13

Creating and Sustaining Change

Magda G. Peck

Think back over the major events of the past year or two that had an impact on you as a public health worker. How many major changes occurred?

Did colleagues come or go? Were your duties reassigned? Is a new boss shaking up your world? Within your organization, were there major budget cuts? Were key programs eliminated? Did fresh funding opportunities foster unexpected partnerships? Did you launch a new initiative to promote healthy behaviors and healthier communities?

How about larger forces at work in your community? Did economic hard times push fragile health-related nongovernmental organizations over the edge? Did a new community health center expand access to primary care? Did you experience a major victory on a public policy issue?

Change—for the better and worse—is always occurring. Much of the time it may seem that things are happening *to* you—by forces beyond your control. This does not change the fact that you have an obligation to shape the changes you believe are necessary to promote and protect the public's health. The leader within you needs to seize opportunities and respond effectively. (See Chapter 12.)

You are in the best position to determine what needs to be changed in your world—in response both to threats and opportunities. Tools abound for helping you make that happen. Personality-based assessments, such as the Myers-Briggs, FIRO-B, the Kirton Adaptation Index, and a host of 360-degree profile tools, offer data that describe and help us understand our preferences and styles. Used appropriately and thoughtfully, they can be powerful aids for making changes in ourselves. (See Chapter 10.)

This chapter focuses on working with others to change the influencing factors in your work and in your surroundings. Armed with knowledge, skills, and strategy, you and other public health workers have the collective power to create significant positive change for the greater good. Business leaders consider the missions and values of their businesses, understand surrounding market forces, and then work to increase profit. Your public health mission is about shaping change that yields healthier lives in healthier communities. Your bottom line is

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striving for the greatest good for the most people. To lead change to protect and promote the health and well-being of populations and communities, you must insist on evidence over opinion and champion social justice for all. To accomplish all this requires major changes.

Making Change Happen for the Public's Health

Your job is difficult because of the inherent complexity of most public health problems. For example, consider the challenge of reducing infant mortality. There are many factors that account for infant mortality, including the preconception health of women, access to quality health care before and during pregnancy as well as during labor and delivery, violence, poverty, and racism. If you want to create and sustain change to reduce infant mortality, you must face all of these challenges—and more. This is the case with most of the complex problems that we tackle: There is no single cause or single solution.

To make change, you cannot act alone. With other public health workers, you must rely on sound practices of communication, cooperation, coordination, and collaboration to align assets and build on shared strengths. You must master the practice of collaborative leadership, creating and fostering mutually beneficial relationships among individuals and organizations to achieve results that would not have occurred as well—or not at all—if you had not worked together. (See Chapter 15.)

For example, assuring the health and well-being of older adults requires strategic cooperation with people in multiple sectors, such as health and human services, housing, transportation, safety, and recreation. Only through effective collaboration can you promote healthy aging and the social inclusion and civic participation of older adults.

In addition to the challenges of complexity and collaboration, creating and sustaining change for the public's health calls for an understanding of the context of change. To be successful, you need to identify and engage diverse *stakeholders*—people and organizations that perceive they have a stake in, or are affected by, the proposed change.[1] There are both internal stakeholders within, and external stakeholders outside of, the organization undergoing change.

As a leader of change, you need to know the perspectives of internal and external stakeholders, and how much they understand and trust what is happening. You need to know how they feel about the change that is proposed or being imposed, and to what extent they are fearful, resistant, or supportive, given potential gains or losses from the change. So, if you are planning to develop school-based health centers in your community, perform a stakeholder analysis to identify, understand, and engage essential supporters as well as potential opponents—a range of people including principals, teachers, parents, clergy, and the media. Ask yourself if inside your organization there is sufficient support for

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expanding the scope of work, especially if this expansion is not accompanied by adequate new resources. (See Chapter 7.)

As a leader of change, you need to assess the external environment to identify potential opportunities and problem areas that can help or hinder change. Environmental scanning helps identify emerging issues, situations, and potential pitfalls that may affect the situation.[2] You may need to determine (a) anticipated support from the policymakers and the public, (b) current policies and regulations that may affect the situation, or (c) the public reputation and public image of your organization. In the above example on a school-based health center, do state laws or regulations allow such a health center to dispense prescription drugs? How well do public and private insurance plans cover the cost of school-based health care?

Learning from Business Models

Anticipating and managing change well is essential for businesses to increase their bottom-line profits. While public health has an additional "bottom line"—optimal health for everyone, every day, everywhere—we can learn from the business sector about creating and sustaining change successfully. Let's consider a business model for leading change that is timeless to understand why most proactive changes fail—and what you can do to get them to succeed.

