Diabetes Management System

(BDM)

2020 Diabetes Audit User Addendum

Version 2.0 Patch 13
February 2020
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Preface

The purpose of this document is to provide users with an overview of the Diabetes Management System (DMS) functionality that pertains specifically to performing a Diabetes Audit.

**Note:** Resource and Patient Management System (RPMS) software, including the DMS, is subject to regular updates. DMS updates are determined by the Indian Health Service (IHS) Diabetes Audit Team and are based in part on changes to the IHS Diabetes Standards of Care & Clinical Practice Resources: [https://www.ihs.gov/diabetes/clinician-resources/soc/](https://www.ihs.gov/diabetes/clinician-resources/soc/).
1.0 Introduction

The Diabetes Management System (DMS) can be used to conduct a Diabetes Audit, including creation of an Audit data file and reports. This manual focuses on the DMS menu options used to prepare for and conduct an Audit. Other DMS functionality is documented in the Diabetes Management System (BDM) General User Manual.

The general steps for conducting an Audit are:

1. Audit Setup (preparing for the Audit)
2. Create an Audit data file and/or reports
3. Upload the Audit data file to the WebAudit (required for Annual Audits, optional otherwise)

The DMS menu system is structured to follow these steps:

1. The Audit Setup menu includes tools for Audit preparation.
2. The Audit Reporting menu includes tools for creating Audit data files and reports.

Additional information about the IHS Diabetes Care and Outcomes Audit can be found on the Audit website: https://www.ihs.gov/diabetes/audit/.

DMS Main Menu

The DMS main menu provides four options (Figure 1-1).

```
THIS SYSTEM CONTAINS CONFIDENTIAL PATIENT INFORMATION COVERED
BY THE PRIVACY ACT. UNAUTHORIZED USE OF THIS DATA IS ILLEGAL
******************************************************************************
**                                                               DIABETES MANAGEMENT SYSTEM **
******************************************************************************
VERSION 2.0 (Patch 13)
DEMO HOSPITAL
MAIN MENU
RM     Register Maintenance ...
AS     Audit Setup ...
AR     Audit Reporting ...
PDM    Prediabetes Audit ..
```

Figure 1-1: RPMS DMS Main Menu

Visual DMS includes the same options to prepare for and conduct an Audit (Figure 1-2).
Figure 1-2: Visual DMS Menu
2.0 Audit Setup – Prepare for an Audit

There are three main steps to follow when preparing to conduct a Diabetes Audit using DMS:

1. Identify the cohort of patients to be included in the Audit. Two ways of doing this are described below. See Section 2.2 for additional information.
   
   • Use the patients who are members of a diabetes register and have a status of active. First ensure that the register is current by:
     
     − Adding patients who are receiving care at your facility but are not currently on the register.
     − Inactivating patients who are on the register with an active status but are no longer receiving care at your facility. Removing patients from the register is not recommended.
     − Updating patients who are on the register with an active status but do not have diabetes on their problem list.
   
   • If the facility does not maintain a diabetes register, use QMAN to create a search template of patients with diabetes who are receiving care.

2. Review and update taxonomies for medications and laboratory tests as needed (see Section 2.3).

3. Run and review a Data Quality Check report. Make corrections as appropriate. See Section 2.4 for additional information.

2.1 Audit Setup Menu

The Audit Setup (AS) menu provides reports and utilities used to prepare for running an Audit. Details of AS menu options are provided in Figure 2-1 and Figure 2-2.
THIS SYSTEM CONTAINS CONFIDENTIAL PATIENT INFORMATION COVERED
BY THE PRIVACY ACT. UNAUTHORIZED USE OF THIS DATA IS ILLEGAL
***************************************************************************
** DIABETES MANAGEMENT SYSTEM **
***************************************************************************
VERSION 2.0 (Patch 13)
2019 DEMO HOSPITAL (CMBA)
AUDIT SETUP

DXNR Patients with DM Diagnosis and not on Register
INA List Possible Inactive Pts in the DM Register
PLDX Patients w/no Diagnosis of DM on Problem List

LMR List Labs/Medications Used at this Facility
TC Check Taxonomies for the 2020 DM Audit
TU Update/Review Taxonomies for 2020 DM Audit
VTAX View/Print Any Taxonomy Used by the Diabetes Audit
VSML View a SNOMED List Used by the Diabetes AUDIT
DAL Display Audit Logic

DQC 2020 Data Quality Check Report

ASPR Prior Years Diabetes Audit Setup (DM16-DM19) ...

Figure 2-1: Audit Setup Menu

Figure 2-2: Visual DMS Audit Setup Menu
2.2 Identify Patients to Be Included in an Audit

Guidelines for Selecting Patients

Per guidance from the IHS Division of Diabetes Treatment and Prevention (Division of Diabetes), for the 2020 Annual Diabetes Audit, include patients who:

- Have a diagnosis of Type 1 or Type 2 diabetes.
- Are American Indian or Alaska Native.
- Have at least one visit to a primary care clinic during the Audit period (12-month time period ending on the Audit date). Primary care clinics include:
  - General (01)
  - Diabetic (06)
  - Internal Medicine (13)
  - Pediatric (20)
  - Family Practice (28)
  - Chronic Disease (50)
  - Endocrinology (69)
- Exclude Patients who:
  - Received most of their primary care outside your facility during the Audit period.
  - Are currently on dialysis and received most of their primary care at the dialysis unit during the Audit period.
  - Have died before the end of the Audit period.
  - Are women who were pregnant during any part of the Audit period.
  - Have prediabetes (impaired fasting glucose [IFG] or impaired glucose tolerance [IGT] only).
  - Have moved – permanently or temporarily (should be documented).

Unless the Diabetes Register is updated frequently, some of the patients identified as being in an active status might not qualify to be included in the Annual Audit. In addition, some patients who do qualify for inclusion may not be on the register in an active status. See Section 2.2.1 for guidance in reviewing and updating the Diabetes Register.

2.2.1 Using the Diabetes Register for the 2020 Diabetes Audit

The Diabetes Register may be used for the 2020 Annual Audit by updating patients who are on the register in an active status, as needed. This may require changing the status of some patients from active to inactive and adding new patients to the register with a status of active.
The QMAN tools and DMS reports below can help identify patients in the Diabetes Register who should and should not be included in the Audit:

- Section 2.2.1.1 describes how to find patients in the Register who have a Register Diagnosis of IGT or Gestational Diabetes Mellitus (GDM) and should not be included in the Audit.

- Section 2.2.1.2 describes how to use the **DXNR Patients with DM Diagnosis and not on Register** report to generate a list of patients who have a diabetes diagnosis and received care during the Audit period but are not currently on the diabetes register. Note that this report is only available in traditional DMS, not Visual DMS.

- Section 2.2.1.3 describes how to use the **INA List Possible Inactive Pts in the DM Register** report to list patients on the register with a status of Active who have not had a primary care visit during the Audit period and therefore do not meet the inclusion criteria. Note that this report is only available in traditional DMS, not Visual DMS.

- Section 2.2.1.4 describes how to change the status of a patient on the Register, as needed, after reviewing the above-mentioned reports. When ineligible patients have been identified, their status can be changed by using the Register Status option under Patient Management in the DMS. The **Patient Management** option can also be used to add a new patient to the register.

**Note:** For the 2020 Annual Audit, the IHS Division of Diabetes requires review of the care provided during the calendar year ending December 31, 2019. Reports identifying patients with an active status should be run for the time period between 1/1/2019 and 12/31/2019.

2.2.1.1 Identify IHS Diabetes Register Patients with GDM or IGT Using QMan

The IHS Diabetes Register allows entry of GDM and IGT as Register diagnoses. It is generally recommended that the IHS Diabetes Register include only patients with a diagnosis of Type 1 or Type 2 diabetes. Separate registries should be set up for patients with GDM and IGT.

The QMan search shown in Figure 2-3 will retrieve a list of patients in the register who have been given a particular Register Diagnosis. In this dialogue, a search is made for patients on the register with a Register Diagnosis of GDM. The same process can be used to find patients on the Register who have a Register Diagnosis of IGT. If any patients are found, their information should be reviewed, and the patient status should be updated appropriately, or the patient should be deleted from the register.

**Note:** QMan searches are not available in Visual DMS and must be performed in traditional RPMS.
Diabetes Management System (BDM) Version 2.0 Patch 13

Q-MAN OPTIONS -> SEARCH PCC Database (dialogue interface)
What is the subject of your search? LIVING PATIENTS // REGISTER <Enter>
REGISTER

Which CMS REGISTER: IHS DIABETES <Enter>

Register being checked to update status of deceased patients

Select the Patient Status for this report
1   Active
2   Inactive
3   Transient
4   Unreviewed
5   Deceased
6   Non-IHS
7   Lost to Follow-up
8   All Register Patients

Which Status(es): (1-8): 1//<Enter>

Select the Diabetes Register Diagnosis for this report

Select one of the following:
1      Type 1
2      Type 2
3      Type 1 & Type2
4      Gestational DM
5      Impaired Glucose Tolerance
6      All Diagnoses

Which Diagnosis: All Diagnoses// 4 <Enter> Gestational DM

Figure 2-3: QMan search to identify patients with Register Diagnosis of GDM

Figure 2-4 shows the QMan output options and list of patients.

***** Q-MAN OUTPUT OPTIONS *****
Select one of the following:
1   DISPLAY results on the screen
2   PRINT results on paper
3   COUNT 'hits'
4   STORE results of a search in a FM search template
5   SAVE search logic for future use
6   R-MAN special report generator
9   HELP
0   EXIT

Your choice: DISPLAY// 1 <Enter> DISPLAY results on the screen
...EXCUSE ME, LET ME PUT YOU ON 'HOLD' FOR A SECOND...

PATIENTS     CMI*DEV NUMBER
--------------------------------------------------------------------
PATIENT,DEMO I* 29693 Total: 1

Figure 2-4: QMan Search results
Note: A patient whose name is marked with an asterisk (*) might have an alias.

2.2.1.2 DXNR – Patients with DM Diagnosis and not on Register

The Patients with DM Diagnosis and not on Register report is used to find patients with a diabetes diagnosis who are being seen at your facility but are not currently on your diabetes register. This report can be especially useful at sites that have not kept their register up to date throughout the calendar year.

Notes: This report does not exclude non-Indian patients. Directions for running this report are shown in the following sequence followed by a sample of the report output.

This report is not available in Visual DMS and must be run in traditional RPMS.

1. At the Diabetes Management System main menu, type AS and press Enter.

2. Select DXNR Patients with DM Diagnosis and not on Register.

3. At the “Enter the Name of the Register” prompt, type some portion of the register name and press Enter.

   DXNR Patients with DM Diagnosis and not on Register.

   This report will list patients who are not on the diabetes register but who have had a visit with a diagnosis of diabetes in a date range specified by the user.

   Enter the Name of the Register: IHS DIABETES

   Enter the time frame to look for visits with a diabetes diagnosis.

   Enter Beginning Visit Date: 1/1/19 (JAN 01, 2019)
   Enter Ending Visit Date: 12/31/19 (DEC 31, 2019)

   Figure 2-5: Enter the register name and time frame to look for visits with a diabetes diagnosis

4. At the “Enter Beginning Visit Date” prompt, type the beginning date and press Enter.

5. At the “Enter Ending Visit Date” prompt, type the ending date and press Enter.

   How many diagnoses must the patient have had in that time period: (1-99): 2//

   Figure 2-6: Type number of diagnoses the patient must have in the selected time period
6. At the “How many diagnoses must the patient have had in that time period” prompt, type the answer as a number and press Enter.

```
Select one of the following:
  P  PRINT the List
  B  BROWSE the List on the Screen
```

Output Type: P// BROWSE the List on the Screen

Figure 2-7: Enter the output type

7. At the “Output Type” prompt, do one of the following:
   - Type **P** and press Enter to print the list.
   - Type **B** and press Enter to browse the list on the screen.

```
Select one of the following:
  I  Include ALL Patients
  E  Exclude DEMO Patients
  O  Include ONLY DEMO Patients
```

Demo Patient Inclusion/Exclusion: E// xclude DEMO Patients

Figure 2-8: Prompt to include or exclude demo patients

8. At the “Demo Patient Inclusion/Exclusion” prompt, do one of the following:
   - Type **I** and press Enter to include all patients.
   - Type **E** and press Enter to exclude demo patients.
   - Type **O** and press Enter to include only demo patients.

The report is printed or displayed as in Figure 2-9:

```
OUTPUT BROWSER              Nov 17, 2019 12:00:26        Page:    1 of   26
********** CONFIDENTIAL PATIENT INFORMATION **********
DR                                                                   Page 1
DEMO HOSPITAL
Patients NOT on the PARKER DIABETES REGISTER Register
with at least 3 visits with a DX of Diabetes between
Jan 01, 2019 and Dec 31, 2019
PATIENT NAME        HRN    DOB        COMMUNITY    LAST VISIT # DM  LAST DM
DXS   DX
---------------------------------------------------------------------------
DEMO,RACHEL PATIENT  100019 03/28/1941 LAKE HAVSU   03/20/17    3  03/20/17
DEMO PATIENT,NEOMI    888885 03/15/1955 KINGMAN      03/22/17    3  03/22/17
PATIENTDEMO,CARLEE   122222 11/12/1993 PARKER       04/03/17    3  02/27/17
DEMO-CARTER,PATIENT A 144444 05/25/1977 PARKER      03/27/17    4  03/19/17
+         Enter ?? for more actions                                     >>>
+    NEXT SCREEN          -    PREVIOUS SCREEN      Q    QUIT
```
2.2.1.3 INA – List Possible Inactive Pts in the DM Register

The **INA List Possible Inactive Pts in the DM Register** option (Figure 2-10) can be used to identify patients who are no longer being seen at your facility but are still marked as active in the diabetes register. Patients on this list can be changed to inactive in the register so they will not be included in the Audit. This report can be especially useful at sites that have large numbers of patients whose Register status might not be accurate.

The report is in the **AS – Audit Setup** menu of the Diabetes Management System.

1. Begin by selecting **AS Audit Setup** . . .
2. Type **INA** to initiate the report for Possible Inactive Patients
3. Enter the name of the Register that is to be reviewed for inactive patients.
4. Select **A** for patients on the Register with a Register status of **ACTIVE**.
5. At the Clinic prompt, type **[BGP PRIMARY CARE CLINICS]**
   This taxonomy contains the primary care clinics used by official GPRA reports. You may use just these six primary care clinics, or you may add additional clinics such as **ENDOCRINOLOGY**.
6. Enter the beginning and ending dates for searching for a visit to one or more of these primary care clinics. Note that the 2020 Annual Audit is for the time frame between January 1, 2019 and December 31, 2019. To be considered as an active patient, there should be at least one documented visit to a primary care clinic during that time frame.
7. Choose the option to Browse the list. Note the number of pages in the report in the upper right hand corner of the screen.

1. The report may be printed by typing **PL** at the “Select Action” prompt.
2. At the “Device” prompt, enter the printer name or number where the report should be printed.

The sequence to generate this report is shown in Figure 2-11:
The report provides a way to identify patients who could possibly be inactivated in the register.

Enter the Name of the Register: IHS DIABETES REGISTER

Select the Patient Status for this report

Select one of the following:

A  ACTIVE
I  INACTIVE
T  TRANSIENT
U  UNREVIEWED
D  DECEASED
N  NON-IHS
L  LOST TO FOLLOW-UP
NON  NONCOMPLIANT
0  All Register Patients

Which Status: A// CTIVE

Enter the list of clinics that you have determined to be primary care clinics. You can enter them 1 at a time or enter a taxonomy using the ']' notation.

Enter CLINIC: [BGP PRIMARY CARE CLINICS       BGP PRIMARY CARE CLINICS]

Members of BGP PRIMARY CARE CLINICS Taxonomy =>

GENERAL
DIABETIC
INTERNAL MEDICINE
PEDIATRIC
WELL CHILD
FAMILY PRACTICE

Enter ANOTHER CLINIC: ENDOCRINOLOGY
Enter ANOTHER CLINIC:

The following have been selected =>

GENERAL
DIABETIC
INTERNAL MEDICINE
PEDIATRIC
WELL CHILD
FAMILY PRACTICE
ENDOCRINOLOGY

Want to save this CLINIC group for future use? No//   (No)

Enter the time frame to look for visits.

Enter Beginning Visit Date:  1/1/19  (JAN 01, 2019)
Enter Ending Visit Date:  12/31/19  (DEC 31, 2019)

Select one of the following:

P  PRINT the List
B  BROWSE the List on the Screen

Output Type: P// BROWSE the List on the Screen
Select one of the following:

I  Include ALL Patients
E  Exclude DEMO Patients
O  Include ONLY DEMO Patients

Demo Patient Inclusion/Exclusion: E// [ENT] xclude DEMO Patients

Figure 2-11: INA List Possible Inactive Pts in the DM Register report

2.2.1.4 Update Patient Register Status

If there are patients currently in an active status in the register, their register status may be updated using the Patient Management tool in the DMS Register Maintenance menu.

2.2.1.4.1 How To Edit Register Status in DMS

1. Open the RM – Register Maintenance menu of DMS.
2. Open the RM – Register Management menu.
3. Open the Patient Management option (Figure 2-12).
LOCAL OPTION:
LOCAL OPTION TEXT:
- Previous Screen  Q Quit  ?? for More Actions
1  Register Status  6  Comments  11 Health Summary
2  Where Followed  7  Local Option Entry  12 DM Care Summary (DPCS)
3  Case Manager  8  Last Visit  13 Print Letter
4  Client Contact  9  Review Appointments  Q  Quit
5  DX/Date of Onset  10 Audit Status
Select Action: Quit/

Figure 2-12: Select Register Status (1)

4. At the “Select Action” prompt, type 1 and press Enter.

STATUS: ACTIVE/

Figure 2-13: Updating the Status

5. To change the Register Status, select the new status from the Status list.

- **A** – Active patients who receive their primary healthcare at a facility and who have had care at that facility within the last year.
- **I** – Inactive patients who have not been seen within the last two years.
- **T** – Transient patients seen at the clinic within the past year but who do not receive their primary diabetes care at a facility and only visit the clinic periodically for medications or other services.
- **U** – Unreviewed patients on the Register who have not had a chart audit and medical review.
- **D** – Deceased patients.

**Note:** This status will be automatically documented if a date of death is recorded in the patient registration file. However, if a patient’s status is changed to deceased in the Register, the patient registration file is not automatically updated.

- **N** – Non-IHS patients who receive their diabetes care at a facility.
- **L** – Lost to follow-up patients seen at a facility within the past two years but who have not had a visit in the last year.
- **NON** – Noncompliant patients with repeated documented refusals of recommended services.

**Note:** There are no official definitions of Register Status, although recommendations for classifying Register patients can be provided by Area Diabetes Consultants or their staff. The definitions above can be used as a guideline in the absence of Area-defined criteria.
2.2.1.4.2 **How To Edit Register Status in Visual DMS**

1. Select the desired Patient using the **Select Patient** tab at the top of the screen.

2. Open the **Patient Management** menu (Figure 2-14).

3. Click **Edit Register Data**. The **Patient Profile** (Figure 2-15) displays.

![Figure 2-14: Selecting Edit Register Data from the Patient Management menu](image)
4. To change the Register Status, select the new status from the Status list. Click the arrow to view the list of available status choices.

5. Click Save.

6. Close the dialog.

2.2.1.5 PLDX – Patients w/No Diagnosis of DM on Problem List

This report identifies patients who do not have a problem list diagnosis of diabetes. In addition, these patients will not have this date of onset documented on the problem list. You will be first prompted to choose between patients on the Register or those with a specified number of diagnoses of diabetes but not an active problem of diabetes. If you select the Register, you will be prompted to identify the name of the Register and the status of the patients you would like reviewed.

