TheAcademy

The Future of Integrated Virtual Care: Closing the Gap to Goal

Insights from Leading Health Systems

As healthcare consumer expectations continue to evolve and health systems grapple with how to provide more personal and holistic care across diverse settings, the role of virtual care is shifting from a nice-to-have to a must-do. In a recent survey, Leading Health System (LHS) executives agreed with 93% reporting they plan to grow most or all of their virtual health offerings in the foreseeable future.[1]

Beyond meeting consumer expectations, there's good reason for this planned investment. LHS CXOs believe the future of care delivery will be measurably different than today—describing future virtual care delivery as integrated, consumer-focused, and scaled. Here's what they mean by that:

- **Integrated:** Offering a seamless and cohesive experience for patients across platforms and entry points to the system (virtual or physical).
- **Consumer-focused:** Giving patients on-demand, omnichannel access to care and ensuring care is affordable.
- **Scaled:** Operating with a unified virtual strategy across the enterprise, rather than disconnected point solutions.

Research Methodology

To answer the question, *what will it take to unlock the future of virtual care, and what's standing in your way?* The Academy conducted research with Chief Strategy Officers, Chief Medical Information Officers, and Population Health Leaders from 38 Leading Health Systems, including:

- Surveyed 30 CXOs across 22 LHS
- Facilitated three in-person discussions with 60 CXOs
- Conducted industry subject matter expert interviews
- Collected secondary data, performed applied literature review

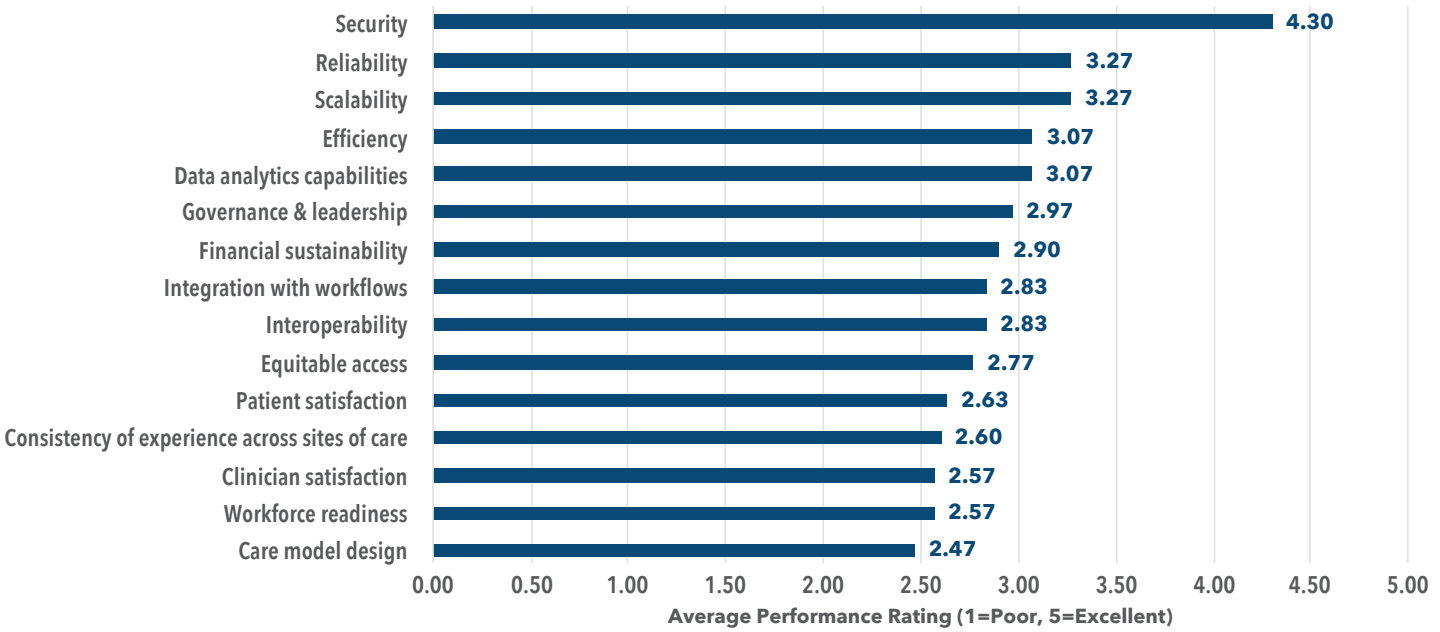
The problem CXOs are facing? How to get there.

