



Whitepaper

Clinical Integration: 7 Myths and a Blueprint for Success

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Clinical Integration Now

The concept of clinical integration has been around for decades. In the past, clinical integration focused on creating physician-hospital organizations (PHOs), mergers, acquisitions and other consolidations to improve negotiation and contracting with payers.¹

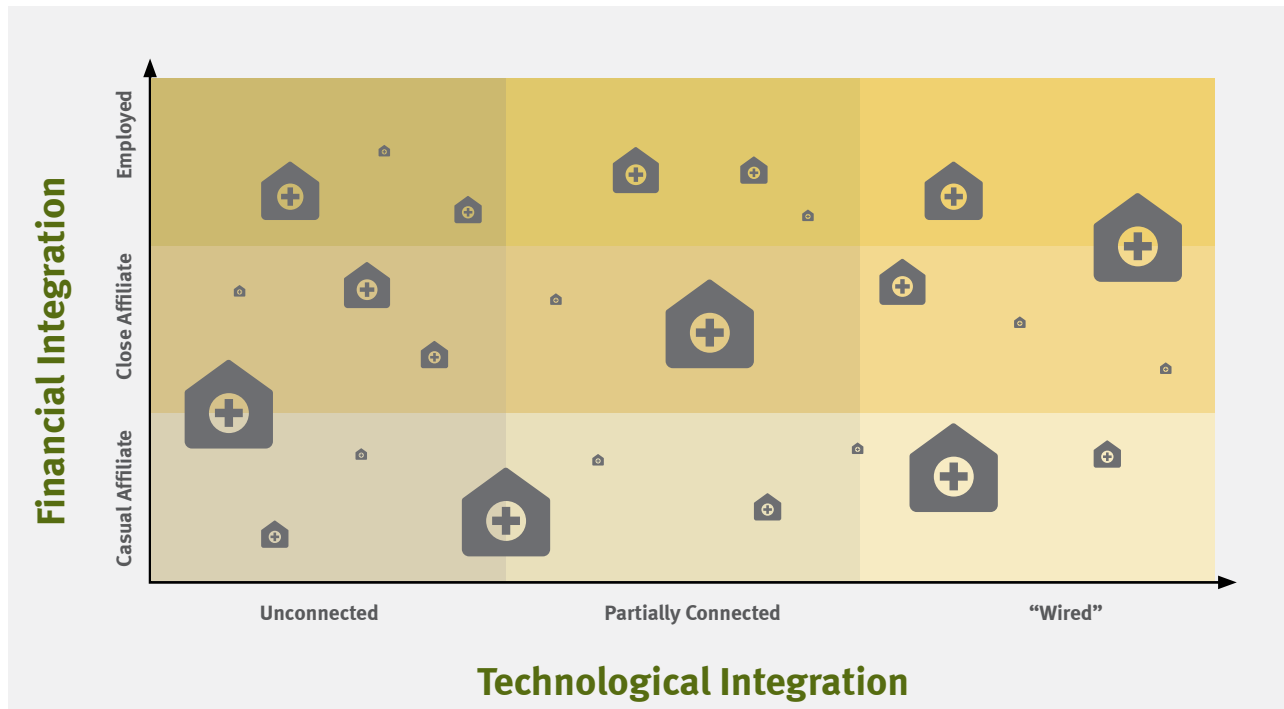
Today, however, providers and health care organizations are expected to deliver **value**—that is, improved quality with controlled costs—and to reduce overuse.² To do this, many health care organizations are rethinking the concept of clinical integration.

In particular, there are three factors making clinical integration an important goal for hospitals, physician groups and other health care organizations now:

