# Community Health Center Board Evaluation Report

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February 2000 - January 2001

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Findings

## Acknowledgments

We would like to thank the Executive Directors, Board Chairpersons, and the entire Board members of the following community health centers for their time and commitment to this project:

- Delmarva Rural Ministries
- Hardeman County Community Health Center
- InterCare Community Health Network
- La Clinica Esperanza
- Norwalk Community Health Center
- White River Rural Health Center

We would also like to thank our colleagues at the following organizations who provided us with valuable feedback, information and insights during the early stages of this project:

- Daniel Diaz, Texas Association of Community Health Centers
- Scot Graff, Community Healthcare Association of the Dakotas
- Judy Jensen, Region VII Health Resources and Services Administration Field Office
- Jay McGath, Region VIII, Health Resources and Services Administration Field Office
- Kim Sibilsky, Michigan Primary Care Association
- Norton Wilson, Community Health Centers of Arkansas

We also appreciate the energy, expertise and patience of the staff within the Office of Data, Evaluation, Analysis and Research, Bureau of Primary Health Care, who engaged in this project as partners.

# Executive Summary

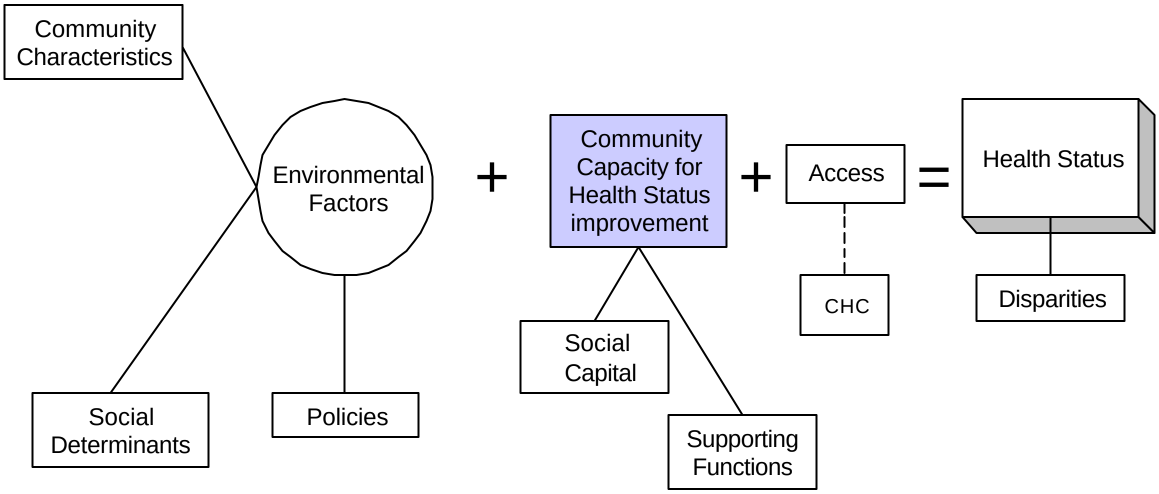
The purpose of this research project involving six (6) community health centers (in as many states), was to accomplish the following:

**Investigate** how Community/Migrant Health Center Boards of Directors contribute to a community's capacity for health improvement. Community capacity is defined as the combination of the community's social capital (networks, relationships, trust, feelings of influence) and the extent to which "functions" such as resource development, information exchange, training and technical assistance, exist so that a community's social capital can be applied.

**Determine** those elements that make a Board most effective at contributing to "community capacity for health improvement."

**Identify and develop** the best measures, and the best process for measuring, the elements that make Community/Migrant Health Center Board of Directors most effective at contributing to their community's capacity for health improvement.

**Community capacity for health improvement** requires both social capital and functions that support the " investment" of that capital in a community environment. Community capacity for health improvement is important to examine in the context of all factors that influence health status; therefore, the framework for the information collected in this project is as follows:



**Community and migrant health centers – governed by a majority consumer Board of Directors – contribute to community capacity for health improvement.**

This contribution advances the C/MHC mission of providing access to comprehensive primary and preventive health care and improving the health status of underserved and vulnerable populations.

## Findings

1. C/MHC Boards of Directors contribute to a community's capacity for health improvement in the following ways, in part by helping to mitigate the effects of poverty, lack of insurance and other access barriers in the community.

***Social Capital Contributions***

- Community health centers use the **networks and influence** of their Board members to enhance the resources and information available to the center. The informal and formal leadership provided by Board members helps to secure political and financial support for the community health center.
- **Trust** between Board members and between the Board and the Executive Director is critical for a functioning relationship. Achieving a high level of trust at the Board level is a value of many Board members.
- **Citizen involvement** on the Board of Directors helps promote broader community ownership for the needs of the underserved, and the value of the safety net providers that assure their access to services.

***Contributions to Community Functions that Support Health Status Improvement***

- Supporting functions essential to maintain and affect health improvement include resource development, information and resource exchange through intermediary support organizations, operating at multiple community sites, training and technical assistance, evaluation and monitoring, and leadership development. **Community/migrant health centers are often the source of these supportive functions for their community, which indirectly can be attributed to the decisions made by C/MHC Boards of Directors.**

2. The following elements help Boards and C/MHCs be most effective at contributing to community capacity for health improvement:

- **Strong Executive Director**
- **Longevity, diversity, adaptability, dependability and communication at the Board level**
- **Knowledge of financing, service delivery and health policy** of the national, state and local health system
- **Understanding and use data on health status and health disparities**

## Application

The findings from this limited but important study have several applications. We suggest these applications in the form of strategies that can support Boards of Directors of Community/Migrant Health Centers to make continued and enhanced contributions to their community's capacity for health improvement. These strategies can be supported by BPHC or Community/Migrant Health Centers.

***Strategies to Support Board Contributions to Community Capacity***

- Provide training and support for Board members to help them understand the basics of C/MHC operations.
- Develop modules, sessions or materials that can help Executive Directors to communicate with and educate Boards about health systems and health economics, and how current forces impact community/migrant health centers.
- Provide clear guidelines for affiliations and mergers to C/MHCs that would allow board members to determine the value of an affiliation.
- Provide training to Executive Directors and Boards of Directors to help Board members use their networks.

- Find ways at the Board level to acknowledge how the center and the Board are contributing to a community's capacity.
- Develop policy statements on the difference between consumer input and involvement for community/migrant health center Boards.
- Support and continue existing resources for training of C/MHC Board members.

***Strategies to help Boards Understand Health Disparities***

- Provide guidance to centers around the type and extent of health disparities data that need to be collected, and what these data mean for C/MHCs.
- Provide guidance and templates to help C/MHC staff report on health status and health disparities to Board members.
- Explore additional program funding that can support the communication and translation of disparities studies into actionable strategies for Community/Migrant Health Centers.

## Project Purpose and Rationale

### Purpose

The mission of Community and Migrant Health Centers (C/MHCs), as a program of the Bureau of Primary Health Care, is to provide access to comprehensive primary and preventive health care and to improve the health status of underserved and vulnerable populations. Community and migrant health centers are governed by a volunteer, and majority consumer, Board of Directors.

The purpose of this research project involving six (6) community health centers in as many states was to accomplish the following:

1. Investigate how Community/Migrant Health Center Boards of Directors contribute to a community's capacity for health improvement. Community capacity is defined as the combination of the community's social capital (networks, relationships, trust, feelings of influence) and the extent to which "functions" such as resource development, information exchange, training and technical assistance, exist so that a community's social capital can be applied.

2. Determine those elements that make a Board most effective at contributing to "community capacity for health improvement."

3. Identify and develop the best measures, and the best process for measuring, the elements that make Community/Migrant Health Center Board of Directors most effective at contributing to their community's capacity for health improvement.

Findings from this project are organized by purpose statement.

### Rationale

Community and Migrant Health Centers (C/MHCs) face challenging times. The Institute of Medicine report in January 2000 on "America's Health Care Safety Net: Intact but Endangered" indicates that the national growth in the number of uninsured, the erosion of subsidies that previously supported safety net providers, and the adverse effects of Medicaid managed care has put the viability of safety net providers at considerable risk. These changes increase the importance of any study or research that supports the role of community-based safety net providers in underserved communities.

The Bureau of Primary Health Care specifies program requirements and responsibilities that must be met for community and migrant health centers to stay operational. In addition to securing the expertise required to meet these requirements and navigate the current health care environment, C/MHC Boards of Directors are 51% patient or "consumer" majority.

