Diabetes Management System

Shortcut & Reference Manual
Western Tribal Diabetes Project
2023

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Diabetes Management System

Section 1: DMS Shortcuts
Enter Patients into the Register

**What:** To add a patient to the diabetes register, the most common (and recommended) method is to enter patients one at a time through the Patient Management menu option. This allows you to verify that patients actually have diabetes before you enter them into the register.

You can also transfer a batch of patients using a Q-Man search template or a File-Manager file. However, when you transfer a group of patients, you risk adding miscoded patients who do not actually have diabetes.

**Why:** To track patient care in relation to the *IHS Standards of Care for Patients with Type 2 Diabetes.*

**When:** When patients are diagnosed or identified as having diabetes.

**How:** From the Diabetes Management System Main Menu:

1. Select Diabetes Management System Option: **RM**
2. Select Register Maintenance Option: **PM**
3. Which Register: (1-3): **Select the number corresponding to your register**
4. Select **PATIENT NAME:** **LAST NAME, FIRST NAME** (any patient name or health record number/chart number)
5. **Add this client to the Register? NO//YES**
6. At this point, you will be directed to the Patient Management screen.

If the patient is not in the register, the system will prompt you to add this patient to the register.
Deleting a Patient from the Register

**What:** You may use the Delete Patient from the Register option to remove any patient who has not been diagnosed with diabetes. (For patients who are deceased or have moved out of the area, change register status under Patient Management #1 - Edit register data, p. 5.)

Note that this only removes the patient from the register. All demographic and visit information remains in the main clinic database (PCC).

**Why:** To delete miscoded patient(s) from your diabetes population.

**When:** As needed.

**How:** From the Diabetes Management System Main Menu:

1. Select Diabetes Management System Option: **RM**
2. Select Register Maintenance Option: **DEL**
3. Which Register: (1-3): **Select the number corresponding to your register**
4. NAME OR CHART: **LAST NAME, FIRST NAME** (any patient name or health record number/chart number)
5. Are you certain you want to do this? **No// Y** (Yes)
6. Press RETURN to continue or ‘^’ to exit. **<Enter>**

Patient information is not removed from the PCC repository, only from the diabetes register.
Patient Management: Register Data

**What:** Register data includes register status, case manager, and review dates. These are only seen by people who use the Diabetes Register. The Patient Management screen also shows items such as the patient’s name, address, health record number, and date of birth, which come from the PCC database and can only be changed by data entry or registration staff.

**Why:** Register data should help you manage your register by allowing you to group patients for reports (examples: running the cumulative audit on only active patients, generating patient panels for case managers) and viewing contact information and comments.

**When:** When patients are added to the register and updated as needed.

**Edit register data**

**How:** From the Diabetes Management System Main Menu:

1. Select Diabetes Management System Option: **RM**
2. Select Register Maintenance Option: **PM**
3. Which Register: (1-3): **Select the number corresponding to your register**
4. Select PATIENT NAME: **LAST NAME, FIRST NAME** (any patient name or health record number/chart number)
5. Select Action: Quit// **Options #1-#13** (register data descriptions are below)

Register Data Descriptions:

**#1 Register Status** – Active, Inactive, Unreviewed, Transient, Deceased, Non-IHS, and Lost to follow-up

**#2 Where followed** – Health center where the patient is receiving care

**#3 Case manager** – This person must be in your clinic database; enter as LAST,FIRST name; can be used to generate several different reports

**#4 Client Contact** – Enter free text (1-30 characters) for reference by your diabetes team

**#6 Comments** - This option will open the word processor, and will display comments on the patient’s PM Screen. To exit the word processor, type F1 (function key) and then E

**#7 Local Option Entry** - This option will allow you to enter a code (which you will need to designate beforehand) to differentiate groups of patients. This is a holdover from the EpiInfo 6 application, and is not used much, if at all

The following Register Data items are updated automatically:

**Entry date** – Provided when the individual is first entered into the diabetes register

**Last edited** – The last date information for the Register Data was was edited
What: Type of diabetes and onset date are tracked here, similar to -- but not the same as -- the patient’s problem list. You can also describe the severity in an optional field.

Why: The type and duration of diabetes have important ramifications for patient care, so it is important to make sure the onset date is included in the patient’s record. The onset date is not necessarily the first visit for diabetes that the patient has at your clinic. The audit reports can find the type of diabetes and onset date from the patient’s problem list, if it has been entered there, but those fields can only be updated by data entry staff at the request of a provider. This register field is convenient for diabetes program staff and can be used for reports.

When: The patient’s diagnosis of diabetes and onset date should be updated when the patient is first entered onto the diabetes register.

#5 - Diagnosis

How: From the Diabetes Management System Main Menu:

1. Select the Diabetes Management System Option: RM
2. Select the Register Maintenance Option: PM
3. Which Register: (1-3): Select the number corresponding to your register
4. Select the PATIENT NAME: LAST NAME, FIRST NAME (any patient name or health record number)
5. Select Action: Quit/ 5
6. Select Action: Quit/ 1 ADD Diagnosis
7. Which Diagnosis(s): (1-4): [Choose diagnosis]
8. Enter Date of Onset: [Enter date of onset]
9. Enter Severity: N-Normal  M-Mild  S-Severe  MO-Moderate (optional)
10. Command: S to save
11. Command: E to exit
12. Select Action: Quit/ <Enter>

If a patient has a diagnosis of diabetes on their problem list, it will show up here.

The Audit Program will determine duration of diabetes from the earliest date recorded in the Register Diagnosis, the Problem List onset date, or the first PCC Diagnosis.
**What:** The diabetes patient care summary provides a complete review of the patient’s care in relation to the *IHS Standards of Care for Patients with Type 2 Diabetes*. It includes the same data items as the audit report except medications.

Some clinics print the diabetes patient care summary at the end of the regular adult health summary.

**Why:** The diabetes patient care summary is an alternative to the individual audit. It gives dates of service, even if those dates are outside the one-year range of the audit date.

Since the diabetes patient care summary parallels the *IHS Standards of Care for Patients with Type 2 Diabetes*, we encourage you to generate this report before each patient visit for case management as well as for quality assurance.

**When:** (1) Prior to each patient visit, (2) prior to the annual diabetes audit

**How:** From the Diabetes Management System Main Menu:

1. Select Diabetes Management System Option: **RM**
2. Select the Register Maintenance Option: **PM**
3. Which Register: (1-3): **Select the number corresponding to your register**
4. Select PATIENT NAME: **LAST NAME, FIRST NAME** (any patient name or health record number/chart number)
5. Select Action: QUIT//12 (DM Care Summary (DPCS))
6. Select Action: +//<Enter> to scroll through, or **PL** and <Enter> to print DPCS to a printer
What: This generates the IHS diabetes audit on one patient, giving a review of the patient’s care over one year in comparison to the IHS Standards of Care for Patients with Type 2 Diabetes.

To print individual audits for all active patients on the register, see the tip box in the Cumulative Audit instructions.

Why: We encourage you to generate this report before each patient visit for case management as well as quality assurance. It is intended to alert providers to diabetes standards of care for which the patient is deficient.

The individual diabetes audit may also be used to check the accuracy of data.

When: (1) Prior to each patient visit and (2) for checking data quality, for example prior to the annual diabetes audit.

#10 – Audit Status

How: From the Diabetes Management System Main Menu:

1. Select Diabetes Management System Option: RM
2. Select the Register Maintenance Option: PM
3. Which Register: (1-3): Select the number corresponding to your register
4. Select PATIENT NAME: LAST NAME, FIRST NAME (any patient name or HRN)
5. Select Action: Quit/ 10 (Audit Status)
6. Enter the Audit Date: T (today) or (any specified date)
7. Do you wish to print the patient’s name on the audit sheet? N// <Enter> or type Y for yes
8. Do you wish to: P// P (to print) or B (to browse)
9. DEVICE: HOME// <Enter> to view on screen or PRINTER NAME to print

The date you specify is the ending date of the audit...the audit will look back one year from the date you specify.
Individual Audit (Option 2)

**What:** The individual diabetes audit provides a complete review of the patient’s care in comparison to the *IHS Standards of Care For Patients With Type 2 Diabetes*. You can use this option to print individual audits for more than one patient. You can choose whether or not to include the patient’s name.

To print individual audits for all active patients on the register, see the tip box in the Cumulative Audit instructions.

**Why:** Since the individual diabetes audit parallels the *IHS Standards of Care For Patients With Type 2 Diabetes*, we encourage you to generate this report before each patient visit for case management as well as quality assurance.

**When:** (1) Prior to each patient visit and (2) prior to the annual diabetes audit

**How:** From the Diabetes Management System Main Menu:

1. Select Diabetes Management System Option: **AR** Audit Reporting...
2. End of taxonomy check. HIT RETURN” <Enter>
3. Select Audit Reporting Option: **DM23**
4. Which Register: (1-3): **Select the number corresponding to your register**
5. Enter the Audit Date: **T** for today’s date or enter any other date
6. Run the audit for: **P//P** Individual Patients
7. Select PATIENT NAME: **LAST NAME, FIRST NAME** (any patient name or health record number/chart number)
8. Select PATIENT NAME: <Enter> or type additional names
9. Enter Print option: **1// <Enter>** Print Individual Reports
10. Do you wish to print the patient’s name on the audit sheet? **N// <Enter>** or **Y** for Yes
11. Do you wish to: **P// <Enter>** to print or **B and <Enter>** to browse on screen
12. DEVICE: **HOME// <Enter>** to view on screen or **PRINTER NAME** to print

THIS SYSTEM CONTAINS CONFIDENTIAL PATIENT INFORMATION COVERED BY THE PRIVACY ACT. UNAUTHORIZED USE OF THIS DATA IS ILLEGAL.

*************************************************************
** DIABETES MANAGEMENT SYSTEM **
*************************************************************

VERSION 2.0 (Patch 16)
CHEMAWA H CT
AUDIT REPORTING

DM23 2023 Diabetes Audit
DM22 2022 Diabetes Audit
DM21 2021 Diabetes Audit
DM20 2020 Diabetes Audit
DM19 2019 Diabetes Audit

Select Audit Reporting Option:
Sample Individual Diabetes Audit

IHS Diabetes Care and Outcomes Audit, 2023

Audit Period Ending Date: 01/26/2023
Facility Name: CHEMAWA H CT
Reviewer initials: SXO
Community: BATTLE GROUND
State of Residence: OR

Name: BUTTER, PEANUT
Chart #: 22469
DOB: 12/16/1965
Sex: FEMALE
Primary Care Provider: SINGLETON, KORI

DATE RUN: 01/26/2023
Page: 1

Date of Diabetes Diagnosis:
DM Register: <not documented>
Problem List: 05/22/2009
First PCC DX: 05/17/2009
DM Type: 2 Type 2
DM Register: <not documented>
Problem List: 250.02
PCC POV's: Type 2

Tobacco/Nicotine Use
Screened for tobacco use (during Audit period): 2 No
Tobacco use status (most recent):
2 Not a Current user NEVER SMOKED 01/05/2012
If 'Current user', tobacco cessation counseling/education received (during Audit period):

Electronic Nicotine Delivery Systems (ENDS)
Screened for ENDS use (during Audit period): 2 No
ENDS use status (most recent): 3 Not documented

Vital Statistics

Height (last ever): 63.00 inches 01/01/2022
Weight (last in Audit period): 170 lbs 09/25/2022
BMI: 30.1

Hypertension (documented diagnosis ever): 1 Yes
Blood pressure (last 3 during Audit period):
120/70 mm Hg 09/25/2022
135/85 mm Hg 07/15/2022
145/94 mm Hg 02/02/2022

Examinations (during Audit period)

Foot (comprehensive or "complete", including evaluation of sensation and vascular status): 1 Yes
Eye (dilated exam or retinal imaging): 1 Yes
Dental: 1 Yes

Depression
Screened for depression (during Audit period): 2 No
Depression active diagnosis (during Audit period): 2 No

Education (during Audit period)

Nutrition: 4 None
Physical activity: 2 No
Other diabetes: 2 No

Diabetes Therapy All prescribed (as of the end of the Audit period):
1 None of the following
2 Insulin
3 Metformin [Glucophage, others]
4 Sulfonylurea [glipizide, glyburide, glimepiride]
5 DPP-4 inhibitor [alogliptin (Nesina), linagliptin (Tradjenta), saxagliptin (Onglyza), sitagliptin (Januvia)]
6 GLP-1 receptor agonist [dulaglutide (Trulicity), exenatide (Byetta, Bydureon), lixisatuglide (Victoza, Saxenda), lixisenatide (Adlyxin), semaglutide (Ozempic, Rybelsus, Wegovy)]
7 SGLT-2 inhibitor [canagliflozin (Invokana), dapagliflozin (Farxiga), empagliflozin (Jardiance), ertugliflozin (Steglatro)]
8 Pioglitazone [Actos] or rosiglitazone [Avandia]
9 Tirzepatide [Mounjaro]
10 Acarbose [Precose] or miglitol [Glyset]
11 Repaglinide [Prandin] or nateglinide [Starlix]
Sample Individual Diabetes Audit

12 Pramlintide [Symlin]
13 Bromocriptine [Cycloset]
14 Colesevelam [Welchol]

ACE Inhibitor or ARB
Prescribed (as of the end of the Audit period): 2 No

Aspirin or Other Antiplatelet/Anticoagulant Therapy
Prescribed (as of the end of the Audit period):
  2 No

Statin Therapy
Prescribed (as of the end of the Audit period): 1 Yes

Cardiovascular Disease (CVD)
Diagnosed (ever): 2 No

Tuberculosis (TB)
TB diagnosis (latent or active) documented (ever): 2 No
TB test done (most recent): 1 - Skin test (PPD) 08/04/1994
TB test result: 2 - Negative 8/4/94 Reading: 0 Result: N
If TB diagnosis documented or TB result 'Positive', treatment initiated
(isoniazid, rifampin, rifapentine, others):
If TB result 'Negative', test date: 08/04/1994

Hepatitis C (HCV)
HCV diagnosed (ever): 2 No
If not diagnosed with HCV, screened at least once (ever): 2 No

Retinopathy
Diagnosed (ever): 2 No

Amputation
Lower extremity (ever), any type (e.g., toe, partial foot, above or
below knee): 2 No

Immunizations
Influenza vaccine (during Audit period): 2 No
Pneumococcal [PCV15, PCV20, or PPSV23] (ever): 1 Yes 10/02/2001
Td, Tdap, DTaP, or DT (in past 10 years): 2 No
Tdap (ever): 1 Yes 05/08/2009
Hepatitis B complete series (ever): 1 Yes
Shingrix/RZV complete series (ever): 2 No

Laboratory Data (most recent result during Audit period)
A1C: 6.9 09/25/2022 HEMOGLOBIN A1C
Total Cholesterol: 157 09/25/2022 CHOLESTEROL
HDL Cholesterol: 53 09/25/2022 HDL CHOLESTEROL
LDL Cholesterol: 176 09/25/2022 LDL CHOLESTEROL
Triglycerides: 256 09/25/2022 TRIGLYCERIDES
Serum Creatinine: 1.1 09/25/2022 CREATININE
eGFR: >60 09/25/2022 EST.GFR
UACR: 36 09/25/2022 MALB.CREAT

COMBINED: Meets ALL: A1C <8.0, statin prescribed, mean BP <140/<90
  2 No A1C: <Not Documented>; statin prescribed: No; Mean BP:

Local Questions
Select one:
Text:
Cumulative Diabetes Audit

**What:** The cumulative diabetes audit summarizes care and outcomes for a group of patients you specify (usually active patients on the register). It shows all items from the *IHS Standards of Care For Patients With Type 2 Diabetes*.

**Why:** You can use the cumulative diabetes audit to set goals and monitor progress in meeting the IHS standards of care (or documenting the care that is provided). It is also required annually as part of the Special Diabetes Program for Indians (SDPI).

**When:** Monthly – quarterly – annually for the IHS Diabetes Audit

**How:** From the Diabetes Management System Main Menu:

1. Select Diabetes Management System Option: **AR** Audit Reporting...
2. Select Audit Reporting Option: **DM23**
3. Checking for Taxonomies to support the 2023 Audit: HIT RETURN: **<ENTER>**
   (Note: You will likely see empty taxonomy errors for taxonomies related to labs and medications not used at your facility. These are OK.)
4. Which REGISTER: (1-3): **Select the number corresponding to your register**
5. Enter the Audit Date: **T** for today or exact date, e.g. 123122 for calendar year 2022
6. Run the audit for: **P**// **C** Members of a CMS Register
7. Do you want to select register patients with a particular status? **Y**// **YES**
8. Which status: **A**// **<Enter>** for Active, or type other status
9. Limit the audit to a particular primary care provider? **N**// **<Enter>** for no
10. Limit the patients who live in a particular community? **N**// **<Enter>** for no
11. Select Beneficiary Population to include in the audit: **1**// **<Enter>**
12. Select whether to include or exclude pregnant patients in the audit: **E**// **<Enter>**
13. Do you want to select: **A**// **<Enter>** for ALL Patients selected so far
14. Enter Print option: **1**// **3** Audit Report
15. Demo Patient Inclusion/Exclusion: **E**// **<Enter>**
16. Do you wish to: **P**// **<Enter>** to print, or **B** and **<Enter>** to browse
17. DEVICE: **HOME**// **<Enter>** to view on screen or **PRINTER NAME**, such as **SLAVE** or **S-O**, to print

Tips: Choose **1** or **4** to print individual sheets for all active patients

Select Audit Reporting Option:
# Sample Cumulative Diabetes Audit

## IHS Diabetes Care and Outcomes Audit - RPMS Audit
Audit Report for 2023 (Audit Period 01/01/2022 to 12/31/2022)
Facility: CHEMAWA H CT
Annual Audit

6827 charts were audited from 7141 patients determined to be eligible
Unless otherwise specified, time period for each item is the 12-month Audit Period

<table>
<thead>
<tr>
<th># of Patients Considered</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Numerator)</td>
<td>(Denominator)</td>
</tr>
</tbody>
</table>

### Gender
- Male: 3145 (6827) = 46%
- Female: 3682 (6827) = 54%

### Age
- <20 years: 26 (6827) = 0%
- 20-44 years: 1087 (6827) = 16%
- 45-64 years: 3329 (6827) = 49%
- >=65 years: 2385 (6827) = 35%

### Diabetes Type
- Type 1: 108 (6827) = 2%
- Type 2: 6657 (6827) = 98%

### Duration of Diabetes
- <1 year: 298 (6827) = 4%
- <10 years: 3036 (6827) = 44%
- >=10 years: 3101 (6827) = 45%
- Diagnosis date not recorded: 690 (6827) = 10%

### Body Mass Index (BMI) Category
- Normal (BMI<25.0): 413 (6827) = 6%
- Overweight (BMI 25.0-29.9): 1147 (6827) = 17%
- Obese (BMI >=30.0): 4544 (6827) = 67%
- Height or weight missing: 723 (6827) = 11%
- Severely obese (BMI >=40.0): 1546 (6827) = 23%

### Blood Sugar Control
- A1C <7.0: 2457 (6827) = 36%
- A1C 7.0-7.9: 1272 (6827) = 19%
- A1C 8.0-8.9: 831 (6827) = 12%
- A1C 9.0-9.9: 516 (6827) = 8%
- A1C 10.0-10.9: 388 (6827) = 6%
- A1C >=11.0: 720 (6827) = 11%
- Not tested or no valid result: 602 (6827) = 9%

### Blood Pressure (BP) - Based on one value or mean of two or three values
- <140/<90: 4356 (6827) = 64%
- 140/90 - <160/<100: 1738 (6827) = 25%
- 160/100 or higher: 469 (6827) = 7%
- BP category undetermined: 264 (6827) = 78%

### Hypertension
- Diagnosed ever: 5297 (6827) = 78%
- Diagnosed hypertension and mean BP <140/<90: 3190 (5297) = 60%
- Diagnosed hypertension and ACE inhibitor or ARB currently prescribed: 3856 (5297) = 73%

### Tobacco and Nicotine Use
- Tobacco use screening during Audit period:
  - Screened: 4838 (6827) = 71%
  - Not screened: 1989 (6827) = 29%
### Sample Cumulative Diabetes Audit

#### Tobacco use status (most recent)

<table>
<thead>
<tr>
<th>Status</th>
<th>Number</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current tobacco user</td>
<td>1930</td>
<td>6827</td>
<td>28%</td>
</tr>
<tr>
<td>In current users, cessation counseling/education received&lt;br&gt;Yes</td>
<td>702</td>
<td>1930</td>
<td>36%</td>
</tr>
<tr>
<td>No</td>
<td>1228</td>
<td>1930</td>
<td>64%</td>
</tr>
<tr>
<td>Not a current tobacco user</td>
<td>4604</td>
<td>6827</td>
<td>67%</td>
</tr>
<tr>
<td>Tobacco use not documented</td>
<td>293</td>
<td>6827</td>
<td>4%</td>
</tr>
</tbody>
</table>

#### Electronic nicotine delivery system (ENDS) use screening during Audit period

<table>
<thead>
<tr>
<th>Status</th>
<th>Number</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screened</td>
<td>2179</td>
<td>6827</td>
<td>32%</td>
</tr>
<tr>
<td>Not screened</td>
<td>4648</td>
<td>6827</td>
<td>68%</td>
</tr>
</tbody>
</table>

#### ENDS use status (most recent)

<table>
<thead>
<tr>
<th>Status</th>
<th>Number</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current ENDS user</td>
<td>71</td>
<td>6827</td>
<td>1%</td>
</tr>
<tr>
<td>Not a current ENDS user</td>
<td>3282</td>
<td>6827</td>
<td>48%</td>
</tr>
<tr>
<td>ENDS use not documented</td>
<td>3388</td>
<td>6827</td>
<td>50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Status</th>
<th>Number</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current user of both tobacco and ENDS</td>
<td>31</td>
<td>6827</td>
<td>0%</td>
</tr>
<tr>
<td>Current user of tobacco and/or ENDS</td>
<td>1970</td>
<td>6827</td>
<td>29%</td>
</tr>
</tbody>
</table>

#### Diabetes Treatment

##### Number of diabetes meds currently prescribed

<table>
<thead>
<tr>
<th>Number of Medications</th>
<th>Number</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1219</td>
<td>6827</td>
<td>18%</td>
</tr>
<tr>
<td>One medication</td>
<td>2369</td>
<td>6827</td>
<td>35%</td>
</tr>
<tr>
<td>Two medications</td>
<td>1903</td>
<td>6827</td>
<td>28%</td>
</tr>
<tr>
<td>Three medications</td>
<td>1029</td>
<td>6827</td>
<td>15%</td>
</tr>
<tr>
<td>Four or more medications</td>
<td>267</td>
<td>6827</td>
<td>4%</td>
</tr>
</tbody>
</table>

##### Diabetes meds currently prescribed, alone or in combination

<table>
<thead>
<tr>
<th>Medication</th>
<th>Number</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin</td>
<td>2322</td>
<td>6827</td>
<td>34%</td>
</tr>
<tr>
<td>Metformin [Glucophage, others]</td>
<td>4158</td>
<td>6827</td>
<td>61%</td>
</tr>
<tr>
<td>Sulfonylurea [glipizide, glyburide, others]</td>
<td>1166</td>
<td>6827</td>
<td>17%</td>
</tr>
<tr>
<td>DPP-4 inhibitor [alogliptin (Nesina), linagliptin (Tradjenta), saxagliptin (Onglyza), sitagliptin (Januvia)]</td>
<td>469</td>
<td>6827</td>
<td>7%</td>
</tr>
<tr>
<td>GLP-1 receptor agonist [dulaglutide (Trulicity), exenatide (Byetta, Bydureon)]</td>
<td>1103</td>
<td>6827</td>
<td>16%</td>
</tr>
<tr>
<td>Tiraglutide (Victoza, Saxenda), liraglutide (Adlyxin), semaglutide (Ozempic, Rybelsus, Wegovy)</td>
<td>1103</td>
<td>6827</td>
<td>16%</td>
</tr>
<tr>
<td>SGLT-2 inhibitor [canagliflozin, (Invokana), dapagliflozin (Farxiga), empagliflozin (Jardiance), ertugliflozin (Steglatro)]</td>
<td>624</td>
<td>6827</td>
<td>9%</td>
</tr>
<tr>
<td>Pioglitazone [Actos] or rosiglitazone [Avandia]</td>
<td>390</td>
<td>6827</td>
<td>6%</td>
</tr>
<tr>
<td>Tirzepatide [Mounjaro]</td>
<td>0</td>
<td>6827</td>
<td>0%</td>
</tr>
<tr>
<td>Acarbose [Precose] or miglitol [Glyset]</td>
<td>17</td>
<td>6827</td>
<td>0%</td>
</tr>
<tr>
<td>Repaglinide [Prandin] or nateglinide [Starlix]</td>
<td>13</td>
<td>6827</td>
<td>0%</td>
</tr>
<tr>
<td>Pramlintide [Symlin]</td>
<td>106</td>
<td>6827</td>
<td>2%</td>
</tr>
<tr>
<td>Bromocriptine [Cycloset]</td>
<td>1</td>
<td>6827</td>
<td>0%</td>
</tr>
</tbody>
</table>
### Sample Cumulative Diabetes Audit

<table>
<thead>
<tr>
<th>Colesevelam [WelchoL]</th>
<th>3</th>
<th>6827</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Statin Prescribed (Currently)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes*</td>
<td>4061</td>
<td>6653</td>
<td>61%</td>
</tr>
<tr>
<td>Allergy, intolerance, or contraindication</td>
<td>173</td>
<td>6827</td>
<td>3%</td>
</tr>
<tr>
<td><strong>In patients with diagnosed CVD</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes*</td>
<td>1638</td>
<td>2236</td>
<td>73%</td>
</tr>
<tr>
<td>Allergy, intolerance, or contraindication</td>
<td>85</td>
<td>2321</td>
<td>4%</td>
</tr>
<tr>
<td><strong>In patients age 40-75 years</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes*</td>
<td>3461</td>
<td>5352</td>
<td>65%</td>
</tr>
<tr>
<td>Allergy, intolerance, or contraindication</td>
<td>143</td>
<td>5496</td>
<td>3%</td>
</tr>
<tr>
<td><strong>In patients with diagnosed CVD and/or age 40-75 years</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes*</td>
<td>3787</td>
<td>5822</td>
<td>65%</td>
</tr>
<tr>
<td>Allergy, intolerance, or contraindication</td>
<td>164</td>
<td>5987</td>
<td>3%</td>
</tr>
</tbody>
</table>

*Denominator excludes patients with an allergy, intolerance, or contraindication.

