

INSIDE EDGE

CMO Outlook 2012

EXECUTIVE SUMMARY

We traditionally kick off the year with our CEO Outlook, in which CEOs of Scottsdale Institute member organizations highlight their top IT-related strategies for the year. Last year we changed perspective a bit and featured CIOs in the Outlook. This year we're changing perspective slightly again and handing over the Outlook to CMOs. What good timing.

CMOs are preoccupied with a deluge of quality reporting requirements that will only escalate. On January 1 CMS added two more National Hospital Quality Measures on which health systems must report. Another two will be added in a year. CMOs say there's no way an organization can do this non-electronically without drowning in paper and adding an army of people. "The days of manual record review are over," says Loran Hauck, MD, CMO at Florida-based Adventist Health System. "You just can't keep up" with the quality reporting demands.

Which leads to one of our major themes: if CMOs are being asked to become more and more IT-savvy, how does that shape the CMO role? Also, where does that leave the CMIO? To help frame the discussion we kick off with an interview

with a top executive from Korn/Ferry, the executive-placement firm that places CMOs and other healthcare executives. Our esteemed panel includes CMOs from Winter Park, Fla.-based Adventist Health System, Phoenix-based Banner Health, Providence, R.I.-based Lifespan and Louisville-based Norton Healthcare. We're not saying we have all the answers about the changing CMO role, but we've certainly got some interesting insights to complement our report on what some top IT strategies are for CMOs in 2012.

Seeking physician executive

"The whole physician-integration strategy is spawning an intense demand for physician executives," says Tom Giella, Chicago-based healthcare practice leader at Korn/Ferry International, the executive search firm and SI Corporate Sponsor. "It's become huge. Practicing clinicians are looking to find better ways to partner with large health systems, and this is not just about employment. Having a physician executive who can think through complex issues and help strategize to find mutually beneficial ways to develop these partnerships is invaluable."

He cites a recent client example of a multi-billion-dollar health system that

Volume 18, Number 2

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is seeking a senior VP for physician integration and innovation who will report to the system CEO. The organization serves five different markets with hospitals ranging from small rural facilities to large teaching hospitals. "No one model of physician integration works for every situation. Therefore this physician executive must be really good at assessing the market dynamics. He or she has to determine which value proposition will be most effective; technological advancements and innovations will play a key role in this value proposition as the market is moving more towards transparency in terms of quality and outcomes, both of which need sophisticated IT systems to measure accurately," he says.

K KORN/FERRY INTERNATIONAL



**Tom Giella, healthcare
practice leader,
Korn/Ferry**

A big driver, of course, is that small physician group practices lack the resources to invest in the IT requirements to compete in the world of EMRs, quality reporting and cost accounting in a bundled payment/accountable care reimbursement model. Clinicians also need larger health systems for greater leverage with the payor community and other vendors regarding contract negotiations and purchasing power than they can muster themselves in smaller group practices. "You do lose some autonomy, but have

a better chance of survival in the long term," says Giella.

The bottom line: health systems are seeking more business-minded physicians to assume senior executive roles because they speak the same language as the wave of physicians knocking at their doors. Giella is quick to note this shift is not merely a fad to help health systems with their physician integration strategy. He believes that over the next five-to-seven years a growing number of physician executives will take leadership of the largest multi-hospital systems in the country. "All things being equal, having a CEO who happens to be a physician sends a strong message that the organization is first and foremost about taking care of patients."

Continuum of business

They'll just have to have great business acumen for designing and managing an exponentially larger healthcare environment. As healthcare continues to move toward outpatient and urgent care settings, for example, there will be an increasing demand for physician executives to set up urgent care networks and move organizations toward value-based purchasing.

"In a value-based healthcare world, you don't want to have physicians doing what non-physician care givers can provide. You need to figure out the appropriate service for each level of care. The people who can figure this out are the ones who will dominate in the long term. If you're

a physician, you have a better chance convincing other physicians on how to deliver the most efficient and effective care for patients,” he says.

