

## 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 based in Portland, Oregon. We are 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 once a year: <http://q-corp.org/compare-your-care>. Q Corp aims to align with quality and resource use measures used for other initiatives, including the Coordinated Care Organization (CCO) incentive metrics. 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?

Funding for Q Corp's measurement and reporting initiative, including the Reporting Portal, *Compare Your Care* public reporting program and regular publications comes from voluntary contributions from health plans who also supply data

## Who has submitted data?

A variety of health plan partners voluntarily supply the data through Q Corp's Data Collaborative. A current list of participating health plan is available online: <http://q-corp.org/our-work/measurement-reporting>

## 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 Measurement and Reporting staff. 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. 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 continue to be tested, added or deleted as the effort matures.

## What data will be publicly reported?

Data is publicly reported through Q Corp's *Compare Your Care* initiative: <http://q-corp.org/compare-your-care>. It is updated twice a year. Public reporting is limited to clinics with three or more practicing primary care providers and at least 30 patients in a 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.

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. Access to the portal is required to provide patient-level feedback to Q Corp, and to request that your data (scores) be reconsidered.

## How will data be publicly reported?

Clinics with rates that are above or below one standard deviation from the statewide average rate are reported as “Better” or “Below,” respectively. As a result, approximately two-thirds of Oregon clinics are reported as “Average.” Q Corp will continue to report results publicly using these categories.

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

Although results for individual providers have not been publicly reported to date, they are provided online for clinic/provider use and quality improvement. In addition, 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 is the only type of high volume data readily available in electronic format. In the future, the reports will be expanded to reflect data from other sources, such as electronic health records (EHRs) and laboratory values.

## How can quality of care be measured using administrative claims data?

Claims data reflects 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.

## 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 are 'lost' (about 33 percent) because only patients who were continuously enrolled in health plans during the measurement period are counted. Additionally, some patients are 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.

## 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 included in public reporting on the consumer website. 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/portal>.

## I think my data is inaccurate. What is the data reconsideration process?

Please visit <http://q-corp.org/portal> to review the "Reconsideration Process and Policy" for detailed instructions. Requests for data reconsideration are due by the last day of the reconsideration period. To contact us, call: 503-241-3571 x118 or email: [info@q-corp.org](mailto: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). Q 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 Q Corp **immediately**. A form is also available for patients who may want to opt out.

**Questions? Contact Q Corp at:** [info@q-corp.org](mailto:info@q-corp.org) Phone: 503-241-3571 x118