In 2025, U.S. health systems will emerge as the engines of a reinvented public health system: a data-driven, highly collaborative ecosystem of public-private entities focused on health and wellness and funded via value-based contracting. That was the message from SI's 2021 Fall Symposium “Cracking the Code: Healthcare 2025,” in Scottsdale, Ariz. The key to success of this ecosystem is a digitally integrated, customer-centered platform that blends clinical, genetic, social and psychographic data into a personalized experience for everyone accounting for age, gender, ethnicity, race or socioeconomic situation.

SI Chairman Don Wegmiller and President & CEO Janet Guptill kicked off the four-day event with a heart-felt welcome to SI's first on-site conference since April 2019. Within what many call a peri-COVID—versus a post-COVID—world, SI has expanded to 63 member organizations from a pre-pandemic 54 by “convening the right people on the right issues” virtually. In 2020 alone, SI conducted seven Summits, 32 Dialogues and 116 Webinars engaging 845 distinguished faculty from 190 organizations for more than 20,000 registered attendees. Affinity Groups, convened around similar concerns and challenges, have grown to 10, with more in the pipeline.

Read on for summary highlights of the spirited and often passionate conversations at the Westin-Kierland. To view all materials—video, audio and PDFs—of the entire SI 2021 Fall Symposium, visit https://scottsdaleinstitute.org/event/si-2021-fall-symposium-cracking-the-code-healthcare-2025/. A Symposium faculty list is on the back page.
Our SI Roadmap highlights three thought-leadership “Milestones” to guide us in the coming year: Experience is Everything, Thinking Digital is Our Culture and Organizational Models are Fluid. Read more.

SI Vice Chairman Tom Sadvary (left) introduced keynote speaker Paul Keckley, Editor, The Keckley Report (right), and moderator of the first panel “Public Health: Whose Job is It & Who Pays for IT?” Mr. Keckley cited key factors to watch:

1. **The economy will be the context for everything during the next three years.** Private equity is trying to take the costs out of healthcare...but private equity is promoting poor healthcare policy. HHS and CMS see no long-term value if we stand back and let private equity solely determine the winners in our healthcare system.

2. **We spend a third less than OECD countries on public health.** As a result, we’ve constricted public health.

3. **In terms of the pandemic, we’re 40 percent likely to experience another wave of infections.** How we respond to that involves more than vaccines and treatments. We need to get past the stigma and politicization of COVID. Unfortunately, we’ll likely languish in the 60th percentile of vaccinations nationally. It’s not behind us.

4. **In 2022 there’s a high probability that the House flips to Republican.** The Biden administration views hospital consolidation as anti-competitive; it hasn’t reduced costs. Our response to the need for price transparency has been pitiful...Hospitals are misreading the marketplace...The drug industry has coopted Congress. Very little has been done on drug prices.

5. **Value is a headscratcher.** What does value mean? How do you shift to value when value is a moving target? Until we get a standard definition, value is merely rhetorical. The Patient-Centered Outcomes Research Institute (PCORI) argues that value should not be based on dollars but on outcomes.

6. **Equity is at the top of the list.** It’s systemic to how you operate. It’s more than just one guy in the C-suite. It’s about how we diagnose, treat and deliver care. Equity impacts everything we do in designing infrastructure, IT and value.

7. **Watch the states.** The stalemate in Washington puts more control at the state level. It’s federalist-ic. Besides Medicaid, states have responsibility for health professions, health plans, definitions of competition and generally have a huge say in how healthcare is delivered.
The following offers a sample of the wide-ranging panel discussion, particularly in response to Mr. Keckley’s question as to whether we’re doing any better in terms of the social determinants of health since it became an issue the past several years:

PATRICK COURNEYA, MD: We’ve been acknowledging that the social drivers of health have a bigger impact on a person’s health, but we haven’t done anything significant about it, notwithstanding the fact that we’re spending nearly 20 percent of GDP on healthcare. So, no I don’t think we have. I don’t think we’ve spent much time figuring out what role we play. And it’s just a role, because if we assume full responsibility, we’ll make it more complicated and expensive than it has to be. I’d give us an F grade.

