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# Why Health Systems Need a Stronger Organizing Blueprint

By Tim Pang, Principal

Health systems are under pressure to improve performance and reduce complexity while also expanding access and adapting to shifting care delivery models. Many are simultaneously evaluating how technology, analytics, and AI can help transform clinical and operational performance. But before health systems can scale new capabilities or improve how work gets done, they need a clear answer to a foundational operating model question:

**How should work be organized across the enterprise?**


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## A critical component of the broader operating model

The organizing blueprint addresses this pivotal question. It is one of seven interconnected elements of a high-performing health system operating model. A complete operating model also includes services and capabilities, roles and accountabilities, governance and decision rights, structure, behavioral norms and culture, and workforce strategy. Each element matters. Together, they define how a health system translates strategy into consistent execution.

More specifically, the organizing blueprint determines how the health system is structured for efficiency and scale – including what gets centralized or decentralized, how workflows and processes are coordinated across the enterprise, and where enabling technology can amplify that design. This blueprint can help health systems reduce fragmentation, improve scalability, clarify where work should sit, and create conditions for better execution.

For health systems navigating financial pressure, workforce shortages, ambulatory migration, technology disruption, and rising expectations for access and outcomes, the deeper question is not simply how the organization should be structured. It is how work should be organized to support strategy, scale capabilities, and deliver consistent performance over time.

## Health systems are often organized by history, not strategy

In many health systems, work has accumulated over time through acquisitions, local adaptations, leadership preferences, and one-off operational decisions. Functions that should operate as enterprise capabilities may become fragmented across entities. Teams may perform similar work in different ways. Decisions may slow down because no one is fully clear on who has the authority to make them.

Getting the organizing blueprint right requires health system leaders to make deliberate choices about where standardization creates value and where flexibility and autonomy is clinically or operationally necessary. Not all processes merit the same approach. High-volume, protocol-driven activities such as surgical pre-authorization, discharge planning workflows, supply chain requisitioning, and revenue cycle processing could be strong candidates for standardization. In these situations, consistency can drive both efficiency and quality. On the other hand, complex care pathways for high-acuity patients or programs serving unique patient populations may require a level of local clinical judgment and adaptability.

A well-designed operating model makes this distinction clear by identifying which processes

The organizing blueprint must be designed as part of the broader operating model. Here's why:

| IF | | THEN |
|---|---|---|
| Roles and accountabilities remain unclear | → | Decision-making will still slow down |
| Governance forums are not designed to resolve the right issues at the right level | → | Work will continue to escalate unnecessarily |
| Cultural norms continue to reward local optimization over enterprise performance | → | Standardization efforts may stall |
| Workforce strategy does not align with the future-state model | → | The organization may not have the roles, skills, or labor mix needed to sustain the change |


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should be standardized system-wide, which should be defined at the service line or entity level, and which should remain at the discretion of clinical teams. Over-standardization erodes clinical quality and workforce engagement, while under-standardization leaves too much variation and may result in significantly higher operational costs. The organizing blueprint helps leaders make those choices deliberately, rather than allowing legacy structures, local preferences, or historical workarounds to define how the system operates.

## Technology should amplify the blueprint, not compensate for fragmentation

When these distinctions are clear, technology can be better leveraged. For example, electronic health record optimization, advanced analytics, and AI-assisted workflows can amplify standardized processes. But if they are layered onto fragmented processes, the results may be sub-optimal and possibly at a higher cost. Technology investments should directly support strategic priorities rather than simply being aimed at providing the latest software and systems that end up adding cost and complexity.

A strong organizing blueprint creates the operating logic that allows technology to scale by:

- Clarifying which workflows should be consistent
- Identifying where data infrastructure is needed
- Defining which decisions require enterprise visibility
- Determining where local adaptation is necessary

In this way, technology becomes an accelerator of organizational performance – extending the blueprint's effectiveness and enabling sustainable transformation at scale.

## AI readiness is an operating model question

Health systems are grappling with margin compression, workforce volatility, and the transformative promise of AI. These pressures demand an organizational model capable of absorbing disruption and executing at speed. Health systems that design their operating models for clarity, consistency, and scale will be better positioned to deploy AI where it matters.

