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Rural-Urban Differences in Consumer Governance at Community Health Centers

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Abstract

Context—Community health centers (CHCs) are primary care clinics that serve mostly low-income patients in rural and urban areas. They are required to be governed by a consumer majority. What little is known about the structure and function of these boards in practice, suggests that CHC boards in rural areas may look and act differently than CHC boards in urban areas.

Purpose—To identify differences in the structure and function of consumer governance at CHCs in rural and urban areas.

Methods—Semi-structured telephone interviews were conducted with 30 CHC board members from 14 different states. Questions focused on board members' perceptions of board composition and the role of consumers on the board.

Findings—CHCs in rural areas are more likely to have representative boards, are better able to convey confidence in the organization, and are better able to assess community needs than CHCs in urban areas. However, CHCs in rural areas often have problems achieving objective decision-making, and may have fewer means for objectively evaluating quality of care due to the lack of patient board member anonymity.

Conclusions—Consumer governance is implemented differently in rural and urban communities, and the advantages and disadvantages in each setting are unique.

Keywords

Community Health Centers; Consumer Governance; Rural-Urban Differences

There is renewed interest in empowering patients to make decisions regarding their health care.¹ From “consumer engagement” to “patient centered medical homes,” the belief is that by actively incorporating patients into the health care system, it will be possible to improve access and quality, while simultaneously controlling costs. While such goals may appear ambitious, there is something intuitively appealing about the notion of empowering the patients for whom the health care system ultimately exists. Perhaps this explains why, for the last 45 years, community health centers (CHCs)—a national group of over 1,200 federally-funded primary care clinics that serve mostly low-income patients—have sought patient

Disclosures

Nothing to disclose.

input at the highest level, through consumer governance. Specifically, federal law requires that at least 51% of CHC board members must be patients at the center they govern.

However, what little is known about the structure and function of CHC governing boards indicates that they face a number of significant implementation challenges, including dominance by social elites,² low levels of consumer participation,³ disparities in working knowledge between consumers and non-consumers,⁴ and unanswered questions about the effect of consumer governance on actual measurable outcomes.^{5–8} Furthermore, because CHCs operate in both rural and urban settings, there may be differences in board structure and function associated with a given center's degree of rurality. This study sought to identify such differences by interviewing CHC board members and found that consumer governance does indeed function differently between rural and urban areas. As the health center program expands—with \$11 billion in new funding under the Affordable Care Act—understanding how this key provision is implemented in different settings is essential.⁹

Methods

Setting

Semi-structured telephone interviews were conducted with 30 CHC board members from 14 different states representing each of the four geographic U.S. Census regions. Male and female board members from CHCs in Alaska, California, Florida, Illinois, Kentucky, Maine, Maryland, Massachusetts, Michigan, New York, Oklahoma, South Carolina, Virginia, and Wisconsin participated in the interviews. CHCs in both rural and urban settings were included, as were both small and large CHCs (as defined by patient load).

Participant Recruitment

The sampling methodology was designed to generate data which would reflect a wide variety of viewpoints, ensure that different realities were uncovered, and produce more generalizable results. Using descriptive statistics from the Uniform Data System, CHCs were classified into one of four categories based on their combined level of service provision and financial performance as “high performers,” “low performers,” “mission dominant,” or “margin dominant.” CHCs were randomly selected with replacement within each stratum, and the executive director was contacted by email and invited to identify 2 board members (1 consumer and 1 non-consumer, if possible) for study participation. This process was continued as needed within each stratum.

Data Collection

Using an interview guide, semi-structured telephone interviews consisting of both open-ended and fixed-response questions were conducted and digitally recorded. Interviews were designed to explore board members' perceptions of the advantages and disadvantages of consumer governance. Specific questions were formulated based on a literature review and were arranged in a logical order that would help the interview to flow smoothly.

The interview began with relatively straightforward questions to help respondents feel more comfortable (eg, “How long have you been on the board?”), proceeded to ask the most

challenging questions in the middle of the interview (eg, “How representative would you say your board is of the patients served at your center?” “What are the biggest disadvantages of including patients on the board?”), and concluded with demographic information, which would be easy to answer in the event of fatigue.

In practice, the interview guide was closely followed, although question order was sometimes altered and not all participants were asked all questions. Each participant received a \$10 gift card. After each interview, the audio file was securely uploaded and professionally transcribed. The interviews generated approximately 23 hours of recorded audio and 363 pages of transcribed data.

