
Technical Documentation For the BridgeIt Annual Clinical Report Set (Version 14)



Serving Sonoma, Napa, Marin & Yolo Counties

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Purpose

This document contains a detailed definition of the data fields and calculations that were used to design the Bridgell annual clinical reports.

Summary of Content

The data fields and calculations used for the denominator and numerator of each report are discussed. In some cases, a logic scheme is used to illustrate how the report works.

Introduction

The annual clinical report set covers the major indicators that are reportable on the UDS (Uniform Data System), QIP (Quality Improvement Project), ACO (Accountable Care Organization), and PIP (Performance Improvement Project) reports. These reports were designed to work for all RCHC health centers. Therefore, it is important that all health centers collect and enter data in similar ways for the major reportable indicators. It is difficult and time-consuming to customize and maintain these reports for each health center.

Users of the reports should be very familiar with how to find and run Bridgell reports, as well as filter and display results. A separate document named “Instructions for Using the Bridgell Annual Clinical Report Set” (version 14, June 2018) describes how to use the reports. This document is referred to as “the annual report Instructions” below. Another document, “System Set-Up For the Bridgell Annual Clinical Report Set” (version 6, July 2017¹) summarizes the eCW configuration needed for the reports to run properly and gives instructions on how to configure and check the system. This document is referred to as “the System Set-up document” below. Data quality should be methodically and regularly checked by the health center throughout the year. The document “Instructions for Using Bridgell Reports to Regularly Validate and Clean eCW Data” (version 5, November 2017) should be used to ensure that the system set-up continues to be complete and that data is error-free.

In general, each Bridgell report displays a specific population, or “universe” of patients (UDS term). This is also called the denominator. In most cases, the initial set of records needs to be filtered in order to

¹ Note that documents from 2017 will probably have a new version later in 2018

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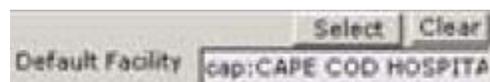
define the appropriate denominator population for the reportable measure. Once the desired population is displayed in the BridgelT datasheet, the numerator columns are summarized using Excel pivot tables (referred to as “the output”).

In most reports, the user enters a measurement period (start date and end date). This is normally a period of a year (for example the UDS uses a calendar year), but health centers can run these reports for any period of time, like a week, a month or a quarter. Just keep in mind that the measurement period defines the visit dates that patients were seen in the clinic (for example, the column PrimCareVisitsPeriod counts the number of visits with a primary care medical provider in the measurement period). It is recommended that health centers examine and validate their data at least monthly in order to identify errors and investigate sources of error. It is also a good idea for management or performance improvement teams to use a dashboard to review their data monthly by looking at trends.

Common Column Definitions

Most reports have standard columns, such as patient first name, last name, date of birth, etc., that come directly from the Patient Information screen in eCW. The reports automatically remove “test” patients (see section “NOTE about “Test” Patients” below). Other columns are determined as follows:

1. AgeEndReporting or AgeStartReporting. This is the age of the patient on the measurement period end date or start date.
2. PrimaryFacility. Default facility is on the Additional Patient Information screen.



3. RenderingProv. On the patient information screen, this is the “Rendering Provider/Primary Care Giver”



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4. RenderingTeam. Rendering providers can be grouped into teams using the Anesthesia License field in their administrative record.



5. insuranceName. On the insurance detail screen, this is the primary insurance.



6. InsClassName. For this column to be accurate, an insurance class must be associated with each insurance name in the eCW set-up. Because some reports focus on populations of patients who have a particular class of insurance (for example, Partnership Managed Care or Medicaid), filtering by class makes it easier to find those patients instead of filtering by individual insurance names.
7. SubscriberNo. The subscriber number is located on the Subscriber tab of the Insurance Detail window. This number corresponds to the Medicaid/Partnership or Medicare/ACO account number and is used to match patients to the patient lists provided by those organizations.

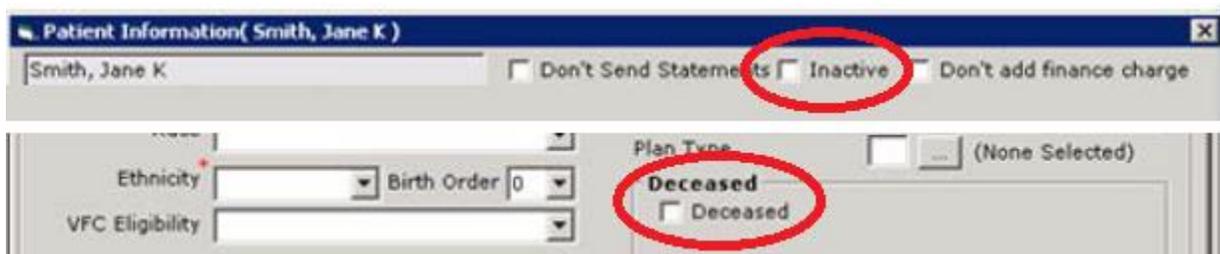


8. PrimCareVisitsPeriod. This is the number of primary care visits on different days between the measurement period start and end dates (chosen by the user) where a patient sees a primary

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care medical provider (as the resource provider) and an assessment was done. Medical providers include only individuals who exercise independent judgment and must have a specialty code in their administrative record like “fam” (Family Medicine), “internal” (Internal Medicine), “ped”(Pediatrics), “obst” (Obstetrics), “gyn” (Gynecology), “midwife” (Midwife), “nurse prac”(Nurse Practitioner), or “physician assist” (Physician Assistant). Therefore, a clinic must have properly assigned providers to the appropriate specialties in the eCW set-up. The visit must be face-to-face, and so cannot have a visit status indicating the patient was not actually seen by the provider (i.e., could not have a visit type like no show, cancelled, or rescheduled). The visit count also does not include telephone or lab visit types.

9. AnyVisitsPeriod. This is the number of completed encounters (visit status equal to check out) with a claim attached. They can be of any visit type with any provider. This column does not appear on all reports and is for your information only (it is not used in defining the denominator for any of the reported measures).
10. ActivePt. A patient will have “Inactive” in this column if any of the following conditions are met: 1) “Inactive” is checked on the Patient Information window; 2) “Deceased” is checked on the General Information tab of the Patient Information window; or, 3) the record has been deleted (for example, if it was a duplicate record).

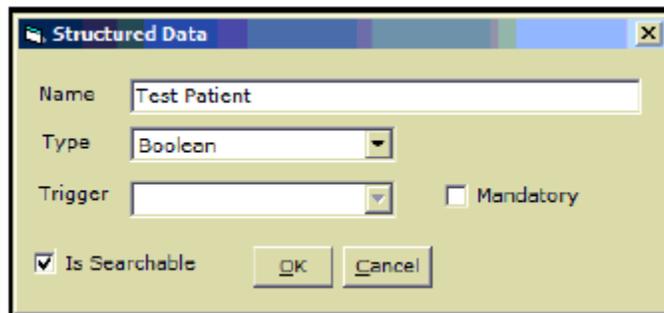


11. LastApptDate and NextApptDate. These columns display the last appointment date and the next appointment date relative to when the report is run. These appointments can be for any appointment type with any provider (therefore, they may be different than appointments with a primary care medical provider). These columns can be used to help make lists of patients for case management purposes. For example, to make a list of patients with diabetes who need to be seen by their rendering provider, the filters can be set to show active patients not seen in the past four months and without an already scheduled appointment (with additional filters, as needed, like A1c over 9%, blood pressure over 140/90mmHg, etc.).

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NOTE about “Test” Patients

In most cases, “Test” patients will not be counted on the clinical reports because they commonly do not have encounters with primary medical providers in the measurement period. However, it is still possible that they may meet the criteria for inclusion into the population of a report. Therefore, it is best that they be identified and automatically excluded by the clinical reports. This can occur in two ways. First, the reports exclude any patients with the last name spelled exactly “Test” or “Template.” Second, the reports will exclude any patients identified as a test patient in patient demographic structured data (see the section General Primary Care Provider Set-up in the set-up document). Basically, a field for “Test Patient” (exact text) needs to be defined in Patient Information Structured Data (see screenshot below). The reports will automatically exclude any patient with “Yes” entered into that field.



NOTE about Meaningful Use Criteria for Labs

Any reports that use lab test results (excluding pap tests) have eClinicalWorks Meaningful Use (eCW/MU) lab test result criteria built into them. The benefit of this is to ensure that all data quality efforts are synchronized and focused on the key lab fields identified by eCW for proper entry into structured data. The eCW MAQ Dashboard contains a reportable indicator called “Clinical Lab Test Results” that will measure how completely lab results are entered into structured data according to Meaningful Use criteria. See the document from eCW titled “eClinicalWorks Meaningful Use Calculations” for further detail.

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According to eCW, the following criteria are used to recognize that a lab is properly entered into structured data:

1. The result date has been entered into the Lab Results window
2. The Received box has been checked on the Lab Results window
3. At least one value has been entered in the yellow row on the Lab Results window

The cervical cancer screening report also utilizes lab results but does not apply the full eCW/MU criteria to define if a pap lab was completed. In addition to the three criteria above, the cervical cancer screening report accepts pap labs with any text in the Result field of the Lab Results window. See the section “Cervical Cancer Screening” below. The associated cervical cancer screening validation report shows if a particular lab conforms to summary report criteria, or to eCW/MU criteria, or both.

For all reports that use lab data, the “lab date” displayed is the collected date of the lab. In the portion of labs without a valid collected date, the result date is used.

Cervical Cancer Screening (UDS, PIP and QIP Reports)

Report name: Cervical Cancer Screening_v9

Denominator definitions: Female patients aged 24 years to 64 years on the measurement period end date are included in the denominator. Furthermore, patients are excluded if they had a hysterectomy with no residual cervix². The report puts the text “Exclude” in the Hysterectomy_Exclude column if it finds any of the following:

1. In the Surgical History text, a word like “hysterectomy” combined with any of the following words: “complete,” “radical,” or “total” (but not “subtotal”). The text “Absence of cervix” is also acceptable.
2. In the Medical History text, a word like “hysterectomy” combined with any of the following words: “complete,” “radical,” or “total” (but not “subtotal”). The text “Absence of cervix” is also acceptable.

² However, if the patient had cervical cancer screening appropriately documented, the report will include the patient in the denominator and numerator regardless of an apparent history of hysterectomy

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3. On the Problem List, a diagnosis code indicating no residual cervix. These are (ICD-9) 618.5, 752.43, V88.01, V88.03 or (ICD-10) Q51.5, Z90.710, or Z90.712. Placing any of the ICD-10 codes on the Problem List is the preferred method to indicate a hysterectomy with no residual cervix.

Additionally, the UDS and PIP reports require that patients had at least one primary care medical visit in the measurement period. This can be done on the data sheet by using a filter where `PrimCareVisitsPeriod > 0`. The QIP report does not have a visit criterion (they use continuous enrollment) but if the health center is approximating the measure using the Bridget report, the same visit filter can be used.

The report takes into consideration the patient's stated gender and transgender status to determine if the patient should be included in the denominator. The preferred way to document transgender patients is by using the Gender Identification field in Patient Information Structured Data or in Social History. See the Cervical Cancer Screening section of the System Set-Up For the Bridget Annual Clinical Report Set document (Version 6, July 2017) for more detail. Front desk and other demographic data entry staff should be trained on proper data entry. An audit should be periodically taken to make sure that patients are being properly marked or else false-positives and false-negatives may make the denominator inaccurate.

Patients are assumed to be in the denominator if they meet any of the following criteria, evaluated in order:

1. The option "Transgender: Male/Female-to-Male" selected for the Gender Identity question in Patient Information Structured Data or in Social History (regardless of selections in the Sex or Transgender fields on the Patient Information screen). In this case, the column `Gender_Identity` will display "Male-T."
2. Marked "F" (Female) for the Sex field on the Patient Information screen AND no transgender option ("Transgender: Female/Male-to-Female" or "Transgender: Male/Female-to-Male") is selected in Patient Information Structured Data or in Social History AND the Transgender checkbox is not marked. In this case, the column `Gender_Identity` will display "Female."
3. Marked "M" for the Sex field on the Patient Information screen AND a check in the Transgender checkbox on the Patient Information screen AND the option "Transgender: Female/Male-to-Female" is not selected in Patient Information Structured Data or in Social History. In this case, the column `Gender_Identity` will display "Male-T."

Therefore, from the above criteria, denominator patients are identified when the column `Gender_Identity` is filtered for "Female" or "Male-T." The Bridget Datasheet initially displays two other categories of transgender patients for quality control purposes, but should not be included in the

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denominator. These patients should be periodically checked to ensure that their gender status is properly displayed (and so that they are appropriately included or excluded from the denominator of the measure), particularly if the report also shows that they ever received a pap. The following categories are evaluated in order:

- i. The option “Transgender: Female/Male-to-Female” selected for the Gender Identity question in Patient Information Structured Data or in Social History (regardless of selections in the Sex or Transgender fields on the Patient Information screen). In this case, the column Gender_Identity will display “Female-T.”
- ii. Marked “F” for the Sex field on the Patient Information screen AND a check in the Transgender checkbox on the Patient Information screen AND no transgender option (“Transgender: Female/Male-to-Female” or “Transgender: Male/Female-to-Male”) is selected in Patient Information Structured Data or in Social History. In this case, the column Gender_Identity will display “Female-T.”

Numerator definitions: Patients are included in the numerator if any of the following criteria are met:

- A. Any patient in the denominator who had a cervical cytology lab performed within 3 years of the end of the measurement period. These labs are defined by either of the following:
 - i. LOINC codes: 10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, or 47528-5
 - ii. The lab name is associated with a pap lab group named “Pap test” (recommended) or “Pap labs”
- B. If the denominator patient did not meet the criterion in (A), the patient can be included if she was age 30 years or more when she had cervical cytology and human papillomavirus (HPV) testing performed on the same date within 5 years of the end of the measurement period. These labs are defined by either of the following:
 - i. The human papillomavirus LOINC codes are: 21440-3, 30167-1, 38372-9, 59263-4, 59264-2, 59420-0, 69002-4, 71431-1, 75694-0, 77379-6, 77399-4, 77400-0, 82354-2, 82456-5, or 82675-0. Both labs must have been ordered on the same date to be counted.
 - ii. If the lab was historical³, human papillomavirus tests are identified by the report as having the text “HPV” in the lab name of the cervical cytology lab defined in (A) above (in other words, it was a combined test).

³ In other words, a lab result was entered into the Results drop-down field in the Labs window of eCW, but there were no lab values in the “yellow brick road” and therefore no associated LOINC codes

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In order for the cervical cytology lab to be included, it must meet the following criteria:

1. The result date has been entered into the Lab Results window;
2. The Received box has been checked on the Lab Results window;
3. At least one value has been entered in the yellow row on the Lab Results window OR any text in the Result field of the Lab Results window.

The report displays the date of the last pap test (using the collected date if present, or the result date) in the column LastPapDate and the last pap/HPV co-testing date (using the collected date if present, or the result date) in the column Last_PapHPVDate. If the last pap test date was within 3 years (less than 36 months) of the measurement period end date, a “Yes” is put in the column PAPLast36Mths. A “Yes” is put in the column PAP_HP_V_Last60Mths if the last pap lab date and last HPV lab date are the same and occurred within 60 months (5 years) of the measurement period end date.

The column Pap_HP_V_Combined_Status displays the numerator for the measure that combines a pap in the past three years with a pap/HPV combination in the past 5 years depending on the age of the patient. Note that regardless of age or which measure is used, a patient is considered as being properly screened if the column PAPLast36Mths = “Yes.”

Part of the validation process should be to identify pap and HPV lab records that do not meet criteria for inclusion in the report, but nonetheless appear to have been completed. See the appendix of the annual report instructions (version 14, June 2018) for a description of a validation report that can be used for this purpose (under the heading “Cervical Cancer Screening List Validation”). This report allows the health center to separate pap and HPV exams and to apply or not apply Meaningful Use criteria for data entry completion.

Version 9 changes: denominator age range aligned for all measures; text for hysterectomy in surgical history or medical history changed; diagnosis codes for hysterectomy on the Problem List changed; LOINC codes used to identify cervical cytology labs and human papillomavirus labs added.

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Breast Cancer Screening (ACO and QIP Reports)

Report name: Breast Cancer Screening_v7

Denominator definitions: The report displays female and transgender patients with age on the measurement period end date between 50 and 74 years. The report takes into consideration the patient's stated gender and transgender status to determine if the patient should be included in the denominator. See the cervical cancer screening report section above for more detail.

Additionally, patients should not have a bilateral mastectomy. The report puts the text "Exclude" in the column "Exclude_BilatMastect" if any of the following conditions are true:

1. Problem List
 - a. Existence of the diagnosis code for bilateral mastectomy (Z90.13, Acquired absence of bilateral breasts and nipples). *This is the preferred method to identify patients with a bilateral mastectomy.*
 - b. Existence of two diagnosis codes for right and left unilateral mastectomies (Z90.11, Acquired absence of right breast and nipple, and Z90.12, Acquired absence of left breast and nipple)
 - c. Existence of any combination of two or more diagnosis codes for specific unilateral mastectomy (Z90.11 and Z90.12, as mentioned above) and general unilateral mastectomy (Z90.10, Acquired absence of unspecified breast and nipple or V45.71, Acquired absence of breast and nipple) along with different Onset dates for each code.
2. Surgical History
 - a. The word "***mastect***" plus one of "***bilat***" or "***double***" (where * is any set of characters) in the description
 - b. The words "***unilat***" and "***mastect***" (where * is any set of characters) in the description along with different surgical dates
3. Past Medical History. The word "***mastect***" plus one of "***bilat***" or "***double***" (where * is any set of characters) in the description

Numerator definitions: Mammograms used in this report have a diagnostic imaging name with the text "mammo" anywhere in it. In order for the test to be included, it must have been collected before the measurement period end date. If there is no collection date, the result date must be before the measurement period end date. The image record must also have some kind of result. Part of the validation process should be to go through the results and make sure there is not text in the results field indicating that a test was actually not done because this will 'fool' the report. See the appendix of the

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annual report Instructions (version 14, June 2018) for a description of a validation report that can be used for this purpose (under the heading “Breast Cancer Screening Image Validation”).

