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The Case for Interoperability

How data sharing and care integration lead to better outcomes

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"Interoperability" has been a buzzword in healthcare for at least 15 years. It is no longer a novel concept; it is becoming a reality that you cannot ignore.

Interoperability is the technology of ***access***; specifically, of expanding access to data in order to improve care. This paper explores the role interoperability plays in expanding access to care for individuals and entire populations, using interoperability and through related concepts such as integrated care and value-based care. It will also highlight technology solutions that support interoperability and help you expand your reach.

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What is interoperability?

The Healthcare Information and Management System Society (HIMSS) defines interoperability as "the ability of different information technology systems and software applications to communicate, exchange data and use the information that has been exchanged." That's a deceptively dry description of a technology innovation that literally has the potential to save lives and reduce healthcare costs.

Healthcare interoperability breaks down barriers to previously siloed information and makes it possible to securely share and then act on that information in a timely manner. The results include improved outcomes, increased efficiency, timely interventions that keep patients out of acute care facilities and a whole lot more.

Laying the groundwork for interoperability

Let's look at how healthcare has changed, and why interoperability is so important as value-based care and integrated care become priorities.

Twenty years ago, recordkeeping was mostly manual. Electronic health records (EHRs) were paper charts, and prescriptions were written on paper for the pharmacy to dispense. Sending records to payers or other providers was done by fax. Determining eligibility involved staff members spending hours calling payers.

In 2009, the United States Congress enacted the American Recovery and Reinvestment Act (ARRA). This legislation established incentive payments to promote the adoption of EHRs and meaningful use by medical professionals and hospitals.

At minimum, "meaningful use" was to include:

- Using certified EHR technology for e-prescribing
- A demonstration that the certified EHR is sufficiently connected for the electronic exchange of health information to improve the quality of health care
- The ability to electronically submit clinical quality measures to the Department of Health and Human Services (HHS)
- Exchange meaningful clinical information among professional healthcare team members

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ARRA set the stage for eliminating paper and centralizing patient records electronically.

With the passage of the Patient Protection and Affordable Care Act (ACA) in 2010, healthcare technology received another boost because ACA contains incentives for providers to develop and implement new systems aimed at increasing efficiency.

Before the ACA, most insured consumers relied on private insurance payers, usually contracted through their employers. The exception was anyone who qualified for public programs such as Medicare and Medicaid. With the passage of the ACA, people could buy insurance through government-run exchanges. Local authorities began administering healthcare plans—sometimes states, and sometimes contracted payers. The federal government's role has also grown with new regulations, oversight and funding. Insurance became **centralized**—which meant records needed to be centralized, too.

These initial stages of interoperability focused on **centralizing** data into patient records, with little regard for quality. This paved the way for new regulations, more robust payment models and better technology.

With all these changes, it was important to ensure consumers were still receiving the right levels of care. Outcomes needed to be measured, and with data more available, providers could do just that. Federal agencies like the Substance Abuse and Mental Health Services Administration (SAMHSA) could use these metrics and results to award future grants and funding, and CMS could use them to incentivize market profitability.

What is value-based care?

Value-based care is a form of reimbursement based on performance. Instead of **fee for service**, value-based care means that payers, partners, local authorities and the government hold providers accountable for the **value** they provide consumers. This is typically measured through consumer outcomes, rather than based on number of visits or services.

Value-based care involves aggregating data to provide a complete picture of individuals that drives insights about the care required, measures outcomes and proves the value of the care provided. That data can also be used to compile and submit detailed reports on key metrics and performance indicators (KPIs). To supply this information, organizations need a way to aggregate enough data.

That's where interoperability comes in. You may recall that interoperability is defined as the ability of technology systems to exchange and use information. Sharing data reciprocally with other providers delivers a more complete data set, which can be used to more accurately measure outcomes. In other words, if a patient has been referred to your organization, you can track their progress based on earlier chart notes and medical records, allowing you to determine if the patient is improving under your care. Among many other benefits, access to this integrated data leads to faster payer reimbursement. With greater access to data, your organization becomes more efficient, improves consumer care and maximizes health plan reimbursement.

