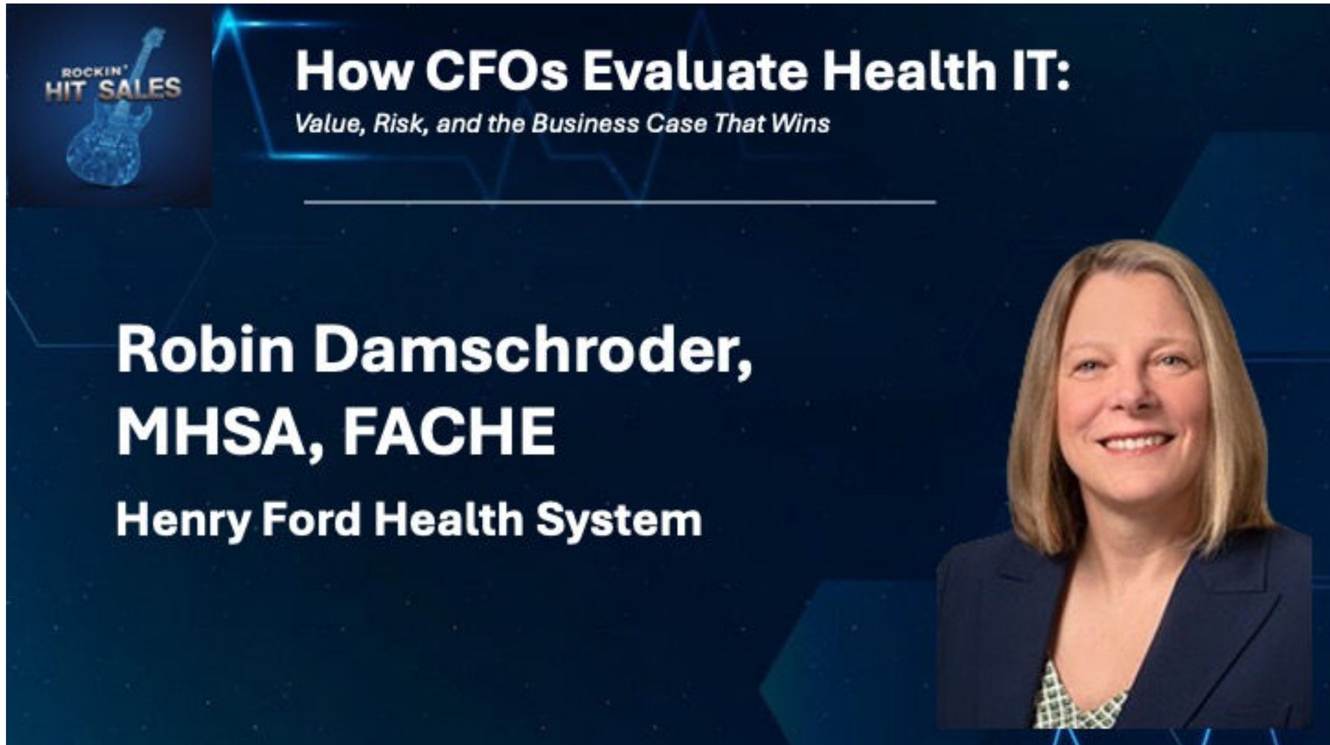

Rockin’ HIT Sales

Episode Transcript

How CFOs Evaluate Health IT: *Value, Risk, and the Business Case That Wins*

Guest: Robin Damschroder, MHSA, FACHE, Henry Ford Health System

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Transcript note: Edited lightly for clarity and readability. Intro and outro omitted.

David Hacker (00:01)
Hi, Robin. Welcome to the Rockin’ HIT Sales podcast.

Robin Damschroder (00:05)
Thank you for having me, David. It’s a privilege to be here, and I look forward to our conversation.

David Hacker (00:11)
I’m very excited to have you here. Most of our listeners don’t often get a chance to hear directly from a health system CFO. That perspective can help them turn what they believe is a strong story into something that actually gets approved and scaled. So let’s dive right in, if that’s okay.

Robin Damschroder (00:30)
Sure.

David Hacker (00:31)
To set the stage for listeners, how do you describe your role as CFO in decisions about digital health, data, and AI-enabled tools at Henry Ford Health?

Robin Damschroder (00:44)

As CFO, you sit at the center of it because people are looking for investments, and that comes through the finance team. I also have the privilege of having the IT and revenue cycle teams report directly to me, as well as some of operations. So I understand both sides: the need to make good investment decisions as CFO, and the need for the teams looking for investment to get ready and prepared here at Henry Ford.

We have installed a governance approach around our AI and IT functions so we can get the most out of them. It's complicated, it's new, and there is a lot of change management involved. It is not just the technology; it is the people and the process.

We have looked at AI governance across three tiers. The first tier is our core enterprise systems, such as Epic and PeopleSoft. The teams that own those systems are developing deeper AI capabilities and deploying them over time, and we can take them on as we are ready.