Data Analysis and Interpretation

All transcripts were reviewed once and compared against the original audio files to ensure accuracy. Transcripts were reviewed a second time to increase familiarity with the content of the interview data. In a third review, start codes were applied to the data using Atlas.ti, with additional codes being created as dictated by the data.

As a validity check, a subsample of 6 randomly selected transcripts (representing 20% of all interviews) was independently coded by a research assistant who was provided a copy of the codebook and instructed in its use. Discrepancies in coding were resolved by a process of discussion until consensus was reached. Additional codes were created as needed, some codes were consolidated, and other sections of the transcripts were recoded. Following the consensus process, these changes were applied to all transcripts as appropriate. Then, the codes were linked to one another in an axial coding process to build a conceptual framework for understanding the interview data, which was used to craft a storyline memo that formed the outline of the qualitative results.¹⁰

Results

Table 1 provides a summary of participant characteristics. The sample consisted of 12 men and 18 women ranging in age from 28 to 75, with a mean age of 56 years. The respondents possessed a range of CHC board experience, with tenures ranging from 3 months to 21 years, with a mean of 6.5 years. Of the 24 respondents who indicated that they were consumers, the length of time for which they had been a consumer ranged from 1 to 30 years, with a mean of 9.7 years. Comparing individual respondents' consumer tenure to their board tenure revealed that 6 of the 24 (25%) joined the board prior to becoming consumers.

Respondents commented extensively about themselves and the CHCs they govern, and indicated that consumer governance has both advantages and disadvantages that are exacerbated among rural CHCs. The advantages include the ability to assemble a board whose consumers closely resemble the CHC's patient population, the ease with which the community's needs are ascertained, and the enhanced potential for consumer board members to promote the organization in the community. The disadvantages include limitations on the ability of consumer board members to function optimally in their role as monitors of CHC quality and a pronounced lack of objectivity in decision-making. By

contrast, urban CHCs do not enjoy these advantages or confront these disadvantages to the same extent as their rural counterparts.

Representing the Patients

Prior research has found that board members who are consumers of the center may not resemble the patient population the health center serves.¹¹ This involves not only the process by which consumer board members are identified and selected to join the board, but also the potential pool of candidates, which varies significantly based on the degree of urbanicity/rurality, with CHCs in rural areas having fewer people to choose from. In both rural and urban areas, it appears that CHC boards are not entirely reflective of their patient population. However, rural CHCs appear more likely to have representative boards. A few respondents, like this consumer from a health center in rural Alaska, described their boards as being at least somewhat representative of the patients served:

“I think we’re relatively representative. The one thing that perhaps we may not be is that...most of those of us on the board are in an upper income bracket for the area...Many of the people on the other end of our sliding scale are up here in subsistence lifestyles and/or seasonal workers, sometimes unemployed... We’re not exactly representative of the lower end of the scale.”

More common, however, were responses like this one from a consumer at a New York City health center, expressing that the board members are not representative of the patients served:

“Basically, most of our board is full time working professionals who have private health insurance and who use various private sources of care. Our patients for the most part are low income people of color who live in inner-city neighborhoods.... On our board, I don’t believe that the nature of the “patients” is representative... There’s a huge, at least on our board, there’s a big class, race, socioeconomic, educational gulf between people like myself and most of the patients.... I’m not really a patient the way the community health center governance requirements were set up. Now, not everybody has to be a patient, you want to have some people like me, but there should be more patient-patients, patients with a capital P as opposed to patients in quotation marks...”

A similar response came from a consumer at a Baltimore health center:

“I think that we’re probably not quite as representative because our board is pretty well educated even though we’re lower to middle income. We’re probably on a little better heel than most of the clients that we see... There is a level of articulation that exists on the board that we would probably not see in our general client base. I think our client base is generally high school educated or less, so that’s a little different then the board because the board has all got some degree of academic background behind them... I suspect that most of our client base is from the lower economic strata and I think our trustee-based clients is probably middle-income, moderate-income. Maybe we have a couple folks on there who are lower to middle-income, but I think there is a little bit of a different situation there... I guess the answer would be something like the regular clients, but not quite the same.”

It seems much easier for the consumer board members on the board to be representative of the patient population of the health center when the health center is located in a small community or rural area, most likely because such communities are a bit more homogeneous, so there is less variation for the board to attempt to represent. Here is what some consumer board members from health centers in rural Alaska and Kentucky had to say:

“Do you think it’s easier to get that very high degree of representation or representativeness because you’re in a small community?”

