COLLABORATING FOR INCREASED EFFECTIVENESS: APHA, ITS SECTIONS AND AFFILIATES

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OBJECTIVES

- Review history of APHA's community
- Discuss APHA's organizational complexity and inter-component conflicts
- Identify examples of collaboration between APHA's organizational units
- Consider APHA's trajectory for collaboration (advocacy, expertise, dialogue)

ORGANIZATIONAL REALITIES

- Communities (e.g., membership organizations) often complex, disorganized
- Diverse constituencies unknowingly share interests but function independently
- Constituencies attend to unique focus, precluding more global view that enhances units and organizational performance

Project Genesis

- Interest in systematic understanding of APHA
- Interpersonal links
- Lack of familiarity with APHA's historical record
- Desire to advance mission of APHA

Methodology

- Review of literature on collaboration and partnering
- Review of APHA's institutional history as captured by organizational documents
- Email survey to APHA staff and organizational leaders (CoA and ISC)

MODELS OF COLLABORATION

- Stages of Collaborative Development
- Elements of Group Collaboration
- Community Model of Collaboration
- The Team Model of Collaboration

Stages of Collaborative Development

- I. Forming: orientation, testing, and dependence
- II. Storming: resistance to group/collaborative influences and task requirements
- III. Norming: openness to members of other group; cohesive action develops; collaborative roles are adopted; roles become flexible and functional; structural issues being resolved; structure can support collaborative actions
- IV. Performing: constructive action
- V. Adjourning: self-evaluation, disengagement or stronger collaborative model

[Source: BW Tuckerman. 1965. "Development Sequence in Small Groups." *Psychological Bulletin.* 63(6):384-399.]

Elements of Group Collaboration

- I. Establish well-defined, forward-looking purpose relevant to both groups; encourage respective group members to work through differences in expectations toward common valued purpose
- II. Respective group participants formulate goals as an intermediary task between purpose and outcomes; need for members of both groups to agree upon and set goals collaboratively and to describe them in measurable terms
- III. Need for good leadership to influence activities toward goal attainment; set and maintain structures for making decisions, managing conflict, listening, coordinating tasks, providing feedback
- IV. Establish regular patterns of communication where all members share ideas and information; ensure clear written records, sufficient time for group collaboration and reflection

Elements of Group Collaboration (continued)

- V. Develop cohesion as a sense of camaraderie and involvement generated by working together over time; develop unique and identifiable team spirit and commitment toward common goals, the team, and trust of individual members; build collaborative's longevity and desire to work together
- VI. High level of mutual respect team members, where individuals are more open to talents and beliefs of each person and their professional contributions and diversity of opinions that may emerge

[Source: SM Mickan and SA Rodger. 2005. "Effective Health Care Teams: A Model of Six Characteristics Developed from Shared Perceptions." *Journal of Interprofessional Care*. 19(4):358-370.]

Community Model of Collaboration

- Members have common interest, affinity, or goal
- Members are often self-grouping
- Members seek to share information
- Members seek to further their understanding of the practice or area of interest
- Membership is loosely controlled
- Membership must be relatively large to be self-sustaining (new content is always needed)
- Large communities are often moderated, facilitated or edited
- All members are encouraged to both read and write content; most members find value in just reading

Community Model of Collaboration (continued)

- Contributors are usually around 10% of the community population
- Most interactions are asynchronous; but recent "chat" communities have sprung up that utilize IM as interaction medium instead of threaded discussions
- Rules of engagement, or appropriate behaviors for the community are often well-defined

[Source: David Coleman, *Collaborative Strategies LLC*. 2003]

The Team Model of Collaboration

This model is used to facilitate the activities of a team. Its characteristics (many of which are shared by teams in general) are:

- Members share a few common objectives
- Members have a shared stake in their success, as well as that of the overall organization (e.g., APHA)
- Members are often bound by the parameters of a project
- Members are interdependent
- Membership is tightly controlled
- Membership is relatively small (2-20)
- Most members both read and write content
- High level of interactivity

The Team Model of Collaboration (continued)

- This model has many characteristics of an e-meeting
- Access and security are tight and often based on roles, groups, or projects
- New members can get up to speed by reading the group "history"
- Content/document management and project management features such as: check-in/check-out, version control, task and issue management, and escalation are common
- Co-editing, project dashboards and/or executive overviews are also common

[Source: David Coleman, *Collaborative Strategies LLC*. 2003]

APHA TODAY

- 24 scientific sections
- 53 state affiliates (including 2 from CA, NY and DC)
- >50,000 national and/or affiliate members

CoA and the AFFILIATES

53 affiliates represented by CoA: 10 regional representatives and 6 APHA appointed regional members-at-large

- Each regional representative serves multiple (state) affiliates in his/her region;
- Appointed by affiliates within a region to serve on Committee on Affiliates (CoA); some nominated by CoA Chair and appointed by APHA President Elect and Executive Director
- Individual affiliate represent own individual organization (ARGCs)
- Affiliates have separate dues structure; minimum membership overlap between affiliate members and APHA members
- Affiliates provide access to local level, grassroots advocacy
- Affiliates primarily have a practitioner focus

SECTIONS

- Actual unit of national APHA; section membership based on interest/expertise
- Dues only to national; affiliate separate membership
- National/scientific focus anchored in Annual Meeting
- Shared interests/concerns expressed via Intersectional Council (ISC)

In the beginning…

"If a date can be assigned to the professionalization of public health, it would be the appearance in 1872 of the American Public Health Association."

