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**Technical Authority for the Unified Clinical Quality Improvement  
Framework**

**Bonnie User Guide**

**Version 1.4**

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# 1. Introduction

## 1.1 Background

Bonnie is a software tool that allows Meaningful Use (MU) Clinical Quality Measure (CQM) developers to test and verify the behavior of their CQM logic. The main goal of the Bonnie application is to reduce the number of defects in CQMs by providing a robust and automated testing framework. The Bonnie application allows measure developers to independently load measures that they have constructed using the Measure Authoring Tool (MAT). Loading the measures into Bonnie converts the measures from their Extensible Markup Language (XML) eSpecifications into executable artifacts and measure metadata. Developers can then use the measure metadata to rapidly build a synthetic patient test deck for the measure from the clinical elements defined during the measure construction process. By using measure metadata as a basis for building synthetic patients, developers can quickly and efficiently create a test deck for a measure. The Bonnie application helps measure developers execute the measure logic against the constructed patient test deck and evaluate whether the logic aligns with the intent of the measure.

Bonnie has been designed to integrate with the nationally recognized data standards the Meaningful Use program uses for expressing CQM logic for machine-to-machine interoperability. This integration provides enormous value to the CQM program and federal policy leaders and stakeholders. The Bonnie tool verifies that the new and evolving standards for the Meaningful Use CQM program are flexible and can be implemented in software.

Bonnie was also designed to provide an intuitive and easy-to-use interface based on feedback from the broader measure developer community. A key goal of the Bonnie application is to deliver a user experience that provides an efficient and intuitive method for constructing synthetic patient records for testing and validating CQMs.

Finally, the Bonnie software is freely available via an Apache 2.0 open source license. The Meaningful Use program makes all or parts of the Bonnie software available for inspection, verification, and even reuse by other government programs or federal contractors.

## 1.2 Purpose

The purpose of this document is to describe the functionality of the Bonnie web application that allows measure developers to test and verify the behavior of their CQM logic. This document provides Bonnie users with step-by-step instructions for testing CQMs by building synthetic patient records.

### 1.2.1 Application Description

The Bonnie application provides the capability to import measures defined in Health Quality Measure Format (HQMF) XML (Extensible Markup Language). The HQMF specification provides the metadata and logic that describe the specifics of calculating a CQM. The Bonnie application can load the HQMF describing a measure and programmatically convert the HQMF specification into an executable format that allows calculation of the measure directly from the specification.

The Centers for Medicare & Medicaid Services (CMS) Measure Authoring Tool (MAT) is the primary source for HQMF documents used by the Bonnie application. Measure developers use the MAT to build CQMs and export those measures as measure bundles containing both the HQMF and value sets used as part of calculation. These measure bundles can be downloaded from the MAT and loaded into the Bonnie user interface for measure testing.

Once a CQM has been loaded into the Bonnie application, a user can inspect the measure logic and then build synthetic test records and set expectations on how those test records will calculate against a measure. This capability to build synthetic test patient records, set expectations against those records, and calculate the measures using those patient records provides an automated and efficient testing framework for CQMs. Through the Bonnie-supported CQM testing framework, measure developers can more clearly understand the behavior of the measure logic and validate that the measure logic encodes their intent and allows validation of multiple iterations of measure updates against a test deck.

In addition, the development of a test deck as part of measure development provides benefits after the measures are finalized. The test deck built as part of measure development can be used to demonstrate the intent of the measure through the patient examples in the test deck.

Furthermore, the test deck provides systems that implement the measures with a means to validate the development of their systems. This validation is provided as a base set of synthetic patient records with known expectations for calculating against the implemented measures. Finally, the test deck could be used to inform the Meaningful Use certification program.

## 2. User Account Creation

### 2.1 Login Page

Users require a valid account to access the Bonnie application. All measures loaded into the Bonnie application and all synthetic test patients are isolated by account. Therefore, users can only view, access, and modify data that they have loaded under their own account. **Error! Reference source not found.** shows the login screen for the Bonnie application. To log in, a user must provide the email address and password for a valid account.

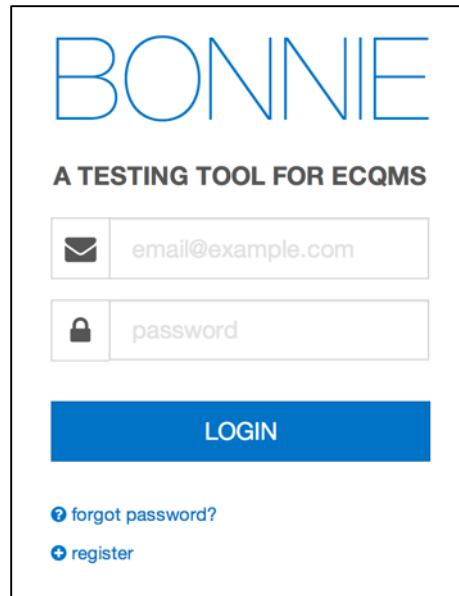
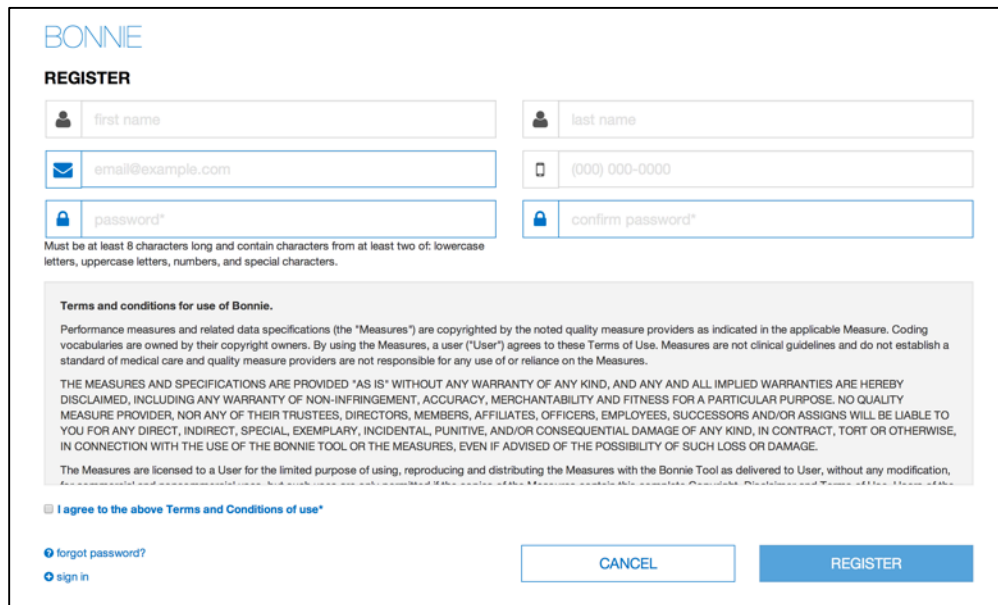
The image shows a login interface for the 'BONNIE' application. At the top, the word 'BONNIE' is displayed in a large, blue, sans-serif font. Below it, the text 'A TESTING TOOL FOR ECQMS' is shown in a smaller, bold, black font. The login form consists of two input fields: the first is for an email address, with a placeholder 'email@example.com' and an envelope icon; the second is for a password, with a placeholder 'password' and a lock icon. Below these fields is a prominent blue button with the word 'LOGIN' in white capital letters. At the bottom of the form, there are two links: 'forgot password?' with a question mark icon and 'register' with a plus icon, both in blue text.

Figure 1: Bonnie Login Page

### 2.2 Creating a New User

A user can create a new account by clicking the “Register” link on the login page. The register link brings the user to the account creation page (**Error! Reference source not found.**). A user can create a new account by filling out the fields in the registration form and clicking the “Register” button. Once an account has been created, the user can log in to the Bonnie application with the email address and password specified as part of account creation.





**BONNIE**

**REGISTER**

first name

last name

email@example.com

(000) 000-0000

password\*

confirm password\*

Must be at least 8 characters long and contain characters from at least two of: lowercase letters, uppercase letters, numbers, and special characters.

**Terms and conditions for use of Bonnie.**

Performance measures and related data specifications (the "Measures") are copyrighted by the noted quality measure providers as indicated in the applicable Measure. Coding vocabularies are owned by their copyright owners. By using the Measures, a user ("User") agrees to these Terms of Use. Measures are not clinical guidelines and do not establish a standard of medical care and quality measure providers are not responsible for any use of or reliance on the Measures.

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The Measures are licensed to a User for the limited purpose of using, reproducing and distributing the Measures with the Bonnie Tool as delivered to User, without any modification, reproduction, or transmission in any form or by any means, electronic or mechanical, including photocopying, recording, or by any information storage and retrieval system.

☐ I agree to the above Terms and Conditions of use\*

[forgot password?](#)

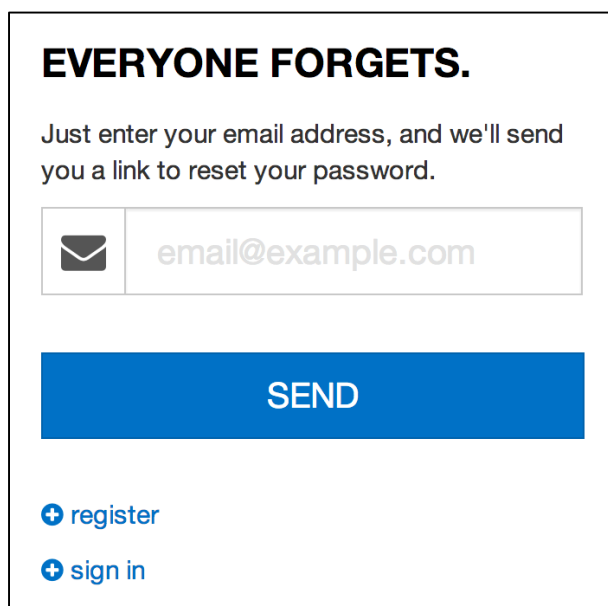
[sign in](#)

CANCEL REGISTER

Figure 2: Account Registration Page

## 2.3 Resetting a Password

In the event that a password is forgotten or an account is locked, the user can reset the password using the password reset page. This page is accessed from the “Forgot Password?” link on the login page (**Error! Reference source not found.**). On this page, the user can provide the email address associated with the account and then press the “Send” button. This action will send an email to the registered email address for the account to allow the user to reset the account’s password.



