Instructions and Technical Documentation for the BridgeIt PHASE Report Set
Version 8b, By Ben Fouts, Redwood Community Health Coalition. May, 2017.

Introduction

A BridgeIT report is available from RCHC that displays patients in the reportable denominators of the Kaiser Permanente PHASE (Preventing Heart Attacks and Strokes Every Day) initiative. Most of these patients are eligible for PHASE-related clinical and case management activities. The newest version of the report can be used for identifying patients for further evaluation and action, and to summarize data for quarterly reporting. Similar to reports in the RCHC BridgeIt Annual Clinical Report Set, the PHASE report can be filtered to display particular patient sub-populations, and has associated output sheets that display an overview of patient results.

The instructions below were written for people who are familiar with the basics on how to run BridgeIt reports. For instance, users will need to know how to import a report from the Warehouse, run it with parameters, filter the results, open and refresh the output sheets, and move between the output sheets in order to copy data from them.

PHASE Population Definition

The initial denominator of the BridgeIT PHASE report is defined as all patients 18 years of age and older with at least one diagnosis code on their Problem List from one of seven diagnosis groups described below, or who have been identified as a the PHASE program participant by the health center. Note that the initial denominator shown by the report is different than the PHASE Eligible population. The PHASE Eligible population does not include patients with only hypertension and not any of the other six diagnosis groups mentioned here.

Below are the lists of ICD-9 and ICD-10 codes that are used by the report to define the initial report denominator[1]. Note that an asterisk (*) denotes any number or no number. Codes must appear on the patient's Problem List to be considered:

Diabetes Mellitus (abbreviated "DM"): ICD-9 are 250.*, 357.2, 362.0*, 366.41 and 648.0; ICD-10 are E10*, E11*, E13* and O24* (but not O24.4* or O24.9*)

Abdominal Aortic Aneurysm (abbreviated "AAA"): ICD-9 are 441.3, 441.4 and 441.9; ICD-10 are I71.3, I71.4 and I71.9.

[1] In the earliest versions of the report, health centers were required to establish and maintain their own diagnosis groups in eCW. The current version of the report selects patients with the codes listed above without regard to diagnosis groups. Furthermore, only ICD-10 codes are used in the newest version of the report.

Coronary Artery Disease (abbreviated "CAD"): ICD-9 are 410.*, 411.*, 412*, 413.*, 414.0*, 414.2, 414.3, 414.8, 414.9, V45.81 and V45.82; ICD-10 are I20*, I21*, I22*, I23*, I24*, I25* (but not I25.3, I25.41 or I25.42), Z95.1 and Z98.61

Peripheral Artery Disease (abbreviated "PAD"): ICD-9 are 440.1*, 440.2*, and 440.4; ICD-10 are I70.0, I70.1, I70.20*, I70.21*, I70.229, I70.235, I70.245, I70.25, I70.269 and I70.299

Transient Ischemic Attack/Cerebrovascular Accident (abbreviated "TIA"): ICD-9 are 433*, 434*, 435, 435.1, 435.2, 435.3, 435.8, 435.9, 436, 438.9 and V12.54; ICD-10 are G45.0, G45.1, G45.8, G45.9, G46.3, G46.4, I63*, I65*, I66*, I67.2 and Z86.73

Atherosclerotic Cardiovascular Disease (abbreviated "ASCVD"): This is a combination of all the codes mentioned above for Abdominal Aortic Aneurysm, Coronary Artery Disease, Peripheral Artery Disease, and Transient Ischemic Attack/Cerebrovascular Accident

Essential Hypertension (abbreviated "HTN" and not considered a necessary diagnosis for the PHASE Eligible population): ICD-9 are 401.0, 401.1 and 401.9; ICD-10 is I10

The report also displays patients if they are identified as PHASE participants by the health center. These patients must have a special diagnosis code and problem name combination placed on their Problem List. The code can be any code designated by the health center, but must have a Problem Name description beginning with the word “PHASE”, such as “PHASE CASE MANAGEMENT.” The recommended ICD-10 codes are Z78.9 and Z71.89, but the report will use any code with the applicable Problem Name description. In general, more than one Problem Name description can be associated with a diagnosis code in eCW (modifying this is usually done in conjunction with the billing department) and so the PHASE description must be specifically chosen when the provider places the code on the Problem List.

