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Transformations in public health

In This Issue

Turning Point Leader Promoted to Federal Position

In July 2005, Dr. Richard Raymond, chief medical officer, of the Nebraska Department of Health and Human Services and a strong supporter of Nebraska's Turning Point initiative, resigned in order to accept the position of federal Undersecretary of Agriculture for Food Safety. Dr. Raymond provided significant leadership in creating unprecedented local public health capacity for the state of Nebraska and in establishing the state as a national role model for innovation in public health infrastructure improvement. Below, with his permission, is an excerpt of his official resignation letter to Nebraska's Governor Heineman.

I have had an action-packed, enjoyable, and productive six and a half years at Health and Human Services System (HHSS) in many roles and responsibilities, but the one I have enjoyed the most has been the role of chief spokesperson and advocate for Public Health. In that role, I have very much enjoyed building relationships with Governor Heineman and Governor Johanns to where I felt public health was appreciated and understood by the Administration. We have made tremendous progress working together to improve the public health infrastructure in Nebraska, and that

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From the Turning Point National Program Office

Turning Point's Contribution to Solving Leadership Challenges

Bobbie Berkowitz, Director

A persistent challenge for public health is effectively promoting health systems and outcomes in the context of frequent changes in high-level leadership. The accomplishment of systems change and health outcome goals takes not months but years, and often decades, to achieve. Although our work is aimed at making both short- and long-term improvements in the health of populations, the leadership structure throughout governmental public health tends to be short term. Throughout the US, state health commissioners average two-year terms, and they are nearly always political appointees.

Within the context of this challenge, what is the benefit we gain from high-level leadership in public health and what method of leadership makes the most sense for our field? Our best leaders, of course, have insights into the field, but perhaps more important, they know how to bring out the talents of their colleagues, listen to divergent interests, and find common values and direction wherever possible. Outside of specific instances where a command structure is most appropriate due to urgency or need for a single authority, public health leadership requires collaborative leadership skills.

One solution to this challenge of frequent turn-over is to integrate leadership throughout the system. By increasing collaborative leadership skills in people at various levels in public health, we increase our ability to chart the course to a common vision and to facilitate the work needed to achieve goals over longer periods of time. Additionally, we take advantage of the unique talents and experience of staff, and in all likelihood, we increase retention for our health departments and the public health field. By developing people, we create sustainability for public health programs, for our long-term vision, and for individual careers in public health.

Another solution to the challenge of changing public health leadership is to fully embrace our notion of broad-based partnership and create public health leaders in other sectors and organizations outside of governmental public health. The usefulness of collaborative leadership in public health is inseparable from the need to develop genuinely active public health partnerships. A partnership in which participants from within and without traditional public health bring their interests, their voices, and their resources to the table in a collaborative fashion can create a strong, on-going vision and direction to ensure progress toward particular public health aims.

One policy approach to this problem of leadership turnover would be to change the way state health commissioners, directors, and secretaries are appointed. Although this change is often discussed, health status outcomes require that we work together now to achieve our goals within the system we have. I hope as you read this issue of *Transformations*, you will discover ways to strengthen your state or community's public health efforts through the use of collaborative leadership principles.

[Promoted—continued from p. 1]

progress has strengthened the system and its ability to respond to any public health emergency that has arisen in the last six years and that is sure to emerge in the future.

I leave very proud of the accomplishments made by the Administration, the Unicameral, the many dedicated state employees, our academic partners, and our partners outside state government. We are too small of a state, population-wise, to have tried to do this all on our own as HHSS. By building collaborative efforts, we have become an "exemplar state," to quote Dr. Julie Gerberding, director of the Centers for Disease Control and Prevention. I will leave knowing that the collaboration and cooperation will not cease or even slow down, but will only grow stronger with the great leadership already in place both internally and externally. Nebraska will not skip one single beat in its journey to being the best it can be as it continues the path laid out six years ago in the RWJF Turning Point Plan to strengthen and improve public health in our state.

