



**Referral sources and
skilled nursing facilities agree:**

Interoperable systems are key to success

**Second biannual interoperability survey reveals growing demand among
referral sources for SNFs that offer higher levels of interoperability and
advanced engagement solutions**



Executive summary

As the skilled nursing industry struggles to regain its footing in a post-pandemic world, a new wave of challenges is forcing leaders to reconsider their technology and growth strategies for 2023 and beyond.

Prolonged workforce shortages are exposing the skilled nursing industry's high dependency on manual resources and processes that are ripe for automation. While their referral sources in the acute and ambulatory sectors have embraced more modern technologies that support automated workflows and data sharing, SNFs are being held back by their outdated systems and siloed data infrastructures.

Acute and ambulatory care providers are accelerating the adoption of value-based care payment models, resulting in increased pressure on SNFs to do their part to avoid costly complications and create closed-loop communications.

While new care delivery models, such as SNF@home and recovery@home are being explored, many SNFs do not have the technology they need to provide high-quality care outside the four walls of their facility.





SNF



As these pressure points increase, so does the industry's understanding of and appreciation for the role technology plays in success, particularly when it comes to the exchange of real-time resident data between disparate systems and care team members.

To help the industry track what skilled nursing leaders are thinking about and doing when it comes to interoperability in these changing market conditions, MatrixCare launched the second biannual Interoperability Market Survey, conducted by independent research firm.

With more than 250 business and clinical leaders and 100 post-acute care referral sources responding, this year's research reveals the skilled nursing industry has made limited progress in bridging the interoperability gap that exists between what their referrals want and what their systems and organizations are able to give.

However, the research also reveals that the majority (79%) of SNFs intend to invest in more advanced interoperability strategies and implement more innovative engagement technologies in the near future, indicating that this will be a year of progress for many.



Track year-over-year industry progress from the 2021 report entitled, "Interoperability: Creative Competitive Advantage for Skilled Nursing Providers."

Key findings

1 Referral sources demand interoperability from skilled nursing facilities

Physicians who typically refer patients to post-acute care (PAC) settings, such as SNFs, made it clear in this year's survey that interoperability plays an important role in deciding where to send patients.

99%

of referral sources reported that they are more likely to send more referrals to SNFs who are more capable of receiving orders electronically.

96%

of referral sources reported that they are likely to send more referrals to SNFs that have more advanced resident/family member engagement capabilities.

100%

of referral sources surveyed say it is important (69% say very important) for SNFs to have a basic level of interoperability to be considered part of their referral network. Last year, **38%** reported that they made care network decisions based on interoperability capabilities.



The good news is that this year, skilled nursing leaders acknowledge that interoperability plays a critical role in their ability to attract referrals, reduce administrative burdens on their staff, and support better health outcomes.



100%

of SNFs acknowledge and accept that interoperability is important to their referral sources, with 83% stating that they believe it is very important. This is up significantly from 71% last year.

100%

of SNFs believe it is important to be able to send and receive electronic data to and from referral sources. On the surface, this shows alignment with referral sources' expectations, but the types of data referral sources want has evolved since last year, requiring SNFs to dig even deeper.

79%

of SNFs intend to invest in more advanced interoperability capabilities in the future, with nearly half of those planning to do so in the next 12 months.

When asked about the progress they've made in the past 12 months, only **46%** of SNF leaders say they have advanced their interoperability capabilities. This is down from 56% who reported progress last year. The top reasons cited for not being able to make advancements this year were more resource-centric than last year's external-centric causes, which referenced uncertainty about the long-term effects of the pandemic.

