Executive Span of Control

Identifying the Optimal Structure

Please note: *Article has been updated to include the most recent data*

In today's increasingly complex health care environment, executives are responsible for driving performance aligned with a health system's mission, vision and values. Span of control, which is generally defined as the number of reports under a leader, should be periodically reviewed to ensure an effective and efficient management structure. Health systems strive to attain optimal span of control to ensure their front line staff have the appropriate amount of supervision, communication, training and performance management in place, while also seeking to optimize the cost of their operating model.

At the senior leadership level, span of control is vital and serves as an important measure of accountability for an executive. Having too many reports or lines of business to oversee can dilute strategic focus if executives become mired in day-to-day operations and compromise a manager's ability to effectively develop and grow talent. Conversely, having too few reports may be an indication of an inefficient management structure with potential duplication of responsibility and approval channels. This can affect the decision-making processes, slow down overall execution, and lead to excess costs.

Finding the optimal mix of management oversight can be challenging.

For this article, SullivanCotter analyzed span of control for more than 4,200 health system executives across different job families and reporting levels in order to identify the typical range of direct reports and help health systems assess their executive span of control structures.

This analysis is based on data from SullivanCotter's Workforce Metrics Benchmark database and represents more than 1,700,000 individuals from 92 not-for-profit health systems (comprising more than 1,400 individual/subsidiary hospitals, locations, and other operating entities) with an average net revenue of over $4.5 billion.

Note: Span of control is a complex and nuanced management topic. The purpose of this article is to provide a conceptual introduction, share key data and benchmarks from SullivanCotter's proprietary Workforce Metrics Benchmark database, highlight key strategies and considerations, and summarize the benefits that health systems can achieve from improving span of control. These benchmarks are aggregated across not-for-profit health care organizations with different operating models and strategic imperatives, and therefore should be used as a general point of reference rather than to create specific performance targets.

Range of Span of Control by Level

SullivanCotter evaluated span of control across four different executive-level roles consisting of Chief Executive Officers (CEOs), Entity CEOs (inluding Entity Presidents,) Executive Vice Presidents, Senior Vice Presidents and Vice Presidents. **Definitions of each role are included in the Appendix.**

Exhibit 1: Range of Span of Control
Number of Direct Reports by Level

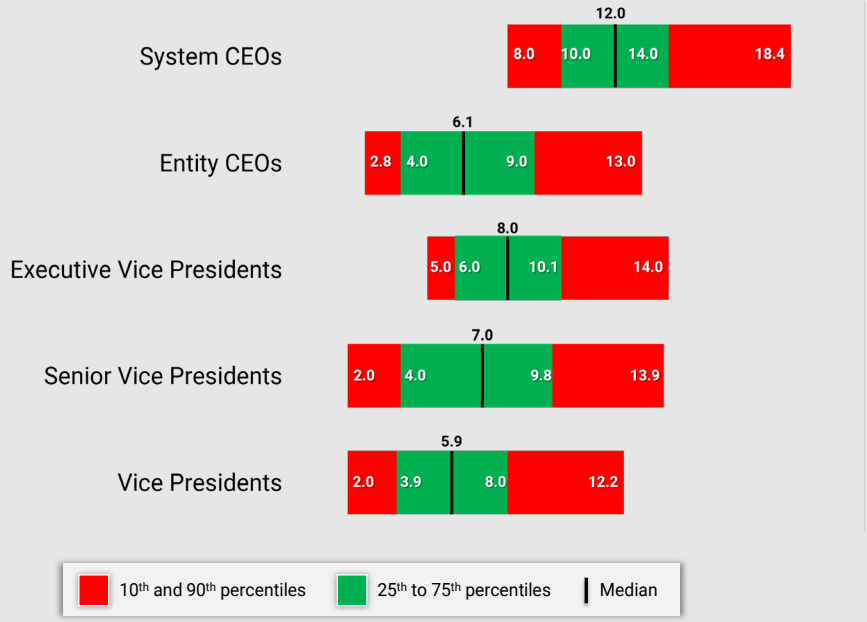


Exhibit 1 shows the range for the number of direct reports per executive. The green shading indicates the 25th to 75th percentiles, while the red shading indicates the 10th and 90th percentiles.

System CEOs and Presidents generally have 10 to 14 direct reports with a median of 12. As we move further down in the Executive ranks, this range tends to decrease. Having less than 4 or more than 10 direct reports for this group would suggest it may be appropriate to review the span of control.

While the number of direct reports is a fundamental component of an executive's scope of responsibility, it is not the only indicator. The combined number of direct and indirect reports (Total Reports) can help to demonstrate total accountability and can vary widely depending on number of functions overseen, organization size, and functional area. For this purpose, 'indirect reports' include all of the individuals who report through an executive's direct reports down the organization hierarchy.

