

ENTREPRENEURSHIP IN THE BOARDROOM: BOARD ROLES IN MANAGING INNOVATION AND RISK

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Abstract:

Today's competitive health care markets demand innovation and risk taking on the part of organizations. However, increased government regulation and stiffer penalties enacted in the wake of recent high -profile corporate scandals and the resulting Sarbanes–Oxley legislation, may render boards less willing to undertake entrepreneurial ventures. This article extends the typology of corporate entrepreneurship (CE) developed by Covin and Miles (1999) by extending the CE types to address governance activities in the health care sector. Four case studies are presented that illustrate each of the typology's forms. In addition, the implications of the typology for health care executives and trustees are discussed and areas for future research are recommended.

Article:

The business world, stock markets, employees, and the U.S. government have been shaken by governance failures at corporate entities such as Enron, Tyco, Adelphia, and Worldcom. The health care sector has been no exception with HealthSouth exhibiting questionable governance oversight and offering little in the way of effective risk management to stockholders prior to its collapse. As a result of these failures, the U.S. Congress intervened quickly and with some fanfare by enacting the Sarbanes–Oxley Act in 2002, which mandated sweeping reforms in the governance policies of publicly traded companies' boards.

Although the legislation specifically targeted public firms, recent efforts by several states' attorneys general indicate that a similar level of discontent is growing among those officials charged with overseeing the public benefit derived from nonprofit organizations. For example, the New York State attorney general, Elliot Spitzer, has demanded that nonprofit boards observe the basic organizational requirements of Sarbanes–Oxley (O'Brien & Spitzer, 2004). In Minnesota the attorney general has gone so far as to prompt the dissolution of the governing board of a large nonprofit, Allina, once regarded as a model for integrated delivery of health care (Reilly, 2003). The net effect of these activities has been to create an environment where health care organizations' directors are playing a significantly larger role in strategic decisions and potentially limiting corporate entrepreneurship (CE) to curtail their own legal liability.

The key features of Sarbanes–Oxley are increasingly well known to the public as a result of high profile investigations, notably HealthSouth. The most prominent feature of the law is the requirement that the CEO and CFO of a publicly traded entity verify the financial statements. In addition, governance "best practices" under the law have also resulted in action to restructure the governance processes of not only publicly traded health care companies such as HCA and Tenet, but also their nonprofit counterparts.

The law has reinforced awareness of the public accountability of trustees. Investment rating firms are increasingly demanding that organizations demonstrate strong board oversight to sustain creditworthiness. These requirements for increased control in some key areas are accompanied by demands for increased independence from trustee control (Hymowitz, 2005). For example, audit committees must comprise independent, outside financial experts. Investment committees must now be incorporated more completely into the governance process as they may recommend actions but not make or manage investments as was often true previously (Haugh, 2004). Orlikoff (2005) observes that rating agencies are using their power to demand

improvement in governance. As a result, boards are increasingly called upon to do business in a more public manner with greater involvement of other actors. The net effect is to reinforce the conservative obligations of a trustee's role to conserve the assets of the entity and avoid risk demanded in entrepreneurial settings.

Corporate entrepreneurship, which embodies a company's innovation, venturing, and risk management activities, is necessary in today's competitive health care markets. However, increased governance regulation and stiffer penalties for trustees who fail to meet the new standards may reduce the willingness of many board members to endorse or allow entrepreneurial activities under their purview. Chiat (2004) has suggested that "our current models of leadership – and governance – have elevated managers to leaders. Boards, as a result, often end up doing work that might be considered management. They look at budgets, they look at facilities plans, they develop market plans to improve their image or attract clientele. Boards have become legitimators, auditors, and custodians of tangible assets. But not leaders." This is a severe indictment of the ability of the contemporary board to function in support of entrepreneurial activity by the organization.

In order to study how boards manage CE it is necessary to have a framework that describes the phenomena in a systematic fashion. Previous research has focused on organizational innovation in conjunction with CE (Covin & Miles, 1999; Ahuja & Lampert, 2001; Lee et al., 2001) or studied board member's ownership stake as it correlates to various levels of CE activity (Zahra, 1996). However, no research we have been able to identify specifically looks at the CE actions and policies taken by boards, either in the general management or health care literatures. To address this gap in the research, we extend the CE typology developed by Covin and Miles (1999) to reflect governance activities specifically. In addition, four case studies are provided that illustrate the different types. Lastly, how health care organization executives and trustees can apply the lessons learned from study is discussed.

NEW CONTRIBUTION

Building on existing concepts of CE and governance, this article suggests a new research agenda to increase the effectiveness of health care organizations' oversight. Given the heightened interest in institutional governance by both the federal and state governments, it is likely that many board members will resist current or future CE activities at their institutions as a form of personal risk management. However, for those boards that can intelligently manage the risk associated with CE in the face of heightened external threats, there is an opportunity to seize sustainable competitive advantages in the marketplace. Therefore, this paper provides a starting point for board education on effectively restructuring their governance in accord with the demands of Sarbanes–Oxley.

WHY HEALTH CARE ORGANIZATIONS?

Nonprofit health care organizations provide an ideal context for studying CE for three reasons. First, in the past 20 years U.S. health care markets have undergone significant reorganization involving fundamental changes to organizational structures and stakeholder relationships that required extensive board involvement (Fottler et al., 1989). Therefore, nonprofit health care boards are active and engaged in the management of their organizations. Second, no board member holds an ownership position in a nonprofit firm, therefore potential agency conflicts are effectively controlled for from a CE research perspective. Lastly, health care delivery organizations' boards are under increasing pressure by purchasers, employers, and governments to change their internal processes to improve quality and reduce medical errors (Kohn et al., 2000; Begun et al., 2003).