**EVERYONE FORGETS.**

Just enter your email address, and we'll send you a link to reset your password.

email@example.com

SEND

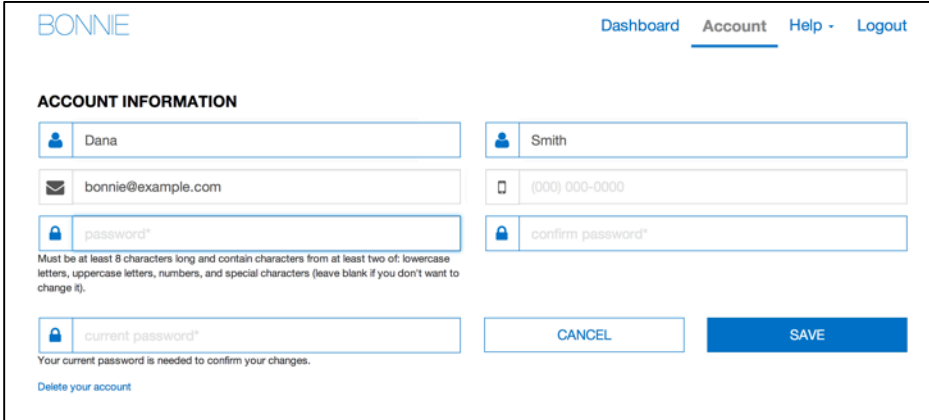
[+ register](#)

[+ sign in](#)

Figure 3: Password Reset Page

## 2.4 Account Management

After logging into the application, the user can change the information associated with the account by accessing the account management page (**Error! Reference source not found.**). The account management page can be opened by clicking the “Account” link in the application header (shown at the top of **Error! Reference source not found.**). From this page, users can change the information provided during the registration process and select a new password for their account.



The screenshot displays the 'Bonnie' account management interface. At the top, the 'Bonnie' logo is on the left, and navigation links for 'Dashboard', 'Account' (which is underlined), 'Help', and 'Logout' are on the right. The main section is titled 'ACCOUNT INFORMATION'. It contains several input fields: a first name field with 'Dana', a last name field with 'Smith', an email field with 'bonnie@example.com', a phone number field with '(000) 000-0000', a 'password\*' field, a 'confirm password\*' field, and a 'current password\*' field. Below the password fields, a note states: 'Must be at least 8 characters long and contain characters from at least two of: lowercase letters, uppercase letters, numbers, and special characters (leave blank if you don't want to change it).' Below the 'current password\*' field, another note says: 'Your current password is needed to confirm your changes.' At the bottom left, there is a link that says 'Delete your account'. At the bottom right, there are two buttons: 'CANCEL' and 'SAVE'.

Figure 4: Account Management Page

## 3. Measure Dashboard

### 3.1 Overview

The Measure Dashboard page, as shown in **Error! Reference source not found.**, is the initial page presented to users when they log into the application. This page displays the current set of measures the user has loaded into the system along with the subpopulations and stratifications associated with the measures. The Measure Dashboard allows users to navigate to the details of individual measures, upload a new measure, or update the definition of an existing measure.

The Measure Dashboard shows the calculation status of each measure loaded into the system. The calculation status shows how many patient records have been built for the measure, whether the measure is currently passing or failing, and how many patients are passing or failing for each measure.

The Measure Dashboard View employs the following user interface (UI) elements (indicated by their item numbers in **Error! Reference source not found.**):

1. Header – Allows the user to navigate to different parts of the application, access account information, send a support email (Contact), and log out of the application.
2. Measure Period Date – Displays the measurement period used for calculating measures.
3. Measures Download Button – Allows the user to download a bundle containing all of their measures.
4. Upload Button – Allows the user to upload a new measure.
5. Expected Column – Displays the percentage of passing patients for the measure.
6. Status Column – Displays the current status of the measure (New, Pass, Fail)
7. Test Patient Column – Displays the number of patients passing out of the total number of patients.
8. Measure Title – Displays the title for the measure and allows navigation to the measure view.
9. Subpopulation and stratification titles – Displays the titles for subpopulations or stratifications of a measure.
10. Edit Title Button – Allows the user to rename a subpopulation or stratification.
11. Update Button – Allows the user to update a previously loaded measure.
12. Add Patient Button – Allows the user to start building a new patient for a measure.

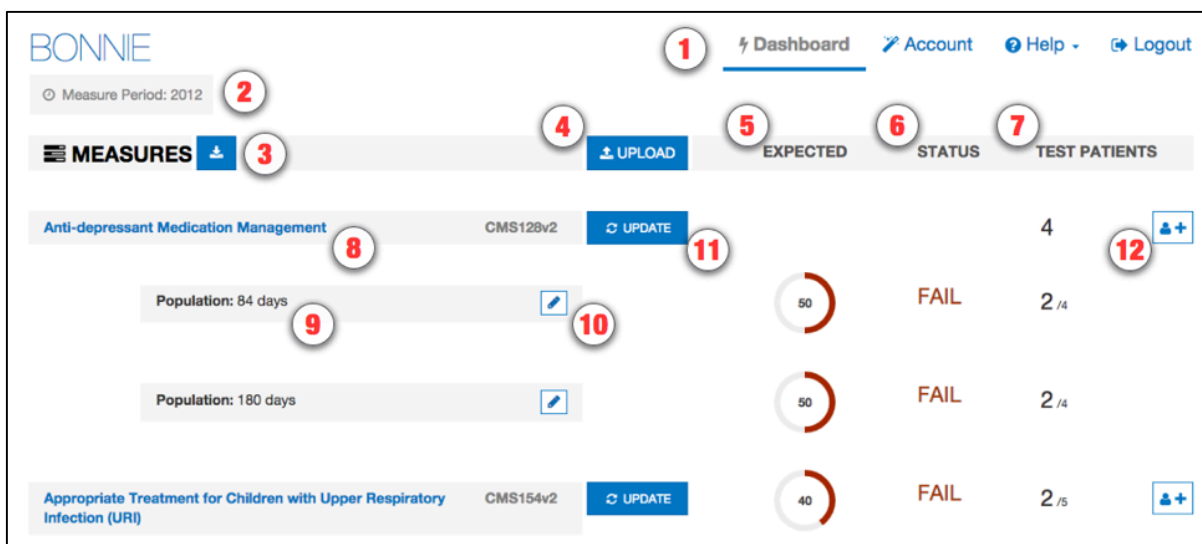


Figure 5: Measure Dashboard View

## 3.2 Loading a New Measure

When a user logs into the system for the first time, there will be no measures associated with the account. The user's first step is to load a measure into the account to begin testing the measure with the Bonnie application.

The steps for loading a new measure are:

1. Click the “Upload” button (item #4) on the Measure Dashboard, which opens the New Measure Dialog (**Error! Reference source not found.**).
2. On the New Measure Dialog:
  - a. Choose a MAT export zip file.
  - b. Specify if the measure is eligible professional (EP) or eligible hospital (EH).
  - c. Specify if the measure is Patient-based or Episode of Care.
  - d. Click the “Load” button.

The action of clicking the “Load” button in the New Measure Dialog uploads the measure to the application for processing. If the measure loaded is Episode of Care or has multiple populations, the user is presented with the Finalize Measure Dialog (**Error! Reference source not found.**). This dialog allows the user to specify the episode(s) of care for the measure and provide titles for subpopulations. Once the Finalize Measure fields have been filled out, the user clicks the “Done” button to finish loading the measure. Once measure loading is complete, the user is taken to the Measure Dashboard (Figure 5) with the new measure available. If the measure is not episode of care or does not have subpopulations, the user will not be presented with the Finalize Measure Dialog because no additional information is required to load the measure.

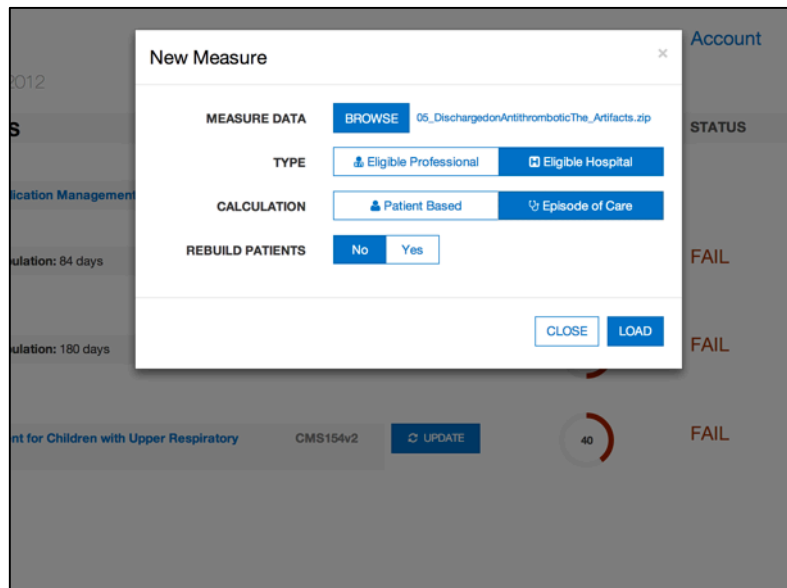


Figure 6: New Measure Dialog

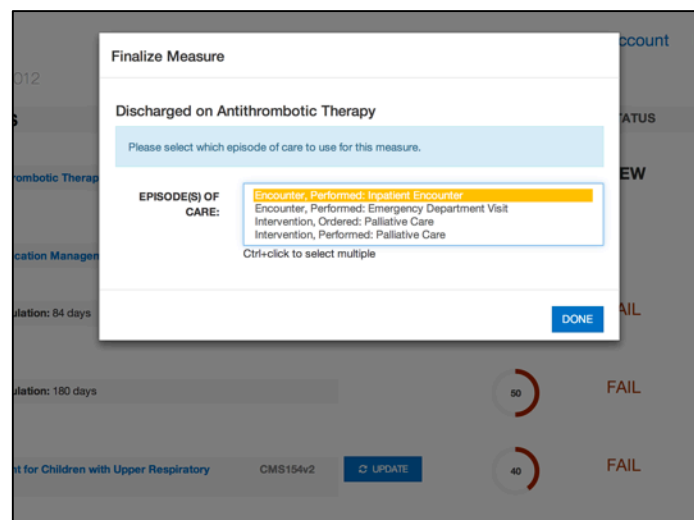


Figure 7: Finalize Measure Dialog

### 3.3 Updating a Measure

Once the measure has been loaded, the testing process may identify issues with the measure. When issues are identified, the logic must be updated in the MAT to resolve these issues. Alternatively, the measure could be updated in the MAT as part of an annual update. Once a measure has been updated in the MAT, it may be necessary to update that measure in Bonnie for testing. To update a measure, follow these steps:

1. Click the “Update” button (#11) on the Measure Dashboard, which displays the “Update Measure” dialog (**Error! Reference source not found.**).
2. Select a new MAT export zip with the updated measure definition.

