

# The Hidden Cost of Point Solutions

Why VBC Success Depends on Platform Thinking

8 MIN READ

**73%**

more digital tools  
since 2016

**\$266B**

annual admin  
waste

**50%**

care team time on  
admin work

## INSIDE THE REPORT

- ✓ A framework to quantify hidden fragmentation costs
- ✓ 4 strategic actions for your next vendor evaluation
- ✓ Platform readiness self-assessment (score your org)

# What's Inside



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# Executive Summary

**Most provider networks are trying to win at value-based care with infrastructure that was never designed for it.**

Value-based care asks provider networks to manage risk, improve outcomes, and protect margins at the same time. Many organizations are trying to do that with a patchwork of vendors layered on top of the EHR. Each new requirement brings another tool. Each tool solves something specific. Together, they create drag.

Fragmented tech stacks chip away at performance in ways that do not always show up on an IT budget line. Care teams bounce between systems. Quality data lives in one place, risk documentation in another. Finance teams chase gaps after the fact. Administrative load keeps climbing, and so does burnout.

This is not a call for better interfaces or tighter integrations. The issue runs deeper. When value-based care depends on coordinated action across roles and settings, disconnected point solutions work against the model itself.

Platform thinking treats architecture as a strategic choice. Instead of stitching tools together, it builds on a shared data layer and embeds functionality inside existing workflows. Organizations that make that shift tend to see better adoption, cleaner data flow, and fewer workarounds.

**Those that keep layering vendors often find themselves managing complexity instead of improving care.**

# The Multi-Vendor Reality in Healthcare

The number of digital health tools physicians use daily has grown 73 percent since 2016, according to the [AMA's Digital Health Care Study](#) and each additional system adds to the cognitive and administrative load care teams carry. Around 40 to 50 percent of their time goes to administrative work between those systems, based on research in [Annals of Internal Medicine](#). Administrative costs make up roughly a quarter to a third of total U.S. healthcare spending, as reported in [JAMA](#) and Health Affairs, with an estimated \$266 billion annually identified as administrative waste. EHR-related burnout is closely linked to workflow fragmentation, according to [Mayo Clinic Proceedings](#) and the AMA.

# 73%

growth in the number of digital health tools physicians use daily since 2016

These numbers do not exist in isolation. They are symptoms of an architecture problem, one that grows worse with every new vendor added to the stack.

The pattern is familiar. A new reporting requirement appears. A new contract introduces different measures of success. A new risk model demands different coding. The response is often to buy a tool or add-on a new mechanism to support the change, impacting the care team workflow. Over time, the organization ends up with a crowded desktop and a long integration queue.

Each product can make sense on its own, but in aggregate, they interrupt the workflow. Care teams toggle between screens. Data moves slowly or not at all. Leaders talk about digital progress while frontline staff feel buried.

# \$266B

identified annually in administrative waste costs





# The Hidden Cost of Point Solutions



## Clinical Cost

**Provider & Care Team Burnout:** Fragmented workflows increase cognitive load. A physician moves from the EHR to a condition assessment paper form, then to a quality tool, then back to an EHR encounter to document the visit. Every switch requires reorientation and pulls attention away from the patient in front of them.

Burnout is tied to lower quality scores, higher rates of medical error and higher turnover, as the [National Academy of Medicine](#) has documented. That link should change how we think about tech strategy: burnout often traces back to system design.



## Financial Cost

**Margin Erosion in VBC:** Value-based contracts depend on accurate, complete documentation to fully capture risk and coordinate care. When workflows are misaligned, documentation suffers. When data does not flow in seamless, actionable ways, quality incentives are missed. Manual reconciliation work adds cost for both providers and revenue cycle management.

[Health Affairs](#) and [CMS](#) reports show that organizations can lose shared savings because of incomplete documentation and workflow gaps. Those losses are not abstract. They show up in lower performance payments and thinner margins.

