The Dissertation Committee for LaRae Dawn Tronstad
certifies that this is the approved version of the following dissertation:

Defining the Communicative Work, Roles, and Inclusion in Patient-Majority Boards

Committee:

Jeffrey W. Treem, Supervisor

Joshua B. Barbour

Jay M. Bernhardt

Michael Mackert

Defining the Communicative Work, Roles, and Inclusion in Patient-Majority Governance

by

LaRae Dawn Tronstad

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The Communicative Work, Roles, and Inclusion in Patient-Majority Governance

LaRae Dawn Tronstad, Ph. D.

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Supervisor: Jeffrey Treem

This study conducted a qualitative examination of how patient and non-patient board members and executive level employees influenced governance communication at four Federally Qualified Health Centers (FQHCs) in the southwest region of the United States. The analysis of 62.5 hours of observation of 41 board events, 42 interviews, and 1,411 pages of board meeting packets identified a significant influence of the patient difference on the communicative work of governance, board member roles, and the process of "getting better" at communicative approaches to inclusion. The first research question examined the communicative work of governance as significant in establishing the board culture and defining the boundary between governance and micromanagement of paid employees. The communicative work of governance in establishing boardroom culture established the values and assumptions in how board members interacted with each other. The communicative work of governance in defining the scope of governing operational activities established the board's relationship with the organization and the senior leadership team (SLT). The second research question examined the dynamics between board members in more depth by evaluating the communicative acts that shaped three

distinct, yet permeable, roles within the boardroom as the Patient, the Contributor, and the Perennial. These roles carried perceived and enacted expectations due to differences in perceived socioeconomic status, differences in who needed to learn what, and differences in their participation in governing activities. The third research question examined how each site of patient-majority engaged in the communicative strategies of inclusion in response to crises of exclusion that divided the board between patients and non-patient board members and to episodes of exclusion of particular board members. The events of exclusion developed further architectures of inclusion in the boardroom by implementing policies and communicative patterns that valued inclusion within the boardroom. These findings hold significant implications in exploring inclusion as a communicative dimension of diversity to understand *how* diversity, particularly socioeconomic diversity, in the boardroom impacts communication among board members and between the board and executive employees.

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Chapter 1

Communicative Organizing within FQHC Governance

The task of board governance dates back to the 1630's in the United States when the Massachusetts Bay Company charter established the first board of directors (Hall, 2003). Today boards permeate organizations throughout the United States in healthcare, education, publicly traded corporations, and nonprofit organizations. In nonprofit organizations, board members represent a specific collection of volunteers donating their time, resources, and experience to govern the organization without monetary compensation. Scholars of governance frequently rely upon existing definitions of governance defined as fulfilling a fiduciary responsibility by executing three duties: the duty of care (i.e., being informed and participate in decisions), the duty of loyalty (i.e., act on behalf of the organization rather than for personal gain), and the duty of obedience (i.e., ensure compliance and mission oriented decisions; Hopkins, 2003). Unfortunately, existing theories of governance lack an empirically driven foundation (Millar, Mannion, Freeman, & Davies, 2013). The lack of empirical evidence has led scholars to provide conflicting recommendations on the practice of governance as they do not understand the processes that take place within the boardroom (Brown & Guo, 2010; Millar et al., 2013) or the competing demands on how to oversee the use of finances to fulfill the mission (see Sanders, 2013). Scholars of governance continue to iterate that board members do not clearly understand the role of governance (Castor & Jiter, 2013) and experience ambiguity in their role (see Castor & Jitor, 2013; Eadie, 2001; Ryan, Chait, & Taylor; 2003). Eadie (2001) argued that as more and more boards provide oversight of the day-to-day of the

organization, the complexity of governance increases. However, studies have yet to examine the significant influence of operational oversight as a theoretically and empirically valuable component that shapes communicative governance in the nonprofit sector. This study addresses this gap by examining the contextually driven governance of an organization's day-to-day activities as a communicative event taking place within board meetings.

Day-to-day operational activities vary from organization to organization; therefore, this study narrows the focus into the governance of healthcare clinics, specifically the governance of Federally Qualified Health Centers (herein referred to as FQHCs). FQHCs represent a significant site of governance for several reasons. First, nonprofit boards do not engage in activities common to corporate governance. For example, nonprofit board members do not receive dividends from organizational profits. Thus, volunteer board members of nonprofit organizations (herein referred to as NPOs) exist outside the "tacit employment contract" of organizational communication scholarship that examines and values studies of paid rather than unpaid work (Clair, 1999). Second, Lewis (2005) argued that governance represents a distinctly communicative phenomenon particularly within the processes of governance and composition within the boardroom; however, limited empirical research exists on the communicative dimensions of organizing extant to governance (for exceptions see Castor & Jiter, 2013; Lewis, Hamel, & Richards, 2001). The gap in research represents a significant unknown and potentially misunderstood importance of the communicative dynamics of board governance. Third, the specific organizing of FQHC boards captures the dynamics of board composition – who does the

work of governance – as they are governed by a patient-majority board. FQHCs. A shift in board composition impacts not only the structure but also the roles of board members (see Paap, 1978; Wright & Martin, 2014) and the communicative acts of inclusion in the boardroom (see Wright, 2013a; Dovi, 2009). Therefore, FQHC governance provides a distinctive and useful context to examine the communicative dimensions of governance in nonprofit clinics serving underserved and marginalized communities executed by volunteers on a patient-majority board.

Federally Qualified Health Centers (FQHCs) in the United States started in 1965 when the Office of Economic Opportunity funded two community health centers in Boston, Massachusetts and Mound Bayou, Mississippi (National Association of Community Health Centers, n.d.). By 2002, the Health Centers Initiative increased access to primary healthcare services through access to additional funding. The increase in access to primary healthcare doubled the number of patients served by FQHCs from 5.8 million to 16 million between 2001 and 2007 (Quorum Health Resources, 2010). This growth continued into 2010 when the American Healthcare Reform Act funneled an additional 11 million dollars to funding FQHCs (Goebel, 2013; Quorum Health Resources, 2010). Today, 1,200 community health centers provide services at 9,200 locations throughout the United States (National Association for Community Health Centers, n. d.). A majority (87%) of the 22 million patients who receive healthcare at FQHCs report an income at or below 150-percent of the federal poverty limit[1] (National Association for Community Health Centers, 2014). The

[1] As defined by HealthCare.gov (2016), the federal poverty limit is "A measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits." In 2016, 150% of the federal poverty level (100%) for a

patient demographic corresponds to the mission of FQHCs to provide affordable healthcare to marginalized communities.

Since 1975, the Office of Economic Opportunity established a requirement that FQHCs operate with a patient-majority board in order to receive federal funding (Quorum Health Resources, 2010; Health Resources and Services Administration, 2014-01). Wright and his colleagues have recently spearheaded studies within the field of public health on the implications of socioeconomic diversity within patient-majority governance (Wright, 2013a; 2013b; 2013c; Wright & Martin, 2015; Wright & Ricketts, 2013). Representing an emerging focus on the quantifying and examining the patient side of governance, the studies expose a need to further examine the dynamics of diversity and voice of all organizational members within patient-majority governance. The patient-majority requirement addressed the "political dimension of poverty by giving the poor a mechanism for expressing their voice" (Martin & Wright, 2014, p. 930). However, the actual implementation and activities within patient-majority governance are not defined by policies of inclusion that enable the patient voice in on the board. In fact, there is a present gap in empirically evaluating how the interactions of patient board members, non-patient board members, and paid executive employees, shape the work of the board, the voice of the patient, and the voice of non-patients.

Organizational communication is aptly poised for identifying the existing communicative acts of organizing with the presence of patient and non-patient board

household size of four is a gross annual income of $36,450 (Health and Human Services Department, 2016).

members and paid executive employees – the central aim of this study. The growth of FQHCs throughout the United States (National Association for Community Health Centers, 2007) drives the need to understand the communication that makes a patient-majority board possible, particularly when individuals with different backgrounds and experiences sit on the board. Additional sites of governance that benefit from this examination include other organizations that utilize consumer governance, such as community banks (see Hartarska & Nadolnyak, 2012), legal aid boards who operate with a 33-percent consumer board (Personal Communication, Participants 4A and 9A), organizations that receive funding from the Federal Emergency Management Agency (see CHAMPS, 2015), and low-income housing projects (Lewis, 2012). Digging deeper into the dynamics of the patient-majority board, this study examines how the board includes individuals with distinct social positions into the fabric of the board through a communicative lens.

The following sections integrate existing scholarship from communication, sociology, public health, nonprofit, governance studies to examine the scope and existing gaps in defining the governance of operations, the roles within the board, and the influential dynamics of diverse board member composition. The review prioritizes peer-reviewed scholarship with empirically grounded findings in addition to independent studies (i.e., BoardSource, a nonprofit for nonprofit boards). Conceptual development of governance builds upon peer-reviewed publications as well as selectively included lay perspectives (e.g., board consultants with experience in working with 100 or more nonprofit boards; Eadie, 2001) as needed to identify the emerging or understudied dynamics of board

governance. This communicative examination into the organizing phenomena of nonprofit boards responds to existing calls for a communicative focus (see Lewis, 2005) to unpack the micro-processes of governance (see Millar et al., 2013). The interdisciplinary review identifies gaps in empirical investigations of governance from within the boardroom (see Leblanc & Schwartz, 2007; Millar et al., 2013; Veronesi, Kirkpatrick, & Altanlar, 2015), investigations of roles within the board (see Castor & Jiter, 2013; Wright & Martin, 2014), and implications of patient-majority board member composition (see Paap, 1978; Wright & Ricketts, 2013; Wright 2013a; 2013b; 2013c). Using techniques of grounded theory (Corbin & Strauss, 2008; Glaser & Strauss, 1967), the study addresses the gaps by examining qualitative data collected from four sites of FQHC governance in the southwest region of the United States.

THE COMMUNICATIVE WORK OF GOVERNANCE

Traditions of governance stipulate that board members ought to fulfill the duties of governance, previously discussed as the duty of care, loyalty, and obedience (Hopkins, 2003). The practice of governance engages a substantial range of tasks for the board. Brown and Guo (2010) identified thirteen tasks of nonprofit boards from the perspective of CEOs: Fund development, strategy and planning, financial oversight, public relations, board member vitality, policy oversight, relationship to executive, provide guidance and expertise, facilitate granting, generate respect, be a "working board," board membership, and become knowledgeable about the organization. The alignment of the perceived tasks of governance with governance theories demonstrates an alignment with ideas that identify what governance *should be* from the perspective of CEOs rather than what exists. For

example, some boards may be highly involved in non-governance activities and engage in activities of common to a "working board." A "working board" typically exists in NPOs with "few staff members and the board by necessity must engage in some management activities" (Brown & Guo, 2010, p. 544). The practice of a "working board" may also represent a cyclical phase in organizing as the board fluctuates between governance and management activities as needed to meet the needs of their organization (see Burns, 2010; Huse & Zattoni, 2008; Wood, 1992). On the other hand, a "governing board" refers to a board removed from management activities as staff subsume the responsibilities. The only common thread between a "working board" and a "governing board" in the nonprofit sector is the involvement of board members in fundraising (see Masaoka, 2009). From this perspective, defining what governance means presents a variety of challenges within the nonprofit sector contingent on the size of the organization (Brown & Guo, 2010; Burns, 2010) that shapes the boards' involvement in daily operations versus operational oversight. These tasks or responsibilities of governance provide valuable insight into what a board may do or ought to do but does not address how the board defines the scope of their work in operational tasks or how the board achieves these tasks of governance within the boardroom.

This study focuses on the work achieved by the board through communicative interaction in the boardroom, and thus emphasizes this particular focus as the *communicative work of governance*. The communicative work of governance examines the interaction within the boardroom to identify how the board achieves and defines the oversight of operations, specifically the operations of FQHCs. The communicative work

of governance is both a perceived and achieved phenomenon identifiable from the perspective of organizational actants who observe and participate in the boardroom and from the perspective of the researcher who observes the communicative interaction. Despite the tradition of governance dating back to the 1630s, only a handful of governance studies examined what actually takes place in the boardroom through observations (for exceptions see Leblanc & Schwartz, 2007; Pye, 2004; Samra-Fredericks, 2000). Qualitative examinations of the organizing phenomenon of governance rely upon self-report interviews (Harrison & Murray, 2012; Brown, 2002), analysis of organizational texts (e.g., meeting minutes) (see Fear, 2012; Schwartz-Ziv & Weisbach, 2013), or a combination of these methods. The challenge of interviews that target board chairs (Harrison & Murray, 2012) or CEOs (Brown & Guo, 2010) is that the studies frequently rely upon only one or perhaps two participants per organization to speak on behalf of all organizational members (see Wright & Martin, 2014), hence capturing a singular perspective of what governance should be and is for the board. In this study, the communicative work of governance is a collectively achieved phenomenon of the whole board, thus requiring the perspectives and contributions of multiple organizational actants to examine the communicative interactions in the boardroom that define and shape the communicative work of governance.

The grounded development of the communicative work of governance in empirical data represents a distinct and rare response to Lewis' (2005) call to examine the communicative phenomenon of governance within nonprofit organizations. Since the call to examine governance of NPOs from an organizational communication perspective, few

studies incorporated a handful of board member participants along with staff and volunteers at nonprofits to examine organizational identity (Mynster & Edwards, 2014), interorganizational collaboration (Milam & Heath, 2014), and organizational discourse (McNamee, 2011; Molloy & Heath, 2014), and the examination of the mission-profit tension in nonprofit studies (Sanders, 2013). Studies that sampled only board members examined participants as key stakeholders who receive information at times of organizational change (Lewis, Hamel, & Richardson, 2001) and the socialization of board members into their role (Castor & Jiter, 2013). Collectively, these findings suggest that board members may lack proper training (Castor & Jiter, 2013), are key recipients of information (Lewis, Hamel, & Richardson, 2001), and represent key decision makers in the organization (Sanders, 2013). However, governance as a distinctly communicative phenomena achieved in and by communicative interaction has yet to be examined within the communication discipline. Without clearly understanding the way in which the board defines and executes the task of overseeing an organization, we remain disconnected from the significant value of governance as the organizing phenomenon within the boardroom. This study tackles this existing gap by defining the work of governance within the context of a patient-majority board taking place in organizational meetings.

The Site of Governance

Meetings in organizations represent "focal points for the strategic activities members" (Jarzabkowski & Seidl, 2008, p. 1393). The micro-analysis of taking turns, the length of individual turns, the creation and preparation of agendas and minutes reflect the structuring process of communication within meetings as a site for organizing to take place

(see Boden, 1994). A quantitative content analysis of conversations conducted by Lehmann-Willenbrock, Allen and Kauffeld (2013) identified that teams who engage in equally distributed procedural behaviors (e.g., managing meeting time, delegating tasks, summarizing acts) expressed higher levels of satisfaction with their meetings. In other words, a group of individuals who equally engage in discussions of what and when people should complete tasks discussed in the meeting reported higher satisfaction. Barbour and Gill (2014) also identified that the communicative behaviors, or techniques of structuring status meetings, reflected the situated ideals of how to conduct meetings in highly regulated organizational settings. These studies frequently seek to identify the communicative interactions that are used by paid staff to effectively solve organizational problems as a team within an organization. Many empirical studies target identifying and improving interaction and satisfaction with board meetings (see Myrsiades, 2000; Nicholson & Kiel, 2004; Parker, 2007) and examining the use of multitasking via information communication technologies during meetings (see Stephens & Davis, 2009; Stephens, 2012). These studies identify communicative patterns that improve the effectiveness of or satisfaction with meetings and the presence of technology without examining how a set of organizational actants gather together as a complete organization – not a team, not a group, not a work-group, but a distinct organization within the boardroom. As this study seeks to examine meetings as the pivotal site of organizing for volunteer board members rather than improve the effectiveness of or satisfaction with meetings, the emphasis on board meetings examines the organizing and organizational communication of board members enacted to

engage in the communicative work of governance –what and how to communicate in a manner of governance.

Meetings represent a significant communicative phenomena in organizations. Yates and Orlikowski (1992) categorize meetings as a genre, where a genre represents "typified communicative actions characterized by similar substance and form and taken in response to recurrent situations" (p. 299), which holds true within board meetings examined in this study. Board meetings and committee meetings (e.g., *ad hoc* and standing committees) take place at a particular time and location (i.e., the *form*). FQHC boards must meet at least once a month according to federal requirements (i.e., the *recurrent organizational situation*). During these meetings, board members carry out their fiduciary responsibilities, such as listening to reports, asking questions, brainstorming solutions as needed, and voting on specific organizational matters (i.e., the *substance*). Even if board members frequently dislike meetings (Renz, 2010), meetings are the "lynchpin" of governance (Nicholson & Kiel, 2004).

The substance of meaningful work in governance requires engaging in important organizational issues where the board involvement is perceived as essential in reaching a solution (see Chait, Holland, & Taylor, 1996). However, as developed previously, a governing board does not actively engage in the work of implementing solutions like a "working board" (see Brown & Guo, 2010; Masaoka, 2009). The different levels of involvement of a board in resolving organizational issues introduces a dynamic in defining the meaning of governance as boards shift from being the executor of a solution to an overseer of activity – a dynamic examined by this study.

Board meetings have been examined from within the disciplines of nonprofit studies or governance using qualitative methods, such as interviews (Harrison & Murray, 2012; Brown, 2002), observation (Leblanc & Schwartz, 2007; Samra-Fredericks, 2000), documentary analysis (e.g., meeting minutes) (see Fear, 2012; Schwartz-Ziv & Weisbach, 2013), or a combination of these. These sources of data provide key insights to particular elements of governance. For example, the examination of meeting minutes revealed competing discourses as nurses and doctors vied for defining the mission of a Welsh healthcare organization (Fear, 2012) or the level of (dis)agreement and discussion among members of government controlled Israeli businesses (Schwartz-Ziv & Weisbach, 2013). However, an examination of meeting minutes only examines a distilled and edited version of the actual communication taking place in the meetings and do not account for the specific experiences or enactments taking place in the boardroom. Studies utilizing interview data frequently examined the perceptions and experiences of board members on board chair leadership (Harrison & Murray, 2012), role ambiguity (Wright & Millesen, 2008), and organizational change (Lewis, Hamel, & Richardson, 2001). Scholars focusing on interview and publicly available data (e.g., meeting minutes) claim that issues of confidentiality surrounding board decisions impedes access to observational data (Leblanc & Schwartz, 2007). However, a handful of studies successfully challenge these barriers to access (Chait, Holland, & Taylor, 1996; Leblanc & Schwartz, 2007) as many more scholars contend for the need for empirical data of the micro-processes enacted during meetings (see Leblanc & Schwartz, 2007; Millar et al., 2013; Veronesi, Kirkpatrick, & Altanlar, 2015; Wright, 2013b). This remains particularly true for patient-majority governance of

FQHCs that has only been recently examined via interviews (Wright & Martin, 2014; Wright & Ricketts, 2013) or from data available through the Unified Data System (see Wright, 2013a; 2013b; 2013c). Building an evidence-based framework defining the communicative work of governance, specific to patient-majority boards, this study responds to a particular need in governance studies to understand the actual interactions extant to defining governance. Termed as the communicative work of governance, this study sets itself apart from existing scholarship that delineates the legal tasks associated with a board's fiduciary responsibility. Instead, the communicative work of governance examines how the board collectively defines oversight of an FQHC.

RQ1: What characterizes the communicative work of governance?

Moving into a more detailed examination of the work of governance taking place within the boardroom, the study also addresses how the board distinguishes the individual work of board members associated with different roles in the boardroom. The identification of roles within the boardroom provides a map to clarify the ambiguity of board member roles identified in nonprofit boards (Castor & Jiter, 2003: Ryan, Chait, & Taylor, 2003) and patient-majority boards (Paap, 1978) by examining not only the role of the board in achieving the work of governance but also the role of organizational actants.

COMMUNICATIVELY ENACTED ROLES

Studies of organizing and organizations may use the term "role" in two different ways. First, "role" is used as a synonym representing an organizational position or a level of involvement in a study (e.g., the "role" of the researcher; e.g., Lindolf & Taylor, 2011). Second, studies target the examination of "role" as a theoretical construct to explain the

positioning of individuals within society (see Allman, 2002) or organizations (see Boden, 1994). This study takes the latter approach using "role" as a theoretically and empirically driven structure of organizations used to understand the expectations placed upon individuals within organizational settings (Paap, 1978). These expectations shape and influence social interaction (Boden, 1994) since "the first condition of having to deal with somebody at all is to know with *whom* one has to deal" (Berger, Cohen, & Zelditch, 1972, p. 241, italics in original). Organizational roles reflect the "official demands of the organization" (Biddle, 1986, p. 73), or an individual's specific position within the organization. This section integrates work from the disciplines of sociology and organization studies to address the contextually driven challenges and inherent assumptions within patient-majority governance.

Role theory (Biddle, 1986) holds a substantive interest within many disciplines such as sociology and organizational communication in examining the impact of individual demographic characteristics, namely gender, on social interaction. The assumption of role theory identifies that "persons are members of *social positions* and hold *expectations* for their own behaviors and those of other persons" (Biddle, 1986, p. 67; italics in original). *Social positions* exist as visible (e.g., age, race, gender) or invisible characteristics (e.g., education or organizational tenure; see Pelled, Ledford, & Mohrman, 1999). Individuals use these characteristics to hierarchically position each other in ways that can prevent access to positions with greater authority (Moore, 1968; Webster & Driskell, 1978). Recent studies support these conclusions identifying that leadership positions are not as accessible to women (see Boulouta, 2013; Chizema, Kamuriwo, & Shinozawa, 2015) and individuals

with a lower income (see Wright, 2013a). With these social positions, individuals hold themselves and others accountable to the cultural, organizational, or even individual role *expectations* that set forth "coherent sets of behaviors" (Forsyth, 2009, p. 149). These behaviors manifested and identified within social interaction may or may not align with stereotypical notions associated with status characteristics; however, relevant status characteristics (i.e., gender and socioeconomic status) associated with roles will manifest within social interaction (Boden, 1994). For example, Wright and Martin (2014) described how board members perceived a low SES as influential in determining a lower level of experience relevant to the work of the board. However, Wright and Martin (2014) did not identify how SES manifested within communicative interaction in the boardroom as relevant to the patient board member, and is thus further examined within this study.

Governance studies examining the position of board members have considered roles from a variety of perspectives. These perspectives include the role of the board in relation to the organization (see Brown & Guo, 2010), the role of board leaders (e.g., board chair; see Harrison & Murray, 2012), and the role of diversity (e.g., gender, SES, race) on influencing organizational outcomes (see Wright, 2013a; 2013b; 2013c). The contributions from these studies identify the important function of the board as a whole (i.e., governance), the importance of leadership within the board, and the positive outcomes that support diversity in board member demographics (i.e., race, gender, age, and SES), respectively. However, one's role in an organization is "an achieved phenomenon" and not explicitly defined by the "organizational hierarchy" (Boden, 1994, p. 101) or demographics. Instead, roles are "produced, shaped, and sustained in communicative

behaviors" (Lehmann-Willenbrock, Beck, & Kauffeld, 2016, p. 37). Studies that assume board responsibilities are (or should be) fulfilled equally and equitably (see Brown & Guo, 2010) do not account for the communicative and individual dynamics taking place within the boardroom. Defining roles within the boardroom addresses the fundamental component of *how* board members construct distinct expectations that shape the communicative interaction within the boardroom.

Empirical studies that examine roles as an individually achieved phenomena within the boardroom consistently point to the ambiguity of roles within the boardroom. Ryan, Chait, and Taylor (2003) noted that governance in the nonprofit sector has been plagued with role ambiguity as board members feel like their roles are meaningless, episodic, and institutional. As mentioned previously, meaningful involvement for board members takes place when the board is presented with organizational issues that require their involvement to resolve (Chait, Holland, & Taylor, 1996). Episodic roles reflect the nature of board work that takes place in bursts of time dispersed throughout a month at committee and board meetings. The institutional dynamics of roles also reflect enacting a role that *ought* to take place. A board member may also be expected to contribute their personal expertise to the board, a factor that may shape and define expectations of their role on the board despite the experience of role ambiguity (Castor & Jiter, 2013). The expectation to contribute personal expertise and engage in a meaningful role as a board member presents a distinct challenge given the composition extant to patient-majority FQHC boards.

Roles within the Patient-Majority Board

The international use of patients serving on the board of directors of community health centers perceives the participation as beneficial for both patients and the quality of services offered by the organization (see Crawford et al., 2002). Patients contribute a valuable voice in governance due to their connection with the community (Crampton et al., 2005) and the experience of receiving care (see Morrison, 1978; Segal & Silverman, 2002). Several studies identified a positive relationship between organizational outcomes and patients serving on the board, such as improved informed consent (Morrison, 1978), personal empowerment of patient board members (Segal & Silverman, 2002), quality of care and addressing patient complaints (Crampton et al., 2005). Unfortunately, Crawford's (2002) meta-analysis of empirical studies found that the link between positive healthcare outcomes and consumer governance is inconsistent at the international level. The inconsistent findings may be traced to two significant gaps in governance research. First, governance research lacks an empirically grounded understanding of what takes place in the boardroom (Leblanc & Schwartz, 2007; Millar et al., 2013; Veronesi, Kirkpatrick, & Altanlar, 2015), introducing a "black box" of unknown mediating factors that influence how the board achieves a positive impact on organizational outcomes. Second, quantitative studies linking patient governance to organizational outcomes assume that patients on the board participate equally in monitoring finances, making decisions on clinic services, setting policy, and developing strategic plans (NACHC, 2007). However, recent studies challenge this assumption as board members question whether patients possess the experience (e.g., law, business, finance) necessary to engage in these conversations equitably (see Wright & Martin, 2014). Studies may seek to address any negative outcomes

of patient governance by placing "continuous calls for 'training' … [that] may be counterproductive" (Paap, 1978, p. 581). Counterproductive training duly reflects the lack of empirical evidence of the micro-processes in the boardroom that contribute to governance, leaving scholars to make double-blind recommendations for improvement (see Millar et al., 2013).

Patient board members involved in governance hold a distinct social position due to their firsthand experience with the delivery of services. Empirical and theoretical work on governance assume that typical status of board membership that assumes the typical "not experience firsthand the life of an institution... [and] are regularly counselled to remain suitably aloof from the daily occurrences" (Chait, Holland, & Taylor, 1996, p. 97). For example, a board member may observe particular organizational activities (i.e., participate in a mock clinic event or tour a clinic) without benefiting directly from the services. Board members of a university are not students of the university. Board members of a cancer aide NPO do not receive health grants from the organization. Board members do not collect bags of food from their foodbank that they govern. However, the federal requirement for patient-majority governance places recipients of services as a key criteria of board composition, thereby creating a significant shift in traditional status associated with board members (HRSA PIN 2014).

With a patient-majority board of an organization predominantly serving low-income individuals, the PBMs challenge a second tradition of board membership. Traditionally, board members represent "conspicuously successful and often powerful and influential individuals, accustomed to leadership roles" (Chait, Holland, & Taylor, 1996,

p. 4). However, as previously noted, a majority (87%) of individuals served by FQHCs in the United States report an income at or below 150-percent of the federal poverty limit[2] (National Association for Community Health Centers, 2014). FQHCs may actively recruit PBMs from the 13-percent of individuals with higher incomes, an issue recently examined and critiqued by Wright and his colleagues. The low-income extant to "truly representative patients" on the board, or those with lower incomes, may hinder the ability of patients to subsume positions of leadership on the board (Wright, 2013a). However, "representative patients" in positions of leadership (e.g., board chair or position on the executive committee) may significantly and positively impact the operating budget of the FQHC (Wright, 2013b). Additionally, an organization with "non-representative patients" (i.e., patients with higher incomes) serving on the executive committee may lead to a slight increase in the amount of uncompensated care provided by the FQHC (1.9% increase per board member; Wright & Ricketts, 2013). These findings indicate that the status (i.e., income) of patient board members in society may impact their position within the organization of the board. However, these findings do not indicate a clear construction of how the socioeconomic status of a patient emerges within social interaction as a role with distinct norms and expectations.

Within three years of implementing the federal mandate for patient-governance of FQHCs, the role of the patient remains "inherently ambiguous" (Paap, 1978, p. 581). Only

[2] As defined by HealthCare.gov (2016), the federal poverty limit is "A measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits." In 2016, 150% of the federal poverty level (100%) for a household size of one four is a gross, annual income of $36,450 (Health and Human Services Department, 2016).

recently did Wright and Martin (2014) examine the role of patients more closely. Based upon 30 interviews with PBMs, Wright and Martin identified the perceived roles to *represent the patients, convey confidence in the organization, assess community needs,* and/or *serve as a secret shopper*. These findings present three gaps in the literature on patient roles in the board. First, the patient role was examined in isolation of the fiduciary responsibility of the board. In other words, the roles identified by Wright and Martin (2014) do not align with the concept of a board's fiduciary responsibility (Hopkins, 2003). The absence of fiduciary responsibility within the patient role of that study begs the question – who is left to subsume that role? – the second gap in the roles within the patient-majority board. Third, the findings only examine the patient board member role from the self-report data of PBMs who do not reflect the SES extant to the majority of FQHC patients. Reliant on self-report data, the findings present a unidimensional perspective of roles within the patient-majority board. Class, a visible characteristic (see Wright, 2013a), may be used by organizational members to create a hierarchical positioning of each other (see Moore, 1968; Webster & Driskell, 1978). Paap (1978) argued that patients serving on the board "need to start from the same structural base as professionals" (p. 581). For example, the patient board member should be able to realize some career benefit from their involvement and enter with some existing power base that equalizes the difference between patient and non-patient individuals. Unfortunately, an equal structural base may prevent access to board membership and reify existing hierarchies that limit participation and representation. This study responds to the concerns of reifying a hierarchical structure base and of focusing

purely on patient board members to examine the roles of patient and non-patient board members identified within social interaction.

Examining the other 49-percent of the board represents a significant component of the understanding the "system of roles" (Katz & Kahn, 1978, p. 78) within the board. Empirically targeting the ambiguity and inherent challenges to the role of the patient in consumer governance fail to address how patient and non-patient board members function together to establish the set of expectations and set of social positions within the boardroom. Non-patient board members may or may not experience the challenges and expectations of board membership. For example, Chait, Holland, and Taylor (1996) identified that the typical board members do not "acclimate easily to the role of one among many constitutionally equal members of an entity that acts collectively" (Chait, Holland, & Taylor, 1996, p. 4). Given the conditions of a typical board member (see Chait, Holland, & Taylor, 1996), non-patient board members may struggle with identifying their role within a board of equal members. The board member is defined by the "*personal* contribution" to the board (Chait, Holland, & Taylor, 1996, p. 58) and may not clearly understand their role (Castor & Jitor, 2013). Thus, even though the role of the patient as a consumer "is inherently ambiguous" (Paap, 1978, p. 581), non-patient board members may experience a similar role ambiguity.

The evidence of role ambiguity for patient board members and non-patient board members drives the second focus of this study to examine roles within the FQHC boardroom. The limited qualitative studies examining the social interaction and micro-processes within the boardroom (see Leblanc & Schwartz, 2007; Millar et al., 2013) to

offer a "*holistic description*…of how members achieve, maintain, and change their status" (Lindlof & Taylor, 2011, p. 134; italics in original). Roles within an organization influence social interaction, and hence influence an individual's perceived and actual forms of communication. With the inherent contradictions extant to the board composition (i.e., who is on the board) of patient-majority governance, this study seeks to examine the roles within the boardroom.

RQ2: What are the roles of board members enacted within the boardroom?

The second research question examines how the communicative interaction of board members influences their role in governance and the contributions that they are able to make regardless of or as a result of their patient status at the FQHC. The development of both patient and non-patient roles establishes the final context for digging deeper into the ways that a board engaging diverse roles and individuals addresses communicative strategies to inclusion (and therefore exclusion) within the boardroom.

INCLUSION AND DIVERSITY IN GOVERNANCE

Studies of inclusion within the traditions of sociology and psychology examine how individuals with specific characteristics (e.g., age, gender, race/ethnicity, SES) may be excluded or marginalized by society because they "represent a particular kind of threat to social harmony" (Allan, 2012, p. 7). Societies and organizations "emphasize differences in social integration are structured by architectures of inclusion that govern and manage how marginal women and men inhabit social space" (p. 1). Phrased as a form of social integration, architectures of inclusion, such as wheel chair ramps or fences around prisons, manage how individuals may participate in society by restricting or enabling certain forms

of participation (Allman, 2013). Inclusion enables individuals to participate while exclusion inhibits their participation. The model of engaging patients in FQHC governance reflects "the standard of inclusion" extant to healthcare initiatives that "underscores the importance of involving the diverse members of the populations whose behavior the intervention claims to influence" (Guttman, 2011, p. 635). Discussed previously, patient-majority governance addressed the "political dimension of poverty by giving the poor a mechanism for expressing their voice" (Wright & Martin, 2014, p. 930). Recent inquiries and arguments critique whether or not patients have a voice in the board, particularly patients from a lower socioeconomic status (see Wright, 2013a; 2013b; 2013c; Wright & Martin, 2014). When the board (potentially) includes individuals of diverse backgrounds, the board becomes "susceptible to their influence [and] requires a tolerance for tension, conflict, error, and ambiguity" (Chait, Holland, & Taylor, 1996). This study seeks to examine how the communicative strategies of inclusion or exclusion surface within the boardroom.

Including consumers as organizational members represents a shift in existing trends of organizational communication scholarship. Bencherki and Snack (2016) contend that the traditions of organizational communication scholarship prioritize organizational members based upon their relationship to the organization instead of prioritizing the acts of communication that "partially" contribute to the organizing phenomenon (p. 279). Consumers represent a stakeholder in the organization (see Fulk, 2014; Hirschmann, 1970; 1980) and governance (see Paap, 1978; Wellens & Jegers, 2013). Previous empirical studies of clients receiving services at NPOs have minimized the engagement of clients as

active contributors to their respective organizations. For example, studies have noted how clients are silenced in favor of donor recognition within organizational newsletters (Gill & Wells, 2014) or represent individuals with emotions that need to be managed by employees and volunteers (see Eschenfelder, 2012). Specifically, in the context of health communication, the examination of patients in healthcare settings focuses on understanding and improving communication to achieve better health outcomes within contexts such as patient-provider interaction, patient satisfaction (Duggan & Thompson, 2011) and patient-centered communication (Roter & Hall, 2011). However, studies of clients and patients have yet to pursue the involvement of a patient or client as an organizational actant whose decisions influence the organization and healthcare for their community. This study represents a new approach to examining the involvement of clients in nonprofit organizing and patients in the healthcare organization by examining their inclusion and exclusion within the boardroom.

Studies examining the empirical and theoretical components of inclusion and diversity remain limited within the areas of organizational communication and governance studies. Within organizational communication, there remains "a lot of work left to do in charting the variety of means, methods, and channels used to practice inclusiveness" (Lewis, 2005). One of the existing trends organizational research focuses on why diversity matters by establishing links to positive organizational outcomes. These studies emphasize the business-case for diversity (Cox, 1991; Cox & Blake, 1991) or the value-in-diversity perspective (Herring, 2009) as diversity financially benefits organizations (see also Miller, 2015). Studies of board diversity align with this approach by establishing positive

correlations between the presence of diverse board members (e.g., females and racial minorities) to organizational outcomes (see Bernstein & Bilimoria, 2013; Erhardt, Werbel, & Shrader, 2003; Gazley, Chang, & Bingham, 2010; Harris, 2014). However, studies examining diverse identities in organizations found that diverse characteristics may not always manifest within communication. For example, Bourke et al. (2014) found that individuals may "cover" or conceal different identities, and Ybema and colleagues (2012) found that diversity "played down…to the extent of being undercommunicated" (p. 50). Thus, conceptualizations of diversity (e.g., race, ethnicity, age, and sex) in organizational communication remain underdeveloped (Sias, 2014). Restricted conceptualization of diversity as categorical demographics that may be undercommunicated in organizations, the impact of diverse individuals in organizational settings remains underdeveloped.

The push towards diversity in nonprofit boards (see BoardSource, 2015; Bradshaw & Fredette, 2012) accompanies recent efforts to theoretically and empirically examine inclusion in defining an inclusive organization and an inclusive board. Mor Barak (2000) defined organizational inclusion as

> the individual's sense of being a part of the organizational system in both the formal processes, such as access to information and decision making channels, and the informal processes, such as 'water cooler' and lunch meetings. (Mor Barak, 2000, p. 52)

Organizational inclusion focuses particularly on the how the differences between individuals in a workplace (both visible and invisible dimensions of diversity) correspond to the perceived access to information and influence in decision making (Mor Barak, 2000). Studies measuring inclusion quantified inclusion through looking at an employee's participation/invitation to meetings (Bortree & Waters, 2014) and work-group involvement

(Hwang & Hopkins, 2015; Mor Barak, Levin, Nissly, & Lane, 2006). Studies on organizational inclusion significantly correlated to a decrease in employee turnover in social work settings (Hwang & Hopkins, 2015) and an increase volunteer satisfaction (Bortree & Waters, 2014). Bradshaw and Fredette (2012) sought to theoretically develop inclusion further by distinguishing between high and low levels of social inclusion (i.e., informal inclusion see Mor Barak, 2000) and functional inclusion (i.e., formal inclusion see Mor Barak, 2000) in the boardroom. However, organizational inclusion in the boardroom of volunteer organizational actants has not been empirically examined.

Moving into the organizing activities of the boardroom, Brown (2002) defined *inclusive governance* as a board that engages in information seeking, developing awareness of key issues, and encouraging contributions from additional community stakeholders. Brown's emphasis on inclusive governance approaches "inclusion" as a concept of including consumer, client, and/or patient contributions into decisions made by the board. However, it does not combine the elements of organizational inclusion to look at the inclusion of diverse backgrounds, namely the patient-perspective, into the boardroom. Specifically, the contributions to patient-majority governance from Brown's (2002) study engaged limited involvement of participants – only one – with experience including consumers in the boardroom. Millar et al.'s (2013) call for empirically grounded conceptualizations of board interactions cautions us from relying upon data from a solitary interview within the context of consumer governance, a gap this study addresses. This study integrates the perspective of organizational inclusion (Mor Barak, 2000), inclusive governance (Brown, 2002), and architectures of inclusion (Allman, 2013) to capture the

communicative interaction surrounding how patient and non-patient board members organize to include or exclude diverse voices.

The emphasis on voice in organizational communication dates back to the work of Hirschman (1970), who defined voice as "any attempt at all to change, rather than escape from, an objectionable state of affairs" by engaging in individual or collective acts of communication (p. 30). Hirschman's definition of voice encounters several inherent challenges within the context of patient-majority governance. First, there is the issue of voice as used to "mobilize public opinion." This is because the governing body is frequently held to strict practices of confidentiality. Thus, within the confines of the board of directors, the 'public opinion' must be limited to the scope of the internal unit of the organization. Second, the board represents an authority in the organization, as they are the unit that hires, fires, and evaluates the executive director of the organization. Third, the existing definition frames voice as a reaction to a negative experience. The definition does not capture the work of a board that may not only be focusing on responding to organizational problems but also proactively engaging in strategy to expand and value the current work of the organization. Finally, there is an implicit assumption that a consumer expresses voice as an alternative to leaving the organization (or no longer receiving services at the organization). The mission of FQHCs is to serve a marginalized, underserved community, who are receive a 51-percent "representation" on the board (PIN 2014). The uninsured, underinsured, and low-income individuals receiving care at an FQHC may not have the ability to simply switch providers, switch clinics, or switch hospitals. As a result, the patient's loyalty to the clinic may not emerge from a "passively

but optimistically hope for improvements" (Gosset & Kilker, 2006, p. 65) typical to other organizational consumers of products and services. Rather, loyalty may be the *de facto* mode of available options for healthcare; the FQHC may be the only place to receive care for the uninsured and underinsured populations. Collectively, these challenges of applying Hirschman's (1970) definition of voice into the context of patient-majority governance is revised within this study as the engaged board requires individuals to express satisfaction and dissatisfaction with the organization.

Board members, regardless of their patient (consumer) status, should be actively engaged in monitoring the current and future state of the organization (see Paap, 1978). Non-patient board members may offer a valuable voice in the organization as they contribute their expertise in business/management, education, and healthcare (Wright, 2013b). Patient board members may also contribute a range of expertise as a consumer of healthcare discussed previously (see Wright & Martin, 2014). Contributions from board members (collectively) may involve the speculation of future problems, such as changes in the community, changes in HRSA policy regulations, and changes in services, scope of care, and financial stability of the organization. Voice does not particularly focus on dissatisfaction per se as it may also focus on improvement. Improvement may solve existing problems and create opportunities for future development. It is entirely possible that an organizational member is "satisfied" and still able to see areas of growth, improvement, and opportunities. Since voice is not merely about the representation of a singular consumer or non-consumer experience or merely expressing dissatisfaction, my definition requires a clear focus on the inclusion of diverse voices regardless of consumer

status and regardless of the state of satisfaction. This study defines voice in the boardroom as *a communicative act that seeks to approve or improve the current or future state of the organization as both a consumer and non-consumer.*

The limited attention to communication within the boardroom introduces a significant challenge in understanding how board members communicatively include or exclude each other. Chait, Holland, and Taylor's (1996) examination of boards of academic institutions makes a strong case for inclusion of diverse individuals. "Inclusive boards find that the most helpful individual contributions sometimes come from trustees who are not experts on the subject at hand" (p. 66). Inclusion in the board requires more than attending a meeting, a symbolic communicative dimension of participating in a meeting. Board members perceive "disengagement of individual trustees to be disruptive" (Chait, Holland, & Taylor, 1996, p. 62). Chait, Holland, and Taylor do not explicitly define the scope of engagement; however, it is loosely represented as a symbolic representation of speaking within the boardroom, an expectation to have a voice within the board. However, the organization of boards do not always lend themselves to inclusive communicaiton.

Empirical studies of governance have alluded to – though not explicitly focused on – exclusive behaviors within the boardroom. Chait, Holland, and Taylor (1996) found that "board members without equal access to information may not feel or act like equal members of the group" (p. 64). For example, board members who represent key stakeholders may be selectively approached at times of organizational change (Lewis, Hamel, & Richards, 2001). Thus, board members may not be included (and thus excluded) in communication at times of change if access to information is restricted or limited.

Scholars have also identified that communicative strategies designed to enhance efficiency within board meetings, such as abbreviated discussions, reflect "less inclusive meetings" that may create frustration for board members (Dearing, Gaglio, & Rabin, 2011). Wright and his colleagues (Wright, 2013a; 2013b; 2013c; Wright & Martin, 2014) targeted the demographic variable of socioeconomic status of patients as a fundamental component of exclusion in FQHC governance. Low-income individuals may also not have previous experience serving on a board of directors, the ability to raise funds for the organization, or financial competency to oversee an organization (Wright, 2013a). When faced with these challenges, patients serving on the board of a FQHC may *not* be representative of the lower socio-economic status of patients served by the organization (see Wright, 2013a, 2013b), leading to question the nature of who and how consumers participate in governance of FQHCs. Collectively, the findings allude to exclusion without explicitly targeting communicative strategies that result in exclusion.

Simply sitting as a board member within the scope of consumer governance does not mean that all individuals make equal contributions or hold equal roles. Even though patients compose a majority of the board, Wright (2013b) suggested that non-patients may need to be excluded from governance to enable the voice of patients to be heard (see also Dovi, 2009). Including the voice of marginalized individuals represents a contested area within the discipline as communication. Scholars articulate the agency of marginalized individuals as the distinction of speaking for oneself, or having someone else speak for you (Alcoff, 1991; Gill & Wells, 2014). Empowering the voice may also lie just outside of organizational communication (Taylor et al., 2001), but current and past communicative

organizing dynamics that include and exclude individuals remains a fundamental component to understanding diversity within the organization.

This study seeks to address this gap by examining the dynamics of exclusion and inclusion of diverse voices within the board organization. The focus on communicative strategies of inclusion and exclusion emphasize that there is more to inclusion than identifying demographics of organizational members, and examines how the voice of board members is included regardless of or due to their patient status. Informed by the previous research questions that examine the work of the board and the role of board members *within* the boardroom, this question empirically examines the nature of voice in a patient-majority board.

RQ3: What are the communicative strategies within the boardroom that include and/or exclude board members?

CHAPTER SUMMARY

In summary, this study examines governance as a communicative phenomenon via using three different approaches. Defining the communicative work of governance (RQ1), establishes the function of communication in bounding what it means for the board to oversee operations of the clinic. The second research question builds upon the role of the board (collectively) in governance to identify the roles enacted within the boardroom (RQ2). Finally, these roles function as a springboard to define how interaction within the boardroom may help or hinder inclusion of patient and non-patient board members in the boardroom (RQ3). The focus on communicative interaction that reflects the work of governance, the roles within the boardroom, and the inclusion (exclusion) of board members is addressed using a qualitative method of inquiry developed in the next chapter.

Chapter 2

Method

I implemented theoretically-driven, qualitative methods of data collection to examine the communicative interactions at four sites of patient-majority governance in the southwest region of the United States. Each site defined their level of participation in the study, resulting in a blend of ethnographic data (i.e., observation, interviews, and social artifacts; see Lindlof & Taylor, 2011) and interview-only data from individuals serving on the board of a FQHC. Qualitative data collected from the four sites between January 2016 and January 2017 resulted in the following set of data: 62.5 hours of participant observation at 41 board events (442 pages of single-spaced, 12-point font data), 42 interviews (M = 49 minutes; Range = 23 to 120 minutes), and 1411 pages of social artifacts (e.g., packets of information distributed at meetings, and recommended reading from participants). Data analysis followed the practices of grounded theory (see Corbin & Strauss, 2008; Glaser & Strauss, 1967) as the study examined the communicative dimensions of the work, the roles, and inclusion extant to governance not previously developed within the communication discipline. Corbin and Strauss (2008) contend that grounded theory is a useful approach when examining new areas and contexts. By using theoretical sampling and constant comparative techniques of data analysis (Corbin & Strauss, 2008; Glaser & Strauss, 1967), my study develops empirically grounded understandings of governance and the boardroom explicitly requested by scholars of governance (see Millar et al., 2013).

In this chapter, I develop an audit trail (Lincoln & Guba, 1985) of the methods used to sample, collect, and analyze data. Sampling techniques blended the practices of

grounded theory (Glaser & Strauss, 1967) and ergonagraphy (i.e., the ethnographic study of organizations, Czarniawska, 1998) at multiple sites of patient-majority governance. The use of qualitative observation responds to challenges associated with qualitative studies of governance (see Leblanc & Schwartz, 2007; Pugliese, Nicholson, & Bezemer, 2015). The type of data collected at each of the four sites varied due the level of access granted to the boardroom, specifically whether the organization consented to full ethnographic data or interview-only data. This data was then analyzed using analytical techniques associated with grounded theory, such as open coding, axial coding, and integration (Glaser & Strauss, 1967; Corbin & Strauss, 2008).

THEORETICAL SAMPLING METHOD

The sampling method used within this study followed the practices of theoretical sampling originally defined as "the process of data collection for generating theory whereby the analyst jointly collects, codes and, and [analyzes] data" (Glaser & Strauss, 1967, p. 45). Whether sampling from within an existing data set (e.g., historical or secondary data) or sampling primary data, each step of data collection is evaluated to determine how best to develop the core concepts within the study (see Corbin & Strauss, 2008). Hood (2007) argued that the iterative nature of theoretical sampling is driven by the need to develop key *concepts* instead of demographics, which is a significant guiding principle in a study that targets how the diversity of a patient-majority board influences and impacts the communicative interactions extant to governance.

Using a model of theoretical sampling demonstrated by Corbin and Strauss (2008), I simultaneously incorporated knowledge from existing literature (both scholarly and

popular press) with data collection to identify both participants and additional sources of data (i.e., news articles, staff, and sites). Informed by existing scholarship on governance (such as Frumkin, 2002; Harrison & Murray, 2012; Millar et al., 2013) and FQHC boards (see Wright 2013a; 2013b; 2013c; Wright & Martin, 2015), sampling criteria targeted formal FQHCs rather than FQHC "look-a-likes" as FQHC "look-a-likes" have not met all the requirements stipulated by the Health Resources and Services Administration (herein referred to as HRSA). Specifically, a patient-majority board accounts for one of the requirements that must be in place for two years prior to the application for FQHC status (6A, SLT). Sampling in this study also initially targeted FQHCs in urban areas as Wright and Martin (2015) identified significant differences in patient-majority governance between urban and rural areas, a criteria later expanded to seek out negative cases and data saturation necessary for validity and reliability of qualitative studies (see Corbin & Strauss, 2008; Lincoln & Guba, 1985; Tracy, 2010). Theoretically driven to study inclusion/exclusion of board members, the sampling criteria focused on including all board members rather than interviewing the board chair and CEO, a common practice in studies of governance (for example see Harrison & Murray, 2011; Wright & Martin, 2015). Thus, recruitment of both sites and individuals in this study focused on the type of organization (i.e., FQHCs rather than FQHC "look-a-likes") and the presence of the individual in the boardroom. Participants were not recruited based upon pre-existing criteria to meet particular representations of age, gender, race, or socioeconomic status.