3. Update the episode of care if it has changed.
4. Click the “Load” button to load the new version of the measure.

Discharged on Antithrombotic Therapy

MEASURE DATA [BROWSE](#)

TYPE Eligible Hospital (EH)

CALCULATION Episode of Care

REBUILD PATIENTS [No](#) [Yes](#)

EPISODE(S) OF CARE: [Encounter, Performed;](#)  
[Encounter, Performed;](#)  
[Intervention, Ordered;](#)  
[Intervention, Performer](#)

[CLOSE](#) [LOAD](#)

Figure 8: Updating Measure Dialog

### 3.4 Creating Synthetic Test Records

Once a set of measures has been loaded into the Bonnie application, users can start building test patients for the measures. To build a test patient from the Measure Dashboard (**Error! Reference source not found.**), click the “Add Patient” button (item #12 in **Error! Reference source not found.**). This action opens the patient builder (see Figure 13). For more information, go to Section 5, *Building a Patient Test Record*.

After the user creates synthetic test patients for measures, the Measure Dashboard will display summary calculation results of the patients associated with each measure loaded by the user (**Error! Reference source not found.**). As shown in **Error! Reference source not found.**, UI elements #5, #6, and #7 on the Measure Dashboard provide the summary results for each measure. In the “Expected” column (item #5), the UI displays the percentage of patients associated with the measure whose calculated values meet the expectations set for the patient. The “Status” column (item #6) indicates the current state of the measure—whether it is passing, failing, or new. A measure is in the passing state if all associated patients are meeting expectations. If one or more patients are not meeting expectations, then the measure is in a failing state. Any measure is in the new state when there are no patients associated with it. Finally, the “Test Patients” column (#7) displays the number of passing patients over the total number of patients as a fraction. The measure view, as represented in **Error! Reference source not found.** in Section 4, shows more detailed results for a measure.

## 4. Measure Results View

### 4.1 Overview

As shown in **Error! Reference source not found.**, the Measure View page displays the detailed information, associated patients, and calculation results for a single measure. The Measure View allows the user to add new patients to a measure, update a measure, and delete a measure. To access the Measure View, click on the “Measure Title” link (#8) on the Measure Dashboard, as shown in **Error! Reference source not found.**.

The Measure View page presents the title and description of the measure along with the logic for the measure. A measure for measure complexity is shown as well. The page also lists the current set of test patients associated with the measure in the column on the right-hand side of the page. This column displays the summary calculation results for the patient test deck associated with the measure along with the list of patients and the individual calculation results for each. This page shows the results of calculation for a single patient along with an overlay of the calculation results on the measure logic.

The Measure View page employs the following UI elements (indicated by their item numbers in **Error! Reference source not found.** and **Error! Reference source not found.**):

1. Measure Title – Displays the title and description of the measure.
2. Measure Actions – Allows the user to delete or update a measure definition, or activate an alternate view of the measure logic.
3. Measure Complexity – Indicates how complex the measure is.
4. Measure Subpopulations or Stratifications – Allows access to different subpopulations or stratifications in the measure.
5. Measure Logic – Displays a representation of the logic for the measure.
6. Logic Highlighted With Coverage – Displays the logic for the measure highlighting which lines of the measure are covered by the test patients.
7. Patient Actions – Allows the user to export patient records and access the Patient Bank.
8. Percent Successful – Displays the percent of patients currently meeting expectations for the measure.
9. Patients Passing Count – Displays the current number of patients meeting expectations over the total number of patients in the test deck for the measure.
10. Test Coverage – Displays the percentage of the measure logic that has evaluated to true for the patient test deck. This measure provides a method for determining how much of the logic has been tested.
11. Add Patient Button – Allows the addition of a new patient to the test deck for this measure.
12. Failing Patient – An example of a patient that is not currently meeting expectations for the measure.

13. Passing Patient – An example of a patient that is meeting expectations.
14. Patient Name – Displays the name given to the patient.
15. Patient Status – Displays PASS or FAIL to indicate if the patient is meeting expectations.
16. Expand Patient Results Button – Allows display of the calculation details of a patient.  
This display will show the expected and actual values for the patient against the measure.
17. Data Criteria – Displays the data elements that can be associated with a patient for a given measure. Clicking on any one of these data elements will show the list of codes associated with that data element (in this case, there is only one code associated).
18. Supplemental Data Elements – Any additional data elements that can be associated with a patient for a given measure. Generally, this includes non-medical patient demographic information.

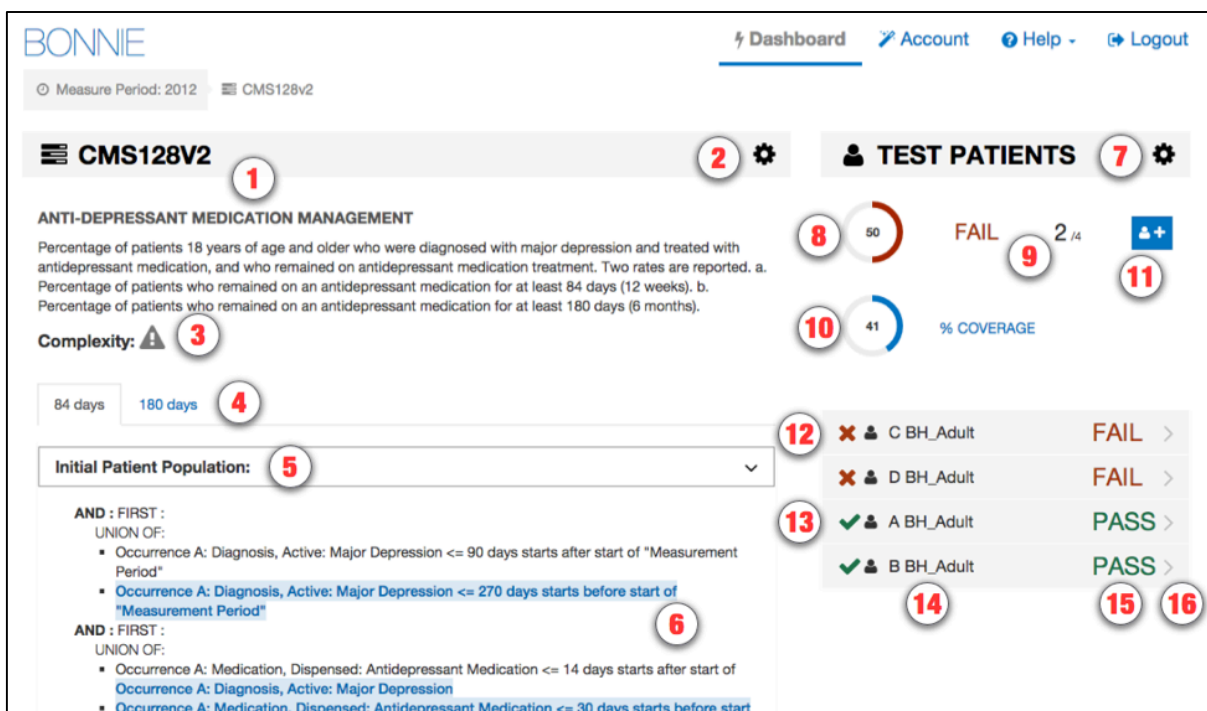


Figure 9: Measure View



DATA CRITERIA <span>17</span>		
2.16.840.1.113883.3.117.1.7.1.292	Encounter, Performed: Emergency Department Visit	Draft
Code System	Code	Name
SNOMED-CT	4525004	Emergency department patient visit (procedure)
2.16.840.1.113883.3.117.1.7.1.299	Diagnosis, Active: Psychiatric/Mental Health Patient	Draft
2.16.840.1.113883.3.666.5.307	Encounter, Performed: Encounter Inpatient	Draft
SUPPLEMENTAL DATA ELEMENTS <span>18</span>		
2.16.840.1.113762.1.4.1	Patient Characteristic Sex: ONC Administrative Sex	Draft
2.16.840.1.114222.4.11.3591	Patient Characteristic Payer: Payer	Draft
2.16.840.1.114222.4.11.836	Patient Characteristic Race: Race	Draft
2.16.840.1.114222.4.11.837	Patient Characteristic Ethnicity: Ethnicity	Draft

Figure 10: Measure Data Criteria and Supplemental Data Elements

## 4.2 Measure Logic

The left-hand side of the Measure View contains the measure title, description, and a representation of the logic. The representation of the measure logic is similar to the human-readable display for the measure provided in the MAT measure exports. Some differences in the structure of the logic are a result of restructuring that is done while parsing the measure logic from the HQMF specification. The most notable difference is that relative timings applied to logical groups are distributed down into the statements of the logical group rather than displayed at the level of the grouping.

The measure logic section can be used to verify that the measure logic was properly loaded from the HQMF without the loss of any logical conditions. The logic can also be used to evaluate the nature of the calculation of a test patient against the logic (please refer to subsection 4.4, *Calculation Results*) and to visualize the test coverage of the measure logic.

## 4.3 Creating a New Test Record

To create a new test record, begin by clicking the “Add Patient” button (item #11) in the Measure View (**Error! Reference source not found.**). This action opens the Patient Builder (shown in **Error! Reference source not found.**). Once a patient record has been created, the application returns the user to the Measure View where the user can evaluate the results of calculating the patient against the measure.

## 4.4 Calculation Results

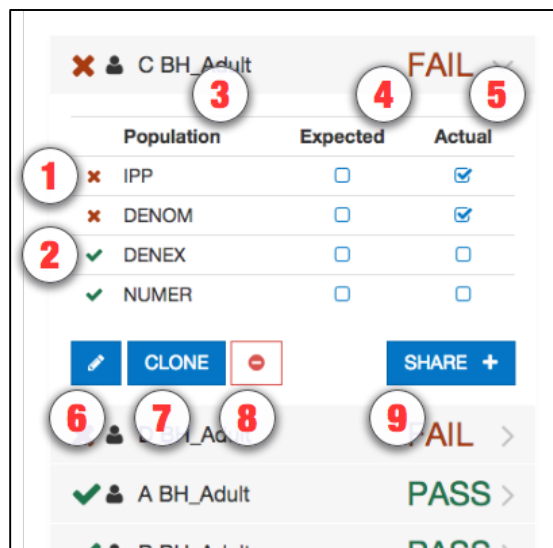
Once the user has constructed a test patient record, the user can calculate that patient against the logic of the measure in the Measure View (**Error! Reference source not found.**). High-level

results are calculated automatically when the Measure View is loaded. These high-level results appear under the test patients section on the right-hand side of the Measure View. These results include the percent of patients passing (item #8), the test coverage (item #10), individual statuses for each patient (items #12–16), and the passing patient count (item #9).