- **Health care reform.** The United States health care system is undergoing systemic changes. Current and future legislation will address meaningful reform to expand coverage, reward effective and efficient care, promote innovation and control cost. According to the American Hospital Association, “Achieving greater clinical integration...is essential to the system change needed to achieve these goals.”³
- **New payment models.** Policymakers are also looking at payment reforms as a means to promote greater collaboration across the health care continuum. The Medicare Payment Advisory Commission’s (MedPAC) 2008 Report to Congress recommended replacing the current Medicare fee-for-service system with one that “would pay for care that spans across provider types and time...and would hold providers accountable for the quality of care and the resources used to provide it.”⁴ MedPAC suggested three approaches to help achieve these goals—medical homes, bundled payments and accountable care organizations (ACOs). Both the federal government and commercial payers have begun to move to value-based reimbursement, with programs that include the CMS program for risk-adjusted reimbursement, pay-for-performance and economic credentialing.⁵ The ultimate goal for each of these models is to promote care coordination to improve quality outcomes while decreasing costs. In one form or another, health care organizations need to prepare for value-based payment models.
- **Advances in health information technology.** To support new reimbursement models, an integrated delivery system must manage a vast network of information. It must collect, maintain and provide appropriate access to administrative, clinical and financial data in order to monitor quality and costs while providing patient-centered care. Health information technology (HIT) has been evolving to meet these new standards and requirements. Today, health care leaders look to several different kinds of HIT solutions—such as electronic medical records (EMRs), health information exchanges (HIEs) and data aggregation solutions—to support care delivery. However, there are serious drawbacks to certain HIT options, and these will have to be considered carefully before purchasing or updating systems. A good HIT solution enables continuous innovation and flexibility as the health care provider’s domain of influence and clinical trading partners rapidly evolve.

Hospitals and health systems face some uncertainty about the path to success under new payment models, given the still-fluid nature of health legislation reform. In addition, organizations have varying levels of alignment across participating providers. As illustrated in Figure 1, clinicians can be employed, contractually affiliated or truly independent along financial lines. In terms of technology, practices range from completely unconnected to “wired.” Considering the market forces in play, one thing is clear: no matter what the structure of your health care organization, clinical integration will be a key component of the future of health care delivery.

Figure 1. Clinical Integration Spans A Range Of Health Care Management Models



The good news is that now there are more options, models and products for becoming a truly clinically integrated health care organization. And the industry is learning more about what works (and what doesn't) to improve quality of care and the patient experience, while strengthening profits and maintaining an engaged physician community.

Defining Clinical Integration

What is clinical integration? There are many definitions, including legal guidelines. The American Medical Association (AMA) describes clinical integration as “the means to facilitate the coordination of patient care across conditions, providers, settings, and time in order to achieve care that is safe, timely, effective, efficient, equitable, and patient-focused.”⁶

In reality, clinical integration spans the spectrum, from multi-setting care coordination efforts around a single condition, to networks of caregivers accessing and exchanging a wide range of clinical and financial information to deliver quality care.

Clinical integration is not a defined set of principles or practices, nor can it be achieved within a “closed” system. **Clinical integration is a continuous process of alignment across the care continuum** that supports the Triple Aim of health care:

- Improving quality of care,
- Reducing or controlling the cost of care, and
- Improving access to care and the overall patient experience.

There are three key areas of alignment to address in order to achieve clinical integration (see Figure 2):

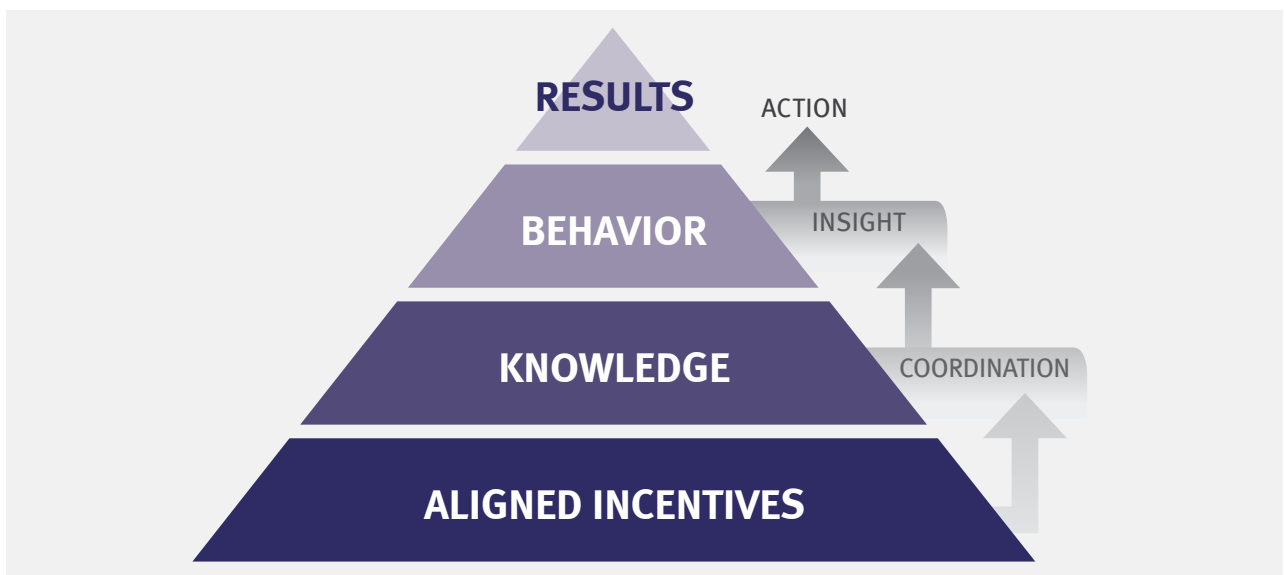
- **Incentives:** Developing a common, measurable picture of success that delineates clear, tangible (ideally financial) benefits to all stakeholders working together in the clinical care continuum, including hospitals and their employed and affiliated physicians, ambulatory surgery centers (ASCs), independent medical groups, and also labs, pharmacies, radiology, patients, and payers;
- **Knowledge:** Surfacing the right information across multiple systems to the right person at the right time, increasing transparency and clarity, minimizing financial risks and offering optimal control over business and clinical processes; and
- **Behavior:** Using aligned incentives and knowledge to support efficiency and quality, such as the creation of standardized processes and preventive and detective controls, to ensure that caregivers, executives, payers, patients and other stakeholders can take the right actions when needed.