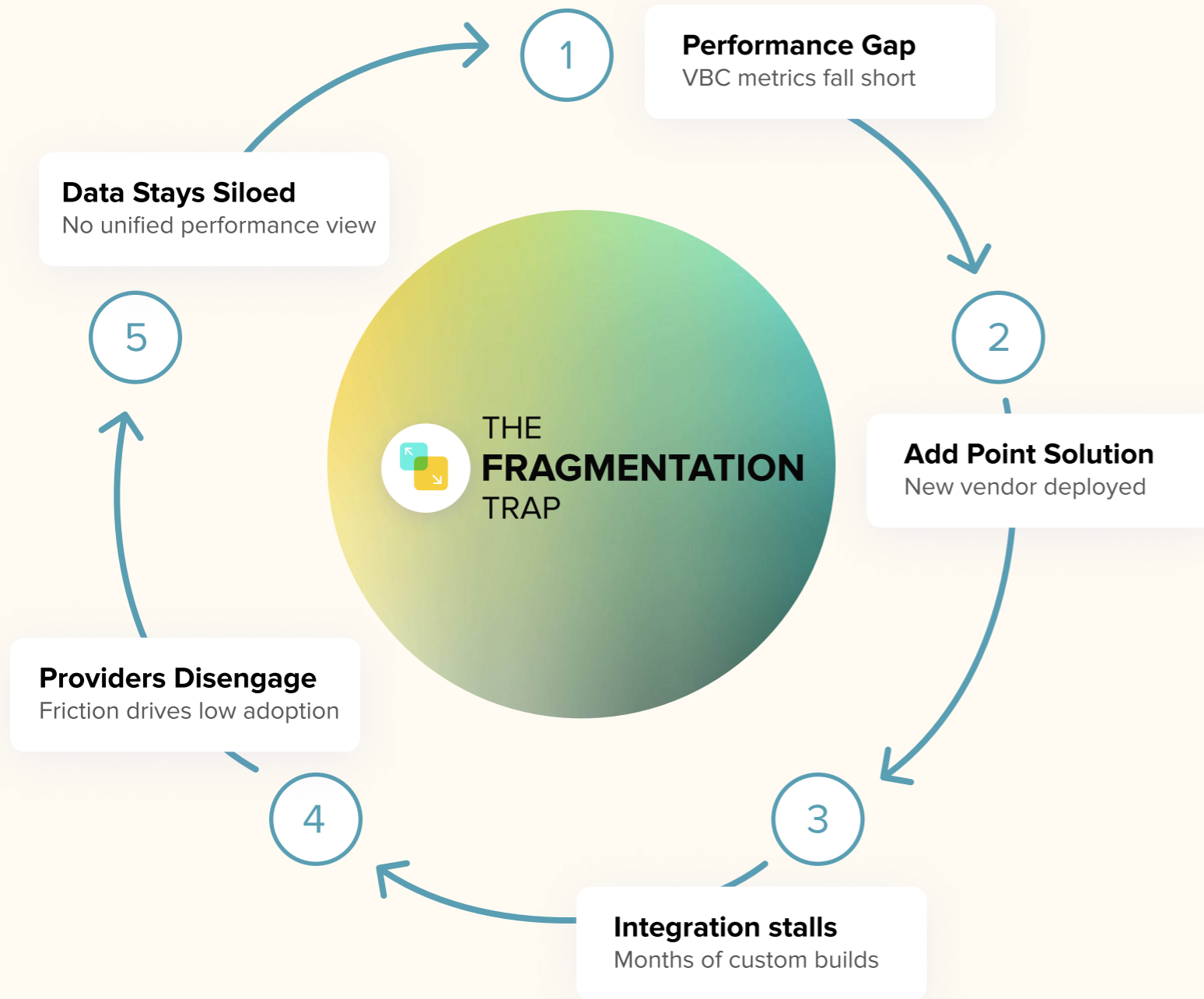


## Strategic Cost

**The Compounding Drag of Complexity:** Every additional vendor brings another integration, another contract, and another training cycle. IT teams spend their time keeping systems connected instead of expanding capabilities and increasing value. Rolling out new VBC programs takes longer because each one has to plug into a more tangled stack.

