



# Managing Healthcare in a Hybrid World



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# 01

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**What you will be able to  
do**



# By the end, you will be able to...

01

Identify effective leadership supporting safe, coordinated, and person-centred hybrid healthcare.

02

Select an appropriate combination of digital and face-to-face care for different patient needs.

03

Use data and evaluate digital tools while considering quality, privacy, accessibility, and equity.

04

Manage change, technology failure, and resistance when introducing hybrid healthcare services.

# 02

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**What this Module is  
about**



# Purpose



*This OER helps healthcare educators and students develop competences in leading hybrid healthcare by selecting and evaluating appropriate digital and face-to-face approaches through brief explanations, realistic scenarios, simulations, practical tasks, and reflection on data, equity, privacy, accessibility, and continuity of care.*

**Practical**

**Accessible**

**Used well**

# Why we are doing this

*Most hybrid care gaps are closed through leadership and digital tools—not complex platforms.*

## The problem

- Digital and in-person care are often poorly coordinated.
- Leaders may lack confidence and digital skills.
- Poor technology choices can reduce safety and quality.
- Digital care may exclude some patients.

## What helps

- Strong, patient-centred leadership.
- The right mix of digital and in-person care.
- Clear communication and relevant data.
- Inclusive planning and backup plans.

# 03

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**Who this is for**



# Audience and needs

## For

- Healthcare educators and lecturers
- Final-year nursing / medical / allied-health students
- Clinical-placement supervisors
- CPD coordinators

## They need

- Practical skills to lead and teach hybrid healthcare
- Confidence in choosing digital and face-to-face approaches.
- Tools to support safe, inclusive, high-quality care.
- Hands-on confidence in 60–90 minutes

### A one-minute story

Maya, a clinical-placement supervisor, supports a final-year nursing student caring for an older patient at home. Together, they review a blood-pressure reading by video, explain wound care, and confirm the next in-person visit. When the connection becomes unstable, Maya must decide what can continue digitally and what requires face-to-face care.

***What can be managed safely by video? What requires an in-person visit? What should Maya do if the connection fails?***

# 04

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## Why do we Need Hybrid Healthcare



