# Clinical Integration, A Roadmap to the Future?

Exploratory Paper

Jason K. Wilson, CPA, FACMPE

July 19, 2016

This paper is being submitted in partial fulfillment of the requirements of Fellowship in the American College of Medical Practice Executives.

## Introduction

As the healthcare environment changes with the implementation of the Affordable Care Act through consolidation in the market and a higher focus on value or quality, physicians need to explore additional alternatives to contract with employers and insurance companies to address their concerns of cost, quality and value. Through a search of available literature and research, this exploratory paper will examine the idea of Clinically Integrated Networks being used as a mechanism for independent physician groups and hospital employed physicians to work together to address the needs of employers and insurance companies in a compliant manner. A good understanding of these concepts will enable practice administrators to effectively lead their practices through these changing times.

Many new alternative payment models are being developed such as Accountable Care Organizations, Medicare Shared Savings Plans and Patient Centered Medical Homes all of which have a renewed focus on delivering value or quality healthcare. The fragmented nature of the U.S. healthcare system does not lend itself to promoting coordinated care between independent providers. In fact many of the current laws and regulations discourage or prohibit independent providers from working more closely together without becoming large physician groups or large integrated systems. In order for medical groups to provide the value that employers and insurers are looking for, finding new ways to create networks of providers and hospitals is becoming a necessity. Whether independently owned or integrated into a hospital system, many physician groups do not have all service lines necessary to service an entire market or are not large enough to cover the entire market geographically. Clinical integration may offer opportunities for unrelated physician groups, hospitals and other entities to work together to provide comprehensive coverage for an entire market and to provide a higher quality of healthcare that employers, insurers and patients will deem valuable.

Clinical Integration is defined as follows:

*"Clinical Integration is a health network working together, using proven protocols and measures, to improve patient care, decrease cost and demonstrate value to the market*."[i]

Becker's Hospital Review

*"Clinical Integration is 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*."[ii]

American Medical Association

*"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*."[iii]

AthenaHealth

*"Clinical Integration is a term that describes the integration of clinical information and healthcare delivery services from distinct entities. Clinical integration refers to the coordination of care across a continuum of services, including preventive, outpatient, inpatient acute hospital care, post-acute including skilled nursing, rehabilitation, home health services, and palliative care to improve the value of the care provided*."[iv]

GE Healthcare Camden Group

**Legal Considerations**

Any discussion of independent physician groups, hospitals or other health care providers working closely together, jointly negotiating contracts and forming contracting networks must begin with a discussion of legal considerations of what is allowed and what is not allowed in order to avoid violating the Sherman Act or other Federal regulations. The U.S. Department of Justice and the Federal Trade Commission issued a document titled "Statements of Antitrust Enforcement Policy in Health Care" in August 1996. Statement 9 of this policy is titled "Multiprovider Networks" and can be the basis of a discussion regarding the legal ramifications of forming a clinically integrated network.

The purpose of a clinically integrated network cannot be just to negotiate higher fees. Antitrust law "condemns as *per se* illegal any arrangement among competitors that fix prices or allocate markets. However, where competitors economically integrate in a joint venture, such agreements, if reasonably necessary to accomplish the procompetitive benefits of the integration, are analyzed under the rule of reason."[v] Historically, the Federal Trade Commission has required providers to become financially integrated. Financial integration was generally defined as accepting capitation or other financial arrangements with risk. The Federal Trade Commission will also take into account nonfinancial ways to integrate (Clinical Integration) to determine whether or not it is allowable for unrelated providers to negotiate joint contracts. The Federal Trade Commission does not view multi-provider networks as *per se* illegal "if the providers' integration through the network is likely to produce significant efficiencies that benefit consumers and any price agreements by the network providers' are reasonably necessary to realize those efficiencies."[vi] The Federal Trade Commission states that the sharing of significant financial risk

among providers or substantial clinical integration can both serve as justification for joint negotiation of fees.

When looking at multi-provider networks, the Federal Trade Commission will apply the "Rule of Reason". The Rule of Reason "determines whether the formation and operation of a joint venture may have a substantial anticompetitive effect and, if so, whether that potential effect is outweighed by any procompetitive efficiencies resulting from the venture."[vii] When applying the Rule of Reason, the Federal Trade Commission will generally look at Market Definition, Competitive Effects (Horizontal and Vertical) and Efficiencies[viii].