In addition to these high-level results, detailed results can be displayed for an individual patient by clicking the “Expand Patient Results” button (#16). This displays a table of expected and actual results for the patient covering each population listed in the measure and shows whether that population is currently meeting or failing expectations.

The Expanded Results View employs the following UI elements (as indicated by their item numbers in **Error! Reference source not found.**):

1. Failing Population – A population for which the patient fails.
2. Passing Population – A population for which the patient passes.
3. Population Column – A list of the population types.
4. Expected Value – The user-defined expected value for the population.
5. Actual Value – The calculated value for that population.
6. Edit Patient Button – Allows editing of the selected patient.
7. Clone Patient Button – Allows cloning of the selected patient.
8. Delete Patient Button – Allows deleting of the selected patient.
9. Share Patient Button – Allows sharing the selected patient to the Patient Bank. If already shared, this will display as “Unshare” and will allow the patient to be retracted from the Patient Bank.



**Figure 11: Expanded Results View**

Clicking the “Expand Patient Results” button also displays the patient results calculated against each line of logic. This information is displayed in the measure logic section of the view by

highlighting the lines of logic. As shown in **Error! Reference source not found.** and **Error! Reference source not found.**, a green highlight (accompanied by a check mark) indicates a passing result for the logic calculation, while a pink highlight (accompanied by an “x” or an “\*”) indicates a failing result over the applicable lines of text.

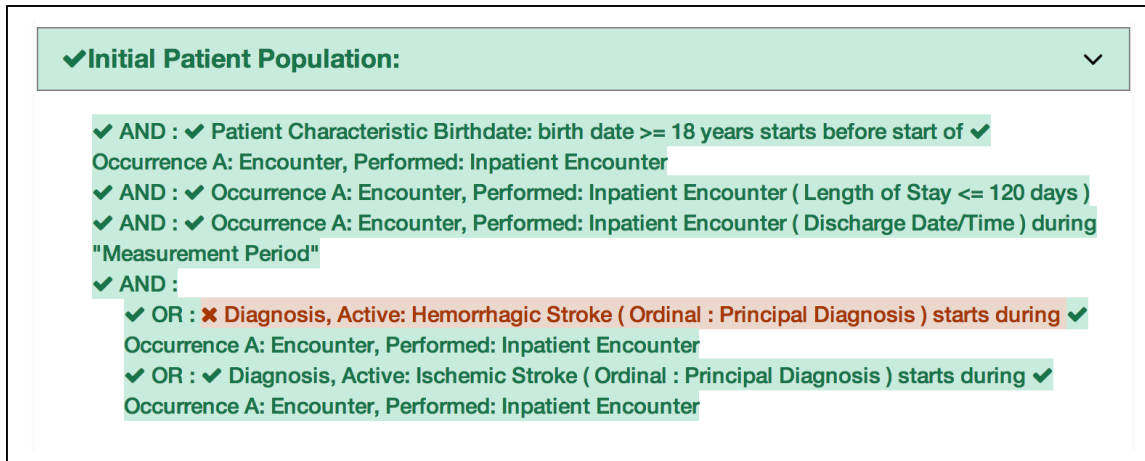


Figure 12: Logic Calculation Highlight – Passing Results

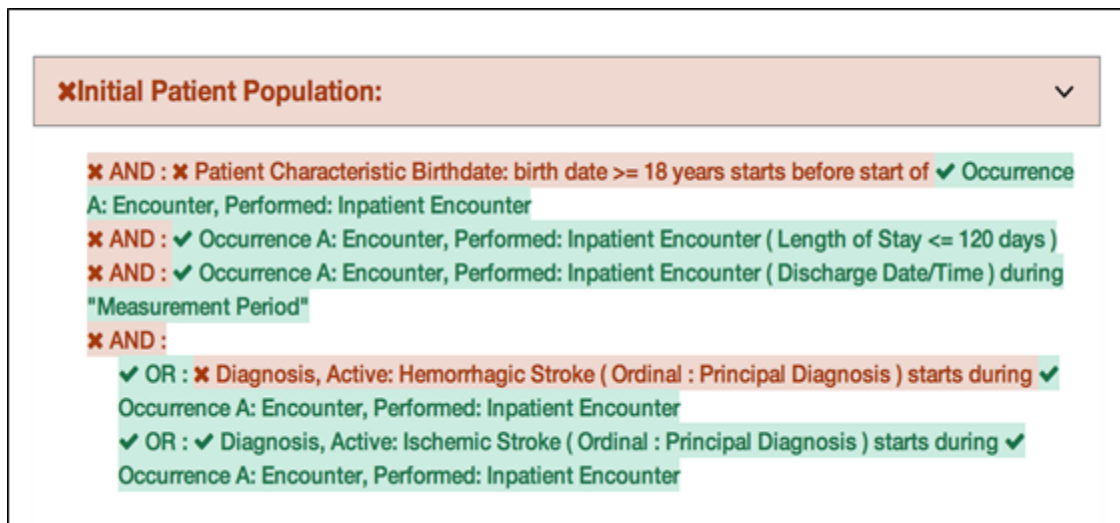


Figure 13: Logic Calculation Highlight – Failing Results

**Error! Reference source not found.** shows the results of a single patient calculated against the measure logic. The highlighting of the measure logic for calculation is intended to provide a clearer understanding of why a patient is calculating to a specific population. The highlighting of the logic text uses the following indications of status:

- **Logic evaluated to TRUE** – green highlighting along with a checkmark icon
- **Logic evaluated to FALSE** – pink highlighting along with an “X” icon
- **Unaligned Specific Occurrences** – pink highlighting along with a bold asterisk icon

The results of the calculation shown in **Error! Reference source not found.** are that the patient aligns with the logic of the initial patient population (IPP). The highlighting of the logic in **Error! Reference source not found.** indicates that every AND condition was evaluated to true and at least one condition from each OR was evaluated to true. Based on this calculation, the IPP evaluates to true for the patient.

In **Error! Reference source not found.**, all the logical statements are highlighted in pink, indicating that all statements evaluate to false. **Error! Reference source not found.** also shows unaligned specific occurrences. This state indicates that the line of logic would evaluate to true if it were not for specific occurrences. Because all logical lines related to a specific occurrence must evaluate to true for any to evaluate to true, the line does not evaluate to true. Therefore, this third indication related to specific occurrences helps to identify which lines referencing that occurrence may cause the calculation to evaluate to false. The results calculated in **Error! Reference source not found.** indicate that the patient is not included in the IPP.

## 4.5 Editing a Test Record

The user can edit a test patient from the Measure View (**Error! Reference source not found.**) by clicking the “Edit” button. The user accesses the “Edit” button for a patient (item #6 in **Error! Reference source not found.**), accessible after expanding the patient result. Clicking the “Edit” button opens the Patient Builder (as shown in **Error! Reference source not found.**) with the data populated for that patient. Once a patient record has been edited and saved, the application returns the user to the Measure View.

## 4.6 Cloning a Test Record

The user can clone a test patient from the Measure View (**Error! Reference source not found.**) by clicking the “Clone” button (item #7 in **Error! Reference source not found.**) to the immediate right of the “Edit” button. This action opens the Patient Builder (Figure 14) with the data populated for the patient being cloned. The difference between editing and cloning a patient is that the clone process creates a new patient based on an existing patient, while the edit process updates the data for an existing patient. Once a patient record has been cloned, edited, and saved, the application returns the user to the Measure View.

## 4.7 Deleting a Test Record

The user can delete a test patient from the Measure View (**Error! Reference source not found.**) by clicking the “Delete” icon (item #8 in **Error! Reference source not found.**) to the immediate right of the “Clone” button. Deleting a patient requires a two-step process for confirmation. Once a user deletes a patient record, the action cannot be undone. To delete a patient record, the user initially clicks the “Delete” button. A second “Delete” button is then displayed. The user must click the second “Delete” button to confirm the deletion of the patient.

## 4.8 Sharing a Test Record

The user can share a test patient from the Measure View (**Error! Reference source not found.**) by clicking the “Share” button (item #9 in **Error! Reference source not found.**) to the right. Sharing a patient allows that patient to be accessible to other users through the Patient Bank. If

the patient is already shared, the user may use this button to stop sharing the patient. Section 6 provides more detail on the Patient Bank.

## 4.9 Updating a Measure

The user can update a measure by clicking the “Update Measure” button, which is accessed by clicking the “Measure Actions” icon (item #2 in **Error! Reference source not found.**). The “Update Measures” button displays the Update Measure Dialog (shown in **Error! Reference source not found.**), which allows the user to specify a new zip package for a measure exported from the MAT. Once the new measure package has been entered, the user clicks the “Load” button, which updates the measure definition and returns the user to the Measure View with the updated measure definition.

## 4.10 Deleting a Measure

The user can delete a measure from the Measure View (**Error! Reference source not found.**) by clicking the “Delete” icon for a measure. To access the “Delete” icon, the user clicks the “Measure Actions” icon (item #2 in **Error! Reference source not found.**). Once a user deletes a measure, the action cannot be undone. To delete a measure, the user initially clicks the “Delete” icon. A second “Delete” icon is then displayed. The user must click the second “Delete” icon to confirm the deletion of the measure. After the measure is deleted, the Measure Dashboard is displayed with the deleted measure no longer present.

## 5. Building a Patient Test Record

### 5.1 Overview

The Patient Builder view, as shown in **Error! Reference source not found.**, allows the addition and editing of clinical data for a synthetic test patient record. The user accesses the Patient Builder view by clicking the “Add Patient” button (item #12) on the Measure Dashboard (**Error! Reference source not found.**), or by clicking the “Add Patient,” “Edit,” or “Clone” buttons from the Measure View (**Error! Reference source not found.**).

The Patient Builder view also provides fields to either add new data or edit existing data for a patient. The patient first and last name can be defined using the associated edit fields. Characteristics such as gender, birthdate, race, and ethnicity can be set in the characteristics section. Quality Data Model (QDM) elements can be added to the patient history section by dragging and dropping an individual element onto the patient history section.