In order to group PHASE participants into a cohort, they need to be associated by enrollment date. The most accurate way to enter the enrollment date is to enter it manually into the “Onset date” field of the PHASE diagnosis code at the time it is added to the patient’s Problem List[2].

The PHASE eligible population is composed of patients with Diabetes, Abdominal Aortic Aneurysm, Coronary Artery Disease, Peripheral Artery Disease, or Transient Ischemic Attack/Cerebrovascular Accident. The initial denominator must be filtered in order to view only these patients, as described below. The filter removes patients with a hypertension diagnosis only (in other words, patients with hypertension and <u>not</u> a diagnosis in any of the other groups and <u>not</u> PHASE identified).

[2] On the report, there is a column named “PHASE_Start_Date” which is tied to the PHASE ICD-10 enrollment code on the Problem List. This column will display the Onset Date, if present. If there is no onset date, the date the problem was added (“Added Date”) or logged on the list (a time stamp) is used, in that order. Note that if your health center is recoding ICD-9 codes, an accurate Onset Date must be entered with the ICD-10 code.

PHASE Report Description

The current version of the BridgeIt PHASE report is named "PHASE_v8" and is located in the Warehouse here at most health centers: Warehouses / Workgroup / RCHN Clinical Folder / Workbook / PHASE[3]. The following description of the report and column names refer to this version.

The PHASE report is used to help identify and prioritize patients who are eligible for the PHASE initiative. The report contains columns for the five diagnosis groups that define the criteria for eligibility, as well as the number of visits in the measurement period, relevant medications, important vitals (blood pressure and BMI), relevant labs (A1c and LDL), and key case management activities (tobacco use assessment and influenza immunization). The user can use combinations of these columns to filter for patient subpopulations, perform case-management activities, and summarize the data for quarterly reporting using the KP PHASE Data Reporting Template.

Upon initially running the report, the user is asked to define a measurement period with a start date and an end date. For quarterly reporting, this is normally a year of time, ending the last day of the quarter (RCHC will provide the measurement period dates, and these periods also appear on a tab in the template). Health centers can use other date ranges (a quarter, a month, a week, etc.) for their own purposes. The number of visits is calculated from the measurement period range as well as other items that are associated with dates (e.g., last lab completed, last blood pressure, etc.). The report initially displays all patients with any of the diagnoses regardless of visits. Typically, the column PrimCareVisitsPeriod is then filtered for those patients having at least one primary care medical visit in the measurement period.

Note that because this is a complex report, it will take a longer time to run as compared to other BridgeIt reports. When this report was tested, it sometimes took between 5 and 10 minutes to complete and display results. During this time, it may appear like BridgeIt is frozen, or text may display indicating the BridgeIt toolbox is "Not Responding." Alternately, the entire screen may look blank or greyed-out. In some situations, a window may pop-up with a message such as "Please wait…" or a message asking if the user wants to restart the program or wait for it to respond (always click to wait). All of this is completely normal.

Checking Proper System Set-Up: Medication Groups

The BridgeIt PHASE Summary Report contains columns for twelve medication groups. If the patient is currently taking a medication belonging to the group, the report will display "Yes" in the associated column. Individual medications must be associated with the appropriate group in eCW in order for them to be recognized by the report. There is a section of the document "System Set-Up For the BridgeIt

[3] Note: some Warehouses have different folder trees. The report will always appear ultimately in a folder named "PHASE"

Annual Clinical Report Set (Version 5)" released by RCHC December 2016 and beginning on page 38 that covers creating Rx Groups and associating medications. The medication groups displayed by the report are:

- Aspirin Therapy (group name "Aspirin Therapy")
- ACE Inhibitors or ARBs (two group names "ACE Inhibitors" and "ARBs")
- Thiazide Diuretics (group name "Thiazide Diuret")
- Other Diuretics (group name "Other Diuretics")
- Beta Blockers (group name "Beta Blockers")
- Calcium Channel Blockers (group name "Calcium Channel")
- Statins (group name "Statins")
- Drug therapy for lowering LDL cholesterol (group name "Other Lipid Med")
- Metformin (group name "Metformin")
- Insulin (group name "Insulin")
- Other hypoglycemic medications (group name "Other hypoglycemic")
- Antihypertensives (group name "Antihypertensiv" or "Anti-Hypertensi")[4]

If a health center does not establish these groups and assign medications to them, the corresponding columns in the summary report will not function (i.e., they will be blank for all patients). Once established, health centers should periodically check the medications assigned to each group to ensure that they are correct and complete[5]. Note that some of these medication groups are used for other clinical measures (typically UDS and ACO measures) and therefore may already appear in the system.