CORPORATE ENTREPRENEURSHIP

Corporate entrepreneurship is the term used to describe the innovative and risk-taking approaches that enterprises adopt to gain competitive advantage in their marketplaces. CE is deliberate, firm-level behavior through which organizations renew, reinvent or redefine themselves, their industries, their markets, or some combination of those factors. The CE designation is reserved for instances where the entire organization, not just individuals or small groups within the organization, acts in ways that would be characterized as entrepreneurial. As such, the CE construct is particularly useful when studying entrepreneurial activities in

relationship to the governing board, the firm structure being ultimately responsible for approving organizational direction and strategy.

Covin and Miles (1999) have developed a typology that classifies the four most commonly observed CE forms (see Table 1). The four forms are domain redefinition, strategic renewal, organizational rejuvenation, and sustained regeneration, which are arrayed in descending order from the riskiest and broadest in scope to the least risky and narrowest in scope. Each form is associated with a distinct entrepreneurial activity focus and serves a basis for gaining competitive advantage.

Table 1. Corporate Entrepreneurship Types.

Type	Domain Redefinition	Strategic Renewal	Organizational Rejuvenation	Sustained Regeneration
Focus of entrepreneurial activities	Organization creates new product/service market that competitors have not discovered or exploited	Organization changes the way it competes with rivals; focus is on the “organization-environment” interface rather than on its own processes	Organization targets innovations to its internal processes, structures, or capabilities; focus is on process improvement rather than new products	Organization produces continuous stream of new products/services (p/s) in its current market and/or enters new markets with current p/s
Basis of competitive advantage	Quick response	Varies with specific form manifestation	Cost Leadership	Differentiation
Frequency of new entrepreneurial acts	Infrequent	Less frequent	Moderate frequency	High frequency
Magnitude of negative impact if entrepreneurial act unsuccessful	Varies with specific form manifestation and contextual considerations	Moderate-to-High	Low-to-Moderate	Low
Level of Board Involvement	High Involvement	Moderate-to-High Involvement	Moderate Involvement	Little-to-No Involvement
Case Example	Alina Health Care System Minneapolis, MN	University Healthcare, Inc. Madison, WI	Swedish Medical Center Seattle, WA	SSM Health Care, St. Louis, MO

Table 1. (Continued)

Type	Domain Redefinition	Strategic Renewal	Organizational Rejuvenation	Sustained Regeneration
Outcome	Alina IDS dissolved in 2001 through divestiture of HMO Medica, in 2004 governance for its 15 hospitals was consolidated into one 20-member board. Regional community boards continue to function only in advisory capacity	UW recently reacquired its HMO from WellPoint	SMC board undertook extensive education for members, developed sophisticated quality reporting tools, and adopted new policies for dealing with reporting results	SSMHC transformed its culture into that of a learning organization and in 2002 became the first health care organization to be awarded the Malcolm Baldrige Award for quality
Changes to Board Structure and Processes	Consolidation of board's power across system	Creation of a new legal entity	New reporting process introduced	Streamlining of board structures and redistribution of responsibility across system

Note: Adapted from Covin and Miles (1999, p. 57).

Covin and Miles (1999) stress that the CE forms should be viewed as generic archetypes of entrepreneurial activity and that in practice firms may exhibit successful hybrid forms. They further point out that the choice of CE form is not totally under managerial control, because organizational evolution that flows from an entrepreneurial process are inherently complex, difficult to predict, and have emergent qualities (Committee on Quality of Health Care in America, 2001). Nevertheless, the typology presents a useful tool in the empirical examination of CE and organizational structure.

ENTREPRENEURSHIP AND ORGANIZATIONAL STRUCTURE

Entrepreneurship in health service firms is closely tied to organizational form. The challenge to existing organizations is to restructure their organization in such a way that CE-Type innovations can occur and be nurtured to fruition in a timely manner (Chandler, 1962; Burgelman, 1983; Burgelman, 1984). This dilemma is particularly acute in the airline industry where so-called “legacy carriers,” such as Delta and United, have launched subsidiary carriers (Song and Ted, respectively), competitors to the low-cost leader Southwest Airlines. To date these efforts have been unsuccessful, but this has not slowed major airlines’ attempts to

appropriate the Southwest model. What is evident from these failed ventures is that without comprehensive organizational modification, efforts to replicate a low-fare model carrier on the Southwest business model are unlikely to succeed (Hamel & Prahalad, 1994).

Henry Mintzberg (1989) has described the attributes of the organizational structure that he defines as the entrepreneurial organization as a simple, informal, and flexible organizational type. Further, the entrepreneurial organizations' strategies often reflect the vision of a charismatic chief executive directing CE initiatives. The strategy process of such organizations is an "often visionary process, broadly deliberate but emergent and flexible in details"(Mintzberg, 1989, p. 117).

Mintzberg argues, however, that the process of bureaucratization typically follows entrepreneurial development and has profound operating ramifications for the organization. In the professional variant of the classic bureaucracy, that generally describes hospitals, he cites the existence of the dual structural characteristics with high degrees of both bureaucracy and decentralization. This unusual combination gives the professional organization some relief from the strict hierarchy of classic bureaucracies. Governance is achieved through impersonal rules and advancement is primarily based on technical proficiency (Weber, 1947).

The advantages of the professional organization form are substantial for the purpose of entrepreneurship. This dual organization form conveys the advantages of democracy and autonomy so highly valued by professionals on whom health care organizations typically rely for technological and process advances (Culbertson & Lee, 1996). Yet, it is also challenged by what Mintzberg (1989, p. 118) regards as "problems of coordination between pigeonholes, of misuse of professional discretion, of reluctance to innovate." In other words, the very latitude that is granted to professionals in organizations may be countered by protection of organizational "turf" in the pursuit of control over professional work (Friedson, 1994).

The response of public sector organizations to these problems is often dysfunctional forms (machinelike). The public's representative body within the nonprofit organization is the governing board. Typically the board has been called upon to exercise its fiduciary role to uphold the policies and procedures of the organization as developed by management rather than professionals within the firm. The net result may be to drive potentially innovative actors from the organization to seek more hospitable opportunities available in other settings. A prime example is the rise of specialty hospitals and surgery centers, which are physician controlled and exist independently of the general hospital (Devers et al., 2003).

