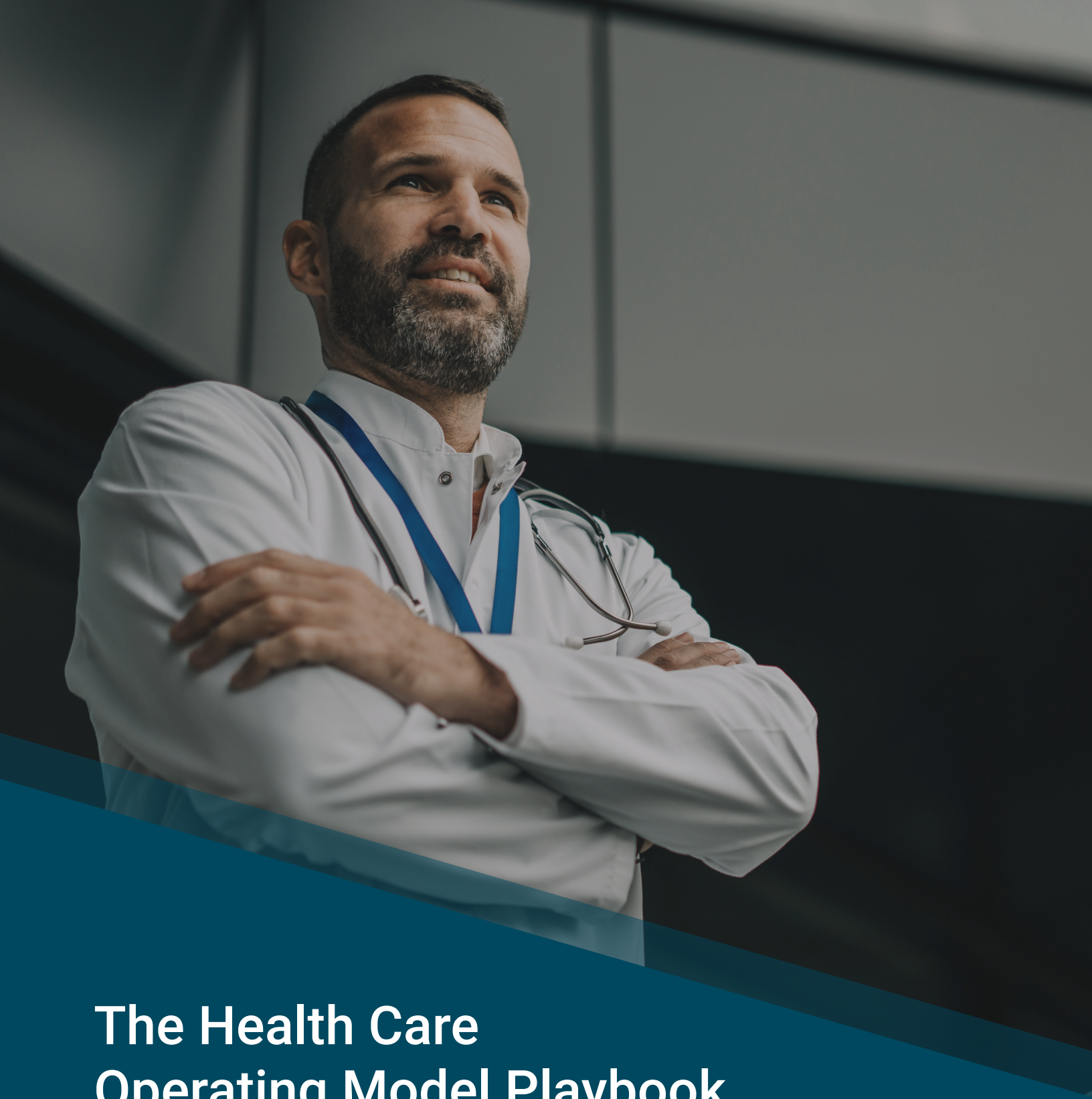


The Health Care Operating Model Playbook

Redesigning Health Systems for Performance, Sustainability, and Growth

SullivanCotter

The Case for Reevaluating the Health Care Operating Model

> A health system's operating model must align directly with its strategic goals and clarify how people collaborate, how decisions are made, and how work gets done to deliver sustained performance.