**Cardiovascular Disease (CVD)**
- CVD diagnosed ever | 2321 | 6827 | 34%
- CVD and mean BP <140/<90 | 1481 | 2321 | 64%
- CVD and not current tobacco user | 1610 | 2321 | 69%
- CVD and aspirin or other antiplatelet/anticoagulant therapy currently prescribed | 1467 | 2321 | 63%
- CVD and GLP-1 receptor agonist currently prescribed | 349 | 2321 | 15%
- CVD and SGLT-2 inhibitor currently prescribed | 213 | 2321 | 9%
- CVD and statin currently prescribed* | 1638 | 2321 | 73%

*Denominator excludes patients with an allergy, intolerance, or contraindication.

**Retinopathy**
- Diagnosed ever | 1138 | 6827 | 17% |

**Lower Extremity Amputation**
- Any type ever (e.g., toe, partial foot, above or below knee) | 158 | 6827 | 2% |

**Exams**
- Foot exam - comprehensive | 2582 | 6827 | 38%
- Eye exam - dilated exam or retinal imaging | 2477 | 6827 | 36%
- Dental exam | 2451 | 6827 | 36%

**Diabetes-Related Education**
- Nutrition - by any provider (RD and/or other) | 2767 | 6827 | 41%
- Nutrition - by RD | 929 | 6827 | 14%
- Physical activity | 3060 | 6827 | 45%
- Other diabetes education | 3563 | 6827 | 52%

Any of above | 4480 | 6827 | 66%

**Immunizations**
- Influenza vaccine during Audit period | 3156 | 6827 | 46%
- Pneumococcal vaccine (PCV15, PCV20, or PPSV23) - ever | 4552 | 6827 | 67%
- Td/Tdap/DTap/DT - past 10 years | 5226 | 6827 | 77%
- Tdap - ever | 5891 | 6827 | 86%
- If not immune, hepatitis B complete series - ever
  - Immune - Hepatitis B | 66 | 6827 | 1%
  - In patients age >=50 years | 1587 | 6827 | 31%
  - Shingrix/recombinant zoster vaccine

Northwest Portland Area Indian Health Board  DMS Shortcut & Reference Manual 2023
**Sample Cumulative Diabetes Audit**

(RZV) series - ever

<table>
<thead>
<tr>
<th>Depression</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Screened during Audit period</td>
<td>3112</td>
<td>4840</td>
<td>64%</td>
</tr>
<tr>
<td>Active diagnosis during Audit period</td>
<td>1987</td>
<td>6827</td>
<td>29%</td>
</tr>
<tr>
<td>Screened and/or active diagnosis during Audit period</td>
<td>5099</td>
<td>6827</td>
<td>75%</td>
</tr>
</tbody>
</table>

**Lipid Evaluation** - Note these results are presented as population level CVD risk markers and should not be considered treatment targets for individual patients.

<table>
<thead>
<tr>
<th>Lipid Evaluation</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>LDL cholesterol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LDL &lt;100 mg/dL</td>
<td>3295</td>
<td>6827</td>
<td>48%</td>
</tr>
<tr>
<td>LDL 100–189 mg/dL</td>
<td>1626</td>
<td>6827</td>
<td>24%</td>
</tr>
<tr>
<td>LDL &gt;=190 mg/dL</td>
<td>35</td>
<td>6827</td>
<td>1%</td>
</tr>
<tr>
<td>Not tested or no valid result</td>
<td>1871</td>
<td>6827</td>
<td>27%</td>
</tr>
<tr>
<td>HDL cholesterol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In females</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HDL &lt;50 mg/dL</td>
<td>1629</td>
<td>3682</td>
<td>44%</td>
</tr>
<tr>
<td>HDL &gt;=50 mg/dL</td>
<td>1150</td>
<td>3682</td>
<td>31%</td>
</tr>
<tr>
<td>Not tested or no valid result</td>
<td>903</td>
<td>3682</td>
<td>25%</td>
</tr>
<tr>
<td>In males</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HDL &lt;40 mg/dL</td>
<td>1092</td>
<td>3145</td>
<td>35%</td>
</tr>
<tr>
<td>HDL &gt;=40 mg/dL</td>
<td>1244</td>
<td>3145</td>
<td>40%</td>
</tr>
<tr>
<td>Not tested or no valid result</td>
<td>809</td>
<td>3145</td>
<td>26%</td>
</tr>
<tr>
<td>Triglycerides [1]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trig &lt;150 mg/dL</td>
<td>1764</td>
<td>6827</td>
<td>26%</td>
</tr>
<tr>
<td>Trig 150-499 mg/dL</td>
<td>2611</td>
<td>6827</td>
<td>38%</td>
</tr>
<tr>
<td>Trig 500-999 mg/dL</td>
<td>195</td>
<td>6827</td>
<td>3%</td>
</tr>
<tr>
<td>Trig &gt;=1000 mg/dL</td>
<td>53</td>
<td>6827</td>
<td>1%</td>
</tr>
<tr>
<td>Not tested or no valid result</td>
<td>2204</td>
<td>6827</td>
<td>32%</td>
</tr>
</tbody>
</table>

**Kidney Evaluation**

<table>
<thead>
<tr>
<th>Kidney Evaluation</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Glomerular Filtration Rate (eGFR) to assess kidney function (In age &gt;=18 years)</td>
<td>5752</td>
<td>6813</td>
<td>84%</td>
</tr>
<tr>
<td>eGFR =&gt;60 mL/min</td>
<td>4719</td>
<td>6813</td>
<td>60%</td>
</tr>
<tr>
<td>eGFR 30–59 mL/min</td>
<td>884</td>
<td>6813</td>
<td>13%</td>
</tr>
<tr>
<td>eGFR 15–29 mL/min</td>
<td>101</td>
<td>6813</td>
<td>1%</td>
</tr>
<tr>
<td>eGFR &lt; 15 mL/min</td>
<td>48</td>
<td>6813</td>
<td>1%</td>
</tr>
<tr>
<td>eGFR Not tested or no valid result</td>
<td>1061</td>
<td>6813</td>
<td>16%</td>
</tr>
<tr>
<td>Urine Albumin-to-Creatinine Ratio (UACR) to assess kidney damage</td>
<td>3249</td>
<td>6827</td>
<td>48%</td>
</tr>
<tr>
<td>UACR - normal: &lt;30 mg/g</td>
<td>2020</td>
<td>3249</td>
<td>62%</td>
</tr>
<tr>
<td>UACR increased:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;30–300 mg/g</td>
<td>972</td>
<td>3249</td>
<td>30%</td>
</tr>
<tr>
<td>&gt;300 mg/g</td>
<td>257</td>
<td>3249</td>
<td>8%</td>
</tr>
<tr>
<td>Not tested or no valid result</td>
<td>3578</td>
<td>6827</td>
<td>52%</td>
</tr>
</tbody>
</table>

**Chronic Kidney Disease (CKD) (In age >=18 years)**

<table>
<thead>
<tr>
<th>CKD [2]</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CKD [2] and mean BP &lt;140/&lt;90</td>
<td>1962</td>
<td>6813</td>
<td>29%</td>
</tr>
<tr>
<td>CKD [2] and ACE inhibitor or ARB currently prescribed</td>
<td>1163</td>
<td>1962</td>
<td>59%</td>
</tr>
<tr>
<td>CKD [2] and GLP-1 receptor agonist currently prescribed</td>
<td>1405</td>
<td>1962</td>
<td>72%</td>
</tr>
<tr>
<td>CKD [2] and SGLT-2 inhibitor currently prescribed</td>
<td>376</td>
<td>1962</td>
<td>19%</td>
</tr>
<tr>
<td>CKD Stage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal: eGFR =&gt;60 mL/min</td>
<td>1638</td>
<td>6813</td>
<td>24%</td>
</tr>
</tbody>
</table>
### Sample Cumulative Diabetes Audit

<table>
<thead>
<tr>
<th>Case Description</th>
<th>Number of Cases</th>
<th>Total N</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stages 1 and 2: eGFR &gt;=60 mL/min and UACR &lt;30 mg/g</td>
<td>906</td>
<td>6813</td>
<td>13%</td>
</tr>
<tr>
<td>Stage 3: eGFR 30-59 mL/min</td>
<td>884</td>
<td>6813</td>
<td>13%</td>
</tr>
<tr>
<td>Stage 4: eGFR 15-29 mL/min</td>
<td>101</td>
<td>6813</td>
<td>1%</td>
</tr>
<tr>
<td>Stage 5: eGFR &lt;15 mL/min</td>
<td>48</td>
<td>6813</td>
<td>1%</td>
</tr>
<tr>
<td>Undetermined</td>
<td>3236</td>
<td>6813</td>
<td>47%</td>
</tr>
</tbody>
</table>

### Tuberculosis (TB) Status
- TB diagnosis documented ever and/or positive test result ever: 356 | 6827 | 5%
- If not diagnosed, TB test done ever: 2830 | 6316 | 45%
- If TB diagnosis documented and/or positive test result, treatment initiated ever: 106 | 356 | 30%
- If most recent TB test result was negative, was test done after diabetes diagnosis: 1234 | 2261 | 55%

### Hepatitis C (HCV)
- Diagnosed HCV ever: 272 | 6827 | 4%
- In patients not diagnosed with HCV and age >= 18 years, screened ever: 4162 | 6541 | 64%

### Combined Outcome Measure
- Patients age >= 40 years meeting ALL of the following criteria: A1C <8.0, Statin currently prescribed* and mean BP <140/<90: 1384 | 5994 | 23%

*Denominator excludes patients with a statin allergy, intolerance, or contraindication

### Diabetes Related Conditions (In age >=18 years)
- Severely obese (BMI >=40): 1542 | 6813 | 23%
- Hypertension diagnosed ever: 5294 | 6813 | 78%
- Current tobacco user: 1929 | 6813 | 28%
- CVD diagnosed ever: 2319 | 6813 | 34%
- Retinopathy diagnosed ever: 1137 | 6813 | 17%
- Lower extremity amputation ever (any type (e.g., toe, partial foot, above or below knee): 158 | 6813 | 2%
- Active depression diagnosis during Audit period: 1982 | 6813 | 29%
- CKD stage 3-5: 1033 | 6813 | 15%

### Number of diabetes related conditions
- Diabetics only: 435 | 6813 | 6%
- Diabetes plus:
  - One: 1549 | 6813 | 23%
  - Two: 2045 | 6813 | 30%
  - Three: 1699 | 6813 | 25%
  - Four: 818 | 6813 | 12%
  - Five or more: 269 | 6813 | 4%

### Footnotes
1. For triglycerides: >150 is a marker of CVD risk, not a treatment target; >1000 is a risk marker for pancreatitis.
2. Chronic Kidney Disease (CKD): eGFR <60 or UACR >=30
Master List

<table>
<thead>
<tr>
<th>What:</th>
<th>This report will list all patients on the Diabetes Register. You will be able to select which patients will be included on the list based on any of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Register Status    - Gender</td>
</tr>
<tr>
<td></td>
<td>- Age     - Case Manager</td>
</tr>
<tr>
<td></td>
<td>- Community of Residence  - Where Followed</td>
</tr>
<tr>
<td></td>
<td>You can also sort by a combination of these register items; for example, a common query is generating an alphabetical list of patients by status.</td>
</tr>
<tr>
<td>Why:</td>
<td>We encourage you to generate the master list periodically and review the patient listing for status changes and/or case management purposes.</td>
</tr>
<tr>
<td>When:</td>
<td>Monthly - Quarterly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How:</th>
<th>From the Diabetes Management System Main Menu:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Select Diabetes Management System Option: <strong>RM</strong> Register Maintenance...</td>
</tr>
<tr>
<td>2.</td>
<td>Select Register Management Option: <strong>RR</strong> Register Reports ...</td>
</tr>
<tr>
<td>3.</td>
<td>Select Register Reports Option: <strong>ML</strong></td>
</tr>
<tr>
<td>4.</td>
<td>Enter the Name of the Register: <strong>IHS DIABETES</strong></td>
</tr>
<tr>
<td>5.</td>
<td>Do you want to select register patients with a particular status? <strong>Y</strong>// <strong>YES</strong></td>
</tr>
<tr>
<td>6.</td>
<td>Select status: <strong>A</strong>// <strong>ACTIVE</strong></td>
</tr>
<tr>
<td>7.</td>
<td>Select another status: <strong>&lt;ENTER&gt;</strong></td>
</tr>
<tr>
<td>8.</td>
<td>Would you like to restrict the master list by Patient age range? <strong>NO</strong>// <strong>&lt;ENTER&gt;</strong></td>
</tr>
<tr>
<td>9.</td>
<td>Include Patients: <strong>A</strong>// <strong>All Communities</strong></td>
</tr>
<tr>
<td>10.</td>
<td>Include which Gender(s): <strong>A</strong>// <strong>ALL Genders</strong></td>
</tr>
<tr>
<td>11.</td>
<td>Do you want to select register patients with a particular CASE MANAGER? <strong>N</strong>// <strong>NO</strong></td>
</tr>
<tr>
<td>12.</td>
<td>Do you want to select patients with a particular facility WHERE FOLLOWED? <strong>N</strong>// <strong>NO</strong></td>
</tr>
<tr>
<td>13.</td>
<td>Select Primary Sort Value: <strong>Patient Name</strong></td>
</tr>
<tr>
<td>14.</td>
<td>Select Secondary Sort Value: <strong>&lt;ENTER&gt;</strong></td>
</tr>
<tr>
<td>15.</td>
<td>Should patients meeting the above criteria that have a Date of Death documented in patient registration be included in the list? <strong>N</strong>// <strong>&lt;ENTER&gt;</strong></td>
</tr>
<tr>
<td>16.</td>
<td>Output Type: <strong>P</strong>// <strong>Print the List</strong></td>
</tr>
<tr>
<td>17.</td>
<td>Demo Patient Inclusion/Exclusion: <strong>E</strong>// <strong>Exclude DEMO Patients</strong></td>
</tr>
</tbody>
</table>

**Note:** These directions will give you Active patients on your register. You can tailor this report further by restricting age ranges, communities, gender, case manager, or where followed. The order of these criteria are above.
**CONFIDENTIAL PATIENT INFORMATION**

**CHEMWA H CT**

**DIABETES REGISTER MASTER LIST**

Total number of patients selected for this report: 40

<table>
<thead>
<tr>
<th>HRN</th>
<th>PATIENT</th>
<th>CASE MANAGER</th>
<th>LAST VISIT</th>
<th>LAST REVIEW</th>
<th>NEXT REVIEW</th>
</tr>
</thead>
<tbody>
<tr>
<td>25634</td>
<td>ABUNE, LOUISE LAVERNE</td>
<td></td>
<td>12/17/18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18623</td>
<td>ADGMUN, KAREN M</td>
<td></td>
<td>06/17/11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32951</td>
<td>AEGLA STEFF, ANGELA T</td>
<td></td>
<td>01/16/96</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8876</td>
<td>BAGEI, DARELYNE L</td>
<td></td>
<td>05/07/14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23840</td>
<td>BAGEI, YOLANDA</td>
<td></td>
<td>11/05/13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>400030</td>
<td>BLACKSLEEVE, EPATIENT</td>
<td></td>
<td>03/15/16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43167</td>
<td>BUOCHERD, CARMINE J</td>
<td></td>
<td>05/18/06</td>
<td></td>
<td></td>
</tr>
<tr>
<td>46515</td>
<td>BYRD, ANDREA L</td>
<td></td>
<td>01/06/14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10434</td>
<td>CHEVAZ, NANCY</td>
<td></td>
<td>05/01/14</td>
<td>03/22/17</td>
<td>12/22/16</td>
</tr>
<tr>
<td>44579</td>
<td>CHOKWO, KELLIE E</td>
<td></td>
<td>11/07/13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6566</td>
<td>CLERK, JAMES S</td>
<td></td>
<td>04/21/14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23801</td>
<td>CLUSSUN, LINDA J</td>
<td>HEAD, DON</td>
<td>10/15/13</td>
<td>12/08/16</td>
<td>06/08/17</td>
</tr>
<tr>
<td>14769</td>
<td>FARGOSUN, GINA LOUANN</td>
<td></td>
<td>01/24/14</td>
<td>05/25/17</td>
<td>06/09/17</td>
</tr>
<tr>
<td>25991</td>
<td>FYNNSUN, LORaine Y</td>
<td></td>
<td>05/05/14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49077</td>
<td>GELEKTYENUFF, LODYNNE</td>
<td></td>
<td>02/27/18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>400026</td>
<td>GREENSLEEVE, APATIENT</td>
<td></td>
<td>02/01/16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19443</td>
<td>HACUCTE, CHARLES D</td>
<td>CYNKUTIS-SIMON,</td>
<td>04/21/14</td>
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<tr>
<td>12706</td>
<td>HANSUN, HENRY A</td>
<td></td>
<td>06/25/13</td>
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<td>28220</td>
<td>HOGGYNS, HERBERT J</td>
<td></td>
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<td>22447</td>
<td>HUOSAR, LANA E</td>
<td></td>
<td>05/05/14</td>
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<td>9505</td>
<td>HYLBORN, MARVEL J</td>
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<td>JECKSUN, ROBIN L</td>
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<td>8410</td>
<td>JOCOTEN, CHRISTOPHER</td>
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<td>05/07/14</td>
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<td></td>
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<tr>
<td>9734</td>
<td>JUHN, PARK H III</td>
<td>ASHRAT, M</td>
<td>01/03/14</td>
<td>06/06/18</td>
<td>06/06/19</td>
</tr>
<tr>
<td>43400</td>
<td>LUFSTRUM, ERIC S</td>
<td></td>
<td>02/28/12</td>
<td></td>
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<tr>
<td>13363</td>
<td>MECKEREVYTZ, EVERETT</td>
<td>HEAD, DON</td>
<td>06/14/12</td>
<td>03/14/17</td>
<td>05/16/17</td>
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<td>36514</td>
<td>PATHTAL, GUILLERMO JR</td>
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<td>06/23/06</td>
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<tr>
<td>39404</td>
<td>PWWALL, KATHY J</td>
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<td>06/27/03</td>
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<tr>
<td>5372</td>
<td>PYNNUCUASA, RUBENA G</td>
<td>CHANG, KUO</td>
<td>02/28/13</td>
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<td>04/18/14</td>
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<td>ROSSALL, MELANIE J</td>
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<td>04/17/14</td>
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<td></td>
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<td>45705</td>
<td>SLAAPINGBAER, ALISA D</td>
<td></td>
<td>06/12/08</td>
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<td>47000</td>
<td>SMITHA, WENDY A</td>
<td></td>
<td>02/02/15</td>
<td>09/15/17</td>
<td>09/15/17</td>
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<td>14870</td>
<td>SMYTH, SHAWNA LOUISE</td>
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<td>04/21/14</td>
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</tr>
<tr>
<td>31778</td>
<td>U'NAYLL, LAURA NOREEN</td>
<td></td>
<td>02/15/13</td>
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<td></td>
<td>08/23/16</td>
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<td></td>
</tr>
<tr>
<td>400027</td>
<td>WHITESLEEVE, BPATIENT</td>
<td></td>
<td>08/01/18</td>
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<td></td>
</tr>
<tr>
<td>43942</td>
<td>WULFLECK, CAROLYN J</td>
<td></td>
<td>07/12/11</td>
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<td></td>
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<tr>
<td>50517</td>
<td>WYLSUN, LEROY MICHAEL</td>
<td></td>
<td>04/10/14</td>
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<td></td>
</tr>
<tr>
<td>400029</td>
<td>YELLWSLEEVE, DPATIEN</td>
<td></td>
<td>08/16/16</td>
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<td></td>
</tr>
</tbody>
</table>
Follow-Up Reports

**What:** The follow-up report allows you to identify members of the register who are due for or have never had, exams, procedures, diabetes patient education, immunizations, vaccines, or lab tests as part of their diabetes care.

The follow-up report displays the patients, chart numbers, and date of last exam. Only those patients who have not had a specific exam in the last 11 months are displayed. The report is sorted alphabetically by patient name within each community. Each of the follow-up reports can be limited to patients within a specific community or followed by a specific primary provider.

**Why:** A quick way to identify patients who are due for care.

**When:** Quarterly, or as needed

**How:** From the Diabetes Management System Main Menu:

1. Select Diabetes Management System Option: **RM** Register Maintenance...
2. Select Register Maintenance Option: **RR** Register Reports...
3. Select Register Reports Option: **FU** Follow-up Needed
4. Which Register: (1-3): **Select the number corresponding to your register**
5. Which Report: **ALL**
6. Which Group: Use Register Members// **Enter**
7. Which patients: Active// **Enter** for Active or type other status
8. Which Diagnosis: All Diagnoses// **Enter**
9. Include list of patient’s upcoming appointments? NO// **Enter**
10. Which one: Community// **Enter**
11. Which Community: **Enter**
12. Which one: Follow-up Report// **Enter**
13. Demo Patient Inclusion/Exclusion: E// **Enter**
14. DEVICE: HOME// **Enter** to view on screen or **PRINTER NAME** to print

**DIABETES REGISTER - FOLLOW-UP NEEDED REPORTS**
(Patients due now or within the next 30 days.)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ALL Exams/Procedures-------------------</td>
</tr>
<tr>
<td>11</td>
<td>Foot Exam</td>
</tr>
<tr>
<td>14</td>
<td>Depressive Screening</td>
</tr>
<tr>
<td>2</td>
<td>ALL Patient Education------------------</td>
</tr>
<tr>
<td>21</td>
<td>Nutrition</td>
</tr>
<tr>
<td>23</td>
<td>General Info</td>
</tr>
<tr>
<td>3</td>
<td>ALL Immunizations/Vaccines-------------</td>
</tr>
<tr>
<td>31</td>
<td>Seasonal Flu Shot</td>
</tr>
<tr>
<td>33</td>
<td>Td/Tdap</td>
</tr>
<tr>
<td>35</td>
<td>Hepatitis B</td>
</tr>
<tr>
<td>4</td>
<td>ALL Lab Tests--------------------------</td>
</tr>
<tr>
<td>41</td>
<td>LDL Cholesterol</td>
</tr>
<tr>
<td>43</td>
<td>Cholesterol</td>
</tr>
<tr>
<td>45</td>
<td>Creatinine</td>
</tr>
<tr>
<td>47</td>
<td>Estimated GFR</td>
</tr>
<tr>
<td>49</td>
<td>Hepatitis C Screening</td>
</tr>
</tbody>
</table>

Type ‘ALL’ to include ALL Follow-up Needed which Report:

Use the one-digit codes to find whole categories and two-digit codes for specific items.

Example: ‘3’ returns all immunizations but ‘31” finds people due for flu shots.