The report then takes the date of the last mammogram (by the definition above) and compares it to the measurement period end date. If the last mammogram was within 27 months of the measurement period end date, a “Yes” is put in the column MammoLast27Mths.

Version 7 changes: Age range changed to 50 to 74 for the initial population with a potential filter to be used for the ACO age range; surgical ICD-9 PCS codes removed from exclusion criteria; text and diagnosis codes used for bilateral mastectomy exclusion changed; two unilateral mastectomies added to exclusion criteria.

Colorectal Cancer Screening (UDS, PIP, QIP and ACO Reports)

Report name: ColRect Cancer Screening_v7

Denominator definitions: Patients initially displayed by the report are between 51 and 75 years of age on the last day of the measurement period. Filtering is needed to define patients with at least one visit during the measurement period and no exclusion criteria.

The column Exclude_Colect_ColCancer displays the text “Exclude” when any of the following conditions are met:

1. The patient has a diagnosis for colorectal cancer or for total colectomy on the Problem List. The ICD-9 codes are 153*, 154, 154.0, 154.1, 197.5, V10.05, and V10.06; the ICD-10 codes are C18*, C19*, C20*, C21.2, C21.8, C7A.02* (but not C7A.020 or C7A.029), C78.5, Z85.038, and Z85.048 where (*) is any number or no number.
2. The text entry into Medical History or Surgical History contains the following combination of words:
 - a. “colorectal cancer” --or--
 - b. “colectomy” combined with “total” and not any of the following: partial, hemi, sub, --or--
 - c. “malignant neoplasm” combined with any of the following: colon, cecum, appendix, hepatic flexure, splenic flexure, rectosigmoid junction, rectum, anus, anal canal, cloacogenic zone, or large intestine

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Numerator definitions: Patients in the denominator are sufficiently screened if they meet any of the five conditions below. To meet the condition, the test must have a collected date or a result date within the required time frame. The column Screened displays “Yes” if any of the following conditions are met:

1. The last fecal occult blood test (FOBT) lab was within one year of the measurement period end date. This lab is identified with the following LOINC codes: 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 2335-8, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2, and 80372-6. The lab must be entered into structured data by MU criteria (see page 8, above). See Appendix C of the System Set-up document for instructions on how to associate a LOINC code to a lab.
2. The last fecal immunochemical test DNA (FIT-DNA) lab was within three years of the measurement period end date. This lab is identified with the following LOINC codes: 77353-1 and 77354-9. The lab must be entered into structured data by MU criteria (see page 8, above). See Appendix C of the System Set-up document for instructions on how to associate a LOINC code to a lab.
3. The last colonoscopy image was within ten years of the measurement period end date. To be included on the report, the image record must have "colonoscopy" in the name and some kind of result in structured data. The image date is either the collected date (taken first, if present) or the result date.
4. The last CT colonography image was within five years of the measurement period end date. To be included on the report, the image record must have "colonography" in the name and some kind of result in structured data. The image date is either the collected date (taken first, if present) or the result date.
5. The last sigmoidoscopy image was within five years of the measurement period end date. To be included on the report, the image record must have "sigmoidoscopy" in the name and some kind of result in structured data. The image date is either the collected date (taken first, if present) or the result date.

Note that if an image has a result containing text that indicates the image was actually not collected or completed, it will “fool” the report. See the appendix of the annual report Instructions (version 14, June 2018) for a description of a validation report that can be used to find records with these kinds of results (under the heading “Colorectal Cancer Colonoscopy and Sigmoidoscopy Image Validation”)

Version 7 changes: denominator age range aligned for all measures; columns removed that described screenings based on CPT or ICD codes; columns for FOBT and FIT-DNA labs separated and a different look-back period applied to the FIT-DNA labs; LOINC codes for labs updated; numerator criteria for CT colonography added; text and diagnosis codes for exclusions updated.

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Blood Sugar and Other Measures Among Patients With Diabetes (UDS, QIP, ACO, and PIP Reports)

Report name: Diabetes_v8

Denominator definitions: Patients initially displayed are between 18 and 75 years of age on the last day of the measurement period and are diagnosed with diabetes. To be recognized with diabetes, a patient must have an active diagnosis code on the Problem List. The ICD-9 diabetes diagnosis codes are like 250.*, 357.2, 362.0*, 366.41, or 648.0* and the ICD-10 diabetes diagnosis codes are E10.*, E11.*, E13.* or O24.* (but excluding O24.4* and O24.9*) where "*" is no number or any number. See the appendix of the annual report Instructions (under the section Diabetes Problem List Validation) for a description of a validation report that can be used to ensure that patients with diabetes have a diabetic diagnosis code in their Problem List.

The exclusion criteria are only for the QIP report (the ACO and UDS reports do not have exclusion criteria for this measure). The QIP report looks at assessments in the past 24 months for patients with gestational diabetes or steroid-induced diabetes (ICD-9 codes 249*, 251.8, 648.8 or 962.0; ICD-10 codes E08*, E09*, O24.4*, or O24.9*, where "*" is no number or any number). The column QIP_Exclude will display "Exclude from QIP denominator" if any of these codes are found.

Numerator definitions: There are several measures for patients with diabetes. Note that the definitions and summary categories sometimes differ among the different funding agencies.

Hemoglobin A1c labs. Labs in this report are defined by LOINC codes. Therefore, the health center must ensure that all appropriate hemoglobin A1c labs are associated with the LOINC codes 17856-6, 4548-4, or 4549-2.

In order for a lab test to be included, it must meet Meaningful Use structured lab data criteria (see the NOTE on page 8, above). Part of the validation process should be to identify lab records that do not meet these criteria and fix them in eCW, when possible. See the appendix of the annual report Instructions (version 14, June 2018) for a description of a validation report that can be used for this purpose (under the heading "Diabetes A1c Lab Test Validation"). Results from this report can also be used for data-entry quality-improvement efforts within your organization.

The BridgeIT diabetes data report shows the last date and result of properly-documented A1c labs taken before the measurement period end date. The last A1c result is then placed into categories, as defined

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by the different reporting agencies, which are summarized in the output. The table below outlines the groupings that are programmed into the Bridget report. Note that all current reporting agencies group the A1c results in different ways and treat patients without an A1c test in the measurement period, or those with no result at all, differently. Please consult the instructions supplied by the funding agencies themselves for more detail.

Reporting agency and summary column name	A1c reporting categories		
	Category 1	Category 2	Category 3
UDS (LastA1CStatus_UDS)	<8%	>=8% and =<9%	>9% or not measured
QIP, PIP and ACO (LastA1CStatus_QIP_ACO)	=<9%	>9% or not measured	--

Blood pressure. Blood pressure results are currently not reported to any funder. However, the measure was left on the report because it is clinically significant and some health centers continue to use it. The blood pressure vital is defined as having a name like *BP* (where "*" is any combination of letters or no letter). The "lowest" blood pressure is determined in a similar manner as on the hypertension report (see page 21). The column LastBPStatus displays text indicating if a blood pressure was taken in the past year and if it under 140/90 mmHg (or otherwise).

Diabetic retinal eye exam. The recommended location for the eye exam is in Imaging with the image name "Diabetic Eye Exam" (however, variations on the name including the text "eye exam" or "retinopathy" somewhere in the name are also accepted). Similarly, the eye exam can exist as a lab (with the lab name including the text "eye exam" or "retinopathy") or entered into structured data (question name "Annual Retinal Exam" in Preventive Medicine). Labs and images must have some kind of result (or lab value) and a collected or result date. Strict meaningful use criteria are not applied to eye exams in lab structured data. The QIP and ACO numerators for this measure accepts a retinal eye exam performed within a year of the end of the measurement period, or a negative result (that is, negative for retinopathy) within two years of the end of the measurement period. To define a negative result, the Bridget report looks for the text "normal," "negative" or "no retinopathy" in the image or lab result. The eye exam status is displayed in the column DM_EyeExam_Status.

Diabetic foot exam. Foot exam results are currently not reported to any funder. However, the measure was left on the report because it is clinically significant and some health centers continue to use it for internal purposes. Similar to the diabetic eye exam, the foot exam can be picked up as a lab (with name "Diabetic Foot Exam"), as an image (with name "Diabetic Foot Exam"), or from structured data (question name "Annual Foot Exam" in Preventive Medicine). The preferred location is as a lab. Again, images and labs must have a result (or lab value) and a collected or result date. Strict meaningful use criteria are not

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applied to foot exams in lab structured data. The foot exam status over the past year is displayed in the column DM_FootExam_Status.

Nephropathy. Because of its complexity, a separate Bridgell report exists to evaluate this measure (see the next section below).

Version 8 changes: UDS criteria for separate diabetes diagnosis and exclusion codes removed from columns of the report; columns for LDL labs removed from report

Nephropathy Screening Test Among Patients With Diabetes (QIP Report)

Report name: Diabetes_Nephropathy_v4

Denominator definitions: The denominator of this report when properly filtered is exactly the same as the denominator of the main Diabetes report (see section above). The initial denominator is composed of patients between 18 and 75 on the last day of the measurement period (as defined by the user) with diabetes. To have diabetes, a patient must have at least one of the following active diagnosis codes on the Problem List: the ICD-9 codes are like 250.*, 357.2, 362.0*, 366.41, or 648.0* and the ICD-10 diabetes diagnosis codes are E10.*, E11.*, E13.* or O24.* (but excluding O24.4* and O24.9*) where "*" is no number or any number.

Patients are excluded if they had a diagnosis for gestational diabetes or steroid-induced diabetes in the past two years. If a patient meets the criteria, the text "Exclude from QIP denominator" will appear in the "QIP_Exclude" column. The exclusion criterion is composed of diagnosis codes appearing on an assessment, which are ICD-9 diagnosis code equal to 249*, 251.8, 648.8 or 962.0 and ICD-10 codes equal to E08*, E09*, O24.4*, or O24.9* where "*" is no number or any number.

Note that the QIP denominator for all three diabetes measures includes patients with at least two primary care medical encounters in the past two years. If you are estimating the exact Partnership indicator, enter the normal year-long measurement period and additionally apply a filter for patients seen at least twice in the past two years (PrimCareVisits_2y > 1). The report makes a calculation for the visits in the past two years using the measurement period end date (i.e., this column displays the number of visits between two years before the measurement period end date and the measurement

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period end date). If using the report for other measurement periods or for purposes other than estimating the exact Partnership indicator, use the regular filter for one or more primary care visits in the measurement period (PrimCareVisitsPeriod > 0).

Numerator definitions: The numerator can be satisfied if the patient had any of the following:

1. Nephropathy screening test within a year of the end of the measurement period, including urine tests for albumin or protein. Partnership Healthplan supplied 70 LOINC codes corresponding to screening tests which are listed in the Appendix at the end of this document.
2. Evidence of nephropathy. This can be any of the following:
 - a. Documentation of a visit to a Nephrologist within a year of the end of the measurement period. The report looks for a referral out with the status of "Addressed" to a provider or organization with a specialty containing the text "nephrologist" or "nephrology." The appointment date is considered as the date the patient saw the Nephrologist.
 - b. Documentation of a renal transplant on the Problem List. The ICD-9 code is V42.0 and the ICD-10 code is Z94.0.
 - c. Documentation of any of the following on an assessment within a year of the end of the measurement period or on the Problem List: Diabetic nephropathy, ESRD, Chronic renal failure (CRF), Chronic kidney disease (CKD), Renal insufficiency, Proteinuria, Albuminuria, Renal dysfunction, Acute renal failure (ARF), Dialysis, hemodialysis or peritoneal dialysis. There are over 250 ICD-9 and ICD-10 codes corresponding to these diagnoses, which are listed in the Appendix at the end of this document.
 - d. Had a prescription for an ACE inhibitor or ARB therapy within a year of the end of the measurement period.

The Diabetes Nephropathy report has been optimized for all QIP measures and therefore also contains columns for hemoglobin A1c test results and eye exams. These columns extract data and make calculations in the same manner as on the regular Diabetes BridgeIT report (see the section above for details).

Version 4 changes: Updates to LOINC codes supplied by Partnership to define nephropathy screening tests.

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Blood Pressure Control Among Patients With Hypertension (UDS, QIP, ACO, and PIP Reports)

Report name: Hypertension_v8

Denominator definitions: Patients initially displayed on the report are between 18 and 85 on the last day of the measurement period and have been diagnosed with essential hypertension. All reports use this as the definition of hypertension and the ICD-9 codes are 401.0, 401.1, 401.9 and the ICD-10 code is I10.

See the appendix of the annual report Instructions (under the heading “Hypertension Problem List Validation”) for a description of a validation report that can be used to ensure that patients with hypertension have a hypertension diagnosis code in their Problem List.

The UDS, PIP, ACO and QIP reports focus on a long-term patient outcome, blood pressure. To be fair, there must be sufficient time for a newly diagnosed hypertensive patient to lower the blood pressure with help from the health center. Therefore, a diagnosis of hypertension must have occurred prior to six months before the end of the measurement period (for example, the UDS report uses June 30 of the reporting year). The column EssHTN_EarliestDiagnosisDate displays the earliest date of a hypertension diagnosis on the Problem List (onset date or added date) or on an assessment. If the earliest date is more than six months prior to the end of the measurement period (i.e., the “Prior Date”), a “Yes” will appear in the column EssHTN_DiagnosisBeforePriorDate.

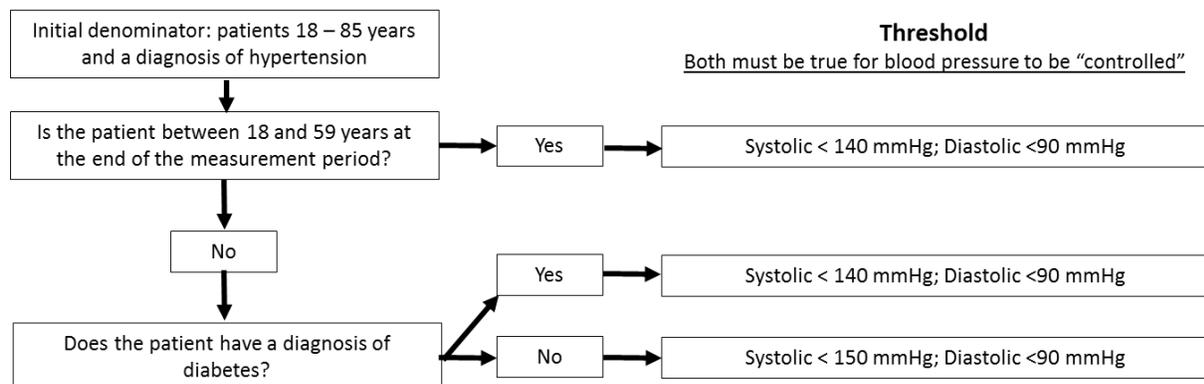
Patients are excluded from the denominator if they had end stage renal disease (ESRD), stage 5 chronic kidney disease, dialysis or renal transplant before or during the measurement period, or were pregnant during the measurement period⁴. A patient with ESRD or stage 5 chronic kidney disease should have any of the following codes entered into the Problem List: [ICD-9] 585.5, 585.6, V42.0, V45.12 or V45.11; or, [ICD-10] N18.5, N18.6, Z99.2, Z91.15 or Z94.0. The report also looks for the following key words in surgical history and medical history: chronic kidney disease stage 5, end stage renal disease, ESRD, renal transplant, kidney transplant, nephrectomy, or dialysis. If any of these conditions are met, the column Exclusion_HTN will display the word “Exclude.”

⁴ A patient is considered pregnant if at least one of the following conditions are met: 1) a date is entered into the OB flowsheet during the measurement period; or, 2) the patient is female, over 10 years of age, and had a pregnancy-related diagnosis code on an assessment during the measurement period. The pregnancy-related diagnosis codes are: [ICD-9] from 633* to 679*, V22*, V23*, and [ICD-10] O*, Z33*, Z34*, or Z36* (where * is any number or no number)

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Numerator definitions: The report shows the last blood pressure with any result taken before the measurement period end date. The blood pressure vital is defined as having a name with *BP* in the name (where "*" is any letters or no letter). The value of the blood pressure on that date is also displayed. Because this field is actually a text field, it sometimes has non-numerical characters in it. The report takes the number before the first "/" and the number after the first "/" to be the systolic and diastolic blood pressures⁵. If more than one blood pressure is documented on the date examined, the lowest blood pressure is used⁶. For the UDS and ACO reports, both the systolic and the diastolic blood pressures must be below the threshold (140 mmHg and 90 mmHg respectively) in order to be considered "Controlled."

