Validating and Reporting the 2018 ACO Clinical Measures (Version 1)

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Purpose

The purpose of this document is to describe how to run the RCHC BridgeIt reports in order to obtain the data for the ACO clinical measures. Note that these instructions are specific to the set of reports released in 2018. Current versions of the reports are documented in the BridgeIt Report Index[1] available on the RCHC Peer Collaboration Portal.

Introduction

These instructions were designed for staff at RCHC-affiliated clinics who are familiar with the basic functions of BridgeIt. The instructions describe the filters and outputs associated with each report, therefore the user must be able to apply filters to the data, open the outputs and refresh the data.

The ACO report denominator usually spans the calendar year. Users are strongly urged to continuously validate their data throughout the year. Most of the BridgeIt reports that summarize data also have associated validation reports that are used to identify records with missing or incorrect data.

The sections below describing the reports are placed in the same order as they appear in the ACO instructions documents. Each section names the current BridgeIt report and version, the parameters and filters needed to obtain the correct numerator and denominator for the measure, where to find the result summary in the Excel output, and how to validate the data. The Appendix features a summary table of the same information. Additional detail on how to run the reports can be found in the Instructions for Using the BridgeIt Annual Clinical Report Set (Version 14, June 2018) and a description of the eCW fields and calculations used in the report design can be found in the Technical Documentation For the BridgeIt Annual Clinical Report Set (Version 14, June 2018). All documents can be obtained from Redwood Community Health Coalition (they are placed on the RCHC website[2]).

The ACO measures focus on patients with Medicare insurance. It is recommended that health centers use a single Insurance Class to identify all individual insurance names that are actually Medicare. The individual insurance names must be associated with the Insurance Class in the eCW setup. See the eCW

[1] As of the writing of these instructions, the most recent version is the December 2018 version. However, this index is periodically updated as new versions of the reports become available.
[2] www.rchc.net, in the Peer Collaboration initiative, under the Data Peer Workgroup and the subsection Additional Resources and Companion Documents

Administrators Guide for further detail. Once all of the Medicare insurance names are associated, only one filter for the Insurance Class is needed to narrow the denominator to patients with Medicare.

It is recommended that health centers add the ACO measures to their dashboard and monitor them monthly using the instructions below. The filters described in this document will give a good estimation of the denominator. However, for actual ACO reporting, the denominator is supplied by CMS. When attempting to match patients from a BridgeIt report to the actual denominator, do not use any filters. This gives the greatest possible number of matches to the denominator list.

List of 2017 ACO Clinical Measures

Measure Category	Measure Title	Web Interface Measure Number	Alternative Measure Number
Care Coordination/ Patient Safety (CARE) Measure	Medication Reconciliation Post-Discharge	CARE-1	ACO 12
	Falls: Screening for Future Fall Risk	CARE-2	ACO 13
Diabetes Composite	Diabetes: Hemoglobin A1c Poor Control	DM-2	ACO 27
	Diabetes: Eye Exam	DM-7	ACO 41
Hypertension (HTN) Disease Measure	Controlling High Blood Pressure	HTN-2	ACO 28
Ischemic Vascular Disease (IVD) Measure	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	IVD-2	ACO 30
Mental Health (MH) Disease Measure	Depression Remission at Twelve Months	MH-1	ACO 40
Preventive (PREV) Care Measures	Breast Cancer Screening	PREV-5	ACO 20
	Colorectal Cancer Screening	PREV-6	ACO 19
	Preventive Care and Screening: Influenza Immunization	PREV-7	ACO 14
	Pneumonia Vaccination Status for Older Adults	PREV-8	ACO 15
	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	PREV-9	ACO 16
	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	PREV-10	ACO 17
	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	PREV-12	ACO 18
	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	PREV-13	ACO 42

Care Coordination/Patient Safety (CARE)

Medication Reconciliation Post-Discharge

Report name: Med_Reconciliation_v2

Parameters and filters: Measurement period start date and measurement period end date. These define the period of time from which hospital discharges and patient visits are drawn. The report is automatically filtered for patients who have had a properly documented discharge from a hospital or inpatient facility. Note that each row represents an individual discharge for a patient and not necessarily unduplicated patients like other BridgeIT reports. Filter for patients with one or more visits in the 30 days after discharge from a hospital or inpatient facility (column HadVisit30Days = "Yes"). If summarizing the data for a dashboard or other estimate, filter for the Medicare Insurance Class used at your health center (which is applied to the column InsClassName).

Result summary: The summary is displayed on the worksheet Medication_Rec.

