Public Health Reporting for Specialists: Avoiding Penalties Isn't the Only Reason to Comply

written by Thomas Dent, M.D. | January 13, 2016

At the heart of CMS's Public Health Reporting Requirements for Meaningful Use is a basic premise: EMR technology must facilitate tracking of public health trends and long-term outcomes improvement. That is why all providers in the Meaningful Use program, regardless of specialty, are now being required to engage in public health reporting to avoid a penalty.

Many specialists don't see the point of reporting for public health reasons or find it too difficult. While it's true that specialists face some specific challenges that require dedicated reporting to fit their clinical operations and to avoid professional and financial risks, there are some clear advantages, as well, to complying with the new requirements. Here's what you need to know to make the most of public health reporting:

Choose a Specialized Registry for Public Health Reporting

Providers may choose among three options for meeting public health reporting requirements: an Immunization Registry, a Syndromic Surveillance Registry or a Specialized Registry. Specialized Registries, which include All-Specialty Registries as well as those associated with specific areas or specialties—such as birth defects registries, chronic disease registries or traumatic injuries registries—have the greatest utility for most specialty care providers.

For the Public Health Reporting Requirements of Meaningful Use (MU) in 2015-2017, Specialized Registry reporting was deliberately defined rather loosely and encompasses reporting to a Clinical Data Registry (CDR). A CDR is also used for provider reporting to CMS on

quality measure performance for the PQRS program and, in some cases, for the Meaningful Use Quality Measures. Note that in Stage 3 of Meaningful Use (required in 2018), reporting to a CDR for MU will be spun out of public health reporting and must be fulfilled separately. If all of this seems confusing, it is. CMS cross-links and overlaps different programs for quality measurement and value-based performance.

What's important to remember is that the public health reporting option of Meaningful Use is provider specific, based on the provider's NPI. This is particularly important for specialists, who often are not as actively engaged in group reporting through ACOs and the Group Practice Reporting Option, but who must be engaged in public health reporting or end up paying the price.

Understand How Public Health Data Is Attributed and Reported

So what does public health reporting look like for specialists, and what will be the value—and risks—of a Specialized Registry for specialists?

1) Specialized Registry data will facilitate long-term performance improvement. Because specialists are often more closely associated with specific outcomes such as cancer survival, surgical outcomes and cure of certain diseases, having access to this data will be advantageous for specialists. For the first time, there will be a wealth of outcomes data that can be put to real use in outcomes research as well as performance improvement programs. Analyses of similarities and differences in groups will pinpoint clinical treatment issues that cannot be seen within a single practice or smaller group of providers. An All-Specialty Registry will have the distinct advantage of helping providers see outcomes for the same diagnosis or procedure across different specialties.

2) Benchmarking will emphasize comparisons among specialists. Benchmarking is a basic requirement of a Specialized Registry; comparison is inevitable. Benchmarked data produced by a Specialized Registry from provider reports will ultimately be important to patients, referring physicians or an organization looking to select or retain providers. You might say the specialist has greater professional and financial risk than the PCP. There is generally more competition among specialty care physicians within the same specialty than among primary care physicians, so the specialty care physician must remain engaged and vigilant as Specialized Registry reporting results become available.

3) Data places referral management and collaboration under scrutiny and will reveal specialty gaps in communication. When a large multispecialty group employs the specialty care physician, data from other physicians in the group may be used to track how well physicians collaborate to manage patients. Referrals are the life-blood of certain specialists, so referral

management is an area of particular importance to specialty care.

Referrals from outside the group won't be captured, but the specialist in the group practice should close the referral loop for colleagues within the practice, and this should carry over to external referrals. This is a Meaningful Use measure for the referring physician, which means that the measure can be structured to do double duty to assess the consulting physician. If, as a primary care physician, I don't get a consultation report back from the ophthalmologist for my diabetic patient, I can't report on one of the quality measures for diabetes (e.g., whether or not the patient with diabetes mellitus had a dilated eye exam in the past year). The actual quality of the consultation or the outcome of the specialist's care is another matter that Specialized Registries will need to address. In the near future, PCPs will be charged with reporting this information to a Specialized Registry.

4) Specialized Registry data will highlight comparison of outcomes, which are more closely attributed to specialists than PCPs. Tracking of outcomes is important for all physicians, but outcomes are generally more closely attached to specialists than primary care physicians. This is particularly the case for procedural specialists. Specialists should choose a Specialized Registry or CDR that enables the provider to see outcome results and make corrections or add explanatory information. While specialty care physicians often articulate that assessments based on outcomes are preferable to processes, they will need to be closely monitoring the outcomes data to ensure that this information accurately reflects their real results.

5) Specialized Registries will put emphasis on performance improvement over time, versus tracking of static performance measures. For all physicians, the CDR and Specialized Registry should lead to performance improvement, which will be critical starting in 2018, when many of the current quality measures will be reassessed and, likely, retired. This requires tracking results or outcomes of interventions—the actions taken to improve performance. The focus is on tracking and understanding changes (the delta), rather than meeting a specific outcome at a specific point in time.

6) A Clinical Data Registry is the best resource for performance improvement. But defining the necessary steps involves more than simply showing data to providers and expecting them to immediately understand the implications or to recognize how the results may vary across sub-populations (which need to be separated out).

Public health reporting, particularly for specialists, requires attention to detail and nuance, but should not be cause for fear. It does not reflect on your value as a physician in your specialty but, rather, serves as a tool to assist you in improving patient outcomes.

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