



Scottsdale Institute 2018
Chief Nursing Informatics Officers

Managing Change and Optimizing Clinical Innovation

April 27-28, 2018 | Scottsdale, AZ

Executive Summary

Wolters Kluwer is publishing this report in partnership with the Scottsdale Institute, a not-for-profit membership organization of 50 health systems and academic medical centers that are collaborating to achieve clinical integration and transformation through information technology.

Eight nurse executives fulfilling the functional role of Chief Nursing Informatics Officers (CNIOs) at major health systems and Scottsdale Institute member organizations met in Scottsdale to discuss “Managing Change and Optimizing Clinical Innovation” on April 27-28, 2018. They talked about such topics as mentorship, encouraging more women to take on IT leadership roles, good hospital citizenship, tamping down the proliferation of one-off apps, dealing with financial pressures and growing this group. This report captures their discussion and shared insights.

Attendees

Judy Blauwet, DNP, RN, Chief Clinical Information Officer, [Avera Health](#)
Jennifer Carpenter, MSN, RN, Vice President, IT Clinical Systems, [University Hospitals](#)
Darby Dennis, RN, Vice President, Clinical Information Technology, [Houston Methodist](#)
April Giard, MSN, System Vice President, Chief Nursing Informatics Officer, [Eastern Maine Healthcare Systems](#)
Sherri Hess, MS-IS, RN, Chief Nursing Informatics Officer, [Banner Health](#)

Candice Larson, RN, Interim Chief Nursing Informatics Officer, [HonorHealth](#)
Ellen Pollack, RN, Chief Nursing Informatics Officer, [UCLA Health](#)
Rosemary Ventura, DNP, RN, Chief Nursing Informatics Officer, [NewYork-Presbyterian Hospital](#)

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Moderator
Pam Holt, RN, MOL, Director,
 Clinical Effectiveness Operational Consulting,
 Wolters Kluwer and Emmi

Theme 1 | What is the role of the CNIO in your organization?

While there is a [standard definition of the CNIO role](#) offered on the HIMSS web site, in real life their duties and obligations vary from institution to institution. In some cases, they embrace responsibilities that might be assigned to the Chief Medical Information Officer or the Chief Information Officer at another organization. In other cases, the individual might not wear the title of CNIO but have all the responsibilities that come with that role as generally understood. At Houston Methodist, for example, the hospital administration limits the number of roles that have “Chief” in their title. Darby Dennis, the current incumbent, says the Chief Nursing Officers regard her as CNIO even though her title is Vice President of Clinical Information Technology. She is looked at as “that nurse technical expert within the organization.” However, she has broader responsibilities that include management for all clinical systems. “System CNOs felt the nurse informaticists from all hospitals (they are decentralized) would have a dotted line to me.”

At NewYork-Presbyterian, Rosemary Ventura views her job as “liaising with a lot of other IT folks, making sure IT is supporting nursing and clinical needs.” Jennifer Carpenter at University Hospitals in Cleveland finds that her day-to-day responsibilities include similar responsibilities as well as a substantial amount of time managing vendors. The person who assumes this role should also be regarded as one of the chief influencers in the hospital, Pam Holt, Wolters Kluwer, notes.

CNIOs serve the distinct role of supporting nursing and their technical needs, but with varied titles across hospitals and health systems. There is a desire to 1) clearly identify the function of this role in organizations and 2) clearly define the role to deliver excellent service to the nurses and clinicians across each organization. This will allow hospitals and health systems to support the technical needs of nursing in a consistent manner.

Theme 2 | Describe your reporting lines

CNIOs have a variety of reporting lines and responsibilities. According to a 2016 [HIMSS survey](#), 34 percent of CNIOs report to the Chief Nursing Officer, 25 percent to the Chief Information Officer and 16 percent to the Chief Executive Officer. About 5 percent report to the Chief Medical Officer and another 5 percent report to the Chief Medical Information Officer. Of the remaining 15 percent, additional roles include Chief Operating Officer, Chief Clinical Officer and other senior-level executive positions.

Ellen Pollack at UCLA Health, likes working with her CMIO, “but I don’t want to report to him. I feel very strongly about this. Our team wants to own the customer experience and the work flow. I want those people reporting to me. We don’t need to have the people actually building the systems and apps.”

Sometimes CNIOs end up being assigned tasks that don’t really fall within their job description or reporting lines. Rosemary Ventura is currently project managing for IT.

