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Nonprofit Board of Director Training: The Experiences of Chief Executive Officers in Western Kentucky

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NONPROFIT BOARD OF DIRECTOR TRAINING: THE EXPERIENCES OF CHIEF
EXECUTIVE OFFICERS IN WESTERN KENTUCKY

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By
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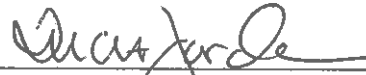
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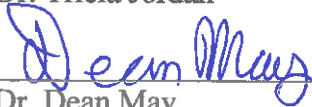
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I dedicate this dissertation to my best friend and wonderful wife Gabrielle. Thank you

for encouraging me to surpass goals that I thought were never possible.

ACKNOWLEDGMENTS

First and foremost, I want to thank my Heavenly Father for blessing me with opportunities to pursue my educational aspirations. As a child living in a rural community with high rates of poverty and low rates of educational attainment, I never thought college was an option for me, let alone pursuing a doctorate. I recognize that I have been blessed beyond measure, and I am thankful for the blessings in my life.

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This reality-oriented inquiry investigates chief executive officers' experiences of board training within 501(c)(3) nonprofit acute care hospitals. This study provides an insight into the practices, barriers, and drivers of board training. Katz's (1955) skills-based leadership model serves as the theoretical framework for this study. The model suggests leadership skills are not innate but can be developed through training. This qualitative study includes nine in-depth interviews with chief executive officers to acquire a rich description of the phenomenon of interest throughout nine 501(c)(3) nonprofit acute care hospitals.

A constant-comparative analysis and inductive analysis are employed to develop six themes related to board training: (1) training is multi-faceted, (2) training is a team approach, (3) time is a scarce commodity, (4) healthcare is exceedingly complex, (5) fiduciary duties are wide in scope, and (6) trained board members often are engaged board members. The research findings provide meaningful information for chief executive officers, senior level healthcare executives, board chairs, and board members interested in developing and refining practices of board training. Likewise, this study has implications for academicians with research interests concentrating on nonprofit leadership, nonprofit governance, and board development.

CHAPTER I: INTRODUCTION

In 2016, 1,571,056 entities in the United States were classified as tax-exempt

nonprofit organizations (National Center for Charitable Statistics, 2016). Without

nonprofit organizations, numerous societal needs would go unmet (Mwenja & Lewis,

2009). Of all nonprofit organizations, the largest category is 501(c)(3) public charities,

which includes hospitals, colleges, human services, museums, and community

foundations (National Center for Charitable Statistics, 2016). Public charities have

experienced steady growth over the last decade. In 2016, 1,097,689 public charities were

registered in the United States, which is 313,878 additional organizations in existence

than in 2003 (National Center for Charitable Statistics, 2013; National Center for

Charitable Statistics, 2016). This figure is due in part to decreased governmental

spending and an increase in local community-based efforts. The National Center for

Charitable Statistics (2016) reported that nonprofit organizations amassed over $1.74

trillion in total revenue and disbursed $1.63 trillion in expenses during 2013. The data

clearly corroborate the immense size and volume of the nonprofit sector with large

annual operating budgets.

Boards of directors are the uppermost leadership within nonprofit organizations

and are legally responsible for the operation of the public charity (Green & Griesinger,

1996; Wiehl, 2004). Under common law, board members must abide by duties of care,

loyalty, and obedience (Association of Governing Boards, 2014; Hopkins & Gross,

2010). Additionally, board members are accountable for providing oversight for

considerable amounts of financial and human capital, while simultaneously facing

important mission-driven decisions. Due to social responsibility and public trust,

nonprofit boards have responsibilities greater than for-profit boards (Green & Griesinger, 1996). In order to perform at an exceedingly high level and to fulfill their obligations to the organization, staff, clients, donors, and the community at large, nonprofit boards of directors must possess a clear understanding of their roles and responsibilities. Ultimately, the long-term effectiveness and sustainability of these organizations are in the hands of boards of directors (Renz, 2010).

This study explores chief executive officers' experiences of board training in nonprofit healthcare organizations and is focused on chief executive officers representing 501(c)(3) nonprofit acute care hospitals in western Kentucky. Practices, barriers, and drivers of board training are examined. The current economic, social, and political climates demand nonprofit boards deliver the best governance possible for the organizations they serve (Inglis, Alexander, & Weaver, 1999; Nicholson, Newton, & McGregor-Lowndes, 2012; Nobbie & Brudney, 2003). As such, nonprofit boards must distinguish themselves through their competence and professionalism (Lichtsteiner & Lutz, 2012). With these high demands placed on boards of directors, it is imperative for nonprofit organizations to focus attention on board training. Thus, the first step to understanding board training is to explore chief executive officers' experiences of in nonprofit acute care hospitals in western Kentucky.

Statement of the Problem

Nonprofit board members are responsible for providing oversight for financial and human capital, while concurrently striving to make mission-driven decisions. For the board and the organization to succeed, board members must be fully engaged in their roles and responsibilities. Wright and Millesen (2007) proposed that training is a tool to

improve board engagement. Unfortunately, training is underutilized and results in board members' uncertainty regarding tasks to complete and altering their performance to meet the expectations of the organization and its constituents. Research has suggested that in the rare instances of board training actually occurring, the training sessions are woefully inadequate (Griffin & Lake, 2013; Stout, 2015).

Scarcity of Nonprofit Leadership Research

Often touted as the father of management, Peter Drucker suggested that no longer are good intentions of nonprofit board members sufficient to gain the trust of stakeholders and to improve board quality (Drucker, 2005). Viewing a nonprofit board appointment as a mere volunteer position or benevolent exercise can lead to underperformance (Bader, 2013). Nonprofit board members may possess a heart to serve, but lackadaisical performance due to the absence of training cannot continue. One method for improving board members' knowledge regarding their roles and responsibilities is to survey the nonprofit leadership literature. However, insufficient empirical studies exist pertaining to nonprofit board leadership. Of those available, finding empirical sources focusing on leading nonprofit healthcare organizations is rare.

Minimal Board Training Knowledge

When a nonprofit organization hires a new staff member, training typically ensues (BoardSource, *n.d.a*). This is not always the case for the highest level of leadership in the nonprofit sector, the board of directors. In order for nonprofit organizations and their leadership to excel, this practice must change. It is not surprising that boards and nonprofit practitioners neglect training, as few studies have related exclusively to board training (Brown, 2007). Future research is needed to understand the nature and practices

of board of director training (Bernstein, Buse, & Slatten, 2015; Brown, Hillman, & Okun, 2012; Miller-Millesen, 2003; Mwenja & Lewis, 2009; Ostrower & Stone, 2006; Urice, 1990).

Diversity in Research Methods

A selective leadership review revealed that the available empirical studies concentrating on nonprofit boards typically are quantitatively driven (Brown, 2007; Herman & Renz, 2000; Hodge & Piccolo, 2011; Inglis et al., 1999; Lichtsteiner & Lutz, 2012; Nicholson et al., 2012; Preston & Brown, 2004; Schulz & Auld, 2006). However, quantitative methodology simply lacks the depth of inquiry offered by qualitative methods. Qualitative methods are invaluable when attempting to thoroughly understand a phenomenon (Jaskyte, 2012; Schulz & Auld, 2006). Qualitative research can impact future practice of nonprofit organizations and boards of directors (Baxter & Jack, 2008). As such, an apparent need exists for additional in-depth, field-based, qualitative studies focusing on nonprofit board training (Bernstein et al., 2015; Cornforth, 2012; Golden-Biddle & Rao, 1997).

Geographic Biases

Based on a selective literature review, the author deems that researchers typically concentrate on nonprofit organizations located in metropolitan areas in the northeastern United States. Also, a dearth of research exists in rural areas. Thus, more research is needed in other areas of the country, particularly in non-metropolitan locales.

Purpose of the Study and Central Research Question

This study brings together the issues described in the Statement of Problem section. First, a dearth of empirical literature can be found related to nonprofit

leadership. Second, practices of board training frequently are omitted in nonprofit

literature. Third, qualitative methods permit thorough exploration of chief executive

officers' experiences of board training. Finally, the nonprofit boards in a southern, rural

locale often are disregarded in lieu of extant research in metropolitan areas.

Thus, the purpose of this study is to explore chief executive officers' experiences

of board training. A qualitative approach is embodied from a reality-oriented inquiry

perspective (Miles & Huberman, 1994; Patton, 2002). A qualitative approach allows the

researcher to interact with chief executive officers while examining nonprofit board

training (Richards, 2009). The study concentrates on chief executive officers

representing 501(c)(3) nonprofit acute care hospitals in western Kentucky. Semi-

structured, elite interviews within nonprofit healthcare organizations in the southern

United States provide an insight into the practices, barriers, and drivers of board training.

Rigorous data analysis and coding permits the researcher to establish themes within the

data to understand training for nonprofit board members representing healthcare

organizations. Therefore, the central research question provides meaningful and rich

information for nonprofit practitioners and academicians: How do chief executive

officers representing 501(c)(3) nonprofit acute care hospitals in western Kentucky

describe their experiences surrounding the practices, barriers, and drivers of board

training?

Theoretical Framework

The skills-based leadership approach suggests three basic leadership skills:

technical, human, and conceptual (Katz, 1955). According to Katz (1955), a skill is an

"ability which can be developed, not necessarily inborn, and which is manifested in

performance, not merely in potential" (pp. 33-34). Technical skills involve "specialized knowledge, analytical ability within that specialty, and facility in the use of the tools and techniques of the specific disciple" (p. 34). Human skills relate to the ability of the individual to work well with others and to build cohesive teams. According to Katz, conceptual skills "involves the ability to see the enterprise as a whole" (p. 35). Leaders possessing these skills have a macro-level understanding of the entity and understand their decisions' effect upon the entire organization. Katz posited that technical, human, and conceptual skills are required at all rungs of the organizational ladder, but the importance of each varies based on the level of the organization. Technical skills are commonplace at the lowest level of an organization, whereas conceptual skills are vital at the highest level.

Based on Katz's (1955) skills approach model, boards of directors are considered high-level administrators. From a skills approach perspective, the three basic skills are not innate but can be developed through training (Katz, 1955; Northouse, 2013). The skills-based leadership theory posits that board members possess the ability to learn leadership skills and to increase their value to the organization they serve. The skills approach is a pertinent theory to guide this study, as it suggests board members can develop the appropriate skills though training. However, training for board members is an atypical occurrence. With the insurmountable pressure from multiple stakeholders demanding engaged nonprofit boards that operate effectively and efficiently, board training is a pertinent topic for study.

Interview Questions

The interview questions developed by the researcher are based on a selective literature review of nonprofit boards and the field of leadership. The questions relate to leadership literature; more specifically, the questions relate to the skills-based leadership approach. By exploring chief executive officers' experiences, the researcher examines practices, barriers, and drivers of board training. Appendix A lists the interview questions utilized in this study.

Delimitations

The following delimitations are present in the study:

1. The participants' experiences surrounding the practices, barriers, and drivers of board training are explored through semi-structured interviews, rather than the researcher's observation of board training.

2. Participants are delimited to nine chief executive officers in a southern locale.

3. The findings are delimited to nine nonprofit acute care hospitals in western Kentucky.

Limitations

The following limitations are present in the study:

1. The findings are limited to the experiences of nine chief executive officers.

2. The information about board training is representative of only nine nonprofit acute care hospitals in the south.

3. Certain responses may be influenced by the fact that a few participants are newly hired chief executive officers.

4. The participants are still employed at the discretion of the board of directors; therefore, they may not be as vocal about board training as one who no longer is employed at the hospital.

Assumptions

The following assumptions apply to the study:

1. A reality-oriented approach is a valid methodology for acquiring a thick description of chief executive officers' experiences of board training.

2. The participants in the study are agreeable to speak candidly about their experiences of board training.

3. A rich description of practices, barriers, and drivers of board training has implications for nonprofit practitioners and academicians.

Definition of Terms

- Critical case sample – A purposeful sampling technique in which a small number of individuals can thoroughly explain the phenomenon of interest (Patton, 2002).

- Elite interviewing – Provides unmatched, valuable information due to an individual's position in an organization (Nader, 1972).

- Purposeful sampling – The selection of specific individuals who can provide copious amounts of information about the research focus (Guba, 1981; Patton, 2002).

- Reality-oriented inquiry – Depicts reality and suggests the phenomenon of interest can be explored through the experiences of others (Patton, 2002; Miles & Huberman, 1984).

- Rich or thick description – A thorough description of the topic of study (Merriam, 1998).

- Semi-structured interviewing – A consistent format for conducting interviews that permits follow-up questions related to the topic of study (Davis, 2012; Ehigie & Ehigie, 2005; Patton, 2002).

- Skills-based leadership model – Proposes that leadership skills are not inborn but are developed through training (Katz, 1955; Northouse, 2013).

Summary

It is essential that competent individuals serve on a nonprofit board. The performance of the board of directors is a prerequisite for successful organizations. Although no litmus test exists for future board members, current members should carefully select the appropriate professionals who have a desire to learn about nonprofit governance. Once selected, formalized training should be provided for board members in an effort to improve role clarity and board engagement. When compared to corporate governance, research centering on nonprofit boards is extremely sparse. The majority of available studies on nonprofit leadership appear to be quantitatively driven. Thus, future research on nonprofit board leadership should embody qualitative methods to provide a rich detail of the practices, barriers, and drivers of board training.

CHAPTER II: LITERATURE REVIEW

Introduction

This reality-oriented study investigates chief executive officers' experiences of board training within 501(c)(3) nonprofit acute care hospitals. More specifically, this qualitative study provides an insight into the practices, barriers, and drivers of board training. As a dearth of nonprofit literature exists pertaining to board training, a qualitative approach permits the researcher to thoroughly investigate nonprofit board training.

Viewing a nonprofit board as a benevolent exercise can lead to disengaged members (Bader, 2013). Disengagement and lackadaisical performance have resulted in nonprofit boards being subject to immense public scrutiny (Lichtsteiner & Lutz, 2012). Drucker (2005) added that nonprofit board members should be considered as unpaid staff rather than altruistic volunteers. Nonprofit boards must distinguish themselves through their commitment of service to the community, as well as their competence and professionalism (Lichtsteiner & Lutz, 2012). Once a board member has been selected, a prevailing challenge for nonprofit organizations is to properly manage and to engage the board of directors (Wright & Millesen, 2007). Disengagement and underperformance often are a result of role ambiguity due to the lack of formal board training.