John Kotter suggests the following eight stages for leading organizational change:

1. *Create a sense of urgency* based on a compelling reason for changing the way things are at present.
2. *Form a powerful guiding coalition* of people with power and influence who are invested in major change and initiate it.
3. *Create a vision* of what can be possible that does not seem possible at present.
4. To translate this possible vision into reality, *communicate the vision* in terms that inform and inspire everyone. (See Chapter 11.)
5. *Empower everyone to act on the vision* by providing sufficient resources, dedicated time, or relaxed rules.
6. *Plan for and create short-term successes*.
7. Since change initiatives must move beyond projects to have broader systems impact, *consolidate improvements and produce still more change*.
8. To sustain change over time, *institutionalize new approaches*. Your sustaining change requires changing the way work gets done throughout the organization or community.[3]

Kotter's sequential model can be challenging for leading change in public health. When public health works, it is invisible, providing, for example, safe food to eat,

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clean water to drink, and universal childhood immunization. The public therefore takes public health for granted. Feeling a sense of urgency—as required in Step 1—requires a visible problem or strongly perceived threat. After a century of public health successes, the U.S. public has become complacent. For example, although childhood immunizations were once presumed to be a universal good, immunizing all children for vaccine-preventable illnesses is not universally applied. Parents and physicians who have never seen measles or polio may minimize the importance of having children immunized. Others who doubt the safety of vaccines or erroneously state that their risks outweigh their benefits oppose childhood immunizations. Leaders for change may have a difficult time overcoming these attitudes and beliefs. Ironically, renewed outbreaks of vaccine-preventable childhood diseases, thought to have almost disappeared, are likely to fuel a fresh sense of urgency.

Chronic disease prevention represents additional challenges for leaders of change in public health, in part because adverse effects of unhealthy behaviors or environmental exposures may not manifest for many years into the future.

In Step 2, a guiding coalition must come together to make a compelling case for the need for change. However, public health priorities compete with other societal needs, such as affordable housing and public education. Generating a common vision (Step 3) and speaking as one voice for change (Step 4) may face similar challenges.

Practical frameworks and tools can help bring about sustainable changes for healthier communities by (a) identifying and aligning the right people and perspectives needed to create and support change, (b) assuring organizational and community readiness for enacting change, and (c) understanding the forces required to overcome resistance to change. Let's consider how to apply such frameworks and tools to improve public health.

TOOLS FOR ALIGNING PEOPLE AND PERSPECTIVES

Public health practice is collaborative—people working together for positive change. To be an effective leader for change, you need to know how to bring the right people together with diverse, complementary views to generate evidence and ideas, shape smart strategies, and translate plans into action. One approach for leading change in public health policy[4] defines three interactive components: (a) building a firm knowledge base among partners to design change, (b) formulating a clear social strategy to implement change, and (c) mustering the political will for making durable change—which is often overlooked or underestimated (Fig. 13-1). In other words, align (a) what we all must know with (b) what we must then do together based on what we know, and then (c) get others to do what must be done to get the desired results.

This framework is useful for understanding why things go right and how they can go terribly wrong. Consider the story of a local health department wanting to

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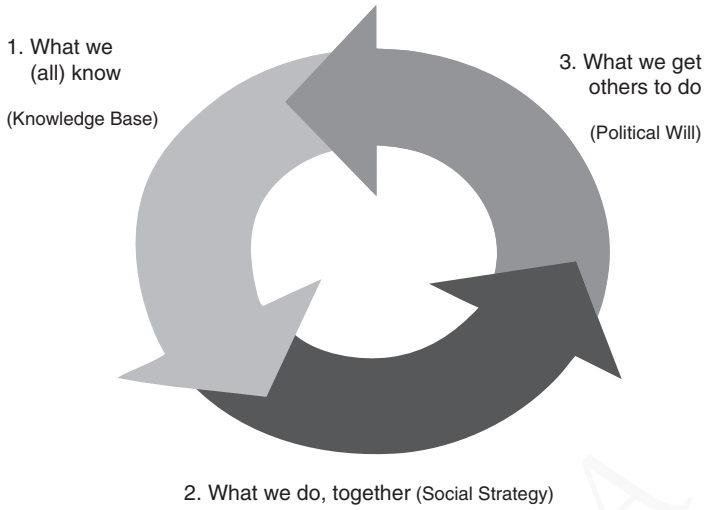

Figure 13-1 Three essential elements for leading and sustaining change. (Adapted from: Richmond JB, Kotelchuck M. Political influences: Rethinking national health policy. In: McGuire CH, Foley RP, Gorr A, Richards RW, and Associates [Eds.]. *Handbook of Health Professions Education*. San Francisco: Jossey-Bass Publishers, 1983, pp. 386–404.)

work with others to reduce the rate of unintended pregnancy in its community. At that time, about half of all pregnancies had not been planned, timed, or wanted. Rates of unplanned pregnancy were highest among teenagers. Published evidence demonstrated that an effective strategy was increasing access to condoms and other forms of contraception in or near middle schools and high schools, together with programs to build self-esteem among students through after-school community service. The health department received a grant for a comprehensive school-based program to reduce teen pregnancy. However, it had not obtained sufficient support from key individuals and organizations in the community, including some socially conservative groups and some school board members. The headline in the local newspaper was: "Got Pencils? Got Condoms!" This was how some community leaders learned of the program. After contentious public hearings, the boards of several public schools suspended their schools' participation and the program was discontinued. In retrospect, program leaders recognized that having a great knowledge base and a strong social strategy, although necessary, were insufficient to overcome the lack of political will.

Consider another example: a state health department's program to send health tips to parents of newborns. A letter from "Pierre the Pelican" described the importance of breastfeeding and childhood immunizations. Generations of young parents pasted this letter into their children's scrapbooks. But when the program was eventually evaluated, it was found that it did not make a significant difference in parents' knowledge or practices about breastfeeding or immunizations.

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Ultimately, the program was discontinued. Tradition (political will) was overridden by a lack of evidence (knowledge base) that it produced the desired results.