A standard practice in theoretical sampling techniques (see Corbin & Strauss, 2008; Hood 2007), my initial set of sampling criteria shifted over the course of data collection to

continue developing the core concepts of the communicative work of governance, the communicative roles, and inclusion/exclusion. First, I noted during the initial months of observation that staff, specifically the senior leadership team (herein referred to as SLT) made significant communicative contributions to meetings by delivering reports, asking and answering questions, and engaging with pre- and post-meeting conversations with board members. Regardless of their non-voting status, the SLT communicative involvement in meetings shaped the overall flow and dynamic of communication. This direct observation of conversations at meetings led to a revision of the sampling techniques to expand the sample set to include SLT members in data collection.

Second, sampling efforts focused on the nature of patient leadership within the board, specifically seeking out instances where the board chair was also a patient board member. The reason for this particular focus emerged as one of the organizations experienced an issue with donors expressing anxiety over a patient seeking the board chair position. Patient status of board members is not always made publicly available, and boards were not pre-screened prior to participation. Therefore, the continuous recruitment of patient-majority governance in addition to conditions of happenstance resulted in a data set that incorporated three boards where patients served as the board chair.

Access

Recruitment of organizations in this study experienced two significant barriers to accessing patient-majority governance – confidentiality and time to acquire access. Common to many studies of governance (Leblanc & Schwartz, 2007), the organizations expressed concern for confidentiality. Due to the organization's concern for

confidentiality, Leblanc and Schwartz (2007) note that studies frequently forgo observation of board meetings, without even attempting to gain access to observational data. A handful of scholars circumnavigated this challenge by being a board member (Currall, Hammer, Baggett, & Doniger, 1999; Huse & Zattoni, 2008; Samra-Fredericks, 2000). As this site engaged in observation of multiple boards, this was not a feasible strategy for this study. Instead, each organization in this study defined their level of participation and hence my access to the board. Two FQHCs granted almost complete access to ethnographic methods of data collection and two granted access to interviews with board members. One of the four sites also requested that I sign a non-disclosure agreement to maintain the confidentiality of board conversations.

The second challenge, particularly for studies engaging in participant observation, is the researcher's concern for balancing time and quality data collection. The challenge with time engages two dimensions – the time necessary to gain access and the time needed to collect data. The time to gain access to the board is an extended process when requesting full consent of the board. As with this study, the request first goes to a committee who then determines if it should go before the board. In the study of corporate governance, Leblanc and Schwartz (2007) specifically noted that they required twelve to eighteen months to obtain access to the boardrooms. In this study, the process of gaining access took up to three months per site. This shortened timeframe may be due to the requirement for FQHC boards to meet once a month, a requirement that is not necessarily imposed all forms of governance. The second dimension of time considers the amount of time necessary to collect data on governance. Samra-Fredericks (2000) study on governance collected data

for five years while Samra-Fredericks served on the board. However, I followed the guiding principle of ergonagraphy (Czarniawska, 1998). Czarniawska (1998) states that the repetitive nature of interactions in organizations enables researchers to target specific events within the organization ("action networks"), thereby condensing the amount of time necessary to obtain the level of data saturation. The "action networks" in this study consisted of committee meetings, full board meetings, and a fundraising event, spending six-months with each board that granted full access to ethnographic methods of data collection.

My study received approval from the university's Institutional Review Board (2015-08-0045) as an exempt study, granting waivers of signed consent. In preparation for a delayed timeline of recruitment and access to the boardroom, site letters were submitted individually as each organization consented to full ethnographic data collection. The site letters followed the university's template to identify the conditions of anonymity and confidentiality for the organization and participants, the focus of the study, perceived benefits, and procedures for collecting qualitative data.

FQHC Recruitment

As the primary researcher, data collection for my study started with a clear understanding of the patient-majority board requirement of FQHCs and a working knowledge of only one FQHC. Therefore, from October 2015 through October 2016, networking, 'cold emails,' and participant referrals were the primary strategies used to recruit organizations. Existing networks of colleagues and professors facilitated initial points of contact to four FQHCs - of which three agreed to participate in the study. Online

lists of FQHCs made available through national and state associations for community health centers, provided extensive lists of FQHCs in the United States to target 'cold' recruitment emails of sites that exhibited the most geographic similarities to the first site (FQHC-A). Cold recruitment of FQHCs relied heavily upon email as the listed phone numbers frequently connected directly to a patient line for scheduling appointments rather than executive or administrative offices. Six FQHCs received the invitation to participate via a 'cold' email to the executive director. Only one of these agreed to participate after a follow-up via a networking connection. Lastly, even though participants frequently expressed very little to no knowledge of other FQHCs outside their city, three participants provided information regarding geographically different FQHCs, resulting in the recruitment of the final site (FQHC-D) in this study.

Of the eleven organizations invited to participate, seven declined to participate and four consented to varying levels of access to the board. For those that declined to participate in the study, they cited the following reasons: "the length of time needed for this project would interfere with the board's work," "the [CEO] will not be able to meet with you," "we are going through a major restructuring at this moment…and the board has a lot on its plate right now," "a very busy period of transition [due to the departure of the CEO]," "now was not the time to incorporate a student into board and committee meetings due to the sensitivity of matters currently under discussion," and two declined to respond. Based upon the immediate response of the CEO, I believe that five of the invitations to participate never made it past the CEO to the board. In the following paragraphs, I detail the specific recruitment timeline and efforts undertaken for the four sites participating in this study.

FQHC-A

I recruited FQHC-A by contacting a current board member via email regarding my study. This individual then connected me with the executive director and board chair at the organization. They requested a one-page letter detailing the project's objectives, procedures, and benefits. The letter moved through the governance committee and then on to the full board for a vote. I attended the board meeting and shared information about the study. After a brief question about anonymity, I left the room and the board voted to ***not*** participate due to concerns about the confidentiality of board information. Fortunately, the board member who connected me with the organization re-approached the board to speak on my behalf and alleviate their concerns at the following board meeting. Through the advocacy efforts of this board member, FQHC-A consented to let me observe meetings (excluding the finance committee) and interview board members and the senior leadership team. The recruitment timeline for FQHC-A went from September 29, 2015 (initial contact with the board member) to December 15, 2015. Data collection commenced January 19, 2016, just over three months after the initial point of contact. Observation of board events ended on June 28, 2016, and the last interview was completed on October 18, 2016.

FQHC-B

A colleague connected me to an individual on the SLT at this organization, who requested a similar one-page summary of the research project. I revised the existing one-page summary to explicitly emphasize the nature of anonymity and confidentiality. Senior leadership forwarded the letter to the CEO and the manager of educational research at the FQHC. After a brief meeting with these two individuals, the CEO consented to share the

information with the board chair. Although he was open to the study, he clarified that he would not 'push' for the board to participate as he did not want to create any unnecessary tension on the board or negatively impact an upcoming performance review. The board chair moved the study through to the executive committee that voted to send the matter to the full board on Monday, May 23, 2016. I offered to prepare a mini-presentation to deliver to the board, but the staff member declined and developed their own presentation for the board. I attended the portion of the meeting where the board members received the report, taking note of a particular lack of key information regarding anonymity, research questions, and potential benefits of the study. Thankfully, these details were contained in the one-page summary distributed to all board members prior to the presentation. The board members did not ask questions after the presentation delivered by the staff member before I left the room for them to vote. After leaving the room, I waited for an email regarding the final decision of the board. After a week, I reached out to the CEO to follow up on the board's decision. The CEO informed me that they were still waiting on the last vote to arrive from an individual who was not present at the meeting. Once the vote was received, the CEO notified me that the board agreed to participate in the study. Data collection at the second organization also started three months after the initial point of contact on June 28, 2016 and ended January 16, 2017.

FQHC-C

The third site engaged the most conflicting recruitment process of all the sites in my study. Initial contact with the executive director via a 'cold call' email lingered without a response. However, by networking with faculty on my committee, I received a more

formal introduction and resent the letter. While waiting for a response from the executive director, a secondary 'cold-call' message was placed with the board chair through a professional social networking site. Within the same day, I received a decline to participate from the CEO *and* a positive consent to participate from the board chair. The CEO declined because the board meetings were closed to the public (as NPOs in this area were excluded from the requirements of an open meeting act, which is common in school boards and city councils). However, the board chair expressed interest and investment in the value of the study and offered to make an announcement to recruit interviewees at the next meeting. The board chair collected a list of individuals interested in participating in the interview and then gave me their contact information via email. Due to the voluntary nature of participation in my research study, the board participated in an interview-only study design. Data collection began within one week of contacting the board chair on September 21, 2016 and ended November 18, 2016.

FQHC-D

Participation of the fourth, and final, FQHC in my study emerged through the referral of a participant in the study. The initial point of contact with the referral's name led to an immediate exchange of emails. The executive director delivered the study information to the board who voted to approve participation in an interview-only study. Data collection commenced one and a half months after the initial point of contact with the CEO on December 30, 2016. The last interview was completed by January 22, 2017.

In summary, the recruitment process involved in getting the board 'on board' with the study required careful consideration of the process of governance and the relationship

of each CEO with their respective board. As expressed by several participants, most studies that take place within the clinic setting are evaluated and approved by the management team, not the board. Thus, this was the first time many participants in this study experienced the process of approving participation in a research study. Only individuals experienced with research design (e.g., healthcare administrators, clinicians, and individuals with a master's or doctoral degree) expressed familiarity with confidentiality and anonymity.

Participant Recruitment

Theoretically driven to explore the nature of communicative work, roles, and inclusion/exclusion in governance, my recruitment of interviewees sought inclusion of all the voices in the boardroom informed by the context extant to patient-majority boards. Corbin and Strauss (2008) define context as the "structural conditions that shape the nature of situations, circumstances or problems" (p. 87) that influence social interaction. Structural conditions of governance fall within two primary categories – those common to all boards and specific to FQHCs.

Generic structural conditions addressed in existing scholarship target leadership positions and models of governance. First, leadership from the board chair, also referred to as the president of the board, may address role ambiguity, offer support to organizational members, and serve as *the* spokesperson for the organization (see Harrison & Murray, 2012). Leadership from the CEO, the singular employee of the board, functions as a filter between the board of trustees and the staff of the organization (Wright, 2015). A CEO may serve as an *ex officio* board member, meaning they are counted as a board member in a name only and do not hold voting privileges (see Frumkin, 2002; HRSA 2014-01). Second,

models of governance influence the nature of participation in this study, as they offer prescriptions regarding not just what is governance and how to execute it, but specifically *who* should be present. Thought leadership in corporate governance advises that staff should not be present at board meetings (Carver, 1992), a perspective that has been critiqued in the nonprofit sector (Bradshaw, 2002; Renz, 2006). This study followed the call placed by Cornforth (2012) to include who was present in the boardroom, such as staff, as a group of individuals who "may contribute to carrying out governance functions" (p. 1129). Implementing techniques of theoretical sampling on inclusion within this context, within these boards, the criteria for inclusion was expanded to include staff. This was a significant but valuable shift within the data set as in FQHC-B, the staff in the room nearly outnumbered the board members. The inclusive study design highlights the influence of all individuals in constructing the communicative strategies to inclusion, and roles, responsibilities, and contributions to the board.

Specific to the FQHC-context, the *a priori* distinction between patient and non-patient board members within my study emerged specifically from the federal mandate that requires 51-percent of board members represent patients whom have received services within the past two-years (see Wright, 2013a; 2013b; 2013c). As clarified by a current CEO of an FQHC (Personal Communication, May 6, 2016), the patient status of board members is reported to and monitored by HRSA every year. Not only is this position defined and monitored at a federal level, it is also empirically significant in recent work of FQHC governance distinguishing between patient and non-patient status in areas of board experience (Wright & Martin, 2014), leadership (Wright, 2013b), finances (Wright,

2013a), and scope of services (see Morrison, 1978; Wright, 2012). Patient status is thus federally and theoretically important.

Theoretical Sampling Summary

Theoretical sampling (Corbin & Strauss, 2008) within this study shifted this preliminary emphasis into three theoretically driven groupings deemed relevant to the constructs in this study: (a) senior leadership team, (b) patient board members, and (c) community board members. This expansion of inclusion criteria deviates from existing scholarship on board governance (in all sectors) as studies of governance – with the exception of Samra-Fredericks (2000) – focus almost exclusively on the perspectives and participation of the executive director and board leadership (Harrison & Murray, 2012, Huse & Zattoni, 2008; O'Neal & Thomas, 1995). Based upon observational data, the senior leadership team play a substantial role in the overall communicative interaction within patient-majority consumer governance.

DATA COLLECTION

Data collection commenced on January 19, 2016 with the first observation (at FQHC-A) and finished on January 22, 2017 with the last interview (at FQHC-D). Depending upon the level of access granted by the site, data collection followed two different paths. Data collection at interview-only sites started as soon as consent was obtained. Data collection at sites granting full access to ethnographic data (participant observation, board packets, and interviews) focused on collecting observations first and interviews after two or three months of observation. This phased approach to collecting observations prior to interviews granted three key advantages: (a) providing time to

develop rapport with board members prior to interview recruitment, (b) offering the ability to collect *naïve* observations of meetings, and (c) enabling member checks of emerging observational findings during the interview. After two to three months of observing meetings, participants were recruited to participate in interviews. Data collection of interviews and participant observation continued for the duration of six months at each site. The rationale and process for collecting observations, interviews, and social artifacts is detailed in the following sections.

Observation

Responding to the calls to observe the interactions taking place within the boardroom (Cornforth, 2012; Millar et al., 2013; O'Neil & Thomas, 1995; Veronesi, Kirkpatrick, & Altanlar, 2015), my study engaged in observation of patient-majority governance by spending six months at FQHC-A and FQHC-B for a total of 62.5 hours of observation of 41 board events. Participant observation of board of directors is rare, frequently relying upon researchers whom are active participants as voting board members (Currall, et al., 1999; Huse & Zattoni, 2008; Samra-Fredericks, 2000) and rarely observing more than one board (for the exception see Leblanc & Schwartz, 2007). In order to maintain a level of objectivity sought by scholars of governance (and desired by participants in this study), this study followed the ethnographic practice of observing meetings as an organizational outsider (see Leblanc & Schwartz, 2007; Pugliese, Nicholson, & Bezemer, 2015). As an observer, I was physically present at meetings to take notes by sitting along the wall at full board meetings or sitting at the table during committee meetings (when there was space at the table).

While taking notes during the meeting, I sought to minimize my presence in the room by typing softly to decrease the volume of rapid clicking of the keyboard, and maintaining verbal silence. In this way, I maintained a higher level of investment in observing the meeting *in situ* rather than altering the shape of the meeting by asking questions. My silence at the meeting was noted by many participants who asked if I was getting the information I needed and some participants expressing concern that I was not getting my questions answered.

Focused on observing participants, there were instances when I "still interact[ed] with them casually, occasionally, and indirectly" (Lindlof & Taylor, 2011, p. 147) before or after a meeting. As an observer, I waited for participants to initiate conversation with me first. Many individuals introduced themselves to me, but few board members engaged in casual conversation with the researcher before or after meetings. However, after collecting interviews with participants, many individuals would engage in conversation with me regarding my studies as a student, healthy eating plans, and weight loss. A few individuals at FQHC-A greeted me with a hug – a greeting similar to how they greeted other persons in the room. At FQHC-B, individuals did not hug the researcher.

Board Events

Twelve months of observation distributed equally between FQHC-A and FQHC-B resulted in attending 41 board events: Board meetings, committee meetings, and one fundraising event. FQHC-A granted access to all events with the exception of executive sessions and the finance committee. FQHC-B granted access to all committee and full board meetings with the exception of executive sessions. Although the frequency of

committee meetings and the committee structure varied between the organizations, both organizations convened committees targeting the following areas: Governance (reviewing bylaws, nominating new members and board leadership positions), compliance/risk (HIPAA breaches, hostile work related incidents), quality of patient experience (environment of care, wait-times, patient satisfaction), and finance (review and approve monthly financial packets). The committee tasked with reviewing and evaluating the CEO (i.e., the executive committee) was not observed during the course of this study. FQHC-A maintained four committees that met regularly (either once a month or once every quarter). FQHC-B maintained five committees that met regularly.

Field Notes

The board meeting rooms were highly conducive to the use of a laptop to collect field notes during the meeting. Maintaining my position as an outsider, my notes consisted of transcribing as much of the real-time communication taking place during the meetings. When an individual speaker spoke faster than my keystroke speed, I inserted ellipses "…" to account for the lapse of information and continued transcribing the real-time flow of conversation following the ellipses. I started a new line to indicate new main points during long reports and a new line every time the speaker changed. When the speaker changed, I noted the speaker's name followed by a full colon and what was said by the individual. If the speaker's name was not known at the time of the meeting (particularly in the initial rounds of meetings), the speaker was labeled with a visible identifier (i.e Lady in Green – LGRN). When the change of speaker happened quickly or overlapped extensively among

individuals at the meeting, my transcript accounted for the names of the speakers in the order of their speaking turn.

Presentations (or reports) given by staff were typically longer in length containing substantial amounts of information. Several times during the presentations – particularly for the medically oriented presentations – the complexity of the information and the engaging nature of the presenter resulted in a pause in transcription as I listened to learn and process the new information. The content, though not verbatim, of these presentations remained available to me in another source of data, the board packets. Reports incorporating a slide deck were frequently used in FQHC-B but rarely used in FQHC-A. Slide decks were made available in the board packets, and field notes included general observations regarding the delivery style and effectiveness of visual aids that would be associated with feedback given to a student giving presentations. Even when pausing to process content within the reports, field notes remained consistent in accounting for any and all interjections of comments and questions from individuals in the room.

Observations of the use of technology focused predominantly on the moments where the use of communication technologies (projectors, laptops, tablets, and cellphones) was deemed *noticeable*. *Noticeable* observations of technology were captured in field notes when a participant or myself recognized the use of technology in the room. For example, certain individuals on the staff frequently engaged in multitasking during the delivery of a report, but this was not considered relevant to the observations unless the silence in the room was interrupted by the heavy clicking on the keyboard. Observations deemed *noticeable* were the occasional interruptions from virtual assistants (e.g., Siri, Cortana)

stating “I’m sorry. I didn’t catch that.” That generated a response of a chuckle or occasional build on the joke to say, “Let me say that again.” Noticeable observations also accounted for the occasional issue experienced with presentation technology, particularly when the issue embedded itself into the content of the conversation taking place. One clear observation regarding technology – consistent across the two observed boards – was that whenever a phone rang during the meeting, there was no pause, even as the board member scrambled to find the phone and turn off the ringer. One board member asked me to assist her before the meeting to turn off her ringer, which was also recorded in the field notes.

Time in the meeting was recorded as routinely as possible throughout the meeting to account for the start of the meeting, new agenda items, and the end of the meeting. Board packet information for FQHC-B also included a pre-planned time on the agenda for each agenda item. My ability to account for the time spent on each agenda item was directly impacted by whether I had access to an agenda at the beginning or if the change between discussion items was made explicit either through a vote on an action item or a statement of “Let’s move to [agenda item].” The level of fluidity between agenda items varied between FQHC-A and FQHC-B and is discussed in the following chapter.

The last observation consistent throughout the field notes were the group responses. Group responses were the moments when a majority of individuals in the room engaged in a shared communicative act, such as laughter or applause or collective “awh-ing” (either for cute baby announcements or to express sadness for the departure of a staff member). Individual instances of laughter were rarely recorded – as they rarely occurred. If two people laughed, it was not recorded.

The act of voting and motioning was not was not captured in the field notes as the official record was acquired when the meeting minutes taken by a staff person were approved the next meeting. Field notes accounted for discussions regarding the accuracy of who was recorded for the 1st or 2nd motion in meeting minutes. Field notes also accounted for any and all instances where a board member would speak up to ask a question after another board member had motioned to approve the agenda item.

Polishing Field Note Data

Following the guidance of Emerson, Fretz, and Shaw (1995), the initial "jottings" of observations were then expanded into field notes by filling in as much information as I could remember within one to two weeks of the event. Because the text/information added to the field notes was not verbatim and relied upon my memory, I differentiated segments of verbatim speech and recollection using different font styles. Inserted areas of content added after the meeting were placed in italics. Segments of verbatim conversation transcribed during the meeting were placed in regular font. Observations regarding technology, group responses, and the quality and delivery of presentations were set apart from conversational text in the field notes by italic text flush with the left margin. These formatting conditions remain consistent throughout the presentation of data in the following chapters.

In addition to making the above finalizations to field notes, I added additional information by labeling when the conversation experienced a significant shift in conversation, either through the change in the agenda item or by a comment/question asked by another person in the room. If the question was directly related to the report at hand, it

was not counted as a shift in the conversation. However, if a question about information on slide 28 was asked when the presenter was on slide 8, then that counted as a change in topic. If the information being delivered within the report did not contain the information requested by the question, then that was counted as a shift in the conversation. For example, "What is the denominator of our cost per encounter?" was counted as a new discussion topic as it broke the flow of the report to include additional information.

Interviews

All four sites in this study participated in interviews, resulting in a total of 42 interviews (FQHC-A = 20; FQHC-B = 10; FQHC-C = 4; FQHC-D = 8). Interviews lasted an average of 49 minutes with a range of 23 minutes to 2 hours. These 42 interviews were included total of 18 patient board members (PBM), 16 non-patient board members or community board members (herein labeled as CBM), and 8 staff members (SLT). The sample of interviewees reflected a majority of patient board members, reflecting the context of patient-majority governance.

Focused on theoretical sampling techniques, the demographics of age, race, and income were not collected from staff members for two reasons. First, staff are not hired at the organization based upon their ability to "represent" the community population as is the requirement for board members. Second, income information of SLT participants is readily available from examining the IRS-990 forms made available online. Thus, the re-identification of senior leadership team members who opted to participate would be easily achieved by participating board members who also have access to this information and

knowledge the few SLT present in the room. Therefore, the demographics of age, race, and income were only collected from board members and are displayed in the Table 1 below.

Table 1: Board member demographics

Demographic	CBM	PBM	Total
Age			
21-30	1	-	2.9%
31-40	4	4	23.5%
41-50	2	3	14.7%
51-60	1	5	17.6%
61+	7	6	38.2%
Race			
African American	5	4	26.5%
Hispanic	3	3	17.6%
Caucasian	8	11	55.9%
Gender			
Female	7	10	50.0%
Male	9	8	50.0%
Perceived Income			
Higher	8	5	38.2%
Equal	5	3	23.5%
Lower	-	10	29.4%
"No Idea"	2	-	5.9%
		-	
Professional Industry			
Business	3	5	23.6%
Education	3	2	14.7%
Engineering	-	3	8.8%
Financial	3	2	14.7%
Legal	2	-	5.9%
Medical	5	3	23.5%
Healthcare	2	-	5.9%
Other	1	1	5.9%

Interview Protocol

The interview guide evolved from a loosely structured interview protocol (Lindlof & Taylor, 2011) at the beginning of the project into a semi-structured interview guide based

upon theoretically and empirically driven data (see Appendix A for the semi-structured interview guide). The semi-structured interview guide contained a set of questions that consistently provided rich responses from participants. In addition to these questions, there were several *ad hoc* questions based upon observation of board events at the organization. For example, in one instance a participant commented on how meetings were always professional and cordial, which prompted a question about a specific instance where a meeting atmosphere shifted as a board member and staff member engaged in an exchange about provider productivity, resulting in a defensive phrasing by a SLT and the board member finally ending his position by dropping the end of a sentence with a heavy sigh, furrowed brow, mumbled "Well-," and leaned back in the chair. *Ad hoc* questions served as a way to engage in member checks during the interview (Lincoln & Guba, 1985) and were added only after a participant provided their response to the related interview question, so as not to prime the participant's response. *Ad hoc* questions about observed interaction and questions about board members interaction with staff were the result of theoretical sampling techniques that emphasized conceptually drive data collection (Corbin & Strauss, 2008; Glaser & Strauss, 1967; Hood, 2007).

Although the boards and participants consented to participation in the study, issues of confidentiality lingered for some. Three participants said they were not willing to disclose the information about the board by providing an example. Three other participants offered several examples off the record. The off-record comments were not included in the study. However, the off-record comments did confirm my initial interpretation of whether particular board members were participating in meetings. The remaining off-record

comments were already present in the existing data set through the disclosure of other participants.

Location

Travel arrangements within and to four separate city/towns enabled for a majority of interviews to be conducted face-to-face at a variety of locations (e.g., coffee shops, on-site, or places of work) selected by the interviewee. Because participants determined the location for the interviews, some participants requested to conduct phone interviews or to answer questions via email as this was more convenient for their schedule and travel arrangements. Thus, I conducted nine interviews via the phone, and one participant responded to questions via email. Sturges and Hanrahan (2004) argue that phone interviews "can be used productively in qualitative research" (p. 107), and found no significant difference between their use of phone versus in person interviews. The only noticeable difference during the phone interviews in this study was that one participant put me on hold while they responded to another phone call (10B, PBM) and another tended to children (7B, CBM). As evidence of the lack of the differentiation between phone and in-person interviews, the shortest interview transcript for an in person interview was six-pages for an in person interview lasting 23 minutes (7A, PBM) while the shortest transcript from a phone-interview resulted in eight-pages for a conversation lasting 41-minutes (5A, CBM). The differences between the transcript lengths for these interviews via separate channels is attributed to differences in the rate of speech for participants. The participant (7A, PBM) spoke quickly broken by pauses and vocal fillers (e.g., "uhm") whereas the participant (5A, CBM) spoke with fewer vocal fillers but at a slower pace, resulting in a similar transcript

length despite lasting 18 minutes longer than the shortest in-person interview. Because all four sites utilized teleconferencing and phones during board interactions, I determined phone interviews as appropriate for the participants and concepts under investigation, a contextually-driven purpose defined by Sturges and Hanrahan (2004).

Transcripts

All but one of interviews were audio-recorded for transcription purposes. The transcript for the interview without a recording was developed by expanding interview notes immediately following the meeting. Transcription of the audio-recorded interviews focused on the content of what was said rather than focusing on the pauses and vocal fillers utilized in studies following the practice of conversational analysis (see Lindlof & Taylor, 2011), which is not the focus of this study. After transcribing the first seven interviews myself, the remaining 35 interviews were contracted out and paid for with personal resources. (This project was not funded by any individual or organization.)

Social Artifacts

As part of data collection, I collected a variety of social artifacts (i.e., organizational documents; Lindlof & Taylor, 2011) pertaining to the board. FQHC-A and FQHC-B shared the board packets for every meeting where materials were provided to board members. This included meeting agendas (when used), copies of slide decks, reports discussed in the committees regarding the quality of care and satisfaction of patients at the clinic, and a variety of reports from committees. I obtained hard-copies of the packets by printing out electronically available packets, picking up packets at meetings, or through the organization shipping the packet to me.

Counting only pages containing text or graphics, the board packets totaled 1411 pages of data. Printed versions of web pages containing information on the organization and board members were not counted individually due to the unnatural formatting that distorts the printed version of many web pages. The communicative content of social artifacts was not the primary focus of this study because the study did not focus on the discourse of meeting minutes (for examples see Fear, 2012; Schwartz & Weisbach, 2013). Thus, the primary purpose of collecting social artifacts was to complement and support the analysis of communicative acts within the boardroom captured via observations and interviews.

Saturation of Data

Scholars have yet to reach a consensus on what represents data saturation but consistently emphasize the importance of an ambiguous and figurative point at how much qualitative data is "enough." In grounded theory, Corbin and Strauss (2008) articulate saturation as "the point in the research when all the concepts are well defined and explained" (p. 145). Well-developed concepts capture the categories, dimensions, and relationships between concepts within the study. My study examined the conceptual development of communicative work, roles, and inclusion/exclusion within governance through intentionally collecting data from a variety of participants (staff, non-patient board members, and patient board members). This sampling not only captures the diversity of structurally defined roles, but also speaks to how each individual in the meeting contributes to shaping the organizing acts of the board. Given the focus of this study on diversity and

inclusion, data collection continued until any individual in the boardroom received an opportunity to participate.

Saturation is also demonstrated by the efforts of the researcher to seek out negative cases, atypical cases that do not fit the conceptual categorization (see Corbin & Strauss, 2008; Lindlof & Taylor, 2011; Miles & Huberman, 1994). Negative cases emerged naturally through the continued recruitment of both FQHCs and interview participants. These negative cases will be presented throughout the analysis in the following chapters to support the interpretation and verification of findings identified in the analysis of data.

DATA ANALYSIS

Data analysis engaged analytical techniques of writing memos, constant comparison, and axial coding that both influenced and reflected the iterative process of data collection and data analysis techniques within grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 2008). Grounded theory requires an iterative process of data collection and analysis that begins immediately after collecting data. The analysis then identifies concepts that generates additional questions necessary for continued data collection to develop the concepts under investigation (Corbin & Strauss, 2008). This iterative and cyclical process of engaging in data analysis and data collection distinguishes grounded theory approaches from general modes of qualitative inquiry (Corbin & Strauss, 2008; Hood, 2007). Scholars operating within the framework of general qualitative inquiry complete data collection prior to conducting analysis of the data whereas scholars of grounded theory dig deeply into a flexible and iterative nature of sampling and analysis.

With different types of data from four sites of governance, the analysis of data maintained links to each form of data through a consistent labeling scheme. Data from interviews indicates three things: The order in which the interview was conducted paired with the site (e.g., 1A, 1B, 1C, 1D) and the status of the participant (CBM | PBM | SLT). Thus, interview data presented through the dissertation is identified within parentheses (e.g., 1A, CBM) for the reader to see the connections and diversity of applications. Data from observations indicates the source as field notes (FN) along with the sequence of the board event within observations collected at each site. For example, "(FN 1A)" indicates the data source as being drawn from field notes collected during the first observation at FQHC-A. As mentioned previously, social artifacts are used only as necessary to provide more complete information to the information contained in field notes. By labeling the type of data and the order in which it was collected and analyzed further aligns with theoretical sampling techniques (Corbin & Strauss, 2008).

Sensitizing Concepts

One of the first techniques of data analysis used in this study was the use of sensitizing concepts (Blumer, 1954; Bowen, 2006). A sensitizing concept "gives the user a general sense of reference and guidance in approaching empirical instances" (Blumer, 1954, p. 7). After orienting myself to each site (two months at FQHC-A and three months at FQHC-B), I identified several elements within the data that stood out as potentially theoretically and empirically significant elements. Sensitizing concepts "draw attention to important features of social interaction" (Bowen, 2006, p. 3). Naturally, some of the sensitizing concepts emerged from the conceptual focus on the work of governance, the

roles of board members, and communicative strategies of inclusion and exclusion. Examples of sensitizing concepts (i.e., words and phrases) that emerged for the focus on the work of governance (RQ1) consisted of references to "work," statements or questions of "Do we need to take action?" and staff statements such as "What we need from you…" Examples of sensitizing concepts for the focus on roles identified statements where the individual indicated personal contributions using "I can do this…" as well as statements indicating potential contributions from another board member "[Board member], why don't you write a check for that? [*Note:* Statement was followed by a light chuckle from several others in the room]." Examples of sensitizing concepts for the communicative dimensions of inclusion and exclusion emerged primarily from the interview data as individuals engaged in pronouns of "us" and "them," discussions of division in the board, and candid statements of appreciation that particularly challenging individuals no longer served on the board.

Sensitizing concepts also emerged from my direct response to observations and interviews. When observing meetings, I took note of moments when I did not understand the information being discussed, or encountered unknown and unexplained acronyms/abbreviations. Many times the explanation or connection surfaced later in the meeting, or was found in agenda materials when composing field notes. These sensitizing moments spurred the examination of when I as a researcher desired to ask questions. As an observer, I could not ask questions without altering the communication within the meeting. The emphasis on questions was noted when participants asked questions (in field note data) and emphasized the importance of asking questions (in interview data).

Sensitizing concepts (Blumer, 1954) served as a valuable shorthand for taking notes and analyzing my initial responses to the data. They generated additional *ad hoc* interview questions as I sought participant's interpretations of my observation findings. They also facilitated the engagement in a more formal and deep dive analysis of 2,400+ pages of data.

Coding

Eight months into data collection, I initiated an in-depth analysis of the existing corpus of the data, word-by-word and line-by-line to parcel data into relevant segments, or events, of communication. These segments varied in length ranging from a page (e.g., a participant giving an in-depth explanation of their family background and who they were in the community) to a sentence (e.g., "[Name], are you on the line? *Followed by silence*" and "Every board has issues"). The codes within the data were identified as applying to the segment or partial segment. Analyzing the data line-by-line, the communicative segments often demonstrated several codes.

Memos, the "written records of analysis" (Corbin & Strauss, 2008, p. 117), engaged in an analysis of raw data to speculate and articulate initial points of significance and interpretation. The memos written about the data applied to the in-depth coding of the data, identifying both the code extant to the segment and/or line. I wrote memos for each observation and interview by hand, numbering each memo on a sheet of brightly colored, unlined paper. Although qualitative researchers may embrace the use of computer software programs to aid their data analysis, my analysis relied upon more traditional approach to analysis, for several reasons. First, as stated aptly by Corbin and Strauss (2008), "Computer programs don't do the thinking, and they can't write the memos (only store them)" (p. 310).

Second, empirical studies continue to demonstrate that hand written notes lead to improved memory retention when compared to typed notes (for example see Longcamp et al., 2008; Smoker, Murphy, & Rockwell, 2009). Finally, an initial round of open coding was conducted through the use of Dedoose, an online qualitative data analysis software, resulting in an unwieldy and disconnected array of codes. Therefore, I continued data analysis via hand written memos and codes. The audit trail (Lincoln & Guba, 1985) remained intact as I retained organized binders and notebooks to store all the documents created throughout the process.

Open coding

Open coding is an analytical technique where I engaged in the "process of breaking down, examining, comparing, conceptualizing and categorizing data" (Corbin & Strauss, 2008, p. 61). Meetings were broken into chunks of conversations relevant to the memo to identify concepts, or "conceptual labels placed upon discrete happenings and events" (p. 61). The assignment of conceptual labels focused on identifying *in vivo* codes whenever possible. *In vivo* codes are labels that emerge from the actual words used by participants. The comparison between chunks of data followed the technique of constant comparison defined as an "analytic process for comparing different pieces of data for similarities and differences" (Corbin & Strauss, 2008, p. 65).Events within meetings were compared to events between similar meetings (e.g., full board meeting to full board meeting, governance committee to governance committee, and finance committee to finance committee), to events within the same organization, and to events between organizations.

The first phase of open coding started on an initial set of observational data capturing seven board events. The codes were analyzed to identify conceptual labels relevant to addressing the research questions on the communicative work, roles, and inclusion/exclusion within patient-majority governance. The memos supported the ongoing analysis of how the codes related to each other, documenting the process of constant comparative coding techniques (Corbin & Strauss, 2008). Stage one involved listing all of the codes identified within the data set. The second stage involved a process of axial coding discussed next.

Axial coding

Each of the codes on the list was then grouped through a process of axial coding defined as

> …a set of procedures whereby data are put back together in new ways after open coding, by making connections between categories. This is done by utilizing a coding paradigm involving conditions, context, action/interactional strategies, and consequences. (Corbin & Strauss, 2008, p. 96)

Each of the *in vivo* codes were then identified as primarily whether the code represented an intervening condition (e.g., organizational history, board history, federal requirements/regulations, board bylaws), the context (e.g., the location of when and where board members engaged in meetings, such as before the meeting, after the meeting, in emails, or in person), the interactional strategies (e.g., questions, answers, reports, votes, and motions), and the consequence or outcome of communication (e.g., resignations, division, professionalism, family, better than before). The distinction between consequences and interaction strategies – particularly for a study examining the communicative work, roles, and approaches of communicative inclusion and exclusion

extant to governance – acknowledged that communication in organizational contexts is mutually constitutive, whereby interaction may lead to outcomes as much as outcomes lead to interaction. For example, the agenda and use of rules of order shapes a 'professional' board, just as much as a 'professional' board reflects the communicative norms of professionalism. The causal connection between action and consequence is thus blurred and not pursued as a determining feature within this qualitative data set limited to four sites of governance.

In vivo codes were then evaluated to determine which ones represented a category (reflected a more abstract level of data) or a property (a piece of data reflective of the category; Corbin & Strauss, 2008). Categories were written separately on the front of a four- by six-inch notecard with corresponding properties written on the back of each card. Categories were then laid out and organized into groups of whether they addressed the research questions posed at the beginning of the data collection (a) the communicative work of governance, (b) the communicatively established roles of board members, or (c) the communicative strategies to inclusion/exclusion. This organization of codes was then written out with one page per research question. The framework developed by axial coding assisted in streamlining the remaining analysis swhile remaining open to development of additional *in vivo* codes. As new codes were identified, they were added to the appropriate respective category.

Integration

After I completed all the memos and open coding of the data, the final step of analysis engaged integration, a "process of linking categories around a core category and

refining and trimming the resulting theoretical construction" (Corbin & Strauss, 2008, p. 263). The existing categories and dimensions present for each research question were re-evaluated to determine an even higher level of abstraction and the appropriate fit of the existing categories for each research question. The process of integration justified adding an additional chapter to develop the context of patient-majority governance to discuss not only case summaries containing the similarities and differences between sites. Integration developed the construction of communicative work of governance (RQ1) focusing on the categories descriptive of the boardroom culture (board member-to-board member) and defining oversight versus micromanagement of operations (board member-to-staff member). Integration for the communicative enactment of board member roles (RQ2) identified three significant roles: The patient, the perennial, and the contributor. Integration for the analysis of the communicative strategies to inclusion within patient-majority governance of FQHCs identified the dynamic tension of engaging situations of exclusion in the boardroom.

SUMMARY

My study engaged in the practices of grounded theory (Corbin & Strauss, 2008; Glaser & Strauss, 1967) throughout collecting and analyzing qualitative data from four sites of patient-majority governance located in the southwest region of the United States. Two sites granted full access to ethnographic data collection (i.e., observation, interviews, and board packets). Two sites granted access to interview-only data collection. The entire corpus of data consisted of 42 interviews (M = 49 minutes; Range = 23 to 120 minutes; 544 pages of single-spaced, 12-point font data), 62.5 hours participant observation of 41

board events (442 pages of single-spaced, 12-point font data), 42 interviews), and 1411 board packet pages. Analysis of qualitative data through the use of memos, open coding, constant comparison, axial coding, and integration techniques essential to theoretical sampling techniques demonstrated by Corbin and Strauss (2008) and guide the collection of data necessary to fully develop the theoretical construction of the research questions. Chapter 3 examines the context of the boardroom meetings and nuances at each site. Chapter 4 presents the analysis of the communicative work of governance. Chapter 5 develops the three overarching, yet permeable roles of board members reflective of communicative norms in the boardroom. Chapter 6 builds upon the previous two chapters to develop the communicative strategies of inclusion and exclusion reflected in the recent past and present experience of patient-majority governance.

Chapter 3

The Context and Sites of Patient-Majority Governance

The four sites of patient-majority governance experienced different yet similar challenges in the organization and the boardroom in working towards their mission of serving marginalized communities in the area. Participants with experience serving on other boards (either previously or concurrently) noted during their interview that the FQHC board was distinctly different. Sometimes it was worse. Sometimes it was better. Analysis of data collected identified the significance of context in the *snapshot of a meeting* and *mini-case studies.* A snapshot of a meeting introduces the board meeting from a "30,000-foot view," echoing a practice in governance where board members receive a 30,000-foot view of clinic operations (2C, PBM | 2D, CBM). The 30,000-foot view of a meeting then shifts to examine the intricacies of patient-majority governance at each site through mini-case summaries. The chapter concludes with a discussion examining how these similarities and differences add value and complexity to our understanding of the communicative construction of work, roles, and exclusion/inclusion extant to patient-majority governance.

SNAPSHOT OF A MEETING

Participants in this study used many terms to describe the board meetings, but "boring" was not one of the terms. During the span of 41 board events, there were two moments when I caught SLT members briefly rest their eyes during a late afternoon (yes, 'caught' as when his/her eyes opened again our eyes locked). It was noticeable that SLT engaged in multitasking on their phone or laptop hybrid (i.e., a 2-in-1 laptop tablet), and board members checked their phone on occasion. However, these momentary shifts in

undivided attention did not detract from the value board members and staff placed on the time of the volunteer board members. Participants spoke candidly that discussions in the boardroom were not always relevant or substantive or that their own personal contributions may have contributed to digging into areas of operations rather than governance (developed in Chapter 4). The complexity of healthcare operations, and particularly the requirements specific to FQHCs created a meeting where the board members had the opportunity to learn – either from the SLT, CBMs, or PBMs (see Chapter 5).

Most of the 41 board events took place during the lunch or dinner hour, and the organization provided meals for all individuals present at the meeting (including staff and myself). Pre-meeting conversations took place as participants selected their meals and included discussions of food, SLT vacations, sports, volunteer activities, and the weather. Pre-meeting conversations typically involved two to four people per conversation, and rarely involved individuals sitting on the other side of the meeting room. FQHC-B experienced a level of pre-meeting silence on two separate occasions that led participants to suggest they "have some music playing" to break the silence. Although FQHC-A did not experience the same level of silence, the length of the conversations was similar between the two boards. The observed pre-meeting conversations did not discuss topics relevant to the *work* of the board (developed in Chapter 4) and are therefore categorized as small talk rather than "informal conversations" (Tierney & Minor, 2004). However, the conversations do surface again in the discussion of communicative work of developing a board culture (see Chapter 4) and potential sources of communicative exclusion/inclusion (see Chapter 6).

Meetings started within five to eight minutes of the scheduled start time. Meeting start times were delayed only in order to reach a quorum of board members or to give key members of SLT time to arrive from another meeting. At FQHC-B, the meeting started with a formal announcement from the chair of the meeting stating, "We have a quorum. It is 5:38, and I will call the meeting to order." At FQHC-A, the announcement was less formal with the chairing saying, "Okay, let's get started."

"Robust agendas" (10B, PBM) provided structure for the meeting, ordering the topics in a fairly predictable (and relatively stable) manner. Committee meetings started with a consent agenda followed by a fairly standard pattern of reviewing measures and metrics of organizational performance (see Chapter 4). Committee meeting discussions were summarized and reported at the next board meeting unless the committee decided that the matter needed further work within the committee. On occasion, a comment or question at the full board meeting generated a report or action item to be discussed back in the committee, but this was the exception and not the rule. In full board meetings, the agenda started with a consent agenda followed by reports from the CEO, the board chair, and the committees, with at least one informational item or board education item embedded. If the board failed to achieve quorum, action items requiring a vote (i.e., consent agendas, committee reports) were moved later and the remaining participants engaged in a "discussion" of topics that did not require a vote (e.g., a CEO report). Representing the exception rather than the rule, this occurred at in only two of the 41 observed board events, both times at FQHC-B. This dynamic of attendance at each site is discussed in greater

detail in the mini-case summaries and resurfaces in the discussion of communicative exclusion/inclusion (see Chapter 6).

Every meeting was structured by an agenda, but the discussion within each agenda item was negotiated by the participants at the meeting. For example, the following excerpt captured the ending point of an agenda item regarding recommendations from the governance committee to the full board on the nomination of new board members (FN 13A):

> CBM 1: Motion to approve them all.
> CBM 2: Second
> *All: Laughter*
> CBM (Chair): Hold that thought. One of the issues is do we elect all five of them for three year terms right out of the gate? …or some serve out the remainder of the year and then vote? …in other words, do we give a partial term to begin with?

Exercising the authority available to any board member, the board chair stopped the motion and started a discussion about whether new board members should serve a partial term or a full term. The discussion was necessary in order to make sure the board understood the complexities of the situations facing nominees, situations that could hinder their ability to perform their work as a board member (i.e., attending board meetings). A partial term was an alternative course of action the board could pursue given the uncertain situation. The vote continued as an affirmation and the work continued to bring on new individuals to the board.

The length of the meetings varied depending upon the material discussed during the meeting. A prime example of a short meeting was a committee meeting that reviewed communication materials to be used by the organization (FN 6A). Later termed “magically

efficient" (18A, CBM) by the committee chair during the full board meeting, each person provided their feedback and discussed updates on the materials received prior to the meeting. The committee covered all the agenda items in approximately 20 minutes via the only teleconference meeting within the observational data.

At the end of the meeting, participants engaged in standing meetings with similar conversational patterns as the pre-meeting small talk. Board members usually left the room within five to ten meetings after the close of the meeting, leaving staff engaged in "informal conversations" (i.e., work related meetings; Tierney & Minor, 2004). On three occasions, I observed a gathering of board members in the parking lot as I walked to my vehicle. Shadowing board members into these "after meetings" was not a part of site access and therefore not included in this study. One community board member at FQHC-B (7B, CBM) shared that based upon their professional experience – and not board experience – it was in after-meeting moments where "most of the meeting took place." The board member indicated uncertainty whether the content of the "after meeting" conversations worked their way back into the boardroom. "Because I'm not in those after meetings, all of them, I don't know." Based upon observational data and level of access, after-meeting data was not collected from either FQHC-B as the observation ended as the board entered an executive session. At FQHC-A, these meetings were discouraged within the board as part of their effort to be "transparent" (developed in Chapter 6).

The primary form of communication outside of meetings involved board members emailing the chair of a meeting or a board member seeking out a member of SLT to learn from them about operations, finances, fundraising, or existing programs. Each of the sites

encouraged these types of activities as long as the informal conversations did not create division in the board. Discussed in greater detail in Chapter 6, two of the sites experienced issues when the informal conversations evolved into division as a group of "key volunteers" that sought to remove the CEO, an action that imploded and exemplified an extreme level of exclusion. Speaking to how the boards were "better than before," the data provided very little evidence that "after meetings" were common to the FQHC boards in this study. Even the participant who thought the after-meeting conversations would be an interesting finding of the study was not able to provide an example of an after meeting that took place on her board. This attested to the commitment of participants in this study to transparency (see Chapter 6), to respect the time of volunteer board members (see Chapter 4), and to keep the work at the meetings.

The Flow of Meetings

Conversations on the board had a dynamic flow. Committee discussions would flow "up" to the board as the committee chair reported the discussion back to the full board. The board discussions could also flow "down" into the committee, an action guided by the board chair or a member of SLT. This downward flow reflected that the committees were designed to do a majority of "the work of the board." Discussion of topics also overlapped across meetings, particularly when the board reviewed topics such organizational issues, strategic directions, or recruitment. The flow of the conversation shapes the communicative work of the board developed in Chapter 4.

The conversational topics also flowed between meetings, continuing the discussion on the topic for two or more months. One example of this was the strategic planning of

FQHC-B. Driven by changes in external funding sources and findings from an internal audit of the FQHC, the board prepared to discuss strategic endeavors of FQHC-B three weeks prior to the strategic planning committee. The first conversation started with exposure to hearing preliminary findings from the internal audit (FN 4B). As the audit report was being finalized the board heard the perspective of external funders at a strategic planning committee (FN 8B). Based upon their knowledge of the internal audit and stakeholder funding changes, the staff drafted a strategic framework that was presented at the strategic planning committee and then approved a week later at the full board meeting (FN 9B). The full ratification of the strategic plan that included the reorganization of the board committee structure took place almost five months after hearing the first meeting where the issues were presented (FN 23B). In this timeline, it was not until the board implemented the restructuring needed to achieve the strategic plan that I pieced together the actual timeline of how isolated meetings feed into each other.

This dynamic flow of conversations in a boardroom reflected the active level of engagement of board members in their "work." Chait, Holland, and Taylor (1996) state that "a single discussion, a clever exercise, or a one-shot retreat will not keep a board steadily attuned to strategy" (p. 114). Noted throughout the observations in this study, the collaboration of the staff and board members on one topic wove together five months of conversations. Each board engaged in a meeting process that did not simply "rubber stamp" ideas (4A, PBM) but instead requested information and suggested changes as they felt needed. Throughout the data, board members frequently requested additional work from staff as a result of the meetings, asking for follow-up, an additional item, or tasking the

staff to resolve a patient. All of these questions provided board members with the answers from staff that made them comfortable (3C, PBM) in "ratifying" the course of action presented by SLT (2D, PBM).

Meeting Reports

Each agenda item was described as a "report" assigned to be delivered by a particular person. The delivery of the information varied depending upon when and who the report was delivered. Staff members delivered the reports in committee meetings (a pattern consistent between both sites of observation). For staff, this is not the type of presentational speaking developed in the context of a public speaking course or delivered at Toastmasters. Staff adapted their presentation to the dynamic interjection of questions and comments subsequently needing "*rewrapped*" (9B, SLT) into the flow of the report. With the exception of FQHC-A, the board member who chaired the committee typically reported the information back to the full board meeting. At FQHC-A, SLT frequently delivered the report on behalf of PBMs chairing a committee. This exception to the rule was clarified during interviews as an act that took place at the request of the PBM, not the request of the SLT. Informational reports and trainings (also referred to as board education) in full board meetings are delivered by staff member (director level or higher) or a guest (i.e., an individual outside the organization, such as consultants or local leaders). As SLT delivered a majority of observed reports, this section develops the context of these reports through describing the stream of interjections and the rewrapping efforts.

The delivery style of staff giving reports focused on an extemporaneous style of speaking, regardless of the meeting type. At FQHC-A, reports were consistently delivered

while seated, and typically utilized handouts rather than a slide deck projected on the wall. On the other hand, reports by staff at FQHC-B were delivered extemporaneously with a slide deck while standing (or sitting). At FQHC-B, board members delivered their committee reports by quickly reading a typed summary of the meeting with only specific participants (namely two) adding any additional commentary or making eye contact with other people in the room. The skill of extemporaneous speaking varied from person to person, but it was one notable presentation that exemplified the skill needed by staff to effectively engage in a negotiated report.

