# Leadership Approaches in Inter-Sectoral Community Health Partnerships

By

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## ABSTRACT

Peyton Neil Williams: Leadership Approaches in Inter-Sectoral Community Health Partnerships
(Under the direction of Anna Schenck)

Inter-sectoral public-private community health partnerships (herein "partnerships") are increasingly popular in public health, linking private and public partners in communities to tackle some of the "wicked problems" in public health requiring collective efforts to solve. These partnerships however are very different from traditional hierarchical organizations. Since membership in partnerships is voluntary, and the individual members maintain their autonomy, partnership leaders lack the same formal authority they wield in traditional organizations.

This paper answers the question, "What are the leadership approaches needed in public health partnerships?" Through a scholarly investigation five main themes emerged in the literature: Create an open decision-making process, balancing perceived costs and benefits, good interpersonal skills, power sharing, and keeping focus on the vision.

These five themes are investigated with implications for leaders discussed.

To my father, Larry Williams, who left our embrace to be held by God only months before he could see me finish this endeavor.

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# CHAPTER 1: INTRODUCTION

Winslow (1920), nearly a century ago, argued that public health involved "…organized community effort for the sanitation of the environment, the control of community infections, [and] the education of the individual in principles of personal hygiene…." Public health has also accepted as an article of faith that the full spectrum of determinants of health cannot be addressed in only the doctor's office. Health status is affected at multiple levels of the social ecological model, spanning the individual, interpersonal, community, societal and policy levels (Golden & Earp, 2012; Sallis, Owen, & Fisher, 2008).

An example involving walking for health is illustrative. Walking has been demonstrated to improve cardiovascular health and literature recommends physicians recommend walking to inactive patients (Murtagh, Murphy, & Boone-Heinonen, 2010). At the individual level a patient decides for themselves, after weighing the perceived costs and benefits of walking, whether or not to walk to improve their health. At the interpersonal level there are one-on-one exchanges and exertions of social control. For example, a physician or person important to the patient may encourage the patient to walk for better health. At the broader community level are factors such as safety of walking in the community (crime, traffic) and the availability of sidewalks in the patient's neighborhood (Saelens, Sallis, & Frank, 2003).

Implicit in the social ecological model is the notion that, in order for interventions to be effective, multiple levels of the social ecological model must be activated to effectuate positive outcomes in health (Golden & Earp, 2012). Yet for the average

citizen these interventions at the community level are difficult, if not impossible, to implement unilaterally. A doctor may successfully prompt a patient to walk to improve their cardiovascular health; however, if the patient lives in a neighborhood that does not have sidewalks or is unsafe, this intention to walk may never be translated into action.

This raises an obvious question: How does society work together collectively to solve this and other difficult public health issues, fulling Winslow's call for "organized community effort?"

An answer can partially be found in inter-sectoral private-public community health coalitions and partnerships (herein "partnerships"). These are voluntary collaborations between private and public entities aggregating their fiscal, intellectual, and other resources towards a common vision of solving complex public health challenges in their community (Butterfoss, Goodman, Wandersman, & others, 1993; Weiner & Alexander, 1998), such as improving the walkability of neighborhoods to promote walking.

Just as solving public health issues in communities is complex, so too is leading these partnerships (Zukoski & Shortell, 2001). Often misunderstood, by both members in partnerships but also funders, is the difficultly in marshalling a group of disparate stakeholders to solve many of the problems of public health (Shortell et al., 2002). Leaders in these partnerships lack the same formal authority common in traditional organizations. They don't have the ability to use sanctions or give or withhold incentives based on performance like a leader (such as a CEO) would enjoy in a traditional company (Alexander, Comfort, Weiner, & Bogue, 2001). Members in the partnerships may have competing interests and turf issues with other members. (Alexander et al.,

2001). Failure rates of partnerships can be high, with research suggesting up to half fail within their first year (Kreuter & Lezin, 1998; in Corbin & Mittelmark, 2008).

A theme the reverberates in the literature is that leadership can be the most important factor determining if a coalition will be successful (Baker, Wilkerson, & Brennan, 2012; El Ansari, Oskrochi, & Phillips, 2010; Kegler, Steckler, Mcleroy, & Malek, 1998; Mitchell & Shortell, 2000; Weiss, Anderson, & Lasker, 2002; Zukoski & Shortell, 2001) and that it predicts member satisfaction (Kegler et al., 1998). Leadership is the "capacity to translate a vision of the future into reality" but, unfortunately, trained and adept leaders to lead partnerships are scarce in public health (El Ansari et al., 2010).

This paper was written to guide leaders of nascent and established partnerships understand approaches necessary to leading. Through a scholarly investigation using a literature review, I aimed to answer, "What are the leadership approaches needed in public health partnerships?"

In this paper, "leaders" refers to those who lead partnerships. These leaders are typically elected among the members but, as noted later, do not have a formal authority wielded by a leader in a traditional hierarchical organization. A partnership may also have more than one leader; for instance, there may be leaders of committees in addition to the partnership-wide leader. Even partnership-wide leadership may be shared by co-leaders.

## CHAPTER 2: BACKGROUND

### History

In her seminal text on community health partnerships, Butterfoss (2007) tracks community organizing in the United States back to at least to the 1800s as figures, such as abolitionist Frederic Douglas and feminist Susan B. Anthony, worked towards improving the human condition.

In 1955 the United Nations first used the neologism “community development” in describing a movement to use the community as the primary vessel for improving the economic and social conditions of the community (Butterfoss, 2007; United Nations, 1955). Butterfoss (2007) proffered the following assumptions underpinning community development in the 1950’s which also underpin the health partnerships’ *raison d'être* today:

- It assumes the community itself, rather than an external hand, can best identify and remediate the issues in the community; thus, the community should build the capacity to solve issues in their community.
- Members of the community should have an active voice in what happens in their community.
- Changes and activities with their genesis from the community, rather than an external hand, are more resilient and lasting.
- Holistic, coordinated approaches to problem solving are better suited than disparate, uncoordinated responses.
- Skills within the community should be developed and learned to solve community issues.

The use of community development to create partnerships dealing with health issues *per se* began gaining popularity in the late 1980s and early 1990s as the U.S. Centers for Disease Control and Prevention (CDC) actively encouraged communities to form health partnerships in their "Planned Approach to Community Health." (Butterfoss, 2007; Green & Kreuter, 1992) The premise of partnerships is that factors influencing health were exogenous to the individual, and community-wide efforts were needed to improve the public's health (Butterfoss, 2007).

**What are Partnerships and their Characteristics?**

While scholars have penned many definitions of a partnership, Butterfoss (2007) looks to Mattessich Murray-Close & Monsey for the most commonly accepted definition in her view:

> *"A mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals. The relationship includes a commitment to a definition of mutual relationships and goals; a jointly developed structure and shared responsibility; mutual authority and accountability for success; and sharing of resources and rewards." (Mattessich, Murray-Close, & Monsey, 2001, p. 7)*

Coalitions and partnerships can be found in a variety of social spaces (such as advocacy groups and business coalitions) but all have five common characteristics, both positive and negative, as defined by Rosenthal (2000). First, a partnership is a "shared creation" created for the common benefit of all partners where they work together towards a shared vision. Second, once the partnership becomes more established, both interdependence and reciprocity develops among partners. That is, the partners become dependent on each other to work together for helping the

community while, at the same time, expecting a semblance of balance between the costs and benefits of being in the partnership. Third, there is a "mutual authority and accountability." Through social control, partners exert influence over each other to be accountable to the partnership at the risk of losing credibility in the partnership and broader community. Fourth, partners share jointly in both the risks and rewards coming from the partnership. No one partner assumes risks for failure but, in theory at least, the partners jointly take credit for successes. Finally, partnering brings conflict and tensions. Partners may represent overlapping sectors in competition with each other and partners may have historical issues with other partners (Rosenthal, 2000).

