

1 CHAPTER 8

3 ENTREPRENEURSHIP IN THE
5 BOARDROOM: BOARD ROLES IN
7 MANAGING INNOVATION AND
9 RISK
11

13 Richard A. Culbertson, Julia A. Hughes and
15 Eric Ford

17 **ABSTRACT**

19 *Today's competitive health care markets demand innovation and risk*
21 *taking on the part of organizations. However, increased government reg-*
23 *ulation and stiffer penalties enacted in the wake of recent high-profile*
25 *corporate scandals and the resulting Sarbanes–Oxley legislation, may*
27 *render boards less willing to undertake entrepreneurial ventures. This*
29 *article extends the typology of corporate entrepreneurship (CE) devel-*
31 *oped by Covin and Miles (1999) by extending the CE types to address*
33 *governance activities in the health care sector. Four case studies are pre-*
35 *sented that illustrate each of the typology's forms. In addition, the im-*
plications of the typology for health care executives and trustees are
discussed and areas for future research are recommended.

35 _____
37 **Strategic Thinking and Entrepreneurial Action in the Health Care Industry**
39 **Advances in Health Care Management, Volume 6, 199–223**
Copyright © 2007 by Elsevier Ltd.
All rights of reproduction in any form reserved
ISSN: 1474-8231/doi:10.1016/S1474-8231(06)06008-3

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

10 Although the legislation specifically targeted public firms, recent efforts
11 by several states’ attorneys general indicate that a similar level of discontent
12 is growing among those officials charged with overseeing the public benefit
13 derived from nonprofit organizations. For example, the New York State
14 attorney general, Elliot Spitzer, has demanded that nonprofit boards ob-
15 serve the basic organizational requirements of Sarbanes–Oxley (O’Brien &
16 Spitzer, 2004). In Minnesota the attorney general has gone so far as to
17 prompt the dissolution of the governing board of a large nonprofit, Allina,
18 once regarded as a model for integrated delivery of health care (Reilly,
19 2003). The net effect of these activities has been to create an environment
20 where health care organizations’ directors are playing a significantly larger
21 role in strategic decisions and potentially limiting corporate entrepreneur-
22 ship (CE) to curtail their own legal liability.

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

30 The law has reinforced awareness of the public accountability of trustees.
31 Investment rating firms are increasingly demanding that organizations
32 demonstrate strong board oversight to sustain creditworthiness. These re-
33 quirements for increased control in some key areas are accompanied by
34 demands for increased independence from trustee control (Hymowitz,
35 2005). For example, audit committees must comprise independent, outside
36 financial experts. Investment committees must now be incorporated more
37 completely into the governance process as they may recommend actions but
38 not make or manage investments as was often true previously (Haugh,
39 2004). Orlikoff (2005) observes that rating agencies are using their power to
demand improvement in governance. As a result, boards are increasingly

1 called upon to do business in a more public manner with greater involve-
2 ment of other actors. The net effect is to reinforce the conservative obli-
3 gations of a trustee’s role to conserve the assets of the entity and avoid risk
4 demanded in entrepreneurial settings.

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

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

31

32

NEW CONTRIBUTION

35 Building on existing concepts of CE and governance, this article suggests a
36 new research agenda to increase the effectiveness of health care organiza-
37 tions’ oversight. Given the heightened interest in institutional governance by
38 both the federal and state governments, it is likely that many board mem-
39 bers will resist current or future CE activities at their institutions as a form
40 of personal risk management. However, for those boards that can

1 intelligently manage the risk associated with CE in the face of heightened
external threats, there is an opportunity to seize sustainable competitive
3 advantages in the marketplace. Therefore, this paper provides a starting
point for board education on effectively restructuring their governance in
5 accord with the demands of Sarbanes–Oxley.

7 9 **WHY HEALTH CARE ORGANIZATIONS?**

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

23 25 **CORPORATE ENTREPRENEURSHIP**

Corporate entrepreneurship is the term used to describe the innovative and
27 risk-taking approaches that enterprises adopt to gain competitive advantage
in their marketplaces. CE is deliberate, firm-level behavior through which
29 organizations renew, reinvent or redefine themselves, their industries, their
markets, or some combination of those factors. The CE designation is re-
31 served for instances where the entire organization, not just individuals or
small groups within the organization, acts in ways that would be charac-
33 terized as entrepreneurial. As such, the CE construct is particularly useful
when studying entrepreneurial activities in relationship to the governing
35 board, the firm structure being ultimately responsible for approving organ-
izational direction and strategy.

37 Covin and Miles (1999) have developed a typology that classifies the four
most commonly observed CE forms (see Table 1). The four forms are do-
39 main redefinition, strategic renewal, organizational rejuvenation, and sus-
tained regeneration, which are arrayed in descending order from the riskiest

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	Allina 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	Allina 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).