For instance, when evaluating Vice Presidents in Nursing (which may include CNOs of affiliate entities) at smaller organizations (less than 5,000 FTEs), the data show that each VP oversees a median of 479 total direct and indirect reports. At larger organizations (over 25,000 FTEs), each Vice President in Nursing oversees a median of 415 total direct and indirect reports. Across most job families in the table below, the number of total reports decreases as organization size increases, with a few factors contributing to this pattern. In smaller organizations, some Vice Presidents might be the top executive and therefore have a much wider total span of control – reflecting accountability for the entire job family. Smaller organizations may also have fewer Vice Presidents for a given employee population – resulting in a wider total span of control. This is combined with certain Vice Presidents in larger organizations possibly having specific strategic or growth accountability that may not

include a corresponding increase in the number of total reports. This highlights the value of scale of an organization in supporting organizational efficiencies. Total reports can also vary by job family as there are more employees within the nursing and operational functions than we typically see in many of the administrative areas (e.g., Marketing, Legal, Human Resources, Finance).

Exhibit 2 below shows the median number of total reports for a Vice President incumbent for select job families by organization size.

Exhibit 2: Vice Presidents – Median Number of Total (Direct and Indirect) Reports
By Job Family and Organization Size

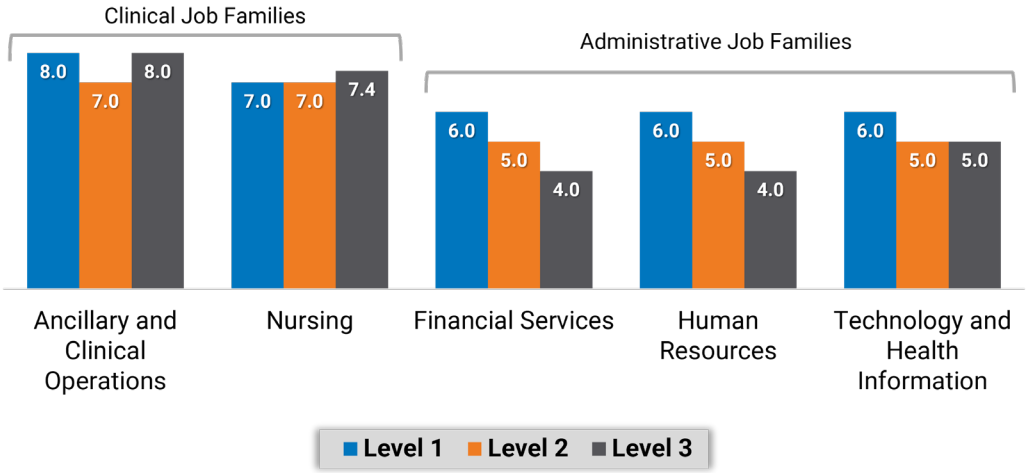
Job Family	Total Reports (<5,000 FTEs)	Total Reports (>25,000 FTEs)
Ancillary and Clinical Operations	252	292
Nursing	479	415
Financial Services	95	22
Human Resources	37	26
Technology and Health Information	82	72

Range of Span of Control by Job Family

SullivanCotter conducted additional research to analyze span of control by job family and each reporting level within that job family (i.e., the Top Executive of a specific job family at level 1, their direct reports at level 2, etc.). This analysis shows how span of control structure can vary across reporting levels for certain job families.

Exhibit 3: Median Direct Reports
By Job Family Reporting Level Within Each Family

Exhibit 3 above highlights the differences between Clinical and Administrative job families.



Explanation of the core functions within each job family is included in the Appendix.

Executives overseeing Nursing and Ancillary and Clinical Operations job families have a more consistent span of control with a median of 7 or 8 direct reports regardless of reporting level. Note that with inpatient nursing having a relatively larger number of employees, median direct span of control for level 2 and 3 nursing executives is the same at 7 to 8. Median span of control in Administrative job families looks different as top executives in Finance, Human Resources and Information Technology functions, for example, have 6 direct reports and the executives at the next two reporting levels have about 4 or 5 direct reports.

To assess the limits of span of control, SullivanCotter analyzed executives at levels combined across Clinical and Administrative job families. We consider typical span of control to fall between the 25th and 75th percentiles, with excessively narrow or wide span of control falling outside of that range. Health systems can use these benchmarks to identify individuals that fall below the 25th percentile or above the 75th percentile. Based on these data, executives in Administrative job families who have fewer than 3 direct reports may have a span of control that is more narrow than market norms. Conversely, executives in Clinical job families who have more than 11 direct reports may have a span of control that is wider than market norms. With inpatient nursing having a relatively larger number of employees, we have looked specifically at the range of data from the 75th percentile to 90th percentile for executives – which is 10 to 15 direct reports.

