DATA REVIEW AND FEEDBACK PROCESS

Overview

The Oregon Health Care Quality Corporation (Q Corp) is dedicated to improving the quality and affordability of health care in Oregon by leading community collaborations and producing unbiased information. The goal of Q Corp's measurement and reporting initiative is to improve patient care by coordinating and consolidating quality and utilization information. Q Corp's data suppliers for Spring 2014 include 12 health plans, Centers for Medicare and Medicaid Services (CMS) and the Oregon Health Authority. This data includes patients who are enrolled in commercial, Medicaid, Medicare Fee for Service and Medicare Advantage plans.

Administrative claims data can provide information for a large segment of the Oregon health care delivery network. These data provide comparative assessments and statewide benchmarks that are not otherwise available. Physicians, nurses and medical group administrators who helped design the reporting initiative and have emphasized that providing medical group, clinic, provider and patient-level detail is essential if claims information is to be valid, trusted and useful.

Based on this feedback Q Corp offers an optional medical group review period following each release of data reports (spring and fall), which provides the opportunity for medical groups to have their scores reconsidered and recalculated. The purpose of this document is to provide instructions for accessing and viewing these detailed data, checking data for accuracy, and requesting reconsideration of data if applicable.

Section 1: Why Should Patient-Level Data Be Checked?

Medical group administrators and providers may choose to review patient medical records to validate and update the data provided in Q Corp reports. Patients eligible for a measure are included in patient data with an indicator showing whether or not there was a record of the service. This is an optional review process.

Typical reasons for medical record review include:

- **Public reporting** – Following the spring reporting period, results for a subset of measures are posted on Q Corp's consumer website for clinics that meet Q Corp's public reporting criteria.
- **Other reporting** – Medical groups may use Q Corp measures for other reporting initiatives, including OHA Patient-Centered Primary Care Home program recognition, CMS Comprehensive Primary Care Initiative gain sharing, health plan contracting, and others.
- **Q Corp data supplier files** – Following each reporting period, Q Corp returns medical group, clinic, and provider scores to its participating data suppliers.
- **Patient care** – Review the medical records of patients in the reports flagged as needing services to ensure services are still applicable prior to contacting patients.
- **Quality improvement** – Medical groups that use Q Corp's reports for internal quality improvement efforts may wish to review their data for accuracy.

- **Learn about care provided in other settings** – Review patient-level results for Q Corp's measures on potentially avoidable emergency department visits and hospital admissions for ambulatory-sensitive conditions. They contain important information about patient care provided in other settings that is not always communicated back to primary care providers and clinics.

Section 2: How Data Feedback Will Be Used By Q Corp

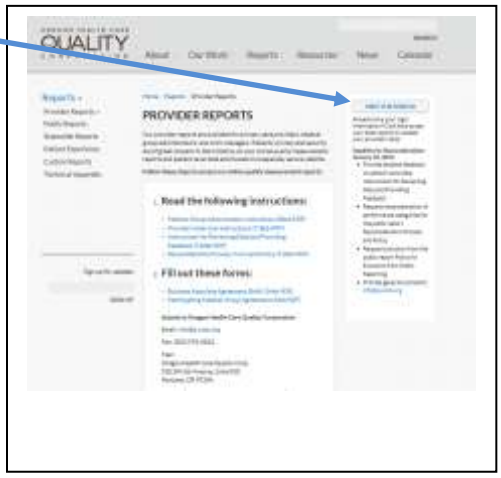
Feedback from medical groups and providers will be used to improve the measures, the measurement processes, and to shape Q Corp's data use policies. This includes processes for assigning patients to providers and clinics, and improving measure accuracy.

Section 3: Access Reports Through Q Corp's Secure Online Portal

During each data release, medical group managers receive hard-copy reports from Q Corp that contain information at the medical group, clinic, and provider levels. Groups that wait to receive hard copy reports will have substantially less time to review their data than groups that access their data through the secure portal at the beginning of the review period. Q Corp sends an email to the medical group secure portal administrator when reports are released on the secure portal. In order to protect patient and provider privacy and ensure HIPAA compliance, additional information – including patient-level data and clinic results – is available only through Q Corp's secure online portal. All online reports are available to view, print or download.