Over time, the organization becomes harder to change. The technology that was supposed to help ends up slowing things down.

# Why Fragmentation Undermines Value-Based Care



Fee-for-service rewarded volume regardless of workflow quality. Value-based contracts do not. Under VBC, incomplete documentation, delayed data, and disjointed workflows directly reduce performance payments. The stakes of fragmentation are fundamentally higher.

Value-based care relies on timely data at the point of care, coordinated workflows across settings, and shared accountability between payers and providers. Point solutions often surface information outside the core workflow. They create duplicate alerts. They force care teams to toggle.

[CMS](#)'s own MSSP reporting requirements have made workflow integration a documented operational barrier, with cumbersome documentation workflows cited as a primary challenge to [ACO performance](#) compliance, and fewer than 1 in 5 eligible ACOs successfully use electronic clinical quality measures as of 2023. [McKinsey](#)'s research on health system digital transformation has found that most organizations continue to face a gap between digital investment intentions and operational results, with legacy infrastructure and implementation complexity consistently cited as primary barriers.

**Value-based care is a systems design problem. Payment reform alone does not fix misaligned architecture.**

# The Case for Platform Thinking

Platform thinking starts with a unified architecture. Instead of aggregating tools, it builds on a shared data layer. Applications run within a common environment. Workflows are embedded rather than bolted on.

In other industries, from finance to retail, platform models replaced fragmented toolchains because they improved scale and speed. Integration costs dropped over time when new capabilities plugged into the same foundation. Adoption rose when users stayed in one workflow instead of juggling several.

Healthcare is more complex than most industries. That is exactly why architecture matters.

Platform thinking means a provider opens their EHR and the right data is already there — not in a separate tab, not behind a login, not waiting to be reconciled. Risk signals, care gaps, documentation prompts, and coordination tools appear at the moment decisions are made. The workflow is the integration.

## Design for the point of care

Technology should fit the way care teams work. If it forces them to adapt to the system, adoption will lag, satisfaction will decrease, and burnout will rise.

Platform models can surface relevant information during the visit and in support of many other workflows and tasks, within the EHR, at the moment decisions are made and actions take place. This reduces cognitive burden and makes it easier to act on relevant insights, external information, and required administrative tasks.

**When the right information appears at the right time, care teams use it. No extra effort or login required.**



# Strategic Recommendations

## For Healthcare Leaders



### Audit fragmentation

List every clinical and administrative tool in use. Map where they overlap. Calculate integration costs and training time. Many leaders are surprised by what this exercise reveals. Organizations that complete this audit typically find 30 to 40 percent of their tools are redundant or underused.



### Evaluate vendors through an architectural lens

Ask whether a solution lives inside the workflow or beside it. Does it reduce context switching or add another screen, document, or task? Does it support shared accountability across stakeholders? The right question is not "what does this tool do?" but "where does this tool live and does that location match where care decisions actually happen?"



### Tie technology to VBC performance

Connect tech investments to specific risk, quality, and margin metrics. Shift procurement conversations from feature lists to architectural fit. A tool that improves a metric in isolation but adds friction to the workflow is a net cost, not a net gain.



### Prioritize scalability

Quick purchases often create long-term drag. It is worth asking how today's decision will look three years from now, once contracts expand and reporting requirements grow. The organizations that scale VBC programs fastest are typically those that built on a shared foundation early, not those that integrated the most tools.

## Platform Readiness Self Assessment

Answer five questions to understand whether your technology architecture supports your value-based care strategy, or whether fragmentation is creating hidden costs and performance risk.

