LEADERSHIP IN VOLUNTEER MULTISTAKEHOLDER GROUPS TACKLING COMPLEX PROBLEMS

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ABSTRACT

This chapter explores distributed leadership in volunteer multistakeholder groups tackling complex problems, focusing on community organizing practices to bridge the gap between health and health care in Columbia, South Carolina. Columbia faces increasing chronic disease, high rates of uninsured, unequal access to healthcare services, and rising costs. Regional leaders periodically tackled these problems together but faced challenges common to multistakeholder groups. In 2010, leaders from Columbia partnered with the authors in a learning enterprise to find new, more sustainable ways to address these challenges. Together we adapted a community organizing approach to develop distributed leadership skills necessary to overcome the challenges of volunteer multistakeholder groups and transform the health system in a local area. In the first year, teams provided health screenings to over 1,000 residents; over 3,000 residents exercised leadership to improve community health; over 5,000 residents pledged to improve their health. Clinic hours were extended; new health coaches focused on primary care and wellness

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programs. Providers and payers committed to reinvesting a share of savings in the community, which has a voice in their use. We show that developing distributed leadership via community organizing offers an approach to solving seemingly intractable community problems.

Keywords: Distributed leadership; organizing; multistakeholder group(s); cross-organizational; leadership practices

What we have ignored is what citizens can do, and the importance of real involvement of the people involved.

Elinor Ostrom

PART 1: INTRODUCTION

Solving complex societal problems requires the resources and capabilities of multiple, independent organizations (Sayles & Chandler, 2009). For example, climate-related crises, such as flooded cities, droughts, severe wildfires, and epidemics, are creating the necessity for cross-entity and cross-sector collaborations, drawing on resources from municipalities, NGOs, and the private sector. Although this kind of problem is increasing in prevalence in the world, very little research has addressed the leadership needs of cross-organizational collaborations (Mendonca, Beroggi, & Wallace, 2001; Sayles & Chandler, 2009). In this chapter, we explore the importance and functioning of distributed leadership, shared responsibility across organizations to define purposes and create conditions for accomplishing those purposes (Hackman, 1987; Wageman & Fisher, 2014) – held by members from a wide array of stakeholder groups.

Among the seemingly most intractable and complex problems worldwide is the production of low-cost, high-quality health care for all. As a consequence, the work of redesigning health systems is an ideal setting in which to explore the functions of distributed leadership for solving complex problems. We define distributed leadership as a social process by which many people across group boundaries and levels within a social system together create the conditions to accomplish shared purposes. Critical to our definition: (1) leadership is a set of *social functions*, not a position; (2) leadership is *shared* among many people in different places in a system; and (3) leadership is exercised *interdependently* by sharing resources, expertise, and authority with each other (Barry, 1991; Gronn, 2002; Spillane, 2012).

To illustrate an instance of distributed leadership in this context: In the U.S. Pacific Northwest, a four-county community had many citizens who lacked healthcare insurance; they typically sought care in emergency rooms, creating terrible burdens on the hospitals, community, and patients themselves (Wageman, 2013). A leadership group convened, composed of senior managers from major local employers, chief executives from two hospitals, primary care practitioners, and a major health insurer. Jointly, this group exercised leadership by mobilizing volunteers to provide care to the underserved and they launched a community health center. Over the last 20 years, more cross-organizational leadership groups have launched additional system redesign projects. They created a sleep lab owned by both hospitals; convened over a hundred institutional partners for a communitywide health-needs assessment; and created a vision for the health of the region's citizens.

This story illustrates how local leaders can solve local problems involving public resources, a view championed by Elinor Ostrom in her Nobel Prize-winning research. Ostrom (2010) refuted traditional economists' position that such problems can be solved only through privatization or government regulations lest communities fall prey to the tragedy of the commons. According to Ostrom, a third way exists: institutions and citizens can align and govern shared resources. Ostrom and her colleagues demonstrated that many communities create distributed leadership to govern common resources, devise democratic forums for solving problems, and establish shared rules to resolve conflicts (Ostrom, 1990, 2010).

In this chapter, we explore the importance of distributed leadership in health system transformation. Based on a multiyear action-research project in Columbia, South Carolina, initiated and funded by the Fannie E. Rippel Foundation,[1] we explore the process of developing distributed leadership throughout a voluntary multistakeholder network. We surface challenges in building momentum to solve complex problems, and we identify leadership practices that enable effective action. We use this effort's lessons to illustrate how the leadership practices of community organizing can help transform health and health care – and offer an approach to developing volunteer, distributed leadership to manage shared resources.

Challenges in Transforming the U.S. Health System

The U.S. health system is notorious for its costly, inequitable, disappointing performance. Americans spend too much for care, yet are in poor health. Despite the proportion of the U.S. economy directed to health

care – greater than that for all other developed nations – the quality of U.S. health care is in the middle of the pack (Kane, 2012). Reformers face several challenges.

First, most reform initiatives are narrowly focused on what one organization can do, and are low leverage. Many deliver results in a particular domain, such as medical care – which accounts for less than 10 percent of the drivers of health – whereas social determinants and health behaviors are much more powerful influences (Eggleston & Finkelstein, 2014; Kottke & Pronk, 2013). Second, America's healthcare system is fragmented. Change demands that those who provide, regulate, and receive care work together in ways that cross traditional boundaries (Kania & Kramer, 2011). Third, we face a crisis in leadership. The stakeholders most "at home" in the health sector are trained to provide a service, not to bring diverse groups together to coproduce health or other valued outcomes. System change will require distributed leadership to develop and sustain effective local redesign efforts.

Responding to These Challenges

Many people are working on solutions to these three challenges. Volunteer coalitions, alliances, and other loosely structured associations are forming across organizations (hospitals, government agencies), sectors (employers, educators, payers), constituency groups (the rural poor, children), geographies (street, neighborhood), and levels of authority (providers, citizens). These collaborations reflect a national trend. Examples include the Beacon Community Cooperative Agreement Program; Robert Wood Johnson Foundation's Aligning Forces for Quality; Centers for Medicare and Medicaid Services' Innovation Challenge Grants and Special Innovation Projects; NRHI Regional Health Improvement Collaboratives; and self-organized, community-based alliances and projects (Alexander, 2013). The goal is a health system anchored in a culture of preventative and patient-driven health that better aligns resources and enables more stable, self-reliant financing structures (Institute of Medicine, 2012; Milstein, Hirsch, & Minyard, 2013; Milstein, Homer, Briss, Burton, & Pechacek, 2011; Swensen, Pugh, McMullan, & Kabcenell, 2013).

Developing a Particular Kind of Leadership

These multistakeholder groups cannot operate in the same ways as traditional hierarchies and therefore require a different form of leadership.

Developing distributed leadership is about creating the conditions for diverse groups to work toward shared goals (Bennett, Wise, Woods, & Harvey, 2003; Doherty & Mendenhall, 2006).

Six challenges must be addressed to develop this kind of volunteer,[2] distributed, multistakeholder leadership for system change:

- *Articulation of shared purpose*. No organizational structure exists with legitimate authority to assert a shared purpose across organizations and sectors, or to impose priorities on others. Therefore, a critical leadership challenge is to find ways of developing genuinely shared purposes that are clear and compelling enough to guide collective action (Doherty & Mendenhall, 2006; Hackman, 2002; Wageman & Hackman, 2010).
- *Engagement and motivation*. Voluntary collaboration has no barriers to exit, and it can be difficult to keep people engaged who work full time or have competing priorities, especially when participation is not – or is only partially – financially compensated. These efforts must rely on commitment, rather than compliance. Leadership of this kind of effort, therefore, means making sure that the purposes, the work, and the rewards build and sustain internal motivation (Catano, Pond, & Kelloway, 2001).
- *Diverse interests and trust*. Conflictual historical and political relationships between individuals, groups, or institutions can limit their ability to work together. Demographic and interpersonal tensions may exist; partners come with different amounts of power and resources. One critical leadership skill is building trust, and countering these centrifugal forces by creating real interdependence and joint action toward mutually valued superordinate goals (Brewer & Chen, 2007; Nadler, Malloy, & Fisher, 2008).
- *Authority*. Authority-based practices cannot be used with peers from other institutions. At the same time, interdependent leadership is not typically practiced inside the institutions involved in these efforts. The establishment of clear norms of conduct among key participants is required for stakeholders to hold one another accountable (Wageman & Fisher, 2014).
- *Decision making and strategizing*. Clearly defined structures of decision making among self-organized groups may not exist, even when a new organization is formed (Glaeser, 2007). Yet "natural" group decision-making practices can result in polarization, false consensus, or dominance of minorities by majorities (Bray, 1978; Hollingshead, 1996; MacCoun, 1989; Sommers, 2006; Van de Ven & DelBecq, 1974). One critical leadership function is collective decision making that can function effectively across diverse groups.

