ROUNDTABLE PARTICIPANTS

Kristin Acree, SVP, Strategic Account Executive, Health Catalyst
Laura Bagus, MBA, VP, IT, Lurie Children’s Hospital of Chicago
Gretchen Brown, MSN, RN, NEA-BC, Associate Chief Nursing Informatics Officer, Stanford Medicine
Bonny Chen, MD, MBA, FACEP, CPHIMS, VP & CHIO, AMITA Health; Regional CMIO, AdventHealth
David Classen, MD, CMIO, Pascal Metrics, Professor of Medicine, University of Utah, SI Board, Executive Committee, Scottsdale Institute
Jim Cramer, IT Operations Executive, Cramer Consulting Services, LLC (Guest)
Carrie Damon, SVP & CIO, Centura Health
George Halvorson, Former Chairman & CEO, Kaiser Permanente; Chair & CEO, Institute for InterGroup Understanding (Guest)
Hans Keil, MBA, SVP & CIO, Beaumont Health
Jerry Nye, EVP, C-Suite Resources
Patrick O’Hare, Former SVP Facilities & CIO, SI Board, Executive Committee, Scottsdale Institute
Amanda Rich, SVP, Strategic Account Executive, Health Catalyst
Tim Skeen, SVP & CIO, Sentara Healthcare
Chuck Scully, CIO, Denver Health (Guest)

Bruce Smith, Former SVP, Information Services; CIO, Advocate Aurora Health, SI Board, Scottsdale Institute
Yohan Vetteth, MBA, Chief Analytics Officer, Stanford Medicine
Chuck Wood, SAVP, EXL Health
Brian Young, MD, MBA, MS, System Physician Informaticist, CommonSpirit Health

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Moderator: Lydon Neumann, VP; Andrew Smith, President and Co-Founder; Peter Smith, CEO and Co-Founder
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Introduction

“The pace of change is so quick, the winners are going to be the ones that can understand that and adapt the most quickly. It’s not always comfortable but now more than ever IT needs to be comfortable being uncomfortable.”
– Michael Carlin, VP Business Technology Solutions & CIO, AbbVie

Scottsdale Institute (SI) exists to connect the connectors and start conversations, providing a space to innovate around healthcare delivery, technology, thought processes and advancements. But CIOs, especially, are experiencing growing pains like never before as new options and choices multiply rapidly, all while certain age-old challenges still seem intractable.

As “Pandemic Speed” accelerated our decision-making and willingness to “fail fast,” other opportunities emerged as longer-term milestones on the health-system roadmap. The question is, which ones will take us where we need to go? In this CIO-focused discussion, moderator Lydon Neumann (LN), VP, Impact Advisors, walked 17 SI Members and guests from 15 organizations through a Conversation of Connectors, tackling topics like innovation versus adoption, desirability versus efficiencies, brands versus platforms, and Pandemic Speed versus sustainability. A collective wisdom emerged from the discussion that offered myriad approaches to first defining, then solving, our common problems... and questioning, then shaping, our future solutions.
LN: This week we’ve been discussing how the pandemic has accelerated healthcare innovation overall but how has this affected your IT-related priorities? What are your reactions when you think of innovation and what comes to mind: technology, workflows, changing behavior?

Gretchen Brown, MSN, RN, NEA-BC, Associate Chief Nursing Informatics Officer, Stanford Medicine

Regarding innovation, when we hear what’s going on in clinical settings, we need to find efficiencies. We’ve done the same things again and again and just keep adding to the old model. Now we need to look back at the patient room we’ve created, for example, and start innovating—make it more intuitive, provide access to MyHealth, allow doctors to virtually round and the like. If we make it more intuitive, there will be less burden on our clinicians. We’ve implemented (during COVID) but now we need to innovate and connect strategies. Everything we do should get us to stronger efficiency, lower costs and decreased burden for clinicians.

Tim Skeen, SVP & CIO, Sentara Healthcare

Everybody wanted to talk about innovation when I started as Sentara’s CIO, but they all defined it differently. It’s risky to use that word without more specifically defining what innovation means and the outcomes desired. I found there were multiple buckets of innovation as defined by Sentara leadership—optimizing and automating to reduce costs, but also reimagining business processes and creating new products, too. We have to define our aspirations in each of these buckets and add a value metric to each initiative, consciously deciding which initiatives to prioritize and how much investment/resource to apply to each bucket. My personal definition of innovation is reimagination. This is different than those who see innovation as incremental improvements.

LN: What are your thoughts about budgeting for innovation?

Yohan Vetteth, MBA, Chief Analytics Officer, Stanford Medicine

Frequently what people describe as innovation are process improvements or automation. These are important but not transformational. Chat bots that help manage patient inquiries are good improvements but do they really fall in the category of innovation? I think true innovation is transformative, something that causes a sea change in how we look at or do something. Many innovation programs talk about their high success rate, but to push the envelope wouldn’t you want a fair percentage of your innovations to fail? Safely of course!

