

**SURVIVAL OF NONPROFIT COMMUNITY HEALTH CLINICS**

A Dissertation

by

RUTH ANN SCHEMMER

Submitted to the Office of Graduate Studies of  
Texas A&M University  
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

May 2006

Major Subject: Sociology

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## **ABSTRACT**

Survival of Nonprofit Community Health Clinics. (May 2006)

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In the provision of public goods such as health care for the uninsured, nonprofit organizations serve important functions in society. Because they often rely on volunteer labor, and funding is frequently unstable, their survival depends on factors not present in either private enterprise or state agencies. This comparison case study examines three clinics, one surviving clinic and two that did not survive, to find patterns that characterize organizational success and survival. Theories about public goods, volunteering, and organizational coordination and communication provide insight into different aspects of the case study. Data was gathered from 19 in-depth interviews with individuals connected to the three clinics.

The analysis employs Ostrom's characterization of eight principles of longstanding common-pool resource organizations, with slight adjustments for the public goods setting. As expected, the successful clinic reflects more of the characteristics, or possesses them to a greater degree, than the unsuccessful ones. Specifically, the successful clinic reflects a greater degree of congruence between organizational rules and local conditions (as evidenced by community support), and collective-choice arrangements (as indicated by the presence of an actively engaged

board of directors). In addition, the successful clinic is loosely nested with other organizations, whereas the nonsurviving clinics were more tightly nested within local organizations; the looser nesting allows for greater autonomy in decision-making.

Finally, an unexpected finding drawn from the interviews concerns the manner in which the clinics framed their message and mission. The successful clinic framed its mission in terms of serving the “working poor,” whereas the nonsurviving clinics stated their mission as charity for the poor and needy. This variance may have contributed to greater community support for the successful clinic.

## **DEDICATION**

A multi-generational dedication:

To my parents, Fred and Janey Schemmer, who loved me unconditionally and supported me unfailingly—you gave me the strength to undertake this course in my life. Thank you for that. I love you both so much.

To my daughters, Bethany and Holly Licht, whose lives have been most profoundly affected by their mother's pursuit of a Ph.D. Your patience, your love, your help and your very presence have given me reasons to persevere. Thank you for being good kids, for becoming wonderful young women, and for loving me through this whole process. You are the lights of my life. I love you more than you can ever know.

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For transcribing, and for culling through mind-numbing microfilms and newspapers, I thank three undergraduate researchers—Fatima Friday, David Pate and Tessa Maring.

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this work, it is because of the high expectations you set for me many years ago. Your impact on my scholarly life is immeasurable.

To my dear friends who were ignored for much of the past few years, especially the past few months, I thank you for remaining my friends, and for encouraging me every step of the way. I promise to be a better friend now. To my family, who has teased me endlessly about being a professional student, I thank you for your support and love, and yes, for the teasing...you kept me grounded.

An accomplishment like this is never completed in a vacuum—we stand on the shoulders of those who support us, who encourage us, who teach us. My most humble and appreciative thanks to all of you for offering me your shoulders.

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## CHAPTER I

### INTRODUCTION

#### Statement of the Problem

This study investigates the factors contributing to the success or failure of non-profit health clinics. Because the clinics are composed of individuals working in an organizational structure and nested in a particular state and governmental context, I will examine individual level, microlevel organization and macrolevel organization variables. I compare one highly successful clinic to two others that have not survived and succeeded. Such a study is important for three reasons: 1) It can help assess what theoretical factors are more important than others in the maintenance of such nonprofit health organizations; 2) With the understanding of these theoretical factors, we can develop policy that might improve the odds that similar organizations will survive, and finally; 3) The documentation of the salient variables adds strength to theoretical assertions concerning the establishment and maintenance of nonprofit organizations in general.

To address these issues, I will consider how this organization is a nested, multi-level organization, in that it is examined on numerous levels—from the traits of the volunteers who contribute their time to the larger community's relationship with the clinic. Studying such disparate levels of an organization involves considering a wide variety of theoretical tools. This research utilizes theories about public goods,

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This dissertation follows the format of the *American Sociological Review*.

individual-level volunteering, organization-level coordination and communication with external organizations. Each of these theoretical traditions informs upon a different aspect of the case studied.

### **The Case Background**

The Valley Health Clinic (HFA), in Carlton, , was founded in 1987, with Dr. Amit Verma initially seeing patients in a motel room located in an economically disadvantaged section of town. Since its makeshift beginnings, it has moved to a number of locations, yet it has remained in operation continuously for over 19 years. This clinic serves individuals with no other form of health care assistance—if individuals either qualify for government aid or have private insurance, they are ineligible for treatment at the clinic. For example, children are rarely seen, after the advent of the Children's Health Insurance Program (CHIP). The clinic currently resides in a storefront in downtown Carlton—a location providing easy access for most of the patients served by the clinic. This organization can be claimed a success because it has survived and provided services for over 15 years.

The organization evolved over time to include a paid office manager, as well as a professional executive director. It has also increased services from one day a week, to five days a week. While it has always relied on volunteer medical labor, as it has grown, other functions must be filled by volunteers as well—patient intake, record-keeping, filing, inventory control.

Important figures in the establishment and ongoing maintenance of this organization include the founding physicians (Drs. Amit and Shilpa Verma—husband

and wife), the current executive director, administrators at both local hospitals, and volunteer coordinators, among others. In addition, the local newspaper periodically runs articles about the clinic, and these articles provide insight into the relationship with the community.

In contrast to this case, Dr. K. Verma was asked to volunteer time at two other clinics in nearby towns, Greenfield and Smithville, approximately 11 years ago. Neither clinic survived. These clinics began under similar circumstances to the Valley Health Clinic—one day per week, one physician offering time. Yet neither one became successful and self-sustaining. The comparison cases provide a unique opportunity to compare the contexts in which the more recent clinics arose with that of the original clinic.

I consider various levels of analysis in exploring the research question: Why has this clinic survived? First, I establish the social context of providing for a public good (health), by setting out the concepts of social dilemmas, which includes public goods and resource goods. Then, I examine individual characteristics of those who volunteer to provide the public good. Finally, I consider organizational factors that make nonprofit organizations unique.

### **Social Dilemmas, Public Goods and Resource Goods**

Social dilemmas are settings in which there is a conflict between an individual's short-term benefit and the collective or group's benefit (see Dawes 1980). We are faced with such dilemmas throughout our everyday activities and throughout our

life. So, for example, living together, families face the dilemma that nobody really wants to clean the house, but all will be worse off if nobody cleans at all. On a more macrosociological level, it is difficult for groups to convince their members to give up time to engage in political activity, but if no groups do so, civil liberties are lost.

Social dilemmas are of two sorts, public goods and resource dilemmas, (see Messick and Brewer 1983 and Sell 1988) and the literatures surrounding both of these are pertinent to the investigation of public health clinics in general, and Valley Health in particular.

Public goods, once produced, are available to all, not just to those who have contributed. This property, nonexcludability, separates public goods from private goods. With private goods, ownership of the good belongs exclusively to the buyer (who, of course, could share it). Private practice doctors for example, trade their services and time for their patients' money. To enter a private hospital, the patient pays the hospital and is afforded the facilities. Just as some are afforded the opportunity, those who do not (or cannot) pay are excluded. But public goods are goods that are not market-based; they are available to those who may have paid or contributed to the good and those that have not. Valley Health, the successful clinic I study, is an example of a public good, because payment is not tied to services, as is the case in a privately owned and operated clinic. It actually represents several types of public goods because the nature of the good changes over time. For example, the initial establishment of the public good presents problems not present in the maintenance of the good. (For discussion, see Sell, 1988)

The provision of public goods encounters two basic problems: (1) incentive problems, and (2) communication/coordination problems. Incentive problems stem from the fact that individuals might receive the good whether or not they contribute. The obvious problem is that if no one contributes (due to the incentive problem), the public good is not produced. In this way, the incentive problem implies that people must be coerced to contribute (through taxation, for example) because it is individually rational to not contribute. (See Samuelson, 1954; 1958)

Olson (1971) developed this assumption of rational action when referring to instances of common pursuit—public goods. He argued that there are examples of successful public good provision because people earn “selective incentives” that make the provision attractive. For example, some groups develop social incentives, especially groups that are small enough to facilitate close interaction—such groups may unintentionally mobilize members simply through group (Leighley 1996). Social incentives may include acceptance, encouragement, even entry into a coveted “inner circle.” Conversely, social disincentives may include a desire to avoid disappointing one’s peers, or others who are depending on one to actively participate in the group’s activities (Olson 1971: 60-61).<sup>1</sup>

The second problem encountered by public goods settings is the communication and coordination problem (for discussion see Sell, Lovaglia, Mannix, Samuelson and Wilson, 2004 and Lovaglia, Mannix, Samuelson, Sell and Wilson, 2005). While all

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<sup>1</sup> Olson primarily addresses cases of labor unions providing insurance for members, or political pressure groups providing members with an outlet for activism. However, he does discuss the differences between small and large groups, noting that small groups more effectively utilize social incentives, whereas large groups may require material or coercive incentives.

organizations face such challenges, the provision of public goods are especially challenged in this regard, as efficiency is affected, but not subject to the discipline of a market or budget forces (in the case of the public sector or government). That is, there must be some effective means by which people coordinate their activities so that the good is developed or maintained. If taxation is a solution to the incentive problem, there must be a method by which the taxes are collected and allocated, for example.

One particularly important coordination issue is communication about the good to be provided, as well as the means by which it is to be produced. When groups cooperate, by definition, they are more effective than when they do not cooperate. In addition, the size of the group may contribute to its overall functioning (Olson 1971), perhaps due to the fact that small groups find it easier to communicate with one another. With traditional incentive structures absent from public goods settings, cooperation is even more essential for optimal functioning—and communication is critical for heightened cooperation levels (Sally 1995; Sell and Wilson 1999). Sell et al., note that communication and even conflict over the best way to accomplish a task may lead to more efficient functioning for a group, as alternative solutions are debated (2004). Bettencourt et al., (1996) found that coordination of activities and communication about the group's plans contributed to the long-term survival of a grass-roots organization.

Related to the concept of public goods is the concept of a resource good. While public goods require contribution of something valuable, resource goods refer to the use of some common resource—the cooperative action involves refraining from using the resource (Messick and Brewer 1983; Sell et al. 2002; Ostrom 1990). For example,

stopping rainforest depletion demands that the resource of the rainforest not be used at its current rate. Like public goods, resource goods suffer from the same problems: free-riding, commitment problems, and monitoring for compliance to agreed-upon rules (Ostrom 1990: 27).

Ostrom (1990) focuses on resource good settings, referring to them as commons. Common pool resources (CPR) are those settings whereby a community or group of individuals shares in the benefits of a particular resource (water, pasture land, fishing rights). When many people engage in use of the resource, without contributing to the ongoing maintenance and replenishment of the resource, a “tragedy of the commons” occurs—it is destroyed. However, she notes that many examples of organizations that protect resources from depletion currently exist; for example, a group of attorneys may organize a firm to practice law. They may determine pay structure, fair shares of the profits, and create a governing board for their firm. No external authority organizes them, nor determines the rules and regulations by which the firm will operate (1990:25). Ostrom argues that although numerous policy prescriptions for resource allocation require some intervention from an outside authority (either the state or privatization by a pre-existing firm), it is plausible that individuals may organize in an efficient manner, if left unimpeded. This is not to say that all such attempts are successful, but they are possible. The basic underlying problem of organizing, according to Ostrom, is “how to change the situation from one in which appropriators act independently to one in which they adopt coordinated strategy to obtain higher joint returns or reduce joint harm.” (also see Sabatier et al. 2005).



In her investigations of long-enduring CPR's, Ostrom delineates a set of principles that differentiate successful ones from the unsuccessful. Several of these principles include the recognition of the nested nature of the groups necessary to maintain the goods. So, for example, Ostrom argues that successful cases are characterized by rules of governance that coordinate at both the local and the larger levels and that there are minimal intrusions into the local rights to organize. Further, successful cases were characterized by collective choice arrangements in which the individuals involved in the local setting can modify participation rules as well as rules about monitoring participation and sanctioning those who violate the rules.

The provision of public goods or the maintaining of resource goods is often a multilevel or nested problem. The good itself must be provided, but there are often many steps necessary before the good itself is delivered. Volunteering is one important aspect of public good provision, because it is a type of contribution that is necessary for the provision of the good, although those who volunteer, by definition, do not receive a service or payment in direct return.

### **Volunteering**

As discussed by Wilson (2000) and Wilson and Musick (1997a), volunteering is part and parcel of American culture. Manser and Cass use the following definition of volunteerism: “those activities arising out of a spontaneous, private effort to promote or advance some aspect of the common good, as this good is perceived by the persons participating in it” (1976, p. 42, as quoted by Block, p. 100). Weber conceptualized

American volunteerism as a “bridge between the hierarchical Old World, and the individualistic New World” (Block 2001: 101). Furthermore, volunteering serves individual needs for group attachment and group solidarity, creating the possibility for joint action (Salamon 2001: 165; Hechter 1987; Taylor and Dube 1986).

Why do individuals contribute to the common good when the rewards are often ephemeral or elusive? Why do they cooperate with a group to achieve a goal in which they may never share? Primarily, individuals join groups to produce goods they cannot produce on their own (Hechter 1987). There are two ways to insure contribution to a public good—coercion (through taxation), and granting rewards, both social and material. Group solidarity increases when individuals feel obligated to contribute to the group’s goals—solidarity is enhanced through the use of reward structures and incentives. Solidarity tends to be higher when individuals actually partake of the goods produced (or the resource being tended)—access to the good provides an incentive for contribution to the public good. One would expect low solidarity in situations where individuals do not personally benefit from the good produced; low solidarity should lead to less cooperation and investment in the group’s goals. In turn, the group would be expected to be less successful than one with higher solidarity.

Furthermore, Wilson notes that individuals operate on many levels when deciding to participate in the production of a public good; they respond to numerous incentives, not simply the incentive of being able to partake of the good produced or resource shared (2000). Volunteering is typically “any activity in which time is given freely to benefit another person, group, or organization” (Wilson 2000: 215). Tilly and

Tilly (1994) note four regions of work—labor markets, the informal sector, household labor and volunteer work. They define volunteer work as “unpaid work provided to parties to whom the worker owes no contractual, familial, or friendship obligations.” Understanding volunteerism involves examining who volunteers and why they volunteer, given the unique incentive structure for unpaid labor.

According to Wilson, rates of volunteering are stable or rising (56% of the U.S. population had volunteered in the past year, according to the 1998 General Social Survey), contrary to popular belief about declining volunteering rates following increases in women’s labor force participation. At the same time that women have increased labor force participation, new types of community organizations and civic involvement have arisen (Wuthnow 1998), and senior citizens are volunteering in ever-increasing numbers. Why do such large numbers of individuals continue to volunteer? What motivates them to participate in such activity?

Theories of volunteering posit a social support function, with three sets of associated factors—individual characteristics, the relationship itself, and community context. On the individual level, both the personal level, as well as the context in which action takes place, are considered. While the public believes that motives and values drive commitment to volunteering, research does not bear out such a relationship—the effects are weak and inconsistent (Wilson 2000: 218).

In discussing one theory of volunteering behavior, Wilson posits that Human Capital theories state that the decision to volunteer is based on a rational cost-benefits analysis, with rational choice theory describing variable inputs which affect the ability to

volunteer. For example, education level is the most consistent predictor of volunteering rates, with education serving as a resource that better enables volunteering activities.

Other resources also influence volunteering: parents provide information and modeling, as well as social support, resources for children to volunteer (Janoski and Wilson 1995).

Occupation is related to volunteering, in that those who work more hours tend to volunteer more hours—it is possible that skills learned in the workplace transfer into volunteer organizations. Wilson notes that rational choice theory predicts higher income levels leading to fewer volunteer hours; however, the research in this area is mixed, and there is no clear pattern.

In addition to describing WHO volunteers, scholars attempt to understand WHY they volunteer. Wilson views exchange theory as emphasizing the benefits to volunteers—what they receive from their investment of time and money. Individuals may volunteer because they have some other attachment to the group (parents volunteering at school functions), because they may need help for themselves someday (work with the elderly), for socialization purposes (with other volunteers), or to seek recognition and leadership opportunities. While exchange theory sheds light on reasons people may volunteer, Wilson criticizes it for assuming self-interested, as opposed to altruistic, behavior and for assuming individual decisions are made in isolation, rather than as a result of social interaction and context.

Wilson's further delineates social resource theory, which states that individuals volunteer due to the social networks they belong to, as well as the ones cultivated by volunteer activity. Extensive social networks, multiple organizational memberships, and

prior volunteer experience all predict likelihood of volunteering. A nurse in Michigan describes her experience with a clinic serving the “minimally employed” as being motivated by her faith, and a desire to use her medical skills to better the community (Coslow 2005). Those with greater social resources—higher SES, married people, parents, more religious—are all more likely to volunteer. Extensive social ties lead to greater trust of those asking one to volunteer, making it easier to donate one’s time. Trust, in turn, provides a social constraint on the free-rider problem, in that individuals will live up to volunteer commitments in order to not disappoint or inconvenience their friends (Wuthnow 1998: 184). However, the effects of social networks on volunteering are multi-faceted: more controversial volunteer work or social activism may be less sensitive to social network effects. As pointed out in other literature, trust may have a dual effect on volunteering, as well—at times, a lack of trust that others will represent one’s interests leads to greater involvement (Focht and Trachtenberg, et al., 2005). As Wilson points out, even family relations have differential effects on volunteering, as the presence of children may both enhance and constrain volunteering. Parents with young children are more likely to volunteer, but for fewer hours. Single parents of young children are less likely to volunteer, however.

Demographically, Wilson shows that volunteering varies by age (rate falls in young adulthood, rises with middle age); gender (females slightly more likely to volunteer); and race (whites have higher rates). All of these effects are mitigated by certain factors, however. Senior citizens with part-time jobs are more likely to volunteer than those without. Females tend to volunteer for certain types of activities (caring);

males tend to serve in leadership capacities more often. Differences between blacks and whites disappear when income, education and status are introduced, and depend on social ties to churches among blacks—race differences essentially offer little variance. Especially germane to this study is Wilson and Musick's (1997b) observation that higher status occupations and public sector workers volunteer in greater numbers. While some argue that younger generations volunteer less, Rotolo and Wilson find no support for such observations (2004).

Organizations that depend primarily on volunteer labor to accomplish their goals must address issues of volunteer commitment and burnout. It is known that more educated individuals, those with greater commitment to personal development values, and those with greater social resources are less likely to drop out of the volunteering role.

A variety of consequences of volunteering activity has been noted, with mixed findings. Volunteers are more politically active (but the causal direction could be reversed), are less likely to be anti-social or mentally unstable. For the elderly, volunteering leads to higher life satisfaction. While there are consequences for the volunteers, there are also consequences for society, as rates of volunteering rise and fall, or types of volunteering become more prevalent (Wilson 2000).

While one level of analysis leads to examining motivations and incentives for individuals who volunteer their time and resources, understanding macrolevel variables requires that organizational variables be considered. Among those variables discussed

will be operating procedures and structures that differentiate nonprofit organizations from for-profit enterprises.

### **Organizational Factors**

Organizationally, nonprofits operate in a unique manner—differing from both for-profit enterprises and public sector agencies. Because they rely on budgets and must conform to that discipline, they have some features in common with the public sector, since neither of them generates profit. On the other hand, both private firms and the state solve commitment and monitoring problems confronting public goods provision through coercion: the state through taxation and punishment, the firm through pay incentives and punitive management methods (Ostrom 1990: 41). These issues alone set nonprofits apart from both for-profit enterprises and the state.

Non-profit organizations hold a particular place in the economy due to a number of reasons: the reliance on volunteer labor, the lack of a profit-generating function, a commitment to public benefit and the evolution of tax-exempt status (Block 2001: 104, Salamon 2001: 164). The non-profit sector arose as a result of historical contingencies, capitalist market failure, and government failure (Salamon 2001: 164). However, Clarke & Estes assert that nonprofits may economically act much like for-profit organizations (1992). A more appropriate analysis would differentiate among types of nonprofits: if they essentially compete in a market with for-profits, the two types will come to resemble one another. As Scott et al., (2000) note in discussing healthcare organizations,

changes in both material and institutional environments necessitate changes in the organizations themselves, if they are to survive.

Block notes that the breakup of feudalism and the advent of industrialism brought the Poor Laws of 1601 in England—designed to institutionalize public responsibility for displaced workers. While this in effect pushed the state to take responsibility for certain aspects of public welfare, much of that function continued to be met by private charities and civic organizations (Block 2001: 98). In the early United States, society was established before the state—communities took care of common concerns without state intervention long before the state assumed responsibility for them (Salamon 2001: 164)

Salamon (2001) indicates that the modern nonprofit sector exists largely because of market failure—capitalism cannot efficiently manage those items consumed collectively, such as air, water, public schools, and transportation, primarily due to the “free rider” problem. Capitalism requires that an individual who will consume a good, must purchase the good. With public goods, however, individuals who consume the good may not contribute toward its provision, and may pay nothing for it. Two solutions to this problem exist: taxation by the state, or establishment of nonprofit organizations (Salamon 2001: 164). Gronbjerg (2001) notes that nonprofits respond when either market failure or contract failure occur: market failure being the result of the demand for services being too low for profitability (AIDS services), contract failure resulting from incomplete knowledge by the consumer (counseling centers).



The state's relationship to nonprofits has evolved largely in terms of institutional support in the form of tax laws (Block 2001). However, in modern times, government and nonprofits have become increasingly intertwined in a mutually beneficial relationship: the state grants subsidies to organizations to provide social services, and nonprofits come to depend on public funding for survival (Saidel 2001: 380). This reality contributes to the granting of tax-exempt status to nonprofit organizations: it is reasoned that without the support of tax exemption, non-profits may cease to exist. Without nonprofits, many social services would either not be provided or would need to be provided by the state.

Block (2001) spells out the history of tax-exemption for nonprofits. Although tax exemption status was granted to community organizations in the early days of the American republic, it wasn't formalized until 1894. Every revenue act since that time has continued to grant tax-exempt status to nonprofits. Tax-exempt status benefits nonprofits in two ways: the organization itself is exempt from corporate taxes, and individuals who contribute to nonprofits may claim tax deductions for their donations, which encourages individuals to support nonprofit causes. Tax support for nonprofits, especially those engaged in providing direct relief to segments of society, allows the state to delegate burdensome or controversial duties to the nonprofit sector. Therefore, tax benefits not only support the nonprofit sector, they also act as a means to legitimate the state (DiMaggio and Anheier 2001).

The very funding mechanisms of nonprofits provide challenges for managing them. Block also addresses the emergence of business management as a profession in the

late 1800's, noting that it relied on maximizing profit margins, ensuring production efficiency, and providing high returns for investors' dollars. Nonprofits, on the other hand, must cope with budget vagaries, fundraising, and plowing all excess resources back into the organization's mission. In addition, managers of nonprofits must coordinate the efforts of a largely volunteer workforce, minus traditional incentives with which to elicit work effort.

Such differences have led Ott (2001) to conclude that a hierarchical model for nonprofit organizations simply does not capture the nuances of such entities; he proposes a model of an atom instead. The various constituencies of a nonprofit circulate around the core activities of the organization. As long as the core activities of an organization respond to some constituent group, the organization will continue to exist. Ott argues that in business, the core of the organization may well consist of upper management and the corporate board; in non-profits, the core activity is the goal or mission to be achieved. Although many nonprofits have established boards, they rarely fulfill a governing function—rather, they serve in an advisory capacity alone. For example, Valley Health's core activity is to provide primary medical care for individuals with no other means to obtain it. In Ott's atom analogy, various constituencies (individuals served, volunteers, board members) circulate around this core, sometimes moving very close to the center (the mission)—other times their orbit is further away. For example, a grassroots movement may arise to clean up a particular waterway. Once the waterway is cleaned, the group's core activity is no longer defined in the same way. However, the organization will continue to exist if the core activity shifts to perhaps another

environmental task—thus fulfilling one constituency’s goal. If it does not make that adjustment, the organization will cease to exist.

As is evident from the previous sections, properly studying the nonprofit organization I propose to study will involve multiple levels of analysis, from the individual level of volunteers, to the macrolevel of organizational variables. For appropriate analysis, I rely on Ostrom’s study of resource goods provision, with grounding in Yin’s analytical framework.

## **CHAPTER II**

### **METHODS**

This project utilizes a comparison case study design to study the success of the Valley Health Clinic, as well as two unsuccessful clinics. The research design draws heavily on Yin (1994) as a guideline. Case studies are empirically based research of a phenomenon as understood in its real-life context. Because all organizations operate in an environment composed of other organizations, including the state, other non-profits, in this case, and private business, a case study is an appropriate method for an organizational study. The strength of the case study method lies in its ability to provide information about varying levels of analysis: individual, group, organizational, and societal. According to Yin, case studies may be either explanatory or descriptive: this study falls into the explanatory category, as it attempts to explain why this clinic has survived and remained in operation for over 15 years. Case studies rely on data collected from numerous sources; this study will follow that framework for collecting data. In addition, case studies allow for comparison to other similar situations. In my study, unsuccessful health clinics in nearby towns will be examined and compared to the successful clinic being studied.

The theoretical question guiding my research is: What factors differentiate between a non profit organization that is created and maintained and other non profits that are created but not maintained?

Empirically, this research becomes, “*Why has the Valley Health Clinic survived for over 15 years, given the unique difficulties non-profit organizations face?*” Whereas the survival of for-profit firms can be traced to successful generation of a profit margin, the same measure is not operative for non-profits, as their existence cannot be linked to profit margins. In addition, many non-profit organizations depend heavily on volunteer labor, whose dedication cannot be explained by traditional incentives, such as pay. If understood as providing a public good, non-profits find themselves subject to free-rider problems (Olson 1965), as well. Why should community individuals participate if the good will be provided by others? Explaining factors contributing to this organization’s survival requires an in-depth exploration of the organization’s founding and ongoing maintenance.

Ostrom’s (1990) theory concerning common-pool resources serves as the framework for relevant propositions. She indicates that successful common-pool resource management organizations contain elements of the following eight principles:

- (1) *Clearly defined boundaries*: Organizations must define who uses the good produced and who does not. Those who use the good are referred to as appropriators. Other boundaries involve the CPR itself—what is the organization, what issue or problem does it address, how far-reaching is its mission?
- (2) *Congruence b/t appropriation/provision rules and local conditions*: The organization is situated in a particular context. This principle addresses how closely the organization aligns itself with its locality. No single set of rules can account for different settings. For example, two projects for shared water usage may be completely different in their conditions—one could be in an area of heavy rainfall and storage capability, another might exist in a place of little rainfall. Rules pertaining to usage in each setting could be expected to vary widely.
- (3) *Collective-choice arrangements*: Appropriators (those who use the resource/good) actively participate in developing rules for the organization’s ongoing functions.