The top barriers for interoperability advancement and maturity this year included:



Dependence on outdated systems that lack advanced interoperability capabilities



Lack of resources available to support interoperability initiatives

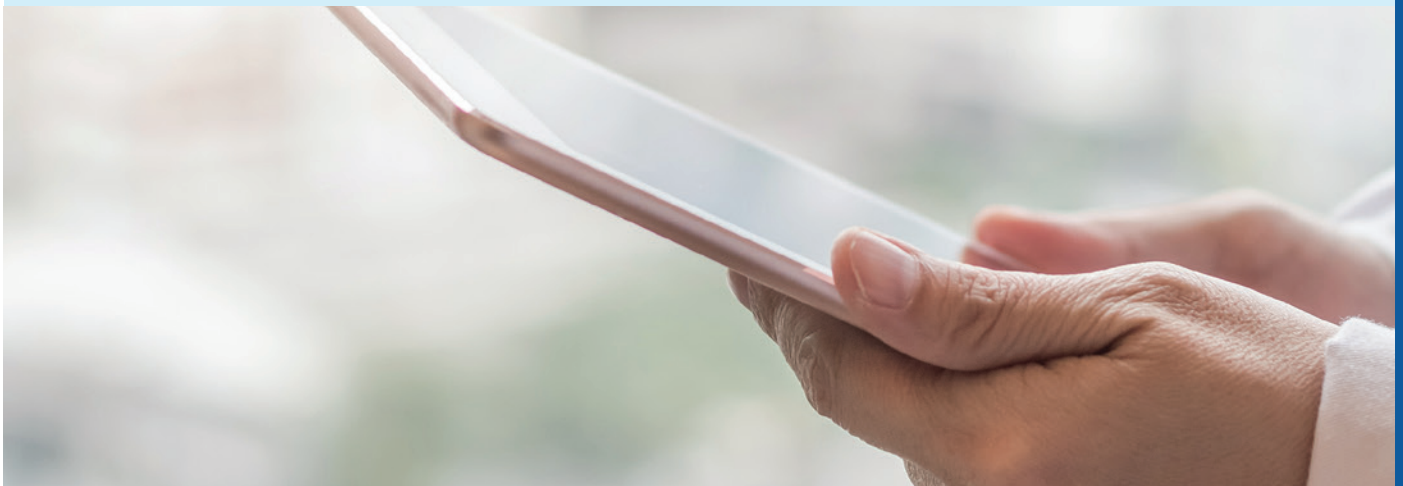


Costs associated with funding interoperability initiatives

At the core of any SNF's ability to expand and mature its interoperability strategy is the electronic health record (EHR) system the organization has chosen.

This year, **65%** of survey respondents reported they were less than fully satisfied with their EHR vendor's ability to meet their most important interoperability needs. While this number does indicate some positive progress from last year's number of **70%** being less than fully satisfied, the industry needs substantial progress as opposed to small, incremental changes.

In fact, **67%** of SNFs say they are either somewhat or very likely to switch EHR vendors to one that better supports their most important interoperability needs. This is a significant increase over last year's number of **49%** who said they would likely switch, which demonstrates the growing urgency and acknowledgement of how important it is to operate on a modern platform that can help SNFs meet today's demands.



One such vendor that is accelerating the pace of interoperability innovation is MatrixCare. The company has been focused on developing its interoperability platform for years, working closely with several national networks, like Carequality and the CommonWell Health Alliance. In these networks, care providers, EHR system vendors, and data exchange vendors all agree to leverage existing health information exchange (HIE) standards and give members access to any data from any participating member for treatment purposes.



The company also actively supports the PACIO Project, which is a collaborative effort specifically designed to advance interoperable health data exchange between post-acute care and other providers, patients, and key stakeholders across the care continuum. The project's primary goal is to establish a framework for the development of Fast Healthcare Interoperability Resource (FHIR) technical implementation guides and reference implementations that will facilitate health data exchange through standards-based, use case-driven application programming interfaces (APIs).

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Value-based payment models put interoperability front and center

As referral sources accelerate their journeys to value-based care, they will continue to place heavier burdens on their PAC networks to reduce hospitalizations, reduce costs, improve outcomes, and enable a better resident experience.

