COMMISSIONER OF SECURITIES & INSURANCE

MONICA J. LINDEEN
COMMISSIONER

OFFICE OF THE MONTANA
STATE AUDITOR

November 2016

Dear Patient-Centered Medical Home:

As a requirement of your qualification in the Montana Patient-Centered Medical Home (PCMH) Program, your clinic must submit a report on the Montana-specific quality metrics identified in administrative rule. The deadline for PCMH practices to submit their report on the uniform set of health care quality and performance measures to the Montana Office of the Commissioner of Securities and Insurance is on or before April 30, 2017. Reports must be created using the reporting instructions and guidance in the attached packet.

Thank you for your participation in the Montana PCMH program. The program is making a difference in patient care in Montana and you are an important part of that ongoing transformation.

Sincerely,

Monica J. Lindeen
Commissioner of Securities and Insurance
Montana State Auditor

Attach: 2017 Quality Metrics Guidance

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PCMH Quality Metrics Guidance Packet

Report Deadline: April 30, 2017

Introduction

Montana PCMHs are required by the Patient-Centered Medical Home Act (Act) to report annually on compliance with a uniform set of healthcare quality and performance metrics. According to Administrative Rule of Montana 6.6.4906-4907, the **annual deadline for quality metric reporting from PCMHs is April 30.** The Administrative Rules of Montana for the Montana PCMH Program can be found here.

Quality Metrics

Montana PCMHs must submit data from calendar year 2016 on at least **four of five** quality metrics: controlling hypertension, tobacco use cessation and intervention, poor A1c control, rate of immunized 2-year-olds, and screening for clinical depression and follow-up plan. PCMHs must use the same metrics as reported in 2015 and 2016. However, a PCMH may report on additional metrics at any time. (A PCMH pediatric practice shall choose at least the child immunization performance measure. Reporting on depression screening is optional for pediatric practices until the 2017 measurement period, for the report due in April 2018. At that time, all pediatric clinics shall report on both the depression and immunization measures.)

The metrics were carefully selected by primary care providers, insurers, and patient advocates because they create a narrow focus in areas that produce data with potential for actionable change that is achievable for all PCMHs. They are reviewed annually for necessary updates. The data reporting instructions are aligned with the CMS electronic Clinical Quality Measure (eCQM) standards. Two options exist for the 2017 report: patient-level data or attested aggregate data. While not required, if your clinic has the capability, please report patient-level data. Research and consultation with national PCMH experts has shown that patient-level data is necessary for accurate and meaningful PCMH evaluation. Please be certain that patient-level data is de-identified.

It is the goal of the Montana PCMH program to collect meaningful data, but not be an administrative burden. That is why we chose performance metrics related to high-cost, chronic diseases which are already reported to other entities. The five measures will track how PCMHs improve the quality of care and health of their patients.

Privacy and Data Usage

Administrative Rules of Montana (ARM) state that the Commissioner may only report to the public aggregate information about quality metrics. Clinic names will not be publically tied to their data. The quality metrics data contributes to the Commissioner's required annual Public Report.

Instructions

Please complete the **(1) Reporting Form** and report the data **in the format prescribed** by the **(2) Quality Metric Reporting Guidance**. If reporting patient-level data (Option 1), refer to the excel spreadsheet template linked here and complete according to the **(3) Patient-Level Reporting Data Elements/Data Dictionary**. **Reports must be submitted through the State of Montana File Transfer Service to Carrie Oser at coser@mt.gov by April 30, 2017.**

ATTACHMENTS: (1) Reporting Form (2) Quality Metric Reporting Guidance (3) Patient-Level Reporting Data Elements (4) State of Montana File Transfer Service Instructions.

ATTACHMENT 1:

2017 Reporting Form for Quality Metrics

(Measurement Period: Calendar Year 2016)

THIS IS A FILLABLE FORM, PLEASE COMPLETE ELECTRONICALLY

PCMH Organization name: _____
(PCMH Name)

PCMH Official providing report: _____, _____
(Name) (Title)

_____, _____
(Phone) (E-mail)

Date report submitted: _ _ / _ _ / _ _ _ _
(Mo/Da/Year)

If the CSI has questions pertaining to the data provided in this report, the data contact person for your organization is: _____, _____,
(Name) (Title)

_____, _____
(Phone) (E-mail)

DATA FROM CALENDAR YEAR 2016
Two options exist for reporting in 2017. Which one are you using?