Health systems across the country are navigating an environment marked by continued workforce shortages, labor cost inflation, thinner operating margins, and an accelerating shift of volume away from the inpatient setting that has historically anchored their revenue base. At the same time, there is a wave of excitement surrounding technology advancements that may transform care delivery – primarily the adoption of artificial intelligence (AI) and growing virtual care environments.

Yet many organizations have legacy operating models designed for an era of health care delivery that no longer exists. This has contributed to a widening gap between the organization's strategic plan (what they hope to achieve) and its operational delivery (what they actually achieve). Health care organizations that have successfully adapted their operating models and clinical capabilities to meet these current industry challenges will be best positioned to meet their mission. Those that do not may continue to struggle in the current environment.

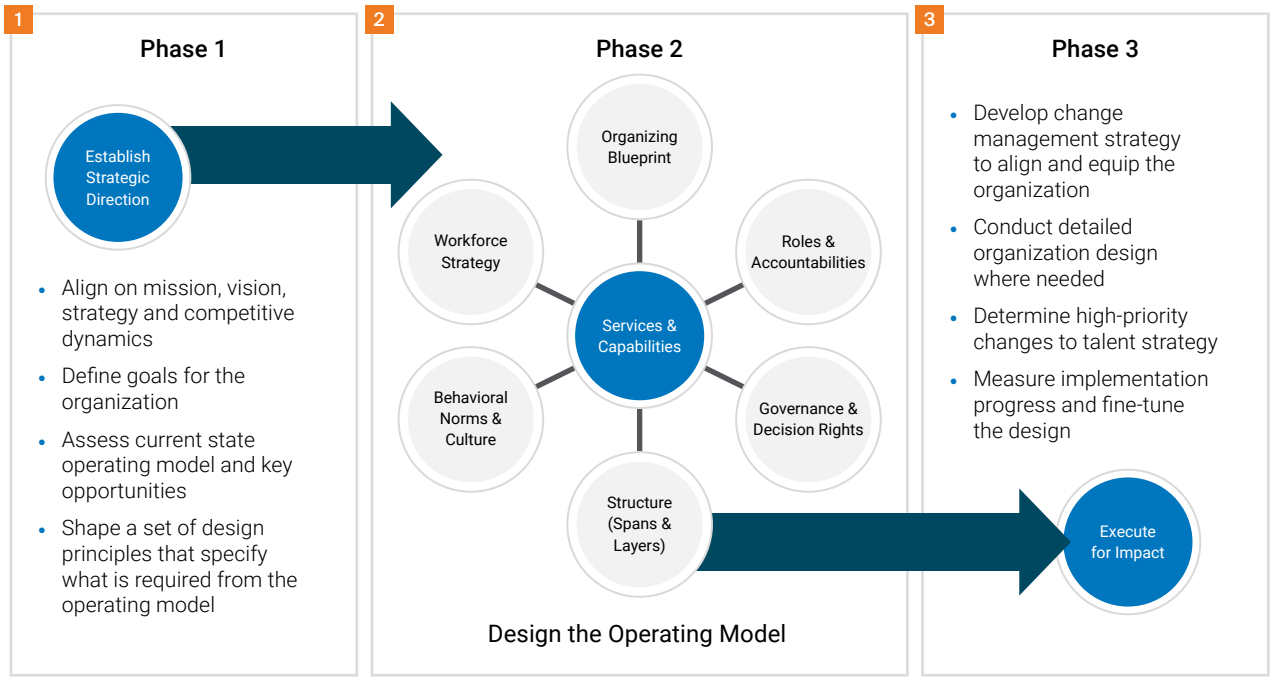
Industry pressures are not confined to clinical delivery health systems. The health care industry is broader, encompassing entities that focus on academics, research, teaching and health plan insurance, to name a few. These present an added layer of complexity, such as with Academic Medical Centers needing to balance clinical delivery against research obligations and teaching mission requirements, each with distinct resource demands, governance structures, and performance metrics. Health plans and payer organizations are navigating their own operating model imperatives as they absorb the effects of regulatory volatility, shifting risk arrangements, and mounting pressure to demonstrate value in an increasingly cost-sensitive market. Despite these varied organizational types, the underlying challenge remains: the operating model was built for a prior era and can no longer support what the future-state strategy requires.