While these five characteristics are common to all partnerships, Weiner & Alexander (1998) and Alexander et. al (2001) go on to define six distinguishing characteristics of *health* partnerships specifically:

- **Voluntary-based collaboration with no hierarchical control** – Leaders in partnerships have no formal authority over members and cannot exert control over partners' actions. Partners are autonomous agents, free to pursue their own self interests. As discussed later in this paper, this presents challenges for leaders of these partnerships.
- **Are multi-sectoral** – Members in partnerships come from wide range of industries. They typically include a public partner, such as the local health department or department of social work, and private partners. Private partners can include a community hospital, local community-based organizations (CBOs) or even private citizens. For some partnerships, there is no "litmus test" to

membership; any interested party can join the partnership, whether they bring expertise or not, or whether than bring the community or their own self-interests to the table.

- **Combine two types of networks** – Partnerships combine two types of networks. First networks of public and private stakeholders focusing specifically on planning and public health, and a second type of network focusing on delivering services. The goal of a partnership is to combine these networks types to create a seamless continuum of care for community members.
- **Disparate levels of commitment and resources among partners** – The partners arrive with varying levels of commitment and resources they can contribute. A partner may only be in the partnership because someone from their home organization asked them to represent the organization or because they feel pressured by peers to be a member and may have little desire to work on partnership activities. Partners also bring different levels of resources. A hospital, for instance, may be able to fund grant money to the partnership for an initiative whereas a smaller partner could not. This has the possibility of creating asymmetries in perceive power among partners as discussed later. There may be also asymmetries in intellectual capital. One partner, such as a health department or hospital, may have better understanding of public health issues, such as the social determinants of health or how to conduct a community assessment, than other organizations.
- **Use a comprehensive approach** – Unsurprisingly, since public health is their foundation, health partnerships cast a wide net across the ecological model when

working on public health issues in a community. They also work with their partnership base to create a seamless continuum of care for community members. They focus their activities on prevention and early detection of diseases, as well as health behavior interventions aimed at the community.

- **Exist to benefit the community – and the partners** – While partners pool resources towards the shared vision of improving community health, this does not mean the partnerships don't also need to create value for the partners themselves. As discussed later, an imbalance between costs and benefits of being in a partnership can cause members to leave.

**Why do Members join Partnerships?**

Motivations for joining a partnership vary between partners, from altruistic reasons to those less so. Shortell et al. (2002) suggests three main reasons:

- **Instrumental**: Will the partnership help the organization achieve their goals? Partners join in order to create synergies.
- **Legitimacy**: Will the partnership make the organization look more credible?
- **Altruistic**: Will the partnership help the community? Partners join because it's the "right thing to do."

Leaders should understand the varying motivations for engaging in partnerships. A leader may be in a partnership because they believe it's the right thing to do for the community; however, they should not assume all partners enter with the same motivations.

While the leader may find less altruistic reasons unpalatable, they can use these varying reasons as opportunities to motivate partners. An example provided by Shortell et al. (2002) is illustrative. Imagine a community hospital joins a partnership to help augment community-based preventive services in the hopes this will ultimately decrease the utilization of their emergency department (an instrumental reason). If this does not materialize, and the hospital questions the value of their participation in the partnership, the leader could note how their abandonment of the partnership would look to others (legitimacy reason) or simply appeal to how their participation is the right thing to do for the community (altruism).

## Differences between Partnerships and Traditional Organizations

Before discussing the approaches needed for leading partnerships, it is helpful to step back and first understand how partnerships differ from traditional organizations (such as CBOs or corporations). Below I discuss some of the key differences noted in the literature followed by a summary in Table 1.

### *A Tenuous Authority*

Leaders of partnerships will typically come from a traditional, hierarchical, organization. That is, they come from an organization with a clear power structure where roles and rank are clearly defined. Within their organization they have a clear authority, whether this be an individual or a board of directors, to whom they answer. Additionally they may also have formal authority over other staff within their home organization (Alexander et al., 2001).

When arriving from their home organization and into the partnership, a partnership leader will be met by a very different structure. The leader will likely notice the formal authority they experienced in their home organization does not exist in the partnership (Alexander et al., 2001).

Leaders in partnerships only hold, what Alexander et al. (2001) describe as, “tenuous authority”. Partnership leaders lack the same formal levers to pull that may be available to them in their home organization. For example, leaders in traditional organizations have the ability to hire and fire staff (Alexander et al., 2001). A leader in traditional organizations can hire staff they feel meets the best interest of their organization, or would be most loyal to them. They can also give financial incentives to employees who are performing well. Leaders in traditional organizations can also fire underperforming employees or levy financial disincentives (such as a pay decrease). In contrast, partnerships are voluntary collaborations. Leaders have no formal authority to admonish partners or levy administrative penalties. Leaders cannot unilaterally decide to remove members from a partnership. All partners are autonomous and do not subordinate authority to the partnership or partnership leadership (Alexander et al., 2001).

### *Coordination of Resources and Turf Issues*

In a traditional organization, especially larger ones, it may not be uncommon for different business units to have overlapping interests. These strategic business units (SBUs), however, are fully or at least partially owned by a parent organization. When SBU interests overlaps, the parent organization and CEO have the authority to

determine which SBU should subordinate interest to another for the sake of efficiency to the larger company. A CEO thus has the authority to quickly, unilaterally, and decisively, remediate any turf issues arising between SBUs (Weiner & Alexander, 1998).

Leaders of a partnership do not have this authority, however. As a voluntary organization, the assets of the partnership are not owned or directed by any one leader. While a partner may allow the partnership to use its resources, the partner themselves has complete ownership of said resources as separate legal entities “capable of plotting their own destiny” (Weiner & Alexander, 1998). Weiner and Alexander (1998) note an important distinction: “While the partnership governing body may possess legitimate authority (either by statute or by consent) to define and interpret the interests of the *partnership*, it does not have legitimate authority to define and interpret the interests of the *partner organizations*.”

In traditional organizations, coordination is effectuated by contracts and formal authority of leadership (Weiner & Alexander, 1998). In partnerships, lacking authority, coordination and cohesion is achieved through various means including *social control*. Social control is the creation and enforcement of norms and standards of behavior by peers through mechanisms including shame, coercion and force (Carmichael, 2012). In the context of a partnership this may involve fearing negative perceptions of fellow partners. Coordination is also met through *mutual dependency* which is “the existence of bilateral dependencies in the dyad, regardless of whether the two actors’ dependencies are balanced or imbalanced" (Casciaro & Piskorski, 2005). As partnerships mature, partners increasingly rely on each other and mutual dependencies form (Rosenthal, 2000).

### *Business norms*

Finally, business norms in a partnership are likely different than a traditional organization (Hearld, Alexander, Bodenschatz, Louis, & O'Hora, 2013). Traditional organizations may be more likely to have well-defined business processes, such as accounting systems, procurement, human resources, than a partnership which may be more likely to have a more modest infrastructure.

*Table 1: Comparison of Traditional Organizations vs. Partnerships*

| Traditional Organization | Partnership |
|---|---|
| • Formal authority. Clear power to set agendas and allocate resources.[1] | • Tenuous authority. More limited means to set agenda and resolve conflicts.[1] |
| • Leadership directs competing parts of organization towards shared goal. [2] | • Turf issues between partners. [2] |
| • Coordination using formal authority, contracts and financial penalties and awards. [2] | • Coordination through social control and mutual dependency. [2] |
| • Formalized business norms. [3] | • Informal business norms. [3] |

([1]Alexander et al., 2001; [2]Weiner and Alexander, 1998; [3]Hearld et al., 2013)

## CHAPTER 3: METHODS

Below I discuss the methods used for the literature search. First I describe the methods used to find literature, followed by methods used to abstract and synthesize the literature.

