

# Oracle® Health Quality Management User Guide



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Oracle Health Quality Management User Guide,

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# Preface

This preface contains the following sections:

- [Documentation Accessibility](#)

## Documentation Accessibility

For information about Oracle's commitment to accessibility, visit the Oracle Accessibility Program website at <http://www.oracle.com/pls/topic/lookup?ctx=acc&id=docacc>.

# 1

## Oracle Health Quality Management Introduction

Quality Management is a modern, AI-powered experience, built to help health systems manage value-based care. This centralized platform unifies previously disconnected core workflows, including tracking quality performance, managing risk contracts, surfacing high-impact patients for outreach, and delivering insights at the point of care.

Quality Management provides capabilities to users across the health system:

- Population health leaders gain a clear view of contract performance, with proactive insights that help them meet shared savings targets before deadlines.
- Quality Managers can see real-time performance on every measure program in one place and quickly identify patients and providers who need attention most.
- Care coordinators get AI-powered patient prioritization that surfaces the highest-impact opportunities first.
- [Oracle Health Quality Management Introduction](#)
- [Application Access Requirements](#)  
You can access Oracle Health Quality Management using a direct link or through the existing Registries application.
- [Audit Quality Management](#)  
Audit Quality Management to view which reports are being viewed most frequently.
- [Oracle Health Quality Management Home](#)  
Oracle Health Quality Management landing page.
- [View Care Gap Closure Opportunities](#)  
View AI-generated open care gap lists.
- [Explore a Patient Cohort List](#)  
View patient details of an open care gap list.
- [View a Patient in a Patient Cohort List](#)  
View recommendations for action on patient open care gaps.
- [Oracle Health Quality Management Help and Support](#)  
Get help and support

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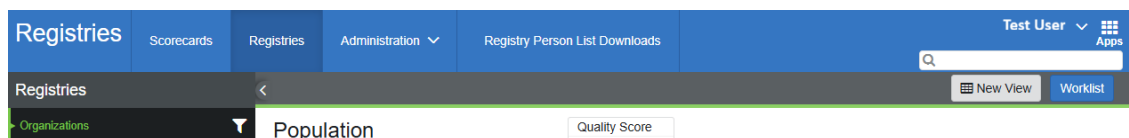
## Application Access Requirements

You can access Oracle Health Quality Management using a direct link or through the existing Registries application.

The following options are available to access Quality Management:

- Use a direct link provided by the Oracle team. Any member of the customer team can use this direct link to access Quality Management.
- Select **New View** in HealthRegistries. You can enable the New View button in the current Registries application which, when selected, takes users to the new Quality Management application. When enabled, the New View button is displayed in HealthRegistries in the Registries tab and the Worklist.

Contact the Oracle product team for instructions about enabling the updated Quality Management experience. See [Accessing HealthRegistries](#) on the Oracle Health wiki for information on how to access the Registries application.



# Audit Quality Management

Audit Quality Management to view which reports are being viewed most frequently.

You can audit Quality Management to determine which reports are being viewed most frequently. Contact your Oracle representative for a list of audit events.

To audit Quality Management:

1. Open P2Sentinel. See [Accessing P2Sentinel](#) for information on gaining access to P2Sentinel.
2. From the Patient Privacy menu, select **Cloud Interactions**, then select **Cloud Discrete Details**.
3. Enter the system name you want to view in the System Names field and select the appropriate system.
4. Select **Submit**. The discrete details for the selected system are displayed.
5. Select the **Selected Events** tab and enter a keyword in the Event Keys field.
6. Select the event you want to view and select **Submit**. Details for that event are displayed.

The table below displays available audit events. When you send the audit event in the Heading column to the system, the system returns the information included in the Attributes column. For example, if you wanted to know which providers have been viewed in the Providers list in the Quality tab, you would send the VIEW\_PROVIDERS\_QUALITY\_PERFORMANCE event. The system would return the names and IDs of the providers that were viewed.

Workflow	Heading	Description	Attributes
Quality	VIEW_PROVIDERS_QUALITY_PERFORMANCE	This event indicates that a user accessed the Providers table in the Quality Tab.	<ul style="list-style-type: none"> <li>• <b>data_category:</b> The providers that were viewed.</li> <li>• <b>providers_name_id_list:</b> The names and corresponding IDs of the providers whose performance was viewed.</li> </ul>
Quality	VIEW_ORGANIZATION_S_QUALITY_PERFORMANCE	This event indicates that a user accessed the Organizations table in the Quality tab.	<ul style="list-style-type: none"> <li>• <b>data_category:</b> The organizations that were viewed.</li> <li>• <b>organizations_name_id_list:</b> The names and corresponding IDs of the organizations for which performance was viewed.</li> </ul>

Workflow	Heading	Description	Attributes
Quality	VIEW_MEASURES_QUALITY_PERFORMANCE	This event indicates that a user accessed the Measures table in the Quality tab.	<ul style="list-style-type: none"> <li>• <b>data_category:</b> The measures that were viewed.</li> <li>• <b>measures_name_id_list:</b> The names and corresponding measure IDs for which performance was viewed.</li> </ul>
Patient List	SAVED_VIEW_ACTION	This event indicates that a user interacted with views from the preference service.	<ul style="list-style-type: none"> <li>• <b>data_category:</b> The view that was interacted with.</li> <li>• <b>personnel_id:</b> The ID of the personnel who interacted with the view from the service.</li> <li>• <b>personnel_name:</b> The name of the personnel who interacted with the view from the service.</li> <li>• <b>smart_rank:</b> Indicates if Smart Rank is being used.</li> <li>• <b>view_id:</b> The ID of the view.</li> <li>• <b>view_name:</b> The name of the view.</li> </ul>
Patient List	VIEW_PERSON_DRAWER	This event indicates that a user interacted with the patient dialog box on the Patients list.	<ul style="list-style-type: none"> <li>• <b>data_category:</b> The persons that were viewed.</li> <li>• <b>personnel_id:</b> The ID of the personnel member who interacted with the person drawer.</li> <li>• <b>personnel_name:</b> The name of the personnel member who interacted with the person drawer.</li> <li>• <b>person_id:</b> The ID of the person who was viewed.</li> <li>• <b>person_name:</b> The name person who was viewed.</li> </ul>

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Workflow	Heading	Description	Attributes
Patient List	DELETE_PATIENT_NOT E	This event indicates that a user deleted a patient note.	<ul style="list-style-type: none"><li>• <b>data_category:</b> The patient note was deleted.</li><li>• <b>note_id:</b> The ID of the note that was deleted.</li><li>• <b>note_title:</b> The title of the note that was deleted.</li><li>• <b>person_id:</b> The ID of the person for whom a note was deleted.</li><li>• <b>person_name_id:</b> The name and ID of the person for whom a note was deleted.</li><li>• <b>user_name:</b> The name of the user who took the action that logged the event.</li><li>• <b>user_personnel_id</b> : The personnel ID from the Oracle Health Data Intelligence security model that is tied to the user and their authorization.</li></ul>

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Workflow	Heading	Description	Attributes
Patient List	UPDATE_PATIENT_NOT E	This event indicates that a user updated a patient note.	<ul style="list-style-type: none"><li>• <b>data_category:</b> The patient note that was updated.</li><li>• <b>note_id:</b> The ID of the note that was updated.</li><li>• <b>note_title:</b> The title of the note that was updated.</li><li>• <b>person_id:</b> The ID of the person for whom a note was updated.</li><li>• <b>person_name_id:</b> The name and ID of the person for whom a note was updated.</li><li>• <b>user_name:</b> The name of the user who took the action that logged the event.</li><li>• <b>user_personnel_id</b> : The personnel ID from the Oracle Health Data Intelligence security model that is tied to the user and their authorization.</li></ul>

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Workflow	Heading	Description	Attributes
Patient List	CREATE_PATIENT_NOTE	This event indicates that a user created a patient note.	<ul style="list-style-type: none"> <li>• <b>data_category:</b> The patient note that was created.</li> <li>• <b>note_id:</b> The ID of the note that was created.</li> <li>• <b>note_title:</b> The title of the note that was created.</li> <li>• <b>person_id:</b> The ID of the person for whom a note was created.</li> <li>• <b>person_name_id:</b> The name and ID of the person for whom a note was created.</li> <li>• <b>user_name:</b> The name of the user who took the action that logged the event.</li> <li>• <b>user_personnel_id:</b> The personnel ID from the Oracle Health Data Intelligence security model that is tied to the user and their authorization.</li> </ul>

Workflow	Heading	Description	Attributes
Patient List	VIEW_PATIENT_NOTES	This event indicates that a user viewed a list of notes for a patient.	<ul style="list-style-type: none"> <li>• <b>data_category:</b> The patient notes that were viewed.</li> <li>• <b>person_id:</b> The ID of the person whose notes were being viewed.</li> <li>• <b>person_name_id:</b> The name and ID of the person whose notes were being viewed.</li> <li>• <b>user_name:</b> The name of the user who took the action that logged the event.</li> <li>• <b>user_personnel_id:</b> The personnel ID from the Oracle Health Data Intelligence security model that is tied to the user and their authorization.</li> </ul>
Patient List	VIEW_PATIENT_LIST	This event indicates that a user accessed the patient worklist.	<ul style="list-style-type: none"> <li>• <b>data_category:</b> The persons viewed.</li> <li>• <b>personnel_id:</b> The ID of the personnel who requested the patient worklist from the service.</li> <li>• <b>person_id_list:</b> The ID of each person on the list.</li> <li>• <b>person_name_id_list:</b> The name and ID of each person on the list.</li> <li>• <b>personnel_name:</b> The name of the personnel who requested the patient worklist from the service.</li> </ul>

Workflow	Heading	Description	Attributes
Outreach	CAMPAIGN_OUTREACH_ACTION	This event indicates that a user interacted with outreach campaign creation.	<ul style="list-style-type: none"> <li>• <b>campaign_name:</b> The name of the campaign.</li> <li>• <b>campaign_id:</b> The ID of the campaign.</li> <li>• <b>campaign_id_list:</b> The ID of each campaign on the list.</li> <li>• <b>campaign_name_list:</b> The name of each campaign on the list.</li> <li>• <b>credential_id:</b> The ID of the CRM credential used.</li> <li>• <b>data_category:</b> The campaign that was interacted with.</li> <li>• <b>personnel_id:</b> The ID of the personnel member who interacted with the campaign from the service.</li> <li>• <b>personnel_name:</b> The name of the personnel member who interacted with the campaign from the service.</li> </ul>
Contracts	UPDATE_TARGET_MEASURE	This event indicates that a user updated a target measure.	<ul style="list-style-type: none"> <li>• <b>data_category:</b> The target measure that was updated.</li> <li>• <b>target_measure_id:</b> The ID of the target measure that was updated.</li> <li>• <b>target_measure_name:</b> The name of the target measure that was updated.</li> </ul>

Workflow	Heading	Description	Attributes
Contracts	CREATE_TARGET_MEASURE	This event indicates that a user created a target measure.	<ul style="list-style-type: none"> <li>• <b>data_category:</b> The target measure that was created.</li> <li>• <b>target_measure_name:</b> The name of the target measure that was created.</li> <li>• <b>target_measure_id:</b> The ID of the target measure that was created.</li> </ul>
Contracts	VIEW_TARGET_MEASURE	This event indicates that a user viewed a single target measure.	<ul style="list-style-type: none"> <li>• <b>data_category:</b> The target measure that was viewed.</li> <li>• <b>target_measure_id:</b> The ID of the target measure that was viewed.</li> <li>• <b>target_measure_name:</b> The name of the target measure that was viewed.</li> </ul>
Contracts	VIEW_TARGET_MEASURES	This event indicates that a user viewed a group of target measures.	<ul style="list-style-type: none"> <li>• <b>data_category:</b> The target measures that were viewed.</li> <li>• <b>target_measure_name_id_list:</b> The name and corresponding target ID of the target measures that were viewed.</li> </ul>
Contracts	UPDATE_DOMAIN	This event indicates that a user updated a domain.	<ul style="list-style-type: none"> <li>• <b>data_category:</b> The domain that was updated.</li> <li>• <b>domain_id:</b> The ID of the domain that was updated.</li> <li>• <b>domain_name:</b> The name of the domain that was updated.</li> </ul>
Contracts	CREATE_DOMAIN	This event indicates that a user created a domain.	<ul style="list-style-type: none"> <li>• <b>data_category:</b> The domain that was created.</li> <li>• <b>domain_id:</b> The ID of the domain that was created.</li> <li>• <b>domain_name:</b> The name of the domain that was created.</li> </ul>

Workflow	Heading	Description	Attributes
Contracts	VIEW_DOMAIN	This event indicates that a user viewed a single domain.	<ul style="list-style-type: none"> <li>• <b>data_category:</b> The domain that was viewed.</li> <li>• <b>domain_id:</b> The ID of the domain that was viewed.</li> <li>• <b>domain_name:</b> The name of the domain that was viewed.</li> </ul>
Contracts	VIEW_DOMAINS	This event indicates that a user viewed a group of domains.	<ul style="list-style-type: none"> <li>• <b>data_category:</b> The domains that were viewed.</li> <li>• <b>domain_name_id_list:</b> The name and corresponding ID of the domains that were viewed.</li> </ul>
Contracts	CREATE_COLLECTION_DOMAIN	This event indicates that a user created a collection domain.	<ul style="list-style-type: none"> <li>• <b>collection_id:</b> The ID of the collection that was created.</li> <li>• <b>data_category:</b> The domain collection that was created.</li> <li>• <b>domain_id:</b> The ID of the domain that was created.</li> </ul>
Contracts	UPDATE_COLLECTION	This event indicates that a user updated a collection.	<ul style="list-style-type: none"> <li>• <b>collection_id:</b> The ID of the collection that was updated.</li> <li>• <b>collection_name:</b> The name of the collection that was updated.</li> <li>• <b>data_category:</b> The collection that was updated.</li> </ul>
Contracts	CREATE_COLLECTION	This event indicates that a user created a collection.	<ul style="list-style-type: none"> <li>• <b>collection_id:</b> The ID of the collection that was created.</li> <li>• <b>collection_name:</b> The name of the collection that was created.</li> <li>• <b>data_category:</b> The collection that was created.</li> </ul>

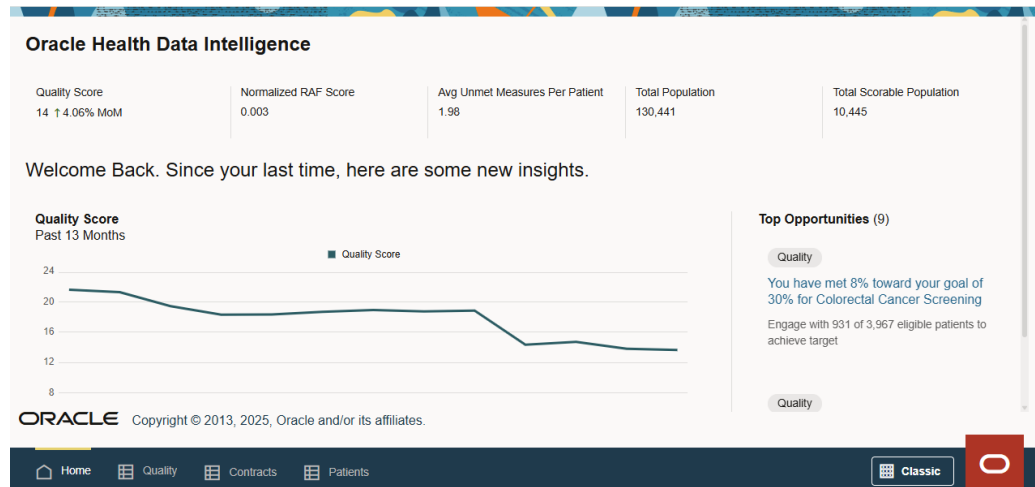
Workflow	Heading	Description	Attributes
Contracts	VIEW_COLLECTION	This event indicates that a user viewed a single collection.	<ul style="list-style-type: none"> <li>• <b>collection_id:</b> The ID of the collection that was viewed.</li> <li>• <b>collection_name:</b> The name of the collection that was viewed.</li> <li>• <b>data_category:</b> The collection was viewed.</li> </ul>
Contracts	VIEW_COLLECTIONS	This event indicates that a user viewed a group of collections.	<ul style="list-style-type: none"> <li>• <b>collection_name_id_list:</b> The name and corresponding ID of the collections that were viewed.</li> <li>• <b>data_category:</b> The collections that were viewed.</li> </ul>
Contracts	VIEW_CONTRACT_DE TAILS	This event indicates that a user accessed a single contract.	<ul style="list-style-type: none"> <li>• <b>contract_name_id_list:</b> The name and corresponding ID of the contract for which performance was viewed.</li> <li>• <b>data_category:</b> The contract that was viewed.</li> </ul>

## Oracle Health Quality Management Home

Oracle Health Quality Management landing page.