The QIP and PIP numerator takes into account a patients age and diabetes diagnosis when determining the threshold for blood pressure. The logic flow is as follows:



The patient’s last tobacco use status was added to the report for case management purposes. The column Last_Tobacco_Use_Status displays four categories of use status, and therefore it must interpret the text that exists in the tobacco use field in Social History structured data. Similar to the BridgIT tobacco screening and cessation report, the hypertension report looks for a question in Social History with text similar to “Are you a...” or something like “Tobacco Use” or “Smoking status.” It then looks for

⁵ Note that blood pressure entries with excessive non-numerical text, or unusual text characters, may not be recognized by the report. Text may be entered before the blood pressure reading, but must end with a colon, for example: “Sitting: 130/80”

⁶ This is defined as the blood pressure with the lowest systolic pressure, unless the diastolic pressure is over 90 mmHg on that same reading. If the reading with the lowest systolic pressure also has a diastolic pressure that is over 90 mmHg, then the blood pressure readings are re-ordered and the blood pressure with the lowest product of systolic plus diastolic pressure is taken.

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wing key words in the response to the structured data element. The following text will appear in the column Last_Tobacco_Use_Status in response to these key words:

- Current: text like Current, heavy, light, uses tobacco or yes
- Never: Never, nonsmoker, or no
- Previous: Previous or former
- No documentation or non-standard text: Unknown or other non-standard text. This option will also display if there was never any documentation of smoking status for the patient

Version 8 changes: all columns and references to general hypertension removed; diagnosis codes for exclusions updated; outputs changed

Early Entry Into Prenatal Care (UDS Report)

Report name: UDS_Prenatal_v5

Denominator definitions: Patients in the denominator must have at least one OB visit (defined as a visit entered into the OB flowsheet) or a delivery (defined as the date entered into the Delivery Date field of the Discharge Tab) during the measurement period.

Numerator definitions: The first of the UDS measures examines the age of prenatal patients. Age is calculated relative to the parameter “UDS Age Date” that is entered by the user. This was done so that the report can be run for time spans other than regular calendar years, but requires the user to choose and enter a specific date. Normally, the UDS Age Date is June 30 when the report spans the calendar year. The UDS age date parameter is necessary for running the report, even if the user is not interested in the age.

The second UDS measure focuses on the trimester the patient entered prenatal care, and if that entry was done at the health center or elsewhere. There are five ways that the report determines trimester of entry into care. Depending on what data is entered into eCW, the report displays the trimester in the column TrimesterOfEntry, which is then summarized in the output. A logic scheme for this process is shown in the chart on page 30.

To determine the trimester, priority is given to these methods in the following order:

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1. Display the trimester of entry, as entered by the provider, when the patient had her first prenatal visit with another provider. When the patient had her first prenatal visit with another provider, the grantee provider must calculate the trimester manually by checking the patient's prenatal records from the outside source and entering this value into the proper field in eCW. In this case, the column `WithGranteeFirstVisit` will be equal to "No" and the trimester text will be displayed in the field `TrimesterOfEntry`. The trimester text for another provider can potentially be pulled from two places in eCW: the initial OB physical (first priority) or FORM A (second priority). The question in eCW for most health centers is something like "Trimester of first visit if not with grantee" (although some variations are accepted). The report will only accept text entered by the provider with any of the following words: 1, 2, 3, first, second or third. Therefore, providers should not use other kinds of free text such as the date of the first visit or "First seen in Mexico" etc. because that will cause the report to display unhelpful information.

The other trimester calculations explained below are determined for patients who have had the first prenatal visit with the grantee provider (i.e., at the health center).

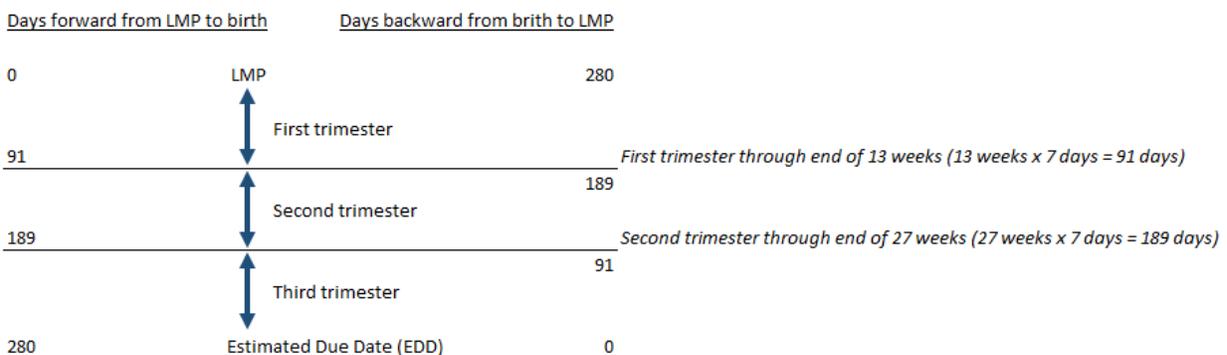
2. Display the trimester of entry, as directly entered by the provider into structured data. Some health centers have decided to enter into eCW the trimester of entry into care calculated by the provider instead of relying on one of the calculations in #3 and #4 below. Again, the trimester text can potentially be pulled from two places in eCW: the initial OB physical (first priority) or FORM A (second priority). If a health center without this field is considering adding it, the recommended text for the question is "Trimester started prenatal care." The report will only accept entered text with any of the following words: 1, 2, 3, first, second or third. When text is entered into this field (and the column `WithGranteeFirstVisit` is equal to "Yes"), the text is displayed in the column `Provider_trimester` and `TrimesterOfEntry`.

3. Calculate the trimester of entry based on the first OB visit date and Estimated Delivery Date (EDD). Both of these dates must be present (and valid) for this calculation to be possible. The first OB visit date can come from one of two sources. First, some health centers allow the provider to directly enter the first OB visit date into structured data. The field for this is on Form A and is called "Date began prenatal care (UDS)." Entry into this field must be a properly-formatted date (for example, "4/15/2018" and not "Apr 15 2018") with no additional text or characters (for example, "4/15/2018" and not "4/2018 in Mexico"). If this field does not exist, or there is otherwise no valid data entered into it, the report will take the first visit date from the OB flowsheet. The column `FirstOBVisit_Location` displays the first OB visit date and the source of the data (from structured data or the flowsheet).

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The other part of the equation is the estimated delivery date (EDD). The report will use the Final EDD from the Estimated Delivery Date tab for this purpose, but if this date does not exist, it uses the Initial EDD. The EDD is displayed in the column EDD_Used. If there are valid dates in the FirstOBVisit_Location and EDD_Used columns, the column Trimest_calc_EDD will display “Yes.” In this case, the trimester is calculated using Naegele's Rule (see below) and displayed in the column TrimesterOfEntry.

The way that trimester is calculated depends on **Naegele's Rule**, which basically states that a pregnancy is considered to last 280 days (40 weeks) from the date of the last menstrual period (LMP). The 2018 UDS Manual (page 82) states that the first trimester lasts “through the end of the 13th week after their last menstrual period.” Therefore, if the EDD is known, we can count backwards from the EDD to define the trimester limits as illustrated in the figure below. The trimester of entry into care depends on the first prenatal date relative to the EDD (counting backwards).



The BridgIT report calculates the number of days between the first prenatal visit date and the EDD. If this is 91 days or less, than the patient entered care in the third trimester. If this is more than 91 days but equal to or less than 189 days, the patient entered care in the second trimester. If the difference is more than 189 days, the patient entered care in the first trimester. This result is displayed in the column Trimest_calc_EDD.

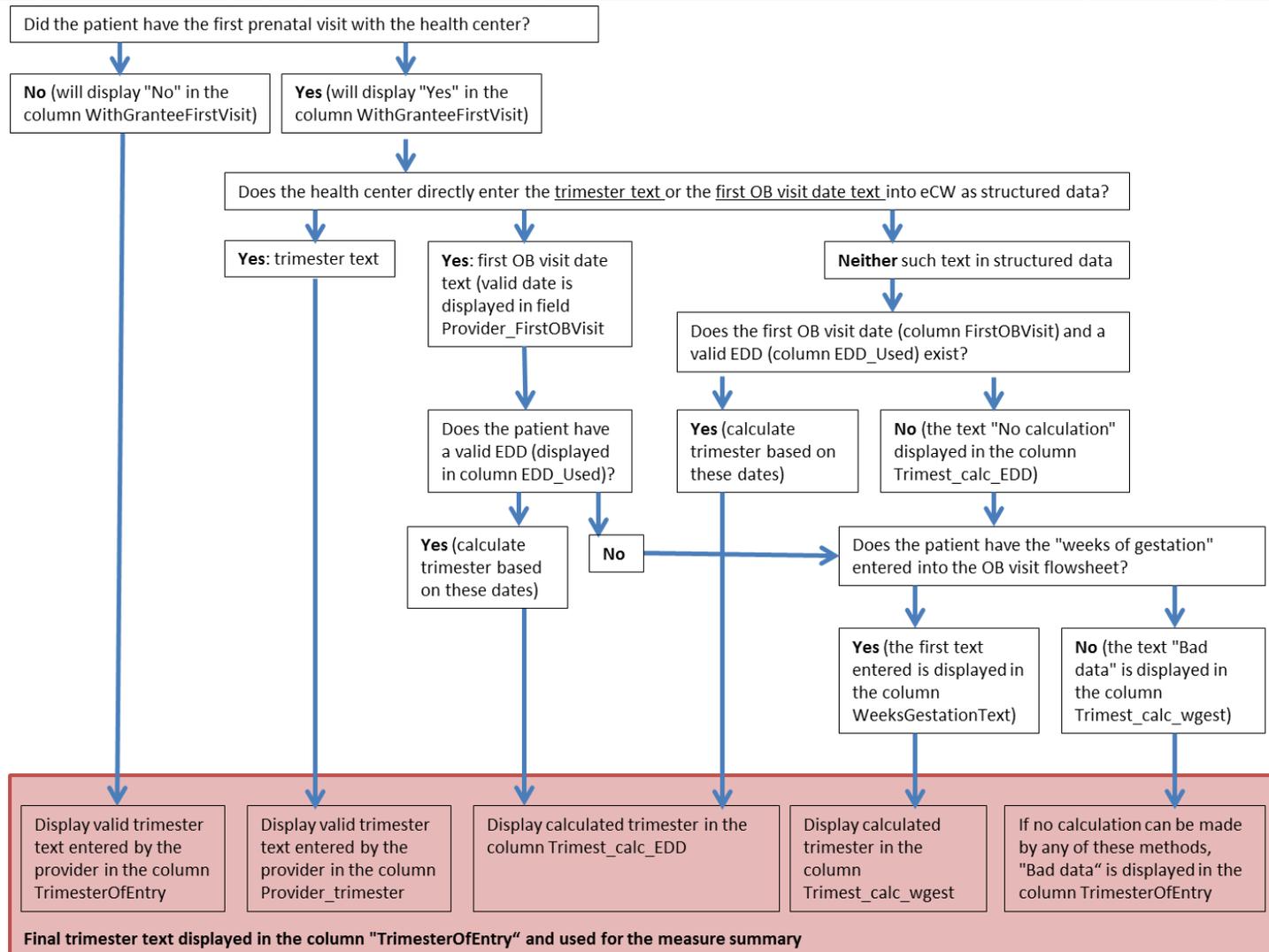
4. Calculate trimester of entry based on first weeks of gestation text entered into the OB flowsheet. If the patient initiated care with the grantee (that is, WithGranteeFirstVisit = “Yes”) AND there is no trimester entered by the provider (Provider_trimester is null) AND a calculation based on EDD and first visit date is not possible (Trimest_calc_EDD = “No calculation”), the report tries to calculate the trimester based on the first time the provider enters “Weeks of gestation” into the OB flowsheet. In this case, the text for weeks of gestation is converted to a number and compared to the trimester range for LMP defined by the UDS report. The weeks of gestation text is displayed in the column

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WeeksGestationText and the calculated trimester is displayed in the columns Trimest_calc_wgest and TrimesterOfEntry. Since this is the last possible way the trimester can be calculated, if weeks of gestation cannot be used, the column TrimesterOfEntry will display the text "Bad data."

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The Logic Scheme for Displaying the Trimester of Entry into Prenatal Care in the Column TrimesterOfEntry of the BridgIT Report



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Birth Weight From Deliveries (UDS Report)

Report name: UDS_Deliveries_v4

Denominator definitions: For table 7, Section A, Column (a), the 2018 UDS instruction manual (page 104) defines the patient universe as “all health center prenatal care patients who delivered during the reporting period... [even] if the delivery is of twins or triplets, or is a still-birth, report only one woman as having delivered.”

The BridgelyT report initially considers all prenatal patients who delivered, as well as prenatal patients who *are likely to* have delivered, in the measurement period. The logic used by the report is the following:

1. Show patients who have a delivery date during the measurement period. The delivery date is entered on the discharge tab.
2. Show patients who do not have a recorded delivery date, but who have a Final EDD (Estimated Delivery Date) during the measurement period. The Final EDD is entered on the EDD tab.
3. Show patients who do not have a recorded delivery date and do not have a Final EDD, but who have an Initial EDD during the measurement period. The Initial EDD is entered on the EDD (Estimated Delivery Date) tab.

This method identifies all patients who are known to have delivered and those who probably delivered (but yet unknown) during the measurement period and then displays information about them to help the user validate the data. Some of the patients might have transferred away or lost the baby during pregnancy. These patients should be filtered out using the text listed in the column “OtherOutcome.” However, there is no standard method used by all of the health centers to enter outcomes other than a delivery.

Numerator definitions: Birth weight is reported on the UDS for live birth deliveries. A live birth is defined as having “Live birth” entered into the “Outcome baby 1” field on the discharge tab. For each live birth, the health center should enter the baby’s weight in grams into the field “Birth weight by grams” but some health centers are still entering pounds and ounces for the birth weight into the fields “Birth Weight (lbs)” and “Birth Weight (OZ)”. These imperial weights are converted to grams and displayed in the column “ConversionGrams.” The column BirthWeightFinal will display BirthWeightGrams, but if BirthWeightGrams is zero, it will display ConversionGrams. The column UDSBirthWtStatus translates the figure in BirthWeightFinal into the UDS categories.

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To help you filter and validate the list of patients, a number of descriptive columns have been added to the report. The column "DeliveryGrantee" corresponds to the structured data item "Delivered by Grantee Provider" on the Discharge tab of the OB Flowsheet and will display the text "Yes" or "No." The column "DeliveryProvider" shows who delivered the baby (that is, the provider listed in the field "Delivered by" or "Delivery Provider"). The column "LiveBirth" will display "Live Birth" if that text was entered into the "Outcome Baby 1" field on the Discharge tab. If "Outcome Baby 1" instead contains text like SAB, stillborn, or miscarriage, this text will be displayed in the column OtherOutcome. The OtherOutcome column may also contain any text that was entered in the "Other outcome" or "Patient status" fields if those exist on the Discharge tab.

Since the UDS report counts the number of deliveries (Table 7, Section A, Line 2) and live births (Table 7, Section A, Columns 1b to 1d), you will need to determine if there have been any multiple births. The column PossibleMultipleBirth will show the text "Check" (meaning, check the patient's record in eCW) when any text is entered into a field on the discharge sheet for the second or third baby (such as "Birth weight by grams-baby 2" or "Outcome Baby 3"). Therefore, superfluous text such as "n/a" or "no twins" etc. should not be entered into those fields or it will "fool" the report.

Child and Adolescent Weight Assessment and Counseling (UDS Report)

Report name: Child_Weight_v7

Denominator definitions: Patients are included in the denominator if they were between 3 and 17 years of age on the last day of the measurement period and had at least one primary care visit during the measurement period. Patients should be excluded from the denominator if they were pregnant any time during the measurement period⁷.

⁷ A patient is considered pregnant if at least one of the following conditions are met: 1) a date is entered into the OB flowsheet during the measurement period; or, 2) the patient is female, over 10 years of age, and had a pregnancy-related diagnosis code on an assessment during the measurement period. The pregnancy-related diagnosis codes are: [ICD-9] from 633* to 679*, V22*, V23*, and [ICD-10] O*, Z33*, Z34*, or Z36* (where * is any number or no number)

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Numerator definitions: Patients included in the numerator must fit *all three* of the criteria below.

