



RESOURCE AND PATIENT MANAGEMENT SYSTEM

# **RPMS Uniform Data System Reporting System**

(BUD)

**User Manual**

Version 10.0  
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Office of Information Technology  
Division of Information Technology

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## Preface

This manual contains the user's guide for the Resource and Patient Management System (RPMS) Uniform Data System (UDS) Reporting System for calendar year 2015.

RPMS UDS Reporting is intended for use by Tribal or urban health facilities receiving grant funds for primary care system development programs administered by the Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA). The RPMS UDS Reporting System provides passive extraction of patient and visit data from the Indian Health Service (IHS) RPMS to produce 10 of the 12 UDS report tables required annually by BPHC Health Center Program grantees.

**Note:** Submit 2015 UDS data by February 15, 2016 in order to assure adequate time for review and correction of data errors prior to final submission. Changes to this data are permitted until March 31, 2016.

The RPMS UDS Reporting System software will be reviewed annually and updated as needed as BPHC reporting requirements change.

Additional information about BPHC grants and BPHC UDS reporting can be found at the following Web site: <http://www.bphc.hrsa.gov/uds/>.

### Rules of Behavior

All RPMS users are required to observe Department of Health and Human Services and IHS Rules of Behavior (Appendix D: ) regarding patient privacy and the security of both patient information and IHS computers and networks. This document provides both RPMS and UDS Rules of Behavior.

## 1.0 About this Manual

This manual provides user instructions for the RPMS UDS Reporting System for calendar year (CY) 2015. The chapters included in the manual cover these main system components:

- System set up, including taxonomies and site parameters
- Reports and patient lists, including descriptions of report logic used and sample output
- Relevant excerpts from the BPHC UDS Instruction Manual

### 1.1 Key Changes for Version 10.0

- Revised environment checker to check for items listed in the install manual only.
- Revised environment checker clearly define any errors during install instead of a generic message, such as the missing package or routine name.

#### 1.1.1 Menu Changes

- Reports Menu Changes
  - Added UD15 UDS 2015 ... menu option.
  - Removed UD06 UDS 2006 ... menu option.
- MU Menu Changes
- LST Submenu Changes
  - LST2 Submenu Changes
    - Revised submenus
      - E-H Table 6B Section E through H
        - Renamed to E-I Table 6B Section E through I
      - I-M Table 6B Section I through M
        - Renamed to J-N Table 6B Section J through N
    - Added submenus
      - E-I Table 6B Section E through I
        - CAD1 All CAD patients 18+ w/Lipid Therapy
        - CAD2 All CAD patients 18+ w/o Lipid Therapy
      - J-N Table 6B Section J through N
        - DEN1 All Patients 6-9 at Risk with First Molar Sealant

- DEN2 All Patients 6-9 at Risk w/o First Molar Sealant
- Removed submenus
  - J-N Table 6B Section J through N
    - CAD1 All CAD patients 18+ w/Lipid Therapy
    - CAD2 All CAD patients 18+ w/o Lipid Therapy
  - LST3 Submenu Changes
    - Revised submenus
      - DM Diabetes Patient Lists
        - DMR2 All DM Pts w/o A1c or >9 by Race & Hisp Identity
    - Removed submenus
      - DM Diabetes Patient Lists
        - DMR2 All DM Pts w/A1c >=8 & <=9 by Race & Hisp Identity
  - Included delimited option for all patient lists.

### 1.1.2 Table 3B

Revised logic to include patients best served in a language other than English

### 1.1.3 Table 4–Selected Patient Characteristics

- Updated poverty calculations using the HHS 2015 Poverty Guidelines.
- Updated table to include line 9a: Dually eligible (Medicare + Medicaid).

### 1.1.4 Table 6A– Selected Diagnoses and Services Rendered

Updated logic to include ICD-10 codes for selected diagnosis and services rendered.

### 1.1.5 Table 6B–Quality of Care Indicators

- Updated logic to include ICD-10 code sets.
- Added Section N – Sealants to First Molars:
  - The number of children age 6-9 years at “elevated” risk (moderate to high risk) for caries who received a dental sealant on a permanent first molar tooth during the reporting period.

### 1.1.6 Table 7–Quality of Care Indicators

- Updated logic to include ICD-10 code sets.
- Revised Hypertension logic to include the denominator exclusion.

- Removed Section C Column 3e: Patients with  $8\% \leq \text{Hb1ac} \leq 9\%$  (3e).

### 1.1.7 Taxonomy Changes

None

## 2.0 Introduction

The IHS RPMS UDS Reporting is intended for use by Tribal or urban health facilities receiving grant funds for primary care system development programs administered by the BPHC, HRSA. The UDS Reporting System provides passive extraction of patient and visit data from the RPMS to produce 10 of the 12 UDS reports. For each of these reports (except Table 9D), RPMS UDS also produces lists of all patients and related visits that are counted in the reports.

**Note:** The UDS 2015 reports are due to BPHC on or before February 15, 2016 in order to assure adequate time for review and correction of data errors prior to final submission. Changes to these data will be permitted until March 31, 2016.  
RPMS UDS Reporting System software will be reviewed annually and updated as needed as BPHC reporting requirements change.

### 2.1 About the BPHC UDS

The BPHC UDS is an integrated reporting system used by all Health Center Program grantees of the following primary care programs administered by the BPHC, HRSA:

- Community Health Center, as defined in Section 330(e) of the Health Centers Consolidation Act as amended
- Migrant Health Center, as defined in Section 330(g) of the Act
- Health Care for the Homeless, as defined in Section 330(h) of the Act
- Public Housing Primary Care, as defined in Section 330(i) of the Act

BPHC collects data on its programs to ensure compliance with legislative mandates and to report to Congress, the Office of Management and Budget, and other policy makers on program accomplishments. To meet these objectives, BPHC requires Health Center Program grantees submit a core set of information annually that is appropriate for monitoring and evaluating performance and for reporting on annual trends. The UDS is the vehicle used by BPHC to obtain this information.

UDS reports provide a comprehensive picture of all activities within the scope of BPHC-supported projects. Health Center Program grantees should report on the total unduplicated number of patients and activities within the scope of projects supported by any and all BPHC primary care programs covered by the UDS.

See Appendix A: for relevant excerpts from the BPHC UDS Manual. Additional information can be obtained from the following web site:

<http://www.bphc.hrsa.gov/uds/>.

## 2.2 RPMS UDS Reporting System Overview

The RPMS UDS Reporting System is a software tool that produces 10 of the 12 reports required annually by BPHC Health Center Program grantees. These reports provide an overview of patients and visits at a grantee health center, including number, age, gender, zip code of residence, insurance sources, and race/ethnicity of patients and number of visits by provider type and by key diagnoses and services, characteristics of special populations, quality of care indicators, health outcome and disparities. The system produces the following reports:

- Patients by Zip Code and Insurance Source
- Table 3A Patients by Age and Gender
- Table 3B Patients by Hispanic or Latino Identity/Race/Language
- Table 4 Selected Patient Characteristics
- Table 5 Staffing and Utilization (Column A)
- Table 5 Staffing and Utilization (Columns B and C)
- Table 6A Selected Diagnoses and Services Rendered
- Table 6B Quality of Care Indicators
- Table 7 Health Outcome and Disparities
- Table 9D Patient-Related Revenue

Additionally RPMS UDS will provide the following lists to assist in verifying data:

- LST1–Lists for Tables Zip Code, 3A&3B, 4, 5, and 6A:
  - Patient list by zip code and primary insurance source, used with the ZIP table.
  - Patient list with age and gender information about the patient and a list of all visits for the patient during the report period, used with Table 3A.
  - Patient list with Hispanic Identity and race information about the patient and a list of all visits for the patient during the report period, used with Table 3B.
  - Patient List used with Table 4, Income As A Percent Of Poverty Level section (Number of patients with an Income as A Percent of Poverty Level; i.e., equal to or less than ( $\leq$ )100%, 101-150%, 151-200%, >200%, Unknown).
  - Patient List used with Table 4, Principle Third Party Medical Insurance Source section (Number of patients with or without a Principle Third Party Medical Insurance Source).

- Patient List used with Table 4, Characteristics - Special Populations section (Number of patients with Characteristics of Special Populations (i.e. migrant workers, seasonal workers, homeless, school based health center patient, or a veteran)).
- Provider list categorized by BPHC-defined categories to assist in manual calculations of Table 5 Column A (Staffing Full Time Equivalents (FTE)).
- Patient list categorized by UDS-defined service categories (primary provider code) and showing all patients with visits to that provider type during the report period, used with Table 5, Columns B (Visits) and C (Patients).
- Patient list showing visits to whom the primary provider was uncategorized (i.e. did not map to the BPHC-defined categories), used with Table 5, Columns B (Visits) and C (Patients).
- Patient list categorized by selected diagnoses regardless of primacy and other services, used with Table 6A.
- LST2–Lists for Table 6B:
  - Patient list by age that had pregnancy-related visits during the past 20 months with at least one pregnancy-related visit during the report period, used with Table 6B Sections A & B.
  - Patient list of two-year-old patients who had their first visit prior to their second birthday, had a medical visit during the report period, and have all required childhood immunizations, used with Table 6B Section C.
  - Patient list of two-year-old patients who had their first visit prior to their second birthday, had a medical visit during the report period, and list the immunizations still needed to complete all required childhood immunizations, used with Table 6B Section C.
  - Patient list of all female patients ages 24–64 who have not had a hysterectomy, had a medical visit during the report period, were first seen in the clinic by their 65th birthday, and had a Pap test in the past three years, or the four years prior to the report period for women age 30-64 when an HPV test is accompanied with the pap test, used with Table 6B Section D.
  - Patient list of all female patients ages 24–64 who have not had a hysterectomy, had a medical visit during the report period, were first seen in the clinic by their 65th birthday, and *did not* have a Pap test in the past three years, used with Table 6B Section D.
  - Patient list of all children and adolescents ages 2-17 who had a medical visit during the report period, were first seen ever by the health center prior to their 17th birthday, and had body mass index (BMI) documented and counseling for nutrition and physical activity during the report period, used with Table 6B Section E.

- Patient list of all children and adolescents ages 2-17 who had a medical visit during the report period, were first seen ever by the health center prior to their 17th birthday, and *did not* have BMI documented or counseling for nutrition and physical activity during the report period, used with Table 6B Section E.
- Patient list of all adults age 18 or older who had a medical visit during the report period and had BMI documented and if overweight or underweight, a follow-up plan documented, used with Table 6B Section F.
- Patient list of all adults age 18 or older who had a medical visit during the report period and *did not* have BMI documented or if overweight or underweight, *did not* have a follow-up plan documented, used with Table 6B Section F.
- Patient list of all adults age 18 or older who had a medical visit during the report period, at least two medical visits ever, were ever seen after their 18th birthday, and were queried/screened about any and all forms tobacco use AND received documented cessation counseling intervention (counseling) or medication (smoking cessation agents) if identified as a tobacco user one or more times during the report period or the prior year, used with Table 6B Section G.
- Patient list of all adults age 18 or older who had a medical visit during the report period, at least two medical visits ever, were ever seen after their 18th birthday, and *were not* queried/screened about any and all forms tobacco use or *did not* receive a documented cessation counseling intervention (counseling) or medication (smoking cessation agents) if identified as a tobacco user one or more times during the report period or the prior year, used with Table 6B Section G.
- Patient list of all patients ages 5-40 with a diagnosis of mild, moderate or severe persistent asthma who had a medical visit during the report period, at least two medical visits ever, who received a prescription for or provided inhaled corticosteroid or an accepted alternative medication, used with Table 6B Section H.
- Patient list of all patients ages 5-40 with a diagnosis of mild, moderate or severe persistent asthma who had a medical visit during the report period, at least two medical visits ever, who *did not* receive a prescription for or provided inhaled corticosteroid or an accepted alternative medication, used with Table 6B Section H.
- Patient list of all patients 18 years of age and older with an active diagnosis of Coronary Artery Disease (CAD) including myocardial infarction (MI), or have had cardiac surgery, and whose last Low-Density Lipoprotein (LDL) was greater than or equal to 130 who were prescribed a lipid-lowering therapy medication or have documented evidence of use by patient of lipid lowering medication during the report period, and does not have an allergy or adverse reaction to lipid-lowering therapy medications, used with Table 6B Section I.

- Patient list of all patients 18 years of age and older with an active diagnosis of CAD including MI or have had cardiac surgery and whose last LDL was greater than or equal to 130 or last recorded LDL is greater than 1yr from last visit in the report year who *were not* prescribed a lipid-lowering therapy medication or has no documented evidence of use by patient of lipid lowering medication during the report period or has an allergy or adverse reaction to lipid-lowering therapy medications Section I.
- Patient list of patients 18 years of age and older who, in the current or prior report year, were diagnosed with Ischemic Vascular Disease (IVD) including acute myocardial infarction (AMI), or discharged alive after cardiovascular surgery (coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA)) and were prescribed or dispensed aspirin or another anti-thrombotic medication or have documented evidence of use by patient of aspirin or another anti-thrombotic medication during the report period, used with Table 6B Section J.
- Patient list of patients 18 years of age and older who, in the current or prior report year, were diagnosed with IVD including AMI, or discharged alive after cardiovascular surgery (CABG or PTCA) and *were not* prescribed or dispensed aspirin or another anti-thrombotic medication or *has no* documented evidence of use by patient of aspirin or another anti-thrombotic medication during the report period, used with Table 6B Section J.
- Patient list of all patients age 51-74 as of December 31 of the report period, not diagnosed with colorectal cancer, who has a documented colorectal cancer screen, used with Table 6B Section K.
- Patient list of all patients age 51-74 as of December 31 of the report period, not diagnosed with colorectal cancer, who did not have a documented colorectal cancer screen, used with Table 6B Section K.
- Patient list of all patients who had a medical visit during the report period and whose first ever HIV diagnosis occurred between October 1 of the prior year through September 30th of the current report year and had a medical visit for HIV care within 90 days of the first-ever HIV diagnosis, used with Table 6B Section L.
- Patient list of all patients who had a medical visit during the report period and whose first ever HIV diagnosis occurred between October 1 of the prior year through September 30th of the current report year and *did not* have a medical visit for HIV care within 90 days of the first-ever HIV diagnosis, used with Table 6B Section L.
- Patient list of all patients 12 years and older who had at least one medical visit during the report year and were screened for depression with a standardized tool during the report year AND had a follow-up plan documented if screened positive, used with Table 6B Section M.

- Patient list of all patients 12 years and older who had at least one medical visit during the report year and does not have a depression screen with a standardized tool during the report year with or without a depression follow-up plan documented, used with Table 6B Section M.
- Patient list of all patients 6-9 years old had at least one medical visit during the report year, had an oral assessment or comprehensive or periodic oral evaluation, were determined to be at moderate or high risk for caries, and had a sealant placed on a first molar during the reporting period, used with Table 6B Section N.
- Patient list of all patients 6-9 years old had at least one medical visit during the report year, had an oral assessment or comprehensive or periodic oral evaluation, were determined to be at moderate or high risk for caries, without a sealant placed on a first molar during the reporting period, used with Table 6B Section N.
- LST3–Lists for Table 7:
  - Patient list of patients that had pregnancy-related visits during the past 20 months, with at least one pregnancy-related visit during the report period, and who have been diagnosed with Human Immunodeficiency Virus (HIV), used with Table 7 Section A.
  - Patient list by race and Hispanic or Latino identity of patients that had pregnancy-related visits during the past 20 months, with at least one pregnancy-related visit during the report period, used with Table 7 Section A.
  - Patient list by race and Hispanic or Latino identity of patients ages 18 to 85 years old who have had two medical visits during the report period and were diagnosed with hypertension before June 30 of the report period, used with Table 7 Section B.
  - Patient list by race and Hispanic or Latino identity of patients ages 18 to 85 years old who have had two medical visits during the report period, were diagnosed with hypertension before June 30 of the report period, and who have controlled blood pressure (less than (<) 140/90 mm Hg) during the report period, used with Table 7 Section B.
  - Patient list by race and Hispanic or Latino identity of patients ages 18 to 85 years old who have had two medical visits during the report period, were diagnosed with hypertension before June 30 of the report period, and who do not have controlled blood pressure (less than (<) 140/90 mm Hg) during the report period, used with Table 7 Section B.
  - Patient list by race and Hispanic or Latino identity of patients ages 18 to 75 years old who have had two medical visits during the report period, with a diagnosis of Type I or Type II diabetes anytime through the end of the report period, and without a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes, used with Table 7 Section C.

- Patient list by race and Hispanic or Latino identity of patients ages 18 to 75 years old who have had two medical visits during the report period, with a diagnosis of Type I or Type II diabetes anytime through the end of the report period, and without a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes and with a most recent hemoglobin A1c of less than 8%, used with Table 7 Section C.
- Patient a list by race and Hispanic or Latino identity of patients ages 18 to 75 years old who have had two medical visits during the report period, with a diagnosis of Type I or Type II diabetes anytime through the end of the report period, and without a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes and with a most recent hemoglobin A1c greater than 9%, or with an A1c with no result, or with no A1c test during the report period, used with Table 7 Section C.

You can run reports for individual quarters as well as for the entire calendar year.

**Note:** Tables 6B and 7 must be run using the Full Calendar Year option. If these reports are run using the Quarterly options, the totals combined will not match the calendar year totals.

The RPMS UDS also includes an option to save all patients that meet the BPHC definition of a patient to an RPMS search template, where it can be used to assist the user with preparing the other needed reports that are submitted to BPHC.

**Note:** BPHC reporting is based on calendar year (January through December) rather than fiscal year (October through September).

See Section 5.2 for a description of the detailed logic for each report.

## 3.0 Manager Utilities for System Setup

This section will describe the steps that you will need to follow for setup functions and to run patient list reports.

You *must* perform the following two functions before the software is used:

- SET Site Parameters Setup, which includes defining one or more sites with associated BPHC UDS identification number and locations (see Section 3.1.1 to identify all visit locations that are eligible).
- TAX Taxonomy Setup, to add your site-specific terminology for nine laboratory tests that are used by Table 6A Selected Diagnoses and Services Rendered and Table 6B Quality of Care Indicators (see Section 3.2.1) for detailed instructions on adding entries to a taxonomy.

**Note:** System Managers must work with laboratory staff to identify all the different terms in the lab file that describes the laboratory test.

Also included are 8 additional medication taxonomies:

- BGP PQA CONTROLLER MEDS
- BGP PQA SABA MEDS
- BGP CMS SMOKING CESSATION MEDS
- BUD DIABETES MEDS TAX
- BUD IPID LOWERING MEDS
- BUD ANTIPLATELET MEDS
- DM AUDIT ASPIRIN DRUGS
- BGP HEDIS ANTIDEPRESSANT MEDS

These taxonomies are used as one of two methods to identify patients with prescribed PQA Controller, SABA, Cessation, lipid lowering, aspirin, and depression medications in Table 6B and diabetes in Table 7. These are prepopulated by National Drug Code, as indicated in Excel spreadsheet *UDS 2015 Medication Taxonomies* and users are able to add and/or remove drugs as necessary. The diagnosis and intervention taxonomies are used to identify patients with a depression follow-up in Table 6B and are pre-populated.

The Manager Utilities menu includes the option to run patient lists that are associated with the summary Table Reports. This option is included here to discourage casual users from accidentally running patient lists that may be hundreds of pages long. Patient lists are intended to be used for detailed data quality checks on the RPMS database and are not a part of normal UDS reporting.

The Manager Utilities menu also includes the option to create a search template of patients that the RPMS UDS has identified as meeting the BPHC definition of a patient and who are included in Table 3A. This search template may be used in other RPMS applications such as QMan and PGen in order to assist the user with completing other tables required by BPHC for annual reporting and which are not currently included in the RPMS UDS application.

Menu options to perform these activities are located under the Manager Utilities (MU) option on the main RPMS UDS menu.

**Note:** After typing each command, press Enter.

1. From the main RPMS menu, type **UDS** at the “IHS Core Option” prompt.

**Note:** Each user will have a different list of RPMS application options to choose from on the RPMS main menu. If **UDS RPMS Uniform Data System Reporting System** does *not* appear as a menu option, ask the site manager to provide appropriate security keys.

```

...ABM      Third Party Billing System ...
...BAT      Asthma Register ...
    BCH      Community Health Representative System ...
    BHS      Behavioral Health Information System ...
    BI       Immunization Menu ...
...BMC      Referred Care Information System ...
    BW       Women's Health Menu ...
...GPRA     IHS Clinical Reporting System (CRS) Main Menu ...
    LAB      Laboratory Menu ...
    PCC      Patient Care Component ...
    RAD      Rad/Nuc Med Total System Menu ...
    SD       Scheduling Menu ...
    SSN      SSN Reports Menu ...
    UDS      RPMS Uniform Data Systems (UDS) Reporting System ...

Select Core Applications Options: UDS <Enter>  RPMS Uniform Data Systems
(UDS) Reporting System
    
```

Figure 3-1: Accessing the Manager Utilities menu, Step 1

The UDS main menu (Figure 3-2) displays.

```

*****
**      RPMS UNIFORM DATA SYSTEM (UDS)      **
*****
                DEMO INDIAN HOSPITAL
                Version 10.0

UD15  UDS 2015 ...
UD14  UDS 2014 ...
UD13  UDS 2013 ...
UD12  UDS 2012 ...
UD11  UDS 2011 ...
UD10  UDS 2010 ...
UD09  UDS 2009 ...
UD08  UDS 2008 ...
UD07  UDS 2007 ...

Select RPMS Uniform Data Systems (UDS) Reporting System Option:  UD15
<Enter>  UDS 2015 ...
    
```

Figure 3-2: Accessing the Manager Utilities menu, Steps 2 and 3

2. Type **UD15** at the “Select RPMS Uniform Data Systems (UDS) Reporting System Option” prompt to access the 2015 version of the software. The UDS main menu (Figure 3-3) displays.

```

*****
**      RPMS UNIFORM DATA SYSTEM (UDS)      **
**                               2015        **
*****
                DEMO INDIAN HOSPITAL
                Version 10.0

REP    Reports ...
MU     Manager Utilities ...

Select UDS 2015 Option:  MU <Enter>  Manager Utilities ...
    
```

Figure 3-3: Accessing the Manager Utilities menu, Steps 4 and 5

3. Type **MU** at the “Select UDS 2015 Option” prompt. The Manager Utilities menu (Figure 3-4) displays.

```

*****
**      RPMS UNIFORM DATA SYSTEM (UDS)      **
**      2015 Manager Utilities              **
*****
                DEMO INDIAN HOSPITAL
                Version 10.0

SET    Update/Review Site Parameters
LST    Patient and Provider Lists Main Menu ...
STP    Create Search Template of Patients on Table 3A
TAX    Update Taxonomies for Use with UDS 2015

Select Manager Utilities Option:
    
```

Figure 3-4: Manager Utilities menu

## 3.1 Site Parameters Setup (SET)

Before running any reports, the site must identify its site parameters. Site parameters include:

- Identifying the site name (multiple site names can be set up for multifacility databases)
- Entering the site's UDS identification number
- Identifying all locations for the site that are eligible for UDS reporting, e.g. main facility, home location, satellite facilities, schools, etc. (See Section 3.1.1 to identify all visit locations that are eligible)

### 3.1.1 Locations

In RPMS, each site has a series of locations (facilities) associated with it, identified by a 6-digit code generally referred to as the Area/Service Unit/Facility (ASUFAC) code. For example, the ASUFAC code for Sells Hospital is 000101, representing Tucson Area (00), Sells Service Unit (01), and Sells Hospital (01).

Not all RPMS site locations can be used to count toward UDS reporting. For example, "Ambulance" or "Other" locations cannot be counted.

The BPHC UDS Manual states:

A visit may take place in the health center or at any other approved site or location in which project-supported activities are carried out. Examples of other sites and locations include mobile vans, hospitals, patients' homes, schools, nursing homes, homeless shelters, and extended care facilities. Visits also include contacts with patients who are hospitalized, where health center medical staff member(s) follow the patient during the hospital stay as physician of record or where they provide consultation to the physician of record...<sup>1</sup>

Typical site locations are included in Table 3-1. "Y" denotes site locations that should not be included.

Table 3-1: Examples of Site Locations

<b>[Site Name] Health Center</b>	<b>Exclude?</b>
XYZ Clinic	
ABC Hospital	
XYZ High School	
School Unspecified	

<sup>1</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 18.

[Site Name] Health Center	Exclude?
Ambulance	Y
CHS Hospital	
[Site Name] A/SA Program	
Regional Treatment Center	
Office	
CHS Physician Office	
Home	
Nursing Home	
CHS Other	Y
Other	Y
Undesignated Locations	Y

### 3.1.2 Adding New Parameters

```

*****
**      RPMS UNIFORM DATA SYSTEM (UDS)      **
**                               2015          **
*****
                                DEMO INDIAN HOSPITAL
                                Version 10.0

SET      Update/Review Site Parameters
LST      Patient and Provider Lists Main Menu ...
STP      Create Search Template of Patients on Table 3A
TAX      Update Taxonomies for Use with UDS 2015

Select Manager Utilities Option: SET
    
```

Figure 3-5: Select Manager Utilities Option

To set up site parameters:

1. Type **SET Update/Review Site Parameters** at the “Select Manager Utilities Option” prompt on the 2015 Manager Utilities menu (Figure 3-5). An explanation of the Site Parameters function displays (Figure 3-6).

```

*** Update/Review UDS 2015 Site Parameters ***

This option is used to set up your site's parameters for UDS reporting,
including entering your BPHC UDS id no. and defining visit locations to be
"counted" toward the report. "A visit may take place in the health center
or at any other approved site or location in which project-supported
activities are carried out. Examples... mobile vans, hospitals, patients'
homes, schools, homeless shelters, and extended care facilities..."

Visits will not be counted toward the report if the visit location does not
match the locations on the UDS Visit Locations list.

Multiple site names can be designated with associated locations. Each site
name must have locations designated.
    
```

```
Select UDS 15 SITE PARAMETERS SITE NAME:
```

Figure 3-6: Site Parameters screen

2. Type the name of your site location at the “Select UDS 15 Site Parameters Site Name” prompt:
  - If multiple names match what you typed, a list displays. Type the corresponding number of the correct site name.
  - If you enter a site name that has not been previously entered, the system will prompt you, “Are you adding ‘[SITE NAME]’ as a new UDS 15 SITE PARAMETERS (the XTH)?” Type **Y** (Yes) if you want to add the new site or **N** (No).
3. Type the site UDS Identification Number (assigned by BPHC) at the “UDS NO.” prompt, if you know it; otherwise, press Enter to skip this prompt.
4. The Update UDS Visit Locations screen (Figure 3-7) displays. If this is a new site, the Locations list will be blank.

```
Select UDS 15 SITE PARAMETERS SITE NAME: san carlos
  1  SAN CARLOS          PHOENIX          SAN CARLOS          01
  2  SAN CARLOS TRIBE   PHOENIX TRIBE/638  SAN CARLOS          80
CHOOSE 1-2: 1 <Enter> SAN CARLOS          PHOENIX          SAN CARLOS          01

Are you adding 'SAN CARLOS' as a new UDS 15 SITE PARAMETERS (the 1ST)? No//
Y <Enter> (Yes)

Update UDS Visit Locations      Dec 23, 2015 11:09:47      Page: 0 of 0
-----
Site Name: SAN CARLOS
Enter all locations to be included in the UDS report.

      ?? for more actions  + next screen  - prev screen
A  Add Visit Location to the list      S  Add All of this SU's locations
R  Remove Visit Location from List     Q  Quit

Select Item(s): Quit//
```

Figure 3-7: Site Parameters Setup, Steps 2–5

5. You can do one of the following:
  - Add individual locations one at a time.
  - Add the entire group of locations associated with the site and refine the list by deleting individual locations.

See Section 3.1.1 for a more detailed description about site locations.

The recommended approach to populate a blank Visit Locations list is to first add all the locations associated with the site and then delete any that do not belong on the list.

- Type **S Add All of this SU's Locations** at the "Select Item(s)" prompt. The system adds all locations listed in the RPMS database that is associated with the site.

```

Select Item(s): Quit// S <Enter> Add All of this SU's locations
Hold on while I gather up all of SAN CARLOS's locations and add them....
SAN CARLOS added
BYLAS added
AMBULANCE added
SCHOOL UNSPECIFIED added
CHS HOSPITAL added
OFFICE added
CHS PHYSICIAN OFFICE added
HOME added
NURSING HOME added
CHS OTHER added
OTHER added
UNDESIG LOCS added

Update UDS Visit Locations
Dec 23, 2015 11:19:13 Page: 1 of 1
-----
Site Name: SAN CARLOS
Enter all locations to be included in the UDS report.

1) AMBULANCE
2) BYLAS
3) CHS HOSPITAL
4) CHS OTHER
5) CHS PHYSICIAN OFFICE
6) HOME
7) NURSING HOME
8) OFFICE
9) OTHER
10) SAN CARLOS
11) SCHOOL UNSPECIFIED
12) UNDESIG LOCS

A Add Visit Location to the list S Add All of this SU's locations
R Remove Visit Location from List Q Quit
Select Item(s): Quit//

```

Figure 3-8: Adding All SU Locations

- Type **R (Remove Visit Location from List)** at the "Select Item(s)" prompt to delete a location.
- Type the number(s) corresponding to the location name(s) you want to remove at the "Which item(s)" prompt. To delete multiple locations, type individual numbers separated by commas or hyphens. To delete location numbers 1, 3, and 7 through 9, type **1,3,7-9**. Do not use spaces between the comma separators.

9. When the location list is complete, type **Q** (Quit) at the “Select Item(s)” prompt.

```
Select Item(s): Quit// R <Enter> Remove Visit Location from List

Which item(s): (1-12): 1,4,9,12 <Enter>
AMBULANCE removed from list
CHS OTHER removed from list
OTHER removed from list
UNDESIG LOCS removed from list

Update UDS Visit Locations      Dec 23, 2015 11:26:58      Page: 1 of 1
-----
Site Name: SAN CARLOS
Enter all locations to be included in the UDS report.

1) BYLAS
2) CHS HOSPITAL
3) CHS PHYSICIAN OFFICE
4) HOME
5) NURSING HOME
6) OFFICE
7) SAN CARLOS
8) SCHOOL UNSPECIFIED

A Add Visit Location to the list      S Add All of this SU's locations
R Remove Visit Location from List    Q Quit
Select Item(s): Quit//
```

Figure 3-9: Update Visit Locations screen, Steps 8–10

10. Processing returns to the Update/Review Site Parameters screen. To add or edit another site, with associated UDS identification number and locations, type **Y** (Yes) at the “Do you want to add/edit another site?” prompt.

**Note:** This feature is useful for sites with multiple facilities running on an integrated database. Each site and its related locations can be identified. The report options will ask for the appropriate site name.

11. If you enter a site name that has not been previously entered, the system will prompt, “Are you adding ‘[SITE NAME]’ as a new UDS 15 SITE PARAMETERS (the XTH)?” Type **Y** (Yes) or **N** (No).

12. If you are adding another new site, follow Steps 5–12 to add the UDS identification number and locations associated with the new site.

```
Do you want to add/edit another site? N// Y <Enter> YES
Select UDS 15 SITE PARAMETERS SITE NAME: KANAKANAK HOSPITAL      ALASKA
TRIBE/638 BRISTOL BAY      01
...OK? Yes// Y <Enter> (Yes)

Are you adding 'KANAKANAK HOSPITAL' as a new UDS 15 SITE PARAMETERS (the
2ND)? No// Y <Enter> (Yes)
UDS NO.:
```

Figure 3-10: Entering another site name

### 3.1.3 Updating Locations or Other Site-Related Data

You can review or edit location or other data that you have previously entered for a site name.

1. Type the site name at the “Select UDS 15 Site Parameters Site Name” prompt.
2. To change the UDS ID number, type a different number at the “UDS No.” prompt. If the ID number is correct as displayed in the default, press Enter to accept the default value.
3. The current site location list displays. Type **A** (Add) or **R** (Remove) to add or delete a location.
4. When you have finished updating the locations, type **Q** to Quit.

## 3.2 Taxonomies

You can use taxonomies to find data items in Patient Care Component (PCC) or other RPMS applications in order to determine if a patient or visit meets the criteria for which the software is looking.

On UDS Table 6A Selected Diagnoses and Services Rendered, BPHC defines standard national codes (International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9 CM), International Classification of Diseases, Complete Draft Code Set (ICD-10 CM), Current Procedural Terminology (CPT), and American Dental Association (ADA)) to identify the diagnoses and services provided to a health center’s users. Using standard national codes ensures comparable data within the agency as well as to external organizations.

For some of the services requested on Table 6A, RPMS UDS uses additional definitions. According to the BPHC UDS Manual, this is allowed.<sup>2</sup> For example, for HIV Test (Line 21), HEP B Test (Line 21a), HEP C Test (Line 21b), and for Pap Tests (Line 23), RPMS UDS uses standard national Logical Observations, Identifiers, Names, and Codes (LOINC) to identify these tests, in addition to site-populated laboratory test names and CPT codes.

RPMS UDS also uses lab taxonomies for these six tests that need to be populated by each individual site, BGP HPV TESTS TAX, BGP HIV TEST TAX, BGP PAP SMEAR TAX, BUD HEPATITIS B TEST, BUD HEPATITIS C TEST, and BGP GPRA FOB TESTS. Taxonomies are used to mitigate the variations in RPMS medical terminology that is not standardized across each facility, such as laboratory

---

<sup>2</sup> BPHC Uniform Data System Manual, 2015 Revision, pp. 73-74.

tests or medications. This means that you can compare one site's Pap smear data to another site, even though the same term is not used for the Pap smear laboratory test.

For example, one site's Lab table might contain the term "Pap Smear" while another site's table may contain the term "Thin Prep" for the same test. RPMS PCC programs have no means for dealing with variations in spelling, spacing, and punctuation. Rather than attempting to find all potential spellings of a particular laboratory test, the application will look for a specific taxonomy name that is standard at every facility. The contents of the taxonomy are determined by the facility. In this example, the application would use the BGP PAP SMEAR TAX taxonomy. The individual facility will enter all varieties of spelling and punctuation for Pap smear tests used at that particular facility.

Other RPMS software, including the Diabetes Management System and the Clinical Reporting System (CRS), uses taxonomies. If your site is using CRS, then the HPV Tests, HIV Test, Pap Smear, FOB, BGP CD4 TAX, and BGP HIV VIRAL LOAD TAX taxonomies are most likely already populated with your site's laboratory test names. UDS 2015 does not contain any new taxonomies; however, taxonomies should may need to be prepopulated prior to first use.

**Note:** System Managers must work with laboratory staff, to identify all the different terms in the lab file that describes the laboratory test.

### 3.2.1 Taxonomy Setup (TAX)

Taxonomy Setup (TAX) is a menu option that transfers the user to the RPMS Taxonomy Setup software. Taxonomy Setup allows you to review, add to, or edit members in the required taxonomies used in any RPMS software, including RPMS UDS.

RPMS UDS uses nine laboratory taxonomies: BGP HPV TESTS TAX, BGP HIV TEST TAX, BGP PAP SMEAR TAX, DM AUDIT HGB A1C TAX, BUD HEPATITIS B TEST, BUD HEPATITIS C TEST, BGP GPRA FOB TESTS, BGP CD4 TAX, and BGP HIV VIRAL LOAD TAX. Seven of these were originally defined for the CRS software: BGP HPV TESTS TAX, BGP HIV TEST TAX, BGP PAP SMEAR TAX, DM AUDIT HGB A1C TAX, BGP GPRA FOB TESTS, BGP CD4 TAX, and BGP HIV VIRAL LOAD TAX. If your site does not currently run CRS, the RPMS UDS software will load the seven taxonomies, but it will not populate them; that is, they will not contain any members. Therefore, you will need to work with your Lab staff to identify and assign tests to these four taxonomies.

**Note:** You should review all taxonomies for completeness before running the first UDS report.

In addition to the lab taxonomies, RPMS UDS uses eight medication taxonomies to identify patients with diabetes, asthma, smoking cessation, lipid lowering, aspirin, and depression prescriptions: BUD DIABETES MEDS TAX, BGP PQA CONTROLLER MEDS, BGP PQA SABA MEDS, BGP CMS SMOKING CESSATION MEDS, BUD LIPID LOWERING MEDS, BUD ANTIPLATELET MEDS, DM AUDIT ASPIRIN DRUGS, and BGP HEDIS ANTIDEPRESSANT MEDS. The RPMS UDS software will load the prepopulated taxonomies. Users are able to add and/or remove drugs as necessary.

1. Type **TAX** at the “Select Manager Utilities Option” prompt from the 2015 Manager Utilities menu.
2. The UDS Taxonomy Update menu displays with the 17 taxonomies used by UDS.

```

UDS TAXONOMY UPDATE           Dec 23, 2015 12:08:36           Page:      1 of 1
TAXONOMIES TO SUPPORT UDS REPORTING
* Update Taxonomies

1)  BGP PQA CONTROLLER MEDS           DRUG
2)  BGP PQA SABA MEDS                 DRUG
3)  BGP CMS SMOKING CESSATION MEDS    DRUG
4)  BGP PAP SMEAR TAX                 LAB
5)  BGP HPV TESTS TAX                 LAB
6)  BGP HIV TEST TAX                  LAB
7)  DM AUDIT HGB A1C TAX               LAB
8)  BUD HEPATITIS B TESTS             LAB
9)  BUD HEPATITIS C TESTS             LAB
10) BUD DIABETES MEDS TAX              DRUG
11) BGP GPRA FOB TESTS                 LAB
12) BUD LIPID LOWERING MEDS           DRUG
13) BUD ANTIPLATELET MEDS             DRUG
14) DM AUDIT ASPIRIN DRUGS            DRUG
15) BGP CD4 TAX                       LAB
16) BGP HIV VIRAL LOAD TAX            LAB
17) BGP HEDIS ANTIDEPRESSANT MEDS     DRUG

      Enter ?? for more actions
S    Select Taxonomy      Q    Quit
Select Action:+//
    
```

Figure 3-11: UDS Taxonomy Update menu

3. Type **S** to select the lab test taxonomy you want to review or populate.
4. Type the number of the lab test taxonomy you want to review or populate; valid choices are:
  - **4** BGP PAP SMEAR TAX
  - **5** BGP HPV TESTS TAX
  - **6** BGP HIV TEST TAX
  - **7** DM AUDIT HGB A1C TAX

- **8 BUD HEPATITIS B TEST**
- **9 BUD HEPATITIS C TEST**
- **11 BGP GPRA FOB TESTS**
- **15 BGP CD4 TAX**
- **16 BGP HIV VIRAL LOAD TAX**

If this is a new taxonomy, an empty Lab Taxonomy screen displays; otherwise, the laboratory tests included in the taxonomy are displayed.

```

UDS LAB TAXONOMY UPDATE      Dec 23, 2015 12:08:45      Page:      1 of      1
Updating the BGP PAP SMEAR TAX taxonomy

      Enter ?? for more actions
A      Add Lab Test           R      Remove Lab Test           Q      Quit
Select Action:+//
    
```

Figure 3-12: UDS Lab Taxonomy Update screen

5. Type **A** to add a laboratory test to the taxonomy.
6. Type the name of the laboratory test at the “Which Lab Test” prompt. Depending on the test name, several types of lab tests specific to your site may display.

```

      Enter ?? for more actions
A      Add Lab Test           R      Remove Lab Test           Q      Quit
Select Action:+// A <Enter>  Add Lab Test

Which LAB Test: CYTO
  1  CYTO ANCA  CYTOPLASMIC ANCA
  2  CYTO ASP. FINE NDLE  FINE NEEDLE ASP. 1
  3  CYTO PAP, GYN 1
  4  CYTO THIN PREP PAP  THIN PREP PAP
  5  CYTOGEN INTERP/REPORT  CYTOGENETICS REPORT
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 3,5 <Enter>
    
```

Figure 3-13: Adding Tests to a Lab Taxonomy

7. Type the number of the test you want to add. To add more than one test at a time, type the individual numbers separated by commas or hyphens, such as 1,3,5–7. Do not use spaces between the comma separators.

```

UDS LAB TAXONOMY UPDATE      Dec 23, 2015 12:09:15      Page:      1 of      1
Updating the BGP PAP SMEAR TAX taxonomy

1)  CYTO PAP, GYN 1
2)  THIN PREP PAP

      Enter ?? for more actions
A      Add Lab Test           R      Remove Lab Test           Q      Quit
Select Action:+//
    
```

Figure 3-14: Completed Lab Taxonomy

8. When all tests have been added to the taxonomy, type **Q** to quit and return to the UDS Taxonomy Update menu.
9. To add to or review tests for another taxonomy, repeat Steps 3–9. Otherwise, type **Q** to return to the Manager Utilities menu.

## 4.0 Report Definitions and Logic Example

In order to understand how the information is reported in the RPMS UDS application, it is necessary to understand how BPHC defines patients, visits, and providers and how those definitions have been applied in the RPMS UDS application.

### 4.1 BPHC UDS Manual Definitions

#### 4.1.1 Definition of Patients

*“Patients are individuals who have at least one reportable visit during the reporting year ...”* As described in the BPHC definition of a patient:

*“The Universal Report includes all patients who have at least one visit during the year which is within the scope of activities supported by any of the grants and programs covered by the UDS. These visits are reported on Table 5. On the ZIP Code Table, Tables 3A and 3B, and in each section of Tables 4 and 6A of the Universal report, each patient may be counted once and only once, even if s/he received more than one type of service (e.g., medical, dental, enabling) or received services supported by more than one BPHC grant...”*

*“Persons who only receive services from community based efforts such as immunization programs, medical or dental screening programs, dental varnishing programs, and health fairs are not counted as patients. Persons whose only service from the health center is a part of the WIC program or other programs are not counted as patients.”<sup>3</sup>*

#### 4.1.2 Definition of Visits

*“Visit definitions are needed both to determine who is counted as a patient (Tables 3A, 3B, 4, 6A, 6B and 7) and to report total visits by type of provider staff (Table 5). Visits are defined as a documented, face-to-face contact between a patient and a provider who exercises his/her independent professional judgment in the provision of services to the patient. To be included as a visit, services rendered must be documented. ... Visits which are provided by contractors, and paid for by the health center, such as Migrant Voucher visits or out-patient or in-patient specialty care associated with an at-risk managed care contract, are considered to be visits to the extent that they meet all other criteria.*

---

<sup>3</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 23.

Further elaborations of the definitions and criteria for defining and reporting visits follow:

1. To meet the criterion for “*independent professional judgment*,” the provider must be acting on his/her own when serving the patient and not assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, recording a history or drawing a blood sample *is not* credited with a separate visit. Independent judgment implies the use of the professional skills gained through formal training and experience associated with the profession of the individual being credited with the visit and unique to that provider or other similarly or more intensively trained providers. Eligible medical visits usually involve one of the “Evaluation and Management” billing codes (99201–05 or 99211–15) or one of the health maintenance codes (99381-87, 99391-97).
2. To meet the criterion for “*documentation*,” the service (and associated patient information) must be recorded in written or electronic form in a system which permits ready retrieval of current data for the patient. The patient record does not have to be a full and complete health record in order to meet this criterion. For example, if an individual receives services on an emergency basis and these services are documented, the documentation criterion is met even though some portions of the health record may not be complete. Providers who see their (existing, previously registered) patients at a hospital or nursing home and make a note in the institutional file can satisfy this criterion by including a summary note upon discharge from the hospital or nursing home indicating activities for each of the dates for which a visit is claimed. Screenings, such as those frequently conducted at health fairs or at schools, immunization drives for children or the elderly, services provided en-mass to identified groups, such as dental varnishes or sealants provided at schools, and similar public health efforts *are not counted* as visits regardless of the level of documentation.