Beyond entity types, these challenges are compounded by the growing diversification of business activity within health systems themselves. Many have expanded beyond traditional care delivery into innovation and commercialization ventures, employer health services, technology partnerships, and new care model platforms. These businesses require new capabilities, commercial acumen, product management, and operations that differ from those needed to run a hospital or medical group. As such, the operating model needs to evolve to enable effective management of this portfolio of activity within a single organizational structure.

This playbook guides senior leaders on how to design and implement an operating model that drives sustained performance in today's health care environment. It lays out a three-phased approach that includes strategy, design, and execution, and describes seven key operating model elements that should be addressed in the process. The goal is to help health care executives link strategy to execution, make disciplined choices about where to simplify, scale, and invest, and ensure their mission and vision can be realized with tangible results.

Three-Phase Approach to Operating Model Design

"Form Follows Function"



Phase 1

Establish Strategic Direction

> In Phase 1, leadership anchors operating model design in the health system's strategic intent. This means clarifying where the organization will focus, how it will create value, and what capabilities set it apart. A clear strategic direction provides the "North Star" for all design decisions.

When health care leaders think about organizational redesign, there may be a tendency to start by changing lines of reporting, adding or removing levels and layers, and making changes to management spans of control. But transforming an organization's performance doesn't happen by redrawing boxes and lines on an organization chart. While these may be steps in the overall process, this structure is only a fraction of what a true operating model encompasses.

That is why operating model design should begin with the health system's strategic intent. Before decisions are made about structure, roles, governance, or workforce, leadership needs to align around three interconnected questions:

- Where will we compete?
- How will we win?
- What truly sets our health system apart?

The answers to these questions become the foundation for every operating model decision that follows, shaping how the organization is structured, governed, and enabled to execute its strategy.

Clarifying Vision and Design Principles

Ensure the leadership team has a shared understanding around growth priorities, competitive positioning, and any strategic shifts. This context will inform the operating model's priorities. For example, the vision may be accelerating ambulatory expansion, building a population health platform, or integrating a recently acquired regional network. The operating model will need to enable these goals.

Design principles are high-level guidelines that govern operating model choices throughout the process. A health system pursuing clinical differentiation might institute a design principle to "protect the integrity of clinical decision-making" or "maximize enterprise-wide utilization of specialty expertise." For a system prioritizing cost reduction, principles might include "standardize everything that does not differentiate us clinically" or "reduce duplicative work across entities." These principles are intended to guide leaders in making consistent design decisions.

Determining the Appropriate Enterprise Corporate Model

Each health system needs to define the role of the corporate enterprise relative to its hospitals, service lines, and care delivery entities. This centralization-versus-decentralization question has implications for how accountability is structured, how resources are allocated, and how decisions are made across the system.

Most health systems operate somewhere along the spectrum of the following four corporate model archetypes. Each model has fundamentally different implications for organizational design:

Network Manager: The enterprise functions primarily as a financial steward, setting performance expectations while granting component entities broad operational autonomy. This model has historically been used by loosely affiliated health systems and multi-hospital networks where individual hospitals retain strong community identities and independent leadership.

Strategic Leader: The enterprise establishes enterprise strategy and shared priorities – clinical programs, growth markets, brand standards – while service lines and hospitals retain meaningful latitude to execute against those objectives in their local contexts. This is generally the model of choice for integrated delivery networks seeking to balance enterprise coherence with market responsiveness.

Operational Leader: The enterprise takes an active role in operational coordination by providing shared clinical and administrative capabilities, setting performance standards, and holding joint accountability for outcomes with service line and hospital leadership. This model is particularly suited to health systems with significant shared services infrastructure or those pursuing aggressive cost reduction through standardization.

Integrated Operator: This is a highly centralized model in which the enterprise directly governs clinical operations, capital allocation, and major strategic decisions. It is most appropriate for health systems in which scale, consistency, and integration are core sources of competitive advantage.

