

Conducting a Dissonant Symphony:
A Case Study of Network Leadership in the National Quality Forum

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A Dissertation submitted to the Faculty of
Virginia Polytechnic Institute and State University
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY
in
Public Administration and Public Affairs

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March 18, 2009
Blacksburg, Virginia

Keywords: Network Administrative Organization, Networks, Network Leadership, Network Management, Health Care Policy

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Dedication

To David, Dad, and Berkeley

Acknowledgments

Supreme Court Justice Thurgood Marshall once said, “None of us got where we are solely by pulling ourselves up by our bootstraps. We got here because somebody (a parent, a teacher, an Ivy League crony or a few nuns) bent down and helped us pick up our boots.” Indeed, writing a dissertation is a shared endeavor, and I could not have navigated this journey successfully without the guidance and support of my teachers, family, and friends.

First and foremost, I want to thank my chair, mentor, and friend, Dr. Joe Rees, for his generous time and commitment. His tough questions and critical insights enabled me to learn and grow as a scholar. This dissertation would not have been possible without his kind words, patience, and general good humor.

To the members of my committee: Dr. Larkin Dudley, Dr. Karen Hult, Dr. Gary Wamsley, and Dr. Jim Wolf. I have enjoyed working with each of you and want to thank you for the advice and encouragement you have given me over the years.

I have been very fortunate to have the support of friends and colleagues as I have pursued my education. I would like to thank Ashley Milam, Sara Perez Webber, Joe Mitchell, Brenda Dean, Edie Moussa-Long, Marybeth Farquhar, Mary Beth Dunkenberger, Nancy White, Ian Birdsall, Rick Morse, Stephanie Newbold, and countless others who have supported me and enriched my journey through CPAP and the dissertation process.

I would like to thank the anonymous interviewees for their willingness to participate in this research. Their participation made this dissertation possible.

Finally, I would like to thank my “SweeTart,” Ginger. You are a loyal dog and a great companion. I appreciate that you sat by my side during the countless hours it took to research and write this dissertation.

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(ABSTRACT)

Networks are an increasingly common aspect of administrative life in almost any policy arena. In 1999 the health care industry created the National Quality Forum, a network administrative organization, whose founding mission was to improve American healthcare through endorsement of consensus-based national standards for measurement and public reporting of healthcare performance data that provide meaningful information about whether care is safe, timely, beneficial, patient-centered, equitable and efficient. The NQF is representative of a network administrative organization because it was created to address issues of health care quality in a new way by bringing together organizations from the public and private sectors and providing them with a forum to discuss and debate measures of quality, and ultimately, to effect change. The NQF thus represents a major administrative experiment in addressing health policy issues. In spite of the popularity of networks, little is known about a network manager's or, more appropriately for this dissertation, a network entrepreneur's critical tasks in creating a network administrative organization. The purpose of this dissertation is to present the results of an empirical study of the critical leadership tasks of the NQF's President and CEO during the NQF's formative stages. This dissertation identifies and conceptualizes three critical leadership tasks of the NQF's President and CEO: defining the NQF's mission, building and maintaining the NQF's social base, and creating the NQF's Consensus Development Process. In addition, this dissertation proposes a series of testable hypothesis based on these three critical tasks that can be used for exploring leadership in other NAOs. The findings indicate that leadership is crucial to the formation of a network administrative organization and fills a gap in our understanding of network management by developing the concept of network leadership and exploring the critical tasks a leader undertakes during the formative stages of building an NAO like the NQF.

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List of Abbreviations

ACS	American College of Surgeons
AFL-CIO	American Federation of Labor and Congress of Industrial Organizations
AHA	American Hospital Association
AHRQ	Agency for Healthcare Research and Quality
AMA	American Medical Association
ANSI	American National Standards Institute
ASRS	Aviation Safety Reporting System
CDP	Consensus Development Process
CGS	Carlo Gavazzi Space
CMS	Centers for Medicare & Medicaid Services
CSAC	Consensus Standards Approval Committee
DOD	Department of Defense
EHR	Electronic Health Record
FDA	Food and Drug Administration
GM	General Motors
HEDIS	Health Plan Employer Data Information Set
HMO	Health Maintenance Organization
IOM	Institute of Medicine
JCAH	Joint Commission on the Accreditation of Hospitals
JCAHO	Joint Commission on the Accreditation of Healthcare Organizations
JOBS	Job Opportunities and Basic Skills
NAO	Network Administrative Organization
NCQA	National Committee for Quality Assurance
NIH	National Institutes of Health
NQF	National Quality Forum
NTTAA	National Technology Transfer and Advancement Act
OPM	Office of Personnel Management
QuIC	Quality Interagency Coordination Task Force
SFB	Strategic Framework Board
TQM	Total Quality Management
UHF	United Hospital Fund

CHAPTER ONE MEDICAL ERRORS: A “WICKED” POLICY PROBLEM

Serious and widespread quality problems exist throughout American medicine.

*--Chassin, Galvin, and the National
Roundtable on Health Care Quality (1998)*

*When the wind changes direction, there are those who build walls
and those who build windmills.*

--Chinese proverb

Statement of the Problem

It is common to hear stories of medical mishaps—stories about babies who were switched at birth, the doctor who operated on the wrong body part, or the patient who received the wrong dosage of medication or the wrong medication. The numbers and types of medical errors are staggering.¹ In *To Err is Human*, the Institute of Medicine (IOM) (1999) estimates that between 44,000 and 98,000 individuals die from medical errors each year, making medical errors the eighth leading cause of death in the United States. According to the IOM, “more people die in a given year as a result of medical errors than from motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516).”² In addition, medical errors generate enormous financial costs, with estimates ranging from between \$17 billion and \$29 billion annually. The health care system also pays for medical errors in terms of opportunity costs (e.g., funds that could be used for other purposes are instead used for the tests or drugs needed to counteract the adverse effects arising from medical errors) (IOM, 1999, p. 2).

Other high-risk industries, including the aviation and nuclear power industries, have implemented error-reporting systems to gather data about the occurrence of errors in order to increase safety (Reason, 1990, 1997; Rees, 1994; Perrow, 1999). The success of error reporting systems in these industries demonstrates that the health care industry might benefit from such a system. For example, the chances of experiencing a medical error are much greater than being involved in an airline accident. This is because the airline industry has spent much more time and money during the last twenty-five years to improve safety (IOM, 1999, p. 5). The increased

¹ For an overview of medical errors, see Bogner, 1994 and IOM, 1999.

² These estimates are subject to debate. In 2000, the Journal of the American Medical Association published two opposing articles outlining the debate. Three physicians, from the Indiana University Center for Aging Research, argue that the IOM’s numbers are exaggerated (McDonald, Weiner, and Hui, 2000). Leape (2000) defends the numbers, arguing that they are too low.

safety is due in part to the establishment of the Aviation Safety Reporting System (ASRS), which is an anonymous, voluntary self-reporting system run by National Aeronautics and Space Administration for the Federal Aviation Administration. The ASRS monitors irregular incidents that may lead to accidents and shares that information with others in order to remedy the occurrence of similar events.

Efforts to establish a medical error reporting system, however, have been frustrated for many reasons, including a lack of legal protection for those reporting incidents; disagreement about what constitutes an error and consequently which errors to report³; disagreement about whether an error reporting system should be mandatory or voluntary⁴; and disagreement about who should collect, process, and disseminate information about incidents. For example, underreporting plagues the Joint Commission’s Sentinel Events program because there are no provisions to protect the confidentiality of individuals reporting events.⁵ More importantly, many of the existing error reporting systems are narrow in scope, only collecting data on medical errors from specific types of health care institutions (e.g., hospitals) or on a specific aspect of health care (e.g., medication errors). For example, two programs administered by U.S. Pharmacopeia, the Medication Errors Reporting program and the MedMARx program, collect information from individuals and hospitals about medication errors. While these programs collect useful information, the lack of a coordinated effort to disseminate and learn from the information gathered hinders the effectiveness of these systems.

The health care industry, plagued by medical errors and other quality problems, faces a “wicked” problem—one that is unwieldy in its scope and complicated by the existence of competing perspectives about how to address the issue (Rittel & Webber, 1973). Luke (1997, p. 31) notes that in an interconnected environment, “problems cross organizational and jurisdictional boundaries, and growing numbers of stakeholders have legitimate interests and rights to insert themselves in problem solving.”

³ No standardized taxonomy for errors exists.

⁴ Mandatory and voluntary reporting systems have different purposes. Mandatory reporting systems focus on holding a provider accountable for an error and collect information about errors that result in serious injury or death. Voluntary reporting systems focus on safety improvement and gather information about “near misses” or events that did not result in serious harm.

⁵ The Joint Commission established its Sentinel Events policy in 1996 to “encourage self-reporting of medical errors in order to learn about the relative frequencies and underlying causes of sentinel events, share ‘lessons learned’ with other health care organizations, and reduce the risk of future sentinel event occurrences.” For information on Sentinel Events and the Joint Commission’s Sentinel Events Policy, visit www.jointcommission.org

In response to these types of problems, we are witnessing the proliferation of networks. Many claim networks can reduce fragmentation by allowing public, private, and nonprofit organizations to share their diverse resources, and they can facilitate the development of innovative solutions to policy problems by encouraging broad stakeholder groups to participate in decision-making (Powell, 1990; Alter & Hage, 1993; Jones, Hesterly, & Borgatti, 1997). Provan and Milward (2001, p. 418) assert that in more formal networks, “network growth and maintenance is often led, coordinated, and governed by a central local administrative entity,” which they refer to as a network administrative organization (NAO).

The health care industry created one such NAO, the National Quality Forum (NQF), as a bold regulatory experiment designed to address quality problems in health care by coordinating the activities of various organizations involved in quality improvement activities.⁶ Established in May 1999, the NQF’s founding mission was to improve American healthcare through endorsement of consensus-based national standards for measurement and public reporting of healthcare performance data that provide meaningful information about whether care is safe, timely, beneficial, patient-centered, equitable and efficient. The NQF thus represents a major administrative experiment designed to overcome the issues that have frustrated other efforts to address medical errors and improve health care quality.

This dissertation primarily examines the NQF as a case study in network leadership. The purpose of this dissertation is to present the results of an empirical study of the critical tasks of the NQF’s President and CEO during its formative stages. I identify and discuss three critical tasks Kizer engaged in during the NQF’s formative years: (1) defining the NQF’s mission in a way that appealed to a broad spectrum of health care stakeholders, (2) building the NQF’s social base, and (3) creating and modifying the NQF’s unique Consensus Development Process (CDP).

Maccoby (2007a, 2007b) notes that leadership is contextual and that one must understand context in order to understand leadership. Dr. Kenneth W. Kizer, the NQF’s first President and CEO, once described the NQF’s work as “conducting a dissonant symphony” (Kizer, 2004). While Kizer was referring to the NQF’s larger role of coordinating and harmonizing quality improvement efforts, the metaphor, however, is an apt one for describing Kizer’s role in building the NQF and conveys the delicate balancing act Kizer often had to engage in as he strove to

⁶ The NQF as an NAO is embedded in the larger health care policy subsystem (Milward & Wamsley, 1984; Thurber, 1996).

create and shape a network organization. It also highlights the importance of understanding the context within which leaders make decisions. That is, Kizer could not act alone in making decisions about the NQF; he had to consider the stakeholders that were interested in and would be potentially impacted by the creation of the NQF. This study, therefore, necessarily explores the context in which Kizer exercised leadership.

Research Questions and Approach

Network organizations raise pressing questions for students of public administration. While scholars have examined why and how network organizations form, much less attention has been focused on how interorganizational relationships are managed. When I became interested in and started researching network management, I found a lack of empirical studies about what tasks network managers engage in during a network organization's formative years.

In the beginning, I sought to address this gap by examining the NQF's origins and development, its consensus-making process, and the role of public managers in managing these networks. I began this research by exploring the following questions:

1. How and why was the NQF created?
2. How is the NQF organized?
3. How does the NQF manage the development of standards?
4. What is the federal government's role in this process?
5. What lessons does NQF's administrative experiment hold for students of public administration?

The NQF was created because of all of the failed attempts in health care to make some headway in quality improvement. In order to improve health care quality, leaders in the health care industry thought it was necessary to bring all of the stakeholders to the table to discuss and debate quality measures. The NQF is essentially an NAO, and Kizer, as the NQF's first leader, was tasked with building the network. This makes network leadership important. Since there were so few empirical studies into the phenomenon of network management, a grounded theory approach seemed to be the most appropriate way to study the "black box" of network management. As I conducted the one-on-one interviews and began to analyze the data, I fine-tuned the research focus and shifted from the original questions to focus on network leadership. The research question, therefore, ultimately became: What critical tasks did the NQF's founding

President and CEO, Dr. Kenneth W. Kizer, engage in during the formative years of establishing the NQF?

Relevance to Public Administration Practitioners and Scholars

This case study will be of interest to two different groups. First, it will be of interest to scholars and practitioners interested in networks as a solution to complex, multi-dimensional public policy problems like health care quality. Scholars have noted the lack of empirical studies related to network management (Agranoff & McGuire, 2003; Barringer & Harrison, 2000). Furthermore, the NAO is a very important element in network management, and one area that has been left out is the role that a leader plays in forming an NAO. In particular, this study fills a gap in our understanding of network management and adds to this literature by developing the concept of network leadership and exploring the critical tasks a leader undertakes during the formative stages of building an NAO like the NQF.

While the primary focus of this research is on network leadership and the critical tasks associated with building an NAO, this study is also pertinent to health care policy. Those interested in health care policy and more generally in public policy will enjoy hearing the story of the creation of the NQF and how it has grappled with medical errors and other quality problems by seeking to reduce the fragmentation that has plagued the health care industry's efforts to develop and implement performance measures.

Organization

Chapter Two sets the stage for this study by describing the fragmented nature of the health care industry and its chaotic efforts to address quality problems such as medical errors. I provide an overview of the history of performance measurement in the health care industry and describe the rise of the NQF as a means of addressing the fragmentation and chaos that has plagued the health care industry's effort to develop and institutionalize performance measures. I also describe the NQF's structure and Kizer's role in leading the NQF. Understanding this background is crucial to understanding the creation of the NQF and the purposeful intention on the part of its founders to create a network organization that would bring together the various health care stakeholders and allow them to work together to overcome fragmentation.

Chapter Three outlines the literature related to network management and network leadership and gleans insights from this literature about some of the critical leadership tasks that should be undertaken during a network's developmental stages.

Chapter Four describes how I conducted this research. In addition to discussing the usefulness of grounded theory as an approach to studying the "black box" of network leadership, I discuss some of the limitations and lessons learned using this approach. Since studies of networks using a grounded theory approach are scant, this chapter provides insight into how to conduct an empirical study into an underdeveloped area using a grounded theory approach.

Chapters Five, Six, and Seven present the findings from this research. The research findings indicate that Kizer engaged in three critical tasks during the early stages of the NQF's development: (1) defining the NQF's mission, (2) building and maintaining the NQF's social base, and (3) creating the NQF's CDP. Each critical task affects the long-term character of the organization and represents the challenges inherent in building a network, especially in such a fragmented area as health care.

Chapter Five discusses how Kizer and others crafted the NQF's mission. As part of this discussion, I discuss some of the factors that influenced the development of the NQF's mission, paying particular attention to how the mission of a network organization like the NQF must be broadly defined in order to encourage participation by diverse stakeholders. I discuss the role Kizer and others envisioned for the NQF in quality improvement activities and deconstruct the NQF's mission statement in order to gain a better understanding of the NQF's means and ends for improving health care quality.

Chapter Six describes how Kizer built and maintained the NQF's social base. A social base consists of two things: those individuals that are internal to the organization (i.e., staff) and those individuals and organizations that are external to the organization (i.e., member organizations). I discuss the importance of building and maintaining a social base, describe the inducements Kizer used to recruit members and staff to join the NQF, and some of the challenges associated with maintaining a social base. Throughout this chapter, I emphasize the importance of the NQF's mission in building a network's social base.

Chapter Seven discusses how Kizer created and modified the NQF's CDP. I discuss some of the key design principles underlying the consensus process and describe some of the modifications the NQF made to the process as a result of the experiences with its first project—

the Serious Reportable Events project. I discuss the importance of having a process that embodies the NQF's values of cooperation and broad participation by health care stakeholders.

Chapter Eight concludes by summarizing the major findings from this foray into network leadership and their broader implications for public administration scholars and practitioners. I briefly discuss some of the NQF's accomplishments and remaining challenges and offer some testable hypotheses and ideas for future research.

CHAPTER TWO

ORIGINS AND STRUCTURE OF A NETWORK ADMINISTRATIVE ORGANIZATION: AN OVERVIEW OF THE NATIONAL QUALITY FORUM

It ought to be remembered that there is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in introducing a new order of things...
--Machiavelli

Introduction

This chapter tells the story of why and how the NQF was created. As I briefly discussed in the introductory chapter, many groups have tried to bring some order to the chaotic, fragmented environment surrounding quality improvement efforts in the health care industry. What has been missing from these efforts, however, is a coordinated effort to bring the diverse groups engaged in quality improvement activities together. The NQF was created to orchestrate quality-improvement efforts in the U.S. health care system (Kizer, 2004). The thesis of this chapter is that the NQF is a product of its environment and in order to understand leadership in a network one must understand the organizational context of leadership. While this may sound like a platitude, we do not have much understanding of leadership in a networked environment. This dissertation empirically explores leadership in this context, and this chapter provides a brief overview of the NQF's origins and structure. The chapter is organized as follows. In Part One, I provide a brief overview of the history of performance measurement in the health care industry, paying particular attention to the issues that have frustrated and hindered the development and institutionalization of standardized performance measures in the health care industry. In Part Two, I discuss the creation of the NQF as a response to some of these issues and provide an overview of the NQF's structure.

A Brief History of Quality Measurement in the Health Care Industry⁷

In the 1990s, a series of high-profile media and research reports were released documenting evidence of medical errors and quality problems, such as avoidable errors (Brennan, et al., 1991; Phillips, Christenfeld, & Glynn, 1998), underutilization of services (Chassin, 1997; Soumerai, et al., 1997), overuse of services (Bernstein, et al., 1993), and

⁷ This section originally appeared in a draft of the paper Marybeth Farquhar and I wrote for *Regulation & Governance*. It draws heavily upon Marybeth Farquhar's work, and I am deeply indebted to her.

variation in service (Wennberg & Cooper, 1998). These reports led the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry in its 1998 report, *Quality First: Better Health Care for All Americans*, to conclude, "while most Americans receive high-quality health care, too many patients receive substandard care" (1998, p. 1). Furthermore, the National Roundtable on Health Care Quality convened by the IOM stated, "serious and widespread quality problems exist throughout American medicine" (Chassin, Galvin, & the National Roundtable on Health Care Quality, 1998, p. 24).

How did the industry arrive at the point where it is mired in quality problems and why have its efforts to improve quality been stymied? The history of performance measurement and the uncoordinated efforts to institutionalize quality improvement throughout the health care industry provides some insight into the answers to these questions. In this section I discuss the history of performance measurement in health care as a means of improving the quality of care, examine the reasons for the limited success in the application of performance measures, and explain how the calls for a more coordinated effort to improve quality in the health care industry via the development and implementation of standardized performance measures ultimately led to the NQF's creation.

The Modern Era and New Delivery Systems (1910-1950)

Measuring the quality of health care in what is now the United States can be traced back to the 1700s with the establishment of hospitals in the colonies. The idea of performance measurement as a tool to gauge quality of care, however, did not emerge until 1910 with Codman's "end result system of hospital standardization," which tracked hospital patients after discharge to determine treatment effectiveness (McIntyre, Rogers, & Heier, 2001). At the same time, the Flexner Report, which evaluated the quality of medical education, was released. Flexner used "common sense" indicators, including the availability of books, lab equipment, and specimens, to determine the adequacy of physician education (Colton, 2000). After the report was released, many medical schools closed and there was a call for the development of standards for physician education and preparation (Ludmerer, 1996).

Codman's ideas and the Flexner report findings stimulated standards development in other areas of health care, specifically hospitals. In 1913, the American College of Surgeons (ACS) resolved to develop standards of hospital construction, administration, and equipment, also known as structure measures, and to establish a structured examination of surgical practice.

While Codman's system became one of the ACS's stated objectives, it was not the basis for hospital standardization. Instead, the ACS employed a new set of objectives, the "Minimum Standards for Hospitals," developed by Franklin Martin, one of the co-founders of the ACS.⁸ Beginning in 1918, the standards were used for site evaluations. In 1919, the results of the first large-scale inspection of hospitals were released. Out of the 692 hospitals that were inspected, only 89 met minimum care standards. Rather than risk the publication of these dismal results, several members of the ACS, which was holding its annual meeting at New York's Waldorf-Astoria Hotel, burned the survey results in the hotel's furnace. Although the reports were incinerated, the ACS did not retreat from its commitment. It continued to work on improving the quality of hospital care, albeit in not so public ways.

According to Brennan and Berwick (1996, p. 100), the efforts of the ACS represented an important attempt to "link intellectually grounded forms of standard setting and audit with the actual conduct of day-to-day care." By the mid-1920s, however, standards as a tool for measuring quality of care had receded into the background and were not widely used by hospitals. The 1950s saw a revival of standards as a result of Lembcke's work and the creation of the Joint Commission on the Accreditation of Hospitals (JCAH).

The Golden Years (1950-1980)

During the 1950s, Paul A. Lembcke developed a medical auditing system that used scientific methods and advocated the use of "explicit and objective measures of quality" as reported in the current literature (Ostrow, 1983, p. 24). With the publication of Lembcke's ideas, a change occurred with regard to hospital accreditation—the American Hospital Association (AHA), the American Medical Association (AMA), the American College of Physicians and the Canadian Medical Association formed a collaborative known as the Joint Commission on the Accreditation of Hospitals (JCAH).⁹ In 1953, JCAH began offering accreditation to hospitals based on its "Standards for Hospitals." JCAH's program was private, voluntary, and basically free to hospitals prior to 1964, when JCAH began charging accreditation fees for ITS services.

⁸ These standards called for organizing hospital medical staffs; limiting staff membership to well-educated, competent, and licensed physicians and surgeons; framing rules and regulations to ensure regular staff meetings and clinical review; keeping medical records that included patient history, physician examination, and laboratory results; and establishing supervised diagnostic and treatment facilities such as clinical laboratories and radiology departments (Roberts, Coale, & Redmen, 1987, pgs. 936-940).

⁹ In 1987, the JCAH changed its name to the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) to better reflect the scope of organizations that were now accredited. It recently shortened its name to the Joint Commission.

With the passage of the Social Security Amendments in 1965, JCAH's dominance of the performance measurement field was assured due to a provision requiring hospital accreditation for participation in Medicare and Medicaid programs. While the JCAH program was not the only mechanism to demonstrate standards compliance, it became the preferred mechanism to demonstrate compliance with quality standards required by the federal government. After meeting the JCAH's standards, hospitals could apply for reimbursement from the government for treating Medicare and Medicaid recipients.

In 1966, the JCAH changed its approach to accreditation and adopted the "optimal achievable standards" approach. The change occurred for three reasons: (1) most American hospitals were already meeting the minimum standards; (2) Medicare set more rigorous guidelines, creating an obligation to respond; and (3) the techniques used to assess and improve quality had grown more and more sophisticated (Luce, Bindman, & Lee, 1994, p. 264). The JCAH's new approach was based on physician Avedis Donabedian's quality measurement model. Donabedian argued that three types of measures need to be considered when assessing the quality of health care, three types of measures need to be considered: (1) structural measures (the setting in which the care is provided), (2) process measures (the care given to a patient), and (3) outcome measures (the status of the patient's health after receiving the care). Donabedian's model forms the basis for most quality measurement activities today.

The Age of Information and Consumerism (1980-2000)

The health care industry began to apply the principles of Total Quality Management (TQM) during the 1980s, which signaled a movement away from the retrospective review of process and outcomes, sometimes known as quality assurance, to a more proactive analysis, known as quality improvement (Colton, 2000). Health care organizations, however, that used TQM usually applied it only to administrative services, with an eye toward eliminating unprofitable services and increasing efficiency and improving outcomes in order to increase profits.

Barriers to the Institutionalization of Performance Measurement in Health Care

Even though the health care industry has attempted to improve quality through the use of performance measures, these efforts have not been effective for several reasons. The health care industry has not been able to develop consensus around what constitutes "good" performance and how to measure it. Performance is difficult to measure either because the parameters are

constantly changing or they are only partially known (Meyer, 1994). Because performance is a moving target, problems also arise with regard to the reliability and validity of measures. Inadequately developed and tested measures can lead to inaccuracies in determining the presence or absence of quality.

Secondly, the fragmented nature of the health care industry contributes to the existence of multiple and, at times, conflicting performance measurement systems. Several organizations, including the National Committee for Quality Assurance (NCQA), the Joint Commission, the AMA, the Agency for Healthcare Research and Quality (AHRQ), and the Centers for Medicare & Medicaid Services (CMS), have developed and marketed different performance measurement systems. Furthermore, there are gaps in the systems that do exist; many of the current measurement systems do not include measures of quality for each of the IOM's stated six aims for quality improvement—safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity (IOM, 2001).¹⁰ The picture of health care quality that emerges from these existing performance measurement systems is fragmented and incomplete.

Finally, while the availability and use of measures to demonstrate quality in health care is accelerating, large gaps remain in terms of understanding their relevance, reliability, and/or meaning. There is also scant evidence of their usefulness, particularly in the area of performance outcomes (Kazandjian & Lied, 1999).¹¹ Furthermore, performance measure development has been “uneven across different settings, populations, and health conditions” (IOM, 2001, p. xi). One of the contributing factors to this problem is that the health care industry lags behind other industries in cataloging, using and sharing information. Efforts to achieve desired goals, such as conducting performance measurement and evaluating health systems, are hindered by the need for an established, standardized information structure (IOM, 2001). The U.S. lags behind other nations in the use of the electronic health record (EHR). Only 17 percent of the physicians in this country use an EHR compared to the eighty percent of physicians in other countries that use it (The Commonwealth Fund, 2006). Data contained in an electronic format can significantly reduce the burdens associated with performance measurement and improvement activities

¹⁰ Measures are lacking or absent in the areas of efficiency, equity, and patient-centeredness.

¹¹ They are the mortality rate studies of patients after coronary artery bypass graft surgery conducted in New York (Hannan, et al., 1994), and the cesarean section cohort study of the Maryland Hospital Association Quality Indicator Project (Kazandjian & Lied, 1998).

because the information can be quickly aggregated and analyzed to provide policymakers with a more complete and accurate picture of the quality of services being provided.

Creation of the NQF

By the late 1990s, it was becoming clear that the health care industry was plagued with quality problems and would have to respond. Health care leaders argued that a comprehensive, industry-wide effort would be needed to “focus the development of quality measures that would enhance the Nation’s ability to evaluate and improve health care” (President’s Advisory Commission, 1998, p. 3). The President’s Advisory Commission report concluded that quality could be improved with the standardization of performance measures that would serve as national benchmarks to measure the quality of health care. While the idea of using performance measures to improve the quality of health care was not new, what had been lacking was “a focal point for raising and sustaining attention to patient safety” (IOM, 1999, p. 7). What eventually emerged from this disorder was the NQF. Health care leaders envisioned that the NQF would bring the diverse stakeholders together and facilitate a focused, coordinated effort for developing a national, standardized system of performance measurement, and that it would seek to improve the quality of health care by “establishing a platform for consistent data reporting and collection” (Kizer, 2001, p. 1214).

NQF’s Mission

Established in May 1999, the NQF’s founding mission was to Improve American healthcare through endorsement of consensus-based national standards for measurement and public reporting of healthcare performance data that provide meaningful information about whether care is safe, timely, beneficial, patient-centered, equitable and efficient. Its aim is not to establish new quality measures and standards; but to encourage organizations throughout the healthcare system to discuss and debate measures of quality and develop a set of measures to serve as the basis for a national medical error reporting system.

Two philosophical precepts underlie the NQF’s activities. The first is that high quality health care is premised on ensuring patient safety and, in order to ensure this safety, performance measurement should be an intrinsic part of the care process (Kizer, 2001). The second philosophical precept underlying all NQF activities is the “belief that health care quality data are a public good and should be in the public domain” (Kizer, 2001, p. 1215). It is further based on

the belief that making reliable, standardized data about health care quality available “will motivate providers to improve the quality of care by providing benchmarks; will facilitate competition on the basis of quality; will promote consumer choice on the basis of quality; and will inform public policy” (Kizer, 2000, p. 320). I discuss the origins of the mission and Kizer’s role in crafting and disseminating the mission in greater detail in Chapter Five.

NQF’s Organizational Structure

While it may appear at first glance that the NQF has the same organizational structure as many non-profit organizations, I maintain that the NQF’s structure, with its broad social base and consensus development process, allows its diverse participants to engage in creative problem solving. Most importantly, I argue that its structure is designed to suit its environment and was created to bring some semblance of order to health care’s chaotic and fragmented environment.

Strategic Framework Board

According to the NQF’s 2000 Bylaws, the NQF established a quasi-independent Strategic Framework Board (SFB) to develop the intellectual architecture and identify the principles to guide a national measurement and reporting strategy. The SFB originally consisted of nine members, appointed by the Board of Directors, with diverse backgrounds in healthcare.¹² The members of the SFB consisted of experts from areas such as health care quality measurement, quality reporting, research, health care purchasing, accreditation and certification, education, information technology, and health care delivery. According to an NQF observer, the members were chosen because they “had a pedigree of knowledge of the technical side of measurement.”

The effort cost over \$1 million to complete and lasted approximately 18 months. From December 1999, when it was formally established, until June 2001, when it presented its recommendations to the NQF Board, the SFB developed a visual conceptual framework and then crafted a purpose statement for a quality and measurement system.

Board of Directors

A 23-member Board of Directors governs and coordinates the NQF’s activities. The Quality Forum Planning Committee laid out the structure for choosing Board members and stated that members should be chosen through a process that includes Board appointment,

¹² The nine members of the Strategic Framework Board were Donald M. Berwick, Christine K. Cassel, Molly J. Coye, Robert S. Galvin, Judith Hibbard, Brent James, Sheila Leatherman, Elizabeth A. McGlynn, and Helen L. Smits.

election by NQF members, and designated seats for HCFA (now CMS) and AHCPR (now AHRQ), two organizations that they deemed essential to the Forum’s effectiveness. A “Governance Committee” nominates members to serve on the Board, and each Member Council elects a chairperson to represent it on the Board.

The Board is comprised of representatives from all segments of the health care industry, including purchasers, consumers, providers, and research and quality improvement organizations. The Board also includes 15 “at large” members. Representatives of the federal government—AHRQ, CMS, and the Department of Veterans Affairs (VA)—hold three of these seats. The Board also includes five non-voting liaison members from the NCQA, the Joint Commission, the IOM, the AMA, and the National Institutes of Health. The composition of the Board reflects the desire of the President’s Advisory Commission and other health care leaders that the NQF be representative of diverse stakeholders in health care. According to one NQF member, those involved in the initial selection of the Board were very cognizant that many would look at the composition of the initial Board as a statement of “who and what the Forum is,” and, therefore, they invested a lot of time and energy into choosing the NQF’s initial Board members.

Dr. Kenneth W. Kizer, the NQF’s First President and CEO

In addition to asking recognized leaders in the health care industry to serve on the Board of Directors and the SFB, the NQF Planning Committee also hired Dr. Kenneth W. Kizer—a recognized leader in the healthcare industry with a track record of instituting rapid organizational change—as the NQF’s first President and CEO. He is a physician trained in emergency medicine and public health who has held a variety of public and private sector positions.

Prior to serving as the NQF’s first President and CEO, Dr. Kizer served as the undersecretary for health at the Veterans Health Administration (VHA). During his five years there, he undertook a large-scale transformation of the VHA. Indeed, his biosketch notes that he is credited with being the “chief architect and driving force behind the greatest transformation of VA healthcare since the system was created in 1946.” One NQF observer notes, “people just shook their head in wonder that he was able to do so much with a bureaucracy that was thought to be very hide-bound and stuffy...” Prior to serving as the undersecretary of health, Kizer served as the Director of the California Department of Health Services, Director of Emergency

Medical Services, and Chief of Public Health for California. He is credited with such accomplishments as helping to get California's no-smoking law passed.

Kizer possesses a number of qualities that lent the fledgling organization immediate credibility. The first quality is that he is recognized and thought of as a good administrator. The second quality is that he is articulate and excellent at synthesizing and presenting and marketing information to diverse groups of people. The third quality is that his work at the VA is recognized as being ahead of the curve in terms of what people were trying to do in order to improve patient safety. He is recognized as being committed to and knowledgeable about performance measurement and safety, and, more importantly, he "had the track record to show of actually implementing significant quality improvements in a large system." This ability to do what he advocates others should do gave him enormous credibility. One interviewee said that all of these traits would be important to being able to getting "something off the ground that was going to have to be sold to people."

