



HHS Public Access

Author manuscript

J Health Care Poor Underserved. Author manuscript; available in PMC 2017 September 08.

Published in final edited form as:

J Health Care Poor Underserved. 2014 May ; 25(2): 930–947. doi:10.1353/hpu.2014.0107.

Mission, Margin, and the Role of Consumer Governance in Decision-Making at Community Health Centers

Brad Wright, PhD and

Assistant Professor in the Department of Health Management and Policy at the University of Iowa College of Public Health

Graham P. Martin, PhD

Professor of Health Organisation and Policy in the Department of Health Sciences, University of Leicester, United Kingdom

Abstract

Objective—We explore the role of consumer trustees in decision-making as community health centers (CHCs) work to navigate the tension between pursuing their mission to provide primary care to all regardless of ability to pay and maintaining their limited finances.

Methods—We interviewed 30 trustees from 16 CHCs in 14 different states, asking extensively about decision-making processes at their CHC related to services and finances, as well as perceived advantages and disadvantages of consumer governance.

Results—Respondents described mission-dominant, margin-dominant, and balanced decision-making philosophies, and different decision-making pathways for service provision and finances. Consumer trustees were lauded for their role in informing the board of service quality and community needs, but criticized for being professionally unskilled and exhibiting a lack of objective decision-making.

Conclusions—While CHC boards do play a role in navigating the tension between mission and margin, executive directors and staff appear to be more influential.

Keywords

Community health center; CHC; consumer governance; patient participation; mission; margin; decision-making; semi-structured interviews

In 1965, the Office of Economic Opportunity (OEO)—the lead agency of President Lyndon Johnson’s War on Poverty—funded the first community health centers (CHCs) to provide primary care regardless of one’s ability to pay. Hoping to empower disadvantaged communities directly, the OEO required the *maximum feasible participation* of community members in all new poverty programs, including CHCs.¹ Office of Economic Opportunity officials suggested that this would ensure that programs targeted the needs of the poor, enjoyed support from community residents, and made lasting differences in the lives of

Address Inquiries to: Brad Wright, PhD, Department of Health Management and Policy, University of Iowa, 105 River St, N240 CPHB, Iowa City, IA 52242, brad-wright@uiowa.edu, 319-384-4369.

vulnerable populations. Initially, however, implementing maximum feasible participation led to confusion, criticism, and racially-charged power struggles across the United States.²⁻⁴

According to some, maximum feasible participation addressed the political dimension of poverty by giving the poor a mechanism for expressing their voice.⁵ Others argued that maximum feasible participation was simply an effort to dupe the poor into believing that they shared in some of the institutional power exerted over their lives.^{1,6} Still others blamed maximum feasible participation for installing incompetent and irresponsible program participants.⁷ As a result, many—if not most—of the OEO programs were defunded, with CHCs being a notable exception, thanks to the dedicated work of bureaucratic advocates within the executive branch.⁸

By 2010, 1,124 CHC grantees were caring for 19.5 million patients across 8,147 delivery sites annually. Like the patients served by the first CHCs, the vast majority of today's CHC patients are poor. At last count, 72% of CHC patients had incomes below the federal poverty level and 76% were either uninsured or enrolled in Medicaid.⁹ Additionally, like the first CHCs, today's CHCs continue to espouse the concept of maximum feasible participation, albeit in a much more clearly defined manner.

It took a decade for Congress to implement maximum feasible participation at CHCs by passing the *Special Health Revenue Sharing Act of 1975*, requiring CHCs to have a consumer-majority governing board. This meant that at least 51% of trustees must be CHC patients, with at least one visit in the last two years.¹⁰ For CHCs, the intent of consumer-majority governance is to ensure strategic influence for those served, and many assert that consumer trustees make CHCs more responsive to the needs of their communities.¹¹⁻¹³ However, governing boards also have important legal and financial responsibilities. For instance, the board is authorized to select CHC service offerings, set the hours of operation, approve the CHC's budget, hire and oversee the executive director, and set general CHC policies (Section 330, Public Health Service Act).

Like other safety net providers, CHCs provide services to individuals whom the market has failed, without adequate means to cost-shift onto insured individuals.¹⁴ Community health centers are legally required to provide primary care to all without regard for ability to pay, but unlike other safety-net providers, they are also required to provide non-clinical *enabling* services designed to overcome non-financial barriers to care and increase access for vulnerable populations. These services, which include things like case management, transportation, and interpretation, are not typically reimbursed by third-party payers. Thus, while CHCs receive federal grants and enhanced Medicaid and Medicare payments, they often struggle to cover the costs of the care they provide, and must navigate the tension between maintaining the organization's finances and pursuing its mission.¹⁰

The tension between mission and margin is not unique to CHCs; arguably, it is a moral issue that must be navigated by the governing board.¹⁵ For instance, in the face of mergers and intense competition for patients, non-profit hospitals also confront the need to reorganize the way in which they operate in order to remain financially viable while continuing to serve the needs of their communities.¹⁶ In fact, non-profits often prioritize margin over mission when

forced to compete with nearby for-profits.¹⁷ In such cases, non-profits may emulate for-profits by avoiding low-income areas, opting against offering services that the uninsured use, and denying access to care for those unable to pay for services.¹⁸ Hospital trustees have occasionally defined their role as ensuring “that the hospital does not stray from its mission because of economics” while realizing that “if you don’t keep your financial situation strong, you’re not going to be there to do the job.”¹⁶ [p. 116] Similarly, when resources are limited, some CHCs cut back on mission-oriented services.^{19–21} What is unknown, however, is the extent to which including consumer trustees on the CHC board influences these organizational decisions, particularly considering that CHC boards are self-perpetuating (i.e., board members are unelected, typically nominated by CHC staff or other board members, and appointed by board vote.)