**The Bureau of Primary Health Care Office of Data, Evaluation, Analysis and Research (ODEAR) was interested in advancing its knowledge of how the Boards of Directors of community health centers contribute to the health improvement mission espoused by all Community/Migrant Health Centers for underserved communities**. ODEAR has been exploring this connection for some time. Anne Dievler conducted a preliminary study in 1998, and suggested that the next phase of research on the Boards of

Directors of Community/Migrant Health Centers include the development of "case studies" that could provide information to trace the relationship between the Board's structure, process and outcome within the context of the community or state where the C/MHC is located -- specifically to see if the Board makes a difference in terms of outcomes or survival. Several of her method recommendations were incorporated in our approach in an attempt to answer these questions.

Ultimately, we believe that community health centers are effective if they contribute to improved health status, and decreased health disparities in communities. FBAs model for health status improvement –the ultimate mission of Community/Migrant Health Centers -- includes community capacity as a key feature (see Figure 1). In this context, and based on findings from our previous research, Felix, Burdine and Associates (FBA) suggested to ODEAR that it would be worthwhile to measure the unique contributions community/ migrant health centers make to the health improvement "capacity" of the communities they serve. Community capacity for health improvement is composed of *social capital* and the *supportive functions* in a community that allow for that capital to be applied.

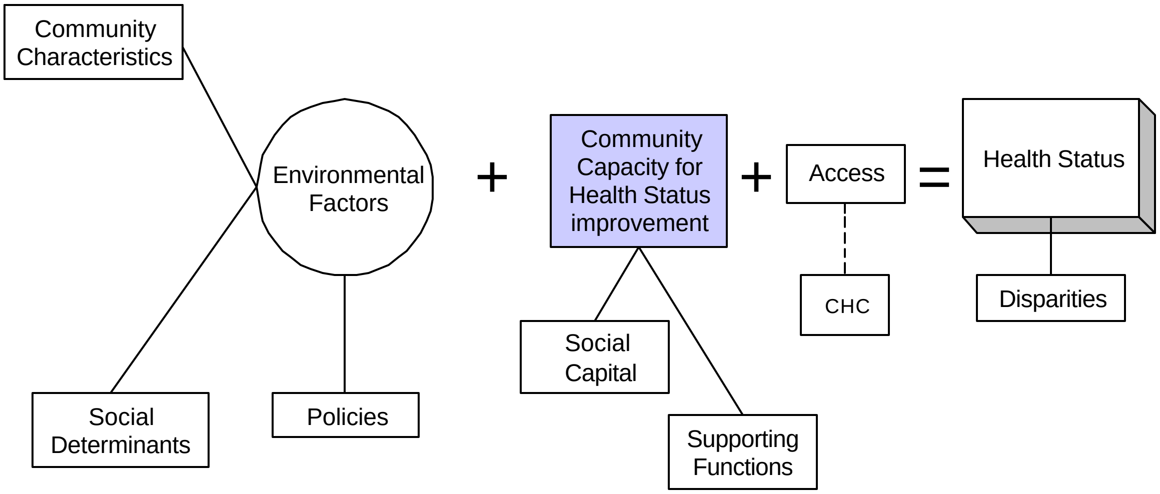


**Figure 1**

In the FBA model, environmental factors (the composition of the population, community characteristics, the general levels of poverty, and insurance coverage) and key policies that impact access or health are also important to understand the health status of a community. Community/Migrant Health Centers are a major factor in assuring access to primary and preventive health services in communities, and to the entire web of safety net services that might be available.

In this project, we explored how C/MHCs (and indirectly their Boards of Directors) play a role in contributing to community capacity for health improvement, such as through

- participation in local health partnerships
- leveraging Board members' networks to bolster the community health center
- the provision of training and technical assistance, acquiring resources, and
- operating at multiple sites or influencing health in multiple ways in the community.

We also attempted to determine if and how the community's social capital -- the trust, networks, perceived influence and involvement of the community -- might impact this capacity. To provide a context, we also attempted to understand the range of environmental forces at work in communities, and the key policies and politics at the national, state and local level that influence access in communities served by Community/Migrant Health Centers.

We talked directly with Boards of Directors to understand what they can do, what they have achieved and what they think their purpose is, in order to piece together each center's "access" story.  We learned that serving on a C/MHC Board of Directors is challenging in the current and complex health care environment.  We learned from the perspective of Board members that the extent of consumer representation on the Board, the strength of the Executive Director, and the relationship between the Executive Director and the Board, all impact the "effectiveness" of the Board.  Additionally, we learned that the longevity of Board members' service, and their leadership and involvement in other community activities and organizations contribute to the effectiveness of the C/MHC Board of Directors.

We also attempted to look at data on health disparities for the population served by the center, and asked questions to help us understand if and how Community/Migrant Health Centers and their Boards understand and apply data on health disparities.

## Note to the Reader

There were six Community/Migrant Health Centers that participated in this study. To preserve their identity, we randomly assigned each center a number between 1 and 6. These numbers are used throughout the report to refer to a particular center, but we will not reveal what center is associated with what number in this document.

## Purpose 1: Investigate how Community/Migrant Health Center Boards of Directors contribute to a community's capacity for health improvement

The model proposed as the framework for this study incorporates several elements in the "equation" for health status improvement. Community/Migrant Health Centers have a mission to improve health and health status in the communities they serve; therefore, we believe these elements are also important to consider in looking at the effectiveness of community health centers.

Community capacity for health status improvement is an element of FBAs model for health status improvement. We believe that this capacity represents in part the ability of a community to mitigate the effects of poverty and other determinants of poor health status. The measures for community capacity are in large part still being debated by public health and population health practitioners, however, we believe there are two items that define this capacity: *social capital, and the supportive functions that allow communities to use that capital for health improvement.* These elements and data collected in this project to measure them are described in this section.

### Social Capital

Research to date has theorized social capital to be constructed of one or more of the following concepts: trust, goodwill, cooperation, civic engagement, reciprocity, collective efficacy, social networks, obligations, and norms (Putnam 1995; Kawachi, Kennedy and Lochner 1997; Sampson, Raudenbush, and Earls 1997; Sirianni and Friedland 1995), or as a resource that represents community health (Cox 1995; Wall 1998). Social capital has also been described as existing in many forms, such as congregation-based community organizing, civic environmentalism, participatory school reform, and County Extension agents (Sirianni and Friedland 1995, 1998).

Research done by Kawachi and colleagues (1999) suggests that social capital relates to general feelings and beliefs which have to do with policy making that supports safety net providers and vulnerable populations. The extent to which this might also be true at a community level would be important in understanding how communities might allocate their resources to support safety net providers if and when federal and state support drops over time. In a general population context, FBA's preliminary research on the social capita-health link suggests that social capital measures and scales show a relationship to the aggregate measure of mental health functioning (as measured by the SF-12).

FBAs work and analysis to date has shown the concepts of **trust, networks of community members, perceived feeling of influence over the environment, and civic involvement** to be the most "reliable" indicators of social capital when these concepts are captured through surveys. **Formal and informal leadership** is also important.

***Qualitative Findings*.** Interviews with Board members and key staff at community health centers suggest that community/migrant health centers contribute to community capacity by fostering the key components of social capital in their communities:

*Civic involvement and participation*. Board members acknowledged that Community/Migrant Health Center Boards are a vehicle for people to be involved in community and political decision making processes -- both formally and informally. The perception that Board members hold about the "effectiveness" of the Board was related to the level of involvement by "consumers" in the Board, and difficulties in recruiting or involving Community/Migrant Health Center patients on the Board was most often mentioned as a reason why Boards were not maximally effective. Boards perceive themselves as most effective when there are no perceived class or racial differences among Board members, which may hinder full participation in Board discussions.

*Trust*. Trust between Board members and between the Board and the Executive Director is critical for a functioning relationship. Achieving a high level of trust at the Board level is a value of many Board members. One of the measures developed by FBA to gage trust in a community has to do with discriminatory treatment. Board members identified that "how people are treated" by the center's staff is one of the most important elements to look at if measuring "effectiveness." Compassion and respect in the treatment of others were important elements of effectiveness to Board members interviewed.

*Networks*. The connections, networks and involvement of Board members in other community organizations inform the Center and help the Executive Director make strategic decisions. One example provided was of a Board member that had knowledge of a local health plan that was not sound financially; the center was considering becoming part of this plan's provider network before this information was transmitted to the Executive Director. The networks of this Board member helped avoid a strategically poor decision. Other networks and relationships bring political, financial or community support and awareness to community/migrant health centers.