When considering market definition, the Federal Trade Commission will look at what alternatives are reasonably available to consumers for the services provided by the network. A high market share does not necessarily imply that collaboration will be anti-competitive, but a low market share can provide assurance that collaboration will not be anti-competitive[ix]. When considering competitive effects, the Federal Trade Commission will consider the effects of both the horizontal (competitors) and vertical (not competitors) agreements between providers. The Federal Trade Commission will also consider the exclusion of certain providers as part of the competitive effects analysis. After defining the market and considering the competitive effects, the Federal Trade Commission will then finally look at efficiencies gained through the network and whether or not these efficiencies will offset any potential anticompetitive effects of the network.

The legal requirements surrounding multi-provider networks and becoming clinically integrated are complex and the penalties severe; therefore, groups considering becoming clinically integrated should obtain qualified legal counsel to help work through the process. In addition to the anti-trust considerations, providers considering becoming clinically integrated

must also consider other regulatory issues such as the Anti-Kickback Statute, the Physician Self-Referral Law ("Stark Law"), tax implications and whether or not any State laws or regulations apply.

**Existing Federal Trade Commission Advisory Opinions**

In September 2007, the Federal Trade Commission issued an Advisory Opinion regarding the Greater Rochester (NY) Independent Practice Association (GRIPA). GRIPA was a multi-specialty physician practice association that included competing primary care and specialist physicians. The GRIPA Advisory Opinion outlined the following key points to achieving clinical integration[x]:

1. The fact that GRIPA physicians agreed to refer patients to other GRIPA network physicians, except in unusual circumstances.
2. The implementation of systems and programs designed to improve quality and efficiency, including case management, disease management and pharmacy management programs.
3. The selective participation of network physicians based on a track record of success in the proposed program and a system designed to ensure compliance.
4. The significant investment of physician monetary and human capital in the proposed program
5. A method to measure and evaluate the performance results, not only within the network but also compared to local, regional and national benchmarks designed to improve patient outcomes and reduce costs and resource utilization.
6. The inclusion of a network education program to keep physicians informed of program requirements and use of technology

7. The increase of technological integration in order to allow physicians to share information across the network. This technological integration included tablet computers, internet access, technical support and the development of a central clinical information system which contained all patients' inpatient and outpatient information.

Based upon the facts of the Greater Rochester Independent Practice Association application, the Federal Trade Commission ruled that the pro-competitive benefits outweighed the anti-competitive loss of competition.

In February 2013, the Federal Trade Commission issued an Advisory Opinion regarding the Norman (OK) Physician Hospital Organization (Norman PHO). In this Advisory Opinion, the Federal Trade Commission added further definition to clinical integration. The Norman PHO Advisory Opinion identifies the following four keys for achieving clinical integration[xi]:

1. The development and implementation of detailed, evidence-based clinical practice guidelines;
2. Limiting participation in the program to providers who are committed to accepting the limitations on independent decision-making which the guidelines entail;
3. Measurement and evaluation of each participating provider's compliance with the guidelines; and
4. Investment by all participating providers of time, energy and financial resources in the development and enforcement of the clinical guidelines, as well as the computer infrastructure needed to facilitate such integration.

Like the GRIPA Advisory Opinion, based upon the facts of the Norman PHO application, the Federal Trade Commission ruled that the pro-competitive benefits outweighed the anti-competitive loss of competition.

Both of these Advisory Opinions outline the criteria the Federal Trade Commission used in granting favorable opinions to these clinically integrated networks and can be used to develop an outline for the key components of a clinically integrated network.

**Key Components of a Clinically Integrated Network**

Based upon the GRIPA and Norman PHO Advisory Opinions, the following four key components should be met to be considered clinically integrated:

1. Physician Leadership & Commitment
2. Development and Implementation of Clinical Practice Guidelines to Improve Performance & Modify Behavior
3. Development of Infrastructure & Technology to Provide Additional Knowledge
4. Financial Incentives for Achieving Goals

Physician leadership & commitment is paramount to the success of any effort to achieve real change in the way physicians practice or to move the healthcare system towards providing value or efficiency. When developing a clinically integrated network, physicians must be in a position to lead and become engaged in the process. The existing fee for service environment incents a physician to focus only on the acute problem being presented and not on the overall health or wellbeing of the patient as required in a value or quality based environment. In order to achieve a change in practice style from a traditional fee for service practice to a practice focused on quality or value, achieving physician engagement or buy-in to the change will be a key to

success. Good physician leadership and good communication are necessary to achieve the goal of moving from fee for service to a value or quality based focus. One of the key items the Federal Trade Commission looks for is an investment by all participating physicians of time, energy and financial resources. Both the Norman PHO and the GRIPA clinically integrated networks formed committees and a leadership structure that involved significant physician involvement which are ways to increase physician engagement and to improve communication between all physicians.

