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PERCEPTIONS OF TRUSTWORTHINESS IN THE EXECUTIVE DIRECTOR OF A SMALL

COMMUNITY HEALTH CENTER: IMPLICATIONS FOR ORGANIZATIONAL

DIRECTION

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Norm Jay Jones

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The dissertation of Norm Jones was reviewed and approved by* the following:

William J. Rothwell
Professor of Education
Dissertation Advisor
Chair of the Committee

Wesley E. Donahue
Associate Professor of Management Development

Judith A. Kolb
Associate Professor of Education

Keith B. Wilson
Professor of Education

Richard A. Walter
Associate Professor of Education
Professor-in-Charge of Graduate Programs in
Workforce Education and Development

*Signatures are on file in the Graduate School

ABSTRACT

Trust is a topic that has evolved from more of a psychological phenomenon associated primarily with personal relationships to a more broadly understood variable in development and maintenance of workplace relationships. Trust and trust development are key to defining the scope of both transactional and transformational relationships between people and groups within the workplace. This qualitative case study explores the subtopic of interpersonal trust— which is simply a delineation that indicates an exchange relationship which exists over time, and the ways in which five individuals associated with a small community health center perceive the executive director of the Center in the context of trustworthiness. The study further explores the implications of these perceptions on organizational direction, specifically as it relates to the Center's current strategic plan. The analysis of the data resulted in the emergence of six primary themes: 1) the strategic plan considered in terms of administrative and board leadership, 2) organizational strategic focus areas, 3) organizational culture and leadership, 4) the senior leadership team, 5) perceptions of the executive director, and 6) perceptions of trust. These themes were synthesized into four areas of discussion: 1) its strategic focus areas as articulated in the current plan, 2) community impact, 3) leadership at the administrative level, and 4) opportunity for more intentional work around interpersonal trust development. The results reflect important connections and disconnections in the reflections of the senior leadership team, the executive director, her peer, and the chair of the board. The identification of these connections and disconnections become even more important in the context of the Center's aspiration to become a Federally Qualified Health Center (FQHC) and reflect the opportunity for further qualitative research into trust development and its implication on organizational direction.

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Chapter 1

Introduction

As leaders in primary care, community health centers (CHCs) serve as crucial partners in national health reform. The American Recovery and Reinvestment Act (ARRA) is radically changing the way healthcare is delivered in the United States, and $2 billion of the $787 billion available is allocated for one time funding for health centers.

During the White House Summit on Healthcare, President Barack Obama (as cited by the National Association of Community Health Centers' Primary Care Access Report, 2009) is quoted as saying, "The problems we face today are a direct consequence of actions that we failed to take yesterday" (p. iii). With the lofty goal of reaching 30 million patients by 2015, health centers must be more vigilant than ever in operating as viable organizations with clear strategy and vision and trusted leadership.

"The primary mission of community health centers (CHCs) is to provide primary and preventive healthcare to the underserved and vulnerable populations, including the uninsured, underinsured and Medicaid beneficiaries" (Baxter et al. 2002 , p. 376). As illustrated below in Table 1, community health centers fall under the jurisdiction of the U.S. Department of Health and Human Services. CHCs have a more than forty- year history of providing both primary and preventive or behavioral healthcare services for low-income people. The history of the centers dates back to President Johnson's War on Poverty initiative in 1965. America's health centers now serve over 20 million people in 7,000 communities in all 50 states (http://www.nachc.org).

Table 1- Hierarchical Jurisdiction of Community Health Centers
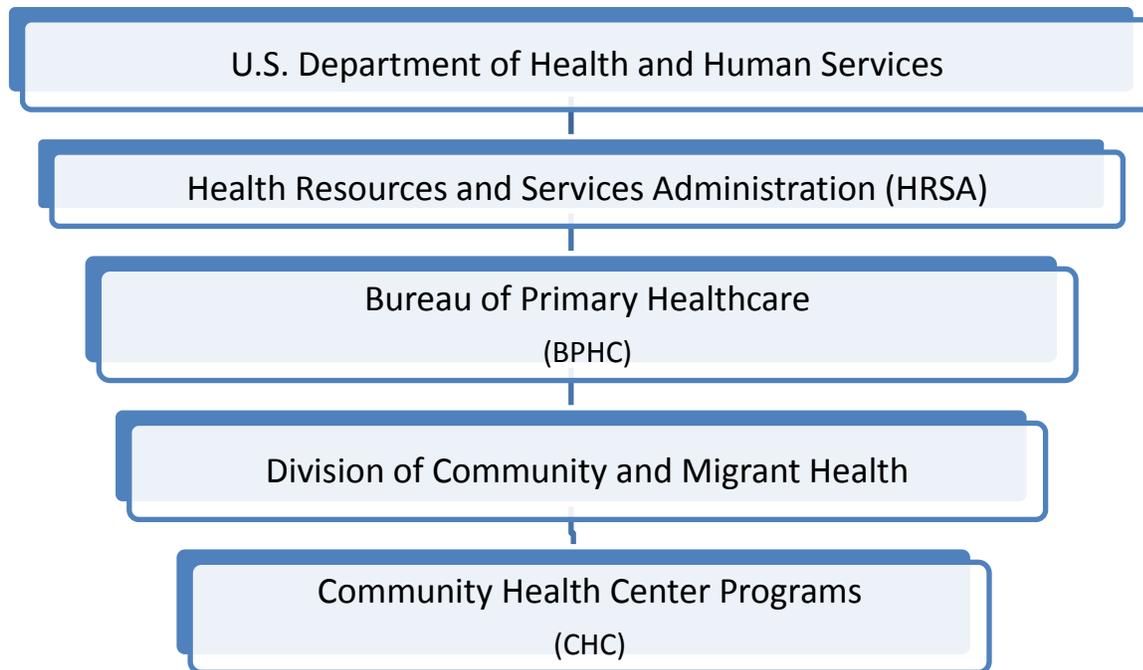
According to the March 2009 Primary Care Access report published by the National Association of Community Health Centers (NACHC), "Access to affordable primary health care has posed one of the most persistent challenges to our health care system" (p. i). Despite the fact that health centers continue to add new patients to their rolls, the number of medically disenfranchised has risen above 60 million.

Health centers have successfully narrowed particular health disparities and have demonstrated savings upwards of $18 billion annually for the national healthcare system. With the launching of the Access for All Americans plan which aspires to reach 30 million patients by the year 2015, healthcare centers stand at the forefront of a strategic national health care agenda.

This repositioning places CHCs in a much more prominent position than they had been before in terms of helping to facilitate the reform agenda. The repositioning also raises the level of accountability for CHCs to operate as forward-moving and forward-thinking organizations

with highly cohesive senior leaders. This cohesion refers to a sense of mutual understanding and affirmation of the direction in which the organization is moving and aspires to move. At the core of this mutuality, lies the question of trust. Trust in this context is distinguished specifically as interpersonal trust that will be discussed later and delineated further in this chapter.

Distrust of the interdependence of a team can erode a sense of clear forward movement in an organization. This paper examines elements of interpersonal trust relationships among senior leaders of a non-profit healthcare organization (HCO). For the sake of confidentiality the paper will refer to the organization as "The Center". The specific leadership group explored was: executive director of The Center, board of trustees chair, medical director, dental director, fiscal director, and president and CEO of the Pennsylvania Association of Community Health Centers (which represents Pennsylvania's 190 federally qualified health centers- FQHC) . This study explores perceptions of interpersonal trustworthiness among these six key group leaders and the extent to which these perceptions influence organizational direction as set forth in the strategic plan.

In the context of the larger healthcare reform conversation, why is such importance placed on community health centers? According to Sardell (1996), "In the current era of consensus about the need to replace costly inpatient care with cost-effective preventive and primary care services, there are important lessons to be learned from the experiences of the health center movement" (p. 447). This moment is the nation's history is an important time for community health centers to take a leadership role in helping communities take charge of their health. The extent to which CHCs are able to do this work is inextricably tied to each center's ability to build and sustain trust within the organization, for that trust is an important ingredient (just as important as planning) in moving the organization forward.

Building Community Within a Community Health Center

Attention to building consensus around the handling of clinical issues is absolutely

critical. As Sardell (1996) stated, "If Medicaid managed care is to reduce emergency room and

inpatient utilization, then accessible primary care services must be available" (p. 438). Lack of

attention to cultivating consensus around such important discussions leads to poor working

relationships and retention challenges, even at higher levels. The National Association of

Community Health Centers (NACHC) has been attending to this work since 1971. According to

Sardell (1996) "In the early 1990s the Department [of Clinical Affairs] engaged in a process of

defining a 'clinical issues agenda' for the organization. This agenda includes a recruitment and

retention campaign for students from elementary school through residency training, programs for

clinicians on services for special populations, the establishment of preceptorship programs at

health centers [and] greater involvement of clinicians in states and regional associations and

NACHC…" (p. 447).

Sardell (1996) further asserted, "The administrative team at a health center (executive

director, dental director, medical director, nursing director, fiscal officer) should function as a

model of collaborative team work for rest of the staff" (p. 443). The notion of collaboration and

teamwork therefore goes beyond transactional relationships and becomes a dynamic and integral

function for the operation of the overall organization. This work becomes extremely challenging

in the absence of interpersonal trust between individuals.

Trust and Healthcare

When it comes to trust, many people subscribe to the notion that trust is not freely given but must be earned. The notion of "earning" trust affirms the extensive research on the subject (Annison & Wilford, 1998; Barber, 1983; Bromiley & Cummings, 1996; Kramer et al, 1996; Lewis & Weigert, 1985; McAlister, 1995; Robinson, 1996; Tyler & Degoey, 1996b), all of which points to the fact that "we cannot survive without others. Thus, we trust because we have no choice but to depend on other people" (Shaw, 1997). The need to trust, however, does not automatically guarantee a person's trustworthiness. This disconnect has given rise to vast literature about trust, its facilitators, barriers and antecedents (Annison & Wilford, 1998; Barber, 1983; Bromiley & Cummings, 1996; Kramer et al, 1996; Lewis & Weigert, 1985; McAlister, 1995; Robinson, 1996; Tyler & Degoey, 1996b).

According to Kramer (2009), "Although social scientists have afforded considerable attention to the problem of defining trust, a concise and universally accepted definition has remained elusive" (p. 4). Trust is a topic that has been studied over the decades and transcends such disciplines as political science, sociology, psychology and economics (Gambetta, 1998; Lewicki & Bunker, 1995; Worchel, 1979) There appears, however, to be little knowledge about how the many theories behind trust in its various forms play out in an organizational context so that viable conclusions can be drawn regarding the actual role of trust in organizational settings and interpersonal relationships (Kramer, 1999).

Jack Gibb and Trust in Organizations

One of the foremost leaders in bringing understanding to the complexity of organizational dynamics was Jack Gibb, an organizational psychologist who wrote entire books devoted to the topic of trust. He is also known for his research on the Trust Level Theory, also known as TORI.

The acronym TORI stands for trusting, opening, realizing and interdepending. According to Gibb these antecedents are at the core of understanding larger systems. Trusting refers to the process of discovering one's self and through realization of one's uniqueness and own essence; therefore being who we are entails trusting ourselves. Opening refers to the process of discovering one's self and others and showing particular attributes to one another through various forms of communication. Realizing refers to the process of discovery and creating one's own path through creating an emerging nature and actualizing that nature. Interdepending refers to the process of co-creating and inter-being by discovering the ways in which we live together as an interdependent community.

Gibb asserted that under "climates of high trust" the process of discovering and creating are indistinguishable and in this context, a person, group and/or organization is a total organism capable of developing these processes (http://www.oocities.com/toritrust/chapter1.htm). Gibb also believed that certain processes which he characterized as "bodymind" processes produced certain high trust level effects: (http://www.oocities.com/toritrust.chapter1.htm)

Gibb also examined the role of motivation, consciousness, emotionality, cognition, action and synergy.

Motivation: Creates and mobilizes energy, increases strength and focus of motivation.

Consciousness: Unlocks energy flow, expands awareness, makes unconscious more available.

Emotionality: Frees feelings and emotions free to energize all processes of the bodymind.

Cognition: Frees energy for focusing on thinking and problem solving.

Action: Releases a person for proactive and spontaneous behavior.

Synergy: Frees the total person for synergistic and holistic integration.

Gibb also asserted that the presence of trust removes the need to defend. "When fears are high, the defensive processes are triggered and nourished. When my trust in myself is love and I experience little trust from my larger environment, I feel the need to defend. I discover and create my fears and my defenses" (http://www.oocities.com/toritrust.chapter1.htm)

The following four primary and interrelated elements characterize the defense process:

1. Depersonalizing: This process entails the act of moving away from one's person or a move from being personal to both discovery and creating roles, usually in response to an organizational or external pressure. The higher the trust, the more likely an individual will be to fill the role in a personal rather than a fear-driven way characterized by a lens of personal, protective coloration.

2. Masking: This process entails an increased sense of focus wherein efforts to discover and to create facades intensifies. The need to protect one's self from dangers represented by intimacy and contact are covered by these created facades, and messages are filtered and distorted. Postures are formal and distant and everything becomes hidden behind the protective coloration.

3. Oughting: This process entails a motivation to discover and create ways to meet the demands and expectations of the groups and organizations to which an individual belongs. This motivation, however, is rooted in fear and defensiveness. The context is marked by "needs" rather than wants, and the filter through which information runs is characterized purely by expectations and demands. An individual who is oughting is defensively and habitually asking what he or she should be doing rather than what he or she wants to do. An important distinction might be marked by the characterization of an

ought/need focus as rooted in power, authenticity, law, structure, rules and obligations to help solve problems as opposed to the notion of choice as rooted in one's self, flow, rhythm, and sense of being. These foci are the resources with which problems an individual chooses to face may be met.

4. Depending: This process entails a confluence of high fear and low trust wherein an individual tries to control his or her actions as well as the actions of those with whom they come in contact. The notion of control masks itself as necessary for keeping life in order therefore individuals become motivated by the creation of boundaries, legalities, rules, contracts, protective devices and other structures that represent notions of perceived control. Protection is also sought in authority but if the response of such authority is not consistent with what is being sought, rebellion and fighting may result. Both rebellion and depending "have roots in the same authority needs" (http://www.oocities.com/toritrust.chapter1.htm)

Kurt Lewin is another theorist who can be credited with bringing the psychology of people to the organizational conversation. The topic of interpersonal trust cannot be appropriately treated without acknowledging the ways in which the notion of change lies at its very core. Both the theory and practice of change management have been demarcated by the research of Lewin. Much of Lewin's work addressed the issue of social conflict, even in organizational settings; however, Lewin is perhaps best known as the creator of a planned approach to change characterized by Field Theory; Group Dynamics; Action Research; and the 3-Step Model.

Field Theory

Lewin (as cited in Burnes, 2004, p.981) believed "that a field was a continuous state of adaptation." Therefore, he believed that the ability to plot and measure the potency of these forces would facilitate better understanding of individual, group and organizational behavior as well as "what forces would need to be diminished or strengthened in order to bring about change" (Burnes, 2004, p. 982).

Group Dynamics

Lewin (as cited in Burnes, 2004, p. 982) believed that "it is not the similarity or dissimilarity of individuals that constitutes a group, but interdependence of fate." It was out of this notion of group behavior based on particular forces that the study of group dynamics was born. In the context of change, Lewin encourages focus on group dynamics rather than individual behavior. In as much as individuals face group pressures to conform, the focus of change should rest at the group level with emphasis on group norms, roles, interactions, and socialization processes.

Action Research

What is immediately noticeable about Lewin's research is that it builds upon itself. Action Research is a direct reflection of Lewin's cumulative learning about (1) Field Theory which seeks to identify the forces that focus on a group and (2) Group Dynamics which help give clarity around group behavior in the context of these forces. Action Research then necessitates that effective change take place at the group level and must be both participative and collaborative. Since the earliest projects, Action Research "has acquired strong adherents throughout the world." (Burnes, 2004, p. 984).

3- Step Model

Lewin's primary concern following the onset of Action Research was that even after particular change interventions, group performance was short-lived. This realization revealed the insufficiency of measuring the success of planned change by the achievement of reaching a different level. The notion of permanency at that level had to become the main objective. Out of this realization came the 3-Step model of change. The steps, in conjunction with the three previously discussed approaches to understanding individual and group behavior, summarize Lewin's sentiment about the planned approach to change at the individual, group and societal levels. Although the 3-Step process may not appear on the short list of models used today, the processes make sense and remain quite relevant in a contemporary context:

Step 1: *Unfreezing*. The complex field of driving and restraining forces alluded to earlier are to blame for the stabilization of human behavior. Lewin's belief was that the equilibrium in which this behavior is based needed to be destabilized or unfrozen so that old behaviors could be discarded and new behaviors could be adopted. This type of change is dynamic, difficult, and complex in that it takes place over an extended period of time and cannot be applied in the same way in all situations.

Step 2: *Moving*. Action Research is the best illustration of this step because it takes the difficulty of planned change into account. True due diligence in a planned change effort first acknowledges and considers all the forces at work and then on a trial and error basis, identifies and evaluates available options. The process of researching, acting, and researching again allows individuals and groups to make informed decisions about change.

This level of work, with specific reinforcements, allow groups to move but also enjoy the benefits of sustained (as opposed to short-lived) change.

Step 3: *Refreezing*. This third step is crucial because it calls for collective change. Lewin marked successful change as change wherein group norms and routines were transformed. In an organizational context these transformations should also be realized in organizational culture, norms, policies and practices (as cited in Burnes, 2004, p. 986).

Interpersonal Trust

Although there are many different types of trust, such as interorganizational trust (Lane & Bachmann, 2002; Kramer & Cook, 2004), interpersonal trust, and system trust (Luhman, 1979; Giddens, 1990), the focus of this study is to determine the perception of interpersonal trust in cultivating organizational relationships among four distinct group leaders in a nonprofit community health center with one individual representing community health centers at the state level. The issue that specifically distinguishes the broad concept of trust from the more focused concept of interpersonal trust as defined by Rotter (1980), Good (1988) and Luhman (1988) is that "interpersonal trust is trust that is directly engendered when two actors are involved in an exchange relationship over time" (p. 121). Boon and Holmes (1991) define trust as "a state involving confident positive expectation about another's motives with respect to oneself in situations entailing risk" (p. 194). McAllister (1995) defined interpersonal trust as the "extent to which a person is confident in, and willing to act on the basis of the words, actions, and decisions of another" (p. 25).

Trust Matters

Most people would agree that trust is critical to the formation and maintenance of a relationship. Although much of others' early research focuses on romantic relationships (Boon

& Holmes,1991; Lewicki & Bunker, 1995) the elements that are key to trust development in personal relationships are equally important in professional ones (Shapiro, Sheppard & Cheraksin, 1992).

The topic of trust is broad and complex. This complexity is exponentially magnified in the context of healthcare. The reasons for this complexity are varied but one primary consideration is that healthcare organizations operate as systems within larger systems therefore, the study of trust within a particular organization must take into account a larger system of healthcare considerations. Annison and Wilford (1998) state "Because good health is central to the quality of life, healthcare leaders have an especially strong obligation and responsibility to earn and maintain trust of the community and the patients they serve" (p. 4). This patient trust, however, is not the only important consideration in the exploration of trust in the healthcare industry. According to Annison and Wilford (1998) "Trust matters in healthcare now more than any other time in the past because there is confusion and uncertainty within the industry. The pace of change has accelerated across boundaries of many nonprofit organizations creating chaos and complexities with the healthcare system" (p. 2).

Declining Trust in Healthcare

Healthcare: What is the issue? Anyone surveying the political landscape over the past ten years knows that healthcare has become a mega-topic out of which emerges a myriad of subtopics that have fueled national and international debate around such concerns as the delivery of care (Xirasagar, 2006) access to quality services (Degling et al, 2001; Hupfield, 1997; Larson, 2002) privatization, challenges for those who are uninsured and underinsured, and many other dimensions of what has become a seemingly insurmountable issue. A growing topic of discussion is the issue of trust within the healthcare system. Whether it is the establishment or

erosion of trust between and among healthcare providers, insurance companies or physicians and patients, the role of trust is key to finding solutions or at least viable short term fixes and incremental change.

It is difficult to broach the subject of trust within the healthcare system without acknowledging the very important role that trust plays in each individual healthcare organization. This function is, after all, how such dynamics pervade a society. The trust dynamic first starts at the micro-level— interpersonal trust (no matter how pervasive) begins and ends with individual relationships (Fukuyama, 1995). Moreover, to the extent that the broad topic of trust in healthcare is seen as important—and it clearly is—there should be a greater emphasis placed on an examination of interpersonal trust manifestations at the organizational level to gauge variances in the roles trust plays, perceptions of trustworthiness between and among key groups and stakeholders and how the interpersonal dynamics of trust affect the overall direction of the organization.

A clearer picture of the "trust landscape" within organizations would facilitate more informed conversations about how these dynamics affect trust relationships outside of individual organizations, be it between healthcare organizations, between healthcare organizations and the communities they serve, between healthcare organizations and insurance companies or between healthcare organizations and the government. These trust relationships all exist on a macro-level and are core to discussions that are occurring at the state and even federal level, which would benefit from meaningful data gathering at the micro-level (data gathering at the local level within particular healthcare organizations).

Annison and Wilford (1998) posited that the restoration of trust in the healthcare system actually begins with leaders changing themselves and then working together to change the

industry. Annison and Wilford (1998) noticed that when leaders clearly articulate organizational

values, and vision statements that advocate future growth and set a strategic directional plan,

attitudes and behaviors change. Annison and Wilford identified four important elements of

discernment: a) leaders have exhausted the benefits of existing management theories about how

they should treat one another, b) tidy organizational charts on their own will not enable leaders to

accomplish what they need them to do, c) trust effects how leaders manage their people and

change and d) trust matters in relationships between healthcare professionals and the people they

serve (pp. 1-4).

These four aforementioned elements of discernment cited by Annison and Wilford speak

directly to organizational considerations as they relate to trust. Dolan (2004) contended that

building trust relationships among multiple groups of leaders within a nonprofit hospital setting

is challenging because of the important differences in how medical providers and administrators

view one another and the world around them. Understanding these differences is important

because this learning can provide insight into how to develop the trusting personal and

organizational relationships necessary to enable effective healthcare delivery.

Statement of the Problem

If we advance the notions of Boon, Holmes, Marshall and many other trust theorists, the

importance of trust in the workplace certainly cannot be denied. This paper examines the role of

trust in a specific context: perceptions of trustworthiness and its relationship to organizational

direction. Unless trust exists in an organization, empowerment is not likely to enhance

cooperation and increase organizational performance (Jones & George, 1998; Tyler & Kramer,

1996). The role of trustworthiness as it applies to personal and organizational leadership is a

topic that appears not to have been sufficiently treated in the literature about healthcare

particularly nonprofit community based healthcare. Although there is an acknowledgement that lack of trust among healthcare leaders can be identified as one of the barriers to healthcare reform, important questions still exist at the micro-level that speak to the issue of trust within individual healthcare organizations. Both employees and boards need to feel comfortable that there is a trustworthy leader at the helm of their organization.

Marshall (2000) stated: "Without trust, our relationships are merely transactions" (p. 44). This quote is profound in many ways, primarily because it illuminates a fundamental truth that has perhaps been lost in the vast sea of trust literature: trust, more than anything else, is about relationships. The use of the word transactions is an indication that many relationships especially those in the workplace are centered around an exchange that does not necessitate trust. Marshall advocates for relationship-based trust as a more viable and useful option than transactional relationships. This fundamental truth is further convoluted in the context of the organizational setting where cultures still struggle with the transformation from transactions to more relational ways of doing business; therefore, for the purpose of this paper, Marshall's key point is being used as a core definition of trust: "Trust is the fundamental building block of human relationships" (Marshall, p. 46). Various theories and other definitions will build upon this position as the research is further explained.

"However desirable trust may be, its purchase— to paraphrase Arrow (1974)— is neither easy nor assured" (Kramer, 1999, p. 587). This study promotes greater understanding regarding the importance of trust in non-profit healthcare management and the establishment, restoration and/or solidification of interpersonal trust between a healthcare executive director in a small community health center and the leaders of five key groups: medical practice, dental practice,

fiscal operation and board of directors. Additionally, this study reports on the perceptions of leaders of their own values concerning personal trust and organizational trust.

There is a need for further examination of building a culture of trust among leaders within healthcare (Deloitte, 2005). O'Grady and Mallock (2003) assert that "the most important task of a leader will be to communicate their vision, not so much by words, but by their actions and behavior." (p. 7) The relationship between healthcare executives and leader groups is an important topic to which questions regarding trustworthiness are inextricably tied. Both interpersonal and organizational trust is particularly important to this area of study.

Interpersonal Trust vs. Organizational Trust

To understand the difference between interpersonal and organizational trust the bifurcation of interpersonal trust must first be established. The foundations of interpersonal trust are divided into cognitive and affective dimensions (Lewis & Weigert, 1985). Trust is seen as cognition-based in that "we choose whom we will trust in which respects and under what circumstances, and we base the choice on what we take to be 'good reason', constituting evidence of trustworthiness" (Lewis & Weigert, 1985, p. 970).

Affective foundations of trust are characterized by emotional bonds between trustor and trustee (Lewis & Weigert, 1985). This level of trust is often as dynamic because it moves beyond the work environment. This emotional basis for trust is formed when care and concern for peers is expressed and the emotional exchange is truly reciprocal (Pennings & Worceshyn, 1987).

Six (2005) confirmed the notion of reciprocity stating that "it would be very difficult to build trust unilaterally if the other individual never reciprocates" (p. 4). There are four theoretically possible situations but only one establishes the necessary conditions for trust

building to happen successfully: A= willing to build trust, B= willing; A= unwilling to build

trust, B= unwilling; A= willing, B= unwilling; A= unwilling, B= willing.

Organizational Trust

There seems to be varying opinion about the difference between interpersonal and

organizational trust (Tyler & Kramer, 1996). Beyond the obvious- one being personal between

two or more people and one being system or enterprise-based- the premise still remains that both

interpersonal and organizational trust hinge on dynamics that either solidify or erode the trust

dimension of relationships.

Bracey (2002) made an observation that supports the intention of this study to illustrate

both interpersonal and organizational trust as essential considerations in assessing organizational

direction. He stated, "Organizational trust is built upon interpersonal trust. It is multi-layered.

Some of the interpersonal layers that form the infrastructure of organizational trust include: trust

between team members, trust between a supervisor and managers, and so on. If employees

cannot trust managers and executives individually, they will not trust the corporation as a whole"

(p. 87).

Bracey said, "In an organization, trust works from the inside out. If it is not happening

one-to-one in the organization, it certainly cannot be happening at the enterprise level.

Interpersonal trust lies at the heart of all organizational trust" (p. 87).

Significance of the Study

This study provides a deeper understanding of some of the critical considerations facing

leaders within a community health situation as they relate to interpersonal trust development and

its role in cultivating organizational relationships and setting organizational direction specifically

in the context of strategic planning. The question of interpersonal trust in an organizational

context is an area that researchers have investigated (Reyes et al., 2004); however, interpersonal trust in healthcare and community-based health systems is a lesser researched area.

Research Questions

The focus of this study is to analyze the perception of trust in the position of healthcare executive director among five groups of leaders in a non-profit healthcare system (medical director, dental director, fiscal director, board chair and a state association peer) and the impact of those perceptions on organizational direction as set forth in the current (2009-2010) strategic plan.

1. In what ways do the characterizations of trust differ among the executive director, her peer, the board chair, and the three department heads (medical director, dental director, and fiscal director)To what extent does the perception of trust vary between the executive director and each member of the leadership group?

2. What are the sources of the variances and in what ways do they differ?

Definition of Key Terms

Calculus Based Trust: Kramer and Tyler (1996) define calculus based trust as "an on-going, market-oriented, economic calculation whose value is derived by determining the outcomes resulting from creating and sustaining the relationship relative to the cost of maintaining or severing it" (p. 120).

(X) Area Health and Wellness Foundation: The (X) Area Health and Wellness Foundation (CAHWF) was created in June of 2001 from the sale of the (local) Hospital and Health Services, Inc. and the transfer of income from related endowments and trusts. The focus of the Foundation is to support primary health-centered programs through the awarding of grants

and being proactive in identifying, addressing and finding healthcare challenges in its service area. The Center is funded in part by a grant from CAHWF (http://www.cahwf.org/about.htm).

Federally Qualified Health Center: "A federal payment option that enables qualified providers in medically underserved areas to receive cost-based Medicare and Medicaid reimbursement and allows for the direct reimbursement of nurse practitioners, physician assistants and certified nurse midwives. Many outpatient clinics and specialty outreach services are qualified under this provision that was enacted in 1989" (http://www.pohly.com/terms).

Health Professional Shortage Areas: "A geographic area, population group, or medical facility that Health and Human Services determines to be served by too few health professional of particular specialties. Physicians who provide services in HPSAs qualify for the Medicare bonus payments. This may also include repayment of medical school loans or other incentives. These reports are published annually by Health and Human Services and can be of assistance to providers or groups wishing to recruit physicians to particular areas" (http://www.pohly.com/terms).

Health Resources and Services Administration (HRSA): "A component of the U.S. Department of Health and Human Services. Included in HRSA responsibilities is the administration of the Ryan White Care funds with a budget of about $1 billion per year to support a continuum of core services for persons with HIV infection" (http://www.pohly.com/terms).

