Journal of Applied Christian Leadership

Volume 8 | Number 2 Article 5

2014

Understanding Board Leadership: Adventist Hospital Board Chair Behaviors and Effectiveness and Organizational Outcomes

Anthony Stahl

Duane M. Covrig
Andrews University, covrig@andrews.edu

Isadore Newman

Follow this and additional works at: https://digitalcommons.andrews.edu/jacl

Recommended Citation
Stahl, Anthony; Covrig, Duane M.; and Newman, Isadore (2014) "Understanding Board Leadership: Adventist Hospital Board Chair Behaviors and Effectiveness and Organizational Outcomes," *Journal of Applied Christian Leadership*: Vol. 8: No. 2, 49-66.
Available at: https://digitalcommons.andrews.edu/jacl/vol8/iss2/5

This Feature Article is brought to you for free and open access by Digital Commons @ Andrews University. It has been accepted for inclusion in Journal of Applied Christian Leadership by an authorized editor of Digital Commons @ Andrews University. For more information, please contact repository@andrews.edu.

ANTHONY STAHL, DUANE COVRIG, AND ISADORE NEWMAN

UNDERSTANDING BOARD LEADERSHIP: ADVENTIST HOSPITAL BOARD CHAIR BEHAVIORS AND EFFECTIVENESS AND ORGANIZATIONAL OUTCOMES

Abstract: Each month, millions of board members meet to provide leadership to thousands of churches, hospitals, schools and other non-profit organizations. Their decisions impact tens of millions of jobs and billions of dollars of allocation. However, there is very limited research on the leadership provided to these boards. This article reviews data collected from 123 board members serving 34 Adventist Health System hospitals. It asked them to provide their perceptions of their chair's leadership behaviors and effectiveness and compared that data to hospital outcome data in the form of patient satisfaction, clinical and financial data. Findings suggest that transformational behaviors and, to a lesser extent, transactional behaviors are central to members' perceptions of chair leadership effectiveness. To the contrary, chair laissez-faire leadership behaviors were viewed as ineffective. In addition, those chairs with more education were perceived as more effective and a higher level of chair education was a predictor of larger financial margins. Findings also suggest that younger chairs are a predictor of financially sound hospitals.

Keywords: *Hospital board governance, board chair effectiveness, transformational leadership, Adventist Health System*

Introduction

It is estimated that there are over two million nonprofit organizations (NPOs) in the United States, which employ about 10% of the American workforce (Zietlow, Hankin, & Seidner, 2007). These organizations touch

Anthony Stahl, Ph.D., FACHE, is the administrator of Florida Hospital Heartland Medical Center-Lake Placid and Vice President of Florida Hospital Heartland Division.

Duane Covrig, Ph.D., is Professor of Leadership and coordinator for the M.A. in Leadership at Andrews University.

Isadore Newman, Ph.D., is Emeritus Distinguished Professor at The University of Akron in Ohio. For the past eight years he has been associated with Florida International University, College of Education as a Visiting Director of Graduate Research and Visiting Scholar, as well as an Adjunct Professor for Andrews University.

almost every aspect of American life, such as libraries, hospitals, schools, churches, and advocacy groups. Hopkins (2009) noted that the United States has the most developed nonprofit sector of any country in the world. Drucker (1992), widely recognized as a leading management expert, states that "today, we know that the nonprofit institutions are central to American society and are indeed its most distinguishing feature" (p. xiii).

The board of an NPO provides governance and leadership to help ensure the mission of the organization is fulfilled and that proper acquisition and use of resources, planning, and oversight support the organization's leadership and goals (Andringa & Engstrom, 2007). In fact, the board's work has been shown to be highly correlated to the organization's performance (Brown, 2005; Preston & Brown, 2004; Purdy & Lawless, 2012). Researchers have also found that the board is involved in the strategic success of the organization and provides the impetus for achievement (Allison & Kaye, 2005).

What is slower to emerge is a clearer understanding of the role of board leadership in board work. Dunne (2005) states that "being a chairman is a tricky job requiring many skills. . . . A clear mind and considerable determination will need to be matched by a keen sensitivity and openness to the ideas of others" (p. 73). The board chair is inarguably critical to nonprofit success and has considerable influence over the board and organizational success (Harrison & Murray, 2012). Indeed, some scholars contend that effective board chairs tend to lead more effective organizations (Cornforth, Harrison, & Murray, 2010). Our own experience with dozens of boards, including universities, hospitals, churches, and schools, has led us to see the importance of the chair and board in non-profit organizations. However, while there is substantial research which focuses on the leader of a nonprofit organization (Maitlis, 2004; Powell & Steinberg, 2006; Pyzdek & Keller, 2010; Riggio & Orr, 2004; Walters, Kroll, & Wright, 2008), there is less empirical research about the board chair and little to no research about the chair's behaviors as they relate to organizational effectiveness.