Four Corporate Model Archetypes

A comparative view of how the role of the enterprise center shifts across models

	Network Manager	Strategic Leader	Operational Leader	Integrated Operator
Management Philosophy	Fully autonomous Subsidiaries	Semi-Autonomous Subsidiaries		Subsidiaries Tightly Controlled by System
Primary Purpose of the System Center	Manage the optimal portfolio of Subsidiaries	Drive strategic alignment by linking clinical service lines	Focus operations and provide functional expertise and support	Run the Subsidiaries and capital funding
Governance of Critical Decisions	Most decisions are left to Subsidiaries	System Center sets strategy and supports execution	System Center provides consultation and a recommended course of action	System Center approves most decisions on behalf of Subsidiaries
Operational Leadership Roles	**System Ctr:** Set P&L expectations **Subsidiaries:** Accountable for results	**System Ctr:** Define key operating performance measures aligned with strategic objectives **Subsidiaries:** Execute against measures	**System Ctr & Subsidiaries:** Share accountability for broader set of operating metrics and KPIs	**System Ctr:** Provide specific set of operating metrics / KPIs **Subsidiaries:** Deliver on metrics / KPIs
Identity & Vision	Each Subsidiary maintains a distinct brand	Patients and providers identify more strongly with Subsidiary brand(s)	Patients and providers identify more strongly with System brand	System Center creates a single shared brand
Support Function Roles	Non-clinical capabilities (e.g., HR) remain embedded in Subsidiaries	System Center sets strategy for non-clinical capabilities and provides leadership and guardrails to support execution	System Center provides enhanced access to functional expertise and support	Non-clinical capabilities are scaled at the System Center and shared across Subsidiaries
Corporate Center Control	Least control →			Most control
Decision-Making Complexity	Direct decision-making →	Matrixed decision-making	← Direct decision-making	

The appropriate corporate model depends on a health system's strategic intent, its market context, its stage of organizational maturity, and its history of affiliation and integration. The choice must be made deliberately with leadership fully aligned on its implications for decision rights, accountability, and resource allocation.

Design Insight

For one regional health system, aligning on the appropriate corporate model became a pivotal design decision, shaping the governance structure, service line accountabilities, and resource allocation mechanisms needed for the broader redesign to take hold.

Phase 1 Takeaway: This strategic alignment creates the foundation for the design work that follows. Once leadership is clear on the health system's priorities, differentiating capabilities, design principles, and desired enterprise role, the organization is better positioned to make disciplined choices about structure, governance, accountabilities, culture, and workforce strategy, and resource allocation.

