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PCMH Quality Metrics
Guidance Packet
Report Deadline: March 31, 2016

Introduction

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 New Rule I, Mar. Notice 6-211, the **deadline for quality metric reporting from PCMHs is March 31.** The PCMH administrative rules are posted on the CSI website at http://www.csi.mt.gov/medicalhomes/index.asp.

Quality Metrics

PCMHs must submit data from calendar year 2015 on at least three of five quality metrics: hypertension, tobacco use and intervention, A1C control, depression screening and childhood immunizations. (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 March 2018. At that time, all pediatric clinics shall report on both the depression and immunization measures.) These 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. The data reporting instructions are aligned with the federal Physician Quality Reporting System (PQRS), except for childhood immunizations which is aligned with the CDC's National Immunization Survey. Two options exist for the 2016 report: patient-level data or attested aggregate data. Please be certain that patient-level data is de-identified. Research and consultation with national PCMH experts has shown that patient-level data is necessary for accurate and meaningful PCMH evaluation. **Therefore, f*or the 2017 report on data from calendar year 2016, all practices must report patient-level data.***

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, and already reported to other entities. The five measures will track how PCMHs improve the quality of care and health of their patients.

Privacy/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 metric data will contribute to a required Annual Report. The Annual Reports will contribute to a report to the legislature in August 2016 and also to serve as an ongoing measure of the success of the program in supporting primary care healthcare providers and improving patient care.

Instructions

Please complete the (1) Data Reporting Form and report the data **in the format prescribed** by the (2) Quality Metric Reporting Guidance. See the example excel spreadsheet for patient-level data linked here. Use all patients to report patient-level data. Reports must be submitted through the State of Montana File Transfer Service to Carrie Oser, at

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

coser@mt.gov by March 31, 2016.

ATTACHMENT 1

2016 Reporting Form for Quality Metrics
(Measurement Period: Calendar Year 2015)

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 2015
Two options exist for reporting in 2016. Which one of these options are you using?

_____ **Option 1:** A **patient-level data report** with the data elements required from the table in Attachment 3 for each measure, for each patient, 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 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.

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Please Note:

- ***In both 2016 and 2017, a PCMH must use the same metrics as reported in 2015. However, a PCMH may report on additional metrics at any time.***
- ***In 2017, for the 2016 measurement period, reporting requirements will change from three out of five to four out of five metrics.***
- ***Also in 2017, for the 2016 measurement period, patient-level data will be required.***

The form below is required for BOTH Options 1 and 2.

Metric 1: Controlling High Blood Pressure
MEASURE NUMBERS: CMS 165v3/NQF 0018/PQRS 236

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.
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 138v3/NQF 0028/PQRS 226

1. _____ (#): denominator - total number of patients aged 18 years and older who had a visit during the measurement period of calendar year 2015.
2. _____ (#): numerator - total number of patients in the denominator population 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.

Metric 3: Diabetes: Hemoglobin A1c Poor Control
MEASURE NUMBERS: CMS 122V3/NQF 0059/PQRS 001

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 2015.
2. _____(#) : numerator - number of patients in the denominator population whose most recent HbA1c level (performed during the measurement period of calendar year 2015) is > 9.0%

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Metric 4: Rate of Fully-immunized 3 year old children
MEASURE NUMBERS: N/A (HRSA Quality of Care Measure)

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

a. Number of children in the PCMH patient population aged 36 months by January 1, 2016 =____
b. Number of children meeting criteria 'a' who received ≥4 doses of DTaP = ____
c. Number of children meeting criteria 'a' who received ≥3 doses of HepB = ____
d. Number of children meeting criteria 'a' who received ≥3 doses of Hib =____
e. Number of children meeting criteria 'a' who received ≥3 doses of IPV =____
f. Number of children meeting criteria 'a' who received ≥1 dose of MMR =____
g. Number of children meeting criteria 'a' who received ≥4 doses of PCV =____
h. Number of children meeting criteria 'a' who received ≥1 dose of VAR =____
i. Number of children meeting criteria 'a' 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, and ≥1 dose of VAR = ____

Metric 5: Screening for Clinical Depression and Follow-up Plan
MEASURE NUMBERS: CMS 2V4/NQF 0418/PQRS 134

PLEASE NOTE: Reporting on depression screening in 2016 is optional, but highly encouraged. Reporting requirements in 2017 will change to four out of five metrics. CSI appreciates clinics willing to optionally submit depression screening data now, in preparation for next year.

1. _____(#): denominator - all patients aged 12 years and older in the entire clinic population with a visit during the measurement period.
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.

