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The Interoperability Gap: What it is and 5 steps to bridge it

A March 2019 survey reveals a significant gap between what referring providers and health systems want and what post-acute care providers are delivering when it comes to interoperability.

In fact, the new research reveals three major gaps that now exist, including a staggering statistic that...



say they would switch to a new post-acute care provider if that organization was able accept electronic referrals.

This may seem troubling to home health and hospice providers; however, the research does more than identify gaps. It also points to ways that you can bridge these gaps to increase your odds of winning more referrals and successfully navigating the new value-based care economy.

The following paper provides an overview of the research results and presents five steps post-acute care providers can take today to close the Interoperability Gap.

A New World Order

If you've been feeling the squeeze as a post-acute provider struggling to meet the growing demands of your referral partners, you're not alone.

As payment models within the healthcare industry begin to rapidly transition away from fee-for-service to a valuebased care form of reimbursement based on performance, post-acute care providers have been thrust into the

spotlight with new responsibilities and big expectations from their referral partners and care networks when it comes to interoperability. Recent research findings from Porter Research report that 70% of home health and hospice organizations report having experienced an increase in the number of referral sources requesting referral data to be sent electronically over the past 1-2 years.

For hospitals and physicians, the changing reimbursement models have made it equally as important to control what happens to patients after they leave the four walls of their facility as what goes on inside. As a result, many hospitals are forming tight care networks with and even acquiring post-acute care organizations. But what many have found is that no matter what the ownership or partnership structure looks like, the inability to share patient data and documents seamlessly between organizations continues to hinder their ability to collectively care for the patient in the most cost-effective manner with the highest possible outcomes.

As hospitals and physicians have been able to forge ahead with faster adoption of advanced technology and automated workflows, the interoperability gap has actually widened.

What is Value-Based Care?

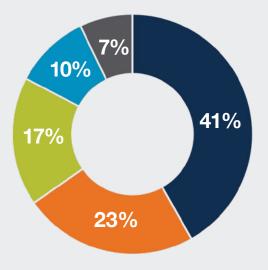
Value-based programs reward health care providers with incentive payments for the quality of care they give to people with Medicare. These programs are part of our larger quality strategy to reform how health care is delivered and paid for. Value-based programs also support our three-part aim of better care for individuals, better health for populations and lower costs. CMS, May 2019

The Origin of Interoperability

In 2010, The Centers for Medicare and Medicaid Services (CMS) launched its federal incentive program promoting the adoption of certified EMR systems. However, post-acute providers didn't have a seat at the table and missed out on millions of dollars delivered to acute and ambulatory providers. Without proper funding and supporting legislation, post-acute organizations were left to fend for themselves.

As a result, many home health and hospice organizations now find themselves ill-prepared to meet the demands

Top frustrations among referral physicians with home health and hospice organizations that do not accept electronic referrals



- Phone tag / phone calls
- Inability to see how my patients are progressing
- Can't perform initial service in acceptable timeframe
- Don't take all payers for those patients referred
- Other

of the digital era. Archaic processes like faxing orders and calling for additional documentation are still rampant among many post-acute care providers. In fact, when asked about their primary mechanism for receiving referrals today, 36% of home health and hospice organizations still use the fax machine to receive referrals and another 20% report that phone calls are their primary means of referral receipt. Only 4% use interoperability like an EMR system.

When physicians were surveyed about the lack of electronic referrals, they indicated that the number one frustration they have with home health and hospice organizations is playing phone tag and managing phone calls.

The big question facing the industry today is how do we close the distance between acute and postacute capabilities for the greater good of patient access to the right care at the right time.

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Patient-centric interoperability is the key to survival in today's healthcare environment.

 Deborah Wesley RN, BSN, MSN, MHA, CEO, Addison County Home Health & Hospice

Defining the Gap

The research indicates that there are three major gaps in terms of what post-acute care providers are doing versus what their referral partners are expecting of them when it comes to interoperability.