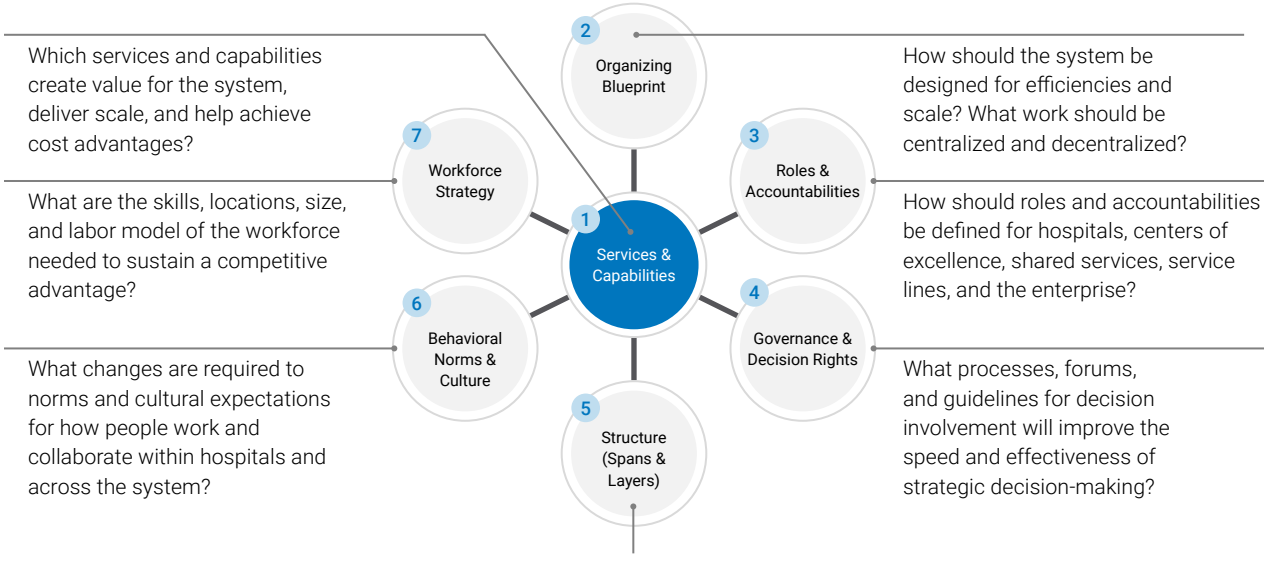
Phase 2

Design the Operating Model

Phase 2 focuses on designing the organizational setup and ways of working to best deliver on that strategy. Rather than merely creating an organizational chart, this phase holistically addresses the critical elements required to translate strategic goals into clear enterprise practices.

An operating model is the complete system by which a health system translates strategy into consistent, high-quality execution. Phase 2 brings that system into focus by addressing seven interconnected elements – each of which must be thoughtfully designed and explicitly aligned with the organization's strategic direction:

Seven Interconnected Elements of a High-Performing Health System Operating Model



1 Differentiating Services & Capabilities

Identify the unique strengths – including combinations of people, processes, and technology – that allow the organization to deliver its value proposition in ways competitors cannot. In what does the health system genuinely excel? Is it the clinical programs, operational capabilities, or patient experience dimensions that create real competitive differentiation? These are the capabilities that patients seek out and that physicians and employees want to be part of.

Leadership should reflect on questions such as:

- What are we genuinely great at according to customers and market perception?
- What capabilities are customers willing to pay a premium for?
- Where do we currently outperform or lag behind competitors – and why?
- What capabilities could disrupt the market and propel growth?

Not every service line may merit enterprise-level investment. A critical function of operating model design is helping leadership teams make disciplined choices about where to concentrate organizational energy, talent, and capital, and where to optimize for efficiency rather than distinction.

2 Organizing Blueprint

The organizing blueprint defines how work should be organized across the health system to support efficiency, scale, and strategic execution. It clarifies what should be centralized, what should remain closer to local markets or clinical teams, and how workflows, processes, and enabling technology should support the enterprise model.

When the organizing blueprint is unclear, work can become fragmented across entities, functions may duplicate effort, and decisions can slow down. A strong blueprint helps leadership determine where standardization creates value, where flexibility is necessary, and how the organization should operate as an integrated system rather than a collection of disconnected parts.

3 Roles & Accountabilities

Clarifying role accountability can have a tangible impact on organizational performance. In many health systems, accountability for critical outcomes can be diffused across business units and even contested by disparate executive stakeholders. Examples include operating margin targets by service line, quality metrics for specific care pathways, and capital allocation decisions for new program development. The result is decision-making that is slow, consensus-dependent, and frequently disconnected from strategic priorities.

Redesigning roles and accountabilities involves making it clear who is responsible for what in order to eliminate ambiguity. This does not simply entail updating job descriptions, but requires defining accountability for organizational outcomes. For example, who owns the P&L for a given service line, and how does that accountability connect to systemwide financial performance? Who is accountable when a care pathway produces inconsistent quality outcomes across entities? Who bears responsibility for executing against an initiative and delivering the projected return? These are the accountability questions that operating model redesign must answer.

The process must also define the level of the organization at which the accountability is held. In practice, this means mapping roles against outcomes rather than activities, and distinguishing between those who hold decision authority, those who must be consulted, and those who execute. Organizations will need to examine any informal accountability structures that have developed over time, such as an executive who may have assumed or inherited de facto ownership of a domain that was never formally assigned, or a matrixed reporting relationship that is too complex. Redesigning roles and accountabilities requires surfacing these patterns and resolving them in the new model.

4 Governance & Decision Rights

Roles and accountabilities define who is responsible for outcomes. Governance and decision rights define how decisions get made; these include the forums, frameworks, and paths through which the organization exercises judgment on matters of clinical, operational, and strategic consequence.