“Because they work in silos. They don’t talk to each other. I end up figuring it out for them.” IT is full of silos based on the application a team supports, Darby Dennis observes. They like to say, “Oh, I don’t do that. Oh, that’s not mine.”

Nurses like to fix things, to bring people and situations back to a state of productive equilibrium. There is a huge opportunity for the person in the CNIO role to exercise this function, to become a kind of IT-enabled process engineer, within the extremely complicated confines of a health system. To maximize this opportunity, to pursue the greatest benefit to the smooth running of the hospital and health system, the optimal reporting structure for the CNIO will vary by organization.



“System CNOs felt the nurse informaticists from all hospitals (they are decentralized) would have a dotted line to me.”

-Darby Dennis, RN, Vice President,
Clinical Information Technology,
Houston Methodist

Theme 3 | Proliferation of EMRs, one-off systems, and apps

Many hospitals, especially those that have undergone mergers and successive waves of combinations or affiliations, now find themselves with legacy IT systems that are not compatible. In some instances, departments or clinics have purchased niche applications or specialty add-ons that clinicians in those departments have requested, or prefer to use. Keeping all these systems running can feel like a herculean labor. Yet it can be a thankless task to attempt to persuade that user group that the niche application requires more expense or time investment than it merits. Most people in IT would prefer to move toward a system-standardized EMR platform, and reduce the number of independent apps, even if they are regarded as best of breed.

NewYork-Presbyterian, for example, operates nine different EMRs. “Nothing is standardized,” notes Rosemary Ventura. “Even the gauze we use is different in each hospital.” System leaders are trying to put a stop to these proliferations. “Unless you have an absolute reason why you’re so special, you can’t get any unique thing through,” she says.

At HonorHealth, clinicians are still accessing those one-off systems. Therefore the system has to continue supporting them, Candice Larson says. After the system’s merger, “we had Noah’s Ark—two of everything, or three in some cases.”

Some of the older applications are not encrypted and not secure. That is one argument that can be used to shut these legacy apps down, suggests April Giard of Eastern Maine Healthcare Systems. Judy Blauwet, Avera Health, is of the opinion that to be truly integrated as a system and

fully outcome-driven, the number of smaller third-party vendors must be reduced. And to do that, it has to start at the top: System leaders have to put their foot down. At Avera Health, “we’re not adding anything more. Our system CIO asks, ‘Have we vetted this? Does it work?’” At Houston Methodist, Darby Dennis comments, the system CEO has told all hospitals and all departments to leverage Epic. If Epic can do it, the system will not introduce a new technology.

That raises the question: Should hospitals wait until Epic or Cerner or Meditech come out with this new feature, or should organizations meet the need immediately and buy a product off the shelf?

UCLA needs fetal monitors. “We’re going to wait a couple years” until the EMR vendor develops that component, Ellen Pollack says. “Because it will be integrated.”

Very often the internal process is part of the problem. People have to be trained to not say “Yes” to the first thing that comes in the door. In some cases, a vendor has approached a unit and the unit wants to buy it, Sherri Hess, Banner Health, explains. There’s already a relationship. “You have to have finance on your side to say, ‘Wait, is this a technology request? Then it has to go through our process.’”

“They can be 90 miles down the road before we even learn of it!” Judy Blauwet interjects. Emotions can come into play. What is the vendor-physician relationship? “At Avera we have system IT governance. This committee, comprised of the system CEO, COO, CIO and CFO, evaluates and resolves these issues, and I am on that committee.”



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UCLA Health



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Governance is at the heart of the matter—"clinical governance, not IT governance," Ellen Pollack believes. UCLA had never had any governance for these issues. "It was willy-nilly. We felt strongly, it had to be clinically led, not just an IT project." The IT department doesn't get to say yes or no. "There is no IT governance. It's clinical governance. Once decisions are made, then IT staff acts on those decisions."

Different departments can have different relationships to their technology. "In the cardiology department, they struggle with making system decisions," Darby Dennis says. "The service line has struggled to find a strong operational owner to lead the decision-making on system-based decisions, especially those impacting the physicians. I put their project on pause seven years ago because there was no operational owner and no physician engagement. This was not an IT issue; rather, it was an operational issue."

Theme 4 | The citizenship role of the CNIO

CNIOs are in a position to reinforce the moral values of their institutions. This set of values, sometimes called system citizenship, can guide employees in their day-to-day interactions with each other, and with patients. But it has to be articulated and demonstrated from the top. NYP has developed a reputation among its employees and physicians for nurturing a "[Culture of Respect](#)".