Kizer's experience prior to joining the NQF gave him a wide breadth of political and practical knowledge. Kizer is known throughout the healthcare industry as an innovator and a transformer. Hiring someone with a proven track record and the political clout to accomplish the tasks the NQF set to undertake was extremely important to getting the NQF started. It was also crucial to getting the initial buy-in from members of the healthcare community.

Member Councils

NQF members serve on one of eight member councils: the Consumer Council, the Health Plan Council, the Health Professionals Council, the Provider Organizations Council, the Public/Community Health Agency Council, the Purchaser Council, the Quality Measurement, the Research, and Improvement Council, and the Supplier and Industry Council.¹³ The Member Council structure, according to one interviewee, serves as a "way of organizing the members and of giving them a home and a place to talk and to share common interests and ideas."

According to the NQF's 2000 Bylaws, the functions of the Member Councils are to:

¹³ Initially, members were assigned to one of four Member Councils: the Consumer Council, the Council on Private and Public Purchasers, the Provider and Health Plan Council, and the Research and Quality Improvement Council. Since this dissertation focuses on the formative years of the NQF, only these four councils are referenced. Over time the number of Member Councils has expanded to eight to recognize the diversity of stakeholders in the health care industry. For more information about each Member Council, please visit: <http://www.qualityforum.org/about/membership/councils.asp>

- a) promote communication within and among Member Councils to share ideas and best practices, and enhance coordination to advance quality measurement and reporting;
- b) communicate the views of the membership of the Corporation regarding policies or administration of the Corporation to the Board of Directors, Framework Board, and standing committees; and
- c) elect a Council Chair or other individual to serve on the Board of Directors.

Funding

The NQF has a \$2.2 million annual budget. Its primary source of funding is membership dues; in FY 2000, the NQF received \$623,000 from membership dues. The amount of dues paid by each organization depends on the type of organization and its operating budget.¹⁴ It received an initial grant of \$2.5 million from the Robert Wood Johnson Foundation and other founding funders included the California HealthCare Foundation, the Horace W. Goldsmith Foundation, the United Hospital Fund (UHF), VHA, the Health Care Financing Administration (now CMS), AHRQ, the Commonwealth Fund, and the Office of Personnel Management.

Like many nonprofit organizations, the NQF struggles to obtain funding. But it is a particular challenge for the NQF because of its turbulent and unstable environment. As I will demonstrate, the chaotic environment influenced the types of projects the NQF pursued during its formative years.

Consensus Development Process

The NQF values diversity, participation, and cooperation and seeks to institutionalize these values in a number of ways. One way is through its Member Council system. Another way is through its CDP, which was created as a means to allow diverse organizations to participate in the development and endorsement of performance measures and to provide a framework to ensure that all viewpoints have a means to be heard.

The seeds of the NQF's consensus process are found in the National Technology Transfer and Advancement Act (NTTAA) of 1995. The NTTAA's aims are to reduce the cost to government of developing standards and the burden of complying with agency regulations, provide organizations with opportunities to develop national standards, promote economy and

¹⁴ The second page of the NQF's Organizational Membership Application outlines the sliding scale membership dues schedule: http://www.qualityforum.org/pdf/organizational_app.pdf

efficiency through the use of nationwide standards, and further government's reliance on the private sector for the provision of goods and services (OMB Circular A-119, 1998). The law encourages federal agencies to adopt technical standards developed by "voluntary consensus standards" organizations rather than requiring federal agencies to develop their own standards.¹⁵ The NQF is a voluntary consensus standards body that possesses all of the formal characteristics outlined in the OMB Circular A-119 for such an organization: openness, balance of interest, due process, an appeals process, and consensus (but not necessarily unanimity).

The current consensus development process (version 1.8) consists of five steps, following a project's conceptualization, prioritization, and planning (NQF, 2007) (see Figure 1). The first step is Consensus Standard Development. During this phase, the NQF convenes a steering committee, comprised of members from the four stakeholder perspectives (i.e. consumer and patient groups, health care purchasers, health care providers and health plans, and research and quality improvement organizations), to direct the particular project to be undertaken by the NQF. The steering committee conducts a thorough analysis of the issue and makes draft recommendations. The second step is Widespread Review, in which the NQF releases the proposed standards, first to its membership and then to the general public for comment. The third step is Member Voting. The fourth step is Consensus Standards Approval Committee (CSAC) Action and Board of Directors Endorsement, in which the CSAC endorses or reconsiders proposed standards. The NQF's Board of Directors affirms or overturns the actions of the CSAC. The final step is Evaluation, during which members can submit feedback about the implementation of specific measures. If needed, the measures are updated.

¹⁵ OMB Circular A-119 defines "voluntary consensus standards" as "standards developed or adopted by voluntary consensus standards bodies, both domestic and international" and "voluntary consensus standards bodies" as "domestic or international organizations which plan, develop, establish, or coordinate voluntary consensus standards using agreed upon procedures."

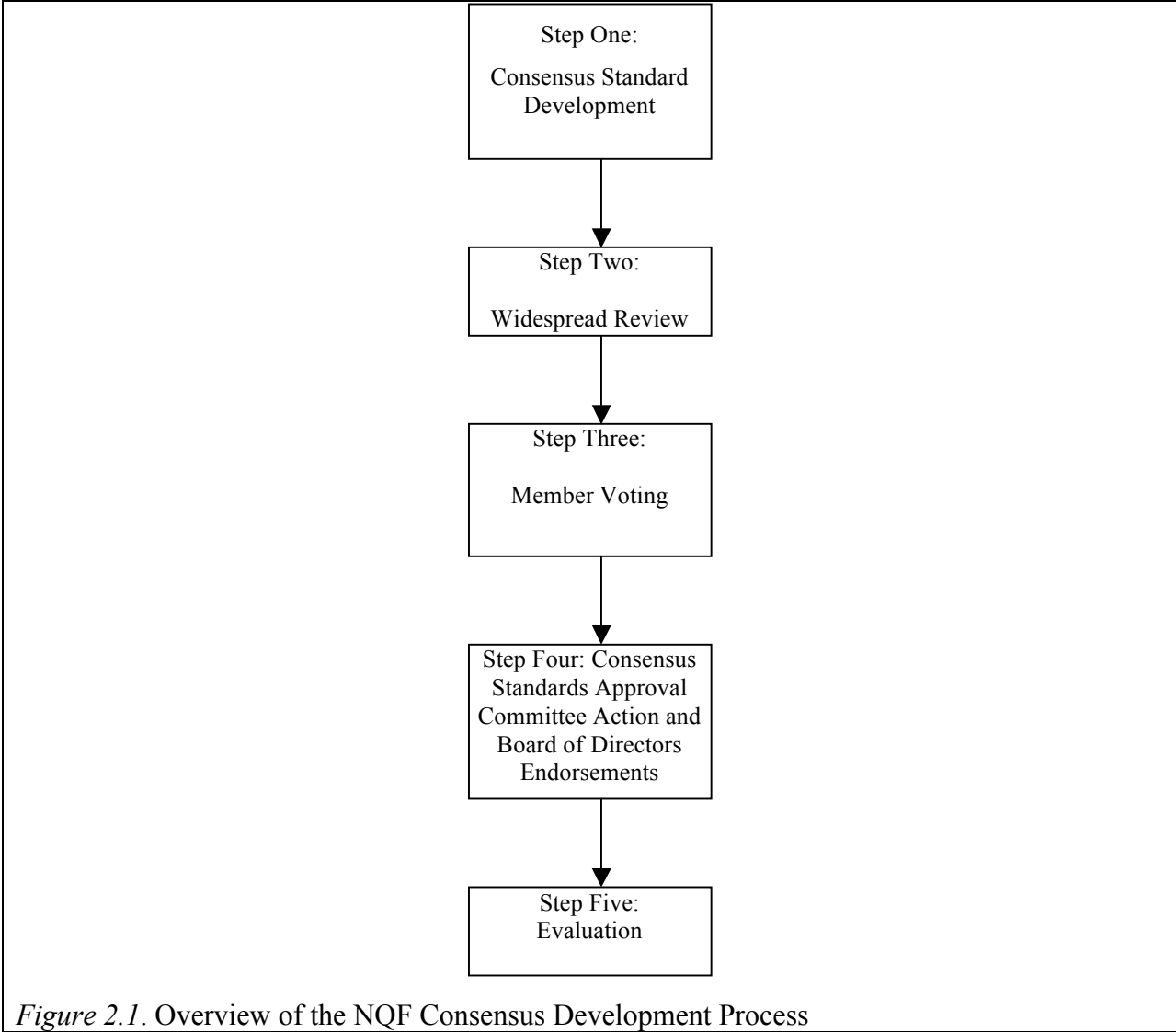


Figure 2.1. Overview of the NQF Consensus Development Process

Health care leaders proposed the establishment of an organization that would encourage participation from a number of diverse stakeholders and coordinate their efforts. The NQF’s mission and organizational structure was designed to be responsive to these needs and to allow it to achieve the ultimate goal of quality improvement in health care through the endorsement of national, consensus-based standards. As soon as the NQF’s organizational structure and consensus development process were in place, the newly minted organization and its members needed a vehicle to test their new structure and processes. As one participant stated, the NQF’s first project needed to be one that “a whole lot of people are interested in and will demonstrate that the NQF is doing something.” The Serious Reportable Events project was just that vehicle.

Serious Reportable Events Project

The NQF's Serious Reportable Events, or the "Never Events," project was the first project to go through the NQF's consensus process.¹⁶ It is a central example of Kizer's efforts to bring representatives of all sectors of the healthcare system together with equal representation and was the first test of the NQF's new system. The goal of the project was to establish agreement on a set of serious preventable adverse events that might form the basis for a national state-based event reporting system and that could lead to substantial improvements in patient care. No standardized reporting system exists across states to provide data on the number and types of medical errors. A standardized medical error reporting system would dramatically improve the quality of healthcare by allowing states to collect data and disseminate information about how to prevent the most common medical errors that occur in hospitals.

The final report, *Serious Reportable Events in Patient Safety: A National Quality Forum Consensus Report*, identifies 27 medical errors that should never occur in healthcare today. The errors are grouped into six categories: surgical events, product or device events, patient protection events, care management events, environmental events, and criminal events (see Table 1). Some examples of the medical errors that should never occur include: surgery on the wrong body part, infant discharged to the wrong person, and patient death or disability associated with a medication error. These 27 medical errors are proposed as the basis for standardizing data collection and reporting of medical errors.¹⁷ According to one interviewee, "the notion here was to identify events that were rare, but were so egregious that there was 100 percent agreement that these are things that should never occur in the course of medical care."

The Never Events project was part of three projects totaling approximately \$1.5 million funded by the federal government, specifically AHRQ and CMS. The other two projects are the Hospitals project and the Safe Practices project. The Hospitals project is the largest of the three. The federal funding for the Never Events project totaled \$25,000. The Milbank Memorial Fund also contributed some initial funding and assisted the NQF with its efforts to establish an ad hoc panel of state representatives who had experience in this type of data collection and activity.

¹⁶ During this project, the NQF Consensus Process, version 1.3 was in effect.

¹⁷ The Member Councils received the report in July, 2001, and submitted comments and voted on the report in August, 2001. With 55 percent of the ballots returned, a majority of those voting in all four Member Councils approved the document. The Board of Directors approved the report in December, 2001.

Table 2.1: List of Serious Reportable Events

I. Surgical Events

- Surgery performed on the wrong body part
- Surgery performed on the wrong patient
- Wrong surgical procedure performed on a patient
- Retention of a foreign object in a patient after surgery or other procedure
- Intraoperative or immediately post-operative death in an ASA Class I patient

II. Product or Device Events

- Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility
- Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
- Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility

III. Patient Protection Events

- Infant discharged to the wrong person
- Patient death or serious disability associated with patient elopement (disappearance) for more than four hours
- Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility

IV. Care Management Events

- Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
- Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-compatible blood or blood products
- Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility
- Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility
- Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates
- Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
- Patient death or serious disability due to spinal manipulative therapy

V. Environmental Events

- Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
- Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility
- Patient death associated with a fall while being cared for in a healthcare facility
- Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility

VI. Criminal Events

- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed healthcare provider
- Abduction of a patient of any age
- Sexual assault on a patient within or on the grounds of the healthcare facility
- Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the healthcare facility

Source: *Serious Reportable Events in Patient Safety: A National Quality Forum Consensus Report*

According to one interviewee, “it was largely involved in assisting in supporting the logistics of the meetings themselves—holding them at the hotel and paying for the room and, in some cases, flying some of the state experts from around the country.”

As a first step, the NQF established a “Never Events” Committee. The purpose of the committee was to identify and develop consensus on a core set of patient safety measurements related to avoidable, serious adverse events in hospital care. Lucien Leape and John Colmers served as co-chairs of the committee. According to one interviewee, “we decided on co-chairs very early on so that it didn’t run the risk of suddenly having no chair. And to just give some sense of balance rather than a chair and a vice-chair which is more common.” The rest of the committee, according to the same interviewee, consisted of members that “had names within a sphere as people who were thinking about, worrying about, and had spoken about patient safety issues...”

When the project initially got underway, there was, according to one interviewee, “a clear progression and fixing of what exactly was going to happen over a period of several years.” According to an NQF observer,

the original vision was that the NQF would do this list, CMS would then fund five states as a pilot project to operationalize the list based on the experience, we would then go back and look at the specifications and the definitions, based on real world reporting experience and make any changes that might be necessary to enhance clarity, reduce ambiguity, all those sorts of things. And then the feds would pursue a national state-based error reporting system.

As with many things, however, it did not pan out the way the NQF anticipated. There was a change in presidential administrations, and with that change, a national medical error reporting system was no longer a top priority. As a result, there was a reluctance to fund the pilot programs. The NQF continues to work with states that want to implement this list. On May 27, 2003 Minnesota became the first state to sign the list into law. About six months later, Texas also passed a law that requires reporting of these events. Today, more than half the states have laws requiring some form of reporting on medical errors.¹⁸

¹⁸ On July, 29, 2005, President Bush signed the Patient Safety and Quality Improvement Act. The act creates a national database for the reporting of medical errors and near misses. Under the act, voluntary reports of medical errors or near misses may be submitted to the newly-created private sector patient-safety organizations.

Under the Minnesota Adverse Health Care Events Reporting Law, hospitals must disclose to the Minnesota Department of Health when any of the 27 events occur and that information is shared then with the public. Eventually, the commissioner of the Minnesota Department of Health will publish annual reports of adverse events by facility. There is also some indication that those within the healthcare industry are taking the standards developed by the NQF seriously. Tri-Care, the Department of Defense's (DOD) managed care organization, recently required all of its companies to report on these events, and the Joint Commission is also requiring its hospitals to report on these events. Even though progress is slow and the implementation different than initially envisioned, according to one interviewee, "this is going to get phased in, but it's going to be more circuitous than was originally envisioned. But, ultimately, we will have reporting on these things."

Conclusion

The story of standards development in health care indicates that it has largely been a mixed success. This is due in large part to the inability of the diverse stakeholders in the health care industry to cooperate and reach consensus about what measures are needed to reflect "good" quality and the best way to develop, test and disseminate measures of quality. Many in the health care industry, however, realized that cooperation among diverse stakeholders just might be the most appropriate means of achieving quality improvement goals. This philosophy is reflected in the language used in the report issued by the President's Advisory Commission: "The Forum will need to be broadly representative of stakeholders. The users and potential users of information on quality must be involved in the process of identifying core quality measures for reporting if those processes are to succeed in addressing their common information needs...its success will depend upon the commitment and influence of a critical mass of stakeholders in the health care marketplace." Health care leaders needed a means of coordinating the efforts of diverse stakeholders and created an organization that would be responsive to these needs, while at the same time would pursue the ultimate goal of quality improvement. The NQF was created to suit its unique environment—one that is characterized by fragmentation, duplicity of effort, and chaos. Through its organizational structure and leadership, the NQF embodies the values of cooperation, diversity, and participation. The larger question of leadership in a network context still needs to be examined more closely. Before I turn to the critical tasks Kizer engaged in that

further shaped and refined the NQF as an organization, I examine the network and leadership literatures to see what insights they might provide into leadership in a network organization.

CHAPTER THREE
NETWORKS AND NETWORK MANAGEMENT AND LEADERSHIP:
A REVIEW OF THE LITERATURE

*The organizations that get things done will no longer
be hierarchical pyramids... They will be systems—interlaced webs of tension
in which control is loose, power diffused.*
--Cleveland (1972)

*Since networks are great laboratories
of contemporary management, empirical research on network process
can make important contributions to management theory.*
--Agranoff and McGuire (1999)

Introduction

The NQF is a network organization that was created to address quality problems in health care. While there are challenges inherent in building any organization, the challenges are even greater when building a network organization like the NQF because of the fragmentation that is inherent in the health care system. In Chapter One, I posed the key question that is the focus of this dissertation: What critical tasks does a network entrepreneur undertake in order to build an NAO? In order to understand the NQF and the challenges and tasks associated with building and managing a network organization, it is necessary to explore the existing literature. As I will demonstrate, the existing literature does not address the formative stages of network development or, more specifically, the tasks a network entrepreneur might engage in to establish a network organization. Furthermore, there is a lack of empirical studies with regard to network management and leadership. This dissertation seeks to fill these gaps by identifying and conceptualizing some of the critical tasks of a network entrepreneur.

The following acts as a roadmap for this chapter. In Part One, I map the terrain of the network literature. The purpose of this section is not meant to be an exhaustive review of the network literature, but rather to highlight some of the topics and landmark studies that scholars have conducted with regard to networks. A brief review, however, of the existing literature is necessary in order to understand the gaps that exist with regard to network leadership during a network's formative stages. In Part Two, I examine two areas of literature that are most relevant to this dissertation—the network management and network leadership literatures. As I will demonstrate, while much is known about how and why network organizations form, little is known about how they are managed (Barringer & Harrison, 2000, p. 396). In fact, the

management of networks is one of the least understood and studied areas in both public administration and healthcare.¹⁹

Networks

In *The Rise of the Network Society* (2000), the first in a trilogy of books about the social, economic, and cultural impacts of the Information Age, sociologist Manuel Castells documents the rise of the Information Age. A defining feature of this new age is interconnectedness, which is manifested through the complex networks that are a ubiquitous part of the Information Age. Networks are everywhere; there are, among other things, global business networks, cellular networks, television networks, social networks, the Internet, and computer networks.

In the public sector we also are witnessing the movement away from bureaucratic, hierarchical organizations toward networks. Rubin (2005) argues that the three-branch metaphor for government is outmoded and that the network metaphor more accurately describes government and intergovernmental relations today. Goldsmith and Eggers (2004) note that this shift has occurred for a number of reasons, including an increase in cross-agency and cross-government initiatives, an increase in public-private collaboration, and the growth of the Digital Revolution, which allows for increased citizen demand for and input in service delivery options.

The scholarly literature on networks is both broad and rich. Scholars from different fields in social science have contributed to the development of network theory. Sociologists have used resource dependency and institutional theory to understand patterns of service provision and the normative aspects of networks (O'Toole, 1997). Three lines of work in economics have contributed to the development of network theory: game theory, transaction cost economics, and public choice (O'Toole, 1997). In political science, four research traditions have influenced the development of network theory: pluralism, agenda research, neo-corporatism, and subsystems/policy communities (Kickert, Klijn, & Koppenjan, 1997).

The literature on networks also is a terminological jungle (Nohria & Eccles, 1992). For example, Borzel (1998) notes that so many different conceptions of policy networks exist in the literature that trying to categorize it is akin to "organizing Babylon." The purpose of this section is to provide an overview of some of the topics scholars have explored with regard to networks.

¹⁹ The literature on networks in healthcare examines networks developed by healthcare providers to obtain managed care contracts and alliances to cut the administrative costs of healthcare delivery (Miller, 1996). For a taxonomy of health networks and systems, see Bazzoli, Shortell, Dubbs, Chan, & Kralovec, 1999.

In order to cut through this jungle in a systematic manner, the literature in this section is organized around five main themes: (1) network definitions, (2) network prevalence, formation, and barriers to collaboration, (3) types of interorganizational relationships and network structures, (4) advantages and disadvantages of networks, and (5) network effectiveness.

Network Definitions

Definitions of networks can be grouped into two categories: networks as organizational structures and networks as governance systems. The first uses networks as an analytical tool for examining the different structures of relations among actors between organizations. The two following definitions arise from two different schools of thought—transaction cost economics and business administration (Ebers, 1997). Scholars from the transaction cost economics tradition define networks broadly and view them as “an intermediate or hybrid organizational form in which some features of both markets and hierarchies are present” (Ebers, 1997, p. 266). Scholars from business administration, on the other hand, define networks more narrowly as “a ‘third’ organizational form with its own distinctive features, different from those of markets and hierarchies” (Ebers, 1997, p. 266).

The second way of looking at networks—as a governance system—is most relevant to this research. Kickert, et al. (1997, p. 6) capture the idea of networks as a form of governance in their definition of a policy network, which they define as “(more or less) stable patterns of social relations between interdependent actors, which take shape around policy problems and/or policy programmes.” Other scholars also emphasize the more informal aspects of networks in their definition of a network (Jones, et al., 1997; Podolny & Page, 1998).

Provan and Kenis (2008) identify and discuss three general types of network governance structures. The first and most common form of network governance is participant governance. In this type of governance structure, they explain, the network “is governed by the network members themselves with no separate and unique governance entity...Network participants are themselves responsible for managing internal network relationships and operations as well as external relations with such groups as funders, government, and customers” (Provan & Kenis, 2008, p. 234).

The second structure that governs networks is a lead organization. In this type of network, “all major network-level activities and key decisions are coordinated through and by a single participating member, acting as a lead organization” (Provan & Kenis, 2008, p. 235). This

type of network structure corrects for the inefficiencies that exist in self-governing networks, but may suffer from the problem of being held hostage to the lead agency's goals.

The third form of network governance—and the one most relevant to this dissertation—occurs through a “network administrative organization” (NAO) (Provan & Milward, 2001). Provan and Milward (2001, p. 418) assert that in more formal networks, “network growth and maintenance is often led, coordinated, and governed by a central local administrative entity,” which they refer to as an NAO. Provan and Kenis (2008, p. 236) further explain,

Unlike the lead organization model, however, the NAO is not another member organization providing its own services. Instead, the network is externally governed, with the NAO established, either through mandate or by the members themselves, for the exclusive purpose of network governance. The NAO may be a government entity, or a nonprofit, which is often the case even when the network members are for-profit firms.

By that definition, the NQF is a prime example of an NAO in that it can be considered the hub of the network and surrounding it are the spokes—its approximately four hundred member organizations, comprised of representatives from the public and private sectors, including healthcare purchasers, providers, consumers, and research and quality improvement organizations. For the purposes of this study, the following definition is employed: A network is a group of organizations with differing perspectives engaged in a cooperative endeavor to resolve an issue whose recurring exchanges of resources (e.g., knowledge, technology and financial resources) are coordinated by an NAO and whose actions are subject to governance by both informal (e.g., social norms and values) and formal (e.g., legal and written procedures) mechanisms.

As mentioned previously, networks, of course, vary in terms of governance structure, with patterns of interaction between participants ranging “from the isolated structure in which no actor is connected to any other actor, to the saturated structure in which every actor is directly linked to every other individual” (Knoke & Kuklinski, 1991, p. 175). It is important to note, therefore, that the network in which the NQF is embedded represents only one type of network—one that can be characterized as a hub and wheel configuration. In this type of network, the hub organizes the activities of the surrounding organizations (Jarillo, 1988; Barringer & Harrison,

2000). The NQF is the hub and surrounding it are its approximately four hundred member organizations.

Network Prevalence, Formation, and Barriers to Collaboration

Linden (2002, p. 9) maintains that collaboration becomes more important as society moves from “mechanistic models to more organic ones.” Although this has been a key assumption underlying much of the research into networks, it has only been recently that scholars have addressed the question empirically of whether networks exist in the public sector and, if they do, their prevalence.

Some public management scholars have documented the frequency and importance of networks (Agranoff & McGuire, 2004; Agranoff & McGuire, 1998; Agranoff, 1996; O’Toole, 1993; Mandell, 1988; Lynn, 1996). Most of these studies, however, focus on networks that exist at the local level, as opposed to the national level. Agranoff and McGuire (1998, p. 88) point to these extensive studies and conclude, “Researchers are solidly building the case that networks are the norm in public management.” Agranoff (2007, p. 220), however, offers the following caveat:

Networks and the network era constitute noble overlays to the bureaucracies and the bureaucratic era. Management by network and network management have therefore become equally important endeavors, but under current conditions the network will neither replace bureaucratic organizations nor is it likely to displace its long-run power.

Schout and Jordan (2005) argue that networks can be classified along a continuum, with informal, weak networks at one end and strong, more formally organized networks at the other end. In fact, there is evidence that some networks, especially NAOs, are organized and governed in a hierarchical manner (Provan & Milward, 2001). Provan and Kenis (2008) argue that the larger the network, the more likely centralized forms of network governance will be adopted. So, despite the prevalence of networks, they will never completely replace bureaucratic, hierarchical forms of organization.

Another question addressed in the literature is how and why networks form (Ebers, 1997; Jones, et al., 1997; Child & Faulker, 1998). Networks are often contrasted with markets and hierarchies (Piore & Sabel, 1984; Powell, 1990; Thompson, Frances, Levacic, & Mitchell, 1991; Jones, et al., 1997). Each offers a different way of organizing and emphasizes different aspects of

organizing. For example, markets and hierarchies emphasize formal contractual relationships between firms and bureaucratic structures in organizations, while networks emphasize the more informal mechanisms of organizing (Thompson, et al., 1991).

Barringer and Harrison (2000) provide an overview of the six most common theoretical paradigms used to explain interorganizational relationship formation. These theoretical paradigms fall along a spectrum from economic rationale to behavioral rationale and include transaction cost economics, resource dependency, strategic choice, stakeholder theory, organizational learning and institutional theory.²⁰ Networks can be found in the semiconductor industry (Saxenian, 1994), the film industry (Jones & DeFillipi, 1996), biotechnology (Barley, Freeman, & Hybels, 1992), and the textile industry (Piore & Sabel, 1984).

In the public sector, networks often form because one organization lacks the resources to provide a good or service on its own. Networks allow organizations to pool their resources in order to provide a good or service (O'Toole, 1997; Kickert, et al., 1997), deal with complex or "wicked" policy problems (O'Toole, 1997), and as a response to changes in the role of government from a direct service provider to one of contracting, steering, and collaborating (Kooiman, 2003).

As McGuire and Agranoff (2007, p. 14) note, "Working collaboratively through networks often times connotes images of some interactive nirvana, where nothing but 'love and kisses' prevail in a sort of a soothing hot tub atmosphere." Experience proves otherwise, and scholars have documented and classified barriers to collaboration in many instances (Jennings & Krane, 1994; Bardach, 1998; Linden, 2002; Agranoff, 2007). Jennings and Krane (1994), for example, interviewed state officials involved in coordinating service delivery for the Job Opportunities and Basic Skills (JOBS) program in order to identify barriers to collaboration. They outline three

²⁰ Scholars from the transaction cost economics perspective emphasize the economic reasons networks arise. Transaction cost theory, usually associated with the work of Williamson (1975, 1985, 1991), argues that organizations organize their activities in such a way to minimize production and transaction costs. The easiest way to understand the concept of transaction costs and how interorganizational relationships can be used to reduce transaction costs is to imagine that there are two firms, Firm A and Firm B. Suppose Firm A wants to use a particular good, but does not have the expertise to produce that good. Therefore, it buys the good from a company that does have the expertise to produce it, Firm B. In a market, however, the opportunity for Firm B to exhibit self-interested behavior is great, driving transaction costs higher for Firm A. Firm A may choose either to produce the good itself (increasing production costs) or to partner with Firm B, thereby reducing both transaction and production costs. At the other end of the spectrum, scholars from an institutional perspective emphasize the normative aspects of network formation and structure. They argue that the environment imposes pressure on firms to "appear legitimate and conform to prevailing social norms" of the business environment (Barringer & Harrison, 2000). Because of these environmental pressures, firms increase their participation in interorganizational relationships as a way to enhance their status, reputation, visibility, and, ultimately, their legitimacy.

broad types of barriers: organizational (e.g., differing missions, professional orientations, agency structure and processes, etc.), legal/technical (e.g., conflicting regulations and reporting requirements, legal restrictions on the use of funds, technological capacities of organizations, etc.), and political barriers (e.g., turf protection, support of leaders, environmental dynamics, etc.).

This study takes a different perspective from most of the research about networks. As mentioned previously, most existing research is about local-level networks, and few empirical studies exist about the occurrence and prevalence of networks at the national level. This study of the NQF sheds some light on why and how an NAO at the national level is formed and identifies some of the challenges a national-level network like the NQF faces during its formative stages.

Types of Interorganizational Relationships and Network Structures

Scholars differentiate between different forms of interorganizational relationships, of which networks are only one type. Barringer and Harrison (2000) identify and discuss the six most common interorganizational forms: joint ventures (i.e., when two firms create a jointly-owned organization), networks (i.e., when firms organize based on social rather than legally binding contracts), consortia (i.e., when several firms join forces to create one organization), alliances (i.e., when two firms are involved in an exchange relationship, but there is no ownership involved), trade associations (i.e., when organizations in a particular industry form a non-profit organization primarily for lobbying and disseminating information) and interlocking directorates (i.e., when an executive from one firm sits on another firm's board or executives from two firms sit on another firm's board). The six most common interorganizational forms range from tightly coupled organizations (e.g., joint ventures, networks) to loosely coupled organizations (e.g., consortia, trade associations), depending on how closely the participants are linked.²¹

Agranoff (2007, p. 49) maintains that networks must be “differentiated by the kind of work they do.” Agranoff's work, *Managing within Networks* (2007), contributes much to our

²¹ The NQF does not fit neatly into any of these categories. What makes it worth studying is that it has characteristics of several of the “ideal types” discussed by Barringer and Harrison (2000), most notably networks, consortia, and interlocking directorates. It is a network in terms of its organizational structure, and it has characteristics of interlocking directorates because many of the individuals that sit on the boards of health care organizations also sit on the NQF's board. It is also a consortium because it was created by the healthcare industry to address quality issues. Barringer and Harrison (2000, p. 390) note, “a novel and theoretically interested aspect of consortia is that they tend to facilitate the cooperation of for-profit organizations, government, and not-for-profit organizations more than other types of interorganizational relationships.”

understanding of the types of public management network structures that exist. From his study of 14 networks, Agranoff (2007) develops a typology of network structures: informational, developmental, outreach, and action. The first three networks allow for organizations to engage in information sharing, capacity-building activities, and program development and implementation, while the distinguishing feature of the fourth type, action networks, is that they engage in policymaking and have statutory support to do so (Agranoff, 2007).

The research about network structures sheds some light on the type of networks that exist. As mentioned previously, most of these studies focus on networks at the local level and neglect networks that form at the national level to address policy problems. This dissertation illustrates that action networks such as the NQF also form on the national level and expands our understanding of this type of network in action.

Advantages and Disadvantages of Networks

The literature on networks identifies an array of advantages and disadvantages. Jarillo (1998) and Powell (1990) maintain that one advantage of networks is that they offer a flexible way for organizations to work together because they are not restricted by the rules and procedures associated with traditional hierarchical forms of organization. Networks, therefore, can reorganize and respond more quickly to any opportunities or challenges that may arise. Networks also allow for innovation by “foster[ing] learning and continuous improvement by providing more timely access to a broader knowledge base than is possible within a single organization” (Goldsmith & Eggers, 2004, p. 31). Barringer and Harrison (2000, p. 388) maintain that the one of the benefits of networks is specialization and explain that the

benefit of organizing in this manner is that each participating firm is permitted to focus on its specialty, leaving secondary activities to members that specialize in those activities or other suppliers. The result is a constellation of firms that each focuses on their distinctive competency in an integrated effort to produce a product, service, or new technology.

Jones, et al. (1997) assert that another advantage of networks is that they allow organizations to bring products to the market in a shorter amount of time, especially in instances of high task complexity, high levels of uncertainty, and limited time. Harrigan and Newman (1986) argue that their sheer size also makes networks a powerful competitive force, and networks, because of their size, can extend the reach of services and programs (Goldsmith & Eggers, 2004).

