IT DELIVERY ASSURANCE

EXECUTIVE CASE STUDY · BOARD-SAFE EDITION

A stalled clinical transformation, recovered before the third re-baseline.

An anonymized account of an independent recovery diagnostic on a multi-hospital regional health system's digital transformation program — two missed go-lives in, a third re-baseline being drafted, a new CIO inheriting the trajectory, and the calm, evidence-based decision that followed.

SECTOR
Healthcare & Life Sciences

SERVICE
Project Recovery Diagnostic

PROGRAM SCALE
Regional EHR & clinical workflow

DECISION HORIZON
Third re-baseline pending

01 Executive snapshot

A multi-hospital regional health system, roughly eighteen months into a multi-year digital transformation, was carrying two missed phased go-lives and a third re-baseline being drafted. An incoming CIO — newly accountable for a program they had not authored — declined to sign the third re-baseline without an independent reading of whether it could still land safely. A four-week recovery diagnostic produced an evidence-anchored answer to a single question: *can this program still be recovered, and if so, on what conditions?*

ENGAGEMENT AT A GLANCE

Sector	Healthcare & life sciences
Engagement type	Project Recovery Diagnostic (focused triage)
Sponsor	Incoming CIO / CMIO / CFO under board pressure
Scope	Regional EHR & clinical workflow modernization
Duration	Four weeks (Recovery Posture Signal in seven days)
Capital envelope	Mid eight-figure multi-year program
Decision horizon	Immediate — third re-baseline pending
Decision supported	Recover, restructure, or stop
Final posture	Recover with conditions — re-sequencing approved, third re-baseline deferred

02 Context and pressure

The program was the operational backbone of clinical care across the network — an electronic health record consolidation paired with a clinical workflow reset, structured across four phased go-live waves over a multi-year horizon. By the time the engagement began, Wave one had landed in a partial state and Wave two had been missed. The program team was drafting a third re-baseline. The previous CIO had departed. The incoming CIO had inherited the program mid-cycle and was being asked to defend a trajectory they had not authored — to a board reviewing the program in six weeks.

The pressure was not in the reporting. Vendor activity was healthy. Configuration velocity looked plausible. The signals were in the parts of the program that no one was explicitly measuring: clinical workflow validation was flat, superuser sign-off was lagging activity, integrated testing throughput had stalled, and the program risk register had quietly begun absorbing items that belonged to clinical governance.

The team could describe each workstream. No one in the room could yet describe how the remaining waves landed safely — in language a clinical safety committee, a board audit committee, and a regulator would all accept.

> "*I am being asked to sign a third re-baseline for a program I did not author. I am not yet willing to do that on the basis of what I have been shown.*"
>
> **INCOMING CIO · INITIAL BRIEFING**

> "*Everyone can tell me what we are doing. No one can yet tell me what we are building toward, in clinical terms, that a safety committee would accept.*"
>
> **CHIEF MEDICAL INFORMATION OFFICER · PRE-ENGAGEMENT WORKING SESSION**

03 The failure mode

The primary pattern was not program collapse. It was a gradual decoupling of activity from clinical readiness — a condition that compounds quietly because every signal looks defensible in isolation, and because the system that should escalate the divergence is often the same system absorbing it. Four behaviors had drifted together; together, they had become difficult to see from the inside.

Replan fatigue substituting for recovery

Two re-baselines had been absorbed in twelve months. A third was being drafted before the second had stabilized. Each plan looked tighter than the last; the underlying delivery position did not. The program was, in effect, planning more than it was recovering.

Clinical readiness lagging activity

Vendor and configuration activity remained healthy. Clinical workflow validation, superuser readiness, and integrated testing throughput were flat against the original plan. Activity was being mistaken for progress in the only dimension that mattered for a safe clinical go-live.

Sponsor handover absorbed without an independent reading

A new CIO had inherited the program. Continuity of decision history, vendor commitments, and clinical safety assurances was thinner than the cadence implied. The incoming sponsor was being asked to defend a trajectory whose underlying assumptions they had not been part of forming.

Clinical safety risk migrating onto the program risk register

Clinical safety items had begun appearing on the program risk register — not because the program owned them, but because no other governance structure was structured to receive them. The program risk register had silently become a clinical safety register, a substitution that would not survive a regulator's reading.

The accumulated exposure was not a single defect. It was the gradual erosion of **recoverability** — the cost of carrying a program forward on the strength of re-baseline drafting that no longer reflected the clinical system's ability to land safely.

04 What we actually did

The mandate was narrow: produce a defensible reading of the program's recoverability in four weeks, with a Recovery Posture Signal inside week one, and without disruption to the active

delivery cadence. The work was forensic reconciliation between four layers that had drifted apart — reported recovery posture, physical work product, integrated clinical readiness, and the program risk register itself.

Reconstructed the recovery history and reconciled completion against clinical readiness

Steering minutes, re-baseline drafts, RAID logs, and vendor escalation records were reconstructed in sequence to determine where recovery decisions had stalled and where re-baselines had been substituted for substantive recovery. Approximately two thousand eight hundred backlog items reported against the original plan were reconciled against clinical workflow validation, superuser sign-off, and integrated testing outcomes — surfacing a directional variance of roughly forty percent between reported completion and validated clinical-readiness state.

