Collective Leadership, Academic Collaborations and Health Disparities: A Framework for Success

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Abstract

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Keywords

collective leadership; community partnerships; collaboration; team science; health disparities

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ABSTRACT

Implementing collaborative approaches to addressing health disparities involves multiple individuals who have leadership roles both within their own sectors and within the collaborative effort's infrastructure. Understanding how that collective leadership operates and the skills and behaviors each member of the team brings to the collaborative process can shed light on what makes for a successful outcome. The Center of Excellence for Health Disparities in the Nation's Capital (CEHD) was a collaborative effort between two universities and among multiple schools within the same institution, across departments and with multiple community partners. This paper presents a case example of collective leadership in an academic setting with the goal of reducing health disparities in the District of Columbia utilizing the leadership model of Kouzes and Posner (2007) as a conceptual framework.The self-assessment of leadership practices within the leadership team of this collaborative effort demonstrated that while across the team there was the array of leadership practices needed to support successful collaboration, no one team member reported high frequencies of all practices. It was the collective profile of behaviors that aligned with the elements needed for successful collaboration.

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INTRODUCTION

Over the past two decades, the scientific community and private and public funders of research have endeavored to create effective responses to the complex health, social and environmental problems that continue to challenge our society. A key component of that response has been the increased investment in what has been termed "team science", an approach that fosters collaboration among scientists trained in multiple disciplines to bring a range of perspectives, skills and methods to addressing the complexity of the challenges facing us (Stokols, Hall, Taylor, & Moser, 2008). While collaboration provides significant opportunities to address complex health

issues through research initiatives, collaboration is neither easy nor automatic—simply bringing together an array of team members does not assure true collaboration. As the array of team members expands and the diversity of knowledge, skills, experiences, vision, and goals becomes more complicated, effective collaboration becomes more challenging (Vogel et al., 2014). Leadership is a key ingredient to addressing these challenges.

Among the complex problems that continue to elude large-scale solutions is health disparities based on race, ethnicity and socioeconomic status. Despite concerted efforts through public policy and research driven interventions, these disparities persist (US Department of Health and Human Services, Agency for Healthcare Research and Quality, 2016). Multiple recommendations have been offered for how to improve research efforts to address health disparities and inequities. Among these is expanding the concept of team science to include the vital role of collaboration with the communities most affected by these disparities—expanding the team beyond academic members to include the perspectives, knowledge and expertise of non-academic partners (Cooper, Hill, & Poe, 2002; Horowitz, Robinson, & Seifer, 2009; Wallerstein & Duran, 2006). Being able to establish truly collaborative efforts across academic partners and with community colleagues magnifies the challenges of the collaborative scientific endeavor.

The Importance of Leadership in Health Disparities Collaborations

Implementing collaborative approaches to addressing health disparities involves multiple individuals who have leadership roles both within their own sectors and within the collaborative effort's infrastructure. Understanding how leadership operates and the skills and behaviors each member of the team brings to the collaborative process can shed light on what makes for a successful outcome. The concept of collective leadership underpins effective collaborations in these circumstances. Collective leadership is the shared leadership capacity in an endeavor that can best be understood as all participants taking responsibility for the success of the endeavor as a whole – not just for their own jobs. It requires distributing the leadership responsibilities to those with the skills and motivation.

All aspects of successful collaboration are influenced by the expression of collective leadership. In the literature addressing frameworks and models of effective collaboration (San Martin Rodriguez, Beaulieu, D'Amour & Ferrada, 2005; Thompson, Perry, & Miller, 2007; Wood & Gray, 1991), three key areas emerge: evolving a shared vision and goals, capitalizing on diversity of motivation and perspectives, and establishing a supportive governance or management structure. In each of these areas, the engagement of collective leadership is essential.

Shared goals and vision need to be addressed from the outset of the collaboration. Imagining the future, building on the hopes and dreams of participants, and identifying common goals despite arrays of differences requires skilled leadership in a collaboration. To address the asymmetry of interests and to achieve common goals implies a well led dialogue and commitment among the participants. Often, one result of achieving these goals and vision is a shared, flexible ownership of the work. In the arena of academic collaborations to reduce health disparities, the compelling social justice issues easily help frame the commonality and ultimate sense of ownership of the work. This collective ownership is an important driver to achieve a successful framework for collective leadership.