- (4) *Monitoring*: Monitors exist to ensure that rules are being followed. This keeps free-riding to a minimum. Monitors must be accountable to the group of appropriators or perhaps are appropriators themselves.
- (5) *Graduated sanctions*: Individuals who violate agreed-upon rules are generally subjected to increasingly harsher penalties, as violations increase in degree. Appropriators (or their agents) usually impose the penalties.
- (6) *Conflict-resolution mechanisms*: Over time, any organization will experience conflict. Some structures must exist, either internally to the organization, or externally, in the community, to resolve disputes over resource use or effort expended. These mechanisms must be relatively easy to use and low-cost.
- (7) *Minimal interference of rights to organize*: For an organization to successfully become established, it must be able to do so with little interference from state officials. If officials are able to circumvent the rules set up by the organization, the organization loses credibility among the appropriators.
- (8) *Nested enterprises*: Appropriators, provision, monitoring, enforcement, conflict resolution and governance are organized in multiple layers of nested enterprises. Volunteers operate at one level, the organization's advisory board at another, accountability to granting agencies at yet another. Rules at one level (local operating rules) must be coordinated with rules at other levels (funding agencies' requirements).

Although I will use Ostrom's eight principles as a framework, they require revision to account for the unique characteristics of public goods provision, as opposed to a common-pool resource. While a common-pool resource is likely to be available for a finite number of appropriators, public goods often benefit entire communities or societies, resulting in less measurable effects of free-riders. Another difference lies in the fact that common-pool resource organizations are typically convened by and managed by the appropriators themselves; however, for public goods, the good may be produced by one group but directly used by another. For example, in a health clinic setting, direct appropriators (patients) rarely possess the time, energy and money to contribute to the establishment of a clinic or its ongoing functions. The other set of appropriators—local

hospitals and clinics—are involved in a tangential way, but not directly in the operation of the clinic. The concept of free-riding is somewhat different for a nonprofit health clinic, as well. Free-riding in this case could be seen as applying to those clinics and hospitals who benefit from, but who do not contribute to the clinic's ongoing operations. However, such free-riding is difficult to pinpoint.

With these differences in mind, and incorporating information gathered through the interview process, I have reformulated Ostrom's eight principles for use in the new context of public goods organizations. The eight principles, adapted for a public goods setting, follow:

- (1) *Clearly defined boundaries*: Organizations must define what the public good is and who benefits from it. Those who benefit may benefit either directly or indirectly, and are referred to as appropriators. The mission of the organization should be clearly delineated or universally understood by those involved in its provision. A recognizable organizational structure must be in place.
- (2) *Congruence b/t appropriation/provision rules and local conditions*: Because organizational success will vary over time and across locations, organizations producing a public good must be well-situated in the local context. Since the provision of most public goods includes funding, the organization must function within the regulations of funding agencies or grantors. Has the organization adapted to its population? Does it take into account the idiosyncrasies of its location? For public goods, one would expect evidence of community involvement or support, as well.
- (3) *Collective-choice arrangements*: No organization will survive long without a means to make and implement decisions. If organizational structure is evident, decision-making structures must be present. Are decisions consciously made or do they simply happen? Who makes decisions—appropriators, founding members, others involved in the organization? Longstanding organizations must also make the transition from original founding and establishment to maintenance and ongoing functioning.

- (4) *Monitoring*: For public goods provision, the notion of monitoring takes on a different connotation. In this context, appropriators may not need monitoring, and in essence, it may not be possible to even monitor free-riders. However, if the organization is subject to certain regulations or rules, monitoring must exist to enhance the organization's credibility, and to ensure the provision of the public good.
- (5) *Graduated sanctions*: Because there is a limit on who direct appropriators are, sanctions may need to be imposed to verify that only those who qualify for the good are allowed to use it. Once one directly benefits, is it possible to lose such privilege? If so, it should be clearly denoted who can restrict access to the good.
- (6) *Conflict-resolution mechanisms*: Because all organizations experience conflict, there should be lines of authority for dealing with conflict. Conflict will likely exist between different constituent groups or individuals—volunteers, the organization, the board, professional volunteers, or paid staff. One should find open acknowledgement of conflict and of the organization's ability to cope with it. Means for working through internal and external conflicts must be evident.
- (7) *Minimal interference of rights to organize*: Organizations are situated within a particular sociopolitical context. As such, resistance from local governmental officials could cause great complications for the provision of a public good. Successful organizations will likely have experienced little difficulty with officials, at the very least. Ideally, the organization will have actually received open support and encouragement from authorities.
- (8) *Nested enterprises*: Stronger organizations will possess ties to other organizations—government agencies, other non-profits, any monitoring agencies, funding agencies. These ties confer a level of credibility and legitimacy on the organization. It should be noted that “nested” does not necessarily implicate “hierarchy.” The organization may be nested and connected to other organizational structures, without necessarily “answering” to them. The central mission of the organization makes up the core, surrounded by volunteers, staff and board. Around that structure may exist other community organizations, funding agencies, or resource generators.

I expect to find evidence of all eight principles in the data I collect on the successful clinic. Conversely, I expect to find gaps in the presence of these variables in the data collected on the unsuccessful clinics.

A crucial understanding in analyzing any public good situation involves examination of incentives. Because nonprofit organizations depend on volunteer labor, I will examine the incentives of the clinics' volunteers. Therefore, I will delineate



incentive structures that led to the founding of this clinic to provide health care for those unable to afford traditional health care. These incentive structures would include, but not be limited to, material gains for local physicians and hospitals, and physicians' adherence to professional norms of providing medical care, regardless of ability to pay. Additionally, incentive structures for the ongoing operation of the clinic will be considered, including volunteer commitment, extent of group identity for physicians, and need for organizational adaptation due to funding requirements. Organizational variables considered include the structure of the organization, existence of a board of directors, paid director, volunteer personnel, and the relationships between each of these functional areas. Macro-level sociological and economic factors will include unemployment rates in the three towns preceding the formation of the clinic, and per capita income in the areas.

I include information about the organization itself, as well as societal and community forces affecting it. Within the organization, I also examine the role of volunteers, both medical and non-medical. How do these volunteers think of their service? What rewards and benefits do they perceive? What costs do they perceive? Given the analysis of various levels of the organization, this study will be an embedded one, incorporating information about numerous levels of analysis. Moreover, studying organizational transformation requires that one follow rule adaptation over time—a case study enables such study using archival and documentation data. While a single case study offers explanation, stronger conclusions may be drawn with a comparison case study. Comparison case studies are most useful when they control for certain variables.

In this case, I will control on society, type of community, and founder differences. Two unsuccessful attempts to establish health clinics will be studied, in addition to the successful one. These clinics were attempted in nearby towns, within the past 5 years, and the founding physician was the same for all these clinics. Characteristics and structures found in the successful clinic will be compared to those found in the unsuccessful ones.

I interviewed 19 individuals in the communities, with ties to any of the three clinics, the successful one or either of the unsuccessful ones. These range from the Executive Director to the founding physician to volunteers at the clinic. I employed a “snowball” technique; as I interviewed individuals, I asked them for referrals of others with knowledge of the clinic’s history and development. Whenever new or different information was acquired from these interviews, follow-up interviews were conducted to check on discrepancies or contradictions. These interviews were audiotaped to allow for transcription of notes taken. Interviews varied in length from 45 minutes to two hours. I constructed the questionnaire to obtain information about the clinics’ establishing, evidence of Ostrom’s principles, and volunteer incentives and motivation (see Appendix 1).

In addition to interview data, archival and document data was collected. Documents include board meetings, legal documents, newspaper clippings, and organizational documents. Archival data include any data kept by the clinic, concerning services and growth over time, when accessible. New privacy laws regarding medical records precluded the use of patient data.

To increase internal validity, pattern matching is employed. Pattern matching compares evidence discovered during data collection with expected patterns, as defined by the theoretical framework (Yin 1994). Data from interviews, and archival and document data will be compared to Ostrom's predicted framework and the adaptations I have suggested. Data from the successful case is expected to more closely parallel Ostrom's principles and my adaptations of the framework; data from the unsuccessful cases is expected to reflect fewer of these principles.

Construct validity is represented by the interview design. While the questions are essentially open-ended, they elicit responses related to the eight design principles previously mentioned. In addition, document data is analyzed in light of these principles and compared to the interview data (triangulation method). Internal validity of the data will be assured through interviewing individuals holding different positions with each clinic, as well as by looking at the clinic's founding and development, as contained in documents, and through interview questions. Case study research is not generalizable to a greater population of cases; rather, it generalizes to theoretical principles. Once completed, a case study may shed light on other similar cases, but its primary relationship is to theory. The reliability and replicability of this study will be assured through careful attention to documentation and preservation of all data, including interview recordings/transcripts, documents, and archival data.

### **Locating the Interviewees**

Before each interview, participants were given an informed consent form to sign, which granted confidentiality to the participants, and the form included permission to audiotape the interviews (see Appendix 2). I interviewed 19 individuals—a 20<sup>th</sup> interview was initially agreed to by one individual, but I was not able to contact him for either an email or phone interview, as that person lived quite a distance away. After repeated attempts to re-establish contact, I determined the interview would not take place. Of the 19, two individuals were from the Smithville clinic, and four were from the Greenfield clinic. The other 13 were from Valley Health, including Dr. Verma, who knew information about all three. When interviewing individuals about events in the past, one must be aware of potential recall problems. Since individuals from all three clinics will be asked to recall events from 10-15 years ago, any recall difficulties will be present in all three settings. As a result, the effects of recall are constant and should not affect interpretation of differences.

I initially contacted the executive director of Valley Health to request permission to study the clinic and to ask for her cooperation, which she granted and offered to help with any information I might need. She set up the interview with Dr. Amit Verma, founding physician of Valley Health, which was a tremendous help since it is difficult to secure an hour of any doctor's time. At the end of the interview with Dr. Verma, the subject of clinics that had not survived was raised and the doctor noted that he knew of two such clinics that he had personally worked with in nearby towns, neither of which

was still functioning. This information led me to the comparison cases of the Charity Clinic in Greenfield and the Helping Hands Clinic in Smithville.

Using the snowball method, I asked both the executive director and the founding physician for more names of people to interview, which they provided. The next set of interviewees offered additional names and contact information for the list of potential interviewees. I subsequently interviewed the clinic coordinator, the pharmacist in charge, a physician assistant on staff, two local hospital administrators, some active volunteers, former and current board chairs, a previous executive director, and the original founder, Dr. Verma's sister. Some were easy to contact for appointments, others were more challenging, but all were willing to be interviewed and audiotaped.

Finding individuals affiliated with the two unsuccessful clinics presented even more of a challenge. Dr. Verma did not recall the names of the people who initiated and volunteered at the clinics, and he was relatively certain some of the key players had moved away from the area. I started in Smithville by calling the office of the local newspaper, and speaking to the advertising salesperson who answered the phone. He, however, had only lived in town for a year and a half, so he was not familiar with the clinic. He told me, however, that if anyone knew about something that had happened ten years ago, it would be Mrs. Peggy Swift, the semi-retired owner of the local Dairy Queen. He gave me the phone number of the DQ and said I should try to reach her there. It took a few weeks for us to make contact with each other, but finally, she was in when I called. The newspaperman was correct—she knew who would know about the clinic: a nurse at the county health department. I called the health department and asked for the

nurse, then asked if she knew anything about the clinic or if she knew who might know. Indeed, she did, she told me—she was the nurse who asked Dr. Verma to come to Smithville. From this nurse, I obtained the name of one other nurse who resided in Smithville and who had volunteered in the clinic.

Having had success with a newspaper contact, I utilized the same approach in Greenfield. I explained what I knew: a clinic operated approximately 7-10 years prior and it was in the hospital (according to Dr. Verma). The newspaper staff person on the phone did not recall any stories about the clinic, but gave me the name of someone to call at the hospital. I called and spoke to that person, who had no knowledge to offer, but knew the name of another hospital employee who was closely involved with the clinic. She put me through to the other employee, who immediately recalled the clinic, agreed to an interview, and offered contact information for a clergyperson who had regularly volunteered at the clinic. A later interview with a hospital administrator in Carlton led to a contact with the Smithville hospital's administrator from those years.

All interviewees agreed to be audiotaped, and the audiotapes were transcribed into written documents. Observations illustrating the eight principles were extracted into data sheets and later assembled into the history and analysis chapters. As a reliability check, a second researcher read the transcribed interviews to verify that my perceptions and categorization of responses was appropriate.

## **CHAPTER III**

### **TWO NON-SURVIVING CLINICS**

#### **History of the Helping Hands Clinic**

The first of the unsuccessful clinics studied was the Helping Hands Clinic in Smithville, a town of 5,100 located 30 miles north of Carlton. The town was established in the mid-1800's and served as a cotton and rail center. Because of its proximity to fertile river bottom lands, plantations flourished as the cotton industry grew. In modern times, however, Smithville has struggled to maintain economic prosperity and been only mildly successful. Being located at the intersection of two U.S. highways, and on two railroad lines has continued to keep Smithville on the map, as it were. It continues to be home to a number of manufacturing interests. The racial makeup of the community quite likely reflects its pre-Civil War connection to a plantation economy: 66% white, 34% minority (with 24% being African American). The community-based hospital closed its doors in about 1990, but All Saints Health System of Carlton operates a family practice clinic in the town for primary care (Fisher interview).

While the year is uncertain, it is thought that in the fall of 1994 (local newspaper article 09/22/94), a free clinic began operations, using the location of the Health Department in Smithville. It was open every Thursday afternoon at 3:30 p.m. Dr. Amit Verma would come at 4:00 or so, after having completed a day of work at his private practice in Carlton. Clerical volunteers and nurse volunteers came from the staff of the Health Department. The clinic drew its name from a local organization that helped

individuals in need with clothing and food. Some initial funds for purchasing medication came from a pre-existing Salvation Army account, since there was no longer anyone in town with the Salvation Army (Harris interview).

The clinic grew out of the public health nurses' realization that people in the families of those they treated, desperately needed a place where they could seek medical care (Harris interview). The Health Department could see only certain clients, and for particular reasons (immunizations, STD's, etc.). It was clear to the nurses that many of the people they saw had no Medicare, Medicaid or insurance, and they needed a place to go for treatment. One of the nurses knows that she was aware of Valley Health in Carlton, but she does not remember if she contacted Dr. Verma, or if he contacted someone at the Health Department (Harris interview). Dr. Verma remembers being contacted by someone in Smithville to ask about the possibility of coming to Smithville to see patients at a free clinic (Verma interview).

The clinic operated for a year or two at the Health Department location, then moved to the Helping Hands organization's location in downtown Smithville. The move was necessary because the Health Department simply had no room to store the amount of prescription medications Dr. Verma regularly used and brought with him. Also, it was not equipped as a Class D pharmacy, which requires a locked space for pharmaceuticals and a registered pharmacist to oversee the proper handling of the medications; additionally, the formulary for a Class D pharmacy is more extensive than that approved for a Health Department setting. The Health Department's pharmacy operated under the auspices of a pharmacist employed by the state and working out of a city 100 miles



away, and could not include pharmaceuticals that Dr. Verma regularly used; therefore, storing those medications at the Health Department would have violated state regulations. At Helping Hands, the building was open during the day for clothing and food distribution, then on Thursday evenings for the clinic. A local pharmacy owner agreed to fill prescriptions at his cost, making no profit, if a prescription beyond the samples Dr. Verma brought with him was needed. Any fundraising activities made funds available for these prescriptions to be filled (Harris interview).

No one is certain when the clinic ceased operations, but it is believed to have been 3-4 years after the move to Helping Hands' building. All together, the nurses who volunteered there believe it operated for 4-6 years. Toward the end of the time, there were not enough volunteer nurses or clerical staff to keep the clinic operative. Assignments had changed dramatically for the public health nurses in town—many of them at that time began to regularly travel to 2 or 3 counties each week. As such, they were not consistently available to volunteer on Thursday afternoons. One nurse simply described it as a period of “burnout” (Harris interview).

Even though this clinic operated for a good many years, they did not take the additional steps of establishing a structured organization, with officers, bylaws or legal standing as a 501(c)(3). One nurse expressed regret that no one had taken the time to seek out or write grants, while noting that the people who volunteered were simply overwhelmed and did not have the kind of time grant-writing would have required (Harris interview).

The next section examines this clinic in light of the eight principles that Ostrom developed to analyze successful common pool resource organizations. The last section addresses the incentives and motivations behind volunteers' involvement in this clinic.

*Ostrom's Eight Principles Regarding the Clinic*

- (1) *Clearly defined boundaries:* Organizations must define what the public good is and who benefits from it. Those who benefit may benefit either directly or indirectly, and are referred to as appropriators. The mission of the organization should be clearly delineated or universally understood by those involved in its provision. A recognizable organizational structure must be in place.

The good produced in this case is improved health care for individuals. The clinic founders determined that the clinic would serve those individuals who had no other access to health care. Children were treated, as well as adults, as were undocumented workers (Harris interview). Few questions were asked of the patients, but they were asked general questions about household income and size. No fee was paid for the medical services. Although the intake process relied on the honor system, as far as verifying what patients reported, each patient's medical history was recorded and complete files were maintained. Patients were not restricted on how many times they could come to the clinic—it was “as much as they wanted” (Edwards interview).

Another appropriators to be considered in the provision of public health would be other physicians' offices and hospitals, who would not be asked to see indigent patients at the same degree as without a free clinic. However, in Smithville's case, the hospital was no longer operating, so the impact of a free clinic on an emergency room was minimal, as the nearest hospital is in Carlton—20 miles away. There was a clinic

operating with 2 physicians. When asked about the effects on the burden for hospitals providing indigent care, one nurse indicated there was little effect (Edwards interview).

It appears that this organization possessed clearly defined boundaries: they knew they wanted to serve those with no insurance or government aid for health care, they wanted to provide absolutely free services, and they wanted no restrictions except access to health care on the patients they would see. One set of appropriators, the patients, was fully considered in this organization's genesis. However, another set of appropriators, local hospitals or physicians, were either nonexistent or uninvolved in the clinic's establishing.

(2) *Congruence between appropriation/provision rules and local conditions:* Because organizational success will vary over time and across locations, organizations producing a public good must be well-situated in the local context. Since the provision of most public goods includes funding, the organization must function within the regulations of funding agencies or grantors. Has the organization adapted to its population? Does it take into account the idiosyncrasies of its location? For public goods, one would expect evidence of community involvement or support, as well.

This principle proved to be the most difficult to explore. While the general interview questions included some that would ostensibly extract this information, they didn't work well for all situations. For example, for this clinic, questions about local funding sources simply didn't make sense, as it never reached the point of community support to any great degree.

The idea of establishing a free clinic in Smithville first emerged as a response to the fact that numerous patients from this community and county were traveling 20 –plus

miles to a similar clinic in a larger city nearby. There was no shortage of need for the clinic. Initially, the clinic held hours in the local Health Department building, with the approval of the regional fiscal manager: “And so, our fiscal manager in the region agreed that we could have Dr. Verma come to that clinic” (Harris interview). Because the Health Department could not accommodate the number of pharmaceuticals the doctor wished to store, the clinic was forced to find a new location about a year later. As noted earlier, the formulary for a health department setting is more limited than that typically used by a primary care clinic. Because Dr. Verma used medications not on the health department’s formulary, and they were taking up far too much physical space for storage, allowing the clinic to continue keeping them on the Health Department’s premises would have violated state regulations.

The clientele in this clinic was estimated by one nurse to be about 25-30% Hispanic, and over 50% African-American, with the remaining being Anglos. This likely collided with longstanding tensions in Smithville: “...Smithville is a really tough community. [There’s] some bias, racial, a lot of welfare, a lot of indigent people there who’ve been on the systems that we were talking about for a long time. [I think there is] burnout in the medical community because of all that...” (Harris interview).

In speaking of local monetary help, it was noted that “the resources in those small towns are just not there” (Harris interview). Another nurse stated it this way: “...help from the community? It didn’t seem to be a strong help” (Edwards interview). Apparently, these two nurses felt little community support or encouragement. Such sentiment is reflected in the relative lack of local newspaper coverage accorded to the

clinic—only one mention was found of the clinic over a period of 3 years, and it was a small announcement on page 8 (local newspaper, 09/22/94).

While the clinic's response to the local community's situation of many patients traveling over 20 miles for basic medical care was firmly grounded in local conditions, it never quite gained support from the community itself. The clinic remained a charity well-known by its clients but not deemed valuable by the larger community.

(3) *Collective-choice arrangements*: No organization will survive long without a means to make and implement decisions. If organizational structure is evident, decision-making structures must be present. Are decisions consciously made or do they simply happen? Who makes decisions—appropriators, founding members, others involved in the organization? Longstanding organizations must also make the transition from original founding and establishment to maintenance and ongoing functioning.

As far as formal organizational structure, a board was never formed for the clinic in Smithville; no by-laws were written: "We didn't have any protocol. [If anything, we] use[d] the Helping Hands by-laws." Helping Hands was the local charity organization, formed by the Ministerial Alliance, that ran a clothing closet and food pantry. The clinic located in the Helping Hands facility, once they were no longer able to operate out of the Health Department. "Well, Helping Hands, the pantry that eventually combined with the clinic aspect of it...had, does still have a board...they kind of took the clinic under that..." (Edwards interview). The author was given the name of someone who had been quite active with Helping Hands as a possible contact, but when contacted, the woman said she really had little to do with the clinic and would not be a reliable source. Although the clinic, while still located at the health department in the fall of 1994, used the name Helping Hands Clinic, there was no mention of free medical services in a

newspaper article about the Helping Hands ministries in March 1995 (local newspaper, 03/03/95).

Funding decisions were limited, as well. A donations box was placed out front, for patients to donate if they could; all money was put into a pharmacy fund, as rent and utilities were covered by the Helping Hands organization. Some initial startup money for pharmaceutical supplies was provided by leftover money from the Salvation Army. A local banker was in charge of that money and he was approached about using it for the clinic—he agreed. A local pharmacist agreed to help out with filling prescriptions at cost only. The few local donations were used to augment a pharmacy fund, as those expenses were the most pressing (Edwards interview).

Recruiting additional volunteers, another aspect of decision-making for a volunteer-based organization, never quite got off the ground for this clinic: “Unfortunately, the physicians in Smithville—we tried to get them involved because we knew Dr. Verma was going to burn out... We never got ‘buy-in’ from those doctors in Smithville. They just didn’t have the vision. They didn’t have that mission to do that” (Harris interview); “...there was a [doctor] in [a nearby rural area who] helped him...once or twice and he was an elderly doctor...and that is the only doctor that came to call when Dr. Verma asked for assistance” (Edwards interview); “So I don’t know why it was so difficult to get the help. It was such a great thing” (Edwards interview). However, it is to be noted that a few patients volunteered “to help us open up—like turn the lights on, get the chairs out” (Edwards interview).

From all indications, the clinic was neither a completely stand-alone organization, nor was it fully integrated into an already existing organization. The clinic never quite made the transition to a more organized, community-based organization. With a paucity of volunteers, no critical mass of individuals involved could make the organizational aspect a priority—simply opening the clinic each week was the priority of volunteers who were stretched thin.

- (4) *Monitoring*: For public goods provision, the notion of monitoring takes on a different connotation. In this context, appropriators may not need monitoring, and in essence, it may not be possible to even monitor free-riders. However, if the organization is subject to certain regulations or rules, monitoring must exist to enhance the organization's credibility, and to ensure the provision of the public good. While formal monitoring may not be possible, coordination with other organizations should involve some oversight and verification.

Primarily, due to the lack of structural organization, this clinic's only monitoring interaction came when it ran up against state laws regarding what pharmaceuticals could be stored at the health department. "[Medications he used] weren't in our formulary...blood pressure, cholesterol... It was an issue there that we had more drugs and you know the security of those drugs was an issue. You have to have a pharmacist come in and review...how you're managing those drugs periodically and that couldn't happen because our pharmacist from [the State Department of Health] managed our pharmacy in [a city 100 miles away] ..." (Harris interview). According to Dr. Verma, "Then [the public health nurse] had on-the-spot...inspection from the Health Department and they saw all these medicines and they got very upset with her. And they gave her 30 days to close it down." The medications Dr. Verma used were not all on the approved formulary for the Health Department, so storing them was in violation of state

regulations. Following this encounter with state regulators of the State Department of Health, the clinic was forced to find a new location, which is when it moved to the downtown building used by Helping Hands.

Since there was no paid staff, there were no staff evaluations involved in this clinic's operations. Effectiveness seems to have been seen in the fact that there was always a demand for services: "We would fill up a roster of only 15 people...[the doctor] didn't want us to go over that amount" (Edwards interview); "There was a steady stream [of patients]" (Harris interview). Patients would come to the clinic on a walk-in basis—the first 15 to sign in formed the roster for that day. The nurses experienced little difficulty in filling up the roster any given week. However, if effectiveness is understood in terms of community support, or number of new volunteers, it is clear this clinic could not be considered as effective using those measures.

So, while monitoring existed to an extent, it was less obvious than it might be in a more fully developed organization. Its effect was profound, in that it precipitated a change of location, but after the move, even that effect was mitigated, as the clinic was no longer subject to the same kinds of regulations it had been when operating out of the Health Department's facility, since state regulations dictated what medications could be stored there. Once the move was made, those regulations were no longer in play, and as a physician, Dr. Verma was the authorized person overseeing the use and storage of the pharmaceuticals he brought with him to the clinic.

- (5) *Graduated sanctions*: Because there is a limit on who direct appropriators are, sanctions may need to be imposed to verify that only those who qualify for the good are allowed to use it. Once one directly benefits, is it possible to lose such privilege? If so, it should be clearly denoted who can restrict access to the good.



Very few violations of agreed-upon rules were evident. No one remembers patients losing treatment privileges, and there was perhaps only one time when the clinic failed to operate because the doctor could not come (Edwards interview). It is therefore difficult to say whether or not this principle was in place, since there appears to have been little need for sanctions.

- (6) *Conflict-resolution mechanisms:* Because all organizations experience conflict, there should be lines of authority for dealing with conflict. Conflict will likely exist between different constituent groups or individuals—volunteers, the organization, the board, professional volunteers, or paid staff. One should find open acknowledgement of conflict and of the organization’s ability to cope with it. Means for working through internal and external conflicts must be evident.

Again, few recollections of conflict exist: “I don’t remember any [conflict]....probably the conflict would be who got in line first” (Harris interview). The previously noted conflict with the State Department of Health simply resulted in the move to a new location. Small conflicts may have occurred after the move, in working with the Helping Hands organization: “...some of the children would run around and get into the stuff...a few complaints the next week...clothes were messed up or something was missing...we just made sure we kept an eye on the kids...” (Edwards interview).

Although the conflicts occurred infrequently, and did not warrant much memory of them, they were addressed easily by the organization, and did not fester. It seems that dispute resolution did take place, albeit on a limited scale. This may mean that coordination and survival issues were so pressing that other conflicts simply did not surface.