_____ **Option 1:** A **patient-level data report** with the data elements required from Attachment 3 for each measure, for each patient in the denominator population, provided in a separate electronic file. Also complete the form below.

OR

_____ **Option 2:** An **attested aggregate data report**, using the form below, with data confirmed by the staff in the organization.

You can use the following to report MT PCMH measures for Option 2:

- Meaningful Use Clinical Quality Measure (CQM) reports out of your 2014 or later certified E.H.R for the full reporting period to provide the numerators and denominators for Option 2 for the measures with the corresponding CMS/NQF numbers.

Which report did you use to create the data you are submitting?

_____ Standard Clinical Quality Measure (CQM) report out of your 2014 or later certified EHR
_____ Standard Uniform Data System (UDS) report out of your 2014 or later certified EHR
_____ Customized report out of your 2014 or later certified EHR
_____ Combination of customized reports out of your 2014 or later certified EHR and chart abstraction
_____ Other - Please define: _____
_____ Unsure

Please Note:

- In 2017, a PCMH must use the same metrics as reported in 2015 and 2016. However, a PCMH may report on additional metrics at any time.
- In 2017, for the 2016 measurement period, PCMHs must report on at least four out of five metrics.

The form below is required for BOTH Options 1 and 2. Please fill in the numerator and denominator for at least four of the five metrics.

Metric 1: Controlling High Blood Pressure
MEASURE NUMBERS: CMS 165v4/NQF 0018

1. _____(#): denominator - number of patients 18 through 85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period of calendar year 2016.
2. _____ (#): numerator - number of patients in the denominator whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.

Metric 2: Tobacco Use: Screening and Cessation Intervention
MEASURE NUMBERS: CMS 138v4/NQF 0028

1. _____ (#): denominator - All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period of calendar year 2016.
2. _____ (#): numerator - Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.

Metric 3: Diabetes: Hemoglobin A1c Poor Control
MEASURE NUMBERS: CMS 122v4/NQF 0059

1. _____ (#): denominator – number of patients 18 through 75 years of age who have the diagnosis of diabetes mellitus (type 1 or type 2), and had a visit during the measurement period of calendar year 2016.
2. _____(#): numerator - number of patients in the denominator population whose most recent HbA1c level (performed during the measurement period of calendar year 2016) is > 9.0%

Metric 4: Childhood Immunization Status
MEASURE NUMBERS: CMS117v4/NQF 0038

PLEASE NOTE: Patients with a medical contraindication to any immunization should be excluded from (1). Patients who refused an immunization should be included in (1).

1. _____ (#): denominator - Children who turn 2 years of age during the measurement period and who have a visit during the measurement period of calendar year 2016.
2. Numerators – Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday.

NUMERATORS

	4 DTAP
	3 polio
	1 MMR
	3 Hib
	3 HepB
	1 VZV
	4 PCV
	1 HepA
	2 or 3 RV
	2 Flu

3. _____number of children meeting criteria '1' who received all of the following: 4 doses of DTaP, 3 doses of HepB, 3 doses of Hib, 3 doses of IPV, 1 dose of MMR, 4 doses of PCV, 1 dose of VZV, 1 dose of HepA, 2 or 3 doses of RV, and 2 Flu vaccines.

Metric 5: Screening for Clinical Depression and Follow-up Plan
MEASURE NUMBERS: CMS 2v5/NQF 0418

1. _____ (#): denominator - all patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period of calendar year 2016.
2. _____ (#): numerator - patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen.

ATTACHMENT 2:

2017 Quality Metric Reporting Guidance

(Measurement Period: Calendar Year 2016)

Please Note:

- **A PCMH must use the same metrics as reported in 2015 and 2016. However, a PCMH may report on additional metrics at any time.**
- **In 2017, for the 2016 measurement period, PCMHs must report on <u>four out of five metrics</u>.**
- **The following instructions apply to both patient-level (option 1) and attested aggregate (option 2) data reporting.**

METRIC: Controlling High Blood Pressure
MEASURE NUMBERS: CMS 165v4/NQF 0018

- Click here to visit the CMS eCQM webpage for CMS 165v4
- Click here for a flow chart showing how to pull the patient population for the numerator and denominator.

DESCRIPTION:
Percentage of patients 18 through 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mmHg) and who had a visit during the measurement period of calendar year 2016.

