The Enterprise Scheduling Roadmap:

Building Alignment that Drives Workforce Transformation

August 2026

Executive Summary

Rising costs and persistent margin pressure necessitate strategic, enterprise-level approaches to cost reduction across all operational domains for health systems. Workforce spending is the health system's largest single expense, yet workforce scheduling and management is still predominantly viewed as merely an operational function. To start approaching these associated costs strategically, systems must bring the same enterprise discipline to scheduling that they apply to functions like revenue cycle, supply chain, or clinical operations.

This report synthesizes findings from a survey of 31 senior health system leaders and qualitative interviews with leading health system executives to assess how organizations approach scheduling strategy, investment, and integration. Respondents were organized along a scheduling integration continuum, from Fragmented, to Consolidated, and finally Integrated, the most mature state of enterprise-level scheduling.

Most systems fall within the first two stages — still working to resolve manual processes, improve enterprise-level data capabilities, and evolve service-line-level optimization that limits data interoperability. Diffused ownership is a defining constraint of these two stages, as scheduling is usually delegated rather than governed through centralized accountability structures. Those that remain in the fragmented and consolidated stages face a widening set of financial, operational, and infrastructure-related risks that are challenging to surface, let alone address pragmatically. The impacts of productivity loss-driven revenue leakage, exposure to cybersecurity risks, and disjointed strategic planning compound in environments where scheduling data is too fragmented to provide early warning. Integrated systems, however, are able to connect scheduling to outcomes well beyond traditional workforce metrics, including regulatory compliance rates, margin improvement, and patient throughput; these systems also report realized benefits across workforce visibility, premium labor reduction, and care team coordination.

To unlock this strategic utility, health system leaders must reposition scheduling from an administrative necessity to a strategic imperative with health system-wide implications. The process begins by replacing manual tools and centralizing accountability. Next, systems set flexible standards for workflows across roles, service lines, departments, and sites of care. Those that complete this transition effectively convert scheduling from an isolated byproduct of workforce management into robust infrastructure capable of guiding enterprise decision-making.

> “If you have a surgeon, but you don't have a nurse and a tech, you cannot do surgery, right? Right now, those schedules and those technologies don't communicate with one another. Living in [a] unified world where all of that connects will make a significant difference for our ability to better leverage the limited resources that we do have.”
>
> ***VP of Workforce Strategy,*** *Regional IDN*

Section 1:

Resolving Fragmentation Costs Through Enterprise Prioritization

"Why do we have five different scheduling platforms? Why do we do it differently in this part of the system versus that part of the system?"

- ***Chief Information Officer,***
New England IDN

Introduction

The next financial crisis facing health systems is already embedded in the cost structure of daily operations. As health systems deliver increasingly complex care to a higher volume of patients, the key inputs of care are rising sharply in cost while operating margins remain thin. Workforce spending, which accounts for 50-60% of health system costs, rose 5.6% in the past year, compounding sizable year-over-year growth since the pandemic.[1] External strain, at the commercial, federal, and state levels amplifies these issues by disrupting the revenue model and reinforcing labor cost rigidity. These pressures are felt system-wide and reinforce the need for an evolving workforce management strategy, especially as it pertains to scheduling and capacity management.

Health systems often demote scheduling to a delegable function instead of leading with an enterprise strategy because of its inherent complexity. The effects of this posture, however, accrue across the entire enterprise, surfacing in the form of financial, operational, and strategic costs: high turnover rates and staff attrition driven by inflexible hours, excessive reliance on premium labor, and administrative drag that occurs when clinical managers spend hours reconciling schedules. While these costs appear across different departments and on different leaders' budgets, collectively they represent a substantial, invisible price.

Comprehensive visibility across a system's entire scheduling ecosystem is a prerequisite to resolve internal inefficiencies and buffer external pressures. This increased visibility links traditionally segmented workforce metrics—such as labor spending, absenteeism rate, schedule efficiency—to enterprise-wide goals like access and throughput, margin improvement, and regulatory compliance. Enhanced operational visibility also enables health systems to model and act on emergent political and regulatory mandates, like site neutrality reform, pragmatically. By fortifying their agility, systems better address pressures before they escalate.

To unlock this strategic visibility, systems must centralize their approach to scheduling enterprise-wide: first by standardizing data within departments, followed by platform centralization across roles, service-lines, and sites-of-care. The result is data that is accurate, interoperable, and timely. Without this foundation, health systems will continue to underutilize workforce scheduling as a strategic lever and forfeit key opportunities to address system priorities.

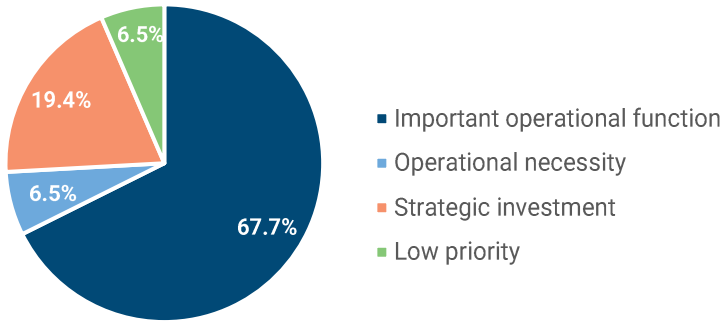
> "Right now, we're expecting our charge nurses to go into a couple of different platforms every four hours and manually pull that data into an Excel spreadsheet and identify whether they're over or understaffed… all of that's manual. It's just frankly not happening. When we initially went into this project, we [found] about $70 million on the table that we are losing because of that productivity [in acute care alone]."
>
> ***VP of Workforce Strategy,*** *Regional IDN*

Resolving Fragmentation Through Enterprise Prioritization

Most (67.7%) leaders indicated that their health system currently positions workforce scheduling as an important operational function, but not necessarily as a top strategic priority. This lack of enterprise-wide prioritization often leads to fragmentation of scheduling processes across the system. While there remains considerable variation from one health system to another, many still rely on a patchwork of scheduling processes rather than a truly centralized scheduling model.