Identification Based Trust: Kramer and Tyler (1996) define identification-based trust as "trust which exists because the parties effectively understand and appreciate the others' wants; this mutual understanding is developed to the point that each can effectively act for the other" (p. 120).

Interpersonal Trust: Six (2005) defines interpersonal trust as "a psychological state comprising the intention to accept vulnerability to the action of another party based upon the expectation that the other will perform a particular action important to you irrespective of the ability to monitor or control that other party" (p. 15).

Kramer and Tyler (1996) define knowledge-based trust as being "grounded in the others' predictability- knowing the other sufficiently well so that the others' behavior is anticipatable" (p. 121).

Organizational Direction: Burke and Litwin (1992) defined organizational direction as the leadership provided by executives. The leadership sets the course for the organization whereby those leaders serve as role models for employees.

Organizational Trust: McAllister (1995) described trust within organizations as "the extent to which a person is confident in and willing to act on the basis of, the words, actions, and decisions of another" (p. 25).

Three Hundred and Sixty Degree Feedback: Thomas and Saslow (2007) described three hundred and sixty degree feedback as a leadership assessment tool used in many executive programs to evaluate leadership skills of program participants based on an organization's core competencies. This assessment is only conducted by surveying superiors, peers, subordinates and outside colleagues to gather feedback to narrow performance gaps.

Broad contributions have been made to both the literature and varying definitions of trust (Annison & Wilford, 1998; Barber, 1983; Bromiley & Cummings, 1996; Kramer et al, 1996; Lewis & Weigert, 1985; McAlister, 1995; Robinson, 1996; Tyler & Degoey, 1996b).To further establish clarity in the context of this study the following terms are offered:

Trust: This study uses the fundamental definition offered by Marshall (2000) that trust is "the fundamental building block of human relationships" (p. 46). Lewis and Weigert (1985) characterize trust as the "undertaking of a risky course of action on the confident expectation that all persons involved in the action will act competently and dutifully" (p. 971).

Robinson (1996) defined trust as a person's "expectations, assumption, or beliefs about the likelihood that another's future actions will be beneficial, favorable, or at least not detrimental to one's interests" (p. 576).

Barber (1983) characterized trust as a set of "socially learned and socially confirmed expectations that people have of each other, of the organizations and institutions in which they live, and of the natural and moral social orders that set the fundamental understandings for their lives" (p. 164- 65).

Other researchers have argued that trust needs to be conceptualized as a more complex, multidimensional psychological state that includes affective and motivational components (Bromiley & Cummings 1996; Kramer et al. 1996; Lewis & Weigert, 1985; McAlisters, 1995; Tyler & Degoey, 1996b).

Limitations of the Study

This study attempted to address what appears to be a gap in the literature related to the specific examination of interpersonal trust in executive leadership within nonprofit healthcare systems. Because the definitions of trust and trust theories are disparate and because models of interpersonal trust are not based solely on one field of study (psychology, sociology, and so forth), the study is limited by an indirect translation between the model(s) and the data that was collected through interviews.

Respondent bias: Those responding to the study may be self-motivated to do so and therefore respond on either extreme of the trust scale (those with low trust levels or those with high trust levels.) The sample is very small but the scope of the research and research questions themselves are intentionally focused on only the leaders of units and not the entire membership of those units. Finally, variability in organizational structure, tenure with the organization, general demographics, specific aspects of one's culture and other unspoken interpersonal and organizational dynamics may have hindered the ability of the participants to respond objectively to the interview questions.

Assumptions

The research was conducted with the following assumptions in mind: First, an assumption was made that explanations for variance in responses would become clearer through the interview process. And second, an assumption was made that any evidence of departmental sub-cultures would confirm both empirical and anecdotal leader interview data.

Conceptual/Theoretical Framework

This study considers Shaw's (1997) conceptual framework for building trust. He asserts that "the key imperatives in building high-trust organizations and teams are achieving results, acting with integrity and demonstrating concern" (p. 14). This balancing act requires superb leadership as well as an organization designed to sustain trust, including both the formal and organizational architecture and the informal culture (Shaw, 1997).

The concept of organizational direction and its relationship to trust is also formed by the theoretical framework of Shapiro (1992) which, according to Tyler and Kramer (1996) asserted that "in professional relationships, trust develops gradually as the parties move from one stage to another" (p. 124).   This premise revolves around three observations:

1. The full progression of a trust evolution or change will move a relationship from calculus-based trust (CBT) to knowledge-based trust (KBT) to identification-based trust (IBT). Because all relationships do not develop fully, trust may not move beyond the first or second stage.

2. Consistency of the other party is required to move from calculus-based trust to knowledge-based trust. If this consistency occurs without significant exception, the parties will move from calculus-based trust to knowledge-based trust and that transition occurs at point J1. This change is based on particular conditions and may not occur if (a) the relationship does not necessitate more than "business" or "arms-length" transactions, (b) the interdependence between the parties is heavily bounded and regulated, (c) the parties have already gained enough information about each other to be aware that any further information gathering is unnecessary or likely to be unproductive, or (d) one or more violations of calculus-based trust have occurred.

3. Successful movement into knowledge-based trust indicates that the parties have experienced and engaged in the activities listed above. Significant numbers of relationships do in fact move into this level (JI).

   The movement from KBT to IBT occurs at point J2 which is characterized by a new level of relationship formation marked by identification with the other's needs, preferences and priorities as one's own. This identification compels each party to search for more information that facilitates deeper identification. Many professional relationships stop at this level and may not transition into IBT because (1) the parties lack time and energy to invest further into the relationship or (2) the parties lack the interest to development the relationship further.

The table below illustrates this evolutionary development:

Table 2- Lewicki and Bunker (1995)

Figure 1   Time

_____
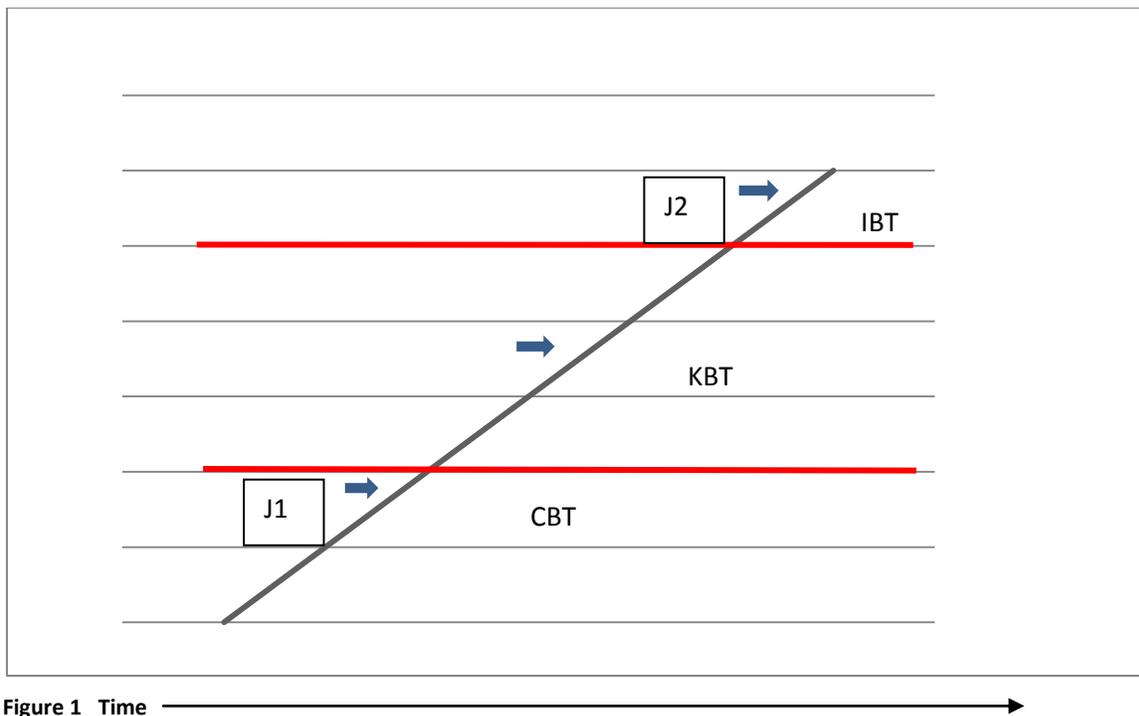
Table used by permission from the author.

The model below offers a representation of the three theoretical relationships that were examined. First, the wisdom of Shaw (1997) who identified achieving results, acting with integrity and demonstrating concern as "key imperatives" in building high-trust organizations and teams" (p. 14). Second, the theoretical framework of Shapiro (1992) who outlines the stages of trust development as beginning with calculus-based trust (CBT), wherein trust is built on "adequacy and cost of deterrence" (Kramer & Tyler, 1996, p. 120), then moving to knowledge-

based trust (KBT) wherein trust is built on the other's predictability such that the other's behavior is anticipatable, and ultimately reaching identification-based trust (IBT) wherein trust is built on identification with the others desires and intentions such that "each can effectively act for the other" (Kramer & Tyler, 1996, p. 122), and third, the schematic advanced by Fratantuono and Sarcone (2008) which assigns equal importance to culture, strategy and environment in achieving organizational success.

Figure 1-1- Relationship between interpersonal trust, strong culture and strategic direction.

Chapter 2

Review of the Literature

This chapter will first examine trust as a psychological state, trust as a choice behavior, dispositional trust, history-based trust, third parties as conduits of trust, category-based trust, role-based trust, rule-based trust, trust and spontaneous sociability, trust as perceived intention, trust as honesty, trust as vulnerability and trust as motivational orientation.

The chapter will also treat social exchange theory in the context of trust dynamics, trust as perceived intention, trust as vulnerability, trust as motivational orientation, the effect of organizational trust on learning, performance and value and finally what the literature offers about trust in healthcare— specifically, community-based health care, physician/administrator dynamics, trust in healthcare governance and implications of public versus private healthcare. Special attention will be given to interpersonal trust theory and its application to a community-based health center. These particular sub-topics were chosen as relevant descriptors and important dimensional aspects of the larger concept of trust and interpersonal trust.

Trust literature is quite extensive (Annison & Wilford, 1998; Barber, 1983; Bromiley & Cummings, 1996; Kramer et al, 1996; Lewis & Weigert, 1985; Degoey, McAlister, 1995; Robinson, 1996; Tyler & Degoey, 1996b) but primarily and historically trust has been treated as a psychological phenomenon. Though trust research is still clearly rooted in psychological theory, there are elements of trust research to which other disciplines have contributed to provide relevant contemporary context.

For example, the literature reveals that given the nature of American healthcare systems, trust within healthcare organizations is extremely critical. This becomes crucially important at the level of community healthcare upon which individuals from lower socio-economic standing

depend for coordinated care. The reliance can be executed more confidently when a community

healthcare center is fortified with strong and trusting relationships that help it to move forward in

logical and strategic ways.

Trust as a Psychological State and Choice Behavior

This sub-section will discuss theories that speak to dimensions of trust and trust

development as a cognitive process. This entails discussion of vulnerability, risk, trustor/trustee

knowledge and incentive, and organizational communication.

Kramer (1999) states that "when conceptualized as a psychological state, trust has been

defined in terms of several interrelated cognitive processes and orientations. First and foremost,

trust entails a state of perceived vulnerability or risk that is derived from individuals' uncertainty

regarding the motives, intentions, and prospective actions of others on whom they depend" (p.

571). This has very real implications within organizations because as Tzafrir et al state "building

trust within organizations, in particular within the context of dyad relationship between

employees and their managers, is crucial for effective operation of the firm" (p. 631).

This dimension of the trust literature was chosen for its attention to motive and

vulnerability. Both of these considerations are integral to the challenges that pervade healthcare

and more specifically community-based healthcare wherein ultimate leadership and

organizational direction fall upon a non-clinical administrator, the executive director.

One particular view of the trust literature is that trust is a choice behavior. "The rational

choice perspective, imported largely from sociological (Coleman 1990), economic (Williamson

1993), and political (Hardin 1992) theory, remains arguably the most influential image of trust

within organizational science" (p. 572). Hardin (1992) further argues that a rational account of

trust includes two central elements. The first is the knowledge that enables a person to trust

another and the second are the incentives of the person who is trusted (the trustee) to honor or fulfill that trust. This is particularly important in the context of the organizational setting because as stated by Tzafrir et al "from a strategic perspective, it is important to note that creating and enhancing trust should and can be established via systems of organizational communication (p. 641). So whether communication is verbal or written it implicates trust within and among members of the organization.

Communication is vital to the conversation around organizational direction. How does an organization communicate its overarching goals, key strategies, expectations for performance and any other important considerations that impact not only the bottom line but the day to day operation and individuals' ability to operate within an open and operative system?

Relational Models of Trust

This sub-section will explore trust as not only a calculative orientation toward risk but also toward other people and groups. These social and relational underpinnings of trust-related choices drive both behavior and choice in the context of trust and trust development within organizations.

"A number of scholars have suggested that an adequate theory of organizational trust must more systematically incorporate the social and relational underpinning of trust-related choices (Mayer et al., 1995; McAlister, 1995; Tyler & Kramer, 1996). According to these arguments, trust needs to be conceptualized as not only a calculative orientation toward risk, but also a social orientation toward other people and toward society as a whole" (p. 573).

This implicates organizational settings and situations because individuals bring their perceptions of relationships and how value is assigned to relationships into their work environment. This perspective on trust is particularly important to the research at The Center

because of the dynamics of a small community health center operation— much of the patient care centers around what is informally observed of relationship among staff. From a cultural standpoint, the notion of risk for those who are likely economically disadvantaged places further importance on presenting a cohesive and trusting work environment as a deliverer of care.

The development of relational conceptions of trust was further fueled by research implicating a variety of macro-level structures, including networks and governance systems, in the emergence and diffusion of trust within and between organizations (Burt & Knez, 1995; Coleman, 1990; Kollock, 1994; Powell, 1996).

The work of Edgar Schien is significant to this research because Schien, like Lewin, was concerned with the people side of organizations. As will be discussed in further detail later in the chapter, Schien examined the notion of culture within organizations. In as much as culture is concerned with the examination of learned behavior within groups, the question of interpersonal trust becomes highly relevant. This work helps to bring clarity to the important intersection between group dynamics and organizational leadership– a leaders carries the responsibility to understand the evolution and development of the group such that leadership expectations may be measured against group behaviors and manifestations.

Like Lewin, Schien was concerned with the ways in which individuals behaved in the context of group behavior and identity. It was the group's behavior that illuminated both Schien and Lewin's research. Schien's research also confirmed the much earlier research of Lewin in terms of understanding group identity. Both were concerned with how groups mobilize around shared identity and shared mission.

Force Field Analysis

As stated earlier, one cannot earnestly discuss trust without discussing change. Returning to Lewin's work on field theory gave rise to what is now referred to as force field analysis. This theory acknowledges the dynamic movement within social systems- also known as change. According to Brager and Holloway (1992) force field analysis "entails the systematic identification of opposing forces. In analyzing a field of forces for organizational change purposes, a range of variables is identified which have a probability of influencing the preferences of significant organizational members with respect to a designed change." (p. 18).

Barriers to Change

According to Cummings and Worley (as cited in Burnes, 2004, p. 987) "OD has become the standard-bearer for Kurt Lewin's pioneering work on behavioral science in general, and approach to Planned change in particular." Notions of planned change have been challenged through the years as organizations have been seen as too dynamic and fluid for the more discreet processes of "freezing" and "unfreezing". MacIntosh and MacLean (as cited in Burnes, 2004, p. 991) noted that "if organizations are too stable, nothing changes and the system dies; if too chaotic, the system will be overwhelmed by change. In both situations, radical change is necessary in order to create a new set of order-generating rules which allow the organization to prosper and survive."

So the question becomes, how does one transform those dynamics which often stymie change into opportunities which promote change? The work of Schein and Lewin serve as examples of particular strategies which focus on culture as a prominent facilitator of change.

This research is significant because it advances foundational trust theory from a psychological phenomenon to an organizational phenomenon. Further, it treats the question of leadership in the context of organizational trust. For example, Shaw (1997) asserts that: "The actions of leaders at all levels significantly influence trust. Senior leaders are particularly powerful in creating or eroding trust. Those seeking to build high-trust cultures must develop a group of leaders whose actions reflect the importance of each of the trust imperatives— and who are capable of balancing these imperatives when they conflict" (p. 101).

Shaw believes that the creation of trust based organizations really hinges on two key leverage points:

1. Leaders at all levels can either create or erode trust, those who seek to create it must balance the trust imperatives (achieving results, acting with integrity, demonstrate concern)

2. Organizational culture reflects the informal operation. High trust organizations create cultures that reinforce the trust imperatives.

In his writing, Shaw draws on the cases of several organizations and their leaders illustrating examples of modeling trustworthy leadership, building trustworthy leadership groups and developing organizational mechanisms that sustain trust. From Chrysler (Iacocca) to AT&T (Wajnert), Shaw focuses on the task and challenge of balancing the demands of organizational leadership: exhibiting trustworthy behavior, building trustworthy teams and influencing culture, which he defines as informal values, rules and operating principles (p. 121).

Shaw defines culture as "those informal aspects of organizational life that have an impact on the performance of a group" (p. 139). Specifically, the following list is offered as critical actions for developing a culture appropriate for a high trust organization (p. 140):

- Develop a common vision and shared view of competitive realities

- Build familiarity across levels and groups

- Encourage a culture of risk taking and experimentation

- Make visible a few powerful symbols of trust and collaboration (a reinforcement of the organization's commitment to each of the trust imperatives.)

There have been contributions from psychological researchers who examined relational trust from a cognitive and motivational perspective. More specifically, within the context of social psychology, there have been attempts to develop frameworks that take into account a closer consideration of social motives that drive trust behavior. These models (unlike resource-based theories) place more of an emphasis on self-concept and identity and the ways in which these individual motives influence trust-related cognition and choice (Kramer, 1999).

There is a substantial body of knowledge that focuses on identifying the bases of trust within organizations (Creed & Miles, 1996; Lewicki & Bunker, 1995; Sheppard & Tuckinsky, 1996; Mayer et al., 1995; Zucker, 1986). This research focuses on antecedent conditions that promote or evoke trust including psychological, social and organizational factors that influence individuals' expectations about others' trustworthiness and their willingness to engage in trusting behavior when interacting with them.

Fratantuono and Sarcone (2008) conducted a case study on Doctors Community Hospital (DCH), a non-profit organization in Maryland. The purpose of the study was to explore connections between environment, culture and strategy in determining organizational success. By using the work of Schein (1985, 1992) and of Kotter and Heskett (1992) they constructed a framework that synthesizes theory and posits that in successful organizations, four conditions will hold:

1. The organization's values are purposefully cultivated by leadership and resonate with members of the enterprise.

2. The organization's culture serves as a foundation for its competitive strategic themes and associated activity systems.

3. The organization's culture and related strategy fit its competitive environment

4. The organization's activities reinforce organizational values.

(p. 29).

To better understand the healthcare environment, academic literature was reviewed on the healthcare industry, hospital industry, association reports and government reports. The study was also informed by the first hand experience of one of the authors who has twenty-five years of direct experience in healthcare management. After reviewing the literature, historical source documents were reviewed (including hospital source documents, and archival records.) Following this review, two tours of the facility were taken, in-person and telephone interviews were conducted with ten members of the hospital's management team (to include physicians, nurses and support staff.) To help guard against bias an effort was make sure that all information found in the data sources converged. Further, all interviewees reviewed and approved the content of the case study prior to publication.

As stated earlier, the authors found that none of the researched models adequately advanced the information gleaned for data collection. Therefore an integration of several ideas was captured in a narrative proposition. Then a description was provided to illustrate how the conditions apply to the case of DCH. There is acknowledgement that this methodology could lead to accusation of circular reasoning. Therefore the authors articulate clear direction which runs from the particular info gathered on DCH to the constructed framework of analysis in the

articulation of "clear strong and balanced links among environment, culture and strategy" (p. 39). Although Fratantuono and Sarcone (2008) acknowledge the methodological consistency in data gathering between their case study and the approach advocated by sociologist Barney G. Glaser and Anselm L. Strauss (1967), they also acknowledge certain limitations. For example, there are methodological inconsistencies in that Glaser and Strauss did not study or analyze single organizations. Secondly, the authors do not profess to have added substantially to theory building, but more so to have stated a more clarified or perhaps nuanced version of previously expressed ideas. Finally, the authors offer the following in the context of limitations:

1. Definition of "success" as managing financial viability and satisfying the key interest of stakeholders is vague.

2. Discovery of a "successful" organization for whom one or more of the propositions does not hold essentially nullifies the logic behind the proposition.

3. The proposition suggests that the evolution and progression of DCH over a ten year period was the result of a coherent model articulated to the CEO at the time he and his team gained independent control.

Despite these limitations, Fratantuono and Sarcone's proposition does hold merit in the context of the supporting strategic management literature. Sorting through the evidence encountered, the authors were able to first develop four strategic themes and thirty eight supporting activities of DCH. From there, following the assertion of Porter (1996) who states that one of the things that makes an organization successful is the ability to decide what activities will and will not be performed, the authors mapped an activity system for DCH which led to the articulation of their second condition for organizational success: The organization's culture serves as the foundation for its competitive strategic themes and associated activities.

Use of particular management theory (which led to the development of a new proposition) and the development of an activity system for DCH allowed Fratantuono and Sarcone to assess the climate of trust among various constituencies, gauge the sense of affiliation within the hospital among staff physicians, nurses and support staff based on their level of involvement with strategic decision-making and ultimately, recognize the value of a less formal, non-top-down management structure that "encouraged individual and collective contributions to innovation in designing operational systems and applying technology" (p. 36).

The contributions of Edgar Schein to trust literature are significant- particularly in the context of organizational culture and leadership. He defines culture as "a pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems" (p. 12).

Schein (1992) says that "culture is the result of a complex group learning process that is only partially influenced by leader behavior. But if the group's survival is threatened because elements of its culture have become maladapted, it is ultimately the function of leadership to recognize and do something about the situation. It is in this sense that leadership and culture are conceptually intertwined" (p. 5).

In as much as culture and leadership are inextricably tied, Schein sees one of the unique functions of leadership as the ability to perceive functionality and dysfunctionality within group culture and manage the evaluation of that culture in such a way that the group survives a changing environment. Schein lays a foundation for understanding and analyzing culture by

asserting that culture cannot be fully explained without first realizing that culture develops in different ways and at different times within the life cycle of an organization.

He describes these levels of culture as beginning with the most visible, surface-level reflections of culture, *artifacts*. Artifacts include such products as physical environment, language, technology, artistic creations, myths and stories about the organization, published lists of values and observable rituals and ceremonies. He reiterates the fact that what is most significant about this level of culture is that one can easily observe it but may be more challenged to decipher it.

The next level of culture is uncovered in exploration of *espoused values*. The emphasis in this level is obviously on the word "espoused". Schein (1992) asserts that "All group learning ultimately reflects someone's original values, someone's sense of what ought to be as distinct from what is" (p. 19). The ability to communicate this sense such that the group buys into it begins a process described as cognitive transformation, a shared perception of success as it relates to problem solving. Over time, shared values or beliefs become shared assumptions based on group perceptions of success. If espoused values and underlying assumptions are fairly convergent, groups can be brought together around shared identity and mission. The identification of future behavior, however, requires a fuller understanding of basic underlying assumptions.

According to Schein, basic underlying assumptions, the third and final stage of his identified levels of culture, are difficult to change because they typically go unchallenged and unconfronted by groups. "…the reexamination of basic assumptions temporarily destabilizes our cognitive and interpersonal world, releasing large quantities of basic anxiety" (p. 22). It is actually culture which defines (as a set of basic assumptions) what things mean, what we should

turn our attention to, and how to act and react. Because the human mind requires cognitive stability, challenging basic assumptions usually provokes defensiveness. In this regard, "the shared basic assumptions that make up the culture of a group can be thought of at both the individual and group levels as psychological cognitive defense mechanisms that permit the group to continue to function" (p. 23).

Ultimately, what Schein suggests is that our assumptions translate into practice. For example, if the assumption in the workplace is that employees are motivated and competent, they will be encouraged to work in their own way and at a pace with which they are most comfortable. Conversely, if the prevailing assumption is that employees are inherently lazy, they might become victims to tighter controls that attempt to ensure productivity. The true power of culture emerges because assumptions that are shared also get reinforced.

According to Schein (1992), when the notion of changing culture is proposed, it involves, at its very core, changing basic assumptions and is, in that sense, a very difficult, time consuming, and anxiety-producing task. But for leaders, particularly those who seek to change the culture of an organization, the challenge and responsibility becomes how to get at deeper levels of culture and decipher the assumptions made at each level (artifacts, espoused values and basic underlying assumptions).

Circling back to the inextricable relationship between leadership and culture, Schein (1992) asserts that leaders "should be sensitive to the power they have to influence the groups with which they work" (p. 143). According to Schein, cultures originate from three sources: (1) the beliefs, values, and assumptions of organizational founders; (2) the learning experience of group members as the organization evolves; (3) new beliefs, values and assumptions brought in by new members and leaders.

When it comes to the ways in which leaders embed and transmit culture, "the things that the group tries out are the result of leader-imposed teaching" (p. 228). Therefore, while it is true that culture is learned (which can be viewed as somewhat passive), greater attention must be paid to the fact that it is also taught (which can be viewed as active.)

Dispositional Trust

Research suggests that one's predisposition to trust and distrust is related with other orientations such as one's beliefs about human nature and interaction (PEW, 1996; Wrightsman, 1991). To explain the origins of such dispositional trust, Rotter (1971, 1980) proposed that people refer to their previous experiences from early trust-related encounters to establish their general beliefs about others.

Rotter further argued that "As expectancies are generalized from one social agent to another …people acquire a kind of diffuse expectancy for trust of others that eventually assumes the form of a relatively stable personality characteristic" (p. 575).

There does not seem to be much evidence that this perspective has contributed greatly to knowledge and research on dispositional trust— beyond possible implications from organizations interested in screening for or selecting more trust-worthy employees (Kipnis, 1996).

Dispositional trust theory is important in conducting this study. The members of the senior leadership team within The Center (like any other work setting) bring their individual and collective experiences with trust into the workplace. But the pre-disposition to trust becomes extremely important in the context of leadership, in as much as each subject is responsible for trusting both the executive director and themselves as leaders of departments, to move the organization forward in a way that affirms the aspirations of the current strategic plan and the

understood intention of where the organization is to go to best serve its direct constituents and surrounding community.

History-Based Trust

Research also shows that elements of trust development are history-based. Individuals' perceptions of others' trustworthiness and their willingness to engage in trusting behavior when interacting with them are largely history- dependent processes (Boon & Holmes, 1991; Deutsch, 1958; Lidskold, 1978; Pilisuk & Skolnick, 1968; Solomon, 1960). According to such models, trust between two or more interdependent actors thickens or thins as a function of their cumulative interaction. Interactional histories give decision makers information that is useful in assessing others' dispositions, intentions, and motives (Kramer 1999).

Evidence of the importance of interactional histories in judgments about trust comes from a substantial body of experimental research linking specific patterns of behavioral interaction with changes in trust. For example, a number of studies have demonstrated that reciprocity in exchange relations enhances trust, while the absence or violation of reciprocity erodes it (Deutsch, 1958; Lindskold, 1978; Pilisuk, et al., 1971; Pilisuk & Skolnick, 1968). History-based trust can be construed as an important form of knowledge-based or personalized trust in organizations (Lewicki & Bunker, 1995; Shapiro et al., 1992).

According to Kramer (1999) while personalized knowledge about other organizational members represents one possible foundation of trust, such knowledge is often hard to obtain. This is not the natural interpersonal inclination within the workplace. Within most organizations, it is difficult for decision makers to accumulate sufficient knowledge about all of the persons with whom they interact or on whom they depend.

The size and degree of social and structural differentiation found within most organizations precludes the sort of repeated interactions and dense social relations required for the development of such personalized trust. As a consequence, "proxies" or substitutes for direct, personalized knowledge are often sought or utilized (Creed & Miles, 1996; Zucker, 1986). For example, third parties sometimes becomes conduits of trust because of their ability to trust relevant information; more often than not, via gossip (Kramer 1999).

A more recent study by Uzzi (1997) examining exchange relations among firms in the New York apparel industry provides further evidence of the crucial role third parties play in the development and diffusion of trust. He found that third parties acted as important "go betweens" in new relationships enabling individuals to "roll over" their expectations from well- established relationships to others for which adequate knowledge or history was not yet available. In explaining how this worked, Uzzi argued that go-betweens transfer expectations and opportunities of existing embedded relationships to newly formed ones, thereby "furnishing a basis for trust and subsequent commitments to be offered and discharged" (p. 48).

This body of knowledge is very important to the scope of this study as it supports the conceptual framework which posits that higher levels of trust center around identification based trust (IBT) marked by an identification with the others' needs, preferences and priorities as one's own. The parties are compelled to search for a deeper meaning with one another.