Research Context, Design and Procedures

One of the more complex nonprofit boards to chair in the United States is that of a hospital. There are almost 6,000 hospitals in America interfacing with a complex workforce of dietitians, nurses, doctors, and therapists. America's healthcare workforce maintains over 800,000 doctors and 2.5 million nurses (Shi & Singh, 2012). Hospitals, along with

their large employment base, form part of the complex healthcare delivery system in the United States, which is facing rapid changes brought about by both technological advancements and political motions. Currently, America spends more per capita for healthcare than any other country in the world. Healthcare costs in the United States have surged from 5.5% of gross domestic product in 1965 to 17% of GDP in 2007 (Shi & Singh, 2012).

This study used an ex post facto research design (Ary, Jacobs, Sorenson, & Razavieh, 2009; Newman and Benz, 1998) with stated and alternative hypotheses that were tested using data from 123 surveys and hospital effectiveness measures. A total of 34 hospitals, 22 boards, 333 board members, and nine board chairs were contacted as part of the study and a 37% response rate was achieved. The study used a repeated measures design where the board chairs' effectiveness and behaviors were measured more than once (Thomas, Nelson, & Silverman, 2011). This survey measured board member perceptions of chair leadership behaviors and chair effectiveness using the Multifactor Leadership Questionnaire (MLQ). It was sent to 333 board members serving 34 Adventist Health System hospitals with a response rate of a little over 36%. Patient satisfaction and clinical and financial data were also collected from each hospital to measure hospital effectiveness. Descriptive statistics, correlations, and multiple regression models were used to describe and interpret the data and the study's hypotheses.

The MLQ has excellent reliability and validity as a survey tool. Bass and Avolio (2004) report reliabilities for each of the scales ranging from .74 to .91 in hundreds of studies conducted over the years. Also, according to Bass and Riggio (2012), the "MLQ scales have demonstrated good to excellent internal consistency, with alpha coefficients above the .80 level for all MLQ scales" (p. 22).

The second source of data came from statistics relating to the hospitals' Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA), Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), and Core Measures (CM). EBITDA numbers provide a way to evaluate a company's performance without having to factor in financing decisions, accounting decisions, or tax environments (Hickey & Brosnan, 2012). EBITDA was collected for the first six months of 2012. HCAHPS is a nationwide, standardized, publically reported survey of patients' perceptions of their hospital experience (Kavaler & Alexander, 2014). The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass eight key topics: communication

Published by Digital Commons @ Andrews University, 2014

with nurses, communication with doctors, pain management, communication about medicines, responsiveness of hospital staff, cleanliness of the hospital environment, discharge information, and quietness of the hospital environment. The survey is 32 questions in length. Over 10,000 patient surveys collected from the 34 participating hospitals are included in this study. The surveys covered the first six months of 2012.

Core Measures (CM) are standardized data points which measure clinical and safety quality of hospitals across the United States. The CMs are based on evidenced-based guidelines established by the U.S. Government and hospital-certifying entities (Hickey & Brosnan, 2012). There are 35 CMs altogether, in four categories (acute myocardial infarction, pneumonia, congestive heart failure, and surgical care improvement project). For each core measure the hospital must track compliance and report the results publically. For example, in the category of acute myocardial infarction, the hospital must track such measures as whether the hospital gave the heart attack patient an aspirin within 24 hours of arrival to the hospital. The percentage of compliance is reported for each hospital.

Context, Board Chairs and Participants

As the numbers suggest, several board chairs oversee multiple boards which can also oversee multiple hospitals. Each Adventist Health hospital has a community board, composed of 9-27 members, which operates under the bylaws of Adventist Health System and state law. Typically the board members are selected by being recommended by the local community board to the AHS governing board. The AHS board, which has oversight over the entire system, then reviews the community board name for approval or rejection. New board community members receive orientation materials and attend initial training relating to their roles.

The leadership of these hospitals typically has a Chief Executive Officer of the hospital who serves as secretary of the board and reports to the chair. The board chairs are typically comprised of regional CEOs and/or Adventist Health System executives. Most AHS hospitals are organized into market-specific regions such as the Orlando, Tampa, or Midwest region. Each region has a market CEO who serves as CEO of the principal hospital and then serves as the board chair of the other facilities within the market. Having one board chair presiding over the boards of hospitals in a market provides standardization and aligned coordination among the facilities. An AHS vice president then serves as the board chair of the market CEO's hospital. In some cases, hospitals do not fit

into a market; at that point an AHS executive serves as the board chair that represents the perspective of the corporate AHS board.

Table 1 presents an overview of the chairs studied in this research. Noticeably, all chairs were male and Caucasian. Their terms of service ranged from 7 months to 12.9 years, with 55% having between 5 and 6 years of service. The analysis shows 11% of the chairs have bachelor's degrees, 67% have master's degrees, and 22% have a doctorate. Finally, the age of the chairs ranges from 38 to 66 years, with 67% having an age of 51 years or older.

