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Lynn Perry Wooten
Stephen M. Ross School of Business
at the University of Michigan

Lise Anderson
Department of Obstetrics and Gynecology
University of Michigan

Joy Pinkerton
Department of Obstetrics and Gynecology
University of Michigan

Tamiko Noll
School of Nursing
University of Michigan

Jodi Lori
School of Nursing
University of Michigan

Scott Ransom
UNT Health Sciences Center

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Lynn Perry Wooten, MBA, Ph.D.
Ross School of Business, University of Michigan
701 Tappan Street
Ann Arbor, MI 48109-1234
(734) 763-0486
E-mail: lpwooten@umich.edu

Lise Anderson, MPH
Joy Pinkerton. MPH
Department of Obstetrics and Gynecology, University of Michigan
NIH Roadmap Disparities Project
UM OBGYN, Lobby K Level 3
Domino's Farms
24 Frank Lloyd Wright Dr.
Ann Arbor, MI 48106
(734) 930-5616

Tamiko Noll
Jodi Lori
School of Nursing
University of Michigan
400 North Ingalls
Ann Arbor, Michigan 48109-0482

Scott Ransom, DO, MBA, MPH
President, UNT Health Sciences Center
3500 Camp Bowie Boulevard
Fort Worth, TX 76107-2699
(817) 735-2509
E-mail: sransom@hsc.unt.edu

Abstract

Healthcare management research overlooks the role of collective leadership actions in alleviating health disparities. However, exploring the strategic actions of collective leaders can provide the field with a different viewpoint of how individuals and organizations partner to solve complex problems such as health disparities. To examine this issue, this paper uses prenatal health disparities as a backdrop. We present our analysis of multiple case study data of nonprofit and healthcare organizations. Through our analysis of this case study data, we develop an understanding of collective leadership and strategies they employ as change agents. In addition, the case studies highlight the importance of collective leadership as of process of learning, the diffusion of knowledge across organizational boundaries, and the empowerment of stakeholders.

Keywords: Strategic Leadership; Health Disparities; Organizational Change

Recent coverage in medical journals and the popular press highlights that the overall health of Americans has improved dramatically over the last century. However, subsets of the population, including people of lower socio-economic status and racial and ethnic minorities, experience poor health outcomes and problems with accessing quality healthcare services. In addition, other research expresses concerns about the care differences provided to women, children, the elderly, and those with chronic illness. These differences often are clustered under the broad heading of "healthcare disparities."

Closing this gap of healthcare disparities has become a major priority for many government agencies, medical researchers, healthcare organizations, and community groups Despite the commitment of multiple stakeholders to closing the gap, there is very little understanding of how leaders can effectively organize to achieve this goal. This is not surprising since in a large segment of healthcare research and practice the organizational perspective has been neglected. Yet, a body of literature exists in organizational theory and management research that examines how leaders strategically work collectively with stakeholders to solve complex problems and create change in their organizations.

Thus, this paper explores strategic leadership as a collective mechanism for alleviating healthcare disparities. The paper focuses on prenatal care as a backdrop to understand the role of collective leadership in alleviating healthcare disparities. We begin the paper by briefly examining the conceptualization of strategic leadership as a collective phenomenon. Then, the paper describes our case study research methodology used to investigate how leaders develop strategies for alleviating prenatal health disparities. After the presentation of our research methodology, we present the case studies and our findings on collective leadership and strategies

they employ as change agents to alleviate health disparities. Finally, this paper concludes with a discussion of our theoretical understanding of this research.

STRATEGIC LEADERSHIP AS A COLLECTIVE PHENOMENON

Leadership is an important aspect of society that has defined civilization values and goals through time (Young, 2004). In many instances, it serves as the focal point and guiding force of a group's behavior by inducing compliance, discharging influence, personifying norms, and mobilizing efforts toward goal achievement (Bass, 1997; Stogdill, 1950). Moreover, leadership has evolved into a strategic activity that includes communicating a vision, developing organizational structures and processes, managing change initiatives, and creating capabilities (Selznick, 1984;Hitt, 2002).Accomplishing these leadership tasks demands the capability to inspire people and mobilize resources. Thus, in the context of leadership that focuses on health disparities, this definition suggests a skill set to understand and maneuver social, political, and economic institutions through decision making and the implementation of policies (Bryson & Crosby, 1992). It also assumes that successful leaders understand the needs and perspectives of the constituents they serve and can create a network of individuals to meet these needs that extends it boundaries beyond the focal organization (Denis, Lamothe, & Langley, 2001).