In general, the consumer governance literature is not encouraging. Studies of Canadian regional boards of health,²² lay health boards in the United Kingdom,²³ health maintenance organizations,^{24,25} health systems agencies,²⁶ and community mental health centers in the United States²⁷ have found consumer governance to be fraught with significant implementation challenges. Such challenges include dominance by social elites,²⁷ low levels of consumer participation,²⁸ disparities in working knowledge between consumers and non-consumers,²⁹ and unanswered questions about the effect of consumer governance on organizational outcomes.^{30–33} These difficulties are often compounded by unclear or overlapping rationales for consumer participation. A variety of potential contributions to be made from *lay*, *consumer*, or *citizen* perspectives has been identified,^{34,35} but these are often conflated in practice. There are also tensions between providing collective voice for a wider constituency or community, and more individual-level, consumer-provided input, which are frequently unresolved.³⁶

Consumer governance may make CHCs more responsive to certain patient demands,³⁷ but given that the typical CHC patient is likely to be low-income, uninsured, and perhaps poorly educated, the potential technical expertise gap between consumers and non-consumers may be wide, especially for finances.^{38,39} While a commitment to the mission of caring for the underserved is integral to the CHC model, it is equally important for CHCs to remain solvent. In this study, we use a qualitative approach to understand how CHC board decision-making functions to work productively with the tension between mission and margin and what role consumer trustees play in the process.

Methods

Setting

We conducted semi-structured telephone interviews with a purposively stratified sample of 30 CHC trustees representing 16 CHCs. To ensure a wide variety of viewpoints, we selected a mixture of small and large CHCs from urban and rural areas, with size determined relative to the average CHC patient volume of 9,293. Trustees from CHCs in Alaska, California, Florida, Illinois, Kentucky, Maine, Maryland, Massachusetts, Michigan, New York, Oklahoma, South Carolina, Virginia, and Wisconsin participated in the interviews, ensuring that each of the four geographic U.S. Census regions was represented.

We also used quantitative descriptive statistics from the Uniform Data System (which contains information on CHC staffing, services, finances, and patient mix), to stratify CHCs into one of four categories representing high-performing, low-performing, mission-dominant, and margin-dominant organizations as shown in Table 1.

Participant recruitment

Once all CHCs were stratified into one of the four groups, we randomly selected CHCs within each group in an attempt to minimize selection bias and maximize organizational variation. We contacted the executive directors at selected CHCs by email with an invitation to identify up to two trustees (one consumer and one non-consumer, if possible) to participate in the study. We continued this process as needed within each stratum until we had arranged a sufficient number of trustee interviews (two trustees from each of 14 CHCs, and one trustee from each of two CHCs). To encourage participation, each respondent received a \$10 gift card. While several CHCs within each stratum did not respond or opted not to participate, we were not attempting to select a statistically representative sample of CHC trustees, but rather seeking to uncover a wide variety of viewpoints through qualitative inquiry.

Data collection

Once a CHC was enrolled in the study, we contacted individual trustees to schedule interviews. We conducted and digitally recorded telephone interviews, which we kept semi-structured through the use of an interview guide containing a mixture of open-ended and fixed-response questions. We developed the specific questions based on our review of the literature and designed them to complement and contextualize prior quantitative inquiries of CHC governance. We revised early drafts of the interview guide to arrange questions in a manner that would help the interview flow smoothly.

Interviews began with simple questions used to help respondents feel comfortable (e.g., *How long have you been on the board of the health center? Are you currently a patient at the health center?*). Next, we asked respondents about the degree of influence the board has vis-à-vis the executive director on decision-making about service provision and center finances (e.g., *Thinking about the services your health center provides, would you say that the board or the executive director was more influential in determining which services would be provided?*).

Then we inquired about the role of the health center's mission in decision-making and organizational responses to budgetary constraints and adverse conditions (e.g., *How much of a role would you say that the health center's mission plays in the decisions the board makes regarding which services to provide? Has your FQHC been faced with budget cutbacks during your time on the board? If so, what specific actions did the board take in response to this pressure?*). Finally, we asked respondents about the role played by consumers on the board (e.g., *What, if any, do you think are the advantages and disadvantages to the health center of having consumers on the board?*).

We concluded the interviews by asking about demographic information, which participants could answer easily in the event of fatigue. In practice, we adhered closely to the interview

guide, although we allowed question order to evolve and did not ask all participants all questions. Following each interview, we had the digital audio files professionally transcribed. The interviews, which averaged 45 minutes in length, generated approximately 23 hours of recorded audio and 363 pages of transcribed data.

Data analysis

We reviewed each transcript at least three times. First, we compared transcripts to the original audio files and edited them for accuracy. Next, we read the transcripts a second time to increase familiarity with the data. Finally, we applied a set of start codes to the data using Atlas.ti, and created additional codes as they emerged from the data.⁴⁰ As a validity check, a research assistant independently coded 20% of the transcripts, which were randomly selected. We resolved all discrepancies by a consensus process in which we created additional codes, consolidated codes, and recoded sections of transcripts. Following the consensus process, we applied these changes uniformly to all transcripts as appropriate. Then, we used an axial coding process to build a conceptual framework by linking codes together in meaningful ways to craft a storyline memo that explained the qualitative results.⁴¹

Results

The interview participants were a diverse group, as shown in Table 2. Their average age was 56 (range 28 – 75), and they possessed varying levels of CHC board experience, with an average tenure of 6.5 years (range three months to 21 years). The 24 respondents who indicated that they were consumers reported having been a consumer for an average of 9.7 years (range one to 30 years). Comparing individual respondents' consumer and board tenures revealed that six of the 24 (25%) were trustees before becoming consumers. As demonstrated by prior research, with respect to education and income levels, this sample appears to be representative of the typical CHC board, although the typical CHC board is not representative of the typical CHC patient population.⁴²

