Notes from April 5, 2013 on Qualified Clinical Data Registries

What is a registry, when considering the Guiding Principles described by ONC/CMS?

-NL:This should be defined more broadly than the offering of societies.

-RB (CHIME) the purpose of the legislation, was indeed just that.

-Much of the EHR reporting that currently is done continues to require some entity/intermediary to manage the data.

-For purposes of this group: a registry meets our needs to ensure data validity, perform analyses and deliver reports to providers/payers.

What requirement will registries have to deliver on the above?

-DK (OK Beacon) There remains a considerable challenge in getting data out of EHRs. What we found was that we have to design our measures to the CCD (or to the 2014 Standard). We needed measures that fit the standards and vice versa. If registry measures were specified to chart abstraction, then they will continue to require herculean efforts for data capture and transmission. EHRs should minimize effort for data transfer and automate the reporting process to registries.

--Have to use the standards to MU.

--Has to be trigger to automate send.

--There has to be fwd and backwards compatibility.

--The HIEs have made more progress. There are requirements on both ends (from both EHRs and QCDRs). If QCDRs will calculate new CQMs they should be constrained by what is being captured and transmitted for MU.

DL: Our joint replacement registry in California has been working in this space with direct data transfers from EHRs.  The value in the registry  is in data integration. The challenge is interoperability.

-Another goal for registries as well is to add a patient engagement and PRO capabilities

-Skeptical that registries have sophisticated measure production, especially for EHR based measurement

-Benchmarking and feedback on quality and data to physicians will be valuable.

TC: Then what we are describing are the core capabilities for QCDRs:

**- Interoperability:**

        -EHR must allow “automatic” export of  relevant data to registries

         -Registries must accept standardized EHR outputs and design quality use standardized terminologies for CQMs

**-Data quality**

                -Registries must ensure that data from EHRs are accurate, credible, and timely

                -(CDamberg)Audits will be required: ?both form the payer to the registry and from the registry to the provider

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