Organization of Literature

The literature review includes three main sections: emerging governance structures, the role of a nonprofit board of directors, and best practices of board training. The first section provides an overview of three board structures that are emerging in healthcare organizations. The next section offers an overview of the roles and duties of

board members. The third section examines best practices of board training. The

summation of these sections provides the framework for exploring chief executive

officers' experiences of board training in nonprofit healthcare organizations.

<center>**Emerging Governance Structures in Healthcare**</center>

According to Bader (2013), three emerging governance models in nonprofit

healthcare include professional, clinical enterprise, and enhanced community-based

governance. The professional governance structure is designed for organizations that are

visualized as health companies striving for exceptional performance and customer

satisfaction. The professional model includes a very small board with higher performance

requirements and involvement than the typical nonprofit board. The clinical enterprise

governance model is comprised of healthcare providers and is professionally managed.

These boards typically include a corporate parent board with independent members who

have ultimate authority; they also include a clinical board of senior clinicians to provide

medical expertise. Bader (2013) postulated that enhanced community-based models are the

most common and are utilized by organizations that view the firm as highly community

driven. The community-based model involves a parent board and places high priority on

strategy and community benefit. Membership typically includes individuals in the service

area in which the organization operates.

In order to understand the anticipated adoption rate of the emerging governance

structures in nonprofit healthcare, Bader (2013) utilized data collected in the FutureScan

survey conducted by the American College of Healthcare Executives (ACHE) and the

Society for Healthcare Strategy and Market Development (SHSMD). The ACHE and the

SHSMD are the leading professional organizations for healthcare executives and

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clinicians. The data were gleaned via a quantitatively driven survey disseminated to

1,153 CEO members of the ACHE and 1,198 senior clinicians belonging to the SHSMD.

The researchers received 625 of the approximately 2,300 surveys that were dispersed, for

a response rate of 26.6%. The data suggested that, by 2018, 50% of healthcare

organizations likely will utilize a professional governance model. Also, 40% of the

respondents proposed they would use a clinical enterprise governance model, whereas

66% suggested their organization would employ a community-based model. As the three

emerging governance structures include a diverse slate of board members with varying

expertise, the fate of nonprofit healthcare boards of directors depends upon the extent to

which members understand their roles and are actively engaged.

Role of a Nonprofit Board of Directors

Lynn (2003) reported that nonprofit organizations typically have limited financial

and human resources at their disposable; therefore, it is crucial that board members fully

understand their governance role. While the role and practice of the board varies based

on the needs of the organization (Bradshaw & Hayday, 2007; Herman, Renz, &

Heimovics, 1997; Iecovich, 2004; Miller-Millesen, 2003; Ostrower & Stone, 2006; Stone

& Ostrower, 2007), some similarities are shared among nonprofit organizations.

First and foremost, nonprofit board members are bound by law to act in

accordance with the fiduciary duties of care, loyalty, and obedience (Association of

Governing Boards, 2014; Hopkins & Gross, 2010). According to Hopkins and Gross

(2010), these duties include the following:

The duty of care requires that directors of a tax-exempt organization be

reasonably informed about the organization's activities, participate in decision

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making, and act in good faith and with the care of an ordinarily prudent person in

comparable circumstances. The duty of loyalty requires board members to

exercise their power in the interest of the tax-exempt organization and not in their

personal interest or the interest of another entity, particularly one with which they

have a formal relationship. The duty of obedience requires that directors of a tax-

exempt organization comply with applicable federal, state, and local laws, adhere

to the organization's governing documents, and remain guardians of the

organization's mission. (p. 59)

According to Legon (2014), one qualification of highly effective nonprofit boards is that

they uphold their fiduciary principles. Considering the complexity of healthcare and the

fact that it is ever-changing, board members must strive toward a higher level of

performance by meeting their fiduciary duties.

 According to Drucker (2005), the role of the board is to devise and to guard the

mission of the organization closely. Drucker noted that board members ultimately are

responsible for evaluating the short-term and long-term performance of the organization;

during times of crises, board members are required to roll up their sleeves and become

involved operationally. Similarly, Hodge and Piccolo (2011) indicated the overarching

role of the board as providing leadership, strategic direction, and financial governance for

the organization for which they serve.

 Renz (2010) provided greater detail surrounding the role of a nonprofit board and

divided it into eight distinct areas: (a) leading the organization; (b) instituting policy; (c)

securing scarce resources; (d) ensuring good stewardship of resources; (e) hiring,

evaluating, and coaching the Chief Executive Officer/Director; (f) engaging with

stakeholders; (g) ensuring accountability with operational and fiscal practices; and (h) striving for board effectiveness. Similar to Renz, Soltz (1997) provided an extensive list of board functions to include: (a) selecting and evaluating the Chief Executive Officer/Director; (b) reviewing and safeguarding the mission of the organization; (c) leading organizational planning; (d) serving as a fiduciary of the organization; (e) ensuring financial accountability; (f) serving as a representative and spokesperson for the organization; (g) providing an external community perspective to the organization; (h) serving as the final decision making body during internal disputes; and (i) assessing the performance of the board.

 While the board should be knowledgeable of the operations, Inglis et al. (1999) suggested it should be more involved with strategic activities that are externally focused, followed by resource planning that is both externally and internally focused, and, finally, involvement in internally focused operation matters. Included in the role of providing strategic leadership is the responsibility to identify and to select new members (Pointer & Orikoff, 2002). These views are contrary to the majority of board meetings in which the board receives and listens repeatedly to operational updates but rarely participates in strategic long-term planning (Inglis et al., 1999).

 Understanding one's role as a board of director member of a nonprofit healthcare organization is pertinent for success and organizational fortitude. Unfortunately, the lack of clarity of one's role results in role ambiguity, which leads to a board that performs as a mere rubber stamp.

Role Ambiguity

Role ambiguity is a perennial issue facing nonprofit organizations. According to Kahn, Wolfe, Quinn, Snoek, and Rosenthal (1964), role ambiguity exists when a board member is unable to perform the role due to a lack of a clear understanding of the actions or functions required of a board of directors. Similarly, Naylor, Pritchard, and Ilgen (1980) described role ambiguity as a misunderstanding of job requirements and awareness of such uncertainty. Although role ambiguity can significantly alter the attitude and behavior of board members representing nonprofit healthcare organizations, minimal research has been conducted on behaviors and practices of nonprofit boards (Doherty & Hoye, 2011).

Roles are determined through communication between role senders (Board President or Executive Director) and role receivers (Board Members) (Wright & Millesen, 2007). During this communication, the sender must clearly articulate the expectations of serving as a board member, and receivers must understand and accept the expectations set forth by the role sender. Role ambiguity begins when a board member lacks role-related information, with unclear or absent communication often the culprit (Wright & Millesen, 2007). To that point, board failure knows no boundaries and is a worldwide issue (Nicholson et al., 2012). Nonprofit healthcare organizations must reduce role ambiguity as a means to improve board engagement.

Reducing Role Ambiguity and Improving Board Engagement

Nonprofit boards are expected to deliver the best governance possible for the organizations for which they serve (Inglis et al., 1999; Nicholson et al., 2012). The board of a nonprofit organization is more effective when the board works collectively as a team

and fully understands its role (Nicholson et al., 2012). While it is rarely used, training can decrease role ambiguity and can improve board engagement (Wright & Millesen, 2007).

In a study by Wright and Millesen (2007) assessing role ambiguity, two thirds of board members reported they were confident in knowing what was expected of them, while only two fifths of the chief executives thought members understood their role and expectations. The discrepancy between the perception of the board members and that of the chief executive officers emphasizes the lack of clarity surrounding the role of a nonprofit board. A study by Griffin and Lake (2013) concentrating on board members from three Midwestern states reported that board members vocalized the need for training to prepare for their roles. Although members recognize the need for training, such sessions rarely are implemented (Brown et al., 2012; Radbourne, 1990).

The underutilization of training results in board members' uncertainty of tasks to complete and the way in which to alter their performance to meet the expectations of the organization and its constituents (Wright & Millesen, 2007). In a study by Brown et al. (2012) in which the researchers surveyed 591 board members in 64 organizations, 20% of the respondents indicated they received limited or no orientation to the board. In a similar study conducted by Radbourne (1990) that focused on board members representing arts organizations, 89% of the respondents received no training for their roles. On the positive side, Radbourne reported that 80% indicated training should be made available for board members.

In a study by Bernstein et al. (2015), the researchers utilized BoardSource survey data from 1,341 chief executive officers and 473 board chairs to study the roles and

responsibilities of members. In their study, Bernstein et al. drew the conclusion that training is a leading factor in improving board engagement and performance. Davis (2012) conducted a similar study to explore relationships between senior managers and directors in an effort to strengthen the cooperation of both parties. In this qualitative study, the 10 interviewees suggested board of director training as a medium to enable them to function at a higher level. Likewise, research has suggested that board members adequately equipped with task expectations and roles generally have higher levels of satisfaction leading to greater levels of engagement and prolonged service (Jamison, 2003).

At the conclusion of a study related to the extent to which board members perform their responsibilities, Iecovich (2004) indicated that chief executive officers and board chairs representing 128 nonprofit organizations often disagree about meeting their obligations as board members. These types of discrepancies suggest training outlining the expectations of board members is not occurring. Based on the research of Iecovich (2004), board practices among nonprofit and non-governmental organizations are similar across the globe, which implies role ambiguity is prevalent among nonprofit healthcare board members. One mechanism to reverse this trend and to improve board engagement is to equip each member with fundamental information through the implementation of training.

Kahn et al. (1964) postulated that, in order to reduce role ambiguity, three criteria must be met: (a) an individual must understand the duties and responsibilities of the position, (b) the member must recognize those actions that will confirm the responsibilities of the role have been met, and (c) the individual must recognize the

consequences that exist if the role is not performed or accomplished. These criteria could

be accomplished by implementing training for board members representing healthcare

organizations. Nonprofits should take advantage of training to communicate the

expectations and roles of the board of directors. As stated earlier, empirical support

exists that suggests training decreases role ambiguity and improves board engagement

(Wright & Millesen, 2007).

<div align="center">**Best Practices for Board Training**</div>

When nonprofit organizations hire new staff members, training generally is used

to introduce them to the organization, policies, expectations, and duties of the job

(BoardSource, *n.d.a*). Unfortunately, this type of training is not always made available

for the board of directors (Gibelman, Gelman, & Pollack, 1997; Holland & Jackson,

1998). While the board of directors may appear to be mere volunteers, they are the

highest-ranking members of the organization and ultimately are responsible for the

sustainability of the firm (Gibelman et al., 1997; Iecovich, 2004; Wry, 1990). It is

unacceptable to assume board members have innate abilities to perform their duties

(Coulson-Thomas, 2008; Gibelman et al., 1997). They must receive the appropriate

training to keep abreast of their directorial duties (Mallin, 2005; Werther & Berman,

2004).

Importance of Training Sessions

Subsequent to the inception of nonprofit organizations, committed volunteers

have served as board members with moral and legal obligations to stay informed of the

organization's activities (Gibelman et al., 1997; Wiehl, 2004). Although nonprofit board

members are bound by law to act in accordance with the fiduciary duties of care, loyalty,

and obedience (Association of Governing Boards, 2014; Hopkins & Gross, 2010), they do not always receive the training required to serve effectively (Coulson-Thomas, 2008). Training sessions should be used to increase the knowledge of new members and quickly engage them in their roles (501(c)ommunity, 2012; Pelletier, 2013; *The NonProfit Times*, 2015; Werther & Berman, 2004). It is equally important to provide board training on a recurring basis. According to *The NonProfit Times* (2015), an organization that supports the board will be supported by the board. Likewise, members report higher levels of satisfaction when participating in formal training sessions (501(c)ommunity, 2012). No individual is born with distinctive skills to be a successful board of director (Gibelman et al., 1997). Thus, training is the first formal step in educating board members (BoardSource, *n.d.a*).

Board training is a valuable tool for nonprofits as an introduction to the organization; its history, mission, and services; and the role of a board member (Community Tool Box, 2015). This ensures each member possesses the same framework for operation of the organization and the way in which members can contribute their knowledge and skills to further the mission of the organization (BoardSouce, *n.d.b*; Community Tool Box, 2015; 501(c)ommunity, 2012; McNamara, *n.d.a*). Thus, with proper training, board members' performance can transform from ordinary to extraordinary (Community Tool Box, 2015; Powers, *n.d.*).

Participants of Training Sessions

The chief executive officer, chair of the board, or senior leaders should be intimately involved in the training sessions, as they possess the greatest knowledge of the organization (BoardSource, *n.d.a*; BoardSource, *n.d.b*; Community Tool Box, 2015;

McNamara, *n.d.a*). Not only are they the most knowledgeable of the nonprofit, they also

bring authority to the training sessions (BoardSource, *n.d.a*).

A nonprofit organization should require all board members to complete training

sessions regardless of their nonprofit knowledge or experience (BoardSource, *n.d.b*;

Coulson-Thomas, 2008; Pelletier, 2013). It is important for new and existing board

members to hear information regarding responsibilities (BoardSource, *n.d.b*; Gottlieb,

2005). When all members participate in trainings, it builds cohesion and reinforces the

role of the board (BoardSource, *n.d.b*). If the members are not familiar with the staffing

of the organization, it is wise to include staff briefly in the training sessions in order that

all parties can meet one another (Community Tool Box, 2015).

Frequency of Trainings

Providing training is essential shortly after an individual begins serving as a board

member (McNamara, *n.d.a*). However, training sessions orienting members are only the

beginning of educating the board. Trainings must persist as long as the organization is in

operation (Brown, 2007; Community Tool Box, 2015; Coulson-Thomas, 2008; Gottlieb,

2005; Powers, *n.d.*). According to Stout (2015), board training should involve a

minimum of 6 to 18 months for new members, and training should be ongoing for

existing members. Other nonprofit sources have indicated it is best to conduct training

on an annual basis to ensure all members are operating from the same framework,

regardless of whether the organization has new board members (Community Tool Box,

2015; McNamara, *n.d.a*).

Training sessions often occur prior to the organization's annual meeting or retreat

(Community Tool Box, 2015). However, training also can take place during regular

board meetings and outside the walls of the organization (Community Tool Box, 2015; Coulson-Thomas, 2008; Holland & Jackson, 1998). Board trainings also are effective through electronic media, online networking forums, newsletters, article discussions, audio classes, conferences, and mentoring (Coulson-Thomas, 2008; Gottlieb, 2005; Griffin & Lake, 2013; Stout, 2015; Taylor, Chait, & Holland, 1996). Utilizing a board quiz to assess and to teach members about their roles and responsibilities is an effective method of training (Gottlieb, 2005). Regardless of the mode, members cannot learn all responsibilities during a single meeting or brief board retreat (Holland & Jackson, 1998).

