Collaborative Leadership and Community Health Governance

David D. Chrislip

In 2002, I participated as a resource participant in the Center for the Advancement of Collaborative Strategies in Health's (New York Academy of Medicine) Community Health Governance (CHG) initiative. The initiative included nine Turning Point partnerships from across the country in a joint learning work group focused on collaborative approaches to agenda setting and problem solving on community health concerns.

When I first reviewed the materials describing the work at each site, I was immediately struck by the wide variation among the sites in terms of governance structure, leadership approach, role definition, who participates, how they participate, depth of understanding about what collaboration means, and what capacities they have. Personal experience with each of the sites at the meetings confirmed these differences while illuminating the varying quality of accomplishments across the sites.

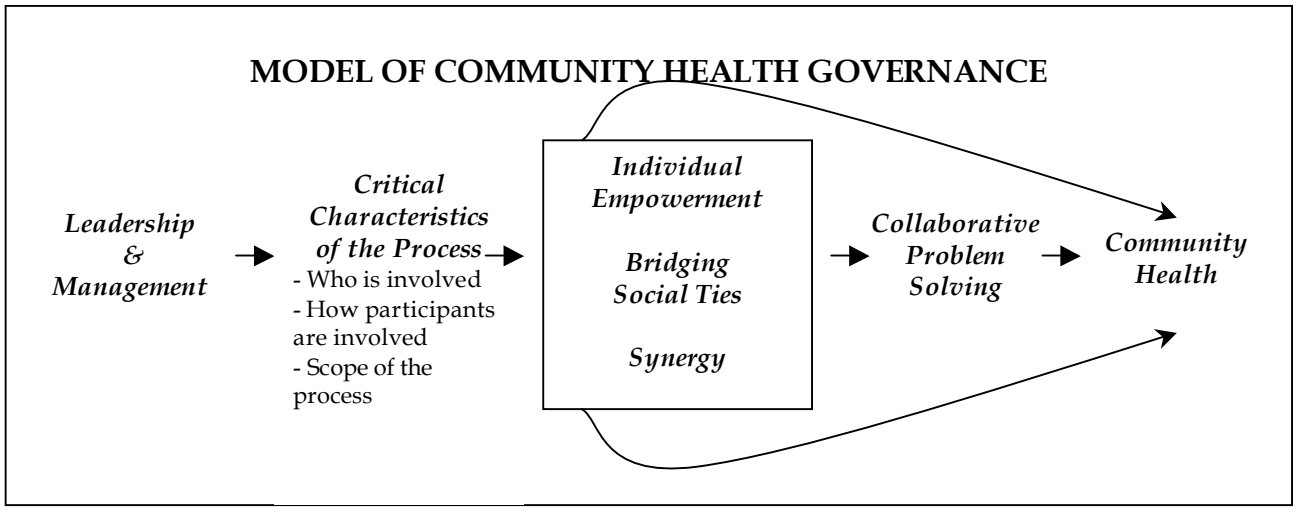
I was also intrigued by how the CHG model was developed and the extent of its usefulness in enhancing each site's understanding of the underlying concepts. When presented with varying approaches to CHG, many of the participants could readily discern those that were consistent or contradictory with the model. The model obviously had some strength in building conceptual understanding though it wasn't clear to me at the time to what extent this understanding translated into practice.