Table 1
Chair Demographic Frequencies Table

Variable	N	Percentage
Gender	N = 9	
Male	9	100
Female	0	0
Ethnicity	N = 9	
Caucasian	9	100
Other	0	0
Chair Longevity (22 boards)	N = 22*	
0-2 years		27
3-4 years		14
5-6 years		55
7-8 years		0
9-10 years		0
>11 years		4
Education	N = 9	
Bachelor's	1	11
Master's	6	67
Ph.D.	2	22
Age	N = 9	
30-40 years	1	11
41-50 years	2	22
51-60 years	3	34
61-70 years	3	34

*Most of the chairs preside over multiple hospital boards. Therefore 22 possible responses are listed for the chair longevity variable.

Published by Digital Commons @ Andrews University, 2014

More information about the members was not collected. First, no direct contact with the board members was deemed appropriate for this study; communication to members and chairs was made through the chief executive officer of the hospitals. This made it more challenging to obtain exact demographic data on community board members. However, anecdotally and from web information, the board members come from diverse backgrounds and include such individuals as lawyers, nurses, doctors, ministers, accountants, entrepreneurs, and community leaders. There are typically more men than women on these boards.

Summary of Findings

The first findings relate to hospital chair leadership behaviors and chair effectiveness as perceived by board members as measured by the MLQ. For purposes of this study three of the most important leadership behaviors identified by Burns (1978) and later Bass (1985) were used—transformational, transactional, and laissez-faire leadership. The MLQ questionnaire asked board members to rank chairs on a scale from 0-4 with regard to leadership behaviors. Transformational leadership behaviors ranked higher than transactional or laissez-faire leadership behaviors. The mean of transformational leadership was 3.27, indicating responses were toward the top of the scale with a standard deviation of 0.062, suggesting low variability. The mean for transactional leadership behavior of the board chairs was 2.38, indicating responses just above the middle of the scale and a standard deviation of 0.78, suggesting low variability (See Table 2). The transactional leadership behavior has a normal distribution. In contrast, board members did not score many chairs as having laissez-faire leadership behaviors. The mean for this behavior is 0.28 with a standard deviation of 0.53 indicating responses at the bottom of the 0 to 4 scale.

Table 2 also delineates three variables used for hospital effectiveness. The hospital financial effectiveness was measured through EBITDA percentages. The lowest EBITDA was -6.30%, indicating a financial loss, while the highest was 28.60%, indicating a strong financial margin. The average EBITDA was at 12.23% with a standard deviation of 7.22, suggesting higher variability. A second measure of hospital effectiveness was clinical effectiveness as measured through CM, which indicates to what degree a hospital is adhering to a set of care practices outlined as best practice. One hospital was so small that CMs were not tracked and thus received a zero percentage ranking. The maximum sum of CM

Table 2
Variable Scale

Scale	Min.	Max.	Mean	SD
Transactional (0-4)	0.90	4.00	2.38	0.78
Laissez-Faire (0-4)	0.00	2.80	0.28	0.53
Transformational (0-4)	1.40	4.00	3.27	0.62
Effectiveness (0-4)	0.80	4.00	3.44	0.70
EBITDA (%)	-6.30	28.60	12.23	7.22
Core Measure Sum	0.00*	99.05	94.26	17.45
HCAHPS (%)	57.00	85.30	69.85	8.13
Chair Age (Years)	38.00	68.00	57.12	10.13
Chair Longevity (Months)	7.00	155.00	61.74	32.35
Chair Education	1.00	3.00	1.88	0.58
1=Bachelor's				
2=Master's				
3=PhD				

Note. Board chair effectiveness and leadership behaviors, as measured by the MLQ, is an ordinal scale as follows: 0 = Not at all, 1 = Once in a while, 2 = Sometimes, 3 = Fairly often, 4 = Frequently, if not always; N = 123. HCAHPS N > 10,000 respondents. The longevity variable is coded in months. The education variable is coded as 1 = Bachelor's, 2 = Master's, 3 = Doctorate.
* No data were available for one hospital as the sample size was too small.

received by a hospital was 99.05%. The average sum of CM was 94.26% with a standard deviation of 17.45, indicating high variability. The high variability is partially due to the lack of data for the small hospital. A final measure of hospital effectiveness was the HCAHPS scores, which measure patient satisfaction. The ratings used were a percentage of the top box scores received by the hospitals between January and September 2012. The lowest score was 57% and the highest was 85.30%. The variable has a mean of 69.85% with a standard deviation of 8.13, indicating low variability.

The relationship between the variables of board chair leadership effectiveness and behavior and hospital effectiveness were interpreted through a Pearson r correlation. Table 3 shows the correlational matrix. Because of the complex nature of this social scientific study and the small to moderate number of responses, significance was set at alpha = .05.

Published by Digital Commons @ Andrews University, 2014

Seven correlations of importance are highlighted here with limited comments and then discussed more thoroughly later. First, there was a significant and positive relationship between chair transformational leadership and effectiveness (r = .869; p = .0009). This suggests that members valued leaders who demonstrated transformational behaviors such as setting vision, growing and empowering members to take board leadership positions.