POPULATION HEALTH MANAGEMENT

Part of value-based care and crucial to success

Interoperability is crucial to population health, where the focus is still on whole-person care and overall health outcomes, but from a broader perspective. Population health includes components such as chronic disease management, care coordination, health promotion and risk stratification. This approach highlights how important interoperability is to not only treating and advancing care, but also to successful community-based outreach.

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The emphasis on value-based care is transforming the way healthcare is delivered. On the human services side, Certified Community Behavioral Health Clinics (**CCBHCs**) combine Medicaid dollars and federal grants to provide comprehensive care to vulnerable populations. CCBHCs must offer behavioral health, primary care, addiction treatment and crisis services. They must also meet stringent reporting and care coordination criteria.

In early 2024, CMS launched another program: the Innovation in Behavioral Health (IBH) Model. This model aims to improve care through a whole-person approach combining behavioral health, physical health and health-related social needs (HRSN).

In the post-acute community, services have been transformed by value-based care. Medicare Advantage, a vital part of the federal Medicare program, uses a value-based model. CMS projects that all of Medicare will become value-based by 2030.

Regardless of the specific model of care, value-based approaches incentivize integrated care through outcomes-based payment. Looking at the past decade, we should expect a continued explosion of reimbursement structures around individual or population health. And our systems should reflect this expectation.

Learn more about the real-world application of interoperability and its influence on improved care outcomes by reading how Hospitality House successfully evolved to meet the needs of modern consumers.

When organizations like Hospitality House offer a variety of behavioral and physical health services, this is known as **integrated care.** It's easy to see how **integrated care** benefits both consumers and providers. Whether inpatient or outpatient, consumers enjoy a one-stop-shop with more comprehensive care than just a therapy visit or a primary care check-up.

For providers, **integrated care** allows for more complete and accurate treatment of the whole person. A nurse practitioner working under the same roof as a psychiatrist can see what medications have been prescribed and use that data to detect physical side effects. A psychiatrist can review co-occurring health conditions when deciding what to prescribe. The psychiatrist can also confer with the consumer's therapist to provide better mind/body behavioral health interventions.

As you can see, this model also benefits organizations by allowing them to add service lines and grow. For all these reasons—consumer experience, whole-person care and organizational growth—**integrated care** is the preferred method of delivering care today. **But it only works if you have interoperability.**

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Why interoperability is crucial to improve care delivery

Let's look at different forms of integrated care. First, let's unpack the multiple service lines model discussed on the previous page. The providers within an organization can only benefit from their proximity to each other—or collaborate in any way—if they have access to each other's data. In other words, only if they can exchange digital information (**interoperability**).

Let's imagine another model of **integrated care**—different providers working together. This happens all the time when there is a referral. The more providers can collaborate to coordinate care, the more they can track the health and risk factors of populations. Once again, this only works if providers can exchange and integrate digital records and data using compatible devices. It requires **interoperability.**

Interoperability requires data—the more meaningful data, the better. Your EHR should be connected to your state's Health Information Exchange (HIE) or a database you can invest in to give you access to trends in population health.

Integrated care is the future because it addresses so many healthcare challenges. With multiple providers creating a network to serve the whole person, consumers are less likely to fall into "gaps" if a referral is missed. Collaboration between providers also results in fewer errors when transferring a client.

For example: after receiving inpatient care, a consumer may be asked to follow up with their primary care provider. Too often, patients don't schedule that visit, increasing the risk of readmission. But if the primary care provider is connected to the inpatient behavioral health clinic through interoperable systems, the primary care provider will see that the patient has been referred for follow up and reach out to make sure the visit happens.

Not only does this decrease physical health risks for people with behavioral health or addiction treatment needs, it also improves outcomes and operational revenue for the organization. It also can lead to new service lines, expansion and growth for organizations housing both providers in an **integrated care** model.

But remember, **integrated care** can't happen without **interoperability**.

Barriers to interoperability

So, what are some current issues that prevent widespread adoption of **interoperability**?

1. Lack of standardization

At minimum, you need to be digital. EHR adoption is only at 64%, with most paper charts and fax clinics located in rural areas. Even if you are using an EHR, you must follow mandated requirements from regulatory bodies to maintain consistency.