There's a relatively large gap between where LHS are today with care delivery and where they want to be, particularly when looking at virtual care performance. When self-ranking their system's performance on virtual health, executives scored overall performance relatively low at 2.9 on a scale of 1-5 (where 1 represents poor performance and 5 represents excellent performance.)

Looking at individual performance indicators, CXOs are most satisfied with their technical measures of virtual health performance, including system security (4.3), reliability (3.27), and scalability (3.27) (Figure 1). The balance of performance indicators scored below average with most ranking below 3.0. These represent many of the human-centered wraparounds to the technology—care model design (2.47), workforce (2.57), clinician satisfaction (2.57), and so on. This discrepancy is understandable given the rapid investment in technologies at the start of the pandemic.

The problem is that technology alone won't solve integrated virtual care. **Health systems need the wrap-around functions that support virtual care technologies.** But because health systems haven't migrated toward organized, system-wide virtual care programs, they haven't yet mastered the critical workforce and organizational inputs required to succeed.

Figure 1. Average Ranking of Virtual Health Strategy Performance by Key Indicators (CSOs, CMIOs, Pop Health)



This brief examines these wrap-around functions more closely and outlines four imperatives that LHS need to do to close the gap between the present and desired future state.

Four LHS Imperatives

1	2	3	4
Digital health strategy exists in name only – and that must change.	LHS need to swap vendor contracts for true partnerships to succeed on consumerism.	To achieve virtual care integration, LHS must secure operational buy-in from the start.	Scale is a catch-22. Proceed with caution.

Each of these imperatives is backed by quantitative survey-data and pressure-tested with LHS executives.

Four Imperatives to Close the Gap on Virtual Care Delivery

Imperative #1: Digital health strategy exists in name only – and that must change.

At LHS, virtual care falls under the broader "digital health" umbrella, which can include everything from digital front door to the multitude of digital apps and tools used by patients and providers. To understand the virtual care delivery road map, it's critical to understand the overall strategy for digital health.

While the vast majority of LHS reported a digital health strategy at the system (73%) or facility (7%) level, most LHS leaders struggled to articulate their strategy in concrete terms. In every facilitated discussion, LHS leaders were quick to ask us to define "digital health" and slow to offer up specific strategy pillars.

This is because at most LHS digital health strategy exists in name only. In turn, LHS leaders are not happy with their system's performance. Only 6% of leaders say their existing digital health system is sufficient to meet their needs as an organization.

Just 6%

of CXOs say their existing digital health system is sufficient for their needs

There are two reasons why LHS digital health strategy remains amorphous.

1. **Health system approaches to digital (and virtual) solutions have been largely reactive.** Across the last few years, LHS were more focused on solving urgent problems necessitating immediate solutions, including the need to rapidly expand virtual solutions. Only recently have leaders been able to return to longer term, proactive planning.

"We experience a problem, and then respond." – CMIO

2. **Perhaps more importantly, health systems are most often using digital solutions as an enabler to strategy but haven't elevated digital to a strategy in its own right.** For example, health systems have a consumer strategy with a digital component. Or a chronic care management strategy with a digital component. But there isn't a clear, cohesive plan across the health system for all digital solutions.

"We're moving so fast that the organization doesn't know there may be existing processes that work well. They're just disconnected from other parts of the organization." – CMIO

The consequence of this disjointed strategy is disjointed digital and virtual solutions. Most LHS are working with a disconnected web of point solutions with siloed ownership and accountability fueled by one-off investments. This results in care fragmentation, an inconsistent consumer and workforce experience, inefficient or redundant technologies, challenges with workflow, and low performance on many of the virtual care performance indicators outlined above.

Health systems leaders are quick to recognize that a clear digital strategy is needed to push forward on integrated care delivery (among many other strategic imperatives). But to do it, LHS need to decide who they want to be as an organization—and for virtual care delivery, what markets they want to play in. These may not be quick or easy decisions, but it's a critical step in moving from disjointed decisions to a scaled, system-wide investment plan.