In complex health systems, governance can be a source of delay and dysfunction, where too many committees with overlapping mandates result in conflict, or on the other hand, a lack of forums where authority is actually exercised. The goal of governance redesign is not to reduce oversight, but to ensure that oversight operates at the right altitude. Health systems should avoid escalation paths that route decisions upward rather than resolving them at the appropriate level. Decisions that can be resolved at the service line or entity level should not require enterprise-level deliberation. Similarly, decisions that carry system-wide implications should not be made without the appropriate cross-functional visibility and authority.

Well-designed governance structures are built around explicit decision rights with a clear articulation of who holds authority to decide, who must be informed, and what escalation path applies when consensus cannot be reached. This includes defining the relationship between enterprise and entity governance and how decisions are made at the local vs system-wide level. Forums or committees need to be sized and scoped appropriately for the decisions they are expected to resolve. Their composition and cadence should reflect the complexity and urgency of the initiatives they oversee.

5 Structure: Spans & Layers

The leadership structure of a health system includes how it is layered, its spans of control, and how authority is distributed across the hierarchy. Structure is more than boxes and lines on an organizational chart – it shapes how information flows, how quickly decisions are made, and how effectively the organization can respond to business needs. In many health systems, we have seen legacy leadership structures accumulate over time through a series of individual talent decisions, internal reorganizations, or through M&A integrations rather than through deliberate design. The result can be a structure with more layers than necessary, spans of control that are inconsistent, and leadership roles without clear oversight scope.

To ensure that design decisions are evidence-based rather than anecdotally driven, structure design should be paired with an analytics process that is supported by comparative benchmarking. This could include an assessment of spans and layers benchmarks from a comparison group of similar health systems. More specifics about data and benchmarking applications using SullivanCotter's proprietary data can be found here.

6 Behavioral & Cultural Norms

Changing structure alone will not lead to an operating model that yields improved results if the organization's behavioral and cultural norms remain unchanged. Organizations must be intentional in addressing these norms and influence how people actually work together in support of the new operating model.

In health care organizations, this dimension is particularly complex as prevailing norms and culture around clinician autonomy, administrative hierarchy, and care delivery may be deeply embedded in certain parts of the system. This can be all the more important in health care organizations where two or more separate legacy organizations may have merged to form a new health system but have not fully integrated.

Effective operating model design requires leadership teams to be explicit about the cultural shifts required for the new model to function. They need to establish accountability mechanisms that reinforce these desired behaviors. For example, a health system pursuing greater enterprise integration may need to recognize and proactively address the existing sentiments around entity autonomy. Alternatively, one pursuing more data-driven decision-making needs to be deliberate

in developing and implementing evidence-based decision-making tools and methods across the system – from frontline patient care situations to senior executive committee meetings.

7 Workforce Strategy

Health systems need to take an active role in developing their workforce to drive the organizational strategy forward. This is wide-reaching and covers many areas such as:

- Planning for the geographic distribution of clinical capabilities and the subsequent talent pool requirements
- Understanding workforce needs around new talent and leadership, particularly in areas of growth or future opportunity
- Investing in growing the current workforce with ongoing training and development, re-tooling and upskilling, career pathing and growth opportunities, and preparing the workforce for new technologies and innovations
- Assessing talent against future-state roles to ensure the continuity of talent in the right roles

Clinical labor represents the largest single cost category of a health system and may also represent the most significant source of operational risk. Developing the right labor model not only impacts key leadership roles, such as the connection between entity and service line leadership to corporate leadership, but also the frontlines of care delivery when it comes to the optimal mix of full-time staff, contract labor, and outsourced services.

Determining the right workforce size, cost structure, and configuration requires more than internal review and deliberation. Many organizations consistently use external benchmarks that reflect how comparable health systems are structured and what labor models are in use. Workforce analytics, including market data on headcount distribution, base salary cost, and spans of control by level and function, provide an objective foundation for making these design decisions with precision and defensibility. Learn more about SullivanCotter's proprietary Workforce Insights360™ data and methodology.

Where Do We Start?

Operating model redesign does not follow a single template. The right scope depends on where the health system's most pressing strategic and operational challenges sit. For some organizations, the work may be enterprise-wide, such as post-merger integration, duplicative governance structures, or a major shift in care delivery strategy. For others, the opportunity may be more focused on improving service line accountability, redesigning a medical group model, or restructuring a function like Finance, Human Resources, or Revenue Cycle.