This report will list patients who do not have Diabetes on their Problem List but who are on a Diabetes Register or who have had at least N diagnoses of diabetes.

Select one of the following:

- R  Those who are members of a Register
- D  Those with at least N Diabetes Diagnoses
List which subset of patients: R// [ENT]

Enter the Name of the Register: IHS DIABETES
Do you want to select register patients with a particular status? Y// [ENT]
Which status: A//[ENT] ACTIVE

Figure 2-16: Patients w/No Diagnosis of DM on Problem List

The resulting report will display alphabetically all active patients on the Register who do not have an active problem of diabetes along with the date of the last diabetes diagnosis and the total number of diabetes diagnoses.

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>HRN</th>
<th>DOB</th>
<th>LAST DM DX</th>
<th># OF DM DXS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT, AMANDA</td>
<td>101500</td>
<td>Sep 19, 1985 F</td>
<td>Jan 01, 1997</td>
<td>1</td>
</tr>
<tr>
<td>PATIENT, BARNEY</td>
<td>101988</td>
<td>Aug 08, 1996 M</td>
<td>Jun 18, 2001</td>
<td>1</td>
</tr>
<tr>
<td>PATIENT, BRANDON</td>
<td>101867</td>
<td>May 06, 1996 M</td>
<td>Jun 18, 2001</td>
<td>1</td>
</tr>
<tr>
<td>PATIENT, GRANT</td>
<td>101857</td>
<td>Jan 30, 1995 M</td>
<td>Jun 18, 2001</td>
<td>1</td>
</tr>
<tr>
<td>PATIENT, GREG</td>
<td>101738</td>
<td>May 16, 1992 M</td>
<td>Jun 18, 2001</td>
<td>1</td>
</tr>
<tr>
<td>PATIENT, JENNIFER</td>
<td>100044</td>
<td>Jul 19, 1938 F</td>
<td>Jan 13, 1997</td>
<td>1</td>
</tr>
</tbody>
</table>

Figure 2-17: Patients w/No Diagnosis of DM on Problem List, report sample

2.2.2 Create a Template of Patients for the 2020 Diabetes Audit

If the IHS Diabetes Register is not current or has not been routinely used for management of patients with diabetes, you can use a QMan search to identify patients with diabetes who have had a visit to a primary care clinic during the Audit period. The template created from this query can be used for the 2020 Annual Diabetes Audit.

Users can run the QMan search using either the general patient population (see Section 2.3.1) or the Diabetes Register (see Section 2.2.1). In either case, if patients with diabetes who are not American Indian or Alaska Native are seen at the clinic or included in the Register, another attribute called Classification can be used to exclude these patients. The Classification for American Indian/Alaska Native patients is 01.

2.2.2.1 Create a Template using the General Population

The QMan search in the sequence that follows shows the creation of a template looking for patients with at least one diagnosis of diabetes during the Audit period and who have had at least one visit to a primary care clinic during the Audit period (Figure 2-18 through Figure 2-20).
***** SEARCH CRITERIA *****

What is the subject of your search? LIVING PATIENTS // <ENTER> LIVING PATIENTS

Include list of upcoming appts for the patient? NO // <ENTER>

Subject of search: PATIENTS
ALIVE TODAY

Attribute of LIVING PATIENTS: VISIT

SUBQUERY: Analysis of multiple VISITS

First condition of "VISIT": CLINIC VISIT ATTRIBUTES

Enter CLINIC: [BGP PRIMARY CARE CLINICS BGP PRIMARY CARE CLINICS]

Members of BGP PRIMARY CARE CLINICS Taxonomy =>

GENERAL
DIABETIC
INTERNAL MEDICINE
PEDIATRIC
WELL CHILD
FAMILY PRACTICE

Enter ANOTHER CLINIC: ENDOCRINOLOGY

The following have been selected =>

GENERAL
DIABETIC
INTERNAL MEDICINE
PEDIATRIC
WELL CHILD
FAMILY PRACTICE
ENDOCRINOLOGY

Want to save this CLINIC group for future use? No // <ENTER> (No)

Next condition of "VISIT": DURING THE PERIOD VISIT ATTRIBUTES

Exact starting date: 1/1/19 (JAN 01, 2019)
Exact ending date: 12/31/19 (DEC 31, 2019)

Subject of subquery: VISIT
CLINIC (GENERAL/DIABETIC...)
BETWEEN BETWEEN JAN 1,2019 and DEC 31,2019@23:59:59

Next condition of "VISIT":

Computing Search Efficiency Rating....

Subject of search: PATIENTS
ALIVE TODAY

Subject of subquery: VISIT
CLINIC (GENERAL/DIABETIC...)
BETWEEN BETWEEN JAN 1,2019 and DEC 31,2019@23:59:59

Attribute of LIVING PATIENTS: DX DIAGNOSES
Enter DX: [SURVEILLANCE DIABETES]  

Figure 2-18: Search Criteria  

Note: Use the taxonomy SURVEILLANCE DIABETES, as it includes all diabetes diagnosis codes, including ICD-9 and ICD-10.

250.00 - 250.93  
E10.10  
E10.11  
E10.21  
E10.22  
E10.29  
E10.311  
E10.319  
E10.321  
E10.329  
E10.331  
E10.339  
E10.341  
<>  

Figure 2-19: Code Listing  

Note: The symbols <> denote a page break. Press Enter to continue listing codes each time <> displays.

(THE FULL LIST OF CODES WILL DISPLAY)  
Enter ANOTHER DX: No or <ENTER>  

Want to save this DX group for future use? No// <ENTER> (No)  

SUBQUERY: Analysis of multiple DIAGNOSES  

First condition of "DIAGNOSIS": DURING THE TIME PERIOD  
Exact starting date: 1/1/19 (JAN 01, 2019)  
Exact ending date: 12/31/19 (DEC 31, 2019)  

Next condition of "DIAGNOSIS":  
Computing Search Efficiency  
Rating............................................  

Subject of search: PATIENTS ALIVE TODAY  
Subject of subquery: VISIT CLINIC (GENERAL/DIABETIC...)  
BETWEEN BETWEEN JAN 1,2019 and DEC 31,2019@23:59:59  
DIAGNOSIS (250.01/250.11...)  
Subject of subquery: DIAGNOSIS  
BETWEEN JAN 1,2019 and DEC 31,2019@23:59:59  

Attribute of LIVING PATIENTS:  

***** Q-MAN OUTPUT OPTIONS *****
Select one of the following:

1. DISPLAY results on the screen
2. PRINT results on paper
3. COUNT 'hits'
4. STORE results of a search in a FM search template
5. SAVE search logic for future use
6. R-MAN special report generator
7. DELIMITED file via screen capture
8. HELP
9. EXIT
0. EXIT

Your choice: DISPLAY// 4  STORE results of a search in a FM search template

Fileman users please note =>
This template will be attached to IHS' PATIENT file (#9000001)

Enter the name of the SEARCH TEMPLATE: DM AUDIT 2020
Are you adding 'DM AUDIT 2020' as a new SORT TEMPLATE? No// Y (Yes)

DESCRIPTION:
No existing text
Edit? NO// <ENTER>

Next, you will be asked about creating your template in background...

Answer 'YES' to run in background.

To run in background means to pass the template creation job off to Taskman. Your terminal will be released so additional RPMS work may be performed while the template is being created. When finished, Taskman will send you a Mailman message indicating that the job is ready. Then, you may use the template in future Qman searches, PGEN, VGEN and other reports that can utilize templates.

Answer 'NO', to create the search template in foreground.

While the template is being created, data will be displayed to your screen. When the job has finished, you will have the opportunity to go to PGEN or VGEN.

Remember ... some templates may take a very long time to finish.

Press ENTER to continue or '^' to quit:

...HMMM, JUST A MOMENT PLEASE...

PATIENTS         DEMO H   ICD CODE  VISIT
(Alive)          NUMBER #
---------------------------------------------------------------------------
DEMOG, ABE      999996 + +
DEMOH, MICKEY*  999997 + +
DEMOJ, JANE*    999998 + +
DEMOK, AMY*     999999 + +
DEMOJ, SHANE    999910 + +
DEMO, JESSICA*  999911 + +
DEMOO, ALEXANDRI 999912 + +
DEMOFAT, RHIANNON 999913 + +
Create a Template of Register Patients for the Audit

If a Diabetes Register exists but Register diagnoses and patient status have not been maintained, it might be easier to create a template (subset) of patients on the register who have had at least one visit to a primary clinic during the Audit year and have a diagnosis of diabetes. The QMan search demonstrating how to create that template is shown in the following sequences (Figure 2-21 through Figure 2-23).

What is the subject of your search? LIVING PATIENTS // REGISTER
Which CMS REGISTER: IHS DIABETES
Register being checked to update status of deceased patients.
Select the Patient Status for this report
1 Active
2 Inactive
3 Transient
4 Unreviewed
5 Deceased
6 Non-IHS
7 Lost to Follow-up
8 All Register Patients
Which Status(es): (1-8): 1// 8
Select the Diabetes Register Diagnosis for this report
Select one of the following:
1 Type 1
2 Type 2
3 Type 1 & Type 2
4 Gestational DM
5 Impaired Glucose Tolerance
6 All Diagnoses
Which Register Diagnosis: All Diagnoses// 3 Type 1 & Type 2.................
There are 74 register patients for the combination selected.
Attribute of IHS DIABETES REGISTER: ALIVE
Alive at least until exactly what date: TODAY//12/31/19 (DEC 31, 2019)
Computing Search Efficiency Rating........................................
Subject of search: PATIENTS
MEMBER OF 'IHS DIABETES REGISTER-4104' COHORT
ALIVE AS OF DEC 31, 2019
Attribute of IHS DIABETES REGISTER: VISIT
SUBQUERY: Analysis of multiple VISITS
First condition of "VISIT": CLINIC VISIT ATTRIBUTES
Enter CLINIC: [ BGP PRIMARY CARE CLINICS BGP PRIMARY CARE CLINICS]

Members of Taxonomy =>
GENERAL
DIABETIC
INTERNAL MEDICINE
PEDIATRIC
CHRONIC DISEASE
FAMILY PRACTICE
ENDOCRINOLOGY

Enter ANOTHER CLINIC:

The following have been selected =>
GENERAL
DIABETIC
INTERNAL MEDICINE
PEDIATRIC
CHRONIC DISEASE
FAMILY PRACTICE
ENDOCRINOLOGY

Want to save this CLINIC group for future use? No// <ENTER> (No)

Next condition of "VISIT": DURING THE PERIOD VISIT ATTRIBUTES

Exact starting date: 1/1/2019 (JAN 01, 2019)
Exact ending date: 12/31/2019 (DEC 31, 2019)

Subject of subquery: VISIT
CLINIC (GENERAL/DIABETIC...)
BETWEEN BETWEEN JAN 1,2019 and DEC 31,2019@23:59:59

Next condition of "VISIT":
Attribute of LIVING PATIENTS: DX DIAGNOSES
Enter DX: [SURVEILLANCE DIABETES
250.00 - 250.93
E10.10
E10.11
E10.21

Figure 2-21: Creating a Template of Register Patients

Note: The SURVEILLANCE DIABETES taxonomy contains all of the ICD-9 and ICD-10 codes pertaining to Diabetes. Not all of the ICD-10 codes are listed in this illustration, as there are numerous pages of them.
Figure 2-22: Sample ICD-10 code

Note: The symbols <> denote a page break. Press Enter to continue listing codes each time <> displays.

Enter ANOTHER DX: No or <ENTER>

Want to save this DX group for future use? No// <ENTER> (No)

SUBQUERY: Analysis of multiple DIAGNOSES

First condition of "DIAGNOSIS": DURING THE TIME PERIOD

Exact starting date: 1/1/19 (JAN 01, 2019)
Exact ending date: 12/31/19 (DEC 31, 2019)

Next condition of "DIAGNOSIS":

Computing Search Efficiency Rating

Subject of search: PATIENTS ALIVE TODAY
  Subject of subquery: VISIT  CLINIC (GENERAL/DIABETIC...)
  BETWEEN BETWEEN JAN 1,2019 and DEC 31,2019@23:59:59
  DIAGNOSIS (250.01/250.11...)
  Subject of subquery: DIAGNOSIS
  BETWEEN JAN 1,2019 and DEC 31,2019@23:59:59

Attribute of LIVING PATIENTS:

***** Q-MAN OUTPUT OPTIONS *****

Select one of the following:
1  DISPLAY results on the screen
2  PRINT results on paper
3  COUNT 'hits'
4  STORE results of a search in a FM search template
5  SAVE search logic for future use
6  R-MAN special report generator
7  DELIMITED file via screen capture
9  HELP
0  EXIT

Your choice: DISPLAY// 4  STORE results of a search in a FM search template

Fileman users please note =>
This template will be attached to IHS' PATIENT file (#9000001)

Enter the name of the SEARCH TEMPLATE: DM AUDIT 2020
Are you adding 'DM AUDIT 2020' as a new SORT TEMPLATE? No// Y (Yes)
DESCRIPTION:
No existing text
Edit? NO/

Next, you will be asked about creating your template in background...
2.3 Taxonomy Review and Setup

An important step in preparing for a diabetes Audit is to make sure that all relevant medication and lab test taxonomies are up to date and include all appropriate drugs and lab tests that are currently being used at your facility.

The taxonomies listed in Figure 2-24 are referenced in the 2020 RPMS Diabetes Audit. You will notice in the list below that several of the taxonomies begin with BGP rather than DM AUDIT. These taxonomies, as well as several of the DM AUDIT taxonomies, are shared between the Government Performance and Results Act (GPRA) program and the DMS. It is imperative that staff work together to review and update these taxonomies.

Even though taxonomies might have been updated for the 2019 Annual Audit, they must be reviewed and updated again before running the 2020 Annual Audit as new medications may have been added to the pharmacy formulary or new lab tests offered.
**TAXONOMIES TO SUPPORT 2020 DIABETES AUDIT REPORTING**

* Update Taxonomies

<table>
<thead>
<tr>
<th>Taxonomy</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) BGP CMS SMOKING CESSATION MEDS</td>
<td>DRUG</td>
</tr>
<tr>
<td>2) BGP CREATINE KINASE TAX</td>
<td>LABORATORY TEST</td>
</tr>
<tr>
<td>3) BGP GPRA ESTIMATED GFR TAX</td>
<td>LABORATORY TEST</td>
</tr>
<tr>
<td>4) BGP PQA STATIN MEDS</td>
<td>DRUG</td>
</tr>
<tr>
<td>5) DM AUDIT ACARBOSIDE DRUGS</td>
<td>DRUG</td>
</tr>
<tr>
<td>6) DM AUDIT ACE INHIBITORS</td>
<td>DRUG</td>
</tr>
<tr>
<td>7) DM AUDIT ALT TAX</td>
<td>LABORATORY TEST</td>
</tr>
<tr>
<td>8) DM AUDIT AMILIN ANALOGUES</td>
<td>DRUG</td>
</tr>
<tr>
<td>9) DM AUDIT ANTIPLT/ANTICOAG RX</td>
<td>DRUG</td>
</tr>
<tr>
<td>10) DM AUDIT ASPIRIN DRUGS</td>
<td>DRUG</td>
</tr>
<tr>
<td>11) DM AUDIT AST TAX</td>
<td>LABORATORY TEST</td>
</tr>
<tr>
<td>12) DM AUDIT BROMOCRIPTINE DRUGS</td>
<td>DRUG</td>
</tr>
<tr>
<td>13) DM AUDIT CESSATION HLTH FACTOR</td>
<td>HEALTH FACTORS</td>
</tr>
<tr>
<td>14) DM AUDIT CHOLESTEROL TAX</td>
<td>LABORATORY TEST</td>
</tr>
<tr>
<td>15) DM AUDIT COLESEVELAM DRUGS</td>
<td>DRUG</td>
</tr>
<tr>
<td>16) DM AUDIT CREATININE TAX</td>
<td>LABORATORY TEST</td>
</tr>
<tr>
<td>17) DM AUDIT DIET EDUC TOPICS</td>
<td>EDUCATION TOPICS</td>
</tr>
<tr>
<td>18) DM AUDIT DPP4 INHIBITOR DRUGS</td>
<td>DRUG</td>
</tr>
<tr>
<td>19) DM AUDIT EXERCISE EDUC TOPICS</td>
<td>EDUCATION TOPICS</td>
</tr>
<tr>
<td>20) DM AUDIT GLITAZONE DRUGS</td>
<td>DRUG</td>
</tr>
<tr>
<td>21) DM AUDIT GLP-1 ANALOG DRUGS</td>
<td>DRUG</td>
</tr>
<tr>
<td>22) DM AUDIT HDL TAX</td>
<td>LABORATORY TEST</td>
</tr>
<tr>
<td>23) DM AUDIT HGB A1C TAX</td>
<td>LABORATORY TEST</td>
</tr>
<tr>
<td>24) DM AUDIT INCRETIN MIMETIC</td>
<td>DRUG</td>
</tr>
<tr>
<td>25) DM AUDIT INSULIN DRUGS</td>
<td>DRUG</td>
</tr>
<tr>
<td>26) DM AUDIT LDL CHOLESTEROL TAX</td>
<td>LABORATORY TEST</td>
</tr>
<tr>
<td>27) DM AUDIT LIPID LOWERING DRUGS</td>
<td>DRUG</td>
</tr>
<tr>
<td>28) DM AUDIT METFORMIN DRUGS</td>
<td>DRUG</td>
</tr>
<tr>
<td>29) DM AUDIT MICROALBUMINuria TAX</td>
<td>LABORATORY TEST</td>
</tr>
<tr>
<td>30) DM AUDIT OTHER EDUC TOPICS</td>
<td>EDUCATION TOPICS</td>
</tr>
<tr>
<td>31) DM AUDIT QUANT UACR</td>
<td>LABORATORY TEST</td>
</tr>
<tr>
<td>32) DM AUDIT SGLT-2 INHIBITOR DRUG</td>
<td>DRUG</td>
</tr>
<tr>
<td>33) DM AUDIT STATIN DRUGS</td>
<td>DRUG</td>
</tr>
<tr>
<td>34) DM AUDIT SULFONYLUREA DRUGS</td>
<td>DRUG</td>
</tr>
<tr>
<td>35) DM AUDIT SULFONYLUREA-LIKE DRUG</td>
<td>DRUG</td>
</tr>
<tr>
<td>36) DM AUDIT TB LAB TESTS</td>
<td>LABORATORY TEST</td>
</tr>
<tr>
<td>37) DM AUDIT TRIGLYCERIDE TAX</td>
<td>LABORATORY TEST</td>
</tr>
</tbody>
</table>

Figure 2-24: Audit 2020 user-populated taxonomies

### 2.3.1 LMR–List Labs or Medications Used at this Facility

This report displays the laboratory tests reported or the drugs prescribed at a facility during the Audit period. In addition to displaying the laboratory tests or drugs, it identifies those that are already included in a taxonomy used by the Audit. This report can be very helpful for reviewing and updating taxonomies. To run the laboratory tests version of this report:

1. At the Diabetes Management Systems menu, type **AS** and press Enter.
2. Type **LMR** (List Labs/Medications Used at this Facility) and press Enter.
3. At the “Do you wish to list” prompt, type **L** (LAB TESTS) and press Enter.
4. Type the beginning and ending dates for the report (1/1/19 and 12/31/19 for the 2020 Annual Diabetes Audit), pressing Enter after each.