Performance improvement and behavior modification are the ultimate goals of clinical integration and essentially the primary factor in avoiding the regulatory barriers of working together as independent groups. Both the Norman PHO and GRIPA clinically integrated networks relied on physician involvement in developing and implementing evidence-based guidelines, particularly in regards to various disease states. Both groups used subcommittees lead by physicians to develop and monitor these guidelines. The GRIPA clinically integrated network even went so far as to require referrals to be made within the network in order to better monitor activities and to try to achieve efficiencies in the way care is delivered. Both of these groups developed internal care management guidelines and tracking mechanisms to monitor physician performance and patient outcomes. The performance of the physicians in the network should be measured against some benchmark to determine whether or not the physician is meeting the expectations of the network in order to improve quality. Measuring clinical guidelines can be complex and difficult. It is important when developing clinical guidelines to develop guidelines that can be measured efficiently and accurately. Preferably guidelines should be measured and reported to the physicians timely in order to provide good feedback. Some government run programs only report metrics back semi-annually or annually which is not often enough to promote real change in behavior. Consideration should also be given to how and where the clinical information is entered into the electronic medical record systems of the various groups in

order to determine how best to extract the data from the systems for measurement. Standardization of how the electronic medical records are used is preferable and may be necessary.

The development of infrastructure and technology to provide additional knowledge is important to be able to accurately measure performance in the clinically integrated network and in order to effect real change. Clinically integrated networks will need to invest resources to develop technology to extract and analyze data from the billing and electronic medical record systems that are being used by the various members. These resources will include the systems to run, accumulate and analyze the data and also the people to run the systems and to do the analysis. Clinically integrated networks will need to invest resources into developing protocols and guidelines to measure performance. The development of these protocols and guidelines will likely involve a significant amount of "sweat equity" contributed by the physicians involved in the network. An additional type of infrastructure needed may be clinical staffing. Many clinically integrated networks have found the need to develop a system of care coordinators to work in the clinic. Additional infrastructure and technology needs may include such things as data analytics tools and systems that are able to extract data from multiple electronic medical records systems or other functions to help manage the care patients receive. Infrastructure and technology will be a key to achieving the goals of the clinically integrated network.

The development of financial incentives to achieve goals will be important to accomplish the purpose of the clinically integrated network and to obtain physician engagement. The Federal Trade Commission has discussed that participation in the network must be limited to providers who are committed to the program and that providers not committed should be financially penalized or ultimately removed from the participation. Physicians may sign a participation agreement with the network; however, the commitment to the clinically integrated network must

be an actual commitment to improve performance and not just a signature on paper. Ideally these financial incentives will be tied to meeting the goals of the clinically integrated network that were used to develop the protocols, guidelines and targets for the network. Physicians involved in the leadership of the clinically integrated network must be willing and have the authority to discipline physicians (up to and including termination from the network) who are not practicing under the protocols and guidelines developed.

**Where Do Clinically Integrated Networks Fit in the Maze of ACOs, PCMHs, PHOs, IPAs?**

A clinically integrated network is a separate entity that serves both similar and different purposes from Accountable Care Organizations (ACOs), Patient Centered Medical Homes (PCMHs), Physician Hospital Organizations (PHOs), Independent Physician Organizations (IPAs).

PHOs and IPAs have been around a long time but are now limited to very strict contracting guidelines that limit their ability to negotiate price. Many serve as nothing more than a way for a group of providers to come together in an organization to negotiate common contractual terms (excluding financial terms) with an insurance company or employer. Most PHOs & IPAs must now "messenger" out the fee schedule portion of the contract to the individual groups that make up the PHO or IPA. The individual groups must choose to accept or not accept the proposed fee schedule. Many times, the PHO or IPA will end up with members having different fee schedules with the insurance company or employer.

