Building Health’s Digital Front Door

SCOTTSDALE INSTITUTE 2021 CTO/VP APPS VIRTUAL SUMMIT

September 10, 2021 | Virtual Event

Sponsored by: Cerner
Executive Summary

As Members prepare for digital transformation—planning for real-time analytics, leveraging data and technology to improve processes, and ensuring engagement and collaboration within the remote workforce—peer-to-peer support becomes even more crucial. As such, The Scottsdale Institute (SI) virtually convened 18 professionals and guests from 14 Member and supporting organizations to share insights and leading practices at its Chief Technology Officer/Vice President of Apps (CTO/VP Apps) Summit, sponsored and moderated by Cerner on September 10, 2021.

This discussion-oriented Summit featured industry experts as they framed the challenges and opportunities in key areas of responsibility that CTOs/VPAs face, such as:

- Optimizing service delivery,
- Fine-tuning virtual tools post-COVID,
- Strengthening telework strategies,
- Outlining problems and framing solutions more clearly, and
- Managing vendors/3rd-party relationships.

Kicking off this first annual CTO/VP Apps Summit, SI and sponsor Cerner queried participants to learn about their strategies, trends and challenges. In recapping attendees’ answers, moderator Tanuj Gupta, MD, VP, Cerner Intelligence, considered the day’s topics to learn how Members are best preparing for Digital Transformation to reap the greatest benefits. “Where should health systems be investing in digital health capabilities to get the ‘last mile’ benefit of connecting virtually with patients?” Gupta asked. “For example, we have models that are reusable by multiple products, but who handles interpretability?”

Members agreed that digital access was one of the top priorities accelerated during the pandemic, even as ongoing challenges remain: Retaining staff and clinicians, balancing remote and in-person work, getting patients to return for in-person care, and recovering financially post-COVID. Regarding health’s digital front door, these CTO/VP Apps professionals know if they build it, consumers will come…but the goal remains to get the most out of their systems’ data, facilitate integration and interoperability and manage the health of their populations as seamlessly as possible.
SUMMIT PARTICIPANTS

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Shariq Ata, Director, Enterprise Architecture & Shared Service, University of Chicago Medicine
Laura Bagus, MBA, VP, IT, Lurie Children's Hospital of Chicago
Tania Bethea, Sr. Director, ERP/Enterprise Business Systems, Spectrum Health
Emily Borlas, AVP-Network Applications, HonorHealth
Ken Buechele, VP-IT, Bronson Healthcare
Dylan Clark (Guest), AVP of Analytics, OU Health
Lynnette Clinton, VP, Applications, BayCare Health System
Brian Connelly, VP & Chief Architect, Ascension
Scott Dresen, SVP & CTO/CISO, Spectrum Health
Glynn Hollis, CIO, HonorHealth
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Bill Lazarus, CTO, UCLA Health
Christian Lindmark, CHCIO, VP & CTO, Stanford Medicine
Jeanne Markland, Chief of Strategy & Integration, IS, UCLA Health
Marjorie Mathews, VP, Healthcare Applications, Beaumont Health
Greg Nelson, AVP, Analytics Services, Intermountain Healthcare
John Tippetts, Chief Architect, Intermountain Healthcare

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Moderators: Tanuj Gupta, MD, MBA, VP, Cerner Intelligence; Tom Goguen, SVP, Architecture, Platform & Data Management

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Introduction: Building Health’s Digital Front Door

In preparing for digital transformation, organizations do well by studying the foundations laid before by others—leading practices, lessons learned and pitfalls to avoid. Kicking off this first annual CTO/VP Apps virtual summit, SI and sponsor Cerner queried participants to learn about their strategies, trends and challenges. Most responding Members suggested that introducing new service lines and moving to adjacent markets outlined their main corporate growth strategy, and that most of these organizations were self-hosting their IT systems today. One area of interest—the Internet of Things in a healthcare environment—sparked additional discussion: In considering home health and the opportunities for technology in the home, most Members were just starting to look at remotely monitoring the most common and easily measured conditions at more regular intervals versus every three months (e.g., diabetes, high blood pressure, pregnancy checkups).

Further, Members agreed that digital access was one of the top trends accelerated during the pandemic, with operational efficiency and changing reimbursements bringing up the rear. And ongoing challenges remain: Retaining staff and clinicians, balancing remote and in-person work, getting patients to return in person for care, and recovering financially post-COVID. Regarding health’s digital front door, these CTO/VP Apps professionals know if they build it, consumers will come…but the goal remains to get the most out of their systems’ data, facilitate integration and interoperability and manage the health of their populations as seamlessly as possible.