THE FIDUCIARY OBLIGATIONS OF THE BOARD

Boards of directors are being held to higher standards of accountability in the performance of their duties. These duties respond to the expectations of the organization's stakeholders. In the for-profit world, the most involved stakeholders are typically the shareholders of the company, with the board elected by those persons as their overseers of corporate affairs. The prime duty of the for-profit health care boards is owed to the shareholders and is measured as a monetary return-on-investment according to Milton Friedman (Coelho et al., 2003). In the nonprofit health care organizations, the stakeholders being represented include patients, physicians both inside and outside the organization, staff, suppliers, and the broader community in general.

In the nonprofit environment, directors' accountability is more varied and complex, and the priorities are more ambiguous as to what constitutes the stakeholders' desired ends and preferred means of achieving them. The classic "duty of care" principle requires that an individual director satisfy the test of performing their duties as a "prudent person" would. In the current climate of calls for enhanced director accountability in all sectors of the economy, it has never been more difficult to meet the prudent person test. Reputational damage has always been a consideration for directors, but now personal liability issues are of greater concern in the aftermath of several years of highly visible corporate scandals and new legislation (Miller, 2001).

Directors' new work related legal exposure has made board activities more complex as it potentially subordinates the organizations' needs to those of the director. Until recently, a director's measure of loyalty

centered their ability to avoid conflicts of interest. In its simplest form, the director is admonished to refrain from self-dealing and is prohibited from using her/his position, or the knowledge gained in carrying out the duties of that position, for personal gain. This role demands strict disinterestedness on the director's part, or the integrity of the governance process is open to question (Darr, 2005).

For directors of nonprofit organizations, concern for protection of tax-exempt status sets the bar for directors' conduct even higher. Maintenance of tax-exempt status requires no private inurement of directors, or the opportunity to benefit financially from the business dealings of the organization. The notion of trusteeship is commonly invoked to describe the obligation of board members to their institutions. However as Darr (2005) has observed, these individuals are generally not true trustees holding title to property and managing it for the beneficiaries of the trust. Nevertheless, the idea of protecting the institution and its corpus is powerful, and directors of nonprofit organizations are expected to preserve the institution's ability to carry out the public service mission which justifies its tax exemption as a charitable enterprise.

THE DEMAND FOR DIVERSIFICATION

Innovation in organizational settings has challenged organizations in the last decade to modify or even abandon traditional structural forms in the interest of successful adaptation to a competitive environment. This challenge has often caused discomfort for directors as their organizations have moved into uncharted territory, such as integrated delivery systems (Short-ell, 1989). If the director narrowly views her/his role as one of protection and conservation of the organization's assets, then aversion to risk taking naturally follows.

The less flattering view of organizational innovation in the nonprofit world is one that sees this activity as "commercialization" rather than a necessary competitive strategy (Bok, 2003). Commercialization is a particularly problematic charge when applied to a nonprofit, which is presumably in existence to pursue financial success only to support its service driven mission (Drucker, 1990). In the instance of higher education, Bok (2003) suggests that commercialization of the educational enterprise poses significant risks for the reputation of the institution. He identifies the generation of revenues by universities through licensing of products and royalties derived from the results of discoveries by faculty researchers as a prime example. Certainly research is regarded as a core mission of academic institutions, and in many instances of health care organizations as well. It is not the research process itself to which Bok objects. The Universities' growing dependence on such sources is the problem.

Proponents of partnerships involving the university in the marketplace defend them as innovative and necessary to assure an appropriate return to the university for its investment of financial and human capital in research endeavors. As long as these ventures are successful, their supporters outnumber their critics. It is when results deteriorate, or public criticism emerges, that governing bodies begin to fear the damage to organizational reputations and their duties as trustees require them to avoid such issues.

CORPORATE ENTREPRENEURSHIP CASE EXAMPLES

Case Example #1: Domain Redefinition at Allina Hospital and Clinics

According to Covin and Miles (1999), domain redefinition is the most risky and least frequently observed of the four CE forms. This label is reserved for organizations whose entrepreneurial innovations focus on deliberate creation of a new product-market sphere or entry into a previously underserved sphere, taking the firm furthest away from its pre-existing products, markets, and strategies. Since the firm is entering new product-market arena, one would expect an accompanying revision of both the organization's mission and its vision for the future. Clearly, for organizational changes of this magnitude, the governing board will be highly involved.

Domain redefinition CE may occur as organizations attempt to avoid adverse circumstances in their current competitive situation, or they may be more opportunistic in nature, as firms attempt to exploit the potential of an unfilled product category. In either case, domain redefinition may lead to first-mover advantages by setting industry standards and the rules of competition for the category, thus becoming the benchmark by which later

entrants are judged. The organization chosen to illustrate the domain redefinition form of CE is the Allina Health System of Minneapolis, Minnesota.

A conscientious trustee, scanning her/his current environment during the era of proposed health care reform in 1994 could not help but be influenced by expert academic and consulting opinion proclaiming the impending dominance of the integrated delivery system model (Shortell et al., 1992). The question prudent trustees would be forced to ask involves whether their organization should join or seek to create such a system? From the vantage point of the director, conventional wisdom clearly supported such innovations; to the point that the prudence of a director could be questioned if her/ his organization stubbornly choose to remain unaligned.

That the formation of integrated delivery systems would pose challenges for governance of the new enterprise has been assumed all along. Pointer, Alexander, and Zuckerman (1997) identified a series of potential governance pitfalls in research conducted for the American Hospital Association. New levels of governance would emerge, accompanied by a need to identify and define roles and responsibilities appropriate to each organizational level. These developments would also require new ways of assessing governance performance, which is often a difficult issue for boards to confront. Finally, the question of physician involvement in governance must be directly confronted and determined (Pointer et al., 1997). Solving these contentious issues might pose an arduous challenge for even the most harmonious boards.