Patrick O’Hare, Former SVP Facilities & CIO, SI Board, Executive Committee, Scottsdale Institute

I look at innovation as changing models and also embracing small, incremental changes, and having people embrace both. When a person living in the woods without plumbing gets plumbing, is that innovative? No: There has to be true change involved.

Carrie Damon, SVP & CIO, Centura Health

I’m new to healthcare and I’ve seen things that are fascinating but nothing that I would call true innovation. There’s so much technical debt and we’re so far behind... I’m curious what other CIOs would say about budgeting for innovation. What are the business problems we’re trying to solve for? I don’t think my people would give me an innovation budget. But if there’s a shared responsibility, a cross-functional committee, then it could be considered a business problem and we could try to get “innovation” funding that way.
Tim Skeen: In my experience from decades on the payer side, we generally had a large budget to leverage innovation within. The way payers fund technology-enabled innovation compared to health systems is night and day. As I’ve shifted, it’s a big issue: I don’t think there can be a single bucket for innovation. We shouldn’t think of it as the money we’re willing to throw away. We need to reimagine our operational processes and then apply innovative technology to create a solution that provides high value back to the system.

Gretchen Brown: We have to try to peel off the things we can automate, have the right conversations with patients and reimagine how to do our workflows. Technology crosses all kinds of accountability lines. When you have an innovation budget, at least you can get certain products across all those VPs; you need to have a little bit of a budget to invest in a proof of concept. But fully reimaging workflows has to cut across everybody… and that’s a difficult thing.

LN: Some say they’d rather be the first mover of innovation versus an adopter. What’s your take?

David Classen, MD, CMIO, Pascal Metrics, Professor of Medicine, University of Utah, SI Board, Executive Committee, Scottsdale Institute

Amazon really disrupted traditional brick-and-mortar and human-to-human purchasing, but it’s almost impossible to speak to a human if there’s a problem! In healthcare, we’re talking about more connection; Amazon is going the opposite direction. It’s something we need to think about. Maybe in certain use cases we shouldn’t make it easier to talk to a human.

Hans Keil, MBA, SVP & CIO, Beaumont Health

I entered healthcare from life sciences and my first impression, pre-pandemic, was that the system is broken. I believe that meaningful innovation happens at the model level; it is not an IT discussion but rather a discussion about what makes sense for your healthcare system in the future. At this meeting, and others I’ve attended recently, I don’t see a lot of discussion at the model level. Instead, many of us are optimizing the model in which we live now, not the future model that’s being shaped and fashioned by multiple forces and players right now. We need to look at our strengths, things like patient loyalty. Are we doing enough to retain it? We know the complexities of healthcare better than anyone else. How can we use that to our advantage?

Laura Bagus, MBA, VP, IT, Lurie Children’s Hospital of Chicago

I think the most valuable conversations are around tying innovation to operations. All of our C-suite leaders want us to be innovators, but we have to operationalize things as well. Also, people go into proof of concept thinking it has to bring something amazing out of it, but we have to be OK with things failing, too.

LN: What role does design thinking play in innovation?

Tim Skeen: I think it’s an important step to maximize the value when you are reimaging an existing solution or creating a new one. The business tends to come to the table with a specific technology vendor looking to find a solution, a hammer looking for a nail. We need to first design the problem we are trying to solve and the value of solving it. Then we can design the solution. Design thinking is a great way to get to drive that design effort to achieve the desired outcome. But my challenge is battling with people who bring me cool stuff. Because the stuff is cool, they start looking for a problem to solve with it. But I’d rather look at the top 10 problems we already have that need solving and go from there. Innovation must be an imperative that everybody wraps their arms around and treats as a team sport. Innovation can’t be tied to a strategic plan the we do every four or five years; the strategic plan needs to be a living artifact that is continuously iterating. I want the organization to have innovation imbedded in their daily thinking and actions.
Chuck Scully, CIO, Denver Health  
(Guest)
When I think of other healthcare systems’ definitions of innovation, it’s really an opportunity to share best practices, like Scottsdale Institute does. If I have to go invent something, I can apply the same energy to what my peers have done on four or five tasks and my return, in terms of advancing quality and patient engagement, will be so much greater because ours is a smaller-funded organization. Do any of us truly know what “innovation” is? It’s so target-rich it’s ridiculous…but we’ve got to go back to our basic mission. There’s a lot of value that can be gotten by innovating around being followers of the Big Dogs. You can map from your strategy versus just reacting.

LN: Let’s talk about platforms, brands, models and ecosystems. What words do you use to describe yourselves? It seems each of you need to do that so your community knows what your role is. For example, each of you might think about the patient journey in a different way.

George Halvorson, Former Chairman & CEO, Kaiser Permanente; Chair & CEO, Institute for InterGroup Understanding (Guest)
I’m on the board of Mayo Clinic, and I believe it has figured out its platform. We’re a school, a hospital, etc.—all component parts are part of the platform. If we think about things in the context of that platform, everything else makes sense. And everyone here is essentially a platform: Once you think of yourselves as a platform committed to continuous improvement, then all the creativity makes sense because you have a place to put your innovations and enhancements to make those pieces function better. Also, you can encourage people to invest in that: People want the platform to be enhanced.