How does your organization currently view workforce scheduling and management?

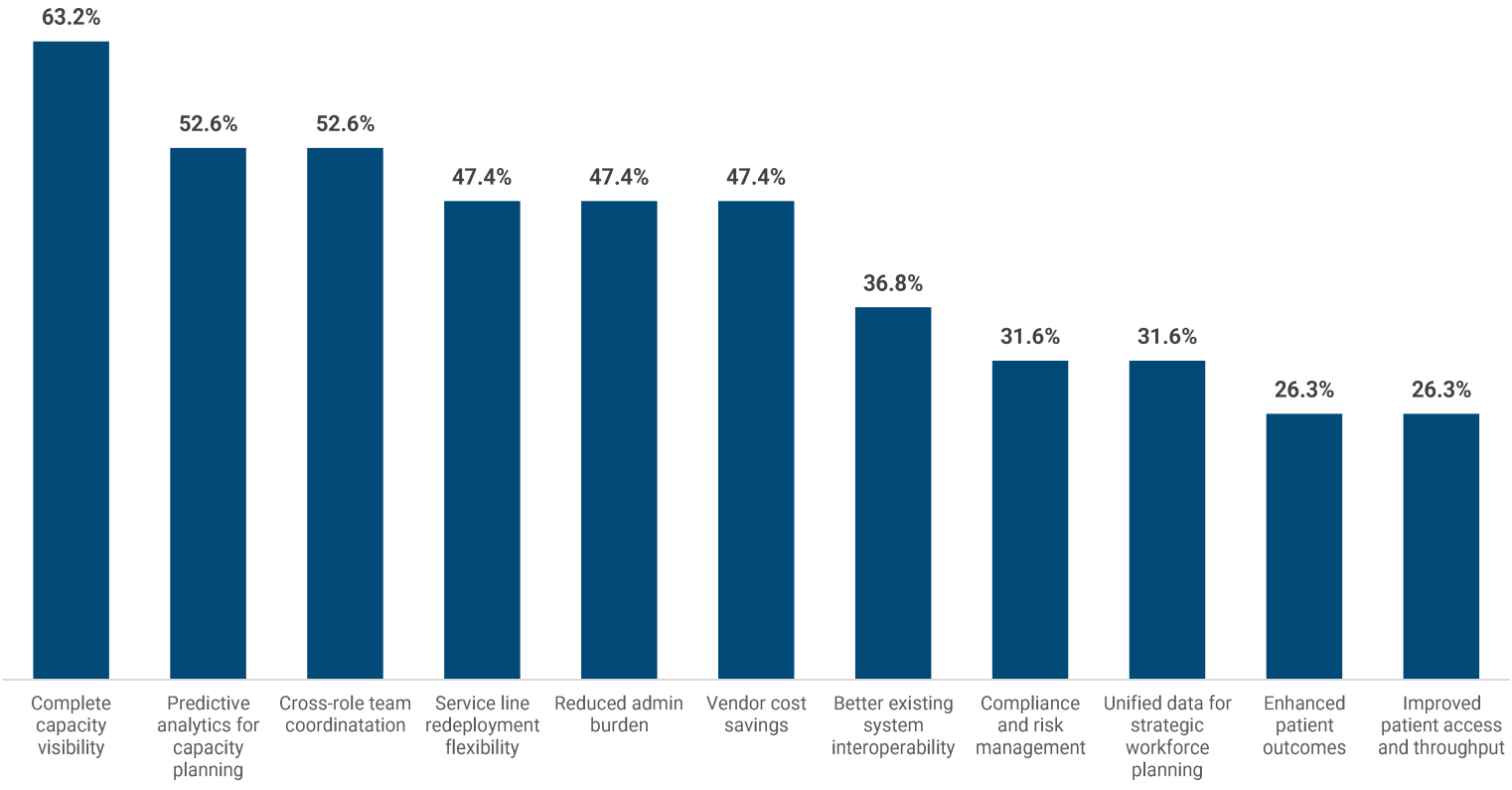
Percentage of respondents



Among systems without a unified platform, the majority of leaders aligned around a core issue: siloed nurse and physician scheduling. 54.1% noted this separation created key operational challenges, resulting in missed opportunities like a lack of capacity visibility, predictive analytics, and cross-care team coordination. Additionally, this group described notable exposure to various workforce scheduling management-related challenges, including excessive reliance on premium labor, difficulty integrating scheduling platforms with existing workflows, and the inability to adjust based on real-time demand.

What opportunities, if any, do you believe your organization is missing by managing physician and nurse scheduling separately?

Percentage of respondents



Constrained data visibility encourages myopic strategic positioning

Relative to respondents with a deployed unified scheduling platform, non-integrated systems reported a reduction in their ability to track, analyze, and apply workforce data in a targeted manner (4.2% compared to 28.6%). When this analytical infrastructure is absent, these systems cannot formulate insight, whether confirmatory or counterintuitive, to inform a pragmatic approach to workforce scheduling. Ultimately, this reinforces an impasse: without the perspective and the resulting capability, systems risk locking themselves into a state of strategic complacency, unable to view scheduling as anything beyond a needed, but not innovative, operational function.

Consequently, when scheduling is viewed through a myopic perspective it is connected to fewer strategic initiatives across the organization. Not only does this limit its strategic influence, but it also narrows its impact to metrics typically associated with scheduling, like productivity, workforce satisfaction, or clinical capacity planning.