The Oracle Health Quality Management home view serves as an entry point to Oracle Health Quality Management, presenting a personalized view of high-value data for quality managers and providers. The home page is designed to add insight to decision-making and facilitate action toward top targets. The following data is available from this page:

- **Key performance indicators (KPIs):** The metrics most relevant to each individual user's scope and goals.
- **Top opportunities:** Opportunities are displayed in order of potential impact and urgency that allow you to engage with the data and determine next steps.
- **Central trend visualization:** Trends in quality scores for quality managers and composite scores for providers are displayed.
  - For users that have access to a single scorecard (for example, providers), a single composite score is displayed. This matches the scorecard displayed in HealthRegistries.
  - For users that have access to more than one scorecard (for example, administrators), a combined quality score is displayed. This matches the quality scored displayed in the Registries tab in HealthRegistries.



## View Care Gap Closure Opportunities

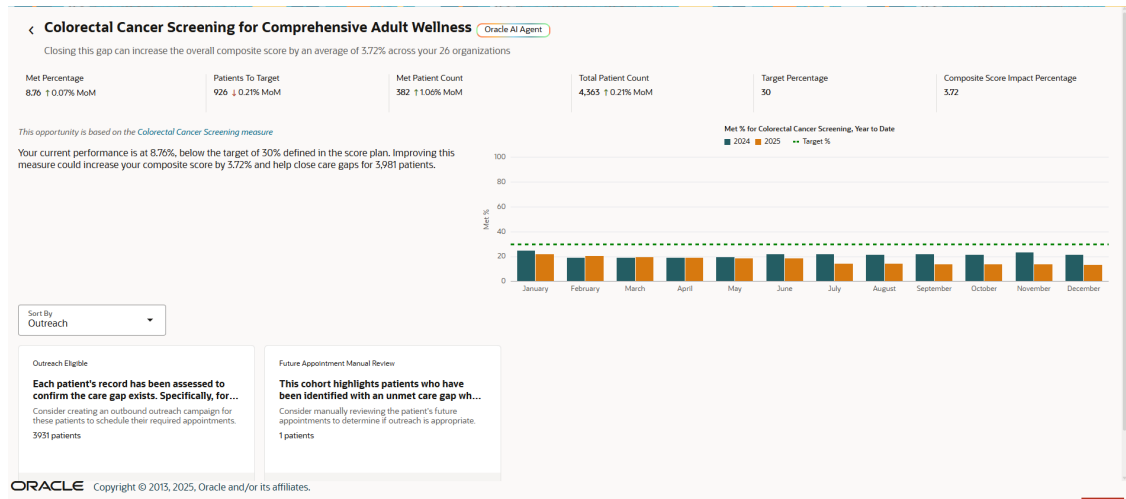
View AI-generated open care gap lists.

Health system quality teams are under increasing pressure to close care gaps quickly and at scale in order to meet value-based care targets, improve patient outcomes, and secure incentive payments. The current process for closing care gaps is highly manual, with quality managers sorting through spreadsheets and reviewing patient charts to identify open care gaps, and coordinating with multiple different departments to create patient outreach campaigns. For large populations managing chronic conditions, streamlining this process has the potential to positively impact both patient care and organizational performance.

Quality Management uses real-time patient and organizational data to identify patients with open care gaps and help you create outreach campaigns to close those care gaps. The system reviews patient measure data, patient history, and future appointments for all patients eligible for a measure and recommends targeted action to help close the patient's care gaps. Currently, all measures in the following three registries are included:

- Clinical Standard v4 Comprehensive Adult Wellness
- Clinical Standard v4 Diabetes
- Clinical Standard v4 Depression

Top Opportunities on the Quality Management home page that are labeled with the Agent Insight badge contain system-generated recommendations for care gap closure and outreach efforts. Select an Agent Insight labeled opportunity to view the care gap closure insight page for that measure.



The following information is included on the care gap closure insight page:

- **Key Performance Indicators (KPIs):** Key targets as defined by your organization and the patient counts for the measure. KPIs displayed include the following information:
  - Met Percentage
  - Patients to Target
  - Met Patient Count
  - Total Patient Count
  - Target Percentage
  - Composite Score Impact Percentage
- **Impact description statement:** A statement describing the potential impact meeting the measure could have on your organization.
- **Year over year comparison chart:** A bar chart displaying monthly performance of the measure for the current year and past year.
- **Patient cohorts:** The system sorts all patients included in the measure into cohorts based on individual health and appointment history, and recommends a primary and secondary action for each group. Patient cohorts are recommended groupings of patients based on their medical and appointment history. Patients can not be removed from a cohort.
 

Select **Send to Outreach** in a cohort box to create a campaign for that subset of patients. See [Patient Outreach](#) for information about creating an outreach campaign.

Select **Explore** to view all patients included in that cohort.

The table below describes possible cohort examples.

Cohort Name	Cohort Description	Recommended Action	Example
<b>Outreach Eligible</b>	These patients have been deemed eligible for outreach based on measure recommendations, patient data, and supporting facts. Each patient's record has been assessed to confirm that the care gap exists. For patients whose records are missing data, meaning no recorded result exists in the identified measurement period and no identified scheduled appointment exists that addresses the care gap, a tailored recommendation specific to the patient and the care gap is provided to prompt appropriate follow-up and close the care gap. Each patient has an outreach message available in their profile.	Consider creating an outbound outreach campaign for these patients to schedule their required appointments.	<p><b>Measure:</b> Breast Cancer Screening (Clinical Standard)</p> <p>Patient is a 48 year old female with a mammogram last documented in December 2024. She is overdue for her breast cancer screening.</p> <p><b>Example Action:</b> Outreach to the patient to suggest scheduling a mammogram.</p>
<b>Value-Based Care Gap</b>	These are patients whose most recent recorded test results fall outside the recommended target range for the specific quality measure. These patients have already completed the relevant appointment or lab work, but their outcomes indicate a persisting care gap.	Consider collaborating with the attributed clinical teams for targeted intervention or specific follow-up actions to address this value-based care gap.	<p><b>Measure:</b> HbA1c &lt; 9% from the Diabetes Registry (Clinical Standard)</p> <p>Patient had an hBA1c test in January of 2026. The result was 11% which does not meet the met criteria.</p> <p><b>Example Action:</b> Work with the patient's associated clinical teams to manage their elevated A1c levels.</p>

Cohort Name	Cohort Description	Recommended Action	Example
<b>Future Appointment Manual Review</b>	These are patients with an unmet care gap who also have an upcoming appointment that may or may not directly address the care gap. The assessment to arrive at this conclusion considers both the reason and type of appointment scheduled, as well as the provider specialty and location when available, and the specific registry.	Consider manually reviewing the patient's future appointments to determine if outreach is appropriate.	<p><b>Measure:</b> Diabetes Eye Exam (Clinical Standard)</p> <p>Patient is overdue for her diabetes eye exam. She has an upcoming annual office visit with her primary care provider.</p> <p><b>Example Action:</b> Suggest a manual review to determine if the patient's upcoming appointment with her primary care provider is the right type of appointment to close the open care gap.</p>
<b>Future Appointment Scheduled</b>	These are patients with an unmet care gap who also have an upcoming appointment that is expected to directly address the care gap. The assessment to arrive at this conclusion considers both the reason and type of appointment scheduled, as well as the provider specialty and location when available, and the specific registry.	Consider collaborating with the attributed clinical teams to ensure the care gap is closed during the relevant appointment.	<p><b>Measure:</b> Annual Office Visit (Clinical Standard)</p> <p>Patient's last documented office visit was in October 2024. Patient is overdue for their annual office visit but has an appointment scheduled on February 20th, 2026.</p> <p><b>Example Action:</b> Consider collaborating with the provider to ensure there is patient follow-through and the care gap is closed.</p>

Additional cohorts include Oncology Patient Manual Review, Hospice Patient Manual Review, Vitals Manual Review, and Manual Review.

## Explore a Patient Cohort List

View patient details of an open care gap list.

When you select Explore from a patient cohort box, a Patients list page is displayed that includes all patients in that cohort. An AI-generated cohort summary describes why the list of patients is included in the cohort. For example, **This cohort contains all patients eligible for outreach for cancer screening care gap closure.**

You can select a thumbs up or thumbs down icon to provide feedback on the summary. This feedback is used to improve the models used to generate recommendations and is not directly provided to customer support.

## View a Patient in a Patient Cohort List

View recommendations for action on patient open care gaps.

Select a patient name to open the patient dialog box and view the targeted recommendations for that patient. The patient dialog box includes the following information:

- The reason the patient was included in the cohort. For example, **No future appointments were found for this patient, therefore no further check for conflict with outreach recommendation is needed. Consider sending the provided outreach message to close the care gap.**
- A sample patient outreach message for patients in an outreach cohort. This message can be used in a patient outreach effort. For example, **Consider talking to your doctor about scheduling a colonoscopy to screen for colorectal cancer.**

You can also select a thumbs up or thumbs down icon to provide feedback on the summary. This feedback is used to improve the models used to generate AI recommendations and is not directly provided to customer support.

Select **Oracle AI summary generated by Oracle HDI** to view the steps taken by the system to generate recommendations. The system reviews patient clinical information, measure logic, appointment history, and future appointments to generate the summary.

### Explanation


AI-generated using the following sources

1. The agent assessed the measure: Colorectal Cancer Screening for indications to solve gaps in care.  
Agent Output:  
\*\*\*\*  
I found the following candidate recommendations that could address the care gap:  
- Recommendation: colonoscopy, Time Window: during the current measurement period  
\*\*\*\*
2. The agent has processed the patient's supporting facts along with the measure information and insights.  
Agent Output:  
\*\*\*\*  
The patient is still eligible for outreach based on the following reasoning.  
I inspected the candidate recommendations and the quality measure, which is for Colorectal Cancer Screening for persons aged 45 through 75 years. The patient data shows that the patient's last colonoscopy was in 2015, and they are currently due for this measure. Given that a colonoscopy is a recommended screening for colorectal cancer and it's been a while since the patient's last one, I chose recommendation 0 (colonoscopy) as the basis for the outreach message. I crafted a patient-friendly message that is succinct, easy to understand, and avoids dense clinical jargon. The message is also professional, respectful, and warm, and it does not include sensitive information about the patient's record or personally identifiable information.  
Outreach Message: Consider talking to your doctor about scheduling a colonoscopy.  
\*\*\*\*
3. No future appointments were found for this patient, therefore no further check for conflict with outreach recommendation is needed.

## Oracle Health Quality Management Help and Support

Get help and support

To access help and support:

- Select **Ask Oracle** () and select **Help** to access Oracle Health Quality Management assistance.

- Visit [oracle.com/health/services/support/](https://oracle.com/health/services/support/) to contact Oracle support.

# 2

## Quality Performance

Quality Management hosts various workflows, starting with Quality Performance workflows from HealthRegistries. Quality Performance workflows include Quality (Scorecards) and Patients (Patient Lists)

- [Quality Performance Introduction](#)  
Quality Performance allows you to view quality initiatives for an organization.
- [Quality Performance Data Requirements](#)  
Quality Performance workflows are available through the Registries application.
- [Quality Performance Personas](#)  
Personnel groups are used to grant access to the Quality Performance workflows.
- [Quality Performance Access Considerations](#)  
Access level determines what information you can view on the Quality Performance summary view.
- [Select a Reporting Project](#)  
Select the reporting project you want to view.
- [View the Quality Performance Dashboard](#)  
The Quality Performance dashboard provides an overview of the measures for an organization.
- [Use Quality Smart Search](#)  
You can filter data that is displayed on the Quality Performance dashboard.
- [Use Pivot Views](#)  
Pivot views provide further insight into measures, organizations, and providers.
- [Measures View](#)  
The Measures view displays a list of relevant quality measures and their current status.
- [Measure Detail View](#)  
The measure detail page displays details for a specific measure.
- [Organizations View](#)  
The Organizations view provides quality performance information from the perspective of different organizations.
- [Providers View](#)  
Administrators can view quality performance information from the perspective of different providers.
- [Search for a Provider](#)  
Locate and view provider details using the Quality tab. Use search or filters to find a provider, then access associated organizations and measures.
- [Search for an Organization](#)  
Locate and view organization details using the Quality tab. Use search or filters to find an organization, then access associated providers and measures.
- [Filter the Measures View](#)  
Filter and refine the measures view using criteria such as scorability, organization, provider, registry, and measure.

## Quality Performance Introduction

Quality Performance allows you to view quality initiatives for an organization.

Quality Performance allows you to manage Healthcare Effectiveness Data and Information Set (HEDIS), Merit-based Incentive Payment System (MIPS), Clinical Standard, and Hierarchical Condition Categories (HCCs) in one place. Goals, trending performance, and patient-level opportunities are displayed in a single interface. The Quality Performance workflows allow population health and quality teams to view, manage, and act on population health opportunities using the platform's measure libraries to target care gap closure for actionable patients.

The following key features are included:

- Displaying which quality goals at the measure level are at risk so the team can effectively identify areas for improvement. Analyzing performance across organizations and providers to determine areas of focus.
- Identifying which patients across an entire organization have unmet measures that need to be addressed so that the team can work to create initiatives targeting these patients and impact the overall organizational goals.
- Displaying a provider's overall performance scorecard and identifying trends for measure performance improvement.

## Quality Performance Data Requirements

Quality Performance workflows are available through the Registries application.

Use HealthRegistries to access the Quality Performance workflows in Quality Management. The Quality Performance workflows use existing HealthRegistries services to determine all measure processing and patient information.

## Quality Performance Personas

Personnel groups are used to grant access to the Quality Performance workflows.

**Table 2-1 Quality Performance Personas**

Personnel Group	Access and Considerations
<b>Registries Whitelist</b>	Grants access to the overall application. This group is required for roles that need to access registry, measure, and patient information.
<b>Registries Administrators</b>	Grants access to all application features and patients.
<b>Registries Reviewers</b>	Grants access to all patients in all organizations.
<b>Population_Intelligence_Allowlist</b>	Grants access to the Quality Management application to all users on the allow list. Optional list you can use if you want to restrict access to Quality Management.

Different roles in the organization may require different levels of access. For example:

- A system administrator or director of population health who needs access to all patients and features in the tenant should be added to the following user groups:

- **Registries\_whitelist:** Access the application.
- **Registries\_administrators:** Access to all patients and features.
- A quality manager who needs access to three different organizations and the associated patients should be added to the following user groups:
  - **Registries\_whitelist:** Access the application.
  - Administrator access for the three organizations for which they need access to the patients, to gain access to all patients in those three organizations.
- A provider who needs access to only patients to whom they are attributed should be added to the following user groups:
  - **Registries\_whitelist:** Access the application.
  - Applicable organization or organizations at which they practice to gain access to their own attributed patients in those organizations.

For a full list of all supported personnel groups in Health Data Intelligence see [Configure Personnel Groups in the Oracle Health Data Intelligence Security Model](#).

## Quality Performance Access Considerations

Access level determines what information you can view on the Quality Performance summary view.

For summary views on the Quality page:

- A member can only view information relevant to them. For example, a member in the Provider tab only sees their own name in the Provider list.
- An administrator can view information relevant to their organization. For example, an administrator in the Provider tab can see all providers in their organization. An administrator in the Organization tab only sees their own organization.
- A system administrator can view all information in their tenant. For example, a system administrator in the Provider and Organization tab sees all providers and organizations across their entire tenant.

## Select a Reporting Project

Select the reporting project you want to view.

A reporting project consists of the following main properties

- Content (Registries and Measures)
- Measurement Period (Calendar year versus rolling 365 days)
- Population

The following table contains examples of two different reporting projects:

Reporting Project	Content	Measurement Period	Population
Clinical Standard	Registries and measures from the clinical standard v4 content catalog are included.	Rolling 365 days, patient outcomes are calculated based on results from last 365 days.	Full HealthRegistries population.

Reporting Project	Content	Measurement Period	Population
HEDIS MY2025	Measures from the HEDIS MY2025 content catalog are included.	Calendar year; patient outcomes are calculated based on results from current calendar year.	Full HealthRegistries population.

The above two reporting projects apply to the same population. The Clinical Standard reporting project hosts information related to the clinical standard measures while the HEDIS MY2025 includes all HEDIS MY2025 measures. Access to multiple reporting projects allows you to view content from various catalogs in the same workflow and application.

You can select the reporting project for which you want to view details from the Reporting Project menu. You can access all reporting projects your organization is tracking against from Quality Management in the Quality view and the Patients view. The default reporting project is Quality Performance and includes the set of content your organization had enabled in HealthRegistries.

