



# Connecting Our World:

How Interoperability is Redefining the New Era of Healthcare  
and Producing Better Outcomes

Teresa Chase, President, American HealthTech



# Executive Summary

## The Challenge

In the new era of healthcare reform, care coordination will be strategic for driving down readmissions and completing EMRs on which proactive, quality care depends. Today's silos of care will be increasingly replaced by strong, interconnected alliances responsible for outcome-driven care instead of volume-driven care.

## The Trend

More and more providers are turning toward secure, standards-based, and repeatable ways of creating interconnected alliances with fellow providers upstream with hospitals, downstream with home care agencies, and with internal partners like pharmacies and labs. Standardized vs. custom connections are increasingly making interoperability technically feasible, easier to set up and affordable.

## The Bottom Line

With fee-for-service care phasing out, you cannot afford to operate on an island anymore. You must coordinate care to decrease readmissions and provide data-driven proof of your success with your newest and toughest customer: the hospital CFO. Those who fail to collaborate and produce superior outcomes that surpass those of competitors risk getting cut out as regional players for Medicare volume.

"When hospitals want to connect, thanks to AHT, we're ready."

*Greg Salwei  
Administrator*

*Wishak Home  
for the Aged*

# Market Forces

“We take comfort in having a partner who can scale as we grow.”

*Laura McDonnell*  
*Business Manager*  
*Merrimack Health Group*

In his 2004 State of the Union Address, President Bush suggested “by computerizing health records, we can avoid dangerous medical mistakes, reduce costs, and improve care.” His remarks touched off a wave of Federal, State, and grass-roots activities to drive digitization across the healthcare industry landscape.

Nearly a decade has passed and we have since witnessed:

- The creation of the Office of the National Coordinator for Health Information Technology to promote standards and certify systems.
- The rise of entities willing to pilot programs for CMS, be held accountable for outcomes, and share in the risk and savings.
- Mounting evidence from these CMS-supported pilots that show value-based episodic bundling saves taxpayers upwards of 5% vs. volume-based fee for service reimbursement models.<sup>1</sup>
- The Patient Protection and Affordable Care Act in March 2010 offered financial incentives and defined “Meaningful Use” by 2014 for physicians and hospitals.

**Reducing potentially preventable hospital readmissions** is seen as a means of saving billions of tax dollars. Beginning in fiscal year 2012, CMS will rank hospitals based on 30-day readmission rate for heart attack, heart failure and pneumonia. Hospitals in the bottom quartile (nationally) from the prior year will have a percentage of total Medicare payments withheld:

- 2013: Up to 1%
- 2014: Up to 2%
- 2015: Up to 3%

CMS’s rules are not limited to preventable, avoidable readmissions. Basically, a readmission is a readmission, and a hospital is penalized even if a patient is readmitted to another hospital. There are two exceptions: readmission for a heart stent or bypass surgery.

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<sup>1</sup> Perspectives: Controlling US Health Care Spending – Separating Promising from Unpromising Approaches, Hussey, Peter, Ph.D., et. al., NEJM, 11/09; accessed via the web 12/09.

# Business Drivers

“With AHT’s integrated EMR application, we have a clean database for connecting all kinds of systems. Therapy? Done. Pharmacy? In process. HIEs? We’re ready.”

*David Houghton, CIO*

*Diversicare Management Services*

Post-acute care has thus far been overlooked with respect to incentive payments and meaningful use, while **market forces** are driving better collaboration within the industry like never before. Why?

- **Protect Medicare census.** Providers are partnering with hospitals, sharing critical care data, driving down readmissions and, as a result, are winning a larger share of short-stay Medicare patients. According to the Health Information Network<sup>2</sup>, among the top ways post-acute providers are lowering readmissions include (percentage = the number of providers surveyed using a tactic):
  - Care transitions management: 65.2%
  - Meds reconciliation 58.7%
  - Improved discharge notes: 56.5%
- **Boost quality.** Informatics-supported care produces superior outcomes. The key here is rounding out Electronic Medical Records (EMRs) with inputs from partners like labs and pharmacies, whose data helps clinicians knit together a full picture of a patient and drive more proactive care.
- **More informed communications.** Physicians benefit from having a complete picture of resident conditions before they make rounds – including visibility online from home. Care teams benefit from as much advance information as possible, to know what medications, special care and equipment an incoming patient might need. And finally, home care agencies and families benefit from real time discharge summaries that show how to best transition care for a loved one.
- **Lower cost.** Double data entry is inefficient, resulting in added labor and overtime. For example, sending discharges to the pharmacy as they happen can save time and reduce your pharmacy costs, because you’ll stop receiving meds immediately for residents that have been discharged.

