I, Bernard B. Young Jr., hereby submit this original work as part of the requirements for the degree of Doctor of Education in Urban Educational Leadership.

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Descriptive Study of Democratized Style of Policy Discussion in Health Care

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Descriptive Study of Democratized Style of Policy Discussion in Health Care

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Abstract

Political and social pressures call for transparency and greater citizen participation in creating solutions to health issues facing communities and in determining policy in constructing healthcare services. This ethnographic research provides a description of factors affecting lay participation in policy formation and management discussions within Federally Qualified Health Care organizations of a local health care network. A participatory evaluation was performed on data collected through observations, interviews and document reviews. The evaluation provided data validation and prioritization of the findings that the evaluation group determined to be important to their ability to be participants in the policy discussion and formulation. The study generated a participant-centered description and recommendations that can be useful in suggesting implications for policy and practice improvement and in guiding future research in this area.

Keywords: Citizen Participation, Declaration, Deliberation, Democracy, Participation, Validation
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A Descriptive Study of Democratized Style of Policy Discussion in Health Care

In the older understanding, people who disagree do not vote; they reason together until they agree on the best answer. Nor do they elect representatives to reason for them. They come together with common interest and equal respect. It is the democracy of face-to-face relationships. Because it assumes that citizens have a single common interest, I have called it “unitary” democracy (Mansbridge, 1980, p. 3).

The United States government and the governments of other Western and Third World Countries are giving particular consideration to the development of services to the poor and the underserved. This expanding consideration had been built around an effort to support the active involvement of lay citizens (consumers and local residents) in the development of services that affect them. Freire (2003) suggested that the power brokers and controllers could no longer “go to the laborers—urban or peasant—in the banking style, to give them "knowledge" or to impose upon them the model of the "good man" (p. 94). I believe that the concept of full citizen inclusion in determining developments in education, services, policies and management is an important ideal leading toward equity in a society. The position that I have taken during this research reflects a belief that the inclusion of a diverse group of affected participants generating ideas serves to legitimize the process and the policy being developed (Abelson, Giacomini, Lehoux, & Gauvin, 2007). The establishment of a diverse discussion group allows the inclusion of ideas that have been influenced by the health marketplace and academia, as expressed through the voices of professionals, organizations, funders, service evaluators and monitors. The input of the real-time life perspective and knowledge provided
through the inclusion of non-professional, consumers and lay citizens brings important information to the discussion (Chin, Walters, Cook, & Huang, 2007; Schneider, Zaslavsky, & Epstein, 2002). Let us not forget that, while finding common interest is the gold standard of deliberation, there are conditions where self-interest and the negotiation of conflicting interests are important contributions. The local community members are able to contribute personal experiences that include cultural and social concerns (Abelson, Gauvin, & Canadian Policy Research, 2006; Tritter & McCallum, 2006). The expanded knowledge base, brought about by the more inclusive input, influences the short-term and long-term utility and economy of health care and disease prevention efforts. In other words, the practice of expanding the conversation to include the knowledge, concerns, observations, and stories directly from consumers and lay citizens brings authenticity to the discussion and allows local cultural concerns and local norms to enter the discussion supporting the development of solutions that are more likely to be effective and acceptable to community health. This has been particularly true concerning issues of health for marginalized and disenfranchised neighborhoods (Taylor, 2007). These communities bear the added the responsibility of responding to overlapping issues of disparity, cultural bias, insurability, family disruption, poverty, language, etc. These issues often conflict with the social and political structures central to the primary decision makers and the existing power structure.

The vocabulary, which includes specialized acronyms and expressions, used by the professionals and some staff members was not always familiar to lay citizens or consumers. It was also true that staff and professionals did not always understand the local terms or “slang”
used by lay citizens and consumers. However, increasing exposure to each other, in collaborative meeting sessions, provided lay citizens, professionals and staff opportunities to gain greater understanding of citizens’ needs and professionals’ roles (Murphy, 2005). The inclusion of a diverse, well-represented coalition of community members in the discussion stimulates a dialogue that exposes each participant to the lives, language and expressiveness of the other participants.

In 1978, the World Health Organization (WHO), through the Declaration of Alma-Ata (World Health Organization (WHO), 1978), stated that all citizens have the right to access primary health care and to participate in the discussion of how these services are provided. Declaration VI of the document states:

> Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. (pp. 1,2)
In principle, this declaration expresses the desire that full inclusion is a primary principle held by the member states of the United Nations, including the United States. However, it is important to point out that among the UN members there is little agreement on the specifics of implementation of this principle of inclusion (National Association of Community Health Centers (NACHC), 2007; U.S. Department of State (USDOS), 2000; United Nations General Assembly, 1966). The World Health Organization has a definition of health that it has recognized for more than thirty years. The definition states, “Health is a state of complete physical, mental, and social wellbeing and not merely the absence of disease and infirmity” (Callahan, 1973, p. 77). The debate has been how to achieve this end. My focus is achieving diversity in this debate. In the United States, there has been increasing focus on technology combined with increasing pressure to maximize health resource availability while minimizing expenditures in a way that secures an acceptable level of prevention and care. At the macro level, the approach that has been taken is expressed in the ongoing discussions around the Patient Protection and Affordable Care Act of 2010, often referred to as "Obama Care." The central focus of the discussion has been to remove barriers to accessing and promoting positive health conditions for all citizens (Kocher, Emanuel, & DeParle, 2010) and to redistribute the risks, involved in supporting health care. Ultimately, the broad themes of health and health care access are passed through filters of market and politics to reach the consumer at the local community level; it is the consumer who, ultimately, must then respond to the specifics regarding health care provision for whom, what, how and for what reason. Hoffman (2011) offers three models
of health care coverage on which to focus debate while determining policy for the facilitation of health care services:

1. Care coverage to sustain health;

2. Care coverage to protect from medical bankruptcy and financial insecurity;

3. Care coverage to cover the cost of health concerns that we cannot reasonably prevent on our own - "unavoidable risk". (p. 1875)

A participatory process that is based on diversity and inclusion could provide an opportunity to enable community response to these three models, including a discussion of beliefs, questions and concerns, as well as providing an opportunity for a deeper understanding of the philosophical differences of each of these models that lead to the formulation of health policy.

The perception that a systemic attribute of democracy is a desire to encourage citizen involvement in the process of policy development, as a right, has been emphasized in the United States since the emergence of environmental concerns in the 1930s. In the 1930s, the government initiated the Tennessee Valley Authority (TVA). Through the establishment of this organization, the United States government intended to demonstrate a means for managing a large initiative through a process that included citizens in determining policy. Although this example fell short of the desired outcome, it provided sociological information that would assess developing consumer and citizen involvement in solving social problems (Selznick, 1949).

Americans are involved in discussions about the efficient management and delivery of health care services. At the highest levels of government, we are hearing our representatives in
combative discussions over the formation of polices that will influence the distribution and accessibility of health care services. The United States began to emphasize the addition of persons (laypersons and consumers) who do not have formal academic or professional training in social problem solving during the 1930s. Koseki and Hayakawa (1979) reviewed ten federal health laws that Congress introduced between 1963 and 1975. These laws were reflective of Congressional desire to initiate a directive to have “consumer participation”. The general trend toward consumer and lay participation peaked in the 1980s. Community and public health is one of the few areas of policy determination that continues to emphasize the inclusion of non-professionals and consumers in the discussion. Much of the support for this emphasis has been associated with an ethical belief that it is the right thing to do because citizens have the right to be heard when it comes to health services. (Koseki & Hayakawa, 1979; Schwartz, Goodman, & Steckler, 1995)

Knowledge of social and cultural elements of health issues in community life are an important contribution that consumers and laypersons can deliver to the policy discussion. Judgments of good, poor, and bad personal, environmental, and social health evolves with cultural standards and the evolution that occurs as beliefs are constantly evolving with the changes that occur as we watch society move from a more intuitive metaphysical response toward a less traditional, more fact-based technology response. However, formulation of a standard understanding for community health care that is acceptable to a given culture or neighborhood is reflective of the collective material desires, sensory expectations and physical perceptions of that community’s members at any given time. Ideally, health policy seeks to
define processes that support positive health status and extend longevity, but in reality, the true measurement of the success of outcomes at the level of the community occurs within parameters of moral and ethical comfort of the persons living in that community (Bourne, 2011; Knabb-Lamouche, 2012).

**Legitimacy**

Dryzek and Niemeyer (2010) established a practice that included, in the planning process, persons for whom products and services were being developed. The inclusion of these consumers was seen as a principle practice in the legitimization of the process to the broadest range of constituents. This is a principle for legitimization that is supported in the work of Arnstein (1969, 1972).

Research has created evidence that social issues and health services hold an interest for the public and that, if given the opportunity and adequate support, laypersons would seek opportunities to participate in ways that would not reduce the quality of outcomes (Beierle, 2002). There are mixed reviews on whether the inclusion of consumers in the development of health policy and service delivery leads to a more effective, efficient and productive decision-making process, in contrast to the decisions of a focus group composed solely of professionals (Nilsen, Myrhaug, Johansen, Oliver, & Oxman, 2006). The esthetic belief that an inclusionary approach is worth the effort is supported by research that indicates that there is an improved sensitivity to the needs of the underserved and consumers when they participate in the process (Aranda-Naranjo, 2007; Nilsen et al., 2006; Parsons & Wright, 1980).
Statement of Problem

This research will seek to identify and describe the communicative practices that occur between health service consumers, laypersons, activists and professionals participating on Federally Qualified Health Clinic (FQHC) boards. Since the mid-1970s, the United States has witnessed an expansion of consumer and other non-professional representation in discussions that take place to resolve health care concerns. These efforts focus on observing stakeholder interaction, determining if there are gaps in informational transparency, and board member self-assessment of efficacy and efficiency in the representative process in which they participate.

What is the environment that the consumer and nonprofessional enter when they join specific FQHC boards? There is a clear belief that the voices of the public (consumer and citizen) should be heard at the level of health care systems and program development (Litva et al., 2002). What are the conditions that deter or support participation in meaningful discussion? The public’s subjective view of health and health needs must work side by side with developing technology and market forces to “provide creative solutions and apply ‘common sense’ to particular problems” (Litva et al., 2002, p. 1831). What are the conditions that allow for consumers, lay citizens and professionals who are concerned with health care policy to rationally discuss their points of concern and identify the points where intuitive belief, scientific knowledge and community norms might come together as policy? What internal and external factors of power and control affect the ability of these participants to recognize areas of
concurrence and compromise in the process of developing policies that improve health conditions and are consistent with community concerns?
Chapter 2 Literature Review

The concept of the involvement of lay citizens and consumers, particularly those individuals not associated with the established power structure (minorities, the poor, recent immigrants, women, and children), in the intimate discussions initiated by government, local communities and social institutions to resolve social problem, establish social policy and initiate debate is a relatively new concept in America, with state and local legislation beginning in the 1920s and federal legislation in the 1960s (Stivers, 2009). Several scholars have influenced my theoretical framework for this research. These scholars include individuals such as Habermas and Rawls, who have affected the political and theoretical perceptions of democracy, inclusion and civic engagement. Habermas (1996) and Rawls (1993) have focused on a democratic perspective that supports deliberative conversation and diverse opportunities for inclusion. They provide a perspective that compares and contrasts the efficacy of allowing the full spectrum of different forms of democratic participation. I was additionally influenced by Nutt (1976) and Dyer (2004), who assessed the question of the merits of citizen and consumer involvement with professionals. Nutt takes the position that an inclusive involvement of all affected parties leads to an improved implementation process by generating positive buy-in to the decisions made. Dyer takes a critical look at the issue of having non-professionals participate with professionals in health care decision making and brings to question the involvement of lay citizens who are not equipped to challenge the “language game” which is part of the discussion process and impacts what is said and when it is said (Morrison &
Dearden, 2013). Finally, I am also influenced by the more recent works of Abelson, who has looked into the trends of participatory practices in health care.

The works of Arnstein and Habermas provided a basis for the research I undertook for this study. Arnstein developed a typology by which levels of citizen participation can be discussed (Arnstein, 1969). Arnstein’s research provided a basic language that can be used as a barometer for comparatively assessing and discussing the development of political power for laypersons participating in the decision making process. In A Ladder of Citizen Participation, Arnstein provides a test of participatory quality utilizing a simplified scale on which to determine the balance of power between the traditional figures of authority and the lay citizen. The relationship falls along a continuum, which ranges between lay citizens with full control (people power) at the top of the ladder to total manipulation of lay citizens (no lay participation) at the bottom. This ladder does not serve as a staircase model of participatory development, in which citizens climb up or down in a step-by-step gain or loss of participatory influence. Rather, the scale represents the overlapping possibilities of influence and gives a perspective for judging what should be expected and strived for in a democratic process. Arnstein’s research provided an opportunity for persons engaged in the “Model Cities” citizen advisory groups, of the 1960s and 1970s, to participate in an interactive participatory process of research. The process allowed citizens to voice their opinions on an urban power management structure while examining the participatory decision-making process of the structure in which they operated. Arnstein’s research emphasizes social, political, and administrative power
sharing as it influences participatory practices in decision-making that includes citizen involvement (Arnstein, 1969, 1972).

Habermas (1996), Rawls (1993), and Taylor (1998) emphasize the desirability of the involvement of multiple voices in assessing social problems. These three scholars see the collaborative process of deliberation among diverse stakeholders as being capable of producing policies that are affective, meaningful, and rational outcomes in policy formation based on the self-focused desires and needs of the persons involved. This is not an easy discussion because it is based on the input of conflicting, concurring and contrasting voices of the participant. Yet, Taylor pointed out that a diverse group that joins as equals, seeking justice and engaging in debate, produces a conclusion based on the compilation of different points of view.

Habermas (1996) and Rawls (1993) suggested that the desire for diverse and inclusive debate between stakeholders exists as a universal concept among rational people. They indicated the debate should not be limited to a self-defined membership, but should include the capabilities for allowing equitable input from all affected parties.

The work of Habermas (1996, 2005, 2006) focused on concepts of democracy and encouraged an empirical study that takes into consideration the interactive elements of language, culture, politics, social status and economics. Habermas (2006) argues for the equitable inclusion of all parties affected by an issue in the process of political debate. Habermas considered the inclusion of all stakeholders as a legitimate means for social problem solving in Western democracy. I agree with this viewpoint, and add that, in my experience, I have found that such inclusion serves as an incentive for the citizen to become a volunteer
participant in policy development. I have also discovered, as did Habermas, that where there was not diversity in a group there was a greater likelihood of influence by “special interests” rather than an effort to meet the requirements of all stakeholders (Habermas, 1984).

Habermas (1984) suggested that, while support for diversification of discussion is expanding, the norm is to have a discussion or process that is led by the most dominate and powerful individual(s) or group and focused on their self-serving concerns. The dominant entity determines the focus of discussion while also mediating the decision. This results in a failure to provide equitable and consensus-driven leadership. The process negatively affects the balance of power by taking influence away from those participants with the least developed power and communication skills. Such control by power holders was characterized by “(a) the lack of face-to-face interaction between present participants in a shared practice of collective decision making and (b) the lack of reciprocity between the roles of speakers and addressees in an egalitarian exchange of claims and opinions” (Habermas, 2006, pp. 414-415). The existence of equity in the shared communication, as participants take on the roles of speakers and listeners, is important to the process of developing rationally formulated, collaborative decisions. Such decisions are produced when all participants understand the various claims offered to validate or explain recommendations. The need for this form of equity holds true in the liberal democracy model, deliberative democracy model, and republican democracy model (Habermas, 1984, 1996),

Both Arnstein and Habermas strongly argued for direct involvement of all stakeholders in the problem-solving process when possible. In this study, I assessed the challenges to initiating
and/or maintaining an equitable process among individual participants at select Federally Qualified Health Center (FQHC) boards in Hamilton County, Ohio. Federally Qualified Health Centers can be generally described as “community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless” (Federally Qualified Health Center, 2013, p. 1). The main purpose of the FQHC Program is to enhance the provision of primary care services in underserved urban and rural communities. These organizations are public and private primary health service programs that have been qualified to receive public funds “under Section 330 of the Public Health Service (PHS) Act” (Federally Qualified Health Center, 2013, p. 1). It is my contention that the tensions of the health care marketplace and the ongoing formation of special interest groups present challenges that demand debate over power and control, legitimacy, and efficacy within FQHC Boards. I would suggest that these tensions are reflected in the practices of those boards.

**Power and Control**

Habermas (1996), Arnstein (1969) and Rawls (1993) see the collaborative process of deliberation among diverse stakeholders as being capable of producing rational outcomes in policy formation based on the self-focused desires and needs of the persons involved. This is not an easy process because it is based on the conflicting, concurring and contrasting voices of the participants. Taylor (1998) points out that, while not an easy task, a diverse group of individuals, willing to join as equals, seeking justice and engaging in debate, could produce a conclusion based on the compilation of different points of view. I suggest that a key here is the development of the ideal notion of group recognition of equity among the participants.
Habermas and Rawls suggest that the desire for diverse and inclusive debate between stakeholders ideally exists as a universal concept among rational people and should not be limited to a self-defined membership, but should include the capabilities for allowing equitable input from all affected parties. The work of Abelson et al. (2007) in assessing cancer research policies provided insight into the effects of having diverse groups of stakeholders participate in “Health Technology Assessments” (HTA). HTA is a process used in Canada to determine broad health care principles and policies that affect issues of health care coverage, accessibility of technology, evaluation of technology’s impact and value, and the funding of technology. This process of policy development provided opportunities for input from professionals and members of “the public” (p. 43). The members of the public who were given an opportunity to participate were highly dependent on the distribution of information regarding the opportunities and the processes of recruitment. Special interests groups, such as community activist groups, service providers, and pharmaceutical companies, sought to recruit their clients and service recipients to the process. As a result, members of these groups self-selected to become members of the different interest groups. Abelson warned that there is a difference between the terms “stakeholder involvement” and “public involvement.” The explanation given was that “stakeholder involvement” is a public involvement that takes on the voices of the sponsoring professionals and corporations (p. 44). These are members who hold an interest that is separate from the interest of the lay citizen and the patient. Each of these separate units of interest possessed varied levels of communication skills. Abelson concluded that this variation in skills was apt to result in power struggles within the group. Abelson, Giacomini, et al (2007)
noted that the HTA process had developed a “Public accountability mechanism” that focused on an internal process to induce public accountability by requiring the “public distribution of recommendations, decisions and their rationales,” along with the establishing of a protocol for internally communicating information between participants at each step of the policy development process. The HTA groups had guidelines that put in place sanctions in an effort to maintain the integrity of this procedural system and to “control misuse and abuse” by those who had developed power within the groups. These sanctions were “operationalized through penalties, incentives, codes of conduct or negative publicity (p. 42).” Despite all of this effort to control the process, the process lacked group accountability and lacked clear, distinctive roles and responsibilities for professional staff, consumers, activists, and non-staff community residents who participated in the process. Abelson and her research team concluded that, as they developed greater ability to articulate their positions, articulate participants were more likely to attempt to manipulate the participants who possessed weaker communication skills, rather than supporting the weaker members in learning to articulate their perspectives and supporting their ability to gain an equitable status. This action by the stronger participants was seen as a means for them to influence citizen support and strengthen public and funder sentiment in their favor, regardless of how it might affect the common good (Abelson, Giacomini, et al., 2007). I assessed this behavior in local FQHC boards with an eye on how power appeared to be distributed and control maintained.

Dyer (2004) conducted a study that looked at the justification for the laity’s involvement in health care decision-making. She focused her research on four models of lay participation:
the “experiential-expert model,” the “non-certified-expert model,” the “extra-scientific public participation model,” and the “scientifically engaged model of public participation model” (Dyer, 2004, pp. 340-341). These models serve to respond to the question of whether the consumer or uncertified layperson, as an individual without specific training, can contribute to the health care discussion on a level that is worthwhile and productive. The first two models, the experiential-expert model and the non-certified-expert model, advocated that individuals who had not received professional or academic training, but had been involved in some way with the delivery of health care services, should be included in the discussion. These models of involvement justify lay participation by emphasizing the belief that, through the experience of participation, laypersons developed knowledge and that this knowledge enabled them to make significant contributions.

The second two models, the “extra-scientific public participation model” and the “scientifically engaged model of public participation model” (Dyer, 2004, p. 341), justify lay participation by emphasizing the values of those being served. These models also see science as a socially interactive process that should not take place independently of the population that it is created to serve. Each of these models brings a different perspective to determining the roles that laypersons of differing competency levels should play in the decision-making process.

Dyer (2004) holds that the process of successfully transitioning theoretically developed and laboratory formulated solutions into the real world of problem solving should occur through a filter that includes laypersons. Mark Sullivan, as cited by Dyer (2004), explains this recommendation in more practical terms:
Facts known only by physicians need to be supplemented by values known only by patients. Outcomes research has pointed to the importance of the patient’s point of view on the goals of medical care in its call to emphasize “patient-centered” outcomes such as quality of life (Dyer, 2004, p. 1595; Sullivan, 2003).

This filter provides a check and balance between technology and the goals, values and morals of citizens. This model supports both an extensive involvement of lay participation and a more restrictive approach of “citizen juries” (Sullivan, 2003, p. 341). “Citizen juries deliberate on a specific ‘charge’ that generally includes a given set of options” (Dyer, 2004, p. 341). A “citizen jury” is constructed with the idea of producing a representative sample of the community, but often, citizen juries fail to include members of some important interest groups (Beierle & Konisky, 1999).

