WHITEPAPER

Optimizing Interoperability:

Leveraging CMS Interoperability Conditions of Participation to Increase Collaboration, Reduce Costs, and Improve Outcomes

The CMS Interoperability and Patient Access final ruling[1] represents an effort to rekindle the mission set forth with the 21st Century Cures Act—to arm patients with the access to and quality of information needed to make confident, smart health decisions.

With the new rules, standards for interoperability ensure greater transparency between hospitals, skilled nursing facilities (SNFs), primary care providers (PCPs), and more. To help facilitate this, CMS has modified its Conditions of Participation to require hospitals—including psychiatric and critical access hospitals—to share data via electronic patient event notifications with certain providers any time a patient is admitted, discharged, or transferred from the ED or inpatient care.

Meeting the new Conditions of Participation will require interoperability and lead to collaboration between hospitals, primary care providers and practice groups, post-acute providers, and other practitioners identified by the patient as responsible for his or her care.

While, at first, this may sound like an administrative nightmare, hospitals that learn to leverage the newest conditions can see added benefits—including decreased care costs, reduction of uncompensated care, improved transitions of care, better patient outcomes, and more.

Contents

collectivemedical®

The Hidden Benefits of the New Conditions of Participation

While the Conditions of Participation aren't optional—the benefits that come from them are. Hospitals that leverage the interoperability scaffolded into the Conditions of Participation to collaborate can see additional benefits—starting with cost savings.

According to an analysis of over nine million Medicaid and dual Medicare/Medicaid claims, costs for patients with uncoordinated care are—on average—75 percent[2] higher than for matched patients with coordinated care. The estimated cost-of-waste, per year, for patients with poor care coordination is estimated to be $45 billion[3], due to things like test duplication, unnecessary hospital admissions and readmissions, and increased dependency on emergency services.

If a hospital were to begin coordinating care for just its population over 65, the impact would be significant. Patients in this age range often have two or more existing conditions—known as comorbidity or multimorbidity—and account for 93 percent[4] of prescriptions and 80 percent of physician visits and hospital stays. Beyond financial benefits, coordinating care for this population could help improve transitions of care from hospital to post-acute settings, resulting in reduced chance of readmissions, and better patient outcomes.

Reducing Readmissions to Improve Care and Cashflow

One Pacific Northwest hospital was struggling to care for patients in an area where most patients were either covered by Medicare or Medicaid—or uninsured. A shortage of primary care meant many of these patients were returning to the ED, wracking up hospital bills upwards of $30K, which could have been prevented and resulted in CMS readmission penalties.

Implementing a system that connected the hospital to primary care providers through automated ADT notifications enabled care teams to work together for better patient outcomes. By redirecting patients from the ED to the appropriate acuity level and facilitating better primary care involvement, this hospital **saved roughly $1 million in unnecessary care costs** within eight months of implementation.

Best Practices for Optimizing the Conditions of Participation

As hospitals across the country pivot to meet the new Conditions of Participation, the organizations that will benefit the most from these new qualifications will be those that use the conditions as a springboard for better collaboration initiatives.

Done correctly, these collaborative initiatives will reduce costs and improve patient outcomes—without significant disruption to care team workflows. The following best practices will help organizations both comply with and benefit from the new Conditions of Participation for optimal results.

Create Value to Avoid Noise

Alert fatigue is a prevalent problem for care teams across the medical community, contributing to provider burnout and desensitization over time. Research suggests that 72-99 percent[5] of clinical alarms are false, which has led more and more providers to ignore alerts coming in and a subsequent rise in patient injury due to malpractice or negligence.

With the new Conditions of Participation, primary care and post-acute providers will receive even more notifications than before—any time a patient is admitted, discharged, or transferred from a hospital. The repetitive nature of these alerts could lead to even more alert fatigue, with one study suggesting that the likelihood of acceptance for alerts will drop 30 percent[6] for each additional alert received per encounter.

To ensure that providers view the alerts facilitated through the Conditions of Participation, organizations need to create value beyond the currently-required ADT notification. As the notifications include key information—such as care guidelines, patient histories, and contact information for other members of the patient's care team—the new notifications will become separated from the noise, yielding a higher read-rate, more informed care decisions, better continuity of care, and overall improved patient outcomes.

Keep it Simple—and Singular

The CMS Conditions of Participation are contingent on improving interoperability between care providers across the medical community. Whatever it takes, hospitals all over the country will have to find a way to automate communications between a number of different stakeholders, including post-acute (SNF, home health, and more), primary care, and others—and preferably in a way that's easy to use.