Key Components of Training

Training manuals serve as a key resource for the work of board members and are the cornerstone for designing training (BoardSource, *n.d.a*; 501(c)ommunity, 2012; McNamara, *n.d.a*). Members should receive a manual and be encouraged to refer to it for questions about the organization and to manage their work as board members (501(c)ommunity, 2012). Updating the manual is very important. To allow for updates, the content should be assembled in a binder (501(c)ommunity, 2012). The format, content, and length for training sessions will differ based on the complexity of the organization and its services (BoardSource, *n.d.b*; Deloitte, 2011; 501(c)ommunity, 2012; Holland & Jackson, 1998). Board members should come away from training sessions with an excellent understanding of the nonprofit and the way in which their service can advance the mission of the organization (BoardSource, *n.d.b*).

Although board training varies based on the organization, training sessions often include a portion or all of the following information (Association of Governing Boards, *n.d.*; BoardSource, *n.d.a*; BoardSource, *n.d.b*; Community Tool Box, 2015; Deloitte,

2011; 501(c)ommunity, 2012; McNamara, *n.d.a*; McNamara, *n.d.b*; National Council of

Nonprofits, *n.d.*; Stout, 2015; Taylor et al., 1996; *The NonProfit Times*, 2011):

    a. General information about the organization: History, mission, and services;

    b. Financial documents: Certificate of Tax Exemption, IRS 990 form, and
current budget;

    c. Legal documents: Articles of Incorporation, bylaws, liability insurance
coverage; and conflict of interest;

    d. Board member agreements: Expectations for attendance, requirements of
fundraising, and code of conduct;

    e. Copy of most recent board meeting minutes;

    f. Contact and biographical information for officers and board members;

    g. A list of standing committees and committee members;

    h. Board and committee self-assessment form;

    i. Calendar of meetings for the year;

    j. Job descriptions for board of directors and executive staff;

    k. Organizational charts with executive staff bios;

    l. Whistleblower policies; and

    m. Personnel policies.

In order to generate topics for board training, it is helpful for board members to

develop a list of items they wish they had known prior to serving (Moore, *n.d.*). This

information can be immensely beneficial for the chief executive officer or board chair

when developing new training opportunities. Also, it is good practice to utilize

information collected on board self-evaluation forms in creating topics for training.

Board self-evaluation forms uncover member deficiencies prior to devising training sessions (McNamara, *n.d.a*).

Chief executive officers and board chairs are charged with coordinating board trainings on a regular basis to ensure members are competent (Coulson-Thomas, 2008; Mallin, 2005). Training can occur on a regular basis three to four times per year or as needed (Community Tool Box, 2015). Based on the complexity of the organization, training can take place at each board meeting. Ongoing training opportunities may include topics such as the work of the board, becoming a productive board member, legal issues facing nonprofit organizations, public relations, problem solving, fundraising, strategic planning, and changes in the sector (Community Tool Box, 2015; Powers, *n.d.*).

Summary

According to Holland and Jackson (1998), very few board members receive adequate training to ensure they are prepared to set priorities and to lead nonprofit organizations, which should not be the case. While ongoing training is necessary for board and organizational success, it does not need to be expensive. Several options have been mentioned throughout this paper. Holland and Jackson postulated that training is inseparable from the work of the board and should not be seen as above and beyond the duties of the board. It is vital to provide training for boards of directors for nonprofit organizations to thrive in the 21st century.

This literature review summarized emerging governance structures, the role of a nonprofit board of directors, and best practices of board training. Each section is pertinent to exploring chief executive officers' experiences of board training in nonprofit healthcare organizations. While literature exists prescribing the manner in which boards

hypothetically should function and operate, a lack of empirical literature exists focusing

on the practices of board training. As such, further research is needed to understand the

practices, barriers, and drivers of board training.

CHAPTER III: METHODOLOGY

Introduction

This study examined board training from the perspective of chief executive officers during their tenure at a hospital located in a southern locale. The purpose of this reality-oriented study was to explore their experiences of board training within 501(c)(3) nonprofit acute care hospitals in western Kentucky. Through a qualitative lens, the practices, barriers, and drivers of board training were explored in nonprofit healthcare organizations. As a dearth of research exists related to the current practices of board training in nonprofit literature, a qualitative approach allowed the researcher to thoroughly investigate nonprofit board training.

Organization of Methodology

Qualitative researchers commonly collect data in natural settings that are sensitive to the individuals involved in the study (Creswell, 2013). Qualitative inquiry seeks to unearth data to tell a story (Padgett, 2012; Patton, 2002). As such, the researcher employed in-depth, semi-structured interviews within hospital settings to collect data related to the current practices, barriers, and drivers of board training for members representing nonprofit healthcare entities. This study involved nine elite, semi-structured interviews that focused on capturing a thorough description of chief executive officers' experiences of board training. The methodology section describes the central research question, interview questions, research design, procedures for data collection, research quality, and data analysis process.

Central Research Question

The following central research question guided this reality-oriented inquiry: How do chief executive officers representing 501(c)(3) nonprofit acute care hospitals in western Kentucky describe their experiences surrounding the practices, barriers, and drivers of board training?

Interview Questions

The interview questions were developed based on a selective literature review of nonprofit boards of directors and organizational leadership. The questions relate to the skills-based leadership model, which suggests skills are not innate but can be developed through training. Practices, barriers, and drivers of board training were examined by exploring chief executive officers' experiences. Appendix A includes the interview questions that were employed in this study.

In addition to the aforementioned semi-structured interview questions, demographic information was collected and used for descriptive purposes. The information included age range, ethnicity, race, highest level of education, and number of years as chief executive officer.

Research Design

A qualitative approach through the use of reality-oriented inquiry was employed to gather data from a sample of chief executive officers representing 501(c)(3) nonprofit acute care hospitals located in western Kentucky. The reality-oriented approach suggests that truth is worth striving for and should be explored through real-world experiences of others (Patton, 2002). This holistic approach is rooted in Positivism, which suggests "only verifiable claims based directly on experience could be considered genuine

knowledge" (Patton, 2002, p. 92). Reality-oriented inquiry permitted the researcher to scientifically investigate board training and to determine the practices, barriers, and drivers of training among nonprofit healthcare boards through the exploration of experiences of chief executive officers. As the researcher concentrated on the issue of training board members, the reality-oriented inquiry approach was well suited for this study. Similarly, qualitative methods are appropriate when seeking to understand complex issues and to acquire a rich description of the phenomenon (Creswell, 2007; Miles & Huberman, 1984; Padgett, 2012; Slavin, 2007).

Semi-structured, elite interviews were utilized to understand chief executive officers' experiences of board training in nonprofit healthcare organizations. Semi-structured interviews provide the opportunity to explore a topic of interest based on the experiences of an interviewee, as well as follow-up questions for further explanation or clarification related to the phenomenon of interest (Davis, 2012; Ehigie & Ehigie, 2005). As Patton (2002) discussed, semi-structured interviews provide a consistent format for conducting interviews.

Marshall and Rossman (2011) asserted that interviewing elites has a robust history in organizational research. Elites provide a top-down viewpoint unparalleled without their participation (Gusterson, 1997; Nader, 1972; Padgett, 2012). While elite status is relative, elites share commonalities such as being well informed, influential, and regarded as experts in areas related to the research. Researchers can gain valuable information from interviewing elites due to their position in an organizational setting (Nader, 1972; Padgett, 2012).

The experiences surrounding the practices, barriers, and drivers of board training derived from chief executive officer interviews were collected through a reality-oriented inquiry approach. The findings provide meaningful and transferable information for nonprofit practitioners seeking to implement training for board members. The study results also provide valuable information for academicians with research interests in nonprofit leadership, nonprofit governance, and board development.

Role of the Researcher

In qualitative studies, the researcher serves as the instrument for data collection and analysis (Creswell, 2007; Merriam, 2002; Merriam, 2009; Slavin, 2007). The researcher for this study is a White male of middle class status who was raised in a rural area in the southeastern United States. He completed undergraduate and graduate degrees, as well as graduate certificates in the areas of management, business, leadership, and nonprofit administration. He also has served in senior-level leadership positions within healthcare organizations. In addition to his academic and professional career, the researcher has served on a myriad of healthcare-related boards of directors and advisory boards.

While extensive nonprofit leadership knowledge of the researcher was beneficial in analyzing data, the need for objectivity was recognized (Kirk & Miller, 1986). As such, the researcher's role was to collect and to interpret the data based upon the copious information gleaned from each interview. Overcoming subjectivity is the principal challenge of qualitative researchers (Slavin, 2007). It is imperative to avoid premature conclusions about the study (Gay, Mills, & Airasian, 2006). A variety of methods were

employed to ensure credibility, transferability, dependability, and confirmability of the study, all consistent with the rigor of reality-oriented inquiry.

Population and Sample

The population for this study included chief executive officers representing 501(c)(3) nonprofit acute hospitals in western Kentucky. For the purpose of this study, counties within the Barren River, Green River, Pennyrile, and Purchase Area Development Districts were considered as western Kentucky. Included in this area were 34 counties and 11 chief executive officers representing 501(c)(3) nonprofit acute care hospitals. The sample consisted of nine chief executive officers, for a response rate of 81.8%. Qualitative research routinely includes a small sample from the designated population, which delivers rich data through holistic investigations of the phenomena (Dworkin, 2012; Gay et al., 2006; Guba, 1981; Merriam, 2002; Patton, 2002; Weiss, 1998). Relative to qualitative research utilizing in-depth interviews, Dworkin (2012) reported that "an extremely large number of articles, book chapters, and books recommend guidance and suggest anywhere from 5 to 50 participants as adequate" (p. 1319).

This study embodied purposeful, critical case sampling to understand board training through the experiences of chief executive officers. In order to participate in the study, individuals were required to have served as a chief executive officer of a 501(c)(3) nonprofit acute care hospital in western Kentucky in which training was provided for hospital board members. As such, each of the nine chief executive officers served as elite, semi-structured interviewees. The sample of individuals within each interview involved professionals within their respective field and included nine chief executive

officers representing nonprofit acute care hospitals throughout western Kentucky. Patton

(2002) noted that participants provide thick information about the research focus through

the use of purposeful sampling. Purposeful sampling also allowed the researcher to

unearth a maximum amount of information about practices of board training (Guba,

1981). By incorporating critical case sampling, the findings are transferable for other

nonprofit organizations (Miles & Huberman, 1994).

Overview of Instrument

An instrument was developed for this study that included a demographic

questionnaire and a semi-structured interview schedule (Appendix A). The researcher

devised each section of the instrument with easy-to-read language that was non-

threatening to participants. The demographic questionnaire provided historical and

demographic information of the individuals in the study. The semi-structured interview

schedule captured chief executive officers' experiences of practices, barriers, and drivers

of board training. The instrument was reviewed and verified by a methodologist and

three content experts. The methodologist possesses a longstanding history of conducting

research and training in organizational settings across the United States. The content

experts have backgrounds in nonprofit governance, nonprofit leadership, and hospital

administration.

Research construct. This study employed a reality-oriented inquiry approach.

Reality-oriented inquiry embodies the language and concepts from the physical sciences

to devise a naturalistic, qualitative study through rigorous data collection and analysis

(Patton, 2002). Patton (2002) suggested that similar to scientific inquiry, reality-oriented

inquiry depicts reality and pursues truth. Miles and Huberman (1984) stated that reality-

oriented inquiry captures a social phenomenon that exists in the real world and seeks to determine its causes. As such, reality-oriented inquiry was ideal for exploring chief executive officers' experiences of board training.

Procedures for Data Collection

Prior to contacting potential participants, the researcher completed an application for investigations involving human subjects and received approval from the university's Institutional Review Board (IRB) (Appendix B). In order to participate in the study, the following inclusion criteria were required: (1) serve as a chief executive officer of 501(c)(3) nonprofit acute care hospital in western Kentucky, and (2) provide training for hospital board members. The potential study participants were identified by reviewing the hospital directory published by the Commonwealth of Kentucky's Cabinet for Health and Family Services. Purposeful, critical case sampling was incorporated, in as the chief executive officers possessed experiences to share about board training for hospital board members (Creswell, 2013; Patton, 2002).

The researcher emailed each chief executive officer of 501(c)(3) nonprofit acute care hospitals located in western Kentucky to explain the study and to inquire about the training provided for board members (Appendix C). A follow-up phone call was made one day after sending the email to confirm its receipt. If the chief executive officers did not respond to the first email or phone call, the researcher sent a second email two weeks following the first to again explain the study and to ask about the training provided for board members (Appendix C). The researcher made a second follow-up phone call one day after sending the second email to confirm receipt of the email summarizing the study. If the chief executive officer did not respond to the second email or phone call, the

researcher sent a third email two weeks following the second to once again explain the study and to ask about the training provided for board members (Appendix C). A third phone call was made to each chief executive officer one day after sending the third email to confirm its receipt. Regardless of the extent of board training provided by the nonprofit healthcare organization, each chief executive officer was invited to participate in the study if the inclusion criteria were met.

Each elite, semi-structured interview was pre-scheduled at a time convenient for the participants. Prior to conducting the interview, the researcher sent a reminder email the day of the interview summarizing the study, methodology, and background of the researcher (Appendix D). The researcher also emailed the consent form (Appendix E) to each individual prior to the interview. The researcher traveled over 1,200 miles to conduct face-to-face interviews with the hospital executives.

Although the consent form (Appendix E) was emailed to the participants prior to the interview, the researcher discussed the form with each chief executive officer. The nature and purpose of the project, explanation of procedures, discomfort and risks, benefits, confidentiality, and refusal/withdrawal concerning the study were discussed with each. Following a conversation regarding the consent form, each chief executive officer signed the consent form for the interview and granting permission to audio record it. The researcher stressed the fact that no names or identifiable information would be included in the findings.

Following consent, each elite, semi-structured interview began with a brief introduction about the researcher and research design. The same open-ended interview questions were utilized for each of the chief executive officers (Appendix A). The

interviews ranged from 40 minutes to 1 hour and 30 minutes in duration; the mean

duration was 60 minutes. The researcher conducted the in-depth, semi-structured

interviews from August 16, 2016, to October 3, 2016. Each was audio recorded for

future transcription. Additionally, the researcher took brief notes during each session.