2. Lag time in information sharing

This refers to situations like transfers and referrals when it takes time for the other provider to receive your records. Once again, your system needs to be digital to share information in near real-time. You also need software specifically created for data exchange.

3. Incomplete information

This occurs in data exchange due to lack of standards adoption. Remember that interoperability first became a priority because records needed to be centralized. Those initiatives (known as meaningful use) evolved over time to include regulations on the quality and standards of data. If you're not using an EHR and abiding by standards and guidelines, you cannot confidently exchange data or records with payers or providers. Recordkeeping errors can correspond to incorrect, inefficient or even unsafe care.

4. Lack of privacy

Not everyone is aware of HIPAA (Health Insurance Portability and Accountability Act) requirements, and what is permitted to be shared with another provider. Be sure to educate your team, and make sure the software you use is HIPAA compliant.

The EHR and beyond

Interoperability is a technology term, and it refers specifically to software. **Technology is the driving force behind interoperability**. You need to focus on the solutions that support the services you offer in order to provide the best outcomes for the communities you serve.

Value-based care is the payer model for **integrated care** organizations. You should have software that tracks metrics, goals and benchmarks. You should be able to generate easy-to-understand metrics and dashboards that represent outcomes.

All of this may seem like a big investment, but the right technology can put your organization on a more profitable track. Let's look at some of the benefits of digitizing your enterprise.

Employee satisfaction

We're in the midst of the most competitive healthcare job market in recent history. To thrive and grow, organizations must focus on recruiting and retaining employees. Even something as simple as the ability to exchange medical records in near real-time during a referral will prevent the lag time discussed previously. Your staff wants documentation to be as effortless as possible. The ability to share records or receive important metrics from data sources will help make that possible.

Records available at the point of care

Did you know that 70% of primary care visits are driven by behavioral health issues? This is just another reason providing integrated care is so important. With primary care and behavioral health being so intertwined, whole-person care requires the ability to share documentation across teams (if you're an integrated care organization) or providers (if you're taking referrals from another organization).

Nothing frustrates your clinical staff more than seeing a client without documentation. When your organization is equipped with the right technology for interoperability, requesting records can be automated digitally. Every medication list, chart note, or report can arrive at your office before the client does. That means you can provide better care.

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Near real-time data for value-based care and payers

To be financially competitive, you must get paid on time, with fewer rejected claims. **Interoperability** software gives you the ability to pull results-oriented data and even create simple, actionable dashboards. Payers require data for reimbursement, and your clinical and back-office employees will burn out if they have to dig up the numbers. Actionable data also allows you to participate in value-based care programs or apply for SAMHSA and other grants. Through interoperability, data is available to track employee performance or benchmark goals for growth and sustainability.

Risk tracking for population health

Comprehensive data strategies can be accessed through your EHR. The more data you have on a specific population (e.g., foster children), the more you can ensure continuity of care. In addition, by looking at the data for a specific population, you can find co-occurring risks. (For example, did you know that children with autism are statistically likely to have at least three co-existing diagnoses?) This kind of data is powerful when providing care to any population, but particularly to the underserved.

Interoperability can level the playing field in places with primarily rural healthcare facilities. And it will give your clinicians a more complete picture of the clients they're trying to help. **Interoperability** has allowed addiction treatment providers to create a national prescription-tracking database. This means if a patient is admitted to the emergency department (ED) with a condition resulting in severe pain, the doctor will be able to see if opioids have been prescribed, how long ago and whether the patient has been treated for an opioid use disorder. This alerts the provider to find a more appropriate pain management solution, based on the patient's risk profile.

Data access exists through technology vendors, states and even the federal government. This encourages provider data sharing within **integrated care** models and serves as an incentive for organizations to apply for grants that could subsidize or cover the cost of **interoperability** software.

Connecting with other providers means reaching more individuals and communities and creating better outcomes. Interoperability is important because we are all in this together. We hope that understanding the higher-level concepts and strategies behind interoperability will help you continue to pave the way towards whole-person care.

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