ACO Patient Submission: The following columns on the BridgeIT data report correspond to the columns on the ACO patient submission template:

ACO Column Text	BridgeIT Report Column Text and Comment
Number of Discharges	Count the number of rows (each row is one discharge) for the patient. The three columns described below must be completed for each discharge (Date 1, Date 2, Date 3, etc.)
Discharge Date 1 (MM/DD/YYYY)	Column DischargeDate
Was the patient discharged from an inpatient facility on the discharge date listed +/- 2 calendar days?	Compare the date in the column DischargeDate to the date provided by the ACO
Were discharge medications reconciled with the current medication list in the outpatient medical record within 30 days following this inpatient facility discharge?	Column HadMedReconciliation30Days

Data validation: Filter for patients discharged within the measurement period and then seen within 30 days (HadVisit30Days = “Yes”) but did not have their medications reconciled

(HadMedReconciliation30Days = “No”). Were there any actions on any medications in the 30 days after discharge (Med_List_Action_30Days has a date in the measurement period)? If so, the electronic record will have to be manually inspected to see if any of the medications with an action were discharge medications. The standard is to record in HPI structured data that discharge medications were reconciled. However, a provider might have typed text in the progress notes or another non-standard field indicating the reconciliation.

Furthermore, look for patients who were discharged from the hospital or inpatient facility but were not seen within 30 days (column HadVisit30Days = “No”). Although they are not part of the measure denominator, you may consider looking at the clinic work flow to ensure that such patients are routinely seen in a timely fashion (and that they undergo a medication reconciliation).

Falls: Screening for Future Fall Risk

Report name: Fall_Risk_v1

Parameters and filters: Measurement period start date and measurement period end date. These define the period of time from which patient visits are drawn. If summarizing the data for a dashboard or other estimate, the BridgeIt report does not require any additional filters except for the Medicare Insurance Class used at your health center (which is applied to the column InsClassName).

Result summary: The worksheet “Fall Risk Assessed” contains the summary of patients assessed for fall risk in the past year.

ACO Patient Submission: The following columns on the BridgeIT data report correspond to the columns on the ACO patient submission template:

ACO Column Text	BridgeIT Report Column Text and Comment
Was the patient screened for future fall risk at least once during the measurement period (January 1 - December 31, 2018)?	Column Fall_Risk_1Y

Data validation: Look for patients with many primary care visits (sort column PrimCareVisitsPeriod descending) but no fall risk assessment (column Fall_Risk_1Y = “No”). Investigate why these patients did not have a documented screening for future fall risk.

Diabetes Composite

Diabetes: Hemoglobin A1c Poor Control (>9%)

Report name: Diabetes_v8

Parameters and filters: Measurement period start date and measurement period end date. These define the measurement period, or the period of time from which patient visits are drawn. Filter for patients with one or more visits in the measurement period (column PrimCareVisitsPeriod > 0). If summarizing the data for a dashboard or other estimate, filter for the Medicare Insurance Class used at your health center (which is applied to the column InsClassName).

Result summary: The output for this measure is named “A1c QIP ACO.”

ACO Patient Submission: The following columns on the BridgeIT data report correspond to the columns on the ACO patient submission template:

ACO Column Text	BridgeIT Report Column Text and Comment
Does the patient have a documented history OR active diagnosis of diabetes during the measurement period and year prior to the measurement period (January 1, 2017 - December 31, 2018)?	A patient with an active diagnosis of diabetes appears on the BridgeIT report
Did the patient have one or more HbA1c tests performed during the measurement period (January 1 - December 31, 2018)?	This is true when the column LastA1CStatus_Detailed is not equal to “Not measured in past year" and not equal to “No Result”
Date drawn (MM/DD/YYYY)	Column LastA1CDate
HbA1c value (enter distinct value)	Column LastA1CResult

Data validation: Filter for any patients with a primary care visit (column PrimaryCareVisitsPeriod > 0) and then sort by last A1c result (LastA1CResult). Look for values so high or so low that they are out of the possible range of A1c values. Also, look for any text in the result field that is making it unreadable by the report.

Next, filter for patients without a recent A1c result (column LastA1CResult is null or not within the last year) and sort the entire list by primary care visits (the column PrimaryCareVisitsPeriod in descending order). Are there patients who have lots of visits in the measurement period but no A1c test or no recent test? Why did these patients not get the required test when they were seen many times?

Note that there are also two validation reports for diabetes described in the Appendix of the Instruction Manual (version 14). The Diabetes Problem List Validation report is used to ensure that all patients with diabetes have an appropriate diagnosis code on their Problem List. The A1c lab test validation report is used to ensure that entry into lab structured data is complete for all associated labs.

Diabetes: Eye Exam

Report name: Diabetes_v8

Parameters and filters: Measurement period start date and measurement period end date. These define the measurement period, or the period of time from which patient visits are drawn. Filter for patients with one or more visits in the measurement period (PrimCareVisitsPeriod > 0). If summarizing the data for a dashboard or other estimate, filter for the Medicare Insurance Class used at your health center (which is applied to the column InsClassName).

Result summary: The output for this measure is named "Eye Exam Status."

ACO Patient Submission: The following columns on the BridgeIT data report correspond to the columns on the ACO patient submission template:

ACO Column Text	BridgeIT Report Column Text and Comment
Did the patient have a retinal or dilated eye exam by an eye care professional during the measurement period (January 1 - December 31, 2018), OR a negative retinal exam (no evidence of retinopathy) by an eye care professional during 2017?	This is true when the column DM_EyeExam_Status is equal to "In numerator: Had eye exam in past year or normal exam in past 2 years" or equal to "In numerator: Had eye exam in past year or normal exam in past 2 years"

Data validation: Filter for patients in the denominator without an appropriate eye exam (column DM_EyeExam_Status = "Not in numerator: No eye exam ever" or "Not in numerator: Old eye exam or abnormal exam") and then sort the list so that patients with the most visits in the measurement period

are at the top (sort the column PrimaryCareVisitsPeriod in descending order). Investigate why patients with many primary care visits never had a retinal or dilated eye exam.