You can access the Reporting Project menu from both the Quality and Patients views. Reporting projects displayed on the menu are enabled in Console. When you access the Reporting Project menu from the Patients view, additional projects may be displayed related to Value Based Care contracts if your organization is using Contract Performance.

From the Reporting Project menu, select the reporting project you want to view. Data for that reporting project is displayed.

**Note**

For information on enabling reporting projects in Quality Performance, see the Oracle Health Quality Management Administrator Guide.

## View the Quality Performance Dashboard

The Quality Performance dashboard provides an overview of the measures for an organization.

The screenshot shows the Quality Performance dashboard interface. At the top, there is a 'Quality' header with a dropdown menu set to 'Quality Performance'. Below this is a search bar with the placeholder text 'Please select a filter or search'. A row of filter buttons includes 'Scorability', 'Organization Class', 'Organization', 'Provider', 'Registry', and 'Measure'. Below the filters, there are three tabs: 'Measures' (454), 'Organizations' (251), and 'Providers' (1571). The main table displays a list of measures with the following columns: Status, Measure, Met, Target, Unmet Patients, Total Patients, vs. Last Month, and vs. Last Year. Three measures are listed as 'Top Opportunity':

Status	Measure	Met	Target	Unmet Patients	Total Patients	vs. Last Month	vs. Last Year
Top Opportunity	Colorectal Cancer Screening (Comprehensive Adult Wellne	8%	30%	3876	4242	↑ 0.32%	↓ 8.02%
Top Opportunity	HbA1c < 7.5% (Pediatric Diabetes)	11%	50%	30	34	↓ 0.43%	↑ 2.20%
Top Opportunity	Breast Cancer Screening (Comprehensive Adult Wellness)	0%	25%	2303	2320	↑ 0.05%	↓ 3.19%

At the bottom of the dashboard, there is a footer with the ORACLE logo and copyright information: 'Copyright © 2013, 2026, Oracle and/or its affiliates.' A navigation bar at the very bottom includes icons for Home, Quality, Contracts, Patients, and Campaigns, along with a 'Classic' button and a red circular icon.

When you open the Quality Performance view, the Quality page is displayed. The Quality page provides a view of your quality measures and the current status of your measures compared to the goals set in the Score Plan tool. The Quality page is the updated view for the existing Scorecard tab in HealthRegistries. The Quality page includes a list of all enabled measures for the organization and a summary view of the current state of the quality measure.

### **Note**

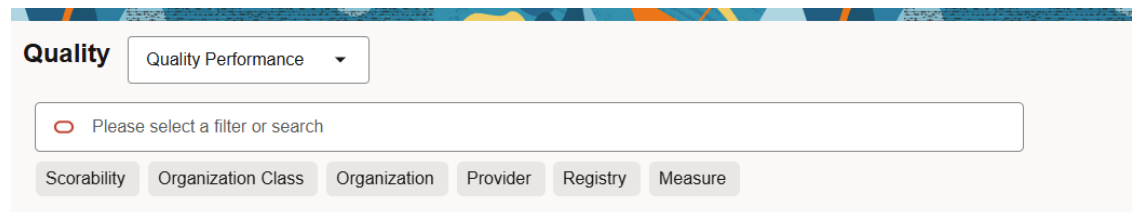
All measures, organizations, and providers are included in the Quality Performance view, including those that are not scorable. To view only items that are scorable, use the Scorable filter.

The Quality page consists of the following components:

- Smart search
- Pivot views

## Use Quality Smart Search

You can filter data that is displayed on the Quality Performance dashboard.



The smart search component allows you to filter data presented in the pivot view tables. To search for specific filter values, select one of the available filtering values and view the options. You can select multiple filters.

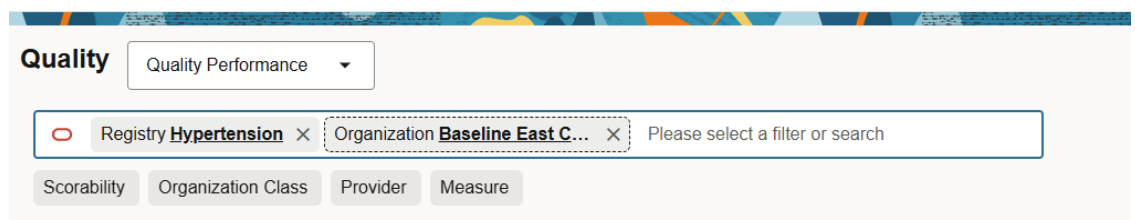
**Table 2-2 Quality Performance filters**

Filter	Definition
Measure	The name of the measure. Use this filter to search and filter for specific measures. For example, Blood Pressure Management.

**Table 2-2 (Cont.) Quality Performance filters**

Filter	Definition
Organization	The name of the organization. If a user is a member or administrator of multiple organizations, they can use this filter to select a specific organization.
	<div style="border: 1px solid #ccc; padding: 10px; margin-top: 10px;"> <p><b>Note</b></p> <p>Patients that are not attributed to any provider and are not affiliated with any organization are grouped together under the No Data organization.</p> </div>
Organization Class	The name of the organization class. If a user is a member or administrator of multiple organization classes, they can use this filter to select a specific organization class.
Provider	The name of the provider. Use this filter to search for and select specific providers in the organization.
	<div style="border: 1px solid #ccc; padding: 10px; margin-top: 10px;"> <p><b>Note</b></p> <p>This filter is available only to administrators. If a user is only a member, they can only select their own name in the Provider filter.</p> </div>
Registry	The name of the registry. Use this filter to narrow down the listed quality measures and view measures from a specific registry.
Scorability	Allows you to view measures, providers, and organizations that are scorable.

For example, if you select the hypertension registry and Baseline East Clinic as the organization, the list of measures in the grid displays measures from the hypertension registry that have been enabled for Baseline East.



## Use Pivot Views

Pivot views provide further insight into measures, organizations, and providers.

The following views provide additional detail on overall quality measure status across your healthcare organization:

- Measures
- Organizations
- Providers

## Measures View

The Measures view displays a list of relevant quality measures and their current status.

The Measures view provides information required to understand the healthcare organization's quality performance and identify areas for improvement. If a provider filter is used, this displays the measures that the specific provider is scored against in the Score Plan tool. If an organization filter is used, measures that the organization is scored against in the Score Plan tool are displayed. If an organization class only has provider score cards set up and no organization score card set up in the Score Plan tool, no measures are displayed in the Measures tab. If a provider filter is added, only the measures the filtered provider is scored against are displayed in the Measure tab.

All measures are displayed by default, both scorable and nonscorable. Nonscorable measures display No Target Set in the Target column. To view only scorable measures, use the Scorable filter.

The screenshot shows the Oracle Quality Performance dashboard. At the top, there is a 'Quality' header with a dropdown menu set to 'Quality Performance'. Below this is a search bar with a filter for 'Scorability Scorable' and a search prompt 'Please select a filter or search'. There are tabs for 'Organization Class', 'Organization', 'Provider', 'Registry', and 'Measure'. A summary section shows 'Measures: 33', 'Organizations: 20', and 'Providers: 58'. The main table displays quality measures with the following columns: Status, Measure, Met, Target, Unmet Patients, Total Patients, vs. Last Month, and vs. Last Year. Three measures are listed:

Status	Measure	Met	Target	Unmet Patients	Total Patients	vs. Last Month	vs. Last Year
Top Oppor...	Colorectal Cancer Screening (Comprehensive Adult Wellne		No Target Set	3907	4275	↓ 7.73%	↓ 7.73%
Top Oppor...	HbA1c < 7.5% (Pediatric Diabetes)		No Target Set	30	33	↓ 2.47%	↓ 2.47%
Top Oppor...	Breast Cancer Screening (Comprehensive Adult Wellness)		No Target Set	2324	2342	↓ 2.08%	↓ 2.08%

At the bottom, there is an Oracle logo and copyright information: 'Copyright © 2013, 2026, Oracle and/or its affiliates.' The footer includes navigation links for Home, Quality, Contracts, Patients, and Campaigns, along with a 'Classic' button and the Oracle logo.

Table 2-3 Measures view columns

Column	Definition
Status	<div data-bbox="1143 348 1468 621" style="border: 1px solid #ccc; padding: 10px; margin-bottom: 10px;"> <p><b>Note</b></p> <p>The Status column is not displayed by default. Set the Scorability filter to Scorable to view the Status column.</p> </div> <p>The status of the measure as defined by the Top Opportunity algorithm. See <a href="#">Overview of the Opportunity Index in HealthRegistries</a> on Oracle Health wiki for details. The status can have one of the following labels:</p> <ul style="list-style-type: none"> <li>• <b>Top Opportunity:</b> Displayed on all top opportunity measures using the Top Opportunity algorithm.</li> <li>• <b>Met:</b> Displayed for all measures where Met percentage is greater than Target.</li> <li>• <b>Below Threshold:</b> This measure does not meet the minimum patient threshold set by your organization. At least X (minimum threshold set by your organization) patients must be included in this measure for it to be scorable.</li> <li>• <b>Partial Credit:</b> This measure is receiving partial credit. To receive full credit, at least X (minimum threshold set by your organization) patients must be included in this measure.</li> <li>• <b>No Valid Patients:</b> This measure has no valid patients in the denominator. At least one patient must be included in this measure for it to be scorable.</li> <li>• <b>Missing Data:</b> This measure is missing data required to understand performance.</li> </ul> <p>All other measures have no status label.</p>

Table 2-3 (Cont.) Measures view columns

Column	Definition
Measure	<p>The name of the measure. The measure name is displayed with the associated registry in parentheses.</p> <p>For example:</p> <ul style="list-style-type: none"> <li>Blood Pressure Measurement (Comprehensive Adult Wellness)</li> <li>Blood Pressure Measurement (Hypertension)</li> </ul> <p>Selecting a measure name directs you to the measure detail page for that measure. See <a href="#">Measure Detail View</a>.</p> <p>You can use the score plan tool to define links for external measures. For links that use placeholder values for organizations or providers, users with access to multiple scorecards must filter by a single organization or provider to view the link; otherwise, no link is displayed. For users with access to a single scorecard, that scorecard is used to fill the placeholder, and the custom measure link is displayed using the user's scorecard.</p>
Met	<p>The met percentage of the specific measure. This percentage is calculated using the total number of scorable patients that have met the specific measure divided by the total number of scorable patients in the measure's denominator.</p> <p>For custom external measures, values can be displayed as numerical or string values.</p>
Target	<p>The target the user has set for this measure in the Score Plan tool. If no target is set, <b>No Target Set</b> is displayed. The target value used in this column is identical to the value used on the scorecard in HealthRegistries.</p> <p>For custom external measures, values can be displayed as numerical or string values.</p>
Unmet Patients	<p>The total count of unmet patients included in this measure based on the measure's inclusion criteria. You can select the numerical value to access the Patients page to view the list of patients for this specific row.</p>
Total Patients	<p>The total count of patients included in this measure based on the measure's inclusion criteria. This includes patients that have both met and not met this measure.</p> <p>You can select the numerical value to access the Patients page to view the list of patients for this specific row.</p>

Table 2-3 (Cont.) Measures view columns

Column	Definition
vs. Last Month	<p>The difference in met percentage between last month's met percentage and the current met percentage. For example, if today is July 5, compare the met percentage with June 1. Snapshots are taken at the beginning of every month, so data points are compared to the beginning of the previous month.</p> <p>If data is not available, the system displays <b>No Data</b>. This can happen if the measure was recently enabled.</p>
vs. Last Year	<p>The difference in met percentage between last year's current percentage and the current met percentage. For example, if today is July 5, 2024, compare the met percentage with July 1, 2023. Snapshots are taken at the beginning of every month, so data points are compared to the beginning of the same month from the previous year.</p> <p>If data is not available, they system displays <b>No Data</b>.</p>

## Measure Detail View

The measure detail page displays details for a specific measure.

The measure detail page displays additional information about the selected measure. Select any measure from the Measures view to open a measures detail page.

For custom or external measures that are not supported by Oracle, but that do include an analytics report in the Score Plan Tool, a link to the report is included in the Measures view.

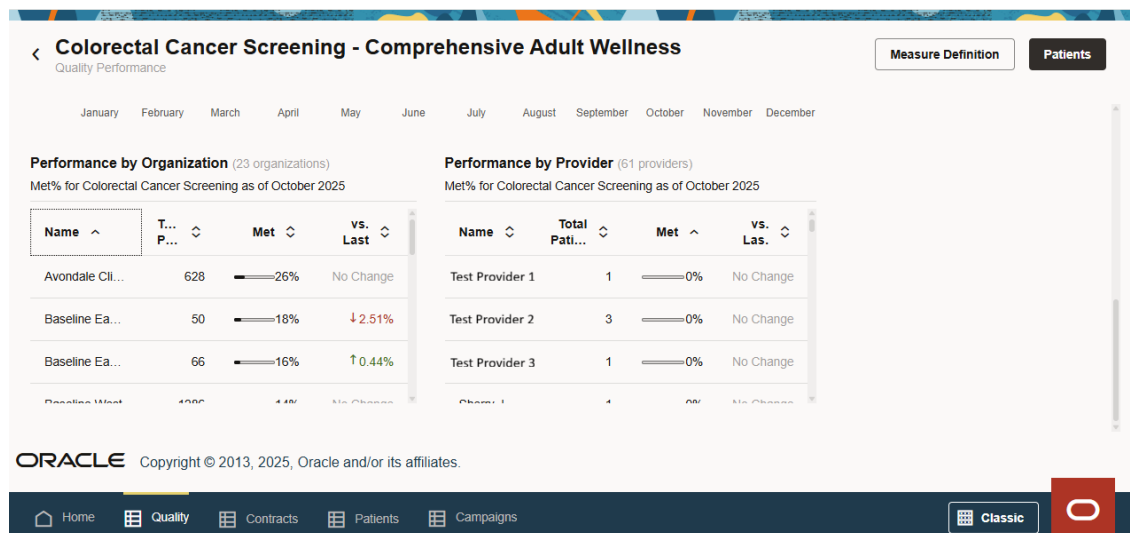
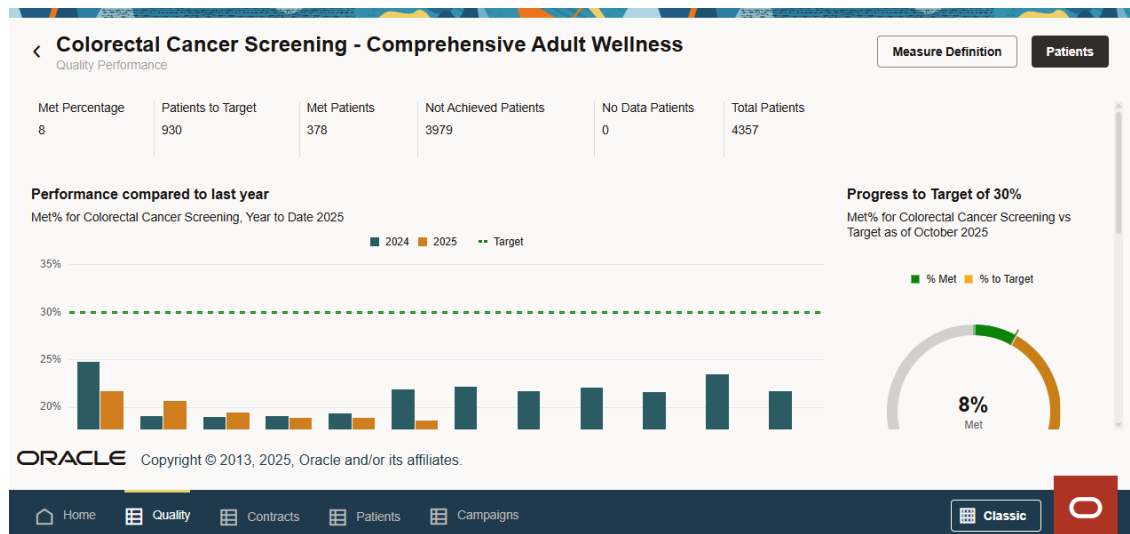
The following information about the measure is included on the measures detail page:

- **Met Percentage:** The percentage of the target goal that has been met.
- **Patients to Target:** The number of patients to target to achieve the measure goal.
- **Met Patients:** The number of patients that have successfully met the measure.
- **Not Achieved Patients:** The number of patients that have not met the measure.
- **No Data Patients:** The number of patients for which there is no data.
- **Total Patients:** The total number of patients eligible for the measure.
- **Performance Compared to Last Year:** A comparison of the met percentage for the measure between the current year and the previous year.
- **Performance by Organization:** A list of organizations and their progress toward the measure goal. You can sort the list by each heading in the table:
  - Name (alphabetic)
  - Total Patients
  - Met (percentage met for the measure)
  - vs. Last (change versus last year)

- Performance by Provider: A list of providers and their progress toward the measure goal. You can sort the list by each heading in the table:
  - Name (alphabetic)
  - Total Patients
  - Met (percentage met for the measure)
  - vs. Last (change versus last year)

Select **Measure Definition** to view a definition of the measure and the registry it is associated with.