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ATTACHMENT 2

2016 Quality Metric Reporting Guidance

(Measurement Period: Calendar Year 2015)

Please Note:

- ***In both 2016 and 2017, a PCMH must use the same metrics as reported in 2015. However, a PCMH may report on additional metrics at any time.***
- ***In 2017, for the 2016 reporting period, reporting requirements will change from 3 out of 5 to 4 out of 5 metrics.***
- ***Also in 2017, for the 2016 reporting period, patient-level data will be required.***
- ***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 165v3/NQF 0018/PQRS 236

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 2015.

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with hypertension seen during the reporting period. The performance period for this measure is 12 months. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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. Do not include blood pressure readings that meet the following criteria:

- Blood pressure readings from the patient's home (including readings directly from monitoring devices).
- Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole).
- Obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy).

Note: If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled."

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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 2015.

> **Denominator Criteria (Eligible Cases):**
> Patients 18 through 85 years of age on date of encounter
> **AND**
> **Diagnosis for hypertension (ICD-9-CM) [for use 01/01/2015-09/30/2015]:** 401.0, 401.1, 401.9
> **Diagnosis for hypertension (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** I10
> **AND**
> **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**
>
> *Please Note: The bolded codes are NOT in a standard PQRS report and are new to the MT PCMH Program report in March 2016.*

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 2015.

> **Numerator Instructions:** To describe both systolic and diastolic blood pressure values, **each must be reported separately**. If there are multiple blood pressures on the same date of service, use the lowest systolic and lowest diastolic blood pressure on that date as the representative blood pressure.

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 the table in Attachment 3.

Exclusions: Documentation of end stage renal disease (ESRD), dialysis, renal transplant or pregnancy.

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METRIC: Tobacco Use: Screening and Cessation Intervention
MEASURE NUMBERS: CMS 138v3/NQF 0028/PQRS 226

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.

INSTRUCTIONS:
This measure is to be reported **once per reporting period** for patients seen during the reporting period. This measure is intended to reflect the quality of services provided for preventive screening for tobacco use.

DENOMINATOR (D#): All patients aged 18 years and older who had a visit during the measurement period of calendar year 2015.

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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**

Please Note: The bolded codes are NOT in a standard PQRS report and are new to the MT PCMH Program report in March 2016.

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.

Definitions:
Tobacco Use – Includes use of any type of tobacco.
Cessation Counseling Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy.

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 the table on Attachment 3.

Exclusions: Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reasons)

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METRIC: Diabetes: Hemoglobin A1C Poor Control
MEASURE NUMBERS: CMS 122V3/NQF 0059/PQRS 001

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 2015.

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients with diabetes seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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 2015.

Denominator Criteria (Eligible Cases):
Patients 18 through 75 years of age on date of encounter.
AND
Diagnosis for diabetes (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62,

250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

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**

Please Note: The bolded codes are NOT in a standard PQRS report and are new to the MT PCMH Program report in March 2016.

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

Numerator Instructions: Report all patients with diabetes that had an HbA1c test during the measurement period with an HbA1c level > 9.0% and all patients with diabetes that did not have an HbA1c test during the measurement period. A lower calculated performance rate for this measure indicates better clinical care or control.

Patient is included in the numerator if:

a. most recent HbA1c level > 9.0%
b. is missing a result
c. if an HbA1c test was not done during the measurement period.

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 the table on Attachment 3.

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

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METRIC: Rate of Fully Immunized 3 year old children

DESCRIPTION:
Percentage of children with their 3rd birthday during the measurement period of calendar year 2015 who were fully immunized before their 3rd birthday.

DENOMINATOR (D#): Number of children who had their 3rd birthday and at least one medical visit during the reporting period calendar year 2015.

> **Denominator criteria:**
> A patient is excluded from the denominator if they have a documented "medical contraindication" to any immunizations. Patients who "refused" any immunization are 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#): Number of children among those included in the denominator who were fully immunized before their 3rd birthday; a child is fully immunized if s/he has been vaccinated or there is documented evidence of contraindication for the vaccine or a history of illness for ALL of the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1VZV (Varicella), and 4 Pneumococcal conjugate, prior to her/his third birthday. Also include number of children included in the denominator who received each of the vaccine series; number who received 4 DTP/DTaP, number who received 3 IPV, etc.

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 the table on Attachment 3.

Note: If there is documentation that a child has a medical contraindication (MC) for an immunization, or that the immunization was offered but refused (R), you may report the number with MC or R.

Immunizations for children aged 3 years:

4 DTAP

3 Polio

1 MMR

3 Hib

3 Hep B

1 Var

4 PCV

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METRIC: Screening for Clinical Depression and Follow-Up Plan
MEASURE NUMBERS: CMS 2V4/NQF 0418/PQRS 134

PLEASE NOTE: Reporting on depression screening in 2016 is optional, but highly encouraged. Reporting requirements in 2017 will change to four out of five metrics. CSI appreciates clinics willing to optionally submit depression screening data now, in preparation for next year.