BILL TIERNEY, MD: I think you’ve got to recognize something. Five years ago we weren’t even talking about the social determinants of health. But now we’ve begun to discuss it. Some health systems are beginning to move upslope. Are we doing anything good yet? No. Are we at scale yet? No.

MICKY TRIPATHI, PhD: We start with data. You need enough data to even identify the issues you must address. In July we published the U.S Core Data for Interoperability, which is the minimum data set required in all EHRs. It covers 95 percent of buyers. We’ve added five social determinants of health categories to the USCDI plus sexual orientation and gender identification. As that starts to roll through you can do stratification to understand populations according to quality measures and decision support. Then you can start intervening upstream. So, we’re looking at an interoperability mechanism that would allow you to refer a patient to housing assistance rather than an expensive MRI. Maybe that’s a better investment.
JAY BHATT, DO: Inequities are America’s chronic condition, yet to date we’ve just used BandAids as solutions. Inequities have a $93-billion impact on care and $40 billion in lost productivity, totaling $133 billion in impact. How do we get to health equity?

MIKELLE MOORE: Twenty-five months ago, we weren’t even talking about health disparities. After George Floyd’s murder we had to. Today, health inequities are factored into all Intermountain’s goal setting, from first-line caregivers to the board level. Our stroke-team data reveals a concrete example of inequity: There’s no disparity in treatment time, but there is in outcomes.

KEN FAWCETT, MD: Ultimately what matters to the patient is outcomes. In terms of health equity, this certainly cannot be the work of just the health system. We need relationships in the community which we can leverage to achieve those outcomes. I use the term countercultural because health systems need to invite the community to the table.

JENNIFER JUNIS: We’ve learned a lot about the digital divide. Initially we missed a lot of preferences, including that some people wouldn’t use their cell phones or other technology; others would. We finally determined care must be very personalized, whether that means a hotline, chatbot or boots on the ground. It goes back to trust. We reaffirmed that no matter what the population is, at the core it’s all about a relationship—either digital or virtual—and you must maintain the same level of caring for all.

JIM WHITFILL, MD: We’re talking about three different topics. First, who’s responsible for public health? We’ve talked about public health being above a payor or a health system. We just went through a once-in-a-century pandemic. You’d think we’d all be speaking in a unified voice, but we’ve never had a greater divide. In fact, there’s a big effort in this country to take what little power public health has. Second, I help run an ACO. We’ve been taking risk. Have we had some influence in how much Medicare costs? Yes. Are we fundamentally influencing the cost curve in healthcare? No. I love value-based care. Is it going to fix our problem? Not the way we’ve done it. Finally, how do we use healthcare IT to move information? We’ve just unleashed a powerful force of interoperability, but it will take us awhile to ingest it. If I had the ear of the president, I’d ask, ‘How do we get a national patient identifier?’ So we would never assign a cancer diagnosis to someone who doesn’t have it. I’ve seen that happen and it’s a disaster.
Late Tuesday afternoon, Symposium attendees toured the Tia clinic, a brand-new “modern medical home for women” based on a holistic health model. The new Scottsdale Tia—it has precursors in New York and Los Angeles—is a collaboration between CommonSpirit and Tia. Rich Roth, chief strategic innovation officer at CommonSpirit and Tia Co-founders Carolyn Witte and Felicity Yost welcomed the group and described how Tia was launched four years ago to provide collaborative team care emphasizing preventive health and the end-to-end experience.

“Every detail is focused on making women feel at ease,” said Yost. “That’s a vision of whole-person care.” She noted that Tia aims to fill a huge gap for comprehensive women’s health: 50 percent of U.S. women lack a primary care provider.