Clinical Integration: Legal Considerations

Because providers and organizations considering clinical integration often use joint ventures with contractual agreements, clinical integration has been officially defined by the Federal Trade Commission (FTC) and the U.S. Department of Justice. This leaves “clinically integrated” groups open to scrutiny for possible anticompetitive practices under antitrust law. While any group should obtain legal advice during the process of integration, in essence, the FTC has indicated that clinical integration is acceptable as long as a group comes together with the goal of improving care—and not simply to bargain for better rates.

Source: Alice G. Gosfield, J.D. and James L. Reinertsen, M.D. Achieving Clinical Integration with Highly Engaged Physicians. 2010. Available at: http://www.wsma.org/Media/PRC-pdf-STEPS/STEPS_Achieving_Clinical_Integration_GR.pdf

Figure 2. Align Incentives, Knowledge and Behavior to Achieve Clinical Integration



Every type of health care organization—from “closed” systems of employed physicians to looser affiliations of caregivers—must figure out how to effectively exchange information both inside and outside the walls of the organization in order to thrive in the future of health care. That is why successfully integrated organizations must put deliberate focus on all three components of clinical integration—aligned incentives, knowledge and behavior—in order to achieve the Triple Aim of health care.

Before moving forward with your organization’s clinical integration plan, it’s important to dispel common misconceptions in order to pursue the most successful strategy.

Myth #1: Acquiring physician practices will ensure clinical integration.

Reality: Acquisition does not guarantee—nor is it required to achieve—clinical integration.

Acquisitions and consolidations of practices have become widespread for a number of reasons: to leverage with payers, to widen the referral base and to provide affiliated physicians with an easy, efficient way to send orders and receive detailed patient information.

Acquisitions may be a defensive measure for many hospital systems and medical groups concerned about declining referrals and transitioning to risk-based payment models. But acquisition alone does not guarantee that medical groups will get better rates with payers or have better systems for exchanging information. In fact, acquisitions can be a costly gamble. A 2011 study in the *New England Journal of Medicine* showed that hospitals lose \$150,000 to \$250,000 per year during the first three years of a physician’s employment.⁷

Instead, health care organizations should begin to think about creating high-performing medical groups within their organization. High-performing medical groups can support clinical integration and sustainability for the organization in the long term by providing leadership and guidance for adapting to new payment models, improved efficiency among providers, better profitability, and improved patient satisfaction.