# Traditional vs. hybrid healthcare

*Hybrid healthcare integrates in-person care with digital health technologies.*

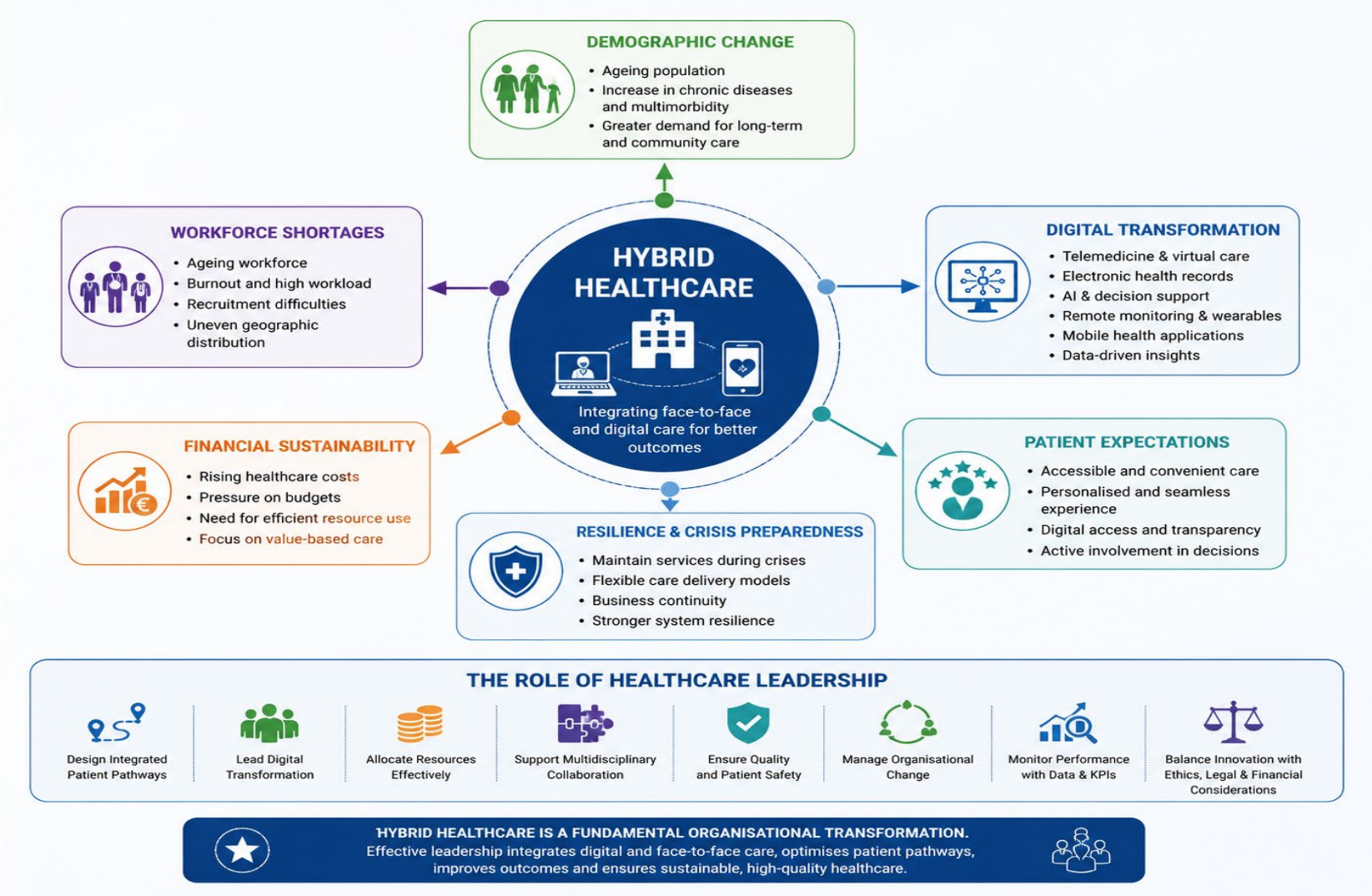
## Traditional healthcare

- **Provider-centred:** Care is organized around healthcare professionals, services and facilities.
- **Siloed delivery:** Teams and organizations work separately.
- **Reactive approach:** Services respond to illness, with less emphasis on prevention.
- **Face-to-face dependent:** Care relies on scheduler, in-person appointments.

## Hybrid healthcare

- **Patient-centred care:** Tailored to individual needs and preferences.
- **Integrated services:** Information shared across teams and settings.
- **Proactive monitoring:** Risks identified and addressed early.
- **Hybrid delivery:** Digital and face-to-face care combined

# Key drivers of healthcare transformation



# 05

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## The Healthcare Tool Tour: Five Categories



# Five categories at a glance

**1**

## Digital access and intake

Scheduling, registration, consent, symptom capture, eligibility checks and asynchronous messaging

**2**

## Virtual care

It works best when modality follows the clinical task – synchronous, asynchronous, team collaboration, safety gate

**3**

## Remote monitoring needs

Connected blood-pressure cuffs, glucose systems, pulse oximeters, scales, wearables and patient-reported outcomes

