WHITEPAPER

Reforming Interoperability:

What Every Organization Needs to Know About the New CMS Conditions of Participation—and Common Pitfalls to Avoid

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.

Done correctly, this interoperability reform can provide multiple benefits for hospitals, downstream providers, and patients alike. But without careful planning and consideration for all parties involved, the interoperability push can quickly become an administrative nightmare—increasing alert fatigue, incurring penalties, and harming patient care.

Learn what providers are doing to ensure a smooth transition to the new rules, avoid common interoperability pitfalls, and even leverage the rules to achieve better patient outcomes—including better transitions of care, fewer readmissions, reduced cost-of-care, and more—in the whitepaper and additional linked resources.

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The Benefits Behind the New Conditions of Participation

While right now, the strain of ensuring compliance may make these rules feel more like a burden than a benefit—the new Conditions of Participation were designed to not only benefit patients, but the providers and care teams that treat them. With the new ruling, clinicians and hospitals can look forward to a number of benefits that will improve workflow, care, and the bottom line.

Easier and Less Expensive Patient Data Requests

Modernizing interoperability through technology will allow clinicians and hospitals to easily provide patients with access to their information in a fully-automated, low-cost way. Adopting secure, standardized application programming interfaces (APIs) allow for this access *without* special effort on the part of the clinician.

No more calling around to manually coordinate transitions of care, request patient records, or track down patient histories—the new rules aim to streamline collaboration in an effort to reduce administrative burden while improving patient outcomes.

Greater App Selections

ONC Cures Act Final Rule calls for open APIs, which encourages secure access to data for applications. The final rule will help ensure these certified APIs are made available in a way that is safe, secure, and affordable. These APIs will also support innovation in the marketplace for health IT and app developers.

Improved Implementation

The Cures Act prohibits information blocking and defines the practices that are considered reasonable and necessary activities that would not constitute information blocking. The ONC's Cures Act Final Rule establishes exceptions to allow clinicians and hospitals "common sense" operational flexibility—including adapting to protect patient privacy and security as well as handle situations where moving data is technically infeasible.

Better Patient Safety

The final rule aims for a thoughtful balance between patient and clinician needs. For example, it encourages transparency around patient safety issues within health IT while also attempting to protect the intellectual property rights of health IT developers who have made large investments in building user interfaces and workflows.

What You Need to Know About the Rules

While the CMS Interoperability and Patient Access rules update a number of policies and regulations, this whitepaper will focus exclusively on those outlined in the Section X provisions.

Section X—Provisions

The provisions update the existing Conditions of Participation to require hospitals—including psychiatric hospitals and critical access hospitals—to send electronic patient event notifications of a patient's admission, discharge, and/or transfer (ADT) to other healthcare facilities or to community providers or practitioners.

Specifically, hospitals need to notify:

- Primary Care Providers: Defined as the patient's established primary care practitioner, practice group, and other practitioners or practice groups identified by the patient as the entity primarily responsible for their care
- Post-Acute Care Providers: Defined as any post-acute care service provider/agency or other outpatient service provider(s) responsible for the patient's follow-up or ancillary care with whom the patient has an established care relationship prior to admission or to whom the patient is being transferred or referred

Event Notification Standards and Requirements

Rather than listing specific data elements or specific methods of sending the information, the rule finalizes a broad requirement for sending necessary medical information in accordance with all applicable laws. Below are the basic standards organizations should be familiar with when considering how to meet the new requirements:

Content of Event Notifications: At a minimum, notifications must include the patient's name, the treating practitioner's name, and the sending institution's name. Organizations wishing to facilitate more meaningful transitions of care may also choose to include more information.

Regulations of Event Notifications: For an action to serve as the basis for a measure under the Promoting Interoperability Program, the action must require the use of certified health IT.

Use of Intermediaries Allowed: An intermediary may be used to facilitate exchange of health information. HIEs as well as third-party aggregators of ADT are also approved intermediaries.

Event Notification Requirements

The rule outlines exchange standards and content regulations for hospitals and/or their intermediaries to ensure full compliance:

1. Notifications must be fully operational in accordance with all state and federal statutes and regulations regarding the exchange of patient health information.
2. Notifications must include the minimum patient health information specified in the final rule (patient name, treating practitioner name, and sending institution name).
3. Notifications are sent directly, or through an intermediary that facilitates exchange of health information, at the time of the patient's registration in the ED or inpatient services.
4. Notifications are sent directly, or through an intermediary that facilitates exchange of health information either immediately prior to, or at the time of the patient's discharge from the ED or inpatient services.
5. The hospital must make a "reasonable effort" to ensure notifications are sent to all applicable post-acute care services, providers, and suppliers—as well as to any of the following practitioners and entities which need to receive notification of the patient's status for treatment, care coordination, or quality improvement purposes.

The Cost-Saving Opportunities of Interoperability

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, racking 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.

Common Pitfalls (and How to Avoid Them!)