This collective action focus of strategic leadership demands ongoing cooperation among stakeholders (Maguire & Hardy, 2005). Instead of relationships controlled by markets or hierarchies, leaders work together, and their work relationship is governed by collaboration needs. Thus, the control mechanisms for collective leadership rely on goal congruence, shared values, and strong feelings of solidarity to govern behavior within the group (Ouchi, 1980). The solidarity of collective leadership stems from the necessary dependence on, respect for each

other, and previous relationships (Kunda, 1992; Yang, 2006). In many circumstances, collective leadership is the result of a process to bring together diverse constituents for a purpose (Taylor, 2005). That is, individual leaders become entwined and engaged through a network of partners connected to solve a problem or create change, and each leader within the network is empowered to contribute throughout the process (Spreitzer, DeJanasz, & Quinn, 1999)

Informed by theory, we propose that collective leadership emerges in many different forms and engages in a diverse set of strategic actions when addressing healthcare disparities. The causes of healthcare disparities are multiple and include poverty, educational level, access to healthcare, societal discrimination, and lack of understanding for how to treat diseases affecting minority populations (Hogan, 2004). This makes it difficult for leaders to craft a viable strategy and define effective mechanisms for alleviating this problem. Hence, the purpose of this study is to explore the various approaches of collective leadership that address prenatal healthcare disparities. Although some organizations have attempted to address this problem, the successes are few, and with the organizations that have succeeded their strategies remain ambiguous. As such, it is our intent to identify the strategic actions that an outcome of collective leadership formed to address prenatal healthcare disparities.

RESEARCH CONTEXT

African American babies have the highest infant mortality rate in the developed world, and twice as many African American babies as white babies die in infancy. Similarly, African American women are three times more likely than white women to die during pregnancy (David & Collins, 1997; Journal of American Medical Association, 2002). This gap in birth outcomes has not only persisted, but also grown in recent years despite federal and state government

attempts to eliminate the difference. Interestingly, this long-standing healthcare disparity has become a medical mystery since it is not easily explained by mother's age, access to prenatal healthcare, or socioeconomic status (Kashef, 2003). Because of the significance of this healthcare problem, the Centers for Disease Control (CDC) and Health Resource and Service Administration have identified this as a priority; and funding and programs have been developed to support individuals, and community and healthcare professionals to close the birth outcome gap between whites and African Americans (United States Department of Health and Human Services, 2000).

The research team for this project was funded by the National Institute of Health as part of a Roadmap for Medical Research grant to take an interdisciplinary approach to help solve the problem of prenatal healthcare disparities. The research team members represent more than a dozen different academic disciplines, such as business, nursing, engineering, medicine, social work, anthropology, and public health. The research group is segmented into three core areas: 1) the provider core focuses on understanding how their interactions with patients influence the quality of care and the evaluation of augmented prenatal care; 2) the patient core looks at the influences of cultural attitudes and socio-economic status as a contributor to prenatal healthcare disparities, and coordination of traditional prenatal care with education, social services, and other alternative approaches; and 3) the leadership core investigates the perspectives and actions of leaders at healthcare organizations, government agencies, and nonprofit organizations responsible for improving access to prenatal care of African Americans and managing the racial gap in birth outcomes.

RESEARCH METHODOLOGY

General Approach

The research team began their journey by meeting bi-weekly with other core areas to create a conceptual framework that would guide our grant research. This framework is illustrated in Figure 1. While developing this framework, the leadership core also created a database of organizations that were engaged with alleviating prenatal healthcare disparities. This database contained more than 75 different organizations, such as hospitals, health clinics, government agencies, and other nonprofit organizations. For each organization in the database, we coded leadership practices, barriers to addressing prenatal healthcare disparities, knowledge management strategies, funding sources, and program outcome measures. As we collected and coded organizations for the database, it became salient that many organizations were adopting a collective leadership approach to address prenatal healthcare disparities. However, the approaches and their outcomes varied across organizations, and the database did not fully capture the process side of each organization's strategy. Thus, we wanted a more in-depth understanding of a sample of organizations within our initial database. To accomplish this goal, we collected case study data from a purposive sample of seven diverse organizations. The case study method was chosen because, similar to other qualitative research methods, it allows researchers to gain a holistic overview of the research's context and capture data on the knowledge of various stakeholders. Case studies also enable researchers to better understand social life by identifying and elaborating on social process theories as they unfold in the data (Glaser & Strauss, 1967; Locke, 2001). Furthermore our purposive sample allowed the research team to study deviant and diverse organizations based on dimensions such as size, strategies for alleviating healthcare disparities, types of collective leadership, and effectiveness (Eisenhart, 1989; Patton, 1990).