The “scientifically engaged model” of citizen participation justifies citizen participation by emphasizing a belief that science is not value neutral and needs laypersons in order to challenge the prioritization, form, and direction chosen by trained professionals, who process data through a lens of professional training and technological expediency (Dyer, 2004, p. 341). Such professionals, the model purports, make their decisions within a vacuum of subjectivity that distances them from the experience of receiving the services and from the values and norms of those for whom the services are targeted.

Dyer (1999) concluded that the joint participation of laypersons with professionals could produce positive results; however, this research also identified several concerns. First, there is a
tendency for lay members of decision-making groups to place great authority in the opinions of
the professionals without appropriate inquiry into the rationale behind their statements; this
has the effect of laypersons reiterating, rather than challenging, the arguments of the
individuals identified as professionals in the group. Second, Dyer (2004) states that, within a
group, professionals usually have greater knowledge and control over governing structures and
processes, thus producing an imbalance, in favor of the professionals, in the management of
power between laypersons and professional participants.

Dyer suggests that no model of lay participation should be removed from consideration,
but that there is a need to be sure that the layperson is trained and prepared to participate. It is
also suggested that clear role statements be identified for all participants.

Research by both Nutt (1976) and Dyer (2004) responded to the issue of the merits of
using different participant types (i.e., activist, consumers, and experts) in the planning and
decision-making processes used in health care. Nutt’s research model created 12 planning
groups, consisting of various combinations of stakeholders. Six of the planning groups worked
on concerns of primary health care planning while the other six groups worked on concerns of
home health care planning. Nutt used a process of data analysis, consisting of forming teams of
trained experts in the fields of primary health care and home health care, to review the
recommendations of the 12 conferring groups. Nutt’s teams of experts scored the
recommendations of each group for quality, quantity, and real world effects produced by the
recommendations. This research also studied the legislation that required the inclusion of
consumers and experts in the planning process. I question the research methods used by Nutt. I
suggest that his methodology of using experts to judge the groups is a substantiation of bias
that induces the professional to exclude non-professional input in the decisive stages of
discernment in situations other than those personally affecting the individual. I further suggest
that it is a bias of inequity in the realm of professionalism that is often not thought about but
that leads to a failure to accept or see as relevant the input of all stakeholders.

An area of continued concern is whether the informed medical service recipients (actual
or potential) speak for themselves, alongside the professionals, in a practical, meaningful and
acceptable manner during conversations of a clinical or technical nature. Can the informed
consumer’s and layperson’s experience lead to the formation of the “non-certified expert”
(Nutt, 1976, p. 340) who is capable of adding worthwhile information and perspective to the
evaluative process? Are consumers important enough to demand a place in these
conversations? Is there greater reason for including consumers other than that they fulfill a
quota and reduce future conflicts or, is this reason enough?

The results of Nutt’s (1976) research suggests that, when comparing recommendations
from groups comprised of activists versus groups of other non-experts citizens, the activists
provided recommendations that were seen as being more innovative then those of consumer
and other lay citizens, but less acceptable to the experts. This research also suggests that, when
health care planning groups were composed of a mix of lay citizens and professionals, the
consumers and lay citizens self-identified into the roles of activist and service recipient. The data
further suggest that consumers, through their experience, had greater knowledge about how
systems operated, but were not perceived by the professionals and providers of services as
activists. The consumers were viewed as providing solutions that were more acceptable to the
experts. Nutt’s study (1976) spoke to the willingness of professionals to be accepting of the
recommendation presented by non-professionals. He did not provide comments on the quality
of the resulting recommendations in terms of improving actual health outcomes. Although Nutt
determined that groups composed entirely of professionals produced higher quality outcomes
than groups of mixed participants, I would suggest that a closer look at the roles, social
structures and cultural differences of citizens and experts would lead to the identification of
factors of inequity which, if appropriately responded to, could produce better outcomes from
the groups of mixed participants. In assessing the recommendations of Nutt’s study, the reader
should consider that the final analysis came from the perspective of the experts and excluded
the viewpoint of the affected community.

Dyer (2004) conducted a survey assessing the efficacy of including consumers in the
policy-making process. Dyer’s data suggests that, when the planning group was composed of
an appropriate balance of consumers, community residents, health care providers, and
government officials working together in the planning and decision-making process, a new and
important perspective was brought to the health planning process. They also offer the
conclusion that a heterogeneous group could efficiently reflect the health needs of the
represented community. This study did not assess the appropriate balance for stakeholders
within a group. The study did suggest the need to measure effectiveness through the way that a
group’s process impacts on the philosophy, service delivery, monitoring, and management of
the health care system (Conway, Hu, & Harrington, 1997). However, the work did not speculate
on the actual positive or negative outcomes that would result. It is noted that, while the inclusion of the public in health care planning and administration is federally mandated, as this review of the literature reveals, there is neither clear consensus on the efficacy of such participation nor on the best model for both engaging public participation and integrating public and expert perspectives to create responsive health policy. The research that I conducted assessed the interplay of stakeholders involved in health care planning and policy development by observing, questioning and assessing the communication practices within FQHC boards.

Conclusion

Studies have shown that, across racial and economic groups, there is a significant disparity on key measures of health care quality in the practice of health care services (Chin, Walters, Cook, & Huang, 2007; Conway et al., 1997). The lack of balance in the availability, distribution, and access of health care services has paralleled the history of segregation and financial disparity in America (Schneider, Zaslavsky, & Epstein, 2002).

Nationally, there is an increasing desire for public transparency and an improved feeling of legitimacy in the system of health care (Blustein, 2008). This desire has been fueled by the belief that the values and concerns of citizens should be as influential in the decision-making process as the technological developments (Abelson, Giacomini, et al., 2007). However, control of technology has been a process of institutional control. In fact, systemic control of technological progress has been a “deliberate strategy” in some communities (1969). Furthermore, in several areas of health care planning and policy development, the involvement of citizens and consumers of service has been legislated in a way that leaves determination of
the role of the citizen to the judgment of the local authorities. This ambiguity makes the roles of stakeholders in the process of power sharing, for the purpose of effective decision making, unclear (Arnstein, 1969; Horlick-Jones, Rowe, & Walls, 2007; Partnership work: the health service–community interface for the prevention, care and treatment of HIV/AIDS, 2002; Rowe, Poortinga, & Pidgeon, 2006).

This research study was borne out of questioning the conversations occurring between non-professionals (consumers and citizens), professionals, and paid program staff participating in health care policy development on a local level. The questioning extended to the practical concerns regarding collaborative participation. The intent was to obtain a descriptive picture of the face-to-face interactions of the participatory practice in a way that would answer the following questions: Research questions should be at the beginning of the paper.

• What are the life experiences and accompanying emotions that the participants bring into the conversation that affects citizen “voice” in the discussion?
• Is there an opportunity for a level playing field with regard to consumers (nonprofessionals), professionals and program staff on FQHC boards? What are the influencing factors?
• Do citizens at the local and regional level get a real chance to discuss regional, local, and agency health policy at Federal Qualified Health Centers?

The contributions of this study are intended to improve the process of cooperative health care decision-making at the community level by identifying potential common sources of conflict between policy makers, community residents, and service participants and positing
strategize for reducing or eliminating the underlying causes of conflict. The methods used in this study are intended to investigate potential causes of the failure to share information while describing the ability of participant groups to participate in a process of policy development and problem improvement.

AT THE END OF THIS SECTION, I WOULD INCLUDE A BRIEF SUMMARY AND STATE YOUR PURPOSE THEN LIST YOUR RESEARCH QUESTIONS WHICH YOU INCLUDE AT THE END ON PAGE 97
Chapter 3 Methodology

The Rationale

The design chosen for this study was ethnography. Ethnography is a framework for establishing a method of field study or research that allows the investigator to gather data from the participants in their environment. It is also a process that takes into account the effects that the researcher brings to the research and data collection process. This approach to research has had a long-standing aim for the researcher “to grasp the native's point of view, his relation to life, to realise his vision of his world” (Malinowski, 2002). The researcher utilizes an organized method of observation, interview, and document review to develop trust and gain insight into the participants’ point of view.

I made every effort to minimize disruption of the natural interactive processes of the individuals and organizations in the study, while allowing for the collection of data that informs the investigation. Using small group techniques, I conducted a series of validation groups. The techniques were modeled after the small group process identified in the work of Rowe and Frewer (2005); (Vaughn & Lohmueller, 1998) and techniques of “A Small Group” used by Peter Block (2007). I initiated the project with full disclosure of the study's intentions, while asking that the individual participants remain open to the research process as it unfolded around them. These two methods of group work allowed for a partnering with the participants and created a relationship that made the researcher accountable to the participants of the research.

The intent of the research was to provide data that could improve equity in the collaborative interactions among individuals of differing motivations, communal roles and
educational backgrounds. A benefit of the study is that the collected data may contribute to an improved understanding of roles among participants on FQHC boards and assist in improving their communication as they work toward the formation of policy.

**Background**

The study was conducted at select Federally Qualified Health Center (FQHC) boards in Hamilton County, Ohio. Hamilton County, Ohio is within the Cincinnati Metropolitan Statistical Area. The county, located in the southwest corner of Ohio, is bordered by Kentucky on the south and Indiana to the west. The Cincinnati Metropolitan Statistical Area consists of 15 counties within three states (Ohio, Kentucky and Indiana). Hamilton County is one of two counties within the region that has lost population between the 2000 and 2010 census. Within that ten year period, Hamilton County’s population of White residents fell by 10.4 percent, or 64,157 (2007, p. 147); yet, Hamilton County continued to have the highest population of the 15 counties within the statistical area, with a total citizenry of 2,130,151 in 2010 (2010 CMSA Race Report - Hamilton County, 2012, p. 83).

Neighborhoods are a strong feature of Hamilton County. There are 48 neighborhoods in the city of Cincinnati alone (2010 CMSA Population Report: Hamilton County, 2011, p. 91). Throughout the county, neighborhoods serve as socioeconomic structures with which residents are likely to self-identify.

The seven area FQHCs offered a mix of services that include prenatal, pediatric, primary, indigent, school-based, and dental care services. These organizations had developed collaborative relationships with external agencies to provide mental and behavioral health
services that would enhance their ability to meet service needs. The three FQHC organizations participating in this study provided services to several urban neighborhoods in the county, with one agency providing services for residents in a single municipality. However, all participating organizations served multiple neighborhoods. The three participating organizations provided services to neighborhoods within or adjacent to the city of Cincinnati, which has a population of 296,943 (Maloney & Auffrey, 2013).

Recruitment

Prior to retirement, I had been a manager at the local health department, with more than 30 years of experience in the public health community and had collaborated with all but one of the contacted organization. Following retirement, I served as a board member with mental health intervention, substance abuse prevention, social service support, and sexually transmitted disease prevention organizations in the area. Moreover, I had maintained cordial relationships within the existing clinical health network. In addition, As both as a former employee of the local board of health and due to my continued connection and relationships with many of the primary gatekeepers at the local health care FQHC organizations, I had anticipated that access to the boards of these organizations would be straightforward. However, I quickly discovered that, although I had experience working with many of the key players, gaining entry, as an investigator would not be easy; when I approached individual gatekeepers at these organizations for recruitment to this research study, the initial responses reflected discomfort, caution, and suspicion. I was confronted with failure to have calls returned, exposure to frequent changes in upper management staffing, multiple rescheduled
appointments, statement of beings “too busy, try again in a few months”, and, on one occasion, a straight-out rejection. Once it was made clear that the research involved direct observation of the board, one organization, to which no less than weekly phone calls and organization visits were made, failed to return phone calls or respond to messages for several months; eventually, a call was received from the CEO offering to make written document available but refusing to allow direct observation. I initially found this response confusing and frustrating. However, I came to understand that I had underestimated the levels of economic stresses, competition for scarce resources, organizational competitiveness, and the resulting tension (to be discussed in chapter 5), that existed in the local and regional health network.

As indicated in the Results chapter, since 1986, as a result of a federal audit, HRSA (Health Resources and Services Administration), had mandated that the five non-governmental health care organizations in Hamilton county separate from the local health department (which operated five clinics of its own) and join a new entity, the Cincinnati Health Network (CHN), that the local health department was forced to both organize and join. CHN was established to receive federal grant funding under Section 330 of the Public Health Service (PHS) Act, monitor funding, and provide the support of a regional director. However, in the mid-1990s, the members of the coalition separated and the FQHCs had become independent entities. In this new environment, the leaders of the FQHC organizations had struggled to maintain their organizations and move from being part of an umbrella coalition, functioning under the local health department, to being independent entities focused on improving their organizational status within the communities they served as health care providers. As a result of these
conditions, demonstrating my trustworthiness and establishing a working relationship with the organizations that I was seeking to recruit, proved to be a crucial initial phase of the research. Persistence, prior personal relationships, and factors related to timing were significant to the recruitment process.

I also faced procedural barriers to access. Two of the three participating organizations did not have research review protocols. In addition, despite the fact that several of the participating FQHCs identified members of their board of trustees on their public web sites and announced their meeting dates and meeting times, the nonprofit, private organizations were not required to hold public meetings (Health Center Program Requirements, 2012; Implementation of the Section 330 Governance Requirements: Policy Information Notice 1998-12, 1998). In reality, only the local public health department operated with an open board meeting policy. Although the nonprofit, private organizations were mandated to bring consumers to the discussion, nothing in the regulations required them to hold public meetings. The non-governmental FQHC organizations are private entities, which maintain control over board meeting attendance and have authority over non-regulatory inspections of the agency. The experience of this particular research study is that the region's private FQHC organizations maintained control of meeting attendance, particularly as it related to issues affecting public relations, media exposure and potential scrutiny (Newkirk, 1996).

At the time of this research, the governmental organization, which termed its FQHC board as the "City of Cincinnati Primary Care Governing Board" (CCPC board), did not formally publish its board roster online, but did hold board meetings that were open to the public.
I designed the research plan with the intent to create an atmosphere that would produce frank and honest input from participants. It was hoped that from this input there would develop an authentic description of the organizational communication within participating FQHC boards. I did not want to emphasize a negative picture of individual organizations. Nor did I propose to rate the effectiveness of one organization against another. I found that with patient, one-on-one conversations and group presentations, I was able to introduce, clarify and develop participant support. All the regional organizations were facing issues of fiscal challenges, federal scrutiny and local competitiveness, which made them mistrustful of external review. The challenge that I faced during recruitment became that of demonstrating that the research was capable of providing a constructive framework on which to plan improvements.

Field Sites

Hamilton County has a land area of 407.36 square miles with a population of 802,374 people, according to the U.S. Census Bureau. Approximately 26 percent of Hamilton county residents are Black (2012). Within Hamilton County, there are eight independent FQHC administrative boards and one FQHC "look-alike" administrative board. I successfully recruited three of these sites as participants in the research study. The population of focus for this study was volunteer board members actively participating on FQHC boards, associated staff members, and board-identified community participants. All three of the field sites provided primary health care services under the requirements of a Federally Qualified Health Center (FQHC). The policy boards provide upper-level administrative support to one or more primary health care centers.
These boards have met, or are working toward meeting, the full requirements of the federal regulations. Collectively, they oversee nineteen different primary health care facilities (see Appendix A).

The participating organizations included two private community health organizations, Neighborhood Health Care, Inc. (NHC) and The Health Care Connection, Inc. (HCC), and one governmental health care organization, the Cincinnati Health Department (CHD). The CHD is a FQHC "look-alike" and for purposes of this study is being referred to as an FQHC because the CHD has duplicated all the requirements of an FQHC. Unlike the other FQHCs in the study, CHD receives funding indirectly under Section 330 of the Public Health Service Act [42 USC 254b] through another FQHC while maintaining an independent FQHC board. All of the organizations involved in the study are recognized by the Health Resources and Services Administration (HRSA) as service providers and are certified by the Centers for Medicare and Medicaid Services (CMS) as meeting the definition of "Health Center" under Section 330 of the Public Health Service Act [42 USC 254b] (Comparison of the Rural Health Clinic and Federally Qualified Health Center Programs, 2006).

**Participant Organizations**

The organizations recruited were functioning boards of community health centers that directly or indirectly received funding made available under Section 330 of the federal government's Public Health Service Act. Board membership structure was a point of focus for choosing to recruit these organizations.
Cincinnati Health Department. As a disclaimer, I must disclose that I was formerly an employee of this organization prior to my retirement in 1997. The Cincinnati Health Department (CHD) is a governmental organization, founded during the 1800's as one of the first public health departments in the country. It began with the purpose of responding to sanitation issues in the city and needed care for the poor. Initially, having health responsibilities necessitated involvement with other jurisdictions and agencies, within and outside the borders of the city. The city’s municipal code, the Ohio Revised Code, the Board of Health Regulations, and general public Health Standards sanctioned it. In an effort to fulfill the given challenges of their mission statement, the CHD continues to express a commitment to providing health services in the most efficient manner possible while striving for a goal of excellence and holding themselves accountable for the work done, while also being mindful that they are keepers of the public trust for tax monies provided.

Historically, CHD sought to meet public need by increasing the quantity and scope of the services it provided. Initially, this expansion made CHD the regional umbrella organization for a whole range of health care services. At its peak, it offered services to as many as 15 Ohio counties and employed more than 500 individuals who provided services ranging from mosquito control, milk inspection, health education, medical care (home health care nursing, neighborhood clinics, HIV/STD clinic, and dental clinics), along with environmental and occupational safety inspections.

CHD was a large organization (approximately 600 employees) which, at the time of the research, did not have the full status of a FQHC, but had qualified as a FQHC look-a-like and
thereby had met all the requirement of governance for at least one of its health care clinics as would be required of a full-fledged FQHC. It had all the freedom and limitations of a FQHC. As a public entity, guest attendance at CHD board meetings could not be restricted in the same manner that it could be with private organizations. CHD also had the added pressures of city politics and an atmosphere of economic decline. CHD was far larger than the county health department in both size and services. However, with changes in administrative policy and pressure from the Cincinnati City Council, the emphasis has changed toward a city focus with regional collaboration.

The HealthCare Connection, Inc. The HealthCare Connection, Inc., (HCC) was a founder-managed organization that had maintained significant consistency with an executive officer who was also the founder of the organization. The organization has constantly shown growth and innovation. The original organization began as a single clinic, the Lincoln Heights Health Center, Inc. Over time, the organization expanded, adding additional clinical sites in the county; the original Lincoln Health Center was maintained as a site while the organization reincorporated under the umbrella name of the HealthCare Connection, Inc.

The Lincoln Heights Health Center thrived in the declining village of Lincoln Heights. This community was established as one of the first 12 “All Negro Towns” established between the 1940’s and 1960’s (Rose, 1965). “All Negro Towns” were defined as communities that were physically or politically separated from their nearest neighbor, were at least 95 percent non-White, and were communities of 1000 or more citizens. Most of these communities had less than 1 percent White residents. At its peak during the 1960s, with a population in excess of
5000 residents (Welcome to the Village of Lincoln Heights. Retrieved August 10, 2014, from http://www.vlho.org/about-us.html), this particular community reached the status of a small city but had a population loss that later reduced it to a village (Rose, 1965).

During the time of the research, HCC was undergoing significant organizational stress due to the sudden departure of an administrative level staff person, which forced the executive director to take on additional duties. Yet, the executive director, as a person who had led the organization for more than thirty years, was a stable and trusted symbol for the organization and the community. The founders of the FQHC organization that serves this community established it in 1967. A group led by the current executive director incorporated the organization in 1970 ("Corporation Details: The Health Care Connection, Inc.," 2013). The health center had grown to become a focal point of the community, while the community underwent increasing stress due to decreasing population and lack of an adequate tax base. According to the 2000 Census, the community had a median income of $19,834. Ten years later little had changed; according to the 2010 census, the median income was $23,047 and the poverty rate was 35.4 percent. (American FactFinder - Community Facts-Lincoln Height Income, 2010).

*Neighborhood Health Care, Inc.* Organization B, Neighborhood Health Care (NHC), Inc. was established in 1972. This organization began as a single clinic meant to serve a low income and predominantly minority neighborhood within the urban core. NHC had originally functioned as an independent clinic under contract to the local health department. As part of a 1986 audit, HRSA (Health Resources and Services Administration), determined that the “independent” clinics in Hamilton County lacked the level of independence mandated by the
federal government. As a result, HRSA mandated the creation of a new entity that the local health department was mandated to organize and join, resulting in the creation of the Cincinnati Health Network. All of the local independent health clinics and the local health department had representation on the board of this organization and worked as collaborative members in order to receive Section 330 grant funds from the Federal government. During the mid-1990s, the Cincinnati Health Network ended. In the wake of the resulting loss of support from the Cincinnati Health Network coalition and the resulting increase in competition for resources, the board of NHC struggled to support and stabilize a new administration (Brunsman, 2014). In December 2013, the four clinics of Neighborhood Health Care closed, leaving 20,000 clients without services.

**Anxiety in the Network**

For a period of time prior to 1972, each of the privately operated primary health care organizations within the county operated under a collaborative umbrella that functioned to coordinate fund distribution and assist with communication between organizations. They also maintained an independent board of trustees made up of professionals, consumers and other nonprofessional citizens. The board functioned as a policy board, while having only limited fiscal control of Section 330 grant dollars (Broadnax, 1986). Over time, these health care organizations were involved in two such collaborative umbrellas. The Cincinnati Health Department served as the first of these umbrella organizations. The second umbrella was the Cincinnati Health Network. The members and contributors of funding of these collaborative groups found the relationships to be less than equitable for the participant organizations and
were forced to either disband or reorganize, petitioning for independence to establish a new cooperative relationship with funders.