As displayed in Figure 1, the staff member fielded a stream of nineteen questions and comments before moving into the next slide. This stream of interjections concluded in the expression of dissatisfaction from CBM1. However, by the end of the report and a handful of shorter sets of interjection, the chair of the committee thanked the staff member for the report and said, "Good job." Whether the report was actually evaluated as a "good report" or was intended to offer encouragement to the staff member, this communicative episode stands in stark contrast to the "outstanding report" observed four months. During the outstanding report, SLT delivered a continuous presentation, where the board rarely interjected. At the end of the report, the same mumbling CBM gave the following feedback: "I just want to say…this is an outstanding report. We identified the problem. Evaluated how to fix…That's real concise, and I salivated on it" (FN 20B). In other words, the board member received all the information s/he felt was needed in order to understand the issues and vote.

Figure 1: A stream of interjections

1. PBM 1: Do you advise that they eventually do them all? All the phases of the program?
2. PBM 1: Do you factor culture in with those?
3. SLT: There's some stigmas associated with pre-diabetes…What kind of interaction management do we do?
4. SLT: What about peer-to-peer (i.e., group counseling sessions)
5. CBM 1: …You have a medical record when you are interviewing the person and it is tied to (your health plan)?
6. CBM 1: …So, you know how well they are handling their diabetes, from a medical standpoint…?
7. CBM 2: Do patients, are they scheduled at a regular interval or?
8. PBM 2: What do you perceive are the biggest needs for the patients to help improve this outcome?
9. PBM 2: Do they sometimes ask for ideas? I went to a dietician class here... there was a guy who was very sad that he couldn't have his menudo…but on the internet you can find healthier ways to make the same recipe...but I don't know if we hand them the literature?
10. PBM 3: I'm wondering if you are taking all this information in any measurable way so you don't have to read much narrative in terms of patient outcomes?
11. PBM 3: I was wondering more on an individual basis for tracking individual basis
12. SLT 2: So, for those who don't meet success are you analyzing the barriers …so as a provider I know what the barriers are?
13. SLT 2: It would be good information for all of us to know…maybe our patient population may have problems?
14. CBM 2: And these goals are self-reported?
15. CBM 2: Is there a way to compare these to something more objective (BMI, weight)?
16. SLT 1: Are there any at risk groups…that stand out that we need to focus on?
17. CBM 1: But we've been doing this since 2012
18. CBM 1: So we ought to have outcomes for this…it's very important to report them and track them…
19. CBM 1: *Mumbling while leaning back into his chair and shaking his head*

Interjections never waited until the end of a presentation and rarely took place when staff stopped to ask, “Any questions?” The sheer quantity of interjections during a report was larger at FQHC-B than at FQHC-A, which may be due in part to differences in size of the organizations and the length of the respective meetings. When interjections started they frequently continued until a board member or SLT brought them back to the content they were ready to discuss, sometimes jumping ahead if requested by the chair of the meeting. Unless a board member delivered reports to a board as part of their professional career (e.g., CFOs), board members were never on the receiving end of the stream of interjections. Engaging in the dynamics of communication between the staff and the board members, the SLT engaged in “rewrapping” with both acceptance and frustration (8B, SLT | 9B, SLT).

“Rewrapping”

The *in vivo* code of “rewrapping” (9B, SLT) encompassed the dynamic interplay between questions and comments inserted throughout the negotiated report from the position of the staff tasked with delivering the information. The analysis of observations led to the development of additional interview questions to ask participants how they perceived the interjections throughout the meeting. Specifically, this question was asked of SLT members and board members with experience delivering reports to a board in a different or similar setting. Participants explained that they rewrapped the information so that board members could understand. Based upon observations, these rewrapping endeavors are categorized into two dimensions: Correcting the paraphrase and adapting to the question.

Correcting the Paraphrase

The density of information provided within the presentations reflected the 'complexity' of the operations and finance of FQHCs (see 5A, CBM) and generated interjections where board members sought to simplify the relationships under discussion (e.g., the relationship between cost per encounter and the number of days the clinic was open). Participant (4C, CBM), a former staff member and current board member, felt that many of the questions experience as a staff member were redundant. However,in observations at FQHC-A and FQHC-B, there were very few times when a board member paraphrased, or summarized, the content into a sentence that SLT said, "Yes, that's correct." Generally, the response was much longer including reiterations of the information that was either previously presented, had yet to be presented, or was not designed to be included in the presentation (based upon information contained in the slide deck).

The following scenario exemplifies a situation in which the question sought repetitive information (FN 11B,):

> SLT: …you might recall that august was a low month … So-
> CBM 1: You mean, July was low?
> SLT: Yes…so that helped offset the fact that we were lower in volume in Medicaid/chip revenue….

Here, a question was used to ask the staff to repeat the information that was written correctly but verbalized incorrectly. As the same meeting progressed, another moment of repetition occurred from the same board member.

> CBM 1: One thing about the budget… our funder is restructuring their payments?
> SLT: Yes, that's what we just talked about
> PBM 1: Page five.
> CBM2: Okay, right.

There are definitely moments as illustrated above when the question sought repetitive information, but sometimes this was not always the case, particularly when summarizing the complexity of operations in the organization.

> PBM 2: So what you are saying is 'A' the order of the stock…so there's a number on the shelf?
> SLT: I don't know it's as strict as that…our PAR number, what you are talking about….we can't say to everyone, "This is how many crutches *you need."*

From the paraphrased statement of the PBM that tries to sum up a report about what changes are being taken operationally in response to findings from an external audit, the essential response of "not really" is rewrapped into the response that states "I don't know it's as strict as that..." Rewrapping modeled an approach of rephrasing and clarifying information.

Adapting to the Question

Although a precise count is not pursued within this qualitative analysis, there were substantial moments where staff adapted their report to the question, regardless of the relevance of the question to governance. For example, there were several instances when questions engaged in information seeking behavior regarding medical treatment protocols. Even though medical treatment protocols are monitored by external organizations, SLT rewrapped their response to questions into the flow of the report. The following example pulls from a report on a program for the improvement of health for diabetic patients.

> PBM 1: So let me understand…you put them on a low dose to protect their kidneys?
> PBM 2: Is that something that should be happening?
> SLT, MD: Not necessarily (response directed to PBM1)… *He continues to describe treatment protocols used by practitioners used to determine when diabetic patients are also prescribed medication for hypertension.*

SLT indicated that treatment protocols used at the clinic are based upon best practices of medicine and guidelines established within the healthcare industry. Regardless of the relevance to the question within the scope of a board's responsibility, the question was answered in order to listen to the PBMs (8A, SLT).

Other examples highlighted adaptations less focused on medical treatment and more focused on asking a question that in part asks, "Why is this such a big deal?" Here an excerpt from a committee discussion asked why there was such an extended discussion on revisions to the call center script, attempting to connect the work of this meeting to previous meetings.

> PBM 1: Isn't scripting (used by our call center) something that has always been updated?
> SLT 1: (…) They took an inventory of all the scripting, drafted new scripting, and trained…they wanted to expand what went to (*and was used by our other clinics*) …
> SLT 2: What we did is standardize it. What I mean by that…we wanted everybody to deliver the consistent message…got everyone in a room and everyone said great
> PBM 1: So the (our vendor) does a bulk of answering the phone but not all the calls?
> SLT 2: Off the top of my head 2/3rds… (*They do 2/3rds of the calls*).

The call center service used by this organization was in place for the term of the board member, but connecting the information to the scope of the service at multiple clinic sites was not made explicit until this moment. The response to the question was both a yes and no because of the complex vendor relationships and the geographical dispersion of clinics. No two clinics ever seemed to be the same, and each clinic experienced substantive changes that influenced the outcomes and measures reported to the board, including vendors for

call centers. Even as the staff tried to translate the complexity as simply as possible, there was not always a simple answer.

The interjections sometimes shifted the formal structuring of the agenda as the topics and presentations (particularly informational items) were interrelated and flowed into each other. This level of fluidity allowed varied according the culture of the board (see Chapter 4) and transitions were not always formally announced, as illustrated in the following excerpt from FQHC-B:

> CBM 1: I just want to say…this is an outstanding report. We identified the problem. Evaluated how to fix…That's real concise, and I salivated on it.
> All: *Laughter*
> PBM 1: I thought you would…
> SLT: Thank you very much…and it's also all the stakeholders (*referencing the next agenda item*).
> (Directing his/her attention to the committee chair) I'm sorry. Am I jumping ahead?
> CMB 2: *The next item is Incidents …* [SLT name] the floor is yours.
> SLT: Incidents. We are leading in disruptives and clockwise from there (*giving a preview of the order in which the graph displayed on the projector would be discussed*) …any questions on that…

In this scenario, the negotiated report continued to proceed into the next agenda item delivered by the same SLT member in a fluid progression of a working meeting. However, respecting the structure of the board, the staff identified the shift in topic and checked in with the chair of the committee responsible for maintain meeting protocols. To better explain how organizational and board differences impact the analysis and interpretation of data, the next section presents mini-case summaries of each site (see Chapter 4 for an analysis of board culture).

THE CASE OF THE PATIENT-MAJORITY BOARD

With four sites of governance, the data incorporated a diversity of participants that influence differences within the organization. This section presents a min-case summary of each site of governance to identify the key elements of difference and similarity for the reader within the context of boardroom logistics, attendance, and executive sessions. Following the narratives of the individual organizations, a summary section recaps the similarities and differences within the case studies and Table 2 that presents additional differences and similarities regarding specific clinic and board descriptive characteristics (e.g., operating budget, number of clinic sites, and board size). (*Note:* See Table 1 in Chapter 2 for demographics of board member interviewees.)

FQHC-A

Established as a private NPO clinic to underserved communities over 40 years ago, the organization transitioned into an FQHC within the past 10 years. "The changing of the guard" (9A, SLT) was a ceremonious ritual as the former board voted on the patient board members, rendered their resignations, left the meeting, and transitioned to the newly formed foundation board. The foundation board had a donor requirement of $2,500 that each board member "can raise through their friends or they can write a check" (19A, SLT). Separate from the FQHC board, the foundation board was not a part of the study but reappears in Chapter 5 as deemed relevant to the development of the roles of board members. The FQHC status and the FQHC board faced a variety of challenges and opportunities as they embraced a period of accelerated growth marked by an increase in revenue and number of clinic sites.

Growth in the organization created an ambiance of excitement and appreciation throughout the boardroom, both in the general atmosphere observed and the explicit statements from the interview participants. Growth in the organization that took place before and during data collection was "exciting" and was expected to continue. "We have a tremendous growth spurt ahead of us" (1A, CBM). This period of growth guided a substantial amount of the conversations and meetings as the board challenged SLT with the task of "flawless execution" in maintaining the bottom-up NPO culture of the organization and in fulfilling the patient centric mission of the FQHC.

The origin of "flawless execution" was not stated but was described as one part joke, one part expectation, and one part staff recognition.

> So I don't know if you heard the [first name of executive director] say this, but we kind of got a joke. I'm kind of happy about this joke, "flawless execution." **[The joke]**
>
> Did you hear [him/her] say that? That's what we said that we want. We want them to move into the new space and open all service lines with "flawless execution." It's sort of easy to say, hard to do. **[The expectation]**
>
> But, we have such a talented management staff; it's just amazing. That's something that I've learned that makes all the difference in the world. You can have the best mission in the world. You can have the best idea, project, whatever. But, if you can't execute, you're toast. And that's where management comes in. You know. It's having the right people that can deliver. **[The recognition]** (1A, CBM)

Although not all people laughed at reference to "flawless execution" during meetings, participants spoke of their desire to uphold the mission and growth of the organization during interviews and in meetings, just as much as they acknowledged the "hard work" done by SLT and the organization. The board would consistently applaud (both figuratively and literally) the accomplishments of the staff and give at least some kind of "shout out"

every meeting (i.e., "I think it's great…"). When the organization reported to the board a HIPAA violation, a PBM commented that "…We can do better" during the negotiated report. However, when the event was summarized at the next full board meeting, the report led to staff recognition from a CBM.

> CBM: How do you know who was in the box [of PHI that resulted in the HIPAA violation]?
> SLT1: I actually don't know the answer myself.
> SLT2: I *do* know the answer. (Italics here indicate emphasis added by staff)
> *All: Laughter*
> SLT 2: The [staff member] has a very specific work flow…so s/he knew which days were in the box (and subsequently which patients were seen on that that day and contained in the box).
> CBM: Just the fact that we are that organized and we know that (information) should blow their minds.
> *All: Laughter*
> PBM: They should give us a reward.
> *All: Laughter continued*

This example illustrates how follow-up questions asking for more detail about the issue challenged the staff to continue to do better (in the committee meeting) and appreciated the work of their staff (in the full board meeting). A quality of work that should "blow the minds" of the regulating agency receiving the report on personal health information breach. Even if the regulating agency did not acknowledge this work, the board's recognition of the meticulous records of the staff member exemplified an almost perfect example of "flawless execution" during the expansion into one of the new sites.

Boardroom Logistics

All meetings (both committee and full-board) were scheduled during or close to the lunch hour, and the organization provided lunch for those attending the meetings (inclusive of board members, staff, and myself). Committee meetings were scheduled for 60-minutes,

and board meetings were scheduled for 90-minutes. Only once during six months of data collection did a meeting run longer than the originally scheduled time frame to the point where a board member needed to leave one committee meeting early to attend the next committee meeting.

Administrative staff staged the boardroom before every meeting by placing a board packet and bottle of water in front of each seat surrounding the large rectangle (that transitioned to a square). Several board members shared that they also received board packet information electronically before the meeting (see 11A, PBM). My access to the board did not include adding me to this email distribution list, however a new community board member ("new" defined as being on the board less than a year) shared that this information was not delivered consistently.

> I was really going to wait a bit before I voiced my concern about this, but I noticed with regard to committee meetings it's not necessarily consistent. Being able to get the materials, so you can at least glance at them prior to the meeting, and have some idea of what the discussion is going to be like is ... I haven't been receiving those before committee meetings that I have wanted to attend. (13A, CBM)

The importance of receiving information before the meeting was a logistical way to facilitate the "consent agenda," where items that did not need a substantial amount of discussion could be approved quickly at the beginning of the meeting (i.e., a review of information for conflicts of interest or review of prior meeting minutes). Providing information early to board members also granted them an opportunity to absorb information and prepare questions or comments that they may have.

Name tents printed on white cardstock with the organization's logo were distributed by the administrative staff as individuals sat down. Depending upon the time of arrival and

the time at which the staff started taking meeting minutes, some participants did not have name tents placed in front of them on a regular basis. Within the first two months at FQHC-A, I was able to learn the names of all meeting participants to increase the consistency of field work (i.e. "the lady in purple gloves" eventually became a name).

Board members arrived approximately 5-10 minutes prior to the start of the meeting. Participants strongly encouraged other meeting participants to eat their boxed lunch prior to the start of the meeting (both to new board members during board orientation and myself throughout data collection). The pre-meeting conversation typically focused on food intermixed with stories and experiences shared from the personal lives of board members. For example, in one committee meeting the conversation consisted of the following topics (listed in order of discussion): Strategies to prevent getting your car towed, a tale of a college roommate accumulating parking tickets, and a study that compared driving while under the influence of marijuana vs. alcohol. This meeting experienced a delayed start, as the conversation was built and added to by several other individuals in the room (FN 8A).

After the meeting, a handful of groups with two to four people would converge to have brief conversations. Occasionally, a small group of three could be seen chatting in the parking lot. Post-meeting conversations in the boardroom were short in length, and the multiplicity of conversations taking place prevented taking note of the content. There was one meeting in particular that transitioned from the committee meeting into a staff meeting, and the executive director, after observing my continued notetaking, motioned that it was time for me to leave. Staff lingered longer after the meeting, but most board members

usually left within 5-10 minutes at the end of a meeting unless they needed to stay onsite for another meeting.

Attendance

Attendance at the board and committee meetings appeared to be consistent throughout the duration of observation, with few exceptions. Very few absences took place over the course of data collection except for one PBM who as unable to attend any meetings. Teleconferencing into the meeting was common by board members managing their work schedule, but attendance in person was the preference. A preference best illustrated as board members called into the meeting while commuting to be physically present at the meeting (discussed in Chapter 6). Except for two observed committee meetings, only one person called into the meeting at a time.

One participant identified a dimension of attendance at committee meetings in FQHC-A as the presence of additional individuals. Neither board members nor staff, these individuals held voting privileges on the committees and was identified as a "work-around" strategy for the FQHC board (13A).

> I just think sometimes your patient board members really don't have either the resources or the time sometimes to really get involved in board work. You have to be able to work around that…What they do on their committee is they have non-board members on their committee. Those non-board members fill-in for the individuals that are on the board that don't have the time to be able to attend the committee. They've done this work-around that addresses that issue. I don't want it to be taken as a negative. I just think it's a work-around that other boards have to realize.

An impression shaped from previous board experience, this individual perceived that non-board members provided necessary support to the committee conversations, contributing to the success of patient-majority governance at this organization.

Executive Sessions

Board best practices recommend the regular use of executive sessions (see Masaoka, 2009) but represented a significant point of divergence between sites of observation. In general, an executive session is a specific dynamic of governance when the board officially goes into a "closed session" without the presence of staff. The board may discuss a variety of topics deemed necessary for a closed room, board-member-only conversation. Executive sessions may be pre-planned before the meeting or spontaneously arise during the course of a board meeting. At FQHC-A, I was aware of only one executive session used to review the performance of the executive director. There was one additional time where the executive director gave me advance notice that the board might go into an executive session during the middle of the meeting. However, in the moment of transitioning into the agenda item, eye contact and hand gestures from the executive director indicated that I could remain in the meeting, as the executive session was not called.

FQHC-B

From the first day of observation at FQHC-B, this board presented itself in stark contrast to the "growing" FQHC-A. The FQHC transition occurred over 10 years ago for this organization that remained primarily funded through federal, state, local, and grant funding. Granting agencies and governmental funding agencies drew a substantial amount of attention from the board members as they continuously heard updates on how the organization achieved (or struggled to achieve) requirements for funds that were both lump-sum grants (i.e., received either at the end or prior to achieving the grant objectives)

or stepwise grants (i.e., metered out as objective criteria were reached). Providing oversight to the largest number of campuses within this study, the board conversations also reflected a focus on how the organization was seeking to improve each site, improve numbers for grant funding, and improve the use of numbers to measure and report the effectiveness of programs (developed further in Chapter 4).

During the six months of observation, I learned of the resignation of the CEO through listening to the board discuss the policies on hiring a new CEO. This resignation was a surprise to at least one of the interview participants who learned that the resignation was linked to an external audit that linked a low level of employee satisfaction to the CEO's performance (5B, PBM). As with other discussions throughout the duration of observation, the board and the organization frequently focused on the theme of "improvement," particularly the actions taken that created or sought to create improvement.

Boardroom Logistics

All the observed committee and board meetings at FQHC-B took place either during the lunch or dinner hour. Committee meetings typically scheduled during the lunch hour lasted between one to one and a half hours whereas full board meetings scheduled during dinner time lasted anywhere from two to three (or more) hours. Historically, participants reported that meetings could last four or more hours, but this was no longer common. Buffet style meals were served in room adjacent to the conference room, and many participants arrived early to eat their meals before the meeting started.

The meeting room itself was a large square room with eight polished, Cherrywood, rectangular tables arranged in a square, leaving a large empty space in the middle. During

board meetings, the 21 seats around the table were prioritized for board members and SLT as guests and additional support staff sat in chairs lined up along two walls of the room. Large flat screen televisions were mounted on the east and west walls of the room, and a projector mounted to the ceiling displayed the slide deck on the south wall. Individuals typically sat in similar locations between meetings, shifting as necessary to sit at the head of the table when chairing a committee.

At full-board meetings, the administrative staff placed name plaques around the table facing the chair-side of the table for each member of the board and SLT. When board members arrived, they would rotate the Cherrywood wedge so that the name plate faced the middle of the room. A custom printed, two-pocket folder containing the board packet was placed on the table along with each name plate. In addition to this hard copy of information, board packets were also made available using on online platforms specifically designed for board packets. At committee meetings, the board did not use name plates and handouts were frequently distributed as the attendees arrived.

Attendance

Attendance to observed board events followed noticeable patterns throughout the collection of data, with a notable distinction from FQHC-A regarding staff attendance and a quorum issue. At the beginning of data collection, it appeared that the number of staff in the room nearly outnumbered the entire attendance of the board. The presence of staff at the meeting was due to the request of the CEO that expected all staff, director level and above, to attend meetings. Only three or four of these individuals ever spoke during a meeting, but were available to aid SLT in answering questions asked by board members.

Immediately following the resignation of the executive director, the SLT dropped this requirement and required staff to only attend meetings to learn how the board operates or to deliver reports. One member of SLT indicated that this shift aligned with the nature of the healthcare organization designed to provide primary care and not hospital services. As a primary care clinic, the organization was not open 24/7 and the staff did not need to be on call 24/7.

The second exception to attendance was that of absenteeism. Consistent absenteeism of board members from meetings was not a point of discussion in meetings until it became a significant concern in achieving quorum for a board meeting (FN 16B). Quorum requirements in the bylaws (specific to the organization) stated that even with the necessary number of board members present, PBMs needed to represent a majority of board members within the boardroom. The meeting started four minutes late as one of the CBMs on the phone was thanked for their service and then asked to hang up (and therefore leave the meeting) to achieve the necessary patient-majority balance for quorum. This quorum issue spurred a round of discussions in subsequent meetings regarding attendance policies and protocols. The final decision maintained the current policies and left the resolution of the issue with particular board members to the leadership of the board.

Attendance marked a historical issue at the organization. The timing of the meetings created challenges for several board members to get from their work to the meeting on time. If board members could not battle rush hour traffic to arrive on time (3B, CBM) or rearrange their work location to telecommute on meeting days (6B, CBM), they could call in as a last resort. Historically, the organization also tried to incentivize attendance and

mitigate transportation barriers for patient board members by providing reimbursement for travel expenses. However, this did not resolve attendance issues with patient board members, and the practice was phased out (9C, SLT). Only one of the participants who missed several meetings volunteered to be interviewed. The board member explained that their absence was due to a medical leave (7B, CBM), which was deemed an excusable absence during the governance committee meeting (FN 19B). The rest of the absentee board members did not consent to the interview; therefore, conclusions about their absence and inclusion are made cautiously in the analysis developed in Chapter 6.

Executive Sessions

Executive sessions were not included in the observational data, and to the best of my knowledge, participants did not disclose confidential information discussed in executive sessions during their interviews. Although information within executive sessions was not obtained, the data a significant pattern in the use of executive sessions at FQHC-B. The board used executive sessions at the end of every board meeting, resulting in a minimum of one executive session per month. The staff were dismissed at the end of the board meeting (that typically lasted around 2 hours), and the board stayed longer until the session adjourned.

FQHC-C

Representing one of the two interview-only sites, a rough sketch of a variety of meeting dimensions were described via the participants during the interviews and are presented here. The board pursued recent strategic for the clinic that resulted in a board where the difference between a patient board member and a non-patient board member was

"indistinguishable" (2C, CBM). This shift was made possible through "diversifying the payer mix," which means that the clinic opened their doors to individuals in the community with private insurance. Diversification of payers to include patients who were uninsured, underinsured, and now privately insured, enabled the organization to seek a financial stability not solely reliant upon federal funding. This is important because an FQHC that relies solely on the 330-grant (i.e., the federal funding to cover part of the expense for providing healthcare) puts the organization at risk for failure with changes in federal budgets and changes in legislation. With the patient pool expanded, the board members recruited from an pool of "diverse skills" that balanced the difference between PBM and CBM, a situation now different from a history where "four people ran the board" (2C, CBM).

Board Logistics

At FQHC-C, the logistics of the meeting were described as professionally presented and adapted to meet the needs of a geographically distributed board and organization. In regards to the board packets, one of the board members compared their current experience to other boards in which they served.

> I didn't really know what to expect. I've been on boards of other organizations, and so I had a little bit of a preconceived notion. When I went to the first meeting, it was very well organized. They had sent the agenda, the consent agenda - any documents that we are going to be reviewing - it was all provided ahead of time. It was actually mailed ahead of time, so it was all bound. Everything that was going to be covered was all sent in the mail about a week ahead of time. Yeah, all bound really professional. (3C, PBM)

This contrasted with other sites – both in this study and their experience – that delivered documents ahead of time electronically rather than via hard copy.

The second acknowledgement of a geographically dispersed board was reflected in board meeting logistics as the board respected the volunteers' time. The organization sought to make the best use of a board member's volunteer time, particularly when considering the time it would take to commute to a meeting.

> Two or three times a year, we have a half hour meeting. [People] are going to drive for forty minutes for a half hour meeting? You've got forty minutes up (*and forty minutes back*). A lot of times then, we'll call them ahead of time and say, "Call in. Don't even bother coming. It's going to be a short meeting." (1C, PBM)

Taking into account the additional time expenditure necessary for volunteers to commute, the board encouraged teleconferencing for these short meetings, a factor contributing to the attendance patterns. If the chair anticipated that a meeting would run longer than usual, the chair would also notify members in advance – even if the announcement was not remembered by individual members (4C, CBM).

Attendance

The monthly board meeting lasted one to one and a half hours, and committee meetings lasted approximately one hour. There was an annual retreat for all board members, and new board members engaged in an extra board event during orientation that involved tour all of the campuses in one day. Unless extenuating circumstances surfaced, the expectation was that board members attend meetings in person. For example,

> It's just impossible for me to get [there], so I've been participating by phone. I really dislike participating by phone because you can't see body language. You can't hear people very well. I feel like I'm missing seeing people. It is an option. I think that we have in our board rules that unless there's some extenuating circumstances like pregnancy, you are supposed to attend in person. You shouldn't call in more than three times per year. You're expected to be there in person. (3C, PBM)

The expectation to physically attend board meetings is developed in more detail in Chapter 6 as a common theme throughout the sites, regardless of the geographical dispersion at FQHC-C.

FQHC-D

Similar to FQHC-A, this organization also experienced a substantial amount of growth in the past 5-10 years, a growth participants attributed to hiring their current CEO and to becoming an FQHC. Activities of growth facilitated a period of growth from a mobile-only clinic (i.e., where services are provided in a vehicle moved around as needed to deliver care) to several brick and mortar establishments and expanding the scope of services to offer dental and after-hour clinics.

Continuing their traditions, every year the organization held an annual fundraiser where board members made a "meaningful contribution." Part of this contribution was resource based (i.e., gifts in kind or monetary donations) while the other part was the time and service necessary to set up and tear down the event. The fundraiser also presented new issues for the board as they battled the perception that the clinic no longer needed donations due to federal funds received from the 330-grant.

Over the years the organization seemed to take different approaches to recruiting board members. Whether for convenience, for funding, for the sake of experimentation, or maybe for the lack of better alternatives, the board at one point recruited CBMs that lived outside of the service area. No longer a part of the board at the time of data collection, this group of CBMs had a much different perspective on the operation of the clinic and caused a bit of division within the board in regards to the performance of the CEO (9D, CBM). As

discussed later in Chapter 6, this became a significant point of tension resolved when board members resigned and were replaced with members living in the communities and zip codes being served by the FQHC.

Interview data from participants at this organization reflected dimensions of board composition not present at the other sites. First, this board had the least amount of socio-economic diversity as all participants identified themselves and others as either middle class or upper-middle class. All but one participant stated that they were "higher than some and equal to others," or "lower than some and equal to others." Only one participant simply stated, "Higher." Second, this board also presented the greatest diversity in age range. Third, the board had the least amount of racial diversity in this study, a factor that improved over the past year to include more persons of color. Finally, of all the participants interviewed, this is the only site where a board member explicitly stated that they did not know they served on a patient-majority board (4D, CBM).

> Me: Do you feel having patients on the board makes an impact on the conversation?
> 4D: Yes it will. I don't know if we have – I don't think we have a patient serving on the board. Do we?
> Me: (Nodding in affirmation)
> 4D: We do? I wasn't aware of that.

My recruitment emails and one-pager sent to the organization included the explicit focus of my study on patient-majority governance. However, if the PBMs did not disclose their personal patient experiences to other board members, then patient-majority governance may not be visible within this board.

Boardroom logistics

At the request of one participant, one interview at FQHC-D was conducted onsite in the conference room where board meetings were held. Initially, I arrived at the wrong site, but the staff called ahead and redirected me to the proper site, located less than 10 minutes away. Similar to the initial observations at FQHC-A, the boardroom consisted of four white, long, rectangular folding tables tucked snuggly together to form a larger rectangle with chairs placed around it. The room was also home to some storage boxes and filing cabinets creating a snug fit, as there appeared to be less than 3 feet between the walls and the chairs around the table.

Attendance

Participants at FQHC-D expressed that they sought to be physically present at meetings, unless they were out of town for work (2D, PBM/CBM). The only concern with attendance of board members was when individuals arrived late *and* left early from the annual fundraiser, leaving the work to be done the other board members who arrived early *and* stayed late.

> I think we've been fairly up front about requesting your time. Talents and treasure is what (we) always say. Essentially, it's as much as you can give. Yes, we expect the board to participate in our fundraiser in the spring. We expect that participation to involve a donation of some type. It can be as simple as a nice flower arrangement, which would probably put it in the $30, $40 range to be auctioned off for hundreds of dollars. Even, I think, our board president last year did a hunting trip for four to [South America].
>
> We donate. It's not like we're putting a dollar figure (on it). We just expect everyone to be contributory. We don't hesitate to say that. If you have not a penny, you can contribute (in) other ways (…) They can always come out, like I mentioned earlier, (and) help put those tablecloths on or clean them up [at the fundraiser]. That type of thing is expected. Participation. Not necessarily a dollar figure. (1D, PBM)

In other words, showing up was expected. Board members at FQHC-A, FQHC-C, and FQHC-D were expected to make a "meaningful" contribution. This meaningful contribution could involve donating financially through donations of tangible items and/or by giving of one's time. Attendance at the event thus required participation and is discussed in more detail in Chapter 6 focusing on the communicative strategies of inclusion and exclusion.

Similarities and Differences

As demonstrated in the case summaries provided above, each organization presented multiple points of similarity and difference within the data set. Among the four sites of patient-majority governance, one instance of each of the following characteristics occurred naturally in the data set: a public-private entity, a religiously-affiliated FQHC, a board with limited SES diversity, a rural FQHC, and an FQHC independent of private donations. Each of these features corresponded to some dimension of the funding structure and, therefore, impacted the conversation of financial opportunities, stability, and risk in the boardroom. Table 2 summarizes much of the data for a variety of organizational and board level variables at each site.

Table 2: Clinic descriptors

Descriptors	FQHC-A	FQHC-B	FQCH-C	FQHC-D
Number of Clinics	≤ 5	10-20	10-20	≤ 5
Private Insurance	Yes	Yes	Yes	Yes
Unique Patients	20,000+	88,000+	--	7,400+
Revenue‡	20	100+	80-100	5

‡ *Note:* Revenue is given in millions of dollars.

Table 3: Board descriptors

Descriptors	FQHC-A	FQHC-B	FQHC-C	FQHC-D
Years as FQHC	< 10 years	10+ years	10+ years	< 10 years
Board Size	15	15	15	15
Required Donation	"Meaningful"	None	"Meaningful"	"Meaningful"
Limited Service[¥]	6	-	12	-
Board Training	Yes	Yes	Yes	Yes

[¥] *Note:* Limited Service indicates the maximum number of years a board member may serve on the board.

Table 2 and Table 3 identify several key similarities among the sites that impacted who and how individuals participated in the board. First, all of the sites accepted private insurance, a strategy associated with the "diversification of the payer mix." Second, each board participating in this study maintained a 15 member board, with a minimum of eight patients serving on the board. Third, all of the FQHCs transitioned fairly recently into an FQHC, and hence patient-majority governance. At least one participant from each site was with the board at the time of the transition.

Altogether the similarities and differences among the sites of patient-majority governance are carefully examined within the study. Following the practice of data representation used within this chapter, the following chapters continue to identify the data source, the site, and the sequence of data collection and analysis. This practice enables the reader to trace the data back to the original source and see the convergence of patterns within the data set. The remaining chapters capitalize on the diversity within the data set as an analytical tool to attest to the strength of the conceptualization of the communicative

work of patient-majority governance (Chapter 4), the communicative construction of roles (Chapter 5), and communicative strategies of inclusion and exclusion (Chapter 6).

Chapter 4

Putting 'Communication' into the Work of Governance

Regardless of a person's aversion or affinity for meetings, meetings represent a fundamental activity of being a board member. Governance takes place at meetings (Chait, Holland, & Taylor, 1996; Nicholson & Kiel, 2004) where board members fulfill their fiduciary responsibility and execute their duties of care, loyalty and obedience (Frumkin, 2002; Hopkins, 2003). The formally prescribed responsibilities and duties depict the purpose of a board meeting without describing the micro-processes of board meetings that fulfill these purposes (see Millar et al., 2013; Veronesi, Kirkpatrick, & Altanlar, 2015). In other words, we do not know *how* communication within the boardroom defines and shapes the work of the board necessary to fulfill formal duties and responsibilities. This study responds to this gap by examining work of governance through the analysis of qualitative data collected from four sites of patient-majority governance in the southwestern United States. Specifically, this chapter responds to the following question: What is the communicative work of governance engaged by board members (RQ1)?

Qualitative data analysis used grounded theory techniques (Corbin & Strauss, 2008; Glaser & Strauss, 1967) to examine the nature of governance. Open coding of data focused on examining interview responses and observed meeting events that spoke to how board members achieved governance through their communicative interactions with each other. Sensitizing concepts (Blumer, 1954; Bowen, 2006) within the communicative interactions highlighted reflections of what participants felt they should do, should not do, and what they did do during meetings to fulfill their responsibilities as a board, both individually and

collectively. Through analysis of similarities and differences between participants and the four sites in the study, a specific pattern emerged regarding how the board communicatively achieved their work of governance. The process of axial coding of existing excerpts related to the communicative governance divided the data into two separate codes. First, the code that addressed "how" individuals communicate within the boardroom; second, the code that addressed "what" to communicate with staff. Thus, the communicative work of governance presented as two related, yet distinct, codes. The first representing the importance of *building a board culture* that established guidelines for how participants behaved in the boardroom. An organizational culture represents a set of "artifacts, values, and assumptions" (Keyton, 2005, p. 21) that instruct individuals how to interact in an organization. In the four sites of patient-majority governance, these are represented as the context of communication (i.e., artifacts), the communicative assumptions about board member composition, and the communicative values evidenced in communicative norms. Pye (2004) argued that the connection between board culture and governance is linked as culture represents a significant component "in determining how board members behave and, to some extent, circumscribes their effectiveness" (p. 83). Thus, board culture is presented as the first category relevant to the communicative work of governance as the second category, *defining the oversight of day-to-day operations*, defined the board's relationship to the clinic's operational activities and hence the staff.

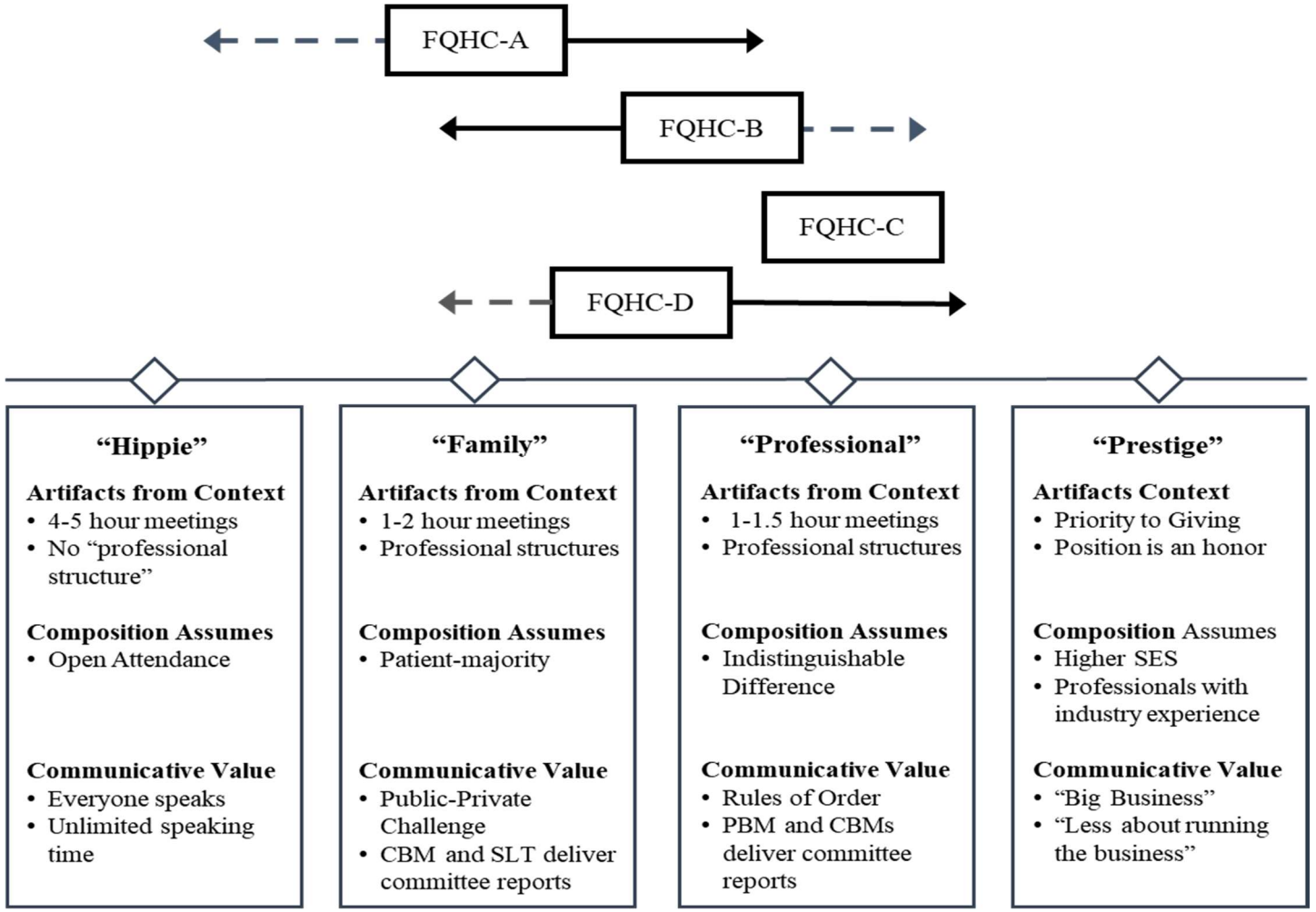
BUILDING THE CULTURE TO GOVERN

The examination of interview data (all sites) and observation data (FQHC-A and FQHC-B) identified four dominant board cultures that presented with specific artifacts,

values and assumptions regarding how things work in patient-majority governance. These four cultures are identified using *in vivo* codes as "Hippie," "Family," "Professional," and "Prestige" cultures. The categories of culture emerged as fluid construct as each board developed approaches to address new challenges experienced in the board and/or the clinic. Each board aligned strongly within the categories of either "Family" or "Professional" but experienced a push-pull dynamic. The push dynamic represented the participants who sought to "develop" the board into the next level of a "Professional" or "Prestige" board. The pull dynamic involved a desire to engage in communicative norms of a "Hippie" or "Family" culture. This push-pull dynamic blurred the boundaries between the categories of culture, identifying a fluid dynamic and relationship between each site of governance. The figure below presents the logical sequencing of the four categories of culture, from the "Hippie" culture on the left to the "Prestige" culture on the right. The location of each site of governance is visually placed above the category of culture that appeared as the anchoring category. Dotted arrows indicate a weak push or pull. Solid arrows indicate a stronger push or pull towards another category. This level of strength was determined by the number of characteristics that participants sought to pursue as well as the observance of these characteristics in the meetings. A weak strength emerged from one or two individuals (representing thirteen percent or less of the board) who desired to enact the communicative interactions that pushed or pulled the board culture into a different realm. A strong strength exemplified three or more individuals who expressed an interest in enacting the communicative interaction that pushed or pulled the board culture into a

different realm. The following sections develop the categories of culture to identify the distinctive characteristics, and the push-pull dynamics at each site governance.

Figure 2: Modeling board culture



"Hippie"

Within the data set, the "hippie" board culture depicted a culture of the past rather than present experienced by board members and staff still on the board. The organization and board reflected the "sort of hippie social context out of which it grew" (3A, CBM). The "Hippie" origin was explained by another participant.

> There were some hippie doctors that were concerned about some of the run-aways and homeless that were kind of hanging out during that era. So they worked…to provide free care to those people. (1A, CBM)

In comparison to the current board culture at FQHC-A, the "hippie" culture was "charming. It was a function of its time" (3A, CBM). Within the culture of the "Hippie" boardroom, the context and composition of the board shaped the way the board reflected the organization's origin.

Artifacts from Context

The hippie meetings took place in an organization with a "shoestring" (12A, PBM) budget. The length of the meeting was unbounded with "4- or 5-hour board meetings." Anyone who attended the meeting "was supposed to be able to go on, and on, endlessly" to allow everybody to have input (3A, CBM). The meetings had "no actual professional structure to what they were doing. It was this big sort of socialist democracy" (3A, CBM). In other words, the board did not exercise the use of "professional structures," such as an agenda, consent agenda, time limits, and rules of order.

Composition Assumptions

The hippie board culture also reflected a specific board composition and meeting attendance. The composition of individuals attending the board meeting was open to "everyone," which included "patients and doctors and every volunteer" (3A, CBM). The composition of the leadership was considered to be "too unprofessional" and the board members did not have the perceived skills to develop the organization (3A, CBM).

Reflecting the Organization

In this dimension the board culture reflected the culture of the clinic as staff, patients, and volunteers engaged in board meetings. One PBM reflected on the history of healthcare services when patients "were asked to take home sheets that they used, wash them and bring them back, help out in that kind of way. It was so shoestring" (12A, PBM). As a patient and/or volunteer, participants knew firsthand and through orientation the "grassroots" type of culture the organization sought to maintain as it experienced its current rapid growth. This "grassroots" culture valued input from the "bottom up" rather than from the top down (FN 12A). The culture reflected a board meeting that was common to "the old hippie days…We had a lot of handshake" agreements with our collaborators (SLT, FN 13A). These handshake agreements reflected the limited focus on formalizing the relationships with policies and contracts that the board reviewed. The Hippie, grassroots culture of the past reflected a board lacking structures but valued participation of patients, doctors, and volunteers during the humble beginnings of FQHC-A.

Participants at other sites also reported a history with humble beginnings as each clinic sought to provide services to underserved, under-insured, or uninsured communities

using mobile vans or vacant buildings. However, each site also expressed that the board developed since the hippie days into a more professional culture, a development that reverted when transitioning into the FQHC board that shifted back to the inclusion of patients on the board once again.

The Family

Participants that perceived their board as a "family" drew comparisons between other experiences working on or with a board of another organization. All participants with previous or concurrent board experiences concluded that the FQHC board was "different form other boards" (9B, SLT).

> I'll describe it like a family where folks are very familiar with one another, and they share a lot on a personal level, more than I've seen in other board interactions…Because of that, you know more about their individual challenges in life and things like that. You know when a board member is sick or depressed or going through a divorce, whatever the issue is. (9B, SLT)

In the "family" culture, board members shared personal information not common to the individuals with board experience at other organizations. Information about who was sick, depressed, going through a divorce, unable to pay for medication, and/or going on vacation was shared with staff and other board members.

At the same time, the "family" culture integrated more "professional structures" that were not present in the "hippie" culture of the past (3A, CBM). These "professional structures" (e.g., agenda, voting procedures, and meaningful contributions) enabled the board to do something rather than "fall asleep."

> I went to (a board meeting at a different organization)… And, these people fall asleep at their meetings. These people are, "Oh, we are a family. That's so good you came." They didn't do anything during the meeting! (2A, PBM)

Stated with tones of sarcasm, the label of a "family" for this other board was meaningless and not reflective of the active level of engagement that this board member saw at FQHC-A. The analysis in this section develops the context and composition of the "family" culture, highlighting how context and composition built into the public-private challenge within the family board culture.

Artifacts from Context

The context of the boardroom presented a specific setting that symbolized the use of both formal and informal practices. Board members attended meetings dressed as business casual or casual. This value surrounding the attire of board members was exemplified in the following example. At one of the committee meetings, the chair arrived dressed in business professional attire and was asked, "What's the occasion?" The chair responded with a joke about anesthesiologists and funerals. Although not indicative of the chair's profession, the staff in the room laughed (FN 8A).

The location of meetings for the "family" culture reflected similarities between FQHC-A and FQHC-D. The board meeting room was a multi-purpose room, used for staff meetings, healthy cooking classes for patients, and other events. At FQHC-A, the meetings could be scheduled close to other events. For example, the chair and I arrived early to one meeting and partnered with staff to rearrange the room after a cooking class made bran muffins. Once the tables were placed together, the gap in the middle of the rectangle was less than half the space at FQHC-B. As discussed in Chapter 3, the size and use of the room

contributed to the feeling of proximity of fellow "family" members and restricted movement around the room during the meeting.

As developed in Chapter 3, the artifacts of the meeting also reflected a more business casual set-up. The board packets were printed and bound with binder clips. Only during the new board member orientation did they receive a three-ring, two-inch binder containing a set of educational materials. The name tags were printed on paper and not always picked up by board members to display in front of them. Food was frequently eaten during the meeting, and delivered in box lunches, a routine that mimicked a family eating dinner together. Only one or two members that regularly arrived early would eat before everyone arrived, a pattern typical of the meeting chair whose time was spent facilitating rather than eating.

Composition Assumptions

A distinguishing feature between the "Hippie" and a "Family" was the composition of the board, who was sitting around the table. One participant worked hard to develop the board by getting "the right people on the board and develop that capacity for leadership and moved it, just moved it in a more professional direction" (3A, CBM). The "right people" in this pre-FQHC status consisted of "community members…with a good finance background or good, successful CPAs" (3A, CBM). As the board evolved into patient-majority governance, the patients exhibited a "capacity for leadership" as demonstrated by their experience in small business, advocacy work, and personal investment in improving the clinic, but not necessarily due to their experience in financial, legal, or healthcare industries. With mentorship, all PBMs were perceived to be capable of serving as the board

chair, a moment that would indicate the organization had come "full circle" (3A, CBM) in returning to the "hippie" and grassroots traditions of the past.

Public-Private Challenge

The challenge with the "family" culture presented in the management of public and private relationships within the boardroom. Discussed earlier, the board members shared of themselves, enabling the development of personal knowledge of each other. Before and after meetings board members would discuss topic of a personal nature: Vacations of SLT, marriages, and baby announcements from CBMs, their college days, their children, and going to school. During committee meetings, it was also common to hear details regarding an individual's healthcare and life experiences regarding breastfeeding, dental visits, and religious activities. Board members in the "family" culture knew other board members and interacted with them socially; but this typically reflected an interaction of CBM-to-CBM, PBM-to-PBM, PBM-to-SLT and *not* CBM-PBM.

In the family culture, the board was perceived to act "like a family making decisions… We have our ups and downs like any other family does" (10C, PBM). These ups and downs were the foundation of the public-private issue discussed by one of the patient board members. One example of the private-public dimension evidenced in the resolution of issues was when board members valued the private relationship – "friendship" – over their responsibility as a board member to speak up on an issue. Individuals who prioritized the private relationship would approach the PBM to ask, "Can you mention this today in your report?" After s/he learned about what happened (and what needed to be mentioned), s/he would say, "No, you tell them." (4A, PBM).

> You have to say what is not acceptable. We have to put it out there, and they wouldn't do it. Because they are so close, they don't know how to hold each other accountable. Okay, so that friendship is more important than-

The example trailed off during the interview, but continued to be developed as a communicative interaction that did not value the work of creating and maintaining a board that held individuals accountable.

Illustrated in another way, the private-public challenge of the "family culture" influenced the style of communication at the time of evaluating the CEO:

> I've known (the CEOs first name) since way back. I know his/her family. But, when I'm at meeting it's, "(Ms./Mr. Last name), CEO of the clinic…" And let's take it from there. It's not: "(first name), my friend that I've known for this time…" You have to learn how to separate (them) and people don't know how to separate. It stays in that personal relationship, and it blocks them from really developing that business relationship, that public relationship. (4A, PBM)

The importance of this private-public relationship was particularly prevalent when evaluating the work of the staff. This became a central component to the evaluation of the CEO (the sole employee of the board) and the evaluation of board members. The board needed to separate the public (i.e., employee or board member) and private (i.e., friendship) relationships. Communicatively using first names versus surnames helped separate the private and public relationships so that the personal relationship did not "block" the development of the business relationship. In other words, a board member saying, "Your performance needs improvement in this area" did not negate the value of the friendship. Public-private challenge extant to FQHC-A and FQHC-B entailed that the simple distinction was not regularly exercised during meetings. CEOs, SLT, and board members were typically called by their first names, except for when that individual was a referenced

as a doctor, specifically a medical doctor (MD) rather than a doctorate of philosophy (PhD). In this way, the board prioritized the "family" culture and the private relationship.

The private-public relationships also surfaced when the board engaged in tense conversations. One participant shared how their chair handled these conversations without losing their temper.