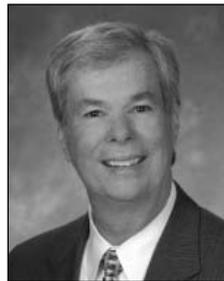
A value-based healthcare world is philosophically counter to the fee-for-service model physicians have been accustomed to where more treatment meant more income. Likewise hospitals will become cost centers versus profit centers. This paradigm shift will work only if there are large, sophisticated and well-integrated delivery systems able to provide comprehensive health services to large networks of people. Payors—both government and commercial—will partner only with systems that can demonstrate real value: provide universal coverage, post strong quality outcomes at low cost and show high customer service scores. Giella continues, “As all of these variables are quantifiable, the onus will be on those systems which have the clinical leadership, technology innovation and financial wherewithal to develop the measurement systems and culture built upon value versus volume.”

All of which puts the CMO in the spotlight.

John Hensing, MD, Banner Health

“We just lost our CMIO,” says John Hensing, MD, CMO at Banner Health, a Phoenix-based integrated delivery system with 23 hospitals in seven states. “We’re at an existential moment and asking ourselves, ‘How does infor-

mation best support where we’re going in healthcare,’ and ‘How do we best provide information to support care and decisions in real time to patients and clinicians to improve individual and aggregate clinical outcomes?’”



John Hensing, MD,
CMO, Banner Health

Key among those challenges is using IT to drive the shift from acute care to accountable care across the continuum—and to do so from a population-health perspective. “Are we going to apply clinical standardization as effectively in the outpatient arena as we have in the inpatient arena? We have only modest levels of experience. The challenge is whether we can influence care delivery in the ambulatory space as much as we do in the inpatient space. The jury is still out, but I think we can.”

Of course, he says, other factors have also conspired to make now the moment for inpatient/outpatient integration: the diffusion of electronic medical records and the exchange of this information; improved access to performance data and the identification of the variation in the performance across units and providers; the public’s realization of the non-sustainability of the current cost growth for healthcare; and the imminent demographic (aging) changes to easily

“The challenge is whether we can influence care delivery in the ambulatory space as much as we do in the inpatient space.”

SI TELECONFERENCES

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Ambulatory Patient Safety

- Erica Drazen, managing director, Global Institute for Emerging Practices, CSC
- Caitlin Lorincz, research analyst, Global Institute for Emerging Practices, CSC

February 27

SI-Cerner Users Collaborative No. 40: Meaningful Use Update

- Roy Foster, director, Regulatory Affairs, Cerner Corporation

February 28

Clinical Decision Support 2011: Understanding the Impact

- Coray Tate, VP, Clinical Research, KLAS

March 1

Centura and Colorado HIE

- Dana Moore, SVP/CIO, Centura Health

March 6

Meaningful Use—Stage 2, 3

- Eric Finocchiaro, specialist leader, Deloitte Consulting LLP

March 8

How to Create a Care Coordination Team Using Spare Parts

- Lyle Berkowitz, MD, FACP, medical director, IT & Innovation, Northwestern Memorial Physicians Group

March 13

Meaningful Use and Accountable Care Series

- Erica Drazen, managing director, Global Institute for Emerging Practices, CSC

continued on next page

outstrip our ability to keep up with demand.

Second, what is the role of IT to support that? How does CDS play out in the ambulatory sector, where most care is given? “We’re examining how to best deploy the intellectual resources of medical and clinical information to achieve the outcomes we need to become a cost-conscious, cross-continuum accountable care organization. We don’t redesign order sets for the clinic setting, except for outpatient surgery. How do you develop order sets that are imaginative, interventional and useful when the amount of decisions, patient interactions and opportunities to make a mistake are enormous compared to inpatient? Those little things can mess up the care of a patient,” says Hensing.

“We have 5,000 physicians total in our physician network. Can we support them as effectively as we have our 800 employed physicians? Those are some questions we ask as we move down this path toward integrated care,” he says.

The role of the CMIO is to consolidate all those IT resources and, at Banner at least, the CMIO has reported to the CMO. “Order sets, design for clinical decision support, complex clinical principles, business intelligence, training people to utilize them. The CMIO is a huge job. It gets even more challenging. Do we need another senior informatics leader over an area that includes nurses, pharmacists, critical

care nurses, administrators, ancillary professionals?”

Beyond the building blocks

Banner is at an important juncture.

“Our focus for informatics for the last six or seven years has been to prepare us for CPOE and a uniform EMR, to build the building blocks. It’s been all about implementation. In the past month we deployed our last hospital CPOE. We’re now a full CPOE system and a Stage 6 HIMSS EMRAM (Electronic Medical Record Adoption Model) company across all systems. We’ve built the infrastructure. Much of this was inpatient focused: how do we design and implement CDS, how we maximize clinical efficiencies, outcomes and safety,” says Hensing.

