



WHEN NO ONE OWNS THE OUTCOME, NO ONE SCALES THE PILOT

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The greatest barrier to scaling digital health initiatives is not technical capability, nor the familiar obstacles of budget, clinician resistance, or EHR integration. Those issues are real, but they are rarely the deciding factor.

Digital health initiatives fail because no one truly owns the outcome.

Not in the way that drives results. Not in the way where a specific individual is accountable to a defined metric, where a department is responsible for performance, and where leadership feels genuine urgency if targets are not met.

Instead, organizations often begin with broad enthusiasm at kickoff, followed by diffuse accountability. The IT team frequently becomes the default owner, while vendors present projected ROI that no internal stakeholder is formally accountable for achieving.

Until health systems address it directly, they will continue to repeat the same pattern: an enthusiastic launch, encouraging early indicators, and a gradual loss of momentum that ultimately leads to the initiative fading out.

Pilots Are Designed to Explore, Not to Prove

The first problem is conceptual. Most digital health pilots are framed as technology explorations when they should be structured as business-value experiments. Those are fundamentally different approaches. One asks whether the technology is interesting. The other asks whether it creates measurable, sustainable value for the organization.

When pilots are designed as explorations, they tend to produce exploration-level results: observations, impressions, and anecdotes. When they are designed as experiments, they generate evidence that leaders can confidently act on.

Clarity must be established before the pilot goes live. Success should be defined across three dimensions in advance:

- A measurable operational metric, such as reduced documentation time, improved throughput, or fewer transfers
- A measurable financial metric, whether through labor hours regained, avoided spend, or expanded capacity
- A clear technical and security readiness assessment to ensure the initiative does not introduce new risk or unnecessary complexity

If these elements cannot be clearly articulated upfront, the organization is not yet piloting with intention. It is still evaluating options.

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IT Becomes the Accidental Owner and That Creates Risk

When outcome ownership is not clearly defined, IT often fills the gap. Not because IT is best positioned to lead clinical workflow redesign or staffing model changes, but because in the absence of clear accountability, someone must coordinate the work and maintain momentum. IT is frequently the most structured and process-oriented team involved, so responsibility defaults there.

This dynamic creates misalignment from the outset. IT can and should own platform integrity, security, integration, scalability, and vendor due diligence. That is the appropriate scope. However, IT cannot be accountable for whether clinical documentation practices change, whether emergency department throughput improves, or whether projected financial benefits are realized. Those outcomes depend on operational leadership and financial oversight.

IT enables the infrastructure. Operations determines how it is used and whether it delivers measurable value. When value realization sits with IT rather than with an operational leader whose performance goals are directly tied to the initiative, the foundation is already unstable. The appropriate operational owner must be engaged from the beginning, not introduced at go-live.

A useful diagnostic is this: if several weeks into a pilot there is still uncertainty about who owns the outcome, or ongoing debate about what success actually means, the initiative is not enterprise-ready. Ambiguity at the pilot stage does not resolve during scale, it intensifies.

Heroic Effort Is Not a Strategy

Another common accountability challenge is more subtle. Some pilots achieve impressive results, not because the design is inherently sound, but because one or two highly committed individuals compensate for structural gaps. They manually extract reports that should be automated. They create informal processes to bridge integration deficiencies. They schedule recurring meetings and oversight mechanisms that were

never formally embedded into the program. Through persistence and institutional commitment, they make the initiative succeed.

When those early results are presented, organizations often interpret them as evidence that the model is ready to scale.

However, individual dedication is not a scalable operating model. Effort that depends on exceptional people cannot be reliably reproduced across multiple sites. What succeeds in a controlled pilot environment can quickly become a staffing, training, and sustainability challenge when expanded. The pilot may demonstrate that the technology can function under ideal conditions, but it does not necessarily prove that the program is operationally scalable.

This is why interoperability is essential. If a solution does not exchange data seamlessly with the EHR and core enterprise systems, the organization is not building a durable program but rather deploying a standalone tool that depends on continuous advocacy to survive. Integration must be operational, not aspirational, and the platform must reduce workflow friction rather than introduce new complexity.

What Boards Actually Want to Hear

In executive and board discussions, a common misstep is presenting technical performance indicators rather than business outcomes. Uptime percentages, API volumes, and integration milestones may be relevant internally, but boards are focused on enterprise impact. They want to understand what changed in operational and financial terms.

Effective board communication centers on predictable, measurable, and repeatable value. That includes productivity gains expressed in tangible metrics such as labor hours recovered or throughput improvements, cost avoidance through reduced reliance on contractors or elimination of manual processes. Most importantly, it demonstrates that the initiative can scale without proportionally increasing headcount.

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There is also a responsibility to present projections with rigor and transparency. Estimates should be framed as ranges informed by early data rather than as precise promises. Distinguishing between hard ROI and softer strategic benefits strengthens credibility. Clear acknowledgment of ramp time and change management requirements further reinforces realism. Executive leaders should see not only the expected impact, but also who within operations is accountable for achieving it.

The Goal Is a Repeatable Process, Not More Pilots

Organizations that consistently succeed in digital health have shifted their focus from individual pilots to building a repeatable capability. The objective is not simply to launch more pilots or accelerate timelines, it is to institutionalize a disciplined process that converts promising ideas into scalable programs.

This approach treats pilots as focused, time-bound sprints with structured checkpoints. Value is assessed regularly rather than retrospectively. Vendors are expected to produce defined deliverables and measurable progress at consistent intervals, ensuring that early indicators of impact surface while there is still opportunity to adjust course. At conclusion, lessons learned are documented and applied systematically to subsequent initiatives, reducing the need to rebuild governance structures each time.

Looking ahead, the defining discipline in digital health will not be limited to AI adoption, interoperability standards, or platform consolidation, important as those are. It will be outcome ownership. Sustainable progress depends on ensuring that every initiative has a designated operational leader, a defined financial metric, and a clear decision framework to scale, redesign, or sunset. Technology enables change, but it does not create it. Lasting impact occurs only when accountability drives behavioral and operational transformation.