The tensions created by the breakdown of these collaborative relationships and the reorganization of the health network created an atmosphere refocused toward competition and survival rather than collaboration. This atmosphere of tension became the environment in which consumers and professionals were asked to join staff to provide organizational governance. As indicated earlier in this chapter, the administrator of Health Care Connection, Inc. (HCC) was a founder-manager who had acquired for the organization a reputation of credibility and trustworthiness. Despite serving a community facing difficult fiscal times and a collapsing demographic structure, related to being reclassified from a city to a village, HCC maintained a positive community image, managing expansion in the face of difficulty and establishing corporate relationships within the served area. Throughout this period, the organization underwent administrative reorganization as it grew; however, the lead administrative position remained stable for over 30 years, establishing many political and social relationships for the organization. The board had also remained very stable with a host of members who had served for over 15 years.

Unlike the Healthcare Connection, Inc. (HCC), Neighborhood Health Care, Inc. (NHC) had undergone three abrupt changes in executive directors in five years. The organization had not established a stable and transparent relationship with funders, vendors, board members, and the communities it served, nor were the administrators able to reconcile differences with the other members of the local health network. At the time of the initial observations, the director
of the program left the organization. This resulted in a brief period of program inactivity, lasting about thirty days, and which ended after the agency hired an executive director from within the organization. The new executive director began establishing a new leadership group and relationships with staff and board. The director was, in the process of, identifying what the organization’s relationships were with the local health network, vendors and the community at large (Cohen, 2008).

The initial responses that individuals and organizations presented when approached with my intent to include them in the research appeared to reflect discomfort. Two of the three participating organizations did not have research review protocols but did express what was interpreted as a hesitancy to have board processes monitored or observed. Among the five organizations that were initially contacted in an effort to recruit participants, one organization, to which no less than weekly phone calls and organization visits were made, failed to return phone call or respond to messages for several months after it was made clear that the research involved direct observation; eventually, a call was received from the CEO offering to make written document available but would not allow direct observation. A second, non-participating organization, reported being in the process of applying for grant funds and therefore not wanting to begin discussion regarding the research.

Ancillary analysis I worked to construct a composite picture of each board’s interactions as reflected in my observations and interviews. Additionally, the effort to seek input from a sampling of the participants provided insight into the boards' operations. I was able to enhance the analysis of the collected data through additional collaboration with a sample of participants.
This group of volunteers, primarily consumers, were brought together to review, discuss and validate the data collected during observation and interviews. The importance of the volunteer participant involvement cannot be overstated, as it was a significant factor in determining what data items were emphasized in the research. The partnering relationship, with the participants in the study, is being restated here to emphasize the significance it had in determining the outcome of the research findings. From the information gathered, I generated a report that may aid in improving the FQHC policy discussion process.

**Gaining Entrée**

I have more than thirty years of professional experience working in different sectors of the local public health, mental health, and substance abuse care systems. This research project made use of my accumulated knowledge, and the guidance provided by the dissertation committee and local Institutional Review Boards, to gain appropriate access to the FQHC organizations and their board members. During the recruitment process, recommendations by past and current administrators of the primary health care organizations within Hamilton County helped me prepare for recruitment efforts and overcome unanticipated obstacles to recruitment.

**Process of entering as an observer**

I self-identified as a participant observer to each of the participating organizations. Prior to initiating the series of observations, I introduced or re-introduced myself to each board and each organization’s administrative staff. I requested time on the agenda of at least one regularly scheduled FQHC board meeting for each agency. This request was made through the executive
directors of boards, staffers, or chairpersons. The intent was to make the research process clear, using verbal presentations and written documents. The potential participants and I discussed research record type and security. I made presentations to explain the methodology of the research project and provide full disclosure, hoping to encourage participation and obtain the appropriate consents. The responses from the organizations were cautiously supportive. Conversations during the regular board meetings were open. As the process moved forward, it became clear that much of the work occurred at the subcommittee level. The early presentations to the organizations expressed my desire to have board members participate in the research, as I believed that they would embody the organizations social and political vision and views. The FQHC organizations began to view me as someone who would provide assistance to them as they responded to questions of compliance to section 330 regulatory requirements for boards of FQHCs, such as local recruitment. They also recognized that, as a resident in their service areas and as a doctoral student, I might be both a potential consumer and a connection to academia.

As a researcher, I received requests from the staff members of the participating FQHC’s for assistance in identifying individuals, particularly consumers, who could be brought to the attention of nominating committees to help the board reach or maintain a membership balance of 51 percent consumer participation. Federal compliance was an ongoing struggle within each of the participating boards, and drove their initial reactions to individuals entering their circle of influence. High on the list of pressures affecting the FQHC’s board recruitment practices was a
desire to identify and recruit citizens who held an interest in the health status of residents of the service areas.

The opportunity to complete the initial introductions and for members of the organization to review, discuss and consent to participate was a key aspect of establishing a relationship of openness and trust with the participating organizations.

The observations in the setting of the regular meetings revealed a number of openly discussed organizational goals. These goals included:

1. Having the organization identified as being a local expert in the field of community health care. This would be in full competition with the for-profit urgent care offices that are expanding in the area and in collaboration with the other FQHC organizations and public health services.

2. Improving and expanding the skill sets of the board members to include processes of board development.

3. Conducting an ongoing process of strategic planning.

4. Establishing three and five year planning for the organization.

5. Establishing a “patient centered medical home” which offers one-stop full service facilities of adequate space, offering physical health and behavioral health services for adults and children.

6. Expanding services for ADHD.
7. Improving organizational documentation and management of documents. This would include the completeness of policy, procedural and compliance manuals and accessibility to these documents by appropriate personal.

8. Expanding services hours, i.e. the change from a partial to full day service and the shifting of hours for the convenience of clients and improving capacity through consistent doctor and nurse practitioner hours with adequate support staff.

9. Involving both board members and staff in the recruitment of board members.

10. Expanding relationships with medical and dental training facilities at the local and state levels.

11. Identifying new sources of income through fund-raising programs.

12. Establishing, monitoring, and maintaining a high quality of services.

13. Determining appropriate cost savings while maintaining service quality and organizational mission.

14. Developing an advisory council to the board.

15. Identifying and establishing staff cost sharing programs with external medical, dental and behavioral health programs.

16. Determining means of evaluating the effectiveness and efficiency of serving the needs of the target clientele.

**Process of entering involving Interview**

The actual method of securing participants for the interview process was site-specific. Due to delays in obtaining organizational consent, this recruitment began several months after
the initial presentation of the research project, and therefore required a reintroduction of the research process. Each participating organization received additional copies of the study and descriptive information (see Appendix B) which identified the units of data collection. I presented information specific to the needs of interview participants and other, general aspects of the research, to the board prior to the actual implementation of the formal research study. There were questions and answer sessions. I used this process as an agenda item at each participating organization’s regularly scheduled board meeting.

**Identification of Participants**

The identification of participant organizations was one of convenience. Participant identification began with the identification of primary health care service programs in Hamilton County, Ohio that provided the opportunity for laypersons to participate with professionals in determining health care policy. Each of the organizations had a volunteer board that participated in health care policy development at the local level. All FQHC organizations were required:

- To have a policy board composed of 51 percent consumers.
- To have no more than 49 percent of the full membership gaining income from sources in the medical field.

I presented my intended research orally to participants at board meetings of the FQHCs. I also provided an informational fact sheet to each attendee. I gave board members the opportunity to opt out of the project's observation phase by requesting that information related to their activity not be included in the research project.
I grouped participants of the study into three overlapping groups: 1) participants of the regular FQHC board meeting who were the subjects of the ethnographic observation process; 2) participants in the key expert interviews; and 3) participants of the validation groups, conducted in the style of a small group process.

The Researcher

I am an African American male who has chosen to live in an urban community. I have over thirty years of direct involvement in public health as a manager and program administrator with community substance abuse prevention and health care organizations. As is the case with all researchers, I bring personal experiences, cultural concepts and goals. I served as the instrument for data collection and had to be fully aware of how personal experiences affected the collection, recording and assessment of the data. The research included, in its design, several layers of review and assessment that were intended to minimize personal biases. The act of having multiple layers of data review offered opportunities to include the community of participants in a critical and expanded assessment of the data.

Data Collection Procedures

I used several methods in the data collection process. Step one involved observation of the board meeting environments and processes. The second step was the performing of participant interviews. The third step of the process was data validation, including a review of relevant, publically available records pertaining to the organization and its board. Each step served as a guide for determining the construction of the method that would follow. Similarly,
after the initial data collection, analysis of the data collected at each phase provided insight that helped to inform the type of data needed in the next step.

Ethnographic observation

Ethnographic methodology has previously been used to assess consumer and citizen involvement in health care decision-making by investigators such as Fudge, Wolfe, and Mckevitt (2008), Abelson and Gauvin (2006), Houston and Cowley (2002), Horlick-Jones, Rowe, and Walls (2007), Gotler et al., (2000), Craig (2008), and Dyer (2004). These researchers made use of surveys, document analysis, key expert interviews, focus groups, and participant observations for data collection. The data collection process in this study included ethnographic observation, document analysis, and key expert interviews to collect descriptive data of participants' involvement, individually identified roles, conduct, and the administrative or procedural controls used in conducting the business of the group. Data collection utilized a data validation process similar to the process discussed by Vaughn and Lohmueller (1998).

I conducted ethnographic observations as a participant observer during the board meetings of participating FQHCs. The direct observation of participants involved in meetings of FQHC boards is an appropriate and efficient means of collecting data. It is efficient because it provided a means of allowing both the collection of data from within the operation being described; because the observer is also simultaneously observed by the participants, this method has the added benefit of creating opportunities for establishing relationships and demonstrating trustworthiness. The observation of FQHC board meetings provided insight into the dynamics of a mandated process of communication, which focused on developing and
supporting policies and practices formulated by each distinct organization. As a participant observer, I took notes on the physical, structural, and behavioral composition of the meetings with an emphasis on the communication efforts of the participants. I documented and included my own personal responses to the observations made. I used an Ethnographic Observation Guidance Matrix (Appendix C) as a management tool for identification and collection of appropriate data (Robson, 2002; Spradley, 1980). The observational categories Spradley (1980) identified in “Participant Observation” were used as categories to assist in managing and understanding the data collected from the observational and interview processes and for presentation in the activities of the group validation process.

**Key expert interviews**

Key experts are synonymous with key informants. Key experts were individuals identified by their peers as having exceptional knowledge about the operations and communication practices of a local FQHC board.

The identification of persons invited to participate in the key expert interview process utilized a snowball sampling process. Using this process of sampling, I asked members of each FQHC board, and their associated staff members, to identify a person that they believed had above-average knowledge of the board's policy development processes and methods of communication; the selected list of individuals became potential participants in the interview component of the study. In turn, I asked the identified individuals to be interviewed and then invited each of the first level interviewees to recommend an additional person whom they felt was knowledgeable about the board's communication and policy development processes and
might be willing to participate in the interviews as key experts. This iterative recruitment process resulted in the 15 individuals who were interviewed.

Potential key expert interviewees received a "personal invitation card" and pre-addressed envelope or e-mail, depending on their personal preferences. The candidates involved in the key expert identification process were offered the option of responding to the invitation by telephone call, postal mail, e-mail, or in person. Acceptance of the invitation led to individual meetings with potential participants. Each meeting was held at a time and location that was mutually convenient. Individual meetings provided an opportunity for potential participants to receive information that outlined the research process and explained the research objectives with an emphasis that participant involvement offered a minimal amount of risk. Potential participants were also encouraged to ask questions before completing the consent process. A journal was kept of all responses and the manner in which information was exchanged.

The key experts were interviewed in a conversational manner that took into consideration the depth of knowledge, level of demonstrated or declared comfort with the types of questions, and the time constraints of each participant; these factors proved to vary considerably among participants.

The interview process made use of three categories of questioning (Spradley, 1979):

- Descriptive
- Structural
- Contrast
During the initial interview session, I made an effort to develop or strengthen my relationship with the participant. My plan was to have the key expert interviewing occur across several meetings, with each session building on the previous one. These sessions focused on descriptive questioning that exposed the expert's knowledge and provided an opportunity for open expression. Examples of descriptive questions include:

- What is your experience as a board member?
- How do you prepare for a board meeting?
- What is it like preparing for a board meeting?
- What would be the character traits that would be desirable in a board member?
- What is it like participating at the monthly board meeting?
- Could you tell me what a board meeting is like?
- Could you tell me about the different functions of the participants of an FQHC board meeting?

The purpose of this interviewing was to get the participant talking, develop rapport, and to focus on the issues that the participant indicated were of interest and importance. During the early stages of interviewing, additional questions were selected to build my understanding of descriptive terms presented by participants and to help me identify terms and phrases that would assist my understanding of participants' roles in communicating information within the FQHC boards, the perceived issues effecting communication within the FQHC boards, and the themes and modes of communicating used by the board members.
Document review and data validation

A number of local records and federal documents were collected pertaining to the organizations. The document review process consisted of a search of publicly available documents (meeting minutes, internal notices, newspaper clippings, public notices, governmental filings, guidance documents, web site images, and other documents) obtained from local, regional and national media and other internal and external sources. I selected documents that were publicly available and would help to explain board communication practices and reveal the sources of information that board members share. This document review process sought to identify both parallels and contradictions that exist between written and verbally communicated information.

In preparation for the process of validating the collected data, I completed a sentence-by-sentence review of the observation field notes and the interview recordings and transcripts. Through the review process, I identified a list of concepts and then divided these concepts into nine nodes or categories, which will be presented in detail later in this chapter.

A full assessment of the data obtained through the ethnographic data collection processes and the participant responses of the validation process were fully reviewed with an emphasis on identifying points of agreement and contradiction. This information was assessed with guidance through the literature and a recognized bias toward the participants, but clearly letting the data drive the outcomes and recommendations.
Validation

Validation of Ethnographic findings: Group Level Assessment (GLA) Conducting a validation group process that allowed participants to discuss, endorse, or reject the observational and interview data created a review process that was reflective of the knowledge, goals and values of the investigated community. The research design allowed for the use of participant feedback in the analysis of consumers’ needs and supported the formulation of research recommendations. In an effort to establish an analytical process that took full advantage of participant's perceptions, the "Group Level Assessment" (GLA) (Vaughn & Lohmueller, 1998) model was used to shape the validation group process. This process supported the equitable balance of power between the participants and me, as researcher. Vaughn and Lohmueller (1998) point out that GLA improves the process of including the voices of the participants by openly recognizing the level of knowledge that the participants can bring to the research through their views, concerns, and values. Such attributes bring a positive benefit to the process of decision-making, outcome determination, and forming concluding statements. GLA takes advantage of developments found in large and small group intervention processes such as Open Space Technology (Bunker & Alban, 1997) and A Small Group (Block, 2007). It was my hope that the GLA process would foster in the participants a sense of ownership in the research process by bringing their voices to the forefront in the analysis of the collected data, and making them active participants in guiding the final interpretation and understanding of population-specific issues and in the recommendation-making process. The design produced a structured procedure, yet provided the ability to generate a content and
agenda that the participants influenced. The participants could express their perceptions of what might be wrongly categorized and misinterpreted. If the individual participants found themselves in a working subgroup within the evaluative process with which they felt uncomfortable, the "Rule of Two Feet" (Crawford, 2007, p. 12) was also strongly emphasized; this rule indicates that a participant who finds that a session is not helpful or is unproductive should take the option of leaving that group with impunity and either joining another group or sitting out that particular discussion. More importantly, the use of this principle assures that those who choose to continue to participate in a group have the opportunity to affect the research process undeterred.

Along with the advantages that this model had in creating a partnership for the process of analysis, there was the recognition that validation group meetings did not mirror the FQHC board meetings in purpose, structure or atmosphere. Data collected from the validation groups was useful in providing additional data on the group's perspectives and in bringing community validation to the data collection and analysis process.

GLA was developed by Reddy as a ten-step process and later refined by Vaughn and Lohmueller (1998) into a seven-step process. I utilized the seven steps developed by Vaughn and Lohmueller with the intent of bringing the participants into partnership with me in the data analysis, outcome recommendation, and planning initiation. The seven steps are as follows:

- Climate Setting: an overview of the session, warm-up:
  - Providing an opportunity for self-introductions;
Providing general presentations that explain the elements and purpose of the research;

Explaining the purpose of the validation group process and the anticipated outcome;

Generating: wall charts were developed that focused on topics identified in the observation field notes, document reviews, and interview data. This process mirrored techniques use by Vaughn and Lohmueller (1998) in seeking insight into the positive/negative, specific/broad, and open-ended/structured responses of participants;

- Appreciating: milling around and looking at data written on the wall charts;
- Reflecting: spending time alone thinking about what the data means;
- Understanding: subgroups discussing specific data items and reporting out;
- Selecting: group discussing and prioritizing data;
- Action: group considering plans of action and recommending next steps based on priorities. (Vaughn, Jacquez, Zhao, & Lang, 2010, pp. 9, 10)

Conclusion

This chapter has delineated the methods used for this descriptive study. I have also provided a rationale for the research. The organizations and individuals who volunteered to participate in the research were volunteers drawn from a regional group of Federally Qualified Health Centers in Hamilton County, Ohio (appendix A). The individual participants were engaged in an overlapping process of observation, interview, and data evaluation. These interactions
involved the researcher leading, but not necessarily solely conducting, the recruitment, orientation, data collection, and validation procedures of the research. A graphic depiction of the process is found in Appendix D. The involvement of individuals as participants in the research study created a path that paralleled the process of data analysis (see Appendix E), which allowed for some participant involvement.

The research makes uses of ethnographic techniques of observation and interview for data collection. There was a use of small group assessment techniques as a means to validate the data and strengthen the partnerships with the participating communities in the research process. The validation process provided a testing ground for forging the data into a practical, understandable and meaningful source for making local recommendations and providing direction for additional studies.

**Exit Strategies**

I distributed copies of my dissertation to each of the participating agencies and board chairpersons. I made a copy of the research findings available to board members on request. In addition, I made a written executive summary available to all participants. I made a formal announcement of a presentation of these findings to interested parties.

**Limitations of the Study**

This study's limits include size of sample and geographic range. The study drew its participant sample from board members, staff, and residents of the service areas of three Federal Qualified Health Center Boards located within Hamilton County, Ohio. These factors make the study limited in scope.
Chapter 4 Observational Data

The primary headquarters of two of the three participant organizations were in facilities that were built for the multiple purposes of providing administrative office space along with clinical service space. The third program housed its administrative offices in a building that had served as an urban three story single family home. This building had been converted to accommodate administrative office space on the third floor with reception and clinical space on the lower floors.

The first organization that showed interest in participating in the research housed its offices in the converted home. The building was located in a neighborhood dominated by a large university and surrounded by student housing and small urban bars catering to neighborhood and student clientele. Within walking distance of the office location were moderate and high priced condominiums and subsidized low income housing. The site was also on the bus line. While I had previous contact with some of the consumers, administrators and clinic staff of this program, at the time of research participant recruitment I had been retired for two years and had not been to this site in several years, nor did I know the current administrative team; I had, however, maintained contact with several members of the board.

After making multiple contacts with this organization, and four other Federally Qualified Health Care organizations, I was able to gain an appointment with the President/Chief Executive Officer (CEO). Arriving at the initial appointment, I parked at the front of the well-kept large Victorian style building in a row of similar buildings that alternated between being converted office buildings, single-family homes, and remodeled multiple apartment buildings. This
particular building had a parking lot behind it, but this was difficult to recognize because of the narrowness and downward slope of the driveway between buildings leading to the parking lot; the parking lot had two levels and a rear exit and entrance.

My first meeting was held outside of regular clinic hours and the front entry was locked with a sign directing visitors to a rear entry. Walking around the building and down into the upper level of the parking lot brought me to the rear entry of the building. Through a series of meeting with the CEO, I felt that I was able to establish rapport as we shared personal stories. During our discussions, the CEO shared feelings of frustrations and the challenges of moving from a corporate, non-health care executive background to the non-profit public health care field. It was indicated that the experience of being a board member was not adequate preparation for the new political and work environment. We were able to agree to agency participation, but it took several weeks to gain a letter of support and written agreement of participation. It was only after pleading my cause to his administrative assistant, getting the assistant to draft a support letter from a template that I had provided, and with the direct assistance of the assistant in obtaining the CEO signature, that I was able to obtain the signed agreement of participation. At this point, I was still seeking additional participants. Two weeks after obtaining the support and commitment, I attempted to contact the CEO to inform him of my progress only to learn, through the telephone system, which was only capable of providing an outgoing message, that the CEO had left the organization and that the program was temporarily closed.
A month later, the organization hired a new CEO from within and was back in business; however, it was several weeks before I was able to meet with the new CEO. I met with her with the previously signed participation agreement document in hand. Nonetheless, during the meeting, I discovered that to gain organization participation I would need to reestablish rapport and obtain new documents and signatures. The new CEO, unlike the predecessor, had been a service unit manager within the organization and had prior non-profit, public health management experience. Over a period of several weeks, I met with the new CEO to re-establish rapport. During this period, the administrative assistant left the organization and a new person was hired; this is significant because the former administrative assistant served as the CEO’s scheduler, gatekeeper, and keeper of board documents. Through continued and persistent efforts, I was able to obtain the necessary agreement and documents to establish the agency’s participation in the research. During this early period, I learned that the board meetings were not held at the primary administrative offices, but at a clinic that the organization operated. Conveniently, this clinic just happened to be located a city block away from my home.