Select **Patients** to view the list of patients eligible for the measure.



## Organizations View

The Organizations view provides quality performance information from the perspective of different organizations.

The Organizations view displays relevant organizations (as set up in Oracle Personnel tool) for the specific user. The Organizations view provides quality performance information from the perspective of different organizations. This view can be helpful when attempting to identify different organization areas and their respective quality measure performance in the same healthcare organization.

All organizations are displayed by default, both scorable and nonscorable. Nonscorable organizations display No Target Set in the Target column. To view only scorable organizations, use the Scorability filter.

The screenshot displays the Oracle Organizations View interface. At the top, there is a 'Quality' section with a dropdown menu set to 'Quality Performance'. Below this is a search bar with the placeholder text 'Please select a filter or search'. A navigation bar contains tabs for 'Scorability', 'Organization Class', 'Organization', 'Provider', 'Registry', and 'Measure'. The main content area shows a table with columns for 'Measures', 'Organizations', and 'Providers'. The table lists three organizations: Northern Hospital, Parker Reed Memorial Hospital, and Christ Pediatric Providers. Each row includes columns for Name, Organization Class, Composite Score, Measures, Met, Total Patients, vs. Last Month, and vs. Last Year. The footer of the interface includes the Oracle logo, copyright information, and a navigation bar with icons for Home, Quality, Contracts, Patients, and Campaigns, along with a 'Classic' button and the Oracle logo.

Name	Organization Class	Comp... Score	Measu...	Met	Total Patients	vs. Last Month	vs. Last Year
Northern Hospital	Region	1.68%	33	44%	92	No Change	↓ 22.28%
Parker Reed Memorial Hospital	MIPS Group Practice Region	6.49%	33	99%	24267	No Change	↓ 26.84%
Christ Pediatric Providers	Calvert Reporting	9.50%	33	33%	1204	↓ 0.38%	↓ 8.28%

**Table 2-4 Organization view columns**

Column	Definition
Name	The name of the organization as configured in the Oracle Personnel tool.
Organization Class	The organization class for this specific organization. Organization classes are defined in the Personnel tool and allow users to group together similar organizations based on criteria such as geography, size, or specialty (for example, pediatric organizations).
Composite Score	The composite score for the organization. See <a href="#">Understanding Composite Scores in HealthRegistries</a> on Oracle Health wiki for details. If the organization has not set up a score plan, <b>No Target Set</b> is displayed.
Measures	The total number of measures being scored (set up in Score Plan tool) for the organization.
Met	The combined met percent for all measures that are scored for this organization. This percentage is calculated using the total number of patients that have met measures in this organization divided by the total number of scorable patients for this organization.

**Table 2-4 (Cont.) Organization view columns**

Column	Definition
Total Patients	The number of patients in the denominator for all measures enabled for this organization. You can select the numerical value to access the Patients page to view the list of patients for this specific row.
vs. Last Month	The difference in composite score between last month's composite score and the current composite score. For example, if today is July 5, compare the composite score with June 1. Snapshots are taken at the beginning of every month, so data points are compared to the beginning of the previous month. If data is not available, <b>No Data</b> is displayed.
vs. Last Year	The difference in composite score between last year's composite score and the current composite score. For example, if today is July 5, 2024, compare the composite score with July 1, 2023. Snapshots are taken at the beginning of every month, so data points are compared to the beginning of the same month from the previous year. If data is not available, <b>No Data</b> is displayed.

## Providers View

Administrators can view quality performance information from the perspective of different providers.

The Providers view displays the list of all providers (as set up in Oracle Personnel tool) for this specific user. Only organization administrators can see multiple providers in this view. A member of an organization can only see themselves in this view. The Providers view provides the administrator with quality performance information from the perspective of different providers. This view can be helpful when attempting to identify different organization areas and their respective quality measure performance in the same healthcare organization. Only members who are part of a scorable personnel group are displayed in this list. If an organization filter is used, only users that are a member of that organization are displayed in this list. If a user is an administrator of the organization, they are not displayed in this list.

All providers are displayed by default, both scorable and nonscorable. Nonscorable providers display No Target Set in the Target column. To view only scorable providers, use the Scorbability filter.

**Table 2-5 Providers view columns**

Column	Definition
Provider	The name of the provider as configured in the Oracle Personnel tool.

Table 2-5 (Cont.) Providers view columns

Column	Definition
Composite Score	The composite score for this provider. See <a href="#">Understanding Composite Scores in HealthRegistries</a> . If the provider has not set up a score plan, <b>No Target Set</b> is displayed.
Measures	The total number of measures being scored (set up in Score Plan tool) for this provider.
Met	The combined met percent for all measures that are scored for this provider. This percentage is calculated using the total number of patients that have met measures for this provider divided by the total number of scorable patients for the provider.
Total Patients	The number of attributed patients in the denominator for all measures scored for this provider. You can select the numerical value to access the Patients page to view the list of patients for this specific row.
vs. Last Month	The difference in composite score between last month's composite score and the current composite score. For example, if today is July 5, compare the composite score with June 1. Snapshots are taken at the beginning of every month, so data points are compared to the beginning of the previous month. If data is not available, the system displays <b>No Data</b> .
vs. Last Year	The difference in composite score between last year's composite score and the current composite score. For example, if today is July 5, 2024, compare the composite score with July 1, 2023. Snapshots are taken at the beginning of every month, so data points are compared to the beginning of the same month from the previous year. If data is not available, they system displays <b>No Data</b> .

## Search for a Provider

Locate and view provider details using the Quality tab. Use search or filters to find a provider, then access associated organizations and measures.

To find a provider:

1. Select the **Quality** tab in Oracle Health Quality Management.
2. Select the **Providers** view.  
A list of all available providers is displayed.
3. Select the **Provider** filter from the smart search component.  
A list of providers is displayed.

4. Scroll to find the provider you want to view, or enter a provider's name in the search field.
5. Select outside the search field.  
The selected provider is displayed.
6. Select the **Organizations** view to view the provider's associated organizations, or the **Measures** view to view the provider's associated measures.

## Search for an Organization

Locate and view organization details using the Quality tab. Use search or filters to find an organization, then access associated providers and measures.

To search for an organization:

1. Select the **Quality** tab in Oracle Health Quality Management.
2. Select the **Organizations** view.  
A list of all available organizations is displayed.
3. Select the **Organization** filter from the smart search component.  
A list of organizations is displayed.
4. Scroll to find the organization you want or enter an organization's name in the search field of the selected filter.
5. Select outside the search field.  
The selected organization is displayed.
6. Select the **Providers** view to view the organization's associated providers, or the **Measures** view to view the organization's associated measures.

## Filter the Measures View

Filter and refine the measures view using criteria such as scorability, organization, provider, registry, and measure.

To filter the measures view:

1. Select **Measures** from the Quality tab.  
All of your organizations are displayed.
2. Select a filter. The following filters are available:
  - **Scorability:** Filters the Measures list by only measures that are scorable. When you select **Scorability**, the Status column is displayed.
  - **Organization Class:** Filters the Measures list based on the selected organization class.
  - **Organization:** Filters the Measures list based on the organization. Measures for the selected organization are displayed.
  - **Provider:** Filters the Measures list based on provider. Measures for the selected provider are displayed.
  - **Registry:** Filters the Measures list based on the selected registry.
  - **Measure:** Filters the Measures list based on the selected measure

# 3

## Patient List

Quality Management hosts various workflows, starting with Quality Performance workflows from HealtheRegistries. Quality Performance workflows include Quality (Scorecards) and Patients (Patient Lists)

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The Patient List includes a list of all patients in the population and key data regarding their clinical status.
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- [AI Patient Prioritization](#)  
AI Patient Prioritization helps identify patients that may benefit from short-term follow up and intervention.
- [View the Patient List Dashboard](#)  
Use the dashboard to filter and sort the Patient list.
- [Select a Reporting Project](#)  
Select the reporting project you want to view.
- [Use Patient Smart Search](#)  
Use Patients smart search to filter and search the list of patients.
- [View the Patients List](#)  
The Patients list includes columns that display relevant patient information.
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Add a note to a patient's record.
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View detailed patient information in a dialog box, including demographics, scores, visits, providers, and associated measures.
- [Select a Reporting Project](#)  
Select a reporting project to view measure data based on content, measurement periods, or populations across your organization.
- [Filter the Patient List](#)  
Filter and view patients using the Patients list.

- [Search for a Person in the Patient List](#)  
Locate and view a person using Oracle Health Quality Management.

## Patient List Introduction

The Patient List includes a list of all patients in the population and key data regarding their clinical status.

The Patients list includes a list of all patients in the population and key data required to evaluate the patient's current clinical status and any next steps needed to help close the patient's open care gaps. You can use the Patient smart search to search for specific patients or filter the list of patients. You can also create, save, export, and share customized views of the Patients list.

## Patient List Data Requirements

Access the Patient List through the HealthRegistries application.

Organizations must use the existing Registries application to use the Patients list workflows in Quality Management. The Patients list workflows use existing Registries services to determine all measure processing and patient information.

## Patient List Personas

Access to the Patients list is managed through personnel groups in the Personnel tool.

The personas and associated security below are available. Roles are managed through the Personnel tool.

**Table 3-1 Patient List Personas**

Personnel Group	Access and Considerations
Registries Whitelist	Grants access to the overall application. Required for roles that need to access registry, measure, and patient information.
Registries Administrators	Grants access to all application features and patients.
Registries Reviewers	Grants access to all patients in all organizations.

Different roles in the organization may require different levels of access. For example:

- A system administrator or director of population health that requires access to all patients and features in the tenant should be:
  - Added to the registries\_whitelist personnel group to gain access the application.
  - Added to the registries\_administrators personnel group to gain access to all patients and features.
- A quality manager that requires access to three different organizations and the associated patients should be:
  - Added to the registries\_whitelist personnel group to gain access the application.
  - Made an administrator for the three organizations for which they need access to the patients, to gain access to all patients in those three organizations.

- A provider that requires access to only patients to whom they are attributed should be:
  - Added to the registries\_whitelist personnel group to gain access the application.
  - Made a member of one or more organizations at which they practice to gain access to their own attributed patients in those organizations.

For a full list of all supported personnel groups see [Configure Personnel Groups in the Oracle Health Data Intelligence Security Model](#).

## Patients List Data Access Considerations

The data access parameters that are set determine what you can view on the Patient List.

The Patients list page includes the following data access considerations:

- **Customers using only Attribution**
  - Organization administrators can see all patients attributed to any member in that organization.
  - Organization members can see only patients who are directly attributed to them.
- **Customers using Attribution and Affiliation**
  - Organization administrators can see the following information:
    - \* All patients attributed to any member in that organization.
    - \* All patients affiliated with that organization.
  - Organization members can see the following information:
    - \* All patients that are directly attributed to them.
    - \* Patients affiliated with their organization but without any attributed providers.

## AI Patient Prioritization

AI Patient Prioritization helps identify patients that may benefit from short-term follow up and intervention.

Artificial Intelligence (AI) powered Patient Prioritization is an advanced feature that assists care teams in identifying adult ( $\geq 18$  years of age) patients that could benefit most from immediate intervention, potentially improving outcomes and preventing unplanned emergency department visits.

The feature is powered by a predictive model that analyzes demographics, medical conditions, symptoms, lab results, vital signs, procedures, and medications to determine whether a patient would benefit from immediate intervention. Patients are ranked as High, Medium, Low, or No Data, and rankings are displayed in the Opportunity column on the Patients list. The top 10 percent of patients are labeled as High; the central 80 percent as Medium; the bottom 10 percent as Low. Patients ranked as No Data do not have a score available in the system.

Position your mouse over the ranking to view recommended actions for the patient and key factors that contributed to the ranking.

**Patients** Quality Performance

Default Columns

Please select a filter or search for a patient using name, MRN or EMPI ID

Organization Class Organization Provider Payer Plan Registry Measure Measure Status Scorability ...

130,331 Persons Export Save View Select View

Opportunity	Name (MRN)	Date of Birth (Age)	Gender (Birth Sex)	Primary Contact	Total Unmet Measures	Provider Name	Recent Visit Date
High	TEST PATIENT 1 MRN: 19776 (Cern...)	Aug 17, 1992 33 years	F Birth Sex: F	123555555 Type: Pager personalM...	25	Test Provider	Mar 12, 2025
High	TEST PATIENT 2 MRN: 27510 (Cern...)	Apr 27, 1955 70 years	M Birth Sex: M	989555555 Type: Home Phone	78	2 Providers	Sep 1, 2024
Medium	TEST PATIENT 3	Jul 11, 1954	M	1234567890	54	2 Providers	Apr 18, 2024

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Home Quality Contracts Patients Classic

**Recommended Actions**

1. Review the patient's chart.
2. Schedule a primary care appointment.

**Key Factors**

- Days since previous Encounter  
5 Days
- Days since last Emergency Room visit  
23 Days
- Days since last Inpatient visit  
29 Days
- Number of Emergency Room visits in last 180 days  
2 Occurrences in the Past 180 Days
- Low Hematocrit %  
14 Occurrences in the Past 30 Days
- Elevated Systolic Blood Pressure  
2 Occurrences in the Past 30 Days
- Glasgow Coma Score (GCS)  
8 Occurrences in the Past 30 Days
- Weight  
9 Occurrences in the Past 30 Days

The AI Patient Prioritization rankings are intended for teams who are focused on reducing acute care utilization. Quality managers can use these rankings to make decisions about scheduling outpatient visits to reduce the risk and associated cost of acute care utilization.

If these rankings do not apply to your role, you can hide the Opportunity column from view. See View the Patient List [View the Patients List](#) for information on customizing the Patient List view.

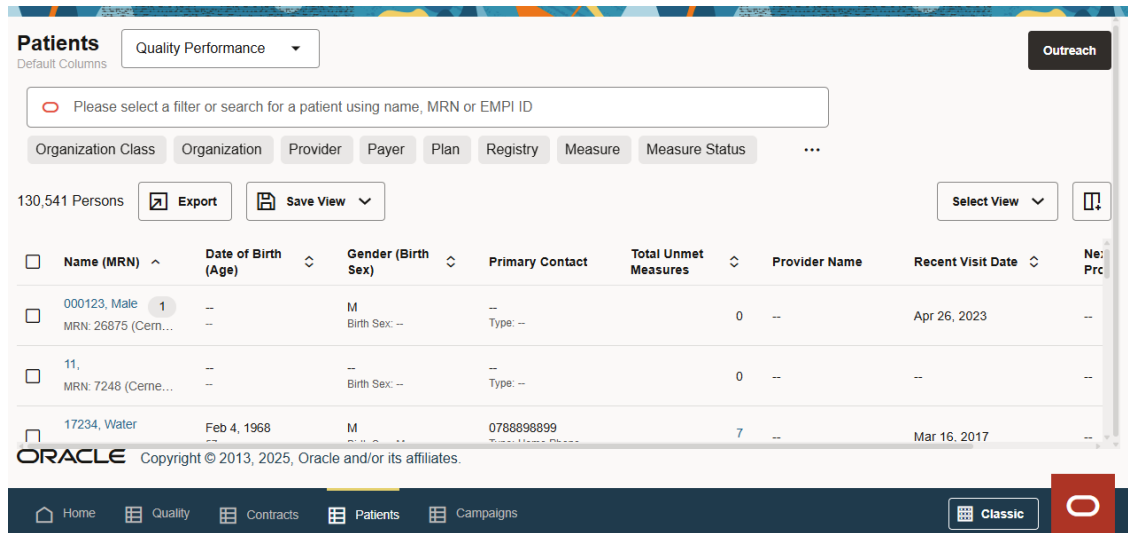
The AI Patient Prioritization model is powered by a predictive algorithm that uses the data elements below. Data is refreshed and prioritized is updated every 24 hours.