Roth noted how the TiaMD platform is designed to be interoperable with other EHRs. For more information visit [https://asktia.com/](https://asktia.com/).

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**Clinical Operations Roundtable Recap**

Jeffrey Rose, MD, SVP Clinical Strategy, Hearst Health, asked participants about their areas of passion and chief concerns, and the resulting conversation showed the ways these two paths intersected—or diverged—as these critically important leaders merge their purposes and passions in a fresh new way.
The panel and audience engaged in a lively discussion about reimagining primary care and the emergence of exciting new care models emphasizing holistic, coordinated care, ease of access, personalized experience and quality outcomes.

**SELECTED NUGGETS**

**RICH ROTH:** When I went to my first primary care visit years ago it was all about time because I was so busy at work. Everybody thinks differently. What excites me is the new models of care are all about personalization. In Phoenix, there’s a reason why Equality Health has emerged as a whole-health company focused on the patient experience and access to value-based care.

**GAUROV DAYAL, MD:** Adult primary care is broken, financially and because of poor outcomes. The fee-for-service economic model necessitates seeing a lot of patients. In fact, we shouldn’t spend time with people. In reality, there’s no shortage of primary care physicians. It’s an artificial shortage. In an ideal world, we have care teams. You don’t need a primary care doctor to refill a prescription.

**JORDAN ASHER, MD:** We’re seeing primary care become a triage model versus a service. That’s why we’re seeing the trend toward mass personalization, mass customization. Do we really need primary care doctors at all?

**CAROLYN WITTE:** Primary care is all about a relationship. Tia is anti-transaction. We’re building a relationship—not a CPT code. Whole health—not a body part. It’s all about prevention, about having a relationship with a health system before something goes wrong. That’s what a relationship care model and service is. The relationship is with Tia, not a doctor.

**LESLIE HAAS:** Consumers want four elements:

1. **Access**—We need to become more like DoorDash. As a new patient I had to wait eight months before I could see a primary care doctor.
2. **Value**—Patients are struggling because they don’t know how much care costs. Even providers don’t know how much it costs.
3. **Coordinated Care**—Patients want a single-entry point and expect those providers to know the next step or connect them to it.
4. **Personalization**—I love the example of Netflix: They can pull your preferences, know what you like and don’t like.
SCOTT WEINGARTEN, MD: It’s been said that two-thirds of clinical data is unstructured—especially data related to a person’s past life and the social determinants of health. Yet we continue to rely on structured and discrete data to make decisions clinically and strategically.

TERRY MYERSON: The idea for Truveta [as a data collaborative of health systems] started when physicians asked Providence CIO BJ Moore, “Does Remdesivir work?” We couldn’t figure it out. We had no ability to address the question. Meanwhile providers were spending millions of dollars on Remdesivir…NLP and image-processing technology is an incredible tool, but it takes an immense technology to process those notes.

JASON JONES: There are a lot of data in physician notes because notes have expanded like a novel in recent years. However, we don’t reliably record patient goals and preferences. A colleague has developed the concept of a “Healthy Day,” which is different for every person. My colleague is a vocalist, so if she gets laryngitis that’s not a healthy day. The question is, does text help lead us to a patient’s goals and preferences?

JOHN HALAMKA, MD: When we focus on social determinants of health [SDoH] data, we need to question how good that data is. At Mayo we call it “The House’s Index” because it includes data for that family living at that address, data such as crime and environmental indices like pollen counts. Data based on population stratification is mostly useless. Those households might be dusty [or subject to some toxic threat]. Algorithms for socioeconomic and SDoH analysis need to be transparent and easily understandable.

To listen to this compelling discussion and other panels and presentations, video and audio recordings and PDFs are accessible on the SI website at https://scottsdaleinstitute.org/event/si-2021-fall-symposium-cracking-the-code-healthcare-2025/.
SELECTED NUGGETS:

ROBERTA SCHWARTZ: Our titles are both operational and passionate in terms of innovation. Only four people have permanent titles in innovation. Whatever we invent we must live with on the operational side. The pandemic taught us that we need to be more consumer focused.