1. BMI percentile recorded within a year of the end of the measurement period. The BMI percentile is identified by a vital name like "BMI Perc*" or "BMI %*" (where "*" means any letter or no letter) and must be entered as a number (no text). The report displays the last date (column LastBMIPcntleDate) and last value (column LastBMIPcntleValue) taken before the end of the measurement period. If the date is within one year of the measurement period end date, "Yes" is displayed in the column BMIPcntle_LastYear (abbreviated from the phrase "BMI percentile in the last year").
2. Patient counseled for nutrition within a year of the end of the measurement period. If true, the column Couns_Nut_LastYear (abbreviated from the phrase "Counseling for nutrition in the last year") will display "Yes." There are three ways this can occur:
 - A. Counseling for nutrition is entered into Preventive Medicine → Counseling → Communication to patient → Counseling for nutrition provided → "Yes." The report displays the last date of nutrition counseling before the end of the measurement period in the column LastCounsel_Nut.
 - B. If any of the CPT codes for nutrition counseling (97802, 97803 or 97804) appeared on a claim. The report displays the last date of the claim before the end of the measurement period in the column LastCounsel_Nut_CPT_Date.
 - C. If the ICD-9 code (V65.3) or the ICD-10 code (Z71.3) for nutrition counseling appeared on an assessment. The report displays the last date of the assessment before the end of the measurement period in the column LastCounsel_Nut_ICD_Date.
3. Patient counseled for physical activity within a year of the end of the measurement period. If true, the column Couns_Phys_LastYear (abbreviated from the phrase "Counseling for physical activity in the last year") will display "Yes." There are two ways this can occur:
 - A. Counseling for physical activity is entered into Preventive Medicine → Counseling → Communication to patient → Counseling for physical activity provided → "Yes." The report displays the last date of physical activity counseling before the end of the measurement period in the column LastCounsel_Phys.
 - B. An ICD-9 code (v65.41) or the ICD-10 code (Z71.82) specific for exercise counseling appeared on any assessment. Furthermore, the report will accept a general counseling ICD-10 code (Z71.89 or Z71.9) on any assessment if that code is paired with the description "Exercise counseling." The report displays the last date of the assessment before the end of the measurement period in the column LastCounsel_Phys_ICD_Date.

If a "Yes" appears in *all three* criteria columns (BMIPcntle_LastYear, Couns_Nut_LastYear, and Couns_Phys_LastYear), the report displays "Met criteria" in the column Final_Measure_Status. Otherwise, this column displays "Did not meet criteria." This column is summarized in the Excel output.

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Version 7 changes: Changed diagnosis code and code/description combinations accepted for physical activity counseling

Adult Weight Screening and Follow-up (UDS and ACO Reports)

Report name: Adult_Weight_v9

Denominator definitions: Patients are displayed in the initial denominator of the report if they were seen when they were 18 years of age or older and had at least one primary care visit during the measurement period. Patients should be excluded from the denominator using a filter if they were pregnant any time during the measurement period or received palliative care during the measurement period.

The column Exclusion_Preg_Pallative: displays “Exclude” if any of the following conditions are met:

1. A visit date entered into the OB flowsheet during the measurement period
2. A female patient over 10 years of age had a pregnancy-related diagnosis code on an assessment during the measurement period. The pregnancy-related diagnosis codes are: [ICD-9] from 633* to 679*, V22*, V23*; and [ICD-10] equal to O*, Z33*, Z34*, or Z36* (where * is any number or no number)
3. A palliative care diagnosis code (Z51.5 or V66.7) was entered into an assessment during the measurement period

Numerator definitions: Patients must meet the following conditions to be included in the numerator:

- BMI recorded during the last primary care visit, or within 12 months prior to the last primary care visit. The BMI is identified by a vital name equal to “BMI” and must be entered as a number (no text).
- If the patient is overweight or underweight during that visit, a follow-up plan to address weight is documented at that visit or within one year of the visit.

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On page 34 is the detailed logic schemes used by the ACO and UDS reports to determine if follow-up is needed (blue vertical box) as well as the final measurement result (red vertical box). The following table contains the ACO and UDS parameters are used to determine if a patient is within normal weight limits or not:

BMI Category	18 years and over	
	Lower range	Upper range
Normal	BMI >= 18.5	BMI < 25
Outside of normal	BMI < 18.5	BMI >= 25

There are three ways that a follow-up plan is recommended to be documented:

1. BMI follow-up entered into structured data. The follow-up plan must be entered into the eCW structured data as follows: Preventive Medicine → Counseling → Care Goal Follow Up Plan → BMI Management Provided → “Yes” (The report will also pick up a similar item if it is in HPI. It will also pick up “Above Normal BMI Follow-up” or “Below Normal BMI Follow-up” in Preventive Medicine with any text entered besides “No.”)
2. Dietary consultation entered into structured data. The report will pick up any question text beginning with “Dietary consultation*” (“Dietary consultation order provided” is preferred, but it will also recognize “Dietary consultation ordered”). This is entered into structured data here: Preventive Medicine → Counseling → Provider to provider communication → Dietary consultation order provided → “Yes”
3. A code related to weight counseling or exercise counseling was used during the visit. The acceptable diagnosis codes are V65.3, V65.41, Z71.3, or Z71.82 on an assessment, the codes Z71.89 or Z71.9 paired with the description “Exercise counseling” on an assessment, or the CPT codes 97802, 97803, or 97804 on a claim.

Additionally, some health centers have created custom fields for documenting two BMI counseling activities:

1. Diet/nutrition counseling. Includes items entered into Preventive Medicine like Nutritional Counseling, Overweight Counseling, etc. To be picked up by the report, the value entered for these items must be “Yes.”
2. Physical activity counseling. Includes items entered into Preventive Medicine or HPI categories and items with key words such as Exercise and Physical Activity along with Counseling. To be picked up by the report, the value entered for these items must be “Yes.”
3. BMI Follow-up. eCW recommends adding items “Above Normal BMI Follow-Up” and “Below Normal BMI Follow-Up” to the Counseling section of Preventive Medicine.

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Several columns in the report display the intermediate steps used to determine the ultimate result of the measurement. These columns are:

- The column “LastBMIDate” displays the last date a patient had a documented BMI (regardless of visit type or provider seen) before the end of the measurement period. “LastBMIValue” is the BMI value at that visit.
- To meet the BMI date criterion, the patient must have had a BMI at the last medical visit or in the 12 months prior to this visit. The column, “BMIDate_MeetsCriteria” will display “Yes” if this criterion is met.
- The column “BMI_Class_CDC” is for your information only. This can be used for case management or performance improvement purposes.
- Patients who are outside of normal weight limits are expected to have a weight management follow-up plan. Dependent on the definition of normal weight, the column “BMICategory” will display the phrase “Follow up plan needed” when the patient is considered underweight or overweight. If the patient is within normal limits, this column will display “Normal weight.” However, if there was no BMI or the BMI date was not within the appropriate time frame of one year, the column will display the phrase “BMI date does not meet criteria.” On the logic scheme, the output for the column “BMICategory” is shown in the blue vertical box.
- The column “LastBMIManagement” shows the last date that a BMI management follow-up plan was documented in Preventive Medicine or HPI structured data before the end of the measurement period.
- The column “Last_Dietary_Consult” will display the last date there was a dietary consult documented in Preventive Medicine structured data before the end of the measurement period.
- The column “Last_Counsel_Code” displays the last date before the measurement period end date that the diagnosis codes V65.3, V65.41, Z71.3, or Z71.82 appeared on an assessment, the codes Z71.89 or Z71.9 paired with the description “Exercise counseling” appeared on an assessment, or the CPT codes 97802, 97803, or 97804 appeared on a claim.
- The column “Last_Dietary_Counsel” will display the last date there was nutrition/dietary counseling documented in Preventive Medicine structured data before the end of the measurement period.
- The column “Last_PhysAct_Counsel” will display the last date there was a physical activity/exercise counseling documented in Preventive Medicine or HPI structured data before the end of the measurement period.
- If the patient had follow-up within one year of the last BMI date, the column “LastYear_HadFollowup” will display “Yes” (otherwise, it will display “No”).
- The column that notes the final measurement result is “Final_Measurement_Result.” On the logic scheme on the next page, the text outcomes are shown in the vertical red box. Any patient that does not meet the BMI date criteria automatically has “Does not meet documentation

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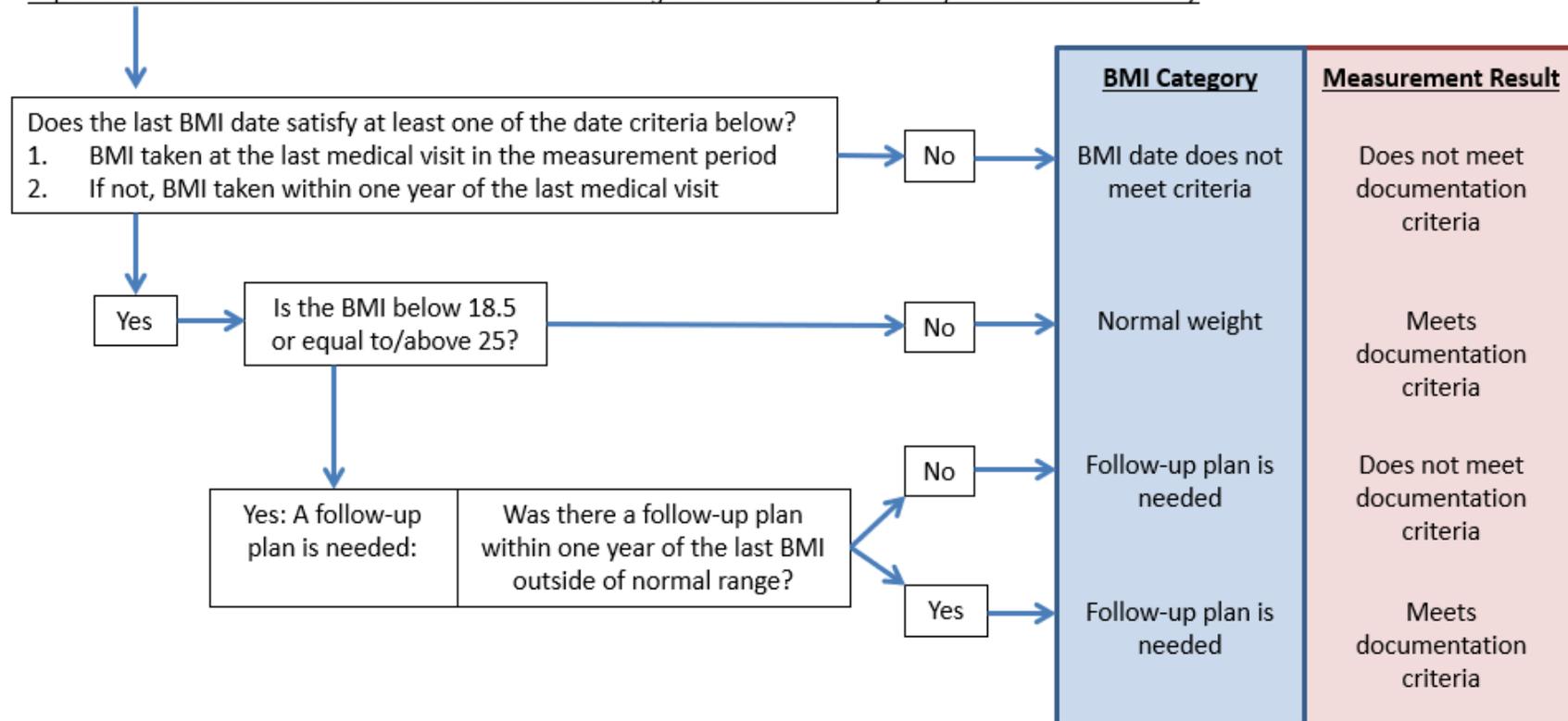
criteria” displayed in the column. Any patient that meets the BMI date criteria and has a BMI within normal limits automatically has “Meets documentation criteria” displayed in the column. If the patient had the last BMI outside of normal limits AND a follow-up plan was documented (within 12 months of the BMI measurement), then the column will display “Meets documentation criteria.” Otherwise, this column will display “Does not meet documentation criteria.”

Version 9 changes: Updated diagnosis codes for exercise counseling; definition of normal weight parameters (BMI \geq 18.5 and BMI $<$ 25) same for both UDS and ACO according to technical documentation; BMI and (if indicated) follow-up plan documented at the last encounter in the measurement period or within 12 months of that encounter.

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Adult Weight Assessment and Required Follow Up

Population: Patients with at least one medical visit during the measurement year after their 18th birthday



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Tobacco Use Screening and Cessation Intervention (UDS and ACO Reports)

Report name: Tobacco_v7

Denominator definitions: Patients are included in the denominator if they were 18 years of age or older at the end of the measurement period. For measurement periods of one year, patients must have at least two primary care medical visits (column PrimCareVisitsPeriod > 1) or at least one preventive visit (PreventiveVisitsPeriod > 0). The column Annual_Visit_Denom displays “Add to annual report denominator” if either of these criteria are met, and this filter should be used when reporting for the UDS or ACO reports.

A preventive visit is defined in the ACO technical specifications. The report counts claims in the measurement period with at least one of the following CPT codes: 99395, 99396, 99397, 99411, 99412, 99420, 99429, 99401, 99402, 99403, 99404, 99385, 99386, or 99387.

Numerator definitions: Patients included in the numerator received a tobacco screening at least once within 24 months (2 years) of the end of the measurement period, and if identified as a tobacco user in that time-frame, received a tobacco cessation intervention in that time-frame. The BridgeIT report contains several columns to display results for the various components of the measure. Column names and sources are summarized in the table below.

Component Category	Data element queried	Column in report
Tobacco Use Screening Component	Social history structured data	StructAssessmWithin2Y
	Tobacco use disorder ICD	TobacUseICDWithin2Y
	Tobacco use cessation counseling CPT or ICD	TobacCounselCPTICDWithin2Y
Tobacco User Component	Social history structured data indicates a user	StructTobacUserWithin2Y
	Tobacco use disorder ICD	TobacUseICDWithin2Y
	Tobacco use cessation counseling CPT or ICD	TobacCounselCPTICDWithin2Y
Tobacco Cessation Intervention Component	Preventive medicine structured data	StructTobacCounselWithin2Y
	Tobacco use cessation counseling CPT or ICD	TobacCounselCPTICDWithin2Y
	Smoking cessation medications	TobacMedWithin2Y

Tobacco Use Screening Component. The column AnyTobacAssessm2Y (abbreviated for “any tobacco assessment within two years of the end of the measurement period”) is the result column that is summarized for the screening component of the measure. This column shows the text “Yes” when at least one of the following criteria is met:

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- A. The column StructAssessmWithin2Y = "Yes." This occurs when the last structured tobacco assessment date (column LastStructTobacAssessm) is more recent than two years before the end of the measurement period. To be counted as a tobacco assessment, any response can be entered into any of the Social History structured data elements below, depending how it is set-up in eCW at your health center.

Bridgell query criteria	Social History Structured Data Text in eCW
Like "Smoking status*"	"Smoking status"
Like "Are you a*"	"Are you a:" or "Are you a...?"
Like "Current Tobacco*"	"Current Tobacco Use:"
Like "Besides cig*"	"besides cigarettes?" or "Besides cigarettes"
Like "Other Tobacco prod*"	"Other Tobacco products used?"

- B. The column TobacUseICDWithin2Y = "Yes." This occurs when there was a diagnosis code for Tobacco use disorder appears on any assessment more recent than two years before the end of the measurement period. The codes are: ICD-9 codes 305.1 or 649.0*; ICD-10 codes F17.2* (but not F17.211, F17.221 or F17.291), O99.33* or Z72.0, where * is any number or no number. It is assumed that if the patient was diagnosed with tobacco use disorder, a tobacco use assessment was somehow performed.
- C. The column TobacCounselCPTICDWithin2Y = "Yes." This occurs when there was a CPT code for tobacco use cessation counseling (codes 99406 or 99407) on any claim, OR the code Z71.6 on any assessment, more recent than two years before the end of the measurement period. It is assumed that if codes for patient tobacco use cessation were used, a tobacco use assessment was somehow performed.

Tobacco User Component. The column TobacUserWithin2Y will display "Yes" if the patient was identified as a tobacco user within two years of the end of the measurement period. To be considered a tobacco user, a patient can have any of the following:

1. Had a tobacco use assessment in Social History (see above) with a value of "Yes" or "Current*" (for example, "Current smoker"). The column LastStructTobacUserDate shows the last date before the end of the measurement period that a tobacco assessment indicated a patient was a current user of tobacco. If this date was within two years of the end of the measurement period, the column StructTobacUserWithin2Y will display "Yes."
2. Had a diagnosis code indicating tobacco use on an assessment. The codes are: ICD-9 codes 305.1 or 649.0*; ICD-10 codes F17.2* (but not F17.211, F17.221 or F17.291), O99.33* or Z72.0, where * is any number or no number. If this date was within two years of the end of the measurement period, the column TobacUseICDWithin2Y will display "Yes."

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3. Had a CPT for Smoking and Tobacco Use Cessation Counseling (99406 or 99407) on a claim or an ICD-10 code for Tobacco Abuse Counseling (Z71.6) on an assessment. If this date was within two years of the end of the measurement period, the column TobacCounselCPTICDWithin2Y will display “Yes.”

Tobacco Cessation Intervention Component. To be considered as having a cessation intervention, a patient must have had tobacco cessation counseling or was using an appropriate cessation medication within two years of the end of the measurement period. The column TobaccoCessIntervWithin2Y displays “Yes” when any of the following conditions are met:

1. The column StructTobacCounselWithin2Y displays “Yes.” This happens when the last date of tobacco cessation counseling (LastStructTobacCounselDate) entered into preventive structured data was within two years of the end of the measurement period. This is entered into structured data as follows: Preventive Medicine → Counseling → Smoking → Patient Counseled on the dangers of tobacco use and urged to quit → Date
2. The column TobacCounselCPTICDWithin2Y displays “Yes.” The last date a CPT for tobacco cessation counseling (99406 or 99407) was billed within two years of the end of the measurement period, or an ICD-10 code for Tobacco Abuse Counseling (Z71.6) appeared on an assessment in the same time frame.
3. The column TobacMedWithin2Y displays “Yes.” This happens when the last date (LastTobacMedDate) a tobacco cessation medication verified by the provider (not including Stop, Discontinued, Not Taking or Unknown) in the Current Medications window was within two years of the end of the measurement period. Tobacco cessation medications are identified by their association with the Rx Group “Tob Cessation.” Therefore, the health center must identify the appropriate tobacco cessation medications in their formulary and add them to the tobacco cessation Rx Group (see Appendix D of the System Set-up document).