While the rules do not specify that the hospital needs to rely on a singular solution for achieving this interoperability, having a number of different softwares for communicating with each different provider base will prove costly and make compliance difficult to implement and expensive to maintain. In order to meet the approaching deadline for implementation, hospitals need intermediaries that can provide interoperability across multiple provider sects and a quick implementation process.

By streamlining intermediaries and establishing a single solution for meeting the conditions, hospital administration can help protect employees and staff from alert fatigue, simplify training through the use of a single platform, and save on vendor costs.

Leverage Existing Workflows to Alleviate Administrative Burden

With the advent of new policies often comes a nightmare of additional administrative work. But with the CMS Conditions of Participation, there doesn't have to be.

A hospital's best chance for successfully implementing not only the new rules but a complimentary care collaboration platform is in integrating the changes into existing workflows. Automating notifications where possible, setting smart-analytics criteria for identifying patients with higher risk, and integrating alerts and care guidelines into existing EHRs can all help hospitals improve the care given—without significant disruption to care team workflows.

Success Stories

The following six case studies show how hospitals, clinics, and psychiatric hospitals across the country were able to improve care and reduce costs by combining simple ADT-based interoperability with actionable care coordination.

Sturdy Memorial Hospital: Improving Behavioral Health Care Through Real-Time Intervention

With just 132 beds, Sturdy Memorial Hospital (SMH) in southeast Massachusetts sees approximately 50,000 ED visits a year. Of its visits, 5 percent are for behavioral health conditions and 50 percent of those patients require inpatient psychiatric care.

As a small, independent hospital, finding beds—or funding—for these patients is often challenging. Sixty percent of these behavioral health patients were waiting in the ED for placement at an inpatient facility for an average of 55 hours.

To better address this population, the ED implemented an electronic notification system that was interoperable with local behavioral health community resources.

The system, provided by Collective Medical, worked by sending ADT-based notifications directly to partnering case managers whenever a patient with behavioral health needs presented at the emergency department. Rather than just using these notifications to follow-up with the patient in a few days, the case managers worked proactively to meet the patient at the ED, and discuss other options for care.

The Results

Leveraging this ADT data to provide real-time intervention for patients, case managers were able to connect patients with the best resources for their needs—preventing the patient from being discharged home without appropriate follow-up in place. In addition, **Sturdy Memorial was able to see a 76 percent[7] reduction in ED utilization from the behavioral health patients enrolled in these care management programs.**

Community Hospital of the Monterey Peninsula: Using Interoperability to Address the Opioid Epidemic

As the opioid crisis continues to be an issue in many parts of the country, regions like Monterey County, California are seeing success in slowing its growth by combining and unifying the efforts of medical providers throughout the area. Community Hospital of the Monterey Peninsula (CHOMP) has combined local opioid prescribing guidelines with state PDMP and care coordination to improve substance use disorder tracking and put a stop to opioid misuse.

With the initiatives, hospital nurses, case managers, and physicians meet regularly with other members of the medical community—including pharmacists, primary care providers, and others—to discuss individual needs of patients and develop care plans unique to each patient. Each plan takes into account the patient's history with substance use disorder and includes appropriate pain management strategies to support patient health and

comfort without contributing to a possible addiction. However, given the transient nature of many of these patients, the key to making these plans work was ensuring that care teams across the county were aware of and had access to these care guidelines.

CHOMP housed the care guidelines in the Collective platform, making them accessible to care teams on the network via the platform itself or through real-time notifications at the point of care. The platform enabled CHOMP to communicate seamlessly with other EDs, PCPs, and other providers across Monterey County and up and down the California coast by sending automatic notifications any time a patient was admitted, discharged, or transferred to any hospital on the network. These notifications shared key information—including care guidelines and integrated PDMP prescription histories—that allowed providers to quickly identify the patient, any potential problems, and make adjustments accordingly. Dr. Reb Close, ED Physician at CHOMP, explains:

.

"If the patient is struggling with something like substance use disorder, we can treat their acute medical condition, but not their on-going addiction and other chronic medical conditions. Connecting the patient to the best resources for their circumstance not only optimizes patient outcomes, but minimizes unnecessary cost for the hospital and results in time savings that can help providers see more of those patients who need them the most."