This looks for the diagnosis entered under Patient Management #5
#1: Sorted by PROVIDER

NPAIHB DIABETES Register - Active Patients
Follow-up Report: EYE EXAM (For Patients due now or within the next 30 days)  
REPORT DATE: JAN 26, 2023  

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>PATIENT</th>
<th>HRN</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPLEGATE-MD, RO</td>
<td>BAGEI, LAVERNA CHAROLETTE</td>
<td>23840</td>
<td>last EYE EXAM MAY 21, 2001</td>
</tr>
<tr>
<td>APPLEGATE-MD, RO</td>
<td>BLECK, CONNIE L</td>
<td>29070</td>
<td>last EYE EXAM DEC 2, 2010</td>
</tr>
<tr>
<td>APPLEGATE-MD, RO</td>
<td>LUFSTRUM, IRVIN</td>
<td>43400</td>
<td>last EYE EXAM FEB 19, 2010</td>
</tr>
<tr>
<td>APPLEGATE-MD, RO</td>
<td>PEPFYN, TODD MYCHAL</td>
<td>35726</td>
<td>last EYE EXAM JAN 27, 2011</td>
</tr>
<tr>
<td>APPLEGATE-MD, RO</td>
<td>WHAALAR, ALVIE D</td>
<td>11083</td>
<td>last EYE EXAM FEB 22, 1993</td>
</tr>
<tr>
<td>BISCHOFF, JASON</td>
<td>NYVELE, CHRYSTOPHER RAY</td>
<td>41963</td>
<td><em>NO</em> EYE EXAM on record.</td>
</tr>
<tr>
<td>HANSON, AARON P</td>
<td>BALGEROA, WILLIAM C L</td>
<td>37859</td>
<td>last EYE EXAM SEP 29, 2010</td>
</tr>
<tr>
<td>HANSON, AARON P</td>
<td>BREFYALD, RITA K</td>
<td>22895</td>
<td>last EYE EXAM NOV 25, 2010</td>
</tr>
<tr>
<td>HANSON, AARON P</td>
<td>CUUNS, BILLY D</td>
<td>36358</td>
<td>last EYE EXAM JAN 27, 2011</td>
</tr>
<tr>
<td>HANSON, AARON P</td>
<td>DEWKYSN, DUSTIN B</td>
<td>40950</td>
<td>last EYE EXAM AUG 29, 2010</td>
</tr>
<tr>
<td>HANSON, AARON P</td>
<td>HUFMENN, TED</td>
<td>41915</td>
<td>last EYE EXAM DEC 12, 2010</td>
</tr>
<tr>
<td>HANSON, AARON P</td>
<td>KULB, COLINDA R</td>
<td>45446</td>
<td><em>NO</em> EYE EXAM on record.</td>
</tr>
<tr>
<td>HANSON, AARON P</td>
<td>LYTMYN, DEBRA</td>
<td>30775</td>
<td>last EYE EXAM NOV 17, 2010</td>
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<tr>
<td>HANSON, AARON P</td>
<td>SOLLI, GEORGE L</td>
<td>26904</td>
<td>last EYE EXAM MAY 16, 2005</td>
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<tr>
<td>HANSON, AARON P</td>
<td>THUMES, VIRGINIA RAE</td>
<td>29944</td>
<td>last EYE EXAM JAN 28, 2011</td>
</tr>
<tr>
<td>NOT LISTED</td>
<td>BLECKBAER, LISA LENORE</td>
<td>28605</td>
<td>last EYE EXAM NOV 4, 2010</td>
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<tr>
<td>NOT LISTED</td>
<td>HELSTAD, RACHEAL CASSANDR</td>
<td>8734</td>
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<tr>
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<tr>
<td>NOT LISTED</td>
<td>SMYTH, MARK CARROLL</td>
<td>42959</td>
<td>last EYE EXAM JAN 14, 2010</td>
</tr>
</tbody>
</table>

#2: Sorted by COMMUNITY

NPAIHB DIABETES Register - Active Patients
Follow-up Report: ALL Patient Education (For Patients due now or within the next 30 days)  
REPORT DATE: JAN 26, 2023  

<table>
<thead>
<tr>
<th>COMMUNITY</th>
<th>PATIENT</th>
<th>HRN</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>BEAVERTON</td>
<td>BLECKBAER, LISA LENORE</td>
<td>28605</td>
<td><em>NO</em> EXERCISE ED on record.</td>
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<tr>
<td>BEAVERTON</td>
<td>HOYSMEN, TAMARA F</td>
<td>40222</td>
<td><em>NO</em> NUTRITION ED on record.</td>
</tr>
<tr>
<td>BEAVERTON</td>
<td>HOYSMEN, TAMARA F</td>
<td>40222</td>
<td><em>NO</em> EXERCISE ED on record.</td>
</tr>
<tr>
<td>BEAVERTON</td>
<td>HUFMENN, TED</td>
<td>41915</td>
<td><em>NO</em> NUTRITION ED on record.</td>
</tr>
<tr>
<td>BEAVERTON</td>
<td>HUFMENN, TED</td>
<td>41915</td>
<td><em>NO</em> EXERCISE ED on record.</td>
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<tr>
<td>CANBY</td>
<td>FUOSA, TONYA L</td>
<td>44027</td>
<td><em>NO</em> NUTRITION ED on record.</td>
</tr>
<tr>
<td>CANBY</td>
<td>FUOSA, TONYA L</td>
<td>44027</td>
<td><em>NO</em> EXERCISE ED on record.</td>
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<tr>
<td>ESTACADA</td>
<td>CREYN, MARCUS L JR</td>
<td>22545</td>
<td><em>NO</em> NUTRITION ED on record.</td>
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<tr>
<td>ESTACADA</td>
<td>CREYN, MARCUS L JR</td>
<td>22545</td>
<td><em>NO</em> EXERCISE ED on record.</td>
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<tr>
<td>FOREST GROVE</td>
<td>SMYTH, KEVIN J</td>
<td>45328</td>
<td><em>NO</em> NUTRITION ED on record.</td>
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<tr>
<td>FOREST GROVE</td>
<td>SMYTH, KEVIN J</td>
<td>45328</td>
<td><em>NO</em> EXERCISE ED on record.</td>
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<td>SMYTH, KEVIN J</td>
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<tr>
<td>GRESHAM</td>
<td>SKYNNAR, BONNIE</td>
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<tr>
<td>GRESHAM</td>
<td>SKYNNAR, BONNIE</td>
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</tbody>
</table>
Creating a Follow-Up Letter

**What:** You can create form letters that are stored on your system. Letter inserts for information such as name, address, and date are filled in when you print.

Form letters can be printed for individual patients through Patient Management, or for groups of patients with the same follow-up needs through Follow-Up Reports.

**Why:** This option simplifies case management by merging patient data in the RPMS system into a letter of your choice.

**When:** As needed. Letters can be created, saved, and modified as you wish.

**How:** From the Diabetes Management System Main Menu:

1. Select Diabetes Management System Option: **RM** Register Maintenance...
2. Select Register Maintenance Option: **LM** Letter Management...
3. Select Letter Management Option: **LAE** ADD/EDIT DMS Letters
4. Which Register: (1-3): **Select the number corresponding to your register**
5. Select Action: Quit// 2 ADD Letter
6. NAME OF LETTER: **FOOT EXAM** (this is an example name)
7. Are you adding ‘FOOT EXAM’ as a new DMS LETTER (the 29TH)? No// Y
8. LETTER:
   - No existing text
   - Edit? NO// Y
9. Type your letter using the INSERTS listed below. To use the inserts, enter the number surrounded by the “|” character. ([SHIFT+\], below the backspace key). For example, |3| will insert the patient’s address in each letter.
   - You can also enter the name of the field, ex: |FIRST NAME|.
   - Tip: It may be easier to write your letter in another program (such as Microsoft Word) and copy and paste it into this window.
10. To save and exit, hit the **F1** key let go, and type **E**. (If that doesn’t work, try either **Num Lock and then E**, **CTRL than E**, or the **End** key.)

**TIP:** You can use this function to create a quick list of the care a patient is due for. Create a letter that contains the following:

|LAST NAME|, |FIRST NAME| |CHART| |PROVIDER NAME| |FOLLOW UP|

Before an appointment, check this in Patient Management, “Print Letter.” Example:

- BUTTER, PEANUT
  12345
- APPLEGATE, ROGER
  FOOT EXAM last FOOT EXAM JUN 7,2014
  EYE EXAM last EYE EXAM FEB 28,2014
  PAP SMEAR last PAP SMEAR JUN 7,2014
The list of inserts is updated periodically. To see all the inserts in RPMS, choose number 4 in step 5 above.

Writing a Follow-Up Letter

---[ WRAP ]---[ INSERT ]-------------[ LETTER ]-------------[ <PF1>H=HELP ]-----

|8|
|1| |2|
|3|

DEAR |1| |2|,
Our records show that you are due for a dental exam.
|12|
Please call the clinic at (555) 555-5555 to make your appointment.

Thank you,

Rachel Smith
Diabetes Coordinator

<=======T======T======T======T======T======T======T======T======T======T======T======

Letter Inserts

<table>
<thead>
<tr>
<th>NO.</th>
<th>INSERT</th>
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<tr>
<td>1</td>
<td>FIRST NAME</td>
</tr>
<tr>
<td>2</td>
<td>LAST NAME</td>
</tr>
<tr>
<td>3</td>
<td>ADDRESS</td>
</tr>
<tr>
<td>4</td>
<td>PRIMARY CARE PROVIDER</td>
</tr>
<tr>
<td>5</td>
<td>REGISTER PROVIDER</td>
</tr>
<tr>
<td>6</td>
<td>FOLLOW UP</td>
</tr>
<tr>
<td>7</td>
<td>CHART</td>
</tr>
<tr>
<td>8</td>
<td>DATE</td>
</tr>
<tr>
<td>9</td>
<td>EDUCATE</td>
</tr>
<tr>
<td>10</td>
<td>FOOT EXAM EDUCATION</td>
</tr>
<tr>
<td>11</td>
<td>EYE EXAM EDUCATION</td>
</tr>
<tr>
<td>12</td>
<td>DENTAL EXAM EDUCATION</td>
</tr>
<tr>
<td>13</td>
<td>FLU SHOT EDUCATION</td>
</tr>
<tr>
<td>14</td>
<td>PNEUMO EDUCATION</td>
</tr>
<tr>
<td>15</td>
<td>TETANUS EDUCATION</td>
</tr>
<tr>
<td>16</td>
<td>TB TEST EDUCATION</td>
</tr>
<tr>
<td>17</td>
<td>A1C HEMOGLOBIN EDUCATION</td>
</tr>
<tr>
<td>18</td>
<td>CREATHINE EDUCATION</td>
</tr>
<tr>
<td>19</td>
<td>URINE PROTEIN TEST EDUCATION</td>
</tr>
<tr>
<td>20</td>
<td>LIPID PANEL EDUCATION</td>
</tr>
<tr>
<td>21</td>
<td>FOLLOW UP WITH EDUCATION</td>
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<td>22</td>
<td>NUTRITION EDUCATION</td>
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<tr>
<td>23</td>
<td>PHYSICAL ACTIVITY EDUCATION</td>
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<tr>
<td>24</td>
<td>A/C RATIO EDUCATION</td>
</tr>
<tr>
<td>25</td>
<td>CENTER</td>
</tr>
<tr>
<td>26</td>
<td>HEP B EDUCATION</td>
</tr>
<tr>
<td>27</td>
<td>FOLLOW UP W/EDUC (W/O DEP, EDUC)</td>
</tr>
<tr>
<td>28</td>
<td>EGFR</td>
</tr>
<tr>
<td>29</td>
<td>EKG</td>
</tr>
<tr>
<td>30</td>
<td>eGFR</td>
</tr>
</tbody>
</table>
Generating Follow-Up Letters

What: You can print a batch of letters to patients who are due for follow-up using one of the form letters created by you or someone else on your diabetes team. You can also request a follow-up report at the same time, which creates a convenient record of who the letters were printed for.

**To print one letter for a specific patient, use Patient Management option #13.**

Why: The follow-up letter can be a convenient tool to contact patients for needed care. It ensures that the IHS Standards of Care For Patients With Type 2 Diabetes is being addressed by your clinic.

When: Monthly, as needed.

How: From the Diabetes Management System Main Menu:

1. Select Diabetes Management System Option: **RM** Register Maintenance...
2. Select the Register Maintenance Option: **RR** Register Reports...
3. Select Register Reports Option: **FU** Follow-up Needed
4. Which Register: (1-3): **Select the number corresponding to your register**
5. Which Report: **ALL**
6. Which Group: Use Register Members// **<Enter>**
7. Which patients: Active// **<Enter>**
8. Which Diagnosis: All Diagnoses// **<Enter>**
9. Include list of patient’s upcoming appointments? NO// **<Enter>**
10. Which one: Community// **<Enter>**
11. Which Community: **<Enter >**
12. Which one: Follow-up Report// **2 (Follow-up letter)**
13. Select Letter No.: **Enter letter #** from list of created letters
14. DEVICE: HOME// **<Enter>** to view on screen or **PRINTER NAME** to print

DIABETES REGISTER - FOLLOW-UP NEEDED REPORTS
(Patients due now or within the next 30 days.)

1  ALL Exams/Procedures-------------------------------
11 Foot Exam 12 Eye Exam
14 Depression Screening 18 Dental Exam
2  ALL Patient Education-------------------------------
21 Nutrition 22 Exercise
23 General Info
3  ALL Immunizations/Vaccines------------------------
31 Seasonal Flu Shot 32 Pneumovax
33 Td/Tdap 34 TB Test
35 Hepatitis B
4  ALL Lab Tests-------------------------------------
41 LDL Cholesterol 42 HDL Cholesterol
43 Cholesterol 44 Triglyceride
45 Creatinine 46 Hemoglobin A1c
47 Estimated GFR 48 A/C Ratio
49 Hepatitis C Screening

Type ‘ALL’ to include ALL Follow-up Needed
Which Report:

The menu is the same for Follow-up Letters and Follow-up Reports. The differentiating step is step 12, choosing either letter, report, or both.
January 26, 2023

PEANUT BUTTER
2084 MCCOY NE
WS CAMPUS, OR 97305

DEAR PEANUT,

Our records show that you are due for a dental exam.

A yearly DENTAL EXAM is recommended to look for evidence of gum disease and other conditions that can both make diabetes harder to control and can lead to premature tooth loss.

Please call the clinic at (555) 555-5555 to make your appointment.

Thank you,

Barbara Gordon
Diabetes Coordinator
Register Patient General Retrieval (GEN)

**What:** Use GEN to search for patients in your register and print custom reports. Reports can be either lists of patients or counts of patients.

First, GEN allows you to search (or select) patients in your diabetes register. *For example, to find all inactive patients, you would search by register status.*

Decide whether you want a listing with one line per patient, or just summary counts.

Next, you choose which information you want to print about the patients you found in step 1. *For example, you may want to print each inactive patient’s name, chart number, and last visit date.*

Lastly, GEN allows you to sort (or group) the resulting list. *For example, you may want to sort your list of patients by name (alphabetical list).*

**Why:** This report can be a useful tool for case management, updating your register, and getting information about your diabetic population.

**When:** As needed.

**How:** From the Diabetes Management System Main Menu:

1. Select Diabetes Management System Option: **RM** Register Maintenance ...
2. Select Register Maintenance Option: **RR** Register Reports ...
3. Select Register Reports Option: **GEN** Patient General Retrieval (Lister)
4. Which Register: (1-3): Select the number corresponding to your register
5. Do you want to use a previously defined report? N// <Enter>
6. Select Patients based on which of the above: (1-47): Choose from the listed criteria to search your register patients. Choose as many as you wish. You will then be asked for more specifics on your chosen criteria. For example, if you chose Register Status, you will need to enter the status you are looking for.
7. Would you like to select additional PATIENT criteria? NO// <Enter>
8. Choose Type of Report: D// <Enter>
9. Select print item(s): (1-56): Choose which of the listed criteria you would like printed for each patient found.
10. Enter Column width for Patient Name (suggested: 20): (2-80): 20// <Enter> (For each criteria you chose to print you will be asked to enter a column width. You are aiming for a total of 80 or less. Simply press enter to choose the default width.)
11. Would you like to select additional PRINT criteria? NO// <Enter>
12. Sort Patients by which of the above: (1-25): Choose which of the listed criteria you would like to have the patients sorted by.
13. Do you want a separate page for each Patient Name? N// <Enter>
14. Would you like a custom title for this report? N// <Enter> (You can choose Yes and type in your own title that will appear at the top of the report.)
15. Do you wish to save this SEARCH/PRINT/SORT logic for future use? N// <Enter>
16. DEVICE: HOME// <Enter> to view on screen or PRINTER NAME to print
### GEN Reports

The Patients displayed can be SEARCHED based on any of the following criteria:

1. Patient Name
2. Patient Sex
3. Patient DOB
4. Birth Month
5. Patient Age
6. Patient DOD
7. Mlg Address-State
8. Mlg Address-Zip Code
9. Living Patients
10. Chart Facility
11. Patient Community
12. Patient Tribe
13. Eligibility Status
14. Class/Beneficiary
15. Cause of Death
16. Medicare Eligibility
17. Medicaid Eligibility
18. Priv Ins Eligibility
19. Primary Care Provider
20. Patient's Last Visit
21. Primary Care Provider
22. Register Status
23. Inactivation Date
24. Case Priority
25. PHN
26. Last Review Date
27. Next Review Date
28. Where PT Followed
29. Date Last Edited
30. Case Comments
31. Register Provider
32. Case History
33. Interventions
34. Intervention Due DT
35. Intervention Result DT
36. Care Plan
37. Care-Plan Comment
38. Complications
39. Complication Onset D
40. Complication Comment
41. Diagnoses
42. Date of Onset
43. Recall Date
44. Etiology
45. Risk Factors
46. Medications
47. Services
48. Diagnostic Criteria

Choose Type of Report: D//

#### PRINT Data Items Menu

1. Patient Name
2. Patient Chart #
3. Patient Sex
4. Patient DOB
5. Birth Month
6. Patient Age
7. Patient DOD
8. Mlg Address-Street
9. Mlg Address-State
10. Mlg Address-City
11. Mlg Address-Zip Code
12. Home Phone
13. Mother's Name
14. Patient Community
15. Patient Tribe
16. Eligibility Status
17. Class/Beneficiary
18. Cause of Death
19. Medicare Eligibility
20. Medicaid Eligibility
21. Priv Ins Eligibility
22. Patient's Last Visit
23. Primary Care Provider
24. Register Status
25. Initial Entry Date
26. Inactivation Date
27. Case Priority
28. Case Manager
29. PHN
30. Last Review Date
31. Next Review Date
32. Where PT Followed
33. Date Last Edited
34. Case Comments
35. Client Contact
36. Register Provider
37. Case History
38. Interventions
39. Intervention Due DT
40. Intervention Results
41. Intervention Result DT
42. Intervent Plan Categ
43. Care Plan
44. Care-Plan Comment
45. Complications
46. Complication Onset D
47. Complication Comment
48. Diagnoses
49. Date of Onset
50. Recall Date
51. Etiology
52. Family Members
53. Risk Factors
54. Medications
55. Services
56. Diagnostic Criteria

Select a list or a range. E.g. 1-4,5,20 or 10,12,20,30

Select print item(s): (1-56):
**GEN Reports**

The Patients displayed can be **SORTED** by any one of the following:

1) Patient Name
2) Patient Age
3) Patient Community
4) Patient Sex
5) Patient Tribe
6) Patient Chart #
7) Primary Care Provider (PCC)
8) Classification/Beneficiary
9) Eligibility Status
10) Cause of Death
11) Patient DOB
12) Patient DOD
13) Register Status
14) Last Review Date
15) Next Review Date
16) Date Last Edited
17) Case Priority
18) Case Manager
19) PHN
20) Where PT Followed
21) Register Provider
22) Inactivation Date
23) Initial Entry Date
24) Mlg Address-Zip Code
25) Mlg Address-State
26) Birth Month

<<If you don't select a sort criteria the report will be sorted by Patient Name.>>

Sort Patients by which of the above: (1-26):

---

**Sample GEN Reports**

**GEN Report for complications**

The following report will print out a patient's name, health record number, case manager, and complications, if any. This report is used to determine which patients have complications, and which complications they have. Patients with multiple complications will have them listed on succeeding lines.

Using the directions on page 26, to print out a detailed patient summary, use the following items to:

**SEARCH**

9) LIVING PATIENTS
38) COMPLICATIONS to specify one or more complications (optional)

**Choose Type of Report: D// <Enter>**

**PRINT**

1) PATIENT NAME,
2) PATIENT CHART #
46) COMPLICATIONS
47) COMPLICATIONS DATE OF ONSET

**SORT**

1) PATIENT NAME

---

**CASE MANAGEMENT PATIENT LISTING**

**NPAIHB1 DIABETES REGISTER**

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>HRN</th>
<th>COMPLICATION</th>
<th>COMPL ONSET DT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADLER, STEVEN</td>
<td>WOR-400000</td>
<td>END STAGE RENAL</td>
<td>02/06/99</td>
</tr>
<tr>
<td>AEGLA, JACQUELINE M</td>
<td>WOR-46027</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>BACK, STELLA J</td>
<td>WOR-16518</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>BAGEI, GLENN L</td>
<td>WOR-632</td>
<td>KLR DIABETIC SH</td>
<td>10/31/11</td>
</tr>
<tr>
<td>BAGEI, TYRONE A</td>
<td>WOR-24432</td>
<td>HYPERTENSION</td>
<td>06/15/10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DEPRESSION</td>
<td>12/07/11</td>
</tr>
<tr>
<td>BEKAR, AMANDA C</td>
<td>WOR-45748</td>
<td>HIGH RISK FOOT</td>
<td>12/06/11</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DRH DEPRESSION</td>
<td>--</td>
</tr>
<tr>
<td>BEKAR, SHARLA M</td>
<td>WOR-39763</td>
<td>HIGH RISK FOOT</td>
<td>11/06/11</td>
</tr>
<tr>
<td>BERRY ALD, CARSON W</td>
<td>WOR-22869</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

Total Patients 108
Sample GEN Reports (continued)

GEN Report for patient status update

The following report will print out a patient’s name, health record number, status, and the last time that they had visited the clinic. This report is used to determine whether your Inactive or Active patients’ status is correct.

Using the directions on page 26, to print out a detailed patient summary, use the following items to:

SEARCH
20) REGISTER STATUS, specify ACTIVE, INACTIVE, TRANSIENT

Choose Type of Report: D// <Enter>

PRINT
1) PATIENT NAME
2) PATIENT CHART #
25) REGISTER STATUS
23) PATIENT’S LAST VISIT

SORT
13) REGISTER STATUS

GEN Report to list patients with upcoming review dates and their case manager

This report will list patients with upcoming review dates, and the case manager, if any, that has been assigned to them. It will also list those patients without a case manager.

Using the directions on page 26, to print out a detailed patient summary, use the following items to:

SEARCH
27) NEXT REVIEW DATE: you will be prompted to enter a beginning date and an end date for the next review dates; enter a time frame that you want to search, like T-7 (last week) for beginning date, and T+7 (next week) for an end date.

Choose Type of Report: D// <Enter>

PRINT
1) PATIENT NAME
2) PATIENT CHART #
32) NEXT REVIEW
29) CASE MANAGER

SORT
18) CASE MANAGER
Sample GEN Reports (continued)

GEN Report to list Active patients by primary care provider with last visit

This GEN report will list the living patients on your register, and their Primary Care Provider (if one is assigned), and their last visit to the clinic.

Using the directions on page 26, to print out a detailed patient summary, use the following items to:

SEARCH
9) LIVING PATIENTS
20) REGISTER STATUS (ACTIVE)
Choose Type of Report: D// <Enter>
PRINT
1) PATIENT NAME
2) PATIENT CHART #
24) PRIMARY CARE PROVIDER
23) PATIENT’S LAST VISIT
SORT
7) PRIMARY CARE PROVIDER

GEN Report to count active patients assigned to primary care provider

This report will list all the primary care providers, and the number of patients that are assigned to each. Instead of the Detailed Patient Summary, at the GEN Output Options screen choose Total Counts and Sub-counts.

SEARCH
9) LIVING PATIENTS
20) REGISTER STATUS (ACTIVE)
Choose Type of Report: D// S (Sub-counts)
SORT
7) PRIMARY CARE PROVIDER
Section 2: Supporting Information
Diabetes Capacity Pyramid

**What:** A self-assessment tool to measure the ability and needs of tribal diabetes data tracking systems.

**Why:** To determine diabetes data system needs of each program and to assess progress at improving diabetes data systems.

**How:** The tribes will use the tool to self-assess their capacity level.

**When:** This tool will either be mailed to sites and followed up with a phone call or will be discussed during site visits.

The Western Tribal Diabetes Project (WTDP) Diabetes Data Capacity Pyramid is a tool to measure the ability and needs of tribal programs to track the care and health statistics of patients with diabetes. A complete, accurate, and comprehensive data system is key to ensuring the standards of care are met for each patient with diabetes. The data system is necessary to determine the true impact diabetes has on American Indians and Alaska Natives, can be used to strengthen the care of those with diabetes and ultimately move the community towards prevention.

The structure of the Pyramid was chosen to illustrate the need for a solid foundation and the step-by-step approach necessary for a stable, sustainable diabetes data system. Progress upward on the Pyramid is dependent on the strength of the levels below. It is likely that programs will gain and lose capacity over time. By using this tool to assess diabetes data capacity WTDP can best target technical assistance and resources to create successful public health systems. This is a tool developed for tracking diabetes data systems, but can be a model for other disease management and prevention activities.

**Components of the Diabetes Data Capacity Pyramid**

- **Data-Informed Prevention** – ability to focus prevention efforts based on objective data
- **Data Utilization** – ability to use data for case management, standards of care, etc.
- **Data Retrieval** – ability to retrieve information from database
- **Data Entry** – ability to enter comprehensive and quality data
- **Data Systems Capacity** – foundation for a data system
Dates
7/15/21
071521
7-15-21
7 15 21
JUL 15 2021

Date Shortcuts
T = Today
T+10 = 10 days from now
T-365 = 1 year ago
T+40W = 40 weeks from today
T-3M = 3 months ago

---[WRAP]----[INSERT]-----[<PFI>H=Help]-----

I'm typing in this screen, and now I'm done, and I want to get out. Q for quit? No, not that. ^ ^ ^ to escape? Hmm, that doesn't work. Now what? Oh, yeah --

F1 then E

<========T=========T========T=========T========T=>
# Defining Register Patient Status

**Register Patient Status:** Each patient in the register must have a register status. This allows you to group patients for reports (example: running the audit on only active patients). There is no standard definition for the different register statuses, but it is helpful if everyone in a clinic has clear guidelines to follow. Here are some examples.