5. At the “Do you wish to” prompt, do one of the following:
   - To print the output, accept the default (P) by pressing Enter. A prompt asking for the device name displays; type the device’s name and press Enter.
   - To browse the output on the screen, type B and press Enter.

A sample report is shown in Figure 2-25.

<table>
<thead>
<tr>
<th>Oct 31, 2019</th>
<th>LAB TESTS Used at DEMO HOSPITAL</th>
<th>Page 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Range:</td>
<td>Jan 01, 2019 - Dec 31, 2019</td>
<td></td>
</tr>
<tr>
<td>LAB TEST NAME</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TAXANOMIES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HDL</td>
<td>244</td>
<td>1</td>
</tr>
<tr>
<td>D纳斯 AUDIT HDL TAX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LDL</td>
<td>901</td>
<td>1</td>
</tr>
<tr>
<td>D纳斯 AUDIT LDL CHOLESTEROL TAX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALBUMIN/CREATININE RATIO</td>
<td>9034</td>
<td>1</td>
</tr>
<tr>
<td>D纳斯 AUDIT QUANT UACR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANION GAP</td>
<td>1160</td>
<td>2</td>
</tr>
<tr>
<td>BASIC METABOLIC PANEL</td>
<td>9999068</td>
<td>2</td>
</tr>
<tr>
<td>C DIFF A+B E/A (R)</td>
<td>9999195</td>
<td>3</td>
</tr>
<tr>
<td>CALCIUM</td>
<td>180</td>
<td>2</td>
</tr>
<tr>
<td>CHLORIDE</td>
<td>178</td>
<td>2</td>
</tr>
<tr>
<td>CHOLESTEROL</td>
<td>183</td>
<td>1</td>
</tr>
<tr>
<td>D纳斯 AUDIT CHOLESTEROL TAX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CO2</td>
<td>179</td>
<td>2</td>
</tr>
<tr>
<td>CREATININE</td>
<td>173</td>
<td>3</td>
</tr>
<tr>
<td>D纳斯 AUDIT CREATININE TAX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRYSTALS, FLUID</td>
<td>9999199</td>
<td>1</td>
</tr>
<tr>
<td>CULTURE, HSV RAPID (R)</td>
<td>9999198</td>
<td>1</td>
</tr>
<tr>
<td>CYCLIC CITRULLINATED PEPTIDE A</td>
<td>9999172</td>
<td>1</td>
</tr>
<tr>
<td>DIAGNOSIS:</td>
<td>9999089</td>
<td>3</td>
</tr>
<tr>
<td>DILANTIN</td>
<td>210</td>
<td>1</td>
</tr>
<tr>
<td>ESTIMATED GFR</td>
<td>9999103</td>
<td>3</td>
</tr>
<tr>
<td>BGP GPRA ESTIMATED GFR TAX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FERRITIN (SQ)</td>
<td>9999175</td>
<td>2</td>
</tr>
<tr>
<td>FREE T3</td>
<td>9999176</td>
<td>1</td>
</tr>
<tr>
<td>GLUCOSE</td>
<td>175</td>
<td>5</td>
</tr>
<tr>
<td>H PYLORI AG EIA</td>
<td>9999183</td>
<td>2</td>
</tr>
<tr>
<td>H. PYLORI AG EIA</td>
<td>9999177</td>
<td>1</td>
</tr>
<tr>
<td>HEMOGLOBIN</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>LEAD</td>
<td>262</td>
<td>1</td>
</tr>
<tr>
<td>LIPASE (R)</td>
<td>200</td>
<td>1</td>
</tr>
</tbody>
</table>

Figure 2-25: Sample Report of Lab Tests Documented during the Audit Period

To run the version of this report for the medications that have been prescribed:
1. At the Diabetes Management Systems menu, type AS and press Enter.
2. Type LMR (List Labs/Medications Used at this Facility) and press Enter.
3. At the “Do you wish to list” prompt, type M (MEDICATIONS) and press Enter.

4. Type the beginning and ending dates for the report (7/1/19 and 12/31/19 for the 2020 Annual Diabetes Audit), pressing Enter after each. This is July 1 rather than January 1, as with labs. The Audit only reviews medications prescribed during the last six months of the Audit period.

5. At the “Do you wish to” prompt, do one of the following:
   - To print the output, accept the default (P) by pressing Enter. A prompt asking for the device name displays; type the device’s name and press Enter.
   - To browse the output on the screen, type B and press Enter.

A sample report is shown in Figure 2-26.

<table>
<thead>
<tr>
<th>Oct 31, 2019</th>
<th>MEDICATIONS (DRUGS) Used at DEMO HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Date Range: Jul01, 2019 – Dec 31, 2019</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICATION/DRUG NAME</th>
<th>IEN</th>
<th># DONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACARBOSE 25MG TAB</td>
<td>84472</td>
<td>4</td>
</tr>
<tr>
<td>DM AUDIT ACARBOSE DRUGS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACETAMINOPHEN 325MG TAB</td>
<td>263</td>
<td>3</td>
</tr>
<tr>
<td>ACETAMINOPHEN WITH CODEINE 30M</td>
<td>342</td>
<td>301</td>
</tr>
<tr>
<td>ACETAMINOPHEN/CODEINE 12MG/5M</td>
<td>3958</td>
<td>5</td>
</tr>
<tr>
<td>ACETAZOLAMIDE 250MG TABS</td>
<td>638</td>
<td>2</td>
</tr>
<tr>
<td>ACETIC ACID 2% HC 1% OTIC</td>
<td>2810</td>
<td>13</td>
</tr>
<tr>
<td>ACETIC ACID 2% OTIC SOL</td>
<td>3868</td>
<td>1</td>
</tr>
<tr>
<td>ACYCOVIR 200MG CAP</td>
<td>83978</td>
<td>7</td>
</tr>
<tr>
<td>ACYCOVIR 800MG TAB</td>
<td>84481</td>
<td>2</td>
</tr>
<tr>
<td>ALBUTEROL 2MG TAB</td>
<td>84348</td>
<td>2</td>
</tr>
<tr>
<td>ALBUTEROL 4MG TAB</td>
<td>84333</td>
<td>5</td>
</tr>
<tr>
<td>ALBUTEROL INHALER 17GM</td>
<td>3769</td>
<td>247</td>
</tr>
<tr>
<td>ALBUTEROL REFILL</td>
<td>84459</td>
<td>1</td>
</tr>
<tr>
<td>ALBUTEROL SOL 0.5%</td>
<td>84042</td>
<td>66</td>
</tr>
<tr>
<td>ALBUTEROL SULFATE SYRUP 2MG/5M</td>
<td>84061</td>
<td>20</td>
</tr>
<tr>
<td>ALENDRONATE SODIUM 10MG TAB</td>
<td>84444</td>
<td>1</td>
</tr>
<tr>
<td>ALLEGRA</td>
<td>84422</td>
<td>8</td>
</tr>
<tr>
<td>ALLOPURINOL 100MG TABS</td>
<td>1391</td>
<td>10</td>
</tr>
<tr>
<td>ALLOPURINOL 300MG TAB</td>
<td>3740</td>
<td>27</td>
</tr>
<tr>
<td>ALUMINUM ACETATE SOLN TAB</td>
<td>83607</td>
<td>1</td>
</tr>
<tr>
<td>AMANTADINE 100MG CAP</td>
<td>1606</td>
<td>3</td>
</tr>
<tr>
<td>AMIODARONE 200MG TAB</td>
<td>84092</td>
<td>17</td>
</tr>
<tr>
<td>AMILODIPINE 25MG TAB</td>
<td>1639</td>
<td>100</td>
</tr>
<tr>
<td>AMILODIPINE BESYLATE 10MG TAB</td>
<td>84337</td>
<td>34</td>
</tr>
<tr>
<td>AMILODIPINE BESYLATE 2.5MG TAB</td>
<td>84335</td>
<td>2</td>
</tr>
<tr>
<td>AMILODIPINE BESYLATE 5MG TAB</td>
<td>84336</td>
<td>22</td>
</tr>
<tr>
<td>AMOXICILLIN 250MG CAP</td>
<td>4601</td>
<td>7</td>
</tr>
<tr>
<td>AMOXICILLIN 250MG/5ML</td>
<td>83611</td>
<td>78</td>
</tr>
<tr>
<td>AMOXICILLIN 500MG CAP</td>
<td>84024</td>
<td>135</td>
</tr>
<tr>
<td>AMOXICILLIN/CLAUVULENATE 400MG/</td>
<td>84434</td>
<td>20</td>
</tr>
<tr>
<td>ANTIFYRINE/SANZOCaine OTIC SOL</td>
<td>83614</td>
<td>19</td>
</tr>
<tr>
<td>ASCORBIC ACID 500MG TAB</td>
<td>1642</td>
<td>421</td>
</tr>
<tr>
<td>ASCORBIC ACID 500MG TAB</td>
<td>84291</td>
<td>1</td>
</tr>
<tr>
<td>DM AUDIT ASPIRIN DRUGS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASPIRIN 325MG E.C. TAB UD</td>
<td>276</td>
<td>310</td>
</tr>
</tbody>
</table>
Figure 2-26: Sample Report of Drugs Prescribed during the last six months of the Audit period

2.3.2 Update Taxonomies

The taxonomies can be reviewed and updated with the TU option under the AS – Audit Setup menu in DMS or the corresponding Visual DMS Update Taxonomy option.

When updating lab test taxonomies, attempting to add a test panel to a laboratory test taxonomy that should only include individual tests results in the display of a warning. This warning is displayed because the Audit cannot correctly determine hemoglobin A1C, lipid breakdown, or estimated GFR if panels are included in the taxonomy. Panel tests have no values associated with them; only the tests within the panels have values.

Some taxonomies might not have any members. For example, if providers at a facility never prescribe INVOKANA, the DM AUDIT SGLP-2 DRUG taxonomy will not have any members.

Taxonomies in the following sections must be reviewed carefully. Possible members of the taxonomies are listed but are by no means to be considered comprehensive.

2.3.2.1 Drug Taxonomies

Table 2-1 provides a list of DM Audit Drug Taxonomies. Review this list with the pharmacist to be sure it includes all that are available at your facility or may be ordered as outside medications.

While there are two separate taxonomies for GLP-1 medications, DM AUDIT GLP-1 ANALOG DRUGS and DM AUDIT INCRETIN MIMETICS, the components of those taxonomies are displayed together as GLP-1 Meds for the Audit.

Combination drugs should be added to the taxonomy for each of the components of that drug.
Medications entered as outside medications via the RPMS EHR can be orderable items, but they might not be in your facility’s drug file. If a medication is not in your facility’s drug file, the outside medication will not be stored in the V Medication file in Patient Care Component (PCC). If that is the case, those medications might not be found as drugs available to add to medication taxonomies, nor will they be included in the Diabetes Audit or Diabetes Patient Care Summary.

**Note:** The BGP PQA STATIN MEDS taxonomy is not included in the list that follows as it is pre-populated using the NDC numbers of Statin Drugs and does not need to be reviewed or populated on a local basis.

Table 2-1: DM Audit Drug Taxonomies

<table>
<thead>
<tr>
<th>Taxonomy</th>
<th>Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>DM AUDIT ACE INHIBITORS</td>
<td>Benazepril (Lotensin)</td>
</tr>
<tr>
<td></td>
<td>Benazepril and hydrochlorothiazide (Lotensin HCT)</td>
</tr>
<tr>
<td></td>
<td>Benazepril and amlodipine (Lotrel)</td>
</tr>
<tr>
<td></td>
<td>Captopril (Capoten)</td>
</tr>
<tr>
<td></td>
<td>Captopril and hydrochlorothiazide (Capozide)</td>
</tr>
<tr>
<td></td>
<td>Enalapril (Vasotec)</td>
</tr>
<tr>
<td></td>
<td>Enalapril and hydrochlorothiazide (Vaseretic)</td>
</tr>
<tr>
<td></td>
<td>Enalapril and diltiazem (Teczem)</td>
</tr>
<tr>
<td></td>
<td>Enalapril and felodipine (Lexcel)</td>
</tr>
<tr>
<td></td>
<td>Fosinopril (Monopril)</td>
</tr>
<tr>
<td></td>
<td>Lisinopril (Prinivil, Zestril)</td>
</tr>
<tr>
<td></td>
<td>Lisinopril and hydrochlorothiazide (Prinzide, Zestoretic)</td>
</tr>
<tr>
<td></td>
<td>Moexipril (Univasc)</td>
</tr>
<tr>
<td></td>
<td>Perindopril (Aceon)</td>
</tr>
<tr>
<td></td>
<td>Quinapril (Accupril)</td>
</tr>
<tr>
<td></td>
<td>Ramipril (Altace)</td>
</tr>
<tr>
<td></td>
<td>Trandolapril (Mavik)</td>
</tr>
<tr>
<td></td>
<td>Trandolapril and verapamil (Tarka)</td>
</tr>
<tr>
<td></td>
<td>Also, include Angiotensin II Receptor Blockers (ARB) in this Taxonomy</td>
</tr>
<tr>
<td></td>
<td>Azilsartan (Edarbi)</td>
</tr>
<tr>
<td></td>
<td>Candesartan (Atacand)</td>
</tr>
<tr>
<td></td>
<td>Eprosartan (Teveten)</td>
</tr>
<tr>
<td></td>
<td>Irbesartan (Avapro)</td>
</tr>
<tr>
<td></td>
<td>Irbesartan and hydrochlorothiazide (Avalide)</td>
</tr>
<tr>
<td></td>
<td>Losartan (Cozaar)</td>
</tr>
<tr>
<td></td>
<td>Losartan and hydrochlorothiazide (Cozaar)</td>
</tr>
<tr>
<td></td>
<td>Olmesartan (Benicar)</td>
</tr>
<tr>
<td></td>
<td>Telmisartan (Micards)</td>
</tr>
<tr>
<td></td>
<td>Valsartan (Diovan)</td>
</tr>
<tr>
<td></td>
<td>Valsartan and hydrochlorothiazide (Diovan/HCT)</td>
</tr>
<tr>
<td>Taxonomy</td>
<td>Drugs</td>
</tr>
<tr>
<td>----------</td>
<td>-------</td>
</tr>
</tbody>
</table>
| DM AUDIT ACARBOSE DRUGS | Acarbose (Precose)  
Miglitol (Glyset) |
| DM AUDIT AMYLIN ANALOGUES | Pramlinitide (Symlin) |
| DM AUDIT ANTIPLT/ANTICOAG THERAPY | Any non-aspirin anti-platelet product including Heparin and Warfarin (Coumadin)  
Apixaban (Eliquis)  
Aspirin and Dipyridamole (Aggrenox)  
Cilistazol (Pletal)  
Clopidogrel (Plavix)  
Dabigatran Etxilate (Pradaxa)  
Dipyridamole (Persantine)  
Edoxaban (Sarvaisa)  
Ticagrelor (Brilinta)  
Ticlopidine (Ticlid)  
Prasugrel (Effient)  
Rivaroxaban (Xarelto)  
Vorapaxar (Zontivity) |
| DM AUDIT ASPIRIN DRUGS | Any Aspirin (ASA) or Aspirin containing product (Verasa, Rubrasa) |
| DM AUDIT BROMOCRIPTINE DRUGS | Bromocriptine 0.8 mg (Cycloset) |
| DM AUDIT COLESEVELAM DRUGS | Colesevelam (Welchol) |
| DM AUDIT DPP4 INHIBITOR DRUGS | Alogliptin (Nesina)  
Alogliptin and Metformin (Kazano)  
Alogliptin and Pioglitazone (Oseni)  
Linagliptin (Trajenta)  
Linagliptin and Metformin (Jentadueto)  
Sitagliptin (Januvia)  
Sitagliptin and metformin (Janumet)  
Sitagliptin and Simvastatin (Juvisync)  
Saxagliptin (Onglyza)  
Saxagliptin and Metformin (Kombiglyze XR) |
| DM AUDIT GLITAZONE DRUGS (a.k.a.: Thiazolidinediones) | Pioglitazone (Actos)  
Pioglitazone and Alogliptin (Oseni)  
Pioglitazone and Metformin (Actoplus met)  
Pioglitazone and Glimeperide (Duetact)  
Rosiglitazone and Glimeperide (Avandaryl)  
Rosiglitazone (Avandia)  
Rosiglitazone and Metformin (Avandamet)  
Troglitazone (Rezulin) – RECALLED in 2000 |
| DM AUDIT GLP-1 ANALOG DRUGS | Albiglutide (Tanzeum)  
Dulaglutide (Trulicity)  
Liraglutide (Victoza) |
<p>| DM AUDIT INCRETIN MIMETICS | Exenatide (Byetta, Bydureon) |</p>
<table>
<thead>
<tr>
<th>Taxonomy</th>
<th>Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DM AUDIT INSULIN DRUGS</strong></td>
<td>Any Insulin product in Drug File – Insulin, REG, NPH, Lente, Ultralente, Insulin Lispro (Humalog), Insulin Glargine (Lantus), Insulin Detemir (Levimir) Insulin Aspart (Novolog), Insulin Glulisine (Apidra), Inhalable Insulin (Affreza, Exubera – discontinued 2007), Pre-Mixed Insulins (70/30, 75/25)</td>
</tr>
<tr>
<td><strong>DM AUDIT METFORMIN DRUGS</strong></td>
<td>Metformin (Glucophage, Fortamet, Glumetza, Riomet) Metformin extended release (Glucophage XR, Glumetza) Metformin and Alogliptin (Janumet) Metformin and Canagliflozin (Invokamet) Metformin and Dapagliflozin (Xigduo) Metformin and Glipizide (Metaglip) Metformin and Glyburide (Glucovance) Metformin and Linagliptin (Jentadueto) Metformin and Rosiglitazone (Actoplus met) Metformin and Sitagliptin (Janumet) Metformin and Repaglinide (PrandiMet) Metformin and Saxagliptin (Kombiglyze XR)</td>
</tr>
<tr>
<td><strong>DM AUDIT SGLT-2 INHIBITOR DRUG</strong></td>
<td>Canagliflozin (Invokana) Dapagliflozin (Farxiga) Empagliflozen (Jardiance)</td>
</tr>
<tr>
<td><strong>DM AUDIT STATIN DRUGS</strong></td>
<td>Atorvastatin (Lipitor) Atorvastatin and Amlodipine (Caduet) Atorvastatin and Ezetimibe (Liptruzet) Fluvastatin (Lescol) Lovastatin (Mevacor, Altocor, Altoprev) Lovastatin and Niacin (Advicor) Pravastatin (Pravachol) Pitavastatin (Livalo) Rosuvastatin (Crestor) Simvastatin (Zocor) Simvastatin and Ezetimibe (Vitorin) Simvastatin and Niacin (Simcor) Simvastatin and Sitagliptin (Juvisync)</td>
</tr>
</tbody>
</table>
### Laboratory Test Taxonomies

Table 2-2 lists the taxonomies that must be reviewed for potential changes in laboratory testing at a facility each year. Note that the DM AUDIT ALT, DM AUDIT AST, and DM AUDIT CREATINE KINASE taxonomies are used to check for test values that would be indicative of an adverse reaction to statin therapy.