- *Sustainability*. Finally, systemwide change requires long-term strategies and maintaining the participation of voluntary stakeholder groups over time.

These challenges are not unique to this setting. Much research has shown the effectiveness of commitment-based and distributed leadership even within hierarchical organizations (Bass & Avolio, 1993; Walton, 1999); and many challenges typical of cross-organizational collaboration also exist within employment organizations.

However, in the setting explored here, commitment-based distributed leadership practices are the *only* option: structures of legitimate authority or of coercive control across institutions do not exist; and when such leadership practices are used, these efforts break down (Farmer & Fedor, 2003; Ryan & Kaplan, 2001). Therefore, developing distributed leadership is the only viable option for addressing the above challenges in this context.

Community Organizing

Community organizing offers the promise of developing a form of distributed leadership that addresses these leadership challenges. As a theory of change, community organizing takes up these questions: (1) Who are my people? (2) What challenges are they facing? (3) How can their resources be mobilized to create the capacity needed to meet those challenges?

Organizing is a set of practices designed to enable a *community* of diverse actors to be transformed into a *constituency* that mobilizes toward a common goal (Ganz, 2010). This is achieved by the development of *interdependent leadership* that enables a constituency to use its collective resources to make change — by translating its values into action. Organizing, in this view, is not a technical solution to health system problems or an advocacy effort: it offers a methodology to *develop the capacity of people to work together* to create a sustainable health system. Organizing develops in individuals and groups the motivational, relational, and strategic skills they need to make choices about how best to effect change together.

PART 2: ORGANIZING: AN APPROACH TO DEVELOPING DISTRIBUTED LEADERSHIP IN VOLUNTEER MULTISTAKEHOLDER SETTINGS

Organizing is an agency-based model of leadership development. Organizers identify, recruit, and develop individuals who can, on their own

initiative, mobilize constituents to take joint, intentional action for a common purpose (Bennett et al., 2003; Northouse, 2013). They develop leadership capacity through mutual commitments between stakeholders around shared values.

The distributed leadership practices associated with organizing enable leaders to engage diverse stakeholders in boundary-crossing dialogues and actions necessary for true reform under conditions of complexity and uncertainty. This approach transforms people's thinking about how to relate to and motivate one another and how to solve problems together (Shults et al., 2009). Organizing practices enable individuals and organizations *together* to assert new public values, to form relationships rooted in those values, and to mobilize power with one another to translate those values into action (Ganz, 2010).

The Project

In 2010, we initiated an action-research project to explore how organizing develops the distributed leadership skills necessary for tackling complex health system changes by voluntary multistakeholder groups. We designed this enterprise in partnership with a community that wished to develop and launch an organizing effort to achieve better health, better care, and lower care costs.[3] The intended results were to attain these outcomes and to learn about development of distributed leadership as a local capacity for solving problems together.

Methodology

We construed this effort as an action-research project (Reason & Bradbury, 2001; Whyte, 1991), engaging a broad group of residents of a region in the question: What can community organizing as an approach to developing distributed leadership contribute to our capacity to lead health system change?

Each phase of the organizing process and the development of shared leadership practices is described below. Throughout these processes, we integrated two core data-gathering practices into the action: (1) every convening of community members, every vision team meeting, each town hall or house meeting offered participants a written instrument, sometimes a structured questionnaire and sometimes an open-ended invitation to reflect on the experience, and (2) we conducted debrief conversations, sometimes called "after action reviews," to reflect collectively on what worked well

and what did not, and what lessons participants felt had been learned from the work.

Our analytic strategy was conducted in two ways. First, throughout the project, we summarized the core findings of the surveys (e.g., the initial survey summarized the main reasons residents wanted to participate in organizing and what they wanted to see changed about their health system; a later survey asked members to identify who recruited to them to the process, as a means of assessing the change in the network of distributed leadership over time). Second, we combined the lessons learned from after action reviews throughout the year-long process, synthesized by the project team, into a set of themes shared with residents and discussed publicly in a learning forum at the end of the project (Argyris, Putnam, & MacLain Smith, 1985).

Below, we describe the elements of the organizing approach to developing distributed leadership. These elements are more iterative than chronological:

(1) Identify and recruit community members to form a multistakeholder vision team.
(2) Use narrative practices to enable the vision team to develop a vision anchored in shared values.
(3) Help them build broad, strategic relationships that will become the effort's core leadership.
(4) Support core leadership teams in engaging the broader community in strategizing and decision making.
(5) Enable broad sets of stakeholders to develop an interdependent, multiteam structure.
(6) Develop organizing skills to mobilize action.

Each element of the organizing methodology was designed to meet some aspect of the leadership challenges described in Part 1.

(1) Identify and Recruit Community Members to Form a Multistakeholder Vision Team

To identify a community partner well-positioned to use organizing as an approach to change, we sought a region that had a positive history of cross-boundary group interactions (McFee, Wageman, & Hilton, 2014). Among our criteria were whether the region: had an identifiable aspiration around which to organize; was open to change processes not driven from the top; was engaged civically; had a group of leaders who would commit to organizing in new ways. Ultimately, we chose Columbia, South Carolina.

Identifying Potential Leaders. One challenge of voluntary multistakeholder leadership is developing strong commitments to work collectively toward the overarching goal. In Columbia, we recruited a local champion who could convene others from diverse, critical stakeholder institutions, who cared about the urgent problem of poor health and had the power to enable joint action. He helped us identify people with strong stakes in the region who wished the effort to be a state and national model. Demonstrating the characteristics seen in Box 1, these leaders worked collaboratively across organizational boundaries; had tried other approaches and wanted to learn new ones; expressed moral responsibility to act.

Of the 40 people we interviewed in Columbia, we chose six to comprise the vision team, whose purpose was to build an organizing effort to transform the health system in Columbia. These were individuals from the state hospital association, the Department of Public Health, a health insurance company, a three-hospital system in Columbia, a community health center, and a nonprofit that offered provider-insured care to disadvantaged community members.

Vision Team. Creating a cross-institutional leadership team addressed several challenges of multistakeholder efforts. First, since no single organizational structure existed for improving the health system, we launched the group as a *team* because it offered a structural model for individuals to work together toward goals, with each team member's equally owning the team's purpose and activities. Team members collectively shared the responsibility of seeing the whole system and acting on behalf of the entire enterprise.

Box 1. Leadership Characteristics.

- Passion and urgency
- Sense of moral imperative
- Network of relationships with other leaders and constituencies
- Interested in learning new approaches
- Self-image as a "pioneer" or "strategic risk-taker"
- Tenacity to try another approach when something doesn't work
- Systems thinking and consensus-building skills
- Comfort with ambiguity, uncertainty, and emergent processes
- Track record of follow-through on commitments
- Ability to dedicate sufficient time

Second, a team takes on the challenge of tenuous authority in volunteer efforts by requiring the development of shared cultures – new language and norms of conduct – that can operate across the community and enable those most affected to exercise leadership. The vision team worked for two days to develop a shared understanding of organizing and create a common language and culture around interdependent leadership practices (Box 2).

A central focus of those two days was to launch the team to function effectively. Researchers have identified three conditions that, if existing at a team's initial launch, increase the team's effectiveness (Hackman, 2002; Wageman, Fisher, & Hackman, 2009; Wageman, Nunes, Burruss, & Hackman, 2008): (1) it is a real team (2) with a shared, compelling purpose and (3) an enabling structure.

Box 2. Leadership Practices in Organizing.

(1) *Narrative:* Creating a shared story that motivates people to turn intrinsic values into action; the practice enables identification of shared, deeply held values and is the basis for building a clear, compelling *purpose* for a joint effort.
(2) *Relationship building:* Deliberate identification by two (or more) parties of shared values and common interests specifying mutual commitments to exchange resources; this practice enables the building of trusting relationships across demographic and institutional lines and engenders internal motivation for collaboration.
(3) *Creating team structures:* Designing and launching self-governing teams, connected as distributed leadership structures across multiple levels of coordination; this practice enables a multistakeholder effort to form and reform temporarily stable, bounded, interdependent teams of actors who craft norms uniquely suited to joint work, and to connect those teams in a loosely coupled organization sitting outside institutional boundaries.
(4) *Strategizing:* Collective decision making about goals and interdependent strategy development; this practice enables actors from different institutions to form high-quality, deliberative practices together and to creatively translate existing resources into outcomes that contribute to the effort as a whole.
(5) *Acting:* Producing specific, observable, and measurable results to evaluate progress, exercise mutual accountability, and adapt strategy based on experience; this set of leadership practices enables volunteer multistakeholder efforts to sustain motivation and commitment through identifiable progress and to build larger changes on a platform of shared accomplishments.