We also look at strategic, large-scale partners to help us do unique things across different platforms. And finally, there are some highly specific, particularly clinical, use cases that are more one-off. We have to look carefully at those because the market is moving fast.

We evaluate total cost of ownership. We evaluate security implications. We ask whether the solution really solves our problem and whether it is going to evolve quickly. We are trying to exercise patience at Henry Ford, particularly in those second and third categories: strategic, large-scale partners and selected one-offs. Those are unique situations, and we are evaluating short-term gain versus long-term impact.

Because the environment is moving so quickly, we are also trying to reduce fragmentation across our systems. We have large amounts of data we use for operations and analytical insights to improve patient care, and we want to minimize cybersecurity risk as well. Hopefully that is helpful as an introduction to how the CFO, and specifically how I, get involved.

David Hacker (03:17)

When a new technology proposal hits your desk, are there two or three questions you automatically or instinctively ask about that technology?

Robin Damschroder (03:31)

Absolutely. I probably have three or four.

First, does it align with one of our enterprise priorities and existing platforms? That is important because there are a lot of things we could work on, but we are trying to solve our highest-priority needs at the moment. We do have areas where we pilot; it does not mean we will not consider something. But if you want to get the attention of an organization our size, it really has to align with one of our priorities.

Anyone who has been in healthcare for a long time knows we have a lot going on. If you are in one of our priority categories, you usually get our attention.

Another key point is people and process change. What is required to be successful? Do we need to upskill our people? Are we going to transition people to other roles because we are automating some of the work? We want to be careful in how we manage our team, and we want to build the right culture around these technologies when we put them in place.

The other question we ask is whether the solution is robust. Is it a single-function one-off, or is it something we believe will be evergreen and embedded? For example, Epic has rolled out toolkits that are largely going to be evergreen. They will update the capabilities over time, and we will implement them as we see the pace of change and where we will get the largest return.

When we look at strategic or one-off solutions, we take time to understand how they integrate with our core systems. If we are going to attach something to a larger platform, we want it to have some longevity.

David Hacker (05:22)

You have mentioned change management a couple of times already, and I think a lot of our listening audience sometimes underestimates that component. New technology changes workflows and changes how things get done. So thank you for bringing that up.

Shifting into business cases, from your perspective, what separates a strong and credible business case from just a shiny proposal when it comes to new technology?

Robin Damschroder (05:58)

I mentioned total cost of ownership. In addition to understanding how much the technology costs and what it might be replacing, I also want to know how much we will need to invest in people and process.

I like a holistic approach. I want to know the KPIs. What operational improvement metrics are we going to get in addition to return on investment? How will it affect consumer engagement and patient engagement? How will it affect our team members?

When we look at KPIs, we look at a well-rounded scorecard. And in the case of AI technology right now, we are usually weighing the cost of short-term versus long-term impact.

David Hacker (06:42)

As your team has those discussions, how important is it that vendors articulate a downside scenario, especially for large enterprise solutions? For example, if their payback period at 100% rollout is one number, is it important for you to understand the financial payback if adoption is only 50%?

Robin Damschroder (07:17)

It is important. If they do not do it, we will do it.

What I like is a partner or vendor who is honest. Usually we look for use cases or business case studies from other customers, if they have them. We ask what lessons were learned. Many times we ask for a customer reference so we can talk to them directly.

We are not trying to shoot holes in the business case. We are trying to assess our own readiness. If we miss assumptions, such as the ramp-up and rollout because we did not get adoption and engagement right with clinicians, then our payback and KPIs may be slower than someone else's experience.

We use those elements to make sure the rollout plan we put in place will be successful, and also to know where we need to own the outcome. If it comes up short, maybe it is not the technology; maybe it was the approach we chose. We should be prepared that our ramp-up or adoption may go slower than the experience in the business case they shared.

Partners should not be afraid to talk about lessons learned. No two health systems are formed exactly the same way. We have differences in how our leadership teams are formed. That is not on the vendor; that is on us.

If they are a good partner, they will assess us and share where they see we may be more challenged than the organizations in the business cases they shared. That is the sign of a true partner. You have to be ready to pivot together. Henry Ford does a lot of collaborations, and our success comes from knowing things are going to happen and that we will have to pivot. The question is how well we pivot together as partners.

David Hacker (09:16)

Financial leaders are balancing margins, access, and workforce strain all at once. How do those pressures show up when you are evaluating a new digital or AI tool or proposal?

Robin Damschroder (09:31)

One concern in the industry and the community right now is whether technology will displace people, and what opportunities you offer people in that situation.

Unlike some industries, many places in healthcare have a lot of unfilled positions or positions people are not interested in moving into. Some of those roles also do not pay enough, so we are trying to automate them quickly and reduce our reliance on premium labor.

But throughout my career, anytime we have made a transition with technology - not just AI - we have been thoughtful because roles and jobs do change. We like to offer people the opportunity to upskill. And because we are a large organization of about 50,000 people, if someone's role is displaced, we often have the opportunity to place them in other roles within the health system.