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<sup>2</sup> Health Information Network Hospital Readmission Survey Dec.

“We constantly get new innovations, helping our teams continuously improve care delivery.”

*Keith Mutschler*  
*Treasurer*  
*Nexion Health, Inc.*

- **Reducing risk.** Adverse drug reactions are a top cause of readmissions, and many errors can be prevented by connecting the right information at the right time between providers and pharmacies. For example, the pharmacy system does a drug alert check when an order is received from the facility electronically or entered at the pharmacy. This is done before the order is filled.
- **Outcomes reporting.** Whether Accountable Care Organizations (ACOs) become the final coordination vehicle or not, we can be certain that some form of “sharing of the risk/savings” will be the new normal in post-acute care. This means providers must seek out partners willing to collaborate and produce better outcomes. The top outcomes against which providers will be measured by hospitals include:
  - **Lowest cost**, as measured by Length of Stay
  - **Quality**, as measured by lower facility-acquired conditions.
  - **Readmissions**, as measured by return to hospital visits, for any reason except heart stent or bypass surgery.

# Who and What

With the “why” out of the way – the primary market forces (the digitization of healthcare to boost quality and reduce costs) and business drivers for post-acute providers (protect Medicare census) more clearly understood, there are two strategic questions to ask with respect to an organization’s goals:

**1. With whom do we need to connect? Examples:**

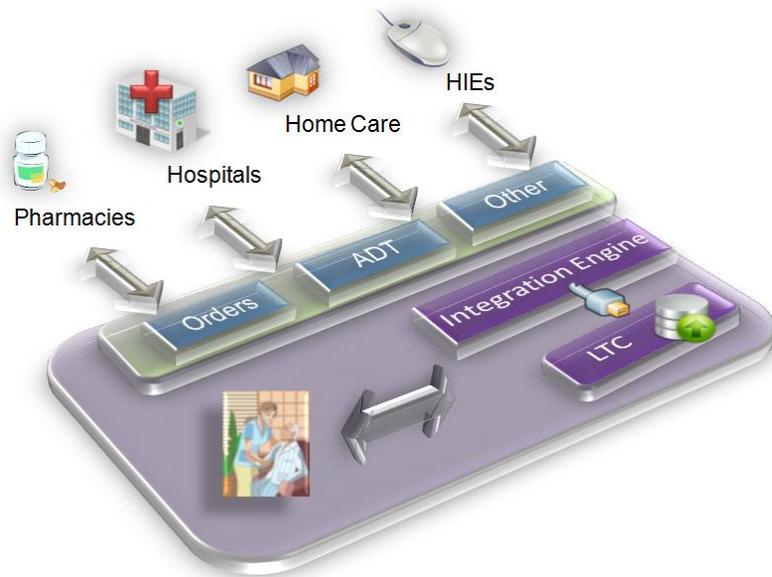
- Fellow providers, like hospitals and home care agencies
- Partners to help round-out EMRs, like laboratories and pharmacies

**2. What data do we need to share? Examples:**

- Admissions, discharge, transfer
- Orders from physicians for medications, labs, etc.
- Labs or x-ray results
- Medical history, special equipment needed

“With a touch of a button we get a medical history, physical, face sheet, DNR, discharge summary and more – the hospital loves how efficiently we transfer patients.”

*Cathy Faught*  
DON  
*Bell-Mont Management*



## Where to Start?

“Nurses pull up the entire chart in one place. We don’t have to piece together data from different systems.”