Data Element	Description
<b>Condition</b>	Presence of clinical condition, problem, diagnosis that is discretely captured documented within the last 180 days.
<b>Medications</b>	Identification and definition of a medication, including its ingredients, that was prescribed, dispensed, or administered (individually or in combination) to the patient within the past 90 days.
<b>Patient Demographics</b>	Gender, race, ethnicity.
<b>Procedures</b>	Discrete procedure documented within last 90 days.
<b>Results</b>	Discrete lab results recorded within last 30 days.
<b>Vital Signs</b>	Discrete vital signs within last 30 days.
<b>Patient Population</b>	Patient age is greater than or equal to 18 years of age as of today's date.
<b>Patient Exclusion</b>	<ul style="list-style-type: none"> <li>• Patients who are deceased any time before the end of the current measurement period.</li> <li>• Patients in hospice care within last 30 days.</li> <li>• Patient with problem = Pregnancy without Pregnancy Completion.</li> </ul>

## View the Patient List Dashboard

Use the dashboard to filter and sort the Patient list.

The Patients page is the updated view for the current Registries worklist. This page is the primary source for users to identify actionable patients in their healthcare organization, and is the starting point for future patient outreach. The Patients page includes a list of all patients in the population and key data required to evaluate the patient's current clinical status and any next steps needed to help close the patient's open care gaps.



The Patients page contains two main components:

- Smart search
- Patients list

## Select a Reporting Project

Select the reporting project you want to view.

A reporting project consists of the following main properties

- Content (Registries and Measures)
- Measurement Period (Calendar year versus rolling 365 days)
- Population

The following table contains examples of two different reporting projects:

Reporting Project	Content	Measurement Period	Population
Clinical Standard	Registries and measures from the clinical standard v4 content catalog are included.	Rolling 365 days, patient outcomes are calculated based on results from last 365 days.	Full HealtheRegistries population.
HEDIS MY2025	Measures from the HEDIS MY2025 content catalog are included.	Calendar year; patient outcomes are calculated based on results from current calendar year.	Full HealtheRegistries population.

The above two reporting projects apply to the same population. The Clinical Standard reporting project hosts information related to the clinical standard measures while the HEDIS MY2025 includes all HEDIS MY2025 measures. Access to multiple reporting projects allows you to view content from various catalogs in the same workflow and application.

You can select the reporting project for which you want to view details from the Reporting Project menu. You can access all reporting projects your organization is tracking against from Quality Management in the Quality view and the Patients view. The default reporting project is

Quality Performance and includes the set of content your organization had enabled in HealthRegistries.

You can access the Reporting Project menu from both the Quality and Patients views. Reporting projects displayed on the menu are enabled in Console. When you access the Reporting Project menu from the Patients view, additional projects may be displayed related to Value Based Care contracts if your organization is using Contract Performance.

From the Reporting Project menu, select the reporting project you want to view. Data for that reporting project is displayed.


### Note

For information on enabling reporting projects in Quality Performance, see the Oracle Health Quality Management Administrator Guide.

## Use Patient Smart Search

Use Patients smart search to filter and search the list of patients.

The smart search component enables you to filter the list of patients and search for a patient in the Patients list. To search for a patient, type the patient's name, medical record number (MRN), or enterprise master patient index ID (EMPI ID) in the search box and press **Enter**. The Patients list is filtered to match only those patients for whom the keyword is relevant. For example, searching for 123 returns all patients who have 123 in their MRN.

To search for specific filter values, select a filter value or multiple values. To access the full list of filters, select Ask Oracle (  ) in the search field or select the ellipsis ( **...** ) .

The Patients page supports the following filters:

**Table 3-2 Patient list filters**

Filter	Definition
<b>Age</b>	The age of the patient.
<b>Attribution Status</b>	Identifies if patient is attributed to a provider or organization.
<b>Contract</b>	The list of the patient's payer-related contracts.
<b>Country</b>	The patient's country of residence.
<b>Date of Birth</b>	The patient's date of birth.
<b>Gender</b>	The patient's gender.
<b>Measure</b>	The name of the measure. Use this filter to search and filter for specific measures. For example, <b>Blood Pressure Management</b> .

Table 3-2 (Cont.) Patient list filters

Filter	Definition
<b>Measure Status</b>	The status of the selected measure. Filter options include excluded, met, no data, and not achieved. When you select the excluded option, patients are displayed that have been excluded based on the measure exclusion criteria and patients that have been manually excluded from this measure.
<b>Next Attributed Provider Visit Date</b>	The date of the patient's next scheduled attributed provider visit.
<b>Next Other Visit Date</b>	The patient's next visit date if the visit is not with their attributed provider.
<b>Opportunity</b>	The Opportunity index for the patient. Opportunity automatically identifies, categorizes, analyzes risk, and identifies the highest impacts on patient health. The insights build on Oracle Health's decade-long investment into an extensive knowledge base of care gaps, chronic diseases, and patient care journeys. Currently, Oracle supports High, Medium, and Low and No Data.
<b>Organization</b>	The name of the organization. If a user is a member or administrator of multiple organizations, they can use this filter to select a specific organization.
<b>Organization Class</b>	The name of the organization class. If a user is a member or administrator of multiple organization classes, they can use this filter to select a specific organization class.
<b>Payer</b>	The payer associated with the patient based on the healthcare organization's enrollment file data in HDI.
<b>Plan</b>	The plan associated with the patient based on the healthcare organization's enrollment file data in HDI.
<b>Postal Code</b>	The patient's postal code.
<b>Preferred Contact Type</b>	The patient's preferred contact method.
<b>Provider</b>	The patient's attributed provider. Use this filter to search for and select specific providers in the organization.
<b>Race</b>	The patient's race.
<b>Recent Visit Date</b>	The patient's most recent visit date.

**Note**

This filter applies only to administrators. If a user is a member, they can only select their own name in the Provider filter.

Table 3-2 (Cont.) Patient list filters


Filter	Definition
<b>Registry</b>	Name of the registry. Use this filter to narrow the list of patients and to view only patients who are part of a specific registry.
<b>Registry Count &gt;=</b>	The total number of registries the patient is included in.
<b>Risk Score</b>	The MARA Risk Score value for the patient.
<b>Scorability</b>	The patient's scorability, determined by each organization's scorability algorithm.
<b>State/Province</b>	The state or province in which the patient resides.
<b>Total Measures &gt;=</b>	The total number of measures for the patient.
<b>Total Unmet Measures &gt;=</b>	The total number of measures in an unmet status for the patient.

For example, if you select the Asthma Registry and Medicaid as the payer, the list of patients displayed in the grid includes only Medicaid patients in the Asthma Registry.

## View the Patients List

The Patients list includes columns that display relevant patient information.

The Patients list is a table with the list of patients based on the selected filters from the search. The list is displayed in the default columns view. To add additional columns, select **Column**

**Configuration** () then select the columns you want to add to the view. Patient information displayed on the Patients list is sourced from preferred demographics.

You can export the patient list to a CSV or Microsoft Excel file by selecting the Export button. The maximum number of patients that you can export is 10,000.

The following columns are supported in the Patient list:

Table 3-3 Patient List columns

Column Name	Included in Default View	Definition
<b>Address</b>	No	The patient's full address.
<b>Contracts</b>	No	List of the patient's related payer contracts.
<b>Country</b>	No	The country in which the patient resides.
<b>Date of Birth (Age)</b>	Yes	The patient's date of birth and age.
<b>Deceased</b>	No	Indicates if the patient is deceased.
<b>Email Address</b>	No	The patient's email address.
<b>Gender (Birth Sex)</b>	Yes	The patient's gender and birth sex.
<b>Language</b>	No	The patient's preferred language in the HDI platform.

Table 3-3 (Cont.) Patient List columns

Column Name	Included in Default View	Definition
List of Registries	No	The patient's list of all registries.
List of Unmet Measures	No	The patient's list of all measures in an unmet status (No Data, or Not Achieved).  When the Scorability filter is set to scorable and you select a single organization or physician, only scorable measures are displayed.
MARA Risk Score	No	The Milliman Advanced Risk Adjusters (MARA) risk score for the patient.
Name (MRN)	Yes	The patient's name and MRN.
Next Attributed Provider Visit Date	Yes	The date of the patient's next visit with their attributed provider.
Next Attributed Provider Visit Provider	No	The name of the provider with which the patient's next visit is scheduled (if the provider is their attributed provider).
Next Attributed Provider Visit Reason	No	The reason of the visit for the patient's next visit with their attributed provider.
Next Other Visit Date	No	The patient's next visit date if the visit is not with their attributed provider.
Next Other Visit Provider	No	The patient's next visit provider if the visit is not with one of their attributed providers.
Next Other Visit Reason	No	The patient's next visit reason if the visit is not with one of their attributed providers.
Opportunity	Yes	The Opportunity index for the patient. Opportunity automatically identifies, categorizes, analyzes risk, and identifies the highest impacts on patient health. The insights build on Oracle Health's decade-long investment into an extensive knowledge base of care gaps, chronic diseases, and patient care journeys.  Currently, Oracle supports High, Medium, and Low.
Payers	No	The payers associated with the patient based on the healthcare organization's enrollment file data in HDI.
Phone Number	No	The patient's phone number.
Plans	No	The plan associated with the patient based on the healthcare organization's enrollment file data in HDI.

Table 3-3 (Cont.) Patient List columns

Column Name	Included in Default View	Definition
Postal Code	No	The postal code for the patient's residence.
Primary Contact	Yes	The patient's primary contact information.
Provider Name	Yes	The patient's attributed providers.
Race	No	The patient's race.
Recent Visit Date	Yes	The patient's most recent visit date.
Recent Visit Provider	No	The provider responsible for the patient's most recent visit.
Recent Visit Reason	No	The appointment reason for the patient's most recent visit.
State/Province	No	The state or province in which the patient resides.
Total Measures	No	The total number of all measures applicable for this patient. Select the number to view the total list of measures for this patient.  When the Scorability filter is set to scorable and you select a single organization or physician, only scorable measures are displayed.
Total Registries	No	The total number of all registries the patient is a part of. Select the number to view the total list of registries for this patient.
Total Unmet Measures	Yes	The total number of all unmet measures for this patient. Select the number to view the total list of all unmet measures for this patient.  When the Scorability filter is set to scorable and you select a single organization or physician, only scorable measures are displayed.

For customers using Diagnosis Insights, the following hierarchical condition category (HCC)-related columns are supported in the Patient List:

Table 3-4 Diagnosis insights columns

Column Name	Definition
<b>RAF Score</b>	A risk adjustment factor (RAF) score is a medical risk adjustment model used by the Centers for Medicare and Medicaid Services (CMS) and insurance companies to represent a patient's health status. The CMS-HCC risk score for a beneficiary is the sum of the score or weight attributed to each of the demographic factors and HCCs in the model.
<b>Total Unaddressed Highly Suspected Conditions</b>	The patient's total number of coding gaps that are highly suspected.
<b>List of Unaddressed Highly Suspected Conditions</b>	The patient's list of coding gaps that are highly suspected.
<b>Total Unaddressed Moderately Suspected Conditions</b>	The patient's total number of coding gaps that are moderately suspected.
<b>List of Unaddressed Moderately Suspected Conditions</b>	The patient's list of coding gaps that are moderately suspected.
<b>Total Unaddressed Persistent Conditions</b>	The patient's total number of coding gaps that are persistent conditions.
<b>List of Unaddressed Persistent Conditions</b>	The patient's list of coding gaps that that are persistent conditions.
<b>Total Unaddressed Suspected and Persistent Conditions</b>	The patient's list of coding gaps that are moderately, highly suspected or persistent.

## View and Add Patient Notes

Add a note to a patient's record.

Quality managers and others with permissions can view and add notes to the patient's profile in Quality Management.

A numbered badge is displayed next to the patient name for patients whose profile contains a note. Select the patient's name to open the patient dialog box, and select **Notes** to view the patient notes.

Select **Add Note** to add a note to the patient's profile.

The table below identifies which personnel groups have permissions to add, view, and delete notes.

Personnel Group	Notes Permissions
system_administrators registries_administrators	Can view, add, edit, and delete notes for all patients.
registries_reviewers registries_allowlist	Can view and add notes for all patients they have access to. Can only edit and delete notes they have created.
demographics_data_entry_clerks	Can view, add, edit, and delete notes for all patients they have access to.

The screenshot shows the Oracle Patients list interface. On the left, there's a 'Patients' section with a 'Quality Performance' filter. Below it, there are filter buttons for 'Organization Class', 'Organization', 'Provider', and 'Payer'. A search bar prompts the user to 'Please select a filter or search for a patient using name'. Below the search bar, there are 'Export' and 'Save View' buttons. A table lists three patients: 'TEST PATIENT 1' (MRN: 28862, Sep 9, 1990, 35 years, F), 'TEST PATIENT 2' (MRN: 972, May 5, 1940, 85 years, M), and 'TEST PATIENT 3' (Jun 10, 1952, M). The 'TEST PATIENT 2' row is selected, and a red box highlights the number '4' in the 'Notes' column. On the right, the 'TEST PATIENT 2' detail panel is open, showing 'Patient Information' and 'Notes (4)'. Below the detail panel, there are 'Expand All' and 'Collapse All' buttons. The bottom navigation bar includes 'Home', 'Quality', 'Contracts', and 'Patients'.

## Create a Customized View

Create a customized view of the Patients list that you can save, share, and export.

You can create and save a customized view of the Patients list. You can then share and export your customized view.

To create a customized Patients list view:

1. Add any additional columns by selecting the column configuration button and selecting the columns that you want to add.
2. Select and customize any filters you want to include on the list. For example, you can select the Age filter and customize it to only show patients over the age of 65.
3. Select **Save View** and then **Save New**.
4. Enter a name for the view and select **Save**.
5. Select **Select View** and verify that your custom view is in the list.
6. To return to the default patient list view, select **Select View** and then **Default Columns**.

Select **Share** to generate a link that you can use to share your view. You can share your view with any other user, but they can only view patients based on their own level of access.

Select **Delete** to delete your view. Once you delete a view, it cannot be recovered.

## Export the Patients List

Export up to 10,000 patients from the Patients list.

Select **Export** to export a customized or default view of the patient list to a CSV or Microsoft Excel file. If the `restrict_patient_export` setting is set to **Yes**, export capabilities are disabled for all users except `system_administrators` and `registry_administrators`. The maximum population count that you can export is 10,000.

You can select specific patients to export by selecting the checkbox next to the patient's name. You can select as many patients as you want.

## Single Measure View

Selecting a single measure introduces four new columns to the Patients list.

From the Patients list, if a single measure is selected as a filter, it introduces the following four contextual columns at the beginning of the list:

**Table 3-5 Single measure columns**

Column Name	Definition
Selected Measure Name (for example, Annual Lipid Panel)	<p>The measure status for the measure you selected. Currently supports the following measure statuses:</p> <ul style="list-style-type: none"> <li>• <b>Met</b> - The patient has a supporting fact in the measurement period that meets the Met Criteria of the measure.</li> <li>• <b>Not Achieved</b> - The patient has a supporting fact in the measurement period but it does not meet the Met criteria of the measure.</li> <li>• <b>No Data</b> - The patient does not have a supporting fact in the measurement period.</li> <li>• <b>Excluded</b> - The patient has been excluded from the measure either manually or based on the exclusion parameters for the measure.</li> </ul> <p>Additionally the Measure Status filter allows you to filter using any one of the above statuses. This filter is always available, even when the user is not in the single measure view.</p> <p>For cases when no measures are filtered, the system behaves as if all measures are selected. For example:</p> <ul style="list-style-type: none"> <li>• Measure Status = Met, no measure selected. All patients are displayed that are in the Met status for all of their measures.</li> <li>• Measure Status = Not Achieved, no measure selected. All patients are displayed that are in the Not Achieved status for all of their measures.</li> </ul> <p>When no measures are selected and you filter for a single measure status, only patients who have all their measures in the selected status are displayed.</p>
<b>Latest Supporting Fact</b>	The patient's latest supporting fact for this measure.
<b>Fact Date</b>	The date of the latest supporting fact for this measure.

Table 3-5 (Cont.) Single measure columns

Column Name	Definition
Scorability	<p>The patient's scorability status for this measure. A patient can either be scorable or not scorable for a specific measure based on scorability algorithms that are used.</p> <p>Additionally the Scorable filter allows you to filter for patients that are Scorable/Not Scorable. This filter is always available, even when the user is not in the single measure view.</p> <p>For cases when no measures are filtered, the system behaves as if all measures are selected. For example:</p> <ul style="list-style-type: none"> <li>Scorable = Yes, no measure selected. This should display all patients that are Scorable for all of their measures.</li> <li>Scorable = No, no measure selected. This should display all patients that are in the Not Scorable for all of their measures.</li> </ul> <p>When no measures are selected and you filter for a single measure status, only patients who have all their measures in the selected status are displayed.</p>

## View Patient Information

View detailed patient information in a dialog box, including demographics, scores, visits, providers, and associated measures.

You can view all patient-relevant information by selecting the patient name in the Patients list to open the Patient dialog box. The patient dialog box includes all relevant patient information in full form that is displayed in the Patients list columns. You can select the patient's name in the Patient dialog box to open the current HealthRegistries patient profile page.