> When somebody challenges him, he has an ability to answer in a way that's acceptable to the person. If he keeps getting tested, instead of losing his temper, he has the ability to draw back and stay with it in a way that is very professional and very nice. He's not rude. He's very good. (19A, SLT)

This quote also speaks to the pull towards professionalism as the board experienced individuals who modeled and encouraged the board to continue to manage private relationships in a professional manner (discussed later in the section for push-pull factors).

"Professional"

The category of the "professional" culture surfaced in the data set after the very first observation at FQHC-B and was developed upon further data collection as participants identified participants used the term "professional" to describe their conversations.

> That's why professional. *I don't like that. It's not that term.* It's not like there's doctors, lawyers, and accountants… It's more – They *are acting more professionally* no matter what their background is… It's maybe sort of more *business-oriented* than it was. The present makeup of our board has *fewer wallflowers,* I guess, than we had before. More people are participating more. We have folks that don't hesitate to question, which is always good. "Why are we doing this? Are we maintaining a focus on our core mission of taking care of those populations that are at risk?" (1C, PBM, italics added for conceptual significance)

"Professional" was the term that participants frequently used first to describe the behavior and communication that was needed regardless of their individual occupations. Digging into the communicative interaction to maintain and build a professional board, the board

members needed to "participate" by asking questions, engaging in conversations, and not act as "wallflowers" by sitting in the meeting and blending in. In comparison to the "family," the professional culture both facilitated the communicative work of governance as participants sought to maintain the professional difference.

Artifacts from Context

The context of the meeting established the following characteristics for the professional board: the professionally produced headshots of board members mounted on the wall of the administration building, the name placards for all board members and SLT, and the number of individuals dressed in business professional (i.e., a suit) rather than simply business casual (i.e., the blouse or collared shirt, possibly a suit jacket with jeans or khakis). Also described in Chapter 3, the name placards were not name tents printed on cardstock paper. The name wedges with names in gold lettering were placed around the table prior to board members arriving at board meetings (though not at committee meetings). The meeting room for the board was labeled "Boardroom" and required key-card access. Staff and board members each had their own identification badges that gave them access to the room and the rest of the administration building even though board members still signed in at the front desk as a visitor. Meals were served buffet style in the catering room adjacent to the boardroom and frequently finished prior to or within 5-minutes of the start of the meeting. Board packets were distributed in folders with the company logo and printed in color for each board member. Three screens projected the slide decks for reports provided by the senior leadership team.

All of these dimensions spoke to the "professional" values extant to the culture. The slide decks, the meeting packets in folders, and the setup of the room indicated a level of preparation required for each meeting. Board members arrived at the meetings ready to eat their meal and listen to reports. Action items followed the practices of voting recommended within Robert's Rules of Order, in a "business casual" manner by not adhering to the procedures "to the T" (6B, CBM). The placement of the names prior to the meeting established a routine, a territory, and a position for each board member. The clothing, whether a spillover from coming to the meeting from work or not, reflected an emphasis on "professional" dress regardless of one's occupation.

Composition Assumptions

The sites that exhibited characteristics of a "professional culture" maintained two similarities within the board composition. First, these boards explicitly stated that they recruited individuals that added a particular professional background, contributing to the diversity of perspectives within the boardroom. Second, and perhaps a byproduct of the diversification of payers, these sites had leadership from a PBM board chair. Within the data set, the contextual factor of board composition emerged as distinctive for both FQHC-C and D, identifying differences between the sites of "professional" culture. The composition of the "professional" culture maintained an almost "indistinguishable" (2C CBM) difference between the PBMs and CBMs as the organization recruited board members who particular professional skills that could fill a need for the board, such as doctors, lawyers, educators, healthcare practitioners, and administrators.

The "Professional" Difference

Within the professional culture, the data presented two dimensions that defined the *professional* difference within the board culture that deviated from the family culture. These two dimensions in the work of communication focused on the varying degree of flexibility in executing meeting rules and the delivery of reports at full board meetings. The difference in executing the rules of order sets forth two excerpts displayed in Figure 2. These excerpts were selected based upon their similarity in that they both were drawn from a committee chaired by a patient board member where both PBM chairs received prompting from a member of the SLT regarding the process for their rules of order. The delivery of reports is developed through highlighting the observational differences between the two sites in who (and how) committee reports were delivered back to the full board.

Table 4: The professional difference

Family (FQHC-A)	**Professional (FQHC-B)**
CBM: Motion approve to?	PBM1: I'm in favor of approving the governance and nominating committee to *meet quarterly with a requirement to meet twice a year*. I'll motion to approve.
There was an extended pause after the motion to approve was prompted. Quick glances exchanged around the table came to rest upon a member of the SLT, who responded:	PBM2: Second. Sorry
SLT: It has to be [PBM X] or [CBM Y]	*It is unclear the direction or motivation for 'sorry.'*
PBM1: Second	PBM1: [name of committee chair]?
There was not a formal statement for a first motion as the question to move seemed to count as a motion. Following the second, there were three ayes stated from the three voting members on the committee.	*A member of the SLT prompted PBM3 – the chair of the committee – in what s/he needed to say to call the votes. The chair repeated the prompting of the SLT verbatim: "All in favor?" "All against?" "Motion approved."*

The scenario presented for FQHC-B, though not executed perfectly, illustrated the emphasis on following the protocol regarding the need for the chair of the meeting to call for a motion, a second, and calling for all votes for or against an item. At FQHC-B, the exact nature of the motion was necessary to include, "I motion to approve *the meeting minutes as presented*." Or "I motion to approve *the meeting minutes with the revisions to who motioned and seconded on items x and y, and spelling corrections*." If a motion was incomplete, then the board member received prompting to add the respective script of what they were approving – regardless of whether it was the only thing the board had discussed during that agenda item. In the "family" culture of FQHC-A, all that was needed was to say, "Motion to approve" or "Motion to approve as amended." The flexibility of FQHC-A

enabled the work of following the rules of order informally in the family culture given more structure as needed at the discretion of the chair on divisive topics (FN 18A).

The second difference in a "professional" culture was observed in the delivery of reports. Regardless of the site, SLT delivered reports at committees and board meetings in an extemporaneous speaking style – with the exception of finance reports that are so saturated with content that a line-by-line presentation required particular attention to the accuracy of the numbers. However, committee reports to the board differed between the sites regarding who and how they delivered the reports. At FQHC-B, committee reports were delivered by board members in the time it took them to read their (frequently typed) description of what the meeting discussed. Very little information was added extemporaneously, and it was unclear whether board members wrote these scripts for themselves or if they were crafted by a staff member. Observational data collected later indicated that, in at least one instance, the meeting report read by board members at FQHC-B were written by staff (see FN 22B). Participants who read these reports did not participate in interviews, therefore the triangulation of data was not obtained.

On the other hand, in the "family" culture, CBMs who chaired a committee delivered an extemporaneous report at the full board meeting whereas SLT delivered extemporaneous reports of committees chaired by PBMs. This distinctive shift reflected the trust of PBMs in the SLT as well as the exacting nature of the information being delivered. One PBM added insights to the report as needed, particularly when the delivery did not require reading information off a sheet of paper. As the board brought on new members, this PBM explained the reason for this work around for the SLT to deliver the

committee report, providing further clarification to the data set and confirmed via interviews with SLT.

"Prestige"

Similar to the category of the "Hippie" culture, participants expressed awareness of a "prestige" culture in other boardrooms that was not reflected in their organization. The *in vivo* label emerged from an interview at FQHC-A.

> If we went back to a full board, we would be a prestige board…So many boards are less about running the business and a little more about, it is prestigious to be on the board of directors. (8A, SLT)

The "prestige" culture reflected a communicative environment in the boardroom where the symbolic meaning of being a board member was perceived as "prestigious" and required less discussion on "the running of the business" or the oversight of operations developed later in this chapter.

Artifacts from Context

Representing a point of comparison with previous or concurrent experiences serving on other boards, participants did not explain any difference in factors in the setting that shaped the "prestige" culture. However, participants indicated that board membership on a "prestige" board was perceived as an honor that came with an expectation for financial contribution to the NPO (1A, CBM | 3A, CBM). One participant reflected how on a different "prestige board" that they felt so honored to be selected for board membership much earlier in their career than originally anticipated. However, when sitting down at the first meeting, there was an envelope in front of every chair, and the first agenda item was

"Everyone make their donation" (1A, CBM). The prioritization of giving as an agenda item also introduces the focus on board member composition developed next.

Composition Assumptions

The composition of the "prestige" board was indicated to represent a board composed of individuals with an ability to give financially to the organization and with industry experience relevant to the organization. This represented a contrast to the sites of patient-majority governance where "90% of individual do not have healthcare experience" whereas a prestige board was more focused with board members who held experience in the industry of the organization (1A, CBM). This also represented a contrast between the financial giving ability of individuals on a foundation board versus a governing board (19A, SLT). The financial giving ability explicitly surfaced within the first month of collecting observations when one of the patient board members initiated pre-meeting conversations with me and shared that there were the millionaires and then there were the patients at the clinic. When planning events, the wealthy donors attended events with hors d'oeuvres and cocktails whereas patients attended events with sandwiches (PBM, FN 4A).

"Big Business"

Representing the final communicative dimension of "prestige" the culture reflected the nature of "big business," or operating budget of the organization. The conceptualization of "big business" drew upon the traditions of governance by typically "conspicuously successful and often powerful and influential individuals, accustomed to leadership roles" (Chait, Holland, & Taylor, 1996, p. 4). Each of the four sites of patient-majority governance experienced a growth in size – both in the financial operations and quantity of

clinics operating under their governance. This growth made the clinics significantly represent an operating margin that reflected a "big business" and an unanticipated consequence of achieving FQHC status.

> I don't think that when the patient-majority requirement was enacted they envisioned the size. We aren't that big, and we're (millions of) dollars. There are hundred million dollars FQHCs out there…who have patient board members with very low business experience. So, I think they anticipated that FQHCs would be much more community based, much more modest in size. (9A, SLT)

The size of the FQHC demanded a particular type of governance and culture. This "big business" impact on culture influenced the selection of board members with the "business experience" necessary to govern a multi-million dollar organization. The lack of experience within the patient-majority board influenced the communicative interaction on the board when board members (PBM and CBMs) asked if the board needed to vote following certain agenda items (17A CBM). The board members with experience identified these as instances of participation not typical to the board of a "big business" with experienced individuals. Although none of the sites that participated in this study presented as a prestige culture, the awareness of the prestige culture in other instances of nonprofit organizing and corporate governance shaped some participants' understanding of their existing board culture.

Cultural Push-Pull

The final component to the model of board culture (see Figure 2) is that of the cultural push and pull experienced by each site to move the board to move forward (push) or draw back (pull) in their culture. On several occasions, participants who reflected during interviews on what they would like to see change were observed as enacting that change in

the next meeting. Whether by raising their hands, verbalizing a statement rather than nodding their head, asking a question, or calling on specific board members, the board members actively engaged in shaping their desired way of how things should work in the boardroom.

Table 5: Communicatively enacting the cultural push-pull

Site	Pull	Outcome	Push	Outcome
FQHC-A	• Desire to preserve the grassroots history of the clinic origin. • Request to reinstate one-on-one meetings to get to know board members	Pursued Declined	• External push to demonstrate board competency to external funders • Screen future board members for their ability to work professionally in a group	Pursued Pursued
FQHC-B	• Desire for "real discussions" • Disclosure of personal information	Practiced	• More structure for meeting participation, such as raising one's hand to speak	Declined
FQHC-C		*Satisfaction with current practices*		
FQHC-D	• Evidence of lingering cliques and drama that hindered the work of governance	Currently being resolved	• Recruit for professional expertise • Training for the board • Fundraising endeavors	Pursued Completed Maintained

With each site depicted as anchored to one cultural category, the push-pull dynamics represent the changeability of organizational culture as participants perceived the culture in relation to their individual experience. The following sections depict the push-pull dynamics at each site as developed using constant comparative techniques (Corbin & Strauss, 2008; Glaser & Strauss, 1967) between organizations. The comparison between organizations identified the following overlapping elements, framed as a desire to change the board culture rather than an unresolved cultural tension in the board.

FQHC-A

The analysis of interview and observational data from FQHC-A led to the conclusion that FQHC-A was anchored within the "family" culture with a push and pull dynamic as the members expressed desires to shift and maintain the value of communication patterns in boardroom. The dynamics of a pull were motivated by a desire to preserve the history of the clinic and to bridge differences between PBMs and CBMs. The pull back to the "hippie" reflected how the "grassroots" nature of the organization made the FQHC unique to their community and to their staff (FN 5A | FN 13A). There was also a desire to reinstitute the use of five-minute, one-on-one conversations with fellow board members at the beginning of each meeting (4A, PBM), a practice that was phased out to make time for the work of the board (1A, CBM | 4A, PBM | 9A, SLT). The *push* towards the "professional" culture at FQHC-A countered these efforts as the board needed to demonstrate competent leadership of the board to private funders (3A, CBM) or as an absolute need in order to resolve board issues by screening PBMs for their ability to participate professionally in a patient focus group (19A, SLT | 1A, CBM | 4A, PBM | 6A,

PBM). The pull dynamic back to the "hippie" culture is thus represented as a dotted line as the request to reintroduce one-on-one meetings was declined by leadership. The push dynamic into the "professional" culture has been represented as a solid line indicating the board implemented more efforts emphasizing "professional" communication in the boardroom.

FQHC-B

The placement of FQHC-B within the "professional" culture presented early in the collection and analysis of data, a conclusion confirmed in later stages of analysis. Anchored within the "professional" dimension, the organization experienced a cultural pull toward the dynamics of a "hippie" and "family" culture. The pull towards a hippie culture was expressed by two board members in retirement that desired to engage in longer meetings where they could engage in "real discussions" (1B, PBM | 2B, CBM). Historically, board meetings could last four or more hours, but professional structures facilitated the shift towards shorter meetings (3A, CBM). The pull towards a family culture was indicated by two participants who indicated the board felt like a "family" (9B, SLT | 10B, CBM) as SLT made sure that PBMs were connected to necessary services, even being known to pay for medication of board members from their own pockets (9B, SLT). In conjunction with the cultural pull, the board also experienced a push towards a more professional board. Participants at FQHC-B expressed the desire to push the board forward into a formal board that implemented Robert's Rules of Order to "a T" or have people raise their hand in order to take a turn to speak (2B, CBM | 6B, CBM). Representing an idea that was declined by the board, the desire represented a weak push.

FQHC-C

Depicted visually in Figure 2, FQHC-C (an interview-only site) aligned just slightly to the right as "very professional" (3C, PBM). Meetings were kept on time with the agenda and were shorter in length than FQHC-B also anchoring them closer to the "Prestige" culture. In contrast to the other sites that experienced a push-pull dynamic, the four participants from FQHC-C did not indicate a desire to shift the culture of the board. Rather they indicated that the current culture of the board was reflective of an intentional strategy necessary for the financial sustainability of the clinic (2A, CBM). Their culture provided opportunities for board members to learn personal information about each other during committee meetings. The board members all expressed satisfaction with their current board; therefore, the site is not represented as experiencing a push-pull dynamic in the model of board culture (see Figure 3).

FQHC-D

As depicted in Figure 2, FQHC-D (an interview-only site) anchored between the "professional" and "family" board culture. The pull towards a more familial culture represented the drama and personal knowledge of fellow board members. Cliques extant to the "family" dynamic reflected a prioritization of the private relationship as board members took "their own personal vendettas into consideration in their decision making" (2D, PBM | 3D CBM). On the other hand the cultural push towards a more "professional" culture was evidenced in the dynamics of board composition, fundraising, and training. Discussed previously in Chapter 3, board members were predominantly middle to upper-middle class individuals with approximately two-thirds of the board members receiving

healthcare at the clinic. In fundraising, the board experienced a push towards the prestige factor as board members donated their "meaningful" contribution of an auction item, such as an international hunting trip for four. Finally, the board underwent an intensive day long training to build up the competency and qualifications of the board indicating a length of training not identified at the other sites of patient-majority governance.

Summary of Building the Culture to Govern

The culture of the board modeled in Figure 2 addressed the influence of context in establishing artifacts of communication and the board, the assumptions behind board member composition, and the valued ways to communicate within board meetings. These features echo the values, artifacts, and assumptions extant to an organizational culture as defined by Keyton (2005). *The "hippie" culture* valued the open participation in board meetings (assumptions backing board member composition) as a way to align with the assumptions of the grassroots and bottom-up approach of the founding volunteers. The hippie culture represented an artifact of the organizations past – a "charming…function of its time" reflective of humble, shoestring beginnings. *The "family" culture* valued the participation of socioeconomically diverse board members (assumptions backing board member composition), where individuals knew more personal information about board members resulting in an identifiable socioeconomic diversity (values of communication). The meetings generated artifacts of agendas and board packets with procedures to help keep the meeting time between one and two hours. *The "professional" culture* assumed a composition of board member participation where there was an "indistinguishable difference" between patient and non-patient board members. The patient board members

needed the experience necessary to govern a "big business." Also, the meeting artifacts of "professional structures" (e.g., agendas, shorter meetings) facilitated the assumption that the board was engaged in professional communication. Finally, *the "prestige" culture* represented the value extant to traditional forms of board leadership composed of wealthier individuals that lacked engagement in operations, emphasized order and procedure, and communicated a position of status for board members.

Each site of governance in this study experienced a transition in the board composition that initiated a shift in culture. The newness of the board meant that issues faced within the boardroom were *de facto* and new, without a precedent on values, artifacts, or assumptions that were relevant to guiding interaction. Even for board members with previous board experience, the culture and composition of a patient-majority board demonstrated substantive differences from participant's previous (or concurrent) board experiences. The current state of the cultures anchored within the "family" or "professional" culture reflected of significant level of either quality or quantity of board member turnover. The commitment to shaping the culture of the board was reflected in perceiving resignations of board members as essential to enabling change.

The fluidity of board culture identified in this study is represented as a push-pull dynamic. Board members made requests to shift the communicative interactions to either pull back towards a "family" culture (e.g., sharing personal information) or a "hippie" culture (e.g., one-on-one meetings, longer meetings). Board members requested to push the board towards a more "professional" culture (e.g., more experienced board members, shorter meetings) or a "prestige" culture (e.g., formalizing Robert's Rules of Order and

turn-taking). The explicit or implicit request to shift communicative interactions on the board signified an approach that could subsequently shift the culture, the way things worked on a governing board.

Board culture as a category of the communicative work of governance signifies that culture is not developed through passive communicative interaction that accepts traditions and patterns of communication defining how to interact on the board. Instead, culture is an active reflection on how to be a part of the organization and choosing which communicative norms to uphold and which communicative norms to change. These efforts signify the importance of culture as a communicative process "in determining how board members behave and, to some extent, circumscribes their effectiveness" (Pye, 2004, p. 83) in achieving governance. Therefore, the culture is part and parcel to completing definitive tasks associated with governance (e.g., duties of care, loyalty and obedience, see Frumkin, 2002; Hopkins, 2003). The next section shifts from the culture of the boardroom that emphasized how things work to address the original RQ1 posed at the beginning: What is the communicative work of governance? What do boards talk about when overseeing operations? How do they talk about their work? The following section answers these questions as the the communicative work engaged by SLT and board members in defining the relationship of the board to the organization, specifically the overseeing clinic operations.

DEFINING GOVERNANCE OF DAY-TO-DAY OPERATIONS

Eadie (2001) proposed that the oversight of operations was being undertaken by more nonprofit boards, yet few studies have examined how a board oversees operations

within a governing board rather than engaging in operational activities as a "working board" (see Chapter 1; Brown & Guo, 2010; Masaoka, 2009). The task of defining the scope of governance within operational activities was something that board members and senior leadership needed to define. Many participants commented on what they felt governance of operations should be based upon their experiences and reading materials.

> Once you read that document [I sent you], you'll understand what governance means, especially [for] the patients that are on the board. We don't do a real good job of that. Basically, because staff asks us to ... I'm trying to pick my words very carefully here ... give our blessing to their actions. In other words, their management decisions they're asking us to (say), "Okay." That is not governance. (1B, PBM)

Participants at each site of patient-majority governance held distinct perceptions of what *should* represent the work of governance, regardless of whether their board fulfilled these expectations. Informed by industry articles, previous/concurrent board experiences, and behavior modeled by other individuals in the boardroom, interview participants reflected on the communicative nature of effectively overseeing the operations of the organization. One board member illustrated the work of overseeing operations of a clinic by using a sports analogy where the board stood on the sidelines of a game being played by the senior leadership team.

> From what I can tell in our organization, we're along the sidelines of their route, of their path. As they come by, we're yelling at them, "Hey, you need to make sure…" Then they're trying to focus and do their daily job. They're getting paid, and this is their career, their livelihood. We're on the sidelines… If you're committed, you're on that sideline… Instead of just staying put, you're throwing stuff at them as they go by. (6B, CBM)

Positioned on the sidelines, the analogy introduces the tension of how participants defined the communicative work of governance, particularly for the oversight of operations, a key component of their work.

As the board governed from the sidelines of the game, participants noted the importance of being careful to not join the game – to *not* micromanage the staff. Micromanagement in governance echoed characteristics of micromanagement in management studies where it is defined as an intent to control the process rather than the outcome (Wilkins, 2014). Micromanagement within the context of the boardroom is not attached to the frequency but directly linked to *how* board members engaged in discussions of operations. Any single act of declaring what *ought* to be done or *ought* to have been done already by staff may result in micromanagement depending upon the *how* it is stated. The significant reason for not defining what *ought* to be done by SLT needed to implement to achieve outcomes reflects the difference in the level of connection to the day-to-day operations. The board of directors do not work within the day-to-day operations of the organization. Attending 40-50 meetings a year did not generate an experience base that enabled board members to fully know all the decisions and implications of decisions made by SLT and the staff. Instead board members knew the high level, the *30,000-foot view* of the organization, with occasional "*deep dives*" into particular issues.

The conceptual development of the communicative work negotiating the boundary between oversight and micromanagement emerged within the data set as participants described what they could (and should) do as a board. Participants expressed a concern with micromanaging, but identifying specific instances of micromanaging during the

interview was easier said than done by participants. The challenge with identifying the boundary was influenced by the information provided by the staff, the level of interest in particular health or organizational topics, and or the byproduct of an organization not achieving goals desired by the board. With the participants' difficulty in defining the boundary with examples, the following analysis draws upon observations of instances reflecting definitions within interview data. The dimensionality for the communicative work of governance and/or micromanagement notably drew upon the following events: *Monitoring measures and metrics, exploring issues with a "deep dive,"* and *experiencing the (patient) tension.*

Monitoring Measures and Metrics

Each site of governance monitored a monthly report of organizational outcomes measured by the clinic in their "dashboard." Separate from the financial report, the "dashboard" summarized metrics of the organization and patient population in a visual display distributed via handouts to the board. FQHC-B also provided dashboard material within the slide deck as it pertained to relevant agenda items. Organizational metrics frequently included items such as annual employee satisfaction scores, staff turnover rates, vacancies, provider productivity, gross (and net) cost per encounter (i.e., the cost of delivering care for a single visit to the clinic). Patient metrics reflected information on the quality of care (e.g., patient satisfaction surveys) and quality of health (e.g., vaccination rates, diabetes and hypertension, HIV/AIDS).

Observation data at both FQHC-A and FQHC-B reflected a level of board member uncertainty regarding who set the goal for each dashboard item. The following excerpt

captures a conversation regarding a measure that dropped from 90% to 63% in a single month due to a change as the federal government redefined criteria for calculating the measure (i.e., expanding what vaccinations needed to be given to patients by the age of two).

> CBM: I was going to ask a question, when HRSA, the feds give us benchmarks…If you aren't hitting that measure, then we look like losers…
> SLT: Two things: HRSA doesn't set goals for performance measures, we set those… (FN 18A)

Seven turns later, the conversation returns to asking about the measure, only this time whether the measure reflected a compliance requirement.

> CBM 2: Did I understand you say that there was a change in terms and we fell out of compliance?
> SLT: Not out of compliance….It's a more stringent measure [now]. It's not a compliance measure. (FN 18A)

Just three months prior to this meeting (FN 8A), SLT also iterated the difference between HRSA requirements and measures monitored by the board. The uncertainty was also phrased in different ways (FN 12A).

> CBM: The 45% is that our personal goal?
> ----
> PBM: Is this one of the things we aren't meeting for HRSA?
> CBM: Internal goal but not HRSA

The concern with meeting HRSA requirements represented a significant component of patient-majority governance. However, many of the goals set within the dashboard reflected goals set by the clinic rather than HRSA.

At times the board questioned the attainability of goals that consistently missed the goal or experienced a sudden drop in achievement (FN 14B).

CBM: …I want to talk about [this metric]…We have our new targets…I wanted to know if we will get back to our target or should we change the target.
SLT: That's a great question…

The pattern of questioning exemplified within the excerpts above and the examination of measures and metrics reflected a consistent questioning of goals surrounding measures and metrics initiated by CBMs. Each of the CBMs in these scenarios also worked within the healthcare industry. Asking questions about the origin of the goal and potential compliance requirements ensured the board understood the measures and metrics reported to the board. Goals for the measures and metrics reflected outcome stipulated within grants (e.g., state, local, federal, foundations, and private donors), a "challenge goal" established by the organization, or an item that concerned a board member. Throughout the data set, the discussion three specific topics referred to as metrics regarding *vaccinations, reporting requirements, provider productivity,* and *cost-per encounter* illustrated the scope of communicative work of governance in overseeing operations versus micromanaging operations. Each of these scenarios develops the way that the board members and staff spoke of who and how the work in the clinic was determined.

Vaccinations

Halfway through the data collection, the Uniform Data System (UDS) redefined how the FQHCs measured vaccination rates of patients from birth to two-years of age. (*Note:* Please see excerpt from observational data provided above). SLT prepared their board (at both FQHC-A and FQHC-B) prior to altering the calculation used to determine the dashboard number by explaining the upcoming and substantial drop (almost 30%), and what the clinic would do to improve their performance. SLT also informed the board that

clinics across the country experienced the same shift in defining vaccination metrics of pediatric patients. After the change went into effect, CBMs with medical background indicated that the goals for these metrics may need to be re-evaluated by the SLT for the board to approve.

Within the discussion of vaccinations, the boards in this study exercised a practice of effective boards identified by Chait, Holland, and Taylor (1996) by asking for benchmarks. How did their clinic compare to other FQHCs at the local, regional, and/or national level? By discussing the outcomes of vaccinations in relation to benchmarks and definitions set by federal regulating agencies, the board engaged in governance rather than micromanagement. Oversight of the operations reflected understanding that changes at the federal level influenced the organization. Despite the upcoming and substantive drop in the organization achieving their dashboard goal on vaccinations, the board did not define the actions management needed to take to re-establish the previous performance. Understanding the change in relation to a national shift experienced by FQHCs nationwide, the board continued to monitor the metric and asked questions about the process of pediatric vaccinations up through age two.

Reporting Requirements

The second example examined a policy regarding provider reporting requirements, an organizational step towards resolving an issue in operations. The excerpt from a committee meeting at FQHC-B exemplifies this discussion furthering the use of benchmarks to determine effective policies for operational tasks (FN 20B):

SLT 1: Lack of timely documentation…really, what we are doing here. We have a whole committee devoted to this…but basically it's creating some standardized reporting…and of course the accountability piece

PBM asks a question of CBM 1 as a side conversation

SLT 1: …And so that is a process that is underway right now…

CBM 2: This first sentence… I think 84 hours is way too long…it needs to be closed out that day…

SLT 1: That group has looked at some other groups with similar policies…we see 3-4 days…

SLT 2: 48-72 hours is standard...

The participant's initial thought that 84-hours was too long was confirmed when SLT reported that the national benchmark was between 48- to 72-hours. The conversation continued and the CBM expressed concern that in the time allowed within the policy "we could lose out on billing" opportunities due to incomplete charting. The financial connection made by the board member represented an effective way to exercise fiduciary responsibilities not consistently or equally understood by all board members (8A, SLT | 9B, SLT). The CBM in this scenario with a background in the healthcare industry enacted what s/he perceived as an important in overseeing operations – to ask questions.

> When I started on the board, it didn't seem like anybody asked very many questions. There was a lot of presentations, but not many questions… I decided I would. I started asking questions and reading the reports carefully, trying to get people thinking about what we were doing…and what results we were getting. (2B, CBM)

Questions about benchmarks represented effective oversight of metrics as well as the policies defining operational practices. The policy was implemented without any changes as the SLT indicated they needed to implement strategies to improve workflow to enable improved policy on reporting requirements in the future. The policy represented an initial efforts towards improved reporting timelines. The process of requesting information on benchmarks reflected a practice of effective boards at academic institutions (see Chait,

Holland, & Taylor, 1996) and further illustrated communicative work of governance to ask questions to get people thinking about how the clinic performed in relation to other clinics at the local, state, or national level. However, the measures and metrics for provider productivity and cost-per-encounter illustrated how both FQHC-A and FQHC-B crossed the boundary of governance into micromanagement.

Provider Productivity

Participants at FQHC-A and FQHC-B identified provider productivity as a metric prone to micromanagement. Provider productivity measures how many patients a provider sees per hour for services that may be submitted for billing (i.e., revenue). Although provider productivity was deemed an important measure to monitor, the complexity of the measure lent itself to micromanagement. Circumstances in the clinic may exacerbate the measure of provider productivity when there is a "lack of space" in the clinic (1A, CBM). Circumstances of delivering care to the safety-net population may also distort the number. For example, FQHCs provide services to a population that operates outside the default mode of health care. For a patient with a heart issue or high blood sugar, "you can't just tell them to eat better" (1A, CBM). Instead, providers needed to spend more time with the safety-net and "indigent" population (2D, CBM) to get to the heart of the issue and provide quality health care. The complexity of delivering services to thousands of marginalized patients was reduced into a single number once a month to measure how many patients a provider saw, stripped from the narrative of delivering care.

Board members may seek more information to help understand the context and factors contributing to a decrease or a static level of provider productivity, within an

appropriate boundary. For example, at FQHC-B a board member sought to understand more about the issue with provider productivity by asking about the formula used to calculate the measure. SLT provided the formula while at the same time saying, “This is not really your role as a board member to know this level of detail of information” (8B, SLT). In this scenario, the interaction between SLT and the board member explicitly established the boundary between oversight and micromanagement by defining the role of the board (oversight) and the role of the staff (management).

Cost-per-encounter

The second metric constructing the boundary between micromanagement and oversight of metrics was that of cost-per-encounter. Cost-per-encounter is defined as the amount of money the organization spends to provide services to one patient. From the perspective of SLT, board members expressed expectations in the clinic that presented conflicting outcomes for the cost-per-encounter.

> Personally, it makes me nutso when they want to rail on cost per encounter as if we don't know how to reduce that. Yet, when we're asked to add a mobile service, we say, “We don't think this is good idea because it's elevating our cost per encounter.” They're like, “Oh, but this way you get to see these people out in these rural areas.” We're saying, “Yeah, but not that many of them. They're not very responsive.” They say, “Oh, but everybody in the community loves it.” You can't have it both ways. (9B, SLT)

The board could not have “it both ways;” they needed to choose the strategic direction. This dimension for the communicative work of governance required the board to effectively engage in the mission-market tension identified by Sanders (2013). Board members desired continued community outreach (i.e., mission orientation) that effectively increased cost-per-encounter (i.e., a market orientation). SLT stood torn between the

contradictory expectations for operational outcomes that could not be "both ways." SLT clarified that the decision to reduce community outreach reflected the cost-prohibitive nature of the effort; however, the board did not withdraw their expectation for continued community outreach. "I'm just thinking, if we are doing well at it, what can we do to grow it" (PBM, FN 1B,). Micromanagement reflected a competing expectation on how the SLT should achieve two interrelated measures in which one counteracted the efforts towards reducing cost-per-encounter.

One factor accompanying the competing expectations reflected how the two board divided the work of monitoring these outcomes into two separate committees. Board members explicitly emphasize decreasing the measure as discussed in detail during the finance committee (cost-per-encounter). However, board members in the operations oversight committee simultaneously discussed increasing a cost-prohibitive outreach program. Discussing dimensions of the same measure in separate committees was also a component of micromanaging the provider productivity at FQHC-B (FN 19B) and represents a consistent issue in studies of governance when "several committees, unbeknownst to the others, discuss interrelated aspects of the same strategic problem" (Chait, Holland, & Taylor, 1996, p. 127). This focus on discussing the details of organizational problems is further developed as an effective practice for governance, within the boundaries of a "deep dive" developed in the next section.

Engaging Issues with a "Deep Dive"

Digging into the day-to-day operations of the clinic was a common occurrence deemed more acceptable within committee settings where the board engaged in a "deep

dive" into the challenges and issues being resolved by SLT. The "deep dive" into the details of day-to-day operations represented a significant component of the communicative work of governance as the board and SLT defined the boundaries of when and how it was appropriate to discuss the details of day-to-day operations. The measures that provided a 30,000-foot view of the organization each had a goal that was sought to be achieved (e.g., a 4.2 average on a scale of 1 to 5 for patient satisfaction). Discussion within the boardroom questioned whether the goals were achievable. At FQHC-B, the SLT and two board members questioned whether it was reasonable for the board to maintain the currently defined goal for measures on patient satisfaction. At FQHC-A, a CBM speculated that the goals for patient satisfaction should be lowered as a perfect score did not necessarily provide valuable information for the clinic. For every measure and metric in the dashboard, the board asked questions that sought to understand why the numbers dropped, did not improve from the last month, or did not move closer to that idealized goal charted on the dashboard. The numbers in relation to the goals and historical data represented a source of meaning for the board members.

The issue with metrics and improvement in an organization presents significant communicative challenges within the boardroom.

> I think that is a communication problem. Because if you get bad results, you have to spend a lot of time talking about how you got there. Not how to fix it, but why it didn't work. (2B, CBM)

The problem was that it took time for SLT to measure, evaluate and communicate why the improvement worked, did not work, or partially worked to achieve the expectations of the

board members. The resolution to the communication issue defined the communicative norm for discussing outcomes and strategies of improvement in the committee.

Take the deep dive in the committee

One of the boundaries that SLT sought to establish was that discussions of certain topics, namely issues, needed to take place at the committee level.

> We've been trying to say this is a topic that can be taken up at the committee level. We could come back to you with some reports of action taken or whatever. The board should set the overall direction. We want the no-show rate to be 15% or something like that. That's your strategic direction. You can say, "What actions have you taken to get there? Are you considering other actions?" To get into the intense detail of, "Well how do you calculate it? Is it worse at the east or west clinic?" That sort of stuff can be taken up with the committee. That's where we try to make that work. (8B, SLT)

Pushing the conversation down to the committee level where the "real conversations" (4A, PBM) took place, the SLT extended the timeline for the discussion in a way that enabled them to prepare a report of what they wanted to say to address the concerns raised by board members. In the meetings at FQHC-B, the SLT typically negotiated for the discussion of the report to take place six to eight-weeks later. Based upon observations and triangulated with SLT interview data, the negotiation for a delay was not designed to create more time for change. Rather, the delay was needed to complete the work necessary to comply with the board's request.

> I think this past committee meeting was a great example. They had asked, "Hey can show us this broken out by age at the next meeting?" And so, for this meeting our analyst did about ten, fifteen hours of work to break it down by age and folks felt listened to. We brought this back, and we talked it over. Is anyone going to actually do anything with that information right now? No. (8A, SLT)

A simple request for examining the breakdown of breastfeeding according to age of the mother increased the workload of the staff to produce information that would create no actionable result, shifting time away from working for the clinic to working for the board. The deep dive in the committee, the provision of an additional report, appeared to be an acceptable practice for the work of governance. However, once a board experienced a "deep dive" into "the weeds" of operations where there was no actionable item for the board to vote on, someone needed to initiate that transition back into the 30,000-foot view appropriate of governance.

Getting back to governance

Developed earlier in Chapter 3, SLT frequently facilitated the conversation back to the 30,000-foot view of governance by streamlining a response to a question into the next presentation point, without a pause and without creating a space for another question. One participant shared the following example of how they would occasionally step back from "the deep dive" to observe the process:

> I watch sometimes… I'll play the dummy…When our banker and our CPA and the CFO are really getting into the weeds about amortization schedules and stuff like that. It's, "Guys, does that mean we're making money or we are not?" (1C, PBM)

The chairs of the board and the committee also facilitated moving this conversation back up to the 30,000-foot view would frequently would complement the value of the contribution, and summarize the board's expectations of management. For example, the chair at FQHC-A flipped a question into a statement, "You know, I think that's a good question. Say, 'Thanks to this fantastic management of our clinic…' so they know their money is well spent" (FN 19A). At FQHC-B, the chair followed a lengthy discussion about

a negative newspaper article by saying, “Just for the board to summarize what we are asking the staff… create a plan to reach, to control the message. Let’s not react to these things” (FN 1B).

Chairs reflected on the challenge of identifying when to step in and close a conversation without hindering the ability for board members to express their views on an agenda item.

> One of the things as a board chair that comes up is probably communication and it's probably the hardest thing in being the chair. That is when a discussion gets going… Letting [it] go far enough that everybody feels like they've had their say, but not to let it get out of control or to let it become repetitious… Sometimes that line as to where do you step in and say, “Okay, I think we need to move on.” (1C, PBM)

Interview participants felt their chair negotiated this timing effectively. These transitions and high level summaries of the deep dive helped monitor the extent of micromanagement as the deep dive consistently involved the exchange of ideas as well as declarations of actions that could (or should) be taken by staff, ideas that could also emerge after the meeting (7B, CBM). The pursuit of improvement in the measures and metrics also required SLT to engage in more boundary development to prepare board members for the timeline to enact change. The communicative work of governance overseeing operations in times of implanting changes in the clinic was limited to monitoring strategy and outcomes rather than assigning who and how clinical changes should be executed. Board members interacting with SLT engaged in communication necessary to understand the work being done by SLT and the clinic staff instead of defining the steps that needed to be implemented. SLT responded to requests for additional information even up to

implementing specific changes required by PBMs (e.g., the hours of operation for the phone line) but also expressed a limit to the role of the board member.

Understanding the timeline of change

A challenge with effective oversight was understanding the timeline for change of metrics or measures followed by the board. For example, clinics reviewed A1C measures on a monthly basis even though the test itself had a cycle of 90-days, the lifecycle of a red blood cell. In months when the measure experienced a "downward trend," any change implemented that day could take three months to demonstrate improved outcomes on the board's dashboard. Not seeing change between meetings at FQHC-B, the committee continued to explore and perhaps request new strategies to improve the measure without knowing if previous strategies created a positive outcome. The discussion of this resolution frequently morphed into the discussion of no-show rates, as patients who missed lab appointments impacted the ability to collect data to demonstrate improved outcomes. This problem-solution oriented deep dive introduced the tension of the "ought" extant to the boundary between management and oversight.

The "ought" of micromanagement

Resonating with the experience of SLT, micromanagement was not necessarily born out of negative intentions but out of the natural tendency for governance to go "off the rails" as board members indicated that their idea "ought" to be the strategy implemented.

> It can get there… For example, you're going to implement text messages to help with the no-show rate. Asking, "What's your progress on that?" Is not necessarily micromanaging. When you get down to saying staff *ought* to do this strategy. "You

> ought to do that strategy. What steps are you taking with that?" Then sometimes things just go off the rails. You know? That's humans. (8B, SLT)

Central to the communicative work of governance, board members could and would follow-up on the progress of improvement strategies without micromanaging the staff. Board members that defined what ought to be done to change any element of the way their clinic operated entered the realm of micromanagement.

The following excerpt (FN 8A) identifies an effective practice of asking about progress (i.e., following up) without stipulating what actions needed to be taken by staff on how to improve patient health outcomes on hypertension.

> SLT: The only real change was the hypertension (on a downward trend)
> CBM: Weren't we going to look into the barriers on that?
> SLT: We have. We are. But we haven't made any progress.

Following up on a discussion from a committee meeting two months prior to this meeting, the CBM provided additional points of contact for the SLT to use as resources towards resolution. No further follow-up on the issue occurred during the time of data collection. There was no follow-up after this point on whether or not the contacts had been reached as the strategy towards resolution was left in the hands of management. The deep dive could provide resources to staff (or not), but the strategies to implement any organizational change needed to remain in the realm of management and not oversight, as demonstrated in the next dimension.

Implementing change as the work of operations

As the boards engaged in a deep dive at the committee level, one concept that surfaced towards the very end of data collection challenged whether solving operational

issues was suitable for a committee of the board. Drawing back to the amount of time spent on site by board members discussed at the beginning of this section, board members, even patient board members, were removed from the day-to-day operations of the clinic. After experiencing several months – perhaps much longer predating the time of data collection – of deep dives into the realm of management, SLT discussed the strategic initiative of shifting the work to where the work needed to be done – an organizational committee.

> It's nice to have a committee of the board…but (the organizational committee) it needs to be a get down and dirty. What are the metrics? What are the problems? Who are the owners? Are they at the table? …it's great to have board members present so they see a purview of the organization… they can bring anything they feel is critical back to the board…But, these are intensive meetings…The reason to keep it to two or three (ex-officio board members) is that if the committee feels like it's meeting for the board, we lose the working function of the committee … we really need to have this be work first... (SLT, FN 19B)

SLT clarified during a committee meeting focused on the oversight of operations that improvements requested by the board required operational changes. These operational changes needed to be strategized, discussed, and determined by the "owners" – the departments and staff responsible for executing the day-to-day operations of the clinic. The presence of board members in the operational committee would shift the meeting away from "work first" and "lose the working function of the committee." As explained by SLT during the meeting, the conversation at these meetings would be "messy" and more detailed than information necessary for board members to know about the operational activities. The presence of board members would impose an atmosphere of reporting to board members rather than resolving the operational issues. This shift defined the level of involvement for board members in governing operations. One or two board members could

sit in on the meeting to report back to the board, but the participation was not expected to be actively making recommendations of what the management should do to fix issues. Instead, resolving operational issues was the work of the staff. (For a study examining the work of paid employees resolving issues of day-to-day operations of an organization see Barbour and Gill's (2014) work on status meetings.)

The boards' limited involvement in the organization prevented them from being able to see the complexity of the existing system, a pattern of governance that could (and did) result in unnecessary board action. For example, the organization previously experienced a time when an ad hoc board team developed recommendations to improve "customer service" complete with approving a six-figure training cost to be completed by a third-party. The decision was reversed the next month when the staff informed the board that the SLT plan – developed prior to the creation of ad hoc board teams – was comparable in strategy at one-fourth the cost of the board's recommendation (8A, SLT). This scenario reflected an importance of not micromanaging the operations of the clinic (i.e., requiring a training for staff based upon limited contact with front-line staff). Board members who are not involved in the day-to-day workings of a healthcare clinic were not able to identify the most fiscally responsible action plan to address the needs of the clinic.

Summary of Deep Dive Findings

These examples demonstrate that the "deep dive" in the committee was considered the appropriate location for the board to discuss clinic issues. However, a board could still engage in micromanaging clinical operations if they defined and assigned tasks to staff and other individuals of the senior leadership team. Oversight within the context

communicative work of governance examined in this study did not engage in the type of procedural communication examined by Lehmann-Willenbrock, Allen, and Kauffeld (2013) or the definition and assignment of operational tasks examined by Barbour and Gill (2014) within status meetings. Instead, the communicative work of governance in overseeing operations *as a board* was to understand the issues, the strategies for improvement, and wait for the outcomes of those strategies to be realized by the clinic.

A "deep dive" in committees enabled board members to understand the strategies and solutions implemented by management without defining operational strategies for the SLT. Through the efforts of preparing a report, SLT sought to craft the information in a way to guide the conversation towards the discussion of the issue, the strategy, and the outcome, transitioning between the deep dive and the 30,000-foot view. Within the deep dives, the board needed to maintain an approach of follow-up rather than explicitly defining what strategy "ought" to be done. Particularly with the realm of driving operational change, follow-up from the board was determined to be more appropriate than a committee of the board designed to deliver solutions to the SLT, clearly defining the scope of oversight versus micromanagement of operations. However, not all board members encountered the same challenges within the communicative work of governance. Patient board members, due to their firsthand experience of receiving services at the clinic, introduced the communicative norms for overseeing operations as a patient.

The (Patient) Tension

The firsthand experience of PBMs with clinic operations placed them directly into communicative interactions with staff (not SLT) and other patients, an interaction not experienced by non-patient board members.

> Just by definition, it sets up some tensions. Patients connect with their experience of the clinic. What was it like to call into the call center? How long did I wait? Do I like my provider? Was the MA polite to me? But if the board's first duty is fiduciary and the golden rule of board management is we don't get into the details, then- . But the details are the patient's experience, right? (8A, SLT)

The distinction between the details of the day-to-day operations (as experienced by PBMs) versus the 30,000-foot view provided to the board, represented the tension for PBMs in defining governance in the patient-majority board. Details discussed in the deep dive in committees were the very components of the patient experience that helped PBMs feel connected to the work of the board.

> They really want to feel connected. They want to feel like they have valuable input. And so how do we create a structure and a set of priorities, where they can both leverage that patient experience, which is a valuable, and function at the high level that you really need a board functioning? It's an interesting tension. (8A, SLT)

The final dimension of the communicative work of governance examined where this experience fit within the oversight of operations navigated by PBMs and SLT to maintain a position of oversight rather than micromanagement.

Operations front-and-center

The first step in examining the patient tension within the communicative work of governance examines the benefits of the patient presence discussed by interview participants. First, the presence of PBMs authenticated data and reports delivered by staff

to the board, representing a type of member-check used within qualitative studies (Lindolf & Taylor, 2011).

> The inclination in other organizations, having been in business for a long time, is that a lot of information gets whitewashed when it goes to the board. This prevents that. It helps keep the actual day-to-day operations front and center. If they pipe up, and say, "Well, the wait for this service-." (17A, CBM)

Dashboard data that "gets whitewashed when it goes to the board" marked a concern of CBMs drawing upon their professional (non-board) and other board experiences. The presence of a patient at the meeting who listened to the data provided a fact-check that a purely non-consumer board could not provide. Patients comparing the numbers to their own experience could speak against any apparent forms of "white washing." Throughout the course of data collection, the PBMs never reported a time when they needed to correct the information provided to the board.

The benefit of credible dashboard data was tempered by acknowledging that a PBM represented one individual among thousands of patients. The PBM may only have direct experience at one clinic with one doctor, one medical assistant, one nurse, one social worker, etc. The dashboard data represented the 30,000-foot view of all clinics, all staff, and all operational items monitored by the board. Sometimes a PBM did not have a direct experience that aligned with patient health outcomes reflected in the dashboard, such as the example with breastfeeding.

> That's really been a big concern, and has always been a concern for me, I want more women breast feeding. I want that fixed. I want it high. It's free. Come on lady. If you are in poverty situation, it doesn't get any better than that. (6A, PBM)

This example illustrated a dimension of when the perception of what a PBM felt ought to be contradicted the actual practice of patients.

Micromanaging to improve experience

When the issues aligned with the PBM experience, there was a careful need to negotiate the line between micromanagement and operations. One poignant example involved a PBMs concern with the hours of operation for the clinic's phone line.

> PBM: What time do the phone banks shut down? 5?
> SLT: 4:30
> PBM: I still have a concern that we should keep the phone lines open until 5…just a suggestion.
> SLT: Sorry, we shut down at 4:30 because you wanted us to stay open during lunch…
> PBM: rotating lunches
> *SLT: Two members of SLT explain that the staff responsible for answer the phones needs time to return calls at the end of the day, sometimes extending their shift to return calls.*
> PBM: just people trying to get in…*they need to have someone answer the phone.*
> *SLT: They elaborate that* "it sounds black and white but it's not." *There are items that need nurses to follow up, and with greatly reduced staffing, there needs to be a cutoff point to get caught up. The topic drops as the PBM initiated a closure to the discussion – not pushing any further.*
> PBM: More [name of the SLT]?

After implementing a specific operational strategy requested by the PBM, the SLT now received a "suggestion" to change the strategy again to keep the phone lines open longer by using staggered lunches. What is significant here in determining and identifying the boundary between operations and micromanagement is that the SLT member explicitly stated "We did X because you said Y." There was an "ought" and an explicit statement of what actions management should take to resolve the issue.

The significance of this instance of micromanagement exemplified how a PBM desired specific changes in the organization to accommodate the needs of all patients without clearly understanding the implementation process. As stated by SLT, the change "sounds black and white, but it's not." The SLT working with staff on a daily basis saw the needs of employees whereas PBMs may only see the need of a patient. However, PBM only see the operation of the clinic when visiting the clinic anywhere from once a year to once every month. The complexity of the operations was not black and white, and SLT needed to examine how implementing one change influenced other areas of operations in the clinic.

Managing complaints

Another tension to navigate in the boundary between operations and oversight unique to patients was *when – or if – staff or patients ask you to make changes.* "You (patients) can't promise to change anything" (1C, PBM). A patient or a staff member may complain to you and ask you to resolve it for them. The appropriate response from a board member was required a statement that "you'll pass it to management" without promising a change. The skill of "how to listen and take that in is a skill they (PBMs) have to develop" (1C, PBM). After passing on the information, the board member has no control over how SLT uses the information. An attempt to control and exert power over this process of change was perceived as micromanagement. Passing information onto SLT did not cross into the realm of micromanaging. For example, one PBM asked the SLT what was being done to manage the overcrowding experienced at one of the clinics providing specialty care (i.e., the lobby so full that patients were standing while waiting for an appointment). SLT

responded that the clinic issues (technically operated by a partner agency) would resolve once the expansion project was completed (FN 5B). At FQHC-A, another PBM brought the attention of a three-hour wait time in pediatrics since the PBM was waiting with three other parents (7A, CBM). This included a need to be aware of how PBMs managed their own complaints regarding healthcare services.

