and the ease of work with the medication administration process after implementation of a bedside bar-coded medication administration system and a medication dispensing system in an intensive care unit (ICU) at a tertiary hospital. METHODS: A prospective cohort study was conducted to compare medication administration time before and after these two interventions using a pre-validated instrument. The bedside bar-coded medication administration system was implemented in 2008 and the medication dispensing system was implemented in 2009. Perception of nurses regarding timeliness of completion, documentation burden, administration burden, and ease of detection of medication errors during the medication administration process were measured using a 5 point Likert scale - from 1 (Strongly Disagree) to 5 (Strongly Agree). Descriptive and comparative (t-test) analyses were conducted using SAS 9.2 to evaluate the impact of technological intervention on the nurses' perception. RESULTS: A total of 99 pre-intervention and 109 post-intervention responses were recorded for every medication administration process. There were significant improvements in timeliness of completion (p = 0.05) reduced from the pre-intervention period (2.8 ± 2.1) to the post intervention period (1.6 ± 2.2). Similarly, mean scores for documentation (pre: 3.2 ± 1.9 vs. post: 1.6 ± 2.2) and administration (pre: 2.8 ± 2.2 vs. post: 1.6 ± 2.2) burden also improved significantly (p = 0.05) after the intervention. There was no significant change in the perception score regarding ease of detection of medication errors (pre: 2.3 ± 2.3 vs. post: 1.7 ± 2.3). CONCLUSIONS: Nurses perceived less documentation and administration burden after the implementation of the technological intervention. These opinions help validate the role of health technology assessment in improving performance.

HEALTH CARE USE & POLICY STUDIES – Patient Registries & Post-Marketing Studies

PHP78 DEVELOPMENT OF A NEW SYSTEM FOR REGISTRATION OF PATIENT REGISTRIES

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OBJECTIVES: Patient registries are an important tool for clinical research, but there is no centralized database designed specifically to list patient registries. A searchable public database that is designed specifically to provide information about patient registries would support research collaborations, reduce redundancies, encourage the efficient use of resources, and improve transparency in observational clinical research. The goal of this project, funded by the Agency for Healthcare Research and Quality (AHRQ) to develop a Registry of Patient Registries (RoPR) system that meets the needs of a diverse set of stakeholders. METHODS: Stakeholders from a broad range of organizations and with varying levels of familiarity with patient registries were identified and invited to participate in a series of meetings to gather and refine the RoPR system requirements. Requirements were also reviewed through public comment periods and usability testing. RESULTS: Over 250 individuals participated in RoPR requirements gathering activities. Participants represented funding agencies (n = 48), government regulatory or public health agencies (n = 13), industry (n = 78), journal editors (n = 6), patient/consumers (n = 30), payers (n = 16), providers (n = 54), physician associations (n = 49), researchers (n = 78), and other (n = 21). Based on stakeholder feedback, it was determined that the RoPR will be integrated with ClinicalTrials.gov and will collect information on registry purpose, objectives, data collection, recruitment and follow-up, analysis plans, quality processes and, in collaboration and/or data sharing opportunities. CONCLUSIONS: The RoPR, which launches in September 2012, will be a publically available, searchable website designed specifically for listing patient registries. The information collected in the RoPR will enable RoPR users to identify registries in which they may wish to participate or that may be suitable for collaborative projects, such as data linkage or embedded studies. By incorporating stakeholder feedback throughout the design and development process, it is hoped that the RoPR will meet the needs of multiple, diverse stakeholder groups.

HEALTH CARE USE & POLICY STUDIES – Population Health

PHP79 CONSISTENCY BETWEEN SELF-REPORTED AND RECORDED VALUES FOR CLINICAL MEASURES

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OBJECTIVES: Concordance between self-reported blood pressure, cholesterol level, blood glucose level, weight, height and computed BMI with recorded clinical measures was evaluated. METHODS: The study sample consisted of employees and covered spouse dependents enrolled in a private insurance plan at a large state university. To be included in the study, individuals had to be 18 years or older and have completed health risk assessments. Data on self-reported systolic blood pressure, diastolic blood pressure, glucose level, weight, height, and cholesterol were taken from data recorded during health screenings. Pearson Correlation analysis was used to assess concordance between self-reported and recorded values. Mean differences, standard deviations and absolute differences between self-reported and recorded clinic measures were calculated to evaluate differences between self-reported and recorded clinical measures. RESULTS: A total of 12,752 respondents satisfied sample selection criteria. A majority of the respondents were older than 40 years (67%) and more than half were females (58.8%). High correlation ranging from 0.89 to 0.97 was observed between self-reported clinical values and recorded clinical measures for diastolic blood pressure, systolic blood pressure, cholesterol, BMI, glucose, weight, and height. Mean differences (95% CI) between reported and recorded values were low, diastolic blood pressure 0.86 mmHg (0.72 to 0.99), systolic blood pressure 0.99 mmHg (0.83 to 1.15), cholesterol 0.10 mmol/L (-0.25 to 0.44), BMI 0.71 (0.65 to 0.77), glucose 0.19 mmol/L (0.30 to 0.67), weight 5.35lbs (1.96 to 8.71) and height 0.05em (-0.04 to 0.09). CONCLUSIONS: Self-reported clinical values for blood pressure, cholesterol, glucose, height and weight had good concordance with recorded clinical measures in a privately insured cohort.