DENOMINATOR (D#): Patients 18 through 85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period of calendar year 2016.

Denominator Criteria (Eligible Cases):
Patients 18 through 85 years of age on date of encounter.
<u>AND</u>
Diagnosis for hypertension (ICD-10-CM) [for use 10/01/2015-12/31/2015]: I10
<u>AND</u>
Encounter during reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, G0402, G0438, G0439, 99385, 99386, 99387, 99395, 99396, 99397

Denominator Exclusions: Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period.

NUMERATOR (N#): Patients whose most recent blood pressure was adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period of calendar year 2016.

GUIDANCE:

In reference to the numerator element, only blood pressure readings performed by a clinician in the provider office are acceptable for numerator compliance with this measure. Blood pressure readings from the patient's home (including readings directly from monitoring devices) are not acceptable.
If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed *not controlled*.

REPORT: (D#) and (N#), and the date of assessment. If reporting patient-level data (option 1), the excel data file must include the variables specified in Attachment 3.

* *

METRIC: Tobacco Use: Screening and Cessation Intervention
MEASURE NUMBERS: CMS 138v4/NQF 0028

- Click here to visit the CMS eCQM webpage for CMS 138v4
- Click here for a flow chart showing how to pull the patient population for the numerator and the denominator.

DESCRIPTION:
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months **AND** who received cessation counseling intervention if identified as a tobacco user.

DENOMINATOR (D#): All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period of calendar year 2016.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter.
AND
Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99406, 99407, G0438, G0439, 99385, 99386, 99387, 99395, 99396, 99397

Denominator Exceptions: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy or other medical reason).

NUMERATOR (N#): Patients who were screened for tobacco use at least once within 24 months **AND** who received tobacco cessation counseling intervention if identified as a tobacco user.

GUIDANCE: If a patient uses any type of tobacco (ie, smokes or uses smokeless tobacco), the expectation is that they should receive tobacco cessation intervention: either counseling and/or pharmacotherapy.

If tobacco use status of a patient is unknown, the patient does not meet the screening component required to be counted in the numerator and should be considered a measure failure. Instances where tobacco use status is unknown include: 1) the patient was not screened; or 2) the patient was screened and the patient (or caregiver) was unable to provide a definitive answer. If the patient does not meet

the screening component of the numerator but has an allowable medical exception, then the patient should be removed from the denominator of the measure and reported as a valid exception.

Exceptions only apply to the screening data element of the measure; once a patient has been screened, there are no allowable exceptions for not providing the intervention

REPORT: (D#) and (N#), and the date of assessment. If reporting patient-level data (option 1), the excel file must include the variables specified in Attachment 3.

* *

METRIC: Diabetes: Hemoglobin A1c Poor Control
MEASURE NUMBERS: CMS 122v4/NQF 0059

- Click here to visit the CMS eCQM webpage for CMS 122v4
- Click here for a flow chart showing how to pull the patient population for the numerator and the denominator.

DESCRIPTION:
Percentage of patients 18 through 75 years of age with diabetes who had hemoglobin A1c > 9.0% and had a visit during the measurement period of calendar year 2016.

DENOMINATOR (D#): Patients 18 through 75 years of age who have the diagnosis of diabetes mellitus (type 1 or type 2), and had a visit during the measurement period of calendar year 2016.

Denominator Criteria (Eligible Cases):
Patients 18 through 75 years of age on date of encounter.
AND
Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2015-12/31/2015]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13
AND
Patient encounter during reporting period (CPT or HCPCS): 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211,99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271, G0402, G0438, G0439, 99385, 99386, 99387, 99395, 99396, 99397

NUMERATOR (N#): Patients whose most recent HbA1c level (performed during the measurement period) is > 9.0%.

GUIDANCE: Patient is numerator compliant if most recent HbA1c level >9%, the most recent HbA1c result is missing, or if there are no HbA1c tests performed and results documented during the measurement period.

Only patients with a diagnosis of type 1 or type 2 diabetes should be included in the denominator of this measure; patients with a diagnosis of secondary diabetes due to another condition should not be included.

REPORT: (D#) and (N#), and the date of assessment. If reporting patient-level data (option 1), the excel file must include the variables specified on Attachment 3.

Note: If A1c is not documented during the measurement period, then A1c is *not controlled* for this measure.