According to The Advisory Board Company, ACOs, PCMHs and Clinically Integrated Networks each have the following broad focuses in the most general terms[xii]:

- ACOs – Focus on care improvement for an entire patient population, across the continuum
- PCMHs – Focus on care improvement for primary care services
- Clinically Integrated Networks – Focus on care improvement for physician practices across specialty lines

While ACOs, PCMHs and Clinically Integrated Networks all have similar focuses of improving the health of populations and controlling costs of care, they each have a specific niche. They can be mutually exclusive of each other or work together. PCMH models have a focus on the primary care portion of the equation. CMS has developed specific guidelines for ACOs that participate in the Medicare Shared Savings Program, but ACOs can also serve non-Medicare populations as well. ACOs generally include primary care, specialty physicians and hospitals as well as other health care providers and have a goal of overall management of a defined patient population.

Clinically integrated networks are generally broader in nature than ACOs and are focused on care improvement for all patients who access the network. Unlike PHOs, clinically integrated networks can jointly negotiate contractual fees as long as the primary purpose of the joint negotiation is out of necessity to achieve the primary goal of care improvement. Clinically integrated networks can support ACOs and PCMHs as part of the clinically integrated network and actually help the ACO or PCMH achieve their goals. Clinically integrated networks can also serve as a mechanism for sharing the cost of infrastructure development across a broader group that is required for successful ACO or PCMH development and administration.

**Reasons to Consider Clinical Integration**

The primary reason to consider clinical integration should be to provide better value by increasing the quality and efficiency of patient care across a population of unrelated providers. A clinically integrated network can help facilitate the collaboration required to achieve better value between independent groups. To be successful, the members of the clinically integrated network should develop protocols to better manage certain disease states, have access to additional data for the group and more effectively share information between providers. A well-developed clinically integrated network will increase collaboration between providers, improve efficiencies and improve care management which should all lead towards the ultimate goal of improved health of the community[xiii].

In addition to the above, there are additional reasons to consider clinical integration for medical groups.

- Joint Contracting - Clinical integration allows independent groups to contract jointly. Clinically integrated networks can negotiate contractual terms with much the same leverage as PHOs and IPAs. Joint negotiation of fees by independent groups is generally prohibited. Unlike PHOs and IPAs a clinically integrated network may be able to jointly negotiate fees if the benefits of improved value offset the anti-competitive risks of joint fee negotiation.

- Alternative to Full Integration – Clinical integration provides an avenue for independent groups to work together who may not want to join together fully as a large physician group or become integrated into a hospital system. Without clinical integration, the options are limited as to the ability for independent physician practices to work closely

together to develop methods to improve the health of the overall population and to jointly negotiate contracts. Clinical integration can break down some of the regulatory barriers and allow groups to continue to remain independent while still working together to improve the health of the population.

- Data Analytics – As the healthcare industry moves towards value based contracting, the need to have data to guide decisions will become more and more important. Many independent physician groups either choose not to or do not have the resources to invest in the technology necessary to extract data from their systems to use in decision making. Being able to pool resources among a larger group may allow economies of scale in adding the technology needed to mine the data out of the various systems used.

- Partnerships with Payers/Employers[xiv] – A well-developed clinically integrated network can develop new relationships with payers and employers to develop models that can encourage participants to be more accountable for improving their health. Payers have tried for years to develop methods of care management or disease management, oftentimes with limited results. Employers, particularly self-insured employers are starting to demand ways to "do things differently" in regards to their healthcare spending. A clinically integrated network can be a basis for providers and hospitals to develop ways to work more closely with participants that can address the desires of payers and/or employers.

- Patient Satisfaction – A clinically integrated network can improve patient satisfaction scores. The current healthcare system is very disjointed, particularly when patients move between unrelated providers. The sharing of data within a clinically integrated network

can allow a healthcare system that is more connected for patients and thereby provide a higher level of continuity of care.