Second, there was a significant and positive relationship between chair transactional leadership and perceived effectiveness as measured by the MLQ (r = .382; p = .0009). This suggests the valuing of behaviors like setting clear expectations and incentives.

Third, there was no statistically significant relationship between laissez-faire leadership behaviors and perceived effectiveness (r = -.122; p = .178). As opposed to one and two, this suggests that board members did not value chair behaviors such as passive leadership, withdrawal from decisions, and unwillingness to make decisions in times of ambiguity.

Fourth, there was a significant and positive relationship between chair education and effectiveness (r = .235; p = .009). This finding suggests chair education levels influence the effectiveness of the chair in carrying out his/her work as the board leader.

Fifth, there was a significant and positive relationship between chair education and EBITDA (r = .349; p = .0009). This suggests that leadership education improves company margins and profits.

Sixth, there was a significant and negative relationship between chair longevity and EBITDA (r = -.233; p = .010). This finding suggests it is healthy to rotate chair leadership before the leader stays too long. Long tenure of the board may negatively affect hospital margins.

Seventh, there was a significant and negative relationship between chair age and EBITDA (r = -.20; p = .024). This finding may indicate that younger chairs have a tendency to take risks and accept change faster than those who are older, thus increasing hospital margins.

These relationships are discussed below as they relate to the hypotheses of this study and the general literature on leadership effectiveness.

Discussion

This section discusses the findings of this study, particularly examining the relationships among chair transformational leadership, chair transactional leadership, chair laissez-faire leadership, chair education, chair longevity, chair age, leadership effectiveness, and EBITDA.

Table 3

Correlation Matrix

Variables	Value	1	2	3	4	5	6	7	8	9	10
Transactional (1)	*r*	1									
	p										
Transformational (2)	*r*	.483	1								
	p	.0009									
Laissez-faire (3)	*r*	.046	-.142	1							
	p	.612	.116								
Effectiveness (4)	*r*	.382	.869	-.112	1						
	p	.0009	.0009	.178							
EBITDA (5)	*r*	-.279	-.109	-.119	-.019	1					
	p	.002	.231	.191	.831						
HCAHPS (6)	*r*	-.125	-.187	-.105	-.160	.169	1				
	p	.174	.041	.257	.083	.066					
Chair Age (7)	*r*	-.032	-.201	-.067	-.169	-.203	.560	1			
	p	.729	.026	.463	.061	.024	.0009				
Chair Longevity (8)	*r*	.047	-.112	.043	-.023	-.233	.221	.638	1		
	p	.608	.216	.641	.803	.010	.016	.0009			
Chair Education (9)	*r*	-.050	.194	-.102	.235	.349	-.043	-.391	-.053	1	1
	p	.584	.031	.261	.009	.0009	.643	.0009	.560		
CM (10)	*r*	-.127	-.074	-.127	-.044	.331	.209	.110	-.070	-.036	
	p	.162	.417	.163	.632	.0009	.023	.228	.444	.690	

Note: Board chair effectiveness and leadership behaviors, as measured by the MLQ, is an ordinal scale in which 0 = Not at all, 1 = Once in a while, 2 = Sometimes, 3 = Fairly often, 4 = Frequently, if not always. The longevity variable is coded in months. The education variable is coded ordinally: 1 = Bachelor's, 2 = Master's, 3 = Doctorate.
**Correlation is significant at the .05 level (two tailed) ** Correlation is significant at the .01 level (two tailed) ***Correlation is significant at the .001 level (two tailed)*

Chair Transformational Leadership and Effectiveness

In this study, the strongest finding was the high correlation between the perception a chair practiced transformational leadership style and their perceived effectiveness (r = .869 and p = .0009). The *r* value of .869 (See Table 3) indicates near perfect correlation. This correlation has been explained throughout the literature and may speak to a widespread belief about leadership. Covey (1992) observed that transformational leaders who were preoccupied with the mission and vision of the organization can motivate individuals to personally perform better. Our findings mirror results from other research regarding leaders who had transformational styles and the link between this style and effectiveness (Kaiser, 2010; Kakabadse & Kakabadse, 2008). This has also been empirically demonstrated by others (Avolio & Bass, 2008; Avolio, Bass, & Jung, 1999; Bass, 1985; Wang, Oh, Courtright, & Colbert, 2011).

Kakabadse and Kakabadse (2008) asserted that trust and integrity are critical to the board chair's role and success of the board. Carver (2011) agrees with this assessment, indicating that successful leaders must demonstrate strong values such as integrity. Again, scholars have repeatedly shown that transformational leadership behaviors inspire personal effectiveness from the work of others (Bass, 1985; Burns, 1978).