The board meeting location was in an urban area that was predominately African American. Within several of the city blocks that surround the clinic, male and female prostitutes walk the streets overnight and during the early morning hours. During the daytime, oil covered street mechanics can be seen working on or under parked cars brought by people looking for inexpensive car repair and maintenance. At night, and sometimes during the day, the sounds of gunshots were a usual occurrence. The more observant would also recognize drug dealing and
the flow of non-residents circling the blocks seeking drugs or prostitutes. They would also recognize that some of the prostitutes and drug dealers come from outside of the immediate neighborhood.

Within three blocks of the clinic, the buildings are a mix of residential, business, manufacturing and warehousing. While most of the residential housing consists of small, medium and large multi-family dwellings, a portion of the housing is single family. Some of these single family homes are Victorian style homes that had been converted to multi-family dwellings and at some point were converted back to single family homes. A number of the single-family homes were owner occupied, which was becoming increasingly common. Children were an obvious feature of the neighborhood, particular in the areas around the multi-family dwellings. The frequently observed groups on the street included African American teenagers and young adults under the age of 30, often in groups of 5 to 20 standing on the corner or in the area around the entrance into one of the multi-family dwelling or walking in the street.

The board meetings for this FQHC organization were held in the conference room of a single story clinic services building that had off-street parking, which usually had a security guard located in a vehicle during business and meeting hours. This conference room was immediately off the entry way and reception area, allowing easy access from the parking lot. The initial meeting that I attended followed a format that was typical of the boards meetings that I attended at all of the participating organizations: prior to the start of the meeting, the early attendees engage in conversations focused on local community issues which occasionally include previous board conversations and questions; prior to, or at the beginning of the
meetings, agendas and supplemental material (i.e. agenda, attachments, reports, minutes, etc.) are distributed around the table; as an opener for the meeting, the FQHC Board Person reads passages from inspirational material or recognizes significant events, such as birthdays or anniversaries; next, the agenda is presented and accepted by majority vote of the board. At this initial meeting, after opening the meeting, the chairperson acknowledged my presence and indicated that I would have a chance to speak as part of new business on the agenda.

An important factor to understanding the behavior and the agenda items at this initial meeting was, an awareness that the CEO had been promoted to this position from within the management staff within the previous three months and was the fourth executive officer in the past ten years. Major concerns discussed at this meeting were 1) the organization’s compliance with federal regulation regarding board structure; 2) descriptors of persons who could be defined as a consumer as it related to board members and the current need to increase the number; and 3) the transition from the old administrative philosophy of CEO, staff and FQHC board interaction to a new philosophy that was termed to be more interactive and express a determination to improve relationships with organizational fund monitors, peers, the neighborhood, and vendors.

My general impressions gathered through the observations of board meetings at this organization were:

1. The board chairperson, who came to the organization as a physician indigenous to the African American community, with a corporate health administrative background and minimal public health experience, and the CEO made use of
humor and sarcasm as a means of responding to, and relieving, tensions expressed by the board and the organization’s staff. This tension resulted from concerns over compliance pressures, staffing difficulties, and maintaining an appropriate level of patient encounters.

2. A large part of the business of the board occurred in discussions away from the primary meeting. These discussions occurred in one-to-one and group discussions among administrative staff and board members. Some of the meetings were held officially in subcommittee groups, with the intent of reporting back, while others were not.

3. Much of the anxiety and feeling of frustration exhibited at the meeting appeared to be channeled or expressed through humor and sarcasm directed at the behaviors and actions of the previous administrators and the recently uncovered results of their actions and behaviors.

4. The compliance issue of appropriate board membership distribution was identified as a concern.

5. Excitement was expressed during the meeting by the CEO regarding the possibility of bringing in-house obstetrics and gynecology (OB-GYN) services that were then being done by referral to another facility. This was expressed as an important routine need of most clinic patients.

6. These primary health care organizations also sought out citizens who they perceived to have the ability to learn about policy and provide feedback about its
effectiveness, as well as about organizational efficiency and quality of services offered. The initial observation and conversations with the staff and board members contained many styles of communication that included but were not limited to humor, sarcasm, anger, persuasion and apathy.

The second organization to be recruited to the research study, The Health Care Connection (HCC), was also a NGO FQHC located in the county but this program provided service outside the primary metropolitan area. An observable difference of this organization is that the areas which the organization served had a rural or suburban appearance with a southern style and less industrial appearance. The neighborhoods that this FQHC supported, as well as the administration and staff, express an awareness of the unique history of the founding community in which the initial clinic was started as the “first African American self-governing community north of the Mason-Dixon Line”. The original Lincoln Height Health Center was founded in 1967 as the first Neighborhood health Center in Ohio. The organization is very aware of a changing dynamic in the community as it responds to a growing population of Latino and French speaking African immigrants moving in and around the community. The CEO, as well as a majority of most of the board and several staff members, had been lifelong members of the neighborhood surrounding the primary clinic facility, which was located in the neighborhood of the initial clinic. This was unique among the three participating organizations. Also, during the time of the
research study, this was the only FQHC board that had racial diversity that extended beyond white and African American to include Africans and Latinos.

My first contact with the organization was with the CEO. The CEO was a founding member of the organization and had served as the agent in submission of the original incorporation application to the state in 1970. I had known the CEO professionally and socially prior to this contact; our conversation lead to her directing me to her Chief Operating Officer (COO) who dealt with the daily operations of the clinic and served as liaison staff to the board of trustees. My initial contact with the COO, over a period of three weeks, focused on educating him about the research project and attempting to gain a letter of support from this organization. During this process, I was able to develop a positive relationship with the COO and had gained the letter of support. However, prior to being able to arrange the initial board contact and introduction, I learn that the COO had left the organization and taken a position in another state. I was made aware that it was not unusual for an upper level administrator in the region to leave an organization, whether by choice, mutual agreement, or organizational demand, with little or no prior notification. The circumstances required that I re-establish a relationship with the CEO and educate her regarding the research process. As with the first participant organization, the circumstance of changing administrative staff had made it necessary to initiate a new process to educate and establish the level of trust needed to gain entry to the board of trustees. It was necessary for me to delay this process for two months in order to allow the CEO to reorganize her activities because she took on the COO’s
responsibilities. Once I was able to establish the appropriate level of trust with the CEO, I was allowed a place on the board meeting agenda in order to introduce the research project.

The regular board meetings were held in the building that also served as the primary clinic facility. The building was built in 2003 and is seen as one of the most imposing health Centers in Ohio and was identified in the board meetings as being a showplace for the state with regard to neighborhood health care facilities.

The concepts gained during the observation of four board meetings at HCC were that:

1. Like the other NGOs involved in this research, HCC undertook to fulfill the legal requirements mandated for FQHCs (these requirements are identified in Chapter 3 - Methodology under the section, “Identification of participants”) while also taking full advantage of rights afforded to them as private entities. While the NGOs were required to have consumer participation on the governing board, there was not a requirement of total transparency: as a result, the NGOs maintained tight control over who, outside of the organization and fiscal monitoring agency, was given access, irrespective of whether such outsiders were members of the media or the general public. However, this level of control is not more, or less, than what might be expected of any private business receiving federal or state grant dollars.

2. The successful involvement of residents of the served communities, many of whom had been board or staff members in excess of 15 years, had produced a well-established relationship with the local residents of each HCC clinic site. This relationship was being enhanced by the stability of the local community.
The proactive efforts to integrate the newly established immigrant community (Latinos and Africans) onto the board and into meaningful staffing position was beginning to encourage a similar level of information exchange as the relationship that had been established with the majority residents.

My initial observations during research of FQHCs included the observation that the participating organizations held several concerns and processes in common. Board meetings were conducted under a loosely structured form of Robert’s Rules of Order. Robert’s Rules of Order provided a structural restraint against disruptive behavior and a method for information management. When tension arose, staff and senior board members responded to these tensions. When possible those who could assert control would respond with actions meant to minimize and control the tensions. These acts focused on establishing agendas that included emphasis on:

- Areas of significant organizational concerns brought forward by staff and board members through reporting (executive, committee, and departmental reports).
- Areas of commonality and unity (i.e. announcing birthdays and anniversaries, reading of inspiring passages from poetry or other literary works, and engaging in a meal or period of casual conversation).
- Areas of personal and organizational competency that could be highlighted and supported (awards, milestones, accomplishments, etc.).
These organizations also maintained an atmosphere that allowed for quick-change decision-making through a consensus model, often accompanied by cajoling, humor, and casual sidebar conversations. All of the organizations sought to fulfill federal requirements. They all recognized that there were risks that citizens must consider when judging their responsibilities on becoming a board member to a nonprofit organization. James G. Wiehl (2004) points out that it is a legal requirement that non-profit boards and board members operate under legal principles which focus on due diligence. These entities are required to be “attentive to the organization’s purpose, activities and finances” and do so with reason and in “good faith” (Wiehl, 2004, pp. 417-418). They must also assure that the organization, its board and its administrative leaders conduct business in a manner that is consist with its mission and prevents persons in leadership positions from using those positions for personal advantage unless doing so is consistent with the best interest of the organization and its mission (Wiehl, 2004, p. 419). The observed organizations have involved their board members in the typical roles identified by Brown and Guo (2010) (which can be reviewed in Table 1). The degree to which the individual organizations emphasized a particular role for its board varied according to the circumstance and the temperament of the administrator and fiscal agent at any given time. Whether assessing the personalization of individual board roles or the consistency in the implementation of board principals, the manner in which board members communicate are critical to managing the effectiveness and efficiency of the board. The actual process of engaging participants in the interviews was a site-specific process. The process began with the same procedure used to introduce myself as a participant observer of the board at certain sub-
committee meetings. Each participating organization received descriptive information (see appendix B) which explained the specific process of data collection. I made oral presentations that focused on the interview process. Each presentation was customized to meet the needs of the particular organization, selected to provide information and stimulate questions regarding confidentiality and risk for interview participants. I provided a brief description of how the project could provide additional benefit for the organization. Individuals who agreed to be interviewed or were identified by me as having specific knowledge or expertise were approached for a one-on-one presentation. The group and individual interactions provided an opportunity to discuss and answer question about different aspects of the research prior to the actual implementation of the different phases of the research study. This one-on-one interaction and my presence on board meeting agendas allowed for periodic presentations on different phases of the research and provided opportunities for question and answer sessions. Such efforts helped in establishing personal relationships with participants while at the same time maintaining and stimulating interest in the research project. The ongoing involvement contributed to participant support at each step of the research.
Chapter 5 Interview Data

This chapter presents the interview data with minimal interpretation. Twelve people were interviewed, producing one hundred and forty-four pages of transcript. The interviews include six consumers, two medical professionals, three administrator of the participating programs (one who, after being interviewed, requested not to have their material included), and two non-medical professionals. Reflecting on the interviews, as presented in this document, I recognized that the full measure of the tone, degree of emphasis and context of these discussions is missing, but I would like to make it clear that the interviewees appeared open and honest, with awareness that the information being presented had the likeliness of being publicly disclosed. The information presented here consist of fragments drawn from several hundred pages of interview transcripts produced from recordings with board members and staff. This information is being provided to help the reader to gain some insight into the interview process and the type of responses that were received.

Among the consumers who were without community advocacy or activist experience it was not unusual to hear that they were recruited through a contact with the Executive director. The response of consumers to recruitment was often a “why me” statement; consumers also indicated that recruitment of them included information that there was a need to balance consumer and non-consumer members on the board. In contrast, the professionals on the board were likely to indicate that they had been recruited by another professional who had experienced being on the board. The majority of professional interviewed were recruited by
other professionals (current or former board members) while the majority of consumers interviewed were recruited by staff.

The following excerpts provide insight into the manner by which many of the consumers and non-professionals were introduced to the idea of becoming board members:

001: I was approached by Dr. X, [Executive Director] she just basically was telling me about how there was a need for the board to have members, I guess 51% members who actually use the health center. I really wasn’t gung-ho about it, because it interferes with an important meeting that I have on Tuesday night. But, since it’s only one night a week, I thought, well that’s one night I’ll be late for my other meeting, but still try to make that meeting I figured if I could be helpful, then it would be a benefit.

BY: So, you were involved in several discussions? Just as an initial invitation and look-see?

001: It was several invitations by her; I procrastinated getting my resume in. I hadn’t done a resume in 20-some years.

Female consumer board member

She goes on to discuss the effort she made prior to joining the board:

001: Because I taught, I was trying to figure out how to set my resume to fit their needs, and finally she just said, “Send your resume.” “They want to know what you’ve been doing,” Because it’s not a paid position, so it’s not like you’re going to be working for them. They just want to see what you’ve been doing. So once I did that, I
was interviewed by Mr. A, and Ms. HH. Mrs. H was asked to come on board. So, the first thing I did was ask to be allowed to go to a meeting. For lack of a better term, on _____ and hope I mean, I just wanted to see. I wanted to see how it worked. I wanted to see what they were talking about. After the meeting, I prayed on the matter, and I thought, well okay, I’ll try. So I agreed to be on it.

004: Right. As a matter of fact, Mr. D, who’s now deceased, put my name up. He had asked me if I would be interested in serving, and once I found out what was being done and so on like that, I said that yes I would, so I’ve been I think I’m just about three years now, and have really participated. I don’t think I’ve missed too many meetings, other than when I was in the hospital. But other than that, I think it’s a great board to serve on. The things that it does for the city and the quality of life of the people in the city is just tremendous, I believe.

- African American Non-health business man with civic involvement in several fields

The following is a medical professional’s experience of becoming board chair and relating back to entry to the FQHC Board:

BY: One of the things I’m looking at is communication between the consumers. You’re in a unique position. You’re a person who comes out of an administrative and medical background, who, during the period that I’ve met you, you were also chair of the board, which puts you in sort of a unique
position, being knowledgeable about a number of different things that are going on. How did you prepare for that?

010: Well, it’s obvious that I didn’t because the reality is I was new in so many ways. I mean, who if you look at it, less than a year after being part of the-- after joining the board I became chair? I came to the board in a crisis and had never been part of this thing before. I had been an administrator for a little bit longer than I had been on the board. I was a practicing physician prior to this. Not in administration. So, everything was new. So, it was one of those learn in the job. Learn in the hot seat thing. That world is totally different than the medical world that I came from. So, it was, it was I thought it was a very difficult position, and made worse by the fact that, this is all in retrospect as I look at this, no one that I was dealing with, at the board level, had any lengthy experience, and I would say good experience, good meaning, not in the sense of good and evil, but good in the sense of well-founded and educationally-based experience in this arena of federally qualified healthcare clinics. So, my initial impression was, well these people really know what they’re doing I need to follow them. To the point, that they [The other board members] don’t know any more than I do, and we’re in a heap of trouble. That a thing.

BY: Now, you’ve used made a little separation in terms, “when you were coming in” and “I” and “you” who are you speaking when you say “these
people” that you came across, is “these” being other board members, or “these” being administration.

010: “These” being other board members. I did not have any contact when I came in, and let me just backtrack so you’ll get the picture of when I came into [the organization] I came into at the meeting before they fired the CEO. So, I came in at a-- in the middle of controversy, with no experience inside of the, inside of the governing, areas of a community health center and was basically thrown into the frying pan and into the fire.

BY: Why did you put yourself into that role, knowing that you came in not knowing a whole lot?

010: Well, the only reason I came in was because I got a call from a longtime friend who happened to be the medical director of [the organization]. He was just hired, and he had never been a medical director in a community health center before. So he was the medical director, and he says, “We need help here. We need somebody who knows about medicine, and somebody who has some, maybe some medical insight to help with the board.” “Will you join the board?” And I said it happened to be P. I said, “P, I don’t have a lot of time. I’m new in my other position but, I will try and help. So that’s how I got in.

I was interviewed by a, by two ladies, one of which I had worked with at Deaconess Hospital, who was on the board, Ms. WW the other lady I had Ms. WW was transferring off of the board, and the other lady was a member who
stayed on the board for another year. I was interviewed by those two people, and then got the invitation. I never met the CEO. I had never seen the CEO, and at the time I was supposed to meet her was the time in which she-- all of the controversy happened and she was-- she was fired.

The following excerpt provides insight into the perception of a consumer regarding the activity of the subcommittees:

BY: Does the subcommittee do its work? Does the board itself act like a committee, is committee work done in the subcommittee, or does committee work go to board?

001: no. I think, is done in the committees with the review, that part has gotten better, because you have it before you get to the meeting, so if you have questions you can formulate the questions so that they can be answered. Which is nice. Which is what I have me coming in for loose and fancy free on a meeting, and then I’ve got to figure out who did what and did where. So that’s a benefit.

– Female consumer board member

Another consumer discusses changes in the community, including changes in demographics, and the clinic’s response:

BY: Now, is your company in the community, or is it outside?
It’s, north of Tri-County Mall. So, it’s right at the edge of West Chester [an upscale neighborhood in Hamilton county] and on the borderline of Springdale and West Chester, or whatever, so, we have patients there. I mean, we have employees there that are patients here, because I’m putting up enough flyers saying, they got bilingual in the dental area, they got this, and whenever we have a health fair this health center sends people to that, because we have 700 employees, so they send, staff people up there to give out literature, I did have a comment at our last meeting as I said, this is my house, and here is where I live: And they have a school-based health center. And there’s been several meetings where-- it’s not Parham and Hoffman anymore, its well, whatever they named the new school where Parham and Rockdale, I mean Mrs. H, they closed both of those and it’s now Evanston Academy. I think that is what it’s called, there and then that’s another one they always seem to mention them, and mention them, and mention them, and what they’re going to do there, and what they’re going to do there, and my question is okay, we haven’t heard anything from Rockdale it’s like no shame in my game. That’s my baby there I don’t know why do they have everything they need? Are you all satisfied?

Dr. [executive director] mentioned that they had been, with Rockdale, one of the longer running stints, and that things seemed to be working well. I’m trying to think who said, they had one of the best turnaround rates as far as getting paperwork and stuff back. But, it wasn’t great, but it was one of the best. I’m like, “Well” someone said, “It seems like you have an advocate for Rockdale. Somebody who could come over here,
face familiar to the parents, and say, “what, we need to get you signed up at the health center, and this is why.” My point with that is, there maybe that’s a place where I can help. Not just Rockdale but maybe something they do here at Rockdale, because they did say that we had a good return maybe there’s something here we’re doing with our parent organization that makes that possible: That we can share with I think’s it Avondale, or whatever the other two schools are that they’re talking about. If you have community people on your board, then you can reach out to your community people, so a little missing of that. The other parent that have now joined us she were recommended by their principal. She’s real strong in the PTO. Now see, she’s a parent who has a child and uses the health center. So that’s a totally different connection to them. So, you’ve got us, but we’re different.

BY: Yeah. one of the questions that I’ve been asking everybody is the, and you hit on it, and that’s how information either flows from the communities through the board members, to the board, that somehow relate to policy, or from the board to check that policy that they have, to get it back, or at least some explanation back to the community, so the community knows what’s going on. It’s does that happen? I mean that many boards, and it’s not that it’s frowned on it just isn’t done very much, where you’ve got much information or input from the board about issues of the services.

001: I have no idea. I have no idea. In fact, I didn’t know that the school-based health center was even attached. I didn’t know. That was six years I didn’t know. I thought the district has school-based health centers.
BY: So you didn’t know they were attached to these clinics, these

001: No.

BY: These FQHC clinics that were actually providing those services or at least
helping to staff those locations.

001: I didn’t know there was any connection whatsoever. When I found out, I was
like, “Well, what this would have been a wonderful place,” what? Even when I asked for
somebody out of the dental services to come to career day. Dr. Rey said she couldn’t
come. She said, “But I’ll send my technician.” Cliff came...Ms. Fears she was on I mean,
not even then does anybody make the connection that we are they or they are we. Oh
my goodness! If I had known that, we may have been able to set him actually set him up
in the health center and the classes could have come down to him and make that whole
connection! This is where health center is now, he wouldn’t be here, but this is what he
would do and you can make that ____ (whispers) I didn’t know that. I didn’t know that.
But I don’t know, because I did not know, sure didn’t. So I don’t know how that
information flows. And they have, Hispanic and English, so that they can get the
information out that we’re here and you can get your healthcare here. And, so that’s
another thing, like doing like community outreach type stuff to reach the people that
you’re serving. So it works out good, too. So I always give them a call, we’re having a
health fair, who are you going to see, and so the last probably two years they’ve sent
their staff person, here, Renee, is it Calhoun-Perry or Perry-Calhoun? I’m not sure about
which name went first, but she always comes and does a health fair, and when the one
West African guy can come, if it doesn’t interfere with his patient care, we can let him know enough ahead of time to free up his schedule. If he doesn’t stay all day, he may come and stay for three or four hours and let people know about the services here. So that’s worked out pretty good.

BY: That’s unique. So you say, you’re seeing this diversity where you work. Are you seeing now are you a resident of Lincoln Heights?

002: Yes, I do live in Lincoln Heights.