<table>
<thead>
<tr>
<th>Status</th>
<th>Example 1*</th>
<th>Example 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Active</strong></td>
<td>Patients who obtain primary care at your facility and have been seen for a diabetes medical visit within the past year. The Active list will be used for the annual IHS Diabetes Audit</td>
<td>Patients with at least 1 primary care visit in the past 12 months or patients who are not attending clinic, but you do not know if they have recently moved or found another source of care</td>
</tr>
<tr>
<td><strong>Inactive</strong></td>
<td>Patients not seen within the past 2 years or patients no longer utilizing any services of your facility, or who have moved away.</td>
<td>Patients who have moved away permanently or who you know to be receiving care elsewhere or who have not had a primary care visit in more than 2 years</td>
</tr>
<tr>
<td><strong>Transient</strong></td>
<td>Patients who are seen for primary diabetes care elsewhere, but visit your clinic periodically for some level of care, e.g., education, medications, dental, etc.</td>
<td>Not a local resident/resides outside of CHSDA</td>
</tr>
<tr>
<td><strong>Deceased</strong></td>
<td>self-explanatory</td>
<td>Patients you know to be deceased (does not require a death certificate on file)</td>
</tr>
<tr>
<td><strong>Non-IHS</strong></td>
<td>Non-Indian patients</td>
<td>Non-Indian patients</td>
</tr>
<tr>
<td><strong>Unreviewed</strong></td>
<td>Patients in your register who have not gone through medical record review. Add new patients to the Diabetes Register as “un-reviewed” until diagnosis of diabetes is substantiated.</td>
<td>Patients on dialysis  Note: The word “unreviewed” has no relationship to dialysis — it is just a category that was not being used. By designating a status for dialysis patients, you can streamline reporting for that group.</td>
</tr>
<tr>
<td><strong>Lost to follow-up</strong></td>
<td>Temporary category where patients can be moved until appropriate status category is determined. These are patients seen at your facility that have not had a visit within the last year, but had a visit within the past two years. EX: “Active” register patient who has not had a visit at your facility in 13 months.</td>
<td>Unable to contact, defined as at least 3 tries in 12 months (should be documented in the patient’s chart)</td>
</tr>
</tbody>
</table>

*Example 1 definitions are taken from recommendations for California diabetes programs in 2005.
Saving the Register as a Template

**How:** From the Diabetes Management System Main Menu:

1. Select IHS CORE Option: **QMAN**
2. Enter RETURN to continue or ‘^’ to exit:  <Enter>
3. Your choice: SEARCH// 1 Search PCC Database
4. What is the subject of your search? LIVING PATIENTS // REGISTER
5. Which CMS REGISTER: **IHS DIABETES** (or the name of your register)
6. Which Status(es): (1-8): 1// 8 (all statuses)
7. Which Diagnosis: All Diagnoses// 6 (all diagnoses)
8. Attribute of IHS DIABETES REGISTER: <Enter>
9. Your choice: DISPLAY// 4 STORE results of a search in a FM search template
10. Enter the name of the SEARCH TEMPLATE: **DRH DM REG 030323**
11. Are you adding ‘DRH DM REG 030321’ as a new SORT TEMPLATE? No// Y (Yes)
12. Edit? NO// <Enter>
13. Want to run this task in background? No// <Enter>

**Sample Results**

<table>
<thead>
<tr>
<th>PATIENTS</th>
<th>SELLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>WATERMAN,RAE*</td>
<td>100003</td>
</tr>
<tr>
<td>WHEELWRIGHT,MAND</td>
<td>100006</td>
</tr>
<tr>
<td>MILLER,SALLY*</td>
<td>100010</td>
</tr>
<tr>
<td>ROBERTS,DIANE*</td>
<td>100018</td>
</tr>
<tr>
<td>WHEELWRIGHT,WALL</td>
<td>100026</td>
</tr>
<tr>
<td>VON BRAUN,RAY</td>
<td>100031</td>
</tr>
<tr>
<td>SMITH,MAUDE</td>
<td>100047</td>
</tr>
<tr>
<td>WASHINGTON,JOAN*</td>
<td>100050</td>
</tr>
<tr>
<td>WINKERBEAN,JESS*</td>
<td>100053</td>
</tr>
<tr>
<td>SMITH,FAY*</td>
<td>100065</td>
</tr>
<tr>
<td>WHEELWRIGHT,MALC</td>
<td>100069</td>
</tr>
</tbody>
</table>

Search template completed...
This query generates 11 “hits”
Time required to create search template: 1 SECOND
Finding New Patients with Diabetes: Step 2

Using the template to exclude register patients from your search

**How:** From the Diabetes Management System Main Menu:

1. Select IHS CORE Option: *QMAN*
2. Enter RETURN to continue or ‘^’ to exit:  <Enter>
3. Your choice: SEARCH// 1 Search PCC Database  
4. What is the subject of your search? LIVING PATIENTS //  <Enter>
5. Attribute of PATIENT: [*DRH DM REG 030323*]  
6. Your choice (1-4): 1// 2 (Living pts must not be a member of the DRH DM REG 030321 cohort)
7. Attribute of PATIENT: *DX*
8. Enter DX: [*SURVEILLANCE DIABETES*]  
9. Press return to continue:  <Enter>
10. Enter ANOTHER DX:  <Enter>
11. Want to save this DX group for future use? No//  <Enter> (No)
12. First condition of “DIAGNOSIS”: SINCE
13. Exact date:  **T-3M** (Dec 30, 2020)
14. Next condition of “DIAGNOSIS”:  <Enter>
15. Attribute of LIVING PATIENTS:  <Enter>
16. Your choice: DISPLAY//  <Enter> to view on screen or PRINTER NAME to print
17. Your choice (1-3): 1// 2 or 3 (see examples below)

**Sample Results**

Please note: Patients whose names are marked with an “*” may have aliases.

<table>
<thead>
<tr>
<th>PATIENTS (Alive)</th>
<th>SELLS NUMBER</th>
<th>DX/ICD9</th>
<th>DATE OF POV</th>
<th>PROVIDER NARRATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMITH, CAROL</td>
<td>122695</td>
<td>250.00</td>
<td>FEB 28,2020</td>
<td>TYPE 2 DM</td>
</tr>
<tr>
<td>SMITH, CAROL</td>
<td>122695</td>
<td>250.00</td>
<td>MAY 25,2020</td>
<td>TYPE 2 DM</td>
</tr>
<tr>
<td>BRADY, MIKE</td>
<td>102695</td>
<td>250.00</td>
<td>MAR 15,2020</td>
<td>DIABETES</td>
</tr>
<tr>
<td>WILLIAMS, JASON</td>
<td>102052</td>
<td>250.00</td>
<td>APR 10,2020</td>
<td>DM SCREENING</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PATIENTS NUMBER</th>
<th>G ROND DX/ICD9</th>
<th>BENEFICIARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>WILLIAMS, M ARCIA</td>
<td>988  +</td>
<td>INDIAN/ ALASKA NA</td>
</tr>
<tr>
<td>DAVIDSON, MARK</td>
<td>888  +</td>
<td>INDIAN/ ALASKA NA</td>
</tr>
<tr>
<td>BRADY, MIKE</td>
<td>34567 +</td>
<td>INDIAN/ ALASKA NA</td>
</tr>
<tr>
<td>FUDD, ELMER</td>
<td>88879 +</td>
<td>INDIAN/ ALASKA NA</td>
</tr>
<tr>
<td>Total: 4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2) List of each patient visit where POV was for DM, with provider narratives
3) Unduplicated list of patients
**PLDX: Patients with no diagnosis of diabetes on problem list**

The following steps can be used to find patients on your register that do not have a diagnosis of diabetes on their problem list. Patients that do not have a diagnosis of diabetes on their problem list may have been miscoded into the diabetes register. For patients that were not miscoded, it is important for the provider to be aware of the patient’s diagnosis of diabetes.

**Option 1: Report for patients on the DMS Register**

1. Open RPMS
2. Go to **DMS** Diabetes Management System
3. Go to **AS** Audit Setup
4. Enter **PLDX** Patients w/no Diagnosis of DM on Problem List
5. Select **R** Those who are members of a registry
6. Enter the Name of the Register: **IHS DIABETES** [or the name of your register]
7. Do you want to select register patients with a particular status? Y// <enter>
8. Which status: A// <enter> ACTIVE
9. Output Type: P// PRINT the List or BROWSE the List on the Screen
10. Enter your **Printer Name**, or use the default "HOME" to display the results on your screen.

**Option 2: Report for patients with at least N visits with diabetes as purpose of visit (POV)**

1. Open RPMS
2. Go to **DMS** Diabetes QA Audit Menu
3. Go to **AS** Audit Setup...
4. Enter **PLDX** Patients w/no Diagnosis of DM on Problem List
5. Select **D** Those with at least N Diabetes Diagnoses
6. How many diagnoses must the patient have had: (1-999): 3// [enter any number]
7. The report will allow you to restrict the results to patients whose last visit was “recent.” Otherwise, the report will give you patients with at least N number of diabetes visits since the start of your RPMS database. [Enter a date, e.g., **T-24M**, or <enter>]
8. Enter your **Printer Name**, or use the default "HOME" to display the results on your screen.
**Patients with No Date of Onset**

**NDOO: Patients with no date of onset**

This report will list patients who are on the diabetes register who do not have an onset date for diabetes recorded in either the problem list or the register data (accessed through the Patient Management screen under #5 - Diagnosis). The Annual IHS Audit tracks the duration of time that patients have lived with diabetes.

1. Open RPMS
2. Go to **DMS** Diabetes Management System
3. Go to **RM** Register Maintenance...
4. Go to **RR** Register Reports...
5. Enter **NDOO** DM Register Pts w/no recorded DM Date of Onset
6. Which REGISTER: (1-5): **Select the number corresponding to your register**
7. Do you want to select register patients with a particular status? **Y// <ENTER>**
8. Which status: **A// <ENTER>**
9. Output Type: **P// PRINT** the List or **BROWSE** the List on the Screen
10. Demo Patient Inclusion/Exclusion: **E// <ENTER>**
11. Enter your **Printer Name**, or use the default “HOME” to display the results on your screen.

---

**TRAINING HC**

**DIABETES REGISTER PATIENTS WITH NO RECORDED DATE OF ONSET OF DIABETES**

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>HRN</th>
<th>DOB</th>
<th>LAST DM DX</th>
<th>#DM DXS</th>
<th>DM ON PL</th>
</tr>
</thead>
<tbody>
<tr>
<td>AEGLA STEFF, AMY M</td>
<td>32951</td>
<td>Jul 17, 1960 F</td>
<td>Apr 19, 2007 2</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>ALLYSUN, JULIE ANN</td>
<td>477</td>
<td>Nov 11, 1927 F</td>
<td>Jun 23, 2003 56</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>BALLYLLA, GERALD A JR</td>
<td>30487</td>
<td>Jan 16, 1939 M</td>
<td>Oct 11, 2003 2</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>BOANU, SHERMAN W</td>
<td>37067</td>
<td>Aug 29, 1967 M</td>
<td>Aug 21, 2003 10</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>BUORESSE, LARRY A SR</td>
<td>40247</td>
<td>Nov 10, 1938 M</td>
<td>Jul 10, 1995 5</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>CREM, JOLYNE M</td>
<td>20989</td>
<td>Sep 23, 1948 F</td>
<td>Mar 24, 1999 6</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>DALGERTYU, HEATHER A</td>
<td>38423</td>
<td>Nov 01, 1972 F</td>
<td>Feb 28, 2002 5</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>DONN, SHEILA J</td>
<td>40457</td>
<td>Feb 18, 1937 F</td>
<td>Aug 04, 2003 2</td>
<td>YES</td>
<td></td>
</tr>
</tbody>
</table>

---

**Last DM DX** refers to the last time a patient received a diagnosis of diabetes. Typically, a patient will receive a diagnosis of diabetes every time that they see a provider for the purpose of diabetes.

**#DM DXS DM** refers to the number of times a patient has received a diagnosis of diabetes. The number usually refers to how many purpose of visit for diabetes the patient has.

**DM ON PL:** Does the patient have a diagnosis of diabetes on their problem list?
Submitting the Electronic IHS Audit

Getting ready

**Update your active diabetes register patients.** These are the people you provide diabetes care to, and who you want to run your reports on throughout the year. If your definition of “active” patients is not the same as the audit definition, you can always use a QMAN search to fix that. (Instructions below.)

**Save a template of active patients for your audit.** You are aiming to include patients who:
- Have type 1 or type 2 diabetes
- Had at least 1 primary care visit in the calendar year
- Are American Indian or Alaska Native

Exclude patients who:
- Are receiving most of their diabetes care elsewhere (through Contract Health, a dialysis center, jail, nursing home, etc.)
- Did not live in the area during the year, or
- You were unable to contact (3 failed attempts in 12 months)

---

**A QMAN Template for your audit population**

**SUBJECT:** REGISTER
**WHICH REGISTER:** <name of your register, ex: IHS DIABETES>
**WHICH Status(es):** 1 (active)
**WHICH Register Diagnosis:** 6 (all diagnoses)
**ATTRIBUTE:** DX
Enter DX: [SURVEILLANCE DIABETES] <enter until next condition>
**ATTRIBUTE:** VISIT
First condition: BETWEEN
Exact starting date: 1/1/2020
Exact ending date: 12/31/2020
Next condition: CLINIC
Enter CLINIC: [BGP PRIMARY] (this uses the GPRA taxonomy for primary care visits)<enter> until you get to the output screen
Your choice: 4 (store results in a search template)
Enter the name of the SEARCH TEMPLATE: DM AUDIT 2020
DESCRIPTION: Edit? Y
Cohort for 2020 Diabetes Audit. Uses Active IHS DIABETES register patients, beneficiary status 01, at least one visit in 2020 for diabetes (SURVEILLANCE DIABETES) coded for a clinic in the BGP PRIMARY CARE taxonomy.<F1, E> to save and exit
Run this task in background? No// <enter>

---

**Check and update taxonomies.** Instructions on pages 48-51.

**Review your audit report.** Follow the steps below. If you have paper charts (not EHR), you may wish to print an individual audit sheet for all patients and review their charts for missing items (print option 4).

1. From the main menu, go to **DMS** Diabetes Management System *(may also be listed as BDM)*
2. Select Diabetes Management System Option: **AR** *(Audit Reporting...)*
3. Select Diabetes QA Audit Menu Option: **DM21** *(2020 Diabetes Audit)*
4. End of taxonomy check. HIT RETURN <enter>
5. Enter the Official Diabetes Register: **IHS DIABETES** *(or the name of your register)*
6. Enter the Audit Date: 12/31/2020 *(The last day of the calendar year)*
7. Run the Audit for: P//S *(Search template of patients, if you made one - C if otherwise)*
8. Enter Search Template Name: <the name you saved>
9. Limit the audit to a particular primary care provider? N// <enter>
10. Limit the patients who live in a particular community? N// <enter>
11. Select Beneficiary Population to include in the audit: 1//Indian/Alaska Native (Class. 01)<enter>
12. Select whether to include or exclude pregnant patients in the audit: E// <enter> Exclude Preg. Patients
13. Do you want to select: A// <enter> *(ALL patients selected so far)*
14. Enter Print option: 1//3 *(Audit Report)*
15. Demo Patient Inclusion/Exclusion: E// <enter>
Submitting the Electronic IHS Audit

16. Do you wish to: P// P to print, or B to Browse followed by PL to print

17. DEVICE: HOME// (enter the name of your printer here)

Create the audit data file

Follow steps 1-13 on the previous page, then:

13. Enter the Print Option: 1// 2 (Create AUDIT EXPORT file)

14. Enter the name of the FILE to be Created (3-20 characters): (Enter a short name, example: DMCLINIC21A. Your file may be saved to a server that is shared with other clinics, so it is useful to include the name or initials of your clinic in the name of the file, plus the year and an “A” in case you have to repeat.)

15. Write down the name of the file, example: DMCLINIC21A.txt

16. Is everything ok? Do you want to continue? Y// <enter>

17. Demo Patient Inclusion/Exclusion: E// <enter>

18. Won’t you queue this? Y// <enter>

Wait a few minutes, then ask your site manager to retrieve the data file for you. It is usually saved in the spub directory (they will know what this is). To get it to you, they should save the file to a secure network drive — please do not send this identified patient information in unencrypted email.

Upload to WebAudit and check for errors

- For audit links, including WebAudit, go to www.diabetes.ihs.gov and click on “Audit” under “Resources” in the navigation list on the left.
- If you don’t have one already, request a WebAudit account.

19. Log in, then click on Diabetes WebAudit, then click on Upload Data and follow the instructions there.

20. Run the Data Quality Check. This will identify any values in your audit data that are unusually or impossibly high or low.

21. Review errors from the Data Quality Check. Some may be actual values (for example, high triglycerides). These can be left as they are.

22. Correct any actual errors (for example, a height of 12 inches) in RPMS/EHR, not in WebAudit. That way, your patient records will be more complete.

- If you see multiple errors with the same lab test, this is usually because (1) the lab is in the wrong taxonomy, or (2) the lab put a phrase such as “see comments” in the result field. If (1), fix the taxonomy before you create a new data file. If (2), note the chart numbers and correct values and save them for correction by hand in WebAudit (see below).

Repeat, if needed

If you had errors and corrected them in RPMS/EHR, you will need to create and upload a new data file (repeat previous steps).

Make final corrections and lock the data

- If you found errors that you were unable to correct in RPMS/EHR, you can go to “Data Entry” and correct them on the individual records, which are identified by chart number.
- Use the Facility Administration section of WebAudit to enter
  - the total number of patients (same as your number of records unless you used a sample)
  - your SDPI grant number
- When your audit is complete, remember to “lock” the records so that IHS will know to retrieve the final file. You should receive a confirmation email within minutes.
Existing Registers on Your System

Note: You will need access to the Case Management System (CASE, CMS, or ACM) to do this, or work with your site manager.

How: From the RPMS main menu:

1. Select IHS Core Option: **CASE** or **CMS** (depends on how your system is set up)
2. Select Case Management System Option: **CR** (Create/Modify Register Structure)

You should see a list of all the registers on your system.

To exit, hit enter.

If the name has the word DIABETES in it, the register can be used with the Diabetes Management System.

Before you can use a register, you must be added as an authorized user. Only the register creator can add users.

Finding & Changing the Register Creator

How: From the RPMS Main Menu:

1. Select Menu Option: **CMS**
2. Select CASE MANAGEMENT SYSTEM Option: **ECR**
3. Select Register: <Enter the name of your register here>
4. REGISTER CREATOR: LASTNAME,FIRSTNAME// <Enter> to keep the same creator or NEWLASTNAME,NEWFIRSTNAME to change the creator

Select Register: IHS PRE-DIABETES
REGISTER TYPE: IHS PRE-DIABETES
DATE ESTABLISHED: DEC 07, 2010
VIEW ALL LIST ENTRIES: NO
ALLOW LAYGO FOR LIST ENTRIES: NO
ELEMENTS: COMPLICATIONS
ELEMENTS: DIAGNOSES
ELEMENTS: RISK FACTORS
ELEMENTS: REGISTER DATA
ELEMENTS: DIAGNOSTIC CRITERIA
ELEMENTS: CASE REVIEW DATES
REGISTER CREATOR: HEAD, DON
AUTHORIZED USER: KAKUSKA, ERIK
AUTHORIZED USER: HEAD, DON
AUTHORIZED USER: LOPEZ, KERRI
REGISTER CREATOR: HEAD, DON//

ABBREVIATION: DM
REGISTER DEVELOPER: POSTMASTER
PCC PROBLEM LIST: YES
RESTRICT CATEGORY USE: YES
Adding Users to Your Diabetes Register

How: From the Diabetes Management System main menu:

1. Select Diabetes Management System Option: **RM** Register Maintenance
2. Select Register Maintenance Option: **RM** Register Management
3. Select Register Management Option: **US** User Setup
4. Which one: 1 Add/Remove DMS Authorized User
5. Select NEW DMS User: LAST NAME, FIRST NAME
6. Do you wish to REMOVE LAST NAME, FIRST NAME as an Authorized User of the Diabetes Management System? **NO**
7. Remove LAST NAME, FIRST NAME’s REGISTER MANAGER AUTHORITY? Enter YES or NO depending on whether this user is allowed manager authority.
8. Which one: “^” to return to the main menu.

OR

How: From the Case Management System main menu:

1. Select Case Management System Option: **AU** Add Authorized Users
2. REGISTER: **IHS DIABETES** (or the name of your diabetes register)
3. Select AUTHORIZED USER: LAST NAME, FIRST NAME
4. Are you adding LAST NAME, FIRST NAME as a new AUTHORIZED USER (the 3RD for this CMS REGISTER TYPE)? **Y**
5. Select AUTHORIZED USER: <ENTER> to exit or LAST NAME, FIRST NAME to enter another user

Creating a New Register

An analogy

Creating a register is like making a bunch of stickers that you can put on patient charts.

Adding patients to the register is like putting those stickers on charts.

Running reports is like reviewing charts that have certain stickers on them.
Creating a New Register (cont.)

You have three options for creating a register. For all options, from the main RPMS MENU:

1. Select IHS Core Option: **CASE** or **CMS** (depending on your menus -- both are for the CASE MANAGEMENT SYSTEM)

**Option 1: Install Pre-Diabetes Register (PDM)**

Select to create a register called IHS PRE-DIABETES with the fields listed in column 3 on the next page. You can create the register and rename it (if you wish) using CR - Option 3.

**Option 2: Install IHS Diabetes Register (IDR)**

Select to create a register called IHS DIABETES with the fields listed in column 1 on the next page. You can create the register and rename it (if you wish) using CR - Option 3.

**Option 3: Create/Modify Register Structure (CR)**

Use this option to create a diabetes register, or to rename either type of register created with PDM or IDR.

1. Select Case Management System Option: **CR**
2. Register: <SOMETHING> **DIABETES** (Typically IHS DIABETES)
   
   **IMPORTANT:** The name must include the word DIABETES or PRE-DIABETES so that you can use it with DMS.

3. Are you adding 'IHS DIABETES' as a new CMS REGISTER TYPE? No // **Y**
4. REGISTER NAME: IHS DIABETES // <enter> to confirm or different name to change
5. DATE ESTABLSD: <today’s date>
6. REGISTER CREATOR: LASTNAME,FIRSTNAME of person responsible for register
7. HEALTH SUMMARY DISPLAY: **Y** (regular Health Summary will show Diabetes Care Summary at the end for patients on the register)
8. BRIEF DESCRIPTION: (optional--a sentence to describe the purpose of the register)
9. ‘A’ to ADD, ‘D’ to DELETE ... == > <enter>
   (note: DMS will take care of these options for you, so you can skip this step)

**ALL OPTIONS: Next steps (required)**

1. Add YOURSELF and anyone else who needs to use the register as an authorized user (see “Adding Users to Your Register” section of this manual).
2. Users must also have security keys for DMS (see “Allocating Security Keys for DMS”).
3. To use the register, go to DMS — DIABETES MANAGEMENT SYSTEM. If more than one register exists on your system, you will be prompted to specify which register.
4. There are no patients on a new register. To add them, use PM — PATIENT MANAGEMENT.
## Diabetes and Pre-Diabetes Register Fields

### Stored in the register

<table>
<thead>
<tr>
<th>Diabetes Register (IDR)</th>
<th>Both types of register</th>
<th>Pre-Diabetes Register (PDM)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gestational DM</td>
<td>Register data</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>Imp Glucose Tolerance (IGT)</td>
<td>(modified in Patient Management, #1)</td>
<td>Gestational DM</td>
</tr>
<tr>
<td>Type 1</td>
<td>Register Status</td>
<td>Imp Fasting Glucose (IFG)</td>
</tr>
<tr>
<td>Type 2</td>
<td>Where followed (clinic name)</td>
<td>Imp Glucose Tolerance (IGT)</td>
</tr>
<tr>
<td><strong>Complications</strong></td>
<td>Register provider</td>
<td>Metabolic Syndrome</td>
</tr>
<tr>
<td>CVA (Stroke)</td>
<td>Case manager</td>
<td>Other Abnormal Glucose</td>
</tr>
<tr>
<td>End Stage Renal Disease</td>
<td>Contact</td>
<td>Type 1</td>
</tr>
<tr>
<td>Fixed Proteinuria</td>
<td>Entry date (i.e. when added to register)</td>
<td>Type 2</td>
</tr>
<tr>
<td>High Risk Foot</td>
<td>Last review [date]</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>Next review [date]</td>
<td></td>
</tr>
<tr>
<td>Laser Tx for Retinopathy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Amputation(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor Amputation(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retinopathy</td>
<td>+ [Any you add]</td>
<td></td>
</tr>
</tbody>
</table>

### Stored in the main database (PCC), but viewable through register reports

<table>
<thead>
<tr>
<th>Registration information</th>
<th>Patient education</th>
<th>ECG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem list</td>
<td>Depression as active diagnosis</td>
<td>Immunizations: Flu, pneumovax, Td or Tdap</td>
</tr>
<tr>
<td>Measurements: Height, weight, BMI, blood pressure</td>
<td>Depression screening</td>
<td>Labs: HbA1c, serum creatinine, estimated GFR, cholesterol, HDL, LDL, triglycerides, urine protein testing</td>
</tr>
<tr>
<td>Tobacco use &amp; counseling</td>
<td>Diabetes medications</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>ACE/ARB use</td>
<td></td>
</tr>
<tr>
<td>Exams: Foot, eye, dental</td>
<td>Antiplatelet therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lipid lower agents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TB testing</td>
<td></td>
</tr>
</tbody>
</table>

### What people see in the regular record of a patient who is on a diabetes register

On the health summary: Diabetes patient care supplement (DPCS) shows up at the end
In iCare: Register name displays in the individual patient’s record
Allocating Security Keys for DMS

From your Site Manager’s menu:

Choose **MENU MANAGEMENT**
Choose **KEY MANAGEMENT**
Choose **ALLOCATION OF SECURITY KEYS**
Allocate key:  **AMQQZMENU**
Another key:  **AMQQZCLIN**
Another key:  **AMQQZEMAN**
Another key:  **AMQQZMGR**
Another key:  **AMQQZPROG**
Another key:  **AMQQZRPT**
Another key:  **BDMZMENU**
Another key:  **BDMZ REGISTER MAINTENANCE**
Another key:  **BDMZ SWITCH OLD DX ENTRIES**
Another key:  **BDMZEDIT**
Another key:  **[Enter]**
Holder of key:  **[LAST NAME, FIRST NAME]**
Another holder:  **[Enter]** or **[Enter Another User]**

<You’ve selected to following holders:

(User Name)

You are allocating keys. Do you wish to proceed? YES// **[Enter]**

<Key is being assigned to:

(User Name)

You will also need to go into Edit User and give user an “M” in the File Manager Access Code.

For the DMS GUI (Visual DMS) there are two SECONDARY MENU OPTIONS under Edit User:

SECONDARY MENU OPTIONS:  **BDMGRPC**
SYNONYM:  **BDMG**
SECONDARY MENU OPTIONS:  **BMXRPC**
SYNONYM:  **BMX**
Check Taxonomies

What taxonomies are for

Some items in RPMS are entered the same way in every clinic that uses RPMS. ICD-10 codes, for example, are standardized internationally, so that R73.09 (ICD-10) always means impaired fasting glucose, no matter where you are.