Raab and Milward (2003, p. 413) note, “most of the literature on networks and collaborations is quite positive.” Scholars, however, are beginning to document the disadvantages or challenges associated with networks. Alter and Hage (1993) argue that one disadvantage of networks is that they are difficult to manage. They cite the ever-increasing number of firms participating in a network and the power imbalances among the participants in a network as two of the reasons why it is difficult to manage a network. More specifically, Goldsmith and Eggers (2004) maintain that managing a network is challenging because it is difficult to align goals amongst diverse stakeholders, provide oversight, avert communications meltdowns, overcome data deficits and capacity shortage, and manage the tension between competition and collaboration. Barringer and Harrison (2000) assert that opportunities for learning may also be slow in a network because while the hub firm is in charge of the final product, the responsibilities for producing different parts of a product are dispersed among the other firms based on their skills and resources.²²

More recently, scholars have begun documenting and researching the impacts of “dark networks” and the “dark side” of network management. Raab and Milward (2003) first coined the term “dark networks” (i.e., networks that may be used for private ends that are not in the public interest) and documented their existence. They reviewed three types of dark networks—drug-trafficking networks, the Al Qaeda Terrorist network, and arms-trafficking networks in West Africa—in order to discover their similarities and differences and explore their policy implications. In a related vein, O’Toole and Meier (2004) argue that network management can have a dark side and that networks and the individual biases that can be manifested in network management can have negative political effects for an organization. They argue that network managers can create problems for an organization by responding to the more politically powerful members of the network, which ultimately creates inequality in the network. They conclude that their results do not fully indicate whether this is happening and that the political dimensions of network management need to be explored further.

The NQF represents an experiment in democracy, and this study of the NQF contributes an empirical understanding of some of the advantages and disadvantages of an NAO. In the

²² This disadvantage illustrates a broader point: each network is unique, and the advantages and disadvantages experienced by participants in each network will differ depending on a number of factors, including the environment surrounding the network and the personalities of actors in a network. For example, this disadvantage can also be viewed as an advantage. The fact that each firm participating in the network can provide expertise in different areas means that it may be more efficient for the firms to combine forces and work together.

following chapters, I will consider the virtues and challenges of the NQF as a network organization for improving health care quality.

Network Effectiveness

The primary issue scholars confront when attempting to evaluate network effectiveness is how to measure effectiveness when so many constituencies are affected in many ways and to different extents (Provan & Milward, 1995; Provan & Milward, 2001). Evaluating networks is also more complicated than evaluating individual organizations because there are a number of organizations providing different parts of a service (the joint-production problem) as well as multiple constituencies (Provan & Milward, 2001). Yet scholars have made some progress in addressing the question of whether networks are effective (Provan & Milward, 1995; Provan & Sebastian, 1998; Milward & Provan, 2000; Provan & Milward, 2001; Provan & Kenis, 2008).

In one landmark study of network effectiveness, Milward and Provan (2000) spent 10 years studying networks of nonprofit organizations that provide mental health services in communities all over the United States. They asked: How can effective institutions be designed in a world of shared power where few organizations have the power to accomplish their missions alone?" (Milward & Provan, 2000, p. 359). They found that a network is likely to be effective when it meets the following criteria: the principal-agent relationship is clear; the principals produce some of the services; the participant relationships are stable; and contracts are rebid infrequently. They conclude, "when a reasonable level of funding is combined with an institutional design that creates incentives for agents to perform as promised and the system is stable, reasonable outcomes are likely to result" (Milward & Provan, 2000, p. 376).

Research regarding network effectiveness is relatively underdeveloped. The literature, for example, does not address the impact of having a strong leader to establish a network organization such as the NQF on the effectiveness of the NAO. This study highlights the importance of network leadership and contributes empirical evidence of the importance of a leader in the early stages of developing an NAO.

While the preceding discussion is useful in some ways for understanding the origins, structure, barriers to collaboration, and the advantages and disadvantages of a network organization like the NQF, it still does not address the questions that are the main focus of this dissertation. In Part Two, I explore the network management and network leadership literatures

and examine what they offer in terms of understanding the leadership tasks that need to be undertaken during network development and formation.

Network Management and Network Leadership

Network Management

In a 1973 study, Galbraith found that participating in interagency projects ranked last in a list of twenty tasks rated by managers. If that study were to be replicated today, that ranking most likely would be much higher. In spite of this, scholars have devoted little attention to the issues of network management and governance.²³ Furthermore, Agranoff and McGuire (2004, p. 35) state, “Our understanding of network management is derived mainly from theoretically examining, rather than empirically cataloging, its tasks.”

Some public administration scholars, however, recognize the growing importance of networks as an approach to management (Kickert, et al., 1997; O’Toole, 1997; Agranoff & McGuire, 2001). Agranoff states that how “to manage in a network is an important 21st Century issue because of networks’ prevalence in the managerial enterprise” (Kamensky & Burlin, 2004, p. 62). O’Toole (1997, p. 45) argues that scholars should “treat networks seriously” because “public administration increasingly takes place in settings of networked actors who necessarily rely on each other and cannot compel compliance on the part of the rest.” He also contends that understanding network management is especially important for those public managers interacting and participating in network organizations. Otherwise, they risk “either operating with inappropriate organizational models or adapting conventional structures to meet the more challenging demands” (O’Toole, 1997, p. 46).

The purpose of this section is to provide an overview of the network management literature and examine the literature to determine what insights it offers for this dissertation. This section is organized around the following themes: intergovernmental relations, intergovernmental management, and network management; existence, importance, and effectiveness of network management; and strategies for managing networks.

²³ Although the term “management” is usually associated with hierarchical management, I use it here in a broader sense. A continuum offers one way of thinking about different management strategies. Management strategies could be located along the continuum with traditional, hierarchical strategies located at one end and management strategies that emphasize cooperation at the other.

Intergovernmental Relations and Network Management

Much of the intellectual heritage of the network management literature developed along a parallel path with the implementation and intergovernmental relations literatures (Hanf & Toonen, 1985; Hjern & Porter, 1981; O'Toole, 1986; Mandell, 1988; Pressman & Wildavsky, 1973; Agranoff & McGuire, 2003). In their 2003 article, in which they attempt to synthesize and integrate the intergovernmental management and network management literatures, Agranoff and McGuire (2003, p. 1403) concluded, not surprisingly, that there is a “natural convergence and synthesis of intergovernmental and network research.”

Collaboration is not new to the American form of government (Powell, 1990). In fact, collaboration is a distinct feature of American federalism and the various levels of government have always collaborated. Intergovernmental relations is the term most often used to describe this complex system. Anderson (1960, p. 3) defines intergovernmental relations as “an important body of activities or interactions occurring between governmental units of all types and levels within the federal system.” Grodzins (1960) popularized the term “marble cake federalism” to describe the interrelationships between the various levels of government.²⁴ He maintained that the metaphor of federalism as a “layer cake” was incorrect and stated, “A far more accurate image is the rainbow of marble cake, characterized by an inseparable mingling of differently colored ingredients, the colors appearing in vertical and diagonal strands and unexpected whirls [*sic*]” (Grodzins, 1960, p. 265).

During the 1960s, as the federal government expanded its federal grants and programs to state and local governments and nonprofit organizations, the term *intergovernmental management* emerged in the lexicon to describe the changing role of managers in this new environment. Mandell (1988, p. 393) notes, “intergovernmental management is distinguished from the concept of intergovernmental relations by three characteristics: (1) a problem solving focus; (2) strategic and coping behavior; and (3) communication networks.”

Pressman and Wildavsky (1973) first discussed implementation as shared administration. Other scholars followed and began to document programs that were implemented and services that were provided through intergovernmental networks (Hanf, Hjern, & Porter, 1978; Mandell,

²⁴ Joseph McLean is credited with first coining and introducing the term “marble cake federalism.” Grodzins, McLean’s student, further conceptualized and refined the term.

1994; Jennings & Krane, 1994). These studies documented that managers operate both vertically and horizontally within intergovernmental networks.

The literature provides some empirical explanation of the importance of managing intergovernmental relations, particularly as it relates to the implementation of programs. What is missing from this literature is an understanding of how different perspectives can be brought into the decision-making process in a network. More specifically, this study sheds some light on how the NQF brought state and local governments into its decision-making process. Furthermore, what is missing, and is perhaps is the focus of a further study, is how the NQF's measures will be implemented by the various states as the NQF's measures are developed and adopted by the states. While interesting, these works are not directly relevant to this dissertation.

Existence, Importance, and Effectiveness of Network Management

Some scholars have explored the link between network management and network effectiveness. Through a study of intergovernmental networking in 237 cities, Agranoff and McGuire (1998) empirically explore the network management activities of managers and their implications. The article shows “the management context of local economic development as collaborative” (Agranoff & McGuire, 1998, p. 87). They conclude that “networking activity is an important dimension of economic development” and that managers are often involved in more than one network (Agranoff & McGuire, 1998, p. 83). Meier and O’Toole (2001) studied the impact of network management on performance. Using data from several hundred school districts in Texas, they studied the network management activities of school district superintendents to determine the impact of networking on performance. They found that network management and performance are positively linked.

These studies provide some insight regarding the correlation between network management activities and the effectiveness of the network. As with other work, this still does not provide us with much insight about the formative stages of network building or the mechanisms producing or inhibiting effectiveness.

Strategies for Managing Networks

The literature that addresses the strategies for managing networks is quite broad. Scholars have researched and theorized about how to manage uncertainty in networks (Koppenjan & Klijn, 2004), goal conflicts (Winkler, 2006), the strategies managers may use for managing networks (Mandell, 1999; Agranoff & McGuire, 1998; Agranoff & McGuire, 1999; Goldsmith

& Eggers, 2004; Klijin, 1996; Agranoff & McGuire, 2001; Bardach, 1999), the role of the state and the strategies the state may use to manage networks (Sorenson, 2006; Hudson, Lowe, Oscroft, & Snell, 2007), and the dimensions or processes that need to be managed in order for collaboration to be successful (Thompson & Perry, 2006). For the purposes of this dissertation, three studies are notable: Chisholm's (1997, 1998) work on building a network organization, and Kickert et al.'s (1997), and Agranoff and McGuire's (2001) strategies for managing networks.

Chisholm (1997, 1998) describes the steps and strategies managers should undertake when building network organizations to enhance economic development activities. In particular, he focuses on five phases in the network development process: recognizing the problem, planning network development, visioning the future, convening community stakeholders, and organizing for action. While enlightening, his work tends to focus on the work that takes place during pre-network development; that is, the work involved with deciding whether to establish a network organization.

One landmark theoretical work by Kickert, et al. (1997) offers public administration practitioners a "toolkit" for managing networks. They argue that public policy is increasingly the outcome of interactions between the public and private sectors—the government is only one player among many. This idea of interdependency in the policy process has led to the introduction of the concept "policy networks." Accordingly, they maintain, "network management is an example of governance and public management in situations of interdependencies. It is aimed at coordinating strategies of actors with different goals and preferences with regard to a certain problem or policy measure within an existing network of interorganizational relations" (Kickert, et al., 1997). They explore several themes about network management including the closed nature of policy networks, the management of perceptions in networks, strategies and games in networks, instruments for network management, and the government's role in networks.

Agranoff and McGuire (2001) authored the seminal piece that focuses on network management. They explore the applicability of traditional management processes to networks, and they conclude that different strategies are used in the management of networks and that "network management is in search of an equivalent to the hierarchical authority paradigm of bureaucratic management" (Agranoff & McGuire, 2001, p. 11). They provide the most illuminating discussion of the literature on network management behaviors and identify the four

behaviors most commonly used by network managers: activation, framing, mobilizing and synthesizing. They argue, however, that more empirical studies are needed to determine the actual management processes used by network managers. This study seeks to fill this gap by elaborating upon the concepts discussed by Agranoff and McGuire and, in particular, by identifying the critical tasks one engages in to create a network organization.

Activation is part of the initial process of forming a network and involves identifying network participants and stakeholders as well identifying the resources that participants can bring to the network (Agranoff & McGuire, 2001). Agranoff and McGuire (2001, p. 13) argue, “Activation is a critical component of network management because resources like money, information, and expertise are the integrating mechanisms of networks.” Deactivation is also important and occurs when a network manager reorganizes the network—often by introducing new players—so it functions more effectively (Agranoff & McGuire, 2001).

Framing involves establishing network rules, procedures, norms and values (Agranoff & McGuire, 2001). Like activation, framing can occur during the initial stages of network formation. In order to increase network effectiveness or stimulate action, a manager can introduce new ideas into the network, which may change the perceptions of the network participants (Termeer & Koppenjan, 1997). By introducing new ideas or offering different ways of thinking about an issue, a manager can then create a new vision of the network that all participants can share.

In order for a network to be effective, a manager must *mobilize* individuals and organizations to participate in the network. Mobilization involves gaining acceptance from network participants about their roles and the scope of network activities (Agranoff & McGuire, 2001). In order for the network to be effective, managers must encourage individuals and organizations participating in the network to agree on the overall goals of the network and the responsibilities of each organization participating in the network. In addition, Agranoff and McGuire (2001, p. 15) argue, “The ability to manage networks is related to the internal support and cooperation of the manager’s primary organization.”

Synthesizing involves encouraging cooperation and minimizing conflict between network participants (Agranoff & McGuire, 2001). The role of the manager in this process is to ensure that the various perspectives of network participants are represented while minimizing dissension. Klijn and Teisman (1997) maintain that the game metaphor best describes the

activities and interactions of networks and argue that networks are like games in that managers can choose from different strategies to influence the rules of the game and achieve the desired outcomes. Agranoff and McGuire (2001, p. 15) state, “Relationships and interactions that result in achieving the network purpose—synthesis—are the aim of the network manager...”

A common thread running through much of this literature is the assumption that managing a network requires a different set of tools and strategies from those needed to manage a traditional bureaucratic organization. In fact, Agranoff and McGuire (2001) and other scholars, including O’Toole (1997) and Bardach (1998), suggest that managing a network is so different from managing a hierarchical organization that we need a POSDCORB for networks.²⁵ I revisit this question in the concluding chapter.

The current literature about network management is underdeveloped. Much of the existing literature about network management strategies is theoretical. Furthermore, the literature tells us very little about the tasks or activities a network leader needs to engage in to build an NAO; that is, the literature sheds no light on the tasks a network leader should engage in during the formative stages of building an NAO. This study provides an empirical contribution to the literature about the tasks a network entrepreneur undertakes in order to build a network. I turn now to a consideration of the literature related to leadership in networks to see if it offers any insights.

Network Leadership

Along with the idea that with the rise of network organizations management requires reconsideration, some scholars argue that networks demand a new type of leadership. There is a small, but growing, literature about leadership in networks. The purpose of this section is to explore the literature that exists about leadership in networks and consider the insights it offers into the leadership tasks that need to be undertaken during an NAO’s formative years. In this section, I cover the following topics: the importance of leadership in networks, the factors influencing the conditions for the emergence of leaders in networks, leadership traits and the likelihood of collaboration, and leadership styles and behaviors in networks.

²⁵ Gulick and Urwick published some “rule of thumb” principles for PA based on experience. POSDCORB is the acronym that can be used for remembering the primary management functions of administration as laid out by Gulick and Urwick: Planning, Organizing, Staffing, Directing, CO-ordinating, Reporting, and Budgeting.

Importance of Network Leadership

If the goal of management is to produce order and consistency, the goal of leadership is to produce change.²⁶ Some scholars have noted the importance of leadership as a critical factor in network success. These studies can be divided into two types: theoretical studies that hypothesize the importance of leadership in a network setting and empirical studies documenting the importance of leadership in networks. In the theoretical vein, Schout and Jordan (2005) challenge the presumed idea of networks as self-organizing structures and instead maintain that network structures can be placed along a continuum from informal, less organized networks to more formal, highly organized networks. They hypothesize that these different network structures require different kinds of leadership skills and behaviors. Looking at networks along a continuum from informal to more formal networks, they hypothesize that more complex problems require different network structures and more complex leadership tasks (Schout & Jordan, 2005).

In an empirical study in which they interviewed state officials about the barriers to coordination and the ingredients they saw as important to coordination in the JOBS program, Jennings and Krane (1994) found leadership to be an integral part of effective coordination. The authors note, “A necessary (but not sufficient) precondition of successful coordination of human service programs is the presence of leadership working to build a closely knit interpersonal network” (Jennings & Krane, 1994, p. 347). The authors note that this finding differed sharply from the factors outlined in the literature for what makes collaboration successful, with the literature pointing to such factors as financial incentives, rules, technology, and training (Jennings & Krane, 1994).

In an empirical study of effective emergency management in the aftermath of Hurricane Katrina, Waugh and Streib (2006, p. 135) note that Kettl, in his testimony before the U. S. Senate Committee on Homeland Security and Governmental Affairs in June 2006, “concluded that leadership was the critical and missing element in the poor Katrina response.” They document and stress the importance of collaboration in dealing with disasters and note the importance of

²⁶Leadership and management are similar in some ways. They both involve influence, working with people, and accomplishing goals. On the other hand, there are some important differences between the two. One of the differences is that leadership has been around since Aristotle’s time, while management grew in response to the needs of the industrial society. Management acts as a means of reducing chaos, and restoring order and efficiency. A leader must also foster and create a culture that supports that vision and mission.

leadership in this new collaborative environment. They argue that this new collaborative environment calls for a new type of leadership—one that is flexible or “adaptive” with ample opportunities for information sharing and collaboration, which would ideally foster organizational learning and facilitate adaptation and improvisation (Waugh & Streib, 2006).

In another empirical study, Nosella and Petroni examined four strategic networks and the lead company, Carlo Gavazzi Space (CGS), and its CEO as the strategic guide for the whole system. Nosella and Petroni (2007, p. 179) state, “It illustrates how the strong leadership of CGS’s CEO plays a significant role in managing the system of networks...” Furthermore, they found that “...the presence of strong leadership, capable of joining partners in a common vision, is fundamental...” (Nosella & Petroni, 2007, p. 199).

In *Administration and Innovation*, Doig and Hargrove (1987) study government entrepreneurs who create organizations to determine the types of skills and traits are needed in that endeavor. This study sheds some light on and emphasizes the importance of a singular leader in establishing and building a network organization.

Factors Influencing the Emergence of Leaders in Networks

Bryson and Kelley (1978) maintain that the political element of leadership is often missing or unaccounted for in the leadership literature. Specifically, they argue that a political approach to understanding leadership emergence in networks is important because all organizations are inherently political systems and the membership of networks often influence leadership selection and policy-making. They propose therefore developing a political approach to understand leadership emergence, stability, and change in organizational networks. In order to develop their approach, they review the public administration and political science literatures to determine the variables that might impact the emergence of leadership in networks. They examine a number of factors affecting leadership emergence, stability and change in network organizations, including individual, processual, structural, and environmental variables, and develop hypotheses about the variables that affect leadership emergence, stability, and change in network organizations. They conclude, “leadership may be seen as a more complicated and political process than much current literature would have one believe” (Bryson & Kelley, 1978, p. 720).

This review of the literature finds that few empirical studies of the choice of leaders for network organizations. This study seeks to broaden our knowledge of some of the factors that

influence the choice of a network leader for an NAO like the NQF. Indeed, I discuss this issue further in the following chapters. Although this literature is useful perhaps for understanding why the NQF's leader was chosen, it does not shed light on the tasks a leader engages in once she is chosen to build an NAO.

Leadership Traits and the Likelihood of Collaboration

One of the earliest studies of leadership and collaboration examined how and under what conditions executives will draw on their resources to establish interorganizational relations in neighborhood human service organizations (Galaskeiwicz & Shatin, 1981). Galaskeiwicz and Shatin (1981) examined the conditions that influenced an executive's decision to engage in collaborative relationships. The variables they identified include uncertainty, turbulence, organizational goals, organizational size and sponsorship, the leader's residence and membership in local organizations, and racial, ethnic, and religious backgrounds of leaders. They propose three hypotheses: (1) leaders are more likely to draw on their resources to establish collaborative relationships in environments that can be characterized as turbulent and uncertain; (2) leaders will seek out other leaders of similar ethnic, religious, or educational backgrounds; and (3) leaders living outside a neighborhood are more likely to establish collaborative relationships than leaders living in a neighborhood (Galaskeiwicz & Shatin, 1981). They found the opposite of what they proposed as Hypothesis One, they found some support for Hypothesis Two, and their findings for Hypothesis Three indicated that a leader's residence had no consistent effect "either on how racial, religious, or educational backgrounds affected interorganizational cooperation or on how overlapping memberships affected the establishment of cooperative ties" (Galaskeiwicz & Shatin, 1981, p. 445).

While this study highlighted the reasons leaders may engage in collaboration and may offer some explanation or insight into Kizer's motives for collaboration, it still did not address the fundamental question this dissertation is concerned with.

Leadership Styles and Behaviors

Scholars also have studied the style and behavior of network leaders. Much of this work emphasizes new leadership styles—styles that rely less on command and control and more on collaboration and facilitation (Mandell, 1999; Luke, 1997; Crosby & Bryson, 2005; Feyerherm, 1994; Newman, 2005; Bardach, 1998). In her study of four community groups created to improve the conditions of families and children in Los Angeles, Mandell (1999) argues that

networks require different management styles and policy instruments than those used for bureaucracies and explores the capacities needed to manage within networks. She examines networks from two perspectives—that of government managers and that of non-governmental participants—and identifies new management styles and policy instruments for each. Among other changes in roles, she argues that government managers need to become more facilitative and non-governmental participants need to develop the skills necessary to participate in this new environment.

Bardach (1998) also examines the behaviors network leaders can use to overcome the challenges inherent in collaborative settings and lead to the success of interagency collaboratives. He explores 19 cases of interagency collaboration and builds a theory of leadership in collaborative settings. He identifies some of the challenges impacting the success of interagency collaboratives and offers some practical suggestions for making collaboratives work. Bardach notes “that effective leadership makes a big difference” to the success or failure of an interagency collaborative. Like Mandell, he finds that leaders should practice facilitative or servant leadership based on four principles advanced by Chrislip and Larson (1994): bringing people to the table, creating an open process, stimulating broad involvement, and keeping individuals upbeat when dealing with frustration.

Feyerherm (1994, p. 253) examined “how leadership behaviors influence processes by which diverse stakeholders come to view the problems of and solutions to air pollution in a similar way.” Through the analysis of two case studies to “examine the patterns of formal and emergent leadership behaviors in these temporary, interorganizational, collaborative systems,” she (1994, p. 253) found that members contribute different forms of leadership and engage in different types of behaviors to facilitate convergence amongst members. Feyerherm (1994) identified three leadership behaviors that are most likely to lead to convergence: those that aid in illuminating a leader’s own thoughts and/or other people’s thoughts about a topic, those that lead to the creation of alternatives, and those that encourage leaders to initiate collective action, including forming structures and developing and presenting proposals.

Like many other scholars, Luke (1997) argues that traditional models of leadership are outdated and not appropriate in an interconnected world and that complex, interconnected problems require a new type of public leader—a catalytic leader. According to Luke (1997, p. 66), this type of leader acts as a catalyst and notes, “catalysts help others not only to focus on the

issue or problem but also to embrace it as a priority. They attempt to get others to see and feel that it is urgent or important enough to warrant investing time and energy.”

Certainly, this dissertation is concerned in some respects with the leadership style of the NQF’s President and CEO, and I explore Kizer’s leadership style further in later chapters. While leadership style is an important factor in the success or failure of many collaborative endeavors, this still does not address the tasks that are at the heart of forming an NAO. Like the network management literature, this is a very underdeveloped line of research, and my research seeks to broaden these perspectives about leadership in networks by specifying the activities a network leader engages in during an NAO’s formation. Some scholars, including Luke (1997), Gage and Mandell (1990), Feyerherm (1994), and Gray (1989), have written about the importance of leadership and leadership styles in networks. Luke (1997) in particular proposes a new model for leadership in an interconnected world and identifies tasks associated with catalytic leadership, but his work does not focus on the tasks associated with creating an NAO.

After reviewing the literature on networks, network management, and network leadership, it appears that, even though they offer some insights that are useful for this study, two gaps exist: (1) the literature does not differentiate between the stages of a network’s life, and (2) it does not investigate either theoretically or empirically the critical tasks a network entrepreneur engages in during the developmental stages of building an NAO. My research seeks to expand and deepen the network literature by focusing on the broader aspect of leadership in a network, especially as a leader focuses on building an NAO.

The key question this dissertation explores is: What critical tasks does a network manager engage in to build an NAO? I consider some relevant literature that might provide insight into this question and propose and develop the idea of network leadership. The specific critical tasks that this research finds a network leader engages in will be elaborated on in the next three chapters.

As discussed previously, few studies pay attention to the formative stages of network development; furthermore, there is scant discussion of leadership in the network management literature, especially with regard to the critical leadership tasks that are required of a network entrepreneur to build an NAO. Luke is one scholar who discusses this issue in networks. More generally, however, the literature is silent about whether leadership matters during the

developmental stages of building an NAO; nor does it distinguish between the different organizational life cycles of a network organization.

Since few scholars concerned with network management have addressed this question, it is necessary to examine some other literature to see what insights it provides. Selznick (1984) offers one useful way of illuminating the role of leadership in a network, especially in creating a NAO like the NQF. He argues that “critical tasks” are at the heart of leadership and affect the long-term character of an organization. Selznick identifies several key tasks performed by leaders: the definition of institutional mission and role, the institutional embodiment of purpose, the defense of institutional integrity, and the ordering of internal conflict (Selznick, 1984, p. 62).

In order to understand the importance of a leader undertaking critical tasks early on, one can look to Selznick’s work and the importance he places on distinguishing a leader’s routine and critical tasks. He differentiates between routine and critical tasks and argues that a leader engages primarily in the latter. Routine tasks are those that deal with day-to-day decisions (Selznick, 1984, p. 31). Broadly stated, these tasks do not affect the character or long-term goals of an organization. Critical tasks, on the other hand, affect not only institutional development, but also the very character of an organization. Selznick (1984, p. 37) argues that critical tasks are at the heart of leadership, stating “it is the function of the leader-statesman—whether of a nation or a private association—to define the ends of group existence, to design an enterprise distinctively adapted to these ends, and to see that that design becomes a living reality.” Through engaging in critical tasks during organizational development, a leader creates institutional character and, as Selznick (1984, p. 37) puts it, “infuses the organization with value.”

As leaders make more and more of these critical decisions, institutionalization occurs. Selznick (1984, p. 27) argues, “In this sense, the leader is an agent of institutionalization, offering a guiding hand to a process that would otherwise occur more haphazardly, more readily subject to the accidents of circumstance and history.” Over time, an institution moves towards “thick” institutionalization. In order to understand this change, it is necessary to explain institutionalization. Selznick (1992, p. 232) contends that institutionalization first occurs with a formal act, such as the adoption of a rule or statute. He maintains, however, that the formal development of an institution is only part of the story. As an organization becomes institutionalized, it takes on a distinctive character and becomes “infused with value beyond the technical requirements of the task at hand” (Selznick, 1992, p. 233). This is part of a two-step

process—the first step being the formal creation of an organization. The second part can be described as “thick institutionalization,” which represents the creation of an informal structure of an organization. This informal structure is “composed of attitudes, relationships, and practices that arise in the course of social interaction—as individuals and groups bring into play their own personalities, values, and interests” (Selznick, 1992, p. 235). As Selznick warns, however, the appearance of an informal system does not diminish the importance of the formal system. In a sense, the informal system upholds the formal system and this “operative system” as Selznick (1992, p. 235) calls it “is the focus of institution-building.”

Conclusion

Kettl (1996, p. 9) argues that the most important change in administrative work over the past century is the increasing interdependence of public organizations: “This interdependence radically changed the jobs of public administrators, who must now not only manage the functions of their own agencies, but must also build critical linkages with others.” Indeed the rise of network organizations such as the NQF and the corresponding research questions they raise have proved fruitful for management scholars, and the scholarly literature on networks reflects their richness as a line of inquiry. Scholars have researched more micro-level questions about the types of interorganizational relationships that exist, the types of network structures, whether networks are effective, and how decision-making occurs in networks as well as more macro-level questions regarding the implications networks for democracy and accountability.

We can draw several conclusions from this foray into the jungle that is the network literature. First, the literature is still relatively theoretically and empirically underdeveloped. Second, this review highlights some of the gaps that exist in the current literature. Most relevant to this study are the gaps that relate to the tasks associated with building an NAO. It is apparent that the literature provides no information about the life cycles of a network. This research expands and deepens the existing network management and leadership literatures by delineating and conceptualizing three critical tasks one network leader engaged in during the NQF’s formative stages. I elaborate on each critical task in the following chapters. Before I turn to a discussion of the tasks, I discuss the methodology used to conduct this study in the next chapter.

CHAPTER FOUR

A GROUNDED THEORY APPROACH TO STUDYING NETWORK LEADERSHIP: METHODOLOGY

*It is a capital mistake to theorize
before one has the data.*
- Sherlock Holmes

*The task of scientific study is to lift the veils
that cover the area of life that one purposes to study.*
--Blumer (1978)

Generating a theory involves a process of research.
--Glaser and Strauss (1967)

Introduction

The purpose of this chapter is to elaborate on the approach and strategy of inquiry I used to conduct this exploratory study of leadership in an NAO. Since I was interested in exploring the phenomenon of network leadership and since there is little existing empirical research in this area, I chose to follow a naturalistic or qualitative approach, or more specifically the grounded theory method, to study the NQF (Glaser & Strauss, 1967; Eisenhardt, 1989; Glaser, 1992; Strauss & Corbin, 1998; Dey, 1999). Through the use of a grounded theory method, this research generated propositions about the critical tasks a network entrepreneur engages in during the formative stages of building an NAO.

The chapter is organized into four sections. In Part One, I discuss the research design and strategy for this study, including a brief overview of the history and nature of grounded theory and its usefulness as an approach for studying networks and leadership. In Part Two, I describe why I chose the NQF as the case study. In Part Three, I discuss data collection and data analysis. In Part Four, I discuss some of the limitations of this study and some lessons I learned from conducting research using a grounded theory approach.

Research Design and Strategy

I used a qualitative research design and, more specifically, a grounded theory approach to conduct this study about network leadership during the formative stages of an NAO. A qualitative research design is most appropriate for this study because it provides the best means to explore complex processes and investigate “little-known phenomena or innovative systems”

such as network leadership, and it is useful when “relevant variables have yet to be identified” as is the case with the critical tasks related to network leadership (Marshall & Rossman, 1999, p. 57).

A qualitative approach also allows one to describe the “naturally unfolding program processes and impacts” and allows for a certain richness in the research—the participants’ thoughts, opinions, and experiences are captured in their own words—that one may not be able to get through the use of another approach (Patton, 1987, p. 14). That is, a qualitative approach allows one to “lift the veils” surrounding an area of study. But this does not mean that this type of research does not follow a process. In fact, it is quite the opposite. Grounded theory allows researchers to follow a process that allows for creativity in discovering and understanding social processes and phenomena (Glaser & Strauss, 1967). I first discuss the origins and philosophical underpinnings of grounded theory and, in the following sub-section, the benefits of a grounded theory approach and justification for why I employed this approach to study network leadership.

Grounded Theory’s Origins and Philosophical Underpinnings

Glaser and Strauss (1967, p. 2) state that grounded theory is the “discovery of data systematically obtained from social research.” Creswell (2003, p. 14) elaborates on their definition by noting that grounded theory is a strategy “in which the researcher attempts to derive a general, abstract theory of a process, action, or interaction *grounded in the views of participants in a study.*” [my emphasis]

Glaser states that grounded theory is useful to “researchers and practitioners in fields that concern themselves with issues relating to human behavior in organizations, groups, and other social configurations” (Glaser, 1992, p. 13). The nature of grounded theory is to ensure that the theory being generated will “fit” the situation being studied and that it will “work” in terms of describing the behavior being observed (Glaser & Strauss, 1967, p. 3). It follows from this, then, that for theory to be useful for understanding social phenomena and behavior, the best way to develop theory is to “ground” it in data.

In using the grounded theory method to develop theory, one begins with an area of study and allows what is relevant to that area to emerge from the data. Two key characteristics define grounded theory: a de-emphasis on the verification of theory and an emphasis on the generation of theory. Glaser and Strauss (1967) proposed grounded theory as a way to counteract the preoccupation with the verification of theory in both qualitative and quantitative research that

had dominated social science since the 1940s, to address some of the weaknesses of qualitative theory and to allow for the development of theory that would be meaningful to both practitioners and scholars.²⁷

Glaser and Strauss (1967) argued that scholars were too concerned with verifying the “grand theories” bestowed on us by “great men” such as Marx, Weber, and Durkheim. After World War II, there was significant growth in the development and distribution of quantitative methods (e.g., survey research) that could be used to test and verify these theories. In *The Discovery of Grounded Theory*, Glaser and Strauss (1967, p. 261) offer a polemic against Robert Merton and the positivist approach:

His reasoning necessarily leads to the position *that data should fit the theory*, in contrast to our position that *the theory should fit the data* [emphasis in the original].

While grounded theory acknowledges that verification of theory is important, it argues that this task should be subordinate to the generation of theory.