- (7) *Minimal interference of rights to organize:* Organizations are situated within a particular sociopolitical context. As such, resistance from local governmental officials could cause great complications for the provision of a public good.

Successful organizations will likely have experienced little difficulty with officials, at the very least. Ideally, the organization will have actually received open support and encouragement from authorities.

This clinic met no resistance from local officials—more likely, it met apathy: “[The clinic was] not really noticed probably” (Harris interview). However, a few local leaders had ties to the clinic, which should have increased its legitimacy among local residents. One bank vice-president made it possible for the defunct Salvation Army funds to be used for pharmaceutical expenses and a pharmacist made a deal to fill prescriptions at cost (Harris interview). As for reactions from local officials, one nurse commented, “I don’t think there was (sic) anything but good reactions” (Edwards interview).

As for other professionals in the area, again, there was little reaction from physicians, other than that they referred patients to the clinic (Edwards interview). Local merchants did not respond negatively, as they were happy to have the Helping Hands ministry keeping the building up: “...downtown Smithville is pretty sad, so you know, the building was kept up...and I think they were happy about that” (Harris interview).

While local officials may not have been wholly aware of the clinic, they quite likely offered no resistance to its establishment. The organization was free to continue on as it wished.

(8) *Nested enterprises*: Stronger organizations will possess ties to other organizations—government agencies, other non-profits, any monitoring agencies, funding agencies. These ties confer a level of credibility and legitimacy on the organization. It should be noted that “nested” does not necessarily implicate “hierarchy.” The organization may be nested and connected to other organizational structures, without necessarily “answering” to them. The central mission of the organization makes up the core, surrounded by volunteers, staff and board. Around that structure may exist other community organizations, funding agencies, or resource generators.

The organization with which this clinic was most closely allied was the Helping Hands organization, which in looking closely, was a good fit for the clinic: "...the people who work with Helping Hands in that county are probably some of the most forward thinking, community-spirited people" (Harris interview). This relationship, however, was quite informal: "...Helping Hands kind of had a restriction on how often they could come in for food—that did not filter over into [the clinic]" (Harris interview). Because there was no true advisory board that specifically oversaw the clinic's operations, that level of organization was simply missing. One nurse saw this as a possible drawback when she stated, "We never really, I guess maybe got organized so that we can go out and recruit as a group or as an agency" (Harris interview).

While the clinic was nested within another organization, this relationship did not particularly or clearly shape the clinic's ability to operate. It represents a potential effect, rather than an actual effect, on the clinic's functions.

### *Incentives for Volunteer Participation*

Both nurses interviewed emphasized Dr. Verma's commitment to the project and his passion for it: "You know, his background and where he came from, I think he had a ...very good understanding of no money and sickness" (Edwards interview); "I think it was cultural and religious, because he came from India and he knew the need there. [H]e said several times how fortunate he had been and he wanted to return, like so many people like him do. They just want to return what they've got back to people" (Harris interview). As for the physician's effect on those with whom he worked, one nurse

stated, “Dr. Verma was just really great to work with and...he appreciated us and he showed that. He was very grateful for the staff that helped. I think if he hadn’t have been, we would’ve quit a long time before ’98” (Edwards interview).

The commitment of the nurses is evident in their statements as well. One nurse remembered that she worked on her own time for the clinic, beyond her full-time job as a public health nurse: “...this was on my days off and weekends sometimes. [I would] spend time wrapping up samples in rubber bands and getting them all together...” (Edwards interview). The other nurse realized that her view of public needs had changed since she had been a public health nurse, after having practiced in private settings for many years. Her understanding came not from her nurses’ training, but from her practice: “I guess you just see the need and that’s why I did it. ...doing public health is so different from clinical-based or hospital-based nursing. ...I had no idea of community needs. It wasn’t in the training...it was in my practice” (Harris interview).

Other incentive structures are missing from this context. With no local hospital seeing immediate effects of emergency visits by the individuals who should be seen in a clinic, there is no incentive for participation by that entity. While physicians may have seen some relief from treating indigent patients in their offices, that aspect is unclear from the information gathered.

### **History of the Charity Clinic**

The second unsuccessful clinic was located in Greenfield, a small rural community of approximately 3100, 30 miles from Carlton. The town is approximately

150 years old, and it is the county seat. Greenfield's early prosperity relied on its location at the intersection of two main highways and proximity to major rail lines. Its population remained stable from 1940 to 1970 at 2100, but oil was discovered in the county in the 70's and the population expanded rapidly. According to townspeople, the economy of Greenfield was hit hard with the oil bust of the 1980's (Lawrence interview). The county's population in 2000 was composed of 74% white, 26% minority. A local hospital opened in 1956, followed by an expanded countywide hospital in 1978, but it closed in 1989 (Cleaver interview). It reopened about a year later as Greenfield Community Hospital.

The concept of opening a free clinic in Greenfield took form in March 1994, with a meeting of concerned community individuals, held at Greenfield Community Hospital. The hospital administrator, at the urging of the CFO, agreed to allow the clinic to convert a patient room into an examination room (Cleaver interview). Dr. Amit Verma spoke to the group, noting that he saw many patients from Greenfield at Valley Health in Carlton (news article, June 1994). The clinic began operations in May 1994.

The local Ministerial Alliance provided clerical volunteers, and local first responders and EMT's worked as screeners (news article; M. Bloom interview). In addition, a collaboration with the local Rotary Club provided immunizations for a number of children. The hospital offered space for the clinic to meet, and it held hours each Tuesday from 3-6 p.m. (news article, June 1994). Dr. Verma arrived at 4:00 each Tuesday, after having completed hours at his private practice in Carlton (Lawrence, I. Bloom interviews).

In addition to providing space for the clinic to meet, one of the hospital's regular employees, Barbara Lawrence, was released from her normal duties on Tuesday afternoons to assist with the clinic. Her presence provided the hospital with some semblance of oversight, since the clinic operated on hospital property. Other local resources include the services of a pharmacist who would fill needed prescriptions at cost. Dr. Verma brought a considerable number of samples with him to use for the patients, but if a prescription was needed, this pharmacist had agreed to be of help in this way. In addition, the hospital administrator agreed to allow Dr. Verma to order x-rays and certain lab tests for the patients (Cleaver interview).

The clinic operated for 15 months, until September or October of 1995. A number of volunteers could not commit to the clinic at that time—a local Cultural Festival, football season, school events, and 4-H all vied for time and commitment. In addition, the Greenfield County Hospital had recently negotiated a lease agreement with All Saints Hospital of Carlton, and All Saints was preparing to begin hospital operations later that fall. All Saints chose to not allow the clinic the use of its space. Since the clinic was not able to secure an ongoing commitment to the space previously used, and it was unable to find a new location, it simply ceased existing (Lawrence interview).

The next section examines this clinic in light of the eight principles that Ostrom developed, but adapted to the new context of public goods provision. The last section addresses the incentives and motivations behind volunteers' involvement in the clinic.

*Ostrom's Eight Principles Regarding the Clinic*

- (1) *Clearly defined boundaries:* Organizations must define what the public good is and who benefits from it. Those who benefit may benefit either directly or indirectly, and are referred to as appropriators. The mission of the organization should be clearly delineated or universally understood by those involved in its provision. A recognizable organizational structure must be in place.

As with the clinic in Smithville, the public good produced is improved health care for individual patients. The clinic's name is a clear indication of what type of care was intended by its founders: free health care for the economically disadvantaged: "This was basically the only place [where people could go for free care]" (M. Bloom interview); "You almost had to have no funds, no resource to anything like Medicare, Medicaid...[it] was designed to catch older people without resources, who fell through the cracks [of the social service system]" (Lawrence interview). The doctor treated children and adults. Undocumented individuals were welcome...and no one asked about official residency papers (M. Bloom, Lawrence). Patients were asked if they were eligible for any other means to pay for the care—including insurance or government programs. If they were, they were referred on to another clinic. They were asked to provide information about family size, income, proof of income and residence, and any eligibility for food stamps (Lawrence interview). They could document this with school records, utility bills, bank statements, or pay stubs (Lawrence). There were no limits on how often a patient could come to the clinic.

The indirect benefactor of this public good was the newly re-opened hospital. The Chief Financial Officer of the hospital lobbied the hospital administrator on behalf

of using empty rooms for the clinic. The administrator noted that “it made perfect sense. [F]inancially...it was space we weren’t using for anything else...the marginal cost of a few more lab tests...is negligible. [T]he real payoff is at least some of them would [have] ended up in your physicians’ clinic, and you wouldn’t be paid for that, or your emergency room. [Y]ou’re taking care of people who need it in the most cost-effective way” (Cleaver interview). The administrator and CFO were keenly aware of the benefit their organization would receive from the presence of such a clinic and were willing to put physical space and service resources behind it (Cleaver interview).

- (2) *Congruence b/t appropriation/provision rules and local conditions:* Because organizational success will vary over time and across locations, organizations producing a public good must be well-situated in the local context. Since the provision of most public goods includes funding, the organization must function within the regulations of funding agencies or grantors. Has the organization adapted to its population? Does it take into account the idiosyncrasies of its location? For public goods, one would expect evidence of community involvement or support, as well.

The clinic was a project of the local Ministerial Alliance, in a sense. Dr. Verma remembers being approached by “a church group” and he told them he would be willing to travel to Greenfield one evening a week if they found the space for him to work (Verma interview). The Ministerial Alliance provided some of the volunteers, especially one minister from the Presbyterian Church who volunteered on a regular basis (M. Bloom interview). It was this community group that secured the hospital space for the clinic to use: “The one in Greenfield was started by a church group. I told them if they found a way to do it, I’ll be glad to come. So they started, they got a room from the hospital” (Verma interview).



When asked why the community felt a need for a clinic at that time (1994), one former volunteer noted: “[In the 80’s], there was an oil boom and...everybody had a job. Oil started petering out in the early 90’s, and my suspicion is, there was a lot of unemployment because the oil boom was over” (M. Bloom interview). However, the hospital staff person who worked the clinic did not believe that higher unemployment was an issue—she saw the clinic as an outgrowth of the Ministerial Alliance’s mission, “to help the community” (Lawrence interview).

None of the individuals interviewed could remember a community board that functioned independently for the clinic. Ms. Lawrence, the hospital staff person, remembered that a few individuals did meet together, but was unsure of how formal the structure was (Lawrence interview). There was no funding to speak of: “The hospital provided us with space and all the volunteers. As far as I know, we did it without any funding” (I. Bloom interview). The small amount of local charitable giving that did make its way to the clinic (\$200 at most) was used for pharmaceutical supplies. When asked if any publicity had been undertaken, the reply was that none was needed. They had plenty of patients already! (Lawrence interview) However, it should be noted that one negative consequence of little publicity might have been a lack of community awareness, which could have resulted in donations of time and money.

One aspect reflecting the local community was the presence of volunteers who could interpret Spanish for the Hispanic population: “There was a lady...from [an outlying Catholic] Church...” (M. Bloom); Barbara Lawrence indicated that they could also use hospital staff to translate if need be, although many of the patients brought their

own translators with them. Other times, the volunteers got by with rudimentary Spanish skills: “We could communicate if we listened very carefully and repeated it” (I. Bloom interview). There appeared to be a pretty universal acknowledgement of the necessity for Spanish translation, however. “We had some Anglos, but we had a lot more Hispanics than we had Anglos” (M. Bloom).

- (3) *Collective-choice arrangements*: No organization will survive long without a means to make and implement decisions. If organizational structure is evident, decision-making structures must be present. Are decisions consciously made or do they simply happen? Who makes decisions—appropriators, founding members, others involved in the organization? Longstanding organizations must also make the transition from original founding and establishment to maintenance and ongoing functioning.

Decisions in this clinic were made by two main individuals—Dr. Verma and Barbara Lawrence. Dr. Verma made the medical decisions, and Barbara made day-to-day operating decisions: “She was sort of our mother (laugh). She told us what to do—what we needed to do” (I. Bloom interview). While there was likely a functioning board, even one consistent volunteer from the Ministerial Alliance knew little about the board, and indicated that organizational decisions were made by “Barbara—who else?” (M. Bloom). Another volunteer EMT said the board “...was Ms. Lawrence’s concern” (I. Bloom). The hospital administrator was not aware of a community board that operated on behalf of the clinic, either (Cleaver interview). Lawrence remembered a board made up primarily of Ministerial Alliance members, but it was not involved in everyday decisions, although it did set a policy of the clinic seeing only patients from Greenfield County. Board minutes might have been helpful in determining more of the board’s

functions; however, Lawrence recalled that all records around 10 years old had been purged from the hospital's storage facility—therefore, those records no longer exist.

Lawrence saw her job as one of coordinating the clinic's operations—she was to “keep volunteers coming in,” make sure the rules of eligibility were followed, and to speak to the hospital administrator if additional lab tests were needed for a patient. Although her primary job was with the hospital, her time with the clinic was encouraged and facilitated by the hospital (Lawrence interview; Cleaver interview). She also issued guidelines to volunteers about proper handling of patient records, what educational material to display and keeping the children waiting in the clinic from running up and down the hospital halls (M. Bloom).

Dr. Verma was unable to recruit other physicians to help him on a regular basis; the clinic “was always sort of marginal, because it depended so much on Dr. Verma's ability to come. Our local doctors did not [volunteer]” (Cleaver interview). There was little relief if Dr. Verma could not come to the clinic any given week: “[W]e had this one doctor...he was okay with the patients. But he was very abrasive with the workers. He was at the clinic a couple of times, when Dr. Verma was away...he was retired” (Lawrence interview).

Other volunteers—nurses, EMT's, office workers—were primarily recruited by word of mouth by others working in the clinic (M. Bloom, Lawrence interviews). According to Lawrence, getting commitments from volunteers in the evening was quite difficult. This problem dogged the clinic throughout its short lifetime.

- (4) *Monitoring*: For public goods provision, the notion of monitoring takes on a different connotation. In this context, appropriators may not need monitoring, and in essence, it may not be possible to even monitor free-riders. However, if the organization is subject to certain regulations or rules, monitoring must exist to enhance the organization's credibility, and to ensure the provision of the public good.

Due to its short time in existence, few monitoring situations presented themselves. There was not much of a functioning board, and no paid staff, so an annual report was never compiled. As with any medical clinic, however, there were regulations that had to be followed for medication dispensing. Dr. Verma brought many sample medications with him, and could dispense them as samples, but the clinic itself could not store medications beyond what Dr. Verma brought with him (Lawrence interview). The hospital was unable to provide resources in the form of pharmaceuticals: "...one of the clearest needs was for drugs, and we really could not divert drugs out of our hospital pharmacy to support that—it was illegal, the way it turned out" (Cleaver interview).

One area of monitoring the clinic undertook was to attempt to keep improper use of the services to a minimum. Because demand was so high, the individuals involved with the clinic felt it important that they not treat anyone who could use other resources to attain medical care. So if a patient came in and said they did not have insurance, but it was known where they were employed, the volunteers would sometimes call the employer to verify whether the person had insurance or not (Lawrence).

- (5) *Graduated sanctions*: Because there is a limit on who direct appropriators are, sanctions may need to be imposed to verify that only those who qualify for the good are allowed to use it. Once one directly benefits, is it possible to lose such privilege? If so, it should be clearly denoted who can restrict access to the good.

If a patient indeed was covered by health insurance by their employer, the clinic would not continue to treat them; they could come the first time, but would not be

allowed to come for treatment the second time (Lawrence interview). With limited time and resources stretched thin, they felt they should not be taking patients who had other access to health care.

Other than those instances, there is no recollection of sanctions for any infraction of spoken or unspoken rules. Because the clinic was in its infancy, few rules had been developed, and few volunteers were involved.

(6) *Conflict-resolution mechanisms*: Because all organizations experience conflict, there should be lines of authority for dealing with conflict. One should find open acknowledgement of conflict and of the organization's ability to cope with it. Means for working through internal and external conflicts must be evident.

A few examples of conflict surfaced in the interviews, primarily between the patients and the organization: "There were occasions when we had to walk amongst the people and be disciplinarians [because of so many children in the waiting area] (M. Bloom interview); "[the lady] said you've got to give me some medicine [and she] had an interpreter who was making threats and stuff. Very ugly, you know. We explained to her—we're here, but we're volunteers. She just got very angry..." (I. Bloom interview). One time, a school sent many students to the clinic with a lice outbreak, but it was too late in the day for them to be seen, because the clinic cut off the patient list at 18 patients each time. The volunteers from the Ministerial Alliance mediated that situation and explained to the school officials that the children simply could not be seen that day, but they could come back the next time (Lawrence interview).

Other conflicts manifested themselves in the relationship between the clinic and the hospital, but they were addressed for the most part. The hospital administrator remembered that "...there was some griping and grumbling [from hospital staff] about

having ‘those people’ waiting around in the lobby. But I...didn’t care.” Apparently some gift store workers and cafeteria workers were unhappy because the children were sometimes difficult to control, and the patients used the coffee/tea/water in the cafeteria, producing more work for the housekeeping department (Lawrence interview). In terms of use of the space, at times, Ms. Lawrence “would come down before the clinic actually opened and said, ‘We’re having this problem with the patients. Can we try to do this?’” (M. Bloom interview). Operationally speaking, the hospital and the clinic came to an understanding about patient records—the hospital did not have additional room to keep the patient records, so they requested that the records be kept with Valley Health’s records (Cleaver interview). According to one volunteer, “The [hospital was] most accommodating” (I. Bloom interview).

As far as conflict with volunteers, there was one doctor who substituted occasionally for Dr. Verma, but “...he was very abrasive with the workers. I had several ladies that told me, ‘I will not come back to work when he is here’” (Lawrence interview). Because he was rarely at the clinic, this posed little difficulty. More pressing were conflicts with regular volunteers over hours they would come: “So many times, Dr. Verma was late...a lot of the workers...were accustomed to volunteering [for other organizations, saying] ‘okay, I’m going to volunteer between 4 and 6:30.’ They expected to be through at 6:30...that was part of the problem” (Lawrence interview). As noted earlier, this lack of volunteer commitment plagued the clinic during the entire year of its operation.

While the individuals interviewed tended not to refer to disagreements as conflict, they could easily point to the resolution of said disagreements.

(7) *Minimal interference of rights to organize*: Organizations are situated within a particular sociopolitical context. As such, resistance from local governmental officials could cause great complications for the provision of a public good. Successful organizations will likely have experienced little difficulty with officials, at the very least. Ideally, the organization will have actually received open support and encouragement from authorities.

Few comments recall any reaction from city or county officials to the clinic's operations, although Lawrence recalled that the clinic was well-received, as local officials were aware of the need for such a clinic. Pointing to the incident with the schoolchildren coming for treatment, a minister noted that "there was word out there [among school officials] that we were here and in service" (M. Bloom interview). Generally, it seems that local officials either paid little attention or helped publicize the clinic's services to potential patients.

As for the two local physicians, they "...were very much supportive of it...otherwise, some of these people would have showed up at that clinic, and they didn't want to see them either" (Cleaver interview). A volunteer nurse recalled, "There was no animosity or anything. No resentment shown to me [by the doctors]" (I. Bloom interview). The doctors in town did not actively volunteer, nor did they provide any roadblocks—the clinic was free to organize without interference.

(8) *Nested enterprises*: Stronger organizations will possess ties to other organizations—government agencies, other non-profits, any monitoring agencies, funding agencies. These ties confer a level of credibility and legitimacy on the organization. It should be noted that "nested" does not necessarily implicate "hierarchy." The organization may be nested and connected to other organizational structures, without necessarily

“answering” to them. The central mission of the organization makes up the core, surrounded by volunteers, staff and board. Around that structure may exist other community organizations, funding agencies, or resource generators.

The organization within which the clinic was most extensively nested was the hospital. It was an “ideal situation,” according to a volunteer nurse: “Number 1, we were part of the hospital. Number 2: we could provide these services, and keep these people out of the emergency room. And it was a good location—people knew where the hospital was” (I. Bloom interview). The hospital provided two rooms, plus waiting room space, as well as “administrative help for [Dr. Verma]” (Cleaver, Lawrence interviews). The hospital administrator knew “that we needed to provide some things, and was I willing to do that? I said, ‘Sure.’ It made perfect sense. Other than providing space, we would provide...some lab tests. I always made sure that Dr. Verma knew that I was glad to have him” (Cleaver interview).

Without community organizations providing funding, the author was simply unable to analyze other nesting examples for this clinic. However, the hospital was firmly and consistently supportive of the clinic, as it provided a good many resources for the clinic’s benefit. Once the hospital changed management to All Saints Health System of Carlton, the clinic was no longer allowed to continue meeting there. This change of the nesting relationship likely precipitated the clinic’s closing.

### *Incentives for Volunteer Participation*

The volunteers interviewed from this clinic felt a personal satisfaction in using their time to volunteer there: “I felt like I was doing some good with my time” (M.



Bloom interview); “I was very depressed when we closed. I was using my training and my experience and I was giving back. [F]or me, it was not only helping somebody, but it was something that I actually helped myself, in so many ways. [W]e were family. We looked forward to seeing each other...we bonded with each other” (I. Bloom).

Lawrence, the hospital staff person who coordinated the clinic’s operations, stated her belief that people volunteer as long as they’re having fun (Lawrence interview).

All of the volunteers appreciated Dr. Verma’s commitment to caring for the patients: “He came *here*. He came to us, after a day in his office...he came here. I know of very few doctors who would do that. And I highly respect him. To me, those are doctors with a big ‘D.’ Something in his life touched him and made him aware of other peoples’ needs. But he is one of the few.” (I. Bloom interview); “...[Dr. Verma] was trying as hard as he could, to do something for these, these poor people” (M. Bloom).

Both the hospital administrator and one of the volunteers were aware of how important it was to have a clinic of this type—it was that awareness that prompted the hospital to provide as many resources as possible (Cleaver, I. Bloom interviews). The nurse observed, “It is a terrible expenditure for the medical centers. If we open this clinic, it would take some of the drag off... you and I. So I am all for clinics” (I. Bloom interview). While the awareness of cost-effectiveness of supporting the clinic drove the hospital’s support, it apparently did not provide enough incentive for the new managers of the hospital.

## **CHAPTER IV**

### **THE SURVIVING CLINIC**

#### **History of Valley Health Clinic**

Carlton was a small city of 55,000 in 1990 in the south central section of the state. It was established in the mid-1800's, and became a center of agricultural production with the building of the railroad system. A nearby college town sprang up a few years later, when a large state university located there. Together, the population of the two towns was approximately 110,000 in 1990. In 2000, Carlton's population was 65% white, 35% minority: Oakwood's was 81% white, 19% minority.

Significantly, for the purposes of this study, in the late 1970's, a medical school was established at the university and now enrolls over 300 students. Two hospitals—a Catholic hospital and a for-profit hospital—operate in the area. Major sources of employment of residents of Carlton and Oakwood are education (the university employs 12,000), and health services (All Saints Regional Health Center, Regional HMO Medical Clinic and the Oakwood Medical Center). Other significant employers include computer and electronics, and financial and accounting services.

Valley Health Clinic began as the brainchild of Priya Sharma, co-owner with her husband of the Twin Oaks Motel in north Carlton, in 1987. “[The motel where we started] is a small unassuming place...with a restaurant, coffee shop kind of diner where everybody comes and gossips and talks about politics...a working class neighborhood. A lot of farmers used to come there...blue collar workers, construction guys... ..you

become friends. They're family" (Sharma interview). The oil boom had busted and "there was quite a depression in those days...[the] late 80's...coffee drinkers who would come and say they had no jobs. And our motels that used to be filled up with all of the workers used to stay empty. There was nobody in the motel. They didn't even have money for coffee really" (Sharma interview).

Ms. Sharma noticed a number of her regulars were dealing with health issues that were quite treatable, and on a regular basis sent them to her brother, Dr. Amit Verma, for treatment. She herself had trained as a physical therapist in Great Britain, and recognized a number of ailments she saw in her customers. Finally, she realized there were so many who needed her brother's help that a different arrangement was required. "[My sister said] 'Why do I have to send all these patients across town? Why don't you come here to see them?' The motel wasn't doing so well, with all the unemployment. 'I'll open a motel room and you can see them there.' So that's how we started—in one motel room. I used to go once a week" (Verma interview). Thus, the clinic became reality (Sharma interview). There were a few concerns, however. Dr. Amit Verma's wife, Dr. Shilpa Verma, was concerned about liability and the possibility of being sued, so they came up with a waiver for patients to sign, releasing the doctor from liability. A few years later, as concerns about liability for other volunteering physicians surfaced, further investigation revealed that a state law was passed in 1987 to provide immunity to physicians volunteering nonemergency services in a nonprofit, 501(c)(3) organization (emergency settings were already covered under the Good Samaritan Law). The law limits liability for said physicians, if the organization for whom they volunteer has a

liability policy of its own (State legal journal). In addition, because of the proximity to the restaurant, Ms. Sharma “worried about...the health department--we had inspectors from the health department coming every two, three months to check the restaurant, check the motel. I don’t know if they turned a blind eye to us realizing what we were doing or what. They could have easily shut us down...but they never even fussed with us” (Sharma). In spite of these misgivings, the clinic remained open and soon was seeing numerous patients each week. According to a former administrator of the university’s medical school, “...it’s quite a story because here is a nonchristian liberal Democrat in a conservative community; he’s Indian and Indians give back in providing free health services, in his sister’s hotel room. [H]e gathered up a critical group of people...that really believed in what he was doing” (F. Wilson interview).

Dr. Verma took a day each week away from his private practice to see patients at the motel. Services were free and all patients who showed up were treated. Dr. Verma’s wife, Shilpa, also a medical doctor, worked one day a week at the clinic, as well. They brought samples of medication with them and distributed as many as possible to the patients. The motel receptionist served as their first receptionist (Sharma interview). Before too many months, it became clear that they would need someone with Spanish skills, as a considerable number of patients were Spanish-speaking. “At that time, Ana Martinez...just walked in when we started over there. She heard from somebody—a maid or somebody—that she was talking to. I think some Spanish families told her there was a free clinic. She just showed up one day, said, ‘Dr. Verma—I heard about your clinic and I want to come and help you.’ And I said, ‘Here’s the desk, here’s the pencil,

sit down.’ She was Spanish-speaking and none of us could speak Spanish....[S]he was really the heart and soul of the clinic” (Verma interview). Ana helped check in the patients and kept the charts straight, which left the medical tasks up to Dr. Verma (Verma interview). Ana’s presence moved the clinic forward, as “a clinic like this just cannot work with the doctor. It has to be a community affair and it has to be people...there’s lots of work behind seeing the patients—documentation, paperwork, lab” (Verma interview).