Other RPMS items differ from one facility to the next. Lab tests and drugs are two examples. One site might call its fasting glucose test “Fasting glucose” and another would call it “Glucose, fasting.” A person would recognize these two descriptions as the same test, but a computer would not. RPMS needs to be programmed to categorize these items correctly. This is done using taxonomies.

Taxonomies are the lists that tell RPMS what belongs in each category. For example, many patients with prediabetes may receive prescriptions for metformin. These prescriptions are not entered as “metformin,” but rather as a specific name and type of metformin, along with a dose level. RPMS needs to reference a list to recognize all of those types and dose levels as “metformin.”

When you run a report, such as the audit report, RPMS searches its patient records for any of those items. If a patient has received any of the metformin prescriptions on the list, the audit report will reflect that.

 DM AUDIT METFORMIN DRUGS
Items currently defined to this taxonomy:
METFORMIN HCL 500 MG TABLETS
METFORMIN 500MG XR
METFORMIN 1000MG

Example of a drug taxonomy on the RPMS training server.

Look at the taxonomy check in your audit report

How: Each time you run an audit report, the system checks for empty taxonomies or panel tests that should not be included.

(You can also run the taxonomy check alone in the AS Audit Setup menu using TC23.)

In order for the 2023 DM AUDIT Report to find all necessary data, several taxonomies must be established. The following taxonomies are missing or have no entries:

- **DRUG taxonomy** [DM AUDIT ACARBOSE DRUGS] has no entries
- **DRUG taxonomy** [DM AUDIT AMYLIN ANALOGUES] has no entries
- **LABORATORY TEST taxonomy** [DM AUDIT CHOLESTEROL TAX] contains a panel test: LIPID PANEL and should not.
- **ADA CODE taxonomy** [DM AUDIT DENTAL EXAM ADA CODES] has no entries
- **DRUG taxonomy** [DM AUDIT GLP-1 ANALOG DRUGS] has no entries
- **LABORATORY TEST taxonomy** [DM AUDIT P/C RATIO TAX] has no entries
- **LABORATORY TEST taxonomy** [DM AUDIT TB LAB TESTS] has no entries

Some common error messages. Only the panel test error message needs to be dealt with. The rest are for medications or labs not used at this facility.

TB LAB TESTS refers to blood tests for tuberculosis, not PPD skin tests.
# LMR—List Labs/Medications and Their Taxonomies

## Run the LMR report to list lab/medications and their taxonomies

**How:** From the Diabetes Management System Main Menu:

1. Select Diabetes Management System Option: **AS** Audit Setup...
2. Select Audit Setup Option: **LMR**
3. Do you wish to list: **L** (for LAB TESTS) or **M** (for MEDICATIONS)
4. Enter beginning Date for Search: **01/01/22** (go back at least to the beginning of the year)
5. Enter ending date for Search: **T** (shortcut for today’s date)
6. Do you wish to: **P//** <enter> to print or **B** to browse

**Hint:** If you choose BROWSE, you can use the PL (“Print List”) command to print the entire report.

### LAB TESTS Used at TRAINING

<table>
<thead>
<tr>
<th>LAB TEST NAME</th>
<th>IEN</th>
<th># DONE</th>
<th>UNITS</th>
<th>RESULT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 HOUR GLUCOSE (PRENATAL GLUCOSE)</td>
<td>1255</td>
<td>12</td>
<td>mg/dL</td>
<td>74</td>
</tr>
<tr>
<td>17-HYDROXYPROGESTERONE</td>
<td>616</td>
<td>1</td>
<td>ng/dL</td>
<td>54</td>
</tr>
<tr>
<td>CORTISOL</td>
<td>114</td>
<td>1</td>
<td>mcg/dL</td>
<td>9.4</td>
</tr>
<tr>
<td>CREATININE</td>
<td>173</td>
<td>2,128</td>
<td>mg/dL</td>
<td>.9</td>
</tr>
<tr>
<td>CREATININE CLEARANCE</td>
<td>1242</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CREATININE, URINE</td>
<td>9999171</td>
<td>7</td>
<td>mls</td>
<td>2.0</td>
</tr>
<tr>
<td>CYSTINE</td>
<td>432</td>
<td>1</td>
<td></td>
<td>NORMAL</td>
</tr>
<tr>
<td>D-DIMER</td>
<td>1665407</td>
<td>1</td>
<td></td>
<td>&lt;250</td>
</tr>
</tbody>
</table>

### MEDICATIONS (DRUGS) Used at TRAINING

<table>
<thead>
<tr>
<th>MEDICATION/DRUG NAME</th>
<th>IEN</th>
<th># DONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>IBUPROFEN 400MG TABLET</td>
<td>305</td>
<td>531</td>
</tr>
<tr>
<td>INDOMETHACIN 25MG CAPSULE</td>
<td>306</td>
<td>119</td>
</tr>
<tr>
<td>INSULIN NPH U-100</td>
<td>5177</td>
<td>216</td>
</tr>
<tr>
<td>DM AUDIT INSULIN DRUGS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>INSULIN REG.U-100</td>
<td>5176</td>
<td>216</td>
</tr>
<tr>
<td>DM AUDIT INSULIN DRUGS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IPRATROPIUM BROMIDE HFA INHALE</td>
<td>84071</td>
<td>197</td>
</tr>
<tr>
<td>IRBESARTAN 300MG TABLET</td>
<td>84557</td>
<td>329</td>
</tr>
<tr>
<td>LISINOPRIL 10MG TABLET</td>
<td>84332</td>
<td>773</td>
</tr>
<tr>
<td>DM AUDIT ACE INHIBITORS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LISINOPRIL 20MG TABLET</td>
<td>84333</td>
<td>541</td>
</tr>
</tbody>
</table>

---

**IEN:** Internal Entry Number, a unique identifier used by the lab/pharmacy for that kind of test/medication.
### Example: Wrong item in the taxonomy

If the wrong items are in the wrong taxonomies, you may see values that look weird on reports.

#### Excerpt of an individual audit report

<table>
<thead>
<tr>
<th>LABORATORY DATA during audit period</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Cholesterol:</strong> 179. mg/dl Oct 20, 2022</td>
</tr>
<tr>
<td><strong>HDL Cholesterol:</strong> 43. mg/dl Oct 20, 2022</td>
</tr>
<tr>
<td><strong>LDL Cholesterol:</strong> 179. mg/dl Oct 20, 2022</td>
</tr>
<tr>
<td><strong>Triglycerides:</strong> 408. mg/dl Mar 15, 2022</td>
</tr>
</tbody>
</table>

#### Why this happened

DIABETES TAXONOMY UPDATE Jan 26, 2023 17:19:25

Updating the DM AUDIT LDL CHOLESTEROL TAX taxonomy

1) LDL
2) CHOLESTEROL

Enter ?? for more actions

A Add Taxonomy Item R Remove an Item

Select Action:+//

The name of the test is printed on the right. Here, you can see that CHOLESTEROL is in the LDL taxonomy because it is showing up on the LDL line.

**Solution:** Delete the extra items from the taxonomy.

**How:** From the Diabetes Management System Main Menu:

1. Select Diabetes Management System Option: **AS** (Audit Setup...)
2. Select Audit Setup Option: **TU** (Update/Review Taxonomies for 2023 DM Audit)
3. Select Action:+// **S** (Select Taxonomy)
4. Which Taxonomy: (1-44): **26** (DM AUDIT LDL CHOLESTEROL)
5. Select Action:+// **R** (Remove an Item)
6. Remove Which Item (1-5): 2
7. Are you sure you want to remove the LDL CHOLESTEROL lab test? **N// Y**
8. Select Action:+// **Q** (Quit)

#### The corrected taxonomy

DIABETES TAXONOMY UPDATE Jan 26, 2023 17:19:25

Updating the DM AUDIT LDL CHOLESTEROL TAX taxonomy

1) LDL

Enter ?? for more actions

A Add Taxonomy Item R Remove an Item

Select Action:+//

(Continued on next page)
Missing Taxonomy Item(s)

Individual audit report after correction

<table>
<thead>
<tr>
<th>LABORATORY DATA during audit period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cholesterol: 179. mg/dl Oct 20, 2020</td>
</tr>
<tr>
<td>HDL Cholesterol: 43. mg/dl Oct 20, 2020</td>
</tr>
<tr>
<td>LDL Cholesterol: 85. mg/dl Mar 15, 2020</td>
</tr>
<tr>
<td>Triglycerides: 408. mg/dl Mar 15, 2020</td>
</tr>
</tbody>
</table>

Example: Missing taxonomy item

When you know that patients are receiving care that is not showing up on reports, the taxonomy may need to be updated.

Excerpt from a cumulative audit report

DIABETES TREATMENT

<table>
<thead>
<tr>
<th>Diet and Exercise Alone</th>
<th>31</th>
<th>42%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin</td>
<td>8</td>
<td>11%</td>
</tr>
<tr>
<td>...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metformin</td>
<td>25</td>
<td>34%</td>
</tr>
</tbody>
</table>

Solution: Add the missing item(s)

1. Run the LMR report for medications, as described in the previous section, to get the name(s) of the missing tests.

MEDICATIONS (DRUGS) Used at TRAINING
Date Range: Jan 01, 2020 - Feb 25, 2021

<table>
<thead>
<tr>
<th>MEDICATION/DRUG NAME</th>
<th>IEN</th>
<th># DONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>METAMUCIL WAFERS</td>
<td>84636</td>
<td>3</td>
</tr>
<tr>
<td>METFORMIN 1000 MG TABLET</td>
<td>84567</td>
<td>431</td>
</tr>
<tr>
<td>METFORMIN HCL 500MG TABLET</td>
<td>84486</td>
<td>714</td>
</tr>
<tr>
<td>DM AUDIT METFORMIN DRUGS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>METHADONE 10MG TAB</td>
<td>319</td>
<td>348</td>
</tr>
</tbody>
</table>

2. Select Diabetes Management System Option: AS (Audit Setup...)
3. Select Audit Setup Option: TU (Update/Review Taxonomies for 2023 DM Audit)
4. Select Action: +// S (Select Taxonomy)
5. Which Taxonomy: (1-44): 28 (DM AUDIT METFORMIN)
6. Select Action: +// A (Add Taxonomy Item)
7. Select DRUG GENERIC NAME: METFORMIN 1000 MG TABLET
8. Select Action: +// Q (Quit)

Update taxonomies at least once a year, or when —

— Elements of care are not showing up on patient summaries, even though you know that the patient received them.
— Results look weird (too high, too low, or exactly the same as another test)
— Percentages on the cumulative audit are unexpectedly high or low
— A new patch has been installed
ICD-9 Codes for DMS and QMAN Searches

### DIABETES and PRE-DIABETES DIAGNOSES

#### Type 1 and Type 2 diabetes 250.00-250.93

**Type 1 diabetes**

- All 250 codes with a 5th digit of 1 or 3
  - Not stated as uncontrolled
    - 250.01, 250.11, 250.21, 250.31, 250.41, 250.51, 250.61, 250.71, 250.81, 250.91
  - Uncontrolled
    - 250.03, 250.13, 250.23, 250.33, 250.43, 250.53, 250.63, 250.73, 250.83, 250.93

**Type 2 diabetes**

- All 250 codes with a 5th digit of 0 or 2
  - Not stated as uncontrolled
    - 250.00, 250.10, 250.20, 250.30, 250.40, 250.50, 250.60, 250.70, 250.80, 250.90
  - Uncontrolled
    - 250.02, 250.12, 250.22, 250.32, 250.42, 250.52, 250.62, 250.72, 250.82, 250.92

#### Diabetes Screening

- V77.1

**Metabolic syndrome, pre-diabetes 277.7**

**Abnormal glucose 790.21-790.29**

- Impaired fasting glucose (IFG) 790.21
- Impaired glucose tolerance (IGT) test (oral) 790.22
- Other abnormal glucose 790.29

**Gestational Diabetes (GDM) 648.80-648.84**

### DIABETES COMPLICATIONS

- End Stage Renal Disease (ESRD) 585, V56.0 (hemodialysis encounter), V45.1 (s/p hemodialysis)
- Lower Extremity Amputation (LEA) 895.0-897.7, V49.70-V49.77 (s/p LEA)
- Hypertension (HTN) 401.0-405.99
- Retinopathy 250.50-250.53, 362.01-362.02
- Laser treatment for retinopathy CPT 67228
- Neuropathy 250.60-250.63, 337.1, 355.9, 357.2
- Proteinuria (includes microalbuminuria) 791.0
- Hyperlipidemia (cholesterol or triglycerides) 272.0-272.4
- Stroke (CVA) 436
- Transient Ischemic Attack (TIA) 435.9
- Heart Attack (MI) 410.00-410.92 (acute MI)
- Tuberculosis 010.00-018.96, 137.0-137.4, 795.5, V12.01
- Non-compliance with medical treatment V15.81

### RISK FACTORS FOR DIABETES and RISK BEHAVIORS

- Obesity 278.00
- Morbid obesity for surgical treatment 278.01
- Acanthosis nigricans 701.2
- Family history of diabetes V18.0
- Polycystic ovarian syndrome (PCOS) 256.4
- Lack of exercise V69.0
- Inappropriate eating habits V69.1
- Smoking 305.1-305.13, V15.82 (history of smoking)
- Depression 296.*, 300.*, 301.13, 308.3, 309.*, 311.*
# ICD-10 Codes for DMS and QMAN Searches

## DIABETES and PRE-DIABETES DIAGNOSES

<table>
<thead>
<tr>
<th>Type 1 and Type 2 diabetes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type 1 diabetes</strong></td>
<td>E10.10-E10.9</td>
</tr>
<tr>
<td>With complications...</td>
<td>ketoacidosis, nephropathy, CKD, retinopathy, diabetic cataract, neuropathy, amylopathy, peripheral angiopathy, arthropathy, dermatitis, foot/skin ulcer, periodontal disease, hypoglycemia, hypersmolality, unspecified</td>
</tr>
<tr>
<td>Without complications</td>
<td>E10.9</td>
</tr>
<tr>
<td><strong>Type 2 diabetes</strong></td>
<td>E11.01-E11.9</td>
</tr>
<tr>
<td>With complications...</td>
<td>ketoacidosis, nephropathy, CKD, retinopathy, diabetic cataract, neuropathy, amylopathy, peripheral angiopathy, arthropathy, dermatitis, foot/skin ulcer, periodontal disease, hypoglycemia, hypersmolality, unspecified</td>
</tr>
<tr>
<td>Without complications</td>
<td>E11.9</td>
</tr>
</tbody>
</table>

**Diabetes Screening**
- Z13.1

**Metabolic syndrome, pre-diabetes**
- E88.81

**Abnormal glucose**
- R73.09
- Impaired fasting glucose (IFG) R73.01
- Impaired glucose tolerance (IGT) test (oral) R73.02
- Other abnormal glucose R73.09

**Gestational Diabetes (GDM)**
- O24.410-O24.439

## DIABETES COMPLICATIONS

<table>
<thead>
<tr>
<th>Complication</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>End Stage Renal Disease (ESRD)</td>
<td>I12.0, I13.11, I13.2, N18.6</td>
</tr>
<tr>
<td>Lower Extremity Amputation (LEA)</td>
<td>T87.33-T87.54</td>
</tr>
<tr>
<td>Hypertension (HTN)</td>
<td>I10, I15.0-I15.9, I27.0-I27.2, I87.301-I87.399, I97.3, K76.6</td>
</tr>
<tr>
<td>Retinopathy</td>
<td>E08.311-E08.359, E09.311-E09.359, E10.311-E10.359, E11.311-E11.359, E13.311-E13.359</td>
</tr>
<tr>
<td>Neuropathy</td>
<td>E08.40, E08.43, E09.40, E09.43, E10.40, E10.43, E11.40, E11.43, E13.40, E13.43</td>
</tr>
<tr>
<td>Proteinuria (includes microalbuminuria)</td>
<td>N06.0-N06.9, R80.0-R80.9</td>
</tr>
<tr>
<td>Hyperlipidemia (cholesterol or triglycerides)</td>
<td>E78.2-E78.5</td>
</tr>
<tr>
<td>Stroke (CVA)</td>
<td>G46.3, G46.4</td>
</tr>
<tr>
<td>Transient Ischemic Attack (TIA)</td>
<td>G45.8, G45.9</td>
</tr>
<tr>
<td>Heart Attack (MI)</td>
<td>I21.01-I25.2</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>A15.0-A15.9, A17.89, A17.9, A18.01-A18.89, A19.0-A19.9, B90.0-B90.9, J65, O98.011-O98.03, P47.0</td>
</tr>
<tr>
<td>Non-compliance with...</td>
<td>Z91.11 (dietary regimen), Z91.14 (medication regimen), Z91.15 (renal dialysis), Z91.19 (medical treatment)</td>
</tr>
</tbody>
</table>

## RISK FACTORS FOR DIABETES and RISK BEHAVIORS

<table>
<thead>
<tr>
<th>Factor</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity</td>
<td>E66.01-E66.9</td>
</tr>
<tr>
<td>Acanthosis nigricans</td>
<td>L83</td>
</tr>
<tr>
<td>Family history of diabetes</td>
<td>Z83.3</td>
</tr>
<tr>
<td>Polycystic ovarian syndrome (PCOS)</td>
<td>E28.2</td>
</tr>
<tr>
<td>Lack of physical exercise</td>
<td>Z72.3</td>
</tr>
<tr>
<td>Inappropriate eating habits</td>
<td>Z72.4</td>
</tr>
</tbody>
</table>
Section 3: Reference Materials

Indian Health Service
Standards of Care and Clinical Practice Recommendations:
Type 2 Diabetes

Diabetes Audit Logic Descriptions
### Diabetes Standards of Care and Resources for Clinicians and Educators

#### Recommendations At-a-Glance

<table>
<thead>
<tr>
<th>Component</th>
<th>Care/Test/Screening</th>
<th>Frequency/Which Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Recommendations for Care</strong></td>
<td>Perform diabetes-focused visit&lt;br&gt;Review care plan: assess goals/strengths/barriers&lt;br&gt;Assess nutrition, physical activity, BMI, and growth in youth</td>
<td>Every 3-6 months&lt;br&gt;Each diabetes visit, revise as needed&lt;br&gt;Each visit</td>
</tr>
<tr>
<td><strong>Aspirin or Other Antiplatelet Therapy</strong></td>
<td>Aspirin therapy 75-162 mg/day (unless contraindicated, or at increased risk of bleeding)</td>
<td>Prescribe if known ASCVD&lt;br&gt;Consider if no known ASCVD but at increased risk for ASCVD (e.g., age 50-70 and 1 or more risk factors for ASCVD)</td>
</tr>
<tr>
<td><strong>Autonomic Neuropathy</strong></td>
<td>Assess CV symptoms; resting tachycardia, exercise intolerance, orthostatic hypotension&lt;br&gt;Assess GI symptoms; gastroparesis, constipation, diarrhea&lt;br&gt;Assess sexual health/function for men and women</td>
<td>At diagnosis, then annually&lt;br&gt;At diagnosis, then annually&lt;br&gt;At diagnosis, then annually</td>
</tr>
<tr>
<td><strong>Behavioral Health</strong></td>
<td>Assess emotional health (e.g., depression, substance abuse)</td>
<td>Each visit</td>
</tr>
<tr>
<td><strong>Blood Pressure</strong></td>
<td>Check blood pressure&lt;br&gt;Adult goal: &lt;140/&lt;90 mmHg&lt;br&gt;Youth goal: Varies with age</td>
<td>Each visit</td>
</tr>
<tr>
<td><strong>Eye Care</strong></td>
<td>Comprehensive dilated eye exam by an eye care professional or retinal imaging</td>
<td>At diagnosis, then annually or as directed by an eye care professional</td>
</tr>
<tr>
<td><strong>Foot Care</strong></td>
<td>Visual inspection of feet with shoes and socks off&lt;br&gt;Perform comprehensive lower extremity/foot exam&lt;br&gt;Screen for PAD (consider ABI)</td>
<td>Each visit; stress daily self-exam&lt;br&gt;At diagnosis, then annually&lt;br&gt;At diagnosis, then annually</td>
</tr>
<tr>
<td><strong>Glycemic Control</strong></td>
<td>Check A1C, set/review individualized goal&lt;br&gt;Address medication adherence, hypoglycemia&lt;br&gt;Review SMBG and/or CGM results, if prescribed</td>
<td>Every 3-6 months&lt;br&gt;Each visit&lt;br&gt;Each visit</td>
</tr>
<tr>
<td><strong>Hep C Screening</strong></td>
<td>Screen for hepatitis C with a hepatitis C antibody test</td>
<td>At least once for persons ≥ 18 years</td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td>Hepatitis B, influenza, pneumococcus, shingles, tetanus/diphtheria/pertussis</td>
<td>See Immunizations Standard of Care for schedules</td>
</tr>
<tr>
<td><strong>Kidney Care</strong></td>
<td>Check UACR&lt;br&gt;Check serum creatinine and estimated GFR&lt;br&gt;If HTN/CKD, prescribe ACE Inhibitor or ARB unless contraindicated</td>
<td>At diagnosis, then at least annually&lt;br&gt;At diagnosis, then at least annually</td>
</tr>
<tr>
<td><strong>Lipid Management</strong></td>
<td>Check fasting lipid profile&lt;br&gt;Lifestyle therapy&lt;br&gt;Statin therapy</td>
<td>At diagnosis, then annually, as needed&lt;br&gt;All patients with diabetes&lt;br&gt;Patients with diabetes aged 40-75 and those with ASCVD regardless of age</td>
</tr>
<tr>
<td><strong>Nutrition</strong></td>
<td>Provide nutrition education and support (health care team)&lt;br&gt;Refer to RD for MNT, if available</td>
<td>At diagnosis, then annually or more as needed&lt;br&gt;At diagnosis, then annually or more as needed</td>
</tr>
<tr>
<td><strong>Oral Care</strong></td>
<td>Inspection of gums/teeth&lt;br&gt;Dental exam by dental professional</td>
<td>At diagnosis, then at least annually&lt;br&gt;At diagnosis, then at least annually</td>
</tr>
<tr>
<td><strong>Preconception, Pregnancy, and Postpartum Care</strong></td>
<td>Ask about reproductive intentions/assess contraception&lt;br&gt;Provide preconception counseling&lt;br&gt;Screen for undiagnosed type 2 diabetes&lt;br&gt;Screen for GDM in all women not known to have diabetes&lt;br&gt;Screen for type 2 diabetes in women who had GDM</td>
<td>At diagnosis, then each visit&lt;br&gt;3-4 months prior to conception&lt;br&gt;At first prenatal visit&lt;br&gt;At 24-28 weeks gestation&lt;br&gt;At 6-12 weeks postpartum, then every 1-3 years lifelong</td>
</tr>
<tr>
<td><strong>Tobacco Use</strong></td>
<td>Assess smoking, oral tobacco use, e-cigarette use, and exposure to secondhand smoke&lt;br&gt;For tobacco users, provide cessation counseling</td>
<td>Screen annually&lt;br&gt;Each visit</td>
</tr>
<tr>
<td><strong>Tuberculosis Screening</strong></td>
<td>Screen for TB with a skin or blood test</td>
<td>At least once after diabetes diagnosis</td>
</tr>
</tbody>
</table>
Clinical Practice Recommendations (Updated 2022)

Diabetes Risk Assessment Tools

Diabetes risk assessment tools can be used to identify asymptomatic individuals at increased risk for diabetes, and determine if a diagnostic test should be performed.

- 60-Second Type 2 Diabetes Risk Test of the American Diabetes Association, which can also be accessed with the Diabetes Risk Test from the National Institute of Diabetes and Digestive and Kidney Diseases
- Prediabetes Risk Test of the Centers for Disease Control and Prevention

Recommendations for Diagnosing Type 2 Diabetes and Identifying Prediabetes

How to Diagnose Type 2 Diabetes

Use one of the criteria below to diagnose type 2 diabetes in non-pregnant people:

- A1C level of 6.5% or higher
- Fasting plasma glucose (FPG) level of 126 mg/dL or higher, after the person has had no caloric intake overnight for at least 8 hours
- 2-hour plasma glucose (PG) level of 200 mg/dL or higher with a 75-gm oral glucose tolerance test
- Random plasma glucose test result of 200 mg/dL or higher in people with symptoms of hyperglycemia, such as increased thirst, increased urination, unexplained weight loss, fatigue, or blurred vision

Two abnormal results from the same or different tests are required for diagnosis (e.g. two A1C levels ≥ 6.5% or an A1C value ≥ 6.5% and an FPG test result ≥ 126 mg/dL). However, a single random test result of 200 mg/dL or higher in a person with symptoms is diagnostic for diabetes.

→ Note: Although point-of-care capillary A1C and/or glucose tests can be used to screen people for diabetes, only laboratory-run tests should be used for diagnosis.

How to Identify Prediabetes

People with prediabetes have blood glucose levels that are above the normal range but not elevated to meet the criteria for diabetes. An individual with prediabetes may also have other risk factors related to diabetes such as obesity, abnormal blood lipid levels, and high blood pressure.

Use any one of the following criteria to identify people with prediabetes.

- A1C level of 5.7% to 6.4%
- Fasting plasma glucose level of 100 mg/dL to 125 mg/dL
- 2-hour plasma glucose value of 140 mg/dL to 199 mg/dL during a 75-gm oral glucose test
Clinical Practice Recommendations (Updated 2022)

How Often to Test Non-pregnant, Asymptomatic AI/AN Adults for Diabetes

Test for diabetes in asymptomatic adults, and then every 3 years thereafter. Consider testing adults more often if they have additional risk factors (such as those listed below):

- Overweight/obese (body mass index [BMI] ≥25 kg/m²), physical inactivity, type 2 diabetes in a first-degree relative, history of gestational diabetes, history of cardiovascular disease, signs of insulin resistance or conditions associated with it (e.g., acanthosis nigricans, polycystic ovarian syndrome, hypertension, or dyslipidemia with HDL cholesterol level lower than 35 mg/dL and/or triglycerides level higher than 250 mg/dL)
- Test people with prediabetes for diabetes each year.