Following the interviews, the electronic audio file and field notes were stored in a locked

file and password-protected computer. The researcher followed up with participants to

confirm the data were captured accurately. Following the interviews and member checks,

each chief executive officer was sent a thank you note for participating in the study.

Overview of Participants

Copious amounts of data related to the practices, barriers, and drivers of board

training were discovered through in-depth, semi-structured interviews with nine chief

executive officers. One participant was in the 36-45 age range, two were in the 46-55 age

range, and six were above 55. Each was of non-Hispanic origin and White. One attained

a bachelor's degree, seven held master's degrees, and one possessed a doctoral degree.

Four had 0-2 years of experience as the chief executive officer of the hospital, one

possessed 3-5 years of experience, two had served for 9-11 years, and two had over 12

years of experience as the chief executive officer of the hospital.

<div align="center">

Research Quality

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Similar to quantitative researchers, qualitative researchers are concerned with

rigor and trustworthiness of the study (Guba, 1981). The researcher utilized the

following techniques to maintain a high level of trustworthiness (Creswell & Miller,

2000):

- Triangulation

- Disconfirming evidence

- Member checking

- Developing an audit trail

- Peer debriefing

The researcher utilized criteria to ensure the study had credibility, transferability, dependability, and confirmability.

Credibility

Researchers establish a value of truth by testing the findings against various sources (Guba, 1981). According to Patton (2002), researchers acquire credibility by means of methodological rigor and valuing qualitative inquiry. Guba (1981) noted that credibility is equivalent to internal validity for quantitative studies. The researcher employed triangulation, member checks, and peer debriefings to add credibility to the study.

Transferability

Qualitative researchers seek findings that are transferable to other contexts (Guba, 1981). According to Marshall and Rossman (2011), transferability is the degree to which the findings are useful in comparable conditions when similar research questions are asked. Guba (1981) indicated that transferability is referred to as generalizability in quantitative studies. Critical case, purposeful sampling assisted the researcher in completing a transferable study.

Dependability

Dependability commonly is referred to as reliability in quantitative research (Guba, 1981). For dependability to exist, the researcher must recognize that change

occurs and should take into account the change (Guba, 1981; Marshall & Rossman, 2011). The researcher left an audit trail of decisions made throughout the study (Anfara, Brown, & Mangione, 2002; Houghton, Casey, Shaw, & Murphy, 2013) in order to capture the changes that occurred and that way in which the changes were handled.

Confirmability

Confirmability is referred to as objectivity in quantitative studies (Guba, 1981). Qualitative studies should allow other researchers to confirm the findings based upon rigorous methods versus interpretation of the researcher (Marshall & Rossman, 2011). As such, Guba (1981) suggested that the data are evidence for objectivity, rather than the interpretation of the researcher. Triangulation, peer debriefings, member checking, thematic memos, disconfirming evidence, and an audit trail added to the confirmability of the study.

<center>**Data Analysis Process**</center>

Similar to quantitative studies, data analysis in qualitative studies begins with data collection. However, the type of data collected in qualitative studies differs from that of quantitative studies. Qualitative data "appear in words rather than in numbers" (Miles & Huberman, 1998, p. 21). Qualitative data analysis is a comprehensive approach structured by a theoretical framework that ends in a narrative composed by the researcher (Merriam, 1998; Yin, 2003). Chapter IV provides a thorough description of the stories and experiences of board training that were gleaned from nine in-depth interviews with chief executive officers leading nonprofit acute care hospitals.

Quality field notes are essential to qualitative studies, as they describe all aspects of the context (Gay et al., 2006; Weiss, 1998). Prior to transcribing the in-depth

interview data, the researcher reviewed field notes and listened to audio recordings multiple times to gain a deeper understanding of board training at the respective hospitals. Following each elite interview, the researcher read field notes many times and expounded upon the abbreviated notes taken during the interview through the use of thematic memos. Marshall and Rossman (2011) suggested that thematic memos provide the avenue for generating insights about the data.

Following each interview and thematic memo, data from the audio recordings were transcribed using Nuance Dragon Professional transcription and dictation software. Member checks were completed to ensure accurate information was collected and transcribed. After finalizing transcription in Nuance Dragon Professional transcription and dictation software, the data were exported to Microsoft Excel, after which the researcher utilized constant-comparative analysis. Constant-comparative analysis is commonplace in qualitative research and includes evaluating initial data for common themes and comparing subsequent data with existing codes to determine patterns (Glaser & Strauss, 1967; Merriam, 2002; Slavin, 2007).

In addition to constant-comparative analysis, inductive analysis was utilized to discover patterns prior to developing categories and themes in the data (Patton, 2002; Thomas, 2006). Merriam (1998) and Weiss (1998) affirmed that data collection and analysis should concurrently take place during qualitative inquiry. Thus, the researcher compared the transcribed interviews with the field notes throughout the data collection and analysis stage to develop a holistic understanding of the practices, barriers, and drivers of board training. Themes were developed after rigorous data analysis to answer the central research question: How do chief executive officers representing 501(c)(3)

nonprofit acute care hospitals in western Kentucky describe their experiences surrounding the practices, barriers, and drivers of board training? Peer debriefings were then integrated into the study, which allowed the researcher to interact with colleagues in order to examine his comprehension of the data and themes derived from the data (Guba, 1981).

While IBM SPSS 24 is a statistical software mainly used for quantitative studies, it can be advantageous in qualitative studies. The researcher utilized IBM SPSS 24 software to analyze demographic information for participants related to their age range, ethnicity, race, highest level of education, and number of years as chief executive officer.

Summary

This qualitative study included nine chief executive officers from western Kentucky. Reality-oriented inquiry and rigorous data analysis permitted the researcher to answer the overarching research question: How do chief executive officers representing 501(c)(3) nonprofit acute care hospitals in western Kentucky describe their experiences surrounding the practices, barriers, and drivers of board training? Throughout the analysis phase, the researcher read field notes, listened to audio recordings multiple times, transcribed the data, conducted member checks, wrote thematic memos, classified the data based on constant-comparative analysis and inductive analysis, and completed peer debriefings. The integration of a variety of methods to ensure credibility, transferability, dependability, and confirmability of the study are consistent with the rigor of reality-oriented inquiry. Chapter IV presents results from the in-depth interviews in a descriptive narrative.

CHAPTER IV: RESULTS

Introduction

This reality-oriented inquiry investigated chief executive officers' experiences of board training within 501(c)(3) nonprofit acute care hospitals. The qualitative study provided an understanding of the practices, barriers, and drivers of board training. A scarcity of nonprofit literature exists pertaining to the practices of board training; therefore, the researcher investigated nonprofit board training systematically through a qualitative lens. Reality-oriented inquiry captures a social phenomenon that exists in the real world (Miles & Huberman, 1984). Thus, this form of inquiry was appropriate for exploring chief executive officers' experiences of board training.

The researcher secured interviews with nine of the 11 chief executive officers representing 501(c)(3) nonprofit acute care hospitals in western Kentucky, and an 81.8% response rate resulted. Purposeful, critical case sampling was utilized for the study sample based on the knowledge possessed by each chief executive officer relative to board of director training. Prior to conducting each in-depth interview, written consent was obtained from each participant (Appendix E), and the researcher reiterated that no names or identifiable information would be included in the findings. As such, the researcher did not refer to any participant by name or reference the respective hospital during the audio recordings. Also, participants were assigned a unique number on the field notes, thematic memos, and transcription in lieu of using their actual name. The researcher traveled over 1,200 miles to conduct face-to-face interviews from August 16, 2016, to October 3, 2016. The interviews ranged from 40 minutes to 1 hour and 30 minutes in duration, with the average interview being 60 minutes in length.

This chapter includes an overview of the central research question and interview questions, a summary of the participants, an overview of the themes, and a rich description of the themes resulting from the qualitative study. The findings are transferable for nonprofit practitioners seeking to implement or to improve training opportunities for board members. Also, the results provide beneficial information for academicians with a research focus on board development and nonprofit governance.

Central Research Question and Interview Questions

This reality-oriented study employed the following central research question: How do chief executive officers representing 501(c)(3) nonprofit acute care hospitals in western Kentucky describe their experiences surrounding the practices, barriers, and drivers of board training?

The following exploratory questions were used to capture chief executive officers' experiences of the practices, barriers, and drivers of board training:

1. How do board members learn what is expected of them during their service on the board (i.e., roles and responsibilities)?

2. How important is training for board members?

3. Tell me about training for board members at your healthcare facility.

4. Who determines the training board members receive?

5. Who conducts the training provided for board members?

6. Tell me about the techniques (or ways) that are used to deliver board training at your organization.

7. Tell me about the frequency of training for board members.

    a. Does training occur often enough?

8. Tell me about any barriers or challenges that exist for offering training for board members.

9. Why would a healthcare organization want to train their board members?

10. Tell me about the impact of training on board members' knowledge of their roles and expectations?

In addition to the semi-structured interview questions, demographic information was collected for descriptive purposes. The information included age range, ethnicity, race, highest level of education, and number of years as chief executive officer.

Participants

Demographic information was collected for each participant prior to asking questions about the practices, barriers, and drivers of board training. The questionnaire captured historical and demographic information about the individuals. IBM SPSS 24 was utilized to analyze the demographic data. Participants were asked to indicate their age using the following age ranges: 18-25, 26-35, 36-45, 46-55, and above 55. Of the nine participants in the study, one (11.10%) was in the 36-45 age range, two (22.20%) were in the 46-55 age range, and six (66.70%) were above 55 years (Table 1).

Table 1

Age Range of Chief Executive Officers

Age Range	Frequency	Percent
18-25	0	0.00
26-35	0	0.00
36-45	1	11.10
46-55	2	22.20
55+	6	66.70
Total	9	100.00

Chief executive officers were asked to indicate their ethnicity and race, and all were of

non-Hispanic origin (Table 2) and were White (Table 3).

Table 2

Ethnicity of Chief Executive Officers

Hispanic Origin	Frequency	Percent
Yes	0	0.00
No	9	100.00
Total	9	100.00

Table 3

Race of Chief Executive Officers

Race	Frequency	Percent
Asian	0	0.00
American Indian/Alaskan	0	0.00
Black/African American	0	0.00
White	9	100.00
Native Hawaiian or Other Pacific Islander	0	0.00
Total	9	100.00

Each individual denoted his or her highest level of education using the following criteria:

high school, associate's, bachelor's, master's, or doctorate. One (11.10%) attained a

bachelor's degree, seven (77.80%) earned a master's degree, and one (11.10%) possessed

a doctorate (Table 4).

Table 4

Highest Level of Education

Highest Degree	Frequency	Percent
High School	0	00.00
Associate's	0	00.00
Bachelor's	1	11.10
Master's	7	77.80
Doctorate	1	11.10
Total	9	100.00

The participants were asked to indicate the number of years they had served as chief

executive officer of the hospital. Four (44.40%) possessed 0-2 years of experience, one

(11.10%) had 3-5 years of experience, two (22.20%) had served as the chief executive

officer for 9-11 years, and two (22.20%) possessed over 12 years of experience (Table 5).

Table 5

Number of Years as Chief Executive Officer

Years as CEO	Frequency	Percent
0-2	4	44.40
3-5	1	11.10
6-8	0	0.00
9-11	2	22.20
12+	2	22.20
Total	9	100.00

<center>**Overview of Themes**</center>

The researcher utilized constant-comparative analysis to evaluate the initial data for common themes and compared subsequent data with existing codes to establish patterns in the data (Glaser & Strauss, 1967; Merriam, 2002; Slavin, 2007). The researcher also inductive analysis to develop categories and themes related to the phenomenon of study (Patton, 2002; Thomas, 2006). The following sections include a rich description of the themes garnered from the participants' experiences as chief executive officers representing 501(c)(3) nonprofit acute care hospitals in western Kentucky. Quotes were used to illustrate the practices, barriers, and drivers of board training in nonprofit hospitals and ranged from short sentences to lengthy segments. The researcher was careful to maintain the integrity of the participants' experiences as described during the interview.

The themes are organized by the practices, barriers, and drivers of board training. Data in qualitative studies routinely are classified into five to eight general themes (Weiss, 1998). The overarching themes derived from nine in-depth interviews included: (1) training is multi-faceted, (2) training is a team approach, (3) time is a scarce commodity, (4) healthcare is exceedingly complex, (5) fiduciary duties are wide in scope, and (6) trained board members often are engaged board members.

<center>**Practices of Board Training**</center>

Theme One: Training is Multi-faceted

In order to understand board training practices and the way in which members learn that which is expected of them during their service on the board of directors, the

<center>43</center>

researcher employed interview questions 1, 3, 6, and 7. Based on the interviews, the researcher concluded that board training is multi-faceted.

Although chief executive officers suggested that their respective hospitals provide board training through various means, face-to-face orientation sessions and ongoing trainings were conducted throughout the nine healthcare organizations. Participant 9 indicated that the verbal and non-verbal communication in face-to-face sessions was superior to other methods of training.

> We use a lot of face-to-face and that's, that's me being old school I guess. I just like to be with somebody, because I feel like if they've got questions they're going to be more apt to ask. Or, if I can tell if they have questions I can get a better sense of it if I'm there in the room with them. At the same time, I want them to develop that comfort level with me and with our staff that they can then feel comfortable coming if they ever have a question. I want to know our board members and I want them to know us. You know, they can just read something, but training and, initial training especially, I want it in person. (Participant 9)

Even prior to a board member's service, the data suggested that some healthcare organizations conducted orientation sessions. Participant 4 reported that the board members had an understanding of the hospital in advance of their service.

> We do have an initial orientation for our board members. And, that is a session that is a couple hours that they spend with me going over the history of the hospital, the board, the bylaws, the mission of the board. I tell them a little bit about what we're working on strategically, and they get, get a hospital tour. We cover the history, mission, financials, tax-exempt status, and IRS 990 form during

orientation. All of our board members go through that before they begin service. (Participant 4)

The healthcare entity in which Participant 5 served went one step further than that of Participant 4. The organization not only provided an orientation prior to board service, but the board members were also required to sign a document confirming they understood their role. Participant 5 stressed the important role of board members, particularly because the organization is a life-and-death organization.