**4**

## Shared records

Shared records, interoperability, reconciliation, minimum test

**5**

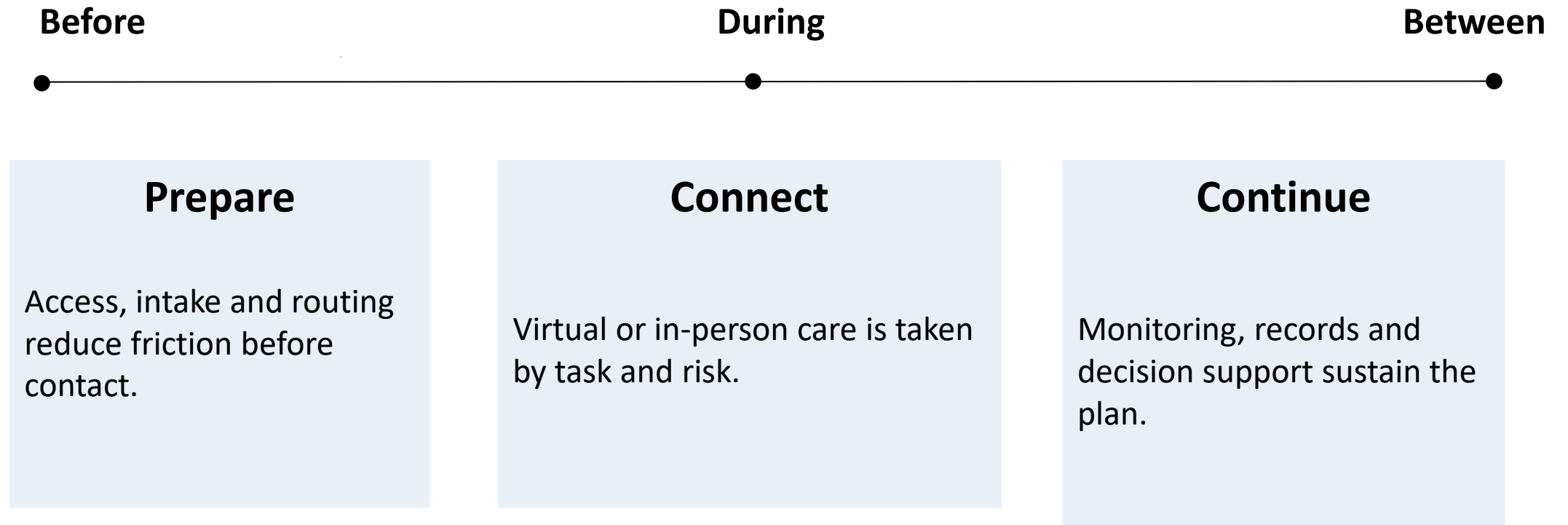
## Clinical AI

Risk flags, guideline prompts, triage support, ambient documentation, summarization and workflow automation

*Hybrid healthcare succeeds when the tool changes with the clinical need: Prepare → Connect → Continue*

# One connected healthcare journey

Hybrid healthcare succeeds when the tool changes with the clinical need.





## Tool Evaluation: Four-Criteria Rubric



## When and how to use four-criteria rubric

- Use this rubric to evaluate a digital or virtual-care tool during selection, piloting, implementation review, or contract renewal.
- Apply it before procurement, following a pilot, and at regular intervals during routine use.
- Evaluate the tool in the context of its intended patient population and clinical workflow, rather than as a stand-alone technology.
- Base scores on available evidence, including workflow testing, patient and staff feedback, audit findings, performance data, and system documentation.



## Tool Evaluation: Four-Criteria Rubric

### 1 Access and intake



Does the tool make it easier for patients to enter and navigate the service?

### 2 Clinical fit



Does the tool support the clinical task and help teams select the appropriate virtual, in-person, or hybrid modality?

### 3 Response ownership



Are alerts, results, and follow-up actions assigned to a clearly named professional?

### 4 Care continuity



Does the tool support shared records and reliable handovers between remote and in-person care?



Score each criterion: 1 = Not met • 2 = Partly met • 3 = Mostly met • 4 = Fully met

## Four-criteria rubric: Scoring guide

| Criterion                 | 1 — Not met                                                 | 2 — Partly met                                              | 3 — Mostly met                                        | 4 — Fully met                                                |
|---------------------------|-------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------|
| <b>Access and intake</b>  | Creates access or navigation barriers.                      | Improves access, but major barriers remain.                 | Easy for most patients, with minor barriers.          | Accessible, inclusive, and easy to navigate.                 |
| <b>Clinical fit</b>       | Does not support the clinical task or care-modality choice. | Provides limited support; major gaps or workarounds remain. | Supports most clinical needs, with minor limitations. | Reliably supports the task and appropriate care modality.    |
| <b>Response ownership</b> | Responsibility and escalation are unclear.                  | Some roles are defined, but gaps remain.                    | Ownership is usually clear, with minor gaps.          | Ownership, response times, escalation, and backup are clear. |
| <b>Care continuity</b>    | Records are fragmented and handovers unreliable.            | Some information is shared, but gaps or delays remain.      | Records and handovers are generally reliable.         | Shared records and handovers are timely and dependable.      |

# How to apply it

## 1. Define the use case

Identify the patient group, clinical task, setting, users, and care modality.

## 2. Gather evidence

Review testing, policies, performance data, incidents, and user feedback.

## 3. Score independently

Each reviewer assigns a score with a brief justification.

## 4. Agree on scores

Discuss differences and record evidence, gaps, and actions.

## 5. Interpret the total

Add the four scores and assess the overall result.

### Total score and interpretation

| Total score | Rating        | Suggested action                                                |
|-------------|---------------|-----------------------------------------------------------------|
| 14–16       | Strong fit    | Proceed, subject to clinical, privacy, and technical assurance. |
| 10–13       | Potential fit | Address gaps and monitor during implementation.                 |
| 7–9         | Weak fit      | Redesign the workflow or conduct further testing.               |
| 4–6         | Poor fit      | Do not adopt without substantial changes.                       |

### Example: Remote-monitoring tool

Access and intake: 3 — Easy registration; limited languages.