3. When a behavioral health provider (i.e., a mental health or substance abuse provider) renders services to several patients simultaneously, the provider can be credited with a visit for each person only if the provision of services is noted in *each* person's health record. Such visits are generally limited to behavioral health services. Examples of such non-medical “group visits” include: family therapy or counseling sessions and group mental health counseling during which several people receive services and the services are noted in each person's health record. In such situations, *each* patient is normally billed for the service. If only one person is billed (for example, where a relative participates in a counseling session for a patient) only the patient who is billed is counted as a patient and only that patient's visit is counted. In addition, when a behavioral health provider conducts services via telemedicine/telehealth, the provider can be credited with a visit only if the service is noted in the patient's record. The session will normally be billed to the patient or a third party. Medical visits must be provided on an individual basis in order to be counted in the UDS. Other categories of telemedicine, patient education or health education classes (e.g., diabetics learning about diet control) are not credited as visits.
4. To meet the criterion for “*location*,” a visit may take place in the health center or at any other approved site in which project-supported activities are carried out. Examples of other sites and locations which may be approved include mobile vans, hospitals, patients' homes, schools, nursing homes, homeless shelters, and extended care facilities. (If visits at these sites occur on a regularly scheduled basis the site must be an approved site within the scope of the agency's grant.) Visits also include contacts with patients who are hospitalized, where health center medical staff member(s) follow the patient during the hospital stay as physician of record or where they provide consultation to the physician of record provided they are being paid by the health center for these services and the patient is billed either for the specific service or through a global fee. A reporting entity may not count more than one inpatient visit per patient per day regardless of how many clinic providers see the patient or how often they do so. When a patient is first encountered in a hospital or nursing home or a similar facility, which is *not* specifically approved as a service delivery site by BPHC, none of the services for that patient are reported on UDS.
5. Ancillary services including but not limited to, as drawing blood, collecting urine specimens, performing laboratory tests (including pregnancy tests and PPDs), taking X-rays, giving immunizations or other injections, and filling/dispensing prescriptions including, prescriptions for substance abuse prevention or treatment *do not* constitute visits, regardless of the level or quantity of supportive services.
6. Under certain circumstances, a patient may have more than one visit with the health center in a day. The number of visits per service delivery location per day is limited as follows. On any given day a patient may have, at a maximum:

- One medical visit (physician, nurse practitioner, physician’s assistant, certified nurse midwife, or nurse).
- One dental visit (dentist or hygienist).
- One “other professional health” visit *for each type of “other professional health” provider* (nutritionist, podiatrist, speech therapist, acupuncturist, etc.).
- One vision services visit (ophthalmologist, optometrist, or optometric assistant)
- One enabling service visit *for each type of enabling provider* (case management or health education).
- One mental health visit.
- One substance abuse visit.

If multiple medical providers deliver multiple services on a single day (e.g., an Ob-Gyn provides prenatal care and an Internist treats hypertension) *only one of these visits may be counted on the UDS. While some third party payors may recognize these as billable, only one of them is countable. The decision as to which provider gets credit for the visit on the UDS is up to the health center. Internally, the health center may follow any protocol it wishes in terms of crediting providers with work performed.*

An exception to this rule, designed to address the operational structure of homeless and migrant programs, allows medical services provided by two *different medical providers* located at two *different sites* to be counted on the same day. This permits patients who are seen in clinically problematic environments (e.g., homeless shelters or migrant camps) by non-physician providers, to be seen later in the same day at the health center’s fixed clinic site by a different, generally higher level, provider.

7. A given provider may be credited with no more than one visit with a given patient in a single day, regardless of the types or number of services provided or where they are provided.
8. The visit criteria *are not* met in the following circumstances:
  - When a provider participates in a community meeting or group session that is *not* designed to provide clinical services. Examples of such activities include information sessions for prospective patients, health presentations to community groups (high school classes, Parent Teacher Association (PTA), etc.), and information presentations about available health services at the center.
  - When the only health service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program (e.g., a health fair or en-mass application of dental varnishes).

- When a provider is primarily conducting outreach and/or group education sessions, not providing direct services.
- When the *only* services provided are lab tests, x-rays, sonography, mammography, retinography, immunizations or other injections, TB tests or readings and/or prescription refills.
- When narcotic agonists or antagonists or mixes of these are dispensed to a patient on a regular basis such as daily or weekly.
- Services performed under the auspices of Women, Infants, and Children (WIC) program or a WIC contract.”<sup>4</sup>

### 4.1.3 Definition of Providers

“A provider is the individual who assumes primary responsibility for assessing the patient and documenting services in the patient’s record. Providers include only individuals who exercise independent judgment as to the services rendered to the patient during a visit. Only one provider who exercises independent judgment is credited with the visit, even when two or more providers are present and participate.”<sup>5</sup> The BPHC UDS 2015 Manual contains a chart listing typical health facility staff with Provider/Non Provider categories designated.

## 4.2 RPMS General Definitions and Logic for All UDS Reports

### 4.2.1 Definition of Patients

RPMS UDS reporting defines “patients” as:

1. Any patient whose name is not “DEMO,PATIENT”, “PATIENT, DEMO”, “PATIENT,UDS” or “PATIENT,CRS,” *and* whose name must *not* be included in the RPMS demo/test search patient template named “RPMS DEMO PATIENT NAMES,” and whose gender is not “Unknown”, *and* who has one or more visits during the time period specified (quarter or full calendar year). Visits are documented face-to-face contacts between a patient and a licensed or otherwise credentialed provider who exercises independent, professional judgment in the provision of services to the patient. This determination is made in Section 4.2.2.1.
2. Each patient is to be counted only once, regardless of the number or types of services received.

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<sup>4</sup> BPHC Uniform Data System Manual, 2015 Revision, pp. 19-20.

<sup>5</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 23.

## 4.2.2 Definition of Visits

### 4.2.2.1 Definition of All Visits for a Qualified Patient

Once it has been determined the patient has at least one qualifying visit, *all of the patient's visits must meet the criteria that follow.*

**Note:** For the Services Rendered section of Table 6A (Lines 21–34), this represents all of the criteria the visits must meet in order to be counted.

However, for Tables 5 and the Selected Diagnoses section of Table 6A (Lines 1-20d), additional criteria must also be met, as described in Section 4.2.2.2.

1. *Must be to a location specified by the site in the Setup option* (see Section 3.1.1). The System Manager will identify in the Site Parameters Setup all the location codes that should be included in the definition of a visit, including home, satellite clinics, schools, or other appropriate locations. The BPHC UDS Manual states "...A visit may take place in the health center or at any other approved site or location in which project-supported activities are carried out. Examples of other sites and locations which may be approved include mobile vans, hospitals, patients' homes, schools, nursing homes, homeless shelters, and extended care facilities. (If visits at these sites occur on a regularly scheduled basis the site must be an approved site within the scope of the agency's grant.) Visits also include contacts with patients who are hospitalized, where health center medical staff member(s) follow the patient during the hospital stay..."<sup>6</sup>
2. *Must be one of the following RPMS Service Categories:*
  - Ambulatory (A)
  - Hospitalization (H)
  - Day Surgery (S)
  - Observation (O)
  - Telemedicine (M)
  - Nursing Home Visit (R)
  - Historical Event (E)
  - In-hospital (I)
3. *Must not have an excluded clinic code.* The RPMS clinic codes shown in Table 4-1 do not fit the BPHC definition of a visit.

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<sup>6</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 18.

**Note:** Clinic Codes 12 Immunization, 63 Radiology, 76 Laboratory Services, and 91 Teleradiology are not included in this table because qualifying visits to those clinics are included in the Services Rendered section of Table 6A (i.e., Lines 21–34). However, for Tables 5 and the Selected Diagnoses sections of Table 6A (Lines 1–20d), visits to those clinics are excluded, as shown in Section 4.2.2.2.

Table 4-1: Excluded Clinic Codes and Clinic Description

Clinic Code	Clinic Description
A3	Ambulance
52	Chart Rev/Rec Mod
98	Diabetes Education-Group
A1	Diabetes Education-Individual
95	Dialysis Laboratory Services
60	Education Classes
68	Employee Health Un
53	Follow-Up Letter
09	Grouped Services
41	Indirect
42	Mail
B1	Maternity Case Mgmt Supp Serv
78	OTC Medications
25	Other
A9	PH Preparedness (Bioterrorism)
39	Pharmacy
B6	Phone Triage
B2	Radiation Exposure Screening
54	Radio Call
B3	SANDS (Stop Atherosc in Native Diab Study)
51	Telephone Call
94	Tobacco Cessation Clinic
36	W.I.C.
D6	Transportation
D7	Online Services
D8	Magnetic Resonance Imaging

4. *Must not be to the same provider (i.e., person) on the same day.* If a patient has two or more visits to the same provider (i.e., person) on the same day, the first visit is kept and the subsequent visits are removed. An exception to this rule occurs if the Service Category is “I” for an inpatient visit. All I visits will be counted, whether or not it is to the same provider on the same day.

5. *Must have only one medical, one dental, one mental health, and one substance abuse visit per day.* For example, a patient may have visits with a physician, a dentist, a psychologist, and a substance abuse counselor all on the same day. However, for example, they cannot have (1) two visits to a physician or (2) one visit with a physician and one visit with a physician's assistant, or (3) two visits to a dentist on the same day because they provide the same type of care. If a patient has two or more visits to the same type of provider on the same day, the first visit is kept and the subsequent visits are removed. An exception to this rule occurs when the patient is seen in multiple different locations. In this case, each of the visits would count if the patient sees different providers in the different locations. However, if the patient sees the same provider in different locations, then only the first visit would be counted. A second exception to this rule occurs if the Service Category is I for an inpatient visit. All I visits will be counted, whether or not it is to the same type of provider on the same day. Refer to Appendix C: for provider codes included for each category of care.
6. *Must have only one other professional health visit for each type of other health provider per day.* For example, a patient may have visits with a nutritionist, podiatrist, and optometrist on the same day but may not have two visits with a nutritionist on the same day because they provide the same type of care. If a patient has two or more visits to the same type of provider on the same day, the first visit is kept and the subsequent visits are removed. An exception to this rule occurs when the patient is seen in multiple different locations. In this case, each of the visits would count if the patient sees different providers in the different locations. However, if the patient sees the same provider in different locations, then only the first visit would be counted. A second exception to this rule occurs if the Service Category is I for an inpatient visit. All I visits will be counted, whether or not it is to the same type of provider on the same day. Refer to Appendix C: for provider codes included for each category of care.
7. *Must have only one enabling service visit for each type of enabling provider per day.* For example, a patient may have a visit with a case manager and a visit with a health educator on the same day but may not have two visits with a case manager on the same day because they provide the same type of care. If a patient has two or more visits to the same type of provider on the same day, the first visit is kept and the subsequent visits are removed. An exception to this rule occurs when the patient is seen in multiple different locations. In this case, each of the visits would count if the patient sees different providers in the different locations. However, if the patient sees the same provider in different locations, then only the first visit would be counted. A second exception to this rule occurs if the Service Category is I for an inpatient visit. All I visits will be counted, whether or not it is to the same type of provider on the same day. Refer to Appendix C: for provider codes included for each category of care.

#### 4.2.2.2 Definition of All Visits for Tables 5 and 6A: Selected Diagnoses Section for a Qualified Patient

*In addition* to the criteria listed in Section 4.2.2.1, visits must also meet the criteria that follow in order to be counted in Column b of Table 5 and Column A of Table 6A-Selected Diagnoses section (Lines 1–20d). Based on the UDS definition, *a patient must have at least one RPMS visit that meets the following criteria in order to be counted as a patient.* If the patient does not have at least one visit meeting the criteria that follow, the patient is not considered a patient for UDS reporting, all processing stops for the patient, and none of the patient’s visits would be counted in any UDS report.

1. *Must be a “complete” PCC visit;* that is, have a primary provider with a nonblank discipline code and a coded purpose of visit (POV) and the POV must not be equal to .9999 (uncoded). This meets the BPHC definition: “Visits are defined as documented, face-to-face contacts between a patient and a provider who exercises independent professional judgment in the provision of services to the patient. To be included as a visit, services rendered must be documented in a chart....”
2. *Must not have an RPMS Service Category of Historical Event (E) or Inpatient Visit (I).*
3. *Must not have an excluded clinic code.* The following RPMS clinic codes shown in Table 4-2 do not fit the BPHC definition of a visit for these tables.

Table 4-2: Excluded Clinic Codes and Clinic Description

Clinic Code	Clinic Description
12	Immunization
63	Radiology
76	Laboratory Services
91	Teleradiology
D6	Transportation
D7	Online Services
D8	Magnetic Resonance Imaging

#### 4.2.3 Definition of Providers

For RPMS UDS, the system uses only the provider type for the primary provider for each visit to categorize Table 5 Staffing and Utilization. See the mapping table in Appendix C: for further information and the BPHC Service Category Definitions for Table 5 in Appendix B: .

### 4.3 RPMS UDS Logic Example

The following example demonstrates how RPMS UDS selects patients and visits for CY2015 for all tables and associated patient lists.

The site has the following visit locations documented in the site parameters:

- Our Hospital
- Satellite A
- Satellite B
- Home

#### 4.3.1 Determine if Patient Meets RPMS Definition of a Patient

1. Each patient on the RPMS computer is reviewed. Any patient whose name is “DEMO,PATIENT”, PATIENT,DEMO”, “PATIENT,UDS”, “PATIENT,CRS”, or whose name is included in the RPMS demo/test search patient template named “RPMS DEMO PATIENT NAMES”, or whose gender is “Unknown” is excluded and all processing stops for that patient. For all other patients, processing continues with Step 2.
2. Determine if patient has at least one RPMS visit that meets the BPHC criteria in Visit List 2, as shown in Section 4.3.2.

#### 4.3.2 Determine if Patient’s Visits Meet the RPMS Definition of Visits

1. All visits for the patient in the report date range specified are found and included in the All Visits List.

Table 4-3: Patient Mary Jones Has 10 visits That Were Found in RPMS for CY2015, And That Comprise the All Visits List.

Visit Date	Location	Service Category	Clinic	Prov Disc	Dx	Services
1/5/2015@9am	Our Hospital	Amb	01-General	71-Internist (Jones)	381.01	
1/5/2015@11am	Our Hospital	Amb	01-General	71-Internist (Jones)	381.01	
1/5/2015@4pm	Our Hospital	Amb	01-General	71-Internist (Smith)	293.01	
3/1/2015@12pm	IHS Clinic ABC	Amb	30-Emergency Medicine	00-Physician	692.02	
4/1/2015@3pm	Satellite A	Chart review	01-General	01-Nurse (Begay)	250.00	
4/5/2015@12pm	Our Hospital	Tele. Call	01-General	01-Nurse (Adams)	250.00	
6/1/2015@3pm	Our Hospital	Amb	01-General	00-Physician	V72.3	Pap
6/4/2015@4pm	Our Hospital	Amb	63-Radiology	76-Radiologist	V76.12	Mammogram
8/1/2015@1pm	Other	Event				Flu shot given at Costco
9/20/2015@2pm	Our Hospital	Amb	39-Pharmacy	09-Pharmacist	V25.2	Given BCPs

2. The list of visits is reviewed, and all visits that would not be used in *any* table calculation are removed from the list. The visits must meet *all* of the following criteria:
  - Must be to a location specified by the site in the Setup option.
  - Must be one of the following RPMS Service Categories: Ambulatory (A), Hospitalization (H), Day Surgery (S), Observation (O), Telemedicine (M), Nursing Home (R), Historical Event (E), or In-hospital (I).
  - Must *not* have one of the following clinic codes, which are excluded from UDS reporting:

Table 4-4: Excluded Clinic Codes and Clinic Description

Clinic Code	Clinic Description
A3	Ambulance
52	Chart Rev/Rec Mod
98	Diabetes Education-Group
A1	Diabetes Education-Individual
95	Dialysis Laboratory Services
60	Education Classes
68	Employee Health Un
53	Follow-Up Letter
09	Grouped Services
41	Indirect
42	Mail
B1	Maternity Case Mgmt Supp Serv
78	OTC Medications
25	Other
A9	PH Preparedness (Bioterrorism)
39	Pharmacy
B6	Phone Triage
B2	Radiation Exposure Screening
54	Radio Call
B3	SANDS (Stop Atherosc in Native Diab Study)
51	Telephone Call
94	Tobacco Cessation Clinic
36	W.I.C.
D6	Transportation
D7	Online Services
D8	Magnetic Resonance Imaging

- Must not be more than one visit to the same provider on the same day, unless the Service Category is I.

- Must not be more than one medical, one dental, one mental health, and one substance abuse visit on the same day, unless the patient sees different providers in different locations or the Service Category is I.
  - Must not be more than one other health visit for each type of other health provider on the same day, unless the patient sees different providers in different locations or the Service Category is I.
  - Must not be more than one enabling service visit for each type of enabling provider on the same day, unless the patient sees different providers in different locations or the Service Category is I.
3. After applying this criteria, the following seven visits were removed:
- 1/5/2015 @11am visit because the patient already had a visit on the same day to the same provider (person) (i.e., Dr. Jones)
  - 1/5/2015 @4pm visit because the patient already have a visit on the same day to a medical provider (i.e., Dr. Jones)
  - 3/1/2015 visit due to location (IHS Clinic ABC) not specified in the Setup option
  - 4/1/2015 visit due to Chart Review service category
  - 4/5/2015 visit due to Telephone Call service category
  - 8/1/2015 visit due to location (Other) not included in Setup and also due to Historical Event service category
  - 9/20/2015 visit due to clinic code of Pharmacy

**Note:** This list is used in calculating the visits included in the Services Rendered section (Lines 21–34) of Table 6A.

Table 4-5: Patient Mary Jones Now Has Three Visits That Comprise Visit List 1.

Visit Date	Location	Service Category	Clinic	Prov Disc	Dx	Services
1/5/2015@9am	Our Hospital	Amb	01-General	71-Internist (Jones)	381.01	
6/1/2015@3pm	Our Hospital	Amb	01-General	00-Physician	V72.3	Pap
6/4/2015@4pm	Our Hospital	Amb	63-Radiology	76-Radiologist	V76.12	Mammogram

4. Visit List 1 is now reviewed for the visits that are eligible to be counted in Tables Zip Code, 3A, 3B, 5 and the Selected Diagnoses section (Lines 1–20d) of Table 6A. The following *additional* criteria are applied:
- Must be a complete visit (have a primary provider with a nonblank discipline code and coded POV, where the POV is not equal to .9999).

- Must not have an RPMS Service Category of Historical Event (E) or Inpatient (I).
  - Visit must *not* have one of the following clinic codes:
    - 12 Immunization
    - 63 Radiology
    - 76 Laboratory Services
    - 91 Teleradiology
    - D6 Transportation
    - D7 Online Services
    - D8 Magnetic Resonance Imaging
5. After applying the criteria, the following visit was removed:
- 6/4/2015 visit due to clinic code of Radiology.

**Note:** This list is used in calculating the visits included in *Tables Zip Code, 3A, 3B, Column B of Table 5 and the visit count for the Selected Diagnoses section (Lines 1-20d) of Table 6A.*

Table 4-6: Patient Mary Jones Now Has Two Visits That Comprise Visit List 2.

Visit Date	Location	Service Category	Clinic	Prov Disc	Dx	Services
1/5/2015@9am	Our Hospital	Amb	01-General	71-Internist (Jones)	381.01	
6/1/2015@3pm	Our Hospital	Amb	01-General	00-Physician	V72.3	Pap

6. To recap:
- Visit List 1 is used in calculating visits included in the Services Rendered section of Table 6A (Lines 21–34).
  - Visit List 2 is used in calculating visits included in Tables Zip Code, 3A, 3B, 4, Column B of Table 5, and the Selected Diagnoses section of Table 6A (Lines 1–20d).

## 5.0 UDS Reports for Zip Code, 3A, 3B, 4, 5, 6A, 6B, 7 and 9D

### 5.1 Overview

The RPMS UDS Reporting System is a reporting tool that provides seven required BPHC UDS reports about patients and visits from local RPMS databases (see Section 2.0 for description of BPHC and their UDS), or data quality checking for each of the five reports. RPMS UDS can also produce lists of all patients and related visits that are counted in the reports (see Section 6.0).

The following reports are produced:

- Patients by Zip Code and Insurance Source
- Table 3A Patients by Age and Gender
- Table 3B Patients by Hispanic Ethnicity/Race/Language
- Table 4 Selected Patient Characteristics
- Table 5 Staffing and Utilization (Column A)
- Table 5 Staffing and Utilization (Columns B and C)
- Table 6A Selected Diagnoses and Services Rendered
- Table 6B Quality of Care Indicators
- Table 7 Health Outcomes and Disparities
- Table 9D Patient-Related Revenue

Additionally, RPMS UDS will provide the following lists to assist in verifying data:

- LST1–Lists for Tables Zip Code, 3A&3B, 4, 5, and 6A
  - Patient list by zip code and insurance source
  - Patient list by age and gender (Table 3A)
  - Patient list by Hispanic ethnicity, race, and language (Table 3B)
  - Patient List Income As A Percent Of Poverty Level (Table 4)
  - Patient List Principle Third Party Medical Insurance Source section (Table 4)
  - Patient List Characteristics - Special Populations section (Table 4)
  - Provider list categorized by BPHC-defined categories to assist in manual calculations of Table 5 Column A (Staffing FTEs)
  - Patient list categorized by primary provider type and showing all patients with visits to that provider type during the report period, used with Table 5, Columns B (Visits) and C (Patients)

- Patient list showing visits to whom the primary provider was uncategorized (i.e., did not map to the BPHC-defined categories), used with Table 5, Columns B (Visits) and C (Patients)
- Patient list categorized by selected diagnoses and other services, used with Table 6A
- LST2–Lists for Table 6B
  - Patient list by age that had pregnancy-related visits during the past 20 months with at least one pregnancy-related visit during the report period, used with Table 6B.
  - Patient list of three-year-old patients who had their first visit prior to their third birthday, had a medical visit during the report period, and have all required childhood immunizations, used with Table 6B.
  - Patient list of three-year-old patients who had their first visit prior to their third birthday, had a medical visit during the report period, and list the immunizations still needed to complete all required childhood immunizations, used with Table 6B.
  - Patient list of all female patients ages 24–64 who have not had a hysterectomy, had a medical visit during the report period, were first seen in the clinic by their 65th birthday, and had a Pap test in the past 3 years, used with Table 6B.
  - Patient list of all female patients ages 24–64 who have not had a hysterectomy, had a medical visit during the report period, were first seen in the clinic by their 65th birthday, and *did not* have a Pap test in the past 3 years, used with Table 6B.
  - Patient list of all children and adolescents ages 2-17 who had a medical visit during the report period, were first seen ever by the health center prior to their 17th birthday, and had BMI documented and counseling for nutrition and physical activity during the report period, used with Table 6B.
  - Patient list of all children and adolescents ages 2-17 who had a medical visit during the report period, were first seen ever by the health center prior to their 17th birthday, and did not have BMI documented or counseling for nutrition and physical activity during the report period, used with Table 6B.
  - Patient list of all adults age 18 or older who had a medical visit during the report period and had BMI documented and if overweight or underweight, a follow-up plan documented, used with Table 6B.
  - Patient list of all adults age 18 or older who had a medical visit during the report period and did not have BMI documented or if overweight or underweight, did not have a follow-up plan documented, used with Table 6B.

- Patient list of all adults age 18 or older who had a medical visit during the report period, at least two medical visits ever, were seen after their 18th birthday, and were queried/screened about any and all forms tobacco use AND received documented cessation counseling intervention (counseling) or medication (smoking cessation agents) if identified as a tobacco user one or more times during the report period or the prior year, used with Table 6B.
- Patient list of all adults age 18 or older who had a medical visit during the report period, at least two medical visits ever, were seen after their 18th birthday, were not queried/screened about any and all forms tobacco use or did not receive a documented cessation counseling intervention (counseling) or medication (smoking cessation agents) if identified as a tobacco user one or more times during the report period or the prior year, used with Table 6B.
- Patient list of all patients ages 5-40 with a diagnosis of mild, moderate or severe persistent asthma who had a medical visit during the report period, at least two medical visits ever, who received a prescription for or provided inhaled corticosteroid or an accepted alternative medication, used with Table 6B.
- Patient list of all patients ages 5-40 with a diagnosis of mild, moderate or severe persistent asthma who had a medical visit during the report period, at least two medical visits ever, who did not receive a prescription for or provided inhaled corticosteroid or an accepted alternative medication, used with Table 6B.
- Patient list of all patients 18 years of age and older with an active diagnosis of CAD including MI, or have had cardiac surgery, and whose last LDL was greater than or equal to 130 who were prescribed a lipid-lowering therapy medication or have documented evidence of use by patient of lipid lowering medication during the report period, and does not have an allergy or adverse reaction to lipid-lowering therapy medications, used with Table 6B.
- Patient list of all patients 18 years of age and older with an active diagnosis of CAD including MI or have had cardiac surgery and whose last LDL was greater than or equal to 130 or last recorded LDL is greater than 1yr from last visit in the report year who were not prescribed a lipid-lowering therapy medication or has no documented evidence of use by patient of lipid lowering medication during the report period or has an allergy or adverse reaction to lipid-lowering therapy medications.
- Patient list of patients 18 years of age and older who, in the current or prior report year, were diagnosed with IVD including AMI, or discharged alive after cardiovascular surgery (CABG or PTCA) and were prescribed or dispensed aspirin or another anti-thrombotic medication or have documented evidence of use by patient of aspirin or another anti-thrombotic medication during the report period, used with Table 6B.

- Patient list of patients 18 years of age and older who, in the current or prior report year, were diagnosed with IVD including AMI, or discharged alive after cardiovascular surgery (CABG or PTCA) and were not prescribed or dispensed aspirin or another anti-thrombotic medication or has no documented evidence of use by patient of aspirin or another anti-thrombotic medication during the report period, used with Table 6B.
  - Patient list of all patients age 51-74 as of December 31 of the report period, not diagnosed with colorectal cancer, who has a documented colorectal cancer screen, used with Table 6B.
  - Patient list of all patients age 51-74 as of December 31 of the report period, not diagnosed with colorectal cancer, who did not have a documented colorectal cancer screen, used with Table 6B.
  - Patient list of all patients who had a medical visit during the report period, whose first ever HIV diagnosis occurred between October 1 of the prior year through September 30th of the current report year and had a medical visit for HIV care within 90 days of the first-ever HIV diagnosis, used with Table 6B.
  - Patient list of all patients who had a medical visit during the report period, whose first ever HIV diagnosis occurred between October 1 of the prior year through September 30th of the current report year and did not have a medical visit for HIV care within 90 days of the first-ever HIV diagnosis, used with Table 6B.
  - Patient list of all patients age 12 or older who had a medical visit during the report period, were screened for depression with a standardized tool during the report year and had a follow-up plan documented if screened positive, used with Table 6B.
  - Patient list of all patients age 12 or older who had a medical visit during the report period, not screened for depression or who were screened for depression with a standardized tool during the report year and does not have a follow-up plan documented if screened positive, used with Table 6B.
  - Patient list of all patients 6-9 years old had at least one medical visit during the report year, had an oral assessment or comprehensive or periodic oral evaluation, were determined to be at moderate or high risk for caries, and had a sealant placed on a first molar during the reporting period, used with Table 6B.
  - Patient list of all patients 6-9 years old had at least one medical visit during the report year, had an oral assessment or comprehensive or periodic oral evaluation, were determined to be at moderate or high risk for caries, without a sealant placed on a first molar during the reporting period, used with Table 6B.
- LST3–Lists for Table 7

- Patient list of patients that had pregnancy-related visits during the past 20 months, with at least one pregnancy-related visit during the report period, and who have been diagnosed with HIV, used with Table 7 Section A.
- Patient list by race and Hispanic or Latino identity of patients that had pregnancy-related visits during the past 20 months, with at least one pregnancy-related visit during the report period, used with Table 7 Section A.
- Patient list by race and Hispanic or Latino identity of patients ages 18 to 85 years old who have had two medical visits during the report period and were diagnosed with hypertension before June 30 of the report period, used with Table 7 Section B.
- Patient list by race and Hispanic or Latino identity of patients ages 18 to 85 years old who have had two medical visits during the report period, were diagnosed with hypertension before June 30 of the report period, and who have controlled blood pressure (less than (<) 140/90 mm Hg) during the report period, used with Table 7 Section B.
- Patient list by race and Hispanic or Latino identity of patients ages 18 to 85 years old who have had two medical visits during the report period, were diagnosed with hypertension before June 30 of the report period, and who do not have controlled blood pressure (less than (<) 140/90 mm Hg) during the report period, used with Table 7 Section B.
- Patient list by race and Hispanic or Latino identity of patients ages 18 to 75 years old who have had two medical visits during the report period, with a diagnosis of Type I or Type II diabetes anytime through the end of the report period, and without a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes, used with Table 7 Section C.
- Patient list by race and Hispanic or Latino identity of patients ages 18 to 75 years old who have had two medical visits during the report period, with a diagnosis of Type I or Type II diabetes anytime through the end of the report period, and without a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes and with a most recent hemoglobin A1c of less than 8%, used with Table 7 Section C.
- Patient a list by race and Hispanic or Latino identity of patients ages 18 to 75 years old who have had two medical visits during the report period, with a diagnosis of Type I or Type II diabetes anytime through the end of the report period, and without a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes and with a most recent hemoglobin A1c greater than 9%, or with an A1c with no result, or with no A1c test during the report period, used with Table 7 Section C.

Reports can be run for individual quarters as well as for the entire calendar year.

<p><b>Note:</b> Tables 6B and 7 must be run using the Full Calendar Year option. If these reports are run using the Quarterly options, the totals combined will not match the calendar year totals.</p>
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This chapter describes the logic for each of the seven reports and how to run the reports from the Reports menu option on the RPMS UDS Reporting System main menu.

**Note:** It is strongly recommended that sites run the Staff List (option ST from the 2015 Reports menu) first and review and edit providers and related provider codes for accuracy prior to running any other reports.

## 5.2 Report Descriptions

### 5.2.1 Patients by Zip Code and Insurance Source

This table reports the number of patients by their most recent (last) zip code as entered in patient registration and their primary health insurance source as of the last visit during the reporting period.

**Note:** Cross Table Check:  
The sum of patients reported on the ZIP code table must equal Table 3A, Line 39, Column A + B (total patients by age and gender).

The total for Column B (Uninsured) must equal Table 4, Line 7, Column A + Column B.

The total for Column C (Medicaid, S-CHIP, and Other Public) must equal Table 4, Line 8 + 10, Column A + Column B.

The total for Column D (Medicare) must equal Table 4, Line 9, Column A + Column B.

The total for Column E (Private) must equal Table 4, Line 11, Column A + Column B.

Patients whose gender is “Unknown” are not included in the counts.

### 5.2.1.1 Logic for Patients by Zip Code Table

The patient's zip code is categorized by the following logic:

- This report includes all patients who have at least one visit for the specified time period that meets the visit definition criteria. The total number of patients on this table should equal the number of total unduplicated patients on Tables 3A, 3B, and 4.<sup>7</sup>
- The patient's most recent (last) zip code is obtained from patient registration.
- The table will be sorted in ascending order by zip code, with the total number of patients having an address with that zip code.
- Zip codes with a count of 10 or fewer will be included in the Other Zip Codes category.
- Patients who do not have a zip code value in patient registration are included in the Unknown Residence category.
- Since there is no way of determining if a patient is homeless or a migrant, all patients without a zip code will be placed in the Unknown Residence category; otherwise these patients will be counted using the zip code entry in the patient registration file (where the patient is being served as a proxy).
- Foreign Nationals: Tourists and other persons passing through the US may have a permanent residence outside the country, will be placed in the Other ZIP Code category
- Primary Health Insurance source is obtained from the patient's registration file and matched to the Insurer type (insurer files, third party liability, and workman's comp files). Logic for determining insurance source is similar to Table 4.

A patient's health insurance is likely to change throughout the year. Report on this table the primary health insurance the patient had at the time of their last visit regardless of whether or not that insurance was billed for or paid for the visit. (Other forms of insurance, such as dental or vision coverage, are not reported.)

Patient's insurance source is divided into four types as follows:

- None/Uninsured (Column b): This line lists those patients who do not have medical insurance.
- Medicaid/Children's Health Insurance Program (CHIP)/Other Public (Column c)
- Medicare (Column d)
- Private Insurance (Column e)

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<sup>7</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 29.

**Note:** Primary medical insurance is defined as the insurance plan/program that the health center would normally bill first for medical services. The categories for this table are slightly different than those on Table 4, lumping together Medicaid, CHIP and Other Public into one category.

The RPMS printed report will emulate BPHC UDS Table 4, as shown in Figure 5-1:

DU	UDS 2015	DEMO INDIAN HOSPITAL			Page 1
UDS No.	000001	Date Run: Dec 15, 2015			
Reporting Period: Jan 01, 2015 through Dec 31, 2015					
Population: All (both Indian/Alaskan Natives and Non 01)					
PATIENTS BY ZIP CODE AND INSURANCE SOURCE					
Zip Code	None/ Uninsured	Medicaid/CHIP/ Other Public	Medicare	Private	Total Patients
(a)	(b)	(c)	(d)	(e)	(f)
87119	744	833	152	922	2,651
87104	321	215	37	202	775
Other Zip Codes	133	92	176	57	458
Unknown Residence	476	483	40	5	1,004
TOTAL	1,674	1,623	405	1,186	4,888

Figure 5-1: Sample RPMS UDS Patients by Zip Code and Insurance Source, page 1

Table 5-1: Example of BPHC UDS Patients by Zip Code and Insurance Source<sup>8</sup>

Zip Code	None/Uninsured	Medicaid/CHIP/ Other Public	Medicare	Private	Total Patients
(a)	(b)	(c)	(d)	(e)	(f)
Other Zip Codes					
Unknown Residence					
Total					

<sup>8</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 33.

### 5.2.2 Table 3A Patients by Age and Gender and 3B Patients by Hispanic or Latino Identity/Race/Ethnicity

Table 3A provides demographic data on BPHC health center patients, by age and gender. The patient's age is calculated on June 30 of the reporting period.

“...[I]nclude as patients all individuals who (1) received at least one face-to-face visit ...” within the scope of any of the programs covered by UDS. Regardless of the scope or volume of services received, each patient is to be counted only once on Table 3A and only once in *each* of the two sections of Table 3B: race and ethnicity, and language, if applicable.”<sup>9</sup>

**Note:** Cross Table Check:  
 The sum of Table 3A, Line 39, Column A + B (total patients by age and gender) must equal Table 3B, Line 8 Column D (total patients by Hispanic/Latino Ethnicity and Race); Total Patients by ZIP Code; Table 4, Line 6 (total patients by income); and Table 4 Line 12, Column A + B (total patients by insurance status).

The sum of Table 3A, Lines 1-18, Column A + B (total patients age 0-17 years) must equal Table 4, Line 12, Column A (total patients age 0-17 years).

The sum of Table 3A, Lines 19-38, Column A + B (total patients age 18 and older) must equal Table 4, Line 12, Column B (total patients age 18 and older).

Therefore, patient whose gender is “Unknown” are not included in the counts.

#### 5.2.2.1 Logic for Table 3A

The report categorizes all patients who met the RPMS definition of a patient by age and gender. The patient’s age is calculated as of June 30, 2015 by subtracting the date of birth from June 30, 2015. If the patient was born after June 30, 2015 and before the end of the calendar year being reported, the age is calculated as “Under age 1” (Line 1). The patient’s gender is also determined. The patient is placed in the appropriate line of Table 3A (see Figure 5-2).

The RPMS printed report will emulate BPHC UDS Table 4, as shown in Figure 5-2

DU	UDS 2015	DEMO INDIAN HOSPITAL	Page 1
UDS No.	000001	Date Run:	Dec 15, 2015
Reporting Period:	Jan 01, 2015 through Dec 31, 2015		

<sup>9</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 34.

Population: All (both Indian/Alaskan Natives and Non 01)

TABLE 3A - PATIENTS BY AGE AND GENDER

AGE GROUPS	MALE PATIENTS (a)	FEMALE PATIENTS (b)	TOTAL PATIENTS
1 Under age 1	28	15	43
2 Age 1	64	68	132
3 Age 2	71	68	139
4 Age 3	58	57	115
5 Age 4	42	66	108
6 Age 5	60	57	117
7 Age 6	61	55	116
8 Age 7	38	46	84
9 Age 8	58	46	104
10 Age 9	37	51	88
11 Age 10	53	45	98
12 Age 11	48	51	99
13 Age 12	38	29	67
14 Age 13	26	34	60
15 Age 14	28	27	55
16 Age 15	28	37	65
17 Age 16	20	30	50
18 Age 17	39	30	69
SUBTOTAL Ages 0-17	797	812	1,609
19 Age 18	25	44	69
20 Age 19	20	33	53
21 Age 20	25	40	65
22 Age 21	27	50	77
23 Age 22	33	48	81
24 Age 23	23	41	64
25 Age 24	30	42	72
26 Ages 25-29	130	189	319
27 Ages 30-34	140	179	319
28 Ages 35-39	114	162	276
29 Ages 40-44	98	140	238
30 Ages 45-49	129	172	301
31 Ages 50-54	129	171	300
32 Ages 55-59	126	166	292
33 Ages 60-64	107	145	252
34 Ages 65-69	72	125	197
35 Ages 70-74	64	79	143
36 Ages 75-79	37	51	88
37 Ages 80-84	17	27	44
38 Ages 85 and over	12	17	29
TOTAL PATIENTS (SUM LINES 1-38)	2,155	2,733	4,888

Figure 5-2: Sample RPMS UDS Patients by Age and Gender, page 1

Table 5-2: Example of BPHC UDS Table 3A Patients by Age and Gender<sup>10</sup>

Age Groups		Male Patients (a)	Female Patients (b)
Number of Patients			
1	Under age 1		
2	Age 1		
3	Age 2		
4	Age 3		
5	Age 4		
6	Age 5		
7	Age 6		
8	Age 7		
9	Age 8		
10	Age 9		
11	Age 10		
12	Age 11		
13	Age 12		
14	Age 13		
15	Age 14		
16	Age 15		
17	Age 16		
18	Age 17		
19	Age 18		
20	Age 19		
21	Age 20		
22	Age 21		
23	Age 22		
24	Age 23		
25	Age 24		
26	Ages 25–29		
27	Ages 30–34		
28	Ages 35–39		
29	Ages 40–44		
30	Ages 45–49		
31	Ages 50–54		
32	Ages 55–59		
33	Ages 60–64		
34	Ages 65–69		
35	Ages 70–74		

<sup>10</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 39.

Age Groups		Male Patients (a)	Female Patients (b)
<b>Number of Patients</b>			
36	Ages 75–79		
37	Ages 80–84		
38	Age 85 and over		
39	<b>Total Patients</b> (Sum Lines 1-38)		

5.2.2.2 Logic for Table 3B

The report categorizes all patients who met the RPMS definition of a patient by Hispanic or Latino ethnicity, race, and linguistic barriers to care. The report uses the logic described in Table 5-3.

1. The patient’s Race, Classification/Beneficiary, and Ethnicity values from RPMS Patient Registration are examined and are categorized by the logic shown in Table 5-3. Unless otherwise noted, both the patient’s [race or classification/beneficiary] and the [ethnicity] values are used to determine the patient’s placement in the table.
2. Line 12 of Table 3B identifies the patients who have linguistic barriers to care and reports on the number of patients who are best served in a language other than English including those who are best served in sign language.

**Note:** RPMS does not collect data on those patients who are best served by or requires sign language to communicate. Patients served in a language other than English, may be estimated if the health center does not maintain actual data in its Electronic Health Record (EHR). If an estimate is required, the estimate should be based on a sample where possible.<sup>11</sup> As a result, the number reported on this line by the UDS software is an estimate based on the patient’s primary language, preferred language, and the need for an interpreter.

Table 5-3: Map to Table 3B (Patients by Hispanic or Latino Identity/Race/Linguistic Barriers to Care)

Map to Table 3B, Race Line # and Ethnicity Column	RPMS Race or Classification/Beneficiary Value	RPMS Ethnicity Value
Line 1–Asian		

<sup>11</sup> This is the only place on the UDS report where an estimate is accepted. BPHC Uniform Data System Manual, 2015 Revision, p. 36.

<b>Map to Table 3B, Race Line # and Ethnicity Column</b>	<b>RPMS Race or Classification/ Beneficiary Value</b>	<b>RPMS Ethnicity Value</b>
Hispanic/Latino (Column A)	A–Asian	H–Hispanic or Latino
Not Hispanic/Latino (Column B)		N–Not Hispanic or Latino U–Unknown by Patient D–Declined to Answer–or– Ethnicity value is blank
Unreported/Refused to Report (Column C)		
<b>Line 2a–Native Hawaiian</b>		
Hispanic/Latino (Column A)	H–Native Hawaiian or Other Pacific Islander	H–Hispanic or Latino
Not Hispanic/Latino (Column B)		N–Not Hispanic or Latino U–Unknown by Patient D–Declined to Answer–or– Ethnicity value is blank
Unreported/Refused to Report (Column C)		
<b>Line 2b–Other Pacific Islander</b>		
Hispanic/Latino (Column A)	5–Pacific Islander (old code)	H–Hispanic or Latino
Not Hispanic/Latino (Column B)		N–Not Hispanic or Latino U–Unknown by Patient D–Declined to Answer–or– Ethnicity value is blank
Unreported/Refused to Report (Column C)		
<b>Line 2–Total Hawaiian/Pacific Islander</b>		
Sum Lines 2a and 2b	N/A	N/A
<b>Line 3–Black/African American</b>		
Hispanic/Latino (Column A)	B–Black or African American 2–Hispanic, Black <sup>12</sup>	H–Hispanic or Latino
Not Hispanic/Latino (Column B)		B–Black or African American 4–Black, Not of Hispanic Origin <sup>13</sup>

<sup>12</sup> This Race value does not require an Ethnicity value in order to determine the patient’s ethnicity; rather, both the patient’s race and ethnicity are determined from the Race value.

<sup>13</sup> Ibid.

<b>Map to Table 3B, Race Line # and Ethnicity Column</b>	<b>RPMS Race or Classification/ Beneficiary Value</b>	<b>RPMS Ethnicity Value</b>
Unreported/Refused to Report (Column C)	B–Black or African American	
<b>Line 4–American Indian/Alaska Native</b>		
Hispanic/Latino (Column A)	3–American Indian or Alaska Native	H–Hispanic or Latino
Not Hispanic/Latino (Column B)	Z–American Indian or Alaska Native-Old (old code) -or- RPMS Classification/Beneficiary Value	N–Not Hispanic or Latino U–Unknown by Patient D–Declined to Answer-or- Ethnicity value is blank
Unreported/Refused to Report (Column C)	01–Indian/Alaska Native	
<b>Line 5–White</b>		
Hispanic/Latino (Column A)	W–White 1–Hispanic, White <sup>14</sup>	H–Hispanic or Latino
Not Hispanic/Latino (Column B)	W–White 6–White, Not of Hispanic Origin	N–Not Hispanic or Latino U–Unknown by Patient D–Declined to Answer-or- Ethnicity value is blank
Unreported/Refused to Report (Column C)	W–White	
<b>Line 6–More than One Race</b>		
Leave blank since there is no such Race code in RPMS	N/A	N/A
<b>Line 7–Unreported/Refused to Report</b>		
Hispanic/Latino (Column A)	D–Declined to Answer O–Other	H–Hispanic or Latino
Not Hispanic/Latino (Column B)	U–Unknown by Patient	N–Not Hispanic or Latino
Unreported/Refused to Report (Column C)	7–Unknown Race value is blank	U–Unknown by Patient D–Declined to Answer -or- Ethnicity value is blank
<b>Line 8–Total Patients</b>		
Sum Lines 1, 2, and 3–7	N/A	N/A
<b>Line 12–Patients by Language</b>		
Patients best Served in a Language Other Than English	N/A	N/A

<sup>14</sup> Ibid.