Capitalizing on the diversity of motivation and perspectives of the participants in the collaboration is, in some ways, a counterintuitive element. All collaborations benefit from diversity of motivations, perspectives and skills. It has been shown that the best decisions result not from

one single "smart" participant's view but from a collective dialogue—the notion that collective wisdom may well exceed the sum of its parts (Page, 2007). Navigating these differences and facilitating their positive effect on decision-making is a critical challenge that requires effective facilitative leadership. Additionally, for collaborations to succeed all the participants must perceive some self-relevant gain whether it be a specific gain or an increased attention to an inherent value or goal. Academic collaborations to reduce health disparities often involve an array of stake holders, both inside and outside the hosting institution, including a range of academic disciplines, consumer and community partners, and other key stakeholder that create this important diversity. The hoped for gains may range from increased publication records and academic advancement to improved and more accessible community services.

Governance of academic collaboratives, as for all collaboratives, must address creating and sustaining connectivity, supporting innovation and implementation, assuring both autonomy and mutuality, establishing communication mechanisms and information exchange structures, and monitoring outcomes. These structures are key to forming academic collaborations for health disparities. Additionally, such collaborations typically lead to new activities and the governance/management has to support this. Structurally, in academic collaborations, a lead convener brings everyone together but a cross sector leadership group comes together frequently to build relationships, capacity, and a culture of trust and mutuality. In this leadership group is manifested the core of collective leadership.

Unique Challenges for Collaboration in Academic Settings

The unique challenges for successful collaboration to reduce health disparities in the academic environment speaks to the siloed culture and structures of academia. Collaboration in academic settings internally includes diverse partnerships between institutions, across schools within universities, and among departments; externally, with outside partners who bring unique perspectives and skills from the affected communities and from community organizations addressing health disparity issues. Academic institutions have structures and policies that often are driven by competition for prestige, funding and other resources. Schools and departments within the same institution have individual organizational structures and designated areas of expertise. Academic settings are also driven by credentials; those deemed to be “experts” or leaders have to demonstrate particular levels of training, experience and expertise that do not match with the expertise and experience that outside partners bring to the table. As a result, academic settings do not naturally provide opportunities for the key activities that support effective collaboration. Evolving a shared vision across the diverse partners needed, capitalizing on the potential diversity of motivation and perspectives available, and creating a supportive governance structure that fosters collaboration can be extremely difficult in the siloed structure and culture of academia. Given these challenges to collaborative efforts in academic settings, the role of leadership to implement the key activities that underpin effective collaboration is critical. However, leadership structures (positions) within academia typically are created within the silos just described. Thus, a different approach to leadership for collaborative initiatives is essential—one that draws on the collective leadership capacities across silos and integrates them into a shared leadership model.

Understanding Collective Leadership in Health Disparities

No studies currently exist that explore the role of collective leadership in the field of health disparities. To better understand the interface between leadership skills and behaviors and the

elements of successful collaboration, the model used by Kouzes and Posner (2007) to identify and assess a range of leadership practices provides an effective framework. Because Kouzes and Posner focus on leadership practices that are key to promoting positive change in individuals and organizations, their model is especially useful for health disparities programs. Importantly in their model they have developed an instrument, The Leadership Practices Inventory (LPI), that captures the key elements of their transformational approach. For this reason, the Kouzes and Posner model and instrument were chosen for this study.

The LPI represents two decades of research (Kouzes and Posner, 2007) that suggest that leadership is a collection of practices and behaviors necessary to achieve defined goals and objectives. Kouzes and Posner identified five exemplary leadership practices for successful leadership that are defined by measurable, learnable and teachable behaviors: Model the Way, Inspire a Shared Vision, Challenge the Process, Enable Others to Act, and Encourage the Heart. They define these areas as follows:

- Model the Way - clarifying values and setting an example.
- Inspire a Shared Vision - envisioning the way and enlisting others.
- Challenge the Process - taking risks and looking for opportunities.
- Enable Others to Act - fostering collaboration and strengthening others.
- Encourage the Heart - recognizing the contribution of others and celebrating successes.