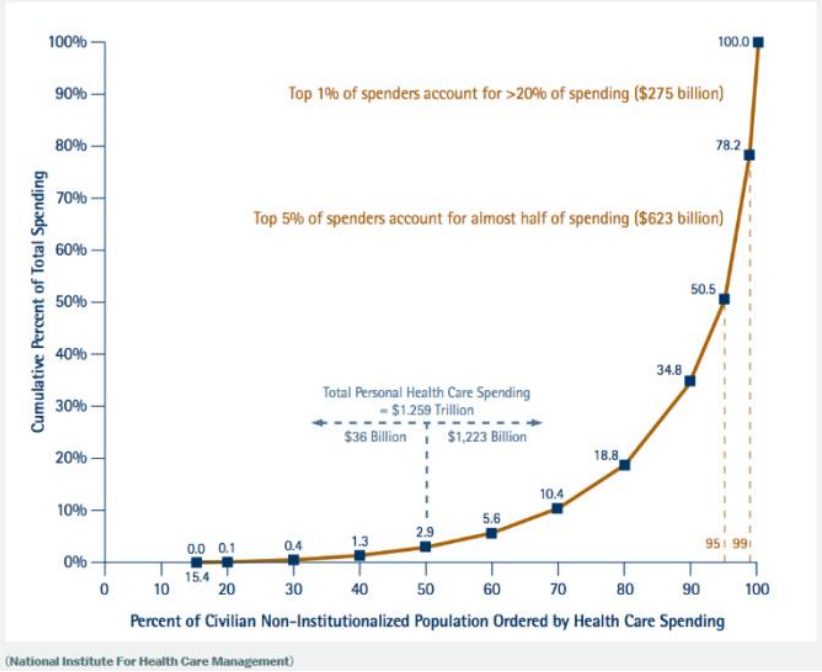
- Potential Reimbursement Increases – Contracting within a clinically integrated network can include shared savings or some sort of risk/reward incentive. Clinically integrated networks that successfully implement protocols and can create efficiencies can see increased reimbursement when compared to the standard contracts prior to the clinical integration. It should be noted that oftentimes risk can be added if the network does not perform in exchange for reward being added if the network does perform.

- Increase of Business – Clinically integrated networks can increase the business of a practice in multiple ways. Clinical integration is designed to find efficiencies within the healthcare system to lower overall costs. In order to find these efficiencies, providers are generally strongly encouraged to refer within the network. Internal referrals can be used to offset the loss of duplicative services provided to patients due to the current lack of coordination of care. Clinically integrated networks also generally have a strong focus on wellness which can increase volumes for preventative services which can offset the loss of acute care or emergency services. Lastly, clinically integrated networks should be able to develop relationships with payers and employers that enable direct contracts which can steer patients towards the clinically integrated networks providers.

**Who Benefits From Clinical Integration?**

Several different stakeholders benefit from clinical integration. These various stakeholders are patients, employers, payers, providers and hospitals.

Patients benefit from clinical integration in multiple ways. The benefits patients see should come through better care coordination between providers and an increased emphasis on preventative medicine and ways to remain healthy. The disease management protocols that are developed by the clinically integrated network should benefit patients dealing with specific high cost disease states. It should help them to manage those disease processes to remain as healthy as possible for as long as possible. Clinically integrated networks also should focus on preventative medicine which should identify issues earlier which should reduce costs over time. Half of all healthcare spending is spent on 5% of the population[xv]. The additional focus that a Clinically Integrated Network can provide to this 5% of the population can improve their health and decrease overall costs.




Employers can also benefit from clinical integration. In the United States, employers currently pay 69% of total healthcare premiums[xvi]. Participating in a clinically integrated network that has a focus on creating efficiencies and value can help an employer control their overall healthcare spend and potentially bend the cost curve. In addition, if the clinically integrated network can decrease absenteeism due to employees remaining healthier, the employer can benefit from improved productivity of employees.

Payers should benefit from clinical integration in that the development of protocols and better coordination between providers should work to reduce overall healthcare costs. This should allow for increased profitability for payers or lower premiums to pass along to consumers. In certain cases Payers are directly involved with the clinically integrated providers and can benefit from increased marketability for their products if the clinically integrated network can decrease overall healthcare costs.

Providers can benefit from clinical integration in several ways. Many providers are frustrated with the continued increase of unnecessary paperwork, regulations, data reporting, "clicks" in the Electronic Medical Record (EMR) that most do not feel lead to improved patient care. Most providers felt a call to provide excellent patient care when they went into medicine. Therefore most providers should experience higher patient satisfaction if clinical integration can provide data that is useful to improve patient care versus the "meaningless clicks" that many feel are currently being required. Any direct contracts the clinically integrated network can develop should increase steerage to the providers' involved thereby increasing market share. Providers could also benefit from increased revenue from shared savings or incentives tied to the contracts that the clinically integrated network negotiates. Lastly, participation in a clinically integrated network can solidify the providers' presence in the market and provide a way for providers to maintain independence but also work closely with hospital systems and other providers to remain successful and viable in this rapidly changing market.

Hospitals can benefit from clinical integration in multiple ways. First, clinical integration should result in lower lengths of stay, lower readmissions and more appropriate care being done within the hospital. Second, clinical integration can allow hospitals to work closely with more doctors in a community without the risk of purchasing or fully integrating the physician practices.