Imperative #2: To succeed on consumerism, LHS need to swap vendor contracts for true partnerships.

Health systems are universally focused on consumerism as a critical strategic goal. In a survey of more than 140 CXOs, executives ranked "consumer-focused digital strategy" as their second most important priority for 2022–following only workforce stabilization.[2] When asked specifically about their goals for digital health, LHS leaders ranked "supporting consumer loyalty" at the top, followed by market expansion/growth, and enabling population health.

And there's good reason for this. The explosion of well-resourced competitors in healthcare is driving the erosion of patient loyalty to the local health system. This is true for two reasons:

1. **Consumers are consumers and that doesn't change when it comes to healthcare.** Consumers expect a convenient, consistent, and unified experience across physical and digital touchpoints with the system–and they're willing to change providers if they're unsatisfied or left waiting longer than they want.
2. **Industry competitors have mastered convenient care.** Industry competitors are digitally-native and spent the last few years mastering the needs of healthcare consumers, particularly in the low acuity space. They are already providing the right care at the right time in the most convenient way.

Consumerism Is Top Goal at LHS for Digital Health Investments

53%

of LHS leaders ranked "supporting consumer loyalty" as the #1 goal for digital health strategy

57%

of LHS leaders reported "increased number of visits/new patients" as the most important KPI for measuring digital health success

82%

of LHS leaders reported "improving access to care" as the most important patient outcome for their digital health strategy

At first blush, it seems like industry competitors have the advantage when it comes to consumers. But health systems maintain an edge here that they often overlook. They are local and most have been serving their communities for decades–a homefield advantage so to speak. If LHS can plug the gaps in their care continuum, they stand to benefit from lifelong consumers who will seek them out for the full range of preventive and acute healthcare services. Taking a page from retail giants and big box stores, LHS are well-positioned to be the go-to resource for consumers looking to have all of their healthcare needs met in one place.

But to leverage the homefield advantage and succeed on consumerism, most health systems agree they need to partner with an industry company that plugs into their care continuum and helps achieve integrated, consumer-focused care delivery at scale. Fortunately, most already are.

77% of LHS are partnering with outside organizations on digital health.

The challenge now for most LHS is moving from vendor contract to true partnership. When asked, most LHS categorized their "partnerships" in the digital space as contracts and transactional in nature. What is needed is skin in the game on both sides.

"We are trying to move away from traditional vendors and move toward long-term partners."

– Director, Consumer Digital Experience

For both health systems and industry organizations, a good partner is not based on metrics like pricing or contract terms. CXOs describe productive partnerships with terms like flexibility, ongoing communication, culture and values alignment, willingness to hear feedback, and long-term delivery on promises. Industry partners echoed similar sentiments, adding the value of long-term partnerships and aligned incentives.

To move from vendor contracts to partnership, there will need to be a shift on both sides.

Helping Clinical Staff Better Understand the Consumer (versus the Patient)

CSOs and other C-Suite leaders have been aligned for some time on convenience as the key driver of consumer behavior. Yet, clinicians often continue to cite quality as the primary motivator for purchasing healthcare services.

While quality does drive patient treatment decisions, it isn't the primary motivator for consumers. CXOs need to continue to make the distinction between these groups clear when gaining support for broader consumerism efforts.

The consumer

- Has a specific but low acuity healthcare need (i.e., annual wellness visit, broken bone, virtual visit for flu-like symptoms)
- Values convenience above all else

The patient

- Has a specific, higher acuity or chronic care need (i.e., diagnosed with cancer, heart attack)
- Values quality and reputation above all else

Key Components of Effective Health System-Industry Partnership

- Partner that is complimentary not competitive to core business
- Shared goals between health system, partner
- Aligned incentives and risks
- Mutual respect
- Candid, consultative relationship
- Long-term commitment

Imperative #3: To achieve virtual care integration, LHS must secure operational buy-in from the start.

Buy-in is critical to the success of any virtual care or technology investment. It affects the uptake of new solutions, effectiveness with which they are deployed, and ability to scale across the system. Without solid buy-in from clinicians or other end-users, it's hard for virtual investments to achieve their intended ROI.

Buy-in has been (and still is) a long-standing stumbling block to new technologies. Only 39% of CMIOs believe their organization secures sufficient clinician buy-in prior to implementing a new technology (Figure 2).