To compound the problem facing governing boards, real-world experience has resulted in questioning the desirability of forming integrated delivery systems given the difficulty in capturing promised synergies. By the dawn of the new century, the integration innovation model appeared ready to unravel (Luke & Begun, 2001). Major operational and policy concerns emerged that threatened the core assumptions of the integrated system innovation. Paradoxically, as discussed in the following Allina Health System case illustration, governing boards found themselves very much at the center of the controversy.

The Allina Vision

At its apex, Allina can be characterized as the leading example of an integrated delivery system to emerge in the 1990s, taking on many of the attributes associated with much more established examples of the genre such as Kaiser-Permanente. The boldness of the Allina vision was articulated by CEO Gordon Sprenger (1994, p. 135), who stated that “Moving from the old fee-for-service model is a major paradigm shift. To encourage our board to look not at occupancy, but at health outcomes, and to look at premium dollars, not how well their individual hospitals are doing is a major difficulty.” The difficulty in governance to which he alludes resulted from the highly innovative and yet ultimately controversial decision to merge with the Medica health plan of the Twin Cities. That merger added 550,000 enrollees to the existing 250,000 Preferred Provider Organization lives already managed by Allina (Sprenger, 1994). With this merger Allina had brought all of the elements of the integrated delivery system model into place, uniting institutional services, professionals (though owned and affiliated medical groups), and an insurance organization in the form of a medical health plan under the control of a single board.

This bold stroke by Allina clearly fits the definition of domain redefinition put forth by Covin and Miles (1999). The decision to merge with Medica was a historic decision that moved the organization into a new competitive position, from which it could compete with established integrated delivery systems such as Health Partners of Minnesota. At the same time, it carried substantial risk for the organization and its governing board by moving away from Allina’s historic dominance of the Twin Cities fee-for-service market in which it enjoyed a comfortable reputation for patient satisfaction and care quality leadership.

The Subsequent Dissolution of the Integrated Board and Strategy

The impetus to reconfigure the Allina organization and its governance structure in 2001 ostensibly resulted from the investigation of Minnesota Attorney General Michael Hatch into allegations of improprieties stemming from insufficient corporate governance oversight and control (Sweeney, 2001). It is precisely these

types of governance challenges in integrated delivery systems, Pointer, Alexander, and Zuckerman (1997) identified earlier.

Lurking behind the stated reasons for the intervention was a difference of opinion between the Attorney General and the Allina management regarding public benefits of integrated delivery system as it existed. In particular, the consolidation of the public delivery entity (Allina) and the for-profit financing organization (Medica) under common governance was a point of contention for the Attorney General (Geist, 2001). In the eyes of critics, the centralization of these forces generated abnormal pricing and contracting powers that worked against the interests of Allina's providers network, on one hand, and purchasers of its health care services on the other (Howatt, 2001a). The strategic benefits gained by Allina as a result of its integration were viewed as anti-competitive and not in the public interest for the broader community that nonprofit trustees are expected to serve (Lotterman, 2001).

The subsequent decision to separate the governance structure of Allina into two separate subsidiaries, Medica (the health plan) and Allina (the delivery system), did not address these underlying concerns. Rather, a public audit of the systems by Attorney General Hatch reported numerous questionable expenditures for travel, executive perquisites, and consulting fees that suggested breach of the fiduciary duties of the disaggregated governing boards to facilitate the separation. In effect, the two boards were still acting as one and not in the interest of the public (Howatt, 2001). The public statements issued by Allina spokesperson Maureen Schriener (2001) sought to minimize the influence of external pressure in effecting the transition to two separate boards, noting that, "A reorganization that we went through a couple years ago already divided them into separate business units," and continues that "Establishing those divisions as two independent organizations is really just the next phase" (Schriener, 2001).

The alleged voluntary nature of this restructuring, dismantling what we have characterized as domain redefinition, is called into question by the statement that members of the reconstituted Allina board (comprising 11 new members and 10 holdovers) received a "promise made by Allina, and ratified by a judge, that they would not be held personally liable for damages from any lawsuits challenging the way the company was managed in the past" (Sweeney & Hammers, 2001). The necessity of such an agreement clearly indicates the deep concern for the personal security of individuals entering into governance roles, based on the allegations that prompted the investigation of Attorney General Hatch.

The Allina experience thus presents a cautionary tale for corporate trustees considering bold CE innovations. As in the case of Attorney General Spitzer's investigations of nonprofits, New York, Attorney General Hatch's investigation was conducted under the authority of the state's nonprofit statutes. These authorities granted to states' attorney generals under nonprofit statutes are emerging as an accepted justification for extending the governance provisions of Sarbanes-Oxley to nonprofits (O'Brien & Spitzer, 2004).

A postscript to the major domain redefinition of Allina is the announcement of Richard Pettingill, the CEO appointed in 2002 to head the reconstituted Allina, that all individual hospital boards of its 15 hospitals will be dissolved into one 20-member central parent board. The new governance structure is presented as an evolution to "one mission, one strategy, one focus" and a step toward a "more patient-centered health care system" (Minneapolis Star and Tribune, 2004).

It should be noted, however, that the creation of the central parent board affects only the Allina delivery organization. The move by Allina to integrate local boards to one health system board is consistent with current practice in multi-hospital systems as a means of achieving uniformity in governance policy and efficiency of management (Brown & Lerner, 1997). This move toward centralized governance for the delivery organization is still significantly diminished in contrast to the prior Allina single board that oversaw the operations of both the delivery system and the Medica Health Plan until its forced dissolution.