***Survey Findings*.** Community health centers draw their Boards of Directors from both the community served and a broader community, maybe even a geographic region. Measures of social capital however, have currently been developed and applied for community level application. Therefore, in addition to interviews of Board members to capture information related to social capital, surveys of Community/Migrant Health Center patients from a specific locale, or of community discussion group participants that were from a specific community served by a Community/Migrant Health Center were conducted to collect social capital measures. These were aggregated from each Community/Migrant Health Center "site" to serve as a measure of "community" social capital.

FBA has social capital data available from fourteen other communities where the data were collected in a similar method. These communities provide comparison data to the five community health centers that provided social capital data for this project. The "communities" in FBAs database range from frontier to urban, from all parts of the country.

Social capital measurement has evolved only to the point where testing and refinement of measures is occurring. The social capital "items" that were measured by the survey instrument used in this study are shown in Figure 2.

***Figure 2***

***Networks***

Feeling like an outsider in the community
Frequency of being treated badly because of race, gender or other factors

***Trust***

People being "out for themselves"
People afraid to go out after dark in their community

***Influence***

People working together
Perception that a small group of people has all the power
Feeling like there is nothing that a person can do to solve problems

***Civic Participation***

Voting in elections
Volunteering
Writing to or calling elected officials
Attending community meetings

***Scales Created from Social Capital Items***

**Social Integration= Networks, Trust and Influence**
**Civic Participation= Voting, Volunteering, Writing/Calling, Attending**

While the social capital survey instrument used in this study represents the state-of-the-art, our ability to assign meaning to the resulting data is limited. However, we believe there is value in a preliminary examination of the *distribution* of scores for social capital items and scales as the next step in understanding if, how, and to what extent community health center boards influence and/or are influenced by community social capital.

Table 1 displays the scores for seven social capital survey items and two scales, social integration (a combined measure of trust, networks and influence) and civic participation. The five CHC communities that provided social capital for data in this study are numbered 1-5 in red; these are the random number assigned to the centers for this study; center six did not supply social capital data for this study. The comparison sites from FBA's community database are identified by letter (a-n). The data are arrayed in rank order by location for each "community" where data were available for this project. The mean for an item or scale is identified with a dark rule in each column. The yellow regions in each column indicate communities with scores that fall above or below one standard deviation from the mean score for an item or scale.

Relevant findings from our analysis of these social capital survey data include the following:

- The extent to which "people work together" (which is a measure of influence) was rated high in four of the five communities from this study as compared to other communities. Several of the study communities were above the mean. This suggests that the very existence of a Community/Migrant Health Center may be a measure of the extent and effectiveness of people working together.
- The item which measures perceptions about "There is nothing I can do to solve problems in my community" also relates to the social capital concept of influence. This item has the highest mean of any item (3.96 on a 5-point scale), and because a higher score indicates disagreement with this statement, results suggest that in at least two of the study sites, people ***do*** feel they can help solve problems in their communities. Communities with Community/Migrant Health Centers -- evidence that they have done something to address a problem around access to health care -- scored lower than other communities on this item. There may be an increased awareness of problems in communities which have organized themselves well enough to secure funding for a Community/Migrant Health Center. The magnitude of the problems to be addressed in underserved communities may also be greater, and feelings about inability to solve problems may persist despite positive community efforts.

Based on both qualitative and quantitative data, we found that the Boards of Community/Migrant Health Centers contribute to social capital of the community in the following ways:

- Community health centers use the networks and influence of their Board members to enhance the resources and information available to the center. The informal and formal leadership provided by Board members helps to secure political and financial support for the community health center.
- Trust between Board members and between the Board and the Executive Director is critical for a functioning relationship. Achieving a high level of trust at the Board level is a value of many Board members.
- Citizen involvement on the Board of Directors helps promote broader community ownership for the needs of the underserved, and the value of the safety net providers that assure their access to services.

# Rank Order By Location (Site)

| Scale is 1-5 | | Scale is 1-5 | | Scale is 1-5 | | Scale is 1-5 | | Scale is 1-5 | | Scale is 1-5 | | Scale is 1-5 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| People Work Together | | People Out for Themselves | | Afraid to Go Out After Dark | | Small Group Has All the Power | | Fell Like Outsider in My Own Community | | Nothing I Can Do To Solve Problems | | Treated Badly | | SOC SCALE | | CIVIC SCALE | |
| ***2*** | ***3.6*** | n | 3.89 | d | 3.95 | n | 3.35 | n | 4.19 | n | 4.32 | g | 5.13 | n | 82.43 | k | 92.5 |
| ***5*** | ***3.23*** | ***1*** | ***3.81*** | a | 3.94 | m | 3.32 | k | 4.11 | k | 4.27 | n | 5.06 | d | 79.04 | d | 91.67 |
| l | 3.07 | d | 3.78 | e | 3.89 | f | 3.23 | ***3*** | ***4.07*** | h | 4.21 | d | 5.05 | e | 78.14 | e | 91.15 |
| ***3*** | ***2.87*** | k | 3.78 | ***3*** | ***3.89*** | ***4*** | ***3.11*** | d | 4.05 | f | 4.17 | e | 5.03 | j | 77.03 | j | 90.75 |
| ***4*** | ***2.85*** | e | 3.72 | g | 3.89 | d | 3.05 | m | 4.03 | d | 4.17 | j | 4.99 | f | 76.17 | h | 89.64 |
| a | 2.82 | j | 3.72 | f | 3.83 | e | 3.02 | f | 4.01 | e | 4.15 | ***3*** | ***4.87*** | k | 75.69 | ***3*** | ***88.97*** |
| b | 2.82 | h | 3.72 | n | 3.81 | k | 2.98 | a | 4.01 | ***3*** | ***4.11*** | m | 4.19 | g | 75.58 | f | 88.59 |
| c | 2.74 | i | 3.71 | j | 3.75 | h | 2.97 | b | 4 | j | 4.1 | k | 4.17 | ***3*** | ***75.14*** | n | 88.39 |
| d | 2.66 | m | 3.68 | h | 3.7 | j | 2.87 | ***1*** | ***3.94*** | c | 4.06 | f | 4.13 | m | 74.17 | b | 87.92 |
| e | 2.5 | f | 3.67 | ***1*** | ***3.66*** | ***5*** | ***2.86*** | c | 3.92 | ***1*** | ***4.01*** | ***2*** | ***4.08*** | ***1*** | ***73.83*** | l | 87.03 |
| f | 2.49 | ***3*** | ***3.55*** | b | 3.47 | c | 2.84 | e | 3.92 | a | 3.97 | a | 4.03 | h | 73.76 | g | 86.98 |
| g | 2.44 | a | 3.53 | ***4*** | ***3.41*** | ***3*** | ***2.83*** | j | 3.9 | b | 3.95 | ***1*** | ***4.02*** | a | 72.34 | a | 86.78 |
| h | 2.44 | c | 3.52 | ***2*** | ***3.19*** | g | 2.81 | ***4*** | ***3.9*** | m | 3.88 | i | 3.9 | ***4*** | ***70.33*** | m | 86.73 |
| i | 2.44 | g | 3.5 | k | 3.32 | ***2*** | ***2.80*** | h | 3.83 | g | 3.87 | ***4*** | ***3.89*** | ***2*** | ***70.32*** | c | 86.4 |
| ***1*** | ***2.33*** | ***2*** | ***3.43*** | i | 3.25 | ***1*** | ***2.68*** | g | 3.72 | ***4*** | ***3.83*** | ***5*** | ***3.88*** | b | 67.97 | ***1*** | ***86.29*** |
| j | 2.31 | b | 3.39 | ***5*** | ***3.22*** | b | 2.67 | ***2*** | ***3.69*** | l | 3.68 | h | 3.83 | c | 67.86 | i | 83.75 |
| k | 2.18 | l | 3.35 | c | 3.18 | a | 2.66 | l | 3.57 | i | 3.52 | l | 3.79 | i | 67.44 | ***4*** | ***75.58*** |
| m | 2.17 | ***4*** | ***3.33*** | m | 3.03 | i | 2.51 | i | 3.48 | ***2*** | ***3.52*** | b | 3.08 | l | 65.89 | ***2*** | ***72.96*** |
| n | 1.85 | ***5*** | ***3*** | l | 2.69 | l | 2.46 | ***5*** | ***3.44*** | ***5*** | ***3.45*** | c | 3.05 | ***5*** | ***65.05*** | ***5*** | ***65.1*** |
| **Mean** | **2.62** | **Mean** | **3.58** | **Mean** | **3.53** | **Mean** | **2.90** | **Mean** | **3.88** | **Mean** | **3.96** | **Mean** | **4.22** | **Mean** | **73.06** | **Mean** | **85.64** |
| ***SD*** | ***0.411*** | ***SD*** | ***0.217*** | ***SD*** | ***0.367*** | ***SD*** | ***0.249*** | ***SD*** | ***0.211*** | ***SD*** | ***0.261*** | ***SD*** | ***0.638*** | ***SD*** | ***4.774*** | ***SD*** | ***7.004*** |
| **+** | 3.03 | **+** | 3.80 | **+** | 3.90 | **+** | 3.14 | **+** | 4.09 | **+** | 4.22 | **+** | 4.86 | **+** | 77.84 | **+** | 92.65 |
| **-** | 2.21 | **-** | 3.37 | **-** | 3.16 | **-** | 2.65 | **-** | 3.67 | **-** | 3.70 | **-** | 3.58 | **-** | 68.29 | **-** | 78.64 |