All of which brings it back to Banner’s CMIO leaving for a job at another health system out east. “It created an opportunity to examine our clinical informatics. When an organization is disrupted, it forces you to ask questions. This has happened to me several times. You have a stable leadership structure and then a leader decides to leave. Before we rush off and replace these people maybe we end up with a different model of utilizing these strengths,” he says.

So, with the health system at a crossroads, Hensing cites four areas of emphasis for the year. First, Banner is organizing and deploying care-improvement models for ambulatory and non-acute care worlds. “We have a model of how we use consensus groups by

organizing resources such as cardiology, critical care and emergency medicine. Now we're going to do that for chronic disease management."

Second, the health system will continue to deploy IT resources to support, understand, measure and improve those outcomes in non-acute-care settings. As part of that effort, Banner is designing the business model for rollout to community physicians of its NextGen outpatient EMR. "We have to determine what the business model is for those physicians. What communication portals can we deploy to facilitate referrals and interaction with physicians? Designing that business model is a huge priority for us," says Hensing.

A third initiative is Banner's patient portal. "We're putting major resources and big bucks into developing a patient portal to allow patients to access their own medical records and schedule their own appointments. To have patient portals directed at patients," he says, and create different avenues for physicians to communicate with those patients, especially members of Banner's physician network.

Fourth, Banner wants to develop a service model that differentiates itself from other organizations through patient engagement and initiatives like chronic disease management. "Rather than having those patients come into our ER, we'll need to reach out to them," he says. "We're exploring eICU technology as a

model for extending teleradiology into the houses of chronically ill patients to keep them healthy and not in our hospitals. Nobody wants to be in a hospital." And under accountable care, hospitals don't want them here either.

**Loran Hauck, MD,
Adventist Health System**

Winter Park, Fla.-based Adventist Health System is the ninth-largest health system in the country with 43 hospitals in 10 states, half of those facilities in Florida. Adventist CMO Loran Hauck, MD, has reported directly to the CEO for 15 years, with dotted-line reporting to the COO, while the CMIO reports to the corporate CIO.

**Adventist
Health**



**Loran Hauck, MD,
CMO, Adventist
Health System**

"We work very closely together," he says of the CMIO. "Until recently, our offices were side by side." While that physical proximity has changed due to

new campus construction, the close collaboration will continue. "The reporting lines are there, but functionally we communicate all the time."

The arrangement has spawned what Hauck views as a unique and successful division of labor that has driven rollout of an advanced clinical IT on an immense system-wide scale. "When we

continued

March 14
Spending Trends Relevant for Successful ACOs

- William D. Marder, SVP, Analytic Consulting and Research Services, Thomson Reuters

March 15
Path to Cloud Computing Foggy: Perception Study

- Erik Westerlind, research director, KLAS

March 19
SI-Cerner Users Collaborative No. 41: Natural Language Processing—Chart Search

- Karl M. Kochendorfer, MD, FAAFP, assistant professor, Clinical Family and Community Medicine, University of Missouri's School of Medicine, director, Clinical Informatics in the Department of Family and Community Medicine

March 21
A Successful Micro ACO as Model for Reform

- William G. Bithoney, MD, National Medical Leader, Thomson Reuters Healthcare, and former interim president and CEO, COO and CMO at Sisters of Providence Health System/Mercy Medical Center

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were implementing our EMR and planning CPOE, the CMIO and I decided to draw a line between the evidence-based content in CPOE and the actual CPOE build and rollout. As CMO, I oversee a team in the Office of Clinical Effectiveness charged with developing and updating evidence-based CPOE content. Then the CMIO and our IS team spent the last three years implementing CPOE. In August 2011 we had all but four of hospitals live with CPOE,” says Hauck. That’s 30-plus hospitals in 36 months—or a CPOE implementation every three weeks.

Content—supported by the vendor Zynx Health—was the CMO’s domain; building the content into the EMR and deployment the CMIO’s. “Like a lot of hospitals where IT deployment is the CMIO’s job, we were able to free up our CMIO from having to do content development. To my knowledge, no one else is using this approach,” he says. By not having to worry about clinical content, the CMIO was able to focus on the critical and time-consuming elements of training, implementation and post-implementation follow-up.

