categorized into four areas. They are:

Organizational Power

- Uses organizational authority
- Provides rewards or allocate resources
- Gains control over resources (e.g. money, personnel) to allocate to the partnership

Prestige/Coalition-building Power

- Empowers others through building coalitions (either internal or external)
- Uses professional/discipline expertise as perceived by others
- Uses others' identification of him/her as a leader
- Espouses and evidences high commitment to the partnership

Participative Governance

- Perceives and attends to the needs of other partnership members

- Provides structural mechanisms for partnership members to accomplish mission
- Communicates a vision
- Actively and consistently seeks input of others
- Provides development activities to enable other partnership members to accomplish goals
- Provides mechanisms for keeping goals visible and communicating progress and activities

Culture/Value Influence

- Communicates the dominant values of the partnership
- Articulates the stories or symbols that represent the real meaning of the partnership
- Defines, shapes, and maintains the value of the partnership

Significant hypotheses from this study conclude that leaders who use a broad range of leadership behaviors are perceived as contributing to a higher level of information exchange in the collaboration, as measured both quantitatively and qualitatively. Secondly, effective leaders use behaviors in the categories other than *Organizational Power*, more often than less effective leaders. The last significant finding was that successful projects have a consistent, identifiable project leader or a small set of leaders, as opposed to self-managed or leaderless collaborative groups.

In order to discuss the conclusions of these articles more specifically, we have categorized leadership behaviors into four areas. They are:

1. Communication Skills
2. Building Relationships
3. Developing a Shared Vision and Inclusion
4. Recognizing Crisis as Opportunity

Communication Skills

Nearly every article reviewed, mentions the importance of effective communication skills. Whether we speak of active listening on the part of the leader, being able to effectively mobilize volunteers to write letters or call legislators, appear at demonstrations, or frame the ways in which complex issues are presented to the media, sophisticated communication skills are strong predictors of effective leadership (Batalden et al. 1998; Bollenbacher & Finley, 1995; Arkus, 1993; Sembor, 1993; Spice, 1992; Carnevale et al., 1988; Gardner, 1987). Leaders who facilitate listening and communication among partners in collaborations are especially valued. (Bland et al., 1999).

Of specific focus, are those behaviors that enhance trust and promote respect. The creation of a respectful and equitable structure and process for deliberation and decision making (Mizrahi & Rosenthal, 2001) and a participatory team environment with shared responsibility and information sharing (Liontos, 1990) is primary among these communication behaviors. Nelson et al. (1999) point out that *a previous history of working together in limited capacities (will often) allow partners to develop trust and respect for one another.* Skills for running an effective meeting, including establishing ground rules (Spice & Gilburg, 1992), breaking down language barriers (Fitzgerald, 1999), developing systems for information dissemination (Peck, 1997) and watching for that individual or agency that is working on its own in isolation (Liontos, 1990) are also mentioned. Batalden et al.

(1998) point out that *leaders will be the ones who have the right questions and who promote local learning with the right questions*.

Mizrahi & Rosenthal (2001) specifically discuss the reluctance of leaders to admit defeat or failure and yet, members of discussion focus groups cite some leaders' capacity to redefine an incident or situation into a more positive light as a valuable skill. Recognizing that an organization has not failed if it does not accomplish everything it set out to do is a particular example used.

When Bland and her co-workers (1999) asked leaders of successful university collaborations what the most significant challenges they faced were, they consistently responded with *1) keeping everyone focused; 2) keeping the group intact 3) building trust 4) managing conflict, 5) interesting public policymakers in their project and 6) acquiring the resources to maintain the project*. It is clear that communication plays a major role in every one of these challenges.

When asked to comment on the skills required to perform as an effective leader of a collaboration, and how this differs from the usual role they played in their profession or business, a very telling response ensued:

> [It calls] for skills that are polar opposites. Flexibility in order not to be rigid and reject ideas. Concreteness in order to set up structures to allow collaboration to happen (p.1235).

One specific set of communication skills involves the leader and the media. Paul-Shaheen (1998) points out that most citizens get their information about public policy from a variety of media sources. The framing of issues for the media has emerged as a crucial skill for effective leaders. Information surrounding public issues is often dense and technical, necessitating the development of a human face (p 350) in an effort to interest the media and the public. Human interest stories often help redefine issues and set the stage for major public policy change.

Gatekeeping has long been a major role of the media. Acquiring supportive public opinion cannot happen if the press has not permitted an issue to emerge. Maintaining a mutually beneficial relationship with the media enhances community relations. (Arkus, 1993). Thus, it is the responsibility of the leader to present complex and technical material in such a way as to interest members of the press and inform the public. Issues presented in the media can arouse the public to the point that legislatures are required to act. Understanding the roles of these entities requires knowing how to present the story as well as knowing to whom to present the story.

Building Relationships

Understanding and presenting complex and technical material is one way that a leader demonstrates competence, but it has been noted repeatedly that understanding the affective side of process is critical to the development of successful collaborations. Drawing in people and other organizations from other sectors is a resource for community connections (Fitzgerald, 1999). The leader's relationship with collaboration members should be as one-to-one as possible, but knowing how to enhance the relationships among the leadership core and between the core and its member organizations is just as important. Continued dialogue about process and structure to determine if what is in place is working is necessary for the creation of the needed comfortable environment (Mizrahi & Rosenthal, 2001).

In the case study of health care reform in seven states (Paul-Shehaan, 1998), periodic task forces were used to create additional opportunity for dialogue

(p.342) among members representing diverse interests in the collaborations. From these dialogues, incentives developed for finding accommodation, that is, common ground (Simon, 1979). The importance of these dialogues to the ultimate outcomes becomes clear with the following quote:

> Through the process of negotiation, compromise, and consensus building, the deals were struck, with each deal satisfying enough of the stakeholderparticipants' expectations such that they were willing to support the recommendations , believing that they are not going to get a better deal elsewhere (p. 144).

Another strategy used successfully in the case of health care reform was a process of member enlightenment. The collaborative participants from both a wide range of legislators and others of diverse partisan, ideological, regional, and economic orientations were educated about the complexities of issues. In their efforts to understand complex and technical material together, a common approach began to emerge and a sense of trust developed.

Developing a Shared Vision and Inclusion

The importance of a clear and shared vision is considered by many to be critical to a successful collaboration (Leape et al., 2000; Bland et al., 1999; View & Amos, 1994; Liontos, 1990). Effective leaders are encouraged to choose topics for collaboration that do not impinge on any one entity's specific turf (Liontos, 1990). Lack of a well-defined aim that is understood and jointly agreed upon can cause participants to drift and sometimes become preoccupied with extended data collection thus preventing a sense of success. (Leape et al., 2000.)

Presenting a vision that reflects the dominant values of the collaborative in story or symbol form has been shown to vary strongly correlated with positive outcomes. The leader who defines, shapes and maintains the value of the partnership through his/her communication is more likely to succeed than through the use of traditional organizational authority (Bland et al., 1999). It was noted:

> …an effective leader uses a broad array of behaviors but particularly emphasizes the vision and uses participative behaviors paired with clear structures (e.g., accountability mechanisms, clear goals and responsibilities) to achieve a successful collaborative partnership (p 1236).

In one study of successful school programs working with social services, the importance of building programs on *mutuality in philosophy and standards* (Ascher, 1990) is mentioned. Further, concentration on issues with mutual relevance, the setting of realistic time frames and the creation of clearly defined responsibilities and assignments is noted.

Building a shared vision requires infinite patience and skill. Fitzgerald (1999) notes that a leader should *never underestimate the role of the community in identifying possible solutions* to a problem. Communicating that vision to others, especially in the effort to attract diverse partners necessitates active and consistent input from others as the vision changes and matures. Likewise, an effective leader finds ways to keep goals visible and to communicate success (Bland, 1999). Provision of means to quantify success is also deemed an important aspect of the shared vision. (Leape et al., 2000).

From the case of a collaborative involving 40 New England hospitals working to reduce adverse drug events, to the university community collaborations set to change curricula, to the collaboration between schools and social services, the importance of including all stakeholders is repeatedly documented. In the hospitals, it was the inclusion of a physician in addition to a pharmacist and nurse that made the teams *more likely* to be successful. In the schools and social services

projects, it was the inclusion of parents as well as teachers that made the difference. This study even mentions the hiring of a staff member from the local community as facilitator of the collaborative effort as a positive decision. Perhaps a quote from the University/Community team changing curricula explains it best:

> …we were successful in that we shared power and clearly you have to be accountable and you have to make decisions and you have to set direction and hold a vision and all the other things we've talked about, but the thing that needs to be perceived is the shared power (Bland et al., 1999, p. 1235).

Including all stakeholders insures that no one feels left out, stimulating a backlash. Power as it is perceived is dynamite, unless handled equitably. Mizrahi & Rosenthal (2001) provide us with an interesting reason to include everyone who is interested:

> As a coalition amasses power, it becomes a place where organizations want to be- which in turn, contributes to its power base and its legitimacy. Understanding the complexity of this dynamic is critical in analyzing the importance given by the coalition leaders to the concept of 'mutual respect and trust' as an element of success….Mutual respect and trust is of considerable importance. We had so many organizations that wouldn't talk to each other, but within the context of the coalition were fine. They trusted the coalition (p 70).

From the study of health reform in seven states (Paul-Shaheen, 1998), we learn some important lessons that include the role of stakeholders. This author describes the coming together of a number of factors for successful health care reform:

> For in each of these states, a series of factors had come to the fore. In each, the issues of rising health care cost and limited access achieved heightened public attention. In each, an entrepreneur or entrepreneurs emerged, willing to serve as a catalyst for and broker in the political process; new stakeholders identified health care as an issue and became engaged in the police debate; legislative leaders gave their tacit approval to undertaking such an effort; the public appeared supportive; and a key task force or commission had also developed a blueprint for action. Thus it was through the 'harmonic convergence' of these factors that a window of opportunity was opened and the stage set for comprehensive reform (p.327).

Recognizing Crisis as Opportunity

Periodic windows of opportunity for change often occur in times of crisis. According to Paul-Shehaan (1998), "such windows occur when a long standing condition reemerges as a problem, or when a solution deemed to address the problem is developed and available for adoption, or when political or environmental changes enhance the timing for policy change" (p. 323). Timing is critical to the establishment of a successful collaborative effort. A sense of urgency among stakeholders will create a momentum necessary to initiate action.

The use of multiple cognitive frames, especially a human resource frame, is recommended by Bland et al. (1999). They point out that the way a leader perceives his/her organization greatly affects what is believed about the best way to influence it.

Frames fall into four basic categories. They are:

1. Structural (emphasizing formal roles and relationships)
2. Human Resource-oriented (focusing on the needs of people)

3. Political (centering on conflict arising over scarce resources)
4. Symbolic/Value-based (viewing organizations as cultures with shared values) (p. 1228)

Failure to view an organization through more than one frame may lead to missing important aspects of the leader's organization, making the leader vulnerable to changes.

By viewing an organization, or collaboration of organizations, through multiple frames then, *a leader may significantly increase his effectiveness, particularly in a changing environment that requires leaders to span several organizations.*

Rosenthal and Mizrahi (1994) describe a similar idea about successful coalition leadership. They tell us that the leader must manage three critical levels simultaneously. They are:

1. Sustaining movement toward external goals by influencing social change targets
2. Maintaining internal relations among the core organizational representatives
3. Developing trust with, accountability to, and contributions from, the coalition membership base (p. 65).

Summary

Finally, in a study that addressed successful interaction among members of the vaccine research and development network in which case studies were reviewed for common themes, a simple but succinct idea emerges. While many points are technical in nature, one specific item jumps out: the critical role-played by individuals or teams who act as 'champions' to overcome the inevitable obstacles (Peter et al., 1999).

Section 4: Conditions and Contingencies

Introduction

Most organizations today are beginning to understand the importance of collaboration. Many are acting on the notion that "having all components share commonality of purpose leads to a productive and positive environment that truly serves the common good" for the entire organization (Linggood et al., 1998, p. 994). However, what is equally important to the process of collaboration is the leadership necessary to promote and sustain it. Lambert (1998) suggests we change our view of leadership as a noun to think, instead, of leadership as a verb. As such, we would view leadership as an action that includes "the processes, activities, and relationships" in which organizations and their members engage to undertake the challenge of collaboration (p. 17). In this section, we endeavor to uncover the conditions surrounding collaborative leadership. We will examine and discuss three main questions. First, we will ask: what are the conditions in an organization that promote collaborative leadership, as well as those which may inhibit or hinder collaborative leadership? Second, we will address whether such conditions differ for urban versus rural settings and organizations. Third, we will revisit the central question: what are the characteristics of a successful collaborative leader? In addition to addressing these three main questions utilizing current research, we will provide case studies that illustrate and embody the findings being presented.

Conditions for Collaborative Leadership

The leaders of most organizations today would most likely agree that collaborative leadership is an important aspect of success. But, what conditions within the organization are most likely to make this notion a reality? Rago (1996) notes, "We have discovered that it is one thing to embrace the concepts of leadership, but it is an entirely different thing for the agency to be organized to achieve this goal" (p. 228).

In order to begin the process of defining the conditions that surround collaborative leadership, we must continue to clarify the idea itself. Interestingly however, this has proved to be problematic. Many authors and researchers offer definitions and opinions of what collaboration is. Goldman et al. (2000) offer a fairly stock definition when they define collaboration as "a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals" (p. 435). And, as we will discuss in detail in a later section, many authors offer explanations for what leadership entails. McCown et al. (1997) proffer, "leadership depends on being able to work with others to shape the vision, take risks, develop two-way communication, and balance clarity and openness with positive regard for others" (p. 17). However, few researchers offer a definition for collaborative leadership in its own right. Perhaps this is due to the fact that there is still some ambiguity regarding how to facilitate collaborative leadership. The remainder of this section will examine the conditions that authors and researchers in this field have found to promote as well as hinder collaborative leadership.

Empowerment

Without a doubt, the overarching theme of every piece of collaborative literature is empowerment. The general consensus is that people must be empowered in order to collaborate successfully on any project. Thus, the very essence of collaborative leadership is knowing how to empower people and do it in such a way that is fruitful for the collaborative and the people involved. Relating empowerment to organizational efforts, Carr (1997) argues, "the inclusion of stakeholder groups in the creation of new systems of human learning is foundational to systems change" (p. 152). When examining the importance of empowerment to a community effort, Zachary (2000) notes that empowerment "offers community leaders a powerful opportunity for encouraging the active participation of neighborhood residents, who in the context of community organizing are the ultimate source of power" (p. 75). With regard to the importance of empowerment to the individuals involved in a collaborative, Reinelt (1994) elaborates, "Empowerment signifies standing together as a community just as it means supportively enabling a person to take risks. Its premise is to give [people] tools to better control their lives and join in collective struggle" (p. 687).

No matter what type of collaborative one is examining, empowerment is the key. However, it is not as simple a notion as it may seem. It is not enough to simply espouse the ideal of empowerment, an organization and its leaders must enact it. And what organizations and initiatives have found is true empowerment is fostered by collaborative leadership. Rago (1996) supports this assertion. "We could proclaim such a mandate, but it we do not work to put into place an appropriate strategy, nothing of substance is likely to happen. It was this realization that led us to the recognition of the importance of leadership" (p. 229).

There are key components, then, that appear to be necessary in order for empowerment to exist. There are certain actions that should be taken, certain conditions that should be met and certain criteria that must be established. Based on the extant research, we have identified five integral components of empowerment. These components are: Assessment, Vision, Shared Planning, Providing Resources, and Trust.