Hypertension (HTN) Disease

Controlling High Blood Pressure

Report name: Hypertension_v8

Parameters and filters: Measurement period start date and measurement period end date. These define the period of time from which patient visits are drawn. Filter for one or more primary care visits in the measurement period (column PrimCareVisitsPeriod > 0), has a diagnosis of Essential Hypertension diagnosed prior to six months before the end of the measurement period (column EssHTN_DiagnosisBeforePriorDate = "Yes"), and no exclusions (column Exclusion_HTN is not equal to "Exclude"). If summarizing the data for a dashboard or other estimate, filter for the Medicare Insurance Class used at your health center (which is applied to the column InsClassName).

Result summary: The ACO summary is shown on the output "BP UDS ACO."

ACO Patient Submission: The following columns on the BridgeIT data report correspond to the columns on the ACO patient submission template:

ACO Column Text	BridgeIT Report Column Text and Comment
Does the patient have a documented diagnosis of essential hypertension within the first six months of 2018 or at any time prior to January 1, 2018 but does not end before January 1, 2018?	This is true when the patient appears on the BridgeIT Data Sheet when it is filtered for column EssHTN_Diagnosis_Code = "Essential Hypertension") and column EssHTN_DiagnosisBeforePriorDate = "Yes"
Was the patient's most recent blood pressure reading documented during the measurement period (January 1 - December 31, 2018)?	This is true when the column LastBPStatus_Detailed is not equal to "No result" and not equal to "Not measured in past year"
HTN-2 BP Drawn Date (MM/DD/YYYY)	Column LastBPDatePeriod
HTN-2 BP Systolic (Enter Number)	Column BPSys
HTN-2 BP Diastolic (Enter Number)	Column BPDias

Data validation: Filter for patients with at least one primary care visit (column PrimCareVisitsPeriod > 0) and then sort by last blood pressure result (column LastBPValuePeriod). Look for any values that are unrealistically high or low for a blood pressure reading. Then, compare text in the column LastBPValuePeriod to the columns BPSys and BPDias for the records near the top and the bottom of the sorted list. Look for any text in the value field that is not readable by the report.

Next, sort by number of primary care visits (sort the column PrimaryCareVisitsPeriod in descending order). Are there patients with many visits but without a blood pressure when it is routine to get a blood pressure reading during a primary care visit?

Furthermore, there is a validation report described in the Annual Report Instruction Manual (version 14) that is used to ensure that all patients with hypertension have an appropriate diagnosis code on their Problem List. See the section "Hypertension Problem List Validation" in that manual.

Ischemic Vascular Disease (IVD)

Use of Aspirin or Another Antithrombotic

Report name: IVD_Aspirin_v7

Parameters and filters: Measurement period start date and measurement period end date. These define the period of time from which patient visits are drawn. The user must filter for one or more primary care visits in the measurement period (column PrimCareVisitsPeriod > 0) and included in the denominator (column Denominator_Type = "Include: IVD code on problem list" or "Include: Myocardial Infarction with Appropriate Date" or "Include: Myocardial Infarction with Appropriate Date" or "Include: Cardiac Surgery with Appropriate Date"), and no exclusion criteria (column Exclusion_Anticoag not equal to "Exclude"). If summarizing the data for a dashboard or other estimate, filter for the Medicare Insurance Class used at your health center (which is applied to the column InsClassName).

Result summary: The output for this measure is named "UDS_Aspirin_Summary."

ACO Patient Submission: The following columns on the BridgeIT data report correspond to the columns on the ACO patient submission template:

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ACO Column Text	BridgeIT Report Column Text and Comment
Does the patient have a documented diagnosis of AMI, CABG or PCI between January 1 and December 31, 2017 OR an active diagnosis of IVD between January 1 and December 31, 2018?	This is true when the column Denominator_Type is equal to any of the following: • Include: Myocardial Infarction with Appropriate Date • Include: Myocardial Infarction with Appropriate Date • Include: Cardiac Surgery with Appropriate Date
Does the patient have documented use of aspirin or another antiplatelet during the measurement period (January 1 - December 31, 2018)?	Column AsprMedWithin1Y

Data validation: There is a validation report described in the Annual Report Instruction Manual (see the section "IVD Problem List Validation") that can be used in two ways to identify candidates for the denominator of this measure. This includes ensuring patients have an IVD diagnosis code on the Problem List, if warranted.

Note that the data report may also show some patients with an "Unknown" denominator status. This means that a code or text in the patient record suggests that there was a cardiovascular event, but there was not enough structured information to determine of the even happened in the past year. Filter for patients with "Unknown" denominator status (column Denominator_Type = "Unknown: Myocardial Infarction on Problem List WITHOUT Date or with Old Date" or "Unknown: Cardiac Surgery in Surgical History WITHOUT date or with old date" or "Problem"). Did any of these patients have an AMI, CABG, or PCI in the past year and are missing that date in their medical record?