> First off, uh, they in advance of even being appointed to the board during the nomination process they receive a five-page document, I want to say it is five pages, that goes to what the roles and responsibilities are for a board member of this organization. And, then on the last page there is a signature line they have to sign and date that comes back to me or my assistant to make sure that going into it that they understand what the roles and responsibilities are. In addition to that, uh, once they are on the board, uh, they also get a copy of the orientation plan that we have here, our orientation program, they get a copy of that to look at, uh, so then again they know what orientation looks like. Um then, we just want them to understand that coming on to a board of this magnitude that this is serious business. Uh, this is not a nonprofit board that is small. This is a life and death organization. (Participant 5)

While all chief executive officers did not indicate orientation sessions occurred prior to a member's service on the board, all nine stated their organizations provide an orientation session that covers the job responsibilities of a board member. The

orientation sessions ranged from three hours to three half days. In addition to the face-to-face orientation, all stated that board members receive a board binder or packet as a reference guide. The data suggested the orientation sessions included the following topics: history, mission, services, organizational structure, committee structure, IRS 990 form, tax exemption, bylaws, conflict of interest, articles of incorporation, credentialing of medical staff, board member agreements, and job descriptions. Training sessions were based on a conceptual understanding of the organization, rather than very specific operational matters. Participant 1 referred to the conceptual aspect of the orientation, stating: "They get the 50,000 flyby in that you tell them about mission, vision, values, roles, responsibilities, and the differentiation of board versus management."

The data suggested most boards include lay people. Therefore, in addition to an orientation session, several participants indicated they provide board members with a glossary of terms to in understanding the language and acronyms used in healthcare. Participant 3 remarked, "We provide board members with a summary of the acronyms we use." In a similar comment, Participant 1 noted that the glossary of terms and acronyms was very helpful.

> We do give out a book on acronyms and glossary terms for healthcare to every
> board member. As I am sure you know, the only group using more acronyms
> than we do is the military. That book is pretty important to give out, and it comes
> from Governance Institute. I think as a board for a nonprofit, you have to
> remember you are dealing with lay people. And sometimes we in healthcare talk
> in PPO, HMO, PHD, ABCs and you can watch their faces glaze over. And my
> job is to make sure my team isn't talking in healthcare, but when talking to the

local farmer, the local businessman, or lawyer that we explain what we are talking about when we talk about ACOs or STDs. It is important that we explain that STD stands for sexually transmitted diseases and that it is not standard daylight time. (Participant 1)

Participant 9 indicated the pamphlet containing healthcare vernacular and acronyms had been impactful for board members.

We have a very small little pamphlet that has the latest in the lingo, and we try to bring them up on that, but as always, any time we are using any of those acronyms in reports we try to use it, but then stop and spell it out for them on exactly what it is for when they hear it in the future. It is interesting as you're going through some of the goals and new acronyms for the first couple of months you would see blank stares back, but now they're repeating it back to us and what it means and how are numbers look great. So, it is really neat to see that. (Participant 9)

Participant 8 commented that the glossary of terms also benefits board members outside the board room as they read newspaper articles about healthcare.

We try to go over healthcare terms just so when they read the paper they will hopefully know as much or more than the average reader. When we talk about target zero, patient safety, and quality we focus on clear communication and phonetic clarification when going through acronyms. We would be called on it if, you know, we used the term ACA and did not say what it was. (Participant 8)

After board members have a basic framework of their roles and responsibilities, the chief executive officers noted that training is offered in ways other than face-to-face.

Participant 9 indicated email was used occasionally as a medium to communicate updates

to the board members, as well as other reading materials.

> Once we start reinforcing things, then you can move to emails or to some of the
>
> other types of communication that we go through. We also provide them with
>
> reading materials. Like any office, we've got all sorts of books on changes in
>
> healthcare or whatever it is, or if we they have a question or special interest we
>
> can get them the information they need. (Participant 9)

Participant 2 stated that newsletters are utilized to convey hot topics in healthcare.

> Uh, they have a couple of newsletters that are entitled, like, "Board Minutes," and
>
> it's like, uh, a two-page newsletter that each one of the board members get each
>
> month. The newsletters are usually really hot topics that are going on in
>
> healthcare. (Participant 2)

> Another recurring method used for board training was webinars. Participant 2

indicated that webinars are utilized monthly to reinforce health-related information.

Webinars are advantageous, as board members can watch the sessions as time permits.

> Then, they also provide webinars every month. There are two to three different
>
> webinars available that we give to the board members. We tell board members
>
> they can sign on it anytime, even at night. Since it's always recorded, they don't
>
> have to watch it when it's actually scheduled. (Participant 2)

The healthcare organization for which Participant 5 served required board members to

participate in no less than four sessions annually. The webinars introduced current

topics, as well as reinforced the nuances in the industry.

They have a tremendous amount of publications and resources that we work from, they have monthly webinars, and they have different publications that all our board members get. In addition to that, we host webinars here, we have lunch here, and we take attendance. In the duties and responsibilities that the board approved, it stipulates that board members have to watch no less than four of those webinars a year. (Participant 5)

The data suggested that all nine facilities utilized board retreats as a means to keep members abreast of the changes in healthcare and to reinforce their roles as board members. As Participants 2 and 8 noted, board retreats are used as platforms to provide education about hot topics in healthcare, as well as to reinforce the responsibilities of the board.

During the board retreat we try to hit on some of the major topics that are going on. One of the things that we particularly try to do in our board retreat is to talk about quality. Every year at our annual retreat we try to cover a lot of our quality things, uh, like what are our responsibilities for quality?; what is the board's responsibility to ensure that quality care is provided at the hospital? (Participant 2)

We're about to have our semiannual retreat, you know, twice a year, planning retreat and so we try to provide education to prep them for what we want to have their input on. (Participant 8)

All nine chief executive officers indicated it is important for board members to attend national conferences. Conferences provide learning opportunities for members to witness that which other boards do and to learn from their colleagues.

Another thing that is important is getting them out to regional and national

conferences because sometimes I think the board is told what is local, and for

your own specific facility. It should make them feel good, and hopefully the

management team feel good, that when they come back from a national

conference they can beat their chest and say, "We are already doing that." But I

think sometimes you don't see the trees for the forest when you stay provincially

local. (Participant 1)

Participant 8 remarked that national conferences are an excellent means for increasing

communication among members representing different organizations.

Um, we also try to expose the board members to people that they would see as

colleagues in similar organizations, and we've done that really for probably the

last eight or 10 years through the Institute of Health Care Improvement where we

use their governing education model that has been tweaked a little bit. We try to

get all our board members to attend in groups, not the entire board, but try to get

groups to go, um, I guess their premier program that is called "Boards on

Boards." That gets our board members talking to other board members. We try

to get a group of people to go every year, um, you know, but the national

programs are pretty available at least quarterly. (Participant 8)

Best practices are important in the field of healthcare. As such, Participant 4

indicated that national conferences are valuable tools to introduce and to reinforce best

practices in the field.

And at these national trustee conferences they have expert faculty from all sources

in the industry, some, some are authors, some are folks tied in with the federal

programs in Washington, DC, some are my peers in the industry, some are board

level peers that speak about their involvement or best practices at their hospitals.

So, these conferences are very valuable. We do provide that as a benefit, you

know, we provide, we cover the tuition and the travel for our board members as a

benefit of them serving on a voluntary basis. And, we have found those to be

very helpful in educating and providing different perspectives for board members.

(Participant 4)

Participants indicated that board training is provided through the use of outside

speakers and consultants. Participants 3 and 4 stated that board members learn from their

interactions with the consultants.

We also invite the board to some other functions that we have. If we have an

outside speaker for the medical staff, we invite the board, and the board members

will take advantage of that, too. When we were setting up our clinically

integrated network we had several different outside people and consultants

helping us do that, so we made sure that when we had any of those formal

meetings we always invited the board to those sessions. (Participant 3)

Frequently, our management company will provide consulting for the board or

will engage a consultant to help with some aspects of our operation. And, so in,

in any consulting engagement you're going to have board member representation

and engagement with that. And, those are great learning opportunities as well.

For instance, our management company team helped us with the visioning for our

strategic plan a couple of years ago, for our long-range strategic plan, and the

board was very involved with that. That really provided great data and great

training to our board in terms of helping them understand what was important

comprising the strategic plan and the implementation of that. And, they were

very involved in the process. So, I think I would suggest that they do get a level

of training with that, just in terms of the interaction with the consultants that we

use. (Participant 4)

While the aforementioned methods of training are important for board members

to understand their roles and expectations, all chief executive officers noted that board

training occurred during board meetings. According to Participant 1, "I think it really

should be an ongoing month-to-month basis at a board meeting that we try to talk about a

topic of currency." Participant 7 said, "Every board meeting that we have, we set aside

anywhere from 20 to 40 minutes at the beginning of each meeting for board education."

Participant 9 reiterated that training sessions are offered during each board meeting: "We

try to do some sort of educational component at board meetings. We will do something

from the industry and then we will do something from the system."

Participant 3 commented that it requires only a few minutes during each meeting

to provide educational updates for members. Participant 3 stressed the importance of

continuous learning for both staff and board members.

We think it's important that we do internal and external training. A lot of times

during board meetings we will have a specific topic to discuss, like the stuff that's

going on, on with Medicaid. Uh, if I have gone to a Kentucky Hospital

Association meeting or our CFO goes to something then we will provide updates

to our board. So we, we find time during board meetings if there's a relevant

topic that we need to discuss with the board. Or, if we as senior leadership go to a

conference we bring that information back to discuss with the board. You know, sometimes it's just a 10- or 15-minute update, but that's all that, you know, they're interested in. They might not be interested in the entire coding piece, but just the overall concept, so we give updates on what we are learning. You know, learning is a continuous learning process for all of us, for us, and for the board. (Participant 3)

While board training is multi-faceted, all chief executive officers referred to training in terms of experiential learning or on-the-job training. Participant 1 said, "You can give them the parameters of what they should ask, learn, and know, but my belief in all my years is that the board learns their job like everybody else does with on the job training." Participant 2 shared the sentiments made by Participant 1.

Really, the bulk of what they learn about board service comes from attending the meetings and really observing. My experience is that our board members typically learn as they go. You frequently see during the first year a lot of them don't contribute a lot because you'll see them kind of listening and learning the nomenclature and all of the, the language of healthcare, but usually by year two they start to get their feet under them and they begin to be very productive as board members. Even though it's not a job, it's a volunteer service and it's very much on-the-job training. (Participant 4)

Theme Two: Training is a Team Approach

While the chief executive officers were intimately involved in agenda setting and embraced their role in board training, the data suggested that multiple individuals are involved in determining the training to be received. The researcher utilized Question 4 to

53

discover the individual who determined the training received by board members in 501(c)(3) nonprofit acute care hospitals in western Kentucky. Participant 1 had the ultimate responsibility for board training but stated, "We have a Governance Committee that really empowers the CEO to do those trainings." Participant 2 indicated that three individuals primarily determined on the topics for training.

> Well, I decide on the education provided at the annual retreat, and the topic is usually focused on quality. Our regional Vice President will actually determine the ongoing education about new topics and present those to the board. If there are new things coming out, like the community health needs assessment, you know, or new regulations, we simply add those items to the agenda for the monthly board meetings. The board agenda is set by the CFO and I. (Participant 2)

Participant 3 suggested that multiple people determined the training for board members, and it ranged from the senior leadership team to the board itself relative to making training decisions.

> It is a joint effort between the senior leadership team. I set up the orientation process. I actually formalized the orientation. It was not formalized when I started as CEO. I met with existing board members and asked them what would be helpful to you if you were a new board member. Then, I met with new board members and asked, "What would be helpful to you?" We also have an ongoing evaluation and modify our training based on input from the board members. (Participant 3)

According to Participant 4, the board chair also assisted in determining the training to be received: "It would be me, uh, uh, in conjunction with my corporate team at our management company, and working with the board chair, obviously."

As it related to the initial orientation process, Participant 5 indicated that the senior leaders were involved in the decision-making process.

> As far as agenda setting, a Vice President works in tandem with the CEO on the orientation process. The Vice President meets with each of the senior leaders that will meet with each new board member during orientation to make sure the topics each board member will hear are pertinent. (Participant 5)

Participant 7 led a hospital that was part of a system, and the training was determined at the local and system levels. Participant 7 also noted that training rested heavily on the Executive Committee of the board.

> The decision is made at the regional and system level. I can draw off of the corporate office for resources to provide as education. Um, there are times in which the corporate office will suggest a popular topic of interest that they want us to cover. Otherwise, it is tailored to the local needs. Again, I try to use my Executive Committee to help identify topics in which they want to study up on. I absolutely lean on the Executive Committee instead of determining the training myself. I am here to serve our board and, it's not about my agenda. It is really about serving their agenda and listening very closely to what the board wants and the direction they want to go. (Participant 7)

Similar to Participant 7, Participants 8 and 9 led healthcare organizations that belonged to systems. As such, the process was formal and training was determined by numerous individuals.

> My experience has been the CEO and board chair really gets together and comes up with a plan about how to orient and educate board members. Now that we are a part of a system, you know, the system is becoming a little bit more formal where they weaved it into what they call Community Needs and Accountability Committee. So that committee has board representatives and medical staff on it and they really focus more on the details, you know, what the expectations will be and the process governance orientation and education. (Participant 8)
>
> Locally, we determine what the need is for the specifics to the hospital or specifics to the organization. As a system, we really work with our system leadership team. It is the system leadership team working with our legal team that really comes up with what is needed and which policies we need to make sure that we're really reinforcing with them or educating them on. (Participant 9)

The data suggested that multiple individuals determined the training that board members receive. As such, the data indicated the decision makers included the chief executive officer, senior level leadership, board chair, system leadership, and various board committees. In a related question, the researcher utilized Question 5 to determine the individual who conducted the training that board members receive. Similar to the team approach utilized in determining board training, the data suggested multiple individuals were involved in conducting board training.

Participant 3 indicated the subject experts from the senior leadership team provided training opportunities for board members.

Our formal training is conducted by the full senior leadership team. We have ongoing training at our monthly board meetings. I mean, I have our CFO to speak about the finance piece and I have our VP of Quality to speak about quality. For credentialing and medical staff information, I have someone from our medical team do that piece. We just have experts in those subject matters to come do that and then the same thing with ongoing things that we do in our board meetings. Whoever is over that area and that's really working in that area could be the person that would do the training, you know, that education piece. (Participant 3)

The senior leaders also were responsible for conducting training at the facilities of Participants 5 and 6.

The senior leaders (Chiefs and VP level) will be responsible for their respective areas of expertise, such as community benefits, advocacy, finance, and etc., during the initial orientation. There are 13 people on the executive team involved. (Participant 5)

It's the senior leadership team that conducts the ongoing training and it depends on their areas of expertise. (Participant 6)

As chief executive officers for hospitals within systems, Participants 7 and 9 stated that local and system leaders conducted training sessions for board members.