To help with case management, there is also a column that displays "Yes" if a patient is taking Warfarin/Coumadin (this is relevant to patients being considered for aspirin therapy). Therefore, all medications with the active ingredient Warfarin Sodium (aka Coumadin) should be added to a new medication group. The recommended group name is "Warfarin sodium" but the report will pick up any group with the text "Warfarin" or "Coumadin" in it[6]. This is not one of the twelve PHASE-related medication groups, therefore it is present with the other 'exclusion' columns and the far right side of the report.

[4] Note that the medication group name is allowed only a certain number of characters in eCW. The report accepts any name like "Antihypertens*" or "Anti-Hypertens*" where "*" is any characters or no characters. Also note that the PHASE program has created a list of suggested medications to add to the antihypertensive group. The document titled "PHASE Clinical and Quality Measures: Oral Medication List for Hypertension" is available from RCHC

[5] There is a BridgeIT report that lists all medications and associated groups. It is named "Clin_Medications and Med Groups" and should be in the Warehouse under Library\Workgroup\UDS and CMS Clinical Setup. This report has a column for Rx Category (eg, CustomRx, MedispanRx, MultumRx, etc) that can help to search for medications in eCW.

[6] The report will <u>not</u> pick-up medication groups with the name "Anticoagulation"

Data Sheet Details

The BridgeIT data sheet opens to show all patients with any of the seven diagnoses, or who have otherwise been identified as participating in the PHASE initiative (as described above in the PHASE Population Definition section). The user can further filter the data to limit the patients by desired characteristics. Normally, this is done for two purposes: to summarize the data, or, to identify patients for additional actions. These two purposes are explained in detail in the section below, “Filters and Output Sheets.”

The columns on the data sheet and a description of the data is in the table below.

Column name	Column description
DatasetName	Health center name
AccountNo	Account number
PatLastName	Patient last name
PatFirstName	Patient first name
DateOfBirth	Date of birth
AgeEndReporting	Age at the end of the measurement period
Gender	Gender
Ethnicity	Ethnicity
race	Race
PrimaryFacility	Primary facility to which the patient is assigned
RenderingProv	Primary provider (the 'Rendering' Provider) to which the patient is assigned
insuranceName	Primary insurance name
InsClassName	Class of the primary insurance
PrimCareVisitsPeriod	Primary care visits in the measurement period (maximum measurement period for this report is 2 years)
LastPrimCareVisitDate	Date of last primary care visit in the measurement period
2Y_PrimCareVisits	Primary care visits in the two years prior to the measurement period end date
AnyVisitPeriod	All visits in the measurement period with a claim
ActivePt	Will display "Active" if the patient is active and not deceased
PHASE_Identified	Will display "Yes" if the patient has a PHASE ICD-10 code on the Problem List
PHASE_Start_Date	The date that the patient was enrolled in the PHASE program at the health center. The date is derived from the Onset Date, or the Added Date, or the logged date (in that order) associated with the PHASE ICD-10 code on the problem list
PHASE_Eligible	Will display "Yes" if the patient has an ICD-9 or ICD-10 code on the Problem List associated with AAA, CAD, PID, TIA or DM
DM_diag	Will display "Yes" if the patient has an ICD-9 or ICD-10 code on the Problem List associated with common Diabetes Mellitus diagnosis codes
AAA_diag	Will display "Yes" if the patient has an ICD-9 or ICD-10 code on the Problem List associated with common Abdominal Aortic Aneurysm diagnosis codes
CAD_diag	Will display "Yes" if the patient has an ICD-9 or ICD-10 code on the Problem List associated with common Coronary Artery Disease diagnosis codes
PAD_diag	Will display "Yes" if the patient has an ICD-9 or ICD-10 code on the Problem List associated with common Peripheral Artery Disease diagnosis codes
TIA_diag	Will display "Yes" if the patient has an ICD-9 or ICD-10 code on the Problem List associated with common Transient Ischemic Attack/Cerebrovascular Accident diagnosis codes