* *

METRIC: Childhood Immunization Status
MEASURE NUMBERS: CMS 117v4/NQF 0038

- Click here to visit the CMS eCQM webpage for CMS 117v4
- Click here for a flow chart showing how to pull the patient population for the numerator and the denominator for each immunization.

DESCRIPTION:
Percentage of children 2 years of age who had the following **by their second birthday**:

- four diphtheria, tetanus and acellular pertussis (DTaP);
- three polio (IPV),
- one measles, mumps and rubella (MMR);
- three H influenza type B (HiB);
- three hepatitis B (Hep B);
- one chicken pox (VZV);
- four pneumococcal conjugate (PCV);
- one hepatitis A (Hep A);
- two or three rotavirus (RV);
- and two influenza (flu) vaccines**.**

DENOMINATOR (D#): Children who turn 2 years of age during the measurement period and who have a visit during the measurement period of calendar year 2016.

Denominator criteria:
A patient with a documented "medical contraindication" to any immunizations is *excluded* from the denominator; a patient who "refused" any immunization is *included* in the denominator.

Patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99381, 99382, 99383, 99384, 99391, 99392, 99393, 99394

NUMERATOR (N#): Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday.

GUIDANCE:
MMR, hepatitis B, VZV and hepatitis A numerator criteria:

- evidence of receipt of the recommended vaccine;
- documented history of the illness;
- or, a seropositive test result for the antigen.

DTaP, IPV, HiB, pneumococcal conjugate, rotavirus, and influenza numerator criteria:

- only evidence of receipt of the recommended vaccine.

Patient Exceptions:

- Patients may be excepted from a particular antigen if they had an anaphylactic reaction to the vaccine;
- Patients may be excepted from the **DTaP** vaccine if they have encephalopathy;
- Patients may be excepted from the **IPV** vaccine if they have had an anaphylactic reaction to streptomycin, polymyxin B, or neomycin;
- Patients may be excepted from the **influenza** vaccines if they have cancer of lymphoreticular or histiocytic tissue, multiple myeloma, leukemia, or have had an anaphylactic reaction to neomycin;
- Patients may be excepted from the **MMR or VZV** vaccines if they have cancer of lymphoreticular or histiocytic tissue, multiple myeloma, leukemia, or have had an anaphylactic reaction to neomycin;
- Patients may be excepted from the **hepatitis B** vaccine if they have had an anaphylactic reaction to common baker's yeast.

The measure allows a grace period by measuring compliance with these recommendations between birth and age two.

REPORT: (D#) and (N#), and the date of the assessment. If reporting patient-level data (option 1), the excel file must include the variables specified in Attachment 3.

Immunizations for children aged 2 years:

4 DTAP

3 Polio

1 MMR

3 Hib

3 Hep B

1 VZV

4 PCV

1 Hep A

2 or 3 RV

2 Flu

* *

METRIC: Screening for Clinical Depression and Follow-Up Plan
MEASURE NUMBERS: CMS 2v5/NQF 0418

- Click here to visit the CMS eCQM webpage for CMS 2v5
- Click here for a flow chart showing how to pull the patient population for the numerator and the denominator.

DESCRIPTION:
Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool **AND** if positive, a follow-up plan is documented on the date of the positive screen.

DENOMINATOR (D#): All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period of calendar year 2016.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 12 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 92625, 96116, 96118, 96150, 96151, 97003, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0101, G0402, G0438, G0439, G0444, 99384, 99385, 99386, 99387, 99395, 99396, 99397

Denominator Exclusions: Patients with an active diagnosis for Depression or a diagnosis of Bipolar Disorder.

Denominator Exceptions:

a) Patient Reason(s): Patient refuses to participate;

OR

b) Medical Reason(s): Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status;

OR

c) Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium.

NUMERATOR (N#): Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool **AND**, if positive, a follow-up plan is documented on the date of the positive screen.

GUIDANCE:
A clinical depression screen is completed on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.

Screening Tools: The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record. The depression screening must be reviewed and addressed in the office of the provider, filing the code, on the date of the encounter. The screening and encounter must occur on the same date. Standardized Depression Screening Tools should be normalized and validated for the age appropriate patient population in which they are used and must be documented in the medical record.

Follow-Up Plan: The follow-up plan must be related to a positive depression screening, example: Patient referred for psychiatric evaluation due to positive depression screening.

REPORT: (D#) and (N#), and the date of the assessment. If reporting patient-level data (option 1), the excel file must include the variables specified in Attachment 3.