Assessment

In order for collaborative leadership to take place, the leaders must be aware of the entire situation. This comes, at least in part, through assessment. Assessment of the current situation leads to understanding of the collaborative and its stakeholders. Empowerment of the stakeholders can only come through understanding their positions. Assessment of a situation may entail myriad processes, depending on the circumstances and goals involved. Many researchers have offered their findings on the importance of assessment. Kadlecek (1997) provides a model for empowerment that, according to him, should always begin "with an understanding and analysis of the economic, demographic, and political trends" of the collaborative in question (p. 179). Williams (1998), in detailing the initial steps of an educational collaborative initiative notes, "To begin, we needed to identify the state of educational reform in the city, identify the key institutional actors, and track any record of successful practices" (p. 51).

Goldman et al. (2000) even argue for assessment of the collaborators by stating, "It is important to know if the decision makers of these organizations have the requisite skills and attributes that would engender successful collaboration with other organizations" (p. 435). Sometimes, assessment is necessary to gain deeper insight into the cultural aspects of a collaborative. Mycek (1995)

examined a local collaborative intended to bridge cultural gaps in a multi-cultural neighborhood between residents and local health care providers. She remarks, "Linguistic and cultural barriers were the greatest challenge we faced. Service providers needed to better understand cultural differences" (p. 12). Weil (1988) supports all of the above assertions by simply calling for any collaborative to undertake "an analysis which identifies the need for empowerment" (p. 71). These findings support the importance of assessment of any collaborative initiative. It is the first step toward the overarching theme of all successful collaborative leadership - empowerment.

Vision

The second component in the endeavor to promote empowerment, thus promoting collaborative leadership, is the need for leaders to provide a vision. Virtually anyone engaged in any type of movement or organization would agree that one cannot move forward without a vision of the end result. Some call this a vision, some call it a mission statement, some simply call it a goal. All would agree it is a necessity. A good collaborative leader is someone who can provide, or assist in creating such a vision. In turn, a strong vision promotes collaborative leadership. Reinelt (1994) asserts, "Organizations need to define what they value … movement leaders [should] work hard to provide an interpretive frame for actions and beliefs that are relevant" to the organization and its stakeholders (p. 691). Rago (1996) claims that a vision provides value in that it empowers stakeholders "as active participants in shaping the services available in the community" (p. 229). Baum (1998) extends the importance of vision to be "not a picture of any specific future for the community, but an image of success for the participants". He notes further that, "the hope that the vision offers matters more than its specific intellectual content" (p. 419).

Shared Planning

The third crucial component of empowerment is shared planning. Shared planning of the process of the collaborative initiative is the step in which the relationship between leaders and stakeholders begin to solidify. The act of shared planning contains two important components. Collaborative leaders must acknowledge the expertise of local/stakeholder leadership and allow them to take part in the planning process. Baum (1998) underscores this necessity by reminding us that leaders "must strive to give citizens the opportunity to have a meaningful impact on the development of plans and programs" (p. 411). Dementi-Leonard et al. (1999) argue that good collaborative leadership "is one that not only acknowledges local expertise and local knowledge but clearly recognizes and marks it" (p. 45). Sweat (1995) discusses the importance of this notion in an urban revitalization project. He asserts that the project has been successful because "the corporate partners are listening and responding to the communities. They are working with the communities, rather than merely imposing their own problem definitions and solutions … the only lasting solution to inner-city problems must be developed with the input and direct participation of its residents" (p. 243). Weil (1988) argues that the success of the collaboration of two client groups she examined is due, in large part, because the program "was revolutionary for its commitment to empowering staff through shared planning and decision-making" (p. 74). Carr (1997) examines community leadership and points out that failure to engage in shared planning could be detrimental to the goal of empowerment. Further, she points out, early acknowledgement of stakeholder expertise "is a crucial step in avoiding the misperception that change is a top-down mandate. Haphazard or delayed identification of stakeholder groups can lead to resentment and sabotage of decision-making efforts and even alienation through inauthentic participation" (p. 153). It is fair to say that one cannot underestimate the importance of involving the stakeholders in a collaborative through acknowledging their

expertise and involving them in the planning process itself. Shared planning fosters a team approach, one in which all members are vital. Clearly, researchers have found this to be of utmost value to the participants in any collaborative. Considering that empowerment is the overarching goal, one cannot expect a participant who has had no input into the process to feel empowered to affect the outcome.

Providing Resources

The fourth key component of empowerment is providing the necessary resources to those involved in the collaborative. This is a crucial component in the discussion of factors that promote collaborative leadership because the very nature of empowerment dictates providing the necessary tools to those involved as part of motivating them to engage and fulfill their goals. Often, organizations collaborate simply in order to pool their resources. More often, providing resources is more complex. It can entail financial resources, to be sure. But, more often, it means providing education and skills training to stakeholders as a step in the journey towards empowerment. Like shared planning, there are several elements that can come into play in the effort to provide resources, and the type of project may dictate which elements prove important to that particular collaborative. For example, due to financial constraints, some collaboratives attempt to utilize existing resources for their projects. This could be in the form of manpower or existing moneys. Iglitzin (1995) discusses an urban village planning project that simply "needed someone with proven leadership skills capable of marshaling the resources of private-citizen activists to galvanize the effort" (p. 624). Another local collaborative project "attempted to use existing resources to support its initiatives … no reinvention, duplication, or redundant services need take place" (Allan, 1995, p. 34).

Other projects pledge to provide support to its stakeholders in any way necessary. Dementi-Leonard (1999) discusses how a language revitalization project was able to do this while keeping the shared planning in effect. She remarks that the leaders "would provide the support that was deemed appropriate and necessary in collective community decisions" (p. 42). Friedell et al. (2001) discuss a cancer control initiative and note that "leadership development and community participation strategies were incorporated into the project design thorough extensive technical assistance. The staff and project-affiliated partners provided skills training and support" (p. 7). They attribute the program's success to the fact that they "provided coalitions with the skills to assess their local needs and resources with regard to cancer control issues and encouraged members to set goals and design a plan" (p. 8). Rago (1996) underscores the assumption of this program's success in his argument that "before a task force can be empowered, it must receive training in skills that will enable it to manage itself" (p. 233).

It is apparent that collaborative leadership cannot exist without the proper assessment, vision, shared planning, skills training, and resource provisions. Research shows that all of these conditions are essential for the creation of a feeling of empowerment, which is the fundamental key to all collaborative leadership. However, once a collaborative exhibits all of these characteristics and conditions, what is the function of the organization and its leaders? How does one ensure that a collaborative project will sustain the momentum created? The answer to this is the last condition that promotes collaborative leadership: trust.

Trust

Mycek (1995) offers that a good collaborative will "equip community residents

with the knowledge and resources to effect change, and then humbly watch it go" (p. 12). She goes on to say that the key to a healthy initiative is one in which "you're helping to facilitate, but then you're letting people go" (p. 13). In his discussion of collaborative leadership within an organization, Rago (1996) supports this assertion by acknowledging that leaders "must develop attitudes of trust in the ability of [stakeholders] to make the best possible decisions" (p. 231). Trust is a key issue in promoting collaborative leadership. If an initiative has truly provided all of the positive elements discussed above, its leaders must trust in the members to utilize them to the utmost benefit of the collaborative. Genuine empowerment cannot exist without trust in those who have been empowered. O'Connor et al. (1996) sum this up nicely with their assertion that the key components to a collaborative are "assessment, team building, a shared vision and continual nurturing of the team. Creating an environment of trust and empathy is critical" (p. 62).

Impediments

Given that there are definite, tangible conditions that promote collaborative leadership, it follows that there would be conditions that hinder it as well. This section endeavors to discover whether there are elements of a collaborative situation that can place constraints on stakeholders' and leaders' abilities to create a successful, empowering collaborative. There are myriad possibilities of things that could impede collaborative leadership. However, based on the research, there are two conditions that are most common. These are politics and differences among stakeholders.

Politics

The most common barrier to collaborative leadership seems to be politics. Most collaborative movements need to deal with political agendas in one way or another, and almost all of them find this to be a difficulty in creating an environment of empowerment. Reinelt (1994) feels that politics create such a problem for initiatives because most are formed out of a desire "to explore for themselves new ways of communicating and interacting that challenged, at least internally, the bureaucratic values and structures of power that dominate our society" (p. 686). In other words, most collaboratives are formed in order to achieve something where they feel the government or society has fallen short. And yet, ironically, they often must still deal with those very channels to achieve their goals. It is antithetical to empowerment to have to deal with bureaucracy. "Passivity and powerlessness are actively produced through bureaucratic processes and discourses" (Reinelt, p. 676).

Several researchers and authors support this feeling about politics and collaboration. Kadlecek (1997) measured activists' perceptions of factors that inhibit collaboration and found that they overwhelmingly agreed on "local autonomy, politics and power, and tax base and annexation issues" (p. 179). Iglitzin (1995) discusses a key to the success of an urban village planning project and notes "a decision that would prove crucial to the way in which the [project] developed was made by those interested in seeing the idea come to fruition: It should be an effort carried on outside of government" (p. 622). Greenberg et al. (1998) support this finding with the argument that "political rhetoric should not be allowed to obscure the reality that … public health researchers and practitioners can make critical contributions" to a movement (p. 1759).

It is clear that dealing with politics can prove to be a daunting and seemingly unempowering task for a collaborative. "How can a group of outsiders penetrate a bureaucracy?" (Reinelt, p. 694). The key to overcoming this impediment seems

to be to maintain focus on empowerment. Bureaucracy will not deter a truly empowered group of stakeholders. Reinelt remarks, "Empowering local activists to act collectively in their own interest rather than waiting for others to act for them" is an important task for collaborative leaders.

Differences Among Stakeholders

To say that there will be differences among people involved in a collaborative movement may be obvious. Yet, it is important to understand that differences must not only be acknowledged, they must be addressed. If they are not, they can pose a serious impediment to collaborative leadership. There are virtually too many possible differences to address. They can range from differences in agendas, to different goals or visions, to differences in communication styles. Like the other elements discussed above, each initiative will experience its own differences and must be examined individually.

Iglitzin (1995) found that differing visions of the outcome of a project can be an impediment to collaborative leadership. She notes, "such differing visions and expectations for the future of the community have a major impact on the outcome". But, this can be overcome by stressing "the interplay of interests and the process of consensus-building in response to personal agendas and decisions" (p. 621). Mycek (1995) agrees when she argues that the key to achieving their vision of a healthy community "will be in stakeholders' ability to rid themselves of personal agendas". She asserts that this is possible, but "the process has to be collaborative, very unselfish and no one can take credit. It helps to realize that no one is letting go of something that someone else isn't also giving up" (p. 14).

Differing agendas and visions of the process can also be affected by cultural differences. Baum (1998) asserts that racial differences can impact collaborative leadership because "no mental stratagem really eliminates racial differences" (p. 420). Differences in socioeconomic status can lead to differing leadership styles. These can be counterproductive if not managed effectively and may hinder collaborative leadership. According to Baum, community leaders can overcome this impediment by making "a commitment to include all significant groups in forging a shared identity and developing policies that represent and serve all" (p. 422).

As previously mentioned, there are numerous possibilities for conditions that could hinder collaborative leadership. Those mentioned here are seemingly the most common. Similar to the answer to dealing with politics, empowerment is again the key to overcoming the possible negative effects of stakeholder differences.

Urban vs. Rural Collaboratives

By and large, there seems to be little variation in the types of conditions that promote collaborative leadership in rural settings versus urban settings. Like the participants themselves, there will always be some differences among initiatives no matter where they are. Partnerships, after all, are all unique because "each community has different needs and partners have varying resources" (Sweat, 1995, p. 242). However, despite this assertion, there are some arguments for the case that rural initiatives face more difficulties, in the areas of service, collaboration, and leadership, than their urban counterparts.

Snavely et al. (2000) posit, "Environmental factors present in rural areas suggest that collaboration may be difficult to accomplish. Clients are scattered over a large geographic area, [they experience] transportation problems,

community financial resources are limited, staff salaries are low, and some rural populations resist service offerings" (p. 145). Friedell et al. (2001) agree with this assertion and consider rural residents to constitute a "special population. Rural Americans tend to be older, poorer, and less educated than their urban/suburban counterparts. And there are systemic factors related to rural life in general, for example, lack of public transportation and lower levels of community services" (p. 5). All of these conditions can affect collaborative leadership in part due to the fact that "organizational problems include the inability of local communities to provide strong financial backing and difficulty in attracting professional staff due to noncompetitive salaries" (Snavely et al., 2000, p. 147). However, Sternweis and Wells (1992) maintain that these factors need not be detrimental to urban initiatives. Like any collaborative, "leadership is a critical factor in determining which rural communities will succeed in their efforts to maintain or improve their quality of life" (p. 41).

Sweat (1997) points out that some urban projects face similar financial difficulties as many of their rural brethren. However, a major advantage that urban initiatives have in this area is the increasing trend for local corporations to become involved and provide financial backing. "The corporate partner is emerging as a major force in community development. They can bring special capabilities to the partnership" (p. 244.). The existence of corporate-sponsored partnership in urban settings does seemingly give these collaboratives an advantage over those in rural settings. However, many leaders would agree with Mulroy & Cragin (1994), "Financial advantage provides a tenuous basis for collaborating in the human services field. It does not provide a long term basis for working together" (p. 31). Regardless of the setting, the real test of a collaborative leadership project is its ability to build capacity by empowering its stakeholders to achieve their vision.

The Collaborative Leader

If the real test of a project is its ability to empower its participants, is there a certain type of person who is more likely than others to embrace a leadership role in this capacity? Perhaps the most obvious answer to the question of what makes the best collaborative leader is someone who can promote all of the conditions previously discussed; someone who can undertake assessment, provide a vision, facilitate shared planning, provide resources and training, and trust their peers. But what kind of person is most likely to do these things? Are there certain types of people more likely to engage in practices that facilitate collaborative leadership? According to Goldman & Kahnweiler (2000), this is an important line of questioning because leaders of collaborative projects "can be expected to possess different characteristics, interests, motives, abilities, and experiences from their internal organization counterparts" (p. 436). Indeed, their assumption is supported by some research. In a study conducted by Goldman and Kahnweiler, they found that successful collaborative leaders are more likely to have a high tolerance for role ambiguity and the stress related to it. Using the Myers-Briggs profile, they found that successful collaborative leaders are more likely to score high on the 'feeling' index than the 'thinking' index, as well as are more likely to be extroverted than introverted. Overall, they list "the essential ingredients for collaborative success" as being "flexibility, patience, understanding of others' viewpoints, sensitivity to diversity, and a cooperative spirit" (p. 449). These characteristics are unquestionably commensurate with the conditions discussed previously that are most likely to promote collaborative leadership. Mycek (1995) most eloquently summarizes the essence of collaborative leadership and all its facets with her assertion that "the best way to lead is to follow" (p. 14).

Case Studies

Thus far, we have provided discussion and examples of conditions that facilitate and hinder collaborative leadership. And we have examined whether these factors differ for certain settings and certain personality types. In this section, we will provide three case studies of actual collaborative movements. These case studies will illustrate some of the aforementioned conditions and their outcomes. They will also underscore the importance of understanding the unique nature of each individual initiative.

The Athabascan Language Preservation Project

This case study documents an alliance among twenty villages in western Alaska who shared "strong concerns for the survival" of their native languages. (Dementi-Leonard, 1999, p. 37). Representatives from the villages met in a series of meetings to discuss strategies to increase efforts of regenesis of the language, as well as educational and program support to maintain the efforts. This case study strongly demonstrates several of the conditions that tend to promote and hinder collaborative leadership, including the need for assessment and shared planning, as well as cultural and political issues.