Exhibit 4 below identifies the number of directs reports that fall within these two categories.

Exhibit 4: Range of Span of Control
By Job Family

Job Family	Narrow Span (10^{th}-25^{th} percentiles)	Wide Span (75^{th}-90^{th} percentiles)
Clinical	3 to 5	11 to 16
Administrative	2 to 3	7 to 10

Strategies for Assessing and Redesigning Executive Span of Control

Improving span of control begins with a current state assessment to understand where the health system may deviate from leading practices. These steps include:

- **Identify a relevant peer group.** Consider the health system's size and operating model and utilize specific studies or industry surveys (such as SullivanCotter's Workforce Metrics Benchmark Survey) that contain benchmarks on span of control and management structures. Management consulting firms may also maintain databases and can develop customized comparative analyses.
- **Complete an overall span of control analysis across the enterprise.** Starting with an overall span

analysis may help to identify specific functions or entities that may have outlier data points for further review. Be sure to include both direct and indirect reports.

- **Conduct a more detailed span assessment for priority functions** such as certain clinical areas or functional support (e.g., revenue cycle, nursing). When conducting detailed analyses for certain clinical or functional support areas (e.g., revenue cycle, nursing), benchmarking against both peer and internal references (e.g., across individual hospitals or entities) is useful in providing additional context. Health systems should also pay attention to individual management incumbents that may be outliers (having many more or less direct reports) compared to benchmarks or to other managers in comparable roles. In particular, management individuals that have no direct reports should be assessed as a priority area for appropriate scope of accountability.
- **Identify priority areas for improvement.** Data-driven insight can help to identify opportunities for improvement. Unique functional nuances or operating models can have an impact on management scope and health systems should consider specific operational characteristics that may contribute to certain individuals having a higher or lower than expected span of control.

In order to right-size executive span of control, there are several key strategies health systems can consider to help facilitate this process:

- **Consolidate functional areas (such as the development of Shared Services).** For health systems that may have a narrow executive span of control, the consolidation of responsibility under fewer executives can help to widen these. It is important to consider the operational and strategic implications of consolidating or redistributing functional areas and to be deliberate about how similar functions should be grouped together under specific executives.
- **Eliminate unnecessary levels.** Some health systems may discover that narrow spans of control are the result of too many layers of management. Eliminating a layer can allow for wider span of control while also reducing the number of individuals involved in decision-making and team communication. This, in turn, can help to increase operational efficiency. The optimal number of layers may differ by job family or functional area. Health systems should retain flexibility in their organizational structure to enable customization rather than attempting a 'one-size-fits-all' approach.
- **Redistribute functional oversight.** Certain sub-functions may be assigned to a different executive who has a more narrow span of control to help balance out the ratio of direct reports. In doing this, it is important to balance the number of direct reports across all executives so as not to simply transfer a wide span of control from one executive to another.
- **Increase the level of intermediate leadership.** Executives with an overly wide span of control may need to add leadership layers in order to spread their scope of responsibility. This does not always

mean adding headcount and labor cost. They may choose to elevate one or more of their direct reports and have a handful of functional areas within their scope of responsibility report to this individual instead.

- **Re-evaluate total rewards.** As individuals are reassigned to different levels, assess their total rewards package to ensure equity across levels. In addition to evaluating market competitive pay based on updated job responsibilities, other total rewards components such as incentive targets, paid time off and benefits eligibility should also be considered.

As health systems select and prioritize these strategies to refine span of control, there are a number of additional considerations to keep in mind:

- **Improving span of control is not just about reducing management headcount. S**pan of control can also influence and impact other aspects of work such as safety, employee engagement, turnover and talent management/professional development. While wider spans of control are considered an industry-leading practice, unnecessarily wide spans of control can be linked to lower employee engagement as oversight gets diluted, leading to reduced talent development and career growth.
- **While a typical span of control metric involves calculating the ratio of managers to direct reports, health systems should not be focused solely on achieving a target metric.** Organization structure needs to be considered in the design of a function to help ensure that the right roles at the right levels are put in place to execute on the operating model. Having the right reporting relationships and management layers in place can also aid with career pathways and succession planning.
- **Evolving workforce dynamics also make span of control about much more than the number of managers and staff.** Health care span of control ratios have historically been measured on direct in-person supervisory relationships. However, health systems are growing increasingly complex as matrixed reporting and dyad management models become more prevalent. With increased outsourcing, contracted services may not show up under a manager's official direct reporting. However, these responsibilities still need to be accounted for. The growth of the remote workforce may also impact how we approach people management. While less time may be spent on in-person supervision, health systems are investing in ways to connect more meaningfully and effectively with their employees - which requires sufficient management capacity to execute.

