Taking a value network from concept to reality: Canadian Health Leadership Network (A case study)

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Abstract—This article describes, in a step-by-step way, how the value network concept has been put to work to increase leadership capacity through the Canadian Health Leadership Network (CHLNet). The three phases in evolving the network are described: start-up, value creation, and consolidation phases. This is a case study that underscores the fact that networks are best facilitated rather than administered; that trust and reciprocity are the twin pillars for sustaining any network; and that leadership without ownership can be a driving force behind the success of a value network.

The purpose of this article is to chronicle the experience of building and sustaining a value network, in this case, focused on growing health leadership capacity in a complex, dynamic policy environment such as Canadian healthcare. The hope is that this retrospective article on the Canadian Health Leadership Network (CHLNet) will help readers to better understand the winning conditions for establishing and sustaining a value network.

A network can be generally defined as “a multiorganizational arrangement for solving problems that cannot be achieved, or achieved easily, by single organizations.” CHLNet was formed around the basic proposition that unless we collectively act to do a better job of identifying, developing, supporting and celebrating excellence in health leadership in Canada, we will all fall short of delivering on excellent healthcare for Canadians.

From the outset, the prime objective of CHLNet was to grow leadership capacity as a key enabler of organizational and system performance. That said, “leadership capacity must reflect the complexity of an organization if it is to contribute to adaptation and performance improvement.” Leadership in building a value network is also situational: a function of time, place, and circumstance.

Not unlike other strategic alliances or partnerships, CHLNet developed because leaders recognized the opportunity to achieve something together that they could not do on their own.

The genesis of CHLNet can also be understood in terms of health leaders recognizing that the challenges or threats to autonomy of not working together exceeded the inherent risks of working together (eg, loss of agility, autonomy, and hard power). It was because of this shared sense of either sink or swim together that CHLNet mobilizers or orchestrators really stumbled across the emerging concept of a network.

If you want to travel fast, travel alone. If you want to travel far, travel together.—African Proverb

In terms of network typologies, CHLNet is, at its core, a community capacity building network. Its capacity-building focus is in contrast with other network types that focus, for example, on product development, service implementation, or problem solving. Although CHLNet is not primarily an information diffusion network, it does perform this role as an important secondary objective but in the context of support for capacity building.

CHLNet can also be described as informal rather than formal. In the early years, the network contemplated a more formal structure, but this was rejected owing to concerns about creating yet another Canadian institution. Another way to describe informal cross-sector collaborations such as CHLNet is along a continuum.

At one end of the continuum are organizations that hardly relate to each other when it comes to dealing with a public problem that extends beyond their capabilities. In the mid-range are organizations that share information, undertake coordinated initiatives, or develop shared-power arrangements. Again, such collaborations are often a result of external imperatives or threats. Increased complexity in healthcare and the fact that the policy playing field is constantly moving, necessitated linkages among organizations to decrease uncertainty and increase organizational stability.

Theory suggests and the CHLNet experience confirms that informal networks are built on “positive patterns of relationships between people that may be based on

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knowledge-sharing, trust, energy, or other characteristics. Savvy leaders—the ones others seek out for their insight—are often called hubs, and those go-to people play critical roles informing and maintaining informal networks.6

Networks also evolve over time and, as mentioned, the stage of evolution of an interorganizational network may have implications for how the network might best be structured to accomplish the goals of individual members.7 CHLNet appears to be following what are generally regarded as the 3 phases in the evolution of intentionally assembled networks, as depicted in the Figure. Where the number of Network Partners (NPs) serves as a proxy for value add and the horizontal axis tracks the 3 phases over time.

In what follows, I examine the 3 phases of what might be referred to as the winning conditions. We begin with the start-up phase that triggered CHLNet through to the value creation phase, as depicted in the Figure. Where the number of Network Partners (NPs) serves as a proxy for value add and the horizontal axis tracks the 3 phases over time.

PHASE ONE: START-UP

When CHLNet was formalized in September 2009, the story of its evolution began much earlier in terms of setting the table or establishing the winning conditions for establishing an interorganizational network. These early days have been chronicled elsewhere in some detail but are summarized here.9,10

Call to action

The network can be traced back to a seminal symposium convened by Dr. Graham Dickson (Centre for Health Leadership and Research) at Royal Roads University (RRU) in December 2004. To realize the need for an interorganizational network, there is a need to recognize a shared or intractable problem: one that goes beyond the range of influence or control of any one organization.11 A total of 25 health leaders from across Canada and internationally were invited to spend a day of reflection sharing their respective personal leadership experiences and their approaches to identifying and developing future leaders. The impetus for the meeting was an increased recognition that leadership was the key to successful health system reform and the “growing awareness of the shifting needs for leadership skills and increasing urgency for leadership succession planning.”11 This led to a call for action from leaders within the community of practice, the first of the winning conditions.