Lastly, filter for patients who meet the denominator criteria but do not meet the numerator criteria for having documentation of use of aspirin or another antithrombotic therapy during the measurement period. Filter for patients seen in the measurement period (column PrimCareVisitsPeriod > 0) and the denominator (column Denominator_Type = "Include…") but not on aspirin or another antithrombotic therapy (column AsprMedWithin1Y = "No"). Then sort descending by the number of primary care visits in the column PrimCareVisitsPeriod. Why would patients with an IVD/AMI/CABG/PTCA diagnosis and many visits not have aspirin or another antithrombotic therapy on their medication list?

Mental Health (MH) Disease

Depression Remission at Twelve Months

Report name: Depression_Remission_v4

Parameters and filters: Enter the same measurement period dates as you would for the other ACO reports. Do not modify the date range to attempt to simulate an initial or remission date range. The report automatically calculates the appropriate ranges needed to identify the PHQ-9 tests. In order to obtain the denominator for this measure, filter the column Denom_Depress_Dysthym_Diag for "Had diagnosis of major depression or dysthymia" and then remove “Exclude” from the column Exclude_Bipolar_Personality_Death and remove “Not in denominator: No Index PHQ-9” from the column Depres_Remiss_Outcome. This leaves patients with the appropriate diagnosis set and with an index PHQ-9 in the appropriate time span. If summarizing the data for a dashboard or other estimate, filter for the Medicare Insurance Class used at your health center (which is applied to the column InsClassName).

Result summary: The ACO summary is shown on the output “Depression_Remission_Summary”

ACO Patient Submission: The following columns on the BridgeIT data report correspond to the columns on the ACO patient submission template:

ACO Column Text	BridgeIT Report Column Text and Comment
Does the patient have an active diagnosis of major depression or dysthymia between December 1, 2016 and November 30, 2017?	Column Denom_Depress_Dysthym_Diag
Did the patient have one or more PHQ-9s administered between December 1, 2016 and November 30, 2017?	This is true if the column Denom_ID_Period_AnyPHQ9 is greater than 0
Did the patient have a PHQ-9 score greater than 9 between December 1, 2016 and November 30, 2017?	This is true if there is a date in the column Index_PHQ9_Date
PHQ-9 Index Date (MM/DD/YYYY)	Column Index_PHQ9_Date
PHQ-9 Score (Enter Number)	Column Index_PHQ9_Score
Did the patient have one or more PHQ-9s administered during the measurement	This is true if there is any number in the column Measure_Assess_AnyPHQ9

ACO Column Text	BridgeIT Report Column Text and Comment
assessment period (12 months +/- 30 days from the index date)?	
Did the patient achieve remission with a follow-up PHQ-9 performed and a score less than 5 at 12 months (+/- 30 days) of the initial Index Date?	This is true if he column Depres_Remiss_Outcome = "Include in numerator: Remission PHQ-9 (score below 5)"
PHQ-9 Follow-up Date (MM/DD/YYYY)	Column Measure_Assess_PHQ9_Date
PHQ-9 Follow-up Score (Enter Number)	Column Measure_Assess_PHQ9_Score

Data validation: It is likely that when this report is run for a measurement period of a year, there will only be a few patients who are in the denominator. Therefore, check the eCW records of a sample og these patients individually. First apply the denominator filters (see above) and then check any patients who have the text "Exclude from numerator" in the column Depres_Remiss_Summary. Patients excluded from the numerator might have not had a remission PHQ-9 performed in the correct time period, or had one performed but with a score of 5 or more. Make sure that the date and total score of all PHQ-9 tests are properly entered into structured data.

- PrimCareVisitsPeriod > 0
- AgeEndReporting not equal to 50
- Gender_Identity = "Female" or "Male-T"
- Exclude_BilatMastect not equal to "Exclude"

Preventive Care (PREV) Measure Module

Breast Cancer Screening

Report name: Breast Cancer Screening_v7

Parameters and filters: Measurement period start date and measurement period end date. These define the period of time from which patient visits are drawn. In the datasheet view, the user should filter for patients with one or more primary care visits (column PrimCareVisitsPeriod > 0), within the proper age range (column AgeEndReporting not equal to 50), gender of female or transgender female-to-male (column Gender_Identity = "Female" or "Male-T") and without a bilateral mastectomy (column Exclude_BilatMastect not equal to "Exclude"). If summarizing the data for a dashboard or other

estimate, filter for the Medicare Insurance Class used at your health center (which is applied to the column InsClassName).

Result summary: The general summary is shown on the worksheet “Mammo_Summ.”

ACO Patient Submission: The following columns on the BridgeIT data report correspond to the columns on the ACO patient submission template:

ACO Column Text	BridgeIT Report Column Text and Comment
Is the patient qualified for this measure?	This is true if the patient appears on the BridgeIT report after the Data Sheet has been filtered for age and exclusions as described above
Was screening for breast cancer performed between October 1, 2016 and December 31, 2018?	Column MammoLast27Mths

Data validation: The main validation question to ask when using the Breast Cancer Screening report is, are there patients who had lots of visits in the measurement period but no mammogram completed? Filter the list for patients without a mammogram (column MammoLast27Mths = “No”) but many visits (sort the column PrimaryCareVisitsPeriod in descending order). Why did these patients not have a mammogram performed?