LATESHA MONTGOMERY: Pre-COVID we already had a good foundation for virtual care, including bi-directional text messaging, which yielded a $600,000 ROI. Our strong foundation enabled us to jump from 115 virtual visits in February 2020 to 37,000 in April; we went from 30 providers to 900 using virtual visits. We’re using Well to help patients digitally navigate the health system and DexCare [a Platform as a Service (PaaS) for health systems that orchestrates digital demand and capacity across lines of care.] We want to eliminate the middleperson from the equation because 80 percent of patients want to self-schedule.

NICHOLAS DESAI, MD: We say ‘consumer’ but we also have to give the same convenience and efficiency to caregivers. We’re initially focused on orthopedic care pathways asking from the patient’s perspective, ‘How do I prep?’ ‘Check in?’ What assistance is needed? Our physicians' mindset has shifted…We’re doubling down on voice. Ambient versus voice: it’s two audiences. Patients are saying, “I want you to be a bird on my shoulder. I might need you to drive commands.”

KEN LETKEMAN: One way we created alignment between innovation and IT was to create DIOP, a collaborative group of “Digital Innovation Obsessed People.” They came up with great ideas aligned with our digital transformation. Our DIOP has the right leadership and broad membership and has a culture to vet new ideas and yet still be operationally focused.

MICHELLE STANSBURY: We’ve been at this for four years. Are we completely different than IT? We’re aligned. Partnership is key. We’re always focused on companies. Every Monday we’re talking to two or three organizations to see if they can help us. It’s good to get in a rhythm. All the app teams report to me. We prioritize, test them out and scale them. We believe voice is the future. Providers and nurses say they need it for easing workflow.

REDEFINING THE USE OF VOICE

VOICE COMMANDS
- Prompt device to Actively Listen
- Command information to present
- Efficiently finds information in EMR
- Complete task-oriented actions in EMR

AMBIENT LISTENING
- Passive Listening Capture sound as conversation occurs
- Create progress note through natural language processing
- Differentiate sound utilizing mics and AI
- Code and create tasks in EMR

USE CASES
- OR Commands: Improve provider experience by easing data capture during surgery
- Hey Epic!: Bring mobility and efficiency to physician interactions within EMR

USE CASES
- HM Pharmacy Skill for Inpatients: Improve HCAHPS scores for medication-related outcomes
- Ambient Listening at Clinic: Vision to create “keyboard-less” clinic room

Redefining the use of voice is a key element of Houston Methodist’s innovation portfolio.
PANEL | DIGITAL HEALTH: WHAT PROBLEMS ARE WE TRYING TO SOLVE?

Moderator Todd Dunn, VP of Innovation at Atrium Health led a discussion panel including Nick Archer, SVP of Consumer Innovation at AdventHealth, Rima Shah, MD, VP & Department Chief, Primary Care and Virtual Health at Spectrum Health and Kevan Mabbutt, Chief Consumer Officer at Intermountain Healthcare.

SELECTED NUGGETS

**TODD DUNN:** I don’t believe in the term digital health. It’s human health using digital means. What problem are we trying to solve?

**NICK ARCHER:** The problem we’re trying to solve is to “alleviate the burden of the consumer.” Our consumers have a hard time navigating the health system as it is, but when they get sick it’s even more burdensome in the context of multiple EHRs, access to care. Our job is to solve problems for people. That’s why we promise immediate virtual response to their inquiries, clear understandable bills and easy access.

**RIMA SHAH, MD:** The most important factor is the digital consumer experience—making it simple, convenient and easy to use. Second, how do we align it with operations. I don’t think we need a digital transformation. We need an operational transformation.