In contrast, consider application of the model proactively to design and implement a local ban on smoking in public places. First, local advocates, working in partnership, accumulated local data about knowledge, attitudes, and practices about smoking. They studied the medical and public health literature for evidence-based solutions, and they visited other communities where this policy change was successful. Second, they implemented a social marketing campaign concerning secondhand smoke, working with physicians and hospitals and offering free smoking-cessation services. Third, they built the political will to support a city ordinance by working with owners of theaters, bars, restaurants, and other businesses. Each of these three elements—convincing knowledge, workable programs, and political will—was necessary for transformative change.

Another tool that can help you engage and align the right people to make change happen is the Data To Action (DaTA) Triangle (Fig. 13-2).[5] You can use it to develop team-based work for the public's health.

The three corners of the DaTA Triangle—data, programs, and policy—correspond to three strengths you need for effective change teams. Some public health workers are strong in data and analysis, relying on data and evidence to shape change initiatives. Others, strong in "on-the-ground" field experience, know much about program planning and service delivery. Still others with much policy experience and political savvy have a broad perspective and often are strong in Systems Thinking (see Chapter 12). Each perspective is valid and needed. Yet too often people from each corner of the DaTA Triangle do not understand or appreciate the perspectives of people from the other corners, who are also essential for success. Service providers believe that demands for data and reports are impediments to caring for clients. Data analysts are frustrated by policymakers who misuse their data and service providers who resist collecting it. And policymakers sometimes demand data to prove that their ideas are right.

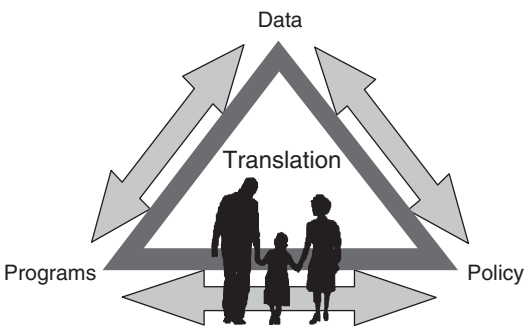

Figure 13-2 The Data To Action (DaTA) Triangle is a tool for aligning people to translate data into action. (Source: CityMatCH [www.citymatch.org])

You can use the DaTA Triangle to strengthen or reconstitute a change team. When you create a team using the DaTA Triangle, the team will have diversity, balance, and interdependence—all of which are keys to successful translation of ideas into action. There is a good probability for achieving desired organizational and systems change when leaders who have expertise in research and data analysis join forces with those who have experience in planning and providing programs and services and those who are policy-oriented and skilled in navigating political situations. Conversely, if one or more of the DaTA Triangle corners is weak or missing, the change process is less likely to succeed.

Another tool-based approach aims to align people to bring about change. Using evidence-based assessment instruments can give you and others information about your own preferences in creating and sustaining change. When diverse people come together to make change happen, by choice or by circumstance, they bring their preferred ways of working that are often well established by personality or habit. Think about the team of people with whom you now work, or when you have been assigned to work on a team to perform work. Have you noticed that some people always seem to want to keep things the ways they are, while others who are dissatisfied with the status quo challenge it? Still others can be relied on to ensure that everyone's perspective is presented. Conflict may arise between people on the team who prefer gradual, incremental change and others who prefer systemic change—between people who relish taking risky steps and others who resist even small changes. When different styles of dealing with change are managed well, the team can be more creative and find greater productivity.

The Change Style Indicator (CSI), a self-assessment instrument designed to capture individual preferences in approaching change, can be used in situations dealing with change.[6] The CSI calibrates *change style*, which can help you increase your flexibility in responding to change and better understand the preferences of others. When you use it in the context of teamwork and collaboration, it can help individuals and the groups in which they participate to better understand dynamics that happen when people with diverse change styles work together. This can be especially useful in public health practice, which requires inclusion and diversity in addressing complex challenges together.

The results of a CSI assessment place you on a continuum of change styles, ranging from being a *Conserver* to being an *Originator*. In the middle of the continuum between these two styles is the *Pragmatist*. Each change style has a set of associated characteristics.

Conservers work to preserve the existing structure of how things are. They prefer gradual, incremental, and continuous change. If you are a conserver, you generally appear to be organized, disciplined, and deliberate in your work. You know the rules and regulations and want people to follow them. For you, the details and facts matter. When faced with change, you strive for efficiency and prefer tested solutions.

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Pragmatists tackle problems by practical, reasonable means to get a workable result. They tend to take the middle-of-the-road approach and are open to both sides of an argument. If the existing structure lends itself to getting the work done, fine; if not, they may support greater changes. If you are a pragmatist, you are likely to appear flexible, agreeable, and team-oriented. When working with a team, your broad perspectives may make it harder to commit to a course of action when you are faced with multiple options. Pragmatists can serve as mediators and bridgers between Conservers and Originators, who may be at odds with each other on how to get work done.

Originators can be relied upon to challenge existing assumptions, rules, and structures. They may be viewed as visionary and as promoters of innovation. If you are an Originator, you likely are an eager agent of change willing to set aside the status quo and welcome risk and uncertainty.