Donahue (2003), one of the few scholars to study effective boards, found that effective characteristics of the board chair include communicator, facilitator, and collaborator. These are also characteristics that portray a transformational leader (Bass, 1985; Lussier & Achua, 2001). Harrison and Murray (2012) studied both effective and ineffective board chairs, and found effective chairs to be charismatic, inspirational, and extroverted (p. 423). Again, these are characteristics of transformational leadership (Bass, 1985; Lussier & Achua, 2001). Our findings are consistent with the literature that transformational leadership behaviors predict overall leader effectiveness.

Beyond this general confirmation from other studies, the high correlation between transformational leadership and leadership effectiveness may be explained by several factors unique to this study. First, only nine chairs were studied. Although a repeated measures model was used that measured each chair-member response as unique, the limited number of chairs in the study does have a tendency to limit variability. As variability is more restricted, there is an increased likelihood of higher correlations. We believe that may explain some of the high correlation. Second, the cultural context in which this study took place, the Adventist Health System, may also be at work in creating a higher correlation. As a hospi-

tal system with strong mission and vision components, there may be created within boards a clear bias towards and desire for strong transformational leadership that focuses on strong cultural beliefs, vision, and mission. This may itself be viewed as leadership effectiveness. What may be influencing these correlations is the strong cultural valuing of transformational leadership at work in these organizations. This cultural or contextual aspect may also explain the low numbers on laissez-faire leadership. There may be a strong cultural influence that undervalues mission naivety or apathy and weeds out leaders from rising to the level of board chair. Finally, one other factor may be at work. In addition, the hospital context may also be influencing the dynamics of this study. Given the high professionalization of hospitals and the presence of highly trained individuals, even on the board, it would be expected that a more transformational approach respects the diffusion of leadership skills that exist in these highly professionalized organizations.

Chair Transactional Leadership and Effectiveness

This study also found that transactional leadership was a predictor of leadership effectiveness ($r = .338$; $p = .0009$). While this behavior does not account for the same level of effectiveness as transformational, it was statistically significant. This form of leadership behavior—exchanging behavior or performance for a reward or punishment—may have little focus on personal development, but it appears useful for helping group dynamics. These findings are consistent with the literature. Bass (1985) indicates that leaders who subscribe to this style of leadership follow closely to the rules, which brings success to groups. Grint (1997) found that "the effectiveness of transactional leaders comes from authority and position" (p. 153). This type of leadership can improve project success and help in times of emergency (Hackman & Johnson, 2009).

This finding is consistent also with what Kakabadse and Kakabadse (2008) found were needed among chairs in framing roles and obligations between the board chair, CEO, and the board. "It is only by clearly delineating boundaries between roles that the board—and the chairman—hold that allows both to effectively function" (Kakabadse & Kakabadse, 2008, p. xx). Transactional leadership has also been shown to help in establishing roles and obligations of subordinates (O'Sullivan & Dooley, 2009).

Bass (1985) has shown that transformational leadership augments the effects of transactional leadership behaviors. This study shows there is a

statistically significant and positive relationship between transactional leadership behaviors and transformational leadership behaviors as seen in Table 3 ($r = .483$; $p \leq .0009$). While transactional leadership lacks the agency of change and visionary elements of transformational leadership, both behaviors appear to overlap in bringing elements of success to an organization.

Chair Laissez-Faire Leadership and Effectiveness

This also study found there was no statistically significant relationship between laissez-faire leadership behaviors ($r = -.122$ and $p = .178$). This would indicate that those chairs who were perceived as having laissez-faire leadership behaviors were also not perceived as effective. The statistical results are consistent with other studies. Schilling (2009) noted laissez-faire leadership behaviors are considered ineffective. Researchers Harrison and Murray (2012) noted the following about less effective chairs:

> [They] used position to advance personal career or agenda; (had a) big ego, dictatorial (reported by some); (were) introverted, nice, well-meaning but not able to inspire others; (were) uncomfortable in leadership position, reactive; inactive, responded aggressively to issues; avoided issues altogether, vacillated; took different positions depending on who s/he spoke to last, and created or avoided conflict. (p. 423)

The laissez-faire leader, unlike the transactional and transformational leaders, does little to inspire the associate and seems to works best in environments where the follower is already highly skilled and motivated. This leadership style avoids issues and generally avoids conflict. This style encompasses passive leader behaviors and does not provide the leader the influence to enact change within the organization (Bass, 1981).

Chair Education and Leadership Effectiveness

Table 3 shows that there was a statistically significant and positive relationship between education and chair effectiveness ($r = .235$; $p = .009$) as measured by the MLQ and perceived by board members. These results are consistent with the literature. Valentine and Prater (2011) observed similar findings in their recent study of 155 public school principals. They found the perceived effectiveness of school principals increased as the level of education increased. Boles's (1976) work also contends that a factor in leadership and maturity is formal education. The findings of these scholars are consistent with our findings and suggest that education levels are important for chair effectiveness in

carrying out his/her duties given that those with higher levels of education have additional skills, knowledge, and habits.