The biggest obstacle to buy-in is simply this: a failure to involve the right leaders at the right time. Unlike clinical investments which typically involve multidisciplinary teams of physicians, nurses, and technical support, technology implementations don't consistently give clinicians a seat at the decision-making table. In some cases, teams that are completely disconnected from clinical workflows (e.g., marketing) may be responsible for overseeing digital solution investments. This means that key stakeholders likely aren't getting exposure to a new solution until implementation—leading to greater mistrust of the technology reinforced by workflow challenges.

Our data shows that it's uncommon for operational leaders to be involved in virtual health strategy, despite often being held responsible for the performance of the tools (Figure 3). The result is that projects end up floundering and leaders wonder why the implementation hasn't been successful. CMIOs and Population Health leaders observe that they are often brought into implementation conversations during the later stages of virtual health investments, negating the chance for them to provide early and actionable feedback.

This is a missed opportunity. Operational leaders are best-positioned to weigh in on anticipated challenges to uptake and implementation of technologies—and thus best-positioned to help solve for potential hiccups.

Beyond early engagement of the right stakeholders, consolidating point solutions will help streamline buy-in. It helps mitigate solution fatigue—making it less likely that health systems will meet resistance when they introduce new technologies.

As LHS navigate workforce buy-in to virtual solutions, historic EHR implementation challenges serve as an apt model for mistakes to avoid. By some estimates, up to 50% of EHR implementations either fail or fail to be properly utilized.[3] Neglecting to achieve stakeholder buy-in is cited as a key reason for these failures. Despite being an IT-led decision, EHR installments represented a significant and disruptive change to clinician workflows. Virtual health implementations today can avoid mistakes of the past by involving key stakeholders early and selectively choosing solutions that make clinicians' lives easier—not more complicated.

Figure 2. CMIO agreement with the statement: "Our organization secures sufficient clinician buy-in prior to implementing new digital health technologies."

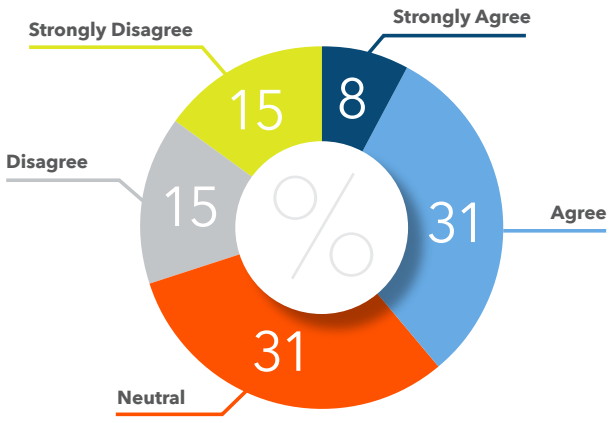


Figure 3. CSO responses to "Which leaders are involved in your organization's digital health strategy and programs?"

Title	Strategy	Operations
Chief Information Officer	70.0%	30.0%
Chief Strategy Officer	70.0%	30.0%
Chief Consumer or Experience Officer	63.6%	27.3%
Chief Medical Officer	55.6%	44.4%
Chief Medical Information Officer	50.0%	50.0%
Medical Group Leaders	30.0%	60.0%
Chief Nursing Officer	28.6%	42.9%
Population Health Leaders	28.6%	71.4%
Chief Nursing Information Officer	0.0%	60.0%

Intentional Management of Point Solutions

Without an overarching strategy to govern virtual solutions, health systems are prone to having redundant applications. One way to mitigate excessive point solutions is through an application development or oversight team charged with managing vendor contracts and reducing redundancies.

While there is nearly universal support around consolidating point solutions, LHS leaders explain the importance and value of consolidation in different ways. CSOs view consolidation of point solutions with an eye toward cost and a goal of having as few vendors as possible. CMIOs view consolidation with an eye toward reducing redundancies in point solutions even if it doesn't necessarily mean minimizing the number of vendors engaged.

LHS leaders will need to see eye-to-eye to ensure they are aligned on the goal(s) of consolidation and to avoid removing critical or well-functioning technologies.

Imperative #4: Scale is a catch-22. Proceed with caution.