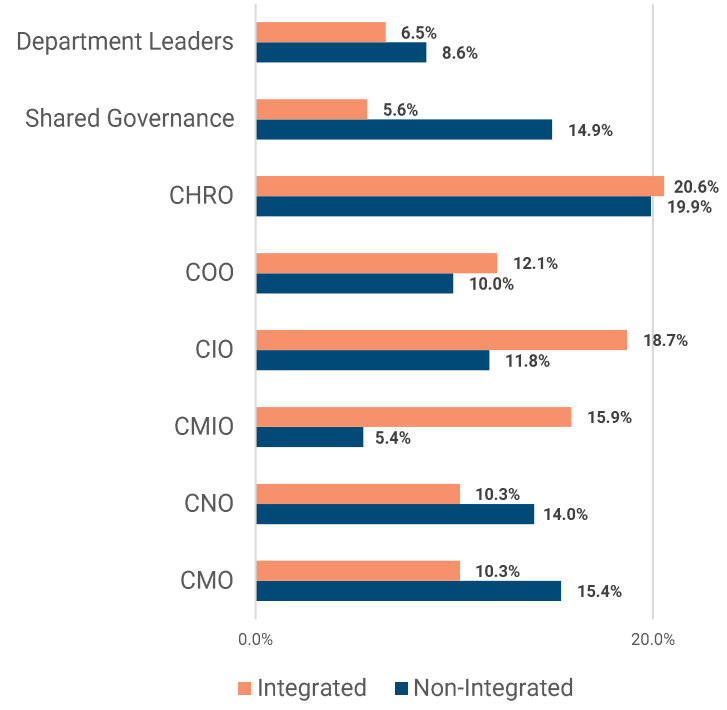
> *"On a scale of 1 to 10, [we're] a zero or a one of [having] a full picture. You can look at [our scheduling systems] individually, but you're not going to see commonality across because in some cases, they're different systems"*
>
> ***Chief Information Officer,***
> *Eastern AMC/IDN*

Fragmentation diffuses ownership across clinical leadership and compounds administrative complexity

Scheduling, like other organizational imperatives, demands enterprise ownership; without it, accountability and day-to-day operations become increasingly entangled. Non-integrated systems distributed scheduling authority more heavily across clinical leadership and cross-functional groups (52.9%) compared to their unified peers (32.7%). In contrast, fully integrated systems designated control more to cross-operational executives, like CIOs, COOs, or CMIOs (46.7% compared to 27.2%); HR leadership representation held steady across both groups, reflecting the function's consistent involvement, regardless of scheduling maturity. Integrated organizations operated on a single platform 82.9% of the time, while non-integrated health systems relied on multiple platforms (45.0%) or manual processes (14.2%). This spread of ownership results in platform decision-making that addresses each clinical executives' specific priorities, not necessarily cross-role or organizational-wide optimization.

Who holds the primary authority for workforce scheduling platforms and strategy?

Percentage of respondents by integration status



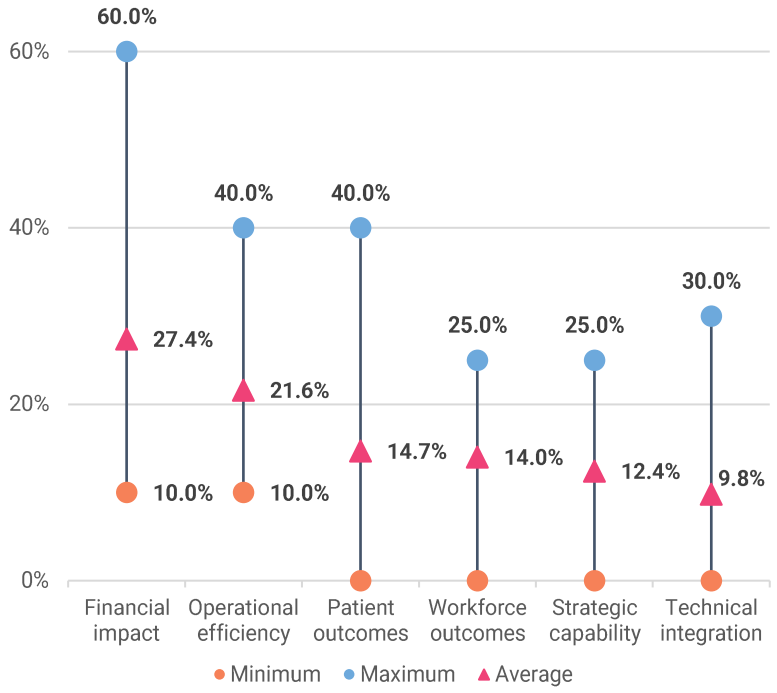
Representative decision-making committees ensure strategic choices align with the realities of clinical operations. While critical, this approach in isolation does not fully address the upstream implications of scheduling data, including its completeness, accuracy, and interoperability within the wider data infrastructure—as well as its direct influence on enterprise-level planning. Therefore, systems must strike a deliberate balance between cross-functional governance and accountability under a single executive. Those that position scheduling as a platform-level issue rather than a delegable function will more effectively address the day-to-day operational drag and impaired foresight results from fragmentation.

Financial decision-making underpins the ROI of scheduling, but a narrow view obscures the entire ROI equation

The value proposition for enterprise scheduling extends well beyond labor cost reduction. Although CHRO, CIO, and CFO respondents identified financial return (average weight: 27.4%) and operational efficiency (21.6%) as the two most important dimensions for evaluating scheduling investments, respondents also consistently attributed value across workforce, clinical, and strategic domains. Evaluating enterprise scheduling through a purely financial lens therefore risks understating its broader organizational impact. This multidimensional perspective is also reflected in what factors drive investment decisions. Executive buy-in (54.8%) was the most commonly cited catalyst for investment, followed by clinical workforce optimization (32.3%) and strategic workforce planning capabilities (19.4%). Collectively, these findings suggest that organizations pursuing enterprise scheduling are building business cases around a combination of financial, operational, workforce, and strategic objectives rather than a single financial outcome.