### Literature search methods

Three main concepts were selected to establish search criteria to identify literature related to the research questions: Partnership (to find literature focused on coalitions), leadership (to find literature related to leading and governing), and public health (to find literature dealing specifically with partnerships in public health, and not others such as grassroots political groups).

Using these concepts I first conducted a search on PubMed to find if these concepts were linked to Medical Subject Headings ("MeSH" terms). MeSH terms are established vocabulary words by NIH to create a consistency in tagging keywords to articles (NIH, 2015). After searching I found all three concepts were linked to a MeSH term by NIH (see table 2). In addition to the MeSH term, I also used synonyms similar to the concept to ensure as much relevant literature that was available would be detected in the search.

*Table 2: Search terms used*

| Concept | Synonyms | NCBI MeSH terms |
|---|---|---|
| Partnership | Coalition | "Public-Private Sector Partnerships"[Mesh] |
| Leadership | Governance | "Leadership"[Mesh] |
| Public Health | Community health | "Public Health"[Mesh] |

Both the MeSH terms and synonyms were used for searching using following search query:

> *("Coalition"[All Fields] OR "Partnership"[All Fields] OR "Public-Private Sector Partnerships"[Mesh]) AND ("Leadership"[Mesh] OR ("Governance (Oxf)"[Journal] OR "governance"[All Fields])) AND ("Public Health"[Mesh] OR "community health"[All Fields]) AND ("1990/01/01"[PDAT] : "3000/12/31"[PDAT])*

The following search criteria were also used:

1. Article was in English.
2. The full text of the article was available.
3. The article was written in 1990 or after.
4. The article was focused on leadership *within* in private-public coalitions, and not leaders external to these partnerships (e.g. funders).
5. The article was focused on leadership in partnerships working specifically on public health issues.
6. The article was peer-reviewed.
7. The article was focused on U.S. domestic partnerships.

An initial search in PubMed on February 11, 2017 found 378 articles. These initial entries were reviewed item-by-item and articles were cut if the title suggested no salience to the research question[1]. This method culled the 386 articles to 39. After these

[1] Examples of excluded titles include: "G7 Health Ministers' Kobe Communiqué"; "Is health impact assessment useful in the context of trade negotiations? A case study of the Trans Pacific Partnership Agreement"; "Control and support: what physicians want from hospitals"; and "The road to smoke-free legislation in Ireland".

initial 39 articles were selected, the abstracts for each article was further reviewed and 21 articles were retained. Articles were excluded if the abstract suggested the article did not meet one of the seven search criteria noted above or did not address the research question. Six of these 21 articles were later removed for being international in scope and 3 were removed for not being relevant, leaving 12 articles.

When reviewing the initial 12 articles from PubMed I discovered a reference in Weiner et al (2002) referencing a prior study conducted by the team in *Nonprofit Management and Leadership*, a journal PubMed does not index. Anticipating this journal could provide salient articles, an additional search was conducted in Google Scholar[2] to search only this journal, since 1990, using the following search term:

> *(coalition OR alliance) AND (leadership OR governance) AND ("public health" or "community health")*

This search in Google Scholar found 10 articles. Six articles were discarded due to not being relevant based on their title[3]. Of the remaining four, one additional article ("Measuring leadership in multisector health care alliances") was focused on developing a survey for measuring aspects of leadership, rather than an investigation of leadership approaches. Three articles were retained from a Google Scholar search of *Nonprofit Management and Leadership.* In total, 17 articles were reviewed (see figure 1).

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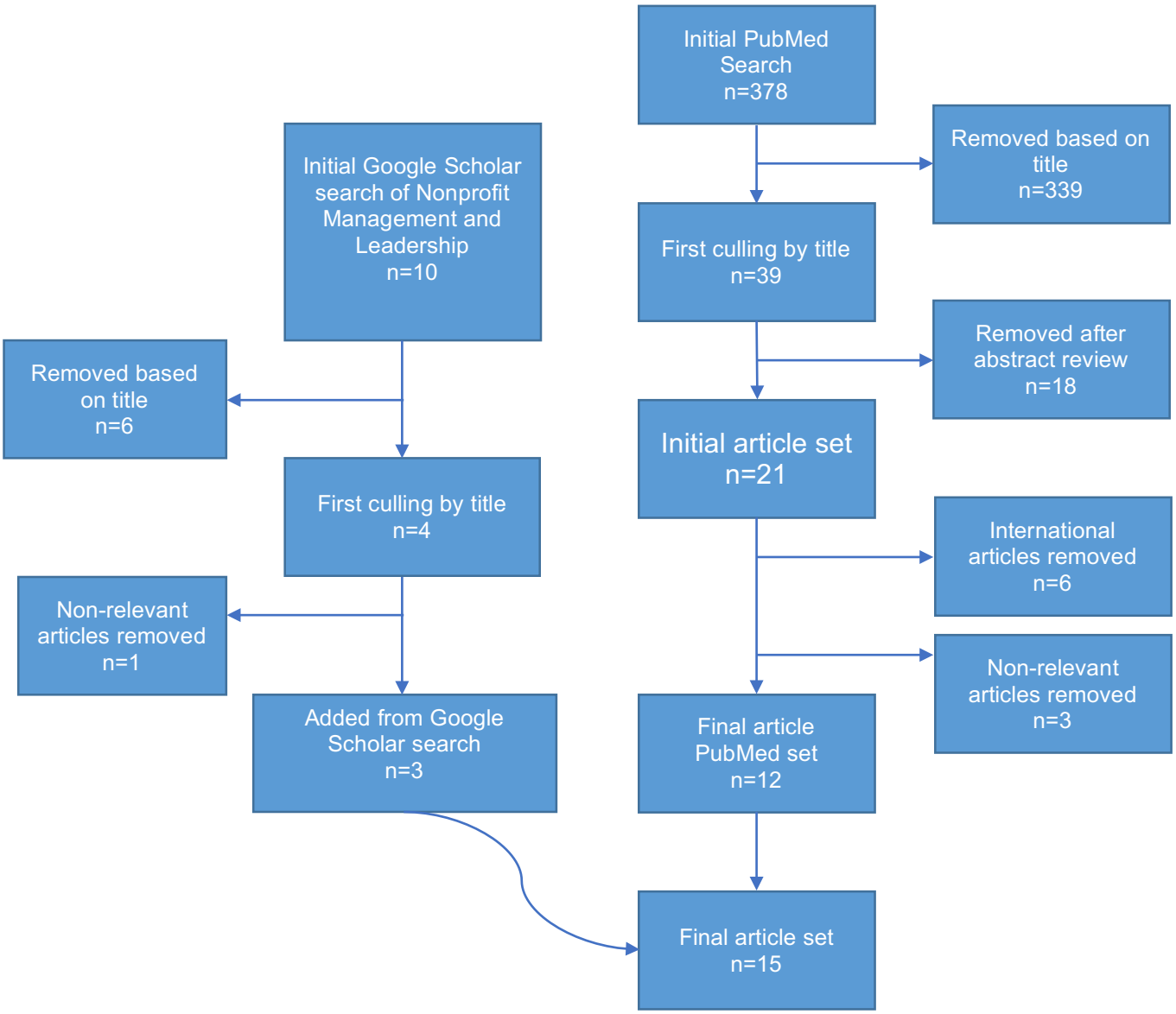
[2] Google Scholar was used rather than the journal's website due to the former having a more sophisticated search tool.

