Training Board Members for Health Planning Agencies

A review of the literature

"The presentation is over and the same members as before raise questions and give reactions. The comments of the main contributors seem to have an overlying message expressing their being part of an in-group. Certain phrases, words, and pieces of humor have special meanings to a few, and letter combinations are used heavily as shorthand titles of organizations and agencies. When the letter combinations are used brief quizzical looks of despair appear on many faces. The conversation is being carried on mainly by provider members; they look tall in their chairs; consumers actually look smaller."

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THE PRECEDING OBSERVATIONS are excerpted from the notes of an observer attending a meeting of a State comprehensive health planning council (*1a*). The observer captures well what more detailed descriptive and quantitative studies consistently record: Consumer participation does not occur naturally. Yet the 1974 act for health planning and resources development sets high aims for consumer participation and gives major responsibilities to the governing bodies of the health system agencies and the State health coordinating councils.

These bodies, composed of providers and consumers and representing all sections of the areas served, are the product of positive assumptions about the ability of persons to accommodate their wants in a constructive and mutually respectful manner in a context of plural interests. The process proposed may be contrasted with other mechanisms for allocating values which aggravate and focus schism, minimize commonality, and create adversaries. The flexibility and creativity possible within the cooperative process are values to be desired. Yet we may assume that the positive gains sought from broad-based participation are not being achieved at meetings where only a few understand the framework and terminology and many are excluded from real contribution.

Under such circumstances, efforts to achieve broad participation may make things worse rather than better. The positive thrust quickly deteriorates if participation does not occur or if the ideas contributed are not tied to realistic courses of action. Productive participation requires that board members have the knowledge and skills necessary to perform effectively and that staff organize the board's work in ways that will optimize board productivity. The alternative, too often allowed to occur, is that untrained people make demands that cannot be met and then they become more discouraged or cynical than they were before they undertook to serve.

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In a recent article, "The Three Citizenships," Norton Long of the University of Missouri at St. Louis charges that a schizophrenia in the American political tradition is generally responsible for this situation. American political principles, he states, are heavily based on the theories of men, most notably John Locke, who "gave much thought to preventing the misbehavior of governors—little to the behavior of citizens or indeed to the realization that citizens in any meaningful sense are not a free gift of nature." Thus, lofty aims are set for citizen participation without attention to understanding and fostering circumstances under which citizen participation is effective. Training programs offer an ideal opportunity to redress this emphasis.

This paper stems from my review of a large number of research studies—many are unpublished and thus not documented here. I also reviewed other materials relevant to board participation in health planning and to the training of board members of health programs. My aim is to distill what we have learned in recent years as a starting point for future endeavors.

Objectives of Training

Need to build trust. Health institutions since World War II have been affected by important changes in American society such as (*a*) a great increase in specialization and the scale of operations accompanied by an increased dominance of institutions by specialists, (*b*) a decrease in trust by consumers for these more-removed specialists and professionals, as individuals, and (*c*) an increase in general education accompanied by a decrease in the number of persons feeling that "you can't fight city hall"—or your health professionals.

While many would like to reinstate the more trusting relationship which previously existed between provider and consumer, the grounds for that trust probably lay in common residence and multiple commonalities. These grounds for trust have been eroded as the society has increased in scale and specialization. We are therefore faced with the need to create trust in institutional forms to replace the trust we formerly conferred on individuals.

Representative health planning bodies offer an opportunity to create trustworthy institutional forms. While there is no strong evidence that such bodies are the answer to what ails us, they suggest creative possibilities. There is some evidence that trust in the equity of local programs is increased when "persons like oneself" participate in the program's governance (*2*). Only through serious effort can we learn what may be achievable.

Need to develop processes of accommodation. In a book on the planning process in voluntary associations, DeBoer (*3*) notes that the controversy which results when people with diverse perspectives meet to plan is not simply the price of democracy but a positive resource in making good decisions. He cites Peter Drucker, the eminent theorist of business management, who urges executives to postpone decisions until controversy has arisen, as follows (*3a*):

> . . . decisions of the kind an executive has to make are not made well by acclamation. They are made well only if based on the clash of conflicting points of view, the choice between different judgments. The first role in decision-making is that one does not make a decision unless there is disagreement.

Decisions are certainly not made well when relevant values and interests remain unknown. At the same time, poorly handled conflict that results in what DeBoer calls "messy human relationships" fails to achieve the goal and causes people to disengage from the frustration.