It is a broad spectrum of folks. It can be internal staff through a member of my executive team if it is a topic we are comfortable with. It can also be someone

from our corporate office, with an expertise in finance, legal, planning, strategy, or marketing. (Participant 7)

Usually the hospital president would be involved. People from pretty much the local senior leadership will take some component of the orientation which they are most familiar or for which they are responsible. We typically have our director of quality so that the board members meet them and have a comfort level with them. We bring in a compliance officer, locally, because we want the board member to understand our compliance program and know the local contact person. We have somebody from the system come down as well. I think the last time it was our chief legal officer and it was our chief quality and information officer. So, we brought these two people down. One person was a physician and talked about quality, safety, and patient experience. The second person was our attorney who understands the conflicts of interest, or who can best explain the conflict of interest, the risk management programs, compliance, and everything to do with that. We really probably bring in a lot of resources to try to make sure we are covering as much as possible with people. (Participant 9)

Barriers of Board Training

Theme Three: Time is a Scarce Commodity

In Question 8, each of the chief executive officers were asked about any barriers or challenges that existed for offering training for board members. Prior to conducting in-depth interviews, the researcher was confident the participants would suggest several barriers. However, this was not the case. An overwhelming number suggested time, availability, and scheduling are the largest barriers to providing training. Eight (88.89%)

of the interviewees stated time, availability, and scheduling as major barriers to providing

training for hospital board members. As these barriers overlapped, the researcher

condensed them into one overarching barrier, which was time.

Participant 1 mentioned that time was a constraint, but it also was a barrier for the

board members.

> I think it's "time." I think the biggest constraint is time not only of myself, but
>
> more importantly time of the volunteer board member. Our board members are
>
> not compensated. Um, if you figure they come to committees plus the board, you
>
> are probably talking maybe in some cases 10 to 15 hours a month of time, let
>
> alone preparation time. When it comes to a not-for-profit board, it is hard to get
>
> them to volunteer yet more hours of their days or weeks to a training session.
>
> (Participant 1)

Participant 2 added that board members own their own businesses and work long hours,

which made it difficult to provide training. "It is time. I think a lot of it is that some of

them have their own business or some of them are working fairly long hours" (Participant

2). Participants 4, 8, and 9 also alluded to the fact that board members are often engaged

in their communities and have busy careers, which made it challenging to provide

training.

> Just "time." Our board members are usually very, very engaged community
>
> members, and they have very busy careers. It's rare when we have a retired board
>
> member, we do occasionally, but you have to understand people that generally
>
> make a commitment to serve are very busy people anyway, but those are the
>
> people that are the most highly engaged. Time is always the biggest barrier and

their ability to break away from their other commitments to the community and

their jobs, or to their vocation is the biggest barrier. (Participant 4)

Yeah, you know, the availability of some of these board members is challenging.

It gets tricky when a guy has to take three days off of work to go attend a training.

You can say you are getting to go to San Francisco, but the guy has a real job and

can't always get three days off work. (Participant 8)

I think it's honestly time. They're volunteers and when you've got volunteers in

the community who have their own jobs and their own careers, uh, you're asking

somebody who owns gas stations, works in the coal mining industry, works in the

banking industry, or works in the school district and your trying to bring in all

these people who have their own jobs and their own companies and asking them

to learn as much about healthcare as they can, then we've asked a whole lot of

them. The biggest barrier is probably just time. (Participant 9)

Participant 6 represented a nonprofit hospital with a large service area and

referred to time as a barrier because it was difficult to get members together when they

are dispersed throughout the region. Participant 6 also suggested board members often

operate their own businesses, which decreased the lack of time for training.

It is always a challenge getting people together in person, especially when you're

a statewide organization like ours. Even with the local board, the members have

their own businesses and having time is an issue. (Participant 6)

Healthcare is an ever-changing sector. Participant 7 remarked that there simply was

insufficient time to provide training on all current issues or hot topics.

I think time is the limiting factor. You know, there is always a hot topic out there.

I would probably give them board education every other week, but we just don't

have the time. To ask our volunteer board members to take time, you know, our

board meetings are already scheduled for three hours and we ask them to take

time for that. The board meetings are from 11:00am to 2:00pm. Also, each of

them are assigned to at least one of the committees with time required for that and

then take them away for a weekend board retreat, I just think that is a huge time

commitment. (Participant 7)

Participant 5 indicated that time was a recurring barrier to training and mentioned

this barrier became increasingly difficult if the organization had a lot of new members

rotating on the board. In a complex sector such as healthcare, it is crucial to remain

focused on the importance of training. Participant 5 referred to this by saying, "You

don't want to make governance look like a grind."

First, it is scheduling. It is scheduling because these are busy people. They are

already committing a lot of time, and particularly if it's a new board member

they're wondering what this is all about. Right? Because they have served on

other boards. They think they know budgets, finances, and how to read a cost

report. That is certainly the biggest challenge. Also, the more new board

members you have coming on the board it gets challenging to provide education

and training. We are all so busy, right? Everyone is so busy, and you don't want

to make governance look like a grind. (Participant 5)

While it was apparent that time was a major barrier to providing training sessions for board members, Participant 9 suggested it was of greater concern for small communities.

In a small town the other part of that is, and it's just because you have less people, you end up with the same people on multiple boards in terms of their commitments within the community and they're stretched already. (Participant 9)

Based on comments, it was evident that chief executive officers faced a challenge relative to balancing members' time commitments to the board with providing adequate and timely training for them to lead in a very complex industry.

Drivers of Board Training

Theme Four: Healthcare is Exceedingly Complex

While conducting in-depth interviews, the researcher utilized Questions 2 and 9 to reveal the drivers for providing training. Question 2 concentrated on the importance of training, while Question 9 focused on the reason a healthcare organization trains board members. The landscape is undergoing immense changes related to closures, acquisitions, payment structures, and regulations. As such, the complexity of healthcare was a recurring theme for providing board training.

When speaking of the complex business of healthcare, Participant 1 made the following statements:

I think they have to get an understanding of healthcare because it is ever changing. I think you know and I know that over the last several years there have been a lot of potential hospital closures, for example critical access hospitals are closing or are being assumed by the larger acute care facilities and funneling

patients to the larger facility, the mothership if you will. You know, those boards have to be realizing they are in the decision-making processes. I will tell you the last three to five years that I think I have seen boards become more expected to be engaged in understanding than years prior because of affiliations, mergers, acquisitions, and the competition between for-profit and not-for-profit.

(Participant 1)

Participant 1 not only mentioned the complexity of healthcare, but also stressed that it continues to change.

I have always said to people that the only guarantee in healthcare is one thing and that is change. If you are not wanting change, then don't be in healthcare. Whether you're a doctor or nurse, it is pharmaceutical changes, surgical interventions, or who knows what, but it is not the same, and God forbid you are doing it that way. You are in deep trouble. (Participant 1)

During the interview with Participant 2, the chief executive officer said, "The first thing I tell board members is that healthcare is the most convoluted business that you will ever get into." The interviewee referenced the immense changes experienced by the healthcare sector and that the field would continue to change in the future:

Healthcare is very convoluted and is ever-changing, you know, and it is going to change continually. I really foresee it, and this is just my opinion, but in the next four to five years we're probably going to see some of the most major changes in healthcare that we've ever seen. For example, as far as payment options, how we're going to get paid, who's going to be the, the providers of the care, you know, what's going to happen out there. I think anything that the board can know

will help prepare them to position this hospital to be here in the future. This is the

reason that we need to provide them with all the education that we can because

things are going to continue to change. (Participant 2)

Although healthcare is complex at the organizational and sector levels, Participant

4 noted that training aides board members in making strategic decisions.

Well, you want the most knowledgeable, well-educated board members that you

could possibly have. Healthcare is, is increasingly complex, and so the more

knowledgeable your board members can be about the challenges in the industry

and the challenges that their hospital faces, the better they can help strike a

leadership position in terms of the direction that the hospital is going to move

strategically, the direction it's going to move competitively, and the direction it's

going to move in terms of service to the community that it provides care for.

(Participant 4)

Participant 4 continued by asserting that board training also impacts the community that

the organization serves.

I think the more board members take advantage of the training that is available to

them the better they are able to understand healthcare, which you know, is very

complex and the better they're able to provide services in the interest of the

community. (Participant 4)

Participant 5 was very candid by suggesting it would be entirely irresponsible on multiple

levels to not provide training for members representing a complex organization.

When they come, you watch them just glassy eyed when they first go through this

for the first couple for meetings. About the third or fourth board meeting, now

that they have gone through orientation, they start to realize that I am not going to

get all this in the first six months, I might not even get this in a year.

Realistically, they realize they might not get what it is in the first term. When you

talk about governance it would be irresponsible, totally irresponsible, to our

patients, to our community, and to that individual that is serving to have them

land here with this organization that operates a complex system and that deals

with people's lives and not do everything we can to provide, not just orientation

on the front-end, but to provide ongoing training. (Participant 5)

Training is the first step to equipping board members with the knowledge to

become engaged, innovative, and to think strategically about the operation of the

hospital. It would be extremely difficult for board members to make decisions in an ever-

changing and regulated industry without training. According to Participant 6, "I just

think everything is complex. You know, there are no cut and dry answers. We are in a

very regulated industry, and we happen to be in a very competitive market."

Participant 7 insisted that board members possess a conceptual understanding of

healthcare. Due to its complicated nature, the board must understand the operation of the

organization and the way in which board members can share their talents.

It takes a village, it really takes a village to operate a very, very complex

organization. First, board members need to understand the environment we are

operating in. They need to understand and they need to have a basic

understanding of what we do and how we do it so they can bring their expertise to

the board to help us improve our operations. (Participant 7)

During the interview, Participant 7 also mentioned that training is imperative and an

organization lacks foresight by neglecting board training.

It is absolutely essential. Our board members come in with most of them not

having any knowledge of healthcare other than maybe being a patient. Uh, they

certainly have skill sets that we need to govern our organization, whether it be an

attorney, a CPA, uh, insurance agent, or a local business person. You name it and

they have that experience. Healthcare is so complex and we use so many

acronyms, not to continue to provide them with an educational opportunity would,

uh, uh, lack foresight on our part.

Participant 9 spoke about the regulations facing healthcare organizations, as well

as the sheer volume of changes that occur daily.

As far as regulated industries, healthcare is right up there with banking. You

know, it is us and banking in the top two. When you have people who are taking

responsibility for an organization or system they have to know what they're

stepping into. They have to be educated and they have to be brought up to speed

pretty quickly, so it's not only just orientation because how many of us get an

orientation manual or go through orientation, but it's what we do to follow up on

that and keeping them up to speed on all the changes. I can't go a day without

having at least 10 or 20 changes coming through as far as what is expected of the

industry, so I need the board members to be aware of the pertinent ones.

(Participant 9)

Theme Five: Fiduciary Duties are Wide in Scope

Quality, safety, and performance discussions begin during orientation and are weaved throughout ongoing training sessions for board members. As the uppermost leadership of healthcare organizations, these individuals are responsible for all aspects of the entity. They are responsible for the financial vitality of the organization; however, as the data suggested, they also are responsible for quality, safety, and performance. Through the use of Questions 2 and 9, the researcher discovered that the breadth of fiduciary duties is a driver for providing board training.

Participant 1 indicated training is important because board members are entrusted to oversee a community investment.

I think in the not-for-profit world most people don't understand that the ultimate person accountable for the quality of care hospital is not the doctor, it is the governing board. And, I think you know, it's a community investment, so the governing body is being entrusted by the community to oversee that community investment. (Participant 1)

Participant 1 elaborated by saying, "The board must understand they are responsible for the care, quality, financials, and the whole shooting match."

Participant 8 claimed that training is essential, as the board is responsible for the overall performance of the hospital.

The board is the group that is ultimately responsible for the performance of the hospital, you know, so you want to make sure that they have everything they feel they need and you feel like they need to be successful. (Participant 8)

Similar to Participant 8, Participant 9 highlighted the extent of fiduciary duties.

In the end everything reports to the board whether its physician credentialing, risk management issues, or the finances they're taking a lot of accountability. Yes, they've got me and yes, they've got the management team of the hospital to take care of that hopefully for them, but in the end they're the ones approving it. (Participant 9)

In a subsequent comment regarding training opportunities, Participant 9 supported the notion that fiduciary duties are large in scope and go beyond the financials.

Um, we go to the quality information because, obviously, 20 years ago I think we focused more attention on the financial side of things, but now we are focusing more on the quality, safety, and patient experience side of things. They need to understand, not only from what our goals are, but they need to understand how quality, safety, and patient experience are impacting the hospital and the reimbursement for the hospital and just the patient care overall, so, uh, that's a huge part of it. (Participant 9)

As chief executive officer of a hospital within a system, Participant 9 indicated that the board desired to begin meetings by discussing quality.

Um, they have the fiduciary responsibility to ensure the success and viability of the organization, they have the public trust and confidence in the governing body of the organization. (Participant 9)

Board training opportunities have evolved from focusing on financial matters to a wide array of topics. Participant 3 revealed that board members recognize they have oversight in more than one area.

I don't think they realized until we started talking about quality that their oversight was not just from a fiscal standpoint, but their oversight was also from a quality standpoint. They have oversight of every service and everything that occurs in this hospital, not just whether we have a bank account or not. Without profit there is no mission, but without patients there's also no hospital. (Participant 3)

When speaking about ongoing training during board meetings, Participant 9 indicated that discussions about quality take precedence over finance, which reinforces that fiduciary duties are wide in scope.

As a lot of organizations, we have changed our agendas for the board meetings. Actually, finance has moved way down. And the majority of the meeting, if you look at the top, it really starts with our patient safety minutes, our good catches, and moves in the safety, quality, and patient experience. That's where the vast majority of the agenda is often spent, so finance is important, but it's making sure you're taking care of patients and doing the right thing. (Participant 9)

In a similar comment, Participant 7 reiterated that, as fiduciaries, board members are responsible for the quality of care.

We spend our time at the governance level on strategy and quality. You know, we, we spend lot of time talking about the strategic direction of this organization and making sure that the quality is appropriate and right on. The board is absolutely responsible for quality. If you do your work right, the financials should follow in a positive way. One of the major responsibilities of the board, and I share this with the board at every board meeting, is the fact they approve new members to our medical staff. That is the one responsibility that they need to

take probably the most serious, because if they hire and let on to their medical

staff the right physicians and the right mid-level providers they have limited their

exposure to problems versus just letting anybody, and then they've opened up a

can of worms. You know, I have been very blessed to have a board that that

resonates with. They take their, their fiduciary responsibility not only from the

financial stance, but also from a quality stance very seriously. (Participant 7)

Theme Six: Trained Board Members Often are Engaged Board Members

Question 10 was utilized to explore the impact of training on board members'

knowledge of their roles and expectations. Based on the plethora of data collected in this

study, it is clear the prevailing theme regarding the impact of training and the driving

force is that training often is a precursor to engaged board members. Participant 3

suggested that training equips board members with the knowledge to ask questions about

the operations of the hospital.