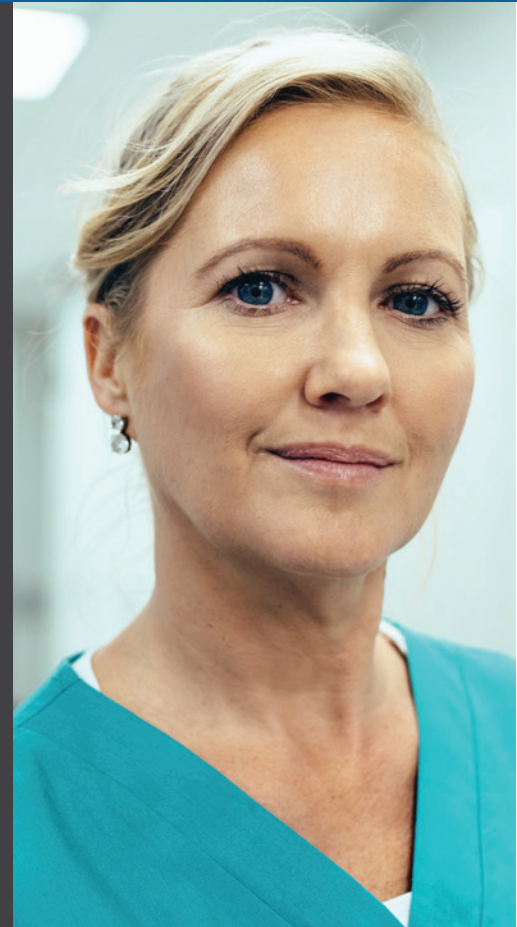
65% of referral sources surveyed reported that more than 25% of their revenue is now tied to value-based care arrangements.

51% expect that percentage to grow over the next 12-18 months.

According to referral survey respondents, the most important role SNFs can play in the continuum of care are:

- 1 Helping prevent costly complications
- 2 Proactively keeping referral partners updated on patient status after the referral is made
- 3 Contributing positively to referring partners' patient satisfaction scores

Being able to exchange data seamlessly and electronically in near real-time is a fundamental premise of successful value-based care models, because without access to accurate and timely data, the risk of costly complications dramatically increases.



Ever-evolving expectations from referral sources

This year's study revealed that referral sources have a growing desire to stay more informed about resident status details via electronic data exchange. In fact, 69% say it is very important and another 30% say it is somewhat important (total 99%) for their SNF partners to be able to electronically send updates on residents' status and the care they are receiving. Unfortunately, only 53% of SNFs say they are able to do so today.

