New Alignment for IT in an Era of Rapid Change

December 8, 2020 | Virtual Event
EXECUTIVE SUMMARY

The Scottsdale Institute convened 25 chief information officers for a CIO Virtual Summit on December 8, 2020, to discuss how a new social pact between health systems and the public is emerging as a result of the COVID-19 pandemic, the economic downturn and the incoming administration in Washington, D.C. The CIOs also addressed how the need for speed is shaping IT’s role in the health system as well as how the CIO’s role has developed quickly into a key operational business executive. Talking points included how:

- The CIO role has changed, with COVID almost “giving permission” to align and move more quickly when needed;
- The recent election revealed massive divisions and fissures in our public health infrastructure, but ultimately value-based care and digital scalability will be critical for health system success and consumer health;
- The healthcare business model for the next five years is a moving target, but primary impetuses to change must include consumer engagement choice, financial sustainability and reimagining the care delivery model; and
- “Lead for Speed” redefines the pace of change in healthcare, where decisiveness, collaboration and trust break down silos, empower teams and provide lasting direction.
SUMMIT PARTICIPANTS

Scott Arnold, EVP & CIO, Tampa General Hospital
Carrie Damon, SVP & CIO, Centura Health
Robert Eardley, SVP & CIO, University Hospitals Cleveland
Brandon Gockley, VP, Technology Services, Mosaic Life Care
Ash Goel, MD, SVP & CIO, Bronson Healthcare
Cherodeep Goswami, CIO, UW Health
Marianne James, SVP, IS & CIO, Cincinnati Children’s Hospital Medical Center
Tricia Julian, CIO, Baptist Health
Paul Keckley, PhD, Managing Editor, The Keckley Report & Healthcare Industry Analyst
Clark Kegley, AVP, IS, Scripps Health
Hans Keil, SVP & CIO, Beaumont Health
Doug King, SVP & CIO, Northwestern Medicine
Ed Kopetsky, CIO, Stanford Children’s Health
Dave Lundal, CIO, Children’s Minnesota
Jon Manis, SVP & CIO, CHRISTUS Health
Heather Nelson, SVP & CIO, University of Chicago Medicine
Geoffrey Patterson, CIO, North Region & VP, Clinical Transformation, Henry Ford Health System
Craig Richardville, SVP & Chief Information & Digital Officer, SCL Health
Andrew Rosenberg, MD, CIO, Michigan Medicine
Jon Russell, SVP & CIO, MultiCare Health System
Tim Thompson, SVP, & CIO, BayCare Health System
Joel Vengco, SVP & CIO, Baystate Health
Ellen Wiegand, VP & CIO, Virginia Mason Medical Center
Laishy Williams-Carlson, CIO, Bon Secours Mercy Health
Eric Yablonka, CIO and Associate Dean, Stanford Health Care and School of Medicine

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Impact Advisors: Andy Smith, Pete Smith, Todd Hollowell, Lydon Neumann, Dan Golder
Moderator: Lydon Neumann
Writer: Dan Golder
Introduction

The group felt that IT’s agility of response to the COVID crisis will stand as one of the most lasting and effective evolutionary changes to healthcare IT going forward. The ability to shift decision-making to a higher speed while becoming more agile was a common thread of discussion among attendees.

Dave Lundal, CIO, Children’s Minnesota, noted, “What we learned is that we’re good in a crisis. All the extraneous stuff in the organization simply fell away. We made decisions fast, and our focus was intense. Everything was very visible, and we had exceptional organizational support.”

IT became more collaborative, said Geoffrey Patterson, CIO at the Henry Ford Health System. “We had to make changes overnight. We had to create ICU beds out of ORs and make many changes that would normally take much more time. IT responded well and became a trusted partner. And now, with a second wave of COVID, we’re finding we can make changes even faster.”