The Composite Result is the combination of the assessment, user, and cessation components. The column Composite_result displays the final result and is used to summarize the data for the UDS and ACO measures. This column is calculated as follows. If the patient was assessed for tobacco within two years of the end of the measurement period and not found to be a tobacco user, the column Composite_result will display “Assessed and intervened with as appropriate.” If the patient was found to be a tobacco user and had an intervention within two years of the end of the measurement period, the column Composite_result will display “Assessed and intervened with as appropriate.” If the patient was not screened within two years of the end of the measurement period, or was found to be a tobacco user but did not receive an intervention in that time, the column Composite_result will display “Not assessed and intervened with as appropriate.”

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Version 7 changes: CPT codes for preventive visits updated; diagnosis codes for tobacco use updated; lookback period for screening and cessation activities changed to two years prior to the end of the measurement period.

Asthma Pharmacologic Therapy (UDS Report)

Report name: Asthma_Pharma_v8

Denominator definitions: Patients must be between the ages 5 and 64 years at the end of the measurement period (initial population automatically filtered for age), have had at least one primary care visit within the measurement period (use the filter PrimCareVisitsPeriod >0), have persistent asthma (HasPersistentAsthma = "Yes") and have no exclusion criteria (Exclude_UDS does not equal "Exclude").

The initial population of the report is all patients in the age group with a general asthma diagnosis code (ICD-10 like J45*) on the Problem List. Therefore, the data sheet must be filtered for those patients with persistent asthma, or in other words, a persistent asthma ICD-10 diagnosis on the Problem List (ICD-10 like J45.3*, J45.4*, or J45.5*). Use the asthma validation report (see the Appendix of the Annual Report Set Instruction manual, version 14) to identify patients without a persistent asthma ICD-10 code on the Problem List, but with such a code on an assessment or claim, or an ICD-9 code with "persistent" in the description on an assessment or claim. The validation report also shows patients with a persistent asthma option selected on the last documented Asthma Severity Classification before the measurement period end date⁸.

Patients are excluded if they have chronic obstructive pulmonary disease, emphysema, cystic fibrosis, or acute respiratory failure. The column Exclude_UDS will display "Exclude" if any of the following diagnosis codes appear on the patient's Problem List: [ICD-9] 277.0*, 491.2*, 492.0, 492.8, 493.2*, 496, 506.4, 518.1, 518.2, or 518.8; or [ICD-10] E84*, "J43*", J44*, J68.4, J96.0*, J96.2*, J98.2, or J98.3 (where * is any number or no number).

⁸ The Asthma Severity Classification is entered into structured data as follows: HPI → Asthma → Asthma Severity Classification (note that this field can also be mapped to a Smart Form). A persistent asthma option has any text including the word "persistent" in the field. Note that placing the persistent asthma ICD-10 code on the Problem List is the preferred method in general and the only method accepted by this report.

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Numerator definitions: Asthma medications are identified by their association with the Rx Group “Asthma Meds.” Therefore, the health center must identify the appropriate asthma medications in their formulary and add them to the asthma Rx Group (see Appendix D of the System Set-up document). The report takes the last date that one of these medications was verified in the Current Medications window (not including Stop, Discontinued, Not Taking or Unknown) before the measurement period end date (column LastAsthmaMedDate). If this date is within one year of the measurement period end date, the text “Yes” appears in the column “AsthmaMedWithin1Y.” One asthma medication name on the last medication date in the measurement period is displayed for your information (column LastAsthmaMedName).

Version 8 changes: Only appropriate ICD-10 codes used to identify patients with general asthma (the initial population) and those with persistent asthma (the filtered denominator population).

Well Child Visits (QIP Report)

Report name: QIP_Well_Child_Visits_v3

Denominator definitions: The denominator for this measure is provided by Partnership. Officially, the denominator consists of patients 3 to 6 years of age continuously enrolled in Medi-Cal nine out of the twelve months of the measurement year.

The BridgeIT report can give a rough estimate of the denominator and numerator. Although continual enrollment is difficult to calculate in BridgeIT, the Insurance Class (column InsClassName) of the patient can be used to show if the patient currently has Partnership Medi-Cal insurance (depending how that is entered in eCW by the health center). To approximation the denominator, filter for active patients (ActivePt = “Yes”) with at least one of any kind of visit in the measurement period (column Count_AnyVisit_MP > 0). Age is automatically filtered by the report.

Numerator definitions: Partnership provided codes to identify well-child visits. To be counted, the patient must have had at least one visit with a PCP provider including at least one of the codes listed below billed within one year of the end of the measurement period:

CPT: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, or 99461

ICD-9: V20.2, V20.31, V20.32, V70.0, V70.3, V70.5, V70.6, V70.8, or V70.9

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ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, or Z02.9

To be included, the provider of the visit must have a specialty like: Family Medicine (fam*), Internal Medicine (internal*), Pediatrics (ped*), Nurse Practitioner (nurse prac*), or Physicians Assistant (physician assist*) where "*" means any letter or no letter.

Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL Cholesterol (UDS Report)

Report name: CAD_LipidLower_v5

Denominator definitions: This report displays the measure for patients with Coronary Artery Disease (CAD) using lipid lowering therapy.

To be included, patients must be 18 years or older at the end of the measurement period, have at least one primary care medical visit in the measurement period, two medical visits ever, and meet any of the following disease criteria:

1. Have an active diagnosis of coronary artery disease (including myocardial infarction) on the Problem List. These codes are: [ICD-9] 410*, 411*, 412*, 413*, 414.0*, 414.8, 414.9, v45.81 or v45.82 or [ICD-10] I20*, I21*, I22*, I23*, I24*, I25* (but not I20.0, I25.3, I25.4*, I25.82, I25.83 or I25.84), Z95.1, or Z98.61 (where * is any number or no number). None of these diagnosis codes are time-limited for the CAD report⁹.
2. Have a history of certain cardiac surgeries. Since these are not time-limited for the CAD measure, key words can come from either Surgical History or Medical History¹⁰. The key words and acronyms are: percutaneous coronary intervention (PCI), coronary artery bypass grafting (CABG), percutaneous transluminal coronary angioplasty (PTCA), or stent (preceded by cardiac or heart).

⁹ Because the myocardial infarction diagnosis is also used for the IVD measure in a time-limited manner, the Onset Date is necessary. See the IVD section for more detail.

¹⁰ Because these surgeries are also used for the IVD measure in a time-limited manner, the preferred location is in Surgical History with a Surgical Date in the format mm/dd/yyyy or mm/yyyy. See the IVD section for more detail.

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Patients are excluded from the measure if they were not otherwise in the numerator and if the value for the last LDL lab in the year prior to the measurement period end date was under 130 mg/dL. LDL labs are defined by LOINC codes (12773-8, 13457-7, 18261-8, 18262-6, 2089-1, 22748-8, 39469-2, 49132-4, or 55440-2) and must meet standard Meaningful Use criteria (see page 8). The validation report DM_LabTest_Validation_v3 can be used to view all LDL labs in a period of time and evaluate their completeness (see the appendix of the Instructions document, version 14, for a description of this report).

Numerator definitions: Patients in the numerator had to be using a lipid-lowering therapy within a year of the end of the measurement period. Lipid lowering medications are identified by their association with the Rx Group “UDS Lipd Meds.” Therefore, the health center must identify the appropriate lipid-lowering medications in their formulary and add them to the UDS Lipd Meds Rx Group (see Appendix D of the System Set-up document). The report takes the last date that one of these medications was verified in the Current Medications window (not including Stop, Discontinued, Not Taking or Unknown) before the measurement period end date (column Last_LL_Med_Date). If this date is within one year of the measurement period end date, the text “Yes” appears in the column “LLMedWithin1Y.”

The column UDS_Final_Result is used to summarize data for the numerator, which relies on the status of lipid lowering medications in the column LLMedWithin1Y described above. The patient may be excluded from the denominator (column UDS_ExcludeLDL = “Exclude”) if the patient was not using a lipid lowering medication in the past year and the last LDL result in that time-frame was under 130 mg/dL.

Version 5 changes: Key denominator text for Surgical History and Medical History updated; all columns associated with the old ACO CAD measure removed; modified exclusion for LDL lab.

Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet (UDS and ACO Reports)

Report name: IVD_Asprin_v7

Denominator definitions: Patients must be 18 years or older at the end of the measurement period, had one or more primary care visits in the measurement period (PrimCareVisitsPeriod > 0), and were diagnosed with ischemic vascular disease (IVD) or had been discharged alive with acute myocardial infarction (AMI), or certain cardiac surgeries in the two years prior to the end of the measurement

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period. The column Denominator_Type is always used to filter for patients in the denominator and displays text beginning with “Include” when a patient meets any of the disease-specific criteria. Patients on anticoagulant medications are excluded from the UDS denominator (Exclusion_Anticoag not equal to “Exclude”).

To define the patient population with IVD, the report looks for particular codes on the patient’s Problem List, and these codes are not tied to any time period. A patient qualifies for the denominator if any of the following codes appear on the Problem List (regardless of Onset Date): [ICD-9] 411.0, 411.1, 411.81, 411.89, 413.0, 413.9, 414.0*, between 414.2 and 414.99, 429.2, 433*, 434*, 437.0, 440*, 444.01, 444.09, 445.01, 445.02, 445.81, or 445.89; [ICD-10] I20* (but not I20.1), I24* (but not I24.1), I25* (but not I25.2, I25.3 or I25.4*), I63.2*, I63.5*, I65*, I66*, I70.1, between I70.20 and I70.799, I70.92, or I75* (where * is any number or no number). If a patient has any of these active codes on the Problem List, the text “Include: IVD code on problem list” will appear in the column Denominator_Type.

Time-limited events that are used to include patients in the denominator are classified in two categories and pulled differently from eCW:

1. An experience, like a Myocardial Infarction. A patient is included in the denominator using a diagnosis code on the Problem List (ICD-10 code like I21* where * is any number or no number) and:
 - A. An Onset Date within two years of the end of the measurement period; or,
 - B. An Assessment within two years of the end of the measurement period with the same diagnosis code as on the Problem List.
2. Surgical procedures, such as a percutaneous coronary intervention (PCI), coronary artery bypass grafting (CABG), percutaneous transluminal coronary angioplasty (PTCA), or a cardiac or heart stent. A patient is included in the denominator if any of these phrases or acronyms appear in Surgical History with an associated date within two years before the end of the Measurement Period.

Dates for these events must have the format mm/dd/yyyy or mm/yyyy (other formats like yyyy or mm/yy will not be calculated).

If a patient has a diagnosis code for a Myocardial Infarction and an associated date in the past two years, the column Denominator_Type will display the text “Include: Myocardial Infarction with Appropriate Date.” If a patient had any key text entered into surgical history with an associated date in the past two years, the column Denominator_Type will display the text “Include: Cardiac Surgery with Appropriate Date.” If a Myocardial Infarction or surgical text is entered without a date or with an old date, the column Denominator_Type will display “Unknown: Myocardial Infarction on Problem List WITHOUT

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Date or with Old Date” or “Unknown: Cardiac Surgery in Surgical History WITHOUT date or with old date” depending on the type. The validation report, IVD_CarVasSurg_Validation_v5, gives more detailed information on the completeness of data entry and location of relevant time-limited events in eCW. This validation report can also identify patients who may be candidates for an IVD diagnosis on the Problem List. See appendix of the BridgeIT Instruction Manual (Version 14) for more information.

Patients with either “Unknown” denominator type should not be included in the denominator. In rare cases, the column Denominator_Type may display “Problem” which indicates there is some conflict with the logic (please let RCHC know).

Patients on anticoagulant medications are excluded from the UDS denominator. These patients had a medication from the Warfarin, Coumadin or Anticoagulant Rx group verified within a year of the measurement period end date (see Appendix D of the Set-up document).

Numerator definitions: Patients in the numerator must have used an Aspirin or other antiplatelet therapy in the year prior to the end of the measurement period. Aspirin or other antiplatelet medications are identified by their association with the Rx Group “Aspirin Therapy.” Therefore, the health center must identify the appropriate Aspirin and antiplatelet medications in their formulary and add them to the Aspirin Therapy Rx Group (see Appendix D of the Set-up report). The report takes the last date that one of these medications was verified (not including Stop, Discontinued, Not Taking or Unknown) in the Current Medications window before the measurement period end date (column Last_Aspr_Med_Date). If this date is within one year of the measurement period end date, the text “Yes” appears in the column “AsprMedWithin1Y.”

Version 7 changes: diagnosis codes for IVD and Myocardial Infarction updated; key words for cardiac surgeries updated; method for identifying the date of a Myocardial Infarction modified (assessments added); events in Medical History removed from consideration; medication group named Anticoagulant added to exclusion criteria.

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Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (ACO Report)

Report name: CVD_Statins_v2

Denominator definitions: Patients in the denominator are considered as being at “high risk” for cardiovascular events and fall into at least one of the following categories:

1. Denominator Population 1: Patients aged 21 years or older at the beginning of the measurement period with clinical arteriosclerotic cardiovascular disease (ASCVD). The diagnosis codes are taken from the Problem List and are defined as: [ICD-9] between 410 and 413.0, 413.9, 414.0*, between 414.2 and 414.9, 429.79, 433*, 434*, 435.0, 435.1, 435.3, 435.8, 435.9, 436, 437.0, 437.1, 438*, 440*, or V12.54; [ICD-12] E08.51, E08.52, E09.51, E09.52, G45* (but not G45.3 or G45.4), G46*, I20*, I21*, I22*, I23*, I24*, I25* (but not I25.3, I25.41, or I25.42), I63*, I67.2, I69* (but not I69.823 or I69.828, and not between I69.851 and I69.862, and not between I69.951 and I69.969, and not I69.891), Z86.73, or I70* (where * is a number or no number).
2. Denominator Population 2: Patients aged 21 years or older at the beginning of the measurement period who have one of the following:
 - a. A fasting or direct laboratory test result of LDL-C \geq 190 mg/dL ever in the past¹¹. The LOINC codes for the LDL lab are 12773-8, 13457-7, 18261-8, 18262-6, 2089-1, 22748-8, 39469-2, 49132-4, and 55440-2.
 - b. An active diagnosis of familial or pure hypercholesterolemia. The diagnosis codes are taken from the Problem List and are defined as: [ICD-9] 272.0; [ICD-10] E78.00 and E78.01.
3. Denominator Population 3: Patients aged 40 through 75 years at the beginning of the measurement period with Type 1 or Type 2 diabetes¹² and with an LDL-C result of 70–189 mg/dL recorded as the highest fasting or direct laboratory test result in three years before the end of the measurement period.

The column Denom_Pop will display Denominator Population 1, 2 or 3 depending on how the patient meets the denominator definition (these are evaluated in order). Additional filters must be used to

¹¹ Like with other reports, LDL labs must be entered according to Meaningful use criteria and have a numerical value for the LDL lab attribute.

¹² The diabetes diagnosis codes taken from the Problem List are the same as used on the diabetes BridgeIT report: [ICD-9] 250*, 357.2, 362.0*, 366.41, or 648.0*; [ICD-10] E10.*, E11.*, E13.* or O24.* (but excluding O24.4* and O24.9*)

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define the denominator: patients must also have at least one primary care encounter in the measurement period (PrimCareVisitsPeriod > 0) and not meet any of the exclusion criteria (column Exclusion_Any = "Exclude").

Patients are excluded if they:

1. Were pregnant or breastfeeding during the measurement period (column "Exc_PregBrstfeed"). Pregnancy is defined in the same manner as other annual reports¹³. The breastfeeding code is Z39.1.
2. Have had an adverse effect, allergy, or intolerance to statin medication (column "Exc_StatAllergy"). In the Allergies and Intolerance section of eCW, this can be entered as an allergy to a specific medication (if that medication is associated with the Statins Rx Group), or as text in the Agent or Substance field that begins with "Statin..."
3. Patients with diabetes who have the most recent fasting or direct LDL-C laboratory test result < 70 mg/dL and are not taking statin therapy (column "Exc_DM_LowLDL"). LDL labs are defined by LOINC codes (see the denominator population section above).
4. Have a diagnosis code on the Problem List for rhabdomyolysis, active liver disease, hepatic disease or insufficiency (including hepatitis A or B), end-stage renal disease (ESRD), or receiving palliative care (column "Exc_Diag"). The diagnosis codes (all together for the column) are: [ICD-9] 070* (but not 070.9), 570, 571* (but not 571.1), 572.4, 572.8, 585.6, or V66.7; [ICD-10] between B15 and B19.99, between K70 and K74.99, K75.4, M62.82, N18.6, O91.03, O91.13, O91.23, O92.03, O92.13, O92.5, O92.70, O92.79, O98.41*, Z22.51, Z39.1, or Z51.5.

Numerator definitions: Patients in the numerator must have used a statin medication in the year prior to the end of the measurement period. Statin medications are identified by their association with the Rx Group "Statins." Therefore, the health center must identify the appropriate statin medications in their formulary and add them to the Statins Rx Group (see Appendix D of the Set-up report). The report takes the last date that one of these medications was verified (not including Stop, Discontinued, Not Taking or Unknown) in the Current Medications window before the measurement period end date (column Last_Statin_Med_Date). If this date is within one year of the measurement period end date, the text "Yes" appears in the column "StatinMedWithin1Y."