The clinic continued to meet at the motel for a number of years. By this time, Sister Lydia Fisher, Chief Executive Officer of All Saints Hospital, had become involved in the endeavor: “I told dear Dr. Amit...if you want other people to contribute and get some kind of tax credit for it...we need to become incorporated. We need to have a set of by-laws. We need to, by the way, clarify and write down our mission” (Fisher interview). In 1990, Articles of Incorporation were filed with the state’s Secretary of State, listing Priya Sharma as President of the Board of Directors, and the address as the Twin Oaks Motel. The Incorporation was requested “so that tax exemption can be granted, allowing for Valley Health, Inc. to support itself on donations from the local community” (Certificate of Incorporation, Secretary of State, 08/15/1990). The fledgling board was put together by Dr. Verma: “Dr. Verma asked a core group...he had a profile of who he wanted. He knew that he wanted another physician. And then the pharmacist. Then the ‘organizations’ person—me” (Fisher interview).

Business continued to pick up on clinic days, and Ms. Sharma expanded to allow 2 motel rooms to be used. However, so many patients were coming to the clinic that they

crowded the parking lot and areas around the motel, which began to negatively impact Ms. Sharma's primary businesses—the motel and the restaurant. “After 6 to 8 months, there was no place to park...people would just stand in line...the waiting room was just too small....so we ended up making another examination room, so that Dr. Verma could go back and forth. And if there was a little ground...they would just sit and wait outside. It was a sight, it really was a sight” (Sharma interview). At this time, in the fall of 1992, the clinic raised money from the community and relocated to a laundromat building formerly used for storage by Ms. Sharma and her husband (Sharma, Verma, Wilson interviews). It was approximately ½ mile north of the motel. With the help of volunteer labor from a local church, it was remodeled into an area with a waiting room, examination rooms and space for the pharmacy (Sharma interview; Local newspaper, 01/20/1992).

The clinic expanded quickly, and another move followed a little over a year later, to a building owned by a local school district, close to All Saints Hospital, in the spring of 1994 (Change of Registered Office papers, Secretary of State, 05/02/1994). They stayed there a little over a year, until the school district needed the space for its health-focused magnet high school. Up to this point, each location had been donated or, in the case of the school building, leased for a very nominal fee. It became clear that the next move would require a commitment to being able to pay rent for a building that would accommodate future growth for the clinic. (Verma interview)

In August 1995, Valley Health established operations in downtown Carlton, in its current location (Secretary of State papers, 08/31/1995). It was affordable and was large

enough to provide space for a waiting room, examination rooms, pharmacy and office space. The clinic has operated out of this location for over 10 years.

The next section examines Valley Health in light of the eight principles that Ostrom developed to analyze successful common pool resource organizations. The last section addresses the incentives and motivations behind volunteers' involvement in this clinic.

*Ostrom's Eight Principles Regarding Valley Health*

- (1) *Clearly defined boundaries:* Organizations must define what the public good is and who benefits from it. Those who benefit may benefit either directly or indirectly, and are referred to as appropriators. The mission of the organization should be clearly delineated or universally understood by those involved in its provision. A recognizable organizational structure must be in place.

The patients that come to Valley Health make up the group of direct appropriators—they directly benefit from the public good produced. Patients include the unemployed, those with no insurance, those not eligible for government assistance, and frequently, undocumented workers (Browning, Garcia, Verma interviews). That mission has not changed, although the clinic currently asks for documentation of income: “We do require that they provide us with their income information. We use HUD guidelines. Which is roughly about 200% above the poverty level—most of our clients never even get that close...” (Browning interview). “[W]e’re here to help anybody but because we just get overwhelmed, we have certain financial criteria that have to be met. We don’t see anybody that has Medicaid, Medicare, health insurance...” (Blackman interview). No fee is paid for services (Garcia, Browning interviews). Most patients are adults, but children are treated, as well. According to a number of sources, the presence of children “dropped from about 10% of what we see to about 4%” (Browning interview), due to

the...Children's Health Insurance Program (CHIP) (Verma, Blackman, Redding, Browning interviews). CHIP "is designed for families who earn too much money to qualify for Medicaid, yet cannot afford to buy private insurance for their children" (state human services website). Since a number of Valley Health's patients fall into this category, CHIP offers the ability to have their children treated elsewhere.

Patients are allowed to come to the clinic as often as needed—there is no limit on the number of times they are seen. In fact, a majority of the patients have chronic illnesses: "...initially, I think Dr. Verma's vision was, we'll have this clinic once a week and people with chicken pox or sore throat...or bronchitis will come and we'll give them medicine and they'll go home and it would be fine. But what we find is 99-100% of all of our patients have underlying health problems" (White interview). Ongoing care for these individuals is essential and Valley Health becomes their primary care physician: "Diabetics and hypertensive people, [we] try to give them 3 months worth of medicine and have them come back in 3 months" (Redding interview). More often than not, the difficulty in treating chronic illnesses was "trying to get people to come back...for hypertension, diabetes, asthma" (Fisher interview). For this population, the availability of free medication is critical: "Only a rich man could afford to buy all of those medicines that they're on. ...unless you've got insurance" (Redding interview).

The indirect appropriators of the public good—improved health care—are made up of local hospitals and physician's clinics, as well as insurance companies and individuals in society who do not have to absorb increased emergency room costs. "...we provide an essential service that is not provided any other way...it benefits the



community which gets cost effective care for this group, who would get it in an ineffective way... So we really are providing a service to the community and a service to folks who presently are the working poor” (F. Wilson interview). Others also mentioned the benefit local hospitals derive from the existence of the clinic: “...one visit in my office costs... roughly \$40—medication and everything— versus the \$500 visit to the emergency room. [W]e are either eliminating or decreasing their emergency care. ...what we’re hoping to do is prevent loss of limbs and other types of things that keep people from being able to continue to work” (Browning); “And All Saints, I mean besides being a wonderful institution...wants these people to not be in the emergency room. So if we can keep one diabetic person under control and make sure their sugar is tested at least every three months...it’s definitely worth the hospital’s while” (White); “All Saints’ emergency room is very happy we exist. I don’t think Oakwood Medical benefits as much as All Saints, but the doctors at Oakwood Medical have a place to refer nonpaying patients” (J. Wilson); “[Reducing the burden of indigent care] that goes to the ER...is the idea” (Olson); “Sister Lydia, [CEO of All Saints], was no dummy and could see that if this patient group is served outside of the emergency room, everybody wins” (F. Wilson); “[If the clinic were not there]...we would probably see an increase in some of the catastrophic things that happen” (Fisher).

A growing and increasingly formalized structure has enabled Valley Health to continue providing comprehensive services for its patients for 18 years. Initial organizational steps included the incorporation of the organization and writing of by-laws in 1990, and attaining 501(c)(3) status in 1992. Incorporation papers filed with the

state exempted the organization from certain state taxes, and required that the organization have 3 directors, by-laws and a constitution. Benefits of attaining 501(c)(3) status include exemption from federal income tax and the ability for donors to give tax-deductible donations to the organization

(<http://www.irs.gov/charities/charitable/article/0,,id=96099,00.html>). In addition, one executive director indicated that having that formal status made applying for funding from agencies much more simple (Browning interview), and as noted earlier, the status offered liability immunity to physician volunteers. The board met regularly as early as 1990, and involved at least one leader of a local hospital, who lent her organizational expertise to the fledgling clinic (Fisher interview). The hospital even offered meeting space for the board, as it grew in size: “[I]n January of 1992...[the board]...went from meeting at Dr. Verma’s to meeting at All Saints’ educational center...and suddenly we began to look like an official organization” (J. Wilson interview).

Sometime between 1990 and 1992, the clinic “went public” with its mission and message: “...we kind of jumped in and told our story to [the local public radio station] and [television station] and did things that were necessary” (J. Wilson). Board minutes from October 1992 indicate that over the preceding year, three articles had appeared in the local newspaper, some local television stories, and some articles in a local magazine. “[By 93, there were] tons of volunteers...doctors, med students, health students...it had grown quite rapidly...we had an optometrist...so it was growing” (Olson). The first full-time executive director was hired in 1993, after the clinic had moved to the renovated laundrymat. This shift to a more organized structure, fully incorporated, with a

functioning board and paid staff, along with the move to a more suitable building, signaled the metamorphosis from a developing organization to one requiring ongoing maintenance.

(2) *Congruence b/t appropriation/provision rules and local conditions*: Because organizational success varies over time and across locations, organizations producing a public good must be well-situated in the local context. Since the provision of most public goods includes funding, the organization must function within the regulations of funding agencies or grantors. Has the organization adapted to its population? Does it take into account the idiosyncrasies of its location? For public goods, one would expect evidence of community involvement or support, as well.

“One of the really critical things, and this is a real tribute to Dr. Verma, is that he was willing to step back from ‘this is my clinic,’ to ‘this needs to be community based and not for profit.’ How could we overcome this obstacle that no other physician is going to take part? And part of that was: ‘Well, it’s not Verma’s clinic, it’s the community’s effort...’ (F. Wilson). Dr. Verma knew the clinic would need to garner community support if it were to continue operating: “We sat down and said either we close this place, because it is going to take the community or we need community help. Ana said, ‘Dr. Verma, you can’t close this clinic and I don’t want to see it close. I’ll do anything to help.’ We went on TV, and wrote an article for the [local newspaper]” (Verma interview). It became clear that community support would be vital to the continued success of the clinic, at about the 5-year mark. According to one newspaper article, Dr. Verma had appealed to the local medical association for ‘soldiers to man the fort,’ but had secured few volunteers (local newspaper, September 22, 1991). “Dr. Verma had just formed an ad-hoc committee to look into funding from a nongovernmental point of view because he had tried hard to receive city funding and

receive the backing of the medical society...and those things hadn't worked out. [M]y husband [was with] the College of Medicine. He allowed some of his people, [a Public Relations person and a Development person], who were with the College of Medicine [to lend their expertise to the clinic]" (J. Wilson). More volunteers and a better facility were needed, so they appealed to the public for help: they told their story to the local newspaper in a well-placed article with pictures and a complete discussion of Valley Health's mission and financial situation. "Verma's free clinic serves 'the people who fall between the cracks.' The clinic has no annual budget and survives on a month-to-month basis" (local newspaper, September 22, 1991). "I said nobody was going to give money to start a clinic just before Christmas. People are too busy. To our surprise, within 6 weeks, we had 25-30 thousand dollars collected. Just like that. With that money...we renovated a place that was right next door to the motel" (Verma interview); "One of Dr. Verma's friends...was a member of [a local] church and he enlisted them and they...converted the laundry mat into a very clean, neat little clinic. But it was too small the next day because with the small clinic came a lot more physician volunteers. Most of the [physicians] started with us when we were in...that facility, because we had three examining rooms...a clean bathroom...a waiting room" (J. Wilson). By this point, two local religious organizations had begun to actively and publicly support the clinic, one of which provided aid for prescriptions (local newspaper, September 22, 1991). Within a few months of the move, the number of physician volunteers doubled, from four to eight, and appeals for additional donations to keep the new clinic in business once again

appeared in local publications (local newspaper, April 1, 1992; local magazine, April 1992).

When the second facility was outgrown, about a year after moving into it, the next move was made possible through community support, as well: “Then we moved to the building that [the school district] had...it was the best financial deal we had. We went and talked with the superintendent...she said, ‘many of our students use your clinic and we would be more than happy to open up the building for you’” (Verma); “...and so [the school district] let us have that space for a song. Token payments” (J. Wilson). The only drawback to this location was its distance from its primary clientele, as it was a few miles from the neighborhood in which it started (Verma, Sharma interviews). The clinic stayed in the school building for 3-4 years, when the school district needed to use the building, then moved to downtown Carlton, where it still operates: “We were lucky to find this [current location]. It was the right place, downtown, the right place for our clients” (Verma); this location was much closer to the neighborhoods where the majority of patients lived and they could easily utilize the local bus system for transportation.

The move to downtown was only possible because of increasing economic support from the community, especially Community Development Block Grants (CDBG), which are essentially federal grants disseminated by local communities. “Sister Lydia, at one of those many board meetings, said, ‘Look, I heard that the cities are going to start funding local agencies. Why don’t you all try for this?’ And [our PR person] wrote a very simple little summary about what Valley Health was doing. ...we got top priority for five years in a row...and the most money from CBDG” (J. Wilson). This

grant made it possible to hire the first executive director (Verma). Later, the local United Way added Valley Health to its recipient list, and the County Health Endowment Fund (tobacco settlement money) gave money to its pharmacy. “Tobacco funds” come from a master settlement reached in 1998 between 46 states and the tobacco industry to reimburse the states for monies they had spent treating individuals with tobacco-related illnesses. However, each state is free to determine how they wish to disburse the funds. In the home state of this study, a fund was established in 1999 to aid in indigent care—organizations apply for amounts that they will put toward indigent care (<http://www.ncsl.org/programs/health/Forum/tobaccomm.htm>). The money is then distributed through the counties to the qualifying organizations. In addition to the organizational funds coming into the clinic, individuals and local churches and civic organizations continued to donate funds through the years, as well: “One time...they ran out of money in the fall...and Jean said no more blood work. Well, I happened to mention it in Sunday School and a guy...in the Lions...said ‘how much money you need?’ And I found out and let him know and he got the Lion’s Club people ...to contribute more than enough money to finish the year with lab work and stuff” (Redding interview). While some funds which come to the clinic originate at the federal level, it is not considered a federally or state funded health clinic.

The composition of the board most certainly reflected local realities: “we really needed a community board...[with] representatives from business...the medical community...a banker...a lawyer. You know, the usual formula” (J. Wilson); “We have membership from Oakwood Medical, All Saints, Local HMO. We have a CPA on the

board...the residency program...local business people. But some of the key points, we try to make sure we have a representative from that organization or group” (Browning). There is no doubt that the passion of early board members, most especially Jane Wilson, brought many talented community people to Valley Health: “...an extraordinary player in this has been my wife...who has gotten so many people involved...she is relentless! I can tell you that the College of Medicine would not ever have been as involved as it has been if she had not been relentless” (F. Wilson); “...so many people have been involved. But I claim having gotten key players and my husband who’s been so instrumental in giving us advice all the way along. ...I think I got [our fundraising chair]. And she knew [the wife of a prominent Carlton banker]...who offered to host our first big publicity type event” (J. Wilson).

Medical businesses, especially the two hospitals and one major HMO clinic, supported Valley Health in a number of ways: “[Oakwood Medical] gives every physician in the community a \$25 donation in his or her name on their birthday. ...300 times, we give a \$25 donation to Valley Health” (Johnson interview); “All Saints had a relationship with the clinic for years and our monthly donation to the pharmaceuticals that the clinic used began with something like \$500 a month. It’s now at \$2500 a month”; “...my husband, [the Dean of the medical school], engineered [us] going to [the HMO’s headquarters] in [a nearby city]. That was probably about 1994...there had been a changeover in leadership and Frank...said this is the time to go. ...she and I went and we ended up getting not only the okay for [the local] clinic to volunteer at the clinic, but

also a check from [the HMO's foundation]. And we have been nicely supported absolutely every year since" (J. Wilson).

Finally, the clinic adapted early on to its clientele, in that Spanish translation was possible almost from the beginning, when Ana Martinez offered to volunteer. At the time of the interviews, both the clinic coordinator and the executive director spoke Spanish (Browning, Garcia interviews). This is an essential part of the clinic's services, as many of the patients are Hispanic. The most helpful student volunteers, according to the clinic coordinator, are those who are bilingual, or who can at least speak a bit of Spanish (Garcia interview).

(3) *Collective-choice arrangements*: No organization will survive long without a means to make and implement decisions. If organizational structure is evident, decision-making structures must be present. Are decisions consciously made or do they simply happen? Who makes decisions—appropriators, founding members, others involved in the organization? Longstanding organizations must also make the transition from original founding and establishment to maintenance and ongoing functioning.

Organizational structure depends on sound decision-making capabilities and division of labor amongst the decision-makers. In the case of this clinic, decisions about structure, fundraising, recruiting volunteers, and what services to offer, are at the heart of the clinic's ability to offer health care.

Quite likely the most pressing decisions and activities revolve around recruiting additional medical volunteers. Without the physicians and nurses, the clinic would cease to function, no matter how many clerical volunteers or community supporters there were. According to Dr. Verma, "It's very difficult. It has been very tough to get physicians' involvement. There is an angle that they are taking enough no-paying



patients in the ER [when they have ‘emergency room call’]. But that is the wrong way of delivering health care. If you want to deliver health care in an economical way, that doesn’t cost society as much, then you need something like this.” Physicians are recruited in a number of ways—mostly, Dr. Verma or other volunteer physicians personally ask their colleagues to come to Valley Health and volunteer some time. At this time, approximately 50 physicians give time to the clinic, in blocks varying from one hour a month to an entire day each week. One memorable instance of recruiting came when the wife of the dean of the medical school, a very active volunteer from the early days in the motel, regularly attended medical alliance meetings: “I [would] think of some excuse to stand up and say, at Valley Health this month, so and so...and they have made a few little donations to Valley Health as a group. [The wife of a prominent physician] called and said ‘you know that place you talk about?’ I said Valley Health...she said yes. She said ‘my domestic has a health problem.’ So she took her cleaning lady...for a walk-in, picked up the telephone, called her husband. ...thirty minutes later [he] was down there with his flight jacket on and his stethoscope. He was our first official... volunteer [from the HMO in town].” This doctor’s experience led to further involvement of other physicians from the HMO clinic.

Other medical volunteers would come from the medical school: “We had Valley Health present to the students in Leadership [at the medical school], as an example of how they could make a difference in the community. Dr. Verma’s daughter was a student here for a while, and she really got those students into it” (F. Wilson). Other times, students on residency rounds would be encouraged to come to the clinic: “Last

month, we had 3 students...doing their residency with [a local doctor], who just told them, 'By the way, I'll be at Valley Health, if y'all want to come....meet me there at 4:00'...all 3 of them came" (Browning). On the other hand, a difficulty arises when first-year medical students or pre-med students from the university come to volunteer, but really want to shadow the doctor on duty, rather than help with clerical tasks. According to the nurse coordinator, "...first year medical students...don't know enough. And they didn't know how to take a blood pressure. But we're not here to teach people. We need people to know a certain amount" (Redding).

For about a year, a grant enabled the clinic to provide services through a full-time, paid Physician Assistant. This arrangement allowed the clinic to always have someone on duty, pretty much 5 days a week; however, that grant has expired and new funds have not been forthcoming (Garcia interview). The clinic again had to rely solely on volunteer medical labor. More than one person interviewed indicated if they won a million dollars in the lottery, they would give the money to Valley Health to establish a fund for a full-time paid physician assistant, to reduce the need for volunteers doctors (Sharma, Garcia interviews). They know that without the doctors, the clinic would no longer exist.

Nurses come from an assortment of settings, too. Most often, a nurse tells other nurses about Valley Health—they are recruited by word of mouth. There are "nursing school students, EMT's sometimes. [We find nurses through] the [senior citizens' volunteer group]...things in the paper...go to seminars. Sometimes people just call the clinic...and want to help" (Redding). An unexpected source of volunteer nurses is the

criminal justice system: “We have judges who look for community service and they’ll say, ‘I see you have [nursing] skills and they need someone over at Valley Health. You can go and be a nurse.’ You know, for a citation, a speeding ticket” (Browning).

Pharmacists have been recruited in much the same manner—word of mouth: one was recruited by a pharmacist-friend, another by the executive director at a children’s dance class (White). In the early years, “All Saints provided the...pharmacy oversight for the clinic. [O]ne of our staff pharmacists...took it on and she even gave it some of her weekend time” (Fisher). One pharmacist regularly sits on the board because, “...the pharmacists think it’s important...and I suspect the board also does and I know [the executive director] does” (White). Bringing in new medical volunteers is a constant theme and concern for the clinic.

Clerical volunteers are frequently students from the university (Garcia, Wilson, Browning interviews); they rely on these students to such an extent that the clinic is squeezed for help during school breaks (Garcia). Students may be pre-med majors, nutrition, sociology, psychology, Spanish...any number of majors with an interest in health care, social services, or using Spanish skills. Bilingual volunteers are in great demand and highly sought after (Garcia). There was no concerted effort to recruit students as volunteers—they somehow managed to find Valley Health on their own. The clinic coordinator mentioned another venue for approaching volunteers: [W]e go to...those health fairs, then I try to give my pamphlets to whoever...attends ...and that’s a good thing, because we’ve been having help from that” (Garcia). Other volunteers are at the clinic because of regulations that concern food stamp assistance. According to the

executive director, individuals with school age children must work 20 hours a week to continue receiving assistance from the state—the position does not have to be paid, but should offer a way to gain some kind of skill, in this case office and clerical skills (Browning). A number of the volunteers doing community service for whatever reasons return to volunteer on a regular basis: “[A] lot of people...need community service hours for a variety of different things...We have a lot of people who stick around” (Browning).

At one time, patients could volunteer at the clinic—in fact, one patient-volunteer eventually earned her pharmacy tech license and worked as the clinic’s pharmacy manager before leaving to take another job (J. Wilson). However, with the advent of more stringent privacy regulations surrounding medical records, the current executive director determined that allowing patients to volunteer was not wise (Browning). In consultation with the rest of the staff and the board, the executive director instituted a formal policy of no patient volunteering. Patients do help out with non-patient related tasks, however: “One of the patients has a large flatbed that we have used to move things” (Verma); “With patient help, we put up a dividing wall to turn what had been one big room into two rooms” (J. Wilson).

Organizational decision-making centers in both the executive director and the board, along with its ad hoc and established committees. The earliest formal decisions included those to incorporate and to apply for non-profit status: “I think one of the keys was bringing in a large cross section of the community. Sister Lydia...came to our modeling meetings and provided all sorts of expertise” (J. Wilson); “I imagine that our first official board meeting we adopted those bylaws, [in 1990 or 91]” (J. Wilson); “We

kept reporting back to the board about the progress [toward attaining 501(c)(3) status]. I think we also used [All Saints'] legal firm who had gotten [All Saints] through the steps" (Fisher); "Sister Lydia had a lot to do with the fact that Valley Health is a non-profit and they went through all the trouble to go get 501(c)(3) status" (Browning). Completing the tedious process later proved quite beneficial: "[For funding agencies], you just give them a piece of paper that says I'm a 501(c)(3) and it's pretty convenient...[it was] a very wise choice" (Browning). The by-laws were written in 1990, to facilitate incorporation (state incorporation papers), and 501(c)(3) status was attained in May 1992 (Internal Revenue Service document, 05/06/1992). These two actions set the stage for more formalized structures and decision-making arrangements, and formed the framework upon which the organization grew.

The decision to hire the first full-time executive director came from the board and Dr. Verma: "The organization was getting too big. And Ana Martinez was moving out of town. And she had applied for a grant, and in the grant, she had asked for an executive director" (Verma); "It was the board's decision. It had grown to the point that it definitely needed a person that would give it full-time..." (Fisher); "Lisa was our executive director for three years and...she really transformed us. She had run many projects. She knew how to make an accounting of our expenses correctly and project needs" (J. Wilson). Once the clinic formally contained an executive director, daily decisions and operational were made by that individual.

As a general rule, operational decisions about Valley Health are made by the executive director on a day-to-day basis, with regular communication between the board

and the executive director. “I think [the sense of trust from the board is] very good. They’ve given me the leniency to make those decisions and feel comfortable that when I’ve made those choices, it was...the best decision for Valley Health” (Browning). The board provides support for the executive director, according to each member’s expertise and community position: “If it’s something, like accounting-wise...I just call...the CPA on the board. If it’s a personnel problem, then I call Wayne Johnson [at Oakwood Medical], and say, ‘Is it okay if I go talk to Mary over at Personnel?’” (Browning). In terms of decisions, the board chair interviewed noted, “The Executive Director would recommend [services] to the board. We added...mental health services last year. And she recommended that” (Johnson). The first executive director echoed current decision-making arrangements, saying decisions about services were “kind of a joint board/executive director/volunteer thing. [I]f an opportunity presented itself, [for example], equipment became available [for an optometrist]. [And we] thought...we should provide this” (Olson). The board itself is divided into committees, and those committees take a good deal of responsibility for making decisions about services: “When we changed formulary to exempt things off of our formulary...it was a Quality Control Committee decision, who said, look we’re no longer purchasing hormones” (Browning); “Final decisions are all made by [the executive director]. There’s a review committee [with a pharmacist on it]...and we set the formulary—what we will do, what we won’t do. [W]e decided that we would order our medications in bulk...and repackage them...to save money” (White); “[We] developed stricter criteria for sponsoring prescription medications and a clinical committee chaired by a physician

made that recommendation to the board” (Johnson). From interviewing both board members and two executive directors, it became clear that operational decisions were truly made in partnership.

Operational decisions are influenced by patient needs, even by results of patient surveys. The earliest patient surveys were based on a longer patient satisfaction survey used by a local hospital (Fisher interview), and they have been collected every few years, with the most recent survey taking place in the last six months (Garcia). While patients may be asked what would make the clinic more useful to them, or what would make them more comfortable, direct medical observations provide the clearest guidance about what services might be initiated or expanded (e.g. mental health services) (Browning).

Fundraising decisions are undertaken primarily by the board and its relevant committees: “...the Board...[the] finance committee [makes fundraising decisions]. It’s been the Board’s philosophy that we would participate in United Way, not file for Medicaid provider number [to receive government funds to care for Medicaid patients], that we would not charge residents on a sliding scale. That we would solicit the community at our Spring fundraiser and...promote an alternative giving program during the holiday season” (Johnson). Since the founders and board made the decision to provide all services free of charge, from the earliest days of the clinic, such fundraising efforts became increasingly important as the clinic grew and the number of patients increased. The dean of the Medical School introduced his Director of Development to Valley Health and she served on the board for many years, offering expertise in

fundraising. She has now passed the torch to her current boss, though she continues to serve on the committee (Thompson, F. Wilson). According to one board member: “I think that’s why you’re asked to serve on the board...on any board in a community. Give money, get money, or don’t bother to serve” (Thompson). Talented community individuals have served on the fundraising committee over the years: well-connected community volunteers, development specialists from the university and medical school, a local banker and his wife. This committee took up where the founders left off, increasing the scope and scale of fundraising beyond anything initially envisioned.

Closely tied to fundraising is grant-writing, which takes up approximately 20% of the executive director’s time: “That’s what they hired me to do. Occasionally, there’s a requirement [for board approval and signature], but not regularly” (Browning). Some executive directors focused more on grant-writing than did others, but each found it to be a big part of the job (Olson, Wilson, Browning interviews). The largest and most often recurring grants have come from the Community Block Development Grants, the United Way, and the County Health Endowment Fund, with smaller grants from local civic and religious organizations. One grant, in cooperation with the public health program of the medical school, provided funds for a full-time physician assistant for a year (Browning). Other funds come into the clinic indirectly, through indigent drug programs sponsored by pharmaceutical companies, whereby individuals qualify for free medications and they are dispensed by the clinic’s pharmacy (White). The result of all the fundraising and grant-writing is that “on \$250,000 a year, [Valley Health] provides over a million dollars worth of care” (Browning).



- (4) *Monitoring*: For public goods provision, the notion of monitoring takes on a different connotation. In this context, appropriators may not need monitoring, and in essence, it may not be possible to even monitor free-riders. However, if the organization is subject to certain regulations or rules, monitoring must exist to enhance the organization's credibility, and to ensure the provision of the public good.