Access to the secure portal is required for this process; please refer to the document "Accessing Patient Level Detail Online" from our website http://q-corp.org/reports/provider-reports for detailed instructions on obtaining an online user ID and managing users within your group. The designated administrator may register other users within the clinic or medical group. This administrator can restrict access so that individuals can view data for only a specific clinic, or so providers can see data for only their own patients. The designated administrator will be responsible for eliminating privileges when users leave the clinic/medical group

To access secure data and information, go to http://q-corp.org/reports/provider-reports. Select the "VISIT THE PORTAL" button and follow the prompts that request the username and password.



Once on the secure site, reports can be accessed for the medical group, each clinic site and primary care provider. Information about patients included in each measure is also available. All reports can be downloaded into a spreadsheet or other formats. Printer friendly versions of reports are also available. Once logged in click on "My Reports."

Section 4: View, Sort, Export and Print Online Reports

If you are a clinic or medical group manager, you will have access to results for the clinics and providers within your medical group. The designated administrator controls how much of the data others can see. You can view, compare and analyze:

- Variation in scores by clinic
- Variation in scores by provider
- Individual or clinic scores to benchmarks
- Patient Export by Group / Clinic and Measure

If you are a medical group manager or clinic manager you can download all of the patient information for your clinic or medical group by selecting "Patient Export by Group and Measure" or "Patient Export by Clinic and Measure" under the "Export Data" section of the main reports page. Select the measure you would like to review and click on the "View Report" button on the right side of the screen.

This is the most useful Q Corp report for reviewing data discrepancies. The spreadsheet can be downloaded and compared to your internal Electronic Health Records system.

To **download or export data**, use the "Select a format" drop-down menu in the bar at the top of your screen, and choose your format of choice. You can download many file types including PDF, Excel, CSV file and other formats. Excel is recommended for most purposes. Then click "Export." After downloading, check the tabs in the Excel workbook, because multiple worksheets may have been created as part of the download.

To **print a report**, use the print function in your application after you export your data. For many providers and clinics, downloading and printing may be the easiest method for using the reports.

To **sort data** when viewing pages with patient-level data, you can select the small, filled arrows at the top of a column. For instance, if you are interested in looking at only patients who are non-compliant with a measure you can sort that column for easier access to the information.

Section 5: Process for Reviewing Data and Providing Feedback

As you begin checking data, it will be helpful to refer to the "Quality Corp Measures Description and Methodologies" document, available at http://q-corp.org/reports/provider-reports, for information on measure definitions and patient inclusion criteria. After reviewing reports and determining if you have feedback to submit to Q Corp you must return to the secure portal to submit this information in order to protect patient privacy and ensure HIPAA compliance.

Important note: Please, do not deliver patient information directly to Q Corp staff. *In the event that you wish to notify Q Corp of any inappropriate or inadvertent patient disclosures, please email info@q-corp.org*.

Select a quality or resource use measure report. Expand the report using the "+" sign until you are able to view the patient level details.

- Review your patients by measure.
- You may want to leave feedback for any patients in the measure results.
- Any patient with a red "**n**" in the compliant column is not in compliance and did not receive the service. Refer to Appendix A for discrepancy reasons.
- To submit feedback on a patient, click on the red exclamation point (**!**) to the right of the patient information.
- A new window will pop up with feedback information which will be transmitted to Q Corp. Choose the proper response from the drop-down box, and include a date with your response, if applicable. For situations not included in the drop-down menu, use the comments section.
- If the same error is found repeatedly, you may simply make a note of it and move on. You do not have to record this error for every patient, as you may have identified a systemic problem that needs to be resolved.

Additional tips – The following are generally not acceptable grounds for correction:

- Patient refused service.
- The wrong provider is assigned to patient, but patient has been seen in the clinic.
- Provider is not responsible for managing the services being measured.
- Service or screening was performed, but not during the defined measurement year.
- Disagreement with a measurement specification, or with the data collection process and/or method.

While we understand that administrative claims data have limited detail, the measures chosen by our Measurement and Reporting Committee tend to be conservative in nature. Patients are only included in a measure if we are highly confident the service is appropriate for them. Q Corp's measurement results may not match rates or results from a medical group or clinic's internal registry (where numerators and denominators are not comparable). If you are unsure about our measure results we would value having a discussion about how and why these data sources may vary.

Section 6: Q Corp's Review of Medical Group Feedback

The purpose of this section is to provide a transparent basis by which Q Corp reviews feedback entered through Q Corp's online secure portal by medical groups and providers.

Medical groups that wish to have their data formally reconsidered and their results recalculated **must return a completed Reconsideration Request form and enter all data corrections through Q Corp's online secure portal by the deadline.** The materials and deadline are posted at http://q-corp.org/reports/provider-reports.