We take that very seriously. Anyone who partners with us at Henry Ford should know we have a huge focus on our people and culture. How we do this matters to us. We do not move faster, particularly around the change process, than we can pay attention to that element.

As vendors deploy these technologies, they often have lessons learned about where opportunities exist for upskilling the workforce and how to do it. We like to partner with people because we want success not only for Henry Ford, but also for our teams and the individuals involved.

David Hacker (11:14)

From your vantage point, what do Health IT companies most often misunderstand about the CFO's role in the decision-making process?

Robin Damschroder (11:25)

I think sometimes they assume I am the only decision maker. The CFO role, the strategy role, or any lead executive role operates within processes, policies, and governance. Following that is very important to me.

People can have archetypes for different CFOs, and I think you need to recognize which archetype you are dealing with. Know the organization and know the person you are talking to.

Where people miss the mark is when they think they can just go to the top of the organization and get a decision made. In the end, I am not the one who will be deploying it. It will be my team or one of the clinical teams. They need to be successful. They need to know the outcomes. They need to own it and drive it. I cannot just force it onto someone. That is not how we work at Henry Ford.

We do talk about big ideas and the need to change. We ask people to look at how a process could change, and we support those change processes through governance and policy.

Budget is a big issue. A lot of people believe the sales cycle in healthcare is too long. But we have to stick to our budget. If you miss the budget cycle, you could be waiting a while because you may not get set into this year's priorities. Vendors and partners need patience and need to understand where they are in the priorities, whether they missed the budget cycle, and how the organization works.

You can go to some organizations and get a decision at the top and start there. That may be a quick decision but a longer implementation. I will tell you: if you take more time on the front end, you will probably get a quicker, more successful implementation afterward. You have to gauge your customer.

David Hacker (13:31)

You brought up the budget cycle. Some facilities, and I'm not sure about Henry Ford Health, have criteria where a realistic payback period at a certain level might allow them to acquire something outside the normal budget cycle. Is that something Henry Ford looks at sometimes?

Robin Damschroder (13:55)

Certainly. We always reserve funds for things that become priorities during the year because we were not anticipating a problem. For example, last year we approved a system upgrade out of cycle.

There are also situations where we may not be finished evaluating systems during the budget cycle, but we know something is a priority for the year. So we may reserve funds for something we are going to make a decision on later.

Again, it comes back to knowing where you are in the process. My revenue cycle or IT leads, or a clinical lead, can tell you where they are, how they are moving something through the governance chain, and whether it has gotten far enough that they believe it has been set as a priority for the year.

David Hacker (14:45)

If you could redesign the standard vendor conversation with anyone on your financial team, is there anything you would add? And is there anything you would want to take away from those conversations?

Robin Damschroder (15:06)

I do not know that I have anything I would necessarily take away. We are pretty thorough. I like my finance and supply chain leaders to understand more than just the financial case. I want them to understand what operations is getting. Are we sure we are going to get patient engagement? Are we going to get operational improvement? Those are critical parts.

If we have not had those conversations, and I see us running toward a decision without alignment, our process will slow down.

What I would like to see from vendors is a clear answer to this: what are you doing for us? Everyone wants us to pay a premium price. That is not where we are going to be, particularly here in Michigan, where commercial reimbursement is around 200% of Medicare. We always look for value.

Vendors should not be surprised, especially as we go forward with OBBA, when we ask how they are contributing to the affordability of healthcare. That comes across in price and in other points of value.

I do think people are going to feel a slowdown in how fast we spend and what we spend on. One of the more surprising parts of the conversation may be that we are going to prioritize solutions with shorter returns versus longer returns because we are on a clock to 2028 with the reimbursement cuts we are going to have. If I were to say how the conversations may change with my finance and supply chain people, I think vendors are going to hear that enter the conversation.

David Hacker (16:57)

We are going to hit what I call the lightning wrap - the final two questions. Simple, hard-hitting, quick-response questions.

If every Health IT company leader had to answer one question before submitting a proposal, what would you want that one question to be?

Robin Damschroder (17:04)

For me right now, it would be: how will your solution not only solve our operating issues, but reduce our cost structure within the next six months? That is going to be a hot topic for us.

David Hacker (17:35)

Is there one thing you are cautiously optimistic about when it comes to digital health and AI systems over the next few years?

Robin Damschroder (17:48)

I am actually profoundly excited about the workplace transformation that AI is going to drive in the enterprise. I grew up in the days when I was an accountant using pencil and paper, seven-column and 14-column worksheets. Then we went to computers, and I watched my life change in three years. Now I am going to watch our workforce’s life change in probably 18 months. I am profoundly excited about that.

David Hacker (18:15)

Robin, it has been a pleasure. Thank you very much for joining me today. I am sure our listeners will walk away with a clear CFO lens on what it really takes for a Health IT investment to be fundable, approvable, and scalable within a health system.

Robin Damschroder (18:32)
Thank you so much for inviting me to participate. I absolutely loved it.