1 and broadest in scope to the least risky and narrowest in scope. Each form is
2 associated with a distinct entrepreneurial activity focus and serves a basis for
3 gaining competitive advantage.

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

13

15 **ENTREPRENEURSHIP AND ORGANIZATIONAL** 16 **STRUCTURE**

17

18 Entrepreneurship in health service firms is closely tied to organizational
19 form. The challenge to existing organizations is to restructure their organ-
20 ization in such a way that CE-Type innovations can occur and be nurtured
21 to fruition in a timely manner (Chandler, 1962; Burgelman, 1983; Burgel-
22 man, 1984). This dilemma is particularly acute in the airline industry where
23 so-called “legacy carriers,” such as Delta and United, have launched sub-
24 sidiary carriers (Song and Ted, respectively), competitors to the low-cost
25 leader Southwest Airlines. To date these efforts have been unsuccessful, but
26 this has not slowed major airlines’ attempts to appropriate the Southwest
27 model. What is evident from these failed ventures is that without compre-
28 hensive organizational modification, efforts to replicate a low-fare model
29 carrier on the Southwest business model are unlikely to succeed (Hamel &
30 Prahalad, 1994).

31 Henry Mintzberg (1989) has described the attributes of the organizational
32 structure that he defines as the entrepreneurial organization as a simple,
33 informal, and flexible organizational type. Further, the entrepreneurial or-
34 ganizations’ strategies often reflect the vision of a charismatic chief executive
35 directing CE initiatives. The strategy process of such organizations is an
36 “often visionary process, broadly deliberate but emergent and flexible in
37 details”(Mintzberg, 1989, p. 117).

38 Mintzberg argues, however, that the process of bureaucratization typi-
39 cally follows entrepreneurial development and has profound operating
40 ramifications for the organization. In the professional variant of the classic

1 bureaucracy, that generally describes hospitals, he cites the existence of the
 3 dual structural characteristics with high degrees of both bureaucracy and
 5 decentralization. This unusual combination gives the professional organi-
 zation some relief from the strict hierarchy of classic bureaucracies. Gov-
 ernance is achieved through impersonal rules and advancement is primarily
 based on technical proficiency (Weber, 1947).

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

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

27

29

THE FIDUCIARY OBLIGATIONS OF THE BOARD

31

Boards of directors are being held to higher standards of accountability in
 33 the performance of their duties. These duties respond to the expectations of
 the organization’s stakeholders. In the for-profit world, the most involved
 35 stakeholders are typically the shareholders of the company, with the board
 elected by those persons as their overseers of corporate affairs. The prime
 37 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 Fried-
 39 man (Coelho et al., 2003). In the nonprofit health care organizations, the
 stakeholders being represented include patients, physicians both inside and

1 outside the organization, staff, suppliers, and the broader community in
2 general.

3 In the nonprofit environment, directors' accountability is more varied and
4 complex, and the priorities are more ambiguous as to what constitutes the
5 stakeholders' desired ends and preferred means of achieving them. The
6 classic "duty of care" principle requires that an individual director satisfy
7 the test of performing their duties as a "prudent person" would. In the
8 current climate of calls for enhanced director accountability in all sectors of
9 the economy, it has never been more difficult to meet the prudent person
10 test. Reputational damage has always been a consideration for directors, but
11 now personal liability issues are of greater concern in the aftermath of
12 several years of highly visible corporate scandals and new legislation (Miller,
13 2001).

14 Directors' new work related legal exposure has made board activities
15 more complex as it potentially subordinates the organizations' needs to
16 those of the director. Until recently, a director's measure of loyalty centered
17 their ability to avoid conflicts of interest. In its simplest form, the director is
18 admonished to refrain from self-dealing and is prohibited from using her/his
19 position, or the knowledge gained in carrying out the duties of that position,
20 for personal gain. This role demands strict disinterestedness on the director's
21 part, or the integrity of the governance process is open to question (Darr,
22 2005).

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

35

37 **THE DEMAND FOR DIVERSIFICATION**

38 Innovation in organizational settings has challenged organizations in the
39 last decade to modify or even abandon traditional structural forms in the

1 interest of successful adaptation to a competitive environment. This chal-
 3 lenge has often caused discomfort for directors as their organizations have
 5 moved into uncharted territory, such as integrated delivery systems (Short-
 7 ell, 1989). If the director narrowly views her/his role as one of protection
 9 and conservation of the organization's assets, then aversion to risk taking
 11 naturally follows.