¹³ A patient is considered pregnant if at least one of the following conditions are met: 1) a date is entered into the OB flowsheet during the measurement period; or, 2) the patient is female, over 10 years of age, and had a pregnancy-related diagnosis code on an assessment during the measurement period. The pregnancy-related diagnosis codes are: [ICD-9] from 633* to 679*, V22*, V23*, and [ICD-10] O*, Z33*, Z34*, or Z36* (where * is any number or no number)

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Version 2 changes: Diagnosis codes updated for ASCVD, hypercholesterolemia and the exclusions; Meaningful Use criteria added to LDL labs and the lab date made more accurate.

Depression Screening and Follow-up (UDS and ACO Reports)

Report name: Depression_Screen_Followup_v8

Denominator definitions: The report automatically filters for patients who are age 12 years or older (calculated relative to the first visit in the measurement period) and at least one visit with a primary care provider during the measurement period.

Patients are excluded from the denominator if they had a diagnosis for depression or bipolar disorder added to their Problem List before the beginning of the measurement period. In this case, the column StartMP_Dx_ProbList_Exclude will display "Exclude." The diagnosis is identified by following codes: the ICD-9 codes are 290.13, 290.21, 290.43, 296.0*, 296.2*, 296.3*, 296.4*, 296.52, 296.6*, 296.7, 296.8, 296.80, 296.82, 298.0, 300.4, 301.12, 309.0, 309.1, 309.28, or 311; the ICD-10 codes are F01.51, F31*, F32* (but not F32.81), F33*, F34* (but not F34.0 or F34.9), F43.21, F43.23, F53, O90.6 or O99.34* (but not O99.344) where (*) is any number or no number.

The diagnosis date is taken from the earliest date associated with any of the appropriate ICD-9 or ICD-10 codes on the Problem List as described above. The most preferred date is the Date of Onset, which should be entered by the provider when the code is added to the Problem List. If there is no such date, the report will next take the Added Date. If the Added Date is missing, it takes the internal date when the code was logged into the system. There is a validation report that can be used to ensure that patients who have been diagnosed with depression have an appropriate diagnosis code on their problem list along with a correct initial diagnosis date (see the Appendix of the Annual Report Instructions for more detail).

There is another column, Current_Dx_ProbList, that indicates if the patient has a depression or bipolar diagnosis code (see codes above) currently on his or her Problem List. This is for your information only and is not used for reporting.

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Numerator definitions

The numerator of both the UDS and ACO reports considers if the patient was screened for depression, and when the patient had a positive screen, if the patient also had follow-up on the same date.

Screening for depression can be entered into eCW in two ways:

- I. The PHQ-2 screen has two questions that are entered into HPI or the Smart Form. Both questions must be answered in order to count as a screen. These questions are “Little interest or pleasure in doing things” and “Feeling down, depressed, or hopeless” (the report will accept minor text variations). The question text appears in HPI here: HPI → Depression Screening (or Depression/Anxiety Screening) → PHQ-2 (or variation) → <question text>. The report will consider a patient screened when any text is entered for both questions (other than a space character). A positive screen will have at least one of the two questions answered with any text other than “No” or “Not at all.”
- II. The screen and result can also be entered into HPI structured data here: HPI → Depression Screening → Intervention → Depression Screening Findings. The report will accept any text as indicating the patient was screened. The number of screens entered into HPI in the measurement period is displayed in the column Count_HPI_Screen_MP. The text “Positive” is necessary for the report to recognize a positive screen. Note that if a patient refuses to be screened, or if there is a legitimate reason why the patient was not screened at the time¹⁴, an explanation can be entered into this field (as long as it does not contain the key word “positive”).

The report combines these screening activities (if present) in the measurement period described above and displays the associated results. The count of depression screens in the Measurement Period is displayed in the columns Count_PHQ2_MP and Count_HPIScreen_MP. If the patient had at least one screen in the measurement period, the column Screened_MP will display “Yes.” If the patient had at least one positive screen in the measurement period, the column Positive_Screen_MP will display “Yes” and the earliest positive screen date in the measurement period will appear in the column First_Positive_Screen_Date. A positive screen is defined as at least one of the PHQ-2 questions being answered with any text other than “No” or “Not at all” or if the answer to the Depression Screening Findings question contains the word “positive.”

¹⁴ Legitimate reasons include urgent or emergent situations or patients whose functional capacity or motivation to improve may impact the accuracy of results of standardized assessment tools.

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Follow-up on a positive screen for depression must occur on the same date as the positive screen (column First_Positive_Screen_Date). There are seven categories of “follow-up” that the report will accept. These are:

1. Additional evaluation for depression using the PHQ-9. This is a completed PHQ-9 entered into HPI or the Smart Form. The location in HPI is: HPI → Depression Screening (or Depression/Anxiety Screening) → PHQ-9 (or variation) → Total Score (or Interpretation). The PHQ-9 must have a value (other than a space character) entered into the interpretation or the score fields, which normally happens automatically in eCW once all of the PHQ-9 questions are answered. If a PHQ-9 was completed on the same day as the first positive screen in the measurement period, the text “Yes” will appear in the column PHQ9_SameDay. The score of that PHQ-9 is displayed for your information only (column PHQ9_Score_SameDay) and is not taken into consideration for any other part of the report¹⁵.

2. Additional evaluation for depression entered into HPI structured data. This is a structured data element here: HPI → Depression Screening → Intervention → Additional Evaluation for Depression. Therefore, if a health center is using this field in HPI or on a Smart Form, there must be clear definition of what constitutes “additional evaluation” relative to the intention of the measure. If additional evaluation for depression was documented on the same day as the first positive screen in the measurement period, the text “Yes” will appear in the column OtherAddEval_SameDay.

3. Pharmacological intervention. An action (other than Stop, Discontinued, Not Taking or Unknown) is taken by the provider on a medication belonging to the “Antidepressants” medication group. See the Set-up document for instructions on how to establish this group and add medications. If there was any documentation of antidepressant medications (not including Stop, Discontinued, Not Taking or Unknown) on the same day as the first positive screen in the measurement period, the text “Yes” will appear in the column AntiDep_Med_SameDay.

4. Referral out to a behavioral health provider. The outside provider can be an individual or facility qualified to diagnose and treat depression. In eCW, this provider can have any of the following text in the Specialty field of their administrative record: Behavioral Health, Mental Health, Psychiatry, Psychiatrist, Psychology, Psychologist or Clinical Social Worker. If an outgoing referral was documented on the same day as the first positive screen in the measurement period, the text “Yes” will appear in the column Referral_SameDay.

¹⁵ HRSA indicated in 2018 that the PHQ-9 is considered follow-up and not a secondary screen. Therefore, logical definitions on the depression screening data and the depression validation reports have been changed from the previous version of the BridgeIT report. This will effect the component and composite results of the measure.

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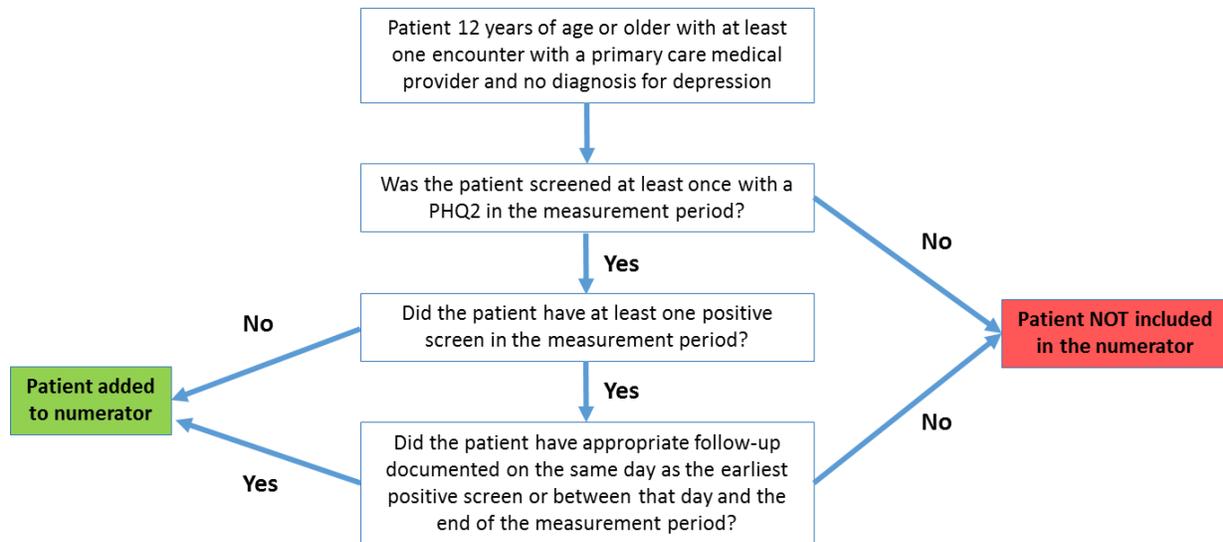
5. An encounter with a health center behavioral health provider. Again, the provider must be qualified to diagnose and treat depression and have any of the following text in the Specialty field of their administrative record: Behavioral Health, Mental Health, Psychiatry, Psychiatrist, Psychology, Psychologist or Clinical Social Worker. If the patient had such an encounter on the same day as the first positive screen in the measurement period, the text “Yes” will appear in the column BH_Provider_SameDay.

6. Documentation of a depression intervention or follow-up entered into structured data. This is entered into structured data here: HPI → Depression Screening → Intervention → Follow-Up for Depression (the report will accept any text entered into that question except “No” or “None”). If this item in HPI was documented on the same day as the first positive screen in the measurement period, the text “Yes” will appear in the column HPI_Interv_SameDay.

7. Patient refusal of a depression intervention documented in HPI. This is entered into structured data here: HPI → Depression Screening → Screening Not Performed → Reason (or Type of Patient Reason). The report will accept any text except a space character (“ ”). If this item in HPI was documented on the same day as the first positive screen in the measurement period, the text “Yes” will appear in the column PatientRefused_SameDay. Furthermore, if a patient did not have a PHQ-2 or screening in HPI completed in the measurement period (see the definitions of depression screening, above) but had a completed HPI/Screening Not Performed question in the measurement period, the patient is also considered screened (Screened_MP = “Yes”).

If the patient had any of the seven types of follow-up documented on the same date as the first positive secondary screen date in the Measurement Period, the column Any_Followup_SameDay will display “Yes, had follow-up on the same day” (otherwise, it will display “No, did not have follow-up on the same day”). The simple logic scheme below illustrates the process:

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There are two result columns included on the report. The first (named Detailed_Outcome) is intended to provide more practical data to inform performance improvement activities. This column displays five possible result options for denominator patients. The second column (named Reporting_Outcome) summarizes the ultimate outcome for reporting purposes, which has two options (i.e., patients included or not included in the numerator).

Version 8 changes: Updated diagnosis codes for depression and bipolar disorder; PHQ-9 changed from secondary screening to follow-up; addition of patient refusal from HPI.

Depression Remission at Twelve Months (ACO Report)

Report name: Depression_Remission_v4

Denominator definitions: Patients 18 years and older with a diagnosis of major depression or dysthymia¹⁶ and an initial PHQ-9 score greater than nine from an encounter during the 'Denominator

¹⁶ The diagnosis codes for major depression or dysthymia must have been placed on the problem list before the end of the Denominator Identification Measurement Period. The identified ICD-9 codes are 296.2*, 296.3*, or 300.4 and the ICD-10 codes are F32.* (but not F32.8, F32.81, or F32.89), F33.* (but not F33.8), or F34.1 where (*) is any or no number..

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Identification Measurement Period.' Patients are excluded if they have a diagnosis of bipolar disorder or personality disorder¹⁷ or were marked as deceased (using the checkbox) on the Patient Information window.

The initial population displayed by the report is comprised of patients 18 years of age at beginning of the Denominator Identification Measurement Period and at least one visit since the beginning of the Denominator Identification Measurement Period. Note that this report is unique because it does not use a filter for visits during the reporting period.

The 'Denominator Identification Measurement Period' is defined as the period of time beginning approximately a year before the start of the Report Measurement Period. The initial PHQ-9, or Index PHQ9, is taken from this period (if one was documented at the time). The Denominator Identification Measurement Period is chosen to give enough time for a second PHQ-9 to be identified approximately 12 months later.

The report defines the Denominator Identification Measurement Period as one year plus one month (or, thirteen months) prior to the measurement period start date to one year plus one month (thirteen months) prior to the measurement period end date. This calculation will allow the report to be run for any period of time, for example for ACO reporting (measurement period is normally a year) or for a health center dashboard (measurement period is normally a month).

The report establishes a Denominator Identification Measurement Period based on the Report Measurement Period entered by the user. It then looks for any PHQ9 administered within the period, and will identify the first PHQ-9 with a score over 9 in the period as the Index PHQ-9. The Index PHQ-9 is associated with an Index Date (column Index_PHQ9_Date) and Index Score (column Index_PHQ9_Score). If there is no PHQ9 with a score over 9 in the Denominator Identification Measurement Period, the patient is not included in the denominator.

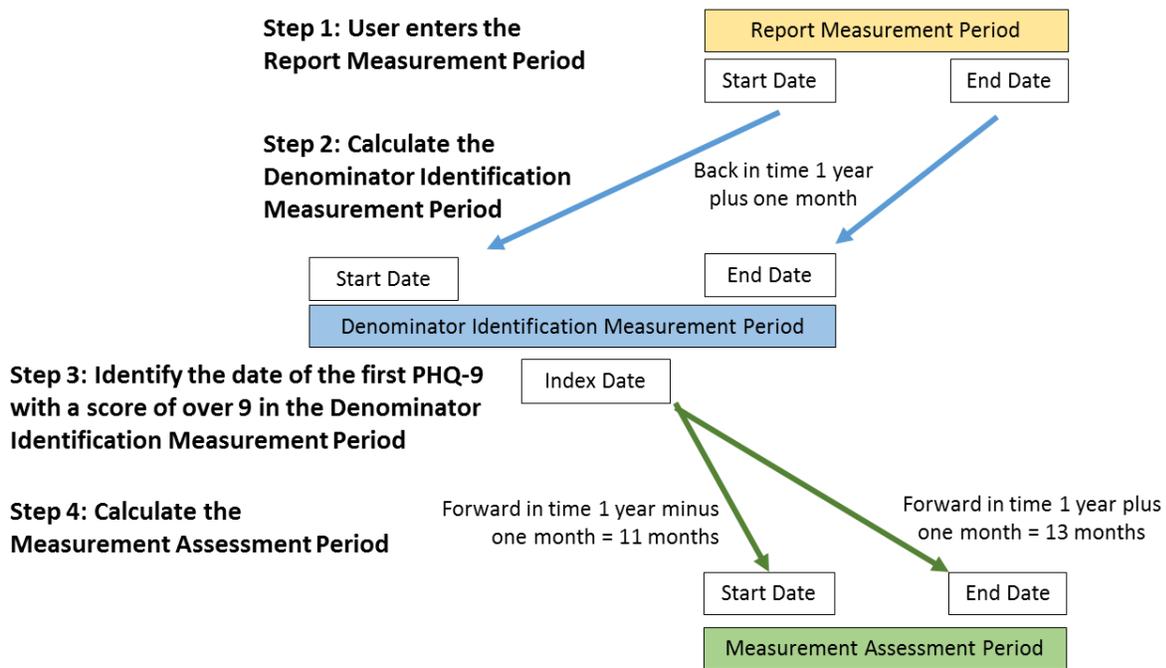
Using the Index Date, the report calculates the Measurement Assessment Period, which is between 11 and 13 months following the Index Date (or, in other words, 12 months after the Index Date, plus or minus a month). To determine the numerator, the report looks to see if any PHQ-9 tests were administered within this period and what was the score of the last one.

¹⁷ The diagnosis codes for bipolar disorder or personality disorder must be on the problem list when the report is run to be used as exclusions. The ICD-9 codes are 301* or 296.*(but not 296, 296.2*, 296.3* or 296.9*) and the ICD-10 codes are F21*, F30.*, F31.*, F34.0, F60.*, or F68.* (but not F68.8), where (*) is any or no number.

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The standard location for PHQ-9 tests is HPI → Depression/Anxiety Screening → PHQ-9 → Total Score. The Total Score is some kind of number.

The figure below displays the steps used to calculate the different measurement periods in the report.