Case Example #2: Strategic Renewal at The University of Wisconsin

The strategic renewal form of CE refers to organizations whose entrepreneurial activities change the way the organization competes in its marketplace. Here the focus of organizational rejuvenation is on the firm itself, and the focus of strategic renewal is on the interface of the organization with its external environment as mediated by the corporate strategy. The strategic renewal label has been used to describe a variety of phenomena in the strategy literature. However, Covin and Miles (1999) reserve this designation for organizations whose new strategies represent significant departures from past approaches leading to meaningful improvement in long-term competitive advantage. Since the variety of strategies open to organizations is nearly infinite, it is impossible to delineate a specific list of strategic changes that would qualify as strategic renewal. Rather, in identifying strategic renewal, one looks for deliberate strategic redirection that reenergizes the organization and significantly improves competitive position in the market or industry.

Although industry leaders at times must engage in strategic renewal to ensure their positions, it is most often observed among organizations attempting to improve their position or take over industry leadership. Strategic redirection is difficult for an organization to implement, so one would expect that this form of CE would be undertaken less frequently than sustained regeneration or organizational rejuvenation. One would also expect a high level of governing board involvement in any major strategic redirection decisions. The organization we have chosen to illustrate the strategic renewal form of CE is the University of Wisconsin Hospital and Clinics and the divestiture and subsequent reacquisition of Unity Health Plan.

The health plan was formed in 1994 through the sale of the internally owned and managed U-care HMO to Blue Cross/Blue Shield of Wisconsin. Over the past decade the plan has grown to 76,000 members and has been managed as a joint venture of Blue Cross/Blue Shield, University Health Care, and the Community Health System consortium of rural hospitals and physicians (University of Wisconsin Health System, 2004). At the time of the initial 1994 transaction the sale of the fledgling HMO was regarded as counterintuitive in the light of prevailing strategies to unify delivery systems and financing vehicles. The sale preceded a 1995 significant governance transformation at the University of Wisconsin–Madison in which a new public benefit corporation undertook operation of the University Hospitals and Clinics and their subsidiary organizations from direct state governance as an agency of the State of Wisconsin. Given the complexity of the ownership and governance structures involving public and private entities, it is surprising in retrospect that the 1994 transaction occurred at all.

More surprising is the decision announced in June 2004 and executed on January 1, 2005, to strategically renew the organization through the reacquisition of the 76,000 member Unity Health Plan from Blue Cross/Blue Shield and its successor organization WellPoint. The transaction is predicated on a provision in the 1994 transaction allowing the University of Wisconsin to reacquire the Plan after 10 years should the joint venture partners decide not to renew.

This option was exercised as a result of strategic direction from the University Health Care Board that reflects the unique characteristics of the Madison market. These characteristics include a generous state-provided benefit support for public employees, a geographically defined service area with minimal presence of national health plans, and the existence of other large organized medical groups in the service area that also own managed care plans.

The transition of the ownership of Unity Health Plan is too recent an event to allow the assessment of operating results. Interestingly, the perceived advantage of this transaction is to allow the parent company, University Health Care, “to increase its focus on remaining directly involved in decisions that impact the care of patients and their families” (Barnett, 2004). Without the unique shared governance model of University Health Care as a not-for-profit consisting of the University of Wisconsin Hospitals and Clinics and also the University of Wisconsin Medical Foundation physicians group, it is unlikely that such an integrative strategy would have been adopted. Thus, a strategy that again appears to go against the now prevailing pattern of health plan

divestiture at prominent academic health systems, such as Duke and the University of Florida, is highly consistent with the focus on organization–environment interface identified by Covin and Miles (1999).

The Unity reacquisition could not have occurred without the restructuring of governance to create the organizationally distinct University Health Care entity and board. The execution of this strategy is made possible through the existence of a governance mechanism that allows other than public funds in completing this transaction. Viewed in this light, the influence of governance and the choices made possible or denied to organizations through governance models in the public and private sectors are evident. Flexibility in governance structure and practice is essential to the achievement of innovation.

Case Example #3: Organizational Rejuvenation at Swedish Medical Center

Organizational rejuvenation is the CE type that focuses on sustaining or improving a hospital's competitive posture by modifying its processes, structures, and/or capabilities. Organizations need not change their fundamental strategies to be entrepreneurial in the organizational rejuvenation sense. Rather, a hospital seeks to increase its profitability and/or to, improve service quality, via existing business strategies, through improved execution (Covin & Miles, 1999). From the board's perspective, organizational rejuvenation and improved strategy execution requires both structures and mechanisms to monitor and act on key outcome measures. To achieve the desired degree of operational involvement, many hospitals' boards have had to reorganize their own structures and implement new processes to engage in continuous quality improvement (CQI) – in effect rejuvenating themselves.

Structurally, boards have created new subcommittees or revitalized old ones' membership to increase financial reporting fidelity, focus on patient safety, oversee executive compensation, etc. A fax poll conducted by The Governance Institute in December 2002 (Bader, 2003) found that more than 80 percent of 103 responding hospitals and health systems have formed one or more board committees to focus on quality-related responsibilities. With respect to improved information flows, two tools many boards are adopting are “dashboards” and “balanced scorecards” to provide comparative performance measures of strategically important hospital processes.

The Swedish Medical Center (SMC) in Seattle, Washington, provides a good example of how a board approaches organizational rejuvenation as it relates to quality improvement and patient safety. In 1998, the board reorganized itself into five committees to upgrade its oversight capabilities. One goal of the reorganization was to improve the measurement of organizational performance and identify meaningful internal and external benchmarks for clinical quality. Achieving this goal took several years, required extensive board member education, the development of new reporting tools, and drafting explicit policies to respond to the reports.

The first capability the board sought to increase was its own understanding of patient safety, customer service, quality measurement issues, and strategic control in hospital settings. At the beginning of each quality committee meeting, SMC's Quality Integration and Improvement Department prepares training sessions using either in-house or external experts. Because of the clinical and organizational complexity surrounding quality improvement, the education process takes, “a sustained effort over several years coupled with a regular flow of meaningful information in order to be effective” according to Dr. Judy Morton (SMC's Vice President of Quality Integration and Improvement).