Yes.”

“[W]e’re all representative of what we serve. We’re in the mountains and we don’t have a black population, we don’t have a Latino population. We’re just all poor-folk. That’s our commonality amongst all of us. Here, even the rich people, even the haves are very familiar with the have-nots and we don’t separate. Fortunately, as a whole we don’t separate ourselves from each other. We’re all pretty well mixed together... We’re all so mixed in here, there’s no identity that we can claim. We can’t say that we’re black; we can’t say that we’re white; we can’t say that we’re Latino. We can’t say anything of these things because we’re just mountain-folk. We don’t divide ourselves that way. We’re fortunate in that manner...”

Conveying Confidence in the Organization

A few respondents also mentioned that having consumer board members was important because it conveyed confidence in the organization. By going to the health center for care, board members are indicating to members of the community that they believe in the organization and the quality of care it provides. It is essentially an endorsement from the highest levels of the organization. This function of consumer governance depends heavily on how small and close-knit the community is, and thus is likely more prevalent in rural areas. In fact, it was mentioned exclusively by a consumer and a non-consumer at a health center in rural Michigan, as well as a consumer from a health center in rural Florida.

“If I’m on [our] board and go down to [another clinic], it certainly displays a lack of confidence in the operation. It’s like the guy working for Ford driving a Volkswagen, it shouldn’t happen. If I’m not satisfied with the services provided there well enough to use it then I certainly should not be on a governance board.”

“The majority of governance should be from the community and should be people who use the facility. If that’s not the case then what are people from the community doing on that board if they don’t have some skin in the game for those facilities themselves.”

“I don’t think you should be on the board and want other people to attend a facility that you won’t attend.”

Assessing Community Needs

Respondents described a number of ways in which health centers become aware of the needs of the community. Several of the processes they described involved the board, while others

involved the staff or even the patients themselves. Typically, identification of the community's needs may originate with the board because of common knowledge about the community or knowledge the board member acquires specifically through their work and life interactions in the community, rather than their patient status. Of course, the more representative a consumer board member is of the patient community, the more likely that the board member will interact with other patients regularly in the community. When the board members bring the needs of the community up at a meeting, it is usually the result of something they have managed to observe or overhear, or they are approached directly by patients out in the community. Examples of the importance of living and working in the community were plentiful, but occurred almost exclusively among respondents from rural areas. Consumers from health centers in Massachusetts and Florida said:

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

“When people in the community people know that you’re on the board they will come to you and make complaints too. We can’t do anything about it. The only thing we can do is inform the CEO. We can’t talk to the people at that clinic, that’s his [the CEO’s] responsibility. That’s something that he has his medical officer or clinic manager handle. By people in the community knowing that you are on the board, you do get feedback and they’re more likely to come to you if they know that you’re a patient too. You’ll know exactly what they’re talking about.”

Consumer Board Members as “Secret Shoppers”

Respondents frequently discussed how consumer governance was advantageous because it provides the board with important feedback about the quality of the service provided during the clinical encounter. In essence, the consumer board members are able to get periodic snapshots of the health center’s operations at the most basic level and this, according to many respondents, provides a mechanism for ensuring that the health center is providing patients with high quality care—or at least addressing problems. Respondents referred to this as being “secret shoppers.” A consumer in Baltimore said:

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

While consumers in rural Kentucky and South Carolina said:

“It helps having patients on the board in that, they come to the clinic regularly and they can see for themselves how things are operating, not that that’s why they come. But I know myself I have come and when I am sitting in the waiting room I listen to other patients comments and most of them don’t know that I’m a board member. But I listen to their comments about the clinic and about how things are working, about their doctor, about the nurses and what have you. You’d be surprised that there are many good comments. There are also comments about why do we have to wait so long and things like that.”

“Oh, I think it’s very...beneficial, because it lets you know what is happening. Usually when I come in, I don’t announce who I am. Or when I call to make an appointment, I just say my name. And we’ve had...new personnel...at the...in the front office, so they don’t know who I am...and so...I’m just treated like a regular patient.”

The smaller the community, the more likely people are to know and interact with each other. As one consumer from a health center in rural Oklahoma put it:

“In this small community, you can hear everything but the bacon frying up here where we live.”

The results of this are that people in small communities tend to enjoy less anonymity than people in larger communities, which can have some limiting effect on the ability of consumer board members to be “secret shoppers” as one respondent from a rural CHC indicated:

“It’s pretty hard for me to be a mystery shopper if you know what I mean.”