These actions are operationalized into specific behaviors and practices and, in a collective leadership model, can be distributed across a leadership team. To understand the relationship between these practices and effective collaboration, Tables 1-3 crosswalk the specific leadership practices and behaviors with the three areas for successful collaboration: evolving a shared vision and goals, capitalizing on diversity of motivation and perspective, and establishing supportive governance.

Table 1. Leadership Behaviors[1] that Support Evolving a Shared Vision and Goals

Leadership Practice Behaviors: Model the Way	**Leadership Practice Behaviors: Inspire a Shared Vision**	**Leadership Practice Behaviors: Encourage the Heart**
• Sets a personal example of what he/she expects of others • Builds consensus around a common set of values for running our organization.	• Talks about future trends that will influence how our work gets done • Describes a compelling image of what our future could be like • Paints the "big picture" of what we aspire to accomplish • Speaks with genuine conviction about the higher meaning and purpose of our work	• Publicly recognizes people who exemplify commitment to shared values

[1] Kouzes, J.M., & Posner, B. (2007). The Leadership Challenge. San Francisco: CA, Jossey-Bass.

Table 2. Leadership Behaviors[1] that Support Capitalizing on Diversity of Motivation and Perspective

Leadership Practice Behaviors: Inspire a Shared Vision	**Leadership Practice Behaviors: Challenge the Process**	**Leadership Practice Behaviors: Enable Others to Act**	**Leadership Practice Behaviors: Encourage the Heart**
• Appeals to others to share an exciting dream of the future • Shows others how their long-term interests can be realized by enlisting in a common vision	• Seeks out challenging opportunities that test his/her own skills and abilities • Challenges people to try out new and innovative ways to do their work • Searches outside the formal boundaries of his/her organization for innovative ways to improve what we do • Asks "What can we learn?" when things don't go as expected • Experiments and takes risks, even when there is a chance of failure	• Actively listens to diverse points of view • Treats others with dignity and respect • Ensures that people grow in their jobs by learning new skills and developing themselves	• Makes it a point to let people know about his/her confidence in their abilities

[1] Kouzes, J.M., & Posner, B. (2007). The Leadership Challenge. San Francisco: CA, Jossey-Bass.

Table 3. Leadership Behaviors[1] that Support Establishing a Supportive Governance/Management Structure

Leadership Practice Behaviors: Model the Way	**Leadership Practice Behaviors: Challenge the Process**	**Leadership Practice Behaviors: Enable Others to Act**	**Leadership Practice Behaviors: Encourage the Heart**
• Spends time and energy making certain that the people he/she works with adhere to the principles and standards that we have agreed on • Follows through on promises and commitments he/she makes • Asks for feedback on how his/her actions affect other people's performance • Is clear about his/her philosophy of leadership	• Makes certain that we set achievable goals, make concrete plans, and establish measurable milestones for the projects and programs that we work on	• Develops cooperative relationships among the people he/she works with • Actively listens to diverse points of view • Treats others with dignity and respect • Supports the decisions that people make on their own • Gives people a great deal of freedom and choice in deciding how to do their work • Ensures that people grow in their jobs by learning new skills and developing themselves	• Praises people for a job well done • Makes sure that people are creatively rewarded for their contributions to the success of projects • Finds ways to celebrate accomplishments • Gives the members of the team lots of appreciation and support for their contributions

[1] Kouzes, J.M., & Posner, B. (2007). The Leadership Challenge. San Francisco: CA, Jossey-Bass.

This framework for understanding the relationship between leadership practices and the elements of successful collaboration forms the basis of the case study presented in this paper. The importance of this range of practices across the leadership team is proposed as a key element of successful collaboration. No one person is likely to implement all of these practices with high frequency; however, if these practices exist across the team, there is a leadership basis for successful collaboration. This paper will present a case example of collective leadership in an academic setting with the goal of reducing health disparities in the District of Columbia utilizing the leadership model of Kouzes and Posner (2007) as a conceptual framework.