Category-Based Trust

Category-based trust is trust predicated on information regarding a trustee's membership in a social or organizational category (Kramer 1999). Women, for example, would be considered a social category. As Brewer (1981) noted, there are a number of reasons why membership in a salient category can provide a basis for presumptive trust. First, shared

membership in a given category can serve as a "rule for defining the boundaries of low-risk interpersonal trust that bypasses the need for personal knowledge and the costs of negotiating reciprocity" when interacting with other members of that category (p. 356).

Further, because of the cognitive consequences of categorization and in-group bias, individuals tend to attribute positive characteristics such as honesty, cooperativeness and trustworthiness to other in-group members (Brewer 1996). As a consequence, individuals may confer a sort of depersonalized trust on other in-group members that is predicated simply on awareness of their shared category membership (Kramer 1999). This has important implications for a community-based healthcare system wherein individuals are often socialized by characteristics outside of professional indices such as age, tenure or place of residence.

Role-Based Trust

Role-based trust represents another important form of presumptive trust found within organizations. As with category-based trust, role-based trust constitutes a form of depersonalized trust because it is predicated on knowledge that a person occupies a particular role in the organization rather than specific knowledge about the person's capabilities, dispositions, motives and intentions.

As Barber (1983) noted, strong expectations regarding technically component role performance are typically aligned with roles in organizations, as well as expectations that role occupants will fulfill the fiduciary responsibilities and obligations associated with the roles they occupy. Thus to the extent that people within an organization have confidence in the fact that role occupancy signals both an intent to fulfill such obligations and competence in carrying them out, individuals can adopt a sort of presumptive trust based upon knowledge of role relations, even in the absence of personalized knowledge or history of prior interaction (Kramer 1999).

This type of trust develops from individuals' common knowledge regarding the barriers to entry into organizational roles, their presumptions of the training and socialization processes that role occupants undergo, and their perceptions of various accountability mechanisms intended to ensure role compliance. As Dawes (1994) suggests, "we trust engineers because we trust engineering and believe that engineers are trained to apply valid principles of engineering, moreover, we have evidence every day that these principles are valid when we observe airplanes flying" (p. 24).

Roles thus lessen the perceived need for and costs of negotiating trust when interacting when others. Role based trust can be quite fragile and produce catastrophic failure of cooperation and coordination, especially during organizational crises or when novel situations arise that blur roles or break down role based interaction scripts (Mishra, 1996, ebb 1996, Weick, 1993). The conversation around roles becomes very complex in the context of a community health center where the executive director is responsible for casting the organizational vision but team leaders are function-specific and directly responsible for articulating roles such that the delivery of care is optimally facilitated.

Rule Based Trust

According to Kramer (1999) if trust within organizations is largely about individuals' diffused expectations and depersonalized beliefs regarding other organizational members, then both explicit and tacit understandings regarding transaction norms, interactional routines, and exchange practices provide an important basis for inferring that others in the organization are likely to behave in a trustworthy fashion, even in the absence of individuating knowledge about them.

Rules, both formal and informal, capture much of the knowledge members have about such tacit understandings regarding transaction norms, interactional routines and exchange practices provide an important basis for inferring that others in the organization are likely to behave in a trustworthy fashion, even in the absence of individuating knowledge about them. Rule-based trust is predicated not on a conscious calculation of consequences, but rather on shared understandings regarding the system of rules regarding appropriate behavior.

Fine and Holyfield (1996) identify the ways trust is created. One way is to award trust to others even when confidence in them may be lacking. Organizations have the opportunity to build a culture whereby there is an "insistence" on trust. Thus, even if members remain privately anxious, their public behavior connotes high levels of trust. Collectively, these displays constitute a potent form of social proof to members that their individual acts of trust are sensible.

A second crucial element in the management of trust within this organization occurs through practices and arrangements that ensure competence and due diligence. This result is achieved partially through meticulous socialization of newcomers to the organization.

Trust and Spontaneous Sociability

Fukuyama (1995) argued that one of the most important manifestations of trust as a form of social capital is the spontaneous sociability such trust engenders. Within organizational contexts, spontaneous sociability assumes many forms. Organizational members are expected, for example, to contribute their time and attention towards the achievement of collective goals (Murnighan et al., 1994; Olson, 1965), they are expected to share useful information with other organizational members (Bonacich & Schneider, 1992), and they are expected to exercise responsible restraint when using valuable but limited organizational resources (Mesick et al., 1983; Tyler & Degoey, 1996a)

Trust as Perceived Intention

The element of perceived intention includes the "reliance upon the communication behavior of another person in order to achieve a desired but uncertain objective in a risky situation" (Giffin, 1967, p. 105). Judgments of intentions are derived from the expectation resulting from communication by others. This creates an expectation that the resultant action will be the behavior reflected in the communicated messages. When the intentions are judged to be originating from a reliable messenger, a determination is made that the messenger possesses "source credibility" (Hovaland, Janie, & Kelly, 1951).

Trust as Honesty

Rotter (1967) defined interpersonal trust as "an expectancy held by an individual or a group that the word, promise, verbal or written statement of another individual or group can be relied upon" (p. 651). Following these earlier researchers, Cook and Wall (1980), Lazaelere and Houston (1980), and Communing and Bromiley (1995) consolidated the communication issues identified previously into an operationalized construct of "honesty" as truthfulness in communication. Mayer, Davis, and Schoorman (1995) link honesty to a broader construct of the trustor's perception of the trustee's integrity.

From these authors, a strong foundation is developed that expectations of the perceived intentions of a trusted other in resolving a trusting decision has, as a central theme, the issue of judging the honesty of communication as a mechanism of perceiving another's intention.

Trust as Vulnerability

This theory is examined in the context of choice and follows the premise that a trusting choice will create a level of vulnerability for the trustor by asserting "greater negative

motivational consequences if the expectation is not confirmed than positive motivational consequences if the expectation is confirmed." (Deutsch, 1957, p. 266).

The trustor is therefore placed in a position to cast certain predictions about the future; predictability establishes its inextricable relationship to trust and its conceptualization. Gabarro (1978) defines trust as the "extent to which one person can expect predictability in the other's behavior in terms of what is normally expected of a person acting in good faith" (p. 294). Zucker (1986) defines trust as "having confidence or predictability in one's expectations" (p. 54). And Ring and Van de Ven (1992) incorporated Zucker's (1986) definition with that of "trust as goodwill, a feeling that the other will act in a way that does not hurt one's interest" (Friedman, 1991) stating trust is "a mixture of the two aspects of having confidence in; being able to predict expectations and the others' goodwill" (p. 488).

The element of risk is considered in the context of both psychological and sociological theory: predictability is seen as an inextricable reducer of risk. Ones behavior is predicated upon an individual conclusion that a perceived negative motivational consequence to self as a result of unfulfilled trust outweighs the positive motivational consequence resulting from the choice to trust and the fact that that trust has been upheld.

The exact placement of risk in juxtaposition to a trusting decision is still a topic of debate (Coleman, 1990; Giffin, 1967; Good, 1988; Lewis & Weigert, 1985; Luhmann, 1988; March & Shapira, 1987; Riker, 1974; Schlenker, Helm, & Tedeschi, 1973). Does risk occur prior to trust? Does the mere existence of trust create risk or is risk an outcome or result of trust? Still other scholars assert that trust is a conscious decision to leave oneself vulnerable to the actions of [trusted] others (Currall & Judge, 1995; Hosmer, 1995; Johnson-George & Swap, 1982).

Trust as Motivational Orientation

A central theme of a trusting decision is "motivational orientation" (Deutsch, 1960). Mead (1938) studied various primitive cultures and found that motivational predisposition to compete, individualize or cooperate exists as fundamental core value. Deutsch (1960), therefore applied Mead's (1938) terminology to characterize the same inclination in the context of making trusting decisions.

Deutsch (1960) asserted that a competitive orientation entails adoption of a strategy whereby one seeks to do well for him or herself while simultaneously attempting to prevent the other from achieving their goal(s). An individualistic orientation, however, involves interaction whereby each party in the exchange attends to their own interest without attention or intervention into the others performance or goal attainment.

Cooperative orientation describes the extension of efforts towards others' goals with the expectation that the extension will be reciprocated. Again, this includes social risk-taking. Deutsch (1960) also defines mutual trust which is established when two individuals have complimentary or comparable trust toward one another. There exists a belief that the other will behave in particular and expected ways and that each perceives the others' intent to also behave in particular and expected ways.

Finally, in an organizational context, Hosmer (1995) defines trust as "the expectation by any one person, group, or firm of ethically justifiable behavior, that is morally correct decisions and actions based upon ethical principles of analysis— on the part of the other person, group, or firm in a joint endeavor or economic exchange" (p. 399). Gambetta (1988) summarizes a definition of multi-party trust as a "particular level of the subjective probability with which an agent assesses that another agent or group of agents will perform a particular action, both before

he can monitor such action (or independently of his capacity to ever be able to monitor it) and in a context in which it affects his own actions" (p. 216).

According to Tzafrir and Gur (2004) "In the organizational setting, mutual trust has the potential to enhance cooperation (Mayer et al., 1995), and increase the sharing of information between employees and managers (Spreitzer & Mishra, 1999) as well as among organizational units, which may eventually improve organizational performance (Collins & Poras, 1997; Sako, 1998)" (p. 4).

Trust is measurable. Tzafrir and Dolan (2004) define trust as "willingness to increase one's resource investment in another party, based on positive expectation, resulting from past positive mutual interactions" (p.116). At the organizational level, employees are looking for indications of a trusting relationship based on notions of reciprocity (Whitnener, 2001). This confirms Tzafrir and Dolan's working definition of trust in that the trust relationship is characterized by one's willingness to make an investment based on previous positive experiences. Although trust can be measured, scholars have not all agreed on what instrument can measure it (Tzafrir & Dolan, 2004).

The trust scale developed by Tzafrir and Dolan (2004) was originally chosen for this particular study because of its focus on perception from the standpoint of an individual trustor (as opposed to intergroup or intragroup trust) as well as its attention to context as it relates to trusting relationships and trust development. This context is marked by questions that speak to particular and important organizational dynamics such as (but not limited to) experiencing difficulty on the job, managers' ability to keep promises, willingness to "forgive and forget", and managers' willingness to make personal sacrifices. The trust scale was also chosen because of

its specificity related to organizational realities within healthcare organizations (HCO) and the relationships that develop within such organizations.

The 16 item instrument developed and validated by Tzafrir and Dolan (2004) has primarily been used to measure employees' trust in management. In 2007, the scale was used to examine the role of trust as a mediator between human resource management practices and perceived service quality within an Israeli community healthcare organization. Although this study is not a quantitative study that seeks to analyze empirical data derived from the scale, responses to the 16 item instrument was intended to supplement and illuminate particular scores given within the context of interviews as well as overall responses to non-scoring interview questions. It was subsequently determined that the information emerging from the interviews was much more valuable and telling than the information offered by the trust scale tabulations. Therefore, the trust scale was dropped from the scope of the study.

When considering the more refined topic of organizational trust, healthcare organizations are unique. Much of this distinction centers on the complexity of healthcare as an institution to which hospitals, clinics, community, families and individuals are connected. The structure of hospitals is a bit different from the structure of community-based health centers or clinics. Most healthcare trust literature seems to focus on intra-organizational trust (that is trust between healthcare organizations), trust between and among patients and physicians or physicians and staff or hospitals and the communities they serve. Therefore, this chapter addresses what appears to be a gap in the literature around trust within a community healthcare setting.

As stated previously, the concept of organizational direction and its relationship to trust is informed by the work of Shapiro (1992) which, according to Tyler and Kramer (1996) asserts

that "in professional relationships, trust develops gradually as the parties move from one stage to another" (p. 124). The premise revolves around three observations:

1. The full progression of a trust evolution or change will move a relationship from calculus-based trust (CBT) to knowledge-based trust (KBT) to identification-based trust (IBT). Because all relationships do not develop fully, trust may not move beyond the first or second stage. What is required to move from calculus-based trust to knowledge-based trust depends upon consistency of the other party. If this occurs without significant exception, the parties will move from calculus-based trust to knowledge-based trust and that transition occurs at point J1. This change is based on particular conditions and may not occur if: (a) the relationship does not necessitate more than "business" or "arms-length" transactions, (b) the interdependence between the parties is heavily bounded and regulated, (c) the parties have already gained enough information about each other to be aware that any further information gathering is unnecessary or likely to be unproductive, or (d) one or more violations of calculus-based trust have occurred.

2. Successful movement into knowledge-based trust indicates that the parties have experienced and engaged in the activities listed above. Significant numbers of relationships do in fact move into this level (JI).

3. The movement from KBT to IBT occurs at point J2 which is characterized by a new level of relationship formation marked by identification with the other's needs, preferences and priorities as one's own. This identification compels each party to search for more information that facilitates deeper identification.

Many professional relationships stop at this level and may not transition into

IBT because (1) the parties lack time and energy to further invest in the

relationship or (2) the parties lack the interest to development the relationship

further.

Tyler and Kramer note that despite the fact that trust has been treated in various

social science literature, "each literature has approached the problem with its own

disciplinary lens and filter" (p. 115). The views can be distilled into three distinct

categories: the views of personality theorists, the views of sociologists and economists,

and the views of social psychologists. We learn that in this third category the focus is

placed on interpersonal transactions between parties. These transactions occur at both the

interpersonal and group levels. In this context trust is defined as "the expectation of the

other party in a transaction, the risks associated with assuming and acting on such

expectations, and the contextual factors that serve to either enhance or inhibit the

development and maintenance of that trust"(p. 116).

What makes calculus-based trust significant is that it is a form of trust based on

consistency of behavior. "Individuals will do what they say because they fear the

consequences of not doing what they say" (p. 119). This theory that posits that trust is

sustained to the degree that punishment is not only possible but likely to occur if trust is

violated. "The trust calculus is made effective, therefore, by the adequacy and cost of

deterrence" (p. 120).

Knowledge-based trust suggests that regular communication and "courtship" are

seen as key processes based on the fact that regular communication serves as a natural

conduit for constant contact with the other party, This exchange often entails articulation

of wants, preferences and approaches to problems (p. 121). "Courtship" refers to a

specific dimension of relationship development. This dimension indicates can

intentionality around learning more about the other party. During this time, behavior in

particular situations might be observed, or bearing witness to the other party's emotional

state in a variety of situations. It is at this juncture that most parties discern and make

determinations regarding how well they can work together.

Identification-based trust reflects the cumulative development of the two

preceding stages. Its distinction is marked by a unique level of empathy shared between

the parties based on the incorporation of the others' psyche into one's identity. This

includes needs, preferences, thoughts, and behaviors (p. 123). Further research around

these three stages deals with the decline of trust and trust repair.

Chapter Summary

This chapter has examined multiple perspectives and theories on trust and trust

development. What ties all of these observations together are the dynamics that manifest in

interpersonal relationships within organizational settings. Trust and perceptions of trust are

integral to the direction an organization takes. Organizations are dynamic and complex and they

are fluid and move in particular directions. Ideally that direction is forward and that forward

moment is characterized by (perhaps among other things) change.

Moving appropriately with or at the speed of change is largely dependent upon

relationships. As Marshall (2000) states, speed happens when people trust each other. Building

trust and developing a relationship-based organization are the only way to achieve superior

performance and sustainable competitive advantage in the future. For some companies, the

question may be whether to evolve at all. For others, it will be a question of how. We must learn new ways to do so at the speed of change, without sacrificing the trust of the workforce.

The literature around trust and more specifically interpersonal trust within organizations is a crucial piece of what healthcare organizations must consider in the context of internal (or inner-organizational) discourse. Porter (1996) asserts that successful organizations must decide what activities they will and will not perform. The Center is doing just that in its strategic planning process. The "trust factor" is critical during a time of strategic decision making when roles, responsibilities, timelines and benchmarks are all being identified. This research further demonstrates that importance by examining trust relationships between a senior leader (in this case the executive director) and her direct reports. According to Tzafrir and Dolan (2004) "Trust [therefore] appears to be an essential intangible resource in organizations, which bonds managers and their subordinates" (p. 4).

Chapter 3

Methodology

This chapter discusses the relevant sections: the problem, research questions, measurement, variables, instrumentation, data collection, and data analysis.

The Problem

Unless trust exists in an organization, empowerment is not likely to enhance cooperation and increase organizational performance (Tyler & Kramer, 1996). The role of trust as it applies to personal and organizational leadership is a topic that has not been sufficiently treated in the literature around healthcare; particularly nonprofit community based healthcare. Although there is an acknowledgement that lack of trust among healthcare leaders can be identified as one of the barriers to healthcare reform, important questions still exist at the micro-level that speak to the issue of trust within individual healthcare organizations. Both employees and boards need to feel comfortable that there is a trustworthy leader at the helm of their organization.

Research Questions

The focus of this study was to examine the perceptions of trust among the Healthcare Executive (Executive Director) and four groups of leaders in a non-profit healthcare system as it relates to particular dimensions of organizational and interpersonal trust. This study is guided by the following questions:

1. In what ways do the characterizations of trust differ between the executive director, her peer (CEO of the Pennsylvania Association of Community Health Centers), the board chair, and the three department heads (medical director, dental director, and fiscal director.)

2. What are the sources of those variances and in what ways do they differ?

Findings for these research questions provide information to discuss the implications of these perceptions on decision-making and organizational direction as set forth in the 2009-2010 strategic plan.

Methods: Qualitative Case Study

Based on the writings of Trice and Beyer, it is difficult to obtain direct measures of interpersonal relationships in a qualitative study. This study examines trust as one indicator of interpersonal relationships.   Given the complexities of the case study research, a brief explanation of the relationships between the findings and research methods is illustrated below. The explanation is divided into three sections that correspond to the research questions. Further, an attempt is also made to connect the important relationships between interpersonal trust, establishment of a strong culture and strategic direction (discussed in chapter one.)

Figure 2-1 depicts the relationship between the first research question and the data and methods used to support the findings. Figure 2-2 depicts the relationship between the second research question and the data and methods used to support the findings. Figure 2-3 considers the ways in which particular pieces of data may implicate organizational direction.

Figure 2-1 Characterizations of interpersonal trust variance among leader group

Trust in Exec. Dir.	Trust in Elements of Strat. Plan	Trust in Strat. Dir.
Key Inf. Interv.	Key Inf. Interv.	Key Inf. Interv.
Interv. Scores	Interv. Scores / Interv. Content	Interv. Scores
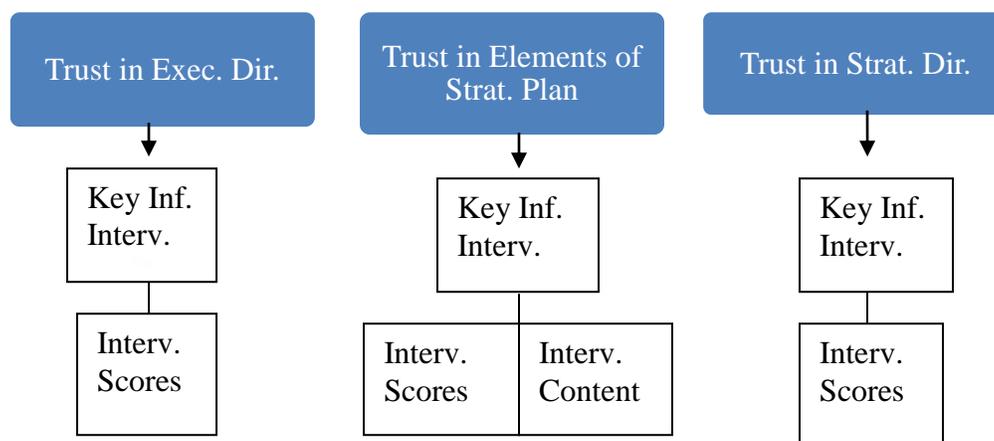
Figure 2-2 <u>Source of variance in interpersonal trust</u>

Trust in Exec. Dir.	Trust in Elements of Strat. Plan	Trust in Strat. Dir.

Key Inf.

Interv. Scores

Key Inf.

Interv. Scores	Interv. Content

Key Inf. Interv.

Interv. Scores	Interv. Content
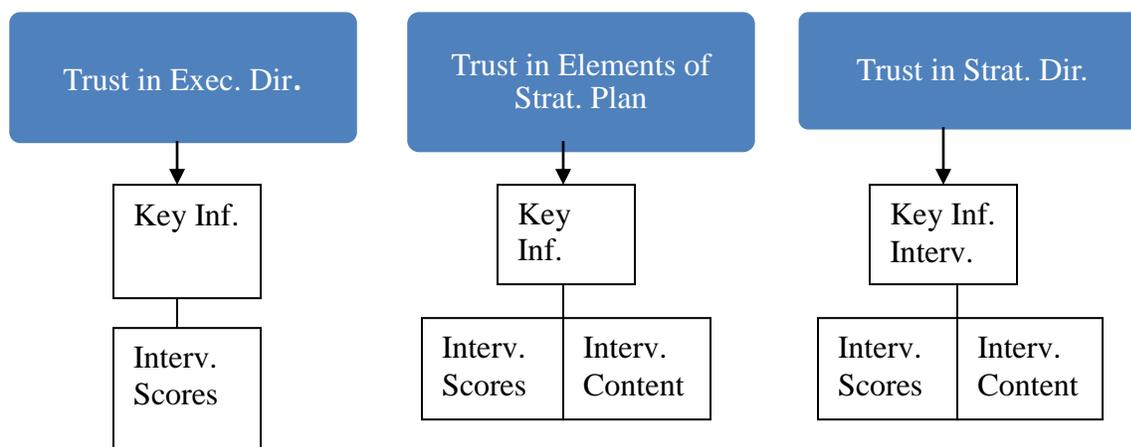
Figure 2-3 <u>Implications for Organizational Direction</u>

	Strat. Goal	Implementing Dept.	Interview Question	Score	Possible Implications for Org. Direction
Exec. Dir.					
Med.Dir.					
Dental Dir.					
Fisc. Dir.					
Brd. Chair					
Peer					

Case Study Design Methodology

A case-study qualitative research method was chosen as the design for this study. This method was not originally selected, but ultimately selected because of the value found in asking open-ended questions and the depth of data collected through face-to-face semi-structured interviews (Krathwol & Smith, 2005). In addition to focusing on qualitative research in an area that has not been extensively studied (perceptions among senior leaders of health centers) case study methodology best supports applicability to interpersonal experiences in dynamic work environments (Yin, 1984).

Target Audience

Of the 67 employees of The Center Health Center, five group leaders were selected as the study sample. These individuals were chosen by virtue of their leadership roles and functions as heads of teams within the organization. Between the board chair, executive director, medical director, dental director and fiscal director, all organizational functions (including governance) are represented. Additionally the CEO of the Pennsylvania Association of Community Health Centers was included in the study in order to provide reflection on perceptions of interpersonal trust in the executive director from the standpoint of a colleague and peer.

Though this study does not focus on issues of race, class and or gender in the context of relationship cultivation, trust development or leadership, it is important to note the race, age and gender of each of the subjects. The executive director is a sixty year old Caucasian woman, the board chair is a fifty three year old Caucasian man, the executive director's peer is a fifty three year old Caucasian woman, the fiscal director is a fifty four year old Caucasian man, the dental director is a sixty year old African American man, and the medical director is a sixty three year old Caucasian man.

The Center was chosen as the area's primary community-based health care clinic. The executive director was contacted by email to gauge preliminary interest in participating in the study. After an affirmative response, a memo outlining the anticipated purpose and scope of the research was distributed to the executive director and board of directors for discussion and approval for their participation.

This study included six subjects (in order of interview): The (immediate past) Board Chair of The Center, the Fiscal Director of The Center, the Medical Director of The Center, the

Dental Director of The Center, the CEO of the PA Association of Community Health Centers
and the Executive Director of The Center.

Instrument Development

The survey was adapted from Tzafrir and Dolan's Trust Scale (2004). Based on this
instrument a 16 item scale was constructed.

In the Fall of 2009, the researcher identified five individuals who agreed to participate in
the research preliminary conversation regarding research methodology . This group of five was
asked by phone to give feedback regarding an adapted questionnaire. An explanation of the
research project and its aim were a part of those conversations as well.

In an effort to elicit feedback, follow up conversations to the survey included such
questions as: Were there any missing questions? How long did the survey take to complete?
Are there recommendations for changes in style, tone or language? Are there recommended
changes in the organization of the questions? Were there particular questions that were difficult
to answer; and do you think the survey will appropriately assess trust levels? As stated
previously, the trust scale was subsequently eliminated from the study.

Data Collection and Analysis

In the early spring of 2010, a personalized cover letter, a copy of the Trust Index, and a
return self- addressed, stamped envelope were mailed to the five participants (Creswell, 2009).
The letter was addressed to the executive director, medical director, dental director, fiscal
director and board chair. The letter described the value of the research and the importance of
participation by each respondent.

The first research question sought to establish the characterizations of trust based on role
and function of each member of the identified leadership team. This question can be further

explored through the responses of each subject during the course of individual interviews wherein experience with and perspective on trust, trust development and trust in the context of strategic planning are also considered.

The second research question examined sources of variance to establish more specific content around how and (perhaps) why variation in trust and perceptions of trustworthiness exists across the organization. This may be examined since each subject was asked the same interview questions.

 The interviews, therefore, were divided into two subcomponents along the following premise: examination of variability adds to the existing body of knowledge regarding various methods of trust measurement. This level of examination acknowledges that trust development is process oriented and there are, therefore, ways to approach its establishment with intentionality. The second consideration is that trust levels may be considered in the context of how trust influenced organizational direction. Given the decentralized structure of many healthcare organizations (particularly community based health centers with executive directors at the helm) examining group/team influences on organizational direction contributes an important perspective on interpersonal trust development.

The subjects for this study included the senior leadership team and one professional associate of The Center, a 67 employee community health center based in central Pennsylvania. Originally, the intended subjects did not include a professional associate. However, because this research is primarily focused on the topic of perceptions of interpersonal trustworthiness in the health center's Executive Director, it became increasingly important to give perspective from an individual who would be viewed as a peer, thus taking the feedback from 180 (three direct reports: Medical Director, Dental Director, Fiscal Director and one superior, Board Chair) to

360 degrees (to include feedback from a professional associate, the CEO of the PA Association of Community Health Centers.) These subjects were chosen as the top leaders having the most contact and impact on high-level organizational and interpersonal conversations with the Executive Director. Additionally, these are the individuals who are most closely tied to both the success of the organization and (to the extent that performance can be externally influenced or impacted) the success of the Executive Director.

The research involved qualitative strategies which included an interview with each of the subjects while gathering data about their specific experiences with trust over the course of their professional careers, their experience with trust in the workplace and specifically The Center, their role within or association to the organization, and various quantitative questions that illuminate perceptions of interpersonal trust in the Executive Director.

The interview questions were developed in consultation with several professors: Dr. Ed Yoder (Pennsylvania State University), Dr. Susan Rose (Dickinson College), Dr. Steven Riccio (Dickinson College) and Dr. David Sarcone (Dickinson College). Therefore, it was ultimately decided that an actual pilot study was not feasible but was replaced by intensive and consistent conversations and revisions to the proposed questions. This took place in multiple face-to-face meetings to flesh out the overall questions, measure and assess open-endedness, determine appropriateness of sub-scoring questions, length and number of questions, tone and clarity and appropriateness of order (which was primarily based on the questions' level of sensitivity.) Interview questions were developed and reviewed in the context of alignment to the trust inventory and thematic overlap. Interviews took place in person in the personal office space of each of the respondents.

The intent of the data collection and analysis was to build upon the literature review and determine perceptions of interpersonal trustworthiness in The Center's Executive Director, the variance in those perceptions and evidence of those variances' impact on organizational direction as articulated by the current strategic plan. Specific source documents were used to gauge perceptions of interpersonal trust in the Executive Director and the alignment between subject feedback and intended organizational direction. These documents included: The Center's organizational chart the immediate past strategic plan, the current strategic plan, benchmarking reports, and board-level work documents establishing roles and responsibilities for execution, monitoring and evaluation of the plan.

IRB Approval

Approval from the Pennsylvania State University Institutional Review Board was obtained prior to the beginning of the study. An Informed Consent form was developed and revised to help guarantee the protection of the research participants and written consent was obtained prior to each interview. All interviews were recorded via a digital audio recorder. The files from that device will be erased two years after the conclusion of the study. All interviews were transcribed so that themes could be determined. The following individuals will have access to the raw data: individual participants who had the ability to review interview transcript for accuracy and agreement, the dissertation chair and committee members and the primary investigator.

The Interview Protocol

Yin (1984) recommended developing an interview protocol during data collection that

enables the researcher to follow a standard format during the interview process. Prior to the

actual interview, participants were each oriented in the following way:

Step One: Thank subject for allowing interview to be scheduled during work day and for agreeing to meet face to face.

Step Two: Review/summarize scope of informed consent.

Step Three: Reiterate purpose of study

Step Four: Remind subject that the interview will be recorded, who will have access to the transcript, that the subject can opt to delete a particular response or responses from the record, that the anticipated length of the interview is two hours, and that the subject will have the opportunity to review the interview transcript for accuracy and mutual understanding, within a specified time frame.

Patton (1987) advocates the method of face-to-face interviews as a valid form of research

and data collection. It is also important to note that a second interview of the Board Chair took

place to incorporate any scoring interview questions that were not part of the first interview.