To view patient information:

1. Select a patient from the Patient list. The Patient dialog box is displayed.
2. Expand a section to view information in that section. See the table below for details about the information that is displayed in each section.
3. Select the **Notes** tab to see any notes associated with the patient.
4. Select the **Next** and **Previous** buttons to view information for the next or previous patients in the list.
5. Select **Close** to close the patient dialog box.

The following sections are included in the patient information dialog box:

**Table 3-6 Patient Information dialog box**

<b>Section</b>	<b>Details</b>
<b>Scores</b>	Displays the following scores: <ul style="list-style-type: none"> <li>• MARA risk score</li> <li>• RAF score</li> <li>• Opportunity</li> </ul>
<b>Patient Details</b>	Displays the following details: <ul style="list-style-type: none"> <li>• Birth Sex</li> <li>• Gender</li> <li>• MRN</li> <li>• Race</li> </ul>
<b>Contact</b>	Displays the following contact information: <ul style="list-style-type: none"> <li>• Address</li> <li>• Country</li> <li>• Email</li> <li>• Language</li> <li>• Phone Number</li> <li>• Postal Code</li> <li>• State/Province</li> </ul>
<b>Payer</b>	Displays the following payer information: <ul style="list-style-type: none"> <li>• Payer</li> <li>• Plan</li> <li>• Source</li> <li>• Member ID</li> </ul>
<b>Providers</b>	Displays the following provider information: <ul style="list-style-type: none"> <li>• Provider</li> <li>• Attribution Status</li> </ul>
<b>Recent Visits</b>	Displays the following recent visit information: <ul style="list-style-type: none"> <li>• Visit Date</li> <li>• Provider</li> <li>• Reason</li> <li>• Type</li> </ul>
<b>Contracts</b>	Displays the following contract information: <ul style="list-style-type: none"> <li>• Name</li> <li>• Type</li> <li>• Payer</li> <li>• Plan</li> </ul>
<b>Recent Visits</b>	Displays the following recent visit information: <ul style="list-style-type: none"> <li>• Visit Date</li> <li>• Provider</li> <li>• Reason</li> </ul>
<b>Next PCP Visits</b>	Displays the following primary care provider (PCP) next visit information: <ul style="list-style-type: none"> <li>• Visit Date</li> <li>• Provider</li> <li>• Reason</li> </ul>

**Table 3-6 (Cont.) Patient Information dialog box**

Section	Details
<b>Next Other Visits</b>	Displays the following next other visit information: <ul style="list-style-type: none"> <li>• Visit Date</li> <li>• Provider</li> <li>• Reason</li> </ul>
<b>Registries</b>	Displays the following registry information: <ul style="list-style-type: none"> <li>• Registry</li> <li>• Unmet Measures</li> <li>• Total Measures</li> </ul>
<b>Measures</b>	Displays the following measure information: <ul style="list-style-type: none"> <li>• Measure</li> <li>• Status: you can view supporting facts for that measure by positioning your mouse over the status.</li> <li>• Due Date</li> </ul>

- [Review Patient Clinical Details](#)  
View detailed clinical information for a selected patient using the Patient View link.

## Review Patient Clinical Details

View detailed clinical information for a selected patient using the Patient View link.

You can view all patient-relevant clinical details by selecting **Patient View** from the patient panel on the Patients page. The Patient View page includes all relevant clinical information about a selected patient.

### Note

All information available on the Patient View page is also available on the patient profile page in HealtheRegistries.

To access the Patient View page, complete the following steps:

1. Select the **Patient** tab at the bottom of the Home page. This opens the Patients page with a list of patients.
2. Select a patient name in the list to open a panel with the name of the patient at the top.
3. Select **Patient View** next to the patient name to open clinical overview details. This page summarizes all the clinical details available in the other tabs. See the following tab descriptions for details:
  - **Overview:** Contains details on information available in each tab. You can select **View Details** under each section to open the corresponding tab.
  - **Conditions:** Lists the diagnosis of the patient. You see the following details:
    - Condition
    - Condition Code
    - Coding System Name

- Effective Date
- Providers
- Source Type
- Status
- **Vitals:** Lists vitals taken from the most recent visit, history of vitals, and report of vitals over a one-year time frame. Select any of the listed vitals on the left to view the following details:
  - Date
  - Measurement
  - Record
  - Interpretation
  - Reference Range
  - Verified
  - Source
- **Results:** Lists test results taken from the most recent visit, history of test results, and report of test results over a one-year time frame. Select any of the listed test results on the left to view the following details:
  - Date
  - Result
  - Record
  - Interpretation
  - Reference Range
  - Status
  - Source
- **Immunizations:** Lists the immunizations of the patient. You see the following details:
  - Immunization
  - Providers
  - Administered Date
  - Product
  - Manufacturer
  - Lot Number
  - Source
  - Status
- **Visits:** Lists all documented clinical visits for the patient. You see the following details:
  - Visit
  - Reason for Visit
  - Providers: If there are more than one provider listed, select the number of providers to view all listed providers.
  - Start Date

- Stop Date
  - Action: If you need to review details on the visit type, visit code, coding system, source, facilities, and claim diagnosis, select > in the Action column to view more details about the visit.
  - **Allergies:** Lists all documented allergies of the patient. You see the following details:
    - Allergen
    - Onset Date
    - Reactions
    - Source
    - Comments
    - Status
  - **Documents:** Lists all documents available for the patient. You see the following details:
    - Title: Select the document title to access the document.
    - Type
    - Author
    - Source
    - Date
4. If you need to review patient demographics, you can select **Demographics** from the top of the page (near patient name) at any time. You see the following details:
- Medical Record Number (MRN). A patient may have one or more MRNs listed.
  - Date of birth (DOB)
  - Age
  - Oracle ID
  - Gender
  - Address
  - Primary Contact
  - Email
  - Payer ID

## Select a Reporting Project

Select a reporting project to view measure data based on content, measurement periods, or populations across your organization.

You can select the reporting project for which you want to view details from the Reporting Project menu. (Add screenshot)

You can access all reporting projects that your organization tracks in Quality Management through the Quality view and the Patients view. Quality Performance is the default report, and it includes the set of content your organization enabled in HealthRegistries.

Reporting projects displayed in the menu are enabled in Console. When you access the Reporting Project menu from the Patients view, additional projects may be displayed related to Value-Based Care contracts if your organization uses Contract Performance.

### **Note**

For information on enabling reporting projects in Quality Performance, see the Oracle Health Quality Management Administrator Guide.

A reporting project consists of the following main properties:

- Content (Registries and Measures)
- Measurement Period (Calendar year versus rolling 365 days)
- Population

The following table contains examples of different reporting projects:

Reporting Project	Content	Measurement Period	Population
Clinical Standard	Registries and measures from the clinical standard v4 content catalog.	Rolling 365 days, patient outcomes are calculated based on results from the last 365 days.	Full HealthRegistries population.
HEDIS MY2025	Measures from the HEDIS MY2025 content catalog.	Calendar year; patient outcomes are calculated based on results from the current calendar year.	Full HealthRegistries population.

The reporting projects above apply to the same population. The Clinical Standard reporting project hosts information related to the clinical standard measures while the HEDIS MY2025 includes all HEDIS MY2025 measures. Access to multiple reporting projects allows you to view content from various catalogs in the same workflow and application.

## Filter the Patient List

Filter and view patients using the Patients list.

To filter the Patients list:

1. Select a filter from the smart search component. To access the full list of filters, select Ask Oracle (Red oval on its side for Ask Oracle) in the search field or select the ellipsis (Three dots in a row for Ellipsis).
2. Select an option from the list, or enter a search term in the filter's search field.
3. Select outside the search field. The Patients list is filtered.

See the table below for the list of filters supported in the Patients list.

**Table 3-7 Patient list filters**

Filter	Definition
Age	The age of the patient.

Table 3-7 (Cont.) Patient list filters

Filter	Definition
<b>Attribution Status</b>	Identifies if patient is attributed to a provider or organization.
<b>Contract</b>	The list of the patient's payer-related contracts.
<b>Country</b>	The patient's country of residence.
<b>Date of Birth</b>	The patient's date of birth.
<b>Gender</b>	The patient's gender.
<b>Measure</b>	The name of the measure. Use this filter to search and filter for specific measures. For example, <b>Blood Pressure Management</b> .
<b>Measure Status</b>	The status of the selected measure. Filter options include excluded, met, no data, and not achieved. When you select the excluded option, patients are displayed that have been excluded based on the measure exclusion criteria and patients that have been manually excluded from this measure.
<b>Next Attributed Provider Visit Date</b>	The date of the patient's next scheduled attributed provider visit.
<b>Next Other Visit Date</b>	The patient's next visit date if the visit is not with their attributed provider.
<b>Opportunity</b>	The Opportunity index for the patient. Opportunity automatically identifies, categorizes, analyzes risk, and identifies the highest impacts on patient health. The insights build on Oracle Health's decade-long investment into an extensive knowledge base of care gaps, chronic diseases, and patient care journeys. Currently, Oracle supports High, Medium, and Low and No Data.
<b>Organization</b>	The name of the organization. If a user is a member or administrator of multiple organizations, they can use this filter to select a specific organization.
<b>Organization Class</b>	The name of the organization class. If a user is a member or administrator of multiple organization classes, they can use this filter to select a specific organization class.
<b>Payer</b>	The payer associated with the patient based on the healthcare organization's enrollment file data in HDI.
<b>Plan</b>	The plan associated with the patient based on the healthcare organization's enrollment file data in HDI.
<b>Postal Code</b>	The patient's postal code.
<b>Preferred Contact Type</b>	The patient's preferred contact method.

Table 3-7 (Cont.) Patient list filters

Filter	Definition
<b>Provider</b>	The patient's attributed provider. Use this filter to search for and select specific providers in the organization.
<div style="border: 1px solid #ccc; border-radius: 10px; padding: 10px; margin: 10px 0;"> <p><b>Note</b></p> <p>This filter applies only to administrators. If a user is a member, they can only select their own name in the Provider filter.</p> </div>	
<b>Race</b>	The patient's race.
<b>Recent Visit Date</b>	The patient's most recent visit date.
<b>Registry</b>	Name of the registry. Use this filter to narrow the list of patients and to view only patients who are part of a specific registry.
<b>Registry Count &gt;=</b>	The total number of registries the patient is included in.
<b>Risk Score</b>	The MARA Risk Score value for the patient.
<b>Scorability</b>	The patient's scorability, determined by each organization's scorability algorithm.
<b>State/Province</b>	The state or province in which the patient resides.
<b>Total Measures &gt;=</b>	The total number of measures for the patient.
<b>Total Unmet Measures &gt;=</b>	The total number of measures in an unmet status for the patient.

## Search for a Person in the Patient List

Locate and view a person using Oracle Health Quality Management.

The Smart Search component enables you to search for a patient in the Patients list.

To search for a patient, enter the patient's name, medical record number (MRN), or enterprise master patient index ID (EMPI ID) in the search box and press Enter. A list of patients matching the search criteria is displayed. For example, searching for **123** returns all patients who have 123 in their MRN.

# 4

## Contract Performance

Oracle Health Contract Performance is designed to provide tracking for value-based contract KPIs, and centralize and automate a value-based contract portfolio for healthcare organizations.

- [Contract Performance Introduction](#)  
Oracle Health Contract Performance provides tracking for value-based contract KPIs.
- [Data Requirements](#)  
You must meet certain data requirements in order to use the Contracts dashboard.
- [Contract Performance Personas](#)  
You must be added to the appropriate Personnel group to access Contract Performance.
- [Contract Performance Access Considerations](#)  
Certain roles can view all relevant information on contract organization and provider summary pages.
- [Console and HDI Application Access](#)  
Access Contract Performance and Console using direct links.
- [Contract Performance Application Workflows](#)  
Contract Performance includes Console and Quality Management workflows.
- [Configure Contract Performance](#)  
You can create, modify, and delete value-based contracts.
- [Contract Performance Tracking](#)  
View contracts that are configured in Console in Contract Performance.
- [Contracts Page](#)  
View the list of contracts.
- [Set Cost and Utilization Targets](#)  
Set cost and utilization targets for a contract.
- [Link Measures to a Contract](#)  
Set targets to link measures to a contract.
- [Create Domains](#)  
You can create groups of measures into domains
- [Set Targets for a Domain](#)  
Set target values for a domain.
- [Select and Assign Weight to Measures for a Domain](#)  
Assign weigh to measures in a domain.
- [Create Domain Groups](#)  
You can create groups of domains.
- [Set Targets for Domain Groups](#)  
Set target values for a domain group.
- [Add Domains to a Domain Group](#)  
Select the domains to add to a domain group.

- [Single Contract](#)  
View details for a specific contract.
- [Contract Overview](#)  
Cost and performance details for a selected contract.
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Cost and utilization details for a selected contract.
- [Quality Performance](#)  
Quality performance details for a selected contract.
- [Organizations](#)  
Organization details for a selected contract.
- [Providers](#)  
Provider details for a selected contract.
- [Contract Information](#)  
Contract details for a selected contract.

## Contract Performance Introduction

Oracle Health Contract Performance provides tracking for value-based contract KPIs.

Oracle Health Contract Performance provides a continuous, forward-looking view of performance across value-based contract key performance indicators (KPIs). The application brings together clinical and claims data to identify where shared savings are at risk, where utilization can be reduced, and where provider or measure performance needs attention. Core functionality includes:

- Providing visibility into all executed contracts across the performance year and tracking KPIs in cost of care, utilization, quality, and risk adjustment.
- Creating a value-based contract (VBC) portfolio that defines the parameters of the contract, key goals, and the patient population. Help to reduce time spent and replace manual VBC portfolios and Excel spreadsheets with an automated solution that drives contract goals and improves financial and quality performance..
- Proactively track current performance against contract KPIs and identify low-performing areas and near meeting opportunities.
- Use AI Patient Prioritization to identify the patients who may benefit most from timely intervention for your contracted population. Help organizations prioritize their resources on patients to improve health outcomes and reduce acute venue of care use.

## Data Requirements

You must meet certain data requirements in order to use the Contracts dashboard.

Customers must use the existing HealthRegistries application, Diagnosis Insights, or HCC Analytics in HDI to qualify to use the Contract dashboard. The current offering includes Medicare Shared Savings Program (MSSP) Measurement Year 2024 and 2025 performance tracking.

MSSP MY 2024 and 2025 Contract Performance Tracking includes the following information:

- An up-to-date payer benefit plan reference data table. See Reference Payer Benefit Plan Data Set - Spec Version 3 (<https://wiki.cerner.com/x/OmJ1jw>) for more information.
- MSSP enrollment.

- MSSP claims
- CMS HCC risk model
- eCQM 2024 measures
- eCQM 2025 measures
- MIPS CQM 2024 measures
- MIPS CQM 2025 measures

**Note**

Customer validation activities for the Contract Performance application workflows do not include validation of the quality measure or hierarchical condition categories (HCC) content. If the quality measure or HCC content has not been previously validated in your organization, Oracle recommends engaging consulting services for content level validation support before using in application workflows.

## Contract Performance Personas

You must be added to the appropriate Personnel group to access Contract Performance.

The following personas and associated security are available. Roles are managed in the Personnel tool.

**Table 4-1 Contract Performance Personas**

Role	Access and Considerations	Can View Patient List	Applies To
<b>Contract Performance Console Administrator</b>	Required to configure contracts in Console. Users in the Console Administrator role can access the Contract Performance Configuration console. Administrators can add, update, delete, and download contracts and templates. Assign contract_performance_console_administrator to these users.	Not applicable	Console

Table 4-1 (Cont.) Contract Performance Personas

Role	Access and Considerations	Can View Patient List	Applies To
<b>Contract Performance Operator</b>	Required for access to Contract Performance workflows in the application. Users in the Performance Operator role can access contract workflows in Quality Management Operators can view financial metrics across contracts, organizations, and providers. Operators also can open an actionable patient list. Assign contract_performance_operator to these users.	Yes	Oracle Health Quality Management
<b>Contract Performance Allow List</b>	Required for access to Contract Performance workflows in the application. Users on the allow list can access all contract workflows in Quality Management and can view financial metrics across contracts, organizations, and providers. Users on the allow list cannot access patient-level details or lists. Assign contract_performance_allowlist to these users.	No	Oracle Health Quality Management

## Contract Performance Access Considerations

Certain roles can view all relevant information on contract organization and provider summary pages.

For contract organization and provider summary pages, a member, administrator, or system administrator can view information relevant to all organizations and providers across their entire tenant for the contract selected.

## Console and HDI Application Access

Access Contract Performance and Console using direct links.