Developing such a team is a critical process for volunteer multistakeholder groups exercising distributed leadership. Because these teams are designed to achieve a purpose not attainable by a single group or organization, they must develop a genuinely shared purpose that is clear and compelling enough to guide collective action. And because there are no barriers to leaving a volunteer context – and only limited ways for people to exercise influence – it is important to create enabling structures that motivate and empower people to work together.

- *A real team* is bounded, stable, and interdependent for a common purpose. This is critical in a context where members are accountable only to each another. Vision team members committed to remain as an intact leadership team through the launch of the full effort.
- *A clear, challenging, and consequential purpose* was crafted by the vision team to make clear the team's purpose, agency, and activities:

> Against the backdrop of shared values and utilizing the platform of the Triple Aim,[4] we will create a vision for community health improvement in Columbia, South Carolina, which will help leverage resources for measurable impact in the management of chronic disease, inspire others to participate, and serve as a model for the nation.

The purpose is challenging yet attainable; and it is consequential: it would have real impact on the lives of others (Hackman, 2002; Wageman & Hackman, 2010).

Articulating a shared purpose addresses at least two challenges that arise when team members have different levels of power and resources: trust and commitment to a joint purpose. First, it confronts the challenge of building trust by suggesting that all partners are created equal; it does so by defining the scope of activity of *the group as a whole*, not of any one individual. Genuine interdependent and joint action toward mutually valued higher goals can overcome negative patterns in intergroup dynamics (Brewer, 1996; Nadler et al., 2008). Second by articulating a shared purpose, it engages, motivates, and publicly commits multistakeholder leaders. It provides a means to demonstrate collective buy-in and ownership of the overarching purpose (Ostrom, 1990).

- *Two enabling structures* – roles and norms of conduct – were put into place by the vision team.

  One challenge in building distributed leadership is that leaders from diverse institutions have their own sets of norms. When there are no barriers to exit, a limited means of influence over behaviors, and only loose-tie relationships, it is especially important to create enabling structures to motivate and enable team members to work together. Teams with explicit

operating norms have a much higher likelihood of achieving their goals, particularly when norms guide them in the early stages (Hackman, 2002; Hackman & Wageman, 2005, 2009; Wageman & Hackman, 2010).

Team members discussed what each might do, based on their skills, experience, and resources; they generated new, explicit norms of conduct and identified joint tasks, volunteering to share the interdependent work. They met monthly to discuss progress on vision and strategy, held weekly phone meetings to discuss tactics, and met one-to-one with team members with whom they did not already work. These practices enabled members to work increasingly well together and stay energized by the shared work (Wageman, 1995).

(2) Use Narrative Practices to Enable the Vision Team to Develop a Vision around Shared Values

A month after its launch, the vision team – armed with data and the fruits of follow-up actions – attended a two-day retreat to imagine what form the effort might take.

One of the chief challenges of volunteer, distributed leadership is arriving at a vision that will motivate volunteers to join in the hard work of a long-term reform effort – a vision superseding individual or competing interests. An equally important challenge is developing trust between participants. The team's approach to both challenges was public narrative.

Develop a Motivating Vision. Public narrative is the practice of creating a shared story around common values to motivate others to join in action (Ganz et al., 2011). It involves three core aspects of narrative: personal stories that illustrate one's values ("story of self"); collective stories that illustrate shared values ("story of us"); and stories that illustrate both the challenges a group faces and the actions that groups can take to address those challenges ("story of now"). *The shared values expressed in these stories form the basis of a motivating vision.*

Together, the vision team engaged in public narrative. They told stories about loved ones who had experienced harm in hospitals; personal trials navigating the healthcare system; patients whose families went bankrupt paying for care. They shared personal, yet universal, moments of grief and loss – and how those moments transformed them as human beings and as providers.

They also told stories about Columbia. They shared stories of hope in which diverse groups had come together: to care for each other; to overcome

a communitywide crisis; to sacrifice individual profit for collective prosperity. They painted a picture of the urgent issues they faced. They described what chronic disease looks like for a patient, her family, and her community. They described how the health system failed patients.

They identified zip code 29203 as the Columbia area most at risk of poor health outcomes. Approximately one third of its residents – 15,000 people – were uninsured; 30.3 percent lived in poverty, and 57.1 percent were low-income. Heart disease, COPD, and obesity were at epidemic levels. Perhaps most strikingly, this area had one of the nation's highest rates of diabetes-related amputations.

The team contrasted 29203's challenges with a picture of "Healthy Columbia." They imagined a community that kept all citizens healthy in the least invasive, lowest cost, highest quality way possible; where everyone – providers, payers, patients – was personally committed to creating that new healthcare system. Everyone had access to patient-centered medical homes with extended hours; patients saw their physician, nutritionist, and pharmacist in one visit; volunteer health workers offered increased care coordination; prescriptions included wellness and health education. Neighborhood associations organized community walks; local businesses sold fresh produce. Residents checked on frail neighbors and advised hospital CEOs about clinic hours. Patients were less likely to require emergency room visits and hospitalizations, saving millions to reinvest in community health.

These stories strengthened the team's individual and collective commitment to the effort; and from them, the team built an initial vision for the Healthy Columbia effort.

Use Narrative to Motivate Action. The vision team used narrative to solicit resources and to recruit others to the core leadership. They shared narratives in "calls to action" at public gatherings, in house meetings, one-to-one meetings, and wellness events. In the first year, they trained over 200 volunteer leaders in using narrative practices.

Soon, vision team members started seeing their leadership differently. Narrative's emphasis on universal values allowed them – all medically trained – to view other stakeholders as equal partners, as opposed to groups that they "served." Providers began seeing patients as citizens taking responsibility to coproduce health.

Healthy Columbia leaders continue to use narrative – in team meetings, one-to-ones, public actions. Narrative provides a method to identify shared values and a framework for developing a collective vision guided by those values – particularly important in the face of competing interests between stakeholders (Wechsler & Schnepp, 1993). A team member

commented: "Different people are motivated to participate for a range of reasons … But it is the use of narrative that connects us around a shared moral purpose, and everyone is united by that."

(3) Help People Build Broad, Strategic Relationships to Develop Core Leadership

A central challenge of developing a broad volunteer effort is ensuring the equal participation of many constituencies from the community. Having developed the first iteration of a vision, the initial team knew that a much wider group of stakeholders was needed to co-create and co-own the effort's strategy. The focus on relationship building allowed Healthy Columbia to address issues arising when stakeholders have different interests and resources, and when historical, racial, and political relationships limit groups' abilities to work together. One physician remarked: "A major outcome of this effort was simply bringing folks together, building new relationships, and going through the process of identifying our collective core issues."

Relational Strategy. A relational strategy is an intentional approach to developing relationships that generate commitment to the overarching goal. This strategy engages the challenges of building participants' commitment and trust, and equalizing their power. Relational *strategies* include recruiting individuals, networks, and organizations. Relational *tactics* involve the means of carrying out the strategies (such as house meetings, trainings).

We developed a relational strategy that could (1) build collective leadership capacity and (2) enlist stakeholders' commitments to a shared purpose.

- *Build collective leadership capacity*. To increase leadership capacity, Healthy Columbia developed a core team who worked to expand the effort's leadership.
  - *Core team*. The initial vision team looked at influential stakeholder groups in 29203 (and throughout Richland County) and considered their expressed values, interests, and resources. From this work, the vision team recruited a core team of 16 leaders to further develop and implement a relational strategy.

    The core team came from five high-impact constituencies:
    - 29203 community members
    - public and private payers
    - providers

- healthcare-related students and faculty
- volunteer health advocates and paid health workers

Members participated in a two-day team launch and organizing training to develop their shared purpose, enabling structures, and organizing skills. The launch marked an important leadership transition that included community leaders from 29203 and others from institutions across Richland County.

- *Expanded leadership*. Over the next seven months, the core team implemented the relational strategy, building expanding tiers of diverse leaders: from 6 team members in January, to 16 in July, 32 in September, 105 in February. Eventually, over 150 members engaged more than 3,000 people in launching the wider campaign (see Fig. 1) (Goodman et al., 1998).

