Emerging trends:
An expert roundtable on interoperability in post-acute care.
A panel of industry experts discuss how emerging trends are driving the need for improved interoperability.
Survey says...

**Brightree survey: What post-acute data says about the need for change**

New research on interoperability reveals a significant gap between what referring providers want, and what post-acute care providers are prepared to deliver. It’s helping us gain great traction for post-acute care settings, and the ability for providers to connect across the care continuum. Post-acute provider organizations who embrace this gap will be able to move forward more successfully than their peers.

In a survey presented by Brightree on interoperability, we found that results matched up with market trends happening in post-acute spaces. **Here are the key findings:**

- 60% of referring physicians have said that they would switch to a new post-acute care provider if that organization was able to accept electronic referrals, and interoperate with them effectively.
- 70% of home health and hospice organizations also report having experienced an increase in the number of referral sources requesting referral data to be sent electronically over the past one to two years.
- Only about 4% of post-acute care providers are using interoperability through technology embedded in their EHR system to process orders today.

**Key frustrations among referring providers**

- Back-and-forth phone calls cause dissatisfaction among patients and providers
- Inability for referring providers to see patient care progress
- Lack of knowledge about which payers are accepted by post-acute provider networks
- Inability to perform initial service in a timeline acceptable to the referral source
Emerging market trends

There’s a clear need for interoperability solutions in the industry, and we’re seeing emerging market trends across the board.

**Home health**
PDGM is driving payment reform in home health, and will have broad implications for how home health agencies respond to referral sources as well as interoperate with the rest of the care continuum.

**Hospice**
Palliative care is an emerging driver in hospice, where most providers have initiatives to expand palliative care offerings into their referral sources.

**Organizations**
CMS and the Office for the National Coordinator for Health Information Technology are just two organizations driving rules for positive change that impact the EHR systems in use by referral sources today. This creates greater opportunity for us to, as a post-acute care industry, plug into those systems and help liberate data to take better care of patients and empower our agency’s businesses.

**National networks**
Not everything related to interoperability is technology- or standards-driven. You still must manage consent, security, patient identification, and several other problems that typically go unnoticed in the emergence of additional interoperability standards. National networks play a key role, and several of them are reaching critical mass in providing very effective interoperability connections for both referral sources and post-acute care agencies alike.

This is leading to a powerful confluence of events that you can leverage to drive positive change for patient care, and for your agency.
5 (easily digested) recommendations to improve connectivity

Those surveyed among referral sources and post-acute care providers had one request – what does Brightree recommend? Here are our five big takeaways to improve connectivity.

1. Evaluate your interoperability capabilities
   For some, this means directly evaluating capabilities to set up their own connections. But for most in the post-acute world, this means agencies need to speak with their vendors about capabilities to connect across the care ecosystem on their behalf.

2. Evaluate the financial implications of your interoperability strategies
   Emerging trends like PDGM virtually require interoperability to be successful, so preparation is key for coming trends like this.
3. Initiate interoperability conversations with your referral partners
Everything in interoperability starts with a conversation among provider groups. While vendors support these conversations, it’s up to you to start talking with your referral sources about interoperability. Rest assured, other organizations will be talking to your referral sources as well – so take this opportunity to differentiate your business.

4. Leverage your interoperability strategy to differentiate your business
Knowing how to have that conversation with your referral sources and being able to showcase how differences in care and differences in care visibility can impact that referral source’s view of you as a post-acute care agency – that can be leveraged to differentiate your organization.

5. Stay informed with the organizations that are driving interoperability in all care settings
CMS and ONC are two of the most influential organizations that drive positive change among systems in use by referral sources today. By knowing what they are up to, and what type of roles they are placing on certified EHRs, you can stay informed and work with your vendor to take advantage of still yet emerging opportunities to improve connectivity success.
A panel of experts

The roundtable: Industry experts discuss emerging trends driving the need for improved interoperability

Experts answer the industry’s toughest questions on the need for interoperability and how it’s being driven by trends like PDGM, palliative care, staffing challenges, and more.
PDGM roundtable

How does PDGM raise the importance of interoperability for your agency and your health system?