Data Analysis

Creswell (2009) identifies the five following steps for analyzing qualitative data. This

approach was used to analyze content, identify relevant and important themes and cross-

reference resource material that articulates organizational direction.

- *Organize and prepare data for analysis*
    - Interviews were transcribed and fed back to the interviewees
    - Notes were also taken for cross-referencing and to address any unforeseen technology issues that may have arisen

- *Read through all the data*

- o All transcripts were reviewed multiple times (constant comparative method) to obtain a general sense of collected data and "reflect on its overall meaning" (Creswell, 2009).

- o Common words or phrases were itemized and categorized.

- *Begin detailed analysis through coding process*

  - o Compare units of data to establish themes

  - o Through color-coding, identified themes were cross-referenced or associated with one or more of the two research questions.

- *Represent themes in the narrative*

  - o Themes were outlined in the fourth and fifth chapters

- *Interpret the Data*

  - o To meaningfully interpret the data, findings from the interview were cross-referenced with relevant dimensions of the literature review.

  - o The study articulated the degree to which this interpretation affirmed or diverged from what the literature suggests and made recommendations for future research.

- *Alignment*

  - o The study clearly laid out the degree to which interpretation of data helped answer research questions.

Quality of the Data Analysis Process

This section provides details regarding the strategies used to enhance the trustworthiness of the information analysis process. Qualitative research experts (Lincoln & Guba, 1985; Hesse-Biber & Leavy, 2006; Creswell & Plano- Clark, 2011) describe four components that collectively provide evidence regarding the trustworthiness or "believability" of qualitative

research. These four components (summarized in Table 3 below) include credibility (internal

validity of the research in the quantitative research process), transferability (external validity of

the results in the quantitative research process), dependability (reliability) and confirmability

(objectivity). Following is a brief description of strategies used in this research study and

grouped within the four components of trustworthiness. The strategies are grouped within the

four components based on a class handout provided by Ed Yoder (AEE 597C, Basic Qualitative

Research, Fall Semester 2010). Even though the strategies are grouped within the four elements

the reality is that there is overlap of strategies across the four elements of trustworthiness. The

strategies I used are summarized in the following table. Following the table is a narrative that

describes how I used each of the strategies.

Table 3- Strategies used to develop trustworthiness.

Elements of Quality	Purpose	Strategies Used
Credibility	Develop confidence in the truth and value of the findings	1.Prolonged and varied field contact 2.Triangulation 3.Member checks 4.Peer review
Transferability	Transferability of findings to other settings	1.Description of participants 2. Discussion of findings with prior research
Dependability	Findings are consistent and could be repeated	1.Audit trail with notes and memos 2.Peer checking 3.Intercoder agreement
Confirmability	Findings are based on information collected and researcher biases are reduced	1.Audit trail 2.Triangulation

Credibility

　　　　Strategies used to enhance the credibility of the qualitative study are intended to provide

high quality data that has been examined systematically. These strategies should help the reader

develop confidence in the truth and value of the research findings.   In other words, the

researcher wants to provide evidence that the results are credible. For this study the following

strategies were used.

1. Prolonged and varied engagement (field contact). The researcher over a period of
   about three months was on site and interacted with the study participants on several
   occasions.

2. Triangulation across cases. In this study this is operationalized by using the constant
   comparative approach (reading and rereading the interview transcripts) to examine for
   similarity of content (ideas and themes) across cases. Although this study does not
   include a formal across case analysis, the researcher and the person serving as his
   peer checker did examine the extent of similar content themes across
   cases/interviewees.

3. Member checks. After the interviews were transcribed the researcher did provide the
   transcription to the interviewees, organized by interview question, to have each
   interviewee verify that the researcher had accurately captured the intended thoughts
   and concepts.

4. Chunk coding by another coder. This is discussed in detail in the dependability
   section.

Transferability

Transferability was a not a major goal of this research. The intent of transferability is to

provide some evidence that the research findings have application in other contexts or situations.

This was a case study of one health system. Establishing credibility was more important to the

researcher than transferability. Having said that, the researcher does believe there may be some

application of the general findings to other contexts by connecting the findings from this study to

results in prior studies as reflected in the discussion section in the final chapter.

Dependability

In the quantitative world this is typically called reliability or internal consistency. In this

study the focus was on using strategies to provide evidence that the findings are consistent and

could be repeated or replicated. The following approaches or strategies were used to enhance

qualitative research dependability.

1. I used a series of my own notes to in essence create an audit trail of my coding. This

   audit trail provides some description of my thinking as I read and reread and

   reflected. My approach to reading the transcripts followed basically a four- step

   process which as described below appears to be very linear; however, in reality it is

   not as linear as the following sequence suggests. First, I took the transcripts and read

   through them to get a sense of what was being said and to orient myself to the process

   of coding. Second I read each of the transcripts in much more detail and started to

   make fairly detailed notes and formulate a framework of ideas emerging from the

   interviews. This in essence served as open coding chunks of information. Third I

   began to synthesize and organize the coding information into groups of open codes

   which served as a form of axial coding (open codes organized around a common

   concept). I then took these axial codes and taped them to a wall to help me visualize

   what I had for each of the research questions. This step also included organizing

   specific comments under the axial codes that supported the code. After further

   reflection and changing my mind frequently, the fourth step involved reflecting back

   on my axial codes and grouping them into my final themes.

By this point, final themes emerged quite clearly based on the relationship between frequently identified areas of focus within the interview and the framework provided by the organization of the current strategic plan, which is divided into four distinct focus areas.

2. Peer checking of information. The CEO of the Pennsylvania Association of Community Health Centers was included in the study after the department heads and board chair were identified as participants. This was done because it became increasingly clear that if feedback was to be gathered from the executive director's supervisors and well as direct reports, in keeping with a 360 degree feedback approach, a peer needed to be identified. Because there is no one who falls on the same "level" as the executive director within the organization, it was agreed that the CEO of PACHC functions as a peer in terms of The Center's relationship with PACHC and therefore would be a viable option to serve as one who could give feedback based on that of a peer.

3. Multiple coder agreement is another strategy I used to check whether another coder saw similar content (codes and themes) in the information. One other coder familiar with qualitative research strategies and with prior experience in administrative positions in public educational systems agreed to review and code approximately 10% of the transcripts. This individual reviewed the research questions then created codes. After coding and grouping the codes into themes, a Cohen Kappa index of agreement was calculated with a value of .72. This indicates there was approximately 72% agreement between my coding and the other coder. In essence for 72% of the coding checked similar concepts or ideas (codes and themes) were identified for the

chunks of information. Landis and Koch (1977, p. 165) developed the following guidelines for qualitatively interpreting intercoder agreement as measured by Cohen's kappa:

   a. .00 - .20   slight agreement

   b. .21 - .40   fair agreement

   c. .41 - .60   moderate agreement

   d. .61 - .80   substantial agreement

   e. .81 – 1.00 almost perfect agreement.

More recently Bernard & Ryan (2010, p. 305) indicate a Cohen kappa of .80 or higher indicates strong agreement, and a Cohen kappa of .70 - .79 represents adequate agreement.

Confirmability

Confirmability reflects the extent the findings are shaped by the responses of the study participants rather than being attributed to researcher bias, motivation or personal interest. I developed notes or memos of my thoughts during the analysis process that became my audit trail(discussed previously under dependability) to enhance the potential for the results to be grounded in the data provided rather than in my own biases. I also triangulated across respondents and with the survey results (triangulating data sources).

Presentation of the Data

Chapter Four re-presents identified themes and makes meaning of the data in the context of the research questions. Data was verified by following up with interviewees. The following individuals were also asked to review the findings and analysis portion of the dissertation:

- Dr. Ed Yoder,-methodology

- Dr. David Sarcone-methodology and articulation of key terms in the context of healthcare and strategic planning

- Dr. Steven Riccio-alignment to chapters one and two

- Dr. Susan Rose- interviewing and coding

- Mr. Matthew Getty- style/ writing

Chapter 4

Results

The primary purpose of this chapter is to address the prevailing themes which emerged

from the research following interviews. Those interviewed were: The Center's medical director,

fiscal director, dental director, board chair, executive director and the executive director of the

Pennsylvania Association of Community Health Centers (who, for the purpose of this study is

being considered a peer of the executive director.) The data are categorized by each of the

study's main research questions presented in the introductory chapter. Aligning the major

themes to the research questions allows the reader to address the commonalities identified among

the interviewees. In addition to commonalities, several notable differentiators will be presented.

Review of the Study

The purpose of this study was to analyze the perception of trust in the healthcare

executive (executive director) among a group of five leaders in a non-profit healthcare system

(medical director, dental director, fiscal director, board chair and state association peer) and the

impact of those perceptions on organizational direction as set forth in the 2009-2010 strategic

plan. The study centered on the experience of these six individuals as they related to the

following research questions:

1. In what ways do the characterizations of trust differ among the executive director, her

   peer, the board chair and the three department heads? (medical director, dental director,

   and fiscal director)

2. What are the sources of the variances and in what ways do they differ?

A qualitative case study from multiple perspectives methodology was used to explore the experiences of participants as they related to the posed research questions. Six interviews were conducted. Observations and informal discussions were held and noted in a field journal. The researcher reviewed all interviews through active listening, transcription and coding. Themes and categories emerged from the open coding process. The periodic comparison of themes produced six primary themes: 1) the strategic plan reflected upon in terms of administrative leader or board leadership, 2.) strategic focus areas 3.) organizational culture and leadership, 4.) the senior leadership team, 5.) perceptions of the executive director, and 6.) perceptions of trust.

Table 4 below outlines the alignment between interview questions and the research questions.

Interview Question	Research Question 1 In what ways do the characterizations of trust differ between the executive director, her peer, the board chair and the three department heads? (medical director, dental director, and fiscal director)	Research Question 2 What are the sources of the variances and in what ways do they differ?
	Interview Question	Interview Question
1.		Describe your position here at The Center?
2.	How long have you been at The Center?	
3.		How did you come into this position?
4.	Generally speaking, what has been your experience with trust in the workplace?	Generally speaking, what has been your experience with trust in the workplace?
5.	On a scale of 0-10, how important is trust for you in the workplace?	
6.	What roles has trust played for you in your professional experience?	What roles has trust played for you in your professional experience?
7.	What are some of the things that facilitate and impede trust?	What are some of the things that facilitate and impede trust?
8.	On a scale of 0-10, how would you describe your level of trust in the E.D.?	On a scale of 0-10, how would you describe your level of trust in the E.D.?
9.		Instances/situations influencing trust
10.	Are there examples that stand out as areas where you have more or less trust?	Are there examples that stand out as areas where you have more or less trust?
11.	How important is each focus area in terms of (a) your ability to leverage success in your area and (b) the org's overall ability to move forward?	How important is each focus area in terms of (a) your ability to leverage success in your area and (b) the org's overall ability to move forward?
12.	Question repeated for each focus area.	Question repeated for each focus area.
13.		
14.		
15.	On a scale of 0-10, to what degree do you trust the E.D.?	On a scale of 0-10, to what degree do you trust the E.D.?
16.	On a scale of 0-10, trust sub-scores	On a scale of 0-10, trust sub-scores

The Center and the Strategic Planning Process

The Center was originally established in 1980 as a free clinic operated by the area's local not-for-profit hospital. The Center was staffed by volunteer physicians and a paid dental staff. In 2002 when the Hospital was sold, the new for profit Hospital gave notice that they would no longer support the organization and it became a 501 c(3) overseen by a non-profit board. In 2003, The Center opened its doors to an ever-growing medical and dental patient population. The Center is the only provider within its service area (Cumberland, Western Perry, parts of Adams and Franklin counties) that has as its mission, "to promote quality primary dental and medical care services to low income populations without regard to their ability to pay."

The Center's service areas have pockets of extremely rural, ethnically homogenous populations mixed with urban pockets of homeless populations. The primary service area is comprised of 37 townships and boroughs located within 37 miles of the Health Center. The

Center also provides a prescription support program known as Healthy Rx and a tobacco cessation program for schools and communities within its service area.

In 2005, The Center was designated as a Federally Qualified Health Center Look-Alike, providing services to the uninsured and underinsured. The majority of health care coverage is based on a sliding fee payment arrangement. Other patients receive some type of government support for their medical care.

The Center's vision reads as follows: "[The Center], a community-focused organization, provides unparalleled health services, delivered by committed, dedicated, and well-trained staff, improving the health and well-being of those most in need within our service area."

Its mission supports the larger aspiration of America's healthcare system relative to equity and access: "[The Center] is a community-focused facility that provides seamless, holistic, quality medical, dental, and behavioral health services and education. Dedicated, committed and well-trained employees welcome patients regardless of ability to pay. We strive to enhance the quality of life for our patients and our staff through support from motivated and engaged community partners."

The Center is not unlike any other organization which engages the strategic planning process to guide its work and to frame organizational direction. The 2007-2008 plan reflects a very different approach to strategic planning from the 2009-2010 plan. This is most immediately evident by virtue of the plan's structure which begins with vision and mission. The document then goes on to articulate five corporate values and definitions: customer service, respect, cooperation, communication and stewardship. Following the corporate values are fifteen assumptions which cover areas from The Center's workforce to the physical plant to interactive service delivery. Following the assumptions are five goal areas

with subsections that not only include objectives but also completion dates for specific tasks (assigned by quarter), person responsible and requisite support staff. Goals are arranged thematically by fiscal goals, administrative goals and governance goals.

The 2008-2009 plan marks the shift to a more streamlined process and document with four strategic focus areas and no more than two strategies assigned to each focus area. Under each strategy goals and resources are listed to guide the organization's work relative to organizational alignment. Subsequent documents were devised to summarize and illustrate progress towards realization of strategic focus areas via quarterly status descriptions.

The 2009-2010 plan adopts this same format and framework with slightly tweaked strategic focus areas. The strategic areas are described below and serve as an integral piece of the scope of questions asked during the interview process with the study's six subjects.

The plan is also illustrated below in Figure 3-1 to provide a visual representation of the plan's physical format and to illustrate its simplicity in comparison to previous plans. It should also be noted that within the following narrative and for reference purposes, to identify the strategies related to particular strategic focus areas, the strategic focus area will be denoted by the number to the left of the decimal point and the related strategy will be denoted by the number to the right of the decimal point. (i.e. strategic focus area #2 and strategy number one would be denoted as 2.1)

Figure 3-1- The Center's 2009-2010 Strategic Plan

Strategic Focus #1
Acquire Resources

Strategy #1
Identify and secure new financial resources and strengthen community support

Strategy #2
Recruit and retain skilled clinical support staff

Goal
To diversify The Center's sources of financial support and to increase community contribution (in time and skills) devoted to the mission

Goal
To fully staff all departments and programs of The Center with skilled clinical and support staff

Resources
Grants, loans, operating funds, staff oversight

Resources
Operating funds, recruitment, firms, consultants

Strategic Focus #2
Build Capacity

Strategy #1
Build and strengthen internal systems

Strategy #2
Build and strengthen external relations

Goal
Strengthen The Center's clinical and administrative standards to meet the formal application requirements for 330 funding

Goal
Build alliances with outside organizations to increase financial resources, gain community support, and serve in a leadership role as community advocate

Resources
Consultant, administrative staff, department needs

Resources
Staff

Strategic Focus #3
Expand Service Offerings

Goal
To develop a collaborative clinical service model comprised of primary care and behavioral health specialists

Goal
Our identified community recognizes The Center as the place to go for health education and prevention services

Strategy #1
Explore related primary care and dental care and specialty care services

Strategy #2
Increase health education/prevention programming for patients/clients of The Center Health Center

Resources
Personnel, consultants, operating funds, CAHWF

Resources
Staff

Strategic Focus #4
Emerging Opportunities

Strategy #1
The Center will embrace opportunities that will compliment and strengthen our service delivery, while demonstrating advocacy measures for current and future programs

Strategy #2
To have collaborative strategic alliances with key partners to assess the management and expansion of services to our identified service area

Goal
To develop an assessment tool capable of measuring The Center's ability to assume responsibility for additional programming

Goal
To create a forum of key The Center stakeholders for the purposes of information exchange, problem solving and collaborative planning on common health and social service programming objectives

Resources
Executive staff, consultants, Board

Resources
Executive staff, consultants, Board

A summary table containing themes is presented first, followed by text which contain verbatim

quotes:

Table 5- Summary of Themes Emerging from Responses to SFA #1- Acquisition of Resources

_____

Common Themes	Descriptions
Of High Importance (this includes not only anecdotal information but also scores of seven and higher (on a scale of 0-10) from six out of six respondents in terms of organizational importance.	Seen as integral to forward movement and organizational success. Also characterized as or related to mission-fulfillment.
Challenging	Beyond recruitment of staff and funding from existing funders, monies must be procured through Grants which are challenging to solidify.
Human Resources as a Priority	Resource Acquisition, more than anything else is about recruitment of staff (specifically medical providers and the notion of getting the right person for the job is just as if not more important than simply filling the position.
Unique Themes	*Descriptions*
Personal Disconnection from Organizational Goal	Acknowledgement of goal as important and necessary but not a goal over which an individual department head has influence and also not a goal that necessarily includes recruitment of staff.
Distinct Advantages	As far as 330 funding is concerned, this particular Funding stream is seen as a "bonus" because infra-Structure is already in place. The 330 funding also assumes medical malpractice cost which represents significant organizational savings and opportunities for re-allocation of resources
Purpose of Resource Acquisition	Importance of acquiring resources not necessarily related to anything operational but saving for future funding ("rainy day fund")

Strategic Focus Area #1- Acquisition of Resources

This focus area is supported by two strategies: (strategy one, identify and secure new financial resources and strengthen community support; strategy two, recruit and retain skilled clinical and support staff) In the following section, comments from the interviews are included.

In interviews, respondents were asked to discuss their perspectives on each goal and also rate that goal (on a scale of 0-10) in the context of The Center's overall ability to move forward but also their ability to move their particular department or area forward.

When asked to score (on a scale of 0-10) and reflect upon the importance of this goal in the context of The Center's overall ability to move forward, the executive director took the following position:

> In terms of being successful, it has to be a 10. We have to, ya know? No margin, no mission. If we don't have a bottom line- and it's not a bottom line that needs to be a break even because in order to grow you have to put money away for the future to develop things because there will be times when you'll want to build programs or you'll need equipment that you can't get out of your operation. So you have to have a rainy day fund. So that's a 10. We have to have that.

Even the executive director seemed quite grounded in the sobering reality that the acquisition of resources is difficult- necessary, but difficult:

> I think as an executive director that's probably a seven (on a scale of 0-10) because for us to acquire resources outside of our immediate reference area, it's very competitive and we have to do it through grants- and there's not a lot of grants out there for us to go after.

An important aspect of resource acquisition relates to human resources and recruitment and retention of staff. Certainly no one understood this better than the executive director:

> If we don't get the right clinical staff, we're not going any place. So that is a big one. You have to have the right people. And not everybody is right for this kind of work. A lot of good people… and we've seen them and even interviewed them. They just don't fit. And we're hiring for the fit and not just the skills. But the skills weren't transferable to our needs.

One department head (later in the interview and in response to a different question) also talked about the importance of "fit":

> We need an operations person. We have leaders responsible for medical and dental and they're good but they've never managed a business and this is a business. And I keep telling (the e.d.) that the mechanics of actually running the operations- let's get an operations person in here. We're at the point where we need that. You don't always want everybody to fit. Another good example is our MA staff- and again this is my opinion. When I came we went through three or four MAs and I wouldn't have put up with them for more than a week. I would have had enough and said see you later. But they were still here. And if we would have continued to hire people that fit into that mold it would be in a hell of a mess. Since (the new HR person) came she has hired some people who are different than what we have and it's making a difference. Putting a little more pressure on the ole' timers we've got here. So you've gotta be careful when you say you wanna get someone who fits what you have cause what you have may not

be what you want or need. You've gotta get the right peson with the right qualifications who can jump in and do the job.

In relationship to the difficulty and necessity of acquisition of resources, the executive director went on to say:

We have to be fully staffed- people have done two or three different jobs and you can't do a good job when you're doing half of everything.

Later in the interview and in response to a different question the executive director talked about the challenge of operating the health center without a team in place:

And when I brought these new people on I would sit them down and say now you need to understand, I've been doing all of this. I was HR, I was quality, I was clinical (even though I'm not clinical) and I was front desk. So I don't wanna get in your way. So if I'm stepping on your toes you need to say "isn't that what you hired me for?" And they have, on occasion, said that- and we laugh. But the best advice I ever got was to hire people who are smarter than you are and more ambitious than you are and stay outta their way. And those people are- and they know their stuff. And they can do the details whereas my executive assistant and I were just kind of putting band aids on things- just trying to keep it together until we could get that infrastructure in place.

Relative to the recruitment and retention of skilled clinical and support staff (strategy 2.1) the executive director spoke of the importance of shared vision in relationship to the ability to recruit and retain talent:

(But) as we are able to bring on the right people sharing the vision and getting help with the strategies helps. For example, recruiting and retaining staff- we got

(the dental director), we got (dentist), now we've got two brand new dentists, but if we didn't have (the dental director) as the leader, I don't think we would be able to attract the caliber of people who are here. And that's true in each of our departments."

But the executive director went on to later say:

(And) there's a leader (meaning department head) here who believes that we can't attract good people. And I say they're wrong. Cause when we look at the people we've been able to attract, some of them, we've been able to attract in spite of that attitude.

And we're bringing people on board- clinicians on board, who say they want to make a difference. So I think that's a shared thing. And they've got to build their department up- knowing this is what my expectation is.

This expectation didn't appear to be clearly telegraphed to the department head of whom she spoke based on that department head's depiction of staff compliment relative to work load. Although it was clear that he felt that he was spending too much time having to see patients, the kind of administrative attention to infrastructure as defined by the executive director and others in the organization did not appear to be of significant value to the department head:

So I spend all this time seeing patients. Now I think that's more important than setting up- what she's talking about is forms and protocols and the big books that "this is what you're supposed to do." The provider knows what you gotta do. So is it nice to have? Yes. The army has it. It's painstakingly detailed and it, I think, in larger organizations helps. But when you have to choose between spending your time seeing patients- I mean I work fifty to sixty hours a week and

I don't' have any time. My wife is always complaining. So do I think it's a bad idea to have internal systems? No, the army has them. Where I disagree is the resources- I mean, if they wanted to pay me just to do this it would be boring but I could do it. But then you wouldn't be able to see the patients.

So for me, what (the executive director) sees as strengthening, I don't have a strong objection to, but I consider it a much lower priority because the higher priority is seeing the patients in today's world with all of the certifications, board certifications, licensing, continuing medical education (CME) and requirements, you know if you have half way decent people you don't have to document every darn thing they're gonna do and how they do everything.

Clearly, from an external perspective the executive director's peer saw the very thing this department head regarded as "lower priority" as high priority, given the direction health centers are expected to go in, per federal standards:

(in reference to strategy 2.1, building and strengthening internal systems) I will tell you that at the federal level, one of the goals that the Health Resources and Services Administration has is that by 2014- a few short years from now- every health center site will be certified as a Patient Centered Medical Home. So paying attention to this becomes even more critical.

There are pilots in the healthcare reform legislation for something called an accountable care organization and there were some demonstrations or joint commission accreditation, those validations that someone external to your organization has come in and said you're a quality organization are gonna become more and more important.

So putting the focus on strengthening the clinical administrative standards but building the capacity in general because HRSA's other goals for 2014 are: doubling the number of people served by community health centers by 2014, so an additional 8000 sites in five years and one hundred percent electronic health record implementation- which I think becomes part of capacity building. And I mean they are big, hairy, audacious goals. But it's those that are at least moving in the right direction that are going to be alive and thrive.

One department head, when asked to score the first strategic focus area on a scale of 0-10 did not see himself as an integral part of the goal or the process:

I consider that low, personally. Three. I consider that more of an admin-type or center management- type responsibility. I mean the only thing I can do is recruit staff.

When asked to reflect upon the same focus area in terms of The Center's overall ability to move forward, a slightly different perspective was offered:

I'd say seven. 'Cause there are limitations. You have to write grant proposals. You may or may not get them. So resources aren't readily available at the snap of a finger. It takes a lot of work and you may or may not get what you would like to get. So a seven, I think, is fair.

The same department head was very positive about the alignment of strategies linked to the first strategic focus area:

Yeah… I was there when this was done. And I believe in everything here. You can't recruit staff if you can't pay 'em. And you can get resources through community support.

The acquisition of resources clearly involved perspective and opinions about the current compliment of staff, the appropriateness and feasibility of hiring more staff and the extent to which department heads must compensate for (perceived) lack of human resources in the context of rapidly growing patient need and demand:

One of the things when I was hired, I was hired to see up to seventy-five percent of what the providers were seeing and there was no bottom number. And I asked the first executive director- cause it wasn't in my contract but it was in some kind of paperwork- well what's the low number and she said fifty percent. So somewhere between fifty and seventy-five percent. But we grew so fast that basically I've been seeing… the first year I think it was eighty eight percent and then ninety three percent and then last year I think it was one hundred percent. And the way I look at it is that the bottom line is that we have to see the patients, that's why we're here. …So I spend all this time seeing patients.

Another department head spoke of his workload:

We had thought at one point to have my head hygienist be the clinical manager and we gave her more managerial responsibility- like evaluating hygienist and assistants and she actually started having medical symptoms and we had to take it from her and it was like a relief to her- and so it's all back on me again. So it's just a lot of extra work that puts me apart from patient care and I don't really care for it. In order to keep up with everything I have to work beyond my normal hours, which I don't like either- especially the older I get. Things are supposed to start settling down a little bit and everything's kinda going up.

The same department head, in relationship to his overall responsibilities said:

> It has increased. Hasn't decreased at all.

He also said:

> I wish I had more time to do certain things. I will take time so that I don't do a crappy procedure and then I end up being late or working through lunch in order to compensate for that. So I won't sacrifice quality for quantity…

The board chair made particular distinctions between his role as an individual and important organizational considerations as it relates to the acquisition of resources:

> If you look at acquisition of resources and the role that I would play- certainly our role is making sure that we have an effective management team in place, I think that that's key and so the resource here is making sure that we have an executive director in place who's doing a good job and to make sure that she has the necessary support in place to have necessary skilled clinical and support staff on hand. So it's a matter of then the resources that apply to that would be encouraging the inter-relationship with the area's Health and Wellness Foundation (CAHWF) to make sure that the relationship continues.

The board chair went on to say:

> I think we have a good relationship with them (CAHWF), obviously… they're our principal funder. So I think my position since I have a good relationship with staff and the management level of the CAHWF board- I think (the executive director of CAHWF) does a pretty good job of having regular updates and meetings and connects our board executive team with her executive team so as far as resources go, I think that's how I see my role- to sort of help to see that the relationship with our principal funder's in place and secondly to make sure that

we have good team leaders at The Center itself and giving (the executive director) the necessary resources to recruit the staff she needs.

In terms of The Center's ability to move forward, he offered the following:

From an organizational standpoint, I mean perhaps there would be, not so much maybe at my level but, as a board we made a decision from the beginning- cause I didn't wanna be a fund-raiser and many other board members didn't want to be fundraisers, acquisition of resources perhaps in the way of physicians volunteering services… we've always been looking at striving to seek application for fully federally qualified health center status which would give us another 650K or 60K per year. I forgot the exact number per year in operating subsidy so from a board perspective or organizational perspective I think that's something that's a little different from what I, as a board leader, would be working towards cause I'm more of a relationship person.

From a board perspective, the chair felt that trust between The Center and its primary funder, CAHWF, was integral to the acquisition of resources:

CAHWF is a very good resource and we have a very good relationship with CAHWF and I think they trust us. So if they trust us, that, to me, is securing perhaps not new financial resources but it's securing on-going financial resources.

The executive director had an interesting perspective relative to financial support from CAHWF. This was offered later in the interview and in response to a different strategic focus area, but highlights a potential difference (or variation) in perspective regarding CAHWF's obligation to The Center:

(Goal for strategy 1.1.) To diversify The Center's sources of financial support and to increase community contributions ('in time and skills') devoted to the mission. I don't know if that's– it's what I want. But I could also argue that we could just fight with CAHWF until they give us all their money, and that would make it real easy. But do I think that's the right thing to do? I don't. I think they have an obligation but they have to be a partner with us. So I think it's a good goal but is it the only goal? No.

The chair also discussed the difficulty of garnering financial support from the community given certain limitations (i.e. aversion to fundraising and the make-up of the board):

This year we're talking about having a Friends of The Center get started. Again, we don't perceive ourselves as a fundraising board. I mean 51% of our members are users (of the center's services)

The chair went on to say:

Now over the years… and frankly it's been a result of the economy, we have people who are well educated. I mean just because they don't have health insurance doesn't mean we don't have smart people who have good experience. And we've noticed a real shift in that. So we have good users but again, they're not connected with the community in the sense of being able to garner that kind of financial support. So hence, I think that's something that's leaning toward the strategic focus of acquiring resources- and we're moving in that direction.

One department head had this to say about the acquisition of resources:

Well, I've said for years- this is probably the most important thing for the administrative section of the whole place. I mean you just have to do it. It all

comes down to resources. So that is certainly a ten and you need the right people and you need the adequate resources. You have to have the correct strategy, the right resources and the right quality and number of people that are going to make it work. So that's where the balance is.