ATTACHMENT 3:
2017 Patient-Level Reporting
REQUIRED Data Elements + Data Dictionary

METRIC	NAME	DEFINITION	WIDTH	TYPE	VALUE/FORMAT
Controlling High Blood Pressure	Patient ID	Patient ID	15	Numeric/String	XXXXXXXXXXXXXXX
	Sex	Sex	1	String	M (Male) F (Female)
	DOB	Date of Birth	10	Date	MM/DD/YYYY
	Date_BP	Date of the most recent blood pressure measure	10	Date	MM/DD/YYYY
	SBP	Systolic blood pressure measure (mmHg)	3	Numeric	xxx
	DBP	Diastolic blood pressure measure (mmHg)	3	Numeric	xxx
Tobacco use screening and cessation intervention	Patient ID	Patient ID	15	Numeric/String	XXXXXXXXXXXXXXX
	Sex	Sex	1	String	M (Male) F (Female)
	DOB	Date of Birth	10	Date	MM/DD/YYYY
	TUS	Current tobacco user	1	String	Y (Yes) N (No)
	TUCI	If tobacco user, cessation intervention	1	String	Y (Yes) N (No)
	Date_TCI	Date of cessation intervention	10	Date	MM/DD/YYYY
Diabetes Hemoglobin A1c poor control	Patient ID	Patient ID	15	Numeric/String	XXXXXXXXXXXXXXX
	Sex	Sex	1	String	M (Male) F (Female)
	DOB	Date of Birth	10	Date	MM/DD/YYYY
	Date_A1c	Date A1c measured	10	Date	MM/DD/YYYY
	A1c	A1c level (%)	4	Numeric	xx.x

METRIC	NAME	DEFINITION	WIDTH	TYPE	VALUE/FORMAT
Childhood Immunization Status	Patient ID	Patient ID	15	Numeric/String	XXXXXXXXXXXXXXX
	DOB	Date of Birth	10	Date	MM/DD/YYYY
	Date last DTAP was administered	Date immunization was administered	10	Date	MM/DD/YYYY
	4DTAP	All 4 doses administered	2	String	Y (Yes) N (No) MC (Medically contra indicated) R (Refusal to be vaccinated)
	Date last polio was administered	Date immunization was administered	10	Date	MM/DD/YYYY
	3Polio	All 3 doses administered	2	String	Y (Yes) N (No) MC (Medically contra indicated) R (Refusal to be vaccinated)
	Date MMR was administered	Date immunization was administered	10	Date	MM/DD/YYYY
	1MMR	1 dose administered	2	String	Y (Yes) N (No) MC (Medically contra indicated) R (Refusal to be vaccinated)
	Date last Hib was administered	Date immunization was administered	10	Date	MM/DD/YYYY
	3Hib	All 3 doses administered	2	String	Y (Yes) N (No) MC (Medically contra indicated) R (Refusal to be vaccinated)
	Date last HepB was administered	Date immunization was administered	10	Date	MM/DD/YYYY
	3HepB	All 3 doses administered	2	String	Y (Yes) N (No) MC (Medically contra indicated) R (Refusal to be vaccinated)
	Date Var was administered	Date immunization was administered	10	Date	MM/DD/YYYY
	1Var	1 dose administered	2	String	Y (Yes) N (No) MC (Medically contra indicated) R (Refusal to be vaccinated)

METRIC	NAME	DEFINITION	WIDTH	TYPE	VALUE/FORMAT
Childhood immunization (cont.)	Date last PCV was administered	Date immunization was administered	10	Date	MM/DD/YYYY
	4PCV	All 4 doses administered	2	String	Y (Yes) N (No) MC (Medically contra indicated) R(Refusal to be vaccinated)
	Date Hep A was administered	Date immunization was administered	10	Date	MM/DD/YYYY
	1 Hep A	1 dose administered	2	String	Y (Yes) N (No) MC (Medically contra indicated) R(Refusal to be vaccinated)
	Date last RV was administered	Date immunization was administered	10	Date	MM/DD/YYYY
	2 or 3 RV	2 or 3 doses administered	2	String	Y (Yes) N (No) MC (Medically contra indicated) R(Refusal to be vaccinated)
	Date last Flu was administered	Date immunization was administered	10	Date	MM/DD/YYYY
	2 Flu	2 doses administered	2	String	Y (Yes) N (No) MC (Medically contra indicated) R(Refusal to be vaccinated)
Screening for Clinical Depression and Follow-Up Plan	Patient ID	Patient ID	15	Numeric/String	XXXXXXXXXXXXXXX
	Sex	Sex	1	String	M (Male) F (Female)
	DOB	Date of Birth	10	Date	MM/DD/YYYY
	Screening	Was the patient screened for depression?	2	String	Y (Yes) N (No) NA (met criteria to be excluded from screening)
	Date_PSN	Date of screening	10	Date	MM/DD/YYYY
	PSN	Was the screening positive?	2	String	Y (Yes) N (No) NA (was not screened for depression)
	FUP	Follow-up plan documented on the date of the positive screen.	2	String	Y (Yes) N (No) NA (was not screened for depression or did not screen positive)