To deliver meaningful information, SMC has developed its own quarterly report for the quality committee and from that report a “dashboard” for the entire board. The dashboard is a summary tool for board members, showing the past quarter's performance on a limited set of key metrics. Previously, board members were inundated with lengthy reports with varying measures from period-to-period that made it difficult to determine whether SMC was actually making progress. The dashboard helped board members look at the total operation and understand whether or not it was doing the things the board wanted in a systematic and efficient fashion.

In addition to measuring the system's current performance, the dashboard has a stoplight icon to indicate if the measure is not within the desired range. For example, should the rate of nosocomial infections rise significantly above the previous period's rate or the allowable ceiling, either a yellow or red light will appear next to the item (see Fig. 1 for an example).

**Swedish Medical Center Performance
Strategic Measures Report - Second
Quarter 2004**

Receive Care		
Patient Safety Pages 2-5	NPU Prevalence Y	Patient Falls G
	Ventilator Pneumonia G	Blood Stream Infections Y
	Safety Climate Score*	Incorrect Procedures G
	Completion of H&P G	
Clinical Effectiveness Pages 5-8	Risk-Adjusted Mortality G	CHF Y
	AMI R	CAP R
Patient Satisfaction Pages 9-10	Inpatient Satisfaction Y	Outpatient Satisfaction R
	ED Satisfaction Y	SPD Satisfaction G
Work Page 11	Employee Satisfaction R	Annualized Turnover R
Practice Page 12	Physician Satisfaction*	
Partner Page 12	Community Benefit*	

Appendix A: Action Triggers, Data Source and Contact Information

Key:	G	Performance improving significantly over time or close to best
	Y	Performance stable and/or approaching action trigger
	R	Action trigger met -- remedial actions indicated and/or implemented
		Data for current time period not available, or no action trigger identified

*For these measures, full Q2-2004 data are not yet available.

Fig. 1. Dashboard Example.

As a matter of board policy, any metric displaying a red or yellow light is an "action trigger." As Morton¹ describes, "when there's a variance from the target, there needs to be some sense of urgency and some activity and action plan in place that brings it back into compliance or achieves the new goal." To do this, the board identifies a "process owner" and empowers that person to form an "action team" to investigate and address the problem. Despite these efforts and process changes, it took several years for them to become integral to the board's culture.

In 2003 at the annual retreat, SMC's board and its corporate leaders had a breakthrough in their thinking about the organizational rejuvenation process and sought to codify each of their roles and more closely integrate SMC's clinical leadership in innovation processes. The board gave itself six key roles that can be summarized as: (1) to understand the Seattle community's expectations of SMC; (2) to establish and monitor key metrics to meet those expectations; (3) to ensure that management develops strategic plans congruent with improving those indicators; (4) to build the health systems' culture surrounding continuous improvement; (5) to

consistently demonstrate the board's commitment to organizational rejuvenation; and (6) to promote collaboration across the organization for improving care and service quality. Collectively, these key roles provide a map to continual improvement and rejuvenation based on the organization's current strategies and market position. The organizational rejuvenation can be contrasted with the sustained regeneration which seeks to fundamentally change strategies on a continual basis.

Case Example #4: Sustained Regeneration at SSM Health Care

The final form of CE in the Covin and Miles typology is sustained regeneration; the most commonly recognized form of organization-level entrepreneurship. Firms engaging in this type of CE are often learning organizations where innovation is the norm, not the exception. They welcome change and frequently battle rivals for market share. Such firms are characterized by organizational cultures, structures, and business systems that nurture continuous innovation and allow them to regularly introduce new products and services to their current markets or to enter unexploited markets with existing products. In addition to new product or market entries, such organizations also pay close attention to the life cycles of existing products, discontinuing products, or exiting markets that no longer contribute to competitive advantage.

In sustained regeneration CE, entrepreneurial innovation is constant and the systems and structures that support it permeate the entire organization. Because of this, one would expect that control for this form of CE would fall under the normal activities of the management team. While one would expect the governing board to be kept apprised of the sustained regeneration activities by management, one would not expect the board to be heavily involved in their planning or control. The organization selected to illustrate sustained regeneration is SSM Health Care (SSMHC) of St. Louis, Missouri, sponsored by the Franciscan Sisters of Mary, one of the largest Catholic systems in the U.S. The SSMHC system has more than 20 acute and post-acute care facilities, a one-third interest in the Premier Medical Insurance Group HMO, as well as numerous physician practices, ambulatory care centers, and other health-related businesses, spread across four states (Missouri, Illinois, Wisconsin, and Oklahoma).

SSMHC began its transformation into a learning organization when it joined the widespread movement to CQI in the early 1990s, according to Sister Mary Jean Ryan, CEO of SSMHC since 1986 (Ryan, 2004). Unlike other organizations that soon dropped CQI and moved onto the next management fad, SSMHC leadership recognized that CQI required a profound cultural shift and that true results would not be forthcoming in the short-term (Ryan, 2004). After reaching an improvement plateau, SSMHC decided to reinvigorate its quality efforts by adopting the rigorous Malcolm Baldrige Award criteria although at that time health care organizations were not eligible for the award (Sandrick, 2003). When the Baldrige rules changed in 1999, SSMHC became the first health care organization to receive a Baldrige site visit, and in 2002 became the first health care organization award winner (Francis & Kosko, 2002).

Through the "framework, focus, and discipline" of the Baldrige process, SSMHC has transformed its culture. "We have established system-wide culture of sharing and replicating," says Sr. Ryan (2004) that provides "a climate in which leaders at all levels can emerge and thrive ... a climate in which people are not afraid to take risks, even if those risks end in failure." Hand-in-hand with SSMHC's success in improving patient care has come increased market success. SSMHC St. Louis facilities have increased market share at the expense of rival organizations (Recognized Best Practices, n.d.) and net patient revenues for the system as a whole have steadily increased as has its fund balance (Unaudited Financials, September 30, 2004; LPMG LLC, 2004).