Mission-dominant, margin-dominant, and balanced philosophies

Respondents spoke about how their CHC responds to a variety of circumstances and navigates the tension between mission and margin. They espoused three underlying philosophies as depicted by the representative quotes shown in Table 3. The first is a *mission-dominant* philosophy, wherein service provision takes priority over financial considerations. For example, several trustees reported that their CHC provides services that lose money because providing the service is consistent with their mission. By contrast, several respondents expressed a *margin-dominant* philosophy, wherein finances are integral in decision-making and are prioritized over pursuit of the mission. Most often, however, trustees indicated a *balanced* philosophy in which mission and margin are equally important in decision-making. These different approaches align well with the mix of high and low mission and margin scores represented by the CHCs in our sample.

Applied examples of the three philosophies can be seen in the ways in which CHCs pursue payment. The Bureau of Primary Health Care permits CHCs to utilize billing and collections

practices for self-pay patients provided they do not conflict with the mission of serving all without regard for ability to pay. However, the point at which pursuing payment from individuals who do not or cannot pay conflicts with the mission is unclear.¹⁰

When asked about strategies employed by their CHC to maximize revenue collection, trustees described various practices. For example, when patients fail to pay their bills, the margin-dominant philosophy motivates the routine use of a collections agency and, in extreme cases, leads CHCs to “fire” patients by refusing to provide care to individuals who can pay but simply choose not to. Conversely, the mission-dominant philosophy considers using a collection agency contrary to the CHC’s mission, and something to be avoided at all costs. Finally, the balanced philosophy leads CHCs to target collection efforts in ways that maximize revenues while minimizing patient financial burden. For example, trustees stressed the importance of identifying and enrolling Medicaid-eligible patients, and pursuing payment from Medicaid more doggedly than from uninsured patients.

Different decision-making pathways for service provision and finances

In addition to discussing the role of mission and margin in decision-making, we asked respondents to discuss the role of the board versus the executive director in organizational decision-making related to service provision and finances. Their responses suggested two similar, but distinct, decision-making processes as presented in Table 4. Both processes are contrary to the role of consumer governance often touted by CHC advocates, who claim that it makes CHCs more responsive to the community’s needs.

According to respondents, ideas for the provision of new services to address unmet patient needs most often arise from the CHC staff, rather than the board. Specifically, providers, through frequent patient contact, are uniquely positioned to observe patient needs, identify trends, and raise concerns to the chief medical officer and/or executive director. These individuals then bring the issue to the board, which may vote or ask the administration to look further into the issue (e.g., identify funding sources, project patient demand for services, etc.)

Very rarely do new service ideas originate within the board. Despite our expectations, given the declared aim of consumer governance to bring a consumer perspective to bear on CHC strategy, only four respondents indicated that the board was more influential than the executive director and staff in determining CHC service offerings. When trustees do bring up community needs at a meeting, it has little to do with whether a trustee is a patient, and is usually the result of something they have observed or overheard, in cases where their identity is unknown:

But I do, if you’re out playing cards or out to dinner...or whatever, you do hear things about the clinic because not everybody knows that I’m on the board... You do hear some things and I think those are important considerations, not that they all need to be acted on, but they all do need to be considered.

Or they may be approached directly by patients in cases where their identity is known:

[P]eople know in the community that I'm on the board and I get told a lot of things which I take back to the board. Patients that are on the board are going to bring real, everyday issues as well as community perceptions to the board.

Finally, respondents discussed how patients and community members who are not trustees also played a variety of roles—some more proactive than others—in making their needs known. For example, patients may identify their needs by complaining to trustees or CHC staff, completing surveys, attending community advisory board meetings, and voting with their feet (i.e., they stop coming to the CHC until their needs are addressed). One respondent described how pro-active patients can raise their concerns to the staff:

I think the most important person there to make us aware is always the public, number one. They will from time to time. You don't have to be a board member to walk up to the front desk and say, "Why don't you do this for me?" or "Why aren't you doing anything about this?" That happens all the time. We take those issues that are brought in by the public, that's the number one source is the public.

When all else fails, patients can make their needs known by voting with their feet:

[We had a] health care provider that was let go and it created a lot of real outrage in the community. Many people wrote articles to the newspaper concerning this. They quit going to the center.

As with service provision, most trustees indicated that the executive director and other staff were more influential than the board in maintaining the CHC's finances. However, in the area of finances, there was a greater sense of shared influence between the board and the administrative staff than was generally portrayed regarding service provision decisions. This stemmed largely from most boards having a finance committee that reviews the budget and resolves concerns before information is brought to the full board for a vote.

Several trustees described the finance committee as where the "real work" happens. By the time the budget or spending request comes before the full board, very little remains unaddressed. Furthermore, the executive director and chief financial officer typically participate in finance committee meetings. Thus, key trustees and executive staff are literally working together on the CHC's finances. While other committees exist, none seem specifically geared to evaluating service provision, and none seem to explicitly involve both key trustees and executive staff in the way the finance committee does, perhaps because no other area places such explicit and individualized responsibility on trustees and the executive as finance.

Overall, respondents' comments make clear that the executive director often has the most influence in the decision-making process vis-à-vis the board. Further, this influence arises predominantly from the executive director's ability to set the agenda and the limited ability of trustees to alter it, effectively limiting the board's options before decision-making occurs.