The purpose of monitoring for an organization providing a public good, and especially one with a fiduciary responsibility to its donors, is to monitor the organization itself—verify that it is operating within accepted standards and in compliance with relevant regulations. Various constituent groups have a stake in organizational monitoring and accountability: individual donors, granting agencies, the board of directors, pharmaceutical companies, and the state. In this case, the direct appropriators (patients) require little monitoring, and it is simply not possible to monitor indirect appropriators (society at large), to eliminate free-riding.

While monitoring of appropriators is minimal in this case, it is still present. Patients are asked to provide "... proof of their income...because you're using public donations...we're very careful to be sure that people qualify..." (Redding). Patients are asked to provide documentation of their financial circumstances, but it can take a number of forms: "HUD voucher...household type of information....letter from the Food Stamp office...check you're receiving from Social Security disability or unemployment...letter from them stating that" (Browning). During the intake process, patients release their information to the clinic, so the clinic staff could go to the state to "collect collateral evidence," if necessary (Browning). Verifying the lack of insurance is more problematic, and the clinic must trust patients to reveal any access to insurance they may have. Requiring documentation became the standard operating procedure with

the arrival of the executive director interviewed—prior to that, no such documentation was required (Browning, Olson, Wilson interviews).

Organizationally, one expected form of monitoring would be evident in annual reports to the board. While these are presented, they have not always been in formal manner: essentially the executive director would present a summary of the year's activity: "...patient logs...unduplicated patients...basic statistics" (Olson interview); "...the kinds of problems...patients had..." (Fisher interview). The executive director prepares the annual summary and makes it available for the board; portions of it are also available for donors at the annual fundraising luncheon (document from luncheon, 04/08/2005). An annual audit is performed by a local accounting firm, the cost of which is a budgeted item each year (Browning, J. Wilson, Thompson interviews).

Also standard is the use of paid staff performance evaluations. The executive director is evaluated by the board, generally the board chair, and the clinic coordinator and pharmacy manager are evaluated by the executive director (Browning, Johnson interviews). This enhances accountability and goal-setting by the staff. Volunteers are not formally evaluated, but "from time to time, there would be people that...wanted to volunteer, but they didn't show up. They weren't invited back" (Fisher interview).

Mostly, the clinic was so delighted to have volunteers that it seemed quite unnecessary to evaluate them! When the PA was on staff, he was evaluated by Dr. Verma, as only a medical colleague would be qualified to evaluate the PA (Blackman interview).

According to the American Academy of Physician Assistants, and in accordance with state laws, a physician must supervise the work of a physician assistant, and be available

for consultation “at all times either in person or through telecommunication systems or other means” (<http://www.aapa.org/geninfo1.html>); Dr. Verma served as the supervising physician for the PA at Valley Health.

Funding agencies require a variety of material to verify that the clinic is using funds wisely. The first executive director, who now works for a foundation which grants funds to nonprofit organizations, noted that compared to what she currently requires from organizations, she was required to furnish “very little. It was a dime-to-dime operation when I took over...it wasn’t real sophisticated” (Olson interview). Since that time, funding agencies have asked for somewhat more information—some may never visit, others make an annual site visit, another requires a monthly report of activity and expenditures (Browning). Keeping up with the different requirements is the purview of the executive director. Computerization has made this aspect of the job much simpler, but even that depended on donations of equipment and technical expertise (Browning).

The most extensive monitoring concerns the pharmacy. As a Class D pharmacy, which requires a locked space for pharmaceuticals and a registered pharmacist to oversee the proper handling of medications, the clinic was held to certain standards. The pharmacy cannot carry particular medications: beta blockers, antipsychotics, narcotics (Blackman, White interviews). The pharmacist in charge carries a good deal of the weight of monitoring: that person must “make sure that what’s on the label is in the bottle. I am responsible for the correct pill being in the correct bottle. Pill counting can only be done according to [state] law in [my] direct supervision. That’s why I have Elvis on my nametag, cause I walk in and say Elvis is in the building and then people can start

counting [a joke—from the days when people thought Elvis Presley wasn't really dead—'Elvis may still be in the building']. All of this must be documented on a dispensing log. The State Board, if they receive a complaint, can cite the clinic and probably ultimately me, if it's something I had control of, but primarily the clinic. ...the license has to be renewed every two years just like an ordinary pharmacy" (White).

Current regulations allow dispensing nurses to give out medication, so the pharmacist in charge does not have to be physically present for each clinic hour. The State Pharmacy Board is empowered to inspect the pharmacy and "if things are not in compliance, then we are informed of it, and we have X number of weeks to become...compliant, and then we send a notification to the board saying, these steps have been done to get us back on track and then everybody is happy..." The regulations for a non-profit health clinic's pharmacy are no different than for any other pharmacy, as far as keeping meticulous dispensing records for medications. "The pharmacists are very well aware...no matter what they do, their license is at stake" (Fisher interview).

Pharmaceuticals dispensed, patients seen, funds disbursed—all are evidence of effectiveness. The interviewed individuals cited a variety of effectiveness measures: number of patients served, amount of medications given out, number of physician volunteers. For the executive director, effectiveness is "all of those things. ...the annual audit...also provides a 'value of service.' So we can go to funding agencies and say: 'On \$250,000 a year, I'm providing over a million dollars worth of care.' So it's not just the numbers, but what is it worth?" (Browning). Still others cite educational measures as reflections of effectiveness: "The effectiveness of the pharmacy can be measured...in

terms of compliance by the patient. ...it means that the person [is] able to tell you how they take their medicine” (White); “Made my day one time—a man...said, ‘I’m walking a mile and a half a day.’ ‘Why?’ ‘Because you told me to.’ So... every once in a while you have a success” (Redding interview). One former board chair expressed the clinic’s record this way: “I’m impressed that the clinic has expanded; the demand has expanded. [It is] able to get more community resources and more dedicated people. [W]e have continued to return most of the dollars back into serving the folks. ...it also makes you more cost effective [to use] volunteers as opposed to paid folks. I see it as really effective because...it has every year maintained and grown in reputation as a valuable community activity. More and more people know about Valley Health” (F. Wilson).

- (5) *Graduated sanctions*: Because there is a limit on who direct appropriators are, sanctions may need to be imposed to verify that only those who qualify for the good are allowed to use it. Once one directly benefits, is it possible to lose such privilege? If so, it should be clearly denoted who can restrict access to the good. For organizational integrity, sanctions should be evident if those providing the good do not maintain proper accountability, either financial or related to the core mission of the organization.

The clinic is only able to treat a finite number of patients, yet the need for medical services in the community far outstrips the clinic’s capacity. At least one individual displayed a certain sense of ambiguity about sanctioning those who do not follow the rules: “We’re here to help anybody but because we just get overwhelmed, we have certain financial criteria that have to be met” (Blackman). As noted above, the clinic staff asks for documentation of income and government programs utilized, but is typically unable to verify lack of private insurance coverage. Sometimes, “other people would tell the clinic that ‘So-and-so said [they don’t have insurance], but...they’ve

really got insurance’” (Fisher). If an ill person comes to see the doctor, he/she is treated the first time, then “they’re given information and told okay, you need to bring these things back to see the doctor next time” (Browning). If the patient fails to produce the requested documentation, he/she is not allowed to see the doctor the second time. “[I]n the past we’ve possibly had a few patients that have abused our services that we’ve had to say, well, this isn’t going to work” (J. Wilson); “...one thing that led to people not being...invited back...would be that they had another source of help for their care” (Fisher). Limiting the availability of services to those who have no other access to health care, either government or private, maximizes how many individuals can be assisted.

Other than misrepresentation of medical care access, it was rare for a patient to lose treatment privileges. Generally speaking, “very improper behavior” is not tolerated at the clinic: “...it has made a world of difference...to say, ‘I’m sorry. You’re no longer welcome in Valley Health. This is a privilege, not a right.’ I don’t like to take that attitude, but it does happen. You’re going to get one opportunity to apologize, cool off, apologize to the staff. I make very clear that this behavior is not acceptable” (Browning); “[W]e had a patient who came in and...got tired of having to wait...and he started getting abusive, and cursing, and I told him... ‘we don’t need that. I won’t tolerate you cursing the staff and personnel and I’m not gonna treat you.’ And I have since sat down with him after things cooled off” (Blackman). In one case, “[a volunteer physician] had a patient who was very rude and very disrespectful and that was [the doctor’s] last visit to Valley Health. ...I can’t afford to lose doctors, nurses, I can’t afford to lose my staff. I

can't afford to lose my volunteers" (Browning). These situations are for the most part rare, but could not be dismissed for the very reason noted here. Most instances involve the individual not being treated at that time, but being allowed to come back to the clinic, once the anger had passed and an apology was made: "...we understand that, but for the grace of God, we'd all be down there too. We do have to set limits and they need to know the boundaries and they have to work within those boundaries" (Blackman).

Other individuals who might be subject to sanctions would be the medical or clerical volunteers. However, "the clinic revolves around the physicians and nurses" (Olson), so it was not logical to impose sanctions on the very volunteers on whom the clinic's existence depends. Although no instances of dangerous behavior by volunteers was mentioned, one might assume that any behavior that would threaten the patients or the clinic would be censured. So what happened when a physician did not arrive for his or her shift at the clinic? "[It's] really upsetting, they have people they're really disappointing. But there really isn't anything you can do" (F. Wilson); "...that unfortunately is a black time...it's really hard on the patients. As a volunteer, I know it tears me up and I get furious with the person who didn't show up. On the other hand, the doctors are volunteers too and they have their emergencies" (J. Wilson); "We have a backup plan—we do have some doctors who I can call" (Browning). Even though the absence of a medical volunteer is a great inconvenience, the rest of the staff and volunteers simply work harder and attempt to cover the services as much as possible. Volunteers are far too precious for the organization to "disallow" them from volunteering because of a missed shift.

Organizational sanctions might be imposed by funding agencies, for noncompliance of regulations or requirements. While this could prove to be quite detrimental, none of the interviewees have any recollection or knowledge of being sanctioned by funding agencies. Indeed, the fact that Valley Health continues to receive funding on a regular basis speaks well for its record of compliance and adherence to funding agency requirements (Johnson). Due to the extent of state regulations concerning licensed pharmacies, another area in which sanctions could be imposed would be the pharmacy; however, the consulting pharmacist knew of no instances of having been cited by the state pharmacy board (White).

Overall, sanctions are used sparingly in reference to appropriators (patients), are non-existent for the providers of care, and have been avoided by the organization in its relationships with outside regulators and agencies.

- (6) *Conflict-resolution mechanisms*: Because all organizations experience conflict, there should be lines of authority for dealing with conflict. One should find open acknowledgement of conflict and of the organization's ability to cope with it. Means for working through internal and external conflicts must be evident.

The people interviewed acknowledged that, though there is little conflict, it does surface once in a while. Internally, it may take the form of unhappy patients, dissatisfied physicians, or organizational malfunctioning. Externally, Valley Health exists in the context of other nonprofit health care agencies, as well as social service agencies, in the community. While little external conflict was noted, a measure of cooperation is necessary for the clinic to function well in the community.

Nearly unanimously, the interviewees cited the executive director as the conduit for resolving patient issues (Browning, Blackman, Olson, Thompson interviews):



“...when a patient is upset about something...feel like they’re not being treated properly...then the executive director will come out, or the clinic coordinator, and handle that” (Thompson). Generally, the patient simply needed to be calmed down, or asked to leave until they could be more respectful. In addition to the executive director working with patients, when needed, “Dr. Verma is real good about saying, ‘Excuse me, but these people are all volunteers. If you’re not happy with what you’re getting, you’re free to go pay someplace else’” (Browning). As noted earlier, when patients complained, it was generally because they did not like the long wait to be seen by the doctor. Because the clinic operates on a first-come, first-served basis, the wait if you were seen at the end of the time could be “a little much for some people” (Olson). Overall, incidents of unhappy patients were few and far between, and for some interviewees, did not warrant mentioning.

Any conflicts with volunteer physicians were generally addressed by the founding physician or the board. There was “...a need for doctors to get more involved in the allocation of prescription medicine...[we] had a team sit down with the attending physicians and talk to them about what we could and...couldn’t do” (Johnson); “...we had one physician...the patients loved her because she took a lot of time with them, but she ordered so many tests and x-rays and we were just really spending a lot of money on that. I think Dr. Verma may have visited with her” (Thompson). In one incident, the first executive director remembered being interviewed for “a newspaper article in the campus newspaper. They were notorious for misquoting people...and they wrote it in a way that kind of insulted doctors. It was not a good situation. [Two influential board

members] came to my defense. I got a couple of calls...it was enough to be uncomfortable for a little while. I decided I'm not going to talk to reporters from the [campus newspaper]" (Olson). The nurse coordinator stated that conflict with nurses occurred "very, very seldom" (Redding).

Conflicts with office volunteers were directed to the clinic coordinator or the volunteer coordinator. However, it was noted that, "Primarily, volunteers, if they don't like it, they're not going to come back. [We tried] to figure out...what jobs would fit best with their personality..." (Olson). The physician assistant observed, "Somebody we've counted on...calls and says we're going to the beach. Well, that's a conflict, they've put us in a bad way. We understand what volunteers are...our expectations are not necessarily as high...we would nicely say, please try to give us a little more notice" (Blackman). There were "little things" that came up, "personality frictions," or volunteers who wanted to work with a friend, rather than on their own, but in general, conflicts with office volunteers took care of themselves, in that the volunteer would self-select out of the situation (Thompson, Fisher, Browning interviews).

Conflicts that affected how the organization functioned internally would have especially centered on the paid staff, and there have been limited instances of conflict. When that was the case, the board became involved in pursuing a solution. The present executive director said "there hasn't been anything. [But] I would probably go to one of the board members, whoever I felt would be able to handle the situation the best" (Browning). One past issue was related by more than one individual: "When I was on the board, we ran into the problem of the executive director bringing her child to the

clinic all the time. ...initially, she was just a baby...it got to be where she was there all the time running around...and it was brought to the board's attention and she had to be told that...she just couldn't bring her little girl any more" (Thompson); "We had an issue with [a] previous executive director...regarding her needing to balance her child care activities with work. And I believe the chair and a...couple of volunteers sat down with the director and tried to work something out" (Johnson); "...her paperwork was wonderful, her reporting was wonderful, her grants...she was very compassionate, but the child that she[brought with her to work] was a great irritant..." (J. Wilson). Other than this memorable example, no other times of major conflict could be recalled, although one volunteer remembered "a staff-related situation. I think [a past board president] stepped in several times...it's such a small organization, you have to have people working along together."

External conflicts with other organizations in the community were not overt, but were evident. At one time, apparently there were community discussions about bringing all community-based health related social services, including a prenatal clinic, the local Medicaid-licensed clinic, and Valley Health, under one organizational umbrella and located on one physical site. The potential change caused a great many discussions amongst board members, the founding physician, and the executive directors involved. The timing is not clear, nor is it clear how many years this possibility was under consideration, but the best educated guess is that these discussions began about eight years after Valley Health was founded. There were arguments for both sides—for remaining independent and for joining forces with other organizations: "there was

discussion about bringing all health services...under one roof. Dr. Verma...wanted us to...stand alone, just do our job. I have a philosophy of coordinating, cause...the better the services would be for everyone. Why duplicate services...and why not share...administrative costs?” (Olson); “...we came very close to joining other agencies in the [social services] complex. There were strong arguments to do so. We rejected it simply because the city was going to require that we would have to be part of a management structure that would make us part of a larger whole. ...we would have to sacrifice our ability to serve the unserved” (F. Wilson); “...we just felt like we wanted to keep our own identity. And we didn’t want to lose our name as part of that process. They’re licensed by the [state] Department of Health and they’re a community health center. And they’re big and sophisticated. [W]e’re the bottom of the safety net and we like it there and we want to stay there” (Johnson). After the pros and cons were carefully considered, the clinic decided to remain independent of the community umbrella. The issue has caused no long-lasting difficulties with the local Medicaid clinic, as the two often refer patients back and forth, depending on the patients’ needs (Browning, Johnson interviews). Those affiliated with Valley Health see the relationship with the other clinics in town as collaborative and cooperative (Thompson, Johnson interviews).

While some conflict has been evident in the organization’s history, by all accounts, it has not been ignored, but has been faced openly. The executive director was given authority to work with any difficulties in day-to-day operations, while the board stepped in to work with physicians or with the executive director on any disagreements.

(7) *Minimal interference of rights to organize*: Organizations are situated within a particular sociopolitical context. As such, resistance from local governmental officials could cause great complications for the provision of a public good. Successful organizations will likely have experienced little difficulty with officials, at the very least. Ideally, the organization will have actually received open support and encouragement from authorities.

The two cities making up the area served by Valley Health have in general been very supportive: “The City of Carlton has been enormously supportive. In fact, they used Valley Health as one of its shining lights in the City of Carlton’s pursuit of an All-American City award....as an example of a characteristic of an ‘All-American City’” (Johnson); “...we were used as a poster kid for an All-American City competition and everything. Valley Health was highlighted” (J. Wilson); “Probably 3-5 years back, Carlton won a national award...Valley Health was part of the quality of life, kind of a feather in their cap” (Browning). In addition, the cities both participate in evaluating proposals and disbursing funds from the Community Development Block Grants, although some disagreement surfaced at one time about how much each municipality would contribute (Thompson interview). City funding enhanced the clinic’s standing and established it as a legitimate provider of health care for those with no other access to health care.

Any local dissatisfaction has stemmed from the clinic’s location in downtown Carlton, and originates with both merchants and local government officials. At the time the clinic first opened its doors in its present location, the downtown area was just sowing the seeds of revitalization, and the clinic’s presence did not always match the image of a vital and energetic downtown: “I do know that we don’t make people completely happy all the time. Because we don’t bring as much money into

downtown...[our] business doesn't overflow into other places" (Browning); "we put a sign on the window without permission and we got a citation for that. They were just trying to hassle us a little. I think they saw [the clinic and the homeless mission] as deterrents to the revitalization of downtown area" (Olson); "[T]he city of Carlton then started to redo downtown...you know they wanted the mission to move. So with the image makeover, they would prefer that we not be there...they won't let somebody else come in that's like us. They're...the downtown subcommittee which is appointed by the city of Carlton" (Thompson). Other times, merchants have complained that the clinic takes too many parking places, leaving few for other patrons to use (Browning, Thompson, J. Wilson). However, official overtures to forcing the clinic to move have not materialized.

Another measure of an organization's legitimacy is the reaction of other professionals to its existence. In the beginning, "...I think there was probably suspicion about what Dr. Verma was doing. [Later], when [my husband] allowed me access to the medical school, and when we got [the HMO] on board... when [an influential physician] was president of the Medical Society...he gave the blessing of the Medical Society" (J. Wilson). Building on those first stirrings of support, the clinic now claims approximately 50 physician volunteers, and has the ongoing support of both hospitals and the local HMO: "All Saints Hospital has always been very supportive. [When we were having to leave Elm Street] All Saints was going to supply us with...a trailer. The Med...supports the luncheon we've had as a fundraiser...[their administrator] was chairman [of the board] last year" (Thompson).

- (8) *Nested enterprises*: Stronger organizations will possess ties to other organizations—government agencies, other non-profits, any monitoring agencies, funding agencies. These ties confer a level of credibility and legitimacy on the organization. It should be noted that “nested” does not necessarily implicate “hierarchy.” The organization may be nested and connected to other organizational structures, without necessarily “answering” to them. The central mission of the organization makes up the core, surrounded by volunteers, staff and board. Around that structure may exist other community organizations, funding agencies, or resource generators.

Valley Health is well-connected to other community health care providers, as well as other related social service agencies: “We refer out to many different places in town. [W]e refer patients to [a local needs assessment clearinghouse]...[they] do a really good assessment [for individuals]” (Browning); “We network a lot here. We have a good relationship with All Saints’ emergency room. We talk to the providers at the Department of Health ...at Planned Parenthood...at BVCAA. And we try to assist each other as best we can” (Blackman); “I’ve seen [the executive director] really bend over backwards to try to help someone who has come into the clinic and we can’t see them because they don’t qualify and she would make a phone call or two to try and get them to be seen. She’s just really very helpful in getting help” (Redding). In addition, the physician assistant noted the importance of electronic access to expertise at a distance: “I’ll utilize the medical schools...we can reach the world now with the internet. I don’t mind emailing Johns Hopkins or Mayo Clinic or wherever I can find ‘em. Jean, Rosa, all of us, we want the best for our patients, and if it means us having to get on the phone or out on email, that’s what we do” (Blackman).

According to the former dean of the medical school, a new partnership may form in the future: “We’re working with the medical school to try and get telemedicine set up between the Family Medicine Center and Valley Health; [resident involvement] would

increase...with a preceptor [from Family Medicine]. They don't get credit for it as their training unless they have a preceptor that is actually supervising" (F. Wilson). This arrangement would benefit both the residents and the clinic, and would likely involve more coordination than financial investment.

The clinic is also consistently tied to local funding agencies—one indication of an organization's credibility is its securing of ongoing and repeating grants. This clinic certainly is evidence of that, as the United Way and the cities' block grants comprise recurring budget amounts for the clinic. The clinic is able to demonstrate effectiveness and sound use of money given in the past: "When we can say that we provide our patients with over a million dollars in pharmaceuticals a year, this strikes a responsive chord because if you have indigent patients and they see a doctor and the doctor can't get the medication, we have no clinic. ...if they don't come back every three months, they don't get a...refill. This is why the pharmacy is one of the most attractive things for the granting institutions" (White); "We've been lucky that we've had sort of a steady...flow of money [from the United Way]" (Browning).

The executive director meets regularly with other agency directors at the Community Partnership Board, which is organized by the local assessment clearinghouse (Browning). It serves as a place for many organizations that provide services to get together and discuss their organizations, coordinate functions, and serve as resources for one another. This would be especially important for maintaining personal contact with those organizations one might refer patients to in the future. As far as communicating with other nonprofit clinics for support and ideas, the first executive



director noted she simply “didn’t take time to seek out what others were doing” (Olson). Likewise, an early board member remembered that there were “...some other places that we accessed information from, but they weren’t right around here...they weren’t even close...” (Fisher). In 1992 (date uncertain), a small group of board members visited a clinic in a city approximately 100 miles away, but the purpose and results of the trip were not documented (Board minutes, 10/05/1992). However, the most recent executive director indicated that other clinics on occasion now ask her for advice: “Sometimes they need to come over and say, ‘How do you do this? How has this worked? They need a lot of support’” (Browning).

Evidence exists of an informal nesting relationships with funding agencies and other local organizations for referral purposes. In addition, somewhat looser ties exist with the staff of local agencies, as well as individuals at other community health clinics. These ties are maintained not through formal organizational channels, but through social networks.

#### *Incentives for Volunteer Participation*

Those who volunteer at Valley Health represent many sources of motivation. None of the interviewees was certain whether local hospitals or clinics offered incentives (time off) for nurses or doctors to volunteer, although one hospital administrator felt it would not be ethical for him to encourage his non-salaried employees to volunteer at Valley Health (Johnson). However, he did not hesitate to allow his salaried management staff time to devote the clinic, if they so desired. The other hospital may offer incentives,

but no one was certain how that was structured (Browning). These volunteers give of their time and energy for reasons that go beyond structural incentives to do so.

The founding physician's dedication to the effort resonates throughout the present organization—it defined the reasons for establishing the clinic and it continues to guide the clinic's mission. When asked about his early passion for this endeavor, he replied, "I personally went into medicine as a public service profession, like a teacher. Or even a priest. I was brought up in Ethiopia—maybe that made the difference. I saw the poverty, I saw the conditions. And then I did my medical school in Bombay. I never thought of being in this country to practice medicine. But it happened because my family was kicked out of [Ethiopia]. I was in my 3<sup>rd</sup> year of training here. So I sort of ended up here because of the turmoil in our country" (Verma). Another physician noted, "I think Verma's commitment is more cultural...Indians tend to believe that you're supposed to give something back..." (F. Wilson). That same dedication is now reflected in other physicians' involvement at the clinic: "Dr. Trong is from Vietnam. Before he joined [my practice], he said, 'Dr. Verma, I'm interested in working in that free clinic. I've been through it and I want to give back to the community.' So sometimes...I see that some people get it, some just don't get it" (Verma); "But the others, it's all the personal satisfaction that comes with helping others. And for the most part...they're coming to help their neighbors" (Blackman); "We have a real handful of physicians that really love it. And I know there are those that just plain enjoy it because they get to just practice medicine, not practice medicine with constraints, [but] with positive feedback..." (J. Wilson); "Those doctors have been working at that clinic for...years...and that

impresses me that they would keep coming down there and working because...there's no question about it that they can only do so much within the financial limitations... But they're dedicated to it" (Redding); "I'm almost 60 and so I'm committed to do what I like to do and it makes me feel good. Every place I've been, I've always established a relationship with the indigent community" (physician assistant Blackman); "...the physicians like [volunteering at Valley Health] because they can practice medicine the way it used to be. They don't have high-tech stuff. They've got to sit down with the patient" (F. Wilson). As stated previously, without physician volunteers, the clinic would cease to exist. Understanding why these physicians continue to give of their time to this endeavor is critical to the clinic's future.

However, one wonders why it is still such a difficult task to secure additional physician volunteers. Dr. Verma indicated this is the most difficult part for him—getting other doctors to volunteer. The doctors and PA had their own ideas about why this is so: "...physicians who grew up through the Depression and went to school during that time...saw a lot of poverty. They still have that public service. I think the profession became very business oriented. And the first thing, the compassionate father, the public service, got lost somewhere along the line. But I hope it will come back" (Verma); "This is not about making money, you know? And I tell the doctors...you went to medical school. You are blessed because for every 10 qualified kids, one got in and the 9 other guys are just as good as you are and the \$100,000 you spend in four years of medical school, that was a drop in the bucket for your medical training, and the guy who works at McDonald's and the woman that works down at Walmart, they put you through

medical school too. And so, all of us have a duty to give back because the whole community made us what we are and we can't just turn our backs on that. You gotta go back to the community and give back to those that helped you" (Blackman). Two noted correlations to medical training, as it is currently practiced: "One of my pet peeves is that...medical schools are teaching them that they are the chosen ones but there's not any duty that comes with that. They all think they have to make at least [\$150,000] as the threshold. Where does it say that in the rule book?" (Blackman); "I was a member of a task force...of very distinguished medical educators...we had with us a national scholar, I think in sociology, and he was a middle-eastern guy, a really good guy. We were talking about why aren't physicians more altruistic. This guy said... 'Do you tell your students that they ought to be altruistic and go out and serve?' There was dead silence. We never told them that the idea of the profession was to serve" (F. Wilson).