1. THE IMPORTANCE GAP.

Only one-third (34%) of home health and hospice providers believe the ability to receive electronic referrals is very important. But remember, it's so important that 60% of referring providers say they would switch to a new home health or hospice referral partner if that partner accepted electronic referrals. As a home health and hospice provider, you must pay attention to the Importance Gap to ensure you remain competitive and protect your most valuable source of new business - referring providers.

2. THE DATA AND DOCUMENTATION GAP.

Nearly 30% of referring providers report that less than half of their post-acute care partners can receive electronic referrals — but 80% of post-acute providers say that

they can receive electronic referrals. The research shows that there is a gap in the understanding of what true interoperability includes. The majority of home health and hospice organizations are simply receiving a PDF and must either attach it to the patient notes (57%) or manually retype the information into their EMR system (34%). Plus, the information coming through is mainly limited to demographic and clinical information (both 34%). Only 26% say they can receive signed physician orders electronically. The Data Gap indicates that most home health and hospice organizations have only a surfacelevel view of what true interoperability means and that by enabling a bi-directional and seamless flow of data and documents between systems, both parties would win.

3. THE PERCEPTION GAP.

More than one-third (34%) of referring providers believe that post-acute care providers are less advanced than physicians and hospitals when it comes to interoperability. While this may be true, this belief seems inconsistent with what the research tells us, because 80% of postacute care providers claim to be able to receive electronic referrals.

Interoperability is vitally important to Hospice. As a hospice organization working to meet the needs of our patients and referral providers, having a program that is able to integrate the required variables of our operations is essential to maximizing efficiencies and supporting a culture of compliance.

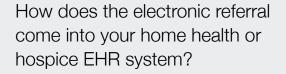
- Sarah Thompson, RN, CHPN, CHPCA, Vice President of Hospice Services, Affinis Hospice

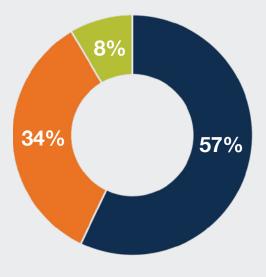
The Pressure is On

According to the survey results, the vast majority of home health and hospice organizations have experienced an increase in demand from their referral partners to receive electronic referrals. For those organizations that are owned by a health system or other healthcare organization, that demand is loud and clear, with 88% and 75% respectively stating that they are feeling the pressure. Even for independent organizations, the demand is there, with 64% of independent agencies reporting an increase in the past several years.

As their referral partners continue to evolve and adopt more at-risk contracts and alternative payment models, home health and hospice organizations who understand and embrace true interoperability will be the winners.

Those who get it realize that interoperability is more than just receiving patient admission, discharge, and transfer (ADT) demographic information and a physician signature on a PDF. It's about two disparate systems speaking the same language closely enough that they can share and map data in a meaningful way; eliminating much of the need for phone calls, faxes, and duplicate data entry.





- Receive a pdf and must attach it to the patient record
- Receive a pdf and must retype the info into the patient record
- Populate the data fields into their local patient record automatically and documents can be stored automatically

Important Technology Talk

A number of key phrases are emerging that home health and hospice organizations may find useful when interacting with their EMR vendors:

- **1. HL7:** Health Level 7 A non-profit international community of healthcare subject matter experts and information scientists collaborating to create a framework for the exchange, integration, sharing and retrieval of health information.
- **2. ADT:** Admission, discharge, transfer -- A common set of patient-related data, such as medical record number, age, name, contact information, that is often exchanged between healthcare providers.
- **3. FHIR:** Fast Healthcare Interoperability Resources The latest standard created by the HL7 organization for exchanging healthcare information electronically. Through proposed rules, CMS and ONC are requiring the use of FHIR-based APIs to make information more available.
- **4. TEFCA:** Trusted Exchange Framework and Common Agreement A common set of principles, terms, and conditions to support the development of a Common Agreement that would help enable a nationwide, secure exchange of electronic health information (EHI) across disparate health information networks.