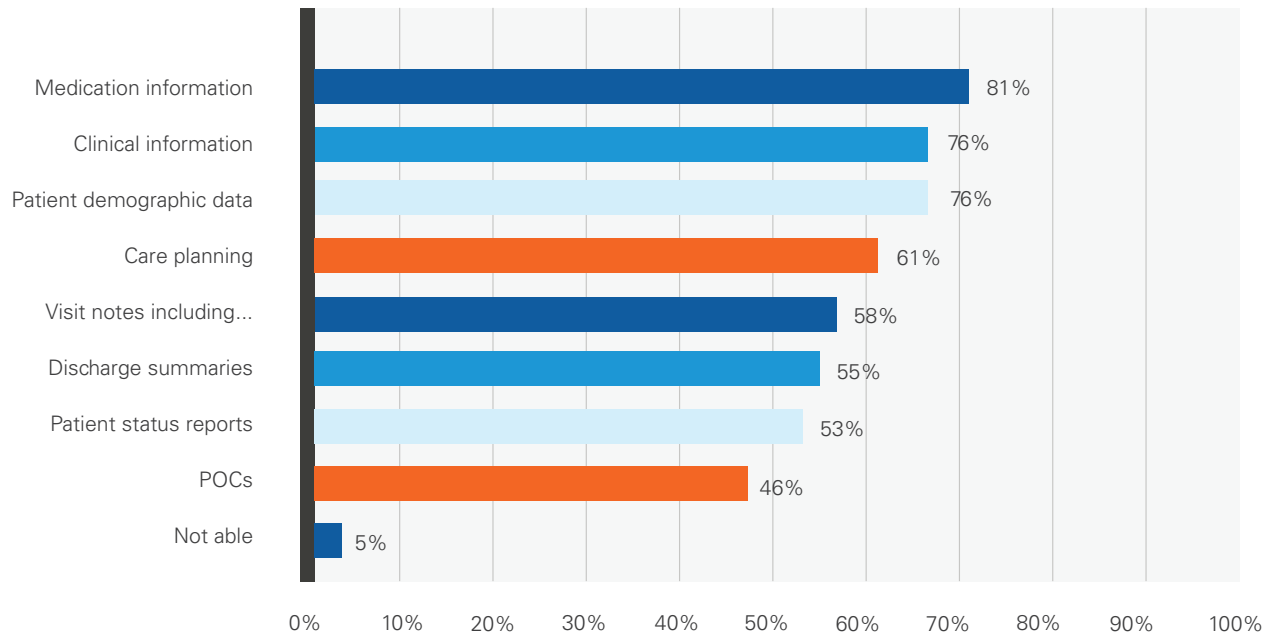


According to one referral survey respondent, "When our patients are admitted to a skilled nursing facility, it is important that we regularly receive clinical updates, such as medication changes and new symptoms that may develop, to ensure we are in sync with the care plans being executed in the facility."

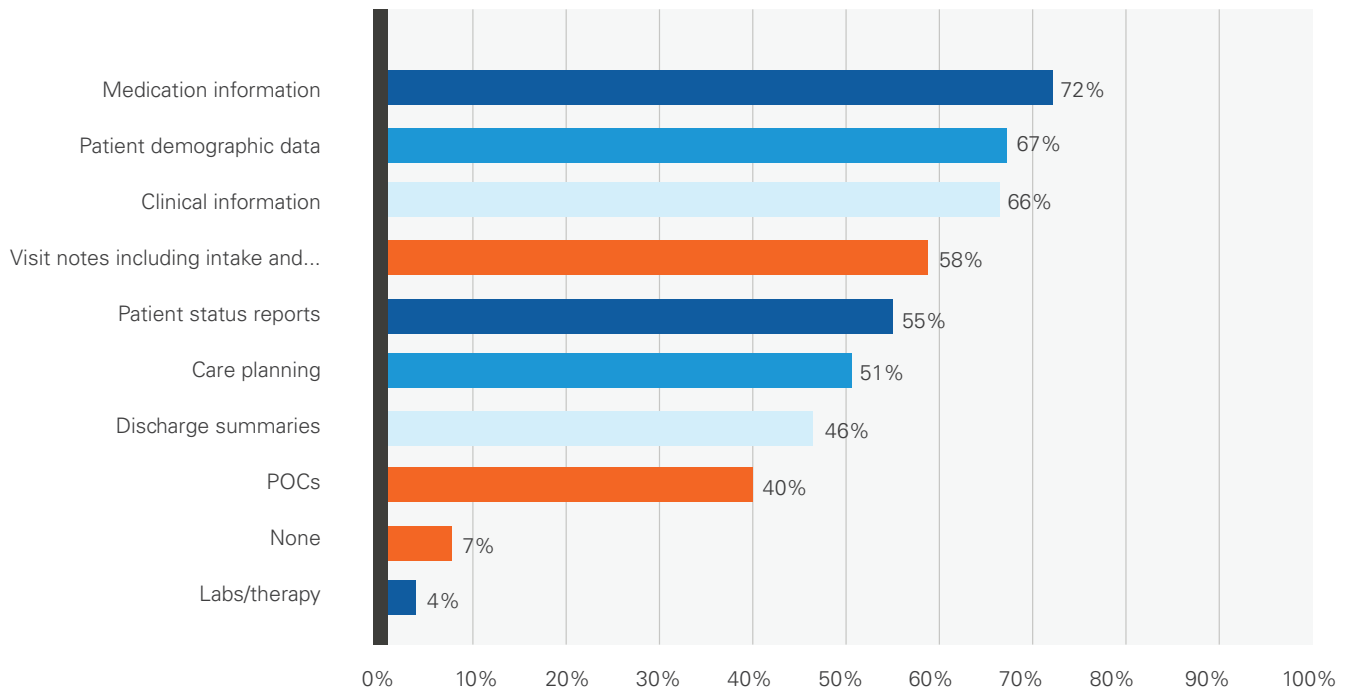
According to one survey respondent, "When we get more complete records from the resident's primary care provider at admission, we can construct more effective, whole-person care plans and be more prepared to help avoid costly complications, such as visits to the emergency room or readmissions."