Clinical integration, and not simply organizational consolidation through acquisitions, is “the real key to reform,” and is an effective way to expand geographic reach and scale, according to William Petasnick, past chair of the American Hospital Association. He describes clinical integration as “an effective tool for promoting innovation, enhancing quality, and aligning incentives.”⁸

Whether or not your organization pursues acquisition, The Advisory Board Company recently concluded that high-performing, clinically integrated medical groups share these defining characteristics:

- Identity as a unified, physician-led network,
- Use of their infrastructure to enhance group performance, and
- Use of incentives to engage individual physicians against group goals.⁹

This means that high-performing, clinically integrated medical organizations need good governance, where the goals and incentives of leadership and management are aligned. This can be a challenge especially for health care organizations with a disparate group of affiliated providers. One area to focus on is the creation of a culture of physician-led and continuous quality improvement using appropriate tools to integrate information from different systems. This can keep information flowing to the right people at the right time in order to ensure the right people are doing the right work. This flow of information also facilitates bidirectional communication between physicians and leadership to keep frontline physicians updated on all group activities and strategic decisions and to allow for reporting and feedback up the chain of command.

Another area to focus on is the use of appropriate incentives to engage physicians (employed or not) against the group's goals. Using compensation to reward only production and RVUs can actually undermine efforts to reduce overuse and improve quality.¹⁰ Instead, some experts recommend using salaries and bonuses to “reflect the values of clinical integration, including collaboration in teams, effective and timely use of ancillary personnel, deployment of communication systems, and techniques that permit patients to manage their care effectively, patient experience of care, and adherence to the evidence-base.”¹¹

Myth #2: Being clinically integrated means all providers are on the same EHR.

Reality: Health care organizations do not need to move all providers to the same EHR platform in order to achieve clinical integration.

In recent years, some hospitals and health care organizations have tried to create hospital information systems (HIS) to facilitate the integration of inpatient and outpatient information. This usually means owning or modifying current infrastructure—servers, IT personnel—to create a single, “closed” HIS network for all participants.

Providers participating in an HIS have access to a single patient health record, and the same information is available to all providers, regardless of where the patient goes in the network. But a major disadvantage of this approach is that all providers and trading partners—labs, pharmacies, radiology centers, ASCs, rehab facilities—will never be on the same network. Without complete patient information, a closed HIS network does not necessarily improve control over ordering and referral patterns, nor does it help drive the right behavior or surface the right information across all settings.

Another crucial disadvantage to this approach is that patient information is typically not integrated with provider EHR workflow. That is, every provider accesses full patient data without any filters or other intelligence available to focus on critical information. So providers must spend valuable time searching for relevant information, often during patient encounters.

In addition, consider the importance of relationships in the integrated system. Affiliate physicians and other partners don't want to be forced to use an EHR that doesn't respect their independence. Anne Rice, CEO of UC Davis Medical Center, points to the importance of systems that protect the reputation, the economic stability and the legal status of each party involved with the organization.¹²

The integrated system needs solutions that give providers the right information at the right time, allows for choice and independence, and enables interoperability among affiliated entities. The good news is that there are solutions that have demonstrated success in integrating across multiple platforms.

Cloud-based, service model solutions can meet these kinds of requirements. Cloud-based HIT systems are strong enablers of interoperability among a wide range of systems because: 1) all information is stored in a secure site and accessed via the Internet, 2) the cloud vendor can provide a care management system to harmonize data

Cloud computing solutions are not equal. In general, “the cloud” refers to working with content that’s available at a shared online location, with the Internet as the point of access for all users. The most innovative cloud solutions...

from multiple sources (e.g., EHRs, practice management, stand-alone HIE platforms), and 3) the creation of interfaces for participating providers is more cost effective, given that an electronic connection needs to be built just once from the cloud architecture to each trading partner. Cloud-based solutions enable a “single source of truth” for appropriate users on the network. Providers can choose the EHR that works best for them while benefitting from true integration with vendors, partners and others in the network.

Table 1. Seven Myths and Realities of Clinical Integration

<p>Myth #1: Acquiring physician practices will ensure clinical integration.</p>	<p>Reality: Acquisition does not guarantee—nor is it required to achieve—clinical integration.</p>
<p>Myth #2: Being clinically integrated means all providers are on the same EHR.</p>	<p>Reality: Health care organizations do not need to move all providers to the same EHR platform in order to achieve clinical integration.</p>
<p>Myth #3: We can become clinically integrated with a Health Information Exchange (HIE) platform.</p>	<p>Reality: HIEs are one way to address part of your organization’s need to align knowledge, but they are insufficient for aligning behavior.</p>
<p>Myth #4: Getting every provider the same complete view of the lifetime patient record will improve health care decisions.</p>	<p>Reality: Too much information takes time away from patient care.</p>
<p>Myth #5: Technology is all that’s needed for clinical integration.</p>	<p>Reality: Clinical integration is more than data exchange and interoperability. It requires aligning incentives, knowledge and behavior.</p>
<p>Myth #6: Clinical integration requires organizational change and we can’t afford to go through a major planning/reorganization process.</p>	<p>Reality: Clinical integration is necessary for future viability, but does not require large capital expenditure.</p>
<p>Myth #7: Clinical integration is an endpoint, a goal to achieve.</p>	<p>Reality: Clinical integration is an ongoing process.</p>