The RPMS printed report will emulate BPHC UDS Table 4, as shown in Figure 5-3.

DU	UDS 2015	DEMO INDIAN HOSPITAL		Page 1
UDS No.	000001			Date Run: Dec 15, 2015
Reporting Period:	Jan 01, 2015 through Dec 31, 2015			
Population:	All (both Indian/Alaskan Natives and Non 01)			
TABLE 3B -				
PATIENTS BY HISPANIC OR LATINO ETHNICITY/RACE/LINGUISTIC BARRIERS TO CARE				
PATIENTS BY RACE	HISPANIC/ LATINO (a)	NOT HISPANIC/ LATINO (b)	UNREPORTED/ REFUSED TO REPORT (c)	TOTAL (d)
1. Asian	0	0	0	0
2a. Native Hawaiian	0	8	0	8
2b. Other Pacific Islander	0	4	0	4
2. Total Hawaiian/ Pacific Islander (Sum Lines 2a+2b)	0	12	0	12
3. Black/African American	1	2	0	3
4. American Indian/ Alaska Native	93	4,739	0	4,832
5. White	2	24	0	26
6. More than one race	0	0	0	0
7. Unreported/ Refused to Report	4	4	7	15
8. Total Patients (Sum Lines 1+2 + 3 to 7)	100	4,781	7	4,888
PATIENTS BY LANGUAGE				NUMBER (a)
12	Patients Best Served in a Language Other Than English			9

Figure 5-3: Sample RPMS UDS Patients by Hispanic or Latino Identity/Race/Linguistic Barriers to Care, page 1

Table 5-4: Example of BPHC UDS Table 3B Patients by Hispanic or Latino Identity/Race/Linguistic Barriers to Care<sup>15</sup>

Patients by Race		Hispanic/Latino (a)	Not Hispanic/Latino (b)	Unreported/Refused to Report (c)	Total (d) (Sum Columns a+b+c)
1.	Asian				
2a.	Native Hawaiian				
2b.	Other Pacific Islander				
2.	Total Hawaiian/Pacific Islander (Sum Lines 2a + 2b)				
3.	Black/African American				
4.	American Indian/Alaska Native				
5.	White				
6.	More than one race				
7.	Unreported / Refused to Report				
8.	<b>Total Patients</b> (Sum Lines 1+2 + 3 to 7)				

Patients by Language		Number (a)
12.	<b>Patients Best Served in a Language Other Than English</b>	

<sup>15</sup> BPHC Uniform Data System Manual, 2015 Revision, Table 3B, p. 40.

### 5.2.3 Table 4 Selected Patient Characteristics

Table 4, Selected Patient Characteristics, provides descriptive data on selected characteristics of health center patients. The table for is included in both the Universal Report and Grant Reports<sup>16</sup>.

**Note:** Cross Table Check:

ZIP Code Table, Column B must equal Table 4, Line 7, Column A + Column B.

ZIP Code Table, Column C must equal Table 4, Line 8 + 10, Column A + Column B.

ZIP Code Table, Column D must equal Table 4, Line 9, Column A + Column B.

ZIP Code Table, Column E must equal Table 4, Line 11, Column A + Column B.

The sum of Table 3A, Line 39, Column A + B (total patients by age and gender) must equal Table 4, Line 6 (total patients by income) and Table 4 Line 12, Column A + B (total patients by medical insurance status).

Table 3B, Line 8 Column D (total patients by race and Hispanic/Latino ethnicity) must equal Table 4, Line 6 (total patients by income) and Table 4 Line 12, Column A + B (total patients by medical insurance status).

The sum of Table 3A, Lines 1-18, Column A + B (total patients age 0-17 years) must equal Table 4, Line 12, Column A (total patients age 0-17 years).

The sum of Table 3A, Lines 19-38, Column A + B (total patients age 18 and older) must equal Table 4, Line 12, Column B (total patients age 18 and older).

The sum of Table 3A, Line 39, Column A + B (total patients by age and gender) must equal Table 4, Line 12 Column A + B (total patients by insurance status).

Therefore, patients whose gender is “Unknown” are not included in the counts.

<sup>16</sup> BPHC Uniform Data System Manual, 2015 Revision, *Instructions for Table 4*, p. 41.

### 5.2.3.1 Logic for Table 4

RPMS UDS reviews every visit (see Section 4.2.2) for patients who meet the RPMS UDS definition of a patient.

#### **Income as a percent of poverty level (Lines 1-6)**

This portion of the table reports the number of patients with an income as a percent of poverty level. BPHC defines income in ranges relative to the Federal poverty guidelines (e.g., less than (<) 100 percent of the Federal poverty level). In determining a patient's income relative to the poverty level, health centers should use official poverty guidelines defined and revised annually. The official Poverty Guidelines are published in the Federal Register during the first quarter of each year (<http://aspe.hhs.gov/poverty/>). As a rule, family income is used, except for minor-consent services; children will always be classified in terms of their parent's income.

RPMS UDS can produce a completed report containing the number of patients with income as a percent of poverty level for Lines 1-6.

#### **Principal Third Party Insurance Source (Lines 7 -12)**

This portion of the table provides data on patients by principal source of insurance for primary medical care services. BPHC defines principal insurance as the primary health insurance the patient had at the time of their last visit *regardless of whether or not that insurance was billed for or paid for the visit*. (Other forms of insurance, such as dental or vision coverage, are not reported.)

- Patients are divided into two age groups (Column A) 0 -17 and (Column B) age 18+.
- Primary patient medical insurance is divided into seven types as follows:
  - Uninsured (Line 7): This line lists those patients who do not have medical insurance.
  - Medicaid (Line 8a, 8b, and 8)
  - CHIP (Line 8b or 10b):
  - Dually eligible (Line 9a): This line is a subset of line nine and lists those patients who are eligible for Medicare and Medicaid without MediGap insurance.
  - Medicare (Line 9): Patients who have both Medicare and Medicaid (but not those with MediGap insurance) will also be reported on line 9a.
  - Other Public Insurance (Line 10a)
  - Other Public (CHIP) (Line 10b)
  - Private Insurance (Line 11)

RPMS UDS can produce a completed report containing the number of patients with income as a percent of poverty level for Lines 7-12.

**Managed Care Utilization (Lines 13a – 13c)**

This section on “Managed Care Utilization” is to report patient Member Months in managed care plans. Because there currently is current method within RPMS for identifying Managed Care program patients, this section of the table will not be calculated.

**Characteristics of Targeted Special Populations (Lines 14 – 25)**

This section on “characteristics” asks for a count of patients from targeted special populations. There are six characteristic categories defined by BPHC and are described in the following bullets.<sup>17</sup> Health Centers are required to report on Line 16 the total number of patients seen during the reporting period who were either migratory or seasonal agricultural workers or their dependents (See definitions that follow). Only Section 330(g) Migrant Health Center grantees provide separate totals for migratory and for seasonal agricultural workers on Lines 14 and 15. For Section 330(g) grantees, Lines 14 + 15 = Line 16.

- **Migratory Agricultural Workers and Their Dependents (Line 14).** Defined by Section 330(g) of the Public Health Service Act, a migrant agricultural worker is an individual whose principal employment is in agriculture on a seasonal basis (as opposed to year-round employment) and who establishes a temporary home for the purposes of such employment. Migrant agricultural workers are usually hired laborers who are paid piecework, hourly or daily wages. The definition includes those individuals who have had such work as their principle employment within the past 24 months of their last visit as well as their dependent family members who have also used the center. The dependent family members may or may not move with the worker or establish a temporary home. Note that agricultural workers who leave a community to work elsewhere are classified as migratory workers in their home community as are those who migrate to a community to work there.

**Note:** Aged and Disabled Former Agricultural Workers: As defined in Section 330 (g)(1)(B), aged and disabled former agricultural workers are individuals who have previously been migratory agricultural workers but who no longer work in agriculture because of age or disability. These individuals and family members of such individuals are included in Line 14.

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<sup>17</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 46.

- **Seasonal Agricultural Workers and Their Dependents (Line 15).** Seasonal agricultural workers are individuals whose principal employment is in agriculture on a seasonal basis (e.g. picking fruit during the limited months of a picking season) and who do not establish a temporary home for purposes of employment. Seasonal agricultural workers are usually hired laborers who are paid piecework, hourly, or daily wages. The definition includes those individuals who have been so employed within the past 24 months of their last visit and their dependent family members who have also used the center. The dependent family members may or may not move with the worker or establish a temporary home. Note that agricultural workers who leave a community to work elsewhere are just as eligible to be classified as migrants in their home community as are those who migrate to a community to work there.

For both categories of workers, agriculture is defined as farming in all its branches, including:

- Cultivation and tillage of the soil;
- The production, cultivation, growing and harvesting of any commodity grown on, in, or as an adjunct to or part of a commodity grown in or on, the land; and
- Any practice (including preparation and processing for market and delivery to storage or to market or to carriers for transportation to market) performed by a farmer or on a farm incident to or in conjunction with an activity describes in clause (ii)

Persons employed in aquaculture, lumbering, poultry processing, cattle ranching, tourism and all other non-farm-related seasonal work are not included.

- **Homeless (Lines 17-23).** Defined as patients who lack housing (without regard to whether the individual is a member of a family), including individuals whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations, and individuals who reside in transitional housing. BPHC defines homeless in the following categories<sup>18</sup>.
  - Homeless Shelter
  - Transitional
  - Doubling Up
  - Street
  - Other
  - Unknown

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<sup>18</sup> BPHC Uniform Data System Manual, 2015 Revision, pp. 47-48.

- School-Based Health Center Patients (Line 24).** A school based health center is a health center located on or near school grounds, including pre-school, kindergarten, and primary through secondary schools, that provides on-site comprehensive preventive and primary health services. BPHC requires these programs to have a clinic code of 22.

**Note:** Includes patients of an approved, in-scope school based clinic – regardless of whether or not special funding was ever obtained for that clinic.

- Veterans (Line 25).** Veterans are defined as patients served who have been discharged from the uniformed services of the United States.

RPMS UDS can produce a completed report containing the number of patients with a special population characteristic.

- Public Housing Patients (Line 26).** Public housing means agency-developed, owned, or assisted low-income housing, including mixed finance projects, but excludes housing units with no public housing agency support other than section 8 housing vouchers.

All health centers should report on public housing patients, consistent with the reporting practice for other statutorily required special populations. Patients should be counted as residents of public housing if they are served at health center sites that meet the statutory Public Housing Primary Care (PHPC) definition (located in or adjacent to public housing) regardless of whether the health center site receives PHPC funding.

**Note:** Public Housing information is not currently captured in RPMS. Therefore, this line will be included in Table 4 for context only and will be left blank (uncalculated).

The RPMS printed report will emulate BPHC UDS Table 4, as shown in Table 5-5.

DU	UDS 2015	DEMO INDIAN HOSPITAL	Page 1
UDS No.	000001		Date Run: Dec 15, 2015
Reporting Period:	Jan 01, 2015 through Dec 31, 2015		
Population:	All (both Indian/Alaskan Natives and Non 01)		
TABLE 4 - SELECTED PATIENT CHARACTERISTICS			
CHARACTERISTIC		NUMBER OF PATIENTS	
INCOME AS PERCENT OF POVERTY LEVEL		Number of Patients (a)	
1.	100% and below	48	

2.	101 - 150%		9
3.	151 - 200%		2
4.	Over 200%		7
5.	Unknown		4,822
6.	TOTAL (SUM LINES 1 - 5)		4,888
<hr/>			
Principal Third Party Medical Insurance		0-17 Years Old (a)	18 and Older (b)
7.	None/Uninsured	414	1,260
8a.	Regular Medicaid (Title XIX)	954	658
8b.	CHIP Medicaid	0	0
8.	TOTAL MEDICAID (LINE 8a + 8b)	954	658
9a.	Dually eligible (Medicare + Medicaid)	2	1
9.	MEDICARE (inclusive of dually eligible and other Title XVIII beneficiaries)	13	392
10a.	Other Public Insurance Non-CHIP (specify:)	1	10
10b.	Other Public Insurance CHIP	0	0
10.	Total Public Insurance (LINE 10a + 10b)	1	10
11.	Private Insurance	227	959
12.	TOTAL (Sum Lines 7+8+9+10+11)	1,609	3,279

Figure 5-4: Sample RPMS UDS Table 4, page 1

DU UDS 2015 DEMO INDIAN HOSPITAL Page 2  
 UDS No. 000001 Date Run: Dec 15, 2015  
 Reporting Period: Jan 01, 2015 through Dec 31, 2015  
 Population: All (both Indian/Alaskan Natives and Non 01)

TABLE 4 - SELECTED PATIENT CHARACTERISTICS

Managed Care Utilization Payor Category	Medicaid	Medicare	Including Non-Medicaid CHIP	Private	Total
	(a)	(b)	(c)	(d)	(e)
13a. Capitated Member months					

13b. Fee-for-service Member months		
13c. Total Member months (Sum Lines 13a + 13b)		
Special Populations		Number of Patients (a)
14. Migratory	(330g grantees only)	2
15. Seasonal	(330g grantees only)	1
16. Total Agricultural Workers or Dependents (All Health Centers Report This Line)		3
17. Homeless Shelter	(330h grantees only)	1
18. Transitional	(330h grantees only)	1
19. Doubling Up	(330h grantees only)	2
20. Street	(330h grantees only)	3
21. Other	(330h grantees only)	3
22. Unknown	(330h grantees only)	1
23. Total Homeless (All Health Centers Report This Line)		11
24. Total School Based Health Center Patients (All Health Centers Report This Line)		13

Figure 5-5: Sample RPMS UDS Table 4, page 2

DU	UDS 2015	DEMO INDIAN HOSPITAL	Page 3
UDS No.	000001		Date Run: Dec 15, 2015
Reporting Period:	Jan 01, 2015 through Dec 31, 2015		
Population:	All (both Indian/Alaskan Natives and Non 01)		
TABLE 4 - SELECTED PATIENT CHARACTERISTICS			
25.	Total Veterans (ALL Health Centers Report This Line)		158
26.	Total Public Housing Patients (All Health Centers Report This Line)		0

Figure 5-6: Sample RPMS UDS Table 4, page 3

Table 5-5: Example of BPHC UDS Table 4 Selected Patient Characteristics<sup>19</sup>

Characteristic		Number of Patients				
<b>Income as Percent of Poverty Level</b>		<b>Number of Patients ( a )</b>				
1.	100% and below					
2.	101 – 150%					
3.	151 – 200%					
4.	Over 200%					
5.	Unknown					
6.	TOTAL (SUM LINES 1 – 5)					
<b>Principal Third Party Medical Insurance</b>		<b>0-17 Years Old ( a )</b>		<b>18 and Older ( b )</b>		
7.	None/ Uninsured					
8a.	Regular Medicaid (Title XIX)					
8b.	CHIP Medicaid					
8.	Total Medicaid (Line 8a + 8b)					
9a.	Dually eligible (Medicare + Medicaid)					
9.	Medicare (Inclusive of dually eligible and other Title XVIII beneficiaries)					
10a.	Other Public Insurance Non-CHIP (specify:)					
10b.	Other Public Insurance CHIP					
10.	Total Public Insurance (LINE 10a + 10b)					
11.	Private Insurance					
12.	TOTAL (Sum Lines 7 + 8 + 9 +10 +11)					
<b>Managed Care Utilization Payor Category</b>		<b>Medicaid ( a )</b>	<b>Medicare ( b )</b>	<b>Other Public Including Non-Medicaid</b>	<b>Private ( d )</b>	<b>Total ( e )</b>
13a.	Capitated Member months					
13b.	Fee-for-service Member months					
13c.	Total Member months (Sum Lines 13a + 13b)					
<b>Special Populations</b>				<b>Number of Patients ( a )</b>		
14.	Migratory (330g grantees only)					
15.	Seasonal (330g grantees only)					
16.	Total Agricultural Workers or Dependents (All Health Centers Report This Line)					
17.	Homeless Shelter (330h grantees only)					
18.	Transitional (330h grantees only)					
19.	Doubling Up (330h grantees only)					
20.	Street (330h grantees only)					

<sup>19</sup> BPHC Uniform Data System Manual, 2015 Revision, Table 4, p. 52

21.	Other (330h grantees only)	
22.	Unknown (330h grantees only)	
23.	Total Homeless (All Health Centers Report This Line)	
24.	Total School Based Health Center Patients (All Health Centers Report This Line)	
25.	Total Veterans (All Health Centers Report This Line)	
26.	Total Public Housing Patients (All Health Centers Report This Line)	

### 5.2.4 Table 5- Staffing and Utilization

Table 5 Staffing and Utilization provides a profile of health center staff, characterizing staff by type (Column A), by number of visits provided (Column B), and the number of patients served (Column C). “...Table 5 is designed to report the number of unduplicated patients *within each of seven major service categories*: medical, dental, mental health, substance abuse, vision, other professional, and enabling. The staffing information in Table 5 is designed to be compatible with approaches used to describe staff for financial/cost reporting, while ensuring adequate detail on staff categories for program planning and evaluation purposes.”<sup>20</sup>

BPHC defines different types of provider and facility staff for each of the seven major staff service categories. For example, Medical Care Services includes physicians, nurse practitioners, physician assistants, nurses, certified nurse midwives, laboratory and X-ray personnel and other medical personnel. See Appendix B: for more detailed definitions.

RPMS UDS can produce a completed report containing Columns B and C (Clinic Visits and Patients). Column A (Staff) must be derived manually; an RPMS Staff List report can be produced to assist sites.

Table 5-6: Example of BPHC UDS Table 5, Staffing and Utilization<sup>21</sup>

	<b>Personnel by Major Service Category</b>	<b>FTEs (a)</b>	<b>Clinic Visits (b)</b>	<b>Patients (c)</b>
1	Family Physicians			
2	General Practitioners			
3	Internists			
4	Obstetrician/Gynecologists			
5	Pediatricians			
7	Other Specialty Physicians			
8	<b>Total Physicians (Lines 1–7)</b>			

<sup>20</sup> BPHC Uniform Data System Manual, 2015 Revision, *Instructions for Table 5*, p. 53.

<sup>21</sup> BPHC Uniform Data System Manual, 2015 Revision, Table 5, p. 65.

<b>Personnel by Major Service Category</b>		<b>FTEs (a)</b>	<b>Clinic Visits (b)</b>	<b>Patients (c)</b>
9a	Nurse Practitioners			
9b	Physician Assistants			
10	Certified Nurse Midwives			
10a	<b>Total NP, PA, and CNMs (Lines 9a-10)</b>			
11	Nurses			
12	Other Medical personnel			
13	Laboratory personnel			
14	X-ray personnel			
15	<b>Total Medical Care (Lines 8 + 10a through 14)</b>			
16	Dentists			
17	Dental Hygienists			
18	Dental Assistants, Aides, Techs			
19	<b>Total Dental Services (Lines 16-18)</b>			
20a	Psychiatrists			
20a1	Licensed Clinical Psychologists			
20a2	Licensed Clinical Social Workers			
20b	Other Licensed Mental Health Providers			
20c	Other Mental Health Staff			
20	<b>Mental Health Services (Lines 20a-c)</b>			
21	<b>Substance Abuse Services</b>			
22	<b>Other Professional Services (specify__)</b>			
22a	Ophthalmologists			
22b	Optometrists			
22c	Other Vision Care Staff			
22d	<b>Total Vision Services (Lines 22a-c)</b>			
23	<b>Pharmacy Personnel</b>			

<b>Personnel by Major Service Category</b>		<b>FTEs (a)</b>	<b>Clinic Visits (b)</b>	<b>Patients (c)</b>
24	Case Managers			
25	Patient and Community Education Specialists			
26	Outreach Workers			
27	Transportation Staff			
27a	Eligibility Assistance Workers			
27b	Interpretation Staff			
28	Other Enabling Services (specify___)			
29	<b>Total Enabling Services (Lines 24-28)</b>			
29a	<b>Other Programs and Services (specify__)</b>			
30a	Management and Support Staff			
30b	Fiscal and Billing Staff			
30c	IT Staff			
30	<b>Total Administrative Staff (Lines 30a-30c)</b>			
31	Facility Staff			
32	Patient Support Staff			
33	<b>Total Admin &amp; Facility (Lines 30-32)</b>			
34	<b>Total (Lines 15+19+20+21+22d+22+23+29+29a+33)</b>			

5.2.4.1 ST Staffing List (Column A)

Table 5-6 Column A reports all facility staff in terms of FTEs.

RPMS cannot provide this information directly. However, a Staff List can be produced from RPMS that categorizes all staff by their Provider Code. Sites can use the Staff List:

- To review assigned provider codes to ensure that all providers are coded correctly; and
- To manually calculate the FTE for each active staff listed.

This option lists all providers with whom patients had visits and the provider was noted as the primary provider in RPMS. RPMS UDS software has mapped the RPMS provider discipline codes to the BPHC UDS definitions (see Appendix D: ). Any staff members with associated provider discipline codes that are not included in the BPHC service categories are identified at the bottom of the report as “Unidentified Provider Category”. The system does not count visits with unmapped provider discipline codes toward visits or patients for Table 5-6 Column B or C.

In Figure 5-7 the provider listed in line 35 is currently categorized as Provider Code 15 Other. This provider should be recoded to Code 22 Nurse Assistant.

```

***** CONFIDENTIAL PATIENT INFORMATION, COVERED BY THE PRIVACY ACT *****
DU                               Dec 15, 2015                               Page 1

*** BPHC Uniform Data System (UDS) ***
Personnel List for Table 5 Column A, By Service Category
DEMO HOSPITAL
Reporting Period: Jan 01, 2015 to Dec 31, 2015
Population: All (both Indian/Alaskan Natives and Non 01)
-----
-

List of all Active Provider Personnel sorted by Major Service Category.

PROVIDER NAME                                PROVIDER CODE                                FTE
-----
-

Line 1  Family Practitioners
PROVIDERA, MARION                            80 FAMILY MEDICINE
PROVIDERB, MICHAEL M                         80 FAMILY MEDICINE
PROVIDERC, SALLY B                           80 FAMILY MEDICINE

Line 2  General Practitioners
PROVIDERD, SUSIE                             18 PHYSICIAN (CONTRACT)
PROVIDERF, SHIRLEY                           18 PHYSICIAN (CONTRACT)

Line 3  Internists
PROVIDERG, JANE                              71 INTERNAL MEDICINE
PROVIDERI, WILLIAM                           71 INTERNAL MEDICINE

Line 35  Unidentified Provider Category
NURSE ASSISTANT, LARRY                        15 OTHER
    
```

Figure 5-7: Sample Staff List by BPHC Categories

#### 5.2.4.2 Table 5 Staffing and Utilization (Columns B and C)

Columns B and C document the number of visits provided and patients served, as categorized by BPHC service categories. There are seven major service categories and the limits for Column B (Clinic Visits) as defined by BPHC:<sup>22</sup>

- Medical Care Services (Line 15). A patient may have one medical visit per day (e.g., visit with a physician, nurse practitioner, physician’s assistant, certified nurse midwife, or nurse).
- Dental Services (Line 19). A patient may have one dental service visit per day (visit with a dentist or hygienist).
- Mental Health Services (Line 20). A patient may have one mental service visit per day (e.g., visit with a psychiatrist, psychologist, or medical social worker).

<sup>22</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 61.

- Substance Abuse Services (Line 21). A patient may have one substance abuse service visit per day (e.g., visit with an alcoholism/substance abuse counselor, family therapist, or mental health).
- Vision Services (Line 22d). A patient may have one eye exam/vision service visit per day (e.g., visit with an ophthalmologist, eye care specialist, optometrist, contract optometrist, optometric assistant or optometry student).
- Other Professional Services (Line 22). A patient may have one “other health” visit *for each type of “other health” provider* (e.g., visit with a nutritionist *and* a visit with a podiatrist *and* a visit with a speech therapist, all on the same day as long as the person providing the services is not the same provider).
- Enabling Services (Line 29). A patient may have one enabling service visit per day *for each type of “enabling service” provider* (e.g., visit with a case manager *and* a visit with a family planning counselor, both on the same day as long as the person providing the services is not the same provider).

The BPHC UDS Manual defines visits as “. . . documented, face-to-face contacts between a patient and a provider who exercises independent professional judgment in the provision of services to the patient”.<sup>23</sup> The blocked out areas in Column B (see Table 5-6) indicate staff categories whose visits are *not* counted.

The system does not count visits with primary providers whose RPMS provider code cannot be mapped to the BPHC UDS provider service categories toward Column B. You can produce a detailed list of visits with uncategorized providers by running List UCP from the List menu option within the Manager Utilities (MU/LST/LST1/UCP) (see Section 6.1).

Column C displays the unduplicated number of patients who received the visits displayed in Column B. A patient is defined as “an individual who has had at least one reportable visit during the reporting year”.<sup>24</sup> (Section 4.2 discusses definitions and logic in more detail.)

For Table 5, the system counts patients for each of the seven separate service categories shown on the previous page. An individual can be counted only once as a patient for each service, even if he/she has multiple visits.

### Table 5 Logic

RPMS UDS reviews every visit (see Section 4.2.2) for patients who meet the RPMS UDS definition of a patient. Based on the PRIMARY PROVIDER discipline code, the visit is tabled according to the RPMS UDS to BPHC UDS mapping logic (see Appendix C: ). For example, a visit with Primary Provider Code 70 Cardiologist is

<sup>23</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 60.

<sup>24</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 60.

counted toward Line 7 Other Specialty Physicians. If the primary provider discipline code does not fit into any of the BPHC categories, a separate line at the bottom of the report is listed with the number of visits that did not map to a category. The RPMS printed report will emulate BPHC UDS Table 5, as shown in Table 5-6.

DU UDS 2015 DEMO INDIAN HOSPITAL		Page 1		
UDS No. 000001		Date Run: Dec 15, 2015		
Reporting Period: Jan 01, 2015 through Dec 31, 2015				
Population: All (both Indian/Alaskan Natives and Non 01)				
TABLE 5-STAFFING AND UTILIZATION				
PERSONNEL BY MAJOR SERVICE CATEGORY		FTEs (a)	CLINIC VISITS (b)	PATIENTS (c)
1.	Family Physicians		3,841	*****
2.	General Practitioners		72,668	*****
3.	Internists		1,507	*****
4.	Obstetrician/Gynecologists		7,950	*****
5.	Pediatricians		1,043	*****
7.	Other Specialist Physicians		2,318	*****
8.	Total Physicians (Lines 1-7)		89,327	*****
9a.	Nurse Practitioners		21,354	*****
9b.	Physician Assistants		6,723	*****
10.	Certified Nurse Midwives		7,901	*****
10a.	Total NP, PA, and CNMs (Lines 9a-10)		35,978	*****
11.	Nurses		16,116	*****
12.	Other Medical Personnel		*****	*****
13.	Laboratory Personnel		*****	*****
14.	X-Ray Personnel		*****	*****
15.	Total Medical Care (Lines 8 + 10a through 14)		141,421	34,272
16.	Dentists		11,438	*****
17.	Dental Hygienists		1	*****
18.	Dental Assistants, Aides, Technicians		*****	*****
19.	Total Dental Services (Lines 16-18)		11,439	6,110

Figure 5-8: Sample RPMS UDS Table 5, page 1

DU UDS 2015 DEMO INDIAN HOSPITAL		Page 2	
UDS No. 000001		Date Run: Dec 15, 2015	
Reporting Period: Jan 01, 2015 through Dec 31, 2015			
Population: All (both Indian/Alaskan Natives and Non 01)			
TABLE 5-STAFFING AND UTILIZATION			
PERSONNEL BY MAJOR SERVICE CATEGORY		FTEs	CLINIC VISITS
		(a)	(b)
			PATIENTS (c)
20a.	Psychiatrists		1,075 *****
20a1.	Licensed Clinical Psychologists		9 *****
20a2.	Licensed Clinical Social Workers		9 *****
20b.	Other Licensed Mental Health Providers		5 *****
20c.	Other Mental Health Staff		2,385 *****
20.	Mental Health Services (Lines 20a-c)	3,483	870
21.	Substance Abuse Services		1,409 631
22.	Other professional services (specify__)		8,357 3,780
22a.	Ophthalmologists		1,715 *****
22b.	Optometrists		5,281 *****
22c.	Other Vision Care Staff		***** *****
22d.	Total Vision Services (Lines 22a-c)	7,029	4,321
23.	Pharmacy Personnel		***** *****
24.	Case Managers		3 *****
25.	Patient and Community Education Specialists		8 *****
26.	Outreach Workers		***** *****
27.	Transportation Staff		***** *****
27a.	Eligibility Assistance Workers		***** *****

27b. Interpretation Staff	*****	*****
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Figure 5-9: Sample RPMS UDS Table 5, page 2

DU	UDS 2015	DEMO INDIAN HOSPITAL	Page 3
UDS No.	000001	Date Run:	Dec 15, 2015
Reporting Period:	Jan 01, 2015 through Dec 31, 2015		
Population:	All (both Indian/Alaskan Natives and Non 01)		
TABLE 5-STAFFING AND UTILIZATION			
		FTEs	CLINIC VISITS
		(a)	(b)
PERSONNEL BY MAJOR SERVICE CATEGORY			PATIENTS (c)
-----			
28.	Other Enabling Services (specify__)		*****
29.	Total Enabling Services (Lines 24-28)		11 34
29a.	Other Programs/ Services (specify__)		*****
30a.	Management and Support Staff		*****
30b.	Fiscal and Billing Staff		*****
30c.	IT Staff		*****
30.	Total Administrative Staff (Lines 30a-30c)		*****
31.	Facility Staff		*****
32.	Patient Support Staff		*****
33.	TOTAL ADMINISTRATION AND FACILITY (TOTAL LINES 30+31+32)		*****
34.	GRAND TOTAL: (TOTAL LINES (15+19+20+21+22d+22+23+29+29a+33)		173,525 *****
209 visits did not fit into any of the above categories			

Figure 5-10: Sample RPMS UDS Table 5, page 3

### 5.2.5 Table 6A Selected Diagnoses and Services Rendered

Table 6A reports the number of visits and patients for 26 selected diagnoses and 21 services rendered, e.g., laboratory tests, mammograms. The system reports all visits with the designated diagnoses and all patients who received these diagnoses, regardless of whether it was a primary diagnosis, a secondary diagnosis, a tertiary diagnosis, or any other level. For services, all specified diagnostic or procedure codes

are counted, even when more than one test or preventive service was documented during the same visit. For example, if an HIV test and a Pap smear were conducted during the same visit, each would be counted in the appropriate report line. Additionally for services only, tests or services found on both completed and “orphan” visits are counted and so are services documented as historical events.

**Note:** ICD-10 codes are notably different from the ICD-9 codes and it is important that health centers use the appropriate coding based on the service and where multiple codes may be indicated on a patient’s chart, special attention is required to ensure that patients and their visits are unduplicated.

On several lines both CPT codes and ICD-9 and ICD-10 codes are provided. Health centers may use either the CPT codes or the ICD-9 and ICD-10 codes for any specific visit, but not both.

Table 6A does not reflect the full range of diagnoses and services offered by a BPHC Health Center, but rather those that are prevalent among BPHC patients and/or are considered key indicators. The diagnoses and services selected represent those that are prevalent among Health Center Program patients or which are generally regarded as sentinel indicators of access to primary care or are of special interest to HRSA

Diagnoses include:

- Symptomatic and Asymptomatic HIV
- Tuberculosis
- Sexually transmitted infections
- Hepatitis B
- Hepatitis C
- Asthma
- Chronic obstructive pulmonary diseases
- Abnormal breast findings, female
- Abnormal cervical findings
- Diabetes mellitus
- Heart disease (selected)
- Hypertension
- Contact dermatitis and other eczema
- Dehydration

- Exposure to heat or cold
- Overweight and obesity
- Otitis media and Eustachian tube disorders
- Selected perinatal medical conditions
- Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive); Nutritional deficiencies in children only. Does not include sexual or mental development.
- Alcohol related disorders
- Other substance related disorders (excluding tobacco use disorders)
- Tobacco use disorder
- Depression and other mood disorders
- Anxiety disorders including PTSD
- Attention deficit and disruptive behavior disorders
- Other mental disorders, excluding drug or alcohol dependence

Services include:

- HIV test
- Hepatitis B test
- Hepatitis C test
- Mammogram
- Pap test
- Selected Immunizations: Hepatitis A, Hemophilus Influenza B (HiB), Pneumococcal, Diphtheria, Tetanus, Pertussis (DTaP) (DTP) (DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatitis B Child)
- Seasonal flu vaccine
- Contraceptive management
- Health supervision of infant or child (ages 0 through 11)
- Childhood lead test screening (9 to 72 months)
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Smoke and tobacco use cessation counseling
- Comprehensive and intermediate eye exams
- Dental: Emergency Services
- Dental: Oral Exams

- Dental: Prophylaxis – adult or child
- Dental: Sealants
- Dental: Fluoride Treatment – adult or child
- Dental: Restorative Services
- Dental: Oral Surgery (extractions and other surgical procedures)
- Dental: Rehabilitative Services (Endo, Perio, Prostho, Ortho)

5.2.5.1 Logic for Diagnoses

For the 26 diagnostic categories (Table 6A Lines 1–20d), BPHC has identified specific ICD-9 and ICD-10 codes. See Table 5-7 and Table 5-8 for lists of BPHC-defined diagnosis codes. RPMS UDS searches the POV field in visits for the codes listed (see Section 4.3) regardless of primacy. For Column A (Number of Visits), counts the total number of visits during the calendar year with a selected diagnosis (POV) matching the BPHC-defined codes for each diagnosis. For Column B (Patients), counts each patient who had at least one visit during the calendar year where the selected diagnosis matches the BPHC description; patients are counted only once in each diagnostic category, even if they had multiple visits with the same primary diagnosis.

**Note:** ICD-10 codes are notably different from the ICD-9 codes and it is important that health centers use the appropriate coding based on the service and where multiple codes may be indicated on a patient’s chart, special attention is required to ensure that patients and their visits are unduplicated.

Table 5-7: Table 6A BPHC Codes for Tests and Preventative Services <sup>25</sup>

Diagnostic Category		Applicable ICD-9-CM Code	Applicable ICD-10-CM Code	Number of Visits by Diagnosis regardless of primacy (a)	Number of Patients with Diagnosis regardless of primacy (b)
<b>Selected Infectious and Parasitic Diseases</b>					
1, 2.	Symptomatic and Asymptomatic HIV	042.xx, 079.53, V08	B20, B97.35, O98.7, Z21		
3.	Tuberculosis	010.xx–018.xx	A15- thru A19-		

<sup>25</sup> BPHC Uniform Data System Manual, 2015 Revision, pp. 81-83.

Diagnostic Category		Applicable ICD-9-CM Code	Applicable ICD-10-CM Code	Number of Visits by Diagnosis regardless of primacy (a)	Number of Patients with Diagnosis regardless of primacy (b)
4.	Sexually transmitted infections	090.xx–099.xx	A50- thru A64- (Exclude A63.0), M02.3-, N34.1		
4.a	Hepatitis B	070.20, 070.22, 070.30, 070.32, V02.61	B16.0-B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51		
4.b	Hepatitis C	070.41, 070.44, 070.51, 070.54, 070.70, 070.71, V02.62	B17.10, B17.11, B18.2, B19.20, B19.21, Z22.52		
<b>Selected Diseases of the Respiratory System</b>					
5.	Asthma	493.xx	J45-		
6.	Chronic obstructive pulmonary diseases	490.xx–492.xx	J40- thru J44- and J47-		
<b>Selected Other Medical Conditions</b>					
7.	Abnormal breast findings, female	174.xx, 198.81, 233.0x, 238.3, 793.8x	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.71-, C50.81-, C50.91-, C79.81, D48.6-, R92-		
8.	Abnormal cervical findings	180.xx, 198.82, 233.1x, 795.0x	C53-, C79.82, D06-, R87.61-, R87.810, R87.820		
9.	Diabetes mellitus	250.xx, 648.0x	E10- thru E13-, O24- (Exclude O24.41-)		

Diagnostic Category		Applicable ICD-9-CM Code	Applicable ICD-10-CM Code	Number of Visits by Diagnosis regardless of primacy (a)	Number of Patients with Diagnosis regardless of primacy (b)
10.	Heart disease (selected)	391.xx–392.0x, 410.xx–429.xx	I01-, I02- (exclude I02.9), I20- thru I25, I26- thru I28-, I30- thru I52-		
11.	Hypertension	401.xx–405.xx	I10- thru I15-		
12.	Contact dermatitis and other eczema	692.xx	L23- thru L25-, L30- (Exclude L30.1, L30.3, L30.4, L30.5), L55- thru L59 (Exclude L57.0 thru L57.4)		
13.	Dehydration	276.5x	E86-		
14.	Exposure to heat or cold	991.xx–992.xx	T33.XXXA, T34.XXXA, T67.XXXA, T68.XXXA, T69.XXXA		
14a.	Overweight and obesity	278.00–278.03, V85.xx excluding V85.0, V85.1, V85.51, V85.52	E66-, Z68- (Excluding Z68.1, Z68.20-24, Z68.51, Z68.52)		
<b>Selected Childhood Conditions (limited to ages 0 thru 17)</b>					
15.	Otitis media and eustachian tube disorders	381.xx–382.xx	H65- thru H69-		
16.	Selected perinatal medical conditions	770.xx, 771.xx, 773.xx, 774.xx–779.xx (excluding 779.3x)	A33-, P20- thru P29- (exclude P22.0, P29.3); P35- thru P96- (exclude P50-, P51-, P52-, P54-, P91.6-, P92-, P96.81), R78.81, R78.89		

Diagnostic Category		Applicable ICD-9-CM Code	Applicable ICD-10-CM Code	Number of Visits by Diagnosis regardless of primacy (a)	Number of Patients with Diagnosis regardless of primacy (b)
17.	Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive); Nutritional deficiencies in children only. Does not include sexual or mental development.	260.xx–269.xx (excluding 268.2), 779.3x, 783.3x–783.4x	E40-E46, E50- thru E63- (exclude E64-), P92-, R62- (exclude R62.7), R63.2, R63.3		

Table 5-8: Table 6A BPHC Codes for Tests and Preventative Services <sup>26</sup>

Diagnostic Category		Applicable ICD-9-CM Code	Applicable ICD-10-CM Code	Number of Visits by Diagnosis regardless of primacy (a)	Number of Patients with Diagnosis regardless of primacy (b)
<b>Selected Mental Health and Substance Abuse Conditions</b>					
18.	Alcohol related disorders	291.xx, 303.xx, 305.0x, 357.5x	F10-, G62.1		
19.	Other substance related disorders (excluding tobacco use disorders)	292.1x–292.8x, 292.9, 304.xx, 305.2x–305.9x, 357.6x, 648.3x	F11- thru F19- (Exclude F17-), G62.0, O99.32-		
19a.	Tobacco use disorder	305.1	F17-		
20a.	Depression and other mood disorders	296.xx, 300.4, 301.13, 311.xx	F30- thru F39-		
20b	Anxiety disorders including PTSD	300.0x, 300.2x, 300.3, 308.3; 309.81	F40- thru F42-, F43.0, F43.1-		
20c	Attention deficit and disruptive behavior disorders	312.8x, 312.9x, 313.81, 314.xx	F90- thru F91-		

<sup>26</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 83.

Diagnostic Category		Applicable ICD-9-CM Code	Applicable ICD-10-CM Code	Number of Visits by Diagnosis regardless of primacy (a)	Number of Patients with Diagnosis regardless of primacy (b)
20d	Other mental disorders, excluding drug or alcohol dependence	290.xx, 293.xx–302.xx (excluding 296.xx, 300.0x, 300.2x, 300.3, 300.4, 301.13), 306.xx–319.xx (excluding 307.xx, 308.3, 309.81, 311.xx, 312.8x, 312.9x, 313.81, 314.xx)	F01- thru F09-, F20- thru F29-, F43- thru F48- (exclude F43.1-), F50- thru F59- (exclude F55-), F60- thru F99- (exclude F84.2, F90-, F91-, F98-), R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0		

If the link to pass data from the Behavioral Health System to PCC is set to the “off” position at your facility, then none of your behavioral data will be included in the UDS reports. If you want this data to be included and counted in the UDS, you must have this link set to the “on” position.

**5.2.5.2 Logic for Diagnostic Tests, Screening, and Preventive Services**

For Column A (Number of Visits), count the total number of visits for the specific listed tests/screening/preventive services. In addition, the logic counts any flagged “orphan” visits with specified services (i.e., visits do not require a primary provider and POV). Services should be those provided at the facility, not any off-site services (e.g., immunizations received at Costco); this is ensured by appropriate selection of Location codes in the Site Setup.

For Column B (Number of Patients), the logic counts each patient who had at least one visit during the calendar year for the specified tests/screening. If the patient had two or more different tests during the same visit, the patient would count once for each separate test/screening/service. For service categories, BPHC identifies CPT, ICD-9, ICD-10, and ADA codes. See Table 5-9 for the BPHC-defined codes.

**Note:** On several lines both CPT codes and ICD-9 and ICD-10 codes are provided. Health centers may use either the CPT codes or the ICD-9 and ICD-10 codes for any specific visit, but not both

Table 5-9: Example of Table 6A BPHC Codes for Tests and Preventative Services <sup>27</sup>

Service Category		Applicable ICD-9-CM or CPT-4 Code(s)	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)
<b>Selected Diagnostic Tests/Screening/Preventive Services</b>					
21.	HIV test	<b>CPT-4:</b> 86689; 86701–86703; 87390-87391	<b>CPT-4:</b> 86689; 86701–86703; 87390-87391		
21.a	Hepatitis B test	<b>CPT-4:</b> 86704; 86706; 87515–87517	<b>CPT-4:</b> 86704; 86706; 87515–87517		
21.b	Hepatitis C test	<b>CPT-4:</b> 86803–86804; 87520-87522	<b>CPT-4:</b> 86803–86804; 87520-87522		
22.	Mammogram	<b>CPT-4:</b> 77052, 77057 OR <b>ICD-9:</b> V76.11; V76.12	<b>CPT-4:</b> 77052, 77057 OR <b>ICD-10:</b> Z12.31		
23.	Pap Test	<b>CPT-4:</b> 88141–88155; 88164–88167; 88174–88175 OR <b>ICD-9:</b> V72.3; V72.31; V76.2	<b>CPT-4:</b> 88141–88155; 88164–88167; 88174–88175 OR <b>ICD-10:</b> Z01.41-, Z01.42, Z12.4		
24.	Selected Immunizations: Hepatitis A, Hemophilus Influenza B (HiB), Pneumococcal, Diphtheria, Tetanus, Pertussis (DTaP) (DTP) (DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatitis B Child)	<b>CPT-4:</b> 90633–90634; 90645–90648; 90670; 90696–90702; 90704–90716; 90718–90723 90743–90744; 90748	<b>CPT-4:</b> 90633–90634; 90645–90648; 90670; 90696–90702; 90704–90716; 90718–90723 90743–90744; 90748		

<sup>27</sup> BPHC Uniform Data System Manual, 2015 Revision, pp. 84-85.