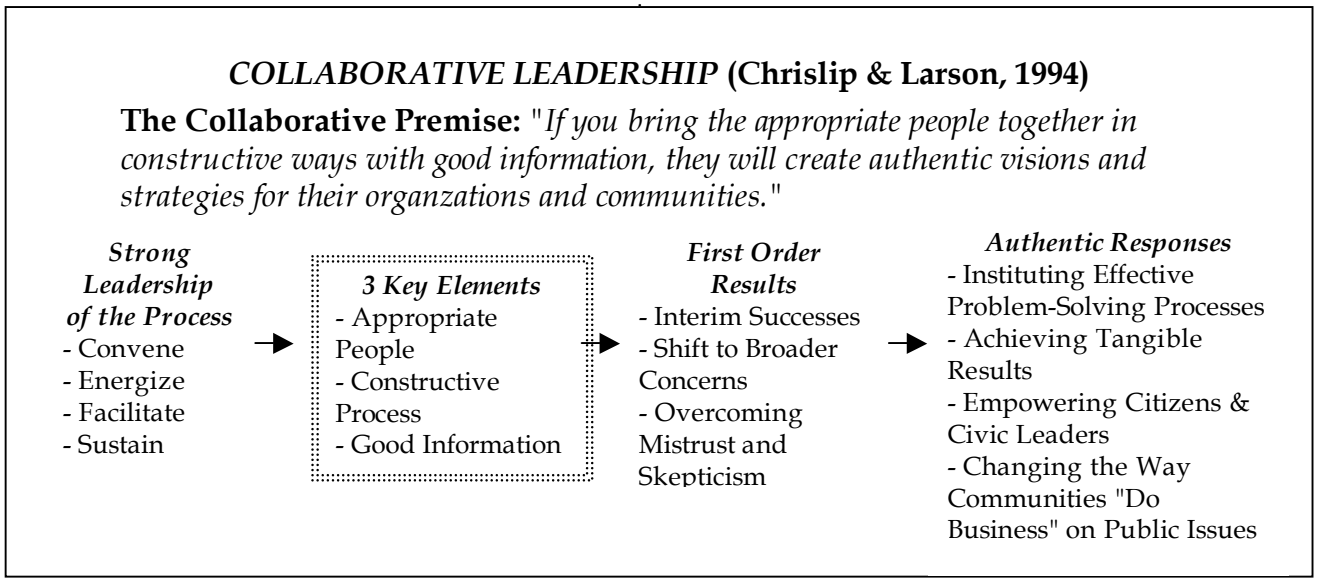
Comparing the CHG Model With the Collaborative Leadership Model

My role was to view the CHG experience through my own lens. As I quickly observed, the emerging CHG model[1] had much in common with my past work reported in *Collaborative Leadership*.[2] The two diagrams below outline the major elements of each model. Although organized in different ways, the two concepts share several common elements.

[1] Lasker, Roz D. and Wiess, Elisa S. "Broadening Participation in Community Problem Solving: a Multidisciplinary Model to Support Collaborative Practice and Research." *Journal of Urban Health.* Volume 80, No. 1, March 2003.

[2] Chrislip, David D. and Larson, Carl. *Collaborative Leadership*. San Francisco: Jossey-Bass, 1994.





Both models assert that effective community problem-solving emerges from a broadly inclusive group of people engaging in constructive ways. Each model recognizes the importance of a special kind of process-oriented leadership that energizes and facilitates these engagements. While there are similarities in the way outcomes and results are described, the two models place emphasis on different aspects. The CHG model introduces the notion of synergy as a first order outcome recognizing the breakthrough potential that can be achieved by a diverse group with the knowledge, skills and capacities to work together effectively. The *Collaborative Leadership* model illuminates the transforming power of collaboration leading to changes in the way communities "do business" on public issues. Incorporating both the synergistic and the transforming aspects of collaboration in future theory and research could enhance both models.

The real insight for me came from recognizing the convergence of findings in the two independently developed models based on data from different though complementary arenas. Further study may indicate a similar convergence with the lessons about collaboration emerging from other arenas - e.g., environmental and resource decision-making.

Since 1994, I have extended the findings of *Collaborative Leadership* into a broader framework explored in *The Collaborative Leadership Fieldbook*.[3]

The Extent to Which the Sites Comprehend and Use the CHG Model

The following framework helped me look at the experiences of the different sites. Most of the sites have achieved some success in establishing collaborative relationships and projects among participating agencies in the *Implementing Solutions & Strategies* phase. Some of the sites have managed to engage both agencies and citizens in *Deciding What Should be Done* (problem-solving) on specific issues. From my observation, none of the sites have really succeeded in constructively engaging a broad cross-section of the community in the *Agenda Setting* phase. In most instances, agenda setting occurs within the confines of the governing body rather than through community engagement. Most sites easily grasp the benefits of interagency collaboration but fail to recognize the need to collaborate in all phases in order to achieve the vision of CHG.

