The AAN’s Axon Registry
Mastering how we are measured

Policymakers and payors are incentivizing the transition away from primarily fee-for-service reimbursement for the volume of services and procedures performed toward rewarding value, defined as (quality + patient experience) divided by cost. The shift from volume to value will ultimately apply to all practices, regardless of type or size.1,2

To date, reimbursement for participation in quality reporting programs has mainly consisted of incentives or penalties added on to traditional fee-for-service claims-based payments, often in a lump sum long after the billable services were rendered. Quality is now becoming more tightly integrated into alternative payment models (APMs). The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), set to start in 2019, will consolidate existing quality programs into the Merit-Based Incentive Payment System. Participation in APMs will be strongly encouraged.3

Quality measures can be reported via claims, paper, electronic health records (EHRs), and qualified registries. While most EHRs were not designed for rigorous performance measurement and reporting, a clinical registry—an observational database focused on a clinical condition, procedure, therapy, or population—is ideal for these tasks.4,5

The best registry for reporting health care quality measures is a Qualified Clinical Data Registry (QCDR), an entity approved by the Centers for Medicare & Medicaid Services (CMS) to collect medical or clinical data to foster improvement in the quality of care provided to patients.6-8 QCDR participation requirements include benchmarking capability, risk adjustment plan integrated with measure specifications if applicable, data validation, and public reporting.

Data submitted to CMS via a QCDR are not limited to Medicare beneficiaries, and cover quality measures across multiple payors. QCDRs can incorporate quality measures not included in the CMS Physician Quality Reporting System (PQRS), such as the following:
1. National Quality Forum–endorsed measures
2. Current 2016 PQRS measures
3. Measures used by boards or specialty societies
4. Measures used in regional quality collaborations

A QCDR represents a much higher bar compared to the current relatively haphazard system in which government and third-party payor programs specify which quality measures count. Most current quality measures that affect payment are designed to reflect primary care physician practice. Few are relevant to neurology.

In this issue of Neurology®, Sigsbee et al.4 present the American Academy of Neurology’s new QCDR, the Axon Registry. Our QCDR includes neurology-specific quality measures that will give us information previously unavailable regarding the quality of care delivered to our patients. Neurologist participants will own their data, will have an easy way to submit PQRS data to CMS, and will be well-equipped to participate in APMs and future MACRA value-based payment programs.

The core principle of medical informatics is “you can’t manage what you can’t measure.” The corollary is if we do not measure, we cannot manage; instead we will be managed. With the Axon Registry, CMS and other payors can endorse measures that matter to neurologists, measures that are patient-centered, driving the best possible health outcomes for our patients. It enables us to be graded on performance measures that are aligned with our specialty. Furthermore, our QCDR will not be a static repository. We can test our quality measures and modify them if needed, based on data from the registry.

The Axon Registry is approved by the American Board of Psychiatry and Neurology as a Maintenance of Certification Part IV Improvement in Medical Practice Clinical Module. Our QCDR may help users qualify for preferred provider networks, participate in APMs, and assess resource use. By linking to population-based databases, the Axon Registry may help to demonstrate the value of neurology by moving beyond analyses based on claims data, to establish neurology’s role in bundled payment systems and other APMs, to help revalue evaluation and management services, and to perform prospective, population-based studies of neurologic disorders using real-world data.9,10

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Go to Neurology.org for full disclosures. Funding information and disclosures deemed relevant by the authors, if any, are provided at the end of the editorial.

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The Axon Registry may allow neurologists to capture quality and outcome metrics automatically, streamlining tasks needed to fulfill documentation and regulatory requirements with minimal changes in clinical workflow. By reducing administrative burden, registry use should decrease burnout and increase satisfaction with practice.11,12

The key issue now will be to define the most important patient-centered quality measures reflective of best practice; typically, these are measures related to the structure, process, or outcome of care that are then incorporated into our QCDR.8,15

The success of a QCDR depends on its integration with the user’s EHR. If there is poor integration, parallel records must be maintained, which is time-consuming, burdensome, expensive, and disruptive to workflow. Some registry implementations have been impeded by the reluctance of EHR vendors and large health care organizations to share data they consider proprietary.8 Consistent data extraction algorithms are needed across different EHRs.8 If an EHR cannot effectively assist users in choosing ICD-10 codes with the highest level of specificity, quality measures and risk adjustment cannot be implemented with maximum effectiveness.

The Axon Registry will need regular external assessment to determine if the data are accurate and if the measures require updating as new evidence emerges.3 If data are not correct, misleading information could be published on CMS Physician Compare.7 CMS holds QCDR vendors responsible for successful implementation of their products and reserves the right to audit and potentially disqualify a QCDR.6

Looking ahead, we will be increasingly asked to integrate our services within larger, population-based systems. CMS recently released draft rules related to improved payment for care coordination services.14 This emerging shift to team-based health care delivery will need to be reflected in future quality measures.

Potentially, our specialty-specific QCDR could be an essential tool to ensure that neurology succeeds and flourishes in a rapidly evolving health care system that prioritizes value and coordination of care. If implemented properly, the Axon Registry will enable us to master how we are measured.

STUDY FUNDING
No targeted funding reported.

DISCLOSURE
Dr. Busis has received honoraria for speaking at American Academy of Neurology courses. Dr. Franklin has received honoraria for educational activities for the American Academy of Neurology. Go to Neurology.org for full disclosures.

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