Data Sources

For this study, the case study data was obtained from seven sites, and the attributes of each site are summarized in Table 1. For each case study, our data collection involved triangulation through multiple sources (Yin, 1999). The case study data for four of the sites were solely based on secondary data from documentary and archival information. This secondary information was collected from computer databases containing newspaper articles and news transcriptions, such as ABI Inform or Lexis/Nexis, books, training manuals, press releases, organizational documents, annual reports, and Web sites. This qualitative data consisted of public accounts provided by legitimate organizational sources regarding the leadership strategy of each organization and provided a rich source of insights into the perspectives of different organizational stakeholders (Forster, 1994). Consistent with Langley's (1999) description of qualitative process data, these accounts provided excellent narratives describing why the organization's leadership focused on prenatal healthcare disparities and the collaborative strategies implemented to alleviate this problem.

In addition to secondary data for three of the case studies, primary data was collected through narrative interviews and direct observations. Through a series of meetings and conferences during the first 18 months of the NIH grant, the interview protocol was developed by the inter-disciplinary research team. This interview protocol is based not only on questions the research team viewed as relevant to the case studies, but also on feedback from industry experts, healthcare practitioners, community leaders, and African American mothers. Similar to our second qualitative data collection process, the interview questions centered around leadership's conceptualization of healthcare disparities as a problem, the organization's capacity to address this problem, the nature of its partnership relationships, and the leader's vision for change. On average, each narrative interview for the case studies lasted 90 minutes, and at least

two team members were present. The interviews enabled the research team to view the research topic from the perspective of the healthcare leader to understand how he or she developed a particular perspective (King, 1994). Also, through the narrative interviews questions were designed to encourage respondents to reveal tacit and abstract knowledge about their experiences (Denning, 2000).Therefore, we perceived the interviewee as a participant in the research by actively shaping the direction of the interview. Their knowledge became the springboard for the case studies by transferring the experience and expertise into learning for the research team.

Data Coding and Analysis

The data for this study included more than 300 pages of archival data and professionally transcribed field notes from interviews and direct observations. The case studies were analyzed by examining and categorizing our data to understand the initial research interest of how leaders collectively strategize as change agents to alleviate prenatal health disparities (Yin, 1994.) This was accomplished by employing grounded theory to guide our process for analyzing case data (Strauss & Corbin, 1998). We used an open-ended coding process by first examining the data for similar themes, and then organized themes into coding nodes that identified concepts and properties. After categories were established, data was double coded by at least two research team members for consistency and entered into Microsoft Word or NVivo, a qualitative data analysis software package. Our data analysis was an iterative process that involved fitting accounts into categories and refining categories as themes emerged. Furthermore, the analyses of cases were done by using both a within-case and cross-case analysis strategy (Miles & Humberman, 1994). Within-case studies allowed us to context actions of a particular organization, whereas the cross-case analysis permitted cross-case comparisons. Figure 2

illustrates our data analysis results in a succinct framework, and the next sections present a detailed analysis of this framework.

ANALYSIS

Collective Leadership As Diverse Partnerships

A recurring theme during our analysis of case study data was the importance of diverse sets of leaders working together to build the capacity needed to alleviate prenatal health disparities. As summarized in Table 1, this constellation of leaders extends beyond the organizational boundaries. This is consistent with institutional theory that contends when confronted with the challenge of solving a complex problem and external environmental pressures for change, organizations will form an interrelated, pluralistic network of leaders (DiMaggio & Powell, 1983; Denis, Lamothe, & Langley, 2001). Thus, a combination of leaders from within the organization and external to the organization provide an extensive network of individuals that can increase the organization's legitimacy, prestige, internal and external commitment, attraction of personnel resources, and survival capabilities (DiMaggio & Powell, 1983; Scott, 1987; Zucker, 1988). Furthermore this inter-organizational constellation of leaders was essential to the organizations in our study because of their dependency on each other for resources. By employing this bridging strategy, the organization expands its resource and knowledge by strengthening the links between the organization and its external stakeholder (Scott, 2003).