The two "scale scores" which are a summary of the measures in the survey are based on a 100-point scale, with 100 being the relative "best." The overall scale for social integration shows that only one study site is below one standard deviation from the mean. The other four study site scores are closely clustered around the mean. The most significant observation we can make from these data is the central tendency of the study sites. The scale for civic participation, also based on a 100-point range, finds three of the five sites more than one standard deviation below the mean. The mean (86.6) and standard deviation (7.0) suggests that this is a very tight distribution.

These results cannot be meaningfully interpreted at this time. More information about social capital in the communities served by Community and Migrant Health Centers as well as communities without centers is necessary.

## Supportive Functions

Chavis, Florin and Felix (1993) identified the following supportive functions as essential to communities and coalitions that seek to maintain and affect health improvement: resource development, information and resource exchange through intermediary support organizations, operating at multiple community sites, training and technical assistance, evaluation and monitoring, and leadership development.

We were able to determine that Community/Migrant Health Centers are often the source of several of these supportive functions for their community. Examples are provided in this section.

***Resource development*****.** C/MHCs are the source of federal dollars for their community. Centers often provide oversight and management of state grants, such as from the state health department for women's cancer detection programs, outreach and enrollment and other services. C/MHCs write grants not only to maintain their operations but to explore new ideas with community partners. Centers participating in this study provided several examples of resource development for their communities:

- Center 1's Executive Director is on the Board of a local grant writing center.
- Center 2 has worked with county governments and local businesses to secure physical plant needs and infrastructure to expand community health center operations into communities of need.
- Center 3's Board of Directors has used Advisory Committees. This has allowed local bankers and business people to observe the center and several charitable contributions have followed because these advisory members understand the value and impact of the center's services.

Interestingly, the obligation of the Board to raise funds – a feature of other not-for-profit Boards – was not mentioned as a strategy for resource development on the part of community and migrant health center Board members, but two centers have placed this on the table as a role for their Boards.

***Information and resource exchange*****.** An access barrier in each of the communities served by the migrant/community health centers involved in this project is the lack of awareness and information about what services are available, for whom, at what times, in what locations in the community. C/MHCs often provide case management services that help individuals combat this lack of information, or they serve as a location or agency that provides this information for the community through information and referral. At the Board level, members are often involved in other community organizations and Boards of Directors and bring information about upcoming programs, opportunities for partnership and the need for services to the C/MHC, which improves information exchange in the community.

***Training and technical assistance.*** C/MHCs serve as the location for training of health professionals and as a source of technical assistance to their communities. For example, centers 1 and 4 serve as training sites for nurses and physicians, respectively. Center 6 has a collaborative agreement with a university for the training of mid-level providers in rural areas. Through coordination from state primary care associations, centers within a state may have help to train each other in financial and management techniques. HRSA has acknowledged the need for cultural competency and awareness in the administration of programs and in the recruitment of providers and staff who serve the underserved. Many bilingual support staff and health care providers receiving their training at C/MHCs and either continue at the centers and train others, or move to other community organizations where those skills are put to use serving a diverse public.

***Leadership development.*** In our observation of communities served by C/MCHs participating in this project, typically, community leaders are present on community health center Boards. Almost all Board members interviewed have some experience or history with being a volunteer, community leader or the Board member at another community organization or institution. Therefore, leadership might be sustained, more than developed. The common and stand out quality among these formal and informal leaders is their willingness to go beyond what is asked to assure that services are available for a community.

***Operating at multiple community sites.*** Many community health centers are becoming multi-site operations. Center 2 for example has expanded at the rate of almost one center per year since its founding, and has even co-located with public health and community mental health services. Center 6 is also a multi site system. Even in communities where centers have only one service delivery site, centers “operate” at multiple sites, through, for example, outreach and enrollment programs, partnerships with WIC and other Maternal and Child Health programs, and outreach to senior centers.

In this study, we did not comprehensively determine the extent to which these supportive functions exist at the community level. A future area of study would be to develop a methodology that would allow an assessment of the extent and quality of those functions as a better indicator of the community’s capacity for health improvement.

## Purpose 2: Determine those elements that make a Board most effective at contributing to "community capacity for health improvement"

### Elements that Influence C/MHC Contributions to Community Capacity

One of the most valuable lessons learned from our work and in this project is that the environment, policies and politics of the communities served by Community/Migrant Health Centers must be fully understood to assess any center's ability to contribute to its community's capacity for health improvement. The most significant policies and conditions in the environment from the perspective Board members and C/MHC leadership are described in this section.

This study purposefully included Community/Migrant Health Centers at all "stages" of development: well-established centers, those who are growing, as well as "start-ups." An interesting result of including this range of centers is finding few supports or information that can help Boards and Executive Directors to acknowledge these stages of development and transition, what pressing issues or challenges should be expected at each stage, and how the Board and Executive Director's roles will shift and change at each stage. Centers that inherently acknowledged and adapted to changes and growth over time often indicated that they felt they were "effective" centers.

A resounding theme from Community/Migrant Health Center Boards and Executive Directors is that the basic infrastructure of their community's safety net system is at risk. In much the same way that "populations" are described as vulnerable or "at risk," the funding streams, political support and subsequent financial viability of community health centers and safety net providers can be described as "at risk" in the current environment. Centers are involved in addressing these risks at the local level. For example, two centers involved in this project are actually lead organizations in local coalitions that have recently been organized specifically to place attention on safety net providers and what they need to remain viable.

Several other external factors are generally recognized by Boards and Executive Directors of Community/Migrant Health Centers as crucial to their ability to contribute to community health status improvement.

***History***. The reason that a community/migrant health center *began* -- the politics and background of the individuals and groups involved in its start-up; the population initially served by the center (e.g., migrant farm workers, poor African American persons, the entire community); and its initial approach to payment ("a free clinic" or "pay on a sliding fee scale") -- influences the perception of Community/Migrant Health Centers in their communities. Even for those centers that are over 25 years old, which have made substantial changes over time in their practices and delivery of care, are described by community members and Board members in light of its origins. Very few centers have been able to outrun a history that includes financial mismanagement, and community or racial politics. Similarly, if centers began as a free clinic, the transition to a sliding fee scale is not always easy, and is a continual process of community and patient education about the center's mission and purpose. Community/Migrant Health Centers are effective when Board members can serve as "historians" for factual purposes. Board members in this role are also effective when they serve as the reporters of change, or when they participate in changes at the center over time. Board members interviewed during this project often described the center's growth in "phases," and shared many scenarios where centers rebounded, particularly from financial trouble. Growth and survival through these phases were included in Board members' perspective of an "effective" center.

***Growth and demographic trends.*** The United States population will continue to collectively age as the baby boomer generation reaches retirement age. The resources required to meet the health needs of a generally older population has not been projected or planned for in most communities, particularly in rural or frontier communities that lack the basic infrastructure required for health services. A trend emerging in communities across the country is the closure of physician practices to new Medicare insured patients. As this trend continues, Community/Migrant Health Centers will continue to be a source of care for persons who become eligible for Medicare. The relatively more complex and costly services required by an older population, and the lack of preparedness for the continuum of service needs of an aging population will in part determine the viability of Community/Migrant Health Centers.

A second demographic trend that is almost universal is the increasing diversity of the United States population's race and ethnicity. Diverse populations have different service demands, such as mental health treatment for abuse or trauma. Additionally, immigrant populations may have different values about "preventive" services such as immunization and dental care. Community/Migrant Health Centers strive to establish the full complement of enabling or supportive services – such as translation, transportation and child care – that help immigrants and other diverse groups to more easily access care.