13 The less flattering view of organizational innovation in the nonprofit
 15 world is one that sees this activity as "commercialization" rather than a
 17 necessary competitive strategy (Bok, 2003). Commercialization is a particu-
 19 larly problematic charge when applied to a nonprofit, which is presumably
 21 in existence to pursue financial success only to support its service driven
 23 mission (Drucker, 1990). In the instance of higher education, Bok (2003)
 25 suggests that commercialization of the educational enterprise poses signifi-
 27 cant risks for the reputation of the institution. He identifies the generation of
 29 revenues by universities through licensing of products and royalties derived
 31 from the results of discoveries by faculty researchers as a prime example.
 33 Certainly research is regarded as a core mission of academic institutions,
 35 and in many instances of health care organizations as well. It is not the
 37 research process itself to which Bok objects. The Universities' growing de-
 39 pendence 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 out-
 number 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.

29

31 **CORPORATE ENTREPRENEURSHIP CASE** 33 **EXAMPLES**

33

35

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

37 According to Covin and Miles (1999), *domain redefinition* is the most risky
 39 and least frequently observed of the four CE forms. This label is reserved for
 organizations whose entrepreneurial innovations focus on deliberate crea-
 tion of a new product-market sphere or entry into a previously underserved
 sphere, taking the firm furthest away from its pre-existing products,

1 markets, and strategies. Since the firm is entering new product-market
2 arena, one would expect an accompanying revision of both the organiza-
3 tion's mission and its vision for the future. Clearly, for organizational
4 changes of this magnitude, the governing board will be highly involved.

5 Domain redefinition CE may occur as organizations attempt to avoid
6 adverse circumstances in their current competitive situation, or they may be
7 more opportunistic in nature, as firms attempt to exploit the potential of an
8 unfilled product category. In either case, domain redefinition may lead to
9 first-mover advantages by setting industry standards and the rules of com-
10 petition for the category, thus becoming the benchmark by which later
11 entrants are judged. The organization chosen to illustrate the domain re-
12 definition form of CE is the Allina Health System of Minneapolis, Min-
13 nesota.

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

23 That the formation of integrated delivery systems would pose challenges
24 for governance of the new enterprise has been assumed all along. Pointer,
25 Alexander, and Zuckerman (1997) identified a series of potential govern- **QA :2**
26 ance pitfalls in research conducted for the American Hospital Association.
27 New levels of governance would emerge, accompanied by a need to identify
28 and define roles and responsibilities appropriate to each organizational
29 level. These developments would also require new ways of assessing govern-
30 ance performance, which is often a difficult issue for boards to confront.
31 Finally, the question of physician involvement in governance must be di-
32 rectly confronted and determined (Pointer et al., 1997). Solving these con-
33 tentious issues might pose an arduous challenge for even the most
34 harmonious boards.

35 To compound the problem facing governing boards, real-world experi-
36 ence has resulted in questioning the desirability of forming integrated de-
37 livery systems given the difficulty in capturing promised synergies. By the
38 dawn of the new century, the integration innovation model appeared ready
39 to unravel (Luke & Begun, 2001). Major operational and policy concerns
emerged that threatened the core assumptions of the integrated system

1 innovation. Paradoxically, as discussed in the following Allina Health Sys-
 2 tem case illustration, governing boards found themselves very much at the
 3 center of the controversy.

5 *The Allina Vision*

6 At its apex, Allina can be characterized as the leading example of an inte-
 7 grated delivery system to emerge in the 1990s, taking on many of the
 8 attributes associated with much more established examples of the genre such
 9 as Kaiser-Permanente. The boldness of the Allina vision was articulated by
 10 CEO Gordon Sprenger (1994, p. 135), who stated that “Moving from the
 11 old fee-for-service model is a major paradigm shift. To encourage our board
 12 to look not at occupancy, but at health outcomes, and to look at premium
 13 dollars, not how well their individual hospitals are doing is a major diffi-
 14 culty.”

15 The difficulty in governance to which he alludes resulted from the highly
 16 innovative and yet ultimately controversial decision to merge with the
 17 Medica health plan of the Twin Cities. That merger added 550,000 enrollees
 18 to the existing 250,000 Preferred Provider Organization lives already man-
 19 aged by Allina (Sprenger, 1994). With this merger Allina had brought all of
 20 the elements of the integrated delivery system model into place, uniting
 21 institutional services, professionals (though owned and affiliated medical
 22 groups), and an insurance organization in the form of a medical health plan
 23 under the control of a single board.

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

33

34 *The Subsequent Dissolution of the Integrated Board and Strategy*

35 The impetus to reconfigure the Allina organization and its governance
 36 structure in 2001 ostensibly resulted from the investigation of Minnesota
 37 Attorney General Michael Hatch into allegations of improprieties stemming
 38 from insufficient corporate governance oversight and control (Sweeney,
 39 2001). It is precisely these types of governance challenges in integrated deli-
 39 very systems, Pointer, Alexander, and Zuckerman (1997) identified earlier.