It has been a great experience, but unfortunately it has inspired in me a desire to try and do even more by going to the federal level. I had no idea public service could be this rewarding. I wish the state of Nebraska the very best, and know it will get the best effort possible from the HHSS Policy Cabinet and the next chief medical officer (CMO). We have always had a working philosophy at the Cabinet level at HHSS that says, "You can't carry a casket alone." That philosophy has served this Cabinet well and helps prevent some of the emotional highs and lows that would interfere with our work if we tried to shoulder all the blame or take all the credit when things are going not so well or are going very well. I know my colleagues will continue that philosophy as they work to assimilate the next CMO into an effective role of public health advisor to you.

I will leave knowing that the collaboration and cooperation will not cease or even slow down, but will only grow stronger with the great leadership already in place both internally and externally.

Probably more than enough said, but I could not leave without pontificating just a little bit. It is a great team I will be leaving. It is not easy. But it is also exciting at the same time.

About Dr. Raymond

Richard Raymond, MD, was confirmed as Undersecretary of Agriculture for Food Safety on July 1, 2005. He had been chief medical officer of Nebraska Health and Human Services since 1999. He also served as director of the health agency's regulation and licensure division.

Dr. Raymond, along with other Nebraska public health leaders including David Palm and Mary Munter, was instrumental in developing local health districts that serve Nebraska's 93 counties. He was also a leader in developing several bioterrorism initiatives and a statewide health alert system.

Dr. Raymond graduated from Hastings College and earned his medical degree from the University of Nebraska Medical Center. He practiced family medicine in the O'Neill area for seventeen years before moving to Omaha in 1990 to establish a family practice residency program at Clarkson Hospital. In 1998 he helped set up the Nebraska Medical Center's hospice program.

The Evolution of the Leadership Development Collaborative

Marleyse Borchard

The Leadership Development Collaborative's (LDC) twenty-plus members were asked to identify public health's unmet needs in the area of leadership development and to work with national experts to develop tools and resources to fill those needs. Like the other Turning Point collaboratives, the LDC quickly discovered that it needed a method of working together to develop a shared vision and plan to achieve its goals. It used key principles of collaborative leadership to build a sense of group cohesion and establish a process by which members would work together, make decisions, and develop products that were acceptable to this diverse group. How did they use these practices to achieve clarity and efficiently and effectively work together?

They assessed the context for change before they acted. At the start the members methodically collected information about the subject by surveying states to find out how they approached leadership development. In addition, they conducted a literature review, researched leadership models, and investigated what practices practitioners and leadership consultants felt were most important. They then selected six key practices for which no public health training materials existed.

They defined shared values. It took a year of quarterly meetings, correspondence, and conference calls to get everyone on the same page. Early on in the process, the group developed a mission and vision and set annual goals and objectives, which it revisited at every meeting. It also developed statements of success that helped members agree on what a successful process would look like.

They conscientiously built trust for developing shared purpose and action. The members took the time to get to know each other before they started producing final products. They also used the statements of success to create an evaluation tool for every meeting to keep them all aware of how they were working together. Early on, they agreed not to place blame on individuals when things got tough, which ensured that the group took responsibility for the challenges they faced.

They shared power and influence. Although one point person, Jeff Wilson, organized and coordinated the meetings, he never asserted more power than the other team members. Each person safeguarded and protected the collaborative process, and everyone walked away from each meeting with an assignment. The group found that by sharing the work, they were sharing the power.

They developed people. Every member had the opportunity to do new things—for example, lead a subcommittee, facilitate trainings, write articles, or speak at national or regional meetings. All members were trained and are now capable of conducting collaborative leadership trainings.

They participated in a process that valued and encouraged self-reflection about their leadership style. The meeting evaluations provided a continual opportunity for self reflection. The LDC's last meeting was a celebration of what they had achieved together, and they gave one another recognition awards that reflected each person's unique contribution to the collaborative.

As with many skills, collaborative leadership skills can be studied on one's own. But to learn them, they must be practiced by working together in a group.

