Putting the "Meaning" in MU Public Health Reporting: How to Move Beyond "Check the Box"

written by Theresa Hush | November 25, 2015

Can Medicare influence health care delivery via the "public health" reporting requirements of the EHR Incentive Program? That question is central to the updated EHR Incentive Program (more commonly known as Meaningful Use, or "MU"). The answer boils down to a fundamental choice: whether providers view the external reporting Objective as just one more compliance effort, or an opportunity to improve.

Apart from governmental reporting, Modified Stage 2 of MU requires eligible providers to submit data reporting to one of three types of "public health" registries: immunization, syndromic surveillance and Specialized Registries. This is reporting for the public good, and one of the first of its type to be encouraged by the federal government in health care, distinct from accreditation, certification or reimbursement requirements.

While the new rules consolidate the reporting options in 2015 and permit some exemptions in view of late federal rules, this flexibility will disappear in subsequent years. At the same time, the payment adjustment for failure to meet MU will increase.

Medicare's intent is clear—the government's investment in rewarding EMR adoption should have a payoff in better public health. Yet, like other Medicare and commercial quality programs, this only works if providers can and do access the benefits of public health reporting. What will it take for this to happen?

Public Health Reporting Obstacles

One issue that can distance providers from getting value is the status of the public health reporting environment. Providers and health care organizations have challenged the MU reporting not only because of the work involved and the issues with their EMRs, but also because there are difficulties in the industry. Medicare's concessions have responded to some of these concerns through timing adjustments and exemptions for reporting, but not in substance.

1. Readiness of Public Health Reporting Repositories. Many (but not all) states have established Immunization Registries that facilitate public reporting under Meaningful Use, and some have defined specifications or standards for data feeds. However, expertise and system development varies among states, and technologies range across the spectrum, from simple portals for providers to submit or research immunization data, to sophisticated technology. Some states with Immunization systems do not have a process or data reporting standards for MU, while others have detailed instructions and HL7 guides and testing processes.

Across state public health departments, syndromic surveillance is newer and less developed than immunization systems. The Centers for Disease Control (CDC) is facilitating by publishing information about states' developments, data standards and Meaningful Use requirements for these two types of public health reporting. But this effort is still in an early stage.

Specialized Registries (and Clinical Data Registries, or CDRs) are a third, rule-specified avenue for providers to meet MU requirements. Some specialty society Registries have been developed over many years around surgery, cardiology and cardio-thoracic surgery and other diseases or branches of medicine, but have relied on voluntary reporting or piggybacking on other data collection programs. The more recent entries into the Specialized Registry/CDR arena have evolved from PQRS and commercial performance measurement and population health. These Registries cross all specialties, can support all MU quality measures and outcomes, and potentially have their own technology and processes for data collection.

ICLOPS is one of these Registries. We believe they hold great promise, not only for quick collection of data from Meaningful Use and other programs, but also for providing a single-source entry point for data that can then be fed to other more specialized entities. The issue with reporting to Specialized Registries is one of awareness, since there is a lack of centralized information on who exists and is ready.

2. Fragmented Data. Even when states' systems are fully realized, the existence of state-by-state systems will reduce the reliability of data on immunizations. Patients are mobile, and state boundaries do not define how health care is received. For syndromic surveillance data, the value of data beyond infectious disease can be enormous, but it will require uniformity

across states and a consensus of purpose, which will certainly take time.

Even for Specialized Registries, which tend to be national in scope, fragmentation by disease category or physician specialty is a hindrance to evaluating the efficacy of outcomes and performing improvement across all specialties. To achieve better value and greater interest, providers will need improved access to data collected by Specialized Registries as well as the other public health agencies, and data sets will need to be available for research, analysis and comparisons.

3. Few Bi-directional Interfaces Between State Systems and Providers. For state systems to achieve the best value of immunizations data for providers, the patient's status at point of care and in population health modules should be clear. But if reporting is only one-way, from provider to state or registry, providers can't derive the value of reported data without additional work of looking up the patient. Interconnectivity between systems with bi-directional functionality will be an important precursor to value for providers.