Service Category		Applicable ICD-9-CM or CPT-4 Code(s)	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)
24a	Seasonal Flu vaccine	<b>CPT-4:</b> 90654–90662, 90672–90673, 90685–90688	<b>CPT-4:</b> 90654–90662, 90672–90673, 90685–90688		
25.	Contraceptive management	<b>ICD-9:</b> V25.xx	<b>ICD-10:</b> Z30-		
26.	Health supervision of infant or child (ages 0 through 11)	<b>CPT-4:</b> 99391–99393; 99381–99383;	<b>CPT-4:</b> 99391–99393; 99381–99383;		
26a.	Childhood lead test screening (9 to 72 months)	<b>CPT-4:</b> 83655	<b>CPT-4:</b> 83655		
26b.	Screening, Brief Intervention, and Referral (SBIRT)	<b>CPT-4:</b> 99408–99409	<b>CPT-4:</b> 99408–99409		
26c.	Smoke and tobacco use cessation counseling	<b>CPT-4:</b> 99406 and 99407 <b>HCPCS:</b> S9075 <b>CPT-II:</b> 4000F, 4001F	<b>CPT-4:</b> 99406 and 99407 <b>HCPCS:</b> S9075 <b>CPT-II:</b> 4000F, 4001F		
26d.	Comprehensive and intermediate eye exams	<b>CPT-4:</b> 92002; 92004; 92012; 92014	<b>CPT-4:</b> 92002; 92004; 92012; 92014		

Table 5-10: Example of Table 6A BPHC Codes for Selected Dental Services<sup>28</sup>

<sup>28</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 85

Service Category		Applicable ADA Code	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
<b>Selected Dental Services</b>					
27.	I. Emergency Services	<b>ADA:</b> D9110	<b>ADA:</b> D9110		
28.	II. Oral Exams	<b>ADA:</b> D0120; D0140; D0145; D0150; D0160; D0170; D0180	<b>ADA:</b> D0120; D0140; D0145; D0150; D0160; D0170; D0180		
29.	Prophylaxis - adult or child	<b>ADA:</b> D1110; D1120	<b>ADA:</b> D1110; D1120		
30.	Sealants	<b>ADA:</b> D1351	<b>ADA:</b> D1351		
31.	Fluoride treatment - adult or child	<b>ADA:</b> D1203; D1204; D1206	<b>ADA:</b> D1203; D1204; D1206		
32.	III. Restorative Services	<b>ADA:</b> D21xx–D29xx	<b>ADA:</b> D21xx–D29xx		
33.	IV. Oral Surgery (extractions and other surgical procedures)	<b>ADA:</b> D7111; D7140; D7210; D7220; D7230; D7240; D7241; D7250; D7260; D7261; D7270; D7272; 7280	<b>ADA:</b> D7111; D7140; D7210; D7220; D7230; D7240; D7241; D7250; D7260; D7261; D7270; D7272; 7280		
34.	V. Rehabilitative services (Endo, Perio, Prostho, Ortho)	<b>ADA:</b> D3xxx; D4xxx; D5xxx; D6xxx; D8xxx	<b>ADA:</b> D3xxx; D4xxx; D5xxx; D6xxx; D8xxx		

Facilities can also identify other logic to meet service category definitions. RPMS UDS uses both LOINC codes as well as four site-populated taxonomies to define lab tests for HIV tests, Hepatitis B tests, Hepatitis C tests and Pap tests (Lines 21 , 21a, 21b and 23) (see Section 3.2.1) for more detailed explanation of how to use taxonomies). BGP HIV TEST TAX and BGP PAP SMEAR TAX from CRS software will be distributed with the UDS software. If these taxonomies already exist on the site RPMS, UDS will *not* replace the existing taxonomies, as they may already be populated. However, it is strongly recommended you review the taxonomy with your lab staff to see if any new tests should be added to the taxonomy. Sites not running the CRS software will have to populate these two taxonomies for UDS. *BUD HEPATITIS B TEST* and *BUD HEPATITIS C TEST* may need to be pre-populated prior to first use.

RPMS UDS has expanded the logic for each test/service category as defined in Table 5-11.

Table 5-11: Expanded Logic for Each Test/Service Category

Test/Service	RPMS Logic
HIV test	<p><b>V LAB:</b> LOINC taxonomy BGP HIV TEST LOINC CODES, site-defined taxonomy BGP HIV TEST TAX  <b>V CPT:</b> 86689; 86701-86703; 87390-87391 (BPHC-defined)</p>
Hepatitis B test	<p><b>V LAB:</b> site-defined taxonomy BUD HEPATITIS B TEST  <b>V CPT:</b> 86704; 86706; 87515-87517 (BPHC-defined)</p>
Hepatitis C test	<p><b>V LAB:</b> site-defined taxonomy BUD HEPATITIS C TEST  <b>V CPT:</b> 86803-86804; 87520-87522 (BPHC-defined)</p>
Mammogram	<p><b>V RADIOLOGY:</b> CPT codes 77052; 77057 (BPHC-defined)  <b>V CPT:</b> 77052; 77057 (BPHC-defined)  <b>V POV:</b> ICD-9: V76.11; V76.12 (BPHC-defined); ICD-10 Z12.31 (BPHC-defined)  <b>Women’s Health:</b> Any procedure called MAMMOGRAM SCREENING, MAMMOGRAM DX BILAT, or MAMMOGRAM DX UNILAT</p>
Pap Test(s)	<p><b>V LAB:</b> Any laboratory test of PAP SMEAR, site-defined taxonomy BGP PAP SMEAR TAX, LOINC taxonomy BGP PAP LOINC CODES  <b>V CPT:</b> 88141-88155; 88164-88167; 88174-88175 (BPHC-defined)  <b>V POV:</b> ICD-9: V72.3; V72.31; V72.32, V76.2 (BPHC-defined); ICD-10: Z01.41-, Z01.42, Z12.4 (BPHC-defined)  <b>Women’s Health:</b> Any procedure called PAP SMEAR  <b>V HCPCS:</b> G0101, G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091</p>
<p>Selected Immunizations:                      Hepatitis A,                      Hemophilus                      Influenza B (HiB),                      Influenza virus,                      Pneumococcal,                      Diphtheria, Tetanus,                      Pertussis (DTaP) (DTP) (DT), Mumps,                      Measles, Rubella,                      Poliovirus, Varicella,                      Hepatitis B Child</p>	<p><b>V CPT:</b> 90633-90634; 90645–90648; 90670; 90696–90702; 90704–90716; 90718-90723; 90743–90744; 90748 (BPHC-defined)  <b>V IMMUNIZATION:</b> CVX Codes 83 HEP A PED, 84 HEP A PED, 104 HEP A-HEP B, 46 HIB, 47 HIBTITER, 48 ACTHIB, 49 PEDVAXHIB, 130 DTap-IPV, 120 DTap-Hib-IPV, 20 DTAP, 01 DTP, 28 DT PED, 35 TET TOX, 106 DTAP 5Pertussis, 107 DTAP NOS, 02 OPV, 89 POLIO, NOS, 03 MMR, 04 MR, 05 MEASLES, 06 RUBELLA, 07 MUMPS, 38 RUBELLA/MUMPS, 09 Td-ADULT, 138 Td (adult), 139 Td (adult) NOS, 10 IPV, 11 Pertussis, 21 VARICELLA, 94 MMRV, 113 TD (ADULT) PRESERVATIVE FREE, 115 TDAP, 22 DTP-HIB, 50 DTap-Hib, 110 DTap-HepB-IPV, 146 DTaP-IPV-HiB-HepB, 43 HEP B ADULT, 08 HEP B PED, 42 HEP B Adolescent, 44 HEP B, DIALYSIS, 45 HEP B NOS, 51 HepB-Hib, 102 DTP-HIB-HEP B, 132 DTaP-IPV-HIB-HEP B historical, 31 HEP A PED, 52 HEP A, 85 HEP A NOS, 17 HIB NOS, 33 PNEUMO PPV23, 100 PNEUMO PED, 109 PNEUMO NOS, 133 PNEUMO PCV13, 152 PNEUMO</p>

Test/Service	RPMS Logic
Seasonal Flu Vaccine	<p><b>V CPT:</b> 90654-90662, 90672-90673, 90685-90688 (BPHC-defined)</p> <p><b>V IMMUNIZATION:</b> 15 INFLUENZA PED, 16 INFLUENZA, WHOLE, 88 INFLUENZA NOS, 111 INTRANASAL INFLUENZA, 135 Influenza High Dosage, 140 Influenza, seasonal, injectable, preservative free, 141 Influenza, seasonal, injectable, 144 INFLUENZA, INTRADERMAL, 149 INFLUENZA, Live, Intranasal, Quadrivalent, 150 INFLUENZA, INJECTABLE, QUAD, PF, 151 INFLUENZA NASAL, UNSPECIFIED, 153 INFLUENZA, INJECTABLE, MDCK, PF, 155 INFLUENZA, INJECTABLE, RECOMB, PF, 158 INFLUENZA, Injectable, Quadrivalent, 161 Influenza, injectable,quadrivalent, preservative free, pediatric. 166 INFLUENZA, intradermal, quadrivalent, preservative free</p>
Contraceptive Management	<p><b>V POV:</b> icd-9: V25.xx (BPHC-defined); ICD-10: Z30- (BPHC-defined)</p>
Health Supervision of infant or child (ages 0 through 11)	<p>For any visit for patients 0-11 as of June 30:  <b>Clinic code:</b> 24 (Well Child) or 57 (EPSDT [Early and Periodic Screening, Diagnosis and Treatment])  <b>V CPT:</b> 99381-99383, 99391-99393 (BPHC-defined)</p>
Childhood lead test screening (9 to 72 months)	<p><b>V CPT:</b> 83655 (BPHC-defined)</p>
Screening, Brief Intervention, and Referral (SBIRT)	<p><b>V CPT:</b> 99408-99409 (BPHC-defined)  <b>Patient Education Code:</b> AOD-INJ</p>
Smoke/tobacco counseling; Smoking cessation treatment	<p><b>V CPT:</b> 99406 and 99407; S9075, 400F, 4001F (BPHC-defined)  <b>Patient Education Code:</b> Containing "TO-", "-TO", "-SHS", 305.1</p>
Comprehensive and intermediate eye exams	<p><b>V CPT:</b> 92002, 92004, 92012, 92014 (BPHC-defined)</p>
Dental: I. Emergency Services	<p><b>ADA:</b> 9110 (BPHC-defined)  <b>V CPT:</b> D9110</p>
Dental: II. Oral Exams	<p><b>ADA:</b> 0120, 0140, 0145, 0150, 0160, 0170, 0171, 0180 (BPHC-defined)  <b>V CPT:</b> D0120, D0140, D0145, D0150, D0160, D0170, D0171, D0180</p>
Prophylaxis—adult or child	<p><b>ADA:</b> 1110, 1120 (BPHC-defined)  <b>V CPT:</b> D1110, D1120</p>
Sealants	<p><b>ADA:</b> 1351 (BPHC-defined)  <b>V CPT:</b> D1351</p>
Fluoride treatment—adult or Child	<p><b>ADA:</b> 1206, 1208 (BPHC-defined)  <b>V CPT:</b> D1206, D1208</p>

Test/Service	RPMS Logic
Dental: III. Restorative Services	<b>ADA:</b> 21xx–29xx (BPHC-defined) <b>V CPT:</b> D21xx–D29xx
Dental: IV. Oral Surgery (extractions and other surgical procedures)	<b>ADA:</b> 7111, 7140, 7210, 7220, 7230, 7240, 7241, 7250, 7251, 7260, 7261, 7270, 7272, 7280, 7290-7294 (BPHC-defined) <b>V CPT:</b> D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, D7260, D7261, D7270, D7272, D7280, D7290-D7290
Dental: V. Rehabilitative services (Endo, Perio, Prostho, Ortho)	<b>ADA:</b> 3xxx, 4xxx, 5xxx, 6xxx, 8xxx (BPHC-defined) <b>V CPT:</b> D3xxx, D4xxx, D5xxx, D6xxx, D8xxx

The RPMS printed report will emulate BPHC UDS Table 6A. Figure 5-11 through Figure 5-19 shows a sample RPMS UDS Table 6A report.

DU	UDS 2015	DEMO INDIAN HOSPITAL	Page 1	
UDS No.	000001	Date Run:	Dec 15, 2015	
Reporting Period:	Jan 01, 2015 through Dec 31, 2015			
Population:	All (both Indian/Alaskan Natives and Non 01)			
TABLE 6A- SELECTED DIAGNOSES AND SERVICES RENDERED				
Diagnostic Category	Applicable ICD-9-CM Code	Applicable ICD-10-CM Code	Number of Visits by Diagnosis regardless of primacy (A)	Number of Patients with Diagnosis regardless of primacy (B)
Selected Infectious and Parasitic Diseases				
1-2. Symptomatic and Asymptomatic HIV	042., 079.53, V08	B20, B97.35, 098.7, Z21	13	9
3. Tuberculosis	010.xx-018.xx	A15- thru A19-	2	2
4. Sexually transmitted	090.xx-099.xx	A50- thru A64- (Exclude A63.0)	3	3

infections		M02.3-, N34.1			
4a.	Hepatitis B	070.20, 070.22, 070.30, 070.32, V02.61	B16.0-B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51	2	2
4b.	Hepatitis C	070.41, 070.44, 070.51, 070.54, 070.70, 070.71, V02.62	B17.10, B17.11, B18.2, B19.20, B19.21, Z22.52	20	13
5.	Asthma	493.xx	J45.	687	459
6.	Chronic obstructive pulmonary disease	490.xx-492.xx	J40- thru J44- and J47-	242	207

Figure 5-11: Sample RPMS UDS Report for Table 6A, Page 1

DU UDS 2015		DEMO INDIAN HOSPITAL		Page 2	
UDS No. 000001				Date Run: Dec 15, 2015	
Reporting Period: Jan 01, 2015 through Dec 31, 2015					
Population: All (both Indian/Alaskan Natives and Non 01)					
TABLE 6A- SELECTED DIAGNOSES AND SERVICES RENDERED					
Diagnostic Category		Applicable ICD-9-CM Code	Applicable ICD-10-CM Code	Number of Visits by Diagnosis regardless of primacy (A)	Number of Patients with Diagnosis regardless of primacy (B)
Selected Other Medical Conditions					
7.	Abnormal breast findings, female	174.xx, 198.81, 233.0x, 238.3, 793.8x	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.71-, C50.81-, C50.91-, C79.81, D48.6-, R92-	10	7
8.	Abnormal cervical findings	180.xx, 198.82, 233.1x, 795.0x	C53-, C79.82, D06-, R87.61-, R87.810, R87.820	36	29
9.	Diabetes mellitus	250.xx, 648.0x	E10- thru E13-,	2,772	976

		O24- (Exclude O24.41-)			
10.	Heart disease (selected)	391.xx-392.0x, 410.xx-429.xx	I01-, I02- (exclude I02.9), I20- thru I25, I26- thru I28-, I30- thru I52-	419	194
11.	Hypertension	401.xx-405.xx	I10- thru I15-	1,339	852
12.	Contact dermatitis and other eczema	692.xx	L23- thru L25-, L30- (Exclude L30.1, L30.3, L30.4, L30.5), L55- thru L59 (Exclude L57.0 thru L57.4)	143	121

Figure 5-12: Sample RPMS UDS Report for Table 6A, Page 2

DU	UDS 2015	DEMO INDIAN HOSPITAL		Page 3	
UDS No.	000001			Date Run: Dec 15, 2015	
Reporting Period:	Jan 01, 2015 through Dec 31, 2015				
Population:	All (both Indian/Alaskan Natives and Non 01)				
TABLE 6A- SELECTED DIAGNOSES AND SERVICES RENDERED					
Diagnostic Category		Applicable ICD-9-CM Code	Applicable ICD-10-CM Code	Number of Visits by Diagnosis regardless of primacy (A)	Number of Patients with Diagnosis regardless of primacy (B)
13.	Dehydration	276.5x	E86-	30	28
14.	Exposure to heat or cold	991.xx-992.xx	T33.XXXA, T34.XXXA, T67.XXXA, T68.XXXA, T69.XXXA	3	3
14a.	Overweight and obesity	278.00-278.03, V85.xx (excluding V85.0, V85.1, V85.51 and V85.52	E66-, Z68- (Excluding Z68.1, Z68.20- 24, Z68.51, Z68.52	149	107

Selected Childhood Conditions					
15.	Otitis media and Eustachian tube disorders	381.xx-382.xx	H65- thru H69	334	280
16.	Selected perinatal medical conditions	770.xx, 771.xx, 773.xx, 774.xx-779.xx (excluding 779.3x)	A33-, P20- thru P29- (exclude P22.0, P29.3); P35- thru P96- (exclude P50-, P52-, P52-, P54-, P91.6-, P92-, P96,81), R78,81, R78.89	9	7

Figure 5-13: Sample RPMS UDS Report for Table 6A, Page 3

DU	UDS 2015	DEMO INDIAN HOSPITAL	Page 4
UDS No.	000001	Date Run:	Dec 15, 2015
Reporting Period:	Jan 01, 2015 through Dec 31, 2015		
Population:	All (both Indian/Alaskan Natives and Non 01)		
TABLE 6A- SELECTED DIAGNOSES AND SERVICES RENDERED			
Service Category	Applicable ICD-9-CM or CPT-4 code(s)	Number of Visits	Number of patients
		(A)	(B)
TABLE 6A- SELECTED DIAGNOSES AND SERVICES RENDERED			
Diagnostic Category	Applicable ICD-9-CM Code	Applicable ICD-10-CM Code	Number of Visits by Diagnosis regardless of primacy
			(A)
			Number of Patients with Diagnosis regardless of primacy
			(B)
17.	Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive) Nutritional deficiencies in children only. Does not include sexual or mental	260.xx - 269.xx (excluding 268.2), 779.3x, 783.3x - 784.4x	E40-E46, E50- thru E63- (exclude E64-), P92-, R62- (exclude R62.7), R63.2, R63.3
			172
			113

development.					
Selected Mental Health and Substance Abuse Conditions					
18.	Alcohol related disorders	291.xx, 303.xx 305.0x, 357.5x	F10-, G62.1	173	111
19.	Other substance related disorders (excluding tobacco use disorders)	291.xx, 303.xx, 305.0x, 357.5x	F11- thru F19- (Exclude F17-), G62.0, O99.32-	77	50
19a.	Tobacco use disorder	305.1	F17-	88	62
20a.	Depression and other mood disorders	296.xx, 300.4, 301.13, 311.xx	F30- thru F39-	311	195

Figure 5-14: Sample RPMS UDS Report for Table 6A, Page 4

DU	UDS 2015	DEMO INDIAN HOSPITAL	Page 5		
UDS No.	000001	Date Run:	Dec 15, 2015		
Reporting Period:	Jan 01, 2015 through Dec 31, 2015				
Population:	All (both Indian/Alaskan Natives and Non 01)				
TABLE 6A- SELECTED DIAGNOSES AND SERVICES RENDERED					
Diagnostic Category	Applicable ICD-9-CM Code	Applicable ICD-10-CM Code	Number of Visits by Diagnosis regardless of primacy (A)	Number of Patients with Diagnosis regardless of primacy (B)	
20b.	Anxiety disorders including PTSD	300.0x, 300.2x, 300.3, 308.3, 309.81	F40- thru F42-, F43.0, F43.1-	172	110
20c.	Attention deficit and disruptive behavior disorders	312.8x, 312.9x, 313.81, 314.xx	F90- thru F91-	103	64
20d.	Other mental disorders, excluding drug or alcohol dependence	290.xx, 293xx - 302.xx (excl uding 296.xx, 300.0x, 300.2x, 300.3, 300.4, 301.13), 306.xx-	F01- thru F09-, F20- thru F29, F43- thru F48- (exclude F43.1-) F50- thru F59- (exclude F55-),	213	113

319.xx (excluding 307.xx, 308.3, 309.81, 311.xx, 312.8x, 312.9x, 313.81, 314.xx)	F60- thru F99- (exclude F84.2, F90-, F91-, F98-), R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0
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Figure 5-15: Sample RPMS UDS Report for Table 6A, Page 5

DU	UDS 2015	DEMO INDIAN HOSPITAL		Page 6	
UDS No.	000001			Date Run: Dec 15, 2015	
Reporting Period:	Jan 01, 2015 through Dec 31, 2015				
Population:	All (both Indian/Alaskan Natives and Non 01)				
TABLE 6A- SELECTED DIAGNOSES AND SERVICES RENDERED					
	Applicable ICD-9-CM or CPT-4/II code(s)	Applicable ICD-10-CM Code or II Code	Number of Visits	Number of patients	
Diagnostic Category			(A)	(B)	
-----					
Selected Diagnostic Tests/Screening/Preventive Services					
21. HIV test	CPT-4: 86689, 86701-86703, 87390-87391 V Lab: BGP HIV TEST TAX & LOINC taxonomy	CPT-4: 86689, 86701-86703, 87390-87391 V Lab: BGP HIV TEST TAX & LOINC taxonomy	102	102	
21a. Hepatitis B test	CPT-4: 86704, 86706, 86715- 87515 or V Lab: [BUD HEPATITIS B TESTS]	CPT-4: 86704, 86706, 86715- 87515 or V Lab: [BUD HEPATITIS B TESTS]	95	91	
21b. Hepatitis C test	CPT-4: 86603- 86804, 87520- 87522 or V Lab: [BUD HEPATITIS C TESTS]	CPT-4: 86603- 86804, 87520- 87522 or V Lab: [BUD HEPATITIS C TESTS]	84	81	
22. Mammogram	CPT-4: 77052, 77057 ICD-9: V76.11, V76.12 or WH Mammogram Scr WH Mam DX Bilat WH Mam Dx Unilat	CPT-4: 77052, 77057 ICD-10: Z12.31 or WH Proc: WH Mammogram Scr WH Mam DX Bilat WH Mam Dx Unilat	50	50	

23. Pap Test(s)	CPT-4: 88141- 88155, 88164- 88167, 88174- 88175 ICD-9: V72.3, V72.31, V72.32, V76.2 or V Lab: [BGP PAP SMEAR TAX] WH Pap Smear	CPT-4: 88141- 88155, 88164- 88167, 88174- 88175 ICD-10: Z01.41- Z01.42, Z12.4 or V Lab: [BGP PAP SMEAR TAX] or WH Proc: Pap Smear	108	105
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Figure 5-16: Sample RPMS UDS Report for Table 6A, Page 6

DU	UDS 2015	DEMO INDIAN HOSPITAL	Page 7	
UDS No.	000001	Date Run:	Dec 15, 2015	
Reporting Period:	Jan 01, 2015 through Dec 31, 2015			
Population:	All (both Indian/Alaskan Natives and Non 01)			
TABLE 6A- SELECTED DIAGNOSES AND SERVICES RENDERED				
Service Category	Applicable ICD-9-CM or CPT-4/II code(s)	Applicable ICD-10-CM Code or CPT-4/ II Code	Number of Visits (A)	Number of patients (B)
24. Selected Immunizations: Hepatitis A, Hemophilus, Influenza (HIB), Pneumococcal, Diphtheria, Tetanus, Pertussis (DTap) (DTP) (DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatitis B Child	CPT-4: 90633-90634, 90645-90648, 90670, 90696-90702, 90704-90716, 90718-90723, 90743-90744, 90748 CVX Codes: See User Manual	CPT-4: 90633-90634, 90645-90648, 90670, 90696-90702, 90704-90716, 90718-90723, 90743-90744, 90748 CVX Codes: See User Manual	514	475
24a. Seasonal Flu Vaccine	CPT-4: 90654- 90662, 90672- 90673, 90685- 90688 CVX: 15,16,88, 111,135,140,141, 144,149,150,151, 153,155,158,161, 166	CPT-4: 90654- 90662, 90672- 90673, 90685- 90688 CVX: 15,16,88, 111,135,140,141, 144,149,150,151, 153,155,158,161, 166	542	536
25. Contraceptive Management	ICD-9: V25.xx	ICD-10: Z30-	179	132

26.	Health Supervision of infant or child (ages 0 through 11)	CPT-4: 99381-99383, 99391-99393; Clinic codes 24, 57	CPT-4: 99381-99383, 99391-99393; Clinic Codes 24, 57	196	177
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Figure 5-17: Sample RPMS UDS Report for Table 6A, Page 7

DU	UDS 2015	DEMO INDIAN HOSPITAL		Page 8	
UDS No.	000001			Date Run: Dec 15, 2015	
Reporting Period:	Jan 01, 2015 through Dec 31, 2015				
Population:	All (both Indian/Alaskan Natives and Non 01)				
TABLE 6A- SELECTED DIAGNOSES AND SERVICES RENDERED					
		Applicable ICD-9-CM or CPT-4/II code(s)	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits	Number of patients
Service Category				(A)	(B)
26a.	Childhood lead test screening (9 to 72 months)	CPT-4: 83655	CPT-4: 83655	0	0
26b.	Screening, Brief Intervention, and Referral (SBIRT)	CPT-4: 99408-99409 Pat Ed: AOD-INJ	CPT-4: 99408-99409 Pat Ed: AOD-INJ	2	2
26c.	Smoke and tobacco use cessation counseling	CPT-4: 99406 and 99407 HCPCS: S9075 CPT-II: 4000F, 4001F Pat Ed: TO-*, -TO*, *-SHS; ICD-9: 305.1	CPT-4: 99406 and 99407 HCPCS: S9075 CPT-II: 4000F, 4001F Pat Ed: TO-*, -TO*, *-SHS;	518	473
26d.	Comprehensive and intermediate eye exams	CPT-4: 92002, 92004, 92012, 92014	CPT-4: 92002, 92004, 92012, 92014	378	356
Selected Dental Services					
27.	I. Emergency Services	ADA: D9110	ADA: D9110	50	49
28.	II. Oral Exams	ADA: D0120, D0140, D0145, D0150, D0160, D0170, D0171,	ADA: D0120, D0140, D0145, D0150, D0160, D0170, D0171,	1,094	950

D0180	D0180
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Figure 5-18: Sample RPMS UDS Report for Table 6A, Page 8

DU	UDS 2015	DEMO INDIAN HOSPITAL		Page 9	
UDS No.	000001			Date Run: Dec 15, 2015	
Reporting Period:	Jan 01, 2015 through Dec 31, 2015				
Population:	All (both Indian/Alaskan Natives and Non 01)				
TABLE 6A- SELECTED DIAGNOSES AND SERVICES RENDERED					
	Applicable ICD-9-CM or CPT-4/II code(s)	Applicable ICD-10-CM Code or CPT-4/ II Code	Number of Visits (A)	Number of patients (B)	
Service Category					
29. Phophylaxis - adult or child	ADA: D1110, D1120	ADA: D1110, D1120	472	447	
30. Sealants	ADA: D1351	ADA: D1351	96	92	
31. Fluoride treatment- adult or child	ADA: D1206, D1208	ADA: D1206, D1208	572	492	
32. III. Restorative Services	ADA: D21xx- D29xx	ADA: D21xx- D29xx	465	385	
33. IV. Oral Surgery (extractions and other surgical procedures)	ADA: D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, D7260, D7261, D7270, D7272, D7280, D7290- D7294	ADA: D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, D7260, D7261, D7270, D7272, D7280, D7290- D7294	202	191	
34. V. Rehabilitative services (Endo, Perio, Prostho, Ortho)	ADA: D3xxx, D4xxx, D5xxx, D6xxx, D8xxxx	ADA: D3xxx, D4xxx, D5xxx, D6xxx, D8xxx	351	267	

Figure 5-19: Sample RPMS UDS Report for Table 6A, Page 9

### 5.2.6 Table 6B Quality of Care Indicators

Table 6B reports the number of patients with selected quality of care indicators, (prenatal care, childhood immunizations, pap tests, childhood and adolescent weight

assessment and counseling, adult weight screening and follow-up, tobacco use screening and cessation intervention, asthma pharmacologic therapy, coronary artery disease (CAD) and lipid lowering therapy, ischemic Vascular Disease (IVD) and aspirin or other antithrombotic therapy, colorectal cancer screening, HIV linkage to care, depression screening, and dental sealants). These indicators are “process measures” which means that they document services which are thought to be correlated with and serve as a proxy for good long-term health outcomes.

Table 6B gives a good overall description of the overall quality of primary care being provided at the BPHC health center, it is clear that this is a subset of possible quality of care indicators and that individual health centers may be using others in addition to these.

**Note:** Visits with a service category of Historical Event are included in all sections of this table when determining if a patient meets criterion definitions.

#### 5.2.6.1 Logic for Sections A and B: Age Categories for Prenatal Care Patients and Trimester of Entry into Prenatal Care

BPHC UDS Manual states that Section A (Table 6B Lines 1–6) is to include *all* women receiving *any* prenatal care, including the delivery of her child, during the reporting year regardless of when that care was initiated, including women who began prenatal care during the previous reporting period and continued into this reporting period and women who began their care in this reporting period but will not/did not deliver until the following year.<sup>29</sup>

BPHC UDS Manual states Section B (Table 6B Lines 7–9) is to include all women who received prenatal care including but not limited to the delivery of a child during the reporting period. The trimester (line) is determined by the trimester of pregnancy that the woman was in when she began prenatal care either at one of the health center’s service delivery locations or with another provider including a referral provider<sup>30</sup>.

The BPHC UDS Manual defines trimesters as:<sup>31</sup>

- **First Trimester**–Women who received prenatal care during the reporting period and whose first visit occurred when they were estimated to be pregnant anytime through the end of the 13th week after conception.

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<sup>29</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 89.

<sup>30</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 89.

<sup>31</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 90.

- **Second Trimester**–Women who received prenatal care during the reporting period and whose first visit occurred when they were estimated to be between the start of the 14th week and through the 26th week after conception
- **Third Trimester**–Women who received prenatal care during the reporting period and whose first visit occurred when they were estimated to be 27 weeks or more after conception.

**Note:** The sum of the numbers in the six cells of Lines 7 through 9 represents the total number of women who received perinatal care from the health center during the calendar year, reported on Line 6 in Section A.

Because there currently is no reliable, consistent method within RPMS for identifying pregnant patients who are receiving prenatal care at a facility, Sections A and B (Table 6B Lines 1–9) will not be calculated and will be left blank. You can produce a detailed list of patients by age that had pregnancy-related visits during the past 20 months, with at least one pregnancy-related visit during the report period by running list titled “All Pregnant Patients by Age” from the List menu option within the Manager Utilities (MU/LST/LST2/A-D/PRGA) to assist you with calculating the information in these sections.

**Note:** The definition of pregnancy is defined in Section 5.2.7.1.

#### 5.2.6.2 Logic for Section C: Childhood Immunizations

This section (Table 6B Line 10) reports on the number of children with at least one medical visit during the reporting period, who had their third birthday during the reporting period, and who were first seen ever by the health center prior to their third birthday and the number of those children who were fully immunized.

**Note:** Those children whose only service was receipt of a vaccination and who never received other medical services are not to be counted as patients on the demographic tables and are not included in the universe for this table.

A child is fully immunized if he/she has been vaccinated or there is documented evidence of contraindication for the vaccine or a history of illness for *all* of the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1 Varicella, and 4 Pneumococcal conjugates prior to or on his/her third birthday. This includes patients who received the vaccines, had a contraindication to a vaccine(s), and/or had a documented history of the illness(es).

**Note:** Detailed patient lists can be produced from the List menu option within the Manager Utilities for "All Patients Age 3 w/All Child Immunizations" (MU/LST/LST2/A-D/CIM1) and "All Patients Age 3 w/o All Child Immunizations" (MU/LST/LST2/A-D/CIM2) to assist sites with verifying the information reported by RPMS UDS.

Dosage and types of immunization definitions:

- **4 doses of DTP/DTaP:** (1) 4 DTaP/DTP; (2) 1 DTaP/DTP and 3 DT; (3) 1 DTaP/DTP and 3 each of Diphtheria and Tetanus; (4) 4 DT and 4 Pertussis; or (5) 4 each of Diphtheria, Tetanus, and Pertussis. The patient must have received the 4 doses of DTaP on or after 42 days of age and before the child's third birthday.

**Note:** DT vaccine does not contain pertussis and can be used as a substitute for children who cannot tolerate pertussis vaccine.

- **3 doses of IPV:** The three polio vaccinations (IPV) with different dates of service must be received on or after 42 days of age and before the child's third birthday.
- **1 dose of MMR:** (1) MMR; or (2) 1 each of Measles, Mumps, and Rubella. The measles, mumps and rubella (MMR) vaccination must be received on or before the child's third birthday.
- **3 doses of Hib:** The three H influenza type B (HiB) vaccination, with different dates of service must be received on or after 42 days of age and before the child's third birthday.
- **3 doses of Hep B:** The hepatitis B vaccinations, with different dates of service must be received on or before the child's third birthday.
- **1 dose of Varicella:** The chicken pox vaccination with a date of service falling must be received on or after the child's first birthday and on or before the child's third birthday.
- **4 doses of Pneumococcal:** The four pneumococcal conjugate vaccinations must be received on or before child's third birthday.

### Contraindications

To be counted as a contraindication, the patient must not have received an immunization(s) for the contraindicated vaccine. For example, if a patient has a contraindication to Varicella, he/she must not have any Varicella immunizations.

For immunizations where required number of doses is greater than (>) 1, only one contraindication is necessary on or before the patient's third birthday to be counted as receiving all immunization(s) for the contraindicated vaccine. The patient may or may not have previously received an immunization(s) for the contraindicated vaccine. For example, if there is a single contraindication for Hib, the patient will be counted as

receiving the required number of doses for Hib. See Table 5-12 for specific contraindication definitions.

**Note:** Contraindications should be looked for as far back as possible in the patient’s history but prior to the patient’s 3rd birthday

Table 5-12: Table 6B Section C Childhood Immunizations BPHC Contraindications <sup>32</sup>

**Childhood Immunizations, Contraindications Definitions**

Vaccine	Contraindication and BPHC-Specified Applicable ICD-9-CM and ICD-10 CM Code(s)	Other Codes to Check (IHS-Specified Codes)
All Vaccines	Allergic reaction to the vaccine or its components: ICD-9: 999.4; ICD-10: T80.51-	Immunization Package contraindication of “Anaphylaxis” for any of the vaccines listed
DTaP/DTP	Encephalopathy: ICD-9 323.5* AND (E948.4 or E948.5 or E948.6), 323.6x; ICD-10: G04.01, G04.02, G04.32 (use T50.A-, T50.B-, T50.Z- to identify vaccine) or G04.00, G04.01, G04.30, G04.31, G04.39, G05.4	
Varicella and MMR	Immunodeficiency, including genetic (congenital) immunodeficiency syndromes: ICD-9 279.*; ICD-10: D80-, D81- (exclude D81.3, D81.5, D81.81-), D82-, D83-, D84-, D89- (exclude D89.0, D89.1, D89.2) HIV-infected or household contact with HIV infection: ICD-9 V08, 042; ICD-10: B20, Z21 Cancer of lymphoreticular or histiocytic tissue: ICD-9 200.*-202.*; ICD-10: C81-, C83-, C82-, C84.0-, C84.1-, C84.4-, C84.6-, C84.7-, C84.9-, C84.A-, C84.Z-, C85-, C86-, C88.4, C91.4-, C96- (exclude C96.5, C96.6) Multiple myeloma: ICD-9 203.0*, 203.1*, 203.8*; ICD-10: C90-, C88- (exclude C88.0) Leukemia: ICD-9 204.*-208.*; ICD-10: C91- (exclude C91.4-), C92-, C93.0-, C93.1-, C93.3-, C93.Z-, C93.9-, C94- (exclude C94.4-), C95-, D45 Anaphylactic reaction to neomycin, defined as any of the following: 1) ^ entry with causative agent of “Neomycin” and reaction of “Anaphylaxis” or 2)	

<sup>32</sup> BPHC Uniform Data System Manual, 2015 Revision, pp. 96.

Vaccine	Contraindication and BPHC-Specified Applicable ICD-9-CM and ICD-10 CM Code(s)	Other Codes to Check (IHS-Specified Codes)
	Immunization Package contraindication of "Anaphylaxis," "Immune Deficiency," "Immune Deficient," "Immune" or "Neomycin Allergy."	
IPV	Anaphylactic reaction to streptomycin, polymyxin B, or neomycin, defined as any of the following: 1) Adverse Reaction Tracking entry with causative agent of "Streptomycin," "Polymyxin B," or "Neomycin" and reaction of "Anaphylaxis" or 2) Immunization Package contraindication of "Anaphylaxis" "Immune Deficiency," "Immune Deficient," "Immune" or "Streptomycin Allergy," "Polymyxin B Allergy," or "Neomycin Allergy."	
Hib	None	None
Hepatitis B	Anaphylactic reaction to common baker's yeast, defined as any of the following: 1) Adverse Reaction Tracking entry with causative agent of "Baker's Yeast" or "Yeast" and reaction of "Anaphylaxis" or 2) Immunization Package contraindication of "Anaphylaxis." or "Baker's Yeast Allergy," or Yeast Allergy".	
Pneumococcal conjugate	None	None

**5.2.6.3 Total Number of Patients with Third Birthday During Measurement Year, Column (A)**

This column includes children who met all the criteria regardless of whether they came to the clinic specifically for vaccinations or well child care, or they came for an injury or illness, including those children who had a contraindication for a specific vaccine.

**5.2.6.4 Number of Charts Sampled or EHR Total, Column (B)**

This column contains the number of charts to be sampled equaling the total number of patients who fit the criteria. This number reported by RMPS UDS will match the number in Column (A).

**5.2.6.5 Number of Patients Immunized, Column (C)**

This column contains the number of children from column b who have received all of the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1Varicella, and 4 Pneumococcal conjugates prior to or on their third birthday. RPMS UDS counts any

of the following as documenting compliance for a given vaccine: evidence of the antigen, contraindication for the vaccine, documented history of the illnesses, or a seropositive test result. For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), find evidence of all the antigens. See Table 5-13 for the BPHC-defined and IHS-specific codes.

**Note:** Because IZ data comes from multiple sources, any IZ codes documented on dates within 10 days of each other will be considered as the same immunization.

Table 5-13: Table 6B Section C Childhood Immunizations BPHC-Defined<sup>33</sup> and IHS-Specific Codes

**Childhood Immunizations Definitions**

<b>Vaccine</b>	<b>BPHC-Specified Applicable ICD-9-CM, ICD-10 CM, and CPT-4 Code(s)</b>	<b>Other Codes to Check (IHS-Specified Codes)</b>
DTaP/DTP	<b>CPT:</b> 90698, 90700, 90701, 90720, 90721, 90723 <b>ICD-9:</b> 99.39	<b>Immunization (CVX):</b> 1, 20, 22, 50, 102, 106, 107, 110, 120, 130, 132, 146
Diphtheria and Tetanus (DT)	<b>CPT:</b> 90702	<b>Immunization (CVX):</b> 28
Diphtheria	<b>CPT:</b> 90719 <b>ICD-9 Procedure:</b> 99.36 Evidence of disease: POV or PCC Problem List (active or inactive) <b>ICD-9:</b> V02.4, 032; <b>ICD-10:</b> Z22.2, A36-	
Tetanus	<b>CPT:</b> 90703 <b>ICD-9:</b> 99.38 Evidence of disease: POV or PCC Problem List (active or inactive) <b>ICD-9:</b> 037; <b>ICD-10:</b> A35	<b>Immunization (CVX):</b> 35, 112
Pertussis	<b>ICD-9:</b> 99.37 Evidence of disease: POV or PCC Problem List (active or inactive) <b>ICD-9:</b> 033; <b>ICD-10:</b> A37-	<b>Immunization (CVX):</b> 11
IPV	<b>CPT:</b> 90698, 90713, 90723 <b>ICD-9:</b> 99.41 Evidence of disease: POV or PCC Problem List (active or inactive) <b>ICD-9:</b> V12.02, 045; <b>ICD-10:</b> Z86.12, A80-	<b>Immunization (CVX):</b> 2, 10, 89, 110, 120, 130, 132, 146
MMR	<b>CPT:</b> 90707, 90710	<b>Immunization (CVX):</b> 3, 94
Measles and Rubella	<b>CPT:</b> 90708	<b>Immunization (CVX):</b> 4

<sup>33</sup> BPHC Uniform Data System Manual, 2015 Revision, pp. 97-98.

<b>Vaccine</b>	<b>BPHC-Specified Applicable ICD-9-CM, ICD-10 CM, and CPT-4 Code(s)</b>	<b>Other Codes to Check (IHS-Specified Codes)</b>
Measles	<b>CPT:</b> 90705 <b>ICD-9:</b> 99.45 Evidence of disease: POV or PCC Problem List (active or inactive) <b>ICD-9:</b> 055; <b>ICD-10:</b> B05-	<b>Immunization (CVX):</b> 5
Mumps	<b>CPT:</b> 90704 <b>ICD-9:</b> 99.46 Evidence of disease: POV or PCC Problem List (active or inactive) <b>ICD-9:</b> 072; <b>ICD-10:</b> B26-	<b>Immunization (CVX):</b> 7
Rubella	<b>CPT:</b> 90706 <b>ICD-9:</b> 99.47 Evidence of disease: POV or PCC Problem List (active or inactive) <b>ICD-9:</b> 056; <b>ICD-10:</b> B06-	<b>Immunization (CVX):</b> 6
Hib	<b>CPT:</b> 90645, 90646, 90647, 90648, 90698, 90720, 90721, 90737, 90748 Evidence of disease: POV or PCC Problem List (active or inactive) <b>ICD-9:</b> 038.41, 041.5, 320.0, 482.2; <b>ICD-10:</b> B96.3, A41.3, G00.0, J14	<b>Immunization (CVX):</b> 17, 22, 46-49, 50-51, 102, 120, 132, 146
Hepatitis B	<b>CPT:</b> 90723, 90731, 90740, 90744, 90745, 90747, 90748 Evidence of disease: POV or PCC Problem List (active or inactive) <b>ICD-9:</b> VO2.61, 070.2, 070.3; <b>ICD-10:</b> B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51	<b>Immunization (CVX):</b> 8, 42- 45, 51, 102, 104, 110, 132, 146
Varicella	<b>CPT:</b> 90396, 90710, 90716 Evidence of disease: POV or Problem List (active or inactive) <b>ICD-9:</b> 052, 053; <b>ICD-10:</b> B01-, B02-	<b>Immunization (CVX):</b> 21, 94
Pneumococcal Conjugate	<b>CPT:</b> 90669,90670	<b>Immunization (CVX):</b> 33, 100, 109, 133

5.2.6.6 Logic for Section D: Cervical Cancer Screening

This section (Table 6B Line 11) reports on the number of women 24–64 years of age who have not had a hysterectomy and who have a cervix and the number of those women who received one or more documented Pap tests during the report period or during the two calendar years prior to the report period or the four years prior to the report period for women age 30-64 at the time of the test when an HPV test is accompanied with the pap test and who had at least one medical visit during the reporting year. Because of the difficulty in obtaining records from third parties, it is

likely that a number of women will not be able to be counted as compliant, even though the health center has referred the patient for services<sup>34</sup>.

**Note:** Detailed patient lists can be produced for “All Female Patients w/Pap Test” (MU/LST/LST2/A-D/PAP1) and “All Female Patients w/o Pap Test” (MU/LST/LST2/A-D/PAP2) to assist sites with verifying the information reported by RPMS UDS.

**Total Number of Female Patients 24–64 Years of Age, Column (A)**

This column includes all females who are 24–64 years old, were first seen by the health center prior to their 65<sup>th</sup> birthday and had at least one medical visit during the reporting period. Women who have had a hysterectomy and who have no residual cervix and for whom the administrative data does not indicate a Pap test was performed are *excluded* from the count.

**Exclusions**

Women who have had a hysterectomy and who have no residual cervix and for whom the administrative data does not indicate a Pap test was performed. Look for evidence of a hysterectomy as far back as possible in the patient's history, through either administrative data or medical record review. See Table 5-14 for specific Hysterectomy definitions.