Glaser and Strauss (1967) also proposed grounded theory as a way of strengthening qualitative research. They argued that qualitative approaches also suffered from an overemphasis on verification, but more importantly were increasingly labeled as “impressionistic” and criticized for not being rigorous or systematic enough. On the other hand, quantitative methods were seen as rigorous and “more scientific.” As a direct result of this, over time, quantitative methods gradually usurped qualitative approaches to studying and gaining insight about social phenomena.

With the publication of *The Discovery of Grounded Theory*, however, Glaser and Strauss tried to formalize and systematize “grounded” theory, and qualitative methods more generally, as

²⁷ Glaser and Strauss’s educational backgrounds heavily influenced why and how they developed grounded theory. Interestingly, Glaser and Strauss both were heavily influenced by the two intellectual traditions they sought to counteract and strengthen through grounded theory—positivism and symbolic interactionism. While at Columbia University, Glaser was influenced by statistical positivism and the logic of justification and the works of Paul Lazarsfeld, Talcott Parsons and Robert Merton in these areas. While at the University of Chicago, Strauss studied under Herbert Blumer and receiving training in what is commonly referred to as the “Chicago tradition” of qualitative methodology, and more specifically, symbolic interactionism. Blumer (1969), who was Mead’s student, coined “symbolic interactionism”, which is premised on three ideas: (1) an individual will view an object in a particular light based on the meaning that object has for them; (2) the meaning is derived from and created by social interaction; and (3) the meaning of an object will change over time. Symbolic interactionism has its epistemological roots in the work of George Herbert Mead and John Dewey, and it underlies much of grounded theory. Since it focuses on discovering the views of the participants, grounded theory shares an intellectual heritage with phenomenology.

a legitimate form of inquiry into social phenomena. What was unique about Glaser and Strauss's approach, however, was that they did not discount the importance and benefits of scientific rigor that had been so lauded in quantitative research:

It is vital to note that the fundamentals of Grounded Theory, the underlying analytic methodology, are in very large measure drawn from the analytic methodology and procedures of inductive quantitative analysis laboriously discovered by researchers and students in the Department of Sociology and the Bureau of Applied Social Research at Columbia University in the 1950's and 1960's (Glaser, 1992, p. 7).

Perhaps the most important difference to note between grounded theory and other approaches to qualitative research is grounded theory's emphasis on theory development. Glaser and Strauss (1967, p. 3) argue that the growth of positivism and the emphasis on verification of theory rather than generation of theory resulted in a significant gap between theory and empirical research. In their view, however, the purpose of theory in the social sciences is "(1) to enable prediction and explanation of behavior; (2) to be useful in theoretical advances in sociology; (3) to be usable in practical applications—prediction and explanation should be able to give the practitioner understanding and some control of situations; (4) to provide a perspective on behavior—a stance to be taken toward data; and (5) to guide and provide a style for research on particular areas of behavior." Theory that was "grounded" in data, they proposed, would contribute toward "closing the embarrassing gap between theory and empirical research" (Glaser & Strauss, 1967, p. vii).

During the past thirty-five years, researchers from a variety of different disciplines, including psychology, information science, education and health care, have used grounded theory as a means of exploring social relationships and phenomena. Denzin (1994, p. 508) states: "the grounded theory perspective is the most widely used qualitative interpretive framework in the social sciences today." Even though its use is gaining in popularity, public administration scholars are just beginning to understand how powerful and promising the approach is to the study of such social phenomena as networks and leadership. In the next section, I discuss the appropriateness of using a grounded theory approach for exploring networks and leadership.

Grounded Theory as a Means of Exploring Networks and Leadership

Scholars argue that new methods are required to research and understand new

organizational forms such as networks. Daft and Lewin (1993, p. i) note the trend away from bureaucratic, hierarchical structures toward more loosely coupled, flexible structures that emphasize learning:

The trend appears to be moving away from the paradigm within which organizations strive for mass production efficiencies, hierarchical organization, and bureaucratic structures that provide central control over activities divided into small parts. The new paradigms may have as their premise the need for flexible, learning organizations that continuously change and solve problems through interconnected coordinated self-organizing processes.

They contend that in order for managers to function in this new environment and for researchers to understand this new environment, these emergent forms of organization, which include networks, require new forms of empirical investigation (Daft & Lewin, 1993). This new form of investigation, according to Daft and Lewin (1993, p. ii), “will be characterized by midrange theory and method, grounded research, and research that does not presume to test hypotheses.” Daft and Lewin (1993, p. iii) argue that the primary benefit of a grounded theory approach to emergent organizational structures is:

A midrange, grounded study of some part of a new organizational form would enable a scholar to learn firsthand about it and provide new theory. We are proposing a role for organizational scholars that is primarily one of developing new variables and theories to describe new phenomena, not to test hypotheses. If done well, the emerging knowledge will advance both organization theory and the practice of management.

More recently, other scholars, including McGuire and Agranoff (2007) and Agranoff (2004), have explored the relevance of grounded theory as an approach to studying networks, noting that employing grounded theory will help answer some of the “big questions” about network management by allowing researchers to delve more deeply into the “black box” of networks and examine them from the inside out.

Leadership, furthermore, is an unexplored phenomenon, and scholars contend leadership theory would be enhanced by the generation of theories that are “grounded” in what leaders are actually doing (Parry, 1998). The applicability of grounded theory to leadership has been demonstrated in a number of studies (Hunt, 1991; Hunt & Ropo, 1995). Hunt and Ropo (1995, p.

381) argue that grounded theory can be effective as a means of studying social processes, such as leadership because “grounded theory emphasizes dynamism, whereas mainstream analysis emphasizes static structure.” Therefore, grounded theory allows one to understand the dynamic of “change” as it relates to leadership, as opposed to traditional approaches, which study leadership at one point in time. As a result of the focus on quantitative methods, there have been increased calls issued for more qualitative work on leadership (e.g., Bryman, Stephens, & a Campo, 1996; Parry, 1998). More specifically, Parry (1998) advocates using grounded theory as an approach to studying leadership and maintains that grounded theory will allow researchers to investigate and understand the emergence and operation of leadership at different levels and in different contexts.

For this research, the choice of grounded theory as a strategy of inquiry was appropriate for several reasons. First, this is an exploratory study in that its purpose is to generate theory about network management strategies that is grounded in empirical evidence. Eisenhardt (1989, p. 547) notes one of the strengths of grounded theory is it “produces theory which closely mirrors reality.” The nature of grounded theory is to move from observations to the development of concepts then to theory development (Locke, 2001). Theory building grounded in empirical evidence promises to contribute to the scholarly literature in public administration, but at the same time be “useful to practitioners in the settings studied, providing them some understanding and control over situations they encounter on a daily basis” (Locke, 2001, p. 18).

The use of grounded theory also was appropriate because the network management literature is underdeveloped; the theories related to network management that do exist were not systematically obtained from observations and may lack validity. Thus, more empirical studies such as this one, need to be conducted (Agranoff & McGuire, 2001). The emergent theory is more likely to be empirically valid because the theory building process is so closely linked with empirical observations. The theory that emerges may be more readily testable, measurable, and verifiable because it has already gone through these processes as part of the theory-building process.

In addition to generating theory that is useful to practitioners and empirically valid, scholars also have noted that theories generated using a grounded theory approach tend to be more creative and novel because mechanisms built into grounded theory limit a researcher’s preconceptions. Eisenhardt (1989, p. 546) notes: “the process of reconciling these contradictions

forces individuals to reframe perceptions into a new gestalt.” When I started this study, there was little focus in the scholarly literature on either leadership in networks or in NAOs. Since this was the case, I had little idea going in that leadership would emerge as the focal point of this research. That is, I had no preconceptions of leadership in networks or in NAOs and was not “looking” for it to emerge. Grounded theory, therefore, allowed the relatively new and understudied phenomenon of network leadership to emerge.

In the next section, I discuss why I chose the NQF as the case study for this research.

Case Selection

I chose the NQF as the focus for this study because it represents the type of network organization—an NAO—that many claim is increasingly seen in public administration.²⁸ In Stake’s (1998) terms, this is an instrumental case study, which is of interest to those who seek to understand an issue or refine a theory. It provided an excellent vehicle through which to explore and gain some understanding about network management strategies and, more specifically, network leadership.

Within the NQF, I chose to look at the “Never Events” project for several reasons. First, medical errors are a pressing public policy issue, and the “Never Events” project appears to have made some headway on developing some consensus around medical errors where others have not. Additionally, the project was the NQF’s first and is appropriate for exploring network leadership during the formative stages of network development.

Data Collection and Analysis

Grounded theory is an iterative process during which there is interplay among data collection, analysis and theory generation. In a grounded theory approach, therefore, data collection and data analysis overlap. Glaser and Strauss (1967) refer to this as the constant comparative method of analysis. The idea behind the constant comparative method is that a researcher gathers data, analyzes the data, and compares them against previously collected data

²⁸ DiMaggio (2001) argues that although it is widely perceived that networks are proliferating, few empirical studies document the numbers and types of network organizations. He argues that even though this may be the case, networks are not new. Rather, we have only begun to develop the vocabulary to explain and conceptualize the existence of networks.

in order to determine variables and uncover emerging relationships between variables and categories.

The overlap of data collection and data analysis serves several purposes. First, it allows the researcher to move ahead with data analysis during the data collection stage. Second, it permits researchers to be flexible with regard to things that might emerge from the data. For example, Eisenhardt (1989, p. 539) notes that it enables one to make adjustments to the data collection instruments that “allow the research to probe emergent themes or to take advantage of special opportunities which may be present in a given situation.” Finally, the constant comparative method serves as a source of validity because the process generates further data and knowledge, leading to theory that is more reliable because it is more clearly defined and less abstract (Parry, 1998).

Scholars maintain that transparency in the process of conducting qualitative research is important in communicating the findings. In the following sub-sections, I discuss how I conducted this research. In keeping with the tenets of grounded theory, I have not separated data collection and analysis into separate sections; instead, I discuss them jointly. I begin by discussing the types of data or “data slices” that Glaser and Strauss (1967) recommend collecting to develop grounded theory. I then discuss the six phases of this research in light of the techniques Glaser and Strauss (1967) discuss and Strauss and Corbin (1998) elaborate on for collecting, organizing and analyzing these data slices and developing theory that is truly “grounded” in the data.

Data Slices: Interviews, Field Notes, Observations and Documents

Locke (2001) maintains “grounded theory...is silent about the mechanisms of gathering data.” Glaser and Strauss (1967), however, do advocate gathering “slices of data”—which others refer to as “triangulation”—as a means of understanding conceptual categories from different vantage points. Caudle (1994, p. 89) defines triangulation as “the combining of methods, data sources, and other factors in examining what is under study” in order to determine whether or not they are congruent and/or complementary. Triangulation provides for “stronger substantiation of constructs and hypotheses” (Eisenhardt, 1989, p. 538). The nature of this research was to uncover recurring patterns and to describe the administrative processes, activities, and resources involved in the development of standards in a network setting. Grounded theory, as distinguished from other forms of qualitative research such as phenomenology, demands that researchers

consider multiple forms of data (Suddaby, 2006). In order to develop theory that takes into account multiple perspectives and different types of data, I collected data from a variety of sources, including one-on-one interviews, field notes, observations and NQF-related documents. I elaborate on each of these “data slices” below.

Interviews

Thirty-nine interviews informed this research. Of these, I conducted semi-structured interviews with 21 individuals who were active in the NQF during its formative years.²⁹ Marybeth Farquhar, also at the time a Ph.D. candidate at the Virginia Tech Center for Public Administration and Policy, was conducting her dissertation research on the NQF. Since both of our studies were investigating aspects of the NQF as a network and our questioning was along the same lines, she and I shared the interviews that we had conducted and transcribed. She shared 18 interviews with me. I analyzed and coded these as I did my own interviews. Strauss and Corbin (1998, p. 213) refer to this type of sharing and coding data sets “secondary analysis” and state a “researcher building theory can code these materials as well, employing theoretical sampling in conjunction with the usual coding procedures.”

Cresswell (2003, p. 13) maintains that Glaser and Strauss recommend “theoretical sampling of different groups to maximize the similarities and differences of information.” According to Eisenhardt (1989, p. 537), “selection of an appropriate population controls extraneous variation and helps to define the limits for generalizing the findings.” The interviewees were representative of the diverse organizations that belong to the NQF and consisted of individuals who were involved at all levels of the NQF, including NQF staff members, and those who served on the Board of Directors, the Never Events Steering Committee and each of the four Member Councils (Consumers, Purchasers, Providers, and Research and Quality Improvement Organizations).

The interviewees initially were contacted by phone or e-mail about participating in the study. Whether by phone or e-mail, I introduced myself, provided them with information about the project, and asked them if they would be willing to participate in an interview. The interviews occurred either by phone or in person from 2002-2004. Each interview lasted

²⁹ I developed an interview contact list in which I tracked the names, titles, role in the NQF, and whether s/he agreed to an interview. Of the 25 people I contacted, 19 agreed to an interview, three said no (one gave no reason for saying no, the other two individuals said that s/he was too busy and his/her agency would not allow him/her to be interviewed), two did not respond, and one referred me to another person, who I interviewed.

approximately one hour, and, in many cases, quite a bit longer. In order to ensure anonymity, I have not divulged the names of the individuals I interviewed or mentioned their names or positions in the text. I gathered additional contacts using snowball or chain sampling. In snowball sampling, interviewees are asked to provide other names of individuals who know about the issue (Caudle, 1994).

Different stages of theory development demand different interview techniques (Polit & Beck, 2004; Wimpenny & Gass, 2000). Glaser and Strauss (1967) state that during the initial period of data collection and analysis, interviews may take the form of unstructured conversations and, as the theory begins to emerge from the data, the interviews will become more focused and structured. During the initial phases of my data collection, the interviews tended to be more conversational and broadly focused. I developed an initial interview guide that reflected this (Appendix B). As the theory began to emerge, I developed an interview guide in which the questions were more focused than they were initially (Appendix C). The interviews themselves became more semi-structured. Fielding (1994) notes that some of the strengths of semi-structured interviews are that they allow the researcher to ask questions in the same way each time, while allowing for flexibility in the sequence of questions and the depth of exploration.

Throughout the process, I taped and transcribed each of the interviews after asking a subject for her consent. All of the interviewees consented to being taped. After I completed each interview, I transcribed it into an MS Word document and uploaded it into QSR N6. Richards and Richards (1994) maintain that software such as QSR N6, NVivo, and Atlas/ti is essential to maintaining precision and rigor in data analysis. After I uploaded the interview into QSR N6, I began coding it; I elaborate on this process in later sections.

The one-on-one interviews not only allowed me to gather information about the specific management strategies the NQF used to manage the development of standards but also permitted me to observe the body language and tone of voice of the network managers and members and the physical setting of the NQF. From the interviews I gleaned quotes and gathered opinions and information about how the participants interacted within the network. I used “memoing” to record thoughts, interpretations, questions and directions for further data collection (Strauss & Corbin, 1998). These memos were written to explore what was emerging from the data, what I

was learning from the literature and how I linked the two in developing an interview guide and theory. Appendix A contains two examples of these memos.

Field Notes

Field notes are an important part of grounded theory research because they allow a researcher to record observations and thoughts about the research process and topic as the research progresses. Eisenhardt (1989) recommends writing down impressions and asking such critical questions as “What am I learning?” and “How does this case differ from the last?” after interviews and observations.

I kept two types of field notes: a set for interviews and a set of notes outlining what I observed at the two NQF Annual Meetings I attended. As part of the interview process, I kept records of notes that I took during the interviews. I also took time immediately after I completed each interview to record my impressions and thoughts about what I learned from the interview. While attending the NQF Annual Meetings, I took notes about the issues discussed at the meetings, differing opinions and who raised them, Kizer’s representation of the NQF, and my reactions to and thoughts about various events and topics discussed.

Written Documents

I also gathered and analyzed documents related to the NQF, including working papers about the “Never Events” project, minutes from committee meetings, and briefing materials. In order to gain access to these documents, I contacted the NQF’s staff members and executive officers involved in overseeing the “Never Events” project as well as individuals involved in the development of the consensus report. A confidential source close to the NQF also provided me with many financial and other documents pertaining to the NQF’s creation and the Never Events project. I also collected data from public sources, including newspaper and journal articles, speeches Kizer gave that were available on the Internet and information from the NQF’s web site.

One can learn a great deal about the organizational structure, operations, history and philosophy of an organization through the examination of written documents, and these documents provided me with a strong sense and appreciation of the NQF as an organization. Furthermore, Strauss and Corbin state: “areas for theoretical sampling can be suggested by the literature, especially in the first stage of research. The literature can provide insights into where (place, time, papers, etc.) a researcher might go to investigate certain relevant concepts” (1998,

p. 51). I used these documents to provide me with information about reports I might want to obtain and the individuals I might want to contact for interviews during the initial stages of my research. In later stages of the research, I compared information in the documents with the information I gathered from the one-on-one interviews to determine whether they supported one another (Caudle, 1994).

Observation

As already mentioned, I also attended and observed the proceedings of two NQF Annual Meetings. The first one I attended was the NQF's 4th Annual Meeting, held September 29 and 30, 2003, in Washington, D.C., and the second, the NQF's 5th Annual Meeting, was held October 6 and 7, 2005 in Washington, D.C. I attended the two meetings for several reasons. First, they gave me an opportunity to observe first-hand how the NQF conducts business. Second, I was able to meet people and question them informally about the NQF at these meetings. Third, as the research progressed and leadership became the focal point of the study, the meetings gave me a chance to observe Kizer in action and determine whether what I was observing matched with what I was hearing from the interviewees. Finally, the annual meetings gave me a chance to learn about and keep up-to-date on the various issues affecting the NQF and its operations. For example, implementation of the NQF's various measures was briefly discussed during the first annual meeting, but by the second meeting it was the "hot" topic.

The Research Phases: Collecting, Analyzing and Developing Theory

Glaser and Strauss (1967) do not prescribe how to conduct research using the grounded theory method in their seminal work. Strauss and Corbin (1998), however, elaborate on the original work and outline some steps for conducting research using grounded theory: open coding, axial coding, and selective coding.³⁰ Strauss and Corbin (1998, p. 58) state that the process is "a free-flowing and creative one in which analysts move quickly back and forth between types of coding, using analytic techniques and procedures freely and in response to the

³⁰ After the initial publication of *Discovery* in 1967, Glaser and Strauss split, with Glaser advocating a less prescriptive and creative approach to developing grounded theory and Strauss advocating a more prescriptive method for conducting grounded theory research. Despite the split between Glaser and Strauss, there are certain elements that they agree must be undertaken in order for research to be classified as grounded theory. They are: joint collection, coding and analysis of data, theoretical sampling, constant comparisons, category and property development, systematic coding, memoing, saturation, and sorting (Jones & Noble, 2007). For an overview of the differences between the two positions, see Jones & Noble, 2007.

analytic task before analysis.” Since I was new to grounded research, I followed the more prescriptive approach outlined by Strauss and Corbin (1998).

As mentioned previously, grounded theory is an iterative process; I therefore moved back and forth between data collection and analysis. I conducted this research in six phases and delineate the tasks I undertook for each phase of the data collection and analysis process in the following sections.

Phase One: Initial Contact with the NQF and Immersion in the Health Care Literature

In the fall of 2001, I initially established contact with the NQF and AHRQ. My advisor, Professor Joe Rees, assisted me in this quest by introducing me to the NQF staff and to John Eisenberg, then Director of AHRQ. Professor Rees, Marybeth Farquhar and I spent the day in Washington, D.C. where both organizations are headquartered. We spent the morning with several of the NQF staff members, including a project director and a vice president. The staff members provided us with an overview of the history and purpose of the NQF and a packet of documents about the organization, including a Board of Directors list, a membership list, and information about the NQF’s Member Council system, the NTTAA, the NQF’s CDP, and the NQF’s Never Events project. In the afternoon, we met with John Eisenberg. He provided us with an overview of quality improvement activities in health care and AHRQ’s role in these activities, particularly as it related to NQF’s activities and its Never Events project.

I read widely about the health care system, including the history of health care in the United States (Starr, 1984; Millenson, 1997); the history of quality improvement efforts (Brennan & Berwick, 1996); quality problems in health care (President’s Advisory Commission, 1998; IOM, 1999, 2001), including research and information about medical errors and patient safety (Bogner, 1994) and quality initiatives underway in the health care industry. I also read about high-reliability systems and human error (Perrow, 1999; Reason, 1990) and error-reporting systems and quality improvement efforts underway in other industries, including the aviation, nuclear and chemical industries (Rees, 1994; Gunningham & Rees, 1997).

Phase Two: Literature Review and Development of Initial Research Questions

During Phase Two (which occurred during 2002), I narrowed the focus of my study to the NQF and its role as an NAO in coordinating quality improvement efforts in the health care

industry. I began to read literature about networks and network management.³¹ From this literature review, I identified the broad questions that would identify the questions that guided the research questions during the preliminary phases of this project: (1) how are these new organizational forms (i.e., networks) managed? and (2) what is the U.S. national government's role in this process? While these two questions outlined the broad purpose of this study, I developed the following questions to guide me initially as I gathered specific information about the NQF:

1. How and why was the NQF created?
2. How is the NQF organized?
3. How does the NQF manage the development of standards?
4. What is the federal government's role in this process?
5. What lessons does NQF's administrative experiment hold for students of public administration?

I continued to identify and collect documents relevant to the NQF and this study, including NQF Annual Financial Statements, congressional testimony, and information about the CDP, the Never Events project, staff, and the President's Advisory Commission and its recommendations. From my initial literature review and document collection efforts, I developed a preliminary interview guide that I used for conducting the initial exploratory interviews. Since the process was exploratory, the interview questions served as probes to generate data that I later tied-back to the existing literature during Phase Three. I also applied for and received Expedited Approval for this research from the Virginia Tech Institutional Review Board.

Phase Three: Initial Interviews and Identification of the Emergent Themes through Open Coding

During Phase Three (which occurred from winter 2002 through spring 2003), I conducted, coded and began to analyze the initial exploratory interviews and continued collecting documents related to the NQF. I interviewed seven individuals involved in the "Never Events" project. During the initial interviews, I asked questions about the following topics: the

³¹ One of the common misperceptions about grounded theory is that a researcher should come into the research as a "blank slate" with no prior immersion in or knowledge about the literature (Suddaby, 2006, p. 634). In their seminal work, however, Glaser and Strauss (1967, p. 79) argue for a link between substantive theory, or the theory associated with a particular subject area, and the generation of grounded formal theory: "We believe that although formal theory can be generated directly from the data, it is more desirable, and usually necessary, to start the formal theory from a substantive one. The latter not only provides a stimulus to a 'good idea' but it also gives an initial direction in developing relevant categories and properties and in choosing possible modes of integration. Indeed it is difficult to find a grounded formal theory that was not in some way stimulated by substantive theory."

history of the NQF, the history and project management activities associated with the Never Events Project, and the NQF's challenges and successes (see Appendix B).

Strauss and Corbin (1998) state that the first step in the process of theory building is the development of concepts. The initial interviews allowed me to begin the process of organizing and interpreting the data. Open coding is the “process through which concepts are identified and their properties and dimensions are discovered in data” (Strauss & Corbin, 1998, p. 101). During open coding, “data are broken down into discrete parts, closely examined, and compared for similarities and differences” (Strauss & Corbin, 1998, p. 102). The process enables researchers “to group similar events, happenings, and objects under a common heading or classification (Strauss & Corbin, 1998, p. 103). Researchers can analyze documents by line, by sentence or paragraph, or as a whole (Strauss & Corbin, 1998). From there, categories are identified and their properties and dimensions are specified (Strauss & Corbin, 1998).

To assist me with the coding process, I used QSR N6. One of the strengths of using qualitative software is that it allows the themes to emerge from the interviews. As I coded the interviews sentence by sentence, I began to pull common themes from them and group them into broad categories. As I coded these interviews, the broad theme of leadership and, more specifically, Kizer's leadership in creating and building the NQF, consistently emerged.

Since the NQF was a relatively new organization, I started thinking about the role of a leader as an entrepreneur/innovator. I asked the following questions to guide me in this quest. “What is the role of a leader in setting-up or establishing a network organization?” “Are the activities different from those undertaken when establishing a bureaucratic organization?” “How are they different?” Since I had initially started the research with a broad area for investigation, network management, asking these questions effectively allowed me to narrow the scope and focus of my research and to develop a more finely tuned research question. This is in keeping with Strauss and Corbin, who state, “Although the initial question starts out broadly, it becomes progressively narrowed and more focused during the research process as concepts and their relationships are discovered” (Strauss & Corbin, 1998, p. 41).

One way to investigate phenomena and develop sensitivity or insight into the data and the concepts being developed is to examine the literature for relevant information (Strauss & Corbin, 1998). I therefore looked at the existing leadership and network management literatures to assist me with the initial conceptualization of “network leadership” and the possible tasks a leader

engages in to create an organization. Eisenhardt (1989, p. 544) explains the importance of looking at a broad range of literature when developing theory:

An essential feature of theory building is comparison of the emergent concepts, theory, or hypotheses with the extant literature. This involves asking what this is similar to, what does it contradict, and why. A key to this process is to consider a broad range of literature.

Furthermore, Eisenhardt (1989, p. 545) argues: “While linking results to the literature is important in most research, it is particularly crucial in theory-building research because the findings often rest on a very limited number of cases.” It is important to look at two types of literature—those that conflict with the findings and those that agree with the findings. The former allows one to be more creative and groundbreaking, and “the result can be deeper insight into both the emergent theory and the conflicting literature, as well as sharpening the limits of generalizability of the focal research” (Eisenhardt, 1989, p. 544). Indeed, this was the case with this study. For example, as I mentioned in Chapter 3, Agranoff and McGuire (2001) postulate that managing in a network organization is so different from managing in a bureaucratic organization that the field needs an equivalent of a POSDCORB for network management. My findings indicate, at least in the formative stages of an NAO, otherwise. As a result, this study deepens and elaborates on their research.

Comparing the findings to extant literature in a different area with similar findings allows a researcher to tie “together underlying similarities in phenomena normally not associated with each other. The result is often a theory with stronger internal validity, wider generalizability, and higher conceptual level” (Eisenhardt, 1989, p. 544). I started looking at the leadership literature in order to determine which area of the literature fit with my project. Since I was hearing in my interviews about the tasks Kizer concerned himself with to get the NQF up-and-running, I decided to focus on and pull concepts from studies that outline the tasks, activities, and roles of leaders; that is, what it is that leaders actually do and the skills that are needed to accomplish their goals. For example, Selznick (1984) in his classic work, *Leadership and Administration*, delineates some of the critical tasks a bureaucratic leader might undertake in order to build an organization and its institutional character and culture, and Doig and Hargrove (1987) examine public sector leadership and discuss the leadership tasks undertaken by leaders during the formative stages of organizational development.

Phase Four: Refinement of the Interview Guide and the Development of Subcategories through Axial Coding

During Phase Four, which occurred from spring 2003 through winter 2004, I conducted and analyzed 14 interviews, collected additional documents about the NQF and attended the NQF's 4th Annual Meeting. After I conducted the initial interviews and started to extrapolate themes, I turned to the literature to help me with the development of a more focused interview guide (see Appendix A). The guide I developed covered the following topics: the role of the member organizations in the NQF, the Never Events project, key organizational actors in the NQF's environment, the NQF's Board of Directors, the Member Councils, the NQF's staff, the role of professional expertise in the NQF, Kizer's role in the NQF, and the NQF's challenges and accomplishments (see Appendix D). I used the in-depth interview instrument of open-ended questions as a guide when interviewing participants.

During this phase, I engaged in axial coding. Axial coding is the "process of relating categories to their subcategories, termed 'axial' because coding occurs around the axis of a category, linking categories at the level of properties and dimensions" (Strauss & Corbin, 1998, p. 123). The purpose of axial coding is "to begin the process of reassembling data that were fractured during open coding" (Strauss & Corbin, 1998, p. 124). Strauss and Corbin (1998, p. 126) identify several tasks associated with axial coding:

1. Laying out the properties of a category and their dimensions, a task that begins during open coding
2. Identifying the variety of conditions, actions/interactions, and consequences associated with a phenomenon
3. Relating a category to its subcategories through statements denoting how they are related to each other, and
4. Looking for cues in the data that denote how major categories might relate to each other.

I began to ask questions about the larger categories (i.e., the three critical tasks) that were emerging from the data: defining the mission, building a social base and managing diverse interests through the consensus development process. These questions allowed me to develop subcategories that explain each category in greater detail. According to Strauss and Corbin (1998, p. 125), "subcategories answer questions about the phenomenon such as when, where,

why, who, how, and with what consequences, thus giving the concept greater explanatory power.”

Phase Five: Refinement of the Theory through Selective Coding

Phase Five occurred from spring 2004 to winter 2005. During this phase, I attended the NQF's 5th Annual Meeting, received Marybeth Farquhar's 18 interviews, and engaged in selective coding. Selective coding is the “process of integrating and refining the theory” (Strauss & Corbin, 1998, p. 143). Integration involves organizing categories “around a central explanatory concept” (Strauss & Corbin, 1998, p. 161). Strauss and Corbin (1998) outline several tools that can be used to assist with integration: telling or writing the storyline, using diagrams, sorting and reviewing memos, and using computer programs. After integration, the researcher begins to refine the theory. “Refining the theory consists of reviewing the scheme for internal consistency and for gaps in logic, filling in poorly developed categories and trimming excess ones, and validating the scheme” (Strauss & Corbin, 1998, p. 156).

As part of the integration phase, I compiled my findings into a conference paper titled “Leadership and Network Management: A Case Study of the National Quality Forum” that I presented at the American Society for Public Administration's 2004 Annual Conference. The conference presentation enabled me to obtain reactions to my findings and refine my data further. In particular, I met one scholar who specializes in the areas of collaboration and network management, Professor Myrna Mandell, who read my paper and provided constructive criticism and advice.

Phase Six: Closure

I decided to stop data collection and analysis in the spring of 2005. Strauss and Corbin (1998) encourage the researcher to consider three things when deciding to conclude data collection and analysis: time, money and, most importantly, theoretical saturation. Although the first two issues are self-explanatory, the third deserves an explanation. In order to reach closure, Eisenhardt (1989) maintains that researchers should constantly ask themselves two important questions. “When should I stop adding cases?” and “When should I stop moving between data collection and analysis?” The answer to both is theoretical saturation, which Strauss and Corbin (1998, p. 143) define as “The point in category development at which no new properties, dimensions, or relationships emerge during analysis.” There is nothing new that can be added through further sampling; that is, collecting further information will not enhance the categories

and their properties any further. Glaser and Strauss (1967, p. 224) maintain that closure should occur “When the researcher is convinced that his [sic] conceptual framework forms a systematic theory, that it is a reasonably accurate statement of the matters studied, that it is couched in a form possible for others to use in studying a similar area, and that he can publish his results with confidence, then he is near the end of his research.”

In the next section, I discuss some of the limitations of qualitative approaches to research and the grounded theory approach more specifically as well as some lessons I learned about conducting research using the grounded theory approach.

Limitations and Lessons Learned

Janesick (1998) uses the metaphor of dance to describe qualitative research. Certainly conducting qualitative research and developing grounded theory requires more art than science. Grounded theory also exemplifies the metaphor of dance in that it is an iterative, creative process, which lends itself to experimentation and exploration of concepts and ideas. While there are strengths associated with this, there are also weaknesses. Below, I discuss some of the limitations of a grounded theory approach and some lessons I learned from my foray into applying grounded theory.

Limitations

One concern associated with grounded theory and this study is whether the findings are generalizable. While Glaser and Strauss (1967, p. 231) do not discuss this issue directly, they discuss credibility and state:

“...the reader’s judgment of credibility will also rest upon his assessments of how the researcher came to his conclusions. He will note, for instance, what range of events the researcher saw, whom he interviewed, who talked to him, what diverse groups he compared, what kinds of experiences he had, and how he might have appeared to various people whom he studied.”

Locke notes that by gathering a lot of diverse data observations, the general applicability or analytic generalizability of the theory can be extended. The critical tasks enumerated here and the propositions listed in the concluding chapter may or may not be applicable to all NAO’s and according to Glaser and Strauss (1967, p. 233), “more rigorous testing may be required to raise the level of plausibility of some hypotheses.”

Another concern is the subjectivity of the researcher. That is, the researcher “becomes the primary measurement instrument in the investigative process, in contrast to that of quantitative research where the researcher tries to stay removed from the process” (Caudle, 1994). In grounded theory, one must let the theory emerge from the data. This is not an easy task, especially considering that researchers bring their own sets of biases and expectations to research, but an astute grounded theorist recognizes and is sensitive to bias. In order to counteract researcher bias, a researcher needs to present evidence that corroborates the data (Caudle, 1994). One way to do this is to gather multiple perspectives and documents about the same incident (Eisenhardt, 1989). By doing so, validity is enhanced because one is relying on more than one person (and more than one document) to provide an understanding of the events that occurred. Lincoln and Guba (1985) also recommend that the researcher find someone to examine the research findings and play “devil’s advocate.” In order to address these issues, I asked several individuals, including my dissertation chair, committee members, and others scholars to serve as my devil’s advocates.