The "secret shopper" role of consumer trustees

Despite describing a rather limited role for the board compared to the executive director in navigating the tension between mission and margin, respondents frequently discussed the

importance of having consumers serve on the board. Specifically, respondents were quick to say that consumer governance was advantageous not because it influences decisions over which services the CHC will provide, but because it provides the board with important feedback about the quality of services. Consumer trustees periodically experience the CHC's operations directly and this, according to many respondents, provides a mechanism for ensuring that the CHC is providing patients with high quality care—or at least addressing problems. One respondent described it as a firsthand, behind-the-scenes process that helps the patient population as a whole to have a voice:

As a user, you're just watching the sausage being made. I think that you are the person that is just—you can give perfect feedback... You are calling up and using the phone system, you are getting the treatment, and you are meeting the staff, giving your urine sample or whatever personal things you're doing. So I think the fact that I, as a non-professional, you know, I'm not a lawyer, I'm not a doctor, I think it's just to be instant feedback to them. I feel like I'm the voice for the clinic users who... I wouldn't say have no voice, but who wouldn't have the opportunity, or perhaps the courage, or maybe even the words to ever give that kind of feedback...

Another respondent spoke of consumer governance as an informal, information gathering mechanism:

...[W]hen I am sitting in the waiting room I listen to other patients' comments and most of them don't know that I'm a board member. But I listen to their comments about the clinic and about how things are working, about their doctor, about the nurses and what have you. You'd be surprised that there are many good comments.

A third respondent considered consumer trustees to be “secret shoppers,” going into the CHC undercover to experience things from the patients' perspective and reporting back to the board:

[W]e can, in fact be secret shoppers, if you will. We've employed that technique where we've had board members go to particular sites that have had some type of issue and we ask them to test it.

While each perspective suggests a role for consumer trustees in providing first-hand, up-to-date intelligence on the patient experience, each emphasizes different consumer trustee contributions. The first respondent characterizes her/his role as one of giving voice to other, disenfranchised patients; the last sees her/his function in terms of individual consumer experience of services provided.

The disadvantages of consumer trustees

While most respondents considered consumer trustees beneficial for the reasons discussed above, about one-third of respondents also expressed concerns with consumer governance. In particular, they worried that consumer trustees might lack the professional expertise needed to govern effectively. As one respondent put it:

I would rather like to see a little more than 51% or 60% or 70% of professionally qualified people to be on the board rather than the other way around as it is now.

That's my preference for the simple reason, people who are technically capable should be on the board....

Another respondent agreed that boards should be filled by those who can effectively govern the CHC, rather than including someone just because they are a patient:

I don't think that [whether or not someone is a consumer] should be the key factor in placing a person on the board. I mean, just to meet the 51% I don't think someone should be brought on just because they are a patient. I think they should have other qualities that would contribute to the well-being of the company.

Others discussed the difficulty in balancing the need for patient representation and the need for professional expertise on the board, given that the typical CHC patient lacks the background sought by most boards:

The only challenge that I think that requirement presents to you is that...these health clinics are not simple operations. These health clinics, you need diligent members on the board, and not to say that low-income people and patients cannot be diligent...They can be some of the smartest people in the world, but they...they just happen...not to have a lot of money...[N]ow you're really lucky if you can have a patient base where you can pull from that patient base some other additional professional and other kind of expertise that the board needs. You're fortunate if you can do that...[T]he only challenge with it is that sometimes, you know, if your patient base doesn't have the additional skills and expertise that you need on your board, it presents a challenge and, we struggle with that...

Another occasionally discussed disadvantage was the lack of objectivity in decision-making that occurs because consumer trustees are sometimes conflicted by having to decide between what is best for the CHC and what is best for them, personally, as patients. This was discussed most often in the context of decisions about terminating specific health care providers or eliminating specific services:

[W]e had a situation where there was a dispute between one of the doctors who had been with us since forever, since the center was open. It was a feud between that doctor and the current CEO and...most of the sentiment was that the doctor was the one that needs to go. Well, one of the board members was a patient of that doctor and she loved her doctor so her stance was less about what we thought was in the best interest of the center and more about, "I don't want you guys to push out my doctor."...That was an example of having a user on the board that was, in my mind, a detriment.

Discussion

The qualitative interview data summarized here indicate that CHCs navigate the tension between mission and margin using three different philosophical approaches, to guide two different decision-making pathways, differentially influenced by consumer trustees. Of the three philosophies, most CHCs appear to be navigating the tension between mission and margin with some success using a balanced approach that gives roughly equal weight to both factors. In contrast, the mission-dominant and margin-dominant approaches represent

opposite extremes, both of which are potentially harmful. While mutual exclusivity of mission and margin is seldom straightforward, focusing exclusively on mission would permit CHC finances to deteriorate, while focusing exclusively on finances may lead to key parts of the CHC mission being ignored and may cost the CHC its grant funding. However, we were unable to ascertain whether CHCs using a mission-dominant or margin-dominant approach were more or less successful over the long term than their more balanced peers.

Consumer governance—even where consumers are in the majority—is not synonymous with consumers having decision-making ability in practice.^{29,43,44} It appears that the executive director and other senior staff—including physicians—are more influential than the board with regard to identifying community needs and making decisions about CHC service offerings. Most boards described a reactive rather than a proactive approach to governance. According to respondents, the community's needs are most often identified by clinicians and reported to the executive director. Because the identification of needs originates this way, it typically motivates the executive director to push for new services, which are presented to the board for their approval. Since the board receives most of its information *via* the executive director, the executive director can set the agenda and effectively circumvent the board's authority. Consequently, it appears that the CHC (*via* the board) may be responsive to the community's needs only if the executive director and staff are responsive to the community's needs. This type of scenario was less commonly described with regards to financial decisions, where key staff and members of the board's finance committee tended to work together more closely.