**Note:** Because very few health centers perform hysterectomies the chance of finding these CPT codes is small. The record may, however, contain textual reference to the procedure, and should be searched for this in the event no current Pap test is identified.

Table 5-14: Table 6B Section D Pap Test Exclusion BPHC-defined<sup>35</sup> and IHS-specific Codes

**Pap Test Exclusion Definitions**

BPHC-Specified Applicable ICD-9-CM ICD-10 CM, and CPT-4 Code(S)	Other Codes to Check (IHS-Specified Codes)
CPT: 51925, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550, 58552-58554, 58570-58573, 58951, 58953,	<b>Women’s Health:</b> Any procedure called Hysterectomy

<sup>34</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 100.

<sup>35</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 99.

BPHC-Specified Applicable ICD-9-CM ICD-10 CM, and CPT-4 Code(S)	Other Codes to Check (IHS-Specified Codes)
58954, 58956, 59135 ICD-9: 68.4-68.8, 618.5 ICD-10: N99.3	

**Number of Charts Sampled or EHR Total, Column (B)**

This column contains the number of charts to be sampled equaling the total number of patients who fit the criteria. Women who have met the exclusion criteria will not be included in the count for this column. The number reported by RMPS UDS will match the number in Column (A).

**Number of Patients Tested, Column (C)**

This column contains the number of female patients who received one or more Pap tests and met all of the criteria in a 3-year period from 2013 through 2015 or received one or more Pap tests in a five year period from 2011 through 2015 and was 30 years of age or older at the time of her last Pap test and chose to have a Pap test and an HPV test done simultaneously. Documentation in the medical record must include a note indicating the date the test was performed and the result of the finding. The Pap test may have been performed at the reporting or another facility. Patients whose charts note a referral to a third party but which do not include a copy of the laboratory report or a report of some form from the clinician/clinic that provided the test, or unsubstantiated statements from patients which cannot be backed up with documentation are not included in the count.<sup>36</sup> See Table 5-15 for specific Pap test definitions.

Table 5-15: Table 6B Section D Pap Test BPHC-Defined<sup>37</sup> and IHS-Specific Codes

**Pap Test Definitions**

BPHC-Specified Applicable ICD-9-CM, ICD-10 CM, and CPT-4 Code(s)	Other Codes to Check (IHS-Specified Codes)
CPT: 88141-88155, 88164-88167, 88174-88175. 3015F ICD-9: 91.46, V72.32 ICD-10: Z01.42	<b>V Lab:</b> Any lab test of PAP SMEAR, site-defined taxonomy BGP PAP SMEAR TAX, LOINC taxonomy BGP PAP LOINC CODES <b>CPT:</b> G0101, G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091 <b>Women’s Health:</b> Any procedure called PAP SMEAR

<sup>36</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 100.

<sup>37</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 100.

Table 5-16: Table 6B Section D HPV Test IHS-Specific Codes

**HPV Test Definitions**

Applicable ICD-9-CM, ICD-10 CM, and CPT-4 Code(s)	Other Codes to Check (IHS-Specified Codes)
CPT: 87620-87622	<b>V Lab:</b> Any lab test of HPV, site-defined taxonomy BGP HPV TAX <b>LOINC:</b> 30167-1, 59420-0, 61372-9, 61373-7 <b>ICD-9:</b> 079.4, 795.05, 795.09, 795.15, 795.19, 796.75, 796.79, V73.81

5.2.6.7 Logic for Section E: Weight Assessment and Counseling for Children and Adolescents

This section (Table 6B Line 12) reports on the number of patients 3–17 years of age with a documented BMI percentile, counseling for nutrition, and counseling for physical activity during report period. **All the elements must be documented in the report year.**

**Note:** Detailed patient lists can be produced for "All Patients 2-17 w/WT Assessment & Counseling" (MU/LST/LST2/E-I/WAC1) and "All Patients 2-17 w/o WT Assessment & Counseling" (MU/LST/LST2/E-I/WAC2) to assist sites with verifying the information reported by RPMS UDS.

**Total Patients Aged 3-17 on December 31, Column (A)**

This column includes all patients who were born between January 1, 1998 and December 31, 2012, were first seen by the health center prior to their 18<sup>th</sup> birthday and had at least one medical visit during the reporting period.

**Note:** Denominator includes patients whose only visits were well child visits (99382-99384, 99392-99394)<sup>38</sup>.

**Exclusions**

Pregnant patients.

**Charts Sampled or EHR Total, Column (B)**

This column contains the number of charts to be sampled equaling the total number of patients who fit the criteria. Patients who have met the exclusion criteria will not be included in the count for this column. The number reported by RPMS UDS will match the number in Column (A).

<sup>38</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 101.

**Number of Patients with Counseling and BMI Documented, Column (C)**

This column contains the number of patients who had a documented Body Mass Index (BMI) percentile documented, a documented counseling for nutrition, and a documented counseling for physical activity during the report period.

**Note:** The BMI is an actual percentile recorded; not just a BMI or Height + Weight. See Table 5-17 through Table 5-19 for specific definitions.

Table 5-17: Table 6B Section E BMI BPHC-Defined<sup>39</sup>

**BMI Definitions**

BPHC-Specified Applicable ICD-9-CM Code(s)
<b>ICD-9:</b> V85.5x (V85.51, V85.52, V85.53, V85.54)
<b>ICD-10:</b> Z68.5-

Table 5-18: Table 6B Section E Counseling for Nutrition BPHC-Defined<sup>40</sup> and IHS-Specific Codes

**Counseling for Nutrition Definitions**

BPHC-Specified Applicable CPT-4 Code(s)	Other Codes to Check (IHS-Specified Codes)
<b>CPT:</b> 97802-97804	<b>Patient Education:</b> Codes ending "-N" (Nutrition) or "-MNT" (or old code "-DT" (Diet)) or containing 97802-97804

Table 5-19: Table 6B Section E Counseling for Nutrition BPHC-Defined<sup>41</sup> and IHS-Specific Codes

**Counseling for Physical Activity Definitions**

BPHC-Specified Applicable ICD-9-CM and ICD-10 CM Code(s)	Other Codes to Check (IHS-Specified Codes)
<b>ICD-9:</b> V65.41 <b>ICD-10:</b> Z71.89	<b>Patient Education:</b> Codes ending "-EX" (Exercise) or containing V65.41 or Z71.89

5.2.6.8 Logic for Section F: Adult Weight Screening and Follow-up

This section (Table 6B Line 13) reports on the number of patients 18 years of age or older with a documented BMI percentile on the last visit during the report period or on any visit within the last six months prior to last visit during the report period, and if they were overweight or underweight (BMI is outside of normal parameters), patient had a follow-up plan documented.

<sup>39</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 102.

<sup>40</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 102.

<sup>41</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 102.

**Note:** Detailed patient lists can be produced for “All Patients 18+ w/BMI & over/underweight w/plan” (MU/LST/LST2/E-I/AWS1) and “All Patients 18+ w/o BMI or w/o follow-up plan” (MU/LST/LST2/E-I/AWS2) to assist sites with verifying the information reported by RPMS UDS.

**Total Number of Patients Age 18 and Over, Column (A)**

This column includes all patients who were age 18 and older as of December 31 of the report period, were last seen after their 18<sup>th</sup> birthday and had at least one medical visit during the reporting period in a medical setting which had equipment present to measure height and weight.

**Exclusions**

Pregnant or terminally ill patients. Terminal illness must be documented on or within six months prior to the last visit during the report period with ICD-9 code V66.7.

**Charts Sampled or EHR Total, Column (B)**

This column contains the number of charts to be sampled equaling the total number of patients who fit the criteria. Patients who have met the exclusion criteria will not be included in the count for this column. The number reported by RMPS UDS will match the number in Column (A).

**Number of Patients with BMI Charted and Follow-Up Plan Documented As Appropriate, Column (C)**

This column contains the number of patients who had a documented Body Mass Index (BMI) percentile documented on the last visit during the report period or on any visit within the last six months of the last visit during the report period, and had a follow-up plan documented if the patient was overweight or underweight.

**Note:** The BMI is an actual percentile recorded; not just a BMI or Height + Weight. See Table 5-20 and Table 5-21 for specific definitions.

Table 5-20: Table 6B Section F BPHC-Defined<sup>42</sup> Overweight/Underweight

**Overweight/Underweight Definitions**

	Age 18-64	Age 65+
<b>Overweight</b>	BMI =>25	BMI =>30
<b>Underweight</b>	BMI < 18.5	BMI <23

<sup>42</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 103.

Table 5-21: Table 6B Section F Follow-Up Plan for Overweight/Underweight IHS-Specific Codes

**Counseling for Nutrition Definitions**

<b>Other Codes to Check (IHS-Specified Codes)</b>
<p><b>CPT:</b> 97802-97804, G0270, G0271</p> <p><b>ICD-9:</b> V65.3, V65.41, 278.00, 278.01</p> <p><b>ICD-10:</b> Z71.3</p> <p><b>HCPCS:</b> G8417, G8418, S9449, S9451, S9452, S9470</p> <p><b>Patient Education:</b> Codes ending "-EX" (Exercise), "-LA" (lifestyle adaptation), "-N" (Nutrition) or "-MNT" (or old code "-DT" (Diet)), or containing "OBS-" (obesity), or containing V65.3, V65.41, 278.00, 278.01, or Z71.3</p> <p><b>Provider Codes:</b> Primary or Secondary codes 07, 29</p> <p><b>Clinic Codes:</b> 67 (dietary) or 36 (WIC)</p>

5.2.6.9 Logic for Section G: Tobacco Use Screening and Cessation Intervention

This section (Table 6B Line 14a) reports on the number of patients 18 years of age or older who were screened for tobacco use at least once during the measurement year or prior year AND who received cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user.

**Note:** Detailed patient lists can be produced for “All Patients 18+ w/tobacco use scrn & cessation” (MU/LST/LST2/E-I/TUA1) and “All Patients 18+ w/o tobacco use scrn or cessation” (MU/LST/LST2/E-I/TUA2) to assist sites with verifying the information reported by RPMS UDS.

**Total Patients Age 18 and Over, Column (A)**

This column includes all patients who were age 18 and older as of December 31 of the report period, were ever seen after their 18<sup>th</sup> birthday, and had at least one medical visit during the reporting period and at least two medical visits ever.

**Charts Sampled or EHR Total, Column (B)**

This column contains the number of charts to be sampled equaling the total number of patients who fit the criteria. The number reported by RMPS UDS will match the number in Column (A).

**Number of Patients Assessed for Tobacco Use and Provided Intervention if a Tobacco User, Column (C)**

This column contains the number of patients who were queried about their tobacco use one or more times during their most recent visit OR within 24 months of the most

recent visit and received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user.

- Tobacco Use Assessment requires documentation that provider or support staff asked patient if they used tobacco and the patient’s response. See tables for specific definitions.
- Tobacco user is defined by any of the codes shown in the table below documented during the report period or within 24 months of the most recent visit during the report period. See tables for specific definitions.
- Tobacco Cessation Intervention requires documentation that the patient identified as a tobacco user received tobacco use cessation services, or received and order for (a prescription or a recommendation to purchase) a smoking cessation medication; this medication may be a prescription or an Over the Counter (OTC) product, or were found to be on (using) a smoking cessation agent. See tables for specific definitions.

Table 5-22: Table 6B Section G Tobacco Use Assessment BPHC-Defined<sup>43</sup> and IHS-Specific Codes

**Tobacco Use Assessment Definitions**

<b>BPHC-Specified Applicable ICD-9-CM Code(s), ICD-10 code(s), and CPT-4 Code(s)</b>	<b>Other Codes to Check (IHS-Specified Codes)</b>
<p><b>CPT:</b> 1000F, 1034F, 1035F, 1036F, 99406-99407  <b>ICD-9:</b> 305.1, 649.00-649.04  <b>ICD-10:</b> F17-, O99.33</p>	<p><b>Health Factors:</b> TOBACCO (SMOKING) and TOBACCO (SMOKELESS – CHEWING/DIP) categories: Current Smokeless, Cessation-Smoker, Cessation-Smokeless, Current Smoker, status unknown, Current smoker, every day, or Current smoker, some day, documented during Report period  <b>Patient Education:</b> Codes containing "TO-", "-TO", "-SHS", 305.1, 649.00-649.04, V15.82, 1000F, 1034F, 1035F, 1036F, F17-, O99.33</p>

Table 5-23: Table 6B Section G Tobacco Users BPHC-Defined<sup>44</sup> and IHS-Specific Codes

**Tobacco Users Definitions**

<b>BPHC-Specified Applicable ICD-9-CM Code(s), ICD-10 code(s), and CPT-4 Code(s)</b>	<b>Other Codes to Check (IHS-Specified Codes)</b>
<p><b>CPT:</b> 1034F, 1035F  <b>ICD-9:</b> 305.1, 649.00-649.04  <b>ICD-10:</b> F17-, O99.33</p>	<p><b>Health Factors:</b> TOBACCO (SMOKING) and TOBACCO (SMOKELESS – CHEWING/DIP) categories: Current Smokeless, Cessation-Smoker, Cessation-Smokeless, Current Smoker, status unknown, Current smoker, every day, or Current smoker, some day</p>

<sup>43</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 105.

<sup>44</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 105.

Table 5-24: Table 6B Section G Tobacco Cessation Intervention BPHC-Defined<sup>45</sup> and IHS-Specific Codes

**Tobacco Cessation Intervention Definitions**

<b>BPHC-Specified Applicable CPT-4 Code(s), ICD-10 code(s), and Tobacco Cessation Prescription</b>	<b>Other Codes to Check (IHS-Specified Codes)</b>
<p><b>CPT:</b> 99406, 99407, 4000F, 4001F  <b>Tobacco Cessation Prescription:</b>                      Documented prescription for a smoking cessation medication (this may be an actual prescription or recommendation of an Over-The-Counter cessation medication) or been on or currently using a smoking cessation agent/medication during the report period or prior year.</p>	<p><b>Patient Education:</b> Codes containing "TO-", "-TO", "-SHS", 99406, 99407, 4000F, 4001F</p>

5.2.6.10 Logic for Section H: Asthma Pharmacological Therapy

This section (Table 6B Line 16) reports on the number of patients 5-40 years of age with a diagnosis of mild, moderate, or severe persistent asthma (either mild, moderate, or severe) who were prescribed accepted pharmacologic therapy during the report period.

**Note:** Detailed patient lists can be produced for “All Asthma Pts 5-40 w/Asthma Therapy Medication” (MU/LST/LST2/E-I/APT1) and “All Asthma Pts 5-40 w/o Asthma Therapy Medication” (MU/LST/LST2/E-I/APT2) to assist sites with verifying the information reported by RPMS UDS.

**Total Patients Aged 5-40 with Persistent Asthma, Column (A)**

This column includes all patients who were age 5-40 as of December 31 of the report period, were last seen while they were between 5 and 40 years of age, were diagnosed with persistent asthma or have persistent asthma as a current diagnosis, and had at least one medical visit during the reporting period and at least two medical visits ever. See Table 5-25 for persistent asthma definition.

**Exclusions**

The following patients will be excluded from the denominator:

- Patients with an allergic reaction to asthma medications.

<sup>45</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 105.

- Patients with a diagnosis of asthma who are discovered, upon review, to have intermittent mild asthma (1039F), or intermittent asthma (ICD-10: J45.2x), not persistent asthma.
- Patients who are receiving a form of treatment other than pharmacologic treatment or whose only pharmacologic treatment is a short-acting bronchodilator for symptomatic relief.

Table 5-25: Table 6B Section H Persistent Asthma BPHC-Defined<sup>46</sup> Codes

**Persistent Asthma Definitions**

<b>BPHC-Specified Applicable ICD-9-CM Code(s), ICD-10 Code(s), and CPT-4 Code(s)</b>
<b>CPT:</b> 1038F, 4015F
<b>ICD-9:</b> 493.x
<b>ICD-10:</b> J45.x (excluding J45.2x) , J45.3x, J45.4x, J45.5x, J45.9x

**Charts Sampled or EHR Total, Column (B)**

This column contains the number of charts to be sampled equaling the total number of patients who fit the criteria. The number reported by RMPS UDS will match the number in Column (A).

**Number of Patients with Acceptable Plan, Column (C)**

This column contains the number of patients who received a prescription for or were provided inhaled corticosteroid accepted alternative pharmacologic agent (inhaled steroid combinations, anti-asthmatic combinations, antibody inhibitor, leukotriene modifiers, mast cell stabilizers, or methylxanthines) during the report period.

**Note:** Requires documentation that medication was prescribed or dispensed.

**Preferred Long-Term Control Medication:** Preferred Long-Term Control Medication is defined as a non-discontinued prescribed inhaled corticosteroid and must have an Inhaled Corticosteroid.

**Inhaled Corticosteroid:** Inhaled Corticosteroid is defined in the medication taxonomy BGP PQA CONTROLLER MEDS. (Medications are: Beclomethasone, Budesonide, Budesonide-Formoterol, Ciclesonide, Flunisolide, Fluticasone, Fluticasone-Salmeterol, Formoterol, Mometasone, Mometasone-Formoterol, Salmeterol, Triamcinolone). Medications must not have a comment of RETURNED TO STOCK.

**Acceptable Alternative Pharmacologic Therapy:** Acceptable Alternative Pharmacologic Therapy is defined in the medication taxonomies BGP PQA

<sup>46</sup> BPHC Uniform Data System Manual, 2015 Revision, pp. 106-107.

CONTROLLER MEDS Medications. (Medications are: Cromolyn, Leukotriene Modifier (Zafirlukast, Zileuton, Montelukast), Nedocromil, Theophylline).

5.2.6.11 Logic for Section I: CAD: Drug Therapy for Lowering LDL Cholesterol (Lipid Therapy)

This section (Table 6B Line 17) reports on the number of patients 18 years of age or older who with a diagnosis of CAD prescribed a lipid lowering therapy (based on current ACC/AHA guidelines) during the report period.

**Note:** Detailed patient lists can be produced for “All CAD patients 18+ w/Lipid Therapy” (MU/LST/LST2/E-I/CAD1) and “All CAD patients 18+ w/o Lipid Therapy” (MU/LST/LST2/E-I/CAD2) to assist sites with verifying the information reported by RPMS UDS.

**Total Patients with Coronary Artery Disease Diagnosis, Column (A)**

This column includes all patients who were age 18 and older as of December 31 of the report period with an active diagnosis (active problem list, or visit diagnosis within report year) of CAD including MI or have had cardiac surgery, and who had at least one medical visit during the reporting year, and were seen after their 18th birthday, and with at least two medical visits ever. See Table 5-26 for coronary artery disease definition.

**Exclusions**

The following patients will be excluded from the denominator:

- Patients with an allergic reaction to lipid-lowering therapy medications.
- Patients with an adverse reaction to lipid-lowering therapy medications.
- Patients whose last LDL lab test was less than 130 mg/dL within one year of last report year visit.

Table 5-26: Table 6B Section I Coronary Artery Disease BPHC-Defined<sup>47</sup> Codes

**Coronary Artery Disease Definitions**

<b>BPHC-Specified Applicable ICD-9 and ICD-10 codes</b>
<b>ICD-9:</b> 410.xx, 411.xx, 412.xx, 413.xx, 414.0x, 414.8, 414.9
<b>ICD-10:</b> I20-, I21- thru I24-, I25- (excludes I20.0, I25.3, I25.4-, I25.82, I25.83, I25.84)

<sup>47</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 108.

Table 5-27: Table 6B Section I Cardiac Surgery BPHC-Defined<sup>48</sup> and IHS Specific Codes

**Cardiac Surgery Definitions**

<b>BPHC-Specified Applicable ICD-9 CM, ICD-10 CM, and CPT codes</b>	<b>Other Codes to Check (IHS-Specified Codes)</b>
<p><b>CPT:</b> 33140, 33510-33514, 33516-33519, 33521-33536, 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980, 92981, 92982, 92984, 92995, 92996</p> <p><b>ICD-9:</b> V45.81, V45.82</p> <p><b>ICD-10:</b> Z95.1, Z98.61</p>	<p><b>CPT:</b> G0290, S2205-S2209</p> <p><b>V Procedure:</b> 00.66, 36.01, 36.02, 36.05, 36.06, 36.07, 36.1*, 36.2*</p>

**Charts Sampled or EHR Total, Column (B)**

This column contains the number of charts to be sampled equaling the total number of patients who fit the criteria. The number reported by RMPS UDS will match the number in Column (A).

**Number of Patients with Prescribed Lipid Lowering Therapy, Column (C)**

This column contains the number of patients who were prescribed a lipid-lowering therapy medication or have documented evidence of use by patient of lipid lowering medication during the report period.

**Note:** Requires documentation that medication was prescribed or dispensed. Patients who are receiving a form of treatment other than pharmacologic treatment or are involved in therapeutic lifestyle changes and/or control of non-lipid risk factors without concomitant pharmaceutical treatment are not included.

**Lipid Lowering Medication:** Lipid Lowering is defined in the medication taxonomy BUD LIPID LOWERING MEDS. (Gemfibrozil and Simvastatin)

5.2.6.12 Logic for Section J: IVD: Use of Aspirin or another Antithrombotic Therapy

This section (Table 6B Line 18) reports on the number of patients 18 years of age and older who were discharged alive for AMI, CABG, or PTCA in the prior year, or who had a diagnosis of IVD during the report period and who had documentation of use of aspirin or another antithrombotic during the report period.

<sup>48</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 108.

**Note:** Detailed patient lists can be produced for "All IVD Pts 18+ w/ASA or Antithrombotic" (MU/LST/LST2/J-N/IVD1) and "All IVD Pts 18+ w/o ASA or Antithrombotic" (MU/LST/LST2/J-N/IVD2) to assist sites with verifying the information reported by RPMS UDS.

**Total Patients with Ischemic Vascular Disease Diagnosis, Column (A)**

This column includes all patients who were age 18 and older as of December 31 of the report period who, in the current or prior report year were diagnosed with IVD or discharged after AMI, or CABG or PTCA between January 1 and November 1 of the year prior to the report period, and who had at least one medical visit during the reporting year. See Table 5-28 for ischemic vascular disease definition.

Table 5-28: Table 6B Section J Ischemic Vascular Disease BPHC-Defined<sup>49</sup> Codes

**Ischemic Vascular Disease Definitions**

BPHC-Specified Applicable ICD-9 codes
<p><b>ICD-9:</b> 411.xx, 413.xx, 414.0x, 414.8, 414.9, 429.2, 433.0, 433.01, 433.10, 433.11, 433.20, 433.21, 433.30, 433.31, 433.80, 433.81, 433.90, 433.91, 434, 434.01, 434.10, 434.11, 434.90, 434.91, 440.1, 440.20, 440.21, 440.22, 440.23, 440.24, 440.29, 440.4, 444.0, 444.1, 444.21, 444.22, 444.81, 444.89, 444.9, 445.01, 445.02, 445.8, 445.81, V45.81, V45.82</p> <p><b>ICD-10:</b> I20-, I21-, I24-, I25-, I63- thru I63.2-, I63-, I65-, I66-, I70.1, I70.20-, I70.21-, I70.22-, I70.23-, I70.24-, I70.25, I70.26-, I70.29-, I70.92, I74-, I75-, Z95.1, Z98.61 (excluding I25.4-, I25.82, I25.83, I25.84)</p>

Table 5-29: Table 6B Section J Cardiac Surgery BPHC-Defined<sup>50</sup> and IHS Specific Codes

**Cardiac Surgery Definitions**

BPHC-Specified Applicable ICD-9 CM, ICD-10 CM, and CPT codes	Other Codes to Check (IHS-Specified Codes)
<p><b>CPT:</b> 33510-33514, 33516-33519, 33521-33523, 33533-33536, 92920, 92924, 92928, 92933, 92937, 92941, 92943</p>	<p><b>CPT:</b> 92980, 92981, 92982, 92984, 92995, 92996, G0290, S2205-S2209</p> <p><b>V Procedure:</b> 00.66, 36.01, 36.02, 36.05, 36.06, 36.07, 36.1*, 36.2*</p>

**Charts Sampled or EHR Total, Column (B)**

This column contains the number of charts to be sampled equaling the total number of patients who fit the criteria. The number reported by RMPS UDS will match the number in Column (A).

<sup>49</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 109.

<sup>50</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 109.

### Number of Patients with Aspirin or Other Antithrombotic Therapy, Column (C)

This column contains the number of patients who were prescribed or dispensed aspirin or another antithrombotic medication or have documented evidence of use by patient of aspirin or another antithrombotic medication during the report period.

**Aspirin Medication:** Aspirin is defined in the medication taxonomy DM AUDIT ASPIRIN DRUGS. (Aspirin)

**Antithrombotic Medication:** Antithrombotic medication is defined in the medication taxonomy BUD ANTIPLATELET MEDS.

#### 5.2.6.13 Logic for Section K: Colorectal Cancer Screening

This section (Table 6B Line 19) reports on the number of patients who are 51 to 74 years of age in the report year not diagnosed with colorectal cancer, who had an appropriate screening for colorectal cancer, which includes colonoscopy  $\leq$  10 years (includes the report year), flexible sigmoidoscopy  $\leq$  6 years (includes the report year), or annual fecal occult blood test (including fecal immunochemical test) during the report period.

**Note:** Detailed patient lists can be produced for “All Patients 51-74 years of age w/CRC Scrn” (MU/LST/LST2/J-N/CRC1) and “All Patients 51-74 years of age w/CRC Scrn” (MU/LST/LST2/J-N/CRC2) to assist sites with verifying the information reported by RPMS UDS.

### Total Patients without Colorectal Cancer, Column (A)

This column includes all patients who were age 51-74 as of December 31 of the report period and had at least one medical visit during the reporting year.

**Note:** Though age 50 to 75 is in the title of this measure, the detail calls for persons to be screened within a year of turning 50 and prior to reaching age 75.

### Exclusions

The following patients will be excluded from the denominator:

- Patients who have or who have had colorectal cancer or colectomy as defined in Table 5-30.

Table 5-30: Table 6B Section K Colorectal Cancer Diagnosis Codes

**Colorectal Cancer Definitions**

Applicable ICD-9, ICD-10, procedure, and CPT-4 codes
<b>ICD-9:</b> 45.8*, 153.*, 154.0, 154.1, 197.5
<b>Procedure:</b> V10.05
<b>ICD-10:</b> C18.*, C19, C20, C78.5, Z85.030, Z85.038, 0DTE*ZZ
<b>CPT:</b> 44150-44153, 44155-44158, 44210-44212, G0213-G0215, G0231

**Charts Sampled or EHR Total, Column (B)**

This column contains the number of charts to be sampled equaling the total number of patients who fit the criteria. The number reported by RMPS UDS will match the number in Column (A).

**Number of Patients with Colorectal Cancer Screen, Column (C)**

This column contains the number of patients who had an appropriate screening for colorectal cancer, which includes colonoscopy ≤ 10 years (includes the report year), flexible sigmoidoscopy ≤ 6 years (includes the report year), or annual fecal occult blood test (including fecal immunochemical test) during the report period.

**Colposcopy:** Colonoscopy is defined by any of the codes shown in Table 5-31 within 10 years of last visit during the report year.

Table 5-31: Table 6B Section K Colonoscopy Codes BPHC-Defined<sup>51</sup> Specific Codes

**Colonoscopy Definitions**

<b>BPHC-Specified Applicable ICD-9 CM, ICD-10 CM, and CPT codes</b>	<b>Other Codes to Check (IHS-Specified Codes)</b>
<p><b>ICD-9:</b> 45.22, 45.23, 45.25, 45.42, 45.43  <b>Procedure:</b> V76.51  <b>ICD-10:</b> Z12.11  <b>CPT:</b> 44388-44397, 45355-45392, 3017F</p>	<p><b>CPT:</b> G0105, G0121, G9252, G9253  <b>ICD-10:</b> 0D5E4ZZ, 0D5E8ZZ, 0D5F4ZZ, 0D5F8ZZ, 0D5G4ZZ, 0D5G8ZZ, 0D5H4ZZ, 0D5H8ZZ, 0D5K4ZZ, 0D5K8ZZ, 0D5L4ZZ, 0D5L8ZZ, 0D5M4ZZ, 0D5M8ZZ, 0D5N4ZZ, 0D5N8ZZ, 0D9E3ZX, 0D9E4ZX, 0D9E7ZX, 0D9E8ZX, 0D9F3ZX, 0D9F4ZX, 0D9F7ZX, 0D9F8ZX, 0D9G3ZX, 0D9G4ZX, 0D9G7ZX, 0D9G8ZX, 0D9H3ZX, 0D9H4ZX, 0D9H7ZX, 0D9H8ZX, 0D9K3ZX, 0D9K4ZX, 0D9K7ZX, 0D9K8ZX, 0D9L3ZX, 0D9L4ZX, 0D9L7ZX, 0D9L8ZX, 0D9M3ZX, 0D9M4ZX, 0D9M7ZX, 0D9M8ZX, 0D9N3ZX, 0D9N4ZX, 0D9N7ZX, 0D9N8ZX, 0DBE3ZX, 0DBE4ZX, 0DBE7ZX, 0DBE8ZX, 0DBE8ZZ, 0DBF3ZX, 0DBF4ZX, 0DBF7ZX, 0DBF8ZX, 0DBF8ZZ, 0DBG3ZX, 0DBG4ZX, 0DBG7ZX, 0DBG8ZX, 0DBG8ZZ, 0DBH3ZX, 0DBH4ZX, 0DBH7ZX, 0DBH8ZX, 0DBH8ZZ, 0DBK3ZX, 0DBK4ZX, 0DBK7ZX, 0DBK8ZX, 0DBK8ZZ, 0DBL3ZX, 0DBL4ZX, 0DBL7ZX, 0DBL8ZX, 0DBL8ZZ, 0DBM3ZX, 0DBM4ZX, 0DBM7ZX, 0DBM8ZX, 0DBM8ZZ, 0DBN3ZX, 0DBN4ZX, 0DBN7ZX, 0DBN8ZX, 0DBN8ZZ, 0DJD8ZZ</p>

**Flexible Sigmoidoscopy:** Flexible Sigmoidoscopy is defined by any of the codes shown in Table 5-32 within six years of last visit during the report year.

<sup>51</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 111.

Table 5-32: Table 6B Section K Flexible Sigmoidoscopy BPHC-Defined<sup>52</sup> Specific Codes

**Flexible Sigmoidoscopy Definitions**

BPHC-Specified Applicable ICD-9 CM, ICD-10 CM, and CPT codes	Other Codes to Check (IHS-Specified Codes)
ICD-9: 45.24 CPT: 45330-45345	ICD-10: 0DJD8ZZ CPT: G0104

**Fecal Occult Blood Test:** Fecal Occult Blood Test (includes Fecal Immunochemical Test) is defined by any of the codes shown in Table 5-33 during the report year.

Table 5-33: Table 6B Section K Fecal Occult Blood Test BPHC-Defined<sup>53</sup> Specific Codes

**Fecal Occult Blood Test Definitions**

BPHC-Specified Applicable ICD-9 CM, ICD-10 CM, and CPT codes	Other Codes to Check (IHS-Specified Codes)
CPT: 82270, 82274	CPT: 89205, G0107, G0328, G0394, V Lab: Any lab test of FOB, site-defined taxonomy BGP GPRA FOB TESTS

5.2.6.14 Logic for Section L: HIV Linkage to Care

This section (Table 6B Line 20) reports on the number of patients whose first ever HIV diagnosis occurred between October 1 of the prior year and September 30 of the report year and were seen for a follow up within 90 days of that first ever diagnosis.

**Note:** Detailed patient lists can be produced for “All Patients w/First HIV Dx & Timely Follow-up” (MU/LST/LST2/J-N/HIV1) and “All Patients w/First HIV Dx w/o Timely Follow-up” (MU/LST/LST2/J-N/HIV2) to assist sites with verifying the information reported by RPMS UDS.

**Total Patients First Diagnosed with HIV, Column (A)**

This column includes all patients who diagnosed for the first time ever with HIV between October 1, 2014, and September 30, 2015 and had at least one medical visit during 2015 or 2014. Patients with an HIV are defined in Table 5-34.

<sup>52</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 111.

<sup>53</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 111.

**Note:** This measure does not conform to the calendar year reporting requirement. The count of patients diagnosed with HIV for the first time in their lifetime. This is not for the first time diagnosed in your clinic or the first time by your provider, but for the first time in the patient’s lifetime.

Table 5-34: Table 6B Section L HIV BPHC Defined<sup>54</sup> Specific Codes

**HIV Definitions**

<b>BPHC Applicable ICD-9, ICD-10, procedure, and CPT-4 codes</b>
<b>ICD-9:</b> 042, 079.53
<b>ICD-10:</b> B20, B97.35, Z21
<b>Procedure:</b> V08

**Note:** These codes will identify ALL patients with HIV. There is no code for newly diagnosed HIV patients. Health centers who expect to see a very small number of such patients should develop alternative methods for tracking within the EHR or medical record.

**Charts Sampled or EHR Total, Column (B)**

This column contains the number of charts to be sampled equaling the total number of patients who fit the criteria. The number reported by RMPS UDS will match the number in Column (A).

**Number of Patients with Appropriate Follow-up, Column (C)**

This column contains the number of patients whose record demonstrates that, within 90 days of the visit where they were tested positive for HIV had a medical visit with a health center provider who initiates treatment for HIV, or a visit with a referral resource who initiates treatment for HIV.

**Note:** The numerator criteria is only fulfilled when the patient attended the medical visit for HIV care within 90 days of HIV diagnosis. If the treatment is by referral to another clinician/organization (such as a Ryan White provider) the visit at the referral source must be completed and the referral loop closed during the 90 day period. That is, the referring provider receives confirmation from the provider to whom the patient was referred that the visit was completed.

<sup>54</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 112.

**Follow-up:** Documentation of a follow up must be by provider or by a referral provider. An HIV follow up must be documented as a medical visit for HIV care within 90 days of first-ever HIV diagnosis. Follow up is noted in EHR or any of the codes shown in Table 5-35, documented during the report period:

Table 5-35: Table 6B Section L HIV Follow-up Definitions

**HIV Follow-up Definitions**

Applicable ICD-9, ICD-10 , and Procedure codes	Other Codes to Check (IHS-Specified Codes)
<p><b>ICD-9:</b> 042, 079.53, 795.71  <b>ICD-10:</b> B20, B97.35, Z21  <b>V-Procedure:</b> V08</p>	<p><b>V Lab:</b> LOINC taxonomy BGP HIV TEST LOINC CODES, site-defined taxonomy BGP HIV TEST TAX, BGP CD4 TAX, BGP HIV VIRAL LOAD TAX  <b>Clinic Codes:</b> 59  <b>Other:</b> Evidence of HIV referral completion  <b>V-Procedure:</b> V65.44  <b>CPT:</b> 86359-86361, 86689, 86701-86703, 87390-87391, 87534-87539, G9214, G9242, G9243  <b>Referral:</b> Completed Referral as noted in EHR (Manual lookup).</p>

5.2.6.15 Logic for Section M: Depression Screening and Follow-up

This section (Table 6B Line 21) reports on the number of patients 12 years and older who were screened for clinical depression using an age appropriate standardized tool during the report period and had a follow-up plan documented if screened positive.

**Note:** Detailed patient lists can be produced for “All Patients 12+ w/DEP and Follow-up” (MU/LST/LST2/J-N/DEP1) and “All Pts 12+ w/o Dep Scrn or w/o Follow-up” (MU/LST/LST2/J-N/DEP2) to assist sites with verifying the information reported by RPMS UDS.

**Total Patients Aged 12 or Older, Column (A)**

This column includes all patients age 12 and older who had at least one medical visit during the reporting period.

**Exclusions**

The following patients will be excluded from the denominator:

- Patients with an active diagnosis for Depression or Bipolar Disorder.
- Depression ICD-9 Diagnosis: 290.13, 290.21, 290.43, 296.2-296.26, 296.3-296.36, 296.82, 298.0, 300.4, 301.12, 309.0, 309.1, 309.28, 311, BUD  
SNOMED BIPOLAR\_DEP DX

- Depression ICD-10 Diagnosis: F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.8, F32.9, F33.0, F33.1, F33.2, F33.3, F33.4, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F43.21
- Bipolar Disorder ICD-9 Diagnosis: 296, 296.01-296.06, 296.40-296.46, 296.50-296.56, 296.60-296.66, 296.7, 296.80, 296.89, BUD SNOMED BIPOLAR\_DEP DX
- Bipolar ICD-10 Diagnosis: F31.0, F31.1, F31.10, F31.11, F31.12, F31.13, F31.2, F31.3, F31.30, F31.31, F31.32, F31.4, F31.5, F31.6, F31.60, F31.61, F31.62, F31.63, F31.64, F31.7, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.8, F31.81, F31.89, F31.9
- Patients who are already participating in on-going treatment for depression.

**Note:** Ongoing treatment is assumed if there is an active diagnosis of depression or bipolar diagnosis; therefore, patients with these active diagnosis are excluded from the denominator.

### **Charts Sampled or EHR Total, Column (B)**

This column contains the number of patients age 12 and older who had at least one medical visit during the report period. The number reported by RMPS UDS will match the number reported in Column (A).

### **Number of Patients with Appropriate Screening for Depression and Follow-up, if Appropriate, Column (C)**

This column contains the number of patients age 12 and older, who had at least one medical visit during the report period and was screened for depression using an age appropriate standardized tool in which the result was negative, or was positive AND had a follow-up plan documented.

**Note:** A standardized depression screening tool is a normalized and validated depression screening tool developed for the patient population in which it is being utilized. Any documented follow-up plan must be documented within the report period. As a result, in an instance where a patient's only positive depression screen occurs at the end of the report period, a documented follow-up plan may not be present. For example, a patient's only positive depression screen occurred on December 31 and the follow-up plan is documented on January 1 of the following year, the patient does not meet the follow-up plan definition. However, if the follow-up plan is documented on December 31, the patient will meet the follow-up definition.

Table 5-36: Table 6B Section M Depression Screening Definitions<sup>55</sup>

**Depression Screening Definitions**

BPHC-Specified Applicable ICD-9 CM, ICD-10 CM, and CPT codes	Other Codes to Check (IHS-Specified Codes)
CPT: 3725F	Exam Code: 36 Measurement in PCC or BH: PHQ2, PHQ9, or PHQT V-Procedure: V79.0 CPT: 1220F HCPCS: G0444

Table 5-37: Table 6B Section M Positive Depression Definitions

**Positive Depression Definitions**

Applicable ICD-9, procedure, CPT-4 codes, and Other Codes
Exam Code: 36 (Positive, Referral Needed)
Measurement in PCC or BH: PHQ2 >=3, PHQ9 >=10, or PHQT >=10

- Depression Follow-up Plan:** Documentation of a follow-up plan must be by provider or by a referral provider (successful completion of follow-up plan is not required). Follow-up plan must be documented along with the documented depression. Follow-up plan is the most recent occurrence on or after the positive depression screen noted in EHR or any of the codes shown in Table 5-38 documented during the report period:

Table 5-38: Table 6B Section M Positive Depression Follow-up Plan Definitions

**Positive Depression Follow-up Plan Definitions**

Applicable ICD-9, procedure, CPT-4 codes, and Other Codes
CPT: 90791, 90792, 90832, 90834, 90837, 90839
Depression Taxonomies: BUD DEP MEDS, BGP HEDIS ANTIDEPRESSANT MEDS, BUD DEP INTERVENTION

5.2.6.16 Logic for Section N: Sealants to First Molars

This section (Table 6B Line 22) reports on the number of children age 6-9 years at “elevated” risk (moderate to high risk) for caries who received a dental sealant on a permanent first molar tooth during the reporting period.

**Note:** Detailed patient lists can be produced for “All Patients 6-9 at Risk with First Molar Sealant” (MU/LST/LST2/J-N/DEN1) and “All Patients 6-9 at Risk w/o First Molar Sealant” (MU/LST/LST2/J-N/DEN2) to assist sites with verifying the information reported by RPMS UDS.

<sup>55</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 114.

### Total Patients Aged 6 through 9, Column (A)

This column includes all dental patients aged 6-9 years old who had an oral assessment or comprehensive or periodic oral evaluation visit during the reporting year and documented as having moderate to high risk for caries during the reporting period.

**Note:** Although not explicitly defined, a visit must meet the UDS definition of a visit.

### Exclusions

The following patients will be excluded from the denominator:

- Children for whom all first permanent molars are non-sealable (i.e., molars are either decayed, filled, currently sealed, or un-erupted/missing).

Table 5-39: Table 6B, Non-Sealable Definitions

### Non-Sealable Definitions

Applicable ICD-9, procedure, CPT-4 codes, and Other Codes
<b>ICD-9:</b> 520.0, 520.3, 521.0, 521.00, 521.02, 521.03, 521.09, 522.0, 522.5, 522.7, 525.13, 525.19 <b>ICD-10:</b> K00.0, K00.3, K02, K02.3, K02.52, K02.53, K02.63, K02.9, K04.0, K04.6, K04.7, K08.1, K08.13, K08.131, K08.132, K08.133, K08.134, K08.139, K08.4, K08.43, K08.431, K08.432, K08.433, K08.434, K08.439

Table 5-40: Table 6B, Oral Assessment Definitions, BPHC-Defined<sup>56</sup> and IHS Specific Codes

### Oral Assessment Definitions

BPHC-Specified Applicable CPT code(s)	Other Codes to Check (IHS-Specified Codes)
<b>CPT:</b> D0191	<b>ADA:</b> 0191

Table 5-41: BPHC UDS Table 6B, Comprehensive or Periodic Oral Evaluation Definitions, BPHC-Defined<sup>57</sup> and IHS Specific Codes

### Comprehensive or Periodic Oral Evaluation Definitions

BPHC-Specified Applicable CPT code(s)	Other Codes to Check (IHS-Specified Codes)
<b>CPT:</b> D0120, D0145, D0150, D0180	<b>ADA:</b> 0120, 0145, 0150, 0180

<sup>56</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 115.

<sup>57</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 115.

Table 5-42: UDS Table 6B, Moderate or High Risk Caries Definitions, BPHC-Defined<sup>58</sup> and IHS Specific Codes

**Moderate or High Risk Caries Definitions**

BPHC-Specified Applicable CPT code(s)	Other Codes to Check (IHS-Specified Codes)
CPT: D0602, D0603	ADA: 0602, 0603

**Charts Sampled or EHR Total, Column (B)**

This column contains the number of dental patients aged 6-9 years old who had an oral assessment or comprehensive or periodic oral evaluation visit during the reporting year and documented as having moderate to high risk for caries during the reporting period. The number reported by RPMS UDS will match the number reported in Column (A).

**Number of Patients with Sealants to First molars, if Appropriate, Column (C)**

This column contains the number of dental patients aged 6-9 years old at moderate to high risk for caries who received a dental sealant on a permanent first molar tooth.

**Note:** Because there are no applicable dental codes for identify a “first molar tooth” in RPMS, the IHS UDS software will include the number of dental patients aged 6-9 years old at moderate to high risk for caries who received a dental sealant. As a result, the counts may be slightly higher than expected.

Table 5-43: Table 6B Section N Dental Sealants Definitions

**Dental Sealant Definitions**

Applicable ICD-9, procedure, CPT-4 codes, and Other Codes
CPT: D1351
ADA: 1350, 1351

Figure 5-20 through Figure 5-26 show a sample RPMS UDS Table 6B report.