In addition to the physician volunteers, the clinic must rely on nurses, pharmacists and clerical volunteers. Their motivations are more varied than those of the physicians: "...everyone wants to make a difference and especially at this point in my life I really feel like I want to make a difference some way. I think the reason we do this is because we represent a group of people who don't have a voice in the community" (J. Wilson); "[A] lot of [our volunteers] need community service hours for a variety of different things. We have a lot of people who [then] stick around" (Browning); "I'm not sure that...in pharmacy school, there was ever any stress about community responsibility. Not everything can be taught in school" (White); "Valley Health is special because it is not a business. It is a calling...a community's response to a real

need. And those of us that provide that interface also benefit by providing something really meaningful” (F. Wilson); “We had a core group of volunteers that would do anything. ...I think that’s what most impressed me. They had that organization and that talent. Carlton/Oakwood has that spirit. That’s hard to find in a lot of places” (Olson); “Dr. Verma’s sister started this concept...to do something different. With an organization like this, you don’t walk away from your “family,” and it’s sort of like part of you. So I think organizations like Valley Health succeed because there’s so much buy-in to it, so much connectedness...it goes a little deeper in the flesh” (Johnson).

While individuals may respond to a variety of personal experiences and commitments to volunteering and supporting the clinic, other stakeholders may have yet different incentives for providing support for the clinic. “A hundred dollar’s worth of antibiotics in the first 24 hours of illness can avoid a \$20,000 bill at the hospital later on” (A. Verma, quoted in local magazine, April 1992). “[Reducing the burden of indigent care] that goes to the ER...is the idea. I don’t think we ever specifically proved that but that was the idea” (Olson); “One visit [at the clinic] costs us \$40—medication and everything—it’s a \$40 visit versus the \$500 visit to the emergency room” (Browning); “...All Saints was very supportive to begin with, in part because it was part of the mission, but Sister Lydia was no dummy and could see that if this patient group is served outside of the emergency room, everybody wins” (F. Wilson); “[Without Valley Health], we would probably see an increase in some of the catastrophic things that happen” (Fisher); “And All Saints, I mean besides being a wonderful institution...wants these people to not be in the emergency room...if this person is hospitalized, we’re out of the

hundreds and into the thousands, and sometimes tens of thousands. So if we can keep one diabetic person under control and make sure their sugar is tested at least every three months...it's definitely worth the hospital's while" (White); "All Saints emergency room is very happy we exist. I don't think Oakwood Medical benefits as much as All Saints, but the doctors at the Medical Center have a place to refer nonpaying patients. They can refer them to Valley Health" (J. Wilson); "...I would say [to any hospital], your organization doesn't have to take care of these patients because they're being treated by Valley Health. I'm not foolish enough not to believe that it stems a lot from how the attitude at the top is. Valley Health benefits both hospitals" (Johnson). Referring to why someone in his position would be involved with the clinic, the hospital administrator just quoted also pointed out: "Another argument that could be made is it will help the image of your organization...it sends a good signal that you care about the community. We're [all] trying to take care of health care—patients with dwindling resources, with rising health care expenses, from nurses to pharmaceutical costs to technology. I think an organization like All Saints Hospital, or...Oakwood Medical Center, ought to have somebody involved...because who else is going to do it, if you're not going to help an organization like Valley Health?" (Johnson).

Comprehending why individuals and organizations contribute time, energy and resources to an endeavor such as this clinic offers insight into why this clinic has survived so long and how it tapped into those volunteer motivations and incentives. The clinic provides a public good—improved health care access—which results in lower health care costs for society, as well as better health for the individual patients. A setting

such as this, however, also offers social goods to those who participate in its provision: volunteers identify with a sense of community, a belief in contributing to something meaningful.

## CHAPTER V

### ANALYSIS OF INTERVIEW DATA

In this chapter, I will analyze the interview data as presented in the previous two chapters, focusing on the eight principles adapted from Ostrom's work. Each principle is reprinted, with the unsuccessful clinics and successful clinic analyzed separately. I will specifically seek evidence and extent of each principle in the data. Then, I compare patterns from the observations to derive logical connections and find evidence of similarities and differences.

Following the eight principles, I will also examine the motivation of volunteers, to see if differences existed among the clinic locations and volunteers. I close with observation about framing each clinic's message, with insights drawn from the interviews and other data.

#### **Analysis of the Eight Principles**

- (1) *Clearly defined boundaries:* Organizations must define what the public good is and who benefits from it. Those who benefit may benefit either directly or indirectly, and are referred to as appropriators. The mission of the organization should be clearly delineated or universally understood by those involved in its provision. A recognizable organizational structure must be in place.

To analyze this principle, I will examine each clinic's ability to establish boundaries, to define appropriators, both direct and indirect, to delineate a mission, and to form an organizational structure.



### *Unsuccessful Clinics*

Both unsuccessful clinics established clear boundaries about whom they served: those with no other resources for obtaining medical care—no government assistance, no health insurance. This included undocumented workers who were not in the U.S. legally. Children were treated, as well as adults. The two diverge on amount of documentation required to prove the patient was truly eligible for treatment. The clinic in Greenfield asked for proof of income, family size, residence and food stamp eligibility (which verified economic need), while the clinic in Smithville asked questions about income, but required no documentation. Both clinics maintained and stored complete medical records on their patients.

For both unsuccessful clinics, the direct appropriators were the patients. They benefited not only from access to a free doctor's visit, but from free pharmaceuticals as well, either from samples the doctor brought with him, or by vouchers for local pharmacies. Donations from patients were accepted, but there were no fees for service.

Indirect appropriators of improved health care include society at large, and more specifically, health care institutions that are relieved from absorbing some amount of indigent care in emergency settings or uncollected fees. One way society becomes an active contributor is through community involvement and support of such an effort, a point to be discussed in greater detail with Principle 2. Briefly, the two communities differ here on the amount of community involvement. Greenfield reflected greater community involvement with the Ministerial Alliance and some newspaper coverage, albeit minimal, while Smithville generated strong support from the active volunteers, but

from few others. As far as health care providers as appropriators, there was little evidence of those benefits in Smithville, as the hospital had closed. In Greenfield, the hospital was visibly supportive, with provision of space, staff, and necessary lab tests.

Organizationally, neither of the unsuccessful clinics fully metamorphosed into a recognizable entity. In Smithville, when I contacted an individual who had served extensively on the board for the umbrella charitable organization, the woman explained that while she was very active in the Helping Hands organization, she really did not know enough about the clinic to answer any questions; she then directed the researcher to one nurse who worked at the clinic. While a board theoretically was attached to the clinic, it was not actively engaged, nor by all indicators, invested heavily, in its success. The nurses who volunteered at the clinic comprised its organizational structure. Clearly their dedication kept the clinic functioning for as long as it did (4-5 years), in spite of the lack of organization. One nurse expressed regret that she was stretched too thin to apply for grants, as the time commitment to such an undertaking is substantial. In Greenfield, the clinic did have a board, although according to the hospital staff member interviewed, the members of that board were either physically not well at this time, or had moved away from the community. However, the organization centered around the hospital staff person who contributed a good deal of time and dedication to the clinic. Neither clinic was incorporated, nor did they seek 501(c)(3) status.

*Successful Clinic*

The mission of Valley Health was the same as for the two clinics above: serve those who fell through the cracks of government assistance and health insurance availability, including those who were undocumented workers. Even through changes and evolving relationships with other local low-income clinics, Valley Health maintained and defined itself as being at the bottom of the safety net—for those with no other place to go for help. When this clinic faced decisions about staunchly defining the mission or being absorbed into a larger entity, they held to the original vision, and perhaps strengthened it as a guiding principle. While the clinic initially operated much like the Smithville clinic, in that they asked questions about income and eligibility, they did not require documentation. Over the past 7-8 years, however, the clinic has required documentation of income, residence, number in family, etc. The only part they cannot easily verify is insurance eligibility, although in some cases, friends and family members will call and tell the clinic if someone is not being honest about their eligibility. When the clinic director instituted the documentation policy, it was seen as a necessary step to protect against misuse of the public good (health care) by those who did not truly need the help—if it were not protected, those who should have access might be denied, due to limited hours and doctor availability.

Again, direct appropriators are the patients. They personally benefit from the public good produced—better health care. Many of them have chronic illnesses and the clinic has become their primary care physician, helping them to manage diabetes, hypertension, or asthma, for example. Because these patients typically take multiple

prescriptions, a very valuable resource is access to free medications, through pharmaceutical companies' indigent programs, samples, or vouchers to a local pharmacy. In addition, they benefit from educational programs the clinic offers that educate patients about diabetes, smoking cessation, or nutrition.

As with the others, society is an indirect appropriators, but in this case, the community became a strong supporter about 3-4 years after the clinic was founded, with the involvement of additional volunteers who were well-connected to the community. Once this group of well-connected volunteers, including the wife of a medical school upper-level administrator, mobilized for fundraising and publicity, the clinic expanded rapidly. The community, as representative of society, supported the clinic through grants, donations, and publicity. Other indirect appropriators abounded in this setting, with two hospitals, an HMO clinic, and numerous physician's clinics in the city. Administrators of both hospitals became directly involved, one very early, and one about 10 years later. Over and over again, interviewees mentioned that one reason they saw value in the clinic was its ability to partially relieve the burden of indigent care from the hospitals. Dr. Verma himself frequently mentioned, in the interview as well as in media accounts, the cost-effectiveness for society of treating individuals in primary care settings, as opposed to emergency rooms. The early involvement of the CEO of one hospital signaled legitimacy, as did the HMO's involvement in encouraging its doctors to volunteer. Later, the other hospital's administrator served as the board chair for Valley Health, further offering legitimacy to the organization. As the clinic attained

legitimacy, it grew in numbers of physicians, nurses, and clerical volunteers, as well as patients. Such growth brought with it requisite needs for organizational structure.

This successful clinic clearly has reached a level of organizational structure not present in the other clinics. On the other hand, it could just as easily found itself struggling at the same point as did the other clinic, as there was a time in its life when it was clear the small number of volunteers could not sustain it. At that point, however, a decision was made to go to the community, tell the story and see what happened. A difference here, and I think it is a critical difference, is the extent to which the board at this clinic was involved in the day-to-day operations of the clinic. Even early on, when the board was informal, it was involved in recruiting volunteers, in telling the story, in deciding to hire a part-time executive director when donations made that possible. It is clear to anyone speaking with the early board members/volunteers that they adopted Dr. Verma's vision as their own. With the addition of the hospital administrator to the board, tremendous organizational resources were brought to bear on the clinic's functions, as she urged them to incorporate, then go through the painstaking process of becoming a 501(c)(3) organization. This resource was quite helpful, as was the volunteer with many connections in the medical community who recruited a number of key people to the cause. The effect of these examples of social capital and organizational expertise cannot be overestimated—they gave the clinic its impetus and firm foundation for moving forward organizationally. With official tax-exempt status, grants were forthcoming, and one grant was written to include an executive director's salary, thus leading to the next level of organization. It is important to note here that the grants and publicity efforts

were not written solely by those who volunteered as nurses and workers in the clinic, but by early board members and concerned individuals. This is a difference from the Smithville clinic, whereby the nurse mentioned above knew the value of grants, but was unable to devote the time to writing them.

Organizationally, Valley Health is in many ways, currently quite sophisticated. There are still questions about what will happen when Dr. Verma retires, or if he should move away, but with 50 physicians currently donating time, and a fully involved board with extensive community support, there is reason to believe that Dr. Verma's original vision has imbued the organization with its essence and will continue to drive the clinic to further service.

### *Comparison*

All three clinics were very clear about their mission and drew nearly identical boundaries around it. They served their direct appropriators well and, generally, had far more patients than they could easily manage. They differ in how much indirect appropriators were involved, however. Neither of the unsuccessful clinics reached the point of being pushed to take their story to the public in order to expand available resources of money and volunteers. The Carlton clinic, on the other hand, went to the community and asked for help—perhaps because the early volunteers were well-connected to community influence centers. As far as support from other indirect appropriators (hospitals, etc.), one unsuccessful clinic had clear and direct support, and in fact, it could not survive the withdrawal of that support, when the new hospital lessee

did not allow the clinic to continue operating on its premises. Contrary to those two situations, the successful clinic enjoyed support and resources offered by the major health care providers in the city, which granted legitimacy as well as monetary resources.

Other things being equal, one would expect social capital to be easier to mobilize in smaller cities because networks are smaller and tend to overlap. Surprisingly, the social network was not mobilized in Greenfield, even though the clinic was located inside the local hospital. An obvious difference between the Carlton clinic and the other two clinics centers on the involvement of those associated with the medical community—spouses of physicians, physicians, hospitals and clinics. Even though the physicians in the smaller communities were said to be “supportive,” they did not become directly involved, thus denying the clinic crucial social capital resources. The successful clinic moved to more solid footing and became more established once the medical community outside the Verma family became officially involved in the clinic’s mission.

(2) *Congruence b/t appropriation/provision rules and local conditions:* Because organizational success will vary over time and across locations, organizations producing a public good must be well-situated in the local context. Since the provision of most public goods includes funding, the organization must function within the regulations of funding agencies or grantors. Has the organization adapted to its population? Does it take into account the idiosyncrasies of its location? For public goods, one would expect evidence of community involvement or support, as well.

For the analysis of Principle 2, I will seek evidence of the organizations adapting themselves to the local communities in which they are situated: a clear understanding of the populations they served, a willingness to adapt to the community’s needs. I will

focus on the organizations' ability to engage the community in the clinic's operations, both as volunteers and as donors.

### *Unsuccessful Clinics*

The two unsuccessful clinics are somewhat different on this principle. They are similar in that those involved in the clinics perceived a definite need in each community for free health care. However, they vary in how much support was shown by the local communities.

These clinics treated somewhat different ethnic populations: in Smithville, the majority of the patients were African-American, while in Greenfield the majority were Hispanic, and the least represented were Anglos in both towns (based on people's recollection and educated guesses). In both clinics, the difficulty of communicating with Spanish-speaking patients was noted, but at the Charity Clinic, the individuals mentioned the importance of having someone at the clinic who could speak Spanish. This may have been due to having a higher percentage of Hispanic patients in Greenfield. One volunteer was bilingual and helped a good deal with Spanish-speaking patients. The clinic in Smithville had no such individual—they got by the best they could with some rudimentary Spanish skills.

In Smithville, a public health nurse noticed that numerous patients from that area were traveling 20+ miles to see a doctor at Valley Health in Carlton; at Valley Health, Dr. Verma was aware that a good many of his patients were traveling in from nearby Smithville. The wishes of these two medical professionals became reality in the clinic's



founding. Initially, the community was directly involved, as the Health Department allowed the clinic to operate out of its building. For those who staffed the clinic, it was quite convenient, since for the most part, the volunteers were nurses and office staff from the Health Department. This support fell apart when pharmaceutical storage for the clinic outgrew the Health Department's ability to offer space and adhere to state regulations for the types of medications that could be kept on the premises. The community was able to provide a place for the clinic in a building occupied during the day by a local charity offering food and clothing to those in need; the clinic operated for another 3-4 years in this location. Notably, however, the board of the charity subsumed the clinic under its umbrella, yet a very active volunteer and board member with the mission indicated she would not be knowledgeable enough about the clinic to help the study. The board's involvement appears to have been tangential, rather than direct in this case. In terms of financial support, the local community, from all accounts, was essentially not involved. One banker who controlled funds that had been designated for the Salvation Army and were subsequently offered to the clinic, was tangentially involved. Beyond that, the nurses who were most involved in the clinic felt little ongoing support or encouragement from the community, perhaps illustrated best by the lack of newspaper coverage. In spite of that, the clinic operated for 4-5 years. However, this action did not translate into wider community awareness or legitimacy. Counter-intuitively, the Smithville clinic survived about three years longer than the one in Greenfield.

The Charity Clinic in Greenfield enjoyed somewhat more support from the community, yet it survived only a year. The Ministerial Alliance, representing a number of local churches, took on the clinic as part of its mission, secured the space in the hospital, and provided a number of volunteers. The hospital clearly understood the need for such a clinic and offered space, staff, and a limited amount of lab resources for Dr. Verma's use. Volunteers came from churches, from EMT squads, and from hospital staff. In a number of ways, the community was actively involved in this clinic's functions. On the other hand, there was essentially no funding from the community, either organizationally or individually, nor was there much news coverage. By the time the clinic had operated for a year or so, the hospital spokeswoman and volunteer clinic coordinator noted she was having increasing difficulty securing volunteers for each day of the clinic—there were too many competing demands for volunteers' time. During roughly the same time period, the new management of the hospital determined they would no longer offer space to the clinic, and no one in the community could find an alternative location, so the clinic's future was in jeopardy. The new hospital arrangement, combined with the lack of volunteers, forced the clinic to make a decision about its future. As stated previously, the Greenfield clinic did not survive as long as the other, possibly due to the removal of the hospital's support.

### *Successful Clinic*

Valley Health was also keenly aware of its placement in a particular location and with a particular population, including Spanish-speaking individuals. Almost from the

beginning, the need for someone who could speak Spanish was stressed, and Ana Martinez' presence on every clinic day was highly prized! That awareness has carried through, in that the current clinic coordinator is bilingual and she values any clerical volunteers who can speak any amount of Spanish. In addition, as the clinic moved from one place to another, the founders conscientiously considered proximity to patients' neighborhoods and to mass transit lines. When one move took the clinic away from patients and from transportation services, it was clear this was not ideal, but was seen as a necessary move to keep the clinic from closing. The next move enabled the clinic to be closer to patients and this was viewed as a distinct advantage of that site.

In addition to the clinic's clear understanding of its patients, it enjoyed community support and involvement of volunteers, funds, and other resources (media coverage). However, this community involvement did not truly congeal until the clinic sought support to expand from the two-motel-room setup, which was approximately 4 years after its founding. As a result of "telling their story" to the media, community donations poured in, a church lent its organizational support and volunteer labor to renovate the new location, and following the move, the volunteer physician numbers doubled. The clinic had progressed from being one family's concern to being a small group's passion to being a valued agency of the community.

Most striking is the medical establishment's support of this clinic. Initially, within a very short time of the founding, Sister Lydia, CEO of All Saints Hospital in town, had lent her organizational expertise, and knowledge of nonprofit status and its benefits. Over the next few years, the hospital donated a monthly amount for

medications, allowed the board to meet in one of its meeting rooms, and actively helped the clinic find a new site for one of its moves, going so far as to offer to provide a trailer if necessary. Also, within the first five years, the local HMO clinic supported Valley Health by publicizing the need for volunteer doctors, and by some of their leaders volunteering themselves, and through a sizable donation from the HMO's foundation based in a nearby city. The university's medical school lent its expertise through development and public relations staff working on the board, and by publicizing the need for volunteers to the medical students. Early organizational support from the hospital, the HMO, and the medical school set the tone for establishing the clinic's value to the community. The other hospital in town became involved in Valley Health some five years later, when the new administrator, who was personally drawn to the clinic's mission, volunteered and eventually served as the board chair. That hospital came to support Valley Health financially, co-sponsoring the annual fundraising luncheon with the other hospital and by honoring physicians on their birthdays with a gift to Valley Health. There is no doubt that ongoing support from medical professionals and organizations has enabled the clinic to be perceived as legitimate, an endeavor worthy of a volunteer's time or a donor's money.

Other local support was evident in funds donated for the clinic's renovation, and the awarding of Community Development Block Grants and United Way funding. Simply being designated as an appropriate recipient of either of these grants served as an indication to other donors of the organization's level of acceptance and credibility. From these agencies, then, the clinic received much-needed funding, which allowed for

additional services and paid staff, and also received additional standing in the eyes of the community. Related to direct financial support was the school district's willingness to lease a building to the clinic for essentially a token sum. This move enabled the clinic to expand, yet to remain fiscally sound at that stage of development. By the time that lease was not renewed, the clinic had become financially secure enough to move to a building requiring rent and utility payments, and the board was well-organized to seek additional fundraising opportunities. Other local civic and religious organizations became supporters as the clinic was more and more entrenched in the community.

The board was made up of local individuals from a variety of backgrounds and links to the community: hospital representatives, a pharmacist, the medical community, a banker, a lawyer, a CPA. These talented and experienced individuals possessed links to the community that might lead to additional funding or volunteers, both medical and clerical. Because one early board chair knew someone in fundraising, who knew the wife of a prominent banker, a large and financially successful development reception was held in the bank. Because the board included individuals skilled in public relations, they knew what outlets to use to tell about Valley Health, and utilized contacts to do just that—stories appeared on the local television station, in the local newspaper, and in a local magazine. Such coverage brought funds, volunteers and yet more legitimacy to the clinic, all of which contributed to the clinic's future stability.

### *Comparison*

The three clinics vary on how well they utilized the local context to establish and maintain the organization, although all three were sensitive to the needs of their patients and attempted to take special circumstances into account when planning services (Spanish translation, clinic location). The clinic in Smithville seemed least able to reach into the community to mobilize support, whether it was to engage volunteers or to raise funds. The volunteer nurses who were passionate about the clinic's mission were simply overwhelmed with the demands of their paying jobs to be able to devote time to publicity or fundraising. In addition, the board that theoretically oversaw this clinic's operations seems to not have been aware of the clinic's activities. The clinic in Greenfield, on the other hand, grew out of a community group's concerns about medical care for the indigent, and was located directly in a medical setting—the local hospital. It had a board, although not a formal one, and those interviewed remembered little about any board at all. As with the other unsuccessful clinic, the individuals staffing the clinic were dedicated to the mission and to seeing it continue, but they were not able to effectively appeal to the larger community for support or help. Given the clinic's location within the hospital itself, and the organizational support of the Ministerial Alliance, this clinic was poised for success, but never achieved the necessary stability for it.

Valley Health could have followed the path of either of the two unsuccessful clinics, as it was no more stable in its first years than either of the others. However, it

achieved credibility in the eyes of the community through a series of circumstances, some planned and others accidental. The board was composed very purposefully of influential people in the community, from different professional backgrounds. This board, in conjunction with the day-to-day volunteers, formulated publicity plans and applied for funding grants. These items did not fall solely on those who were devoting their time on a regular basis to the clinic's operations, as they would have in the other two clinics. In the other two, it was all the regular volunteers could do to keep the clinic staffed once a week. They typically held fulltime, demanding jobs outside the clinic and were simply stretched too thin to include additional clinic plans. Other events in Valley Health's history were not planned, but in the long run, contributed to its success, especially the multiple moves. This clinic was faced with forced moves, just like the unsuccessful ones were—but this one was able to find other community resources to facilitate the moves. Each move brought challenges to the clinic, but they also brought additional opportunities for media coverage, which helped to firmly plant the clinic in the community's consciousness. In addition to the board's efforts to make organizational and financial plans for the clinic, establishing credibility with the local medical and funding agency communities was critical. Such legitimacy meant doctors and others were more willing to donate time, and donors were more willing to donate money. This legitimacy formed the basis on which the clinic's success rests.

- (3) *Collective-choice arrangements*: No organization will survive long without a means to make and implement decisions. If organizational structure is evident, decision-making structures must be present. Are decisions consciously made or do they simply happen? Who makes decisions—appropriators, founding members, others involved in the organization? Longstanding organizations must also make the

transition from original founding and establishment to maintenance and ongoing functioning.

The ability to make decisions is crucial for any organization's ability to function well. Which decisions are most important may depend on what type of organization one is studying. In these cases, decisions about volunteer staffing and fundraising take center stage, with day-to-day operations figuring prominently as well. This analysis will focus on who makes these decisions, and how effective the decisions have been. Also, I will briefly examine whether or not the clinics made the transition into ongoing maintenance from the initial founding stage.

### *Unsuccessful Clinics*

The unsuccessful clinics did not have extensive decisions that were necessary; however, what decisions were made seemed to be relatively similar in their method. Dr. Verma made all medical decisions having to do with treatment, and one other person in the clinic would make most day-to-day operating decisions. In Greenfield, a hospital employee took on the role of clinic coordinator: she opened the clinic, put the roster together for the day, secured other volunteers, served as liaison to the hospital, and issued guidelines to the volunteer staff. In Smithville, one of the volunteer nurses typically opened the clinic, set up the chairs, and organized the daily roster. Any decisions having to do with how many patients and which patients could be seen were made by whichever nurse and clerk were on duty the day of the clinic. In addition, the woman in Greenfield assumed the task of getting more volunteers in to help, so she communicated with the Ministerial Alliance and other individuals she knew personally



to increase the number of office volunteers for the clinic. The nurse in Smithville attempted to find others outside the Health Department staff to help out in the clinic, but she was unable to do so.

As noted earlier, the Helping Hands clinic was taken under the wing of the larger Helping Hands board, but this board was not involved in decisions for the clinic. The Charity Clinic in Greenfield had a board, but few of those interviewed knew of its existence. According to the hospital staff person who was most closely involved with the clinic, the board set policy, but was not really involved in operations or making ongoing plans for the clinic.

Both clinics were acutely aware of the lack of medical volunteers, especially when they needed a substitute for Dr. Verma, if he was out of town or called away on an emergency. For all intents and purposes, neither clinic had dependable volunteers doctors they could call, although a couple of retired physicians offered some relief. Dr. Verma approached the physicians in both communities, but was unable to secure commitments from them to volunteer. The nurses in Smithville came from the Health Department, and in Greenfield they came from the hospital, or the local EMT's; many times, Dr. Verma brought a nurse from his clinic with him. There was never a question about Dr. Verma visiting both towns, however; he was willing to continue both clinics, as long as there was a place to practice and volunteers to run the clinic.

The clinic in Smithville never made the transition from the founding individuals to an organization needing ongoing maintenance and structure. Those involved at the beginning were essentially those involved as the clinic closed, 4-5 years later. The

Charity Clinic in Greenfield was much the same, but it had a few more volunteers with the involvement of the Ministerial Alliance. With no formal board, neither set of volunteers could disperse the responsibilities of making such a transition to others who were also invested in the clinics' missions.

### *Successful Clinic*

Decisions at Valley Health are divided between medical and operational ones. Dr. Verma makes medical decisions, and the board and executive director share responsibility for operational decisions. Early in the clinic's existence, the board took an active role in planning for the clinic, as they recruited volunteers, embarked on publicity campaigns, and attained both incorporation and nonprofit status within five years of the clinic's founding.

The decisions that caused Dr. Verma the most concern, yet were arguably the most critical were those having to do with recruiting volunteer physicians. While Dr. Verma routinely approached doctors to tell them about Valley Health, one volunteer's connections to the medical community proved to be especially beneficial. By addressing a meeting of the medical auxiliary, she aroused the curiosity of the wife of a doctor, who brought her housekeeper to the clinic for treatment. She told her husband, an influential doctor at the local HMO clinic, and he began to volunteer at Valley Health. Other doctors from the HMO soon followed as volunteers. This issue never ends, however; the most difficult part of keeping the clinic open is getting doctors to volunteer, according to Dr. Verma, even though the number of participating physicians has increased to over 50.

The board is also actively engaged in recruiting other volunteers—one pharmacist on the board recruited another pharmacist, hospital administrators pass along information about the clinic to their employees, and they generally serve as mouthpieces for the clinic's work in the community. The executive director also participates in recruitment, as she has made presentations to medical school classes and student organizations. At one time, patients could volunteer at the clinic, but because of increasing concerns about patient confidentiality, they are no longer allowed to volunteer in treatment-related areas of the clinic. They have, however, regularly helped renovate the current location and move large items in and out as needed.