Tested clinical workflow sequencing and vendor commercial structure

The clinical workflow dependency map was traced end to end against the original go-live waves. Two critical workflow dependencies were structurally uncoupled from the integration layer they assumed; Waves three and four were dependent on clinical readiness that had not been earned and could not be earned within the existing schedule. Vendor contracts and SLAs, analyzed against demonstrable clinical-readiness contribution rather than activity volume, confirmed a structural incentive misalignment — high compliance with activity-based SLAs, low contribution to integrated clinical readiness.

Reconciled the program risk register against clinical governance

The program risk register was reconciled against the network's clinical governance register. Several clinical-safety items were found living on the program register by default rather than by design — a finding the organization had not yet surfaced internally, and one that would not survive an external regulator's reading.

05 The decision

The validated position was not catastrophic. It was, however, materially different from the position the third re-baseline was being drafted around. Two trajectories were placed in front of leadership.

ASSUMED TRAJECTORY

A nine-month catch-up plan supported by vendor escalation and additional capacity. Third re-baseline as the instrument for committing the new schedule.

VALIDATED POSITION

A directional twelve- to fifteen-month additional delay required for safe clinical landing of remaining waves. Material additional capital exposure if continued under existing vendor commercial structure. Recoverability conditional on re-sequencing, not re-planning.

Three options were placed on the table — continue under existing conditions, recover with conditions, or controlled stop — each described in terms of the exposure it carried, not the comfort it provided. Continuation was ruled out on evidence, not opinion. A controlled stop was ruled out as disproportionate to the recovery work actually required. The defensible path was **recover with conditions**: defer the third re-baseline, re-couple Waves three and four to validated clinical-readiness milestones, reset the vendor commercial structure ahead of any new commitment, and route clinical-safety items off the program risk register and into dedicated clinical governance.

RECOVERY POSTURE

Recover with conditions · Re-sequence, do not re-plan

VALIDATED · DEFENSIBLE · BOARD-READY

The decision was anchored in reconciled clinical-readiness evidence rather than in re-baseline drafting. It restored the incoming sponsor's ability to describe, defend, and time the recovery in language the board and the network's clinical governance committee would both survive.

06 What changed

The diagnostic did not rescue the program. It restored the conditions under which leadership could act on it. The shift was structural and operational rather than dramatic.

Capital exposure brought under explicit control

A previously implicit pattern of unproductive burn was made visible, quantified, and re-allocated to recovery-critical activities. Capital ceased to be spent against a trajectory that could not be defended in clinical terms.

Third re-baseline deferred, recovery substituted

The drafted third re-baseline was deferred. A validated recovery scope was substituted in its place. The program moved from planning recovery to executing it.

Sequencing re-coupled to clinical readiness

Remaining go-live waves were re-sequenced behind validated clinical-readiness milestones rather than calendar dates. Quality gates were tied to clinical-safety closure rather than configuration completion.

Risk-register boundary restored

Clinical-safety items were reconciled off the program risk register and into dedicated clinical governance. The distinction between program risk and clinical-safety risk became explicit again — a finding that would not survive an external regulator's reading otherwise.

None of this was framed as transformation. It was framed as the restoration of operating conditions the organization could, in principle, sustain on its own — with independent validation retained only where the exposure warranted it.

07 Lessons for leadership

Four observations the engagement left with the executive group. Each is offered for reflection, not prescription.

Re-baseline production is not the same as recovery.

A program that can draft a third re-baseline is not necessarily a program that is recovering. Plans tighten; underlying conditions often do not. The instinct to plan more is easily mistaken for the discipline to recover more from inside the cadence.

Activity is a poor proxy for clinical readiness.

Vendor velocity, configuration throughput, and ticket closure can remain healthy long after the dimensions that matter for a safe clinical landing have stopped advancing. Superuser sign-off, integrated testing, and clinical workflow validation are not the signals that show up most cleanly in a steering pack.

Sponsor handovers compound delivery risk that is already in motion.

A new sponsor inheriting a multi-year program absorbs not only the work but the unstated assumptions behind it. Defending a trajectory you did not author, in front of a board, is a category of risk worth supporting with an independent reading before the next major commitment.

A program risk register is not a clinical-safety register.

Where no other governance structure is positioned to receive clinical-safety items, the program risk register will quietly absorb them. The substitution is rarely deliberate; it is also rarely defensible under external review.

VALIDATION POSITION · POINT-IN-TIME RECONCILIATION

This account reflects a forensic snapshot of recoverability at the time of the engagement. Material changes to vendor structure, clinical leadership, or funding envelope would alter its validity and require renewed reconciliation. All client, vendor, geographic, and financial detail has been generalized for board-safe publication; no information here is sufficient to identify the organization, its vendors, or its clinical population.

Independent IT Delivery Assurance works alongside live delivery, without disruption to clinical operations or execution cadence, and produces a single answer leadership can stand behind — typically in two to four weeks.