DU	UDS 2015	DEMO INDIAN HOSPITAL	Page 1
UDS No.	000001	Date Run:	Dec 15, 2015
Reporting Period:	Jan 01, 2015 through Dec 31, 2015		
Population:	All (both Indian/Alaskan Natives and Non 01)		
TABLE 6B - QUALITY OF CARE INDICATORS			
SECTION A: AGE CATEGORIES FOR PRENATAL PATIENTS			

<sup>58</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 115.

DEMOGRAPHIC CHARACTERISTICS OF PRENATAL CARE PATIENTS	
AGE	NUMBER OF PATIENTS (a)
1 LESS THAN 15 YEARS	
2 AGES 15-19	
3 AGES 20-24	
4 AGES 25-44	
5 AGES 45 AND OVER	
6 TOTAL PATIENTS (SUM LINES 1-5)	

  

SECTION B - TRIMESTER OF ENTRY INTO PRENATAL CARE		
TRIMESTER OF ENTRY INTO PRENATAL CARE	WOMEN HAVING FIRST VISIT WITH HEALTH CENTER (a)	WOMEN HAVING FIRST VISIT WITH ANOTHER PROVIDER (b)
7 First Trimester		
8 Second Trimester		
9 Third Trimester		

Figure 5-20: Sample RPMS UDS Report for Table 6B Page 1

DU UDS 2015 DEMO INDIAN HOSPITAL Page 2  
 UDS No. WWH Date Run: Dec 15, 2015  
 Reporting Period: Jan 01, 2015 through Dec 31, 2015  
 Population: All (both Indian/Alaskan Natives and Non 01)

TABLE 6B - QUALITY OF CARE INDICATORS

SECTION C - CHILDHOOD IMMUNIZATION			
CHILDHOOD IMMUNIZATION	TOTAL NUMBER PATIENTS WITH 3RD BIRTHDAY DURING MEASUREMENT YEAR (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS IMMUNIZED (c)
10 MEASURE: Children who have received age appropriate vaccines who had their 3rd birthday during measurement year (on or prior to 31 December)	121	121	78

SECTION D - CERVICAL CANCER SCREENING

PAP TESTS	TOTAL NUMBER OF FEMALE PATIENTS 24-64 YEARS OF AGE (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS TESTED (c)
11 MEASURE: Female patients aged 24-64 who received one or more Pap tests to screen for cervical cancer	1,234	1,234	529
SECTION E - WEIGHT ASSESSMENT AND COUNSELING FOR CHILDREN AND ADOLESCENTS			
CHILD AND ADOLESCENT WEIGHT ASSESSMENT AND COUNSELING	TOTAL PATIENTS AGED 3 - 17 ON DECEMBER 31 (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH COUNSELING AND BMI DOCUMENTED (c)
12 MEASURE: Children and adolescents aged 3 - 17 during measurement year (on or prior to 31 December) with a BMI percentile, and counseling on nutrition and physical activity documented for the current year	1,138	1,138	7

Figure 5-21: Sample RPMS UDS Report for Table 6B Page 2

DU UDS 2015 DEMO INDIAN HOSPITAL Page 3  
 UDS No. WWH Date Run: Dec 15, 2015  
 Reporting Period: Jan 01, 2015 through Dec 31, 2015  
 Population: All (both Indian/Alaskan Natives and Non 01)

TABLE 6B - QUALITY OF CARE INDICATORS

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SECTION F - ADULT WEIGHT SCREENING AND FOLLOW-UP

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ADULT WEIGHT SCREENING AND FOLLOW-UP	TOTAL PATIENTS AGED 18 AND OLDER (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH BMI CHARTED AND FOLLOW-UP PLAN DOCUMENTED AS APPROPRIATE (c)
13 MEASURE: Patients aged 18 and over with (1) BMI charted and (2)	1,930	1,930	266

follow-up plan documented if patients are overweight or underweight			
SECTION G - TOBACCO USE SCREENING AND CESSATION INTERVENTION			
TOBACCO USE SCREENING AND CESSATION INTERVENTION	TOTAL PATIENTS AGED 18 AND OLDER  (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL  (b)	NUMBER OF PATIENTS ASSESSED FOR TOBACCO USE AND PROVIDED INTERVENTION IF A TOBACCO USER  (c)
14a MEASURE: Patients aged 18 and older (1) were screened for tobacco use one or more times in the measurement year or the prior year AND (2) for those found to be a tobacco user, received cessation counseling intervention or medication	2,876	2,876	2,411

Figure 5-22: Sample RPMS UDS Report for Table 6B Page 3

DU	UDS 2015	DEMO INDIAN HOSPITAL	Page 4
UDS No.	WWH	Date Run:	Dec 15, 2015
Reporting Period: Jan 01, 2015 through Dec 31, 2015			
Population: All (both Indian/Alaskan Natives and Non 01)			
TABLE 6B - QUALITY OF CARE INDICATORS			
SECTION H - ASTHMA PHARMACOLOGIC THERAPY			
ASTHMA PHARMACOLOGIC THERAPY	TOTAL PATIENTS AGED 5 - 40 TOTAL PATIENTS AGED 5 - 40 WITH PERSISTENT ASTHMA (a)	NUMBER CHARTS NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH NUMBER OF PATIENTS WITH ACCEPTABLE PLAN (c)
16 MEASURE: Patients aged 5 through 40 diagnosed with persistent asthma who have an acceptable	146	146	113

pharmacological treatment plan			
SECTION I - CORONARY ARTERY DISEASE (CAD): LIPID THERAPY			
CORONARY ARTERY DISEASE (CAD): LIPID THERAPY	TOTAL PATIENTS 18 AND OLDER TOTAL PATIENTS 18 AND OLDER WITH CAD DIAGNOSIS (a)	NUMBER CHARTS NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS NUMBER OF PATIENTS PRESCRIBED A LIPID LOWERING THERAPY (c)
17 MEASURE: Patients aged 18 and older with a diagnosis of CAD prescribed a lipid lowering therapy	5	5	0

Figure 5-23: Sample RPMS UDS Report for Table 6B Page 4

DU UDS 2015	DEMO INDIAN HOSPITAL	Page 5	
UDS No. WWH	Date Run: Dec 15, 2015		
Reporting Period: Jan 01, 2015 through Dec 31, 2015			
Population: All (both Indian/Alaskan Natives and Non 01)			
TABLE 6B - QUALITY OF CARE INDICATORS			
SECTION J - ISCHEMIC VASCULAR DISEASE (IVD): ASPIRIN OR ANTITHROMBOTIC THERAPY			
ISCHEMIC VASCULAR DISEASE (IVD): ASPIRIN OR OTHER ANTITHROMBOTIC THERAPY	TOTAL PATIENTS 18 AND OLDER WITH IVD DIAGNOSIS OR AMI, CABG, OR PTCA PROCEDURE (a)	CHARTS CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS NUMBER OF PATIENTS WITH ASPIRIN OR OTHER ANTITHROMBOTIC THERAPY (c)
18 MEASURE: Patients aged 18 and older with a diagnosis of IVD or AMI, CABG, or PTCA procedure with aspirin or another antithrombotic therapy	228	228	173
SECTION K - COLORECTAL CANCER SCREENING			
COLORECTAL CANCER SCREENING	TOTAL PATIENTS 51 TO 74 YEARS OF AGE	CHARTS SAMPLED OR EHR TOTAL	NUMBER OF PATIENTS WITH APPROPRIATE SCREENING FOR COLORECTAL

	(a)	(b)	CANCER (c)
19 MEASURE: Patients age 51 through 74 years of age during the measurement year (on or prior to 31 December) with appropriate screening for colorectal cancer	1,003	1,003	365

Figure 5-24: Sample RPMS UDS Report for Table 6B Page 5

DU UDS 2015 DEMO INDIAN HOSPITAL Page 6  
 UDS No. WWH Date Run: Dec 15, 2015  
 Reporting Period: Jan 01, 2015 through Dec 31, 2015  
 Population: All (both Indian/Alaskan Natives and Non 01)

TABLE 6B - QUALITY OF CARE INDICATORS

SECTION L - HIV LINKAGE TO CARE

HIV LINKAGE TO CARE	TOTAL PATIENTS FIRST DIAGNOSED WITH HIV (a)	CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS SEEN WITHIN 90 DAYS OF FIRST DIAGNOSIS OF HIV (c)
20 MEASURE: Patients whose first ever HIV diagnosis was made by health center staff between October 1 and September 30 of the measurement year and who were seen for follow-up treatment within 90 days of that first ever diagnosis	29	29	18

Figure 5-25: Sample RPMS UDS Report for Table 6B Page 6

DU UDS 2015 DEMO INDIAN HOSPITAL Page 7  
 UDS No. WWH Date Run: Dec 15, 2015  
 Reporting Period: Jan 01, 2015 through Dec 31, 2015  
 Population: All (both Indian/Alaskan Natives and Non 01)

TABLE 6B - QUALITY OF CARE INDICATORS

SECTION M - PATIENTS SCREENED FOR DEPRESSION AND FOLLOW-UP			
PATIENTS SCREENED FOR DEPRESSION AND FOLLOW-UP	TOTAL PATIENTS AGED 12 AND OLDER  (a)	CHARTS SAMPLED OR EHR TOTAL  (b)	NUMBER OF PATIENTS SCREENED FOR DEPRESSION AND FOLLOW-UP PLAN DOCUMENTED AS APPROPRIATE  (c)
21 MEASURE: Patients aged 12 and older who were (1) screened for depression with a standardized tool AND IF SCREENING WAS POSITIVE (2) had a follow-up plan documented	2,967	2,967	2,110
SECTION N - DENTAL SEALANTS			
DENTAL SEALANTS	TOTAL PATIENTS AGED 6 THROUGH 9 IDENTIFIED AS MODERATE TO HIGH RISK FOR CARIES  (a)	CHARTS SAMPLED OR EHR TOTAL  (b)	NUMBER OF PATIENTS WITH SEALANTS TO FIRST MOLARS  (c)
22 MEASURE: Children age 6-9 years at moderate to high risk of caries who received a sealant on a permanent first molar tooth	58	58	46

Figure 5-26: Sample RPMS UDS Report for Table 6B Page 7

### 5.2.7 Table 7 Health Outcomes and Disparities

Table 7 reports data on selected health outcome indicators by race and Hispanic/Latino identity (HIV positive pregnant Women, deliveries and low birth weights, hypertension and diabetes Glycemic control) to provide information on the extent to which health centers help reduce health disparities. They are “intermediate outcome measures,” which means that they document measurable outcomes of clinical intervention as a proxy for good long term health outcomes.

Table 7 gives a good description of the overall quality of primary care being provided at the BPHC Health Center Program grantee facility, it is clear that this is a subset of possible health outcome indicators and that individual health centers may be using others in addition to these.

**Note:** Visits with a service category of Historical Event are included in all sections of this table when determining if a patient meets criterion definitions.

#### 5.2.7.1 Logic HIV Positive Pregnant Women

This section of the table reports the total number of pregnant women served by the facility who have had at least two positive HIV diagnosis anytime through the end of the report period, with at least two pregnancy related visits during the past 20 months with no documented miscarriage or abortion occurring after the second pregnancy related visit and during the past 20 months and with at least one medical visit during the report period. All health centers are to report the total number of HIV positive pregnant women served by the health center in column (i) *regardless* of whether or not they provide prenatal care services.<sup>59</sup>

**Note:** A detailed list of "All Pregnant Patients w/HIV" from the List menu option within the Manager Utilities (MU/LST/LST3/PRG/PRGH) to assist sites with verifying the information reported by RPMS UDS.

#### HIV Positive Pregnant Definitions:

- **Pregnancy:** At least two visits with any of the following POV or Problem List diagnosis during the past 20 months (calculated using 30.4167 days per month), with one diagnosis occurring during the reporting period and with no documented miscarriage or abortion occurring after the second pregnancy POV and during the past 20 months (calculated using 30.4167 days per month).

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<sup>59</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 124.

Table 5-44: Pregnancy Definitions

**Pregnancy Definitions**

Applicable ICD-9, ICD-10, procedure, CPT-4 codes, and Other Codes
<p><b>ICD-9:</b> 640.*-649.*, 651.*-676.*, 678.*, 679.*  <b>ICD-9 Procedure:</b> 72.*, 73.*, 74.*  <b>V-Procedure:</b> V22.0-V23.9, V24.*, V27.*, V28.81, V28.82, V28.89, V72.42, V89.01-V89.09  <b>ICD-10:</b> O09.00 thru O10.02, O10.111 thru O10.12, O10.211 thru O10.22, O10.311 thru O10.32, O10.411 thru O10.42, O10.911 thru O10.92, O11.1 thru O15.1, O15.9 thru O24.02, O24.111 thru O24.12, O24.311 thru O24.32, O24.41*, O24.811 thru O24.82, O24.911 thru O24.92, O25.10 thru O25.2, O26.00 thru O26.62, O26.711 thru O26.72, O26.811 thru O26.93, O29.011 thru O30.93, O31.* thru O48.*, O60.0*, O61.* thru O66.*, O68, O69.*, O71.00 thru O71.1, O71.89, O71.9, O74.0 thru O75.81, O75.89, O75.9, O76 thru O77.*, O88.011 thru O88.02, O88.111 thru O88.12, O88.211 thru O88.22, O88.311 thru O88.32, O88.811 thru O88.82, O90.3, O91.011 thru O91.019, O91.111 thru O91.119, O91.211 thru O91.219, O92.011 thru O92.019, O92.20, O92.29, O98.011 thru O98.02, O98.111 thru O98.12, O98.211 thru O98.22, O98.311 thru O98.32, O98.411 thru O98.42, O98.511 thru O98.52, O98.611 thru O98.62, O98.711 thru O98.72, O98.811 thru O98.82, O98.911 thru O98.92, O99.011 thru O99.02, O99.111 thru O99.12, O99.210 thru O99.214, O99.280 thru O99.284, O99.310 thru O99.314, O99.320 thru O99.324, O99.330 thru O99.334, O99.340 thru O99.344, O99.350 thru O99.354, O99.411 thru O99.42, O99.511 thru O99.52, O99.611 thru O99.62, O99.711 thru O99.72, O99.810, O99.814, O99.820, O99.824, O99.830, O99.834, O99.840 thru O99.844, O99.89, O9A.111 thru O9A.12, O9A.211 thru O9A.22, O9A.311 thru O9A.32, O9A.411 thru O9A.42, O9A.511 thru O9A.52, Z03.7*, Z32.01, Z33.1, Z34.*, Z36.  <b>CPT:</b> 59000-59076, 59300, 59320, 59400-59426, 59510, 59514, 59610, 59612, 59618, 59620, 76801-76828</p>

- **Miscarriage:** Occurring after the second pregnancy POV and during the past 20 months (calculated using 30.4167 days per month).

Table 5-45: Miscarriage Definitions

**Miscarriage Definitions**

Applicable ICD-9, ICD-10, procedure, CPT-4 codes, and Other Codes
<p><b>ICD-9:</b> 630, 631, 632, 633*, 634*  <b>ICD-10:</b> O03.9  <b>CPT:</b> 59812, 59820, 59821, 59830</p>

- **Abortion:** occurring after the second pregnancy POV and during the past 20 months (calculated using 30.4167 days per month).

Table 5-46: Abortion Definitions

**Abortion Definitions**

<b>Applicable ICD-9, ICD-10, procedure, CPT-4 codes, and Other Codes</b>
<p><b>ICD-9:</b> 635*, 636* 637*</p> <p><b>ICD-9 Procedure:</b> 69.01, 69.51, 74.91, and 96.49</p> <p><b>ICD-10:</b> O00.* thru O03.89, O04.*, Z33.2</p> <p><b>ICD-10 Procedure:</b> 0WHR73Z, 0WHR7YZ, 10A0***, 3E1K78Z, 3E1K88Z</p> <p><b>CPT:</b> 59100, 59120, 59130, 59136, 59150, 59151, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260-S2267</p>

- **HIV:** Documented on the Problem List or documented with 2 POVs occurring anytime through the end of the report period

Table 5-47: HIV Definitions

**HIV Definitions**

<b>Applicable ICD-9, ICD-10, procedure, CPT-4 codes, and Other Codes</b>
<p><b>ICD-9:</b> 042, 042.0-044.9 (old codes), 079.53</p> <p><b>ICD-10:</b> B20, B97.35, R75, Z21, O98.711 through O98.73</p> <p><b>V-Procedure:</b> V08</p> <p><b>ICD-9 Procedure:</b> 795.71</p>

5.2.7.2 Logic for Section A: Deliveries and Low Birth Weight by Race and Hispanic/Latino Identity

BPHC UDS Manual states that Section A (Table 7 Columns 1a through 1d), only health centers that provide or assume primary responsibility for some or all of a patient's prenatal care services, whether or not the health center does the delivery, are required to complete this section. All prenatal care patients who delivered during the reporting period, and all children born to them, are to be reported.<sup>60</sup>

**Prenatal Care Patients Who Delivered During the Year (Column 1a)**

Report the total number of women who were known to have delivered during the year regardless of the outcome, even if the delivery was done by another provider.

**Deliveries Performed By Health Center Provider (Line 2)**

Report the total number of deliveries performed by the BPHC facility clinicians during the reporting period in Column (i). On this line *only*, health center is to include deliveries of women who were not part of the health center's prenatal care program during the calendar year.

<sup>60</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 125.

### Birth Weight of Infants Born To Prenatal Care Patients Who Delivered During the Year (Columns 1b-1d)

Report the total number of *live* births during the reporting period for women who received prenatal care from the health center or referral provider during the reporting period regardless if the health center did the delivery, referred the deliver to another provider or the woman transferred to another provider on their own, according to the appropriate birth weight group.

**Note:** The number of deliveries reported in Column 1a will normally not be the same as the total number of infants reported in Columns 1b-1d because of multiple births and still births.

Because there currently is no reliable, consistent method within RPMS for identifying pregnant patients who are receiving prenatal care at a facility, Section A (Table 7 Columns 1a-1d) will not be calculated and will be left blank. You can produce a detailed list of patients titled “All Pregnant Patients by Race & Hisp Identity” from the List menu option within the Manager Utilities (MU/LST/LST3/PRG/PRGR) to assist you with calculating the information in this section.

**Note:** This line is not reported by the race/Hispanic/Latino identity of the women delivered. The definition of pregnancy is defined in Section 5.2.7.1.

#### 5.2.7.3 Logic for Section B: Hypertension By Race And Hispanic/Latino Identity

This section of the table reports by race and Hispanic/Latino identity the number of patients 18 to 85 years old (i.e., prior to 85th birthday), who have been diagnosed with hypertension any time before June 30<sup>th</sup> of the report period and who had at least two medical visits during the reporting period and the number of those patients who have controlled blood pressure (less than 140/90–systolic 140/diastolic 90).

**Note:** The blood pressure measurements must have been taken during the report period. If the patient has more than one blood pressure measurement during the report period, the last blood pressure measurement is used to determine if the patient meets the criteria. Patient reported blood pressure measurements may or may not be eligible: see BPHC UDS manual for clarification.<sup>61</sup>

<sup>61</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 127.

**Total Hypertensive Patients (Column 2a)**

Report the total number of patients by race and Hispanic/Latino identity who are age 18–85, had two medical visits during the report period, been diagnosed with Hypertension prior to June 30<sup>th</sup> of the report period. BPHC describes Hypertension evidenced by an ICD-9 code of 401.xx–405.xx or ICD-10 code of I10- thru I15. It does not matter if Hypertension was treated or is currently being treated.<sup>62</sup>

**Exclusions**

The following patients will be excluded from the denominator:

- Patient has a pregnant diagnosis: The definition of pregnancy is defined in Section 5.2.7.1.
- Patients with end state renal disease (ESRD) diagnosis.

Table 5-48: End State Renal Disease Definitions

**End State Renal Disease (ESRD) Definitions**

Applicable ICD-9, ICD-10, procedure, CPT-4 codes, and Other Codes
<p><b>ICD-9:</b> 585.6</p> <p><b>ICD-9 Procedure:</b> 38.95, 39.27, 39.42, 39.43, 39.53, 39.93 through 39.95, 54.98, 55.6*</p> <p><b>V-Procedure:</b> V42.0, V45.1 (old code), V45.11 V45.12, V56.*</p> <p><b>ICD-10:</b> N18.6, Z48.22, Z49.*, Z91.15, Z94.0, Z99.2</p> <p><b>CPT:</b> 36145 (old code), 36147, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831 through 36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90918 through 90925 (old codes), 90935, 90937, 90939 (old code), 90940, 90945, 90947, 90951 through 90970, 90989, 90993, 90997, 90999, 99512, G0257, G0308 through G0327 (old codes), G0392 (old code), G0393 (old code), G9231, S2065, S9339</p>

**Number of Charts Sampled or EHR Total (Column 2b)**

Report the total number of Hypertensive BPHC facility patients by race and Hispanic/Latino identity, regardless of whether or not they were specifically treated for hypertension.

**Patients with HTN Controlled (Column 2c)**

Report the total number of Hypertensive patients with a systolic blood pressure measurement of <140 mm Hg and diastolic blood pressure of <90 mm Hg at the time of their last measurement during the report period.

<sup>62</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 127.

**Note:** Under no circumstances may a health center report more hypertensive Hispanic/Latinos or individuals from any given race on Table 7 Column 2a than reported on Table 3B.

Under most circumstances line h will be zero. Use line h only if you specifically ask a patient their race and whether or not they are Hispanic/Latino and they specifically refuse to answer the questions. Those who do provide their race but do not check that they are Hispanic/Latino on an intake form should be considered non-Hispanic/Latino.<sup>63</sup>

### Blood Pressure Definitions:

- **Actual Blood Pressure Measurement:** Most recent blood pressure measurement during the report period < 140/90. If both the systolic and diastolic measurements are not less than 140/90, the values are considered not controlled and are not to be included in the count.
- **CPT II Code Indicating Controlled Blood Pressure:** Systolic 3074F, 3075F, or 3077F *with* Diastolic: 3078F or 3079F. Systolic and diastolic values do not have to be recorded on the same day. The following combinations represent BP less than (<) 140/90:
  - CPT 3074F (Most recent systolic BP less than (<) 130 mm Hg) *and* 3078F (Most recent diastolic BP less than (<) 80 mm Hg)
  - CPT 3074F (Most recent systolic BP less than (<) 130 mm Hg) *and* 3079F (Most recent diastolic BP 80-89 mm Hg)
  - CPT 3075F (Most recent systolic BP 130-139 mm HG) *and* 3078F (Most recent diastolic BP less than (<) 80 mm Hg)
  - CPT 3075F (Most recent systolic BP 130-139 mm HG) *and* 3079F (Most recent diastolic BP 80–89 mm Hg)

**Note:** Detailed patient lists can be produced from the List menu option within the Manager Utilities for “All HTN Patients by Race & Hisp Identity” (MU/LST/LST3/HT/HTR), “All HTN Pts w/Contr BP by Race & Hisp Identity” (MU/LST/LST3/HT/HTCR) and “All HTN Pts w/Uncont BP by Race & Hisp Identity” (MU/LST/LST3/HT/HTUR) to assist sites with verifying the information reported by RPMS UDS.

<sup>63</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 128.

#### 5.2.7.4 Logic for Section C: Diabetes by Race And Hispanic/Latino Identity

This section of the table reports by race and Hispanic/Latino identity the number of patients 18 to 75 years old diagnosed with Type I or Type II diabetes and whose most recent hemoglobin (HbA1c) was less than or equal to 9% and without a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes and who had at least two medical visits during the report period. Results are to be reported in two categories: less than 8% (good control) and greater than 9% (poor control).

##### **Total Patients with Diabetes (Column 3a)**

Report the total number of patients by race and Hispanic/Latino identity who are age 18-85, had two medical visits during the report period, been diagnosed with Diabetes prior to the end of the report year. It doesn't matter if Diabetes was treated or is currently being treated or when the diagnosis was made.<sup>64</sup>

BPHC describes Diabetes evidenced by an ICD-9 code of 250.xx, 648.0, or ICD-10 Codes E10-, E11- O24- (Excludes E28.2, E09-, E16.4, E16.8, O99.81, T38.0xxA), or from pharmacy data (those who were dispensed insulin or oral hypoglycemics/antihyperglycemics.<sup>65</sup> These medications will be defined with medication taxonomy BUD DIABETES MEDS TAX (see spreadsheet UDS 2015 Medication Taxonomies) and are prepopulated during the install of RPMS UDS.

##### **Exclusions**

- Patients who do not have two visits with a diagnosis of diabetes during the report period or the year prior to the report period *and* have been diagnosed with polycystic ovaries during the report period. Polycystic ovaries defined as (POV or Problem List) ICD-0 code 256.4 or ICD-10 code E28.2.
- Patients who have been diagnosed with gestational diabetes (POV or Problem List ICD-9 code 648.8\* or ICD-10 code O99.81) or steroid-induced diabetes (POV or Problem List ICD-9 codes 962.0, 249.xx, or 251.8 or ICD-10 codes E16.4, E16.8) during the report period.

##### **Number of Charts Sampled or EHR Total (Column 3b)**

Report the total number of Diabetic BPHC facility patients by race and Hispanic/Latino identity, regardless of whether or not they were specifically treated for Diabetes.

##### **Total Patients with HbA1c < 8% (Column 3d1)**

Report the total number of patients by race and Hispanic/Latino identity who are age 18–85, had two medical visits during the report period, been diagnosed with Diabetes

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<sup>64</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 129.

<sup>65</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 129.

any time prior to the end of the report period whose most recent HbA1c was less than 8%.

### **Total Patients with HbA1c > 9% OR No Test during the Report Year (Column 3f)**

Report the total number of patients by race and Hispanic/Latino identity who are age 18–85, had two medical visits during the report period, been diagnosed with Diabetes any time prior to the end of the report period whose most recent HbA1c was greater than 9% or who did not receive a HbA1c test during the report period or whose test results were missing.

**Note:** Under no circumstances may a health center report more diabetic Hispanic/Latinos or individuals from any given race in Column 3a than reported on Table 3B.

Under most circumstances line h will be zero. Use line h only if you specifically ask a patient their race and whether or not they are Hispanic/Latino and they specifically refuse to answer the questions. Those who do provide their race but do not check that they are Hispanic/Latino on an intake form should be considered non-Hispanic/Latino.<sup>66</sup>

### **Hemoglobin A1c Definitions:**

- **CPT:** 83036, 83037, 3044F-3046F:
  - CPT 83036 and 83037 indicate tests with no result and will be included in the A1c greater than (>) 9% numerator (Column 3f)
  - CPT 3044F indicates an A1c level less than (<) 7% and will be included in Column 3d1 (less than (<) 8%)
  - CPT 3046F indicates an A1c level greater than (>) 9% and will be included in Column 3f
- **LOINC taxonomy; or site-populated taxonomy DM AUDIT HGB A1C TAX**
  - A1cs documented by LOINC or with a lab test included in lab taxonomy DM AUDIT HGB A1C TAX will be reported in the appropriate category according to the A1c result.

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<sup>66</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 131.

**Note:** Detailed patient lists can be produced from the List menu option within the Manager Utilities for “All DM Patients by Race & Hisp Identity” (MU/LST/LST3/DM/DMR), “All DM Patients w/A1c less than (<) 8 by Race & Hisp Identity” (MU/LST/LST3/DM/DMR1), and “All DM Pts w/o A1c or greater than (>) 9 by Race & Hisp Identity” (MU/LST/LST3/DM/DMR2) to assist sites with verifying the information reported by RPMS UDS.

Figure 5-27 through Figure 5-32 show a sample RPMS UDS Table 7 report.

DU	UDS 2015	DEMO INDIAN HOSPITAL	Page 1		
UDS No. 000001			Date Run: Dec 15, 2015		
Reporting Period: Jan 01, 2015 through Dec 31, 2015					
Population: All (both Indian/Alaskan Natives and Non 01)					
TABLE 7 - HEALTH OUTCOMES AND DISPARITIES					
SECTION A: DELIVERIES AND BIRTH WEIGHT BY RACE AND HISPANIC/LATINO ETHNICITY					
0 HIV Positive Pregnant Women*****   12					
2 Deliveries Performed by Health Center’s Providers*****					
Line #	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: <1500 grams (1b)	Live Births: 1500-2499 grams (1c)	Live Births: =>2500 grams (1d)
Hispanic/Latino					
1a	Asian				
1b1	Native Hawaiian				
1b2	Other Pacific Islander				
1c	Black/African American				
1d	American Indian/Alaska Native				
1e	White				
1f	More than One Race				
1g	Unreported/Refused to Report Race				
	Subtotal Hispanic/Latino				

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Figure 5-27: Sample RPMS UDS Report for Table 7 Page 1

DU UDS 2015		DEMO INDIAN HOSPITAL		Page 2	
UDS No. 000001		Date Run: Dec 15, 2015			
Reporting Period: Jan 01, 2015 through Dec 31, 2015					
Population: All (both Indian/Alaskan Natives and Non 01)					
TABLE 7 - HEALTH OUTCOMES AND DISPARITIES					
SECTION A: DELIVERIES AND BIRTH WEIGHT BY RACE AND HISPANIC/LATINO ETHNICITY					
Line #	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: <1500 grams (1b)	Live Births: 1500-2499 grams (1c)	Live Births: =>2500 grams (1d)
Non-Hispanic/Latino					
2a	Asian				
2b1	Native Hawaiian				
2b2	Other Pacific Islander				
2c	Black/African American				
2d	American Indian/Alaska Native				
2e	White				
2f	More than One Race				
2g	Unreported/Refused to Report Race				
	Subtotal Non-Hispanic/Latino				
Unreported/Refused to Report Ethnicity					
h	Unreported/Refused to Report Race and Ethnicity				
i	Total				

Figure 5-28: Sample RPMS UDS Report for Table 7 Page 2

DU	UDS 2015	DEMO INDIAN HOSPITAL	Page 3
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UDS No. 000001 Date Run: Dec 15, 2015  
 Reporting Period: Jan 01, 2015 through Dec 31, 2015  
 Population: All (both Indian/Alaskan Natives and Non 01)

TABLE 7 - HEALTH OUTCOMES AND DISPARITIES  
 SECTION B: HYPERTENSION BY RACE AND HISPANIC/LATINO ETHNICITY

#	Race and Ethnicity	Total Hypertensive Patients (2a)	Charts Sampled or EHR Total (2b)	Patients with HTN Controlled (2c)
Hispanic/Latino				
1a	Asian	0	0	0
1b1	Native Hawaiian	0	0	0
1b2	Other Pacific American	0	0	0
1c	Black/African American	0	0	0
1d	American Indian/Alaska Native	4	4	3
1e	White	0	0	0
1f	More than One Race	0	0	0
1g	Unreported/Refused to Report Race	0	0	0
	Subtotal Hispanic/Latino	4	4	3

Figure 5-29: Sample RPMS UDS Report for Table 7 Page 3

DU UDS 2015 DEMO INDIAN HOSPITAL Page 4  
 UDS No. 000001 Date Run: Dec 15, 2015  
 Reporting Period: Jan 01, 2015 through Dec 31, 2015  
 Population: All (both Indian/Alaskan Natives and Non 01)

TABLE 7 - HEALTH OUTCOMES AND DISPARITIES  
 SECTION B: HYPERTENSION BY RACE AND HISPANIC/LATINO ETHNICITY

#	Race and Ethnicity	Total Hypertensive Patients (2a)	Charts Sampled or EHR Total (2b)	Patients with HTN Controlled (2c)
Non-Hispanic/Latino				
2a	Asian	0	0	0
2b1	Native Hawaiian	0	0	0
2b2	Other Pacific			

	American	0	0	0
2c	Black/African American	0	0	0
2d	American Indian/Alaska Native	5,181	5,181	2,464
2e	White	0	0	0
2f	More than One Race	0	0	0
2g	Unreported/Refused to Report Race	0	0	0
	Subtotal Non-Hispanic/Latino	5,181	5,181	2,464
Unreported/Refused to Report Ethnicity				
h	Unreported/Refused to Report Race and Ethnicity	31	31	17
i	Total	5,216	5,216	2,484

Figure 5-30: Sample RPMS UDS Report for Table 7 Page 4

DU UDS 2015 DEMO INDIAN HOSPITAL Page 5  
 UDS No. 000001 Date Run: Dec 15, 2015  
 Reporting Period: Jan 01, 2015 through Dec 31, 2015  
 Population: All (both Indian/Alaskan Natives and Non 01)

TABLE 7 - HEALTH OUTCOMES AND DISPARITIES  
 SECTION C: DIABETES BY RACE AND HISPANIC/LATINO ETHNCITY

#	Race and Ethnicity	Total Patients with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with Hbalc <8% (3d1)	Patients with Hbalc >9% Or No Test During Year (3f)
Hispanic/Latino					
1a	Asian	0	0	0	0
1b1	Native Hawaiian	0	0	0	0
1b2	Other Pacific Islander	0	0	0	0
1c	Black/African American	0	0	0	0

1d	American Indian/ Alaska Native	9	9	4	4
1e	White	0	0	0	0
1f	More than One Race	0	0	0	0
1g	Unreported/ Refused to Report Race	0	0	0	0
	Subtotal Hispanic/Latino	9	9	4	4

Figure 5-31: Sample RPMS UDS Report for Table 7 Page 5

DU UDS 2015 DEMO INDIAN HOSPITAL Page 6  
 UDS No. 000001 Date Run: Dec 15, 2015  
 Reporting Period: Jan 01, 2015 through Dec 31, 2015  
 Population: All (both Indian/Alaskan Natives and Non 01)

TABLE 7 - HEALTH OUTCOMES AND DISPARITIES  
 SECTION C: DIABETES BY RACE AND HISPANIC/LATINO ETHNCITY

#	Race and Ethnicity	Total Patients with Diabetes  (3a)	Charts Sampled or EHR Total  (3b)	Patients with HbA1c <8%  (3d1)	Patients with HbA1c >9% Or No Test During Year  (3f)
Non-Hispanic/Latino					
2a	Asian	0	0	0	0
2b1	Native Hawaiian	0	0	0	0
2b2	Other Pacific Islander	0	0	0	0
2c	Black/African American	0	0	0	0
2d	American Indian/ Alaska Native	898	898	243	580
2e	White	1	1	0	1
2f	More than One Race	0	0	0	0
2g	Unreported/ Refused to Report Race	2	2	1	0
	Subtotal Non- Hispanic/Latino	901	901	244	581

Unreported/Refused to Report Ethnicity					
h	Unreported/ Refused to Report Race and Ethnicity	0	0	0	0
i	Total	910	910	248	585

Figure 5-32: Sample RPMS UDS Report for Table 7 Page 6

### 5.2.8 Table 9D Patient-Related Revenue

Table 9D, Patient-Related Revenue collects information on charges, collections, supplemental payments, contractual allowances, self-pay sliding discounts, and self-pay bad debt write-off. Table 9D is included only in the Universal Report<sup>67</sup>.

**Note:** Because there is no way to distinguish between non-managed care, capitated managed care, and fee-for-service managed care in RPMS, only the totals lines (3, 6, 9, 12, and 14) and line 13 will be calculated. Table 9D: Patient-Related Revenue (Delimited Rept) can be used to help sites complete this table.

#### 5.2.8.1 Rows – Payor Categories and Form of Payment

There are five payor categories defined by BPHC and are described in the following bullets. Except for Self Pay, each category has three sub-groupings: non-managed care, capitated managed care, and, fee-for-service managed care.

- **Medicaid (Lines 1–3).** All services billed to and paid for by Medicaid (Title XIX) regardless of whether they are paid directly or through a fiscal intermediary or an HMO. The following is included in the counts for these lines:
  - Medicaid (Title XIX)
  - CHIP paid through Medicaid.
  - Cross-over services that are reclassified to Medicaid after initial submission to Medicare are reported here.
- **Medicare (Lines 4–6).** All services billed to and paid for by Medicare (Title XVIII) regardless of whether they are paid directly or through a fiscal intermediary or an HMO.

<sup>67</sup> BPHC Uniform Data System Manual, 2015 Revision, *Instructions for Table 9D*, p. 147

- **Other Public (Lines 7–9).** All services billed to and paid for by State or local governments through programs other than indigent care programs. The following is included in the counts for these lines:
  - CHIP when it is paid for through commercial carriers.
  - Family planning programs such as Breast and Cervical Cancer Control Programs with various state names, other dedicated state or local programs, and state insurance plans.

Reporting on state or local indigent care programs that subsidize services rendered to the uninsured is as follows:

- Report all charges for these services and collections from patients as "self-pay" (line 13 columns a and b of this table);
- Report all amounts not collected from the patients as sliding discounts or bad debt write-off, as appropriate, on line 13 columns e and f of this table; and
- Report collections from the associated state and local indigent care programs on Table 9E and specify the program paying for the services. State/local indigent care programs are reported on line 6a on that table.

Do not classify anything as an indigent care program without first reviewing this in a UDS Training Program or with the UDS Help line.

- **Private (Lines 10–12).** All services billed to and paid for by commercial or private insurance companies and *do not* include any services that fall into one of the other payor categories. The following is included in the counts for these lines:
  - Insurance purchased for public employees or retirees such as Tricare, Trigon, the Federal Employees Insurance Program, Workers Compensation, etc.
  - Contract payments from other organizations who engage the clinic on a fee-for-service or other reimbursement basis such as a Head Start program that pays for annual physical exams at a contracted rate, or a school, jail, or large company that pays for provision of medical care at a per-session or negotiated rate.
- **Self pay (Line 13).** All services and charges where the responsible party is the patient, including charges for indigent care programs.

**Note:** This includes the reclassified co-payments, deductibles, and charges for uncovered services for otherwise insured individuals which become the patient's personal responsibility.

#### 5.2.8.2 Columns: Charges, Payments and Adjustments related to services delivered (Reported on a cash basis) Definitions

Because RPMS does not collect data for c-c4 and sites may use different codes for columns e and f, only columns a, b, and d will be calculated.

- **Column a: Full charges this period**

This column records the total charges for each payor source. This should always reflect the full charge (per the fee schedule) for services rendered to patients in that payor category.
- **Column b: Amount collected this period**

This column records the amount of net receipts for the year on a cash basis, regardless of the period in which the paid for services were rendered.
- **Column c: Retroactive Settlements, Receipts or Paybacks**

This column gives details on cash receipts or payments for FQHC reconciliation, managed care pool distributions, payments from managed care withholds, and paybacks to FQHC or HMOs are reported in Columns c1 - c4.
- **Column c1: Collection of Reconciliation/Wrap around, Current Year**

This column lists details on cash receipts or payments for FQHC reconciliation, managed care pool distributions, payments from managed care withholds, and paybacks to FQHC or HMOs are reported in Columns c1 - c4.
- **Column c2: Collection of Reconciliation/Wrap around, Previous Years**

This column displays FQHC cash receipts from Medicare and Medicaid that cover services provided during previous reporting periods.
- **Column c3: Collection of other retroactive payments including risk pool/incentive/withhold**

This column displays other cash payments including managed care risk pool redistribution, incentives, and withholds, from any payor. These payments are only applicable to managed care plans.
- **Column c4: Penalty/Payback**

This column lists payments made to FQHC payors because of overpayments collected earlier and payments made to managed care plans (e.g., for over-utilization of the inpatient or specialty pool funds).
- **Column d: Allowances**

This column displays allowances that are granted as part of an agreement with a third-party payor.
- **Column e: Sliding Discounts**

This column lists reductions to patient charges based on the patient's ability to pay, as determined by the helath center's sliding discount schedule.

- **Column f: Bad Debt Write Off**

This column lists only bad-debts from patients are recorded on this table.

**Table 9D Logic**

RPMS UDS reviews every visit (see Section 4.2.2) for patients who meet the RPMS UDS definition of a patient. This report includes A/R transactions for patients who are considered to be “UDS” patients (patients included in Table 3A) during the report period.

Figure 5-33 through Figure 5-38 show a sample RPMS UDS Table 7 report.