BY: Are you seeing changes in Lincoln Heights? So much, but

002: Over the years, there was a time it was just all black. Then, you’d get the interracial thing going on. So you’d get some mixed kids and could just be the one parent was here another parent in another community, but the children came. Then they had grandparents here, so they might be visiting them, but I have seen where I’ve actually seen kids in a school, in elementary school, we have white kids. I don’t know if there are any Hispanic kids. Well, for a while there were, maybe a few Hispanic kids came through the school system it’s been minimal, where it used to be nonexistent. So I don’t know what the race is, I mean the racial mix is right now. But the school system drives, you can see from there what’s in the community and, when I was out doing some, canvassing for the Democratic Party, I knocked on some doors up in some of our, subsidized housing areas and, there were couples there that were not black. I mean, the husband or the wife or the children. So I think as the economy is getting what it is, people are living
where they can. I mean, they need housing, so they’re moving, they’re willing to take
that risk, if this is a clean decent house, and this is where I can afford.

BY: you’re getting new people. You’re getting and I-- certainly it’s very visible that
you’re getting, like a large Hispanic-- I certainly see the African clientele coming here.

02: And they do things by word of mouth. I mean, that’s just their culture, is that,
they ’cause we have people that actually come from Middletown to where I work
because they hear that you can still get a job if you don’t speak English, and that they
have English as a second language Clearances to help you, in that if you can count to
patty some meat, you can get a job there and you have good punctuality, so then when
they hear there’s a place you can get healthcare if you don’t have insurance, or you’re
not maybe totally a legal resident, or whatever But you’re sick And if you can pay for
your service that you can come here and you can get the healthcare service you need, so
they’re lined up when I’m leaving to go to work in the morning. The place doesn’t even
open till 9. But at 8:30, they are at the door because

BY: Waiting.

002: They’re sick and they heard that they could be treated here.

BY: That’s probably a good reputation.

002: It’s a plus. It’s a plus. Yep that’s how they, find their services, by
somebody else saying well you can go here and you can get the help that you
need, and they spread that amongst their communities and show up.
BY: You think you’re losing like the local clientele in these neighborhoods?

Or, do you think they’re doing enough to recruit local clientele?

002: I think, and I’ve been saying it for a while now, that we need to do marketing. We need to market that we’re here. And remind people, you don’t have to go to the emergency room. We’re open these hours during the day. If you get sick at night, that’s another story, but we’re here if you’ve got, whatever service you’d get, coverage you’d get from the Department of Health and Services or whatever, if you’ve got insurance you can come here, if you don’t have insurance you can come here. If you have, what is it? Medical card, Care Source I don’t know what the terms are now, but that you can still be seen and have your healthcare needs taken care of right here, because a lot of them still are using the emergency room when they don’t need to be! That’s what I tell my kids they have kids now, they’re grown, but I’m like, wait a minute if you didn’t feel well on Thursday, then why do you want to go to the emergency room Friday night when you could’ve called and seen someone? No. I mean, you use the doctor’s office first, not the emergency room first. “Well, I was hurt, but I thought I’d get better” No. That’s not You need to use these facilities, the clinics that’s what they’re here for, to serve, the population that’s uninsured and underinsured, so they need to get that message out.

BY: Do you think they do that because they think that they’re going to charge, or they just don’t want to be bothered?
I don’t know where their minds are. But, they don’t want to take the kids out of school. I don’t know what it is. But I think that, there’s a lot of young single moms in the community and that in the areas where they have the, the big apartment complexes, and that they just need they’re just young and naïve and they don’t have any education on how you should go about getting, like you need wellness care for your children, not wait till they’re sick to take them to a doctor. that you need to be getting a physical every year, that you need to go get your teeth cleaned twice a year, that somebody needs to teach them these things because they don’t know because their parents didn’t do it for them, and they, like my daughter, because I took them to the doctor and made sure they went to the dentist, now she’s grown she doesn’t want to go. I’m like, what do you mean you haven’t been to the dentist in two years? Come on now you have to. I said you don’t wait till you have a pain in your mouth and then that’s when you want to go find a dentist. You need to have an established doctor, an established dentist, somebody that has your records and knows about your body so that they can treat you and keep you well, not wait till you get sick to look for help. And I think a lot of them in her age group, they don’t even think about going to doctors to stay well. They want to go to doctors when they’re hurting or they’re sick, and that’s the only reason they want to go, so they don’t have an established medical place to, as they term it in our meetings, a medical home that’s what they need there’s one that people here can walk to, so use it, If you have medical coverage
through the Health Department, or whatever this what we used to call Welfare I don’t know what that word is down there today Job and Family Services, or whatever. Then, they allow you to get a physical every year. That’s covered, if you need glasses, if you need to go to the dentist, if you have a foot problem go and get those things taken care of. Don’t wait till it’s an emergency and you’re in so much pain you can’t bear it, and then you’re running out to the hospital. And creating these big giant medical bills that don’t need to be created if someone was taking care of you all along, and then if you end up with diabetes or something, somebody’s been checking you, so you would know that you’re leading up to that point, so you could make lifestyle changes to avoid it. But they don’t the young people don’t think like that. I guess they think they’re young and they’re going to stay healthy, and until something happens, that’s when they’re running around trying to find a doctor. I even have them call, and they’re like, “Can you help me get an appointment?” I’m like, are you a patient there? “No, I haven’t been to the doctor in three years.” And I’m like, well, you need to, don’t call me because you’re hurting right now and say can I help you get an appointment, and then if you feel better next week you go back and you don’t even keep the appointment. “Well, I know Veronica said you’re on the health center board, so can you get me in?” like, it doesn’t work like that. You need to go down there and have a physical once a year and be an established patient so that when you do have something that ______, you can call and say, I’m a patient
and I need an appointment. You don’t need somebody to try to go behind the scenes and help you get in there in the next 24 hours because you haven’t seen anybody in three or four years. So that I think they-- if they could get somebody to do, I mean, every now and then you get a grant and you could do something for the year that that grant is going on, then when the funds are gone you don’t have the resources and the time and the staff to do it, but if they could do some education in this community about, medical homes and just wellness care, and I don’t know if the WIC program is still working or not. They used to deal with it with the moms and the babies and that helped them get a good start, and then hopefully they kept it going after they weren’t eligible for WIC anymore but that was-- it gave education along with the service. And I think that’s one of the needs out here that needs to be addressed.

The following conversation speaks to the balance of consumers and professional on the board:

**BY:** The only thing that I recognized is, consumer versus non-consumer definitely is not an issue of education or employment.

**005:** No. That’s never come up on this particular board. I would say in comparison with the other boards, I notice that I was actually the last real community person. I think that whole board is now full of doctors. Which is interesting. Before, we seemed to have a half and half consumer not consumer, but, community versus doctor,
breakdown so now you have all these doctors, where’s the community focus? And I think, with that written in to the FQHC guidelines that you have of 51% consumer participation versus the professional participation, or I use quotation marks “professional” I think, you keep it grounded in that respect because it’s supposed to be about the people.

BY: Do you think the, CCPC Board balances out the regular board in some way?

005: I think it can. I think it can in that respect.

BY: Do you think the commissioner makes use of it in that way?

005: I think he does.

BY: He seems pretty relaxed in that meeting.

005: I think there could be more done in that work. Because, one of the things I was thinking about was and I got this understanding in the beginning was that there would be somebody sitting on the regular board or the Board of Health from this group, sort of as a liaison or as a representative, and I don’t see where that, at least the president of our board should be that person, or the vice president, whoever, should be able to go to that regular board meeting and say, “This is what the CCPC Board is doing,” or if there is a concern, “This is what we have concern with.”

In the following conversation provides a board members view of staff motivation and the staff’s relationship with the community:
BY: The other thing that’s interesting to me, too, is that much of that administrative staff that is present at the board is fairly new.

006: Yes. They don’t have a long— a longevity of folks, and that’s probably because financially, really there’s not a lot of money that goes out to pay salaries. So you’re looking at people that are willing to work for little. Because of the cost. It’s not just, this is my job, and when a new job opens up that I can do and I can make better for my family, I’m going to move on. So, that’s the reason why you see a constant turnover in staff. You see a constant turnover in the providers. There’s always going to be a movement, but it’s even more so when you’re not able to pay them a really good salary to begin with. That’s my take on it.

BY: that’s interesting because each of these organizations, in that sense, in terms of people moving on, have different things going on. The Health Department, because it is a public organization, people tend to try to stay forever.

006: You’ve got your retirement out there somewhere.

BY: That you’ve got a commissioner who may leave or may stay, depending. But, relative to the other administrative staff, they hang in.

006: Sure.

Here a consumer speaks to the board’s influence on health policy:
BY: Do you think the board does affect the policies or the direction of healthcare in those communities that you serve, or do you think it’s primarily driven by the laws and regulations and the clinic manager?

002: It’s, I mean, well, you’ve got your federal guidelines that you have to deal with, but, I think, we do a pretty good job serving the needs of what the patients. We are being able to make changes as we need to. Like, when we hear that there was going to be a bunch of immigrants coming in from other countries and we try to make arrangements so that we can get them physicals, see what their needs were, and we did that, once we knew that the information was out there that the need was going to be happening, then the board discussed that and talked about it. I can’t remember, what year it happened and stuff, but there was, I don’t know, a bunch of refugees coming into the Cincinnati area so we made arrangements, that we would help those people, so we’re adapting to things as they change. When the Hispanic population exploded, because I know when it wasn’t what it is today, then we knew we had to have, clinic days where we had interpreters here, people that could, speak to them on the phone to get the appointment set up, and learn something about their culture, get some bilingual staff people in. So, we’re pretty good at trying to adapt to the change of the environment that we’re serving. And when it changes, then, we have to change too. So, well now we have, someone, I think a doctor, on staff that can speak to the West Africans, he knows French and knows some of the other dialects that they have, so that, when they come in as patients he can express [cultural concerns],
This is a similar response from a non-health professional that served as board chair:

**BY:** You think that the staff really listens to the board, and what feedback do they give you?

**004:** I think that they do. I know that I meet with the CEO before every meeting, and we go over the agenda, and I’ve made it clear that I don’t like surprises, and I think the CEO is very, very capable. And, I’ve had a lot of good experience, and as a result of that things seem to come together and go pretty well. Then I also have good relations with the health commissioner... We knew a lot of the same people and things of that nature right there, so we’ve got something above and beyond just the working relationship itself, and as a result of that what I see is that the Health Department, in my estimation, does a very, very, very good job for the city with the limited resources that they have, and it’s unfortunate that they just don’t get as much publicity as they should for the good work that they do. That’s not to say that we don’t have some problems, and one of the major things that I think right now is the level of staffing, especially of physicians, so that we would be able to see even more people, and so on like that.
Chapter 6 Results

The intent of this chapter is to describe the information obtained through the research process. The research provided the opportunity to explore the culture of the communities of Federally Qualified Health Center boards in a specific geographical region.

Data Presentation

The intent of this section is to provide additional detail on the methodology of the study, the data collected, and the resulting findings. The analysis of data collected during observation and interviews generated several hundred pages of information that was distilled into 378 distinctive items. The identified items were catalogued into nine primary nodes consisting of similar items that could be systematically presented. This reduced the massive amount of data into topical units that could be easily presented to several groups for discussion, validation and prioritizing. This organizing of data provided a systematic way of eliminating redundancy and allowed a process for mapping parallel and contrasting information.

I collected the data as a participant observer during regular and special board meetings of the participating organizations and during individual interviews with key informants. During the interview process, the participants openly discussed a wide range of issues that they viewed as central to their functioning. Interviews were held at locations selected by the participants and identified by the participants identified as convenient, comfortable, and neutral locations. The interview process was personalized for the comfort of each participant. I conducted interviews that ranged from 20 minutes to two hours in length.
This section of the study presents the concepts used in organizing the resulting information by looking at the sub-categories of activities that participants identified. One element of self-identification presented by participants was place of residence. In some instances, participants identified the clinic where they received services as patients. During these interviews, the participants were able to identify staff members and clinic services of which they had knowledge and from which they developed impressions of the organization. The consumer members of the board held a broader knowledge than members whose contact was limited to administrative staff and some middle managers. The categories of activity known by individual board members were reflective of the range of personal exposure to the organization that was a result of opportunity and initiative of the individual who participated in the interview process.

The interviewing process supported my perception that the consumers on the board did not generally mirror the average consumer of the services of the FQHC’s. The consumers on the board made self-identifying comments that distinguished their current social, economic or educational circumstance from that of their perception of the typical clinic patient. However, they also related belief in a direct connection by way of geographical connection (current or past). Some consumer member also reported earlier life experience that they associated with the typical patient. Several exceptions did exist: particularly among those interviewed individuals self-identified as community activists. Most consumer members of boards came to board service with identifiable skills. Most were acquired during work experience in middle management or higher, or in self-employment or small business management.
Several of the identified consumers had community organizing experience. While this was the first board participation for most, there were a few with previous board experience. Most lived in a community directly linked to the location of the clinical services of the organization that they served, but there were also several who lived outside of their organization's geographic service area and traveled some distance to receive services.

When asked why they became board members, most indicated that it was because they were asked. Only one stated that he asked to be a board member. Among the non-consumers interviewed, there was a range of experience and reasons for board participation. Non-consumers included individuals representing interested organizations such as law firms, health service providers (including hospital administrators, a social service administrator, mental health counselors, a retired Social Service administrator, physicians, and mental health practitioners), pastors, housewives, teachers, nurses and others.

During the interview process, participants openly discussed a wide range of issues that they viewed as central to their functioning. These interview sections of the study offered participants an opportunity to present activities they identified as being major and minor activities. This process helped me create a listing of different levels of categories of activities that participants used to describe their FQHC board involvement. The defining categories across and within the individual boards were as diverse as the interest of individual board members. Many participants identified their strength of association with the organization as a byproduct of their residency. They included proximity to the clinic affecting either themselves or their
family. For others this association was influenced through acquaintance of local individuals who were patients or potential patients of the clinic.

This section will provide an ethnographic presentation of the data with an effort not to philosophize or present conclusions. The collecting of this data required re-immersing myself into a population from which I had a three year separation.

**Introduction to node and tiers.**

As reported in the methodology section, a validation group was presented with the information that was obtained through observations and interviews. The information that they received was comprised of 378 issues divided between nine node categories that emerged from the data itself. Through the validating group process, participants reviewed and discussed the node categories and the actions and issue statements listed within each node. The prioritizing of data items led to a process of discussing, contrasting and reviewing how the collected data reflected the participants' ability to contribute to the board process. The validation process resulted in producing five categorical nodes that the validation group identified as having real effects on the communicative process of FQHC Boards. The five nodes contained 89 weighted issues. The weighting of a given issue was based on its having received at least one vote within the validation group. This vote was a recognition by that participant, and most likely by at least one other board participant, that they felt that a given issue held a significant role in the participatory practice of their respective FQHC Board.

It should be noted that each node represents a specific perspective, as assessed through the lens of the participant validation group. This lens helped to provide a local perspective,
which was provided by the attention that participants gave to it, either in the interviewing
process or as perceived through the observations. An effort was made to include all viewpoints
for review by the validation group to maintain, delete or clarify. As a result, there may be the
appearance of duplication across some categories.

Acts

The leading individual action affecting participant involvement, particularly consumer
involvement, is the simple action of asking questions. The willingness of the participant to ask
questions and the ensuing discussions had several influencing factors. The factors identified as
having influence on citizens’ and consumers’ ability to join the discussion and ask questions
contributes to policy development. These factors include the expressed levels of openness of
the participants, particularly the leading liaisons (primary staffer, CEO, COO, CFO, etc.), board
officers, committee chair, willingness to tolerate the potential anxieties, time commitments, and
side tracking created in the process of questioning. The questioning identified in the research
was often expressed as a self-educating process where that questioner provided the other
participants with an indication of both limits and the expansion of individual knowledge,
allowed for the building if exploratory platforms for additional lines of question and role
learning. The process of questioning also allowed individuals the opportunity to indicate their
personal areas of interest and mirror their level of understanding of others' concerns or relative
limit of the concern of others.

The identification of individual actions affecting the development of policy was the act
of attending. Comments related to attendance included “that is the way we learn,” “[regular
that’s the thing that is critical in having good dialogue and having good communication,” and “I would try to get 100 percent attendance at board meetings.” These types of comments were reflective of the perceived importance of attendance at primary meetings, subcommittee meetings and special events such as trainings, retreats, and fund-raising events. Such activities were regarded as important to the process of developing enough credible knowledge thereby gaining a respected position on the board. Several interviewees identified attendance as the mechanism that allows citizens, consumers, professionals, and staff to understand and form realistic beliefs about each other and the mission of the organization.

Reaching out and sharing knowledge of the services and experiences of the organization with friends and neighbors in the service area, was considered by the interviewees to be a significant act affecting a consumer or citizen’s participation in the policy conversation. The process of outreach was identified as both a means for data collection and a way to maintain a connection between board members and the communities the organization served. Several interviewees expressed a desire to support community health needs that they were not yet aware of by maintaining independent conversations with those in the organization’s neighborhood. They felt that they could bring information back to the board’s conversation. One participant acknowledged an awareness of a growing community of West African immigrants. This information proved to be important to service and strategic planning. She became aware of this group through a process of community outreach. This information affected conversations ranging from cultural competency and staff diversity to clinic hours and staff scheduling.
The act of fiscal review was another action of the board members that had a significant effect on the openness of conversation and the participation level of board members. The significant effects of fiscal review participation held particularly true for board members in their first year of participation. Not all participants respond positively however. One consumer felt that she was being uncomfortable and intimidated by fiscal review, stated:

“I want to be active. If I’m going to [be active], (you know I’m giving you my Tuesday) I don’t have a problem with being a board member who is helping to work his way out. One of my skills is working with people. Every time the CFO gets started, (you’re not giving me any money to spend!) I really don’t want to hear what you say, Okay. I’m being as honest as I can be. I’m sitting there, or even looking at the overhead, or looking at the sheets in front of me, and I’m going, ‘Okay, okay, okay! All right, um-hmm. Yeah, fine! You done? Yeah, I mean, it’s money. It’s, how much did you take in, how much didn’t you spend, how much did you save? Red and black. Okay, fine! Nice talking to you.’ I’ll second it. Okay, bye! See you in 30 days, and then we move on.’ I’ll tell you when I had fun, when the medical part of the center did their little 5th year anniversary thing. I came; they needed help in the kitchen. I went in, I cooked cake, I made punch...you know, helped set up.”

The level of frankness demonstrated in this emotional “one on one” interview was not a common practice in open board meetings. The statement demonstrates frustration over having to respond to unclear meeting reports. It also expressed the desire of this consumer to be an active participant in a way that produced a measurable contribution, particularly as it related to
board fiscal responsibility. Dyer (2004) pointed out that this type of experience could result in discouraging or minimizing lay participation in policy generating and governing groups.

This participant’s response was in contrast to a response from a participant in another group that maintained an active role on a finance committee. This individual was responding to the question, “Does this board get a good look at finances?”

Absolutely, actually that is an FQHC requirement. So periodically, we have, I think it’s either bi-monthly or quarterly; we actually have a fiscal report, a financial report that is prepared by our finance director, he actually comes and gives us an update as to day-to-day operational financial issues. You know the overall budget situation here in the city that we have. But we are required to report to our board any concerns that we have financially, what our financial, you know, outlook actually looks like and where we’re going financially. If we foresee trouble or problems in the near future, we are told to communicate that openly with our board so that then they can begin to make decisions about what direction we should be looking to go.

This quote demonstrates the significance that a consumer’s perception of being in a role of measurable contribution can have on confidence and willingness to contribute to the policy and governance discussions.

**Activities**

Tier 1 activities identified in the validation group process consisted of the following activities:
Several board members talked about the identification of issues as an important role as board members. In the discussion of issues identification, board members acknowledged connecting with potential sources of topics, identifying the issues within the topics and the prioritizing of issues. Within the meetings of FQHC and CCPC boards, the single most consistently observed activity was the process of staff presenting reports for the board review and sometimes questioning. These presentations included information such as fiscal reports, subcommittee reports, board education about disease trends and reports on other related community services. There were also outcome reports drawn from surveys, SWOT (Strength, Weakness, Opportunity, and Threat) analyses, audits and grant condition responses. These wide-ranging informational reports touched on nursing, HR, patient visit, clinical patterns, etc.

The defining the topics for issue identification and the subsequent prioritizing were identified as roles for board members. Board members spoke about by whom and through what channels issues were allowed to work their way to them as individuals. These statements described a flow of topics expressed by community, line staff, administrative staff, and other board members.

The board members pointed out that those competing topics were not limited to health issues, but included social and behavioral factors within the served community and among staff and management. This broad notion of topics is suggested in this statement:
“It’s more than health issues out in the community and not just from [administrative or board support] staff. There have been a couple of issues where there were staff that were disgruntled and trying to be heard through [a] couple board members, but we were all understand[ing] we’re advisory. We’re not management.”

On reviewing the sources of topics for issue identification surfaced during the interviews, I found statements that indicated that issues were competing for their attention. These issues were inside the system structures (staff, funders, and monitors) and the serviced community (residents, consumers). A challenge board participants had to determine was how much could they bring to the board discussion from their personal experiences, without violating the confidence of friend, family or neighbors. There was also a concern about the degree to which individual or family information was emphasized by the individual in board discussions.