Once you invest in the training I can see the impact even after we've gone to the

conference and people come back and say, "I heard this at the conference, so can

you tell us what we're doing?; why we're doing it?; or not doing it?" I think those

are the kind of questions that are very helpful. (Participant 3)

While board training often leads to well-informed board members, Participant 4

indicated that it also ignites the members' desire to serve in leadership roles on the board.

I have found that my most engaged board members typically end up in key

leadership positions on the board. They end up serving as committee chairs, they

end up as vice chair of the board, and ultimately even as board chair. Typically,

the more training that a board member, that he or she takes advantage of, I have

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found the more interest they have in serving in leadership positions on the board.

Certainly that knowledge and that education benefits me and my administrative

team in the hospital as they lead the hospital from the standpoint of their position

on the board. (Participant 4)

Participant 5 commented that board training is a prerequisite for an engaged board. Once

members have received adequate training, Participant 5 believed the board members are

able to think critically and strategically about the issues facing the organization.

There is nothing better than setting up an issue or situation for the board to

consider and allowing them to have a strategic, governance conversation around

that issue and understanding their responsibility around that particular issue. You

can't fake that. You just can't fake that. It comes from bright people ingesting

information and critical thinking about information that they wouldn't have had

otherwise without attending meetings, getting education, and longevity on the

board. Some people think you just give the board members all the information

you can give them, but we want to set the situation up for them, hear their

thoughts, and let them think critically about the issue. (Participant 5)

While speaking about the way in which training improves board engagement,

Participant 6 indicated that an engaged board is invaluable because they ask thoughtful

questions and challenge the leadership team.

We also, uh, aspire to provide high quality, safe care, and we're a very innovative

organization that wants to be state-of-the-art. We need people to challenge us and

who test our assumptions. Uh, we, we are really sometimes so close to the issue

that we need that outside perspective. They're also a great conduit for me to get

information from the community. They're invaluable, they really ask the right

questions, and they challenge myself and my leadership team. I very frequently

test ideas with them and get their opinion on things, even at the very beginning of

initiatives that we're working on. (Participant 6)

Similar to the comment made by Participant 6, Participant 9 suggested that training often

results in an engaged board that asks questions and puts their training to practice.

I like how the board is asking things because they are learning more. I feel better

when I have a board that is questioning because then I know that they're engaged,

they're paying attention, and that they are thinking about the business as a whole

and I see that regularly. You know, you can give people information and whether

they comprehended or, or even if you give them something to read whether they

read it, you just you don't completely know. In this case, I feel like the last couple

of boards that I've had I've had an engaged board very willing to read, willing to

listen, and willing to ask questions. Overall, that just helps the organization.

(Participant 9)

Although board training requires an investment of time and money, Participant 8

believed the return on investment is worth it.

I feel like the investment that we've made in training of our board members, you

know, you can see the payback in their ability to participate, their ability to be

supportive of the hospital and the health system in difficult times. (Participant 8)

Participant 5 shared the same sentiments related to making investments in governance.

This individual felt that healthcare entities with superior outcomes are "doing governance

right." Participant 5 continued by suggesting that training be required by law.

There is a legal responsibility they accept and we have a responsibility to provide

education so they can carry out their duties. The driving force is it is

irresponsible, just irresponsible to not provide them with information. If you want

to look around at the healthcare organizations that you hear about or read about

that are doing things right, they are also doing governance right. You just don't

fake governance. (Participant 5)

Summary

Through rigorous data analyses, six themes concerning board training emerged

from the experiences of the chief executive officers representing 501(c)(3) nonprofit

acute care hospitals in western Kentucky. The overarching themes related to the

practices, barriers, and drivers of board training included: (1) training is multi-faceted, (2)

training is a team approach, (3) time is a scarce commodity, (4) healthcare is exceedingly

complex, (5) fiduciary duties are wide in scope, and (6) trained board members often are

engaged board members. Chapter V summarizes the findings, provides implications for

practice, and makes recommendations for future research.

CHAPTER V: DISCUSSION, IMPLICATIONS, AND CONCLUSIONS

Introduction

The purpose of this inquiry was to provide a rich description of chief executive officers' experiences of board training within 501(c)(3) nonprofit acute care hospitals in western Kentucky. Through a reality-oriented lens, this qualitative study provides rich insights into the practices, barriers, and drivers of board training based on the experiences of nine chief executive officers. The researcher employed rigorous data analyses through the use of constant-comparative analysis and inductive analysis. The meticulous data analyses and coding permitted the researcher to establish themes to understand training for board members representing nonprofit healthcare organizations.

This chapter provides an overview of the central research question and a summary of the themes. It also includes a discussion of themes, limitations of the study, implications for practice, and recommendations for future research.

Central Research Question

The following research question guided this reality-oriented study: How do chief executive officers representing 501(c)(3) nonprofit acute care hospitals in western Kentucky describe their experiences surrounding the practices, barriers, and drivers of board training? In-depth interviews were employed with nine chief executive officers to address the research question.

Summary of Themes

Through the use of constant-comparative analysis and inductive analysis as described in Chapter III, the researcher categorized copious amounts of data into six primary themes related to board training: (1) training is multi-faceted, (2) training is a

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team approach, (3) time is a scarce commodity, (4) healthcare is exceedingly complex, (5) fiduciary duties are wide in scope, and (6) trained board members often are engaged board members.

Discussion of Themes

The summation of the interviews provides a comprehensive understanding of the practices, barriers, and drivers of board training in 501(c)(3) nonprofit acute care hospitals in western Kentucky. The participants repeatedly stated that training is multi-faceted. Also, each participant articulated a team approach utilized to provide initial and ongoing training for board members. An overwhelming number claimed that time is the primary barrier to providing training sessions. The data revealed multiple drivers for providing training. All participants indicated training is needed, as healthcare is exceedingly complex. Due to the breadth of fiduciary responsibilities, all participants articulated the need for training. The majority believed that trained board members often are engaged board members. Thus, ongoing training is necessary. Based on the perspective of the researcher, understanding the practices, barriers, and drivers for training has implications for both nonprofit practitioners and academicians.

Theme One: Training is Multi-faceted

All participants reported that orientation and ongoing training sessions were offered through numerous modalities to equip board members with knowledge for their governing roles. These findings are supported by Katz's (1955) seminal skills-based leadership model related to leaders developing skills through training. During the interviews, all chief executive officers indicated board training was provided on a wide

spectrum of topics. The previous works of Mallin (2005) and Werther and Berman (2004) support these findings regarding an assortment of training methods and topics.

The chief executive officers noted that orientation sessions for new board members focus on a conceptual understanding of the organization and the healthcare industry. For existing board members, the participants reported that training sessions are offered on a continual basis. The ongoing training is focused on providing board members with a conceptual understanding of healthcare. The seminal work by Katz (1955), which served as the theoretical framework for this study, supports the findings of this study related to providing the uppermost leadership in an organization with conceptually-based training.

The participants included in this study declared that board training is offered through methods ranging from internal sessions to outside conferences. The works of Coulson-Thomas (2008) and Holland and Jackson (1998) support these findings in regard to providing board members with internal and external training opportunities. The chief executive officers suggested that board training and information sharing occurs through the use of orientation sessions, board meetings, committee meetings, newsletters, webinars, email messages, board retreats, conferences, and consultants. The multi-faceted training approach garnered from this study is supported by the works of Coulson-Thomas (2008), Gottlieb (2005), Griffin and Lake (2013), Stout (2015), and Taylor et al. (1996).

Theme Two: Training is a Team Approach

The participants suggested that multiple individuals are involved in determining and providing training for board members. While some represented hospitals belonging

to healthcare systems, the study also included individuals who represented independent hospitals. Hospitals belonging to a system may appear to have had more human capital at their disposal, but both independent hospitals and those within systems rely upon multiple individuals for training. A recurring theme was that trainings within their respective facilities are not a result of the efforts of one individual; the trainings are a product of teamwork.

While few empirical sources exist related to board practices (Doherty & Hoye, 2011), practitioner-based resources suggested the chief executive, chair of the board, or senior leaders should be involved in training sessions because they possess abundant organizational knowledge (BoardSource, *n.d.a*; BoardSource, *n.d.b*; Community Tool Box, 2015; McNamara, *n.d.a*). As such, data garnered from the participants suggested that chief executive officers, senior leaders, system leaders, board chairs, and board members determine training topics. Additionally, data indicated that chief executive officers, senior leaders, and system leaders deliver the training for board members in 501(c)(3) nonprofit acute care hospitals in western Kentucky. The participants suggested that they relied upon a team of individuals with subject matter expertise to determine and to deliver training for their respective board members. The aforementioned findings related to a team approach for training are supported by practitioner-based resources (BoardSource, *n.d.a*; BoardSource*, n.d.b*; Community Tool Box, 2015; McNamara, *n.d.a*).

Theme Three: Time is a Scarce Commodity

Throughout the interviews, the participants suggested time, availability, and scheduling are the largest barriers to providing training for board members. As these

barriers overlapped, they were condensed to one overarching barrier, which was time. A

recurring comment was that the nonprofit board members are volunteers, and it is

difficult to find time to schedule and to provide training. The participants indicated that

board members not only are responsible for their board and committee tasks, but also

they typically are employed full time. The chief executive officers suggested that their

board members are extremely busy individuals who often own their own businesses, have

demanding careers, and are active in their communities. A few participants indicated that

it is uncommon to have board members who are retired and have available spare time.

While the participants indicated the board members of their respective

organizations are volunteers, all expressed that board members ultimately are responsible

for the organization. These findings are supported by the works of Gibelman et al.

(1997), Iecovich (2004), and Wry (1990) in regard to the board being the highest-ranking

members of a nonprofit organization. As such, the participants vocalized the need for

combating time barriers to provide quality training. The lack of time was mentioned not

only as a challenge for board members, but participants also responded that the lack of

time is an issue for chief executive officers as well. It was apparent that chief executive

officers are charged with the difficult task of balancing the board members' time

commitment with providing sufficient training for them.

Theme Four: Healthcare is Exceedingly Complex

The healthcare sector has witnessed immense changes in previous years, which

continue. Regardless of geography, healthcare entities have witnessed closures,

acquisitions, complex payment structures, and increased regulations. Board members

representing these organizations are faced with difficult situations that are unparalleled to

prior years. Throughout the interviews, the complexity of healthcare was articulated as a

driver for providing training for board members. According to the participants,

healthcare is exceedingly complex, and they do not foresee an end as it pertains to the

ever-changing environment. The participants believed training is necessary for board

members to understand the complex healthcare environment and to utilize their talents to

improve the operations of the organizations. These findings are supported by the writings

of Katz (1955) as they pertain to board members developing skills through training and

increasing their value to the organization they serve.

As the uppermost leadership in nonprofit organizations, the participants suggested

training is necessary for the board to make strategic decisions and to position these

organizations to exist in the future. The writings of Drucker (2005) support these

findings related to the board being engaged and performing at an exceptionally high level

in order for a nonprofit organization to remain sustainable and to meet its obligations to

the community. The chief executive officers reported that changes transpire in their

facility on a daily basis and occur daily in the healthcare industry. As such, the

participants stressed the importance of keeping board members abreast of the pertinent

changes facing the organization and the industry. These findings challenge previous

work by Coulson-Thomas (2008) in regard to board members not receiving the training

required to serve effectively. The organizations in this study appeared to be proactive

when compared to others found within nonprofit literature.

It was stated during the interviews that healthcare organizations deal with life and

death situations, unlike that of other types of public charity. The chief executive officers

were very candid about the irresponsible actions of nonprofit entities that do not provide

continuous training opportunities for board members. The findings of this study

contradict previous studies by Griffin and Lake (2013), Brown et al. (2012), and

Radbourne (1993) that revealed training sessions to be rare occurrences in nonprofit

organizations. As healthcare organizations in this study deal with life and death, as the

chief executive officers articulated, this may be the reason board training is more

prevalent than in other 501(c)(3) public charities such as colleges, human services,

museums, and community foundations.

Theme Five: Fiduciary Duties are Wide in Scope

Throughout the interviews, the breadth of fiduciary duties was considered to be a

driver for providing training for board members. As the highest-ranking leaders in

nonprofit healthcare organizations, the board of directors is accountable for all aspects of

the entity. In previous years, the participants alleged that both organizations and board

members focused greater attention on the financial vitality of the organization. However,

in a complex healthcare environment with ever-changing regulations, fiduciary

responsibilities are at the forefront of trainings. Training opportunities for board

members continue to expand and to improve, as chief executive officers and board

members recognize the board's fiduciary duties expand beyond the finances. The

members are not involved in the minutia of day-to-day operations, but the participants

indicated the board of directors is responsible for the organization, albeit at a conceptual

level. These findings are supported by the writings of Gibelman et al. (1997), Griffin and

Lake (2013), Iecovich (2004), and Wry (1990) related to training being necessary in

order to prepare board members for their roles. These findings also are supported by

Katz's (1955) skills-based leadership model, which suggests that leaders at the top of an organization are responsible from a conceptual versus a technical level.

Committed volunteers serve as board members with moral and legal obligations to stay informed of the organization's activities (Gibelman et al., 1997; Wiehl, 2004). As such, the participants indicated training is required to keep the board well-informed of all governance duties. These findings are supported by the Association of Governing Boards (2014) and Hopkins and Gross (2010) pertaining to board members being bound by law to act in accordance with the fiduciary duties of care, loyalty, and obedience. The participants noted that orientation occasionally begins prior to a member's service on the board, and training continues throughout the member's tenure. These findings contradict the writings of Brown et al. (2012), Coulson-Thomas (2008), and Radbourne (1993) that suggested nonprofit board members rarely receive the training required to serve effectively.

The participants also iterated that the physicians are not accountable for the quality of care; the governing board has responsibility as part of their fiduciary duties. The participants stated the fiduciary duties are wide in scope. The board members are accountable for credentialing of medical staff, ensuring appropriate risk management systems are in place, maintaining patient safety and satisfaction, cultivating a high performing organization, protecting the community's investment, and preserving the organizational mission.