ASCVD_diag	Will display "Yes" if the patient has an ICD-9 or ICD-10 code on the Problem List associated with common Atherosclerotic Cardiovascular Disease diagnosis codes
HTN_diag	Will display "Yes" if the patient has an ICD-9 or ICD-10 code on the Problem List associated with common Essential Hypertension diagnosis codes
EssHTN_ DiagnosisBeforePriorDate	Will display "Yes" if the earliest essential hypertension diagnosis date is 6 or more months prior to the Measurement Period end date
DM_Perscript_Denom	Will display "Yes" if the patient has an ICD-9 or ICD-10 code on the Problem List associated with common Diabetes Mellitus diagnosis codes AND is between 55 and 75 years of age at the end of the measurement period AND had at least one primary care medical visit in the measurement period AND had at least two primary care medical visits in the two years prior to the end of the Measurement Period AND has no exclusion criteria (for exclusions see the column Exclusion_DM below)
DM_Clin_Denom	Will display "Yes" if the patient has an ICD-9 or ICD-10 code on the Problem List associated with common Diabetes Mellitus diagnosis codes AND is between 18 and 75 years of age at the end of the measurement period AND had at least one primary care medical visit in the measurement period AND had at least two primary care medical visits in the two years prior to the end of the Measurement Period AND has no exclusion criteria (for exclusions see the column Exclusion_DM below)
HTN_Denom	Will display "Yes" if the patient has an ICD-9 or ICD-10 code on the Problem List associated with common Essential Hypertension diagnosis codes AND is between 18 and 85 years of age at the end of the measurement period AND had at least one primary care medical visit in the measurement period AND was diagnosed with Essential Hypertension at least six months prior to the end of the Measurement Period AND has no exclusion criteria (for exclusions see the column Exclusion_HTN below)
All_Pts_Denom	Will display "Yes" if the patient is included in the diabetes, hypertension or ASCVD denominators
AspirinTherapy_meds	Will display "Yes" if the patient is currently using a medication associated with the Aspirin Therapy medication group
ACE_ARB_meds	Will display "Yes" if the patient is currently using a medication associated with the ACE Inhibitors or ARBs medication group
ThiazideDiuret_meds	Will display "Yes" if the patient is currently using a medication associated with the Thiazide Diuret medication group
BetaBlockers_meds	Will display "Yes" if the patient is currently using a medication associated with the Beta Blockers medication group
CalciumChannel_meds	Will display "Yes" if the patient is currently using a medication associated with the Calcium Channel medication group
OtherDiuretics_meds	Will display "Yes" if the patient is currently using a medication associated with the Other Diuretics medication group
Statins_meds	Will display "Yes" if the patient is currently using a medication associated with the Statins medication group
OtherLipidMed_meds	Will display "Yes" if the patient is currently using a medication associated with the Other Lipid Med medication group
Metformin_meds	Will display "Yes" if the patient is currently using a medication associated with the Metformin medication group
Insulin_meds	Will display "Yes" if the patient is currently using a medication associated with the Insulin medication group
OtherHypoglyce_meds	Will display "Yes" if the patient is currently using a medication associated with the Other hypoglycemic medication group
Antihypertensive_meds	Will display "Yes" if the patient is currently using a medication associated with the Antihypertensives medication group
Had_Statin_1Y	Will display “Yes” if the patient had a statin medication within one year of the measurement period end date
Had_ACE_ARB_1Y	Will display “Yes” if patient had either an ACE or ARB medication within one year of the measurement period end date
Had_Statin_ACE_ARB_1Y	Will display “Yes” if patient had statin AND either an ACE or ARB medication within one year of the measurement period end date
Had_Antihypertensive_1Y	Will display “Yes” if patient had an antihypertension medication within one year of the measurement period end date
LastBPDate	Date of the last blood pressure before the end of the measurement period
LastBPValue	Value of the last blood pressure before the end of the measurement period
BPSys	Value of the last systolic blood pressure before the end of the measurement period