The Outcomes

By optimizing the notifications sent to include more than just ADT information, Monterey County providers were able to better collaborate on and care for their patients. Coordinating efforts through local opioid prescribing initiatives, as of 2018, the county has seen:

- A **32 percent reduction in opioid deaths**[8]
- A **59 percent reduction in ED visits**
- A **47 percent reduction in variable cost avoidance** in recurrent ED visitors under care management
- Over a **50 percent reduction in the number of narcotic pills prescribed** at local primary care clinics

Marquis/Consonus Companies: Reducing Hospital Readmissions with SNF Integration

In recent years, readmissions have become a major concern for many skilled nursing facilities (SNFs) and hospitals across the country. New payment models incentivize providers for keeping recently discharged SNF patients out of the hospital, and failure to do so can result in costly readmissions, CMS penalties, and reduced quality of patient care.

Marquis/Consonus Companies owns and maintains senior healthcare and assisted living facilities in Oregon, California, and Nevada. Operating through a network of home health care, assisted living, post-acute rehabilitation, Alzheimer's care, pharmacy and rehabilitation, intermediate care, and residential care facilities, Marquis was looking

to reduce unnecessary admissions for its patients. Without visibility, however, into patient activity post-discharge, it was often impossible to know about readmissions—much less prevent them.

Marquis implemented the Collective platform to gain real-time visibility into patients across care settings, alleviating the financial burden on providers and improving patient outcomes. With the platform, Marquis providers get an instant ADT-based notification seamlessly delivered within their pre-existing workflows, allowing the SNF to reach out to the hospital and potentially readmit the resident to the SNF, avoiding a costly hospital readmission.

By actively following up on these notifications, Marquis reduced readmission rates from 19 percent to 6.3 percent—an overall drop of 60 percent[9]—in under six months.

Real-time Visibility

"Before utilizing the Collective platform, our providers could only see what happened within their four walls. Now, with real-time visibility, they're able to support patients with the best possible care and keep them out of the hospital."

-Anthony Laflen, Director of Data Analytics, Marquis Companies

Preston Memorial Hospital: Interoperability and the Rural Community

The new Conditions of Participation include critical access hospitals in the requirements to send ADT data to pertinent care teams. This is due, in part, to the fact that many individuals living in rural America currently face significant health disparities when compared to the overall population.

According to the CDC, rural areas have higher mortality rates for common chronic conditions, including heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke. Drug overdose rates are also unproportionately high in rural communities, despite lower rates of use when compared to more urban areas.

Preston Memorial Hospital is a small, 25-bed critical access hospital in Kingwood, West Virginia. As part of an ACO, the hospital looks to close care gaps while reducing costs. Using Collective Medical's care collaboration platform, it tags patients with chronic care management needs to help track care and address potential gaps. Care guidelines are housed in the platform, and pushed via fax notification whenever a tagged patient is admitted, discharged, or transferred from the hospital.

With its automated communication and attached insights, Preston Memorial has been able to maintain a top-notch population health program for its patients—receiving one of only three five-star CMS ratings awarded in the state of West Virginia while reducing ED utilization by three percent. In addition, **Preston Memorial was able to reduce ED utilization for 53 percent[10] of its patients with high utilization patterns.**

The Portland Clinic: Improving Transitional Care Management Coding and Involving Primary Care Providers

The Portland Clinic has six locations scattered throughout the Portland metropolitan area—including primary care, multispecialty, and two ambulatory surgery centers.

As the clinic participated in more value-based payer arrangements, leaders looked for better ways to transition patients from hospital to clinic—preventing unnecessary ED readmissions and optimizing patient care. They soon realized that by connecting their primary care providers with hospitals in real time as patients were presenting, they could improve follow-up care and avoid costly readmissions.

Using Collective's real-time notifications to initiate follow-up, The Portland Clinic saw a 13 percent reduction in ED visits for patients with patterns of high ED utilization after transition of care plan implementation. In addition, the clinic was able to increase transitional care management coding rates by 33 percent—resulting in a 30 percent[11] increase in revenue.

Navos Mental Health Solutions: The Importance of Including Psychiatric Hospitals

Interoperability with psychiatric hospitals is a requirement of the new CMS CoP. With many patients struggling with comorbid behavioral and physical diagnoses, psychiatric hospitals and providers contribute key insights into patient health that would be otherwise unavailable to traditional hospitalists, nurses, and care teams. Comorbid diagnoses directly impact the efficacy of physical treatments, with studies suggesting that the presence of more than one disease worsens the prognosis of all diseases present—leading to complications and increased difficulty in treatment.

Navos Mental Health Solutions specializes in serving patients with moderate to severe mental illnesses and substance use disorders. With outpatient, community, inpatient, residential, crisis, involuntary psychiatric hospital, and after-hours triage services, the organization provides a broad continuum of care to better help these patients. Careful coordination of care between these care settings is key to ensuring each patient gets appropriate care for the best outcomes.