[3] Examples of excluded titles include: "Merger as a strategic response to government contracting pressures"; "Performance evaluations of for-profit and nonprofit US hospitals since 1980"; and "Positive and negative effects of external influences on program design".

*Figure 1: Search of leadership in public health partnerships, 1990 to present.*




**Abstraction Methods**

The 17 articles were read and then summarized into a matrix. The matrix included a column for the article name, lead author, year published, journal and key findings. The key findings section tracked findings related to the research question. In

the key findings section a common taxonomy was devised to make a qualitative synthesis between articles more manageable. For example, some authors used different words and terminology to describe similar concepts; for my review, I used a common vocabulary to facilitate synthesis. The full data table created from the articles is included as in Appendix A. Key findings are summarized in the next chapter.

# CHAPTER 4: RESULTS

> *"All happy families are alike; every unhappy family is unhappy in its own way."*

Tolstoy's opening line from *Anna Karenina* observes that creating family harmony is very difficult, requiring a favorable alignment of many factors, but success looks similar across families. Discord though is very easy and every family finds its own way to fail. Emanuel (2002) reflected on this quote as being valid to understanding what makes partnerships work. Partnerships, he said, that succeed all have common features making them successful, but unsuccessful ones find their own ways to fail. Unquestionably, having the proper approach to leadership is a crucial part of making a coalition successful, but what are the ingredients to successful leadership?

Below are leadership approaches for cross-sectoral partnerships noted in the literature. Results are ordered first on the theme that emerged most frequently in the literature (creating an open decision-making process) and ending with the theme least frequently mentioned (power sharing). In total, I identified from the literature five main approaches to leadership of cross-sectoral partnerships.

## Creating an Open Decision-Making Process

As noted earlier, partnerships are inter-sectoral and incredibly diverse, bringing together a panoply of partners from diverse business cultures and organizations. This diversity is an asset but also Achilles' heel of partnerships. For leaders, creating consensus in partnerships can be difficult as the members bring competing and diverging interests and goals to the partnership (Tsasis, 2009; Hearld et al., 2013). In

this section I discuss one way to create consensus in the face of this pied assortment of partners.

### *Empirical Data*

For the leader, one strategy for creating consensus, backed by empirical data, is through creating an open decision-making process in the partnership. Three papers (Hearld et al., 2013; Metzger, Alexander, & Weiner, 2005; Weiner, Alexander, & Shortell, 2002) in the literature review specially addressed decision-making openness and fairness[4].

In a mixed-methods analysis, Hearld et al. (2013) conducted quantitative and qualitative research to understand how a partners' perception of fairness in decision making affects perceived level of consensus in the partnerships' *vision* and *strategies*[5]. Hearld et al. (2013) defines consensus as "the perceived level of agreement among alliance members." They further distinguish between two types of consensus: vision and strategy. *Vision* is the "sense of purpose" for partnership, its ethos guiding why it exists and what it hopes to accomplish. Thus, *vision consensus* creates a "shared identity" among partners and creates a compass to guide the collective consciousness of the partnership towards a **common** vision. *Strategy* is the methods and means a partnership uses to reach its vision. *Strategy consensus* is agreement among partners with how the partnership is realizing its vision (Hearld et al., 2013). Using a cross-

[4] Of note two papers, Weiner et al (2002) and Metzger (2005), both used data from the same data set in separate analysis done by the researchers.
[5] Hearld also examined the effect of the perceived fairness of the distribution of benefits and costs on vision and strategy consensus in this same study. This is discussed later.

sectional survey, Hearld et al. (2013) conducted two separate surveys with 745 members of partnerships. From the quantitative data the team found the following:

- A more *inclusive* decision making process was positively associated with perceived vision consensus. (OR = 1.86, 95% CI =1.30-2.57)
- Perceived fairness in both decision-making *transparency* (OR 1.52, 95% CI = 1.27-1.82) and *inclusiveness* (OR 1.63, 95% CI =1.17-2.27) were positively associated with strategy consensus.

Both Weiner et al. (2002) and Metzger et al. (2005) find evidence supporting decision-making fairness. They analyzed data from a cross-sectional self-administered survey with 433 respondents who were members of partnerships funded by the Community Care Network (CCN) Demonstration program. Twenty-five partnerships were funded nationally and survey data were collected for members of all 25 partnerships.

From the CCN data, Metzger et al. (2005) used path modeling to investigate how three governance leadership variables (openness of decision making; collaborative decision-making process; and empowering leadership style) affected vision consensus[6]. *Openness of decision making* was defined by the authors as incorporating "clear and unambiguous standard procedures for decision making" that were often available in written form. *Collaborative decision-making* enshrines "[w]illing cooperation, honesty,

[6] The authors also investigated other dependent variables, including participation costs and participation benefits, which are discussed later. Unlike Herald (2013) the authors did not investigate strategy consensus as a dependent variable.

truth, and free sharing of ideas…." Finally an *empowering leadership style* was defined by the authors as "leadership that seeks out and utilizes the views, skills, and expertise of all coalition members and provides ample praise and recognition of their contributions." Metzger et al. (2005) found vision consensus was positively associated with all three governance and leadership variables.

Also from the CCN data, Weiner et al. (2002) found the perceived clarity of decision making and perceived level of personal influence[7] were associated with perceived procedural fairness in the partnership, partners' satisfaction with decisions, partners' personal engagement in the partnership, and finally, organization integration into the partnerships vision and strategy. A summary of the findings across the three papers can be found in Table 3.

[7]The authors also noted a third important independent variable, collaborative conflict decision making, that is discussed later.

*Table 3: Summary of Leadership Approaches to Decision-Making*

| Author | Having this approach… | Increased this outcome… |
|---|---|---|
| Hearld et al. (2013) | • A more inclusive decision-making process. | • Vision consensus. |
| | • Perceived fairness in both decision-making transparency and inclusiveness. | • Strategy consensus. |
| Metzger et al. (2005) | • Open decision making, collaborative decision-making and empowering leadership. | • Vision consensus. |
| Weiner et al. (2002) | • Perceived clarity of decision-making.<br>• Perceived personal influence in decision making. | • Perceived procedural fairness.<br>• Partners' satisfaction with decisions.<br>• Partners' personal engagement in the partnership.<br>• Organizational integration into the partnerships vision and strategy. |

In qualitative interviews with members of partnerships in four counties of North Carolina, Parker et al. (1998) heard from members that having a clear governance decision-making process was vital for functioning. One quote from a partner is illustrative:

> *"Having the governance structure in place, I think, it's an important milestone… Without the governance structure we had not structure or format….It's hard to make decisions collectively. It's easier to make decisions [with a decision-making framework], easier to organize the structure of the coalition." (Parker et al., 1998)*

**Balancing Perceived Costs and Benefits**

A partner's involvement in a partnership carries an inherent number of costs and benefits to their membership. Butterfoss (2007; 1993), Kramer (2005) and El Ansari (2004) delineate a number of costs and benefits associated with membership in a partnership (see Table 4).