Denise Schrader (MSN, RN, NEA-BC), Mosaic Life Care, Vice President for Integrated Services:

“The ability to have – at our fingertips – patient information from our hospital, our clinics, our specialty clinics, and other outside providers, is critical in our success, especially as we face the challenge of billing every 30 days. In the past, in our intake process, you’d have the phone call exchanges, you’d play phone tag with your physicians, or your hospitals, or your care managers.

“Now we’re able to hit a button in our clinical record and push our information to the hospitals and the clinics. In addition, we’re able to pull the clinical information into our records. In other words, we have more efficient, and in addition, we have more complete and more accurate, patient information.

“Those are very, very critical under PDGM. You’re looking for coding – accurate coding, not five days down the road, but within the first 24 hours.

“With interoperability, information is bi-directional – information you push, information you pull. With a compressed revenue cycle, we had to look at: How long is it taking us for the coding? How long is it taking us for critical steps within our processes? We used some lean principles, and we flow charted out the referral intake process. We looked at the current process, we looked at a transitional process, which we modified a couple of steps, and then we looked at our process for January 1st.

“We’re looking at each critical point before we get the rap submitted – from our first billable visit to the last billable visit to close. Our total we’d like to be is about seven days, and our current whole process is about 11, so we’re reducing.

“With electronic signatures and the technological ability to grab and send information, that has sped up our process in reducing the revenue cycle. We’re feeling good about being prepared for PDGM.”
PDGM roundtable

What have you done to prepare for any anticipated changes in case mix under PDGM?

Deborah Wesley (RN, BN, MSN, MHA), Addison County Home Health & Hospice, CEO & Vice President of Clinical Services:

“PDGM really presents a change in how we’re going to think about this, and we really needed to step back and understand the differences and the financial impact on our referrals. We used our referral analysis within the EHR, first off, and reviewed our referral sources. From that, we developed a marketing strategy that really allowed us to look at who we were getting referrals from, where we should focus more, and where we needed to increase our visibility within the community, with our community liaison. So we look at that analysis weekly, and we see where we are changing and where we need to be.

“With that data, it helped us to understand where we were getting the referrals, where compared to six months ago, things had dropped off, and it was very timely. That allowed us also to focus more on particular diagnoses, so we’ve been able to reorganize our community liaisons to be more visible with other groups.

“We’ve also done a lot of education and preparation with our liaison team and our internal team to be ready for that, so that they have an understanding of the diagnosis groupings. We used the PDGM analysis within the EHR to look at our diagnosis, to look at all of the patients we had on service for a set group of time, to see how we fared within, if PDGM was happening now. That really gave us, as a team, from initial referral to final claims, any insights into what we needed to do. It gave us real-time data that allowed us to determine how are we going to evolve and change our practices, and what level within the organization along the continuum did we need to do that.

“We got eFax within Brightree, so we noticed that our referrals are coming in faster, which allows us to get the referral out to the interdisciplinary team as they prepare for that admission work in a quicker fashion. And it facilitates a smoother admission. Everybody has the same information, and it’s at their fingertips.

“We’re finding it easier to review our admissions with that team, and get a plan of care in place as if we’ve prepared our care plans from an IDG perspective, as if we were already within PDGM.

“We’re doing an IDG group with our teams now, to prepare them for looking at how they’re going to do their visits, and how they’re scheduling their care. We’ve been able to, in real time, look at our calendars, our schedules, our interdisciplinary team, and prevent redundancy within the visit, and have our care plans be more expansive to the interdisciplinary team versus disciplinary specific.”
How have you made sure your ICD-10 coding process is up to the task of coding under PDGM?

**Janelle Solomon, Sangre de Cristo Community Care, Director of Compliance:**

“We definitely started with the education focus. We wanted to make sure that everyone fully understands what goes into PDGM, what the appropriate diagnosis groupings are, as well as how to obtain the right information, and really focus on the right diagnosis information, and how to get it into our EMR system appropriately.

“We had a united front of education with our clinical team and our billing team to make sure that we were all working together and using all of the resources we had available to us, to make sure we had the full information related to diagnosis and ICD-10 coding.