***Poverty, employment, and health insurance.*** The industrial and manufacturing bases of most communities are giving way to a service-based economy. Jobs are readily available, however, most typically, these jobs pay minimum wages. Health insurance benefits typically do not accompany these positions, and if health insurance can be purchased through the employer, many employees may not choose to do so. Welfare reform has increased the number of people who are working but uninsured, and with incomes that are too low to afford the purchase of insurance. Despite the expansions in state Medicaid programs, and the implementation of the state children's health insurance program (SCHIP), these changes have often resulted in an increased number of people using C/MHCs who are uninsured, and paying on a sliding fee scale.

***Lack of a public or private transportation infrastructure.*** Lack of affordable, available or convenient public transportation is most often mentioned as the primary barrier to accessing services in communities – both those participating in this study as well as in our experience across the country. The public and private infrastructure available in communities to help transport people to services, and the extent to which these programs work together, have a direct impact on access to care. Many Community/Migrant Health Centers, particularly those serving rural areas, have implemented systems for van pick up and delivery in order to help patients to keep their medical appointments. Health services and other programs are often more expensive in underserved communities, because of the resources that must be devoted to transportation in order to connect clients with services. Community/Migrant Health Centers continue to supply this supportive service to the best of their capacity despite financial pressures and lack of public support for transportation.

***Lack of centralized, accessible, accurate information on what services are available from which agency, at what cost, and for what population.*** Most communities cite that the greatest barrier to accessing services is the lack of knowledge and awareness -- on the part of both consumers and providers -- of the range of safety net services available in a community and how to access these services. Often, there is no centralized place or system for making referrals to the range of health and human services in a community. There are often several directories or automated phone systems, coordinated by different agencies, but they are not up to date, or cannot provide specifics on the extent to which an agency may be at capacity or not accepting referrals. Collaboration and relationships are the current strategy for overcoming this lack of information.

***Extent of commercial managed care penetration.*** Other providers, including hospitals, in a community are affected by the extent of commercial managed care contracts in the local marketplace. As the proportion of discounted contracts or payments to health service providers increase, these providers are less likely to offer services to, or accept referrals to treat uninsured persons. This has been documented in the literature, and was also shared anecdotally as part of this study.

***Medicaid managed care and the benefits covered by the Medicaid program in a state.*** In states where Medicaid managed care has been implemented, C/MHCs typically lose revenue and Medicaid insured patients to the private sector. The generosity of coverage through these plans; the timeliness of their payment; and inclusion of essential primary care providers as part of health plan networks all financially impacts Community/Migrant Health Centers. In several states, primary care associations have been a vehicle for C/MHCs to offer a Medicaid managed care product that keeps the C/MHC as a primary care provider for their patients. Participation in and acceptance of these C/MHC driven managed care plans by hospitals and other providers – and thus the ability to “complete the network” in a community – is a critical and challenging aspect of assuring access for Medicaid insured persons.

Medicaid managed care implementation has influenced the financial standing of many Community/Migrant Health Centers, and often becomes the topic of Board discussion. However, Board members may lack the policy details and knowledge of the health care system required to provide guidance on this matter. Navigating through Medicaid managed care has largely been the domain of Executive Directors. Board members are typically not involved in negotiations or discussions at the state level around Medicaid managed care or reimbursement for the center; however, the state primary care associations that advocate for Community/Migrant Health Centers may reach out to Board members to build support for legislative or policy changes that support centers.

***Affiliations and relationships with hospitals and perception of C/MHC staff by the local medical community.*** Accepting and open relationships with local, private medical providers -- whether community or hospital based -- have been a long-standing tenet and priority for C/MHCs. An affiliation with a tertiary care center appears to have a positive relationship to the effectiveness of Community/Migrant Health Centers. These affiliations allow centers to assure access to specialty care services and hospital care for their uninsured patients, which is often the biggest barrier for the population served by C/MHCs. Board members from centers with a strong hospital relationship perceive their center to be more effective than Board members from centers without this policy or support in place.

We also learned in this study that the perception of the C/MHC medical staff in the community is important to effectiveness. At several centers, the Medical Director is an established and respected expert in their field and can offer competencies not currently "on staff" from the local provider base. For example, on Medical Director from a study site is an infectious disease expert, another is trained in drug testing and evaluation. This respect allows the center to develop and build relationships with the local medical community and hospitals that are essential for their survival. Boards indicated that regular reports from the Medical Director and involvement in clinical committees help Board members to understand how the center is meeting the medical and health needs of the population served.

The impact of the 1997 Balanced Budget Amendment, pending HIPAA implementation, and recovery from Y2K have strained resources at the local hospitals - public and private – that admit C/MHC patients. As resources become increasingly strained, these safety net providers will continue to evaluate their capacity to provide services for the low income and uninsured of the community and implement strategies to address the bottom line. Positive relationships between the center's medical and administrative leadership and other medical providers in the community help establish a solid basis for discussion of options into the future.

## Elements that Help Boards of Directors to Contribute to the Community's Capacity for Health Improvement

A GAO report released in March 2000 titled "Community Health Centers: Adapting to Changing Health Care Environment Key to Continued Success" (GAO/HEHS –00-39) indicates that the Balanced Budget Amendment, Y2K and now HIPAA compliance requirements, as well as other funding changes at the state level are seriously undermining the ability of ***other*** community safety net providers, such as hospitals, to continue providing care to a growing uninsured and underserved population. This same report suggested that C/MHCs that respond to market changes by participating in managed care and forming alliances are more likely to succeed. Typically "their management teams demonstrate strong business skills and a dedication to the health center's mission of providing services to vulnerable populations. Their boards take an active role in overseeing (from a policy perspective) the center."

We found similar strengths and success "elements" in the centers that participated in this project. Interviews with Community/Migrant Health Center Board members and Executive Directors, as well as with key staff in some cases, serve as the information base for identifying these elements, which are described in this section. (*Note: these are in no particular order)*

***Strong Executive Director.*** Board members of community/migrant health centers acknowledged that they are volunteers with a large amount of responsibility. Universally, Board members cited that a "strong" Executive Director, that shares all information and decisions and also participates in the Board decision making process, is essential for effectiveness. Several community/migrant health centers shared that their Executive Directors had found the perfect balance between helping to lead but not control the Board. For example, many Executive Directors help to set and organize Board committee meetings, and are the primary source of detailed information that Boards need to make decisions. This type of involvement is welcomed by Boards.

As a variation on this theme, we observed to be a more formal model for Board/Executive Director interaction. At these centers, Board meetings are longer and more intensive, with extensive discussion and deliberation. The executive director may do some work with Board members to present ideas or identify critical issues, but the Board meeting is the forum for discussion. Committees of the Board meet on their own and have their own agenda, but may involve the Executive Director. The executive director is viewed more as a staff person that supports the Board process, and a strong Board chairperson, often with many years of experience is at the helm.

In more informal approaches, the executive director spends time individually working with and presenting ideas to Board members before the Board meeting, so the meetings become largely a forum where policies are approved. The relationships and connections that make a Board "effective" work outside of the formal Board processes.

In any relationship, clear, and honest and frequent communication between Board members and the Executive Director is an indicator of effectiveness to the Board members interviewed. Organizations arrive at this level of communication in different ways: time "alone" between the Executive Director and the Board; and social events that bring people together on a personal level were some of the ways mentioned by Boards.

***Longevity, diversity, adaptability, dependability and communication at the Board level.*** Several characteristics were identified frequently by Board members as critical to an effective Board and organization. The most important may be the longevity of Board membership, which helps preserve the knowledge of regulations and requirements that C/MHC Board members acquire over time. This skill and knowledge base is crucial to maintain over time for Boards to be effective. Board members also acknowledged that diversity in the Board composition was important. Economic and "professional" diversity – in terms of the incomes, professions, or background of Board members -- was the most frequently perceived characteristic of diversity. "Political" and geographic diversity were mentioned as characteristics of effective Boards as well.

Boards of Directors that reflect and operationalize in their process those elements of social capital important at the community level -- trust, use of networks, and their influence in the community to support the center -- feel that they are being effective. Hatch and Eng (1984) assert that assessing the communication between neighborhood health center representatives and their community is of great importance to understanding the effectiveness of a health center. Several Board members interviewed –at both multi site centers where their role is to be a contact for a specific community, and in single site centers -- acknowledge that their role is to serve as a repository for community members comments and feedback on the services offered by the center, and that their role is to bring this feedback to the organization.