In addition to defining the patient data, the Patient Builder view allows the user to set expectations on the patient using the “Expectations” section. Expectations represent how the user expects the patient being defined to calculate against the measure. The “Expectations” section will be different based on the type of measure for which the user is building the patient record. The “Expectations” section for patient-based measures provides a check box for users to select the appropriate expected populations (numerator, denominator, etc.) within which the patient will be included. The “Expectations” section for episode of care-based measures allows users to select the number of episodes of care that are expected to be included in each population using a number picker. Continuous variable measures allow users to define the expected value(s) the measure is expected to calculate for the patient.

In addition, the Patient Builder’s logic section displays the logic of the measure against which the patient test record is constructed. As data is entered, the application continuously calculates the patient against the measure logic, and the results are displayed against the measure using the logic highlighting. Subsection 4.4 provides additional information about the descriptions of the logic highlighting technique based on calculation results shown in **Error! Reference source not found.** and **Error! Reference source not found.**

The Patient Builder View employs the following UI elements (as indicated by their item numbers in **Error! Reference source not found.**):

1. Patient Name – Allows the entry of a first and last name for the patient record.
2. Patient Characteristics – Allows the definition of characteristics data for the patient.
3. Measure Information – Shows the description for the patient’s associated measure.
4. Expectations – Allows users to set the calculation expectation for each population of the measure.
5. Actions – Allows users to save or cancel a patient record.

Figure 14: Patient Builder View

## 5.2 Building a Synthetic Patient

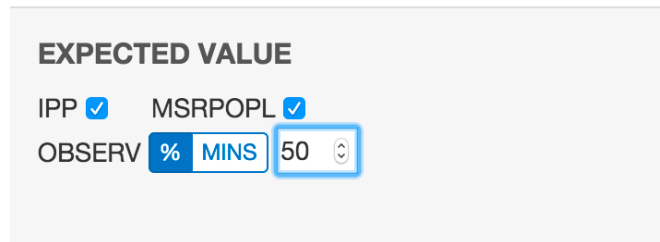
The first step to building a synthetic patient record is defining the name of the patient. The patient's first and last name can be set in the "Patient Name" section (item #1 in **Error! Reference source not found.**). The user can then add patient notes and define patient characteristics in the "Patient Characteristics" section (item #2). Characteristics for the patient include data such as birthdate, race, ethnicity, gender, payer, and living status.

After defining the patient's name, the user defines the expectations for how the patient will behave and be calculated against the measure. The user sets the expectations for the patient in the "Expectations" section (item #4). If the user expects the patient to align with the initial patient population logic, then the user should set that expectation in item #4. Expectations are used throughout the Bonnie application to determine if a patient is passing or failing against the measure.

If the expected results for the patient align with the actual results from calculating the patient against the measure logic, the patient passes. If the expected results do not match the actual calculated results, the patient fails. This system provides the capability to build patients and set expectations for those patients based on the intent of the measure. Once the measure is calculated, the passing state indicates that the measure logic aligns with the intent, while the failing state indicates that either the measure logic does not align with the intent or the synthetic patient was constructed improperly.

Note that in **Error! Reference source not found.**, the depicted measure has a discrete expected value. Accordingly, the NUMER, DENOM, and DENEX options are shown. For continuous variable measures that rely on an aggregate calculation (e.g., a median time between ED arrival and ED departure), the OBSERV, MSRPOPL, and (optionally) MSRPOPLEX options are

shown, as in **Error! Reference source not found.**. Although discrete measures offer only a checkbox for including patients in the NUMER population, continuous variable measures offer the ability to set a certain percentage or minute value for a given patient calculation. This value is only available if the patient is in the MSRPOPL population.



**EXPECTED VALUE**

IPP ☒ MSRPOPL ☒

OBSERV % MINS 50

**Figure 15: Continuous Variable Measures Expected Populations**

### 5.3 Building the Patient History

The following UI elements are shown in **Error! Reference source not found.**:

1. Elements Section – Contains QDM elements that the user can add to the patient history.
2. QDM Element – Shows a condensed summary of a QDM element.
3. Expand/Collapse Details – Allows hiding or expanding the details of an element.
4. Start Date/Time – Allows setting the start date/time for an element.
5. End Date/Time – Allows setting the end date/time for an element. The checkbox allows specifying that the end date/time is undefined (ongoing event).
6. Codes Section – Allows adding codes to the element. Note that Bonnie will automatically find an appropriate code and add it.
7. Medication or Value Section – Allows adding values to the element (i.e., laboratory result values). This element shows details for adding a medication, allowing the user to specify amount prescribed, regimen, amount filled, and the times the prescription was filled.
8. Fields Section – Allows adding fields to the element (i.e., ordinality).
9. Negation Section – Allows indicating that the element is not done with a reason.
10. Delete Button – Allows deleting an element from the patient history.



The screenshot displays the CMS128V3 Patient History interface. On the left, the 'ELEMENTS' sidebar lists 'CONDITIONS' (1), 'ENCOUNTERS', and 'MEDICATIONS'. The main 'PATIENT HISTORY' section shows a timeline of events: an 'ENCOUNTER' (Annual Wellness Visit, 02/05/2012 - 02/06/2012), a 'DIAGNOSIS' (Major Depression, 02/14/2012 - 02/14/2012), and a 'MEDICATION' (Antidepressant Medication, 02/19/2012 - 02/19/2012) (2). The medication event is expanded, showing its configuration: 'START' (02/19/2012, 8:00 AM) (4), 'STOP' (07/09/2012, 8:15 AM) (5), 'CODES' (RxNorm: 835591) (6), 'PRESCRIPTION' (10 mg) (7), 'FILLED' (900 mg, 02/19/2012 9:15 AM), and 'FIELD VALUE' (Coded) (8). A 'NOT PERFORMED' checkbox (9) is at the bottom. The right sidebar shows the 'CMS128V3' header and configuration options for 'population 2', including 'INITIAL PATIENT POPULATION', 'DENOMINATOR', 'DENOMINATOR EXCLUSIONS' (AND: Medication, Active: Antidepressant Medication <= 90 days starts before start of Occurrence A: Medication, Dispensed: Antidepressant Medication), and 'NUMERATOR' (AND: Medication, Active: Antidepressant Medication (Cumulative Medication Duration >= 180 days) <= 231 days ends after start of Occurrence A: Medication, Dispensed: Antidepressant Medication).

Figure 16: Building Patient History, including Edit Clinical Element View

After the user defines the patient characteristics, the user builds a patient history from QDM elements extracted from the measure. The available elements from the measure are organized by category and listed in the “Elements” section (item #1). The user can click a category to expand the list of available elements. Expanding this list allows the user to click and drag an individual element onto the patient history (item #2).

**Error! Reference source not found.** depicts four events in the patient’s history—an encounter, a diagnosis, and two medications—based on data elements from the measure. When a QDM element is added to the patient history, it becomes an event in the patient’s history, which warrants a duration and associated fields. When an event is first created, it is given default start and end date/times and is associated with a code from each value set associated with the source QDM element. These defaults as well as additional data can be edited by expanding the event.

Figure 16 shows an example of an expanded event from the patient history that can be edited. By clicking the expand/collapse details icon (item #3), the user can edit the details of the element.

Several fields in the Edit Clinical Element View can be edited for an event in the patient history using the controls shown in **Error! Reference source not found.**. These fields include the start date/time of the event (items #4 and #5), codes (item #6), values (item #7), various fields (item #8), and negation rationale (item #9). The start and end date times can be set for an event by either typing into the text fields directly or by using the date/time pickers that are displayed when the field is selected. An undefined end time can be set for the event (used for active or ongoing events) by selecting the “Undefined” checkbox. Selecting the “Undefined” check box clears the end date/times, indicating that the event has not ended.

Values, fields, and negation rationale also can be set for an event. Values can be set by electing the type of the value (scalar or coded) and entering a scalar value or selecting a coded value from a drop-down listing of all the value sets associated with the measure. Fields such as ordinal, severity, discharge date/time, etc. can be added using the “Fields” section. Fields are added by selecting the type of the field (scalar, coded, or time) and entering a scalar value, selecting a value set, or entering a date.

Negation rationale can be defined for the event to indicate that the event was not done for a specific reason. Negation rationale is added by clicking the “Not Performed” checkbox in the negation section and selecting a value set representing the reason the event was not done.

Finally, events can be removed from the patient history by clicking the “Delete” icon (item #10). Deletion requires a two-step process. After initially pressing the “Delete” icon, the user is prompted to depress the “Delete” icon a second time to confirm the deletion.

### 5.3.1 Patient History Items that Fulfill Past Items

In the course of creating the patient timeline, there may be some items that fulfill other items that occurred in the past. For example, a note or report may fulfill a specific order or referral. As of Bonnie v1.4, users may now relate these two items using the “References” section, as seen in Figure 17.



Figure 17: References Section of the Patient History Builder

### 5.3.2 Representing a Cumulative Medication Duration

To represent a Cumulative Medication Duration (CMD), a medication is added to the patient history and the “Prescription,” “Regimen,” and “Filled” options are adjusted appropriately, as shown in Figure 18 In the example shown in **Error! Reference source not found.**, a

prescription is specified as 10mg. This represents a single dosage of the medication. The regimen is set to 1 day(s), meaning that the single dosage is taken once per day.

The Filled section allows simulation of this prescription being filled. It takes a date, time, and amount of medication. In this example, 900mg is entered to represent a 90-day supply of this medication (based on a 10mg daily dose). Pressing the plus-sign button (+) will add this prescription amount.

**Medication: Active: Antidepressant Medication**

**START** 02/19/2012 8:00 AM **STOP** 07/09/2012 8:15 AM

☐ UNDEFINED

**CODES**

RxNorm: 835591

Code Set ---

**PRESCRIPTION** 10 mg **REGIMEN** 1 day(s)

**FILLED**

900 mg: 02/19/2012 9:15 AM 900 mg: 05/19/2012 9:15 AM

08/17/2012 9:15 AM 900 mg

**FIELD VALUE**

---

☐ Coded ---

☐ NOT PERFORMED

**Figure 18: Editing a Medication**

These steps lead to a CMD of 90 days. Additional prescriptions can easily be added by pressing the plus-sign button again; once more brings the total to 180 days, twice more to 270 days, and so on.