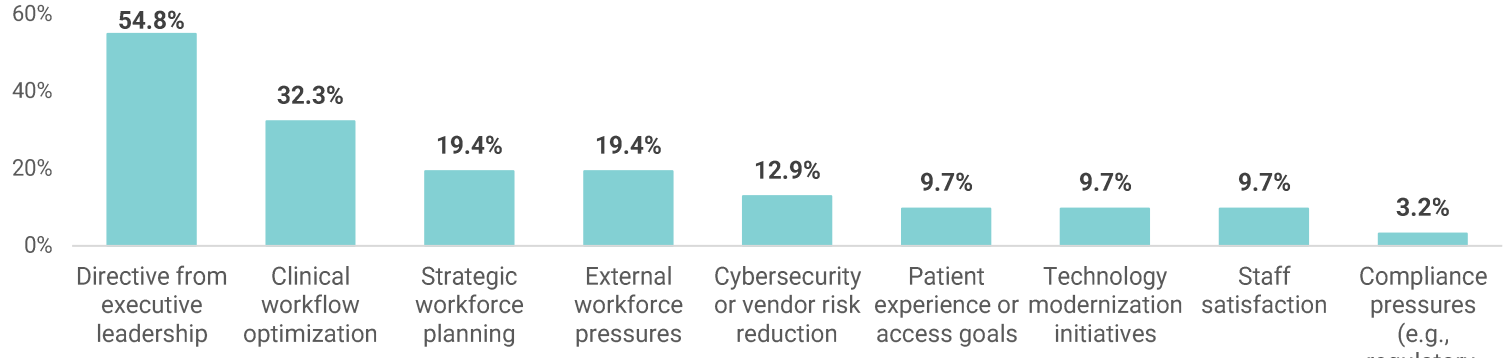
How much weight would you attribute to each domain to assess a unified scheduling platform investment?

Percentage weight reported by respondents



What would be/was the most compelling driver for your organization to consolidate workforce scheduling systems enterprise-wide?

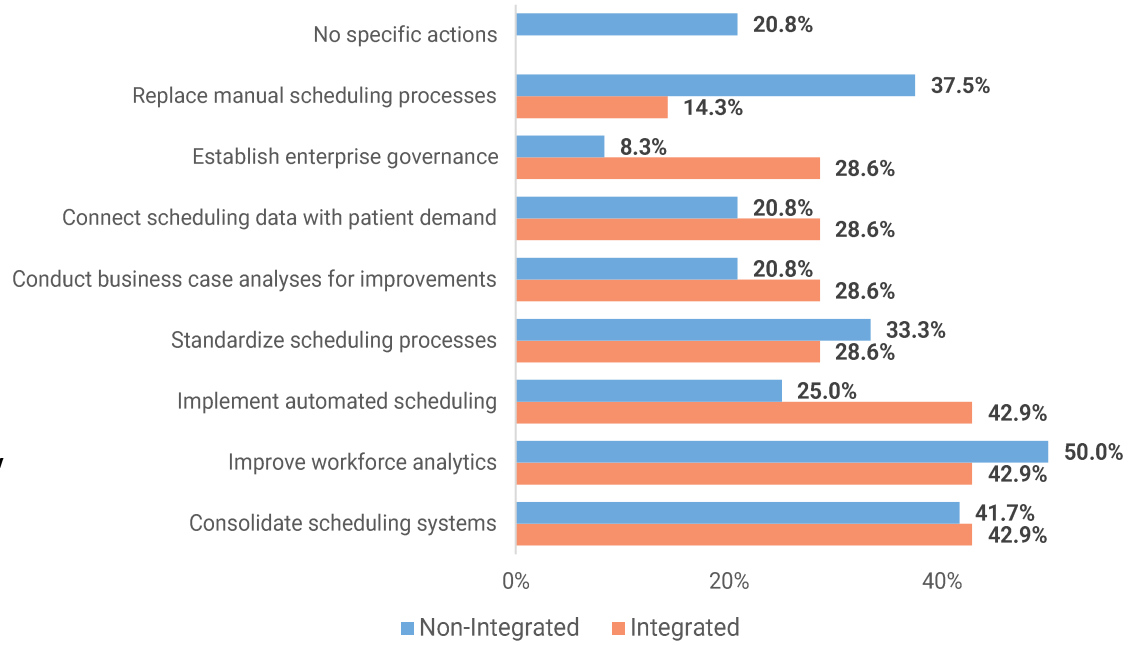
Percentage of respondents



Conversely, organizations less inclined to pursue unified scheduling most frequently cited unclear ROI as a barrier. Among respondents who were neutral to very unlikely to invest, 38.5% identified uncertain return on investment as a primary concern, compared with 0% among respondents who were likely or very likely to invest; this suggests that perceived value is influenced not only by expected outcomes, but also by how broadly organizations define and measure return.

Which of the following actions is your organization currently taking or planning to take regarding workforce scheduling in the next 12 months?

Percentage of respondents by integration status



Responses further suggest that technology investments alone are unlikely to produce enterprise value. Among non-integrated organizations, planned initiatives focused primarily on enhancing workforce analytics (50.0%), consolidating scheduling platforms (41.7%), and eliminating manual scheduling processes (37.5%). By comparison, only 8.3% of integrated systems reported plans to establish enterprise scheduling governance. Without corresponding investment in governance, ownership, and enterprise operating models, organizations risk improving individual scheduling capabilities without fundamentally addressing the fragmentation that limits enterprise workforce optimization.