<table>
<thead>
<tr>
<th>Taxonomy</th>
<th>Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DM AUDIT SULFONYLUREA DRUGS</strong></td>
<td>Acetohexamide (Dymelor)</td>
</tr>
<tr>
<td></td>
<td>Chlorpropamide (Diabinese)</td>
</tr>
<tr>
<td></td>
<td>Glimepiride (Amaryl)</td>
</tr>
<tr>
<td></td>
<td>Glimepiride and pioglitazone (Duetact)</td>
</tr>
<tr>
<td></td>
<td>Glimepiride and rosiglitazone (Avandaryl)</td>
</tr>
<tr>
<td></td>
<td>Glipizide (Glucotrol)</td>
</tr>
<tr>
<td></td>
<td>Glipizide and metformin (Metaglip)</td>
</tr>
<tr>
<td></td>
<td>Glyburide (Diabeta, Micronase, Glynase, Glycryn)</td>
</tr>
<tr>
<td></td>
<td>Glyburide and metformin (GlucoVance)</td>
</tr>
<tr>
<td></td>
<td>Tolazamide (Tolinase)</td>
</tr>
<tr>
<td></td>
<td>Tolbutamide (Orinase)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Taxonomy</th>
<th>Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DM AUDIT SULFONYLUREA-LIKE DRUGS</strong></td>
<td>Nateglinide (Starlix)</td>
</tr>
<tr>
<td></td>
<td>Repaglinide (Prandin)</td>
</tr>
<tr>
<td></td>
<td>Repaglinide and Metformin (PrandiMet)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Taxonomy</th>
<th>Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BGP GPRA ESTIMATED GFR TAX</strong></td>
<td>Estimated GFR, Calculated GFR, _GFR, Estimated, _GFR</td>
</tr>
<tr>
<td></td>
<td>Non-African American, EST GFR, eGFR</td>
</tr>
<tr>
<td><strong>BGP CREATINE KINASE TAX</strong></td>
<td>CK, CPK, Creatine Kinase, Total CK</td>
</tr>
<tr>
<td><strong>DM AUDIT ALT TAX</strong></td>
<td>ALT, SGPT</td>
</tr>
<tr>
<td><strong>DM AUDIT AST TAX</strong></td>
<td>AST, SGOT</td>
</tr>
<tr>
<td><strong>DM AUDIT CHOLESTEROL TAX</strong></td>
<td>Cholesterol, Total Cholesterol, _Cholesterol, POC</td>
</tr>
<tr>
<td></td>
<td>Cholesterol</td>
</tr>
<tr>
<td><strong>DM AUDIT CREATININE TAX</strong></td>
<td>Creatinine, POC Creatinine, Serum Creatinine, _Creatinine</td>
</tr>
</tbody>
</table>

(Be careful not to include any tests for Urine Creatinine.)
With the advent of reference laboratory interfaces and Point of Care result entry, there is considerable variation in test nomenclature. Diabetes program staff are encouraged to solicit assistance from both laboratory and pharmacy staff in updating taxonomies.

When deciding which tests should be included in a taxonomy, it may be useful to review test results on a health summary for a known patient with diabetes whose Standards of Care are current. Once test names are determined, the appropriate tests can be added or deleted from taxonomies.

Figure 2-27 shows a Health Summary sample with the name of the taxonomy that the test is included in noted underneath the lab test.

<table>
<thead>
<tr>
<th>Taxonomy</th>
<th>Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>DM AUDIT HDL TAX</td>
<td>HDL, HDL Cholesterol, POC HDL Cholesterol, _HDL Cholesterol</td>
</tr>
<tr>
<td>DM AUDIT LDL CHOLESTEROL TAX</td>
<td>LDL, Direct LDL, LDL Cholesterol, LDL Cholesterol (calc), POC LDL Cholesterol, _LDL Cholesterol</td>
</tr>
<tr>
<td>DM AUDIT MICROALBUMINURIA TAX</td>
<td>Microalbumin, _Microalbumin, Albumin, Urine, POC Microalbumin</td>
</tr>
<tr>
<td>DM AUDIT TB LAB TESTS</td>
<td>QFT-G, T SPOT-TB, Quantiferon GOLD</td>
</tr>
<tr>
<td>DM AUDIT TRIGLYCERIDE TAX</td>
<td>Triglyceride, POC Triglyceride, _Triglyceride</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Test Name</th>
<th>Date</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>HGB A1C-GLYCO (R)</td>
<td>01/16/09</td>
<td>5.7 % 4.3-6.1</td>
</tr>
<tr>
<td>DM AUDIT LDL CHOLESTEROL</td>
<td>01/16/09</td>
<td>44 MG/DL 40-125</td>
</tr>
<tr>
<td>TRIGLYCERIDE (R)</td>
<td>01/16/09</td>
<td>109 MG/DL 30-150</td>
</tr>
<tr>
<td>LDL CHOLESTEROL (R)</td>
<td>01/16/09</td>
<td>97 MG/DL 0-130</td>
</tr>
<tr>
<td>HDL CHOLESTEROL (R)</td>
<td>01/16/09</td>
<td>163 MG/DL 0-130</td>
</tr>
<tr>
<td>LIPID PROFILE (R)</td>
<td>01/16/09</td>
<td></td>
</tr>
<tr>
<td>ALT (SGPT) (R)</td>
<td>01/16/09</td>
<td>15 U/L 0-40</td>
</tr>
<tr>
<td>AST (SGOT) (R)</td>
<td>01/16/09</td>
<td>18 U/L 0-40</td>
</tr>
<tr>
<td>BUN (R)</td>
<td>01/16/09</td>
<td>11 MG/DL 5-12</td>
</tr>
<tr>
<td>ALBUMIN (R)</td>
<td>01/16/09</td>
<td>4.2 GM/DL 3.9-5.0</td>
</tr>
<tr>
<td>CHLORIDE (R)</td>
<td>01/16/09</td>
<td>104 MMOL/L 96-108</td>
</tr>
</tbody>
</table>
2.3.3 View/Print Any DM Audit Taxonomy

The View/Print Any DM Taxonomy option may be used to review any of the Diabetes Audit taxonomies, including CPT Codes, Diagnoses Codes, LOINC Codes, Medications, Laboratory Tests, or Education Topics. To review a taxonomy:

1. Select AS (Audit Setup) from the DMS main menu.
2. Select VTAX View/Print Any DM Audit Taxonomy.
3. When prompted, type 2020 as the Audit year. A list of the taxonomies used in the 2020 Diabetes Audit display (Figure 2-28). Note that there are multiple pages of taxonomies. Use the up arrow or down arrow to browse the list.
4. Type S to indicate a selection will be made. Then type the number preceding the taxonomy of interest.

The taxonomy contents may be browsed on the screen or printed to a RPMS printer. Figure 2-29 shows a sample of the taxonomy contents for the creatinine kinase test.
View Taxonomies

1) APCH TD CPTS CPT
2) BGP ADV EFF CARDIOVASC NEC ICD DIAGNOSIS
3) BGP ALCOHOL HEPATITIS DXS ICD DIAGNOSIS
4) BGP ALT LOINC LAB LOINC
5) BGP ASA ALLERGY 995.0-995.3 ICD DIAGNOSIS
6) BGP AST LOINC LAB LOINC
7) BGP BREATFEEDING DXS ICD DIAGNOSIS
8) BGP CABB CPTS CPT
9) BGP CABB DXS ICD DIAGNOSIS
10) BGP CABB PROCs ICD OPERATION/PROCEDURE
11) BGP CMS SMOKING CESSATION MEDS DRUG
12) BGP CMS SMOKING CESSATION NDC NDC/UPN
13) BGP CPT FLU CPT
14) BGP CPT FOOT EXAM CPT
15) BGP CREATINE KINASE LOINC LAB LOINC
16) BGP CREATINE KINASE TAX LABORATORY TEST

S Select Taxonomy to View
Q Quit
Select Action: +/S

Which Taxonomy: (1-95): 16

Select one of the following:
P PRINT Taxonomy Output
B BROWSE Taxonomy Output on Screen

Do you wish to: B//

Figure 2-28: Taxonomy list for 2020 Diabetes Audit

Listing of the BGP CREATINE KINASE LOINC taxonomy

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2157-6</td>
<td>CREATINE KINASE:CCNC:PT:SER/PLAS:QN</td>
</tr>
<tr>
<td>24335-2</td>
<td>CREATINE KINASE PANEL: - :PT:SER/PLAS:QN</td>
</tr>
<tr>
<td>50756-6</td>
<td>CREATINE KINASE:CCNC:PT:SER/PLAS:QN</td>
</tr>
</tbody>
</table>

Figure 2-29: Sample of a Taxonomy for Creatine Kinase LOINC Codes

### 2.3.4 View a SNOMED List Used by the DM Audit

The View a SNOMED List Used by the DM Audit option may be used to review any SNOMED list that is used by the Diabetes Audit.

1. Select AS (Audit Setup) from the DMS main menu.
2. Select VSML View a SNOMED List Used by the DM AUDIT.
4. The SNOMED Lists used in the 2020 Diabetes Audit will display (Figure 2-30).
5. Type S to indicate a selection will be made.
6. Enter the number preceding the SNOMED List of interest. The contents of the SNOMED List may be browsed on the screen or printed to a RPMS printer.

```
DM AUDIT SNOMED LIST VIEW  Nov 02, 2019 11:30:36   Page:  1 of    1
SNOMED LISTS TO SUPPORT 2020 DIABETES AUDIT REPORTING
* View SNOMED Lists
1)  BREASTFEEDING PATIENT ED
2)  DEPRESSION DIAGNOSES
3)  PXRM BGP DM ATK AMP
4)  PXRM BGP DM BTK AMP
5)  PXRM BGP DM RETINOPATHY
6)  PXRM BGP QUIT TOBACCO
7)  PXRM BGP TOBACCO SMOKELESS
8)  PXRM BGP TOBACCO SMOKER
9)  PXRM BGP TOBACCO TOPICS
10) PXRM DIABETES
11) PXRM ESSENTIAL HYPERTENSION
12) PXRM HEPATITIS C
Enter ?? for more actions
S Select SNOMED List to View     Q    Quit
Select Action: +//S   Select SNOMED List to View
Which SNOMED List:  (1-5): 5
Select one of the following:
P         PRINT Taxonomy Output
B         BROWSE Taxonomy Output on Screen
Do you wish to: B//
```

Figure 2-30: Selecting a SNOMED List used in the 2020 Diabetes Audit

```
OUTPUT BROWSER      Dec 11, 2019 10:51:50   Page:   1 of    5
BHS                                    Page 1
2019 DEMO HOSPITAL
Listing of the PXRM BGP DM RETINOPATHY SNOMED List
-------------------------------------------------------------------------------------
4855003                  Diabetic retinopathy
25412000                 Diabetic retinal microaneurysm
59276001                Proliferative diabetic retinopathy
193349004               Preproliferative diabetic retinopathy
193350004               Advanced diabetic maculopathy
232020009               Diabetic maculopathy
232021008               Proliferative diabetic retinopathy with new vessels on
232022001               Proliferative diabetic retinopathy with new vessels els
232023006               Diabetic traction retinal detachment
311782002               Advanced diabetic retinal disease
312903003               Mild non-proliferative diabetic retinopathy
+ Enter ?? for more actions   >>>
+     NEXT SCREEN       -    PREVIOUS SCREEN     Q    QUIT
Select Action: +//
```

Figure 2-31: Browsing a selected SNOMED List used in the 2020 Diabetes Audit
2.4 Run a Data Quality Check Report

This report identifies potential errors in the data extracted for your Audit data file and/or report – the same errors that would be identified by WebAudit Data Quality Check. The DMS version of the report includes patient identifiers, which the WebAudit version does not, making it easier to locate and correct the relevant data. It is highly recommended that you run this report using DMS and fix all possible errors prior to uploading any data file to the WebAudit.

The Data Check Report has two sections, one listing the details of each potential error and one listing the number of potential errors for each Audit item. An Audit item with a large number of errors may indicate a taxonomy or some other systematic issue. It is recommended that these issues be resolved as the first step in data cleaning.

**Note:** When running this report, use the exact same parameters that you will be using when creating the Audit data file.

The Data Quality Check Report (DQC) is on the AS (Audit Setup) menu.

<table>
<thead>
<tr>
<th>DXNR</th>
<th>Patients with DM Diagnosis and not on Register</th>
</tr>
</thead>
<tbody>
<tr>
<td>INA</td>
<td>List Possible Inactive Pts in the DM Register</td>
</tr>
<tr>
<td>PLDX</td>
<td>Patients w/no Diagnosis of DM on Problem List</td>
</tr>
<tr>
<td>LMR</td>
<td>List Labs/Medications Used at this Facility</td>
</tr>
<tr>
<td>TC</td>
<td>Check Taxonomies for the 2020 DM Audit</td>
</tr>
<tr>
<td>TU</td>
<td>Update/Review Taxonomies for 2020 DM Audit</td>
</tr>
<tr>
<td>VTAX</td>
<td>View/Print Any Taxonomy Used by the Diabetes Audit</td>
</tr>
<tr>
<td>VSML</td>
<td>View a SNOMED List Used by the Diabetes AUDIT</td>
</tr>
<tr>
<td>DAL</td>
<td>Display Audit Logic</td>
</tr>
<tr>
<td>DQC</td>
<td>2020 Data Quality Check Report</td>
</tr>
<tr>
<td>ASPR</td>
<td>Prior Years Diabetes Audit Setup (DM16-DM19) ...</td>
</tr>
</tbody>
</table>

Figure 2-32: Audit Setup Menu

Figure 2-33 shows a script on how to run the Data Quality Check Report.

Diabetes Management System ...

AS – Audit Setup

DQC – Data Quality Check

In order for the 2020 DM AUDIT Report to find all necessary data, several taxonomies must be established. The following taxonomies are missing or have no entries:

- **DRUG taxonomy** [DM AUDIT AMYLIN ANALOGUES] has no entries
- **DRUG taxonomy** [DM AUDIT COLESEVELAM DRUGS] has no entries
- **DRUG taxonomy** [DM AUDIT INCRETIN MIMETIC] has no entries
- **DRUG taxonomy** [DM AUDIT SGLT-2 INHIBITOR DRUG] has no entries
- **DRUG taxonomy** [DM AUDIT SULFONYLUREA-LIKE] has no entries

End of taxonomy check. HIT RETURN: <Enter>
ASSESSMENT OF DIABETES CARE, 2019

PCC DIABETES AUDIT

Enter the Official Diabetes Register: IHS DIABETES

Enter the date of the audit. This date will be considered the ending date of the audit period. For most data items all data for the period one year prior to this date will be reviewed.

Enter the Audit Date: 12/31/19 (DEC 31, 2019)

Select one of the following:

P  Individual Patients
S  Search Template of Patients
C  Members of a CMS Register
E  E-Audit (predefined set of patients)

Run the audit for: P// C  Members of a CMS Register

Do you want to select register patients with a particular status? Y// ES
Which status: A// <Enter> ACTIVE
There are 873 patients in the IHS DIABETES register with a status of A.

You have selected a register or template/cohort of patients.
You can run the audit just for the subset of patients in the cohort or register who live in a particular community or have a particular primary care provider.

Limit the audit to a particular primary care provider? N// <Enter> O
Limit the patients who live in a particular community? N// <Enter> O

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 the audit: 1// <Enter>
Indian/Alaskan Native (Classification 01)

Select one of the following:

I  Include Pregnant Patients
E  Exclude Pregnant Patients

Select whether to include or exclude pregnant patients in the audit: E// <Enter> xclude Pregnant Patients
okay, hold on...this may take a few minutes..

Note: When not running an official Audit, you may choose to include pregnant patients. Pregnant patients are identified as those who have had two or more pregnancy-related visits during the Audit period to a non-pharmacy clinic, or where the provider is not a CHR. The list of pregnancy-related diagnoses may be reviewed under the View/Print Taxonomy Lists.

There are 860 patients selected so far to be used in the audit.
Select one of the following:
A ALL Patients selected so far
R RANDOM Sample of the patients selected so far

Do you want to select: A// <Enter> ALL Patients selected so far

Select one of the following:
P PATIENT NAME
E ERROR FIELD NAME

How should the report be sorted: P// <Enter>

Select one of the following:
I Include ALL Patients
E Exclude DEMO Patients
O Include ONLY DEMO Patients

Demo Patient Inclusion/Exclusion: E// <Enter> Exclude DEMO Patients

Select one of the following:
P PRINT Output
B BROWSE Output on Screen

Do you wish to: P// BROWSE Output on Screen

Figure 2-33: Running a Data Quality Check Report

If the Print Output option is selected, at the “Device” prompt, type the printer name. This report can be queued to run later as shown in Figure 2-34.

Figure 2-34: Device prompt

Note: A queued report cannot be printed to a locally connected printer, usually referred to as a Slave printer.

A sample 2020 Data Quality Check Report is displayed in Figure 2-35.

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>HRN</th>
<th>DOB</th>
<th>SEX</th>
<th>AGE</th>
<th>VALUE</th>
<th>ERR TYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEMOA, CHARLENE</td>
<td>111111</td>
<td>12/06/1985</td>
<td>F</td>
<td>27</td>
<td>POTENTIAL</td>
<td></td>
</tr>
</tbody>
</table>

LAB                              Nov 03, 2019                  Page 1

DIABETES AUDIT EXPORT DATA QUALITY CHECK REPORT
Audit Date 12/31/2019 (01/01/2019 to 12/31/2019)
Facility: 2019 DEMO HOSPITAL (CMBA)
ERROR: ALL KEY DATA MISSING-Data is missing for all key fields: weight, blood pressure, Alc, LDL, uACR.

DEMOB, MARIE 222222 09/15/1970 F 42 145 POTENTIAL
ERROR: HDL VALUE <12 OR >140-HDL Value is less than 12 or greater than 140. Check the value, if accurate no action necessary.

DEMOC, LORI 333333 04/28/1992 F 20 2 POTENTIAL
ERROR: TX INSULIN / DM TYPE 1-Value for this medication is inconsistent with DM Type 1. Check the value for insulin therapy and DM Type. DEMOD, MARY ANN 444444 10/14/1940 M 72 28 POTENTIAL
ERROR: DIASTOLIC 1 <30 OR >140-Diastolic 1 is less than 30 or greater than 140. Check value.

DEMOF, MINNIE 555555 01/10/1969 F 43 15.6 POTENTIAL
ERROR: BMI <16 OR >80-BMI is less than 16 or greater than 80. Check values and if necessary correct HT/WT. If value is correct, no action is necessary.

DEMOG, ANGELA 666666 08/17/1920 F 92 7 POTENTIAL
ERROR: HEIGHT IN FEET HIGH FOR AGE >9-Height is high (>6) for patient age >9. Check the patient's last height value. DEMOH, JOHN MITCHELL 777777 09/07/2014 F -1 03/07/1997 DEFINITE
ERROR: DATE OF DX BEFORE YOB-Date of Diabetes Diagnosis is before year of birth.

LAB Nov 03, 2019 Page 36

DIABETES AUDIT EXPORT DATA QUALITY CHECK REPORT
Audit Date 12/31/2012 (01/01/2012 to 12/31/2012)
Facility: 2019 DEMO HOSPITAL (CMBA)

PATIENT NAME HRN DOB SEX AGE VALUE ERR TYPE
---------------------------------------------------------------------

SUMMARY OF POTENTIAL ERRORS

ERROR MESSAGE # OF POTENTIAL ERRORS
AGE OVER 100 1
ALL KEY DATA MISSING 25
BMI <16 OR >80 2
CREATININE VALUE <0.3 OR >15 1
DATE OF DX BEFORE YOB 1
DIASTOLIC 1 <30 OR >140 1
DURATION OF DM 1
EGFR VALUE <5 OR >250 2
HBA1C DATE <20 DAYS BEFORE DOO 1
HDL VALUE <12 OR >140 4
HEIGHT IN FEET HIGH FOR AGE >9 1
HEIGHT IN FEET LOW FOR AGE <19 1
HEIGHT IN FEET LOW FOR AGE >18 2
HEIGHT IN FEET MISSING 1
HEIGHT TOTAL <24 AGE<18 1
HEIGHT TOTAL <48 AGE>17 2
HEIGHT TOTAL >60 AGE <10 4
HEIGHT TOTAL >84 AGE >9 1
TB TEST DATE < YOB 2
WEIGHT LESS THAN 80, AGE >17 1

Figure 2-35: Sample Data Quality Check Report
3.0 **2020 Audit Tools**

Instructions for creating and submitting a Diabetes Audit data file are provided in the Audit 2020 Instructions which can be found on the Audit website: [https://www.ihs.gov/diabetes/audit/audit-resources/](https://www.ihs.gov/diabetes/audit/audit-resources/).

