



Interoperability Is Not the Problem Adoption Is

What post acute care IT leaders should prioritize as 2027 approaches

PACT Pulse | September 2026

A patient is discharged from a hospital to a skilled nursing facility. The referral packet is in one portal, claims history is available through another connection, and the medication list has reached the electronic health record. Yet the admitting nurse still calls the hospital because the current orders, last medication administration times, wound details, and functional status are incomplete or hard to reconcile.

That is the interoperability paradox facing post-acute care. More data can move across organizational boundaries than ever before, but the final mile often depends on a phone call, a fax, a manual rekey, or a clinician searching across multiple screens. The technical transaction succeeded. The operational handoff did not.

The statement that interoperability is no longer the problem is intentionally provocative. Standards gaps, patient matching, inconsistent terminology, incomplete records, and vendor limitations remain real. But as 2027 approaches, many post-acute organizations will gain more from improving adoption than from waiting for another standard or another interface. The question is no longer only whether data can arrive. It is whether the right person can trust it and use it at the moment a care decision is made.

A connected system can still produce a disconnected care experience.

Why 2027 changes the conversation

The policy environment is making the technical foundation harder to ignore. Under the CMS Interoperability and Prior Authorization Final Rule, impacted payers generally must implement Provider Access, Payer to Payer, and Prior Authorization application programming interfaces beginning January 1, 2027. These interfaces use FHIR standards and are intended to expand access to claims, encounter, clinical, and prior authorization information. TECCA is also establishing a nationwide framework for trusted exchange.

Post-acute providers are not the primary regulated entities for every one of these requirements, but they will feel the effects. Payers, hospitals, clinicians, health information networks, and software vendors will have more ways to exchange data. That creates an opportunity for skilled nursing, home health, inpatient rehabilitation, long-term care hospitals, hospice, and community-based providers to reduce delays at the transitions where risk is highest.

It also raises expectations. Once data is technically available, referral partners and payers will have less patience for admissions that still depend on avoidable manual work. Post-acute organizations will need to show that connectivity improves time to decision, start of care, medication safety, authorization performance, and continuity after discharge.

Why data access still fails to change care

A 2023 report from the HHS Office of the Assistant Secretary for Planning and Evaluation found that long-term and post-acute care providers had adopted electronic health records for clinical and business needs, while interoperable exchange was still not routine or widely used. That distinction matters. Installing technology and making a connection are implementation milestones. Adoption occurs only when staff consistently use the information to complete work.

Several conditions keep organizations in the gap between connection and use. Data may arrive outside the primary workflow, forcing an intake coordinator to sign into a portal or search a document queue. The record may be technically complete but clinically unusable because it contains duplicate medication lists, stale problem data, or long documents without the elements needed for a decision. Staff may not know which source is authoritative. Ownership may be split among IT, clinical operations, revenue cycle, compliance, and referral management, leaving no one accountable for the full process.

Post-acute care also faces a practical constraint that enterprise interoperability programs often understate: adoption must succeed in environments with tight margins, high turnover, distributed sites, and limited time for training. A workflow that adds two minutes, another login, or one more inbox may be abandoned even when the technology works exactly as designed.

The 2027 priority should be workflow adoption

The most effective strategy is to organize interoperability work around a small number of high-value workflows rather than around interfaces. For most post-acute organizations, the first candidates are referral and admission, medication reconciliation, eligibility and authorization, change in condition, and discharge to the next setting.

For each workflow, IT and operations leaders should define the decision being made, the minimum information required, where that information should appear, who is responsible for acting on it, and what happens when the data is missing or conflicts with another source. The design should start with the user who owns the decision, not with the system that sends the message.

Consider hospital to skilled nursing referral. The goal is not to ingest every available document. The goal is to help the receiving team determine whether it can safely accept the patient and prepare for admission. That may require a concise set of current information: diagnoses, medications and last administration times, pending tests, wounds, functional and cognitive status, behavioral considerations, equipment needs, isolation status, payer details, and discharge orders. If those elements cannot be found quickly, data volume becomes another form of friction.

The same discipline applies to home health. A successful exchange should help the agency confirm eligibility, obtain complete orders, schedule the first visit, reconcile medications, and identify risks before the clinician arrives at the home. A PDF delivered electronically may satisfy a transmission requirement while leaving every downstream step manual.

Measure use rather than connection

Traditional interoperability dashboards count interfaces, messages, participating partners, and successful transactions. Those measures are useful for operating the infrastructure, but they do not prove adoption. Executive dashboards should connect technical performance to the work and outcomes the exchange is meant to improve.

Workflow	Adoption measures
Referral and admission	Time from referral to decision Percent of referrals complete on first review Manual touches per admission
Medication reconciliation	Percent completed within the target window Discrepancies resolved before the first dose Calls required to clarify orders
Authorization	Submission to decision time Avoidable denials Requests returned for missing documentation
Clinical exchange	Percent of exchanged records viewed and reconciled Time from receipt to action Staff use by role and location
Care transition	Percent of discharges with information available to the next provider Follow up completed Potentially preventable return to hospital

These measures change the executive conversation. If the interface is available but completion time, manual work, or staff use does not improve, the organization has an adoption problem. If staff use the workflow and performance still does not improve, leaders can investigate data quality, process design, staffing, or the underlying clinical policy.

What IT executives should do now

1. **Select two transitions that matter most** Choose workflows with visible clinical, financial, or capacity consequences. Avoid launching a broad interoperability program without a defined operational result.
2. **Map the last mile** Observe how information moves from receipt to action. Count logins, handoffs, manual entries, work queues, calls, and exceptions.
3. **Set a minimum useful data standard** Agree with referral partners and internal teams on the information required for each decision. More data is not automatically better data.
4. **Give one leader end to end accountability** Technology, clinical operations, and revenue cycle all have roles, but one accountable owner should be responsible for adoption and performance.
5. **Build training into the workflow** Use role based guidance, realistic cases, and feedback from frontline staff. Training should explain what to do when information is missing or contradictory.
6. **Make adoption part of vendor governance** Require vendors to demonstrate workflow integration, usability, monitoring, exception handling, and measurable use. Standards support is the starting point, not the acceptance test.

The question for 2027

The coming year will bring more APIs, more data sources, and more pressure to coordinate care across organizational boundaries. Post-acute care does not need to wait for perfect interoperability before acting. It needs to make the exchange already available more reliable, relevant, and usable.

The leaders who pull ahead will not be those with the longest interface inventory. They will be the ones who can show that a nurse received the right medication information before the first dose, an intake team made a faster and safer admission decision, an authorization moved without repeated manual follow up, and the next provider had what it needed before the patient arrived.

By the end of 2027, interoperability should be judged less by whether systems can exchange data and more by whether people consistently use that data to improve care. That is the adoption standard worth building toward now.

Sources

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