Each change style can have strong perceptions of the other styles, which can lead to conflict and dysfunction within teams and organizations. Conservers may seem to others to be cautious, bureaucratic, or traditional, or to hold the group back by sticking to the rules—no matter what. To others, Originators may seem spontaneous, undisciplined, or unorganized, although they know just where to find specific files in their cluttered offices. In their thirst for new ideas, they may seem irreverent toward how things have been done, or advocate change for the sake of change. Conservers may see Originators as being impulsive, starting things they don't finish, or lacking an appreciation of already proven ways. Originators may view Conservers as having their heads in the sand, lacking new ideas, or being stuck in the status quo. While Conservers want to keep things running smoothly and build on what works, Originators are pushing the envelope to pursue new possibilities others have not imagined. And both Conservers and Originators may view Pragmatists as indecisive or noncommittal. Through use of the CSI approach, you can reframe conflict from a position of "right or wrong" to one of differences in perspective and style.[6]

Awareness and understanding of differences in preferences and styles also can translate into better collaboration and more creative solutions. A combination of styles can translate a bold idea into a workable solution with measurable results. A void in any one of these three styles in a team can leave a team stuck. Full of ideas and possibilities, Originators provide inspiration for new initiatives. Full of practicality and energy, Pragmatists are great at turning that new concept into a concrete reality. With their attention to detail and reliable follow-through, Conservers can be relied on to refine the solution and make sure the final product is on time and on target. When the strengths of the each style are appreciated and aligned strategically, major positive change is more likely to be sustained.

The CSI tool can help you better understand your individual and collective contribution to your organization and community. CSI findings, based on individual assessment, can help you identify a preferred work environment in which you can be an effective and valued agent of change.

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All three styles have strengths—none is better than another. CSI is not about competence or effectiveness, but about "hard-wired" preferences. Knowing and using your style and the styles of others can help you anticipate common pitfalls and improve change outcomes.

TOOLS FOR ASSESSING READINESS FOR CHANGE

In response to a persistent problem in community health, public health workers and their organizations may choose to adopt practices or policies that have been shown to work. However, all too often they neglect to ask a fundamental question: "How ready are we to seize this opportunity?" In other words, they miss the opportunity to assess their combined readiness for change.

Another practical tool can help you and others assess your combined readiness for change. Readiness Tenting is based on five elements:

1. Partners planning to use new approaches to address a shared public health challenge must articulate, in understandable terms, clear *reasons* for using a specific approach with a specific population at a specific time. Together they must make a unified, compelling case for pursuing the strategy for the desired change.
2. They must describe intended, measurable *results* of changing practices and/or policies.
3. Everyone must agree on the primary *roles and responsibilities* of the people and organizations that will implement the desired programmatic or policy changes.
4. All key people in the change initiative must recognize and accept individual and institutional *risks and rewards* in the proposed activities.
5. There must be adequate human and financial resources, sufficient time, and political will to complete the initiative.[7]

Using a structured tool for community engagement, Readiness Tenting invites self-assessment and collective discussion for each of these five elements. It uses the metaphor of raising a tent. Change team participants first calibrate their individual scores on the strength of each of the elements (1 is very weak; 5 is very strong). After comparing perspectives and interacting among themselves, members of the group agree on a single consensus score for each of the five elements. The tent's shape—revealed by connecting the plotted scores across the tent's five "poles"—describes the readiness status of the group to change. Figure 13-3 shows the ideal readiness tent shape, called "Palladian Power," resulting from the highest possible consensus scores across all five tent poles.

Public health workers sometimes participate in change initiatives in which participants are driven by a common passion for change and willing to take whatever risks are necessary—but little progress is made because there is no clear plan or

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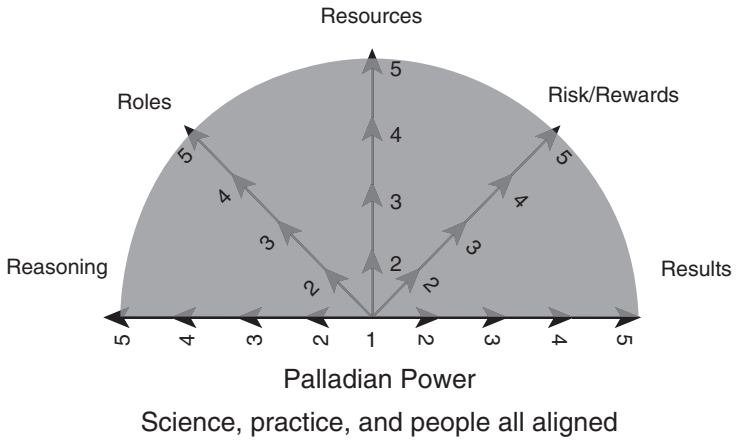

Figure 13-3 Palladian Power.

no expectations. If no additional resources are obtained to fuel the work, the "tent" cannot rise or may have a dysfunctional configuration called a "Balanced Heart" (Fig. 13-4). In this configuration, the change process is inadequately supported by a clear rationale, planning, measurable results, or adequate resources.