*Table 4: Benefits and Costs to Partners for Participation in a Partnership*

| Benefits | Costs |
|---|---|
| • Bettering personal skills. [1, 2, 3]<br>• Enjoying the work of the coalition. [1, 2]<br>• Appearing legitimate in their community, gaining respect. [2, 3]<br>• Receiving personal recognition. [1, 2]<br>• Networking with other partners. [1, 3]<br>• Sharing of information among partners. [1, 2]<br>• Access to pooled resources. [1, 3]<br>• Improving community. Being involved in a cause important to them and achieving results. [1, 3] | • Devoting time to partnership at expense to other activities. [1, 2, 3, 4]<br>• Devoting other scarce resources to partnership. [1, 2]<br>• Not having autonomy when making decisions with other partner members. [1, 2]<br>• Contending with unfavorable opinions of one's self held by other partners. [1, 2]<br>• Poor leadership direction. [1, 2]<br>• Not having skills necessary to contribute to partnership. [1, 3] |

[1]Butterfoss, 2007; [2]Butterfoss, Goodman, Wandersman, & others, 1993; [3]Ansari & Phillips, 2004; [4]Kramer et al., 2005

A clarion call to potential leaders is the consensus in literature that participation in a partnership will be higher as perceived benefits increase and perceived costs decrease. (Butterfoss, 2007; Butterfoss, Goodman, & Wandersman, 1996; El Ansari et al., 2010; El Ansari & Phillips, 2004; Metzger et al., 2005; Prestby, Wandersman, Florin, Rich, & Chavis, 1990; Shortell et al., 2002). When benefits are higher than costs,

members have greater satisfaction with the partnership (Butterfoss et al., 1993). There is no consensus about a “magic ratio” of costs to benefits, however, it is clear that the relative value of costs vis-à-vis benefits will drive participation in a partnership.

El Ansari claims there should be 60% more benefits than costs (El Ansari & Phillips, 2004). Weiner & Alexander (1998) disagree, asserting, given the social mission of partnerships, partners don’t expect “an exact equivalence of benefits” to costs. Partners do expect a balance between the costs and benefits, however. Weiner & Alexander (1998) poignantly note, "The good of the whole [partnership] cannot usurp the good of the parts [the partners], as it can in a hierarchically structured organization. Rather, what's good for the whole must also be good for the parts, even if imperfectly so.” Below are findings from Hearld et al. (2013), Metzger et al’s. (2005), Shortell et al. (2002) that speak directly to balancing costs and benefits.

***Empirical Data***

In addition to the above mentioned research from Hearld et al. (2013) on decision-making, the team also examined how the perceived fairness in the distribution of costs and benefits affected vision consensus and strategy consensus. They found a perceived fairness in the distribution of costs and benefits was positively associated with an increase in both vision consensus (OR = 1.94, 95% CI = 1.56-2.42) and strategy consensus (OR = 2.33, 95% CI = 1.91-2.86).

Analysis of the CCN data by Metzger et al. (2005), noted earlier, examined how the three leadership and governance variables (openness of decision making, collaborative decision-making process and empowering leadership style) also affected

participation benefits and participation costs. They found collaborative decision-making directly increased the perception of participation benefits and lowered the perception of participation costs. Additionally, they found empowering leadership decreased perceived participation costs, but did not increase perceived benefits. As noted above, the three leadership and governance variables (openness of decision making, collaborative decision-making process and empowering leadership style) all increased vision consensus, and, notably, vision consensus was demonstrated to increase perceived participation benefits and lower perceived participation costs. Thus all three leadership and governance variables also have an indirect effect on increasing the value of participation

Shortell and colleagues (2002) conducted quantitative research with partner members of CCN into how a partnerships' overall management capabilities (leadership, vision and management) affected the perception of benefits minus costs among partners. Leadership was measured through a composite of 17 scaled statements including "leadership makes members feel welcome," is "accessible to members," "gets things done," and "works collaboratively with partnership members." Vision was a composite of 4 scaled statements which included the partner's organization concordance between its and the partnership's mission and role, and if the partnership had a clear and shared vision. Management was measured through six scaled statements including if the purpose of agenda items are well defined and if people understand the role of partnership staff vs. members. Shortell et al. (2002) found the overall management capabilities of a partnership were positively associated with perceived benefits minus costs ($p<.001$). That is, as management capabilities

increased, or at least the perception of them, so too did the net value of participation. A summary of the findings across the three authors can be found below in Table 5.

*Table 5: Summary of Approaches to Balancing Perceived Costs and Benefits*

| Author | Having this approach or attribute… | Led to this outcome… |
|---|---|---|
| Hearld et al. (2013) | • Perceived fairness in the distribution of costs and benefits | • Increased vision consensus<br>• Increased strategy consensus |
| Metzger et al. (2005) | • Collaborative decision-making | • Increase perceived benefits<br>• Decreased perceived costs |
| | • Empowering leadership | • Decreased perceived costs |
| | • Vision Consensus | • Increase perceived benefits<br>• Decreased perceived costs |
| Shortell et al. (2002) | • Overall management capabilities (leadership, vision and management) | • Net increase of perceived benefits over costs |

**Interpersonal Skills**

The most important resource of any partnership is, without question, the partners themselves (Butterfoss et al., 1993; Metzger et al., 2005). Metzer et al. (2005) called participation by partners the “lifeblood” of a partnership. Collectively the partners pool their resources that are *sine qua non* for a partnership’s functioning. Contributions of partners can range from structural, such as providing meeting space, financial, such as funding a coordinator for the partnership, to intellectual, such as providing expertise in

fund raising and content expertise in a public health issue (Butterfoss et al., 1993). Without partners – and their active participation – partnerships fail to achieve a long-term success (Metzger et al., 2005).

Unsurprisingly then, the literature converges on the necessity of interpersonal skills for a leader (Kegler & Swan, 2012; Parker et al., 1998; Weiss et al., 2002; Wolff, 2001). Interpersonal skills are methods used by individuals to "achieve certain goals that include persuading, informing, comforting, challenging, and other modes of dealing with people." (Sullivan, 2009)

### *Empirical Data*

Kegler et al. (1998) conducted a cross-sectional survey with 430 members of North Carolina partnerships. Their research indicated the quality of communication between the coalition staff and members was positively associated (.73 Spearman rank order correlation, $p<.05$) with satisfaction with the partnerships work. Additional research from Kegler and Swan (2012) demonstrated leadership ($p < .001$) and communication ($p < .01$) positively influenced perceptions of social capital (networking, trust and norms of reciprocity).

In a separate quantitative study, Weiss et al. (2002) investigated how partnership synergy was associated with several independent variables, including leadership. *Partnership synergy* was the quality of how partnerships combined perspectives, knowledge and skills together among diverse members of a partnership to create a "whole that is greater than the sum of its parts." (Weiss et al., 2002) That is, the partnership has reached its full potential for collaboration. Leadership in this study was

measured by a 10-item scale[8], including five items addressing interpersonal factors: How well does the leader resolve conflict between partners; how well does the leader create an environment where partners feel comfortable speaking; inspire and motivate the partners; empower the partners; and, how well does the leader foster respect between partners. In their study, Weiss et al. (2002) found a positive association between effectiveness of leadership and partnership synergy ($\beta = .27$, $p < .05$) suggesting the importance of a leader's interpersonal skills for realizing the full collaborative potential of a partnership.

In a qualitative study Parker et al (1998) found that dealing with conflict in a partnership plays a role in how well the coalition functions. In some partnerships the leadership was remiss in acknowledging simmering tension between partners, possibly leading to larger future issues.

**Power Sharing**

Alexander et al., (2001), Shortell et al. (2002), and Wolff (2001) all arrive at the conclusion that leaders should share power. That is, leaders should distribute authority for making decisions among members of the partnership. Doing so creates a joint sense of ownership of the partnership among the partners (Alexander et al., 2001).