Taking action

A second winning condition was to actually take action. Despite all the unknowns and political sensitivities at the time, a number of key actions came out of the RRU symposium that proved to be pivotal. The first was that the then Deputy Minister of Health of British Columbia (Dr. Penny Ballem) took the decision to invest $3 million in support of leadership development. These funds, which were made available early in 2006, were administered through the Health Care Leaders Association of British Columbia and were entrusted to a former senior Assistant Deputy Minister, Mr. Geoff Rowlands (a partner in the sponsorship of the December 2004 RRU symposium). This provided the seed funding for the development of a by health, for health leadership capability framework that came to be known as the LEADS in a Caring Environment leadership framework. As we will see, the development of the LEADS framework and associated by health, for health leadership tools became critical to formalizing and then sustaining CHLNet. There will be more on this as we look at the importance of tangible benefits being a critical success factor to sustaining a value network.

Forming the G-6

A third winning condition was the formation of a small group of national health Chief Executive Officers (CEOs) or what Kotter refers to as the guiding team.12 This CEO

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Figure. Evolving an interorganizational value network.8 (Colour version of the figure is available on-line).
group was committed to searching for a better collective understanding of the emerging discipline of leadership as it applies to the unique, complex system of healthcare.\textsuperscript{12} The group of 6 (or the G-6, as we came to be known), dedicated the financial and staff resources needed to establish the business case for better leadership. In 2004, the Canadian College of Health Service Executives (CCHSE), now known as the Canadian College of Health Leaders (CCHL), formed a Leadership Advisory Committee in an effort to secure federal funding for a sector table on health leadership, ultimately to no avail. The merging of the two endeavours was facilitated by the CEO of CCHL (who was also a member of the G-6). This was also pivotal to moving the network forward and avoiding competition for the health leadership space.\textsuperscript{9}

**Doing your homework**

Forming a network involves gathering the evidence or doing your homework. Casual empiricism at the time in terms of the large and growing leadership gap needed corroboration. Studies were commissioned by the G-6 to explore the extent of the leadership gap in healthcare.\textsuperscript{13} It also became clear from a series of high-level consultations that traditional structures, policies, and processes were seen as unreliable or unable to address the large and growing leadership gap challenge.\textsuperscript{14} A variety of reports over the subsequent years have built on the original 2007 benchmarking study, all of which have consistently confirmed high-impact leadership as a linchpin for meaningful transformation of health systems.\textsuperscript{15}

**Leadership without ownership**

It was recognized very early on that no one organization could own the leadership space for a host of political and economic reasons. Leadership capacity development is fundamentally a quasi-public good, with all the challenges this entails (eg, externalities and excludability). Each of the founding organizations had a vested interest in growing individual leaders. Together the challenge was to build shared leadership capacity that reflected the overall social benefits and social costs of leadership development and underdevelopment, respectively. CHLNet also made an intentional, strategic decision not to interpose itself between network partners and their individual members, despite the short-term economic imperatives to do so. The focus was on finding ways for organizations to collaborate to share resources and find cost-effective solutions for leadership development that would then be available to their members—through a broader array of programs, and less expensive solutions (based on an economy of scale). It was also recognized that there were many advantages of cross-fertilization of learning by bringing different organizational members together.

The G-6 was expanded to include other key national shareholders. In the event, 12 founding partners convened early in 2009 to form a transition board that cut across health disciplines and the lifecycle of leadership (ie, that included nascent Emerging Health Leaders).\textsuperscript{16} Governmental and non-governmental organizations needed to get on board. This is why the inaugural co-chairs needed to be widely acknowledged as effective leaders from both sectors.

It is amazing what you can accomplish if you do not care who gets the credit.—Harry S. Truman

**PHASE TWO: VALUE CREATION**

Moving from concept to reality required that CHLNet move from the intangible to the tangible and from the informal to more formal arrangements. It also involved reaching out to jurisdictions across Canada. With reference to the Figure, this takes us to the second, or value creation, phase of CHLNet’s evolution.

**Getting the governance right**

The literature discusses a range of options for establishing interorganizational networks. Without being aware of this, CHLNet has, in fact, considered all 3 of those described by Provan et al.\textsuperscript{17} Early in 2009, the founding partners formalized CHLNet as an unincorporated entity. Formal bylaws had been drafted and seriously considered. They were rejected for a host of reasons, including the general discomfort of unnecessarily ceding any power or control to a separate legal entity. At least one founding partner made this a condition of joining.\textsuperscript{9}

**Securing secretariat support**

A provisional funding agreement was established to support a Secretariat. Each NP was asked to contribute $5000 per annum to the venture (or what they could reasonably afford). The Founding Executive Director was appointed in September 2009 (from among the CEOs of the G-6).