  Previously trained leaders trained new people to lead, thus building relationships across stakeholder groups, launching interdependent teams connected by an overarching structure, and developing a common language. These two-day trainings were opportunities for stakeholders at all levels to build relationships and cross boundaries by working side by side. A team member noted: "The trainings brought community members, providers, payers all together for two days, taught us the same vocabulary, the same ways of thinking and leading. We shared our values, our resources, built relationships. It made us work as equals."

- *Enlist stakeholders' commitments to a shared purpose*. Mutual commitments are critical in meeting the challenge of developing trust among multistakeholder groups. Conflicts springing from different perspectives can be overcome by mutual commitments to take joint action for overarching goals (Nadler et al., 2008; Ricketts & Ladewig, 2008). Moreover, these commitments develop engagement with and motivation for the overall effort – thereby responding to another challenge in volunteer multistakeholder leadership.

The relational strategy, therefore, developed not only leadership capacity but also a broader commitment to the effort's vision and strategy. Over time, reliable and mutual exchanges built trust between stakeholders who had not worked together before. "Providers, patients, payers and community members were all at the table and working to develop power together," noted a community leader. And a hospital leader stated:

> The work of community engagement is driven by having a specific initiative [like this] going on; and we need to build a system of leaders at all levels of the community that can decide together where to focus their contribution to the overall effort. That is a different way of doing things – of starting with our people, focusing on one another, and then tackling our problems – instead of the other way around … All of it starts with building trusting relationships.

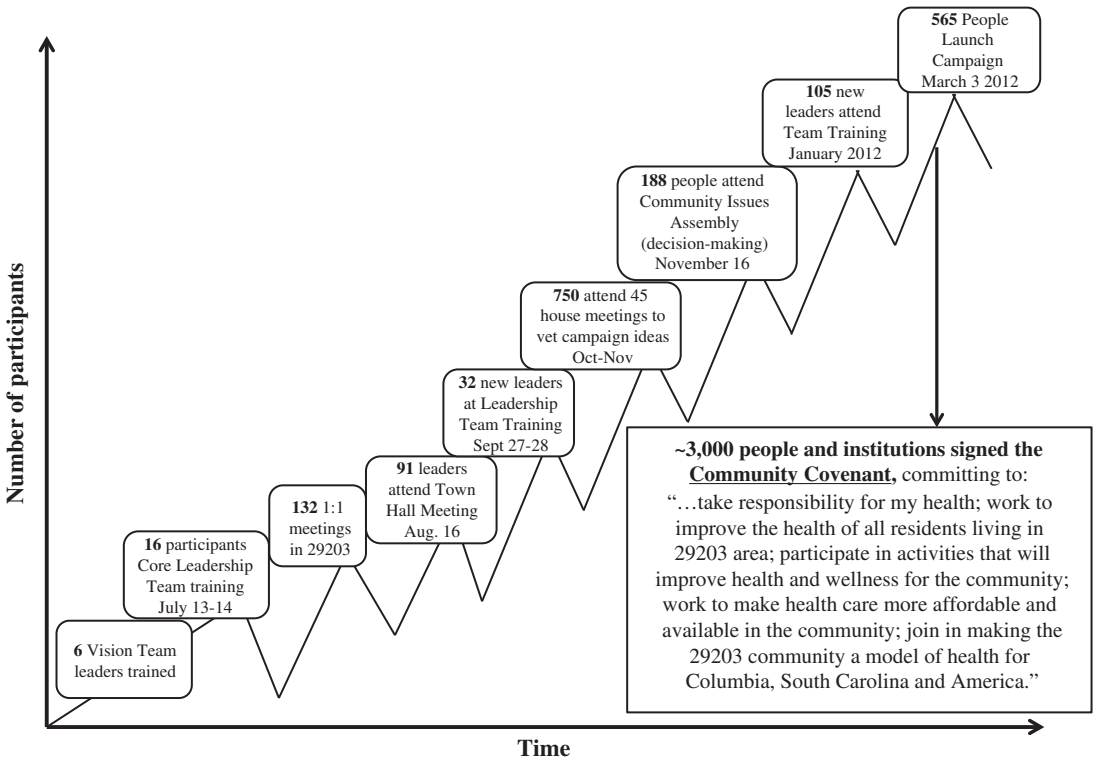

Fig. 1. Healthy Columbia Relational Strategy. July 2011 to March 2012.

Relational challenges still arose. Stakeholders brought different interests and, at times, conflicting ways of thinking. And as noted, prior histories, politics, and demographic differences made it hard for various stakeholders to trust one another. In hindsight, we might have encouraged leaders to address conflicts early on.

- *Tracking engagement outcomes*. Overall, the teams delivered on the relational strategy. To track outcomes, we conducted a network analysis of campaign leadership over time, collecting the data at three leadership trainings (July 2011, September 2011, February 2012). We used network analysis to visualize growing collaboration and describe its interconnectivity, particularly among strong and weak ties. Figs. 2–4 depict the leaders and their network positions (dot size). Consolidated patterns of dots show whether colleagues of colleagues are likely to be colleagues, and which subgroups are isolated.

The network analysis in Fig. 2 indicates that "MD5" and "MD9" (both care providers) have many strong ties within the network of core leaders. Strong ties are the connections between people who have some

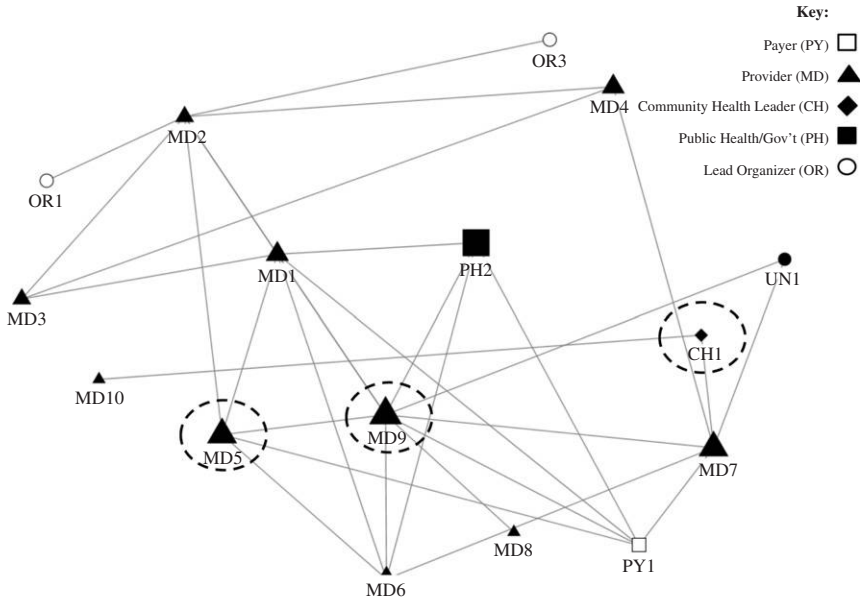

Fig. 2. Healthy Columbia Core Leadership Team. Organizing Training, July 2011. *Source*: Created with NodeXL (http://nodexl.codeplex.com).

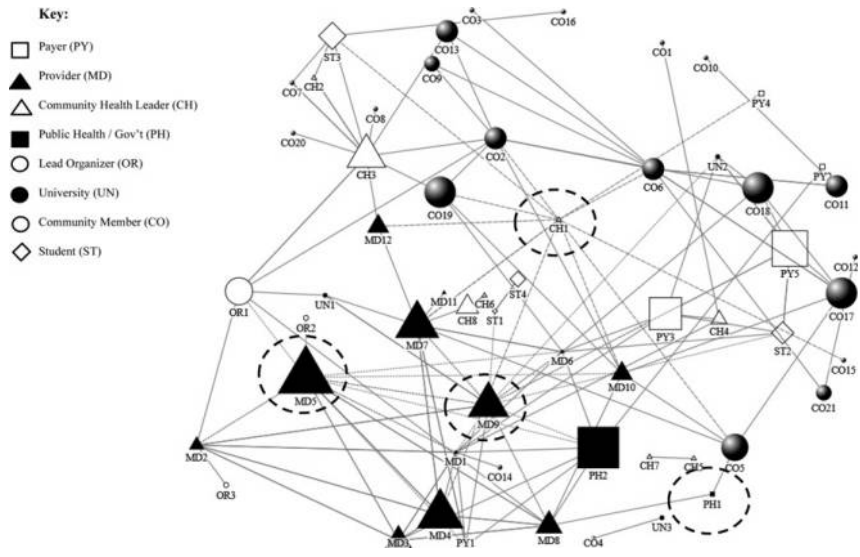

Fig. 3. Healthy Columbia Multistakeholder Leadership Teams. Organizing Training, September 2011. *Source*: Created with NodeXL (http://nodexl.codeplex.com).

fundamental similarity – for instance, within professional groups and among people of similar racial or income backgrounds (Granovetter, 1973). These ties build a powerful sense of identity and connection.