PREPARING FOR DIGITAL TRANSFORMATION

“Beyond providing just brick-and-mortar opportunities, our approach to digital transformation is to really provide that anytime, anywhere care for patients, members and caregivers,” said John Tippetts, Chief Architect, Intermountain Healthcare. “That’s when we really started to get serious around cloud acceptance and usage, when those digital experiences were developing.”

Intermountain considers all of the following to fall under its digital transformation initiatives.

- Improving and expanding the core value proposition of providing safe, effective, anytime-anywhere care
- Boosting cloud acceptance and usage
- Leveraging previous investments and discerning future direction (e.g., Intermountain Digital Platform)
- Providing digital experiences for patients, providers and caregivers
- Expanding telehealth and using intelligent automation, advanced visualization and AI/ML

Tippetts acknowledged it’s not inexpensive to go the Digital Transformation route, but Intermountain’s digital platform has helped to expand the pathways so its patients and health plan members can find the care they need, receive it through the channels most convenient for them and manage it more successfully. They have expanded their use of telehealth, advanced visualization and cloud services, with the ultimate goals of providing care in myriad ways and increasing their speed and agility to deliver technology solutions, even spinning up digital systems quickly to establish its COVID Command Center or develop chatbots and virtual assistants within a day.

The technology (for remote health monitoring) is already there, so we (hospitals) have to adapt or some start-up/tech company more nimble will do it. It’s typically been harder for hospitals. We tend to move slowly; however, COVID proved we are capable of making transformational changes quickly.

—Christian Lindmark, VP & CTO, Stanford Medicine
STEPPING UP TO THE CLOUD

“We’ve had big concerns about security and privacy. Intermountain didn’t accept the use of public cloud offerings until 2017 or so. While we had portals, websites and mobile apps, cyber security initially pushed the Office 365 initiative and the cloud followed,” Tippetts detailed. “It’s a work in progress for cyber and privacy but, in partnership with Enterprise Architecture, we have been able to put in place the necessary security controls and architecture to start to take true advantage of what the cloud has to offer. The cloud will also play a major role with our multi-year initiative around application modernization and rationalization that entails analyzing some 2,500 applications and technologies, grouped into 15 portfolios, and identifying which to keep, which will continue to support our digital journey, which to modernize for a move to the cloud, and which to eliminate. We have a lot of legacy apps that are difficult to connect but we are leveraging cloud technologies to be able to connect these to our digital front door work.”

DETERMINING NEXT MOVES

Intermountain has a “cloud first” multi-cloud strategy, utilizing Microsoft Azure as its primary and Google GCP as its secondary. They’re leveraging the public cloud in areas such as MyHealth+ (their digital front door), new developments (provider- and caregiver digital experiences), precision medicine/genomics, biorepository, digital pathology, app modernization, imaging and next-gen data platforms.

“Our comfort in using SaaS solutions has increased significantly with the use of Salesforce, Workday, UKG Dimensions and others,” Tippetts said. “But it doesn’t always make sense to move all things to the cloud; we learned that early on by trial and error—mostly error. Any new in-house software development we want to be cloud-focused, but first a cost analysis is conducted; only then do we decide whether it should be done in the cloud or on-premise.”
Tippettts says Intermountain is asking better critical questions. As an example, for Azure Cognitive Services, his team is determining whether they want to build out or leverage what Microsoft is doing and plug in. They have the capability in-house to develop these services but if they can leverage what Microsoft is doing as the base and build on those services and platform, that is generally the direction they go.

“MyHealth+ was our first application where we used the public cloud—our first steps in doing a truly cloud-delivered application. Now, we’re using it elsewhere throughout the enterprise. For example, we are able to scale up and down our compute resources for things like genomic sequencing or image rendering, both of which are needed to access GPUs—that’s one of the best uses for the cloud that we’ve seen,” he reported. “We are also expanding our use of cloud for data storage and archiving with the goal of being able to make that data easily available for the work we are doing in Computer Vision, Machine Learning and Artificial Intelligence.”

**THOUGHTS ON TRANSFORMATION**

We’re actively doing some things with digital front door with a mobile app, and developing more for next year. We’re also moving from a heavy footprint, on-premise warehouse to a cloud solution next year. Cloud work makes sense to us for a lot of things, but we have Cloverleaf as our integration engine and that doesn’t make sense to have in the cloud, so we’ll keep it on-prem for now.