Operational and fundraising decisions extensively involved the board, as well. Standing or ad hoc committees of board members met to discuss particular issues: Quality Control might address drug formulary changes, the Development and Publicity committee might decide if and when to hold a fundraising luncheon. The executive director would have input into each of these areas, but the advice of the board was integral to the smooth functioning of the clinic over the years. Each board member brought resources related to their professional background and used them to address clinic issues and make future plans for the clinic. At least one former board member explained that she understood part of her responsibility to be securing funds for Valley Health, by either giving money or raising money. Decisions about applying for specific grants currently fall under the purview of the executive director, as grant-writing makes up about 20% of the job. In the past, board members also worked on grant proposals. For example, a board member and Ana Martinez, the part-time executive director from

the early years, collaborated to write a grant that included enough funding to hire a fulltime executive director. This record of regular communication and cooperation between executive directors and board members has served the clinic well—as a small organization, it effectively shared organizational duties.

### *Comparison*

Fewer decisions were made in the two unsuccessful clinics, as they did not raise money or pursue formal organizational status (incorporation or nonprofit status). However, individuals from both clinics knew they would need additional volunteers to keep the clinics open. Unfortunately, they were unable to mobilize adequate numbers of additional volunteers to contribute on a regular basis to the clinics' operations. This lack of involvement by others outside the initial volunteers put an undue burden on those responsible for the weekly operations of the clinic to also provide organizational structure and community outreach. Although the Greenfield clinic apparently had a board, it did not function as a group that helped to guide and move the clinic forward. The Smithville clinic had no board that was dedicated specifically to the clinic's mission—therefore, the clinic volunteers had no one to help with organizational duties.

Dr. Verma was unsuccessful in recruiting additional doctors to volunteer time in either clinic. The local physicians certainly posed no threat, nor did they put obstacles in the clinics' paths, but they also did not volunteer their time in either clinic. Even so, Dr. Verma noted that he was willing to continue going to the two towns, one afternoon a week at each, as long as the volunteers had a location and volunteers to staff the clinics.

Ultimately, the Greenfield clinic had no location, and Smithville had no volunteers, but they did not cease operations for lack of a medical volunteer.

In contrast, the Carlton clinic began modestly, much as the others had: a doctor, a few volunteers, a makeshift clinic. It, too, reached a point where additional help from the community was required, to find a new location and to provide additional clinic volunteers. The main difference is that by this time, an informal board had been assembled and its members put many hours into securing recognized organizational status, raising funds, and telling the story of the clinic to the media. This “media blitz” pushed the organization into the community limelight, which resulted in more donations and doctors. From interview accounts, it seems that at about 4-5 years, in 1991-92, the clinic turned a corner and became a community organization, moving away from its beginnings as one family’s clinic. Initial movements in that direction did not secure the clinic’s future by any means, but it established it as an accepted and credible community organization.

- (4) *Monitoring*: For public goods provision, the notion of monitoring takes on a different connotation. In this context, appropriators may not need monitoring, and in essence, it may not be possible to even monitor free-riders. However, if the organization is subject to certain regulations or rules, monitoring must exist to enhance the organization’s credibility, and to ensure the provision of the public good.

In public goods settings, monitoring is somewhat different than in resource-based settings. For a health clinic, it makes little logical sense to monitor patients, and it is generally impossible to monitor indirect appropriators, even though it is in the group of indirect appropriators that free-riding is most likely to occur. However, it is important that any nonprofit that accepts donations comply with any and all regulations pertaining

to its operation, in order to establish itself as a responsible organization worthy of donations.

### *Unsuccessful Clinics*

Neither of the unsuccessful clinics had many areas that could be monitored, although there were some. Because neither employed paid staff, there were no personnel evaluations. Annual reports were not compiled, as no organizational structure requiring or requesting such a report existed. Both clinics were well aware that demand for their services exceeded the supply of medical help; the Charity Clinic asked for verification of income, Helping Hands did not. For the Charity Clinic, the most difficult verification was making sure patients did not have access to health insurance. Volunteers were known to call a patient's employer to ask if they provided health coverage for their employees, if it was known where the patient worked.

One area that entails monitoring even for nonprofit health clinics is the pharmacy. For the Charity Clinic, there were no applicable regulations concerning pharmaceuticals, as they were only able to use what Dr. Verma could bring with him, and he was the authorized professional with the authority to dispense the medications. The hospital could not direct any of its pharmaceutical resources for the clinic's use and the medications were not stored at the hospital. In Smithville, however, the State Department of Health regulated the local health department's pharmacy—what medications could legally be kept there, and who would supervise that. Because the clinic used medications not on the health department's formulary, and because the

medications were being stored on site without proper pharmacist or physician oversight, the clinic ran afoul of state regulations. After an onsite inspection, the clinic was given 30 days to leave that location and it then moved into the Helping Hands charity organization's building.

Measuring effectiveness is a self-monitoring process employed to determine whether or not an organization is accomplishing its mission. Neither of the unsuccessful clinics purposely kept records to check numbers of patients or numbers of volunteers—no annual reports or summaries were prepared. The volunteers noted that they were always busy; every clinic day had a full roster of patients to be seen. If demand for services is a rough measure, then they were surely effective, but the numbers were not officially counted and recorded.

### *Successful Clinic*

The direct appropriators, the patients, are mildly monitored at Valley Health, in that they are asked to verify that they qualify for the services. They must document income and size of household, but the clinic has no easy way to verify that patients have no access to health insurance coverage. At times, friends or family will call the clinic to tell them a patient really does have coverage. Patients are not allowed back for treatment, if they really are covered by insurance. Such monitoring is seen as a way to serve only those who truly need the services, as they must at times turn even those patients away because of the overwhelming demand for treatment.

Organizationally, this clinic possesses more fully developed structures, which allow for easier internal monitoring. The board evaluates the executive director, and the executive director evaluates the other paid staff members each year. When a physician assistant was employed with grant money, that person was evaluated by Dr. Verma, the supervising physician. Such evaluations help to ensure accountability and assist with individual goal-setting. An annual report, or annual summary, is presented to the Board of Directors each year, and a summary is available for donors who attend the annual fundraising luncheon. An accounting firm is contracted to conduct a full audit each year as well.

Externally, each funding agency may require somewhat different information from the clinic. Having 501(c)(3) status simplifies the process, as there are certain regulations the organization must meet for that designation. The annual audit provides further verification of responsible use of funds. Some agencies prefer a site visit, another may want monthly reports of activity, yet another may come for tours, but not necessarily a site visit for evaluative purposes. The fact that Valley Health continues to receive ongoing grants from these agencies speaks well for its ability to account for funds spent and document how they were spent. Because the executive director keeps records for the agencies, she is able to tell any funding agency how much care is provided yearly and how much it costs.

The monitoring with the greatest force of law behind it concerns the pharmacy. As a Class D pharmacy, the clinic is required to have a locked space for pharmaceuticals and a registered pharmacist to oversee the proper handling of medications. Class D



pharmacies are not allowed to carry certain medications, and the pharmacist in charge must be present for any counting and repackaging to take place. Complaints can be lodged against them, like any other pharmacy, and the pharmacist in charge must bring the pharmacy into compliance. The pharmacist lists this pharmacy on his/her license and is liable for any missteps as would be the case in a retail or institutional pharmacy. If the pharmacy does not follow state regulations, the pharmacist's license could be in jeopardy.

Self-monitoring to determine effectiveness on the part of this clinic is a bit more documented than for the other clinics, as the staff keeps track of medications given out, number of patients, number of medical and office volunteers. In addition, reaching patients through education was important, but less measurable. This clinic considers itself effective if it reaches as many people as it possibly can any given year.

### *Comparison*

Only one of the two unsuccessful clinics had much interaction with external monitoring: Helping Hands' experience with the State Health Department's regulators. This particular event profoundly affected the clinic, as it precipitated a physical move to a new location. However, the clinic continued to operate for another three years or so in the new location.

Internally, only the Charity Clinic, of the two unsuccessful ones, asked for proof of income and household size. While both clinics were aware that rare resources should

be spent only on those truly in need, the Smithville clinic simply did not adopt a practice of verifying the patients' status, while the Greenfield clinic did.

In Carlton, the clinic did not initially require documentation of income and qualifying characteristics of the patients; that was true at least through 1996—9 years after the founding of the clinic. However, in recent years, the executive director had instituted a practice of requiring documentation, so the clinic could be relatively assured that the services were reaching its intended patients. Patients were allowed one visit without documentation, but were asked to bring it back with them for the second visit.

Because the Carlton clinic operated with a board after only a few years, it began to document its activities early in its history, although it was not known exactly where one could find those reports. Such internal monitoring of activity and effectiveness laid the foundation for information that would be needed for later external monitors. Achieving Class D pharmacy status required extensive pharmacy compliance and monitoring on the part of the supervising pharmacist and on the part of the state. Applying for grants required documentation of funding expenditures, and of the organization's legal status as a nonprofit corporation.

If measured at the same time period, out of the three clinics, only the clinic in Greenfield required patients to document their financial status. External monitoring is most evident in pharmacy regulations for both Smithville and Carlton clinics, but is also present in providing funding agencies with proper feedback about the clinic's ability to use funds wisely and for the core mission of the organization. Effectiveness for all three was clearly perceived as number of patients served, but was not universally measured or

documented. For the unsuccessful clinics, knowing that the clinic could not keep up with the demand for services proved that the clinic was effective. Alternatively, the Carlton clinic closely documents the clinic's activities, mostly for the board and for funding agencies, tracking numbers for everything from volunteer hours to the value of medication provided.

- (5) *Graduated sanctions*: Because there is a limit on who direct appropriators are, sanctions may need to be imposed to verify that only those who qualify for the good are allowed to use it. Once one directly benefits, is it possible to lose such privilege? If so, it should be clearly denoted who can restrict access to the good.

When boundaries exist, individuals may find where those boundaries are and how much deviance from accepted behavior will be tolerated. Organizations cannot continue to function smoothly, if the boundaries are constantly being pushed. This analysis probes whether such a situation existed with any of the clinics studied.

### *Unsuccessful Clinics*

Neither of the unsuccessful clinics had much experience with “rule-breaking.” Because the Smithville clinic did not ask for verification of income or of availability of insurance, the basic rules for being treated at the clinic were not verifiable or enforceable. In Greenfield, there were a few times when someone might not qualify for income purposes, or it was discovered that an individual was covered by health insurance. When this happened, the individual would not be allowed to visit the clinic for treatment the second time.

Because the Greenfield clinic was essentially in its infancy, and the Smithville clinic required no patient documentation, evidence of this principle operating in either

location is slim. Neither clinic received organizational funding, so there were no sanctions imposed in that area of concern. Although the Smithville clinic ran up against state health department regulations concerning the storage of medications early on, over the final years of the clinic, no such regulations existed for the second location.

### *Successful Clinic*

As with the clinic in Greenfield, the Carlton clinic asks for documentation of income and sometimes are able to verify that someone is covered by health insurance. Likewise, if it is found that a patient does not qualify for services, they would not be allowed a second doctor's visit, although they are allowed one treatment, if they have no documentation material with them. Both clinics viewed this as a way to maximize the number of people served who truly needed the services, and represented a more responsible means to use the sparse resources. Establishing this boundary protected the appropriators as a group from being displaced by those not qualified to partake of the public good.

At Valley Health, there have been times when patients have exhibited rude or abusive behavior toward volunteers, doctors, or staff. When this happens, generally the executive director or the physician on duty would speak to the patient, give them an opportunity to cool off, and let them know that they can return on another day, but only if they act in a respectful manner. One instance resulted in a volunteer physician choosing to not return to the clinic, and volunteers were considered far too precious to

allow an irate patient to drive them away. Establishing this boundary protected another scarce resource—the volunteers providing the good, improved medical care.

As far as sanctions doled out to the volunteers, there have been few, and those would be informal. For example, if an office volunteer did not work out at all, that person might not be invited back. Most who did not work out realized it was not the right setting for them, and self-selected out of the situation—they simply did not return. As far as physicians, none had been “dis-invited.” Their services compose the crux of the clinic’s mission, so if they did not show up for a shift (usually due to an emergency), there were some “back-up” doctors who could be called upon for help. No instances of abusive or dangerous behavior on the part of any medical or office volunteers were mentioned, but one might assume that such behavior would precipitate the imposition of sanctions.

None of the interviewees could remember that the clinic had ever been sanctioned by funding agencies for non-compliance with agency requirements. Indeed, the fact that this clinic is routinely funded year after year by the same agencies and has secured new grants over the years, is in itself a testament to the clinic’s record of responsibility and accountability. The consulting pharmacist said there had been no citations by the state board of pharmacy, either.

### *Comparison*

In both the Greenfield and Carlton clinics, sanctions were used to protect a scarce resource (clinic services) and in Carlton, they protected an additional resource, the

volunteers. No such sanctions were utilized in Smithville. For the successful clinic, the threat of formal sanctions by funding agencies and state regulators perhaps ensured that such sanctions would not be needed. The clinic staff and board were very careful to adhere to all regulations, knowing that noncompliance would bring undesirable consequences for the clinic.

- (6) *Conflict-resolution mechanisms:* Because all organizations experience conflict, there should be lines of authority for dealing with conflict. Conflict will likely exist between different constituent groups or individuals—volunteers, the organization, the board, professional volunteers, or paid staff. One should find open acknowledgement of conflict and of the organization’s ability to cope with it. Means for working through internal and external conflicts must be evident.

Because organizations represent collections of individuals, it is expected that some amount of conflict will be evident over time. Finding evidence of conflict should not be a concern, as long as mechanisms for resolving conflict work and work well. These mechanisms can be either formal or informal, as long as they effectively deal with the clinic.

### *Unsuccessful Clinics*

Those interviewed from the clinic in Smithville remembered little conflict or disagreements, most of which came from patients who were upset at how long they had to wait, or if they were unable to get their name on the roster for any given day. This seemed to not even warrant much of a response from the clinic—nothing was said about how this was handled. Other conflicts surfaced once the clinic shared space with the rest of Helping Hands’ ministries—the children of patients might make a mess out of a clothes rack. So the clinic volunteers tried to keep the space picked up and keep the

children out of trouble. The only major conflict was the previously discussed situation with the health department regulators and the pharmaceuticals stored, and the move to a new location addressed that issue. Few conflicts occurred, but were resolved easily. Simply absorbed so much time and energy that conflicts simply did not surface.

There were only a few instances of conflict in Greenfield, as well, but a few more were remembered. The same kinds keeping the clinic in working order may have of issues with patients arose—unhappiness about waiting in line, or not getting the medication one might want. The school district sent a bus of children for lice treatment late in the afternoon one day, but they could not be seen; a Ministerial Alliance volunteer explained that the children would have to come back on another day. Since the clinic met in the hospital, there were a few disgruntled employees who complained about having “those people” in the waiting area. The hospital administrator essentially discounted such rumblings, but there were times when patients’ children made messes in the cafeteria, which resulted in additional work for the housekeeping staff. The clinic coordinator tried to find solutions for the volunteers to keep a better eye on the children, and to let the parents know what was acceptable and what was not. Some negotiation over patient records took place—the hospital did not have enough space for them, so they asked the clinic to keep them with Heath for All’s records.

In Greenfield, there was one retired doctor who was a bit abrasive with the workers, but he was not there often, so this posed little difficulty. However, a serious source of conflict came with the office volunteers, who wanted to be able to volunteer only until 6:30 p.m.; however, depending on the type of illnesses treated, the doctor

might be working far past that time. That issue caused a drop in volunteers, a difficulty that contributed to the clinic's closing, so it is clear it was not addressed satisfactorily from either the clinic's or the volunteers' viewpoint.

In both clinics, the interviewees were hesitant to call the disagreements "conflict," but they were very clear on how disagreements were resolved.

### *Successful Clinic*

Just as with the other clinics, conflict for Valley Health is evident with patients, volunteers, and in this case, the external community. Perhaps because this clinic has survived longer, conflict has become more recognizable for it.

Internal conflict took many forms. The first full-time executive director, who came to Valley Health about five years after its founding, recalled that either she or Dr. Verma would work with impatient or upset patients. Presently, the executive director is the authority for resolving most patient issues: she may ask them to calm down, or to leave until they can be calmer. They would typically be upset about the long wait, but those instances were few and far between. Some physicians would prescribe medications not on the clinic's formulary, or would order too many diagnostic tests. When that happened, either a board committee or the medical director would speak to them about what limitations the clinic must work with on the cost of care. One example of internal conflict happened when the campus newspaper misquoted the executive director in such a way that it offended the physician volunteers. Some board members came to the executive director's defense and spoke to the doctors who were upset. Conflicts with



office volunteers generally took care of themselves, as the volunteer would choose to not come back if the job wasn't a good fit. There was one clear example of conflict with paid staff person: a former executive director had a young baby she brought to work with her, but as the child grew, it became difficult for the clinic to function with a toddler always around. The board chair addressed the situation, and explained it was not going to work, and the executive director made other child care arrangements. The board became involved when the conflict surrounded a paid staff member.

Externally, the example noted by a number of people referred to community efforts to bring all community health services under one organizational umbrella, discussions which took place in the mid-90's. Such discussions even caused dissent within the clinic—some argued for consolidating with other services, to maximize amount of service that could be provided, while others argued that to join with the others would compromise Valley Health's identity and mission. Those who wished the clinic to remain independent prevailed, and the community discussions have had no lasting repercussions, as this clinic and the local Medicaid-licensed clinic refer patients back and forth on a regular basis. Clinic representatives characterized the present relationship with other clinics in town as collaborative.

The person who took responsibility for conflict resolution varied by the problem and the location. Because the executive director is on-site, it makes sense that she would address patient issues, and since physicians can best speak to other physicians about treatment issues, the medical director would step in there, while the board would resolve issues with paid staff persons. This de facto division of labor is logical and works well.

### *Comparison*

The clinic in Greenfield and the clinic in Carlton resemble one another on this principle, as both looked to certain individuals to resolve issues: both generally referred patient issues to the clinic coordinator/executive director. In another aspect, the two unsuccessful clinics were alike in that the clinic volunteers found it necessary to corral the children of patients, since they shared space with other organizations. Because the successful clinic did not share space with another organization, it had no issues of keeping children from causing harm to the building, at any stage.

However, differences are evident in the amount of organizational resources the Carlton clinic currently has available to draw on for conflict resolution, although one would expect that to be the case for a surviving, structurally more complex organization. For the minimal amount of conflict noted in the unsuccessful clinics, it appears that it was easily addressed and caused no ongoing difficulty for the clinics.

(7) *Minimal interference of rights to organize*: Organizations are situated within a particular sociopolitical context. As such, resistance from local governmental officials could cause great complications for the provision of a public good. Successful organizations will likely have experienced little difficulty with officials, at the very least. Ideally, the organization will have actually received open support and encouragement from authorities.

This principle could be analyzed on two dimensions: First, is the clinic subject to bureaucratic obstacles by local officials? Second, is the clinic actively supported by local officials? In other words, one explores whether or not a clinic is being harmed by local officials, the other explores the possibility that local officials are actively supportive.

*Unsuccessful Clinics*

Neither unsuccessful clinic reported any roadblocks being placed by local officials; in Smithville, officials more than likely were simply apathetic to the clinic's operation. In Greenfield, the clinic knew that school district officials were aware of the clinic's existence when a busload of children showed up for lice treatment. Other local leaders were involved to various extents: a banker in Smithville released money formerly given to the Salvation Army to the clinic to be used for medication costs, and local pharmacists in both towns offered to fill prescriptions at cost, making no profit on those sales.

Local medical professionals also offered no resistance to the clinics' establishment. They did not volunteer, other than a retired doctor who lived out of town and filled in two or three times, but they did refer patients to it, and generally left the clinic alone. In both locations, the clinics were free to provide services as they saw fit; on the other hand, they did not enjoy the active support of local officials.

*Successful Clinic*

In Carlton, as with the other two, local officials have not erected obstacles to the clinic's ability to function. Not only have officials not stood in the way, they have actively supported the clinic's operations. A particular example was the use of Valley Health to demonstrate one of the positive aspects of Carlton, when city leaders applied for a national award, which they subsequently won. In addition, both local municipalities support the clinic through the block grants, and both participate in the awarding of those

monies. Both types of support certainly enhanced the clinic's legitimacy in the eyes of the community.

A local development committee, in conjunction with some downtown merchants, has provided the small amount of resistance to the clinic, since it does not match the image of a revitalized and economically growing downtown area. The patients at Valley Health typically spend little money when they are downtown, and may even take parking spaces other merchants wish to use for their customers. While the clinic may represent a bit of a thorn in the side of revitalization efforts, no official moves have materialized to force the clinic to move.

Although there may have been initial suspicions of Dr. Verma's motives, local medical professionals and institutions became active supportive of the clinic, starting in the early years: when the clinic still met at the motel, two doctors other than the Verma's volunteered, All Saints Hospital donated a small amount each month for medication purchases and All Saints' administrator sat on the first board. With the move to the renovated laundry-mat five years later, the clinic added volunteers from the local HMO and the medical school. Presently, both hospitals support the clinic financially and through direct involvement on the board, a large local HMO clinic has a number of physicians who volunteer, and the medical school has provided staff expertise and regularly publicizes the clinic to its students. Just as city officials and funding agencies legitimated the organization with their support, additional legitimacy comes from involvement of the local medical establishment.

### *Comparison*

All three clinics found little to no negative reactions from city or county officials. The obvious difference between the unsuccessful clinics and the successful one is that in Carlton, not only did officials not get in the way, they actively supported and valued the organization. This legitimacy, coupled with the blessing of local medical professionals, contributed to the clinic being able to grow and flourish in the community.

(8) *Nested enterprises*: Stronger organizations will possess ties to other organizations—government agencies, other non-profits, any monitoring agencies, funding agencies. These ties confer a level of credibility and legitimacy on the organization. It should be noted that “nested” does not necessarily implicate “hierarchy.” The organization may be nested and connected to other organizational structures, without necessarily “answering” to them. The central mission of the organization makes up the core, surrounded by volunteers, staff and board. Around that structure may exist other community organizations, funding agencies, or resource generators.

Analyzing the strength and type of ties to other organizations should offer insight into how the clinics functioned in their particular environments. Since nested relationship could conceivably confer legitimacy, these should be beneficial for the clinics’ survival.

### *Unsuccessful Clinics*

Both of the unsuccessful clinics were well-situated within other organizations, with close nesting relationships. In Smithville, the clinic was taken under the auspices of a local charity organization that gave out food and clothing; in fact, the clinic physically shared space with the mission. Philosophically, the two would have meshed quite well. However, what could have been a potentially close relationship never seemed to quite

reach its potential. The board of the charity mission was not really aware of the clinic; they merely knew that the clinic used the building one evening a week.

In Greenfield, the clinic also was nested closely with an organization, and shared space with that organization—the local hospital. From all accounts, this was an excellent, mutually beneficial relationship. The location was well-known, the hospital offered certain resources, and the clinic kept a few patients out of the emergency room. The hospital administrator was very happy to have the clinic meeting on the premises and offered help and resources. The arrangement made sense for the clinic and for the hospital. This beneficial relationship came to a halt when the hospital changed management to All Saints Hospital System of Carlton, and the clinic was no longer allowed to use the space.

### *Successful Clinic*

Valley Health had no close nested relationship, as the other two did. It was nested more informally with local funding agencies, and other local service agencies. The clinic regularly refers patients to other local services from which they could benefit, which entails having enough of a relationship to be able to call and refer patients back and forth. Working with local hospitals, specialists, and the medical school allowed for partnerships to develop (e.g., the medical school's residency program, which was seeking to use telemedicine methods to help train its residents).

This clinic is tied closely to local funding agencies, and because of the clinic's excellent reputation, it continues to receive funding. Many of the grants repeat and they

would not continue to award them if the agencies determined that Valley Health was misusing the funds. The clinic is responsible for meeting agency expectations, and for accounting for how the grants are spent. The pharmacy especially helps with this, as they require that chronically ill patients come in at least every three months for prescription refills. This is one way to prove improved health for these patients—they are monitored periodically. The ties to funding agencies are more formal and required by the review process, while the ties to other local agencies and clinics are informal ties maintained through social networks.

### *Comparison*

A noticeable difference between the successful clinic and the two unsuccessful ones is that in Smithville and Greenfield, the clinics were nested quite closely with another organization and another institution, a situation that might be expected to carry with it institutional support and would bode well for survival. However, neither of these clinics survived. I suggest that a nesting relationship that is too close (shared space or organizational board) places the organization at the mercy of what is affecting the umbrella organization. In the case of the clinic in Smithville, because the board only offered space for the clinic to meet, without truly investing in its mission and work, the clinic did not have an effective liaison to the community and a conduit for recruiting additional volunteers. In Greenfield, the clinic was most certainly subject to the needs of the hospital, as the management change signaled the end of the clinic, when the new managers determined there would not be space for the clinic to operate.

Perhaps one reason the Carlton clinic survived is that it was independent, as far as location and future plans went, but it forged secure, albeit looser, nesting relationships with local agencies, thereby gaining legitimacy and support from those connections. This could serve as another argument for not joining with the other social service health agencies under one organizational umbrella—it would directly subject the clinic to forces affecting the other organizations.

Clearly, the three clinics differ in certain areas, and are remarkably similar in others. A summary table is included below, indicating which of the principles were present in each clinic and to what extent (Table 1).



**Table 1. Presence of Ostrom's Eight Organizational Principles in the Three Clinics**

<b>Principle</b>	<b>Valley Health Clinic (at 4 years)</b>	<b>Helping Hands Clinic (at 4 years)</b>	<b>Charity Clinic (at 1 year)</b>
(1) Clearly defined boundaries	XX	X	X
(2) Congruence between provisions and local rules	XX	X	XX
(3) Collective-choice arrangements	XX	X	X
(4) Monitoring	X (external)	X (external)	X (internal)
(5) Graduated sanctions	---	---	X
(6) Conflict resolution mechanisms	X	X	X
(7) Minimal interference of rights to organize	X	X	X
(8) Nested enterprises	X	XX	XX

**Incentives for Volunteer Participation**

Understanding why volunteers devote time to this kind of clinic offers insight into how clinics managed or did not manage to mobilize.

*Unsuccessful Clinics*

There is nothing unique or unexpected about the motivations noted by the volunteers for the two unsuccessful clinics. They mentioned personal satisfaction, a

bonding with other volunteers, a desire to give back to the community, and an awareness of the incredible need for decent medical care for vulnerable populations. To a person, the volunteers noted and expressed deep appreciation for Dr. Verma's commitment and vision, going so far as to say that was the sole reason the Smithville clinic survived as long as it did. Only Greenfield could respond to the needs of the hospital, as there was no hospital in Smithville, but volunteers felt that the clinic helped improve the cost-effectiveness of treating patients outside the emergency room.

