ATTACHMENT 1:
MONTANA PCMH PROGRAM
2016 Reporting Form for Quality Metrics
(Reporting 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 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 in 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~~SM~~/NQF numbers.

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 form below is required for BOTH option 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 seen for at least two visits or at least one preventive visit during the measurement period
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

Commented [NM1]: This definition is different from what is contained in the guidance document

Metric 3: Hemoglobin A1C Poor Control
MEASURE NUMBERS: CMS 122V3/NQF 0059/PQRS 001

1. _____(#) : denominator - number of patients 18 through 75 years of age with a diagnosis of diabetes mellitus in the entire clinic population
2. _____(#) : numerator - number of adults in the denominator population whose most recent HbA1c level (performed during the measurement period of calendar year 2015) is > 9.0%

Commented [JR2]: Guidance form states those who had a visit during the reporting period

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

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 = ____

Commented [JR3]: May want to be explicit here: based on the guidance document – this is where refusals should be documented.

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 greatly appreciates clinics willing to optionally submit depression screening data now, in preparation for next year.

1. _____(#): denominator - all patients aged 12 years or 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

ATTACHMENT 2:
MONTANA PCMH PROGRAM
2016 Quality Metric Reporting Guidance
(Reporting 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 reporting 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."

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

Commented [NM1]: These codes are not in the 2015 individual measures specifications document and we understand that there was a desire to capture patients who have only preventive/wellness visit encounters during the measurement period. These are preventive medicine visits for persons age 12 and older. We recommend highlighting this in the guidance for all measures that now include these additional codes so that the clinics are aware of this addition.

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 age 18 years and older during the reporting period of calendar year 2015.

Commented [JR2]: The reporting form document states: total number of patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

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

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 (eg, 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 18-75 years of age with diabetes who had hemoglobin A1C > 9.0% and had a visit during the reporting 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 18-75 years of age who have the diagnosis of diabetes mellitus (type 1 or type 2), and had a visit during the reporting 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

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

Patient is numerator compliant if:

a) most recent HbA1c level >9%

b) is missing a result or

c) if an HbA1c test was not done during the measurement year.

Commented [JR3]: This structure makes this a bit more clear.

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: Immunizations: Rate of Fully Immunized 3-Year-Old Children

DESCRIPTION:

Percentage of children with their 3rd birthday during the reporting 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.

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. Patients documented as a "refusal" should be included in the number of non-immunized patients, but patients with a "medical contraindication" should be excluded.

Immunizations for children aged 3 years:

4 DTAP

3 Polio

1 MMR

3 Hib

3 Hep B

1 Var

4 PCV

* *

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 greatly 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:

Commented [NM4]: Highlight in guidance that these are new preventive visit encounters for children. You may want to remove 99381 and 99391 as this is applicable only to children under the age of 1 and remove 99383, 99384, 99393, and 99394 as they are applicable to children older than age 3.

Commented [JR5]: This has changed from the guidance last year where MC and R were counted as non-immunized, but as written is still confusing. Do you want them to separately report MC and R as numerator counts? Do you want the MC children excluded from the denominator? It appears that children of parents who refused would still be in the numerator and denominator. Is that what you one? One reason for handling in the same manner as the MC children is that providers may feel as if they are being penalized for something beyond their control. But, the health department may have a different view and want to include the refusals in the denominator and numerator for non-immunized patients.

Commented [JR6]: Still not including Rotovirus and seasonal flu?

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 with an encounter 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 ~~ed~~ 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

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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 Table 1.

Please Note:
If a ~~S~~screening for clinical depression is documented as negative, a follow-up plan is not required.
If a ~~S~~screening for clinical depression is not documented, document~~ation~~ stating the patient is not eligible.

Commented [JR7]: What is trying to be conveyed here? If the patient is not screened for depression, they are not eligible for the measure? That does not seem to align with the measure intent.

ATTACHMENT 3:
MONTANA PCMH PROGRAM
2016 Patient-Level Data Elements/Data Dictionary

- **Use the format and definitions in the table below for the required data elements**
- **Include the patient-level data elements below for all patients in the denominator and the numerator for each measure**
- **Include patient ID numbers, such as 1-600, for reference when conducting quality control.**

MEASURE	NAME	DEFINITION	WIDTH	TYPE	VALUE/FORMAT
Blood pressure control: 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 cessation: 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

MEASURE	NAME	DEFINITION	WIDTH	TYPE	VALUE/FORMAT
Poor A1C 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
	Data_A1C	Date A1C measured	8	Numeric	MMDDYYYY
	A1C	A1C level (%)	4	Numeric	xx.x
Age appropriate immunization: children aged 3 years	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	All 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)

MEASURE	NAME	DEFINITION	WIDTH	TYPE	VALUE/FORMAT
Depression Screening and Follow-Up Plan: patients aged ≥12 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	Possitive 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)

Please Note:

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- ***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.***