Use a direct link provided by the Oracle team to access the applications needed for Contract Performance. See [Accessing and Granting Access to Console](#) for more information on accessing Console.

# Contract Performance Application Workflows

Contract Performance includes Console and Quality Management workflows.

The following three core application workflows are available for Contract Performance and security considerations for both the Console and Oracle Health Quality Management applications:

- Contract Performance Configuration (Console)
- Contract Performance Tracking (Quality Management)
- Patients (Quality Management)

## Configure Contract Performance

You can create, modify, and delete value-based contracts.

Contract build and maintenance workflows contain the building blocks for creating a value-based contract portfolio in Oracle Health Quality Management. You can create, modify, and delete value-based contracts in Console.

## Contract Performance Tracking

View contracts that are configured in Console in Contract Performance.

Contract Performance is used to view contract performance for the contracts that have been configured in Console. The Contract Performance workflows allow you to view an expanded list of performance metrics across the value-based contract portfolio.

## Contracts Page

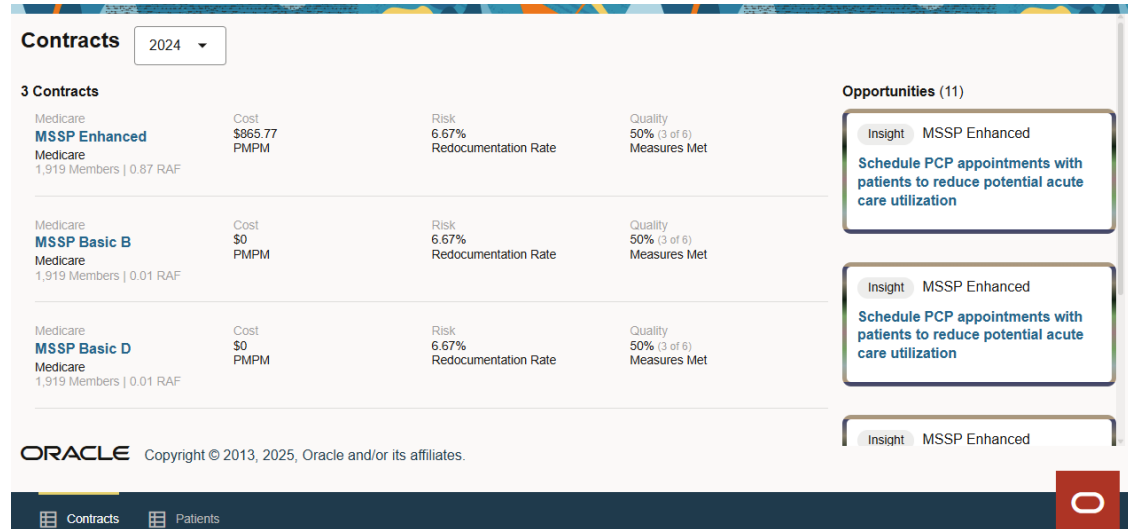
View the list of contracts.

All contracts for the selected year, and top opportunities across all contracts closing care gaps are displayed on the Contracts page. At a glance, the Contracts page identifies which contracts have downside risk and the delta between the actual and the organizational goal.

### Note

For users who have access to both Quality and Contracts, the Quality page is displayed by default when you sign in. To access the Contracts page, select the Contracts tab at the bottom of the page.

Figure 4-1 Contract Page



The following information is available on the Contracts page:

- **Filter:** Filter by year to view contracts for a specific year.
- **Contracts:** A list of contracts that have been uploaded in Console for performance monitoring. Contract-specific attributes and metrics are displayed per contract.
  - **Line of Business:** The line of business selected (if available) during the contract configuration.
  - **Cost:** Actual expenditure cost per member per month (PMPM).
  - **Risk:** HCC Redocumentation Risk. The HCC Redocumentation rate is the percentage of previously documented Hierarchical Condition Category (HCC) conditions that are accurately documented again in the current year.
  - **Quality:** Measure Quality displays the percentage of overall measures that are currently meeting their target.
  - **Opportunities:** Action items identified by both artificial intelligence (AI) and by contract parameters that can be used to help meet contract goals. Opportunities are ranked in order of highest patient opportunity and are categorized as follows:
    - \* AI Patient Prioritization Insight: AI-based member monitoring aims to help identify which patients are at highest risk for acute utilization and suggest the next best action to reduce the likelihood of acute care utilization. The recommended action is to schedule a primary care provider (PCP) visit.
    - \* Condition Documentation: Alerts to ensure that previously documented conditions are accurately and consistently documented in a patient's record each year. Displays a list of persons with four or more undocumented conditions during the performance period and persons who have the top two highest suspected conditions that are undocumented.
    - \* Quality: Insights related to care gap measures associated with the contract. Displays the top three underperforming contract measures that are closest to the target.

If a contract name is selected, you are directed to a detailed view of the selected contract where additional KPIs, estimated financial performance, and opportunities for improvement are available.

## Set Cost and Utilization Targets

Set cost and utilization targets for a contract.

You can set cost and utilization targets for your contract in the Contracts section of Oracle Health Quality Management. Targets are established in the hard copy of the contract, but entering them into Oracle Health Quality Management allows you to track your targets against real-time data, and identify progress toward your goals.

To set cost and utilization targets:

1. From the Contracts tab, select **Edit Target Plan** next to the contract you want to edit. The target tool is displayed, and the cost and utilization targets page is displayed.
2. Select **Edit Target** for the contract metric for which you want to set a target, incentive, or contract gate. The contract metric page is displayed.
3. Select one of the following options from the Target Type menu:
  - Simple Completion Percentage
  - Simple Completion Number
  - Tiered Completion Percentage
  - Tiered Completion Number
4. From the Target Value field, enter a target value.
5. If available, select an option from the Desired Trend menu. Some metric's trends are predefined and cannot be changed.
6. From the Payout Type menu, select one of the following options:
  - Per member per month (PMPM)
  - Per member per year (PMPY)
  - Lump sum
  - Per Care Gap Measure Closure
7. In the Payout Values field, enter a payout value.
8. Enter an organizational goal, if applicable.
9. Set the Contract Gate field to Yes or No, depending on whether the metric acts as a contract gate.
10. Select **Save** to save your changes.
11. If you want to remove targets from the metric, select **Clear Target**.

## Link Measures to a Contract

Set targets to link measures to a contract.

You can link measures to a contract by setting target information for the measure. Once targets are set, the target is added to the count of measures assigned to the contract at the top of the page.

To link measures to a contract and define their target attributes:

1. From the Contracts tab, select **Edit Target Plan** next to the contract you want to edit. The target tool is displayed.
2. Select **Measures** from the right side of the page. The Measures page is displayed.
3. Select **Edit Target** for the measure for which you want to set a target, incentive, or contract gate. The measure page is displayed.
4. From the Target Type menu, select one of the following options:
  - Simple Completion Percentage
  - Simple Completion Number
  - Tiered Completion Percentage
  - Tiered Completion Number
5. From the Target Value field, enter a target value.
6. If available, select an option from the Desired Trend menu. Some measure's trends are predefined and cannot be changed.
7. From the Payout Type menu, select one of the following options:
  - Per member per month (PMPM)
  - Per member per year (PMPY)
  - Lump sum
  - Per Care Gap Measure Closure
8. From the Payout Values field, enter a payout value.
9. Enter an organizational goal, if applicable.
10. Set the Contract Gate field to Yes or No, depending on whether the metric acts as a contract gate.
11. Select **Save** to save your changes. The Targets Set field is set to Yes and the measure is added to the Measures Assigned count.
12. If you want to remove the link to the measure, select **Clear Target** to remove targets.

## Create Domains

You can create groups of measures into domains

You can create groups of measures into a domain. A domain is a specific category or dimension of care used to evaluate, track, and improve quality. For example, you may want to create a domain of patient screening measures to track how the contract is performing against different screenings like breast cancer, diabetes, or colorectal cancer.

To create a contract domain:

1. From the Contract tab, select **Edit Target Plan**, next to the contract for which you want to create a domain.
2. Select **Domains** from the right side of the page. The Domains page is displayed.
3. Select **Add Domain**.
4. Enter a name for the domain and a description.
5. Select **Save**.

## Set Targets for a Domain

Set target values for a domain.

You can set target information for a domain. Depending on the contract, you may have targets set at the measure level or at the domain level, or both.

To set target information for a domain:

1. Select **Edit Domain** next to the domain for which you want to set a target.
2. Select **Add Target** to add a target value to the domain.
3. Select a value from the Score Type menu. Options include:
  - Weighted Average
  - Unweighted Average
  - Measures Meeting Goal - measures meeting organizational goals defined at the measure level
4. Select a value from the Target Type menu. Options include:
  - Simple Percentage
  - Simple Number
  - Tiered Percentage
  - Tiered Number
5. Enter a value in the Target Value field.
6. Optionally, select a value from the Payout Type field. Options include:
  - PMPM
  - PMPY
  - Lump Sum
  - Per Care Gap Measure Closure
7. Optionally, enter a value in the Payout Values field.
8. Optionally, enter a value in the Organizational Goal field.
9. Optionally, select a value from the Contract Gate field.
10. Select **Save**.

## Select and Assign Weight to Measures for a Domain

Assign weight to measures in a domain.

You can assign different weight to measure in a domain. Weight values help organize and prioritize measures for care gap closure within a domain.

To assign weight values to measures in a domain:

1. Select **Edit Domain** next to the domain for which you want to select measures and assign weights.
2. Select each measure that you want to include in the domain.
3. Assign a weight to each selected measure.

4. Select **Save**.

## Create Domain Groups

You can create groups of domains.

You can create groups of domains called domain groups. This helps to track groups of measures and improve quality.

To create a domain group:

1. Select **Edit Target Plan** next to the contract for which you want to create a domain group.
2. Select **Domain Groups** from the right side of the page.
3. Select **Add Domain Groups**.
4. Enter a name for the domain group and a description.
5. Select **Save**.

## Set Targets for Domain Groups

Set target values for a domain group.

You can set target information for a domain group.

To set target information for a domain group:

1. Select **Edit Domain Groups** next to the domain group for which you want to set a target.
2. Select **Add Target** to add a target value to the domain.
3. Select a value from the Score Type menu. Options include:
  - Weighted Average
  - Unweighted Average
  - Measures Meeting Goal
4. Select a value from the Target Type menu. Options include:
  - Simple Percentage
  - Simple Number
  - Tiered Percentage
  - Tiered Number
5. Enter a value in the Target Value field.
6. Optionally, select a value from the Payout Type field. Options include:
  - PMPM
  - PMPY
  - Lump Sum
  - Per Care Gap Measure Closure
7. Optionally, enter a value in the Payout Values field.
8. Optionally, enter a value in the Organizational Goal field.
9. Optionally, select a value from the Contract Gate field.

10. Select **Save**.

## Add Domains to a Domain Group

Select the domains to add to a domain group.

You can add domains to a domain group to group similar domains together.

To add domains to a domain group:

1. Select **Edit Domain Group** next to the domain group you want to edit.
2. Select the domains you want to add to the domain group.
3. Select **Save**.

## Single Contract

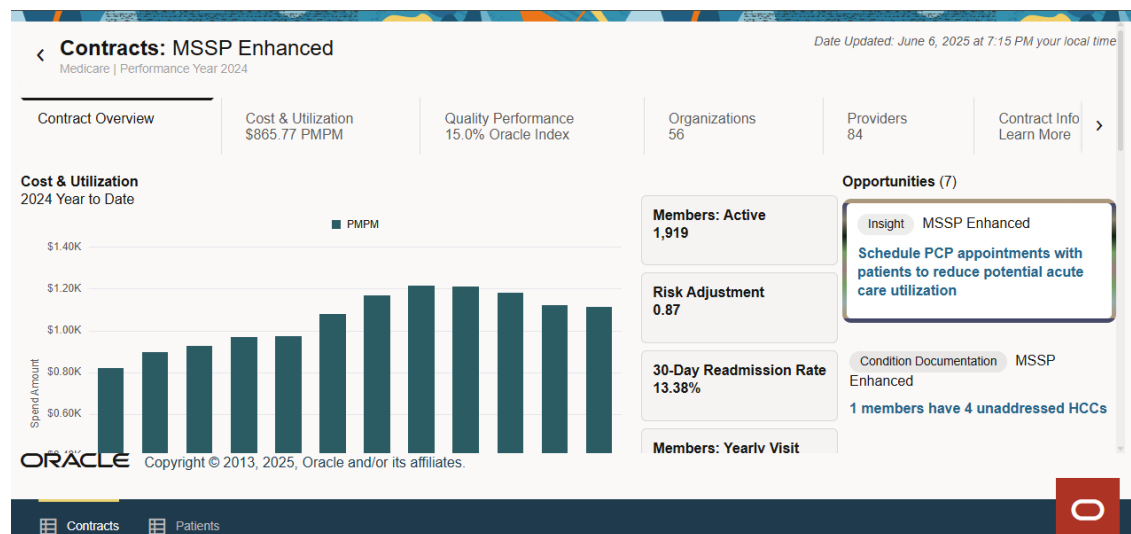
View details for a specific contract.

The single contract view provides an overview of a selected contract. To access the single contract view, select the contract name from the contract list on the Contracts page. If multiple contracts are available in the contract list, you can use the search and filter functionality to locate a specific contract.

## Contract Overview

Cost and performance details for a selected contract.

**Figure 4-2 Contract Overview**



The Contract Overview tab contains a snapshot of contract performance. Included in this view is the estimated achieved value of the contract and any contract gates that may be impacting the contract's total value. By displaying the contract gates in the contract overview, you can focus on measures and targets that most affect the contract's overall performance.

The following key performance indicators (KPIs) are included:

- The average cost per member per month (PMPM), displayed as a graph.
- HCC redocumentation percentage, displayed as a graph.
- Inpatient and emergency department admissions per 1,000, displayed as a graph.
- **All Members:** A count of all members
- The risk adjustment score.
- The readmission rate (30-day)
- **Members (yearly visit):** The percentage of members who have any outpatient visit during the performance year.
- **Members (CPE/AWV):** The percentage of members who have received a comprehensive physical exam (CPE) or adult wellness visit (AWV) during the performance year.
- **Opportunities:** A list of actionable opportunities that support access to a patient worklist. In a filtered state, opportunities are specific to the contract selected.
  - **AI Patient Prioritization Insight:** Artificial intelligence (AI)-based member monitoring aims to help identify which patients are at highest risk for acute utilization and suggest the next best action to reduce the likelihood of acute care utilization. The recommended action is to schedule a primary care provider (PCP) visit.
  - **Condition Documentation:** A list of persons with four or more undocumented conditions during the performance period and persons who have the top two highest suspected conditions that are undocumented.
  - **Quality:** The top three underperforming contract measures that are closest to the target.

## Cost and Utilization

Cost and utilization details for a selected contract.

When you select the Cost and Utilization tab, the Analytics Dashboard is displayed in a new window and additional details about cost and utilization are displayed.

## Quality Performance

Quality performance details for a selected contract.

Figure 4-3 Quality Performance tab

Measure	Met	Target	Unmet Patients	Total Patients
MIPS 134: Screening for Clinical Depression and Follow-Up Plan	12.28%	97.24%	50	57
CMS2v13 - Preventive Care and Screening: Screening for Depression ...	2.94%	0.00%	33	34
CMS165v12 - Controlling High Blood Pressure	23.52%	0.00%	13	17

A list of contract measures defined using the Console contract upload process and a list of key insights to improve performance is displayed in the Quality Performance tab. The following columns are supported:

- **Status:** The organization goal set for that contract's population.
- **Measure:** the name of the measure.
- **Met:** the percentage of patients included in the measure that currently have a measure status of Met.
- **Target:** The target set for this measure in the Score Plan tool.
- **Unmet patients:** The total count of patients included in this measure that have a measure status of Not Achieved or No Data.
- **Total patients:** The total count of patients included in this measure based on the measure's inclusion criteria. This includes patients that have both met and not met this measure.
- **Maximum potential:** The maximum incentive value available for this measure based on full achievement of performance targets.
- **Year to date (YTD) potential earnings:** The incentive amount achieved based on current performance. This number is expected to change based on your organization's performance level. Contract performance numbers are processed weekly.

## Organizations

Organization details for a selected contract.