METHODS

Case Study Site: The Center of Excellence for Health Disparities in the Nation's Capital (CEHD)

The Center of Excellence for Health Disparities in the Nation's Capital (CEHD) was a collaborative effort between two universities and among multiple schools within the same institution, across departments and with multiple community partners. The Center was funded for five years by the US Department of Health and Human Services, National Institute on Minority Health and Health Disparities. A primary goal of the CEHD was to build bridges between the scientific and the lay community in an effort to eliminate and/or reduce health disparities that impact the minority population, particularly African- Americans, residing in the District of Columbia.

The objectives of the project fell into three categories - research, research training and education, and community engagement. The specific objectives were as follows:

- Objective 1. Research - to explore methods to decrease disparities in two specific chronic conditions impacting the health of African Americans in Washington, DC: breast cancer and stroke.
- Objective 2. Research Training/Education - to promote careers in minority health and health disparities research through educational and training programs that meet the needs of investigators and students at all levels of experience, with particular emphasis on recruiting students and faculty from minority health populations.
- Objective 3. Community Engagement - to foster collaborations with community organizations in conducting disease prevention and/or intervention activities and research.

The administrative structure of the CEHD was designed to support these objectives noted above and was organized around four cores: Administration (AC), Research (RC), Research Training/Education (RTC), and Community Engagement (CEC). The Administrative Core (AC) provided the essential administrative structure to support the research, training, and community engagement goals of the CEHD. Below is schematic diagram of the organizational structure of the center (Figure 1).

Successful Achievement of Objectives of the CEHD

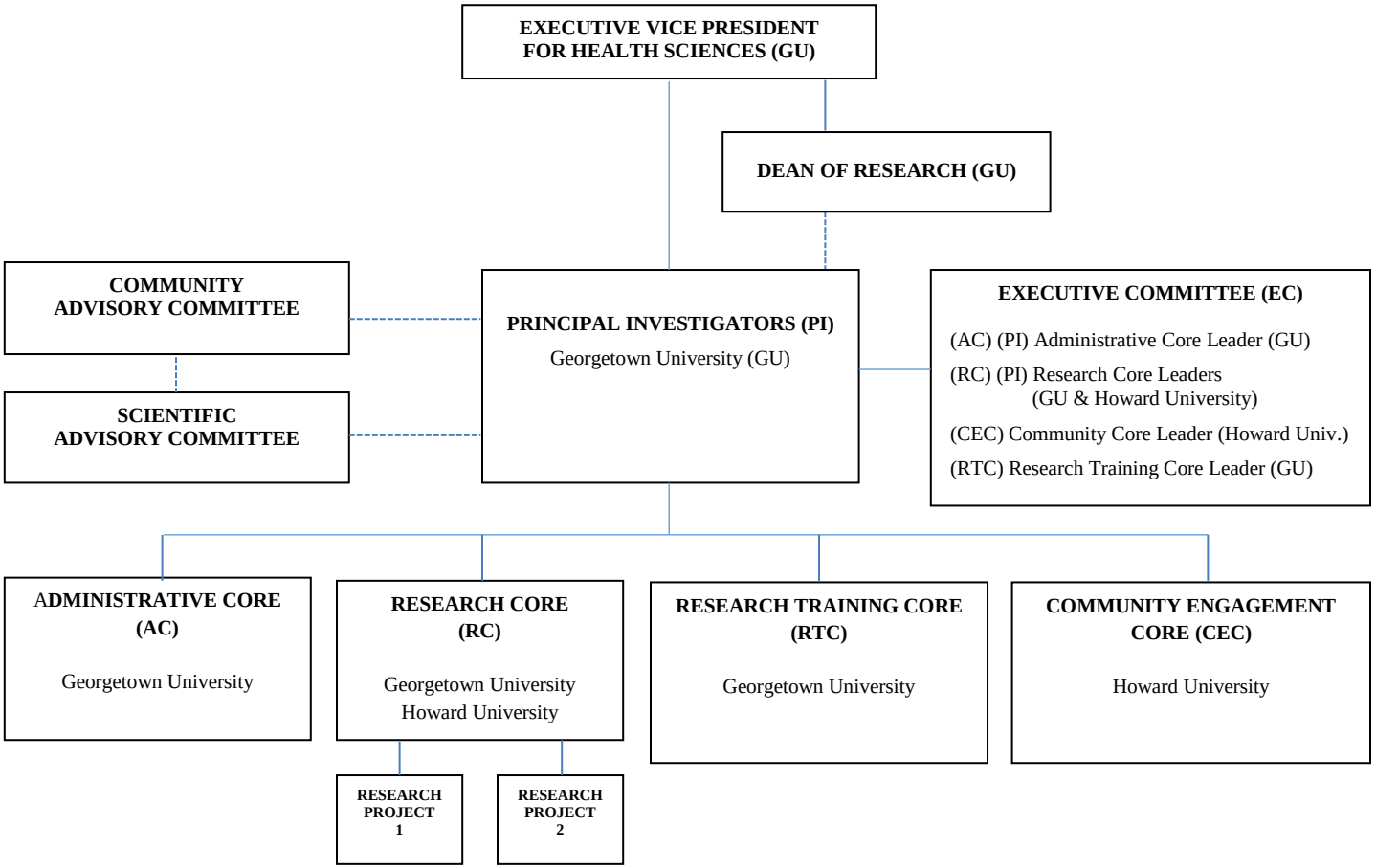
Effective collaboration at multiple levels led to the successful achievement of a range of activities to meet center objectives. The following are a few examples of successful activities to reach each of the project objectives and the types of collaboration needed to accomplish them.