Chair Education Relationship to EBITDA

Findings suggest that chair education moderately correlates (r = 3.49) with EBITDA in these hospitals. It suggests that higher levels of chair education will predict larger hospital margins (r = .349; p = .0009). There may be various reasons for this relationship. These findings mirror some research about the connection of education to higher production. For example, Horn and Schaffner (2003) state that "education is highly valued by employers, who interpret the educational level of their workforce as an indicator of company productivity and, by extension, profit" (p. 154). Frisch (2012) shows that a company's top leaders' education affects the strategic decisions of the organization and thus profits.

Also, the chair's education may influence chair business acumen, leading the board in high-level strategic initiatives of expense management and revenue generation. Therefore it is reasonable that the chair's level of education has a positive relationship to the hospital's earnings.

Chair Longevity Relationship to EBITDA

This study also showed that chairs with more years presiding over a hospital had lower EBITDA percentages than those with fewer years of experience (r = -.233; p = .010). There are several possible explanations for this. Chaganti, Damanpour, and Mankelwicz (2005) argue that if top leaders such as the CEO stay too long, they may have a negative impact on organizational performance. Huber (2003) argues that leaders in positions for long periods may become callous to the business environment, and this tends to affect the finances of the company. They become "stale in the saddle." This is a potential explanation for the negative relationship between chair longevity and financial margins. Another explanation may be that leaders who are in positions for a long time become more sensitive to issues other than money and soften to human needs of employees that don't always translate into financial effectiveness.

Chair Age Relationship to EBITDA

This study found that younger chairs more highly predicted financially sound hospitals. The results could be explained in several ways. First, research shows younger leaders are more transformational than older leaders (Kuhn, 2001). This study mirrors the research showing that there was a relationship between younger chairs and transformational leader-

Published by Digital Commons @ Andrews University, 2014

ship (r = -201; p = .06). As indicated previously by Bass (1985), transformational leadership is considered a more effective leadership behavior than others. In addition, research shows there is a relationship between transformational leadership and company profits (Krumm, 2000), thus supporting the suggestion in this study that the younger leaders have a tendency to have better EBITDA percentages.

A second explanation is that younger leaders may be willing to take more risks. They also may be willing to work harder for results. Bass and Bass (2009) point out that "older leaders have been found to be generally more conservative and more likely to avoid taking risks. . . . They want more information and higher probabilities of success and may be content with lower payoffs as a consequence" (p. 181). Other scholars echo this (Hämäläinen & Saarinen, 2007; Ihlenfeldt, 2011; Iorg, 2007).

Third, this study shows younger chairs had higher levels of education (r = -391; p = .0009) and also found there was a relationship between education and EBITDA (r = .349; p = .0009). Researchers such as Horn and Schaffner (2003) also found that leader education was tied to company profits. This study mirrors the research by suggesting that younger, highly educated and transformational chairs account for stronger financial margins (EBITDA).

Recommendations

The results of this study have practical applications for chairs of the Adventist Health System, as well as other similar hospital boards. This study identified transformational leadership as an effective behavior for chairs. Secondly, the study identified chair level of education as having a relationship to hospital effectiveness and financial margins. Given this:

1. Recruitment procedures may be designed and administered to assist in finding transformational chairs. Search committees may be armed with improved information in recruitment stages to select chairs who better fit the profile needed to lead. Leblanc and Gillies (2010) argue that the recruitment of a high performing chair is vital. An effective chair begins with the selection process. Leblanc and Gillies state that "there is no doubt that the leadership skills of the chair of the board are the most important factor in assuring effective board processes and wise decision-making" (p. 249).

2. The information from this study may assist in creating diagnostic tools such as 360-degree surveys to assist current chairs in understanding their leadership behavior strengths and weaknesses.

3. AHS may wish to work towards having board chairs possess a minimum of a master's degree in the recruitment stage, and in the case of current board chairs, AHS may wish to bring all chairs to a minimum of a master's-level degree.

4. Given there is a statistically significant and negative relationship between chair longevity and EBITDA ($r = -.233$; $p = .010$), boards may wish to consider rotation of chairs or term limits.

5. More training is needed for chairs and board members to work together to create a transformational environment within their facilities. Currently there are few training modules for chairs that are centered on evidence-based training or that highlight the key leadership behaviors of an effective chair.

A Final Thought

John Maxwell (2008) once said, "Everything rises and falls on leadership" (p. 123). Echoing Maxwell's sentiments, Bass stated that leadership is the most critical factor to organizational success (Bass & Stogdill, 1990). These are bold statements of which the fine points will be argued for years to come. However, there is no doubt that leadership is important to organizational change management and success. Given that modern healthcare is going through a greater change than that of the second industrial revolution (Hagenow, 2001), there is ongoing need for hospital leaders at all levels to perform at the highest caliber.