**KEVAN MABBUTT:** The biggest problem is the cultural mindset. From a digital point of view, when I joined Intermountain four years ago, we spent a lot of time with consumers and providers, a lot of immersion. We focused on helping consumers find access to care, manage that care and pay for care—bringing price with lack of fear.
PANEL | REDESIGNED, TECH-ENABLED HEALTHCARE TO EMPOWER PROVIDERS AND PATIENTS – ASCENSION CASE STUDY

SELECTED NUGGETS from a discussion on Ascension’s plan to digitally transform itself.

EDUARDO CONRADO: During the next five years, Ascension’s profile, including 145 hospitals, 2,200 clinics in 19 states and 2.6 million virtual visits to date, will look very different. In 2019 we were in a no-win situation. Gerry and I said Ascension is going to change rapidly. There are five pieces: One, technology is fundamental to our mission; Two, delivering a distinctive experience to consumers and patients is essential; Three, insights gained from our massive and complex data will be the source of competitive and clinical differentiation; Four, we have an imperative to prepare our technology and analytics organization to deliver on Ascension’s strategic priorities; and Five, Despite being a careful steward of our resources, there is an opportunity to deliver technology services more efficiently.

GERRY LEWIS: Three years ago, we started to evaluate our technology organization including how it was structured and what kind of talent we had. We were essentially a “run” organization, spending 98 percent of our time keeping the lights on. First, we decided to move from being a run-based organization to a strategic enabler. Our teams have been able to change and move at velocity. Second, we simplified the IT organization by moving to the cloud. Third, we doubled down on creating a seamless, end-to-end platform whose last mile is to the home. At the end of the day, it’s all about service delivery.

GAGAN SINGH: Because of Ascension’s size and scale we have a huge infrastructure to tap when we need to use our data. One, make sure there’s a leadership construct, and two, make sure the healthcare system is on board. When I came to Ascension, we launched a data strategy focused on data quality: we are improving data timeliness, accuracy and quality. To improve care at the site of care we’re building a longitudinal patient record. And, we’re building a modern data platform in the cloud, harmonizing data at the source for population health and clinical research.

KARTHIK RAJA: Data scientists have traditionally worked in a basement room. We want our data scientists to be in the room where it happens. Our chief strategy is to build our forecast ability. Our second focus is to work with our chief clinical officer to take quality from regulatory to clinical. Third is investing in registries. Fourth is the ambulatory setting. How do we nudge and reach out to the patient to encourage wellness? We’ve invested a lot in the social determinants of health.
Christopher Shudes (CS), Principal, Deloitte, moderated this breakout session to discuss recruiting talent, designing hybrid work models, facilitating continued innovation, strengthening the new work culture and navigating change management at a time when both traditional and futuristic healthcare models are more necessary than ever.
THURSDAY, NOVEMBER 18

“The Social and Moral Determinants of Health: Implications for Healthcare”

Keynote: Donald Berwick, MD, Senior Advisor, Institute for Healthcare Improvement, CMMI

Michael Shabot, MD, former EVP & Chief Clinical Officer, Memorial Hermann Health System and SI Executive Committee Member, introduced Dr. Berwick who spoke to the audience virtually.

The Following are Some Selected Nuggets from His Talk:

- Inequity in American health was one of the glaring lessons from COVID.
- Michael Marmot’s book, “The Health Gap” (2015), sharply exposes these inequities and should be required reading.
- According to Marmot, the U.S ranks low in social determinants of health compared to other advanced nations:
  - Early childhood experiences—U.S. is lowest among 17 nations. Astonishingly strong stresses early on that carry into adult health
  - Education—Strong generally but very uneven across population
  - Work and workplace—U.S. ranks low
  - Experiences of Elders—We’re the lowest due to factors like isolation and loneliness
  - Community Resilience—in factors like transportation, violence, recreation, we rank very low
- These five categories vary enormously among advanced nations largely due to fairness, for which the U.S. ranks low.
- Adverse Childhood Experiences (ACEs) predict adult health more than anything else. Child Opportunity Index (COI) measures 29 components like education, health & environment, socioeconomic factors.
- Only 6 percent of white kids live in low-opportunity neighborhoods; 40 percent in very high opportunity neighborhoods.
- 45 percent of Black kids live in low-opportunity areas; 9 percent in high.
- U.S healthcare is a repair shop. We might reconsider how we might redirect the $3 trillion, 18 percent of our economy. We’re experiencing a confiscation of our resources that could go into schools, housing, etc.
- Key Question: What would a redesign of healthcare look like? Single payer, while not perfect, is probably our best shot. The status quo is not working.