Coordinating Better Outcomes

"A lot of the people we serve are people that do not have much engagement with us. If we weren't able to see their care histories and utilization patterns, they would continue to fly under the radar, and we wouldn't know how often they were using the ED or that they were having management issues with physical or mental health, or substance use disorder.

With a more complete view of these patients, we have the visual data needed to see where these patients are going and understand their patterns of ED utilization. We can even identify patterns that help us identify social determinants of health. We can see patterns of ED utilization that show someone presenting could just be hungry and without food, or feeling unsafe at home, and engage with the patient to see what else we can do to help our patients address the root of the problem."

Navos case managers use the Collective platform to receive notifications when their patients return to the hospital—enabling them to collaborate with ED care teams on best practices moving forward. This helped ensure that neither medical nor behavioral diagnoses were overlooked, and that patients received the cumulative care needed. With the notifications and appropriate follow-up collaboration, Navos care teams saw:

- A **15 percent[12] increase in follow-up rates** within 7 days of hospital discharge, from 37 percent to 52 percent
- Ability to **predict readmissions of patients with 92 percent accuracy**, and adjust care accordingly
- Patients are now twice as likely to receive appropriate follow-up care within 30 days

About Collective Medical

Collective Medical provides the nation's largest and most effective ADT-based network for care collaboration. Our risk-adjusted event notification and care collaboration platform spans across all points of care—including emergency departments, hospitals, payers, behavioral and physical ambulatory, and post-acute settings. This technology integrates seamlessly with existing workflows and allows providers to identify and support at-risk patients in real time—avoiding preventable admissions and utilization and providing better care.

The Collective platform ensures hospitals fully meet the requirements under the new CMS Conditions of Participation as part of the Interoperability and Patient Access final rule—eliminating the need for multiple intermediaries.

To learn more about the new Conditions of Participation, and how you can comply, visit collectivemedical.com/impact/adt-based-care-collaboration:

Sources

1. (2020, May). Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans. Retrieved from https://www.cms.gov/files/document/cms-9115-f.pdf

2. Berry, Leonard L., et. al. (2013, February). Care Coordination for Patients With Complex Health Profiles in Inpatient and Outpatient Settings. Retrieved from https://www.mayoclinicproceedings.org/article/S0025-6196(12)01043-9/fulltext

3. Berwick, Donald M. (2012, March). Eliminating Waste in US Health Care. Retrieved from https://christianacare.org/documents/valueinstitute/Berwick-Hackbarth%20-%20Eliminating%20Waste.pdf

4. Blumenthal, David. (2012, May). Performance Improvement in Health Care—Seizing the Moment. Retrieved from https://www.nejm.org/doi/full/10.1056/NEJMp1203427

5. Sendelbach, S., et. al. (2013, December). Alarm Fatigue: A Patient Safety Concern. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/24153215

6. Ancker, Jessica S., et al. (2017, April). Effects of Workload, Work Complexity, and Repeated Alerts on Alert Fatigue in a Clinical Decision Support System. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/24153215

Sources (Cont.)

7. Siwicki, Bill. (2019, December). Care Collaboration Tech Helps Hospital Reduce Unnecessary Psychiatric ED Visits by 78%. Retrieved from https://www.healthcareitnews.com/news/care-collaboration-tech-helps-hospital-reduce-unnecessary-psychiatric-ed-visits-78

8. Siwicki, Bill. (2019, December). Care Coordination Notifications Help Reduce Opioid Deaths by 32% at County Hospital. Retrieved from https://www.healthcareitnews.com/news/care-coordination-notifications-help-reduce-opioid-deaths-32-county-hospital.

9. (2019, April). Collective Medical Helps Skilled Nursing Provider Cut Hospital Readmissions by 60%. Retrieved from https://collectivemedical.com/resources/case-study/collective-medical-helps-skilled-nursing-provider-cut-hospital-readmissions-by-60/

10. (2020, April). Helping Rural Hospitals Manage Costs & Provide Quality Care. Retrieved from https://collectivemedical.com/resources/case-study/helping-rural-hospitals-manage-costs-provide-quality-care/

11. Donovan, Fred. (2019, February). Portland Clinic Boosts Communication about Emergency Department Visits. Retrieved from https://hitinfrastructure.com/news/portland-clinic-boosts-communication-about-emergency-department-visits

12. Leventhal, Rajiv. (2020, February). Behavioral and Physicial Care Coordination Gets Real in the Pacific Northwest. Retrieved from https://www.hcinnovationgroup.com/population-health-management/care-management/article/21127022/behavioral-and-physical-care-coordination-gets-real-in-the-pacific-northwest