Beyond cost savings and removing redundancy, consolidation of point solutions enables scale—which is a critical part of moving toward integrated, consumer-focused care delivery. The current pattern of investment in one-off solutions has made fragmented care the default setting for LHS. The more point solutions health systems deploy, the more disjointed consumer care will continue to be.

To solve for care fragmentation, LHS need to scale virtual care solutions. But scale can also present a catch-22: If an organization doesn't scale, care will continue to be fragmented. Yet, if an organization scales poorly, care will be further fragmented. For example, consider a scenario where a health system invests in a system-wide virtual solution without appointing centralized leadership to oversee the function. This runs the risk of localized and inconsistent deployment across the organization. This would be scaling poorly.

To beat this catch-22 and scale well, LHS must conduct an honest assessment of their virtual health maturity by looking at key indicator performance such as governance, data and technology management, financial sustainability, and clinical integration—each of which represents a critical component to scale (Figure 4).

Academy research revealed that just over half (54%) of LHS have achieved mid-stage virtual health maturity.[4] This is characterized by governance over digital technologies still becoming centralized, no system-wide virtual care budget, early-stage implementation of new technologies, and clinicians engaging in virtual care at a basic level.

Figure 4. Key Indicators of Advanced Virtual Health Maturity [5]

Governance	Data & Technology	Finance	Clinical
■ Explicitly prioritizes virtual care among C-level executives ■ Centralizes virtual care governance at a system/ enterprise level	■ Has established and implemented virtual care technology and integrated into a single user-friendly platform ■ Has implemented maximum cybersecurity measures and continuously monitoring for threats	■ Works with payers to develop virtual care payment bundles or other economically compelling arrangements ■ Integrates virtual care encounters into the revenue cycle management workflow	■ Seamlessly integrates virtual care and in-person care, with flexibility afforded to clinicians regarding their workflow within the 'new normal' ■ Supporting a culture of innovation, championed and adopted by clinicians, that encourages use of new technologies

Organizational self-assessment across these maturity indicators can help health systems determine their readiness for scaling virtual health solutions. However, most LHS still have a long way to go before they will be ready to scale. They will need to focus on solidifying and planning for the governance, sustainable financing and more of their virtual health programs before attempting to scale across the organization.

Additionally, LHS will need to decide on their preferred approach to technology implementation. For instance, does the organizational culture support a "fail fast and fail forward" model, or a "crawl, walk, run" model of technology implementation? Answers to these questions will be critical to share with technology partners to assess implementation synergies. They will also inform the type, scope, and scale of investments health systems will make.

The Homestretch: Closing the Gap to Goal

Integrated virtual care delivery will move forward with or without health systems on board. If not health systems, there is an abundance of disruptors waiting in the wings to win over consumers. And the choices health systems make now will make or break their future success (and ability to remain competitive.) The roadmap for succeeding on integrated virtual care will require significant organizational alignment with a defined digital health strategy serving as the foundation. True partnerships help plug gaps in the care continuum. Operational buy-in supports effective implementation. And finally, scale lends itself to a cohesive consumer experience. Each of these imperatives is a necessary, can't skip step to catapulting LHS toward the future of integrated virtual care.

Resources

1. The Academy. Virtual Health: Assessing the Strategy, Business Model, Implementation, and Future Considerations Among Leading Health Systems, March 2021.
2. The Academy's 2022 CXO Priorities Survey.
3. Gesulga, et al. Barriers to Electronic Health Record System Implementation and Information Systems Resources: A Structured Review, Procedia Computer Science, Volume 124, Pages 544-551, 2017.
4. The Academy. Virtual Health, March 2021.
5. The Academy. Virtual Health, March 2021.

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The Health Management Academy (The Academy) is a membership organization exclusively for executives from the country's Top-100 Health Systems and most innovative healthcare companies. The Academy's learning model identifies top priorities of health system leaders; develops rich content based on those priorities; and addresses them by convening members to exchange ideas, best practices, and information. The Academy is the definitive trusted source for peer-to-peer learning in healthcare delivery with a material record of research and policy analysis. Offerings include C-suite executive peer forums, issues-based collaboratives, leadership development programs, research, advisory, and media services. The Academy is an accredited CE provider. More information is available at www.hmacademy.com

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