1 Lurking behind the stated reasons for the intervention was a difference of
3 opinion between the Attorney General and the Allina management regard-
5 ing public benefits of integrated delivery system as it existed. In particular,
7 the consolidation of the public delivery entity (Allina) and the for-profit
9 financing organization (Medica) under common governance was a point of
11 contention for the Attorney General (Geist, 2001). In the eyes of critics, the
13 centralization of these forces generated abnormal pricing and contacting
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 (Lotter-
man, 2001).

QA :4

QA :5

QA :6

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 ques-
tionable 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 organiza-
tions 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 trust-
ees considering bold CE innovations. As in the case of Attorney General
Spitzer’s investigations of nonprofits, New York, Attorney General Hatch’s

1 investigation was conducted under the authority of the state's nonprofit
2 statutes. These authorities granted to states' attorney generals under non-
3 profit statutes are emerging as an accepted justification for extending the
4 governance provisions of Sarbanes-Oxley to nonprofits (O'Brien & Spitzer,
5 2004).

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

12 It should be noted, however, that the creation of the central parent board
13 affects only the Allina delivery organization. The move by Allina to inte-
14 grate local boards to one health system board is consistent with current
15 practice in multi-hospital systems as a means of achieving uniformity in
16 governance policy and efficiency of management (Brown & Lerner, 1997).
17 This move toward centralized governance for the delivery organization is
18 still significantly diminished in contrast to the prior Allina single board that
19 oversaw the operations of both the delivery system and the Medica Health
20 Plan until its forced dissolution.
21

23

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

25

26 The *strategic renewal* form of CE refers to organizations whose entrepre-
27 neurial activities change the way the organization competes in its market-
28 place. Here the focus of organizational rejuvenation is on the firm itself, and
29 the focus of strategic renewal is on the interface of the organization with its
30 external environment as mediated by the corporate strategy. The strategic
31 renewal label has been used to describe a variety of phenomena in the
32 strategy literature. However, Covin and Miles (1999) reserve this designa-
33 tion for organizations whose new strategies represent significant departures
34 from past approaches leading to meaningful improvement in long-term
35 competitive advantage. Since the variety of strategies open to organizations
36 is nearly infinite, it is impossible to delineate a specific list of strategic
37 changes that would qualify as strategic renewal. Rather, in identifying strate-
38 gic renewal, one looks for deliberate strategic redirection that reenergizes
39 the organization and significantly improves competitive position in the
40 market or industry.

1 Although industry leaders at times must engage in strategic renewal to
2 ensure their positions, it is most often observed among organizations at-
3 tempting to improve their position or take over industry leadership. Stra-
4 tegic redirection is difficult for an organization to implement, so one would
5 expect that this form of CE would be undertaken less frequently than sus-
6 tained regeneration or organizational rejuvenation. One would also expect a
7 high level of governing board involvement in any major strategic redirection
8 decisions. The organization we have chosen to illustrate the strategic re-
9 newal form of CE is the University of Wisconsin Hospital and Clinics and
10 the divestiture and subsequent reacquisition of Unity Health Plan.

11 The health plan was formed in 1994 through the sale of the internally
12 owned and managed U-care HMO to Blue Cross/Blue Shield of Wisconsin.
13 Over the past decade the plan has grown to 76,000 members and has been
14 managed as a joint venture of Blue Cross/Blue Shield, University Health
15 Care, and the Community Health System consortium of rural hospitals and
16 physicians (University of Wisconsin Health System, 2004).

17 At the time of the initial 1994 transaction the sale of the fledgling HMO
18 was regarded as counterintuitive in the light of prevailing strategies to unify
19 delivery systems and financing vehicles. The sale preceded a 1995 significant
20 governance transformation at the University of Wisconsin–Madison in
21 which a new public benefit corporation undertook operation of the Uni-
22 versity Hospitals and Clinics and their subsidiary organizations from direct
23 state governance as an agency of the State of Wisconsin. Given the com-
24 plexity of the ownership and governance structures involving public and
25 private entities, it is surprising in retrospect that the 1994 transaction oc-
26 curred at all.

27 More surprising is the decision announced in June 2004 and executed on
28 January 1, 2005, to strategically renew the organization through the reac-
29 quisition of the 76,000 member Unity Health Plan from Blue Cross/Blue
30 Shield and its successor organization WellPoint. The transaction is pred-
31 icated on a provision in the 1994 transaction allowing the University of
32 Wisconsin to reacquire the Plan after 10 years should the joint venture
33 partners decide not to renew.

