INTEROPERABILITY: ARE WE READY TO ROCK AND ROLL?
INTRODUCTION

Like many fast-moving trends, emerging healthcare interoperability has been met with confusion, trepidation and excitement. Some observers may consider the pace of change to be reckless while others would say change is long overdue. Still, some are in denial that change is coming. And while it's certainly accurate to label interoperability as “transformational” or perhaps “disruptive,” much confusion remains about what the future holds and when it will arrive.

IF IT’S SO COOL, WHY ISN’T EVERYONE DOING IT?

It's probably good to start with just what “it” is and what is involved. Interoperability is more than the exchange of data between disparate systems; it's also about making the data valuable and actionable after it is exchanged. This has implications not just for technologies that move the data, it may also require new workflows and business processes. Practically every stakeholder in healthcare has a system that needs to talk to another for some reason and each of these cases drives specific unique technical and functional requirements — what the industry calls “use cases”. If the goal is just to “connect everything” it is a hard problem to solve. Enabling every use case is a more difficult problem, followed by the even more complex issue of making the information transmitted in the use case digestible and usable.

While everyone seems to be talking about the topic, some within provider organizations remain ambivalent about the sharing of healthcare data. Some believe the patient’s record is the property of the healthcare system — an asset to be carefully protected and shared only with “partners.” Still others are afraid of what it means to co-mingle data collected on a patient in another facility with the data collected locally, perhaps wondering “do they take the same care as we do?” And “how will my data look in the other system — does this put me at risk?”

Increasingly, the prevailing attitude, both in government and among consumers, is shifting to the notion that data should at least flow wherever a patient seeks care — and that this data is actually the property of the patient themselves, making interoperability more of a moral issue. Technology is emerging to make such exchange much easier, but there are many barriers preventing progress. The interoperability “roads” are out there (interoperability standards, HIEs, national networks, secure messaging), yet interoperability is still catching on and the frequent flow of protected health information (PHI) is not happening quite yet. So what still needs to happen?

In a recent interview, Janine Akers, CEO of DataFile Technologies, likened interoperability to rock and roll music. “The innovation of rock and roll shaped music as we know it today,” said Akers. “Interoperability will change healthcare delivery, but it’s a process. Just like rock and roll, it’s important that we accept, embrace and adapt to change.”

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CEO, DataFile Technologies
INTEROPERABILITY MOTIVATORS

Healthcare is in the midst of an evolution, and interoperability will play an important role. Faced with spiraling costs and poor quality of care compared to other developed nations, healthcare reform underway in the United States is meant to drive the “triple aim”:

- Decreasing costs of delivering care,
- Increasing the quality of the care experience, and
- Improving the overall health of our citizenry.

In support of these three goals, interoperability can improve decision-making in the care process, prevent duplication, and increase care coordination between disparate organizations using different systems.

As the largest single buyer of healthcare, the government is providing “encouragement” — laws, incentives and penalties to coax the data to flow. The latest of these are the million-dollar penalties for “data-blocking” that were introduced in last year’s 21st Century Cures Act. This fully transitions interoperability from a trend to a mandate, “do it or you will pay.” The 21st Century Cures Act also mandated a trusted exchange framework be built. The Trusted Exchange Framework and Common Agreement, referred to as TEFCA and introduced in draft form in January 2018, creates a common set of rules and provisions for organizations to be part of this nationwide movement toward interoperable exchange. This common agreement is an additional and necessary step towards communication among disparate systems and networks.

Another government incentive was through a healthcare IT modernization program, which became known as “Meaningful Use.” This incentive program was designed in part to offset the costs of implementing process automation in an industry that lagged behind almost all others in such investments. A more important goal of the program was to reduce the cost of care itself while improving quality. Once the whole industry is “digitized,” the system can help clinicians do the right thing more often and avoid costly, inappropriate or unneeded activities.

The goal is to save dollars and lives at the same time — a worthy goal. However, this only works if the many different systems in use function like they were a single system.

TIMES, THEY ARE A CHANGIN’

In order to change the incentives inherent in the system, healthcare reform efforts are transitioning care from a “fee-for-service” to a “pay-for-quality” model. These new incentives are built into the way providers are reimbursed by both public and private insurance. In order to prove to insurance companies that quality care was delivered, complete, coded, structured clinical data will need to be communicated. Likewise, this same data will need to flow between the different provider systems where the patient has data so that care-coordination is possible. Structured and coded data is required to make the transported data of use to a system, so it functions in precisely the same way it would have if it were entered in system directly.
Meaningful Use has prescribed specific mechanisms to make data portable and usable as it flows between systems. One of these mechanisms defines a document with specific slots where data elements can be placed. Under the regulations, Electronic Health Record (EHR) companies must use the same language, or nomenclature, to code these data. For example, medications must be communicated with a code along with the name of the medication so no translation or mapping is required as this data is communicated. With thousands of systems to “connect,” mapping this data after the fact is simply a non-starter. The regulations that both the EHR companies and the provider organizations must comply with have been expanding in scope as well so that more of these elements must be portable and structured over time. As a part of the latest regulations, systems must be able to both produce these structured documents called C-CDAs (consolidated-clinical document architecture documents) and import the data into the EHR and reconcile a few key data elements with what is and already present in the record.

In order for any of these mechanisms to have the desired effect, the data must be captured in a structured fashion in the EHR to begin with. If, for example, the only report of a given medication or allergy or condition of the patient is in the text of a transcribed dictation or even in a clinical document entered by typing into the system, it will not be easily exported by one system to another. Many providers have only been using electronic systems to document care for a few years and have yet to master the best approaches within their system. Likewise, information received by fax from another organization scanned into the record as a flat file or PDF will not be available to reconcile to data already in the record. Many organizations have processes that trap data in “blobs” like these, making even manual retrieval of the information embedded within them difficult.