## 5.4 Incremental Calculation

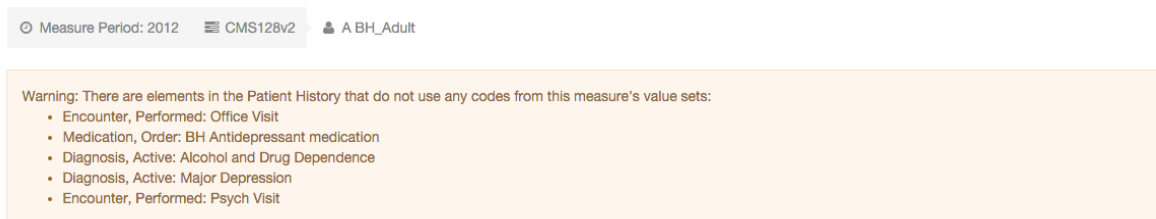
The final section of the Patient Builder View is the logic section. This section displays a representation of the logic for the measure against which the patient is constructed. The logic can be a reference to help describe the details of the data that should be added in building the synthetic patient.

The logic section continuously displays the results of calculating the patient against the measure by means of the logic highlighting described in **Error! Reference source not found.** and **Error! Reference source not found.** Any modification made to a patient triggers a recalculation of the patient against the measure, which updates the results of the calculation displayed by the logic highlighting. Therefore, while the user constructs the patient record, the user can inspect the behavior of the logic relative to the patient.

When the user has completed constructing a synthetic patient, the user clicks the “Save” button in the Patient Builder View. This action adds the patient to the test deck for the measure and returns the user to the Measure View. After the user creates the first patient, additional patients can be created from scratch or cloned from existing patients to extend the coverage of the test deck against the measure.

## 5.5 Outdated Code Sets

As value sets are modified over time, some previously built patients may contain codes that no longer exist in a given value set. To help with troubleshooting these occurrences, Bonnie will display a warning message at the top of the patient record page as shown in Figure 19.



**Figure 19: Error Message for Outdated Patient Codes**

## 6. Importing Patients from the Patient Bank

### 6.1 Overview

As of Bonnie version 1.3, users can import test patients through the Patient Bank View. Through the Patient Bank, test patients can be shared between different user accounts and between different measures. Shared patients are accessible to anyone using Bonnie. Users can select patients from the Patient Bank for export or for cloning into their own measures. Patients imported in this manner will be copies of the original patient; therefore, any edits made on the original patient will not affect a cloned patient and vice versa.

The Patient Bank shows all patients who have been shared across the Bonnie application. The Patient Bank View employs the following UI elements (as indicated by their item numbers in **Error! Reference source not found.**):

1. Measure Information – Shows the name and description of the measure.
2. Measure Patient Count – Shows the number of patients in the measure.
3. Measure Logic – Shows the coverage of logic.
4. Filters – Allows filtering on the patient results.
5. Result Count – Shows the number of shared patients.
6. Patient Indicator – Indicates whether patient is already in your measure.
7. Patient Calculation Result – Indicates how the patient calculates against the measure.
8. Selected Patient Count – Shows the number of patients selected by the user.
9. Patient Bank Actions – Allows exporting or cloning of selected patients.

To use the Patient Bank, the user must first navigate to a measure as shown in Figure 20. From the Measure View (shown in **Error! Reference source not found.**), the user can click the “Patient Actions” button (the gear icon on the upper right, marked as item #7 in Figure 9) and then click the “Add Patient Button” icon to access the Patient Bank.

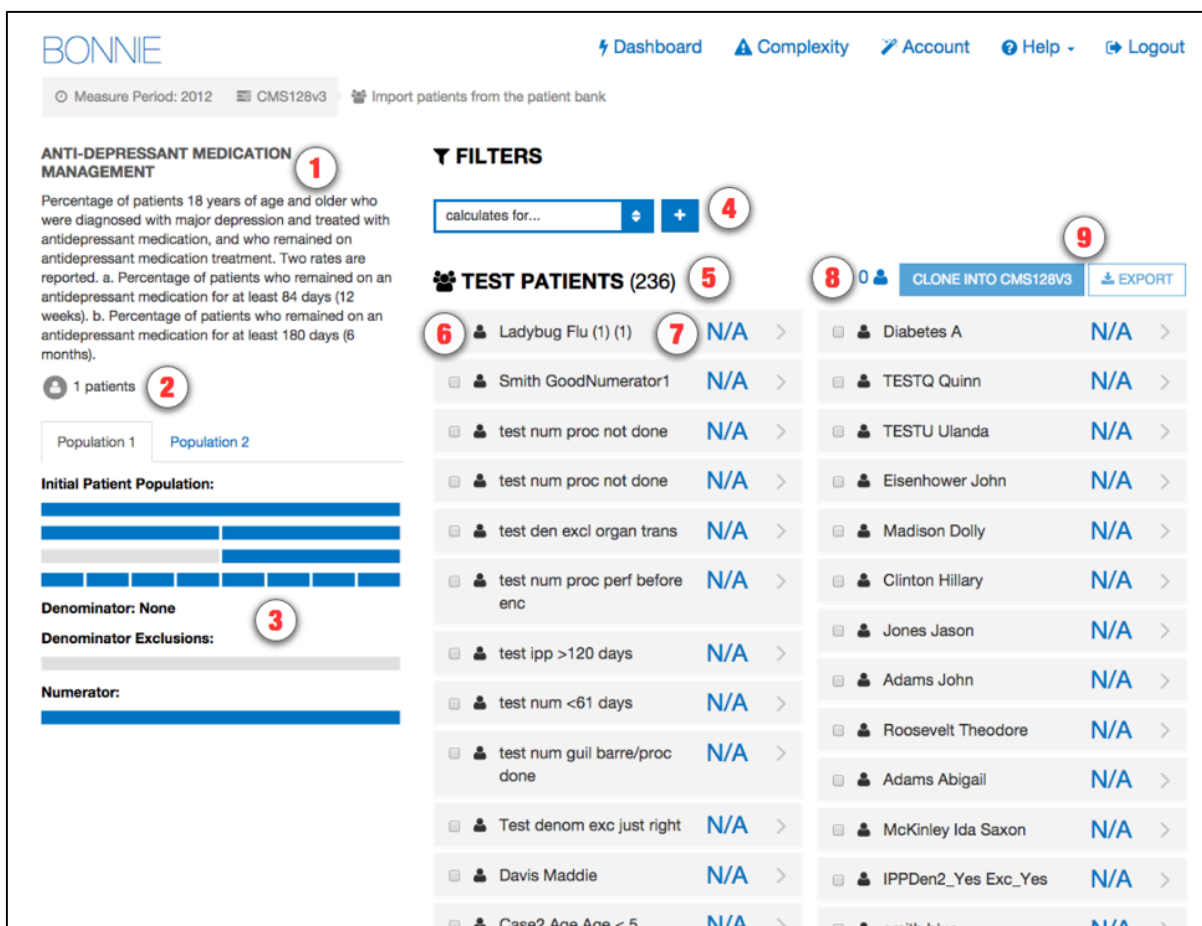


Figure 20: Patient Bank View

Note that the Patient Calculation Result (item #7 in Figure 20) will display “N/A” rather than pass or fail if that patient was constructed for a different measure (i.e., this patient has no expectations set for this measure).

The Patient Indicator will highlight patients already in that measure with an enclosed icon (as shown by the example, “Rockland Johnny”, in Figure 21 (the last patient already belongs to the user)).

<input type="checkbox"/>	O'Tester Jaime	N/A	>
<input type="checkbox"/>	VTE-1 1029 (1)	N/A	>
<input checked="" type="checkbox"/>	Rockland Johnny	PASS	>

Figure 21: Patient Listing Example

## 6.2 Filtering Patient Results

The Patient Bank includes powerful filtering capability to help the user find specific test patients. There is no limit to the number of filters; however, the results returned only contain test patients satisfying **all** the filters applied. It is recommended to set all desired filters before selecting test patients. The user can filter the results by the following:

1. Population – Allows filtering results by whether the patient passes for a selected population for the currently displayed stratification.
2. Measure – Allows filtering results by measure. The user can enter all or part of a measure code (e.g., “CMS142v2” or “142” will both work).
3. Associated User Account – Allows filtering results by user. The user can enter all or part of an email address associated with a Bonnie user account.

**Error! Reference source not found.** shows the Patient Bank filtered by whether the patient passes for the measure’s numerator for the stratification named “Population 1.” This example has one result.

The screenshot displays a web interface for filtering patient results. At the top, there is a section titled "FILTERS" with a downward arrow icon. Below this, a filter is applied: "Population 1: NUMER" with a close icon (x). Underneath, there is a search bar containing "IPP" and a plus icon (+). Below the filters, the section "TEST PATIENTS (1)" is shown with a group icon. To the right of this section are two buttons: "CLONE INTO CMS128V3" and "EXPORT". Below the "TEST PATIENTS" section, a single patient result is listed: "Carter Rosalind" with a checkbox icon to the left and a green "PASS" status with a right arrow to the right.

Figure 22: Example Filter Usage

## 6.3 Using Test Patients

Each test patient result can be expanded to show further details on that patient. Figure 23 shows the patient summary and the calculated results for that patient.

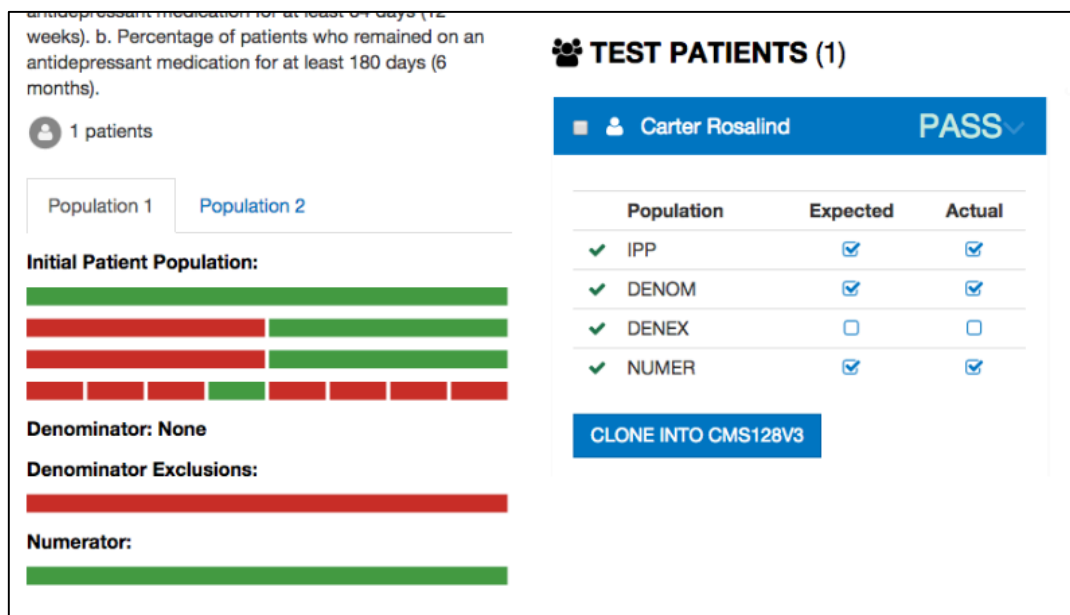


Figure 23: Patient Result Details

When the patient result is expanded, the measure logic view updates to show how the patient meets the data criteria. The patient has data criteria that meet the green lines of logic shown in the measure logic view.