Successful planning, then, depends on the presence of alternative viewpoints and of constructive modes of expression and accommodation. While successful controversy is correlated with skills and perspectives some acquire on their jobs, most people do not fall naturally into the kinds of roles required for members of the State health coordinating councils and the health systems agency boards or governing bodies. Many factors are entailed, including substantive health knowledge (an area in which health professionals have a head-start), group dynamics and conflict management (where executives and labor leaders probably are best prepared), and knowledge of community needs and moods (where friends and neighbors may be the only ones who know). However, none of these advantages is as complete as the possessor may feel, and none stands independently as a dominating attribute.

Need to overcome alienation and hostility. We know quite a bit from social science theory about the circumstances which lead to personal and organized hostility. Grievances, often small or even trivial taken singly, feed upon one another until at some point hostility is great enough to justify in a person's mind an act of aggression—be this a picket line, a crime, or a lawsuit. Moreover, the process of alienation is one in which individual grievances accumulate not only by individuals but by groups of people gradually brought together by shared grievances. Interaction increases within aggrieved groups and decreases between them. Increasingly the problem is defined in either-or, zero-sum terms and is combative. Previously unthinkable solutions become thinkable.

In the past we were not accustomed to the citizen who was cynical and hostile about the professionals and institutions that served him. Today, we are rapidly becoming familiar with this reaction. Too often, the response of the professional is to strike back in ways previously considered "unprofessional"—particularly, to refuse service. Professional responsibility and consumer trust, however, are part of a single model—neither side of which is easily maintained in the absence of the other.

Minority persons and younger adults still tend to feel most alienated—they believe that health professionals are unaware of their needs and that particular groups dominate planning at the expense of others (*4*). Thus, we must educate members of all strata in ways of bringing needs into focus so that understanding and response can occur, and we must strive to bring these particularly dissatisfied groups into the mainstream of planning.

Conditions for Training

Tendency of consumers and providers to join in common causes. The lack of trust and communication between consumers and providers does not seem to correspond to any dramatic differences in the goals they seek. None of the studies I reviewed turned up any major differences in objectives. Board factions exist, for example, between persons emphasizing acute-care needs and those emphasizing preventive care, but these factions comprise both consumer and provider members. Where differences were found between providers and consumers as groups, the differences concerned greater emphasis by consumers on amenities, extension of services, and dignity for the patient receiving services (*4–7*).

Cost of training. Training requires large time commitments from staff, consumers, and providers. Observers agree that training must be ambitious and continuous. The cost in time is a peculiar sort of double-edged sword. Several reports (*1,4,5,8*) indicate that board members find the work entailed in membership almost overwhelming and that the heavy workload may be an important reason for the poor attendance, or sometimes poor performance, of board members. Under these circumstances, it is understandable that directors of planning programs might be reluctant to ask members to participate in additional programs—even if the intent of the programs is to improve the members' ability to understand the topics, sort out the chaff, and work more effectively in the group.

Interest in training. The desire of board members for training was notable in the studies I reviewed. Although this interest was most often expressed by consumers, several reports (*1b,5a,8a*) indicate that even some professionals poorly understand the jargon used, the structure, and the topics of board meetings. In all the studies, providers and consumers thought that training would enhance participation. Thus, it seems that the means of dealing with a work overload would not be to dispense with or to minimize training. A preferable strategy would be to offer training and other assistance to members who wish to become more effective participants and to eliminate members who do not wish to invest the time. Other costs of participation, which sometimes become subsumed in this issue, need to be addressed separately; for example, the inability of members to obtain transportation or babysitters or to take time from their work. Such problems can be addressed by interested agencies in a variety of constructive ways.

Major Problems and Potential Solutions

Dealing with poor attendance. In one study where attendance of board members was carefully monitored, the nonattendees in both consumer and provider categories outnumbered the attendees (*4*). In another study 50 percent attendance was cited as evidence of strong commitment (*1c*). While low attendance tends to be characteristic of both consumer and provider members, it is especially pronounced among consumers. Usually, consumers are not a working majority despite their 51 percent majority on the roster (*1,4,5,8*). Domination of meetings by provider members is particularly characteristic of task forces and working committees. Poor attendance must certainly detract from the sense of task importance and thereby from the morale and commitment of the attending members.

Different planning units have dealt differently with poor attendance. For example, to insure that a consumer majority was present for votes in spite of high absenteeism, the Puget Sound Health Planning Council determined that certain providers would abstain from voting or that voting would be postponed until a consumer majority was present (*5b*). The Utah "a" agency board established a mechanism for removing members who missed three consecutive meetings unexcused (*9*). A consumer subgroup of the Michigan Capitol Area Comprehensive Health Planning Board sought to enter a similar provision into its bylaws to eliminate nonfunctioning members (*8*).