Let's examine an alternate scenario. A few talented grant writers or a small group of colleagues submit a well-written proposal for a project to bring about change. If the project gets funded, a variety of busy people have each agreed to work on it for a small percentage of time—but the project is not a priority for any of these people and it does not have a clear leader. The "tent" here is likely to have a "Witch's Hat" configuration (Fig. 13-5): While the grant proposal may seem

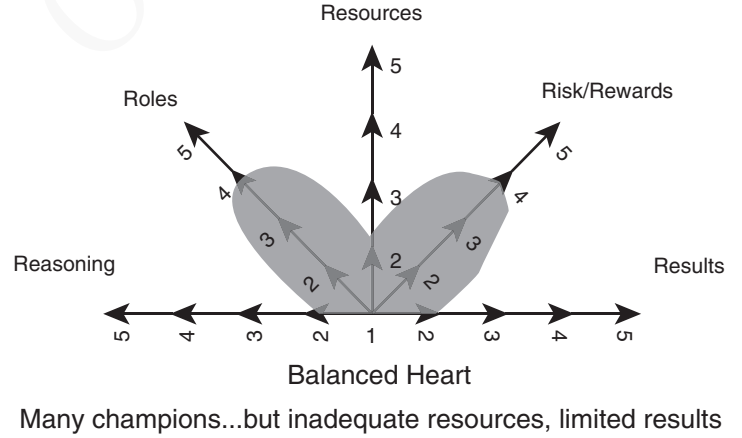

Figure 13-4 Balanced Heart.

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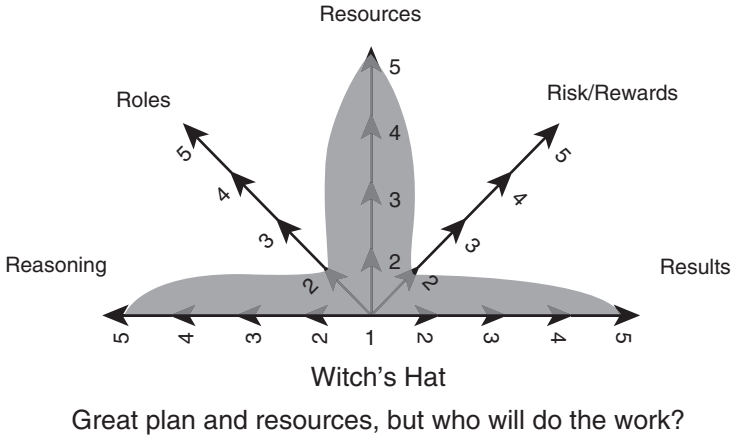

Figure 13-5 Witch's Hat.

impressive, there is inadequate human capital and insufficient institutional buy-in to translate the proposal into action for sustainable change.

TOOLS FOR OVERCOMING RESISTANCE TO CHANGE

As you start any change process, expect that there will be resistance. Some people are satisfied with the current state of affairs. Others believe that change will not improve the situation—or will make it worse. Still others believe that change is not feasible or will cost too much.

To counter resistance, you may want to consider the Change Formula[8]:

$$D \times V \times F > R$$

R stands for Resistance to significant change in policies or programs affecting public health. R can be overcome by a combination of three counterforces:

1. Dissatisfaction (D) with the status quo, fueling a desire for change
2. Vision (V) for what is possible to improve health
3. First steps (F) toward achieving the desired future

Each of these counterforces is necessary to bring about change, but each counterforce alone is insufficient to overcome resistance to change without the other two forces. And because the model is multiplicative, if any one of the three counterforces is absent (equal to zero), change will fail to occur.

The Change Formula can help you identify and understand counterforces that can overcome resistance to change. Be aware that small First Steps (F) are important but are unlikely to grow to scale for larger systems change without fueling sustained Dissatisfaction (D) with how things are. A sufficient number of people have to want to change the status quo. Disseminating compelling reports on a

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problem or writing an "op-ed" piece for the local newspaper may raise awareness and Dissatisfaction. Accompanying a growing desire for change, there must be a compelling Vision (V) for what can be possible.

Conclusion

Change is difficult. Assessing your organization's readiness and capacity for sustainable and effective change is necessary for success. Measuring progress helps to ensure that partners and others feel that they are on the right path. Change leaders must understand and practice effective strategies and they must also have strong personal resilience to sustain themselves through the journey from the present state to a new future.

References

1. Kee JE, Newcomer K. *Transforming Public and Nonprofit Organizations: Stewardship for Leading Change*. Vienna, VA: Management Concepts, Inc., 2008.
2. Albright KS. Environmental scanning: Radar for success. *Information Management Journal* 2004; 38:38.
3. Kotter J. The eight stage process. In: *Leading Change*. Boston: Harvard Business School Press, 1996, p. 33.
4. Richmond JB, Kotelchuck M. Political influences: Rethinking national health policy. In: McGuire CH, Foley RP, Gorr A, Richards RW, and Associates (Eds.). *Handbook of Health Professions Education*. San Francisco: Jossey-Bass Publishers, 1983, pp. 386–404.
5. CityMatCH. *Data To Action (DaTA) Triangle*. Available at: http://webmedia.unmc.edu/community/citymatch/CityLights/CLs p00. pdf. Accessed on October 18, 2010.
6. Musselwhite WC, Ingram RP. *Change Style Indicator Facilitator Guide*. Greensboro, NC: Discovery Learning Press, 1995.
7. Peck M (CityMatCH). *Readiness Tenting for Change*. Available at: http://www.citymatch.org/ppor_how.php. Accessed on October 19, 2010.
8. *Change Equation–Beckhard*. Available at: http://www.valuebasedmanagement.net/methods_beckhard_change _model.html. Accessed on October 18, 2010.

RESOURCES

Books

Heath C, Heath D. *Switch: How to Change Things When Change Is Hard*. New York: Broadway Books, 2010.

Using great stories of people and organizations wanting to make large and small changes happen, this accessible book lays out a three-part framework for making the "switch."