Board members also shared that the following are indicative of an effective Board:

- Board members preserve the confidentiality of decisions.
- Board meetings have a quorum.
- Board members have questions at Board meetings.
- The Board has active committees that meet on their own, and use advisory committees to expand the community input and involvement at the center. (Note: creating community advisory Boards as an incubator for Board familiarity and

participation has worked well for current Board members and Executive Directors who have the responsibility of recruiting and orienting new Board members once identified.)

- Board members are knowledgeable about programs and providers of the center.

***Knowledge of financing, service delivery and health policy drivers of the national, state and local health system.*** Boards of Directors which have members who understand the complexities and implications of health system change are an ingredient to effective Boards. For example, these members help the Executive Director to communicate the impact of future demographic, economic or policy changes (such as in Medicaid reimbursement, or other changes in policy made by other community health service providers, such as closing practices to Medicare patients) to other Board members.

***The ability of center leadership and the Board to understand and use data and on health status and health disparities.*** The ability to analyze, interpret and translate the meaning of health status data and health disparities data is critical. This skill needs to be developed within the leadership infrastructure of the Community/Migrant Health Center, so it can be shared with the Board of Directors. We observed many reasons for the importance of this element of effectiveness:

- Disease specific initiatives, such as the BPHC Diabetes Collaborative, and other process improvement initiatives such as Primary Care Effectiveness Review (PCER) and JCAHO accreditation, require collection and application of data by Community/Migrant Health Centers.

- The national initiative to eliminate disparities in health, announced in 1998, built on the work initiated by the Healthy People 2000/2010 effort to systematically decrease disparities in health status, particularly among racial and ethnic minority populations as compared with the overall population. This initiative specifically targeted the following chronic conditions and health issues for disparity reduction:
  - Cancer – and addressing cancer screening and management among minority populations
  - Infant mortality
  - Cardiovascular disease
  - Diabetes
  - HIV/AIDS
  - Immunizations, among both children and the elderly

Important research by the Bureau of Primary Health Care has demonstrated how community health centers are successfully addressing these disparities through their services to underserved and minority populations, particularly in cancer screening for women (Regan, Lefkowitz and Gaston, 1999). However, an important article published in the American Journal of Public Health in 1996 by Andres et. al., describes the rationale for Community/Migrant Health Centers to understand disparities relative to a broader population. This study found a higher incidence of breast cancer in the counties surrounding the immediate area served by the community health center, due to a higher rate of detection at early stages, but no differences in the detection of advanced stage breast cancer between the immediate area served by the center and the surrounding counties. The authors concluded that there was an under-detection of early stage breast cancer among the women in the immediate area served by the community health center.

The larger lesson is that single and simple indicators of health status on a patient population do not give community health centers the entire picture of the task that lies before them in eliminating disparities. Population-based data, as well as patient specific data must be looked at together to understand the health status of a population. In our observation from this project, the need for this comparative data, and the lack of uniformly available health disparities data to community/migrant health centers is a missing piece of the "effectiveness" puzzle.

## Purpose 3: Identify and develop the best measures, and the best process for measuring, the elements that make Community/Migrant Health Center Board of Directors most effective at contributing to their community's capacity for health improvement

FBAs approach to this project is shown in Figure 2.

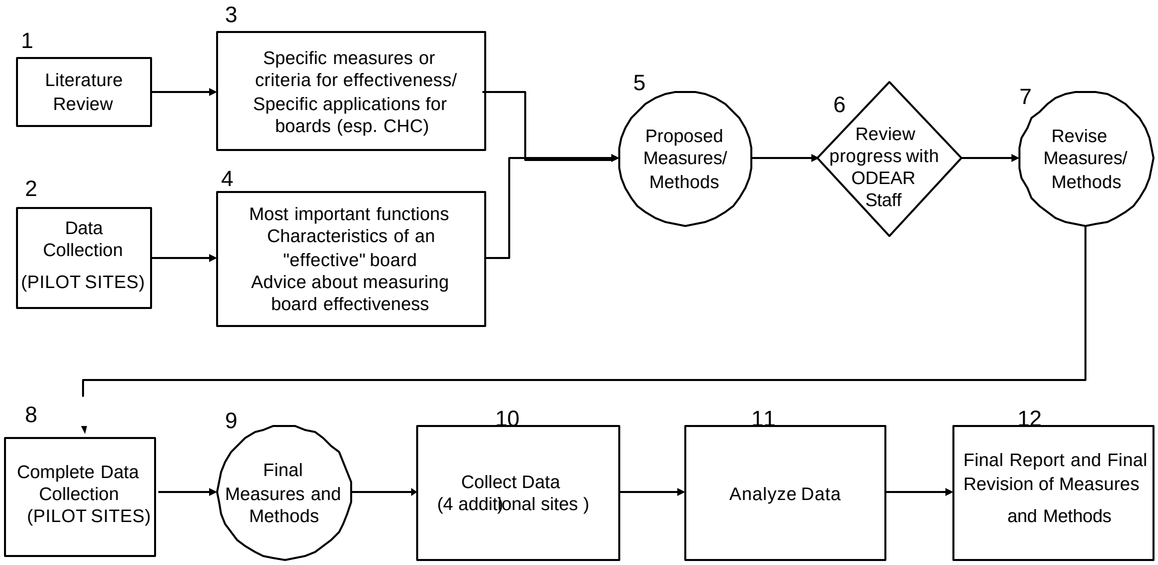


**Figure 2**

There are several strengths to the design and our approach to this project:

- The process accommodates both qualitative and quantitative data collection, and puts both in the context of current relationships, politics, local economies and health care markets.
- The process for collecting information and working collaboratively with the centers involved in this project is ideally suited for identifying technical assistance needs.
- The process puts attention on the need for baseline measures of policy, community capacity and health status.

Each element of the approach is described in this section.

## 1. Review literature

We reviewed literature on measuring the effectiveness of nonprofit Boards of Directors, as well as previous studies and research conducted specifically on C/MHCs by the Bureau of Primary Health Care, and the General Accounting Office. Literature on other concepts important to this project, such as population health, primary care, the safety net, and social capital were also reviewed. [A bibliography is included with this report.]

FBA also examined monitoring and evaluation strategies that incorporate a review of Community/Migrant Health Center governance. We sought to understand where an assessment of Board "effectiveness" fit with these current efforts. The Primary Care Effectiveness Review (PCER) and Joint Commission (JCAHO) accreditation are two major strategies that review governance of community/migrant health centers for compliance with regulations and standards; however, these approaches do not investigate the "effectiveness" of center operations.

## 3, 4, 5. Develop data collection protocol and measures

The data collection protocol for this project included the following elements:

***Interviews*** with the Board Chair as well as other Board members. The Executive Director and other center staff who may have a reporting relationship to the Board of Directors (e.g., Clinical Director, Medical Director, Finance Officer or Personnel Director) were also interviewed. A list of the questions used to facilitate these interviews are included in the Attachments.

***Community discussions*** designed to gather information on the community, and where the health center "fits" in the local health care marketplace. The agenda for the community meetings was as follows:

- How would you describe or define this/your community?
- What are the local issues/challenges, especially around health
- What resources exist to meet health issues and challenges?
- What is the local history of collaboration around health and what are the current efforts to improve health?
- What advice would you have for how access could be improved or disparities addressed in this community?

***Collection of social capital data*** on measures determined to potentially be related to health: trust, influence, networks and civic involvement. Social capital data were collected from persons who live in the "community" where the Community/Migrant Health Center is located. A copy of the survey questionnaire is included in the Attachments.

***Review and analysis of health existing data*** from the community/migrant health center "needs assessment" to capture the number of patients served, scope of services, center history, Board composition, and health issues and disparities in the community or population.

## 6, 7. Review project, purpose and measures

FBA discussed this project, its purpose, and value with colleagues at several Health Resources and Services Administration (HRSA) Regional Field Offices, as well as with leadership of several state primary care associations. We acknowledge and thank those colleagues for their guidance in this project. Centers 1 and 2 served as the "pilot" sites for the project, and data collection results from these centers were reviewed with ODEAR staff in April 2000 before data were collected from the remaining four sites. There were no substantive changes in data collection *elements* between the pilot sites and remaining four sites. The variation in data collection *protocol* at each site was a reflection of local characteristics, suggestions and needs.

## 2, 8, 10. Recruit sites to participate in the project and collect data

***Recruitment of sites***. Felix, Burdine and Associates used its working relationships with centers from past HRSA, BPHC and State Primary Care Association projects as the basis for recruiting community/migrant health centers to participate in this project.