*Cheryl Clapp-Coleman  
Administrator  
Clapp’s Nursing Center*

Unfortunately there are no silver bullets when it comes to technology strategy, including the business drivers for connectivity. One size technology roadmap does not fit all, given the high degree of variability of providers on the technology adoption curve. Industry wide, we’re witnessing these steps:

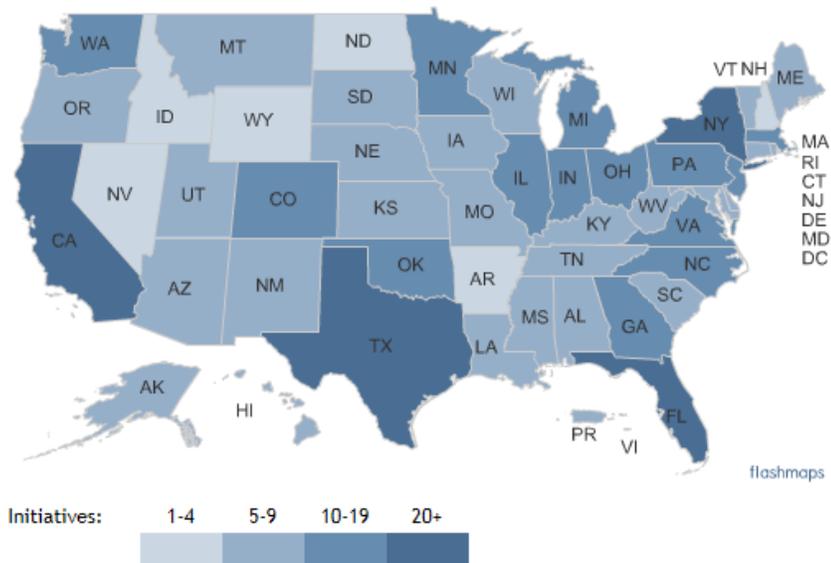
- 1) **Get your EMR house in order.** The more you have digitally ready to share, the more you can round out not only your own EMR but those of your partners. For an example of an organization who implemented full EMR across 45 facilities in under 18 months, link to this case study: [www.healthtech.net/diversicare](http://www.healthtech.net/diversicare).
- 2) **Create secure, standardized, low-cost connections** vs. custom connections with strategic providers and partners. There are a variety of middleware options on the market which are cost-effective and straightforward to implement. The general idea with these solutions is to build one main, standards-driven connection with your EMR, and then reuse/recycle the connection in a secure way with partners. The middleware is a transaction manager to monitor transmission of your data packages and ensure they are secure and complete.

Most providers have some type of custom interface between their system and a least one ancillary partner’s system. Anyone who has used an interface knows that they are expensive and time-consuming to develop and maintain. As the need for more connections or interfaces grows so do costs and complexity. Cost-effective middleware is a growing and viable alternative.

- 3) **Focus on boosting outcomes.** Entities responsible for bearing risk will measure your costs by diagnosis, your quality and most importantly, your readmissions to protect Medicare revenues. You’ll be rewarded with census as you smooth care transitions and lower readmissions, especially for those hospitals at risk for penalties.

# HIEs

Health Information Exchanges (HIEs) are emerging everywhere. Every state has at least one and a number of states have many. The Healthcare Information and Management Systems Society (HIMSS at [www.himss.org](http://www.himss.org)) offers a “dashboard” that shows HIE activity by state.



HIEs are evolving from grant-based, loosely defined entities to large, technically sophisticated organizations that exchange clinical summary data and even more sophisticated electronic sharing. Many are funded by grant money and increasingly by participating organizations.

There are two models of HIEs:

- **Pass through.** This model allows providers to have one connection to health information from multiple providers instead of initiating and supporting multiple connections – much like claims clearing houses do on the payor side.
- **Data repository.** In this model, third parties warehouse data and providers pay to access patient data, sometimes in a clinical summary review.

As you reach out to fellow providers to help produce outcomes, it's worth a visit to the HIMSS site to see with which HIEs they might be engaged.

## About the Author

**Teresa Chase** is President of American HealthTech. With over 30 years of leadership roles in healthcare, Teresa is passionate about helping providers form the alliances, access, and answers on which quality outcomes depend in the new era of post-acute care. Teresa empathizes with the demands of a people-intensive business in hiring, motivating, and devoting one's life to helping others. Prior to American HealthTech Teresa served 21 years at Blue Cross & Blue Shield, including VP of Customer Relations and HR.

## About American HealthTech

American HealthTech is **Your Ultimate Connectivity Partner**, connecting caregivers, partners, and healthcare networks to drive higher outcomes in the new era of post-acute care. Coast to coast, over a quarter of the nation's providers depend on AHT daily for innovations that free hands to care for others. For more information, visit [www.healthtech.net](http://www.healthtech.net).

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