In the Appendix of the Annual Report Instruction Manual (version 14), there is a description of a validation report that can be used to view mammograms ordered in more detail. Follow the instructions in the section “Breast Cancer Screening Image Validation” to ensure that the imaging records are complete and accurate.

Colorectal Cancer Screening

Report name: ColRect Cancer Screening_v7

Parameters and filters: Measurement period start date and measurement period end date. These define the period of time from which patient visits are drawn. Filter for patients having at least one primary care medical visit in the measurement period (column PrimCareVisitsPeriod > 0), and no exclusion criteria (column Exclude_Colect_ColCancer not equal to “Exclude”). If summarizing the data for a dashboard or other estimate, filter for the Medicare Insurance Class used at your health center (which is applied to the column InsClassName).

Result summary: The colorectal screening result is shown in the worksheet “Colorectal Cancer Screen Summ.”

ACO Patient Submission: The following columns on the BridgeIT data report correspond to the columns on the ACO patient submission template:

ACO Column Text	BridgeIT Report Column Text and Comment
Is the patient qualified for this measure?	This is true if the patient appears on the BridgeIT report after the Data Sheet has been filtered for exclusions as described above
Is the patient's colorectal cancer screening current?	Column Screened

Data validation: Look at patients who have not been properly screened (column Screened = “Never screened” or “Old screen”) and have no exclusion criteria (column Exclude_Colect_ColCancer not equal to “Exclude”) but have many visits in the measurement period (sort the column PrimCareVisitsPeriod in descending order. Investigate why these patients were not screened.

There are two associated validation reports described in the appendix of the Annual Report Instruction Manual (version 14). The first is the lab test validation report (see the section “Colorectal Cancer Lab Test Validation”) that can display lab records that do not meet the eCW/Meaningful Use structured data criteria. The second validation report is for Diagnostic Images (see the section “Colorectal Cancer Image Validation”) and displays records that have incomplete or incorrect data entry.

Influenza Immunization

Report name: Influenza_Immuniz_v3

Parameters and filters: This is a unique report because it has two sets of parameters: one for the measurement period and one for the flu season. The ACO measure looks at patients with visits in the measurement period and in the flu season. The reporting measurement period is a calendar year and the flu season begins on October 1 of the year prior to the calendar year and ends on March 31 of the calendar year. For example, if the calendar year is January 1 to December 31, 2018, the flu season would be October 1, 2017 to March 31, 2018[3]. The measurement period is entered into the standard parameters (“1 Measurement period start” and “2 Measurement period end”) and the flu season is entered into the parameters “FluSeason_Start_Oct1” and “FluSeason_End_March31.”

The report is automatically filtered for patients seen at least once during the flu season. If gathering data for the annual report, patients must also have had at least two visits or one preventive visit in the measurement period (column Annual_Visit_Denom = "Add to annual report denominator"). If gathering data for an estimate of the measure using a measurement period shorter than a year, instead add a filter to take patients who had at least one visit in the measurement period (column PrimCareVisitsPeriod > 0).

In all cases, add a filter to remove patients who are allergic to eggs (Exclusion_EggAllergy not equal to “Exclude”). Optionally, filter for the Medicare Insurance Class used at your health center (column InsClassName) to see only patients who currently have Medicare.

Result summary: The summary of patients in the denominator is shown on the output worksheet “InfluenzImmun.”

ACO Patient Submission: The following columns on the BridgeIT data report correspond to the columns on the ACO patient submission template:

ACO Column Text	BridgeIT Report Column Text and Comment
Is the patient qualified for this measure?	This is true if the patient appears on the BridgeIT report after the Data Sheet has been filtered for exclusions as described above

[3] Note: the date range is specifically for the flu season. The report automatically includes flu shots given two months before the beginning of the flu season, as specified in the RCHC BridgeIT Technical Document (version 14)

ACO Column Text	BridgeIT Report Column Text and Comment
Did the patient receive an influenza immunization OR report previous receipt of an influenza immunization between August 1, 2017 and March 31, 2018?	Column Influenza_Immuniz_Status

Data validation: Run the report with the same measurement period and flu season date range as described above. Then sort the list for patients with many visits in the flu season (sort the column PrimCareVisitsPeriod descending) but no influenza vaccine (column Influenza_Immuniz_Status = "Did not have influenza immunization during specified flu season"). Investigate why patients seen many times did not get vaccinated.

Pneumonia Vaccination Status for Older Adults

Report name: Pneumonia_Vacc_v2

Parameters and filters: Measurement period start date and measurement period end date. These define the period of time from which patient visits are drawn. The filter for one or more primary care medical visits in the measurement period is automatically applied and so there are no other filters needed for reporting. If summarizing the data for a dashboard or other estimate, filter for the Medicare Insurance Class used at your health center (which is applied to the column InsClassName).