Houston Methodist is "very strong on culture." Non-employed physicians are expected to behave in a way that supports the "[ICARE](#)" values of integrity, compassion, accountability, respect and excellence in all they do. Nurses are the biggest advocates for these values, with the result that the hospital has "the most patient-centric approach of any organization I have worked in," Darby Dennis says.

Yet this sense of citizenship and mutual obligation may not be present at every hospital in a system. In a particular system represented at the Summit, one hospital and board feel like they have to cater to a particular group of physicians because the group drives so much business into the hospital. "I told the CNO, I feel sorry for you, that you have to deal with this," the system CNIO told the group. "It's not like this in our other hospitals."



"How can we get more women leaders in healthcare IT? IT leadership tends to be about 99 percent male. We need to mentor more women leaders on boards."

-Sherri Hess, MS-IS, RN, Interim Chief Nursing Informatics Officer, Banner Health

Theme 5 | Women in IT leadership roles

CNIOs can be found at the intersection of two of the most gender-determined career paths in U.S. life. As nurses they are part of a profession that until the last 20 years has been mostly female. As IT experts they operate in a world that is overwhelmingly male. As women executives propelled to leadership within the nursing work force, they are asked to harness the male IT workforce to the clinical needs of the female users.

“How can we get more women leaders in healthcare IT?” Sherri Hess asks. “IT leadership tends to be about 99 percent male. We need to mentor more women leaders on boards.” Darby Dennis sees more women in IT roles than ever before. Of the three vice presidents in her organization, two are women. It is less of an issue than it used to be, she thinks.

One thing that may be holding women back is their personal style. “Men are commonly very direct,” Jennifer Carpenter, University Hospitals, observes. “I am more reserved in my initial approach than many male colleagues. I have a tendency to work through a situation internally first. It’s not that I don’t have opinions. I just voice them differently.”

Plenty was heard from CEOs, CFOs, CMIOs and CIOs at the Scottsdale Institute conference, Darby Dennis points out. “There was not a focus on CNIOs (who are mostly females). I would like to see that change. I would like us to take a full role in the annual conference.”

Clearly, there is a need to mentor more women as leaders, and particularly women as IT experts. “How do we mentor women?” Judy Blauwet asks. “How can we make sure we have the skills to be competent and confident to step forward and take a role on leadership teams? It’s not as though women have no power in some of our organizations. As an example, Avera Health is owned by Catholic Sisters. Thus women will be making the final decision for our next CEO.”

Mentoring and professional growth is happening in the field. At Eastern Maine, nurses teach the informatics immersion course. At Banner Health, nurses on the informatics team will get their [ANCC certification](#).

At UCLA, certification is not required as part of the hiring process. But it is expected that nurses will acquire certification during their time at the health system, Ellen Pollack notes. The nurses created a study group. “It was a nice bonding exercise for the nurse informaticists,” she says. They took the certification exam together.



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-Jennifer Carpenter, MSN, RN,
Vice President, IT Clinical Systems,
University Hospitals



A CNIO is born

One participant at the CNIO Summit, Candice Larson, was about to start a new position the following Monday as Interim Chief Nursing Informatics Officer at HonorHealth, a five-hospital system in Phoenix and Scottsdale. Candice has been a nurse since 1985 and has been with HonorHealth 30 years this May.

“What would you advise a person who is stepping into this role,” Pam Holt asks.

“Candice Larson starts as interim CNIO next week. What should we tell her?”

- “It’s about relationships.” – Ellen Pollack
- “Listen to their needs.” – Jennifer Carpenter
- “Know yourself. Know your strengths and weaknesses.” – Darby Dennis
- “Do not be afraid to voice your opinion, and show your knowledge. You got this position because they saw something in you.” – Rosemary Ventura

Ten days after the CNIO Summit, we reached out to Candice by phone to check in.

What did you hear at the CNIO Summit that struck you?

The candidness of everybody. We all have similar experiences, whether it’s issues we encounter, or successes. They’re very humble people as far as sharing that information. They are very collegial.

Another theme: How do we shift those perceptions on the projects we’re involved in to make it not so much an IT-driven initiative? How do we make it more clinically driven or relevant, versus IT leading the path? I am curious to hear their stories on how they have attempted to shift that, placing themselves at the table, partnered with IT. That was my biggest takeaway.