Lastly, clinical integration should allow hospitals to develop closer relationships with payers and employers which could drive additional business to the hospital system.

**Developing a Clinically Integrated Network**

Developing a clinically integrated network is a complex, time consuming process. The first step is for a group of physician leaders to come together and decide whether or not a clinically integrated network is the best alternative for the market. In order to be effective, clinically integrated networks must be physician led and physician driven and physicians must have a voice in designing the structure of the network.[xvii] After determining the need for a clinically integrated network, the leadership will need to determine the organizational structure of the network, work with legal counsel, determine who will be asked to participate and determine how to define quality, develop accountability and implement the changes necessary to be successful. The organizational structure must provide broad opportunities for physician participation[xviii] in order to create the buy-in and engagement necessary to be successful. While a hospital system or systems likely will be involved in the clinically integrated network, physicians should make up the majority of the boards and committees. It should be noted; however, that hospitals as major participants may need to be granted some reserve powers[xix] in order to maintain their not-for-profit status. The participants in the clinically integrated network will likely include various physician groups as well has hospital systems. Care should be taken to identify groups who will "buy into" the concept of being clinically integrated and actively work to meet the goals of the network. After these steps are accomplished, other major areas to consider are:

- Infrastructure[xx] - Clinically integrated networks will need infrastructure beyond what most physician practices have currently. Infrastructure will be needed that can analyze

the data and provide the information needed to monitor as close to real time as possible quality, cost and the other metrics being tracked by the network. Measurement of metrics and reporting back to the providers actionable patient level data as quickly as possible is necessary in order to improve performance and meet targets. Infrastructure will be needed to connect various EMR systems between the parties participating in the clinically integrated network in order to provide real time data to all providers throughout the network. It is not required that all providers have the same EMR; however, it is imperative that some sort of communication be allowed between systems.

- Communication[xxi] – The participants in the clinically integrated network must communicate much more closely than they have previously. Clinical integration is a major change initiative[xxii] which requires frequent communication, listening and gathering of input. This increased communication is not just for administrative reasons. It must occur to actually change the way that patients are cared for in the system. A clinically integrated network cannot just be formed and everyone go back to "business as usual" to be successful. Increased communication and the way the independent participants work together is vital to the success of the network.

- Selection of Metrics[xxiii] – The selection of the metrics to be tracked will be an important piece of the initial development of the clinically integrated network and an important factor as the network matures. Clinically integrated networks should be careful to choose metrics that can be effective in improving quality and reducing cost and that focus across the continuum of care. Clinically integrated networks should be cautious to not choose too many metrics to begin with at once. The metrics should be continually monitored and adjusted to ensure that they are meeting the goals of the clinically integrated network. Mary Will and Claire Heideman of the Camden Group recommend that clinically

integrated networks should "begin modestly and build on experience" [xxiv] when developing metrics. It is important to have some metrics that should be early "wins" and others that should be stretch goals. As the network matures, additional metrics should be created to address other areas and continue to move the transition of care forward.

- Determine a Distribution Method for Incentives[xxv] – The clinically integrated network should develop a method to distribute any incentives that are earned that aligns the distribution of any funds received with the behavior of the participants that is desired. It has often been said that "the behavior you incent is the behavior you will get." This is especially important when trying to effect change in an organization. This distribution method must be well thought out to be measurable, transparent, rewarding for individual contributions and also maintain a certain level of simplicity[xxvi]. Achieving all four of these components in one distribution model can be challenging. The model should also be designed to provide physicians time to learn the system and adjust their practice style before being "docked" for not meeting some predetermined goal.

- Measure Performance – The clinically integrated network must be able to measure its performance and how quality, value and cost have been impacted. Measuring this performance can often be difficult and is important to consider when identifying the metrics to be used and the infrastructure investment needed. Even though measuring performance can be difficult, it is vital to be able to prove the success of the clinically integrated network. The clinically integrated network must also provide timely feedback on this performance measurement both to the individual physicians and to the leadership.

- Contract Development – The development of a contract with payers and/or employers should be discussed. In order to meet many of the goals of forming the clinically

integrated network, terms of contractual relationships with payers and/or direct with employers must be negotiated. The terms of these contracts should include ways to determine that value is being delivered to the payer or employer, how steerage to the network is to work and fee schedules, amongst other things.