1. Do your providers use more than 3 separate health IT tools to manage their VBC-related workflows? **YES / NO**
2. Has any clinical technology deployment taken longer than 6 months to go live in your organization? **YES / NO**
3. Do you manually reconcile data from multiple systems to produce a single performance report? **YES / NO**
4. Have you experienced low provider adoption on a clinical tool despite significant investment? **YES / NO**
5. Is your current technology infrastructure making it harder, not easier, to respond to new VBC contract requirements? **YES / NO**

### SCORING GUIDE

<b>0-1 YES</b>	<b>Architecturally Sound</b> Your infrastructure is well-positioned for VBC performance. Focus on deepening platform utilization and expanding program coverage.
<b>2-3 YES</b>	<b>Fragmentation Risk</b> You have measurable fragmentation creating hidden costs and performance drag. A platform consolidation assessment is recommended before your next contract
<b>4-5 YES</b>	<b>Fragmentation Is Costing You Now</b> Your current architecture is a material liability to your VBC strategy. A platform migration conversation is urgent. The cost of inaction compounds each performance period.

# Unified platform integration drives results.

## Point solutions add cost and administrative burden.

How your technology is integrated, not just what it does, determines whether your VBC strategy succeeds or stalls.

	THE OLD MODEL Point Solution Model	THE VIM APPROACH Platform Thinking
EHR INTEGRATION	<p>✗ <b>Custom-built per EHR</b> Every new deployment requires new engineering work.</p>	<p>✓ <b>Build once, deploy everywhere.</b> Works natively across most EHRs with zero custom builds.</p>
TIME TO VALUE	<p>✗ <b>12 to 18 month implementation cycles</b> before clinicians see any impact.</p>	<p>✓ <b>Initial practices go live within 60 to 90 days,</b> with a structured rollout designed to minimize disruption to existing workflows.</p>
PROVIDER EXPERIENCE	<p>✗ <b>Another login, another tool.</b> Physicians lose time and resist adoption.</p>	<p>✓ <b>Embedded inside the EHR.</b> Surfaces at the right moment, with no new tab and no added friction.</p>
DATA FRAGMENTATION	<p>✗ <b>Each tool creates its own silo,</b> with no unified view of performance or patient insights.</p>	<p>✓ <b>One layer, unified intelligence.</b> All programs share a single infrastructure and data picture.</p>
SCALABILITY	<p>✗ <b>Adding a program means another vendor,</b> another contract, another integration.</p>	<p>✓ <b>Add programs without adding complexity.</b> New use cases layer onto existing infrastructure.</p>
CARE GAP CLOSURE	<p>✗ <b>Low adoption, inconsistent follow-through.</b> Relies on providers remembering to check and logging into additional portals.</p>	<p>✓ <b>Care gap alerts surface inside the EHR at the point of care,</b> supporting consistent, timely follow-through across your provider network.</p>
TOTAL COST	<p>✗ <b>Hidden costs compound:</b> implementation, maintenance, retraining, and vendor sprawl.</p>	<p>✓ <b>One platform, predictable cost structure.</b> Eliminates duplicated spend across programs.</p>
STRATEGIC ALIGNMENT	<p>✗ <b>Vendor incentives misalign with outcomes.</b> Tools optimized for usage, not performance.</p>	<p>✓ <b>Built for outcomes at every level.</b> Every feature is designed to drive performance and eliminate the administrative burden that stands in the way of care.</p>

# From Integration to Orchestration

Healthcare has spent years connecting systems with occasional, marginal improvements to the work at hand. The next step is coordinating them around real workflows in ways that alleviate provider and care team burden to drive better outcomes, performance, and satisfaction.

Digital health is moving towards embedded intelligence, cross-organization collaboration, and lower administrative friction. Financial alignment will depend on architecture that supports shared data and shared action without disruptive burdens.

Organizations that keep adding tools are already feeling the weight of that complexity. Those that rethink their architecture now have a better chance of improving performance and care teams' experience for years to come.

Multi-vendor chaos is hard to sustain in a value-based care world. It is up to leaders to determine what kind of technology foundation can support the next decade of risk-based care and take action now to set their organizations up for success.

The question is not whether to modernize. It is whether to do it before the architecture gets in the way.

Vim is that foundation: a platform built to embed the right workflows, data, and intelligence directly inside the EHR, purpose-built for value-based care organizations serious about what comes next.

[Request a Demo ↗](#)