PRACTICAL STEPS TO BRIDGE THE GAP

Many post-acute care providers are now coming to terms with the business necessity of having strong interoperability. Already, 30% of home health and hospice organizations say they are planning to expand their efforts in interoperability this year, and 31% claim that they would even switch EHR systems if they found one that could better support their interoperability needs.

But knowing where to start, how to justify the investment and how to stay on top of the regulatory changes can seem overwhelming. Here are 5 practical steps postacute care providers can take today to start bridging the Interoperability Gap

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MOVE TOWARD A COMMON DEFINITION OF TRUE INTEROPERABILITY.

To gain better alignment between post-acute care providers and referring providers and care networks, both sides must first agree on the meaning of true interoperability. The research survey found that from a definition standpoint, both sides are fairly well aligned.

When presented with three different definitions of interoperability, the definition that most directly resonated with survey responders among both referring entities and home health/hospice organizations was: "The ability of different info technology systems and software applications to communicate, exchange data and use the information that has been exchanged".

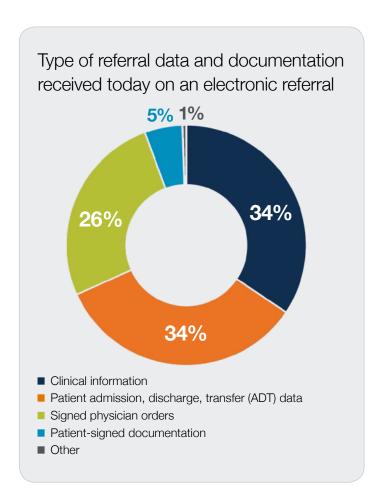
Home health and hospice organizations should speak directly to their referral partners and care networks to ensure a common definition of interoperability is understood. A great place to start the conversation with your referral partner is around the most common application of interoperability – electronic referrals.

In an ideal scenario, the data flows from the referral physician's EHR system directly into a patient record on the post-acute care provider's EHR system, so there is no need for duplicate data entry and less risk of human error or lost orders. Unfortunately, 92% of home health and hospice organizations reported that they were not able to automatically populate their EMR systems with data and documentation. PDFs that lock data in a document and require rekeying into another system is hardly usable.

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Even with great relationships with your referral sources, obtaining all of the necessary information on intake can be very difficult. Patient-centric interoperability has the ability to improve care from dayone, enhance clinician satisfaction and save time through automation.

Tarrah Lowry, CEO, Sangre de Cristo Home Health,
Hospice & Palliative Care



INVESTIGATE THE MATURITY OF YOUR EMR'S INTEROPERABILITY CLAIMS.

To remain competitive and meet the growing demands of your referral partners, you need to be able to depend on your EMR vendor. That means that they provide the proper platform for the seamless flow of data and documentation between your business and your referral sources' business. From a technology stand point, ONC is proposing to increase the standards such as the API standard called Fast Healthcare Interoperability Resources (FHIR) that EMR vendors must be able to support going forward.

When asked if their EMR system currently accepted electronic referrals, 52% of responding organizations said no, even though many of the vendors they reported using do offer some form of interoperability. Another 13% of responders said that they didn't know if their EMR vendor supported electronic referrals. Of the remaining group that replied yes to accepting electronic referrals, most (45%) were pure home health providers, while 34% were combination home health and hospice providers, and 29% were pure hospice organizations.

According to the survey results, users of the Brightree home health and hospice solution were among respondents reporting the highest ability to receive electronic referrals properly. For the past three years, Brightree has been featured in the national Health Information and Management Systems Society (HIMSS) Interoperability Showcase, demonstrating use cases of true interoperability between acute, ambulatory and post-acute care settings.

In addition, Brightree was the first post-acute care EMR vendor to join the CommonWell Health Alliance®, a network of major EMR vendors and other healthcare stakeholders that have come together to drive health data exchange to improve care coordination and health outcomes nationwide. Brightree also forged partnerships with acute and ambulatory vendors to enable the direct flow of patient data into its system.