The hidden implications of the status quo reinforce health system vulnerabilities

Notably, 20.8% of non-integrated respondents indicated no specific additional investments in scheduling actions planned. While maintaining the status quo results in a path of least resistance, non-action is double-edged: not only does it fail to address healthcare's current macro-level threats, but it also exposes health systems to emergent systemic risks. These vulnerabilities range from being administrative, like revenue leakage from productivity loss or unused capacity, to relating to a system's infrastructure, such as cybersecurity incidents or forced end-of-life scheduling platform transitions. As such, investing in scheduling is justified equally by what it prevents and what it enables.

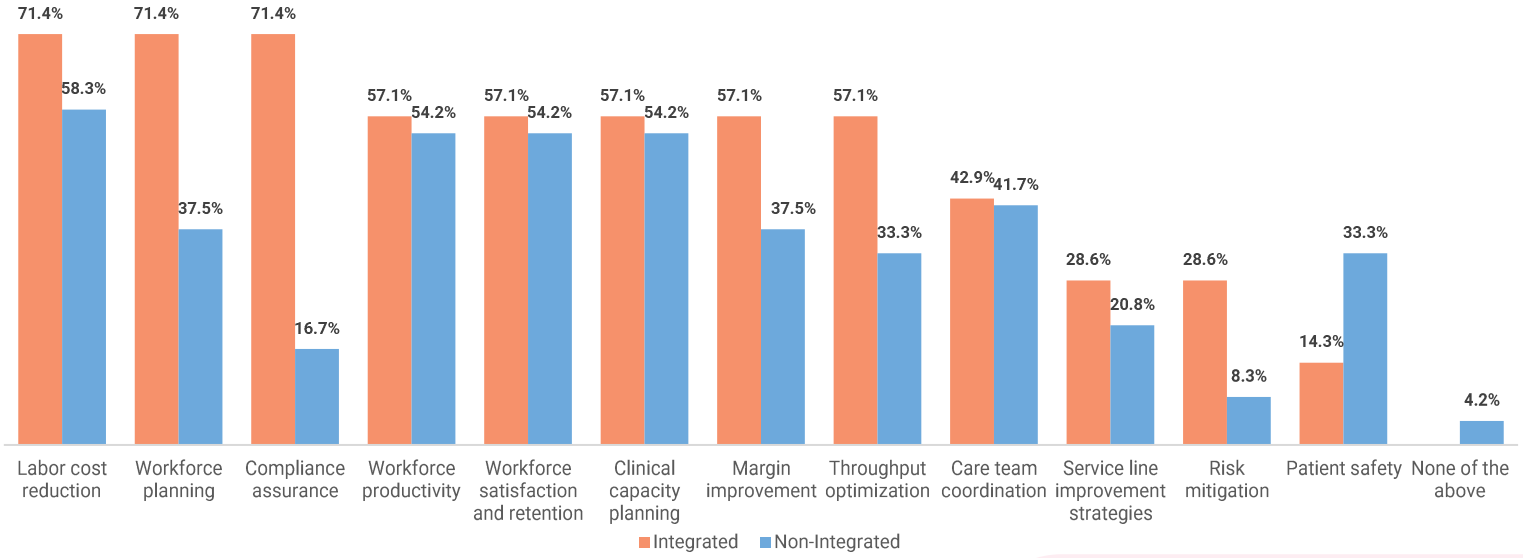
> *"Coming out of [the malware attack event], we knew for sure when it came to scheduling, time, and attendance that we really needed to standardize on a platform across the organization and a platform that would meet everybody's needs."*
>
> ***Chief Information Officer,***
> *Midwestern IDN*

Elevating workforce scheduling as an enterprise strategic directive unlocks its influence beyond workforce metrics

Positioning scheduling as an enterprise-wide directive requires embracing it not just as a cost-management and compliance tool, but as a function that guides access strategy and growth. Integrated and non-integrated systems alike shared a series of core metrics connected to their scheduling initiatives; these included productivity, satisfaction and retention, and clinical capacity planning. While essential to assess performance, the utility of this data remains siloed within workforce-dominant contexts. Scheduling unification enables systems to expand their analytical foundation. The result is two-fold: deeper workforce enhancement and broader cross-functional impact on other priorities.

Which of the following strategic initiatives is workforce scheduling currently connected to in your organization?

Percentage of respondents by integration status



Beyond core metrics, integrated systems connected scheduling more deeply to labor cost reduction (71.4%) and workforce planning (71.4%). Enhanced visibility across coordinated roles surfaces gaps that fragmented systems cannot see, including burnout indicators among cross-trained employees whose workload spans multiple environments. Additionally, scheduling integration is connected to cross-functional priorities including compliance assurance (71.4%), patient access and throughput (57.1%), and margin improvement (57.1%). A unified data repository gives finance the ability to track staffing levels against revenue and patient throughput, enhancing scheduling data as an input for financial and operational decision-making.

> *"Once we have a unified platform integrated [with the EHR] to see our census, [we can] provide a dynamic tool for us to… automatically [alert] the charge nurse: 'You should be sending X person home at this time because of volume.'"*
>
> ***VP Workforce Strategy,*** *Regional IDN*

Among fully integrated respondents, the most commonly realized benefits included improved workforce visibility and planning, reduced premium labor costs, and better care team coordination. Thus, the costs and limitations of fragmentation are addressable, not inevitable. Systems willing to shift to treating scheduling as an asset, not just another checkbox to fill, will reap the data's full strategic potential.

Section 2:

The Scheduling Integration Continuum

"For us, it's been a gradual [process] trying to get a single source of truth [and reduce] the number of applications and platforms we have. There's a benefit to that from an operational perspective."