Tim Skeen: In my world, platform drives technology, product and solution. Since the word platform tends to make the business only focus on technology, I use the term “ecosystem” for us. We think of the ecosystem as products, services or even others within the ecosystem (vendors, service delivery)... it’s multiple partners trying to achieve a certain outcome.

Brian Young, MD, MBA, MS, System Physician Informaticist, CommonSpirit Health
If you look at patients as the platform and design solutions to support them, things will work better... I used to think that was complex across patients with access challenges (no broadband internet, no smartphone), but with an omnichannel approach we could maybe get 80 percent there.

LN: What are some surprises around technology, innovation and efficiencies? What value do you see in sharing or incorporating what others are doing?

David Classen: There’s a number of large companies that strategize as close followers versus fast movers. The Robert Wood Johnson Foundation looked at innovation from this junction: The most innovation was going on in health systems—not with outside vendors, but using their own systems to innovate! I expected to hear that Google and Microsoft were doing all the innovating, but it was the health systems themselves. And while we don’t normally think of predictive analytics in a clinical operations way, that’s what we’re finding—for example, using data to predict complications pre- or post-surgery, or sharing safety information with patients and families via a real-time safety dashboard accessed from home. This is the innovation going on in the health systems... not the big vendors. I believe that operationalizing and sustaining innovation are our biggest challenges. Anybody can innovate, but the successful ones also operationalize.
Gretchen Brown: I think there’s an opportunity in healthcare where tech could help us move data in a more efficient way. When Epic rolls out a new model, for example, they have a cadence of meetings all through the process: There’s an opportunity to get on the phone and link up and hear how everybody’s doing it. That’s what SI can do: There are certain workflows that could be shared with other members, and I think there’s a big value in that.

Hans Keil: I’ve wondered how we’re going to tackle these big topics and what we CIOs are going to do to push the envelope. I’d like to hear a couple of futurists discuss what they think will be happening in the next 10- to 20 years so we know where the puck is going and how to skate in that direction.

LN: The pandemic enabled a “Just Do It” culture. Do you think we can we replicate that in a more rapid way to keep that speed going?

George Halvorson: There’s always going to be a need for acute environment settings—sometimes geriatric, sometimes nursing homes, sometimes hospitals. There will always be some surgeries: You can’t get a proton beam over the Internet to have surgery at home. So we have to think about the entire continuum of care, the platform we want and how to optimize our role within that setting. We have to think in terms of decades: What do we need to survive one decade from now? What’s our value, and what dividend do we pay? If we think in terms of decades, it’s more about our footprint, our staffing and culture.

Tim Skeen: It’s funny: I just came from a Sentara Strategy 2030 planning meeting focusing on where we need to be in 10 years, and then saw how quickly we pivoted to focusing on a three-year roadmap time horizon. I don’t disagree with George, but I’m not sure that this is the muscle and strength of this nonprofit world. It must be driven from the top. How do I create a crisis every week (to mimic COVID) so we innovate faster? Can we only do great things when there’s a crisis? To me, it’s the difference in the organization looking at their watch versus their calendar in terms of how quickly they can execute.

Andrew Smith, President, Impact Advisors
COVID yielded clarity of thinking and purpose and I hope we can keep that. If we could just do that—accelerate both successes and failures—we’d be in a much different place.

Bonny Chen, MD, MBA, FACEP, CPHIMS, VP/CHIO, AMITA Health & Regional CMIO, AdventHealth
I think we can find ourselves spending too much time on micro-problems. We need to think further than the one-, five- or even 10-year plan. We’re here in healthcare because we have an ability to positively impact healthcare for generations. That is our moral imperative. We have to think beyond the traditional timelines, look further, and take action.
Conclusion

In this “peri-pandemic” world today, integrating technology and operations is no longer optional, it is an imperative. Healthcare executives who are leading their organizations through these rapids of change acknowledge that both innovation and operations are critical for success; speed and agility are as necessary as sustainability; and brands and platforms are essential strategies for efficient, effective future solutions.

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The Scottsdale Institute (SI) is a not-for-profit membership organization of more than 60 prominent, advanced, not-for-profit health systems and academic medical centers whose mission is to improve healthcare quality, affordability, equity and personal experience through digitally integrated platforms connecting ecosystems of community and industry partners. Our North Star is Thought Leadership via SI’s Three Pillars of Collaboration, Education and Networking. We convene intimate, informal and collegial forums for senior executives, including but not limited to CEOs, CIOs/ CISOs and CMIOs/CNIOs as well as leaders in Analytics, Innovation and SDoH/ Employee Health to share knowledge, best practices and lessons learned. Our role: Gather the right people to discuss the right topics at the right moment.

For more information, visit www.scottsdaleinstitute.org

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