Home health and hospice organizations must more thoroughly inspect the capabilities of their vendors, and vendors need to do a better job educating their customers on these capabilities due to the rising level of importance they play in providers' ability to attract referral sources.

True interoperability is about solving for patient and provider needs across the continuum of care. We know that patients in post-acute care see providers in other care settings, too, and it is imperative that we unlock the data to help improve care delivery and the patient experience — their care journeys are unique, so our solutions must be comprehensive.

Nick Knowlton, board member for CommonWell Health Alliance and VP of strategic initiatives with Brightree

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EVALUATE THE FINANCIAL IMPLICATIONS OF YOUR INTEROPERABILITY STRATEGY (OR LACK THEREOF).

The lack of adoption of interoperability strategies and technologies among post-acute care providers and their referral partners is a major contributing factor to our nation's high care delivery costs. Without timely and accurate sharing of data across the continuum of care, patients too often fall through the cracks or end up back the hospital with unnecessary readmissions.

Inefficiencies due to lack of automation and reliance on manual labor within the post-acute care sector also drains profit margins among providers. These manual labor costs are significant.

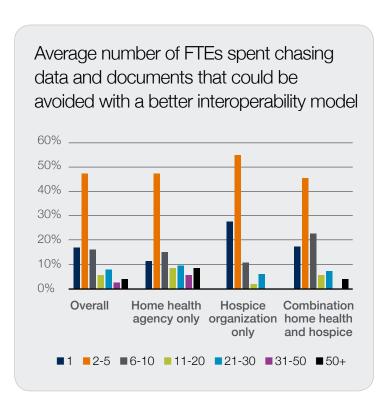
According to the survey findings, almost two-thirds (63%) of home health and hospice organizations waste 2-10 FTEs on average each month tracking down data and documents that they feel could be obtained with better interoperability models in place. As expected, larger organizations would spend even more because they process more work. There are no economies of scale as the business grows unless technology strategies are put in place.

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Engaging the patient and caregivers and establishing their trust is key to success in the care transition process. Communicating the care plan in an effective way and always keeping the patient at the center has been an important factor in our success at naviHealth. It is critical to anticipate potential gaps and partner with providers, and the community, to find optimal solutions for the patient on their journey to recovery.

 Cheri Bankston, Sr. Director of Clinical Advisory Services, MSN, RN, ACM-RN, NaviHealth As the new Patient-Driven Grouping Model (PDGM) payment system takes effect January 1, 2020, it will become even more critical for home health agencies to know more about the patients coming into their care.

With truly interoperable systems that are connected to nationwide networks (such as CommonWell), agencies can query for more complete patient histories, including important items such as co-morbidities, recent hospitalizations, and past home-health episodes of care. Given the financial pressures your agency is under from multiple angles, the time for interoperability is now!





ERAGE YOUR INTEROPERABILITY STRATEGY TO DIFFERENTIATE YOUR BUSINESS.

The survey indicated that other than providing the best patient outcomes, referring providers agree that "being easy to do business with" was the second most important attribute of a post-acute care referral partner.

Being able to accept patient data and physician documentation electronically into your system and being able to share important patient progress notes directly with the referring physician can be a big differentiator for your organization. Not only does it make your business easier to do business with, it also enables you to participate as a valuable player in the emerging at-risk payment models, like bundled payments. The data collected in the home health setting can be easily pushed back to the preferred partner's system for more thorough and easy tracking.

Brightree eReferral has tremendously helped, not only us, but our referral sources, as well.

> - Sarah Kivett, BSN, RN, OCN, CHPN Director of Community Partnerships, Hospice & Palliative Care of Iredell County

Being owned by one of the most forwardthinking health systems in the country, we are constantly looking for new ways to support our referring providers with easy access to the patient insights we gain while we are in the home. One of the ways we are able to do so is through our EMR system's connection to the CommonWell Health Alliance. With the push of a button, we're able to make all of our work easily discoverable by others in our care network. It makes our work more visible and valuable to the physicians, and it demonstrates the important role we play in the care network.

