Quality Measurement & Reporting Frequently Asked Questions

Overview

This document addresses many of the most common questions about the measurement and reporting initiative of the Oregon Health Care Quality Corporation (Q Corp):

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Who is the Oregon Health Care Quality Corporation?

The Oregon Health Care Quality Corporation is an independent, nonprofit organization dedicated to improving the quality and affordability of health care in Oregon by leading community collaborations and producing unbiased information. We work with the members of our community – including consumers, providers, employers, policymakers, and health insurers – to improve the health of all Oregonians.

What is Q Corp's measurement and reporting initiative?

Q Corp coordinates a statewide initiative that brings together consumers, providers, employers, policymakers, and health insurers to measure, report, and improve the quality and affordability of health care in Oregon. The goal of this measurement initiative is to improve patient care by coordinating and consolidating quality and utilization information. The initiative produces reports for primary care medical groups and clinics across the state. Reports have expanded over time to now include measures on chronic disease care, women's preventive services, utilization, well-child visits, potentially avoidable ED visits, and hospital admissions. Some measure results are publicly reported on Q Corp's consumer website, www.PartnerForQualityCare.org. Recently, Q Corp elected to add measures at the provider level that align with quality and resource use measures used for Coordinated Care Organization (CCO) incentives. These results are produced

independently by Q Corp and represent insured populations including commercial, Medicaid and Medicare.

How is Q Corp's measurement and reporting initiative funded?
Support for Q Corp's measurement and reporting initiative, including the *Partner for Quality Care* program, comes from:

ATRIO Health Plans
BridgeSpan Health Company
CareOregon
FamilyCare, Inc.
Freelancers CO-OP of Oregon
Health Net of Oregon
Kaiser Permanente
LifeWise Health Plan of Oregon
Moda Health Plan, Inc.
Oregon Health Authority Division of Medical Assistance Programs
Oregon's Health CO-OP
PacificSource Health Plans
Providence Health Plans
Robert Wood Johnson Foundation
Regence Blue Cross/Blue Shield of Oregon
Tuality Health Alliance
Trillium Community Health Plan

Who has submitted data?
The health care claims and enrollment data used in Q Corp's fall 2013 reports were contributed by the following data suppliers:

ATRIO Health Plans
CareOregon
FamilyCare, Inc.
Health Net of Oregon
Kaiser Permanente
LifeWise Health Plan of Oregon
Centers for Medicare & Medicaid Services (CMS)
Moda Health Plan, Inc.
Oregon Health Authority Division of Medical Assistance Programs
PacificSource Health Plans
Providence Health Plans
Regence Blue Cross/Blue Shield of Oregon
Tuality Health Alliance
Trillium Community Health Plan

How were measures selected?
Q Corp's Measurement and Reporting Committee, composed of consumers, providers, employers, policymakers, and health insurers, studies measurement issues and makes recommendations to the Q Corp board of directors. The committee identified principles for measure selection and the first set of Oregon measures. To ensure measures adhered to national standards set by the National Quality Forum (NQF), the committee primarily chose measures from the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS), a subset of the measures endorsed by NQF and the most widely used set of measures for ambulatory care.

Since the first round of reporting in 2009, additional measures have been added. These include measures of appropriate low back pain imaging, appropriate testing for children with pharyngitis, well-child visits, generic drug fills, potentially avoidable Emergency Department (ED) visits, hospital admissions for ambulatory-sensitive conditions and 30 day all-cause readmissions. The generic drug fill

measures were developed by Milliman, Inc., and have been used by the Washington Health Alliance; the potentially avoidable ED visits measures were developed by the MediCal Managed Care Division of the California Department of Healthcare Services; and the composite measures of hospital admissions for ambulatory-sensitive conditions are among the set of U.S. Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQIs). Q Corp added measures of the population rates of potentially avoidable ED visits in response to requests from multiple medical groups following spring 2012 reporting. Measures will continue to be tested and added or deleted as the effort matures.

What data will be publicly reported?

The refresh of clinic results on the website www.PartnerForQualityCare.org will occur in July 2014. Q Corp's public reporting criteria were revised in 2013 by the Measurement and Reporting Committee. Beginning in 2013, public reporting is limited to clinics with three or more practicing primary care providers and at least 30 patients in the measure. Clinics receiving reports for the first time have one round of private reports before their data will be considered for public reporting. Clinics with less than three primary care providers will not have their scores reported on the public website, though they will continue to receive private reports from the initiative and may opt-in to public reporting by contacting Q Corp. Clinics have the opportunity to review their data prior to the refresh of public scores, during the medical group review period (May 1–31, 2014).