Clinical fit: 4 — Clear thresholds and review routes.

Response ownership: 2 — No reliable backup for alerts.

Care continuity: 3 — Records updated with delays.

**Total: 12/16 — Suitable if alert ownership is improved.**



## Leadership - Patient Pathway Mapping and Handover Risk

# Mini case study 1. Remote review to urgent face-to-face assessment

## PATIENT

## PATHWAY

## POTENTIAL HANDOVER RISKS

## LEADERSHIP CHALLENGE

### Look for moments where hybrid care breaks down

- Marta, 68, has heart failure and limited confidence using digital technology. Her daughter normally helps but is unavailable today.
- Marta reports increased breathlessness through secure messaging. An administrator forwards the message to a general clinical inbox. A nurse conducts a telephone review and recommends an urgent face-to-face assessment at another site. The receiving clinic cannot see the original message or the nurse's full notes.
- The message is not clinically triaged quickly; responsibility is unclear while the message sits in a shared inbox; the receiving clinic lacks the patient's symptoms, observations and medication information; - Marta does not understand how urgently she must attend or how to reach the site; and no one confirms whether she arrived.

*Your turn: Establish clear inbox ownership, closed-loop transfer to the receiving clinic, accessible patient instructions, and a follow-up process if Marta does not attend.*

## Mini case study 2. Hospital discharge to home monitoring

### PATIENT

### PATHWAY

### POTENTIAL HANDOVER RISKS

### LEADERSHIP CHALLENGE

#### Look for moments where hybrid care breaks down

- Daniel, 54, is discharged after treatment for uncontrolled hypertension. He receives a connected blood-pressure monitor and is told that the community team will review his readings.
- The hospital uploads a discharge summary, but the medication change is not highlighted. The monitoring platform sends readings to a dashboard shared by several community staff. Daniel records several high readings over the weekend but assumes the system will automatically alert someone.
- The community team does not know that monitoring has started; medication changes are overlooked; nobody has named responsibility for dashboard review outside normal hours; Daniel does not know which readings require urgent action; and technology creates a false expectation of continuous monitoring.

*Your turn: Define acceptance of the referral, dashboard ownership, review frequency, patient escalation instructions and weekend contingency arrangements.*

## Mini case study 3. Multidisciplinary follow-up with a carer

### PATIENT

### PATHWAY

### POTENTIAL HANDOVER RISKS

### LEADERSHIP CHALLENGE

#### Look for moments where hybrid care breaks down

- Aisha, 42, has diabetes and a visual impairment. She attends some consultations by video and relies on her partner for help with written information.
- Her specialist changes her insulin plan during a video appointment. A summary is sent through the patient portal, but it is not accessible to her screen reader. Her primary-care clinician and community pharmacist have not yet received the updated plan. Aisha later contacts the pharmacist because the instructions are unclear.
- The patient receives information in an inaccessible format; consent and the partner's role are not clarified; different professionals work from conflicting medication plans; the pharmacist cannot verify the latest instruction; and responsibility for checking understanding is unclear.

*Your turn: Coordinate an accessible, consent-based handover; reconcile the medication plan; confirm patient understanding and establish a single source of current information.*

# Five-Item Identification Quiz

**Instructions:** Read each situation and identify the missing safety control, relevant safety concept, or required leadership action. Give one concise answer for each item.

1. **Case 1:** Marta's message remains in a shared clinical inbox, with no one clearly accountable for reviewing or acting on it. *What essential governance control is missing?*
2. **Case 1:** Marta is referred urgently to another clinic, but the receiving team cannot access her symptoms, observations, medication information, or the nurse's full notes. *What safe-handover principle has not been followed?*
3. **Case 2:** Daniel assumes that his connected blood-pressure monitor is being watched continuously, although no one is assigned to review the dashboard over the weekend. *What patient-safety risk has the technology created?*
4. **Case 3:** Aisha receives her updated insulin plan in a portal document that is incompatible with her screen reader. *What communication requirement has not been met?*
5. **Case 3:** Aisha's specialist, primary-care clinician, and community pharmacist may be using different versions of her insulin plan. *What system-level control is required to prevent conflicting medication instructions?*

# Answer key

1. Clear ownership and accountability for inbox monitoring and clinical triage.
2. Complete, structured, closed-loop transfer of clinical information.
3. False reassurance or an incorrect expectation of continuous monitoring.
4. Accessible communication and reasonable adjustment.
5. Medication reconciliation and a single authoritative source of current information.