“We are also utilizing an outside billing company to make sure that we are efficiently looking at everything accurately, using the technology in our EMR system to the fullest extent. This ensures that we are working smarter – not harder – using reports and eFax, and clinical documents. Making sure that we have all the information at our fingertips to work efficiently and smoothly on a united front was the most important thing for us.”
PDGM roundtable

What operational processes have you changed with clinical staff in order to prepare for PDGM?

Denise Schrader (MSN, RN, NEA-BC), Mosaic Life Care, Vice President for Integrated Services:

“Our therapists, our nurses, actually drive our revenue. The nurse doesn’t drive the DRG, it’s the coding. It isn’t what somebody puts in an OASIS assessment, it’s not scored that way, so I’m always advocating and trying to remind the team how important our clinical staff is in the entire revenue cycle.

“In other words, clinical has to be connected to the entire revenue cycle. When I look at the operations and changes to clinical staff, it starts from the coding. What was the overall revenue impact going to be for us? How many changes were we really going to make, and where were those changes needed?

“We looked at our non-qualifying episodes, what was the percentage, how many diagnoses would we have received the extra comorbidity, the admission source, episode timing, early or late, LUPA analysis, etc.

“We provided to our physicians and to those who are employed by us, and to specialists who are not employed by us, education around what PDGM is. We made a list of the top 25 diagnoses that are no longer acceptable. It will be a process over time, but we are already doing it, and they’re getting used to it.

“The key piece to clinical management is doing an effective and efficient plan of care. We have frequent IDT meetings, but we’re going to have them more, probably twice a week now, and really address not just that this is what therapy is doing, or this is what nursing is doing, but really the skill mix. So real collaboration.

“We will front load visits in order to prevent readmissions, then we’re going to taper them. we took our first 10 diagnoses, and we’re developing best practice care paths out of those for all of our disciplines. We’re going to challenge our clinicians. Because some of our clinicians have been here for a long time, and to get the past practice behavior to break, you need a new way of thinking. And that new way of thinking is going to have to come from leadership. Leadership is asking them: What’s better for the patients?

“LUPA management is going to be tough, but we believe we have an EMR that is going to help us, it’s going to support us, to help us prevent too high a rate of LUPAs. We’re currently assessing LUPAs in the first episode and the second episode, and then we’re assessing: Why do we have LUPAs? Were they related to patient refusal, staffing issues, an unplanned physician visit? Then we’re going to try to put processes in place, or interventions, so we can avoid those.

“It’s really about measuring, monitoring, and managing – the three Ms – and we have great individual clinician scorecards for accountability. We feel pretty good where we’re at right now.”
How has your agency addressed concerns that therapists will be out of work with PDGM?

Deborah Wesley (RN, BN, MSN, MHA), Addison County Home Health & Hospice, CEO & Vice President of Clinical Services:

“In actual fact, our therapy team is leading our PDGM plan. They are the people out in front, working the hardest to make this an effective team that is able to really manage this change. We at times do struggle with a nursing shortage, and our therapy team is looking at how, as an interdisciplinary team, can we meet the needs of the care plan, and maximize the care that we’re giving?

“Our care plans are no longer discipline specific. They’re evolving as interdisciplinary care plans, and we actually have a couple of physical therapists that are undergoing wound care. We have another therapist who is going under lymphedema training, so we’re really looking at ways to support our patients more efficiently with our entire interdisciplinary team.

“We were really concerned how this would impact us, but it is our entire therapy team that has led this charge.”
Why is it critically important to have interoperability in place as we move into this upcoming PDGM era for home health?

Jessica Rockne, MatrixCare/Brightree, Product Manager of PDGM & Revenue Cycle:

“The speed in which home health agencies can gather that detailed patient history and diagnosis information is really critical. Not only is it important to be able to accurately code the home health periods under PDGM, but also to access patient information that will help them to make better informed decisions about the patient’s care.

“Interoperability reduces the back and forth communication with physician offices, and provides access to patient information from specialists, or hospital stays, that an agency may not even know has existed.”

What is the best path for planning for the temporary decrease in cash flow when PDGM starts?