DU	UDS 2015	DEMO INDIAN HOSPITAL	Page 1
UDS No.	000001		Date Run: Dec 15, 2015
Reporting Period:	Jan 01, 2015 through Dec 31, 2015		
Population:	All (both Indian/Alaskan Natives and Non 01)		
TABLE 9D - PATIENT-RELATED REVENUE (SCOPE OF PROJECT ONLY)			
PAYOR CATEGORY	FULL CHARGES THIS PERIOD (a)	AMOUNT COLLECTED THIS PERIOD (b)	
1. Medicaid Non-Managed Care			
2a. Medicaid Managed Care (capitated)			
2b. Medicaid Managed Care (fee-for-service)			
3. TOTAL MEDICAID (LINES 1+2A+2B)	10,120,940.50	7,520,297.69	
4. Medicare Non-Managed Care			
5a. Medicare Managed Care (capitated)			
5b. Medicare Managed Care (fee-for-service)			
6. TOTAL MEDICARE (LINES 4+5A+5B)	5,578,328.27	2,158,319.01	
7. Other Public including Non-Medicaid CHIP (Non Managed Care)			
8a. Other Public including Non-Medicaid CHIP (Managed Care Capitated)			

8b.	Other Public including Non-Medicaid CHIP (Managed Care fee-for-service)		
9.	TOTAL OTHER PUBLIC (LINES 7+8A+8B)	0.00	0.00

Figure 5-33: Sample RPMS UDS Table 9D, page 1

DU UDS 2015 DEMO INDIAN HOSPITAL Page 2  
 UDS No. 000001 Date Run: Dec 15, 2015  
 Reporting Period: Jan 01, 2015 through Dec 31, 2015  
 Population: All (both Indian/Alaskan Natives and Non 01)

TABLE 9D - PATIENT-RELATED REVENUE (SCOPE OF PROJECT ONLY)

PAYOR CATEGORY	FULL CHARGES THIS PERIOD (a)	AMOUNT COLLECTED THIS PERIOD (b)
10. Private Non-Managed Care		
11a. Private Managed Care (capitated)		
11b. Private Managed Care (fee-for-service)		
12. TOTAL PRIVATE (LINES 10+11A+11B)	12,178,983.63	1,658,168.44
13. Self Pay	3,084.51	0.00
14. TOTAL (LINES 3+6+9+12+13)	27,881,336.91	11,336,785.14

Figure 5-34: Sample RPMS UDS Table 9D, page 2

DU UDS 2015 DEMO INDIAN HOSPITAL Page 3  
 UDS No. 000001 Date Run: Dec 15, 2015  
 Reporting Period: Jan 01, 2015 through Dec 31, 2015  
 Population: All (both Indian/Alaskan Natives and Non 01)

TABLE 9D - PATIENT-RELATED REVENUE (SCOPE OF PROJECT ONLY)

RETROACTIVE SETTLEMENTS, RECEIPTS AND PAYPACKS (c)

COLLECTION OF RECONCILIATION/WRAP	COLLECTION OF RECONCILIATION/WRAP AROUND	COLLECTION OF OTHER RETROACTIVE PAYMENTS INCLUDING	PENALTY/PAYBACK
-----------------------------------	--	--	-----------------

PAYOR CATEGORY	AROUND CURRENT YEAR (c1)	PREVIOUS YEARS (c2)	RISK POOL/ INCENTIVE/ WITHHOLD (c3)	(c4)
1. Medicaid Non-Managed Care				
2a. Medicaid Managed Care (capitated)				
2b. Medicaid Managed Care (fee-for-service)				
3. TOTAL MEDICAID (LINES 1+2A+2B)				
4. Medicare Non-Managed Care				
5a. Medicare Managed Care (capitated)				
5b. Medicare Managed Care (fee-for-service)				
6. TOTAL MEDICARE (LINES 4+5A+5B)				

Figure 5-35: Sample RPMS UDS Table 9D, page 3

DU UDS 2015 DEMO INDIAN HOSPITAL Page 4  
 UDS No. 000001 Date Run: Dec 15, 2015  
 Reporting Period: Jan 01, 2015 through Dec 31, 2015  
 Population: All (both Indian/Alaskan Natives and Non 01)

TABLE 9D - PATIENT-RELATED REVENUE (SCOPE OF PROJECT ONLY)

PAYOR CATEGORY	RETROACTIVE SETTLEMENTS, RECEIPTS AND PAYPACKS (c)			
	COLLECTION RECONCILIATION/ WRAP AROUND AROUND CURRENT YEAR (c1)	COLLECTION OF RECONCILIATION/ WRAP AROUND PREVIOUS YEARS (c2)	COLLECTION OF OTHER RETROACTIVE PAYMENTS INCLUDING RISK POOL/ INCENTIVE/ WITHHOLD (c3)	PENALTY/ PAYBACK (c4)
7. Other Public including Non-Medicaid CHIP (Non Managed Care)				
8a. Other Public including Non-Medicaid CHIP (Managed Care Capitated)				
Other Public including				

8b.	Non-Medicaid CHIP (Managed Care fee-for-service)
TOTAL OTHER PUBLIC	
9.	(LINES 7+8A+8B)
Private Non-Managed	
10.	Care
Private Managed Care	
11a.	(capitated)
Private Managed Care	
11b.	(fee-for-service)
TOTAL PRIVATE	
12.	(LINES 10+11A+11B)
13.	Self Pay
TOTAL	
14.	(LINES 3+6+9+12+13)

Figure 5-36: Sample RPMS UDS Table 9D, page 4

DU	UDS 2015	DEMO INDIAN HOSPITAL	Page 5
UDS No.	000001	Date Run:	Dec 15, 2015
Reporting Period:	Jan 01, 2015 through Dec 31, 2015		
Population:	All (both Indian/Alaskan Natives and Non 01)		
TABLE 9D - PATIENT-RELATED REVENUE (SCOPE OF PROJECT ONLY)			
PAYOR CATEGORY	ALLOWANCES (d)	SLIDING DISCOUNTS (e)	BAD DEBT WRITE OFF (f)
1.	Medicaid Non-Managed Care		
2a.	Medicaid Managed Care (capitated)		
2b.	Medicaid Managed Care (fee-for-service)		
3.	TOTAL MEDICAID (LINES 1+2A+2B)	9,502,679.80	
4.	Medicare Non-Managed Care		
5a.	Medicare Managed Care (capitated)		
5b.	Medicare Managed Care (fee-for-service)		

TOTAL MEDICARE		
6.	(LINES 4+5A+5B)	4,382,506.95
Other Public including		
7.	Non-Medicaid CHIP (Non Managed Care)	
Other Public including		
8a.	Non-Medicaid CHIP (Managed Care Capitated)	
Other Public including		
8b.	Non-Medicaid CHIP (Managed Care fee-for-service)	
TOTAL OTHER PUBLIC		
9.	(LINES 7+8A+8B)	0.00

Figure 5-37: Sample RPMS UDS Table 9D, page 5

DU UDS 2015 DEMO INDIAN HOSPITAL Page 6  
 UDS No. 000001 Date Run: Dec 15, 2015  
 Reporting Period: Jan 01, 2015 through Dec 31, 2015  
 Population: All (both Indian/Alaskan Natives and Non 01)

TABLE 9D - PATIENT-RELATED REVENUE (SCOPE OF PROJECT ONLY)

PAYOR CATEGORY	ALLOWANCES (d)	SLIDING DISCOUNTS (e)	BAD DEBT WRITE OFF (f)
10. Private Non-Managed Care			
11a. Private Managed Care (capitated)			
11b. Private Managed Care (fee-for-service)			
12. TOTAL PRIVATE (LINES 10+11A+11B)	5,359,062.71		
13. Self Pay		0.00	
14. TOTAL (LINES 3+6+9+12+13)	19,244,249.46		

Figure 5-38: Sample RPMS UDS Table 9D, page 6

### 5.3 How to Run Reports

**Note:** Before any reports are run, the system manager must identify all visit locations that should be counted toward your site’s UDS reporting in the Site Parameters Setup. Your report will have no values if no locations are defined. (See Section 3.1.1 to identify all visit locations that are eligible.)

To begin:

1. From the UDS 2015 Main Menu, type **REP** at the “Select UDS 2015 Option” prompt.

```

*****
**      RPMS UNIFORM DATA SYSTEM (UDS)      **
**                               2015          **
*****
                                DEMO INDIAN HOSPITAL
                                Version 10.0

REP      Reports ...
MU       Manager Utilities ...

Select UDS 2015 Option: REP <Enter> Reports
    
```

Figure 5-39: UDS 2015 Main Menu

2. The UDS 2015 Reports menu displays.

```

*****
**      RPMS UNIFORM DATA SYSTEM (UDS)      **
**                               2015 Reports  **
*****
                                DEMO INDIAN HOSPITAL
                                Version 10.0

Z       Patients by Zip Codes and Insurance Source
3A      Table 3A: Patients by Age and Gender
3B      Table 3B: Patients by Hisp Identity/Race/Language
4       Table 4: Selected Patient Characteristics
ST      Table 5 (a): Staffing List only (column A)
5       Table 5 (b&c): Staffing and Utilization (cols b&c)
6A      Table 6A: Selected Diagnoses and Services Rendered
6B      Table 6B: Quality of Care Indicators
7       Table 7: Health Outcomes and Disparities
9D      Table 9D: Patient-Related Revenue (Totals Only)
DR      Table 9D: Patient-Related Revenue (Delimited Rept)
M       Multiple/ALL Tables Zip through 9D

Select Reports Option:
    
```

Figure 5-40: UDS 2015 Reports Menu

3. Type the number or letter corresponding to the report you want to run at the “Select Reports Option” prompt.

4. A description of the report you have requested displays.

```

                                DEMO INDIAN HOSPITAL
                                UDS 2015

UDS searches your database to find all visits and related patients during
the time period selected. Based on the UDS definition, to be considered a
patient the patient must have had at least one visit meeting the following
criteria:
- must be to a location specified in your visit location setup
- must be to Service Category Ambulatory (A), Hospitalization (H), Day
  Surgery (S), Observation (O), Telemedicine (M), Nursing home visit
  (R), or In-Hospital (I) visit
- must NOT have an excluded clinic code (see User Manual for a list)
- must have a primary provider and a coded purpose of visit
- the patient must NOT have a gender of 'Unknown'

TABLE 5 (b&c): STAFFING AND UTILIZATION
This report will produce UDS Table 5 that itemizes visits and patients
(columns b and c only) by primary provider discipline.
Enter your site:
    
```

Figure 5-41: Running UDS Reports, Steps 3–4, selecting one report

5. If you select the M Multiple/ALL Tables Zip through 9D option, a second menu of report choices displays. Type the numbers of the reports you want to run at the “Include Which Tables” prompt, separated by commas or hyphens. For example, to select Tables 1, 3, and 4, type **1,3-4** with no spaces between entries.

**Note:** Tables 6B and 7 must be run using the Full Calendar Year option. If these reports are run using the Quarterly options, the totals combined will not match the yearly totals.

```

UDS Table Selection

1  Patients by Zip Code and Insurance Source
2  Table 3A: Patients by Age and Gender
3  Table 3B: Patients by Hispanic or Latino Identity/Race/Language
4  Table 4: Selected Patient Characteristics
5  Table 5 (a): Staffing List only (column A)
6  Table 5 (b&c): Staffing and Utilization (cols b&c)
7  Table 6A: Selected Diagnoses and Services Rendered
8  Table 6B: Quality of Care Indicators
9  Table 7: Health Outcomes and Disparities
10 Table 9D: Patient-Related Revenue (Totals Only)
11 Table 9D: Patient-Related Revenue (Delimited Rept)
12 Multiple/ALL Tables Zip through 9D
Include which Tables: (1-12): 1// 1,3-4 <Enter>
    
```

Figure 5-42: Running UDS Reports, Step 5, selecting multiple reports

6. Enter your site name at the “Enter your site” prompt.

7. The system will check to see if all taxonomies are present and will display a message. If all taxonomies are present, press Enter to continue. If all taxonomies are not present and you want to cancel the report, type a caret (^) and then follow the steps in Section 3.2.1 to edit the taxonomies.
8. Type the calendar year at the “Enter Calendar Year” prompt.
9. Type the number corresponding to the time period (quarter or full year) for the report.
10. Select the Patient Classification to be used for the report.
11. If Table 9D: Patient-Related Revenue (Delimited Report) enter a filename for the delimited report at the “You have selected to create a delimited output file for Table 9D. Enter a filename for the delimited output (no more than 40 characters):” prompt. If Table 9D: Patient-Related Revenue (Delimited Report) is *not* selected, skip to Step 13.
12. Type the name of the printer or electronic file to which you want the report to print.

```

Enter your site:      DEMO INDIAN HOSPITAL
Checking for Taxonomies to support the 2015 UDS Report...

All taxonomies are present.

End of taxonomy check.  PRESS ENTER: <Enter>

Enter the Calendar Year.  Use a 4 digit year, e.g. 2003, 2007
Enter Calendar Year:  2015 <Enter>  (2015)

      Select one of the following:

          1          1st Quarter (January 1-March 31)
          2          2nd Quarter (April 1-June 30)
          3          3rd Quarter (July 1-September 30)
          4          4th Quarter (October 1-December 31)
          F          Full Calendar Year (January 1-December 31)

Choose the time period to report on: F// F <Enter> Full Calendar Year
(January 1-December 31)

Your report will be run for the time period: Jan 01, 2015 to Dec 31, 2015

      Select one of the following:

          1          Indian/Alaskan Native (Classification 01)
          2          Not Indian Alaskan/Native (Not Classification 01)
          3          All (both Indian/Alaskan Natives and Non 01)

Select Beneficiary Population to include in this report: 1//
Indian/Alaskan Native (Classification 01)

You have selected to create a delimited output file for Table 9D. Enter a
filename for the delimited output (no more than 40 characters):
DemoDelimited9DReport

```

```
When the report is finished your delimited output will be found in the  
Q:\ directory. The filename will be DemoDelimited9DReport.txt  
  
DEVICE: HOME//
```

Figure 5-43: Running UDS Reports, Steps 6–11, selecting the Time Period

## 6.0 Patient Lists

For each report, RPMS UDS can also produce a corresponding list of patients and visits that are counted in the report. These lists can be used by a site to either verify data for accuracy or assist you with calculating reports where the data is not automatically calculated (e.g., Table 5 Column A (FTEs), Table 6B Sections A & B, Table 7 Section A) and to use as report backup for an auditor. Lists include:

- LST1–Lists for Tables Zip Code, 3A&3B, 4, 5, and 6A
  - Patient List by zip code and insurance source
  - Patient list with age and gender information about the patient and a list of all visits for the patient during the report period, used with Table 3A
  - Patient list with Hispanic Identity and race information about the patient and a list of all visits for the patient during the report period, used with Table 3B
  - Patient List used with Table 4, Income As A Percent Of Poverty Level section (Number of patients with an Income as A Percent of Poverty Level (i.e. equal to or less than ( $\leq$ ) 100%, 101-150%, 151-200%, greater than ( $>$ ) 200%, Unknown))
  - Patient List used with Table 4, Principle Third Party Medical Insurance Source section (Number of patients with or without a Principle Third Party Medical Insurance Source)
  - Patient List used with Table 4, Characteristics - Special Populations section (Number of patients with Characteristics of Special Populations (i.e. migrant workers, seasonal workers, homeless, school based health center patient, or a veteran))
  - Staffing (Provider) List categorized by BPHC-defined categories to assist in manual calculations of Table 5 Column A (FTEs)
  - Patient List categorized by UDS-defined service categories (primary provider code) used with Table 5, Columns B (Visits) and C (Patients)
  - Patient List of visits for patients to whom the provider was uncategorized (i.e. did not map to the BPHC-defined categories), used with Table 5, Columns B (Visits) and C (Patients)
  - Patient List categorized by selected diagnoses regardless of primacy and other services, used with Table 6A

**Note:** The Visits with Uncategorized Primary Providers list report produces a list of visits that are not counted toward Table 5 Column B (Visits), allowing sites to re-categorize the provider code, if necessary.

- LST2–Lists for Table 6B

- Patient list by age that had pregnancy-related visits during the past 20 months with at least one pregnancy-related visit during the report period, used with Table 6B Sections A & B.
- Patient list of two-year-old patients who had their first visit prior to their second birthday, had a medical visit during the report period, and have all required childhood immunizations, used with Table 6B Section C.
- Patient list of two-year-old patients who had their first visit prior to their second birthday, had a medical visit during the report period, and list the immunizations still needed to complete all required childhood immunizations, used with Table 6B Section C.
- Patient list of all female patients ages 24–64 who have not had a hysterectomy, had a medical visit during the report period, were first seen in the clinic by their 65th birthday, and had a Pap test in the past three years, or the four years prior to the report period for women age 30-64 when an HPV test is accompanied with the pap test, used with Table 6B Section D.
- Patient list of all female patients ages 24–64 who have not had a hysterectomy, had a medical visit during the report period, were first seen in the clinic by their 65th birthday, and *did not* have a Pap test in the past three years, used with Table 6B Section D.
- Patient list of all children and adolescents ages 2-17 who had a medical visit during the report period, were first seen ever by the health center prior to their 17th birthday, and had body mass index (BMI) documented and counseling for nutrition and physical activity during the report period, used with Table 6B Section E.
- Patient list of all children and adolescents ages 2-17 who had a medical visit during the report period, were first seen ever by the health center prior to their 17th birthday, and *did not* have BMI documented or counseling for nutrition and physical activity during the report period, used with Table 6B Section E.
- Patient list of all adults age 18 or older who had a medical visit during the report period and had BMI documented and if overweight or underweight, a follow-up plan documented, used with Table 6B Section F.
- Patient list of all adults age 18 or older who had a medical visit during the report period and *did not* have BMI documented or if overweight or underweight, *did not* have a follow-up plan documented, used with Table 6B Section F.
- Patient list of all adults age 18 or older who had a medical visit during the report period, at least two medical visits ever, were ever seen after their 18th birthday, and were queried/screened about any and all forms tobacco use AND received documented cessation counseling intervention (counseling) or medication (smoking cessation agents) if identified as a tobacco user one or more times during the report period or the prior year, used with Table 6B Section G.

- Patient list of all adults age 18 or older who had a medical visit during the report period, at least two medical visits ever, were ever seen after their 18th birthday, and *were not* queried/screened about any and all forms tobacco use or *did not* receive a documented cessation counseling intervention (counseling) or medication (smoking cessation agents) if identified as a tobacco user one or more times during the report period or the prior year, used with Table 6B Section G.
- Patient list of all patients ages 5-40 with a diagnosis of mild, moderate or severe persistent asthma who had a medical visit during the report period, at least two medical visits ever, who received a prescription for or provided inhaled corticosteroid or an accepted alternative medication, used with Table 6B Section H.
- Patient list of all patients ages 5-40 with a diagnosis of mild, moderate or severe persistent asthma who had a medical visit during the report period, at least two medical visits ever, who *did not* receive a prescription for or provided inhaled corticosteroid or an accepted alternative medication, used with Table 6B Section H.
- Patient list of all patients 18 years of age and older with an active diagnosis of Coronary Artery Disease (CAD) including myocardial infarction (MI), or have had cardiac surgery, and whose last Low-Density Lipoprotein (LDL) was greater than or equal to 130 who were prescribed a lipid-lowering therapy medication or have documented evidence of use by patient of lipid lowering medication during the report period, and does not have an allergy or adverse reaction to lipid-lowering therapy medications, used with Table 6B Section I.
- Patient list of all patients 18 years of age and older with an active diagnosis of CAD including MI or have had cardiac surgery and whose last LDL was greater than or equal to 130 or last recorded LDL is greater than 1yr from last visit in the report year who *were not* prescribed a lipid-lowering therapy medication or has no documented evidence of use by patient of lipid lowering medication during the report period or has an allergy or adverse reaction to lipid-lowering therapy medications Section I.
- Patient list of patients 18 years of age and older who, in the current or prior report year, were diagnosed with Ischemic Vascular Disease (IVD) including acute myocardial infarction (AMI), or discharged alive after cardiovascular surgery (coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA)) and were prescribed or dispensed aspirin or another anti-thrombotic medication or have documented evidence of use by patient of aspirin or another anti-thrombotic medication during the report period, used with Table 6B Section J.

- Patient list of patients 18 years of age and older who, in the current or prior report year, were diagnosed with IVD including AMI, or discharged alive after cardiovascular surgery (CABG or PTCA) and *were not* prescribed or dispensed aspirin or another anti-thrombotic medication or *has no* documented evidence of use by patient of aspirin or another anti-thrombotic medication during the report period, used with Table 6B Section J.
- Patient list of all patients age 51-74 as of December 31 of the report period, not diagnosed with colorectal cancer, who has a documented colorectal cancer screen, used with Table 6B Section K.
- Patient list of all patients age 51-74 as of December 31 of the report period, not diagnosed with colorectal cancer, who did not have a documented colorectal cancer screen, used with Table 6B Section K.
- Patient list of all patients who had a medical visit during the report period and whose first ever HIV diagnosis occurred between October 1 of the prior year through September 30th of the current report year and had a medical visit for HIV care within 90 days of the first-ever HIV diagnosis, used with Table 6B Section L.
- Patient list of all patients who had a medical visit during the report period and whose first ever HIV diagnosis occurred between October 1 of the prior year through September 30th of the current report year and *did not* have a medical visit for HIV care within 90 days of the first-ever HIV diagnosis, used with Table 6B Section L.
- Patient list of all patients 12 years and older who had at least one medical visit during the report year and were screened for depression with a standardized tool during the report year AND had a follow-up plan documented if screened positive, used with Table 6B Section M.
- Patient list of all patients 12 years and older who had at least one medical visit during the report year and does not have a depression screen with a standardized tool during the report year with or without a depression follow-up plan documented, used with Table 6B Section M.
- Patient list of all patients 6-9 years who had an oral assessment, were determined to be at moderate or high risk for caries and had a sealant placed on a first molar during the reporting period, used with Table 6B Section N.
- Patient List of all patients 6-9 years who had an oral assessment, were determined to be at moderate or high risk for caries and did not have a sealant placed on a first molar during the reporting period, used with Table 6B Section N.
- LST3–Lists for Table 7
  - Patient list of patients that had pregnancy-related visits during the past 20 months, with at least one pregnancy-related visit during the report period, and who have been diagnosed with HIV, used with Table 7 Section A.

- Patient list by race and Hispanic or Latino identity of patients that had pregnancy-related visits during the past 20 months, with at least one pregnancy-related visit during the report period, used with Table 7 Section A.
- Patient list by race and Hispanic or Latino identity of patients ages 18 to 85 years old who have had two medical visits during the report period and were diagnosed with hypertension before June 30 of the report period, used with Table 7 Section B.
- Patient list by race and Hispanic or Latino identity of patients ages 18 to 85 years old who have had two medical visits during the report period, were diagnosed with hypertension before June 30 of the report period, and who have controlled blood pressure (less than (<) 140/90 mm Hg) during the report period, used with Table 7 Section B.
- Patient list by race and Hispanic or Latino identity of patients ages 18 to 85 years old who have had two medical visits during the report period, were diagnosed with hypertension before June 30 of the report period, and who do not have controlled blood pressure (less than (<) 140/90 mm Hg) during the report period, used with Table 7 Section B.
- Patient list by race and Hispanic or Latino identity of patients ages 18 to 75 years old who have had two medical visits during the report period, with a diagnosis of Type I or Type II diabetes anytime through the end of the report period, and without a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes, used with Table 7 Section C.
- Patient list by race and Hispanic or Latino identity of patients ages 18 to 75 years old who have had two medical visits during the report period, with a diagnosis of Type I or Type II diabetes anytime through the end of the report period, and without a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes and with a most recent hemoglobin A1c of less than 8%, used with Table 7 Section C.
- Patient a list by race and Hispanic or Latino identity of patients ages 18 to 75 years old who have had two medical visits during the report period, with a diagnosis of Type I or Type II diabetes anytime through the end of the report period, and without a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes and with a most recent hemoglobin A1c greater than 9%, or with an A1c with no result, or with no A1c test during the report period, used with Table 7 Section C.

Patient lists are run from the Manager Utilities menu option. Because patient lists may be hundreds or even thousands of pages long, depending on the size of a site's patient population, the menu options are "hidden" where casual users will not run them by accident.

**Note:** It is strongly recommended that patient lists be printed to an electronic file since they may be hundreds or thousands of pages long.

## 6.1 Patient List Definitions

### 6.1.1 ZIP–All Patients w/Visits by Zip and Ins Source

This report lists all patients counted toward the Zip Code Table who have at least one visit for the specified time period that meets the visit definition criteria. Sorted by patients descending, community, gender, name, and their insurance source this report lists all patients that fit the definition.

### 6.1.2 USVA–All Patients w/Visits, By Age and Gender (Tables 3A)

This report lists all patients who have at least one visit for the specified time period that meets the visit definition criteria. Sorted by community, age, and gender and lists all visits that fit the definition. Age is calculated as of June 30th of the report year.

### 6.1.3 USVR–All Pts w/Visits, by Hispanic or Latino Identity & Race (Table 3B)

This report lists all patients by Hispanic or Latino Identity/Race/Language who have at least one visit for the specified time period that meets the visit definition criteria. Sorted by race/Hispanic identity, age, gender, and community and lists all visits that fit the definition. Age is calculated as of June 30th of the report year.

### 6.1.4 IPPL–Income Percent of Poverty Level (Table 4)

This report lists all patients with an income percent of poverty level (equal to or less than ( $\leq$ ) 100%, 101-150%, 151-200%, greater than ( $>$ ) 200%, Unknown) who have at least one visit for the specified time period that meets the visit definition criteria. Sorted by Income as Percent of Poverty Level, community, age, and gender and lists all visits that fit the definition. Age is calculated as of June 30th of the report year.

### 6.1.5 PMIS–Principle Third Party Medical Insurance (Table 4)

This report lists all patients and the type of medical insurance the patient had as of the patient's last visit, if any, during the report period and who have at least one visit for the specified time period that meets the visit definition criteria. Sorted by Principle Third Party Medical Insurance, community, age, and gender and lists all visits that fit the definition. Age is calculated as of June 30th of the report year

### 6.1.6 CHAR–Characteristics of Special Populations (Table 4)

This report lists all patients who are migrant workers, seasonal workers, homeless, school based health center patient, or a veteran during the report period and who have at least one visit for the specified time period that meets the visit definition criteria. Sorted by Special Characteristics, community, age, and gender and lists all visits that fit the definition. Age is calculated as of June 30th of the report year

### 6.1.7 PROV–Provider/Staff List (Table 5 Column A)

This report provides a list of all providers and other facility staff who are documented in RPMS and with whom patients had visits during the report period where the provider was the primary provider, categorized by BPHC-UDS-defined service categories. You should use this list to manually calculate FTEs for each staff category to document in Table 5 Column A (FTEs).

### 6.1.8 SER–All Patients By Service Category (Table 5, Columns B and C)

This report lists all patients and related eligible visits, categorized by BPHC UDS-defined service categories (primary provider code) and sorted by community, age, and gender. See Appendix C: for how UDS disciplines are mapped to RPMS provider codes. Age is calculated as of June 30th of the report year.

### 6.1.9 UCP–Visits w/Uncategorized Primary Provider (Table 5, Columns B and C)

This report provides a list of patients who had visits during the specified calendar year to providers who were not mapped to any BPHC major service category and sorted by community, age, and gender. (See Appendix C: for details of how RPMS provider codes are mapped to UDS service categories.) Age is calculated as of June 30th of the report year.

### 6.1.10 DIAG–All Patients by Selected Diagnosis (Table 6A)

This report provides a list of patients who had visits during the report period, had a specified diagnosis, had a specified diagnostic test or screening performed, or who had a specified dental service performed and sorted by community, age, and gender.

### 6.1.11 M–Multiple/ALL Lists Zip through 6A

This report enables the user to run all lists or to select multiple lists to run for the Zip Code, 3A, 3B, 5, and 6A tables.

### 6.1.12 PRGA–All Pregnant Patients by Age (Table 6B Sections A & B)

This report provides a list of patients by age that had pregnancy-related visits during the past 20 months, with at least one pregnancy-related visit during the report period, sorted in age brackets by age. You should use this list to manually calculate Sections A & B (Lines 1–9).

### 6.1.13 CIM1–All Patients Age 2 w/All Child Immunizations (Table 6B Section C)

This report provides a list of three year old patients who had their first visit prior to their 3rd birthday, had a medical visit during the report period, and have all required childhood immunizations (4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1 Varicella and 4 Pneumococcal conjugate) sorted by last name. Age is calculated as of December 31.

### 6.1.14 CIM2–All Patients Age 2 w/o All Child Immunizations (Table 6B Section C)

This report provides a list of three year old patients who had their first visit prior to their 3rd birthday, had a medical visit during the report period, and list the immunizations still needed to complete all required childhood immunizations (4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1 Varicella, and 4 Pneumococcal conjugate) sorted by last name. Age is calculated as of December 31.

### 6.1.15 PAP1–All Female Patients w/Pap Test (Table 6B Section D)

This report provides a list of all female patients ages 24–64 who have not had a hysterectomy, had a medical visit during the report period, were first seen in the clinic by their 65th birthday, and had a Pap test in the past three years or received a pap test accompanied with an HPV test done during the measurement year or the four years prior for women over 30 years of age sorted by age and last name. Age is calculated as of December 31.

### 6.1.16 PAP2–All Female Patients w/o Pap Test (Table 6B Section D)

This report provides a list of all female patients ages 24–64 who have not had a hysterectomy, had a medical visit during the report period, were first seen in the clinic by their 65th birthday, and did not have a Pap test in the past three years or the four years prior to the report period for women age 30-64 when an HPV test is accompanied with the pap test sorted by age and last name. Age is calculated as of December 31.

### 6.1.17 WAC1–All Patients 2-17 w/WT Assessment & Counseling (Table 6B Section E)

This report provides a list of all patients ages 2-17 who have documented BMI percentile, counseling for nutrition, counseling for physical activity, had a medical visit during the report period, and were first ever seen in the clinic by their 17th birthday sorted by age and last name. Age is calculated as of December 31.

**Note:** The patient must turn three during the report period; therefore, patients in this list will range from the age of 3 to 17.

#### 6.1.18 WAC2–All Patients 2-17 w/o WT Assessment & Counseling (Table 6B Section E)

This report provides a list of all patients ages 2-17 who does not have documented BMI percentile, or counseling for nutrition, or counseling for physical activity, had a medical visit during the report period, and were first ever seen in the clinic by their 17th birthday sorted by age and last name. Age is calculated as of December 31.

**Note:** The patient must turn three during the report period; therefore, patients in this list will range from the age of 3 to 17.

#### 6.1.19 AWS1–All Patients 18+ w/BMI & over/underweight w/plan (Table 6B Section F)

This report provides a list of all patients 18 years and older who have documented BMI percentile on the last visit during the report period or on any visit within the last six months of the last visit during the report period, and are overweight or underweight, and patient had a follow-up plan documented, had a medical visit during the report period, and were ever seen after their 18th birthday sorted by age and last name. Age is calculated as of December 31.

#### 6.1.20 AWS2–All Patients 18+ w/o BMI or w/o follow-up plan (Table 6B Section F)

This report provides a list of all patients 18 years and older who does not have documented BMI percentile on the last visit during the report period or on any visit within the last six months of the last visit during the report period, or who are not overweight or underweight, or does not have a follow-up plan documented, had a medical visit during the report period, and were ever seen after their 18th birthday sorted by age and last name. Age is calculated as of December 31.

#### 6.1.21 TUA1–All Patients 18+ w/tobacco use scrn & cessation (Table 6B Section G)

This report provides a list of all patients 18 years and older who were queried/screened about any and all forms tobacco use AND received documented cessation counseling intervention (counseling) or medication (smoking cessation agents) if identified as a tobacco user one or more times during the report period or the prior year, had at least one medical visit during the report period, and with at least

two medical visits ever, and were ever seen after their 18th birthday. Age is calculated as of December 31.

#### **6.1.22 TUA2–All Patients 18+ w/o tobacco use scrn or cessation (Table 6B Section G)**

This report provides a list of all patients 18 years and older who were not queried/screened about any and all forms tobacco use or did not receive a documented cessation counseling intervention (counseling) or medication (smoking cessation agents) if identified as a tobacco user one or more times during the report period or the prior year, had at least one medical visit during the report period, and with at least two medical visits ever, and were ever seen after their 18th birthday. Age is calculated as of December 31.

#### **6.1.23 APT1–All Asthma Pts 5-40 w/Asthma Therapy Medication (Table 6B Section H)**

This report provides a list of all patients 5-40 years of age with an active diagnosis of persistent asthma (either mild, moderate, or severe) who were prescribed either the preferred long term control medication or an acceptable alternative pharmacological therapy during the report period, had at least two medical visits ever, and had a medical visit during the report period sorted by age and last name. Age is calculated as of December 31.

#### **6.1.24 APT2–All Asthma Pts 5-40 w/o Asthma Therapy Medication (Table 6B Section H)**

This report provides a list of all patients 5-40 years of age with an active diagnosis of persistent asthma (either mild, moderate, or severe) who were not prescribed either a preferred long term control medication or an acceptable alternative pharmacological therapy or patients 5-40 years of age without an active diagnosis of persistent asthma who were prescribed either the preferred long term control medication or an acceptable alternative pharmacological therapy during the report period, had at least two medical visits ever, and had a medical visit during the report period sorted by age and last name. Age is calculated as of December 31.

#### **6.1.25 CAD1–All CAD Patients 18+ w/Lipid Therapy (Table 6B Section I)**

This report provides a list of all patients 18 years of age and older with an active diagnosis of CAD including MI, or have had cardiac surgery, and whose last LDL was greater than or equal to 130 who were prescribed a lipid-lowering therapy medication or have documented evidence of use by patient of lipid lowering medication during the report period, does not have an allergy or adverse reaction to lipid-lowering therapy medications, had at least two medical visits ever, and had a medical visit during the report period. Age is calculated as of December 31.

**6.1.26 CAD2–All Patients 18+ w/o Lipid Therapy (Table 6B Section I)**

This report provides a list of all patients 18 years of age and older with an active diagnosis of CAD including MI or have had cardiac surgery and whose last LDL was greater than or equal to 130 or last recorded LDL is greater than 1yr from last visit in the report year who were not prescribed a lipid-lowering therapy medication or has no documented evidence of use by patient of lipid lowering medication during the report period or has an allergy or adverse reaction to lipid-lowering therapy medications, had at least two medical visits ever, and had a medical visit during the report period. Age is calculated as of December 31.

**6.1.27 IVD1–All IVD Pts 18+ w/ASA or Antithrombotic (Table 6B Section J)**

This report provides a list of patients 18 years of age and older who, in the current or prior report year, were diagnosed with IVD including AMI, or discharged alive after cardiovascular surgery (CABG or PTCA) and were prescribed or dispensed aspirin or another anti-thrombotic medication or have documented evidence of use by patient of aspirin or another anti-thrombotic medication during the report period, and had a medical visit during the report period. Age is calculated as of December 31.

**6.1.28 IVD2–All IVD Pts 18+ w/o ASA or Antithrombotic (Table 6B Section J)**

This report provides a list of patients 18 years of age and older who, in the current or prior report year, were diagnosed with IVD including AMI, or discharged alive after cardiovascular surgery (CABG or PTCA) and were not prescribed or dispensed aspirin or another anti-thrombotic medication or has no documented evidence of use by patient of aspirin or another anti-thrombotic medication during the report period, and had a medical visit during the report period. Age is calculated as of December 31.

**6.1.29 CRC1–All Patients 51-74 years of age w/CRC Scrn (Table 6B Section K)**

This report provides a list of all patients age 51-74 as of December 31 of the report period, not diagnosed with colorectal cancer, who has a documented colorectal cancer screen, and had at least one medical visit during the reporting year. Age is calculated as of December 31.

**6.1.30 CRC2–All Patients 51-74 years of age w/o CRC Scrn (Table 6B Section K)**

This report provides a list of all patients age 51-74 as of December 31 of the report period, not diagnosed with colorectal cancer, who did not have a documented colorectal cancer screen, and had at least one medical visit during the reporting year. Age is calculated as of December 31.

**6.1.31 HIV1- All Patients w/First HIV Dx & Timely Follow-up (Table 6B Section L)**

This report provides a list of all patients whose first ever HIV diagnosis occurred between October 1 of the prior year through September 30th of the current report year and had a medical visit for HIV care within 90 days of the first-ever HIV diagnosis, and had at least one medical visit during the report year. Age is calculated as of December 31.

**6.1.32 HIV2- All Patients w/First HIV Dx w/o Timely Follow-up (Table 6B Section L)**

This report provides a list of all patients whose first ever HIV diagnosis occurred between October 1 of the prior year through September 30th of the current report year and did not have a medical visit for HIV care within 90 days of the first-ever HIV diagnosis, and had at least one medical visit during the report year. Age is calculated as of December 31.

**6.1.33 DEP1- All Patients 12+ w/DEP and Follow-up (Table 6B Section M)**

This report provides a list of all patients 12 years and older who were screened for depression with a standardized tool during the report year and had a follow-up plan documented if screened positive, and had at least one medical visit during the report year. Age is calculated as of December 31.

**6.1.34 DEP2- All Pts 12+ w/o Dep Scrn or w/o Follow-up (Table 6B Section M)**

This report provides a list of all patients 12 years and older not screened for depression or who were screened for depression with a standardized tool during the report year and does not have a follow-up plan documented if screened positive, and had at least one medical visit during the report year. Age is calculated as of December 31.

**6.1.35 DEN1- All Patients 6-9 at Risk with First Molar Sealant (Table 6B Section N)**

This report provides a list of all patients 6-9 years who had an oral assessment, were determined to be at moderate or high risk for caries and had a sealant placed on a first molar during the reporting period. Age is calculated as of December 31.

### 6.1.36 DEN2- All Patients 6-9 at Risk w/o First Molar Sealant (Table 6B Section N)

This report provides a list of all patients 6-9 years who had an oral assessment, were determined to be at moderate or high risk for caries and did not have a sealant placed on a first molar during the reporting period. Age is calculated as of December 31.

### 6.1.37 M6B–Multiple/ALL Lists for Table 6B

This report enables the user to run all lists or to select multiple lists to run for Table 6B.

### 6.1.38 PRGH–All Pregnant Patients w/HIV (Table 7 HIV Positive Pregnant Women)

This report provides a list of patients that had pregnancy-related visits during the past 20 months, with at least one pregnancy-related visit during the report period, and who have been diagnosed with HIV sorted by age and last name. Age is calculated as of June 30.

### 6.1.39 PRGR–All Pregnant Patients by Race & Hisp Identity (Table 7 Section A)

This report provides a list of all pregnant patients by race and Hispanic or Latino identity, with most recent pregnancy related visits during the past 20 months, with at least one pregnancy-related visit during the report period sorted by race/Hispanic identity, community, age and last name. Age is calculated as of June 30. You should use this list to manually calculate Sections A (Lines 1-5).

### 6.1.40 MPRG–Multiple/ALL Lists for Pregnant Patients (Table 7 HIV Positive Pregnant Women & Section A)

This report enables the user to run all lists or to select multiple lists to run for Table 7 HIV Positive Pregnant Women Line and Section A (Deliveries and Birth Weight By Race and Hispanic/Latino Identity, Lines 1–5).

### 6.1.41 HTR–All HTN Patients by Race & Hisp Identity (Table 7 Section B)

This report provides a list by race and Hispanic or Latino identity of all patients' ages 18 to 85 years old who have had two medical visits during the report period and were diagnosed with hypertension anytime before June 30 of the report period. The list displays the patient's most recent hypertension diagnosis before June 30 of the report period sorted by race/Hispanic identity, community, age and last name. Age is calculated as of December 31.

#### 6.1.42 HTCR–All HTN Pts w/Contr BP by Race & Hisp Identity (Table 7 Section B)

This report provides a list by race and Hispanic or Latino identity of all patients ages 18 to 85 years old who have had two medical visits during the report period and were diagnosed with hypertension any time before June 30 of the report period and who have controlled blood pressure (less than (<) 140/90 mm Hg) during the report period. The list displays the patient's last blood pressure (less than (<) 140/90 mm Hg) sorted by race/Hispanic identity, community, age and last name. Age is calculated as of December 31.

#### 6.1.43 HTUR–All HTN Pts w/Uncont BP by Race & Hisp Identity (Table 7 Section B)

This report provides a list by race and Hispanic or Latino identity of all patients ages 18 to 85 years old who have had two medical visits during the report period and were diagnosed with hypertension any time before June 30 of the report period and who do not have controlled blood pressure (less than (<) 140/90 mm Hg) during the report period. The list displays the patient's last blood pressure results or no blood pressure taken sorted by race/Hispanic identity, community, age and last name. Age is calculated as of December 31.

#### 6.1.44 MHT–Multiple/ALL Lists for HTN Patients (Table 7 Section B)

This report enables the user to run all lists or to select multiple lists to run for Table 7 Section B (Hypertension By Race and Hispanic/Latino Identity, Lines 6–8).

#### 6.1.45 DMR–All DM Patients by Race & Hisp Identity (Table 7 Section C)

This report provides a list by race and Hispanic or Latino identity of all patients ages 18 to 75 years old who have had two medical visits during the report period, and were diagnosed with Type I or Type II diabetes anytime through the end of the report period, and without a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes sorted by race/Hispanic identity, community, age and last name. Age is calculated as of December 31.

#### 6.1.46 DMR1–All DM Patients w/A1c <8 by Race & Hisp Identity (Table 7 Section C)

This report provides a list by race and Hispanic or Latino identity of all patients ages 18 to 75 years old who have had two medical visits during the report period, and were diagnosed with Type I or Type II diabetes anytime through the end of the report period, and without a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes and whose most recent hemoglobin A1c of less than 8% sorted by race/Hispanic identity, community, age and last name. Age is calculated as of December 31.

### 6.1.47 DMR2–All DM Patients w/o A1c or >9 by Race & Hisp Identity (Table 7 Section C)

This report provides a list by race and Hispanic or Latino identity of all patients ages 18 to 75 years old who have had two medical visits during the report period, and were diagnosed with Type I or Type II diabetes anytime through the end of the report period, and without a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes and whose most recent hemoglobin A1c is greater than (>) 9%, or did not have a result, or the patient did not have an A1c test during the report period sorted by race/Hispanic identity, community, age and last name. Age is calculated as of December 31.

### 6.1.48 MDM–Multiple/ALL Lists for DM Patients (Table 7 Section C)

This report enables the user to run all lists or to select multiple lists to run for Table 7 Section C (Diabetes By Race and Hispanic/Latino Identity, Lines 9–13).

## 6.2 How to Run Patient and Provider Lists

RPMS UDS will produce both the summary table report and the corresponding patient list. This will enable you to directly compare summary results with the RPMS data that is current at the time the report is run.

1. From the main RPMS UDS 2015 main menu, type **MU** (Manager Utilities).
2. From the Manager Utilities menu, type **LST** at the “Select Manager Utilities Option” prompt.

```

*****
**  RPMS UNIFORM DATA SYSTEM (UDS)  **
**      2015 Manager Utilities      **
*****
                DEMO INDIAN HOSPITAL
                  Version 10.0

SET      Update/Review Site Parameters
LST      Patient and Provider Lists Main Menu ...
STP      Create Search Template of Patients on Table 3A
TAX      Update Taxonomies for Use with UDS 2015

Select Manager Utilities Option:  LST <Enter>  Patient and Provider Lists
Main Menu
    
```

Figure 6-1: Manager Utilities menu

3. The 2015 Patient and Provider Lists menu is displayed. Type **LST1** to view the available lists for Tables Zip Code, 3A, 3B, 4, 5 and 6A.

```

*****
**  RPMS UNIFORM DATA SYSTEM (UDS)  **
** 2015 Patient and Provider Lists  **
    
```

```

*****
                DEMO INDIAN HOSPITAL
                Version 10.0

LST1  Lists for Tables Zip Code, 3A&3B, 4, 5, and 6A ...
LST2  Lists for Table 6B ...
LST3  Lists for Table 7 ...

Select Patient and Provider Lists Main Menu Option: LST1 <Enter>
    
```

Figure 6-2: Patient and Provider Lists menu

- The list options are displayed. Type the letter corresponding to the individual patient list you want to produce, or type **M** to select more than one list.

```

*****
**                RPMS UNIFORM DATA SYSTEM (UDS)                **
**                2015 Patient and Provider List                  **
** Lists for Tables Zip Code, 3A&3B, 5, and 6A                    **
*****

                DEMO INDIAN HOSPITAL
                Version 10.0

ZIP    All Patients w/Visits by Zip and Ins Source
USVA   All Pts w/Visits, by Age & Gender (3A)
USVR   All Pts w/Visits, by Hispanic Identity & Race (3B)
IPPL   Income Percent of Poverty Level (Table 4)
PMIS   Principle Third Party Medical Insurance (Table 4)
CHAR   Characteristics of Special Populations (Table 4)
PROV   Provider/Staff List (Table 5 col A)
SER    All Patients by Service Category (Table 5 col B&C)
UCP    Visits w/Uncategorized Primary Prov (Table 5 B&C)
DIAG   All Patients by Selected DX (Table 6A)
M      Multiple/ALL Lists Zip through 6A

Select Lists for Tables Zip Code, 3A&3B, 5, and 6A Option:
    
```

Figure 6-3: Lists for Tables Zip Code, 3A&3B, 5 and 6A menu

- A message is displayed advising you that the list may be very long and that it is best to print the list to a file. Press Enter to continue.
- A patient list description and definition displays.

```

Select Lists for Tables Zip Code, 3A&3B, 4, 5, and 6A Option: USVA <Enter>
All Pts w/Visit, by Age & Gender (3A)

                DEMO INDIAN HOSPITAL
                UDS 2015

NOTE: Patient lists may be hundreds of pages long, depending on the size of
your patient population. It is recommended that you run these reports at
night and print to an electronic file, not directly to a printer.

Press Enter to Continue: <Enter>
    
```

The Patient List option documents the individual patients and visits that are counted and summarized on each Table report (main menu option REP). The summary Table report is included at the beginning of each List report. UDS searches your database to find all visits and related patients during the time period selected. Based on the UDS definition, to be counted as a patient, the patient must have had at least one visit meeting the following criteria:

- must be to a location specified in your visit location setup
- must be to Service Category Ambulatory (A), Hospitalization (H), Day Surgery (S), Observation (O), Telemedicine (M), Nursing home visit (R), or In-Hospital (I) visit
- must NOT have an excluded clinic code (see User Manual for a list)
- must have a primary provider and a coded purpose of visit
- the patient must NOT have a gender of 'Unknown'

ALL PATIENTS BY AGE & GENDER (Tables 3A)

This report lists all patients who have at least one visit for the specified time period that meets the visit definition criteria. Sorted by community, age, and gender and lists all visits that fit the definition. Age is calculated as of June 30th of the report year.

Figure 6-4: Running a Patient List, Steps 3–6

7. If you selected M Multiple/All Lists Zip through 6A, another list will be displayed. Type the numbers corresponding to the patient lists you want to produce, using commas or hyphens to separate the entries. For example, to select Lists 1, 2, 3, and 5, type **1-3,5**.