From a qualitative analysis, Shortell et al. (2002) described being a "subsidiary leader" (the practice of properly delegating) an important quality for leaders. When tackling public health problems, a leader should understand the strengths and

[8] The Cronbach's alpha internal consistency of the 10-item scale was .97.

weaknesses of their partners and delegate responsibilities appropriately to the partner closest to the problem. Wolff (2001) describes “collaborative leadership” where leaders share power, rather than using power to enforce a hierarchy. Wolff notes this definition from Chrislip and Larson (1994) that further explicates what a collaborative leader is:

> *“Collaborative leaders are sustained by their deeply democratic belief that people have the capacity to create their own visions and solve their own problems. If you can bring the appropriate people together . . . in constructive ways . . . with good information (bringing about a shared understanding of problems and concerns) it will create authentic visions and strategies addressing the shared concerns of the organization or community. The leadership role is to convene, energize, facilitate and sustain this process.” (Chrislip & Larson, 1994, p. 146)*

**Keeping Focus on the Vision**

The attentive reader will note vision has been a recurring theme in this paper. The vision represents the forging of partners’ abstract aspirations for the partnership into a reified statement of direction. It encapsulates what the partnership wants to become in the future and gives reason to the collective efforts of the partnership (Alexander et al., 2001). Leaders should leverage this vision fully when creating and implementing strategy.

***Empirical Data***

In the vision-setting process, leaders have an important role in creating a clear and inclusive decision-making process for vision setting. Metzger et al. (2005) found when partners felt they had a substantive role in defining a vision for a partnership, they not only felt more aligned with this vision, but also felt this vision was their own. Vision consensus increases the relative value of a partnership when evaluating costs and

benefits to participation (Metzger et al., 2005); conversely having no clarity in vision can hobble partnerships (Baker et al., 2012).

# CHAPTER 5: DISCUSSION

The literature review identified five main approaches to leadership discussed in the literature. Below I discuss methods for applying these approaches in the day-to-day leadership of partnerships.

## Creating an Open Decision-Making Process

Empirical findings from Hearld et al. (2013), Metzger et al. (2005) and Weiner et al. (2002) converge into a clear theme: The importance of a clear and inclusive decision-making process. Having an inclusive, transparent and clear decision-making processes were associated with a range of positive outcomes for partnerships, including increased vision and strategy consensus, perceived procedural fairness, partners' satisfaction with decisions, partners' personal engagement in the partnership, and organizational integration into the partnership strategy and vision (Hearld et al., 2013; Metzger et al., 2005; Weiner et al., 2002).

These intermediate outcomes are important because they are often associated with the long-term effectiveness and viability of a partnership (Weiner et al., 2002). Partnerships invariably have power imbalances, perceived or otherwise (Bolda, Saucier, Maddox, Wetle, & Lowe, 2006; Kramer et al., 2005). Smaller partners may be suspicious of the larger partners usurping the partnership to advance their agenda. But, if a formal-decision making process is adopted, and there a clarity in decision making, partnerships will be more resilient to these power imbalances (Bolda et al., 2006). Wells (2009) believes spending the extra effort and time to clarify roles and strategies will also long term create foundation for partner agreement even in the face of goal divergence.

How does a leader create a clear and open decision-making process? From the qualitative data in their research, Hearld et al. (2013) recommend two main strategies that emerged from their interviews.

First, they recommend creating a formal decision-making framework. A formal decision-making framework are written and clear directions detailing how decisions are made. Even though a partnership is a voluntary collaboration among autonomous actors, a formal decision-making process helps "coalesce members' perceptions about important alliance issues, and help members more clearly define their roles in the decision-making process" (Hearld et al., 2013). It helps partners understand how to navigate the decision-making process in the partnership, how the partnership gets from point A to point B, how they can bring issues to the table and what conditions are necessary for decisions to be made (e.g. is unanimous consensus required or only a simple majority). It helps to explain if all partners get the same vote or if voting is proportional to financial contribution. Hearld et al. (2013) found that partners said a formal decision-making process helped them understand that decisions are not made on an *ad hoc* basis and helped build fairness.

Second, Hearld et al. (2013) heard from partners that the process of being transparent and inclusive in decision making should start early for new partnerships. By being transparent leaders can create trust among the partners while inclusiveness created cohesion between partners. The "honeymoon" phase of partnerships, when interest is high and excitement abounds, is an important time to be inclusive and open in decision making. A transparent and inclusive process help to "set the tone" for the future decision-making processes of the partnership. Hearld et al. (2013) acknowledge

this type of decision making comes as the expense of expediency and new partnership leaders will find themselves challenged to balance this expediency and exclusiveness with transparency and inclusiveness.

Hearld et al. (2013) warns leaders that, in general, vision consensus is typically easier to achieve than strategy consensus. It is much easier to agree on *where* the partnership wants to go than to ultimately decide *how* to get there. Their qualitative data revealed - the process to decide on strategy often breeds more conflict, slowing the process of creating strategy consensus. Hearld et al. (2013) authors presage what leaders will find for themselves: Creating consensus is “a process, not an event.”

**Balancing Perceived Costs and Benefits**

Leaders will find it difficult to directly lower some of the costs of participation. A leader cannot create time for a partner they may not have or relieve them of obligations they experience from their home organization.

Still though, keeping perceived costs and perceived benefits in check is an important task. Doing so creates what Hearld (2013) calls “distributive justice” which is “the distribution of benefits, costs, and other outcomes resulting from organizational decisions.” That is, do partners perceive they are receiving benefits from their participation in the partnership relative to the costs. Partners who perceive the costs and benefits in balance are both less likely to perceive opportunistic behaviors by other partners and also are less likely to engage in these behaviors themselves (Hearld et al., 2013). In other words, an environment with balanced costs and benefits creates a “safe space” for partners and they are more likely to take part in the “give and take” required

to find common ground (Hearld et al., 2013). The research provides insight to balancing these costs and benefits.

First, an open and collaborative decision-making process can balance perceived costs, either directly or indirectly (Metzger et al., 2005). This is a process where opportunities for partners to have a voice in partnership vision and strategy is open and accessible to all members, regardless of their perceived power in the partnership. Having vision consensus has a direct effect on creating a favorable balance between costs and benefits (Metzger et al., 2005). Metzger et al. (2005) believe this happens for five reasons. First, once a vision has been decided upon, the value of the partnership is reified and comes into focus for partners. Partners more fully understand how their participation in the partnership creates value for the community and themselves. Second, the process of setting a clear vision is itself a demonstration that the partners have balanced the costs and benefits of participation. Third, with this balance established in the vision, partners will longer term be more amenable to disruptions in the cost-benefit balance. Fourth, setting a clear vision may increase confidence among partners that they won't be "working at cross purposes" with each other which would increase perceived costs. Finally, a vision serves as a clear cue for potential partners to evaluate their suitably and vision alignment with the partnership (Metzger et al., 2005).

Second, capabilities (vision, leadership and management) also increased the perceptions of the overall net value to participation, lowering perceived costs and increasing perceived benefits (Shortell et al., 2002). But Shortell et al. (2002) goes on to say while management capabilities are necessary to create value, by themselves they are insufficient.

Third, both Shortell et al. (2002) and Bolda et al. (2006) say *centrality* can create balance in value to being in a partnership. Centrality is when a partnership becomes central “and important to the economic, political, and social viability of the community.” (Shortell et al., 2002) Even in the face of increased costs to themselves, partners may not leave a partnership in fear their image or status in the community could be in put in peril by leaving the partnership (Shortell et al., 2002) leading to increased sustainability of a partnership (Bolda et al., 2006). Bolda et al. (2006) provided examples of how other partnerships have worked to create centrality:

- Have the partnership pen a weekly newspaper column on health.
- Have the partnership narrate a weekly radio story.
- Become a credible source of health data by broadly disseminating community health survey findings. Create media attention around health data.
- Create and publish community health reports. Ensure it is seen by policy makers.