Result summary: The output "Pneumo_Vacc_Status" displays a summary the vaccination status of all patients in the datasheet.

ACO Patient Submission: The following columns on the BridgeIT data report correspond to the columns on the ACO patient submission template:

ACO Column Text	BridgeIT Report Column Text and Comment
Is the patient qualified for this measure?	This is true if the patient appears on the BridgeIT report
Has the patient ever received a pneumococcal vaccination?	Column Pneumo_Vacc_Status

Data validation: Filter for patients without a vaccination (column Pneumo_Vacc_Status = "Did not ever have pneumococcal vaccine documented") but with many visits in the measurement period (sort PrimCareVisitsPeriod descending). Investigate why these patients with many visits did not get vaccinated.

Body Mass Index (BMI) Screening and Follow-up Plan

Report name: Adult_Weight_v9

Parameters and filters: Measurement period start date and measurement period end date. These define the period of time from which patient visits are drawn. To display the denominator, remove patients with exclusion criteria (column Exclusion_Preg_Pallative not equal to "Exclude"). If summarizing the data for a dashboard or other estimate, filter for the Medicare Insurance Class used at your health center (which is applied to the column InsClassName).

Result summary: The final ACO results are displayed on the sheet "Final_Summary."

ACO Patient Submission: The following columns on the BridgeIT data report correspond to the columns on the ACO patient submission template:

ACO Column Text	BridgeIT Report Column Text and Comment
Is the patient qualified for this measure?	This is true if the patient appears on the BridgeIT report after the Data Sheet has been filtered for exclusions as described above
Did the patient have a BMI documented during the most recent visit or in the last 12 months prior to the most recent visit?	Column BMIDate_MeetsCriteria
Was the patient's BMI within normal parameters?	Column BMICategory
Was a follow-up plan documented?	Column LastYear_HadFollowup

Data validation: To validate the report, look for patients without a recorded BMI (column LastBMIDate is null) but many visits (order descending the column PrimCareVisitsPeriod). Investigate why they were seen many times but did not have a documented BMI (i.e., weight and height).

Also, look for patients who were expected to have a weight management plan (column BMICategory = "Follow up plan needed") but did not have one documented (column Final_Measurement_Result = "Does not meet documentation criteria" or column LastYear_HadFollowup = "No"). These patients should be sorted by number of primary care visits (sort the column PrimCareVisitsPeriod in descending order) so that the patients with the most visits are examined first. These patients had the most frequent opportunities for weight follow-up.

Tobacco Use: Screening and Cessation Intervention

Report name: Tobacco_v8

Parameters and filters: Measurement period start date and measurement period end date. These define the period of time from which patient visits are drawn. If summarizing data for the annual report, filter for visit criteria (column Annual_Visit_Denom = "Add to annual report denominator"). If summarizing the data for a dashboard or other estimate, you do not have to filter for visits (this is automatically set to one or more visits in the measurement period), but you can filter for the Medicare Insurance Class used at your health center (which is applied to the column InsClassName).

Result summary: The final outcome is summarized on the output named Tobac_Composite.

ACO Patient Submission: The following columns on the BridgeIT data report correspond to the columns on the ACO patient submission template:

ACO Column Text	BridgeIT Report Column Text and Comment
Is the patient qualified for this measure?	This is true if the patient appears on the BridgeIT report after the Data Sheet has been filtered for visits as described above
Was the patient screened for tobacco use at least once during the measurement period and year prior to the measurement period (January 1, 2017 - December 31, 2018)?	Column AnyTobacAssessm2Y = "Yes"
Was the patient identified as a tobacco user during the most recent tobacco use screening?	Column LastAssessmResult = "Tobacco User"
Did the patient receive tobacco cessation intervention?	Column TobaccoCessIntervAfterLastUser = "Yes"

Data validation: Data validation should be done on patients without a tobacco assessment in Social History over the past two years (column AnyTobacAssessm2YVisit = "No") but with many primary care visits in the measurement period (sort descending the column PrimCareVisitsPeriod and examine patients at the top of the list). Investigate why a tobacco assessment was not done.

Data validation should also be done on tobacco users (column = LastAssessmResult = "Tobacco User") who did not have a documented tobacco cessation intervention (column TobaccoCessIntervAfterLastUser = "No"). Start with patients with many primary care visits in the measurement period (sort descending the column PrimCareVisitsPeriod). Investigate why tobacco counseling was not completed for a patient identified as a tobacco user during the last assessment.

Screening for Clinical Depression and Follow-up Plan

Report name: Depression_Screen_Followup_v8

Parameters and filters: Measurement period start date and measurement period end date. These define the period of time from which visits, depression screens, and follow-up activities are drawn. You must filter the data sheet for patients with no diagnosis of depression or bipolar disorder at the beginning of the measurement period (the column StartMP_Dx_ProbList_Exclude not equal to "Exclude"). The criterion for patients with one or more primary care visits during the measurement period is automatically applied. If summarizing the data for a dashboard or other estimate, filter for the Medicare Insurance Class used at your health center (which is applied to the column InsClassName).

Result summary: The ACO summary is displayed on the output Outcome_Summ.