Weak ties are also critical. For example, "CH1" in Fig. 2 and "PH1" in Fig. 3 reflect weaker ties. Weak ties connect those who have not hitherto worked together; their differences ensure that new resources, knowledge, and networks can be combined (Granovetter, 1973).

Fig. 3 indicates network patterns three months after one-to-one meetings and other recruitment tactics. It shows a "bridging network," where individuals serve as bridges between disparate individuals and groups (Battilana & Casciaro, 2013). As one example, "CH1," previously a weak tie, by September had become a strong one, having served as a bridge to bring community stakeholders into the leadership.

In Fig. 4, the pattern demonstrates differences between community members' networks (spheres) and providers' networks (solid triangles). We see a large set of strong ties in the 29203 community. In the providers' network, "CH1," "MD5," and "MD9" continue to have broad relationships – revealing that they hold the most power and decision-making influence. Collaborative growth is revealed by data such as

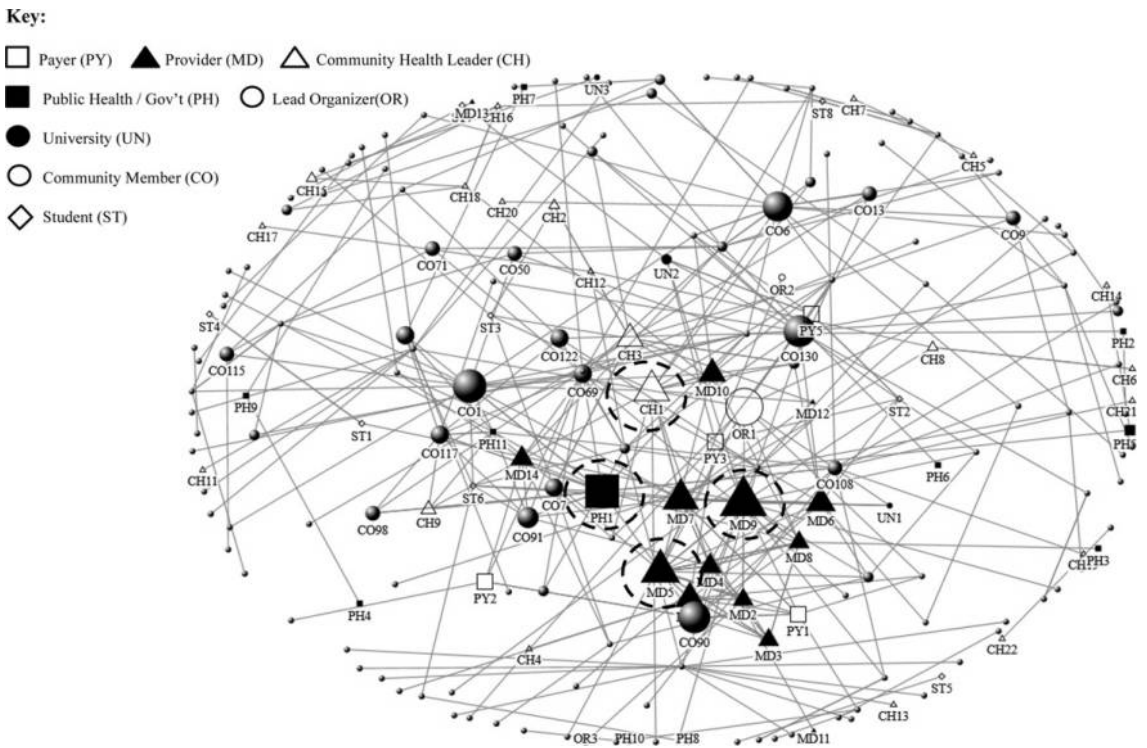

Fig. 4. Healthy Columbia Multistakeholder Leadership Teams. Organizing Training, February 2012. *Source*: Created with NodeXL (http://nodexl.codeplex.com).

"PH1" increase in relationships since July 2011. Fig. 4 also shows fewer overall gaps between groups than in September, suggesting that the bridging network has evolved into a "cohesive network." In a cohesive network, people connect directly and thereby can build trust and mutual support, facilitating communication and coordination (Battilana & Casciaro, 2013).

These patterns illustrate the building of distributed leadership: people collaborated more over time as they built relationships across groups, increasing the relational capital of Healthy Columbia as a whole. Some stakeholders were central, holding the most relationship-based resources, including the trust and respect of others. These people were change agents and thus had a clear advantage in influencing strategy, regardless of their position (or not) in organizational hierarchies. Other individuals strengthened their network position over time, bringing many more people into the overall structure of who could exercise leadership across stakeholder groups.

(4) Support Core Teams in Engaging the Community in Strategizing and Decision Making

The combined use of the collective strategizing and decision-making processes shaped the Healthy Columbia effort and addressed other challenges that multistakeholder groups face – such as some groups' feeling alienated from the process or not feeling ownership in the effort. Healthy Columbia avoided these pitfalls by combining the focused work of the strategy team with broader input from community members at town hall meetings, leadership trainings, house meetings, and the community assembly.

To overcome the leadership challenge of dominance by some participants and for aligning actions between stakeholders, the *strategizing* process enabled actors from different constituencies to conduct high-quality deliberation together. The challenge of avoiding unseen or informal decision making that can be inherent in multistakeholder groups requires that *decision-making* practices be collective, explicit, and developed in conjunction with *collective strategizing* activities. To keep stakeholders motivated and engaged, everyone must see both processes as legitimate.

Developing Strategy and Decision Making in Concert. These processes are iterative: developing strategy; testing its viability through on-the-ground

actions; and building consensus – and public commitment – for decisions that draw on lessons from those actions.

Strategy Team. The effort developed a strategy team of community members, providers, and public health professionals. The team's aim was to identify health system challenges facing 29203 residents, community-based assets and resources, and system-based solutions.

Meeting together, community team members reported lived experiences that they faced daily, while team health officials and providers shared evidence-based concerns. Their back-and-forth exchanges helped members to learn from and collaborate with each other – and to develop a system-based, data-driven strategy. The strategy team's inclusive membership meant they saw the whole, ensuring that they consider short- and long-term consequences on multiple stakeholder groups at multiple system levels.

Community Decision Making. In conjunction with the strategy team's work, the core leadership team deployed a community decision-making process. At public meetings and at leadership trainings, tactics were brainstormed, then "returned" to the strategy team for refinement and incorporation into evolving ideas. This feedback loop sharpened the effort's use of community-based tactics and assets.

Aligning Strategizing and Decision Making with Relational Strategy. The team also aligned strategizing and collective decision making with the relational strategy used to enlist stakeholder commitments (see Fig. 1). They did this by using tactics that engaged the wider community and solicited its input and leadership. Below, we discuss some primary tactics of the relational strategy, briefly noted earlier.

One-to-One Meetings. The relational strategy relied heavily on one-to-one meetings. Stakeholders used narrative to identify values; in building relationships, they identified one another's shared interests and resources as the bases of making mutual exchanges to reach overarching goals.

From over 130 one-to-one meetings, core team members recruited 90 residents to attend a town hall meeting where they identified health challenges and community-based assets and solutions, such as improved access to care (e.g., coordinated services, longer hours, available transportation); higher health literacy (e.g., information on the cost of care); and healthier behaviors (e.g., exercise, access to nutritious food). From this town hall meeting, new people joined the effort; they participated in a training in

which 12 diverse stakeholder teams (four to six people each) were formed to brainstorm community-based tactics. These teams narrowed their best ideas to three, launched a house-meeting campaign to vet those three, and invited the community to choose one.

House Meetings. The house-meeting campaign was an iterative process of testing the strategies' viability and mobilizing people's commitment. In 6 weeks, 35 team members engaged over 750 people in 45 house meetings in 29203. House meetings took place in community centers, school gymnasiums, senior centers, church basements, and homes.

Each meeting began with participants' sharing narratives. They exchanged stories with partners, then shared as a group. Leaders then presented the story of the effort to date. They asked for input on community-based strategies chosen by the stakeholder teams and sought commitments to attend a community assembly to select the one strategy the campaign would use.