One department head saw the acquisition of resources as extremely important to both his area as well as the overall organization:

That one right there today is a 10. Looking at the specific things we need to do this year like 330 application and hiring the dentist and hiring the medical providers- that is critical. That's a 10 for my area and that's a 10 for The Center.

That same department head went on to say:

From the recruiting side, we've gotta be able to build up our provider staff. I mean we had two dentists leave- probably one should have gone, the other we should have been able to save. And on the provider side, we just gotta get the providers in here- and we have space. So it would be nice to be able to get a couple or three more providers in here, we'll up the exam rooms, and then if one leaves we aren't where we are today. We've gotta have providers and part of that is looking at our incentive program for the providers, which is a financial thing.

The executive director's peer, CEO of the Pennsylvania Association of Community Health Centers (PACHC) clearly found the acquisition of resources to be important:

(rated on a scale of 0-10 for her personally, then The Center, respectively) Probably a nine and ten. The Center is very strategically positioned. I have personal bias that starting off as a federally quality health center (FQHC) look alike helps with success because you can't survive with that federal grant without

developing strong community partnerships and connections. With The Center, it's not just the Foundation (CAHWF). You have to become woven into the tapestry of the community and I think once you've done that, when you get the grant it's a cushion, it's a bonus. You already have a strong infrastructure without that monetary piece of it.

In relationship to the first strategic focus area, the CEO of the PACHC ranked both strategies (1: identify and secure new financial resources and strengthen community support and 2: recruit and retain skilled clinical and support staff) as 10s (on a scale of 0-10):

The first strategy is about 330 funding so this would be a 10, cause it also takes the medical malpractice off your hands.

In response to the second strategy, she said:

This one I would rank equally as high, 10. You don't have access if you don't have clinicians.

The first strategic focus area, acquisition of resources, was clearly important to all subjects and represented a goal without which the organization would not be able to successfully move forward. The primary differences seemed to be concentrated in two areas: how these resources are defined in terms of hiring staff as opposed to putting particular systems in place (i.e. infrastructure, protocols, etc.) It is also interesting to note that the executive director did not define the acquisition of resources purely in the context of the 330 funding, in as much as that is just one possible funding stream, though a significant one.

Table 6- Summary of themes emerging from responses to Strategic Focus Area #2- Build
Capacity

Common Themes	Descriptions
Respondents seem to gravitate toward strengthening internal system	Emphasis was placed on a specific sub strategy (strengthening internal systems as opposed to the overall strategic focus area (build capacity)
Unique Themes	*Descriptions*
Funding for electronic medical records	Depending on how quickly the organization can mobilize its efforts to transition to use of electronic medical records (a core piece of the 330 requirement) there's money at the federal level to assist with that particular change effort. This was therefore seen as a very important organizational priority.
'A Catch 22'	Challenging to build capacity via strengthening of internal and external systems because of patient culture characterized, in part, by "no-shows" which affects the bottom line as far as production is concerned.
Influence over decision-making	In terms of decision-making around internal systems, fiscal manager and board chair seen by one department head as having greater influence over this particular organizational goal.
Seeing the bigger picture	Both sub-categories under this strategic focus area are critical to the larger goals of the Health Resources Services Administration (HRSA). So healthcare is moving in this direction anyway.
Disagreement with method	Agreed upon as an important strategic focus area but there was disagreement regarding how the organization should go about achieving it.

Strategic Focus Area #2- Build Capacity

This strategic focus area is supported by two strategies: (strategy one) build and

strengthen internal systems and (strategy two) build and strengthen external relations.

The notion of building capacity clearly meant different things to different people. When

asked to rate the importance of this focus area departmentally and organizationally (on a scale of

0-10) one department head reflected upon the following:

The big one on the internal systems, in my opinion, is electronic medical records. And I would say that's a 10 both in (my area) and the Center. And the reason I give it a 10 for (my area) is if we get moving soon enough there's money at the federal and state level to help pay for it. And the longer we delay the lower the amount of money becomes – so that's why it's critical we get moving on it. Becoming (the Pennsylvania Association of Non Profit Organizations) PANO certified , complying with the 330 standards, that's probably an 8 out of 10 but the electronic medical records are certainly the highest priority I think.

The only other respondent to specifically mention electronic medical records as a distinct priority was the executive director's peer:

(So) putting the focus on strengthening the clinical administrative standards but building the capacity in general because HRSA's other goals for 2014 are: doubling the number of people served by community health centers by 2014, so an additional 8000 sites in five years and one hundred percent electronic health record implementation- which I think also becomes part of capacity building. And I mean they are big, hairy, audacious goals. But it's those that are at least moving in the right direction that are going to be alive and thrive.

The notion of building capacity through both internal systems and strengthened external relations is not easily achieved according to one department head:

A lot of patients… they build up that relationship. They don't wanna see anyone else. They trust you. I mean I have good word in the community. As director, my hands are kind of tied- I mean I can't make everyone little robots of myself so I have to deal with their particular personalities and good and bad points and I try

to keep the bad ones down as far as I can to make the place as attractive as I can for patients.

The department head went on to say:

There are patients that we see or you see and there are certain procedures that you may be better at than another dentist or another dentist may be better at than you- so you wanna try to get those patients to the appropriate provider. And then we still have the bottom line where we have to hit certain numbers that the administration wants. We try and coordinate that- but with this type of situation and with our type of patients there's always no-shows, which affects the bottom line as far as production.

One department head felt somewhat limited in terms of the ability to influence capacity building:

They're (The Center's) capability would be 10, their ability might be a 7. But they make the decision based on resources- like how many chairs we have available…if we need to expand… they have that control, I don't. I can make recommendations.

That same department head continued in saying:

I think the board really listens to the director. I mean half the board are users of the clinic and most- like I'm on the board of (a local non-profit organization) and as board members you really don't have management responsibilities. You kinda listen to the director and go by their suggestions. So really the key players would be the financial manager, who the director works very closely with. So the board has responsibilities but its only based on what the director dictates.

One respondent was able to link the second strategic focus area to a macro-issue, which is the relationship between the community health centers and the strategic goals of the Health Resources and Services Administration:

> I will tell you at the federal level, one of the goals that the Health Resources and Services Administration has is that by 2014- a few short years from now- every health center site will be certified as a Patient Centered Medical Home. So paying attention to this becomes even more critical.

That respondent went on to say:

> There are pilots in the healthcare reform legislation for something called an accountable care organization and there were some demonstrations of that concept already happening. I will tell you that having either of those certifications or joint commission accreditation, those validations that someone external to your organization has come in and said you're a quality organization are gonna become more and more important.

The respondent elaborated:

> So putting the focus on strengthening the clinical administrative standards but building capacity in general because HRSA's other goals for 2014 are: doubling the number of people served by community health centers by 2014, so an additional 8000 sites in five years and one hundred percent electronic health record implementation- which I think also becomes part of capacity building. And I mean they are big hairy audacious goals. But it's those that are at least moving in the right direction that are going to be alive and thrive.

The notion of providing quality service is a habit of mind community health centers are admonished to develop sooner rather than later:

> You want to be, frankly, a provider of choice not just a provider of last resort, If healthcare reform plays out the way it's envisioned many more people will have options- insurance options through the exchange of insurance, through the increase in qualifying for medical assistance to 133% of the poverty level.

The respondent went on to say:

> You don't want to be just where people go if they can't get in anywhere else. You want to be the provider of choice and the only way you do that is making sure that you have strong adherence to the clinical and administrative standards and that you have a strong team- both clinical support staff and your board.

One department head expressed a sense of disconnection from the *method* of building capacity:

> Yeah, see.. this is where (the e.d.) has her view and I don't necessarily agree with what she wants to do… this is the basic problem here. One of the things when I was hired, I was hired to see up to seventy-five percent of what the providers were seeing and there was no bottom number. And I asked the first executive director- cause it wasn't in my contract but it was in some kind of paperwork- well what's the low number and she said fifty percent. So somewhere between fifty and seventy-five percent. But we grew so fast that basically I've been seeing… the first year I think it was eighty eight percent and then nine three percent and then last year I think it was one hundred percent. And the way I look at it is that the bottom line is that we have to see the patients, that's why we're here.

The department head continued:

>So I spend all this time seeing patients. Now I think it's more important than setting up- what she's talking about is forms and protocols and the big books that say "this is what you're supposed to do." The provider knows what ya gotta do. So is it nice to have? Yes. The army has it. It's painstakingly detailed and it, I think in organizations, helps. But when you have to choose between spending your time doing that and spending your time seeing patients- I mean I consistently work fifty to sixty hours a week. So do I think it's a bad idea to have internal systems? No. The army has them. Where I disagree is the resources- I mean, if they wanted to pay me just to do this it would be boring but I could do it. But then you wouldn't be able to see the patients.

The department head went on to say:

>So for me, what (the e.d.) sees as strengthening (internal systems) I don't have a strong objection to, but I consider it a much lower priority because the higher priority is seeing the patients and in today's world with all the certifications, board certifications, licensing, continuing medical education and requirements, you know if you have half way decent people you don't have to document everything darn thing they're gonna do and how they do everything. So, "build capacity"… I don't have any problems with and I can see that it would be a nice thing but it's a matter of practicality of how you do it and what do you lose in order to do that. So as far as scores, I would put it at a five for me and for The Center, it depends on how you define The Center. If you define The Center as

(the e.d.), it's a 10. I don't think it's a huge priority. It's not that it's not important but within the context of resources it's more like a six.

For the board chair, capacity building was clearly just as important to the internal system as it was to the external ones:

> As far as internal systems, I like to meet weekly with the e.d. I think I've established that there's a pattern of internal communications and I think that that's important in strengthening the actual operational standards within any organization.

The respondent continued:

> It encourages her because I know that she has regular meetings with staff to make sure that everything is operating smoothly and that we have the necessary operational standards in place. But from an organizational standpoint again… I think it's not so much me- I think that it's what (the e.d.) and her management team would do, cause that's them making sure that on a day-to-day basis they're operating in accordance with our FQHC look alike standards to make sure that we're meeting those standards.

Building external relations (the second strategy under capacity building) should not be underestimated in terms of importance to the community and the reputation of the organization:

> I see our (board) role and my role to be to help the e.d. and the management team continue external relations and that kind of ties in to what I said before about acquisition of resources because I think they're interrelated in the sense of monitoring the external relationships within the community in particular to make sure that we have the necessary support here and I think that that would be more

personal interrelationships that are established within the organizations and other leaders in those organizations.

The respondent went on to say:

I know (the e.d.) mentioned talking to the president of PACHC. She has done a pretty good job of outreach to that state-wide organization, which increases the visibility of the organization. In fact, she's (the e.d. of PACHC) been to our board meetings. We start off our board meetings with just a speaker on a topic that would be of interest to the board. So I think the board encourages (the CEO) to continue that outreach with her peers.

It was interesting to note the diverse interpretations of the various strategic focus areas and related strategies. One department head had the following reaction to building and strengthening external relations:

If you look at the sign out front, I would never have written this- just because of my personality- it says "[The Center]… health and education for everyone." Well, first of all, we've agreed that we're trying to limit to the poor and underinsured. We purposely don't take a lot of the insurances because we don't want to have the other providers think we're stealing patients from them. And education… I'm very familiar with this in the army. People don't care about that. I mean the idea was a nice one. I think they pictured people pouring in here on a Tuesday night to listen to a lecture on diabetes. It just ain't gonna happen! So…the idea is good, it's just very difficult. I mean there's all kinds of stuff that would be great educationally, but people don't show up. No one shows up for dietary, stress management- they always ask for stress management then nobody

shows up…nobody! I guess partly because it sounds good. I mean what are they gonna do? Show up and say "I'm a stressed out failure?" So, how important? I think it's nice but… what? seven? I don't care.

The respondent went on to say:

The problem is how to do it and it's so expensive. In today's world, people don't want to come home from work and then go sit in a class on diabetes and asthma. And the people who don't work… they're even more annoying- they're never able to make anything. They don't work and they don't have a schedule.. and they can't make it. It's impressive! So again… they'd be nice, I'm not opposed to them, worth a try.

This issue of attendance was corroborated by other respondents:

I have ideas for people to come in and learn how to take care of their oral hygiene cause a lot of it will effect birth rates, heart problems, diabetes. I mean there's a relationship between germs in the mouth and things that could happen medically as well as orally. But we've tried doing general classes in the past and no one came. So the only control I have now is in the chair.

My staff try and educate our patients as much as possible while they're here because this may be the only place that we can get them to do this service for them.

Ideally I'd like to do it in a classroom setting but it hasn't worked in the past. It's labor intensive and I don't know if that's feasible right now.

The second strategic focus area, build capacity, also touched on areas related to the development of both internal systems and strengthening external relations. Again, no subjects

disagreed with the goal area in principal, but the reflections of who really "owns" capacity building in terms of key organizational decision-makers seemed to vary from subject to subject. However, all subjects reflected, in some way, on the fact that the ability to build capacity further solidified the importance of establishing a quality continuum of care that would compel patients of The Center to make it their medical home.

Table 7- Summary of themes emerging from responses to Strategic Focus Area #3- Expand Service Offerings

Common Themes	*Descriptions*
Collaboration and partnerships	Expansion of services requires more intentional focus on the creation of key collaborations and partnerships with other pre-existing healthcare providers within the community
Integration of Behavioral Health	No contesting the need to address the inextricable relationship between behavioral and medical health. The question is how.
Education	Desire to proactively educate the community on preventive care. Again, difficult to do but important to offer.
Unique Themes	*Descriptions*
Relationship Between Behavioral Health and Medical Issues	Articulation of the realization that lack of attention to behavioral health will make resolution of medical issues virtually impossible.
Part of Trust Development	Expansion of service offerings increase chances that a patient will choose The Center as their medical home because of the comprehensive services provided.
Never-Ending Cycle	Uncontested important but of low importance to a particular department head because of the belief that expanded service offerings will never meet the demand. This department head's area just moved three short years ago and they've already outgrown their space.
Community Perception	Community (users) are not thinking in terms of what other services could be offered or expanded. It is not on their "radar" because in some ways, their expectations have already been met and exceeded.

Other Priorities	Not seen as important because the strengthening of internal systems is a more eminent priority in terms of organizational change efforts.
Mission-Drift	Expansion of services is not necessary or important in terms of mission-fulfillment. The organization is already doing what it's supposed to be doing.

Strategic Focus Area #3- Expand Service Offerings

This strategic focus area is supported by two strategies: (strategy one) explore related primary care and dental and (strategy two) increase health education /prevention programming for patients/clients of The Center Health Center.

It could be argued that with the increased demand and the dearth of free or heavily subsidized health care services, the notion of expanding services offerings may seem unrealistic, unattainable and perhaps even inappropriate. The reality, however, is that The Center has chosen to focus on the development of a model that will allow for collaborative clinical services to include both primary care and behavioral healthcare. This focus also involves increased health education and prevention programming.

The executive director's peer, when rating the importance of the strategic focus areas on a scale of 0-10 had this to say regarding the expansion of service offerings:

"…Not as critical, but when you talk about trust… for example, dental is such a high need…often people who will come to you because they can't get dental anywhere else will learn to like and trust the organization and they start coming.

This respondent went on to say:

And some of the things that I mentioned that The Center is doing that are a little bit more non-traditional like the smoking cessation and some of the wellness things, it's again an opportunity to establish the relationship and the trust before they're making the commitment to say this is going to be my medical home.

The respondent also shared that:

> There's a movement state-wide and nationally to try to do this- the integration of behavioral/medical health. Some of the payment streams make that more challenging. But frankly, if you don't' address the behavioral health , you're never going to resolve the medical issues. This would be more like a 6 or 7.

The chair of the board did not see himself as integral to the facilitation of this particular goal but he did feel that the board was an important "voice" in the conversation around how the organization should approach the expansion of service offerings:

> In my position as chairperson… you know I really think that's more a board thing- not so much me. I can sort of help with this at my level whereas the board would certainly wanna look at expanding service offerings without going into the specific strategies but that is definitely an area we are involved with and should be involved with.

The board chair continued:

> One thing we have done this year is, we have now engaged the Hospital to provide OBGYN services to our patients so that is actually a big thing. That's under specialty care services. I really think under this one we would say OBGYN services but I think there's other work to be done in other collaborative relationships.

Rating the importance of each strategic focus area was done on the two levels: importance to the individual and importance to the organization. One department head had this to say:

As director, all I can do is make recommendations. I would give it a three. That would be more so on the center… based on need. I think we've already outgrown our capacity up here. So we're already ready to expand even though we just moved up here three years ago- we've already outgrown it. So that center… I would give it a 10.

The same department head spoke passionately about the challenge of quality and quantity as it related to the balance between productivity and patient care:

We have no choice but to put a cap or limitations on what we bring in. Cause right now, it's wearing me out… trying to see these numbers and also do what I would call quality work at the same time. It's wearing me out trying to get both things done. I mean based on what we have we had to cap. If we could expand the sky would be the limit but right now it affects the quality of care.

The expansion of service offerings would also come with certain internal responsibility and perhaps pressure based on a department head's ability to support the staff responsible for quality care in an expanded context:

I'm still under the gun and I try to be the one to take as much - and my staff knows this- I try to keep all the pressure on myself rather than passing it on to them- which I know some managers- or other managers would do, and I'm not that type of manager. So I try to take as much heat away from them- but they still know that I'm under heat so it still ends up being a personal thing for them- maybe to try and please me- without me forcing it on them. But yeah… it effects quality.

The department head also said:

> I wish a had more time to do certain things. I will take time so that I don't do a
> crappy procedure and then I end up being late or working through lunch in order
> to compensate for that. So I won't sacrifice quantity for quality but that's still
> over my head.

Another department head spoke specifically of the importance of establishing collaborative relationships as it relates to the expansion of service offerings:

> You have to set up relationships with the specialists because in general, they lose
> money when they see our patients. So you have to build positive relationships.
> It's not necessarily my job to do… I try to find specialists that accept our patients
> based on the insurances involved.

That respondent went on to say:

> I have talked with some specialists to see if they could work out payment plans
> because I'm really interested in a certain kid's occlusion or their bite. I've
> worked out relationships with oral surgeons if I'm concerned about a particular
> lesion in the mouth that I think needs to be seen right away and so we have some
> oral surgeons that will do that for us. But that's just for a few patients- it's not for
> a lot of them. If we saw a lot of patients, that flow would stop. So it's kind of
> like a case by case basis.

The second strategy under expansion of services deals with increased health education and prevention programming. One department head had this to say:

Health education and prevention is key with our particular patients. Most of our patients are under educated. They don't know what to do with themselves, not to mention their children… so they need to be educated. That's a key.

As previously mentioned, the irony surrounding this strategy is that as much as the providers would like to offer increased health education and prevention programming, the organization struggles with getting users to attend the programs:

I have ideas for classes for people to come in and learn about how to take care of their oral hygiene cause a lot of it will effect birth rates, heart problems, diabetes. I mean there's a relationship between germs in the mouth and things that could happen medically as well as orally. But we've tried doing general classes in the past and no one comes. So the only control I have now if just in the chair.

The department head went on to say:

My staff try to educate our patients as much as possible while they're here because this may be the only place that we can get them, to do this service for them. I'd really like to do it in a classroom setting but it hasn't worked in the past. It's labor intensive and I don't know if that's feasible right now.

Expanding service offerings evoked disparate reflections from the e.d. especially as it related to distinguishing between importance to her versus importance to the organization:

This is important for me so I'd say a 10. Because I want to give people what they need in this community and identify what those needs are- not necessarily for The Center to do it but to help in the community to get things done. But from a community perspective, people don't know about us unless they need us. So I don't think it's real important. People think we're successful now- and if we did

nothing else they'd still think we're successful. So I think it may be a 4 or 5 about expanding service offerings- cause it's just not on people's radar- unless they need it.

The executive director went on to say:

I just think this is the biggest challenge in that we may think it's important to move forward but I'm not sure the community sees it that way. And if we do it, they'll say "oh, that's marvelous!" But I don't think they think of it.

For the executive director's peer, the value proposition in this strategic focus area had to do with building trust among patients and goodwill in the community:

Extending service offerings… not as critical but when you talk about trust… for example dental is such a high need… often people who will come to you because they can't get dental anywhere else will learn to like and trust the organization and they start coming.

And some of the things that I mentioned that The Center is doing that are a little bit more non-traditional like the smoking cessation and some of the wellness things, it's again giving an opportunity to establish the relationship and the trust before they're making the commitment to say this is going to be my medical home.

For one department head, scoring the importance of expanding service offering for his areas and for the organization had to do with the extent to which the expanded services could be funded:

This is pretty important, this merging behavioral health in with primary care. But the idea there is that you'll have a psychiatrist- type person there and when the

patient comes in for their medical visit and the provider sees that there's some

need for some behavioral health treatment then they'll leave that person in the

room, being the behavioral health person in while they're already here and do

whatever they need to do. From a financial standpoint, I see a lot of money going

out and that's not gonna pay for itself- we'll need grant funds to help support that.

One area that is important here- and it isn't listed but our group talked about it- is

going out and recruiting specialists. One area that we need help in is getting

specialists in the area that will see our patients. And we have a good many but we

could always use more. That's something you have to continually work on to

build a base.

That same department head was less enthusiastic about education and prevention programming:

Yeah… ok… remember you're talkin' to the finance guy here so that's probably a

three for me and a seven for The Center. You know, I just see all the other work

we need to do- to get the providers in here, to get the 330 grant and the electronic

medical records and I would spend a lot of time doing that.

One department head agreed with the idea of expanding service offerings but the idea of how to achieve the goal seemed to differ from other leaders within the organization:

I have a little different philosophy on this. I think your basic bread and butter

primary care is what we've been doing and what we should be doing. So I don't

know where they can really expand that much. Dental care- I think going out to

Perry County, I think that's a good idea but it's hard to do. Specialty care

services… we've been going around and around on this for years. And the

problem is we've had different specialists call us and want to come here. But I

think it's worth continuing to try to do. The answer that I've said for years is

have them agree to see our patients at their clinic because then when they don't

show up at least they haven't lost an hour just to travel.

That same department head had some hesitation concerning the feasibility of collaborative clinical services involving primary care and behavior health specialists:

The basic problem is they're never cost-effective so when the money people look

at it they always get upset. The VA has a great system but they have the wealth to

be able to do it. And they have a big center so that psychiatrists and psychologists

can interact with the primary care but are close enough to psychiatric patients that

they can keep them relatively busy. But again, it's the balance of what can you

afford to spend your money on? That's the basic underlying problem with the

healthcare in the country- is that for all the healthcare that it would nice to have

and good to have, we just can't afford it all. So it's either gonna be rationed one

way or another.

This same department head was also not particularly supportive of increased health education and prevention programming:

I think that, to be honest, the problem is that they end up making more work than

what you get out of it.

Although articulated in different ways, the third strategic focus area, expand service offerings, already emerged as a less important or critical area of focus. At the core of this goal is the fundamental question of feasibility. Although expansion is necessary, the organization contends with the day to day reality that it is struggling to meet patient demands even under its

current configuration. This is also the goal area that identifies the need to educate the community around important health related topics. The challenge of that should not be underestimated. More than one subject reported that it is very difficult to get patients to attend educational events, which places even more importance on thinking of ways to creatively educate them while they are receiving care.

Table 8- Summary of themes emerging from responses to Strategic Focus Area #4- Emerging Opportunities

Common Themes	Descriptions
None	There were no consistent themes which ran throughout even two responses to interview questions regarding the fourth strategic focus area.
Unique Themes	Descriptions
Extremely Important to E.D.	This area is the primary source of motivation for the executive director because she is most connected to the 'visionary' dimension of her job.
Ambiguous	Seen as a "catch-all" goal where organizational ambitions are placed when they have no clear home.
Under-developed	Seen as the only strategic focus area out of the four where there is significant lack of movement, basic understanding and buy-in.
Role Clarification	Specific organizational question of who's job/role it is to identify emerging opportunities.
An Inevitable Organizational Issue	Consideration of emerging opportunities is important in the larger healthcare world. The 11 billion flowing to healthcare centers through healthcare reform sort of forces health care centers to think intentionally about emerging opportunities.
Facilitates Partnership/Collaboration	Helps the organization with the responsibility of finding strategic partners and getting to know surrounding areas including who holds the resources in those areas.
An Unnecessary Direction	The Center is too small and too busy seeing patients to justify radical expansion of its infrastructure.

Strategic Focus Area #4- Emerging Opportunities

This strategic focus area is supported by two strategies: (strategy one) embrace opportunities that will compliment and strengthen our service delivery, while demonstrating advocacy measures for current and future programs, and (strategy two) to have collaborative strategic alliances with key partners to access the management and expansion of services to our identified service area.

The executive director seemed most drawn to the emerging opportunities focus area. She felt that this is where the true work of a visionary is done:

> Well I have to tell you, this is what I love- cause I love to dream and from a community perspective of us moving forward I don't think it's on their radar but it's where I live. I'm always up in the clouds, I'm a 10. I gotta be thinking about what opportunities are out there that we can either partner with, we can take the lead on, or we can incubate for someone else to do it. Cause this is what keeps me coming to work every day. It's not the everyday stuff that doesn't change, it's the opportunity to do something that makes a difference.

The executive director went on to say:

> I think it's all about relationship building and communication and information. So my challenge is how do I get that information to the community? Cause I can't. I don't have a history here- I have a short history and I think it's a good history… but who needs to be my messenger to help me? And that's always the difficult piece is to find that person who can be that champion for me.

The executive director also added:

Part of this emerging opportunities is that I want to create a legacy for this community. And that legacy is The Center, cause it will be here long after I'm gone. And it has nothing to do with me but that the community takes pride in the ownership. And in my head, I envision having a The Center Legacy Club and everybody in this community is a card-carrying The Center Legacy member and they give 10.00 or 20.00 a year towards that legacy and so people know about it. They never have to use it but as a community they've been able to build something. Cause nobody wakes up and says "oh I hope I can be poor" or "oh, I hope I can do drugs" or "oh, I hope I can beat my kids" Nobody says that. And we can make a difference so that people who find themselves in that situation can know that they don't always have to be in that situation. We'll always been here but you don't always have to be here. So that's my dream.

One department head found this strategic focus area to be less concrete and had this to say of emerging opportunities:

It's kind of hard. This where if something comes up, this is where we stick it. Good example is our employee benefits package. We have a cafeteria plan and it keeps getting more and more expensive. It's almost impossible- well it's impossible for an MA and a clerical person to cover dependents on our health insurance- cause they gotta pay the whole thing and the cost is just out of reach. So we need to look at our benefits package and try to make it more cost-effective. So that's an emerging opportunity- that's something we're working on now because we know we've got an issue there and we need to get it fixed. So I don't

know of anything specifically there we've targeted yet but I'm sure by the time the middle of the year comes along there will be half a dozen things on that list.

The board chair had this to say in relationship to emerging opportunities:

We now have what we call a dream team. I have to give (the executive director) credit for this. We have the committee chairs, essentially, meet quarterly to sort of think about this main area- really looking at our future opportunities and have a discussion of those opportunities. So there's definitely activity in that area.

From a governance perspective, emerging opportunities would first need to be vetted at the committee level:

Perhaps we have a committee structure that we have necessary discussion that takes place because obviously at the board meeting you can't zero in on all the nitty gritty details that are at the committee level- that we have a good discussion of opportunities and encourage the executive director to bring those to the committee or committees- whatever committee it might be- to have thorough discussion of that for the board to act on and move forward with a potential opportunity.

Even with those compelling observations, the board chair had less positive reflection on the extent to which the organization was actually pursuing the first strategy, which deals with embracing opportunities that will compliment and strengthen service delivery while demonstrating advocacy measures for current and future programs:

I don't get a sense that we're real strong in that area, to be honest with you.

The same was true for the second strategy which deals with forming strategic alliances with key partners to assess the management and expansion of services to the identified service area:

> I don't really get a sense that we're doing much in that area either. So I think emerging opportunities will need work.

The board chair went on the say:

> I'm not getting a sense that we as a board have identified what these emerging opportunities are. I mentioned about the OBGYN but that's kind of an emerging opportunity from two years ago- or maybe it was even three years ago, so that's kind of come to a conclusion, so we need some- perhaps more guidance from the executive staff so that the board can embrace whatever those opportunities are.

An interesting theme that seemed to run throughout many of the observations was the question of role clarification. That same theme emerged relative to the fourth strategic focus area, emerging opportunities:

> So I think- I mean… who's role is it? I guess that's the bottom line…who's role is it? Is it the board that's supposed to come up with what those strategic alliances would be or should we look to the executive director and executive staff to identify what those are so we can work on them? So I think this one definitely needs work and that's probably something we wanna touch upon at the strategic planning meetings.

It was interesting to note the peer's macro-view of the fourth strategic focus area, especially given the reflections of the board chair:

This is going to be important whether you want it to be or not. It's going to be imposed on you or you're going to embrace it gladly because there's 11 billion dollars flowing to health care centers through health care reform. Other players who didn't want a thing to do with health centers in the past all of a sudden look very attractive. What's going to be important is to develop the infrastructure to evaluate those opportunities. Prior to being approached or approaching you have to have your conditions or your values of engagement so that you have something to evaluate the opportunities against.

The strategy linked to emerging opportunities seemed a bit confusing to the executive director's peer:

I don't know what "demonstrating advocacy" means.