Theme Six: Trained Board Members Often are Engaged Board Members

One of the prevailing challenges for nonprofit organizations is to engage the board of directors (Wright & Millesen, 2007). A recurring theme during the interviews

was that trained board members often are engaged board members. Hence, this theme

served as a driver for providing training for board members. Throughout the course of

the in-depth interviews with chief executive officers, the participants suggested that board

engagement often improves with training. These findings are supported by previous

research conducted by Bernstein et al. (2015), Jamison (2003), and Wright and Millesen

(2007), which suggested training leads to engaged board members.

The participants stated that internal and external training equips board members

with the conceptual framework to ask questions about the operations of the organization,

to think strategically, and to challenge the assumptions of management. The findings are

supported by the seminal work of Katz's (1955) skills-based leadership model stating that

conceptual skills are vital at the highest level of an organization. Additionally,

participants alluded to the fact that trained board members benefit the management team

and the organization in achieving superior outcomes. In overwhelming responses, the

participants indicated that an engaged board of directors is worth the investment of time

and money to provide training sessions. Engaged board members not only think critically

about external issues facing the organization, but participants indicated the board

members think critically about the entire healthcare industry. These findings are

supported by the work of Inglis et al. (1999) pertaining to the importance of boards being

involved with externally focused, strategic issues.

<center>**Limitations of the Study**</center>

A reality-oriented inquiry approach was employed to thoroughly explore chief

executive officers' experiences of board training (Miles & Huberman, 1984; Patton,

2002). This study adds meaningful information to the dearth of empirical sources related

to the practices of board training. However, the findings are limited to the experiences of nine chief executive officers. While the findings from qualitative studies are transferable to similar settings (Guba, 1981; Marshall & Rossman, 2011), the results from this study are not generalizable for all nonprofit organizations. For a broader understanding of the practices of board training, additional research is needed, including a more diverse sample.

Qualitative methods were well suited for this study, as the researcher sought to acquire a rich description of the phenomenon (Creswell, 2007; Miles & Huberman, 1984; Padgett, 2012; Slavin, 2007). Findings provide meaningful information for nonprofit practitioners seeking to develop or to improve training endeavors for board members, as well as valuable information for academicians with research interests in nonprofit leadership, nonprofit governance, and board development. However, the information acquired is representative of only nine 501(c)(3) nonprofit acute care hospitals in a southern locale. Additional research, including a sample from a larger geographic area, is needed.

The sample for this study included participants with experience ranging from 0-2 years to more than 12 years as the chief executive officer of their respective hospitals. As 44.4% of the participants possessed 0-2 years of experience at their respective hospitals, certain responses may have been influenced because some participants were newly hired chief executive officers. Similarly, 44.4% had nine or more years of experience as chief executive officer of their hospitals; therefore, longevity in the position may have influenced the comments provided by the participants.

At the time of the interviews, the participants were employed at the discretion of the board of directors. The researcher assured each chief executive officer that no names or identifiable information would be included in the findings, although the participants may have been less vocal about board training as an individual no longer employed at the hospital. The researcher believes this study helps to fill the void of nonprofit literature related to board practices; however, additional research is needed to remain current with training practices.

Implications for Practice

This study provides a thorough exploration of the practices, barriers, and drivers of board training among nine chief executive officers representing 501(c)(3) nonprofit acute care hospitals in western Kentucky. Chief executive officers, senior-level healthcare executives, board chairs, and board members can utilize the findings to refine practices of training. Similarly, academicians can use the findings in future research pursuits.

While chief executive officers stated that board training in 501(c)(3) nonprofit acute care hospitals is multi-faceted and accomplished through a team approach, participants suggested that continuous improvement is essential for training endeavors. In order to help board members remain well informed, training topics and methods should evolve as the sector changes. Chief executive officers and other senior-level nonprofit leaders could implement the strategies garnered from this study to improve board training practices. Board training and information sharing could be implemented through the use of orientation sessions, board meetings, committee meetings, newsletters, webinars, email messages, board retreats, conferences, and consultants. Training must be

continually improved to keep volunteer board members abreast of the healthcare sector and organizational information.

As board members typically lack extensive healthcare knowledge, it would be advantageous to provide each new member with a glossary of healthcare terms. Hospital tours would be appropriate learning opportunities for new and existing board members. Tours would bring the trainings full circle and allow board members to experience and to observe that which they primarily had heard about only in training sessions. Recognizing the drivers of board training, it is pertinent for chief executives to work with their respective board members to overcome the constraints of time in order to provide quality training for new and existing members. Due to the complexity of the healthcare industry, both chief executive officers and boards must work diligently to provide comprehensive training opportunities.

Governance drives nonprofit organizations; therefore, board training cannot be underestimated. As new members begin their service on nonprofit boards, the need exists for initial and continuous training. Training is a vital component of ensuring board members are equipped with the appropriate knowledge to uphold their fiduciary duties and to lead organizations effectively. Also, training may improve engagement among new and existing members. The information garnered from this qualitative study could be employed by nonprofit leaders in an effort to develop or to refine training efforts.

Recommendations for Future Research

This study focused on the experiences of nine chief executive officers representing nonprofit healthcare entities. Future studies investigating members' experiences of board training could yield meaningful information for nonprofit leaders

and academic researchers. An in-depth inquiry capturing members' experiences would provide a thick description of the perspectives of a recipient of board training. Similarly, future studies concentrating on board chairs' experiences of training could yield beneficial information. While chairs are considered to be board members, their leadership experience could enhance the understanding of board practices in nonprofit organizations.

The information gathered on board training is representative of nine nonprofit acute care hospitals. While qualitative studies typically involve small samples (Dworkin, 2012; Gay et al., 2006; Guba, 1981; Merriam, 2002; Patton, 2002; Weiss, 1998) to reach a point of generalizability, future studies could include survey research among a diverse slate of healthcare executives within a larger geographic area. Surveys could be administered throughout an entire state or region of the country. Also, the findings were not analyzed based on gender; therefore, future research could focus on the gender differences related to the perceptions and experiences of board training among chief executive officers, board members, and board chairs.

Certain responses may have been influenced by the longevity of the chief executive officers at their respective hospitals. Future studies could employ correlational methods to determine the extent to which years of experience is related to chief executive officers' perceptions of board training. As the participants were employed at the discretion of the board of directors, the chief executive officers may have been less open about board training when compared to an individual no longer employed by the hospital. To add another layer of anonymity, future research could involve survey research to capture practices, barriers, and drivers of board training.

Summary

The findings from this reality-oriented study include six themes related to the practices, barriers, and drivers of board training: (1) training is multi-faceted, (2) training is a team approach, (3) time is a scarce commodity, (4) healthcare is exceedingly complex, (5) fiduciary duties are wide in scope, and (6) trained board members often are engaged board members. In an ever-changing healthcare industry, the six aforementioned themes indicate a need for additional scholarly pursuits to understand and to improve board training practices in nonprofit organizations. While a scarcity of empirical sources exist related to nonprofit leadership, this study assists in filling the void. The findings provide vital information for a myriad of individuals, including chief executive officers, senior-level healthcare executives, board chairs, and board members involved in developing and refining practices of board training. Additionally, academicians can use the findings from this study to conduct future research on nonprofit leadership, nonprofit governance, and board development.

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Interview Conversation Guide

Demographics:

Age Range (circle one)

               18-25   26-35   36-45   46-55   55+

Ethnicity (circle one)

              Hispanic Origin: Yes   No

Race (circle as many as apply)

  Asian   American Indian/Alaskan Origin   Black/African American

        White   Native Hawaiian or Other Pacific Islander

Highest level of education completed (circle one)

  High School   Associate's   Bachelor's   Master's   Doctorate

Number of years as chief executive officer/executive director (circle one)

      0-2   3-5   6-8   9-11   12+

Practices, Barriers, and Drivers of Board Training:

1. How do board members learn what is expected of them during their service on the board (i.e. roles and responsibilities)?

2. How important is training for board members?

3. Tell me about training for board members at your health care facility.

4. Who determines the training board members receive?

5. Who conducts the training provided for board members?

6. Tell me about the techniques (or ways) that are used to deliver board training at your organization.

7. Tell me about the frequency of training for board members.

    a. Does training occur often enough?

8. Tell me about any barriers or challenges that exist for offering training for board members.

9. Why would a health care organization want to train their board members?

10. Tell me about the impact of training on board members' knowledge of their roles and expectations?

APPENDIX B
Institutional Review Board Approval

DATE: August 9, 2016

TO: Matthew Hunt
FROM: Western Kentucky University (WKU) IRB

PROJECT TITLE: [943796-1] Nonprofit Board of Director Training: The Experiences of Chief
                 Executive Officers in Western Kentucky
REFERENCE #:   IRB 17-027
SUBMISSION TYPE: New Project

ACTION: APPROVED
APPROVAL DATE: August 9, 2016
EXPIRATION DATE: August 9, 2017
REVIEW TYPE: Expedited Review

Thank you for your submission of New Project materials for this project. The Western Kentucky University
(WKU) IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit
ratio and a project design wherein the risks have been minimized. All research must be conducted in
accordance with this approved submission.

This submission has received Expedited Review based on the applicable federal regulation.

Please remember that informed consent is a process beginning with a description of the project and
insurance of participant understanding followed by a *signed* consent form. Informed consent must
continue throughout the project via a dialogue between the researcher and research participant. Federal
regulations require each participant receive a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this office prior to
initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and UNEXPECTED
adverse events must be reported promptly to this office. Please use the appropriate reporting forms for
this procedure. All FDA and sponsor reporting requirements should also be followed.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this
office.

This project has been determined to be a Minimal Risk project. Based on the risks, this project requires
continuing review by this committee on an annual basis. Please use the appropriate forms for this
procedure. Your documentation for continuing review must be received with sufficient time for review and
continued approval before the expiration date of August 9, 2017.

Please note that all research records must be retained for a minimum of three years after the completion
of the project.

If you have any questions, please contact Paul Mooney at (270) 745-2129 or irb@wku.edu. Please
include your project title and reference number in all correspondence with this committee.

- 1 -

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Western Kentucky University (WKU) IRB's records.

APPENDIX C
Initial Announcement Letter

Date

Name of Participant
City, State Zip

Dear Name of Participant,

My name is Matthew Hunt. I am a doctoral student in the organizational leadership program at Western Kentucky. My program requires that I complete practitioner-based research.

The purpose of my research study is to explore chief executive officers' experiences of board training within 501 (c)(3) nonprofit acute care hospitals. This study will provide an insight into the practices, barriers, and drivers of board training.

I would greatly appreciate your participation in a conversation as I seek to learn more about board training within your health care organization. Your experience will be valuable and serve as an integral component of my research as I explore board training in nonprofit health care organizations. Your responses in the one-on-one interview session will remain confidential.

If you have any questions about my research, please contact me at (270) 202-6603 or at matthew.hunt@wku.edu.

Thank you in advance for your participation in my research.

Sincerely,

Matt Hunt
matthew.hunt@wku.edu

APPENDIX D
Follow-up Correspondence with Participants

Date

Name of Participant
City, State Zip

Dear Name of Participant,

As a reminder of our conversation today, I am a doctoral student in the organizational leadership program at Western Kentucky. My program requires that I complete practitioner-based research.

The purpose of my research study is to investigate chief executive officers' experiences of board training within 501 (c)(3) nonprofit acute care hospitals. This study will provide an insight into the practices, barriers, and drivers of board training.

I am looking forward to our one-on-one interview at_____ as I learn more about board training within your health care organization. Your experience will serve as an important part of my research. Your responses will remain completely anonymous and confidential.

If you have any questions about my research, please contact me at (270) 202-6603 or at matthew.hunt@wku.edu.

Thanks again for your participation in my research.

Sincerely,

Matt Hunt
matthew.hunt@wku.edu

Informed Consent Document

Project Title: Nonprofit Board of Director Training:
The Experiences of Chief Executive Officers in Western Kentucky

Investigator: Matthew Hunt, Doctorate of Education Student, Western Kentucky University
Phone: 270-202-6603   Email: matthew.hunt@wku.edu

You are being asked to participate in a project conducted through Western Kentucky University. The University requires that you give your consent to participate in this project.
You must be 18 years old or older to participate in this research study.

The investigator will explain to you in detail the purpose of the project, the procedures to be used, and the potential benefits and possible risks of participation. You may ask any questions you have to help you understand the project. A basic explanation of the project is written below. Please read this explanation and discuss with the researcher any questions you may have.

If you then decide to participate in the project, please sign this form in the presence of the person who explained the project to you. You should be given a copy of this form to keep.

1.   **Nature and Purpose of the Project:** The purpose of this study is to explore chief executive officers' experiences of board training. This study will provide an insight into the practices, barriers, and drivers of board training.

2.   **Explanation of Procedures:** If you chose to participate in this study, the researcher will ask you two questions to determine if you meet the inclusion criteria for the study (chief executive officer of a 501 (c)(3) nonprofit acute care hospital in western Kentucky and training is provided for hospital board of directors). If you agree to participate in this study, data collection will occur through audio recorded, face-to-face interviews.

3.   **Discomfort and Risks:** Participation in the study will include only minimal risks for the participants such as inconvenience, the use of personal time, and/or increased awareness/concern about board training occurring at the health care organization.

4.   **Benefits:** The study findings will not directly benefit the participants; however, the information obtained will inform health care leaders of the practices, barriers, and drivers of board training in 501 (c)(3) nonprofit acute care hospitals in western Kentucky.

5.   **Confidentiality:** Your answers during the interview will remain confidential.

6.   **Refusal/Withdrawal:** Refusal to participate in this study will have no effect on any future services you may be entitled to from the University. Anyone who agrees to participate in this study is free to withdraw from the study at any time with no penalty.

WKU IRB# 17-027
Approval - 8/9/2016
End Date - 8/9/2017
Expedited
Original - 8/9/2016

You understand also that it is not possible to identify all potential risks in an experimental procedure, and you believe that reasonable safeguards have been taken to minimize both the known and potential but unknown risks.

_____   _____
Signature of Participant   Date

_____   _____
Witness   Date

- I agree to the audio/video recording of the research. *(Initial here)* _____

THE DATED APPROVAL ON THIS CONSENT FORM INDICATES THAT
THIS PROJECT HAS BEEN REVIEWED AND APPROVED BY
THE WESTERN KENTUCKY UNIVERSITY INSTITUTIONAL REVIEW BOARD
Paul Mooney, Human Protections Administrator
TELEPHONE: (270) 745-2129

WKU IRB# 17-027
Approval - 8/9/2016
End Date - 8/9/2017
Expedited
Original - 8/9/2016