Positive Outcomes

A number of benefits associated with rightsizing span of control have been discussed in this article. The following diagram recaps some of these positive outcomes that health systems have achieved.

Streamlined Decision Making Health systems with efficient management structures can come to conclusions more quickly and move on to execution and implementation as fewer individuals are involved in the decision-making process.	**Efficient Communications** Health systems that streamline management layers find that certain types of information, especially when communicated verbally, flows from senior leaders to staff much faster when less interim levels of management need to receive and in turn pass on those communications.	**Stronger Talent Development** With the appropriate reporting relationships and manager-to-staff ratios customized for each function, employees can build strong coaching and development ties with their managers. These structures also facilitate succession planning as employees are well positioned to develop into future leaders.
Greater Operational Efficiencies Health systems that streamline through consolidation of functions have realized benefits in operational efficiencies such as shared staffing, common data sources, increased interaction and collaboration that drives towards common results.	**Improved Clinical and Staffing Outcomes** Health systems should avoid overly high span of control as that can be linked with lower employee engagement and poor adherence to work standards due to limited managerial investment and day-to-day oversight. In clinical settings, research has shown that a greater span of control can correlate with higher rates of patient infection, employee injuries and staff turnover.[1]	**Labor Cost Control** Improvements in span of control are not only about headcount reductions. While some health systems have realized labor cost savings through position eliminations when streamlining their management structure, others have been able to focus on other changes such as shifting positions from VP levels to director levels to prevent a "top heavy" organization structure.

[1]Omery, A., Crawford, C.L., Dechairo-Marino, A., Quaye, B.S., Finkelstein, J. (2019). Reexamining the Nurse Manager Span of Control with a 21st-Century Lens. Nursing Administration Quarterly, 43(12), 230-245. doi:10.1097/NAQ.0000000000000351

Conclusion

The data show that spans of control vary significantly among different operations and functional support areas as well as by executive level. As health systems evaluate their leadership structures, differentiated spans of control should be applied for various cohorts of leaders. Robust benchmark data provide an important reference as health systems determine the optimal spans of control.

Span of control is one aspect to consider when evaluating the ideal management oversight model and should not be reviewed in isolation without other performance metrics. Department leaders must still be accountable for achieving their expected outcomes and quality measures.

So while health systems may set targets for executive oversight, they must not become fixated on achieving a specific numerical ratio and lose sight of the overarching goal of balancing the need for senior leaders to focus on strategy and growth while also effectively leading their functions to achieve these goals.

APPENDIX

Executive Level Job Definitions

Enterprise Chief Executive Officers (CEOs) – Associates mapped to this level are the enterprise chief executive reporting to the Board of Directors.
Entity CEOs and Presidents – Associates mapped to this level typically have overall responsibility for a distinct organizational entity.
Executive Vice Presidents – Associates mapped to this level are typically managers of one or more Senior Vice President subordinates. Typically has responsibility for multiple job families and is found at the second reporting level in the organization. Within SullivanCotter's standard titling structure jobs found at this level are typically referred to as "Executive Vice President" or "EVP, Chief Officer".
Senior Vice President – Associates mapped to this level are typically managers of one or more Vice President subordinates. Typically has responsibility for one job family and is found at the second or third reporting level in the organization. Within SullivanCotter's standard titling structure jobs found at this level are typically referred to as "Senior Vice President" or "SVP, Chief Officer".
Vice President – Associates mapped to this level are typically third level managers of one or more Director subordinates. Typically has responsibility for multiple functional areas and is often found at the third, fourth or fifth reporting level in the organization. Within SullivanCotter's standard titling structure jobs found at this level are typically referred to as "Vice President" or "VP, Chief Officer".

Select Core Functions within Clinical and Administrative Job Families

Clinical	Administrative
Ancillary and Clinical Operations includes executives in behavioral and mental health, laboratory, pharmacy and rehabilitation, as well as executives that oversee hospital operations such as the COO and VP of Operations. **Nursing** includes executives in care management, inpatient and outpatient nursing, surgical services, transitional care, clinical education, emergency medical services and women's health.	**Financial Services** includes executives in functions such as financial administration, tax, audit, planning and analysis, managed care financing, revenue cycle, treasury and investments. **Human Resources** includes executives in functions such as diversity and inclusion, employee and labor relations, organizational development, HR operations, leadership and workforce development, talent acquisition and total rewards. **Information Technology (IT) and Health Information** includes executives in functions such as IT administration, health information management, IT security, instructional and learning technology, network and infrastructure management, programming and systems development and web services.

Note: As the purpose of this article was to evaluate select job families for conceptual illustration, not every job family or function was analyzed. Examples of other job families not included in the analysis are dietary, housekeeping, maintenance, supply chain, service lines and medical group operations (though ambulatory/outpatient nursing executives are included in Nursing).