The County Health Coalition in our case study is one example of leaders collaborating across organizational boundaries. This nonprofit organization was created in 1992, in response to the high rates of infant mortality in the geographical region it serves. From its inception a unique set of partners were invited to help the organization achieve its mission of improving the health

of its residents through quality, cost-effective care. These formal partners include providers and corporate purchasers of healthcare, consumers, committee county residents, government representative, and insurers. As communicated by the director:

> *Solving our area's healthcare problems is a big challenge. The issues are complicated and the answers are complex. By working together, we can do so much more than any of us could ever accomplish working alone.*

In contrast, Focusing on Pregnancy has a different tactic for is partnering relationship. Focusing on Pregnancy was developed by a nurse midwife, and it is group model of prenatal care that has positive outcomes for reducing disparities. Presently, more than 60 independent health organizations have been trained in and have adopted this approach that is similar to a franchised model business. In each satellite location, there is a leader responsible for implementing the program. In many instances, this leader is a nurse midwife, so the leadership partnership is informally governed by a shared professional ideology. Through training and socialization, nurse midwives form a collective dominant logic that shapes their professional work ideology and defines a holistic approach to patient-centered care aligned with the Focusing on Pregnancy model of group prenatal care (Weick, 1979; Wooten & Crane, 2003). Normative isomorphism facilitates the diffusion and protection of this work ideology into organizations. (DiMaggio & Powell, 1983). This philosophy is captured on a patient brochure from a Focusing on Pregnancy affiliate that describes the program benefits by emphasizing the work ideology of the nurse midwife profession:

> *Midwives have been available to women since the beginning of time. The very word "midwife" means to be "with women." A midwife works to teach, support, love, and empower women throughout all stages of life*.

Interestingly another of our case studies sites, The March of Dimes, financially supports the expenses associated with implementing the Focus on Pregnancy approach at select locations. This is an example of the March of Dimes' ability to align with external partners to achieve its mission. However, the focal point of the March of Dime's collective leadership manifests in a complex organizational structure of boards, councils, and affiliate chapters coming together to make the future better for babies (March of Dimes, 2005). The boards and councils support the March of Dimes' mission by representing a diverse set of discipline and constituents, such as the research community, other nonprofit partners, volunteers, nurses, epidemiologists, and public policy professionals. Furthermore, there are chapter leaders in every state as well as Puerto Rico and the District of Columbia. The chapter leaders are instrumental in fundraising efforts on a grassroots level, responsible for organizing a large portion of March of Dimes' special events, and planning outreach programs to educate their local communities.

Each of these cases illustrates the power of diversity and collectivism to solve a complex community problem. Diverse leaders extended the organizational boundary, and by coordination and cooperation their efforts built social capital to address the problem of prenatal health disparities (Flanagin, Stohl, & Bimber, 2006). From a macro-level viewpoint, this social capital is built upon commitment to a cause, networks and trust (Putnam, 1996). Thus, social capital evolved into a resource that unified stakeholders and facilitated the pursuit of common benefits (Lee, Chen, & Weiner, 2004).

Collective leadership manifested through diverse partnership is consistent with the community-based model of public health (Pestronk, 2000). This model argues that more than one person or organization is needed to improve the public health of a community. Diverse leaders

working on public health problems bring a different epistemological style. When collective leaders' partners are treated equally and trust each other, their diverse views relating to the cause of public healthcare problems and the methodology to solve them produces a synergistic approach to tacking these complex problems (Pestronk & Frank, 2003).