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.

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients seen during the reporting period. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. The follow-up plan must be related to a positive depression screening, example: "Patient referred for psychiatric evaluation due to positive depression screening."

DENOMINATOR (D#): All patients aged 12 years and older in the entire clinic population with a visit during the measurement period.

Patients Not Eligible/Exclusions – A patient is not eligible for this metric and may be excluded if one or more of the following conditions are documented:

- **Patient has an active diagnosis of Depression**
- **Patient has an active diagnosis of Bipolar Disorder**
- Patient refuses to participate
- 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
- 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

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**

Please Note: The bolded codes are NOT in a standard PQRS report and are new to the MT PCMH Program report in March 2016.

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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.

> **Numerator Instructions:** 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.

Definitions:

Screening – Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record.

Examples of depression screening tools include but are not limited to:

- **Adolescent Screening Tools (12-17 years)** Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), and PRIME MD-PHQ2
- **Adult Screening Tools (18 years and older)** Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS),Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD-PHQ2

Follow-Up Plan – Documented follow-up for a positive depression screening ***must*** include one or more of the following:

- Additional evaluation for depression
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

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.

Please Note: If a screening for clinical depression is documented as negative, a follow-up plan is not required.

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ATTACHMENT 3:

2016 Patient-Level Reporting
REQUIRED Data Elements + Data Dictionary

METRIC	NAME	DEFINITION	WIDTH	TYPE	VALUE/FORMAT
Controlling High Blood Pressure Adults aged 18 through 85 with a DX of hypertension	Patient_ID	Patient ID	15	Numeric/String	XXXXXXXXXXXXXXX
	Sex	Sex	1	String	M (Male) F (Female)
	DOB	Date of Birth	8	Numeric	MMDDYYYY
	Date_BP	Date of the most recent blood pressure measure	8	Numeric	MMDDYYYY
	SBP	Systolic blood pressure measure (mmHg)	3	Numeric	xxx
	DBP	Diastolic blood pressure measure (mmHg)	3	Numeric	xxx
Tobacco use screening and cessation intervention Adults aged 18 and older	Patient_ID	Patient ID	15	Numeric/String	XXXXXXXXXXXXXXX
	Sex	Sex	1	String	M (Male) F (Female)
	DOB	Date of Birth	8	Numeric	MMDDYYYY
	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	8	Numeric	MMDDYYYY
Diabetes Hemoglobin A1c poor control Adults aged 18 through 75 with diabetes	Patient_ID	Patient ID	15	Numeric/String	XXXXXXXXXXXXXXX
	Sex	Sex	1	String	M (Male) F (Female)
	DOB	Date of Birth	8	Numeric	MMDDYYYY
	Date_A1c	Date A1c measured	8	Numeric	MMDDYYYY
	A1c	A1C level (%)	4	Numeric	xx.x

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METRIC	NAME	DEFINITION	WIDTH	TYPE	VALUE/FORMAT
Rate of fully-immunized 3 year old children	Patient_ID	Patient ID	15	Numeric/String	XXXXXXXXXXXXXXX
	DOB	Date of Birth	8	Numeric	MMDDYYYY
	Date Administered	Date immunization was administered	8	Numeric	MMDDYYYY
	4DTAP	All 4 doses administered	2	String	Y (Yes) N (No) MC (Medically contra indicated) R (Refusal to be vaccinated)
	3Polio	All 3 doses administered	2	String	Y (Yes) N (No) MC (Medically contra indicated) R (Refusal to be vaccinated)
	1MMR	1 dose administered	2	String	Y (Yes) N (No) MC (Medically contra indicated) R (Refusal to be vaccinated)
	3Hib	All 3 doses administered	2	String	Y (Yes) N (No) MC (Medically contra indicated) R (Refusal to be vaccinated)
	3HepB	All 3 doses administered	2	String	Y (Yes) N (No) MC (Medically contra indicated) R (Refusal to be vaccinated)
	1Var	1 dose administered	2	String	Y (Yes) N (No) MC (Medically contra indicated) R (Refusal to be vaccinated)
	4PCV	All 4 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 Patients aged 12 years and older	Patient_ID	Patient ID	15	Numeric/String	XXXXXXXXXXXXXXX
	Sex	Sex	1	String	M (Male) F (Female)
	DOB	Date of Birth	8	Numeric	MMDDYYYY
	PSN	Positive screening	1	String	Y (Yes) N (No)
	Date_PSN	Date of positive screening	8	Numeric	MMDDYYYY
	FUP	Follow-up plan documented	1	String	Y (Yes) N (No)

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