Getting the most from the board members' time. Poor attendance may also be an indication of frustration—the sense of not getting anywhere. At least part of this frustration seems attributable to poor organization of the decision process and poor understanding of the board's place in it. In the studies of boards that I reviewed, there is evidence that groups consider their greatest achievement to be getting themselves organized to work. While some starting-up problems are inevitable, staff should pay deliberate attention to organizing the planning process better and to making board members aware of its characteristics.

DeBoer presents a useful discussion of the decision process (*3*). Writing for boards of voluntary organizations, DeBoer highlights the nature of the process with particular sensitivity to the frustrations that cause persons to abandon the voluntary effort. When the steps of the planning process are clearly in mind, the part bears known relationship to the whole, and the separate roles of the board and staff are clear, boards are less likely to become lost in diversions, minor issues, and unproductive detail.

Board members should learn to recognize and expect

to contribute to decisions of policy and to demand appropriate staff work. Staff should expect to provide the backup work that will optimize the value of the board members' time. Staff work should focus on the problems, the goals, and the options, as well as on summarizing and simplifying relevant data. As a result, in many cases, staff will dump less material on board members than is currently the practice but will obtain more information and ideas from them.

Relating board members to their constituents. Consumer and provider members serve most commonly out of a sense of obligation to the community or a desire to serve it. When members do not represent identifiable organizations or associations, however, they tend to act singly and on the basis of their personal estimate of what the community good is. The lack of a systematic relationship to a constituency also indicates an absence of social support. This lack of connectedness and support is especially characteristic of consumer members and may contribute to their lesser participation.

One must also question the extent to which persons with no systematic communication with their constituencies are, in fact, in touch with those constituencies. In the studies reviewed, majorities of consumers and providers stated that they represent others in the community, but they did not clearly understand what this representation means. For example, in one study, a sample of respondents were asked to indicate which among them (consumers, providers, or staff) performed each of 13 tasks. Consumers were assigned only one task: "to represent the community problems and opinions." Yet the other tasks on the list which would seem to make this a meaningful role ("helping people be aware of health needs, informing the community about health problems and services") were identified as staff responsibilities (*8b*). Thus, a possible component of board training—usually not emphasized but often should be—is the working relationship of the member with the constituencies that member represents.

One comprehensive health planning agency that incorporated issues of representation in its training manual was the State agency in Utah (*9*). Although the specifics of the task are not spelled out in the manual, board members are instructed that it is their responsibility to serve as a communication link between their constituency and the advisory council. This task includes (*a*) representing the interests of their constituency, (*b*) making regular reports to the constituency, (*c*) developing a working knowledge of the health problems of their constituency and making them known to the board, and (*d*) developing an awareness of real and potential health issues in the areas they represent.

Staff role in board effectiveness. Most observers suggest that the way to enhance board autonomy and effectiveness is to provide board members with their own staff. This action is particularly important for those board members who do not have access to professional assistance through their places of employment or association. Yin and associates (*2*), based on a systematic analysis of case studies of consumer participation, identified staff reporting directly to consumers as the most important factor in successful consumer performance.

Under any arrangements, specific types of staff work are required. Some types of staff work, however conscientiously performed, do not advance the self-sufficiency of the board. Bishop and Beck found staff doing most of the tasks which would seem to belong to consumers (*8*). Moreover, in that study both consumers and providers desired less staff influence, considering existing provider influence appropriate and consumer influence too small. Chenault and Brown suggest another danger, that of strong staff persons nurturing consumer participation but allowing the participation to become dependent upon the nurturance (*6a*).

Many staff persons will need to increase their skill in supporting rather than, however inadvertently, subverting board members. The need is how to get their opinions, make them visible to their constituencies, and respond to other requests. Staff should not automatically be considered trained in the processes of working with boards. Like consumers and providers, staff are usually experiencing a new situation and will need support and guidance.

Training Strategies

Limit focus to immediate interest. Training is most effective when it occurs in conjunction with problems of immediate interest. Training programs that provide relatively limited information to work groups and are focused on particular problems to which the information is immediately applicable are more effective than those which present broadly relevant information. The limited topic focuses attention and provides a framework for arranging and remembering the information. As people come to understand the topic of immediate interest, the interrelationship of that focus with other components of the health system helps the trainee to understand and appreciate the more extensive information which would have been overwhelming at the outset. Thus, training geared to the tasks of working committees and task forces can be expected to be more successful than efforts to orient the board members in general to the problems facing health systems agencies (*1,2,8,10*).