The user can select one or more patients by clicking the checkbox associated with each patient as depicted in Figure 24.

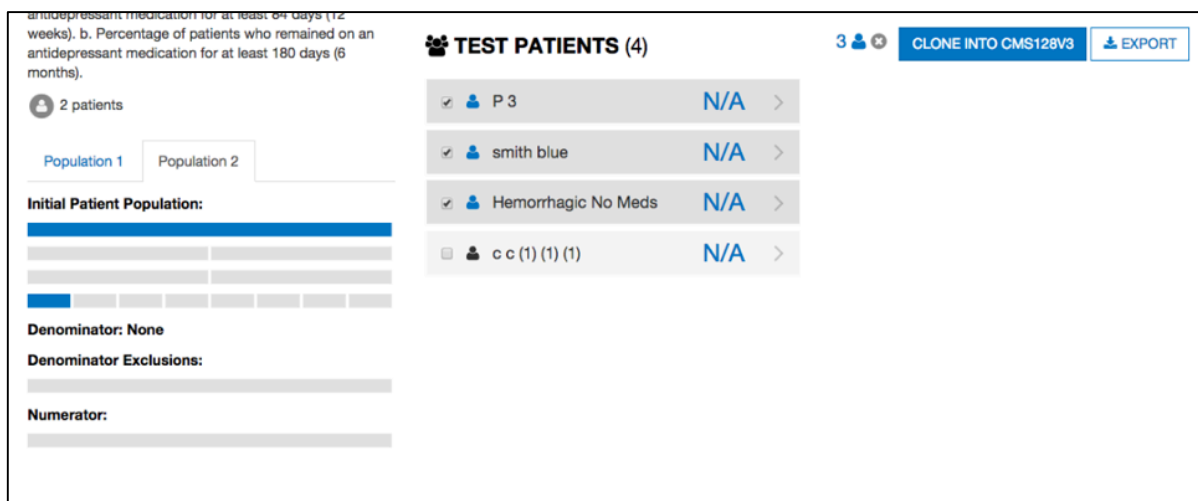


Figure 24: Selected Patients

Selecting patients will highlight those records with a darker background color and a blue icon. The selected patients will also be reflected in the measure logic view at right: the blue sections indicating the sections are measure logic covered by the set of selected patients. The display



shows the number of patients selected; the user can unselect all patients at once by clicking the “x” icon.

Once patients have been selected, the user can either clone these patients into the measure or export these patients in Quality Reporting Document Architecture (QRDA) and Hypertext Markup Language (HTML) formats.

## 7. Additional Tools

Bonnie features additional tools that may be activated on a per-account basis by sending an email to the Bonnie feedback list [bonnie-feedback-list@lists.mitre.org](mailto:bonnie-feedback-list@lists.mitre.org).

### 7.1 Complexity and Change Dashboard

The Complexity and Change Dashboard is available to explore how measures change between releases. Users who have this feature activated can access it from the “Complexity” link on the navigation bar as shown in Figure 25. The initial page invites the user to select two sets of measures for comparison before proceeding. Figure 26 provides a screenshot of the complexity graph produced and Figure 27 shows the complexity grid available from this screen.

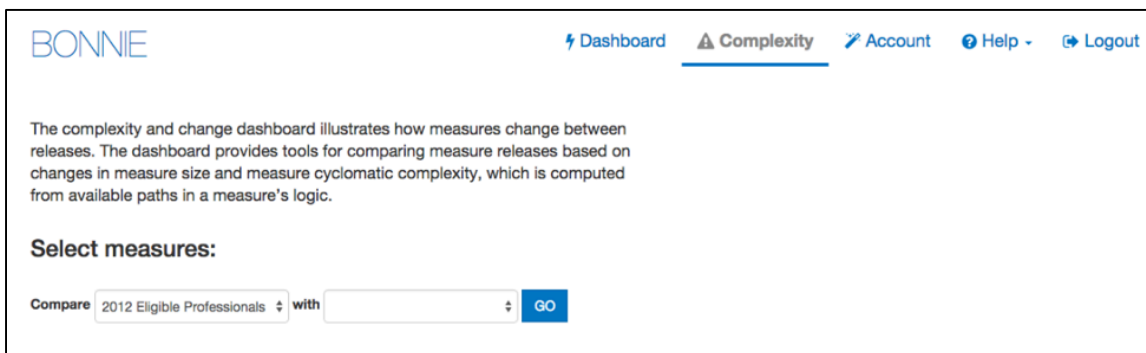


Figure 25: Selecting Sets of Measures to Compare

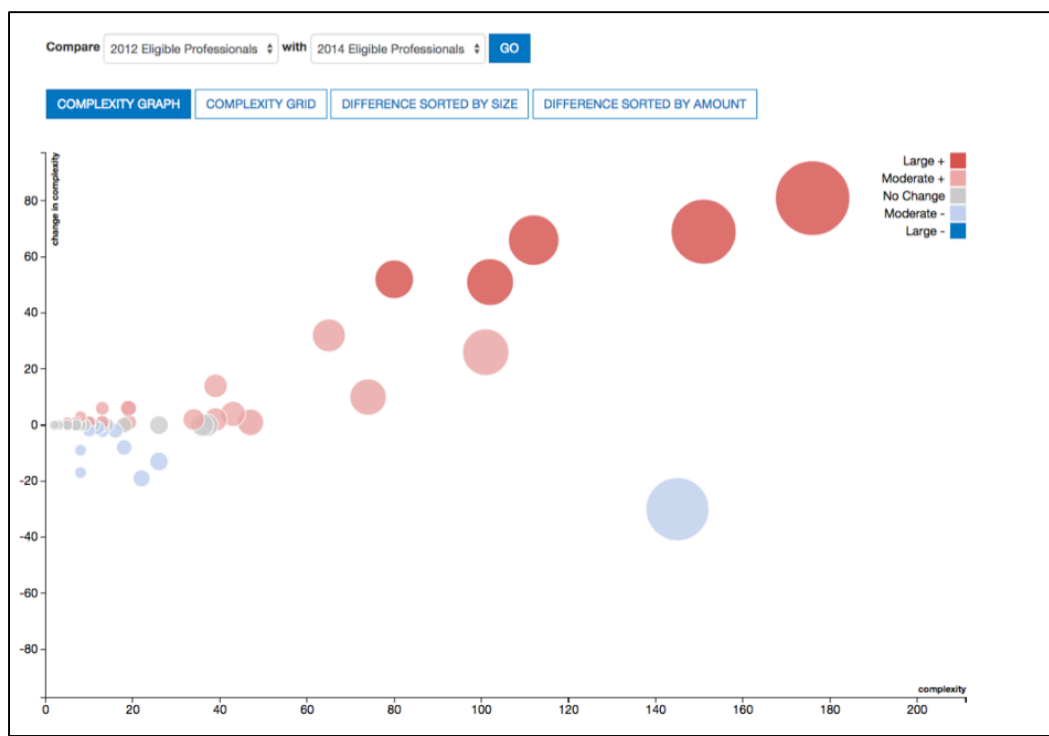


Figure 26: Complexity Graph

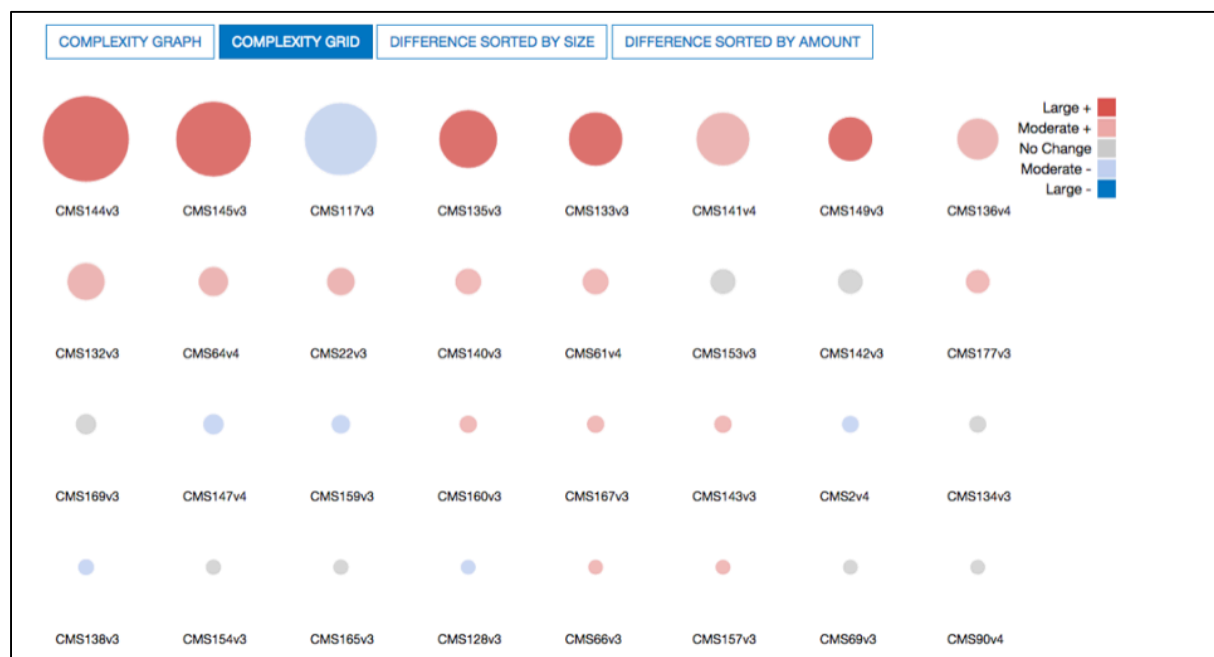


Figure 27: Complexity Grid

On either view, hovering over the circles will show a popup with more details on how that measure has changed. In Figure 28 the measure shows a change from a slightly complex denominator exclusion to a simple one.