Research. A key research activity was a study to compare the impact of a supervised facility-based and a home-based exercise intervention on obesity, metabolic syndrome and known breast cancer biomarkers in postmenopausal African- American women. This study entailed a 6-

month randomized exercise intervention trial that assessed the impact of exercise interventions on biomarkers related to obesity, insulin-related pathways, inflammation, and hormones. Extensive collaboration among departments to create an interdisciplinary research team was required for the success of this activity. Partners included faculty from Epidemiology, Internal Medicine, Oncology, and Biostatistics. In addition, ongoing collaboration with community and community-based organizations supported effective recruitment and enrollment of subjects to meet research goals including connecting with potential enrollees through community churches, grocery stores, libraries, and community gatherings. Finally, collaboration between Georgetown and Howard Universities allowed for sharing of study sites to make participation convenient for subjects in various parts of the city.

Research Training. A series of activities to implement research training was successfully implemented, all requiring collaboration across schools within Georgetown University as well as among departments within those schools. One example was the Summer/Academic Semester Opportunity for Achievement in Research-Minority Health Disparities Research Internship. The opportunity was designed to provide qualified undergraduate students from underrepresented minority and other disparity populations an opportunity to participate in a mentored research experience that would encourage them to choose careers in minority and health disparities research. The program provided didactic sessions taught by faculty from multiple departments in both the Georgetown University School of Medicine and the Graduate School of Arts and Sciences. Mentors for the interns' research experiences were also drawn from both schools and from the

Figure 1. Organizational Chart



multiple departments including Pediatrics, Oncology, Psychology, and Neurology. The program was designed in collaboration with faculty at Howard University based on a previously successful model they had implemented.

Community Engagement. To fulfill this objective, the CEHD developed a network of community based organizations, community health advocates, practitioners, and researchers and brought them together to build collaboration and identify areas for research on health disparities. The effort included a community engagement conference whose outcome was a collaborative cross-institution initiative with the Georgetown-Howard Universities Center for Clinical and Translational Science to create a community scholars program. The program was designed to co-train community representatives and researchers with a series of webinars on topics to build collaborative research efforts.