Marleyse Borchard is public relations and communications manager in the National Program Office.

To learn more about the six practices of collaborative leadership and find tools and resources, visit the Collaborative Leadership Web site: www.collaborativeleadership.org.

Turning Point Member Profile

Jeff Wilson

During the nearly ten years of Turning Point's existence, names and reputations of certain individuals have become practically synonymous with the initiative. For a program focused on public health system change, you'd expect these leaders to be dyed-in-the-wool public health types, but this is not always the case. From the start, one of our movers and shakers has been Jeff Wilson, of Virginia, a self-described strategist. As the point person for both the Virginia State Partnership and the Leadership Development National Excellence Collaborative, Jeff has exemplified the special talents needed to incorporate partnership and broad-based deliberation into steady progress toward tangible outcomes.

Jeff has a direct, genuine manner and tireless work ethic. Harvesting wheat, baling hay, and feeding cows as a kid on the family farm in Kansas probably gave him an industrious nature and plenty of time to think over his future. If you'd asked him then what he wanted to be when he grew up, he would have said a diplomat or an architect. At the University of Kansas he majored in communication studies, political science, and French. After graduating, he moved to Washington, DC, to work for the State Department's Bureau of Diplomatic Security and later the US Office of Government Ethics and discovered to his surprise that working in the policy arena required the communication skills of a diplomat and the strategic planning skills of an architect.

Governmental work in Washington, DC, honed his policy skills, and it also brought him together with Karen, his wife. After following her to Richmond, Virginia, where she was going to graduate school, Jeff took a position at the Office of the Secretary of Health and Human Resources as a policy analyst. He quickly learned about the Virginia health landscape with its major players, resource issues, and health outcome challenges. Just as his appointment was about to end in 1998, Jeff landed the job of Turning Point Coordinator for the Virginia Turning Point Partnership.

Jeff's contribution has also been felt outside of Virginia. His personal commitment to collaborative leadership made him a natural fit as the chair of the Leadership Development National Excellence Collaborative, where he models the leadership skills the Collaborative is promoting.

Since Turning Point began, Jeff and Karen have had three children, AJ (6), Tess (4), and Bennet (2). While juggling a career and raising a family, Jeff also managed to acquire a Masters in Health Administration. Although he recently moved into the position of assistant adminstrator of Business Development and Marketing at John Randolph Medical Center in Hopewell, Virginia, Jeff remains committed to public health and, perhaps more importantly, to collaborative leadership. As he says, "For public health to be successful in the future we need to work outside of organizational boundaries. Public health serves everyone from birth to death, and yet we simply can't be all things to all people. It is critical to work effectively in partnership to achieve our goals. Collaborative leadership is crucial for solving both acute and chronic public health challenges."

Timing Is Everything

The ELN experience was a perfect fit for Fawzi Awad

Dorothy Bliss

Complex and controversial. That's the best way to describe the issues around handling the waste generated by health care systems, according to Fawzi Awad, of the Ramsey County Department of Public Health, Environmental Health Section.

Over the past six years, Fawzi has been studying the issue of hospital hazardous waste management. For the last few he has been chairing a committee charged with developing a coordinated hazardous waste management plan, first for Minnesota's Twin Cities area hospitals, and then for all hospitals in the state.

"The Emerging Leaders Network (ELN) came at just the right time for me," Fawzi says. "I had been chairing this committee and knew that to accomplish our task we would need to find ways to encourage everyone to do their part on this huge issue. ELN provided me with the tools I needed to practice collaborative leadership right here, right now."

The Emerging Leaders Network was developed in 2002 to support the vision of Minnesota's Turning Point Partnership—to strengthen the public health system. It was designed to mentor and give confidence to future leaders by providing them with training and the tools of collaborative leadership.