Kee JE, Newcomer KE. *Transforming Public and Nonprofit Organizations: Stewardship for Leading Change*. Vienna, VA: Management Concepts, 2008.

This practical public administration text is designed to assist workers in the public and nonprofit sectors lead change processes for the greater good.

Kotter J. *Leading Change*. Boston: Harvard Business School Publishing, 1996.

This accessible, timeless textbook on the change process is written for the business sector but is applicable to public health practice. It is a primer on why most transformative changes fail, and what leaders can do to increase the odds of success.

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Kotter J, Cohen D. *The Heart of Change*. Boston: Harvard Business School Publishing, 2002.

This follow-up book to Leading Change tells the stories of people and companies undergoing transformational changes in the context of Kotter's eight-step approach to change.

Kotter J. *A Sense of Urgency*. Boston: Harvard Business School Publishing, 2008.

This book adds to Kotter's eight-step approach by focusing on the first step: creating a sense of urgency.

Musselwhite C, with Jones R. *Dangerous Opportunities: Making Change Work*. Bloomington, IN: Xlibris Corporation, 2004.

This book, from the founder of Discovery Learning and creator of the Change Style Indicator, shows the reader how to use this tool effectively.

Assessment Tool

The Change Style Indicator (CSI). A product of Discovery Learning, Greensboro, NC. Available at: http://www.discoverylearning.com. Accessed on July 15, 2011.

The Change Style Indicator is administered by a certified trainer. It is used to help individuals assess their Change Styles and use their profiles for being strategic agents for change.

Tool Kit

The Readiness Tenting Toolkit, www.citymatch.org

Developed by CityMatCH founding chief executive officer Magda Peck in 1997, this tool kit for public health action learning collaboratives has helped public health teams navigate the change process.

OUP - USA

Commentary 13-1: Fluoridation: Bringing About and Maintaining Change

Myron Allukian, Jr.

Less pain, less infection, and lower dental bills. About 4 million people on 141 public water systems in Massachusetts are receiving these health and economic benefits of fluoridation. But it wasn't always this way.

In 1967, Massachusetts ranked 48th among the states in percentage of people living in fluoridated communities—only about 8% of its population—compared with 53% for the United States as a whole.[1] The state health commissioner had stated that by, age 13, 99% of children in the state had bad teeth and that 10% of them had never seen a dentist. The average 16-year-old in the state had 15 teeth affected by tooth decay. Only a few communities were fluoridated because fluoridation had been a controversial and political issue in Massachusetts for many years.

The Problem Personified

"TAKE THEM OUT. TAKE THEM ALL OUT!"

These were the cries of a 10-year-old boy with a dental abscess at a community health center. Both of his parents and his 18-year-old brother had no teeth at all. For this family and for this community, dental care was having your infected teeth removed. There had to be a better way.

My colleagues and I performed a needs assessment of adults in this Boston neighborhood and found that half of adults had no upper teeth and one third had no teeth at all. There had to be a better way.

What could we do? There weren't enough dentists in the city or state to treat—or willing to treat—everyone who needed dental care. We needed to focus on prevention. Fluoridation of public water supplies was clearly the answer to prevent future tragedies. Fluoridation is the foundation to better oral health.

From 1957 to 1967, the law in Massachusetts required that people in a given city or town needed to vote, in a public referendum, in favor of fluoridating its water supply before its board of health could order fluoridation. In 1967, a state legislative commission on dental health recommended that this law be changed.

In 1968, we worked with the Massachusetts Citizens' Committee for Dental Health (MCCDH), a group of citizens interested in better dental health, to change the state law so that, on recommendation of the state health commissioner, the board of health of any town could order fluoridation.[2] This order could be halted only if 10% or more of the registered voters of that town signed a petition, within

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90 days, requesting a public referendum to determine whether the water supply in that town would be fluoridated. If the public vote was subsequently against fluoridation, it could not be implemented at that time.

THE PLAN

Changing the law took vision, passion, persistence, a well-organized and informed constituency, and much difficult work. Ultimately, we were successful. Once we changed the state fluoridation law, we aimed to get Boston fluoridated. Since its water supply was part of a larger water system of 31 other cities and towns, we realized that a regional approach would be much more cost-effective. We had to develop a plan.[3]

First, we needed to find out whether there was sufficient interest in fluoridation among the 32 communities served by the Metropolitan Water District (MWD) in the Boston area. In early 1969, the MCCDH asked the mayor of Boston to write a letter to the 31 other communities in the MWD to determine their interest in regional fluoridation. When most of the communities demonstrated interest, a joint committee for regional fluoridation was formed. This committee had 16 members, reflecting a wide range of disciplines, including administration, community organization, dentistry, water supply engineering, health education, law, medicine, and public health. We then formed a small working committee to draft a strategy and plans for consideration by the joint committee, which were then implemented. Over a 6-year period, an operational program was developed.

Critical Steps

COMMUNITY PROFILES

For each community in the MWD, we collected information on the child population, current status of fluoridation, and attitudes toward regional action. We identified key people and collected information on the organization of local government. In about half of the communities, there was a favorable attitude toward fluoridation; the response was mixed among the others.

SURVEY

We performed an informal survey based on community questionnaires. We interviewed members of boards of health of all the communities. On fluoridation, 25 of the 31 boards had a favorable position, one was unfavorable, and five had no position. We determined the attitudes of key individuals in these communities.