The Case Study Question and Study Participants

Having noted that there were many examples of successful collaboration within the CEHD and recognizing the crosswalk between successful collaboration and leadership, the focus of this exploration was to understand the role of collective leadership in these successful collaborations within the CEHD. The data reported in this paper was collected as a routine part of quality improvement for the Center.

In the governance structure of the CEHD the Executive Committee represented the core of collective leadership for the center. This cross sector leadership team was composed of the two Principal Investigators and the core leaders for administration, research, training, and community engagement. These five individuals (PI's overlapped with other areas) were homed in four different departments at two different academic institutions. They were deemed the most relevant members of the center to participate in this exploration. All agreed to participate in an individual leadership assessment that would form the basis for understanding the role of collective leadership in the success of the center.

Measure Used

The instrument chosen for the assessment was the Leadership Practices Inventory (LPI) which measures the behaviors related to the conceptual framework on the intersections between leadership practices and elements of successful collaboration previously discussed in this paper. The LPI is an especially useful tool because, according to its authors (Kouzes & Posner, 2007), it enables individuals and organizations to measure their leadership competencies and act on their discoveries. It is a learning tool as much as it is an assessment with over 30 years of empirical research to support its approach (Kouzes & Posner, 2007).

With regard to the psychometric properties of the LPI, particularly its validity,

- factor structures consistent with the five subscales of the LPI have been reported in a variety of organizational settings (Posner, 2016)
- concurrent validity has demonstrated a strong relationship between leaders' effectiveness and their leadership practices (Posner, 2016), and
- discriminant analysis differentiated high and low performing managers beyond the .001 level of chance probability (Posner, 2016).

The LPI is composed of a total of 30 items representing six behavioral statements in each of the Five Exemplary Practices areas: Model the Way, Inspire a Shared Vision, Challenge the Process, Enable Others to Act, and Encourage the Heart. Individuals rate themselves on each of

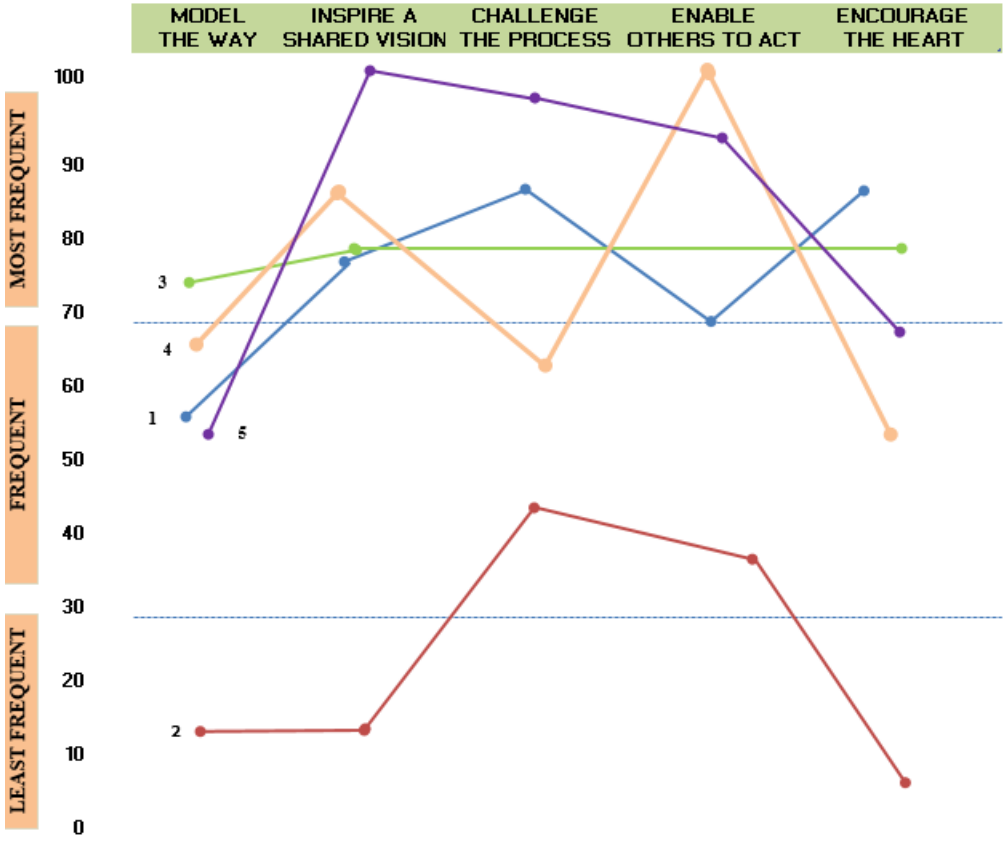
the practices with respect to frequency of evidencing the practice or behavior using a scale of 1 (almost never) to 10 (almost always).