Several studies of CHCs have found support for a negative relationship between mission and margin,^{21,45–47} and the results of this study provide evidence in support of prior findings that CHCs may occasionally respond to financial pressures and capacity constraints in ways that seem antithetical to their mission, such as aggressively pursuing payment or even turning patients away.^{48–50} Respondents did not indicate that this was common, but rather suggested that it was unavoidable when the alternative, absent a course correction, is a long-term reduction in the capacity to fulfill the mission, or even closure.

With the board seeming less influential and/or beneficial in the CHC decision-making process for services and finances, most respondents still hold a favorable view of consumer governance. However, respondents view the role of consumer trustees not as identifying the community's needs, but as a valuable way for the board to obtain information on the patient experience and the quality of care at the CHC. These results strongly reinforce prior findings that consumer trustees are valued more for their role in providing patient feedback than for their role as representatives of the community.⁵¹

Yet, the dual role of the CHC board, with its responsibilities for both determining service provision strategy and effective corporate governance of the organization, meant that some participants expressed strong doubts over the merit of the current arrangements and expectations regarding board composition. While some members may both fulfill the criterion of being a consumer and provide the range of professional skills and personal competences required to engage in the complex task of overseeing a healthcare organization, these were seen as the exception. Almost by definition, the CHCs' consumers are unlikely to

be professionally qualified in fields that are important to effective governance such as law and accounting. Furthermore, the complicated personal circumstances of many consumer trustees mean that they cannot always reliably fulfill their responsibilities to their boards, creating major problems for effective management. This finding, and the challenges described by interviewees in seeking to fill the remaining 49% of board seats with professional occupants, or find consumers with sought-after skill sets, suggests that CHCs can find it difficult to address their “margin” (and other areas of corporate governance) given current requirements—though the responses also suggest some of the creative ways in which they overcome this challenge. These inherent difficulties may well explain why prior work finds that consumer trustees are often not descriptively representative of the typical CHC patient.⁴²

Perhaps more surprisingly, however, the findings also suggest considerable challenges in the role of consumer trustees in ensuring strategic influence for those served by CHCs. Consumer trustees are seen by many participants as being too particular in their perspectives and interests, and therefore unable to provide the breadth of insights about the needs and views of a wider constituency. Indeed, respondents suggest that health care providers are better able to access, account for, and synthesize the views of the community than consumer trustees, who may be able to offer specific insights into experiences of care provision, but cannot speak for the wider patient body. This points to ambiguities in the idea of “consumer governance,” and in the role of the “consumer trustee.”

In particular, it parallels findings from other contexts on the breadth of expectations that is placed upon the figure of the “consumer,” whose position in the health care system is seen to offer a wide variety of insights and perspectives.^{22,35,52} Martin discusses how participants in public forums in the United Kingdom (UK) are expected to be both ordinary—i.e., typical individuals who embody the needs and concerns of the so-called *average patient*—and extraordinary in their ability to access, understand and articulate the views of a large, heterogeneous wider public.⁵² A similar burden of roles is placed upon the consumer trustee position, but evident from our findings is that it is very difficult to find individuals who can play such diverse roles adequately. This appears to occur primarily because most consumer trustees are not representative of the typical consumer, while those few who are more representative are not trained adequately to be effective in their role vis-à-vis more sophisticated trustees. Providing feedback on personal experiences of care, and also voicing the collective concerns of the wider public served, are not necessarily mutually exclusive roles, but our data show that they can be antagonistic, and it certainly requires an exceptional—rather than an ordinary—consumer trustee to reconcile them.

Once the need for professional knowledge is added into the desirable skill set for the consumer trustee, the difficulties of filling board seats with those who can truly achieve the manifest aim of majority consumer governance—strategic influence and popular control of CHCs, per Congress’s mandate—become clear. The result, in most of these CHCs, is a governance model which is rather different in practice, with consumer trustees prized for their individual experience but not their representative role, which, ironically, is seen by some interviewees as better fulfilled by the professional staff on account of their regular contacts with patients. This assumes—perhaps problematically—that a form of

“representation by proxy,” built on interpersonal contact rather than shared interests, is an adequate means of representing consumer interests. The fact that it is seen as less problematic than representation through consumers, however, is indicative of the way in which the multiple demands on the consumer trustee may undermine their representative function.

There are important implications from this study for exercises in consumer participation in other contexts. In the UK, for example, a recent innovation is *foundation hospital trusts*, which are intended to reduce government control of health care services and foster ownership by local communities.⁵³ One of the key means of achieving this is a board of governors including patient representatives, who are intended to hold directors to account and ensure local influence on strategy and operations. Our study, however, highlights the challenges of realizing such an aim by pluralizing the functions of a board, which must also contend with other concerns—including those, such as margin, that can become dominant. Indeed, some critics in the UK have suggested that “limited powers, upward accountabilities and legislative locks on assets and services present serious obstacles to any notion of community ownership” of foundation hospitals trusts.⁵⁴ [p.365] Consequently, it is argued, a better way for them to achieve influence is to disregard their representative function and instead to draw on their personal motivations to seek to instill “public interest values within the organizational conscience of [foundation trusts], and of holding managers, executives and clinicians to account against substantive social values and wider regulatory aims.”⁵⁴ [p. 366] As with our study of CHCs, this implies a neglect of the manifest function of consumer governance in favor of a rather different latent role—but as with CHCs, it is one that consumer trustees may be better placed to serve, and which is still founded in a commitment to the public good.

Limitations

We must acknowledge some limitations of this study. First, selection bias is possible, as non-participants may have answered questions differently than participants did. This may have occurred at both the CHC level and the trustee level. The first instance would occur if CHCs where the executive director agreed to participate were significantly different from CHCs that did not participate. The second instance would occur if the trustees identified for participation by the executive director differed significantly from the trustees not identified for participation. A purposively stratified random sample was used to minimize potential selection bias. However, future research should consider using in-depth case studies to ensure that the views of all trustees are proportionately represented.