-Lynnette Clinton, VP Applications, BayCare Health System

Regarding digital path and imaging systems, every time we look at moving them to the cloud, we find the storage costs are much more expensive in the cloud vs. on-prem (Co-location site). As we look into new vendors, when we agree on cloud at the beginning of the value propositions, it can make more sense. But to move after the fact—that cost difference makes it very challenging.

-Christian Lindmark, VP & CTO, Stanford Medicine

Last December we brought on a new director of architecture who said, “Let’s spend six months defining what our cloud strategy is.” With various team members and differing backgrounds, we went through what we have in our environment and determined our go-forward strategy to be with Microsoft...but we also understood we’d not be a single cloud provider. We pushed infrastructure and tools on the Azure platform because our folks were comfortable in that space and then, for certain workflows/initiatives/studies, we utilized AWS.

-Laura Bagus, VP IT, Lurie Children’s Hospital of Chicago

We’re also recognizing how IS thinks about application infrastructures. We can have OpEx overruns, how they architect applications is key to the journey of making cloud economics work.

-Scott Dresen, SVP & CTO/CISO, Spectrum Health

If you do not know the business context and desired outcome of why you’re doing it, you have to look at what it’s costing to continue to throw tech at the problem. We all have constraints on staff, funding and ability to execute at business speed, so we have to determine what we focus on to ensure success. People say, “Oh, just migrate to the cloud to address your constraints,” but that’s a fool’s errand—someone still has to maintain the care and feeding of those products...and without addressing the architecture to properly consume cloud services, migrating will not fix things. The cloud should provide the capabilities and scale you need to address your business problems with greater agility, not just be a new place to dump all the things.”

-Brian Connelly, VP & Chief Architect, Ascension
Real-Time Algorithms & Analytics: Use Cases & Plans

In starting the second session, moderator Tanuj Gupta noted that there are not a lot of real-time use cases in a clinical setting—that is, a lot of clinical data that’s important to consider isn’t necessarily needed in real-time (e.g., risk of readmissions, risk of falls, even some bed usage stats). “People say they want real-time data but, in our setting, we have to understand how often the underlying data actually change and how often the algorithm needs to run,” explained Greg Nelson, Intermountain’s AVP, Analytics Services. “We really need to focus on strategic opportunities—bettering patient and caregiver experiences in healthcare. How might we improve access and coordinate care for patients across care settings and specialties?”

To grow its mission-driven model and influence, Intermountain aims to provide uncompromising clinical excellence, make care accessible and affordable to all, extend its reach across and beyond its region, promote equity and health for caregivers and communities, and deliver the best consumer experience in healthcare. Regarding the latter, Intermountain is incorporating journey mapping to better illustrate the complete stories around relationships and resulting experiences that unfold over time—the good and the bad, the innovative and the preventable. And toward this end, Nelson introduced us to 34-year-old “Shakira.”

“Let’s say our patient Shakira presents at an urgent care for a skin concern, and findings suggest possible melanoma so she needs a dermatology consult ASAP,” Nelson outlined. “So: what often happens? The doctor completes a paper referral, which is problem one; faxes it to the dermatology office, which is problem two; and the paper gets lost so care is delayed, which is problem three. By the time Shakira follows up and gets to the dermatologist, her condition has progressed and she’s diagnosed with metastatic melanoma. What’s the overall experience here? What does it tell us about the patient journey?” (see figure below)
Nelson believes analytics hold the key to better managing such a “system” of engagement. By studying other industries, healthcare can envision individual solutions that then can be coalesced into a full, fluid system (see figure below). Instead of Shakira’s reactions and responsibilities fluctuating wildly during her long wait, Intermountain envisions an AI-enabled process that could meet her at each decision-making point with assistance. From virtual assistant and pre-authorization reminders, to suggestions for more research, to connections to other patients like her, this system could make care far more seamless, predictable and manageable during what oftentimes can be a wrenching and emotional time.
Intermountain aims to design its data-driven, digital innovation efforts toward accelerating decision-making, achieving breakthrough performance and capitalizing on emerging opportunities. Their three pillars embed insights at the points where they matter most, empower by asking the right questions around data and engage toward functional product creation. But moving from current to future digital innovation platforms will require an exponential shift in the way team members work and think (see figure below).