Collective Leadership and Capacity Building

In addition to the importance of a diverse set of leaders working together on prenatal healthcare disparities, our case studies reinforced the significance of capacity building as a collective leadership activity. Capacity building refers to leaders creating an infrastructure (staff, skills, resources, and structures) to address more effectively healthcare or other social problems (Joffres, Health, Farquharson, Barkhouse, Latter, & MacLean, 2004). In the context of public healthcare, capacity building expands beyond the short-term goal of putting into practice pre-designed healthcare programs to the long-term investment in a systematic approach to helping communities solve healthcare problems. In the vein of the resource-based view of organizations, the capacity building research acknowledges that for organizations to succeed they must acquire and leverage a unique set of valuable skills and assets (Wernerfelt, 1984). However, the dominant focus of capacity building is not competitive advantage through profit maximization or some related strategic goal. Instead, nonprofit and healthcare organizations engaging in capacity building perceive their financial objectives as not an end, but as a means to achieving their objectives (Ritchie & Weinberg, 1999). In the majority of our case study organizations, securing funding to support their aspirations was an essential capacity-building activity. For instance, leaders in a county affiliate of the state health department indicated how they took the initiative

to find external funding sources, to support a program that had a proven track record of improving birth outcomes of African American women.

> *Our funding organizations bought into this like United Way and others because they said--we were going after big bucks. We were writing grants for five hundred thousand. We've written grants for a million. Now we haven't been successful in all of these grant applications, but the thing that really a lot of our local foundations and people said here was, "You know, we're so tired of seeing people just kind of throw pennies at issues and problems in community-- and they said it was--they wanted to jump on the bandwagon on this program because number one, it's been proven that if you follow this regime, you'll get--you should get a similar result and certainly, we have here. We've proven that out over six years."*

For the Focus on Pregnancy program, external funding was sought from grants not only to finance the cost associated with it program, but also to conduct research that validates the program's effectiveness. This brought legitimacy to the program and helped the founder better promote it.

Another common theme that emerged from our data was the focus on capacity building as a human resource management task. Frequently, the organizational leaders in the case studies exerted energy on linking a solution for alleviating prenatal disparities with the appropriate human capital and created systems to ensure they would excel at their job. At Parkland Memorial Hospital, where the African-American neonatal death rate is roughly half the national average, the top management team has designed a rigid hierarchy supported by teamwork and a strong organizational culture:

> *The professional staff in Parkland's L&D areas is divided into an elaborate hierarchy. At any given moment, there are 14 distinct levels of medical staff, from nurse's aides ("OB techs") to attending physicians with years of experience. The hierarchy involves a precise definition of duties and authority at every level: There are three different kinds of nurses, for instance, each allowed to do different things. And yet in practice, the L&D floors could not be less hierarchical. L&D has an egalitarian, all-hands-on-deck spirit.* (Fishman, 2002: 106).

Building human resource capacity also involved addressing the issue of being too understaffed to accomplish their goals; this was a frequent problem discussed by the leaders we interviewed. However, many of the leaders were innovative in addressing this issue. Confronted with this situation, the South Carolina Department of Health decided to work with the African Methodist Episcopal churches to alleviate prenatal healthcare disparity in its state (March of Dimes, 2005). This faith-based alliance has been successful at raising awareness of infant mortality in the African American population, teaching about the value of folic acid and the signs and symptoms of preterm labor. The program also aims to reduce SIDS risk among its 609 congregations (200,000 members) in South Carolina. Program leaders believe they have successfully raised awareness about pre-conceptual health (Speed & Miles, 2003).

Collective Leadership and Organizational Learning

Organizational learning is a natural consequence of capacity building through collective leadership (Sandmann & Vandenberg, 1995). Effective collective leadership embraces knowledge as a key asset, and understands its importance in providing substance to an organization and informs leaders' actions. Individual leaders not only bring knowledge into the group, but also create knowledge through a learning cycle. In a circular manner, these learning cycles combine reflecting, planning, and acting. Hence the group is always searching for innovative ways to solve a problem, such as by recombining resources, challenging the status quo, or adopting new models (Argyis, 1977). This requires the involvement of leaders who possess a skill set to identify relevant information, assimilate it, and apply it toward a new goal (Boal & Hooijberg, 2001).

The Cincinnati, Ohio, program Every Child Succeeds is illustrative of collective leaders engaging in organizational learning. It a partnership between public and private groups and has adapted the management practices of Procter & Gamble to reduce infant mortality disparities in the Cincinnati area. This learning was inspired by the former CEO, John Pepper, and former comptroller, David Walker. Similar to Procter & Gamble it has relatively narrow results and is run to produce specific results that will have the greatest impact (Naik, 2006). Like Procter & Gamble, the program targets markets, constantly monitors its performance, and expects partners implementing its program to produce. Every Child targets high-risk, first-time mothers early in their pregnancy. With these first-time mothers the core activity is the frequent structured home visits with nurses and social workers that are monitored by a quality assurance coordinator. Also, the program borrows ideals from Japanese manufacturing techniques, such as the Red/Green chart to measure performance.