I was also interested to hear how vastly different the role of the CNIO is among all of us, how it’s customized to the needs of the organization. One person was very heavily involved in the contracting, versus another one who was more involved in work flows and process at the bedside. That variety of approaches to the role was very interesting.

Aside from your operational goals for this position, what are your larger, more strategic interests?

What I’d like to bring to the table is thoughtful planning, doing our due diligence from a technology and workflow perspective. I think we will have increased successes and adoption once we have done that preparation up front.

I feel like sometimes I would hear that IT is a black hole: “We’re not sure what goes on in there.” There are a lot of moving parts in the IT world that people don’t really understand: the infrastructure, the timing of getting various systems in place and refreshed. These play into the timelines of projects. There is also a perception in the clinical world that IT is driving it, but in reality we have to get the clinicians to lead. Otherwise you’re going to have a situation of frustrated clinicians or unreliable technology.

For example, if growing mobile technology at the bedside for clinicians is on our horizon, it is essential to ensure the wireless and infrastructure is adequately in place. In some areas it has to be refreshed or expanded. You can’t make quick decisions to layer on applications without the foundation to support it.

Theme 6 | The impact of financial pressures on nursing and IT

The CNIOs in attendance agree that the increasing financial pressures on their hospitals present a large challenge.

Ellen Pollack remarks that it's now imperative that new projects show value added. "We need things we can really quantify. We need to show an ROI. Several of our participants couldn't be here today because of travel restrictions. The financial thing is spreading and real. It's hard to quantify these things. A lot of things you do you know add value, but it's hard to attach a dollar value."

Eastern Maine changed charting requirements to bring average charting time down from one hour to 30 minutes. "You can multiply out [reduced charting time] to time and money saved," April Giard says. "That was a big effort. We just went live three weeks ago. It's a huge win."

Beyond the financial pressures, hospitals and clinical IT departments are facing other challenges as well. At UCLA, Ellen Pollack is responsible for telehealth strategy. She is having trouble finding people in the departments to lead and champion implementation. Analytics is another gap she notices. "We're not keeping up. That needs to be a goal for this year. I don't know whether the nurses on my team can speak to it."

The effort to keep costs down almost always has an IT component. "So these IT requests come showering down on us," Darby Dennis says. "It's been extremely disruptive to our IT organization. The strategy makes no difference. We are having to redo our strategy for this year. We are talking to our vendor about how to work through this."

At University Hospitals, Jennifer Carpenter says, "I have spent more time in the last year on revenue-cycle management than I ever imagined. The financial side of healthcare was not something I considered much when I was in practice. I did not think about how much things cost. Now, as a health-system leader who is also a nurse, I find myself looking at all sides of a situation. Documentation of IV start-and-stop times sounds like a simple 'must do' to a finance leader, but to a nurse, signing off the med once feels like enough. The nurse is juggling so many responsibilities and complexities that Informaticists and IT professionals need to find ways to help automate and simplify this work."

Theme 7 | The importance of metrics

How do CNIOs measure their impact on nursing practice, in terms of satisfaction, quality, efficiency, return on investment?

"Not well," answers Jennifer Carpenter. "I have a lot of measurement reports for different priorities, but I don't yet have a cohesive scorecard." The problem, adds Rosemary Ventura, is that "everything is a priority. You are trying to get things off the checklist. Unfortunately, this becomes a 'nice to have.' We would like to have the luxury of doing pre-surveys of the status quo and analyze the data afterward."

Judy Blauwet notes that at her organization, quality is not the issue. "We do great on quality. But everything is about bending the cost curve. We have great variability in nursing documentation in terms of efficiency." The EHR system in use at her hospitals has a tool that tracks nurses in the background as they document. They have been concentrating on quality of documentation and efficiency. She plans to use nationally published benchmark data



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for the pre-survey starting point. “I hadn’t thought of including nursing satisfaction, but why not?”

April Giard’s system collects all the data and tells her in a monthly dashboard what the biggest opportunities for improvement are. For example, last year Eastern Maine implemented changes in documentation for nurses. “We identified that our NICU nurses are spending much more time documenting in the EMR than national averages. When we looked into it, they were not using all the tools available to them in the system. They’d been trained but when the documentation changes went live they also moved into a new space and had many changes at once. This resulted in the nurses holding onto existing practice during a stressful time. After a re-education effort, we are seeing improvements. As the system CNIO, it’s important to understand this is more than implementation—implementation is the easier part. It’s how we use it. How do we make sure we’re on top of improvement and changes, and how well it’s being used? That’s where the CNIO can really add value.”