Myth #3: We can become clinically integrated with a Health Information Exchange (HIE) platform.

Reality: HIEs are one way to address part of your organization’s need to align knowledge, but they are insufficient for aligning behavior.

As of 2012, there were more than 250 active electronic health information exchanges (HIEs), including 56 grantees of the Office of the National Coordinator (ONC) State HIE Cooperative Agreement Program.¹³ Ideally, HIEs allow doctors, nurses, pharmacists, other health care providers and patients to store and access patient information through a shared data repository.

There are three forms of health information exchange:

- Directed Exchange—providers can send and receive secure information electronically to support coordinated care, such as orders, referrals, test results and discharge information.
- Query-based Exchange—providers can find and/or request information on a patient from other providers, often used for unplanned care.
- Consumer Mediated Exchange—patients can aggregate and control the use of their health information among providers.¹⁴

Unfortunately, state-funded public HIEs have been slow to develop financial sustainability, instead relying on grants and public funding. In the meantime, the need for electronic patient information exchange has continued to grow, so private HIEs have proliferated. By investing in a private HIE solution, hospitals and physician organizations may have more control over the design and implementation of their HIE, and may worry less about sustainability because the business model only applies to their specific environment. But with private HIEs, the concern about financial sustainability remains. Specifically, HIEs require a large up-front investment with no clear return on investment (ROI), require a large number of participants to be effective, and may not be aligned with the goals of the clinically integrated organization.

Ideally, HIEs allow health care providers and patients to store and access patient information through a shared data repository. But there are concerns about the sustainability of public HIEs and the interoperability of private HIEs.

What's more, there are widespread concerns about the interoperability of private HIEs. For example, a 2012 survey by the eHealth Initiative concluded that HIEs developed for one organization may not be able to communicate with HIEs outside of the community of providers for whom it was developed. Therefore, complete and easy access to health data may not be possible among all private HIEs.¹⁵

Providers are also not convinced that HIEs provide complete, accessible, secure patient information. Some HIEs function as larger “islands” of data, which may or may not connect all relevant care providers. A 2012 study by the Bipartisan Policy Center (BPC) reported that 71 percent of clinicians surveyed thought the lack of interoperability and the lack of HIE infrastructure were major challenges.

Additional findings from this study include:

- A majority of clinicians (69 percent) cited the associated costs of developing and maintaining interfaces and exchanges as a barrier to exchanging information with other providers.
- Twenty-five percent of clinicians cited privacy and liability concerns as barriers to exchanging health information.
- When receiving health information from an outside clinician or practice, 57 percent of clinicians say they prefer to “pick and choose” from that outside information what they want to include in the EHR, compared to only 16 percent of surveyed clinicians who prefer to upload and include all of the information.¹⁶

Another study concluded that barriers to using HIEs were cost, privacy and liability concerns, and technical barriers. A positive return on investment could not be documented.¹⁷

The HIE landscape will continue to evolve. Whether or not your organization participates in a public HIE or builds its own private HIE, it is a mistake to assume that HIEs alone will help achieve clinical integration. The HIE is an attempt to effectively exchange information across systems to bring us closer toward the Triple Aim of health care. Your organization will be asked to address this area. To do so, consider the following recommendations from the eHealth Initiative for making effective information exchange a long-term, sustainable goal:

- Define a vision for your organization’s participation in HIEs or other information exchange programs that stakeholders and physicians can buy into.
- Create a viable governance entity and engage the provider community.
- Develop a sustainability model based on the needs and resources of the community, taking into account the significant costs associated with connecting to or building an HIE.
- Identify value by determining the most essential functions of the HIE based on the needs of providers within the community and enable those within the exchange.
- Ensure continuity with the workflow of a hospital or physician practice with limited interruptions.
- Work with public HIEs because it is important that all systems work together to enable data exchange between networks and across state boundaries.¹⁸

Myth #4: Giving every provider the same complete view of the lifetime patient record will improve health care decisions.