Clark Kegley, AVP, IS, Scripps Health, agreed. “The ability existed for us to be nimble for a long time, but what changed was having a thoughtful analysis surrounding our large project portfolio. We put things into two buckets—‘essential’ and ‘non-essential.’ This freed up time by identifying those non-essential items and allowing us to harness and release needed resources. Consequently, we saw a shift in being able to now leverage our own expertise, rather than simply falling back on external resources which we might have done in the past.”

CHANGED CIO ROLE

The conversation shifted as the CIOs debated whether this new speed and agility would indelibly change their role and how IT provides services. Laishy Williams-Carlson, CIO, Bon Secours Mercy Health, suggested it would. “What we experienced was that our organization changed. With COVID we had perfect alignment on agendas. Historically our team had to manage competing operational priorities, but, boy, can you go fast when you’re aligned. COVID allowed us—and essentially gave us permission—to move quickly. The question now is whether our organization will pivot back to the complexities of managing competing agendas.”
Robert Eardley, SVP & CIO, University Hospitals Cleveland agreed. “That was our experience as well. IT was historically centralized, with an overlay of system leadership. With COVID we morphed—we unified command at a system level. We met four times a day and made decisions quickly. IT then had one voice to speak to a unified command, and consequently it became easy to be responsive in the moment.”

“Centralized Corporate Command Emerged Quickly”

“We are similar to Robert—our surge was massive in Ann Arbor,” said Andrew Rosenberg, MD, CIO, Michigan Medicine. “As it dissipated, we tried to leverage the lessons we learned during the lull before we expected a resurgence. We saw the benefits of command and control, and the need to make rapid decisions—so we kept that mindset, we maintained huddles and have now (with a resurgence in cases) reverted back to ‘command and control.’ The key question now is, how do we take these lessons and apply them in the future?”

“I could not be more pleased or proud of the IT response to COVID. Many historical obstacles fell away, and we increased both speed and agility. With telehealth, remote monitoring and virtual consultations, we enabled and supported the provision of care. We were also instrumental in enabling a virtual workforce and establishing virtual connections between isolated COVID patients and their loved ones,” added Jon Manis, SVP & CIO, CHRISTUS Health. “These tools and technologies already existed, but we were able to fast-track implementations as organizational and political barriers fell away in response to the pandemic. However, as an industry, we may have missed an important opportunity: Certainly, we did ‘faster and better,’ but we didn’t do things differently. We didn’t really redesign the care model for a consumer-centric future. The pressure (and danger) for our industry will be to revert to the old status quo. Now, given the benefit of all we have just learned, we need to rethink care delivery in the digital age.”
CIOS ARE DIRECTLY INVOLVED IN THE REDESIGN OF DIGITAL CARE

“We’ve made a number of no-to-low-touch tools that we’ve put in the hands of patients as a result of COVID, and I think we will continue to create new ways to engage patients moving forward,” said Craig Richardville, SVP & Chief Information & Digital Officer, SCL Health. “Staff may want to return to in-person care but there are risks, so staff are now asking ‘How can I serve a patient without being hands-on?’ We’re now starting to bring these services into the acute care space—how can we design an in-home experience for a patient, even if he or she is isolated in a room? How do we make them feel more comfortable?”

The New Social Pact for Health Systems and the Public

Paul Keckley, PhD, Managing Editor, The Keckley Report, provided an inside-the-Beltway perspective on the recent presidential election, its impact generally and for healthcare 2021 and beyond.

“The election was not what anyone expected—it was not a blue wave, not a red wave—but it did highlight the bifurcation and massive divisions in society between the ‘haves’ and the ‘have-nots’ in our economy. Those invested in the stock market are doing well, and the rest are not—and the number that are not is growing faster than the number that are.

“Biden’s proposed appointments may also be portending his direction—Xavier Becerra [proposed HHS Secretary] is a fierce defender of the Affordable Care Act,” he said. “Biden said that he’d navigate healthcare to the center—he’ll expand the subsidy, raise taxes on those earning over $400,000 per year, and he’s against consolidation of hospitals (which have resulted in higher rather than lower costs). Hospital mergers have paradoxically not improved quality—instead they have strengthened the bargaining power of health plans and raised healthcare costs.”
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HOW MUCH CHANGE AHEAD?