The issue of personal complaints with healthcare needed to follow the channels appropriate of either a board member (at the level of oversight) or as a patient (through patient complaint lines). Indeed, a patient who circumvented the space between oversight and frontline staff to demand better services was a breach deemed significant enough by participants to require immediate resolution by the SLT and board chair. Mentioned previously, the resolution to such a concern was that issues with patient experiences needed to be handled by either contacting the patient complaint line (10B, PBM) or through sharing the issue with the SLT either in a committee or one-on-one, the latter practice discussed by participants at FQHC-A, FQHC-C, and FQHC-D.

As a board member, it was important to participants in this study that patients understood the realm of governance. Participating as a governing body, there was a perception that that decisions catered to the patient, the majority of the board:

> There's this perception that what the patients want is what the decision is going to be… It's part of the reason why we tend to approve management decisions as our board action, rather than to start discussion on major topics to move the business forward. (1B, , PBM)

Speaking from the perspective of a patient board member, the focus on making management decisions rather than governance decisions reflected the level of information

shared with the board (2B, CBM). The desire to engage patients on the board may alter some of the typical features of governance to generate a sense of value (8A, SLT) for all board members.

Enforcing boundaries

The need to communicatively negotiate the boundary between oversight and management presented particular issues and communicative interactions within the boardroom to maintain boundaries for all board members.

> You never should try and correct something in the clinic and undermine the staff…There are boundaries. We are in charge with oversight and governance and setting goals for the organization and thinking higher level. Then it's the staff's job to make sure that they hit those things…This is common in a lot of nonprofits. They want to do the work. They want to be in the weeds. I think one of the good characteristics of a good board is to stay away from that. You have to think higher level. You got to think goals. (10B, CBM)

A challenge germane to the nonprofit sector, and subsequently FQHCs, the boundary defining the communication appropriate for the work of governance required attention to goals, staying out of the weeds, and letting staff do the job that they are there to do.

> I think the biggest challenge is helping everyone to understand what their role (as a board) is…Just like with the health insurance premiums. There was not a decision to be made. The decision had been made and appropriately so by the committee. So structuring the agenda and the presentations in a manner that you get response that you're looking for. But at the same time balancing that with not trying to steer them. Share all the information that should be shared, because that's what they are there for, and that's their responsibility. But not too much that it just confuses the issue and gets side-tracked and off on a tangent is probably the biggest challenges. (10A, SLT)

Defining the work of the board and the work of the committee, the example highlights the importance of making space for the "deep dive" in the committee and just the right amount of information to keep the discussion focused. The communicative work engaged by the

SLT, PBMs, and CBMs contributed to defining the meaning of governance. The realm of governance was perceived by participants as the collective action of the board, but micromanagement a result of the individual board member.

Summary of Defining Governance of Day-to-Day Operations

The findings within the communicative work of governance exemplify the importance of how interaction among and between participants established the relationship of the board to the operations of the clinic. The board and SLT defined and shaped the involvement of the board in operational matters of the clinic as they discussed measures and metrics, operational issues, and the patient experience. This dynamic is demonstrated throughout the presentation of data by maintaining the integrity of the data source that identifies the status of the participant (i.e., SLT, CBM, and PBM), engaging the dialogue at meetings between SLT, and including the discussions described during interviews. The dynamic between the SLT and board was significant when engaging in the "deep dives" and engaging in the (patient) tension.

When defining the communicative work of governance, the board and SLT established limitations regarding how and when the board involved themselves in the oversight of clinic operations. This was evidenced differently depending upon the depth of the information (30,000-foot view or deep dives in the committee) and the status of the participant (CBM or PBM).

The monitoring of operational measures and metrics offered a 30,000-foot view of the health of clinics and patients without offering the detailed information of how the measures were calculated or how goals for each metric were determined. Board members

that wanted more details received clarification by SLT on the role of the board in relation to the level of detail that was deemed appropriate for oversight. If the board requested more information from the staff, effective oversight took place within committees where a "deep dive" could take place. The (patient) tension examined how the board and SLT defined the boundaries of how to and when to incorporate the requests, ideas, and observations that built upon the first-hand experience of PBMs.

Individuals in the boardroom demonstrated a valuable contribution to the information in the boardroom. The presence of the patient on the board communicated a symbolic validity to operational reports delivered to the rest of the board, preventing the "white washing" effect to measures and metrics. When determining the level of information discussed by the board or board members within deep dives, the board chair and the SLT represented influential individuals in deciding when to move the discussion of issues from the details (that risked the board engaging in micromanaging behaviors) to the high-level dashboard information and policy (i.e., the scope of governance).

When the board discussed issues in the organization, the board and SLT identified concerns regarding micromanagement from the board. When entering the "deep dives" into operational issues, the board needed to maintain a focus on the policy and high-level details rather than declaring what the staff *ought* to do to resolve the issue. For PBMs, who connected more with their experience of the clinic rather than financial spreadsheets and aggregate data provided in the dashboard, introduced additional risks of micromanagement from PBMs who may demand better treatment at clinics or may demand staff change specific elements of service. The board and SLT reinforced the boundaries of governance

"from the sidelines" in overseeing the operation of the clinics by speaking to individuals who crossed the boundary from governance into micromanagement.

The examples analyzed in this section exemplify the communicative work of governance as the board and SLT negotiated the relationship of the board with the operations. As exemplified in discussions surrounding measures and metrics, deep dives into operational issues, and reinforcing boundaries of governance, the SLT demonstrated a significant role in making the board members feel "listened to" (8A, SLT). SLT made adjustments requested by board members, even if it was an operational decision within the purview of the staff. SLT also provided additional reports and information to the board, even if the additional information would not result in board action. These responses by SLT were deemed an appropriate way for staff to communicate to board members that they were listening to what they said at meetings.

THE COMMUNICATIVE WORK OF GOVERNANCE

Grounded theory approaches to data collection and analysis (Corbin & Strauss, 2008) identified two categories of communicative work deemed significant by participants – building an effective *board culture* and defining *governance* of the day-to-day operations. First, the communicative work of building a board culture illustrated the values, assumptions, and artifacts that surfaced within the boardroom. An organization's culture is defined as "a system of artifacts, values, and assumptions" (Keyton, 2005, p. 21). Culture has been theoretically and empirically linked to high performing companies as culture shapes and defines how individuals interact to achieve their mission (see Miller, 2015; Griffin, 2006). Thus, building board culture represented an emergent

dimension when identifying the communicative work of governance. Board culture influenced communicative norms at each site while each site pursued the similar task of overseeing clinic operations. The second category of the communicative work of governance consisted of the board and senior leadership team defining what it meant to govern operational activities. This dimension defined the relationship of the board to the organization in defining the level of involvement and information that distinguished governance from micromanagement. The descriptive and explanatory findings of how the board built and shaped their culture and work through communicative interaction contributes to existing studies of governance and organizational communication in identifying the shared meanings and shared labor of a collection of volunteer organizational members.

Dynamic Board Cultures

Identifying board culture as a significant component of the communicative work of governance addresses the vital position of board culture "in determining how board members behave and, to some extent, circumscribes their effectiveness" (Pye, 2004, p. 83). Although the effectiveness of the board was not quantified and measured as a focus of this study, the board members expressed a specific effort to maintain specific communicative norms within the boardroom. Qualitative studies of board culture are rare (for exceptions see Pye, 2004; Samra-Fredericks, 2000). The similarities and differences between sites contributed to the conceptualization of four categories of culture: "hippie," "family," "professional," and "prestige." The arrangement of the cultures from left-to-right in the model (see Figure 3) was facilitated by comparing the values, artifacts, and assumptions

that re-occurred across the FQHC sites. The alignment of the categories next to each other also enabled the development of a cultural anchoring point, the cultural category (or categories) that best represented the current communicative interactions of the board.

The identification of overlapping board cultures and anchoring points resulted from the multi-site approach. The qualitative, multi-site method to examining culture, particularly within board culture, represents a significant element in studying differences and similarities of organizations with similar missions. As identified within this study, the cultures were distinct at each site, yet overlapped, which may be a result of the regimented structures of governance (e.g., fiduciary responsibility and rules of order).

Culture in organizational communication represents that which *is* the organization rather than something the organization possesses (see Griffin, 2006, p. 277). The values, attitudes, and artifacts imply stability of culture over the course of time as rituals and practices of communication reinforce and reify existing culture. This reification of culture through rituals, communicative norms, and studies of organizational culture that present a snapshot of a culture at one moment in time, provide an appearance of organizational culture as static rather than dynamic. However, organizational culture is dynamic and shifting as organizational members take action to shift or reinforce how to communicate effectively within the board (Pye, 2004; Samra-Fredericks, 2004). This study addressed the dynamism of communication that can shape and reshape the organization, and therefore the culture, by portraying cultural dynamism as push-pull factors. Depicted in Figure 3, push-pull factors identified the expressed desires of participants who asked for change and/or enacted cultural change through communication. Framing the dynamics as

a push-pull factor, the findings captured the dynamism of the culture within the board organizing for governance. Push factors sought to engage in communicative interactions of a more "professional" culture whereas pull factors sought to engage in communicative norms of a familial or hippie culture. Some of these requests were made within the study and others where requested explicitly during meetings or directly to the board chair. At the same time, these efforts did not continue consistently into subsequent meetings. Thus, during the time of data collection, the push-pull factors did not represent a norm, but a desire for norms within the board.

Within the study, each of the four FQHC sites of governance experienced significant amount of turnover. Turnover in a nonprofit board represents a common phenomenon as a board may be completely regenerated within as few as six years (BoardSource, 2015). However, turnover in this study also provided opportunities for the board to engage in shaping and defining their desired culture of governance. Chait, Holland, and Taylor (1996) note that board member turnover represents a key event within the board that creates opportunities for the organization to improve the effectiveness of the board. In this study, participants reinforced desired communicative norms during new board member orientations and ongoing board member education. In addition to the natural turnover within the boardroom as board members reached their term limits, each site of FQHC governance also experienced a transition into the patient-majority governance model, a federal requirement that introduced a significant turnover – turnover that was almost ritualistic at FQHC-A. This chapter presents the findings of turnover as a positive contributing factor to shaping the existing practices whereas Chapter 6 examines the

negative aspects of turnover as a result of communicative exclusion. However, this chapter identified that the newness of the patient-majority composition and turnover of board members contributed to the emergent and shift-able culture of the board.

Communicative Work of Governing Operations

Board members of nonprofit organizations represent a particular type of volunteer activity existing outside of the realm of management and operations of the organization (see Eadie, 2001; Hopkins, 2003), and outside the "tacit employment contract" extant to organizational communication scholarship (Clair, 1999). Previous studies of boards within organizational communication focused on larger theories, such as organizational change (see Lewis, 2001) or socialization (see Castor & Jiter, 2014), without fully exposing the vitality of a board defining and shaping the culture and work of the board. Governance literature is replete with definitions, policies, and procedural practices for board members to exercise the duties of care, loyalty, and obedience in governance (Hopkins, 2003). However, the growing practice of boards overseeing operations (see Eadie, 2001) leaves a gap in defining what governance means beyond the financial spreadsheet. As the board takes on a governing role that oversees the operations of the organization, it is important to understand how the boards define their scope of oversight when the discussion focuses primarily on specific details and issues of operations within the NPO. Therefore, describing the appropriate involvement of a board in operations represented a significant element of defining the communicative work of governance.

Defining the scope of oversight for the patient-majority board shaped the relationship of the board to the organization. Previous studies within organizational

communication that identify board members as key stakeholders at times of change (Lewis, Hamel, & Richardson, 2001) who make significant decisions for the organization (see Lewis, 2005; Sanders, 2013) approach the board as a type of organizational unit to be sought out by management at pivotal moments in the organization. However, this study examined the ways in which the board actively engaged in connecting themselves with the operations of the organization. The active involvement of board members into discussions of organizational operations shifts our attention to recognizing the board as an active entity that organizes with the intention to govern.

Positioned on the sidelines of the organizational operations, board members engaged in a 30,000-foot overview of the organization's activities reflecting their level of time spent with the organization. In contrast to the staff who actively played the game of the organization as their paid job, the board engaged in 45-50 meetings a year to review organizational issues, metrics, strategy, and quality metrics. The distinction between the involvement of staff and board members in operations indicated a boundary in the amount of communicative interaction in the organization, and thus, defining the contributions of a specific set of stakeholders in the clinic (Wellens & Jegers, 2013). Bencherki and Snack (2016) argue that organizational communication scholarship should focus on defining who counts as an organizational actant by first evaluating communicative events instead of just considering specific types of individuals (e.g., employees). The focus on communication enables scholars to move beyond the tacit employment contract and the traditional boundaries that bind organizations to a physical space (e.g., home, office, coffee shops, and boardrooms). Within this study, the emphasis on the communicative enactments of

board members engaging in the work of governance demonstrated their relationship and level of contribution to the clinic as stakeholders (see Wellens & Jegers, 2013). The board's relationship to the organization was defined and limited by SLT and board members to not become too involved in operational decisions, enactments that would breach the boundary of micromanagement.

The emphasis on defining micromanagement in this study examined the limitations of the board as defined by the board members and senior leadership team (for the exception see Samra-Fredericks, 2002). In this study, board members who asked questions, commented, or followed up about the progress meeting after meeting demonstrated effective governance of operations. However, board members who spoke of specific ways senior leadership ought to achieve goals for each metric engaged in micromanagement or sought out highly detailed levels of information reached beyond the scope of governance.

There are many individuals in the boardroom who shape the appropriate boundaries for what counts as governance in a governing board. Each of the four sites of FQHC governance in this study reflected existing practices of a governing board rather than a "working board" (see Brown & Guo, 2010; Masaoka, 2009). As a governing board, typical board members did not engage in actively managing the organization. With the exception of two or three participants who were medical pracitioners, the board did not actively participate in the work of delivering healthcare to patients at the clinic. They did not command the work of direct doctors, nurses, medical assistants, accountants, etc. Instead the board monitored the steps and actions being taken by staff to achieve satisfactory

outcomes for patient health (e.g., vaccinations, wait times) and organizational measures (e.g., provider productivity, compliance).

The examination of how the board actively engaged in establishing a connection to the organization also contributes to defining meaningful governance. Chait, Holland, and Taylor (1996) argue that meaningful work at the board level requires the board to perceive "issues before the board as important" and their involvement essential in resolving the issues. As demonstrated in the negative case regarding micromanagement of training, the board's involvement may not be necessary in securing contracts and vendors or implementing the best practices for organizational initiatives. However, the involvement in the board in monitoring measures and metrics that are meaningful to these issues presented as meaningful governance.

Defining the boundary between effective oversight and micromanagement introduced a tension specific to the subset of patient board members. In nonprofit organizations engaged in the delivery of services (e.g., food banks, ride share services, cooperative grocery stores, mentoring, education, and social services), the presence of consumers of the services can significantly impact the priorities of the organization and the work of the board. Patient board members "have skin in the game" (6B, CBM), which means they have a vested interest in seeing improvement and resolution to issues. However, consumers possess first-hand knowledge of the organization's services, which is not a common or recommended practice in board membership (see Chait, Holland, & Taylor, 1996). This contradiction in FQHCs required consumers to resolve the tension through understanding the work of the board versus the experience of being a patient (*Note*: This

tension is examined in more detail in Chapter 5.) Effectively engaging as a board member, and specifically as a consumer board member, required a specific type of engagement with providers and other consumers that did not guarantee improvement but provided an additional channel of communication for providers and consumers to express their voice to the senior leadership team.

Future directions

Future evaluations of board culture and the execution of board responsibilities will benefit from modifying existing measures to address the complex communicative dynamics identified in this study. Existing trends in quantitative measurements demonstrating relationships between the board and organizational outcomes relegate the board members into a single category of service – attending a meeting. However, the hallmark of participation in a board comes with the expectation "that you will do more than just show up" to meetings (Chait, Holland, & Taylor, 1996, p. 63). Future studies of governance in communication should consider the board's relationship to external funders. Due to the limited number of participating sites in this study, the analysis of the donor-board relationship was beyond the scope of the present analysis. However, this is an important endeavor to examine given the significant variable of diversity (i.e., board member composition; see Chapter 6) within board culture and organizational outcomes, such as the operating budget (see Wright, 2013a; Harris, 2007). Board members in nonprofit organization also typically bear the responsibility of participating in fundraising activities. This indicates that another dimension of the communicative work of fundraising

for the board could be more fully developed using a mixed-method approach from multiple nonprofit organizations.

CHAPTER SUMMARY

Organizations are shaped and reshaped by communicative interaction (Boden, 1994). The communicative work of governance identified how the board interacted with each other based upon their respective board culture and how the board defined the ways in which to oversee the operations of the clinic as a governing board. The emphasis on the culture of the board prioritizes the shared meanings and expected communication of any and all board members, thereby glossing over the individual differences between board members. The individual difference remained as significant as the similarities within the data set. Thus, the next chapter examines the differences between board members via the lens of communicatively negotiated roles.

Chapter 5

Roles within FQHC Boards

Board members are tasked with completing the work of governance, and how governance is completed by individuals is influenced by their respective roles. Polzer (1995) defined roles as "a set of recurrent behaviors appropriate to a particular position in a social system" (p. 495). Research on board member roles have defined roles by characteristics specific to the individual, such as income level (see Wright 2013a; 2013b; 2013c), race, and gender (see Bernstein & Bilimoria, 2013; Gazley, Chang & Bingham, 2010; Harris, 2014). However, studies have yet to identify how social positions in the boardroom manifest as communicative norms and boundaries that define how the role influences social interaction. This is significant as social positions "hold expectations for their own behaviors and those of other persons" (Biddle, 1986, p. 67). Castor and Jiter (2013) found that board members are expected to use their prior background within the boardroom for the benefit of the organization. Given the distinct composition of the FQHC board, this chapter examined qualitative data collected across four sites of patient-majority governance in the southwest region of the United States to answer the question, *what are the roles within the patient-majority boardroom?*

This chapter identifies three roles with specific norms, boundary limitations, and levels of permeability as individuals fulfilled one (or more) roles of the Patient, Perennial, or Professional in the boardroom. The Patient role was grounded in communication defining how and when to incorporate their firsthand experience with receiving services at the organization. The Perennial emerged as a significant role of individuals who

communicatively engaged in a cyclical pattern of board service and funding the organization. The Contributor role looked at how individuals working in particular industries contributed their specialized skill sets to the work of governance. The Contributor role represents a distinction from the professional culture developed in Chapter 4 due to different unit of analyses and emphasizes roles versus culture. Board culture examined how the board (collectively) works together whereas role theory examines the responsibilities and expectations of individual board members based upon specific characteristics.

The development of these three roles started with examining the ways participants spoke of their contributions and perceived boundaries for their contributions within the board. The communicative approach demarcates a shift away from Wright's (2013a; 2013b; 2013c) categorization of roles based upon socioeconomic status of an individual (e.g., the *representative patient*). In this study, demographics were not used as an *a priori* distinction of who belonged within a specific role. This is important particularly when considering the "patient" status was not as visible to the researcher (FQHC-B) or to participants (FQHC-C | FQHC-D). Although demographics were not the starting point for differentiating participants into separate roles, the communicative analysis of roles accounted for factors extant to the social environment of board members at the external, organizational, and individual level. External factors represented an architecture of inclusion (Allman, 2002) or the societal expectations (external to the organization) that encouraged individuals to participate in the volunteer work of a board member. Organizational factors represented the ways that board bylaws and organizational needs

described the roles of board members. Individual factors demonstrated the demographics collected within interviews extant to the specific categorical role (e.g., age, perceived income level). It should be noted that the demographics were not used as an *a priori* distinction of who belonged within a specific role, representing a shift away from Wright's categorization of *representative patient* purely based upon socioeconomic status of an individual (2013a; 2013b; 2013c). This is important particularly when considering the "patient" status was not as visible to the researcher (FQHC-B) or to participants (FQHC-C and D).

Grounding the roles within patterns of communication, these roles were not created to reify an expression of hierarchical status because all board members share an equal responsibility for fulfilling the duties of care, loyalty, and obedience (Hopkins, 2002), for attending meetings, for voting, and for participating in board education. Every vote by a board member counted equally. The foundation for identifying roles as they emerged within communicative practices also reflected the centrality of communication from the perspective of participants. As represented from each site, these exemplar quotes selected from each site highlighted the perceived importance of speaking when describing their role on the board.

> I need to negotiate my own role. I'm not the most important person, even though I think that at the time I *open my mouth*. (12A, PBM).
>
> I guess my role, as I've seen it, *is to be vocal*. (2B, CBM)
>
> Outside of any, as you said, "official role," I see myself as someone who has many years of experience in health care…I know how government views healthcare and some of the bureaucracies and the things that go along with that… *I share with the*

> *board* the relationship of Joint Commission/HRSA visit, the FQHC standing of the clinic, the purpose of the visit, and the outcomes of the visit. (1C, PBM)
>
> I think I've been effective. I think I've been respect- I don't know that everybody liked me. I know *I was one to call people out sometimes*, not by name… I think I've filled most of the roles. I'm content with the job I did. *I don't feel like I left anything laying*. (1D, PBM)

To value their contribution at the "time I open my mouth," "to be vocal," to bring "share with the board," and to not have "left anything laying," the individual roles of the board members worked together to achieve the communicative work of governance. The analysis demonstrates that participants emphasized the norms and contributions for each role as valuable to FQHC governance. The next section develops how the data was analyzed to identify the roles, norms, and boundaries for the Patient, Perennial, and Professional.

Analysis of Communicative Interaction for Roles

The analysis of observational and interview data engaged the techniques of constant comparison (Corbin & Strauss, 2008) and sensitizing concepts (see Chapter 2; Blumer, 1954; Bowen, 2006) to identify communicative events where participants explicitly spoke of their role within the board (e.g., "my role," "their role," "his/her role," and "I should do…"). Specific to the analysis of interview data, the entire transcript was examined as a whole to determine the communicative role of the participant. As participants reflected on their perceived contribution to the board, what has changed, and their positive and negative experiences serving on the board, their responses contributed to the conceptualization of roles as they shared details of their interactions with other board members. Roles were analyzed within the similarities of individual activity across the data set. Sequential

analysis of data demonstrated saturation of qualitative data (Lindolf & Taylor, 2011) with all codes represented within the set of three roles.

This analysis linked interview data to segments of observed interaction to triangulate the communicative foundation of roles and boundaries for the roles. The reason for triangulation represents a significant point of analytical verification required of qualitative studies. Additionally, participants disclosed knowledge of the set of expectations for themselves within the board. Instead of taking an either-or approach defining roles solely through interviews (see Brown & Guo, 2010) or through recorded conversation (see Boden, 1994; Lehmann-Willenbrock, Beck, & Kauffeld, 2016), my study takes a both-and approach. As active participants in their own role, participants are deemed as the key source of knowledge in what it means to be them. Thus, role behaviors are duly noted in observed interaction and the participant's perception of their role. Participants identified the boundaries for their role in governance regarding when, where, and how board members should exercise their responsibility to the board. Identification of boundaries also engaged in explicit member checks during interviews by asking participants how they were received and how they perceived the boundaries as appropriate and necessary for the respective role. Participants who presented a dual role status on the board demonstrated permeability of the borders for each role (see Clark, 2000).

The analysis examined the distinction between patient board members and non-patient board members (herein referred to as community board members, or CBMs) for several reasons. First, the "patient" status represents a distinctive characteristic reported to and monitored by HRSA. Second, the "patient" status was based primarily upon my ability

to determine the "visibility" of the status characteristic of board members (Pelled, Medford, & Mohrman, 1999) unless a participant self-identified as a patient during interviews. Finally, the patient dynamic was inherent to the interview question of "What do you believe is the value of patient-majority governance?" My attention to the "patient" within the analysis of data for this research question provided a valuable tool within the analysis of roles to determine the permeability of the boundaries between the roles, and the factors within the organization that shaped the desired characteristics for individual board members. Discussions during interviews and observations surrounding recruitment of board members also grounded the analysis of "patient" status and "representation" (see Chapter 5) in empirical data.

The following analysis indicates that the PBM and CBM classification did not clearly delineate into two separate communicative roles, and identified a much richer picture of the roles extant to each site of patient-majority governance. The following analysis develops the range of status characteristics, communicative norms, and boundaries that emerged for the roles of the Patient, the Contributor, and the Perennial. These findings are then integrated to expand the conceptualization of roles as versatile and more complex based upon one's role within the boardroom.

THE PATIENT

The first role identified and discussed within this chapter is one that was present at all four sites of patient-majority governance. The patient was a significant category of participation with direct experience receiving care at the clinic, someone who has "skin in the game" (6B, CBM).

> I know people who've been on other boards…that because of a contentious relationship, the apathy, or the lack of empathy some boards have with the organization they're directing. It's a different thing that I sit on the board, and then I go visit my doctor afterward. I go through the process, and I understand firsthand. This is my body and my health and my life. When you have a majority of people on the board that the quality of their healthcare is at stake and at their direction – that makes a huge difference. It doesn't diminish the importance of having community board members at all, because their contributions are outstanding. I'm not saying one type of board member is better than the other. I'm saying that the mix and the diversity is really important. It brings a lot to the table. (11A, PBM)

From the boardroom to receiving healthcare at the clinic firsthand, the Patient member is a type of board member that increases the diversity of the boardroom. This "firsthand" experience at the clinic gives them a perspective of the positive and negative elements of the clinic, with little opportunities for quality of care to be "whitewashed" (17A, CBM | discussed in Chapter 4). They experienced firsthand the long wait-times, stained ceiling tiles, crowded lobbies, understaffed patient intake areas, clinic furniture that did not accommodate a wide range of body types, and many other dimensions of the healthcare. The Patient "makes a huge difference" in governance by contributing to the diversity of perspectives without discounting the value of the community board members in the room.

Eighteen of 32 interview participants identified themselves as engaging in the Patient role. The distinctiveness of the FQHC patient experience and the "default" patient experience emerged as a significant foundation for the Patient role. The following analysis develops the range of external, organizational, and individual factors associated with the Patient role and three communicative norms. Each of these communicative norms defines how participants engaged in their work (i.e., *the learning curve*), what to share with the board as a significant contribution (i.e., *the* patient experience), and the lack of anonymity

regarding their board member status (i.e., the *not-so-secret shopper*). The roles were further defined by the discussion of boundary violations and permeability discussed by participants in interviews and committee meetings.

Range of Status Characteristics

Data collected within this study identified several external, organizational, and individual characteristics within the role of the patient beyond simply their status of being a patient or legal guardian of a patient. *External characteristics* mentioned previously in Chapter 2 identified that the initial "architecture of inclusion" (Allman, 2002) driving inclusion of patients was the federal policy mandating a patient-majority board. *Organizational characteristics* for the patient role identified board bylaws that may stipulate that patients must have equal representation in the leadership of committees. For example, both FQHC-A and FQHC-B explained how they sought to maintain a balance in leadership of patients as the chair of committees. *Individual factors* of patients represents one of the significant findings of patient-majority governance in this study in that a majority of the patient board members in this study identified that they themselves were "not the typical patient" of the clinic regardless of their socio-economic status. In fact, many patient participants spoke of their educational background ranging from a GED up through a doctorate degree as a characteristic that differentiated them from the typical patient.

Even when perceiving their income level as lower or perhaps significantly lower than other board members in the room, they did not want to be defined by this label.

> I hope that I'm able to help people understand that income does not, should not label us as not being capable of learning how to operate as a board member. My disability-…Everyone is given that opportunity to consider them. So this is a growing-, a learning process for many people… I see everyone; at the national level, we are board members.

Regardless of their income, board members (that participated in the interviews) indicated that they were capable of being a board member not because of their low-income but because of their ability to learn how to be a board member. This particular finding offers an alternative perspective from previous studies conducted by Wright (2013c) who imposed a categorical distinction between what he determined were "representative" patients (i.e., low-income) and "non-representative" patients (i.e., not low-income). In this study, the role of the patient was not exclusively a factor of income. Perceiving one's income status as lower was a factor reflective of retirement, disability, nonprofit service, or entrepreneurial occupations rather than a lack of employment or unemployment.

Communicative Norms

Reflecting a wide variation in educational levels, SES status, and occupations, the communicative norms for the Patient role represented the significant unifying condition of role member status. These norms were *the learning curve, "the patient voice,"* and the *not-so-secret shopper.* This role emphasized that the patient-population and nature of primary care at a Federally Qualified Health Center represented a substantively unique experience, operating outside the realm of the "default mode" of healthcare available to individuals not in a marginalized, low-socioeconomic demographic (1A, CBM).

Learning curve

With the exception of three participants, patient board members reflected that this was their first time engaging in the volunteer service specific to board members.

> I come from a long line of charity workers and presidents of women's clubs. My grandmother and my mother, that's all they did was volunteer work to benefit the community. So I'm well aware of the importance of doing that, but- what was the question?
>
> *(Interviewer) How has it been like serving on the board?*
>
> So, I had never been on a- there's a big learning curve. I never felt really comfortable being on the board. They didn't have the board mentorship or- it's like you're on the board. Here's your chair. Here's your name tag. You know? Like (gestures with palms facing up moving across the table away from the body)

Initially indicating a level of discomfort serving on the board, this PBM indicated that when the transition initially happened, the board experienced a huge learning curve as all the different roles started to emerge.

> It was new for them too… I don't think they understood the obstacles that patients would come into because all of those people had been on the board for years. They rotate off and then come right back on. So, that group was well versed in how to run the clinic. But our group (the patient group) was like, "What's an FQHC?" I mean, we were at the very basic-, I had no idea what all those acronyms meant, what my role was to be, stuff like that.
>
> I was confused about the role, like what was my duty. I wanted to be more involved in the day to day of the hospital, the clinic, and didn't really realize that that wasn't our position. I wanted to go and help out, so that was a big fuzzy area for me. I thought I was supposed to go over there and work every day, kind of volunteer, set policy, and now it's much clearer to me. (3A, PBM)

Years after joining the board, the PBM reflected how today they understood the work of governance more clearly, something that needed to be learned at the beginning.

The learning curve represented a communicative experience for all the individuals in this study, including myself. Participants constantly asked me if I was learning anything,

expressed concern that I wasn't asking questions during the meetings, and mentioned this as a conversation point as we left the meeting rooms. As the findings indicate, learning was a common feature for all the roles, but the style of learning shifted based upon the topic of learning. For the Patient role, much of the learning curve focused on the work of governance (discussed in Chapter 4) and what it meant to be a volunteer board member instead of a typical volunteer (i.e., completing tasks). To learn the acronyms, to learn the policy, to learn the finances, to learn about the conflict of interests, was the hallmark of the Patient role. PBMs with dual roles as a Professional (developed later) still engaged in a similar learning curve.

The first communicative act of learning engaged a communicative pattern of listening. Listening was the communicative act of silence as board members did not speak frequently or at all during board meetings. As PBMs were interviewed, they were asked about the nature of their participation in meetings (e.g., when and how to express their concerns or ask questions for more information).

> Patient: Is today a day to ask questions or just listen?
> SLT: Ask questions. The chair will let you know if it's too many. (FN 16A)

Participants in this study perceived their own silence and the silence of others as an act of engagement, an act of listening (for exceptions see Chapter 6). Silence was deemed an appropriate communicative act to demonstrate learning. However, silence was not always symbolic of learning as individuals who did not speak during the full board meeting did speak during committee meetings. (Three PBMs at both FQHC-A and FQHC-B followed this pattern.) Thus, silence as the learning curve was highly dependent upon the context

(e.g., committee versus board meeting), the tenure (e.g., 3 months or 60 months), and the topic (e.g., financial audits versus communication campaigns).

The second communicative act of learning was asking questions – a pattern that presented different levels of learning for the Patient role. Some of the learning for the Patient engaged very substantive questions such as, "How do we measure the success of our healthcare model?" (14A, PBM) on the first day and first meeting of being a board member (FN 16A). Another example of a question from a Patient role within the first month of serving as a board member was, "Is this an appropriate time for me to share my experience at [a referral site]?" (12A, PBM | FN 18A). Both of these board members were in the process of not only learning their role in governance, but learning their role as a Patient in the boardroom. In the learning curve, they asked questions of substance as well as questions of permission. From within the same board, this contrasted from more tenured Patients who never spoke up during full-board meetings (7A, PBM) or frequently asked the same question about the same acronym, "What does AR mean?" (Accounts Receivable) at several meetings throughout the six-months of observation at FQHC-A.

At FQHC-B, the learning curve of the Patient was a point of concern for certain individuals in the boardroom. Participants expressed concern that a few PBMs did not want to learn or did not have the capacity to learn how to be in the role – specifically regarding the dimensions of representing *the* patient experience and serving as the not-so-secret shopper. For these individuals, the silence indicated an unacceptable level of engagement with the learning curve for the board member. Observational data at sites FQHC-C and FQHC-D was not accessible; however, PBMs shared during interviews that they engaged

in learning by asking questions during meetings and meeting one-on-one with staff. Another influential point of learning for the Patient was attending the national and regional conferences where they attended sessions and other events that targeted their learning. However, the national conference was cost prohibitive to send more than one board member at a time – averaging approximately $3,000 per year, limiting participation to one board member per national conference (9B, SLT).

"The patient experience"

One of the challenging moments within the communicative norms for the Patient role was to represent "*the* patient experience" not just "*a* patient experience." This meant that to share their personal experience represented "a patient experience," but sharing experiences of others represented "the patient experience," giving representation to the voice of the thousands of patients served by the clinic (see Table 2, Chapter 2). Constructed by PBM, CBM, and SLT participants, the role of the patient was to remember that their experience was only one of many.

Part of this communicative norm was distinguishing between idiosyncratic experiences and typical patient experiences. The difference between the two was exemplified in the following quote from a participant:

> I think as a patient member I am strongly encouraged, or I want to- I feel like I want to represent everybody else. Once I waited 45 minutes for a blood test with my children after 6pm, no snack. There were 3 or 4 other moms, and it's tricky. Where is the line? When you are thankful to have a service versus "What's going on you guys?" So those are the kind of things that I'm happy to have the opportunity to express represent.

> I think it's very interesting to see the take of the board upstairs in a beautiful meeting room with a catered lunch versus when you come as a patient and you wait three hours and you can't get through to make a phone call. (7A, PBM)

Waiting for the doctor with other patients with kids for three hours without snacks, struggling to get through on a phone call were typical issues for the patient community (7A, PBM) than a single doctor visit years ago where the doctor makes one feel uncomfortable by commenting on one's clothing (12A, PBM).

Participants in the study identified three appropriate scenarios for sharing the patient experience as a board member. First, you could talk directly with the SLT:

> I also have talked to any of the staff, "How do handle this? Do you test for this? And if not, what can I do? Why don't you let me see a doctor until so far into the future?" [They] have been helpful in looking into their policies and whether we can change it or not…So I feel like I could bring it up in the board meeting, but I don't want to because it is my personal medical information. But, at least I can find the right people versus just standing at the front desk being like, "Who do I talk to?"

The Patient role gained direct access to the management and leadership of the clinic to ask for clarification and whether change was possible. Examining the extensive field notes, these disclosures of personal medical information to a medical professional discussing issues with the quality of care were not disclosed by staff during meetings. In other words, SLT never repeated or identified the names of board members in relation to the patient experience. Rather, the SLT maintained a focus on the measures and metrics examined by the board.

Second, a PBM shared their patient experience with the board – whether positive or negative – both patients and non-patient board members indicated this experience was suited for discussions in committee targeting patient experience and satisfaction.

> I think that at the board level we probably don't need to have those kind of conversations (with hearing about narratives of the patient experience). But, at the committee level where we are talking about our operations, I think that's helpful. (1A, CBM)

When taking place at the committee level, one of the new PBM initiated the disclosure by asking permission (FN 17A).

> Patient: Can I report my experience with (our referral site)?
> CBM: Yes

As the meeting adjourned, the information shared regarding referrals was reiterated as a valuable contribution: "Sharing experiences, like (first name of PBM). It's very helpful to know that. There are no bad questions. We are all here to learn and support" (Professional | Perennial, FN 17A). Representing an impromptu disclosure of a personal experience at a referral site, the contribution in the committee was reinforced as valuable by CBMs. The rest of the observed stories about one's personal or another person's patient experience at both FQHC-A and FQHC-B were spontaneously shared without asking for permission. The decision between sharing the experience with a staff member or with the committee was based upon whether or not the issue fit within the flow of the conversation (e.g., dental services, breastfeeding, and wait times), if the experience was positive and shared during announcements (FQHC-B), and whether the individual served on the committee overseeing operations of patient care.

Formal requests to discuss patient experience were not always accepted, presenting a pivotal negative experience and negative case for analysis at FQHC-B. One participant expressed a desire to deliver a presentation to the board regarding their personal experience with poverty to clarify misconceptions shared by the executive director who "went native"

to experience poverty for a day (1B, PBM). The request to share *the* patient experience from the perspective of someone who lived the experience was denied by the chair and not permitted to be a part of the board agenda.

The third communicative pattern for disclosing the patient experience was to engage in using the formal channels of communication available to all patients – the patient complaint line.

> We try to orient our board members to say if you see an issue follow the rules. That's important to us. We have a patient complaint hotline. We can bring issues up to our CEO. He or she is our sole employee. (10B, PBM)

The use of the patient complaint hotline was explicitly referenced as a practice to be used within FQHC-B. None of the other clinics expressed this as the appropriate channel of communication to express the patient experience. This pattern also influenced the content of the conversations in committees as patients did not discuss their personal patient experience at the committee level unless it was a positive experience or explained why they were asking the question (e.g., discussing cultural sensitivity within a program designed to help patients eat healthier; FN 3B). This communicative expectation connected directly to the issue of PBMs overstepping their role into micromanaging operational decisions made by SLT (developed in Chapter 4).

Triangulated between data from observations and interviews, this norm to discuss the patient experience at the committee level aligned with the communicative work of governance designed to take "deep dives" within the committees rather than with the full board (see Chapter 4). Patients who shared their experience with staff or with the committee also reinforced the need to monitor the patient tension discussed in Chapter 4

because patients did not get stuck “in the weeds” of their own experience. The communicative work of governance was to represent *the* patient experience not simply *a* patient experience, leaving the resolution of issues in the hands of management. This effectively bounded the experience within the framework that the board needed to keep a focus on the measures and metrics of the organization, and as the patient experience aided in connecting and exploring the issues within the metrics, the discussion was valuable and an effective demonstration of the patient role.

The not-so-secret shopper

The third communication norm emerges from both the data and the literature as a topic relevant to patient board member communication with clinic staff outside of board responsibilities – specifically when scheduling and receiving healthcare at the clinic. Although Wright and Martin's (2014) identified the status of a 'secret shopper' as a role for patient board members, data within this study indicated that a secret shopper was more a practice of communication than an official role. Specifically, data identified that true anonymity necessary for a secret shopper was not achievable due to five reasons. First, patient members may be a board member based upon the explicit recommendation and recruitment efforts of their provider (FQHC-A, B, and C). As discussed during meetings and interviews, none of the sites used a self-selection recruitment process where patients could volunteer themselves to serve on the board. Patient board member recruitment relied solely upon the referral of providers or other board members. Second, PBMs may specifically thank staff members that they encounter while receiving healthcare because they want to explicitly state their appreciation.

> I think that they do [know me] now because I thank them in the lab. I thank them. I ask them, “What can I take back to the board? Do you have anything that needs to be conveyed?” I believe that’s my responsibility. (2A, PBM)

By explicitly thanking staff for their work, the patient removed the anonymity extant to the conceptualization of the “secret shopper” receiving services covertly. Third, clinics posted the names of board members on their websites, accessible by internal and external audiences. Some sites also included pictures and biographies (e.g., FQHC-B) thus reducing anonymity through public profiles. Fourth, FQHC-B and FQHC-C both had framed pictures of the board members in at least one of the clinic locations. Finally, by participating in site visits, staff presentations, and/or organizational events (e.g., fundraisers and annual celebrations), board members were announced and made visible to the staff members at the organization.

> Actually, my primary doctor didn't know I was a board member until last Christmas party when they had the board members just stand up. That's when she knew. I hadn't said anything. I never do. The next time I saw her, she says, "Mrs. [name], I didn't know you were ..." “Yes, I am.” To let you know, did I see a change in care after that? No. She still treated me the same. (1C, PBM)

Both the digital communication platforms on the organizations websites, and the physical presence of board members at major organizational events made PBMs more visible to the organization. Thus, even if staff were not explicitly told by patients of their board status, there were several ways to link patients to their board member status.

The lack of anonymity indicated the need for PBMs to engage in reflexivity. Specifically, PBMs needed to acknowledge that their patient experience may actually be the best care available because of their board status.

> Usually, the docs know who we are. We get old and a bit special. You know that. The other part of knowing that is knowing that you're getting as good as it gets. If you think this isn't all [perfect], remember other people are getting less service than you. The board members can be. Sometimes it's tenuous to how secret you are. (1C, PBM)

Even for the participants who sought to maintain their anonymity through silence (11A, PBM), the ability to engage in the value added benefit of secret shopping value noted by Wright and Martin (2014) was identified as by participants as tenuous. Instead board members hoped they were treated the same as other patients (4C, PBM). Although PBMs lacked anonymity, the busy-ness of the clinic and the staff was perceived as an equalizing factor between the experience of the PBM and the other patients.

> I am constantly going to the doctor. I observe and see what's going on. For instance, the appointment I was just in for my renal. It's been very crazy and chaotic. I mean chaotic. You cannot believe how many people that they stick in this room. People are standing up, and I feel bad for them. Some of them are not in the best of shape. You know what I mean? They have to stand to wait for their appointment. That's not good. Being at the appointments and seeing what's going on in the seating end… I can give that experience back to (management). (5A, PBM)

Reiterating that the patient experience should be relayed back to the management, not specifically to the board, the PBM shared similar conditions experienced by all patients. Thus, the concern that PBMs received the best of the best care available was not evidenced by any of the personal observation of participants, but represented a cautionary tale of the Hawthorne effect in real life.

The negative case

One perspective that challenged the value of the Patient role in the boardroom emerged during ethnographic conversations with community leaders who believed "everyone is a patient – somewhere." This perspective iterated that CBMs may be able to

"secret shop" certain aspects of the healthcare experience, such as walking through a clinic to see the environment of care or to calling the clinic to experience the long the phone wait-times (FQHC-A | FQHC-C). However, the important dynamic here is that participants – both CBMs and PBMs – understood to some extent that healthcare delivery to the "safety net" population was not the same as the "default" mode of healthcare. For example, take the experience of a CBM who participated in a site visit:

> Going in there with the populations that we serve, it's tough. I think it's tough on some patients and it's tough on the providers. You have violence…When you go into a clinic, you may hear just basic arguments [between patients, and patients with staff] that you wouldn't hear anywhere else. Whether you're okay with that and the wait time and things like that-. It is an eye-opening experience. (6B, CBM)

In addition to the arguments and violence in the lobby that is specific to particular FQHC clinic sites, the CBMs also reflected on the transportation issues, financial issues, work issues, and family issues (1A, CBM | 3A, CBM) that impacted the delivery of care at the clinic.

The distinction between the "FQHC" and the "default" mode of healthcare came full circle in the observation of one of the meetings at FQHC-B regarding the process of booking appointments. CBMs in the default mode of healthcare can schedule a 3 month follow up appointment at the end of their visit. SLT indicated during one of their meetings that their no-show rate increased significantly for any appointment scheduled beyond six weeks; thus, the organization implemented a policy that limited how far out appointments could be scheduled. This dynamic created a discussion within the boardroom at FQHC-B regarding the differences between the "safety net population" and the "default" mode of healthcare.

CBM: Why is our population so much different than *me*? … I don't understand. Why we can't treat our patients the way I'm treated?

SLT 1: We want a step above that…we want to match our schedule *to the schedule of patients*…for many of our patients it's easier to say, "I have a day off in the next 5-6 days. *Can I schedule an appointment then?"* …

CBM: [But] the next *available* appointment is 14 days

PBM 1: and with that…we need to have labs *completed within* a month of our appointment.

***

SLT 1: …if we just kept overbooking…we are not meeting the patient's needs when it is convenient for them...

CBM: What do you mean by convenient 8-5 Monday through Friday?

SLT 1: *Offered an explanation*

CBM: …well telling them come back in 3 months *when they can't schedule an appointment for another 8 weeks* … Well that's- (heavy exhale in frustration and dissatisfaction)

In the above excerpt, several communicative dynamics take place (FN 14B). One CBM challenges the scheduling policy as the current practices of the organization do not reflect the needs of patients. The CBM in this excerpt also asked why patients in the safety net population are not receiving the same type of care as the CBM within the "default" mode of healthcare (1A, CBM).The PBMs picked up the conversation in the meeting to identify that the clinic used to perform much worse in this area. Although the PBMs did not discredit the continued need for improvement, one PBM stated that "Personally, I know that I'm responsible…you are going to have to have ownership" from patients to show up to appointments (FN 14B). Thus, the interaction between the Patient role with the CBMs affirmed the significance of the firsthand experience with FQHC services contributing to the Patient role.

Boundary violation

The patient experience of the clinic represented a significant element of ownership of the clinic that CBMs did not experience (11A, PBM | 6B, CBM), but ownership was limited. Every conversation in the boardroom did not always focus on the patient experience.

The primary boundary violation emerged when board status was leveraged for special treatment at the clinic. (*Note*: Data below is not linked to the interview participant or site to maintain confidentiality and anonymity of the informant.)

> We also have to be pretty insistent with them that they don't use their board position to try to pull rank on staff. We have many instances of that. Yes, where they walk into one of our clinics and not have an appointment and say I need to be seen today. The clinic will say well we don't have an appointment today. What do you need to be seen for? Let us see if we can't get you worked in. They'll say, "Do you know who I am?"
>
> We've had multiple instances of that in the past. We had to pull folks aside and say listen we can help facilitate you receiving care. We can help you understand and navigate the system. We can't go in there and threaten staff and pull rank.

Representing the negative case, or the rare case, these instances were identified by a candid disclosure by an individual aware of the violation. The ability to ask any question of SLT during the report did not translate into the ability to demand results from frontline staff.

Instead the Patient role was bounded within the scope of observation of *the* patient experience. Not truly secret shoppers, PBMs noticed the availability of space in waiting rooms (5B, PBM), stained ceiling tiles (2C, CBM), and wait-times (FQHC-A & FQHC-B). Knowable by the staff, the PBMs who participated in the interviews indicated that they did not notice any difference in the quality of care they received once their provider learned

of their board status. As a board member, they could share their experience back to the SLT or in a committee or say “Thank you” to the staff for their work while at the clinic.

Boundary Permeability

The Patient role required direct experience with receiving services at the clinic. All the FQHCs within this study accepted patients, regardless of their means of payment (e.g., uninsured, underinsured, Medicaid/CHIP, and/or privately insured). As a result, a board member that was a CBM could self-select to receive services at the clinic. This enabled individuals within the role of the Perennial and the Contributor (developed later in this chapter) to select to receive services at the clinic.

> When I got on the board, I thought I need to live this in order to understand it if I'm representing it at the board level. Not everyone does it, but I decided to do that. Some of the coolest things is when I go to my doctor’s visits or get lab work done. It's sitting in the waiting room and seeing all the people in there. You hear things like I love my doctor or what not. You hear the not so good things. Nonetheless it's that feeling of wow, I'm really impacting lives with the work that I'm doing. The first time I did that it was really eye-opening. It was like these are real people, real families, everyone's fighting their own battles. You're just trying to make sure that you're giving them the best experience that you can. (10B, PBM)

However, choosing to receive services was not something that every CBM selected.

> I feel like if I put my all into something, I should be all in. This gets me back to the consumer part. They have not asked me directly, but that's the only thing I'm not fully divested in is getting my care at our clinic…What would it hurt if I went in? Again, going in there with the populations that we serve, it's tough. I think it's tough on some patients and it's tough on the providers. (6B, CBM)

For individuals who were Contributors or Perennials who selected to receive services at the clinic, it was a personal choice.

The choice to become a PBM, to experience services, contrasted with the dominant traditions identified in governance literature that recommends board members “remain

aloof from the daily occurrences … [and] do not experience firsthand the life of an institution" (Chait, Holland, Taylor, 1996, p. 97). At the same time, contributors who opted into being a patient felt they made positive recommendations to the SLT, to increase security measures for staff (2D, PBM), improve cleanliness of the facilities (4D, PBM), and to make improvements to text-alerts (10B, PBM).

Within the data set, CBMs selecting to receive services at the clinic was more common at FQHC-D, the site with approximately two-thirds of the board counted as PBMs. This is in contrast to the FQHC that declined participation in the study that was known for actively recruiting wealthy individuals onto their board with the requirement that they needed to receive care at the clinic (9A, SLT). The practice of recruiting wealthy individuals to be board members *if* they became patients was not the acceptable practice discussed by any of the participants in the study nor within observations of board events. Rather, the organizations emphasized that, "We recruit patients from our health centers that in and of itself can be a challenge. We're reaching out to people" (10B, PBM). This act of actively recruiting patients from the clinic to serve on the board emphasized the value of the Patient role. For CBMs who selected to receive services at the clinic, they made an investment in understanding the patient experience firsthand, further valuing the role of the Patient in the board.