In the same way, lessons in group dynamics and conflict management are best learned in the context of focused objectives. The learning should be systematic, however, not only because it is more efficient but also because there is evidence that initial interpersonal patterns tend to become fixed, with the result that members' initial errors may limit their effectiveness long after the lesson is learned (*6b,8c*). Skill in group man-

agement is correlated, not surprisingly, with the social and occupational backgrounds where it is commonly used—managerial and professional jobs and high income (*4a,7a*). Yet, researchers and experienced trainers attest to the ability of training programs to provide even low-income consumers and others the needed perspectives and skills (*11*). This outcome requires, however, that the means are clearly related to achieving the ends (*1*).

Persons "at ease." It may seem self-evident that the participation of individuals in a group is likely to be fuller and of higher quality when they feel free to speak and to ask questions. Yet, the circumstances which foster open communication continually recur as problems. To be specific—small groups work better than large ones, small rooms are less intimidating than large ones, and rooms which are equally familiar or unfamiliar to all members are preferable to those which are the turf of some members. Informal contact creates easy relationships and improves the quality of formal participation (*1*). A variety of mechanisms that have been documented as successful in training are mechanisms which result in informal interaction among participants.

A training program that shows particular sensitivity to putting persons at ease was developed by the Genesee Regional Health Planning Council. In the introduction to the training manual, the authors state that "the method used for the formal and informal orientation is designed to bring members face to face with the PEOPLE, PLACES and THINGS necessary to their participation with a health planning committee" (*12*). The tone and wit of this orientation are perhaps best captured by its health system scavenger hunt. With the help of a mentor, trainees do such things as collect the initials of various persons important to health planning, find health facilities (and get corridor wall colors), locate documents containing health planning information, and track down the meaning of various items of jargon and of inside jokes. Participants also learn a good deal about the tastes and interests of other committee members and of the staff.

The Genesee orientation has several virtues. It involves old as well as new members and persons who do not feel that they need training as well as those who do (perhaps pointing up to the old members some of the deficiencies in their own knowledge base). It breaks down the barriers between people and points the way to independent sources of information, thus supporting the autonomy of the board.

A board training program which incorporates assumptions of personal commonality contributes to the depersonalization of conflict. When conflict occurs among persons who have different viewpoints but solid human respect, it becomes more likely that issues can be resolved and values allocated in a mutually respectful manner.

Common vocabulary. A major barrier between participants is vocabulary. No manual or training program fails to provide a glossary explaining organizational acronyms and professional jargon. There are indeed good reasons for the use of specialized vocabularies, and board members have to learn the meanings of technical words and common abbreviations. Explanation of specialized jargon is often useful in furthering understanding of key issues. The successful functioning of a committee can occur only when understandable vocabulary is used. Staffs should further make it clear to board members that one service they can expect from staff is necessary translation.

Flexibility. Members bring different levels of substantive, organizational, and planning skills to committee assignments. The educational activity must be flexible enough to accommodate diverse backgrounds, maximize learning among group members, and initiate new members as they arrive. A good training program will allow for differences and provide different persons and committees with the types of experiences appropriate to their knowledge and interests. It will make use of different formats, forums, and community resources as the situation requires.

Continuous education. The word "training" may be misleading—seeming to imply that the graduate is ready to "practice" the new skill once he or she has acquired it. On the contrary, continuous education and self-examination are necessary. Members of the Puget Sound Health Planning Council believed that they would need training or workshops two to three times a year to keep abreast of health issues (*5c*). The health field is complex and constantly changing: board members must have the means and resources necessary to keep up.

Initial orientation should include experiences which inform trainees of the times when and the means by which they should acquire information. Careful thought should be given, however, to a continuous program related to the focus of the group, on the one hand, and to taking advantage of slack periods, on the other.

The Council of Planning Librarians has provided examples and references which may assist such an effort. One is a selected and annotated bibliography of sources which focus on group problem solving, organizational procedures, and administrative techniques (*13*). Another is selected and annotated references to literature of substantive interest to board members—the hospital (*14*). Documents such as these are highly useful and flexible resources providing information adaptable to individual and group needs as these develop.

Realism. Subservient acquiescence to authority has never been part of the American character. Changes in the society and in its health institutions make it still unlikely in the future. However, the fact that health

rogram board members so consistently desire training a resource to be valued and cultivated. As with any major undertaking, results will not be quick, dramatic, r easy. If, however, we are able to take advantage of eginnings made and learn from efforts to be under-ken, we may build toward a health system which, its governance, benefits from, rather than copes with, e society it serves. As Norton Long points out, re-ponsible effective citizens are not "free gifts of nature" but they are the kingpin of our health system and r nation.

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