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REGIONAL MEETING

We convened a regional meeting for local health officials and representatives of all 32 communities. Almost all participated. Commissioners of the city and state health departments, representatives of the MWD, the presidents of the Massachusetts Dental Society and the Massachusetts Health Officers Association, and representatives of the MCCDH, the Massachusetts Medical Society, the New England Water Works Association, and the regional office of the then U.S. Department of Health, Education, and Welfare attended—as well as student representatives from each of the three dental schools in Boston. We presented information that demonstrated that half of the many new cavities among children in the area could be prevented through fluoridation—at a savings of approximately $7 million over a 20-year period.

Members of our working committee then encouraged the communities to order fluoridation. In some communities, grassroots support was needed before and after the board of health ordered fluoridation. We undertook an intensive educational and supportive process. Within 4 months after the regional meeting, 27 of the 32 boards of health—representing 91% of the 2 million people in these communities—had ordered fluoridation. In two communities that later held referenda on fluoridation, the fluoridation order was upheld by a ratio of 4 to 1. The orders of the boards of health were uncontested in the other communities. Five communities did not order fluoridation and remained neutral.

Once a majority of the 32 communities had ordered fluoridation, the state health department ordered it for the entire MWD. However, the MWD commissioner did not comply with the order immediately and requested a legal opinion from the state's attorney general. A year later, after a legislative hearing on a bill to require fluoridation for these communities, the attorney general issued a decision that the MWD had to fluoridate the water supply of the 32 towns in the district.

Financing and Legislation

Initially, the MWD commissioner succeeded in getting the state legislature to appropriate $25,000 to finance an engineering feasibility study. Subsequently, a legislative appropriation of $100,000 was made for the design of fluoridation facilities. Later, an appropriation of $1.15 million for construction was authorized by the state legislature. For each of these legislative appropriations, our coalition stimulated strong continuous community support.

Construction and installation of equipment was completed in early 1978. However, under the threat of a preliminary restraining order, the MWD commission voluntarily stopped progress on fluoridation. But, a month later, the county

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superior court denied the restraining order. Fluoridation was implemented the next day. Within the next 15 days, a dozen anti-fluoridation bills were filed with the state legislature, but all of them were defeated.

Success

As a result of the Greater Boston Area becoming fluoridated, Massachusetts increased its ranking to 24th in the nation in fluoridation status—as half of its population resided in fluoridated communities.

Our work demonstrated that a well-organized interagency program can succeed in eliciting official community support for a regional approach to fluoridation. During the 8-year period of this initiative, at least 70 bills were submitted to the state legislature to block or weaken our fluoridation efforts. All were defeated. And we demonstrated that a regional approach to fluoridation for several municipalities on the same central water supply can be more practical and economical.

The key to the success of our efforts was the collective action and support of a number of public agencies and nonprofit organizations, working together toward a common goal. The support of many dentists and physicians who had provided care for individual legislators and had discussed fluoridation with them was also helpful. We found that there was a significant correlation between (a) a dentist or physician being in favor of fluoridation and having discussed fluoridation with a legislator, and (b) the legislator's support of fluoridation. First-term legislators who lived in fluoridated communities were also more likely to support fluoridation. We concluded that practicing dentists and physicians have a responsibility to educate all of their patients about the benefits of fluoridation, especially patients who are legislators or community decision-makers.[4]

By 2010, almost 4 million residents living in 141 communities in Massachusetts were receiving the health and economic benefits of community water fluoridation. Massachusetts is now 65% fluoridated, compared to 73% for the nation as a whole, and it is ranked 32nd among the states.[5]

Critical to our success was our transformation of the City of Boston's Bureau of Community Dental Programs, beginning in 1970.[6] It provided key leadership in fluoridation and other oral health initiatives. Its basic goal was to improve dental health for the Boston community. It went from a crisis-oriented dental treatment program for children only to a population-based family and neighborhood dental program. Its primary objectives were:

- To provide stimulation, consultation, and expertise for private, voluntary, and public agencies, organizations, and institutions to respond to the dental needs of the Boston community
- To stimulate, develop, implement, support, and evaluate preventive and dental care programs to improve dental health

This dental program became a great resource for Boston and the state by bringing many non-dental organizations and agencies together for a common goal: better oral health.

We found that a well-planned city dental program can have a meaningful impact on the dental health of inner-city communities, as well as improving the accessibility, quality, and scope of dental services provided in these communities. We also found that the program served as a beacon for better oral health for the rest of the state, with a focus on prevention and fluoridation.

The Future

Fluoridation of community water supplies is the foundation to improve the oral health of a community, state, or nation. Additional initiatives and programs must be designed and implemented to build on the benefits of fluoridation in order to:

- Strengthen the dental public health infrastructure
- Improve access to dental care for underserved populations
- Make oral health a much higher priority on the local, state, and national levels to reduce and eliminate disparities in oral health
- Include oral health as a key component of all federally funded health programs
- Promote and use individual and population-based preventive programs and services, such as by providing oral health education in all schools and school-based dental prevention programs in high-risk communities
- Improve the oral health component of Medicaid and Medicare
- Modify and augment the oral health workforce, including training more dentists from minority backgrounds in dentistry and dental public health
- Make dental practice acts less restrictive and more responsive to the needs of the public in such areas as national reciprocity of licensees and expanded duties for dental hygienists and assistants
- Explore new and less-expensive primary dental care models, such as by using dental therapists and advanced dental hygiene practitioners
- Support fluoridation of additional communities—27% of U.S. communities with public water supplies still do not have fluoridation[7]