**Digital Innovation Platform**

"On the left, we see a classically designed environment. If we want to develop a patient risk model or flow, when we do this work the scale of analytics requires we have experts at every level; we can basically do one thing at a time," Nelson explained. "A better question is, how can we create an ecosystem in which we can create thousands of experiments simultaneously?"

The image on the right depicts thinking about analytics in a more replicable way—building reusable services to put atop the interoperability layer, determining specialized algorithms and delivering them to the right consumer of data. From Intermountain’s perspective, they’re transforming how they deliver data products by working through the strategies and refining the roles of product managers and product owners.

"What’s the most important thing that we can invest in? We’re trying to get folks to stay in the problem space long enough to know what ‘success’ looks like,” he suggested. “The cycle of problem-to-solution usually is measured in nanoseconds but, just as in my marriage, I’ve learned to stay in the problem area long enough to really understand what needs to be improved.”
Leveraging Data & Technology: Improving Process & Customer Satisfaction

Nelson switched gears in his second presentation, which focused on driving behavior change through data. Illustrating how the frictions that frustrate and slow us can distance us from people and processes, Nelson shared about scheduling a town hall meeting after last winter’s rise in COVID cases post-Thanksgiving. To thank the hundreds of caregivers gathering, he wanted to deliver something of value that was more personal than a gift card. Crumbl Cookies fit the bill.

“I called my local store, told them my idea and was thrilled to hear them say they could deliver to everyone in a single afternoon, right before the town hall meeting. All I had to do was place 300 separate orders, add 300 addresses and enter my credit card number 300 times,” Nelson deadpanned. “I wanted the whole logistics problem to be solved; they only solved the cookie-baking problem, not the entire buying and delivery experience.”

SOLVING FOR SOLUTIONS

We tackled the annoying wait for physicians at our clinic. Initially we thought the problem was that we needed to process patients through faster, but the real issue was uncertainty: Was it going to be a two-minute wait, or an hour-long wait? Updating patients before they got there, having them engage with the portal, employing TVs and things that made waiting more comfortable all were successful.

–Emily Borlas, AVP – Network Applications, HonorHealth

A lot of times, it’s not even clear who the owners of the problem are.

–Bill Lazarus, CTO, UCLA Health

We can have a solution, lose sight of the core of the problem we’re trying to solve, get disconnected and start offering capabilities that were never needed. Now we spend more time discussing the why than the what.

–Scott Dresen, SVP & CTO/CISO, Spectrum Health

Listen a bit longer to those who experience the problems of what you’re trying to solve; otherwise, you’re just an evangelist for whatever your team is producing (aka “a solution looking for a problem”). What problem are we as a health system trying to solve, and specifically what tech do we apply to solve that problem?

–Brian Connelly, VP & Chief Architect, Ascension

We have a committee vote out all AI models. They look at data and validate it...and nothing goes into production unless it’s validated that it adds any value.

–Shariq Ata, Director, Enterprise Architecture & Shared Service, University of Chicago Medicine

Until people come up with good use cases and describe what they’re looking to do with AI/ML tools, we’re not pushing those options, because it’s a solution in search of a problem.

–Lynnette Clinton, VP Applications, BayCare Health System
FRAMING OUR SOLUTIONS

When we think about creating experiences for people, what problem are we solving? And how much? Nelson cited common drive-through challenges with fast food restaurants. “They have a throughput problem; there’s never a good physical layout, and they want people to behave differently and they’re not,” he described. “So depending on how we frame our problems, our solutions will mirror that.”

In Nelson’s estimation, Chick-fil-A owns their throughput problem: They have a dedicated innovation space (Hatch) that creatively addresses the challenges facing customers and they’ve built a culture of innovation with the ability to understand, imagine, prototype, validate and launch their projects. Citing Little’s Law, common fast food throughput goals entail reducing the average number of customers in the system (requests), increasing the arrival rate (number of customers served) and lowering churn (time spent in line). In Chick-fil-A’s case, they took the time to understand the problem fully instead of moving immediately into the solution space. To rephrase the problem: Waiting is annoying. How can we make it more personal and thus make it “feel” shorter?

“So how does this translate to healthcare? The way we think about problems can help frame the wrong solution,” Nelson explained. “We then tweak our systems trying to affect the wrong thing. If we continue to design in the same way, we’ll get the same short-sighted thinking applied to our systems and impacting our patients and staff.”