To make the pursuit of metrics meaningful, observes Darby Dennis, you have to operate in partnership with your CNOs; this is how you can maximize your influence. “You have to be both a leader and a partner. Part of my role is bringing statistics to them. For instance: ‘We are at risk for not hitting our targets on meaningful use. What is going on? What is happening on the units?’ It’s a matter of guiding them, showing them the information behind it. Their first answer is always, ‘The technology is broken; the barcode scanner doesn’t work.’ But when you dig down, it is one nurse who isn’t using the tool, or it’s one drug that isn’t being documented properly. Once I have that information, then we can solve the problem.

I can go back to IT and say, ‘This is what we have to do.’ “

Medical doctors may be the revenue generators, leading the model of care to be based around their needs. But nursing informaticists can fill a critical role within the organization. At UCLA, “Our nursing informaticists are highly regarded. The minute a regulatory body walks in the door, the first call is, ‘Get a nurse informaticist!’” says Ellen Pollack. “But we don’t really think about quantifying our ROI. Everybody in the organization calls me for help. But I am really glad nursing is in my title.”

This might present another opportunity for CNIOs to raise their profile within the organization.

Judy Blauwet observes that sometimes it is hard to figure out what it is you truly need. “We’re drowning in data! We need to move it from data to knowledge. The end-user needs to have the ability to manipulate the data and derive information from it.”

Deciding what should be automated and what should be done by hand is also a sticking point. NewYork-Presbyterian has manual boards in the nursing units to track performance on key metrics. “The question has arisen, should we automate the process?” Rosemary Ventura relates that some people like doing it by hand, and other people want to automate it. “People standing in front of the board, making entries by hand—they are forced to engage with it. Some of our managers don’t want to lose that tactile feel,” she says.

At Houston Methodist, “Our CMO wants to automate this. We will see how it goes,” says Darby Dennis with a shrug. “It’s a pilot.”



Nurturing the Next Generation of Clinical Informaticists

UCLA Health is an academic medical center with three hospitals on two campuses and approximately 900 licensed beds. Ellen Pollack and two colleagues from the hospital gave a presentation at the Scottsdale Institute conference on how the health system is preparing the next generation of clinical informaticists. Here are some key points from their talk:

Software projects at large medical institutions often fail. The hospitals spend a fortune on software, often going over budget, and the software doesn't always deliver as anticipated. Having nurse and physician informaticists on hand assures a smoother, more successful implementation.

UCLA has 20 physician informaticists on staff who spend 20% to 50% of their time on informatics. It has six nurse informaticists who work full-time on clinical informatics, and another 20 nurses who work with the IT shop.

To assure a pipeline of qualified personnel, the hospital has established two programs for doctors:

1. A two-year fellowship program for doctors who want to become informaticians. There are three currently in that fellowship. This is a very new field. Before 2014 there were no such programs in the country; today there are 25 programs.
2. An informatics track that medical residents can volunteer to be a part of. They do a project and receive didactic instruction. Those who come into residency with a curiosity about informatics can measure their interest.

The hospital created a nursing informatics fellowship this past January. Five fellows work with the current nursing informaticists in this one-year program. Fellows learn informatics as they develop their nursing skills.

"It's for succession planning, so we have a pool of nurses trained in informatics if someone decides to leave our team," Ellen Pollack says. Developing this nursing informatics fellowship curriculum turned out to be "a terrific bonding experience for our team," she says.

Pollack recommends this course of action to other large systems and academic medical centers. "A lot of nurses go through a master's program in nursing informatics, but if you don't have experience, it's hard to get a job. This fellowship gives you a chance to see people in action, how easily they respond, how quickly they learn concepts if a need arises."

Theme 8 | CNIOs as change leaders

Among their other duties, CNIOs function as change agents within their organizations. Leading change in complex organizations requires a panoply of soft skills that are unique to the role. "It's about developed relationships and trust with your leaders," says Darby Dennis. "We don't own it, they own it. But we give them the keys to make it happen."

Some hospitals may have "hot spots" where leaders are resistant to change. To address them, "We have to be strategic," suggests Rosemary Ventura. "We have to teach them messaging. I have to target particular people, coach them on the message. So they don't say, 'Oh, because the hospital says we have to do it this way.' That's not what you want out there."