Phase	Who is involved	How are they involved	Leadership
Agenda Setting • Agreement on Priorities	Stakeholders Reflecting the Broader Community	Consensus-Seeking Collaborative Engagement	Strong Facilitative Leaders (credible convenors & catalysts for collaboration)
Deciding What Should be Done • Defining Problems & Visions • Defining Solutions & Strategies	Stakeholders Reflecting the Community (relevant to presenting issues & concerns)	Consensus-Seeking Collaborative Engagement	Strong Facilitative Leaders (credible convenors & catalysts for collaboration relevant to presenting issues & concerns)
Implementing Solutions & Strategies	Implementing Organizations & Institutions along with citizens as needed	Collaborative Partnerships &Teams	Team Leaders & Managers (including community members)

[3] Chrislip, David D. *The Collaborative Leadership Fieldbook*. San Francisco: Jossey-Bass, 2002.

Leadership and Governance of Collaborative Processes

Each of the sites has developed its own structure and model for leadership and governance. These differences in approach have led to widely varying performance. I will briefly summarize the experience of the four sites I am most familiar with and then attempt to draw some tentative conclusions.

Site 1

Site 1's report highlighted the partnership's success in helping make the community aware of alternative approaches to health concerns by sharing knowledge of successes in other communities and regions. Site 1 began the journey through community meetings explaining its purpose and seeking information related to health concerns. On a parallel track, the partnership helped members develop their leadership capacities and, eventually, sponsored a community leadership development conference in the town. Over time, Site 1 used its credibility to educate others about its purpose and role and to convene and catalyze efforts to solve specific health problems. Until recently, the partnership has cultivated good working relationships with local government.

The partnership has a record of accomplishment in the community and, through its indicator reports, has evolved into a credible and reliable source of information on health concerns. These reports have led to a deeper understanding of these concerns in the community and consensus on an evolving and broad definition of community health. Issues and priorities raised by the reports have helped the partnership create new initiatives for problem solving and action in specific areas.

Site 1 has created a flexible shared leadership model that allows leadership to shift as people and needs change. This helps create a sense of shared responsibility for the work of the partnership. At the same time, the shared leadership model and lack of staff does not provide the infrastructure to support outreach activities in the community and has often left the partnership adrift depending on the energy and capacity of those involved. Newly elected leaders are not aware of partnership's work. Agenda setting work remains confined to partnership members. The come and go as needed policy doesn't lend itself to sustained participation or strong direction. As a result, Site 1 is in danger of losing momentum, commitment and support unless it can build on past successes

If the partnership is to succeed, it needs to reenergize participation, review the effectiveness of the shared leadership model, and establish new strategies to renew the initiative.

Site 2

Site 2's journey led to the search for new partnership models for coping with public health issues in the region. The Turning Point initiative eventually culminated in the

creation of a health partnership authority to guide and coordinate health related services and activities through on-going community assessment and priority setting.

This extended planning process brought criticism that the partnership focused too much on planning and not enough on action. The lack of early successes or other meaningful results caused the loss of energy and participation in partnership work.

The governing structure of Site 2's initial partnership included major organizations and groups responsible for and interested in public health in the region. It has excluded major parts of the community including schools, public safety, elected officials and the general public. The work of the partnership itself tended to be dominated by the stronger organizations and groups. "Junior" partners felt underutilized and, over time, their participation declined. Local health departments and elected officials have not been deeply involved in the creation and implementation of the health authority so it has little credibility with local government. As few citizens have been involved in Site 3's work and the creation of the initial partnership, citizens in the region have little knowledge of these efforts.

The legislation establishing the authority circumscribes the role and governing structure of the organization and limits flexibility. The new health authority board includes several health providers as well as citizen representatives ostensibly as equal partners. There is some resistance or fear about expanding participation on the new board. Some members of the initial partnership do not understand the purpose and role of the new health authority and how it might extend and complement past work. The extended time required for the board to develop a better understanding of limitations and constraints has slowed implementation and action.

The challenge for the executive director and other key leaders is to shape the culture of the new organization in the face of this history in ways that enhance its capacity to serve the community health governance function.

Site 3

Site 3's work has moved from assessment to priority setting to implementation of new programs and partnerships. Despite some successes, Site 3 remains relatively unknown in the region. The makeup of the board and the way it operates contribute to this obscurity. Board members include agency executives and representatives from city government but not citizens from the community itself. Assessment for Site 3 has meant getting input through focus groups and surveys rather than engaging citizens directly. Similarly, agenda setting has been done by the board.