At the end of the medical group review period, Q Corp staff retrieves and reviews all the patient-level feedback entered by medical groups through the secure online portal. (Patient identifiers are blinded to Q Corp staff.) One of the following four actions is set to occur during measure recalculation:

- **Exclude This Round** – Remove the patient from the measure denominator for this round of reporting; patient may reappear in future rounds if they meet the measure inclusion criteria.
- **Permanent Exclusion** – Remove the patient from the measure denominator; add patient to permanent exclusion list to prevent them from reappearing in future rounds.
- **Compliant** – Add patient to measure numerator.
- **No Change** – No change to the measure result.

The table in Appendix A outlines the most common feedback received from medical groups, and the corresponding action taken. Some types of feedback are evaluated on a case-by-case basis by Q Corp staff, with input from Q Corp's Measurement and Reporting Committee as needed.

Section 7: Q Corp Support

Q Corp staff is available to assist you with online and paper reports, data review and the reconsideration process. In addition, a recording of Q Corp's January 10, 2012 webinar, *Using Quality Reports to Improve Care*, is available at http://q- corp.org/resources/webinars/using-quality-reports-improve-health-care.

Q Corp is very interested in receiving input from medical groups, clinics, and providers and their staff so that the reporting process is continually improved.

If you already have a username and need assistance logging onto the secure site, retrieving a forgotten username or password, or for other technical questions, please call 877-514-8465 or email: medinsight.support@Milliman.com.

To provide input about the quality measurement reports or the measurement initiative, or to update medical group, clinic, or provider information, please contact us in one of the following ways:

Email: info@q-corp.org
Phone: (503) 241-3571
Fax: (503) 972-0822
Mail: Oregon Health Care Quality Corporation
Attn: *Karri Benjamin*
520 SW 6th Ave, Suite 830
Portland, OR 97204

Appendix A

Q Corp Process for Review of Medical Group Feedback

Discrepancy Reason	Other Required Field(s)	Action
This provider left the medical group. (Please provide termination date in date field.)	Date (mm/dd/yyyy)	**Exclude This Round** – if date occurs during or before the measurement year **No Change** – if date occurs after the measurement year
This provider is a specialist (not a primary care provider) and should not be assigned patients.		**Exclude This Round**
The wrong provider is assigned to the patient, but patient has been seen in the clinic.		**No Change**
Patient dismissed from clinic or transferred care. (Please provide date in date field.)	Date (mm/dd/yyyy)	**Exclude This Round** – if date occurs during or before the measurement year **No Change** – if date occurs after the measurement year
Patient was not seen during the two year attribution period.		*Determined on a case-by-case basis*
Patient seen for urgent care only.		**Exclude this Round**
Patient is unknown to clinic.		**Exclude This Round**
Well-Child 0-15 Mths only – Patient established care with the clinic after age 2 months.	Date (mm/dd/yyyy)	**Exclude This Round**
Chlamydia Screenings only - Patient is not sexually active.		**Exclude This Round**
Patient refused service.		**No Change**
Patient belongs in measure and DID receive screening or service. (Please provide date of service in date field.)	Date (mm/dd/yyyy)	**Compliant** – if date occurs during measurement period (2 years for BCS, 3 years for CCS) **No Change** – if date occurs outside the measurement period
Appropriate Use of Antibiotics for Children with Sore Throats only – No test administered because patient's family member tested positive for strep		**No Change**
Appropriate Low Back Pain Imaging, Appropriate Use of Antibiotics for Children with Sore Throats, and Generic Prescription Fill measures only – Patient did not have screening or service / Medical record has no evidence of screening or service.		**Exclude This Round** – if measure is LBP, CWP or Generic (any) **No Change** – other measures
Patient does not belong in measure. (Please provide reason in exclusion field.)	Reason to exclude: [DROP-DOWN LIST] 1. Patient had bilateral mastectomy. 2. Patient had total hysterectomy. 3. Patient does not have asthma. 4. Patient does not have heart disease. 5. Patient has gestational diabetes, not type 1/ 2. 6. Patient does not have diabetes. 7. Other	1. **Permanent Exclusion** – if measure is BCS 2. **Permanent Exclusion** – if measure is CCS 3. **No Change** 4. **No Change** 5. **Exclude This Round** – if measure is CDC 6. **No Change** 7. *Determined on a case-by-case basis*
Other reason not on this list. (Please explain.)	Comments	*Determined on a case-by-case basis*