This study sought to determine the relationship between leadership behaviors and effectiveness of chairs and that relationship to hospital effectiveness. The collective evidence reported through this study adds to the body of literature, which indicates that transformational leadership is a predictor of leadership effectiveness. In addition, multiple chair demographics, including education level, had a positive relationship to hospital effectiveness metrics. May this study provide information inspiring effective hospital leadership for the 21st century.

References

Allison, M., & Kaye, J. (2005). *Strategic planning for nonprofit organizations: A practical guide and workbook*. Hoboken, NJ: Wiley.

Andringa, R. C., & Engstrom, T. W. (2007). *The nonprofit board answer book: A practical guide for board members and chief executives*. San Francisco, CA: Jossey-Bass; BoardSource.

Ary, D., Jacobs, L. C., Sorenson, C., & Razavieh, A. (2009). *Introduction to research in education* (8th ed.). Belmont, CA: Wadsworth.

Avolio, B. J., & Bass, B. M. (1985). *Multifactor leadership questionnaire* (3rd ed.). Menlo Park, CA: Mind Garden.

Avolio, B. J., & Bass, B. M. (2000). *Multifactor leadership questionaire* (Form 5x). Redwood City, CA: Mind Garden.

Avolio, B. J., & Bass, B. M. (2008). *Developing potential across a full range of leadership: Cases on transactional and transformational leadership*. Mahwah, NJ: Lawrence Earlbaum.

Avolio, B. J., Bass, B. M., & Jung, D. I. (1999). Re-examining the components of transformational and transactional leadership using the Multifactor Leadership Questionnaire. *Journal of Occupational and Organizational Psychology, 72*(4), 441-462. doi:10.1348/096317999166789

Bass, B. M. (1981). *Bass & Stogdill's handbook of leadership: Theory, research, and managerial applications* (2nd ed.). New York, NY: Free Press.

Bass, B. M. (1985). *Leadership and performance beyond expectations*. New York, NY: Free Press.

Bass, B. M., & Avolio, B. J. (2004). *MLQ manual & sampler set* (3rd ed.). Retrieved from http://www.mindgarden.com/products/mlqc.htm#mlqrs

Bass, B. M., & Bass, R. (2009). *The Bass handbook of leadership: Theory, research, and managerial applications*. New York, NY: Free Press.

Bass, B. M., & Riggio, R. E. (2012). *Transformational leadership*. London, England: Taylor & Francis.

Bass, B. M., & Stogdill, R. M. (1990). *Bass & Stogdill's handbook of leadership: Theory, research, and managerial applications*. New York, NY: Free Press.

Boles, H. W. (1976). *Multidisciplinary readings in educational leadership*. New York, NY: MSS Information.

Brown, W. A. (2005). Exploring the association between board and organizational performance in nonprofit organizations. *Nonprofit Management and Leadership, 15*(3), 317-339. doi:10.1002/nml.71

Burns, J. M. (1978). *Leadership*. New York, NY: Harper & Row.

Carver, J. (2011). *Boards that make a difference: A new design for leadership in nonprofit and public organizations*. Somerset, NJ: Wiley.

Chaganti, R., Damanpour, F., & Mankelwicz, J. (2005). CEO power cycles and corporate performance cycles: An examination of the relationship between changes in power and changes in performance. In A. Rahim & R. T. Golembiewski (Eds.), *Current topics in management* (Vol. 10; pp. 133-160). New Brunswick, NJ: Transaction.

Cornforth, C., Harrison, Y., & Murray, V. (2010, January). *What makes chairs of governing boards effective?* Paper presented at the National Council for Voluntary Organizations and the Charity Trustee Network, Seattle, WA.

Covey, S. (1992). *Principle-centered leadership*. New York, NY: Free Press.

Donahue, J. (2003). A case study of select Illinois community college board chair perspectives on their leadership role. *Community College Review, 31*(2), 21-46. doi: 10.1177/009155210303100202

Drucker, P. F. (1992). *Managing the non-profit organization: Practices and principles*. New York, NY: HarperBusiness.

Dunne, P. (2005). *Running board meetings: How to get the most from them*. London, England: Kogan Page.

Frisch, S. (2012). *The impact of a CEO's task knowledge on the leader life cycles*. Munich, Germany: GRIN Verlag. doi:10.3239/9783656221050

Grint, K. (1997). *Leadership: Classical, comtemporary, and critical approaches*. New York, NY: Oxford University Press.

Hackman, M. Z., & Johnson, C. E. (2009). *Leadership: A communication perspective*. Long Grove, IL: Waveland Press.

Hagenow, N. R. (2001). Care executives: Organizational intelligence for these times. *Nursing Administration Quarterly, 25*(4), 30-35.

Hämäläinen, R. P., & Saarinen, E. (Eds.). (2007). *Systems intelligence in leadership and everyday life*. Helsinki, Finland: Helsinki University of Technology, Systems Analysis Laboratory.