Through narrative and relationship building, people focused on shared values and a vision of what was possible. This built consensus around *values* before leaders invited feedback on strategies for action. Participants' sharing of how they experienced the health system increased their identification with each other, and thus their weak-tie relationships; and seeing the system from multiple perspectives allowed people to see the system as a whole and, together, identify community-based assets and solutions.

People inside and beyond 29203 hosted house meetings together. The logic was to allow community members and other stakeholders to gain access to each other's thinking and expertise in order to test the feasibility of the collective strategy and develop a shared understanding of how various tactics would lead to outcomes.

Healthcare providers particularly benefitted from understanding residents' circumstances and perspectives, as well as community values and perspectives of what it means to be healthy. The asset-based approach to brainstorming revealed sources of community pride, leaders already doing good work, and information about how the community had met related challenges. One senior hospital leader explained:

> Instead of coming to the house meetings with a service-based mentality, saying to community members, "Here is what we [providers] think you should do," we said, "We want to learn from you: what are you going to do, and how can we partner with you?"

The conversation likewise shifted for community members. No longer asking providers, "What can you do for us?" they were now saying, "Here is how you can help."

Community Assembly. The next step was to decide on the effort's strategy at a community assembly. The 188 local residents in attendance selected the strategy and agreed on the Healthy Columbia mission:

> To use community organizing to build leadership to enable individuals and communities to take action to lead healthier lives and collaborate with providers to efficiently improve health and health care.

The community looked for leverage – actions that could make a big difference (see Fig. 5). They ratified multiple system-based strategies:

- Develop a community-centered health hub employing social determinants and lifestyle programs *to keep people healthy*;
- Advance policies and partnerships between grasstops and grassroots leaders focused on health in neighborhoods, congregations, and schools *to improve community health*;
- Extend doctors' office hours, improve transportation options, and use pharmacists as primary care extenders *to make primary care more accessible*;

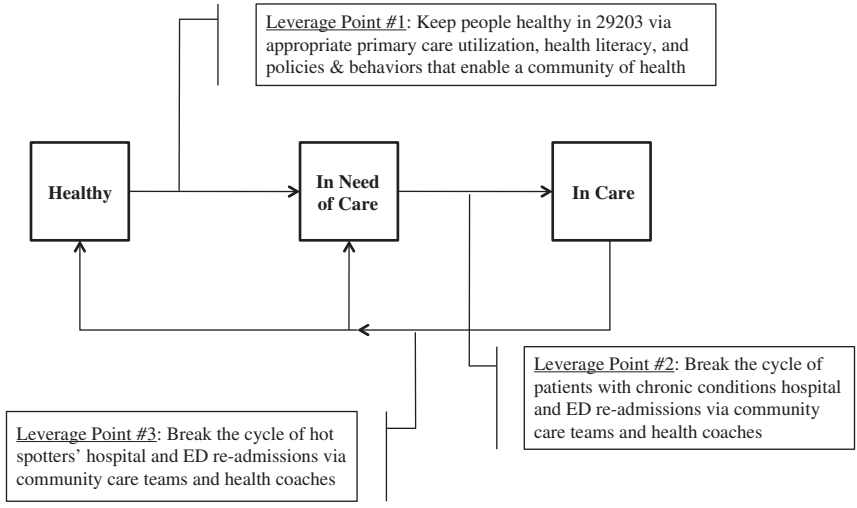

Fig. 5. Healthy Columbia Leverage Points.

- Focus efforts of nurse practitioners, parish nurses, and community-based health workers in microsites *to break the cycle of "hot spotters" in emergency departments and reduce hospital readmissions*;
- *Reinvest savings* from decreased emergency department and hospital use in prevention and primary care.

Launching the Effort Publicly. With mission and strategy decided, the strategy team developed initial tactics to launch the effort. The core team and campaign organizers trained and deployed 105 new volunteer leaders to get 3,000 people to pledge support for the Community Covenant. From the mayor to the director of Health and Human Services to the CEOs of payer and provider groups, leaders and institutions publicly pledged support at the kickoff event. They also committed in-kind resources – such as employees' time, participation in the stewardship group, and full-time health coaches.

The Community Covenant served as a Healthy Columbia's public charter; it provided a mechanism for individuals and institutions to commit to it publicly:

> Working together, we can support each other and our community in improving health and health care. We can make sure that everyone has access to cost-efficient, great care in our community. Please join us in building a Healthy Columbia.

Volunteer teams asked residents to sign covenant cards pledging them to:

- take responsibility for their health
- work to improve the health of all residents in 29203
- participate in activities to improve community health and wellness
- work to make care more affordable and available in 29203
- join in making the 29203 community a model for health

Healthy Columbia combined the focused work of the strategy team with broader input from community members. This dual process built the strategic foundation for the campaign to kickoff – and resulted in the leadership of hundreds of volunteers and the engagement of thousands of community members. As a disabled veteran leading the men's health team remarked:

> The greatest thing that I've learned is how to build relationships with different types of people. I bring important knowledge to the effort by being from the community – but I have also learned that even I need to build new relationships within my community … and I have learned so much from leaders outside of 29203!

(5) Enable Broad Sets of Stakeholders to Develop an Interdependent, Multiteam Structure

Strategies are supported by structures. A critical challenge for volunteer, multistakeholder leadership is developing an organizational structure where there is none. As one element in addressing this challenge, Healthy Columbia developed a distributed leadership structure connecting multistakeholder teams across multiple levels of coordination. This enabled the effort to form and reform – and coordinate – temporarily stable, bounded, interdependent teams of actors for specific work.

Healthy Columbia developed a structure of "community teams" and "provider teams." One risk with choosing this structure was that it replicated the racial homogeneity and existing silos among stakeholder groups; one benefit was that it reinforced relational commitments between teams. An alternative would have been to mix the stakeholder groups within each team. This may have enhanced their interdependency but would also have placed functional and geographic limitations on them.

In the "snowflake" model of a distributed leadership structure used by the effort, teams were grouped into four focus areas:

- care access and coordination
- community leadership and health activities
- stewardship
- infrastructure support

The core leadership team was composed of leaders who coordinated each of the four areas. They received input from another tier of teams "on the ground" and built that input into the overall strategy. In turn, the "on the ground" teams took overarching strategic aims back, to develop their own tactics around them (see Fig. 6).

Each team created the strategy and timeline for its level of responsibility. Then teams recruited and built the next level of teams (beyond that depicted in Fig. 6). At every level, each team had a clear purpose and the freedom to strategize creatively. This structure allowed Healthy Columbia to create ambitious goals, break them down into achievable chunks, spread out and coordinate across stakeholder groups, the 29203 community, and even particular neighborhoods (or "turfs"). It offered multiple points of entry for volunteers and multiple opportunities to learn and to exercise leadership.

Each team's role in the effort determined its decision-making responsibilities; and the core leadership team refined the overall strategy based on

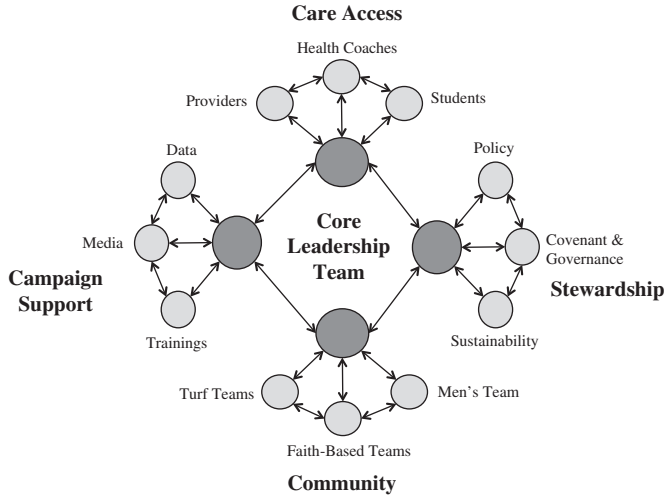

Fig. 6. Healthy Columbia Distributed Leadership Structure ("Snowflake" Model).

lessons learned by other teams. This distributed leadership structure built an equal-status contract between stakeholder groups – developing trust through teams' reliance on each other.

As noted, Healthy Columbia's structure fell short of interdependence in certain ways. For instance, community members (predominantly black) and providers (predominantly white) were on separate teams, reflecting both the failure to break down racial divisions and the tendency to replicate the status quo. Health coaches, students, providers, and community members were all on separate teams, who called on each other to support the campaign's activities across the overarching structure.