Summary of the Patient Role

Based upon the observational and interview data, the Patient role was present at all the sites of patient-majority governance within this study. With few exceptions (see 4A, | 11A, | 20A | 2D), the Patient did not typically join the board with prior board experience;

therefore, it was appropriate for the patient to sit back and engage in the learning curve through silence and asking questions. The Patient represented the not-so-secret shopper due to the visibility of their position, but this status was used to appreciate staff and serve as a vessel when relaying information back to SLT. When speaking about their experience as a board member, the Patient abided by specific guiding principles for who to speak with (i.e., to the board, SLT, or the patient complaint hotline), when and where to speak (i.e., committee vs. board meeting), and what to re-present as a board member (i.e., *the* patient experience). Board members violated the boundary of the Patient role if they said, "Don't you know who I am?" as a means to leverage their board status for better services at the clinic. The boundary was also permeable if a Professional or Perennial member (developed later) selected to receive services at the clinic. Through participating as a patient, board members abided by particular communication patterns that illustrated how, what, when, and with whom these patient experiences were shared within the scope of communicative work of governance.

THE PERENNIAL MEMBER

The "Perennial" member surfaced as an *in vivo* code within the observational data during a round of introductions at FQHC-A. During introductions, one CBM led their personal introduction by saying, "I'm a board member, like [name] and [name], a perennial member" (3A, CBM). This communicative event served as a sensitizing concept (Blumer, 1954; Bowen, 2006) through which to interpret other communicative segments within the observations and interview data. Building upon this particular individual, the study

identified a total of six participants across four sites who represented the Perennial member, one of which represented a potential for Perennial status.

Range of Status Characteristics

For the six individuals within this role, they exhibited a range of status characteristics associated with their position. *External characteristics* indicated that board service was a common philanthropic endeavor within their social circle, an element that was distinctly identifiable in FQHC-A after the transition to the patient-majority board.

> So the new challenge is, obviously, it's easy to have this comfortable board know you and you are all the same sort of people. I mean, these are the people I socialize with, so that's a comfortable board set up and that's what you have with a lot of boards. I kind of like the idea that we are going to have to get out of our comfort zone.
>
> You know we are all there, well-intentioned, successful community members, wanting to do something good for those that have less, but it was interesting there was some discomfort to actually get really up close and personal with the people that we are there to serve. (3A, CBM)

Organizational characteristics that appeared to drive this role were the organizational needs, notably donations, to create opportunities for individuals to recruit other individuals from within the group of individuals that they "socialize" with outside of the boardroom. These board members could cycle off the board into foundation boards or into committees, and then later cycle back onto the board. The establishment of term limits and conflicts within the board (discussed in Chapter 6) identified significant ways in which perennial board members left the organization. However, board term limits did not limit one's capacity to continue serving on the committee or a foundation board. *Individual characteristics* associated with this role were that individuals perceived their income as

"higher" than most and/or "equal to some." In the excerpt above, the Perennial reflected the "well-intentioned, successful community member" (3A, CBM) on the board.

Communicative Norms

The communicative norms for the Perennial board members within patient-majority governance required them to "stretch" themselves in learning from consumer stakeholders and take ownership of fundraising and donor relationships. The communicative patterns within each of these dimensions is developed within the following sections.

The Stretch

All of the patient-majority boards that participated in this study transitioned into FQHCs within the past 15 years, a transition that significantly altered the board composition. The remaining perennial members needed to learn how to engage with a board that was now interspersed with individuals who lacked board experience and represented a different perspective. When FQHC-A transitioned, it was observed by one participant that

> It was new for them too… I don't think they understood the obstacles that patients would come into because all of those people had been on the board for years. They rotate off and then come right back on. So, that group was well versed in how to run the clinic. (6A, PBM)

Particularly at the time of transition, the Perennials demonstrated that they were "well-versed" in the operations of the clinic after their rotations on and off the board. With the transition, a new type of learning for Perennials emerged as they needed to engage in the "stretch" (an *in vivo code*).

> Learn some new skills yourself. Learn how to stretch those board members when you work in a community of all the like-minded. We do get stretched as just human beings to be working with people with such different backgrounds. (3A, CBM)

The stretch of the Perennial was to truly engage with the new dynamics of the patient-majority governance. The Perennial offered the following example of what the "stretch" looked like within the diverse board.

> Well, I think the realization that first of all there was going to be an immediate need to be a mentor to people and to try and cross the divide and form a real relationship. I think what people were nostalgic about in embracing our board is that people had real personal relationships going on in there and we broke them up…But, yeah, I think they just didn't know what to expect in what their role was going to be and how to integrate these new members into the culture of this board. I think everybody recognized right away that it was never going to be what it was. (3A, CBM)

The new dynamic was one where the Perennials needed to step into the mentoring role that stretched them to form new relationships with the PBMs. Part of this stretching was illustrated in the relationship development and clarification of how the diverse backgrounds contributed to acknowledging the limitation of their own understanding.

> It's presumptuous for a person like me to believe that I really understand what all those situations are that are so very different from me and my life experiences. So putting others from backgrounds that are so different than mine is certainly, it just helps me to have a better appreciation for the goals of the clinic. (5A, CBM)

Transitioned into a new board composition, the Perennial role needed to engage in a "stretch" of learning directly from the patients at the clinic, individuals who were "so very different" in terms of life experiences and backgrounds. The stretch was achieved through speaking to patient board members with different experiences from individuals within the Perennial role.

The presence of patients surprised some participants at FQHC-A when the freshly minted patient-majority board re-evaluated the sliding-fee scale that determined how much patients paid per visit based upon household income.

> They were talking about fees, whether or not they should just not even have fees. They were assuming that it would be hard for patients to pay. They were just being incredibly charitable. The patient board members were like, "Oh, no. They need to pay." The board members were a little bit taken aback. They (the patients) had the credibility to say that. It just informs them, you know? It just woke them up a little bit on what it's like on that side. (19A, SLT)

The decision to keep a sliding-fee scale in this organization was directly relevant to the Perennial members. With patients at the table, the charity of the Perennials and the perspective of the Patients emerged as a useful tool for finalizing decisions on the sliding fee scale.

Stretching their perspective through having their assumptions challenged, the Perennial acknowledged the importance of continued education for existing board members:

> We can’t expect anybody, even community members necessarily, to step in and be as good as we need them to be. To know what their roles are, what their responsibility is, what the limits of their responsibilities are, and how to function in a productive way within the board structure. And I for one, I have sat in on a ton of boards, but nobody, it’s rare that we are in a setting where anybody really orients you well and consistently in what your role is. (3A, CBM)

Triangulated in observational data (FN 7A | FN 10A | FN 13B | FN 19B), board education was not to be selectively applied to only new or patient board members, but all individuals in the boardroom.

Fundraising

In terms of fundraising, the communicative expectation of the Perennial role was to engage with private donors on behalf of the organization. As mentioned by Brown and Guo (2010), fundraising represents a key component of board work. However, this study identified fundraising as predominantly a task for the Perennial role. They were expected to know how "to ask" and engage with other wealthy donors (FN 9A).

> PBM: So when we have the party, are we still supposed to be hitting up (donors) for money?
> SLT: Let [the name of a Perennial] do it.
> CBM: In the classy way
> *All: Laughter*

The communicative norm here illustrated that the individual solely in the Patient role was to leave the "ask" to the Perennial member who knew the "classy way" to ask for money.

In addition to being the individuals to "ask" or "schmooze" private donors (FN 14A), the Perennials also demonstrated an explicit capacity for large, personal donations. Within the data set, self-identification of "Perennial" status within the boardroom emerged within specific interactions, such as the introductions (discussed earlier) and financial discussions. The explicit financial giving capacity of individuals was stated in meetings: "[Perennial], can you write a check for that?" (FN 19A). Also, anonymous donations were also made visible in board conversations, "[Perennial], didn't want me to know, but is covering the cost for the sign" (FN 7A). However, the emphasis on the capacity of Perennials to donate was only present at sites that requested a "meaningful contribution" from board members (see Table 2, Chapter 3).

Boundary violations

Boundaries for the Perennial role identified additional expectations when non-Perennials perceived boundary violations and disclosed these violations during interviews. As roles are a set of expectations held by others (see Biddle, 1986), the violations represent significant element of how other board members held expectations of Perennials that may or may not be met by individuals in the role. Boundary violations identified in this study reflected socially constructed interpretations surrounding patterns of meeting attendance, limiting learning, and recruitment of CBMs versus PBMs. The following sections examine each of these boundary violations, starting with meeting attendance.

Attendance

Part and parcel to bringing together the diversity between the Perennial and the Patient roles was navigating the expectations regarding attendance. One of the expectations discussed openly in all the interviews and observations (across all four sites) was that regardless of the role, it was expected that board members physically attend meetings unless they absolutely needed to call-in or were unable to make it for some other excused reason (discussed in Chapter 3). Attendance (in person) symbolized commitment to the board. One participant shared candidly during the interview a concern that the Perennial board members did not prioritize the board meeting time and would miss meetings or call-in when they were on extended vacations.

> I mean, I get really mad at board members – who I like – but they are off skiing in [the mountains] and spending the summer [abroad], and they don't show up at the meetings. I don't think that's appropriate.

> One of the things at the national conference was that some boards won't let their board members call in. If you can't make this commitment, then you don't need to be on the board.
>
> I understand that someone had a surgery. That's a once in a lifetime thing. But, schedule your vacations around your commitments. My mother died, there's nothing I can do about that. Those things happen. But, I really think that rule should be in place. If you miss three board meetings, then "bye-bye." It's been selectively enforced. Trust me.
>
> I don't like that, but they don't want to piss off the people with the money. It's like there's a different set of rule for the people with the money. (6A, PBM)

Attendance requirements stipulated in board bylaws appeared to be "selectively enforced" so as not to "piss off the people with money." The Patient role in this scenario pushed back communicatively, during the interview as well as in observations, using material acquired at the national conference to open up a discussion for a more stringent attendance requirement for board members – three absences period plus the requirement to attend meetings in person (FN 5A | FN 7A).

The Perennial role was more pronounced in the data set for FQHC-A compared to the other sites. This is attributed to the range of SES within the board (see Table 2, Chapter 2), the giving requirements, the presence of (or lack of) foundation board, and the use of "work-arounds" not present at the other sites of governance. At FQHC-B, there was not explicit discussion of absences of any board member *by a board member* during interviews. The only discussion of board member attendance at FQHC-B focused on discussing aggregate data indicating a majority of board members were out of compliance with the attendance bylaws (FN 13B).

Discouraging Learning

Although Perennials maintained a longevity with the organization that granted them institutional knowledge and board experience in governance that could be beneficial for the mentorship of new board members, there were times that sarcastic humor or short responses could discourage learning in the boardroom. Representing an opportunity for mentorship and growth, the Perennial role could answer questions regarding financial reports and board procedures asked by new and existing board members. For example at FQHC-A, new members who are less familiar with the organization or new to board service engage in distinct communicative actions, such as listening (silence), asking informational type questions (e.g., "What does AR mean?"), and meeting with staff to learn more about specific topics. At the same time, individuals in the Perennial role may inadvertently discourage the learning curve of other board members.

Representing a negative case and exemplifying how a Perennial may discourage learning within meetings, the following excerpt from field notes picks up the end of a report regarding the use of a "reserve account."

> Perennial A: I'd be glad to answer any questions.
> Staff: I'm going to volunteer [Staff]. The new board members…if you wouldn't mind staying after…
> Perennial B: I find that very confusing. [*stated with tone of sarcasm*]
> *All: Laughter*
> Perennial A: I thought that was SLT's nice way of saying, "And, those that need remedial assistance…"
> *All: Laughter*

The board meeting conversation on the issue continued as several board members (PBM and CBMs) asked questions, but no one asked any further questions about the "reserve account." Despite the humorous response to the Perennial comment throughout the room,

none of the board members approached the staff member following the meeting. However, the topic resurfaced in the next meeting to include a clarification of what a "reserve account" was prompted by the question by a PBM.

Bounded Recruitment

The last boundary established within the Perennial role surfaced in conversations was also shared by several within the Contributor role regarding the specifics of recruitment. Consistent throughout all the interviews with participants identified a lack of recruitment of PBMs by Perennials. The only exception to this rule was the recruitment of a Professional that by the time of the interview self-selected into being a patient.

Both FQHC-A and FQHC-B discussed the challenges of recruiting PBMs. FQHC-A discussed the potential for patient-based self-selection and the potential of board members sitting in the waiting rooms to recruit patients.

> PBM: Will we start having our meetings at the new building? I would be willing to just talk to patients before the meeting. I've done it before while waiting for the doctor. ..I think that's the way to do it.
> CBM: Direct to consumer…that's something.

Of the variety of ways to promote self-selection onto the board discussed during this meeting (e.g., a poster in the waiting room, an announcement on social media, recruiting for an advisory committee), one PBM suggested that talking with patients in the waiting room was something that s/he engaged and was willing to do that again. As the conversation around the board evaluation where the patient self-selection surfaced, the conversation turned towards responsibility for these actions, specifically identifying a boundary between patient and non-patient board members.

CBM: So just to close this on the board evaluation. Action item a procedure for the orientation within the first month. Board learning. Add board recruitment
PBM A: who's going to do it?
SLT: I think I'm doing these things.
PBM B: Everyone *should be responsible for the board recruitment*
SLT: I do think it's hard for community members to find patients
PBM B: I don't think it's hard.

The act of recruiting patients before a meeting, sitting down and having a conversation with patients sitting in the waiting room was perceived as something that was "hard" for community members according to SLT. The conversation did not define what was "hard" or not "hard" for CBMs in recruiting PBM. Based upon interview data, this indicated the "stretch" for Perennials involved getting outside of one's social circle, and sitting in a clinic waiting room was not reflective of moving beyond one's social circle. The end of this conversation left the recruitment of patients outside the purview of Perennial members and a role for SLT and individuals within the Patient role.

Boundary Permeability

In this study, all participants in the Perennial role came from the pool of CBMs, which led to an emergent question of whether PBMs could also become Perennials regardless of their socioeconomic status. With the newness of the FQHC status, it was challenging to determine if PBMs returned to the board at a later time or continued volunteering in committees or other volunteer activities after leaving the board. At FQHC-A, all but two of the PBMs were present at the original FQHC transition. One former PBM was identified by participant (8A, SLT) to have cycled off the board onto a committee, which followed a pattern of participation extant to the Perennial role. FQHC-B did not utilize the work-around of having non-board members on the committees, nor did they

have a foundation board. FQHC-C and D also did not report having a situation where the Patient could remain involved in an advisory committee, etc., once leaving the board. The ability to transition off onto a foundation board may also be challenging for PBMs given the minimum giving potential required of foundation board members to raise or donate a predetermined amount of money – which was different from the "meaningful" contribution expected while serving on the FQHC board at A, C, and D.

Boundary permeability for individuals to enter into the Perennial role was limited unless the individual had qualifications or giving capacity to continue participating in the either the board committees or the foundation boards, respectively. This lack of permeability was attributed to the high rate of PBM turnover and the hope that PBMs circumstances would improve.

> I mean one of our challenges, it is and always will be I think, is keeping our board appropriately populated with our patient members. There has been more turnover there than I think the community members and I understand that. I think it's inevitable. It's not anyone's fault. It's not anything I think we can avoid. I mean, I think that certainly people in the patient population, if their circumstances improve they are probably going to move on. And that's a good thing. That's not a bad thing. But it does mean that we have more turnover there. (5A, SLT)

This idea of improvement creates a contrast between the individuals within the Patient role and the Perennial role. A Perennial role, with a financial situation that may be arguably more secure with the giving potential to join a foundation board, would hopefully remain connected to the board. However, if the situation of a Patient role improved, "they are probably going to move on" and not stay connected with the board. Instead, the analysis of data identified that only individuals with either a dual role as a Patient and a Professional or single role as a Professional transitioned into the Perennial role. Based upon the data,

there was at least one Contributor role per organization that was either in the transition or transitioned into the Perennial role at the clinic's board.

Summary of the Perennial Role

Altogether, the role of the Perennial was identified within conversations inside the boardroom and by other participants during the interviews. The range of status characteristics for the Perennial role aligned with existing traditions in governance, drawing upon successful community leaders (Chait, Holland, & Taylor, 1996). The Perennial member engaged in a different type of learning that required "the stretch" to learn directly from individuals outside of their existing social circle – the patients of the clinic. Their presence at orientations, meetings, and trainings at FQHC-A and FQHC-B could reinforce or discourage learning of new and existing members. Their (lack of) attendance at meetings scheduled at the beginning of the year demonstrated a lack of commitment to PBMs and created a point of difference in how the attendance bylaws appeared to be selectively applied to the Perennial role. Of the multi-faceted role of the Perennial, it was specifically the references to continued board service (cycling on and off the board) and the capacity of giving (e.g., "Can you write a check for that?") that distinguished these participants from the Contributor role developed next.

THE CONTRIBUTOR

The Contributor represented the third role within patient-majority board. This role contributed to the diversity of the board within "discipline and knowledge" necessary for the work of the board (1C, PBM). The contributor role represented individuals "trained in operating clinics," with "financial expertise" (CPAs or accountants), "health education

professionals," the "PhD professors," and the "entrepreneur business types" that are good at "planning, etc." (1C, PBM | 2B, CBM). Individuals with these types of working backgrounds were perceived as able to contribute their experience to the benefit of the clinic at the board level. The contributors represented a pivotal role within the board that was caught between the PBMs and "other board members" in the Perennial role at times of conflict (18A, CBM).

Range of Status Characteristics

Individuals who fell within the bounds of the Contributor role identified a wide range of structural factors that influenced their communicative role. *External characteristics* that influenced the participation on a board were that board members were (a) part of a professional association that encouraged individuals to give back to their community by serving as board members (e.g., accountants or lawyers), part of (b) a profession devoted to service (e.g., educators), or (c) semi-retired or employed full-time individuals working in an industry similar or related to healthcare (e.g., consultants, healthcare practitioners). *Organizational characteristics* contributing to the participation of the contributor in the board was typically driven by the organizations desire to fill particular needs on the board in the areas of finance, policy, and/or healthcare (1C, PBM | 2B, CBM | 2B, CBM). *Internal characteristics* that defined the role of the contributor were that they all reported a middle to high income level. After an extended amount of time, the contributor could transition into a perennial board member.

Communicative Norms

The communicative norms for the Contributor role required triangulation between the interview data and observational data as the communicative dimensions were explicitly stated during interviews but implicitly practiced during board meetings. Extant to the practices at the four sites of patient-majority governance, three distinct communicative norms emerged within context specific learning, the pragmatic voice, and the neutral voice.

Context Specific Learning

Participants within this role may have been recruited specifically due to their professional occupation or involvement with the organization/healthcare industry. Most of the participants had prior or concurrent board experience at other organizations, or relevant experience working with some form of board of directors. Emerging from these two factors, the Contributor engaged in a specific contextual learning of the healthcare industry. Participants provided the explanations that their finance background transferred to the clinic.

> At the same time, I had no healthcare background when I got on the board. I'm a financial analyst by trade. Now, I understand industries and trends and what not, but I don't have a medical background. (10B, PBM)

For the individuals without a medical background, they learned the healthcare industry.

Contributors also needed to adapt their experience to the context of the nonprofit sector.

> Honestly, at the end of the day, the argument that is really different is obviously the grants that come in and whether or not they have restrictions on them. If they do, we have to make sure that we meet those requirements in order to spend that money and to the different names that you call certain accounts. For a for-profit, you would have net income and loss. A nonprofit you would have a surplus or a deficit. I mean a bit of the data really is similar. (4B, CBM)

The distinction between the nonprofit and for profit sector identified in literature (see Frumkin, 2002; Lewis, 2005) influenced the norms for learning for Contributors. The data is similar between the spheres of accounting in the profit versus nonprofit world, but was represented with a name and money came with restrictions linked to requirements and the need to spend the money.

Board members with a healthcare background engaged in learning about the nature of primary care services for the safety-net population.

> [CBM] is a very educated, knowledgeable person, very interested in the work that we do. I don't think [CBM] knows as much about primary care as they think they do. We sometimes struggle in that space… I know [CBM] hasn't been in a role of having direction over primary care providers. (9A, SLT)

There was a "struggle in that space" of the particular focus of the nonprofit, primary care provide by the FQHC. There was a struggle in the governance of measures and metrics that consistently underperformed as the board monitored the strategies used to achieve outcomes as the strategies did not always align with how the Contributor would engage the issue in their own career.

The Pragmatic Voice

The "pragmatic" voice of the contributor surfaced around particular issues discussed and approved of by the board, particularly within finances. Essential to the scope of exercising the board's fiduciary responsibility – a focal point in much of the governance literature (see Hopkins, 2002) – they applied their knowledge and experiences to the best of their ability.

> My contribution to the board is on the business side of things. Making sure that finances are well run, efficiently used, prudently applied, risks are managed, and that we have a pragmatic voice on the board that cares a lot about the patient experience, and wants to make sure we have the adequate resources to deliver. (11A, PBM)

The pragmatic voice was the voice that spoke on the "business side" of the clinic and engaged the dynamics of risk, loss, efficiency. In other words, was the money being spent pragmatically in a way that contributed to the patient experience? Did the clinical culture negatively impact staff in ways that hindered the staff's ability to provide quality care? This emerged specifically within the monitoring of new and existing grants and spending

The pragmatic voice in monitoring grants. One of the dynamics of the funding streams for all sites of patient-majority governance within this study was the pursuit of grant funding for clinic services. A common feature of board meetings was a list of grant applications approved at the beginning of the meetings on the consent agenda.

> Professional | Perennial: Grants for approval
> SLT: We bring to you a list of all the grants we are going to approve so you know what we are doing.
> Professional | Perennial: *(Finds the list in the packet, holds it up)* This is the list of grants. Just to be clear, this is money coming into the clinic.
> Patient: It's also a way for you to help us get money…Your sister or brother may be sitting on one of these boards. (FN 16A)

Listed on the consent agenda, the application for grants was never discussed in detail during the six-months of observation at FQHC-A or FQHC-B.

Grants (outside of the federal funding drawn from the 330 grant) awarded to the clinic received literal applause by the board of at FQHC-A. However, meeting the requirements of a grant – the requirements needed to receive the funding and the requirements needed to spend the money already received – were a consistent topic of

conversation in the committees at FQHC-A and FQHC-B. Interview participants at FQHC-C and FQHC-D also discussed the significance of monitoring grants in their interviews (4C, CBM | 5D, PBM). The staff challenges of meeting grant reporting requirements have been dually noted in existing scholarship (see Carcharan et al., 2015), but at the board level the conversation was shaped by the impact on the staff and availability of funds.

One participant in the Contributor role with a background in FQHCs saw their primary contribution to the board as monitoring the grants in terms of the impact that a grant would have on the work of the staff.

> For example, community centers have to deal with a lot of grants…Sometimes these grants can come in with what I call luggage – a lot of hoops that the providers have to jump through to make sure that they meet criteria to keep getting these moneys and documentation in case they ever get audited…
>
> This documentation really has the impact on the providers because it really in a busy clinic it can really slow down the efficiency when you're having to fill out so much paperwork. At one time, providers were having to comply with three to four additional paperwork that one had to fill out for documentation purposes in order to continue qualifying for those grants. Situations like did impact the providers and their efficiency and their ability to see patients and keep the patient flow going. (4C, CBM)

With previous experience in doing the work necessary to remain eligible for grants, this CBM knew that a grant could negatively impact the patient experience and provider productivity. The financial restructuring at the clinic enabled the FQHC to rely less upon the external grants, which resolved many of this participant's concerns when s/he joined the board. However, it was still a concern and a need to understand the need for the funding for the organization as well as the (potentially negative) impact on metrics.

Staff appreciated board members who went the extra step to understand the work that went into securing resources in the nonprofit sector, such as grants and donations. However, the dimension that was harder to see within the Patient role.

> The patient board members are very much champions of staff. They, or many of them are, I shouldn't say all. Many of them really are, so my hardship is in trying to get that board to understand that money doesn't just magically appear for us. It seems that way for them. They don't understand how hard the CEO and I are working, twenty four hours a day, to make sure that we are well funded. (19A, SLT)

The senior leadership worked hard to secure funding for the organization, and the amount of work involved was not necessarily understood all in the Patient role.

Drawing upon observational data, this pragmatic voice also monitored sources of revenue in an environment with shrinking funding sources. The following dialogue engaged the discussion lead by individuals within the Contributor role, Patient role, and the SLT (FN 2, de-identified site):

> Professional A: (Professional C), you've discussed fundraising
> Professional B: We've talked about this
> SLT A: I was on mute
> Professional A: …we need to make sure there's financial strategies…I'm afraid of losing money…we are a nonprofit… but we are the only ones that don't…I think it should be explored
> Patient A: I think that we did…a long time ago…they said that there was a board activity to that…a gala
> Professional A: I know (someone) who throws great galas (*said while making eye contact with a professional board member with experience throwing galas*)
> Professional B: My next one is going to be XXX…we just got to be *aware that they take time to build, and it costs money to raise money.*
>
> [Shift in Topic]
> Professional C: Participate in [an annual, community-wide fundraising campaign]?
> Professional A: We don't participate in any at all?
> Professional B: It's growing it's ridiculously
> Patient A: Paid (*the organizers take approximately 8% of the donations to cover the cost of the event*)

Professional B: It's not the same thing

[Shift in Topic]
SLT B: Another thing is we can look at the payer mix…how the others survive that the …payers that offset
Professional A: it's a great story (referring to fundraising stories)
SLT C: You are going to get more bang for your buck *with the payer mix*…
Professional A: I understand but there's intangibles *to fundraising and donations*...
Professional B: I will only say that it is very competitive…everyone knows the children hospital *has successful fundraisers*…I think it's a both-and *situation.* …Fundraising as an event is not an event … Six-figures? That takes years to build.

The Contributors engage in a debate surrounding the concern of funding for the organization when they were being expected to "do more with less" (FN 22B). The SLT offered alternative suggestions that did not engage fundraising efforts, such as diversifying the payer mix (see Chapter 4).

The pragmatic voice in monitoring spending. At each site of governance, bylaws defined the amount of an expenditure that needed to come to the board for approval. These frequently focused on big expenditures for the organization.

> A couple of years ago we had to make some decisions about what to do with our electronic health record situation. Our vendor was no longer going to host it, and we had to make some decisions to make there. They had lobbed us an offer, that I thought didn't make sense.
>
> They had lobbed us an offer to pay a certain amount of money to get some custom stuff done that we just weren't getting a return on. It would have been easy to say, "Yes" to that, but the more difficult and yet more efficient and pragmatic answer was to go elsewhere. And that was ultimately where we ended up going. I couldn't let that decision go without proverbially sticking to my guns on where we should be going with that. (11A, PBM)

The Contributor who decided to "stick to their guns" contributed via communicatively using their IT experience when evaluating the contract. This enabled the transference of

their work experience into the clinic experience to make a fiscally responsible decision for the clinic to find a vendor that met their IT needs at a reasonable rate. The choices to re-evaluate vendors and contracts was also a discussion at FQHC-B when evaluating the best vendors for lab work and call center support.

FAHC-B discussed monitoring spending in operational issues in relation to several specific operational matters, such as the turnover of medical assistants, which was defined by SLT as a position that nationally experienced the highest rates of turnover. The monitoring of expenses in this scenario examined whether they should pay medical assistants more.

> SLT: Correct…we have been going position by position…but we did know we were getting anecdotal that people were leaving for 50 cents or a dollar more per hour
> Professional A: I was looking at some random internet articles. Turnover has been on my mind a lot…you train your employees well enough to leave and treat them well enough that they don't want to…I know it's hard but we need staff…Without the staff here we have no access *to services.*
> Professional B: To that point…but when we are at that point…They are still low paying jobs…leaving for another one dollar, two dollars …that's the nature of the beast at that level…I think it should always …I don't think we are going to take 20 to 10 percent *turnover rate.*

The Contributor discussed the big picture. Two individuals in the Patient role participated in the discussion as well with the following contributions: "But compared to (other FQHCs), are we higher or lower?" "How much do you think the school will help us with interns?" and "Question, when we have turnover, it's within the first six months…I was wondering if we pay any sign-on bonuses after 9 months or a year?" or "I was wondering if we've done group health club membership free or-?" The difference between the Contributor and Patient communication was that the Patient role did not engage in the

presentation of their perspective on turnover and pay. Of course, the board did not always express the pragmatic voice collectively when making decisions. As discussed in the scenario within Chapter 4, a board could easily approve a six-figure contract for employee training when the staff were able to secure a contract at a quarter of the cost approved by the board.

The Neutral Voice

In times of conflict, the contributors represented *a neutral voice* between the perennials and the patients. The contributor spoke from a distinct position in the boardroom, not as a PBM seeking to represent *the* patient voice or as the Perennial who could speak of how things had been done before (pre-FQHC). Instead the Contributor represented a neutral voice particularly at times of dispute.

> Part of my job and the other one or two people who were in the same boat, was trying really hard to be neutral, but also explain why we're siding on particular issues the way we were. I had a couple phone calls or emails, both patient board members and the old holdover board members...
>
> I think I was viewed as a neutral player in this dispute. It wasn't even like they were lobbying me. It was like, "What the heck do you think? What could make this be better?" It was that kind of a conversation no matter who it was with. It wasn't an active lobbying thing. It was more like "What are you thinking? How can we make this better?" and "You're less crazy about this than the people who are currently fighting about this." (18A, CBM)

Another participant reflected how the neutral voice of the Contributor was valued.

> When somebody challenges him, he has an ability to answer in a way that's acceptable to the person. If he keeps getting tested, instead of losing his temper, he has the ability to draw back and stay with it in a way that is very professional and very nice. He's not rude. He's very good. (19A, SLT)

When considering these two perspectives, the neutral voice of the Contributor demonstrated an ability to tailor their messages in a way that was understandable and " acceptable" to both Perennials and Patients.

> Something that happened here one time…We called a meeting, an emergency meeting. I said, "No, they are not going to do this. We are all board members. What the heck is going on?"
>
> That was a very good example of them thinking, "Well, we could have told you, but we didn't know how to explain it, or if you would understand."
>
> It's like, "What? We understand English. Explain it to us." (4A, PBM)

The role of the Contributor surfaced at times such as this when the board experienced conflicts over how to share a perspective in a neutral way.

The neutral voice was also valued by the CEO who was frequently the focal point of the dispute between the board members.

> About three years ago there was such a divide or a group. We had some people who didn't like the way the CEO was running things, questioned her quite a bit. Then we had that group that thought she was doing a good job. A few of us tried to stay neutral. We almost lost her because she almost resigned. Then those board members that were against her quit. We've settled down again. (7D, CBM)

The ability to stay neutral was part and parcel to the boundaries of the Contributor. They offered a perspective that was perceived as neutral by not having a vested interest in how "their money was spent" (as with the Perennial | 4A, PBM) and were perceived as a person that was specifically recruited for their experience outside of the board (2B | CBM).

The neutral voice of the Contributor was evidenced at FQHC-A and FQHC-D rather than at FQHC-B and FQHC-C. The difference among the sites may be due to differences in board composition. At FQHC-C, the distinction between a PBM and a CBM

was “indistinguishable” (1C, PBM). At FQHC-B, the visible distinction between a PBM and CBM was challenging to identify as an observer until the explicit conversation of PBM attendance four-months into data collection. The findings examined in Chapter 4 also identified that FQHC-B and FQHC-C were anchored within the culture of professionalism and explicitly sought to recruit PBMs with professional qualifications. FQHC-B and FQHC-C were also larger organizations than FQHC-A and FQHC-D.

Boundaries

The analysis of data in the Contributor role also examined role expectations and behaviors based upon boundary violations and boundary permeability. The Contributor role boundaries defined by participants engaged the recruitment of capable contributors, the boundary for too many questions, and not being tapped for their experience.

Recruiting for Diversity

One of the boundaries that surfaced for the contributor was that they wanted board members who were diverse, who reflected the demographics of the community. “Community” within this context was ideally the service area – both in the form of the federally defined zip code area of coverage and the emergent zip codes linked to the patients that self-selected into the patient population. This emerged as a consistent topic of interviews at FQHC-B, FQHC-C, and FQHC-D, and was observed in meeting discussions at FQHC A. This is also distinct from the “Representation” within the Patient role, as individuals in the Patient role were to re-present *the* patient experience whereas the Contributor role was ideally “representative” or reflective of the demographic diversity in the patient population.

The participants reflected on the process of recruiting individuals to meet an identifiable need on the board in both interviews and observed meetings. The growth of the FQHC indicated an explicit need to recruit "educated" individuals from the pool of patients in a diversified payer mix that enabled the board to recruit "more high-end consumers" to address issues with PBMs not engaging in the meetings (2C, CBM).

Based upon discussions, board members nominees represented their community as well as fill the gaps on the board.

> Well, we look at what we don't have on the board and what we have on the board. Then we do a deliberate recruiting effort for that. Early on I realized we didn't have a banker, so we deliberately tried to find a banker. We found (CBM name now a PBM). We then wanted to have a CPA, so we did a deliberate search and found (CBM name)… Same thing with (CBM) who is a lawyer. (3B, CBM)

Each of the three recruited board members in the above statement also contributed to the racial and gender diversity on the board. These individuals recruited based upon their occupations were recruited to meet the perceived needs of the board in a way that also contributed to the diversity of the board.

These recruitment processes described at FQHC-B and FQHC-C reflected an emergent, communicative practice to recruit individuals from the community and from the existing patient population to serve on the board. Recruitment requirements could also be much more formalized into the bylaws. At FQHC-D,

> Our bylaws specifically say the ideal case would be people who are involved in the medical profession…The board can be a variety of people. I am not in the medical field... It certainly helps to have a nurse or a doctor there who can say well, this is what's happening and give you much more details.
>
> We certainly like to be representative, represented by the various professions. Certainly you need someone who's going to understand what you're doing.

> That's the process, the clergy, the medical professions, maybe the accounting profession, because we've just become a more and more significant budget that we have to deal with. Money matters. Those are the type of things we're looking for. I think, maybe in that order, I'm not sure…Then we can look into other useful areas. Then we do like finance or public relations, media type thing, the newspaper or one of the county officers. (1D, PBM)

Not every organization, nor every participant, reflected an order of professions that mattered to the board. However, the emphasis to recruit individuals who "understand what you're doing," who were "educated," and could fill a need for the clinic that were also demographically diverse in terms of race/ethnicity and gender was a valuable contribution to the board.

At FQHC-A, two of the three discussions surrounding diversity *in situ* are presented in the following data display (FN 2A, | FN 7A). The following discussions, though collapsed, focus on discussions surround demographic diversity that of patient and non-patient nominees and needs of the board.

Figure 3: Discussions of diversity and representation

Conversational Excerpt	**Representation**	**Role**
CBM: Do any of these (patient) individuals have a background that would prepare them for this position? SLT: Small business	*Small Business*	Patient
CBM: S/he's a Millennial	*Age*	Contributor
CBM: In terms of diversity. We don't have much youth PBM A to PBM B: How old are you? PBM B: I don't know do I look young enough? SLT: S/he represents two groups – a patient and a parent of a patient.	*Youth*	Patient & Contributor

Figure 3 continued

Conversational Excerpt	**Representation**	**Role**
CBM: Discussion of (CBM) who they believed to be a Persian. PBM: I think he was a patient when he was at the university…our physicians have delivered both of his children CBM: He's got some experience in public health or…	*Race/Ethnicity Healthcare*	Patient
CBM: In terms of diversity Asian and African. The neighborhood of this clinic will be heavily Asian.	*Race*	Patient
CBM: In terms of ethnicity we are missing Chinese Vietnamese. Aren't those the two groups" PBM A: (we need a) Millennial – a Chinese millennial	*Race & Age*	Unspecified
PBM B: what's the age cut off (for a board member)? SLT: 18 is the youngest that a board member can be. Medicaid might have an issue (with someone younger). CBM: question about adolescent health, and the representation for adolescent health SLT: Clarified that the parents of adolescents can serve on the board. PBM C: It would be a good" to have more representation SLT: A parent CBM: A parent of an adolescent	*Adolescent*	Unspecified
CBM: How about gender? SLT: More women than men which is representative CBM: What's the gender demo of patients SLT: 70/30 women	*Gender*	Unspecified

Demographics, particularly those that were not currently represented on the board were discussed in relation to either the representation and/or needs of the board. The qualifications of the patient individuals was a targeted question asked after the nominees participated in an initial round of screening (i.e., "Do any of the individuals have a background that would prepare them for this position?"). Interestingly, after interviewing these new individuals, the reference to prior experience of participant (19A, PBM) who worked on the staff side of nonprofit boards was not referenced, but their demographic diversity was discussed.

This type of explicit discussion regarding diversity was not openly discussed during meetings at FQHC-B, which may be related to the factor that data collection finished two months before the cycle of board recruitment at that site. When I shared this observation with one of the board members, they reflected, "You know why I think that is? It is because it's so diverse" (6B, CBM). The other organizations also appreciated the diversity on their board that was not always the case.

> The other thing I like about the CEO is she's getting a multi-cultured board. She's getting an array of people all over the community that can be valuable to the clinic. I think that's wonderful. The CEO has four Caucasian representatives, Hispanic representatives, black representatives, Asian representatives, so the CEO has quite an array of people on that board of the cross section of the population of (the community). (4D, CBM)

By the end of data collection, all of the boards exhibited diversity within the realms of race/ethnicity, gender, and occupations. The recruitment efforts that targeted qualified individuals increased the permeability between the border of contributors and patients.

Too Many Questions

The contributor with experience working on the staff side of the boardroom noted that their questions were not always well-received by other board members.

> I think I've had times when I ask questions ... I don't know if it's intimidating too, because of our background. I can listen to the financial reports. If I ask a question, everybody's like (*nonverbally demonstrating raised eyebrows and eye glances to the side*) ... It's like, no. It's not like that. I just want to know... They think an accountant knows everything. No, I don't. But, I'll ask, so I can find out. Yeah, I think it's intimidating, which bothers me. Yeah, that's the only thing that bothers me. That it's like do I ask a question or not? I ask questions and everybody gets tense.
>
> I think they're thinking I'm saying something bad. I'm not auditing them. I'm trying to get an understanding of what do you mean? (6D, CBM)

Although the contributor may be recruited for intellectual/professional contributions on the board, there was a limit to their contribution if they asked too many questions. Even though the questions were deemed relevant and appropriate as questions they would answer in their own occupation, fellow board members and staff responded to the questions with tension. The contributor with an accounting background may know the exact type of questions to ask so that board members understand the oversight of financials. However, board members do not always receive these questions as a sign of competency. Instead, peers responded to questions with raided eyebrows and sideward glances.

One board member phrased this tension as a reflexive process regarding whether the question was necessary.

> Some board members, myself included, are really detail oriented. For me in particular, in terms of patient care and those kind of operations, I could ask questions all night long. How does it work here, and how does it work there? I often have to, before I open my mouth, ask myself, “Okay, is this really a question for wearing my board hat? Is this a question for me as public health person or just inquisitive member of the public?” (3C, PBM)

The participant engaged in the self-questioning strategies of whether the concept fell within the purview of the "board hat" as opposed to the other occupational roles in public health. This individual reflected how they had not yet been pulled aside and requested to ask fewer questions, but it was a moment of metacommunicative reflection to discuss the boundaries of when questions became irrelevant to the work of the board and too focused on one's personal interest.

Boundary Permeability

Mentioned previously in the analysis of previous roles, the boundary of the Contributor was permeable for individuals who desired to transition into the Patient role and/or the Perennial member. However, for individuals in the Patient or Perennial role, the status of a Contributor was already present prior to joining the board. However, the findings from this study identified that the Contributor was not permeable by the Perennial or Patient role while serving on the board. Instead, the Patient and/or Professional who was also a Professional represented a dual role status, a transition that was not achieved during board service but an anchoring point for Patient-Contributors and Perennial-Contributors. Given the debate regarding the representation of PBMs on the board (see Wright, 2013a; 2013b; 2013c; 2014), this section examines this dual role status of the Patient-Contributor role to unpack the meaning and processes embedded in maintaining a dual role status within the board as a Professional PBM.

The following excerpt from FQHC-B engaged several questions targeting how the contributor crossed the border into the Patient role, defining how the CBM needed to (a)

volunteer to be a patient, (b) see a doctor within the timeframe stated in bylaws, and (c) meet expectations for "reasonable utilization" of clinic services (FN 10B).

[Reasonable Utilization]
SLT: …every year I have to run an audit every year…we are out of compliance. **One of our board members has not used our services at all**.
PBM A: At all?
SLT: At all.

[Bylaws & Volunteering]
PBM B: **How long have they *been a consumer member if* they have never seen *the inside of the clinic?***
SLT A: This policy says the first meeting of the last fiscal year.
SLT B: Why don't we change that policy?

[Bylaws & Volunteering]
PBM B: **How did they become the consumer member?**
SLT C: See a doctor
PBM A: See a doctor
SLT A: Has not *seen a doctor.*

[Volunteering]
PBM B: **How did they become a consumer member?**
SLT A: They volunteered…

[Reasonable Utilization]
PBM B: **Can we give them a flu shot?**
SLT A: No.
SLT C: We have time to get them in compliance…I will personally call and make sure it's done by that time…
PBM A: *I will follow up as well since that is a board issue.*
SLT C: **But it will be easy?**

[Reasonable Utilization]
PBM A: **Just to be clear…since they declare themselves as a consumer…**
SLT A: …Throughout the course of 2 years. I've seen 2 visits, 4 visits, and that is just within one year…that is **reasonable utilization**…having one a year or just a vaccine would not be effective utilization.
PBM A: *We need to start* recruiting patients and put them in a pipeline…
SLT C: *We discuss them* every 2-3months.

PBM A: We will talk to these board members…is that by the end of the fiscal year…
SLT A: Right away. …

In this discussion of the permeability of a Professional into the Patient role, the participants asked several questions to determine the meaning behind the consumer status. How did this person become a consumer board member? How were they able to become a consumer without using services first? What services count towards being a consumer board member – a patient at the clinic? The conversation addressed the voluntary motivation towards opting-in to become a patient. The bylaws stipulated the timeframe by which a board member needed to utilize services. The boundary of Professional → Patient role was permeable, but could put the board at risk if they did not remain in compliance with a "reasonable utilization" that was stipulated in the bylaws. Specifically, this meant that those who represented *the* patient experience needed to get more than just a flu shot every year. Within the time frame of three weeks, the compliance issue was resolved, and the full board was reminded at the next meeting regarding the policy of "reasonable utilization" to represent *the* patient voice (FN 13B).

Within the data set, only one interviewee indicated that they were no longer using services at the clinic, transitioning out of a PBM and back into a Contributor role. However, for reporting requirements the organizational artifacts still counted the individual as a "patient." This scenario took place at FQHC-D that had more than the required 51-percent patient-majority board, and therefore, the drop was not significant in putting the clinic out of compliance. The ideal situation for the Patient-Contributor was exhibited by the

individuals who first selected to receive services at the clinic before joining the board, a total of 5 of the 18 PBM interview participants.

Summary of the Contributor Role

Individuals with occupational backgrounds in a variety of industries (i.e., healthcare, education, accounting, law, business, engineering, nonprofit leadership) were recruited to the board for their ability to contribute to the needs of the patient-majority board. These board members engaged in learning specific to the FQHC and nonprofit sector, transferring their occupational skills into a new environment. The Contributor offered a pragmatic voice in the board by comparing vendor contracts to their professional experiences, and advocated for alternatives. They also monitored the funding environment extant to grants and the fundraising. The contributors surfaced at pivotal times in FQHC-A and FQHC-D in times of division on the board to represent a neutral voice – a voice that explained their position of why they selected their position.

The boundaries for the Contributor role was that the organizations sought representation of the patient population in terms of race/ethnicity and gender. There was also a discussion of diversity in terms of age, although parents of patients counted as representation of age. The boundaries of representation marked a point of permeability for the Patient and the Contributor roles. Contributors were not exclusively CBMs as they could choose to become patients or had already selected the clinic as their primary care facility. However an existing patient with a professional background in finances, education, or healthcare represented ideal nominees.

ROLES WITHIN THE PATIENT-MAJORITY BOARD

As developed in Chapter 1, existing scholarship of roles in governance frequently examines the role in inconsistent ways. For example, studies may examine the role of the board collectively (see Brown & Guo, 2010; Hopkins, 2003), or the role of leadership (e.g., board chair; see Harrison & Murray, 2012; Wright, 2013a), or the role of diversity (e.g., gender, SES, race) in impacting organizational outcomes (see Boulouta, 2013; Wright, 2013b; 2013c). Existing studies within the context of patient-majority governance frequently examined the role of the patient as the singular phenomenon without addressing the roles of remaining board members (see Crampton, et al., 2005; Paap, 1978; Wright & Martin, 2014). The qualitative examination of roles as grounded in perceived and achieved expectations identified by participants in interviews and demonstrated in meetings identified significant roles within the boardroom. This focus on determining roles from the level of social interaction (both perceived and observed) rather than *a priori* designations of status reflected that one's role within the board was "an achieved phenomenon" (Boden, 1994, p. 101) rather than a static demographic characteristic (see Pelled, Ledford, & Mohrman, 1999; Wright, 2013a; 2013b; 2013c). The focus on defining roles based upon communicative interaction within this study identified that that one's role was not exclusively defined by categorical status markers of income and patient status, but rather the contributions one was able to make from their professional and/or personal lives to the board. Figure 4 summarizes the range of status characteristics, communicative norms, boundary violations, and level of permeability identified in the Patient, Perennial, and Contributor roles. Similar to Castor and Jiter's (2013) work on nonprofit governance, each

of these roles identified in this chapter contributed to a specific area of expertise: *the* patient voice (the Patient role), the historical function of the board (the Perennial role), and the skilled contribution of their occupation (the Contributor role). The examination of roles within the boardroom contributes to existing literature on the permeability and duality of roles (i.e., Patient-Contributor) and expands the role of the patient in health and organizational communication.

Figure 4: Summary of role findings

	The Patient	The Perennial	The Contributor
Status characteristics	*External*: FQHC status requires 51% patient-majority board *Organizational*: Board bylaws for an equal number in leadership positions *Individual*: Lower to higher SES	*External*: Philanthropy and exist within the same social circles *Organizational*: NPO financial business needs *Individual*: Higher SES	*External*: Professional affiliations (e.g., Legal/ Accounting Associations) *Organizational*: Contribute to the intellectual diversity of the board *Individual*: Lower to Higher SES
Communication Norms	*The Curve*: Learning about the work of governance, healthcare, and nonprofit • Listening • Asking questions • Attending regional and national conferences	*The Stretch*: Engage in learning from individuals with diverse perspectives • Participate in calling the patient scheduling lines to experience the wait-time • Tour the clinic sites	*Context-Specific:* Learning about the healthcare industry and nonprofit sector • Understand industry trends • Different non-profit terms for finances • Identify similarity in data • Learn the context of primary care

Figure 4 continued

	The Patient		The Perennial		The Contributor	
Communicative Norms	*The* Patient Experience: Focus on sharing the experience common to all patients rather than idiosyncratic PBM experiences.	• Discuss wait times and referral experiences during committee meetings • Share safety concerns with SLT • Use patient complaint lines to report complaints	*Fundraising*: Take ownership of fundraising with private donors	• Ask donors for money in the "classy way" • Substantial influence in fundraising events (e.g. luncheons, galas, and auctions)	*The Pragmatic Voice*: Provide a business perspective when examining financial opportunities and expenses	• Ask questions about staff work load related to new and existing grants • Engage in discussions about working environment and potential need for resources
	Not-so-secret shopper: Lack of anonymity of PBMs within the clinic	• Thanking staff • Online identification • Sharing			*Neutral contribution:* Maintain a neutral position in conflicts between patient and non-patient board members	• Stay professional • Don't be rude • Being "less crazy" on polarizing issues

Figure 4 continued

	The Patient		The Perennial		The Contributor	
Boundary Violations	*Pulling rank*	While in the clinic as a patient, using one's board member status for faster or better services saying, "Do you know who I am?!"	*Attendance*	Not prioritizing meeting attendance when scheduling personal vacations	*Too many questions*	Asking questions that give other board members the impression that you are auditing the staff
			Discouraging learning	Engaging in sarcasm about "remedial" learning that would be beneficial for other board members	*Recruiting for Diversity*	Emphasize recruiting patients with professional skills and expertise who reflect the demographic diversity of the clinic's patient population
			Bounded Recruitment	Identify potential nominees for CBM but not PBM positions		

Figure 4 continued

	The Patient		The Perennial		The Contributor	
Permeability	*Permeable by Perennials & Contributors*	Volunteer to become a patient and maintain reasonable utilization	*Permeable by Contributors*	Remain connected following board service	*Permeability into the Contributor role*	A pre-existing status of Patient and Perennial dual-role status

Although status characteristics represented a significant variable in previous studies that differentiated patients with lower incomes and higher incomes (see Wright, 2013a; 2013b; 2013c), income in this study was framed as a perception. Income, a perceived social characteristic with certain degrees of visibility (see Pelled, Ledford, & Mohrman, 1999), introduced a range of how the participants perceived their financial situation in relation to other board members. This focus on the perceived level of income (i.e., higher, lower, or about the same as other board members) reflected the social construction of income for the participants. Individuals within the patient role did not distinguish a difference between high-income and low-income patients, as it was the experience of being in the clinic that provided access to *the* patient experience. Perceived levels of income (higher, lower, or about the same) to their board counterparts also indicated that patients were not always representative of the low-income status of FQHC patients, nor were contributors always representative of individuals from a higher socioeconomic status. However, individuals in the perennial role perceived their income as higher than other board members. Although *a priori* distinctions led to statistically significant relationships with organizational outcomes (see Wright, 2013a; 2013b; 2013c), findings from this study indicate that SES was not categorically exclusive to specific roles, with the exception of the Perennial role. Future studies should consider the significance of socially constructed positions within the boardroom in addition to the objective measures to better understand the impact of board composition on roles within the boardroom on organizational outcomes.