Reality: Too much information takes time away from patient care.

While interoperability and access to patient information across systems is a key for clinical integration, looking at lifetime patient records is not necessary at all times for all providers. In fact, if too much patient information is available without intelligence or filters, providers must spend valuable time sifting through a mass of data to find needed information. This undermines efforts to improve quality, profitability and the patient experience.

Providers need tools that surface information at the right point in the workflow, without requiring providers to change their frame in order to review and take action. Organizations need systems that are continually evolving to capture and intelligently filter data from all delivery settings. HIEs and other systems that aggregate patient data provide a great deal of information. But they cannot provide insight, which is knowledge that can be filtered and is actionable.

Without clear visibility across the network—and the ability to influence behavior at the point of care—revenue goals and care outcomes become difficult to achieve.

Myth #5: Technology is all that's needed for clinical integration.

Reality: Clinical integration is more than data exchange and interoperability. It requires aligning incentives, knowledge and behavior.

For any clinical integration strategy to work, it must address relationships, knowledge and behavior.

First, clinical integration must incorporate physician leadership. “The first pillar of clinical integration,” according to Daniel J. Marino, President and CEO of Health Directions, “is a shared governance body with strong physician leaders.”¹⁹ This is important because, according to Marino, “A strong physician-led governance body will be able to create the clinical strategies required to pursue risk-based or value-based contracts with commercial payers, develop innovative care contracts with employers and take advantage of accountable care opportunities in the Medicare Shared Savings Program.”²⁰

Clinical integration requires strong physician leaders to drive cultural change.

Clinical integration also requires strong physician leaders to drive cultural change. Clinically integrated physicians will need to adopt new behaviors that align with outcomes-based reimbursement, such as collaborating across specialties, sharing information, managing utilization and providing proactive care.

But it must be in everyone's best interest to participate in clinical integration efforts. That's why maintaining relationships with stakeholders through financial incentives or formalized contracts may be the answer to deeper and lasting clinical integration. For employed and affiliated physicians, that might mean financial incentives for accessing jointly negotiated payer contracts, rewards for referring to in-network or other quality-focused providers and getting more referrals by focusing on cost and quality. Entities such as labs and radiology benefit from clinical integration with more efficient ordering and operations, less work for their staff and the ability to process more orders.

Nurturing relationships can be as simple as designing incentives that support improved information sharing.

Nurturing relationships can be as simple as designing incentives that support improved information sharing. With risk-based reimbursement contracts, a clinically integrated network needs more structured relationships that align medical success with financial success. These contracts could be shared savings models, capitation, global budgets or bundled payments.

While developing these relationships is critical, organizations need to create processes (the “who,” “what,” “when,” and “how”) to help physicians understand and work toward performance objectives. Processes and behaviors that support clinical integration include:

- **Standardization of clinical care:** Ensure that caregivers are using clinical care guidelines. Caregivers need the right protocol data to appear at the point of care and need to see embedded controls to maximize adherence to these protocols.

- **Care management:** Ensure that system-wide data can identify high-risk patients and establish standard protocols and processes for outreach to these patients. Care managers should follow care protocols and support caregivers by alerting them to gaps in care and reduce overutilization of services.
- **Shared measurement:** Develop and implement shared clinical quality measures and clinical integration measures across the network to emphasize adherence to care guidelines and the provision of quality care.
- **Workflow optimization:** Adopt tools (which can be continually updated and innovated) to standardize workflows to ensure the right information is captured, the right decisions are considered and the right recipients receive the information they need throughout the system.
- **Clinical integration compliance:** Ensure participation of all stakeholders. Networks can encourage compliance with clinical integration through participation requirements, credentialing criteria, provider education, provider report cards and other trainings.

Clinical integration depends on services and solutions that are flexible and affordable and that can provide appropriate access to patient data across clinical settings, different EHRs and a range of affiliates and vendors. Tools and technology should support *a continuous process of alignment across the care continuum*, bringing the right information to the right person at the right time and prompting appropriate care events.

Myth #6: Clinical integration requires organizational change and we can't afford to go through a major planning/reorganization process.

Reality: Clinical integration is necessary for future viability, but does not require large capital expenditure.