Also key to that successful model: strong executive-level support. “I report directly to the CEO and it’s been his vision to have one, standardized CPOE build. We have no hospital-A build, no hospital-B build. It was going to be standardized,” says Hauck. In the last six years, the health system has

designed evidence-based content into 600 standardized electronic order sets.

All prelude to Adventist facing a completely new reform-shaped healthcare environment—and its first area of emphasis for 2012. “We’re entering the era of value-based purchasing,” he says. “We have to make sure we’re hitting on all the National Hospital Inpatient Quality Measures [NHIQM] which tie to CMS reimbursement. Our CMIO and I had a vision several years ago that most of the clinical data for NHIQM would be located in the EMR database. We needed a tool to pull that data out for the attending physician, consulting physicians, bedside nurses and case managers. As a result we worked with our EMR Vendor to develop an active dashboard for the national quality measures.”

Dashboard to drive quality

The application—dubbed the Quality Measures Console or QMC—was so good that Cerner, Adventist’s EMR vendor, has built it into Millennium as part of its product offering. For example, using color coding the dashboard can alert a clinician that four of eight quality measures are in the red or out of compliance. More specifically, it can highlight a single measure like, ‘Did you administer aspirin within 24 hours to a heart-attack patient?’

While the system automatically populates the dashboard with data, it’s not foolproof: it relies on the bedside

By not having to worry about clinical content, the CMIO was able to focus on the critical and time-consuming elements of training, implementation and post-implementation follow-up.

caregiver remembering to activate the console on appropriate patients. Still, Hauck says it's part of the organization's effort at maximizing the potential of the EMR to deliver evidence-based medicine and real-time quality reporting. "We need to capture quality-measure data as part of the clinician's daily workflow. Our vision with our EMR vendor is to become certified with CMS for direct submission of NHIQM data directly without any third-party vendor for data abstraction," he says.

A second area of emphasis is development of a private-label health information exchange [HIE] for Adventist Health System and its affiliated physicians. After conducting a vendor review, the health system decided to adopt an HIE platform from its EMR vendor Cerner that would support both that vendor's physician office EMR as well as one from NextGen. "We want the ability to have key information in the physician EMR to be available in the hospital EMR and vice versa," he says.

Last fall, Adventist piloted the HIE at its Florida Hospital Flagler, which enabled it to become only the 65th hospital in the country and the first in Florida to earn HIMSS Analytics EMRAM Level 7, the highest designation in its EMR Adoption Model. With 99 beds, Flagler is the second smallest hospital in the nation to achieve Level 7. The real significance is that if a patient presents in the hospital's

ED at midnight, the ED physician can click on the "iNetwork" tab to display that patient's HIE record and view information such as a list of current medications, allergies, lab-test results and imaging studies from physician practices. Eventually, the vision is to also link Adventist-owned long-term care facilities and home-health agencies. That should improve the quality of care and reduce duplicative testing. The HIE design anticipates eventual linkage with local and statewide HIEs.

"I'm incredibly bullish about it," says Hauck of the HIE. "In competitive markets an HIE should make it more desirable for docs to practice at and make referrals to our hospitals."

A third area of emphasis for 2012 is EMR and CPOE optimization. Optimizing the system for improved workflow and efficiency is the next step for Adventist. "Now we're focusing on things like physician and nursing workflow. Is there anything we can do to change the current workflow design to make the process easier? Clinical IT is not the end game. Quality, safety and efficiency are. How can we optimize the design of informatics and workflow to achieve those goals? We're poised now to begin this optimization journey," says Hauck.

Adventist's rapid EMR deployment process standardized CPOE to the extent that in 2011 physicians entered 22.3 million orders directly using CPOE, 6.6 million of which were medication orders.

"Clinical IT is not the end game. Quality, safety and efficiency are."

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About a half-million of those medication orders triggered an alert to the physician which caused them to change their planned order due to such factors as a patient allergy to the medication, duplicative therapy or reduced renal or hepatic function.

Mary Cooper, MD, JD, Lifespan

Mary Cooper, MD, JD, needs another degree...in informatics. The senior VP and CQO at Lifespan Corp. in Providence, R.I., who no longer practices medicine or law, is ready to go back to school again. She and the CMOs at the five-hospital system serving the Rhode Island market agree their jobs are demanding more and more knowledge of informatics and clinical IT.