# Cross-Functional Project



## Online Leadership Simulation: Launching a Hybrid Healthcare Service

A cross-functional team will participate in an online leadership simulation to prepare for the launch of a hybrid healthcare service. Clinical, administrative, digital, operational, and workforce colleagues will work through realistic patient journeys that move between remote and face-to-face care.

During the simulation, the team will:

- **Clarify roles and accountability:** Agree who is responsible for triage, clinical decisions, digital support, referrals, follow-up, handovers, and escalation.
- **Assess workload and staffing capacity:** Determine whether staffing levels, skills, schedules, and technical support are sufficient to meet anticipated demand.
- **Strengthen continuity of care:** Examine how patient information, clinical responsibility, and follow-up are transferred between remote and in-person services.

**Task output:** A shared operating model that defines responsibilities, staffing requirements, handover points, escalation routes, and priority actions for a safe and coordinated service launch.



## Launching a Hybrid Healthcare Service: Questions

### 2. What should the team clarify to avoid gaps or duplication in patient care?

- A. The service's marketing strategy
- B. The design of staff uniforms
- C. Responsibility for triage, decisions, referrals, handovers, follow-up, and escalation
- D. The number of patient information leaflets

**C Why:** Clear roles and accountability ensure that each task has a named owner and that critical work is not missed or duplicated.

### 3. Which factors are most important when assessing service capacity?

- A. Office location and furniture
- B. Staffing levels, skills, schedules, demand, and technical support
- C. The number of meetings held before launch
- D. Staff preferences for remote working only

**B Why:** These factors determine whether the service can manage expected demand safely, including during busy periods and outside normal working hours.

### 4. What is required when a patient moves from remote to face-to-face care?

- A. The patient must repeat all clinical information from memory
- B. The receiving team should conduct a new assessment without reviewing earlier information
- C. The digital team should retain responsibility for all clinical decisions
- D. Relevant information, clinical responsibility, and follow-up requirements must transfer clearly

**D Why:** A complete and clear handover protects continuity of care and reduces the risk of missing information, delayed decisions, or unclear responsibility.

### 5. What should the shared operating model contain?

- A. Only a list of digital systems
- B. Only the clinical team's responsibilities
- C. Responsibilities, staffing requirements, handover points, escalation routes, and priority actions
- D. A general description of the proposed service

**C Why:** These components provide the practical structure needed to launch and operate a safe, coordinated hybrid healthcare service.

# 06

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## How to Choose a Tool



# Scenario Decision: Choosing Hybrid Care

Which combination of digital and face-to-face care would best meet this patient's needs?

## Patient

Amina is 58 and has type 2 diabetes and hypertension. Her latest HbA1c is 76 mmol/mol (9.1%), and her clinic blood pressure is 156/94 mmHg. She missed two reviews last year because the clinic requires a 55-minute bus journey each way, costing £5.20.

Amina:

- Has experienced dizziness since a medication change.
- Needs a medication review, foot examination and blood-pressure assessment.
- Prefers telephone calls to video consultations.
- Has unreliable broadband and limited mobile data.
- Prefers a Bengali interpreter for complex decisions.
- Does not own a blood-pressure monitor.
- Would like fewer clinic visits but values seeing the same nurse.

## Service data

| Care option                           | Completion rate                                                            | Staff time      | Important limitation                                               |
|---------------------------------------|----------------------------------------------------------------------------|-----------------|--------------------------------------------------------------------|
| Face-to-face appointment              | 82%                                                                        | 32 minutes      | Travel, cost and missed work                                       |
| Telephone consultation                | 90%                                                                        | 18 minutes      | No visual or physical examination                                  |
| Video consultation                    | 71%                                                                        | 25 minutes      | Broadband and digital-confidence barriers                          |
| Remote blood pressure (BP) monitoring | 64% submit sufficient readings without support; 88% with navigator support | 8-minute review | Requires a validated monitor, onboarding and an escalation process |

# Scenario Decision: Choosing Hybrid Case

*Select the best combination*

## Decision:

1. All care face-to-face
2. Video consultations plus an app
3. Telephone consultations only
4. One face-to-face assessment, supported home BP monitoring and telephone follow-up

**Recommended decision:** Option 4: One face-to-face assessment, supported home BP monitoring and telephone follow-up.

- **Week 1** — Face-to-face: medication review, foot examination, assessment of dizziness, accurate BP measurement and provision of a validated home monitor. Book a Bengali interpreter.
- **Weeks 1–2** — Digital monitoring: Amina records BP readings at home. A digital navigator provides setup support and large-print Bengali instructions.
- **Week 2** — Telephone: the same nurse reviews the readings and discusses treatment with an interpreter.
- **Week 6** — Follow-up: telephone if stable; face-to-face if symptoms, abnormal readings, examination needs or patient preference require it.