Because "language is a part of a complex web of culture and identity and as such must be viewed only through the local meanings it holds for community members", it was necessary for this project to engage in "community-generated and community-owned direction and planning" (p. 41). The project was led by the Tanana Chiefs Conference (TCC), a consortium of 43 Athabascan tribal governments that acts as an agency to administer health and social service programs to native residents. From the outset, according to Dementi-Leonard, "TCC recognized the limits of its own role and respected the autonomy of any community decisions regarding the use of the Athabascan language at the community level" (p. 42). This was facilitated by creating a safe place in the meetings for community members to openly express ideas that would not have felt comfortable expressing in the presence of outsiders. The importance of this was echoed by a community member who lamented about past collaborative attempts, "It's been all these years of other people coming and saying how things should be … it's their way or no way. Now we're trying to get everybody back to where they feel good about what they can do – and trying to undo many years of the total opposite" (p. 42). As part of the effort to enact this quote and regenerate the native language, the community decided that, not only should programs increase natives' knowledge of the language, but should teach local, non-native educators to speak the language as well. This, they felt, would prevent the "outsider" culture from trying to acculturate natives to white culture.

Another factor that contributed to the effectiveness of the shared planning of this project was that "many of these individuals participated in and presented at the project meetings. Their leadership roles were crucial and significant" (p. 45). In other words, TCC did not seek initial input from community members and then disregard them once the project gained momentum. Their input was valued all the way through the process. This, according to the members, led to empowerment. "The collective voice of the participants conveyed a strong sense of pride, cultural identity, and self-determination" (p. 45).

This case study demonstrates the importance for collaborative leaders to assess the past and current situations, facilitate shared planning by acknowledging and utilizing local expertise, and trusting in stakeholders to use their empowerment to work toward their goal.

Collaboration Among Rural Nonprofit Organizations in southern Illinois and the Mississippi Delta

This case study presents a discussion of nonprofit organizations in southern Illinois and the Mississippi Delta region engaging in collaborative leadership efforts. According to Snavely & Tracy (2000), these organizations do experience some of the common rural impediments, however, "despite these difficulties, nonprofits in the two rural regions do engage in significant collaborations, and their leadership shows strong commitment to partnering with other organizations" (p. 145).

The conditions that the seven Illinois counties and six Delta region counties encounter include large expanses of land dotted with small towns that experience high rates of poverty and unemployment. Yet, it is precisely these conditions that led the two regions to decide to collaborate. It was the lure of the pooling of their individually scarce resources that brought them together. According to Snavely & Tracy, this has led to "commitment to working closely with [each other] where their missions overlap and intersect and where the combining of resources leads to improved service effectiveness and efficiency" (p. 147). There could be some hesitancy for rural organizations to collaborate this way. After all, competition for already scarce resources is common in areas where the population is spread over a large geographic area. However, these counties worked together to decide what resources to pool to the maximum benefit of everyone involved. The organizations purposely shied away from difficult-to-manage areas such as "shared staffing, joint budgeting and purchasing, and the pooling of finances" (p. 149). These practices would be too expensive and time-consuming for poorly staffed, poorly financed organizations to handle. Instead, they decided to focus on more attainable collaborative efforts such as case management referrals, community issue assessment, and community planning.

The collaborative leadership of the projects in these counties demonstrates "a philosophy of inventiveness, mutual obligation, and sharing" (p. 151). According to the participants, they "recognize the community wide benefits to collaborative planning" (p. 151). This case study proves that, while rural organizations may sometimes face unique impediments, they can still create conditions which foster collaborative leadership and are certainly not lacking in innovative, competent leaders to carry this out. More importantly, this case study exhibits that these leaders exhibit a sense of understanding for the factors that promote collaborative leadership. "The leaders establish personal connections with each other, building up bonds of trust, and they commit organizational resources to collaboration" (p. 153).

Principal Leadership and Community Participation

This case study explores how the leadership styles engaged in by principals of four middle schools relates to the community participation at each school. This is an especially interesting case study because it provides examples of the conditions that both promote and impede the collaborative leadership of the stakeholders involved in these community organizations. For this case study, stakeholders are defined as "those attempting to influence the allocation of resources or intended direction of the school system" (Carr, 1997, p. 153). In this instance, that essentially refers to parents as opposed to a broad spectrum of community members. Nevertheless, notes Carr, "understanding the complex relationship between leadership and participation can yield important insights for systemic change" (p. 154). Through observation of meetings, analysis of notes, and interviews with parents and principals, the principals' primary leadership styles were determined as well as their effects on the participation of the parents involved.

McGregor Middle School

The principal of this school, Mr. F., initially presented a goal of shared planning and empowerment at the first meeting. "You are gonna help run and drive the direction this school is going. This group will have power and voice in what happens at McGregor" (p. 156). However, despite these statements, this principal in actuality set up many impediments to the parents' participation. For example, he required parents to obtain a pass from the office if they came to the school and to give one day's notice if they wished to observe a class. Also in contrast to his initial claim of parental inclusion, Mr. F. hosted another meeting, during which he took almost the entire time to argue that the improvement of the children's math scores should be the focus for improvement that year. According to Carr, as a result of this contradiction to his early philosophy of empowerment, "parents passively accepted his agenda and did not suggest an alternative focus for the groups work" (p. 157).

Yo Wick Middle School

Ms. O., the principal at Yo Wick Middle School expressed a slightly different leadership style. From the beginning, she dominated the group's meetings. The first meeting, for example, had been billed on paper as being an opportunity for community members to choose representatives for the Parents Advisory Council (PAC). Once in attendance, however, parents were told right away that Ms. O. had already chosen the representatives for the council. No discussion was allowed and no formal vote was taken. At every meeting throughout the year, Ms. O. dominated and she never suggested or asked for anyone else's participation. According to Carr, statements from some of the parents speak strongly to the feeling Ms. O. created in these meetings about the importance of the PAC. One parent comments "I wouldn't say the council was powerful. That implies we had the opportunity or the ability to change existing practices and procedures in school" (p. 159).

Jefferson Davis Middle School

The principal of Jefferson Davis, Ms. B., announced at the first meeting that "the purpose of the PAC at Jefferson Davis is to involve as broad a segment of the community as possible in the school so as to get a variety of ideas" (p. 160). Ms. B. "generally took only limited control of meetings" (p. 160). The interplay among the parents, the PAC advisory board, and the principal was noticeably different from the two situations above. Ms. B. fostered a sense of shared planning and empowerment in the group. Evidence of this is seen in the following comment from one parent. "I felt that valuable input was heeded and the structure of the council was controlled by the parents". Another parent's comment speaks directly to the ability to promote collaborative leadership. "The principal made it powerful. We had direct support from the principal" (p. 160). As a result of these conditions promoted by the principal, the parents designed a homework policy that "actively engaged them in the process and displayed independent critical thinking" (p. 160).

Merrimack Middle School

Ms. J., the principal at this school, expressed a larger, more long-range interest in the future of her school and its students. At the very first meeting, she noted that, somehow parents had been taken out of the process of their children's education and they needed to be brought back in. She expressed a desire for a shared vision and for *all* parents to become actively involved in the creation process. Ms. J. exhibited a strong concern for the global issues that affect local

children. According to Carr, "this sort of global, selfless concern dominated the Merrimack school council. The members of the council did not promote individual agendas. They expressed concern for all children and created an environment characterized by future-oriented thinking and a shared vision" (p. 161).

Summary

These case studies serve as compelling illustrations of how many of the conditions discussed in this section can promote and hinder the process of collaborative leadership. Every initiative has unique circumstances, to be sure, and must be understood vis a vis its own circumstances. However, those interested in collaboration should be aware that politics and differences among stakeholders are likely to emerge as impediments to collaborative leadership. On the other hand, assessment of the situation, creating a vision, shared planning of the process, provision of resources, and trust are conditions which are more likely to promote collaborative leadership. All of these elements foster an environment of empowerment. Empowerment, as this section has shown, is the most crucial factor in the facilitation of collaborative leadership. Perhaps Bowers (1999) illustrates this best with the following credo. "If you tell me, I will forget; if you show me, I will remember; but if you involve me, I will understand" (p. 35).

Section 5: Leadership Development Strategies and Methods

Introduction

When the Institute of Medicine (1988) reported that the public health system was in disarray, it identified leadership development as a key factor in this dilemma. The report urged for a more focused initiative to develop leaders, observing a present lack of direction and intentionality in public health leadership development. Scutchfield, Spain, Pointer and Hafey (1995) in citing the IOM report, claimed that, "There is no literature on leadership development or leadership education specifically for public health." (p. 304). This report helped to stimulate more research and training, such as the Public Health Leadership Institute, which focuses on senior public health officials (Scutchfield, Spain, Pointer, & Hafey, 1995). But while the literature and training programs may still be limited, there are many other fields of leadership study that might provide models to inform, shape and build vision for public health leadership development. Many strategies and techniques from other fields were also born out of a dearth of attention to succession planning and leadership training, for the leadership gap is not partial to public health alone. A recent survey of Fortune 500 companies discovered that "the average company expects 30 percent turnover at the executive ranks in the next five years, with one-third of human resources executives believing they'll have significant difficulty finding suitable replacements" (Ashby, 1999, p. 3).

The struggle for leaders is widespread, and often thought to be a result of the increase in demands and changing role or charcteristics of the leader today. The shift from authority focused leadership to collaborative and team oriented leadership has not been met with adequate leadership education and training. Ashby suggests that the leadership need for the future "is both quantitative and qualitative" (1999, p. 9). Not only do critical leadership positions need to be filled as vacancies and restructuring occur, but also leaders with capacities and characteristics to meet the current challenges and innovations in the work place are essential. In the field of public health, and particularly for those in the Turning Point Initiative, capacities for collaborative leadership development need to be in clear focus of any development plan (2001).

Pre-requisites in Considering Leadership Development Plans

The American Society for Training & Development (Fulmer & Wagner, 1999), together with several professionals in the field of leadership conducted a study in 1998 to identify key factors in strong innovative leadership development processes. They surveyed 35 organizations that had well developed leadership development programs. They further narrowed the study to six organizations with the most innovative or strong leadership development processes. Ashby (1999) summarizes their key findings of best practices in leadership development programs through the following highlights:

1. Leadership development does not stand alone. It must be aligned to the overall strategy of the organization.
2. Senior-level executives with extensive line experience must be involved in the design of the leadership development program.
3. A model of leadership competencies is developed which is consistent throughout the organization and reflects the values of the organization.
4. Best-practice organizations develop their own leaders rather than recruit them from other companies.
5. Action, not knowledge, is the goal of best-practice leadership development.
6. The leadership development process is linked to the organization's succession planning.
7. The leadership development process is a symbiotic tool of effective leadership.
8. Successful programs are continuously assessed. Although the study showed companies used a variety of assessment methods, all assessed results on a regular basis, reflected on the results, made adaptations, and kept listening and learning (Ouellette, Lazear, & Chambers, 1999).

These best practices give guidance to approaches and strategies for leadership development in public health.

In developing any leadership program, two questions must be asked initially: "What is the goal of the training or development?" and "Who is to be trained or developed. The first question is outcome and skills oriented and taken up in another section, but the latter is important to articulate before a review of possible strategies and techniques is relevant. During a discussion of the Turning Point Leadership Development Plan (2001) experts in collaborative leadership development suggested three levels to consider in nurturing sustainable leadership. Level one is focused on the individual and the leadership capacity developed from within. The second level is focused on individuals working within an organizational context. "Organizations typically are the distribution mode for how we create change…large scale change…in communities" (p. 86). The third level broadens to the community. Collaboration becomes critical at this point as community members begin working across boundaries to stimulate change and solve problems. The development process for collaborative leadership in public health must consider various venues that allow for an ever-expanding sphere of influence from the individual leader, to many leaders within an organization, to the broad leadership available in communities.

Adults as learners present unique challenges to any development process or program. Renowned education theorist Malcolm Knowles, who is considered by many as the father of adult education, provides several key principles for training or developing a learning process for adults. Five foundational principles of his theory are considered essential for a vital learning experience (Knowles, 1990; Adams, 2000). They can be summarized as:

1. Adult learning should be an active, not passive endeavor. While lecture is important for information dissemination, adults tend to remember only 10 percent of what they hear (Adams, 2000). Add visual and the learning jumps to 50 percent. Add discussion and retention increases to 70 percent. Combine demonstration and visual with auditory and learning often increases to 90 percent. Therefore, methods that provide for active participation will increase learning in adults.

2. The adult learner must relate to the training and the training to the learner. Adults bring a breadth of life experience to their learning that provides a richer frame of reference. Training and development of adults will be more effective when this is taken into consideration.
3. Learning is enhanced when it is purposeful and meets a need. Adults will seek to apply what is learned immediately. The value of learning needs to be directly linked to the learner's need or dilemma. Assessment to determine clear purpose and needs is foundational to this.
4. Learning is facilitated when adults share in their own goal setting. Self-directed learning helps to personalize and stimulate interest in any training or development program.
5. Learning is enhanced when it draws on the expertise of the learner and is applied immediately. Optimal learning occurs when the learner in turn teaches what he or she has learned.

Strategies, techniques, and methods for leadership development that incorporate these principles will encourage greater learning and satisfaction in meeting desired outcomes.

Organizational Attitude and Leader Identification

If Knowles (1990) assessment of adult learners is correct, a range of approaches in leadership development is requisite. As best-practice competencies and skills are identified, an assessment of those in existent leadership and potential leadership needs to be performed. Many private companies and public agencies have benefited from Peter Senge's concept of the learning organization. In *The Fifth Discipline* (1994) Senge comments on the factor of personal mastery in learning organizations claiming that "no one can increase someone else's mastery. We can only set up conditions which encourage and support people who want to increase their own" (p. 193). In addition to this attitude and atmosphere of learning that nurtures leadership development, Tichy and Cohen (1998) state that a learning organization must also become a "teaching organization" (p. 52). In other words, the learning cannot stop with the learner but must be passed along to others in the organization if they hope to survive turbulent environments. They suggest, "teaching organizations are more agile, come up with better strategies, and are able to implement them more effectively" (p. 52). After researching a variety of companies including GM, IBM, American Express, Westinghouse, General Electric, and Intel, the Tichy and Cohen discovered that the difference in a company's success or failure was "a function of leadership throughout. Winning companies win because they have solid leaders not only at the top, but also at all organizational levels" (p. 54). The literature implies that an organizational attitude of continuous learning and teaching provides optimal conditions for leadership development.

Part of this organizational attitude includes what Blodgett calls a "top-to-bottom culture of leadership" (1999, p. 77). One artifact of this culture is the identification process of possible leaders. An example of this is the Sears company who seriously examined their succession policies and devised a process for identifying people who may be ready for leadership within the company (1999). They divided these employees into three groups, including those immediately ready for a leadership position, those who may become candidates in the next few years and those who are at least three to seven years away from leadership capacities. One method for securing this assessment is through the 360-degree feedback or review process (Blodgett, 1999; Kaye, 1999). Peers, managers and reportees all contribute to create profiles of possible leadership capacities in the evaluated employee. This feedback becomes the foundation for a personal

development plan. Since most entities experience their greatest need for leaders when it is too late, developing an organizational attitude that considers leadership identification and development critical at all times is one way to circumvent such a crisis.