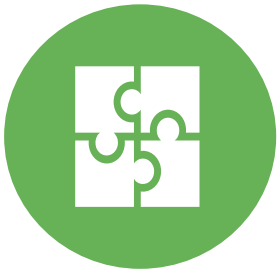
- ***Chief Information Officer,***
Midwestern IDN

The Scheduling Integration Continuum

As health systems evolve away from disparate processes, they move along a scheduling integration curve with three recognizable stages defined by the distinct problems leaders are working to solve.

Each stage reflects patterns observed across survey data and interviews with health system executives. The model outlined in this section groups survey respondents into three segments: fragmented, consolidated, and integrated. “Fragmented” encompasses survey respondents who self-identified as completely decentralized (limited standardization across the organization) and partially fragmented (a mix of enterprise solutions and department-specific approaches). “Consolidated” comprises mostly integrated respondents who, with some exceptions, manage role-specific scheduling on common platforms. “Integrated” includes respondents who reported managing clinical workforce scheduling on a single platform.

Each level of integration can be characterized by where standardization starts to deteriorate—at the unit level (*fragmented*), or the service line level (*consolidated*), or if processes and platforms remain relatively standardized at the enterprise level (*integrated*).



Fragmented

Scheduling is managed independently at the unit or department level, each with bespoke processes and limited enterprise standardization or data centralization.

Consolidated

Scheduling practices have achieved some level of enterprise connectedness, but still rely on distinct platforms, processes, and workflows at the service line level.

Integrated

Scheduling operates as a unified enterprise function, with standardized data infrastructure, consistent policies, and single governance structures that deliver full visibility.

Fragmented: Siloed, Manual Scheduling

Although possible among large integrated health systems, fragmentation is more prevalent within smaller, rural, or resource-constrained organizations with limited or outdated technology infrastructure. Fragmentation manifests as individual departments using different scheduling tools, spreadsheets, or other manual protocols. In practice, data cannot flow through these methods; costing systems the data centralization leaders need to make strategic decisions like resource reallocation, workflow standardization, and workforce deployment optimization. Manual optimization is often necessary to maintain peak functionality within a unit or service line, but it can come at the cost of strategic agility.

Half of fragmented respondents reported actively replacing manual scheduling processes compared to merely one in seven among fully integrated systems; and half of the fragmented group also indicated they are working to standardize scheduling processes across departments.

This group experiences several operational pain points "somewhat" or "to a great extent," including:

- Challenges integrating current scheduling solutions with other workflow management solutions (6 of 10).
- Difficulty coordinating care team members (5 of 10).
- Excessive reliance on premium labor (5 of 10).
- Inability to track workforce productivity in an effective or timely manner (5 of 10).

While few respondents identified payroll errors or compliance risks as major challenges, this should be interpreted cautiously. Organizations that exist in fragmented scheduling environments may lack the visibility required to detect these risks consistently.

Diagnostic Assessment

Use these questions to assess whether your health system would be categorized as "fragmented."

- ☐ Does your system heavily rely on manual scheduling processes like spreadsheets, whiteboards, or text messages?
- ☐ Is there limited standardization of scheduling workflows across units or departments?
- ☐ Is there limited trust in enterprise-level reporting on capacity, productivity, or workforce planning?
- ☐ Is there significant administrative effort dedicated to scheduling, whether through dedicated FTEs or substantial managerial time?
- ☐ Does your system utilize premium labor to an extent that exceeds what budgeted staffing shortages alone would predict?
- ☐ Is there limited ability to redeploy staff across departments, facilities, or care settings because scheduling information is outdated or disconnected?

Scoring Guide

0-1 "Yes"	2-3 "Yes"	4-6 "Yes"
Localized Fragmentation: Gaps exist in pockets, but basic coordination holds across departments.	**Operational Fragmentation:** Disconnected processes are creating inefficiencies and limiting visibility.	**Systemic Fragmentation:** Scheduling operates independently with no enterprise-level data flow.

Priority Actions for Fragmented Systems

*If you responded "yes" to several of the diagnostic questions above, your system is likely aligned with the **fragmented stage**. The following tactics can accelerate movement along the scheduling integration continuum.*

Quantify the opportunity costs

- Measure premium labor spend beyond budgeted staffing deficiencies.
- Estimate productivity-associated revenue leakage resulting from fragmented scheduling and its impact on patient access.
- Assess the administrative burden/cost associated with current scheduling practices (e.g., clinical leadership spending time negotiating and balancing schedules, or through dedicated scheduling FTEs).
- Evaluate workforce impact and cost—specifically, how fragmentation drives overtime variability, excess overtime, and staff burnout.

Identify business champions and align stakeholders

- Identify executive sponsors with authority to champion enterprise scheduling and remove organizational barriers.
- Engage executive and operational leaders across finance, operations, nursing, physician leadership, HR, IT, and frontline scheduling leaders.
- Align stakeholders around the enterprise impact of fragmented scheduling and define a shared vision for improvement.
- Pair executive messaging with peer-led delivery: site-level champions who communicate the vision at every level, surface local pain points, and deliver updates directly to staff can carry credibility that top-down communication cannot.
- Discern likely sources of resistance early, then tailor engagement strategies accordingly.
- Establish common success measures and organizational objectives that extend beyond individual departments or units.

Establish foundational governance

- Begin documenting and standardizing scheduling workflows across departments.
- Define common data standards and definitions (e.g., productive vs. non-productive hours, premium labor categories, float classifications) so scheduling information becomes comparable across departments.
- Build the governance structure required to support enterprise-wide scheduling oversight and investment decisions.
- Document standardized scheduling workflows and governance decision-making rationale to promote long-term consistency in face of staff and leadership turnover.