To hear Dr. Berwick’s complete Keynote, which many attendees noted was the highlight of an already rich and thought-provoking Symposium, visit [https://scottsdaleinstitute.org/event/si-2021-fall-symposium-cracking-the-code-healthcare-2025/](https://scottsdaleinstitute.org/event/si-2021-fall-symposium-cracking-the-code-healthcare-2025/).
On Thursday morning, SI Chairman Don Wegmiller (top row) moderated a CEO Roundtable and Open Forum featuring (l-r) Nancy Howell Agee, President & CEO, Carilion Clinic; JP Gallagher, President & CEO, NorthShore University Health System; Andrea Walsh, President & CEO, HealthPartners; and David Entwistle, President & CEO, Stanford Medicine.

**SELECTED CEO NUGGETS**

**NANCY HOWELL AGEE:** Six years ago, in Virginia we ranked communities by their health outcomes and found that the zip code in which our large quaternary hospital we were so proud of was ranked at the very bottom.

I went to our board and said we’re failing at our mission. Something’s fundamentally wrong. We pulled together the heads of police and fire and community leaders and they said, ‘It’s one community.’ Grandparents were caring for children. We partnered with community leaders who were mostly older women and worked with elementary schools and identified social isolation, kids home alone, home safety. Focusing on asthma we’ve improved outcomes by 22 percent. You can do it quickly, but it takes a lot of effort.

**DAVID ENTWISTLE:** Today we’re doing 34.6 percent of our visits virtually. It allows us to access and treat different populations than previously. On average we’d spend 67 minutes for an in-person visit versus 22 minutes for a telehealth visit. We could triple our volume if we used only telehealth. 98 percent of our providers have used telehealth at least once; 99 percent of psychiatry. How do we adapt technology to achieve equity? It involves ensuring bandwidth, language and privacy. We call it “tequity.”

*continued on next page*
SELECTED CEO NUGGETS

ANDREA WALSH: We are truly an integrated health system with a health plan of 1.8 million members and a research institute that helps us align strategically. We were founded by four leaders in the Twin Cities as a consumer-led organization because the number-one cause of bankruptcy at the time was the cost of healthcare. Affordability is still the number-one challenge in healthcare. You can buy a new car for less than you pay for health insurance. We view technology as a relationship enabler. Relationships are fundamentally built on trust. We’re using our health-plan and care-delivery data to run personalization campaigns in the community. For example, data showed us that several of our Black and indigenous male members over 50 were overdue for colorectal cancer screening, so we implemented a mail-in FIT (stool sample) test program that was easier than scheduling and prepping an invasive colonoscopy.

JP GALLAGHER: We’ve learned some painful lessons. We were originally Evanston Community Hospital, which until 1970 was known as “the white hospital.” It wasn’t accessible to all. We’ve traditionally been in a box, a destination, but not thinking creatively. When the FTC blocked our merger with Advocate a few years ago, our board conversation asked, what’s the path forward? What can we do well? We decided to become a trusted and indispensable health partner. We’re doing that as never before. Chicago is very fragmented, highlighting the importance of vibrant, community-based healthcare, really driving local care. We’re working with other organizations to connect us to patients who might not feel connected to us initially. We have a $200-million endowment to focus on community investment.