“Fully understanding the challenge comes first. Then, once you identify the right solution you can employ the right technology. Technology is an enabler in support of the business and business strategies.”

—Tom Goguen, SVP Architecture, Platform Management and Data, Cerner

To avoid the problem-solution loop, Nelson suggested making space between problem-framing and problem-solution. For example, the problem of a too-slow elevator might be solved by installing a new lift, upgrading a motor or improving the queuing algorithm. Reframing the problem more generally around the experience of waiting opens up a new landscape of opportunity. Similarly, the problem of excess waste in ORs might be solved by utilizing AI to evaluate product remaining on trays versus having nurses count items used, write details on clipboards and later enter data manually. “Apple is a great example of a company that reduces friction for its customers...so where might we start reducing friction in our healthcare systems?” Nelson queried.
BROADENING POSSIBILITIES

Echoing some facets of John Tippetts’ earlier presentation, Nelson noted Intermountain’s Intelligent Automation Center for Enablement is helping caregivers document existing processes to identify and evaluate stronger options via Robotic Process Automation (RPA) or other solutions using application programming interfaces (APIs). If tasks are defined narrowly, a solution may entail writing simple code; if challenges are broader, combining API and data exchange options might address the larger problem while also affording a mechanism toward constant enhancement—that is, building in the ability for the model to improve itself over time via data interaction. Factoring in both process- and data-driven solutions, Nelson discussed the sample AI-enhanced process automation flow outlined in The Difference Between Robotic Process Automation and Artificial Intelligence, below.
Intelligent Automation

**Process Automation**
- Robotic Desktop Automation with manual intervention
  - Excel macro
  - Website scraping
  - Data entry
  - Data collection
  - File collection
- Robotic Process Automation with digital triggers or self-service
  - Rule based chat bot
  - Orders system
  - Supply chain reorder
  - Pharmacy refill

**AI Enhanced**
- Machine Learning with prescriptive analytics & decision engines
  - Next best action recommender
  - Augmented interventions
  - Fraud identification
  - Process routing
- Artificial Intelligence with deductive analytics
  - Patient NLP driven chatbot
  - Order Recommendation Automation
  - Supply chain product selection and management
  - Privilege granting automation

“We joke about *when worlds collide*. We have Centers for Enablement and routine automation which are both process-oriented, and then we have things governed by AI and Data Science Center for Excellence—areas where models are deployed that would otherwise require human thought,” Nelson explained. “If the left side is governed by John’s (Tippetts) team and the right is governed by our AI and Data Science COE, how do we do this? Working to govern RPA versus advanced analytics...we haven’t solved that problem yet...but we are committed to collaborating across lines to ensure we focus on the right outcomes.”

Ensuring Engagement & Higher Collaboration with Remote Work

Throughout the day’s presentations and discussions around technology advancements that were unimaginable even a decade prior, Members reaffirmed their most valuable resources were human resources, especially the people who ensure the digital front door is human-scaled: approachable, user-friendly and flexible. And to that end, Members agreed that keeping teams engaged, challenged, committed and forward-thinking took on an even greater importance during the pandemic.
“We’d always offered a remote work option, even before COVID, but like many organizations it’s been difficult to find resources, keep staff engaged and stay supportive of what employees are going through while we also try to fulfill our mission,” explained Laura Bagus, VP, IT, Lurie Children’s Hospital of Chicago. “When COVID hit, Lurie had several hundred users who hadn’t previously worked remotely and who needed Citrix Remote Access ASAP. We also had some users who needed laptops, others who required some applications and tools that weren’t available after going remote, and non-exempt users who needed to clock in and out. Simply said, there were a lot of challenges.”

MEASURING PRODUCTIVITY

While originally Lurie’s non-tech teams were allowed to work remotely up to three days per week (with tech teams at two days per week), continued eligibility always had been based on productivity and performance via annual reviews. The pandemic, of course, forced additional protocol and guidelines. In response, Lurie implemented a Workforce Task Force that focused on designing overall policies, equipping leaders to help manage remote workers, offering flexibility, supporting out-of-state workers, making recommendations for office space use and addressing mental health needs. Further, they developed a remote work policy to support the organization as a whole and implemented a new stipend program to assist those working offsite.