The seamless flow of data between primary care providers and SNFs is critical to reducing costly complications

Data able to SEND from your system



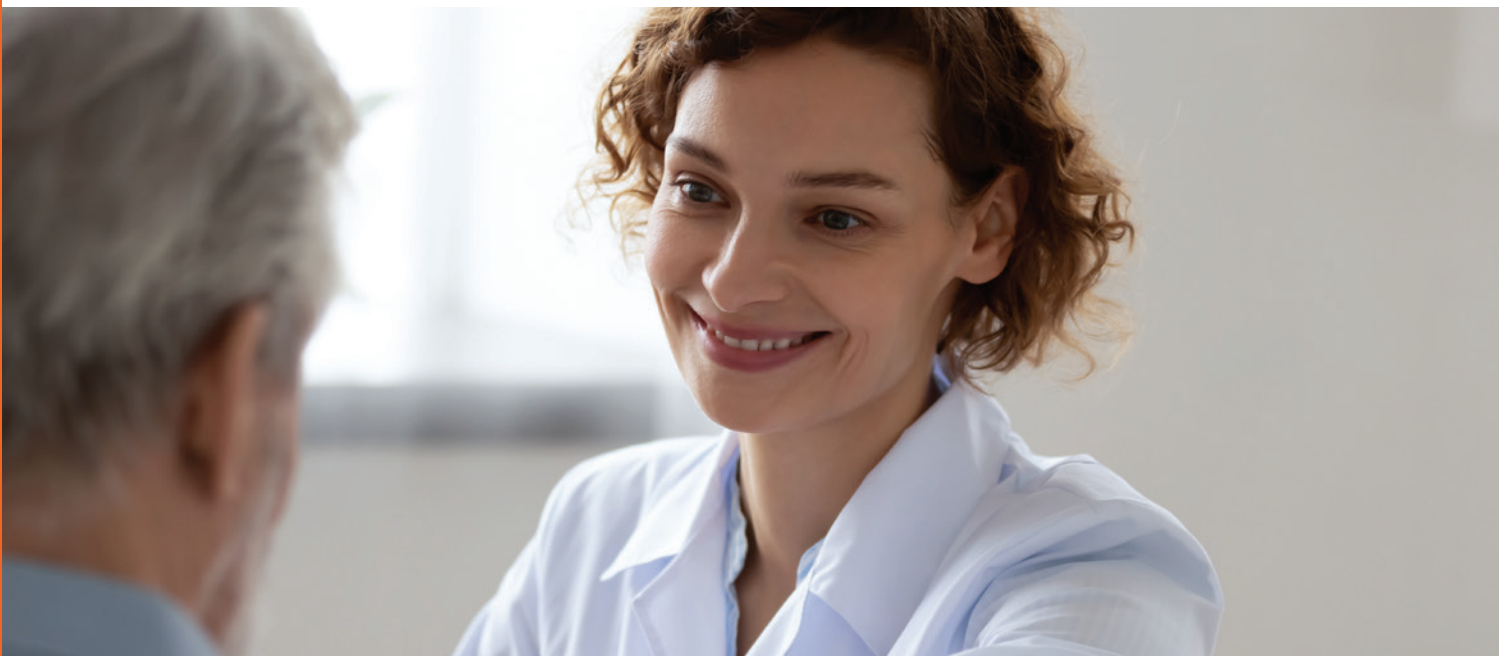
Data able to RECEIVE from partner system



3

Emerging care delivery models

SNF@home and other alternative care delivery models are rapidly gaining momentum, driven by patient preference, healthcare cost savings, and advancements in remote care technologies. Being able to communicate and engage with remote clinical teams, family members, and other caregivers presents new challenges for SNFs that have traditionally been focused on facility-based care and face-to-face communication.



SNF@home requires access to data that typically resides in on-site EHR systems that can be challenging for remote care team members to access in a timely and secure manner. In addition, remote care requires more advanced, real-time engagement capabilities that not only make it easier (and possible) for care teams to stay connected and up-to-date, but also facilitate better communications with family members who are often in/out of the home. And finally, remote care delivery typically involves an extended care team, including HME providers to ensure the proper equipment is present and working in the home, and other specialists.