The centers that agreed to participate represent both new/start-up centers, as well as established centers; 330 funded and "look alike" centers; migrant as well as non-migrant centers; centers serving both urban and rural communities; centers from states with different degrees of Medicaid managed care. All centers serve a diverse population, which includes African American and Hispanic persons.

Centers were recruited in a two-step process. First, the Executive Director was sent a letter describing the project and its requirements, as well as intended outcomes. Second, Felix, Burdine and Associates contacted each Director in follow up to this letter, to answer questions and clarify the outcomes and benefits of participation. Agreement to participate in the project was usually reached during that call.

The following centers participated in this project:

- *Delmarva Rural Ministries*: a 330 funded, migrant health center that also recently established a center for the uninsured in Central Delaware as part of a community partnership activity. South American farm workers at camps are the primary patient population served. Established in 1974.
- *Hardeman County Community Health Center*: a 330 funded single site community health center that serves Hardeman County in eastern Tennessee, which is 40% African American. Established in 1992.
- *InterCare Community Health Network*: a 330 funded, seven-site, migrant and community health center serving several diverse communities along the western coast of Michigan. Established in 1972.
- *La Clinica Esperanza*: a 330 funded, JCAHO accredited, two-site community health center serving a 13 county region, which is 35% Hispanic. Established in 1994.
- *Norwalk Community Health Center:* a federally qualified, look-alike health center, staffed by a local hospital residency program, serving a diverse city population. Board established in 1994, services initiated in 1998.
- *White River Rural Health Center:* a 330 funded, JCAHO accredited, eleven- site community health center which serves a diverse Delta community that is approximately 35-40% African American. Established in 1986.

Interestingly, and "unanimously," a condition of participation requested by both Board members and Executive Directors was for their information to be kept confidential and "blinded" -- not identified specifically with their center. FBA agreed to this condition and shared this request with ODEAR staff in an April 2000 project meeting. Centers participating in this project have been assigned a “center” number; from this point on, information or findings about a center will be described as “Center 1, for example, ...”

Several Executive Directors presented this project to their Board of Directors *before* data collection progressed.

- Center 2 invited FBA to a Board meeting where the study was described, FBA was introduced and the desire to contact and interview Board members were presented. The Board accepted, and FBA was then familiar to Board members when telephone calls for interviews were scheduled after the meeting.
- Center 3 asked FBA to present the idea to the Board’s Executive Committee and answer questions prior to contacting other Board members.
- Centers 1, 5 and 6 presented a description of the study and obtained permission from the Board at a regular Board meeting before FBA proceeded with the study.

***Data Collection***. The following data collection methods were used in the project.
*Interviews*. The Executive Directors at each center provided guidance and suggestions for which Board members and key staff should be interviewed. At Centers 1 and 2, almost all current Board members were interviewed. The Executive Directors at Centers 3 and 4 suggested interviews of the Executive Committee and two or three other key Board members. Center 5 and Center 6 suggested interviews of a selection of key board members, including the Board Chair. At Centers 1, 2 and 4, the Executive Director, key staff, and Board Chair were interviewed in person by FBA, as part of a special day of meetings arranged for this study’s purpose by the Executive Director. At Centers 3, 5 and 6, all Board members participating in the study were interviewed by phone.

*Community Discussions.* FBA incorporates this qualitative data collection method in each of our assessment and research projects. FBA had worked with Centers 1, 3, 4, and 5 within the previous 24 months on BPHC-related projects that incorporated the use of community discussion groups with a cross section of community leaders, health and human service providers and consumers. Adequate community discussion group data for use in this research from these centers was obtained by reviewing notes from those community discussions. Center 2 organized one (1) community discussion group with residents from one county specifically for this project. Due to time constraints, Site 6 was unable to organize a community discussion by the project deadline.

*Social Capital Data.* As with the community discussion data, FBA had collected social capital data from community discussion group participants from Centers 1, 3 and 4 at the time of the community discussions. Centers 2 and 5 both collected social capital survey data specifically for this project from a sample of 50 patients within one county of the center’s service area. Center 2 also collected these data from participants in a community discussion group. Due to time constraints, and the multi-site nature of the community health center, social capital data were not collected for Center 6.

*Review of existing data on health and health status.* At each center, the latest community health center grant submission was reviewed, specifically the needs assessment portion. This write-up often contains the center’s best and most recent data on critical indicators of health status, access and disparities. For Centers 1, 3, 4 and 5, FBA had acquired additional background data as part of previous and separate projects focused on improving access and addressing health disparities.

## What are the best methods and measures?

This project was successful in obtaining participation from centers because the project was first proposed, discussed and clarified with the Executive Director. As in this project, we would recommend that the first step is a letter of explanation and request to Executive Director. A second step of obtaining the approval of the Board, either through a memo or at a Board meeting also helps the process to go smoothly. The letter that introduces the study or project to the Executive Director should request time at a Board meeting, for the researchers to physically be present to explain the project and answer Board members' questions.

The time available on the part of Executive Directors and Board members is very limited for this kind of "un-reimbursed" project and activity. We acknowledge this and recommend that at least two months are allowed between the date of the initial letter and when final agreement to participate must be provided by the center. Similarly, once agreed, at least one month must be allowed for centers to arrange for interviews or meetings if they are part of the data collection -- a shorter time frame will not work, creates pressure, and does not optimize participation. We estimate that Executive Directors spent 3-5 hours on arranging the community meeting(s) and interviews with Board members and staff as part of this project. Additionally, if FBA visited the center to conduct these interviews, an additional day was devoted to the project. Therefore, the timing of this project is important to consider. Grant writing and development, timing of Board meetings or Board retreats, and ability of the Executive Director and other key staff to devote time to interviews and organizing meetings based on what is happening in the community and within the center often drives if or how centers can be involved in this type of project.

Key to the success of this project was that participation was voluntary. There were several centers approached for this project who declined participation for many reasons; however, there are no "punitive" or negative impacts on centers who declined to participate. We believe that the potentially more positive reflection of Board functioning and effectiveness that come from voluntary participation far outweighs the more sterile findings that might come from a "mandatory" sampling of centers. We recommend that this feature be preserved in future applications of this approach. Flexibility within the data collection protocol was a second key to involving community health centers in this project. Allowing executive Directors or Board members to choose when data are collected or interviews conducted, and to incorporate their suggestions in the process – which may lead to variation – was the key to getting buy in from the centers. Assuring confidentiality and respect for the information shared about the center was another important feature of the project that secured buy in and participation.

We determined that the following data collection protocol would provide optimal feedback in future applications of this approach:

***Organize at least three community discussion groups*** –one each with leaders, consumers and health and human service providers – to gather information on the community system at large and the center's role in that system from the community perspective. Compensate the center for the expenses associated with arranging the community meetings.

***Conduct an interview with the Board Chair, and an interview with the Executive Director in person.*** The following questions yielded the most valuable and useful information for this project:

| Questions for Board Chair | Questions for Executive Director |
|---|---|
| What is the history of the community health center? How and why did it begin?<br>What is the "community" served by the center?<br>What are the center's relationships with other service providers in the community?<br>What is the Board's philosophy in working with the Executive Director?<br>What is the most important thing the Board does?<br>What advice would you give to us about how to look at the effectiveness of a community/migrant health center Board of Directors?<br>What is the center's greatest challenge? | What is your background, history/experience?<br>Who does the center serve?<br>What is the history of the community health center? How and why did it begin?<br>What is the status of relationships with other health care providers in the community and the center? What has been the impact of Medicaid managed care on the center? Other policy changes that have had a big impact on operations?<br>What is the center's greatest challenge?<br>What is your philosophy in working with the Board? What is your role in working with committees or organizing/facilitating meetings?<br>How does the center use data and information on health? |

***Interview at least the Executive Committee of the Board, and a minimum of 50% of the other Board members by phone.*** Conduct these interviews after the Executive Director has presented the project at a Board meeting, or after a day spent in meetings in the community or at the center. The following questions yielded the most valuable information from Board members:

- Who do you see as the population served by the center?
- How is the center perceived in the community?
- What is the most important thing the Board does?
- How does the Board evaluate itself? How often does this happen?
- How were you recruited to the Board?
- What would you look for to know if a Board and center are effective?
- What advice would you give to other Board members across the country?

***Board members' suggestions for measures*** that would indicate effectiveness included (as part of questioning the Board or reviewing documents):

- The most common indicator of "effectiveness" was to observe if the center was growing in the number of sites, patient encounters, or the proportions of underserved persons being reached. Another suggestion was to see if over time, emergency room use was decreasing and volume at the community health center increasing.