“There’s really no way around that. I think most agencies simply have to plan either for a line of credit, or to have cash reserves on hand. Although the decrease in cash flow is temporary, you’re now receiving 20% of half of what you used to, so agencies need to plan for that. There should be tools in your EMR, I know there are also consulting companies that can help with that. But depending on the agency’s time to bill, they could see those decreases in January, or they may not see those decreases until February or March.”
Palliative care roundtable

Can you describe the rising importance of palliative care programs for hospice agencies, and the impact that has on needs for interoperability?

Sarah Kivett (BSN, RN, OCN, CHPN), Hospice & Palliative Care of Iredell County, Director of Community Partnerships:

“We believe that our growth in our palliative care department really does come down to relationships, and communication back to our referral sources. This has been a real focus for us, as our current palliative care census is a little over 400, and this past year we became the primary referral source for our hospice service line. We do believe that this has to do with the relationship building that we have done with our primary care physicians, but also the communication piece. I can’t really stress that enough.”

“Having that ease of communication with the referral sources, whether that’s with e-referrals coming directly to us, or whether that is our direct messaging through our EMR back to the physicians (all scripts particularly), we are able to communicate within 24 hours or less.

“This communication has been imperative as we try to get our plans of care to be very concise, and know what the goals of care for that patient really are. With our hospice not having to wait on paper faxes, and doing phone tag with patients that are ready to transition into hospice, our referral sources can do the e-referrals. This is helping us to shorten our order to start-up care time, which our goal in hospice is same-day admission, if at all possible. Interoperability has really allowed us to be much more efficient, much more timely, and our communication much more thorough.

“We have also worked very hard to decrease our patients’ hospital encounters, and we have done this by about 30% over this past year. CommonWell has helped us with that.”
Palliative care roundtable

Can you describe the rising importance of palliative care programs for hospice agencies, and the impact that has on needs for interoperability?

Janelle Solomon, Sangre de Cristo Community Care, Director of Compliance:

“We are really focusing on diminishing or decreasing re-hospitalizations. You can’t control everything, or have that crystal ball to know what the patient is going to need or do, but just having interoperability in place, to have all the documents at your fingertips, and really focusing on all of the needs of the patient to decrease those re-hospitalizations, is really important. It also improves your relationship management with your care providers, the hospitals, and your agency’s region to make sure that you continue to build on and grow those referral sources – because they’re very satisfied with what you’re doing for them.”
Palliative care roundtable

What is different about interoperability and palliative care, such as the importance of synchronization?

Nick Knowlton, Brightree, Vice President of Strategic Initiatives:

“In palliative care, you’re delivering care in some different care settings, some of which could be inpatient units that have a dedicated facility EHR in place. One of the key things that we see for requests coming out of these type of domains is the ability to tackle advanced interoperability concepts, such as syncing up patient notes in real time, so that it’s documented in both places without necessitating a care provider to physically log into multiple systems to document the exact same encounter.

“Active meds is another one that we hear about quite a bit. A lot of the interoperability modalities from the last generation of technology were able to pull information and sync up a meds list to be reconciled upon discharge.

“This is going back to our point about staying abreast of what rules are emerging out there for interoperability, or at least working with your EHR vendor to understand their capabilities, because some of those emerging CMS and ONC rules provide much clearer and easier methods to build the right railways to make sure that a patient’s med list in a palliative care setting – that’s being delivered inside of a facility – are fully synced with your post-acute EHR as well.”
Palliative care roundtable

What is it like to approach your referral sources about interoperability, and how has it helped your agency in terms of those relationships?

**Darcie Peacock (BSW, MS, OTR/L), Solace Pediatric Home Healthcare, CEO & Administrator:**

“We started this approach by looking to our collaborative partners, and we basically sent our IT team out to their actual practices to meet with those on the other side. I have to say it was rather slow going at first. Even though we understood that by coordinating and setting up this connection, it would save both of us so much time and manual processes in the long run, we just weren’t getting a lot of buy in. So what we’ve done is we’ve changed up that process a little bit, and we’ve really leaned on our connection with CommonWell and Care Quality – just because of the fact that those on the other side don’t actually have to do anything. No one there has to set up any systems, or push any buttons, we just automatically have their documents.