At Eastern Maine, April Giard says, clinical informatics team members get training classes on presenting, on how to handle those conversations. Pam Holt noted that can help “connect the person’s sense of self to the mission, and buy-in to what you’re trying to change. If you can do this, you will motivate them and improve morale.”

CNIOs are in a position to actually improve physician and nurse satisfaction by encouraging mastery of the electronic medical record system, says Jennifer Carpenter. “The more we can help providers and nurses use the tools more effectively, the more we can help reduce frustration and burnout.” Also: “It gives them hope if you tell them what’s coming next. You have to give them a reason to believe things are going to get better.”

If you see a clinician who is spending too much time, staying late (charting), show them some tips and tricks to make the EMR work better for them, to give them back their family time, says Darby Dennis. “Help them get home for dinner. That’s what they all want.”

The thing about EMRs is that very often the patient story is still hard to find, Jennifer Carpenter continues. “You can put a blue button on the screen that leads to all MRIs but still, only a fraction of people will know it’s there, even if it flashes.” Helping create awareness of system efficiencies has become another opportunity for CNIOs to demonstrate their value to the organization as a whole.

Theme 9 | Artificial intelligence

The next major leap in healthcare informatics is likely to be the introduction of artificial intelligence (AI) into hospital-management systems. Many people subscribe to the notion that AI is replacing a human. Actually, AI is not replacing a human, it is supplementing the human.

Pilot studies have already started at some of the hospitals represented at the CNIO Summit. University Hospitals is working on a number of innovations that leverage AI and automation. “There’s a benefit to automating things,” Jennifer Carpenter says. “But it can also mean you take your attention away from human interaction and nuance, and that’s one of our challenges to manage.”

You have to resist the commonplace idea that you can “just plop in technology,” Rosemary Ventura warns. Like using the iPhone in the clinical setting, for example. “This was the most painful project I ever worked on.” Implementing texting into the clinical environment seemed to be a clinical challenge for all of the CNIOs in the room.

“How confident do you feel with AI?” Darby Dennis asks the group. “I mean, talking about it intelligibly in conversation?” She took a course on AI from online learning through MIT. “It was awesome. A seven-week course. I was putting 20 hours a week into this course. It cost \$2600. There was a lot of reading. You write a paper each week. It includes a combination of AI and robotics. Now I know what we’re getting into. It was the best thing I did to educate myself.”



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– Rosemary Ventura, DNP, RN, Chief Nursing Informatics Officer, NewYork-Presbyterian Hospital

Theme 10 | Further Development of this group

The group agreed that they would like to continue to meet regularly. The question arose, how to enlarge and deepen the conversation? The people sitting around the conference table in Scottsdale all have “Chief” in their title—if not literally, then implicitly. It’s not about trying to be all things to all people. The SI Member CNIOs represent organizations that are grappling with multiple sites of care and different geographies. It’s a matter of finding the right people who are interested in talking about the right things.

Several participants voiced the wish to include major EMR system vendors. “I would like Epic and Cerner to be at this table,” Ellen Pollack says. “As we progress, I would like them to hear what we need and what we want.” A conversation followed about how vendors might be included in the conversations.

But some participants felt otherwise. “This was so valuable, the entire session, because you have the chance to hear thought leaders from across the country,” says Darby Dennis. “I don’t want to hear from vendors. That’s not valuable to me. This is why I don’t go to HIMSS anymore. You feel like the sales people are ready to jump on you.”

We need to build the networking for these roles, offers Rosemary Ventura. “People out there don’t know we exist. It’s peer-to-peer learning. It’s not academic. I get frustrated going to those seminars. Our focus is operational, practical applications. It’s extremely difficult to try to solve these complex problems by yourself. So now I am going to call all of you!”

Final thoughts

“We are specialists in utilization of technology in nursing practice. That is the definition of who this group is,” suggests Jennifer Carpenter.

Implicit in the two-day conversation has been a theme for further discussions among this group:

- How does the CNIO bring value to an organization?
- What is the work that needs to be done?
- How do we make sure the machinery is working for us?

Continuing to expand the CNIO community will benefit all of the health systems that are engaged in the Scottsdale Institute and the industry.

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The **Scottsdale Institute (SI)** is a not-for-profit membership organization of prominent healthcare systems whose goal is to support our members as they strive to achieve clinical integration and transformation through information technology (IT). SI facilitates knowledge sharing by providing intimate and informal forums that embrace SI's "Three Pillars:"

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- Networking

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