The tools provided by his ELN experience meshed perfectly with Fawzi's skills, his goals, and his immediate needs. Hospital hazardous waste generation and management is a significant public health concern, one that is also governed by complex local, state, and federal regulations. To ensure compliance, however, Fawzi emphasizes the importance of working with, not against, the hospitals themselves. "We are not dealing with just one waste stream per hospital," he says. "We need their assistance to help identify and understand where hazardous waste is being generated and how it is being handled."

Fawzi's committee had to come up with a coordinated plan for getting all hospitals in compliance with EPA regulations. "I was told that we had a very large mountain to move," Fawzi explains, "and I took that very seriously. I wanted this 'mountain' to move in a positive direction." Fawzi says that he uses tools such as self-reflection (examining the results of every meeting) and the other practices of collaborative leaders to help him guide the committee. (*Read more about collaborative leadership skills at www.collaborativeleadership.org.*) He says that it also was very helpful to be given specific steps to use in conflict resolution and power sharing. As a result, participants have come to feel comfortable sharing their concerns and have learned to respect one another's perspectives. And the committee is on track with their plan for protecting the environment from hospital hazardous waste.

"There is a difference between making people do things and making them want to do things," Fawzi says. "As a coach for kids, I like to say that the success of a soccer team is not just about the one who is skillful in playing the game, but the one that others trust and look to for encouragement, guidance, and consistency—the one who motivates them to stay focused on the task. That's what collaborative leadership is all about. And those are the tools that the ELN gave to me."

Dorothy Bliss, MA, is in the Community and Family Health Division, Office of Public Health Practice, at Minnesota Department of Health.

South Carolina TEAM UP Builds Collaborative Leadership Skills

Pamela S. Gillam

What do you do when an unexpected leadership change happens and trust is broken? How do you deal with power struggles when the national partnership requires certain organizations to participate? These are two questions that South Carolina (SC) TEAM UP partners are trying to answer in order to successfully collaborate. SC TEAM UP is a state chapter of the national TEAM UP partnership to increase breast and cervical cancer screening among rarely or never screened individuals. Partners include the American Cancer Society, Centers for Disease Control and Prevention, National Cancer Institute, and the US Department of Agriculture.

In April 2005, the national TEAM UP partnership visited SC TEAM UP and appointed a new leader of the state partnership. The leadership change was made, in part, due to the national partnership's adoption of a new structure based on the results of the Lasker and Weiss Partnership Self-Assessment Tool. The tool measures a partnership's functioning. The scores from the SC TEAM UP assessment were in the "Work Zone" or "Danger Zone," which means that effort is needed to maximize the partnership's collaboration.

The new leader of the group was concerned because she was put in the leadership role with no warning and worried about how other members of the partnership would respond. She also had to continue to work with the former leader. As might be expected, tension was in the air at the next meeting, and little was accomplished. The new leader felt that if the group was going to work together successfully, it would need to deal with the issues of broken trust and of sharing power.

The new leader felt that if the group was going to be able to work together successfully, they would need to deal with the issues of broken trust and sharing power.

The new leader asked the author, Pamela Gillam (a Turning Point Leadership Development National Excellence Collaborative member), to help her deal with these issues. Gillam facilitated a half-day session with members of the SC TEAM UP leadership team, including the new and former leaders. The focus of the session was to determine where the team stood with regard to building trust and sharing power, and what it needed to build trust and share power among the members of the SC TEAM UP partnership.

Using the Building Trust and Sharing Power modules from the *Collaborative Leadership Learning Modules Series,* Gillam walked the leadership team through a series of steps to explore their issues of power and trust. She focused on where the group currently was and how they needed to move forward. First, she had the group talk about trust and how trust can be built and how it can be broken. Then, she had the group talk about the various sources of power members brought to the table to help the group be successful. Key sources identified were expertise, networks and alliances, and staff time. Then Gillam presented a table of all of the elements that make up partnership synergy, from Lasker and Weiss's assessment tool. She had them go through the table and identify areas where building trust and sharing power were key practices. Last, Gillam helped the leadership team begin to define working agreements that the group could follow to help them better work together. The activities from the modules series were quite a hit! In fact, Gillam will facilitate a full-day session in September 2005 with the entire SC TEAM UP partnership to continue its efforts to become a more effective and successful collaboration.