Lack of Objective Decision-Making

A second disadvantage experienced by CHC boards in rural areas is that board members in small communities may also have a more difficult time being objective decision-makers:

“The negative, and particularly in a community like this one, I think, is that we’re so small that we know these people as neighbors as well as providers and so forth. This just adds another layer to that. So you’re going to add some personal viewpoints in there that perhaps should not be when you’re dealing on a management issue.”

Respondents discussed how this could interfere with decision-making especially in cases where the board attempted to terminate the employment of a board member’s personal physician. However, any time that board members are closely acquainted with the objects of the decision-making process, a loss of objectivity is a very real concern, and smaller communities increase the likelihood that this will occur.

Discussion

Based on these interview data, it appears that consumer governance functions differently at rural versus urban CHCs. Specifically, CHCs in rural areas are likely to have boards that look more like the patients being served, boards that convey confidence in the CHC to members of the community, and boards that are more aware of the needs of the community. At the same time, these rural CHCs are likely to have boards that lack objectivity in decision-making and whose consumer members are not able to function effectively as “secret shoppers” because there is limited anonymity in smaller communities. In more urban CHCs, the opposite is typically true. What remains unclear is the relative importance of each of these characteristics. For instance, if having a representative board is more important than having “secret shoppers,” CHCs in rural areas are likely to have more effective boards. Conversely, if the opposite is true, CHCs in urban areas will be more effective.

Prior qualitative research finds that consumer board members are valued more for their role in providing patient feedback than for their role as representatives of the community,¹² and the current study strongly reinforces these findings. According to interview participants, consumer board members acting as “secret shoppers” provide feedback on the quality of the services they receive at the center. In this role, less representative board members may provide an advantage. For example, having more professional consumer board members may prove beneficial to the extent that these individuals possess higher expectations for the quality of care they receive and a greater ability to articulate their concerns to the full board. Of course, to the extent that their socioeconomic status is readily perceived by others, there is also some concern that the clinical staff will interact differently with these board members, leading to a biased perception of the quality of care provided to other CHC patients more generally. That is, the “secret shoppers” will not actually be “secret” any longer.

There is also potential for conflict between consumer board members as secret shoppers and consumer board members as conveyors of confidence in the organization, because the former requires a certain degree of anonymity that would explicitly prohibit the latter function. That is, to be a secret shopper, consumer board members must not be known to others as a board member, while to convey confidence in the organization, they must be known to others as both a board member and a consumer. This does not mean that a given consumer board member cannot fulfill both roles, but it makes it highly unlikely that they can fulfill both roles simultaneously.

For example, if the consumer board member’s physician does not know that they are on the board, the consumer board member is equipped to act as a secret shopper but will not display confidence in the organization to the physician. On the other hand, if the physician knows that the consumer board member is on the board, confidence may be conveyed, but the board member may become no longer a “secret shopper” but merely a “shopper.” That is, they can still provide feedback on the quality of the care they receive, but there is now the chance that they received preferential treatment as a known board member.

This study does have some potential limitations. First, there is the possibility of selection bias, as non-participants may have answered my questions differently than participants did. Specifically, there could have been selection bias at the health center level, and selection bias at the board member level. The first instance would occur if CHCs where the executive director agreed to participate were significantly different from CHCs that did not participate. The second instance would occur if the board members identified for participation by the executive director differed significantly from the board members not identified for participation. By using a purposive stratified random sample, I hope to have minimized the consequences of any response bias.

Second, there is the possibility that the data suffer from social acceptability bias. Participants may have told me that consumer governance was a good thing because they thought that that was the “right” answer. In this case, interview participants may have underreported the disadvantages of consumer governance. Finally, because interviews were conducted over the telephone, this limited my ability and that of the participants to respond to non-verbal cues

and draw non-verbal inferences. Future research should consider using in-depth case studies and in-person interviews to ensure that the views of all board members are proportionately represented and richly understood.

Consumer governance is one way of giving a voice to a traditionally disenfranchised population, but a “one-size-fits-all” approach may not be wholly appropriate. While the mechanism of consumer governance is intended to increase decentralization in decision-making leading to interventions targeted to meet local needs, the results of this study suggest that the mechanism itself—and not just the outcomes it generates—operates differently in different communities. Health centers in both rural and urban areas should carefully consider these findings and strive to embrace the strengths and offset the weaknesses of consumer governance in their particular geographic context.

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Table 1

Summary Statistics of Interview Sample (N = 30)

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