**Interpersonal Skills**

In the early days of a partnership, Kegler and Swan (2012) speak to the importance of carefully selecting leaders to “ensure the requisite interpersonal and organizational skills to create coalition process that instill a sense of belonging.” (Kegler & Swan, 2012)  Baker, Wilkerson & Brennan (2012) say these leaders need to have a “diplomatic personality” to be successful. These may be difficult skills for a leader to learn later, necessitating that partnerships need to carefully select a leader with excellent intrapersonal skills from within their ranks.

Having these intrapersonal skills are essential, however. They can better create positive interactions between the partners, facilitate trust, bridge cultures and perform "boundary-spanning functions" which all have a positive impact on helping a partnership fully realize its collaborative potential (Weiss et al., 2002).

Wolff (2001) recommends leaders invest time building relationships with partners and personally visiting key local players who are not in the partnership. Leaders of other successful partnerships have emphasized the importance of forging these strong personal relationships (Wolff, 2001).

One of the most important interpersonal skills for a leader is arguably managing conflict between partners. Conflict between partners is seemingly inevitable, but not necessarily a negative; conflict can be a cathartic process to unearth issues and problems that may otherwise go unrecognized and simmer in the background (Butterfoss, 2007). There are five strategies for leaders to employ for managing conflict discussed by Butterfoss (2007):

- **Listen actively:** Understand, acknowledge and reflect on what others say. Listen intently and make sure the partners know that you understand their view, even if you don't agree with it.
- **Keep emotions in check:** This includes not only the emotions of others, but yours too. Create ground rules that prohibit *ad hominem* attacks and don't vent emotions. When tensions rise too high, call a recess in the meeting.
- **Separate people from the problem:** Don't let the problem become entangled with your views of the person demonstrating conflict. Understand why someone feels need to express dissent and deal with those issues.

- **Focus on interests, not positions:** Positions are stances partners decide on, interests are “the underlying cause of that position”. When positions are in conflict, focus on interests to find common ground there. Leaders, when considering common interests, may find new alternative positions that are more agreeable among partners.
- **Reframe:** When you hear someone yelling, rather than viewing them as disruptive and rude, shift your paradigms to consider that the person may lack effective communication skills or possibly there are hidden issues bothering them. Leaders can also reframe a person’s comments by asking the person what do they think would be an acceptable solution to the issue.

**Power Sharing**

One method to practice subsidiary and collaborative leadership is by creating workgroups. Leaders skilled in subsidiary leadership should empower their partners with resources and authority to work on public health challenges (Shortell et al., 2002). Both Baker, Wilkerson & Brennan (2012) and Bolda et al. (2006) described efforts by leaders to create working groups to deal with different tasks to help distribute work.

An example can be found in Durham, North Carolina at the Partnership for a Healthy Durham. Leadership created different committees tasked to tackle specific community health needs. One committee, tasked with HIV and STDs issues, includes a committee co-chair who leads a CBO experienced in HIV and STD testing (Partnership for a Health Durham, n.d.).

But power sharing does not come easily to all leaders; using power feels “familiar and natural” whereas sharing it does not (Alexander et al., 2001). It takes time for leaders to recognize power is not a fixed quality and power sharing is not a zero-sum game, leading to loss of power to them (Alexander et al., 2001). Leaders also must take a leap of faith and have the courage to trust others, whose competence and reliability may not be known, to make decisions (Alexander et al., 2001). If power sharing is done authentically though, and not simply for show, leaders will ultimately realize one of the greatest paradoxes in leadership: Sharing power leads to greater control (Alexander et al., 2001).

**Keeping Focus on the Vision**

Goals and objectives of a partnership should be “concrete, attainable, and, ultimately, measurable,” but coalitions often struggle with creating these (Wolff, 2001). To help set vision, Wolff (2001) recommends leaders use a “visioning process” with their members. In an example provided by Wolff (2001), leaders would ask the members to imagine the local newspaper wrote an article about the partnership in two years. What would the article say about the partnership and what would the headline be? Through a visioning process leaders can uncover the “unstated hopes and wishes” of their members and help set a vision reflecting the aspirations of the partnership (Wolff, 2001).

Once vision was set, Metzger et al. (2005) and Alexander et al. (2001) recommend leaders continue to “lead through vision.” (Metzger et al., 2005) Leaders will be confronted with multiple pathways to take the partnership. Leaders should use the

vision as a blueprint to guide the collective actions of the partnership towards a clear goal that all partners have bought into (Alexander et al., 2001; Metzger et al., 2005). Leaders should continue using the vision to “align potentially disparate member interests and demonstrate how the coalition creates value, not only for its members and other stakeholders but also for the larger community.” (Metzger et al., 2005) Leaders of partnerships should keep focus on the partnership’s vision by continually linking the strategies of a partnership back to the vision (Shortell et al., 2002; Wolff, 2001). Shortell (2002) found the most successful partnerships in his study consistently linked the initiatives they worked on back to their vision whereas less successful ones did not.

# CHAPTER 6: CONCLUSION

This paper found five core leadership approaches necessary in private-public community health partnerships:

- **Creating an open decision-making process**: Partners benefit by clearly understanding how decisions in a partnership are made and how they can take part of the process. A clear, open and fair decision-making process brings a number of benefit including vision consensus, strategy consensus and procedural fairness.
- **Balancing costs and benefits**: Partners will become disillusioned and often leave when perceived costs of participation surpass benefits. Leaders can balance costs and benefits by creating vision consensus and strategy consensus. When partners are on board and have agreement on what they want to achieve in the partnership, they become more resilient to a cost-benefit imbalance.
- **Developing Interpersonal Skills**: A leader will shepherd a diverse array of partners with different business cultures, beliefs and priorities. A leader with better interpersonal skills can better motivate partners towards collective action.
- **Power Sharing**: Though uncomfortable and requiring a leap of faith, leaders may want to share power with members, especially to those closest to the problems. Powering sharing will help create a shared ownership among partners.

- **Keeping Focus on the Vision**: The vision is imbued with the collective hopes and aspirations of a partnership. As a first step, leaders are recommended to first work with all partners to achieve vision consensus and then continue to lead through the vision.

These five approaches are necessary, but likely insufficient, to leading, however. The challenges of public health can best be described as “adaptive challenges” rather than “technical problems.” (Heifetz, Grashow, & Linsky, 2009) *Technical problems* can be either simple or complex problems, but they are problems where the solution is known and can be addressed through current knowledge. *Adaptive challenge*s though “can only be addressed through changes in people’s priorities, beliefs, habits, and loyalties”. (Heifetz et al., 2009). Problems in public health are often complex than don’t have ready-made solutions, necessitating the collective efforts of partners to solve.

When working on these adaptive challenges, leaders in partnerships will experience leadership differently than in a traditional hierarchical organization. In partnerships, leaders lack the formal authority to solve turf issues or levy administrative penalties. They cannot hire or fire partners; instead they rely on the voluntary efforts of the partners. However, as Heifetz (2009) notes in his book, *The Practice of Adaptive Leadership*, “People have long confused the notion of leadership with authority, power and influence.” Whether in a formal or informal power structure, authority is granted to leaders by others in part by trust; members trust leadership to pursue a set of goals they, the members, hold dear (Heifetz et al., 2009).

This can be a hindrance to leaders, however. Heifetz (2009) warns leaders about the seductive label of "leader" – it can adversely hold you where the partners want you, dealing only with technical problems, problems they want you to solve, and not the adaptive challenges. Solving adaptive challenges requires *adaptive leadership*, which is much more disquieting to partners.