However, are special interests like Big Pharma too entrenched to expect change?

“We expect the drug pricing benefits promoted by Trump are likely to remain in place with Biden. Yet we have to recognize that Pharma has a significant influence on Congress, and likely little will get done. There are structural impediments that exist to hamper any significant changes to the pharmaceutical industry. For example, we have recently approved 49 specialty drugs—this means they are protected by patents, will be expensive and will be controlled by pharma; this is simply the nature of structural power that pharma enjoys. There may be some changes around the edges, but significant change is unlikely,” asserted Keckley.

“Similarly, the Hospital Price Transparency promoted by Trump that begins in January 2021, where hospitals are required to post their cost and pricing data for 300 ‘shoppable services,’ has historically done nothing. Fewer than two percent of patients have been shown to pay attention to these tools,” he said. “The question here is whether Biden will reverse this executive order. He could also simply disregard it, or potentially delay its implementation. Remember, historically, every administration puts out 200 or so executive orders, and the next administration then ‘cherry picks’ ones they like and ignores those they don’t, and that’s what we’re expecting here.”

VALUE-BASED CARE FOCUS FOR INCOMING ADMINISTRATION

There’s a common thread (in terms of healthcare appointments): What’s the future of value-based care? “CMS also may become more federalized, with more federal control. Trump let the governors deal with Medicaid. Biden may rely less on the states and move CMS to have more federal oversight. Currently 39 states subcontract to private entities to manage their Medicaid populations, and getting access to data from those private companies is difficult. This will be a key issue for Biden.”
Shifting to the federal deficit, Keckley said, “Every administration has added to the deficit other than Clinton. Trump has added $3 trillion from his tax cut and job act, which reduced tax rates. He’s given every company more profit, and that’s accrued to large-cap companies. Healthcare is now driven by big companies and investors. Pharma is investor-owned, and our economy is showing that additional deficit is not sustainable. Our economy is forecast to be down 3.7 percent this coming year. If you think about it, our debt-to-equity ratio is 3:2. We have to do something unless our economic growth is off the charts; our GDP needs to grow by 5 percent and that’s not going to happen. The economy is going to be down 6 percent for the first half of next year. The jobs aren’t coming back,” he declared.

“This is reflected in the ‘K’ economy: The have-nots, including seven million healthcare workers, will have more issues. We need to prop up the underserved—43 percent will face problems paying bills—and we need to find money for this elsewhere. The Epics and Cerners will see tougher sledding going forward,” predicted Keckley.

“So, the question now becomes, how do you recover and bring back normalcy? We now have to look to the mid-term election in 2022. Remember, Clinton’s first mid-term election resulted in the loss of 54 seats, and Obama lost 63 seats in 2010.

There’s a tension that permeates American politics: “Joe Six-Pack believes that more divided government is better. He doesn’t want any political party to go crazy, so the trend will be to want to limit government. Yet, if you want to pass meaningful legislation—transformational change that might make sense—that is not going to happen with divided government.” Such transformational change now is possible with the Democrats controlling the House and Senate.
THE QUEST FOR SCALE

Keckley shifted the focus to the challenges with health-system M&As. “Scale is key to health systems’ success; larger organizations have an advantage. They have access to capital that smaller organizations simply don’t. We lost 130 hospitals this year, and that number will continue to increase. State legislators will nip around the fringes in the nonprofit space. They’ll start looking at things like requiring disclosures beyond 990s, executive compensation and perks, and will want to demonstrate that consolidation can actually lower cost.”

He said increased transparency is going to be required. “The hospital industry is not in favor among elected officials. COVID had an impact, and the acute sector won’t be riding a tail of goodwill as a result. For most—those 43 percent struggling to pay bills, including in many cases hospital bills, and those getting collection letters—those people will continue to be reminded of financial benefits afforded to the healthcare system versus benefits on behalf of the public and public health.”