Pamela S. Gillam, MPA, is research associate at the Center for Health Services and Policy Research, Arnold School of Public Health, University of South Carolina. She was also the South Carolina Turning Point Coordinator.

Read more about the Collaborative Leadership Learning Modules Series *at www.collaborativeleadership.org.*

Can Credentialing Assure a Competent Workforce?

Betty Bekemeier

Credentialing public health workers is a controversial notion. Cash-strapped public health systems, particularly at the local level, already have difficulty paying for staff who have specialized education or credentials. Shortages of nurses and other disciplines further reduce the supply of qualified public health workers, particularly in rural areas. And credentialing could become one more barrier to establishing a more ethnically and racially diverse workforce and, particularly, diverse leadership.

Meanwhile, the Council on Linkages' ten Essential Public Health Services include "assuring a competent public health workforce" as one of the primary responsibilities of an adequate public health system. The IOM's *Who Will Keep the Public Healthy?*, describing the looming shortage of well-trained public health workers, states that the need to certify the public health workforce has grown as weaknesses in the public health system have become more pronounced. Responding to these concerns, national public health leaders have been considering whether credentialing for the public health workforce could enhance the effectiveness, quality, and visibility of public health and public health workers.

Benefits of credentialing

Credibility. The IOM committee expects that credentialing for public health workers will increase the visibility of public health practice and assist in ensuring that public health needs are met across the country. An ideal standard of workforce training that is recognized by a credential provides a visible and credible goal for public officials and communities to achieve on behalf of the public.

Workforce development. A Public Health Workforce Expert Panel on Incentives, convened by CDC as part of a series of national forums from 2000 to 2003 on public health workforce development, concluded that public health certification provides opportunities for a better-prepared workforce, enhanced leadership competency in management and advocacy, and an improved image for public health. The CDC panel perceived certification as a viable strategy for developing organizational support for workforce development (Cioffi, et al, 2003).

Accountability. Trends related to accountability, demands for a well-prepared workforce, and the complexity of modern public health problems that reach beyond traditional bureaucracies and geographic boundaries indicate an increasing need for public health workers with the skills to manage the health of populations. Ensuring that a standard skill set is in place will help our fragmented public health systems provide more effective and coordinated leadership in managing the public's health needs.

Standardized competencies. The public health community has, only in the past decade, adopted a core set of public health competencies as crucial for our effective work with populations. Although the competencies exist as a tool for directing our educational programs, worksite training, curricula, and opportunities for advancement in leadership, a credential would provide recognition of mastery in the competencies.

Accreditation. The topic of credentialing the public health workforce also comes up in the context of discussions regarding the accreditation of public health departments (Cioffi et al, 2003; Thielen, 2004). Accreditation is an endorsement given to an agency or institution when it has met specific standards of practice. These

standards authenticate and verify an expectation of a certain level of service or quality. The skills and preparation of the workforce that delivers those services are integral to meeting the standards of practice. It is likely that national work on a system for the accreditation of health departments will put increased pressure on the perceived need for workforce credentialing.

Credentialing challenges

How can we create a system of credentialing that takes advantage of these benefits and, at the same time, avoids potential pitfalls, increases leadership opportunities for public health workers, and assists in improving population health status? Expert panelists who participated in CDC's Panel on Incentives, as well as other public health leaders around the US, acknowledge that challenges related to cost, achieving agreement on competencies, acceptance by the workforce, avoiding unintended consequences, and ensuring access to training are daunting (Cioffi, et al, 2003; Tilson and Gebbie, 2004).