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

1 The transition of the ownership of Unity Health Plan is too recent an
2 event to allow the assessment of operating results. Interestingly, the per-
3 ceived advantage of this transaction is to allow the parent company, Uni-
4 versity Health Care, “to increase its focus on remaining directly involved in
5 decisions that impact the care of patients and their families” (Barnett, 2004).
6 Without the unique shared governance model of University Health Care as
7 a not-for-profit consisting of the University of Wisconsin Hospitals and
8 Clinics and also the University of Wisconsin Medical Foundation physicians
9 group, it is unlikely that such an integrative strategy would have been
10 adopted. Thus, a strategy that again appears to go against the now pre-
11 vailing pattern of health plan divestiture at prominent academic health sys-
12 tems, such as Duke and the University of Florida, is highly consistent with
13 the focus on organization–environment interface identified by Covin and
14 Miles (1999).

15 The Unity reacquisition could not have occurred without the restructur-
16 ing of governance to create the organizationally distinct University Health
17 Care entity and board. The execution of this strategy is made possible
18 through the existence of a governance mechanism that allows other than
19 public funds in completing this transaction. Viewed in this light, the influ-
20 ence of governance and the choices made possible or denied to organizations
21 through governance models in the public and private sectors are evident.
22 Flexibility in governance structure and practice is essential to the achieve-
23 ment of innovation.

25

26 *Case Example #3: Organizational Rejuvenation at Swedish Medical*
27 *Center*

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

1 Structurally, boards have created new subcommittees or revitalized old
2 ones' membership to increase financial reporting fidelity, focus on patient
3 safety, oversee executive compensation, etc. A fax poll conducted by The
4 Governance Institute in December 2002 (Bader, 2003) found that more than
5 80 percent of 103 responding hospitals and health systems have formed one
6 or more board committees to focus on quality-related responsibilities. With
7 respect to improved information flows, two tools many boards are adopting
8 are "dashboards" and "balanced scorecards" to provide comparative per-
9 formance measures of strategically important hospital processes.

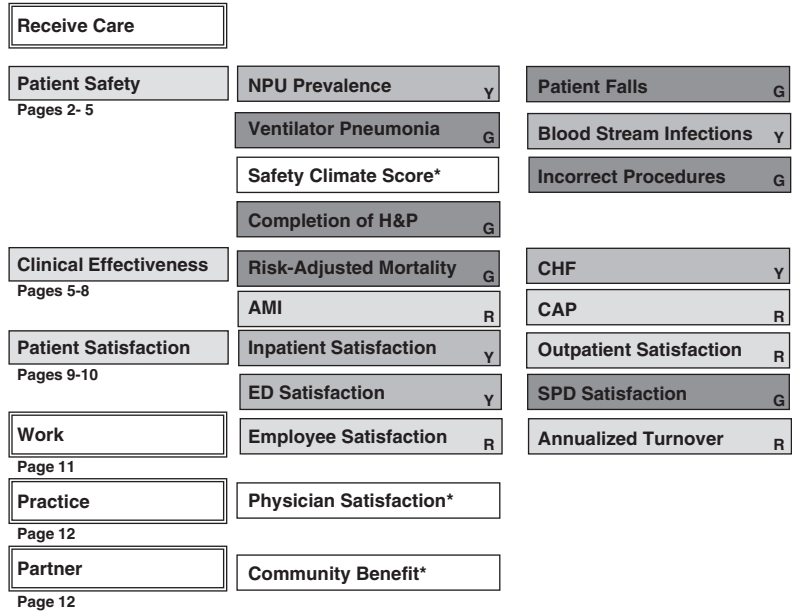
10 The Swedish Medical Center (SMC) in Seattle, Washington, provides a
11 good example of how a board approaches organizational rejuvenation as it
12 relates to quality improvement and patient safety. In 1998, the board re-
13 organized itself into five committees to upgrade its oversight capabilities.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

19 The first capability the board sought to increase was its own understand-
20 ing of patient safety, customer service, quality measurement issues, and
21 strategic control in hospital settings. At the beginning of each quality com-
22 mittee meeting, SMC's Quality Integration and Improvement Department
23 prepares training sessions using either in-house or external experts. Because
24 of the clinical and organizational complexity surrounding quality improve-
25 ment, the education process takes, "a sustained effort over several years
26 coupled with a regular flow of meaningful information in order to be effec-
27 tive" according to Dr. Judy Morton (SMC's Vice President of Quality In-
28 tegration and Improvement).

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

38 In addition to measuring the system's current performance, the dash-
39 board has a spotlight icon to indicate if the measure is not within the desired
40 range. For example, should the rate of nosocomial infections rise

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



25 **Appendix A: Action Triggers, Data Source and**
 27 **Contact Information**

Key:		Performance improving significantly over time or close to best
		Performance stable and/or approaching action trigger
		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.

33 *Fig. 1. Dashboard Example.*

35 significantly above the previous period’s rate or the allowable ceiling, either
 37 a yellow or red light will appear next to the item (see Fig. 1 for an example).
 39 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

1 plan in place that brings it back into compliance or achieves the new goal.”
2 To do this, the board identifies a “process owner” and empowers that person
3 to form an “action team” to investigate and address the problem. Despite these efforts and process changes, it took several years for them to
4 become integral to the board’s culture.