Consolidated: Developing, Locally Optimized Scheduling

This is where most systems reside along the continuum. These organizations have largely addressed the foundational challenges associated with fragmented scheduling. However, workforce decisions continue to be optimized locally rather than across the health system—limiting enterprise-wide visibility, cross-setting workforce flexibility, and the ability to optimize staffing and capacity at scale. Standardization typically breaks down between hospital-based and non-hospital-based services (e.g., inpatient surgery vs. ASC, inpatient infusion vs. ambulatory infusion, hospital-based imaging vs. outpatient imaging).

A majority (71.4%) of consolidated respondents characterized their systems' ability to use workforce scheduling data for strategic decision-making as "developing." This is the cohort's defining trait: they have made meaningful progress on data visibility but remain analytically and strategically constrained, and continue to experience enterprise-level operational pain points "somewhat" or "to a great extent," including:

- Premium labor utilization remains elevated despite improved scheduling visibility (11 of 14).
- Continued difficulty adjusting staffing to real-time patient demand (10 of 14).
- High costs of maintaining several enterprise scheduling processes (9 of 14).
- Challenges integrating current scheduling solutions into other workflow management solutions (9 of 14).

This cohort also had the highest share of organizations describing their current state as "good enough" (5 of 14), a signal that partial integration risks becoming permanent, leaving vendor consolidation and enterprise-wide operational efficiencies unrealized.

Diagnostic Assessment

Use these questions to assess whether your health system would be categorized as "consolidated."

- ☐ Is your scheduling standardized within individual service lines or care settings, but not across the enterprise?
- ☐ Does enterprise reporting exist while workforce decisions are still made primarily within service-line boundaries?
- ☐ Do different operational domains continue to rely on specialized scheduling solutions with limited enterprise centralization (e.g., ambulatory care settings operating on separate scheduling platforms from hospital-based services)?
- ☐ Are managers able to optimize staffing locally, but limited in their ability to optimize workforce capacity across the organization?
- ☐ Does premium labor remain necessary despite improved scheduling processes?
- ☐ Does staff redeployment across facilities or service lines require significant manual coordination?
- ☐ Does your organization lack a single operational lens for viewing and managing enterprise workforce capacity?

Scoring Guide

0-2 "Yes"	3-4 "Yes"	5-7 "Yes"
Localized Consolidation: Most areas have moved beyond service-line siloes and are approaching enterprise level infrastructure.	**Operational Consolidation:** Standardization holds within service lines, but enterprise-level optimization remains constrained.	**Systemic Consolidation:** Enterprise reporting exists, but workforce decisions are still optimized locally—risking permanent partial integration.

Priority Actions for Consolidated Systems

*If you responded "yes" to several of the diagnostic questions above, your system is likely aligned with the **consolidated stage**. The following tactics can accelerate movement along the scheduling integration continuum.*

Quantify the enterprise opportunity

- Measure the financial impact of limited workforce flexibility by evaluating avoidable premium labor utilization and overtime variability across service lines.
- Assess where care delivery bottlenecks exist across the care continuum and determine the extent to which fragmented scheduling contributes to those constraints. Quantify the resulting impact on patient access, throughput, and productivity-associated revenue.
- Identify opportunities to consolidate vendors and reduce administrative complexity.

Establish enterprise ownership and align stakeholders

- Identify an executive accountable for enterprise scheduling strategy.
- Align finance, operations, nursing, physician leadership, HR, and IT around shared enterprise workforce objectives.
- Tailor engagement to resistance-prone cohorts, including 24/7 departments, staff with multiple job classifications, and clinical teams weary from prior technology rollouts.
- Clarify governance, decision rights, and success measures that extend beyond individual service lines.
- Intervene where independent service-line scheduling decisions create enterprise inefficiencies (e.g., premium labor, capacity bottlenecks, limited workforce flexibility).

Develop an enterprise scheduling strategy

- Align on organizational objectives and key results tied to identified inefficiencies.
- Prioritize opportunities to increase enterprise visibility across scheduling platforms and operational domains.
- Develop a phased roadmap for expanding enterprise scheduling capabilities, beginning with the highest-value service lines and workforce groups.
- Sequence short-term wins within a long-term ROI story, building early momentum while benchmarking enduring value from the outset.
- Measure adoption metrics alongside operational outcomes and regularly communicate early successes to sustain organizational momentum.

Integrated: Unified, Enterprise-Wide Strategic Scheduling

Full integration is rare, achieved by highly strategic systems with strong cross-functional foundations. These systems have centralized scheduling at the enterprise level and have achieved robust data visibility through unified data models, synchronized policies, and shared governance.

This facilitates organization-wide visibility and workforce coordination across operational domains, facilities, and care settings, rather than within individual service lines. Integration transforms visibility into tactical capability that measurably affects staffing agility and, ultimately, the bottom line.

All fully integrated survey respondents reported improved enterprise workforce visibility and planning capabilities, demonstrating they have largely moved beyond foundational scheduling challenges. Now, they are focused on maximizing enterprise performance and connecting enterprise-level scheduling coordination to other strategic initiatives:

- Reduced premium labor utilization and improved care team coordination (6 of 7 each).
- Better data quality and analytics, improved staff satisfaction, enhanced patient safety, and reduced administrative burden (5 of 7 each).
- Most plan continued investment in workforce scheduling capabilities over the next 24 months (6 of 7).

Remaining challenges center on expanding interoperability, strengthening integration with adjacent workforce systems, and continuously refining enterprise scheduling capabilities as organizational needs evolve.

Diagnostic Assessment

Use these questions to assess whether your health system would be categorized as "integrated."

- ☐ Can workforce capacity be viewed and managed across the enterprise in near real time?
- ☐ Can staff be flexed across facilities, operational domains, or care settings when operationally appropriate?
- ☐ Is scheduling data routinely used to support workforce planning, capacity management, patient access, and financial decision-making?
- ☐ Does enterprise governance establish common scheduling standards, decision rights, and accountability across the organization?
- ☐ Is scheduling viewed as a strategic enterprise asset rather than an operational or departmental function?