Q Corp has established policies for groups that wish to have their data reconsidered and groups that believe they have special circumstances that should exclude them from public reporting. These policies are available at http://q-corp.org/reports/provider-reports. Requests are due by **May 31, 2014**. Access to the portal is required to provide patient-level feedback to Q Corp, and to request that your data (scores) be reconsidered.

Q Corp's Measurement and Reporting Committee reviewed the list of measures that will be included on the *Partner for Quality Care* website during the July 2014 refresh. Measures will be reported publicly or privately according to the table below.

Publicly Reported Measures (Summer 2014)
Appropriate Asthma Medications (age 5-18)
Appropriate Low Back Pain Imaging (age 18-50)
Appropriate Use of Antibiotics for Sore Throats (age 2-18)
Breast Cancer Screening (age 50-74)
Cervical Cancer Screening (age 21-64)
Chlamydia Screening (age 16-24)
Diabetes Care , HbA1c Test (age 18-75)
Diabetes Care – LDL-C Test (age 18-75)
Generic Prescription Fills: Statins (age 18 and older)
Generic Prescriptions Fills: SSRIs, SNRIs & DNRIs (age 18 and older)
Heart Disease Cholesterol Test (age 18-75)
Well-Child Visits 0-15 Months, Six or More
Well-Child Visits 3-6 Years

Privately Reported Measures (Summer and Fall 2014) All measures to the left plus:
Breast Cancer Screening (age 40-49)
Breast Cancer Screening (age 40-69)
Breast Cancer Screenings (age 75-84) – *New!*
Breast Cancer Screening (age 85 and older) – *New!*
Diabetes Care, Kidney Disease Test (age 18-75)
Diabetes Care, Eye Exam (age 18-75)
Hospital Admissions for Ambulatory-Sensitive Conditions, Rate per 100 Patients – Overall Composite (age 18 and older)
Hospital Admissions for Ambulatory-Sensitive Conditions, Rate per 100 Patients – Acute Composite (age 18 and older)
Hospital Admissions for Ambulatory-Sensitive Conditions, Rate per 100 Patients – Chronic Composite (age 18 and older)
Potentially Avoidable ED Visits, % of Total Visits (age 18 and older)
Potentially Avoidable ED Visits, % of Total Visits (age 1-17)
Potentially Avoidable ED Visits, Rate per 100 Patients (age 18 and older)
Potentially Avoidable ED Visits, Rate per 100 Patients (age 1-17)
Well-Child Visits 0-15 Months, Five or More
30 Day All-Cause Readmissions, Unadjusted (age 18 and older)
Alcohol Misuse: Screening, Brief Intervention, Referral for Treatment (SBIRT) (age 18 and older) – *New!*
Ambulatory Care: Outpatient Visits (age 18 and older) – *New!*
Ambulatory Care: ED visits (age 18 and older) – *New!*
Generic Prescription Fills: Anti-hypertensives (age 18 and older) – *New!*
Developmental Screenings in the First 36 Months of Life – *New!*
Adolescent Well-Care Visits (age 12-21) – *New!*
Follow-up Care for Children Prescribed ADHD Medications: Initiation (age 6-12) – *New!*
Follow-up Care for Children Prescribed ADHD Medications: Continuation and Maintenance (age 6-12) – *New!*
Ambulatory care: Outpatient Visits (age 0-17) – *New!*
Ambulatory care: ED Visits (age 0-17) – *New!*

How will data be publicly reported?
As a multi-stakeholder organization, Q Corp proactively seeks input from consumers, providers, employers, policymakers, and health insurers for public reporting. During initial rounds of reporting, clinic results were presented only in categories (no raw rates) on the public website www.PartnerForQualityCare.org. Clinics with rates that were above or below one standard deviation from the statewide average rate were reported as "Better" or "Below," respectively. As a result, approximately two-thirds of Oregon clinics were reported as "Average." Q Corp will continue to report results publicly using these categories. Beginning in summer 2012, clinic rates (%) were reported on the public website in a drill down layer for users that want more detail. The added layer included the category and rate for all measures for a clinic on one page. This change was based on feedback obtained through usability testing of the public website with consumers/patients. The term "doctor's office" is used in place of the term "clinic" on the public website for easier consumer understanding.