ACO Patient Submission: The following columns on the BridgeIT data report correspond to the columns on the ACO patient submission template:

ACO Column Text	BridgeIT Report Column Text and Comment
Is the patient qualified for this measure?	This is true if the patient appears on the BridgeIT report after the Data Sheet has been filtered for exclusions as described above
Was the patient screened for depression using an age appropriate standardized tool during the	Column Screened_MP = "Yes"

ACO Column Text	BridgeIT Report Column Text and Comment
measurement period (January 1 - December 31, 2018)?	
Was the screen positive for depression during the measurement period (January 1 - December 31, 2018)?	Column Positive_Screen_MP = “Yes”
Was a follow-up plan for depression documented during the measurement period (January 1 - December 31, 2018)?	Column Any_Followup_SameDay = “Yes”

Data validation: Look for patients who are not included in the numerator, but had several visits in the measurement period and so had a higher likelihood of being appropriately screened and experiencing a follow-up activity. To do this, filter the column Screened_MP = “No” and the column Dep_Dx_ProbList_Exclude to not display “Exclude” and then sort the column PrimCareVisitsPeriod in descending order. This will show patients not screened at all in the measurement period but with many visits at the top of the list. Investigate why these patients were not screened in the measurement period even though they were seen frequently.

Then, filter for patients who had a positive screen and many visits, but no follow-up for depression. Filter the column Positive_Screen_MP = “Yes” and the column Any_Followup_SameDay = “No” and the column Dep_Dx_ProbList_Exclude to not display “Exclude” and then sort the column PrimCareVisitsPeriod in descending order. This will show patients with at least one positive screen and many visits in the measurement period, but no depression follow-up documented on the same date as the positive screen.

There is a validation report described in the Instruction Manual (version 14) called Positive Depression Screens and Follow-up Validation Report. This report shows the individual dates of the positive PHQ-2 screens during the measurement period in the rows, along with secondary screening (PHQ-9) and follow-up activities performed on the *same date* as the positive PHQ-2. This report differs from the data summary report because it shows individual positive screens in rows, not unduplicated patients in rows. This makes it easier to examine individual screens for validation or performance improvement purposes.

Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Report name: CVD_Statins_v2

Parameters and filters: Measurement period start date and measurement period end date. These define the period of time from which visits are drawn. The report initially displays high risk patients of any age so that health centers can potentially create lists for case management activities. For reporting purposes, the initial population must be filtered for visits in the measurement period (column PrimCareVisitsPeriod > 0), meeting denominator criteria (column Denominator_Pop not equal to "Not in denominator"), and not meeting exclusion criteria (column Exclusion_Any not equal to "Exclude"). Although detailed filter combinations are described below, no additional filters are needed for reporting.

Patients in the denominator are included in one of the following populations, evaluated in order by the report.

1. Population 1. Patients meet these criteria when column Denominator_Pop = "Pop 1". This population has age equal to or greater than 21 years (column AgeStartReporting >=21) and a diagnosis code for ASCVD appears on the patient Problem List (Diag_ASCVD = "ASCVD Diagnosis").
2. Population 2. Patients meet these criteria when they do not meet the criteria for Population 1 and the column Denominator_Pop = "Pop 2". This population has age equal to or greater than 21 years (column AgeStartReporting >=21) with either a diagnosis code for hypercholesterolemia on the patient Problem List (Diag_Hyperchol = "Hypercholesterolemia Diagnosis") or an LDL-C result of 190 mg/dL or greater ever documented (column LDL_190_Ever = "Yes"). For your information, the last LDL date over 190 mg/dL is displayed (column LDL_190_Ever_Date) along with the value (column LDL_190_Ever_Value).
3. Population 3. Patients meet these criteria when they do not meet the criteria for Population 1 or Population 2 and the column Denominator_Pop = "Pop 3". This population has age between 45 and 75 years (column AgeStartReporting between 45 and 75), a diagnosis code for diabetes on the patient Problem List (Diag_DM = "DM Diagnosis") and an LDL-C result between 70 and 189 mg/dL recorded as the highest value in the three years prior to the end of the measurement period (column DM_LDL_70_189_3y = "Yes"). For your information, the last LDL date of the highest LDL within that value range is displayed (column DM_LDL_70_189_3y_Date) along with the value (column DM_LDL_70_189_3y_Value) for patients with diabetes.

Patients are excluded from the denominator if they meet any of the following conditions:

1. Pregnant or breast feeding in the measurement period (column Exc_PregBrstfeed = "Exc pregnant or BF")
2. Allergy or intolerance to statin medication (column Excl_StatAllergy = "Excl allergy statin")
3. Has a diagnosis of diabetes, not using statin, and the last LDL result in under 70 mg/dL (column Excl_DM_LowLDL = "Excl DM with LDL under 70"). For your information, the last LDL date, if it has a value under 70 mg/dL, is displayed (column DM_LDL_Under70_Last_Date) along with the value (column DM_LDL_Under70_Last_Value) for patients with diabetes.
4. Has a diagnosis code for hepatitis A or B, other liver disease, end-stage renal disease (ESRD), rhabdomyolysis, or palliative care on the patient Problem List (column Exc_OthrDiagn = "Other Exclusion Diagnosis")

Result summary: The ACO summary is displayed on the output StatinUse_Summary.