“So when we share that, we can give a real-life example of the fact that we didn’t have to call you, and here are all the things that we have, and so we’re better able to care for the patient. Then we’ve automatically got this hook, and now they can see that potential. So now that we have that piece, we’re going back in and talking more about the e-referral, and the things that require them to do that one-time setup, and they’re much more likely to go through that. That’s really how we’ve approached it in talking with our referral partners.”

**Sarah Kivett (BSN, RN, OCN, CHPN), Hospice & Palliative Care of Iredell County, Director of Community Partnerships:**

“70% of referral sources do want this capability. One of our biggest surprises that we had when we first started this was from a referral source, a physician, that was pretty adamant that he was not going to use this EMR, and that he was not going to stop the faxing, they were not going to make any changes. But ironically, after he saw how smooth it was, he was one of the first ones, and his office was one of the first ones to use it, and has continued to do that. I do think that this shows that the ease of the option is a very positive one for any referral source.”
Palliative care roundtable

What challenges have you experienced working with different providers using different softwares, and how have you overcome those challenges?

Janelle Solomon, Sangre de Cristo Community Care, Director of Compliance:
“The most important thing we do (and learned) is make sure we all understand each other’s lingo, and sometimes that difficulty just boils down to making our systems – or making our software – come together, even though we’re not talking that same language. That really helped us when we thought something was just a brick wall, and we couldn’t utilize interoperability with one of our particular referral sources. Come to find out, as soon as we changed up the language, we were talking about the same thing, and we were able to break down that barrier and find a solution with a very minor workaround. Our will to have that conversation and to keep pushing for interoperability, even though we faced a small challenge, allowed us to find the solution.”

What was your experience being able to get face-to-face documents through CommonWell and Care Quality?

Darcie Peacock (BSW, MS, OTR/L), Solace Pediatric Home Healthcare, CEO & Administrator:
“The first time that happened, we literally threw a party in our hallway – because when we had first started learning about this process, and what it was going to look like, we had these really, really high hopes that were based around face-to-face. That was really our top delay in our revenue cycle. I would say, too, it was one of those things that drove a wedge between us and some of our physician partners, just because they had such a hard time understanding the concept. No matter how many of their patients we saw, understanding our need for that documentation was a challenge.

“We’ve had fantastic success, in the last month or so, in having some of these documents that we’re able to look through, and they meet the entire face-to-face requirements – and nobody had to lift a finger. Nobody had to call anybody, and what we actually heard last week was from one of the practices we work with regularly. They commented, ‘You guys are calling us a lot less, what’s going on?’ I’m like, here, let us tell you. So that was really a great avenue in, and we consider it to be a huge success.”
Differentiating your organization roundtable

How does interoperability help keep you competitive and relevant within your market?

Darcie Peacock (BSW, MS, OTR/L), Solace Pediatric Home Healthcare, CEO & Administrator:

“We had a big breakthrough with one of the larger hospital systems in our market, and we found that they’re just truly looking for that actual partner. Their big concern was, when we give you this patient, how will we know what’s going on, how things are working, how will you know what goals we were working to address?

“So just sharing that we can connect right to their system, we’ve got these notes, we are able to look at a patient that we share currently, and what we already have available to us. There were a lot of great selling points that we had for this partnership, but that one really pushed us over the top of the competition. From their angle, it was looking at, how do we do all of this and not add overhead and more manual processes? We were able to solve that, and ensure that we were already doing it.”
Differentiating your organization roundtable

Why are networks important, and why isn’t interoperability just referring to tech specs and APIs?

Nick Knowlton, Brightree, Vice President of Strategic Initiatives:

“While the network effect is important, as well as tech standards and modern architectures for modern EHR systems, interoperability in the healthcare world is about so much more than that.

“We as an industry, compared to other areas that have experienced a high amount of technology adoption the past several years, have multiple different regulations that we must abide by. Everything from patient choice, and patient consent, to managing security, being able to quickly and easily confirm that a patient in one provider location is the same patient in another provider location – that really speaks to the fact that we’re one of the few developed countries out there that does not have a national patient identity system.