Barriers to increased workforce diversity. A significant problem that proponents of credentialing must address is workforce diversity. In national testimony to the Sullivan Commission on Diversity in the Healthcare Workforce in 2003, Colorado Turning Point's Ned Colonge stated that our public health workforce, particularly the leadership, is not adequately diverse and that ensuring a competent workforce in public health "can be done only if diversity issues are addressed in workforce development." A system for building capacity in the public health workforce through credentialing must not become a barrier that excludes racial and ethnic minority workers from positions of leadership and growth. Instead it should be developed as a means to create increased leadership opportunities among minorities in public health.

Conflicting credentialing systems. Another concern is the potential for conflict with certification programs already in development. States such as Illinois and Wyoming, for example, have been working toward a state certification program based on workforce training opportunities and public health workforce competencies.

The Association of Schools of Public Health (ASPH) also recently announced that it is moving forward on a system for credentialing graduates from accredited schools of public health, recognizing those who will meet specific competencies after completing their masters in public health. The limits on eligibility set by ASPH's credential, however, suggest that it will not address the needs of the practice-based workforce, since only ten percent of MPH graduates go on to work in governmental public health agencies.

Workforce acceptance. A credentialing system that is not supported by incentives for workers, recognition of the credential, relative ease of acquisition and maintenance, and adequate marketing will likely falter or fail, even if it does have the potential to improve the outcomes of public health service delivery. Public health nurses, as an example, have struggled to facilitate the adequate utilization of the decades-old Community/Public Health Nursing credential.

Tackling the issue of diversity

Individual Turning Point states have tackled the thorny issue of improving capacity within the public health workforce. None of them developed systems for state-wide credentialing or certification, but several have acted on workforce diversity, shortages, competencies, and leadership. Both Colorado and Minnesota's Turning Point initiatives, for example, made a strong and effective push toward actively developing additional public health leaders who represent racial and ethnic minority populations.

Colorado established a scholarship program that ensures at least five scholars a year receive leadership training through the Regional Institute for Health and Environmental Leadership (RIHEL), based in Denver. The scholarships have stimulated many more people than these annual five to participate, which has made RIHEL the most diverse public health leadership institute in the country.

Minnesota's Emerging Leaders Network focused on the growth and development of less-experienced public health workers with an interest in and potential for leadership. Chief among the priorities in the Emerging Leaders Network was to develop a more representative cadre of public health leaders, better equipped to address health disparities.

Agreement on standards. Establishing a national set of standards regarding who is eligible to sit for a credentialing exam and what level of competency the credential represents is also a challenge. Controversy already exists regarding what an expected entry level of education ought to be for a public health worker and who we should expect to be able to meet certain competencies. In light of workforce shortages in many of the public health disciplines, care must be taken to avoid further restrictions among those population groups who suffer most from worker shortages and to set expectations reasonably high, but still achievable, such that the community benefit will be a more effective public health system.

Cost and coordination. A final challenge revolves around funding concerns, including the price of administering a credentialing system, the cost to workers to become credentialed, and the increased salary costs to already financially burdened public health agencies for credentialed workers.

Taking action on credentialing

The National Association of County and City Health Officials (NACCHO) has made it a priority to support actions that document and review current practices in credentialing that will ultimately contribute to the knowledge necessary to help with decision making about certification, credentialing, and accreditation (NACCHO, 2004, unpublished).

CDC has also made the exploration of credentialing systems a priority (CDC, 2005). It particularly wants to see a systematic examination of existing discipline-specific credentialing systems that have been employed in the public health sector. Through review of credentialing systems that have already been implemented within public health systems, we can better understand the barriers they have encountered, the perceived value of the credential, the advantages acquired by employers and the public, and the lessons they have learned.

As support for and discussions related to credentialing of the public health workforce grow, it becomes even more crucial to understand the feasibility of and the factors related to the implementation of a successful public health credentialing program. A move toward development of a credentialing system must start with an examination of the following issues:

- The potential effect of credentialing on the diversity of the workforce.
- The experience of credentialing and certification among major public health disciplines, such as public health nurses and sanitarians
- The relationship between public health workers' credentials and their actual practice competencies
- The relationship between practice competencies and population health status
- The most effective systems for managing and supporting an accessible credentialing system

To answer the question "Can credentialing assure a competent public health workforce?" time, attention, resources, research, and open dialogue are needed. And whatever credentialing system grows out of this effort must give us more leadership opportunities for the racial and ethnic minority members of our public health workforce, ensure support for rural areas in creating and maintaining a competent workforce, and be accessible and cost effective for both agencies and public health workers.

Betty Bekemeier is deputy director of the Turning Point National Program Office.

Resources

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Good Books on Leadership

Bennis, Warren. ***On Becoming a Leader.*** Addison-Wesley Publishing; 1989. Summarizes in-depth interviews with more than two dozen individual leaders in an attempt to discover the most important aspects of their leadership.

Capper, Stuart A. et al. ***Public Health Leadership and Management; Cases and Context.*** Sage Publications; 2002. Describes the use of public health cases to improve public health leadership and management, and details of the environmental context for public health. The cases cover many aspects of leadership and management in public health practice.

Chrislip, David D. and Larson, Carl E. ***Collaborative Leadership: How Citizens and Civic Leaders Can Make a Difference.*** Jossey-Bass Publishers; 1994. One of the very few books on collaborative leadership, it defines the process of collaboration, ways to build collaboration in communities, and the need for leadership in government to embrace this approach to building a stronger civic society.

Chrislip, David D. ***The Collaborative Leadership Fieldbook: A Guide for Citizens and Civic Leaders.*** Jossey-Bass Publishers; 2002. Based on the 1994 *Collaborative Leadership*, it provides practitioners and public officials with tools for building collaborative processes.

Frydman, Bert et al. ***The Power of Collaborative Leadership: Lessons for the Learning Organization.*** Butterworth-Heinemann; 2000. The insights of two organizational learning experts suggest areas of organizational inquiry that can be used on a journey of improvement ending in better organizations and more thoughtful leadership.

Gardner, John W. ***On Leadership.*** The Free Press; 1990. John Gardner, a leader in government as well as business, writes about the nature of leadership and the motivation of individuals to make groups of people more effective.

Kotter, John P. ***Leading Change.*** Harvard Business School Press; 1996. Summarizes Kotter's work as a consultant and the eight steps needed to transform an organization.

Kouzes, James M. and Posner, Barry Z. ***The Leadership Challenge: How to Keep Getting Extraordinary Things Done in Organizations.*** Jossey-Bass Publishers; 1995. Describes five fundamental practices of successful leaders at all levels, based on data from 10,000 leaders and 50,000 constituents.

Novick, Lloyd F. et al. ***Public Health Leaders Tell Their Stories.*** Aspen Publishers; 1997. A compilation of public health leaders' accounts, ranging from budgetary and policy issues to strategic and implementation issues. First published in the *Journal of Public Health Management and Practice.*

Oakley, Ed and Krug, Doug. ***Enlightened Leadership: Getting to the Heart of Change.*** Simon & Schuster; 1991. Rather than focusing on problems, the authors focus on what people and organizations are doing well.

Rowitz, Louis. ***Public Health Leadership: Putting Principles into Practice.*** Aspen Publishers; 2001. This text on public health leadership includes principles and theories of leadership along with exercises and case studies to stimulate the learning process. Based on personal experiences directing a regional Public Health Regional Institute and on systematic interviews with public health leaders in the United States and abroad.

Woltring, Carol S. and Barlas, Carole. ***Journey to Leadership: Profiles of Women Leaders in Public Health.*** Artists-Writers Publishing; 2001. Summarizes interviews from thirty-six women leaders in public health who were graduates of the Public Health Leadership Institute, and shares key insights and lessons learned.

Transformations in Public Health is a publication of *Turning Point: Collaborating for a New Century in Public Health*. The goal of this initiative is to transform and strengthen the public health infrastructure in the United States so that states, local communities, and their public health agencies can respond to the challenge to protect and improve the public's health in the 21st century. The University of Washington School of Public Health and Community Medicine serves as National Program Office for the initiative.

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