In 1999, SSMHC underwent an organizational and governance streamlining, bringing the entire system under a single parent corporation controlling four regional corporations and paring the system's legal entities from 90 to 60 (SSMHC Family Tree, n.d.). The new corporate board has responsibility for setting overall system direction and policy, while regional boards are left to determine how their local facilities can best serve the needs of their communities within the framework of those system-wide policies. The corporate board's goals are developed through its year-long Strategic, Financial, and Human Resources Planning Process (Recognized Best Practices, n.d.). System-wide goals are communicated to the regions, facilities, and departments using standardized forms

and definitions to ensure alignment with the systems' overall direction. Strategic goals are translated to the employee level using individual "Passports," a performance management tool consisting of a card containing SSMHC mission and values along with entity, departmental and personal goals, signed by the employee and his/her manager (Passports, n.d.).

SSMHC's dissatisfaction with the status quo, its relentless quest to improve quality, and its culture and governance structure that foster organizational learning all support continuous innovation in ways of serving SSMHC patients that are the hallmarks of sustained regeneration CE.

IMPLICATIONS FOR HEALTH CARE MANAGERS AND BOARD MEMBERS

This study highlights the tensions facing corporate boards of health care organizations caught between pressures to pursue advantage-enhancing CE activities to survive in a competitive marketplace, on one hand, and the countervailing conservative forces surrounding corporate governance innovations post Sarbanes–Oxley. A nonprofit health care organization's leadership should recognize that boards, by their nature and in light of the current political environment, are inherently conservative and will act to minimize or guardedly manage risk, while CE activities require that firms embrace innovation and intelligently manage risk to gain competitive advantage. Indeed, among their counterparts in the for-profit sector, firms often depend on their boards for leadership and direction of CE activities.

This is a role that is often foreign to trustees of not-for-profit organizations who view their role as first and foremost one of asset preservation in the face of increased legal and public scrutiny of trustee performance. Orlikoff (2005) has written that "The risk is that boards will become so consumed by compliance with regulations, standards, legislation, and mandates that they will be unable, or forget, to govern. This, plus fear of directors' and officers' liability, may motivate boards to become cautious, detail-oriented plodders that lack the vision and willingness to take the risks necessary to provide the real leadership that is so much needed in these challenging times." It is exactly this caution that is antithetical to the spirit of entrepreneurship in organizations and the exercise of bold initiatives cited in the case studies presented in our article.

Nonprofit health care organizations must develop educational approaches to prepare their boards to be intelligent analyzers of risk rather than anchors holding fast to the strategies and structures of the past, regardless of their suitability for current marketplace conditions. In considering proposed innovations, organizational leaders can use the CE typology to evaluate the nature and extent of proposed board involvement. The CE activity's position in the typology can also provide valuable insights as to whether the current board structure will allow for meaningful strategic control of that innovation, or whether new board policies or structures will be necessary. As outlined in Table 1, the level of board involvement declines. Finally, our analysis highlights the additional risks to willingness to engage in entrepreneurial initiatives posed by application of Sarbanes–Oxley fiduciary responsibilities on nonprofit health care boards.

FUTURE RESEARCH AGENDAS

Although CE has been the focus of much research over the past decade, to our knowledge this work is the first to relate the CE typology developed by Covin and Miles (1999) to policy and restructuring decisions made by governing bodies in the context of health care. Future research is indicated along several lines. The first would focus on the advancement or expansion of the theoretical model itself, as it applies to health care firms. Work in this theme would address the questions: Which specific adaptive health care management strategies characterize each of the four forms of the CE typology? Is there sufficient mutual exclusivity among the adaptive strategies that characterize domain redefinition, strategic renewal, organizational rejuvenation, and sustained regeneration that the expanded model might prove useful in understanding the behavior of health care corporate boards in relationship to CE activities? How should the model's parameters, such as frequency of CE acts, magnitude of negative impacts if unsuccessful, and structural change be defined or operationalized? A second theme would focus on the application of the model in empirical investigations. Retrospective or longitudinal studies should be used to validate the model as a useful approach to measuring the effectiveness of health care organization governing board policy and structuring decisions in light of CE activities.

For example, financial outcomes for organizations whose CE activities are classified as domain redefinition, strategic renewal, organizational rejuvenation, or sustained regeneration could be compared.

A third area of research could focus on the application of readily available research tools to the relationship of governance and entrepreneurship. For example, through examination of the AHA's annual survey of hospitals one might track the creation or deletion of new services and the correlation of such moves to changes in governance. One might also track changes in organizational and board processes as new requirements such as independent audit committees are increasingly implemented. Does this lead to hospitals foregoing opportunities to avoid external disapproval?

Finally, the question of whether Sarbanes–Oxley may inhibit health care boards from pursuing CE innovations clearly warrants careful study from both the practice and policy perspectives. The implementation of Sarbanes–Oxley reforms is still in an early stage, and the consequences of these initiatives in the governance process will become more evident as their adoption spreads.