“We tweaked our small policy to more broadly support our leaders and workers. We focused more on mental health needs, for those trying to work with kids at home, and stipends and equipment for those who didn’t previously have a home work space,” Bagus said. “Then, as remote work continued, we evaluated as we went. We felt teams were highly efficient, as they completed numerous projects and initiatives. We continued to implement and deploy other ventures and heard that folks were feeling even more productive without their long commutes; those hours went back into their days.”

SOLVING FOR SOLUTIONS

We’ve really focused around employee choice: Where will they be most productive? Some want to be in the office. Also, offering quarterly town halls helps to create an open-door feel. We have to be incredibly intentional about that sort of culture, and leadership is struggling to find the time to do so.
- Ken Buechele, VP-IT, Bronson Healthcare

We’re expecting IT employees who don’t need to be hands-on to stay remote, and eventually are looking at them coming back at three days per week.
- Phillip Arthur, VP & CTO, Technology Planning & Architecture, AdventHealth

We’re learning a new etiquette: Teams chat can be constant, with people expecting immediate responses. We need to consider, “If I were meeting in person with a colleague, would I want someone to bust open the door and start talking?”
- Emily Borlas, AVP-Network Applications, HonorHealth

At Froedtert, we embraced fully remote when the pandemic hit. We were working remotely one- to two days per month before; then, we turned on a dime, sent all IT folks home and all the necessary equipment with them. From the IT side, with the exception of desktop support, we’re 100 percent remote, and it seems to be working well.
- Janet Kummeth, VP-Enterprise Applications & Services, Froedtert & Medical College of Wisconsin

We ping people now; if no one answers, we wait until later; we also have shortened our meetings to 50 or 20 minutes at the beginning of the hour to maximize productivity. Finally, we’ve set an expectation that you can live where you want but know and commit to the fact that when we want you onsite in the office, you’ll need to be there.
- Jeanne Markland, Chief of Strategy & Integration, IS, UCLA Health

We’ve fully embraced remote; it’s a complete 180 from where we were before the pandemic.
- John Tippetts, Chief Architect, Intermountain Healthcare
FACILITATING COLLABORATION

Bagus noted that Lurie had some 250 workers in information management who previously had been spread out over two office floors and throughout the hospital. After switching to primarily remote work, they reduced their footprint to a single floor but also sensed, like so many other organizations during the pandemic, that perhaps they weren’t quite as collaborative as when they were all in the office. Complaints arose within and across teams, as drop-in collaboration and in-person communication plummeted.

To counteract this, Lurie implemented remote quarterly all-staff meetings with ice-breaker events and quarterly senior-leader virtual drop-ins for any and all topics of discussion. Further, they expanded their Microsoft Teams sites to strengthen manager collaboration; utilized surveys in Teams meetings to vote on opportunities, topics and issues; and offered “retreats” (both in-person and virtual) to work on team building, collaboration and communication.

“We always plan to ask three questions around how they’re doing with their homes and families, how their professional development is going, and whether they’re leveraging tools and taking opportunities for advancement,” Bagus relayed. “We also try to ensure there’s a chance to talk about leadership without leaders there so it’s a safe space to share and, by implementing Microsoft Teams, it’s been a much better experience for everyone.”

EVALUATING PERFORMANCE

Lurie fashioned its performance blueprint to depict both workers’ and managers’ responsibilities toward time reporting, expectation management, availability, communication and professionalism.

“We had to educate our organization and work with our leaders as to how time would be reported, plus our expectations of staff,” Bagus stated. “There’s an etiquette to remote work, and we had many who’d never worked—or managed—remotely before. That information needed to go back to our leaders as to how to best manage a remote workforce.”

“Remote work now is an expectation as a staff; if we’re not offering a remote option right out of the gate for new people, we’re going to lose out,” Bagus warned. “That said, we’ve got a team retreat in November, which will be the first time seeing each other in person in 20 months...and that will be good.”

ABOUT THE SPONSORS

The Scottsdale Institute (SI) is a not-for-profit membership organization of over 60 prominent, advanced, not-for-profit health systems and academic medical centers whose mission is to improve healthcare quality, efficiency and personal experience through IT-enabled transformation. Our North Star is thought leadership guided by SI’s Three Pillars of Collaboration, Education and Networking. We convene intimate, informal and collegial forums for senior healthcare executives, including but not limited to CEOs, CMOs, CIOs, CMIOs and CNIOs, to share knowledge, best practices and lessons learned. Our goal: Gather the right people to discuss the right topics at the right moment.

For more information, visit www.scottsdaleinstitute.org

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