Second, social acceptability bias is possible, as respondents may have given what they perceived to be the right answer about the advantages of consumer governance, while minimizing discussion of the disadvantages. This seems especially likely in cases where participants were unable (or unwilling) to mention any disadvantages of consumer governance. Fortunately, enough participants shared what they perceived to be the disadvantages of the requirement to allow some inferences to be made in this regard. Finally, because interviews were conducted over the telephone, the use of non-verbal cues was

limited, which might make the data less robust. Future research should consider the use of in-person interviews to the extent that available resources permit.

Conclusion

While consumer governance is a hallmark of the CHC model and is often touted by advocates of the program, our results suggest that the executive director typically has more influence than the board on decision-making, particularly about services and finances that help the CHC to pursue its mission while maintaining its margin. This does not mean that CHC boards are unimportant or that consumer trustees do not play a valuable role. It is clear from this study that there are both significant advantages and significant disadvantages to the requirement that CHCs be governed by a consumer majority. What is not entirely clear is the extent to which these advantages and disadvantages are present across all CHCs, or the extent to which one set outweighs the other within any given CHC. In fact, it is quite possible that a CHC's ability to survive, and even thrive, is determined—at least in part—by how well its board is able to balance the advantages and disadvantages that are an inherent aspect of consumer governance. To contribute more to our understanding of CHC decision-making in the context of the tension between mission and margin, future work should seek to evaluate the characteristics of executive directors at high and low-performing CHCs. More research is also needed to examine the variety of latent functions served by consumer trustees in addition to, or instead of, the manifest aim of consumer governance.

References

1. Moynihan, DP. *Maximum feasible misunderstanding: community action in the war on poverty*. New York: Free Press; 1969.
2. Levitan SA. The community action program: a strategy to fight poverty. *Ann Am Acad Pol Soc Sci*. 1969; 385(1):63–75.
3. Rubin LB. Maximum feasible participation: the origins, implications, and present status. *Ann Am Acad Pol Soc Sci*. 1969; 385(1):14–29.
4. Sundquist, JL. The end of the experiment?. In: Sundquist, JL., editor. *On fighting poverty*. New York: Basic Books; 1969.
5. Greenstone, JD., Peterson, PE. *Race and authority in urban politics: community participation and the war on poverty*. New York: Russell Sage Foundation; 1973.
6. Brieland D. Community advisory boards and maximum feasible participation. *Am J Pub Health*. 1971; 61(2):292–296. [PubMed: 5541872]
7. Morone, JA. *The democratic wish: popular participation and the limits of American democracy*. New Haven, CT: Yale University Press; 1998.
8. Sardell, A. *The U.S. experiment in social medicine: the community health center program, 1965–1986*. Pittsburgh, PA: University of Pittsburgh Press; 1988.
9. National Association of Community Health Centers. *United States health center fact sheet*. Washington, DC: National Association of Community Health Centers; 2011. Available at: <http://www.nachc.com/client/US11.pdf> Accessed December 14, 2012
10. Bureau of Primary Health Care. *Health center program expectations (PIN 98-23)*. Aug 17. 1998 Available at: http://www.fachc.org/pdf/cd_programexpectations.pdf. Accessed August 24, 2012
11. Zwick DI. Some accomplishments and findings of neighborhood health centers. *Milbank Mem Fund Q*. 1972; 50(4):387–420. [PubMed: 4565573]
12. Davis, K., Schoen, C. *Health and the war on poverty: a ten-year appraisal*. Washington, DC: Brookings Institution; 1978.