In the end, this structure nonetheless allowed stakeholders to take action *with* one another by bringing teams together for particular actions. Instead of doing something *to* another stakeholder group, or providing a service *for* them, they were acting together.

As one healthcare provider stated: "The senior leaders in the healthcare system who were most engaged in the effort's actions had the most exposure to community members. It changed how we saw ourselves in relationship to each other."

Sustaining the Effort over Time. A major leadership challenge is sustaining a volunteer, distributed multistakeholder effort over time. Transforming

a complex healthcare system requires long-term vision; commitment to a sustainable, collectively beneficial system rather than to the short-term benefits of individuals; and a strategic approach to accomplishing the goals of all stakeholders over time. In her research on sustainable self-governance of local resources, Ostrom's design principles (Ostrom, 1990, 2010) particularly emphasize the importance of a leadership group of "resource users" who collectively craft rules and procedures, monitor outcomes, impose sanctions, and resolve disputes among members over time.

To build this kind of ongoing structure and organization, we worked with the campaign's core leadership team to secure $120,000 from the institutions supporting the effort and to hire interns, a local campaign director, and a community organizer. They opened an office in 29203 and applied for nonprofit status. Its board ("Stewardship Board") represents all stakeholder institutions; in addition, 50 percent of its members are residents of 29203 and nearby neighborhoods. The group's composition is intended to enable it to institutionalize power and ownership of the effort in ways that make it accountable to local residents (Bryson, Crosby, & Stone, 2006). The Stewardship Board exists to create collaborative governance among stakeholders; its mission is to sustain the vision of Healthy Columbia over time, continue the focus on learning and capacity building, garner and deploy financing for the effort, and "see the whole" on behalf of all stakeholders.

(6) Developing Organizing Skills to Mobilize Action

There are many moving pieces to coordinate the transformation of a community's health system. Healthy Columbia needed to align an "upstream" population and behavioral health strategies, "downstream" care access and coordination strategies, and payment reform and reinvestment. These goals require a long-term timeline – one of the challenges in building distributed, multistakeholder leadership. People want to see immediate headway, and – worse – time can undo progress and send stakeholders back to entrenched silos.

In addition, a crucial leadership challenge in a broad-based volunteer effort is building trust among diverse participants. To meet both of these challenges, participants must be genuinely interdependent and engage in joint actions toward a shared goal. Volunteer multistakeholder efforts must set broad, audacious goals with clear, measurable outcomes (Doherty &

Mendenhall, 2006; Roussos & Fawcett, 2000; Shortell et al., 2002). They must start small to learn and refine, then scale up, and expect iterations along the way (Foster-Fishman & Behrens, 2007; Zakocs & Edwards, 2006). Early and often, stakeholders must generate outcomes *together*, constantly strengthening their relationships. This requires clear and consistent communication between teams across the networks. It requires people who are comfortable with ambiguity and willing to learn, and infrastructure to feed learning back into the group's ongoing strategizing process (Emerson, Nabatchi, & Balogh, 2011; Zakocs & Edwards, 2006).

Recognizing these challenges, Healthy Columbia dedicated the first year after the campaign's launch to collaborative action among stakeholder groups across the leadership structure. Inviting *all* stakeholders to contribute to one goal was an important way to build relationships between groups while maintaining their motivation. When everyone *feels* that they have something to contribute, then they do have something to contribute. And in a distributed leadership model, when many people contribute to an effort, it's *their* victory or loss. This creates motivation – and a sense of ownership that fosters accountability. For both of these reasons, it's critical that each action is viewed as one small step that leads to greater outcomes.

Health Screenings. The primary goals of health screenings were to build relationships, move people to action to improve their health, and recruit more leaders to reinforce the larger effort. Screenings built the stakeholders' power with one another – or their collective capacity to exercise change. Secondary goals were to improve the experience of care; improve the health of the 29203 population; and reduce the per capita cost of health care.

The target was 1,500 health screenings in the first year. Building on community assets, volunteer multistakeholder teams attended 27 church, neighborhood, club, and community events. In total, over 350 volunteers donated 3,000 hours – and achieved 1,032 screenings.

Screenings developed the stakeholders' *collective* capacity to make change. Volunteers included community members, physicians, nurses, medical students, and medical residents. They braved heat, cold, and rain on Saturdays at local events and on Tuesdays at "brown-bag" screenings, where teams reviewed community members' medications. Organizational partners ranged from a national pharmacy chain to local food banks.

Teams focused on self-care, primary care, and crisis care. They checked body mass index, blood pressure, blood sugar, body fat, eyes, and fall risk. Teams administered social-determinant surveys that included questions about smoking and health insurance, then pointed people to appropriate resources. An interprofessional team of medical, social work, and public health professionals reviewed findings, discussed implications with community members, and used motivational interviews to set goals and overcome barriers to sustained change. Leaders asked residents whether they wished to take on leadership, and if so, where: in a neighborhood, school, workplace, or other setting.

Of the first 500 residents screened: 125 received referrals (and follow-up calls) for physician visits; 175 committed to behavioral health or lifestyle programs; 65 became leaders to disseminate information about health resources in 29203.

Other Actions. These early actions strengthened collaboration among volunteers, which led to Healthy Columbia's next actions. For those, community leaders created tactics that reflected their collective identities: the men's health alliance team hosted a public event, "Mind, Body & Abs: The Healthy 6-Pk," focused on men's health and featured a personal trainer, cooking demonstrations, a basketball shoot-out, and health screenings. One turf team secured a mobile produce bus (accepting food stamps) to visit its neighborhood. Due to efforts of interprofessional student teams from the University of South Carolina's medical, nursing, pharmacy, social work, and public health schools:

- USC's family medicine program formalized a track for students to see patients in 29203 after-hours clinics.
- A Healthy Columbia family practice medical school rotation now exists, with screenings targeted for low-income housing and underserved areas.
- Planning is underway for medical students to work alongside community-based health workers.
- Faculty are partnering with students to integrate community-based work within health science education.

These young people are changing the thinking and leadership of a rising generation of doctors, nurses, pharmacists, and public health and social service workers — while moving the Healthy Columbia effort forward.

Not only do short-term actions build capacity for more actions and outcomes but also pave the way for other, even unforeseen, outcomes:

- Two hospitals asked Healthy Columbia to outreach to 29203's "hot-spotters" (uninsured, chronically ill residents who frequently use emergency services).
- A private payer credits Healthy Columbia with catalyzing its partnership to build a patient-centered medical home in 29203.
- The CEO of a health center credited Healthy Columbia as the reason it received a $2.4-million innovation award to train 15 health coaches in 29203.
- Other institutional leaders are establishing Healthy Columbia as a pilot Community-Based Organization (CBO) to provide compensated community health workers for the Columbia area, and as a model for community-driven, statewide health reinvestment policies.
- Healthy Columbia is partnering with the Department of Health and Arnold School of Public Health to conduct a community assessment of health needs and to build leadership to align resources.
- South Carolina's statewide health council is modeling its distributed leadership approach on Healthy Columbia's effort.

In Part 3, we summarize the lessons from our beginning efforts in Columbia.

PART 3: IMPLICATIONS: DEVELOPING DISTRIBUTED LEADERSHIP FOR SYSTEM CHANGE

The Healthy Columbia effort illustrates how organizing can develop distributed leadership to enable communities to tackle complex problems. Organizing is an approach to building a network of leaders who use already-existing strengths in more intentional and collectively understood and practiced ways, including forming relationships, telling stories, and making plans together. Organizing enabled many residents of Columbia to exercise leadership over problems of importance to them.

While systemic outcomes (improved population health, reduced care costs, and widespread access to excellent care) have not yet shifted dramatically, the effort achieved many changes representing significant movement toward improved outcomes. Almost two years after the initial vision team formed, we engaged 28 leaders in harvesting lessons from the project. Their observations raise lessons and questions about distributed leadership of

system transformation that warrant further reflection and investigation. We discuss three themes below.

Thinking Differently about Outcomes

It's important to consider a complex array of outcomes in evaluating organizing's effectiveness as a means of building distributed leadership. The effort's goal – to transform a health system – was recognized by participants as long-term, challenging, and only incompletely achieved over the course of a year. Their continuing sense that the ultimate vision is elusive and its path unclear raised some frustration. At the same time, participants underscored unexpected outcomes as measures of success.