WARINESS AROUND VACCINE DISTRIBUTION OVERHYPE

Private equity will play a big role in what health systems look like in the near future.

“So, we can expect further consolidation and M&A activity. Remember, private equity is flush and can cherry-pick—there is plenty of cash available to pick hospitals and create leaner models. What’s interesting is that vertical consolidation hasn’t faced the same challenges as horizontal consolidation and, in fact, vertical consolidation is encouraged by the law. Capitated plans (such as Medicare Advantage) save about one in five dollars spent in Medicare, and people are thinking that maybe we need to get in the business of whole person care, and that perhaps we need to own or co-sponsor a plan, and indeed Medicaid may be going this way as well.

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Additionally, the market is killing not-for-profit hospitals, and these may effectively become public utilities under Biden. Remember: We have experienced a shift in healthcare recently towards outsourced or contracted services. We began with a first wave where we outsourced things like environmental and dietary services. The second wave saw revenue cycle and procurement being outsourced, and now the third wave will likely be looking at outsourcing of clinical care and other ‘mission critical’ programs—clinical, risk management, compliance. How we look at healthcare services is going to continue to evolve.

M&As will have to pass a public-benefit test, Keckley explained. “People will begin asking whether a merger is in the benefit of community. This is going to be revisited. Right now, there are 37 states with CONs in place, and yet evidence shows us that CONs offer no benefit in helping to reduce duplication of services and lower costs... and that’s the whole reason for having CONs. We likely may see this revisited; Biden may force more of this to the fore and may take some of the autonomy of the states back to the federal government.”

Lundal asked about market disruptors like CVS and Walgreens, and whether Keckley thought Amazon and others will force us to be more aggressive as they are coming after our business? In response, Keckley posed an existential question: What is our business? “Why does United or Aetna or Google need an inpatient capability when they can simply buy it on the spot market as we have excess capacity? Hospitals will soon contract with others to provide services; boards will need to step back and consider these market forces and ask some hard questions—will we eventually be a commodity? How do we become a viable subcontractor?”

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He concluded with a sobering thought. “Remember, we feel that we’re large organizations and can dictate terms with payers and others and, yes, relative scale is an advantage. Yet when we compare ourselves to Amazon, Google and others, we give up scale; we’re simply not at a size where we can compete with them, and this is something we have yet to fully realize.”

Factors Driving the Pace of Healthcare Going Forward

On this front, most CIOs cited the factor of internal pressure to redefine care.

“The key question for us is what business model are we chasing? Historically for us it was to procure enough margin to promote our academic mission,” said Robert Eardley. “Now we’re asking what the new model is for the next five years, and it’s still undefined. Is it retail medicine, digital or something else?”

Manis offered a different perspective. “Pressure to redesign care is critically important. But the primary impetuses for change are consumer choice and financial sustainability. Can we provide a safe, secure and high-quality clinical outcome at value as defined by consumers? Can we improve the experience of those seeking our services? Do we have the ability to remain financially viable in a value- and service-based competitive environment?” he asked. “The truth is, we continue to be divided and conquered by new entrants into the healthcare marketplace. These new competitors are digital natives, leveraging consumer preference data. They have a service mindset and a passion for customer service. And they are only interested in capturing low-risk/high-margin health and wellness services. They are perfectly content to leave traditional health systems with the high-risk/low-margin services, such as ICU, critical care, complex surgeries, those with significant comorbidities and those at the end of life.”

Laishy Williams-Carlson concurred. “What fuels our redesign is the need to get to a better model that is financially viable. If nothing changes, we will not be able to generate a margin that we can reinvest in the organization.”

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Added Manis, “Scale alone won’t solve our challenges—that’s like Blockbuster acquiring Hollywood Video. We need to reimagine the care delivery model. We need an operating model that provides value as defined by consumers. We need a model that predicts and prevents disease. When care is required, our systems must offer safe, secure, compassionate care and a high-quality clinical outcome. Consumers also want easy, immediate access to services when, where and how it is most convenient for them, not us. Finally, consumers are demanding—and deserving of—an exceptional experience at a market-competitive price. Scale alone is not the long-term solution. We must rethink the delivery model.”