In RPMS, Diabetes Audits can be run for individual patients, a template of patients, patients in a Register, or a random sample of patients in a Register. Additional options exist for running the Audit by Primary Care Provider, by Community, and for only American Indian/Alaska Native Patients, non-Indian/Alaska Native Patients, or both.

Output options include an individual Audit, the Audit Report, the SDPI RKM Report, and an Audit Data (Export) file. Even those doing manual Audits may find it useful to print individual Audits which most likely have some information on them, such as measurements.

3.1 **Individual Audits**

Individual Audits list all of the Audit data items for a particular patient. These can be run either via the Audit Reporting menu or the Patient Management option. To run using the Audit Reporting menu, please refer to the DMS General User Manual. To run an individual Audit using the Patient Management option do the following:

1. At the **Diabetes Management Systems** menu, type **RM** for Register Maintenance and press Enter, then type **PM** for Patient Management and press Enter.

2. At the **Patient Management** menu, type **10** (Audit Status) and press Enter.

3. At the “Enter the Audit Date” prompt, type the ending date of the 12-month Audit period desired and press Enter.

4. At the “Do you wish to print the Patient’s Name…?” prompt, do one of the following:
   - To not print the patient’s name on the Audit sheet, accept the default (N) by pressing Enter.
   - To print the patient’s name, type **Y** and press Enter.

5. At the “Do you wish to” prompt, do one of the following:
   - To print the output, accept the default (P) by pressing Enter. A prompt asking for the device name displays; type the device’s name and press Enter.
   - To browse the output on the screen, type **B** and press Enter.

A sample individual Audit is shown in Figure 3-1.
IHS Diabetes Care and Outcomes Audit, 2020  

Audit Period Ending Date: 12/31/2019  
Facility Name: 2019 DEMO HOSPITAL (INST)  
Reviewer initials: LAB  
Community: PARKER  
State of Residence: NM  
Chart #: 144227  
DOB: 05/07/1993  
Sex: MALE  
Primary Care Provider: DEMO,BARBARA A R N  

Date of Diabetes Diagnosis:  
DM Register: <not documented>  
Problem List: 04/01/1990  
First PCC DX: 10/16/2019  
DM Type: 2  
Type 2  
DM Register: <not documented>  
Problem List: E11.9  
PCC POV's: Type 2  

Tobacco/Nicotine Use  
Screened for tobacco use (during Audit period): 1  Yes  
Tobacco use status (most recent):  
1  Current user CURRENT SMOKER, EVERY DAY  
If 'Current user', tobacco cessation counseling/education received 
during Audit period): 1  Yes 10/16/2019 449861000124107-L  

Electronic Nicotine Delivery Systems (ENDS)  
Screened for ENDS use (during Audit period):  
1  Yes NEVER USED ENDS USER  
ENDS use status (most recent): 2  Not a current user  

Vital Statistics  
Height (last ever): 70.00 inches 10/16/2019  
Weight (last in Audit period): 190 lbs 10/16/2019  
BMI: 27.3  

Hypertension (documented diagnosis ever): 1  Yes  
Blood pressure (last 3 during Audit period): 130/80 mm Hg 10/16/2019  

Examinations (during Audit period)  
Foot (comprehensive or "complete", including evaluation of 
sensation and vascular status): 1  Yes 10/14/2019 Diabetic Foot Exam  
Eye (dilated or retinal imaging): 1  Yes 10/14/2019 Diabetic Eye Exam  
Dental: 2 No  

Mental Health  
Depression an active problem/diagnosis: 2 No  
If 'No', screened for depression (during Audit period): 2 No  

Education (during Audit period)  
Nutrition: 2 Yes (Non RD) NRD: DM-N 10/16/2019  
Physical activity: 1 Yes DM-EXERCISE 10/16/2019  
Other diabetes: 2 No  

Diabetes Therapy All prescribed (as of the end of the Audit period):  
1 None of the following  
2 Insulin  
X 3 Metformin [Glucophage, others]
X 4 Sulfonylurea [glipizide, glyburide, others]
   5 DPP4 inhibitor [Alogliptin (Nesina), Linagliptin (Tradjenta),
   Saxagliptin (Onglyza), Sitagliptin (Januvia)]
   6 GLP-1 agonist [Dulaglutide (Trulicity), Exenatide (Byetta,
   Bydureon),
   Liraglutide (Victoza), Lisinaglutide (Adlyxin), Semaglutide
   (Ozempic)]
   7 SGLT-2 inhibitor [Canagliflozin (Invokana),
   Dapagliflozin (Farxiga), Empagliflozin (Jardiance),
   Ertugliflozin (Steglatro)]
   8 Pioglitazone [Actos] or miglitol [Glyset]
   9 Acarbose [Precose]
   10 Repaglinide [Prandin] or Nateglinide [Starlix]
   11 Amylin analog [Symlin]
   12 Bromocriptine [Cycloset]
   13 Colesevelam [Welchol]

ACE Inhibitor or ARB
Prescribed (as of the end of the Audit period):
   1 Yes 10/16/2019 LISINOPRIL 40MG TAB *

Commonly prescribed medications include:
ACE Inhibitors: Benazepril (Lotensin), Enalapril (Vasotec, Epaned),
Fosinopril (Monopril), Lisinopril (Prinivil, Zestril), Ramipril
(Altace)
ARBs: Irbesartan (Avapro), Losartan (Cozaar), Telmisartan (Micardis),
Olmesartan (Benicar), Valsartan (Diovan, Prexxartan)

Aspirin or Other Antiplatelet/Anticoagulant Therapy
Prescribed (as of the end of the Audit period):
   1 Yes 10/16/2019 ASPIRIN 325MG TABLET

Commonly prescribed medications include:
Anticoagulants: Apixaban (Eliquis), Dabigatran (Pradaxa),
Rivaroxaban (Xarelto), Warfarin (Coumadin)
Antiplatelets: Cilostazol (Pletal), Clopidogrel (Plavix),
Prasugrel (Effient), Ticagrelo (Brilinta)

Statin Therapy
Prescribed (as of the end of the Audit period): 2 No

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

Tuberculosis (TB)
TB test done (ever): 3 Unknown
TB test result:
   If TB result 'Positive', treatment complete (isoniazid, others):
   If TB result 'Negative', test date:

IHS Diabetes Care and Outcomes Audit, 2020    DATE RUN: 10/24/2019    Page: 3
Audit Period Ending Date: 12/31/2019
CHART #: 144227    DOB: May 07, 1993    SEX: MALE

Hepatitis C (HCV)
HCV diagnosed (ever): 2 No
   If not diagnosed with HCV, screened for HCV at least once (ever):
      1 Yes 10/16/2019 HEPATITIS C PROFILE (NE)

Retinopathy
### Laboratory Data (most recent result during Audit period)

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
<th>Date</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1C</td>
<td>12.1</td>
<td>10/16/2019</td>
<td>HGB Alc (R)</td>
</tr>
<tr>
<td>Total Cholesterol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HDL Cholesterol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LDL Cholesterol</td>
<td>100 mg/dl</td>
<td>10/16/2019</td>
<td>LDL CHOLESTEROL</td>
</tr>
<tr>
<td>Triglycerides:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>eGFR:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quantitative Urine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Albumin: Creatinine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ratio (UACR) value:</td>
<td>350</td>
<td>10/16/2019</td>
<td>..ALBUMIN/CREATININ</td>
</tr>
</tbody>
</table>

COMBINED: Meets ALL: A1C <8.0, statin prescribed, mean BP <140/<90
This is only calculated for patients 40 years of age and older without a statin allergy or intolerance.

### Local Questions
- Select one:
- Text:

---

### 3.2 Audit Report

The Audit Report summarizes all of the Audit data items for a selected group of patients. Figure 3-2 shows a script for running an Audit Report. The Audit Report can be either queued using the DM20 option in Visual DMS or run from the traditional RPMS menu. It is highly recommended that the 2020 Audit Report be run and reviewed twice before creating a data file to submit via the WebAudit for the Annual Audit.

The first time run the Audit Report on all active members of the register with Type 1 or Type 2 Diabetes or on the created template of eligible patients with Type 1 or Type 2 Diabetes.
Review the initial Audit Report carefully and look for Audit items that have no data or that have far larger or smaller numbers than would be expected. If any are found, this may be due to improperly populated taxonomies. If necessary, review taxonomy set up and edit taxonomies as needed. Then run and review the Audit Report again to make sure that problems are corrected before creating the Audit Data (Export) file.

**Note:** It is possible to have taxonomies with no members, if the drugs or laboratory tests referenced are not used at a facility. See Section 2.3 for more information.

Figure 3-2 shows the steps for generating an Audit Report.
Which status: A// <Enter> ACTIVE

There are 873 patients in the IHS DIABETES register with a status of A.

You have selected a register or template/cohort of patients.
You can run the audit just for the subset of patients in the cohort or register who live in a particular community or have a particular primary care provider.

Limit the audit to a particular primary care provider ? N// <Enter> O

Limit the patients who live in a particular community ? N// <Enter> O

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 the audit: 1// <Enter>
Indian/Alaskan Native (Classification 01)

Select one of the following:
I   Include Pregnant Patients
E   Exclude Pregnant Patients

Select whether to include or exclude pregnant patients in the audit: E// <Enter> Exclude Pregnant Patients

okay, hold on...this may take a few minutes..

Note: When not running an official Audit, you may choose to include pregnant patients. Pregnant patients are identified as those who have had two or more pregnancy-related visits during the Audit period to a non-pharmacy clinic, or where the provider is not a CHR. The list of pregnancy-related diagnoses may be reviewed under the View/Print Taxonomy Lists.

There are 543 patients selected so far to be used in the audit.

Select one of the following:
A   ALL Patients selected so far
R   RANDOM Sample of the patients selected so far

Do you want to select: A// <Enter> ALL Patients selected so far

Select one of the following:
1   Print Individual Reports
2   Create AUDIT EXPORT file
3   Audit Report (Cumulative Audit)
4   Both Individual and Cumulative Audits
5   SDPI RKM Report

Enter Print option: 1// 3  Audit Report (Cumulative Audit)

Select one of the following:
I   Include ALL Patients
E   Exclude DEMO Patients
O   Include ONLY DEMO Patients
46

Figure 3-2: Running a Cumulative Audit (Audit Report)

If the **Print Output** option is selected, at the “Device” prompt, type the printer name. This report can be queued to run later as shown in Figure 3-3.

**Note:** A queued report cannot be printed to a locally connected printer, usually referred to as a Slave printer.

A sample 2020 Audit Report is displayed in Appendix D.

### 3.3 Audit Export (Data) File

IHS recommends that the Annual Audit include all eligible diabetes patients. There may be patients on your register who do not have Type 1 or Type 2 diabetes or otherwise do not meet the inclusion and exclusion criteria outlined in the Audit 2020 Instructions and in Section 2.1. If that is the case, you may need to edit your register or create a separate template of patients for the Audit.

The option to create an Audit Export (Data) File is on the **AR Audit Reporting** menu. To generate this report:

1. At the **Diabetes Management System** main menu, type **AR** and press Enter.
2. Select **DM20** (2020 Diabetes Audit) and follow the prompts as shown in the script in Figure 3-4.

<table>
<thead>
<tr>
<th>DM20 2020 Diabetes Audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>In order for the 2020 DM AUDIT Report to find all necessary data, several taxonomies must be established. The following taxonomies are missing or have no entries:</td>
</tr>
<tr>
<td><strong>DRUG taxonomy</strong> [DM AUDIT AMYLIN ANALOGUES] has no entries</td>
</tr>
<tr>
<td><strong>DRUG taxonomy</strong> [DM AUDIT COLESEVELAM DRUGS] has no entries</td>
</tr>
<tr>
<td><strong>DRUG taxonomy</strong> [DM AUDIT INCRETIN MIMETIC] has no entries</td>
</tr>
<tr>
<td><strong>DRUG taxonomy</strong> [DM AUDIT SGLT-2 INHIBITOR DRUG] has no entries</td>
</tr>
</tbody>
</table>
Select DIABETES Register

<table>
<thead>
<tr>
<th>No.</th>
<th>Register Name</th>
<th># Active</th>
<th># members</th>
<th>Last patient update</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2017 DIABETES REGISTER</td>
<td>37</td>
<td>40</td>
<td>02/07/2019</td>
</tr>
<tr>
<td>2</td>
<td>IHS DIABETES</td>
<td>552</td>
<td>555</td>
<td>11/14/2018</td>
</tr>
<tr>
<td>3</td>
<td>CLINIC DIABETES REGISTER</td>
<td>29</td>
<td>29</td>
<td>10/05/2018</td>
</tr>
<tr>
<td>4</td>
<td>DEMO DIABETES REGISTER</td>
<td>1,002</td>
<td>1,012</td>
<td>10/03/2018</td>
</tr>
<tr>
<td>5</td>
<td>ANOTHER DIABETES REGISTER</td>
<td>158</td>
<td>158</td>
<td>10/04/2018</td>
</tr>
</tbody>
</table>

Which REGISTER: (1-5):

Enter the date of the audit. This date will be considered the ending date of the audit period. For most data items all data for the period one year prior to this date will be reviewed.

Enter the Audit Date: 12/31/19 (DEC 31, 2019)

Select one of the following:

P Individual Patients
S Search Template of Patients
C Members of a CMS Register

Run the audit for: P// C Members of a CMS Register

Do you want to select register patients with a particular status? Y// <Enter> ES
Which status: A// <Enter> ACTIVE

There are 543 patients in the IHS DIABETES register with a status of A.

You have selected a register or template/cohort of patients. You can run the audit just for the subset of patients in the cohort or register who live in a particular community or have a particular primary care provider.

Limit the audit to a particular primary care provider? N// <Enter> O
Limit the patients who live in a particular community? N// <Enter> O

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 the audit: 1// <Enter> Indian/Alaskan Native (Classification 01)

Select one of the following:

I Include Pregnant Patients
E Exclude Pregnant Patients

Select whether to include or exclude pregnant patients in the audit: E// <Enter> Exclude Pregnant Patients

okay, hold on...this may take a few minutes..

Note: When not running an official Audit, you may choose to include pregnant patients. Pregnant patients are identified as those who have had two or more
pregnancy-related visits during the Audit period to a non-pharmacy clinic, or where the provider is not a CHR. The list of pregnancy-related diagnoses may be reviewed under the View/Print Taxonomy Lists.

There are 861 patients selected so far to be used in the audit.

Select one of the following:

A       ALL Patients selected so far
R       RANDOM Sample of the patients selected so far

Do you want to select: A// <Enter> ALL Patients selected so far

Select one of the following:

1       Print Individual Reports
2       Create AUDIT EXPORT file
3       Audit Report (Cumulative Audit)
4       Both Individual and Cumulative Audits
5       SDPI RKM Report

Enter Print option: 1// 2  Create AUDIT EXPORT file

The file generated will be in a "^" delimited format. You can use this file to review your data in EXCEL if you so choose.

Enter the name of the FILE to be Created (3-20 characters): DKR 2020 AUDIT

I am going to create a file called dkr 2020 audit.txt which will reside in the X:\EXPORT directory on your RPMS server.

It is the same directory that the data export globals are placed. See your site manager for assistance in finding the file after it is created. PLEASE jot down and remember the following file name:

**********  dkr 2020 audit.txt  **********

It may be several hours (or overnight) before your report and flat file are finished.

The records that are generated and placed in file dkr 2020 audit.txt are in a format readable by Excel. For a definition of the format please see your user manual.

Is everything ok?  Do you want to continue? Y// <Enter> ES

Select one of the following:

I       Include ALL Patients
E       Exclude DEMO Patients
O       Include ONLY DEMO Patients

Demo Patient Inclusion/Exclusion: E// <Enter> Exclude DEMO Patients

Won't you queue this ? Y// <Enter> ES

Requested Start Time: NOW//T@2000

Figure 3-4: Creating an Audit Export file
Make a note of the file name you provided and notify the RPMS site manager that a Diabetes Audit Export file has been created. Provide the file name and the directory where the file is stored. The site manager will place the file in a shared folder on the server where it can be accessed and uploaded to the WebAudit.

3.4 SDPI Report

The option to create an SDPI RKM Report is on the AR Audit Reporting menu. To generate this report, do the following:

1. At the Diabetes Management System main menu, type AR and press Enter.

2. Select DM20 (2020 Diabetes Audit) and follow the prompts as shown in the script in Figure 3-5.
There are 873 patients in the IHS DIABETES register with a status of A. You have selected a register or template/cohort of patients. You can run the audit just for the subset of patients in the cohort or register who live in a particular community or have a particular primary care provider.

Limit the audit to a particular primary care provider? N/ <Enter> O

Limit the patients who live in a particular community? N/ <Enter> O

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 the audit: 1/ <Enter> Indian/Alaskan Native (Classification 01)

Select one of the following:

I. Include Pregnant Patients
E. Exclude Pregnant Patients

Select whether to include or exclude pregnant patients in the audit: E/ <Enter> Exclude Pregnant Patients

Okay, hold on...this may take a few minutes...

Note: When not running an official Audit, you may choose to include pregnant patients. Pregnant patients are identified as those who have had two or more pregnancy-related visits during the Audit period to a non-pharmacy clinic, or where the provider is not a CHR. The list of pregnancy-related diagnoses may be reviewed under the View/Print Taxonomy Lists.

There are 861 patients selected so far to be used in the audit.

Select one of the following:

A. ALL Patients selected so far
R. RANDOM Sample of the patients selected so far

Do you want to select: A/ <Enter> ALL Patients selected so far

Select one of the following:

1. Print Individual Reports
2. Create AUDIT EXPORT file
3. Cumulative Audit Only
4. Both Individual and Cumulative Audits
5. SDPI RKM Report

Enter Print option: 1/5

Select one of the following:

I. Include ALL Patients
E. Exclude DEMO Patients
O. Include ONLY DEMO Patients

Demo Patient Inclusion/Exclusion: E/ <Enter> Exclude DEMO Patients
Select one of the following:
P  PRINT Output
B  BROWSE Output on Screen

Do you wish to: P// <BROWSE or PRINT as desired>

Figure 3-5: Running an SDPI RKM Report

The SDPI RKM Report is displayed in Figure 3-6.