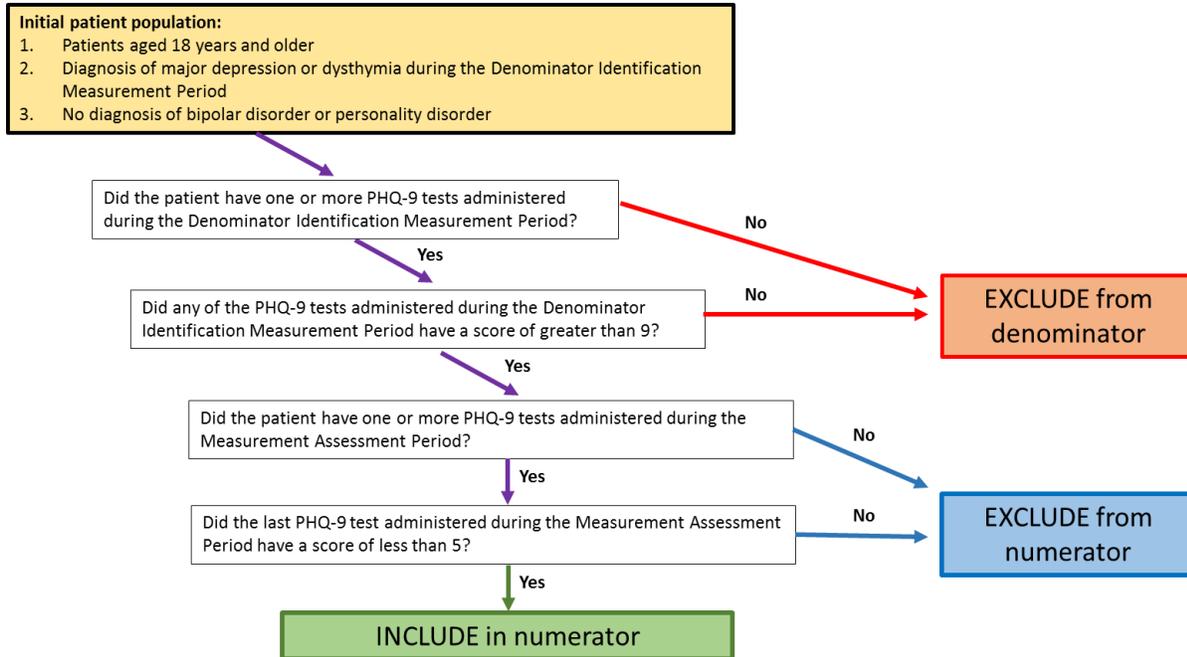


Numerator definitions: To calculate the numerator from patients included in the denominator, the report first looks to see if there were any PHQ-9 tests administered in the Measurement Assessment Period. If no tests were given in this two-month period of time, the patient is not included in the numerator.

If one or more PHQ-9 tests were administered in the Measurement Assessment Period, the report displays the test date (Measure_Assess_PHQ9_Date) and score (Measure_Assess_PHQ9_Score). If the score was less than 5, the patient is included in the numerator. If the last PHQ-9 test does not have a score of less than 5, the patient is not included in the numerator.

The figure below shows the logic scheme for including patients in the denominator and numerator of the measure.

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Version 4 changes: Updated diagnosis codes for major depression or dysthymia

Newly Identified HIV Cases With Timely Follow-up (UDS Report)

Report name: HIV_Timely_Followup_v4

Denominator definitions: The initial (unfiltered) population displayed by this report is all patients with an active HIV diagnosis (ICD-9 codes 042, 079.53, or V08; ICD-10 codes B97.35, B20 or Z21) on the Problem List. Further filters are needed to define the measure denominator.

Note that this report can also be used to display HIV Positive Pregnant Women (UDS Table 7, Line 0). The filters needed for this measure are discussed in the Instructions document, “Instructions for Using the BridgeIT Annual Clinical Report Set” (version 14, June 2018). Pregnant patients are identified by having a pregnancy-related diagnosis code on any assessment in the measurement period (see the footnote on page 20 [above] for the pregnancy-related codes) or an OB flowsheet encounter date in the measurement period.

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For the measure on newly identified HIV cases with timely follow-up, the report can be filtered to display patients with a documented new HIV diagnosis date between the date three months before the start of the measurement period and the date three months before the end of the measurement period¹⁸. The new HIV diagnosis date can be entered in two locations: 1) the Date of Onset attached to the diagnosis code placed on the Problem List; or, 2) the date of the initial positive test entered into structured data here: HPI → HIV → Date of positive test. A date without additional text must be entered into either of these fields for the report to recognize it.

The earliest HIV diagnosis date in either location is displayed in the column HIV_diag_date. If this date falls within the HIV diagnosis date reporting period, the column HIV_diag_date_MP-3M will display “First diagnosed in HIV diagnosis reporting period.” This column is filtered to define patients in the measurement denominator. Note that patients missing a documented date or with the wrong date will be missed by the report. There is a validation report available to help to endure that all patients with HIV also have an initial HIV diagnosis date (see the Appendix in the Instructions document for further detail).

Numerator definitions: Appropriate follow-up with denominator patients can consist of any of the following actions within 90 days of the initial diagnosis date (in column HIV_diag_date):

- A. An outgoing referral to an individual or facility specializing in HIV care. Make sure that outside providers (individuals or facilities) to whom you are referring newly diagnosed HIV patients for follow-up have the word “HIV” anywhere in their eCW Specialty field. The referral must have an appointment date and have the status “Addressed.” The report shows three characteristics of such an appointment: the date the referral was made (column ReferTo_ApptMade), the date of the appointment itself (column ReferTo_ApptDate) and to whom the patient was referred (ReferTo_Name). If the appointment was made within 90 days of the initial HIV diagnosis date, the column HIV_Followup_Outcome will display “Had HIV Followup.”
- B. An outgoing referral with an HIV diagnosis code (042, 079.53, V08, B97.35, B20 or Z21) as the attached primary diagnosis code. The referral must have an appointment date entered and have the status “Addressed.” The report shows the referral date, the appointment date, and to whom the patients was referred in the same manner as the referral mentioned directly above. If there is more than one referral of any type, the first referral after the initial HIV diagnosis date is displayed.
- C. An encounter with a health center primary care medical provider where an HIV diagnosis code (042, 079.53, V08, B97.35, B20 or Z21) appears on the assessment. The date of the encounter is

¹⁸ For our purposes, this is called the HIV diagnosis date reporting period. For example, if the measurement period is January 1, 2018 to December 31, 2018, the HIV diagnosis date reporting period would be October 1, 2017 to September 30, 2018.

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displayed in the column First_HC_Prov_Enc. If this date falls within 90 days of the initial HIV diagnosis date, the column HIV_Followup_Outcome will display “Had HIV Followup.”

Medication Reconciliation After Discharge (ACO Report)

Report name: Med_Reconciliation_v2

Denominator definitions: Patients aged 18 years and older (at the start of the measurement period) who were seen by a primary care medical provider, nurse or clinical pharmacist within the measurement period and had at least one visit within 30 days of discharge from a hospital or inpatient facility. The visit can be of any visit type as long as the resource provider was one of the specialties described¹⁹.

The preferred location for documenting the date of discharge is here: HPI → Interim History → Transition of care visit from hospital → Date of discharge from hospital (or Date of discharge from inpatient facility). An actual date must be entered into this field.

Numerator definitions: Patients are included in the numerator if the date of medication reconciliation is within 30 days following discharge from a hospital or inpatient facility. The preferred location for documenting medication reconciliation is here: HPI → Interim History → Transition of care visit from hospital → Discharge medications reviewed and reconciled from hospital. The preferred options for documenting the reconciliation are “Medications left unchanged” and “Medications changed.” The date of medication reconciliation is taken to be the encounter date when the reconciliation was documented.

As a method to check the quality of data entry for the review of discharge medications into HPI, the report also will display the first date that there was *any* action taken on the patient’s Medication List in the 30-day period after discharge from the hospital. If the column HadMedReconciliation30Days displays “No,” the column Med_List_Action_30Days can be filtered and used to check the eCW record for possible reconciliation with discharge medications, but with improper documentation in HPI.

¹⁹ This includes the specialties normally designated as Primary Care (see pages 6 to 7, above) as well as any staff with a Specialty name including the text “nurse” or “pharm” in it

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Screening for Future Fall Risk (ACO Report)

Report name: Fall_Risk_v1

Denominator definitions: Patients aged 65 years and over at the beginning of the measurement period and at least one primary care medical visit in the measurement period. These criteria are automatically applied and so no filters are necessary.

Numerator definitions: The preferred location for documenting the fall risk assessment is here: Preventive Medicine → Screening → Fall Risk Screening → Fall Risk Assessment. The report will also pick up the same item from HPI. The report accepts any text entered for these items.

Pneumonia Vaccination for Older Adults (ACO Report)

Report name: Pneumonia_Vacc_v2

Denominator definitions: Patients aged 65 years and over at the end of the measurement period and at least one primary care medical visit in the measurement period. These criteria are automatically applied and so no filters are necessary.

Numerator definitions: Patients who have received either the PCV13 vaccine (commonly called “Pneumovax”) or the PPSV23 vaccine (commonly called “Pneumovax”) at any time before the end of the measurement period. The report recognizes PCV13 as mapped to CVX code 100 or 133, or CPT code 90670. The report recognizes PPSV23 as mapped to CVX code 33, or CPT code 90732. These codes are directly associated with the immunization documented in the Immunizations window of eCW

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Influenza Immunization (ACO Report)

Report name: Influenza_Immuniz_v3

Denominator definitions: To define the initial patient population, the report displays patients with at least one visit between the flu season start date and end date (entered by the user in the parameters). Normally, the flu season begins on October 1 of one year and lasts until March 31 of the following year. Furthermore, patients must have at least one visit in the measurement period (this requires a filter on the column PrimCareVisitsPeriod). For the ACO report, this is normally the calendar year (entered by the user in the parameters, which is January 1 to December 31), but for other purposes (dashboard, performance improvement activities, etc.) it can be any period of time like a month or a quarter. The user should just be sure to enter the appropriate flu season relative to the measurement period.

Denominator patients must be at least 6 months of age at the beginning of the measurement period and not be allergic to eggs. Age criteria is automatically applied the data sheet but the exclusion for an egg allergy is a filter. The column Exclusion_EggAllergy displays "Exclude" when the patient either has an egg allergy entered into the Problem List or the Allergies and Intolerance sections of eCW. The column Eggs_ProbList displays "Egg ICD" when a patient has any of the following active diagnosis codes on the Problem List: T78.08XA, T78.08XD, T78.08XS, Z91.012, 995.68, or V15.03. The column Egg_Allergy_Text displays "Egg text" when there is an active allergy containing the text "*egg*" (but not "*eggplant*" where * is any or no other characters) in the Allergies and Intolerance window of eCW.

Numerator definitions: The numerator is composed of patients who had an influenza vaccine within the appropriate time limits. These limits are defined as August 1 before the start of the flu season (on October 1) through the end of the flu season (March 31, the next year). The actual flu season date range is entered by the user in the parameters. Influenza vaccines are recognized by a CVX code (88, 111, 135, 140, 141, 144, 149, 150, 151, 153, 155, 158, 161, 166, or 168) or a CPT code (90630, 90653, 90655, 90656, 90657, 90658, 90660, 90661, 90662, 90664, 90666, 90667, 90668, 90672, 90673, 90685, 90686, 90687, or 90688) directly associated with the immunization documented in the Immunizations window of eCW. All immunizations, whether given by the health center or another provider, should be recorded in the Immunizations window in eCW.

Version 3 changes: small change to how vaccine codes are pulled; egg allergies added to exclusion

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Childhood Immunization Combo 3 (QIP Report)

Report name: QIP_Child_Immun_v1

Denominator definitions: The denominator includes all patients who turned two years of age during the measurement period chosen by the user (in other words, who had a second birthday in the measurement period). No visit criteria are applied to the denominator.

Numerator definitions: To be included in the numerator, members of the denominator must have the required number of seven different vaccines, or in some cases have had the preventable illness, and no exclusion criteria.

The table below displays the seven vaccines and the criteria applied to each. There is a brief explanation of the criteria following the table.

Vaccine Name	Abbreviation	Number of immunizations	Range of Administration	Or documented history of illness
Diphtheria, tetanus and acellular pertussis	DTaP	4	42 days after birth to 2 years	No
Polio	IPV	3	42 days after birth to 2 years	No
Measles, mumps and rubella	MMR	1	Up to 2 years	Yes
Haemophilus influenza type B	HiB	3	42 days after birth to 2 years	No
Hepatitis B	HepB	3	Up to 2 years	Yes
Chicken pox	VZV	1	Up to 2 years	Yes
Pneumococcal conjugate	PCV	4	42 days after birth to 2 years	No

In order to be counted, immunizations must be given on different dates of service and within the range described in the table above. Any immunizations given after the patient's second birthday are not counted.

All immunizations must be properly entered into the Immunizations/Therapeutic Injections window of eCW with the immunization name and date given. The report counts the immunization whether it is given directly by the health center or entered as historical. The BridgeIT report identifies immunizations using a CVX or CPT code that is associated with the immunization itself (not billed). Therefore, the health

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center should insure that all appropriate immunizations have an associated CVX code (preferred) or CPT code using the validation report named List_Immuniz_v1²⁰. There is an additional validation report for this measure that displays all of the immunization records for these vaccines individually for all denominator patients. See the Appendix of the Instruction Manual (Version 14, June 2018) for details on this report.

Additionally, for three of the vaccines (MMR, HepB and VZV), if the patient had a history of the actual illness, a full vaccination schedule for that illness is not necessary. These illnesses are defined by diagnosis codes on the Problem List or on Assessments. Therefore, a patient is considered appropriately vaccinated if the patient had the required number of vaccines or, for the three mentioned, the actual illness.

The following table displays the CVX, CPT and, where applicable, the ICD-9 and ICD-10 illness diagnosis codes for each vaccine that is being used by the report.

Abbreviation	CVX	CPT	Diagnosis Codes
DTaP	20, 50, 106, 107, 110, or 120	90698, 90700, 90721, or 90723	n/a
IPV	10, 89, 110, or 120	90698, 90713, or 90723	n/a
MMR	03 or 94	90707 or 90710	Measles: 055* or B05* Mumps: 072* or B26* Rubella: 056* or B06*
HiB	17, 46, 47, 48, 49, 50, 51, 120, or 148	90644, 90645, 90646, 90647, 90648, 90698, 90721, or 90748	n/a
HepB	08, 44, 45, 51, or 110	90723, 90740, 90744, 90747, or 90748	070.2*, 070.3*, V02.61, B16*, B17.0, B18.0, B18.1, B19.10, B19.11, or Z22.51
VZV	21 or 94	90710 or 90716	052*, 053*, B01*, or B02*
PCV	100, 133 or 152	90669 or 90670	n/a

*Diagnosis Codes: displayed where * is a number or no number*

Patients who have a contraindication or reaction to vaccines and otherwise do not meet all of the numerator criteria are considered for the exclusion. This can be an anaphylactic reaction or side-effect to a vaccine or components of the vaccine, or immunodeficiency (including HIV), lymphoreticular cancer, leukemia, or multiple myeloma. The report will pick-up the following diagnosis codes from the Problem List (column Excl_ProbList_Code) or Assessments (column Excl_AssessEver_Code): [ICD-9] 042, 079.53, 200*, 201*, 202*, 203*, 204*, 205*, 206*, 207*, 208*, 323.51, 999.42, E948.4, E948.5, E948.6, or V08;

²⁰ This report is normally stored in the UDS Modified folder, apart from the Annual Clinical Report Set reports

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[ICD-10] B20, B97.35, D89.9, G04.32, T50.A15A, T50.A15D, T50.A15S, T80.52XA, T80.52XD, T80.52XS, Z21, C81*, C82*, C83*, C84*, C85*, C86*, C88* (but not C88.0), C90*, C91*, C92*, C93*, C94* (but not C94.4* or 94.6), C95*, C96* (but not C96.21, C96.22, C96.29, C96.5, or C96.6), D80*, D81* (but not D81.3, D81.5 or D81.81*), D82*, D83*, D84*, D89.3, or D89.8* (where * is a number or no number).

Exclusions can also come from the Allergies and Intolerance window of eCW. The report searches the text in the Agent/Substance field and indicates if any key word combination is found in the column Excl_AllergyIntoler_Text. The key words are:

- Vaccine or vaccination combined with any of the following words: DTaP, diphtheria, tetanus, pertussis, IPV, polio, MMR, measles, mumps, rubella, HiB, haemophilus influenzae type B, hepatitis B, VZV, chicken pox, PCV, pneumococcal conjugate
- Neomycin
- Streptomycin
- Polymyxin B
- Common baker's yeast

Immunizations for Adolescents (QIP Report)

Report name: QIP_Adolesc_Immun_v1

Denominator definitions: The denominator includes all patients who turned thirteen years of age during the measurement period chosen by the user (in other words, who had a thirteenth birthday in the measurement period). No visit criteria are applied to the denominator.

Numerator definitions: To be included in the numerator, members of the denominator must have the required number of three different vaccines and no exclusion criteria.

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The table below displays the three vaccines and the criteria applied to each. There is a brief explanation of the criteria following the table.

Vaccine Name	Abbreviation	Number of immunizations	Range of Administration
Meningococcal	MCV	1	Between 11 th and 13 th birthday
Tetanus, diphtheria toxoids and acellular pertussis	Tdap	1	Between 10 th and 13 th birthday
Human papillomavirus	HPV	2	Between 9 th and 13 th birthday, and at least 146 days apart

In order to be counted, immunizations must be given on different dates of service and within the range described in the table above. Any immunizations given after the patient’s thirteenth birthday are not counted.

All immunizations must be properly entered into the Immunizations/Therapeutic Injections window of eCW with the immunization name and date given. The report counts the immunization whether it is given directly by the health center or entered as historical. The BridgeIT report identifies immunizations using a CVX or CPT code that is associated with the immunization itself (not billed). Therefore, the health center should insure that all appropriate immunizations have an associated CVX code (preferred) or CPT code using the validation report named List_Immuniz_v1²¹.

The following table displays the CVX and CPT codes for each vaccine that is being used by the report.