A third concern relates to the interview process and document analysis. For example, interviewees might be hesitant to participate in interviews. Once interviews are granted, there also is a concern with being able to move beyond “scripted” responses in order to get the “real” story. Potential problems related to document analysis include identifying the relevant documents and, once identified, gaining access to those documents. Another concern is whether or not the documents reflect reality. That is, do they accurately reflect decision processes and decisions or were they written to protect individuals? For example, one concern might be that the minutes might not have been written in a way that reflects the actual discussions and debates that occurred. Another concern is whether minutes and memos contain more than cursory information. In order to address these concerns, I collected as many documents as possible and spoke to a wide variety of individuals to verify that the stories I had heard were indeed accurate.

A final concern is with the reliability or dependability of the research (Neuman, 2003). The concern with a study’s reliability can be remedied with replication. In qualitative research, however, nothing remains static; that is, reality is constantly changing, making replication difficult. Furthermore, it is impossible to replicate such things as semi-structured interviews. Qualitative researchers argue that because processes are not stable over time and the research process itself is supposed to be dynamic the preoccupation of “positivist” researchers with regard

to replication is unfounded (Neuman, 2003; Chenitz & Swanson, 1986; Denzin, 1970). Indeed, Chenitz and Swanson (1986) point out that replication is not important to grounded theory. They maintain it is more important that researchers be able to use the grounded theory to explain, understand and predict phenomena in similar situations.

Lessons Learned

Grounded theory is not easy to master. There are few prescriptions for how to conduct grounded theory research. Furthermore, many researchers have found that competence in using grounded theory techniques improves over time and with experience (Suddaby, 2006). In my experience, Suddaby (2006, p. 639) is correct in observing: “The seamless craft of a well-executed grounded theory study...is the product of considerable experience, hard work, creative and, occasionally, a healthy dose of good luck.” Learning to use grounded theory techniques requires patience, flexibility, the ability to tolerate ambiguity and time. The constant movement between data analysis and data collection requires patience. Developing grounded theory also demands that the researcher be able to remain flexible and responsive to emerging themes. It requires flexibility in the sense that one must be willing to follow the data’s recommendations and pursue an unintended line of inquiry. A researcher therefore also must be comfortable with ambiguity in the research process. Since the data drive the direction of the research and the lines of inquiry, grounded theory cannot be “mapped” in advance. Researchers who must “map” the research path ahead of time may have some difficulty conducting research using a grounded theory approach. These characteristics also mean that grounded theory research is time-consuming.

Grounded theory research requires a process. One of the benefits of conducting grounded theory research is that it leads to fresh insights about the social phenomenon under investigation. Achieving this requires researchers to be intuitive, flexible, and open-minded. This does not mean, however, that when conducting grounded theory research that “anything goes” (Suddaby, 2006; Jones & Noble, 2007). Although I certainly found that there is tension between creativity and the rigorous application of formal rules in conducting grounded theory, the perception that grounded theory is an excuse to throw methodological rigor out the window is wrong. Suddaby (2006, p. 640) notes that in evaluating grounded theory research, he checks that a researcher has followed the core analytic tenets of grounded theory, including theoretical sampling, constant comparison, theoretical sensitivity, and the technical language a researcher uses to describe the

research process is accurate, because he believes “there is a clear connection between rigor in language and rigor in action.” Through this research I have learned that being transparent about how I collected, coded and analyzed my data is as important in qualitative research as it is in quantitative research, and I have tried to be as transparent about this as well.

Qualitative software programs are helpful in conducting grounded theory research. A grounded theory approach can leave one feeling inundated by tons of data that can be characterized as thematically diverse. I found that using a software program, in particular QSR N5 and later N6, helped to counteract the feeling that I was “drowning in data” by providing me with the tools to organize and analyze the data efficiently. Although I ultimately decided how to interpret the data and which categories to focus on, QSR N5 and N6 allowed the categories and themes to emerge from the data. The programs, however, had too many “bells and whistles” that I did not use and was a bit complex for my research needs. Perhaps as I continue this study and refine my findings, I will be able to use N6 to its fullest capacity.

Transcribing my own interviews was essential to understanding the data. The more exposure one has to the data, the more familiar it becomes and the more likely the researcher will be able to “listen to” and “hear” what the data are trying to tell her. When one is conducting an interview, one is more focused on asking the questions and guiding the interview than on analyzing what is actually occurring during an interview (tone of voice, body language, etc.). Similarly, if one does not transcribe their own interviews but reads a transcription, one misses “hearing” the interview and the subtle cues and insights that might be conveyed by listening to the interview.

Finally, and perhaps most importantly, grounded theory has contributed substantially to my personal growth as a scholar and researcher. Strauss and Corbin (1998, p. 7) outline the characteristics of a grounded theorist and emphasize that these skills do not need to be developed prior to engaging in grounded theory research:

- The ability to step back and critically analyze situations.
- The ability to recognize tendency toward bias.
- The ability to think abstractly.
- The ability to flexible and open to helpful criticism.
- Sensitivity to the words and actions of respondents.
- A sense of absorption and devotion to the work process.

I have always been very intuitive and able to identify themes, and grounded theory enabled me to draw on these strengths. As a new researcher, conducting grounded theory research refined and sharpened my ability to identify and ask broader research questions and connect these questions to the broader scholarly literature in the areas of network management and leadership.

Strauss and Corbin (1998), however, neglect to mention one important aspect of the research process that the grounded theory approach, and qualitative methods more generally, help new researchers develop: developing and designing interview questions and guides and conducting interviews. As a new researcher, this process, with its emphasis on constant comparison between data collection and analysis, helped me to develop and fine-tune relevant questions. Furthermore, when I began this research, I found it difficult and stressful to conduct interviews. With more experience, I became more comfortable with the interview process.

Conclusion

Scholars are beginning to recognize the importance of networks and are in the embryonic stages of collecting and analyzing data about network management and network leadership processes. Grounded theory, with its focus on deriving theory from empirical data, offers researchers a distinctive way of studying little-known phenomena and is therefore well suited to exploring networks and network management processes. Overall, my foray into grounded theory research has been positive. The grounded theory approach has not only allowed me to grow as a researcher, but the findings from this research shed some new light on the phenomenon of network leadership. In the next three chapters, I present the findings from this study and discuss the three critical tasks Kizer engaged in as a network entrepreneur to establish the NQF. I begin with a discussion of Kizer's first critical task, defining the NQF's mission.

CHAPTER FIVE CRITICAL TASK ONE: DEFINING THE MISSION

The setting of goals is a creative task. It entails a self-assessment to discover the true commitments of the organization, as set by effective internal and external demands.

The failure to set aims in the light of these commitments is a major source of irresponsibility in leadership.

--Selznick (1984)

Introduction

In Chapter Two, I discussed the fragmentation that exists in the health care industry and how this has frustrated efforts to improve health care quality. Once the health care industry committed to making a dedicated effort to improving health care quality by creating the NQF, Kizer was charged with finding a way to bring the diverse stakeholders together and creating a shared sense of purpose. A mission is one way a leader can create a shared sense of purpose, and leadership scholars have identified the creation of a mission and the articulation of how to attain that mission as one of the most important leadership tasks (Yukl, 1998).³²

The NQF's founding mission was to:

Improve American healthcare through endorsement of consensus-based national standards for measurement and public reporting of healthcare performance data that provide meaningful information about whether care is safe, timely, beneficial, patient-centered, equitable and efficient.

The NQF's mission statement can be divided into two parts: the end, which is to improve health care quality, and the means of achieving improved quality, which include developing performance measures, reporting on those measures, and using a consensus-based process to accomplish these two tasks. What were some of the factors that influenced the development of this mission statement? What was Kizer's role in crafting and communicating the NQF's mission? The purpose of this chapter is to explore these questions. The thesis of this chapter is that creating a mission for a network organization is a critical leadership task, because without a mission that the various stakeholders can buy into, the network organization will not be successful. In other words, the mission is the glue that holds the various stakeholders in an organization together.

³² For the purposes of this research, I am using the terms "mission" and "vision" interchangeably.

The chapter is divided into two parts. In Part One, I discuss two factors that influenced the development of the NQF's mission: how stakeholders framed the issue of health care quality and what role they envisioned for the NQF in quality improvement activities. In Part Two, I deconstruct the NQF's mission statement and discuss the three means by which the NQF seeks to improve health care quality: the standardization of performance measures, public reporting of these measures, and the use of a consensus process for the endorsement and standardization of measures.

Factors that Influenced the Development of the NQF's Mission

Kizer has compared the NQF to a symphony orchestra. Kizer acts as the conductor, health care stakeholders make-up the various sections of the orchestra, and the consensus process provides the rules for participation. But, just like an orchestra, an organization must have a good idea of its starting point and the means of achieving its goals. Just like a melody provides a symphony with “a specific tone that constitutes a starting place, a focal point, and a finishing place, and to which other tones in the tune are related” (Goulding, 1992, p. 28), an organization's mission conveys to others what the organization is about—it offers a picture of the starting point, the end point, and the means by which the organization will get there.

Van Wart (2005, p. 246) states that a mission “means *defining and expressing an organization's purpose, aspirations, and values*” [author's emphasis]. Gulick and Urwick (1937, p. 37) refer to it as an organization's “central dominant theme.” Wilson contends that a mission means that a coherent message about an organization is sent out (Wilson, 1991). He argues that an organization acquires a mission when it answers two questions: what shall we do and what shall we be? A mission offers a way of thinking about and communicating this to an organization's stakeholders.

In this section, I discuss two factors that influenced the development of the NQF's mission and Kizer's role in creating and disseminating that mission. I begin by discussing how the issue of quality was framed.

Factor One: Framing the Issue of Health Care Quality

A melody is ordered around a central note, referred to as a tonic. One can look at this central note and read the composition's starting point, end point, and all of the variations in between that culminate in the finale. A public philosophy serves the same purpose and states

how an organization will go about achieving its ends. In the NQF's case, the central note, or tonic, contained in its mission statement is to improve the quality of American health care. Kizer states that: "In operational terms, high quality health care is viewed as care that is known to be effective; to produce better health outcomes, greater patient functionality, and improved patient safety; and that is easy to access resulting in a satisfying experience for all concerned" (Kizer, 2001a, p. 1215). The NQF hopes to improve the quality of health care by "establishing a platform of for consistent data reporting and collection" (Kizer, 2001a, p. 1214).

Two philosophical precepts underlie the NQF's activities. The first is that high quality health care is premised on ensuring patient safety (Kizer, 2001a, p. 1215). The second philosophical precept underlying all NQF activities is the "belief that health care quality data are a public good and should be in the public domain."³³ "It is further based on the belief that making reliable, comparative data on health care quality will motivate providers to improve the quality of care by providing benchmarks; will facilitative competition on the basis of quality; will promote consumer choice on the basis of quality; and will inform public policy" (Kizer, 2001a, p. 1215).

As a starting point for developing a mission, leaders have to define an issue. Stone (1997) refers to this as issue framing. The framing process "consists of naming and explaining the problem, opening the door to alternative solutions, and suggesting outcomes" (Bryson & Crosby, 1992, p. 48). Luke (1997, p. 63) argues, "Framing should simplify a complex issue, making it more understandable and highlighting one salient element of an interconnected problem over another. Simply put, framing provides a succinct label...which can then crystallize thinking, focus attention, and stimulate discussion". Ideally, this definition should take into account a variety of perspectives. In order to develop a feel for the different perspectives and stakeholders, leaders often engage others in a discussion about the situation now and what the situation could

³³ The notion of a "public good" is a contested concept. "Public goods" are usually contrasted with "private goods." I'll offer one way of thinking about the two. Take a car. It is a private good because it is characterized by excludability in that the owner can determine who can use it and by rivalry in consumption—when one is using it another cannot. On the other hand, a lighthouse is an example of a public good. Unlike a car, there is little way that other users can be excluded from using it and there is no rivalry in consumption. Therefore, a lighthouse can be termed a pure public good. Health care contains aspects characteristic of both public and private goods. It is a national or public resource in that we all benefit from good health, but it is also private in that it serves individuals and relies on market mechanisms for production and distribution. Health care could thus be labeled a "quasi-public good." In much the same way as health care is a quasi-public good, standards are also a quasi-public good. Standards are developed through cooperative activities of a number of individuals and organizations, all of which are subject to the laws and customs of the various U.S. states.

be. From those conversations, leaders define the problem in concrete terms and provide an overview of the problem's technical and political dimensions.

Issue framing is an important part of developing a mission; indeed, Luke argues that it is an essential task of a catalytic leader (Luke, 1997). Catalytic leaders recognize that public problems are socially constructed (Luke, 1997). Different stakeholders will frame public problems differently and, therefore, propose different alternatives to deal with the problems (Luke, 1997). Luke (1997, p. 66) states, "catalysts attempt to frame a problematic situation in ways that capture the attention of key decision makers and the larger population." Catalytic leaders use the media, academic studies, stories, triggering mechanisms, and framing to focus attention and urgency on a public problem. Issue framing affects the mission that a leader creates for an organization. The framing of an issue is directly related to the perceived urgency of an issue, the ability to generate and synthesize results, and organizational outcomes (Bryson & Crosby, 1992). An organization's leader must have a good grasp of the policy problem and its various nuances in order to create a mission that will allow it to develop creative solutions to the policy problem.

In the NQF's case, several groups were involved in framing or defining the problem of quality in the health care industry, namely the President's Advisory Commission, the SFB, and Dr. Kenneth W. Kizer, the NQF's President and CEO. In the following discussion, I describe how the President's Advisory Commission framed the issue of health care quality, while the SFB took the Commission's work and outlined how the NQF would approach improving health care quality. I then discuss how Kizer assimilated these views, incorporated his own ideas, and created and disseminated his vision for the NQF.

President's Advisory Commission

The President's Advisory Commission first highlighted the severity of the issue with its 1998 publication that outlines and describes widespread quality problems in the health care industry. The report underscores that while the U.S. has some of the best medical knowledge and technology, there are large gaps between the care that people are receiving and the care they should receive. It states, "quality problems include wide variation in health care services, underuse of some services and overuse of others, and an unacceptable level of errors" (President's Advisory Commission, 1998, Chapter 1).

The President's Advisory Commission concludes that quality can be improved with the standardization of performance measures. These performance measures would serve as national benchmarks against which quality of care could be measured. Additionally, consumers and purchasers of health care could use these performance measures to make decisions that would allow them to hold health care providers accountable for providing high quality health care. The President's Advisory Commission thus framed the issue by defining it as a problem important to consumers, purchasers, and providers. It was not only important to a variety of stakeholders, but the solutions it proposed (performance measures) could be used by all three groups as a means to improve the quality of health care.

Strategic Framework Board

In order to realize the goals charged to the NQF by the President's Advisory Commission, the nine member SFB was established in 1999 to develop recommendations and a conceptual framework for a national strategy for health care quality measurement and reporting. The SFB was charged with developing the intellectual architecture and identifying the principles to guide a national measurement and reporting strategy (McGlynn, 2003). Specifically, the SFB was convened to "(1) propose a national strategy for health care quality measurement and reporting; (2) articulate guiding principles and priorities for health care quality improvement, including the roles of key players; and (3) identify potential barriers to successful implementation of the recommended national strategy, and possible solutions to those barriers" (Kizer, 2003, p. I-87).

The SFB's purpose statement indicated that a national quality and measurement reporting system should: "evaluate the degree to which the U.S. health care system is providing safe, effective, timely and patient-centered care; assess whether the delivery of the high quality care is efficient and equitable; enable substantial progress to be made toward achieving established national goals; provide easily accessible information on quality to a variety of audiences, including consumers, purchasers, and providers, to facilitate individual and collective decision making; provide information that regulators, purchasers and providers can use to support continued improvement and achievement of goals" (McGlynn, 2003, p. I-3). While developing recommendations for the NQF, the SFB considered several questions:

- What type of data elements should be collected on a national level?

- Under what circumstances and of what time along the process of care would data be collected?
- What types of data sharing arrangements are necessary to reduce burden?
- When does information need to be available to providers of care?
- When does information need to be available to consumers?
- How can you integrate systems that are useful to consumers and providers alike? (National Business Coalition on Health, 2001, p. 5).

During its deliberations, the SFB selected one diagnostic area and applied their framework to see what the intended and unintended consequences of it would be. The SFB developed a visual conceptual framework and subsequently crafted a purpose statement for a quality measurement and reporting system.

Over the course of 18 months, the SFB met 11 times in person and conducted biweekly conference calls (McGlynn, 2003, p. I-2). During this time, the SFB developed a visual conceptual framework and then crafted a purpose statement for a quality and measurement system. According to one interviewee, the SFB

laid out kind of a grand design and I would say the Forum operates within that design, but the full realization of what the experts felt we ought to do is probably not so much a statement of what the Forum needs to do, it's what the country needs to do.

The SFB presented its final report, *A National Framework for Healthcare Quality Measurement and Reporting*, to the NQF in May 2001. The recommendations included a discussion of “the setting of national standards, local adoption, measurement and reporting, evidence based standards, quality measurement and reporting, public awareness, and the development of a reporting strategy” (National Business Coalition on Health, 2001, p. 3).³⁴ The recommendations were put through the NQF’s consensus process, were slightly revised and subsequently approved by the NQF membership.³⁵ The Board of Directors approved the final

³⁴ In order to disseminate its findings, the SFB also published a series of articles in a 2003 Supplement to the journal *Medical Care*. The articles, according to one interviewee, laid out a “technical set of specifications for how the Forum should approach measurement.”

³⁵ Version 1.5 of the NQF’s CDP was used.

report in May 2002.³⁶ The final report outlines the three purposes of the NQF's National Framework for Healthcare Quality Measurement and Reporting:

First, it provides a standardized framework for identifying voluntary consensus standards that has been widely endorsed by a broad cross section of the myriad stakeholders concerned about healthcare quality. This nationally endorsed framework will be used as a foundation for many of the NQF's activities. It is also available for use by other organizations seeking to improve healthcare quality through measurement and reporting.

Second, the framework identifies key strategic areas that the NQF will pursue to maximize the potential for improvement once standardized healthcare quality measures are available.

Third, the framework sets forth an NQF-endorsed, consensus-driven platform and statement of principles for healthcare quality improvement in the United States.

Kenneth W. Kizer

The next step was to take the President's Advisory Commission and the SFB's work and package it for public consumption. Kizer was responsible for taking the ideas formulated by these two groups and crystallizing, magnifying, and transmitting them.³⁷ He believed very passionately that it was part of his job to develop the NQF's mission. Indeed, one interviewee said that Kizer is "a very strong leader and so he puts his imprint on things." According to one interviewee

What he does believe in very strongly that does come across is it is the CEO's responsibility to set the vision and the direction and help everybody know where they are going and why it's important. So I mean he does believe that organizations need a common sense of direction and that in an effective organization, the CEO's responsibility is to make sure that there is a sort of common vision of where you are going and why it's important to him this is interesting because I have never thought of this until I met Ken but he takes the

³⁶ After the SFB finished its work, it eventually morphed into the Strategic Advisory Council. This council has not met.

³⁷ I examined numerous articles Kizer wrote and speeches he gave to determine his thoughts on the origins of the NQF, its mission, its underlying philosophical precepts, its unique qualities, its role in the health care system, and its challenges during its formative years. There is ample evidence of Kizer's thoughts on each of these topics to draw from—in 2000 alone, Kizer gave over a hundred speeches about the NQF.

word lead in leadership seriously. He actually does believe that his job is, you know, as CEO from the perspective of the staff is to lead...he considers that he has a responsibility to set the agenda where things are going so that people don't sort of feel like they're fooling around out there without, you know, connections, that sense of where the that light is out there.

Kizer (2000, p. 321) states that he sees the mission of the NQF as being to improve health care quality; that is, to promote delivery of care known to be effective; to achieve better health outcomes, greater patient functionality, and a higher level of patient safety; and to make health care easier to access and a more satisfying experience.

Kizer maintains, quite simply, that there is a quality problem in health care and that the NQF was created in response to this problem. Furthermore, he argues that the numerous forces affecting health care have "created a turbulent environment that requires a new approach to establishing health care performance standards" (Kizer, 2000, p. 321). He observes that while we know so much more about quality in other industries, such as aviation, when it comes to quality improvement in health care, we do not know what works, how it works, and how best to diffuse innovations.

Kizer maintains that the quality of health care should be improved in order to lower costs, to optimize health care expenditures, to improve patient safety, to provide information to consumers, and most importantly, to serve the public interest. Because of these reasons he argues, "quality improvement should be the essential business strategy for healthcare" (Kizer, 2000, p. 321).

In the next chapter, I discuss how Kizer built the NQF's social base by disseminating this message widely to the different stakeholders through presentations, articles, and speeches.

Factor Two: The NQF's Role in Society

Like any new organization, the NQF faced a number of questions about its role, organization, and mission. Some of the debates were more philosophical, dealing with bigger questions about the role and place of the NQF in society, and some were practical, dealing with the organizational structure and funding issues. I have already examined and answered several important questions about the NQF, including "Why was the NQF created?" and "What does the NQF hope to accomplish?" In this section, I discuss some of the other questions that were raised

about the NQF in its early years, including “Should the NQF be a public or private entity?” and “How will the NQF work with other organizations to accomplish its goal of improving the quality of health care?” and the accounts that were given in response to these questions. The answers to these questions help to establish the organization’s role in its larger environment. In order to describe how an organization’s public philosophy helps it determine its place in society, I will use two concepts, organizational domain and accounts, to frame the discussion.

Organizational domain refers to the types of services or products an organization provides and the types of populations it serves (Levine & White, 1961; Thompson, 1967). While organizational domain is concerned with the types of activities an organization will engage in, it also outlines the organization’s roles or functions (Scott, 1998, p. 195). It helps as well to establish the position of an organization relative to the other organizations in the industry by addressing which stage of the production process an organization will engage in. It sets the boundaries of an organization in a particular industry. In order to do this effectively, however, an organization’s leaders must bargain and negotiate with the other organizations so no one is stepping on anyone else’s toes. In other words, there must be a high level of consensus about the organizational domain. As Scott (1998, p. 195) states, “The higher the consensus on an organization’s domain, the easier it will be for its members to conduct routine transactions.” The organizational domain also helps an organization to establish legitimacy in a particular industry. This is particularly important in an interconnected environment. If there is little or no agreement about an organization’s purpose and activities as well as its relationships relative to other organizations in the same industry, there will not be buy-in from the various stakeholders, and the organization will not be able to get much accomplished.

Accounts, on the other hand, are the philosophical complement to the more practical organizational domain issues because they can be used to explain or legitimate the domain-related decisions an organization makes. Scott and Lyman (1968, p. 46) define an account as a “linguistic device employed whenever an action is subjected to valuative inquiry.” Accounts, according to Scott and Lyman (1968, p. 46), “bridge the gap between action and expectation.” They are the way we give meaning to our actions (Wuthnow, 1996). Accounts also convey the values underlying an organization’s activities and how those values contribute to the betterment of society, which might help an organization to gain legitimacy within a particular industry.

Let me give a simple example. Suppose someone asks me “Why are you pursuing a Ph.D. in Public Administration?” I might jokingly respond “for the money”! After the initial joke, however, I would more than likely respond that I am getting a Ph.D. for a number of reasons, including personal growth, intellectual stimulation, and, more generally, an interest in the field and in public service. I have just given an account (albeit a short one) of why I am pursuing a Ph.D. The account hints at some of the values that are important to me and keeps me motivated during the more challenging times of pursuing a degree; but accounts also serve a number of other purposes, including alleviating uncertainty, explaining and interpreting the significance of an unusual event, and legitimating the choice of a particular action in light of larger societal values (Wuthnow, 2006). By examining the structure of an organization that has emerged as a result of asking and answering domain-related questions and examining the accounts given as to why an organization made the decisions it did, one gets a more complete picture of an organization.

In carving out the NQF’s domain in the health care industry, Kizer and others (e.g., the President’s Advisory Commission members and Strategic Framework Board members) had to address two important domain-related issues and give an account of why they made the decisions they did. Some of the domain-related issues that Kizer had to consider how the NQF was going to coexist with existing performance measurement and regulatory systems and where it placed itself in relation to other quality improvement groups and in the larger health care environment. By examining both the decisions the NQF made about these domain-related issues and the accounts of how it made the decisions, we can gain a richer sense of the NQF as an organization.

One domain-related question that was raised at the outset was whether the organization should be public or private. The President’s Advisory Commission recommended the creation of the two entities—one public sector entity and private sector entity—to provide leadership in the creation of standardized quality of care measures and a strategy of reporting on these measures.³⁸

³⁸ The Advisory Council for Health Care Quality, the public sector counterpart to the NQF, was never created. It was envisioned to be the public sector entity that would be responsible for (1) identifying national goals and objectives for quality measurement, improvement, and reporting and (2) tracking the nation’s progress on goals and objectives in an annual report to the President and Congress (McGlynn, 2003, p. I-2). The Forum for Health Care Quality Measurement and Reporting was envisioned to be a private-sector entity responsible for (1) implementing a comprehensive plan for measuring and reporting health care quality, (2) identifying core measures for standardized reporting, and (3) promoting development of core measures (McGlynn, 2003, p. I-2). The White House, under Vice President Al Gore’s leadership, convened the Quality Forum Planning Committee to design and initiate actions to establish a National Forum for Health Care Quality Measurement and Reporting, which is now known as the NQF.

The President's Advisory Commission urged public and private sector collaboration in order to address issues of quality because the

U.S. health system is characterized by the intertwined activities of the public and private sectors in the delivery, purchase, and oversight of health care. Despite ongoing change in the system, these important and overlapping roles are likely to continue for the foreseeable future. As documented in this report, both the public and private sectors are substantial purchasers in the health care marketplace. As such, they collectively bring considerable market power to influence the health care industry. In addition, both sectors have contributed to the base of knowledge and experience concerning quality measurement and reporting. Quality oversight organizations operating in both sectors have employed that knowledge and experience to undertake initiatives designed to protect consumers and improve the quality of health care...In a combined effort, the nimbleness of the private sector can compensate for the slower deliberative processes inherent in the public sector, while the greater representativeness of public processes can inform the more focused efforts of the private sector (President's Advisory Commission, 1998, Chapter 4).

An NQF observer notes, "The conclusion was that it [the NQF] should be a private sector [entity]." The same individual indicated that this decision "represented a deep cultural value in the U.S. that for things as essential as health care, most Americans don't want the government to control." Another NQF observer confirms this, stating, "What was needed are non-regulatory approaches to policy adoption and change." So at a practical level, we can already see that the recommendation made by the President's Advisory Commission and the Institute of Medicine and the subsequent decision by Kizer and others to make the NQF a private organization highlights the importance of self-regulation as a value in American health care. If one takes a closer look at another account of the decision to make the NQF a private organization, however, one can see that in addition to self-regulation, other values permeated their thinking, namely collaboration by diverse stakeholders through consensus-making.

Another domain related issue the NQF had to address was how it would build upon, coordinate, and systematize the many quality improvement-related activities already underway by others. Related to this was the question of how to develop an agenda that would unite the

diverse organizations that belong to the NQF and establish a track record of creating consensus amongst its stakeholders. The NQF had to be especially sensitive to the existing organizations and the territory they had already carved out for themselves in the health care industry. From its inception the NQF sought to emphasize the values of collaboration and diversity. In deciding where it fit in with the activities of quality improvement groups in the health care industry, the NQF had to listen and take into account the activities the other groups were engaged in and find a place for them in the NQF. In other words, the NQF did not want to step on anyone's toes. The NQF settled on a middle-of-the-road approach to these questions by setting itself up, as Kizer put it, as "the national coordinating body for health care quality" and emphasizing the values of collaboration and consensus-making (Deloitte & Touche & Deloitte Consulting, 2001, p. 4). Kizer argues that the NQF can provide leadership because "it has all the stakeholders at the table to bring it together" (Deloitte & Touche & Deloitte Consulting, 2001, p. 4). He elaborates by outlining the five qualities that distinguish the NQF from any other organization in health care and that will allow the NQF to do what no other organization has been successful at—bringing the diverse stakeholders of the health care industry to the table in order to develop consensus-based standards to improve the quality of health care. These are: open membership; a broad representation of stakeholders (including public agencies) on the Board of Directors; the SFB; "a blend of consumer, purchaser, and provider perspectives, and its use of the market power of a public-private partnership to leverage quality improvement"; and the consensus development process.

An organization's public philosophy conveys what problem an organization will address and describes the organization's *raison d'être*. The preceding discussion considered two factors that influenced the development of the NQF's mission. First, stakeholders framed the quality debate as needing cooperation and collaboration by diverse organizations in order to achieve quality improvement. Secondly, stakeholders envisioned that the NQF would bring together the diverse stakeholders and provide the forum to discuss, debate and generate agreement around standardized performance measures. As the network leader, Kizer was charged with taking the President's Advisory Commission and the SFB's work and using these to think about and carve out a niche for the NQF. Kizer and others then carefully crafted the NQF's mission statement to reflect the role they and other stakeholders interested in quality improvement had identified for the NQF. In the next section, I discuss the end product of this work—the NQF's mission

statement—in greater detail. In particular, I deconstruct the NQF’s mission statement and describe the means by which the NQF seeks to improve health care quality.

Performance Measurement, Public Reporting and the Consensus Development Process

A public philosophy can be likened to the process of planning a trip. First, I decide where I would like to go and how I will get there. Let’s say I decide to drive from Blacksburg, Virginia to Taos, New Mexico. I would start planning my trip by looking at a roadmap to determine which road I would like to take to get there. I might consider a number of factors in making my decision, including whether I am going for business or pleasure and whether I would prefer to get there as soon as possible or take my time to stop at parks or other sights along the way. Let’s assume for argument’s sake that I have unlimited time to get to my destination. The choice I make then about which road to take will reflect a lot about who I am as a person and what I value when I take a trip—am I inclined to believe that getting there is part of the journey or am I just inclined to get there? If, for example, I do believe that getting there is part of the journey, I might value openness to new experiences and will probably choose to take the longer, more scenic route.

I want to emphasize two points from this illustration. First, just as a roadmap provides me with the means of getting to my final destination, a public philosophy acts as a kind of conceptual roadmap for an organization. And, second, the public philosophy outlines an organization’s goals (the ends) and how it will go about reaching those goals (the means).³⁹ Implicit in this statement is another subtler, but just as important, point. If we look closely at and dissect an organization’s mission statement, we can begin to see the values contained in that statement, even if they are not explicitly stated. The means and ends outlined in a public philosophy often wittingly or unwittingly reflect an organization’s values. The public philosophy

³⁹ The choice of means and ends are critical, character-defining events for an organization. This discussion illustrates the interconnection of means and ends, which Dewey refers to as “the continuum of means and ends.” In his discussion of Dewey’s means-ends continuum, Selznick highlights three key points (Selznick, 1992, pgs. 328-329). The first is that both means and ends are instrumental. The ends serve as guides to inform choice of means. The second is that means and ends should be valued for themselves. To refer back to my example, one should consider the journey of going from Point A to Point B as valuable, regardless of the road that is chosen. Finally, the ends cannot be determined to be beneficial if the means of achieving those ends are not considered. If the means chosen to get from Blacksburg to Taos, for example, involve stopping in China along the way just because I want to stop in China, this choice brings a level of absurdity to the means I have decided on. I cannot just choose any set of means to get from Blacksburg to Taos; the consequences of my choice have to be examined in light of the ends. Dewey, therefore, cautions against divorcing means and ends because they are so interdependent.

is the roadmap that frames the problem(s) that the organization hopes to address, provides organizational legitimacy by describing how the organization fits into the larger environment, provides justification for why individuals and other organizations might be interested in joining the organization, and outlines the means of achieving the organization's goals (Van Wart, 2005, p. 247).

The United States has some of the best medical knowledge and technology, yet there are large gaps between the care that people are receiving and the care they should receive. Kizer states that “quality should be healthcare’s number one priority, and quality improvement should be healthcare’s essential business strategy” (Kizer, 2001b, p. 47). He comments that “one of our highest priorities is to standardize measurement and reporting; we think that is critically important today” (Blades & Cholewka, 2000, p. 21). The strategy that Kizer identifies for the NQF is threefold (Kizer, 2001c, p. 72). First, the NQF should facilitate the review and standardization of measures currently in use (Kizer, 2001c, p. 72). The primary means the NQF uses to do this is its CDP. Second, the NQF should encourage public reporting of quality of care data to inform purchaser and consumer decision-making (Kizer, 2001c, p. 72). Third, the NQF should encourage purchasing decisions to be made on the basis of the data (Kizer, 2001c, p. 72). The NQF’s mission statement backs Kizer’s ideas up and outlines how it will go about addressing quality problems in the health care industry—through the standardization of existing performance measures and public reporting of these performance measures. If one looks closely at the NQF’s mission statement, it also reveals a third means—the use of a consensus process to standardize performance measures. In what follows, I discuss each of these aspects of the NQF’s mission statement.