AI adoption is not simply about access to technology. It is about organizational readiness, which is a direct product of how the operating model is designed. Each of the seven operating model elements carries implications for AI enablement.

Processes and workflows must be designed around AI-assisted decision support rather than retrofitted with AI after the fact. Governance and decision rights must establish who holds accountability for AI-enabled decisions, how model performance is monitored, and what oversight mechanisms ensure clinical and ethical integrity. Roles and accountabilities must evolve to reflect a new division of labor between human judgment, authority, leadership, and machine-assisted intelligence. This does not always equate to eliminating or reducing roles, but instead it is about redefining what clinicians, administrators, and executives are accountable for in an AI-augmented environment.

Health systems that address these considerations during the design phase are significantly better positioned to deploy AI at scale than those that wait until implementation to consider them.

Practically, this means design teams must identify the clinical and operational domains where AI has the greatest near-term potential to shift performance. This could be in areas such as clinical documentation, prior authorization, revenue cycle


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automation, demand forecasting, early warning systems for patient deterioration, and population health risk identification. Organizations then build the enabling conditions for those applications into the operating model itself. It requires decisions about data governance architecture, the capabilities and capacity of the workforce that will operate AI-enabled workflows, the leadership accountabilities for sustaining performance over time, and the cultural norms that will determine the degree to which clinicians and leadership trust and act on AI-generated insights.

Health systems should not treat AI as a capability to be built on top of the future-state operating model. Instead, they need to approach operating model redesign with AI enablement as an explicit design criterion. It should be built into process flows, governance structures, workforce planning, and leadership accountabilities from the outset, better enabling organizations to convert AI's clinical and operational potential into sustained, measurable performance improvement.

## Build for scale, organize work around strategy

Health systems cannot design only for the current state. The organizing blueprint should anticipate future growth, acquisitions, market expansion, ambulatory migration, and shifts in care delivery. Otherwise, the model may not be able to absorb the next acquisition, market expansion, or shift in care delivery without requiring another redesign.

A blueprint built for scale defines the conditions under which work should move from distributed to centralized. It establishes common platforms, performance standards, and integration mechanisms that allow the enterprise to operate coherently across hospitals, service lines, ambulatory settings, and shared functions – which is particularly important for health systems that have grown through acquisition. Without a clear organizing logic, the system may just become larger without becoming more integrated.

A strong organizing blueprint gives health systems a clearer way to determine where work should sit, how capabilities should scale, and how the enterprise should operate across its component parts. By moving beyond legacy structures and one-off decisions, leaders can create a more deliberate model for organizing work around strategy and sustaining execution over time.

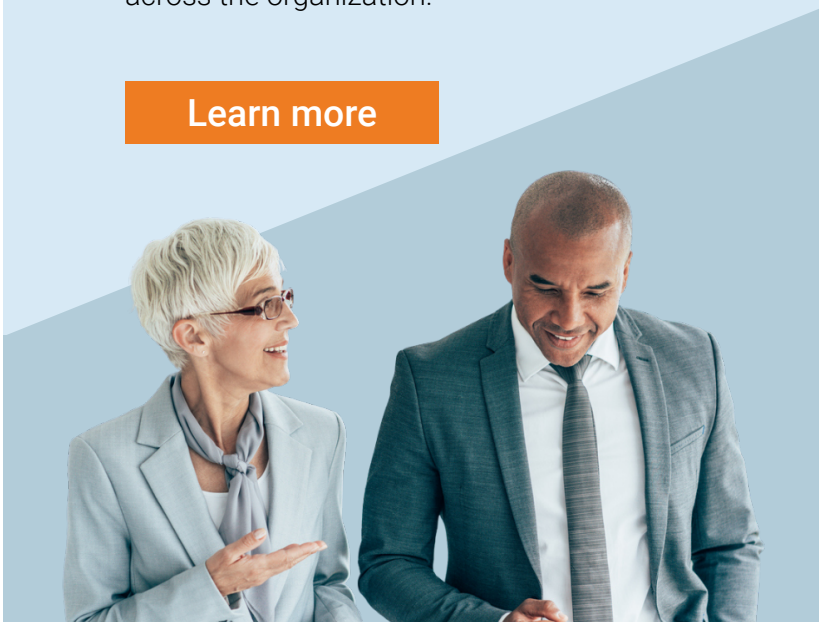
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