How Often to Test Asymptomatic AI/AN Youth for Diabetes

Test overweight and obese youth (those with a BMI in the 85th percentile or higher) at the onset of puberty or after age 10 years (whichever comes first), and then every 3 years thereafter.

Consider testing children and adolescents more frequently if they have additional risk factors, such as:

- Increasing BMI over time
- Maternal history of diabetes or gestational diabetes during the child’s gestation
- Family history of diabetes
- Signs of insulin resistance or conditions associated with it (e.g., acanthosis nigricans, polycystic ovarian syndrome, hypertension, dyslipidemia, or small-for-gestational-age birth weight)

Test children and adolescents with prediabetes for diabetes each year.

→ Note: In patients who present with hyperglycemic symptoms, testing for diabetes is warranted regardless of risk factors listed above.

For a copy of the complete version of the IHS Standards of Care visit: www.diabetes.ihs.gov
Notes: Audit Logic uses several taxonomies that are used by other national RPMS programs, including diagnosis codes, CPT codes, LOINC codes, SNOMED codes, and medications. The contents of those taxonomies may be reviewed by using the VTAX (View/Print Any DM Audit Taxonomy) report option, found in the Diabetes Management System Reports menu.

View or print the contents of site-populated taxonomies by using the TU (Update/Review Taxonomies for 2022 DM Audit) menu option under the AS menu option of the Diabetes Management System menu.

View contents of SNOMED lists by using the VSML (View a SNOMED List Used by the DM AUDIT) menu option.

REPORT DATE
Description: Date report was generated
How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): Date report was generated
Audit Logic: N/A
Audit Report: The date the report was generated is included in the header of the report
Audit Export Field Name and Details: N/A

AUDIT DATE
Description: Last day of 12-month Audit period for which data are reviewed
How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): N/A
Audit Logic: This date, supplied by the user, determines the time period for which data are reviewed for the Audit. For most items, data are reviewed for the 12 months prior to the Audit date, known as the Audit period. For example, if the Audit date is December 31, 2022, data are reviewed for the year prior to this date (January 1-December 31, 2022).
Audit Report: AUDIT DATE (AKA AUDIT PERIOD ENDING DATE) is used to determine the Audit period and is displayed in the header of the report. (Audit Period 01/01/2022 to 12/31/2022.)
Audit Export Field Name and Details: AUDITDATE MM/DD/YYYY

FACILITY NAME
Description: Facility Name
How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): N/A
Audit Logic: This is the name of the facility at which the Audit is being run. It is the division or facility to which the user logged in. (The DUZ(2) variable is used.)
Audit Report: FACILITY NAME Facility name is displayed in the report header.
Audit Export Field Name and Details: FACILITYNA (max length 20)

AGE
Description: Patient age
How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): Age of patient in years on the date the report or file was generated.
Audit Logic: Age of the patient as of the Audit date.
Audit Report: Age in years is grouped into the following:
<20 years
20-44 years
45-64 years
≥65 years
Age is also used in various sections that have age specific items.
Audit Export Field Name and Details: AGE Age in years as of the Audit date # with maximum of 3 digits and no decimal places Calculate as: integer part of difference in days between AUDITDATE and date of birth, divided by 365.25.

REVIEWER INITIALS
Description: Reviewer initials
How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): N/A
Audit Logic: Initials of the person running the Audit. A maximum of 3 initials may be used. This information is taken from the New Person (file 200) entry for the user.
2023 Diabetes Audit Logic Descriptions

Audit Export Field Name and Details: REVIEWER

**STATE OF RESIDENCE**
**Description:** Postal abbreviation for patient’s last known state of residence.
**How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** N/A
**Audit Logic:** This is the state in which the patient resides at the time the Audit is conducted. This is captured from the mailing address.
**Audit Report:** N/A
**Audit Export Field Name and Details:** STATE 2-character state abbreviation.

**CHART NUMBER**
**Description:** The Patient’s Health Record Number.
**How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** The Health Record Number at the facility at which the summary was generated.
**Audit Logic:** Health record number of the patient at the facility where the Audit is run.
**Audit Report:** N/A
**Audit Export Field Name and Details:** Not included in the Audit Export (Data) File and not uploaded to the WebAudit.

**DATE OF BIRTH**
**Description:** Patient’s date of birth.
**How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** Patient’s DOB from Patient Registration.
**Audit Logic:** The patient’s Date of Birth. Obtained from data entered through patient registration.
**Audit Report:** Date of Birth is used to calculate age – see item 4.
**Audit Export Field Name and Details:** MOB YOB Only the month and year of birth are in the Audit Export (Data) File and can be uploaded to the WebAudit.

**SEX**
**Description:** Gender of patient.
**How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** Male, Female or Unknown, from patient registration.
**Audit Logic:** The gender of the patient. Obtained from data entered through patient registration. Male, Female or Unknown.
**Audit Report:** Gender – Male, Female
**Audit Export Field Name and Details:** SEX 1=Male, 2=Female, 3=Unknown

**PRIMARY CARE PROVIDER**
**Description:** Primary Care Provider name
**How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** The name of the Primary Care Provider from RPMS.
**Audit Logic:** The name of the primary care (designated) provider documented in RPMS. Taken from field Primary Care Provider (#14) of the patient file.
**Audit Report:** N/A
**Audit Export Field Name and Details:** Not included in the Audit Export (Data) File and not uploaded into the WebAudit.

**DATE OF DIABETES DIAGNOSIS**
**Description:** Date of diabetes onset
**How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** First, the system looks for a Register in the Case Management system that contains the term “DIAB.” If one exists, it will look for this patient and get the date of onset from the date of onset field of the register. If none exists, the PCC Problem list is scanned for all problems in the ICD diagnosis code ranges defined in the SURVEILLANCE DIABETES taxonomy or SNOMED code defined in PXRM DIABETES SNOMED subset. For each problem on the problem list in these code ranges the date of onset is picked up. The earliest of all the dates of onset found is used. Where the date of onset was found is also displayed.
**For the selected date: if year only documented, 0701 is used for month/day; if month/year are documented 15 is used for the day.**
**Audit Logic:** The diabetes onset date. This date is used in the calculation of the duration of diabetes. The system obtains the date from three different dates in the following order:
- The date of onset from the Diabetes Register.
- The earliest date of onset from all diabetes related problems on the problem list. The problem list is scanned for all problems in the ICD diagnosis code ranges defined in the SURVEILLANCE DIABETES taxonomy or SNOMED code defined in PXRM DIABETES SNOMED subset.
- The first recorded diagnosis (POV) of diabetes in PCC. ICD codes: SURVEILLANCE DIABETES taxonomy.
**Audit Report:** Duration of Diabetes: When calculating the duration of diabetes, the earliest of the date of onset from the diabetes register or the problem list date of onset is used. Duration of diabetes is calculated from that date to the Audit date. If neither the date of onset in the register nor the date of onset in the problem list is recorded, the duration of diabetes is not...
2023 Diabetes Audit Logic Descriptions

calculated. Please note: The first diagnosis date from POV is not used. Audit Report categories: Duration of Diabetes:
- < 1 year
- <10 years
- ≥ 10 years
- Diagnosis date not recorded

Audit Export Field Name and Details: DODX Audit Export (Data) File: The earliest date found from the Diabetes register or the problem list is exported. Format: MM/DD/YYYY.

**DM TYPE**
Description: Type of Diabetes (Type 1 or Type 2)

**How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** N/A

**Audit Logic:** The following logic is used to determine diabetes type. Once a ‘hit’ is made, no further processing is done:
- If the diagnosis documented in the Diabetes Register is NIDDM the type is assumed to be Type 2.
- If the diagnosis documented in the Diabetes Register is "TYPE II" the type is assumed to be Type 2.
- If the diagnosis documented in the Diabetes Register contains a ‘2’ the type is assumed to be Type 2.
- If the diagnosis documented in the Diabetes Register contains IDDM the type is assumed to be Type 1.
- If the diagnosis documented in the Diabetes Register is "Type I" the type is assumed to be Type 1.
- If the diagnosis documented in the Diabetes Register contains a ‘1’ type is assumed to be Type 1.
- If no diagnosis is documented in the Diabetes Register, or it does not contain any of the above strings the problem list is then scanned. If any diabetes diagnosis on the problem list [SURVEILLANCE DIABETES taxonomy] is also in the DM AUDIT TYPE II DXS taxonomy then the type is assumed to be Type 2.
- If any diabetes diagnosis on the problem list or in the diabetes register, then the last PCC purpose of visit related to diabetes is reviewed. If the diagnosis is contained in the DM AUDIT TYPE II DXS taxonomy the type is assumed to be Type II, if it is contained in the DM AUDIT TYPE I DXS taxonomy it is assumed to be Type 1.
- If type is not determined by any of the above, type is assumed to be Type 2 for the Audit (Data) Export File and Audit Report. For RPMS individual audit sheet, “Not Documented” is displayed.

**Audit Report:** Diabetes Type:
- Type 1
- Type 2

See AUDIT LOGIC for how this is determined.

If the system cannot determine the diabetes type, Type 2 is assumed.

**Audit Export Field Name and Details:** DMTYPE:
- 1=Type 1
- 2=Type 2 (or uncertain)

If the system cannot determine the diabetes type, Type 2 is assumed.

**SCREENED FOR TOBACCO USE**

Description: Was the patient screened for tobacco use during the audit period?

**How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** See Audit Logic. For the summary the last screening done ever is displayed, it does not have to fall into a certain period of time.

**Audit Logic:** If any of the following items is documented during the Audit period, then a value of 1 - Yes is assigned. Otherwise, a value of 2 - No is assigned.
- Health Factor in the TOBACCO (SMOKING) Category.
- Health Factor in the TOBACCO (SMOKELESS - CHEWING/DIP) Category.
- The PCC Problem list and purpose of visits are scanned for any diagnosis contained in the BGP TOBACCO DXS taxonomy or the SNOMED subsets PXRM BGP TOBACCO SCREENED and PXRM BGP CURRENT TOBACCO.
- Any visit with Dental ADA code 1320 documented.
- Any visit with the following CPT codes documented: BGP TOBACCO SCREEN CPTS taxonomy.

**Audit Report:** Value is used in the Tobacco and Nicotine Use section of the Audit Report.

**Audit Export Field Name and Details:** TOBSCREEN
- 1=Yes
- 2=No

**TOBACCO USE STATUS**

Description: Tobacco Use Status (most recent documented), does not have to be documented during the report period.

**How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** The last documented of the following items is documented during the Audit period, then a value of 1 - Yes is assigned. Otherwise, a value of 2 - No is assigned.
- Health Factors in the categories TOBACCO (SMOKING) and TOBACCO (SMOKELESS - CHEWING/DIP) that relate to the patient's tobacco use status. As of the DM Audit 2023 these are the health factors available: (the ones with one asterisk (*) indicate a current user, those with two asterisks (**) are non-tobacco users, the others are put in the "Not Documented" category):
  - CURRENT SMOKELESS TOBACCO (SMOKELESS - CHEWING/DIP)
  - PREVIOUS (FORMER) SMOKELESS TOBACCO (SMOKELESS - CHEWING/DIP)
2023 Diabetes Audit Logic Descriptions

**CESSATION-SMOKELESS TOBACCO (SMOKELESS - CHEWING/DIP**
SMOKELESS TOBACCO, STATUS UNKNOWN TOBACCO (SMOKELESS - CHEWING/DIP)
**NEVER USED SMOKELESS TOBACCO TOBACCO (SMOKELESS - CHEWING/DIP**
**NON-TOBACCO USER TOBACCO (SMOKING)**
*CURRENT SMOKER, STATUS UNKNOWN TOBACCO (SMOKING)**
**PREVIOUS (FORMER) SMOKER TOBACCO (SMOKING)**
**CESSATION-SMOKER TOBACCO (SMOKING)**
*CURRENT SMOKER, EVERY DAY TOBACCO (SMOKING)**
*CURRENT SMOKER, SOME DAY TOBACCO (SMOKING)**
**NEVER SMOKED TOBACCO (SMOKING)**
SMOKING STATUS UNKNOWN TOBACCO (SMOKING)**
*HEAVY TOBACCO SMOKER TOBACCO (SMOKING)**
*LIGHT TOBACCO SMOKER TOBACCO (SMOKING)**

If a factor is found in each of these categories, the one that indicates active use is used. If one is found in just one category, it is used. For example, patient has LIGHT TOBACCO SMOKER and NEVER USED SMOKELESS TOBACCO documented - the LIGHT TOBACCO USER is used. If the patient has NEVER SMOKED and CURRENT SMOKELESS documented, CURRENT SMOKELESS is used.

- Diagnoses contained in the BGP TOBACCO DXS taxonomy or SNOMED subsets PXRM BGP TOBACCO SCREENED and PXRM BGP CURRENT TOBACCO. Both the V POVs and Problem List are checked. The latest documented diagnosis that is contained in the taxonomy is used. Diagnoses that indicate a tobacco user: diagnoses codes in the BGP TOBACCO USER DXS taxonomy and diagnoses codes in the BGP GPRA SMOKELESS DXS taxonomy, all others are considered non-tobacco user. If a SNOMED is found and it is contained in the PXRM BGP CURRENT TOBACCO subset it is used.
- Dental ADA code 1320 - TOBACCO USE INTERVENTION TO PREVENT DISEASE. If this code is documented the patient is considered a tobacco user.
- A CPT code documented that is in the BGP TOBACCO SCREEN CPTS taxonomy. If the code found is in the DM AUDIT TOBACCO USER CPTS taxonomy the patient is considered a tobacco user, all others are considered a non-tobacco user.

Audit Logic: The last documented of the following items is found:

- Health Factors in the categories TOBACCO (SMOKING) and TOBACCO (SMOKELESS - CHEWING/DIP) that relate to the patient’s tobacco use status. As of the DM Audit 2023 these are the health factors available: (the ones with one asterisk (*) indicate a current user, those with two asterisks (**) are non-tobacco users, the others are put in the “Not Documented” category:
  - CURRENT SMOKELESS TOBACCO (SMOKELESS - CHEWING/DIP
  - **PREVIOUS (FORMER) SMOKELESS TOBACCO (SMOKELESS - CHEWING/DIP
  - **CESSATION-SMOKER TOBACCO (SMOKELESS - CHEWING/DIP
  - SMOKELESS TOBACCO, STATUS UNKNOWN TOBACCO (SMOKELESS - CHEWING/DIP
  - **NEVER USED SMOKELESS TOBACCO TOBACCO (SMOKELESS - CHEWING/DIP
  - **NON-TOBACCO USER TOBACCO (SMOKING
  - **CURRENT SMOKER, STATUS UNKNOWN TOBACCO (SMOKING
  - **PREVIOUS (FORMER) SMOKER TOBACCO (SMOKING
  - **CESSATION-SMOKER TOBACCO (SMOKING
  - *CURRENT SMOKER, EVERY DAY TOBACCO (SMOKING
  - *CURRENT SMOKER, SOME DAY TOBACCO (SMOKING
  - **NEVER SMOKED TOBACCO (SMOKING
  - SMOKING STATUS UNKNOWN TOBACCO (SMOKING
  - *HEAVY TOBACCO SMOKER TOBACCO (SMOKING
  - *LIGHT TOBACCO SMOKER TOBACCO (SMOKING

- Dental ADA code 1320 - TOBACCO USE INTERVENTION TO PREVENT DISEASE. If this code is documented the patient is considered a tobacco user.

Audit Report: Value is used in the Tobacco and Nicotine Use section of the Audit Report. It is also used when determining whether tobacco use is a diabetes related condition.

Audit Export Field Name and Details: TOBACCO

- 1=Current user
- 2=Not a current user
- 3=Not documented
2023 Diabetes Audit Logic Descriptions

TOBACCO CESSATION COUNSELING
Description: If the patient is a tobacco user, were they provided cessation counseling during the audit period.
How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): Any cessation counseling found in the past 365 from the date the summary is run is found. If counseling is found, a yes is displayed along with a description of what was found. See logic for cessation counseling under Audit Logic.
Audit Logic: If the tobacco use status is "1 - Current user" then counseling documented in the past year is searched for. Counseling is defined as any of the following:
- A visit to clinic 94 - TOBACCO CESSATION CLINIC
- A patient education topic that meets any of the following criteria:
  - Begins with TO- (e.g., TO-Q)
  - Ends in -TO (e.g., CAD-TO)
  - Begins with any Tobacco User diagnosis (taxonomy is BGP TOBACCO USER DXS) (e.g., 305.1-L)
  - Begins with any Tobacco User CPT code (e.g., 99407-L) Taxonomy is DM AUDIT TOBACCO USER CPTS
  - Begins with a SNOMED code from any of the following SNOMED subsets:
    • PXRM BGP TOBACCO SMOKER
    • PXRM BGP TOBACCO SMOKELESS
    • PXRM BGP TOBACCO SCREENED
    • PXRM BGP CURRENT TOBACCO
To see a list of these codes, use option VSML View a SNOMED List used by the DM AUDIT which can be found on the Audit Setup menu.
- Any of the following CPT codes documented. These indicate tobacco use counseling:
  • D1320
  • 99406
  • 99407
  • G0375 (old code)
  • G0376 (old code)
  • 4000F
  • 4001F
  • G8402
  • G8453
  • G9016
  - Dental ADA code 1320.
The latest documented of the above four data elements is displayed along with the date. If no counseling is found, then the system will look for a smoking aid prescribed:
  - Any prescription for a medication in the site-populated BGP CMS SMOKING CESSATION MEDS taxonomy that does not have a comment of RETURNED TO STOCK.
  - A prescription for any medication with name containing "NICOTINE PATCH", "NICOTINE POLACRILEX", "NICOTINE INHALER", or "NICOTINE NASAL SPRAY" that does not have a comment of RETURNED TO STOCK.
If any the above is found, then a value of 1 - Yes is assigned. Otherwise, a value of 2 - No is assigned.
Audit Report: Value is used in the Tobacco and Nicotine Use section of the Audit Report.
Audit Export Field Name and Details: TOBCOUNSEL
- 1=Yes
- 2=No
- Blank if value for TOBACCO is not 1=Current user

ELECTRONIC NICOTINE (ENDS)-SCREENED DURING AUDIT PERIOD
Description: Was the patient screened for Electronic Nicotine Delivery Systems (ENDS) use? ENDS include vapes, vaporizers, vape pens, hookah pens, electronic cigarettes (e-cigarettes or e-cigs), and e-pipes.
How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): The last documented health factor in the category E-CIGARETTES is found and displayed. If none are found "Never" is displayed.
Audit Logic: The last documented health factor in the category E-CIGARETTES during the Audit period is found. Screened for electronic nicotine delivery system (ENDS) use during Audit period:
- If a health factor is found a value of 1 - Yes is assigned.
- If no health factors have been recorded during the Audit period, a value of 2 - No is assigned.
Audit Report: Value is used in the Tobacco and Nicotine Use section of the Audit report.
Audit Export Field Name and Details: ENDSSCREEN
- 1=Yes
- 2=No

ENDS USE STATUS
Description: Most recent ENDS use status documented.
How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): The last documented health factor in the category E-CIGARETTES is found and displayed. If none are found "Never" is displayed.
Audit Logic: The last documented of the following health factors in the category E-CIGARETTES is found.  
Note: The health factor CURRENT E-CIG USER W/OTHER SUBSTANCE(S) is not taken into consideration.

Use status is assigned as follows:
- CURRENT E-CIGARETTE USER W/NICOTINE:  1 Current User
- CESSATION ENDS USER:  2 Not a current user
- FORMER E-CIGARETTE USER:  2 Not a current user
- E- NEVER USED ANY E-CIGARETTE:  2 Not a current user
- No health factor recorded: 3 - Not documented

Audit Report: Value is used in the Tobacco and Nicotine Use section of the Audit report.

Audit Export Field Name and Details: ENDSSSTATUS
- 1=Current user
- 2=Not a current user
- 3= Not documented

HEIGHT
Description: Height (most recent)

How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): The last measurement HT is found. The date obtained and the value is displayed in inches.

Audit Logic: The last recorded height value (measurement HT) taken on or before the Audit date. Total height in inches is displayed for the Individual Audit.

Audit Report: Height is used to calculate BMI, which is categorized as Body Mass Index (BMI) Category:
- Normal (BMI < 25.0)
- Overweight (BMI 25.0–29.9)
- Obese (BMI ≥ 30.0)
- Height or weight missing
- Severely obese (BMI ≥ 40.0)

Audit Export Field Name and Details:
- FEET (combine with INCHES)
- INCHES (total or in combination with FEET)
- Last recorded height prior to the Audit date either in feet and inches or just inches. Inches are rounded to two decimal digits. For example, 1.25 inches.

WEIGHT
Description: Weight in lbs

How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): The last recorded measurement WT is found, the date and value in lbs. is displayed.

Audit Logic: The last weight value during the Audit period is found and displayed.

Audit Report: Weight is used to calculate BMI, which is categorized as:
- Body Mass Index (BMI) Category
- Normal (BMI < 25.0)
- Overweight (BMI 25.0–29.9)
- Obese (BMI ≥ 30.0)
- Height or weight missing
- Severely obese (BMI ≥ 40.0)

Audit Export Field Name and Details: WEIGHT. Last recorded weight during the Audit period, truncated to the nearest whole pound.

BMI
Description: Calculated BMI

How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): BMI is calculated as:

\[ \text{BMI} = \left( \frac{\text{weight}}{\text{height} \times \text{height}} \right) \times 703 \]

where:
- weight = the last weight (in lbs).
- height = the last height (in inches) recorded any time.

If the patient has a pregnancy diagnosis on the date of the weight, the BMI is not calculated or displayed.
If the patient is < 19 years of age the height and weight must be on the same day or the BMI is not calculated.

Audit Logic: BMI is calculated as:
\[ \text{BMI} = \left( \frac{\text{weight}}{\text{height} \times \text{height}} \right) \times 703. \]

weight = the last weight (in lbs.) documented during the Audit period.
height = the last height (in inches) recorded any time before the Audit date.

Audit Report: Body Mass Index (BMI) Category:
- Normal (BMI < 25.0)
- Overweight (BMI 25.0–29.9)
**2023 Diabetes Audit Logic Descriptions**

- Obese (BMI ≥ 30.0)
- Height or weight missing
- Severely obese (BMI ≥ 40.0)

**Audit Export Field Name and Details:** Not included in the Audit export (Data) File and not uploaded into the WebAudit.

**HYPERTENSION DOCUMENTED**

**Description:** Has this patient had a diagnosis of Hypertension

**How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** If hypertension is on the problem list or the patient has had at least three visits with a diagnosis of hypertension ever, then it is assumed that they have hypertension and a value of Yes displays. Otherwise, a No is displayed. Taxonomy used: SURVEILLANCE HYPERTENSION. SNOMED List: PXRM ESSENTIAL HYPERTENSION.

**Audit Logic:** If hypertension is on the problem list or the patient has had at least three visits with a diagnosis of hypertension ever, then it is assumed that they have hypertension and a value of 1 - Yes is assigned. Otherwise, a value of 2 - No is assigned. Taxonomy used: SURVEILLANCE HYPERTENSION. SNOMED List: PXRM ESSENTIAL HYPERTENSION.

**Audit Report:** Hypertension Diagnosed ever: Diagnosed hypertension and mean BP <140/<90 Diagnosed hypertension and ACE inhibitor, or ARB prescribed Also used when determining diabetes related conditions.

**Audit Export Field Name and Details:** HTNDX 1=Yes 2=No

**BLOOD PRESSURES (LAST 1, 2 or 3)**

**Description:** Last three Blood Pressure values recorded during the Audit period.

**How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** The last three non-ER Blood Pressures values and the date they were obtained are displayed.

**Audit Logic:** The most recently recorded systolic and diastolic blood pressure values (up to three on different days) on non-ER clinic visits during the Audit period are obtained. If more than one blood pressure is recorded on anyone day, the latest one is used.

**Audit Report:** Blood Pressure (BP) - Based on one value or mean of two or three values:
- <140/<90
- 140/90 - <160/<100
- 160/100 or higher
- BP category undetermined
- If age ≥60 years, <150/<90

**Audit Export Field Name and Details:**
- SYST1
- DIAST1
- SYST2
- DIAST2
- SYST3
- DIAST3

The blood pressure values are exported but mean blood pressure is not.

**FOOT EXAM - COMPLETE**

**Description:** Foot exam (comprehensive or “complete”) during the Audit period.

**How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** The last foot exam done in the past year (from the date the summary is run) is obtained and displayed. The logic used in determining if a comprehensive or complete foot exam has been done is as follows:

- A documented DIABETIC FOOT EXAM, COMPLETE (CODE 28) is searched for in the past year. This is recorded in V Exam. If found, no other processing is done, an exam is assumed to have been done.
- CPT codes 2028F, G0245, G0246, and G9226 in V CPT [Taxonomy: BGP CPT FOOT EXAM]
- A visit on which a podiatrist (provider class codes 33=PODIATRIST, 84=PEDORTHIST or 25=CONTRACT PODIATRIST) that is not a DNKA visit is searched for in the year prior to the Audit date. If found, it is not assumed the exam was done so the term “maybe” is displayed with the date of the visit.
- A visit to clinic 65=PODIATRY or B7=Diabetic Foot clinic that is not a DNKA is searched for in the year prior to the Audit date. If found, it is not assumed the exam was done so the term “maybe” is displayed with the date of the visit.

**Audit Logic:** The logic used in determining if a comprehensive or complete foot exam has been done is as follows:

- A documented DIABETIC FOOT EXAM, COMPLETE (CODE 28) is searched for in the year prior to the Audit date. This is recorded in V Exam. If found, no other processing is done, an exam is assumed to have been done.
- CPT codes 2028F, G0245, G0246, and G9226 in V CPT [Taxonomy: BGP CPT FOOT EXAM]
  - If found, no other processing is done.
  - If any of the above is found, a value of 1 - Yes is assigned.
  - If none of the above are found, the value is 2 - No.