### *Successful Clinic*

The successful clinic reflects many of the same concepts already explored above: Dr. Verma's initial vision and ongoing commitment; volunteer desires to give something valuable back to the community; a wish to practice medicine in a more hands-on manner; a calling to speak for those without a voice in the community, the most powerless; even a need for community service for some legal infraction. All formed reasons for volunteers to give their time to Valley Health.

In addition, local hospitals could not escape the fact that a primary care clinic like this keeps a certain number of patients out of the emergency room. These patients cannot afford an emergency room bill, so the hospital absorbs that cost. With a clinic operating locally like Valley Health, those costs can be reduced for any medical institution. For one hospital administrator, this represented at least one reason for him to be involved, the other being a demonstrated willingness to care for the community.

Yet, Dr. Verma sees the recruitment of physician volunteers into the clinic to be the most difficult part of keeping the clinic open. Two interviewees pointed to possible deficits in medical training—medical schools students are treated as though they are owed a big salary, and the training rarely tells students that one part of being a physician is public service. Dr. Verma himself despaired over the shift of the practice of medicine to a business rather than a social service. How much this will affect the clinic is yet to be seen, as most of the medical professionals interviewed believed that younger doctors are less likely to adhere to a philosophy of public service medicine. If so, this demographic shift will occur sometime in the future, as an older generation of doctors retires or dies.

### *Comparison*

Clearly, there are no blatant differences among the volunteers' motivations in the three locations. Dr. Verma's commitment remained the same, and carried the same infectious zeal no matter where he practiced. The volunteers engaged in meaningful work, giving to their communities, while gaining social ties and a sense of community within the organization. One main difference appears in the difficulty of securing enough volunteers in Greenfield—that was certainly a concern for the clinic coordinator at that location. While the volunteers in Smithville noted the lack of others to help, they functioned for a longer time with a skeleton crew of volunteers. In Carlton, the early involvement of volunteers and board members beyond those who worked each week in the clinic was advantageous, as it dispersed the organizational work among a larger circle of individuals.

The Greenfield and Carlton clinics both possessed institutional contributors, as well—hospitals whose administrators understood well the benefit their organization gained from patients seeking treatment in a primary care facility as opposed to an emergency room. As stated before, however, this aspect evaporated in Greenfield with the arrival of new management.

### **Framing the Messages**

A common theme appeared in a number of data settings, yet it did not easily fall into the questions I had posed: this theme addressed how the clinic was perceived and how its story was told to the public.

For Valley Health, the theme revolved around providing services to the working poor, “many of whom are caught in a financial Catch-22: they can’t afford medical care, but they make too much to qualify for Medicaid” (local newspaper, April 1, 1992). In a story that included Valley Health’s work in the community, a local magazine writer asked, “What about the ‘working poor’...who can afford neither health care nor health insurance and fall through the social safety nets of Medicare and Medicaid?” (local magazine, April 1992). The idea that the clinic served a good many employed individuals came up time and again: “We see a ton of [national retailer’s] employees. [The retailer] is notorious for 39 hour work weeks, no benefits. And, we see [local meatpacker] employees...[university] employees...[city and county] employees and their families. Somebody who’s at a menial job making \$10 an hour with three kids, they can’t afford that extra family policy even if insurance is provided and they qualify

because they're within the poverty guidelines" (Blackman); "[We provide] a service to folks who are presently the working poor" (F. Wilson); "[A] large percentage of our patients do work...for agencies, or places that can't provide health insurance, or it's too expensive" (Browning).

A promotional video produced for Valley Health prominently features a middle-aged, well-educated engineer telling his story: he thought his life was planned and moving along well toward retirement, then he found himself laid off from his employer, a top energy corporation. He no longer had a job or health insurance, but he still had a heart condition. He heard about Valley Health and was relieved to discover he could see a doctor and obtain his necessary medication. He credited Valley Health with keeping him healthy. He went on to say he was employed once again, but with a small firm that was unable to provide health insurance for its employees. This man's story formed a substantial portion of the short video—his narration began the video, and carried through it (video screened at annual fundraising luncheon, 2005).

Related to the framing of patients as the working poor were statements that emphasized the common human condition: "[D]on't you just love it when people talk about 'those people?' I mean, we're all in this together" (Fisher).

Such framing of the message did not take place as consistently in the unsuccessful clinics. The very name of the clinic in Greenfield carries the connotation of a handout, something designated for second-class citizens: the Charity Clinic. One volunteer expressed thoughts about the patients this way: "Sometimes, I wondered how they could possibly live. Especially if they had 3 or 4 kids. [Don't know] why they

didn't know where kids came from. On the other hand, the more kids you have, the more welfare you get" (M. Bloom). Yet, the same volunteer later indicated that though they tried to help "those poor, poor people," he was well aware that "there but for the grace of God go I" (M. Bloom). At the very least, ambiguity was present.

In Smithville, the volunteers acknowledged that the majority of patients were not employed: "I said working poor but, yes, probably less than 50% [worked]. [A] lot of the adult population who honestly had been the products of the... Medicaid system, who had never worked because they got on programs that provided their health care and provided food stamps" (Harris interview).

I found no evidence that the clinic in Carlton had consciously set out to frame its message in terms of serving the working poor, but the terminology was visibly present in media coverage and in the interviews. This may have been instrumental in helping the message to resonate with the community, who could identify with someone who worked but could not afford health insurance. This framing began as early as 1992, but has continued through media reports, the video and volunteer interviews carried out for this study.

## **CHAPTER VI**

### **DISCUSSION AND CONCLUSIONS**

This research utilized case studies to answer questions about survival of community health care clinics. Three clinics were studied: one survives, while two did not survive past five years. I began the study by asking what differentiated among these clinics. What important factors differentiated the successful from the unsuccessful?

Using Yin's approach toward case studies, I chose these clinics based upon their theoretical variation on the most important of outcomes, survival. Because the clinics involved the same state, and the same region, I was able, in essence, to control on these geographic and political variables that might potentially account for differences. Additionally, the same physician started all three clinics. Such data would be rare and they afforded me an extremely unique opportunity.

In the last chapter, I examined evidence for each of the eight adapted principles plus examination of volunteer incentive and "framing" of the clinics' message in terms of the communities involved.

The most accurate comparisons are among the clinics at approximately the same stage of development; I will analyze them from the standpoint of what was present during the establishment of the clinic and what then developed as the successful clinic evolved into an organization requiring ongoing maintenance. Relying on data obtained, I have set the timeframe for founding as a one-year process. Once that milestone was

achieved, the next step would be the establishment phase, from about one year to four to five years. Beyond that point, an organization would enter the maintenance stage.

Two clinics survived beyond the founding stage—one did not. Clearly, a necessary condition for making this transition would be the presence of a physician and someone in a clinic coordinator role. However, this did not constitute a sufficient condition. The two that survived past one year did not encounter the loss of structural support, as did the clinic in Greenfield, when it lost its location. The clinic in Smithville also was forced to move early in its life, but another location was provided for it. The community's ability and willingness to provide an alternative site proved to be the sufficient condition necessary for moving to the establishment phase.

Both Valley Health and the Helping Hands clinics entered the establishment stage of development, but were faced with similar crises at the maintenance stage—one survived, one did not. Both noticed a sense of burnout at this point, and gave strong consideration to the possibility that the clinic could not continue without additional help. Valley Health's board members, by capitalizing on community ties, brought individuals with a variety of skills and viewpoints into the clinic's mission. The presence of an active, engaged board consisting of community members from a variety of backgrounds, proved to be another necessary condition for moving to ongoing maintenance of a mature organization. Successful navigation of that crisis for Valley Health resulted in further organizational structure and additional ties to the community.

One of the most important aspects of the surviving clinic's structure was the involvement of an active Board of Directors in setting the tone for the clinic's operation



and actively participating in the mission. This effect was evident, as it reflected multiple principles of success: organizational structure, community support, and decision-making. This single observation accounts for a good deal of the reason Valley Health survived, as the board provided extra people on which the clinic could depend for assistance, as well as incredibly salient connections to the community. The board members volunteered at the clinic, but also helped write by-laws and gain nonprofit status, recruit new members, and publicize the clinic to the media. Valley Health's board enabled it to successfully navigate the crisis at four years of determining whether or not the clinic could remain open, as it needed a new home and more volunteers.

An active board sharing the vision of the founder was glaringly absent in the other two clinics. While a board in a smaller town would be expected to have fewer directors, there is no reason to believe this could not be duplicated in another location—every community has its leaders and civic-minded individuals. Both of the other towns had local newspapers, but no one capitalized on the possible goodwill and publicity such coverage might have brought. Rather than use the newspaper to expand the patient load (which was already plenty full), it could have been used to publicize the need for volunteers.

As far as the availability of a doctor, there is no doubt the non-surviving clinics had fewer medical volunteers—just Dr. Amit Verma and occasionally, Dr. Shilpa Verma. Hardly any of the local physicians chose to, or were mobilized to volunteer at the clinics. However, it is important to note that neither clinic closed due to lack of a doctor. Dr. Verma was willing to continue to visit the towns one evening a week, as long

as the community could provide a location and volunteers for the clinic. At the same time in its development, the surviving clinic only had 4 physicians, 2 of whom were the Verma's, but the clinic was able to be open more days each week than the outlying clinics. Lack of medical personnel in the communities does not appear to be a major reason the clinics closed.

Dr. Verma had his own ideas about the connection between community support and the clinic in Smithville: "I was willing to be there...I told them if they want to get it started again, I would help. But then the nurse left town—all it takes is one person who is interested—and she left town. There was no help, no one to open the clinic, no one to run it. [C]ommunity support was just missing. Even a place like [Valley Health] would close down without community support" (Verma interview).

Another important effect was initially unexpected and somewhat counterintuitive. I expected to find that the setting most closely nested with other organizations to be the clinic that survived, but that did not turn out to be the case. The close nesting relationships of the two unsuccessful clinics may have subjected them to the level of functioning and organizational change of the umbrella organizations. In one instance, change in management of the hospital contributed heavily to the Greenfield clinic's closing. In Smithville, the clinic was "adopted" into a pre-existing organization and board, but the board was likely not focused on the clinic's mission, but on the original organization's mission. The surviving clinic was the least nested with other organizations, yet it survived. However, it did possess numerous looser, more informal nesting ties to the community, and to fundraising organizations. The combination of

informal nesting with the autonomy of being an independent organization appears to have provided the most beneficial setting for the surviving clinic.

While initially counterintuitive, upon closer examination and analysis, the positive effects of looser, more informal, community ties provide further support for a “strength of weak ties” hypothesis (Granovetter 1973, 1983). While strong ties between individuals may provide greater social cohesion, they may also inhibit the expansion of ideas and sharing of information, in that “social systems lacking in weak ties will be fragmented and incoherent” (Granovetter 1983: 202). One may think of weak ties as being informal, with strong ties being formal and defined by organizational relationships (volunteer, coordinator, director). Valley Health Clinic’s ability to maximize weak community ties led to an expansion of ideas about organizing and marketing the clinic to potential volunteers. Inasmuch as the members brought numerous weak ties, through volunteers and community ties, the early board of the successful clinic contributed greatly to its success. Through these weak community ties, the clinic expanded horizontally into the community, establishing organizational ties, rather than vertically, by forming strong ties with an umbrella organization. The horizontal expansion offered greater autonomy, and ultimately, greater chances for success.

Other principles drawn from Ostrom’s framework seemed roughly equivalent in the three clinics: monitoring, sanctions, conflict resolution, and minimal interference from local officials. These principles were more applicable to understanding the ongoing functions of the mature, more complex Valley Health clinic, as it moved past establishment into maintenance. It is likely that variability of these factors fit into

examining the efficiency or effectiveness of clinics that have already been firmly established in a community. Another difference among the clinics was how the clinics presented their messages to their communities. While the individuals from the two non-surviving clinics had no data after ten years on which to base their statements, they typically did not perceive the clinics' primary missions to be treating employed individuals with no access to health care. Whereas, both respondents' reports and media messages of Valley Health were consistent in describing the "working poor" as the large group the clinic served. By emphasizing "working," the clinic supporters were likely to broaden their base of backers. Most people can identify with someone who is employed, but cannot afford health insurance, as health insurance premiums have risen sharply over the past few years. Whether this has been a conscious decision to present the clinic in this light is unknown, but its posited effects are clear. On the other hand, the two clinics that did not survive framed the clinics in terms of "Charity"—which certainly projects the old image of "charity for the poor" or, a handout, and "Helping Hands" indicating helplessness.

A common theme running through each of these observations is that community support was critical for the clinic to survive, whether through the board's active involvement, informal nested community relationships, or a common message represented to the community. Attaining such community support requires coordination within the organization (with an active board and dedicated volunteers), and communication with the community, to "tell the story" and bring others into the mission and vision of the clinic.

## **Methodological Assessment**

The purpose of a comparative case study analysis is not generalization to a specific population. And indeed, I cannot directly generalize my case studies to other clinics. As in any case study, the results are culturally and historically bound. However, these case studies do inform the theoretical principles and in this sense the case studies serve as a test. The theoretical principles were drawn, in large part, from Ostrom's framework. The framework did seem to fit the cases we examined and the modification of her principles seemed to fit the analysis.

One limitation of the study is that only one successful case was examined. Had other surviving clinics been located and investigated, it is possible that greater explanatory power might have obtained and allowed more fuller comparison. However, as I have discussed, the fact that all three clinics shared so many characteristics (state, general location, doctors involved) strengthens confidence in the results.

Finding other successful clinics and surveying their volunteers, as well as those from this study, would add methodological and theoretical strength. Other settings would include a clinic in a nearby city, and perhaps the clinic in Michigan mentioned earlier. Since it seems that avoiding volunteer burnout and providing community support are critical for clinic success, a study examining such characteristics would possess great applicability for other community health clinics seeking to maximize the chances for viability.

There are some other plausible explanations for the differential survival of the clinics. Some we can rule out by virtue of other evidence, but some cannot be absolutely

ruled out. For example, one explanation might be simply that clinics in larger communities might have greater chances for survival, as there are inherently fewer potential volunteers to tap in a small town. Similar deductions about the office volunteers could be made, as well. Because Dr. Verma drove 20-30 miles one way to each of these clinics, one could not expect a great number of volunteers to come from surrounding areas, either. Valley Health was located in a larger community than the other two clinics. However, the size of the community may affect how large a board is, but not whether it is actively involved. A smaller community may open the clinic for fewer hours than in a larger community, but that in itself should not determine the success of a clinic. Another, related issue might be that the availability of doctors and nurses is great in large towns. Certainly, in a larger town, more medical professionals are potential volunteers. One hospital administrator noted that if there were 30 medical volunteers in Carlton, out of a population of 300 practicing physicians, it would constitute a 10% participation rate (Johnson interview). The correlation to that would be out of a population of 2 practicing physicians in Smithville, a 10% participation rate would be 0.2 physicians. Again, that may affect how many hours the clinic could function, but in the two non-surviving cases, the medical volunteer was still willing to provide services.

### **Applied Implications**

According to Families USA, a nonprofit organization that advocates for high-quality, affordable health care for Americans, the number of uninsured in the U.S. has

grown from 38.7 million in 2000 to 45.8 million in 2004. Fewer individuals have insurance provided through their employers, and when they do, employees are paying a higher premium than they did five years ago (<http://www.familiesusa.org/resources/newsroom/statements/presidents-health-initiative.html>). There is no reason to believe that the demand for clinics such as Valley Health will decrease anytime in the near future. This being the case, it would be prudent to seek implications that could be applied to new settings of similar clinics.

One clear implication of the study is that coordination and communication are absolutely critical for a public goods organization. Coordination provides a structure for the goodwill and vision of the people involved, in that an active board, working with office staff, volunteers, and medical personnel, provides the support needed for the organization to continue to expand. Without that support, very dedicated volunteers will find themselves burning out and feeling overworked and underappreciated by their community. The first recommendation stemming from this research would be that the organization must have a guiding Board of Directors, dedicated to the organization's mission, and bringing a set of skills and roles with them into the board position.

While a physician's skills and willingness to donate time are necessary conditions for any clinic to succeed, they do not comprise sufficient conditions, as seen in the two unsuccessful clinics. Without additional office volunteers, proper locations and funds provided by the community, there is only so much a physician can accomplish. In addition to the medical community, other subgroups of the community must be involved—the press, local government officials, local businesses. The second

recommendation is that the clinic must achieve visibility in the community with a message that resonates with individuals, inducing them to volunteer time and donate money.

Both of these recommendations hinge on coordination and communication. Without a good deal of inter-group coordination, perhaps facilitated by board members' community networks, the message would not be heard in the community. The ability to communicate the organization's mission to the public forms the basis for the organization's survival and expansion. Such coordination and communication are simply not possible, if the only volunteers are those keeping the clinic open every week—they are consumed with day-to-day exigencies, rather than long-term planning and coordination.

Other implications involve pragmatic steps that ensure an adequate number of volunteers. Clinics such as the ones studied depend on volunteer labor, for medical services and office tasks. As such, practitioners must consider volunteer incentives and motivation, so as to maximize the possibility that enough volunteers would be available for the clinic's operation. Securing physicians seems to be the most difficult issue for a clinic, even with the founder personally recruiting other physicians, so it is imperative that a clinic begin with a doctor who is dedicated to the mission and has the necessary vision for this kind of clinic. Beyond that, a change in medical school curriculum to add an emphasis on community service as a norm for the profession would be helpful, but such an organizational shift is out of the control of clinic organizers. Creatively seeking ways to contribute to medical school education, perhaps using distance technology to



engage medical students, would be another means to increase medical volunteering. Producing educational materials about the societal cost-effectiveness of primary care clinics, as opposed to emergency room visits, may provide an avenue to reach additional physicians, physician assistants or nurse practitioners.

To avoid volunteer burnout, clinics must seek a supportive network of individuals who may or may not volunteer in the clinic on a regular basis, but who may serve as advisors or board members. These individuals should be well-connected in the community. According to what is known about rates of volunteering, those individuals more likely to volunteer are middle-aged, in high status occupations, and may be public service employees (Wilson 1997, 2000). These individuals also possess higher levels of social capital and resources; therefore, engaging them leads to a network that will bring in even more volunteers. In fact, this seemed to be the case, especially for Valley Health. In practice, taking the clinic's message to groups or individuals most likely to volunteer as board members would be a place to start building one's volunteer board: medical auxiliaries, professional associations (e.g., public relations, communication), interfaith clergy alliances, local and state bar associations, chambers of commerce. For example, in the case of the clinic in Michigan previously mentioned (Coslow 2005), the founding doctor spoke at a church, the nurse writing the article heard the vision articulated, and volunteered to be a part of it, bringing her skills and social contacts to the endeavor. Another good practice would be to educate local judges, who seek venues for individuals who must complete a community service requirement as part of a sentence. In some states, being on welfare may carry a requirement of working a certain number of hours

per week; in the state studied here, those hours did not have to be paid, but did allow the individual to receive basic office training. In Valley Health's experience, these "forced volunteers" frequently stayed on as regular volunteers, once they became acquainted with the clinic.

While volunteers give their time for numerous reasons—desire to return something to the community, a feeling of connectedness, belonging to a group—these alone were not enough to sustain the clinics, nor to bring in new volunteers. When the clinic in Greenfield closed, one volunteer described feeling depressed because the clinic meant so much to her. The nurses in Smithville expressed distress that they had not been able to keep the clinic operating—they enjoyed the interaction and the feeling they were contributing to the community. Yet, both of these clinics required more structural support to sustain the volunteers, not a deeper sense of belonging. The greatest volunteer incentive may be a sense of being valued and supported by the community, which may be manifested in additional volunteers or an active board.

### **Future Research Directions**

Building on the above discussion, future research might focus on developing more information about networks and social capital. Some of the community development literature and the literature on disaster recovery have taken this approach and my research suggests that it might be important to integrate the very different literatures. (see, for example, Krishna, 2002.) One could include a form of network analysis to assess board members' community connections. In addition, it would be

useful to know how new volunteers heard about the clinic—this would give insight into what publicity methods were most effective in spreading the word about volunteer needs.

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## APPENDICES



## **APPENDIX A**

### **INTERVIEW INSTRUMENT**

#### **History and Development of the Valley Health Clinic**

The first set of questions address the development of the clinic: its founding. The second set of questions, broken down by design principle, addresses the ongoing maintenance of the organization. Problems of incentive structure will be included in both development and maintenance questions.

#### **I. DEVELOPMENT OF THE CLINIC**

When was the Valley Health Clinic founded?

Where was it first located?

Why was it founded? More indigent during that time? Higher unemployment?

Who was it founded to serve?

Who were the initial medical volunteers?

Is there a hospital in B/CS that is required by government regulations to take indigent patients? Was the clinic able to refer serious cases to that hospital?

How did the founding physician recruit medical personnel to the cause of volunteering in the clinic? Where did he recruit? Who presently handles recruitment of physicians and nurses? Are medical students encouraged to volunteer?

##### **Incentive structure questions:**

What principles guided the founding physician? Professional norms? Religious values? Cultural expectations?

Before the clinic opened, how much of the founding physician's practice was devoted to indigent care? After the opening? Currently?

What % of a physician's practice is typically devoted to indigent care? Is there a professionally expected level?

#### **II. MAINTENANCE OF THE CLINIC AS AN ORGANIZATION**

1. **Clearly defined boundaries: individuals or households who have rights to withdraw resource units from the CPR are clearly defined.**

Who is eligible for health benefits through the clinic?

Unemployed? Covered by Medicaid? No insurance? Undocumented persons?

Is there a needs-assessment performed during “intake”? If so, what are the minimum requirements that must be met? What is the income cut-off level?

How does a patient document that he/she is eligible for these benefits?

Are children treated, as well as adults?

How often is a patient allowed to come to the clinic?

Have these requirements changed over time? Were they the same when the clinic was founded?

**2. Congruence between appropriation and rules and local conditions.**

What verification methods have granting agencies required?

Is the board entirely made up of local individuals?

Are these rules tailored to the local population served?

Is there any government money, federal or state, that comes to the clinic? If so, what procedures must be followed to retain these grants?

**3. Collective-choice arrangements: individuals affected by rules participate in modifying them.**

When were by-laws first adopted?

How were they developed? Who authored them?

Who made the decision to hire the first executive director?

Who makes decisions about eligibility?

Who makes decisions about fund-raising activities? Who authors grant proposals?

Who makes decisions about services offered, expanded or cut back?

How are decisions made—board approval, executive director?

Are patients allowed or encouraged to volunteer at the clinic?

Do patients have any say in how the clinic is run? What hours it operates? Are they surveyed to find out most pressing health needs?

**4. Monitoring: consists of active auditing, accountability to appropriators.**

Does the Board of Directors receive an annual report? Who prepares it? When is it presented?

How do funding agencies (i.e. the United Way) verify that proper procedures are being followed?

Does the pharmacy have to account for all medications dispensed? Who does that?

How is effectiveness measured? By number of patients served? Funds raised? Volunteers recruited?

Who evaluates paid staff performance?

5. **Graduated sanctions for violators exist: appropriators are sanctioned, at increasingly severe levels.**

Do clients ever lose treatment privileges? Are there sanctions before that point?

What behavior would precipitate the loss of treatment privileges?

What happens when volunteers don't show up for their shift? M.D.'s, nurses?

Has the organization ever been sanctioned by a funding agency for non-compliance with grant requirements?

6. **Conflict-resolution mechanisms: rapid access to low-cost local arenas to resolve conflict.**

Who mediates conflict between patients and organization?

Between Executive Director and board?

Between organization and office volunteers?

Between organization and volunteer medical personnel?

Has the organization come into conflict with other clinics in the local community? If so, how is that resolved?

7. **Recognition of rights to organize: unimpeded by officials.**

Was the clinic's founding opposed by local officials?

Was the clinic's relocation to downtown Carlton opposed by local merchants?

Was the clinic ever used as a political stance?

8. **Nested enterprises: activities organized in multiple layers of nested enterprises.**

Is there cooperation between Valley Health and the other clinic in Carlton?

What is the bureaucratic relationship between the clinic and funding agencies, such as the United Way?

How do cutbacks in local giving, and subsequently United Way funding, affect the clinic?

Is there government money which comes into the clinic? Medicaid? Grants?

If there is, how does that affect the operation of the clinic? What is required? What changes as a result?

Is there any sharing of methods, of successes, of organizational structures among other clinics?

**Incentive structure questions: why do the medical volunteers continue to give time?**

Do any local clinics offer incentives for participation? Days off?

Is there a particular amount of community service that medical professionals are expected to perform?

Does the existence of the clinic reduce the burden of indigent care borne by private clinics and hospitals?

What group norms do the medical professionals identify most closely with? Medical norms? Community service? Religious values?

## APPENDIX B

### Informed Consent—Valley Health

I agree to participate in a study of the history and development of the Valley Health Clinic in Carlton. The study will involve interviews of about 25 to 30 men and women. I will be asked questions concerning the history of the clinic, how the clinic operates on a day-to-day basis and how various volunteer activities are coordinated. The questions will be asked in an interview that I can schedule where and when it is convenient for me. The interviews can take varying amounts of time from about fifteen minutes to about an hour. If there are any questions I would prefer not to answer, I can simply skip them. Additionally, the interviews will be audiotaped, but if I am uncomfortable with the audiotaping, I can ask that all or part of it be erased, and the researcher will erase the tape. The audiotapes will be kept for seven (7) years and then destroyed.

There is no compensation for the interview. At the end of the study, however, we will provide you with a full report of the findings of the study.

This research study has been reviewed and approved by the Institutional Review Board – Human Subjects in Research, Texas A&M University. For research related problems or questions regarding subjects' rights, the Institutional Review Board may be contacted through Dr. Michael W. Buckley, Director of Support Services, Office of the Vice-President for Research at (979) 458-4067.

I have read and understand the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study.

I have received a copy of this consent form.

I can choose to have my name associated with my comments and opinions or I can choose for all my comments to remain confidential. I have indicated my choice below:

I wish my responses to remain confidential (    )

I wish my name to be associated with my responses (    )

---

*Signature of Respondent (Subject)*

*Date*

---

**Signature of Principal Investigator**

**Date**

**Informed Consent (page 2 of 2)**

History and Development of the Valley Health Clinic, Carlton

I voluntarily agree to be audiotaped for the study being conducted by Ruth Schemmer. I understand the tapes will only be used for a research study of the Valley Health Clinic. Only Ruth Schemmer and Dr. Jane Sell's research team will have access to these tapes. My name will be used in these tapes. The tapes will be kept for seven years and then erased. They will be kept in room 305 of the Academic building.

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**Signature of Respondent**

**Date**

---

**Signature of Researcher**

**Date**

I do NOT agree to be audiotaped for the study being conducted by Ruth Schemmer. By refusing to be audiotaped, I understand that I may continue to participate in the study.

---

**Signature of Respondent**

**Date**

---

*Signature of Researcher*

*Date*

**VITA**

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