General Electric is one such example of developing leaders as a core competency of their company. "Every professional-level employee at GE has a career map that describes where they are in their career relative to positions they've had and may hold in the future" (Tichy and Cohen, 2000, p. 29). This map involves personal assessment, intentional coaching, and organizational structures to support leadership development as well as systems and processes that expect employees to further the development of others. Job performance is not just based on strategies and delivery of goods or services; rather job performance is also judged by the ability to develop others. Having a pipeline of leaders has provided "bench strength" (p.29) for them as a company. This same bench strength is required in the human service sector as noted by 21 executive directors of nonprofit agencies in Baltimore (Menefee, 1997). Responding to questions regarding the impact of turbulent times on the success of their organizations, three critical areas emerged: planning, management and leadership development. Whether in private or public enterprises, continuous assessment of leadership possibilities coupled with an attitude and plan to develop leaders is crucial for sustaining an organization's effectiveness.

Assessment Tools

As mentioned earlier, 360-degree feedback is one tool that has proven useful in leadership identification, assessment and development. Known more as an instrument for annual performance reviews, this tool "provides individuals with insight into how they are perceived by people at all levels of an organization" (Frankel, 1997, p. 27). This full circle feedback process from all of the constituencies relating to a leader or potential leader gives depth and stronger validity to perceptions of skills and abilities. This feedback can be used to create a development program to capitalize on already perceived strengths and correct areas of growth still required. The success of this tool according to Church and Bracken (1997) is it's "simple assumption, derived in part from measurement theory, that observations obtained from multiple sources will yield more valid and reliable (and therefore more meaningful and useful) results for the individual" (p. 150). Frankel (1997) also suggests three keys to follow for success in using this tool as being: 1. wide distribution of the instrument to those related to the employees work, 2. anonymity so that honesty is garnered, and 3. composite scoring and feedback by a neutral third party so that the focus is not on individual responses but trends that will prove useful for the employee's development.

One of the benefits of the 360-degree feedback instrument is that it can be customized to the competencies, skills and goals of a given agency or leadership position. In a team of hospital administrators in Scandinavia a form was developed to increase the team's honesty in communication and feedback with one another (Frankel, 1997). The instrument was developed around those issues and coupled with a two-day program of training followed by coaching for honest communication. In this way, they were in keeping with Cashman and Reisberg's claim that, "For 360-degree feedback to be valuable, it needs to be seen in a larger context. What are the developmental implications of these perceptions?" (1994, p. 9). In a division of Mobil Oil the 360-degree feedback process is used as a starting point in their Individual Leadership Development Process (ILDP). In an effort to respond to a threatening shortage of leadership in the early 1990's, Mobil developed a leadership model that began with a clear

definition of what was meant by leadership and a delineation of the competencies and behaviors required to lead within their organization (Stryker, 1999). These definitions and competencies were then used to develop an appropriate 360-degree instrument that helped form an employees ILDP. This tool in conjunction with a leadership plan and action learning is one reason why the company moved in ranking from 12th among 13 major oil companies in 1993 to 1st in 1997.

Another assessment that focuses primarily on leadership is the Leadership Practices Inventory developed by Kouzes and Posner (1995). This particular tool, which has psychometric properties reporting internal reliability and validity, has the advantage of providing consistent assessment across gender, ethnicity, and culture in addition to cross-functional organizations. It also focuses on a conceptual framework that Kouzes and Posner developed through extensive interviews and case studies. It assesses five key leadership factors: 1) Challenging the process, 2) Inspiring a shared vision, 3) Enabling others to act, 4) Modeling the way and 5) Encouraging the heart. Used as a feedback tool and in conjunction with a leadership development plan, the LPI not only enriches one's personal understanding and awareness, but also provides an opportunity to enhance leadership capabilities.

Other tools noted in the literature include the Myers-Briggs Type Indicator (Mani, 1996), the Adjective Check List (Mani, 1996), Blanchard's Leader Behavior Analysis instrument (Stromei, 1999) case studies and personal inventories or questionnaires (Manz, Muto, & Sims, 1990). Each of these may have specific appropriateness to certain situations. The Myers-Briggs Type Indicator (MBTI) was used in an organizational development initiative in the Internal Revenue Service (Mani, 1996). Used as self-information in a voluntary management development program, the IRS encouraged personal use of the data. Guided by an ethic of voluntary participation in this self-assessment tool, the IRS program affirmed the following use of the assessment:

> Rather than suggest that people of a given type cannot possibly be successful managers, the participants learn that people of all types occupy managerial and non-managerial positions. They learn that the data suggest that some behaviors might be more difficult for them than others, and that they could use that information to set goals for their careers and their personal growth (Mani, 1996, p. 6).

Used as self-awareness then, the MBTI could assist leaders in their self-awareness and leadership development goals. In addition to the MBTI, the IRS also used the Adjective Check List (Mani, 1996) that quantifies observations about a person's traits and needs. Used with the MBTI, the ACL can provide greater awareness on creativity, responsiveness to change and leadership capacities.

The Sandia National Laboratories in a mentoring program of training for middle managers utilized the Blanchard's Leader Behavior Analysis (Stromei, 1999). This tool provides assessment of leadership styles in order to understand their suitability to certain functions required. Used as both a pre-test, before training or mentoring, and then as a post-test, this instrument has the capability of measuring any changes in leadership skills. Such information could be used in any ongoing development plan.

In the move from traditional leadership to self-leadership and "Super Leadership" (Manz et al., 1990), the demands on managers are great. It is not easy to shift from manager to SuperLeader. But Manz, Muto and Sims suggest that it begins with gaining awareness through an assessment exercise such as "What is Your Leadership Style?" (1990, p. 13) or through the use of a case study that stimulates some primary insight regarding leadership situations. Used in group discussions, these methods allow for shared learning that can enlarge individuals

thinking about leadership. Whatever the method, self-awareness and informed goal-setting seem foundational to any leadership development plan. A combination of approaches seems wise in order to provide the greatest reliability and breadth of information from which to develop a personal leadership growth plan.

On a final note, assessment and personal awareness is not just about inventories and tangible tools. It involves a deeper sense of knowing that is addressed in *Leadership in the New Economy: Sensing and Actualizing Emerging Futures* (Jaworski & Scharmer, 2000). During this interview project, W. Brian Arthur articulates a helpful model of the stage sequencing in creating personal awareness or knowledge that will jettison leaders into a transformational understanding of themselves and their contexts. "Observe, observe, observe. Become one with the world" (Iwasiw, Andrusyszyn, & Moen, 2000) is the first stage. Then "Reflect and retreat. Listen from the inner place where knowing comes to the surface" (p. 8). Finally, "Act in an instant. Incubate and bring forth the new into reality" (p. 8). Jaworski and Scharmer (2000) expanded this three-stage sequence by identifying seven practices that make up the process of leadership in the New Economy. Although described sequentially, they are sometimes experienced more simultaneously. These practices are:

1. Listen to your call
2. Observe, observe, observe: become one with the world
3. Uncover intent and surrender into commitment
4. Allow the inner knowing to emerge (Illumination)
5. Crystallize and broadcast intent
6. Act in an instant
7. Work: execute, learn, let go (Jaworski and Scharmer, 2000, p. 9).

While tools and surveys are invaluable in the assessment and personal awareness stage foundational to leadership development, these authors encourage a condition of the heart and mind that allows for deeper knowledge and change.

Leadership Development Approaches

Coaching and Mentoring

Coaching has been defined as simply "the facilitation of learning" (Verlander, 1999, p. 65). It is touted as a cost-effective method of leadership development because of its focused results. With the fast pace changes of today's current work setting, more and more leaders, particularly executives, are enlisting the help of coaches to focus their effectiveness in a demanding work environment. Coaching may take several forms in leadership development plans. Verlander suggests three types of personal coaching situations (1999). The first he calls ***"Shadow Coaching"*** (p. 65). This intense form of coaching requires the working alongside of the leader, observing and assessing the leader's skills and leadership needs. It allows for reality based feedback and action planning. This one-to-one time with an expert coach has been used to develop managers into leaders within Dr Pepper/Seven Up, Inc. (Krayer, 1999). In this case the coach helped a manager identify problems contributing to an overall lack of quality in customer service. They then devised an intervention plan that required an emphasis of leadership rather than management skills in a department that had lost vision. After 6 weeks of implementing a new system derived from a comprehensive assessment with input from reports and observations, error rates in customer service was reduced from 20% to 2%. In other cases, experts coached work groups who were peers (Donaghue, 1992; Schmidt, 1999).

A second type of coaching is the ***"Feedback-Based Coaching"*** (Verlander, 1999, p. 68). The idea is to maximize the use of personal assessments such as a 360-degree feedback instrument and others mentioned through coaches. Coaches can become neutral 'mirrors' in the assessment and feedback phase of any leadership assessment and consequent growth plan (Frankel, 1997). The Allstate Corporation, which is the largest U.S. personal line and publicly held insurance company, began a leadership program to develop 200 officers in 1996 (Stephens, 1999). A 360-degree instrument was utilized and participants identified coaches who helped them develop intervention and development plans. Results of this effort in 1997 suggested that, "The correlation between leadership behavior and superior business results is significant and has led to an increased emphasis and urgency for leadership development" (Stephens, 1999, p. 24-24).

A third type of coaching that Verlander identifies is ***"Just-In-Time Personal Coaching"*** (1999, p. 74). Harrison (1999) provides an example of personal coaching that is focused on an executive who, having been through all of the 'right' assessments, including 360-degree feedback, and training, was not performing well in relationships with his colleagues. Improvement in this area was deemed necessary for any further advancement. In this case the expert coach focused on critical events that had eroded healthy work relationships. These incidents were re-enacted, critiqued and role-played for new behavior development. In a very compacted amount of time using specific feedback and practice, transformational change was reported amongst the executive's colleagues as well as reports. Harrison argues that, "Whatever methodology is used, selection of the specific behavior needed for change is essential" (1999, p. 140). That way the intervention can be focused and, through hard work, stimulate real leadership change.

Peer coaching also appeared as a method in the literature. In a case study of the nurse manager role, internal peers in cross-functional leadership roles partnered with the nurse leader to provide specific coaching in higher function operational demands (Schmidt, 1999). In the earlier sited case of communication skill development in a Scandinavian hospital, peer coaching was a primary method for learning (Fankel, 1997). Team participants were paired with coaching buddies who provided critical feedback and insight to one another in communication skills development. The case conclusion noted that the strength of this method in this program was the already high functioning nature of this team. Had the team not know each other so well already, the ability to honestly coach a peer might not have been so high.

Finally, ***mentoring*** has served useful in several settings where individual at various levels of expertise can be paired to benefit the person with lesser skills and experience. A case study of Sandia's mentoring program affirmed a high rate of leadership transfer skills for those involved (Stromei, 1999). Not only did pre-test and post-test scores show an increase in 13 percent of leadership effectiveness for those involved, but leadership style flexibility also increased 22 percent. While the program began with very little structure, Stromei soon noticed key factors that contributed to the success of the mentoring and created a model. The model she proposed creates a more formal mentoring program for an organization. It includes four activities or centers of focus that mentors and protégés move in and out of together. They include:

1. Individual Diagnosis, Evaluation, and Assessment (IDEA)
2. Training Instruction Practical Tips (TIPS)
3. Center for Organizational Problem Enlightenment (COPE)
4. Friendship, Understanding and Nurturing (Stromei, 1999, p. 120)

The program has successfully promoted the concept of continuous quality improvement and has been modeled in other divisions to teach additional skills.

Mentoring has also been successfully used within the broader community related to women and long-term care or nursing home care. Women comprise the largest population of those in long-term care and those who are the caregivers of residents in long-term care (Flippen, 1998). Yet issues of consumer choice, health insurance, and wages of caregivers have been poorly addressed. The Coalition for Women in Long Term Care (COWL) implemented a grassroots mentoring program that included the local, state and national boards of leadership dealing with these issues. Their hope is to stimulate healthcare reform by increasing the conversations between informed, mentored women and legislators. Mentoring in this arena can go far beyond the confines of one organization's boundaries.

Distance Learning

Web-based Instruction (WBI) and coaching has the advantage of linking experts and developing leader when they are separated by distance and time. On-line courses even make international learning possible. Computer conferencing and ***video-teleconferencing*** was used in the Canada-Norway Nursing Connection in order to provide "international educational experience about nursing leadership" (Iwasiw, 2000, p. 81). Besides providing an international learning experience at a lower cost, this program helped nursing leaders develop global perspectives that will serve them well in a globalized world of health.

WBI also was used in a Masters of Science nursing leadership course offered at Sonoma State University (Geibert, 2000). Although the pilot course experienced numerous setbacks through technical difficulties, students found it provided a unique experience in collaboration that allowed them to work within their own time frames. Not only were collaborative leadership goals exceeded in learning outcomes, but technological skills were increased as well.

Virtual coaching provides a tremendous opportunity for continuous learning. Unhindered by conflicting time schedules, virtual coaching is reportedly "a highly accessible, practical, and interactive one-on-one development process between coach and participant that provides continuity for learning, change, and growth at any time and from any place, via telephone, fax, or email" (Hakim, 2000, p. 42). It makes it possible for some to finally pursue development goals.

Workshops, Retreats and Comprehensive Training

The ***meeting and workshop*** oriented training is common to most leadership development programs. Affirming Malcolm Knowles (1990) adult learning principles, the literature suggests that the best of leadership training programs utilize many different forms or venues for learning. Combinations of lectures, discussion groups, role-plays, simulations, personal assessment and reflection, action learning projects and coaching are utilized often.

In a comprehensive study of rehabilitation teams in the Midwest conducted by the University of Chicago Center for Psychiatric Rehabilitation, a multiphase assessment was utilized in order to develop a leadership training curriculum (Garman & Corrigan, 1998). The study began with an assessment phase utilizing an open-ended staff inventory regarding leadership training needs. Once training needs were clearly identified, the second phase of developing training materials was initiated. A ***12 monthly-meeting focused curriculum*** was created. It used a variety of training methods including personal study or reading; focused exercises including the development of mission statements and problem

statements; group projects with peers; discussions and role-plays on key topics such as participative decision making, goal setting, diversity issues and conflict resolution. The third phase involved the evaluation or validation of the curriculum. A follow-up plan that included instructor and peer feedback several months after the curriculum is completed promoted retention and application of key concepts.

Retreats particularly provide a condensed amount of time to go deeper and explore core competency issues. In a training program for utility industry leaders (Kiser, Humphries, & Bell, 1990), skills that move beyond the rational manager capacities are explored. Human emotions are integrated into the executive program in order to delve into such thorny issues as authority, competition, teamwork and acceptance of others.

The Public Health Leadership Institute (PHLI) goes further in providing a rich variety of events and features of their training program for senior public health officials. This successful ***one-year program*** included personal study, leadership self-assessment, seminars which included teleconferencing and computer conferencing, peer coaching, a week long retreat and action-learning projects (Scutchfield et al., 1995). This multiple point training offers variety to enhance the continuous learning concept.

Another approach to a comprehensive training experience is that offered in the field of medical education. Offering a ***two-year fellowship program***, cluster committees form the core experiential learning opportunity (Thomas C.P., Cashman, & Fulmer, 1995). "The ***cluster committee*** is simultaneously a vehicle for establishing linkages between the community, its public health sites, experts in public health, clinicians and those training in the COPC (community oriented primary care) model" (Ouellette et al., 1999). Students awarded fellowships learn over a two year period about involving the community in their own health care. The cluster committee becomes the vehicle for this collaboration and the learner is integrally involved in its formation, goal setting, maintenance and leadership development. This practicum oriented approach to leadership development provides a realistic learning setting that bridges the gaps between community service and classroom academics.