The current Secretariat consists of the co-chairs (current and founding), the CEO of the host organization (currently the CCHL), 2 liaison members from across the country, the Senior LEADS Policy Advisor, and the CHLNet Executive Director. Informal networks, in contrast to other constructs, are not administered; they are managed, facilitated, or supported. The CHLNet experience confirms that taking a distributed leadership approach was key to “… influencing others to take action toward a common constructive purpose.”\textsuperscript{16}

**Developing a strategic plan**

The formalization of CHLNet in 2009 led to the development of a detailed 3-year strategic plan that helped clarify the shared leadership space and the value add of the network. Three value streams or core businesses were identified: advancing the LEADS framework and tools; brokering leadership dialogue and engagement among NPs; and brokering leadership research and evaluation across Canada. The plan was updated and extended in
2013, with the addition of a fourth value stream: advocating for a Canadian Health Leadership Action Plan.

Early wins

The 3-year strategic plan was approved in 2010. As Kotter’s Leading Change model suggests, this needed to be accompanied by some early successes. Some examples of early wins included the following: CHLNet was instrumental in working with Dickson and RRU to secure a 3-year, $450,000 research grant from the Canadian Institutes of Health Research (CIHR), Partnerships for Health System Improvement (PHSI) and Michael Smith Foundation for Health Research exploring the important link between leadership and health redesign; it also secured a $100,000 grant from Health Canada to create a leadership inventory and worked with RRU to secure $50K to validate the by health, for health LEADS capabilities framework; and it secured a series of high-profile speakers as part of the successful dinner dialogue series. Through the combined efforts of CHLNet, the Health Care Leaders Association of British Columbia, RRU, and the CCHL, the LEADS framework has become the leadership learning platform of choice across Canada. All of these early wins helped underscore, in a more tangible way, the value of working together as part of a network. It helps to explain the growth in the network and the fact that the network was able to establish a much more stable financial footing over time. Our vision of Better Leadership, Better Health—Together was now becoming firmly rooted.

PHASE THREE: CONSOLIDATION OF VALUE ADD

With reference again to the Figure, at the time of preparing this article, CHLNet was transitioning to what might be considered a third value curve or the third phase of network development. It had approved the new 3-year strategic plan and had just co-hosted a major Canadian Health Leadership Forum (February 2014). (See CHLNet.ca for summary report of Montreal Leadership Forum.) This forum reaffirmed the qualitative findings of the CIHR multiyear health leadership study in terms of the importance of addressing the large and growing leadership gap. These qualitative findings were supported by a second (March 2014) benchmarking study building off the original 2007 study, which also provided a more granular assessment of both the overall supply-demand leadership gap as well as the skills gap. At the time of writing this, the proposed Canadian Health Leadership Action Plan was on track to be considered by the Conference of Deputy Ministers of Health in the fall of 2014.

Handoffs

One of the critical success factors in sustaining any network is succession planning. CHLNet has managed to attract leaders of leaders to the co-chairs positions and has carefully renewed co-chairs and liaison members of the Secretariat on a staggered basis. CHLNet has also just successfully transitioned from the founding Executive Director to a very capable, skilled, experienced successor who is now in place.

The other key handoff has involved establishing an arms-length business unit to coordinate the rising demands for LEADS-based leadership tools. The LEADS Collaborative is just getting underway and will, it is expected, become a key success factor for CHLNet jumping to the next value curve. The LEADS Collaborative comprises CHLNet, the CCHL, RRU, and Graham Dickson. It serves as the business arm to advance the LEADS leadership platform, to help ensure high-quality offerings and to ensure that it will be ever-greened over time.

REFLECTIONS ON CHLNET AS A CASE STUDY

CHLNet now appears, in the language of business, to be on the verge of becoming a going concern. That said, if it is to reach its full potential, it is important to remember and respect the winning conditions set out here. The twin pillars for going forward remain trust and reciprocity. CHLNet must continuously reinforce, build, and maintain trust, openness, transparency, and accountability. Reciprocity is also critical. If all NPs give even marginally more, on balance, than they take out of the network over time, then the network thrives. If they do not, it does not.

CHLNet was born out of an overwhelming sense of frustration of individual leaders and their organizations’ inability to keep up with the complexities of leadership in 21st century healthcare. The healthcare system is even more complex today than it was 10 years ago. The need for CHLNet has therefore grown not diminished. The original objective was to triple the number of network partners over 3 years. This objective was in fact surpassed, with 40 Network Partners having joined CHLNet by 2014. (Like all networks, there is a U-curve as diminishing returns can set in as the network tries to accommodate an increasingly diverse agenda. As a cautionary note, more may not be merrier if the focus of the network is not repeatedly reinforced.)

Finally, CHLNet must continue to recognize that no one organization can own the leadership in health space. Leadership without ownership continues to be the driving force behind CHLNet’s success.

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