5 In 2003 at the annual retreat, SMC’s board and its corporate leaders had
6 a breakthrough in their thinking about the organizational rejuvenation
7 process and sought to codify each of their roles and more closely integrate
8 SMC’s clinical leadership in innovation processes. The board gave itself six
9 key roles that can be summarized as: (1) to understand the Seattle community’s
10 expectations of SMC; (2) to establish and monitor key metrics to meet those expectations; (3) to ensure that management develops strategic
11 plans congruent with improving those indicators; (4) to build the health
12 systems’ culture surrounding continuous improvement; (5) to consistently
13 demonstrate the board’s commitment to organizational rejuvenation; and
14 (6) to promote collaboration across the organization for improving care and
15 service quality. Collectively, these key roles provide a map to continual
16 improvement and rejuvenation based on the organization’s current strategies
17 and market position. The organizational rejuvenation can be contrasted with the sustained regeneration which seeks to fundamentally change
18 strategies on a continual basis.

23

24 *Case Example #4: Sustained Regeneration at SSM Health Care*

25

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

33 In sustained regeneration CE, entrepreneurial innovation is constant and
34 the systems and structures that support it permeate the entire organization.
35 Because of this, one would expect that control for this form of CE would fall

1 under the normal activities of the management team. While one would
2 expect the governing board to be kept apprised of the sustained regeneration
3 activities by management, one would not expect the board to be heavily
4 involved in their planning or control. The organization selected to illustrate
5 sustained regeneration is SSM Health Care (SSMHC) of St. Louis, Mis-
6 sissippi, sponsored by the Franciscan Sisters of Mary, one of the largest
7 Catholic systems in the U.S. The SSMHC system has more than 20 acute
8 and post-acute care facilities, a one-third interest in the Premier Medical
9 Insurance Group HMO, as well as numerous physician practices, ambulatory
10 care centers, and other health-related businesses, spread across four
11 states (Missouri, Illinois, Wisconsin, and Oklahoma).

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

25 Through the “framework, focus, and discipline” of the Baldrige process,
26 SSMHC has transformed its culture. “We have established system-wide
27 culture of sharing and replicating,” says Sr. Ryan (2004) that provides “a
28 climate in which leaders at all levels can emerge and thrive ... a climate in
29 which people are not afraid to take risks, even if those risks end in failure.”

30 Hand-in-hand with SSMHC’s success in improving patient care has come
31 increased market success. SSMHC St. Louis facilities have increased market
32 share at the expense of rival organizations (Recognized Best Practices, n.d.)
33 and net patient revenues for the system as a whole have steadily increased as
34 has its fund balance (Unaudited Financials, September 30, 2004; LPMG
35 LLC, 2004).

36 In 1999, SSMHC underwent an organizational and governance stream-
37 lining, bringing the entire system under a single parent corporation con-
38 trolling four regional corporations and paring the system’s legal entities
39 from 90 to 60 (SSMHC Family Tree, n.d.). The new corporate board has
responsibility for setting overall system direction and policy, while regional

1 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.
3 The corporate board’s goals are developed through its year-long Strategic,
Financial, and Human Resources Planning Process (Recognized Best Prac-
5 tices, n.d.). System-wide goals are communicated to the regions, facilities,
and departments using standardized forms and definitions to ensure align-
7 ment with the systems’ overall direction. Strategic goals are translated to the
employee level using individual “Passports,” a performance management
9 tool consisting of a card containing SSMHC mission and values along with
entity, departmental and personal goals, signed by the employee and his/her
11 manager (Passports, n.d.).

SSMHC’s dissatisfaction with the status quo, its relentless quest to im-
13 prove quality, and its culture and governance structure that foster organ-
izational learning all support continuous innovation in ways of serving
15 SSMHC patients that are the hallmarks of sustained regeneration CE.

17

19 **IMPLICATIONS FOR HEALTH CARE MANAGERS** 21 **AND BOARD MEMBERS**

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

33 This is a role that is often foreign to trustees of not-for-profit organi-
zations who view their role as first and foremost one of asset preservation in
35 the face of increased legal and public scrutiny of trustee performance. Or-
likoff (2005) has written that “The risk is that boards will become so con-
37 sumed by compliance with regulations, standards, legislation, and mandates
that they will be unable, or forget, to govern. This, plus fear of directors’
39 and officers’ liability, may motivate boards to become cautious, detail-ori-
ented plodders that lack the vision and willingness to take the risks

1 necessary to provide the real leadership that is so much needed in these
2 challenging times.” It is exactly this caution that is antithetical to the spirit
3 of entrepreneurship in organizations and the exercise of bold initiatives cited
4 in the case studies presented in our article.