Abbreviation	CVX	CPT
MCV	108, 136, or 147	90734
Tdap	115	90715
HPV	62, 118, 137, or 165	90649, 90650, or 90651

Patients who have a contraindication or reaction to vaccines and otherwise do not meet all of the numerator criteria are considered for the exclusion. This can be an anaphylactic reaction or side-effect to a vaccine or components of the vaccine. The report will pick-up the following diagnosis codes from the Problem List (column Excl_ProbList_Code) or Assessments (column Excl_AssessEver_Code): 999.4, 999.42, T80.52XA, T80.52XD, or T80.52XS.

²¹ This report is normally stored in the UDS Modified folder, apart from the Annual Clinical Report Set reports

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Exclusions can also come from the Allergies and Intolerance window of eCW. The report searches the text in the Agent/Substance field and indicates if any key word combination is found in the column Excl_AllergyIntoler_Text. The key words are: Vaccine or vaccination combined with any of the following words: MCV, meningococcal (partial text “mening” acceptable), Tdap, tetanus, diphtheria, pertussis, HPV, or human papillomavirus (partial text “papilloma” acceptable).

Dental Sealants (UDS Report)

Report name: Dental_Sealants_v1

Denominator definitions: This version of the Bridgell report does not display the correct denominator for the measure. Health centers will need to perform an audit using dental charts to obtain the correct denominator. A suggested procedure for using the Bridgell report to obtain candidates for the audit appears in the document “Instructions for Using the Bridgell Annual Clinical Report Set” (version 14, June 2018).

The initial population displayed by the Bridgell report consists of patients between the ages of 6 and 9 years at the end of the measurement period and with at least one encounter with a dental provider in the measurement period. A dental provider is defined as a Resource Provider with the word “dentist” or “dental” in the Specialty field of the Provider’s administrative record in eCW.

There are three components that qualify a patient for the denominator of the measure. Only two of them may appear in Bridgell. The components are:

1. The patient had at least one oral assessment, comprehensive evaluation or periodic oral evaluation in the measurement year. Information can come from Bridgell (column Had_OralEval = “Yes) or the dental record. The Bridgell report looks for the CDT codes D0120, D0145, D0150, D0180, or D0191 on a claim in the year prior to the end of the measurement period.
2. The patient had a caries risk assessment of moderate or high risk. Information can come from Bridgell (column Risk_Carries = “Moderate to high risk”) or the dental record. The Bridgell report looks for the CDT codes D0602 or D0603 on a claim in the year prior to the end of the measurement period.
3. The patient does not have all non-sealable first permanent molars (i.e., molars are either decayed, filled, currently sealed, or un-erupted/missing). Information comes the dental record.

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Numerator definitions: This version of the Bridgell report does not display the correct numerator for the measure. Health centers will need to perform an audit using dental charts to obtain the correct numerator. Thus, the report does not contain any output sheets.

The Bridgell report displays the text “Had sealant on any tooth” in the column Had_Dental_Sealant if the CDT code D1351 appears on a claim in the year prior to the end of the measurement period. Note that this code is for the general application of any dental sealants, not just those for permanent first molar teeth. Therefore, the last date that a sealant was given (column Last_Dental_Sealant) can be used to guide the dental chart audit, but is not sufficient evidence for inclusion of the patient into the numerator.

The column Random_Number displays a different random number every time the report is run. The numbers potentially range from 1 to 1000 and there can be duplicates. The column can be sorted to provide the necessary randomization of records for the chart audit.

Annual Monitoring for Patients on Persistent Medications (QIP Report)

Report name: QIP_PersistentMeds_v2

Denominator definitions: The set of denominator patients for this measure is provided to the health center by Partnership Healthplan. Nonetheless, the Bridgell report can give a good estimate of the denominator. Officially, the denominator consists of patients continuously enrolled Medi-Cal nine out of the twelve months of the measurement year. Although continual enrollment is difficult to calculate in Bridgell, the Insurance Class of the patient can be used to show if the patient currently has Partnership Medi-Cal insurance (depending how that is entered in eCW by the health center).

Health centers can run the report for a period of one year (standard for the QIP) or shorter periods of time. If matching patients from the report to the list of Patients supplied by Partnership, do not use any filters. If summarizing the data from a measurement period of one year, do not use any visit filters. If using a measurement period less than a year to summarize the data, add a filter for primary care visits in the measurement period (PrimCareVisitsPeriod > 0).

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The denominator of this measure takes patients who have used “persistent medications” for 180 days or more within the year prior to the end of the measurement period. There are two classes of persistent medications and each is evaluated separately to see if the minimum 180 limit was reached. They are: 1) ACE inhibitors or ARBs; and 2) diuretics. The report uses Medication Groups (Rx Groups) to identify these medications. The names of the groups are “ACE Inhibitor,” “ARB,” and “Diuretic” (with some flexibility given to the name in eCW, for example plural “ARBs”). The health center is responsible for assigning the appropriate medications to the Medication Group in eCW. See Appendix D of the System Set-up document for more detail on how to assign medications to groups.

To be recognized as using a persistent medication, the patient must have had at least one action on the medication list for a medication belonging to appropriate Medication Groups. A medication action means that the provider has selected the medication on the patient’s medication list and indicated that this medication is somehow being used on that date. Examples of actions are Start, Continue, Increase, Refill, Taking / Brought Forward, etc. Actions that imply the patient is actually not using medications, such as Stop, Discontinued, Not Taking or Unknown, are not considered by the report.

To determine the number of days that the patient has been on persistent medications, the report looks back one year prior to the end of Measurement Period and compares the first medication action date with the last medication action date in that period. The number of days between those two dates is displayed in the columns DaysOn_ACE-ARB_1Y and DaysOn_Diuret_Med_1Y, depending on which is being used. If either of those columns show that the patient was on persistent medications 180 days or more, the column PastYear_180Days_PersMed will display “Include in denominator: 180 days or more on persistent meds in past year.” This column should be used to also filter for denominator patients. There is not an exclusion column on this report.

Note that the report is simply comparing the first and last medication dates in the measurement period to identify patients who have been on either persistent medication for at least 180 days in the past year. Because prescription details like dose, frequency and duration are entered as free-text into eCW, the BridgeIT report has difficulty interpreting the total number of days the patient has been prescribed persistent medications. Furthermore, it cannot consider days on persistent medications that overlap the beginning and end dates of the year-long medication period. Therefore, the days displayed in the columns DaysOn_ACE-ARB_1Y and DaysOn_Diuret_Med_1Y may not be the same number of days that a human would calculate by reading the text in the medications window during the period and adding up the total days that the patient has those medications available to use. Additionally, there may be patients who start and stop a persistent medication, and then begin it again later during the year-long period. Since the report takes the first and last dates of medication use without considering any non-

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continuous period in-between, patients such as these would be included in the denominator if the difference between the dates was still more than 180 days.

That said, there is a column on the report that adds the days of duration entered into the Current Medications window during the year prior to the end of the Measurement Period. This method appears to be less reliable than the method described above to calculate the minimum number of days the patient has been on persistent medications in the past year. Therefore, it is not recommended that this column be used directly as the denominator, but it may be useful to further research patients who are close to the 180 days limit. The columns are named ACE-ARB_DurationDays_1Y and Diuret_DurationDays_1Y. These columns display the sum of all the numbers of days entered into the Duration column for identified medications in the year prior to the end of the Measurement Period. It recognizes days as a number followed by any text with the fragment “day” (for example “30 days”). The report does not compute weeks or months entered into that column, nor does it use information in the Dose, Frequency, or other columns of the Current Medications window. If the total number of days is 180 or more, the column PastYear_Duration_180Days_PersMed will display “180 days or more of ACE/ARB or diuetic duration in past year.”

These denominator considerations are relevant to those health centers that will use the report for monthly dashboards or other internal performance monitoring or improvement activities. For reporting patient outcomes out to Partnership, a denominator does not need to be determined because Partnership provides the denominator to you using information from MedImpact (which, presumably, contains better structured data on prescriptions).

To give you additional information on patients using persistent medications, the report contains an additional column that shows if the patient has been on persistent medications 180 days or more ever, regardless of the year-long look-back period (Ever_180Days_PersMed). To make this determination, the report looks back at the very first date that any action was taken on the persistent medications in the patient’s history (columns First_ACE-ARB_Date and First_Diuret_Date). The report also displays some additional information about the number of times that there was an action (Number_Dates_ACE-ARB_MedAction_MP and Number_Dates_Diuret_MedAction_MP) and there was a printed, faxed or electronic prescription (Number_Dates_ACE-ARB_Prescript_MP and Number_Dates_Diuret_Prescript_MP) in the measurement period. It also shows the medication and provider on the last date in the measurement period where there was an action on a persistent medication.

Note that because the report displays unduplicated patients, it cannot show more than one medication or provider if the patient had more than one on the last date. And because the report is designed to

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measure the QIP indicator only, it does not display additional data relevant to case management such as prescription details, lab results, etc.

Numerator definitions: There are two groups of labs that qualify for the numerator of the report. They are: 1) the metabolic lab panel, and 2) serum creatinine AND serum potassium. Labs accepted by the report for the numerator must have occurred within one year prior to the end of the Measurement Period.

These labs are identified as follows:

1. Lab panel has a lab name similar to “comprehensive metabolic panel” or “basic metabolic panel.”
2. Serum Creatinine has a lab attribute name similar to “Creatinine, Serum” or any of the following LOINC codes: 11041-1, 11042-9, 12195-4, 13441-1, 13442-9, 13443-7, 13446-0, 13447-8, 13449-4, 13450-2, 14682-9, 16188-5, 16189-3, 21232-4, 2160-0, 2163-4, 2164-2, 26752-6, 31045-8, 33558-8, 35203-9, 35591-7, 35592-5, 35593-3, 35594-1, 38483-4, 39955-0, 39956-8, 39957-6, 39958-4, 39959-2, 39960-0, 39961-8, 39962-6, 39963-4, 39964-2, 39965-9, 39966-7, 39967-5, 39968-3, 39969-1, 39970-9, 39971-7, 39972-5, 39973-3, 39974-1, 39975-8, 39976-6, 40112-5, 40113-3, 40114-1, 40115-8, 40116-6, 40117-4, 40118-2, 40119-0, 40120-8, 40121-6, 40122-4, 40123-2, 40124-0, 40125-7, 40126-5, 40127-3, 40128-1, 40248-7, 40249-5, 40250-3, 40251-1, 40252-9, 40253-7, 40254-5, 40255-2, 40256-0, 40257-8, 40258-6, 40264-4, 40265-1, 40266-9, 40267-7, 40268-5, 40269-3, 40270-1, 40271-9, 40272-7, 40273-5, 44784-7, 50380-5, 50381-3, 51619-5, 51620-3, 59826-8, 59834-2, or 62425-4.
3. Serum Potassium has a lab attribute name similar to “Potassium, Serum” or any of the following LOINC codes: 12812-4, 12813-2, 2823-3, 2824-1, 29349-8, 32713-0, 39789-3, 39790-1, 41656-0, 51618-7, 6298-4, 75940-7, or 82722-0.

The last lab dates are displayed in the columns Last_LabPanel_Date , Last_SerCreatin_Date, and Last_SerPotass_Date respectively. If the date for the last metabolic lab panel or the dates for both the serum creatinine and potassium labs are within a year prior to the end of the measurement period, the column Monitoring_Lab_Status will display the text “Had persistent meds monitoring lab in past year.” This is the column that is used to summarize the numerator.

In order for a lab test to be included, it must meet Meaningful Use structured lab data criteria (see the NOTE on page 8, above). Part of the validation process should be to identify lab records that do not meet these criteria and fix them in eCW, when possible. See the appendix of the annual report Instructions (version 14, June 2018) for a description of a validation report that can be used for this purpose (under the heading “Persistent Medications Lab Test Validation”). Results from this report can also be used for data-entry quality-improvement efforts within your organization.

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Note that the Persistent Medications report also contains columns that displays the last date that a lab panel (column Last_LabPanel_Billed) or serum creatinine/serum potassium tests (column Last_CreatPotass_Billed) were billed before the end of the Measurement Period²². These columns are intended to help you identify set-up issues or records that may have incomplete data²³. Note that the results from these columns are not intended to be simply added to the numerator without first checking the medical record. If your health center does not use any of these codes or uses alternate billing codes, simply ignore the columns.

Version 2 changes: LOINC codes updated; columns for serum creatinine and serum potassium separated

²² CPT Codes for Lab Panel: 80047, 80048, 80050, 80053 and 80069. CPT Codes for Serum Creatinine: 82565 and 82575. CPT Codes for Serum Potassium: 80051 and 84132

²³ For example, filter for patients who are not included in the numerator (Monitoring_Lab_Status does not equal “Had persistent meds monitoring lab in past year”) but with a lab panel billed or serum creatinine/serum potassium tests billed (column Last_LabPanel_Billed or Last_CreatPotass_Billed filtered for the date range equal to a year prior to the end of the Measurement Period). Investigate what lab was billed on that date and why it is not being recognized by the report. For example, there may be labs with unusual names, or there may be labs without all the structured data fields completed, yet were still billed as such.

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Appendix: Nephropathy Screening Codes Supplied by Partnership Health Plan

The following are the LOINC codes used for Nephropathy Screening Tests, including urine tests for albumin or protein.

11218-5	17819-4	30001-2	47558-2	57735-3
12842-1	18373-1	30003-8	49002-9	5804-0
13705-9	20454-5	32209-9	49023-5	58448-2
13801-6	20621-9	32294-1	50209-6	58992-9
13986-5	21059-1	32551-4	50561-0	59159-4
13992-3	21482-5	34366-5	50949-7	60678-0
14956-7	26801-1	35663-4	51190-7	63474-1
14957-5	27298-9	40486-3	53121-0	6941-9
14958-3	2887-8	40662-9	53525-2	6942-7
14959-1	2888-6	40663-7	53530-2	76401-9
1753-3	2889-4	43605-5	53531-0	77253-3
1754-1	2890-2	43606-3	53532-8	77254-1
1755-8	29946-1	43607-1	56553-1	77940-5
1757-4	30000-4	44292-1	57369-1	9318-7

The following are the ICD-9 and ICD-10 codes used for documenting ESRD, stage 4 chronic kidney disease and kidney transplant.

55.61	585.5	N18.5	V45.11	Z94.0
55.69	585.6	N18.6	V45.12	Z99.2
585.4	N18.4	V42.0	Z91.15	

The following are the ICD-9 and ICD-10 codes used for documentation of treatment for nephropathy and other disorders.

250.4	403.00	403.90	404.03	404.9	405.11
250.40	403.01	403.91	404.1	404.90	405.91
250.41	403.1	404.0	404.10	404.91	580
250.42	403.10	404.00	404.11	404.92	580.0
250.43	403.11	404.01	404.12	404.93	580.4
403.0	403.9	404.02	404.13	405.01	580.8

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580.81	585.3	I13.10	N03.6	N07.7	Q61.4
580.89	585.9	I13.11	N03.7	N07.8	Q61.5
580.9	586	I13.2	N03.8	N07.9	Q61.8
581	587	I15.0	N03.9	N08	Q61.9
581.0	588	I15.1	N04.0	N14.0	R80.0
581.1	588.0	N00.0	N04.1	N14.1	R80.1
581.2	588.1	N00.1	N04.2	N14.2	R80.2
581.3	588.8	N00.2	N04.3	N14.3	R80.3
581.8	588.81	N00.3	N04.4	N14.4	R80.8
581.81	588.89	N00.4	N04.5	N17.0	R80.9
581.89	588.9	N00.5	N04.6	N17.1	
581.9	753.0	N00.6	N04.7	N17.2	
582	753.1	N00.7	N04.8	N17.8	
582.0	753.10	N00.8	N04.9	N17.9	
582.1	753.11	N00.9	N05.0	N18.1	
582.2	753.12	N01.0	N05.1	N18.2	
582.4	753.13	N01.1	N05.2	N18.3	
582.8	753.14	N01.2	N05.3	N18.9	
582.81	753.15	N01.3	N05.4	N19	
582.89	753.16	N01.4	N05.5	N25.0	
582.9	753.17	N01.5	N05.6	N25.1	
583	753.19	N01.6	N05.7	N25.81	
583.0	791.0	N01.7	N05.8	N25.89	
583.1	E08.21	N01.8	N05.9	N25.9	
583.2	E08.22	N01.9	N06.0	N26.1	
583.4	E08.29	N02.0	N06.1	N26.2	
583.6	E09.21	N02.1	N06.2	N26.9	
583.7	E09.22	N02.2	N06.3	Q60.0	
583.8	E09.29	N02.3	N06.4	Q60.1	
583.81	E10.21	N02.4	N06.5	Q60.2	
583.89	E10.22	N02.5	N06.6	Q60.3	
583.9	E10.29	N02.6	N06.7	Q60.4	
584	E11.21	N02.7	N06.8	Q60.5	
584.5	E11.22	N02.8	N06.9	Q60.6	
584.6	E11.29	N02.9	N07.0	Q61.00	
584.7	E13.21	N03.0	N07.1	Q61.01	
584.8	E13.22	N03.1	N07.2	Q61.02	
584.9	E13.29	N03.2	N07.3	Q61.11	
585	I12.0	N03.3	N07.4	Q61.19	
585.1	I12.9	N03.4	N07.5	Q61.2	
585.2	I13.0	N03.5	N07.6	Q61.3	