Experiential Learning/Simulations/Exercises

Experiential training focuses on the process of learning (Wright, 1995). As such it involves the learner as an active participant who finds and uses appropriate information to solve problems. The trainee is presented with learning methodologies that foster exploration, questioning, hypothesizing, planning, testing and evaluating. This approach utilizes "participant-centered exercises, hands-on experience, practice and drills" (Kohls, 1995). Cusins (1995) defines experiential learning as "a change in behaviour which results from the disciplined reflection on an experience…associated with the discovery that something new is possible" (p. 4). Experiential learning is based on two phases. The first is the experience and the second is reflection of the experience.

> It is disciplined in that learners follow a series of steps in a specific sequence. During this reflection the learner looks back critically at the experience and gains new insights which provide the basis for a change in future behavior. (Cusins, 1995, p. 4)

Exercises and simulations often form the first phase of the experiential learning sequence and will help reveal default behavior in individuals and groups that may work against their personal development. In a program to foster team building in the U.S. factory, a "first step exercise" (Midas, 1986, p. 40) was used to reveal the competition the team had within it. The exercise simulated a real-life dilemma that factory workers may encounter. It usefully surfaced the destructive nature of

competition and distrust that erodes a team's effectiveness. Such information is invaluable for true change when followed up with reflection and action plans.

Stumpf, Watson and Rustogi (1994) discuss the life-like experiences of global leaders learning through microworld ***simulations*** such as Foodcorp and Globalcorp. "Behavioral simulations such as these stand apart from computer simulations in that they attempt to reproduce individual and collective behaviors that would normally be observed in a managerial work environment…" (Sogunro, 1997). As daylong events, the Foodcorp and Globalcorp simulation allow for extensive debriefing and exploration of changes needed to meet similar real-life situations. Personal reflection, peer feedback and discussion set the stage for self-awareness and action planning for change.

Storytelling is another form of experiential learning and information production that can stimulate change. In a Canadian community health care delivery reorganization, staff desired a collaborative partnership with clients (Cameron & Wren, 1999). The organizational change towards collaboration involved three steps: "1) identify the need for change, 2) let go of the past, and 3) institutionalize the changes" (p. 97). During the second stage of their collaborative work, storytelling allowed staff and community members to explain and understand their new values. Concurrent case studies were written that stimulated dialogue that helped make sense of how and what to do within their new framework.

An exercise of ***storytelling*** was also used to better understand cross-functional members of a health service team in Yorkshire, England's health service (Jones, 1992). This approach encouraged doctors and managers to disclose their personal responses to their work setting together, providing crucial information "to design management development programmes" (p. 201). The success illustrated to Jones how important it is "to go on asking for people's stories and listening carefully to their answers" (1992, p. 201).

On-the-job experiential learning is one of the most natural venues for personal growth. Although riskier than simulated settings, application is real and motivation for improvement is high. In the changing environments of professional nursing, teams provide a place "to work together and grow together" (Jones, 1994, p. 34). The Franciscan Health Systems of Aston, PA sought to develop and prepare leaders at every level of their organization. They formed their model around Peter Senge's (1990) five learning organization disciplines of personal mastery, shared vision, systemic thinking, mental models and team learning. A collaborative effort involving joint meetings, brainstorming, problem solving and action planning was established with peers and cross-functional units to focus on the reduction of admissions time in emergency care. Through shared governance and ownership of the problem and solutions, they were able to implement change together that greatly reduced elopement rates. Leadership was shared and learning occurred simultaneously.

Frankling Hospital in Baltimore also provides a case example of leadership development on the job (Wood, 1995). The nursing leadership desired to create a more coordinated approach to care by integrating physician and nurse activities, involving the patient more actively, maintaining professionalism of all roles and keeping workloads stable but quality strong. Physicians and nurses created a case management pilot project through dialogue. Meetings were held bi-weekly to establish "critical pathways, teaching records for each practice and an effective communication system" (Wood, 1995, p. 57). Once the collaboration was established, continuous training including two-day seminars were held. Local nursing schools, case managers, and interested community professionals interested in the program were included. Both patient and care team professionals reported increased satisfaction from the collaborative practice model developed and learned together.

Action Learning

Much is being written and spoken about the use of action learning in leadership development. Cusins (1995) defines action learning as:

> …a syndrome of four main activities which, when performed effectively, enhance and expand each other to create a context for creative decision making in uncertain situations, resulting in the learner feeling more confident of an effective outcome. (A syndrome may be thought of as meaning, "a number of things which flow together", from syn=together, and drome=to run or flow.) (p. 3).

The process followed in action learning includes experiential learning, creative problem solving, acquisition of relevant knowledge and co-learner group support (Cusins, 1995, p. 3). Action learning integrates one of the adult learning principles mentioned earlier. Learning is enhanced when it is purposeful and meets a need.

In some instances, action learning might be considered service learning as in the case of academic institutions. In an undergraduate nursing course in Missouri, class team projects were required that connected the team to a real hospital nursing situation, including multidiscipline staff (Rantz, Porter, & Burton, 1996). Volunteer mentors served to guide the teams in addressing clinical collaborations and decision-making. Topics and real world settings provided students with the opportunity to make a contribution and learn from a real life setting simultaneously. The new curriculum increased the confidence of the students as they enter the clinical work world and the mentors who received benefits from their involvement were very satisfied with the projects.

The Public Health Leadership Institute also utilizes action learning projects (Scutchfield, Spain, Pointer and Hafey, 1995). Leaders choose and describe their chosen projects in preparation for the on-site training week. They are grouped according to project categories in order to consult and collaborate with each other during their training. Computer conferencing by teams continues the consulting and collaboration through the project completion.

TRW, an automotive, aerospace and information systems company includes action learning projects as a part of its global leadership program (Neary, & O'Grady, 2000). Global leadership is seen as their greatest requirement for continued strength and growth internationally. Developing leaders throughout their international organization is top priority. Neary and O'Grady (2000) state, "To leverage the learning process, action learning projects were incorporated into the curriculum, linking classroom learning to actual business issues" (p.186). Leaders were assigned a six-member team that traveled to a global site to address a particular issue. Together they created a strategy and plan utilizing specific concepts and tools they had learned prior in the training. Implementation of the project was not expected, as priority was placed more on expanding and adapting skills through focused experiential learning.

Large-Scale Leadership Development

Concerns arose at the conference on Collaboration and The Turning Point Initiative (Larson, 2000) regarding the need to be developing larger numbers of leaders with collaborative skills. Several key experts noted that training must not be so exclusive that it fails to meet the constant turn over and demands in the public health arena. Strategies that provide for larger scale leadership development are required. Ameritech, a large and very successful Midwestern telephone company, provides an example of meeting this challenge (Pasalis, 1998). Faced with fierce competition and constant environmental changes, Ameritech's managers,

executives and union members identified core competencies required for effective leadership in the industry. A one-week National Leadership Development Program was created around the core areas of: "leadership, planning, performance management, communication and interpersonal skills" (Pasalis, 1998, p. 17). 1,400 supervisors were trained between 1996 and 1997. The experience based workshop was coupled with personal development plans stretching four to six months beyond the training event. Through pre- and post-evaluation including 360-degree surveys, it was reported that "80% of the participants improved their productivity and quality results" (p. 18).

Badovinac (1997) details two workshops offered across a Canadian province for health promoting policy change. Over 1,000 public health practitioners and advocates profited from these three to six hour multi-instructional workshops. The shorter workshop, while generic in content and theory on policy change process, was created for basic advocacy and lobbying. Badovinac (1997) notes, "Three basic instructional methods—mini-lectures, individual pen-and paper exercises, and small-group activities—were used" (p. 280). Small group discussions allowed for application of general theory into local issues. The full-day workshop was designed for engaging more deeply with leadership theory and skill development related to policy change issues. Again discussion and workbooks allowed participants time to apply theory to local issues. Each workshop was hosted and recruited for by a local organization, thereby reducing costs. Post-workshop surveys suggested high retention and application of learning.

Broad Constituency Leadership Development

In addition to larger numbers of leaders needed to accomplish public health effectiveness, broader involvement of stakeholders is also crucial. Leadership training programs and goals need to be extended to the community at large if the complex issues facing American communities are to be effectively approached (Flynn, Rider, & Ray, 1991). The Indiana model of the Healthy Cities program offers a comprehensive example of "a process of enabling people to have a unified voice for health in order to bring about planned change to foster improvement in community life, services, and/or resources" (Flynn, Rider and Ray, 1991, p. 334). This collaborative effort includes a community leadership development stage involving 16-28 community members representing many populations such as those at risk, minority groups, the poor, community health leaders, and city officials. The community leaders are developed in their capacity through "social contracting, modeling, and self-directed application" (p. 338). Social contracting involved a written commitment to the notion of healthy communities. Modeling occurred as leaders rubbed shoulders and learned from mentors in other healthy city programs. As the leaders gain confidence in their knowledge and skills, action projects were implemented to promote focused community health. Flynn, Rider and Ray reported, "The sustainability of such action through promotion of healthy public policies is the ultimate goal of this approach" (1991, p. 345). This is dependent upon sustaining an active and skilled local leadership.

This understanding of the power for change that broad community led initiatives can produce is echoed in a community mental health collaborative in South Florida (Ouellette, Lazear and Chambers, 1999). Like the Healthy Cities initiative a community based leadership group was assembled including a wide spectrum of representatives from various populations and influence. Utilizing a team approach to community needs identification and problem solving, experiential learning, shared vision and priority setting exercises contributed to individual leadership development and action plans. Weekly meetings allow for feedback,

evaluation and support on community projects that enhance leadership. Ouellette, Lazear and Chambers (1999) noted that Leadership Enhancement and Development (LEAD) groups followed four phases in their development: Phase one, the engagement phase, included group membership, developing shared values and beliefs, and identifying leadership themes and needs. Phase two involved the setting of priorities and discussion of community projects. The third phase offered change acceleration as "participants begin to activate specific action plans with respect to their community project" (p. 179). Lastly the fourth phase of LEAD groups involved feedback through self and group reflection and evaluation. This model "attempts to apply concepts of team building, trust building, and empowerment with people most affected by the change to better meet the needs of children and families" (Ouelette, Lazear and Chambers, 1999, p. 180).

While many of the leadership programs reviewed were urban in focus, one rural program in Canada is worth highlighting (Sogunro, 1997). This program also involved a broader constituency in its training efforts. The Rural Education and Development Association (REDA) is undergirded by the notion that "leadership can be made more effective if organizations are concerned with the training of all its members rather than training just the few designated leaders" (Sogunro, 1997, p. 734). The program offers leadership training on three levels to rural organizations that often experience limited resources for such training. Each level of training is offered in a one week program utilizing multi-instructional methods such as "lectures, question-and-answer periods, small group discussions, leadership simulations, case studies, structured experiences and role-plays" (p. 715). Sogunro's (1997) pre- and post- training evaluations and interviews suggest a significant increase in leadership development from the workshop training and as applied on the job.

The Healthcare Forum claims that "Leaders no longer question whether to create healthier communities, but where to begin" ("How do you", 1995, p. 94). The Forum provides one more method that may facilitate broader community based leadership initiatives, The Healthier Communities Action Kit. Designed to be self-led, this seven-step kit provides four modules that lead you through "strategies, models, case studies, resources and tools you can use to create a healthier community" (p. 94).

Sustaining any broad-based and community grassroots leadership endeavor can be challenging. Ouellette, Lazear, and Chambers (1999) suggest five factors from their research and literature review that keep people involved in the learning process. Summarized here, they are:

1. The work of the group needs to be important and relevant to participants.
2. The group needs to function effectively offering positive interdependence.
3. There needs to be a sense of support and community.
4. The tasks need to be interesting and resourced.
5. A contribution needs to be sensed (p. 182).

Summary

Developing leaders is not a static activity. The changing environments and concurrent demands for leadership in the public realm call for multiple strategies and methods in preparing people to lead. No one curriculum or approach may serve all. Rather a blending of several approaches and customizing to the local situation seems most appropriate. One thing is sure, however, "Research clearly suggests that tomorrow's leaders will not, and cannot, be satisfied with the status quo" (Ashby, 1999, vii). The learning is not over for effective leadership development plans.

Section 6: Collaborative Technologies

Introduction

All the experts agree. An organization in today's society must be involved with networking technology. The amount of technology available to today's organization is almost as varied as the number of organizations themselves. However, we have narrowed the focus to those types of technologies that will be helpful to a collaborative initiative such as Turning Point.

This section discusses collaborative technologies. We will begin by examining the importance of information technology to the fields of health and collaboration. We will then discuss some of the extant technologies available today, including telecommunications, software packages, and web-based technologies, such as the internet. We will provide examples of organizations to illustrate some of the working technological capabilities available. In addition to examining technologies available, we will also provide two specific and interesting examples of organizations that are using and offering such technologies. The first example will provide specific information on one of the software options we felt to be most applicable to the Turning Point Initiative. The second example will illustrate how other health-related organizations are utilizing the web to communicate and achieve their goals. The overall discussion, as well as these specific examples, should provide a broad spectrum of options to the Turning Point group.

The Role of Technology in Collaboration and Health

Researchers in the fields of health, technology, collaboration, and the like posit that the role information technology plays in today's organization is critical. Technology affects every organization on the community side, as well as the organizational side. First, consumers are turning to web-based and networking technologies to expand their health care knowledge and capabilities. "A surprising 17.5 million adults in America – or forty-three percent of the 40.6 million who use the Internet – are using the internet to search for health information" ("43 Percent of Consumers", 1999, p. 6). Mcnerney (1995) argues that successful community health initiatives must maintain a creditable information system and, in addition, should "provide technical assistance" to assist the community it serves in navigating its information base (p. 41). Kelly (1998) discusses the role of technology in health information management and asserts "automated information is essential for effective and efficient quality, utilization, disease, and resource management" (p. 40).

Further assertions are made with regard to the health organization itself and the importance of collaborative technology. Shortliffe (2000) asserts "Today's health care community needs to anticipate and influence the next generation of the Internet and to work to ensure its effective and suitable role as a critical element in the health care system" (p. 1).

Biancamano (1996) posits that all health organizations "need a communications infrastructure that … can support our enterprise today, but can also expand to meet our future acquisitions, alliances, and community outreach efforts" (p. 14).

Linial (1998) notes that technological advances have provided new ways for organizational members to continue to learn. He argues that continued learning is "central to being an effective healthcare leader" (p. 56). Nunamaker et al. (1997) specifically reference the need for today's collaborative efforts to include technology. They note "People must collaborate to solve tough problems. As business becomes more global in scope and computers become more ubiquitous in the workplace, the need for collaboration-and computer-based collaboration – will surely continue to increase" (p. 164).

Benefits of Communication Technology

In addition to the fact that today's society practically demands it, the use of technology-based communication systems has many benefits for the organization. Most of the benefits are simple, yet important to any organization. The benefits offered in this section are general. Benefits specific to the various technologies will be discussed in individual sections.

Brandon and Hollingshead (1999) note that communication technologies are "free from time/place constraints and support many-to-many communication" (p. 109). They also note that communication technology provides many new options on how to deliver information to the public. Therefore, the benefits affect the organization as well as its constituents. Marion & Marion (1998) claim the main benefit of information technology is its ability to "promote collaboration" (p. 9). And LaPlant says simply, "Technology helps you better manage time and professional communications. It also offers opportunities to access the latest research in both management and clinical realms" as well as "enhancing communication both outside and inside the organization" (1997, p. 18). Coile (1999) offers important end products to enhanced technological communication such as "clinical analysis, quality assurance, and outcome assessment" (p. 16). While Fonner (1993) notes that collaborative initiatives can benefit from technology because "community health requirements can be met more efficiently and effectively. Costs may be maintained and there may be fewer time lags from start to finish of initiatives" (p. 18).