The following criteria are used to determine clinic eligibility for public reporting:

- Three or more primary care providers in the clinic or medical group
- Minimum 30 patients that meet the specifications for the measure
- Medical group has been included in one round of private reports

These criteria are subject to revision prior to summer 2014, and medical groups will be alerted to any changes. Although results for individual providers have not been publicly reported to date, they are provided in hard copy and online for clinic/provider use and quality improvement. Clinics with fewer than three providers that wish to have their data included in public reports may opt-in to the initiative. Health plans receive unblinded information on providers and clinics for their insured members.

Why does the initiative base measurement on administrative claims data?
For accurate measurement and comparison across the community, large data sets are essential. Currently claims data are the only type of high volume data readily available in electronic format. In the future, the report will be expanded to reflect data from other sources, such as electronic health records (EHRs) and laboratory values.

For more information on the accuracy and usefulness of claims data, see "Quality Corp Measures Description and Methodologies" available at http://q-corp.org/reports/provider-reports.

How can quality of care be measured using administrative claims data?
Claims data reflect information submitted by primary care and other providers to payers as a part of the billing process. While not all medical care shows up in billing data, it does include useful information about diagnoses and services provided. Using claims data, for example, one can measure 'care processes' such as "What percentage of patients with diabetes were given an HbA1c test at least once during the measurement period?" Claims data will also let providers know whether patients have, in fact, received a service or filled a prescription. Use of claims data assumes clinics and practices are billing accurately and comprehensively for services rendered.

For more information on the accuracy and usefulness of claims data, see "Quality Corp Measures Description and Methodologies" available at http://q-corp.org/quality-reports/providers.

Why doesn't the initiative use electronic health record (EHR) data?

Q Corp has completed a pilot project testing the feasibility of merging electronic medical records (EMR) with claims data for enhanced reporting. Three Central Oregon clinics and the Central Oregon IPA (COIPA) volunteered to participate in the pilot, and EMR data was extracted from three different EMR systems. Sponsors of this project included CareOregon, the Robert Wood Johnson Foundation, Oregon Health Authority, Moda Health and Oregon Educator's Benefit Board. Preliminary results demonstrated that patient information can be successfully crosswalked between the two data sources. Plans to expand this work are a key element in Q Corp's new technology plan to be implemented in 2014.

Why are these scores different than the scores from my electronic health record (EHR)/data system?

Scores in this report may differ from those based on your EHR/data system for any of the following reasons:

- The claims data used for these scores only represents a subset of your actual patient population. Not all of Oregon's health plans participate in the initiative. Also not included are denied claims and self-insured or uninsured visits.
- Evidence of services is not always captured in claims; this is usually due to coding issues.
- To maintain the integrity of the measures, strict inclusion criteria are imposed to ensure that everyone included in a measure is truly in need of the service. As a result, the number of patients included in a particular measure may be fewer than the number identified in your medical record as having a particular condition.

Why is the number of patient cases so small for some of these measures?

Despite the large number of claims in the dataset, some providers and clinics may have only a small number of patients for some measures. In the aggregation process, patients were 'lost' (about 33 percent) because only patients who were continuously enrolled in health plans during the measurement period were counted. Additionally, some patients were not captured in the measures because: (1) their condition may not have been coded in a claim, (2) they are not members of a participating health plan, (3) they don't meet extremely strict inclusion criteria (especially asthma and heart disease measures), or (4) they were assigned to a different provider. In some cases, the provider may not have had a full-time, full-year experience at the medical group during the measurement period (July 1, 2012 – June 30, 2013).

Can my clinic be excluded from public reporting?

Clinics that have been included in Q Corp's reports for at least one round, have three or more primary care providers, and at least 30 patients in the measure denominator are eligible for public reporting on the consumer website www.PartnerForQualityCare.org. If your clinic or medical group does not meet these criteria or if you have other reasons why you should not be publicly reported, please review the "Exclusion from Public Reporting Policy" available at http://q-corp.org/reports/provider-reports

I think my data is inaccurate. What is the data reconsideration process?
Please visit http://q-corp.org/quality-reports/providers to review the "Reconsideration Process and Policy" for detailed instructions. Requests for data reconsideration are due by May 31, 2014.

To contact us, call: 503-241-3571 or email: info@q-corp.org.

How does this program comply with HIPAA privacy and security standards?
Health plans' communications to providers about population- and patient-level information is permitted as treatment and operations under Health Insurance Portability and Accountability Act (HIPAA). Quality Corp coordinates this communication in order to make it more useful to medical groups, clinics and providers. Participation agreements, business associate agreements, and multiple levels of security for technical processes are in place to assure the security and protection of patients' privacy. Any breach in a patient's protected health information should be reported to staff at Quality Corp **immediately**. A form is also available for patients who may want to opt out.

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