

PLANK 6

Registry Used to Track Hypertension Patients

A method is in place to identify all hypertension patients before each visit and to note whether they have co-morbid conditions that could affect their BP control, whether they are at goal, and whether there are gaps in care. Outreach should be performed to patients who miss scheduled appointments or are overdue for a follow-up visit, according to protocol.

What Is a Registry?

Effective chronic illness care is virtually impossible without information systems that assure ready access to key data on individual patients as well as populations of patients. A comprehensive clinical registry can enhance the care of individual patients by providing timely reminders for needed services, with the summarized data helping to track and plan care. At the practice population level, a registry can identify groups of patients needing additional care as well as facilitate performance monitoring and quality improvement efforts. Specific functions that registries provide often include:

1. Patient lists, a “population” view that includes all patients who have a particular chronic condition or should be receiving certain types of preventive care, such as screenings and immunizations
2. Decision support tools used at the point of care, making providers aware of the patient’s status on preventive measures and recommended care for chronic conditions, even if the current visit is for an unrelated acute problem
3. Exception reports to identify patients who are not meeting management goals, ideally with some form of priority ranking, which can be used to drive patient outreach initiatives
4. Predictive analytics, identifying those patients who are at greatest risk for poor outcomes or unusually high resource use over the coming months, which can be used to prioritize individualized case management interventions
5. Progress reports to examine provider and staff performance in delivering recommended care
6. Population-level reports that monitor patient status and outcomes, which can be helpful in quality improvement and resource planning
7. Benchmarking reports and population dashboards
8. Risk stratification of patients
9. Automated notifications and communications

What Should I Look for in a Registry?

Conceptually, Electronic Health Registries (EHRs) and disease registries are complementary. EHRs focus on the care of individual patients, while registries provide a population view. EHRs focus on patients who are being seen, while registries identify patients who are not being seen but should be.

Early registries were separate from EHRs and varied from Excel spreadsheets to large-scale databases, but increasingly, EHR vendors are integrating registry functionality. This avoids duplicate data entry, which is costly and error-prone, as well as duplicate maintenance of chronic care guidelines.

A key issue is how the registry data are populated. Are patients included solely on the basis of problem lists or diagnosis codes on claims, or does the system search clinical data such as lab results and prescribed medications to identify patients who may have a chronic condition but no problem list entry or diagnosis code?



Supporting Literature and Resources

Office of the National Coordinator for Health IT (ONC). What is a disease/immunization registry?
www.healthit.gov/providers-professionals/faqs/what-diseaseimmunization-registry
Introduction to disease registries and criteria for selection with resources from AHRQ, HRSA, and the Office of the National Coordinator for Health Information Technology.

Suggested AMGA Case Study

Providence Medical Group: Developing Effective Interventions to Support Patient and Provider Co-Management of Hypertension
www.amga.org/Research/Research/Hypertension/Compendiums/providence.pdf

Because of the complexity of setting up registries and the variety of EHRs used at healthcare organizations, no tool is provided for this plank.