Performance Measurement

During the past couple of decades, many different types of organizations have experimented with performance measures as a means of ensuring the delivery of high quality goods and services. Reporting on these performance measures occurs primarily through the use of organizational report cards. Gormley and Weimer (1999, p. 3) define organizational report cards as a “regular effort by an organization to collect data on two or more *other* [authors’

emphasis] organizations, transform the data into information relevant to assessing performance, and transmit the information to some audience external to the organizations themselves.”⁴⁰

Gormley and Weimer (1999) argue that organizational report cards have proliferated and are now used by school districts, the health care industry, and local governments as a means of comparing service providers and communicating who is providing high quality services. A 1995 survey of organizational report cards in education found, for example, that 42 states issue statistical reports on school districts and half of those states require dissemination of these reports to the public (Gormley & Weimer, 1999, p. 1). The growth of these report cards has given parents greater choices about where to send their children to school. Local governments are also using organizational report cards to share performance information about fire, police, and business services (Gormley & Weimer, 1999, p. 2). Many local governments also use report cards to compare themselves to comparably sized municipalities (Gormley & Weimer, 1999, p. 2).

With the increased attention that is being focused on quality problems in health care, we are witnessing the resurgence of performance measures as a means of reporting on and improving health care quality. Many health care organizations are providing information about quality in hospitals, health maintenance organizations (HMOs), and nursing homes. The NCQA, for example, provides data and reporting on the quality of care for HMOs and the Joint Commission collects and provides information about the quality of care in hospitals.

The use of performance measures has proliferated in health care for several reasons. The rising costs of health care and the development of what some have referred to as the “new era of consumerism” in health care are two drivers behind the quality improvement movement and the demand for performance measures in health care. The new era of consumerism in health care is a direct result of the increased publicity of deaths and injuries from medical errors. Consumers

⁴⁰ For the purposes of this research, I am using “organizational report cards” and “performance measures” interchangeably. Performance measurement systems are similar to benchmarking in several ways. Benchmarking is defined as “the continuous process of measuring products, services, and practices against one’s toughest competitors or a renowned industry leader” (Camp, 1989, p. 10). Benchmarking allows organizations to compare actual data with pre-set levels of performance. Current practices are often called into question in light of data gathered from benchmarking. Benchmarking allows organizations to change their current methods in light of new information about better methods. As a result, benchmarks can force an organization to explore other possibilities, thereby generating new ideas about how to improve performance. The differences between performance measurement systems and benchmarking are that they are “not necessarily limited to comparisons with favorable performers. Also, benchmarking may or may not involve regular data collection and an external assessment” (Gormley & Weimer, 1999, p. 4).

want to make sure that they are not putting themselves in harm's way and, as a result, are more concerned with and educated about the quality of care they receive. Consumers are demanding information about who is and who is not providing quality care.

As the costs associated with health care increase, consumers also want to make sure that they are paying for the highest quality health care. In addition to consumers, public and private organizations that are purchasers of health care services and plans, such as DOD, General Motors, and other large organizations, have issued calls for more information to help them make decisions about who provides high quality care. Like consumers, purchasers want to make sure that they are paying for health insurance plans that provide the best value for the money. Providers have also called for more information about quality of care primarily to learn who is providing high quality care and the techniques for providing high quality care. Research and quality improvement organizations also use data about quality of care to compare practices across different organizations, to generate better measures of quality and to generate evidence-based practices.

As the network leader, Kizer must deal with the inevitable tension that arises when these stakeholder groups come to the table to discuss and reach consensus on performance measures. In Chapter Seven, I discuss some of the design principles Kizer built in to the NQF's CDP to manage these tensions, but following are some challenges Kizer faces with regard to performance measures.

One problematic belief that Kizer must constantly address is the assertion that quality cannot be measured. Kizer firmly disagrees, stating: "such a belief is just wrong. There are many aspects of quality that can be measured; for example, whether someone is on a B-blocker after a myocardial infarction is a process measure of quality. The data are clear that if you are [taking a B-blocker], you are about 40% less likely to have a repeat MI" (Vastag, 2001, p. 869).

Related to this is the problem that there are no standardized measures available to allow for comparison of quality. This is where the NQF comes in. It is not supposed to develop new performance measures, but rather to take the existing performance measures from research, accreditation and oversight organizations and review, modify, and standardize them through its CDP.

As I discussed earlier, one of the NQF's philosophical precepts is that health care quality is premised on patient safety, and to ensure this safety, the NQF asserts that performance

measurement should be an intrinsic part of the care process. Once the measures have been standardized, the NQF advocates public reporting of these measures.

Public Reporting

The second philosophical precept underlying all of the NQF's activities is that health care quality data are a public good and should be available to the public. Purchasers and consumers are increasingly seen as the drivers for quality improvement. The public reporting of measures is one way to hold health care providers accountable for the quality of health care they deliver. Public reporting represents a sort of "Good Housekeeping Seal of Approval" on quality that consumers and purchasers can use to make informed decisions. Public reporting also "encourage[s] purchasers to buy from those providers that demonstrate the most commitment to quality improvement" (Blades & Cholewka, 2000, p. 21). Proponents also make a case that public reporting will reduce costs in the long run (Vastag, 2001). Kizer, for example, contends that this is not necessarily the only reason to encourage public reporting, but that it is a beneficial side effect.

The NQF's role in promoting public reporting arose from two sources—the IOM report and the report of the federal government's Quality Interagency Coordination Task Force (QuIC). The IOM recommended that the NQF be charged with "promulgating and maintaining a core set of reporting standards to be used by states, including a nomenclature and taxonomy for reporting" (IOM, 1999, p. 88). The QuIC also recommended that the NQF "identify a set of patient safety measurements that should be the basic component of any medical errors reporting system" and "identify a set of patient safety practices critical to prevention of medical errors" (Quality Interagency Coordination Task Force, 2000).

One issue that the NQF has had to overcome is the resistance to public reporting. Many organizations have had perplexing experiences with fragmented reporting systems, which have led them to conclude that public reporting of measures is too burdensome. As a result, many health care organizations and providers prefer to opt-out of reporting, leading to an incomplete and inaccurate picture of quality. The NQF seeks to make reporting on performance measures less burdensome by standardizing performance measures. Standardization of the measures will help to reduce the burden of compliance and, at the same time, make the measures more useful. Kizer argues that high quality health care begins with patient safety, but the measurement and reporting of quality must not be a burden on the providers, stating:

I believe, and I think there are others who share this view, that one of our biggest contributions in the first few years will be standardizing the data measures to reduce the burden. At the same time, we would hope that the usefulness or the value of the measures also could be increased. Clearly the benefit of standardization from a national perspective is that we could then start making apples-to-apples comparisons, which is now essentially impossible because of all the different measures, terminologies, report cards, and other things that are out there, including the different ways things are defined and the nuances such as how things are collected (Blades & Cholewka, 2000, p. 21).

Consensus Development Process

The mission statement states that the NQF aims to “improve American healthcare through endorsement of *consensus-based* [my emphasis] national standards for measurement and public reporting of healthcare performance data...” The NQF’s CDP is the third means the NQF is using to accomplish the standardization of and public reporting on performance measures. A network setting is a delicate environment and a critical task of a leader is to manage the participants’ diverse interests. Like the citizens that Tiebout (1956) and Tullock (1971) argue can “vote with their feet” any time they are unhappy with the decisions of local politicians and bureaucrats, network participants also can leave any time they think they have not been heard or treated fairly. The management of diverse stakeholders therefore is especially important in a network setting. A leader must be attuned to the various perspectives of each stakeholder group and maintain that delicate balance among the different stakeholders so that one group does not gain too much power. One of the means of accomplishing this is through the use of a fair and equitable process, such as the NQF’s CDP, to manage the stakeholders’ diverse interests. I discuss Kizer’s role in developing, managing, and the CDP’s development and evolution further in Chapter Seven.

Conclusion

This chapter examined a network entrepreneur’s role in crafting an organization’s mission. This task is especially important in a network setting because a leader must create a mission with its intended audience in mind. In this chapter, I described how Kizer worked with others to design and disseminate the NQF’s mission in such a way to develop and ensure a broad

base of support for the NQF. Kizer's critical task involved defining the means and ends the NQF would use to improve health care quality and how the NQF's mission would communicate its larger role in society. It is to the detriment of a network if a leader neglects to consider her audience in crafting a public philosophy because it helps a leader build an organization's social base. In the next chapter, I discuss how Kizer disseminated the newly developed mission statement through presentations, articles, and speeches to different stakeholders in order to attract potential members and staff to the NQF.

CHAPTER SIX
CRITICAL TASK TWO: BUILDING AND MAINTAINING
THE NQF'S SOCIAL BASE

*It is the task of leadership, in embodying purpose,
to fit the aims of the organization to the spontaneous interests
of the groups within it, and conversely to bind parochial group egotism
to larger loyalties and aspirations.*
--Selznick (1984)

*When organizations are created, the organizational entrepreneur works hard
to discover what incentive, or combination of incentives, will attract members...*
--Wilson (1995)

Introduction

“Beyond the definition of mission and role lies the task of building purpose into the social structure of the enterprise...of transforming a neutral body of men into a committed polity” (Selznick, 1984, p. 90). Selznick (1984) is referring here to another critical leadership task, building an organization’s social base. An organization’s social base can be thought of in terms of two related parts: individuals who are internal to the organization (e.g., staff) and individuals who are external to the organization (e.g., members). Although scholars recognize that building a strong social base is important for traditional, hierarchical organizations, few scholars have considered the activities and challenges a leader faces as she strives to build a social base for a network organization. Nor have scholars considered some of the activities a leader must undertake in order to create a sustainable organization. The purpose of this chapter is twofold: to outline some of the inducements Kizer offered to potential members and staff in order to build the NQF’s social base and to describe some of the challenges he faced in maintaining that base.⁴¹ The thesis of this chapter is that the challenges associated with the construction and maintenance of a social base are greater in a network organization than a traditional bureaucratic organization because the foundations of a fledgling network organization are shaky and managing diverse interests is difficult. Therefore, Kizer had to find creative ways to overcome these challenges and encourage others to participate in the NQF.

This chapter is divided into two parts. In Part One, I discuss how Kizer built the NQF’s social base, paying particular attention to the inducements he offered in order to recruit members

⁴¹ Portions of this chapter appeared in Hoflund and Farquhar, 2008.

and staff. In Part Two, I discuss how Kizer created sustainability by ensuring continued financial resources and deftly managing member relations.

Building the Social Base

In building a network's social base a leader confronts the question of ends and means. A key question Kizer faced was how to design an organization that would address the challenges the health care industry had faced in trying to improve quality. More specifically, he confronted three challenges related to building the NQF's social base: (1) how could he acquire the expertise, or distinctive competencies, the organization needed to make headway in improving health care quality; (2) how could he acquire the financial resources necessary to developing and growing the organization without sacrificing its mission; and (3) how could he create a structure that was inclusive and would allow the NQF to overcome the fragmentation inherent in the health care industry? In an effort to overcome these and other challenges, Kizer relied on inducements as the means to recruit members and staff and to attract the necessary resources to the NQF.

The idea of "inducements" as a means to encourage others to participate in an organization was initially discussed by Barnard and elaborated on by Wilson in *Political Organizations* (1995). In *The Functions of the Executive*, Chester Barnard (2001, p. 140) discusses the idea of inducements or incentives as a means of holding an organization together: "...from the viewpoint of the organization requiring or seeking contributions from individuals, the problem of effective incentives may be either one of finding positive incentives or of reducing or eliminating negative incentives or burdens."⁴²

Wilson built on Barnard's original ideas about inducements and developed four categories of incentives: material incentives, purposive incentives, and specific and collective solidary incentives (Wilson, 1995). Material incentives are tangible and include money, fringe benefits and services that one would otherwise have to pay for. Purposive incentives, on the other hand, are intangible and generate a sense of satisfaction from being involved in a worthwhile cause. Specific and collective solidary incentives are also intangible rewards that can

⁴² Barnard (2001) identifies two types of inducements: specific inducements and general inducements. Specific inducements are those that can be offered to individuals and include such material things as money and good working conditions, and nonmaterial things such as prestige and power. General inducements are those that cannot be specifically offered to individuals and include the opportunity to engage in a cause larger than oneself and a feeling of compatibility with others involved in the organization.

be provided to or withheld from either groups or individuals. Some examples of solidary incentives include honoring individuals for their association with the group and the sense of conviviality and exclusiveness shared by group members when they come together.

Wilson (1995) notes that when an organization is in its developmental stages and access to material resources is limited, leaders will rely on solidary and purposive inducements to attract members. This study extends Barnard's and Wilson's analyses by applying their ideas about inducements to a network organization and discussing the types of inducements Kizer offered to member organizations and staff as a means of building and sustaining the NQF's social base.

Recruiting Members

Selznick (1984, p. 104) argues, "among the critical decisions facing leadership, closely related to the definition of mission, is the selection of a clientele, market, target, allies, or other segment of the environment to which operations will be oriented. Personnel recruitment, public relations, and many other areas of decision will be affected by this key choice of an external 'social base'." A social base can be defined as all of the resources (financial, technical, and organizational) that individuals and organizations external to the network bring to the organization. While a network organization like the NQF depends on many different kinds of resources from its members including funding, expertise, experience, and legitimacy, different members bring different resources to the table. That is why acquiring these and other types of resources are the main reasons why building a social base is so important.

In recruiting members to the NQF, Kizer faced several challenges. One challenge was how to build a broad social base that would allow the NQF to acquire expertise from a wide range of sources and build on those in order to become a premier organization. Selznick refers to this as "distinctive competence" (Selznick, 1984). Distinctive competence refers to the expertise an organization acquires over time that makes it stand out as the go-to organization among all others in a particular industry (Selznick, 1984).

This point can be illustrated with a simple example. One cannot, for example, improve one's health if one does not have a way of gaining expertise about eating well, getting the proper exercise, and understanding and measuring one's blood pressure, cholesterol, etc. over time. It is very difficult to acquire this expertise unless one devotes oneself to this full-time. So the obvious alternative is to consult a nutritionist, a personal trainer, and a medical doctor. That way, one can develop a network of health professionals in which each brings their own distinctive competence

to the table. Over time, one can build knowledge about how to best take care of one's health. An organization builds its distinctive competencies in very much the same way to reach its goals; it brings a variety of experts to the table and learns over time how to provide a service, how to develop a product, or how to implement a program. The different forms of knowledge, however, found in a network can create organizational and coordination challenges—a point that I elaborate on later in the chapter.

Another challenge Kizer had to confront was how to secure funding for the NQF. One interviewee stated that Kizer "...hardly ever has a conversation without mentioning the funding issue. So it's almost obsessive and he has just looked at every place he can for funding. He's been pretty good about it. I mean, they have found project support but it has been absolutely relentless. I haven't asked him but I bet he would say it's 80 percent of his job right now." Another interviewee states that Kizer has "...really had to be very resourceful in order to find the funding and negotiate a project that could keep the funding going."

Obtaining financial resources is often a challenge for networks organizations. Traditional bureaucratic organizations, for example, have a budgetary base each year to draw from that can be increased or decreased at the will of the president and/or Congress. Usually this budgetary base continues to grow, and it frequently is hard to get rid of an organization once it is created. This is not so with a network organization. Such organizations are constantly trying to get funding, and most do not have a baseline budget that ensures their survival year after year. Network organizations like the NQF depend on the word-of-mouth of their members to provide news of their good deeds and good work so they can get funding for projects that are important to network members. That is, network members provide the nourishment needed for the network to survive. Network organizations are dependent upon their members for funding and projects that will keep the network alive. In essence, building a social base is about building relationships and, therefore, increasing their chances of getting funding opportunities from those relationships. It is like building an investment portfolio, one diversifies risk in hopes that something will work out; in the event that a stock declines, one has not invested all of the funds in that stock and will not lose everything.

In the next section, I discuss the four inducements Kizer offered to potential members in order to overcome these challenges and encourage them to join the NQF. Interwoven throughout this discussion is the importance of mission as a means of tying this collaborative community

together and allowing the various organizations to see how they can contribute their distinctive competencies to achieving the larger goal of improving the quality of healthcare.

Inducement One: A Shared Sense of Purpose

The NQF's public philosophy was crafted with one end in mind—to improve the quality of healthcare. The public philosophy acts creates a common purpose that ties the disparate groups together. Furthermore, “a sense of mission confers a feeling of special worth on the members, provides a basis for recruiting and socializing new members, and enables the administrators to economize on the use of other incentives” (Wilson, 1991, p. 95). To put it in Barnard's terms, it serves as a general inducement that allows individuals to buy into a purpose larger than them. In a sense, the public philosophy contributes to building a collaborative community in which each group is able to contribute the resources needed to accomplish the agreed-upon ends. It allows an organization to develop the distinctive competencies it needs in order to engage in creative problem solving.

In order to create a shared sense of purpose, Kizer communicated the newly developed mission to a broad range of potential members and encouraged them to become members of the NQF. He disseminated the NQF's newly developed public philosophy through journal articles and public speaking engagements. In 2000 alone, Kizer gave over one hundred speeches about the NQF to various health care stakeholders at conferences and workshops, including those held by IOM, Virginians Improving Patient Care and Safety, the Colorado Patient Safety Coalition, the World Congress Leadership Summit on Healthcare Quality and Pay-for-Performance Contracting, and the Hewlett-Packard Worldwide Health Symposium. Whether speaking or writing, Kizer consistently articulated the same message about the NQF to the various stakeholder groups—that the NQF valued diversity, participation, and cooperation and sought to institutionalize these values in its quality improvement activities.

Kizer's choice of the Never Events project as the NQF's first project also created a shared sense of purpose amongst the disparate groups in health care interested in improving the quality of health care. Kizer thought that the choice of the Never Events project as the NQF's project would signal that the NQF was serious about its goal of improving health care quality, and he recognized that the project's significance would most likely attract broad participation from a number of groups.

The NQF's mission enabled it to build a social base by communicating to potential members why they should join. How each member organization buys into the mission through translating and molding the mission to fit with its identity will ultimately influence how that organization acts (Latour, 1988; Heckscher & Adler, 2007). Some organizations indicated that they joined the NQF because they identified with the NQF's mission and quality improvement goals for health care. According to one interviewee, "it really would have been illogical for us not to [join the NQF]. We share all the interest in promoting quality and patient safety that the Forum does..." Another interviewee pointed to the work that NQF is undertaking to reduce the fragmentation that has plagued the health care industry and noted, "If the Forum were to go away, we would just have total chaos out there."

Inducement Two: Providing Access to Elites

One means Kizer used to attract organizations to the NQF was to focus on bringing in high profile well-known individuals in health care to serve on the NQF's Board of Directors and as Steering Committee chairs. Agranoff and McGuire (2001) refer to this as *activation*. Activation involves identifying network participants and stakeholders as well identifying the resources that participants can bring to the network (Agranoff & McGuire, 2001). They argue, "Activation is a critical component of network management because resources like money, information, and expertise are the integrating mechanisms of networks" ((Agranoff and McGuire, 2001, p. 13).

One can imagine a leader confronting this critical task and choosing between different paths or alternatives for whom to bring into the organization. After all, these decisions during a network's formative stages help shape the organization's culture and influence its future direction. In order to do this effectively, Kizer, according to one interviewee, needed "the vision to help identify people to serve on the committee and make sure that it was broadly representative of the constituencies of the Forum, but at the same time have sufficient expertise to be able to render a credible product." For example, Kizer purposefully recruited Lucien Leape, an internationally recognized leader of the patient safety movement, to serve as chair of the Never Events Steering Committee. According to one interviewee, "The rest of the Committee was people who had various levels of technical expertise or represented important constituencies that needed to be at the table as we were debating it."

In trying to “recruit the rock stars” of the health care industry, Kizer hoped that offering a specific inducement would contribute to members’ feelings of prestige and power through association with the NQF; the philosophy of “if you build it, they will come” would attract members and staff. Indeed, several interviewees mentioned that it was the quality of individuals involved in the NQF—many were nationally known leaders in health care—that motivated them to join the NQF initially. Another NQF member observes that having recognized leaders, such as Gail Warden (then President and CEO of the Henry Ford Health System), serve on the Board and the fact that other well-recognized organizations, such as the American Academy of Family Practice, had joined the NQF already made a difference for those organizations that were thinking about joining.

Inducement Three: Facilitating Access to Resources

The NQF membership consists of more than four hundred members from a variety of sectors in the health care industry, including purchasers, consumers, providers, and quality improvement organizations. There are different kinds of resources organizations can bring to the network, including experience, expertise, information, and financial resources.

One of the benefits a network like the NQF with such a large and diverse social base is that it offers a way to reduce the overall costs of developing performance measures and reporting systems if everyone shares the costs; that is, it reduces the transaction costs of each organization. One reason members joined the NQF is because they recognized, to paraphrase one interviewee, “it was understood that the quality issue was an important one...and getting more prominent.” Although they recognized the importance of quality improvement as an activity, they did not necessarily have their own resources to devote to it. On the other hand, some organizations were already pursuing work in quality improvement and saw the NQF’s work as relevant to what they were already doing in this area.

Another reason organizations decide to participate in a network is that it allows network members to engage in creative problem solving and participate in something larger. Being able to challenge routine and habit and imagine new possibilities is key to pragmatist organizations and networks are a pragmatic form of organizing. Networks allow participants to draw on a wealth of knowledge to experiment with and develop innovative solutions to unwieldy problems (Werhane, 1999).

Each of the NQF's member organization brings a different perspective and varying tools to the quality debate. Several interviewees indicated that they have found the diversity of experience and knowledge valuable in trying to address the quality problems that have plagued the health care industry. For example, the health care provider organizations that belong to the NQF, such as the AHA, regional hospital associations, and individual hospitals, bring, according to one NQF member, "a lot of intelligence about what is clinically significant, and what is feasible to measure." They also provide valuable input about the ease or difficulty with which the various quality measures under consideration can be implemented.

The research and quality improvement organizations, such as AHRQ, NCQA, and the Joint Commission, seek to improve the safety, quality, and effectiveness of medical care by researching and gathering data on various indicators of health care quality. They create and act as a repository for performance measures, and are most likely to bring measures to the table for discussion and debate. They provide valuable input about their experiences with developing and testing measures, and create the "evidence base" for health care outcomes, cost, and quality. They also accredit some of the health care providers and are in charge of oversight and monitoring of the services some of these providers deliver. So, they are also on the front lines and need to be aware of how easy it might be to implement some of these measures and get reporting on them.

Provider and research and quality improvement organizations offer information and knowledge about the more scientific and technical aspects of performance measures to the NQF. Consumer and purchaser organizations bring a different perspective. According to one NQF member, consumer and purchaser organizations "put less emphasis on the scientific perfection of a particular measure" and, in general, bring their knowledge about the intersection of cost, quality, and consumer needs to the NQF.

Purchasers of health care, including CMS and GM, emphasize the moral imperative of improving the quality of health care. Their commitment to improving health care quality arises from, according to one NQF participant, their "role in paying for the cost of poor quality not only [in terms of] mortality and morbidity but the cost of health care and what it's doing to the liability of businesses."

Consumer organizations, such as the AARP, March of Dimes, and American Federation of Labor and Congress of Industrial Organizations (AFL-CIO), bring an understanding of

consumers' needs and wants to debates about health care quality. For example, the March of Dimes brings expertise about child health care measures, while the AARP brings expertise about what is important to the over-50 population. Consumer groups want to see quality improved and get involved in the NQF to improve quality because consumers are demanding more for their money. They do not want to spend thousands of dollars on a surgery only to find a sponge has been left inside someone, or worse, experience the death of a loved one because of a botched surgery. In essence, consumers are demanding that someone be held accountable for the quality or lack of it in the healthcare system today. Frugality and accountability seem to be the two keywords linked to why consumers are interested in the quality movement.

Inducement Four: An Opportunity to Influence Measure Development through a Seat at the Table

One benefit of NQF membership is a “seat at the table” in national decision-making. For example, providers want to get involved in the quality movement for several reasons. First, most providers care about the quality of care their patients receive and want to deliver good quality care. In order to provide good quality care, they must keep up with and implement cutting edge medical knowledge. Providers are also the ones delivering health care so they offer a good perspective about whether certain quality measures are feasible. They are the street level bureaucrats in terms of making decisions and exercising discretion about how to care for each patient. In another move related to self-interest, if they are going to be the ones implementing and being judged according to these measures, they do not want others making decisions for them; they want to maintain some sense of autonomy in this. So they want to have a hand in creating or examining the performance measures that they are going to have to implement. Providers want to make sure that their fees do not rise. In this sense, they are purely self-interested. Just like consumers who do not want to pay more for faulty healthcare, providers do not want to continue to pay more for malpractice insurance and raise their other fees, which might drive patients away. Providers are self-interested for another reason: as a means of ensuring industry self-regulation, the NQF allows the providers to maintain a certain amount of autonomy.

Similarly, purchasers want to participate in order to help protect the interests of the organizations that buy health care. GM, for example, purchases a large amount of health care and

if quality continues to suffer, it will see its costs continue to skyrocket. If the costs continue to increase, they will have to cutback on the amount of health care they provide to their employees.

A network like the NQF relies on a strong social base to accomplish its goals. Since the organization was new, Kizer confronted significant challenges and questions from other organizations as to why they should join the NQF. In order to convince others to join the NQF, Kizer offered a number of inducements. By offering the incentives he built a strong social base that consisted of a number of the different stakeholders in health care. Offering incentives to recruit members is one thing, but Kizer also had to ensure that he would be able to attract staff to the NQF.

Recruiting Staff

Recruiting staff is just as important as recruiting members. Selznick (1984, p. 105) states, “The creation of an institutional core is partly a matter of selective recruiting, and to this extent overlaps with the task of selecting a social base.” That is, it is important to an organization that the staff reflects the dynamics of the external environment. In recruiting employees, Kizer faced some significant challenges. The NQF was a new and as yet unproven organization with limited financial resources. One interviewee painted a picture of the NQF’s stark offices during that start-up period: “...there was no furniture at all. Ken was working off of essentially a card table and she [Robyn Nishimi] was doing the same and another employee who had been hired at that point was working out of her house.” In this section, I discuss the type of staff member Kizer sought to attract, some of the challenges he faced, and some of the inducements he offered to potential staff members.

In recruiting the NQF’s staff, Kizer had to consider the types of staff members that the organization needed in order to accomplish its mission. The NQF is a distinctive organization and requires a different set of skills for their employees than most other organizations. Kizer sought to recruit employees who embodied three characteristics. It is helpful if the staffers have some experience, either clinical or research, in the medical field. Furthermore, Kizer sought staff that had experience in a particular area. But, to paraphrase one interviewee, it is important if they want to continue as staff once a project is finished that they have an interest in applying their expertise in more general ways. That is, the NQF values flexibility in its staff. At the same time, staff members need to be politically astute and able to deal with the various stakeholders that are members of the NQF. According to one interviewee, “that’s what this place is—it’s about

occasionally highly technical topics but it takes place in an extremely political, small ‘p’ political, environment where they’re negotiating things. You’re trying to mediate sometimes really contentious discussions...”

Although Kizer ideally sought to hire individuals that embodied these three characteristics discussed, the reality was different, and he faced significant challenges in hiring staff. Funding served as the primary constraint. One interviewee noted that many times during the initial stages of hiring staff the conversation never moved beyond salary. Staffing the NQF is particularly difficult because while it can offer salaries competitive with the federal government and other not-for-profit organizations, it cannot compete with consulting firms. The consequence was that the NQF often did not get its first choice of employees. Kizer did not have the money necessary to hire his “ideal” staff, so it was important for him to develop other types of inducements. A second challenge was to find individuals skilled in the science of performance measurement and consensus building. As one interviewee noted, “those are not skills that commonly come together.” Another challenge was to find some way to convince potential employees to leave their current jobs with pay and benefits—not to mention office furniture—and come to work at an organization that, to paraphrase one interviewee, offered no job description, no benefits during the start-up period, and no guarantee that the organization would exist for any long period of time. The same interviewee in referring to taking the job as the “ultimate job insecurity” conveyed the gravity of making that decision: “It was the first time I’ve ever asked in a job interview, ‘What are the chances you can actually cut me a paycheck six months from now?’” To overcome some of these challenges, Kizer offered potential staff a series of inducements.

Inducement One: To Become Involved in a Purpose Larger than Oneself

Just as finding its place in the larger society rewards an organization, participating in something larger than oneself also rewards individuals. One inducement, therefore, that Kizer used to recruit initial prospective NQF staff members was the vision that he crafted for the NQF. To put it in Barnard’s terms, many of the initial staff members felt that by working for the NQF, they had a chance to become involved in a purpose larger than themselves. The NQF’s mission not only communicated to potential members, but also to potential staff, that it was serious about achieving quality improvement. One interviewee described her reaction to the NQF as “fascinating” because it was experimenting with something new in order to improve quality.

They recognized that the other structures and attempts to improve health care quality were outmoded and outdated. The NQF, on the other hand, according to one interviewee, represented a completely different organizational structure—one that was “trying to achieve not just a diversity of input, but a balance among the diversity of inputs.” The NQF’s staff members, therefore, were intrigued and excited by the opportunity to be getting in on the ground floor of an organization that they sensed might be able to make a difference in health care quality.

Inducement Two: To Carve out a Niche

Closely related to the idea of the gratification of serving a higher purpose is the notion that a job can offer individuals an intellectual and creative outlet. The NQF was a new organization, and, as I mentioned earlier, there were no well-defined job descriptions for the positions. Since the NQF was sailing into uncharted territory and Kizer, as mentioned previously, did not have the financial resources to offer to potential employees, he told applicants that they would have a chance to create their own jobs and emphasized that they would have the chance to work on something that had never been done before. And, it worked. As one interviewee put it, “We all like inventing something.” While this served as an inducement and attracted many individuals to the organization, it also meant that the initial employees had a hand in shaping the NQF’s long-term character and culture.

Inducement Three: Kizer’s Reputation as a Change-Agent

Just as access to elites was an inducement Kizer offered to potential members, the chance to work with an elite like Kizer was an inducement for staff to work at the NQF. Kizer was known widely to be a change-agent in the health care industry and can be thought of as a transformational leader. Transformational leadership is defined as a process that changes and transforms individuals (Burns 1978). It is concerned with how leaders inspire their followers to accomplish great things. Transformational leaders are known for moving and changing things “in a big way” by communicating to followers a special vision of the future and tapping into followers’ higher ideals and motives. They generate emotion, energy, and excitement and encourage followers to make significant personal sacrifices in the interest of the mission and perform above and beyond the call of duty.

We have already seen how Kizer achieved this by communicating the NQF’s mission to potential staff and members. His passion and drive for improving health care quality is one reason that one staff member said, “everyone works here because of him [Kizer].” When asked

why staff members were drawn to the NQF, several noted that Kizer “walked the walk” and that he had a “track record of actually doing things and making change.” Furthermore, they also recognized that improving health care quality would be an achievable goal as long as he was involved.

Earlier, I used the metaphor of a house to discuss two stages in organizational development. A leader must first build an organization’s social structure, much like one builds the foundation of a house. During the NQF’s formative years, Kizer was concerned with building the network’s social base. In order to do so, he offered a variety of inducements to potential NQF members and staff. Once a house is built, however, one must ensure that it remains livable. In the next section, I discuss how Kizer focused on creating a sustainable organization.

Maintaining the Social Base

It is one thing to create an organization; it is another to maintain it. Just like one must deal with routine house maintenance, Barnard (2001) notes that organizations must engage in organizational maintenance. All organizations struggle with sustainability, and network organizations are no exception. Organizational maintenance requires constant attention and it is a leader’s responsibility to address the issues and challenges that may arise in order to ensure the organization’s sustainability. The key question for a leader during this stage is how to maintain the integrity of the network organization without sacrificing participation or resources. In walking this line, leaders find that they have to sacrifice certain things or make tradeoffs in order for the organization to grow and survive. In this section, I discuss two key challenges Kizer confronted—maintaining financial resources and managing member relations—and some of the implications of the decisions he made as he wrestled with these challenges.