This respondent also noted the importance of utilizing the State Association as a mobilizing agency:

Well, I will tell you, I don't see primary care listed under resources. But actually, I think The Center does leverage much better than a lot of other health centers. I mean they rely on us for advocacy behind the scenes but forget sometimes that we're a phone call away, ya know? When you're doing an environmental scan, what does it look like at the state level? You can get so involved in your community that you don't stop to ask "is what I'm considering unique or different?" or "have others gone down that path and what has been the outcome?" and we can bring that to the assessment.

The executive director's peer went on to say:

> The other thing is agreements. We can reach out to other associations and draft
> agreements. The educational programs- you know if we're hearing that
> something is a focus for a health center, what are you most hungry for
> information and education on? We do what we call peer inquiries, so if the e.d.
> wonders what the rest of the health centers are doing in the state on…whatever…
> I started this in my hospital association role and the questions are so incredibly
> varied. And the way we do it- the questions come in to me, I send them out
> blinded to all the CEOs (health center e.d.s) they have the opportunity to blind
> copy their responses if they want to. Only the people who respond get the results-
> so you can't just be an observer. And it provides feedback to the person who
> posed the question. It supports networking among peers.

The executive director's peer added:

> If something comes up as a question from one health center (and I've had this
> philosophy ever since I've been in the association world) there are at least two
> others who have the same question they just haven't asked it. And so I really find
> it to be a win-win. We know resources at the national level, at the state level.
> Part of our role is essentially the state level relationships so that when you need
> the relationship it's already there.

Much like the acquisition of resources, one department head felt somewhat detached
from the fourth strategic focus area:

That's not my job, that would be the director and maybe the board to an extent-
board members who actually have influence. And just the director to keep their
eyes and ears open for anything that would benefit the center.

In terms of ranking importance, that same department head had very definitive reflections
on and seemed more connected to the second strategy of emerging opportunities which had to do
with building strategic alliances with key partners:

I'd give that a 10. Because you do have to make contacts. That's how we got our
Perry County clinic started- by making contacts with some of the key members.
The key foundation up there is the (X) Foundation. And if you wanna expand you
have to know your area and you have to identify key people who might help, you
gotta identify financial resources you can attempt to get monies from… so that
would be a 10.

A different department had a less optimistic view of building strategic alliances and
found it quite challenging from his perspective and experience:

"Primary care and dental care specialty services" What does that mean? Um… I
have a little different philosophy on this. I think your basic bread and butter
primary care is what we've been doing and what we should be doing. So I don't
know where they can really expand that much. Uh, dental care- I think going out
to Perry County, I think that's a good idea but it's hard to do. Specialty care
services, we've been going around and around on this for years. And the problem
is we've had different specialists call us and want to come here and see some of
our patients here. But out patients never show up. So then they've taken half a
day of their clinic to show up here to see eight people and one person shows up

and they get pissed. But I think it's worth continuing to try to do. The answer that I've said for years is have them agree to see our patients at their clinic because then when they don't show up at least they've haven't lost an hour just to travel.

One department head was in agreement with the idea of emerging opportunities but less optimistic that such opportunities could be feasibly implemented given the growing demand on staff time and talent:

Well…see… what this is… who would argue with that? You can't argue with that, right? But "while demonstrating advocacy measures…" that means the documentation- and the issue again comes down to do you have the time and energy and resources to devote to documenting everything you're doing? Just for one example, and again… not saying the people who want to do this are wrong.., it's just that from my point of view sometimes I think they think we're like the Mayo Clinic or the VA or the military system. They say "well, what you're supposed to do is analyze something then you make a plan to change it, then you measure your improvement. Well, in the VA or a big center, yeah…you can do that. Like the army has like one hundred people in their quality assurance division. They can do that- that's their whole job but here we're so small, you really don't learn that much by doing that. And the amount of effort it takes and what you get out of it… it's kind of minimal. So I'm not saying that this is wrong I just think it's again… priorities. We get more bang out of our buck letting our providers see patients rather than spending a lot of time documenting studies on such a small group.

The fourth strategic focus area, emerging opportunities, resonated most with the executive director as the foremost visionary within the organization. Other subjects seemed a bit more ambivalent about what this goal truly means and represents. Furthermore, there seemed to be significant confusion and uncertainty about how this goal would actually be implemented and who would be involved in the implementation of such a goal.

Table 19- Summary of themes emerging from responses to Organizational Culture and Leadership

Common Themes	Descriptions
Infrastructure	Reflections on The Center's start, including convening of the board, obtaining 501 c(3) status, getting key staff in place and cultivating board/staff relationships.
Decision-Making	Various perspectives on what goes into decision-making and when it is appropriate to change one's mind.
Unique Themes	*Descriptions*
Growing Pains	Reflections on how staff and the executive director have adjusted in terms of personality, leadership style, managing expectations and developing interpersonal trust.
Organizational Growth	Sentiment that the organization has grown to the point that it needs an "operations person."
Advantages of an FQHC Look Alike	In one respondent's opinion, none of the healthcare centers (FQHCs)who *first* got the grant, then opened their doors, are "strong." The Center is "strategically positioned" for success by virtue of its starting off as an FQHC look-alike and putting certain systems in place before seeking FQHC status.
Organizational Growth/Capacity	Since executive director joined in the Center, it enrolls 180-200 new patients a month.
Healthcare Centers as Part of Larger Enterprise	Health care centers are part of the largest primary care network in the nation but the requirement that the majority of the board be users of the services make it a very "local" entity. It is the only community majority board requirement among healthcare providers.

Organizational Culture and Leadership

Organizational culture and leadership is at the core of The Center's strategic planning process. But the respondents all had very different reflections on how culture and leadership inform organizational direction:

The board chair offered background on The Center's start and how he came to be involved in its leadership:

> Well it started when I was on the The Center Health Center Task Force- which was something the Health and Wellness Foundation (CAHWF) put together to look at the future direction for the then Health Center which was under a private managed care organization, the for profit purchaser of the local Hospital. So I was asked to join the task force and out of that I was asked to be the first board chair. And then I basically assembled other potential board members and formed the corporation in 2002 and I've been board chair from the beginning. My role as chair is to be the executive leader of the board and I look at it as kind of the main point of contact with the management team at The Center. I sit on the executive committee so that would sort of be the team. So that's kind of what I see as my role.

The executive director spoke about organizational culture and leadership when reflecting on the state of the organization when she was first hired:

> I came to The Center and forgot to really ask about the finances. Because I got so excited about the potential. But we had an accountant who spent two hours a month going over our numbers and preparing stuff for the board, and didn't give

me a copy of it until the morning of the board meeting… I was like, "C'mon!"

We had no HR person, we had 27 employees, we were seeing five to eight

patients a day and thinking we were working hard. And I was like a kid in a

candy store- there was so much to be done here. And I thought "we can make this

be a community legacy. We can really develop something" But I didn't have any

real support structurally.

The executive director went on to explain how she strategically put her team in place:

I first hired (the executive assistant). She was my first hire- and a smart one.

Then I said "we really need a full time fiscal person. I can ask the questions but I

can't keep the books, that's not my area of expertise." And we had some good

candidates and at the very last minute our board treasurer said "my husband's

boss has given his notice at work and he just wants to get into something that will

give back to the community and he's an accountant. Would you consider him?"

And I 'm thinking, "how could I afford him?" And she said "It's not for the

money, he just wants to give back." So he came in and we had three candidates

and I had four department heads at the time interview him and they did not want

him at all- they wanted some other guy and I just knew he was the right person

and I thanked them for their input and certainly welcomed it but it had to be my

decision and we offered the position. Well now everybody loves him and he's

like the best thing that ever happened to us. He's a hard worker and he's

dedicated and he's smart and he really caught on. And he's still learning cause

he's been here I think four years but boy did he catch on and he helped turn things

around and we were worried that we wouldn't be able to keep him busy cause we

were going from a two-hour per month consultant to a full-time position…he's busy. So that was a good hire.

The executive director went on to talk about the medical staff:

And then clinically we had (the medical director) but we didn't have any clinical support staff. We had all MAs and one LPN. And I really felt we needed to have someone who had an RN and that was hard to find. People didn't wanna come for what we had to offer. So we inquired a couple of times and finally (the office manager) applied and she's been a wonderful addition. She's fair and consistent and has good clinical skills so that gave us some more meat.

The executive director went on to explain how she filled additional positions:

And then we needed a front desk manager and we went through a bunch- it's a tough position but now we have someone who's been here almost three months now and she's perfect for the job. She has the respect of people- cause people here can eatcha up! And there's like an eighth grade mentality of exclusion if they don't like you- they'll gang up on ya. And we got an HR person and we got a quality person and so I feel like now our management team is strong and good for the organization.

The executive director spoke candidly about the cultural shifts that took place once her team was in place and the new people to do the jobs she was at one time doing, essentially, by herself:

We need an operations person. And when I brought these new people on I would sit them down and say now you need to understand, I've been doing all of this. I was HR, I was quality, I was clinical (even though I'm not clinical) and I was

front desk. So I don't wanna get in your way. So if I'm stepping on your toes you need to say "isn't that what you hired me for?" And they have, on occasion, said that- and we laugh. But the best advice I ever got was to hire people who are smarter than you are and more ambitious than you are and stay outta their way. And those people are- and they know their stuff. And they can do the details whereas my executive assistant and I were just kind of putting band aids on things- just trying to keep it together until we could get that infrastructure in place.

The executive director gave specific examples of the challenges of building strong inter-relationships among staff and assessing organizational culture:

People here- well… in every organization I've gone to- people, including myself, operate under a thing of fear like if they make a mistake they're gonna be killed. And I talk to people a lot about that because I had very kind mentors who would say "ok, you made a mistake, what have you learned from it?" And what I learned is that if nobody dies, you can correct things. And if we can all get together and talk about it and process it, we're going to have a better outcome. And if we make our decision based on what we have right now, and if we get information that's different in five minutes to make a better decision, you're allowed to change your mind. And what I've seen in so many businesses is that they make a decision and they'll go to the death for it- even though they have different information and that confuses people a lot of times because they'll think "oh, well she's indecisive." "No…. you brought me different information. What do you think we should do now?"

Ironically, one department head, in answering a different question, referred to his perception of the executive director as indecisive:

> I think the only negative that I've seen working here is that (the e.d.'s) a little wishy-washy. Not a little wishy-washy…. she's wishy- washy.

In answering a question about the importance of trust, one other department head mentioned the executive director's decision making:

> (And) I think one of the problems is that if a staff member is not working to our expectations, the Director takes too long to make a decision to release them.

The executive director spoke specifically about the quality assurance position in the context of changing organizational culture:

> The QA position was created about six months ago. We finally got permission and we had one person who didn't last- just a couple of months and the current person's only been with us about six weeks. She's an RN. She had done QA but never as a focus. She's wonderful. She's bright, she's hard working, she's articulate, she's really done a lot in the time that she's been here. And she's really helping staff because I think we do QA everyday- we're always trying to do better but we don't call it QA and we don't give each other the credit that they need. And so she's helping people to understand what QA is and to do projects so we pick something, we see what's going on, we see if we need to make some sort of intervention, then we see if the intervention works and if it didn't, we see what we have to do next. So it's kind of a circle of a circle of QA and she's been helping people to pick projects that will make a difference- and I said "pick easy ones so you can get buy-in. We can get to the harder ones later on."

In terms of organizational culture and leadership, the executive director spoke of her own sense of comfort her with leadership style and the way she relates to staff:

> A lot of my career, people have wanted to know exactly how they're going to get there and I'm not a detail person. And I say that to people. Details are not my specialty. I see the big picture, I know where I want to go. I trust you have the ability to get me there. And then people are afraid. They don't want that responsibility. So I think we're better now than we certainly were the day I came here. I knew a couple of the other candidates and I know that they didn't want me. But I came anyway. And I think that people have respect for me. They don't necessarily have to like me but I do want them to not just respect me but respect this position. So I'm working on that. So it's not the best place that I've ever been with trust but it's not the worst place either.

Despite the commitment to cultivate a strong sense of team among leaders, the executive director was also very clear that she needed to clarify her relationship with the board to establish her own philosophies and parameters and distance herself from the way things may have been handled by any of her predecessors:

> The e.d., not the interim, but the e.d. before me- people felt they had the power to get rid of people. And that power's not there anymore. My relationship with the board is solid. And even when an attempt was made it didn't work. They already knew everything that this person was bringing to them 'cause I already told them. I wasn't keeping anything, there are no secrets. They knew the good, the bad and the ugly. And so that made a change in where- well it's not really about power- but maybe- it made a change in the influence- about what could or could not be

done here. And that was the day we really started to grow. And it was hard. And (that department head) still doesn't trust me, no matter what I've done. But you know what? I've told him I can't wait for him- I can't wait 'til he retires to make the changes- cause it's not about him, it's about this organization.

In terms of organizational culture and leadership in the context of board governance, one department head had the following reflection:

I think the board really listens to the director. I mean half the board are users of the clinic, as board members you really don't have management responsibilities. You kinda listen to the director and go by their suggestions. So really, the key players would be the director and the financial manager, who the director works very closely with. So the board has responsibilities but it's only based on what the director dictates.

One department head spoke about the role of the budget and departmental needs as an important element and in relationship to the effect on organizational culture:

The budget is set about a year in advance and it's based on what you used the year prior to that- which is also based on staffing. So there's really not a competition between let's say medical and dental. It's just are we gonna be able to get as much as we need to do what we need to do? So we're not really fighting for money. But we have to have a certain amount to work with. But (the e.d.) knows that. We spend more- but we also bring in more.

One department head spoke about the importance of strong management as a key element of organizational culture:

We need an operations person. We have leaders responsible for medical and dental and they're good but they're not managers. They've never managed a business and this is a business. And I keep telling (the e.d.) that the mechanics of actually running the operations- let's get an operations person in here. We're at the point where we need that. You don't always want everybody to fit. Another good example is our MA staff- and again this is my opinion. When I came we went through three or four MAs and I wouldn't have put up with them for more than a week. I would have had enough and said see you later. But they were still here. And if we would have continued to hire people that fit into that mold it would be in a hell of a mess. Since (the new HR person) came she has hired some people who are different than what we have and it's making a difference. Putting a little more pressure on the ole' timers we've got here. So you've gotta be careful when you say you wanna get someone who fits what you have cause what you have may not be what you want or need. You've gotta get the right person with the right qualifications who can jump in and do the job.

That same respondent felt very optimistic about The Center's future based on its successes to date: In the past, you could get a grant and start building your center. None of them are strong, at least not in PA, that started that way. But I think the biggest resource that any health center has is its community.

The Center is very strategically positioned. I have personal bias that starting off as a FQHC look alike helps with success because you can't survive with that federal grant without developing strong community partnerships and connections. You have to become woven into the tapestry of the community and I think once

you've done that, when you get the grant it's a cushion, it becomes a bonus. You

already have a strong infrastructure without that monetary piece of it.

That respondent went on to say:

I think The Center does the best job of getting positive local press. You can feel it

as a part of the community just by reading the press on it. I think that The Center

is very well positioned to get the federal funding when that opportunity comes out

later this year. But I think it's already wealthy in a way that a lot of health centers

are not. And that's because of the way it has become sort of integral to the

community. I think since the e.d. joined it's 180-200 new patients a month. I

mean that's incredible growth!

The executive director's peer spoke about the governance structure for community health

centers and the relationship between the local and national organizational frameworks:

For me, being relatively new to the health center world, one of the most positive

attributes of the health center program is that you are part of the largest primary

care network in the nation by far- yet because of the requirement for board that is

has to be community majority, it's a very community, very local organization at

the same. So you get the best of both worlds.

The peer went on to say:

And there are no waivers for that requirement. And it's probably the number one

reason that, for example, there aren't a lot of hospitals starting federally qualified

hospitals- they're not willing to give up control- which goes back to the trust

thing…. are you willing to trust the community to run the board? It's a very

unique model. It's the only health provider that has a community majority board requirement,

When asked of her reaction to the model, the executive director's peer said:

I have mixed emotions. I can tell you that when I was on the outside looking in I thought, "what a crazy requirement! Don't you want the best and brightest no matter where they come from?" Having now had a couple of years experience with the health centers under my belt, if you put enough focus into board development, I think that requirement can be one of your biggest assets.

Table 10- Summary of themes emerging from responses to Administrative Leadership and the Strategic Plan

Common Themes	*Descriptions*
Federal Funding	Preparation for and filing of the 330 application has been an integral piece of The Center's recent strategic planning efforts.

Unique Themes	*Descriptions*
Ownership of the Plan and Process	Executive director's thoughts about it not being her plan but belonging to the organization with everyone having an important piece of it.

Strategic Planning As It Relates to Administrative Leadership

The board chair spoke of the on-going nature of strategic planning and goal-attainment:

The way I look at these is I never look at these (strategies) as reaching a conclusion. I mean you don't reach a point where you say "oh, we're done with that and we can pull that off the shelf." I mean in particular, "recruit and retain skilled clinical and support staff"… that's an ongoing battle- I'll use that term. We just had to let go of two doctors- I mean dentists. So… you know, that is a

constant struggle- and (the e.d.) and I have talked about this a lot. I mean there's no magic button that you can push to ensure that you have the right team in place and I don't know what it is, to be honest with you. So I think that is a real struggle.

A significant piece of the strategic plan (which will forever set it apart from previous and subsequent plans) is the application for FQHC status. The executive director discussed what that process entailed:

It's been hard work, cause there's a lot of research that had to be done; a lot of statistics, needs assessments, statistical information from a county, state and federal level. That becomes labor intensive. You have to put together a healthcare plan, you have to put together a business plan, you have to look at quality- quality is a big thing. From the medical side there was a lot of resistance because it is hard work. But one of the things I learned early in my career is that if you're good and people think you're good, eventually they're gonna ask you to prove that you're good. And we're good- and we look good but we can't prove that we're good. That's the big deal about having the QA person and putting policies and procedures in place and having privileging and credentialing and doing all the things that are requirements that we've had some resistance to putting in and had- well… we had a little conversation and things are changing.

The e.d.'s peer was optimistic about The Center's forward movement- even in the absence of significant increase in federal funding:

I think The Center is very well positioned to get the federal funding when that opportunity comes out later this year. But I think it's already healthy in a way that a lot of health centers are not. And that's because of the way it has become

sort of integral to the community. And I think that the fact that without ever advertising really, I think since the e.d. joined its' 180-200 new patients a month. I mean that's incredible growth!

The e.d. spoke of the importance of shared vision when it comes to the strategic plan:

This is not *my* strategic plan. This is the organizations, we all have a piece of it.

One department head spoke of the importance of leadership during the strategic planning process:

Well I think, to put it in perspective, being an army war college grad, a lot of it deals with leadership and how organizations function. For example, the masters in strategic studies. I mean they put that in the course but it had always been there- the emphasis on strategy. I mean the War College has its own strategy. In fact I've heard references to the three-legged stool thing. That's been at the War College for many years and I don't' know if it originated there or not but they acted as if it did. And basically it was planning, resources and the personnel to carry out the plan and they had to be in balance.

That same department head spoke of the challenge of the actual process of strategic planning:

I mean that's the way you're supposed to be and sometimes, ya know… not everybody agrees and you kind of argue back and forth but hopefully the end result is a good one because you don't' kind of go unchecked one way or the other. So that's a good thing. And you just hope you don't kill each other in the process.

Table 11- Summary of themes emerging from responses to Governance and the Strategic Plan

Common Themes	Descriptions
Strategic Focus Areas	Acknowledgement of goals/strategies never "reaching a conclusion" in the healthcare world, especially as it relates to recruitment and retention of staff. Referred to as "an ongoing battle."
Board Involvement	Board has been very involved in the planning process, particularly at the committee level. Board began with the ultimate intention of seeking FQHC status.
Unique Themes	Descriptions
Measurement of Success	Important for the board to have "hope" and to see what is possible and work toward that possibility. Must also grapple with the question "how will we know that we've been successful?"

Strategic Planning As It Relates to Governance

The board chair saw strategic planning as more of a benchmarking exercise in as much as

organizations are constantly in a state of planning, reaching goals, and developing new ones:

The way I look at these is I never look at these (strategies) as reaching a

conclusion. I mean you don't reach a point where you say "ok, we're done with

that one- we can put that on the shelf."

The e.d. spoke specifically about board's role in the strategic plan:

From a board perspective, these are the areas I want them to focus on. I don't'

want them to focus on operations. So we need to talk in our management team

about "ok, so 'increase health education' what are we gonna do?" This is the

goal. What are we gonna do so that when we report back to the board we know

that we've been successful? So I went through this with the board. And we have

another document that says "how are we gonna know that we've been successful?

What do you want to see?" So under financial resources, they wanted to see three

or four grant applications being put in- that would be success to them. So that

we're not running off of two different ideas saying "oh this is what I thought- well

I thought you meant this." So we got them to sit down and do that. And we'll go

over it every quarter. And every quarter the dream team talks about our

successes- that's the executive committee of the board and all chairs and myself.

The executive director went on to say:

I thought it was important for the board to have hope. You know, Id' hear them

say "I can't believe we've done this. I can't believe where we are" You know,

they didn't even know of the possibilities. And that wasn't bad it's just that they

hadn't had the same experiences that I had. And I had seen it from other places.

And I know what we can do and cannot do. And they knew only what they knew.

When asked about the decision to move toward FQHC status, the e.d. offered the

following reflection:

When the board first looked at the type of organization they could create, they

picked the FQHC model because they eventually saw that there was some

additional money and some things that could happen. Having CAHWF give us

those dollars has been very helpful. So from the very beginning they've wanted

to go after FQHC.

The board chair spoke of the importance of leadership at the board level, specifically

during a strategic planning process:

This board is so much unlike so many other boards in the sense that we have a

very engaged board membership and so consequently, I'm very engaged as well.

Like I said, we have weekly meetings, we have very well-attended finance

committee meetings and like many non-profits that might only have one or two committees or have a board that only shows up once a month at the board meeting, this is a much more engaged organization. And it's a challenging field, they are challenging employees. You have big turnover of employees in the medical field and so there's a big challenge for the e.d. and the board to follow through on the strategic plan because of these very issues.

One department head talked about the role of the board during the strategic planning process:

The board… they're nice people and they're well-intentioned and so is (the e.d.) they're well intentioned, they have good hearts. But they try to do too much that gets into the weeds and gets in the way more than it helps. Now last year I thought (the strategic plan facilitator) did a wonderful job of leading them away from getting in the way and having a plan that made, at least to me, made sense. This year, I thought he had a little bit more trouble. Put part of it, I think, is the hand he was dealt.

The board chair spoke of the sub-committee of the board as a group helping to advance particular elements of the strategic plan:

We now have what we call a dream team. I have to give (the e.d.) credit for this. We have the committee chairs, essentially, meet quarterly to sort of think about- and this is the main area- is really looking at our future opportunities and have a discussion of those opportunities. So there's definitely activity in that area.

Table 12- Summary of themes emerging from the topic of the senior leadership team.

Common Themes	Descriptions
Role of Trust	Trust was seen as an important element of team building at the department level and among the senior leadership team.
Information-Sharing	Previously, people felt they gained power by keeping their knowledge (information) to themselves. That is shifting to a greater appreciation for "shared wisdom" wherein different perspectives are more frequently offered in team settings.
Unique Themes	Descriptions
Clarification of Roles	There is no formal name for the three department heads who serve as leaders at The Center. However, the executive director identifies those three individuals as her "go-to people" and the "absolute leaders" of the organization.

Senior Leadership Team

Despite the membership of what she calls the "management team" the e.d. explained that she essentially has three "go-to" people that address overall organizational strategy:

> The HR and QA persons are part of the peer group (fiscal director, dental director and medical director) because we have the management team. And they're part of the management team. So the department heads as well as (the fiscal, medical and dental directors) and myself are part of that team. But if push comes to shove and we need to do strategy, it's the dental director, medical director, fiscal director and I that are in this room. It doesn't look that way on the organizational chart but they are my go-to people; they are the absolute leaders of the organization. And the rest are department heads but their input is very important.

The e.d. went on to talk more in-depth about leadership and building her team:

The more we talk, I think there's a shared wisdom that no one person has all the answers but together we can give different perspectives. And that was a hard nut to crack because everybody who was in a position of authority really felt like if they kept their knowledge to themselves they had power. And that's not how it works. You get power by giving it away. And so our team meetings have changed and are still changing for the better where people are trusting. And that's the big issue: building those relationships and having people trust each other enough to say, "I messed up" or "what can I do next?"

The e.d. was particularly complimentary of one of the department heads:

I've seen such a huge change in (the department head) since I've been here, of really stepping up and taking a leadership role and being willing to try things. And now it's not just a job to him. He sees that he is seen as a leader and he's attracted these wonderful people who would die for him, because he's given them leadership. Not all of our department heads are at that level but…

When asked to score (on a scale of 0-10) how important trust is in the context of work relationships, one department head offered the following:

Well, ya gotta have it. I can speak for myself. I can't speak for the other department heads whether or not there's trust issues or whether there's a good flow of communication. I consider that imperative to myself and the director, as well as communication between the two of us. I mean it's huge. But all the managers have to be involved in it. If the director has trust issues, that's gonna be a cog in the work. And I can't speak for the director, but I know that the director

has a positive trust relationship with me but I can't speak for the other managers.

So I would give it a 10.

Table 13- Summary of themes emerging from responses to the topic of perceptions of trust.

Common Themes	Descriptions
Of High Importance (this includes not only anecdotal information but also scores of 7 and higher (on a scale of 0-10) from 6 out of 6 respondents in terms of importance.	Even with the least supportive viewpoint of trust as an important factor and consideration, all of the respondents spoke in some way about the critical nature of establishing and maintaining trusting relationships and attending to trust development in the workplace.
Team cohesion	Trust as an important element of building and maintaining a sense of solidarity both within a two-person situation as well as a team situation.
The Role of Perception	Perceptions of trust and whether or not someone should be trusted has a lot to do with ones personality, past experiences, communication style and being perceived as honest or dishonest.
Unique Themes	Descriptions
Leadership Lessons	Leaders must be consistent and fair which sometimes has implications on interpersonal trust and trust development. This is particularly hard for one respondent who labeled themselves as a "people pleaser."
Combating Fear in a Effort to Build Trust	The culture of fear at The Center had become so profound that many employees were apprehensive that their mistakes would cost them their jobs. The executive director had to work hard to get staff to believe that unless someone dies, most mistakes can somehow be fixed.
Important, but not the only answer	Trust is important but cannot take the place of strong internal systems of control which an organization puts in place to protect itself and its employees.
The Challenge of Absolute Trust	With absolute (or even high) trust comes a level of power and influence and accountability that may be difficult to accept and maintain.

Perceptions of Trust

In terms of the importance of trust, one department head said:

Well, I mean in general, trust is a key factor. Without it, it's gonna fall apart, you're gonna lose patients and you may yourself drop out or quit if you can't trust the director or the people that you're answerable to. So it's a huge factor.

That department head went on to say:

If your staff can't trust you, you're not gonna keep them. And there's going to be discord, disharmony and distrust. And on the opposite, if you can't trust your staff, I'm not gonna keep them. Because it's a key factor. If you or myself or my staff are not trustworthy, patients are going to pick that up and we're going to lose patients. So there has to be harmony in the clinic. If not, the clinic's going to fail. And I consider that true in life as well.

The same department head had the following general reflection on trust:

I had more control over trust issues post-military. Prior to that I was subject to the whims and needs of the army and my superiors whether I trusted them or not. But now I'm at the position where I have more control, which I appreciate.

In terms of scoring the importance of trust on a scale of 0-10, the e.d. found it to be of the utmost importance:

Pretty close to a 10. I need to trust the people I work with. I need to trust them and I need them to understand I've got their back, ya know? We're gonna get through this. And I'm not going to embarrass them or yell at them in front of others. We might have that conversation privately but I've got their back and I wanna feel they've got mine.

The e.d. spoke more specifically about some of the cultural challenges she faced upon joining the The Center team:

> (in reference to "having one another's backs") That hasn't always happened here. And because I've been able to grow and understand and maybe forgive myself so I can forgive others, we've had to have conversations, and they were very hard, when somebody didn't have my back or deliberately stepped away to leave me exposed when I didn't think that I'd done anything. And I'd say "when have I ever done anything like that to you?" Cause I wanna learn… "was it something about my behavior that caused you to set me up for that?" And nobody's ever given me an explanation but at least I put it on the table and some of the behavior stopped.

The e.d. went on to discuss the process of learning to trust herself and others:

> When I started in my career I didn't trust anybody, I can tell ya that! I was closed. And my graduate work really helped. We did this wonderful program on leadership- on different styles where we looked at the Jeharri Window and I saw- cause we did it twice- we did it sort of at the beginning of our program and then again towards the end. And at the end it was like… off the paper! And so you know.. you grow. You grow in leadership styles and function. So it's been good. And learning not to take everything so personally, that's been the hardest lesson I've had to learn as a leader. Cause I'm a people-pleaser. I wanna make everybody happy. Nobody has to be sad. But when you're a leader you have to be consistent and fair. And that's how people learn and that helps to build trust too. Because I would hope that if you ask people if I'm consistent and fair they

would say yes. They may not always like it but they're gonna get the same answer every single time and everybody's gonna get that answer, even if it's not what they wanna hear.