# Decision justification

This combination uses face-to-face care where physical assessment is necessary while reducing avoidable travel.

## TELEPHONE

Telephone care is more accessible than video for Amina and has the highest local completion rate.

## MONITORING

Navigator-supported monitoring increases expected submission from 64% to 88% and provides better trend data than a single clinic reading.

## NURSE

A named nurse must review alerts. Dizziness, concerning readings or missing data should trigger telephone assessment or an urgent face-to-face review.

## PATHWAY

A non-digital pathway must remain available.

# 07

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Spot → Pick → Set →  
Reflect



How the session runs: Spot → Pick → Set → Reflect

## Spot the gap

SPOT

PICK

SET

REFLECT

**Look for moments where digital access and intake make the front door easier to navigate**

- A new client completes a mobile-friendly intake form before arrival and is guided directly to the right service. He may struggle to find the right service or repeat their information.
- Focus on a mobile-friendly intake form that routes them correctly.
- Pilot it with new clients for four weeks and track completion, routing accuracy, and time saved.
- Review client and staff feedback—what became easier, where people still got stuck, and what to change next.

*Your turn: name one moment when digital access or intake could help someone reach the right service more easily.*

How the session runs: Spot → Pick → Set → Reflect

## Pick the right tool

SPOT

PICK

SET

REFLECT

### Match the gap to the clinical task.

- Identify one gap in the patient journey.
- Match it to one category—access, assessment, treatment, monitoring, or follow-up.
- Choose the modality that best fits the clinical task: virtual, in-person, or hybrid.
- Consider what worked, what did not, and whether the modality supported safe, effective care.

*Your turn: identify a moment in your settings when virtual care is well suited to the clinical task.*

How the session runs: Spot → Pick → Set → Reflect

## Set it up well

SPOT

PICK

SET

REFLECT

### Remote monitoring needs a named response owner

1. Identify a moment when remote monitoring detects a change in a patient's condition.
2. Select the alert or result that requires action.
3. Assign a named professional to review, respond, document, and escalate when needed.
4. Check whether ownership, response times, and escalation routes are clear.

*Your turn: name a remote-monitoring moment in your setting that needs a clearly identified response owner.*

How the session runs: Spot → Pick → Set → Reflect

## Reflect on what changed

SPOT

PICK

SET

REFLECT

### Shared records keep hybrid care connected

- Identify where information could be lost as a patient moves between virtual and in-person care.
- Choose one handover where access to a shared record is essential.
- Agree what must be recorded, who is responsible, and when the record should be updated.
- Consider whether every professional can see the information needed to provide safe, coordinated care.

*Your turn: name a moment in your setting when a shared record could prevent care from becoming fragmented.*

*Exit ticket: What is one action you will take to improve information-sharing across virtual and in-person care?*

# 08

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## Equity, Next Steps and Sources



# Equity and inclusion

*A simple tool can quietly exclude people. Plan for that from day one.*

| Who can be left behind                                                                                                                                                                                                                 | How exclusion shows up                                                                                                                                                                                                 | What to do                                                                                                                                                                                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Older patients without smartphones</li><li>• Carers managing on a parent's behalf</li><li>• Patients with low literacy or non-native language</li><li>• Areas with poor connectivity</li></ul> | <ul style="list-style-type: none"><li>• App-only access (no SMS or phone path)</li><li>• Sign-up needs a national digital ID</li><li>• Long onboarding videos</li><li>• No screen-reader / large-text option</li></ul> | <ul style="list-style-type: none"><li>• Always pair the tool with one offline route</li><li>• Test onboarding with a non-expert before pilot</li><li>• Plain-language messages, default ON</li><li>• Document who the tool is NOT for</li></ul> |

# Take it into your week

Pick ONE thing to do in the next 7 days.

## TEACH

Add a 10-minute Spot → Pick → Set → Reflect activity to your next class

## TRY

Configure one tool using the four-criteria rubric, then save a screenshot of the completed evaluation.

## SHARE

Send the rubric to one colleague and compare picks

## ASK

Ask one patient or student which tool they would realistically use, map where it fits within the patient pathway, and identify any associated handover risks.

# Sources and further reading

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