Maintaining Financial Resources

Nonprofits rely on money to achieve their goals, and financial security is essential to a nonprofit’s survival. The reality for many nonprofits, however, is that funding is not easy to obtain, and many have to rely on funding in the form of grants and contracts from external funders. This is true for the NQF as well. Ideally, in order to achieve its mission, Kizer would have liked to have had unlimited funding with no strings attached so the NQF could pursue the most important projects. The reality, however, is that Kizer faced numerous challenges in maintaining the NQF’s financial resources, which had significant implications for the

organization during its developmental stages. The NQF's experience illustrates the importance of the relationship between an organization's budget and its ability to achieve its priorities.

In FY 2000, the NQF had a budget of approximately \$2.2 million. The NQF's primary source of funding is membership dues: in Fiscal Year 2000, the NQF received \$623,000 from membership dues. The amount of dues paid by each organization depends on the type of organization and its operating budget, with dues ranging from \$1,000 to \$25,000 per year. Everyone agrees that this level of funding is insufficient for the NQF to achieve its ultimate goal of improving the quality of health care. Some participants argue that one of the problems with relying on a membership model is that it will not generate the funds needed to conduct quality improvement activities and to do them well.

The NQF's reliance on a membership model, supplemented by grants and contracts, has significant implications. One of the consequences is that the NQF cannot focus on its top priorities. Many members express concern that as the NQF does not have a core source of funding and, therefore, has to pursue funding on a grant-to-grant basis, it is reduced to being a "money chaser." One participant provides a hypothetical example to illustrate this point:

many times we'll hear of things sort of after the fact or incidentally we're doing a needle stick project. You know, why are we doing that? Well, because there's money available to support it. Well, how does a needle stick project advance the quality agenda?

The needle stick example drives home an important point – that funding can skew priorities. Critics maintain that external funders shape the NQF's priorities by determining the types of project they will fund and by setting the parameters of those projects. These grants, however, might be peripheral to the larger issue of quality improvement.

But because there is money to support those projects, the NQF conducts the work. Some skeptics maintain that without a comprehensive vision to guide its efforts and a core source of funding to buttress this vision, the NQF's ability to make significant headway in addressing quality problems will be limited.

Another concern the NQF faces with regard to funding is the issue of who should shape the products that emerge from the consensus process. Funders like to set parameters for the projects they fund. Coupled with this is the often-implicit assumption that the funders will be able to exert some control over the end product. The NQF's experience with the Serious

Reportable Events project bears this out; in fact, the project initially was delayed because of this very issue. One NQF observer notes that this delay arose because the federal government typically does not write “contracts in which it does not exert some pretty specific control over what the product is supposed to be. In this case, the product had to be whatever went through the process.”

This reflects a fundamental tension the NQF faces with regard to resources – the need to balance the funding agency’s desires with those of its member organizations. The NQF relies on continued funding from many of its grantees, but it must also guarantee that the consensus process is equitable and transparent. One member notes that while funders may balk at their lack of control over the final product and this may hinder the NQF’s ability to obtain funding, it also acts as a “protective mechanism” for the NQF: “whenever the members feel that the funders might exert too much control, they get nervous so and correctly so.”

One of Kizer’s goals was to secure a more permanent form of funding for the NQF. He and others I interviewed thought that the best way to achieve this would be to have a percentage of Medicare funding allocated to the NQF. The NQF has been unable to secure a long-term, stable source of funding, and, according to one NQF stakeholder, doing so is not an easy task because

this country has an underdetermined commitment to quality. I’ve never talked to anybody who is opposed to quality in healthcare, but when you talk about putting money on the table to support quality measurement and reporting, everybody disappears.

Managing Member Relations

It is challenging to sustain a level of high-quality participation on the part of member organizations and, more generally, a membership that is vital, energized, and engaged. A major difference between a network organization and a bureaucratic organization is that employees in a bureaucratic organization are paid to work there, and leaders assume that this will ensure that they come to work everyday. The NQF’s members are busy individuals whose primary job is elsewhere. Thus, Kizer as a network leader must make a special effort to ensure a balance between maintaining a level of participation on the part of members that keeps the organization functioning, yet not overloading members so much that they refuse to participate in or decide to leave the organization. This is quite a precarious position for a network leader to be in. In this

section, I discuss some of the challenges related to managing member organizations that Kizer faced and that continue to plague the NQF and some of the consequences of these challenges.

Power imbalances are one major impediment to participation. The NQF is supposed to level the playing field among the diverse interests in the quality debate. Differing levels of financial resources, however, have created imbalances among organizations that would like to participate in the quality debate. Some of the NQF's critics have noted that joining the NQF is expensive and, because of the high membership dues, some organizations and individuals are "priced out" of the process, particularly consumer and purchaser groups. As one participant puts it, "if you have money you can be a player at the table. If you don't have any money, you can't be a player. That's one of the biggest complaints I hear from those wanting to join the NQF."

The NQF is structured so that 51 percent of the organization is controlled by purchasers and consumers. Yet, as one participant notes, although many provider and research and quality organizations have the funds to join the NQF, keeping the balance of purchasers and consumers at 51 percent is a challenge because

...the consumers and business [i.e. purchasers] people keep their money a little closer to the vest and some of them, the consumer organizations in particular, don't have a lot of money to spend...if you look at the people who show up to play from time to time, it's not 51 percent consumers and purchasers. They just can't get them to come.

The amount of time organizations must commit to the NQF is another impediment to participation. Member organizations also put a lot of time and effort into reviewing and critiquing the products that go through the consensus process. One participant stated that some of

...the indirect costs, at least to members, have to do with the enormous amount of work that goes into responding to the various reports that come out. In creating comments, most of us, because we are associations, ship the reports out to three or four other people for review. I've never tried to price it out, but if I did I'm sure it would be fairly costly per word for the responses.

There are consequences associated with these impediments. One consequence is a lack of creativity. One participant expressed concern that as not everyone can afford to participate in the NQF's quality improvement activities, creative proposals to address quality improvement might be stymied: "they have the same players at the table all the time. I think that in order for health

care to move where it needs to, it needs fresh ideas and not just the same old folks saying the same old thing.’’

The NQF also suffers from a free-rider problem that saps the energy of the process because some organizations are either slightly engaged or not engaged. Many participants note that some organizations participate in the NQF only to protect their own interests, while others limit their participation to their “pet” projects. On the other hand, one NQF member speculates that the laissez-faire attitude exhibited by some member organizations is because quality improvement is not their core business. They therefore cannot devote the time that is required to actively participate in a member organization such as the NQF. These examples illustrate the classic free rider problem confronting many organizations; that is, members reap the benefits of belonging to an organization even though they may not invest a lot of time in the organization’s activities.

Conclusion

In this chapter, I describe how Kizer built the NQF’s social base by providing inducements for members and staff to join the NQF. This critical task builds on the first critical task in which a leader creates a mission in order to create shared meaning among individuals and encourage them to join the change effort (Bryson & Crosby, 1992, 67). Kizer’s deep understanding of the larger picture about how to improve quality and the NQF’s role in achieving that goal allowed him to recruit members and staff that would elevate the NQF’s status from just another organization in healthcare to one that could do what others are not capable of doing—engaging broad participation to develop consensus-based standards. Kizer’s third critical task was to create a framework that would allow the NQF’s participants to engage in creative problem solving in an effort to improve health care quality. Related to this is how the diverse interests of the network participants are managed. I explore both of these issues in the next chapter.

CHAPTER SEVEN
CRITICAL TASK THREE: CREATING THE NQF'S
CONSENSUS DEVELOPMENT PROCESS

...where leadership is required...the problem is always to choose key values and to create a social structure that embodies them.

--Selznick (1984)

...one of the principal administrative dilemmas for leaders and managers in collaboration is managing the inherent tension between self-interests and collective interests.

--Thompson and Perry (2006)

People are sensitive to procedural nuances because procedures are viewed as manifestations of basic process values in the group, organization, or institution using the procedure. Because procedures acquire substantial significance as symbols of group values, individuals are concerned as much or more with what happens within the procedure as with whether the procedure promotes the attainment of some extra-procedural goal.

--Tyler and Lind (1992)

Introduction

In *A World of Standards*, Brunsson and Jacobsson (2002) examine how standards are developed and some of the key ingredients or design principles that are featured in standards making processes. What is missing from their discussion, however, is consideration of a leader's role in developing the institutional architecture of a standards making organization. In *Law and Society in Transition*, the classic treatise on responsive regulation, Nonet and Selznick (2005, p. 111) state, "A new kind of lawyerly expertise is envisioned—expertise in the articulation of *principles of institutional design and institutional diagnosis* [emphasis in the original]." Two key questions are of particular importance: (1) how does a leader design a standards making process that is responsive to the needs of the organization's environment; and (2) which principles guide a leader in the development of a consensus making process? This chapter sheds some light on these questions by examining the principles that guided Kizer in his development of the NQF's CDP, the steps he engaged in to create this process, and how he managed the diverse interests of the network participants once the process was in place.

External forces can play a strong role in the success or failure of an organization, and it is a leader's critical task to determine how to respond those forces. In *The Moral Commonwealth*, Selznick (1992) discusses responsiveness and maintains that an organization is responsive when it can listen, learn and change its ways as new circumstances arise and new voices are heard. The

key to understanding Kizer's role in the design and implementation of the NQF's CDP is responsiveness. In designing the NQF's CDP, Kizer strove to create a deliberative process that involved multiple stakeholders, which involves being responsive to the larger environment the NQF operates within. In trying to achieve this goal, he could have ignored members' concerns, or he could have tried to respond to everyone's concerns. Either way, an organization may suffer negative consequences from being too insular or being too opportunistic. Kizer exhibited responsive leadership in navigating these tensions by exercising discrimination and being selective in responding to environmental cues. In exercising responsive leadership, Kizer incorporated five design principles, or dimensions of responsiveness, into the NQF's consensus process. The thesis of this chapter is that one of Kizer's critical tasks with regard to creating and implementing the NQF's CDP was to assess the external conditions that might enhance or frustrate the NQF's progress and incorporate certain design principles into the NQF's consensus process in order to make it more prone to success than failure.

This chapter is divided into two parts. In Part One, I discuss the five key design principles that Kizer considered in developing and shaping the consensus process. In Part Two, I examine the challenges the NQF faces as it struggles to fulfill these design principles.

Key Design Principles of the NQF's Consensus Development Process

Health care leaders realized that in order to make significant headway in improving health care quality, it would be essential for health care stakeholders to cooperate in order to achieve industry wide acceptance of standards. The NQF was born out of these needs, and health care leaders hoped that the NQF would be the vehicle that would allow the various health care stakeholders to cooperate and bring some order to the existing disjointed and duplicative system of standards. Once the NQF was created, however, Kizer still faced the challenge of creating a decision-making process that would enable cooperation and participation across all sectors of the health care industry. In this section, I discuss how Kizer developed the NQF's participatory framework and how he used this framework to as a bridge to overcome fragmentation. In particular, I highlight five key design principles that influenced the development of the NQF's CDP.

Key Design Principle One: Broad Participation

As Kizer and his staff considered the design of the consensus process, the first key question, or design principle, they had to consider was the purpose of the process. The goal underlying the NQF's CDP is to encourage participation by a broad set of health care stakeholders. How did the NQF decide on this goal? It looked back at the disjointed and duplicative system of standards that was the result of well-intentioned efforts on the part of health care stakeholders trying to improve the quality of health care. What was missing from these efforts was an inclusive process or forum that allowed diverse health care stakeholders to participate in the debate to shape a national standardized system of measures for health care quality.

Kizer and the NQF staff also looked at the efforts of other industries and organizations in developing consensus-based standards, including the accreditation standards for the American National Standards Institute (ANSI), the requirements of the NTTAA for voluntary consensus standards organizations, and reports by the National Science Foundation on voluntary consensus standards; basically, as one interviewee put it, "anything they could find that was related to what a voluntary consensus process should look like."

In examining these documents and the values that underlay the different existing consensus processes, Kizer and his staff began to think about the types of values they wanted to institutionalize in the NQF's consensus process. In particular, they were influenced by the five values that arose from the NTTAA and are listed in OMB Circular A-119: openness, balance of interest, due process, an appeals process, and consensus (but not necessarily unanimity).

After reviewing these documents and reflecting on the fragmented nature of current quality improvement efforts, Kizer and his staff decided that the underlying goal of the NQF's consensus process would be to encourage broad input in shaping and developing quality improvement initiatives. With participation occurring on a broad level, the hope, according to one interviewee, was that "nobody in effect will have an excuse to say 'well, you know, we can't go along with that'." Furthermore, the NQF and its participants strongly believed that with increased opportunities for input, there would be "as much possibility there for activity in quality improvement as possible." What emerged was a process that, according to one NQF observer, "was designed to make sure that this organization fully represented the stakeholders, and in

particular, since it was dealing with public reporting, that it specifically made sure that it was representing the public, primarily the purchasers and the consumers.”

Before the NQF’s creation, the health care industry’s efforts to establish and disseminate quality measures were not inclusive. With the creation of the NQF and its unique CDP, Kizer hoped to encourage broad participation by diverse health care stakeholders. The first design principle emphasized the design of a CDP that would encourage broad participation by all interested health care stakeholders in the NQF. In developing the NQF’s consensus process, Kizer took steps to ensure that all health care stakeholders would be able to have a voice in the process and would be able to bring their different expertise to the table. According to one participant, “the consensus process was set-up in a way to try to ensure that as much opinion, input, feedback, ideas, etc. go into the process of adopting any particular measures in a given area.” What emerged from these efforts is a consensus process that allows opportunity for input by diverse organizations and is adaptable to experience. As a next step, Kizer had to choose a project that would allow the consensus process to demonstrate broad participation in an area that would make a significant contribution to improving health care quality.

Key Design Principle Two: Advancing Quality Improvement

Kizer had to be particularly careful about choosing the first project to go through the consensus process, and his choice was a strategic one. After all, the project was the NQF’s first effort at attempting to make some headway in improving health care quality by standardizing measures, and the success or failure of this project would signal whether the NQF was capable of making headway in addressing quality problems. It would also signal his ability as a leader to assess a situation and choose the appropriate course of action.

One can imagine two scenarios Kizer faced in thinking about and choosing the NQF’s first project. On the one hand, he did not want to pick a project that would be too challenging. A project that was too complex or contentious might drive the members of the fledgling NQF away. On the other hand, he did not want to pick a project that was too easy and risk that others might come to view the NQF as a “lightweight” in the quality improvement area.

In making decisions like this, leaders have to use their judgment to assess and respond to a situation. The ability to judge and respond to a situation relies on experience, and the leaders who are the most successful in sizing-up a situation and choosing the appropriate action have a multitude of cases, or experiences, to draw from. Flyvbjerg states, “The person who possesses

practical wisdom (*phronimos*) has knowledge of how to manage in each particular circumstance that cannot be equated with or reduced to knowledge of general truths about managing” (in Schram & Caterino, 2006, p. 70). The practical, as opposed to the theoretical, is what is emphasized and valued. Martha Nussbaum, in *The Fragility of Goodness* and *Aristotle’s De Motu Animalium*, refers to this as the “priority of the particular” (Nussbaum, 1986, 1978). She argues that leaders cannot apply a formula to a situation; rather, they have to use their judgment to assess a situation and pick the appropriate course of action.

Kizer eventually decided on the Never Events project as the NQF’s initial focus for several reasons. First, the Never Events project would be particularly important to the NQF because it would serve as the mechanism to move the organization from simply talking about process to undertaking a project using the newly developed consensus process. That is, according to one NQF participant, it “gave a focal point for starting to talk about something rather than just process.” The project would also, according to one NQF observer, provide the NQF with a way of attracting members. As one interviewee stated, “there was an attitude of ‘let’s pick something that a whole lot of people are interested in and will demonstrate that the NQF is doing something’.” Another participant noted that Kizer envisioned that if the NQF undertook a high-profile project in which the measures developed were eventually implemented at the state level, then the NQF would begin to achieve credibility, which in turn would lead to future projects and more members. Another observer noted that the Never Events project also was important because “it was among the first set of activities that NQF had undertaken and so in some ways we were plowing new ground and setting precedent for future activities.” The same interviewee reports that some of the questions dealt with included:

What was the process going to be like? How public was it going to be? How were decisions going to be rendered? Were there going to be votes? Was it going to be by consensus? And then when our work was completed, how was the thing going to be adopted or not by the membership of the Forum? And so all of those things were simultaneously having to be answered at the same time we were doing the work on developing the list of so-called never events.

As I discuss in the next section, these concerns about procedure were paramount. As the Never Events project progressed through the consensus process, Kizer had to navigate tensions that

arose between member organizations and respond in a way that would ensure that the process remained fair and legitimate.

Key Design Principle Three: Fairness

The NQF's consensus process is fragile. Fragility is inherent in such a process, particularly in the beginning, because, according to one NQF observer, "membership organizations are very process-oriented. Not so much to the point of worrying about the quality of the outcome or the final product, but was there due process? Did we have a chance for an input? Was our input considered? Was the product revised based on our input or somebody else's input?" The observer is pointing out something very important—that it is not necessarily the outcomes of the process that member organizations are concerned about (although, in order for the NQF to improve health care quality, this has to be a concern), but rather the sense of fairness of the process.

Tom Tyler, a psychologist who has written extensively on issues of trust and fairness in group decision-making processes, finds that individuals are more concerned about procedural fairness than outcomes. Furthermore, an individual's perception of procedural justice, or lack thereof, influences his or her evaluation of an institution (Tyler, 2006). In his study of authority relations, particularly as it relates to the police and courts, Tyler and Lind (1992, p. 115) argue that "people view group authorities as representatives of the group, and are therefore sensitive to how those authorities exercise their authority. Using fair procedures to exercise authority both communicates that the people one is dealing with are respected by the group, and it suggests that the group is one that is worth identifying with and being involved in." Fairness in terms of dealing with police and fairness in developing standards occur in two very different contexts. The fundamental point, however, remains the same—the value of fairness underlies and drives the NQF's consensus process just as it underlies police interaction with citizens. It is useful to think of Kizer's role in ensuring the fairness and equity of the NQF's CDP in this light.

Initially, Kizer sought to create a process that embodied the values of broad participation, openness, and fairness. One interviewee characterized the relationship between the NQF and its member organizations as "difficult because you have a very interesting situation here in which to begin with, you're trying to reach consensus among stakeholders who start with quite different views." Kizer, therefore, had to play what Agranoff and McGuire (2001) refer to as a *synthesizing* role by ensuring an even playing field that would allow all members access to the

process and a chance to be heard. To ensure an even playing field amongst members, Kizer created the Member Council system and ensured that purchaser and consumer organization would comprise 51 percent of the organization. As the previous chapter mentioned however, Kizer faced significant challenges in maintaining this balance.

Once the process was created, one of Kizer's key tasks became one of ensuring the fairness of the process. This involved managing the conflicts that arise among members as projects move through the consensus development process. One NQF participant refers to this as "coordination or the soft side of building consensus." As part of this, Kizer had to manage the relationships between the four Member Councils and the Board and the relationships among the Member Councils. The Never Events project in particular was one in which Kizer walked a tightrope because it dealt with sensitive issues related to the identification and reporting of medical errors. During the Never Events project, one interviewee stated, "Certainly we spent more time conceptually understanding how to, you know, find middle ground..."

Another interviewee stated,

People who work in these institutions and the institutions themselves are understandably nervous about how that process is proceeding. And so they have to be assured that their concerns are being heard and being addressed, yet at the same time, making sure that the broader interests that the Forum has for having a credible product and something that is defensible and in the long-term providing an environment that encourages a safer and higher quality level of care that's being rendered...that's not an easy task.

Kizer engaged in a delicate balancing act with regard to the fairness and legitimacy of the NQF's CDP. He had to nurture healthy relationships constantly and address conflict among these entities, while ensuring that the process remained legitimate and produced products that were credible and perceived as encouraging a higher level of quality. This was not an easy task. Kizer and the NQF faced serious consequences, such as lost time and distraction from the larger goal of quality improvement, if others perceived the process as unfair. But Kizer and the NQF also faced a larger, potentially devastating consequence—that of members defecting from the organization. As I mentioned previously, most of the NQF's support comes from membership dues. If members felt that the process was unfair and Kizer was not receptive to their comments about the process, they could voice their dissatisfaction by leaving the organization. Not only

would this be detrimental to the NQF's long-term survival, but it would also negatively impact the NQF's ability to make strides in quality improvement.

Key Design Principle Four—Nimbleness

The issue of time in developing consensus-based performance measures is an important consideration and points to some challenges that Kizer had to navigate. While the issue of time has not been explored widely in standards-making processes, it impacts the NQF's consensus process in two ways. First, standards making is an inherently time-consuming process because it can be quite difficult to bring together multiple stakeholders possessing very different perspectives and ask them to achieve consensus around a measure quickly. Secondly, the individuals who participate in the NQF's activities are doing so in addition to their other responsibilities, and therefore, the time they can commit to the NQF is limited. Like navigators trying to steer between the two great monsters Scylla and Charybdis in the Strait of Messina, Kizer had to balance these tensions and create a process that would be sensitive to these issues while enabling the NQF to develop consensus around measures that would actually improve health care quality.

According to Brunsson and Jacobsson, the average time to develop a standard at the ISO is seven years (Brunsson & Jacobsson, 2002). Several interviewees mentioned that they have observed that it can take anywhere from 10-15 years to create and modify a standard before it is implemented. This is can be a danger for two reasons. First, there is a very narrow window of time in which to develop meaningful and useful standards. Secondly, consensus processes that are too lengthy also risk producing measures that are technologically irrelevant by the time they are developed. This is particularly true for the health care industry where technological changes occur at a very rapid pace. In order to address these concerns, the NQF created a consensus process that is, in the words of one interviewee, "capable of rapid development and, when necessary, rapid change" and would "accommodate the pace of technological change in health care." At the same time, the NQF still remains sensitive to the consensus process becoming too procedural and the danger that "it will become a ten-year process without meaning to."

Most standards-making bodies rely on full-time, paid employees to develop standards. The story for most nonprofit organizations, including the NQF, is a bit different. Most nonprofit organizations rely on the good will and free time of individuals who volunteer to participate in the organization's activities in order to further its goals. In *The Nonprofit Sector: A Research*

Handbook, Powell and Steinberg (2006) discuss some of the reasons why volunteers are motivated to participate in nonprofit work, including that it imparts something of intrinsic value beyond what paid employees receive from their work. Volunteer work, however, write Powell and Steinberg (2006, p. 166), “is chosen only after primary decisions about paid labor force participation have been made and other time commitments (to one’s family and children, for instance) have been met.” The NQF, therefore, faces a challenge that, unlike other standards-making bodies, such as ANSI and the International Standards Organization, most of the individuals who participate are not working as full-time, paid employees. They are essentially volunteers and the work the NQF requires of them is on top of their normal job duties and responsibilities.

In order to get around these issues, the NQF identifies existing measures and encourages member organizations to put their measures through the NQF’s consensus process. This significantly cuts down on the amount of time needed because the measures are not being developed from scratch. On the other hand, as I will discuss below, this creates a challenge because the member organizations that have invested the time and energy into creating and shaping these measures initially face a trade-off in making their measure sets public. Before I discuss this, I discuss the learning component Kizer and the other architects of the NQF’s consensus process built into the process.

Key Design Principle Five: Continuous Improvement

The most striking thing about the NQF’s consensus process is that there have been eight versions of it to date and, during the six years (1999-2005) that Kizer served as the NQF’s President and CEO, the NQF’s consensus process was revised eight times. For the NQF, organizational learning is key, and Kizer and his staff wanted to create a learning process not only within the network but also within the CDP. As one interviewee puts it, the NQF’s consensus process, “should change, it should be adaptable to experience and what actually doesn’t work...there are things in it that still really need to be thought through and potentially modified as we keep getting experience with why something didn’t quite go smoothly.”

Kizer was the person to whom NQF members reported any problems or concerns they had about the consensus process. As such, he was responsible for recommending changes to the process. One NQF observer notes that over time Kizer became more sensitive in responding to the concerns of member organizations, stating:

...if somebody has brought up a their concern about you know the process that was being used, Ken would go back and say “well let me show you that we did follow the process as laid out in the agreed document number one”. So it’s not like we were just capriciously ignoring our agreed upon process, but number two, ok, then we need to talk about whether that process should be changed.’ Clearly, there has been some kind of modifications and tweaking in the process all along to respond to some of those issues.

One can think about the NQF’s revisions to its consensus process as a form of continuous quality improvement. The automobile industry was the first industry to engage in continuous quality improvement in order to improve the quality of products coming off of the assembly line. The philosophy underlying continuous quality improvement is that everything can be improved. It focuses on improving organizational processes and, in order to do so, emphasizes gathering data and learning from experience. In this section, I discuss some of the changes made to the consensus process after the completion of the Never Events project.

One of the organizational outcomes of the Never Events Project was that it directly led to the refinement of the consensus process. In March 2002, Kizer announced that the CDP had been revised as a result of the Never Events project and that the revised version (version 1.5) had been approved.⁴³ The changes to the process involved both logistical and technical alterations. According to one interviewee, the consensus development process has changed over time in order to accommodate questions about it, including misunderstandings of the verbiage and clarification of its steps. In general, Version 1.5 was reformatted to read more clearly, and several steps within the process were clarified and made more explicit.

One change relates to how comments are disseminated, gathered, weighed, and reported back through each step of the process. For example, to make it easier for member organizations to read the comments on proposed measures posted by others, the NQF starting posting its members’ comments on the “Members Only” section of its web site.

A second change clarifies the role of the Member Councils during Product Review. Specifically, the new version states, “Each Member Council is responsible for establishing its own procedures by which it may opt to provide synthesized comments on behalf of the entire

⁴³ The Never Events project used Version 1.3. Version 1.4 was never operational, so I am most concerned here with the next operational version, Version 1.5.

Council.” Furthermore, it states that each Member Council’s leader is responsible for presenting the views of that Member Council to the Board of Directors. The role of the Member Councils in reviewing products had not been mentioned prior to this.

A third change relates to product approval. Version 1.3 did not discuss how votes are cast and counted. Version 1.5 articulates how votes cast during product approval are to be counted and states that only votes cast will be counted; a specific option to abstain will be offered, but approval will not require that a majority of votes be cast. Furthermore, voting on items will occur on a recommendation-by-recommendation basis, rather than en bloc. The minutes from the February 13, 2002 Board of Directors meeting noted that this change occurred because under en bloc voting, the Federal government members would be required to defer participating because several of the recommendations might include specific fiscal or public policies for which the Administration had not taken a position.

A fourth change that occurred as a result of the Never Events project was to establish an ad hoc advisory committee comprised of state representatives. This panel was established once the Steering Committee members recognized that the product would most likely be implemented at the state level, and therefore it would be useful to include in the discussions individuals from the states who had experience with this type of data collection and reporting. Member organizations advocated for the establishment of a state panel, according to one interviewee, because the NQF “had very few state members and if this is going to be implemented by the states they needed to be involved in at least giving advice even if they weren’t members of the Forum and voting on it.” Another interviewee affirms the reasons for having a state panel, stating, “one of the things that struck us was that in all likelihood the implementation of this was going to occur at the state level. And if you were going to do that at the state level, there’s probably experience that some of those states had in implementing portions of this already.” Another interviewee noted:

they were the type of people that would actually have to implement it so while they weren’t technical from the point of view of patient safety or healthcare, they knew if I can take this can I run with it and push it through the Kansas legislature...is this something that actually makes sense for me as a layman-politico? So they provided valuable input from that perspective.

Selznick (1992, p. 338) states, “Established structures, rules, methods, and policies are all open to revision, but revision takes place in a principled way, that is, while holding fast to values and purposes.” While the consensus process has undergone some refinements, the underlying values and purpose of the consensus process have never changed. The process has undergone some minor refinements to make it flow more smoothly. In addition, with each new project that goes through the consensus process, the process continues to change.

Challenges

Maimonides, the philosopher/physician, wrote daily self-scrutiny is a great thing, stating that “the perfect man needs to inspect his moral habit continually, weigh his actions, and reflect upon the state of his soul every day” (Maimonides, 1983, p. 73). The same principle applies to organizations. We live in an imperfect world, however, and organizations face trade-offs and challenges as they try to accomplish their missions. As this new regulatory structure gains a foothold in the healthcare industry, it is even more pressing that we begin to identify and address some of the challenges associated with the NQF’s CDP.

While some scholars have addressed the limits of consensus making in the environmental (Coglianese, 1999; Weber, 1998) and utility (Raab, 1994) policy areas, few have examined the challenges associated with consensus making in the health care area. The data from the interviews conducted for this research suggest that even with these design principles underpinning its consensus process, the NQF still faces continuing challenges. The reality for a consensus process like the NQF’s is that there are tradeoffs, and it will never be a perfect process. In this section I discuss four challenges associated with the NQF’s consensus process: its time-consuming nature, its ability to make only incremental changes in health care quality, the tension in balancing timeliness and quality, and the challenges associated with bringing measures developed in the private sector into the public sector.

Time plays a role in the ability of the NQF to develop meaningful and useful standards. Opportunities for learning may be slow in a network because while a network’s hub organization is in charge of the final product, the responsibilities for producing different parts of the product are dispersed among the other organizations based on their skills and resources (Barringer & Harrison, 2000). The sheer amount of time it takes for the proposed measures to work their way through the consensus process is an issue, both because the process has been characterized as

“cumbersome” and because, as one participant put it, “the process is at times a killer, because there is so much process.” Some interviewees expressed concern that since projects take too long, “ultimately the patients, [who] should be benefiting from better surveillance and measurement, continue to pay a price in terms of quality defects while people are trying to make up their minds.” But another participant disagrees with this assessment, stating “Consensus takes time! I think that’s a healthy tension to have.”

Furthermore, some NQF critics argue that the standards are not bold enough to improve health quality in the long run. One such critic stated,

...the consensus process seeks the lowest common denominator and that generally will lead to measurements that have an air of timidity about them; they’re not really courageous, bold compelling measures. They’re rather safer than they should be.

This reflects a broader criticism of democratic experimentalism and pragmatism more generally; that is, only incremental change can be made (Dorf & Sabel, 1998; Strauber, 2003).

There also is an inherent tension between wanting to move the measures through the consensus process quickly and ensuring that the resulting measures are high quality. The NQF is sensitive to the fact that if it wants to institute change within the health care industry, it has to develop standards fast enough to keep pace with technological changes in health care. This is similar to the tension the Food and Drug Administration (FDA) confronts in its drug approval process. In approving drugs, the FDA must balance safety with timeliness.

A fourth challenge related to the consensus process is the sunk costs to membership organizations in developing and maintaining performance measures. Most people do not equate performance measures with a commodity, but it is useful to think of performance measures like a product. As an example, Mrs. Fields sells a product, namely cookies. In baking the cookies, Mrs. Fields has a proprietary recipe that it is not willing to share with anyone. After all, if everyone had the recipe, no one would buy the cookies, and Mrs. Fields would not make any money. Performance measures also can be thought of as a commodity. Just as Mrs. Fields is in the business of selling cookies to make a profit, some organizations are in the business of developing and selling performance measures to make profits. Like Mrs. Fields, which expects to make a profit on its cookies, these organizations expect to make profits on their measures. In health care, most of these measures have been developed by private sector organizations that have invested a

lot of time and money into measure development. This monetary investment represents the “sunk costs” an organization would forgo if the measures were to become public, as they certainly would if they went through the NQF’s consensus process.

One way to evaluate the NQF’s success is by the number of measures that go through its consensus process. The more measures that go through the process, the more likely the NQF is achieving success in reducing fragmentation. Encouraging the member organizations that develop and maintain performance measures to put their measures through the NQF’s consensus process is key; the NQF is doomed to failure if these bodies do not participate. It is, however, a challenge for two reasons. First, the development of performance measures is resource intensive and therefore represents sunk costs for the organizations that develop and maintain these measure sets. Depending upon what type of measure is being developed, the cost could range from \$500,000 to \$4 million, which includes measure refinement, testing, and analysis. The process is also lengthy – it takes anywhere from two to five years to develop a measure, depending upon the amount of testing to be completed. As one interviewee put it, organizations that may want to put their measure sets through the NQF’s consensus process have to “be prepared to forfeit or sacrifice some of the economic investment they’ve made in a particular measure set.” Second, some organizations are leery of bringing some measure sets through the NQF’s consensus process because they would become part of the public record. According to one participant, the NQF has struggled to develop a policy on proprietary measures:

Basically, the policy states that any organization that wants to have a set of measures endorsed has to agree that they are open source and that there is no cost to access those measures beyond maybe the cost of aggregating the data with a vendor for reporting purposes. And that’s made it very difficult, for example, for the NCQA to see an economic rationale for bringing the HEDIS [Health Plan Employer Data Information Set] measures through NQF which would get them the imprimatur of the NQF consensus and make them compliant with the Technology Transfer Act if CMS ever wanted to mandate those measures. But, because they would have to make them open source, as opposed to a proprietary source of revenue for NCQA, they’ve been reluctant to bring those through.