INITIAL ABSENCE OF COLLABORATION

"Great care was taken to protect (the Association) from those internal dissensions which wreck so many societies."

"...never attended a society which disposed of so much scientific and so little secular matter in the same length of time."

LIMITED COLLABORATION

- “You must have someone who will be responsible, and shut out the mass of matter that would otherwise be put upon you.”

  1881, Minutes of Executive Directors

GEOGRAPHIC AWARENESS

"Resolved to contact each state governor to urge efficient sanitary organization and to secure representative from each state to prepare proposal for national health department."

Executive Committee, 1873

APHA AS PRIVATE CLUB

- 1900's concern to remain professional but also popular
- Evolution of sections as home for specific interests (1899, Central Insane Hospital in Indianapolis, first meeting of first section – Bacteriology and Chemical)

GROWING PAINS

- With increased specialization came feeling that structure inflexible
- Decided need for more representative governance through “delegates from the various sections of the countries represented” but business management in hands of “small body of long-term trustees.” (1905)

EXTERNAL COLLABORATION

- Open to external links more than internal networking
- Formal structure adopted for cooperation with AMA, American Health League and other groups with eye toward coalition building (1909)
- Branch associations considered across US (1910)

“Trespassing on our preserves…”

- Proliferation of professional and voluntary health organizations
- Confused public, waste of resources, duplication of effort
- Structure reorganized to align with other groups (e.g., 1916 joint session with National Mouth Hygiene Association, “Kissing as a Fine Art: The best methods of preventing unpleasant aftereffects”

RECEPTIVITY TO CHANGE

"[APHA] is not encompassed by four walls. It is a fluid, mobile organization that changes its policy and plans as such change in required... We have no axe to grind. We are not interested in any particular diseases. We...as representatives of the public are interested in one thing only, that is, in public health."

1919, APHA President Frankle

TIME TO BEND

- Reorganization to focus on section interests, increase professionalism through ‘fellows’ category, dues thought to commercialize organization
- Refocus APHA as parent organization, with affiliated state/county societies (1922)
- APHA viewed as “practically inactive” in molding public opinion while strong as association of technical health workers

COLLABORATION WITHOUT STRUCTURE

- Affiliate services planned in exchange for APHA membership
- Absence of response caused membership requirement to be dropped
- “It is evident that affiliated societies have not added considerably to the membership of the parent Association; in fact, it is difficult to point to any recent increase as a result of state society effort.”

COLLABORATION BREEDS FRICTION

- Concern that APHA meddling; “aid when requested” became watchword
- Dissension among sections with APHA growth; unequal membership; unequal funding
- Debate of too much diversity to offer combined voice as well as overgrowth of units (1939)

WITH GROWTH COMES PROCEDURAL EMPHASIS

- Recognition of need to reexamine APHA's objectives in changing world (1951)
- Continuing dialogue about relationship with affiliates, with push for central office rather than regional services
- Arden Report (1956) urged strengthening of all components, dues increase, and agency membership but offered no meaningful mechanisms for change

WHERE ARE WE NOW?

- ’90s collaboration marked by ignorance and indifference
- Issues largely adversarial when section: affiliate ‘sharing’ considered
- CoA: framed strong section presence
- ISC: speaks to interests of all sections without parochialism risked by single-section lens; counterbalance to CoA

CHANGE HAPPENS

- Collaborative dialogue improved as personalities recognized common concerns
- Shared meetings (Midyear and Annual)
- Identification of shared frustrations & missions
- Majority of members removed from APHA's organizational introspection
- Recognition that CoA and ISC serve different member bases but in much the same way

LINGERING TENSIONS

- Kellogg Grant
- Voting power
- Staff resources
- Candidates
- Joint memberships – affiliate members as APHA Section members, and vice versa
- “Blessed and cursed” by diversity and membership status

WHY COLLABORATE?

- “Great contentious exhilarating messy policy development process”
- Understanding helps all
- Potential for increased membership
- Informed policy and policy makers
- Expertise in both sections and affiliates
- Support colleagues’ advocacy and policy development – at national and state/local levels

WHY COLLABORATE?

- Enhance APHA's policy and programmatic effectiveness at local, national and global level
- Maintain anchor with the real world
- Bring increased scientific expertise to the state and local level
- Inform development of public health infrastructure and educational needs
- Increase cost-effectiveness through joint undertakings

COLLABORATION THE APHA WAY

- Process oriented membership organization
- Provide formal structures within which collaboration can be nurtured
- Success hinges on individuals willing to exert collaborative energy
- System “isn’t broken”; just needs some “fine tuning”
- Increased engagement/collaboration on APHA Executive Board
- Checks and balances within the APHA family

WHO ARE WE?

- Stages of Collaborative Development: Forming, storming, norming -- performing?
- Elements of Group Collaboration: Groups, goals, leadership, communication, cohesion, respect
- Community Model: affinity, grouped, sharing, understanding, control – size & self-sustaining? engagement?
- Team Model: share, interdependence -- control, interactivity, engagement

FOR YOUR CONSIDERATION

- Clarity of purpose to collaboration?
- Assurance of continuity and common commitment among leadership?
- External guidance to spur continued efforts?
- Importance of tangible goals?
- “Sounds good in the abstract but what do we really mean?”

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