13. Hawkins DR, Rosenbaum S. Health centers at 40: implications for future public policy. *J Ambul Care Manage*. 2005; 28(4):357–365. [PubMed: 16172565]
14. Lewin, ME., Altman, SH., editors. *America's health care safety net: intact but endangered*. Washington, DC: Institute of Medicine, National Academy Press; 2000.
15. May, WF. The trustees of nonprofit hospitals: dealing with money, mission, and medicine. In: Jennings, B.Gray, BH.Sharpe, VA., et al., editors. *The ethics of hospital trustees*. Washington, DC: Georgetown University Press; 2004.
16. Gray, BH., Weiss, L. The role of trustees and the ethics of trusteeship: findings from an empirical study. In: Jennings, B.Gray, BH.Sharpe, VA., et al., editors. *The ethics of hospital trustees*. Washington, DC: Georgetown University Press; 2004.
17. Schlesinger M, Gray BH. How nonprofits matter in American medicine, and what to do about it. *Health Aff (Millwood)*. 2006; 25(4):w287–w303. [PubMed: 16787932]
18. Marmor TR, Schlesinger M, Smithey RW. New look at nonprofits: health care policy in a competitive age. *Yale J Regul*. 1985; 3:313–350.
19. Breyer PR. Neighborhood health centers: an assessment. *Am J Pub Health*. 1977; 67(2):179–182. [PubMed: 835766]
20. Feldman R, Deitz DM, Brooks EF. The financial viability of rural primary health care centers. *Am J Pub Health*. 1978; 68(10):981–988. [PubMed: 717609]
21. Ricketts TC, Guild PA, Sheps CG, et al. An evaluation of subsidized rural primary care programs: III. stress and survival, 1981–82. *Am J Pub Health*. 1984; 74(8):816–819. [PubMed: 6742273]
22. Contandriopoulos D. A sociological perspective on public participation in health care. *Soc Sci Med*. 2004; 58(2):321–330. [PubMed: 14604618]
23. Pickard S, Smith K. A 'third way' for lay involvement: what evidence so far? *Health Expect*. 2001; 4(3):170–179. [PubMed: 11493323]
24. Schwartz JL. Participation of consumers in prepaid health plans. *J Health Human Behav*. 1964; 5(2/3):74–84. [PubMed: 14184868]
25. Cross MA. Should consumers be present on an HMO's board of directors? *Managed Care*. 2002; 11(11):22–28.
26. Vladeck B. Interest-group representation and the HSAs: health planning and political theory. *Am J Pub Health*. 1977; 67(1):23–29. [PubMed: 831558]
27. Robins AJ, Blackburn C. Governing boards in mental health: roles and training needs. *Adm Policy Ment Health & Ment Health Serv Res*. 1974; 2(1):37–45.
28. Windle C, Bass RD, Taube CA. PR aside: initial results from NIMH's service program evaluation studies. *Am J Community Psychol*. 1974; 2(3):311–327. [PubMed: 4374080]
29. Paap WR. Consumer-based boards of health centers: structural problems in achieving effective control. *Am J Pub Health*. 1978; 68(6):578–582. [PubMed: 655318]
30. Scherl DJ, English JT. Community mental health and comprehensive health service programs for the poor. *Am J Psychiatry*. 1969; 125(12):1666–1674. [PubMed: 5770185]
31. Thomson R. The whys and why nots of consumer participation. *Community Ment Health J*. 1973; 9(2):143–150. [PubMed: 4710301]
32. Dudley JR. Citizens' boards for Philadelphia community mental health centers. *Community Ment Health J*. 1975; 11(4):410–417. [PubMed: 1204325]
33. Grant J. The participation of mental health service users in Ontario, Canada: a Canadian application of the consumer participation questionnaire. *Int J Soc Psychiatry*. 2007; 53(2):148–158. [PubMed: 17472088]
34. Abelson J, Forest PG, Eyles J, et al. Deliberations about deliberative methods: issues in the design and evaluation of public participation processes. *Soc Sci Med*. 2003; 57(2):239–251. [PubMed: 12765705]
35. Martin GP. 'Ordinary people only': knowledge, representativeness, and the publics of public participation in healthcare. *Sociol Health Illn*. 2008; 30(1):35–54. [PubMed: 18254832]
36. Vincent-Jones P, Hughes D, Mullen C. New Labour's PPI reforms: patient and public involvement in healthcare governance? *Mod Law Rev*. 2009; 72(2):247–271.

37. Wright B. Consumer governance and the provision of enabling services that facilitate access to care at community health centers. *Med Care*. 2012; 50(8):668–675. [PubMed: 22531649]
38. Lefkowitz, B. *Community health centers: a movement and the people who made it happen*. New Brunswick, NJ: Rutgers University Press; 2007.
39. LeRoux K. Paternalistic or participatory governance? examining opportunities for client participation in nonprofit social service organizations. *Public Adm Rev*. 2009; 69(3):504–517.
40. Muhr, T. *ATLAS.ti*. Berlin, Germany: Scientific Software Development. 2008. Available at: <http://www.atlasti.com>. Accessed June 3, 2013
41. Corbin, JM., Strauss, AL. *Basics of qualitative research: techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage Publications; 2008.
42. Wright B. Who governs federally qualified health centers? *J Health Polit Policy Law*. 2013; 38(1): 27–55. [PubMed: 23052684]
43. Kramer, RM. *Participation of the poor: comparative community case studies in the war on poverty*. Englewood Cliffs, NJ: Prentice Hall; 1969.
44. Steckler AB, Herzog WT. How to keep your mandated citizen board out of your hair and off your back: a guide for executive directors. *Am J Pub Health*. 1979; 69(8):809–812. [PubMed: 453415]
45. Hoag SD, Norton SA, Rajan S. Federally qualified health centers: surviving Medicaid managed care, but not thriving. *Health Care Financ Rev*. 2000; 22(2):103–118. [PubMed: 12500323]
46. Roby, DH. *An analysis of the characteristics of health centers facing financial deficits* Doctoral Dissertation. George Washington University; Washington, DC: 2006.
47. Martin BC, Shi L, Ward RD. Financial performance and managed care trends of health centers. *J Health Care Finance*. 2009; 35(3):1–21.
48. Gusmano MK, Fairbrother G, Park H. Exploring the limits of the safety net: community health centers and care for the uninsured. *Health Aff (Millwood)*. 2002; 21(6):188–194.
49. Cunningham PJ, Bazzoli GJ, Katz A. Caught in the competitive crossfire: safety-net providers balance margin and mission in a profit-driven health care market. *Health Aff (Millwood)*. 2008; 27(5):374–382. [PubMed: 18332492]
50. Jacobson PD, Dalton VK, Berson-Grand J, et al. Survival strategies for Michigan’s health care safety net providers. *Health Serv Res*. 2005; 40(3):923–940. [PubMed: 15960698]
51. Bracken, NJ. PhD diss. Medical University of South Carolina; 2007. The impact of the user board majority requirement on the governance of community health centers.
52. Clarke J. Enrolling ordinary people: governmental strategies and the avoidance of politics? *Citizenship Studies*. 2010; 14(6):637–650.
53. Callaghan G, Wistow G. Governance and public involvement in the British National Health Service: understanding difficulties and developments. *Soc Sci Med*. 2006; 63(9):2289–2300. [PubMed: 16879903]
54. Wright JSF, Dempster PG, Keen J, et al. The new governance arrangements for NHS foundation trust hospitals: reframing governors as meta-regulators. *Public Adm*. 2012; 90(2):351–369.