<table>
<thead>
<tr>
<th></th>
<th># of Patients</th>
<th># Considered</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin or Other Antiplatelet Therapy in Cardiovascular Disease</td>
<td>2</td>
<td>395</td>
<td>1%</td>
</tr>
<tr>
<td>Blood Pressure (BP) Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BP &lt;140/&lt;90 mmHg</td>
<td>339</td>
<td>960</td>
<td>35%</td>
</tr>
<tr>
<td>(one value or mean of 2 or 3 values)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Kidney Disease Screening and Monitoring</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In age &gt;=18 years, both UACR and eGFR done</td>
<td>89</td>
<td>932</td>
<td>10%</td>
</tr>
<tr>
<td>Dental Exam</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental exam received</td>
<td>108</td>
<td>960</td>
<td>11%</td>
</tr>
<tr>
<td>Depression Screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In patients without active depression, screened for depression</td>
<td>147</td>
<td>869</td>
<td>17%</td>
</tr>
<tr>
<td>Diabetes-Related Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any diabetes topic (nutrition, physical activity, or other)</td>
<td>252</td>
<td>960</td>
<td>26%</td>
</tr>
<tr>
<td>Eye Exam - Retinopathy Screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye exam - dilated or retinal imaging</td>
<td>129</td>
<td>960</td>
<td>13%</td>
</tr>
<tr>
<td>Foot Exam</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot exam - comprehensive</td>
<td>104</td>
<td>960</td>
<td>11%</td>
</tr>
<tr>
<td>Glycemic Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A1C &lt;8.0%</td>
<td>92</td>
<td>960</td>
<td>10%</td>
</tr>
</tbody>
</table>

***NOTE: 11 Patients were not included in this report because their date of onset was after the Audit end period date.***
### Hepatitis C (HCV) Screening

<table>
<thead>
<tr>
<th>Screened for HCV ever</th>
<th>191</th>
<th>932</th>
<th>20%</th>
</tr>
</thead>
</table>

**LAB**

Nov 02, 2019

---

**Hepatitis C (HCV) Screening**

- **Screened for HCV ever**: 191 out of 932 (20%)

---

**Immunizations: Hepatitis B**

- **Hepatitis B complete series - ever**: 527 out of 957 (55%)

---

**Immunizations: Influenza**

- **Influenza vaccine during report period**: 37 out of 960 (4%)

---

**Immunizations: Pneumococcal**

- **Pneumococcal vaccine - ever**: 641 out of 960 (67%)

---

**Immunizations: Tetanus/Diphtheria**

- **Td/Tdap/DTap/DT - past 10 years**: 619 out of 960 (64%)

---

**Lipid Management in Cardiovascular Disease**

- **In patients age 40-75 years and/or with diagnosed CVD, statin prescribe**: 2 out of 784 (0%)

---

**Nutrition Education**

- **Nutrition education - by any provider (registered dietitian and/or other)**: 106 out of 960 (11%)

---

**Physical Activity Education**

- **Physical activity education**: 64 out of 960 (7%)

---

**Tobacco Use Screening**

- **Screened for tobacco use during report period**: 174 out of 960 (18%)

---

**Tuberculosis (TB) Screening**

- **TB test done ever (skin or blood)**: 497 out of 960 (52%)

---

Figure 3-6: Sample SDPI RKM Report
4.0 Upload the Export (Data) File to WebAudit

Audit Export (Data) files can be uploaded to the WebAudit for data cleaning, report generation, and submission of data to the IHS Division of Diabetes. For further information and resources, visit the IHS Division of Diabetes Audit website at https://www.ihs.gov/diabetes/audit/. To upload a file:

1. Request a WebAudit account if you do not already have one.
2. Log in to WebAudit.
3. From the main or left menu, select Facility Administration, then Enter Facility Information.
4. Select an Audit Type. For the Annual Audit submitted to the Division of Diabetes, select Annual Audit. For all other Audits, select Interim Audit. Click the Go button.
5. Enter the number of patients who meet the inclusion and exclusion criteria found in the 2020 Audit Instructions and Section 2.1 of this manual.
6. Click the Submit button.
7. Select Upload file for this facility from the onscreen menu or click on Data Processing in the left-hand menu, then select Upload Data.
8. Individuals with access to multiple facilities will need to select a Facility.
9. Select the electronic health record system that was used to create the file (RPMS if you used RPMS/DMS).
10. Click on the Choose File button and navigate to your data file, then click on the Open button.
11. Click on the Upload File button.
   - If the data file upload is successful, you will receive a message on the screen to that effect.
   - If the upload is unsuccessful, you will receive an error message telling you that the file upload attempt was unsuccessful and details about the problems found.
12. Once the file is successfully uploaded, proceed with checking the data quality, if you have not already done so in DMS, as described in the Audit 2020 Instructions, which can be found on the Audit website: https://www.ihs.gov/diabetes/audit/audit-resources/.
13. Generate and review the Audit Report, as described in the Audit 2020 Instructions.
5.0 Import the Audit Export (Data) File to Excel

When researching patients or data values, it may be helpful to import the Audit Export file into Excel to view, sort, and/or filter the data. The 2020 Diabetes Audit Export file is a delimited text file with all of the Audit data items for each patient in a single row separated by caret symbols (^). Not only can the file be uploaded to the WebAudit, but it can also be opened with Notepad or imported into Excel for local use. The data items are identified by headers in the first row of the file.

**Note:** The Excel file cannot be uploaded to the WebAudit; the original delimited text file must be uploaded.

Section 3.3 provides details about the Audit Export file format and field definitions.

Figure 5-1 shows a sample Audit Export file opened in Notepad.

![Sample Audit Export file displayed in Notepad](image)

Figure 5-1: Sample Audit Export file displayed in Notepad

To import a file into Excel:

1. Open Excel and select a blank workbook.
2. Click **File**, then **Open**; browse to the folder containing the Audit Export file.
3. Change the file type from **All Excel Files** to **All Files** (Figure 5-2). This is necessary to see and select the Audit Export file, which is not in Excel format.

4. Select the Audit Export file to import.

5. Click **Open**. The **Text Import Wizard – Step 1 of 3** dialog (Figure 5-3) displays.
6. If the Text Import Wizard does not correctly identify that this is a delimited file, select the **Delimited** option button.

7. Click **Next**. The **Text Import Wizard – Step 2 of 3** dialog (Figure 5-4) displays.
8. Under Delimiters, select the **Other** check box and type a caret (^) in the field to the right of the check box.

9. Deselect the **Tab** check box.

10. Click **Next**. Vertical lines will display between the columns of data.

11. Click **Finish** to complete the import to Excel. Expand columns and sort data as desired.

12. To save the file in Excel format, select **Save As**.

13. Save as an Excel file. Save the Excel file in a secure folder as identified by the Information Technology (IT) staff at your facility.

**Note:** The Excel file cannot be uploaded to the WebAudit; the original delimited text file must be uploaded.
6.0 **Identify Patients with Potential Errors in the Audit Export File**

The DMS Data Quality Check report can identify potential data errors prior to uploading data to the WebAudit (see Section 3.2). The DMS version of this report includes patient identifiers, which the WebAudit version does not. If you do need to identify patients from the WebAudit version of the Data Quality Check, you can use the instructions that follow:

1. In the WebAudit, use the Data Quality Check tool to run the Annual Audit Potential Data Entry Errors Details report.

2. Scan through the errors. Edit the data and/or add comments for each item in the list, as needed. Clicking on the icon in the **Edit** column will open a full screen with all of the data for the selected patient, for review and/or editing.

   - The Year and Month of Birth, Sex, and Date of Diagnosis may all be used to identify the patient via iCare. The RPMS Data Quality Check report may also be used to identify the patients with errors. Running this report is described in Section 2.4. The RPMS Data Quality Check report includes the patient’s name and chart number.

   - Once the patient is identified, either edit the record directly in the WebAudit using the View/Edit Data tool or correct the data in RPMS, then generate and upload a new Audit Export file.

There are two ways to use the GEN Report to identify patients. (Please review the *BDM Version 2.0 Patch 13 User Manual* for additional detail on this functionality):

- By Date of Diagnosis
- By Register Status, Sex, and Year and Month of Birth
7.0 **Display 2020 Diabetes Audit Logic**

The logic for the 2020 Diabetes Audit is provided under the DAL menu option in the AS – Audit Setup menu, as shown in Figure 7-1.

1. At the **Diabetes Management Systems** menu, type **AS** and press Enter.

2. At the “Select DMS Audit Item Descriptions Audit Year” prompt, type **2020** for the Audit year and press Enter to display the item list.

<table>
<thead>
<tr>
<th>DM AUDIT ITEM DESCRIPTION</th>
<th>Nov 02, 2019 13:21:37</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) AUDIT DATE (AKA AUDI</td>
<td>Nov 02, 2019 13:21:37</td>
</tr>
<tr>
<td>2) FACILITY NAME</td>
<td>Nov 02, 2019 13:21:37</td>
</tr>
<tr>
<td>3) REVIEWER INITIALS</td>
<td>Nov 02, 2019 13:21:37</td>
</tr>
<tr>
<td>4) STATE OF RESIDENCE</td>
<td>Nov 02, 2019 13:21:37</td>
</tr>
<tr>
<td>5) CHART NUMBER</td>
<td>Nov 02, 2019 13:21:37</td>
</tr>
<tr>
<td>6) DATE OF BIRTH</td>
<td>Nov 02, 2019 13:21:37</td>
</tr>
<tr>
<td>7) SEX</td>
<td>Nov 02, 2019 13:21:37</td>
</tr>
<tr>
<td>8) PRIMARY CARE PROVIDE</td>
<td>Nov 02, 2019 13:21:37</td>
</tr>
<tr>
<td>9) DATE OF DIABETES DIA</td>
<td>Nov 02, 2019 13:21:37</td>
</tr>
<tr>
<td>10) DM TYPE</td>
<td>Nov 02, 2019 13:21:37</td>
</tr>
<tr>
<td>11) TOBACCO - SCREENED D</td>
<td>Nov 02, 2019 13:21:37</td>
</tr>
<tr>
<td>12) TOBACCO USE STATUS</td>
<td>Nov 02, 2019 13:21:37</td>
</tr>
<tr>
<td>13) TOBACCO CESSATION CO</td>
<td>Nov 02, 2019 13:21:37</td>
</tr>
<tr>
<td>14) ELECTRONIC NICOTINE</td>
<td>Nov 02, 2019 13:21:37</td>
</tr>
<tr>
<td>15) ENDS USE STATUS</td>
<td>Nov 02, 2019 13:21:37</td>
</tr>
<tr>
<td>16) WEIGHT</td>
<td>Nov 02, 2019 13:21:37</td>
</tr>
<tr>
<td>17) BMI</td>
<td>Nov 02, 2019 13:21:37</td>
</tr>
<tr>
<td>18) HYPERTENSION DOCUMEN</td>
<td>Nov 02, 2019 13:21:37</td>
</tr>
<tr>
<td>19) HYPERTENSION C - SCREEN</td>
<td>Nov 02, 2019 13:21:37</td>
</tr>
<tr>
<td>+</td>
<td>Nov 02, 2019 13:21:37</td>
</tr>
</tbody>
</table>

Figure 7-1: 2020 Diabetes Audit Logic (DAL) items

3. At the “Select Action” prompt, type **S** and press Enter to enable selection of an Audit logic item for review.

4. At the next “Select Action” prompt, type the number of the logic item to be displayed and press Enter.

5. Once the Audit logic for a selected item displays, print it by typing **PL** at the “Select Action” prompt of the logic item display.

6. Enter the desired printer for the output at the “Device” prompt.

Appendix A provides a complete listing of the logic for all Audit items.
8.0 Audit Resources

- The complete DMS v2.0 User Manual (bdm_020u.pdf) can be found on the RPMS Web site: https://www.ihs.gov/RPMS/PackageDocs/BDM/bdm_020u.pdf.

- Diabetes Audit 2020 information can be found on the IHS Division of Diabetes website: https://www.ihs.gov/diabetes/audit/.

- IHS Diabetes Standards of Care & Clinical Practice Resources can be found on the IHS Division of Diabetes website: https://www.ihs.gov/diabetes/clinician-resources/soc/.
Appendix A: 2020 Diabetes Audit Logic

| Notes: Audit Logic uses several taxonomies that are used by other national RPMS programs, including diagnosis codes, CPT codes, LOINC codes, SNOMED codes, and medications. The contents of those taxonomies may be reviewed by using the VTAX (View/Print Any DM Audit Taxonomy) report option, found in the Diabetes Management System Reports menu. View or print the contents of site-populated taxonomies by using the TU (Update/Review Taxonomies for 2020 DM Audit) menu option under the AS menu option of the Diabetes Management System menu. View contents of SNOMED lists by using the VSML (View a SNOMED List Used by the DM AUDIT) menu option. |

| A.1 Report Date |
| Description: Date report was generated |
| How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): Date report was generated |
| Audit Logic: N/A |
| Audit Report: The date the report was generated is included in the header of the report |
| Audit Export Field Name and Details: N/A |

| A.2 Audit Date |
| Description: Last day of 12-month Audit period for which data are reviewed |
| How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): N/A |
| Audit Logic: This date, supplied by the user, determines the time period for which data are reviewed for the Audit. For most items, data are reviewed for the 12 months prior to the Audit date, known as the Audit period. For example, if the Audit date is December 31, 2019, data are reviewed for the year prior to this date (January 1-December 31, 2019). |
| Audit Report: AUDIT DATE (AKA AUDIT PERIOD ENDING DATE) is used to determine the Audit period and is displayed in the header of the report. (Audit Period 01/01/2019 to 12/31/2019) |
| Audit Export Field Name and Details: AUDITDATE MM/DD/YYYY |
A.3 Facility Name

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

A.4 Age

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

A.5 Reviewer Initials

- **Description:** Reviewer initials
- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** N/A
- **Audit Logic:** Initials of the person running the Audit. A maximum of 3 initials may be used. This information is taken from the New Person (file 200) entry for the user.
- **Audit Report:** REVIEWER INITIALS Displayed in the Audit Report header.
• Audit Export Field Name and Details: REVIEWER

A.6 State of Residence

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

A.7 Chart Number

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

A.8 DOB

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

A.9 Sex

• Description: Gender of patient.
• **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** Male, Female or Unknown, from patient registration

• **Audit Logic:** The gender of the patient. Obtained from data entered through patient registration. Male, Female or Unknown

• **Audit Report:** Gender – Male, Female

• **Audit Export Field Name and Details:** SEX 1=Male, 2=Female, 3=Unknown

---

### A.10 Primary Care Provider

• **Description:** Primary Care Provider name

• **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** The name of the Primary Care Provider from RPMS.

• **Audit Logic:** The name of the primary care (designated) provider documented in RPMS. Taken from field Primary Care Provider (#14) of the patient file.

• **Audit Report:** N/A

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

---

### A.11 Date of DM Onset

• **Description:** Date of diabetes onset

• **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** First, the system looks for a Register in the Case Management system that contains the term “DIAB.” If one exists, it will look for this patient and get the date of onset from the date of onset field of the register. If none exists, the PCC Problem list is scanned for all problems in the ICD diagnosis code ranges defined in the SURVEILLANCE DIABETES taxonomy or SNOMED code defined in PXRM DIABETES SNOMED subset. For each problem on the problem list in these code ranges the date of onset is picked up. The earliest of all the dates of onset found is used. Where the date of onset was found is also displayed.

• **Audit Logic:** The diabetes onset date. This date is used in the calculation of the duration of diabetes. The system obtains the date from three different dates in the following order:
  - The date of onset from the Diabetes Register.
  - The earliest date of onset from all diabetes related problems on the problem list. The problem list is scanned for all problems in the ICD diagnosis code ranges defined in the SURVEILLANCE DIABETES taxonomy or SNOMED code defined in PXRM DIABETES SNOMED subset.
  - The first recorded diagnosis (POV) of diabetes in PCC. ICD codes: SURVEILLANCE DIABETES taxonomy.
• **Audit Report:** Duration of Diabetes: When calculating the duration of diabetes, the earliest of the date of onset from the diabetes register or the problem list date of onset is used. Duration of diabetes is calculated from that date to the Audit date. If neither the date of onset in the register nor the date of onset in the problem list is recorded, the duration of diabetes is not calculated. Please note: The first diagnosis date from POV is not used. Audit Report categories: Duration of Diabetes:
  - < 1 year
  - <10 years
  - ≥ 10 years
  - Diagnosis date not recorded

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

### A.12 Diabetes Type

• **Description:** Type of Diabetes (Type 1 or Type 2)

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

• **Audit Logic:** The following logic is used to determine diabetes type. Once a 'hit' is made, no further processing is done:
  - If the diagnosis documented in the Diabetes Register is NIDDM the type is assumed to be Type 2.
  - If the diagnosis documented in the Diabetes Register is "TYPE II" the type is assumed to be Type 2.
  - If the diagnosis documented in the Diabetes Register contains a '2' the type is assumed to be Type 2.
  - If the diagnosis documented in the Diabetes Register contains IDDM the type is assumed to be Type 1.
  - If the diagnosis documented in the Diabetes Register is "Type I" the type is assumed to be Type 1.
  - If the diagnosis documented in the Diabetes Register contains a '1' type is assumed to be Type 1.
  - If no diagnosis is documented in the Diabetes Register, or it does not contain any of the above strings the problem list is then scanned. If any diabetes diagnosis on the problem list [SURVEILLANCE DIABETES taxonomy] is also in the DM AUDIT TYPE II DXS taxonomy then the type is assumed to be Type 2.
  - If any diabetes diagnosis on the problem list is also in the DM AUDIT TYPE I DXS taxonomy then the type is assumed to be Type 1.
If no diagnosis exists on the problem list or in the diabetes register, then the last PCC purpose of visit related to diabetes is reviewed. If the diagnosis is contained in the DM AUDIT TYPE II DXS taxonomy the type is assumed to be Type II, if it is contained in the DM AUDIT TYPE I DXS taxonomy it is assumed to be Type 1.

If type is not determined by any of the above, type is assumed to be Type 2 for the Audit (Data) Export File and Audit Report. For RPMS individual audit sheet, "Not Documented" is displayed.

- **Audit Report**: Diabetes Type:
  - Type 1
  - Type 2
  See AUDIT LOGIC for how this is determined.

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

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

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

### A.13 Screened for Tobacco Use

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

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

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

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

- **Audit Export Field Name and Details**: TOBSCREEN
A.14 Tobacco Use Status

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

- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** The last documented of the following items is found and displayed:

  - Health Factors in the categories TOBACCO (SMOKING) and TOBACCO (SMOKELESS - CHEWING/DIP) that relate to the patient's tobacco use status. As of the DM Audit 2020 these are the health factors available: (the ones with one asterisk (*) indicate a current user, those with two asterisks (**) are non-tobacco users, the others are put in the "Not Documented" category):

  - **CURRENT SMOKELESS TOBACCO (SMOKELESS - CHEWING/DIP**
  - **PREVIOUS (FORMER) SMOKELESS TOBACCO (SMOKELESS - CHEWING/DIP**
  - **CESSATION-SMOKELESS TOBACCO (SMOKELESS - CHEWING/DIP**
  - SMOKELESS TOBACCO, STATUS UNKNOWN TOBACCO (SMOKELESS - CHEWING/DIP**
  - **NEVER USED SMOKELESS TOBACCO TOBACCO (SMOKELESS - CHEWING/DIP**
  - **NON-TOBACCO USER TOBACCO (SMOKING**
  - **CURRENT SMOKER, STATUS UNKNOWN TOBACCO (SMOKING**
  - **PREVIOUS (FORMER) SMOKER TOBACCO (SMOKING**
  - **CESSATION-SMOKER TOBACCO (SMOKING**
  - **CURRENT SMOKER, EVERY DAY TOBACCO (SMOKING**
  - **CURRENT SMOKER, SOME DAY TOBACCO (SMOKING**
  - **NEVER SMOKED TOBACCO (SMOKING**
  - SMOKING STATUS UNKNOWN TOBACCO (SMOKING**
  - **HEAVY TOBACCO SMOKER TOBACCO (SMOKING**
  - **LIGHT TOBACCO SMOKER TOBACCO (SMOKING**
If a factor is found in each of these categories, the one that indicates active use is used. If one is found in just one category, it is used. For example, patient has LIGHT TOBACCO SMOKER and NEVER USED SMOKELESS TOBACCO documented - the LIGHT TOBACCO USER is used. If the patient has NEVER SMOKED and CURRENT SMOKELESS documented, CURRENT SMOKELESS is used.