“The networks are of paramount importance because they’re handling all of those processes that are specific to healthcare on the back end. It allows the technology to really do its job, and enable providers and patients to expect their healthcare data to follow them from location to location.

“It’s really important to understand that network effects are important, and the ease of adoption is also important. These modern connections to some of the national networks are much easier to activate than going to a hospital system and asking them to build a custom interface for you. Post-acute can really move forward by adopting some of these things that have gained legs in other care settings, both health system and physician practice alike.”
Denise Schrader (MSN, RN, NEA-BC), Mosaic Life Care, Vice President for Integrated Services:

“When it came to the organization, it was loud and clear that our clinicians were not happy with our current EMR. So in the process of our selection, we involved the clinicians – whose satisfaction was our number-one priority. We wanted to stop the turnover rate, caused by a difficult EMR. Our second priority was interoperability, because we recognized the time the clinicians spent, the critical need for exchange of information, and medication lists for our ED doctors, for our hospitalists, and for our primary care medical homes.

“We did a survey prior to implementation of our new EMR with four simple questions on work-life balance and ease of use of technology to our clinicians, our therapists, and nurses. After implementation, we sent the same survey, and I was astounded at the result. So rewarding to see that there was significant improvement in the clinician level of satisfaction. They actually have a work-life balance, the technology is easy to use, and that is the interoperability piece of it.

“But our therapists and nurses can now get information from the hospital at their fingertips. They have fewer calls back and forth from the offices. Basically, it’s just a time saver and it’s better care.”
“Our therapists and nurses can now get information from the hospital at their fingertips. They have fewer calls back and forth from the offices. Basically, it’s just a time saver and it’s better care.”

Denise Schrader (MSN, RN, NEA-BC), Mosaic Life Care, Vice President for Integrated Services
Do you see interoperability as a selling point in attracting talent?

**Darcie Peacock (BSW, MS, OTR/L), Solace Pediatric Home Healthcare, CEO & Administrator:**

“I do, definitely. In the past, the technology was something that a lot of clinicians really wanted to keep at arm’s length, and we would almost undersell that as a part of our organization when we were recruiting. It felt like it was more work for the team, or that’s how clinicians perceived it. The tide is changing on that, particularly in our market, with Colorado’s implementing EVV pretty early, so a lot of organizations that were not on systems, are scrambling to do so. Now we can really leverage that as a selling point.”

How have you addressed any staffing changes needed due to the increased volume in billing?

**Denise Schrader (MSN, RN, NEA-BC), Mosaic Life Care, Vice President for Integrated Services:**

“We gained some efficiencies with our software through auditing, OASIS auditing, and review. We recognize that we’re going to have increased volume in our billing, so we’ve moved an FTE from the OASIS auditing to the coding and the billing. That’s basically what we’ve done so far.”
In closing

Interoperability: A true necessity for post-acute care providers

Most organizations have already come to terms with this fact, and the experts agree – post-acute care providers need interoperability to achieve success in today’s market. Our industry is already playing catch-up when it comes to embracing this technology, but with 60% of referring providers saying they would switch to new post-acute care providers if they accepted electronic referrals, there is tremendous opportunity to stay relevant and competitive.

Following the steps to close the interoperability gap will move you from mere survival to success in today’s value-based economy.

The leader in post-acute technology

Brightree parent company ResMed is focused on being the leader in out-of-hospital care and post-acute technology.

They have invested in two major market leaders in the FAS arena – Brightree, the leader in CME and pharmacy, as well as home health and hospice. And MatrixCare, the leader in everything from senior living and skilled nursing facilities, to private duty and build-out assets such as referral management in CRM.

For providers in today’s environment, this means there is a solution to staying competitive and relevant. Brightree/ MatrixCare will help you connect to the larger health ecosystem through their interoperability leadership for post-acute care, with access to CommonWell Health Alliance and Care Quality.
With Brightree/MatrixCare, your EMR can be more than just an electronic medical record.

For more information or to request a demo, please visit www.brightree.com/demo or call us at 1.888.598.7797.