Definition of a Disease Registry

- A disease registry is a special database that contains information about people diagnosed with a specific type of disease.
- A population-based registry contains records for people diagnosed with a specific type of disease who reside within a defined geographic region.
- CCHN/IDS is creating an electronic diabetes registry that will include most of the diabetics in Chautauqua County.
History

- With P2/UNYNET, CCHN collected and analyzed data for a Diabetes registry in an 18 month project starting in January 2009.
  - Incorporated all diabetes patients from 4 PCP's.
- In July of 2009, a Diabetes patient registry for our Medicare Advantage plan was implemented.
  - Has ran for two years and incorporates about 500 diabetic patients.

Birth of an Integrated Registry

- We wanted a common registry that would encompass the entire county.
- CCHN wrote a grant to get it started in the Winter of 09-10 and was officially awarded in August 2010.
  - Chose Covisint/DocSite as our web-based electronic patient registry.
- Initial focus is on Diabetes and then moving to Cardiovascular disease.
**Goals**

- **Project Goals:**
  - To align 14 independent primary care practices (80+ providers) under a common Electronic Patient Registry system.
  - Monitor/analyze performance metrics to improve population health.
  - Provide QI support to enable practices to engineer and integrate workflows to improve performance through coaching, care coordination, and collaborative learning.

---

**Key Quality Performance Measures**

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>Less Than 140/90 mmHg</td>
</tr>
<tr>
<td>Blood Glucose (HbA1c)</td>
<td>Less than 8.0%</td>
</tr>
<tr>
<td>LDL</td>
<td>Less Than 100 mg/dl</td>
</tr>
<tr>
<td>Urine Screening for Microalbumin</td>
<td>Annual Screening</td>
</tr>
<tr>
<td>Dilated Eye Exam by Ophthalmologist or Optometrist</td>
<td>Annual Screening</td>
</tr>
<tr>
<td>Influenza vaccine</td>
<td>Annual Immunization</td>
</tr>
<tr>
<td>Pneumonia vaccine</td>
<td>One-time Immunization</td>
</tr>
<tr>
<td>Body Mass Index (BMI)</td>
<td>Less Than 25 kg/m²</td>
</tr>
<tr>
<td></td>
<td>Less Than 30 kg/m² (Age 65+)</td>
</tr>
</tbody>
</table>

Hospital admissions and readmissions for diabetics, as well as, diabetics suffering from congestive heart failure will also be tracked.
Why Collect Data?

- Evaluate clinical performance
  - Goal is to better manage chronic, complex, and preventative health needs.
- Increase patient compliance,
  - Individual patients, as well as, the entire targeted population.
- To drive point of care tools:
  - Real time alerts, reminders, and feedback to identify required additional screening, education, and/or care coordination services.
- Ultimately improve outcomes.

Care Coordination

- In pursuit of the goal of improving outcomes, CCHN/IDS will be utilizing various models to assist patients in receiving the best possible care.
  - Registry will assist staff in identifying the need for:
    - Scheduling nurse visits, outreach and telephone follow-up, education and coaching, etc.
    - Referrals to the Chronic Disease Self Management Program
  - Consumer Engagement & Education Activities
Successes and Challenges

- Established links to the HEALTHeLINK regional health information exchange to enhance data collection.
- Data flow processes have been established for pilot practice.
- Data mapping is tedious, but very important.
- Working with various vendors to create an interoperable solution that works for everyone – Tough but ultimately worth it!

Thank You!

Any Questions?

Kalan Brown
brown@cchn.net
CCHN/IDS
200 Harrison St
Suite 200
Jamestown, NY 14701
716.338.0010