Available Technological Capabilities

This section reviews some of the technological capabilities available to today's collaborative organization. Because there are so many variations of each type of technology and even more applications of them, we have chosen to highlight the ones we felt to be most useful to the Turning Point Initiative. This section also breaks down the extant technologies into two categories: those dealing specifically with inter-organizational collaboration and those dealing with public information/community outreach possibilities. Some of the technologies discussed in this section are very specific examples of how one organization has utilized a certain available system. While others examined are generic presentations of the types of technologies available to organizations.

Technology for Collaboration within the Organization

Distance Education

Distance education is fast becoming the answer to the question of how to facilitate learning and training capabilities within organizations. Distance education is also sometimes referred to as 'distance training', 'collaborative learning' and, in the health-related fields, 'telemedicine'. But, all of these terms

basically reference the same idea, which is the use of technology to facilitate learning, training, and collaboration in organizations where the members may be separated in space and/or time from one another.

Distance education has actually been around for a number of years. However, until recently, it was primarily utilized for those concerned with training individuals who were isolated from the rest of the organization. Due to its many advantages, however, the practice of distance education has flourished during the recent technological age. Hollingsworth (1999) outlines some of the specific advantages to distance training. These include:

- Increased accessibility – training is accessed from within (or near) trainees' homes or offices
- Lowered costs – Costs are reduced as travel time is minimized
- Saved time – Reduced travel results in more productive use of time
- Increased audience – More people can obtain the information at one time
- Enables timely communication – For time-critical information, sites can be quickly linked
- Increases consistency of messages and information
- Facilitates interactivity – Requires a person's active participation
- Expands knowledge base – promotes sharing of ideas across a broad audience
- Provides unity – Provides a shared sense of identity and feeling more a part of the group
- Offers adaptability – Technology can be used to discuss, inform, train, educate, or present
- Increases quality – Higher quality of efficiency, organization, interaction and understanding (p. 1 & 2).

Brandon & Hollingshead (1999) supplement this assertion of the many benefits to distance education. They note that it promotes "increased responsibility, initiative, and participation" in its group members (p. 109).

The concept of distance education actually encompasses several types of technology. These can include telephone (audio) conferencing, videoconferencing, web-based training and computer-mediated communication, and computer-based multimedia. Audioconferencing has been in existence for some time and does not actually include any advanced technological capabilities that enhance distance education. Therefore, we will first examine videoconferencing.

Videoconferencing can also be thought of as "interactive video" since it allows parties to see and interact with one another freely. The most efficient and effective videoconferencing systems are generally PC-based (as opposed to satellite-based) systems. Once you get past the initial start-up costs, these systems are cost-effective. They are fully interactional and allow for "real time" interaction between group members to facilitate discussion. One example of a videoconferencing system is the one utilized by the Northshore Health System. They were in search of a videoconferencing system that was "PC-based, easy-to-use, and appropriate for telemedicine consults, educational purposes, and administrative meetings" (1997, p. 55). They chose VTEL's LC5000 Advanced Smart Videoconferencing system, which is "designed for installation on large, enterprise-wide networks" (p. 55). According to Northshore's spokesperson, the system has been successful for them, allowing them to hold videoconferences for "continuing education, administrative meetings, and community education programs" (p. 55). INTEGRIS, the largest privately owned health system in Oklahoma, also employs a videoconferencing system from VTEL to enhance its

collaborative efforts. Conklin (1998) reports that INTEGRIS has seen a dramatic reduction in long-distance charges since the implementation of their videoconferencing system (p. 33). The INTEGRIS videoconferencing system is equipped to enable users to write notes and draw diagrams during videoconferences. INTEGRIS reports that the system has "fulfilled the needs of geographically dispersed facilities by streamlining administrative activities and making medical education and consultation more widely available" (p. 34).

Web-based training and computer-mediated communication are both the use of the computer to train or educate with computer-mediated communication being slightly more advanced or complex. Neither of them offers "real time" interaction; therefore, most of their advantage would be for those groups interested solely in training and not collaboration. However, either of them can be a nice supplement to other technologies. Hollingsworth (1999) defines web-based training as "training materials, including content, exercises and evaluation that are accessed through a Web page and its associated links" (p. 66). Examples of this include websites that offer documents, tests, etc. to supplement information and training as well as any applicable links to other websites. Linial (1998) defines computer-mediated communication as "relying on computer applications that facilitate communication" between the instructor and the trainees (p. 56). Examples of this include electronic mail and electronic bulletin boards. One exception to the notion that computer-mediated communication is not "real time" communication is the chat room. These are essentially websites that allow users to "chat" using synchronous timing so that the messages back and forth are nearly instantaneous.

Computer-based multimedia is "a still-developing generation of powerful, sophisticated, and flexible computing that integrates various voice, video, and computer technologies into a single, easily accessible delivery system" (Linial, p. 56). It is a young field at this point; however, there is one very promising option for multimedia communication, especially with regard to the field of collaborative organizations. We will discuss this option in detail at the end of the next section, which outlines available software.

Software Capabilities

Group Support Systems is a type of software that has been touted by its supporters as very beneficial to collaborative groups. "Group support systems (GSS) are interactive computer-based environments that support concerted and coordinated team effort toward completion of joint tasks. Besides supporting information access, GSS can radically change the dynamics of group interactions by improving communication, by structuring and focusing problem solving efforts, and by establishing and maintaining an alignment between personal and group goals" (Nunamaker et al., 1997, p. 134). Group Support Systems are also sometimes referred to as "Group Decision Support Systems." Both systems are essentially commercial software packages that are available to organizations. These Group Support Systems have four generic functions: (1) information generation; (2) information retrieval; (3) information sharing; and (4) information use. However, their capabilities can be broken down a bit more specifically. For example, GSS can support functions like "electronic polling and voting, multicriteria evaluation, team outlining and writing, and shared drawing tools, to name but a few" (Nunamaker et al., p. 135). Commercial software packages like GroupSystemsTM, Symphony, Framework, GURU, Encore, Smartware, and LotusNotes are available to organizations and typically include tools like electronic spreadsheets, graphics, database management systems, text and outline processors, and telecommunications modules to support their decision-making. GSS software packages also provide tools like calendars, spreadsheets, and

graphic design. One hospital executive uses a computer software package to "set up meetings with the push of a button. Through the computer, I can see which staff are available and enter the time and date of the proposed meeting [or videoconference] directly into their calendars" (LaPlant, 1997, p. 19).

Group Support Systems offer both tangible as well as intangible benefits to collaborative groups and their efforts. For example, Nunamaker et al. report "the use of group support systems may increase the likelihood that participants will buy into the final results of the group effort" (p. 166). They also report benefits like a group being able to move through a process more quickly than by conventional means. And they report that "members of teams that use GSS participate much more evenly and fully in team interactions than do members in conventional teams" (p. 167). Another interesting benefit they found is "laboratory studies have shown that groups using GSS produce many more unique ideas of higher quality than groups using standard meeting techniques" (p. 167). Some of the more tangible benefits of GSS to an organization include increased productivity and cost savings. Boeing Corporation studied whether their implementation of GSS was beneficial and found "an average labor saving of 71 percent and an average reduction of elapsed times for projects of 91 percent" (p. 170).

Centrinity

Centrinity is, technically, a software package. However, it is so much more advanced and complex, we have given it its own category in this section. Centrinity is a current example of the computer-based multimedia options discussed earlier in the distance education section. While one author described this field as being merely under development, Centrinity seems to offer a challenge to that notion. Centrinity is a company that offers a software package that they describe as "providing all the tools for electronic collaboration – messaging, discussion groups, document sharing, conferences, and shared knowledge-bases" (http, Centrinity web page, 2001). They also offer unified communications by providing "a single mailbox for all messages – email, fax, voice – accessible anywhere, anytime, using any device – web browser, personal digital assistant [a Palm Pilot, e.g.], cell phone, and new and emerging devices" (http, Centrinity web page, 2001). According to Centrinity, the unified messaging capability gives the organization a single, network-based access point from which all information can be managed using any of the previously mentioned access devices. This means two benefits for the collaborative organization. First, a member can share any and all information (audio, video, documents, etc.) they wish with the rest of the group, no matter where they are. Second, any member can access this information from any modern device, no matter where they are. Centrinity's software also provides tools for calendaring (including automated message and event notification), publishing, creating websites, and address books, just to name a few.

The Centrinity website offers the Turning Point Initiative leader a host of technological capabilities. Overall, Centrinity's software package is an example of a very modern, advanced computer-based multimedia software package that could be an exciting possibility for a collaborative initiative such as Turning Point.

Technology for Collaboration with the Community/ Public

The Internet

Almost any example today of a health organization providing information to the community sees the internet as its device for doing so. The internet, or "web", allows healthcare professionals, organizations, and the community to access a nearly endless variety of resources and information. Supplying and finding information on the web provides benefits such as the availability of opinions from other health professionals, as well as time and cost savings. The web provides tools and services that range anywhere from "published materials regarding given medical conditions to forums for discussing clinical and administrative issues with other professionals" (LaPlante, 1997, p. 19). Cowan et.al. (1998) say that the internet and the ability it provides to "browse, search, and acquire data is essential for the establishment of community networks" (p. 61).

EurakAlert! is a collaborative community-based information website that is geared more toward the scientific community; however, nonetheless provides an interesting example of how to use the website to promote information sharing between organizations and their targeted communities. According to Makulowich (1997), EurekAlert! Is "a Web-based news and information public-service project that posts the latest research advances in science, medicine, health, and technology" (p. 13). It reportedly allows both professionals and the public "free public access to material with the latest findings from international peer-reviewed journals, research institutions, and scientific organizations on subjects ranging from policy to public meetings" (Makulowich, p. 13). The interesting aspect of this particular website is that it allows for a two-way exchange of information. It allows professionals and the public to gather information, but it also allows professionals to publish information on the website. In addition, the website offers a service whereby interested parties can sign up to have journals and digests emailed to them daily or weekly. The spokeswoman for the website felt strongly, when asked, that the notion behind this scientific website could easily be applied to any organization whose goals is to "improve public understanding" of their discipline (p. 16).

A community in Canada known as Canada's Technology Triangle has created a "community-based digital library called the CTT Community Network" (Cowan et al., 1998, p. 61). CTT uses commercially available software such as Cold Fusion or LivePAGE to link databases which store community-based information to the web. This allows users to search for various kinds of information on the CTT community that its webmasters have uploaded. Any organization interested in starting a community network can visit www.afcn.com and find out more about how to create such a website.

Also technologically helpful is the HRSA Community Health Status Indicators Project. This is a community-based health organization that is utilizing the web to promote information and knowledge dissemination. According to their website, this project was begun "in response to requests for health assessment information at the local level" (http, HRSA website, 2001). This website provides county-based access to information on population characteristics, health measures, causes of death, risk factors, etc., to both health professionals and the public. There are countless websites available that provide health-related information to the public such as this. The internet is a rapid way to provide a plethora of information to the community and is fast becoming the central avenue by which the public chooses to obtain such information.

Summary

This section on collaborative technologies has provided information regarding the importance and benefits of technologies to collaborative initiatives and health-related organizations. We have presented a discussion of some of the technological capabilities available to today's organization such as distance education, including videoconferencing and web-based training, software packages, and the internet. We have supplied information regarding an organization that supplies a computer-based multimedia software package. And we have presented a specific example of how a current health organization is utilizing the internet to achieve their goals. This section is intended to provide helpful information on the kinds of technologies that are not only available, but could be useful to an important collaborative initiative such as the Turning Point Initiative.

Bibliography

43 Percent of Consumers Turn to Internet for Answers About Their Healthcare. (1999). *Health Management Technology, 20,* 6.

Adams, S. (2000). Five principles of sound training. *Professional Safety, 45,* 40-41.

Allan, R. (1995). Step-Up: Old Values, New Opportunities. *Journal of Housing and Community Development, 52,* 31-36.

Arkus, C. (1993). Enhancing community relations in a health reform environment. *Trustee, 46*(7), 14-15.

Ascher, C. (1990). Linking Schools with Human Service Agencies. *ERIC/CUE Digest,* 62.

Ashby, F. C. (2001). The past, present, and future of leadership development. In J.Phillips & F. C. Ashby (Eds.), *Effective leadership programs* (pp. 1-10). Alexandria: American Society for Training & Development.

Avery, C. (1999). All power to you: Collaborative leadership works. *Journal for Quality & Participation, 22,* 36-40.

Avolio, B. J. (1999). *Full leadership development: Building the vital forces in organizations.* Thousand Oaks, Calif.: Sage Publications.

Badovinac, K. (1997). Policy advocacy for public health practitioners: Workshops on policy change. *Public Health Nursing, 14,* 289-285.

Baltalden, P.B., Cronenwett, L.R., Brown, L.L., Moffatt, C. and Serrell, N.P. (1998). Collaboration in improving care for patients: how can we find out what we haven't been able to figure out yet? *Joint Commission Journal on Quality Improvement, 24*(10), 609-618.

Bass, B. M. & Avolio, B. J. (1994). *Improving organizational effectiveness through transformational leadership.* Newbury Park, CA: Sage.

Baum, H. (1998). Ethical Behavior is Extraordinary Behavior. It's the Same as All Other Behavior: A Case Study in Community Planning. *Journal of the American Planning Association, 64,* 411-423.

Beck, J. & Yeager, N. (1996). How to prevent teams from failing. *Quality progress, 29,* 27-31.

Beckham, J. (1991). Tools for staying ahead in the nineties (Part 1). *Healthcare Forum, 34,* 84-90.

Beckham, J. (1998). The hunger for leadership. *Healthcare Forum, 41,* 60-61.

Bennis, W. G. & Nanus, B. (1985). *Leaders: The strategies for taking charge.* New York: Harper and Row.

Biancamano, J., Caniff-Gilliam, C.I., Spivey, M.D., Wicks, B.E. (1996). Top Executives Share I/S Strategies. *Health Management Technology, 17,* 13-16.

Blake, R. R. & McCause, A. A. (1991). *Leadership dilemmas: Grid solutions.* Houston, TX: Gulf.

Bland, C.J., Starnaman, S., Hembroff, L., Perlstadt, H., Henry, R., and Richards, R. (1999). Leadership Behaviors for Successful University-Community Collaborations to Change Curricula. *Academic Medicine, 74*(11), 1227-1237.

Blodgett, M. (1999). Teaching Johnny to lead. *CIO, 13,* 76-81.

Bollenbacher, G., and Finley, D.A. (1995). Employee enhancement as a competitive differentiator – Part 1. *Bankers Magazine, 17*(2), 49-54.

Boufford, J. I. (1999) Crisis, Leadership, Consensus: The Past and Future Federal Role in Health. *Journal of Urban Health: Bulletin of the New York Academy of Medicine. 76*, 2, 192-206.

Bowers, B. (1999). Consortium Gets the Ball Rolling. *Best's Review, 99,* 35.

Brandon, D.P. & Hollingshead, A.B. (1999). Collaborative Learning and Computer-Supported Groups. Communication Education*, 48,* 109-126.

Bridging the leadership gap in healthcare. (1992). *Healthcare Forum, 35,* 49-64.

Bryman, A. (1992). *Charisma and leadership in organizations.* Newbury Park, CA: Sage.

Bureau of Health Professions. Health Resources and Services Administration and Public Health Practice Program, Center for Disease Control: The Public Health Faculty/Agency Forum, Rockville, MD, June 1991.

Burns, G. (1995). The secrets of team facilitation. *Training and Development Journal, June, 49,* (6), 46-52.