- Diagnoses contained in the BGP TOBACCO DXS taxonomy or SNOMED subsets PXRM BGP TOBACCO SCREENED and PXRM BGP CURRENT TOBACCO. Both the V POVs and Problem List are checked. The latest documented diagnosis that is contained in the taxonomy is used. Diagnoses that indicate a tobacco user: diagnoses codes in the BGP TOBACCO USER DXS taxonomy, all others are considered non-tobacco user. If a SNOMED is found and it is contained in the PXRM BGP CURRENT TOBACCO subset it is used.
  - Dental ADA code 1320 - TOBACCO USE INTERVENTION TO PREVENT DISEASE. If this code is documented the patient is considered a tobacco user.
  - A CPT code documented that is in the BGP TOBACCO SCREEN CPTS taxonomy. If the code found is in the BGP TOBACCO USER CPTS taxonomy the patient is considered a tobacco user, all others are considered a non-tobacco user.
    - If the patient is a user, then "1 - Current user" is assigned.
    - If the patient is not a tobacco user, then "2 - Not a current user" is assigned.
    - Otherwise "3 - Not documented" is assigned.

- **Audit Logic**: The last documented of the following items is found:
  - Health Factors in the categories TOBACCO (SMOKING) and TOBACCO (SMOKELESS - CHEWING/DIP) that relate to the patient's tobacco use status. As of the DM Audit 2020 these are the health factors available: (the ones with one asterisk (*) indicate a current user, those with two asterisks (**) are non-tobacco users, the others are put in the "Not Documented" category):
    - *CURRENT SMOKELESS TOBACCO (SMOKELESS - CHEWING/DIP
    - **PREVIOUS (FORMER) SMOKELESS TOBACCO (SMOKELESS - CHEWING/DIP
    - **cessation-SMOKELESS TOBACCO (SMOKELESS - CHEWING/DIP
    - SMOKELESS TOBACCO, STATUS UNKNOWN TOBACCO (SMOKELESS - CHEWING/DIP
    - **NEVER USED SMOKELESS TOBACCO TOBACCO (SMOKELESS
    - **NON-TOBACCO USER TOBACCO (SMOKING)
• *CURRENT SMOKER, STATUS UNKNOWN TOBACCO (SMOKING)
• **PREVIOUS (FORMER) SMOKER TOBACCO (SMOKING)
• **CESSATION-SMOKER TOBACCO (SMOKING)
• *CURRENT SMOKER, EVERY DAY TOBACCO (SMOKING)
• *CURRENT SMOKER, SOME DAY TOBACCO (SMOKING)
• **NEVER SMOKED TOBACCO (SMOKING)
• SMOKING STATUS UNKNOWN TOBACCO (SMOKING)
• *HEAVY TOBACCO SMOKER TOBACCO (SMOKING)
• *LIGHT TOBACCO SMOKER TOBACCO (SMOKING)

− 3. Dental ADA code 1320 - TOBACCO USE INTERVENTION TO PREVENT DISEASE. If this code is documented the patient is considered a tobacco user.
− 4. A CPT code documented that is in the BGP TOBACCO SCREEN CPTS taxonomy. If the code found is in the BGP TOBACCO USER CPTS taxonomy the patient is considered a tobacco user, all others are considered a non-tobacco user.
  • If the patient is a user, then "1 - Current user" is assigned.
  • If the patient is not a tobacco user, then "2 - Not a current user" is assigned.
  • Otherwise "3 - Not documented" is assigned.

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

• Audit Export Field Name and Details: TOBACCO
  − 1=Current user
  − 2=Not a current user
  − 3=Not documented

A.15 Tobacco Cessation Counseling

TOBCOUNSEL
1=Yes
2=No
Blank if value for TOBACCO is not 1=Current user

• Description: If the patient is a tobacco user, were they provided cessation counseling during the audit period.
• **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** Any cessation counseling found in the past 365 from the date the summary is run is found. If counseling is found, a yes is displayed along with a description of what was found. See logic for cessation counseling under Audit Logic.

• **Audit Logic:** If the tobacco use status is "1 - Current user" then counseling documented in the past year is searched for. Counseling is defined as any of the following:
  
  - A visit to clinic 94 - TOBACCO CESSATION CLINIC
  
  - A patient education topic that meets any of the following criteria:
    
    - Begins with TO- (e.g. TO-Q)
    
    - Ends in -TO (e.g. CAD-TO)
    
    - Begins with any Tobacco User diagnosis (taxonomy is BGP TOBACCO USER DXS) (e.g. 305.1-L)
    
    - Begins with any Tobacco User CPT code (e.g. 99407-L)
    
    - Begins with a SNOMED code from any of the following SNOMED subsets:
      
      - PXRM BGP TOBACCO TOPICS
      
      - PXRM BGP TOBACCO SMOKER
      
      - PXRM BGP TOBACCO SMOKELESS
      
      - PXRM BGP QUIT TOBACCO
      
      - PXRM BGP TOBACCO SCREENED
      
      - PXRM BGP CURRENT TOBACCO

    To see a list of these codes, use option VSML View a SNOMED List used by the DM AUDIT which can be found on the Audit Setup menu.

  - Any of the following CPT codes documented. These indicate tobacco use counseling:
    
    - D1320
    
    - 99406
    
    - 99407
    
    - G0375 (old code)
    
    - G0376 (old code)
    
    - 4000F
    
    - 4001F
    
    - G8402
    
    - G8453
− Dental ADA code 1320.
The latest documented of the above four data elements is displayed along with the date.

If no counseling is found, then the system will look for a smoking aid prescribed:

• Any prescription for a medication in the site-populated BGP CMS SMOKING CESSATION MEDS taxonomy that does not have a comment of RETURNED TO STOCK.

• A prescription for any medication with name containing "NICOTINE PATCH", "NICOTINE POLACRILEX", "NICOTINE INHALER", or "NICOTINE NASAL SPRAY" that does not have a comment of RETURNED TO STOCK.

If any of the above is found, then a value of 1 - Yes is assigned. Otherwise, a value of 2 - No is assigned.

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

• **Audit Export Field Name and Details:** TOBCOUNSEL
  − 1=Yes
  − 2=No
  − Blank if value for TOBACCO is not 1=Current user

### A.16 Electronic Nicotine Delivery Systems Screening

• **Description:** Was the patient screened for Electronic Nicotine Delivery Systems (ENDS) use?

• **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** The last documented health factor in the category ELECTRONIC NICOTINE DELIV SYSTEM (ENDS) is found and the date documented is displayed. If none are found “Never” is displayed.

• **Audit Logic:** The last documented health factor in the category ELECTRONIC NICOTINE DELIV SYSTEM (ENDS) during the Audit period is found. Screened for electronic nicotine delivery system (ENDS) use during Audit period:
  − If a health factor is found a value of 1 - Yes is assigned.
  − If no health factors have been recorded during the Audit period, a value of 2 - No is assigned.

• **Audit Report:** Value is used in the ENDS use screening section of the Audit report.

• **Audit Export Field Name and Details:** ENDSSCREEN
  − 1=Yes
A.17 ENDS Use status

- **Description:** Most recent ENDS use status documented.

- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** The last documented health factor in the category ELECTRONIC NICOTINE DELIV SYSTEM (ENDS) is found and displayed. If none are found “Never” is displayed.

- **Audit Logic:** The last documented health factor in the category ELECTRONIC NICOTINE DELIV SYSTEM (ENDS) is found. Use status is assigned as follows:
  - CURRENT ENDS USER: 1 - Current User
  - CESSATION ENDS USER: 1 - Current User
  - PREVIOUS ENDS USER: 2 - Not a current user
  - NEVER USED ENDS USER: 2 - Not a current user
  - No health factor recorded: 3 - Not documented

- **Audit Report:** Value is used in the ENDS use screening of the Audit report.

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

A.18 Height

- **Description:** Height (most recent)

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

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

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

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

### A.19 Weight

- **Description:** Weight in lbs

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

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

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

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

### A.20 Body Mass Index

- **Description:** Calculated BMI

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

\[
BMI = \frac{\text{weight}}{\text{height} \times \text{height}} \times 703
\]

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

If the patient has a pregnancy diagnosis on the date of the weight, the BMI is not calculated or displayed.

If the patient is < 19 years of age the height and weight must be on the same day or the BMI is not calculated.

- **Audit Logic:** BMI is calculated as:
BMI = (weight/height*height) x 703.
- weight = the last weight (in lbs.) documented during the Audit period.
- height = the last height (in inches) recorded any time before the Audit date.

- **Audit Report:** Body Mass Index (BMI) Category:
  - Normal (BMI < 25.0)
  - Overweight (BMI 25.0–29.9)
  - Obese (BMI \( \geq 30.0 \))
  - Height or weight missing
  - Severely obese (BMI \( \geq 40.0 \))

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

### A.21 Hypertension Diagnosed

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

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

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

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

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

### A.22 Blood Pressure

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

- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** The last three non-ER Blood Pressures values and the date they were obtained are displayed.
• **Audit Logic:** The most recently recorded systolic and diastolic blood pressure values (up to three on different days) on non-ER clinic visits during the Audit period are obtained. If more than one blood pressure is recorded on anyone day, the latest one is used.

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

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

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

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**Foot Exam**

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

• **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** The last foot exam done in the past year (from the date the summary is run) is obtained and displayed. The logic used in determining if a comprehensive or complete foot exam has been done is as follows:
  - A documented DIABETIC FOOT EXAM, COMPLETE (CODE 28) is searched for in the past year. This is recorded in V Exam. If found, no other processing is done, an exam is assumed to have been done.
  - CPT codes 2028F and G9226 in V CPT [Taxonomy: BGP CPT FOOT EXAM]
  - A visit on which a podiatrist (provider class codes 33=PODIATRIST, 84=PEDORTHIST or 25=CONTRACT PODIATRIST) that is not a DNKA visit is searched for in the year prior to the Audit date. If found, it is not assumed the exam was done so the term “maybe” is displayed with the date of the visit.
A visit to clinic 65=PODIATRY or B7=Diabetic Foot clinic that is not a DNKA is searched for in the year prior to the Audit date. If found, it is not assumed the exam was done so the term “maybe” is displayed with the date of the visit.

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

- A documented DIABETIC FOOT EXAM, COMPLETE (CODE 28) is searched for in the year prior to the Audit date. This is recorded in V Exam. If found, no other processing is done, an exam is assumed to have been done.
- CPT codes 2028F and G9226 in V CPT [Taxonomy: BGP CPT FOOT EXAM]
- A visit on which a podiatrist (provider class codes 33=PODIATRIST, 84=PEDORTHIST or 25=CONTRACT PODIATRIST) that is not a DNKA visit is searched for in the year prior to the Audit date. If found, it is assumed the exam was done and no further processing is done.
- A visit to clinic 65=PODIATRY or B7=Diabetic Foot clinic that is not a DNKA is searched for in the year prior to the Audit date:
  - If found, no other processing is done.
  - If any of the above is found, a value of 1 - Yes is assigned.
  - If none of the above are found the value is 2 - No.

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

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

### A.24 Eye Exam

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

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

- The system looks for the last documented Diabetic Eye Exam in the year prior to the date the summary was generated. Diabetic Eye Exam is defined as:
  - EXAM 03 - Diabetic Eye Exam
  - CPT in either the BGP DM RETINAL EXAM CPTS or the BGP DM EYE EXAM CPTS taxonomy.
If one of the above is found, Yes, along with the date the exam was found is displayed.

- If none of the above is found, then all PCC Visits in the year prior to the Audit date are scanned for a non-DNKA, non-Refraction visit to an Optometrist or Ophthalmologist (24, 79, 08) or an Optometry or Ophthalmology Clinic (17, 18, or A2).
- If found, the term “Maybe”, along with the date the visit was found is displayed. Refraction is defined as a POV on the visit of: [DM AUDIT REFRACTION DXS]. DNKA is defined as any visit with a primary purpose of visit with a provider narrative containing the following phrases: DNKA, DID NOT KEEP APPOINTMENT, DID NOT KEEP APPT.
- If none of the above are found, a “No” is displayed.

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

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

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

### A.25 Dental Exam

- **Description:** Dental exam performed during the Audit period
• **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** See Audit Logic. For the DPSC if the only item found is a visit to a dentist or to dental clinic then “Maybe” is displayed rather than a “Yes”.

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

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

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

A.26 Depression an Active Problem?

• **Description:** Is Depression an active problem for this patient?

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

• **Audit Logic:** The patient's problem lists in both PCC and the Behavioral Health module are reviewed for any problem with a code that is contained in the BGP MOOD DISORDERS taxonomy; or for the following Behavioral Health problem codes: 14, 15. If no problem is found on the problem list, then the PCC and BH systems are reviewed for at least two diagnoses (POV) of the codes listed above in the year prior to the Audit date.
  
  − If either a problem is found on the problem list or two POVs are found then the value assigned is 1 - Yes.
- If not, then a value of 2 - No is assigned.

**Audit Report:** Depression an Active Problem:
- Yes
- No

Also used to determine if depression is a diabetes related condition.

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

### A.27 Depression Screening

**Description:** For patients without a diagnosis of depression, were they screened for depression in the audit period.

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

**Audit Logic:** This item is only reviewed if depression was not found on the problem list and the patient is not currently being seen for depression. (See item DEPRESSION AS AN ACTIVE PROBLEM).

The PCC and Behavioral health databases are reviewed for any of the following documented in the past year:
- Exam 36 or Behavioral Health Module Depression Screening.
- Diagnosis - V POV V79.0 ; Z13.3*
- Measurements PHQ2, PHQ9, PHQT.
- Behavioral Health Module Diagnosis (POV) of 14.1.
- Diagnosis in the BGP MOOD DISORDERS taxonomy used as a Purpose of Visit
- Diagnosis in the BGP MOOD DISORDERS taxonomy used as a Purpose of visit in the Behavioral Health system.
- Problem Code of 14 or 15 used as a Purpose of Visit in the Behavioral Health system.
- CPT codes 1220F, 3725F or G0444 in PCC or Behavioral Health.
- If any of the above is found, then a value of 1 - Yes is assigned. If not, then a value of 2 - No is assigned.

**Audit Report:** Depression an Active Problem:

In patients without active depression, screened for depression during Audit period:
- Screened
- Not screened
• **Audit Export Field Name and Details:** DEPSCREEN
  
  - 1=Yes
  - 2=No
  - Leave blank if value for DEPDX is not 2=No

A.28 Nutrition Education

• **Description:** Was nutrition education provided during the audit period?

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

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

All visits in the year prior to the Audit date are examined. Chart review visits are skipped (service category of C or clinic code of 52).

  - If the primary provider on any visit is a DIETITIAN or NUTRITIONIST (codes 29, 07 or 34) then RD is assigned.
  
  - If the visit does not have one of the above providers but has a Diagnosis of [BGP DIETARY SURVEILLANCE DXS] then Other is assigned.
  
  - If the visit has a CPT documented of 97802, 97803, or 97804 then RD is assigned.

  - If the visit contains any of the following education topics:
    
    - Topic in the DM AUDIT DIET EDUC TOPICS taxonomy
    - Topic ending in -N
    - Topic ending in -DT
    - Topic ending in -MNT
    - Topic beginning with MNT-
    - Topic beginning with DNCN-

    The V Patient Education entry is examined:
    
    - If the provider documented in that entry is a Dietitian or Nutritionist, the RD is assigned.
• If the provider is blank or not a dietitian/nutritionist then Other is assigned.

At this point:
• If RD is assigned and Other is not then the value assigned is 1 - RD.
• If RD and Other is assigned then the value assigned is 3 - Both RD & Other.
• If Other is assigned and RD is not then the value assigned is 2 - Other.

Processing stops if a value is assigned.

If none of the above is documented, the value 4 - None is assigned.

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

• **Audit Export Field Name and Details:** DIETINSTR
  − 1=Yes by RD
  − 2=Yes by non-RD
  − 3=Yes by RD & non-RD
  − 4=None

### A.29 Physical Activity Education

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

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

• **Audit Logic:**
  − All visits in the year prior to the Audit date are examined. If either of the following is true:
    • There is a visit on which a patient education topic in the DM AUDIT EXERCISE EDUC TOPICS taxonomy
    • Any topic ending in "-EX" is documented
    A 1 - Yes value is assigned. No further processing is done.
  − All visits in the year prior to the Audit date are examined for a POV of V65.41 (there are no ICD10 codes):
    • If one is found a 1 - Yes is assigned.
    • If none of the above is documented, the value 2 – No is assigned.
• **Audit Report:** Diabetes-Related Education. Physical Activity

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

A.30 Other Diabetes Education

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

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

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

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

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

A.31 Diabetes Therapy

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

• **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** N/A
Note: Medications can be found in other sections of the health summary.

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

It is assumed that a medication entered as an EHR Outside Medication is active until it is discontinued. If any medication in the taxonomy specified is found, then an 'X' is placed by the therapy name DM therapy items.

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Taxonomy Name(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin</td>
<td>DM AUDIT INSULIN DRUGS</td>
</tr>
<tr>
<td>Metformin</td>
<td>DM AUDIT METFORMIN DRUGS</td>
</tr>
<tr>
<td>Sulfonylurea</td>
<td>DM AUDIT SULFONYLUREA DRUGS</td>
</tr>
<tr>
<td>DPP4 inhibitor</td>
<td>DM AUDIT DPP4 INHIBITOR DRUGS</td>
</tr>
<tr>
<td>GLP-1 agonist</td>
<td>DM AUDIT INCRETIN MIMETIC DRUGS</td>
</tr>
<tr>
<td>GLP-1 agonist</td>
<td>DM AUDIT GLP-1 ANALOG DRUGS</td>
</tr>
<tr>
<td>SGLT-2 inhibitor</td>
<td>DM AUDIT SGLT-2 INHIBITOR DRUG</td>
</tr>
<tr>
<td>Pioglitazone, rosiglitazone</td>
<td>DM AUDIT GLITAZONE DRUGS</td>
</tr>
<tr>
<td>Acarbose, miglitol</td>
<td>DM AUDIT ACARBOSE DRUGS</td>
</tr>
<tr>
<td>Rapaglinide, Nateglinide</td>
<td>DM AUDIT SULFONYLUREA-LIKE</td>
</tr>
<tr>
<td>Amylin analog</td>
<td>DM AUDIT AMYLIN ANALOGUES</td>
</tr>
<tr>
<td>Bromocriptine</td>
<td>DM AUDIT BROMOCRIPTINE DRUGS</td>
</tr>
</tbody>
</table>
Diabetes Management System (BDM) Version 2.0 Patch 13

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Taxonomy Name(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colesevelam</td>
<td>DM AUDIT COLESEVELAM DRUGS</td>
</tr>
</tbody>
</table>

- **Audit Report:** Diabetes Treatment section
  - Number of diabetes medications currently prescribed
  - Diabetes meds currently prescribed, alone or in combination
    - Insulin
    - Metformin
    - Sulfonylurea
    - DPP4 inhibitor
    - GLP-1 agonist
    - SGLT-2 inhibitor
    - Pioglitazone or rosiglitazone
    - Acarbose or miglitol
    - Repaglinide or Nateglinide
    - Amylin analog
    - Bromocriptine
    - Colesevelam

- **Audit Export Field Name and Details:** See Audit logic.
  - If any med is found in a category, value=1 for the corresponding field, otherwise value=2.
  - If no meds are found value=1 for TXNONE.
    - TXNONE
    - TXINSUL
    - TXMETFORM
    - TXSUREA
    - TXDPP4
    - TXGLP1MED
    - TXSGLT2
    - TXGLIT
    - TXACARB
    - TXSUREALK
    - TXAMYLIN
A.32 Ace Inhibitor or ARB

- **Description:** Was an ACE Inhibitor or ARB prescribed to the patient as of the end of the Audit Period?