**Audit Report:** In the Exam section of the Audit report. Foot exam – comprehensive

**Audit Export Field Name and Details:** FOOTEXAM:
- 1=Yes
- 2=No
2023 Diabetes Audit Logic Descriptions

**EYE EXAM (dilated or retinal imaging)**

**Description:** Eye Exam (dilated or retinal imaging) performed during the Audit period.

**How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** The logic used in determining if a diabetic eye exam has been done is as follows:

- The system looks for the last documented Diabetic Eye Exam in the year prior to the date the summary was generated. Diabetic Eye Exam is defined as:
  - EXAM 03 - Diabetic Eye Exam
  - CPT in either the BGP DM RETINAL EXAM CPTS or the BGP DM EYE EXAM CPTS taxonomy.
- If one of the above is found, Yes, along with the date the exam was found, is displayed.
  - If none of the above is found, then all PCC Visits in the year prior to the Audit date are scanned for a non-DNKA, non-Refraction visit to an Optometrist or Ophthalmologist (24, 79, 08) or an Optometry or Ophthalmology Clinic (17, 18, or A2).
  - If found, the term "Maybe," along with the date the visit was found is displayed. Refraction is defined as a POV on the visit of: [DM AUDIT REFRACTION DXS]. DNKA is defined as any visit with a primary purpose of visit with a provider narrative containing the following phrases: DNKA, DID NOT KEEP APPOINTMENT, DID NOT KEEP APPT.
- If none of the above are found, a "No" is displayed.

**Audit Logic:** The logic used in determining if a diabetic eye exam has been done is as follows:

- The system looks for the last documented Diabetic Eye Exam in the year prior to the Audit date. Diabetic Eye Exam is defined as:
  - EXAM 03 - Diabetic Eye Exam
  - CPT in either the BGP DM RETINAL EXAM CPTS or the BGP DM EYE EXAM CPTS taxonomy.
- If one of the above is found, the value 1 - Yes is assigned and no further processing is done.
- If none of the above is found, then all PCC Visits in the year prior to the Audit date are scanned for a non-DNKA, non-Refraction visit to an Optometrist or Ophthalmologist (24, 79, 08) or an Optometry or Ophthalmology Clinic (17, 18, or A2). If found, then the value 1 – Yes is assigned and an indication of what was found is displayed. Refraction is defined as a POV on the visit of: [DM AUDIT REFRACTION DXS]. DNKA is defined as any visit with a primary purpose of visit with a provider narrative containing the following phrases: DNKA, DID NOT KEEP APPOINTMENT, DID NOT KEEP APPT.
- If none of the above are found, the value 2 - No is assigned.

**Audit Report:** In the Exam section of the Audit report. Eye exam – dilated or retinal imaging.

**Audit Export Field Name and Details:** EYEEXAM
- 1=Yes
- 2=No

**DENTAL EXAM**

**Description:** Dental exam performed during the Audit period.

**How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** See Audit Logic. For the DPSC if the only item found is a visit to a dentist or to dental clinic then "Maybe" is displayed rather than a "Yes".

**Audit Logic:** The logic used in determining if a dental exam has been done is as follows:

- A documented DENTAL EXAM (CODE 30) is searched for in the year prior to the Audit date. If found, the value 1 - Yes is assigned and no other processing is done.
- A visit to clinic 56 - DENTAL clinic that is not a DNKA is searched for in the year prior to the Audit date. If found, and there is any ADA code other than 9991, then it is assumed the exam was done, the value 1 - Yes is assigned and no other processing is done.
- A visit on which a dentist (provider class code 52 - DENTIST) that is not a DNKA visit is searched for in the year prior to the Audit date. If found, and there is any ADA code other than 9991, then it is assumed the exam was done, the value 1 - Yes is assigned and no further processing is done.
- A Visit on which a CPT code from the BGP DENTAL VISIT CPT CODES taxonomy was recorded. If found, then it is assumed the exam was done, and the value 1 - Yes is assigned.
- If none of the above are found, the value 2 - No is assigned.

**Audit Report:** In the Exam section of the Audit report. Dental exam.

**Audit Export Field Name and Details:** DENTALEXAM
- 1=Yes
- 2=No

**DEPRESSION ACTIVE DIAGNOSIS**

**Description:** Does patient have depression as an active diagnosis during the Audit period?

**How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** See Audit Logic.

**Audit Logic:** The PCC and BH systems are reviewed for at least two visits with any of the following in the year prior to the Audit date.

- Diagnosis (POV) contained in the BGP MOOD DISORDERS
- Behavioral Health Problem Codes 14 or 15
  - If two POVs are found, then the value assigned is 1 - Yes.
  - If not, then a value of 2 - No is assigned.
2023 Diabetes Audit Logic Descriptions

Audit Report: Depression section:
- Active diagnosis during Audit period
- Screened and/or active diagnosis during Audit period
Also used to determine if depression is a diabetes related condition.

Audit Export Field Name and Details: DEPDX2
- 1=Yes
- 2=No

DEPRESSION SCREENING
Description: Was patient screened for depression in the audit period?

How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): See Audit Logic.

Audit Logic: The PCC and Behavioral health databases are reviewed for any of the following documented in the past year:
- Exam 36 or Behavioral Health Module Depression Screening.
- Diagnosis - V POV, V79.0, Z13.3, [BGP DEPRESSION SCRNS DXS]
- Measurement of PHQ2, PHQ9, PHQT.
- Behavioral Health Module Diagnosis (POV) of 14.1.
- CPT codes 1220F, 3725F or G0444 in PCC or Behavioral Health. Taxonomy: [BGP DEPRESSION SCREEN CPTS]
  If any of the above is found, then a value of 1 - Yes is assigned. If not, then a value of 2 - No is assigned.

Audit Report: Depression section:
- Screened during Audit period
- Screened and/or active diagnosis during Audit period

Audit Export Field Name and Details: DEPSCREEN2
- 1=Yes
- 2=No

NUTRITION EDUCATION
Description: Was nutrition education provided during the audit period?

How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): All DM education provided in the year prior to the date the summary is generated is displayed on the DPSC. For DM education definition see Audit Logic for nutrition education, physical activity education and other DM education.

Audit Logic: The values for the Audit are:
- 1 RD (Registered Dietitian)
- 2 Other
- 3 Both RD & Other
- 4 None

All visits in the year prior to the Audit date are examined. Chart review visits are skipped (service category of C or clinic code of 52).
- If the primary provider on any visit is a DIETITIAN or NUTRITIONIST (codes 29, 07 or 34) then RD is assigned.
- If the visit does not have one of the above providers but has a Diagnosis of [BGP DIETARY SURVEILLANCE DXS] then Other is assigned.
- If the visit has a CPT documented of 97802, 97803, 97804, G0270, G0271 then RD is assigned.
- If the visit contains any of the following education topics:
  Topic in the DM AUDIT DIET EDUC TOPICS taxonomy
  Topic ending in -N
  Topic ending in -DT
  Topic ending in -MNT
  Topic beginning with MNT-
  Topic beginning with DNCN-
  The V Patient Education entry is examined:
  - If the provider documented in that entry is a Dietitian or Nutritionist, the RD is assigned.
  - If the provider is blank or not a dietitian/nutritionist then Other is assigned.

At this point:
- If RD is assigned and Other is not then the value assigned is 1 - RD.
- If RD and Other is assigned then the value assigned is 3 - Both RD & Other.
- If Other is assigned and RD is not then the value assigned is 2 - Other.
Processing stops if a value is assigned.
If none of the above is documented, the value 4 - None is assigned.

Audit Report: Diabetes-Related Education. Nutrition - by any provider (RD and/or other) Nutrition - by RD

Audit Export Field Name and Details: DIETINSTR
- 1=Yes by RD
- 2=Yes by non-RD
- 3=Yes by RD & non-RD
- 4=None
**2023 Diabetes Audit Logic Descriptions**

**PHYSICAL ACTIVITY EDUCATION**

**Description:** Physical activity education provided during the audit period.

**How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** All DM education provided in the year prior to the date the summary is generated is displayed on the DPSC. For DM education definition see Audit Logic for nutrition education, physical activity education and other DM education.

**Audit Logic:**
- All visits in the year prior to the Audit date are examined. If either of the following is true:
  - There is a visit on which a patient education topic in the DM AUDIT EXERCISE EDUC TOPICS taxonomy.
    Any topic ending in “-EX” is documented.
  - All visits in the year prior to the Audit date are examined for a POV of Z71.82 taxonomy BGP EXERCISE COUNSELING DKS
    If one is found A 1 - Yes is assigned.
    If none of the above is documented, the value 2 – No is assigned.

**Audit Report:** Diabetes-Related Education. Physical Activity

**Audit Export Field Name and Details:** EXERCISE:
- 1=Yes
- 2=No

**OTHER DIABETES EDUCATION**

**Description:** Diabetes education, other than nutrition or physical activity, provided during the audit period.

**How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** All DM education provided in the year prior to the date the summary is generated is displayed on the DPSC. For DM education definition see Audit Logic for nutrition education, physical activity education and other DM education.

**Audit Logic:** All education topics documented in the year prior to the Audit date are examined.
- If any topic meets the following criteria, then the value assigned is 1 - Yes:
  - Topic does not end in -EX, -N, -DT or -MNT.
  - Topic does not begin with MNT-.
  - Topic is a member of the DM AUDIT OTHER EDUC TOPICS taxonomy OR the topic begins with one of the following:
    - DM- (e.g., DM-L)
    - DMC- (e.g., DMC-L)
    - An ICD Diagnosis code that is a member of the SURVEILLANCE DIABETES taxonomy (e.g., 250.00-L, E10.51-L)
    - A Diabetes SNOMED code (e.g., 46635009-L)
  - If none of the above is documented, the value assigned is 2 – No.

**Audit Report:** Diabetes-Related Education. Other diabetes education

**Audit Export Field Name and Details:** DMEDUC:
- 1=Yes
- 2=No

**DIABETES THERAPY**

**Description:** Diabetes Therapy – all medications that the patient has been prescribed in the six months prior to the audit date.

**How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** N/A

**Audit Logic:** The following logic is used to determine if the patient is currently taking any medication in each of the categories below:
- Looks for any PCC V Medication entry for any drug in the taxonomy of drugs being searched for where the visit date of the V Medication is in the six months prior to the Audit date. (Looking to see if the patient had at least one fill in the past six months.)
- If no V Medication is found, the Prescription file (file 52) is searched for any drug in the taxonomy of drugs being searched for. The prescription number must begin with an X (an X indicates that the prescription was e-prescribed). If the prescription begins with an X the following calculation is done:
  - Days’ supply times (# of refills +1) (this is the total number of days the prescription covers)
  - Number of days calculated above + issue date (this is the last date the prescription covers) - If the date calculated above is greater than the Audit date minus 180 days it is assumed the patient was taking that medication in the six months prior to the end of the Audit date.
- If no medications are found in the searches shown above the system will look for any EHR Outside Medication that fits into one of medication categories. EHR Outside Medications are found in the V Medication file and have a value in the EHR Outside Medication field and no discontinued date. The system will go back 10 years to find one of these medications.

It is assumed that a medication entered as an EHR Outside Medication is active until it is discontinued. If any medication in the taxonomy specified is found, then an ‘X’ is placed by the therapy name DM therapy items.
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<table>
<thead>
<tr>
<th>Therapy</th>
<th>Taxonomy Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin</td>
<td>DM AUDIT INSULIN DRUGS</td>
</tr>
<tr>
<td>Metformin</td>
<td>DM AUDIT METFORMIN DRUGS</td>
</tr>
<tr>
<td>Sulfonylurea</td>
<td>DM AUDIT SULFONYLUREA DRUGS</td>
</tr>
<tr>
<td>DPP4 inhibitor</td>
<td>DM AUDIT DPP4 INHIBITOR DRUGS</td>
</tr>
<tr>
<td>GLP-1 agonist</td>
<td>DM AUDIT GLP-1 ANALOG DRUGS</td>
</tr>
<tr>
<td>SGLT-2 inhibitor</td>
<td>DM AUDIT SGLT-2 INHIBITOR DRUG</td>
</tr>
<tr>
<td>Pioglitazone, rosiglitazone</td>
<td>DM AUDIT GLITAZONE DRUGS</td>
</tr>
<tr>
<td>Acarbose, miglitol</td>
<td>DM AUDIT ACARBOSE DRUGS</td>
</tr>
<tr>
<td>Repaglinide, Nateglinide</td>
<td>DM AUDIT SULFONYLUREA-LIKE</td>
</tr>
<tr>
<td>Pramlintide</td>
<td>DM AUDIT AMYLIN ANALOGUES</td>
</tr>
<tr>
<td>Bromocriptine</td>
<td>DM AUDIT BROMOCRIPTINE DRUGS</td>
</tr>
<tr>
<td>Colesevelam</td>
<td>DM AUDIT COLESEVELAM DRUGS</td>
</tr>
</tbody>
</table>

Audit Report: Diabetes Treatment section
- Number of diabetes medications currently prescribed.
- Diabetes meds currently prescribed, alone or in combination:
  - Insulin
  - Metformin
  - Sulfonylurea
  - DPP-4 inhibitor
  - GLP-1 receptor agonist
  - SGLT-2 inhibitor
  - Pioglitazone or rosiglitazone
  - Tirzepatide [Mounjaro]
  - Acarbose or miglitol
  - Repaglinide or Nateglinide
  - Pramlintide
  - Bromocriptine
  - Colesevelam

Audit Report: Cardiovascular Disease (CVD) section
- CVD and GLP-1 receptor agonist currently prescribed
- CVD and SGLT-2 inhibitor currently prescribed

Audit Report: Chronic Kidney Disease (CKD) section
- CKD and GLP-1 receptor agonist currently prescribed
- CKD and SGLT-2 inhibitor currently prescribed

Audit Export Field Name and Details: See Audit logic.
- If any med is found in a category, value=1 for the corresponding field, otherwise value=2.
- If no meds are found value=1 for TXNONE.
  - TXNONE
  - TXINSUL
  - TXMETFORM
  - TXSUREA
  - TXDPP4
  - TXGLP1MED
  - TXSGLT2
  - TXGLIT
  - TXTIRZEP
  - TXACARB
  - TXSUREALK
  - TXAMYLIN
  - TXBROMO
  - TXCOLESEV

ACE INHIBITOR OR ARB
Description: Was an ACE Inhibitor or ARB prescribed to the patient as of the end of the Audit Period?
How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):
Audit Logic: The taxonomy used to find ACE Inhibitors and angiotensin receptor blockers (ARBs) is DM AUDIT ACE INHIBITORS.
any drug in this taxonomy is found using the logic that follows a value of 1 - Yes is assigned, no further processing is done.

- Searches for any PCC V Medication entry for any drug in the taxonomy of drugs being searched for where the visit date of the V Medication is in the six months prior to the Audit date. (DM Audit is looking to see if the patient had at least one fill in the past six months.)
- If no V Medication is found the Prescription file (file 52) is searched for any drug in the taxonomy of drugs being searched for. The prescription number must begin with an X (an X indicates that the prescription was e-prescribed).

If the prescription begins with an X, the following calculation is done:

- Days’ supply times (# of refills +1) (this is the total number of days the prescription covers)
- # of days calculated above + issue date (this is the last date the prescription covers)

If the date calculated is greater than the Audit date minus 180 days, it is assumed the patient was taking that medication in the six months prior to the end of the Audit date.

- If no medications are found in the previous two searches, the system will look for any EHR Outside Medication that fits into one of these medication groups.
  EHR Outside Medications are found in the V Medication file and have a value in the EHR Outside Medication field and no discontinued date. The system will go back 10 years to find one of these medications. It is assumed that a medication entered as an EHR Outside Medication is active until it is discontinued.

If no relevant drugs are found, then a 2 - No is assigned.

Audit Report:
- Hypertension section:
  - Diagnosed hypertension and ACE inhibitor or ARB currently prescribed
- Chronic Kidney Disease (CKD) section:
  - CKD and ACE inhibitor or ARB currently prescribed

Audit Export Field Name and Details: ACE:
- 1=Yes
- 2=No

ASPIRIN/ OTHER ANTIPLATELET/ANTICOAGULANT THERAPY

Description: Was the patient prescribed Aspirin or Other Antiplatelet or Anticoagulant Therapy as of the end of the Audit period?

How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): N/A

Audit Logic: Two taxonomies are used to find Aspirin and Other Antiplatelet/Anticoagulant therapy:
- DM AUDIT ASPIRIN DRUGS
- DM AUDIT ANTIPLT/ANTICOAG RX

If any drug in these taxonomies is found using the logic that follows, a value of 1 - Yes is assigned, no further processing is done.

- Searches for any PCC V Medication entry for any drug in the taxonomy of drugs being searched for where the visit date of the V Medication is in the six months prior to the Audit date. (DM Audit is looking to see if the patient had at least one fill in the past six months.)
- If no V Medication is found the Prescription file (file 52) is searched for any drug in the taxonomy of drugs being searched for. The prescription number must begin with an X (an X indicates that the prescription was e-prescribed). If the prescription begins with an X the following calculation is done:
  - Days’ supply times (# of refills +1) (this is the total number of days the prescription covers).
  - Number of days calculated above + issue date (this is the last date the prescription covers).
  - If the date calculated is greater than the Audit date minus 180 days, it is assumed the patient was taking that medication in the six months prior to the end of the Audit date.
- If no medications are found in the searches, the system will look for any EHR Outside Medication that fits into one of medication groups. EHR Outside Medications are found in the V Medication file and have a value in the EHR Outside Medication field and no discontinued date. The system will go back 10 years to find one of these medications. It is assumed that a medication entered as an EHR Outside Medication is active until it is discontinued.
- The Non-VA meds component in the pharmacy patient file is reviewed for any drug in the above-mentioned taxonomies or an orderable item whose first seven characters is “ASPIRIN” and whose eighth character is not a “/”.

If no relevant drugs are found, then a 2 - No is assigned.

Audit Report:
- Cardiovascular Disease (CVD) section:
  - CVD and aspirin or other antiplatelet/anticoagulant therapy currently prescribed.

Audit Export Field Name and Details: ASPIRIN
- 1=Yes
- 2=No

STATIN THERAPY

Description: Statin Therapy prescribed as of the end of the Audit period.

How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): N/A

Audit Logic: One taxonomy is used to find Statin therapy medications: BGP PQA STATIN MEDS. If any drug in this taxonomy is found using the logic that follows, a value of 1 - Yes is assigned, no further processing is done.

- Searches for any PCC V Medication entry for any drug in the taxonomy of drugs being searched for where the visit
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date of the V Medication is in the six months prior to the Audit date. (DM Audit is looking to see if the patient had at least one fill in the past six months.)

- If no V Medication is found, the Prescription file (file 52) is searched for any drug in the taxonomy of drugs being searched for. The prescription number must begin with an X (an X indicates that the prescription was e-prescribed).
  - If the prescription begins with an X, the following calculation is done:
    - Days’ supply times (# of refills +1 (this is the total number of days the prescription covers)
    - Number of days calculated + issue date (this is the last date the prescription covers)
  - If the calculated date is greater than the Audit date minus 180 days, it is assumed the patient was taking that medication in the six months prior to the end of the Audit date.

- If no medications are found in the searches described, the system will look for any EHR Outside Medication that fits into one of medication groups. EHR Outside Medications are found in the V Medication file and have a value in the EHR Outside Medication field and no discontinued date. The system will go back 10 years to find one of these medications. It is assumed that a medication entered as an EHR Outside Medication is active until it is discontinued.

Statin Allergy defined as: Adverse drug reaction/document statin allergy defined as any of the following:
- ALT and/or AST > 3x the Upper Limit of Normal (ULN) (i.e., Reference High) on two or more consecutive visits during the Audit Period.
- Creatine Kinase (CK) levels > 10x ULN or CK > 10,000 IU/L during the Report Period.
- Myopathy/Myalgia, defined as any of the following during the Report Period: Dx in the BGP MYOPATHY/MYALGIA DXS taxonomy.

Any of the following occurring anytime through the end of the Report Period:
- A) POV ICD-9: 995.0-995.3 AND E942.9
- B) "Statin" or "Statins" entry in ART (Patient Allergies File)
  - "Statin" or "Statins" contained within Problem List or in Provider Narrative field

Test Definitions:
- ALT: Site-populated taxonomy DM AUDIT ALT TAX or the BGP ALT LOINC taxonomy.
- AST: Site-populated taxonomy DM AUDIT AST TAX or the BGP AST LOINC taxonomy.
- Creatine Kinase: Site-populated taxonomy BGP CREATINE KINASE TAX or the BGP CREATINE KINASE LOINC taxonomy.

Statin Intolerance/Contraindication defined as:
- Contraindications to Statins defined as any of the following
  - Pregnancy (see definition below)
  - Acute Alcoholic Hepatitis, defined as POV ICD-9: 571.1; ICD-10: K70.10, K70.11 during the Report Period.
  - NMI (not medically indicated) refusal for any statin at least once during the Report Period.

Pregnancy definition: At least two visits during the Audit Period with Documented codes in the following taxonomies:
- BGP PREGNANCY DIAGNOSES 2; BGP PREGNANCY ICD PROCEDURES; BGP PREGNANCY CPT CODES where the provider is not a CHR (Provider code 53). Pharmacy-only visits (clinic code 39) will not count toward these two visits. If the patient has more than two pregnancy-related visits during the Report Period, the Audit will use the first two visits in the Report Period. The patient must not have a documented miscarriage or abortion occurring after the second pregnancy-related visit. Miscarriage definition: Codes documented that are contained in the following taxonomies: BGP MISCARRIAGE/ABORTION DXS; BGP ABORTION PROCEDURES; BGP CPT ABORTION; BGP CPT MISCARRIAGE.

Audit Report: Statin Prescribed section
- Yes*
- Allergy, intolerance, or contraindication

These three items also reported:
- In patients with diagnosed CVD
- In patients age 40–75 years
- In patients with diagnosed CVD and/or age 40–75 years

*Excludes patients with an allergy, intolerance, or contraindication

Audit Export Field Name and Details: LLSTATIN2
- 1=Yes
- 2=No
- 3=Allergy/intolerance/contraindication
- Look for yes, then allergy or intolerance or contraindication, then no.

CARDIVASCULAR DISEASE
Description: CVD Diagnosed Ever?
How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): See Audit Logic.
Audit Logic: CVD diagnosis (using DM AUDIT CVD DIAGNOSES taxonomy) is searched for on the patient's problem list. If a diagnosis is found, a 1 - Yes is assigned. If no problem is found on the problem list, then the V POV file is searched for the following, if found, a 1 - Yes is assigned along with the visit date on which the item was found:
- One diagnosis ever of any code in the BGP CABG DXS taxonomy.
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- One diagnosis ever of any code in the BGP PCI DXS taxonomy.
- Two diagnoses ever of any code in the DM AUDIT CVD DIAGNOSES taxonomy.
- One procedure ever documented of any code in the BGP PCI CM PROCS taxonomy.
- One procedure ever documented of any code in the BGP CABG PROCS taxonomy.
- One CPT procedure ever documented of any code in the BGP PCI CM CPTS taxonomy.
- One CPT procedure ever documented of any code in the BGP CABG CPTS taxonomy.
- If none of the above are found, a value of 2 - No is assigned.

Audit Report: Cardiovascular Disease (CVD) section:

- CVD diagnosed ever
- CVD and mean BP <140/<90
- CVD and not current tobacco user
- CVD and aspirin or other antiplatelet/anticoagulant therapy currently prescribed
- CVD and GLP-1 receptor agonist currently prescribed
- CVD and SGLT-2 inhibitor currently prescribed
- CVD and statin currently prescribed*

*Excludes patients with allergy, intolerance, or contraindication

Audit Export Field Name and Details: CVDDX

- 1=Yes
- 2=No

TB (LATENT OR ACTIVE) DIAGNOSIS (EVER)

Description: Was Tuberculosis (TB) (latent or active) diagnosed ever?

How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): Any health factor in the TB STATUS category is found, if one is found that health factor is display. If no health factor found, then the problem list and purpose of visits are examined for any that are contained in the DM AUDIT TUBERCULOSIS DXS diagnosis taxonomy or the PXMR BQI TUBERCULOSIS SNOMED subset. If one is found, it is displayed.

Audit Logic: If the patient has a TB health factor recorded, TB on the problem list, or any diagnosis of TB documented in the PCC, a 1 – Yes is assigned. If none of these are found, a value of 2 - No is assigned. Definition of diagnosis:

- TB Health Factor – any health factor in the TB STATUS category.
- Problem list diagnosis and Purpose of visit in the DM AUDIT TUBERCULOSIS DXS taxonomy or the PXRM BQI TUBERCULOSIS SNOMED subset.

Audit Report: Tuberculosis (TB) Status section:

- TB diagnosis documented and/or positive test result
- If not diagnosed, TB test done (skin test or blood test)
- If TB diagnosis documented and/or positive test result, treatment initiated
- If TB negative test result, was test done after diabetes diagnosis

Audit Export Field Name and Details: TBDX

- 1=Yes
- 2=No

TB TEST DONE (MOST RECENT)

Description: In patients with no diagnosis of Tuberculosis (TB) Was a TB test done ever? Skin Test; Blood test; No test documented.

How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): TB - Last Documented Test. The date of the last documented TB test is displayed along with what type of test was done. See Audit Logic for TB Test definition.

Audit Logic: If there is not a TB diagnosis documented, a TB test is searched for in the following way:

- All recorded PPD entries and TB lab tests using the DM AUDIT TB LAB TESTS TAX prior to the Audit date are gathered.
  - If at least one is found the latest one is used, if it is a Skin test then 1 - Skin test (PPD) is assigned, if it is a lab test then 2 - Blood Test is assigned.
  - If no TB test is found, then the value is 3 - No test documented.