**CHANGE IS DIFFICULT, ESPECIALLY FOR PROVIDERS**

The hardest organizational changes are those that alter the activities of providers themselves. As the EHR systems were deployed, some legacy ordering and documentation processes were left in place to limit change for physicians. As organizations struggle to comply with new requirements, these processes frequently need to be revisited. Some organizations are applying non-physician resources or using outside services to help deal with the new requirements. While a doctor may be very good at telling the “story of the patient” in a coherent narrative, having data elements trapped within this text will mean they are not easily portable between systems or for that matter, available for decision support system within the local EHR to utilize. Capturing data in a structured and coded form is a part of the meaningful use of such a system. That said, as data is actually shared between systems, the narrative that has been meticulously crafted by the doctor is also keenly of interest. **Interoperability may mean that structured and unstructured data must be made available.**

**WHAT ABOUT OTHERS WHO WANT PHI?**

Federal legislation (mostly HIPAA) provides some guardrails so patient data can flow freely, even without patient consent, to those who need it for enabling appropriate **treatment**, facilitating **payment** and streamlining an organization’s **operations**. Such releases of information are described with the shorthand “TPO disclosures.” Multiple initiatives, both regional and national have worked to fulfill the promise of TPO data exchange.

*Interoperability isn’t restricted to TPO requests; it can also address exchanges which require a patient authorization.*
While HIPAA explicitly allows TPO disclosures, it mandates specific requirements on disclosures for any other purpose. While interoperability will have an effect on how we fulfill these “non-TPO” requests from life insurance companies, law offices or anyone else who requests records, the HIPAA required “authorization” remains a requirement even with interoperability in place. The contents of the authorization are specified in the law, and it’s a “breach” to release data with an incomplete or invalid authorization.

In a quest to reduce the cost and effort of releasing data for these purposes, both engineers and lawyers have been busily working to eliminate manual steps. While there are many technical approaches to making the authorization available to the provider organization, there is no mechanism yet to automate the review of the authorization’s validity. To address this, it is becoming more common for requestors to provide assurances that all requests will have valid authorizations and legal remedies like indemnification if a disclosure occurs based on a non-compliant authorization. The authorizations can be viewed upon request or audited in arrears. There is no clarity from the government about whether such approaches of not providing the compliant authorization before fulfillment of the data is permissible. Currently it appears to be a provider organization’s choice if they are willing to trust that a given requestor will always have valid authorizations without verification – but with that trust could come improper disclosures of PHI. The old saying “trust, but verify” certainly can be applied to confirming proper authorizations for interoperable PHI exchange.

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EASY ENOUGH, WHAT COULD GO WRONG?

As an organization that provides release of information services, examining both the authorization and the records to be released ensuring the compliance of every request, we have visibility to how often authorizations on these requests are non-compliant.

An evaluation of nine months of requests shows that nearly 1 in 50 of all requests are initially non-compliant and are sent back for additional information. The most common issues include authorizations not supplied with the request at all or authorizations that are missing patient signatures or signature dates. Our healthcare data experts also make certain the records to be disclosed are only on the patient described in the authorization. It is not uncommon in the new world of electronic health records and interoperability to find documents accidentally misfiled within a patient chart are not caught on audit and disclosed as a part of releases. Inappropriate disclosures to requestors that are neither covered entities nor business associates are more likely to be categorized as a breach requiring reporting both to government agencies and to the patient whose data was breached. Even if the requestor agrees to pay legal costs for a breach, the damage to the reputation of the organization can affect business prospects in addition to tarnishing an image.
MAKING THE TURN TO INTEROPERABILITY

In order for the industry to meet the expectations of both regulatory bodies and consumers, industry stakeholders will all need to “accept, embrace and adapt” in fundamental ways. There will be growing pains and work-arounds along the way. But once the healthcare business incentives completely change, effective data exchange and patient engagement strategies will be their own reward. Knowing about procedures or tests done elsewhere will mean improved profitability instead of missed opportunity. Access to provider care plans for a patient will save an organization money if they continue to follow it. If the patient has the ability to interact with their record in a meaningful way they can be a full partner in managing their health, improving provider visibility to their health status and desires. Providers can know much more about what has been happening with their patient since their last visit, both improving satisfaction and care.

There are lots of technical ways to make data move from place to place, but without standards based, structured, coded data, meaningful interoperability is not possible. Communicating the narrative “story of the patient” is also important but is not enough on its own. Making this data available for standards-based exchange on as many channels as are available will enable care-coordination, eliminate redundancy and ultimately reduce costs and improve quality.

Developing strategies for automating the “non-TPO” exchanges will be important but must be done while maintaining processes to review the validity of authorization so organizations can prevent HIPAA violations and breaches. DataFile Technologies’ health information management professionals can help you with these challenges among others, even as the data begins to flow more freely.
ABOUT **DATAFILE TECHNOLOGIES**

We understand today’s healthcare provider is overburdened with a changing healthcare landscape and required to do more with less. As a business outsourcing partner, DataFile takes on arduous administrative tasks to allow your practice to return to patient care. Our catbird seat to interoperability allows us to advocate on the behalf of the provider — arguing the liability and cost burden should not fall on the provider’s shoulders. If you are looking for assistance filling in the gaps of structured data, talk with us — we are ready to help you make the turn to interoperability.