**Taking ownership**

The consumers on the boards perceived the taking of ownership in the organization as a two way process of shared responsibility. The responsibility was not just taking on the care and continuation of the organization. A full share of ownership included getting to know and taking ownership in the health concerns of the community served. This was a belief that significantly affected the staff, professional and consumer collaboration. The degree to which the values drawn from these perspectives were shared set the tone for policy discussions. The belief that board members were taking ownership of the organization and that those who were entering from outside the community were taking on some community perspectives served to confirm the FQHC-community partnership. The political and social connection that is established
through the linking of community members taking ownership is strengthened by the perceptions of board members and staff giving some visible witness to this relationship. These perceptions become significant to both consumer and layperson involvement and voice. The belief in a positive, appropriately balanced ownership is expressed in statements such as, “I think it’s more important that people are made to feel that their decisions are more a part of the operation for the policy setting.” This and similar comments were repeated during both the observation. However, not everyone agreed on how ownership should be acted out. In actual practice, consumers responded by personal giving, be it, money, expertise, etc.; some consumers took an extreme view and attempted to take control, tried to assume a management role and micromanage; attempted to represented the organization without authority, etc. However, the majority of consumers, non-consumers and staff come to the organization with some perceived idea of teamwork and camaraderie forming collective concerns for the organization that did not always support the personal desires of the individuals and their families. These concerns entered the debate. The degree to which the boards took ownership of the knowledge brought forward through these debates served to influence the inclusiveness and direction of policy discussions.

*Maintaining trust and confidence.*

The belief in organizational trustworthiness and confidence was generally taken for granted among active board members who had not been exposed to experiences of mistrust among FQHC organizations during the mid-1970 through the 1990s. However, following a
negative organizational incident and a failure to inform the board members of the incident which created major turmoil in the organization, one board member explained:

> See, this is what it actually took me too long to see. I didn’t know what I didn’t know! My assumption was because this is the way it was in my medical work, you write an order, it’s done like you say. You ask somebody for vital signs, you trust them that they tell you what is correct. So, you know, that was the currency that I lived in, in terms of the people that I worked with. If there was something that I needed to know, you told me. You didn’t not tell me that my patient had a fever last night because you didn’t want me to know. You told me. That was the currency that I took to the board.

This type of response was common to all board members who had been active members at the time of the incident and generated the question of there were not questions coming from members who joined later. This belief in trustworthiness of the organization was shared among board members. Even for the members who had responded to the identified incident there was a feeling of resolve and a high degree of trust for the staff that were in place. However, whenever a failure to inform results in a temporary condition of lack of trust by board members for the organization, the results were changing trust expectations in staff and a questioning of how trust should be managed and why someone in the organization did not take the initiative to inform the board.

> It hit everybody in the face because we didn’t know where this hostility was coming from. When we found out that, there was this wall that sucked up all the information and never let it get through to us from every aspect. So, I mean,
now the question is did the leadership know, Because, I found out after he was
gone, that they [staff] weren’t allowed to talk to us. My opinion always was, well,
geez, if something was bad, people would be telling us. Somehow, somebody.

Exactly.

This was an immediate response of a majority of the board that when explored in the
interviews was a repeat of previous responses as reported by members who had undergone
other administrative disappointments but dissipated with the hiring of a new, administrator
who was perceived to be trustworthy.

The observations and expert interviews revealed a number of stated institutional goals
that were openly discussed during the interviews and verbalized in the settings of the regular
meetings. Some concepts were being discussed as institutional goals rather that organizational
goals because they seemed to have a universal appeal across the participating organizations.
The participants saw these concepts as being consistent with their understanding of the
regulated role of the FQHC.

**Organizational Goals**

The Organizational Goals consist of these tier one items:

- Developing and initiating a marketing plan
- Establishing board diversity and balance
- Improving community awareness

The institutional goal of marketing the services was identified as an activity that affected
board member recruitment and retention as well as consumer response. The activity of
marketing health services was a motivating factor, according to several interviewed board members. It energized their participation on the FQHC board. These individuals, who were consumers, stated that at the time they became involved as FQHC board members they knew that some of their neighbors were continuing to use hospital emergency room services as their primary health care provider. It was an important fact that these neighbors and many other community members lacked a relationship with an identifiable primary care physician. This knowledge sparked the desire on the part of these individuals to become directly involved in making other community residents aware of the services available through the FQHC clinics. When the interviewees were asked what the organization’s response to these concerns should be, the general response was to increase marketing. The suggestions for an approach to marketing ranged from seeking paid or voluntarily-initiated support from a marketing firm, to expanding staffing, to involving community workers going door to door. As an immediate and practical course of action, it was suggested that each board member be encouraged to distribute written materials and make contact with persons who might be eligible for program services. When asked how the organization should be responding one interviewee stated:

I’ve been saying it for a while now, that we need to do marketing. We need to market that we’re here and remind people, you know, you don’t have to go to the emergency room. We’re open these hours during the day. If you get sick at night, that’s another story, but we’re here, and, you know, if you’ve got whatever service you’d get, coverage, you’d get from the Department of Human Services, or whatever. If you’ve got insurance you can come here. If you don’t have insurance, you can come here. You know
if you have. What is it? ‘Medical card’, ‘Care Source’...I don’t know what the terms are now, but that you can still be seen and have your health care needs taken care of right here.

When the interviewee gave this statement he went on to explain how some friends, family members and neighbors responded to these comments:

Lot of them still are using the emergency room when they don’t need to be, you know? And that’s what I tell my kids. They have kids now, they’re grown, but I’m like, wait a minute, if you didn’t feel well on Thursday, then why do you want to go to the emergency room Friday night when you could’ve called and seen someone? No. I mean, you use the doctor’s office first, not the emergency room first. Well, I was hurt, but I thought I’d get better. The expressed need to construct a coherent marketing strategy to expand community knowledge of FQHC services was identified as a universal concern across the participating FQHC organizations.

**Board diversity and balance**

There were interviewees who identified the organizational goal of assuring that their board have economic, racial, ethnic, gender, and age balance. The individual citing this need felt that this balance would inform policy discussion. This goal was often expressed as a desire to help broaden the perception of who the organization served. One board member put it this
way: “I think in some ways the more balance that we can have, then people might stop looking at it as, oh, this is just for Black people, or this is just for poor people.”

**Improving community awareness and relevance of the FQHC as organization.**

The process of improving the relationships between clinic sites maintained by the individual organizations and their respective communities carries with it a broad range of concerns. Some community board participants found these concerns to be basic reasons for involvement in the local boards and influential factors in identifying topics for discussion and policy direction. However, effective improvement requires a response by board members and organizational staff. Each of the participating organizations has between four and eight site locations. The primary health care clinic sites that these organizations operate serve specific communities with diverse and ever-changing demographics. The communities that the clinic sites serve include consumers, contributors, other services providers, and suppliers, as well as non-consumers and elected officials. Over the course of time, necessary relationships within the communities floundered, gained strength, lost purpose or suffered strain. This community called for an ongoing effort for board members and staff to focus on the needs of a changing community.

It was very common to hear consumers focus on what they recognized as positive program attributes and make statements such as, This is one beautiful building” and God, it’s nice. You know. Uh, and we’re constantly inviting people here to, uh, to look at what we have here, so you understand, when you come to Lincoln Heights,
you’re just not coming to an all-Black neighborhood. You’re coming to a...a place where anyone is welcome to come... You know, even they don’t understand that.

These were statements of pride and community solidarity.

The participating FQHC’s existed in neighborhoods that were affected by moderate to high levels of substance abuse. Reflective of the awareness of the effects of crack, marijuana, ecstasy, illicit pharmaceuticals and other forms of drug misuse on the neighborhoods the goal of combating substance abuse was identified through the validation group process as high level rallying point for board member participation. Identified in the interviews, comments showed a concern for the negative contributions to community health status that substance abuse makes and how the issue stimulated ideas for the policy discussion.

Events.

Each of the participating FQHC boards held several primary events, a monthly board meeting (a National institute of Health requirement), sub-committee meetings and an annual board retreat. These events were accompanied by additional training events and community interactions. As might be expected, the participants in this study identified board events, retreats, trainings, primary and subordinate board meetings, as events having an impact on their comfort level as board members.

The interview data indicated that the timing and sequence of board events had an impact on the distribution, management and coordination of information within the FQHC boards. One consequence of event timing and sequencing described by participants was the manner by which they gained a historical perspective of the organization’s development. The
coordination of events also influenced how they established points of reference for the identification of specific community and organizational issues. This is particularly true as it relates to the time and place of previous conversations regarding conflict, or administrative change or the statement “We already tried that.” While the written record was identified as the long-term qualifier, the points of time and event reference were most often used to establish timelines and recall participant perspective on issues. It was particularly a reference point on who held significant administrative and board positions during times of crisis, member recruitment, single-issue board discussions, and periods of organizational stability and instability.

The identified Tier 1 events that were validated as having held significance are:

- General sub-committee meetings
- Regular board meetings

*Sub-committee meetings.* The General sub-committee meetings were identified, by participants as events where much of the real work of the FQHC board happens. It was indicated that in the sub-committee meetings, time was allowed for the full discussion of the details of the various concerns. It was in the sub-committees that the sensitive concerns of consumers, professionals, staff and the monitoring agencies were brought to the forefront for discussion and negotiation. One interviewee pointed out that it is in the sub-committee that:

> A lot of it [information] probably more of it [information] comes in when I was on Quality [Control Committee] that they [committee members] were talking about the quality of the service and the health care, the quality of the connections to the patients
and stuff, so maybe they deal[t] with that a little more than they have [to]. Now they have all these government indicators that they have to think about."

It was also pointed out that sub-committee meetings provided the greatest potential for conflict and the expression of control issues among board members and administration. The sub-committee is the primary forum for detailed discussion of reports, regulations, surveys, etc., as well as the place where feedback from patients and citizens not seated as members on the FQHC boards takes place. This is reflected in this comment:

So that we can get feedback, you know, on how the health center and the connections with the patients are going. And that gives us some ideas and makes us think about, you know, I mean that’s what we’re here for, is to serve the patient.

However, the management of sub-committee activity was not equal among the participating organizations in this study. It was observed and supported in the interviews that usually efforts to gain membership in sub-committees was through delegation by the FQHC chairperson. This was often done with limited knowledge of participant skill or response to participants’ (other than chairpersons) first or second level of interest. There was also inconsistency in establishing regular meeting schedules for most subcommittee meetings. The finance and executive committees were the exceptions to this. It should be pointed out that the validation process identified the executive committee meetings as being particularly significant among the sub-committee meetings.

*Standard board meetings.* As expected, the regular FQHC board meetings have been identified, through the validation process as being significant events for determining and
affecting the involvement of board members in the policy discussion and development process. Board meetings differ from subcommittee meetings because they are the only meetings where critical policies can be officially finalized. Information collected during the observation process indicated that the regular board meetings were structured in a way that emphasized predetermined leadership roles (executive officer, financial officer, staffer, etc.); formal meeting rules of order (chairperson, treasurer, committee chair, secretary, etc.) and local tradition (founder, matriarch, patriarch, elder, etc.), established within the organization. In most cases, the depth of information sharing, the level of negotiation, and the detail allowed in an agenda topic discussion is far more expansive in subcommittee meetings than in the primary board meetings. The FQHC board members interviewed stated that they could accomplish the bulk of the detailed work of policy discussion in the subcommittee meetings. They also presented this as a preference. However, detailed, “committee work” would occasionally be addressed in the board meetings. Yet, regular FQHC board meetings purposely maintained limited time to share information, and express personal opinions.

**Personal goals.**

This section discusses the personal goals of individual board members who participated in the interviews. The development of personal goals by the participants was prioritized through the validation process as having significantly affected policy formation by the board. The effects of these goals influenced the formation of alliances and adversarial relationships among board members and among board and staff.
Some interviewees identified personal goals that they drew from personal experiences as they discussed health care service needs:

Yeah. It’s like...my parents passed away 10 years ago, and so I needed something to fill that void, because they lived in my home and I cared for them. And so, I started doing things in the community. And then, now you know I need some me time, so I’m trying not to be spread too thin, and this year there’s an election, and my parents were patients of the health center, so this is like a giving back thing for me, you know? The doctors here cared for my parents, so I think I should help keep this place open so that they can care for other people, so, that’s why I’m involved, but, you know, like I said, you kind of get a little burnt out some time and I might need to step away and take a break. But I feel indebted to this health center, so that’s why.

Included in Tier1 are:

- Know my responsibility
- Personally marketing the organization
- Maintaining good communications and dialogue
- Maintain full compliance with federal guidance
- Keep the clinic services in a given community
- Support financial stability
- Support full disclosure to the board

*Know my responsibility.* A goal identified by all of the consumers and a number of non-consumer/professionals was that of knowing their individual responsibilities as board members.
Several of the consumers explained why they were asked to serve or recommended as a board member. Several reflected on the lack of knowledge of the roles they would play as board members. This was also true of a board member who was a corporate representative assigned by their organization.

*Personally marketing the organization.* The idea of personally marketing the services of individual health organizations and their clinic sites was a stated personal goal of several interviewed individuals. It was also validated as an important aspect of board member involvement and contribution to policy concerns of the organization. In the words of one consumer,

> We need to market that we’re here and remind people, ‘You don’t have to go to the emergency room. We’re open these hours during the day. If you get sick at night, that’s another story, but we’re here, and, we’ve got whatever service you’d get, coverage you’d get from the Department of Human Services or whatever, if you’ve got insurance you can come here, if you don’t have insurance you can come here. If you have Medical card (Care Source) I don’t know what the terms are now, but you can still be seen and have your health care needs taken care of right here. This personal goal is a natural complement to the parallel institutional goal of marketing in support of the organization. This goal also supports a belief expressed by many of the consumers that marketing strengthens and sustaining primary and preventative services in the locales hood and makes them available to the board member’s neighbors, friends and family. It also supports the desire
to create behavior change that will increase usage of preventative care and get people to thinking, “You use the doctor’s office first, not the emergency room first.”

Consumers and board professionals see marketing as a way to express willingness of organization to be open to dialogue with the community. This sentiment was shared in this way:

I think it’s important to get the viewpoint of any and everybody if they can come, and I wouldn’t...I wouldn’t allow somebody to come and disrupt a meeting, but on the other hand, if they want to come and provide feedback and provide their view on something, then I think that’s important, and I think that we should listen to them.

*Maintain good communication and dialogue.* I used the processes of observation and interview to identify factors of communication as impacting on full participation across the organizations. Within all organizations communication that allowed participants to work together cooperatively while still permitting opposing views were seen as important. It was pointed out during the interviews that there are times when a member may be insensitive to personal communications and “doesn’t recognize discomfort in other people, or he disregards it.” It was also observed that the individual who communicates insensitively is viewed as an outsider unless an identified leader in the group intervenes to offer a positive interpretation. Examples of such communication style include statements by two community members of the board. One community member constantly referred to the client base as “those people” and on several occasions made statements that the agency was serving a clientele that no other agency wanted. These statements were intended as positive remarks about the staff dedication and the critical need to serve the target population. However, because of the context, phrasing, and
intonation of the comments, the staff and a majority of board member were highly offended. In another circumstance, a consumer consistently presented his lengthy recollections of experiences that were unrelated to the immediate conversation. These comments resulted in “sidebar” conversations questioning the usefulness of the conversation. In this case, the chairperson regularly served as gatekeeper and interpreter of the information, drawing our attention to the possibly relevant point of the statement and easing tensions. The communication in one of these examples resulted in an ongoing disruption while the other resulted in a member being accepted as a respected consumer who needed some allowances to express a point.

Another communication activity that held significance to participants related to the broad sharing of critical information (positive and negative) in a timely manner among board participants. Timely communication includes vertical and horizontal sharing of information between the administration and board, officers and members as well as across committees and among peers. When questioned about board activities, one board member who was also board chairperson stated,

I think that a board is in place to set the direction to, you know, review the policy and to ensure that things go in the direction that you want it to go in, and then to review the work that is being done. But, I don’t see it being the board’s job to interfere with the CEO. More so, to make sure that we continue to have good communication and good dialog so that no surprises come back to the board, no embarrassment comes back to the board, that the things get done that the board is responsible for. But, the people who carry
out that responsibility are really the staff, the ones who are getting paid for it. We as board members are volunteers. There are some political things that the staff cannot get involved in because of the law and because of regulations and so on like that.

When asked if the administrative staff had good communication with the board members one community board member who served as chairperson stated:

I think that they do. And I know that I meet with the CEO before every meeting, and we go over the agenda, and I've made it clear that I don’t like surprises, and I think the CEO is very, very capable and, you know, I’ve had a lot of good experience, and as a result of that things seem to come together and go pretty well.

At the time of this study, this was the general sentiment at each of the participating boards despite the fact that one of the organizations was recovering from learning about negative communication experiences with the past two consecutive administrators.

A common but inconsistently practiced goal of providing personal financial support to the organization was identified through the interview process. Most persons who were interviewed identified an obligation to share their personal financial resources with the organization as a goal. However, several outliers totally balked at the idea of sharing their personal funds. This appeared to be a counter response to their giving volunteer time and seemed to accompany a lack of board training. The majority of board members showed openness to personally contributing to the support of the organization. This quote generally expresses that goal:
So you know, even if you’re a patient and you don’t have income, and you’re on one of those medical cards or Care Source from Child and Family Services, can you give $5 dollars a month, you know? Can you commit to that or $1 dollar, $2 dollars, something so that we can actually go out, when we ask for dollars [and] we can say we have 100 percent board support, that they are supporting us financially...the pools of dollars are getting smaller because of the economy, and the need is getting greater, so the dollars aren’t as free-flowing as they used to be, so you have to have that when you go knocking on doors looking for somebody else to support your organization.

This was a common, though not unanimous, point in discussions with board members and staff.

However, when exposed to the question, most of the interviewees saw donation and participation in fund-raising as a way of promoting the organization and gaining ownership or “buying skin in the game” of the organization. Among the interviewees, there were individuals who saw personal donation as a negative part of participation. These individuals responded with emotions ranging from mild anxiety about possibly being asked to donate or to solicit funds to a strong desire not to donate personal funds. The statements that focused on fund raising and personal donation as a part of the conversation invited a wide range of interpretation that seemed to vary with how the issue developed within the culture of the organization.

For the governmental organization, there was the least amount of urgency expressed about fundraising. The focus was more on asserting that the agency was politically well situated
within the city structure and grant compliance for future funding. During the period that the
governmental organization was in the process of seeking full Federal Qualified Health Center
(FQHC) status, one board member expressed it this way:

I don’t see outside of what dollars are coming in from the city. Well, I take
that back. Maybe you could say that there are the dollars that are coming in from
the other grants that they have gotten as a result of the defending of certain parts
of that budget. But, nevertheless I think, to get a whole board [the] whole federal
designation [FQHC status], which I think is a better. I think it's a much longer-lasting
funding source than some of your other grants could possibly be.

The same individual provided these comments about fund-raising: “Yeah, we haven't
gotten into that, any fund-raising or anything like that mainly because we're in the city. I would
imagine some of the other ones probably would because they're more of a stand-alone more so
than we are”.

From the opposite perspective, a board member from one independent organization
stated:

I mean, probably 10 or 15 years ago, all of our board members didn't do it
[donate money], but we learned when we were trying to get dollars for this
building and doing capital campaigns, that if you don't have a board that's
supporting you financially, then you find doors shut in your face when you go to
ask for funds from somebody else, when the people that are, you know, your board
members aren't willing to give up dollars. You can't say that you've got 100percent
giving here. Then, when you go here and you ask, ‘Will you donate dollars?’ and they'll say, well, what does your board do? Does your board support, you know the people...the board support the clinic you know, that they're serving as board members for... so, you know, I said you need to make this...well, I didn’t say, but it was said ‘We knew that, you know, we can't go out and ask for dollars from someone else when we're not offering dollars at home from ourselves.

*Provide full disclosure to the board.* The sharing of information with the board in a timely manner is both a concern and a goal of several board members. The context of this question centers on a concern of whether information of a difficult or embarrassing nature is appropriately shared with the board and whether relevant questions have been asked. There is an expressed desire for complete disclosure between the organization and its board. When the board and staff addressed this two issues emerged. First, how much do disclosure requirements border on micromanagement or supervisory interference? Secondly, what kind of disclosure is necessary for the board to be able to do due diligence as policy makers for an organization that receives federal, state and publicly donated dollars, making them stewards of organization and public trust?

For several of the organizations, this issue had surfaced previously due to questionable management, financial risk taking, unanswered grant requirements, and general organizational dysfunction, all brought to the board's attention only at the point of organizational disaster.
Focus on providing an efficient service. Several respondents reflected on the closure of clinics in the area and expressed the goal of increasing the efficiency of the organization. One individual, during his reflection, stated,

We recently had a healthcare center totally go under, my friend. So, the circumstances are not always that simple. You know, just because the need is there doesn’t necessarily mean that you’re going to be able to meet that need. So there’s a lot of pieces that have to go into place in order for it to work.

This consumer recognized that just because there is a need for service, residents would not always respond in a positive way. Interviewees also felt that board members should become informed well enough to respond to the community’s questions on service quality.
Chapter 7 Discussion and Conclusions

The data collected in this study do not support the current belief in a global opportunity for equitable sharing in the process of policy development among the diverse groups of consumers, professionals and supporting staff of the participating Federal Qualified Health Centers studied. The data provided a picture of a health network with agencies members, professionals, consumers, and non-consumers who conduct board work with varied levels of cooperation, anxiety, and efficiency. While they work very hard to respond to the pragmatic concern of their families, neighborhoods and the agencies that they serve, they fail to give way to the full weight of the opportunity to compromise and reach a balanced state of collaboration. The data supported the potential for a state of collaboration and compromise at all levels but only with the initiation of appropriate balances of education, trust, transparency, conflict, openness and enquiry. However, this balance would be difficult and would require deliberate efforts on the part of participants.