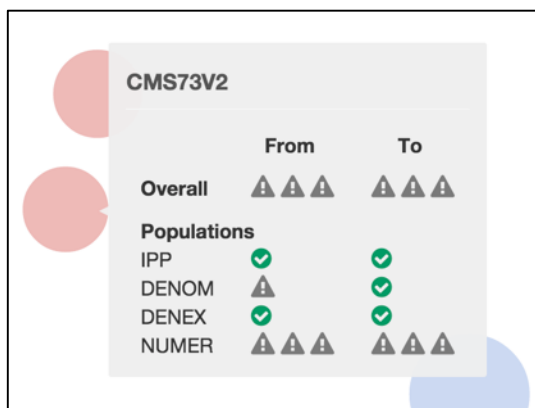


Figure 28: Measure Complexity Change Details

Alternatively, the changes in measures can be viewed more granularly by clicking “Difference Sorted by Size” or “Difference Sorted by Amount.” Each view illustrates a measure as a set of lines and highlights lines that have been added, removed, or unchanged between the two sets. Figure 29 shows the measure difference sorted by size.

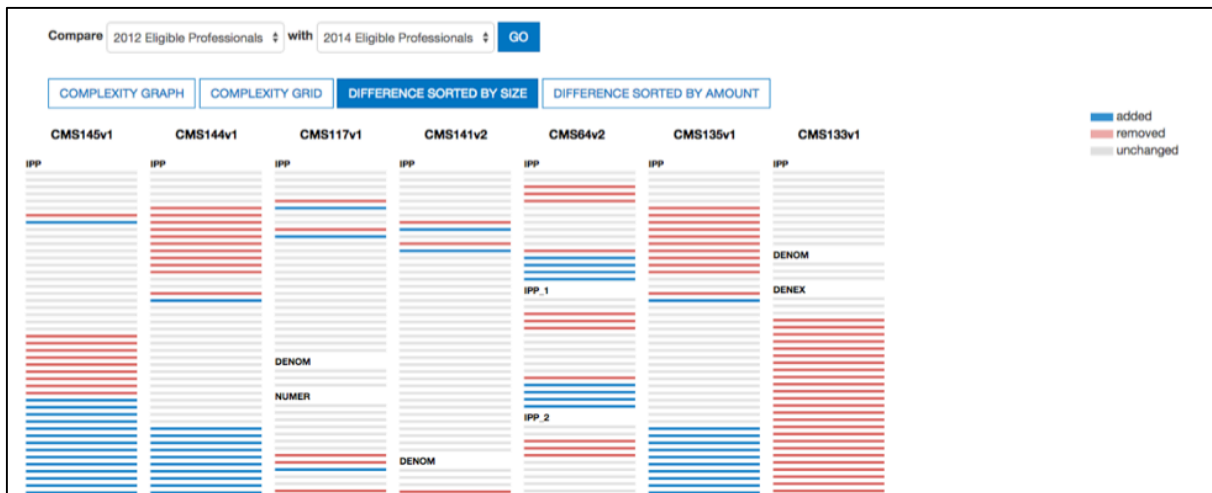


Figure 29: Measure Difference Sorted by Size

## 8. Feedback and Support

An issue tracker and feedback email list are available to support the resolution of issues and to answer questions related to the Bonnie application. The Bonnie issue tracker is available on the ONC Jira system using the following URL: <http://jira.oncprojecttracking.org/browse/BONNIE>

The issue tracker should be used to report bugs encountered when using the Bonnie application, to ask questions, or to request new features. To add an issue, a login account must be created in the Jira system. Once an issue has been entered, the Bonnie team will review and prioritize it. Alternatively, questions can also be addressed to the Bonnie feedback list at [bonnie-feedback-list@lists.mitre.org](mailto:bonnie-feedback-list@lists.mitre.org). The Bonnie feedback list email can be accessed using the “Contact” link in the main Bonnie navigation menu at the top of every page.

In addition to feedback provided through the issue tracker, users may join the Bonnie user group for community support. This group offers the opportunity for Bonnie users to ask and respond to questions about Bonnie and receive feedback from other community members. Bonnie developers will monitor and periodically provide input as well. To join the Bonnie user group, users may click on the “User Group” link on the splash page (**Error! Reference source not found.**) or the User Group option in the Help menu in the application header (**Error! Reference source not found.**).



Figure 30: User Group Link on Bonnie Splash Page

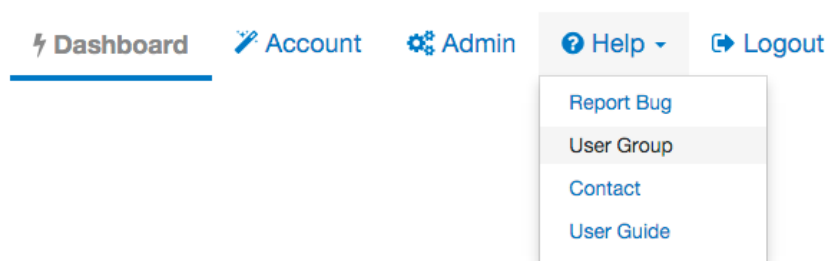


Figure 31: User Group Link in the Application Header

## 9. Frequently Asked Questions

Does Bonnie replace Cypress or is it an alternative to Cypress for certification?

Bonnie is a testing tool for measure developers to test measures as they are being authored, while Cypress is the Meaningful Use certification tool. Bonnie cannot be used for Meaningful Use certification for vendors. Bonnie has been designed to provide insight into the details of how measure logic behaves. This makes it useful to vendors, measure developers, and others in the clinical quality measure space who would like to better understand the behavior of clinical quality measures. The Bonnie testing tool uses the same measure calculation engine as the Cypress tool. Therefore, Bonnie can be used to better understand the behavior of the measures when implementing a measure prior to certification.

Can I export patient records from Bonnie?

Bonnie allows test patients constructed using the tool to be exported in a human-readable (HTML) format and in the QRDA Category 1 format.

Can I load patient records into Bonnie?

Currently, Bonnie does not support loading patient records into the tool. If you would like to calculate clinical quality measures using existing patients, the popHealth tool may be a better solution.

Does Bonnie automatically generate patient records?

Currently, Bonnie does not offer the capability to automatically generate patient records based on the measure logic. The goal of Bonnie is to allow the construction of carefully considered patient scenarios. These synthetic patient records are intended to have an expected result based on the intent of the measure. Automatically generating patient records would generate patients that aligned with the measure logic as written, but they might not align with the intent of the measure if there are issues in the measure logic.

My patient does not match the logic of the Initial Population. Why is the patient passing?

A test in Bonnie is based on assigning an expected outcome to a synthetic patient record based on the intent of the measure. A patient can be constructed with the expectation that the patient calculated is to be included in the Initial Patient Population. If the patient actually calculates to the Initial Patient Population, then the test passes. If the patient does not calculate to the Initial Patient Population, then the test fails.

The patient's alignment with the expectations needs to match exactly. For instance, if the expectation is set for only the Initial Patient Population, and the patient calculates to the Initial Patient Population and the Denominator, the test fails. Similarly, a patient can be constructed with the expectation that the patient does not align with any of the measure populations. In this case, if the patient does not calculate into the initial patient population, the test will pass. If a patient is constructed that has the expectation set that they do not align with any of the measure populations and that patient calculates into the Initial Patient Population, that test will fail.

### Can I use patients that I've built in one measure for another measure?

Bonnie allows patient records built for one measure to be copied to another measure using the Patient Bank. The Patient Bank allows patient records to be copied between measures in the same account or in different accounts. Once a patient test record is copied from one measure to another, modifications to the patient record in one measure will not modify the copied patient record.

### Where can I get help with Bonnie?

The Bonnie application has a Help menu in the header. Once you log into the application, you can use the help menu to send an email to the Bonnie feedback list asking a question directly; access the Bonnie issue tracker to enter a bug, ask a question, or request a feature; and access the user guide that provides step-by-step instructions on using the Bonnie tool.

### What measure formats can I load into the Bonnie tool?

The Bonnie application can currently load Health Quality Measures Format (HQMF) release 1 and release 2. HQMF can either be loaded directly using an HQMF xml file or it can be loaded using a Measure Authoring Tool export zip file containing an HQMF xml file. Bonnie can also load measures defined in the MAT SimpleXML format either directly using the XML file or through a MAT zip file export. Note that when loading a SimpleXML or HQMF file, you will need a National Library of Medicine (NLM) Value Set Authority Center (VSAC) account to download the value sets associated with the measure.

### Do I have to be a measure developer to use the Bonnie tool?

No. Anyone can sign up for a Bonnie account using the register link on the login page.

### Do I need to be a Measure Authoring Tool user to use the Bonnie tool?

Measures can be loaded into the Bonnie tool either by using a Measure Authoring Tool zip file export or by directly loading the measure using HQMF that has been released to the CMS website. Loading measures using a MAT zip file export will require a MAT account to download the export zip; however, if you do not have a MAT account, you can get HQMF files for the released versions of the measures from the electronic Clinical Quality Measures (eCQM) Library page on the CMS website.

### Can Bonnie be used to calculate the results for a large number of patient records?

Bonnie is not designed to handle calculations for more than a few hundred patient records per measure. If you are interested in calculating clinical quality measures against a larger number of patient records, the popHealth tool may be a better solution.

## Acronyms

<b>CMD</b>	Cumulative Medication Duration
<b>CMS</b>	Centers for Medicare & Medicaid Services
<b>CQM</b>	Clinical Quality Measure
<b>eCQM</b>	Electronic Clinical Quality Measure
<b>ED</b>	Emergency Department
<b>EH</b>	Eligible Hospital
<b>EP</b>	Eligible Professional
<b>HHS</b>	Department of Health and Human Services
<b>HQMF</b>	Health Quality Measure Format
<b>HTML</b>	Hypertext Markup Language
<b>MAT</b>	Measure Authoring Tool
<b>MU</b>	Meaningful Use
<b>NLM</b>	National Library of Medicine
<b>ONC</b>	Office of National Coordinator for Health Information Technology
<b>QDM</b>	Quality Data Model
<b>QRDA</b>	Quality Reporting Document Architecture
<b>UI</b>	User Interface
<b>VSAC</b>	Value Set Authority Center
<b>XML</b>	Extensible Markup Language