ATTACHMENT 4
The State of Montana File Transfer Service Instructions

The State of Montana's File Transfer Service allows for easy, secure transfer of large electronic files to and from customers of state government. Access the File Transfer Service at this web address: https://transfer.mt.gov. To become a registered ePass Montana customer you must create an ePass Montana account.

The transfer service only requires a web browser and all aspects are securely encrypted, ensuring that customers meet all security requirements under state and federal information privacy regulations. An automated reminder system notifies the recipient of files they have available for download, and the system tracks receipts for all transfers, showing detailed information about when a file is uploaded as well as when it is downloaded. Customers can upload files as large as can be transferred in one hour, or 2GB, whichever is less. Files must be downloaded within fifteen days, after which the transfer expires and the files are automatically removed from the service.

Creating an Account

If you do not yet have an ePass Montana account, then you must create one. Create an ePass Montana account.

1. Click the Login button to Login with ePass Montana.
2. Click on the Create an Account button.
3. Enter the required personal, contact, and login information on the form.
4. Add File Transfer Service to your new ePass Montana account
    1. Enter the code that was emailed to you
    2. Submit
    3. Now you are able to login using your ePass Montana username and password

Logging In

ePass Montana Customers - Enter your ePass Montana username and password to login.

Inbox Management

After logging in, you will be able to view your sent and received files. Also, you will see the options to send files or view the received transfers. If you wish to sort the sent or received files by name, file, date, or status, then simply click (ascending) or double click (descending) the column label in the title bar. To delete files, you must check the box(es) to the left of the file(s) and then select the "Delete Selected Files" button at the bottom of the page.

File Transfer Status

Following are the status definitions for files transferred:

- **Processing File:** This will occur immediately after the file is uploaded. The file is migrated to the server and waiting for a virus scan.
- **Incomplete - Select Recipients:** The file has been moved onto the server, but it doesn't have a recipient available to download the file. To Add a recipient, select the file name and you will then be able to add recipients to the file.
- **In Transit:** The file is in the process of being moved to another server.
- **Scanning for Viruses:** The file is being scanned for viruses. If a virus is found, you will be notified through email and the file will be immediately removed from the server. It will not be available for download.
- **Complete:** The file has resided on the server for the maximum of 15 days and has been removed. The file can no longer be downloaded.
- **Ready for Download:** The file has been scanned for viruses and is ready for the recipients to download.

Sending Files

1. To send a file you must select the link “Send a new file or files”.
2. Browse to the file you would like to send, and then select “+ Add to File List”. If you would like to add more files, then browse again and select “+ Add to File List”.
3. To remove a file, select the one that you wish to remove and select “- Remove from File List”.
4. When satisfied with file selection(s), continue.
5. Select the recipient(s) of the files either a State Employee, ePass Montana Customer, or Previous Recipient.
    1. You can add a state employee by using lookup or giving their full email address then select “+ Add to Recipient List”.
    2. You can add an ePass Montana Customer by giving their full email address and then select “+ Add to Recipient List”.
    3. You can add a Previous Recipient by selecting the name and selecting “+ Add to Recipient List”.
    4. To remove a recipient, select the one that you wish to remove and select “- Remove from Recipient List”.
    5. At the bottom of the page, you can enter a message to send with the file(s).
    6. Send.
6. A receipt containing the recipient(s) and the file(s) that you sent will appear. You can print the receipt, or go to the home page.

Receiving File(s)

1. To view the received file(s), select either the Received tab or select “View a List of Received Transfers”.
2. When the status says it is “Ready to Download”, select the file that you wish to download.
3. To download, select the “Download File” button, and then open or save the file.