The LPI is self-administered and requires no special training for use. Directions are self-explanatory. Scoring is done electronically and a profile is generated for each inventory. There is a Self and Observer form. They are identical. When used as a 360 process, individuals select appropriate observers to complete the form. In this study only the Self form was used because of time and administrative constraints.

RESULTS

To understand if and how the range of leadership practices manifest within the CEHD leadership team, scores on each of area of practice were plotted for each team member on each of the five leadership dimensions. Figure 2 illustrates the percentile ranking for the five key members of the cross-sector leadership team for the five exemplary practice areas.

Figure 2. LPI Percentile Ranking of Executive Committee Members



Using the 85th percentile or above and the Most Frequent Zone as markers of significant evidence of a given leadership exemplary practice, the leadership group collectively showed the pattern described in Table 4.

Table 4. Exemplary Leadership Practices of the CEHD Cross Sector Leadership Team

Exemplary Leadership Practice	Number of Members 85th Percentile or Over	Number of Members Frequent Zone
Model the Way	0	1
Inspire a Shared Vision	2	4
Challenge the Process	2	3
Enable Others to Act	1	4
Encourage the Heart	1	2

In considering the relationship of the leadership behaviors exhibited by the team to the three areas for successful collaboration—evolving a shared vision and goals, capitalizing on diversity of motivation and perspective, and establishing supportive governance—the following Tables 5-7 summarize the relevant team responses to the specific related items on the LPI. For each area of successful collaboration, no one member of the Executive Committee reported demonstrating high levels for all of the leadership behaviors that would support that key component. For, example, in the area of evolving a shared vision, important behaviors such as build consensus and common values and share an exciting dream of the future, only two of the five members of the reported high level frequency (See Table 5). Tables 6 and 7 illustrate similar patterns of a spread of needed leadership behaviors across the Executive Committee for the other two areas for successful collaboration, but with no one or even two reporting high frequency for all of them. On the other hand, when one considers the collective capacity of the five participants representing the Executive Committee all behavioral practices are noted at a high frequency level.

Table 5. Evolving Shared Vision and Goals Frequency of Behavioral Practices

LPI Item #	Behavior/Practice	Executive Committee Members				
		1	2	3	4	5
1	Set a personal example			*	*	*
2	Discuss future trends			*	*	*
7	Describe a compelling image of future			*	*	*
12	Share an exciting dream of the future	*				*
27	Speak with conviction about higher meaning of the work	*		*	*	
20	Publically recognize commitment of others	*		*		*
21	Build consensus and common values	*				*

* =A score of 10 (Almost Always) or 9 (Very Frequently)

Table 6. Capitalizing on Diversity of Motivation and Perspectives Frequency of Behavioral Practices

LPI Item #	Behavior/Practice	Executive Committee Members				
		1	2	3	4	5
12	Share an exciting dream of the future	*				*
3	Seek out challenging opportunities				*	*
8	Challenge others to try new and innovative ways	*		*	*	*
13	Reach outside the formal organizational boundaries	*	*	*	*	*
18	Ask "what can I learn" from the unexpected	*	*	*		
28	Experiment and take risks	*				*
9	Actively listen to diverse points of view	*	*	*	*	
14	Treat others with dignity and respect	*		*	*	*
29	Ensure people grow in their jobs	*		*	*	*
10	Show confidence in the ability of others			*	*	*