Starting from the standpoint of grounded theory (Corbin & Strauss, 2008; Glaser & Strauss, 1967), this study identified a significant feature of role permeability in governance.

Permeable roles are defined as the degree to which participants may inhabit the domains of multiple roles (see Clark, 2000). Permeability of roles in studies of organizational communication is almost exclusively examined within the context of work-life balance (see Berkelaar & Tronstad, forthcoming; Clark, 2000) or micro-role transitions within individual identities (see Ashforth, Kreiner, & Fugate, 2000: Cheney, Christensen, & Dailey, 2014) rather than maintaining dual roles in a single organization. Given the significance of "representative patients" on the board (i.e., patient's with a low SES; Wright, 2013a; 2013b; 2013c), the permeability between the patient and contributor role in this study represents a key finding for studies of consumer governance. For participants who were both a patient and a professional, the directionality and intention of engaging in dual role status was significant. Individuals in the contributor role who wanted to fully commit to the organization engaged in the transition to receiving healthcare at their clinic. The board actively sought out patients with a professional background for board service. Specifically, an existing patient with experiences that met the needs of the board, such as knowledge of finances or healthcare, provided a valuable opportunity for an individual to be both a Patient and a Professional, simultaneously. The role with the least amount of permeability was the Perennial as it required a length of service with the board and a financial giving capacity.

The differential permeability among and between the roles identifies the values associated with maintaining dual roles (Contributor-Patient | Contributor-Perennial) and the limitations experienced by the Patient role. For individuals with a dual role as a Contributor-Patient or Contributor-Perennial, the Contributor experience and background

that benefited the work of the board (e.g., business, finance, education, or healthcare) was acquired before and not during board service. For the individual solely within the Patient role, none of the participants expressed that they experienced an external benefit or prestige status from serving on the FQHC board. Paap (1978) argued that structural equality (i.e., PBMs and CBMs benefit equally from board member status) was essential for achieving effective governance within the patient-majority board was not evidenced in this study. However, this lack of evidence may also be due to the qualitative nature of the study and limited representation of external status benefits acquired by PBMs, and future studies would benefit to explore this further. Additionally, the individuals solely within the Patient role did not experience the same opportunities to remain involved in the post-governing board dynamics of the FQHC after they reached their term limits. A Patient cycling off onto a foundation board or onto a committee represented the exception not the rule in this study. Third, the ability for a Contributor to opt-in to receive services at the clinic (i.e., represent a dual role status of Contributor-Patient) also indicated that there was a level of choice for Contributor-Patients that was not necessarily available for existing PBMs. Finally, the practices of recruiting PBMs in this study emphasized the desire to recruit existing patients with a professional background that would benefit the clinic. Patients with a professional background were perceived as having the skills and representation that was most beneficial for the work of a board, and thus not lacking the background previously identified by Wright and Martin (2014).

One unanticipated dynamic of identifying roles within the boardroom emerged in the role of interpreting the absence of communication and how participants defined this as

an expectation associated with different roles. Silence, the act of not speaking, within communication is significant means to "question, promise, deny, warn, insult, request, or command…" (Saville-Troike, 2003, p. 24), to identify a conversational abnormality (Sacks, et al., 1974), or to silence a marginalized group (Covarrubias, 2011). However, in this study, participants defined silence as a productive engagement essential to learn or express one's role. Given the temporal constraints extant to the meeting, participants reflected that everyone speaking for a pre-determined amount of time was not pragmatic. The limitations of formal meetings with "a rather stable set of interactants and some rather specific turn-taking modes" (Boden, 1994, p. 89) shaped an alternative and positive meaning to not speaking up that has yet to be examined within the board literature. Traditional assumptions that emphasize everyone should speak equally about every agenda item was not the desired state for the sites participating in this study. Instead participants spoke on matters they relevant to their role, and not to just speak for the sake of speaking.

Of the roles identified within this study, the role of the patient challenges traditional perspectives of what counts as participation of consumer involvement in organizational communication. Stakeholder theory (see Fulk, 2014; Wellens & Jegers, 2013) perceives patients as a consumer or client with a vested interest in the success of an organization with limited power. Hirschman's (1970; 1980) frames patients as consumers with a voice that needs to be heard, perhaps best heard within patient satisfaction surveys (see Roter & Hall, 2011). However, the patient board member introduces a new organizational position for both scholars of organizational and health communication. They are both a consumer with

a voice that may be heard through patient-satisfaction surveys or complaint lines (see Roter & Hall, 2011) as well as a board member with direct access the executives.

The role of a patient board member introduces an unquestioned tension for patient board members regarding both their anonymity and privacy. With the exception of a few participants in the study who sought to keep their board member status concealed from their providers, most participants were recognized by staff as board members. This finding counters a previous finding by Wright and Martin (2014) for the role of the patient to be a secret shopper for the board. Secret shopping indicates that participants pose as a regular consumer who will then later evaluate the quality of service provided. However, in this study, participants were known or discovered as patients with board member status. Several patient board member participants questioned and perceived that due to their known board member status they were already receiving the best of the best care available at the clinic. This further questions the ability for patient board members to maintain a secret-shopper identity within the organization. Thus, this study examined the tenuous nature of board member anonymity within the context of a not-so-secret shopper.

In relation to privacy of personal health information (PHI), this study complicates disclosures of health information by PBMs. Developed previously in Chapter 4, the presence of patient board members served as a form of authentication of operational data presented to the board – preventing the "whitewashing" that may take place within board meetings. For the board, this is a valuable insight. However, for the individual patient, this exposes the patient to disclosing PHI to non-medical professionals (i.e., other board members and guests in the boardroom). Concerns with privacy in health communication

engage almost exclusively on the privacy within the context of PHI exchange between health insurance companies and employers (for a review see Geist-Martin & Scarduzio, 2011) and information exchange with patients and their providers (for a review see Guttman, 2011). Within this study, the patient board members may disclose PHI to other board members (e.g., homelessness, HIV, diabetes, hypertension) auspices of representing *the* patient experience. Although patient board members expressed that they would willingly speak about their healthcare experience to the board when relevant, certain disclosures of PHI may engage more risk of privacy (e.g., HIV versus pregnancy) and require further investigation.

CHAPTER SUMMARY

The prioritization of communication as the foundation for identifying and developing roles identified the boundaries and the permeability of roles within an organizational context. The roles in this chapter speak to value participants placed on the individual contributions of board members made in overseeing a clinic with a mission to deliver quality healthcare to the safety-net community. Chapter 6 critically examines the challenges associated with this distinct board composition as the organizations overcame the challenges of exclusion to achieve inclusion within the context of patient-majority governance.

Chapter 6

Communicative Exclusion and Inclusion

The requirement of a patient-majority governance stipulates a particular form of board member composition without defining the nature of communication within formal board meetings. Demographic data of board members presented in Chapter 2 and Chapter 5 indicated that a "patient" status was not purely defined by the socioeconomic status of a person. Instead, a "patient" reflected an individual's decision to receive healthcare service at the FQHC as a commitment to the community, organization, and board. The "patient" status thus emerged as a significant position in the boardroom in addition to representing a federally mandated requirement. Previous studies on board composition focused on justifying the need for a diverse board by demonstrating a functional relationship between board diversity and organizational outcomes (see Crawford et al., 2002; Gazley, Chang & Bingham, 2010; Harris, 2014; Wellens & Jegers, 2013; Wright & Ricketts, 2013). The findings explain why diverse board composition matters by examining the significant ways in which individual differences impact organizational outcomes. However, the studies do not identify the processes enacted within board meetings that lead to these outcomes (see Millar et al., 2013). With the fundamental role of communication in meetings, this study examines communicative strategies of inclusion and exclusion in board meetings. This study contributes to existing literature by examining how differences in the social position of the "patient" majority and the "non-patient" minority define inclusion and exclusion within the boardroom. This chapter addresses the gap in research by examining the

communicative approaches that include and/or exclude board members within the particular composition of patient-majority governance (RQ3).

The analysis of data followed the grounded theoretical approach (Corbin & Strauss, 2008; Glaser & Strauss, 1967) to identify the communicative meaning and development of inclusion in four sites that recently transitioned into a patient-majority board composition. The focus of this study and the analysis of data examined inclusion from the perspectives of participants (CBMs, PBMs, and the SLT) and the observation of boardroom meetings at FQHC-A and FQHC-B. Data collection and analysis challenged in framing inclusion as any isolated communicative act within the boardroom as participants indicated, "I don't believe we can *be* inclusive. Inclusion is something we *feel*" (8A SLT). Indeed, the speed of turn-taking among 20 or more individuals engaged in numerous verbal and nonverbal communicative interactions may not be experienced equally by all individuals in the room. However, participants defined their understanding of how to create inclusion within the boardroom as they reflected on issues of exclusion in the past. Grounding the definition of communicative inclusion within qualitative data defined inclusion as a process of identifying and resolving exclusive patterns of communication. The resolution of exclusive events towards more inclusive communication illustrates a dynamic rather than static state of inclusion. The sites of patient-majority governance had a past that was punctuated by particular episodes of exclusion resolved within the board to become more inclusive.

SUMMARY OF ANALYSIS

The analysis of data in this chapter engaged the technique of axial coding within interview data first and then triangulated within the observations. The primacy of interview

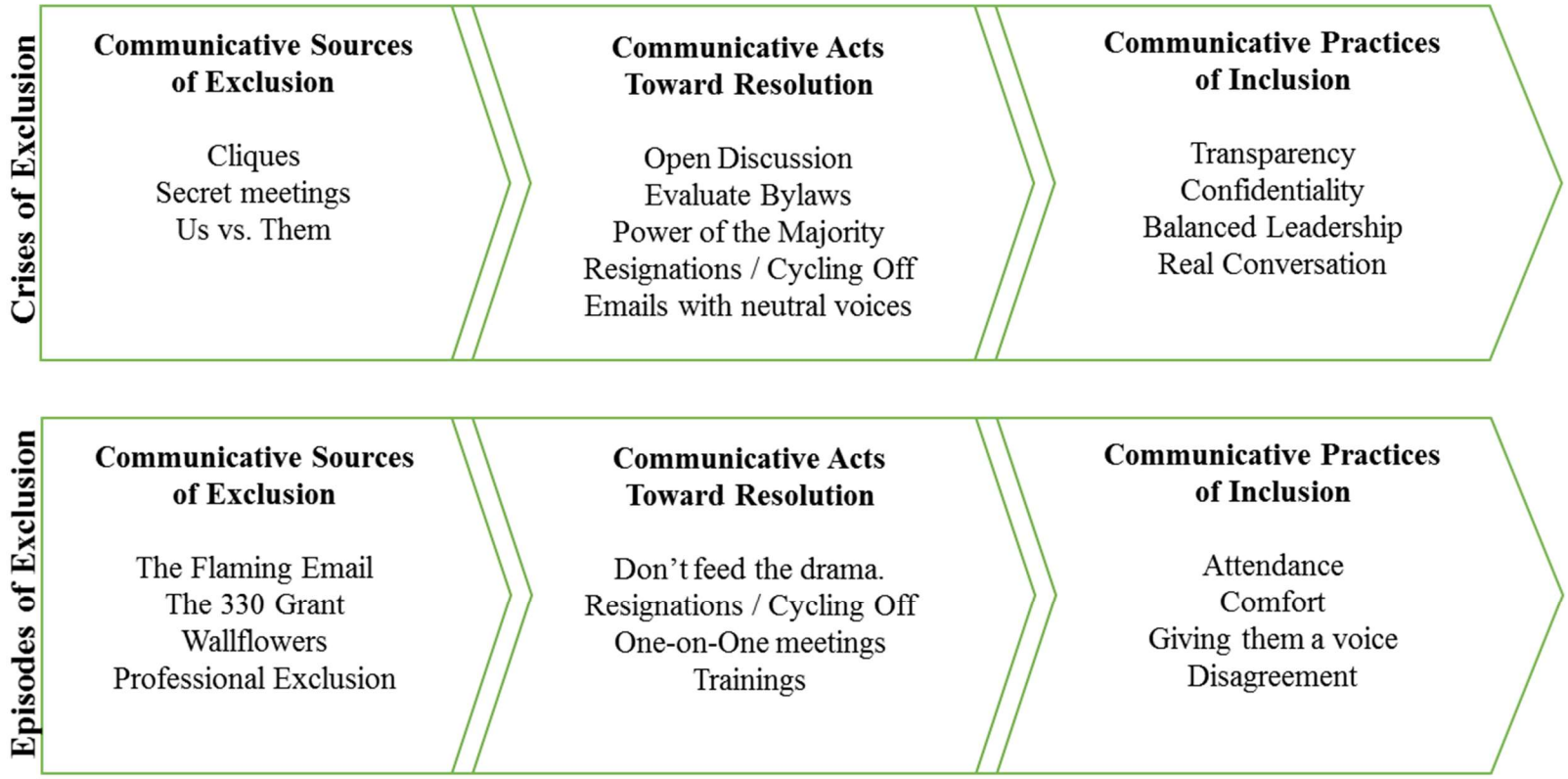
data preserved a perspective of inclusion from the point of view of participants as they represent the primary source of past incidents of exclusion. Axial coding identified exclusion at the group and the individual levels. In order to manage the different levels of exclusive communication, I added the following terminology to distinguish between group level exclusion (i.e., labeled a *crisis of exclusion*) and the individual level exclusion (i.e., labeled as an *episode of exclusion*). The process of resolving the exclusion on the board established communicative strategies of inclusion through establishing policies that ensured a more inclusive board, not plagued with the past hindrances of exclusion. The processes of resolving issues of inclusion emerged as individual, staff and board level initiatives to train the board members to participate and not be "wallflowers" (1C, PBM) on the board. The existing patterns of communication reflected the policies and norms within the present state of the board that was deemed appropriate and valuable by interview participants.

The conceptual development of communicative strategies to include and exclude individuals is presented visually in Figure 4. The analysis develops the crisis of exclusion before addressing the episodes of exclusion. Each of these situations iterated particular strategies of inclusion, building upon existing conceptualization of architectures of inclusion (Allman, 2002) and organizational voice (Hirschman, 1970) to establish inclusion as a significant communicative dimension in organizational communication scholarship.

MODELING EXCLUSION AND INCLUSION

Figure 5 depicts the communicative interactions of the boards started at the point of exclusion where the board enacted strategies to achieve higher levels of inclusion. Exclusion within the context of this study focused on situations that resulted in communicative efforts to resolve the issue through one-on-one meetings, board members resigning, and/or the creation of new policies. Whether presenting as a crisis of exclusion (i.e., group level) or an episode of exclusion (i.e., individual level), participants identified these points as pivotal moments in identifying a lack of inclusion. Board members leveraged the issue to indicate how each board improved significantly on inclusive communication patterns over the course of three years (preceding participation in this study). The arrow marking the point of communicative strategies of inclusion indicates that the starting point of inclusion identified in this study are limited to the four sites of patient-majority governance. These organizations may experience future growth or improvement within inclusive communication. Additionally, sites of patient-majority governance not included in this study may express a broader range of inclusive communication. Therefore, the arrow indicates a hope and opportunity for continued evolution of organizing for inclusion. To develop the communicative strategies of inclusion, the following sections present the analysis of crisis of exclusion and episodes of exclusion.

Figure 5: Modeling the communicative process of inclusion



CRISIS OF EXCLUSION

Three of the four sites of patient-majority governance reflected how their board experienced a divide between the patient and non-patient board members within the past five years. Representing a past event, the interview data from participants across three sites (FQHC-A, FQHC-B, and FQHC-D) identified an issue involving the CEO that divided their board. The hires, fires and evaluates the CEO – the sole employee of the board. The crises of exclusion divided each board between the CBMs and the PBMs and linked to the resignation of board members following the resolution of the issue.

The divide between CBMs and PBMs enacted differences across the three sites; therefore, the analysis presents a discussion of each distinctly different scenario that is specific to each site. *The* "*key and no-key leaders*" (4A, PBM | 6A, PBM | 9A, SLT) represented the division of the board at FQHC-A as ten participants still serving on the board discussed the issue with the replacement of the CEO. *The Interim* crisis of exclusion at FQHC-B represented the division of the board surrounding the decision of hiring a new CEO based upon the contributions of three interview participants and observation of two board meetings. *The Clique* represented the division of a set of board members at FQHC-D and is constructed from the three participants still serving on the board that experienced the issue. The difference in the number of participants who reflected on these situations indicated the number of board members still on the board who were present at the time of exclusion. Recruiting individuals who left the board was not part of theoretical sampling techniques in this study as individuals who left the board were not part of constructing the current inclusive strategies – the focus of this study. The shrinking number of participants

at each site reflects a natural mortality rate in the phenomenon of governance as each site experienced turnover on their board. The turnover within the board did not minimize the significance of the crises of exclusion as fieldnote data obtained at FQHC-A and FQHC-B accounted for how the issues were re-introduced into the boardroom during orientations and discussions of key issues. Additionally, new board members at FQHC-D discussed during interviews how they heard about the "drama" of the past. Triangulation with new board members and observational data, exclusion represented a significant and residual impact of inclusive communication on the current board.

The "Key and No-Key Leaders"

The transition into a patient-majority board signaled the potential for conflict, particularly at FQHC-A.

> I always knew that there was going to be a conflict. We call it the "have" and the "have nots"… the "key members" and the "no-key members." They, [the CBMs], were the key members, and we, [the PBMs], were the no-key members. I knew at some point there was going to be some sort of come to Jesus meeting. I didn't know when, but, I was surprised the way it happened, when it did, and how it backlashed onto [the CEO] as opposed to the no-key members. I thought it would be more about the patients, but it was more about [the CEO]. (6A, PBM)

Even with the anticipation for a conflict, the conflict surprised the PBM by backlashing onto the CEO. Spearheaded by a former board member, the "key volunteer" spoke to CBMs on the board and individuals in the community *not* serving on the board. These conversations resulted in developing a group of "key volunteers" (9A, SLT). The "key volunteers" perceived issues with the financial management of the clinic and started holding "secret meetings." During the secret meetings, the key volunteers "put together this little ultimatum" calling for the resignation of the CEO (9A, SLT).

The pivotal moment in this crisis of exclusion was that patients were not included in the secret meetings or included in the group of "key volunteers."

> I think that backfired in their face because all the no-key members really surrounded the CEO and said, "No." Because the CEO was the reason we got the FQHC and was the reason we were moving forward. But the change I think was too much for the established- and they didn't like the way it was going. (6A, PBM)

The division created an "us" versus "them" as the discussion from secret meetings surfaced in the boardroom, a point at which the PBMs rallied around the CEO. This crisis of excluding the PBMs from secret meetings resulted in a moment when the "consumers exercised their muscle" (9A, SLT). To the benefit of the CEO, "the patients, as the majority, began to recognize they had power, and exercise power in the face of key volunteers trying to backdoor their preferred personnel" (9A, SLT).

Altogether this crisis of exclusion "was difficult…and not pretty" (2A, PBM). It placed the organization at financial risk of potentially losing private donors. Four board members eventually resigned (three CBMs and one PBM), and four new members joined. However, turnover did not resolve the crisis of exclusion. The resolution required the board to come together to resolve the risk introduced by former board members – a continued step of inclusion within the boardroom.

> Attacked from our own board members, we circled the camp and got down to business to make sure that nobody stepped out of line and everybody stepped in place. We were very conscientious of who we were speaking to and what we were saying. Nobody made another misstep, which was very beautiful. (6A, SLT)

The resolution to the crisis of inclusion required communication to keep everyone stepping "in place" and "conscientious" established the inclusive communication, emphasizing "transparency" and "confidentiality" that are developed later in this chapter.

The Interim

At FQHC-B, the board experienced division when deciding which candidate to hire as CEO for their organization.

> Primarily, the consumer members were very invested in the interim CEO. The consumer board members knew this person, liked this person, felt like they were doing a good job and really didn't want to look elsewhere. They weren't really finding any compelling reason to move to anyone else. (9B, SLT)

The CEO hiring process identified two potential candidates. PBMs desired to hire the interim CEO whereas CBMs desired the outside candidate for the CEO.

> The reason the meeting, in my opinion, went sideways is because at the time we had two board members who, rather than having the organization's interests at heart, were single issue board members. They let that single issue dominate their thinking and their actions and their approach to everything with regard to the board. It was a single issue. (3A, CBM)

The divide between the PBMs and CBMs started within the committee tasked with the hiring of the CEO. The committee involved one CBM, two PBMs, and two external non-board members. Based upon a bad experience with the individual, two board members wanted to fire the interim CEO. “That's all they wanted to do, and that's a corrupted mentality for board governance” (3A, CBM).

The committee, the place where the “work of the board” is done (see Chapter 4), voted against the interim CEO. The decision in “the direction of a new person, ousting the interim CEO. The consumer members had a fit and rallied all the other consumer members” (9B, SLT). In contrast to the rallying that took place at FQHC-A, the rallying of PBMs did not reverse the decision on the committee. Instead the resolution of the issue was the establishment of policy stating that the board could not hire an interim CEO as the permanent CEO.

The issue and the subsequent policy that emerged from this crisis of exclusion surfaced years later as the board entered another transition of CEO leadership. The revisiting of the issue took place just prior to entering an executive session.

> PBM 1: The executive committee discussed the SOP (standard operating procedure) for the CEO…The acting CEO should not be someone who is being considered for the official position
> CBM: SO you want people to chime in? Because I will. This came from…the experience you all had last time with the interim …that being said, we discussed it at length, and we came to a conclusion that it should not be a requirement…If you are applying for the job it shouldn't preclude you from being an interim…there was some hesitant…it got discussed and reiterated that it is a common practice…
> PBM 2: I can't understand….*there is too much noise on the phone*.
> PBM 1: Thank you [PBM 2] we will make note of that
> CBM: It is standard operating procedure.
> PBM 1: [name of guest]
> Guest: I would like to discuss where that came from…the world of hurt you were in years ago…we can talk about that now or wait until the executive session…
> PBM 1: …I would rather talk about it while we are on the topic…let's officially move into executive session.

The board moved into an executive session ending the observation of the conversation surrounding the past incident of division on the board (FN 16B). PBM 1 and CBM speaking at this time were not on the board at the time of the division.

The beginning of this conversation drew upon the realm of a "standard operating procedure" in any organization and the "standard operating procedure" for *this* board based upon the crisis of exclusion. Discussed during the meeting and fieldnote excerpt above, the "standard operating procedure" in any organization meant that an individual serving as an interim CEO was not automatically barred from succeeding into the permanent position. Even though the board created the policy years ago as an attempt to resolve the crisis of

exclusion, the policy did not reflect the "standard operating procedure" in the industry. Now that the board indicated a substantive amount of turnover in board membership (six interview participants joined the board after the crisis), the board engaged in an in-depth discussion about the history of this policy within the executive session. For a board with a "professional" board culture, the guest who facilitated the conversation in the executive session, and thus, not detailed in observations nor discussed during interviews due to conditions of confidentiality

The "Clique"

The final crisis of exclusion at FQHC-D centered also on the evaluation of the CEO, creating a division that started with a "clique."

> I'm going to use one word first. Dramatic. You notice this in other boards. Sometimes it gets **cliquey**. People group up, and they feel the need to do that. I don't know why. Again, people forget the scope of the work that we're supposed to be doing. They take their own personal vendettas in consideration, in their decision making…It hampers us doing and performing our board duties…I'm not going to name any names. Maybe you'll interview some people, and you might be able to spot them. I might be one of them. Who knows? Who knows? (2D, CBM)

The "clique" with groups of individuals taking up "personal vendettas" impacted the performance of "board duties." However, it also created division in the board around the CEO.

> About three years ago there was such a divide or a group. We had some people who didn't like the way the CEO was running things, questioned the CEO quite a bit. Then we had that group that thought s/he was doing a good job. A few of us tried to stay neutral. (7D, CBM)

The divide centered on the CEO with a divide that was nearly split between patient and non-patient board members, and primarily initiated after the board "acquired a group of

people" who lived in one of the new service areas. "That's when we had our biggest split," and the two groups "did not agree on anything" (7D, CBM).

Based upon the retelling of the event from the participant with the longest term of service, the split around the CEO led to the CEO contacting the board member.

> S/he called me one day, and said, "I don't know how you feel, but I'm getting such bad vibes from these people. I think I'm going to resign." I said, "Well, I don't think you ought to do that. We're talking about three of four people. I just think you ought to stick it out. It's tough right now. We got a couple of other little cliques on the board, but I don't think all of them feel the way this one group does."
>
> S/he said, "Well, I just wanted to know if I could count on you to vote for me?"
> I said, "I think you're doing a great job. In fact, you're wearing too many hats. Probably, you need some help with all the work that you have to do as CEO…I will definitely vote to keep you on if it came to that." (7D, CBM)

The conflict never came to a vote as members of the clique resigned from the board.

FQHC-D represented the site with the largest amount of board member turnover within the past year. Prior to data collection, four new board members served only four months before resigning (4D CBM). At the time of data collection, four of the interview participants were new, three participants experienced the drama of the cliques, and one cycled off the board during the course of data collection. The turnover enabled the board to establish and train board members on desired communicative interactions for the board, a symbolic effort to change communicative interaction by changing the interactants.

> Often times, I would get frustrated for lack of respect by some of the board members. Their lack of respect being shown to some of the employees of the organization. I don't know all the full details of it. I'll tell you every now and then, you can still see it. (2D, CBM)

The cycle of refreshing the board members was the resolution to the "lack of respect by some of the board members" towards the SLT.

The significant amount of turnover in the board resulted in a mandatory training hosted by a third-party in the organization. A "well done" training that lasted "all day…a full day…from 8:00 in the morning until 5:00 in the evening" (4D CBM). Representing almost a freshly minted and re-trained board, participants reflected that the current meetings were not divided like in the past.

> I don't think that we'll see it this next coming year, because I think that there are several board members that they've reached their term capacity, or they're not going to renew their term per se. (2D, CBM)

The residual drama of the conflict around the CEO was not perceived as a current concern with the current board.

The Negative Case

Participants from the fourth site in this study, FQHC-C, did not reflect on a crisis of exclusion in their board. Instead, participants reflected how their experience was nothing like the "horror stories" shared at trainings or conferences. For example, one of the "horror stories" shared at a training was a board that had "armed police" present because the meetings would get so intense (1C PBM). This point of comparison led participants at FQHC-D to conclude that "some boards don't work as well as we do." At the same time, the board composition received a recent overhaul as part of the board's strategy for the clinic. This strategy enabled the board to recruit individuals from the patient population who were "indistinguishable" from non-patient board members (2C CBM). Characterized as a professional culture (see Chapter 4) with several PBMs that served dual roles as both a patient and a contributor (see Chapter 5), FQHC-C appeared to have existing inclusive structures in place for discussing the performance of their CEO.

> You let (the board chair) know if you think that CEO needs to be fired. If that's the case…we're going to need to have a major executive session. I think you're going to be out there alone because I sure as hell don't see it. (1C PBM)

For the limited sample size of four participants, each of the PBMs and CBMs at FQHC-C spoke positively of the current work of the CEO, particularly in comparison to the former CEO (2C CBM). However, board leadership ensured any issues with the CEO would be moved into an executive session. In the executive session, the board could freely discuss the evaluation and assessment of the CEO in a confidential session without staff or other external stakeholders present.

Board Level Communicative Strategies of Inclusion

Participants at each site that experienced a crisis of exclusion identified that their board was now better than before.

> If you had arrived three years ago. You would have said, "This is going down the tubes." Well, it didn't. They really got through it. (1A, CBM)

> We, those of us that were there at the time, laugh at now and say, "Thank God we're better than that now." (3B CBM)

> I think that we're moving forward in a progressive manner now. We need to continue that momentum of being efficient and respectful. (2D, CBM)

Communicative strategies of inclusion surfaced as a result of the past crises of exclusion. FQHC-A established the policies of transparency, confidentiality, and balanced leadership. FQHC-B established a policy that was later retracted years later as the board entered in a new round of hiring a CEO. FQHC-D experienced a high level of turnover and training that resolved the cliques of the past.

Transparency

Transparency reflected an intention, or strategy, of establishing and maintaining open communication within the board, removing barriers between board members. First, transparency in the boardroom enabled and encouraged board members to attend any and all committee meetings.

> I think people are comfortable that we recognized what happened. We've learned from it. It really came down to making sure that we maintained transparency and full communication between all members of the board because I think the breach and the disruptive breach occurred when just a segment of the board started to meet and have and make executive decisions that weren't inclusive of the whole board. (3A, CBM)

In other words, there was not a meeting that a board member was restricted from attending. During orientation of new board members, they were encouraged to attend any and all committees (FN 16A). This communicative act symbolically valued engagement of the board members in any and all decisions taking place at meetings. "No one person runs the ship. We are all captains of the ship…and we all make the plans of where our destination is" (6A, PBM). The communicative emphasis on equal votes ensured that there was not "1st class or 2nd class" members on the board (1A, CBM). There was also an emphasis in not identifying individuals as a "patient board member."

> Overall, we much more have moved to not all the time identify as patient board members and community board members. Some of the patient board members were very much want to identify as being patient board members. It's certainly a requirement as an FQHC. It's an important aspect of being FQHC, so it's certainly something that's there. In terms of my dealing with them, I really do my best not to distinguish between whether a patient board member or community board member. (16A, SLT)

Here the inclusive strategy drew back to the distinguishing which board members counted as a "patient board member" for the purposes of the federal reporting requirements but not

necessary within board meetings. Despite the minimization of the "patient" distinction taking place by individual on the SLT, every PBM at FQHC-A introduced themselves as a "patient board member" when onboarding new board members (FN 16A, see also Chapter 4). This indicates that the balance between inclusion and exclusion was not the removal of the label "patient." Instead, the communicative strategy of transparency included the individuals in meetings and considered "patient" status as an important feature in balanced leadership.

Formal policies for board leadership represented the final dimension of *transparency.* Transparent selection of leadership positions was an "overt" process that ensured that the "consumer" and community members chaired an equal number of committees. The transparency in leadership selection had yet to come "full circle" at FQHC because they had not yet had a PBM serve as a board chair (3A, CBM). The barriers to achieving transparency in a patient board chair required additional transparency between external stakeholders and the board that valued the structure of transparent patient-majority leadership (3A, CBM).

Confidentiality

The second outcome of this crisis of exclusion was the development of *confidentiality*. Confidentiality reflected a strategy of keeping communication within the board, creating a barrier between the board and external stakeholders. By making the efforts to "circle the camp" to protect the organization, all board members participated in the circle and maintained the confidentiality of conversations within that circle. "We were very conscientious of who we were speaking to and what we were saying" (6A, PBM).

When a board member needed to speak to external stakeholders, the board new what that individual would say and the organization trained them on how to present in front of key funders (19A, SLT) or at community events (FN 6A). New board members were also explicitly oriented to the expectation that conversations of the board stay would in the board (FN 16A) as board members were reminded about "the importance of confidentiality."

Confidentiality, aligns with the governance literature as the duty of loyalty (Hopkins, 2003), prioritized conversations of the board as conversations that should take place within the boardroom. Confidentiality sought to resolve the "breach" (6A, PBM) that took place when board members included non-board members into secret meetings that divided the board. As an inclusive communicative strategy, confidentiality reinforced transparency within the boardroom by bringing everyone together to "circle the camp." Circling the camp meant that board members needed to talk with each other to resolve issues instead of disclosing issues to outside stakeholders without consent of the full board. Speaking to external stakeholders without the knowledge and approval of fellow board members, excluded board members from having a voice in what was disclosed and to whom information was disclosed.

Confidentiality that drives transparency. Policies within the boardroom represented an organizing text in the boardroom to frame communicative strategies of inclusion as desirable and expected. Transparency emphasized that board members could participate any meeting they desired whereas confidentiality emphasized that board conversations needed to stay within the meetings.

> The patient board members, some of them would get super aggravated at the facts that those people (CBMs) would talk to each other. There's literally no way to stop that from happening, I would argue. (18A CBM)

Although patient board members at FQHC-A indicated that they participated in the same recreational activities outside the board, they did not indicate that they spoke of board related matters during these interactions taking place outside of meetings (6A, PBM | 12A, PBM). Interaction between certain board members outside the boardroom was "unavoidable" (18A CBM) but there were no more "secret meetings."

Participants indicated that they may email the board chair a question after the meeting or say something after the meeting to the board chair, but interactions with staff and other board members regarding board-related matters was limited.

> No. All my contacts are within the board meeting. I don't do that extra stuff. I don't believe in it, number one. I feel like if you're going to talk about something that pertains to the board and that pertains to (the clinic), it should happen in the committee meetings or the board meetings. Anything after that, actually, I don't have time. You know what I mean? (5A PBM)

The extra conversations outside the meeting meant extra time. If it pertained to the clinic and the work of the board, participants desired the discussion to occur within the boardroom. A strategy echoed by the CBM participants.

> No, I don't meet with them at all. I have met with CEO sometimes outside and with the board chair. I had lunch with (a member of SLT) when I first got on the board to find out what was going on. As far as other interactions really, I had a little interaction with (another SLT member) about compliance. I really don't have that much communication with staff. If it is, it's just a short email. "What about this?" (2A, CBM)

With the exception of meeting with staff to prepare agendas for committee meetings, learn about the operation of the clinic, finances, or fundraising, the participants indicated limited

interaction with staff outside of the boardroom. Limiting the interaction outside of the boardroom prioritized transparent communication within the boardroom that included any and all individuals present at meetings.

Transparency represented a significant component in establishing transparent, or overt, policies that ensured patient and non-patient board members in positions of leadership within the board. The balance of leadership on the boards was identified as a significant feature of the board (6B, CBM | 1A, CBM) and reflects previous findings that patient and non-patient board members were equally likely to hold positions of leadership (Wright, 2013a). Observations of these two sites confirmed that the policy reflected organizational activities. Even though balanced leadership was perceived as valuable to the FQHC board, the position of board chair leadership required a PBM that fit was perceived as possessing a specific kind of "optics."

> Now, I do think that the person we had teed up to ascend presented themselves very well in front of this donor and showed the skill set that we value, and I think they would be receptive to that member. But they haven't had the same opportunity, with another member who is very interested in taking the position, and who optically is a little more challenging to accept. I'd love it if that person was there. But, I think it would be a BIG step for (donor) to deal with. (3A, CBM)

This indicated that in addition to the "skill set" valued by the FQHC the board chair also needed to be "optically" accepted by donors. The donor represented an external driving force that resulted in the organization changing their succession plan. The PBM (de-identified for purposes of anonymity) that was approached to step down from the position of leadership agreed to do so as it was the decision that was "best for the clinic" regardless of personal desires to serve in the position of leadership.

> Obviously we weren't handicapped with this because we had set in place a patient member to ascend. And, we had to retract that. So these are pressures that are coming from the outside. (3A, CBM)

One of the suggested ways to resolve this issue involved developing a succession plan of individuals moving from secretary to treasurer to vice chair to board chair. However, the board declined the initiative to establish this succession plan into higher positions of leadership (1A, CBM). Instead, the balance of leadership positions between PBMs and CBMs remained open to any board member into a position of leadership without experiential requirements, thus, retaining a transparent strategy.

Disagreement and "Real Conversation"

Although the crisis of exclusion focused on a point of division and conflict on the decision being made by the board, inclusive communication was *not* the pursuit of unanimous votes on all decisions. Participants perceived disagreement recorded in non-unanimous votes desirable.

> We have, as a board, only ever had two votes that were not unanimous. That's wrong. That right there should be a sign that something is wrong. There should be differing opinions and serious discussion that causes division of some sort. (1B, PBM)

In contrast to the exclusive events that divided the board, the participants sought out disagreement and "real conversation" (4A, PBM) Real conversation was a time when questions were asked and disagreement surfaced. However, the time constraints and structure of the agenda limited the ability for the board to engage in this type of conversation (4A, PBM | 1B, PBM | 6D, CBM | 3C, PBM).

> One of the things as a chair that comes up is probably communication…that is, when a discussion gets going and letting it go far enough that everybody feels like

> they've had their say, but not to let it get out of control or to let it become repetitious… Sometimes that line as to where do you step in and say, "Okay, I think we need to move on." That's a fine line to walk. It's like this is a board chair, as a chairman of a committee, in progress. (1C PBM)

Chairs of the committees and the board chairs needed to decide the point at which everyone "had their say" without the conversation becoming "repetitious." Allowing space for disagreement and conversation was "in progress" and not deemed to be fully achieved, indicating that higher levels of discussion could take place in the future.

> That's one thing, they taught in Leadership, which doesn't work too well in a board as big as this. If you're having a conversation about a subject and somebody hadn't pitched in, the chairman could ask them directly, "Well, what do you think about this?" to try to draw everybody into the discussion. (2B, CBM)

The strategies to facilitate conversation in meetings did not "work too well" (2B, CBM) in the board due to the size. Instead the chair "left open" the discussion for longer, which gave individuals a "chance to say what they want to say" without specifically drawing every single person to speak on every agenda item.

If tension after a vote persisted, the board chair revisited *a decision* evidenced by participants at FQHC-C and FQHC-D. Participants expressed how the meeting after a tense vote on substantive topics (e.g., the CEO and expansion projects), the board chair restarted the conversation at the next meeting. For FQHC-D, the tension leading up to the vote on an expansion project created division and drama as board members took sides on the issue (1D PBM). After the chair revisited the decision at the next meeting, the board reversed their initial position. Following the second vote, board members who disagreed shifted their focus to, "Okay, you got it. Now, let's see what you do with it" (5D, PBM). The "side conversation outside the board [at] places of work…almost ceased. It did cease once the

vote was taken" (5D, PBM). Revisiting the vote presented a new vision for the organization – to achieve effective expansion. The method to achieve the vision was then the work of management. The vote symbolically represented the final point of the disagreement as the board members needed to move forward with the decision.

Throughout the presentation of data, the communicative norms within the boardroom that expected individuals to speak up when they wanted to speak up and to say what they want to say also introduced the need to examine the way in which the board included individual board members who did speak. Inclusion of individual board members required additional analysis of the individual experiences with exclusion, developed next as episodes of exclusion.

EPISODES OF EXCLUSION

Analysis of episodes of exclusion that impacted individual board members identified two dimensions. The first dimension involved board members who conducted themselves in a manner not appropriate for the work of the board, specifically and exclusively excluding patient board members. The second dimension involved participants who perceived they were not involved in a discussion relevant to their role. This dimension was experienced by CBMs and PBMs within the contributor role. Participants identified these experiences in the interviews and further developed the challenges of resolving exclusion to achieve communicative strategies of inclusion.

Exclusion of patient board members

The analysis of interview data also identified significant events within communicative interaction specific to the exclusion of PBMs within the boardroom. These

episodes of exclusion reflected issues in PBMs effectively engaging in unprofessional communication (i.e., "the flaming email"), understanding organizational policies and requirements (i.e., "the whistleblower policy," "the 330 grant,"), and effectively engaging in the work of governance (i.e., "wallflowers," "there for the food," and "not contributing in substantive in areas"). The episode of the flaming email highlighted a high level of individual actions deemed inappropriate for the boardroom. The episode of the 330 grant highlighted exclusion surrounding matters of policy, similar to the episode of the whistleblower policy. However, the 330-grant represented an issue at understanding federal policies that supersede organizational policies (i.e., the whistleblower policy) and, therefore, is the more significant episode of exclusion selected for analysis. The issue with "wallflowers" represented a substantive area reflecting the dimensions of board members who attended meetings for the free food and/or did not make significant contributions to the board discussions.

The Flaming Email

The episode of exclusion reflected the recent past of FQHC-A when a former PBM became "the lady in red," feeding off and instigating drama within the board (1A, CBM), targeting the CEO, and culminating in a "flaming email" sent to a fellow PBM. Targeting the CEO, the PBM "was aloof and uninvolved, until there was a crisis. In a crisis, the PBM was all over it. Then, I was either on a pedestal or in the ditch" (9A, SLT). The constant fluctuation from issue to issue led to the non-clinical assessment that the PBM was acting "crazy" (7A PBM). However, the SLT was not the only target of "the lady in red" (1C

CBM) as the PBM took issue with another PBM, creating the full episode of the "flaming" email (1C CBM).

Pivotal to the episode of the "flaming email," the "lady in red" violated the board's established communicative strategy of resolving concerns offline before ever putting it in an email. "If you had a concern, you would go to the person and not put it in writing, unless you felt that what you expressed was ignored" (6A, CBM). The "lady in red" violated this expectation by targeting a new board member via email with "this huge long memo calling her out and airing the dirty laundry" (6A, PBM). The target of the flaming email recalled how the email was sent to the whole board, but "nobody was really answering the email." The lack of responses from other board members left the PBM unsure of what "everyone else is thinking." However, the board members had already decided to not respond to drama incited by the "lady in red." The silence around the email was broken at the following board meeting.

> Man, I let her have it at the board meeting. I said, "You're just a bully, and this is unacceptable behavior. She just got on the board. Give her a chance. If you have a problem with her talk to her." (6A, PBM)

The PBM delivered the verbal reprimand the PBM attacking a new PBM via email. Labeling the communicative act as bullying behavior, the PBM reiterated the board approved way of talking about issues in person rather than via email, unless the concern was not resolved through the face-to-face conversation.

Reinforcing the communicative norms and expectations for board members, the board rallied together again in two ways. First, they collectively made an effort to not encourage further drama.

> I felt confident in my notion that drama queens abhor tranquility. If we kept the drama out of it, she would become bored. We wouldn't be her fun plaything anymore. She would leave. And she did. Dramatically (laughter). It wasn't quietly (quiet chuckle) - with one last flame mail. (1C CBM)

The board came to a "no nonsense" approach after a board training. The board chair "drew the line" and "was willing to stand up to the PBM whereas most CBM are excessively differential to the patients" (9A, SLT). The line that was drawn was that the board would not feed the drama. Questions of the "lady in red" would be answered. However, board members would not feed into the drama and hold the line for the appropriate communicative work of governance.

One participant followed the "proper way" to resolve the issue by speaking with the "lady in red" one-on-one (4A, PBM). However, the result of the one-on-one interaction did not alter the course of the individual who continued to engage in what was perceived as inappropriate communicative engagement for a board member. With the one-on-on ineffective in correcting behavior, the board rallied again together at a closed meeting, or an executive session (not a secret meeting) with all board members with the intention of evaluating the "lady in red."

> Long story short, one of our board meetings we had a closed meeting and we did a presentation. It was like a case the way he did it. Because he went back. She was writing dirty notes. She would show up at the office and publicly just say awful stuff when clients were there. She was doing all this stuff. It was easy for us. (4A, PBM)

The presentation of concrete examples of actions taken by the "lady in red" concluded with the recommendation for the removal of the board member.

> Okay, he didn't have to go that far. But, he did a very thorough job of all the evidence about why she should not be on the board anymore, and we voted her out.

> And she was there when he did all that presentation. And we asked, "Is there anything you have to say?" "No." she didn't try to argue it or anything, and we got her off! (4A, PBM)

The resignation of the board member concluded the episode of exclusion, but continued to live on as a point of instruction for new board members at the orientation (FN 16A).

> CBM1: (PBM) reminded me…If you want to send out emails to multiple people, *that's okay*…don't send out flame emails
> CBM2: It's so much fun though.
> *Laughter*

There was no additional explanation describing what types of emails were "flame emails" during the orientation. However, the board members were encouraged to "keep things professional."

The value of communicative inclusion indicated that individuals needed to express differences of opinion in the proper ways.

> We can have a difference of opinion, but you don't go in for the jugular in a public way… I may be wrong, but I don't think that's the proper way that things get accomplished… Everybody was really glad that she resigned. (6A, PBM)

Within the context of FQHC-A, the single PBM became the target of exclusion by violating the "proper way" to communicate with the board. A collection of issues centered on the individual who was over-involved in the operations of the organization and sending flaming emails to the board about a new board member. The participants were very clear that it was not the difference of opinion that led to the exclusion of the board member, but the communicative actions of the behavior that resulted in the desire for the resignation of the board member. This represents a significant element of exclusion that identifies how unprofessional board behavior is not tolerated from CBMs or PBMs simply for the sake of

inclusion and patient representation on the board because unprofessional behavior hinders effective engagement of other board members.

The 330-Grant

The episodes of exclusion surrounding FQHC policies presented within the situations of the 330-grant and the whistle blower policy. Both situations expressed the way a PBM took action on a substantive policy of the organization in a manner that was contradictory to the success of the organization. The whistle-blower policy took place at FQHC-A while the 330-grant took place at FQHC-B. To provide a representation of episodes of exclusion distributed throughout the sites participating in the study, this section develops the episode of exclusion for the 330 grant at FQHC-B.

The episode of the 330 grant started when "consumer board members who, for whatever reasons, would refuse to vote to approve the section 330 grant" (3B CBM). Part and parcel to the particularity of a Federally Qualified Health Center, the 330 grant represents the source of federal funding made available to clinics that meet the 21-requirements of an FQHC. In other words, the "330 grant is the funding which makes the organization an FQHC" (3B CBM). "That just seems like shooting yourself in the foot. 'Let's not be an [FQHC]. I'm not going to vote to be an FQHC'" (3C, CBM). By refusing to approve the 330 grant, the PBM symbolically communicated that they were not invested in the FQHC. Interestingly, the PBM voted against funding linked to the FQHC status, the status that required patient-majority governance and the reason for their presence in the vote.

In this episode of exclusion, “the board member wanted to read” the document before voting for the 330 grant (3C, CBM). This document for the 330 grant was a “pretty fundamental document. It's this thick” (gesturing a thick stack of papers; 3C, CBM). It was not discussed whether this board member read through the entire document, but a unanimous decision was not required to move forward with the vote for the 330 grant. However, the situation represented an “unintended consequence” of patient-majority governance. The “unintended consequence” where “there may be a lack of experience or background or training to put you in a position to be in the legal fiduciary obligation of managing a (multi-million) dollar corporation.” When an individual who “might have made it through the twelfth grade” wanted read the entirety of the document, it created a “dangerous position” for the organization (3C, CBM). The specific PBM “cycled off” and was replaced by a different representative. “We were very fortunate to have the (diversity) representative that we have now. That board member does have a college degree, and brings a methodical thought process to things” (3C, PBM).

The outcome of the issue resulted in not only the eventual replacement of the PBM with a “fortunate” selection of a patient with a college education, but also emphasized the importance of “ongoing board training.” The board thought it was “important to coach up our board members, so they can grow and develop during their tenure on the board. I think the organization has been quite successful at” doing the training. In the midst of the successful training, individuals on the SLT indicated that the most recent training was not as successful as they intended due to scheduling issues (8A SLT | 9A, SLT). However, three of the four board members (3 PBM and 1 CBM) who attended the training reported

back to the board meeting that it was "informative" and "well done" (FN 13B). The training efforts within the organization educated board members on the requirements of FQHCs, the work of governance, and the role of the board, and thus, offered a solution to future incidents of a board member voting against standard activities, such as pulling down the 330-grant and counteracting the fundamental components of what makes an FQHC an FQHC.

"Wallflowers"

Similar to the work conducted by Chait, Holland, and Taylor (1996) where disengagement is perceived as a disruptive experience on the board, the analysis of wallflowers indicated that board members not engaged in key areas were perceived as excludable. In contrast to engaging in efforts that contradicted the nature of an FQHC (i.e., voting against the 330-grant), the episode of a "wallflower" exemplified the ways in which PBMs were perceived as not contributing on substantive topics for the board. A phenomenon explicitly referenced at two sites in this study, the participants identified an issue within including PBMs who appeared to be there "for the food" (9A, SLT), "for the free meal" (1B, PBM). "Wallflowers" represented the description of participants, particularly PBMs, who "during the meeting do not say anything. They may have no idea what 'health parameters' mean, but they do not ask for clarification, for understanding of what is being discussed" (2C CBM).

> There are these small dynamics working that should be raised and haven't. They're getting stagnant. They believe they're disenfranchised. You'll notice some of them don't even speak. All during the board meeting, they just don't speak. It's wrong. (1B, , PBM)

The concern with "wallflowers" was that when they did choose to contribute to the meeting, they were not perceived as contributing to "substantive areas" of the discussion. For example, the individual may take issue on whether the clinic would be closed on a holiday (2C CBM) but never engage in discussions about financials, strategic goals, measures and metrics. The lack of speaking on any substantive topic was a potential indicator that the individual may not have the "capacity to learn how to be a contributing member of the board" (8A SLT).

The importance of understanding "wallflowers" as episodes of exclusion fell within the distinction between attending meetings and taking on the role of a board member.