5 Nonprofit health care organizations must develop educational approaches
6 to prepare their boards to be intelligent analyzers of risk rather than anchors
7 holding fast to the strategies and structures of the past, regardless of their
8 suitability for current marketplace conditions. In considering proposed in-
9 novations, organizational leaders can use the CE typology to evaluate the
10 nature and extent of proposed board involvement. The CE activity’s po-
11 sition in the typology can also provide valuable insights as to whether the
12 current board structure will allow for meaningful strategic control of that
13 innovation, or whether new board policies or structures will be necessary.
14 As outlined in Table 1, the level of board involvement declines. Finally, our
15 analysis highlights the additional risks to willingness to engage in entrepre-
16 neurial initiatives posed by application of Sarbanes–Oxley fiduciary respon-
17 sibilities on nonprofit health care boards.

18

19 **FUTURE RESEARCH AGENDAS**

20

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

1 For example, financial outcomes for organizations whose CE activities are
2 classified as domain redefinition, strategic renewal, organizational rejuve-
3 nation, or sustained regeneration could be compared.

4 A third area of research could focus on the application of readily available
5 research tools to the relationship of governance and entrepreneurship. For
6 example, through examination of the AHA’s annual survey of hospitals one
7 might track the creation or deletion of new services and the correlation of
8 such moves to changes in governance. One might also track changes in
9 organizational and board processes as new requirements such as independ-
10 ent audit committees are increasingly implemented. Does this lead to hos-
11 pitals foregoing opportunities to avoid external disapproval?

12 Finally, the question of whether Sarbanes–Oxley may inhibit health care
13 boards from pursuing CE innovations clearly warrants careful study from
14 both the practice and policy perspectives. The implementation of Sarbanes–
15 Oxley reforms is still in an early stage, and the consequences of these ini-
16 tiatives in the governance process will become more evident as their adop-
17 tion spreads.

19

NOTES

21

22 1. The authors thank Dr. Morton for providing first-hand insights into the SMC’s
23 experiences and reviewing an earlier version of this manuscript

25

ACKNOWLEDGMENTS

27

28 We thank W. Jack Duncan at the University of Alabama Birmingham,
29 James W. Begun at the University of Minnesota, and Judy Morton of the
30 Swedish Medical Center in Seattle, Washington for their input on earlier
31 versions of this manuscript.

33

REFERENCES

35

36 Ahuja, G., & Lampert, C. M. (2001). Entrepreneurship in the large corporation: A longitudinal
37 study of how established firms create breakthrough inventions. *Strategic Management
Journal*, 22(6/7), 521–543.

38 Bader, B. S. (2003). Best practices for board quality committees. *Great Boards*. 2004: Board-
39 room Briefing.

Barnett, J. (2004). *University Health Care to Purchase Unity*.

- 1 Begun, J. W., Zimmerman, B., et al. (2003). Health care organizations as complex adaptive
 2 systems. In: S. S. Mick & M. E. Wyttenbach (Eds), *Advances in health care organization* **QA :8**
 3 *theory*. San Francisco: Jossey-Bass.
- Bok, D. (2003). *Universities in the marketplace*. Princeton, NJ: Princeton University Press.
- 5 Brown, F., & Lerner, W. (1997). On governance and governing. Integrated delivery systems (pp.
 6 269–278). Chicago, IL: Health Administration Press. **QA :9**
- Burgelman, R. A. (1983). Corporate entrepreneurship and strategic management: Insights from
 7 a process study. *Management Science*, 29(12), 1349–1363.
- Burgelman, R. A. (1984). Designs for corporate entrepreneurship in established firms. *Cali-*
 8 *fornia Management Review*, 26(3), 154–166.
- 9 Chandler, A. D., Jr. (1962). *Strategy and structure: Chapters in the history of the American*
 10 *industrial enterprise*. Cambridge, MA: MIT Press.
- 11 Chiat, R. P. (2004). The problem with governance: Restoring board leadership will take a new
 12 model — and a new way of thinking. *The magazine for nonprofit boards and chief*
 13 *executives (Board Member Special Edition)*, 13(4), 6.
- Coelho, P. R. P., McClure, J. E., et al. (2003). The social responsibility of corporate man-
 14 agement: A classical critique. *Mid-American Journal of Business*, 18(1), 15.
- 15 Committee on Quality of Health Care in America. (2001). *Crossing the quality chasm: A new*
 16 *health system for the 21st century*. Washington, DC: National Academy Press.
- 17 Covin, J. G., & Miles, M. P. (1999). Corporate entrepreneurship and the pursuit of competitive
 18 advantage. *Entrepreneurship Theory and Practice*, 23(3), 47–63.
- 19 Culbertson, R., & Lee, P. R. (1996). Medicare and physician autonomy. *Health Care Financing*
 20 *Review*, 18(2), 115–130.
- 21 Darr, K. (2005). *Ethics in health services management*. Baltimore, MD: Health Professions
 22 Press.
- 23 Devers, K., Brewster, L., et al. (2003). Specialty hospitals: Focused factories or cream skim-
 24 mers? *Center for Studying Health System Change Issue Briefs* (No. 62).
- Drucker, P. (1990). *Managing the non-profit organization*. New York: Harper Collins.
- 25 Fottler, M. D., Blair, J. D., et al. (1989). Assessing key stakeholders: Who matters to hospitals
 26 and why? *Hospital & Health Services*, 34(4), 525–546.
- Francis, T., & Kosko, J. (2002). *NIST announces SSMHC wins MBNQA*. SSM Health Care
 27 Web Site, 2004.
- Friedson, E. (1994). *Professionalism Reborn: Theory, prophecy, and policy*. Chicago: University
 28 of Chicago Press.
- 29 Hamel, G., & Prahalad, C. K. (1994). *Competing for the future*. Boston: Harvard Business
 30 School Press.
- 31 Haugh, R. (2004). The ratings game: Finance agencies aren't wishing for better oversight by
 32 boards. They're demanding it. Hospitalconnect.com, Hospitals & Health Networks.
- 33 Howatt, G. (2001). *Hatch wrapping up probe, will not Sue Allina Execs*. Minneapolis, MN:
 34 Minneapolis Star Tribune.
- 35 Hymowitz, C. (2005). In Sarbanes–Oxley era, running a nonprofit is only getting Harder. *Wall*
 36 *Street Journal*, B1. **QA :10**
- 37 Kohn, L. T., & Corrigan, J. M., et al. (Eds) (2000). *To err is human: Building a safer health*
 38 *system*. Washington, DC: National Academy Press.
- 39 Lee, C., Lee, K., et al. (2001). Internal capabilities, external networks, and performance: A
 40 study on technology-based ventures. *Strategic Management Journal*, 22(6/7), 615–640.