BPDias	Value of the last diastolic blood pressure before the end of the measurement period
LastBPStatus_DM	Blood pressure status category associated with the measure for controlled blood pressure for diabetes (under 140/90 mmHg)
LastBPStatus_HTN	Blood pressure status category associated with the measure for controlled blood pressure for hypertension (under 140/90 mmHg or under 150/90 mmHg, depending on age and diabetes status)
LastA1CDate	Date of the last A1c test before the end of the measurement period
LastA1CResult	Value of the last A1c test before the end of the measurement period
LastA1cStatus_9%	Summary category of last A1c result (including under 9% category)
LastLDLDate	Date of the last LDL test before the end of the measurement period
LastLDLResult	Value of the last LDL test before the end of the measurement period
LastLDLStatus	Summary category of last LDL result
LastInfluImm	Date of last influenza immunization
InfluImm_Result	Summary category of last influenza immunization date
LastStructTobacAssessm	Date of last Social History tobacco assessment entered into structured data before the end of the measurement period
StructAssessmWithin2Y	Will display "Yes" if the last Social History tobacco assessment date was more recent than 2 years before the end of the measurement period
TobaccoUserLastAssessm	Will display "Yes" if the last Social History tobacco assessment indicated that the patient used tobacco
LastBMIDate	Last BMI date before the measurement period end date
LastBMIValue	Value of BMI at the last date one was taken before the measurement period end date
BMI_Class_CDC	Summary category of last BMI value, according to CDC categories for BMI (underweight, normal weight, overweight, and obese)
Exclusion_HTN	Will display "Exclude" if the patient meets the standard hypertension exclusion criteria (which are: pregnant during reporting period or with end state renal disease (ESRD), dialysis, or renal transplant before or during the measurement period)
Exclusion_DM	Will display "Exclude" if the patient meets the standard HEDIS/QIP diabetes exclusion criteria (which are: a diagnosis of gestational diabetes or steroid-induced diabetes during the measurement year or the year prior to the measurement year)
Exclusion_WarfCoumad_meds	Will display "Exclude" if the patient is currently using a medication associated with the Warfarin/Coumadin medication group
Exclusion_ASA_allerg	Will display "Exclude" if the patient had an allergy, contraindication or reaction to a medication in the Aspirin Therapy medication group documented before the end the measurement period

Filters and Output Sheets

Filters are used to further define segments of the denominator population, depending on what specifically is desired by the user. Once the segment or sub-population is defined on the data sheet using filters, rows from the data sheet can be copied to Excel (if doing some kind of case management or other activity with individual patients) or summarized on the output sheets (if aggregating data), as needed.

In almost all cases, the number of visits the patient had in the measurement period is one of the filters applied. The user can run the report for a measurement period up to two years in length. If summarizing the measures for the quarterly PHASE report, the user should choose a period of one year (for example, April 1, 2016 to March 31, 2017 for first-quarter 2017 reporting). For internal performance improvement purposes, if the health center defines “current” patients as having been seen at least once in the past 18

months, the user can enter that period of time. In any case, the number of times the patient has been seen in the measurement period by a primary care medical provider is displayed in the column PrimCareVisitsPeriod[7]. If aggregating data based on a time period, this column should be filtered for one or more visits. For other purposes (for example, to get a list of patients known to be in the area within a period of time), the column AnyVisitPeriod displays the number of times the patient had a visit in the measurement period by any staff member for any reason. For case management and recall activities, the column ActivePt should be used to identify active patients[8] (however, this column is not used for reporting).

A. Using the Report to Identify Patients for Case Management Activities

Once familiar with the column definitions on the data sheet and how to apply filters, the user can be creative and apply any number of filters to prioritize patients for further intervention. Below are some examples.

1) Make a list of current patients seen in the measurement period who are eligible for inclusion in the PHASE initiative.
   a) PrimCareVisitsPeriod > 0
   b) ActivePt = "Active"
   c) PHASE_Eligible equal to "Yes"

2) Make a list of current patients identified as participating in the PHASE initiative.
   a) PrimCareVisitsPeriod > 0
   b) ActivePt = "Active"
   c) PHASE_Identified equal to "Yes"

3) Make a list of current patients seen in the measurement period who are eligible for inclusion in the PHASE initiative, but are not yet identified as participating in PHASE.
   a) PrimCareVisitsPeriod > 0
   b) ActivePt = "Active"
   c) PHASE_Eligible equal to "Yes"
   d) PHASE_Identified not equal to "Yes"
   e) Sorting the list in descending order by the column PrimCareVisitsPeriod will display those patients with the most visits at the top (this prioritizes the list by number of visits, but you can also sort by variables like last blood pressure, last LDL, last BMI, etc.)