Regardless of where the work begins, the design should be connected to the organization's broader strategic priorities and built to strengthen coherence across the system. Even a targeted redesign should not be treated as an isolated reorganization. The seven operating model elements provide a common lens for evaluating the current state, identifying where misalignment exists, and designing changes that improve how the health system makes decisions, allocates resources, builds capabilities, and executes against its strategy.

An Approach Powered by Data and Analytics

Effective operating model redesign should be grounded in more than internal judgment or anecdotal evidence. Data and analytics provide an objective foundation for understanding where structural opportunity exists, how the current model compares to relevant peers, and what changes may create the greatest impact.

Workforce Insights360™ (WI360™), SullivanCotter's proprietary workforce intelligence database, uses market-calibrated benchmarks to inform operating model design decisions. WI360™ can help evaluate workforce size and distribution, base salary cost, spans of control, management layers, and headcount distribution by level, job family, and function. This insight is especially valuable in areas such as leadership structure, workforce strategy, and labor model design. Benchmarking can reveal where management oversight may be too concentrated, where spans are too wide, where layers may be slowing decision-making, or where workforce cost and headcount distribution may be misaligned with strategic priorities.

By bringing this level of analytical rigor into the redesign process, health systems can build a more credible case for change, support defensible design decisions, and establish a baseline for measuring whether the future-state model is delivering the intended results.

Case Study

Scaling Structure After Rapid Growth

A large regional health system had nearly doubled its employee base through the acquisition of several hospitals and care sites. As part of a broader operating model redesign effort, the advisory team used WI360™ to benchmark the system's management structure against a custom peer group to compare management headcount, spans of control, manager-to-individual-contributor ratios, and leadership role distribution. The analysis identified where the system diverged from peer norms, including areas of duplicative oversight, unclear accountability, and disproportionate supervisory headcount. These insights gave senior leadership a shared, data-grounded view of where redesign opportunities existed.

Case Study

Quantifying the Opportunity for Redesign

A leading academic medical center was preparing for a broad operating model redesign and needed to understand the magnitude of structural opportunity before committing to the full effort. As part of the engagement, the advisory team used WI360™ benchmarking to conduct an enterprise-level spans and layers analysis and functional deep dives. This helped leadership identify where layers had accumulated, where spans of control were inconsistent with peers, and where similar or duplicative work was distributed across the system. Translated into headcount and cost terms, the findings helped leadership align around the scale of opportunity and prioritize where design investment could generate the greatest return.

Phase 3

Executing for Impact

> Phase 3 is about putting the future-state operating model into action, managing the transition from current state to target state, and driving change across the health system. This phase focuses on embedding new ways of working and continuously refining the model to ensure it delivers the intended strategic results.

While designing the optimal operating model is critical, so is assessing the organization's ability to implement and sustain it. In this phase, the future-state design is translated into day-to-day operations. Health systems must align leaders and stakeholders, equip teams to work in new ways and reinforce the behaviors, processes and accountabilities required for the model to take hold. Execution is not a discrete endpoint, but an ongoing discipline that depends on leadership alignment, organizational capability, and sustained reinforcement.

A Framework for Successful Change: Align, Equip, and Sustain

Align
Clarity + Commitment

- Ensure clarity around the business case for change (the "why")
- Secure commitment to the vision of the change

+ Equip
Capabilities + Competencies

- Design and implement new processes and work systems
- Build manager and leader skills to more effectively lead change implementation
- Deploy change management infrastructure (e.g., PMO) to drive change execution, coordination, and risk management

+ Sustain
Acceleration + Continuous Improvement

- Identify and share wins (realized benefits of the change)
- Measure and monitor results and continuously improve
- Embed changes into interdependent systems, processes, and culture

= Successful Change

Aligning Leadership and Stakeholders Around the Change

Successful execution begins with alignment across the leadership team and key stakeholder groups. In health care organizations, this is particularly challenging given the complexity of the stakeholder landscape and the reality that operating model redesign often introduces meaningful disruption. Changes to roles, reporting relationships, decision rights, and ways of working can create real or perceived loss for leaders – even when those changes are necessary to position the organization for long-term success.