Implementing these changes has created unique challenges for hospitals and other providers—leading to a number of concerns from hospitals and ambulatory providers about the potential pitfalls the interoperability rules may cause.

Among these concerns, there are three leading issues acute and downstream providers foresee with the Conditions of Participation—including disruption of ambulatory workflows, greater risk for financial penalties, and uncertainty surrounding the ability of existing EHRs to satisfactorily meet the requirements. The next section will cover how to address them to avoid unnecessary administrative or financial burden.

Addressing Ambulatory Workflow

Ambulatory workflow is notably ignored in this rule.

Provider alert fatigue is already an issue and adding substantially to the quantity of data being received by providers without clear tools to manage will only further strain provider resources—forcing them to ignore most notifications and creating provider blowback on rule makers, hospitals, sending data, and technology providers. Not only will this exacerbate provider frustration but also perpetuate the fragmented healthcare system the rules aim to repair.

To help facilitate better collaboration with ambulatory and other downstream providers, hospitals can take into account the workflow of primary care and post-acute providers when choosing an intermediary to fulfill the CMS requirements. For example, implementing a solution that can understand and recall specific provider preferences for notifications—like an institutional direct messaging inbox, a provider-specific inbox, or other option—can help reduce administrative burden for both the hospital and its downstream providers.

In addition, sending notifications where they can be easily accessed by providers—when and where appropriate—improves ambulatory workflow and lowers the likelihood that these notifications will lead to burnout, or be ignored altogether.

Avoiding Unnecessary Penalties

Because this interoperability is required as a Condition of Participation, those organizations who are not in compliance can be penalized. This would mean not getting paid for any Medicare work. Yikes!

Unclear verbiage around the standard of reasonableness are contributing to hospital administration fears around incurring unwanted financial penalties. For example, hospitals must make a "reasonable effort" to ensure notifications are sent to the appropriate primary and post-acute care providers, but little direction is given as to what constitutes "reasonable efforts."

While further clarifications will likely be released as the 2021 implementation deadline gets closer, for now, the following has been outlined:

Mechanism	Requirement
Patient Reported	Required
Prior Post Acute (from EMR, patient reported)	Required
Medicare, Medicaid, other Attribution Files	Unclear, but likely
RLS data from ambulatory locations (i.e. ADT Aggregators, HIEs, or Commonwell)	Unclear

One of the things hospitals can do now when considering how to meet the participation requirements is evaluate intermediaries' ability to prove "reasonable efforts" quickly and easily. By ensuring that the solution not only sends notifications—but can pull automated reports that show and track these collaborative efforts—hospitals can rest easier knowing that the conditions have not only been met, but that compliance can be quickly and painlessly proved.

Understanding What Your EMR Needs to be Compliant

Currently existing singular EMR systems may not fully satisfy the CoP, leading to a need for more intermediaries.

But many intermediaries and EMRs are offering functionality that only offers partial compliance with the CoP, necessitating the use of multiple intermediaries to meet the requirements. Reasons for partial compliance include:

- Only offering access to ADT data
- Missing attribution files
- Lack of persistent records
- No functionality for post-acute or PCP sharing
- Lack of integration into physician workflow
- No workflow or data management tools for community providers
- Solution fragmentation

To help supplement what existing EMRs are missing and ensure compliance, some organizations are turning to multiple intermediaries to fill these gaps. The more intermediaries are required to comply, the more financial, privacy, and functionality concerns hospitals can expect to face as the organization IT and care teams scramble to implement and train on multiple different platforms.

Finding a singular solution that satisfies all—not just some—of the participation requirements can reduce cost and administrative headache and ensure a smoother implementation process by the 2021 deadline.

Additional Resources for Successfully Leveraging the Conditions of Participation

Best Practices

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.

Keep it Simple—and Singular

The CMS Conditions of Participation are contingent on improving interoperability between care providers across the medical community.

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.

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.

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.

Avoiding Alert Fatigue

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.

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.

The Outcomes

By optimizing the notifications sent to include more than just ADT information, organizations across the country have been able to better collaborate on and care for their patients and see:

- A **32 percent reduction in opioid deaths,** a **59 percent reduction in ED visits,** and a **47 percent reduction in variable cost avoidance** in recurrent ED visitors under care management[8]
- Reduced **readmission rates by 60 percent**[9] for post-acute care
- An increase in transitional care management coding of 33 percent, leading to a **30 percent**[10] **increase in revenue**
- A **15 percent**[11] **increase in follow-up rates** within 7 days of hospital discharge

Additional Reading

The sources listed below give additional insights into the interoperability rules, as well as ways hospitals and other care providers are optimizing interoperability to ensure better provider workflows, reduced costs, and improved patient care.

In addition, the companion whitepaper to this piece, "Optimizing Interoperability: Leveraging CMS Interoperability Conditions of Participation to Increase Collaboration, Reduce Costs, and Improve Outcomes" delves more into not only the rules themselves but the hidden benefits hospitals can gain by leveraging the conditions appropriately. Download the whitepaper.

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

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.

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