Collective Leadership through Empowerment

In addition to organizational learning**,** we found in our case studies that the ability to empower others was a behavior associated with collective leadership. This notion of empowerment has historical roots in the social change movement of the 1960s and 1970s, when it unfolded as a process for the "oppressed" to use their strengths to take charge of their lives (Reinelt, 1994). The empowerment process, viewed through a social change lens, involves increasing personal, interpersonal, or political power so that individuals, families, and communities can take action to improve their situations (Gutierrez, 1994). More recently, empowerment has been conceptualized in the organizational behavior literature as the delegation and passing on of power from higher organizational levels to lower ones (Forrester, 2000;

Carson & Knight, 2005). When empowered, individuals have the freedom and ability to make decisions because they are provided with clearly defined roles, have access to the necessary resources, and socio-political support (Spreitzer, 1996). So collaborations and partnerships become the common governance mechanism for empowerment relationships (Holosko, Leslie, & Cassano, 2001).

In our case studies, empowerment emerged in multiple situations and in different types of relationships. For instance, in some interviews leaders discussed the importance of empowering patients to alleviate prenatal health disparities. This idea of patient empowerment assumes that positive health behaviors are both strengthened and learned as the result of a participatory experience and sense of control over health encounters with medical professionals (Ouschan, Sweeney, & Johnson, 2000). Patient empowerment is the discovery and development of an inherent capacity to be responsible for one's health and well being (Anderson et al., 1991). Patients become empowered when they have the knowledge, skills, resources, and self-awareness to improve the quality of their health. With this approach, the healthcare provider acts as an advocate by supporting development and becoming part of the patient's resource network (Manning, Cornelius, & Okundaye, 2004).

The state health department is an example of leaders adopting a patient empowerment model of prenatal healthcare. In certain counties, prenatal care programs empower patients by providing individualized attention and mentoring through the healthcare systems. Alleviating bureaucratic obstacles embedded in healthcare systems has improved access to and the quality of healthcare for prenatal patients in this state. The healthcare leaders implementing Focusing on Pregnancy embrace a group model of patient empowerment. This program brings women out of the exam room into groups for augmented prenatal care. The women have their initial intake in a

traditional obstetric care setting, and then join groups of 8-12 with similar due dates. Although group time is led by a healthcare provider, such as a certified nurse midwife, pregnant participants are responsible for monitoring their health statistics and contributing to the group's learning process.

In addition to patient empowerment, leadership at both the March of Dimes and the state health department has invested in grassroots community programs as a mechanism for empowerment. These investments provide resources to design and implement prenatal programs specifically tailored to address disparity problems in local communities. By diffusing resources, power is transformed to local groups, and they are responsible for allocation of these resources and producing results (Himmelman, 2001). Since these grassroots investments encourage the participation and representation of local stakeholders, they take more ownership in ensuring the program's success (Couto, 1998).

CONCLUSION

We begin this research journey with the goal of exploring strategic leadership as a collective mechanism for alleviating healthcare disparities. Thus, the analysis of our case studies viewed leaders not as individuals, but as members of a community of practice working together to alleviate healthcare disparities. As proposed, collective leadership emerged as a complex construct. Because of the multi-faceted nature of prenatal healthcare disparities, leadership partners were diverse and their networks extended across organizational boundaries. This enabled the organizations to leverage social capital when implementing programs reduce prenatal health disparities. Furthermore, we found in our case studies that the strategic actions of collective leadership focused on capacity building and organizational learning. As a capacity-

building activity, leaders spent much of their time securing and managing resources. Although these resources served as the fuel to implement their ideas, organizational learning was the key to innovative programs. This learning process translated the tacit knowledge of leadership groups and knowledge from other disciplines into effective health programs. Finally, the organizations we studied highlight the significance of empowerment. Collective leadership not only involved sitting in the boardroom and crafting a strategy, but also entailed empowering those who can make a difference in the implementation of this strategy.

