

USE A PATIENT REGISTRY



An up-to-date registry exists and is utilized to identify all patients with Type 2 diabetes. Reviewed prior to a patient visit, the registry will inform the care team if the patient is not meeting care goals. Outreach is performed to patients who missed scheduled appointments, have gaps in care, or are overdue for follow-up.

Just as an electronic health record (EHR) is an essential tool for caring for individual patients, a registry is essential for managing populations. EHRs provide a single-patient view with clinical decision support to apply evidence-based protocols to each patient and workflow tools to support team-based care. Patient registries aggregate EHR data on individual patients to provide a population view.

Conceptually, a registry is layered on top of an EHR, integrating key data on all patients who make up a certain population, such as all patients with Type 2 diabetes. This cross-patient view may be a separate system or simply an additional module from the EHR vendor. Registries can also be used for risk stratification, which can range from simply identifying patients whose HbA1C is above their individual target to using statistical predictive models that use trends in multiple lab values and historical utilization patterns to stratify patients by risk of a hospital admission.

Many times, EHRs and registries overlap in terms of applying care protocols prior to, during, and after a patient visit. The EHR, for instance, ensures that all of a patient's chronic conditions and preventive care needs are addressed at every visit. Meanwhile, a registry applies the same protocols to patients who are not scheduled for a visit, to identify patients for outreach.

For organizations that possess a functioning registry, awareness and training is essential as well as protocols and accountability embedded into workflow for how the care team utilizes the tools. Ensure the data is timely and accurate, and create a feedback process to improve data quality.

PRIOR TO THE VISIT

Registries can facilitate pre-visit planning to assure efficient use of office visits. A list of patients with Type 2 diabetes who require labs and preventative services is reviewed by the team. For example, standing orders can be implemented to facilitate ordering of required tests and services prior to the visit. Ensure care teams have access to registry reports with adequate time for pre-visit planning.

DURING THE VISIT

Notifications or alerts are communicated to the provider during the patient visit about specific recommended tests or services. Sharing reports with the patient during the visit can empower patients to self-manage their disease by promoting discussion about self-management and progress toward goals.

AFTER THE VISIT

Care coordination can be enhanced between practice visits by outreach to patients needing additional services. Many patients identified as being at greatest risk for poor outcomes can be prioritized for case management. The registry can provide population-based results for quality improvement. Feedback about performance on specific measures can direct the team's diabetes improvement efforts.