**Evolving Health System**

Richardville suggested that, currently, commercial payers essentially carry the government payers...so how can we create opportunity to serve all our patients while recognizing large segments that represent such huge losses?

“Consolidation has helped us survive. That’s the value proposition—improving our ability to negotiate helps ensure our survival,” Williams-Carlson noted. “No one is consolidating solely to reduce costs; the challenge is to have the scale needed to remain viable.”

Rosenberg called for a larger perspective: “I think we’re framing this the wrong way. Perhaps the right question is, how do we fit into the evolving health system, not how do we fit with big tech,” he said. “Consider the things that are happening as healthcare is evolving; we know we will have remote work for staff and patients. How do we then maintain patient relationships and revenue in that environment? Other industries that are already successful in this environment will have advantages. At U of M, we tend to affiliate rather than merge.

What fuels our redesign is the need to get to a better model that is financially viable. If nothing changes, we will not be able to generate a margin that we can reinvest in the organization.
We feel this is the key advantage—faster and deeper affiliations. If we keep trying to figure out how to stay ahead of big tech, we aren’t framing it right. We have to realize it’s about how we evolve.”

“You’re absolutely right,” replied Manis. “Yet most systems are carrying around high capital cost depreciating assets; no one wants to be admitted for a hospital stay anymore. This is an extremely important lesson from the pandemic. It is also an extremely important opportunity. Consumers are asking for something very different and the industry has been slow to respond,” added Manis. “New entrant competitors have recognized this opportunity and they are filling the gap with some very creative remote and virtual operating models that offer high value and exceptional service—just look at PlushCare, Amwell, MDLive, Lemonaid, Heartbeat Health, Talkspace, or even SmileDirectClub.”

Rosenberg agreed, adding, “We need to move away from brick and mortar. Mobility and automation can avoid costs and help us advance.”

The Need for Speed

Cherodeep Goswami, CIO, UW Health, outlined how the fast pace of change prevalent in other industries might be the emerging paradigm for healthcare.

‘There are five principles that I’d like to cover as we contemplate how to ‘Lead for Speed’ The first being speed of decision making…and this is indeed the essence of good governance.

“In healthcare we typically govern by consensus rather than collaboration, yet consensus leads to mediocrity. COVID allowed us to focus on not having to please everyone, as speed was of the essence. Now, after COVID we’re asking some hard questions, such as whether we need to reopen some services. If we lived without it for nine months, do we still need it?” he asked.

Decisiveness must be seized. “We have to be willing to push for a decision. We often suffer from ‘analysis paralysis,’ but we need to be comfortable forcing a decision. It’s better to be decisive rather than indecisive. We have to recognize our competitors are doing this—we’re the only ones playing by our (old) rules,” Goswami asserted.
CIO AS BUSINESS LEADER

“Next, we have to build team and trust. How do we bring in cross-functional leaders? We are all preaching to each other. The CIO needs to be a business leader first—we need to know the business, not technology. Technology is simply a platform, and we need to recognize that digital is a strategy. Consumers and their expectations are changing; we’re the only industry where the consumer does not want to be in the workplace—they don’t want to be there! If technology can help keep them out of our four walls, that’s where we can make a difference.”

He encouraged CIOs to become more critical thinkers, to engage in direct debate and not be too nice. “We’re ‘Midwest Nice’ and often happy and comfortable in our silos. And culture also is important: In many organizations ‘mandatory’ means it’s optional, and ‘optional’ means don’t do it,” he explained. “Our metrics need to be based on outcomes. We need to push people to play devil’s advocate and challenge the team.”

SUCCESS STARTS WITH US

Goswami believes teams need to be empowered and that, often, we can have 10,000 good ideas we never get to.