Figure 4-4 Organization tab

Contracts: MSSP Enhanced  
Medicare | Performance Year 2024  
Date Updated: June 6, 2025 at 7:15 PM your local time

Contract Overview | Cost & Utilization \$865.77 PMPM | Quality Performance 15.0% Oracle Index | **Organizations 56** | Providers 84 | Contract Infor Learn More

**Organizations**

Name	Members	Readmission Rate (30-day)	RAF Score (normalized)	HCC Redoc	Avg. Care Gaps/Pt.
Baseline West	516	15.67%	0.05	0.08%	9.88
Baseline West	516	0%	0.05	0.08%	0
Baseline West Medical Center	492	6.4%	0.06	0.08%	4.9
Oakbrook Clinic	450	4.7%	0.06	0.07%	0.4

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Contracts Patients

The Organizations tab contains the list of organizations defined in the Oracle Personnel tool and a list of standard metrics are displayed per organization for a selected contract. You can filter to a specific contract to view organizational performance metrics. The following columns are supported:

- **Organization:** The name of the organization.
- **Members:** The count of active members associated with the organization.
- **Readmission Rate (30-day):** The percentage of patients who are readmitted within 30 days of their initial discharge.
- **RAF Score (normalized):** A normalized risk adjustment factor (RAF) score is a risk score adjusted to a baseline value of 1.0 representing the average expected cost of care.
- **HCC Redoc:** Percentage of persistent conditions that are redocumented during the contract period.
- **Avg. Care Gaps/Pt:** The average count of open care gaps per patient.

## Providers

Provider details for a selected contract.

The Providers tab contains the list of providers defined in the Oracle Personnel tool and a list of standard metrics are displayed per provider. You can filter a specified contract to view provider performance metrics. The following columns are supported:

- **Name:** Provider name
- **Members:** The count of active members associated with the provider.
- **Readmission Rate: (30-day):** The percentage of patients who are readmitted within 30 days of their initial discharge.
- **RAF Score (normalized):** A normalized RAF score is a risk score adjusted to a baseline value of 1.0 representing the average expected cost of care.
- **HCC Redoc:** Percentage of persistent conditions that are redocumented during the contract period.

- **Avg. Care Gaps/Pt:** The average count of open care gaps per patient.

## Contract Information

Contract details for a selected contract.

The Contract Information tab contains all relevant information about the contract, including:

- General Information
  - Contract name
  - Payer
  - Line of business
  - Contracting entity/ACO
  - Member attribution methodology
  - Plans
  - Benefit class types
  - Contract categories
  - Performance period start date
  - Performance period end date
  - Initial term start date
  - Initial term end date
  - Lives
  - Tags
  - MSSP track
  - MSSP level
- Cost and Utilization
  - Benchmark expenditure
  - Premium
  - Rate selection
  - Minimum savings rate (MSR)
  - Minimal loss rate (MLR)
  - Percent share of loss
  - Percent share of surplus
- Quality and Condition Documentation
  - Shared savings weighted by quality
  - Shared risk weighted by quality
  - Quality gate
  - Contract measures
  - Risk model
- Financial

- Budget
- Target
- Projected earnings
- Shared savings (payer reported)
- Downside risk (payer reported)
- Pay-for-performance (payer reported)
- Care coordination (payer reported)
- Maximum downside risk (contractual)
- Maximum shared savings (contractual)
- Maximum pay-for-performance risk (contractual)
- Maximum care coordination fee (contractual)
- Build
  - Reporting project
  - Claims source
  - Enrollment source
  - Population name

# 5

## Population AI Assistant

The Population AI Assistant displays patient information in a sidebar format for customers who are working in non-Millennium platform electronic health records (EHRs).

- [Introduction](#)  
The Oracle Health Population AI Assistant application provides quick access to patient information.
- [Use Cases](#)  
Use cases for the Oracle Health Population AI Assistant.
- [Sign In](#)  
Sign in to the Oracle Health Population AI Assistant application.
- [Requirements](#)  
Review system and access requirements for using Oracle Health Population AI Assistant.
- [Access Oracle Health Population AI Assistant](#)  
Gain access to the Oracle Health Population AI Assistant.
- [Search for a Patient](#)  
Search for a patient using the Oracle Health Population AI Assistant application.
- [View Care Gaps](#)  
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View coding gaps for a patient.
- [Suppress Conditions](#)  
Suppress hierarchical condition categories.
- [View Patient Summary](#)  
View the patient summary for a patient.
- [Adjust the Date Range](#)  
Adjust the date range for Oracle Health Population AI Assistant.
- [Minimize, Expand, and Close the Application](#)  
Minimize and expand the application.

### Introduction

The Oracle Health Population AI Assistant application provides quick access to patient information.

The screenshot displays the Oracle Health Population AI Assistant interface for a patient named 'TEST PATIENT'. The patient's MRN is 20827, and they were born on July 11, 1954 (70 years old). Their address is 1234 Main Street, Lees Summit, MO 64065. The patient has 2 allergies, is diabetic, and is an outpatient. The interface shows a 'CARE PLAN' with goals and activities, an 'ACTIVITY LOG' with three entries, and a 'PATIENT SUMMARY' section. The summary includes a date range for AI-generated information (September 3, 2025, 12:39pm EST) and a supporting facts section. The patient is a 71-year-old male with an allergy to bee venom and has been diagnosed with the following chronic conditions: Right hip repl (296.44), Tonsil removal (296.44), and in obese.

Oracle Health Population AI Assistant is an agentic companion experience that delivers AI-powered summaries alongside any EHR. Population AI Assistant is designed for physicians, care teams, outreach staff, and anyone working to close patient care gaps.

Population AI Assistant displays the following information:

- A patient's open care gaps (for example, an overdue annual wellness visit, or an overdue eye exam for a patient with diabetes).
- A patient's hierarchical condition codes (HCCs).
- An existing check-in prep summary based on a patient's longitudinal record. See [Overview of Check-In Prep](#) for more information.
- Suspected risk coding opportunities.

## Use Cases

Use cases for the Oracle Health Population AI Assistant.

The following are use cases for the Population AI Assistant:

- Care managers and primary care providers can view clinical encounters that the patient has had since the last check-in with the team.
- Care managers and primary care providers can view when and where clinical information was originally gathered.
- Care managers and primary care providers can view any new labs, vital signs, or procedures that the patient completed since the last check-in.
- Care managers and primary care providers can view if the patient has had any new medications prescribed to discuss medication adherence.
- Care managers and primary care providers can view care gaps, such as screenings and labs, so that they can be addressed during check in.

- Primary care providers can identify the most accurate diagnosis code for the patient during clinical encounters so that they can document an up-to-date health status for the patient so that the health system is reimbursed properly.

## Sign In

Sign in to the Oracle Health Population AI Assistant application.

### Note

Users in your organization who want to access the application must be part of the extensibility\_allowlist personnel group.

To access Population AI Assistant:

1. As an administrator, log in to [Personnel Tool](#) .
2. From the search box, type "extensibility\_allowlist".
3. Add members to the personnel group.

### Note

Changes can take up to 24 hours. Users added to this group can view the HDI-based information for all patients in a given population.

## Requirements

Review system and access requirements for using Oracle Health Population AI Assistant.

To use Oracle Health Population AI Assistant, ensure that the following requirements are met:

- Your device must be a Windows 10/11 64-bit environment.
- You must be a member of the extensibility\_allowlist personnel group.
- To view care gaps, ensure that your site is using Registries.
- To view coding gaps, ensure that your site is using Hierarchical Condition Categories.
- To view the Summary tab, ensure that your site is using Check In Prep.

## Access Oracle Health Population AI Assistant

Gain access to the Oracle Health Population AI Assistant.

To access Oracle Health Population AI Assistant:

- Extract the files from the ZIP file from the Oracle Health product team to download and open the application.
- Open the application and enter the tenant mnemonic when prompted. This is a one-time requirement when you first open the application.
- Use your HDI credentials when prompted to enter a username and password.
- Select your EHR from the list of available EHR sources for your tenant.

## Search for a Patient

Search for a patient using the Oracle Health Population AI Assistant application.

When you open Population AI Assistant, the application automatically searches for the medical record number (MRN) of the patient whose record is currently displayed in the main screen. You can also search for a patient manually using their name, MRN, or enterprise master person index number (EMPI ID).

To search for a patient:

1. Enter a patient ID (for example, an MRN) into the search box and select **Enter**.
2. Select **View** next to the patient to access additional content.



## View Care Gaps

View care gaps for a patient.

To view care gaps:

1. Select the **Care Gaps** tab at the bottom of the application.
2. Select the **arrow** icon for the care gap that you want to view.

Supporting facts, including name, source, and date for the corresponding care gap, are displayed. If the Supporting Facts button is unavailable, no supporting facts are available for the selected care gap.

## View Coding Gaps

View coding gaps for a patient.

To view coding gaps:

1. Select the **Coding Gaps** tab at the bottom of the application.
2. Select the **arrow** icon for the coding gap that you want to view.

Supporting facts, including name, value, source, and date for the corresponding coding gap, are displayed. If the Supporting Facts button is unavailable, no supporting facts are available for the selected coding gap.

## Suppress Conditions

Suppress hierarchical condition categories.

You can remove conditions from the coding gap list that you believe are included in error or that have been resolved. Once removed, the suppressed conditions are displayed below the active conditions, and can be moved back the active condition list.

To suppress a condition from the coding gap list:

1. Select the **Coding Gaps** tab at the bottom of the application.
2. Select the **ellipsis** button (...) next to the condition you want to suppress. The following options are displayed:
  - View Details
  - Disagree with suspected
  - No longer applicable
  - Other
  - Reject
  - Resolve
3. Select the appropriate option. The suppressed condition is displayed on the Suppressed list underneath the active conditions, with the reason for suppression also displayed.

To move a suppressed condition to the list of active conditions:

1. Select the **ellipses** button (...) next to the condition you want to move.
2. Select **Undo Disagree with suspected**. The suppressed condition is moved back to the active conditions list.

## View Patient Summary

View the patient summary for a patient.

To view patient summary information:

1. Select the **Summary** tab at the bottom of the application. By default, the past 30 to 31 days are displayed.
2. Select the supporting facts link to view any supporting facts. Supporting facts may include the description, source, and date for the following data elements in the summary:
  - Allergies
  - Conditions
  - Encounters (visits)
  - Medications
  - Procedures
  - Lab/vitals (observations)
  - Immunizations

 **Note**

Supporting facts source displays a unique identifier, but enhancements match to the matching source name.

## Adjust the Date Range

Adjust the date range for Oracle Health Population AI Assistant.




To adjust the date range:

1. Select **Change Date Range**. The current maximum look back range is 45 days.
2. Select the month and date of the look back range.
3. Select **Generate Summary**. A new summary is generated.

## Minimize, Expand, and Close the Application

Minimize and expand the application.

To adjust your view of the application:

1. Select the **minimize** icon  to minimize the application.
2. Select the Oracle icon  to expand the application again.
3. Select the **ellipsis** icon  to close or log out of the application

# 6

## Patient Outreach

Create clinically informed outreach campaigns.

Oracle Health Quality Management allows you to connect with patients by creating clinically-informed outreach campaigns. You can use CRM Connector to create a campaign that targets patients based your outreach objective, for example patients that have open care gaps. You view a list of your current and past campaigns on the Campaigns tab.

- [Introduction](#)  
Create patient outreach campaigns with CRM Connector.
- [Requirements](#)  
Requirements to use CRM Connector.
- [Create a Campaign Segment in Quality Management](#)  
Campaign segments are used for targeted patient outreach.
- [Create a Campaign in Oracle Eloqua](#)  
Create a campaign in Oracle Eloqua.
- [View Campaigns](#)  
View previously created campaigns.
- [Patient Outreach FAQs](#)  
Frequently asked questions about patient outreach.

### Introduction

Create patient outreach campaigns with CRM Connector.

CRM Connector integrates Oracle Health Quality Management with a CRM or marketing automation platform, enabling workflows for clinically-informed outreach campaigns. CRM Connector currently supports integration with Oracle Eloqua.

CRM Connector works with the following components:

- **Oracle Health Quality Management:** Oracle Health Quality Management is a central hub for population health workflows such as AI Patient Prioritization on the Patients list, Contract Performance, and Contract Performance. See [Application Access Requirements](#)
- **Oracle Eloqua:** Oracle Eloqua is a marketing automation platform that helps you design, execute, and track personalized, multichannel marketing campaigns. See [Oracle Eloqua](#) to access the application. If you do not have access, contact your Oracle Eloqua administrator.

### Requirements

Requirements to use CRM Connector.

Access to Oracle Health Quality Management and Oracle Eloqua is required to use CRM Connector. Your Oracle team member can assist with the initial connection to Oracle Eloqua.

Access to CRM Connector is available to system administrator roles and those included on the outreach allow list in your organization.

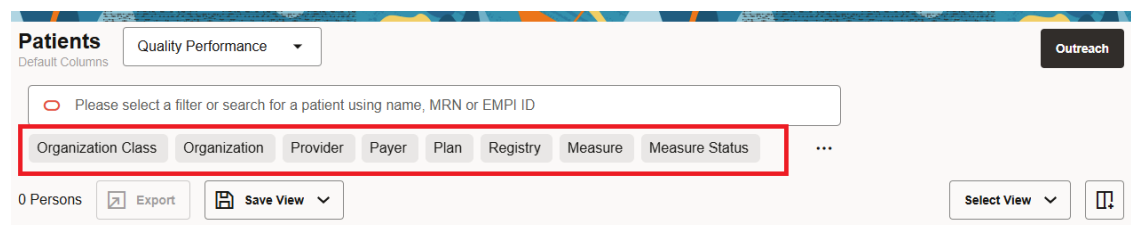
## Create a Campaign Segment in Quality Management

Campaign segments are used for targeted patient outreach.

A campaign segment is the targeted patient list created in Oracle Health Quality Management and sent to Oracle Eloqua for outreach. To build segments, you can apply insight filters that correspond to specific patient data including:

- Demographics
- Open care gaps
- Conditions
- Visit history

You can refine your audience based on your campaign's outreach objective.



To create a campaign segment:

1. In Oracle Health Quality Management, select the **Patients** tab.
2. Apply criteria for your campaign using the insight filters below the search field. By selecting insight filters, you are defining the audience for your outreach campaign. To view additional insight filter options, select the **ellipsis (...)**.
3. When you have selected all applicable insights, select **Outreach** from the upper-right corner.
4. Complete the Campaign Information page, then select **Continue**.
5. Review the information on the Patient List page, then select **Continue**.
6. Review the information on the Summary page, then select **Save**.

## Create a Campaign in Oracle Eloqua

Create a campaign in Oracle Eloqua.

Once you have created and saved a campaign segment in Oracle Health Quality Management, the campaign segment is available in Oracle Eloqua. The segment represents the clinically informed audience that you defined based on patient data. You can use the campaign feature in Oracle Eloqua to build and execute the outreach campaign.

**Note**

Oracle Eloqua does not allow multiple contacts with the same email address by default. Oracle Eloqua uses the email address as the unique key for each contact record. It is not recommended to use personalization in emails as it could potentially identify another contact with the same email address.

See [Creating simple email campaigns](#) on the Oracle Eloqua Help Center.

## View Campaigns

View previously created campaigns.

To view previously created campaigns, select the **Campaigns** tab in Quality Management. You can select the appropriate CRM provider from the CRM Provider menu. Campaign information on the page includes the following information:

- Campaign name
- Campaign ID
- Status
- Campaign description
- Created date
- Start date
- End date

Select **Edit** to update a campaign.

## Patient Outreach FAQs

Frequently asked questions about patient outreach.

This topic provides information about frequently asked questions (FAQs) for CRM Connector and other topics related to patient outreach. If you do not find an answer to your question, you can log a product-specific service record (SR) in eService.

### How do I connect to Oracle Eloqua?

Your Oracle team members can assist in the initial connection to Oracle Eloqua.

### What types of patient data can be used as filters?

The filters depend on your available data in the platform. The following filters can be included:

- Organization class
- Organization
- Provider
- Payer
- Plan
- Scorability
- Attribution status

- Gender
- Race
- State
- Country
- Risk score
- RAF score
- Total measures
- Registry count
- Age
- Date of birth
- Total unmet measures
- Contract
- Visit data
- Postal code
- Condition data

#### What is an example of filters for a breast cancer screening campaign?


For a breast cancer screening campaign, the following data filters in Oracle Health Quality Management can be used:

- Attribution status - Attributed
- Registry - Comprehensive Adult Wellness
- Measure - Breast Cancer Screening
- Measure status - No Data, Not Met

This campaign targets patients in the Comprehensive Adult Wellness registry who have a primary care provider and have not met the breast cancer screening measures. The campaign encourages these patients to complete their screening.

#### How do I change a campaign segment after I save it?

To change a saved campaign:

1. Select the **Campaigns** tab in Quality Management.
2. Select **Edit**  next to the campaign you want to edit.
3. Edit the campaign information and patient filters.
4. Select **Save** on the summary page when you are done editing.

#### Note

Campaign segments may take up to 24 hours to refresh after editing.

# Glossary

# Index