This dynamic can make alignment difficult to achieve and sustain. Leaders may understand the rationale for change while still resisting its implications for their teams or areas of responsibility. Without deliberate effort, this can lead to passive resistance, delayed decision-making, or attempts to preserve elements of the current state within the new model. As a result, alignment requires more than agreement in principle; it requires a level of shared ownership and willingness to act in support of the enterprise, even when trade-offs are involved.

Executive sponsorship is central to navigating this tension. The CEO and senior leadership team must act as visible and consistent champions of the new operating model, reinforcing its priorities in governance forums, modeling expected behaviors in decision-making, and holding one another accountable for operating in accordance with the future-state design.

Alignment must also extend beyond the executive level. Clinical and operational leaders are more likely to support changes that are clearly connected to patient care quality, clinical outcomes, and care delivery effectiveness. Engaging these leaders as active participants in shaping how the model is applied within their domains can strengthen ownership and reduce resistance. Addressing the human side of change also requires transparent communication, consistency in leadership actions, and meaningful opportunities for involvement throughout the process.

Equipping the Organization to Operate in the Future State

Once this alignment is established, organizations must ensure that leaders and teams are equipped to operate effectively within the new model. This requires translating design decisions into practical clarity around how work gets done, how decisions are made, how teams collaborate across the system, and how accountability is exercised.

Implementation should be approached in a phased manner that reflects the differing timelines associated with various types of change. Structural changes, such as reporting relationships and governance forums, can often be implemented relatively quickly, while process redesign, technology enablement, and shifts in behavioral norms typically require longer-term effort.

Equipping the organization also involves building the capabilities required to sustain the new operating model. This may include leadership development to support more integrated ways of working, investments in operational capabilities such as standardized workflows and data-driven decision-making, and targeted training to support adoption of new processes. Providing practical tools, such as governance charters, decision-rights frameworks, and performance dashboards, helps translate design intent into consistent execution across the organization.

A deliberate focus on early wins is also important. Identifying tangible improvements within the first several months of implementation can provide visible proof that the new model is generating value. These early wins help validate the design, build confidence, and support organizational momentum over the course of a multi-phase transformation.

Sustaining Performance and Embedding New Ways of Working

Sustaining the impact of an operating model redesign requires ongoing management and reinforcement. Once implemented, the model must be actively managed with clear metrics and governance forums to regularly assess progress.

Senior leadership should monitor performance against outcomes such as operating margin, clinical quality, workforce engagement, and decision-making effectiveness, and be prepared to make adjustments where the model is not delivering as intended. Those that address gaps early are better positioned to sustain momentum and realize the full benefits of the redesign.

Embedding the operating model into day-to-day operations is equally critical. This includes incorporating the future-state design into onboarding for new leaders, aligning leadership development with required capabilities, and reinforcing desired behaviors through accountability and recognition mechanisms. Cultural and behavioral norms must be actively managed to ensure they support the structural and governance changes that have been implemented.

Over time, the operating model will require refinement. As strategic priorities, market conditions, and organizational capabilities evolve, so too must the model. Health systems that build in periodic reassessment and are willing to recalibrate are better positioned to sustain performance and maintain alignment between strategy and execution.

A clear operating model is what links bold strategic intent to lasting measurable impact. With the right model in place, vision and execution move in lockstep, positioning the health system to advance its mission, strengthen performance, and achieve its goals now and in the future.

Conclusion

The forces reshaping health care are not temporary headwinds. They represent a structural transformation in how care is delivered, financed, staffed, and experienced. Health systems that are capable of operating with greater strategic focus, organizational discipline, and consistency of execution will be better positioned to thrive amid continued disruption.

A thoughtfully designed and effectively implemented operating model enables health system leaders to make faster, more informed decisions, deploy resources toward genuinely differentiating clinical capabilities, build the workforce and labor model for sustained performance, and respond rapidly to market and environmental changes with speed and adaptability.

Partnering with SullivanCotter

Specialized expertise for health system operating model transformation

SullivanCotter partners with health systems to design and implement operating models that strengthen organizational performance, improve accountability, and support long-term strategic execution.

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