> I think the role of being a board member period should be equal regardless of whether it's a patient or not. To me it's making a commitment to learn about the facility and the community you are representing...it's going to be upon each of us…Because just attendance shouldn't be satisfactory. I think it is how engaged are we. What part are we contributing? What are we doing?" (4A, PBM)

Attendance was not the goal of being a board member, even if attendance was a challenge for some board members (2A, PBM | 9B, SLT). It was a communicative effort to demonstrate a "commitment to learn about the facility and the community," to communicatively ask questions, to "contribute on substantive topics," and to not be a wallflower.

The resolution to this episode of exclusion was fleeting. The chair of the board or the committee could explicitly ask individual board members if they had anything they would like to contribute.

> We've actually tasked the board chairman to call on these board members. It worked for one meeting. I don't know how to move that dynamic. It's been discussed over and over again. (1B, CBM)

However, observational data collected for six months at FQHC-A and six months at FQHC-B identified that the open invitation of a chair asking, “Does anyone have any questions, comments or concerns?” never resulted in an individual speaking up. Individuals who asked questions or provided comments during the meetings appeared to come from a state of preparation or individual initiative taken by CBMs and PBMs rather than a response to an open invitation to speak. Only twice was a particular board member called upon within FQHC-B, asking the CBMs their thoughts. The response in each situation was that their question had been answered or their concern was already addressed.

The resolution to this episode of exclusion was fleeting. Each site of governance conducted trainings and board member education. Each board chair opened the floor to more questions before going into a vote, “Does anyone have any questions?” Each board chair reflected that they could maybe improve on calling on specific individuals to speak on a matter. In the extreme event of a board member being “there for the food” a resignation or cycling off the board enabled the board to recruit a new, more qualified PBM. Based upon the observational data, the essential dimension of identifying participation and “wallflowers” was a combined assessment of speaking up during committee meetings and board meetings. If a board member spoke frequently on the committee but less in the board meeting, they were not counted as a “wallflower.” However, the board members who did not speak at all, missed several meetings, and exhibited behaviors of a “wallflower” resulted in the SLT questioning their ability to learn what it meant to be a board member and questioning why the person had their board term renewed (8A SLT). In the midst of

SLT questioning their involvement, board members did not name names of "wallflowers" currently on the board. Instead, they questioned the participation in general, "You aren't doing anything. Why do you want to be on the board?" (4A, PBM). The explicit references to particular "wallflowers" examined within this section focused on the participation of former board members. When these individuals left the board, it was deemed a "relief" (2C CBM). When individual wallflowers left the board either through resigning, cycling off, or reaching the end of their term limit, it enabled the board to move together into a more inclusive board where individuals contributed more equally, invested in learning about the clinic and the work of the board.

Contributor Based Exclusion

The second dimension of episodes of exclusion applied to PBM and CBMs within their Contributor role at FQHC-A and FQHC-D. This dimension is the only factor of exclusion that was identified within the analysis by marking an absence of communicative interaction between SLT and board members with specific expertise. Board members represented a variety of individuals.

> On the Board of Directors, we have community leader personalities. We have, as you know, patients. Then we also have other people who have specific talents that contribute to the board that way. They're not necessarily people who are big community leaders in the city. They have great expertise, which is invaluable for us. (19A, SLT)

SLT acknowledge that their board composition included board members with "specific talents" that contributed to the work of the board (see also Chapter 5). However, board members reflected on instances when SLT did not ask for their expertise, preventing them from making a potential contribution to operations of the clinic as a board member.

The episodes of contributor-based exclusion emerged as board members learned of actions taken by SLT, representing a retrospective and reflective point of exclusion. If the SLT "were making a financial decision, they would go talk to the people in the finance committee and people with CPAs" (18A CBM) just as lawyers addressed legal matters. SLT did not always come to board members with "specific talents" outside of the typical financial or legal realm. Event planning was one particular example.

> It was a meeting that had nothing to do with board… I found out in that meeting that …they worked out something with a vendor where they're just going to pass out…all this pre-fab stuff in little bags. So much waste, and little bottles of water. (12A, PBM)

Even after offering a suggestion that would be more "decorative" and "scream healthy," the suggestion "fell completely flat" (12A, PBM).

In a separate situation at FQHC-A, a CBM experienced exclusion when the clinic sought to a hire a consultant in an area that the board member "actually knew about."

> As a board member, you do know this is one of the things that I can have a very informed opinion about and help you…it seemed weird to me not to ask for my expertise in that case. It was weird, not in terms of my desire to…tell you what the right answer is…but I actually do know about this. It would make sense to come to me…That was weird to me, not taking advantage of the skills of a board member. (18A CBM)

Disclosing a potential conflict of interest in the matter and a potential for micromanagement, the board member reflected how it was "weird" to not utilize the skills on the board.

In contrast with the previous episodes of exclusion experienced by PBM, Contributors did not voice their experience with exclusion to staff or other board members; therefore, no actions were taken or requested to resolve the situation. One contributor

verbally offered to participate in event planning (7D, CBM); however, it took approximately two years for the individual to be included in the event. The other participants who experienced contributor-based exclusion did not indicate that they made any verbal attempts to ask SLT to include them nor did they indicate that any other board member spoke on their behalf. Participants reflected that even though they were not included per se, the act of asking to be included on operational activities introduced the concern of micromanagement, reaching beyond the scope of governance (see Chapter 4). With the CEO representing the sole employee of the board, these instances of contributor-based exclusion engaged instances of other SLT members not asking board members about their input on a matter related to operations.

Individual Level Communicative Strategies of Inclusion

As the board encountered episodes of exclusion, the issues introduced a time when the board re-evaluated the communicative strategies to resolve the known issues of exclusion. In contrast to the crises of exclusion that spurred the formation of policies discussed earlier, the subsequent inclusive communication strategies focused on the dimensions that enabled individuals to be included and to include themselves within discussions on the board. The starting point of an individual being included was *attendance*. Once present at the meetings the inclusion of individual board members expressed three additional dynamics of communicative strategies to inclusion regarding the *speaking comfort*, *giving others a voice*, and *allowing disagreement*.

Attendance

Participants viewed attendance at board meetings as the beginning point of participating in meetings – the starting point of including oneself in the conversation taking place. Attendance surfaced in the explicit statements from board members regarding the absence or presence of board members during meetings. Attendance requirements at each site required a board quorum (a majority) to take action on any listed item. FQHC-B also established a PBM quorum policy that required a majority of the board quorum also include a majority of PBMs for board meetings (though not extended to committee meetings, see FN 14B). Attendance policies for the board limited the number of absences for board members, but allowed for extenuating circumstances (e.g., maternity leave, medical leave).

In addition to these policies, the factor of attendance emerged within observations as a significant point of discussion at the beginning of meetings and when making plans. At the beginning of every meeting, participants discussed whether or not they needed to wait for CBMs, PBMs, and SLT not yet present. When planning upcoming events at FQHC-A, the presence of PBM board members was explicitly discussed as a significant component to interviewing candidates for the board – to have a PBM and a CBM present at the meeting (FN 7A). The importance of attendance was also reflected in discussions of who was absent during specific conversations, and notably the absence of specific PBMs. An exemplar illustrating this dynamic took place at FQHC-B, when a PBM was absent from a meeting taking action to dissolve a committee chaired by that individual (FN 19B). Within these examples, the absence of PBMs required a symbolic form of attendance took place when the PBM was metaphorically 'looped in' to the plans made during the meeting.

From the presence and absence at meetings, attendance represented the starting point of participants including themselves into the discussions at board meetings, a dimension developed next.

Comfort

All interview participants indicated that they felt included in the board and were "comfortable" speaking as a board member, a comfort of taking action to include oneself in meetings. Two of the PBMs indicated that that they were not always as "comfortable" in speaking up on the board. "I had to come to where I would feel comfortable to be able to express myself…But that was part of me, more about me" (2A, PBM). For the two interview participants who expressed an initial level of discomfort speaking up on the board, they established their comfort by drawing upon their experience outside the board.

> I knew that I had to advocate. I believe in advocacy. I've learned to speak on the issues that are near and dear to me as well as (the clinic). I'm just saying that I've already dealt with it out here (at my work) and now I'm in a different arena (the FQHC board). (2A, PBM)

The PBMs stepped into the new "arena" of board leadership at the FQHC where they achieved a level of comfort to "speak on the issues that are near and dear" to the individual and the clinic. Participants who felt comfortable speaking did not identify a specific point in time when they achieved comfort to speak up during meetings. Nor did participants identify a specific person that made them comfortable. Instead participants reflected a general atmosphere of the board as "welcoming" to their contributions. Comfort represents a significant dimension of conceptually developing the communicative process of inclusion as board members indicated comfort as an individual characteristic or trait that enabled

them to verbally include their ideas during meetings. As PBMs expressed the importance of "comfort" – including oneself – in speaking up, CBMs and SLT expressed a dimension of including PBMs by *giving them a voice*, examined next.

Giving Them a Voice

When asked about the value of patient-majority governance, SLT and CBM participants expressed an appreciation of the "patient" voice on the board. "I think not only is it important to our patients to feel like they have a voice, but it's important for the rest of *us to give them one*" (5A CBM). This perspective of giving PBMs a voice on the board acknowledged the difference in life experiences between the PBMs and CBMs. As developed in Chapter 5, the Perennial board members were "stretched" to learn about experiences different from their own. The presence of PBMs who experience "situations…so very different" from the Perennial board members "helps me to have a better appreciation for the goals of the clinic" (5A, CBM).

Giving them a voice was triangulated in observational data at FQHC-A and FQHC-B when board members explicitly discussed making an absent PBM "happy" with the decisions being made in the committee. The following field note data (FN 19A) captures one of these explicit references to seeking out a PBM voice regarding a committee decision.

> CBM: Can we talk about what is happening to the patient experience committee again? What does [name of absent PBM] think about that?
> SLT: *Had not talked to that PBM yet.*
> PBM: I can talk to her...
> ---
> CBM: Make sure that [name of absent PBM] is happy
> SLT: Yeah … make sure.

Of the eight PBMs on the board, this discussion captured the absence of one PBM. This PBM expressed a high level of commitment in chairing a committee now being dissolved and absorbed into a different committee of the organization (not the board). When PBMs were absent from meetings, CBMs and SLT reached out to the absent individual to discuss the change or upcoming event with the individual. Giving the patient a voice in the process did not mean that the board or committee needed to wait for the absent PBM to speak before taking a vote on an agenda item. However, the PBM with a vested commitment in the committee (i.e., committee chair) needed to be informed about the decision even without a vote on the committee.

Disagreement

Inclusion of members meant that individuals needed the opportunity to express disagreement with other board members, a topic also discussed previously within group levels of exclusion. Each site of patient-majority governance expressed the sentiment that sought a consensus though not always unanimous decisions (1C CBM). One example of this taking place at FQHC-A was when the board experienced individual levels of disagreement on whether the organization should take a position against the use of e-cigarettes in public spaces.

> That was one of the few times I remember, where there was a really disagreement and things did ultimately come to a vote. That was interesting…I think everybody was respectful of everybody else and share information that eventually people vote and see where things stand. I didn't get the sense that anybody got their feathers ruffled or feelings hurt by doing it. I think people had an opportunity to be heard on these issues. (16A, CBM)

Observational data of the meeting accounted the course of the discussion that eventually resulted in a motion and vote to continue the discussion and final vote to email for an e-vote. Although included on the five emails exchanged, the final vote was not announced via email. The CBM in the quote above shared how the vote was time-sensitive. With the delay in reaching a decision, the vote was no longer needed as the deadline passed, meaning that the organization did not announce a position on the matter of using e-cigarettes in public.

Disagreement on the board maintained a level of respect for the actions of board members, even if they acted outside the previously established "proper ways" to communicate.

> I can't speak for the others because I do respect the others that did not see it the way that I saw it. I was very respectful of them. But, I had to sit back and question hard. I did. Because my responsibility is to the people that we serve. I have a responsibility to other board members, but truly? We are there to serve the people and get their needs met (1A, CBM)

Inclusion within the board meant respecting "others that did not see [an issue] the way I saw it" as long as the different view point fulfilled the board member's responsibility to serve the people. Different opinions were respected and anticipated within the boardroom. Thus, inclusion did not require all individuals to see issues in the same way. Inclusion was a process of expressing and respecting disagreement within board discussions.

THEORETICAL IMPLICATIONS FOR COMMUNICATIVE STRATEGIES OF INCLUSION

The analysis within this chapter identified a significant relationship between communicative strategies of inclusion and exclusion experienced at each of the four sites of patient-majority governance. *Communicative strategies of inclusion* represent the

intention to use communication as individuals and as a board to build awareness of *how* to include individuals within the organization who represent diverse positions. Diversity, and the diversification of demographics within the boardroom, represents a strong trend in nonprofit board leadership according to the most recent examination of US based nonprofit boards (BoardSource, 2015). Existing studies of diversity in the boardroom highlight *why* diversity matters (see Bradshaw & Fredette, 2012; Chizema, Kamuriwo, & Shinozawa, 2015; Cornforth, 2012; Cox, 1991; Wright 2013a; 2013b; 2013c) without examining *how* diversity matters. The conceptual development of communicative strategies of inclusion examined *how* the board became more inclusive in response to an awareness of exclusive situations. Each communicative strategy of inclusion originated with the identification of exclusion – identifying who was being excluded and how they were being excluded – and a decision to resolve the issue by implementing architectures of inclusion.

The analysis of communicative strategies of inclusion contribute to existing scholarship in several areas. First, the analysis of communicative strategies of inclusion is inextricably linked to exclusion and not isolated as specific expectation linked to the internal and external flow of information in organizations (see Bradshaw & Fredette; 2012; Brown, 2002; Mor Barak, 2000). Second, communicative strategies of inclusion represented an emergent and dynamic use of organizational policies to establish a shared understanding of voice and power for the board. Lastly, the study of communicative strategies of inclusion identified significant contributions in examining voice in relation to both the desire for disagreement and approach to examining organizational voice and exit (Hirschman, 1970; 1980). This section examines these contributions.

Linking Inclusion to Exclusion

Developed previously in Chapter 1, Mor Barak (2000) and Brown (2002) sought to develop a conceptual framework for inclusion in organizational contexts. According to Mor Barak (2000), organizational inclusion is an "individual's sense of being a part of the organizational system" (p. 52) whereas the framework of inclusive governance, according to Brown (2002) reflects a board that engages in information seeking, developing awareness of key issues, and encouraging contributions from the community. The context of patient-majority governance, and other forms of consumer governance, integrate Mor Barak's (2000) focus on the individual's engagement in the organization and Brown's (2002) emphasis on an NPO boards use of consumer/client/patient feedback into one organizing phenomenon. Communicative strategies of inclusion require both a consideration of the individual's sense of involvement, the board's involvement of consumer feedback *that result from the awareness of exclusion that takes places at both the group and/or individual level.* In this study, forms of communication that lacked transparency (e.g., forming cliques, secret meetings), that lacked confidentiality (e.g., discussing issues with outside stakeholders), or openly bullying board members via email (e.g., the flaming email) spurred the exclusion of board members – almost exclusively the exclusion of patient board members. With the theoretical focus on strategies of inclusion in the board, the study did not pursue the investigation into the motivation behind such episodes of exclusion, particularly since many of the board members engaged in these activities were no longer on the board. However, the findings support the significance of establishing a shared understanding of what it meant to exclude and include individuals

regardless of an individual's motivations. Within the context of the boardroom, participants identified specific instances where exclusion was perceived as appropriate. For example, exclusion was appropriate when a board member attempted to bully a board member or SLT or engaged in communication that violated the norms respective to the individual's role or the board culture. Existing literature emphasizing the importance of inclusion in patient-majority governance prioritizes the need for the representation of the patient population on the board (see Wright 2012; Wright, 2013a; Wright & Martin, 2014) without identifying how interactions within the boardroom may result in unnecessary exclusion of PBMs (e.g., cliques and secret meetings) or necessary exclusion of individual members (e.g., the flaming email). Even if a PBM has equal access to information from SLT (see Mor Barak's (2000) definition of organizational inclusion), they may be excluded from conversations that take place in secret meetings. However, the majority of the board (51% PBMs) expressed the ability to overcome obstacles of unnecessary exclusion by coming together as a group. Future examinations of organizational inclusion (Mor Barak, 2000) and inclusive governance (Brown, 2002) should consider the influence of the minority and the majority in defining and shaping the nature of interaction within the boardroom.

Nonprofit organizations that are currently or have recently undergone a transition from a "working board" to a "governing board" may also take note of the level of exclusion identified by individuals within the contributor role in this study. The exclusion experienced by individuals regarding a potential and effective use of their professional expertise may be indicative of the sites of governance following the practices of a governing board rather than a "working board" (see also Chapter 4). A "working board"

may make greater use of professional expertise by enabling board members to contribute to event planning, management, and typical volunteer activities (e.g., cleaning, registering attendees at events) whereas a governing board may only engage the board in the operational activities associated with fundraising (see Brown & Guo, 2012; Masaoka, 2009). Connecting with findings from Chapter 4, board members experienced and episode of exclusion when staff did not ask the board member to contribute to an area that they "knew something about." Specifically, board members with experience outside the scope of financial, healthcare, or legal industries experienced episodes of exclusion. Given that SLT went out of their way to ensure that a patient board member be present in discussions related to patient care, SLT may also need to reflect this form of including contributors (i.e., seeking out board members with experience relevant to education, contract management, and event planning).

Establishing Shared Meanings via Organizational Policy

Community health centers that implemented the model of patient-majority governance responded to a federal policy mandating consumer representation in the board. However, the federal requirement represents only the starting place for inclusion in the boardroom. Within this study, the four sites of FQHC governance organized responses to exclusion by implementing board policies to define and shape how board members were to be included in the boardroom. These policies reflected the organizing response to create architectures of inclusion specific to their organization, shifting the focus of patient-majority governance from the sociological level of architectures of inclusion (i.e., federal requirement) to an organizational level of architectures of inclusion, such as policies of

transparency. In the nonprofit literature, transparency in the nonprofit organization represents a gold standard for organizations (Scott, 2013) to establish relationships with stakeholders external to the nonprofit (Eisenberg & Eschenfelder, 2009; Jensen & Meisenbach, 2015). However, in this study, transparency emphasized the nature of communicative interaction necessary to maintain accountability *within* the organization of the board, particularly between patient and non-patient board members. The examination of inclusion as a phenomenon *within* the boardroom rather than a dynamic of including stakeholders *outside* of the board, follows the argument of Chait, Holland and Taylor (1996) that

> a more accurate conceptualization…would emphasize inclusiveness within the board as opposed to friendship outside the board…assure trustees of their unconditional membership – equal opportunity to participate, obtain information, influence events and the confidence to be critical without fear of recrimination or isolation. (p. 8-9)

The focus on communicative strategies of inclusion *within* the boardroom identified the ways that the sites of patient-majority governance developed additional policies and communicative expectations for inclusion.

The communicative strategies of inclusion defined the dynamics of how multiple stakeholders (see Fulk, 2014; Wellens & Jegers, 2013) came together to make decisions of governance. As a category of organizational policy identified by Canary, Blevins, and Ghorbani (2015), architectures of inclusion (see Allman, 2002) echoed aligned with policies of both voice and power. Policies of voice and power "discuss who has a voice in the policy…and indicate that laypeople know the difference between lip service to

participation and true participatory practices" (Canary, Blevins, & Ghorbani, 2015, p. 55-56).

This study examined the ways in which the organization empowered the voice of board members to be heard within the boardroom. The voice of the consumer may be silenced in organizational newsletters (Gill & Wells, 2013), managed by employees (Eshenfelder, 2012), or used to mobilize change (Hirschmann, 1970; 1980). Studies conducted by Wright and his colleagues (Wright, 2013a; 2013b; 2013c; Wright & Martin, 2014; Wright & Ricketts, 2013) targeted exclusion as a phenomenon associated with lower socioeconomic status of patient board members. However, in this study, patient board members were not excluded purely due to their socioeconomic status. Instead, the crises and episodes of exclusion almost exclusively centered on the exclusion of the patient board members.

A significant dimension of voice within communicative strategies of inclusion in this study was the value placed on disagreement and real conversation within the boardroom. In contrast to Cox (1991) conceptualization of a diverse organization where intergroup conflict was minimal, these sites valued the difference that diversity brought to the organization. The findings of inclusiveness in this study align with Holland, Chait, and Taylor's (1996) identification that open disagreement between board members was a dynamic of "cohesive boards." Participants in this study explicitly expressed an interest in the board experiencing *more* disagreement and real conversation within the meeting as a way to improve the communication in the boardroom. The boundary with disagreement required following the communicative strategies of inclusion within the board that

prioritized face-to-face communication with board members over flaming emails, expressed the vested interest in the welfare of the clinic over "single issue" board members, and maintained transparent conversations within the board as a conversation kept confidential.

Defining Inclusion following Organizational Exit

The final contribution of this study in examining communicative strategies of inclusion examined the response of the organization in defining who they were following the exit of board members. Studies of voice at times of organizational dissent and exit (see Gosset & Kilker, 2006; Hirschman, 1970) examine the decision of individuals in the moment rather than the response of the organization following exit. In this study, the turnover of board members following situations of exclusion facilitated the ability to change communicative. As reflected by Chait, Holland, and Taylor (1996) the departure of board members represents a pivotal moment for improving board performance. The individuals who remained on the board significantly expressed a continuing desire to shape what it meant to have a voice in the board, defined as *a communicative act that seeks to approve or improve the current or future state of the organization* (see Chapter 1; Hirschman, 1970; 1980). In this study, improving board performance aligned with improving communicative strategies of inclusion. A time of turnover in the board enables the board to re-evaluate the inclusive strategies in the board to determine who has a voice. Dovi (2009) states that that "not only do some voices need to be brought in, some voices need to be muted." However, the muting of voices was not the particular goal of the board

as exclusion did not always result in the resignation of board members. Instead, those who remained in the organization participated in defining inclusive communication.

FUTURE STUDIES

Future studies of patient-majority governance and boardroom diversity should continue to examine the dynamics of communicative strategies of inclusion. One of the recommended strategies experienced by participants was to ask board members if they had any more questions or call on specific board members for their perspective. However, this was not deemed effective in drawing out conversation. Additionally, the process of everyone taking a turn for a specific amount of time in each meeting was also deemed ineffective for sites in this study due to the size of the board. Future studies should examine alternative means of increasing verbal participation from board members who may otherwise spend a majority of time in silence, engaged in learning about the organization without expressing a voice to provide oversight to the organization. Future studies should also consider the significance of verbal versus nonverbal forms of participation in board meetings in relation to achieving board outcomes and the perceived level of inclusion on the board.

Future studies should also examine the appropriate ways in which board members may express their dissent outside of the boardroom. Participants in this study identified that to voice disagreement outside of the boardroom to rally other board members, to gain media attention, or to discuss details with private funders as inappropriate. These communicative breached the level of confidentiality expected of their fellow board members. Participants also noted that anonymous reports to regulatory agencies reflected

a lack of understanding the work of governance and the complexity of policies and operations of the organization. This dynamic introduces specific concerns within the realm of voice in the redressing potentially damaging organizational practices in the boardroom. If an individual on the board identifies an issue in the organization, the board member needs to express this within the board meetings. However, what happens if voicing the concern is over-ridden by the majority? At what point, does going beyond the board make a difference in prioritizing the organization and fulfilling the duty of loyalty to the organization? In this study, the communication of board members on their way out who shared confidential information to media outlets or submitted an anonymous report of wrongdoing to federal agencies was deemed inappropriate. This may be due to the outcome that all audits of the organization resulted in no actionable violation taking place in the organization. Future studies regarding confidentiality as a communicative strategy of inclusion should examine the dynamics of voice in incidents that resulted in violations of federal policies and regulations for NPOs, and specifically FQHCs. If the organization is actually in the wrong, then the communicative strategy of breaching confidentiality may take on a redemptive dimension rather than a divisive dimension within the board.

CHAPTER SUMMARY

In summary, communicative strategies of inclusion within patient-majority governance required additional architectures of inclusion to develop new strategies and policies that symbolically valued the inclusion of the patient voice in the boardroom. These communicative acts provide meaningful ways for other organizations that engage in using consumer and stakeholder feedback in organizational decision making. When encountering

exclusion on the board, board members at each site of governance sought ways to resolve the issue. The resolution to exclusion established additional policies that enabled and supported strategies of inclusion (e.g., transparency, confidentiality, and balanced leadership). Through exercising inclusive communication, participants in this study identified that the board was "getting better" and was not what it used to be even five years prior to this study. At the same time, they reflected that there was still room for improvement in engaging even higher levels of discussion that would bring disagreement to the surface. With the existing strategies of inclusion in place, the participants appeared to take on disagreement in a professional way for the benefit of the organization.

Chapter 7

Discussion

Representing an exploration into communicative interaction in the boardroom, this study examined qualitative data collected from four sites of patient-majority of governance in the Southwest region of the United States. Using grounded theory techniques of data collection and analysis (Corbin & Strauss, 2008; Glaser & Strauss, 1967), findings from this study moved beyond framing the board as a stakeholder contributing in organizational decisions (see Lewis, 2005; Lewis, Hamel, & Richards, 2001; Sanders, 2013) to positioning the board as an organization actively organizing to achieve a distinct set of governance activities to contribute to the clinic. As an organization, the board is tasked with the responsibilities of governance achieved within a system of roles (see Chapter 3 and Chapter 4). The diverse composition within the patient-majority board introduced a system of roles and a variety of exclusive and inclusive communication as board members worked together to achieve the communicative work of governance. This chapter integrates the findings from the communicative work, roles, and inclusion to address the overarching theoretical and applied contributions, limitations, and future directions of the communicative dynamics of board organizing.

THEORETICAL CONTRIBUTIONS

Following the argument of Lewis (2012), the theoretical contributions of this study do not seek to emphasize or prove the uniqueness of the nonprofit sector that has already been substantively established by Frumkin (2002) nor do the contributions seek to demonstrate that governance is best studied in nonprofit organizations. Instead, the

theoretical contributions of this study grappled with the "big questions" regarding effective governance and diversity and inclusion in nonprofit boards. The following sections examine the contributions regarding nonprofit governance from a communicative perspective before addressing the dynamics of inclusive governance.

Nonprofit Governance

In contrast to the trends of governance literature that emphasize the fiduciary responsibility defining the role of NPO boards (see Frumkin, 2002; Hopkins, 2003), this study examined the specific component of defining the scope of governance in relation to the oversight of operations. Operational oversight represents a growing trend in board governance, according to Eadie (2001), a consultant to over 400 nonprofit organizations in the United States. However, few studies have examined this dynamic, more importantly few studies of governance differentiate between the status of a "working board" and a governing board. In a "working board," board members remain involved in the day-to-day operations by completing operational tasks. However, in a governing board, the board shifts to a focus on overseeing the financial and operational activities of the organization (see Brown & Guo, 2010; Masaoka, 2009). With paid employees completing the work of operations and the board overseeing the work of management, the interaction between board and SLT becomes central to understanding the limitations in oversight of operations. However, few studies examine the dynamic relationship between senior management teams and board members (for exceptions see Samra-Fredericks, 2000; Sanders, 2013). In this study of governing boards, participants identified this interaction of discussing operational issues with the senior leadership team as influential in shaping the boundary

between micromanaging or overseeing operational activities conducted by paid employees. At the same time, participants expressed that the achievements of the organization and resolution of issues discussed in board meetings as a valuable source of meaning for the being a volunteer board member. This finding supports Chait, Holland, and Taylor's (1996) identification of the "meaningful work" for a board, where board members are involved in organizational issues and find their involvement to be necessary for the final resolution of the issue, with one caveat. The board's involvement in the issue does not necessarily require the board to engage in doing the work of paid staff (i.e., as in a working board) or in defining the steps that need to be done (i.e., micromanagement). However, the governing board's involvement was to ask questions as necessary until they understood the issue, the strategy to resolve the issue, and the resulting outcomes of the solution.

The system of roles within the organization of the board (Katz & Kahn, 1978) is plagued with ambiguity (see Castor & Jiter, 2013; Paap, 1978). Existing scholarship on consumer governance, particularly the patient governance of community health centers, emphasizes the role of the patient (see Crampton et al., 2005; Cornforth, 2012; Morrison, 1978; Segal & Silverman, 2002; Paap, 1978; Wright & Martin, 2014) without simultaneously addressing the role of the other 49-percent of board members, a gap this study addressed. In contrast to the previous work of Wright (2013a; 2013b; 2013c) that imposed an a priori distinction between high and low income FQHC PBMs, participants in this study did not distinguish between PBMs with a high income or a low-income. Instead, the unifying experience of receiving healthcare at the organization represented the defining feature of who to include within the patient role. The voluntary self-selection to be a patient

or consumer represents a significant difference in the practice of consumer governance at FQHCs than at other types of NPOs. For example, community board members do not self-select to be homeless in order to keep the organization eligible for FEMA funding. Community board members at legal aid clinics must meet criteria for limited incomes before being eligible for services. The distinct strategy of diversifying the payer mix (i.e., a strategy to achieve financial stability) creates a substantive need to further examine the duality of roles, particularly for the contributor-patient board members. The diversification of payers, the permeability and duality of roles in the patient-majority board supports the need to prioritize the meanings constructed within the boardroom of what it means to be a "patient" and thus a PBM at the clinic.

Because roles in organizations reflect the behavioral expectations of individuals based upon their position in the organizing activity (see Biddle, 1986), findings from this study indicate that future studies should continue to examine roles grounded in interaction rather than solely based upon demographic characteristics (e.g., SES, gender, race). In this study, the focus on interaction identified that although participants spoke of SES within boardroom conversations, an individual's socioeconomic status was a defining characteristic for Perennial roles but *not* for Patient and Contributor roles. Specifically, Perennials held a significant position in fundraising activities when asking major donors for private donations or making their own personal contributions to the NPO. However, Patient and Contributor roles did not speak of their SES within the boardroom. Additionally, Patient and Contributor roles represented a diverse range of perceived income status within the board. This presents an interesting and contrasting finding to

Wright's series of studies (2013a; 2013b; 2013c) that emphasized low-SES as *the* defining characteristic of status for patient board members because in this study, income of Patient and Contributor roles was not explicitly discussed in conversations. Thus, findings in this study challenge the explicit visibility of income status of both community board members and patient board members *within interaction.* The self-identified perception of one's income for the Patient and Contributor roles held less significance in defining their interaction based role in the boardroom compared comparison to the Perennial role. De-emphasizing income for Patient and Contributor roles may represent an opportunity for future developments in examining the roles and the meaning of diversity priorities (i.e., intellectual diversity vs. demographic diversity vs. experiential diversity) within the context of consumer governance and the broader framework of NPO governance. If board members are no longer required to fit the traditions of successful leaders of financial means (see Chapter 1; Chait, Holland & Taylor, 1996), then it is necessary for governance scholarship to address the ways in which board member income remains a significant contribution and interactional behavior for some but not all individuals.

Inclusive Governance

Although BoardSource (2015) indicates that diversity is a growing trend in nonprofit boards, there is very little conceptual development of diverse boards that move beyond the business-case for diversity (Cox, 1991; Cox & Blake, 1991) or the value-in-diversity perspective (Herring, 2009) that examine diversity as it financially benefits organizations (for examples of this approach in the boardroom see Bernstein & Bilimoria, 2013; Erhardt, Werbel, & Shrader, 2003; Gazley, Chang, & Bingham, 2010; Harris, 2014).

Conceptual development of inclusion and diversity in organizational communication scholarship remains underdeveloped (see Lewis, 2005; Sias, 2014) and unable to capture the full range of inclusion and diversity in organizations. To move beyond the limitations of pre-determined demographics and status characteristics, this study started with the assumption that organizations do benefit from diversity and examined what it meant at each site to exclude and include individuals within the boardroom.

The theoretical contributions of this study examined what it means for the board to be included individually into the board and to be included as part of the nonprofit organization. This indicates that the board experiences organizational inclusion (Mor Barak, 2000) within the board, inclusive governance (Brown, 2002) within the patient-majority requirement, *and* inclusion with the organization. Mor Barak (2000) defined organizational inclusion as a "sense of being a part of the organizational system" (p. 52). Findings from this study indicate that a governing board remains separate from yet connected to the clinic; therefore, a governing board may feel excluded when their expertise is not used within the organization, particularly at times when they do not perceive their work as meaningful (see Chait, Holland, & Taylor, 1996). At the same time, a board and/or board member may experience a necessary feeling of exclusion – not being a part of the clinic – so they do not micromanage the staff hired to do the work. Therefore, inclusion of the board, when imagined as a part of a whole organization, may not be the desired or desirable level of inclusion especially for a governing board. In an organization, it is necessary to understand what it means to be excluded, who is being excluded, and whether or not the excluded individual desires to be included. For example, findings

presented in Chapter 4 identified that access to *all* organizational information may not be necessary for a board member; therefore, limiting board members' access to information may be a necessary component of defining the scope of governance. Additionally, findings in Chapter 6 identified that a board member who experiences contributor-based exclusion (i.e., not being invited by SLT into conversations relevant to their experience) may not advocate for their own individual inclusion on the matter due to the boundary between governance and micromanagement of operations. Examinations of inclusion in organizational settings should consider the dynamics and expectations extant to specific organizational actants. For example, board members and paid executive level staff may experience different inclusion differently than front-line staff (e.g., medical assistants, nurse practitioners, doctors, IT administrators, accountants, etc.) because the nature of their "work" and participation in the organization varies. Future studies of inclusion should continue to examine the empirical and theoretical distinctions in how board members experience and define communicative strategies of inclusion differently than other unpaid volunteers and paid employees.

Findings from this study also build upon Brown's (2002) conceptualization of inclusive governance. Brown's original statement of inclusive governance emphasized the importance of a board including consumer and community stakeholder feedback in decisions. Specific to forms of consumer governance at FQHCs, legal aid agencies, low-income housing developments, and organizations receiving funding from FEMA, the dynamics of including consumers as board members represents a substantively different form of inclusive governance than having a consumer advisory council or consumer

satisfaction survey (Brown, 2002). The distinction is that board members have a vote and place at the table in the very discussions leading up to the decisions whereas advisory councils typically only provide information and recommendations. Consumer governance defies traditional expectations of board memberships that encourages board members to "remain suitably aloof" (Chait, Holland, & Taylor, 1996, p. 97) from day-to-day operations. Findings from this study indicate that a consumer board member experiences particular challenges in defining their role as a board member versus their role in governance to not micromanaging staff, not pulling rank on staff, and being included in the board.

Future examinations of inclusive governance (Brown, 2002) and organizational inclusion (Mor Barak, 2000) should consider how an individual's sense of being involved in an organization is considered an appropriate level of involvement, particularly for a board member. These studies should cautiously differentiate inclusive governance extant to a governing board versus a working board (see Brown & Guo, 2010; Masaoka, 2009), as a working board is a common though not universal phenomenon of nonprofit governance. Eadie (2001) argued that overseeing operational activities is a growing responsibility of governing boards, which identifies a significant relationship between volunteer board members and paid employees of the senior leadership team; but few studies have examined this dynamic between the board and senior leadership (for exceptions see Samra-Fredericks, 2000; Sanders, 2013). Future studies should continue to examine the dynamics of what it means for a board to be included in the oversight of operations.

Finally, this study sought to examine inclusion (and hence exclusion) as a communicative strategy and *not* a phenomenon of organizational culture. By separating culture from inclusion, this study prioritizes an agenda for inclusion *as an expectation in organizing* rather than a value to be realized by organizations. In this study, each site shared a similar point of exclusion and strategies of inclusion regardless of their board culture (see Chapter 3). Data from this study also supports that communicative strategies of inclusion result from the experience and resolution to crises and episodes of exclusion within the board. This differs from previous conceptualizations of organizational inclusion (Mor Barak, 2000) and inclusive governance (Brown, 2002) by identifying inclusion as something that is achieved by identifying exclusion and deciding to resolve issues of exclusion. In order for exclusion to be resolved and the subsequent establishment of norms for inclusion, the organization must engage in a conversation about exclusion and what inclusion will look like in the future (e.g., transparency, confidentiality, or attendance). Although transparency, confidentiality and attendance are emphasized as habits of effective boards (see Chait, Holland, & Taylor, 1996), the boards in this study did not necessarily follow these strategies until after experiencing an issue with exclusion of board members. Findings of the study within the boardroom, indicate that discussions of exclusion are more likely to take place when a crisis of exclusion divides the board between the patient and the non-patient board members. Individual episodes of inclusion, specifically for patient board members, were typically resolved by participants in this study when supported by or initiated by patient board members. In this way, the patient status in the boardroom represents a significant position in the identification and support of

communicative inclusive. Given the majority status of the patient board members, this represents an influential and significant factor in considering the resolution of exclusion and implementation of inclusion within the boardroom. Future studies of inclusion and diversity in organizations would benefit to pull away from the cultural metaphors of diversity to acknowledge existing patterns of inclusion, identify instances of exclusion, and enable organizations to realize even higher levels of inclusion.

APPLIED CONTRIBUTION

The applied contributions of this study focus on two primary areas: targeted training and developing a board bench for consumer members. First, in targeted training, practitioners of patient-majority governance may find a tiered training program useful in targeting the needs of each board member role identified in this study – the Patient, the Contributor, and the Perennial. Contributors and Patients without previous board experience needed to learn both what it meant to be a board member. Contributors and Patients and Perennials without specific knowledge of the primary healthcare delivery to marginalized communities also expressed a need for training of the community and/or healthcare industry. This reflected the communicative patterns of learning about the role of a board member and defining one's own role as a Contributor and/or Patient. The Contributor role engaged in learning the context specific knowledge of the nonprofit FQHC environment, translating their occupational experiences into a new context. The Perennial role engaged in "the stretch" when shuffling the board composition and engaging directly with the patient population at the clinic. The Patient role engaged learning about what it means to be a voluntary board member, the healthcare industry, and connecting *the* patient

experience to the 30,000-foot view of measures and metrics monitored by the board. Thus, each role reflected a different communicative norm surrounding one's orientation towards learning about the board, the organization, and the other board members. In contrast to the "counterproductive" calls for more training of patient board members (Paap, 1978, p. 581), this study identified an empirical basis for the value of targeted and continuous training of all board members.

Second, FQHC boards will benefit from developing a metaphorical "board bench" for training and retaining patient board members (PBMs). A board bench draws upon sports metaphors where players who have trained and practiced with the team wait to be called up to play in the game. In the FQHC boardroom, this indicates that the clinic may need to create opportunities for patient participation in volunteer activities in a way that aids patients in developing knowledge and connection with the clinic. For example, one of the organizations in this study maintained a series of diversity forum panels where patients could attend and discuss key issues relevant to their community. Patients who participate in diversity forums with an experienced facilitator are granted an opportunity to think and strategically discuss their health care in relation to the needs of their FQHC. Alternative ways to build the board bench may be to engage patients in feedback forums, community outreach activities, community gardens, healthy eating and exercise programs, programs for reading in waiting rooms, or collaborations with other nonprofit, advocacy organizations within the community. Patients who invest in this type of participation develop experiences in partnering with the organization's mission, a key component of the work of a governing board.

In addition to building the patient board bench prior to joining the board, the board bench may also consider ways to build the bench by retaining high performing PBMs. In the same manner that board members in the Perennial role were able to cycle off the board onto a foundation board or onto a committee, PBMs with investment and commitment in the organization may be highly valuable to retain on a Patient Advisory Committee, a committee that was not mentioned by any of the sites in this study. This committee, without board member voting authorities, offers patients a channel to advocate on behalf of patient needs and offers a structured opportunity to contribute ideas and understand concerns facing the clinic.

VERIFICATION AND RELIABILITY

Verification of qualitative analyses of data abide by a range of practices and principles to attest to the integrity of data collection, analysis, and interpretation involved in empirical research. Lincoln and Guba (1985) indicate that the trustworthiness of a qualitative study is based upon the credibility, dependability, and transferability.

Credibility within qualitative research re-presents the findings, the interpretation of data, as believable to the reader and obtained through active engagement in the process of research activities (Lincoln & Guba, 1985). This study relied upon the research activities of triangulation, negative case analysis, and member checks (Lincoln & Guba, 1984; Tracy, 2010). Triangulation of qualitative data uses the process of checking texts against texts, such as observations to interviews, to demonstrate multiple points of confirmation that guided the interpretation of events (Czarniawska, 1998). Czarniawska (2008) states that the text of interviews "elicit standard accounts of a practice" that may be contrasted with

"novel readings" of interactions observed during data collection (p. 30). Any gap between interview (standard practice) and observation (novel readings) serves as a "source of knowledge" (Czarniawska, 2008, p. 30). Member checks engage participants in giving feedback on a summary of interpretations to verify the researcher's interpretation and categorization resonates with the participants (Lindlof & Taylor, 2011). In this study, a handful of participants initiated member checks by asking for my own thoughts and reflections regarding communication in their boardroom (see Chapter 2). Third, the analysis used negative case analyses throughout the analysis to demonstrate a full utilization of data and to illustrate the variation of responses provided by participants.

Dependability, or reliability of qualitative research, indicates that the process by which conclusions were drawn may be replicated by providing an audit trail of the process of collecting, analyzing, and interpreting data (Lincoln & Guba, 1985). Chapter 2 presents the audit trail for data collection and analysis, a process that is iterated in more depth when examining the analysis techniques specific to the work of governance (Chapter 4), the roles (Chapter 5), and the communicative strategies of inclusion (Chapter 6). Data presented within the analysis of findings also substantiates a more detailed audit trail by linking excerpts of data to the interpretations presented within the findings.

Transferability is the qualitative equivalent of the idea of generalizability within the quantitative world. Researchers provide the details and elaboration of contexts and situations in such a way that readers would be able to determine whether or not the findings may be applied into another context (Lincoln & Guba, 1985). Patient-majority governance of FQHCs represents a particular instance of inclusive governance (Brown, 2002);

however, the findings of the study contribute through empirically defining the nature of governance and micromanagement and the issues of exclusion that may exist within any form of governance. The roles of board members within patient-majority governance are also transferable within similar forms of governance – specifically consumer governance.

LIMITATIONS

Representing a qualitative inquiry of board governance, scholars and practitioners should apply findings presented within this study by evaluating the similarities between the context of this study and future settings. For example, PBM participants in this study represented unpaid board members. However, federal requirements of FQHCs do allow consumer board members with transportation difficulties to be reimbursed for travel expenses and they also permit financial compensation of patient board members (PBM) who make less than $10,000/year to be paid for the time that board work takes away from their paid employment (see HRSA, 2014). However, no participants in this study indicated that their board engaged in compensating patient board members for time at board meetings. In addition to considering the scope of allowable reimbursements and payments of patient board members, the level of participation and access to the four sites varied significantly within this study. A consequence of the varied level of access particularly to the committee meetings at FQHC-A and FQHC-B resulted in a focus on the oversight of organizational operations rather than emphasizing the oversight of finances. The limited access to observe meetings at FQHC-C and FQHC-D also prevented triangulation of observational and interview data. Instead, triangulation of data relied upon the triangulation of interview data between participants at each site. Findings from this study are also limited

to the scope of governing boards that transitioned into a patient-majority board within the past ten years. The communicative work of governance, specifically the range of micromanagement or nature of board culture, may be significantly different in FQHCs with more extensive organizational history of how to approach issues.

FUTURE DIRECTIONS

Future studies of governance emphasizing a communicative approach to organizing should continue to examine the dynamics of diversity and inclusion, organizational exit, and the use of profession skills within the scope of a governing board. First, communicative strategies of inclusion identified within this study may not represent the full range of inclusion available within the boardroom. By examining inclusion within additional forms of governance (i.e., consumer and non-consumer governance), scholars may identify new and innovative ways to include diverse individuals within the organization. Additionally, studies of governance should examine the conditions under which opening the floor to additional comments before a vote actually results in continued participation. In this study, this was referenced as a recommended communicative strategy; however, these efforts by chairs of committees and the board did not result in a significant response from board members.

Future studies of NPO board governance should continue to examine the dynamics of turnover within the boardroom. Although board members may be limited to how long they may serve, each site of governance in this study experienced significant levels of turnover not linked to the individual reaching a term limit. Specifically, many episodes of exclusion accompanied the organizational exit of a board member. Because this study

focused on examining the existing inclusive communication, the inclusion of departed board members in the sample size was not a part of the theoretically driven sampling techniques (see Corbin & Strauss, 2008; Glaser & Strauss, 1967). However, studies examining the exit of board members may provide additional insight into the tensions leading up to and following organizational exit.

Finally, future studies of governance in the nonprofit sector should examine the targeted recruitment and use of Contributors in the boardroom. A board may recruit contributors outside the industry of the organization (e.g., individuals employed outside of healthcare to serve on a healthcare board) to establish intellectual diversity on the board (see Bourke, et al., 2014; Chait, Holland, & Taylor, 1996). The spirit of volunteerism within a board member with professional skills may result in a board member who desires to be more actively involved in tasks common to a "working board" (Brown & Guo, 2010; Masaoka, 2009). However, for a governing board, these skills may be underutilized within a well-established nonprofit organization where paid employees execute the operational tasks. A board member with skills to contribute and a desire to engage in activities common to a "working board" may impact their ability to identify with policy driven work of a "governing board."

CONCLUDING REFLECTIONS ON PATIENT-MAJORITY GOVERNANCE

When I first stumbled across the model of patient-majority governance, scholars argued the importance of communicative interaction of consumers and non-consumers as key participants in organizing and organizational phenomenon. Scholars within the fields of governance and public health have argued and examined the benefits and challenges of

including patients in the boardroom (see Morrison, 1978; Paap, 1978; Segal & Silverman, 2002; Wright & Martin, 2014), but the patient, as a distinct type of consumer, represents a stakeholder frequently not incorporated into organizational or health communication research. Consumers in organizational research may be examined as individuals who are managed by paid employees (see Eschenfelder, 2012) or silenced within organizational newsletters (see Gill & Wells, 2014). Patients in health communication have yet to examine the engagement of patients in organizational positions, such as a board chair. Thus, the integration of patients as a key contributor in the organizing acts of governance presented several challenges in rationalizing and integrating literature from several disciplines to substantiate both why and how the examination of PBMs as a significant organizational phenomenon.

Within this study, the communicative dimensions of inclusion and exclusion in governance of community health clinics aligned with a growing interest in the diversity and inclusion of nonprofit boards (Bernstein & Bilimoria, 2013; Wright, 2013a; 2013b; Wright & Martin, 2015; see also BoardSource, 2015), demonstrating the timeliness this study. Wright (2013c) critiqued the demographic representation of patient board members, championing the argument for excluding individuals who do not reflect the socioeconomic diversity of FQHC patients (see also Dovi, 2009). In contrast to the position for exclusion, participants in this study expanded my perspective of inclusion and exclusion in two ways. First, the work of governance and position of board membership is not – and perhaps should not be – open to just any patient. In this study, the "indistinguishable difference" between contributors and patients indicated the effort of the board to recruit the most qualified *and*

representative patients from their community. With only eight board positions available for a patient population of thousands, board membership still bears structural features of exclusivity.

Exclusivity of board membership in NPO boards is often marked by donation requirements that may request large donations from board members. Thus, donation requirements potentially limit the participation of low SES individuals on the board. However, the specific funding structures of FQHCs receiving federal funding and using fee-for-service models of revenue generation enabled PBMs with lower incomes to participate. Three out of four sites in this study still required a "meaningful contribution" (i.e., a financial donation), even though almost one-third (29.4%) of board members in this study perceived their income as lower than other patient and non-patient board members. The federal funding and fee-for-service models of nonprofit organizing facilitated the incorporation of low-income individuals on the board who were able to individually define their "meaningful contribution" as small as one dollar. Sites that maintained fundraising initiatives (e.g., fundraising luncheons) met the challenge of crafting messages to demonstrate the need for donations to supplement federal funding. This dynamic was not a focus of the study, but presents an interesting point of contemplation should other nonprofits seek to implement models of consumer governance to be more inclusive in their governance models (i.e., consumer governance).

At the outset of this project, several sources projected an increase in the patient population to be served by FQHC's, an anticipated growth linked to the Affordable Care Act (ACA) that increased access to health insurance within the United States (Goebel,

2013; Quorum Health Resources, 2010). The most recent 2017 legislative session questions the longevity and funding initially linked to the ACA, which may impact the future reach and scope of community health centers, specifically FQHCs in the United States. Although, federal funding is linked directly to the requirement of patient-majority governance, communities and FQHCs need to consider the benefits of maintaining this model regardless of changes in federal requirements and funding initiatives.

Appendix A: Interview Guide

1. How did you get involved in the clinic and eventually the board?

2. What has it been like serving on the board of an FQHC?
    a. What (if anything) has changed over your appointment as a board member?

3. What do you feel is (or has been) your contribution to the board?

4. How would you describe conversations/communication at the board meetings, committee meetings, or teleconferencing?

5. What types of roles (or responsibilities) do you find valuable in meetings (board and/or committee meetings)?

6. In your interactions over the years has there ever been one that you thought was great? Something that you found memorable and/or sharable?

7. In your interactions over the years have you ever had a negative experience, a situation you would not want to have happen again?

8. What is the value of having consumer governance (a patient-majority board)?

9. When talking about diversity and inclusion, what does that look like to you?

Demographics

10. Do you perceive your income level as higher, lower, or equal to other board members?

11. What is your occupation?

12. What race, ethnicity, or other dimensions of diversity to you identify as?

13. Have you received services from the organization in the past two years?

14. What age demographic do you represent?

    20-30 30-40 40-50 50-60 60+

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