The e.d. further elaborated on the challenge of cultivating trust relationships within the organization:

> To know that… "yeah, she does have my back" You know, people come in and they say "am I gonna get fired?" And it's like "for what?" And they tell me and I'm like "well did anybody die?" "No." "Then let's fix it." And don't place blame, that's what I'm working on right now. Every time something happens people don't want to take responsibility. They want to blame everybody else. And it's like, "we're not here to blame, we're here to fix." And that's why you're here.. you're here to fix things. You know we can all point out where the big issues are and who's at fault but then if we did that then we wouldn't need you. Cause we need you to fix it. And that's new for a lot of people. But again, I'm leading from what I learned from people who led me. And I had some great teachers. Whenever I needed a mentor they just showed up. I didn't ask for one- I didn't even know what one was, but they did.

One department head spoke of the importance of trust in the context of patient care and departmental leadership:

> A lot of patients, they build up that relationship. They don't wanna see anyone else, they trust you. I mean I have good word of mouth in the community. As a director, my hands are kind of tied. I mean I can't make everyone little robots of myself so I have to deal with their particular personalities and good and bad parts

and I try to keep the bad ones down as far as I can to make the place as attractive as I can for patients.

In response to the importance of trust (rated on a scale of 0-10) the board chair offered the following:

It certainly plays a big role. Your board has to trust in the e.d. and you have to have staff who supports and trusts their leader from an employee perspective. It's critical. And before (the current e.d.) came on board we had a situation where there was total distrust, which led to her removal. So we've had experience with the trust element. It plays a very big role. Ten.

When asked about his general perception of trust in the context of workplace relationships, one department head recalled the following story:

Before we moved I used to be treasurer at our church and of course it's a small church and I was it. I wrote all the checks, I did everything. So from a control standpoint it was … if I was a dishonest folk, it would have been pretty easy to take off with whatever I wanted. There were not many controls there. So I shared with the pastor and with the council and they said "it's ok.. .we trust you." I said "well you know, when you're talking about internal control, trust isn't an internal control." It's not that I don't trust you but when you're structuring how you do things in an organization you don't rely from an accounting standpoint, or money standpoint, you don't rely on trust. You rely on internal controls and having two people involved and all that kind of stuff. It's nice that you trust them but at the end of the day, you can't say "what's your internal control?" "well… I trust'm" that doesn't work.

That same department head felt that trust was very important but certainly not the only thing that work relationships require:

> It's nice you can trust folks and you've got to be able to trust folks but you also need controls and systems in place that take that factor totally out of it. I would say that trusting their decisions and trusting them just as a person to know they'll do the right thing- you've got to have that. And if I didn't have that then I had an issue with that person. I had to know that if I wasn't there and they had to make a decision and they were going to make a decision on their own (which is what they're paid to do) that they would more or less probably make the right decision or at least have the right goal in mind when they made the decision. We all make bad decisions but at least they were heading in the right direction when they tried to make the decision. So I think generally, you have to trust your employees but not to the extent of weakening internal controls, because you've got to have these controls.

When asked to rate the importance of trust on a scale of 0-10, this department head said:

> For me, I wouldn't go to ten. I'd probably go to seven or eight. It would be up in there somewhere. Having absolute 100% trust… your support can't be based on that. They need to be based on strong internal controls, they can't be based on trust. It's nice to be able to trust them but if any of my employees were to come in here and say "I need to go down the street and get keys made and it's gonna cost me five bucks," I'll give you ten bucks out of petty cash- that's easy. Now would I say "ok, here's 800,000. This needs to get to the bank." Am I gonna say "ok, take care of it tomorrow" or "take it home and just keep it in your dresser

drawer until tomorrow"? No, I don't think so, no matter who you are or whether or not I trust you. It's just not something you do. If the auditors are sitting across the table from me and ask how I make this or that happen, I don't say "well, I trust them."

One department head offered the following relative to trust formation in general:

Well, I think part of it is how personalities kind of get together.   Most folks will have an impression of somebody within minutes and if they think they're not trustworthy, then it's going to take time to build that up. And it basically comes down to being either honest or perceived as honest. So if one person finds another person not being truthful in certain areas, that harms the trust. Sometimes I think people misinterpret… that one person really didn't' mean it that way or they interpret something as being dishonest but it may be something else. The communication comes down to trust.

The department head went on to conclude:

So if two people trust each other the communication can be inaccurate but effective, cause it doesn't matter. They make up the difference. And if people don't trust each other, they're so defensive or looking askew at the other's activities that they think are dishonest but they really aren't. And that's a matter of perception. Who is it… Robert Frost… he was on Meet the Press and his observation was that most of the trouble in the world are the results of people objecting to being stepped upon, whether they were actually being stepped upon or not.

When asked to score the importance of trust on a scale of 0-10, one department head said:

Ten. It makes all the difference. It makes everything pleasant or unpleasant. It

works or it doesn't work.

That same department head went on to talk about his personal experience with trust—

how it's built and how it functions in relationships:

You know, when you're starting off a lot of this you don't really think about too

much, but over the years you look back on it and it's really the essence of not only

working relationships but personal relationships and everything else. Are you

familiar with Covey? I mean he sums it up very nicely. He does a wonderful job

explaining the importance of trust and how it takes time to build it up and only a

second to lose it. And looking back and just the difference between the places-

I've been many places because of being in the army, moving around. I taught

school for a while, I coached high school basketball and I've been different

places- some have been wonderful and some have been unpleasant, at least

temporarily. And the ones that were unpleasant in retrospect, they were

unpleasant because of a combination of trust and personalities. I think there are

some people that just try to control folks so much that it makes things not work

well.

That same department head went on to give examples of how trust is sometimes built in

unconventional ways:

Certainly if Covey were looking at it, I'm sure he'd look at it from the perspective

of trust. I mean it's really just one of the keys. And even in the military, the

whole idea of the unit… band of brothers. I mean that whole idea in military

academies… you know, the hazing? And part of that is making people so

miserable that you kind of build a bond through that. Much of what they do in the military units, a lot of it, even the rules, may seem strange but the essence of it comes down to that trust. So that they can function and trust that if somebody says they're gonna be somewhere they're gonna be there. They're not gonna do something behind your back.

When asked to score the importance of trust, the e.d.'s peer had this to say:

Ten. To me, it's critical. It has been critical to me personally moving along a certain leadership path. Ive always had someone who had confidence in my ability and gave me what I call creative freedom which is probably the most essential elements of a position for me, that is I see an issue that I have the freedom to address it. And you already get that if they trust you. And when you're trusted it becomes reciprocated. You're not gonna risk if you don't trust yourself and feel that others trust you too.

The e.d.'s peer spoke of the ways in which trust levels can be influenced by perspective and outlook:

(my husband) and I do a presentation called "Power Talk" It's the top 10 expressive style attributes that people of influence share, and one of these is that when positive things happen you see that as part of a pattern of positive things happening, and when negative things happen you see it as an exception. So I think that someone who has a tendency to be more pessimistic or take a singular event and paint a broader brush with it, even a single incident could seriously impact the trust level.

The e.d. spoke candidly about her overall struggles with trust and trust relationships:

I grew up in a challenged family where trust was a big issue and the reality of what might be happening and the reality of what I was feeling was sometimes in conflict so it was very hard for me to build trust and to understand how important trust was because of my personal experiences with having trust betrayed. So it's a struggle for me. I know how important trust is and I try to trust people even though I sometimes think, "ok, am I gonna be disappointed?" But that's how we learn and that's how we grow. So trust, to me, is a big leap of faith in a lot of ways. Ive learned that you're only as good as your word and when I say I'm going to do something even if it causes me a lot of personal angst- and so I'm very careful when I say "don't worry about that, I'll take care of it." So I'm learning about trust and trusting people in organizations and for a long time I was attracting all the wrong people in my life and I went through some personal work to change that and now I can't believe how many good people there are and they keep finding me.

The e.d. went on to say:

So I mean trust… it's a difficult thing and I think that having a mission and sharing the mission and vision of an organization is real important to building that trust but as long as people aren't doing it deliberately and I see it in some organizations, that that happens. That people use people and they hurt people and they just throw them away and I don't' want any part of that. I was just waiting for the other shoe to fall. My husband calls it the stroke and choke method where somebody tells you you're doing wonderful and then they choke you because you're getting too high off your horse. So I was always waiting for the other shoe

to fall and it just never happened and the more you get into those kinds of relationships, the more willing and ready you are to open up a little bit and trust people just a little more. People believed in me when I couldn't believe in myself. I still don't know why… luck? And I learned so much. They allowed you to make mistakes and helped you learn from them. And that to me was something new. It was a new experience.

When it comes to perceptions of others' trust levels in hers, the e.d. had some interesting reflections:

(on a scale of 0-10) I would say an eight. And that's because sometimes I don't want to be trusted. It's like… I don't want that on me, that power and influence. So sometimes that's difficult. And I think that I've been fair and consistent but I think that people bring their own experiences and some of the people who come here from a military background have a different perspective on trust and I think there's some people here who don't believe that I am who I am; that I'm pretending to be somebody else and it'll take more years of just coming to work every day to get them to do that. I also think that not everybody shares the same mission and so because they have different agendas they may not feel the trust in me that I wished they had in me.

Table 14- Summary of common themes emerging from responses to the topic of facilitators and impediments of trust

Common Themes	Descriptions
Honesty/Being Forthright/ Transparency	People being "up front" with you. A willingness to give you the good and bad news. Being authentic. Believing a person until there's reason to do otherwise.
Unique Themes	Descriptions

Be Able to Receive Critical Feedback	A trusting relationship includes a willingness to tell and be told the truth regardless of how it makes one feel or one's level of agreement.
Appreciate the Context	Acknowledge the fact that "everyone has a story." There is more to people than what they present and this has implications on trust development

Facilitators and Impediments of Trust

When asked what specific things impede trust, one department head offered the following:

> Well, what impedes trust is if you talk to someone and you don't always get a straight answer. You get an answer but you find out that what they told you was true but there was a little bit more to the story and you would like to have heard the rest of the story because it might have made a difference in the decision- so I think that impedes trust where they aren't up front, they don't give you all the facts, they don't tell you everything that's going on or they tend to hide things from you. For me, that impedes trust.

As far as facilitators of trust, the same department head offered the following:

> On the other side as far as supporting trust, I think when someone can call you and tell you that the crap just hit the fan and "I screwed up." And when someone can tell you "I screwed up" you know that they aren't afraid to come to you and say "I messed up, can you help me fix it?" or "what do I need to do to fix it?" When people are up front with you. I always told employees who would come to me with questions (this is in another role) they would come to me and ask questions about this, that and the other thing and I would say "you guys can come and see me anytime and you can ask me questions about whatever you wanna ask me and I'll give you an answer. I'm not going to tell you you'll always like the

answer but you're entitled to an answer." And I think that helped those folks have more trust in me because they might not have always liked what I had to say- but it was best decision for the business. So I think being up front with people.

The e.d.'s peer had the following insights relative to impediments and facilitators of trust:

Integrity… I mean I believe you until it's proven that that's not a good thing to do. I think being forthright and authentic. And when you sense that there's a disconnect between who someone's presenting as and who they are, there's an innate distrust.

When asked to identify those things which impede and facilitate trust, the e.d. offered the following observations:

I think this both facilitates and impedes trust and that's being open. Cause sometimes it scares people and then sometimes it's like "wow… she's human too." So I think relationships really build trust. To know and understand that everybody has a story. And a lot of them are really sad. But I've taken the time to know people and to understand. And you never know when an action is gonna make a difference in the life of somebody. And so, just trying to do something nice everyday- I think that helps to build trust and to be consistent and fair.

The e.d. went on to say:

I think things that impede trust are fear- fear of personal failure, fear of being exposed that you don't know everything- and I pick that up in people and it makes me laugh. I often laugh with them and say "you think you're the only person who's afraid of that? C'mon!" and they look at me like I have two heads like "how could you tell that?" It's easy. So I think sharing our stories helps. I think

punishment impedes trust but I think people expect punishment and they

shouldn't. But that's what society upholds and it's rewarded. And I think

acknowledging that people come from different experiences helps to build trust.

There's not always just one way and there's not always just one answer. So that

you're listening. I think good listening and communication skills build trust; poor

listening and communication skills- no trust. And I have a heart that's here

(pointing to shoulder) and that's difficult at times. And sometimes I wish I

wouldn't, cause sometimes it hurts.

Table 15- Summary of themes emerging from responses to the topic of perceptions of the executive director.

Common Themes	Descriptions
High trust level (this includes not only anecdotal information but also scores of 7 and higher (on a scale of 0-10) from five of six respondents in terms of their overall trust of the executive director (note, this includes the e.d.'s self-score)	The executive director is characterized as generally trustworthy by a number of indicators including her willingness to admit mistakes, her openness to learning and openness to engage in critical conversations, and several other areas of relationship-building.
Unique Themes	**Descriptions**
Decision-Making	Two different department heads speak of the e.d.'s lack of decision-making.
Transparency	At least two respondents talked about the e.d.'s willingness to discuss her challenges and areas for growth.
Community Engagement	The e.d. is very well connected and engaged with the community which helps to establish her own credibility as well as that of the organization.
Communication	Multiple respondents spoke of the e.d.'s willingness to engage in helpful and important discussion as well as a general knack for making them feel like they are more than just an employee or professional colleague.

Perceptions of the Executive Director

When asked to score (on a scale of 0-10) the level of trust in the e.d. one department head offered the following:

> I would say 6 to 7. In dealing with (her) I would trust her if she comes in and says "I need the company credit card" I trust her if there's money involved, I trust her, there's not gonna be an issue. If my grandchild comes in and she takes my grandchild for a walk down the street, I trust her. It's not a big deal. I think the only negative I've seen working here is that (she's) a little (indecisive). And a couple of things that can happen because of (that) concern me a little bit.

The department head went on to offer an example:

> We had an employee who – well… there are a couple of employees that are no longer here. One that's no longer here and one that was demoted. And I don't feel- although I think the decision to terminate them and demote them was correct, I think the way we got there was all wrong. I thought it should have been handled a lot better. We sort of made things up and put 'em on the spot. We took the one girl from the role she was in and put her into this other role and it wasn't working and instead of saying "it's not working, you need to go" and have some constructive conversation before we actually had terminated her, we said "we're eliminating the position." Well, the position was a good position. It was a position we needed. So I think we've done some things with a few employees that I didn't think were right.

The department head went on to talk about how he navigates this perceived inconsistency:

I know that because of the way (the e.d.) is I've learned that a lot of times I'll document what I say just because I know she'll forget. So you might go to (her) and say "this is what's going on" and she might say "oh, we gotta address this" or "I'm gonna address that." "This is going on." "Why didn't you tell me?" "I did tell you." "No, you didn't tell me that." So when you know that's the way the person is, now you send an email. That's the good thing about email, you can say "well, here it is, I told you. If you chose not to act on it that's fine but don't say I didn't tell ya." And a lot of times it's my job to tell (the e.d.) about something that's going on, particularly as it relates to finance- that's my role. And in a lot of cases, I'll document that in an email so I can say "you know, I did tell you and you chose not to do anything about it and that's fine because that's your job but don't ever go to the board and say (he) never told me. (laughter)

The department head went on to elaborate on the trust relationship between he and the e.d.:

(She) knows how I feel- I don't' mind telling her my opinion. And a lot of times when she knows that I don't agree with the direction she's about to go she may not involve me until the decision's made- which is ok, I mean I'm ok with that because she knows my opinion- but I've noticed that a lot of times she'll make a decision or do something contrary to where she knows I would probably go and she avoids me in that discussion. If it's a financial decision or financial issue I would say she involves me all the time- I don't know when she hasn't. It's more of an issue where I have my nose in another department. It might be a personnel issue in…let's say dental and I'll say "why are we wasting time with this? Let's

just cut the cord here and move on." And she might say "well, I don't know…" and she and (the dental director) might make a decision that's different from what I would make. But she knew my opinion and she doesn't have to come talk to me about it and that's ok. But if it's a financial decision, she's going to come talk with me.

The last question of the interview asked respondents to score their level of trust in the e.d. along a specific set of criteria:

- (asks what resources are needed to do your job) Ten. Always asks…not a problem.

- (ability to identify with your experiences) She would do that. She would identify with how I feel. I would say nine. She understands how I feel and my opinion. We don't always make the same decision but that's ok.

- (support of your department's goals) I'd say nine. And she'd expect them to be done. And I guess if I needed something, she'd get it for me or point me in the right direction. But she'd expect it to be done.

- (ability to relate to you as a whole person) We'll that's where she's really pretty good. Ten. Whereas I'm not as much as she is. She always says "Family comes first. If something comes up during the day, take care of that. If you're not taking care of that you're no good to me here." and that's so true.

The board chair spoke about the importance of trust in his relationship with the e.d.:

If (the e.d.) calls and says "I just want to let you know" or "I just want you to be aware of" To me, a lot of it is communication and you don't want to have to hear

about a problem or issue from somebody else or from some other means. So if

you hear about that in advance then that tells me that that person is respectful of

our role as board members and how we rely upon the e.d. to really be the eyes and

ears of the board on a day to day operational level and to have consistent

communication with the e.d. tells me that the e.d. understands that relationship

and therefore I'm gonna have a higher trust level with that e.d. So communication

is important, having constant communication. It can be a minor thing or a major

thing but that, to me, is an important aspect of it.

The board chair went on to speak of other dimensions of the trust relationship, even from

an external community relations perspective:

Hearing from others in the community about the e.d. and others in the community,

other organizations, just other individuals in the community. Hearing about the

interrelationship with the e.d. almost all positive. It shows that others look up to

the e.d. and there's a certain element of trustworthiness because there's an

understanding that what she's doing is a good job and they will try to relay that to

me.

In terms of community connections, the chair added:

She's become very engaged in the community. She belongs to a number of

different organizations and service clubs. I hear of her being involved in things

and I think "oh wow, that's great that she's involved in that." So because she's

willing to expose herself to more organizations and individuals in the community,

that sort of denotes a trustworthiness.

The board chair went on to discuss the importance of trust and regular communication:

She and I meet regularly. We meet every Friday. I think it's important to have regular contact and so with that I think we've developed a good rapport. She really doesn't have anyone else to talk to, so to speak so she'll tell me about things. It could be minor things she'll tell me about it and so that way I know she'll tell me about the things that maybe she doesn't wanna tell me – and she does. She tells me about things that aren't gonna necessarily be in a good light. So I guess it all ties back to communication.

The board chair added:

I'm a really strong believer in having constant communication because I've been in organizations where you don't have that (I mean on other boards) where you don't' really have that inter-connection between the board and the management team and especially when you have a strategic plan. I mean you could have the e.d. going this way and board going that way if you don't have that inter-connection.

The board chair acknowledged the challenge of communicating activity that may not always work in favor of the e.d.:

She does it with the understanding that there could possibly be something negative that could be done against her- and I don't wanna say that that goes on a lot because it certainly doesn't. And I know this is gonna come out when you talk to (one of the department heads) I mean the two of them are not in sync- let me put it that way. So I mean there have been issues dealing with that situation. Because you have this very well educated (person) who doesn't wanna have the e.d. be their superior. And that's constantly what's going on. That's always been

an issue here, at least from his standpoint- so over the years we've kind of had to
massage the relationship. It's just been an on-going issue.

The board chair added:

It really goes back to the open communication that I discussed. As an example, if
the board is not kept in the loop on things and you find out or hear about issues
that arise from someone other than the e.d., you begin to wonder whether there is
something that's being hidden or whether there may be something else out there
that the board should be told about. So, regular and open communication is
important in facilitating trust.

In terms of specific impediments of trust, the board chair added:

Other things that facilitate or impeded trust are whether there is timely follow
through on tasks, evidence of whether or not staff is supportive, and whether or
not the e.d. has a positive image among peers in the industry.

In terms of the e.d.'s connection to people, the board chair offered the following:

People hear her name; they run into her- it just helps with the whole package so to
speak… acceptance of her. And if you have an e.d. who sits in their office and is
a hermit without that social interaction with staff, without other organizations,
other peers, there's no history to based trust on.

The chair also spoke about the ability to trust the e.d.'s message:

If we're not getting the right message, a trustworthy message we could be heading
down the wrong path so to speak. So you have trust in your e.d. that she's giving
you the right information, that you can make effective and proper decisions going
forward. But then in that inter-relationship with the community, it goes back to

acquiring resources, it's key that you have someone you can trust and rely upon that can be our mouthpiece in the community. So it's key to have the relationship with trust. And as it relates to the relationship with staff, you're gonna find when you speak with some of the other staff members, that it's gonna be a key component. There has to be an element of trust on all levels of staff- that the leader of the team is a good leader of the team.

One department head scored the e.d. at an eight out of ten in terms of the level of trust:

I would give it a solid eight. And that's simply because she hasn't had a lot of experience with a dental clinic and how we run things which means she listens to other people as far as productivity and I know how things works and sometimes it's hard to get that across because she's looking at the bottom line. But she's always open to listen.

That department head went on to say:

Cause as far as productivity, medical and dental are two different animals. Medical can see a lot more patients because they don't have to actually do a lot of treating. Most of theirs is diagnosis, referrals, getting lab work, etc. etc. We have to do the same thing except we also have to treat and produce a product which may be a filling or a root canal or whatever. So there's no way we can keep up with their numbers because we actually do things. Not that medical doesn't but that's just the way it is.

In terms of the topic of productivity, the respondent went on to say:

I mean it comes at the sacrifice of patient care. If you have to speed working on an actual product, which may take time, because there are always variables

involved. So we just… sometimes you just have to stop and realize that we're just different.

This respondent had one other reflection in terms of the trust relationship with the e.d.:

Mainly… I mean productivity is the main thing. I can't really think of anything else. Maybe to a certain extent, budgeting constraints. Cause in order to see more patients we have to spend more money because we utilize more supplies which are more expensive than medical. And if there are restrictions to our budget that is going to restrict our patient care and sometimes I don't think our director can see that. But if you wanna produce more you're gonna have to spend more.

When speaking about perceptions of trust and the importance of trust, one department head reflected upon the difficulty of balancing trust at the departmental and organizational levels:

Well… I certainly have to trust my staff. And I think one of the problems is that if a staff member is not working up to our expectations, the director takes too long to make a decision to release them. Ultimately, I can make recommendations. Also, I've had staff member that I trusted that the director did not trust and I actually had to protect them from being fired on the spot.

This department head further elaborated by giving an example:

I'd say it's probably a difference in observation. The one person I'm thinking of is actually gone now. But I probably kept her from being fired for at least two years and that's because I had known her for a long time and I knew her capabilities. And I knew her limitations and things she'd get in trouble with because she had a big mouth and that just rubbed our director the wrong way-

especially because there are other areas in the clinic- not only dental just the whole clinic- where there's gossiping and feeding frenzy as far as that type of situation and sometimes my assistant would be in the middle of it or too close to it and the director picked up on that and zeroed in and there were times she was ready to fire them on the spot and I had kind of talk her down- cause I think she was a little too emotionally involved.

The same department head further reflected on his leadership in the context of trust and decision-making:

I'm not a class-A person. So sometimes I probably take a little too long to make a decision because I'm analyzing and over-analyzing and thinking... looking at different sides of a matter. So I don't make a quick conclusion because a lot of times it can be wrong. So I'm the kind of person that's more of a coach- in listening to all sides- an arbitrator, I should say.

One department head was very candid when asked to rate his level of trust in the e.d. He simply stated:

Low.

That same department head went on to talk about the challenge of building a trust relationship with the e.d.

Personality... it comes from personality. Basically, you know I was Commander at the military hospital and so I was in charge a lot of the time. And maybe that causes me to be threatening or maybe it's my personality, I don't know. But essentially, uh... very very controlling. They... undermine. So it makes it pretty much impossible for me to actually be a director. Tries to control everything.

The same department head offered the following scores (on a scale of 0-10) when about the trust relationship with the e.d.

- (inclusion in key decisions) I think I'm included but the decision's already been made. So five.

- (asked what's needed to do job) I think the resources… I mean my main issue is the time. I'm just asked to do too many things- I don't think it's a matter of resources, it's a matter of time." (No score given)

- (ability to identify with workplace experience) Zero.

- (provide support needed for goal attainment) Four. Cause I think some things, we're in total agreement, it's just that some of this kind of gets in the way.

- (ability to relate to the whole person) Five.

The e.d.'s peer offered the following:

(the e.d.) is very responsive. If our organization reaches out and says we really need to make legislative contact, for example, (the e.d.) can always be counted on. Also I've met jointly with (the e.d.) and our senator and she's proud of the accomplishments of The Center but she's just as willing to talk about the challenges. You just get the sense that she is going to give you the unvarnished truth. And you feel her passion… I think that's the important part of it too.. the non-verbal supports her message.

That same respondent said:

I think going back to what I said first about (the e.d.) and her responsiveness, she is unafraid about reaching out to us or anyone for help and we can count on her

when we reach out to her, which is really nice. We put a lot of energy into

creating education programs that we believe are of value to health centers. I can

always count on her sending someone.

The respondent added:

In terms of board development, some of the health centers don't' put as much

energy into that and she really tries to get her folks to things so that they can see

The Center in the broader context. Plus, speakers she brings into the board- I

think she doesn't want you to get too isolated. You need to fit into the

community but I think it's also important as a leader to create that vision of where

you fit into the broader community- particularly for health centers.

The e.d.'s peer offered the following reflection on her resourcefulness:

I think a lot of health centers don't think about us until they've exhausted all their

other options. (the e.d.) is much more inclined to take advantage of what we have to

offer.

That same respondent also offered scores (scale of 0-10) relative to her trust

relationship with the e.d.:

- (Inclusion in key decisions) I would say nine. And the only reason
  even with that caveat is life's busy.

- (asked what's needed to do job) Actually, I would score her higher
  than others. I'm trying to think of another e.d. in the health center
  world that would ask me that…she would. Which tells me she
  more than understands that dual relationship that I'm a better

support to her if she's reaching out to me. I would probably say a seven.

- (ability to identify with experiences) Actually, nine.

- (support of goal achievement) Nine

- (identify with you as a whole person) Nine.

Chapter 5

Summary, Conclusions and Recommendations

The purpose of this study was to examine perceptions of trustworthiness in the executive director of a small community health center among five key leaders within her leadership team. This chapter provides a discussion of the findings of this study, conclusions and recommendations for future research. The primary goal of the chapter discussion is to connect the results discussed in chapter four to particular aspects of the research literature as well as conceptual frameworks and also to consider implications for future research.

This chapter will examine an overall summary of the study and conclusions drawn from both the data as well as my own experience in conducting the study and recommendations regarding The Center's operation but also community health care centers in general.

The research questions focused on characterizations of trust, trust development, and trust relationships among six participants. The questions also focused on identification of variances among the characterizations and the nuances of those variations. The analysis of data resulted in the emergence of six primary themes: 1) the strategic plan considered in terms of administrative and board leadership; 2) organizational strategic focus areas; 3) organizational culture and leadership; 4) the senior leadership team; 5) perceptions of the executive director; and 6) perceptions of trust.

The discussion within this chapter will synthesize these themes into four areas. First, a re-examination of Shaw's conceptual framework in the context of three key imperatives: achieving results, acting with integrity, and demonstrating concern. Second, a re-examination of Shapiro's framework in the context of the three progressive stages of trust development: calculus-based trust (CBT), knowledge-based trust (KBT), and identity-based trust (IBT). Third,

consideration of the relationship between interpersonal trust, strong culture and strategic direction, and fourth, an exploration of four elements of the current strategic plan which correlate to The Center's change efforts as it evolves into an FQHC: four distinct strategic focus areas, community impact, administrative leadership and opportunities for more individualized and intentional work around trust development.

Implications for Organizational Direction: Conceptual Frameworks Revisited

Considering the assertions of Shaw (1997) who posits that "the actions of leaders at all levels significantly influence trust, senior leaders are particularly powerful in creating and eroding trust. Those seeking to build high trust cultures must develop a group of leaders whose actions reflect the importance of each of the trust imperatives- and who are capable of balancing these imperatives when they conflict" (p. 101).

Achieving Results

The first imperative, achieving results, has to do with the juxtaposition of one's articulated intentions and actual outcomes. Because The Center is in a strategic planning process, the notion of achieving results can be framed, and least in part, through goal realization. In fact, two significant examples of this are the document titled "How will we know we've been successful?" and the quarterly report which benchmarks progress toward each strategic focus area via corresponding strategies and identified resources.

In many ways, it is safe to say that the organization has a firm grasp on achieving results from a work product, outcomes perspective. But Shaw offers a list which speaks to the "critical actions for developing a culture appropriate for a high trust organization" (p. 140).

These very specific action items are inherently addressed in many of the comments offered by those interviewed, so the capacity to address trust and the cultivation of a stronger

trust culture is available. The table below illustrates specific examples of 'pockets' of work that was not necessarily undertaken with the intention of addressing trust, but certainly facilitate the possible inclusion of conversations regarding the extent to which the organization might consider more intentional work around trust development.