For example, members cited the formation of new, substantive relationships among individuals and institutions. Said one health system leader:

> How many times do payers and providers sit down to talk? Once a year to renegotiate their rates. What about payers, providers, and community members? Never, at least to the extent that I've been involved. How about payers, providers, and community members working on how money should be reinvested and used at the community level? *Never!* We are completely changing the conversation.

This expanded relational capital across groups is a basis for the further exercise of distributed leadership, as noted in Part 2.

Second, during this work, some groups' leadership practices became more widely distributed across the leadership network. For example, members cited their new appreciation of how to use measurement to enable action. Early on, public health leaders introduced a data-driven approach to health risks that helped residents identify the populations they most needed to engage. Later, systematic methods for connecting patient data with the effort's outcomes provided a robust baseline from which to measure progress. Now, at screenings, residents sign waivers allowing the effort to connect new-member data to useful local services. A second example of practice spread is, in the words of one leader, the "wide recognition that the community-based approach is worthwhile." Hospital leaders are using organizing practices to create change in other contexts. One hospital leader:

> It is not easy to effect change at the hospital and provider side; it is infinitely harder to figure out how to partner with the community. This effort has shifted our thinking from a service-oriented model to an organizing model – in which we all have commitments to make. It is not easy. There are history, race, and class dynamics embedded.

> But the most important thing from the standpoint of the providers and payers is the recognition that the community has to be involved for us to achieve true transformation …[U]ntil the community is involved we are not going to see tremendous changes in wellness and the overall health of the population.

The capacity of a community to tackle increasingly challenging problems over time, as measured by the presence of deeper networks and more widely shared leadership practices, might be considered a measure of success for multistakeholder volunteer efforts in its own right (Ganz & Wageman, 2008; Hackman, 2002; Kreuter, Lezin, & Young, 2000; Nowell & Foster-Fishman, 2010).

Individual Leadership

Distributed leadership does not preclude a significant role for the exercise of individual leadership. This effort significantly benefitted from the vision, moral authority, network of relations, and persistence of one significant leader widely cited as a key champion of the effort and, as evidenced by our network data, a vital source of important participants. This "champion" had broad networks of colleagues throughout the state who trusted him and admired his leadership. He convinced others that organizing could build a new way of practicing distributed leadership, engage deeply with residents, and be spread as a leadership approach across institutions and the state. At vital challenging moments and milestones in the effort, his presence, his obvious commitment, and his personal story were cited as continuing sources of motivation. His ability to recruit other admired and needed individuals was also critical to the vision team's launch and, ultimately, the composition of the core leadership team and Stewardship Board.

The question of whether the formation of every distributed leadership network needs a champion, or what critical leadership functions may be best served by an individual, has attracted much attention in the leadership literature (Crosby, 1999; Doherty & Mendenhall, 2006; Kotter, 1995; Nadler & Nadler, 1998; Shortell et al., 2002). Our own observations suggest that two particular leadership functions were frequently fulfilled by this effort's champion: convening individuals from different institutions and calling them to lead on behalf of the whole; and sustaining conviction that new ways of working together were possible. No obvious others had the moral authority and broad network of relations to perform these functions. Consistent with other research on critical leadership functions (Kanter,

2010; Podolny, Khurana, & Hill-Popper, 2004; Wasserman, Anand, & Nohria, 2010), we suspect that convening others, calling them to take a moral stance, and modeling sustained conviction are especially vital roles for "champions."

Role of Outsiders

A third set of themes was the role of outsiders vis-à-vis the community in the effort – for better or for worse. The organizing of distributed leadership in Columbia was significantly catalyzed by organizers from outside the community and funded by an outside foundation. How do outside trainers or consultants avoid undermining residents' experienced ownership of the efforts, especially when a clash of aims and approaches arises between insiders and outsiders? What is the potential of foundations to take a more effective role than providing money in multistakeholder system change? This effort's events suggest that both groups might best be thought of as *part* of the network of distributed leadership, with distinct roles.

Organizers

Residents identified positive contributions from outside organizers that insiders might not have been able to bring: (1) our organizing approach (emphasis on narrative, building new structures for teamwork, practices for group decision making) was different than prior approaches to "engaging the community" and offered many more opportunities for residents to take leadership; (2) system-dynamics ideas – about both the health system and interrelations among community groups and institutions in affecting health – helped them think differently about strategies for improving health; (3) curiosity about ReThink Health and new financial resources brought people to the table even when they felt that their problems had proved intractable before. Capacity building, convening, providing new ideas – all these are leadership functions that might be fulfilled especially effectively by outsiders.

However, risks were associated with outsiders' being part of the leadership. First, the very novelty of our approach was at times felt to be contrary to local norms and approaches. Said one leader, "Sometimes there's a tension between what we know works and what you guys think works." Second, new approaches to system dynamics sometimes left local participants feeling "lost in the weeds" or disconnected from the ability to lead coherent action, rather than enabled. Finally, the attraction of undertaking an effort supported –

for a time – by outside resources was balanced by a concern that those resources would leave long before the goal was achieved. Some felt that insufficient support existed during the transition to local ownership, stalling momentum. "We could [have] use[d] more hand-holding as we [were] charged with taking more ownership of the campaign," one leader said.

Foundations

The effort in Columbia suggests several ways that outside funders might accelerate local efforts and become a sustaining part of the distributed leadership network.

One possible role is funding and building the infrastructure for a learning network that would enable complex efforts like this one to stand on the shoulders of others that have confronted related challenges (Green & Kreuter, 2002). Many participants cited the need for other examples and an overall roadmap – a sense of how long different aspects of such efforts typically take (e.g., defining a vision, building leadership groups). While most well-defined community efforts can find grant funding, it is much rarer to identify sources focused on generating and sharing, across groups, the lessons learned from many efforts.

Moreover, foundations can be conveners – neutral parties known to hold strong values, able thereby to bring key institutions, even competitors, together across a common table. As such, they serve as champions – and create gatherings that would not otherwise happen.

Finally, we saw the need for resources beyond the energized and capable members of the campaign itself. While participants donated immeasurable time and skills, like most volunteers they were chronically at risk of burnout. Complex efforts need skills in communications and management, finance and accounting, data management and analysis. Building partnerships with individuals and organizations that can provide those supports is another potential role for foundations experienced in creating constructive partnerships.

CONCLUSION

Sustaining distributed leadership depends on the degree to which shared leadership practices and relationships are strengthened and constructed over time. In any complex effort, turnover of leaders is a continual process. The infrastructure to train and socialize new members in the core practices

of collaborative leadership takes deliberate building and maintenance (Doherty & Mendenhall, 2006). A critical aspect to watch in the future of this effort is the degree to which an ongoing coaching structure is embedded in the work and reinforces the shared practices across institutions over time. In the words of one leader: "Convening and connecting people, catalyzing their ability to work together – people see its value but undervalue the associated costs because it is not technical in nature. We *have* to invest in this kind of work."

The effort in Columbia to bring the leadership practices of community organizing to the transformation of health and health care offers, we think, much potential as an approach to developing distributed and interdependent leadership for system change. While the effort's long-term impact on the system's outcomes – population health, care quality, costs of healthcare for residents – will have to unfold over time, organizing as an approach to capacity development did, indeed, result in new, broadly shared leadership of the local system. And, as we have suggested above, it raises additional questions and potentially fruitful avenues of exploration about how such leadership might best be developed and sustainably supported over time.

NOTES

1. The Fannie E. Rippel Foundation is a catalyst for new ways of thinking about and addressing the complex and growing challenges of the U.S. health system. Its flagship initiative, ReThink Health, advances knowledge and tools needed to support regional leaders in their efforts to find new ways to transform health and health care in their community.

2. We refer to participants in this kind of leadership as "volunteer," but not in the colloquial sense of "unpaid." By volunteer, we mean people operating for purposes beyond their organizations' aims and boundaries, choosing to engage in cross-organizational, collective work. As one executive put it: "I am committed to the 'greater good' – or to a larger effort for systemwide change for health." Volunteers participate as individuals, though they may at times act on behalf of their organizations. Some participate as part of their paid work, having requested permission from their institutions to participate in light of their personal convictions.

3. The project's design criteria included: (1) engage volunteer multistakeholder groups in action; (2) respond directly to a community's expressed values and interests; (3) use organizing to achieve outcomes; (4) build new team and leadership capacity; and (5) achieve measurable goals.

4. The Institute for Healthcare Improvement (IHI) first developed the Triple Aim as a framework for optimizing health system performance. Its goals: (1) improving

patients' experience of care, (2) improving population health, and (3) reducing per capita cost of care.

ACKNOWLEDGMENTS

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