In the same way, Specialized Registries or CDRs will need to offer ways to view outcomes that are integrated with the providers' EMR. While the heavy lifting of analyses and research can remain in the Registry's sphere, the EMR or a readily accessible portal of the EMR to the Registry may well be the best vehicle for seeing that data in context of both patient visits and for general performance improvement. In the current competitive environment, this will be challenging—but it is achievable.

Overcoming Provider Obstacles in Public Health Reporting

We've reviewed the issue of whether providers can receive value for their efforts in MU. There is also this question: Will providers strive toward getting that value, or simply check the box on the MU attestation, get a receipt for dumping their data into one or more reporting repositories and consider that they've done their job?

There is precedent for the check-the-box method: PQRS. Perhaps health care idealists once believed that measuring performance through PQRS would pave the way for providers to really examine performance (I confess). And in many health systems this has led to more activity. But it is also true that PQRS reporting has been commoditized into a compliance effort without any understanding or connection to the value of the data. Providers are busy and simply want to get the job done. Or, they see it as busywork. They may not have had the opportunity to see the underlying data—it might not even have been shared with them.

Overcoming these attitudes will take several collaborative and technology development steps that pave the way for providers to get better value:

1. Value from Enriched Data of the Specialized Registry/CDR. Many EMRs provide some benchmarking information to their providers, so encouraging providers to use CDR or Specialized Registry data will require more than just a bigger data set. Developing methods of analyses and identifying associations in the data could trigger providers' interest for more and must be a part of the Specialized Registry value. By definition, the Specialized Registry/CDR focuses on outcomes over time and the improvement of those outcomes; the creation of outcome sets, associations and episodes over time will be essential to consider—along with risk adjustment and special analyses of data. In short, the Specialized Registry/CDR will have to look more like a collaborative research entity and less like a technology or data repository to have value, because data is becoming a commodity.

2. Transparency to Providers. Unless providers can see and interact with their data (as well as question and dispute it), there will be little value, because providers are not engaged. As we have seen from years of stagnation in efforts to fix our health care system, a centralized system of performance measurement with top-down information is not very effective. Whether this transparency will involve portals accessible via the EMR, or direct displays of information to provider, or some other means of EMR-CDR integration, is not clear, but we will have to enable a collaborative environment to achieve it.

3. Easy and Cheap Data Transfers. EMRs and Specialized Registries/ CDRs need to do advance preparation for data aggregation. Providers will make choices; if the data stream can be developed in advance, it will be cheaper to do this on a large scale than one-by-one. Nothing will alienate the client provider faster than difficulty with data transfers from the EMR to meet reporting requirements. EMRs will be vulnerable to charges of not being Stage 2-ready, and Registries will have a difficult time proving any value if they cannot accommodate EMR data.

4. Coordinated Registry Activities. MU reporting to several out-bound data vehicles will be problematic, but collaboration among various Registries can manage this. The broadest CDR can collect data and parse it out to various Specialized Registries, as well as to immunization and syndromic surveillance, with benefit to providers, EMRs, various Registries and their outcomes and research efforts. This may be health care idealism, but the possibility exists—along with an enormous benefit in economy of effort.

5. Ability to Reduce Providers' Self-Financed Data Efforts. The current environment is fueled by data collection and analytics efforts that are dedicated and private to every health system or provider group. Vendors and consultants have built up proprietary solutions that re-deliver the providers' own data in needed and digestible nuggets. This won't change, but with the aggregation of data under public health reporting, there should be a mechanism to reduce the costs of benchmarking, while increasing the availability of data and allocating provider

financing to performance improvement.

6. Availability of Specialized Registry/CDR Information, Guidelines and Documentation. Apart from the Qualified Clinical Data Registry list from CMS, nothing exists at this point to help providers understand what they can get from public health reporting. Enough said. That needs to be rectified, STAT.

The positive benefits of public health reporting? We envision a future in which having data is less of a struggle, where there is an alignment of interests in collaborating to produce better outcomes for people. This will not be easy to achieve, if only due to the complexity and disappointments of enduring many years of change. But speaking as a health idealist in a Specialized Registry/CDR, I believe this is a goal well worth the effort.

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