4) Make a list of current patients with diabetes identified as participating in PHASE with last A1c equal to or greater than 9% or not measured, and belonging to provider Dr. XYZ.
   a) PrimCareVisitsPeriod > 0

[7] The primary care visits column is calculated in the same manner as the other RCHC BridgeIt Annual Reports. See page 6 of the RCHC technical document (version 12) for details.
[8] The active patient column is calculated in the same manner as the other RCHC BridgeIt Annual Reports. See page 7 of the RCHC technical document (version 12) for details

b) ActivePt = “Active”
c) PHASE_Identified equal to “Yes”
d) DM_diag = “Yes”
e) LastA1cStatus_9% = “A1c >= 9%” or “No A1c lab performed within the past year”
f) RenderingProv = “Dr. XYZ”

5) Make a list of current patients identified as participating in PHASE with coronary artery disease who are overweight or obese, smokers, and have the last blood pressure reading over 140/90 mmHg.
   a) PrimCareVisitsPeriod > 0
   b) ActivePt = “Active”
   c) PHASE_Identified equal to “Yes”
   d) CAD_diag = “Yes”
   e) BMI_Class_CDC = “3. Overweight (between 25 and 30)” or “4. Obese (over 30)”
   f) LastBPStatus_DM = “BP not < 140/90 mmHg”
   g) TobaccoUserLastAssessm = “Yes”

6) Make a list of current patients identified as participating in PHASE and not seen for at least six months, belonging to Dr. XYZ, and on a statin medication at last visit. Run the report for a measurement period of 18 months.
   a) PrimCareVisitsPeriod > 0
   b) ActivePt = “Active”
   c) PHASE_Identified equal to “Yes”
   d) LastPrimCareVisitDate on or before the date exactly six months before end of measurement period
   e) Statins_meds = “Yes”
   f) RenderingProv = “Dr. XYZ”

7) Make a list of current patients identified as participating in PHASE who could be recalled for an influenza immunization clinic. Run the report for a measurement period of 18 months.
   a) PrimCareVisitsPeriod > 0
   b) ActivePt = “Active”
   c) PHASE_Identified equal to “Yes”
   d) InfluImm_Result = “Old influenza immunization” or “Never had influenza immunization”

B. Using the BridgeIt Report to Summarize Data

The output sheets on the PHASE BridgeIT report display summary data for several measures on the PHASE Health Center Reporting Template. The measures are generally focused on patients who are eligible for PHASE or have hypertension. They are not exclusively focused on patients identified as participating in the PHASE initiative. The three measures in the Screening and Follow-up section are based on the general patient population (and use UDS definitions). Therefore, three other BridgeIT reports are used for those measures.

Below are the measure definitions from the reporting template along with the BridgeIT filters needed to obtain the measure *denominator*. None of the measures are based on the initial patient population displayed by the report, so appropriate filters must be used. At the very least, patients for all measures must have been seen by a primary care medical provider in the measurement period (PrimCareVisitsPeriod > 0). Filters can be added to the data sheet[9], but filters for most measures can also be applied on the output sheet. For your convenience, the section below beginning on page 13 contains a table that briefly describes the filters, output sheets, and rows with the denominator and numerator data (where applicable) for each measure.

Section 1: Patient Population Measures

1. Diabetes patients. The number of patients with a diagnosis of diabetes (type 1 or type 2) who are aged 18-75 years, have been seen in the measurement period, have had at least two primary care medical visits in the two years prior to the end of the measurement period, and have no exclusions. Use the filter DM_Clin_Denom = "Yes." This filter is equivalent to:

a) DM_diag = "Yes"
b) AgeEndReporting between 18 and 75
c) PrimCareVisitsPeriod > 0
d) 2Y_PrimCareVisits > 1
e) Exclusion_DM not equal to "Exclude"

2. ASCVD patients. The number of patients with a diagnosis of Clinical ASCVD, any age. NOTE: manual filters on the data sheet must be applied for this measure.

a) PrimCareVisitsPeriod > 0
b) ASCVD_diag = "Yes"