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REFERENCES

- Ahuja, G., & Lampert, C. M. (2001). Entrepreneurship in the large corporation: A longitudinal study of how established firms create breakthrough inventions. *Strategic Management Journal*, 22(6/7), 521-543.
- Bader, B. S. (2003). Best practices for board quality committees. *Great Boards*. 2004: Boardroom Briefing.
- Barnett, J. (2004). *University Health Care to Purchase Unity*.
- Begun, J. W., Zimmerman, B., et al. (2003). Health care organizations as complex adaptive systems. In: S. S. Mick & M. E. Wyttenbach (Eds), *Advances in health care organization theory*. San Francisco: Jossey-Bass.
- Bok, D. (2003). *Universities in the marketplace*. Princeton, NJ: Princeton University Press.
- Brown, F., & Lerner, W. (1997). On governance and governing. *Integrated delivery systems* (pp. 269–278). Chicago, IL: Health Administration Press.
- Burgelman, R. A. (1983). Corporate entrepreneurship and strategic management: Insights from a process study. *Management Science*, 29(12), 1349–1363.
- Burgelman, R. A. (1984). Designs for corporate entrepreneurship in established firms. *California Management Review*, 26(3), 154–166.
- Chandler, A. D., Jr. (1962). *Strategy and structure: Chapters in the history of the American industrial enterprise*. Cambridge, MA: MIT Press.
- Chiat, R. P. (2004). The problem with governance: Restoring board leadership will take a new model - — and a new way of thinking. *The magazine for nonprofit boards and chief executives (Board Member Special Edition)*, 13(4), 6.
- Coelho, P. R. P., McClure, J. E., et al. (2003). The social responsibility of corporate management: A classical critique. *Mid-American Journal of Business*, 18(1), 15.
- Committee on Quality of Health Care in America. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press.
- Covin, J. G., & Miles, M. P. (1999). Corporate entrepreneurship and the pursuit of competitive advantage. *Entrepreneurship Theory and Practice*, 23(3), 47–63.
- Culbertson, R., & Lee, P. R. (1996). Medicare and physician autonomy. *Health Care Financing Review*, 18(2), 115–130.
- Darr, K. (2005). *Ethics in health services management*. Baltimore, MD: Health Professions Press.

Devers, K., Brewster, L., et al. (2003). Specialty hospitals: Focused factories or cream skimmers? Center for Studying Health System Change Issue Briefs (No. 62).

Drucker, P. (1990). *Managing the non-profit organization*. New York: Harper Collins.

Fottler, M. D., Blair, J. D., et al. (1989). Assessing key stakeholders: Who matters to hospitals and why? *Hospital & Health Services*, 34(4), 525–546.

Francis, T., & Kosko, J. (2002). NIST announces SSMHC wins MBNQA. SSM Health Care Web Site, 2004.

Friedson, E. (1994). *Professionalism Reborn: Theory, prophecy, and policy*. Chicago: University of Chicago Press.

Hamel, G., & Prahalad, C. K. (1994). *Competing for the future*. Boston: Harvard Business School Press.

Haugh, R. (2004). The ratings game: Finance agencies aren't wishing for better oversight by boards. They're demanding it. Hospitalconnect.com, Hospitals & Health Networks.

Howatt, G. (2001). Hatch wrapping up probe, will not Sue Allina Execs. Minneapolis, MN: Minneapolis Star Tribune.

Hymowitz, C. (2005). In SarbanesOxley era, running a nonprofit is only getting Harder. *Wall Street Journal*, B 1.

Kohn, L. T., & Corrigan, J. M., et al. (Eds) (2000). *To err is human: Building a safer health system*. Washington, DC: National Academy Press.

Lee, C., Lee, K., et al. (2001). Internal capabilities, external networks, and performance: A study on technology-based ventures. *Strategic Management Journal*, 22(6/7), 615640.

LPMG LLC (2004). SSM health care: Combined financial statements December 31, 2003 and 2002. SSM Health Care Web Site.

Luke, R., & Begun, J. (2001). Have integrated health networks failed in healthcare? *Frontiers of Health Service Management*, 17(4), 45–50.

Miller, L. B. (2001). *Boards under fire*. Washington, DC: Volunteer Trustees Foundation.

Minneapolis Star and Tribune. (2004). Allina plans to consolidate board to streamline governance. Minneapolis, MN: Minneapolis Star and Tribune.

Mintzberg, H. (1989). *Mintzberg on management*. New York, NY: The Free Press.

O'Brien, L., & Spitzer, E. (2004). How to restore the fiduciary relationship: An interview with Eliot Spitzer. *Harvard Business Review*, 82(5), 70–77.

Orlikoff, J. E. (2005). Building better boards in the New Era of accountability. *Frontiers of Health Service Management*, 21(3), 3–12.

Passport (n.d.). SSM Health Care Web Site. 2004.

Pointer, D., Alexander, J., et al. (1997). *Loosening the Gordian Knot of governance in integrated delivery systems*. Integrated delivery systems (pp. 221–254). Chicago, IL: Health Administration Press.

Recognized Best Practices (n.d.). SSM Health Care Web Page. 2004.

Reilly, P. (2003). No more Minnesota nice. *Modern Healthcare*, 33(21), 14.

Ryan, S. M. J. (2004). Calling forth the spirit of leadership: Pathway to organizational transformation. Premier, Inc. Governance Education Conference, Scottsdale, Arizona.

Sandrick, K (2003). *Tops in quality*. Trustee, 13–16.

Schriner, M. (2001). Allina expects seamless transition. *Medfax Newsletter*.

Shortell, S. M. (1989). New directions in hospital governance. *Hospital & Health Services Administration*, 34(1), 7–23.

Shortell, S. M., Morrison, E. M., et al. (1992). *Strategic choices for American hospitals*. San Francisco: Jossey-Bass Publishers.

Sprenger, G. (1994). A multiregional system. In: J. McMahon (Ed.), *The role of hospitals in an evolving delivery system* (pp. 133–138). Durham, NC: Duke University.

SSMHC Quarterly (2004). SSMHC Quarterly Unaudited Financial Results: September 30, 2004 and 2003. SSM Health Care Web Site.

SSMHC Family Tree (n.d.). SSMHC Family Tree Has Been Restructured. SSM Health Care Web Site.

Sweeney, P., & Hammers, D. (2001). *New Allina board Shielded from Suits*. St. Paul, MN: St. Paul Pioneer Press.

University of Wisconsin Health System. (2004). *University health care to purchase unity*. Madison, WI: University of Wisconsin Health System.

Zahra, S. A. (1996). Governance, ownership, and corporate entrepreneurship: The moderating impact of industry technological opportunities. *Academy of Management Journal*, 39(6), 17131735.