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

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

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

6 Minneapolis Star and Tribune. (2004). *Allina plans to consolidate board to streamline govern-*
ance. Minneapolis, MN: Minneapolis Star and Tribune.

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

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

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

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

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

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

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

16 Ryan, S. M. J. (2004). *Calling forth the spirit of leadership: Pathway to organizational trans-*
 17 *formation*. Premier, Inc. Governance Education Conference, Scottsdale, Arizona.

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

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

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

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

23 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.

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

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

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

29 University of Wisconsin Health System. (2004). *University health care to purchase unity*. Mad-
 30 ison, WI: University of Wisconsin Health System.


31 Zahra, S. A. (1996). Governance, ownership, and corporate entrepreneurship: The moderating
 32 impact of industry technological opportunities. *Academy of Management Journal*, 39(6),
 33 1713–1735.

35

37

39

AUTHOR QUERY FORM

	Book : AHCM-V006	Please e-mail or fax your responses and any corrections to:
	Chapter : 6008	E-mail:
		Fax:

Dear Author,

During the preparation of your manuscript for typesetting, some questions may have arisen. These are listed below. Please check your typeset proof carefully and mark any corrections in the margin of the proof or compile them as a separate list*.

Disk use

Sometimes we are unable to process the electronic file of your article and/or artwork. If this is the case, we have proceeded by:

- Scanning (parts of) your article
 Rekeying (parts of) your article
 Scanning the artwork

Uncited references: This section comprises references that occur in the reference list but not in the body of the text. Please position each reference in the text or delete it. Any reference not dealt with will be retained in this section.

Queries and / or remarks

Location in Article	Query / remark	Response
AQ1	The reference "Weber, 1947" not listed in the reference list. Please check.	
AQ2	Please check if "Pointer, Alexander, and Zuckerman (1997)" is the same reference as "Pointer, Alexander, et al. (1997)".	
AQ3	The reference "Sweeney, 2001" not listed in the reference list. Please check if it is "Sweeney and Hammers, 2001".	
AQ4	The reference "Geist, 2001" not listed in the reference list. Please check.	
AQ5	The reference "Howatt, 2001a" not listed in the reference list. Please check.	
AQ6	The reference "Lotterman, 2001" not listed in the reference list. Please check.	
AQ7	In reference Barnett, J. (2004), please provide the complete details.	
AQ8	Please provide all authors name in following references: Begun et al (2003); Coelho et al. (2003); Devers et al. (2003); Fottler et al. (1989); Kohn et al. (2000); Lee et al. (2001); Pointer et al. (1997); Shortell et al. (1992).	
AQ9	In references Brown and Lerner (1997) and Pointer et al. (1997) please provide editors name.	
AQ10	In references Hymowitz (2005) and Sandrick (2003), please provide volume numbers.	

Thank you for your assistance