Site 3's board is primarily made up of representatives of health organizations and agencies. The partnership has relied on an influential and dynamic executive director to energize its work rather than devolving the work to organizational and agency partners and further to the community. This reliance on the executive director (ED) has allowed governing partners to defer initiative to the ED and reinforced a limited role

for them. Because of a lack of an appropriate understanding of CHG and community engagement, the mission, governing structure, staffing and staff capacities often contradict and undermine Site 3's capacity to fully engage the community. Because of the narrow range of participants (there has never been a community member on the board), Site 3 has had a difficult time establishing its credibility with the community. The lack of credibility of Site 3 in the community and the minimal leadership role of governing partners has led to limited and variable commitment on the part of government and community leaders.

The shift to a new executive director offers an opportunity to re-conceive the role of the organization, the board and the staff. If the board is to serve as a convenor and catalyst to engage citizens in assessment, prioritizing and problem solving, it must be a credible reflection of the broader community. By expanding the board to include citizens as well as agency executives and city representatives, the board can enhance its credibility in the community.

As the board develops more credibility in the community as a catalyst and convenor for community work, Site 3's work should shift from organizational partnerships to engaging citizens in the community. This could include using different approaches to assessment that would bring heterogeneous groups together to create a shared understanding of the broader needs of the region. From this, community engagement could be extended to setting priorities.

Site 4

Site 4 has made substantial progress over several years in creating a viable, credible and sustainable infrastructure for addressing health concerns. From the beginning, Site 4 focused on the inclusiveness of who is involved in defining and addressing health concerns and the kinds of processes used to gain input and participation. Early successes on narrow, focused problems helped Site 4 develop its credibility in the region. Building on these successes, Site 4 leadership helped convince others that collaborative approaches to health concerns could work.

While Site 4 has instituted more inclusive and engaging processes to address health concerns, broad participation in the community assessment process and in setting priorities remains elusive. In the past, community assessment information came primarily from surveys, key informant interviews and community discussion sessions. This information was summarized and analyzed by the board to establish community priorities. Site 4 then initiated project task teams to address these priorities. The agenda setting and prioritizing work tended to come more from community input than community engagement. The discussion sessions were often conducted with homogeneous groups with participants responding to a general invitation. This limited participation in the sessions to narrow sectors of the community precluded a shared understanding of others needs.

Site 4 recently began to further expand participation in assessment through presentations and discussions at meetings of community organizations and through recruiting missing perspectives to community assessment meetings. Further steps may include additional meetings that engage people from many perspectives rather than homogeneous groups to help build shared understanding across groups. Site 4 is also considering how to engage a cross-section of citizens in the priority setting process rather than limiting this work to the board.

The makeup of the board of Site 4 - agency representatives, members of prominent organizations and local government, and citizens - lends broad credibility to the work of the partnership. Ownership and responsibility for the work of the partnership seems to come predominantly from the board not the staff. The staff model for Site 4 enhances and supports the work of the board through facilitative processes and communication. The staff reports to the Site 4 board and is funded by multiple agencies.

LESSONS FROM SITE EXPERIENCES:

• Initial successes using collaborative and inclusive modes for addressing health concerns help establish credibility and momentum;
• In order to sustain momentum, initial small successes must be followed by deep, meaningful results achieved through inclusion and collaboration;
• Becoming knowledgeable of collaborative and inclusive modes for addressing health concerns, including knowledge of experiences in other places, helps create a sense of possibility that new modes can work;
• As a partnership develops, educating others about its purpose, role and how "it does its business" helps build awareness of its work and credibility in the community;
• Building good working relationships amongst citizens and unlikely partners brings credibility to the CHG work and helps spark small successes on specific problems;
• Governance structures that include members that reflect the broader community are more credible than those that do not;
• Diverse and inclusive participation in partnership governance requires a disciplined approach to identifying potential members and a strong recruitment effort to ensure participation;
• A shared leadership model within the governance structure helps spread the responsibility for energizing the partnership;
• Governing members of partnerships need clear understanding and agreement about the role of the partnership in working with the community to set agendas, solve problems and act;
• Clear understanding and agreement on the role of the partnership is not enough unless the governing members and staff have the leadership skills and capacities to operate in a manner congruent with this role;
• Learning the leadership skills and capacities for engaging citizens comes through capacity building experiences. These experiences must be included as a structured part of governing and staff members development;

• Staff members need the skills and capacities to support the leadership role of the governing members. Their role as process guides for the partnership and for the community may be more important than their content knowledge;
• Partnerships work better with staff than without. This allows for more follow through and community outreach.