Cameron, G. & Wren, A. M. (1999). Reconstructing organizational culture: A process using multiple perspectives. *Public Health Nursing, 16,* 96-101.

Carnevale, A.P., Gainer, L.J., Meltzer, A.S. and Holland, S.L. (1998). Workplace Basics: The Skills Employers Want. *Training & Development Journal, October, 42 (*10), 22-30.

Carr, A. (1997). Leadership and Community Participation: Four Case Studies. *Journal of Curriculum and Supervision, 12,* 152-168.

Cashman, K. & Reisberg, S. (1994). Road to leadership. *Executive Excellence, 11,* 9-10.

Chiaramonte, P. & Mills, A. J. (1993). Self-reflection counselling as an instrument in organizational learning. *British Journal of Guidance & Counseling, 21,* 145-155.

Chrislip, D. & Larson, C. (1994). Collaborative leadership: How citizens and civic leaders can make a difference. San Francisco, CA: Jossey-Bass Inc.

Church, A. H. & Bracken, D. W. (1997). Advancing the state of the art of 360-degree feedback. *Group & Organization Management, 22,* 149-161.

Clark, K. E. & Clark, M. B. (1990). *Measures of leadership.* West Orange, NJ: Center for Creative Leadership.

Cohn, L.H., D. Rosborough, & J. Fernandez, J. Reducing Costs and Length of Stay and Improving Efficiency and Quality of Care in Cardiac Surgery. (1997). *Annals of Thoracic Surgery. 64,* 6 S58-60.

Coile, R.C., Jr. (1999). The Three C's: Consumerism, Cyberhealth, and Co-Opetition. In Roderick W. Gilkey (Ed.). *The 21st Century Healthcare Leader.* San Francisco, CA: Jossey-Bass.

Conger, J. A. (1989). *The charismatic leader.* San Francisco: Jossey-Bass.

Conklin, G. (1998). Voice/Video/Data Telemedicine at INTEGRIS Health: How it Fits into the Overall Telecommunications System. *Health Management Technology, 19,* 32-34.

Cook. J.A., Horton-O'Connell, T., Fitzgibbon, G., & Steigman, P. (1998). Training for state-funded providers of assertive community treatment. In P.Corrigan & D. W. Giffort (Eds.), *Building teams and programs for effective psychiatric rehavilitation* (pp. 55-64). San Francisco: Jossey-Bass.

Corrigan, P.W., & D.W. Giffort. (1998). (Eds.) Building Teams and Programs for Effective Rehabilitation. *New Directions in Mental Health Services. 79.*

Corrigan, P.W., & S.G. McCracken. (1997). *Interactive Staff Training: Rehabilitation Teams That Work.* New York: Plennium Press.

Corrigan, P.W., & S.G. McCracken. (1999). Training Teams to Deliver Better Psychiatric Rehabilitation Programs. *Psychiatric Services. 50,* 43-45.

Cowan, D.D., Mayfield, C.I., Tompa, F.W., & Gasparini, W. (1998). New Role for Community Networks. *Communications of the ACM, 41,* 61-63.

Crystal, B. (1995). Collaboration in the Carolinas. *Healthcare Executive. 10,* 1, 17-20.

Cusins, P. (1995). Action learning revisited. *Industrial & Commercial Training, 27,* 3-10.

Davidhizar, R. & Shearer, R. (1997). Giving encouragement as a transformational leadership technique. *Health Care Supervisor, 15,* 16-21.

Davis, A. & Kleiner, B. (1989). The value of humour in effective leadership. *Leadership and Organization Development Journal, 10,* i-iii.

Dementi-Leonard, B. & Gilmore, P. (1999). Language Revitalization and Identity in Social Context: A Community-Based Athabascan Language Preservation Project in Western Interior Alaska. *Anthropology & Education Quarterly, 30,* 37-55.

Denis, J., Langley, A., & Cazale, L. (1996). Leadership and strategic change under ambiguity. *Organization Studies, 17,* 673-699.

Dentico, J. (1999). *Games leaders play: Collaborative leadership development through simulations in knowledge based organizations.* Doctor of Education University of San Diego.

Donaghue, C. (1992). Towards a Model of Set Adviser Effectiveness. *Journal of European Industrial Training, 16,* 20-26.

Donnelly, R. & Kezsbom, D. (1994). Do project teams "walk their talk"? Survey research on project team effectiveness. *American Association of Cost Engineers Transactions* HF2.1-HF2.8.

Doody, M. (2000). Broader range of skills distinguishes successful CFO's. *Healthcare Financial Management, 54,* 52-57.

Farrell, J. & Robbins, M. (1993). Leadership competencies for physicians. *Healthcare Forum, 36,* 39-42.

Fawcett, S. B., Paine-Andrews, A., Francisco, V. T., Schultz, J. A., Richter, K. P., Lewis, R. K., Williams, E. L., Harris, K. J., Berkley, J. Y., Fisher, J. L., & Lopez, C. M. (1995). Using empowerment theory in collaborative partnerships for community health and development. *American Journal of Community Psychology, 23,* 677-698.

Fitzgerald, M., (1999). Lessons Learned: Profiles of Leading Urban Health Department Initiatives in Maternal and Child Health from the CityMatCH Urban MCH Leadership Conference, *CityMatCH,* University of Nebraska Medical Center, Department of Pediatrics, 982170 Nebraska Medical Center, Omaha, NE 68198-2170, 1999.

Flamm, B.L., D.M. Berwick, & A. Kabcenell. (1998). Reducing Cesarean Section Rates Safely: Lessons from a 'Breakthrough Series' Collaborative. *Birth. 25,* 2, 117-124.

Flippen, S. (1998). Why there's a coalition for women in long-term care. *Nursing Homes, 47,* 54-56.

Flynn, B., Rider, M., & Ray, D. (1991). Healthy cities: The Indiana model of community development in public health. *Health Education Quarterly, 18,* 331-347.

Fonner, E. (1993). Five Practical Steps for Improving Collaboration in Health Care. *Health Care Strategic Management, 11,* 14-18.

Frankel, L. P. (1997). Using 360-degree feedback instruments: Holding up the mirror. *Employment Relations Today, 24,* 37-50.

Franklin, C. & Streeter, C. (1995). School Reform: linking public schools with human services. *Social Work, 40,* 773-782.

Frey, L. (1995). *Innovations in group facilitation: Applications in natural settings.* Cresskill, N.J.: Hampton Press.

Friedell, G.H., A.M. Rubio, B.A. Garland. (2001). Community Cancer Control in a Rural, Underserved Population: The Appalachian Leadership Initiative on Cancer Project. *Journal of Healthcare for the Poor and Underserved. 12,* 1, 5-19.

Fulmer, R. & Wagner, S. (1999). Leadership lessons from the best. *Training & Development, 53,* 28-33.

Galton, F. (1869). *Hereditary genius: An inquiry into the laws and consequences.* London: Macmillan. (Paperback edition by Meridian Books, New York, 1962).

Gardner, J.W. (1997). Leadership: A Collaborative Act (Part 3). *New Management, 5*(1), 10-17.

Garman, A. & Corrigan, P. (1998). Developing effective team leaders. In D.Corrigan & D. W. Giffort (Eds.), *Building teams and programs for effective psychiatric rehabilitation* (pp. 45-54). San Francisco: Jossey-Bass.

Geibert, R. (2000). Integrating web-based instuction into a graduate nursing program taught via videoconferencing: Challenges and Solutions. *Computers in Nursing, 18,* 26-34.

Glenzer, K. & Middleberg, M. L. (1999). Preparing for the global health transition. In R.Grilky (Ed.), *The 21st century health care leader*. San Fransisco, CA: Jossey-Bass.

Goldman, S. & Kahnweiler, W. (2000). A Collaborator Profile for Executives of Nonprofit Organizations. *Nonprofit Management & Leadership, 10,* 435-450.

Goss, J.R., R.W. Whitten, R.C. Phillips, J.J. Johnston, B.O. Hofer, P.B. Mansfield, S.L. Tidwell, J.A. Spertus, & J.P. Lo Gerfo. (2000). Washington State's model of physician leadership in cardiac outcomes reporting. *Annals of Thoracic Surgery. 70,* 695-701.

Greenberg, M., Lee, C., & Powers, C. (1998). Public Health and Brownfields: Reviving the Past to Protect the Future. *American Journal of Public Health, 88,* 1759-1760.

Greene, J. (1998). Coaching the entire team. *Healthcare Executive, 13,* 16-19.

Guarriello, M. (1996). The management of leadership. *Hospital Material Management Quarterly, 17,* 17-20.

Gustafson, B. (1997). Leadership essentials for the patient financial services professional. *Healthcare Financial Management, 51,* 90.

Guthrie, M. (1999). Challenges in developing physician leadership and management. *Frontiers of Health Services Management, 15,* 3-26.

Gyarfas, Ivan. (1992). Review of Community Intervention Studies on Cardiovascular Risk Factors. *Clinical and Experimental Hypertension - Theory and Practice.* A14, 1 & 2. 223-237.

Hacker, K. & Wessel, G. (2001). School-based health centers and school nurses: Cementing the collaboration. *Journal of School Health, 68,* 409-410.

Hakim, C. (2000). Virtual coaching: Learning, like time, stops for no one. *Journal for Quality & Participation, 23,* 42-44.

Hamburg, David, Alexander George, & Karen Ballentine. (1999). Preventing Deadly Conflict. *Archives of General Psychiatry. 56,* 11, p. 972.

Harrison, R. (1999). Transformational coaching: A new paradigm for executive development. In J.Phillips & F. Ashby (Eds.), *Effective leadership programs* (pp. 129-148). Alexandria: American Society for Training & Development.

Hart, E. (1995). Executive leadership teams: Exorcising demons, exercising minds. *Planning Review, 23,* 14-19.

Henley, R. (2000). Update your skills to advance your career. *Healthcare Financial Management, 54,* 14-15.

Hern, W. (1997). The essence of leadership. *Healthcare Financial Management, 51,* 14.

Himmelman, A. & Nevarez, C. Community building and collaborative leadership for health promotion. (1998). National Public Health Leadership Development Network. Ref Type: Pamphlet

Hollander, E. P. & Offermann, L. R. (1990). Relational features of organizational leadership and followership. In K.Clark & M. Clark (Eds.), *Measures of Leadership*. West Orange, NJ: Leadership Library of America.

Hollingsworth, H. (1999). *Introduction to Distance Training: Technology, Implications for Instructional Design, and Resources.* Denver, CO: JSI Research & Training Institute.

Hotko, B. & Van Dyke, D. (1998). Peer review: Strengthening leadership skills. *Nursing Management, 29,* 41-44.

How do you create a healthy community? (1995). *Healthcare Forum, 39,* 94.

Centrinity. http://www.centrinity.com

The Community Health Status Indicators Project. http://www.communityhealth.hrsa.gov

Hudak, R., Brooke, P., Finstuen, K., & Riley, P. (2001). Health care administration in the year 2000: Practitioners' views of future issues and job requirements. *Hospital & Health Services Administration, 38,* 181-195.

Iglitzin, L.B. (1995). The Seattle Commons: A Case Study in the Politics and Planning of an Urban Village. *Policy Studies Journal, 23,* 620-635.

Iwasiw, C., Andrusyszyn, M., & Moen, A. (2000). Graduate Education In Nursing Leadership Through Distance Technologies: The Canada-Norway Nursing Connection. *Journal of Nursing Education, 39,* 81-87.

Jaworski, J. & Scharmer, C.O. (2000). *Leadership in the new economy: Sensing and actualizing emerging futures*. Society for Organizational Learning.

Jones, B., Wilker, M. & Stoner, J. (1995). A meeting primer. *Management Review, 84,* 30-32.

Jones, H. (1992). Biography in management and organization development. *Management Education & Development, 23,* 199-206.

Jones, L. (1999). Implementing quality in higher education: A must for leaders in the new millennium. In J.Phillips & F. Ashby (Eds.), *Effective leadership programs* (pp. 149-176). Alexandria: American Society for Training & Development.

Jones, P. (1994). Developing a collaborative professional role for staff nurse in a shared governance model. *Holistic Nursing Practice, 8,* 32-37.

Joplin, J. (1994). *Constructing and testing a model of leadership development processes in organizations.* Doctor of Philosophy The University of Texas at Arlington.

Kadlecek, J. (1997). Cooperation Among Local Governments. *National Civic Review, 86,* 175-179.

Kanter, R. (1989). The new managerial work. *Harvard Business Review, 67,* 85-92.

Kar, S., Pascual, C. & Chickering, K. (1999). Empowerment of Women for Health Promotion: A Meta Analysis. *Social Science & Medicine. 49*, 1431-1460.

Kaye, D. (1999). Leadership education and dialogue model: Creating a learning organization for continuous leadership development. In J. Phillips & F. Ashby, (Eds.), *Effective leadership programs* (pp. 177-198). Alexandria: American Society for Training & Development.

Kazemek, E. (1994). Beware of the ego triangle. *Modern Healthcare, 24,* 112.

Kelly, J.T. (1998). After the Chaos: Expected Benefits of Health Information Management. *Health Affairs, 17,* 39-40.

Kent, T., Johnson, J., & Graber, D. (1996). Leadership in the formation of new health care environments. *Health Care Supervisor, 15,* 27-34.

Kirkpatrick, S. A. & Locke, E. A. (1990). Leadership: Do traits matter? *The Executive, 5,* 48-60.

Kiser, A. G., Humphries, T., & Bell, C. (1990). Breaking through rational leadership. *Training & Development, 44,* 42-45.

Knowles, M. S. (1990). *The adult learner.* Houston: Gulf Publishing Co.

Kohls, L. R. (1995). Education, training, orientation and briefing compared. In L.R.Kohls (Ed.), *Training know-how for cross-cultural and diversity trainers* (pp. 9-11). Duncanville, TX: Adult Learning Systems. Inc.

Kotter, J. (1990). What leaders really do. *Harvard Business Review, 68,* 103-111.

Kouzes, J. M. & Posner, B. Z. (1995). *The leadership challenge: How to keep getting extraordinary things done in organizations.* San Francisco: Jossey-Bass Publishers.

Kowalski, R. & Campbell, M. (2000). Leadership skills help financial managers achieve career success. *Healthcare Financial Management, 54,* 50-52.

Krayer, K. (1999). A customer service trifecta: Situational leadership, quality, and satisfaction. In J.Phillips & F. Ashby (Eds.), *Effective leadership programs* (pp. 31-44). Alexandria: American Society for Training & Development.

LaBranche, G. (1991). Suiting style to stage. *Association Management, 43,* 87-91.

LaFasto, F. & Larson, C. (1989). *TeamWork: What must go right/What can go wrong.* Newbury Park, CA: Sage.

Lambert, L. (1998). How to Build Leadership Capacity. *Educational Leadership, 55,* 17-19.

LaPlant, C. (1997). Putting Information Technology to Use. *Healthcare Executive, 12,* 18-23.

Larson, C. (2001). Collaboration and the turning point initiative. In (pp. 1-109). University of Denver.

Leape, L.L., Kabcenell, A.I., Gandhi, T.K., Carver, P., Nolan, T.W. and Berwick, D.M. (2000). Reducing Adverse Drug Events: Lessons from a Breakthrough Series Collaborative." *Journal on Quality Improvement, 26*(6), 321-331.

Lehner, G. P. (1993). *Collaborative leadership development: Impact on leadership behaviors of principals and special education directors.* Doctor of Philosophy University of Georgia.

Lentz, S. (1999). The well-rounded leader. *The Healthcare Forum, 42,* 38-40.