Scoring Guide

0-1 "Yes"	2-3 "Yes"	4-5 "Yes"
Foundational Integration: Some enterprise elements are in place, but visibility is inconsistent.	**Operational Integration:** Core infrastructure supports workforce planning, with room to extend into strategic decision-making.	**Strategic Integration:** Scheduling functions as an enterprise asset with real time visibility and cross-functional impact.

Priority Actions for Integrated Systems

*If you responded "yes" to several of the diagnostic questions above, your system is likely aligned with the **integrated stage**.*

Organizations at this stage should focus less on transformation and more on maintaining and extending enterprise scheduling capabilities. Integration is not a static end point, but a state maintained through continued investment. As health systems change and expand, scheduling connectivity must be refined—underpinned by strong technical integration with information systems and supported by resilient change management structures.

Maintain enterprise governance

- Continue reinforcing standardized scheduling policies and accountability to prevent fragmentation from re-emerging as organizational priorities evolve.

Extend integration through organizational growth

- Apply enterprise scheduling standards and governance to newly acquired organizations, service lines, facilities, ambulatory sites, and other expansions to maintain a unified scheduling strategy. A documented rollout playbook, informed by prior implementation wins and frontline input, smooths each successive expansion.

Continuously optimize enterprise performance

- Leverage enterprise scheduling data to improve workforce flexibility, patient access, capacity planning, and operational performance, while selectively adopting advanced capabilities such as AI and predictive staffing where they deliver measurable value.

Key Takeaways

This research surfaced four key takeaways for health systems to reflect upon when considering their level of integration and plan to advance along the scheduling integration continuum. These findings underscore what leaders must understand for their systems to realize the strategic benefit of integration:

1. **A robust strategy cannot be built on data that remains invisible**
When scheduling platform decisions occur in isolation, systems lose the ability to spot their own inefficiencies. With no way to generate insight, leaders never surface the misalignment that would otherwise demand a revised strategy. Standardizing processes and consolidating data across the enterprise enables the first step, analytical visibility.

2. **Diffused accountability amounts to obscured ownership and disjointed decision-making**
Without a centralized structure, decision-making splits across leaders with their own priorities. While governance committees ground decisions in the clinical reality, they do not fully address upstream data accuracy and interoperability concerns. Systems must balance shared decision-making with maintaining a centralized accountability under a cross-operational executive.

3. **A finance-heavy ROI discounts the other domains influenced by scheduling investment**
Across roles surveyed, leaders aligned on financial return as the most important measure. However, they also indicated significant value across clinical, operational, and strategic domains. Scheduling's impact is innately multidimensional, and its value framing must account for more than just financial ROI as a result.

4. **Strategy maturity determines the utility of scheduling data for enterprise-planning**
Health systems progress through three distinct stages of scheduling integration: Fragmented, Consolidated, and Integrated. Most fall within the first two groups, where manual processes, siloed platforms, and departmental-level optimization remain the norm. Integrated systems centrally locate their data, allowing other departments to easily cross-reference workforce metrics against their own KPIs. Within these systems, scheduling is not just optimized for performance but also acts as an input to wider enterprise planning.

Today, most health systems undervalue the potential of workforce scheduling, forfeiting key financial, operational, and clinical benefits as a result. Instead, systems must manage scheduling as a strategic asset, rather than continuing to passively absorb the mounting opportunity cost. Those that standardize their data, consolidate their processes, and designate clear ownership are the systems that move toward strategic, system-wide integration. This foundation is what allows systems to move beyond managing schedules by role, toward using workforce data as a true enterprise asset for enterprise-wide insight.

Methodology Overview

The Health Management Academy (THMA), in partnership with QGenda, surveyed 31 workforce management leaders across US health systems. Participants answered questions that detailed how their systems enable scheduling strategy, including ownership, methods, persistent challenges, and investment decision-making. Additionally, five in-depth interviews were conducted to add nuance to the findings presented.

About The Health Management Academy

Since 1998, The Health Management Academy has cultivated the premier community of influential changemakers in healthcare. Our members are aligned around a common goal of improving health for all, and a core belief that partnership will accelerate progress. Our member community includes Leading Health Systems – the approximately 150 innovative integrated delivery systems with over $2B in total operating revenue – and innovative Industry Partners that are working alongside health systems to drive health forward. We power our members by building our community and fostering connections through executive peer learning. We support professional growth through talent and development. We accelerate understanding by delivering timely and actionable data and insights on key challenges. And we catalyze transformation by building alliances in areas where the power of the collective is greater than the power of one.

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- **Wes Adams,** Managing Director, Industry Insights

About QGenda

QGenda optimizes healthcare workforce management everywhere care is delivered. The QGenda healthcare workforce management platform empowers organizations to effectively deploy workforce resources, with solutions for scheduling, credentialing, on-call management, clinical capacity management, time and attendance, residency management, and workforce analytics. More than 4,500 healthcare organizations, including leading physician groups, hospitals, academic medical centers, and enterprise health systems, use QGenda to advance workforce scheduling, optimize capacity, and improve access to care. QGenda is headquartered in Atlanta, Georgia. Learn more at www.qgenda.com.

About Hearst Health

The mission of Hearst Health is to guide healthcare organizations by delivering essential intelligence and software that improve the quality, safety and efficiency of care. Hearst Health has been innovating with care for more than 40 years, with a commitment to making a lasting positive impact on health. The Hearst Health companies — FDB, Homecare Homebase, MCG, MHK, QGenda, and Zynx Health — elevate care by informing and empowering participants across the health journey. To learn more, visit www.hearst.com/hearst-health.