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Real-time care team and family collaboration is critical

Medical team member connections

Today, many (44%) SNFs use the phone as the primary mechanism to communicate with disparate medical team members, such as medical directors, specialists, and pharmacists. **Top frustrations when engaging with other medical professionals involved in residents' care included:**

33% Keeping all team members up to date

25% Capturing data necessary for care

21% Capturing signatures on orders/requirements

15% Capturing demographic data on patient and responsible party



As many SNFs consider adding healthcare@home services, they must acknowledge that the complexities of care coordination grow exponentially once they reach outside of their four walls. Clinicians are accessing patient data in remote locations versus at a workstation down the hall. Schedules are constantly changing, requiring tighter and more instantaneous communication channels. Highly interoperable EHR systems and purpose-built remote engagement technologies will be required.

The ability to create real-time care collaboration teams that include both medical and non-medical team members is possible with today's modern systems like those of MatrixCare.

Non-medical team member connections

Family members, home aides, community services, and other non-medical services typically play a larger role in the care team when care is being delivered in the home versus in a facility.

For interacting with non-medical care team members today, most (66%) SNFs use the phone as their primary means of communicating. Another 14% primarily use email and 11% use a patient portal. Depending on these outdated mechanisms results in unnecessary frustrations, wasted time, and higher risks.

When asked what their biggest challenges were when trying to engage with non-medical team members, respondents said:

38% Trouble connecting with people on the phone

22% Coordinating with multiple parties

15% Managing schedules and appointments

15% Lack of security/risk of HIPAA violation

Again, as new care delivery and value-based care models are considered, SNFs must also consider the unique requirements of connecting with many other non-medical care team members. Some technologies, like CitusHealth, accommodate these complexities. For example, SNFs can set up patient discussion groups so that everyone in the patient/resident's circle of care is connected in real-time via the app. **Members of the group can:**

- Securely communicate in real time via text or video chat regarding patient status to help reduce the risk of costly complications and eliminate time-consuming phone tag
- Receive notifications, such as schedule updates, to avoid gaps in care and missed appointments
- Sign and send documents to expedite workflows and revenue cycles

The good news is that SNFs appear to recognize the importance and value of having advanced engagement technologies, as 68% say they intend to invest in more advanced caregiver/resident and medical professional engagement technologies in the near future, with 36% planning to do so in the next 12 months.

Rise of consumerism in healthcare

Today's patients expect more mobile-friendly, app-based engagement with their healthcare providers because that is how they engage in every other aspect of their lives. **78%** of family caregivers say they would choose a provider that enabled direct, instant communication, according to a 2021 report.



The interoperability advantage

While interoperability has been a hot topic of discussion across the healthcare industry for more than a decade now, the urgency for SNFs to act now is here.

Referral sources have made it clear this year: advance your interoperability capabilities or risk being left behind. More referrals will go to those organizations that can more seamlessly exchange important resident data, including resident status, and that can engage more effectively with residents and other non-medical care team members.

To ensure SNFs are properly equipped to meet the interoperability challenge and bridge the gap between what their referral sources want and what they are able to provide, SNFs must consider moving to a more modern EHR system.

But what does modern really mean?

- Cloud-based to bring fewer IT burdens and greater agility and security
- Interoperable to seamlessly exchange data across the care continuum
- Engagement with patients and caregivers to improve efficiencies and outcomes
- Remote collection of clinical and physiologic data to minimize costly complications and gaps in care

SNFs that do not run their organizations on systems that can support their interoperability strategies run the risk of losing referral sources, jeopardizing resident care, being excluded from narrowing care networks, and not being able to participate effectively in value-based care models. Even though the shift to a new system can have near-term challenges, the long-term rewards of more referrals, improved patient outcomes, increased efficiencies, reduced administrative burden on staff and higher resident satisfaction are worth the effort.

To learn more about how SNFs can protect and grow their patient populations, visit www.matrixcare.com.

About MatrixCare

[MatrixCare](#) provides software solutions in out-of-hospital care settings. As the multiyear winner of the Best in KLAS award for Long-Term Care Software and Home Health and Hospice EMR, MatrixCare is trusted by thousands of facility-based and home-based care organizations to improve provider efficiencies and promote a better quality of life for the people they serve. As an industry leader in interoperability, MatrixCare helps providers connect and collaborate across the care continuum to optimize outcomes and successfully manage risk in out-of-hospital care delivery.

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