Liang, A. P., Renard, P. G., Robinson, C., & Richards, T. B. (1993). Survey of leadership skills needed for state and territorial health officers, United Sates, 1988. *Public Health Reports, 108,* 116-120.

Linggood, R., Govern, F., & Coleman, N. (1998). A Blueprint for Linking Academic Oncology and the Community. *Journal of Health Politics, Policy & Law, 23,* 973-994.

Linial, G. (1995). Effective coalition building. *Healthcare Executive, 10,* 45.

Linial, G. (1998). Distance Education. *Healthcare Executive, 13,* 56.

Liontos, L.B. (1996). Collaboration between Schools and Social Services. *ERIC Digest Series*, 48.

Littlepage, G., S. Jones, R. Moffett, T. Cherry, & S. Senovich. (1999). Relationship Between Leadership, Potency, Group Processes, and Work Group Effectiveness. Paper presented at the Society for Industrial and Organizational Psychology Annual Conference, Atlanta, GA, 1999.

Lord, R. G. & Engle, E. M. (1996). Leadership Teams and culture change: Changing processing structure and dynamics. In M.M.Beyerlein, D. A. Johnson, & S. T. Beyerlein (Eds.), *Advances in Interdisciplinary Studies of Work Teams* (pp. 211-237). Greenwich, Connecticut: JAI Press Inc.

Luz, J., & M. Greene. (1997). Sickness Absenteeism from Work – A Critical Review of the Literature. *Public Health Review. 25,* 2, 89-122.

Lyons, M. (1999). Transitional leaders for transitional times. *Frontiers of Health Services Management, 15,* 36-41.

Makulowich, J. (1997). Science Web Site Uses Innovative Model. *Information Today, 14,* 13,16.

Malenka, D.J., & G.T. O'Connor. (1995). A Regional Collaborative Effort for CQI in Cardiovascular Disease. Northern New England Cardiovascular Study Group. *Joint Commission Journal on Quality Improvement. 21,* 11, 627-633.

Mani, B. (1996). TQM management development in public agencies using the Myers-Briggs type indicator and the adjective check list: A retrospective case study in the IRS. *Review of Public Personnel Administration, 16,* 79-96.

Manz, C., Muto, M., & Sims, H. (1990). SuperLeadership creates a new perspective for managers. *Journal for Quality & Participation, 126,* 12-15.

Marion, L. & Marion, D. (1998). Information Technology Professionals as Collaborative Change Agents. *American Society for Information Science, 24,* 9-12.

McCown, C., Eakin, C., & Dusenbery, K. (1997). Developing Urban School Leaders. *Journal of Staff Development, 18,* 16-19.

McEnroe, J. (1995). Portrait of outstanding leaders. *American Hosptial Publishing Inc, 48,* 6-9.

Mcnerney, W. (1995). Community Health Initiatives are Widespread, Challenging Our Sense of Civic Obligation. *Frontiers of Health Services Management, 11,* 39-44.

Menefee, D. (1997). Strategic administration of nonprofit human service organizations: A model for executive success in turbulent times. *Administration in Social Work, 21,* 1-19.

Midas, M. (1986). Leadership: Three American tools. *Quality, 25,* 40-42.

Misener, T., Alexander, J., Blaha, A., Clarke, P., Cover, C., Felton, G., Fuller, S., Herman, J., & Rodes, M. S. H. (1997). National delphi study to determine competencies for nursing leadership in public health. *Image: Journal of Nursing Scholarship, 29,* 47-52.

Mizrahi, T. and Rosenthal, B.S. (2001). Complexities of coalition buildings: Leaders' successes, strategies, struggles, and solutions. *Social Work, 46*(1), 63-78.

Molt, M. (1995). *Relationship of on- and off-the-job expereiences to the leadership development of dietitians in management practice.* Doctor of Philosophy Kansas State University.

Montgomery, L.A., & G.K. Budreau. (1996). Implementing a Clinical Practice Guideline to Improve Pediatric Intravenous Infiltration Outcomes. *AACN Clinical Issues, 7,* 3, 411-424.

Mulroy, E. & Cragin, J. (1994). Training Future Community-Based Managers: The Politics of Collaboration in a Turbulent Urban Environment. *Journal of Teaching in Social Work, 9,* 17-35.

Mycek, S. (1995). Letting Go for a Healthier Community. *Trustee, 48,* 12-14.

Naughton, C. (1997). 12 self-renewal tools for executive directors. *Nonprofit World, 15,* 46-48.

Neary, D. B. & O'Grady, D. A. (2000). The role of training in developing global leaders: A case study at TRW Inc. *Human Resource Managment, 39,* 185-193.

Nelson, J.C., Rashid, H., Galvin,V.G., Esslen, J.D., Levine,L.M., (1999). Public/ private partners. Key factors in creating a strategic alliance for community health.. *American Journal of Preventative Medicine, 16*(3), 94-102.

Niederman, F., & Volkema, R. (1999). The effects of facilitator characteristics on meeting preparation, set up, and implementation. *Small Group Research, 30,* (3), 330-360.

Nunamaker, J., Briggs, R., Mittleman, D., Vogel, D., & Balthazard, P. (1997). Lessons from a Dozen Years of Group Support Systems Research: A Discussion of Lab and Field Findings. *Journal of Management Information Systems, 13,* 163-207.

O'Connor, M., Dami-Boone, J., Conley, K., & Hagan, G. (1996). Manager as Developer: Facilitating Collaboration. *Nursing Management, 27,* 61-63.

O'Leary, J. & O'Leary, P. (1999). What is the future for nurse executives? *Nursing Administration Quarterly, 23,* 4-10.

Ouellette, P., Lazear, K., & Chambers, K. (1999). Action leadership: The development of an approach to leadership enhancement for grassroots community leaders in children's mental health. *Journal of Behavioral Health Services and Research, 26,* 171-184.

Pasalis, D. (2001). Leading strategic change: Tools & techniques. *Human Resource Planning, 2,* 17-18.

Paul-Shaheen, P.A. (1998). The states and health care reform: the road traveled and lessons learned from seven that took the lead. *Journal of Health Politics, Policy and Law, 23*(2), 319-361.

Peck, M. G. and Fitzgerald, M. (1997). Lessons learned: Profiles of leading urban health department initiatives in maternal and child health. *Highlights of the CityMatCH Urban Maternal and Child Health Leadership Conference* (Atlanta, GA, September,1997) CityMatCH, University of Nebraska Medical Center, Department of Pediatrics, 982170 Nebraska Medical Center, Omaha, NE 68198-2170.

Peck, Magda G. (ed.) (1994). *Improving Urban MCH Linkages: Highlights of the 1993 Urban Maternal and Child Health Leadership Conference*. ERIC, Accession #ED372846, U.S., Nebraska, 1994.

Perce, K. (1998). Project management skills. *American Association of Occupational Health Nurses, 46,* 391-403.

Peter, G., des Vignes-Kendrick, M., Eickoff, T.C., Fine, A., Galvin, V., Levine, M.M., Maldonado, Y.A., Marcuse, E.K., Monath, T.P., Osborn, J.E., Plotkin, S., Poland, G.A., Phillips, A. (1998). Effective communications skills are career essentials. *Healthcare Financial Management, 52,* 90.

Quinlisk, M.P., Smith, D.R., Sokol, M., Soland, D.B., Whitley-Williams, P.N., Williamson, D.E. and Breiman, R.F. (1999). Lessons learned from a review of the development of selected vaccines. National Vaccine Advisory Committee. *Pediatrics, 104* (4), 942-50.

Rantz, M., Porter, R., & Burton, S. (1996). Preparing students for health care delivery of the future: A service education partnership. *Journal of Nursing Education, 35,* 423-428.

Reinelt, C. (1994). Fostering Empowerment, Building Community: The Challenge for State-funded Feminist Organizations. *Human Relations, 47,* 685-705.

Research pinpoints new skills. (1999). *Association Management, 51,* 22-23.

Rifkin, G. (1996). Leadership: Can it be learned? *Forbes, 157,* 100-109.

Robinson, R. D. (1995). Some principles of adult learning. In L.R.Kohls & H. L. Brussow (Eds.), *Training know-how for cross cultural and diversity trainers* (pp. 61). Duncanville, TX: Adult Learning Systems. Inc.

Rorie, J.A., K.A. Richardson, & R. Gardner. (1997) Public health approaches to community-based needs: Boston's infant mortality crisis as a case study. *Journal of Nurse-Midwifery. 42,* 6, 527-535.

Rosenthal, B. and Mizrahi T. (1994*). Strategic partnerships: How to create and maintain interorganizational collaborations and coalitions*. New York: Education Center for Community Organizing, Hunter College of Social Work.

Ross, A. (1992). Do we expect too much from our leaders? *Frontiers of Health Services Management, 8,* 31-33.

Rough, J. (1992). Leaders slay dragons, don't they? *Journal for Quality & Participation, 15,* (4), 45-58.

Schmidt, D. Y. (1999). Financial and operational skills for nurse managers. *Nursing Administration Quarterly, 23,* 16-28.

Schwartz, R. & Pogge, C. (2000). Physician leadership is essential to the survival of teaching hospitals. *The American Journal of Surgery, 179,* 462-468.

Scutchfield, F., Spain, C., Pointer, D., & Hafey, J. (1995). The public health leadership institute: Leadership training for state and local health officers. *Journal of Public Health Policy, 16,* 304-323.

Sembor, E.C. (1993). Citizen education for the community: The local public administrator as instructional leader. *Public Administration Quarterly, 17*, 2, 227-242.

Senge, P. (1990). *The fifth discipline.* New York: Currency Doubleday.

Sheppard, M. (1992). Contact and collaboration with general practitioners: A comparison of social workers and community psychiatric nurses. *The British Journal of Social Work, 22,* 419-436.

Shortliffe, E. (2000). Networking Health: Learning From Others, Taking the Lead. *Health Affairs.* 1-13.

Simon, H.A. (1979). Rational decision making in business organization. *American Economic Review, 69*, 4, 493-513.

Singleton, R. (1997). Evolving medical group models need special leadership skills for success. *Health Care Strategic Management, 15,* 14-15.

Sirio, C.A., & D. Harper. (1996) Designing the optimal health assessment system: The Cleveland quality choice (CHQC) example. *American Journal of Medical Quality. 11,* 1, S66-69.

Smith, C. (2000). Effective facilitation. *Manage, 51,* (3), 16-17.

Snavely, K., Tracy, M. (2000). Collaboration Among Rural Nonprofit Organizations. *Nonprofit Management & Leadership, 11,* 145-165.

Sogunro, O. A. (1997). Impact of training on leadership development. *Evaluation Review, 21,* 713-737.

Sorensen, A. A., Bialek, R. G., & Steele, R. (2000). *Universal Competencies in Public Health.*

Spice, M. and Gilburg, (1992). A. Leadership for empowerment. *Public Manager, 21*, 3, 27-31.

Stephens, T. (1999). Leadership development as a business strategy. In J. Phillips & F. Ashby (Eds.), *Effective leadership programs* (pp. 11-30). Alexandria: American Society for Training & Development.

Sternweis, L. & Wells, B. (1992). The Missing Perspective: Leadership in Rural Women's Terms. *Social Development Issues, 14,* 41-49.

Stromei, L. (1999). Training tomorrow's leaders using yesterday's techniques. In J. Phillips & F. Ashby (Eds.), *Effective leadership programs*. (pp. 109-128). Alexandria: American Society for Training & Development.

Stryker, J. (1999). Individual Leadership development process. In J. Phillips & F. Ashby (Eds.), *Effective leadership programs*. (pp.237-254). Alexandria: American Society for Traning & Development.

Stumpf, S., Watson, M., & Rustogi, H. (1994). Leadership in a global village: Creating practice fields to develop learning organizations. *Journal of Management Development, 13,* 16-25.

Sweat, D.E. (1995). The Role of Corporations in Urban Revitalization: the Experience of the Atlanta Project. *National Civic Review, 84,* 239-247.

Taunton, Rona, Diane Boyle, Cynthia Woods, Helen Hansen, & Marjorie Bott. (1997). Manager Leadership and Retention of Hospital Staff Nurses. *Western Journal of Nursing Research. 19,* 2 205-222.

Telemedicine, Education and Administration Meetings are Among Northshore Health System's Videoconferencing Uses. (1997). *Health Management Technology, 18,* 55.

Thomas C.P., Cashman, S., & Fulmer, H. (1995). The cluster committee: Setting the stage for community-responsive care. *American Journal of Preventive Medicine, 11,* 9-18.

Tichy, N. & Cohen, E. (1998). The Teaching Organization. *Training & Development, 52,* 26-34.

Verlander, E. (1999). Executive coaching. In J.Phillips & F. Ashby (Eds.), *Effective leadership programs* (pp. 59-80). Alexandria: American Society for Training & Development.

View, V.A. and Amos, K.J. Living and Testing the Collaborative Process: A Case Study of Community-Based Services Integration. The Promoting Success in Zero to Three Services Project. Virginia: Zero to Three/National Center for Clinical Infant Programs.

Warihay, F. (1992). Are good facilitators born or can they be developed? *Journal for Quality & Participation, Jan/Feb, 15,* (1), 60-63.

Weil, M. (1988). Creating an Alternative Work Culture in a Public Service Setting. *Adminstration in Social Work, 12,* 69-82.

Williams, C.G. (1998). The Collaborative Leader. *New Directions for Community Colleges, 103,* 51-56.

Wilson, O'Hare & Shipper. (1990). In K.Clark & M. Clark (Eds.), *Measures of Leadership*. West Orange, NJ: Leadership Library of America.

Wood, H. (1995). A collaborative practice model in a community hospital. *Nursing Management, 26,* 57-59.

Wright, A. P. (1995). Contrasting roles of traditional and experiential trainer. In L.R.Kohls & H. L. Brussow (Eds.), *Training know-how for cross cultural and diversity trainers* (pp. 5-6). Duncanville, TX: Adult Learning Systems. Inc.

Wright, K., Rowitz, L., Merkle, A., Reid, W. M., Robingson, G., Herzog, B., Weber, D., Carmichael, D. B. T., & Baker, E. (2000). Competency development in public health leadership. *American Journal of Public Health, 90,* 1202-1207.

Yammarino & Bass. (1990). In K.Clark & M. Clark (Eds.), *Measures of Leadership*. West Orange, NJ: Leadership Library of America.

Yukl, Wall & Lepsinger. (1990). In K.Clark & M. Clark (Eds.), *Measures of Leadership*. West Orange, NJ: Leadership Library of America.

Zachary, E. (2000). Grassroots Leadership Training: A Case Study of an Effort to Integrate Theory and Method. *Journal of Community Practice, 7,* 71-93.

Zaleznik, A. (1992). Managers and leaders: Are they different? *Harvard Business Review, 70,* 126-137.

Zimmerman, J., Shortell, S., Rousseau, D., Duffy, J., Gillies, R., Knaus, W., Devers, K., Wagner, D. & Draper, E. (1993). Improving Intensive Care: Observations Based on Organizational Case Studies in Nine Intensive Care Units: A Prospective, Multi-center Study. *Critical Care Medicine. 21,* 10, 1443-1451.

Zuckerman, H., Kaluzny, M. L., & Ricketts, D. (1995). Alliances in health care: What we know, what we think we know and what we should know. *Health Care Management Review, 70,* 54-64.

www.turningpointprogram.org

TurningPoint
Collaborating for a New Century in Public Health

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

6 Nickerson Street, Suite 300, Seattle, WA 98109-1618
Phone 206-616-8410 • Fax 206-616-8466
turnpt@u.washingon.edu