Harrison, Y. D., & Murray, V. (2012). Perspectives on the leadership of chairs of nonprofit organization boards of directors: A grounded theory mixed-method study. *Nonprofit Management and Leadership, 22*(4), 411-437. doi: 10.1002/nml.21038

Hickey, J. V., & Brosnan, C. A. (2012). *Evaluation of health care quality in advanced practice nursing*. New York, NY: Springer.

Hopkins, B. R. (2009). *Starting and managing a nonprofit organization: A legal guide* (5th ed.). Hoboken, NJ: Wiley.

Horn, C. E., & Schaffner, H. A. (2003). *Work in America: An encyclopedia of history, policy, and society*. Santa Barbara, CA: ABC-CLIO.

Huber, G. P. (2003). *The necessary nature of future firms: Attributes of survivors in a changing world*. Thousand Oaks, CA: Sage.

Ihlenfeldt, W. A. (2011). *Visionary leadership: A proven pathway to visionary change*. Bloomington, IN: AuthorHouse.

Iorg, J. (2007). *The character of leadership: Nine qualities that define great leaders*. Nashville, TN: B & H.

Kaiser, M. M. (2010). *Leading roles: 50 questions every arts board should ask*. Waltham, MA: University Press of New England.

Kakabadse, A., & Kakabadse, N. (2008). *Leading the board: The six disciplines of world class chairmen*. New York, NY: Palgrave Macmillan.

Kavaler, F., & Alexander, R. S. (2014). *Risk management in healthcare institutions: Limiting liability and enhancing care* (3rd ed.). Burlington, MA: Jones & Bartlett Learning.

Krumm, D. J. (2000). *Psychology at work: An introduction to industrial/ organizational psychology*. New York, NY: Worth.

Kuhn, T. M. (2001). *The relationship between employee personality traits and preferred leadership style* (Unpublished doctoral dissertation). University of Nevada, Reno.

Leblanc, R., & Gillies, J. M. (2010). *Inside the boardroom: How boards really work and the coming revolution in corporate governance*. Toronto, Canada: Wiley.

Lussier, R. N., & Achua, C. F. (2001). *Leadership theory, application, and skill development*. Cincinnati, OH: South-Western College.

Maitlis, S. (2004). Taking it from the top: How CEOs influence (and fail to influence) their boards. *Organization Studies, 25*(8), 1275-1311. doi: 10.1177/0170840604046318

Maxwell, J. (2008). *Go for gold: Inspiration to increase your leadership impact.* Nashville, TN: Thomas Nelson.

Newman, I., & Benz, C. R. (1998). *Qualitative-quantitative research methodology: Exploring the interactive continuum.* Edwardsville, IL: Southern Illinois University Press.

O'Sullivan, D., & Dooley, L. (2009). *Applying innovation.* Thousand Oaks, CA: Sage.

Powell, W. W., & Steinberg, R. (2006). *The nonprofit sector: A research handbook.* New Haven, CT: Yale University Press.

Preston, J. B., & Brown, W. A. (2004). Commitment and performance of nonprofit board members. *Nonprofit Management and Leadership, 15*(2), 221-238. doi: 10.1002/nml.63

Purdy, J. M., & Lawless, J. (2012). Learning about governance through nonprofit board service. *Journal of Management Education, 36*(1), 33-65. doi: 10.1177/1052562911418196

Pyzdek, T., & Keller, P. A. (2010). *The Six Sigma handbook: A complete guide for green belts, black belts, and managers at all levels.* New York, NY: McGraw-Hill.

Riggio, R. E., & Orr, S. S. (2004). *Improving leadership in nonprofit organizations.* San Francisco, CA: Jossey-Bass.

Schilling, J. (2009). From ineffectiveness to destruction: A qualitative study on the meaning of negative leadership. *Leadership, 5*(1), 102-128. doi: 10.1177/1742715008098312

Shi, L., & Singh, D. A. (2012). *Delivering health care in America: A systems approach.* Burlington, MA: Jones & Bartlett Learning.

Thomas, J. R., Nelson, J. K., & Silverman, S. J. (2011). *Research methods in physical activity*. Champaign, IL: Human Kinetics.

Valentine, J. W., & Prater, M. (2011). Instructional, transformational, and managerial leadership and student achievement: High school principals make a difference. *NASSP Bulletin, 95*(1), 5-30. doi:10.1177/0192636511404062

Walters, B. A., Kroll, M., & Wright, P. (2008). CEO ownership and effective boards: Impacts on firm outcomes. *Strategic Organization, 6*(3), 259-283. doi: 10.1177/1476127008093519

Wang, G., Oh, I.-S., Courtright, S. H., & Colbert, A. E. (2011). Transformational leadership and performance across criteria and levels: A meta-analytic review of 25 years of research. *Group & Organization Management, 36*(2), 223-270. doi: 10.1177/1059601111401017

Zietlow, J. T., Hankin, J. A., & Seidner, A. G. (2007). *Financial management for nonprofit organizations: Policies and practices*. Hoboken, NJ: Wiley.