“Nurses, for example, know how to improve patient experience and care, but there’s no direct ROI, so those ideas never got prioritized,” he said. “So what we did was to take those ideas and give our staff ‘creative time’ on a regular basis to solve the problem...and now we are knocking out good ideas on a regular basis. You don’t need a business case; you know the problems on the floors, you just need to empower your teams. Another example was to integrate ServiceNow with Epic so providers could seamlessly enter a help ticket. It was a simple solution, but it never would have had the visibility to be approved without this program.”

Speed of communication also is important. “PowerPoint and SBARs...these are just middle management spending thousands of hours. Instead, send me a text, and make it effective: Start with the outcome,” he continued. “Think about the strategy documents we create; they simply sit on a bookshelf. They are written once, never opened. Instead, we use Playbooks; these are regularly refreshed, and they have goals, actors, timing. They’re never pretty—they have blood, sweat and tears—but they drive outcomes.”
“Fourth, we must recognize that we are ‘Partners in Excellence,’” said Goswami. “For example, we embrace ‘Shadow IT’ (which we actually call ‘Allied IT’ to emphasize how we view this partnership). We recognize we will never have the resources to do everything, so we look to partner with others where we share the desire to achieve common outcomes. We call this ‘insourcing.’ We have situations where everyone’s intentions are good, but we’re not unified in our direction, and so we strive to provide that direction.”

Find ways to partner with vendors. “Can we co-develop? We all want to be pioneers…but vendors simply have better access to resources and technology. We need to focus on our core competencies—recognize what we’re good at in IT, and then find partners for the remainder. That’s the key to success.”

**VELOCITY HAS DIRECTION**

“Lastly, we need to realize that while speed is good, we also need direction—and that’s velocity. When you’re setting direction, look to your portfolio. When things are not getting done, there are only three reasons: Is it capacity, capability or commitment? When you look at it, it’s more often capability and not capacity,” he said.

“Our talent is our capability. How are we grooming talent for the hot jobs in 2024? This is the true measure of successful leadership,” he explained. “Commitment: Is this as strong as necessary to meet our goals? It’s ok to have a skeptic but not a cynic.”

Further, Goswami believes there’s a difference between innovation, invention and novelty. “Too often healthcare focuses on the novelty—our tech is often funded by venture capital, and we’re simply selling ideas. Invention (think Bell Labs) is creating something new. Innovation is applying good things to my organization—making tomorrow better than today; it solves a problem. Novelty is simply a cool toy, and yet that is where we often focus.”

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GETTING TO THE NEXT LEVEL

“In summary, what’s our role?” asked Goswami. “Most of us are order takers. Maybe we’re utility players—COVID has made many of us this. But for some organizations, IT is a value innovator. We all need to challenge ourselves to add value: Do I have a scorecard that shows value? If I spend $1 million on pharma, how have I improved outcomes? How do we lead our organizations to the next level? How do we stay consumer-centric (and not provider-centric)? It’s outcomes that count.”

Carrie Damon, SVP & CIO, Centura Health, cited the value of experience outside healthcare. “I’ve worked in seven different industries, and what’s surprising is that in those industries we were part of innovation. We need to show the value that we can bring to a healthcare organization. Healthcare is very collaborative—we’re here to support each other.”

Ed Kopetsky, CIO, Stanford Children’s Health, offered a contrasting perspective. “I’ve spent my career in healthcare including a consulting firm. I believe we have to evolve the innovation and thinking. No one has the answer. Just saying ‘do what the customer says’…well, my answer is no; they’re often uninformed or only imagining the current methods. IT brings a higher level of systems thinking and clarity around what problem we are trying to solve. If the answer is wrong, we have to get to a better answer.”

Added Williams-Carlson, “I’ll repeat what Jon Manis said in an earlier SI conference: We need to adopt what is done outside of healthcare. We don’t need to reinvent solutions. Just because it is not invented in healthcare doesn’t mean it’s not worthy of our attention.”

New Alignment for IT in an Era of Rapid Change

Doug King, SVP & CIO, Northwestern Medicine, led the CIOs in a discussion on how IT might realign itself in our post-COVID era.

