Ready for Registries?

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At Jefferson Medical College, our faculty’s practice plan, consisting of 450 physicians, is on the road toward implementing an ambulatory electronic medical record (EMR) in the next two years. We embrace the important contribution that an EMR can make in decreasing medical errors and improving the quality of ambulatory care. We also are cognizant of the burgeoning number of existing pay-for-performance programs, and we intend to compete vigorously, based—in no small part—on our documented improvement in performance.

However, I am acutely aware that an EMR is not a panacea. Changing the systems of health care can go a long way toward improving quality, but an EMR by itself cannot improve those systems. It takes a rigorous self-evaluation and a willingness to question every aspect of practice to achieve progress withinin the systems upon which we all rely.

As a result of this understanding regarding the systems-based nature of health care, I am intrigued about registries for chronic disease and the role that they might play when they are grafted onto an EMR platform. First, let me offer some definitions of a clinical or disease registry and then examine how it might be employed in practice. We can then speculate about its future impact.

Although there is no generally accepted definition of a disease registry, it is usually thought to be a “computer application used to capture, manage, and provide information on specific conditions to support organized care management of patients with chronic disease.”1 Disease registry support has come to be called the “chronic care model,” often promoted by Ed Wagner and colleagues, and it has been extensively described in the literature.2 Registries can be used in at least five ways:3

- They can generate performance feedback reports to physicians on patient levels of glycosylated hemoglobin and other clinical endpoints.
- They can provide physicians with exception reports that identify patients who are not receiving care according to practice guidelines or whose laboratory values remain out of therapeutic range.
- They can create point-of-care reminders that summarize the tasks for a patient’s care and identify which tasks are imminent.
- They can produce reminder notices to be sent to patients when care management tasks are due.
- They can be used to create lists of high-risk patients to show which patients require more intensive management.

There is mounting evidence that registries that are linked with patient reminders are associated with statistically significant improvements in medical care by all available indicators.

Do these registries work in everyday practice? How are they related to P&T committees?

Recent reports3 have demonstrated, in both large and small practices, that registries—even those that are not computerized—enable physicians to close the feedback loop for performance improvement. Registries thus provide physicians with information about their own practices, in a nonpunitive way, in relation to a local peer group. When handled appropriately, this information enables physicians to evaluate themselves and to seek ways to improve health care.

It might be an uphill battle in a number of settings, but I am convinced that when doctors are given the opportunity to review their own performance, compared with that of their peers, they will stam-pede to improve. I frankly do not care whether the medical practice has five doctors or 450 doctors, as we have at Jefferson.

Recently, major national not-for-profit foundations, such as the California Healthcare Foundation, have studied both computerized and non-electronic disease registries. The foundation has provided us with an unbiased review of these registries and has helped us understand the various types, their function, their cost, and their workflow design, as well as how to choose between a registry and an EMR. More information is available at the foundation’s Web site (www.chcf.org) under the topic “computerized disease registries.”

However, there is still a dark side to the registry story. In a report from 2005, researchers found that disease registries were not used by 50% of the surveyed physician organizations in the nation.1 They found this fact to be disturbing, because registries have the potential to bring about needed improvement in health care management for chronic care patients. What can we say about the 50% of practices that are not yet on board?

Disease registries are inextricably linked to P&T committees. Here is how the process might work:

A physician practice would decide how it is going to tackle various chronic conditions according to guidelines that are readily available. Using these national guidelines, the practice would also decide which family of pharmaceutical products is appropriate for each clinical condition. The P&T committee would then evaluate the choice of pharmaceutical agent based on the practice guideline and would endorse or modify it as needed. In this manner, P&T committees help “bake” the appropriate pharmaceutical choice into the disease registry, if you will.

So, here are some key question for the future:

- Is your workplace ready for registries?
- Has your P&T committee raised the topic of registries with your practitioners—whether they are in small physician groups or in large multi-specialty, medical school-based faculty practices?
- Have you been able to demonstrate

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that registries are directly linked to improved health care of patients with a chronic illness?

I believe that the topic of registries for chronic disease is a fertile territory for additional health services research. There might be a great deal for us to gain as we adopt these registries more fully.

As usual, I am interested in your views. I would also like to hear from readers who have used any proprietary Web-based or pen-based chronic disease registries.

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REFERENCES