It's true that clinical integration requires leadership from hospitals and physicians, organizational changes, support from payers and a great deal of effort. It also requires the right tools and processes, which include HIT and staff who can work with physicians to develop and implement improvements and greater coordination in clinical processes.²¹

But according to the American Hospital Association, "There is a growing consensus that there is a need for significant health care delivery change, and that such change must involve increased clinical integration among health care providers. Clinical integration holds the promise of greater quality and improved efficiency in delivering patient-centered care."²²

It may not be necessary to make large up-front investments to begin the process of clinical integration. According to James J. Pizzo and Mark E. Grube of Kaufman, Hall & Associates, "If an organization starts with a limited number of contractual arrangements to reward participating physicians for their quality improvement/cost reduction efforts, large capital investments are typically not needed."²³ What is needed is the participation and support of a large portion of the medical staff. Clinical integration also typically requires the creation of a joint contracting entity that can negotiate fees, set quality targets and distribute incentive payments.²⁴

It is not necessary to make large capital investments to begin the process of clinical integration.

Many hospitals and health systems are already assessing their readiness for becoming an ACO and for moving from an activity-based payment model to the bundled or risk-and-outcomes-based model. No matter what the details of health reform look like, it is clear that clinical integration is a necessity for surviving the change to come.

Myth #7: Clinical integration is an endpoint, a goal to achieve.

Reality: Clinical integration is an ongoing process.

There is no single path or endpoint to clinical integration. Hospitals and physicians have explored clinical integration in a variety of ways and are likely to develop many more approaches in the future.²⁵

A general approach for progressing toward clinical integration might touch on these steps:

- Assessment of readiness (both in culture and execution capabilities) for implementing a clinical integration strategy
- Legal assessment of compliance with FTC guidelines
- Development of a communication strategy and key messages, as well as a plan for physician involvement, shared incentives, program implementation and governance
- Development of HIT strategy and tools to support meaningful data exchange
- Implementation of care standards, optimized work flows, shared measurement and care management
- Economic alignment around compliance with clinical integration
- Ongoing management—analyzing the process, tracking progress, making improvements and communicating with stakeholders

The key to achieving clinical integration is a flexible strategy that emphasizes: 1) aligned incentives among stakeholders in the clinical care continuum; 2) a flexible backbone of tools that surfaces the right information across multiple systems to the right person at the right time, and 3) processes that support efficiency and quality.

A Vision for Clinical Integration

To implement a successful clinical integration strategy, hospitals and health care systems need solutions that:

- Align and engage providers across the spectrum of clinical, technical, cultural and financial integration;
- Are nimble enough to change as quickly as the health care industry, crossing the chasm between fee-for-service and risk, and resulting in success under any future payment scenario;
- Have long-term economic sustainability; and
- Support the sanctity of clinical encounters by embedding necessary insight natively into the workflow of the office, influencing action at the point of greatest leverage without interrupting the flow of the visit.

Cloud-based services and software offer the most cost-effective, flexible and robust solutions for hospitals and health care organizations moving toward true clinical integration. A cloud-based services vendor offers a combination of software, networked knowledge and back office support with low up-front costs. What's more, this kind of solution can quickly adapt to future payment models and many other changes to come.

Cloud-based service vendors can help your organization:

Align the enterprise

Cloud-based software provides an easy-to-use framework to manage and ensure consistent workflows, from scheduling patient encounters to billing and order management. Since a single instance of software exists in the cloud, the vendor can make regular updates to the network instantly available to all clients. This rapidly effects change and drives results by offering a single source of “truth” including:

- A central source of revenue-cycle knowledge
- Key performance indicators by location, department or role
- Population health tools such as identification of cohorts to be targeted for outreach

Continually updated, cloud-based services also make it easy for providers to do business with your facilities. Providers get an instantly updated, streamlined order process, you get full visibility into order patterns, and patients get a better experience. That's because the cloud offers a single, shared instance of software that is continually updated. You'll have the information arsenal to focus on particular providers within your community, and will be able to keep them satisfied with a speedy, closed-loop order process.

Ensure seamless data integration

Since the cloud enables interoperability across different systems, a cloud-based services vendor can provide services that track compliance and performance against contractual quality goals and published guidelines—by patient, provider or practice. It can normalize all payer data sources into standardized service categories so you can see trends over time and against budget. The cloud can also integrate data from disparate EHRs to support alignment between care and quality managers. This will help transform your population health data into a single source of actionable insight, with a consolidation of clinical and claim data from across your network.