- Demonstrate the Value Created[xxvii] – Once performance is measured and data is gathered that illustrates how the clinically integrated network is positively impacting the quality and cost of care received and therefore creating value, those results should be shared with all constituents of the network including payers, patients and employers. All of the impacts of a clinically integrated network will not be apparent from the first day, first month or even the first year. The true value will come over time as the network develops and matures. Payers and employers may want to see results quickly so it will be important to be able to demonstrate value by showing that quality metrics are moving in the right direction. However, the true value of the network may not be seen for years. At that time, it will be important to look back on the history of the network to show the improvement over time.

**Conclusion**

Prior versions of healthcare reform focused on physician practice acquisition by hospital systems to create large integrated systems. Clinical integration can create ways for independent physician groups to play a significant role in developing the direction of the current healthcare reform movement without fully integrating with a hospital system. Creating a clinically integrated network is a complex undertaking but can provide many benefits to independent physician groups, hospital systems, payers, employers and most importantly patients. As physician groups are looking at strategies to meet the goals of the Triple Aim of Healthcare

(Improving the Patient Experience, Improving the Health of the Population and Smarter Spending) and to survive in a rapidly changing healthcare environment, the development of a clinically integrated network should be considered.

---

[i] Butts, Dennis; Strilesky, Michael; Fadel, Matthew. "The 7 Components of a Clinical Integration Network". *Becker's Hospital Review*. http://www.beckershospitalreview.com/hospital-physician-relationships/the-7-components-of-a-clinical-integration-network.html

[ii] "Clinical Integration: 7 Myths and a Blueprint for Success". *AthenaHealth*. http://www.athenahealth.com/whitepapers/clinical-integration-model/

[iii] "Clinical Integration: 7 Myths and a Blueprint for Success". *AthenaHealth*. http://www.athenahealth.com/whitepapers/clinical-integration-model/

[iv] "What Is Clinical Integration?". GE Healthcare Camden Group. http://www.thecamdengroup.com/thought-leadership/blog/clinical-integration-an-overview/

[v] "Statements of Antitrust Enforcement Policy in Health Care". *U.S. Department of Justice and Federal Trade Commission*. https://www.justice.gov/atr/statements-antitrust-enforcement-policy-health-care#CONTNUM_106. Statement 9A

[vi] "Statements of Antitrust Enforcement Policy in Health Care". *U.S. Department of Justice and Federal Trade Commission*. https://www.justice.gov/atr/statements-antitrust-enforcement-policy-health-care#CONTNUM_106. Statement 9A

[vii] "Statements of Antitrust Enforcement Policy in Health Care". *U.S. Department of Justice and Federal Trade Commission*. https://www.justice.gov/atr/statements-antitrust-enforcement-policy-health-care#CONTNUM_106. Statement 9A

[viii] "Statements of Antitrust Enforcement Policy in Health Care". *U.S. Department of Justice and Federal Trade Commission*. https://www.justice.gov/atr/statements-antitrust-enforcement-policy-health-care#CONTNUM_106. Statement 9A

[ix] Leary, Thomas. "Guidance for Clinical Integration". *Hogan Lovells for the American Hospital Association*. http://www.aha.org/content/00-10/070417clinicalintegration.pdf

[x] "FTC Staff Advises Rochester Physician Organization That It Will Not Recommend Antitrust Challenge to Proposal to Provide Member Physicians' Services Through "Clinical Integration" Program. *Federal Trade Commission*. https://www.ftc.gov/news-events/press-releases/2007/09/ftc-staff-advises-rochester-physician-organization-it-will-not

[xi] Donovan, Thomas. "FTC Further Defines Clinical Integration". Legal Insight. *K&L Gates*. http://m.klgates.com/files/Publication/fc2de2e2-eaf1-4c06-8f33-749bd4e6c152/Presentation/PublicationAttachment/140a0193-858f-40d6-b9c1-7b17fcd2afdb/Antitrust_Alert_03252013.pdf

[xii] O'Hara, Sarah. "The Care Transformation Alphabet: What's the Difference Between CI, ACO, and PCMH". *The Advisory Board*. https://www.advisory.com/research/care-transformation-center/care-transformation-center-blog/2014/09/deciphering-the-reform-alphabet

[xiii] Mercury, Marge. "10 Benefits of Clinical Integration". *The Camden Group*. http://www.thecamdengroup.com/wp-content/uploads/10-Benefits-of-Clinical-Integration.pdf

[xiv] Mercury, Marge. "10 Benefits of Clinical Integration". *The Camden Group*. http://www.thecamdengroup.com/wp-content/uploads/10-Benefits-of-Clinical-Integration.pdf