Community reorganization and power redistribution

Recently, I had the opportunity to attend a meeting of public health professionals and community activists. The participants of this meeting came together to discuss how they could work collaboratively to combat disparity in issues of economics, health, gender disparity, housing, mass incarcerations, violence and a host of other concerns that influence health and human well-being. This was a regional meeting of community activists and public health officials from several Midwestern states. The National Association of County and City Health Officials and the PICO National Network sponsored the meeting. During that meeting, one of the
facilitators, Dr. Renee Canady, Health Officer for the Ingham County Health Department in Michigan, stated that Federally Qualified Health Centers serve “as a community organizing movement.” This statement offers a perspective on the significance of establishing a democratized process in health care service determination, delivery, and management. The changing and rousing national narrative regarding health, resources and health care coverage is being reflected in the ongoing discussion of the Patient Protection and Affordable Care Act of 2010 (ACA) (The Patient Protection and Affordable Care Act of 2010, 2010). The new narrative brought with it a greater personalization in the approach to defining health and determining the direction for funding, utilizing, and distributing health care resources. ACA introduced new health service entities which include “health home” (The Patient Protection and Affordable Care Act of 2010, p. 219) and the “Shared Decision Making Resource Centers” (The Patient Protection and Affordable Care Act of 2010, p. 529). The new entities hope to improve the conversation between patient and health care provider and to personalize health care services by moving toward “a one-stop shop” model of mental and physical health delivery organizations, providing full access. They also support patient centered treatment and patient centered outcome determination (Sullivan, 2003). The movement toward a patient centered approach requires an in depth understanding of patient measures of quality of health and life. A focus on morbidity and mortality and the presence or absence of disease does not provide full enough information. The new narrative requires a disclosure of cultural, social and emotional measures. This determination would certainly require exposure of professionals and administrators of FQHCs to the voices of the patients, families, and communities that they serve. This would mean that
they would need to recognize and make use of the power that the shared information would hold, and to release a share of their power of control to the consumer.

Within the served neighborhoods of the FQHC’s study, a substantial number of the residents suffered from economic disparity. The programs involved in the research study operated within or in close proximity of the City of Cincinnati, where, in the years from 2009 through 2012, 29.4% of the population lived below the federal poverty level ("Cincinnati (city) QuickFacts from the US Census Bureau," 2013). The organizations involved tended to serve neighborhoods consisting primarily of racial minorities (native African, African American, and Hispanic/Latin American) or communities with a dwindling number of White residents. This would suggest that the inclusion of minorities and the economically disenfranchised of the community should be a part of the policy discussion. However, there has continued to be a question of the way that the infusion of their ideas would influence the power distribution and control of the policy discussion and thereby set the public narrative (Identify points of reference from Taylor, Habermas, Mann, etc.).

Changing the public narrative alters the balance of power within the community by bringing additional points of view into the conversation. Change in the public narrative affects the lens through which values, goals and objectives influence community health focus and standards. The experience of this research is that identified disenfranchised communities have individuals that are willing to engage formally in conversations of policy. However, there is a lack of information regarding who these individuals are and to what degree they are accepted and permitted to engage with FQHC board and staff in the discussion of health care. At the Regional
At the Regional Building Networks for Health Equity: The Breakthrough Initiative, David Mann, Minnesota Director of Grassroots Policy Project, in a presentation explaining the powerful nature of being involve in that health care policy discuss stated that, The level of engagement by diverse segments of the community control the health care conversation and the level of open information sharing in a given community. The shared information of those who participate serves which as a point of social and political conflict for the existing power structure thereby developing as a potential point of reform (Mann, 2013).

**Local Environmental Conditions**

This research began with the expectation that it would take several months to a year to complete the data collection. However, from the point of introducing the research to the health network, through the observation, interviews and validation groups it took approximately five years to complete. Difficult life situations I experienced did produce some delay; however, the conditions of systemic and organizational tension and stress within the studied organizations impacted the establishment of functional participatory relationships with potential participant organizations. These factors include changes in administrative staffing. These changes resulted in loss of contact continuity, thus requiring reestablishment of the relationships needed to conduct the research. This occurred in all of the participant organizations. One organization lost its executive director. In another, the chief operating officer left the agency to take other employment. In yet another case, agency staff reorganization forced a delay in the establishment of a relationship. As pointed out in the results section, the local health network of private non-profit and governmental organizations had to contend with a host of internal and
external pressures that required a pragmatic response to issues of agency survival. This at times appeared to supersede the organization’s ability to respond to other issues. Yet, these organizations needed to continue to hold fast to their established mission statements, values and goals. Each of the three participating agencies operates out of significantly different cultural and management histories that have influenced how they operate. Therefore, the history of each organization has an important role in the cultural atmosphere that participants (board members and staff) function in as active support agents, advocates and board members.

Each agency acted with great deal of autonomy as a result of it individual experiences related to trust, competition, and survival. Yet, because of their geographical proximity to each other, they operated as a network of health service providers that included additional primary health care organizations, public and private hospitals, and a host of organizations that provided specialty services (i.e., supports for mental health, homeless, substance abuse, addiction, etc.) Yet, for the board members much of the focus of their attention was limited to local community health care concerns of which they had firsthand knowledge. I would suggest that for the consumer and average citizen all health concerns are local. The interviews held with staff and board members gave them the opportunity to express their feelings about a lack of cross-organizational contact. While a few board members acknowledged knowing members of other boards on a personal basis, this was not the rule. It also appeared that there was very little communication between boards. The participating organizational staff seldom identified formal conversations with their counterparts outside their own organization. When broader conversations were conducted, it was generally between upper administrative level staff and
often involved an underlying tension or ongoing competition. When reviewing the collective
histories of the organizations in the health care network, including those that have not survived,
the underlying tensions were cause for each organization to keep an eye on the other,
producing an environment of caution that was understandable.

Yet, there existed a belief within each board, that a collaborative relationship should be
cultivated. Out of an examination of the past history and current relations between members of
the regional health network and if with the underlying belief that collaboration is desirable, it is
recommended that interaction between FQHC boards be expanded across the network. A
collaborative network that includes board interaction would improve the perceptions that have
developed between organizations and facilitate regional policy development and thereby
strengthening the premise that the establishment of FQHCs is a process of community
organizing, this type of strengthening would support a process of improving trust by stimulating
more one on one and collective conversations among members of FQHC boards. The type of
interaction would stimulate debate regarding the redistribution of social, political, and
economic power regarding health care at the local level, as it relates to policy informing and
developing health care policy. The focus would be to encourage inclusive involvement, reflective
of neighborhood trends and perceptive visions of future developments in demographics. This
discuss is becoming more important as the private health service sector is gearing up to the
demand of supplying a newly insured population under the ACA (Affordable Care Act). FQHCs
need not to compete with each other and the private sector and should think about how they
could reach past the poorest segments of insured individuals to the new group of health care patients who could be supported by a new source of health care dollars.

Who is in the discussion?

A primary objective of this research was to identify and describe those given access to the opportunity to share in the discussion. Who are the people at the table? Chung, Grogan and Mosley (2012) did a case study of underserved urban communities in Chicago and suggested that while the intent of the organizers was to broaden representation, the individuals that were invited to represent the community in the health care discussion were reflective of a stereotypical concept of who could be trusted and who were the appropriate individuals that should be at the table. This research would support this observation. Reflecting on the three organizations, the major of consumer and lay citizen participants held prior administrative, professional or managerial background. These categories are staff, health professionals, non-health professionals, consumers, and other nonprofessionals. Additionally, I identified certain primary categories of participants. These individuals were staff members, health professionals, non-health professionals, consumers, and other nonprofessionals. The non-staff members included a limited number of highly sought after individuals who had income sources directly related to health care. However, these members had confirmed themselves to be absence of a direct or indirect conflicted relationship with the FQHC organization during the period of time that they were serving as board members. The limited number was reflective of a FQHC requirement that limited board members with a health Care related income source (Federally
The participating organizations reflected diversity among their boards in respect to race, gender, sexual orientation, public health experience and cultural diversity. This broad range in diversity exists across participating organizations and to a lesser extent within individual boards. The differences were reflective of the demographic of the neighborhoods serviced by individual organizations. For example, the organization that experienced a perceived influx of Hispanics and French-speaking Africans recruited cultural representatives of these groups to their board.

In the next discussion, I will offer information regarding the characteristics seen in the categories of FQHC board participants within the investigated organizations.

The staffs of the organizations are the least flexible of the participants. The staff interaction with the FQHC boards represents two different level of contact. The first level organizational contact for board-consumer interaction within the agency is obviously with staff members who have casual or no assigned relationship with board members. This type of contact generally involves staff members that are outside of the administrative circle. Consumers held their second level contact with staff members in administrative positions and with board support assignments. The assigned staff members included, but were not limited to, Chief Executive Officer (CEO)/Executive director (ED)/Assistant Commissioner, Chief Financial Officer, (CFO) Medical Director (MD), Chief Operations Officer (COO), Administrative Assistant (AA)/Clerk of the Board, and Nursing Supervisor and often include unit supervisors and others who are in the administrative circle. These two groups have influenced board members’
perceptions regarding the culture, effectiveness, and efficiency of services of the organization and its relationship with the community.

The staff members that lack an assigned relationship with the board and are usually outside the administrative circle, and are generally the initial organizational contacts of consumers. For most consumers, these contacts provide a limited perspective of the scope of services offered by the organization. Yet this level of contact is often what sparks an interest in involvement. Seldom did an interviewed consumer indicate that she or he sought out involvement or became involved as a board member without having the idea first being suggested by a board member, staff member, political figure or community activist, an event generally preceded by staff input. Another characteristic of this group of staff members was they would aggressively search for the support of individual board member when there were disputes, conflicts, or concerns on their part. This type of request could be made to any board member and appeared to be based on board members’ perceptions of their relationship with administrative and line staff. If for example, a board member felt either a lack of trust or relationship with administration there was a greater indication that they would seek information directly through other staff members. From the other perspective if the board member did not receive orientation or held a personal relationship with a staff person as client, neighbor or family member the chance of intervening for or focusing some discussions around information coming directly from unassigned staff. Such aggression is not encouraged by administrative staff and can be a point of confusion and conflict for staff and board. This particular issue was described during the interviews with indications that both intervention by
board leadership (staff and chairperson) and board training are the best means for managing
the occurrence and relational effect of these types of issues.

Consumers have a direct and ongoing relationship with staff members. Therefore, they
often become a point of temptation for staff members on boards. They may consider board
contact as an avenue for advocacy, criticism, or political impact. While this could occur within
any staff member/board member relationship, this research suggested that it was predominant
among board members who had ongoing staff contact where consumers had ongoing
interactions as neighbors and social peers of staff. The board members who take on active roles
as staff collaborator or advocates do exist; for the most part board members avoid this role as it
is likely to generate major conflict between board members and administrative staff when it
does occur.

**Assigned and upper-level staff.** Each of the participating FQHC Boards had assigned staff
members. The assigned staff included at least an upper level administrator and clerical support.
These assigned individuals supported the operational and educational needs of the board.
These staff members were the first line of official board contact and information exchange. They
worked to establish strong bonds with the board and to provide guidance about parameters of
board duties and responsibilities. These individuals set the tone for the expressions of trust,
openness, and communication between the board and the organization. It was assigned staff
that provided information on availability of board training opportunities and shared regulatory
and monitoring requirements with other staff and board members.
In addition to assigned staff members, the three participating organizations frequently involved other members of the administrative circle to provide reports, serve as consultants and respond to questions by the board. This is particularly true of fiscal officers, medical directors, human resources specialists, nursing supervisors, and, where available, epidemiologists. These individuals served as the experts to the board. Each participating board’s membership consisted of a broad range of varied levels of knowledge, skill, assertiveness, trust and experience. The traits of assertiveness, skill and trust presented as influencing the levels of board member enquiry. These traits were shown to be important in determining the level of discussion that occurred when confusing or specialized information was presented to the board and a degree of confusion or lack of understanding seemed evident. In situations of confusion, if the presenter did not begin to speak at a level that was clearly understood by all or to offer to clarify information and other staff did not intervene, it would be up to a board member to respond. For the consumer and layperson understanding was assumed if no questioning was offered. The initiative to question was not universally used.

The health professionals at the participating organizations included individuals who worked or had worked as auxiliary health service managers, physicians, nurses, nurse practitioners, counselors, and social workers. These individuals had varied levels of experience and knowledge in public health. Yet, there was little distinction made by the consumers and laypersons on the board, regarding public health experience among those individuals in the conversations and debates within the board and committee meetings. The non-health professionals on the board often sought guidance from this group of individuals. As a collective
body, the health professionals appeared to be the most confident about their roles and contributions to the board.

The non-health professionals often came to boards with business, legal, finance, social or political expertise. In several of the organizations, the non-health professionals were individuals assigned by a business to fulfill a social responsibility. Half of the individuals interviewed who had such an assignment were also junior employees and had limited or no board experience (under 18 months). The other half had been long-term board members and had well-established organizational and board relationships. The less experienced members who participated in the interviews were unclear as to what they could or should offer and considered their responsibility a potential liability as FQHC board members. These individuals gained membership to the FQHC boards as individuals with limited knowledge of their roles. They received little or no initial board training. Although this information was shared with me in interviews, these points of frustration were not shared with FQHC staff, nor were there indications that staff was aware of their uncertainty. Participating organizations aggressively pursued consumers that they identified as managers in business, community activists or as individuals who had taken on leadership roles prior to an invite to the FQHC board. Many of these individuals were identified as non-health related professionals or semiprofessionals if they were not consumers.

Persons who were neither consumer nor professionals of some type were the least represented on these boards. These individual were community leaders or the spouses of individuals with leadership roles (i.e. spouses of ministers, business owners, medical personnel,
etc.). These individuals also come to the board with other board experience and/or political experience.

As indicated earlier in this document, the consumers became board members with some knowledge about the organization. Seldom did a consumer come to the board as a young, politically or socially inactive individual without skills training. A number of them were caretakers for their grandchildren or other relatives. Some consumers had moved out of the targeted neighborhood, but continued to commute to the organization’s clinics because of a relationship with the neighborhood, staff, or local family members and friends within the clinic’s targeted neighborhood.

Among the participating boards, consumers often confessed an initial lack of understanding of the reason for their recruitment to the FQHC. This was particularly true for those who did not have activist backgrounds. Within the participating organizations, only two consumers identified as having approached their FQHC board to request membership. This is consistent with the finding in the research that the consumers were seldom aware of the intricacies of their organization at the time that they joined the board, and often lacked understanding of their roles prior to orientation and board training.

Who is not in the Discussion?

Viewing all participating organizations, there were no youth (under the age of 21) participating on these FQHC boards. The participating FQHC consumer board membership consisted primarily of African Americans and White Americans; however, there were a few members of smaller served populations such as Hispanics, Asians, French-speaking Africans and
the LGBT community. At the time of the research these secondary groups self-identified on only one of the participating boards. During the period of board observation, there was discussion about persons living below the poverty line as potential board members. However, very little active effort went toward their recruitment. Recruitment efforts were focused on seeking individuals with identifiable skills who could represent consumers. Economic, racial and gender diversity was not a primary consideration. I discerned that the lack of recruitment in these areas more as an effort to conserve resources than a deliberate ignoring of the limits of the existing diversity. The majority of individuals on participating boards self-identified as middle-class.

The research indicated that participants joined FQHC boards with a wide range of health knowledge, exposure to the service communities, occupational experiences, motivation to learn and exposure to cultural diversity. In this chapter under the subsection, “Who is in the discussion” the professional and personal experience of board participants prior to board membership is discussed as viewed in major categories. Of note, however, is a particular point that was specific to a subgroup of the professional participants. Several board members received board appointment through their association with businesses and corporations. The businesses that they represented had cultures of community mindedness, and civic involvement. Several of the employees maintained that heavy workloads on their jobs made it difficult for them to attend special FQHC board meetings or board trainings. There were underlying assumptions held by most board members and staff that these representatives came to the board processes and roles, however, except those senior board members or those with past experience, this was not the case. Junior corporate and business board members
interviewed stated that though they had been board members for nearly a year, they were still uncertain about their responsibilities or ability to contribute to the board, and that they felt both frustrated and isolated on the board. They also indicated that they had shared these feeling with me because I had asked directly.

Another indication drawn from the interviews and the observations was that several health professionals and other business professionals on these boards had very little or no public health or non-profit organization experience prior to coming on the board. For many board members, especially consumers interviewed, little or no distinction was made between public and private health services. In many cases the consumers of services on boards often had greater knowledge of public health than the professional without previous experience.

As indicated both here in the “Chapter 4 – Results” consumers came to the table with knowledge about a limited portion of the services, an understanding of the community; the clients; and a family and neighborhood view of the organization.

The observation and interviews of the research strongly indicated that board training and orientation positively affects board cohesiveness and board members’ knowledge of their responsibilities. These factors influence board effectiveness, interaction, communication, and trust.

The Conventions in the Language

One of the greatest barriers to equity for participants in the board conversation is the level of confusion and lack of communication among FQHC participants created by their diversity. The observation and interview process offered examples of the use of acronyms,
technical language and slang that created confusion when presented without clarification.

While there was no indication during the research process that indicated deliberate acts to confuse or to miscommunicate, there was a suggestion that presenters shared information in a way that was comfortable, efficient and economical for them. There was also an effort to minimize conflict and “engineer consensus” rather than “reveal diversity” that a full debate would indicate ("2010 CENSUS - CENSUS TRACT REFERENCE MAP: Hamilton County, OH," 2010, p. 322).

**Power structure conditions**

Each participant organization developed its own hierarchy of control for the FQHC board. For example one organization held the support staff responsible for calling and calling subcommittee meetings; while another board left these determinations up to the subcommittee chairpersons. Similarly, one board managed subcommittee membership by volunteer choice with confirmation by the chairperson while another had membership on committees dictated by the board chairperson. These patterns of practice eventually formed the culture of the board, helping to determine the levels of practice for board versus staff dependency and the levels of independent decision making between peers on the board.

Burgess et al. (2007) called the practice of citizen participation “the practice of involving the public with other stakeholders in agenda setting, decision-making and policy-forming activities” (p. 253). Ultimately, the conditions being assessed in this research are the levels of inclusion and the distribution of power within. These levels will inform the inclusion of members in board interaction. Expansion of participant diversity has been ideally expressed as
the act of expanding equity and extending greater control to those who receive health care services through FQHCs. Several studies have shown this to be the case for those who are active partners at the discussion table (Rowe & Frewer, 2005).

What environmental conditions brought to the board by participants affect the “voice” of the citizen in the discussion? The research indicates that the starting point is the general geographic, demographic and political realities in the region studied. Kentucky and Indiana border Hamilton County, Ohio to the south and west. The city within the county is a medium size city that because of its location is influenced by the relatively conservative attitudes of a southern state (Kentucky) boarded by the Ohio River on the south, it has been a commercial distribution and manufacturing area. The region has attracted company headquarters of such corporations as Proctor and Gamble and Kroger. Such organizations along with newer innovative companies have attracted populations from rural and southern areas seeking employment. This research indicated that the three participating organizations had operated under historically stressful conditions since the 1980s. This stress was not equally distributed among either board participants or participating organizations.

The need for a leveling of the playing field for discussion was visible within each of the participating programs. This need was particularly true for the improvement in participation of consumers who did not have an activist background. The research indicated that the three participating organizations responded to this need in the areas of 1) board education, 2) inclusive communication, 3) targeted skepticism, 5) mutual respect, 6) persistent camaraderie, and 7) skills recognition. From all indications, most board members who did not have prior
board experience needed organizational support that would provide support in all of these areas.

Concluding Statements

Nationally, there is an increasing desire for transparency in the administration of public services and a desire to improve the sense of legitimacy in the services that are provided. This is particularly true for in the system of health care (Abelson, et al., 2007). A parallel belief that the values and concerns of citizens should have some influential in the decision-making process as technological developments (Arnstein, 2003) adding increasing complexity. In fact, systemic control of technological progress has been a "deliberate strategy" in some communities (Partnership work: the health service–community interface for the prevention, care and treatment of HIV/AIDS, 2002). Furthermore, in several areas of health care planning and policy development, the involvement of citizens and consumers of services have been legislated in a way that leaves determination of their roles vague and incoherent, and dependent on the judgment of local authorities. This ambiguity makes the roles of stakeholders in the process of power sharing for the purpose of effective decision making unclear (Arnstein, 2003; Horlick-Jones et al., 2007; Rowe, 2005, 2006). While great emphasis was being placed on the establishment of consumer participant in local FQHC board, a lack of clear understanding of consumer and lay citizen roles on these boards was consistent. This research suggested that the circumstance of role was consistently the responsibility of the local organization to determine. Role was influence by organizational and administrative stability. A less stable or less experience
organization or administrate was less likely to expand board power among participating organization.