Audit Report: Tuberculosis (TB) Status section:

- TB diagnosis documented and/or positive test result
- If not diagnosed, TB test done (skin test or blood test)
- If TB diagnosis documented and/or positive test result, treatment initiated
- If TB negative test result, was test done after diabetes diagnosis

Audit Export Field Name and Details: TBTESTDONE3

- 1=Skin test (PPD)
- 2=Blood test (QFT-GIT, T-SPOT)
- 3=No test documented
- Blank if TBDX is not 2=No.

TB TEST RESULT

Description: Result of the most recent TB Test.

How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): TB Test Result: The last
documented TB Test result is displayed. See Audit Logic for TB Test definition.

**Audit Logic:** If there is not a TB diagnosis documented and a TB test was done, the test result is determined in the following way:

- All recorded PPD entries and TB lab tests using the DM AUDIT TB LAB TESTS TAX prior to the Audit date are gathered.
  - If at least one is found the latest one is used.
  - If it is a Skin test and the reading or result is Positive (reading >9), then it is assigned as 1 – Positive.
  - If reading or result of last PPD is negative, then the values is 2 - Negative.
- If the test type is a blood test then the value of the test is examined:
  - If it is Positive then 1 -, Positive is recorded.
  - If it is negative then 2 -, Negative is assigned.
  - If the results are null the value 3 -, No result documented is assigned.
- If no result is found, then the value assigned is 3 - No result documented.

**Audit Report:** Tuberculosis (TB) Status section:

- TB diagnosis documented and/or positive test result
- If not diagnosed, TB test done (skin test or blood test)
- If TB diagnosis documented and/or positive test result, treatment initiated
- If TB negative test result, was test done after diabetes diagnosis

**Audit Export Field Name and Details:** TBTESTRSLT2

- 1=Positive
- 2=Negative
- 3=No result documented
- Leave blank if value for TBTESTDONE3 is not 1 or 2

**TB Treatment**

**Description:** If TB diagnosed ever and/or result positive, was treatment initiated?

**How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** See Audit Logic for definition of treatment initiated. The value of the last TB Health factor or medication displayed.

**Audit Logic:** If TB diagnosis documented ever is YES or the value of the TB Test result is POSITIVE, then the last TB health factor and TB medication taxonomy are looked at for determining TB Treatment status. The last recorded TB Health factor is displayed. The TB Health factors are:

- TB – TX COMPLETE
- TB – TX INCOMPLETE
- TB – TX UNKNOWN
- TB – TX UNTREATED
- TB – IN PROGRESS

The value assigned is based on the last recorded health factor or prescription of any medication from the TB medication taxonomy (DM AUDIT TB MEDS/DM AUDIT TB DRUG NDC) ever:

- TX COMPLETE: 1 – Yes
- TX INCOMPLETE: 1 – Yes
- TX UNTREATED: 2 – No
- TX IN PROGRESS: 1 – Yes
- TX UNKNOWN: 3 – Unknown
- TB medication prescribed 1-Yes

**Audit Report:** Tuberculosis (TB) Status section:

- TB diagnosis documented and/or positive test result
- If not diagnosed, TB test done (skin test or blood test)
- If TB diagnosis documented and/or positive test result, treatment initiated
- If TB negative test result, was test done after diabetes diagnosis

**Audit Export Field Name and Details:** TBINHTX2

- 1=Yes
- 2=No
- 3=Unknown
- Leave blank if value for TBDX is not 1=Yes or TBTESTRSLT2 is not 1=Positive

**TB TEST DATE**

**Description:** Date of last TB test.

**How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** TB - Last Documented Test. The date of the last documented TB test is displayed along with what type of test was done. See Audit Logic for TB Test Done for definition of a TB test.

For the selected date: if year only documented, 0701 is used for month/day; if month/year are documented 15 is used for the day.

**Audit Logic:** If the value of TB test result is NEGATIVE, then the date of the last TB test is displayed.

**Audit Report:** Tuberculosis (TB) Status If negative TB test, test done after diabetes diagnosis.

**Audit Export Field Name and Details:** TBTESTDATE MM/DD/YYYY
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Leave blank if value for TBTESTRLT2 is not 2=Negative

HEPATITIS C (HCV)
Description: Hepatitis C (HCV) diagnosis ever
How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): See Audit Logic
Audit Logic: The Purpose of Visits are scanned for any diagnosis ever contained in the BGP HEPATITIS C DXS taxonomy. If one is found the value of 1 - Yes is assigned, if no diagnosis is found the Problem List is scanned for a diagnosis contained in the BGP HEPATITIS C DXS taxonomy or a SNOMED contained in the PXRM HEPATITIS C SNOMED list. If that is found on the problem list a value of 1 - Yes is assigned, if not found a value of 2 - No is assigned.
Audit Report: Hepatitis C (HCV) section:
- Diagnosed HCV ever
- In patients not diagnosed with HCV and age ≥ 18 years, screened ever
Audit Export Field Name and Details: HCVdx
- 1=Yes
- 2=No

HEPATITIS C SCREEN
Description: Screened for HCV at least once (ever) if no diagnosis of Hepatitis C
How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): See Audit Logic. The date, test name and the test result are displayed.
Audit Logic: If the patient has a diagnosis of Hepatitis C, this item is skipped.
Hepatitis C Screening (Ab Test) is determined by the following:
- CPT 86803
- BGP HEP C TEST LOINC CODES taxonomy
- Site-populated lab test taxonomy BGP HEP C TEST TAX.
The V LAB file is scanned for any test contained in the lab test and LOINC taxonomies. The V CPT file is scanned for CPT 86803.
- If a lab test or CPT code is found a value of 1 - Yes is assigned
- If a lab test or CPT code is not found a value of 2 - No is assigned
Audit Report: Hepatitis C (HCV) section:
- Diagnosed HCV ever
- In patients not diagnosed with HCV and age ≥ 18 years, screened ever
Audit Export Field Name and Details: HCVscreen2
- 1=Yes
- 2=No
- Blank if value for HCV is not 2=No

RETINOPATHY (DIAGNOSED EVER)
Description: Retinopathy diagnosed ever?
How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): See Audit Logic. The date of the diagnosis is displayed.
Audit Logic: If retinopathy is on the problem list or the patient has had at least one visit with a diagnosis of retinopathy ever, then it is assumed that they have been diagnosed with retinopathy and a value of 1 - Yes is assigned. Otherwise, a value of 2 - No is assigned.
Taxonomy used: BGP DM RETINOPATHY DX
SNOMED List: PXRM BGP DM RETINOPATHY
Audit Report: Retinopathy Diagnosed ever. Also used in calculation of diabetes-related conditions.
Audit Export Field Name and Details: Retinopdx
- 1=Yes
- 2=No

LOWER LEG AMPUTATION (EVER)
Description: Lower Extremity Amputation (ever), any type (e.g., toe, partial foot, above or below knee).
How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): See Audit Logic.
Audit Logic: The patient's electronic record is scanned for documentation of any of the following items:
- The purpose of visits is scanned for any diagnosis in the BGP DM BTK AMP DXS or the BGP DM ATK AMP DXS taxonomies. If a diagnosis is found a value of 1 - Yes is assigned.
- The problem list is scanned for a diagnosis in the BGP DM BTK AMP DXS or BGP DM ATK AMP DXS taxonomies or a SNOMED in the PXRM BGP DM BTK AMP or PXRM BGP DM ATK AMP SNOMED subsets.
- The procedures are scanned for a procedure in the BGP DM BTK AMP PROC or BGP DM ATK AMP PROC taxonomies.
- The CPT codes are scanned for a CPT in the BGP DM BTK AMP CPTS or BGP DM ATK AMP CPTS taxonomies.
If any of the above are found, a value of 1 - Yes is assigned, otherwise a value of 2 - No is assigned.
Audit Report: Lower Extremity Amputation, any type ever (e.g., toe, partial foot, above or below knee). Also used in calculation of diabetes-related conditions.
Audit Export Field Name and Details: Lea
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- 1=Yes
- 2=No

INFLUENZA VACCINE
Description: Influenza vaccine received during the Audit Period
How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): See Audit Logic for definition of Influenza vaccine. The date of the vaccine since August 1st is displayed. If no documented Influenza vaccine is found, a search is done for a documented refusal or contraindication, if found, it is displayed.
Audit Logic: The patient’s data is scanned for an influenza vaccine in the 12 months prior to the Audit date. Influenza vaccine is determined by:
Immunization CVX codes: See DM AUDIT FLU IZ CVX CODES taxonomy
- 15 INFLUENZA, SPLIT [TIVhx] (INCL
- 16 INFLUENZA, WHOLE
- 88 INFLUENZA, NOS
- 111 INFLUENZA, Intranasal, Trivale
- 135 INFLUENZA, HIGH DOSE SEASONAL
- 140 INFLUENZA, seasonal, injectable
- 141 INFLUENZA [TIV], SEASONAL, INJ
- 144 INFLUENZA, INTRADERMAL
- 149 INFLUENZA, Live, Intranasal, Q
- 150 INFLUENZA, INJECTABLE, QUAD, P
- 151 INFLUENZA NASAL, UNSPECIFIED
- 153 INFLUENZA, INJECTABLE, MDCK, P
- 155 INFLUENZA, INJECTABLE, RECOMB,
- 158 INFLUENZA, Injectable, Quad rav
- 161 INFLUENZA, Injectable, quad riva
- 166 INFLUENZA, intradermal, quadri
- 168 INFLUENZA, Trivalent, adjvant
- 171 Influenza, injectable, MDCK, p
- 185 influenza, recombinant, quadri
- 186 Influenza, injectable, MDCK, q
- 197 FLU-HIGH4
- 205 FLU-V4ajv
CPT codes: BGP CPT FLU
- If any of the above is found, a value of 1 - Yes is assigned.
- If none of the above are found, a value of 2 - No is assigned.
Audit Report: Immunization section: Influenza vaccine during Audit period.
Audit Export Field Name and Details: FLUVAX2:
- 1=Yes
- 2=No

PNEUMOCOCCAL VACCINE
Description: Pneumococcal vaccine [PCV15, PCV20, or PPSV23] vaccine (ever)
How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): See Audit Logic for the definition of a pneumococcal vaccine. The date of the last pneumococcal vaccine is displayed. If no documented vaccine is found a search is done for a documented refusal or contraindication, if found, it is displayed.
Audit Logic: Data is scanned for pneumococcal vaccine any time prior to the Audit date. A pneumococcal vaccine is determined by:
Immunization CVX codes: See BGP PCV15 CVX CODES:
- 215 PNEUMOCOCCAL CONJUGATE PCV15
BGP PCV20 CVX CODES:
- 216 PNEUMOCOCCAL CONJUGATE PCV20
BGP PPSV23 CVX CODES:
- 33 PNEUMOCOCCAL POLYSACCHARIDE PPSV23
- 109 PNEUMOCOCCAL, NOS
- Diagnoses: V03.82 (Note: There are no ICD-10 codes.)
- Immunization CPT codes:
  BGP PCV15 CPT CODES:
  - 90671
  BGP PCV20 CPT CODES:
  - 90677
  BGP PPSV23 CPT CODES:
  - 90732, G0009, G8115 (old code), G9279
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• If any of the above is found, a value of 1 - Yes is assigned.
• If none of the above are found, a value of 2 - No is assigned.

Audit Report: Immunization section:
• Pneumococcal vaccine [PCV15, PCV20, or PPSV23] – ever

Audit Export Field Name and Details: PNEUMO
• 1=Yes
• 2=No

Td, Tdap, DTaP, or DT IN PAST 10 YEARS
Description: Td, Tdap, DTaP, or DT in past 10 years.

How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): See Audit Logic for the definition of the vaccines. The date of the last vaccine is displayed. If no documented vaccine is found a search is done for a documented refusal or contraindication, if found, it is displayed.

Audit Logic: Immunizations are scanned for any tetanus vaccine in the 10 years prior to the Audit date. Logic used to find a TD vaccine: Immunization CVX codes: DM AUDIT TD CVX CODES.
• 9 TD (ADULT)
• 113 TD (ADULT) PRESERVATIVE FREE
• 115 Tdap
• 138 Td-NA
• 139 Td,NOS
• 1 DTP
• 20 DTAP
• 28 DT (PEDIATRIC)
• 35 TETANUS TOXOID
• 106 DTAP, 5 PERTUSSIS ANTIGENS
• 107 DTAP, NOS
• 112 TETANUS TOXOID, NOS
• 22 DTP-HIB
• 50 DTAP-HIB
• 110 PEDIARIX
• 120 PENTACEL
• 130 KINRIX
• 132 DTaP/IPV/Hb
• 196 Td-LF, NOS
• 198 DTAP-HbH5
• CPT codes: 90714, 90715, 90718 Taxonomy DM AUDIT TD CPTS

If any of the above is found, a value of 1 - Yes is assigned.
If none of the above are found, a value of 2 - No is assigned.

Audit Report: Immunization section:
• Td/Tdap/DTaP/DT - past 10 years

Audit Export Field Name and Details: TD2
• 1=Yes
• 2=No

Tdap (Ever)
Description: Tdap given ever

How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): See Audit Logic for the definition of Tdap. The date of the last Tdap is displayed. If no documented vaccine is found a search is done for a documented refusal or contraindication, if found, it is displayed.

Audit Logic: Immunizations are scanned for a Tdap vaccine ever. A Tdap vaccine is determined by:
• CVX code 115 Tdap
• CPT code 90715

If either of the above is found, a value of 1 - Yes is assigned. If neither is found, a value of 2 - No is assigned.

Audit Report: Immunization section:
• Tdap – ever

Audit Export Field Name and Details:

HEPATITIS B COMPLETE SERIES (EVER)
Description: Hepatitis B complete series received ever.

How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): See Audit Logic for definition of Hepatitis B vaccines. If no documented vaccine is found, a search is done for an immune contraindication which, if found, is displayed.

Audit Logic: Data is scanned for Hepatitis B vaccine any time prior to the Audit date. HEP B (3 DOSE SERIES) is determined by:
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- CVX codes:
  - 8 HEP B, ADOLESCENT OR PEDIATRIC
  - 42 HEP B, ADOLESCENT/HIGH RISK IN
  - 43 HEP B,ADULT
  - 44 HEP B, DIALYSIS
  - 45 HEP B, NOS
  - 51 HIB-HEP B
  - 102 DTP-HIB-HEP B
  - 104 HEP A-HEP B
  - 110 DTaP-Hep B-IPV
  - 132 DTaP-IPV-HIB-HEP B, historical
  - 146 DTaP,IPV,Hib,HepB
  - 193 Hep A-Hep B, pediatric/adolescent
  - 220 HEP B, recombinant, 3-antigen, Al(OH)3

- CPT codes contained in the BGP HEPATITIS CPTS taxonomy: 90636, 90697, 90723, 90731, 90739, 90740, 90743, 90744, 90745, 90746, 90748, 90759, G0010, Q3021, Q3023

- HEP B (2 DOSE SERIES) is determined by: CVX code 189 Hep B, adjuvanted
  Vaccinations must be given at least 20 days apart. If the appropriate number is found (two for the two-dose series or three for the three-dose series) a value of 1 - Yes is assigned.
  If less than the required number of vaccines are found, the system will look for an Immune Contraindication in the Immunization contraindications file. If it is found, a value of 3 - Immune is assigned. The system then looks for evidence of disease: Problem List or V POV of [BGP HEP EVIDENCE] Taxonomy. If it is found, a value of 3 - Immune is assigned.
  If none of the above are found, a value of 2 - No is assigned.

Audit Report: Immunization section:
- If not immune, hepatitis B complete series – ever
- Immune - Hepatitis B

Audit Export Field Name and Details: HEPBVAX2:
- 1=Yes
- 2=No
- 3=Immune

SHINGRIX COMPLETE SERIES (EVER)
Description: Shingrix complete series received ever.

How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): See Audit Logic below. If no documented vaccine is found, a search is done for a documented refusal or contraindication, if found, it is displayed.

Audit Logic: Data is scanned for Shingrix vaccine any time prior to the Audit date. Shingrix vaccine is determined by documentation of 2 doses:
- CPT Code 90750
- CVX Code 187, zoster recombinant

Audit Report: Immunization section:
- In patients age >=50 years Shingrix complete series - ever

Audit Export Field Name and Details: SHINGLESVAX:
- 1=Yes
- 2=No

A1C
Description: Hemoglobin A1C test performed during the Audit period.

How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): The date, test name and result of the last A1C test is displayed. See Audit Logic for the definition of an A1C test.
For the selected date: if year only documented, 0701 is used for month/day; if month/year are documented 15 is used for the day.

Audit Logic: All lab tests in the V LAB file in the year prior to the Audit date are found using the DM AUDIT HGB A1C TAX taxonomy and the BGP HGBA1C LOINC CODES taxonomies. Only tests that have a result are used, if the result of the V LAB is blank, contains "CANC" or contains "COMMENT" the V Lab is skipped.
Individual Audit: The date and result of test are displayed.

Audit Report: Blood Sugar Control section:
- If result contains ">" counted in >=11.0 category.
- If result contains "<" counted in <7.0 category.
- Otherwise, everything is stripped from the value except numbers and ".". If remaining value is something other than a number, counted in the "Not tested or no valid result" category.
- If remaining value is numerical, it is counted in the appropriate category(ies):
  - A1C <7.0
  - A1C 7.0-7.9
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A1C 8.0-8.9
A1C 9.0-9.9
A1C 10.0-10.9
A1C >= 11.0
Not tested or no valid result
A1C <8.0
A1C >9.0

Audit Export Field Name and Details:
• HBA1C
• HBA1CDATE
• When exported, all characters that are not a number or a “.” are stripped from the value. For example, if the value is <7.0, 7.0 is exported. A maximum of 4 digits is exported.
• Date is in MM/DD/YYYY format

TOTAL CHOLESTEROL
Description: Most recent Total Cholesterol value.
How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): The date, test name and result of the last Total Cholesterol test is displayed. See Audit Logic for the definition of a Total Cholesterol test.
Audit Logic: The last lab test with a result in the year prior to the Audit date that is a member of the DM AUDIT CHOLESTEROL TAX taxonomy or the BGP TOTAL CHOLESTEROL LOINC taxonomy is found in V LAB.
Audit Report: Not reported.
Audit Export Field Name and Details: CHOLVALUE All characters other than numbers and “.” are stripped from the value which is then rounded to the closest whole number and truncated to a total of three characters with zero decimal digits. Rounding is done by adding .5 to the result and sending the non-decimal portion.
• E.g., Value in RPMS is 100.1, then .5 is added to get 100.6; then 100 is sent to the audit
• E.g., Value in RPMS is 100.5; then .5 is added to get 101.0; then 101 is sent to the audit

HDL CHOLESTEROL
Description: Most recent HDL Cholesterol value.
How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): The date, test name and result of the last HDL Cholesterol test is displayed. See Audit Logic for the definition of a HDL Cholesterol test.
Audit Logic: The last lab test with a result in the year prior to the Audit date that is a member of the DM AUDIT HDL TAX taxonomy or the BGP HDL LOINC CODES taxonomy is found in V LAB.
Audit Report: HDL cholesterol section: If result is blank OR first digit is not a number, then counted in the "Not tested or no valid result" category. For example, if the value is "cancelled".
• In females
  HDL < 50 mg/dL
  HDL ≥ 50 mg/dL
  Not tested or no valid result
• In males
  HDL < 40 mg/dL
  HDL ≥ 40 mg/dL
  Not tested or no valid result
Audit Export Field Name and Details: HDLVALUE All characters that are not numbers or “.” are stripped from the value which is then rounded to the closest whole number and truncated to a total of three characters with zero decimal digits. Rounding is done by adding .5 to the result and sending the non-decimal portion.
• E.g., Value in RPMS is 45.1; then .5 is added to get 45.6; then 45 is sent to the audit
• E.g., Value in RPMS is 60.5; then .5 is added to get 61.0; then 61 is sent to the audit

LDL CHOLESTEROL
Description: Most recent LDL Cholesterol value.
How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): The date, test name and result of the last LDL Cholesterol test is displayed. See Audit Logic for the definition of a LDL Cholesterol test.
Audit Logic: The last lab test with a result in the year prior to the Audit date that is a member of the DM AUDIT LDL CHOLESTEROL TAX taxonomy or the BGP LDL LOINC CODES taxonomy is found in V LAB. Tests with a result containing CANC” are ignored.
Audit Report: LDL cholesterol section:
If the first digit of the result is not a number, then counted in the "Not tested or no valid result" category. For example, if the value is “UNK”.
• LDL <100 mg/dL
• LDL 100-189 mg/dL
• LDL >=190 mg/dL
• Not tested or no valid result
Audit Export Field Name and Details: LDLVALUE
TRIGLYCERIDES
Description: Most recent Triglyceride value.

How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): The date, test name and result of the last Triglyceride test is displayed. See Audit Logic for the definition of a Triglyceride test.

Audit Logic: The last lab test with a result in the year prior to the Audit date that is a member of the DM AUDIT TRIGLYCERIDE TAX taxonomy or the BGP TRIGLYCERIDE LOINC CODES taxonomy is found in V LAB. Only tests with a result are used; tests with a result containing "CANC" or "COMMENT" are also skipped.

Audit Report: Triglycerides section: If the result is blank OR first digit is not a number then counted in the "Not tested or no valid result" category. For example, if the value is "cancelled".

• TG <150 mg/dL
• TG 150-499 mg/dL
• TG 500-999 mg/dL
• TG ≥1000 mg/dL
• Not tested or no valid result

Audit Export Field Name and Details: TRIGVALUE
All characters other than numbers and "." are stripped from the value and which is then rounded to the closest whole number and truncated to a total of three characters with zero decimal digits. Rounding is done by adding .5 to the result and sending the non-decimal portion.

• E.g., Value in RPMS is 100.1; then .5 is added to get 100.6; then 100 is sent to the audit
• E.g., Value in RPMS is 100.5; then .5 is added to get 101.0; then 101 is sent to the audit

SERUM CREATININE
Description: Most recent Serum Creatinine value.

How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): The date, test name and result of the last Serum Creatinine test is displayed. See Audit Logic for the definition of a Serum Creatinine test.

Audit Logic: The last lab test with a result in the year prior to the Audit date that is a member of the DM AUDIT CREATININE TAX taxonomy or the BGP CREATININE LOINC CODES taxonomy is found in V LAB. All tests with a result containing "CANC" are skipped.

• Specimen types are not examined so if the same creatinine test is used for serum creatinine as for urine creatinine, the Audit is unable to distinguish between these values.
• Result reporting: For the individual Audit, the actual value that is in V LAB is displayed.

Audit Report: Not reported
Audit Export Field Name and Details: CREATVALUE
All characters other than numbers and "." are stripped from the value which is truncated to a total of four characters with two decimal digits.

• E.g., Value in RPMS is 6.25; then 6.25 is sent to the audit

eGFR (ESTIMATED GFR)
Description: Most recent Estimated GFR value.

How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): The date, test name and result of the last eGFR test is displayed. See Audit Logic for the definition of an eGFR test.

Audit Logic: For patients that are 18 or older, the last lab test in the year prior to the Audit date that is a member of the BGP GPRA ESTIMATED GFR TAX or the BGP ESTIMATED GFR LOINC taxonomy is found. For the individual Audit, the actual value that is in V LAB is displayed.

Audit Report: Kidney Evaluation section: If the first character of the value is ">," it goes into ≥ 60 ml/min. Otherwise, all characters other than numbers and "." are stripped and the resulting value is placed in the following categories:

• eGFR ≥60 mL/min
• eGFR 30-59 mL/min
• eGFR 15-29 mL/min
• eGFR <15 mL/min
• Not tested or no valid result

Also used in the CKD Stage section.
Audit Export Field Name and Details: EGFRVALUE
All characters other than numbers or "." are stripped from the value which is truncated to a total of 5 characters with 1 decimal digit.

QUANTITATIVE URINE ALBUMIN CREATININE RATIO (UACR) Value
Description: Most recent Quantitative Urine Albumin-to-Creatinine Ratio (UACR) value.
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How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): The date, test name, and result of the last UACR test is displayed. See Audit Logic for the definition of a UACR test.

Audit Logic: The system looks for a test contained in the DM AUDIT QUANT UACR lab taxonomy or DM AUDIT A/C RATIO LOINC taxonomy, if found and the test has a valid numeric result then the result of the test is assigned to UACR value. If the test found does not have a valid numeric result, then the system will look for a urine microalbumin test on the same visit date using the DM AUDIT MICROALBUMINURIA TAX taxonomy. If found, the result of that test is evaluated. If the result contains a < symbol or the words ”less than,” a value of 5 is assigned to UACR value. If the result contains a ’>’ symbol or contains the words ”greater than” a value of 999 is assigned to UACR value.

Result reporting: For the individual Audit, the resulting value is displayed.

Audit Report: Kidney Evaluation section:
- UACR - normal: <30 mg/g
- UACR increased: 30-300 mg/g
- UACR increased: >300 mg/g
- Not tested or no valid result

Also used in the CKD Stage section.

Audit Export Field Name and Details: UPACRVAL
All non-numeric characters are stripped from the value.

LOCAL QUESTIONS
Description: Single digit 1-9 Locally defined data element.

How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): N/A

Audit Logic: Data is obtained from the LOCAL OPTION field of the Diabetes Register.

Audit Report: Not reported

Audit Export Field Name and Details: LOCAL #, single digit, 1-9. This field may be left blank for all patients if the facility does not choose to populate it.

EXTENDED LOCAL QUESTIONS
Description: Extended Local Question Locally defined data element.

How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): N/A

Audit Logic: Data is obtained from the LOCAL OPTION TEXT field of the Diabetes Register.

Audit Report: Not reported.

Audit Export Field Name and Details: LOCALEXT character (max length=50). This field may be left blank for all patients if the facility does not choose to populate it.
This manual was created by the Western Tribal Diabetes Project of the Northwest Portland Area Indian Health Board’s (NPAIHB) Tribal Epidemiology Center.

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