- Denise Schrader, RN, MSN, NEA-BC, Vice President, Integrative Services, Mosaic Life Care



STAY INFORMED WITH THE ORGANIZATIONS THAT ARE CREATING AND ENFORCING THE STANDARDS.

CMS and ONC are taking major steps to ensure both healthcare providers and the vendors who serve them are enabling greater sharing of patient data. In fact, the two organizations simultaneously released proposed rules on February 11, 2019, designed to promote greater interoperability for the healthcare industry and patient access to their health information.

The CMS "Interoperability and Patient Access" proposed rule outlines the technical path to greater care coordination and health information exchange requirements via open application programming interfaces (APIs) that must be enabled by all major stakeholders. According to an Advisory Board 2019 report, "The proposal follows and expands on the CMS MyHealthEData initiative and reflects much of the same requirements for providers in their Promoting Interoperability (PI) Programs – where APIs must be enabled to provide patients with access to their health information using an application of their choice."

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Our mission at CommonWell is to break down longtime technological and process barriers so individuals and caregivers can access important health data efficiently, affordably and securely. Through interoperability, we look to connect all participants involved in a patient's care journey, and that includes the critical care delivered outside of a physician's office or four walls of the hospital. We're thrilled to be welcoming a new wave of home health and hospice providers into the network and we commend our member Brightree for its leadership in this space.

 Jitin Asnaani, executive director of CommonWell Health Alliance The ONC proposed rule is focused mainly on the vendors who supply the systems healthcare providers use. By updating the provision in the 2017 21st Century Cures Act, the ONC is setting new IT standards by which systems must collect and share information. For example, the rule formally adopts FHIR by which all systems must be able to write to maintain their certification (CEHRT).

By staying informed and engaged in the developments of these rules, you can make sure that your organization is properly represented and that the unique complexities of home care services are well understood by policy makers and legislators.

Interoperability: A real necessity for post-acute care providers

As an increasing number of patients choose to receive care in their homes and as hospitals, physician practices and skilled nursing facilities are pressured to move patients to the lowest cost of care sooner, the complexities of sharing data across the care continuum will continue to rise in terms of importance. When combined with the pressure to improve patient outcomes and the patient experience, accessing a single view of the patient across care settings and disparate care providers becomes even more urgent.

As a home health and hospice organization, you're playing catch-up to your acute and ambulatory partners when it comes to embracing true interoperability. But following the steps to close the Interoperability Gap will move you from mere survival to success in today's value-based care economy.





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Anyone who has had a loved one in home health or hospice knows the setting can produce quite the care coordination challenge. Direct Secure Messaging, enabled by the DirectTrust network, allows the frequent changes of care plans to be communicated securely and quickly. We're proud to provide a secure means for facilitating communication between the primary care provider who knows the patient's history and condition and the professional caregivers responsible for ensuring patient care and comfort.

Scott Stuewe. President and CEO of DirectTrust

About Porter Research

Porter Research has been providing custom research for the healthcare industry for nearly 30 years. Combining unparalleled experience, proven methodologies and knowledge-based analysis, Porter provides the unbiased results that clients need to make informed strategic business decisions. With significant experience working with Fortune 500 healthcare companies and venture-backed emerging technology companies, Porter Research has built a significant practice in the healthcare technology, provider, payer and life sciences sectors.

About Brightree

Brightree enables out-of-hospital care organizations to improve their business performance and deliver better health outcomes. As an industry-leading cloud-based healthcare IT company, Brightree provides solutions and services for thousands of organizations in home medical equipment and pharmacy, home health, hospice, orthotic and prosthetic, home infusion, and rehabilitation home care. Brightree is a wholly owned subsidiary of ResMed (NYSE: RMD, ASX: RMD). To learn more, visit www.brightree.com and follow Brightree on social media.