In the study of coordinating councils, Abelson, Forest, et al. (2007) suggested that diverse groups that are structured to provide organizational governance in responding to difficult community issues provide a potent way of introducing change to a community, but that effectiveness is not universal across organizations. He further suggested that the level of a group’s potential to effect change regardless of the challenges it faces is dependent on, “the creation of an inclusive climate and the engagement of a broad array of critical stakeholders” (p. 61). When assessing the data of this study I for that the level of the participating agencies to bring change to their neighborhoods was not equal. The level of emphasis neighborhood change was in proportion to the survival issues of the organization. As the organization grew in stability and escaped the shadow of past history the more involved was the board in discussions of neighborhood change and policy determination. Full and open participation among the consumers, lay citizens and health professional was dependent on critical concerns in the historical memory of the participants. Perceptions of competitive survival tactics and perceptions of unequal power distribution by organizations in the local health service network. A heightened belief in these perception resulted in limited across board interaction even though some board members know their counterparts on other FQHC boards.

The observations, interviews, validation process, and document research drove the research toward a focus on issues of history, diversity, trust, communication and leadership. The analysis of documents, observation, and interviews revealed a local health network that had
undergone a history of major and minor administrative and network clashes that dated back to the mid-1970s. These clashes were often the basis for cross-agency disputes and served as the foundation for tension and mistrust within the agency. This historic cross-agency tension ranged from questions of equitable funding between agencies through the placement of strain on the trustworthiness of one agency toward another regarding on a business. Adding to this tension was the history that several agencies had regarding the change or loss of an executive administrator for less than honorable causes. Often this information was held by and reflected on by staff and senior board members, however, very little of this history was shared with incoming board members, who were left to respond to the existing tensions. This information suggested that these issues influenced the environmental characteristics for deliberation and collaboration. Yet, there existed among individual board participants a desire to be involved in the health care conversation, including past history that impacted the current environment.

In an ideal world, the FQHC communication process is rational, equitable, and respectful of community health concerns in its service area. These programs would, in turn, under the guidance of effective, unbiased leadership, share rational information and reason its way toward regional policies that would be culturally, technically, economically and intellectually acceptable. However, it is a tall order to try to meet all these standards. However, the review of the collected data, by the evaluative group, identified issues that were important to the level consumer of involvement these were open discussion with adequate ability to appropriately question administrator, adequate diversity recruitment, board education and mentoring process.
Studies have shown that there is a significant disparity on key measures of health care quality across racial and economic groups in the practice of health care services (Chin, Walters, Cook, & Huang, 2007; Schneider, Zaslavsky, & Epstein, 2002). The lack of balance in the availability, distribution and access of health care services has paralleled the history of segregation and financial disparity in America (Blustein, 2008).

Nationally, there is an increasing desire for public transparency and a desire to improve the sense of legitimacy in the system of health care (Abelson, et al., 2007). This desire has been fueled by the belief that the values and concerns of citizens should be as influential in the decision-making process as the technological developments (Arnstein, 2003). However, control of technology has been an approach of institutional control. In fact, systemic control of technological progress has been a "deliberate strategy" in some communities (Partnership work: the health service–community interface for the prevention, care and treatment of HIV/AIDS, 2002). Furthermore, in several areas of health care planning and policy development, the involvement of lay citizens and consumers of services have been legislated in a way that leaves roles vague and incoherent, and dependent on the judgment of local authorities. This ambiguity makes the roles of stakeholders in the process of power sharing for the purpose of effective decision making difficult. Full and open participation within the group is dependent on critical understanding of concerns in the historical memory of the participants, perceptions of competitive, managing survival tactics and equalization of the power distribution by organizations in the local health service network in support of education and a less skill more diverse layer of the community to the process in a way that they are more equipped.
References

2010 CENSUS - CENSUS TRACT REFERENCE MAP: Hamilton County, OH. (2010). [County or statistically equivalent entity].


## Appendix A of Hamilton County Federally Qualified Health Networks

<table>
<thead>
<tr>
<th>FQHC Network</th>
<th>FQHC Unit Name</th>
<th>Unit Address</th>
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<tr>
<td>Cincinnati Health Department (CHD)</td>
<td>Elm Street Health Center- Cincinnati Health Department</td>
<td>Elm St Cincinnati 45202-6957</td>
<td>513-352</td>
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<tr>
<td>Cincinnati Health Network, Inc. CHN</td>
<td>Healthcare for the homeless and HIV/AIDS</td>
<td>400 Oak St, Ste M-2 Cincinnati 45219</td>
<td>513-961-0600</td>
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<tr>
<td>Crossroad Health Center (CHC)</td>
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<td>5 East Liberty St Cincinnati 45202-8202</td>
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<tr>
<td>Lincoln Heights Healthcare Connection (LHHC)</td>
<td>Forest Park Health Center</td>
<td>924 Waycross Rd Cincinnati 45240</td>
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<td>Lincoln Heights Healthcare Connection (LHHC)</td>
<td>Kemper Heights Health Center</td>
<td>924 Waycross Rd Cincinnati 45240-3022</td>
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<td>Lincoln Heights Healthcare Connection (LHHC)</td>
<td>Lincoln Heights Health Center</td>
<td>1401 Steffen Ave Lincoln Hts. 45215</td>
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<td>Lincoln Heights Healthcare Connection (LHHC)</td>
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<td>Anthony Munoz Pediatric Health Center</td>
<td>270 Southern Ave Cincinnati 45219</td>
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<td>Neighborhood Health Care, Inc. (NHC)</td>
<td>Adapt For Men</td>
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<td>Adapt for Women</td>
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<tr>
<td>Neighborhood Health Care, Inc. (NHC)</td>
<td>Rockdale Academy School Based</td>
<td>335 Rockdale Cincinnati 45229</td>
<td>513-363-4704</td>
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<tr>
<td>Neighborhood Health Care, Inc. (NHC)</td>
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<tr>
<td>Neighborhood Health Care, Inc. (NHCI)</td>
<td>Spring Grove Center</td>
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<td>The Bridge</td>
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Descriptive Study of a Democratized Style of Policy Discussion in Health Care

Bernard B Young
Research Project Brief

Who am I?

My name is Bernard Young. I am a student at the University of Cincinnati. I am working on a Doctor of Education degree. The degree is in Urban Educational Leadership. I have worked in the areas of alcohol and drug abuse, social services and health services as a counselor and program manager. My last place of employment was with the Cincinnati Health Department. I have been retired for the past two years.

Purpose

I want to present my research project to you. I will study the communication that takes place among the members of the Federally Qualified Health Center (FQHC) boards and observe the dynamics and the outcomes of those dynamics. The study is intended to add to understanding of the communication in health care policy development. It is not intended to criticize any person or agency in action or process. It will provide a chance for the volunteers to become partners to the researcher in the process.

A doctoral committee reviews my work. My chairperson is Dr. Mary Brydon-Miller, PhD. She is Director of the Action Research Center and a professor of educational studies and urban educational leadership.
The focus of the study is FQHC boards that offer primary health care services to communities. The government requires these FQHCs to include consumers as members of the FQHC boards I will be collecting data from these boards using the following methods:

1. Ethnographic Observation – Observing two to four meetings of each FQHC board involved. I will produce notes of my observations.
2. Key informant interviews – identify and interview individuals who are knowledgeable about the history and operations of the FQHC board.
3. Document review – public documents including minutes, notices, newspapers, magazines, newsletters, internet, external organizations, etc. will be reviewed for information about FQHC boards.
4. Focus Groups – The focus group will provide a way for the members of FQHC boards to be partners in the review and analysis of data that are collected.
5. Of FQHC boards to be partners in the review and analysis of data that is collected.

Research Project Parameters

<table>
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<th>Parameter</th>
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<tr>
<td>Time</td>
<td>The total research process will last approximately eight months.</td>
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<tr>
<td>Cost</td>
<td>The research project will not result in any cost to the participants.</td>
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<tr>
<td>Risk</td>
<td>Risk will be minimal. Anonymity cannot be promised</td>
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### Parameter | Amount
--- | ---
Benefit | The research project not provide any direct benefits to the participants it will add to the knowledge base of the FQHC board
Scope | The research project will focus on FQHC boards in Hamilton County, Ohio.
Quality | The quality of the research process is monitored by the University of Cincinnati Institutional review board and the Doctoral Dissertation Committee.

**Participants and roles in the study**

Participating partners in the study include the Cincinnati Health Department; Health Care Connection, Inc.; and Neighborhood Health Care, Inc. These programs are being asked to serve as partners in reviewing the data gathered in the study and making recommendations for future actions. Specifically, they will be asked to:

- Provide a letter of support indicating the agency is willing to take part in the study
- Allow me to observe 2 to 4 FQHC board meeting
- Identify space at the agency that can be used to hold key expert interviews or focus groups

**FQHC board members are asked to:**

- Suggest who know about the FQHC board and who are willing to be key experts about the board’s process;
- Support board members becoming focus groups members of the study.

**Agency staff that have been associated with the FQHC board process will be asked to:**
• Suggest people in the community who have or had direct association with the FQHC and who have knowledge of FQHC communication and procedural processes of the board and are will be key experts;

• Be open to participate focus group meetings of the study;

• Be a resource to report any discomfort identified by a participant and to direct the reporting person to my Faculty advisor, a contact on my dissertation committee or to me.

I will provide:

• A clear and brief statement of purpose, risks and benefits of the research process;

• Clearly identity myself to the FQHC board members, staff, and facilitator as a participant observer and data collector at those board meetings that will be observed for the study

• Supply all required and appropriate paper work relating to confidentiality, informing participants of private data collection, maintenance, and use;

• Provide copies of the confidentiality statements and related forms associated with the research process;

• Provide the participants with copies of the final product of the research
Appendix C  Ethnographic Observation Guidance Matrix

The ethnographic observation is styled after the example offered by Spradley (1980) and further developed by Robson (2002). This style makes use of nine data categories:

1. **SPACE** - layout of the physical setting; rooms, outdoor spaces, etc.
2. **ACTORS** - the relevant details of the people involved excluding name
3. **ACTIVITIES** - the various activities of the actors
4. **OBJECTS** - physical elements: furniture etc.
5. **ACTS** - specific individual actions
6. **EVENTS** - particular occasions, e.g. meetings
7. **TIME** - the sequence of events
8. **GOALS** - what actors are attempting to accomplish
9. **FEELINGS** - emotions in particular contexts (Spradley, 1980, p. 320)

For the purpose of observing Federally Qualified Health Center (FQHC) there will be a separation of personal identifying information from the observation recording form and field record. I will code the identity of volunteer participants in field notes and on observation forms. The PI will maintain participant’s personal identifying information in a separate file maintained in confidence at the PI’s residence.

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## Observation Matrix Guidance

<table>
<thead>
<tr>
<th>Space</th>
<th>Object</th>
<th>Act</th>
<th>Activity</th>
<th>Event</th>
<th>Time</th>
<th>Actor</th>
<th>Goal</th>
<th>Feeling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Space</td>
<td>Can you describe in detail all the places?</td>
<td>What are all the ways space is organized by objects?</td>
<td>What are all the ways space is organized by acts?</td>
<td>What are all the ways space is organized by events?</td>
<td>What spatial changes occur over time?</td>
<td>What are all the ways space is used by actors?</td>
<td>What are all the ways space is related to goals?</td>
<td>What places are associated with feelings?</td>
</tr>
<tr>
<td>Objects</td>
<td>Where are the objects located?</td>
<td>Can you describe in detail all objects?</td>
<td>What are all the ways objects are used in acts?</td>
<td>What are all the ways objects are used in activities?</td>
<td>What are all the ways objects are used at different times?</td>
<td>What are all the ways objects are used by actors?</td>
<td>How are objects used in C goals</td>
<td>How are objects used in C goals</td>
</tr>
<tr>
<td>Act</td>
<td>Where do acts occur?</td>
<td>How do acts incorporate the use of objects?</td>
<td>Can you describe in detail all acts?</td>
<td>How are acts parts of activities?</td>
<td>How are acts parts of events?</td>
<td>What are all the ways acts are performed by actors</td>
<td>What are all the ways acts are related to goals</td>
<td>What are all the ways acts are related to goals</td>
</tr>
<tr>
<td>Activity</td>
<td>What are all the places activities occur?</td>
<td>What are all the ways activities incorporate objects?</td>
<td>What are all the ways activities incorporate acts?</td>
<td>Can you describe in detail all the activities?</td>
<td>What are all the ways activities are parts of events?</td>
<td>How do activities vary at different times?</td>
<td>What are all the ways activities involve actors?</td>
<td>What are all the ways activities involve goals?</td>
</tr>
</tbody>
</table>

---

**Appendix C Continued**

- **Space**
  - Can you describe in detail all the places?
- **Object**
  - What are all the ways space is organized by objects?
- **Act**
  - What are all the ways space is organized by acts?
- **Activity**
  - What are all the ways space is organized by events?
- **Event**
  - What spatial changes occur over time?
- **Time**
  - What are all the ways space is used by actors?
- **Actor**
  - What are all the ways space is related to goals?
- **Goal**
  - What places are associated with feelings?
<table>
<thead>
<tr>
<th>Event</th>
<th>Space</th>
<th>Object</th>
<th>Act</th>
<th>Activity</th>
<th>Event</th>
<th>Time</th>
<th>Actor</th>
<th>Goal</th>
<th>Feeling</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are all the places events occur?</td>
<td></td>
<td>What are all the ways events incorporate objects?</td>
<td>What are all the ways events incorporate acts?</td>
<td>What are all the ways events incorporate activities?</td>
<td>Can you describe in detail all the events?</td>
<td>How do events occur over time? Is there sequencing?</td>
<td>How do events involve the various actors?</td>
<td>How are events related to goals?</td>
<td>How do events involve feelings</td>
</tr>
<tr>
<td>Where do time periods occur?</td>
<td></td>
<td>What are the ways time affect the objects?</td>
<td>How do activities fall into time periods?</td>
<td>How are activities fall into time periods?</td>
<td>How do events fall into time periods?</td>
<td>Can you describe in detail all the time periods?</td>
<td>When are all the times actors are “on stage”?</td>
<td>Which actors are linked to which goals?</td>
<td>When are feelings evoked?</td>
</tr>
<tr>
<td>Where do the Actors place themselves?</td>
<td></td>
<td>What are all the ways actors use objects?</td>
<td>What are all the ways actors use acts?</td>
<td>How are actors involved in activities?</td>
<td>How are actors involved in events?</td>
<td>How do actors change over time or at different times</td>
<td>Can you describe in detail all the actors?</td>
<td>Which actors are linked to which Goals?</td>
<td>What are the feelings experienced by actors?</td>
</tr>
<tr>
<td>Where are goals sought and achieved?</td>
<td></td>
<td>What are all the ways goals involve the use of objects?</td>
<td>What are all the ways goals involve acts?</td>
<td>What program activities are goal seeking or linked to a goal?</td>
<td>What are all the ways events are linked to goals?</td>
<td>Which goals are scheduled for which times?</td>
<td>How do various goals affect the various actors</td>
<td>Can you describe in detail all the goals?</td>
<td>What are all the way goals evoke feelings?</td>
</tr>
<tr>
<td>Where do the various feelings states occur</td>
<td></td>
<td>What feelings lead to the use of what objects?</td>
<td>What are all the ways feelings affect acts?</td>
<td>What are all the ways feelings affect activities?</td>
<td>What are all the ways feelings affect events?</td>
<td>How are feelings related to various time periods?</td>
<td>What are all the way feelings involve actors?</td>
<td>Can you describe in detail all the feelings?</td>
<td></td>
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</tbody>
</table>

### Observation Matrix Guidance Form

<table>
<thead>
<tr>
<th>Space</th>
<th>Object</th>
<th>Act</th>
<th>Activity</th>
<th>Event</th>
<th>Time</th>
<th>Actor</th>
<th>Goal</th>
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<td>Goal</td>
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<td>Feeling</td>
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</tbody>
</table>
Appendix D  Participant flow Sheet

Recruiting Organization

Introduction of agencies to the research project

Presentation to organization executive officer/board staff person and distribution of Research Project Informational Brochure (5 organizations)

Open to involvement (3)

Rejected involvement (2)

General Recruitment for individuals

Presentation of process to board members and support staff at regular meetings. Distribution of General Observation information Sheets. 36 board members (BM); 12 staff (S); member 4 other (O)

Rejection by Board 0

Acceptance by the board 3

Acceptance by individuals 28 (BM); 6(S) 1(O)

Non-acceptance by individuals 0

Observation process

Observation of 5 board meetings at each of the three organization

Do not document requests 0

Allowed Documentation

Data produced from observations

Interview process

See next page
Interview Process

Presentations on interview process to recruited boards and staff at regular meetings. Distribution of General information brochures and Expert interviewee confirmation forms. 28 board members (BM); 6 staff (S); member 1 other (O)

Lack of or negative response

Expressed oral or written interest

Individual are contacted by telephone or in person to discuss interview process options and informed consent and schedule a meeting time and place

Not consented 21

Consented 14

16 interview sessions
3 administrative staff
11 board members

Do not document requests
1 staff

Data produced from interviews

Validation group process

Group and individual presentations on validation process given to present and former board members and staff. Distribution of General information brochures and Expert interviewee confirmation forms. 28 board members (BM); 6 staff (S); member 1 other (O)

Failed to volunteer or show interest
Indicated interest

Consented and participation in validation focus group process meeting, 9 board members

Process of validating observational and interview data by participant group

Research closure

Final data analysis and thesis preparation
Appendix E  Data Analysis Process Flow

Objective
This process will map the data evaluation process of Conducted in Descriptive Study of Democratized Style of Policy discussion in Health Care

Actors / Roles
Primary Investigator, Three Federally Qualified Health Center (FQHC) their Boards and Staff

Context
Urban and Suburban Health Service Clinics
Observation of Board meetings
Conduct Observations of three Federally Qualified Health Center (FQHC) Boards

Documentation of observations
Documenting the observations made during the observations. Documentation consisted of "field notes."

Observation Matrix
The observation matrix was drawn from the work of Spaulding (1980), which offers nine matrix categories consisting of space, object, act, activity, event, time, actor, goal, and feeling, these categories were used as prime

Code list of specific observations
Code observation, Generate list of specific observations, Code using the Spaulding Grid which makes use of the five categories of Space, Object, Act, Activity, Event, Time, Actor, Goal, and Feeling.

List of observations Items
Generate un-prioritized list of specific points identified during the observations,

Issues needing further investigation
Information identified during observations that seemed to be of interest but call for additional clarification or confirmation during the interview process.

Descriptive & exploratory Questions
Area of question where Identified based on the FQHC Board Meeting observations. Of particular interest were common and contrasting observation across organizations around meeting procedures, information distribution, committee activity, discussion of neighborhood interaction, recruitment patterns, etc.

Expert Interviews
Ethnographic personal interview of FQHC participants who have been identified has being willing to participant and provide their perspectives on involvement in the FQHC board discussion and policy development

Interview Notes and Recordings
Audio recording were done during each interview. Follow the interview field notes and transcripts were established.

Nvivo Coding and Cataloging
Nvivo is a Research software that facilitate the cataloging, comparing, contrasting, and coding of qualitative data.

Statements list by nine observation categories
As a part of the coding process, interview statement and observational made during the

Categorical listing of all Data
Categories: Space, Actors, Activities, Objects, Acts, Events, Time, Goals, and Feelings

Evaluation Group Meeting
Participants were presented with the categorized data.

Evaluation and Prioritization
Categorized Items were evaluated as to being or not being an influence on the ability of the individual to participate in the FQHC Board Processes.

Group comments & advice
Comments and recommendations of the Evaluation Groups members were collected

High priority Item
Items were recognized as being of high priority of greater that 51 percent of the evaluation group participants

Focus of Current Research
High priority items where brought into the study report.

Consider for future research
Low priority items were identified for possible future study.
## Tables

### Table 1 Respondents Who Indicated This Role

<table>
<thead>
<tr>
<th>Rank</th>
<th>Role</th>
<th>Number</th>
<th>Percentage of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Be a “working board”</td>
<td>8</td>
<td>7</td>
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<tr>
<td>2</td>
<td>Relationship to executive</td>
<td>2</td>
<td>2</td>
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<tr>
<td>3</td>
<td>Provide guidance and generate respect</td>
<td>2</td>
<td>1</td>
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<tr>
<td>4</td>
<td>Facilitate granting</td>
<td>1</td>
<td>1</td>
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<td>5</td>
<td>Policy oversight</td>
<td>3</td>
<td>2</td>
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<tr>
<td>6</td>
<td>Public relations</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>Board member vitality</td>
<td>3</td>
<td>3</td>
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<tr>
<td>8</td>
<td>Board membership</td>
<td>8</td>
<td>7</td>
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<tr>
<td>9</td>
<td>Become knowledgeable</td>
<td>7</td>
<td>6</td>
</tr>
</tbody>
</table>

| Rank | Total number of respondents  | 121    | 100                        |

Note: average number of roles per respondent = 3.22.

(Brown & Chao Guo, 2010)
Images

Table 1  Photo graphs of Validation Group Process
DEMOCRATIZED POLICY DISCUSSION IN HEALTH CARE

Space

The layout of the physical setting: rooms, outdoor spaces, etc.

Single Table
Multiple Tables
Circumferential Seating (no head table)
Rectangular Seating
Cafeteria Seating (bench table)
Lobby
Clinic Building
Office Building
Conference Meeting space
Office Space

(interview information)
Aesthetically Planning Setting
Agency Manual/Information Packets
American Flag
Charts
Clock
Code of Regulations
Bylaws
Computers
Email
Grant Documents
Statement of Goals
Mission Statement
Multi-Media Equipment
Specialized Guidance Information