Table 16- Critical Actions Related to Feedback (Shaw, 1997)

Shaw's Critical Actions	Related Respondent Feedback
Develop a common vision and shared view of competitive realities	With the exception of one respondent, there appeared to be general agreement related to the vision for the organization. However, the notion of competitive realities was not prominent in any of the feedback. Taking up this aspect of the critical action may represent an opportunity for trust development between the executive director and her senior-most leaders, specifically in light of the peer's external perspective on the direction of community health centers: "You want to be, frankly, the provider of choice not just a provider of last resort."
Build familiarity across levels and groups	The executive director spoke of the management team meetings and the cultural shift that is gradually taking place in terms of building shared vision and trust. But there is also evidence, based on feedback for all but the e.d.'s peer, that relationship-building across groups and levels is needed. For example, reflections were offered on the organization as having an "8th grade mentality", "People here will eat ya up!", the notion that making mistakes may get you fired- all of these speak to the importance of building community across levels so that expectations are placed in the context of shared philosophy and the notion of being "vulnerable"- which the e.d. speaks of as being important for her leadership team to embrace, is also seen as important for the organization to embrace as it grows as a unit.
Encourage a culture of risk-taking and exploration	The e.d. demonstrated through much of her feedback, that she is working diligently to encourage risk-taking and ownership of one's

	decisions. Based on the feedback, the work still to be done involves gaining agreement on the scope of the risks in relationship to patient demand and limited resources.
Make visible a few powerful symbols of trust and collaboration (a reinforcement of the organization's commitment to each of the trust imperatives)	There seem to be opportunities for the e.d. to do some very concise and visible things to demonstrate her aspiration to build a strong culture of trust. One very specific action item might be a reinforcement of the ways in which she intends to actively address any residual ideologies that linger from previous administrations that apparently operated more so in a culture of fear.

Acting with Integrity

Shaw's second trust imperative is acting with integrity. Honesty and truthfulness in communication has been identified by Commings and Bromiley (1995) as consolidated communication issues linked to the broader construct of a trustor's perception of the trustee's integrity. This research is reinforced because Shaw's assertion that acting with integrity is a critical action and trust imperative which illuminates the importance of key leaders viewing the executive director as a person of integrity. This work entails gaining shared perspective on what constitutes integrity not only in the context of organizational outcomes but also day-to-day operations and relationship building between the e.d. and the key leaders, and the extent to which these shared perspectives are being honored from the standpoint of the e.d. as well as the senior leaders.

Demonstrate Concern

Shaw's third and final trust imperative is to demonstrate concern. It is important to note that both narrative and scoring questions that addressed the notion of demonstrating concern were met with fairly high scores and commentary for all respondents. The e.d.'s reflection that she can sometimes be a "people pleaser" and that "nobody has to be sad" were shared and

characterized as possible shortcomings from her perspective. But in light of some of the more problematic aspects of culture and fear, low trust and lack of shared vision throughout the organization, the e.d.'s personal approach to leadership seems to be appropriate and necessary.

It is also important to note that above all, the e.d. demonstrated a clear understanding that her commitment is to the organization as its leader. So her "concern" does not operate outside the parameters of organizational vision and what is expected of her as well as her own expectations of herself. To the extent that the illustration of her concern operates outside of a shared vision, it is quite possible that the e.d. may not consistently be seen by her team as "concerned." Evidence of this was seen intermittently in comments regarding staff hiring/firing approaches and philosophies, building infrastructure, and the timeliness in making key decisions. These present as three distinct areas of opportunity for growth and relationship development between the e.d. and specific members of her leadership team.

Shaprio's Framework

According to Tyler and Kramer (1996), the theoretical framework of Shapiro (1992) asserts that "in professional relationships, trust develops gradually as the parties move from one stage to another" (p. 124). This premise revolves around three observations:

1. The full progression of a trust evolution or change will move a relationship from calculus-based trust (CBT) to knowledge-based trust (KBT) to identification-based trust (IBT). Because all relationships do not develop fully, trust may not move beyond the first or second stage.

2. What is required to move from calculus-based trust to knowledge-based trust depends upon consistency of the other party. If this occurs without significant exception, the parties will move from calculus-based trust to knowledge-based trust and that

transition occurs at point J1. This change is based on particular conditions and may not occur if: (a) the relationship does not necessitate more than "business" or "arms-length" transactions, (b) the interdependence between the parties is heavily bounded and regulated, (c) the parties have already gained enough information about each other to be aware that any further information gathering is unnecessary or likely to be unproductive, or (d) one or more violations of calculus-based trust have occurred.

3. Successful movement into knowledge-based trust indicates that the parties have experienced and engaged in the activities listed above. Significant numbers of relationships do in fact move into this level (JI).

   The movement from KBT to IBT occurs at point J2 which is characterized by a new level of relationship formation marked by identification with the other's needs, preferences and priorities as one's own. This identification compels each party to search for more information that facilitates deeper identification. Many professional relationships stop at this level and may not transition into IBT because (1) the parties lack time and energy to further invest in the relationship or (2) the parties lack the interest to development the relationship further.

The figure below illustrates this evolutionary development:
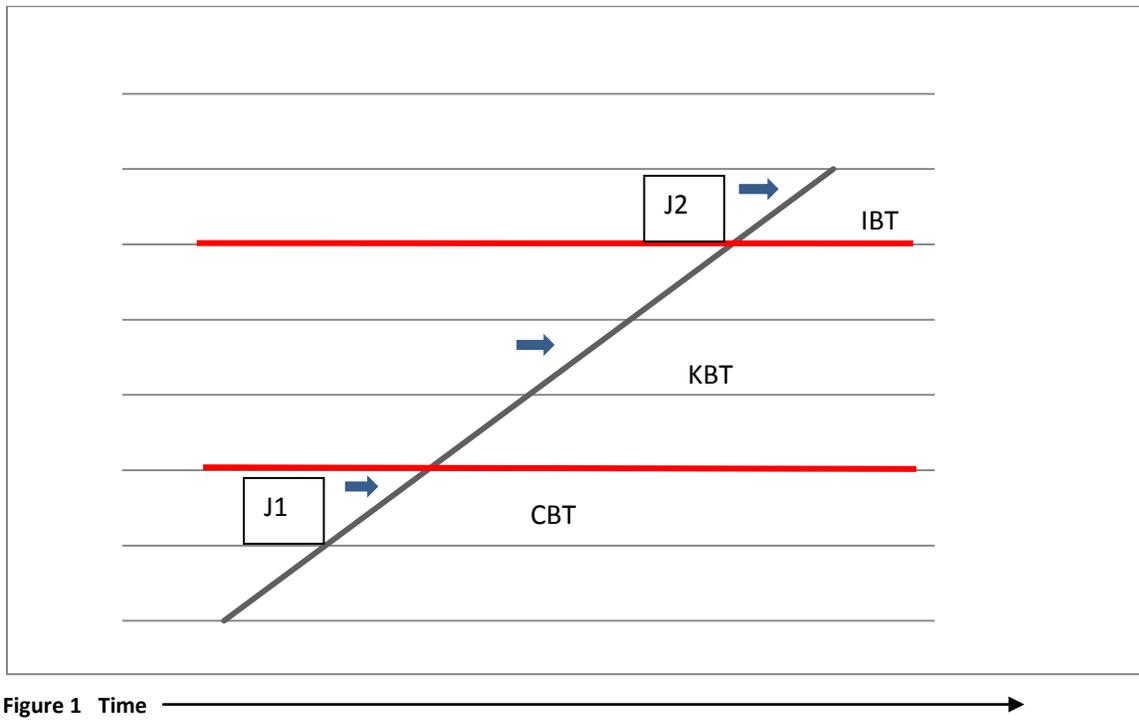
Figure 4-1- Lewicki and Bunker (1995)

Figure 1   Time

_____

Table used by permission from the author.

Calculus Based Trust

Kramer and Tyler (1996) define calculus-based trust as "an on-going, market-oriented, economic calculation whose value is defined by determining outcomes resulting from creating and sustaining the relationship relative to the cost of maintaining or severing it" (p. 120). Internally, the notion of a market-oriented, economic calculation, can in fact be fairly easily translated into the formation or development of a relationship based upon those whom individuals see as primary 'customers' and the cost (from a resource perspective) of serving those customers. In this particular case, the customers are patients (users of The Center's services) and the need for trust development between the executive director and particular

department heads is critical because shared vision around patient care is necessary for trust development in a community health center.

Calculus-based trust, then, has to do with the extent to which the market and economic implications of strong patient care are advanced or stymied by the interpersonal trust relationship between the executive director and a particular department head. This is why shared vision is so very critical. The executive director must be able to gain buy-in from her senior leadership team around resource allocation and the trust relationship then becomes (at least in part) a conduit through which those allocations are stewarded.

Knowledge-Based Trust

Kramer and Tyler (1996) define knowledge-based trust as "being grounded in the others' predictability, knowing the other sufficiently well so that the others' behavior is anticipatable" (p. 121). Much of the feedback regarding the trustworthiness of the e.d. did in fact illustrate a familiarity with the way she operates and her general leadership style. In this sense, it is safe to say that the organization does not struggle with issues of fundamental disconnection with basic understanding of their leader as a professional.

The critical component of this dimension on Shapiro's theory is not so much predictability but the second part of the definition: "knowing the other sufficiently well so that the other's behavior is anticipatable." This introduces an interesting situation wherein a presupposition that one can aniticipate another's behavior and somehow fold that knowledge into an actionable element of trust development is, perhaps, faulty logic. In fact, one respondent spoke of "knowing how she is" when reflecting on his reasons for putting things in an email to the executive director in the event that she forgets certain conversations.

So the notion of being able to predict or anticipate the e.d.'s response serves as an opportunity for the members of the senior leadership team to attend to interpersonal trust relationship development based not only upon a certain level of predictability but also the opportunity to engage in conversations about what behaviors are seen as predictable and the ways in which these behaviors facilitate or impede interpersonal trust development.

Identification-Based Trust

This final stage of trust development is marked by identifying another's needs, preferences, and priorities as one's own. Ironically, this highest form of trust, which few relationships reach, has the potential (based on its elements) to characterize the trust relationship enjoyed by the executive director and her senior staff. When the dimensions of what should *not* take place in order to reach this position are considered, the interpersonal relationship between the executive director and her leadership team may be beyond the point at which identity-based trust is possible. But assuming this is not the case across the board, there are distinct areas in which senior leaders have the ability to articulate targeted and focused areas of need, preference and priority.

This is essentially at the core of the strategic planning process; a way of thinking about organizational direction and planning based on need, preference and priority. So the question becomes, to what extent does the senior leadership team see themselves as advocates for their departments in articulating needs, preferences and priorities in a way that compels the executive director to see them as her own?

Relationship Between Interpersonal Trust, Strong Culture and Strategic Direction

The conceptual framework of both Shaw and Shapiro in connection to the schematic advanced by Fratantuono and Sarcone (2008), which assigns equal importance to culture, strategy and environment in achieving organizational success, prompts one to consider the possible relationship between interpersonal trust, strong culture and strategic direction. The next section will take up this question in the context of the actual strategic plan. But first, the definitions of interpersonal trust, strong culture, and strategic direction offer insight on a conceptual level as to possible relationships between the three as they play out in the trust relationships between the executive director and members of her leadership team (including the board chair and peer).

First, interpersonal trust, having to do with an exchange relationship that exists over time, has very profound implications for the establishment and maintenance of strong culture. It is, in fact, the trust relationships entered into by senior leaders within the organization that carries with it, unspoken elements of organizational socialization which help shape employee expectation, organizational norms and traditions and a sense of where the organization is heading in relationship to where it finds itself.

This also lends credence to the thoughts offered by several respondents regarding facilitators and impediments of trust and the fact that transparency and open dialogue about not only achievements but challenges, becomes critically important in establishing trust relationships within the organization. The relationships serve as conduits through which trustors and trustees form perspectives about their work. These perspectives are communicated in overt and subtle ways, formal and informal, spoken and unspoken ways, all of which shape the organization's culture. So the assertion that an organization's culture serves as the foundation for its

competitive strategic themes and associated activities leads to the third and final element, strategic direction.

Strategic organizational direction as identified by Mintzberg (1994) wherein planned change and evolution converge to produce what is actually implemented, embodies the frame within which The Center's current situation exists. The organization has set a strategic direction based not only upon its current plan but also its intention to become a Federally Qualified Health Center (FQHC). These major elements of change will create lasting effects within the organization as they are foundational to issues of organizational identity and leadership. This strategic direction is also externally impacted by the larger community healthcare system which has also set a strategic direction. When considering the issue of trust in healthcare as an industry, the same elements which prove true for The Center as an organization are being engaged in the field at large:

Annison and Wilford (1998) posit that the restoration of trust in the healthcare system actually begins with leaders changing themselves and then working together to change the industry. They noticed that when leaders clearly articulate organizational values, vision statements that advocate future growth and set a strategic directional plan, attitudes and behaviors change. Annison and Wilford identified four important elements of discernment: a) leaders have exhausted the benefits of existing management theories about how they should treat one another; b) tidy organizational charts on their own will not enable leaders to accomplish what they need them to do; c) trust effects how leaders manage their people and change and; d) trust matters in relationships between healthcare professionals and the people they serve (pp. 1-4).

Conclusions

There are four aspects of The Center's current strategic plan that are core to the organization's change efforts as it evolves into an FQHC: 1) its strategic focus areas as articulated in the current plan; 2) community impact; 3) leadership at the administrative level; and 4) opportunity for more intentional work around interpersonal trust development.

Strategic Focus Areas

Taken together, The Center's four strategic focus areas (acquire resources, build capacity, expand service offerings, and identify emerging opportunities) represent fairly significant undertakings as far as change efforts are concerned. The expansion of service offerings, for example, seeks to expand existing services which are barely meeting demand in terms of limited staff and increased patient load. Nevertheless, the need for a collaborative clinical service model comprised of primary care and behavioral health specialists is very necessary and very appropriate inasmuch as no such model exists for the community health center population. The fact that operating funds and staff (in addition to consultants and CAHWF) have been identified as resources under this goal is a strong illustration of the organization's intention to achieve this expansion as an important and necessary component of comprehensive change.

Another example of a significant change effort is the acquisition of resources-specifically the recruitment and retention of skilled clinical support staff. By the executive director's own acknowledgement, "…if we don't have the right clinical staff, we're not going anyplace." She went on to say, "And not everybody is right for the kind of work." So there's a clear intention to move beyond simply filling positions. Even the board chair talked about the recruitment and retention of staff as "an on-going battle." So The Center's organizational maturity is clearly tied to its ability to not only attract but retain staff (and specifically clinical

staff) who understand the vision, want to be there, and are willing to be part of a dynamic team and dynamic change.

Community Impact

The executive director said something very powerful in her interview when reflecting on her "dream" for users of The Center's services. She said, "We'll always be here but you don't always have to be here." When it comes to The Center, the notion of community impact moves far beyond provision of services. It is very clear that the absence of The Center would have a significant and extremely negative impact on the community and the surrounding areas which it serves.

Patients may come in the door for a specific issue but many (if not most) leave with an intention to make The Center their medical home, which means it is the place where their primary care needs will be met. This is significant for a population of underserved, underrepresented and underinsured people who are in need of primary care services.

The executive director's intention to not 'put all the eggs in the 330 application basket' represents informed and calculated change and decision-making capability. Because even as the e.d.'s peer points out, when health centers are attentive to building systems and having solid infrastructures in place, the 330 funding becomes "a bonus." So the organization is seeking other grants and even planning a "Friends of The Center" campaign so that the community itself can not only take ownership in The Center's growth process but also celebrate The Center as a very successful community health center, one that has an extremely amicable relationship with the local hospital (which is not always the case in health center/hospital relationships and certainly not he case where for-profit hospitals are concerned) and one that is substantially supported by a very reputable health and wellness foundation. The statistics speak for

themselves: 180-200 new patients a month since the executive director joined the organization.

That is, as the e.d.'s peer put it, "incredible growth!"

Administrative Leadership

Leadership is so vast and so broadly defined that it becomes very difficult to even discuss

with any level of comfort that others know what you are talking about. Inasmuch as leadership

entails or involves influence, the e.d.'s leadership warrants expanded commentary. Three basic

themes emerged from the interview with the e.d., her peer, the board chair and her three primary

department heads.

First, the executive director has clearly established herself as the leader of the

organization. Whether respondents reflected on aspects of the executive director's leadership

with which they agreed or disagreed, all five exhibited a very clear acknowledgement and

affirmation of the executive director as one who articulates expectation and vision, is ultimately

accountable to the board, represents The Center in the community, is responsible for helping

both board and staff understand and embrace the strategic plan and its relevant parts and one who

convenes the management team for the purpose of strategy and planning.

Second, the executive director has struggled to be seen as consistent and fair and to help

her staff trust that she's learning just like the rest of them. Her leadership style is, in some ways,

challenging for some staff to see as authentic because the previous culture of the center was (by

the account of several) devoid of trust and teamwork. Collaborative thinking and risk taking

were not part of the organization's DNA. So the e.d. has had to be patient with establishing

herself as an authentic, credible and genuine leader who is just as invested in developing and

leading individuals as she is developing and leading the organization

Even the executive director's own reflection of her leadership and leadership style is fascinating in the context of her team's observations. For example, what one respondent identified as being somewhat "wishy washy" at times was addressed directly by the e.d. without any sort of prompting. Though she was not responding to any particular employee's perspective or opinion of her, she acknowledged what often gets (by her account) mistaken for indecisiveness on her part is actually an effort to carry out due diligence which involves gaining assurance that all of the necessary and relevant information has been obtained before making a decision. And even after a decision is made, the executive director asserted that "if we get information that's different in five minutes to make a better decision, you're allowed to change your mind."

So one very clear disconnect (but more importantly, an opportunity for growth, based on observation) is a difference in the way senior leaders see decision-making taking place within the organization. At the core seems to be the two-fold question of who should be involved in making key decisions and how will we go about gaining agreement on the time sensitivity of that decision. All three department heads spoke about this dimension of decision-making in one way or another.

Third, the executive director must be very diligent in addressing resistance from one particular department head. The only outlier in terms of observations on leadership was the somewhat tenuous relationship between the e.d. and a particular department head. At the core of this seems to be fundamental disagreement about how things should be run within that department head's area and consequently, within the larger organization. This tension is confirmed by both comments and scores offered in the department head's interview as well as the executive director's interview. This was further confirmed by the other two department

heads and board chair. So all of those internal to the organization in some way referenced

particular challenges between the e.d. and a particular department head.

The bottom line, from a leadership perspective is that the e.d. has articulated a clear

vision for the organization. This vision is both validated and supported by the strategic focus

areas and identified goals within the current strategic plan. To the extent that the department

head has disconnected from these goals, the e.d. seems to have made it clear that that disconnect

(however perceived or real) will not stymie the work of the Center. This is particularly relevant

in the context of the move to an FQHC inasmuch as the changes that must take place are largely

in this department head's area. So the notion of leadership not only for the e.d. but also for the

department head is critical at this juncture in The Center's current history.

Opportunities for More Intentional Work Around Interpersonal Trust Development

Some of the concerns of department heads have been mentioned previously. Generally

speaking, the trust relationship between the e.d. and members of her team is quite healthy. There

are, however, 'pockets' of opportunity where the interpersonal trust relationship could be

strengthened. This is evidenced by information gained in interviews as well as questions that

asked respondents to score levels of trust.

The table below offers a summary of key observations that were offered in the interviews.

Please note, department heads have been assigned numbers to protect anonymity.

Table 17- Key Observations Around Trust

Respondent	Notable Trust Reflection (+)	Notable Trust Reflection (-)
Dept. Head #1		• No score given for trust in e.d. only the word "low" • General agreement with *what* should be done but disagreement with *how* to go about doing it • Rationale for struggle with trust development characterized as "personality" related
Dept. Head #2	• Healthy trust relationship with e.d. • Must have trust in his own department and expects it with and from the e.d. • Finds that the trust is built because of open and consistent communication • Part of this entails knowing when, where and how to approach the e.d. with issues. • Trust is e.d. scored high (8)	• Gaining agreement on timeliness of personnel decisions • Mounting pressure to "produce" implicates the bottom line. E.D. understands this but the challenge is still a difficult one and described more than once as "pressure"
Dept Head #3	• Absolute trust in terms of personal affairs. (i.e. would trust e.d. to take grandchild for a walk or to take the company credit card • Trust in e.d. scored somewhat high (7)	• At times, lacks trust that what is articulated as the intent will be what actually happens.
		• Trust relationship somewhat compromised by two personnel decisions with which the dept. head did not agree

		• Should be noted that there was acknowledgement that the decision was not his to make but his reflections had to do with the way he feels the whole organization was affected by these decisions and the degree to which these decisions represented questionable leadership on the e.d.'s part (in his opinion)
Brd. Chair	• Sees e.d. as very transparent- willing to share the "good, bad and ugly" • Well aware of existing tensions with one particular dept. chair • Feels confident about e.d. being the "face" of The Center in the community because of the trust relationship they have. • Trust in e.d. scored high (10)	
Peer	• Sees e.d. as someone who wants to learn as is willing to tell and hear "the unvarnished truth" • Communicative • Seen as reliable and consistent • Trust in e.d. scored high (9)	
E.D.	• Scored high (8) • Wishes to be seen as trustworthy • Believes that as organizational culture is shifting, trust is building	• Realizes there are trust issues with a particular department head but also sees it as very "personal" and therefore can be worked around in terms of day-to-day operations and continuing to move forward. • Sometimes wishes that high trust didn't equate to higher levels of responsibility and accountability

Insights of the Researcher

Taken together, the conceptual frameworks, the examinations of relationships between trust, culture and strategic direction and important elements of The Center's change efforts as it evolves into an FQHC, it is safe to say that the organization is heading in the right direction. When best practices in the field of community health are reviewed, the organization is hitting all the appropriate key performance indicators. So in the context of the scope of this study, attention can be turned to strengthening an important dimension of the internal system and infrastructure-trust. In Table 18 five recommendations are offered in reference to how the organization might advance in this area while realizing the goals set forth in the current strategic plan.

Table 18- Key Recommendations Around Interpersonal Trust Development

#	Recommendation	Rationale
1	In addition to addressing issues within the more challenging department, clearly identify who will lead particular aspects of the change effort in areas closely related to or in the department	The change associated with this area is not optional based upon the elements of 330 funding and what is mandated at the federal level regarding what must be put in place before funds are released
2	Re-design organizational chart to reflect most recent staff compliment	Two of the six participants referenced the need to update the organizational chart. This allows not only new employees but those who are already on staff to clearly understand organizational structure and reporting lines. Also helps during planning process to see where particular tasks are to be assigned and what cross-functional teams need to be put in place or convened.
3	The e.d. and others have acknowledged the need for "an operations person" It seems logical to move sooner rather	Preparation to transition to an FQHC involves a lot of

	than later on the hiring of that person.	logistical work as well as re-purposing particular areas of the organization to "fit" the new operation. Getting a staff person in at the ground level and front-end of this will facilitate a smoother transition.
4	Begin to empower the senior-most leaders through meetings which only involve them. Though there is a management team, the three department heads have been identified as the "absolute leaders of the organization" On a regular basis, these individuals should be convened to engage higher level strategic thinking.	As The Center matures as an organization, the successful recruitment of staff should free up the medical and dental directors to do more administrative work/oversight. The expectation that administrative work continue at a certain level while patient load increases does not present as sustainable or organizationally sound. This will become even more critical as The Center morphs into an FQHC and department heads begin to operate under a different paradigm. Because departmental leadership will be crucial during this period of transition, there is a unique opportunity to bring together the medical, dental and fiscal directors for strategic conversation which can and should include aspirations around interpersonal relationship-building.
5	Make a concerted effort to develop an intentional plan which addresses identified trust issues, trust development and trust maintenance with key staff	Whether it starts with senior leaders or a larger subset of the workforce, consider the framework of Shaw and Shapiro in terms of trust imperatives and the stages of trust development. Think about some of the critical feedback in the context of various perspectives and philosophies on leadership and

	how trust is gained/breached and begin to address issues of trust with open and honest conversation about inter-relationships and how these relationships affect the work and direction of the organization. Outside consultation is encouraged so that all parties may participate fully and equally.

Recommendations for Additional Research

There are several areas within the trust research literature that remain unexplored or underexplored. This study explored interpersonal trust relationships within a small community health center. Because of the absence of comparable case studies it is not possible to generalize but there are certainly elements of the research that would prove useful for other community health centers desiring to examine interpersonal relationship building and development through the trust lens. The Pennsylvania Association of Community Health Center and the National Association of Community Health Centers have also expressed interest in reviewing the research to perhaps expand its perspective in terms of support and resources provided to the community health centers with which they are affiliated.

Trust relationships in community health centers are vitally important because unlike hospitals, protocol and hierarchy is not historically imbedded into organizational culture. And because the senior most leader is typically not a clinician, there are unique opportunities to examine leadership in the context of service, team-building, appreciative inquiry, change management, small group dynamics and many other interesting subtopics of organization development.

Opportunities for Further Research at The Center

Another area for future research involves the local research site. The intention of this study was to examine trust in one direction, that being trust in the executive director. Another interesting and perhaps necessary study would involve a deeper consideration of the trust relationship based upon examination of trust in and trust from the executive director to her peers, subordinates and superiors. And finally, if the research from that study yielded useful information, there would be two case studies examining trust within the The Center Health Center that could be used as prototypes for further research at the departmental level, so the topic of interpersonal trust could be fully exploited throughout every level of the entire organization.

There are also rich opportunities to examine trust at the community level. The benefit of community health centers (by way of their funding) is that they will serve their communities regardless of a patient's ability to pay. Significant ethnography has been done around health awareness in various kinds of communities. The decision to make a community health center one's medical home comes with a certain level of trust in the provider. This would be an interesting relationship to dissect. Once trust is built between a provider and a patient, there would possibly be more realistic opportunities to make that patient aware of the critical connections between behavioral and medical issues. As a medical home, The Center is well positioned to attempt this education and integration with its patients.

Recommendations Around Policy

The final area of recommendation deals with the opportunities to assess policy and program implementation. As the laudable goal of reaching 30 million patients by 2015 looms large, the nation's economy continues to necessitate more and more cuts in federal funding (including funding for community health centers). Most providers are having to do more with

less. How will this affect the government's goals around access and quality care? Will this situation cause somewhat of a paradigm shift which fundamentally changes the way communities think about delivery of care? Are there implications for the hospital/community health center relationship and if so, are the senior leaders of those organizations prepared to define that relationship and articulate it to their respective communities? Internally, it would also be interesting to follow the change effort within community health centers who are becoming FQHCs. Just one small dimension of the change, such as the transition to medical records, has significant implications of employee staff time, training, culture shift, leadership, communication, establishment of infrastructure, quality assurance and many other operational aspects. Although these changes are mandated per FQHC policy, how does the implementation of a new operation affect the organization and the work relationships between the employees who work within the organization?

These and many other questions are interesting areas of discovery that healthcare centers should engage as they seek to understand not only their industry but also the unique relationships that form within community health center sub-cultures.

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APPENDIX

The Center Interview Questions

1. Describe your position here at The Center

2. How long have been at The Center?

3. How did you come into this position?

4. As you know, my research is looking at perceptions of trustworthiness and the role of trust in setting organizational direction. Generally speaking, what has been your experience with trust in the workplace?

5. On a scale of 0-10, how important is trust for you in the workplace? Please explain your response.

6. What role has trust played in your professional experience?

7. What, in your opinion, are some of the things that facilitate and impede trust?

8. I want to narrow our focus now to The Center and the Executive Director. On a scale of 0-10, how would you describe your level of trust in the E.D.?

9. What are some of the experiences that shaped your response to the previous question? In other words, can you talk about particular instances and situations that have influenced your trust level?

10. Are there examples that stand out as areas where you have more trust or less trust?

11. I want to shift now to a focus on the current strategic plan. Let's take each strategic focus separately. The first is to acquire resources and there are two strategies that have been offered as mechanisms to reach the goal or strategic focus. How important is this focus area in terms of (1) your ability to leverage success in your area and (2) the organization's overall ability to move forward.

12. (Repeat for each strategic focus area)

13. On a scale of 0-10, to what degree do you believe each *strategy* will help the organization reach its strategic goals?

14. Taken separately, do you believe the strategies are appropriately aligned to the strategic goals? Explain why or why not.

15. On a scale of 0-10, to what degree do you trust the Executive Director? (** only ask this general question if not answered previously in #8)

16. On a scale of -10 to what degree do you trust the Executive Director to:

    a. Regularly include you in key decisions?
    b. Ask you what you need (resources) to do your job?
    c. Identify with your experiences in the workplace (whether positive, negative or otherwise)
    d. Provide the support needed for you to achieve the strategic goals most closely aligned to your area?
    e. Recognize and relate to you as a "whole person" not just an employee?

<div align="center">

VITA

Norm Jay Jones

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PROFESSIONAL EXPERIENCE

Assistant to the President   2006-Present
Dickinson College
Carlisle, PA

Associate Dean of Students   2004-2006
Dickinson College
Carlisle, PA

Director of Student Development   2001-2004
Dickinson College
Carlisle, PA

Special Assistant to the Superintendent   1998-2001
Harrisburg School District
Harrisburg, PA

EDUCATION

Ph.D. Workforce Education and Development   2011
The Pennsylvania State University
University Park, PA

Masters of Public Administration   2002
The Pennsylvania State University
University Park, PA

BA, English   1996
Morehouse College
Atlanta, GA