> *"Adaptive leadership is not about meeting or exceeding your authorizers' expectations; it is about challenging some of those expectations, finding a way to disappoint people without pushing them completely over the edge. And it requires managing the resistance you will inevitably trigger. When you exercise adaptive leadership, your authorizers will push back, understandably. They hired you, or voted for you, or authorized you to do one thing, and now you are doing something else: you are challenging the status quo, raising a taboo issue, pointing out contradictions between what people say they value and what they actually value. You are scaring people. They may want to get rid of you and find someone else who will do their bidding." (Heifetz et al., 2009, p. 26)*

Being an adaptive leader can be uncomfortable to leaders and they may face resistance. It may require you asking partners to check their turf issue and work, not for their organizations' interest, but for the community's interest, and shaking up the status quo in the partnership.

Though difficult, adaptive leadership can be a powerful force to create and advocate for changes to improve a community's health through partnerships. Partnerships can help tackle a range of issues from improving sidewalks to improving continuity of care between partners. These partnerships embody the spirit of collective action underpinning public health, and creates opportunities for community health improvement that may otherwise go unrealized. Partnerships can, and are, realizing Winslow's century-old vision for "organized community effort" in public health.

## APPENDIX A: DATA TABLE

| Year Published | Lead Author | Title | Study Design | Main Findings | Decision-making fairness | Cost-benefit balance | Power sharing | Inter-personal skills | Vision focus |
|---|---|---|---|---|---|---|---|---|---|
| **2001** | Alexander, J.A. | Leadership in collaborative community health partnerships | Case study | Main themes of collaborative leadership: systems thinking, vision-based leadership, collateral leadership, power sharing, process-based leadership. | | | ● | | ● |
| **2012** | Baker | Identifying the Role of Community Partnerships in Creating Change to Support Active Living | Mixed Methods | Qualitative: Leadership qualities: Previous experience, networker, diplomatic, listener, passionate, perseverance, dedication, adaptability. Articulate a clear vision. Build trust. Interpersonal. No right governance Quantitative: Not focusing on vision. Weak leadership. | | | | | ● |
| **2006** | Bolda | Governance and Management Structures for Community Partnerships: | Cross sectional, Qualitative | No right governance. Centrality. Power imbalances. | ● | | | | |

| Year Published | Lead Author | Title | Study Design | Main Findings | Decision-making fairness | Cost-benefit balance | Power sharing | Inter-personal skills | Vision focus |
|---|---|---|---|---|---|---|---|---|---|
| | | Experiences From the Robert Wood Johnson Foundation's Community Partnerships for Older Adults Program | | | | | | | |
| **1993** | Butterfoss | Community Coalitions for Prevention and Health Promotion | Thought piece | n/a - Commentary | | ● | | ● | |
| **2013** | Hearld, L | Decision-making fairness and consensus building in multisector community health alliances: a mixed-methods analysis | Cross sectional | Quantitative findings: 1) Perceived fairness of distribution of costs vs. benefits positively associated with perceived level of consensus by members (OR = 1.94, 95% CI = 1.56-2.42), Perceived fairness is decision making associated with level of perceived consensus (OR = 1.86, 95% CI =1.30-2.57); 3) Perceived | ● | ● | | | |

| Year Published | Lead Author | Title | Study Design | Main Findings | Decision-making fairness | Cost-benefit balance | Power sharing | Inter-personal skills | Vision focus |
|---|---|---|---|---|---|---|---|---|---|
| | | | | fairness of distribution of costs vs. benefits positively associated with level of consensus regarding alliance strategies (OR = 2.33, 95% CI = 1.91-2.86); 4) Perceived fairness in decision making transparency (OR 1.52, 95% CI = 1.27-1.82) and inclusiveness (OR 1.63, 95% CI =1.17-2.27) associated with consensus on PPP strategies<br>Qualitative findings: Consensus-building is facilitated by creating formal decision-making frameworks and involving members in decision-making process early. | | | | | |
| **2012** | Kegler | Advancing coalition theory: the effect of coalition factors on | Secondary analysis from coalition member survey | Leadership associated with new skills development, social capital and sense of community. | | | | ● | |

| Year Published | Lead Author | Title | Study Design | Main Findings | Decision-making fairness | Cost-benefit balance | Power sharing | Inter-personal skills | Vision focus |
|---|---|---|---|---|---|---|---|---|---|
| | | community capacity mediated by member engagement | | | | | | | |
| **1998** | Kegler | Factors that contribute to effective community health promotion coalitions: a study of 10 project assist coalitions in North Carolina | Cross sectional survey | Leadership positively associated with member satisfaction. Decision making positively associated with resource mobilization. | | | | ● | |
| **2005** | Kramer | Coalition models: Lessons learned from the CDC's Community Coalition Partnership Programs for the Prevention of Teen Pregnancy | Cross sectional | Most (9 or 13) of PPPs had committee. Time was a cost. Power differential | | ● | | | |

| Year Published | Lead Author | Title | Study Design | Main Findings | Decision-making fairness | Cost-benefit balance | Power sharing | Inter-personal skills | Vision focus |
|---|---|---|---|---|---|---|---|---|---|
| **2005** | Metzger, M | The Effects of Leadership and Governance Processes on Member Participation in Community Health Coalitions | Cross sectional | Three leadership/governance variables (openness of decision making, collaborative decision-making, empower leadership style) all directly increase vision consensus, which increases participation benefits and lowers participation costs. Collaboration direction increases benefits and directly decreases costs. Empowering leadership directly decreases costs. | ● | ● | | ● | ● |
| **1998** | Parker | Coalition Building for Prevention: Lessons Learned from the North Carolina Community-Based Public Health Initiative | Qualitative | Factors important for functioning are: Participation; communication; governance; staff/member relations; technical assistance and skills training; conflict recognition and containment. | ● | | | ● | |
| **2002** | Shortell | Evaluating partnerships | Mixed Methods | Qual: Top partnerships have: | | ● | ● | | |

| Year Published | Lead Author | Title | Study Design | Main Findings | Decision-making fairness | Cost-benefit balance | Power sharing | Inter-personal skills | Vision focus |
|---|---|---|---|---|---|---|---|---|---|
| | | for community health improvement: tracking the footprints | | Size and diversity, three-component leadership, focus, manage and channel conflict, recognize life cycle.<br>Quant: Management capability is a predictor of perceived costs/benefits. | | | | | |
| **2002** | Weiner, B | Management and Governance Processes in Community Health Coalitions: A procedural justice perspective | Cross sectional | Perceived clarity in decision-making and perceived collaboration in conflict resolution were positively associated with perceived fairness of PPP decision making. This perceived fairness was associated with satisfaction of decisions made by PPP. However, this perceived fairness was not associated with personal engagement in PPP or organizational integration into PPP activities. | ● | | | | |

| Year Published | Lead Author | Title | Study Design | Main Findings | Decision-making fairness | Cost-benefit balance | Power sharing | Inter-personal skills | Vision focus |
|---|---|---|---|---|---|---|---|---|---|
| **2002** | Weiss, E. | Making the Most of Collaboration: Exploring the Relationship Between Partnership Synergy and Partnership Functioning | Cross sectional | "Partnership synergy" measures how a partnership is combining the perspectives, knowledge and skills together in such a way that the sum is greater than the parts. Can help measure collaborative process. | | | | ● | |
| **2001** | Wolff, T | A Practitioner's Guide to Successful Coalitions | Commentary | n/a - Commentary | | | | ● | |
| **2009** | Wells, R | Factors affecting member perceptions of coalition impact | Cross sectional | Partnerships with “better performance strategies” were associated with member perceptions of community impact. Making decisions based on data may improve member’s perceptions of the partnerships impact on the community. | | | | | |

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