ACO Patient Submission: The following columns on the BridgeIT data report correspond to the columns on the ACO patient submission template:

ACO Column Text	BridgeIT Report Column Text and Comment
Does the patient have a diagnosis of atherosclerotic cardiovascular disease (ASCVD)—active or history of—at any time up through December 31, 2018?	This is true if the column Denominator_Pop = "Pop 1"
Has the patient ever had a fasting or direct laboratory test result of LDL-C ≥ 190mg/dL OR were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia?	This is true if the column Denominator_Pop = "Pop 2"
Is the patient aged 40-75 years of age and has a diagnosis of Type 1 or Type 2 diabetes?	This is true if the column Diag_DM = "DM Diagnosis" and column AgeStartReporting is between 40 and 75
Has the patient had an LDL-C of 70-189 mg/dL between January 1, 2016 and December 31, 2018?	This is true if the column DM_LDL_70_189_3y = "Yes"
Was the patient taking or prescribed statin therapy during the measurement period (January 1 - December 31, 2018)?	This is true if the column StatinMedWithin1Y = "Yes"

Data validation: Validation should be done on patients in the reporting denominator (columns PrimCareVisitsPeriod > 0, Denominator_Pop not equal to “Not in denominator” and Exclusion_Any not equal to “Exclude”) who are not on a statin (column StatinMedWithin1Y = “No”) and have many visits (sort column PrimCareVisitsPeriod descending). Check their medical record in eCW to see if they were using a specific statin medication in the past year not correctly added to the Statin medication group? Also check to see if there is any indication that they did not actually meet one of the denominator population criteria sets for the measure.

Appendix: Summary of Filters and Output Sheets

All reports should be run for the measurement period, which is the calendar year for the ACO report (1/1/2018 to 12/31/2018).

Measure	Report Name	Filters on data sheet	Output sheet
Medication Reconciliation Post-Discharge	Med_ Reconciliation_v2	HadVisit30Days = "Yes"	Medication_Rec
Screening for Future Fall Risk	Fall_Risk_v1	None	Fall Risk Assessed
Diabetes: Hemoglobin A1c Poor Control	Diabetes_v8	PrimCareVisitsPeriod > 0	A1c QIP ACO
Diabetes: Eye Exam	Diabetes_v8	PrimCareVisitsPeriod > 0	Eye Exam Status
Controlling High Blood Pressure	Hypertension_v8	• PrimCareVisitsPeriod > 0 • EssHTN_DiagnosisBefore PriorDate = "Yes" • Exclusion_HTN not equal to "Exclude"	BP UDS ACO
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	IVD_Aspirin_v7	• PrimCareVisitsPeriod >0 • Denominator_Type = "Include: IVD code on problem list" or "Include: Myocardial Infarction with Appropriate Date" or "Include: Myocardial Infarction with Appropriate Date" or "Include: Cardiac Surgery with Appropriate Date" (filter for any of these options, if available) • Exclusion_Anticoag not equal to "Exclude"	UDS_Aspirin_Summary
Depression Remission at Twelve Months	Depression_ Remission_v4	• Denom_Depress_Dysthym_ Diag = "Had diagnosis of major depression or dysthymia" • Exclude_Bipolar_Personality _Death not equal to "Exclude" • Depres_Remiss_Outcome not equal to "Not in denominator: No Index PHQ-9"	Depression_Remission_ Summary

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Measure	Report Name	Filters on data sheet	Output sheet
Breast Cancer Screening	Breast Cancer Screening_v7	• PrimCareVisitsPeriod > 0 • AgeEndReporting not equal to 50 • Gender_Identity = “Female” or “Male-T” • Exclude_BilatMastect not equal to “Exclude”	Mammo_Summ
Colorectal Cancer Screening	ColRect Cancer Screening_v7	• PrimCareVisitsPeriod >0 • Exclude_Colect_ColCancer not equal to “Exclude”	Colorectal Cancer Screen Summ
Influenza Immunization	Influenza_ Immuniz_v3	• Annual_Visit_Denom = "Add to annual report denominator" • Exclusion_EggAllergy not equal to “Exclude	InfluenzImmun
Pneumonia Vaccination Status for Older Adults	Pneumonia_ Vacc_v2	None	Pneumo_Vacc_Status
Body Mass Index (BMI) Screening and Follow-Up Plan	Adult_Weight_v9	Exclusion_Preg_Pallative not equal to "Exclude"	Final_Summary
Tobacco Use: Screening and Cessation Intervention	Tobacco_v8	Annual_Visit_Denom = “Add to annual report denominator”	Tobac_Composite
Screening for Clinical Depression and Follow-Up Plan	Depression_Screen _Followup_v8	StartMP_Dx_ProbList_Exclude not equal to “Exclude”	Outcome_Summ
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CVD_Statins_v2	• PrimCareVisitsPeriod > 0 • Denominator_Pop not equal to “Not in denominator” • Exclusion_Any not equal to “Exclude”	StatinUse_Summary