INTEGRATION PARTNER CHECKLIST

Before You Choose an Integration Partner, Ask These Questions

A framework for evaluating EHR integration alternatives — built for value-based care organizations, ACOs, CINs, and HIEs.

The organizations that navigate these transitions well aren't the ones that move fastest. They're the ones that had already asked the right questions.

01 Is your integration platform owned by a company whose core business is healthcare EHR integration?

Acquisitions aren't inherently bad. But when an integration platform is absorbed into a larger data company whose primary focus is somewhere else, the integration product often becomes a lower priority. Support slows. Development stalls. Roadmap commitments become harder to track.

LOOK FOR:

A vendor whose entire business is built around EHR integration — not one that acquired an integration product as part of a broader data strategy.

> *Know who owns your platform — and what their incentives are.*

02 Is your current integration truly bidirectional?

Many platforms were built to pull data out of EHRs for analytics and reporting. That was enough for a while. But value-based care programs increasingly require data to flow in both directions — extracting clinical data AND delivering information back into the EHR workflow.

LOOK FOR:

Bidirectional capability — not just data extraction, but the ability to deliver information back into the EHR workflow where care teams need it.

> *If your platform is read-only by design, that's a structural limitation, not a configuration issue.*

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EHR Integration Without API Limitations. Without Vendor Involvement.

03 When your EHR's API doesn't cooperate, what happens?

EHR APIs are inconsistent. Certified doesn't mean reliable. Vendors interpret standards differently, optional fields get omitted, and custom implementations create gaps that standard API connections can't bridge — especially when critical clinical data lives in unstructured documents that APIs can't reach at all.

> *Ask your integration vendor directly: what happens when the API doesn't expose the data we need? The answer will tell you a great deal about how the platform was built.*

04 How dependent is your integration on your EHR vendor's cooperation?

Some integration approaches require active participation from the EHR vendor — credentialing, API agreements, custom development. That creates a dependency that adds time, cost, and risk every time your EHR environment changes.

> *If your vendor mix evolves — through practice acquisition, network expansion, or EHR consolidation — how much does that disrupt your integration layer?*

05 Will the integration support 100% of our data requirements, across all EHR brands?

Many integration platforms perform well with major EHRs but struggle with mid-market, specialty, or hosted systems. If even one EHR in your network isn't supported, your reporting has a gap.

LOOK FOR:

Multi-modal integration — FHIR, HL7, API, database, AND UI automation — so the platform isn't dependent on any single approach when vendor constraints change.

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DEPLOYMENT AND TIMING

The Right Time to Evaluate Is Before You Have To

06 How quickly can it deploy — and what does the transition require from our team?

When you're working against a deadline, deployment speed matters. But so does internal burden. Some platforms require significant EHR vendor involvement, IT resources, or clinic staff time — which adds weeks or months.

LOOK FOR:

A platform that deploys in days to weeks — not months — without requiring EHR vendor involvement or clinic IT resources to get started.

> *Ask directly: what do you need from us to get this done?*

07 How long until the first integration is live — and does that timeline hold across the long tail?

> *"Weeks" for the easy ones and "someday" for the hard ones are not real answers.*

08 What does your integration architecture look like in three years?

This is the question most organizations skip. They evaluate platforms based on current needs, current EHR mix, current payer relationships. But healthcare networks don't stay static. Practices get acquired. Payer contracts evolve.

> *The integration model you choose today should be able to move with you — not require a rebuild every time something shifts.*

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BEFORE YOU COMMIT TO A REPLACEMENT

Make Sure You Can Check All Five Boxes

- ☐ My replacement handles bidirectional data exchange — not just extraction
- ☐ It reaches every EHR in my network — not just the major ones
- ☐ It can surface unstructured clinical documents — not just structured data fields
- ☐ The transition requires minimal effort from my clinic staff and IT team
- ☐ No EHR vendor involvement or vendor fees — required

AS YOU FUTURE-PROOF YOUR STRATEGY, ENSURE YOUR INTEGRATION PLATFORM CAN:

→ Overcome API limitations — including the next quality-measure change, not just today's.

→ Reach unstructured data — the notes and documents where quality evidence lives.

→ Exchange data bidirectionally — moving it back into the workflow, not just out of it.

→ Reach deep into the long tail of EHRs — consistently, across the non-certified and legacy systems your network actually uses.

700+	90+	Days to Weeks
delivered across value-based care organizations	EHR platforms supported — including mid-market and hosted	Typical deployment timeline

The organizations that transition well aren't the ones that move fastest. They're the ones that asked the right questions first — before the decision got made for them.

Start With an Architecture Consultation — Not a Sales Pitch.

Our team will help you map your reporting dependencies, evaluate your transition options, and figure out what you actually need — before you commit to anything.

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