* =A score of 10 (Almost Always) or 9 (Very Frequently)

Table 7. Establishing a Supportive Governance Frequency of Behavioral Practices

LPI Item #	Behavior/Practice	Executive Committee Members				
		1	2	3	4	5
6	See that others adhere to agreed standards and principles			*		
11	Follow through on promises and commitments	*		*	*	*
26	Show clarity about philosophy of leadership			*	*	*
4	Develop cooperative relationships with others			*	*	*
9	Actively listen to diverse points of view	*	*	*	*	
14	Treat others with dignity and respect	*		*	*	*
19	Support decisions others made on their own				*	*
24	Give freedom of choice in how to do work	*	*	*	*	*
29	Ensure people grow in their jobs	*		*	*	*
5	Praise others for a job well done	*		*	*	*
15	Reward others for their contribution to projects	*				
25	Find ways to celebrate accomplishments	*		*	*	
30	Give team members appreciation and support for their contributions	*		*	*	

* =A score of 10 (Almost Always) or 9 (Very Frequently)

DISCUSSION

Addressing health disparities requires the expertise, skills and perspectives of a broad array of partners working collaboratively to find new knowledge and new approaches to improving health and healthcare access for populations affected by health disparities. As noted previously in this paper, successful collaboration can be characterized by three key elements: evolving a shared vision and goals, capitalizing on diversity of motivation and perspectives, and establishing a supportive governance/ management structure. The leadership practices needed within a team to implement those successful elements has been explored within the framework of the Kouzes and Posner (2007) model. A case study of CEHD in the District of Columbia, a successful collaboration among universities, schools, departments and with broad community representation, was presented to illuminate the importance of collective leadership in such efforts to assure the full range of leadership practices within the team. The self-assessment of leadership practices within the leadership team of this collaborative effort demonstrated that while across the team there was the array of leadership practices needed to support successful collaboration, no one team member reported high frequencies of all practices. It was the collective profile of behaviors that aligned with the elements needed for successful collaboration.

Limitations of the study include the fact that the LPI is typically administered in a 360-degree assessment process rather than just as a self-report measure. Because of time constraints, the LPI was only self-administered in this exploration. A follow-up study could include the participation of observer completion of the inventory for each participant to get a deeper understanding of the leadership behaviors of the team members. This also would be an opportunity to see if the feedback from the inventory prompted any changes in leadership behaviors. Since the LPI is a behaviorally based inventory that can be used by participants to expand their leadership behaviors, it can be used as a coaching opportunity in team science settings

Importantly, because in this study no observer ratings were available, it is important to understand the potential variance if such observations had occurred. There have been equivocal findings about the differential between observers and the participant ratings (Grafton, 2008; Rozeboom, 2009) and whether individuals rate themselves higher than others who rate them. Assuming that individuals might over estimate their level of practice due to the social desirability of the items presented, however, the conclusion that it required multiple team members to assure the presence of all needed practices is not negated. In this study, many practices were rated as below the optimal level by team members.

The utility of the LPI in understanding the leadership capacity of a health disparities team is only one benefit of implementing it in any team science setting. Because it is intended to be used as a vehicle for self-awareness and behavioral change and because it is designed to measure strength of exhibiting specific leadership behaviors, it is an excellent coaching tool. Health disparities collaboration efforts could be enhanced by administering the LPI in its 360 format and providing feedback/coaching as needed to improve program performance.

CONCLUSION

Leadership capacity of team members in collaborative efforts to address health disparities is a critical area for further study. While an array of leadership practices is needed to succeed in collaborative efforts, no one leader will embody all the behaviors needed. Thus there needs to be more of a focus on this set of skills and how it is assessed and how it is considered in choosing

team members for collaborative efforts. Subject expertise alone may not lead to a balanced team that can effectively implement the three critical elements of successful collaboration—there also needs to be attention given to the issue of leadership behaviors and practices. The implications of this study suggest the need for further study of the role of collective leadership in health disparities initiatives and the effect of interventions to improve leadership behaviors in settings where such leadership is not optimal.

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