Table 1

Organization	***Data Sources***	***Strategic Focus for Addressing Prenatal Healthcare Disparities***	***Leadership Partners***
Focusing on Pregnancy (Organizational name disguised for anonymity)	Primary & Secondary Organizational Documents Newspaper Articles Journal Articles Interviews Research Presentations	Empowering group care for pregnant women and their families	Professional Associations Hospital Healthcare Providers Patients
Midwest State Health Department (Organizational name disguised for anonymity)	Primary & Secondary Interviews Organizational Documents	Focus on eliminating the state's health disparities by ensuring policies, programs, and implementation strategies are culturally and linguistically tailored to reduce mortality and morbidity rates. Collaborate with state, local, and private sectors to advance and implement health promotion and disease prevention strategies. .	Community Leaders National Nurse-Family Partnership State Health Department
Midwest Health Coalition (Organizational name disguised for anonymity)	Primary & Secondary Direct Observations Interviews Organizational Documents	Improving the health status of their residents, and the quality and cost-effectiveness of health systems in our region.	Community Leaders State Health Department Federal Health Agencies Local Corporations Hospitals Healthcare Providers
Every Child Succeeds	Primary & Secondary	Every Child Succeeds is a prevention program. It seeks	Children's Hospital Medical Center of Cincinnati

Organization	***Data Sources***	***Strategic Focus for Addressing Prenatal Healthcare Disparities***	***Leadership Partners***
	Organizational Documents Newspaper Articles	to optimize child development by working with children and their families prior to the emergence of problems in health.	Cincinnati-Hamilton County Community Action Agency/Head Start United Way of Greater Cincinnati Procter & Gamble (informal link)
March of Dimes	Primary & Secondary Organizational Documents Newspaper Articles Television & Radio Transcripts Videos	To improve the health of babies by preventing birth defects, premature birth, and infant mortality. We carry out this mission through research, community services, education, and advocacy to save babies' lives	Researchers Local Affiliates Celebrities Healthcare Providers
Parkland Hospital	Secondary Organizational Documents Newspaper Articles Television & Radio Transcripts Videos	Provides high-quality, low-cost medical, hospital, and other health-related services to all in a manner that is consistent with the patient's needs, values, and recognized belief systems, including to the indigent and medically needy of Dallas County; and provides services that improve the health of the community.	Employees Community Organizations Affiliate Hospitals Research Consortium
South Carolina Department of Health	Secondary Organizational Documents Newspaper Articles	Dedicated to reducing the infant mortality rate in the African American community by helping parents access	Healthcare Professionals African American Churches Federal Government Healthy Start Programs

Organization	***Data Sources***	***Strategic Focus for Addressing Prenatal Healthcare Disparities***	***Leadership Partners***
	Research Presentations Community Presentations	information and resources to ensure better health and well being for their children and families.	