“The relationship between the CIO and CEO will be where we’ll need to focus,” he said. “At Northwestern, we have about 950 IS employees, and our services span applications, infrastructure, analytics, informatics, call center and innovation. Our organization has set five-year plans focusing on specific strategic priorities, namely Quality, Access, Finance and Human Resources. We have our own plan in IT (what we will do) but we are also a key enabler of the other four. IT is pervasive—people won’t be able to get things done without IT, and it effectively becomes the ‘second call’ from the COO. We want to be known as the most collaborative IT department in the nation. For us, that means focusing on reliability and efficiency as well as enabling and advancing our digital capabilities.”
ACCELERATING DECISION-MAKING, ENHANCING FOCUS

“With COVID we had five things going 1,000 miles per hour, whereas before COVID we had 1,000 things all going just 5 miles per hour. COVID meant we had to be hyper-focused,” said King. “We had to trust our decision making and have less reliance on committees. COVID shifted us to value: We were asked to help solve problems rather than to just implement something.

“Now, our key initiatives are prioritized at a health system level—they have the focus of our CEO and are tied to bonuses, and our digital program and innovation center are on the list,” he said. “We can now have the broader conversation: What does digital mean? What is its value to our organization? We need to develop digital literacy throughout the IS department. We need to have a ‘digital mindset’ that folks can meaningfully articulate. Digital literacy, though, is incredibly hard, and we’re continuing to iterate. When everyone is aligned it becomes very impactful.”

VALUE MAY REPLACE KPIS

To achieve these important initiatives, King has shifted away from year-over-year KPIs to a focus on agile principles, talent management (including when to outsource) and efficiency (with VPs being held accountable) to take them to the next level.

“We’re then managed quarterly, with presentations made to leadership—and the key question is ‘How are we creating value?’” said King. “This is a shift from an operating model. For example, where can digital have a big impact on care? We are being asked to focus on and show the value. Value is key: If we’re not showing value or having an impact on healthcare or our bottom line, then it’s just going to be ‘cool stuff’ without an ROI,” he said.

Thus, their IS metrics are now tied to the business, and he believes there is no reason IT success can’t be measured in margin: They’re now measured the same way the business is.

ACADEMIC HEALTH SYSTEMS

Healthcare is different, especially in academic medical centers.

“How you organize and execute is tricky; people receiving the services have different mindsets, and you need different tactics to be effective. Academic medical centers have a triad of research, teaching and patient care, and in that complex environment it’s going to take time to find the new normal,” said Eric Yablonka, CIO, Stanford Medicine. “With COVID, medical schools are now simply looking to get students back on campus safely, and fully restart medical and basic science research. We’re not yet sure what the ‘new normal’ is going to look like.”
Tricia Julian, CIO, Baptist Health, said her organization is counting on a vertically-integrated future. “Baptist is wondering how healthcare will be delivered 10 years from now. How do we respond to telehealth that is now mainstream? We’re also less interested in hospital integration and more interested in vertical integration. We want our ambulatory footprint to enable us to be in the right neighborhood at the right time with the right level of care. We too experienced increased ‘speed to results’ with COVID, and we’re now asking how to keep that going. How do we do a few things very well, and then move on, rather than trying to do a large number of things all at once?”

King described a well-balanced academic medical center. “Our university is a separate entity but linked to our health system. We have both a Dean and a CEO, and we also have separate budgets. This has worked to our advantage as we can work together for vendor negotiations for example. It’s also worked well with digital. Our health system funds Azure, but we also have faculty helping to lead this, and this shared ownership helps with the budgeting conversation. Our EDW is another example: The health system operates it, and research contributes the budget,” he explained.

HEALTHY TENSION

King believes their challenges come with the pace of shared decision making, which is sometimes difficult. Northwestern’s school of medicine is typically more measured, wanting to proceed more slowly than the hospital. But he believes if you can agree ahead of time who will own it and who will pay for it, a shared model can work well.