Add intelligence without cost

The cloud-based network's services and software are infused with continually updated intelligence. That means fresh information is embedded directly into the user's workflow. Without added cost, your organization has access to expert research to capture new revenue opportunities, along with industry benchmarks and best practices, which ensure your enterprise is running at its full potential. The collective knowledge amassed in the cloud gives health care organizations instant access to the latest payer and clinical rules. You get better visibility and transparency into business processes, with targets for improving your organization's workflows and cash flows, translating into increasing value over time.

Implement optimum workflows

As we have seen, providers do not benefit from access to full patient data without intelligence or filters. A cloud-based service can embed updates into workflows, where they are easy for staff to capture or act on. This means information is available within the workflow to allow providers to make high-value, high-quality clinical decisions at the point of care. In addition, the cloud-based network can continually update and revitalize workflows based on industry best practices or new standards and guidelines. This creates enormous efficiencies when it comes to revising paperwork and researching updates; your staff can spend the workday—and save money—concentrating on patient care and managing the organization.

Be prepared for the future

The element of co-sourced, cloud-based services that offers the most value is the “work” component. That is, the cloud-based vendor can offer built-in, behind-the-scenes support to research and anticipate changes such as Meaningful Use Stages 2 and 3, the conversion from ICD-9 to ICD-10, and 19 million new beneficiaries in Medicaid by 2019²⁶ —all without extra cost. It has the people and processes already in place to optimize collections, eliminate workflow inefficiencies, aggregate disparate data and provide deep visibility into your business processes, clinical activity and referral patterns. Your organization has access to expert research to capture new revenue opportunities, along with industry benchmarks and best practices, which ensure your organization is running at its full potential. You get better visibility and transparency into business processes, with targets for improving your organization’s workflows and cash flows, translating into increasing value over time.

The athenahealth difference

athenahealth is a company focused on making health care work as it should. To us, clinical integration is a continuous process of alignment across the care continuum that supports the Triple Aim of health care. Our clinical integration model focuses on delivering **the right information to the right person at the right time** by helping to align incentives, build relationships and create efficient behaviors with the use of appropriate technology.

We focus on delivering results by creating efficient processes, services and interfaces to capture data from all delivery systems, because we know that patient information—clinical, financial and demographic—is a cornerstone of clinical integration. We also believe that provider time is sacred and should be treated as the most valuable practice or hospital asset. So our services supply intelligence to captured data and translate that data into actions for caregivers and staff. By surfacing the right information along with directives within the workflow, athenahealth empowers providers and staff to make high-value, high-quality clinical decisions at the point of care.

About athenahealth

athenahealth is a leading provider of cloud-based, Best in KLAS electronic health record (EHR), practice management, and care coordination services to medical groups and health systems. Our mission is to be the most trusted service to medical caregivers, helping them do well by doing the right thing. To learn how our services can help your organization, contact us at **866.817.5738** or athenahealth.com/hospitals.

athenaClaritySM

athenaClarity is a cloud-based service that delivers actionable insight, helping you manage your caregiver networks and patient populations under any payment model. Unlike a business intelligence tool or static HIE, athenaClarity harmonizes data from multiple systems (EHR, practice management, claims) and turns it into insight that can be acted upon directly in native workflows. By converting insight into action, you can align providers across the spectrum of clinical and financial integration.

athenaCoordinator[®]

Optimize network performance with a breakthrough cloud-based service that enables health systems to grow and strengthen their physician network without the high costs of conventional methods. athenaCoordinator addresses care coordination inefficiencies by providing streamlined order transmission and insurance pre-certification and patient registration services, all designed to give hospitals and health systems greater control of referral patterns and make them easier to do business with.

athenaOne[®]

Increase your network's productivity with our integrated suite of cloud-based services, which help improve performance while keeping providers focused on patient care. athenaOne includes our Best in KLAS practice management and EHR services*, plus a comprehensive patient communications solution. With our cloud-based software, networked knowledge and back-office service teams that take on a practice's most burdensome work, athenaOne improves every step of the workflow. Providers stay up-to-date and prepared for every industry change, from ICD-10 to Stage 2 Meaningful Use.

Endnotes

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