3. Hypertension patients. The number of patients with a diagnosis of Essential Hypertension, who were diagnosed with Essential Hypertension at least six months prior to the end of the Measurement Period, who are aged 18-85 years, have been seen in the measurement period, and have no exclusions. Use the filter HTN_Denom = "Yes." This filter is equivalent to:

a) HTN_diag = "Yes"
b) HTN_DiagnosisBeforePriorDate = "Yes"
c) AgeEndReporting between 18 and 85
d) PrimCareVisitsPeriod > 0
e) Exclusion_HTN not equal to "Exclude"

4. Unduplicated patients. The number of unduplicated patients who meet at least one of the above criteria for diabetes patients, ASCVD patients or hypertension patients. NOTE: manual filters on the data sheet must be applied for this measure.

a) PrimCareVisitsPeriod > 0

[9] If adding filters to the data sheet, user must always manually "refresh" the data in the output. This must occur each time a new filter is applied. If applying filters in the output, refresh once just after opening the output for viewing.

b) All_Pts_Denom = “Yes” (this filter is equivalent to all of the filters for the measures #1 to #3 above).

Section 2: Prescription Measures

5. to 7. Prescription measures for diabetes patients. The number of patients with a diagnosis of diabetes (type 1 or type 2) who are aged 55-75 years, have been seen in the measurement period, have had at least two primary care medical visits in the two years prior to the end of the measurement period, and have no exclusions. Use the filter DM_Perscript_Denom = “Yes.” This filter is equivalent to:

a) DM_diag = “Yes”
b) AgeEndReporting between 55 and 75
c) PrimCareVisitsPeriod > 0
d) 2Y_PrimCareVisits > 1
e) Exclusion_DM not equal to “Exclude”

8. Prescription measure for hypertension patients. This denominator is the same as the hypertension patient population in Section 1, above. It is the number of patients with a diagnosis of Essential Hypertension, who were diagnosed with Essential Hypertension at least six months prior to the end of the Measurement Period, who are aged 18-85 years, have been seen in the measurement period, and have no exclusions. Use the filter HTN_Denom = “Yes.” This filter is equivalent to:

a) HTN_diag = “Yes”
b) HTN_DiagnosisBeforePriorDate = “Yes”
c) AgeEndReporting between 18 and 85
d) PrimCareVisitsPeriod > 0
e) Exclusion_HTN not equal to “Exclude”

Section 3: Screening and Follow-up Measures

9. Tobacco screening & follow-up. The number of patients aged 18 years and older seen for at least two primary care medical visits in the measurement year or at least one preventive visit in the measurement year. Use the report Tobacco_v6 (Version 6.2) with the filter Annual_Visit_Denom = “Add to annual report denominator.”

10. BMI screening & follow-up. The number of patients who were 18 years of age or older seen for at least one primary care medical visit in the measurement year. Use the report Adult_Weight_v8 with the filter Exclusion_Preg_Pallative not equal to "Exclude."

11. Depression screening & follow-up. The number of patients aged 12 years and older seen for at least one primary care medical visit in the measurement year. Use the report Depression_Screen_Followup_v6 with the filter StartMP_Dx_ProbList_Exclude not equal to “Exclude”

Section 4: Clinical Quality Measures

12 and 13. Diabetes controlled blood pressure and controlled A1c. This denominator is the same as the diabetes patient population in Section 1, above. It is the number of patients with a diagnosis of diabetes (type 1 or type 2) who are aged 18-75 years, have been seen in the measurement period, have had at least two primary care medical visits in the two years prior to the end of the measurement period, and have no exclusions. Use the filter DM_Clin_Denom = "Yes." This filter is equivalent to:

a) DM_diag = "Yes"
b) AgeEndReporting between 18 and 75
c) PrimCareVisitsPeriod > 0
d) 2Y_PrimCareVisits > 1
e) Exclusion_DM not equal to "Exclude"

14. Hypertension controlled blood pressure. This denominator is the same as the hypertension patient population in Section 1, above. It is the number of patients with a diagnosis of Essential Hypertension, who were diagnosed with Essential Hypertension at least six months prior to the end of the Measurement Period, who are aged 18-85 years, have been seen in the measurement period, and have no exclusions. Use the filter HTN_Denom = "Yes." This filter is equivalent to:

a) HTN_diag = "Yes"
b) HTN_DiagnosisBeforePriorDate = "Yes"
c) AgeEndReporting between 18 and 85
d) PrimCareVisitsPeriod > 0
e) Exclusion_HTN not equal to "Exclude"

The output sheets are named after the measure numerator (for example, the sheet "Hypertension_BP" is used for the hypertension controlled blood pressure measure). A list of what output sheet to use for what measure appears in the table beginning on the next page. Each sheet has optional filter(s) above the data summary table that can be used instead of filters on the data sheet.