Scott Arnold, EVP & CIO, Tampa General Hospital, also shared some of the inherent challenges within an academic medical center. “We’re also teaching for USF, so we have that healthy tension of Dean and CEO, but also tension with clinical research. We experience similar challenges and successes as others. We have lots of innovation and things are happening faster. A third of our workforce is now remote, but that puts a load on our infrastructure. The silver lining is we’ve been able to button up some problems we’ve been ‘admiring’ for some time, and we’ve now dealt with them quickly.”

Added Heather Nelson, SVP & CIO UChicago Medicine, “We are also working to foster collaboration. Over the last nine months, we have been the provider for COVID tests and PPE, and we’re at capacity virtually every single day. Our challenge is how we can
support patients in ‘technology deserts’ where patients don’t want to come in. How do we ensure they get access to care? Maybe it’s just a follow-up phone call. For us, keeping it simple and not over-engineering have been effective solutions.

“Here, IT is seen as a partner—we are at the table with operations for things like vaccination plans, and we can help make a difference,” Nelson concluded.

The Next Generation CIO

Richardville led the discussion on the changing role of the CIO. “What, then, are the responsibilities of the CIO?” he asked. “Our title is evolving, as the CIO role so often now includes digital and digital innovation. And while our responsibilities are changing, culture also plays an important part, especially with the trend in mergers and acquisitions. We must focus our business—the west doesn’t care about the east and vice versa. We need to recognize that we can’t do everything; we need to be relevant in a few markets and not irrelevant in a number of markets.”

ALL ABOUT RELATIONSHIPS

“Who we are now is relationships. It’s about influence. We can reach out to different regions by extending Community Connect; it is a different way to grow rather than by merger. We’re also focusing on excellence—Epic gold stars, honor roll, an eHealth Care Leadership award—are all measures of improved quality. You can also learn from other industries (where you’ll often find you’re not that special). What we produce is data…and people make decisions based on the data we produce,” Richardville said. “The next-generation CIO therefore needs to understand that it is about the business and not about you. Our strategic plan is the system strategy (and not the IT strategy). We support the organization’s imperatives.”

SIMPLICITY AND LEADERSHIP

There are a number of ways IT can focus on and help the business. “Understand the complex, but keep it simple. Speak in their language and terms—no one should know you’re the CIO because of your language. Similarly, recognize it’s not about the EMR; the technology works best when people don’t know it,” he said.

Further, leadership is a critical element. He believes there are lots of hats for the CIO to wear but accountability is key. “Our budget needs to be reflected in how well we serve the organization and its patients—that includes innovation, digital transformation, patient self-service—but the bottom line is it’s about leadership,” he said.
And there’s much to be said about leaving a legacy so your organization is better than when you arrived. “Become a ‘professional parent’ by growing and developing the next generation of leaders. The greatest compliment we’ll ever receive is when other industries say, ‘I need someone from healthcare’ (rather than the other way around, as it is now). We need to get to this level,” he stated. “People: That’s what separates me from my competitors. We all need to be nurturers, teachers and students.”

Lastly? Expect the unexpected. “We need to react with the ‘Four Fs: Fast, Fluid, Flexible and Focused,” Richardville said. “Healthcare and the CIO role are both evolving, and our ability to adapt with agility will be the key to our success.”

Joel Vengco, SVP & CIO, Baystate Health, summarized the groups’ collective role going forward: “The CIO role needs to look at the horizon. We need to continue to push and transform our business and organizations. The proving ground of the pandemic has elevated our ability for innovation. We’ve seeded new ground for new ways of thinking, and someone has to serve as the periscope of the organization.

“The CIO needs to focus on information and not just technology—and now we’re being asked to combine these to create ‘digital.’ Yet data remains at the core of it all—and we must realize that we are the primary stewards of that data, its liquidity, and its capabilities. Our organizations are realizing how important this investment in data is, and therefore the pivotal role we all play as CIOs,” Vengco concluded.

“"We need to react with the ‘Four Fs: Fast, Fluid, Flexible and Focused’. Healthcare and the CIO role are both evolving, and our ability to adapt with agility will be the key to our success."
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