"The CMO role is changing. There will come a time when the roles of the CMIO, as it is envisioned currently, and the CMO will merge. CMOs are taking over the same oversight of IT implementation at the bedside that CMIOs used to do. We're seeing CMOs across our system taking leadership of successful rollout of IT because the providers are already used to listening to them—and the CMOs listen to the providers," she says, noting not surprisingly that the ones who feel the need for formal informatics education range in age from (upper) 50s to (lower) 60s. CMIOs are going to be the ones who hold us to IT standards, give us insight into the technology future, and suggest technology solutions to the problems we have been seeing for years.



Mary Cooper, MD, JD,
CMO, Lifespan



Lifespan

L i f e s p a n ' s
Medical Director
of Information

Services, who reports to the CIO, has taken a more direct hand in developing the organization's IT strategy, while the CMO has just begun to move into informatics. "Finance, HR and specialty systems used to drive a lot of IT investment and implementation. But as we see the continuing evolution of EHRs, the need for escalating our integration with ambulatory, and the implementation of Meaningful Use, the clinical systems are really at the forefront. As clinical quality and safety have taken center stage, the CMOs see informatics woven into everything they do," says Cooper.

A lot of work has been done with the CMOs—and the CNOs—guiding the effort. All of the hospitals are at least at HIMSS level 6, and the CMO/CNO teams led their hospitals to certify in Meaningful Use in 2011. "They didn't roll out unit by unit," says Cooper. "Once they decided to move forward, the partnership between the CMOs and IT allowed IT to turn on a whole hospital at a time."

Sitting down to validate the data has been another joint effort between IT and

the CMOs. “They know the processes,” says Cooper, “and therefore they know where data can be collected in a way that doesn’t disrupt workflow. The staff on the frontline expect their leaders to resist putting in systems and processes that don’t make sense. And the CMOs and their partner CNOs have risen to the task.”

A major emphasis has become the need for disparate information systems to talk to each other within hospitals and the health system itself. “Interoperability is just not there yet at the field level,” she says. “In fact, we are starting to see significant errors and near misses—where the ‘n’ has the potential to be in the thousands—that arise from a lack of interoperability. No matter how good our IT staff are, they are dealing with systems that require our entire clinical staff to be vigilant. Having the face of the CMOs to preach that message allows the medical staff to hear it without feeling the need to rebel against the systems, taking them down and unwinding all the work that has been done.”

Cooper cites as a key example the medication error that occurred in all Lifespan hospitals at the end of October. Fortunately, attention to early warning signs and all the training effort by CMOs and CNOs to encourage front-line staff to report variances paid off. A nurse and mid-level practitioner noted their patient’s prescription on discharge did not match the medication the patient was on in the hospital. The CMO heard

about the error within four hours, and working with IT, was able to put a quick fix in place. That error impacted 2,000 patients.

“In some hospitals, an error like that would have brought down all the IT systems,” says Cooper. “Because the medical staff felt the CMOs were working with IT to solve the error, they were patient. Even when the interim solution required more work, the medical staff were patient. IT alone would not have been able to develop that level of trust. IT is not going into the ORs to operate, or seeing patients in ambulatory sites.”

New matrix, new world

As a result of this event, Lifespan hired outside consultants to evaluate its processes for testing and user training. “We’ve put all of our users on high alert because, while we assume the systems are reliable, our assumption is not always correct. The impact if anything goes wrong is of a magnitude exponentially greater than anything we’ve known before,” she says.

A second major focus for Lifespan this year is on the new quality measures. “The number of measures coming out of the federal government is overwhelming organizations. If you don’t have an electronic strategy to accommodate them,” says Cooper, it will be impossible to comply with them. “There are so many and they’re so broad.”

Third and final, Lifespan is making a heavy investment in training, especially

“We are starting to see significant errors and near misses—where the ‘n’ has the potential to be in the thousands—that arise from a lack of interoperability.”