[xv] Kliff, Sarah. "8 Facts That Explain What Is Wrong With American Healthcare". *Vox.com*; http://www.vox.com/2014/9/2/6089693/health-care-facts-whats-wrong-american-insurance

[xvi] "Table 4. Medical Plans: Share of Premiums Paid by Employer and Employee for Family Coverage, National Compensation Survey, March 2015". *United States Department of Labor, Bureau of Labor Statistics*. http://www.bls.gov/news.release/ebs2.t04.htm

[xvii] Rodak, Sabrina. "7 Strategies to Develop a Clinical Integration Network". *Beckers Hospital Review*. http://www.beckershospitalreview.com/hospital-key-specialties/7-strategies-to-develop-a-clinical-integration-network.html

[xviii] Will, Mary and Heideman, Claire. "Top 10 Steps to Creating a Successful Clinical Integration Model". *The Camden Group.* http://www.thecamdengroup.com/thought-leadership/top-ten/top-10-steps-to-creating-a-successful-clinical-integration-model/

[xix] Will, Mary and Heideman, Claire. "Top 10 Steps to Creating a Successful Clinical Integration Model". *The Camden Group.* http://www.thecamdengroup.com/thought-leadership/top-ten/top-10-steps-to-creating-a-successful-clinical-integration-model/

[xx] Rodak, Sabrina. "7 Strategies to Develop a Clinical Integration Network". *Beckers Hospital Review*. http://www.beckershospitalreview.com/hospital-key-specialties/7-strategies-to-develop-a-clinical-integration-network.html AND Will, Mary and Heideman, Claire. "Top 10 Steps to Creating a Successful Clinical Integration Model". *The Camden Group.* http://www.thecamdengroup.com/thought-leadership/top-ten/top-10-steps-to-creating-a-successful-clinical-integration-model/

[xxi] Rodak, Sabrina. "7 Strategies to Develop a Clinical Integration Network". *Beckers Hospital Review*. http://www.beckershospitalreview.com/hospital-key-specialties/7-strategies-to-develop-a-clinical-integration-network.html AND Will, Mary and Heideman, Claire. "Top 10 Steps to Creating a Successful Clinical Integration Model". *The Camden Group.* http://www.thecamdengroup.com/thought-leadership/top-ten/top-10-steps-to-creating-a-successful-clinical-integration-model/

[xxii] Rodak, Sabrina. "7 Strategies to Develop a Clinical Integration Network". *Beckers Hospital Review*. http://www.beckershospitalreview.com/hospital-key-specialties/7-strategies-to-develop-a-clinical-integration-network.html

[xxiii] Rodak, Sabrina. "7 Strategies to Develop a Clinical Integration Network". *Beckers Hospital Review*. http://www.beckershospitalreview.com/hospital-key-specialties/7-strategies-to-develop-a-clinical-integration-network.html AND Will, Mary and Heideman, Claire. "Top 10 Steps to Creating a Successful Clinical Integration Model". *The Camden Group.* http://www.thecamdengroup.com/thought-leadership/top-ten/top-10-steps-to-creating-a-successful-clinical-integration-model/

[xxiv] Will, Mary and Heideman, Claire. "Top 10 Steps to Creating a Successful Clinical Integration Model". *The Camden Group.* http://www.thecamdengroup.com/thought-leadership/top-ten/top-10-steps-to-creating-a-successful-clinical-integration-model/

[xxv] Rodak, Sabrina. "7 Strategies to Develop a Clinical Integration Network". *Beckers Hospital Review*. http://www.beckershospitalreview.com/hospital-key-specialties/7-strategies-to-develop-a-clinical-integration-network.html AND Will, Mary and Heideman, Claire. "Top 10 Steps to Creating a Successful Clinical Integration Model". *The Camden Group.* http://www.thecamdengroup.com/thought-leadership/top-ten/top-10-steps-to-creating-a-successful-clinical-integration-model/

[xxvi] Rodak, Sabrina. "7 Strategies to Develop a Clinical Integration Network". *Beckers Hospital Review*. http://www.beckershospitalreview.com/hospital-key-specialties/7-strategies-to-develop-a-clinical-integration-network.html

[xxvii] Will, Mary and Heideman, Claire. "Top 10 Steps to Creating a Successful Clinical Integration Model". *The Camden Group.* http://www.thecamdengroup.com/thought-leadership/top-ten/top-10-steps-to-creating-a-successful-clinical-integration-model/