Many organizations have spent a considerable amount of time and money to develop and test their measure sets, and because of the NQF’s current policy on proprietary measures, many

organizations would lose potential sources of revenue if they were to take their measures through the NQF's consensus process.

Conclusion

It is important for a network organization like the NQF to increase the support and buy in of its member organizations, or it risks losing the support of the very member organizations it depends on for resources and expertise and long-term survival. This chapter examines how Kizer was responsive to external values and, by building those values in to the NQF's consensus process, took the first steps toward creating a sustainable organization. The NQF's CDP is fragile, especially in the beginning, and the key to dealing with fragility is responsiveness. This chapter highlights five dimensions of responsiveness: creating a participatory framework, choosing the first project judiciously, creating a nimble project, ensuring a fair and legitimate project, and engaging in continuous improvement. By creating a framework that would show that the NQF would be responsive to its members' concerns by making needed changes to its consensus process, Kizer lent increased legitimacy and value to the NQF's consensus process.

CHAPTER EIGHT CONCLUSION

Introduction

The NQF was created by the health care industry to address problems of quality. Health care leaders envisioned that the NQF would bring diverse stakeholders together and facilitate a focused, coordinated effort to develop a national, standardized system of performance measurement to improve health care quality. With its emphasis on cross-sector collaboration by diverse stakeholders, the NQF represents the type of network organization we are seeing more of as the public and private sectors work together to address complex policy problems. Network organizations such as the NQF raise a number of interesting research questions for scholars and practitioners. While many public administration scholars recognize the growing importance of networks as a management tool (O'Toole, 1997; Kickert, 1997; Agranoff & McGuire, 2001), they are just beginning to explore empirically leadership and management in networks.

This dissertation tells the story of how Dr. Kenneth W. Kizer, as the NQF's first President and CEO, built this NAO and presents the results of an empirical study of the critical tasks of the NQF's President and CEO during its formative stages. The critical tasks Kizer engaged in during these formative years included defining the NQF's mission in a way that appealed to a broad spectrum of health care stakeholders, building the NQF's social base, and creating and modifying the NQF's CDP.

The purpose of this chapter is to summarize the major findings from this foray into network leadership, discuss some of broader implications of these findings for students of public administration, outline some of the NQF's accomplishments and challenges, suggest some hypotheses to test regarding the critical tasks of a network leader during an NAO's formative years, and provide an overview of future research directions.

Major Findings

In *Leadership and Administration: A Sociological Interpretation*, Selznick (1984) distinguishes between routine tasks (the domain of managers) and critical tasks (the domain of leaders). My dissertation research focuses on the latter and presents the results of an empirical study of the leadership tasks the NQF's President and CEO engaged in during its formative stages. The findings from this study indicate that Kenneth W. Kizer engaged in three tasks

during the NQF's early years: defining the NQF's mission, building its social base, and creating and modifying the CDP.

The first critical task Kizer engaged in was to define the NQF's mission. The mission becomes the common purpose that ties the disparate groups in the network together. In order to build a sustainable network, a leader must create an organization's mission with its intended audience in mind. Kizer and others framed the quality problem as one that could not be solved unless the disparate organizations in health care could come together and discuss and debate alternatives. Kizer viewed the NQF as the "national coordinating body for health care quality." In framing the issue this way, he defined the NQF's purpose in a way that would appeal to a wide variety of health care stakeholders.

Kizer then turned to the critical task of building the organization's social base. Building the NQF's social base included assembling a staff and recruiting organizations to join the NQF. Kizer engaged in three activities in order to build the NQF's social base. He initially served as the main outreach mechanism for the NQF and, in this capacity, he communicated the newly developed mission to potential members and encouraged them to become members of the NQF. He did this primarily through speeches and writing and publishing articles about the NQF. In 2000 alone, Kizer gave over one hundred speeches about the NQF to various health care stakeholders, he also spoke informally with others and persuaded them to join the NQF. Whether speaking or writing, Kizer consistently articulated the same message about the NQF to the various stakeholder groups—that the Forum values diversity, participation, and cooperation and seeks to institutionalize these values in its quality improvement activities. Kizer also chose the Never Events project, the NQF's first project, strategically. Kizer thought that the choice of the Never Events project would signal that the NQF was serious about its goal of improving health care quality and recognized that the project's significance would most likely attract broad buy-in from a number of groups. He was correct on both counts.

There are some challenges inherent in building a social base that Kizer had to confront. For example, potential member organizations want to know why they should spend the money to join such a new organization. To attract organizations to the NQF, Kizer focused on offering incentives to potential member organizations. Such incentives included finding high profile, well-known individuals in health care, such as Lucien Leape (an internationally recognized leader of the patient safety movement) who Kizer asked to serve as chair of the Never Events

Steering Committee. In trying to “recruit the rock stars” of the health care industry, Kizer hoped that the strategy of “if you build it, they will come” would attract members and staff. Indeed, several interviewees noted that it was the quality of the individuals who were initially involved in the NQF that motivated them to join the NQF.

Kizer’s third critical task was to create the NQF’s CDP and modify it as needed based on experiences as projects went through the process. In creating the NQF’s CDP, Kizer had to be responsive to external cues, including taking into account the views of the different stakeholders and considering the NQF’s mission and goals. In designing the CDP, Kizer incorporated five design principles into the process. These include: creating a participatory framework, choosing the NQF’s first project, ensuring a fair and legitimate process, creating a nimble process, and incorporating a spirit of continuous improvement into the process. As good as the NQF’s CDP is, it is not perfect, and two challenges still exist: the process is time-consuming and there may be sunk costs for organizations that are considering putting their measures through the process.

The NQF’s Accomplishments and Challenges

Since its establishment, the NQF has accomplished much. First, there is some evidence that the NQF is making some headway in institutionalizing the value of quality throughout the healthcare system. The best examples of this can be seen in the passage of laws in several states and the requirement by several healthcare organizations for mandatory reporting on the 27 medical errors identified by the NQF as the most egregious. This accomplishment alone demonstrates that the goal of trying to improve health care quality is not hopeless. A second accomplishment is that the NQF has been able to do what no one has done before; that is, it has provided a forum for stakeholders with diverse perspectives to sit down together and discuss, debate, and develop consensus around measures in very contentious areas. A final accomplishment and, perhaps the most significant one, is that the NQF still exists. After all, the NQF was created as an experiment to address issues of quality in health care and no one was quite sure how it would work out.

Despite these accomplishments, several significant challenges remain for the NQF. One of the challenges I mentioned earlier is what one NQF observer stated is the country’s “undetermined commitment to quality improvement.” Several interviewees indicated that while policymakers might pay lip service to improving health care quality, the goal of actually

improving quality is not high on their agenda, and there is a reluctance to put money toward the effort. As it looks to the future, leadership and governance issues continue to present a challenge to the NQF. A key concern is the type of leadership style the NQF requires as it moves forward. The skills a leader possesses to start an organization may not be the skills needed to lead the organization into the future. In 2005, Kizer departed from the NQF, and Janet Corrigan took the helm as the NQF's President and CEO.

Hypotheses Related to the Three Critical Leadership Tasks

The results of this foray into the critical leadership tasks required for the formation of an NAO can be used to guide scholars as they investigate this phenomenon in the future. From this research, I have developed six testable hypotheses. The six hypotheses fall into the three areas that this identifies as important leadership tasks during an NAO's formation: defining an NAO's mission, building and maintaining an NAO's social base, and creating and modifying an NAO's decision-making process.

Defining an NAO's Mission

Defining a mission is important for almost any organization; it outlines an organization's goals provides a roadmap for the organization to achieve its goals. Thus, one could predict the following:

Hypothesis 1: During an NAO's formative stages, an NAO leader will define the NAO's mission.

This research also indicates that developing and defining a mission that will attract the buy-in from a broad group of stakeholders is integral to creating an NAO that will be well equipped to address complex policy problems. Therefore, I posit the following hypothesis:

Hypothesis 2: During an NAO's formative stages, an NAO leader will engage diverse stakeholders in mission development.

Building and Maintaining an NAO's Social Base

Encouraging individuals and organizations with a variety of skills and resources to join and participate in an NAO's activities is integral to its long-term success in confronting complex policy problems. This suggests the following:

Hypothesis 3: During an NAO's formative stages, an NAO leader will build an NAO's social base.

A new organization does not have a track record of accomplishments. This may affect an NAO's ability to attract members and staff. This research indicates that an NAO in its developmental stages might have to get creative about the means it employs to attract members and staff and, therefore, suggests:

Hypothesis 4: During an NAO's formative stages, an NAO leader will offer incentives to recruit members and staff.

Creating and Modifying an NAO's Decision-Making Process

This research indicates that developing a decision-making process for the NAO was crucial to its ability to make strides in quality improvement. If an NAO wants to make headway in addressing complex problems, one might presume that the existence of a decision-making process that enables the participants to make decisions in a fair and equitable manner would facilitate this goal. This suggests:

Hypothesis 5: During an NAO's formative stages, an NAO leader will develop a decision-making process for the NAO.

The NQF's CDP, with its emphasis on broad participation and consensus, lends it an air of legitimacy. In designing the NQF, Kizer took cues from the environment in terms of which values should be emphasized in the NQF's CDP. In the NQF's case, several values were deemed important, including fairness, broad participation, and consensus, and Kizer strove to design a decision-making process that embodied these values. Therefore, one could predict the following:

Hypothesis 6: In developing an NAO's decision-making process, an NAO leader will be responsive to external conditions by incorporating decision principles that reflect those conditions into the NAO's decision-making process.

Implications

This study is important for two reasons. First, although scholars have studied why and how network organizations form, they have paid much less attention to the critical tasks of a network entrepreneur during the early stages of building a network organization. Indeed, as discussed in Chapter Three, there is a paucity of empirical studies about network management. There are also no studies such as this one that discuss the critical tasks network entrepreneurs undertake in order to build a network organization. While Agranoff and McGuire have perhaps the best-developed theory of network management, their theory suffers in that it is not grounded

in empirical analysis. This study is different, because it is grounded and therefore expands and deepens the existing network management and leadership in networks literature by delineating the key tasks a network entrepreneur engaged in during an NAO's formative stages.

Second, this research provides some insight into the question of whether the tasks of a network leader differ from those of managers of traditional organizations, especially during the stages of organization- or network-building. The assumption has been that network leadership is a different animal from bureaucratic leadership. Agranoff and McGuire argue, for example, that managing a network is so different from managing a hierarchical organization that network management needs its own POSDCORB. I went into this research expecting to find that network entrepreneurs and bureaucratic leaders engage in different tasks during organizational development. I found the opposite. The findings from this study indicate that network management tasks are not really that different from traditional management tasks and, therefore, challenges the notion that we need a POSDCORB for network management.

The two types of leaders engage in very similar activities. At one level, the tasks are similar, but at another level they are distinguished by the degree to which a network entrepreneur and a bureaucratic leader engages in these activities. This is where the difference is strong. For example, both network entrepreneurs and bureaucratic leaders must build relationships with diverse stakeholders. The difference, however, is that an NAO must look farther and wider than a bureaucratic organization for its social base. Imagine some of the tasks AHRQ's director engages in and compare those to the NQF's president. AHRQ's director is assured of a budget line each year. She has access to the resources needed to pay staff, and she has a well-structured civil service system from which to hire staff. On the other hand, Kizer did not have guaranteed access to these resources; he had to build a social structure that would enable the NQF to draw-on and share resources with other organizations. Related to this is the idea of creating organizational culture. Both leaders must create culture, but again the network leader must develop a mission statement that will appeal to a broader, more diverse set of stakeholders.

Conclusion and Future Research Directions

To summarize, Kizer engaged in three critical tasks: defining the NQF's mission, building the NQF's social base, and creating and modifying the NQF's CDP. Much of Kizer's work involved the careful orchestration of the multiple agendas and interests of the diverse

stakeholders in health care. The results of this research indicate that leadership is crucial to creating and establishing an NAO.

This research indicates that leadership in an NAO is worth further exploration and raises additional questions that are worth exploring. This research has yielded a number of testable hypotheses that other scholars can use as a jumping off point for exploring the critical leadership tasks associated with NAO development in other NAOs. The hypotheses presented in this chapter may be used to test whether the critical leadership tasks identified in this research are similar in other NAOs.

Another natural extension of this research would be to focus on delineating a leader's tasks as a network moves through its organizational life cycle. Some of the questions to explore would include: What are the critical tasks of a leader at each stage? What type of leadership style is needed at each stage? How do the tasks identify compare with those of leaders of traditional, hierarchical organizations?

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Appendix A Examples of Memos

Memorandum One

TO: Joe Rees

FROM: Bryce Hoflund

DATE: February 25, 2003

SUBJECT: Linking Interview Questions to Concepts in the Literature

I. Doig and Hargrove Checklist

Following is the checklist of activities that Doig and Hargrove provided for their authors to follow in studying their subjects. To what extent, and how, did our executives:

1. identify *new missions and programs* for their organizations;
2. develop and nourish *external constituencies* to support the new goals and programs, and to support the organization generally, while neutralizing existing and potential opposition;
3. create *internal constituencies* that supported the new goals (while eliminating opposition), through changes in organizational structures, in recruitment systems and key appointments, and in reward and penalty systems;
4. enhance the organization's *technical expertise* (through recruitment of skilled personnel and addition of new equipment) in order to improve its capacity to identify and develop interesting program options, and to implement new goals and programs;
5. *motivate and provide training for members* of the organization so that they would have the skills to work efficiently in old and new program areas and the desire to extend their efforts beyond standard or accepted levels of performance; and
6. systematically scan organizational routines, and points of internal and external pressure, in order to *identify areas of vulnerability* (to mismanagement and corruption and to loss of the leaders' own power and position), followed by remedial action.

II. Interview Questions

I organized my interview questions around each of the six areas:

1. New Missions and Programs

As stated in a recent NQF Update e-mail, the NQF is revising its mission statement and asking for member input. Why does the NQF mission need to be changed?

What is the process for changing it?

Who will be involved in that process?

What are some of the debates or issues that might arise during this process?

What is the process by which new projects are chosen?
Who are the key players involved in the decision?
What are some of the important factors that influence a project being chosen?
What have been some of the biggest challenges or disagreements involved in choosing new projects?
How are they resolved?

Have there been any projects that were rejected?
What were they?
Why were they rejected?

What role does K.K. play in soliciting and/or choosing projects?

2. External Constituencies

In some of my previous interviews, people mentioned that such organizations and individuals as Gail Warden, the United Hospital Fund, RJW, and AHRQ got involved in NQF initially. How did they learn about the NQF?

Why do you think these member organizations initially joined the NQF?
What were some of their goals or strategies in joining the NQF?
What were some of the biggest challenges in getting member organizations to join the NQF?
How were they resolved?

In some of my previous interviews, people mentioned key players, such as Lucian Leape, that got involved in the Never Events project initially. Who were some others that got involved in this project?

How did they hear about this project?
Why do you think they got involved initially in this project?
What were some of their goals or strategies in becoming involved with this project?

What are some of the strengths of the NQF in dealing with member organizations?
Where do you see room for improvement in dealing with member organizations?

Tell me about K.K.'s role in dealing with member organizations.
What are some of the most important ways he gets involved?
Would it make a difference if he wasn't involved?

3. Internal Constituencies

Why was it decided that the NQF would be governed by a Board of Directors?
Who was involved in making this decision?
What were some of the key debates?
How were they resolved?

How were members of the Board originally recruited?
Who was involved in that process?
What were they looking for?

Why was it decided that member organizations would participate in the NQF through Member Councils?

Who was involved in making this decision?

What were some of the key debates?

How were they resolved?

What is the process by which staff positions are filled?

How were staff members originally recruited?

Who led the process?

When you hire new staff, what do you look for?

What was K.K.'s role in all of this?

4. Technical Expertise

Tell me about the role of professional expertise in the organization.

What kinds of expertise are important to the NQF?

Why?

How?

Examples?

Why do you think K.K. was asked to head the NQF?

What are the most important contributions K.K. makes?

How would the NQF be different if K.K. wasn't involved?

5. Motivate and Provide Training for Members

What type of training, literature, etc. do new Board members receive? In other words, how are they socialized into the NQF?

Member organizations?

Staff?

Initially, what were some of the staff's most important tasks?

Have they changed over time?

If so, how?

Why did they change?

How would you characterize K.K.'s leadership style?

What are some of his strengths?

Where do you see room for improvement?

6. Identify Areas of Vulnerability

Was there any initial opposition to the NQF?

What were some of the key debates?

Who were some of the key players?

How were they resolved?

During some of my previous interviews, several people mentioned that the NQF faces a major challenge in terms of funding. What are some of the other challenges facing the NQF?

Why are they significant?

How does K.K. in particular deal with some of these challenges?

Memorandum Two

TO: Joe Rees

FROM: Bryce Hoflund

DATE: July 1, 2003

SUBJECT: Kizer's Leadership Tasks

I categorized Kizer's tasks according to the Doig and Hargrove framework and Selznick's ideas about routine and critical tasks (see I. and II. below) and started linking his tasks to theory (See III. below).

I. Kizer's Leadership Tasks (Doig and Hargrove)

1. identify *new missions and programs* for their organizations;
 - a. Shaping the vision and mission of the organization
 - b. Identifying which projects to take on—developed criteria for how new projects are chosen
 - c. Sets the agenda for the NQF
2. develop and nourish *external constituencies* to support the new goals and programs, and to support the organization generally, while neutralizing existing and potential opposition;
 - a. Presents the mission and vision of the NQF to other individuals and groups—he sells the NQF by educating others and writing and publishing articles describing the purpose and role of the NQF, providing updates on projects, and outlining the needs in quality measurement and improvement and patient safety
 - b. Encourages others to join the NQF
 - c. Encourages/facilitates dialogue
3. create *internal constituencies* that supported the new goals (while eliminating opposition), through changes in organizational structures, in recruitment systems and key appointments, and in reward and penalty systems;
 - d. Developed the consensus process
 - e. Facilitates common ground between groups or individuals when disputes arise
 - f. Encourages/facilitates dialogue
 - g. Strives to maintain balance between the Board and the member organizations
4. enhance the organization's *technical expertise* (through recruitment of skilled personnel and addition of new equipment) in order to improve its capacity to identify and develop interesting program options, and to implement new goals and programs;

5. *motivate and provide training for members* of the organization so that they would have the skills to work efficiently in old and new program areas and the desire to extend their efforts beyond standard or accepted levels of performance; and
 - h. Hired initial staff
 - i. Delegates authority to staff for projects
6. systematically scan organizational routines, and points of internal and external pressure, in order to *identify areas of vulnerability* (to mismanagement and corruption and to loss of the leaders' own power and position), followed by remedial action.
 - j. Modifies the consensus process in response to concerns that may arise
 - k. Ensures that projects are conducted according to the dictates of the consensus process

Related to Character

- Known as someone who can get things done in a relatively short period of time
- Previously developed patient safety program at the VA which is looked at as a model
- Staff have come to the NQF because of him—has a track record of actually doing things and making change—there's a weight attached to what he does
- Staff interviews also imply that many of the members are participating because of him
- He drives the organization intellectually

II. Kizer's Routine and Critical Tasks (Selznick)

Shaper

- Developed the initial Never Events list—in turn shaped the dialogue that followed (see below)—Routine
- Reviews/changes products before they go out the door—Routine
- Establishing but more often overseeing and signing off on policies—Routine
- Develops mission/vision for the organization—Critical
- Sets the agenda for the NQF—Critical

Facilitator

- Encourages/facilitates dialogue—Critical
- Facilitates common ground between groups or individuals when disputes arise—Critical
- Developed the initial Never Events list, which started the dialogue between members involved with the project—Routine
- Strives to maintain balance between the Board and the member organizations—Critical

Enabler—Finding Projects

- Developed criteria for how new projects are chosen—Critical
- Conversations with individuals turn into projects—Routine
- Works out the details of the projects (funding, scope, etc.) after the above occurs—Routine

Manager—Project Management Tasks

- Leads the projects in concept—Critical
- Is visible—out there pushing and/or publicizing the project—Routine
- Hiring initial staff—Routine
- Taking the “hits” for staff at the Board level—Routine
- Delegates authority to staff for projects—Routine

Seller of the Organization—Outreach Tasks

- Presents the mission and vision of the NQF to other individuals and groups—he sells the NQF by educating others and writing and publishing articles describing the purpose and role of the NQF, providing updates on projects, and outlining the needs in quality measurement and improvement and patient safety
- Encourages others to join the NQF—Routine

Developer—Consensus Process Tasks

- Developed the initial consensus process—Critical
- Ensures that projects are conducted according to the dictates of the consensus process—Routine
- Modifies the process to respond to issues that may arise—Critical

III. Discussion

Selznick distinguishes between a leader’s routine and critical tasks. Routine tasks are those that deal with day-to-day decisions. In other words, routine tasks “have to do with the conditions necessary to keep organizations running at efficient levels” (Selznick, 1984, p. 31). Broadly stated, these routine tasks do not affect the character or long-term goals of an organization. Critical tasks, on the other hand, affect not only institutional development, but the very character of an organization. Selznick argues that critical tasks are at the heart of leadership, stating: “it is the function of the leader-statesman—whether of a nation or a private association—to define the ends of group existence, to design an enterprise distinctively adapted to these ends, and to see that that design becomes a living reality” (Selznick, 1984, p. 37). Selznick identifies several key tasks performed by leaders: the definition of institutional mission and role, the institutional embodiment of purpose, the defense of institutional integrity, and the ordering of internal conflict (Selznick, 1984, p. 62).

As leaders make more and more of these critical decisions, institutionalization occurs. Selznick argues: “In this sense, the leader is an agent of institutionalization, offering a guiding hand to a process that would otherwise occur more haphazardly, more readily subject to the accidents of circumstance and history” (Selznick, 1984, p. 27). Over time, an institution moves towards “thick” institutionalization. In order to understand this change, it is necessary to explain institutionalization. Selznick argues that institutionalization first occurs with a formal act, such as the adoption of a rule or statute (Selznick, 1992, p. 232). He argues, however, that the formal development of an institution is only part of the story. As an organization becomes institutionalized, it takes on a distinctive character or function and becomes “infused with value beyond the technical requirements of the task at hand” (Selznick, 1984, p. 233). This is part of a two step process...the first step being the formal creation of an organization described above. The second part can be described as “thick institutionalization,” which represents the creation of

an informal structure of an organization. This informal structure is “composed of attitudes, relationships, and practices that arise in the course of social interaction—as individuals and groups bring into play their own personalities, values, and interests” (Selznick, 1984, p. 235). As Selznick warns, however, the appearance of an informal system does not diminish the importance of the formal system. In a sense, the informal system upholds the formal system and this “operative system” as Selznick calls it “is the focus of institution-building” (Selznick, 1984, p. 235).

One can see this phenomena occurring in the NQF. The above list outlines some of Ken Kizer’s routine and critical tasks, according to Selznick’s framework. Kizer’s routine tasks include hiring staff, reviewing products before they go out the door, ensuring that policies are followed, etc. These tasks represent the day-to-day decisions that keep the organization functioning. On the other hand, three tasks on the above list jump out as critical—defining the mission and vision of the NQF, selling the NQF, and developing and modifying the consensus process. Each of these tasks affects the long-term character of the organization.

Appendix B

Interview Guide One

Introductory Question

Please tell me a little about yourself and how you got involved in the NQF.

History of the NQF

Why was the NQF created?

Who were the key players?

Why did they get involved?

What were their significant contributions?

What would you have liked to see them contribute that they didn't?

What were some of the key debates?

What were some of the biggest challenges?

How were they resolved?

The NQF's Never Events Project

Why did the NQF undertake this project?

Who were the key players?

Why did they get involved?

What were their significant contributions?

What would you have liked to see them contribute that they didn't?

What were some of the key debates?

How were they resolved?

What government agencies were involved?

What was their role?

What were their significant contributions?

What would you have liked to see them contribute that they didn't?

Please describe the process by which the core measures were developed.

How was this process developed?

Who was involved?

What were some of the issues involved in its development? (i.e., what is consensus?)

Did this process change over time? If so, how?

Project Management

Please tell me about the day-to-day management of this project.

How does it work?

Was there a process for deciding who would be responsible?

What was that process?

Did their responsibilities change over time?

Were there any records kept of this project? If so, what are they?
What's in them?
Where are they?

What were the major administrative challenges of the project?
How were they resolved?

What improvements could be made to the process?

Who are some good people to talk to about this project?
May I use your name when contacting them?

To develop an in-depth understanding of the NQF and its Never Events project, what documents should I read?

Concluding Questions

What are the major challenges facing the NQF?
What do you like the most about the NQF?
Where do you see room for improvement?
BTW, can I talk to you further?

Appendix C

Interview Guide Two

New Missions and Programs

As stated in a recent NQF Update e-mail, the NQF is revising its mission statement and asking for member input. What's going on?

What will be the process for changing it?

Who will be involved in that process?

What are some of the debates or issues that might arise during this process?

Who defined the original mission?

What were some of the debates surrounding the development of the mission?

How were they resolved?

What is K.K.'s vision for the NQF?

Tell me how new projects are chosen.

Who are the key players involved in the decision?

What are some of the important factors that influence a project being chosen?

What have been some of the biggest challenges or disagreements involved in choosing new projects?

How were they resolved?

Have there been any projects that were rejected?

What were they?

Why were they rejected?

What is K.K.'s role in soliciting and/or choosing projects?

Member Organizations

I'd like to discuss the member organizations and the role they play in the NQF. In some of my previous interviews, people mentioned that such organizations and individuals as Gail Warden, the United Hospital Fund, RJW, and AHRQ got involved in NQF initially. Which of these organizations/individuals are you most familiar with?

How did they learn about the NQF?

Why do you think they joined the NQF?

What were some of the reasons they joined the NQF?

What were some of the biggest challenges in getting member organizations to join the NQF?

How were they resolved?

Now I'd like to talk a little about the Never Events project. In some of my previous interviews, people mentioned key players, such as Lucian Leape, that initially got involved in this project—I've been told that they were chosen because they had name recognition and credibility. Does this ring true to you? What do you mean by recognition and credibility? Why is each important to the NQF?

Are there any other individuals that fall into that category?

Tell me how and why they got involved.

How did they hear about this project?

Why do you think they got involved in this project?

Motivations?
Goals?
Incentives?

I'd like to switch gears for a moment. How would you characterize the NQF's relationship with member organizations? (Some possible ways of thinking about relationships—Combative, Adversarial, Cooperative, Open)

What kinds of member organizations have the best relationship with the NQF?

Why?

Any that are strained? Examples?

Where do you see room for improvement in dealing with member organizations?

Tell me about K.K.'s role in dealing with member organizations.

What are some of the most important ways he gets involved?

Would it make a difference if he wasn't involved?

Have there been any power struggles between the member organizations?

Examples?

How have they been dealt with?

Have any organizations left the NQF? Tell me about it.

Has it made any difference for the NQF? What?

All membership organizations have some organizations that are strongly committed to the organization and others that are weakly committed. Do you take any special steps to deal with those weakly committed organizations and keep them on-board?

Key Organizational Actors in the NQF's Environment

I'd like to discuss the other key organizational actors in the NQF's environment. Which organizations or individuals are you most familiar with?

Which governmental organizations or individuals are the most significant ones?

What makes them significant?

How did they learn about the NQF?

How would you characterize the NQF's relationship with them?

Which NQF projects are they most interested in? Why?

In what ways do they impact the NQF?

Which non-governmental organizations or individuals are the most significant ones?

What makes them significant?

How did they learn about the NQF?

How would you characterize the NQF's relationship with them?

Which NQF projects are they most interested in? Why?

In what ways do they impact the NQF?

Tell me a little bit about the politics between or among these organizations?

Any Power Struggles?

Examples?

How have they been dealt with?

What is K.K.'s role in relation to these individuals or organizations?

Board of Directors

I'd like to switch topics and discuss the organizational structure of the NQF. Tell me about the Board of Directors.

Who was involved in making the decision to have the NQF governed by a Board?

What were some of the key debates?

Were any alternative forms of governance considered?

How were they resolved?

How were the members selected?

Who was involved in that process?

What were they looking for?

What role did K.K. have in selecting Board members?

What have been some of the main kinds of issues discussed at this level?

Examples?

How have they been dealt with?

What type of training, literature, etc. do new Board members receive? In other words, how are they socialized into the NQF?

Member Councils

Turning now to the Member Councils—what is the idea behind the Member Councils? Where did that idea come from?

Who was involved in making this decision?

What are some of the strengths of the Member Councils?

Weaknesses?

Were any alternative forms of governance considered?

What is K.K.'s role in relation to the Member Councils?

What type of training, literature, etc. do new member organizations receive? In other words, how are they socialized into the NQF?

I'd like to get more specific and talk about each Member Council.

Consumer Council

What is the purpose behind having consumer organizations in the NQF? What are you hoping to accomplish by involving them in the NQF?

What type of consumer organizations do you want to join the NQF and which kinds do you not want to join?

Examples? Why?

What would you say are the consumer organizations most important tasks?

What resources do they bring to the organization?

What expertise do they bring to the organization?

What are some of the most important contributions they've made to the NQF?

What are some of the challenges in working with consumer organizations?

What is K.K.'s role in relation to the Consumer Council?

Purchaser Council

What is the purpose behind having purchasers in the NQF? What are you hoping to accomplish by involving them in the NQF?

What type of purchaser organizations do you want to join the NQF and which kinds do you not want to join?

Examples? Why?

What would you say are the purchasers most important tasks?

What resources do they bring to the organization?

What expertise do they bring to the organization?

What are some of the most important contributions they've made to the NQF?

What are some of the challenges in working with purchasers?

What is K.K.'s role in relation to the Purchaser Council?

Provider and Health Plan Council

What is the purpose behind having providers and health plan organizations in the NQF?

What are you hoping to accomplish by involving them in the NQF?

What type of providers and health plan organizations do you want to join the NQF and which kinds do you not want to join?

Examples? Why?

What would you say are the providers and health plan organizations most important tasks?

What resources do they bring to the organization?

What expertise do they bring to the organization?

What are some of the most important contributions they've made to the NQF?

What are some of the challenges in working with providers and health plan organizations?

What is K.K.'s role in relation to the Provider and Health Plan Council?

Research and Quality Improvement Council

What is the purpose behind having research and quality improvement organizations in the NQF? What are you hoping to accomplish by involving them in the NQF?

What type of research and quality improvement organizations do you want to join the NQF and which kinds do you not want to join?

Examples? Why?

What would you say are the research and quality improvement organizations most important tasks?

What resources do they bring to the organization?

What expertise do they bring to the organization?

What are some of the most important contributions they've made to the NQF?

What are some of the challenges in working with research and quality improvement organizations?

What is K.K.'s role in relation to the Research and Quality Improvement Council?

Staff

Now I'd like to discuss staff recruitment. What types of individuals were you looking for initially?

What are some of the important things you look for in staff? Why?
How were staff members originally recruited?
Who led the process?
What were the biggest challenges involved in staff recruitment?
What was K.K.'s role in all of this?

Originally, what were some of the staff's most important tasks?
Have they changed over time?
If so, how?
Why did they change?

What type of training, literature, etc. do new staff receive? In other words, how are they socialized into the NQF?

Technical Expertise

Tell me about the role of professional expertise in the organization. In some organizations, for example, the expertise of doctors is extremely important, while in others, lawyers have a greater influence.

What kinds of expertise does the NQF need the most?
Why?
How?
Examples?
What are some of the challenges in getting that expertise?
Does any one professional group have the most influence in the NQF?
Why?
How?
Examples?

Leadership

I'd like to turn to the leadership of the NQF. Why do you think K.K. was asked to head the NQF?

How was he chosen?
Who was involved in the selection?
Were there any others considered for his position?
What are the most important qualities K.K. brings to the NQF?
How would the NQF be different if K.K. wasn't involved?

How would you characterize K.K.'s management style?
Has his style changed over time?
How?
Why?

What are some of his strengths?
Where do you see room for improvement?

What would you say are his most critical tasks in relation to the Board? Why?
Examples?

Member Councils? Why? Examples?
Staff? Why? Examples?
Which tasks does he spend the most time on? (Top 3)

Challenges

What have been the NQF's most significant accomplishments? Why?
What have been some of the biggest disappointments? Why?

Funding

During some of my previous interviews, several people mentioned that the NQF faces a major challenge in terms of funding. Does this make sense to you?

Why is the NQF having a hard time getting funding?

How does it affect its ability to do its job?

Who's involved in fundraising for the NQF?

To really do its job right how much money would it take?

What would the NQF do differently?

What's K.K.'s role in funding for the NQF?

Other Big Challenges

What are some of the other challenges facing the NQF? (Maybe probe implementation issue—based on previous interviews—does this make sense to you?)

Why are they significant?

How does K.K. in particular deal with some of these challenges?

Overall, what have been the biggest challenges to K.K.'s leadership?