PANEL | BUSINESS MODELS TO REWARD HEALTH AND CARE

Moderator Joe Fifer, President of HFMA (far right), led a discussion on emerging healthcare business models with (l-r) Craig Samitt, MD, Former CEO, Blue Cross, Minnesota and Scott Weingarten, MD, Chief Innovation Officer, SCAN Health Plan, Professor of Medicine, Cedars-Sinai and SI Board Member. Darryl Elmouchi, MD, President, Spectrum Health West Michigan, participated virtually.

continued on next page
SELECTED NUGGETS

CRAIG SAMITT, MD: We’re at an inflection point. The world has changed. We now have a choice. What I worry about is when the pandemic passes, we will go back to a heads-and-beds philosophy. It’s more about money than health. In the past disruptive change agents were acquired by incumbents and forgotten. What’s different now is that the disruptors are having their day in the sun and they’re well-funded. They are going to force us to change.

SCOTT WEINGARTEN, MD: About $21 billion has been invested so far in digital health. It’s a big bubble that will burst. Nine out of 10 startups go away. Disruptors can provide high-quality, safe and affordable care. How many health systems can build their own health plan? I see disruptors that are looking to partner.

DARRYL ELMOUCHI, MD: There’s a big dilemma with COVID. Traditional legacy healthcare providers are vital to public health. The system needs them. What does the public health infrastructure look like? Will this pandemic be the catalyst to move to value-based care? The penetration of non-fee-for-service is only 16 percent. So, the vast majority is still on fee-for-service. This is really challenging. Think of the financial straits last year. Insurers had excess dollars. Seems like a perfect opportunity to change the model. Last year we signed a radical risk arrangement with ourselves.

PANEL | HOW NON-PROFIT HEALTH SYSTEMS CAN BENEFIT FROM ENTREPRENEURSHIP

Michelle Conger, Chief Strategy Officer, OSF HealthCare System and CEO of OSF OnCall Digital Health (far right), moderated a discussion with panelists (l-r) Dave Dirks, VP Strategy, Intermountain Healthcare; Craig Anderson, Director of Innovation, BayCare Health System; Anne Wellington, Executive Director, Digital Strategy, Cedars Sinai and Managing Director, Cedars-Sinai Accelerator and Aaron Martin, EVP & Chief Digital and Innovation Officer, Providence.
AARON MARTIN: We look for ways to ‘move the needle.’ We do a rigorous process of stack-rating opportunities. I lead the consumer-facing digital side. The goal is to reduce leakage—to predict when a patient might be in the market for a procedure. That strategy has generated an 8:1 ROI. We’re also partnering with Truveta and 20 other health systems to develop a data-analytics capability. We have invested $300 million on the venture side with a portfolio of 26 companies, three of which we spun off after creating them internally.

ANNE WELLINGTON: Innovation is an obligation—for research improvement and performance improvement. I run the external-startups unit that accelerates early-stage companies. The accelerator program focuses on how to improve the product and ensures it’s technology we can use. We also invest in the companies. The goal is less in terms of revenue; we want a strong ROI and to foster a culture of innovation. We don’t want a custom solution that only we can use.

CRAIG ANDERSON: When I arrived four years ago the CEO said what we want is change. I sat down with our CIO and we knew with the right technology change we could help care teams. We also wanted technology to automate operations.

For our COO it’s all about cost. We’re a regional health system; we’re not going to be a VC. It’s all about our mission. My job is to establish that innovation is everybody’s job.

DAVE DIRKS: We talk about ‘escaping the gravity of the system.’ Gravity exists for a reason. It’s not a bad thing. It’s how do we escape that gravity to freely innovate. It’s how we created Castell, the population-health management firm. That wouldn’t have happened without escaping the gravity of the traditional health system. How do you create the space you need, then reengineer the innovation back into the organization?
Dr. Glaser kicked off the highly interactive discussion with a question about what COVID’s legacy—the New Normal—will look like.