FIGURE 1

Conceptual Framework: Health Disparities -- Leaders, Providers, and Patients

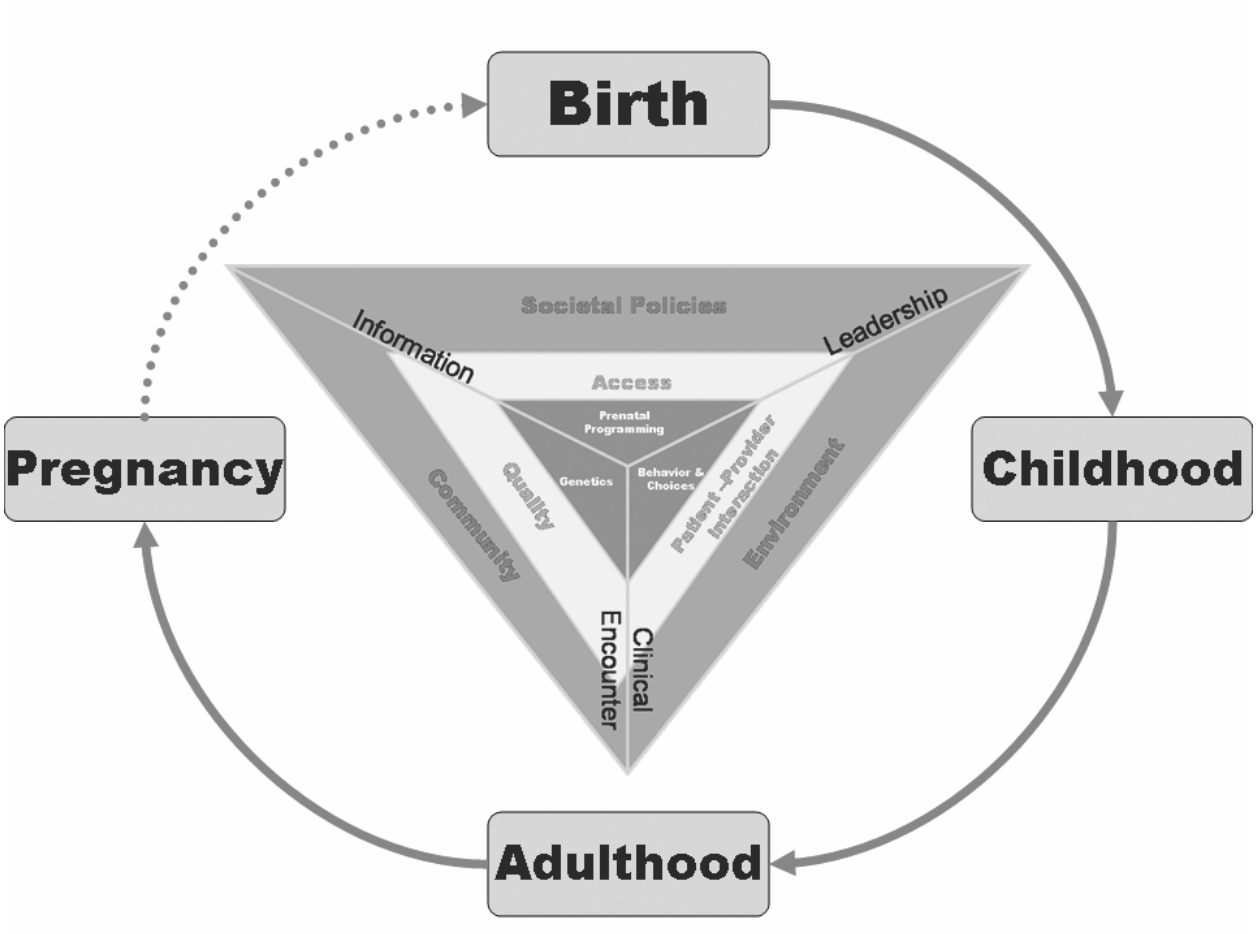
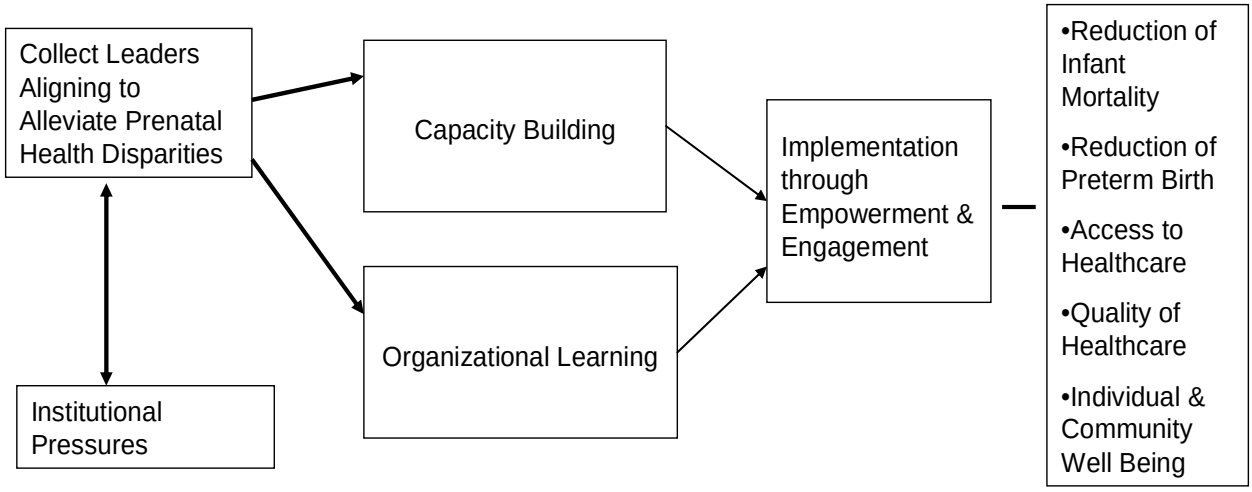


Figure 2

A Framework**:** Collective Leader Strategizing as change agent in closing the gap of parental health disparities



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