Ironically, that means health systems are returning to more IT training even though user sophistication has increased.

for recent hires. “Because so many of the younger generation are coming into hospitals IT—and—social-media savvy, we have not focused on training them in IT standards,” she says. Absent that guidance—and armed with the false confidence from having been weaned on technology—these new users develop their own shortcuts and workarounds that often circumvent established practice in the hospital. Ironically, that means health systems are returning to more IT training even though user sophistication has increased. A related challenge is the lack of availability of trainers. “There’s such a dearth of people going into IT fields, that we’re facing an increasing number of people who need training and at the same time an increasing scarcity of trainers with both clinical and IT skills,” says Cooper.

***Steven Hester, MD,
Norton Healthcare***

Louisville, Ky.-based Norton Healthcare is well-known for its trailblazing Healthcare Quality Report, which graphically displays on its website [<http://www.nortonhealthcare.com/QualityReport>] how well its five hospitals are performing in terms of patient satisfaction and 600 nationally recognized quality indicators. As senior VP and CMO, Steven Hester, MD, is committed to expanding that kind of analytical capability for Norton in 2012.

“We’re becoming more and more dependent on technology to determine not just quality but cost as an entire orga-

nization,” he says, adding that’s why he views the CMIO role, which reports to him, as a strong complement to the CMO. Hester, who served as a CMIO for two years before becoming CMO, sees the CMIO title only increasing in importance. “It’s not just a matter of completing an implementation of an EMR and being done. It’s a continual process of optimization. I see the CMIO charged with getting the maximum value from our IT investments.”



**Steven Hester,
MD, CMO, Norton
Healthcare**

First on Norton’s list of IT-enabled priorities, he says, is completing its enterprise-wide implementation of the Epic EMR both in ambulatory clinics and inpatient

settings. “We’ll have 100-plus employed-physician offices [Norton employs 572 physicians] done by August and two of our hospitals completed by the end of the year. The remainder will be done in 2013.”

A second objective is to complete the build-out of Norton’s data warehouse. “We’ve been working with Microsoft Amalga to aggregate data to a single place. The value is the ability to generate a cross-sectional view of clinical and business data for cost and quality,” says Hester.

Closely related is Norton's third IT-related emphasis for this year, which is to continue to evolve the organization's business intelligence tools. "One of the things in healthcare today is the unbelievable amount of data. But its value depends on how well we can turn it into information for clinicians and the management team," he says. BI tools might include, for example, dashboards for time of care, efficiency of care or how many patients have been readmitted with infections.

A fourth and final area of emphasis, notes Hester, is to answer a multi-dimensional question: "How do we start

looking at tools to evaluate population health and what we ought to do in a risk-based structure?" Norton, a Brookings-Dartmouth ACO pilot, must determine how to manage populations and become more accountable, he says.

Conclusion

In choosing CMOs as the focus for our 2012 Outlook issue we picked the executive title most squarely in the eye of the storm transforming healthcare today. Quite simply, the CMO best embodies the union of the clinical, operational and business worlds in healthcare, a union so critical to the still-emerging landscape of coordinated and accountable care.



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Missoula, MT**Dignity Health**, San Francisco, CA**HealthEast**, St. Paul, MN**Heartland Health**, St. Joseph, MO**Henry Ford Health System**,
Detroit, MI**Integris Health**, Oklahoma City, OK**Intermountain Healthcare**,
Salt Lake City, UT**Lifespan**, Providence, RI**Memorial Health System**,
Springfield, IL**Memorial Hermann Healthcare
System**, Houston, TX**The Methodist Hospital System**,
Houston, TX**Munson Healthcare**,
Traverse City, MI**New York City Health & Hospitals
Corporation**, New York, NY**New York Presbyterian
Healthcare System**, New York, NY**Northwestern Memorial
HealthCare**, Chicago, IL**Norton Healthcare**, Louisville, KY**Oakwood Health System**,
Dearborn, MI**Parkview Health**, Ft. Wayne, IN**Partners HealthCare System, Inc.**,
Boston, MA**Piedmont Healthcare**, Atlanta, GA**Provena Health/Resurrection
Health Care**, Mokena and Elk Grove
Village, IL**Scottsdale Healthcare**,
Scottsdale, AZ**Sharp HealthCare**, San Diego, CA**Sidra Medical and Research
Center**, Doha, Qatar**Spectrum Health**, Grand Rapids, MI**SSM Health Care**, St. Louis, MO**Sutter Health**, Sacramento, CA**Texas Health Resources**,
Arlington, TX**Trinity Health**, Novi, MI**Trinity Mother Frances Health
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