Table 1

Stratification of CHCs for Interview Sampling

		Mission	
		High	Low
Margin	High	<ul style="list-style-type: none"> • High-Performing CHCs <ul style="list-style-type: none"> a. Above average provision of: <ul style="list-style-type: none"> i. Enabling services ii. Uncompensated care b. Above average for: <ul style="list-style-type: none"> i. Operating margin ii. % of non-grant revenue iii. Cost per medical encounter 	<ul style="list-style-type: none"> • Margin-Dominant CHCs <ul style="list-style-type: none"> a. Below average provision of: <ul style="list-style-type: none"> i. Enabling services ii. Uncompensated care b. Above average for: <ul style="list-style-type: none"> i. Operating margin ii. % of non-grant revenue iii. Cost per medical encounter
	Low	<ul style="list-style-type: none"> • Mission-Dominant CHCs <ul style="list-style-type: none"> a. Above average provision of: <ul style="list-style-type: none"> i. Enabling services ii. Uncompensated care b. Below average for: <ul style="list-style-type: none"> i. Operating margin ii. % of non-grant revenue iii. Cost per medical encounter 	<ul style="list-style-type: none"> • Low-Performing CHCs <ul style="list-style-type: none"> a. Below average provision of: <ul style="list-style-type: none"> i. Enabling services ii. Uncompensated care b. Below average for: <ul style="list-style-type: none"> i. Operating margin ii. % of non-grant revenue iii. Cost per medical encounter

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Table 2

Summary Statistics of Interview Sample (N = 30)

Variable	n	(%)
Gender		
Male	12	40.0
Female	18	60.0
Race		
White	16	53.3
Black	12	40.0
Other	2	6.7
Education		
Doctorate	6	20.0
Masters	5	16.7
Bachelors	12	40.0
Some College	6	20.3
High School	1	3.3
Household Income		
> \$80,000	17	56.6
\$60–80,000	2	6.7
\$40–60,000	6	20.0
\$25–40,000	3	10.0
< \$25,000	2	6.7
Consumer Status		
Patient	24	80.0
Non-patient	6	20.0
Position on Board		
Chair	6	20.0
Vice-chair	3	10.0
Secretary	7	23.3
Treasurer	1	3.3
Member	13	43.4

Table 3

Three Board Decision-Making Philosophies in Community Health Centers

Mission Dominant	Margin Dominant	Balanced Approach
<p>“There’s a lot of cancer in this particular area. We have been successful in getting a new digital mammography machine, and so we’ve been doing outreach and letting people know that we are going to do mammograms for a minimal fee. They were \$25, which is a loss, but it’s worth it to get these patients in to take it. The very first one we did had cancer, so we felt like that was worthwhile....Flu shots are another thing. This year we had to take a loss in flu shots, but its better in the long run to do these things as a service to the public.” “I don’t believe anything has ever been sent to collections, ever. That’s not who we are.”</p>	<p>“I don’t think we have ever approved anything knowing it was going to lose money to start with. I don’t recall any incidents like that, that we would ever approve anything that was going to put us in the red from the beginning.” “We typically bill patients. Some of the bills are sent to collections every month. We review the total amount of bills every month that need to be sent to collections.”</p>	<p>“Oh yeah, I mean we aren’t in the business to make money so-to-speak, we’re in the business to provide the best patient care that we can, but we have to remain financially stable or we would be unable to accomplish our mission. We don’t look to make money on each and every segment of the services that we provide.”</p>

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Table 4

Different Pathways for Community Health Center Decision-Making

Dominant Influence	Service Decisions	Financial Decisions
Governing Board	“I think the board is [more influential] because our executive director...generally runs any kind of auxiliary services through us before she implements them.”	No examples given.
Executive Director	<p>“Actually, the staff initiates that. As the doctors providing the services here, when they see patients they realize what we need here to better serve the patients that they’re seeing...With that in mind, they began to target this, then that brought discussion with the CEO. The CEO then brings that discussion to the board. Then the board, we talk about it and then we assign committees to get a report if that is necessary. Then that committee will come back to us...with their report. Then we make a conclusion of what we should do...and then we make that recommendation to the CEO who then makes the final decision.”</p> <p>“I think the senior team and the individual clinics director are more involved in those decisions because they’re in a much better position to understand the needs of the different communities...The clinic directors really know, you know, do we need Saturday hours, do we need a late night, do we need childcare at this location... Obviously, it has significant financial implications that go through our financial committee and ends up being considered at that level, but overall I would say that’s more of an operation decision for the senior management team...We aren’t necessarily the initiators.”</p>	<p>“Definitely the CEO would be a bigger influence on the finances. Obviously, the board members are all volunteer members and we meet once a month. We have a full-time CEO and he hired a CFO. Actually, I’m on the finance committee so what we’ll do is we also meet once a month, typically the day before our full board meeting. After the finance meeting the members of the finance committee will hear reports as to what the previous month’s revenues and expense were. If there are any big items we need to talk about or if management has a suggestion that we move money from one CD to another or getting through the issues of us doing some expansion. The question may be, all right, the board has already approved us doing this expansion and now the CFO has put together a couple of options, we can borrow all the money, we can put up some of our money here, we can do this and that, so that’s pretty much how that’s presented to us. As far as actually maintaining the finances, that’s certainly something that management does and really kind of reports back to the board, this is the current state of things and obviously answer questions if we raised them or something doesn’t sound right. That’s pretty much how we’ve operated.”</p>
Shared	No examples given.	<p>“I think it’s pretty equal. I think our finance committee people are real dedicated and real on top of it. One of the members of the finance committee is a doctor who has been on the board from the very beginning and he’s very conscientious... We’re exceptionally financially healthy now and have been for a few years. I would say that the major credit for that is due to the CEO, but I do think our finance committee is very active and attentive and on top of it.”</p>

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript