The National Public Health Leadership Institute: Evaluation of a Team-Based Approach to Developing Collaborative Public Health Leaders

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Recent public health literature contains calls for collaborative public health interventions and for leaders capable of guiding them. The National Public Health Leadership Institute aims to develop collaborative leaders and to strengthen networks of leaders who share knowledge and jointly address public health problems. Evaluation results show that completing the institute training increases collaborative leadership and builds knowledge-sharing and problem-solving networks. These practices and networks strengthen interorganizational relationships, coalitions, services, programs, and policies. Intensive team- and project-based learning are key to the program's impact. (*Am J Public Health*. 2005;95:641–644. doi: 10.2105/AJPH.2004.047993)

Many authorities assert that public health improvements will require the sustained actions of coalitions and partnerships[1–4] and frequently call for leaders with the vision and skills to foster them.[2,3,5–8] The National Public Health Leadership Institute (PHLI) seeks to develop collaborative leaders who convene or participate in partnerships,[9–13] and to strengthen national networks of leaders who trust one another, share knowledge, and work together to improve public health.[14–26]

The Centers for Disease Control and Prevention (CDC) founded PHLI in 1991 and remains its sponsor. For its first 9 years, PHLI was offered in California and annually enrolled 50 to 60 individual leaders (or "scholars").[27,28] In 2000, the CDC selected a new partnership to offer PHLI: the University of North Carolina at Chapel Hill (UNC) School of Public Health, the UNC Kenan-Flagler Business School, and the nonprofit Center for Creative Leadership, Greensboro, NC.

PHLI now enrolls multiorganizational teams of 2 to 4 senior leaders, and requires intensive teamwork-based learning projects.[29–31] (The program has begun to accept several individual scholars each year in addition to teams, to accommodate the preference of some learners; but at the time of this study all learners came in teams.) Learning methods for the 12-month program include leadership style assessments, personal feedback and coaching, assigned readings, interactive lectures/discussions, case studies, regular conference calls with experts, and a team project.[32] A week-long retreat includes seminars and simulations in leadership, teamwork, systems thinking, negotiation, communication, and succession planning.[33] Recent evaluation questions included (1) what are the effects of PHLI on scholars' leadership understanding, perspectives, and practices; and (2) what have the team leadership projects achieved during the program and after graduation?

METHODS

A telephone interview was completed[34] with 1 member of each team (n=25) from the first 2 cohorts 12 to 18 months after graduation to ascertain activities and accomplishments, lessons learned, whether scholars had applied those lessons to other situations, changes in scholars' joint problem-solving activities, [15] and the number and identity of other leaders that they talk with about their challenges. Interview transcripts and project final reports were analyzed using content analysis methods.[34] For a third cohort, only project final reports were examined.

RESULTS

Individual Outcomes

Many scholars said their PHLI experience helped them understand that activities are often best carried out by partnerships instead of single agencies (Figure 1), and described a shift in their perspective away from the individual leader to shared roles among many leaders in the whole system of organizations concerned. Scholars attributed to PHLI their ability to engage in new leadership practices, including coaching and teaching others, managing conflicts, negotiating win–win partnerships, and securing funding through collaboration. Most interviewees (92%) said that, not counting their team project, they had taken on more or different kinds of leadership roles since PHLI, such as serving on state or national boards or running new programs.

Network Outcomes

Most interviewees (96%) said their PHLI experience had increased both the number of leaders they talk with about challenges and how often they talk with them. Of these, 88% said that they still talk with team members, 46% still talk with other class members, and 33% still talk with other people met through PHLI, such as CDC staff. Scholars reported that collaborations within and outside of the project team had led to more relationships that possess the network characteristics of trust, information transfer, and joint problem solving.[15] Many scholars turned their project work into an area of expertise that they share with regional or national working groups.

Team Project Outcomes

Teams addressed issues such as workforce development, improving access to care, reducing disparities, and improving data. Of all the respondents in the 3 UNC cohorts (Table 1), 81% completed a needs assessment or other research, several strengthened an existing coalition (9%) or developed a new one (19%), and others developed new policies and procedures for collaboration within (14%) or among (30%) organizations. Still others planned (21%) or implemented (16%) a new program or service, obtained increased resources (staff, funding, space, materials) (42%), or developed new communication tools (33%). Several teams started leadership development institutes.

Project work was almost always sustained; 50% of respondents had put more than 5

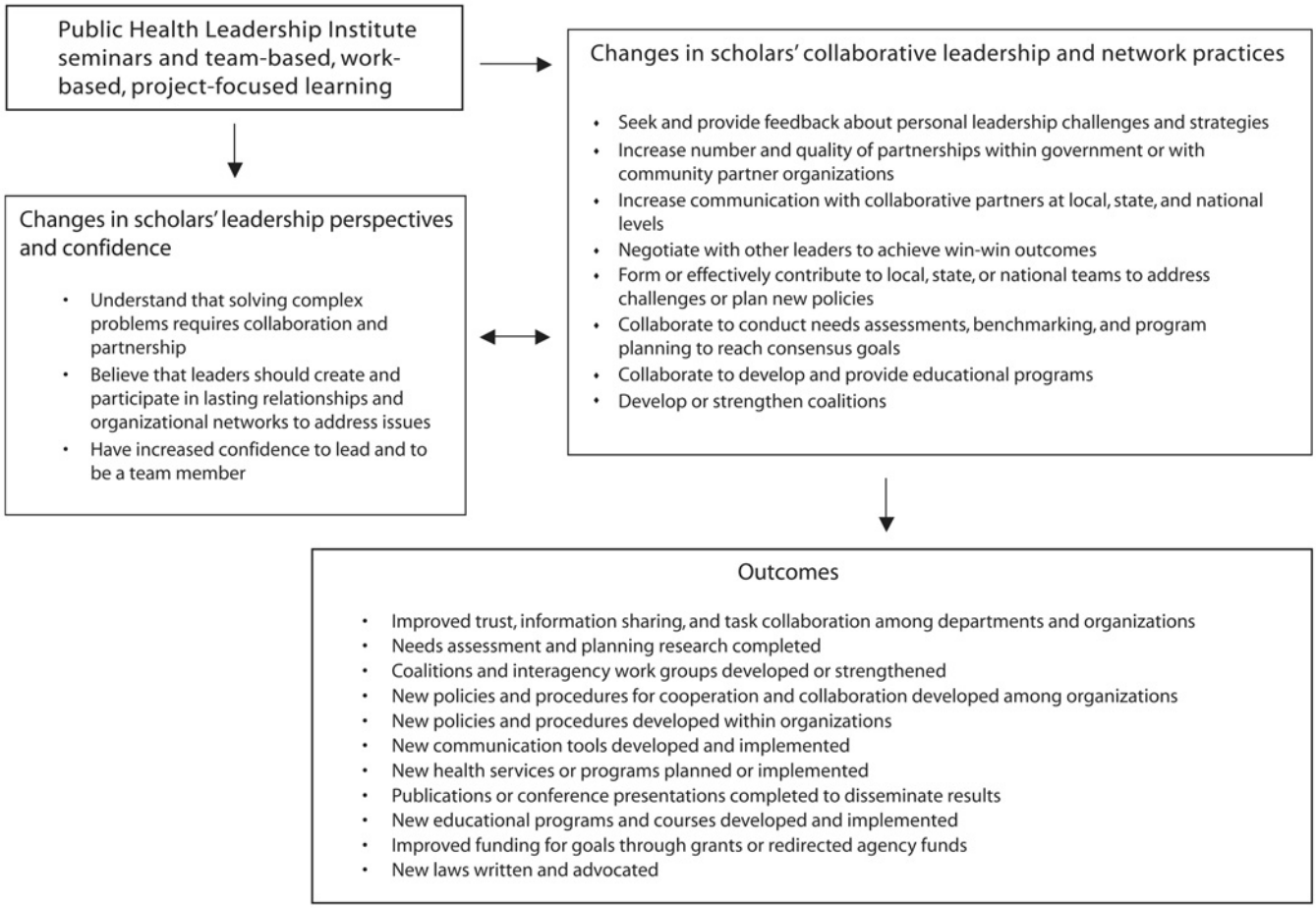

FIGURE 1—National Public Health Leadership Institute evaluation findings: changes in leadership perspectives and practices and their outcomes.

person-days of work time into the project beyond the scholar year, 17% put in 3 to 5 days, and 29% put in 2 or fewer days (data not shown). A portfolio of learning projects is available online.[35]

DISCUSSION

Our evaluation supports the proposition that networks and collaborative leaders can be developed through education, and that groups thus created can improve services and programs. Many scholars reported that they more fully understood leadership as a collaborative activity, and had widened their collaboration and networking activities. Enrolling teams and using an intensive work-based learning project contributed strongly to learning and outcomes reported, and is consistent with global trends in leadership and management development.[29–31,36–40] Limitations include having interviewed only 1 member per team, and having only interview data on team outcomes as opposed to more robust and concrete evidence.

Collaborative leadership development contributes to the social capital[25,41] of the public health community, defined as the resources available to leaders and organizations through professional and interorganizational networks.[25] Social capital should be considered an important aspect of the public health infrastructure, alongside financial capital, human capital (well-trained staff), organizations, and information systems.[42] The relationship between strengthening leadership and improving the social capital of the public health community should be the focus of more theory development, interventions, and evaluation[43,44] in the near future. ■

About the Authors

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TABLE 1—Major Team Leadership Project Outcomes for Scholars: 43 Teams from First 3 Cohorts (2000–2003)

Outcomes	n (%)[a]	Examples
Work or advisory group formed, with stakeholders included	17 (40)	• Developed task force with members from state board of health and 2 city/county boards
		• Assembled local county officials, health department leaders, hospital emergency management, and fire and police department leaders for joint planning on emergency services delivery
Needs assessment or research completed	35 (81)	• Conducted multiple county surveys assessing health care access and determinants
		• Documented statewide nursing shortage via survey as background for advocating policies
New coalition developed	8 (19)	• Developed coalition of county/city health departments and medical/university organizations to implement educational program
		• Formed 2-city comprehensive health and social services coalition
Existing coalition strengthened	4 (9)	• Strengthened county collaboration around treating hypertension
New policies/procedures for cooperation and collaboration developed among organizations	13 (30)	• Partnered statewide Injury Prevention Unit with Trauma Program to provide more comprehensive emergency medical services
		• Partnered territorial health department with university to establish regional leadership training institute
		• Established the Australian Rural Health Research Collaboration to consolidate department research
New policies/procedures developed within organization	6 (14)	• Developed consolidated contract process that streamlines state funding of local health departments
		• Started state "internships" for county and city department managers to improve mutual understanding
		• Tailored national public health competencies for health department administrators to the state's needs
New communication tools developed	14 (33)	• Developed statewide videoconferencing system to improve communication among partners
		• Developed video, wall chart, and brochures on zoonotic diseases to educate professionals and public
New health program or service planned	9 (21)	• Developed plan to prevent drowning and falls among the elderly
		• Completed an asthma prevention and management plan for metropolitan area
New health program or service implemented	7 (16)	• Developed new dental clinic for underserved patients in a state with severe dental professional shortages
		• Chartered nonprofit 501(c)(3) organization to receive funding for efforts to improve access to care
Publication or presentation on completed project	11 (26)	• Researched and developed report on scope and severity of state's nursing shortage
		• Presented project work at state or national public health conferences
New educational or workforce training program developed	15 (35)	• Planned and implemented national or regional public health leadership institutes serving Ireland, Puerto Rico, Nevada, and Utah
		• Trained nurses on how to provide standard diabetes care follow-up
New resources (human, financial) obtained	18 (42)	• Received more than $450 000 in grant funding to develop and implement dental clinic for the underserved
		• Received 3-year health research infrastructure grant to improve workforce training
		• Added staff positions to prevention services
New law written and advocated	2 (5)	• Wrote and submitted new bills to state legislature to improve automobile safety
		• Wrote bill to restructure state's public health system

[a]Many teams achieved several outcomes. Thus, total of all outcomes does not total 100%.

Contributors

K. Umble conceptualized and led the evaluation planning, data collection, and analysis, and wrote and edited much of the brief. D. Steffen helped conceptualize the evaluation, design the instruments, and analyze and interpret the data, and also commented on drafts. J. Porter offered conceptual help in study design and data interpretation. D. Miller, K. Hummer-McLaughlin, and A. Lowman helped with instrument design, data collection, and data analysis and interpretation, and also offered comments on drafts. S. Zelt helped develop the literature review and the interpretative framework for the study, and helped with decisions about which data to present.

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Human Participant Protection

This research was approved by the Public Health Institutional Review Board, Office of Research Ethics, University of North Carolina at Chapel Hill.

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