### SELECTED NUGGETS

**SCOTT WEINGARTEN, MD:** I’m certain that areas like the adoption of telehealth and vastly improved syndromic surveillance will become permanent parts of the healthcare landscape. But addressing the affordability of healthcare is an imperative in the New Normal. Five thousand families go bankrupt each year and two-thirds of individual bankruptcies are triggered by healthcare costs. It’s scary for us to overlook.

**GEORGE HALVORSON:** I have a strong sense moving into this new world that five components of the healthcare system will endure: Hospitals; Clinics; Other types of ambulatory sites; Home; and the Internet. We need the data about all five sites of care. Then step back and incorporate RNA and DNA. Developers took CRISPR [gene-editing technology] and used the genetic material of the COVID virus to create vaccines that are 95 percent effective. How do we take advantage of new technologies including AI to analyze collaborative databases to build better algorithms and care plans?

**JOSEPH FIFER:** Remember the term ‘per-member-per-month?’ That term never came up during our symposium. I love all the new ideas, but if we don’t get the payment system right, we’ll never achieve affordability in the New Normal. In 1984, when I was just out of grad school, healthcare was 12 percent of GDP. Thirty years later it’s nearly 20 percent of GDP.

**PAUL KECKLEY, PhD:** If what we’ve heard here about healthcare’s attractiveness to the private market is valid, then we’re not a good value. There’s a med-tech bubble coming. They’re going to collapse. No one knows what’s going to happen in healthcare. In the near-term economy is going to shape everything. There’s no perfect model. I would bet on the centerpiece of the system being physicians as a hub. $39 billion has gone into physician practices in the last four years.

**DAVID CLASSEN, MD:** One thing the pandemic showed was that we’ve destroyed our public health system by underfunding it and politicizing it. That public health system failed kids. A second point: accessibility and affordability. CVS just announced it’s closing 900 stores, but they’re in poor communities. We’ve seen lots of attempts by big retailers and ‘payviders’ to disrupt healthcare. Optum will employ 100,000 physicians within a year.

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In closing the SI 2021 Symposium, Don Wegmiller, Chairman and Janet Guptill, President & CEO of Scottsdale Institute thanked all the speakers, panelists and engaged attendees who made the Symposium such a success and reminded everybody to “mark your calendars” for next April 20 to 22 for the 2022 SI Annual Conference in Scottsdale.

To view all materials—video, audio and PDFs—of the entire SI 2021 Fall Symposium, visit [https://scottsdaleinstitute.org/event/si-2021-fall-symposium-cracking-the-code-healthcare-2025/](https://scottsdaleinstitute.org/event/si-2021-fall-symposium-cracking-the-code-healthcare-2025/). A Symposium faculty list is on the back page.
CIO ROUND TABLE

CIO Roundtable Recap

Lydon Neumann, VP, Impact Advisors, helped SI Members dissect innovation versus adoption, desirability versus efficiencies, brands versus platforms, and Pandemic Speed versus sustainability, and the subsequent conversation revealed a collective wisdom that depicted myriad approaches to defining our common problems and shaping our future solutions.

MAYO PLATFORM DISCUSSION

Friday morning was reserved for a presentation by John Halamka, MD, President of Mayo Clinic Platform. He described the genesis and progress of the Mayo Clinic Platform, a business model that leverages a repository of de-identified longitudinal patient records in the Google Cloud. In partnership with Nference, Mayo is developing machine learning-enabled algorithms for use by health systems and life sciences companies to better diagnose and treat patients. To listen to Dr. Halamka’s entire presentation visit https://scottsdaleinstitute.org/event/si-2021-fall-symposium-cracking-the-code-healthcare-2025/
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Former SVP & Chief Medical Officer, American Hospital Association

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Chief Strategy Officer, OSF Healthcare System; CEO, OSF OnCall Digital Health

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EVP and Chief Strategy and Innovations Officer, Ascension

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John Halamka, MD
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