In conclusion, the key elements in our ability to bring about and sustain change were:

- Assessing community needs and resources
- Defining the problem and developing a cost-effective solution
- Agreeing to a common goal
- Executing an action plan with a well-informed and organized constituency
- Providing guidance
- Being patient, persuasive, and persistent

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References

1. Allukian M. Fluoridation—A continual struggle in Massachusetts. *Harvard Dental Alumni Bulletin* 1968; 28:77–80.
2. Hendricks JR, Allukian M. Water fluoridation in Massachusetts: A thirty-year review. *J Mass Dental Soc* 1998; 42:8–17.
3. Allukian M, Steinhurst J, Dunning JM. Community organization and a regional approach to fluoridation of the Greater Boston area. *J Am Dental Assoc* 1981; 104:491–493.
4. Allukian M, Ackerman J, Steinhurst J. Factors that influence the attitudes of first-term Massachusetts legislators toward fluoridation. *J Am Dental Assoc* 1981; 104:494–496.
5. Centers for Disease Control and Prevention. *2008 Water Fluoridation Statistics*. October 22, 2010. Available at: http://www.cdc.gov/fluoridation/statistics/2008stats.htm. Accessed on December 13, 2010.
6. Allukian M. The role of a city dental program in improving the dental health of inner-city communities. *J Public Health Dentistry* 1981; 41:98–102.
7. Allukian M Jr. The neglected epidemic and the Surgeon General's report: A call to action for better oral health. *Am J Public Health* 2008; 98(Suppl 9): S82–S85.

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Commentary 13-2: Build the Stomach for the Journey*

Ronald Heifetz, Alexander Grashow, and Martin Linsky

Adaptive work generates what can feel like maddening digressions, detours, and pettiness. People often lose sight of what is truly at stake or resort to creative tactics to maintain equilibrium in the short run. All of this can leave you deeply discouraged or burn you out. You may start questioning whether the whole thing is worth it and be tempted to downgrade your aspiration. You may numb yourself to these frustrations. Or you may decide to throw in the towel. It is hard to stay in the game in the face of hopelessness or despair. But to lead change, you need the ability to operate in despair and keep going. And that calls for building the stomach for the journey.

Building resilience is similar to training for a marathon. You need to start somewhere (for example, running a mile or two each day for a few weeks and then gradually working up to the longer distances). In an organizational context, this kind of training can take the form of staying in a tough conversation longer than you normally would, naming an undiscussable problem facing your team, and not changing the subject at the first sarcastic joke designed to move off the uncomfortable topic.

Marathoners in training use benchmarks. You can track your progress if you have clearly defined short-term goals along the way. Targeting a monthly or quarterly goal that feels realistic may help you build stamina for the long haul. Or bringing warring factions together in the same room for even just a few minutes may be good practice for conducting a longer meeting later.

To further build your stomach for the adaptive leadership journey, keep reminding yourself of your purposes. Runners look forward, not down. Staying focused on the goal ahead will help keep you from becoming preoccupied or overwhelmed by the number of steps necessary to get there.

Early in his career, Alexander and a colleague worked with the New York City Department of Health, assessing the patient-care capacity in all forty-seven of the city's public hospitals and health-care centers. They met with resistance at the first few centers they visited. Uncooperative managers refused to supply the necessary data because they were anxious that they would not come out looking good. After these visits, Alexander and his colleague were exhausted. To stay in the game, the two of them made a decision: after each subsequent visit, they would

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* Excerpted from Heifetz R, Grashow A, Linsky M. *The Practice of Adaptive Leadership: Tools and Tactics for Changing Your Organization and the World*. Boston: Harvard Business Press, 2009, pp. 260–262.

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spend time together reminding themselves of their long-term goals and eating a healthy lunch rather than comfort food to keep their spirits up.

Building a strong stomach requires relentlessness. You probably have a limit to how hard you are willing to push an initiative forward. If opponents of your intervention sense that limit, they will know exactly how hard they have to resist. One of the best practitioners of leadership we know used to say at the beginning of tough meetings when everyone knew this was going to be a difficult conversation, "I am willing to stay in this meeting as long as necessary." As soon as he indicated that he was there for however long it would take, people for whom the issue was not such a high priority would begin to back away rather than stall or sabotage the discussion. He would then be that much closer to getting the needed work done.

Leading adaptive change will almost certainly test the limits of your patience. Even after you have accomplished a lot—for example, increased market share, built more low-income housing, or put your issue on the top team's agenda for the first time—you might well find yourself having trouble celebrating that progress because you know how much more work remains to be done.

Impatience can hurt you in numerous ways. You raise a tough question at a meeting and do not get an immediate response. So you jump right back in and keep pounding on the question. Each time you pound, you send the message that you are the only person responsible for that question. You own it. And the more you pound away, the less willing people are to share ownership of the question themselves. And if they do not feel any ownership of the question, they will have less investment in whatever the resolution turns out to be.

Where are you supposed to find the patience when there is such a long way to go on the issues for which you feel so strongly? You can find patience by tapping into your ability to feel compassion for others involved in the change effort. Compassion comes from understanding other people's dilemma, being aware of how much you are asking of them. Your awareness of their potential losses will calm you down and give you patience as they travel a journey that may be more difficult for them than it is for you.

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