- Determine if the center's services are meeting the community's most pressing health needs.
- For multi-site centers, determine how well decisions or programs for a specific community are supported by the entire Board.
- Determine how well the center works with other community organizations
- Determine if the Board's concept of what it is supposed to be doing matches what the Bureau of Primary Health Care says it should be doing.

Interestingly, few Board members indicated that "improved health" in the population was a measure that could be considered as part of looking at effectiveness. To determine if access is improving in populations where community health centers exist, baseline measures as well as ongoing monitoring of changes at the population level are required.

***Use the "needs assessment" section of the C/MHCs 330 grant application as the source of background and population data on the communities served.*** Determine at least the following for both the broader population and the population served by the center: percent of the population in poverty and <200% FPL, percent uninsured/ Medicare/ Medicaid/ commercially insured, the percent over age 65 and less than 18, and the racial/ethnic distribution. Supplement these data with data related to the key health disparities identified in the 1998 Presidents' Initiative on Health Disparities, after which the Bureau has modeled its "100% Access and Zero Health Disparities" Campaign.

## Study Limitations

This project and study have several limitations. First, the protocol developed for data collection was purposefully implemented with variation with each community/migrant health center. This variation allowed us to meet our purpose in understanding the best methods and measures for this type of project. However, the relatively small number of centers involved, and this variation required some "art" in interpreting the results from the data collected through interviews and discussion.

This project was implemented with an eye toward cost effectiveness. FBA utilized our past and current relationships with community/migrant health centers and state primary care associations to recruit centers to participate in this study. In several cases, we had data on centers valuable for this study from previous projects. Therefore, data used from multiple sources, spanning several years were used in this project. All data were collected within the past three years; data from interviews of Board members and C/MHC staff were all collected in the year 2000.

The study of community capacity as we have defined it in our work is relatively new. Therefore, we are at the point in the research where we can make relative statements, but not statements of absolute value, around these measures. There is no external reference for poor measures of social capital or community capacity, only comparisons. There is also not a current tool to establish the value of the varying degrees to which the functions that support community capacity to improve health might exist in a community. One challenge from this study may be that communities with community health centers have already crossed some threshold of capacity.

Another similar challenge to this field of study is that while social capital might be measured, there is not an organized body of literature on the "best practices" to improve social capital at the community level.

We sincerely appreciate the time and effort that centers took to participate in this study. Clearly, given their current and future time and resource constraints, it will be necessary to clearly spell out the benefits to participation in similar studies in the future. Additionally, financial incentives for participation may need to be offered. These supports would remove the limitations that come from the varying ability of centers to participate in studies and special projects.

## Application

The findings from this limited but important study have several applications. We suggest these applications in the form of strategies that can support Boards of Directors of Community/Migrant Health Centers to make continued and enhanced contributions to their community's capacity for health improvement.

### Strategies to Support Board Contributions to Community Capacity

***Provide training and support for Board members to help them understand the basics of C/MHC operations.*** Specifically, topics for this training might include: the basics of policy setting; rules and regulations for community/migrant health centers; financial statements "101" – how to read and understand a community/migrant health center financial statement; making the transition from a "start up" to a fully operational Board, specifically for Board members of C/MHC new starts; and role of the Board of Directors in raising financial support and awareness of the center in the community.

***Develop modules, sessions or materials that can help Executive Directors to communicate with and educate Boards about health systems and health economics, and how current forces impact community/migrant health centers would be a benefit to centers.*** Many Board members acknowledge that there are larger forces at work that impact their center, however, they are not knowledgeable about the health economics that produce those factors. Board members rely heavily on the Executive Director to navigate and translate healthy policy issues.

Educational sessions or materials that can summarize for Boards the strategies being used by health plans, hospitals and hospital systems to manage costs would also be beneficial. Knowledge of these strategies can help centers better predict the behavior of local hospitals, mental health providers, private practitioners, and other necessary for the full continuum of care for community/migrant health center patients.

***BPHC can provide clear guidelines for affiliations and mergers that would allow board members to determine the value of an affiliation.*** These guidelines could spell out BPHC values (e.g., local control) and what benefits to seek in an affiliation (e.g., ability to provide services previously unavailable, access to expertise and resources like information systems).

***Provide training to help Boards use their networks.*** The networks and influence of Board members are a clear benefit to C/MHCs. Specific training sessions could be developed that can teach or reinforce for Board members how their networks and relationships can bring resources to the center. As one example, Board member involvement in negotiations with hospitals, health systems and health plans as partners with the Executive Director -- or as "door openers" to negotiations -- could be the topic of a module that seeks to teach Board members about the use of their networks.

***Find ways at the Board level to acknowledge how the center is contributing to a community's capacity.*** Boards could specifically acknowledge when and how they are contributing to the community's capacity through contributions to social capital (trust, networks and influence) or civic involvement. For example, decision making or voting by the Board could be recognized as a means to give underserved persons the ability to influence their environment. As a second example, there are community/migrant health centers that have espoused “trust” between the Executive Director and the Board as a value.

***BPHC can develop policy statements on the difference between consumer input and involvement for community/migrant health center Boards.*** There may be strategies that can promote the input or involvement of consumers – particularly from groups that are challenging to incorporate in a regular and fixed location “meeting” process, like migrant farm workers – that have not been explored in the current community/migrant health center governance model. Centers work with challenging consumer populations and assistance in recruiting and retaining consumer Board members would be welcomed.

***Support and continue existing resources for technical assistance and support of C/MHC Board members.*** For example, the publication “Across the Board,” posted on the BPHC website is one venue for education and information to be disseminated to Board members. While NACHC conferences were also mentioned as helpful, it is often prohibitive for Board members to attend. Financial and other support for more Board members to attend these conferences would promote involvement.

## Strategies to help Boards Understand Health Disparities

These are three specific strategies that can be supported and advanced by the Office of Data, Evaluation, Analysis and Research, and the Bureau of Primary Health Care:

***Provide guidance to centers around the type and extent of disparities data that need to be collected, and what these data mean for C/MHCs***. Data could be collected or analyzed for the broader population as well as for the population served by the C/MHCs participating in this project for each of the six disparities identified as part of the initiative to eliminate racial and ethnic health disparities. These data could be compared to show “disparities” for the populations served by C/MHCs. Ultimately, a strategy is needed that places the most relevant population indicators for the entire population as the context for community health center patient data.

From our research and observations in this and other studies, income, insurance status, and education level are the greatest disparities by race and ethnicity, and even regardless of race, these factors are at the heart of the greatest disparities in health. The interpretation of the results of the study and potential strategies that could be implemented to address disparities could be provided to centers as well.

***Provide guidance and templates to help C/MHC staff report on health status and disparities to Board members.***

***Explore additional program funding that can support the communication and translation of disparities studies into actionable strategies for Community/Migrant Health Centers.*** ODEAR could summarize and share the results of research conducted by the Bureau on health disparities with C/MHCs. Suggestions for programs or interventions that C/MHCs can reasonably implement to address disparities based on this research could also be provided to centers.

## Application of Study Products by Community/Migrant Health Centers

FBA developed a case study for each center participating in this project (see Attachments). The case studies might have several applications:

- The case study could be used in support of securing resources or assistance for strategies planning, or as background information for organizations that would conduct strategic planning for a C/MHC.
- The case study could be shared with Board members as part of a Board education session during a Board meeting.
- The case study could support requests or applications for technical assistance to analyze data or understand health disparities in the community.
- Observations about the critical role of community health centers from the perspective of the community can be shared with local and state policy makers as part of educational efforts that secure interest and resources for community health centers.

## Next Phase of Research

The greatest application of the information from this study would be to apply lessons learned to a next phase of research and evaluation. We would propose a next phase of research involving 20 communities, 10 with and 10 without a community/migrant health center, matched on some key demographics (poverty, racial/ethnic/cultural mix, insurance coverage).

The study would be conducted over three years using the best methods and measures from this project. The first year would collect baseline data, and the third year would measure change over the baseline. We would utilize measures suggested by Board members interviewed in this study – which focus on process and increased access – and also measure improved health status of the patient population relative to the overall population, as a strategy that holds promise for the future as a way to look at the effectiveness of centers and their Boards. Emphasis would be placed on looking at the six disparity areas identified by the President's Initiative. We would propose the use of similar questions around community capacity; however, this next phase of study could lead to the development of meaningful "means" for these measures.

In communities with a community/migrant health center, a technical assistance intervention would be available and implemented to address training or other capacity needs of the Board within the study period, and the impact examined over the baseline.

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