**Note:** Do not use spaces between entries.

UDS Patient and Provider List Selection

```

1 All Patients w/Visits by ZIP Code and Insurance Source
2 All Patients w/Visits, by Age & Gender (Tables 3A)
3 All Patients w/Visits, by Hispanic or Latino Identity & Race
(Table 3B)
4 Income Percent of Poverty Level (Table 4)
5 Principle Third Party Medical Insurance Source (Table 4)
6 Characteristics of Special Populations (Table 4)
7 Provider/Staff List (Table 5 col A)
8 All patients by Service Category (Table 5 col B&C)
9 All Visits w/Uncategorized Primary Prov (Table 5 col B&C)
10 All Patients by Diagnosis (Table 6A)
11 ALL Patient Lists for LST1 -Sub Menu
Include which Lists: (1-11): 1// 1-3,5 <Enter>
```

Figure 6-5: Selecting Multiple Lists

8. Enter your site name at the “Enter your site” prompt.
9. The system will check to see if all taxonomies are present and will display a message. If all taxonomies are present, press Enter to continue. If all taxonomies are not present and you want to cancel the report, type a caret (^) and then follow the steps in Section 3.2.1 to edit the taxonomies.

10. Type the calendar year at the “Enter Calendar Year” prompt.
11. Type the number or letter corresponding to the time period for the report (quarters or full calendar year) at the “Choose the time period to report on” prompt.
12. Select the Patient Classification to be used for the report.
13. RPMS UDS will provide a final reminder that the reports may take time to run and include several hundred pages. To exit from the menu now, type **Y** (Yes) at the “Do You Want to Exit This Program Now?” prompt. To proceed with the report, type **N** (No).
14. Select an output type for the report:
  - Print Report on Printer or Screen
  - Create Delimited output file (for use in Excel)

**Note:** Output type defaults to Print Report on Printer or Screen option.

```

Enter your site:      DEMO INDIAN HOSPITAL
Checking for Taxonomies to support the UDS Report...

All taxonomies are present.
End of taxonomy check.  PRESS ENTER: <Enter>

Enter the Calendar Year.  Use a 4 digit year, e.g. 2003, 2007
Enter Calendar Year:  2015 <Enter>  (2015)

      Select one of the following:

          1          1st Quarter (January 1-March 31)
          2          2nd Quarter (April 1-June 30)
          3          3rd Quarter (July 1-September 30)
          4          4th Quarter (October 1-December 31)
          F          Full Calendar Year (January 1-December 31)

Choose the time period to report on: F// F <Enter>  Full Calendar Year
(January 1-December 31)

Your report will be run for the time period: Jan 01, 2015 to Dec 31, 2015

      Select one of the following:

          1          Indian/Alaskan Native (Classification 01)
          2          Not Indian Alaskan/Native (Not Classification 01)
          3          All (both Indian/Alaskan Natives and Non 01)

Select Beneficiary Population to include in this report: 1// 3  All (both
Indian
/Alaskan Natives and Non 01)

Depending on the size of your database, this report may take 2-4 hours to
run and produce patient reports that are hundreds of pages long.  It is
recommended that these reports be run at night and printed to an electronic
file, rather than directly to a printer.

```

```

Do you want to exit this program now? N// NO <Enter>

Please choose an output type. For an explanation of the delimited file
please see the user manual.

Select one of the following:

P          Print Report on Printer or Screen
D          Create Delimited output file (for use in Excel)

Select an Output Option: P//
    
```

Figure 6-6: Running a Patient List, Steps 8–14

- a. For Printed report output, type the name of the printer or electronic file at the “Device” prompt.

**Note:** It is recommended that patient lists be printed to electronic files, as they may be several hundred or thousands of pages long, depending on the size of the facility’s patient population. The patient list report will be displayed below the appropriate RPMS UDS table for the selected patient list.

```

Select an Output Option: P// P

DEVICE: HOME//
    
```

Figure 6-7: Running a Patient List, Step 14a

- b. For Delimited report output, select an output option:
  - SCREEN - delimited output will display on screen for capture
  - FILE - delimited output will be written to an output file

**Note:** Output option defaults to SCREEN - delimited output will display on screen for capture option

- For Screen output option, type the name of the output device as the “Device” prompt.

```

Select an Output Option: P// D Create Delimited output file (for use in
Excel)

You have selected to create a delimited output file. You can have this
output file created as a text file in the pub directory, OR you can have
the delimited output display on your screen so that you can do a file
capture. Keep in mind that if you choose to do a screen capture you CANNOT
Queue your report to run in the background!!

Select one of the following:

S          SCREEN - delimited output will display on screen for capture
F          FILE - delimited output will be written to an output file
    
```

```
Select output type: S// SCREEN - delimited output will display on screen
for capture

DEVICE: HOME//
```

Figure 6-8: Running a Patient List, Step 14b, Screen output option

- For File output option, type a filename (no more than 40 characters), hit enter, and type Y or N at the queue prompt.

**Note:** Queuing question defaults to Yes (Y) option.

```
Select output type: S// FILE - delimited output will be written to an
output file
Enter a filename for the delimited output (no more than 40
characters):[File_Name]

When the report is finished your delimited output will be found in the
X:\EXPORT directory.
Won't you queue this ? Y//
```

Figure 6-9: Running a Patient List, Step 14b, File output option

**Note:** It is recommended to select the file output option for the delimited patient lists report, as they may be several hundred or thousands of pages long, depending on the size of the facility’s patient population. The delimited patient list report will not contain the RPMS UDS table for the selected patient list.

### 6.3 Create Search Template of Patients on Table 3A

This option will be used to create a search template of patients the RPMS UDS has identified as meeting the BPHC definition of a patient and who are included in Table 3A. This search template may be used in other RPMS applications such as QMan and PGen in order to assist the user with completing other tables required by BPHC for annual reporting and which are not currently included in the RPMS UDS application.

1. From the main RPMS UDS 2015 main menu, type **MU** (Manager Utilities).
2. From the Manager Utilities menu, type **STP** at the “Select Manager Utilities Option” prompt.

```
*****
** RPMS UNIFORM DATA SYSTEM (UDS) **
** 2015 Manager Utilities **
*****

DEMO INDIAN HOSPITAL
Version 10.0
```

```

SET      Update/Review Site Parameters
LST      Patient and Provider Lists Main Menu ...
STP      Create Search Template of Patients on Table 3A
TAX      Update Taxonomies for Use with UDS 2015

Select Manager Utilities Option:  STP <Enter>  Create Search Template of
Patients on Table 3A

```

Figure 6-10: Manager Utilities menu

### 3. The information screen is displayed.

```

                                DEMO INDIAN HOSPITAL
                                UDS 2015

UDS searches your database to find all visits and related patients during
the time period selected. Based on the UDS definition, to be considered a
patient the patient must have had at least one visit meeting the following
criteria:
  -must be to a location specified in your visit location setup
  -must be to Service Category Ambulatory (A), Hospitalization (H), Day
  Surgery (S), Observation (O), Telemedicine (M), Nursing home visit (R),
  or In-Hospital (I) visit
  -must NOT have an excluded clinic code (see User Manual for a list)
  -must have a primary provider and a coded purpose of visit
  -the patient must NOT have a gender of 'Unknown'

PRESS ENTER: <Enter>
TABLE 3A:  PATIENTS BY AGE AND GENDER WITH SEARCH TEMPLATE CREATION

This option will create a search template of all patients who meet the
definition of a patient above and who are included in UDS Table 3A.
You may use this search template in other applications (QMAN, PGEN) to
assist you in completing UDS tables not produced by the IHS/RPMS UDS
application.

Patients must have at least one visit during the selected time period, as
defined above.  Age is calculated as of June 30th of the year you select.

This option will also produce UDS Table 3A, an itemization of users
(patients) by age and gender.

Enter your site:

```

Figure 6-11: Creating a Search Template

4. Enter your site name at the “Enter your site” prompt.
5. The system will check to see if all taxonomies are present and will display a message. If all taxonomies are present, press Enter to continue. If all taxonomies are not present and you want to cancel the report, type a caret (^) and then follow the steps in Section 3.2.1 to edit the taxonomies.
6. Enter the calendar year at the “Enter Calendar Year” prompt.

7. Type the number corresponding to the time period (quarter or full year) for the report.
8. Select the Patient Classification to be used for the report.
9. Enter the name of an existing search template that will be overwritten or the name of a new search template that will be created.
10. Type the name of the output device for the report.

```

Enter your site: DEMO INDIAN HOSPITAL
Checking for Taxonomies to support the 2015 UDS Report...

All taxonomies are present.

End of taxonomy check.  PRESS ENTER: <Enter>

Enter the Calendar Year.  Use a 4 digit year, e.g. 2003, 2007
Enter Calendar Year:  2015 <Enter> (2015)

      Select one of the following:

          1          1st Quarter (January 1-March 31)
          2          2nd Quarter (April 1-June 30)
          3          3rd Quarter (July 1-September 30)
          4          4th Quarter (October 1-December 31)
          F          Full Calendar Year (January 1-December 31)

Choose the time period to report on: F// ull Calendar Year (January 1 -
December 31)

Your report will be run for the time period: Jan 01, 2015 to Dec 31, 2015

      Select one of the following:

          1          Indian/Alaskan Native (Classification 01)
          2          Not Indian Alaskan/Native (Not Classification 01)
          3          All (both Indian/Alaskan Natives and Non 01)

Select Beneficiary Population to include in this report: 1// 3  All (both
Indian/Alaskan Natives and Non 01)

* You may enter an existing Template Name or Save results in a New Template
*
Patient Search Template: MYSEARCHTEMPLATE
  Are you adding 'MYSEARCHTEMPLATE' as a new SORT TEMPLATE? No// Y  (Yes)

An unduplicated PATIENT list resulting from this report will be stored in
the MYSEARCHTEMPLATE Search Template.

DEVICE: HOME//

```

Figure 6-12: Creating a Search Template, Steps 4-9

## Appendix A: Quick Reference Guide

Follow these steps to implement the RPMS UDS Reporting System. The section numbers listed in parentheses refer to appropriate sections in the RPMS UDS User Manual:

1. Load software on your RPMS server.
2. To open the software on your computer, type **UDS** at your RPMS main menu prompt.
3. Review the BPHC definitions of “visit” and determine which RPMS location codes should be included in your UDS reporting. Most locations probably should be included; examples of locations *not* to include are “Ambulance” and “Other” (Sections 4.1.2 and 3.1.1).
4. Consult with laboratory staff to identify lab tests that need to be included in the HIV Test, the Pap Smear, HPV Tests, the DM Audit HGB A1C Tax, the Hepatitis B test, the Hepatitis C test taxonomies, and the FOB test (Section 3.2).
5. Set your site parameters: Enter site name, UDS identification number, if known, and associated location codes (MU/SET menu options) (Section 3.1).

<p><b>Note:</b> Use the “S Add All SU locations” option to add all locations associated with the site, and then delete those few that you don’t need.</p>
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6. Set up lab taxonomies for HIV Test, Pap Smear, HPV Tests, DM Audit HGB A1C Tax, Hepatitis B test, Hepatitis C test, and FOB test (MU/TAX menu options) (Section 3.2.1).
7. Run the Staff List (Table 5) first (REP/ ST menu option). Review the list of providers and ensure that all staff is coded correctly (Section 6.2).
8. Update your Provider file in RPMS if necessary. Rerun the Staff List (Table 5) report again to ensure correct coding.
9. Run the nine Reports (REP menu option) (Section 5.0).
10. Review the results to identify any RPMS data issues. If you think the summary reports are substantially inaccurate (e.g., total patients or visits are too low or too high), run and review associated patient lists (MU/LST/ menu options) to verify that the correct site is selected, and that all appropriate locations have been identified in the Site Parameters file (MU/SET menu options).

**Note:** Depending on the size of your RPMS database, patient lists may take two to four hours to run and may print out hundreds or thousands of pages. It is recommended to print the reports to an electronic file or use the file option for delimited patient lists to run the report overnight. (Section 6.0)

11. Update RPMS as needed.
12. Ensure that data entry has completed entering all visit data through December 31, prior to running final reports.
13. For final reports, run the reports only (not the patient lists) (REP menu option) (Section 5.0).
14. To complete Column A on Table 5, run the Staff List report from the MU/LST/LST1/ menu and manually calculate your FTEs by BPHC-defined provider categories (Section 6.2).
15. Manually enter your summary data from the RPMS UDS reports into your BPHC UDS software.
16. To complete Section A and B of Table 6B, run the PRGA report from the MU/LST/LST2/A-D/ menu and manually calculate your prenatal care patients (Section 6.2).
17. To complete Section A of Table 7, run the PRGR report from the MU/LST/LST3/PRG/ menu and manually calculate your deliveries and birth weight patients by race and Hispanic/Latino identity (Section 6.2).

## Appendix B: BPHC Service Category Definitions for Table 5

### B.1 Personnel by Major Service Category

Staff is distributed into categories that reflect the types of services they provide. Major service categories include: medical care services, dental services, mental health services, substance abuse services, other professional health services, vision services, pharmacy services, enabling services, other program related services staff, and administration and facility. Whenever possible, the contents of major service categories have been defined to be consistent with definitions used by Medicare.<sup>68</sup> The following summarizes the personnel categories; a detailed list is in Appendix B: .

- Medical Care Services (Lines 1–15)
  - Physicians: M.D.s and D.O.s, except psychiatrists, pathologists, and radiologists. Naturopaths, acupuncturists, community health aides/practitioners, and chiropractors are not reported here.
  - Nurse Practitioners
  - Physician Assistants
  - Certified Nurse Midwives
  - Nurses: Registered nurses, licensed practical and vocational nurses, home health and visiting nurses, clinical nurse specialists, and public health nurses
  - Laboratory Personnel: Pathologists, medical technologists, laboratory technicians and assistants, phlebotomists
  - X-ray Personnel: Radiologists, X-ray technologists, and X-ray technicians
  - Other Medical Personnel: Medical assistants, nurse’s aides, and all other personnel providing services in conjunction with services provided by a physician, nurse practitioner, physician assistant, certified nurse midwife, or nurse. Staff who support the quality assurance/Electronic Health Records (EHR) program, medical records, and patient support staff are not reported here.

**Note:** Quality Assurance Personnel—Individuals in any or all of the above positions may be involved in Quality Assurance and EHR activities. They will be classified on the line that describes their main responsibility.

- Dental Services (Lines 16–19)

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<sup>68</sup> BPHC Uniform Data System Manual, 2015 Revision, p. 54.

- Dentists: General practitioners, oral surgeons, periodontists, and endodontists. Dental health technicians are not reported here.
- Dental Hygienists
- Other Dental Personnel: Dental assistants, aides, and technicians
- **Mental Health Services (Lines 20a, a1, a2, b, c and 20)**

**Note:** Behavioral health services include both mental health and substance abuse services. Centers using the “Behavioral Health” designation need to divide their staff between Lines 20 and 21 as appropriate.

- Psychiatrists (Line 20a)
- Licensed Clinical Psychologists (Line 20a1)
- Licensed Clinical Social Workers (line 20a2)
- Other Licensed Mental Health Providers (Line 20b): Psychiatric social workers, psychiatric nurse practitioners, family therapists, and other licensed Master’s Degree prepared clinicians.
- Other Mental Health Staff (Line 20c): Unlicensed individuals, including “certified” individuals, who provide counseling, treatment, or support to mental health providers.
- **Substance Abuse Services (Line 21)**–Substance abuse workers, psychiatric nurses, psychiatric social workers, mental health nurses, clinical psychologists, clinical social workers, family therapists, and other individuals providing counseling and/or treatment services related to substance abuse.

**Note:** Behavioral health services include both mental health and substance abuse services. Centers using the “Behavioral Health” designation need to divide their staff between Lines 20 and 21 as appropriate.

- **All Other Professional Health Services (Line 22)**–Occupational and physical therapists, dietitians, nutritionists, podiatrists, naturopaths, chiropractors, acupuncturists, and other staff professionals providing health services.

**Note:** WIC nutritionists and others working in WIC programs are reported on Line 29a, Other Programs and Services Staff.

- **Vision Services (Line 22a–22d)**
  - Ophthalmologist (Line 22a)
  - Optometrist (Line 22b): Optometrists (O.D.), non-physicians who largely perform vision correction exams and prescribe glasses for patients

- Other Vision Care Staff (Line 22c): Contract Optometrist, Ophthalmologist/Optometric assistants, aides, technicians, and optometry students providing vision services.
- **Pharmacy Services (Line 23):** Pharmacists (including clinical pharmacists), pharmacist assistants and others supporting pharmaceutical services. Note that time (and cost) of individuals spending all or part of their time in assisting patients to apply for free drugs from pharmaceutical companies are to be classified as “Eligibility Assistance Workers” on Line 27a.
- **Enabling Services (Lines 24–29):**
  - Case Managers (Line 24): Staff who assist patients in the management of their health and social needs, including assessment of patient medical and/or social service needs, and maintenance of referral, tracking, and follow-up systems. Case managers may, at times, provide health education and/or eligibility assistance during the course of their case management functions. Staff includes individuals who are trained as, and specifically called, Case Managers, as well as individuals called Care Coordinators, Referral Coordinators, and other local titles. Nurses, social workers, and other professional staff who are specifically allocated to this task during assigned hours, may be included here, but not when these services are an integral part of their other function.
  - Patient and Community Education Specialists (Line 25): Health educators, with or without specific degrees in this area; family planning specialists, HIV specialists, and others who provide information about health conditions and guidance about appropriate use of health services that are not otherwise classified under outreach.
  - Outreach Workers (Line 26): Individuals conducting case finding, education, or other services to identify potential patients or clients, and/or facilitate access or referral of potential health center patients to available health center services.
  - Transportation Workers (Line 27): Individuals who provide transportation for patients (van drivers) or arrange for transportation, including persons who provide for long distance transportation to major cities in some extremely remote clinic locations; no visits are recorded for these workers.
  - Eligibility Assistance Workers (Line 27a): All staff providing assistance in securing access to available health, social service, pharmacy and other assistance programs, including Medicaid, Women, Infants, and Children (WIC), Supplemental Security Income (SSI), food stamps, Temporary Assistance for Needy Families (TANF), and related assistance programs.
  - Interpretation Staff (Line 27b): Staff whose *full time or dedicated time* is devoted to translation and/or interpretation services. *Do not include* that portion of the time of a nurse, medical assistant or other support staff who provides interpretation or translation during the course of their other activities.

- Personnel Performing Other Enabling Service Activities (Line 28): All other staff performing services as enabling services, not described here. There is a “specify” field that must be used to describe what these staff are doing.
- **Other Programs and Related Services Staff (Line 29a):** Some health centers, especially “umbrella agencies,” operate programs which, while within their scope of service, are not directly a part of the listed medical, dental, behavioral or other health services. These include WIC programs, job training programs, head start or early head start programs, shelters, housing programs, child care, frail elderly support programs, Adult Day Health Care programs, fitness or exercise programs, public/retail pharmacies, etc. The staff for these programs are reported under Other Programs and Related Services. There is a “specify” field that must be used to describe what these staff are doing.
- **Non-Clinical Support Services (Lines 30a–32)**
  - Management and Support Staff (Line 30a): Management team including Chief Executive Officer, Chief Financial Officer, Chief Information Officer, and Chief Medical Officer; other non-clinical staff and office support (secretaries, administrative assistants, file clerks, etc.) for health center operations within the scope of the program. Report only that portion of the management team’s full-time equivalent corresponding to the management function.
  - Fiscal and Billing Staff (Line 30b): Staff performing accounting and billing functions in support of health center operations for services performed within the scope of the grant, *excluding the Chief Financial Officer*.
  - IT Staff (Line 30c): Technical information technology and information systems staff supporting the maintenance and operation of the computing systems that support clinical and administrative functions performed within the scope of the grant. Staff managing an EHR/EMR system are reported on Line 30c, but design of medical forms, data entry and analysis of EHR data, as well as helpdesk, training and technical assistance functions are included as part of the other medical personnel functions reported on Line 12.
  - Facility (Line 31): Staff with facility support and maintenance responsibilities, including custodians, housekeeping staff, security staff, and other maintenance staff.
  - Patient Services Support Staff (Line 32): Intake staff, front desk staff, and medical/patient records; eligibility assistance workers are reported on Line 27a, not here.

**Note:** The Non-Clinical category for this report is more comprehensive than that used in some other program definitions and includes *all* personnel working in a BPHC supported program, whether or not that individual's salary was supported by the BPHC grant or other funds included in the scope of the project.

## Appendix C: RPMS Provider Codes Mapping to UDS Service Category for Table 5

Line	Personnel by Major Service Category	IHS Provider Code	Column B
1	Family Physicians	80 Family Practice	Y
2	General Practitioners	00 MD 18 Contract Physician 44 Tribal Physician 45 Osteopathic Medicine 15 Other AND must have Location Name beginning with "CHS" (e.g. CHS Office)	Y
3	Internists	71 Internal Medicine	Y
4	Obstetrician/ Gynecologists	72 OB/GYN 41 Contract OB/GYN	Y
5	Pediatricians	75 Pediatrician	Y
7	Other Specialty Physicians	82 Anesthesiologist 70 Cardiologist 86 Dermatologist 68 Emergency Room Physician B2 Endocrinologist B1 Gastroenterologist A9 Hepatologist 64 Nephrologist 85 Neurologist B6 Neurosurgeon B4 Oncologist–Hematologist E5 Allergist/Immunologist E6 Reconstructive Surgeon 73 Orthopedist 74 Otolaryngologist B5 Pulmonologist B3 Rheumatologist A1 Sports Medicine Physician 77 Surgeon 78 Urologist	Y
9a	Nurse Practitioners	21 Nurse Practitioner 16 Pediatric Nurse Practitioner	Y
9b	Physician Assistants	11 Physician Assistant	Y
10	Certified Nurse Midwives	17 Nurse Midwife	Y

Line	Personnel by Major Service Category	IHS Provider Code	Column B
11	Nurses	01 Clinic RN 32 Contract Public Health Nurse 05 Licensed Practical Nurse 13 Public Health Nurse 14 School Nurse	Y
12	Other Medical Personnel (providing services in conjunction with services provided by physician, nurse practitioner, PC, nurse, nurse midwife)	47 CRNA 38 EMT/Paramedic 03 Health Aide C3 Medical Assistant 20 Medical Student 22 Nurse Assistant 27 Student Nurse B8 Surgical Technician D9 Cardiovascular Technologist E1 Cardiovascular Technician E2 Echocardiographer E3 Emergency Room Technician	
13	Laboratory Personnel	A2 Medical Technologist 23 Laboratory Technician 83 Pathologist	
14	X-ray personnel	76 Radiologist 59 X-ray Technician 87 Ultrasound Technician	
16	Dentists	52 Dentist	Y
17	Dental Hygienists	46 Dental Hygienist	Y
18	Dental Assistants, Aides and Technicians	60 Dental Assistant 61 Dental Lab 54 Dental Assistant (prenatal) B7 Dental Health Aide Therapist	
20a	Psychiatrists <b>Note:</b> For Table 5, Columns B & C, count only visits and associated patients for listed Provider Codes <i>that do not have</i> POV 303.*, 304.*; 305.*, or Behavioral Health System (BHS) Problem Codes 27-30 (i.e., any visits/patients who are <i>not</i> included in Line 21 definition).	49 Contract Psychiatrist 81 Psychiatrist	Y
20a1	Licensed Clinical Psychologists	50 Contract Psychologist 12 Psychologist	Y

Line	Personnel by Major Service Category	IHS Provider Code	Column B
20a2	Licensed Clinical Social Worker	63 Contract Social Worker 62 Licensed Clinical Social Worker D5 Licensed Clinical Social Worker	Y
20b	Other Licensed Mental Health Providers <b>Note:</b> For Table 5, Columns B & C, count only visits and associated patients for listed Provider Codes <i>that do not have</i> POV 303.*, 304.*; 305.* (i.e., any visits/patients who are <i>not</i> included in Line 21 definition).	D1 Behavioral Health Nurse Practitioner D2 Behavior Analyst D4 Licensed Professional Counselor D6 APRN Psychiatric Nursing Specialty 96 Family Therapist A6 In School Therapist 95 Mental Health (Master only) 92 Psychotherapist	Y
20c	Other Mental Health Staff <b>Note:</b> For Table 5, Columns B & C, count only visits and associated patients for listed Provider Codes <i>that do not have</i> POV 303.*, 304.*; 305.* (i.e., any visits/patients who are <i>not</i> included in Line 21 definition.)	C5 Behavioral Health Student C9 Behavioral Health Aide/Practitioner A7 Domestic Violence Counselor 06 Medical Social Worker 94 Mental Health (BA/BS only) 19 Mental Health Technician	Y
21	Substance Abuse Services <b>Note:</b> <i>Except for Provider Code 48 Alcoholism/Sub Abuse Counselor</i> , for Table 5, Columns B & C, count only visits and associated patients for listed Provider Codes <i>and any</i> POV 303.*, 304.*; 305.* <i>Provider Code 48 does not require a specific POV.</i>	C5 Behavioral Health Student C9 Behavioral Health Aide/Practitioner D1 Behavioral Health Nurse Practitioner D7 Tobacco Treatment Specialist 48 Alcoholism/Sub Abuse Counselor 49 Contract Psychiatrist 50 Contract Psychologist 63 Contract Social Worker A7 Domestic Violence Counselor 96 Family Therapist A6 In School Therapist 62 Licensed Medical Social Worker 06 Medical Social Worker 19 Mental Health Technician 94 Mental Health (BA/BS only) 95 Mental Health (Master only) 81 Psychiatrist 12 Psychologist 92 Psychotherapist	Y

Line	Personnel by Major Service Category	IHS Provider Code	Column B
22	Other Professional Services	A3 Naturopath Doctor A4 Naturopath Physician A5 Acupuncturist 28 Audiologist 89 Audiology Health Technician 43 Audiometric Technician 69 Chiropractor C8 Community Health Aide/Practitioner 24 Contract Optometrist 25 Contract Podiatrist 84 Podiatrist 99 Dietetic Technician 29 Dietitian 55 Disease Control Program 02 Environmental Health 36 Eye Care Specialist C7 Fitness Specialist C6 Massage Therapist 97 Nutrition Technician 07 Nutritionist 90 Occupational Therapist 51 Papago Nutrition Program 10 Physical Therapist C2 Physical Therapy Technician 33 Podiatrist 26 Respiratory Therapist C4 Respiratory Therapy Technician 39 Speech Therapist 58 Speech Ther-Discontinue 42 Speech/Language Path 93 Traditional Medicine Practitioner 34 Tribal/Contract Nutritionist B9 Chaplain D3 Early Childhood Intervention Specialist E4 Physical Therapy Student	Y
22a	Ophthalmologist	79 Ophthalmologist	Y
22b	Optometrist	08 Optometrist 24 Contract Optometrist	Y
22c	Optometric Assistant	31 Optometric Assistant 36 Eye Care Specialist 65 Optometry Student D8 Ocularist	

<b>Line</b>	<b>Personnel by Major Service Category</b>	<b>IHS Provider Code</b>	<b>Column B</b>
23	Pharmacy Personnel	67 Clinical Pharmacy Specialist 09 Pharmacist 30 Pharmacy Practitioners A8 Pharmacy Tech C1 Pharmacy Student	
24	Case Managers	66 Case Managers	Y
25	Patient and Community Education Specialists	04 Health Educator 37 Family Planning Counselor	Y
26	Outreach workers	53 Community Health Representative 35 Outreach Workers	
27	Transportation staff	40 Ambulance Driver	
27a	Eligibility Assistance Workers	None	
27b	Interpretation Staff	None	
28	Other Enabling Services	91 PHN Driver/Interpreter	
29a	Other Programs and Services	None	
30a	Management and Support Staff	57 Administrative	
30b	Fiscal and Billing Staff	None	
30c	IT Staff	None	
31	Facility Staff	98 Food Service Supervisor	
32	Patient Support Staff (e.g., medical records, intake)	88 Coding/Data Entry 56 Health Records	
35	Unassigned	15 Other (if Location Name does not begin with "CHS") Any qualifying visit where the primary provider code is not included in the previous lines.	

## Appendix D: RPMS Rules of Behavior

The Resource and Patient Management (RPMS) system is a United States Department of Health and Human Services (HHS), Indian Health Service (IHS) information system that is **FOR OFFICIAL USE ONLY**. The RPMS system is subject to monitoring; therefore, no expectation of privacy shall be assumed. Individuals found performing unauthorized activities are subject to disciplinary action including criminal prosecution.

All users (Contractors and IHS Employees) of RPMS will be provided a copy of the Rules of Behavior (RoB) and must acknowledge that they have received and read them prior to being granted access to a RPMS system, in accordance IHS policy.

- For a listing of general ROB for all users, see the most recent edition of *IHS General User Security Handbook* (SOP 06-11a).
- For a listing of system administrators/managers rules, see the most recent edition of the *IHS Technical and Managerial Handbook* (SOP 06-11b).

Both documents are available at this IHS Web site: <http://security.ihs.gov/>.

The ROB listed in the following sections are specific to RPMS.

### D.1 All RPMS Users

In addition to these rules, each application may include additional RoBs that may be defined within the documentation of that application (e.g., Dental, Pharmacy).

#### D.1.1 Access

RPMS users shall

- Only use data for which you have been granted authorization.
- Only give information to personnel who have access authority and have a need to know.
- Always verify a caller's identification and job purpose with your supervisor or the entity provided as employer before providing any type of information system access, sensitive information, or nonpublic agency information.
- Be aware that personal use of information resources is authorized on a limited basis within the provisions *Indian Health Manual* Part 8, "Information Resources Management," Chapter 6, "Limited Personal Use of Information Technology Resources."

RPMS users shall not

- Retrieve information for someone who does not have authority to access the information.
- Access, research, or change any user account, file, directory, table, or record not required to perform their *official* duties.
- Store sensitive files on a PC hard drive, or portable devices or media, if access to the PC or files cannot be physically or technically limited.
- Exceed their authorized access limits in RPMS by changing information or searching databases beyond the responsibilities of their jobs or by divulging information to anyone not authorized to know that information.

### D.1.2 Information Accessibility

RPMS shall restrict access to information based on the type and identity of the user. However, regardless of the type of user, access shall be restricted to the minimum level necessary to perform the job.

RPMS users shall

- Access only those documents they created and those other documents to which they have a valid need-to-know and to which they have specifically granted access through an RPMS application based on their menus (job roles), keys, and FileMan access codes. Some users may be afforded additional privileges based on the functions they perform, such as system administrator or application administrator.
- Acquire a written preauthorization in accordance with IHS policies and procedures prior to interconnection to or transferring data from RPMS.

### D.1.3 Accountability

RPMS users shall

- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Log out of the system whenever they leave the vicinity of their personal computers (PCs).
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local Information System Security Officer (ISSO).
- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.

- Abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior, and information technology (IT) information processes.

#### D.1.4 Confidentiality

RPMS users shall

- Be aware of the sensitivity of electronic and hard copy information, and protect it accordingly.
- Store hard copy reports/storage media containing confidential information in a locked room or cabinet.
- Erase sensitive data on storage media prior to reusing or disposing of the media.
- Protect all RPMS terminals from public viewing at all times.
- Abide by all Health Insurance Portability and Accountability Act (HIPAA) regulations to ensure patient confidentiality.

RPMS users shall not

- Allow confidential information to remain on the PC screen when someone who is not authorized to that data is in the vicinity.
- Store sensitive files on a portable device or media without encrypting.

#### D.1.5 Integrity

RPMS users shall

- Protect their systems against viruses and similar malicious programs.
- Observe all software license agreements.
- Follow industry standard procedures for maintaining and managing RPMS hardware, operating system software, application software, and/or database software and database tables.
- Comply with all copyright regulations and license agreements associated with RPMS software.

RPMS users shall not

- Violate federal copyright laws.
- Install or use unauthorized software within the system libraries or folders.
- Use freeware, shareware, or public domain software on/with the system without their manager's written permission and without scanning it for viruses first.

### D.1.6 System Logon

RPMS users shall

- Have a unique User Identification/Account name and password.
- Be granted access based on authenticating the account name and password entered.
- Be locked out of an account after five successive failed login attempts within a specified time period (e.g., one hour).

### D.1.7 Passwords

RPMS users shall

- Change passwords a minimum of every 90 days.
- Create passwords with a minimum of eight characters.
- If the system allows, use a combination of alpha-numeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.
- Change vendor-supplied passwords immediately.
- Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts or batch files).
- Change passwords immediately if password has been seen, guessed, or otherwise compromised, and report the compromise or suspected compromise to their ISSO.
- Keep user identifications (IDs) and passwords confidential.

RPMS users shall not

- Use common words found in any dictionary as a password.
- Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user's name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).
- Share passwords/IDs with anyone or accept the use of another's password/ID, even if offered.
- Reuse passwords. A new password must contain no more than five characters per eight characters from the previous password.
- Post passwords.
- Keep a password list in an obvious place, such as under keyboards, in desk drawers, or in any other location where it might be disclosed.

- Give a password out over the phone.

### D.1.8 Backups

RPMS users shall

- Plan for contingencies such as physical disasters, loss of processing, and disclosure of information by preparing alternate work strategies and system recovery mechanisms.
- Make backups of systems and files on a regular, defined basis.
- If possible, store backups away from the system in a secure environment.

### D.1.9 Reporting

RPMS users shall

- Contact and inform their ISSO that they have identified an IT security incident and begin the reporting process by providing an IT Incident Reporting Form regarding this incident.
- Report security incidents as detailed in the *IHS Incident Handling Guide* (SOP 05-03).

RPMS users shall not

- Assume that someone else has already reported an incident. The risk of an incident going unreported far outweighs the possibility that an incident gets reported more than once.

### D.1.10 Session Timeouts

RPMS system implements system-based timeouts that back users out of a prompt after no more than five minutes of inactivity.

RPMS users shall

- Utilize a screen saver with password protection set to suspend operations at no greater than 10 minutes of inactivity. This will prevent inappropriate access and viewing of any material displayed on the screen after some period of inactivity.

### D.1.11 Hardware

RPMS users shall

- Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
- Keep an inventory of all system equipment.

- Keep records of maintenance/repairs performed on system equipment.

RPMS users shall not

- Eat or drink near system equipment.

### D.1.12 Awareness

RPMS users shall

- Participate in organization-wide security training as required.
- Read and adhere to security information pertaining to system hardware and software.
- Take the annual information security awareness.
- Read all applicable RPMS manuals for the applications used in their jobs.

### D.1.13 Remote Access

Each subscriber organization establishes its own policies for determining which employees may work at home or in other remote workplace locations. Any remote work arrangement should include policies that:

- Are in writing.
- Provide authentication of the remote user through the use of ID and password or other acceptable technical means.
- Outline the work requirements and the security safeguards and procedures the employee is expected to follow.
- Ensure adequate storage of files, removal, and nonrecovery of temporary files created in processing sensitive data, virus protection, and intrusion detection, and provide physical security for government equipment and sensitive data.
- Establish mechanisms to back up data created and/or stored at alternate work locations.

Remote RPMS users shall

- Remotely access RPMS through a virtual private network (VPN) whenever possible. Use of direct dial in access must be justified and approved in writing and its use secured in accordance with industry best practices or government procedures.

Remote RPMS users shall not

- Disable any encryption established for network, internet, and Web browser communications.

## D.2 RPMS Developers

RPMS developers shall

- Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.
- Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.
- Only access information or code within the namespaces for which they have been assigned as part of their duties.
- Remember that all RPMS code is the property of the U.S. Government, not the developer.
- Not access live production systems without obtaining appropriate written access, and shall only retain that access for the shortest period possible to accomplish the task that requires the access.
- Observe separation of duties policies and procedures to the fullest extent possible.
- Document or comment all changes to any RPMS software at the time the change or update is made. Documentation shall include the programmer's initials, date of change, and reason for the change.
- Use checksums or other integrity mechanism when releasing their certified applications to assure the integrity of the routines within their RPMS applications.
- Follow industry best standards for systems they are assigned to develop or maintain, and abide by all Department and Agency policies and procedures.
- Document and implement security processes whenever available.

RPMS developers shall not

- Write any code that adversely impacts RPMS, such as backdoor access, "Easter eggs," time bombs, or any other malicious code or make inappropriate comments within the code, manuals, or help frames.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

## D.3 Privileged Users

Personnel who have significant access to processes and data in RPMS, such as, system security administrators, systems administrators, and database administrators, have added responsibilities to ensure the secure operation of RPMS.

Privileged RPMS users shall

- Verify that any user requesting access to any RPMS system has completed the appropriate access request forms.
- Ensure that government personnel and contractor personnel understand and comply with license requirements. End users, supervisors, and functional managers are ultimately responsible for this compliance.
- Advise the system owner on matters concerning information technology security.
- Assist the system owner in developing security plans, risk assessments, and supporting documentation for the certification and accreditation process.
- Ensure that any changes to RPMS that affect contingency and disaster recovery plans are conveyed to the person responsible for maintaining continuity of operations plans.
- Ensure that adequate physical and administrative safeguards are operational within their areas of responsibility and that access to information and data is restricted to authorized personnel on a need-to-know basis.
- Verify that users have received appropriate security training before allowing access to RPMS.
- Implement applicable security access procedures and mechanisms, incorporate appropriate levels of system auditing, and review audit logs.
- Document and investigate known or suspected security incidents or violations and report them to the ISSO, Chief Information Security Officer (CISO), and systems owner.
- Protect the supervisor, superuser, or system administrator passwords.
- Avoid instances where the same individual has responsibility for several functions (i.e., transaction entry and transaction approval).
- Watch for unscheduled, unusual, and unauthorized programs.
- Help train system users on the appropriate use and security of the system.
- Establish protective controls to ensure the accountability, integrity, confidentiality, and availability of the system.
- Replace passwords when a compromise is suspected. Delete user accounts as quickly as possible from the time that the user is no longer authorized system. Passwords forgotten by their owner should be replaced, not reissued.
- Terminate user accounts when a user transfers or has been terminated. If the user has authority to grant authorizations to others, review these other authorizations. Retrieve any devices used to gain access to the system or equipment. Cancel logon IDs and passwords, and delete or reassign related active and backup files.

- Use a suspend program to prevent an unauthorized user from logging on with the current user's ID if the system is left on and unattended.
- Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator's database.
- Shall follow industry best standards for systems they are assigned to, and abide by all Department and Agency policies and procedures.

Privileged RPMS users shall not

- Access any files, records, systems, etc., that are not explicitly needed to perform their duties.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

## Glossary

### **ASUFAC Number**

Area Service Unit Facility; unique identifier for each facility within IHS. is comprised of a six-digit number where the first two digits identify the Area, the next two digits identify the Service Unit, and the last two digits identify the Facility.

### **CPT Codes**

One of several code sets used by the healthcare industry to standardize data, allowing for comparison and analysis. Current Procedural Terminology was developed and is updated annually by the American Medical Association and is widely used in producing bills for services rendered to patients. CPTs include codes for diagnostic and therapeutic procedures, and specify information that differentiates the codes based on cost. CPT codes are the most widely accepted nomenclature in the United States for reporting physician procedures and services for federal and private insurance third-party reimbursement. UDS searches for CPT and other codes as specified in the logic definition to determine if a patient meets a denominator or numerator definition.

### **CRS**

CRS is a component of the RPMS software suite. CRS provides sites with the ability to report on GPRA and developmental clinical performance measures from local RPMS databases.

### **CY**

The abbreviation for calendar year, January through December.

### **Device**

A device that either displays or prints information.

### **Enter Key**

Used interchangeably with the Return key. Press Enter to show the end of an entry such as a number or a word. Press Enter each time you respond to a computer prompt. If you want to return to the previous screen, simply press Enter without entering a response. This will take you back to the previous menu screen. Enter on some keyboards is shown as the Return Key. Whenever you see [ENT] or Enter, press the Enter or Return Key.

### **File**

A set of related records or entries treated as a single unit.

**FileMan**

The database management system for RPMS.

**FY**

Abbreviation for fiscal year. The fiscal year for the federal government is October 1 through September 30.

**Health Record Number**

Each facility assigns a unique number within that facility to each patient. Each Health Record Number with its facility ASUFAC identification make a unique identifier within all of IHS.

**ICD Codes**

One of several code sets used by the healthcare industry to standardize data. The International Classification of Disease is an international diagnostic coding scheme. In addition to diseases, ICD also includes several families of terms for medical-specialty diagnoses, health status, disablements, procedure and reasons for contact with healthcare providers. IHS currently uses ICD-9 for coding. UDS searches for ICD and other codes as specified in the logic definition to determine if a patient meets a denominator or numerator definition.

**IHS Direct, Tribal, and Urban**

In general, all components of the Indian health care system.

**Logic**

The detailed definition, including specific RPMS fields and codes, of how the software defines for the UDS a patient and a patient's visits and denominators and numerators.

**LOINC**

Logical Observations, Identifiers, Names, and Codes. A standard coding system originally initiated for Laboratory values, the system is being extended to include non-laboratory observations (vital signs, electrocardiograms, etc.). Standard code sets are used to mitigate variations in local terminologies for lab and other healthcare procedures, e.g., Glucose or Glucose Test. IHS began integrating LOINC values into RPMS in several pilot sites in 2002.

**Mandatory**

Required. A mandatory field is a field that must be completed before the system will allow you to continue.

**Menu**

A list of choices for computing activity. A menu is a type of option designed to identify a series of items (other options) for presentation to the user for selection. When displayed, menu-type options are preceded by the word “Select” and followed by the word “option” as in Select Menu Management option: (the menu’s select prompt).

**Mnemonic**

A short cut that designated to access a particular party, name, or facility.

**Namespace**

A unique set of alpha characters assigned by the Database Administrator, which uniquely identifies package components; for example, BUD is the namespace for the RPMS Unified Data System (UDS).

**Option**

As an item on a menu, an option provides an opportunity for users to select it, thereby invoking the associated computing activity. Options may also be scheduled to run in the background, non-interactively, by TaskMan.

**Performance Measure**

Performance measures are definitions of specific measurable objectives that can demonstrate progress toward the goals stated in the strategic and/or performance plans of an organization. An example of a performance measure is: Maintain at the previous year’s level the proportion of eligible women who have had a pap smear documented within the past three years.

**Queuing**

Requesting that a job be processed at a later time rather than within the current session.

**Receipt Dates**

The date that the party received the information

**Receiving Party**

The person or organization that is receiving the information.

**Sequential**

Arranged in a particular order.

**Site Specific**

Particular to a specific site.

**STAT**

Immediately.

**Tagged**

Marked with a specific identifier.

**Taxonomy**

Taxonomies are groupings of functionally related data elements, such as specific codes, code ranges, or terms, that are used by various RPMS applications to find data items in the PCC to determine if a patient meets a certain criteria. To ensure comparable data within the agency as well as to external organizations, as much UDS logic as possible is based on standard national codes, such as CPTs or ICD-9. For terminology that is not standardized across each facility, such as lab tests or medications, UDS uses taxonomies that can be populated by each individual facility with its own codes.

## Acronym List

Acronym	Term Meaning
ADA	American Dental Association
AMI	Acute Myocardial Infarction
ASUFAC	Area Service Unit Facility
BMI	Body Mass Index
BPHC	Bureau of Primary Health Care
CABG	Coronary Artery Bypass Graft
CAD	Coronary Artery Disease
CHIP	Children's Health Insurance Program
CPT	Current Procedural Terminology
CRS	Clinical Reporting System
CY	Calendar Year
FTE	Full Time Equivalent
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HRSA	Health Resources and Services Administration
I/T/U	IHS direct, Tribal, and Urban
ICD	International Classification of Diseases
IHS	Indian Health Service
IVD	Ischemic Vascular Disease
LDL	Low-Density Lipoprotein
LOINC	Logical Observations, Identifiers, Names, and Codes
MI	Myocardial Infarction
PCC	Patient Care Component
POV	Purpose of Visit
PTCA	Percutaneous Transluminal Coronary Angioplasty
RPMS	Resource and Patient Management System
UDS	Uniform Data System

## Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

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