

## **AQA Principles in the Use of Registries for Enhancing Quality of Care through Performance Measurement**

### **Overview:**

Clinical data registries are currently used for several purposes, including managing the care of individual patients, and understanding and monitoring the process and outcomes of care. Clinical data registries have been established for chronic diseases, acute conditions, and for procedures, treatments, and medical technologies. While there is increasing demand for information on physician performance, at present, monitoring physician performance through the use of clinical data registries is limited. Potential uses for data registries include quality improvement, public reporting, quality based payment, maintenance of board certification, and privileging.

The purpose of this document is to set forth principles for the design, development, and use of information from existing and future data registries to enhance quality of care through performance measurement.

The following principles should apply to those registries that are created for the purpose of performance measurement.

### **Content, Structure and Access**

- 1) Registries should be populated with clinical and administrative data as required to appropriately measure quality.
- 2) Data should be collected in a manner that minimizes burdens and disruptions to physicians, physician groups, hospitals, integrated delivery systems and health insurance plans.
- 3) The breadth of registry-based measures and measure sets should cover all medical specialties, where appropriate, and should take into account the predominant disease states and patient population cared for by a physician, and should cover a critical spectrum of a physician's practice.
- 4) Registries may apply to more than one specialty. Therefore, registry-based measures and measures sets should not be solely assigned to single specialties for the sole purpose of attempting to reduce the measurement burden of other specialties. Not all measures potentially assignable to a physician specialty, or based on the physician's disease burden being treated, need to be used.
- 5) Data submitted to registries should enable comparative reporting to inform choices, quality improvement or quality assessment.
- 6) Data sources should be multi institutional with agreed upon policies for data submission.
- 7) Registries should have an infrastructure to support and maintain expansion in data capacity and analysis of trends.
- 8) Registries must meet all rules that assure compliance with HIPAA.
- 9) Where possible, registries should include data that helps define appropriateness. Registries should include data elements that would allow for some judgment of appropriateness including antecedent patient characteristics.

- 10) Resources required to establish, maintain and contribute data to registries should be fairly distributed among all who benefit. The physician contribution should not exceed the "in-kind" cost of collecting the data in the office environment.
- 11) All methodologies used to aggregate and analyze submitted data should be transparent to both those participating in the registry and to those who receive reports from the registry.
- 12) All registries should allow participation by any interested physician within the group that is sponsoring it.

### **Interoperability**

- 13) Publicly available protocols that encompass common nomenclature, data definitions, data collection, sample size, sampling and data transfer protocols (when appropriate) and reporting format should be standardized among institutions reporting to the registry.
- 14) To the extent that data on the same procedure(s) is transmitted and collected by multiple registries (e.g., different specialty societies collecting data on the same clinical procedure), data collection and submission procedures should follow the same data field definitions, protocols, and methodology. Ideally, national standards should be used or developed whenever possible.
- 15) To ensure appropriate data comparison, data must be risk-adjusted according to an agreed upon methodology.
- 16) Where possible, registries should be able to accept the electronic transfer of data.

### **Data Integrity**

- 17) If a centralized registry is being used for quality improvement it should to the extent possible contain data that is nationally representative, both geographically and demographically. If data submitted to a centralized registry is not nationally representative, appropriate statistical methodologies should be applied to ensure that reports from the data registry accurately reflect the population.
- 18) To ensure adequacy and quality of submitted data, an independent verification process (audit) must exist for each registry ensuring that data was entered, analyzed (where applicable) and transmitted accurately.
- 19) Individuals inputting data must be adequately trained and participate in additional training as needed. Training protocols and records of training should be available for audit. Training should be easily accessible for all individuals participating in registries.
- 20) Health data registries should be built to minimize human factor errors and entry.
- 21) Centralized registries should have a mechanism for accepting corrected data from both internal sources (e.g. managed care organization analysts) and external sources (e.g. practitioners receiving the registries). Corrections should be subject to the same accuracy and audit standards of other data in the registry. It should be possible to correct any of the data elements in the registry, as well as whether or not the patient has been correctly assigned to the registry.