Note that the output sheet named "Number_patients" simply counts the number of patients displayed on the data sheet (once the filters are placed and the output refreshed). Therefore, it can be used to count the number of patients identified as PHASE participants (PHASE_Identified equal to "Yes" and PrimCareVisitsPeriod > 0). It can also be used to count the number of patients eligible for PHASE but not yet identified as participants (using the filters PHASE_Eligible equal to "Yes," PHASE_Identified not equal to "Yes" and PrimCareVisitsPeriod > 0).

Filters and Output Sheets: Completing the KP PHASE Health Center Reporting Template (Clinical and Quality Measures)

All measures on the KP PHASE Data Reporting Template can be obtained using BridgeIt reports. Most of the data comes from the main PHASE report (PHASE_v8), but the three measures in the section "Screening and Follow-up" use reports from the BridgeIT Annual Clinical Report Set. The measurement period for all reports should be one year ending on the last day of the quarter, as specified by Kaiser. Follow the brief instructions below to obtain the data for each measure.

Measure	Report Name	Filters on data sheet or output	Output sheet and data to copy
Patient Population			
Diabetes patients	PHASE_v8	• DM_Clin_Denom = "Yes"	• Sheet "Diabetes_BP" • Denominator: "Grand Total"
ASCVD patients	PHASE_v8	• PrimCareVisitsPeriod > 0 • ASCVD_diag = "Yes"	• Sheet "Patient_Count" • Denominator: "Total"
Hypertension patients	PHASE_v8	• HTN_Denom = "Yes"	• Sheet "Hypertension_BP" • Denominator: "Grand Total"
Unduplicated patients	PHASE_v8	• All_Pts_Denom = "Yes"	• Sheet "Patient_Count" • Denominator: "Total"
Prescription			
Diabetes statin	PHASE_v8	• DM_Perscript_Denom = "Yes"	• Sheet "Diabetes_Statin" • Numerator: "Yes" • Denominator: "Grand Total"
Diabetes ACE/ARB	PHASE_v8	• DM_Perscript_Denom = "Yes"	• Sheet "Diabetes_ACE_ARB" • Numerator: "Yes" • Denominator: "Grand Total"
Diabetes statin and ACE/ARB	PHASE_v8	• DM_Perscript_Denom = "Yes"	• Sheet "Diabetes_Statin_ACE_ARB" • Numerator: "Yes" • Denominator: "Grand Total"
HTN antihypertensive	PHASE_v8	• HTN_Denom = "Yes"	• Sheet "Hypertension_Meds" • Numerator: "Yes" • Denominator: "Grand Total"
Screening and Follow-up			
Tobacco screening & counseling	Tobacco_v6	• Annual_Visit_Denom = "Add to annual report denominator"	• Sheet: "UDS_ACO_Composite" • Numerator: row "Assessed and intervened with as appropriate" • Denominator: "Grand Total"
BMI screening & follow-up plan	Adult_Weight_v8	• Exclusion_Preg_Pallative not "Exclude"	• Sheet: "ACO_Summary" • Numerator: row "Meets documentation criteria" • Denominator: "Grand Total"
Depression screening & follow-up plan	Depression_Screen_Follow up_v6	• StartMP_Dx_ProbList_ Exclude not "Exclude"	• Sheet: "Outcome_Summ" • Numerator: row "Appropriately screened/followed-up" • Denominator: "Grand Total"

Clinical quality			
Diabetes controlled blood pressure	PHASE_v8	• DM_Clin_Denom = “Yes”	• Sheet “Diabetes_BP” • Numerator: “Yes” • Denominator: “Grand Total”
Diabetes controlled A1c	PHASE_v8	• DM_Clin_Denom = “Yes”	• Sheet “Diabetes_A1c” • Numerator: “Yes” • Denominator: “Grand Total”
Hypertension controlled blood pressure	PHASE_v8	• HTN_Denom = “Yes”	• Sheet “Hypertension_BP” • Numerator: “Yes” • Denominator: “Grand Total”