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

  **Note:** Medications can be found in other sections of the health summary.

- **Audit Logic:** The taxonomy used to find ACE Inhibitors is DM AUDIT ACE INHIBITORS. If any drug in this taxonomy is found using the logic that follows a value of 1 - Yes is assigned, no further processing is done.

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

  - If no V Medication is found the Prescription file (file 52) is searched for any drug in the taxonomy of drugs being searched for. The prescription number must begin with an X (an X indicates that the prescription was e-prescribed). If the prescription begins with an X the following calculation is done:

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

    - # of days calculated above + issue date (this is the last date the prescription covers)

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

  - If no medications are found in the previous two searches the system will look for any EHR Outside Medication that fits into one of these medication groups.

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

    If no relevant drugs are found, then a 2 - No is assigned.
• **Audit Report:**
  − Hypertension section:
    Diagnosed hypertension and ACE inhibitor or ARB prescribed
  − Chronic Kidney Disease (CKD) section:
    CKD and ACE inhibitor or ARB prescribed

• **Audit Export Field Name and Details:** ACE:
  − 1=Yes
  − 2=No

A.33 **Aspirin or Other Antiplatelet/Anticoagulant Therapy**

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

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

**Note:** Medications can be found in other sections of the health summary.

• **Audit Logic:** Two taxonomies are used to find Aspirin and Other Antiplatelet/Anticoagulant therapy:
  − DM AUDIT ASPIRIN DRUGS
  − DM AUDIT ANTIPLT/ANTICOAG RX
    If any drug in these taxonomies is found using the logic that follows, a value of 1 - Yes is assigned, no further processing is done.

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

  − If no V Medication is found the Prescription file (file 52) is searched for any drug in the taxonomy of drugs being searched for. The prescription number must begin with an X (an X indicates that the prescription was e-prescribed). If the prescription begins with an X the following calculation is done:
    Days’ supply times (# of refills +1) (this is the total number of days the prescription covers)

    Number of days calculated above + issue date (this is the last date the prescription covers)
If the date calculated is greater than the Audit date minus 180 days, it is assumed the patient was taking that medication in the six months prior to the end of the Audit date

- If no medications are found in the searches the system will look for any EHR Outside Medication that fits into one of medication groups. EHR Outside Medications are found in the V Medication file and have a value in the EHR Outside Medication field and no discontinued date. The system will go back 10 years to find one of these medications. It is assumed that a medication entered as an EHR Outside Medication is active until it is discontinued.
- The Non-VA meds component in the pharmacy patient file is reviewed for any drug in the above-mentioned taxonomies or an orderable item whose first seven characters is "ASPIRIN" and whose eighth character is not a "/". If no relevant drugs are found, then a 2 - No is assigned.

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

### A.34 Statin Therapy

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

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

**Note:** Medications can be found in other sections of the health summary.

- **Audit Logic:** One taxonomy is used to find Statin therapy medications: BGP PQA STATIN MEDS. If any drug in this taxonomy is found using the logic that follows, a value of 1 - Yes is assigned, no further processing is done.
  - Searches for any PCC V Medication entry for any drug in the taxonomy of drugs being searched for where the visit date of the V Medication is in the six months prior to the Audit date. (DM Audit is looking to see if the patient had at least one fill in the past six months.)
  - If no V Medication is found the Prescription file (file 52) is searched for any drug in the taxonomy of drugs being searched for. The prescription number must begin with an X (an X indicates that the prescription was e-prescribed). If the prescription begins with an X the following calculation is done:
    - Days’ supply times (# of refills +1 (this is the total number of days the prescription covers)
Number of days calculated + issue date (this is the last date the prescription covers)

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

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

Statin Allergy defined as: Adverse drug reaction/documentated statin allergy defined as any of the following:

• ALT and/or AST > 3x the Upper Limit of Normal (ULN) (i.e. Reference High) on two or more consecutive visits during the Audit Period

• Creatine Kinase (CK) levels > 10x ULN or CK > 10,000 IU/L during the Report Period

• Myopathy/Myalgia, defined as any of the following during the Report Period: Dx in the BGP MYOPATHY/MYALGIA DXS taxonomy

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


Test Definitions:

• ALT: Site-populated taxonomy DM AUDIT ALT TAX or the BGP ALT LOINC taxonomy.

• AST: Site-populated taxonomy DM AUDIT AST TAX or the BGP AST LOINC taxonomy.

• Creatine Kinase: Site-populated taxonomy BGP CREATINE KINASE TAX or the BGP CREATINE KINASE LOINC taxonomy.

Statin Intolerance/Contraindication defined as:

Contraindications to Statins defined as any of the following

• Pregnancy (see definition below)

• Acute Alcoholic Hepatitis, defined as POV ICD-9: 571.1; ICD-10: K70.10, K70.11 during the Report Period

• NMI (not medically indicated) refusal for any statin at least once during the Report Period.

Pregnancy definition: At least two visits during the Audit Period with Documented codes in the following taxonomies:

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

• **Audit Report:** Statin Prescribed section
  - Yes*
  - Allergy, intolerance, or contraindication
These two items also reported:
  - In patients with diagnosed CVD
  - In patients age 40-75 years
  - In patients with diagnosed CVD and/or age 40-75 years
*Excludes patients with an allergy, intolerance, or contraindication

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

**A.35 Cardiovascular Disease**

• **Description:** CVD Diagnosed Ever?

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

• **Audit Report:** Cardiovascular Disease (CVD) section:
  - CVD diagnosed ever
  - CVD and mean BP <140/<90
  - CVD and not current tobacco user
  - CVD and aspirin or other antiplatelet/anticoagulant therapy prescribed
  - CVD and statin prescribed*
  *Excludes patients with allergy, intolerance, or contraindication

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

A.36 TB test done (ever)

• **Description:** Tuberculosis (TB) Was a TB test done ever? Skin Test; Blood test; Unknown/not offered

• **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** TB - Last Documented Test. The date of the last documented TB test is displayed along with what type of test was done. See Audit Logic for TB Test definition.
• **Audit Logic:** The type of TB Test done is determined in the following way:
  - If the patient has a TB health factor recorded, TB on the problem list or any diagnosis of TB documented in the PCC then the test type is assigned as 1 - Skin Test (PPD), no further processing is done.
  - All recorded PPD entries and TB lab tests using the DM AUDIT TB LAB TESTS TAX prior to the Audit date are gathered. If at least one is found the latest one is used, if it is a Skin test then 1 - Skin test (PPD) is assigned, if it is a lab test then 2 - Blood Test is assigned.
  - If no TB test is found, then the value is 3 - UNKNOWN/NOT OFFERED.

• **Audit Report:** Tuberculosis (TB) Status section:
  - TB test done ever (skin or blood)
  - If test done, skin test
  - If test done, blood test
  - If TB test done, positive result
  - If positive TB test, treatment completed
  - If negative TB test, test done after diabetes diagnosis

• **Audit Export Field Name and Details:** TBTESTDONE2
  - 1=Skin test (PPD)
  - 2=Blood test (QFT-GIT, T-SPOT)
  - 3=Unknown/not offered

### A.37 TB Test Result

• **Description:** Result of the most recent TB Test

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

• **Audit Logic:** If a TB test was done, the test result is determined in the following way:
  - If the patient has a TB health factor recorded, TB on the problem list or any diagnoses of TB documented in the PCC then the test result is assigned as 1 - Positive, no further processing is done. Taxonomy Used is DM AUDIT TUBERCULOSIS DXS.
  - All recorded PPD entries and TB lab tests using the DM AUDIT TB LAB TESTS TAX prior to the Audit date are gathered.
    - If at least one is found the latest one is used
    - If it is a Skin test and the reading or result is Positive (reading >9) then it is assigned as 1 – Positive
    - If reading or result of last PPD is negative, then the values is 2 -Negative
• If the test type is a blood test then the value of the test is examined:
  − If it is Positive then 1 - Positive is recorded
  − If it is negative then 2 - Negative is assigned.
  − If the results are null the value 3 - Unknown/Not offered is assigned
  − If no result is found then the value assigned is 3 - Unknown/not offered.

• **Audit Report:** Tuberculosis (TB) Status section:
  − TB test done ever (skin or blood)
    • If test done, skin test
    • If test done, blood test
    • If TB test done, positive result
  − If positive TB test, treatment completed
  − If negative TB test, test done after diabetes diagnosis

• **Audit Export Field Name and Details:** TBTESTRSLT2
  − 1=Positive
  − 2=Negative
  − 3=Unknown
  Leave blank if value for TBTESTDONE2 is not 1 or 2

**A.38 TB Treatment**

• **Description:** If TB result positive, is treatment complete?

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

• **Audit Logic:** If the value of the TB Test result is POSITIVE then the last TB health factor is looked at for determining TB Treatment status. The last recorded TB Health factor is displayed. The TB Health factors are:
  − TB - TX COMPLETE
  − TB - TX INCOMPLETE
  − TB - TX UNKNOWN
  − TB - TX UNTREATED
  − TB – IN PROGRESS
The value assigned is based on the last recorded health factor:
  − TX COMPLETE: 1 - Yes
  − TX INCOMPLETE: 2 - No
  − TX UNTREATED: 2 - No
• TX IN PROGRESS: 2 - No
• TX UNKNOWN: 3 - Unknown

• **Audit Report:** Tuberculosis (TB) Status section:
  TB test done ever (skin or blood)
  If test done, skin test
  If test done, blood test
  If TB test done, positive result
  If positive TB test, treatment completed

• If negative TB test, test done after diabetes diagnosis
• **Audit Export Field Name and Details:** TBINHTX2
  − 1=Yes
  − 2=No
  − 3=Unknown
  − Leave blank if value for TBTESTRSLT2 is not 1=Positive

**A.39 TB Test Date**

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

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

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

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

• **Audit Export Field Name and Details:** TBTESTDATE MM/DD/YYYY
  Leave blank if value for TBTESTRSLT2 is not 2=Negative

**A.40 Hepatitis C (HCV)**

• **Description:** Hepatitis C (HCV) diagnosis ever

• **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** See Audit Logic
• **Audit Logic:** The Purpose of Visits are scanned for any diagnosis ever contained in the BGP HEPATITIS C DXS taxonomy. If one is found the value of 1 - Yes is assigned, if no diagnosis is found the Problem List is scanned for a diagnosis contained in the BGP HEPATITIS C DXS taxonomy or a SNOMED contained in the PXRM HEPATITIS C SNOMED list. If that is found on the problem list a value of 1 - Yes is assigned, if not found a value of 2 - No is assigned.

• **Audit Report:** Hepatitis C (HCV) section:
  - Diagnosed HCV ever
  - In patients not diagnosed with HCV and age ≥ 18 years, screened ever.

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

### A.41 Hepatitis C Screen

- **Description:** Screened for HCV at least once (ever) if no diagnosis of Hepatitis C

- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** See Audit Logic. The date, test name and the test result are displayed.

- **Audit Logic:** If the patient has a diagnosis of Hepatitis C this item is skipped.

  Hepatitis C Screening (Ab Test) is determined by the following:
  - CPT 86803
  - BGP HEP C TEST LOINC CODES taxonomy
  - site-populated lab test taxonomy BGP HEP C TEST TAX.

  The V LAB file is scanned for any test contained in the lab test and LOINC taxonomies. The V CPT file is scanned for CPT 86803.
  - If a lab test or CPT code is found a value of 1 - Yes is assigned.
  - If a lab test or CPT code is not found a value of 2 - No is assigned.

- **Audit Report:** Hepatitis C (HCV) section:
  - Diagnosed HCV ever
  - In patients not diagnosed with HCV and age ≥ 18 years, screened ever

- **Audit Export Field Name and Details:** HCVSCREEN2
  - 1=Yes
  - 2=No

### A.42 Retinopathy Diagnosis

• **Description:** Retinopathy diagnosed ever?
• **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** See Audit Logic. The date of the diagnosis is displayed.

• **Audit Logic:** If retinopathy is on the problem list or the patient has had at least one visit with a diagnosis of retinopathy ever, then it is assumed that they have been diagnosed with retinopathy and a value of 1 - Yes is assigned. Otherwise, a value of 2 - No is assigned.

  Taxonomy used: **DM AUDIT RETINOPATHY DIAGNOSES**

  SNOMED List: PXRM BGP DM RETINOPATHY

• **Audit Report:** Retinopathy Diagnosed ever. Also used in calculation of diabetes-related conditions

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

A.43 Lower Extremity Amputation

• **Description:** Lower Extremity Amputation (ever), any type (e.g. toe, partial foot, above or below knee)

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

• **Audit Logic:** The patient's electronic record is scanned for documentation of any of the following items:
  - The purpose of visits are scanned for any diagnosis in the BGP DM BTK AMP DXS or the BGP DM ATK AMP DXS taxonomies. If a diagnosis is found a value of 1 - Yes is assigned.
  - The problem list is scanned for a diagnosis in the BGP DM BTK AMP DXS or BGP DM ATK AMP DXS taxonomies or a SNOMED in the PXRM BGP DM BTK AMP or PXRM BGP DM ATK AMP SNOMED subsets.
  - The procedures are scanned for a procedure in the BGP DM BTK AMP PROCES or BGP DM ATK AMP PROCES taxonomies.
  - The CPT codes are scanned for a CPT in the BGP DM BTK AMP CPTS or BGP DM ATK AMP CPTS taxonomies.

If any of the above are found, a value of 1 - Yes is assigned, otherwise a value of 2 - No is assigned.

• **Audit Report:** Lower Extremity Amputation, Any type ever (e.g., toe, partial foot, above or below knee).

  Also used in calculation of diabetes-related conditions
A.44 Influenza Vaccine

- **Description:** Influenza vaccine received, or refusal documented during the Audit Period

- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** See Audit Logic for definition of Influenza vaccine. The date of the vaccine since August 1st is displayed.

- **Audit Logic:** The patient's data is scanned for an influenza vaccine in the 12 months prior to the Audit date. Influenza vaccine is determined by:

  Immunization CVX codes: See BGP FLU IZ CVX CODES taxonomy
  - 15 INFLUENZA, SPLIT [TIVhx] (INCL
  - 16 INFLUENZA, WHOLE
  - 88 INFLUENZA, NOS
  - 111 INFLUENZA, Intranasal, Trivale
  - 135 INFLUENZA, HIGH DOSE SEASONAL
  - 140 INFLUENZA, seasonal, injectable
  - 141 INFLUENZA [TIV], SEASONAL, INJ
  - 144 INFLUENZA, INTRADERMAL
  - 149 INFLUENZA, Live, Intranasal, Q
  - 150 INFLUENZA, INJECTABLE, QUAD, P
  - 151 INFLUENZA NASAL, UNSPECIFIED
  - 153 INFLUENZA, INJECTABLE, MDCK, P
  - 155 INFLUENZA, INJECTABLE, RECOMB,
  - 158 INFLUENZA, Injectable, Quadrav
  - 161 INFLUENZA, injectable, quadriva
  - 166 INFLUENZA, intradermal, quadri
  - 168 INFLUENZA, Trivalent, adjuvant
  - 171 Influenza, injectable, MDCK, p
  - 185 influenza, recombinant, quadri
  - 186 Influenza, injectable, MDCK, q

  CPT codes: BGP CPT FLU

  Diagnosis codes: BGP FLU IZ DXS (there are no ICD10 codes)
  - If any of the above is found, a value of 1 - Yes is assigned.
If no documented immunization is found, a search is done for a documented refusal in the Audit period. If one is found, then a value of 3 - Refused is assigned.

If neither of the above are found, a value of 2 - No is assigned.

- **Audit Report**: Immunization section: Influenza vaccine during Audit period. Refused - Influenza vaccine

- **Audit Export Field Name and Details**: FLUVAX:
  - 1=Yes
  - 2=No
  - 3=Refused

### A.45 Pneumococcal Vaccine

- **Description**: Pneumococcal vaccine (ever)

- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement)**: See Audit Logic for the definition of a pneumococcal vaccine. The date of the last pneumococcal vaccine is displayed.

- **Audit Logic**: Data is scanned for pneumococcal vaccine any time prior to the Audit date. A pneumococcal vaccine is determined by:
  - - Immunization CVX codes:
    - 33 PNEUMOCOCCAL
    - 100 Pneumococcal, PCV-7
    - 109 PNEUMOCOCCAL, NOS
    - 133 Pneumococcal, PCV-13
    - 152 Pneumococcal, Unspecified
  - - Diagnoses: V03.82 (there are no ICD10 codes)
    - - CPT codes: BGP PNEUMO IZ CPTS taxonomy (90669, 90670, 90732, G0009, G8115, G9279)
  - - If any of the above is found, a value of 1 - Yes is assigned.
  - - If none is found, the refusal file is checked for a documented refusal of this vaccination. Refusals documented in both the PCC and the Immunization register are reviewed.
    - - If one is found, then a value of 3 - Refused is assigned.
    - - If neither of the above is found, a value of 2 - No is assigned.

- **Audit Report**: Immunization section:
  Pneumococcal vaccine – ever
  Refused - Pneumococcal vaccine
**Audit Export Field Name and Details:** PNEUMOVAX
- 1=Yes
- 2=No
- 3=Refused

### A.46 Td, Tdap, DTaP, or DT in Past 10 Years

**Description:** Td, Tdap, DTaP, or DT in past 10 years

**How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** See Audit Logic for the definition of the vaccines. The date of the last vaccine is displayed.

**Audit Logic:** Immunizations are scanned for any tetanus vaccine in the 10 years prior to the Audit date. Logic used to find a TD vaccine: Immunization CVX codes:
- 115 Tdap
- 9 TD (ADULT)
- 113 TD (ADULT) PRESERVATIVE FREE
- 115 Tdap
- 138 Td-NA
- 139 Td,NOS
- 1 DTP
- 20 DTAP
- 28 DT (PEDIATRIC)
- 35 TETANUS TOXOID
- 106 DTAP, 5 PERTUSSIS ANTIGENS
- 107 DTAP, NOS
- 112 TETANUS TOXOID, NOS
- 22 DTP-HIB
- 50 DTAP-HIB
- 110 PEDIARIX
- 120 PENTACEL
- 130 KINRIX
- 132 DTaPIPVHHb

If neither of the above is found, a value of 2 - No is assigned

**Audit Report:** Immunization section:
- Td/Tdap/DTaP/DT - past 10 years
- Refused - Td/Tdap/DTaP/DT
A.47 Tdap (ever)

- **Description**: Tdap given ever
- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement)**: See Audit Logic for the definition of Tdap. The date of the last Tdap is displayed.
- **Audit Logic**: Immunizations are scanned for a Tdap vaccine ever. A Tdap vaccine is determined by:
  - CVX code 115 Tdap
  - CPT code 90715
  If either of the above is found, a value of 1 - Yes is assigned. If none is found, the refusal file is checked for a documented refusal of this vaccination. Refusals documented in both the PCC and the Immunization register are reviewed.
    - If one is found, then a value of 3 - Refused is assigned.
    - If neither is found, a value of 2 - No is assigned.
- **Audit Report**: Immunization section:
  - Tdap – ever
  - Refused - Tdap
- **Audit Export Field Name and Details**: TDAP
  - 1=Yes
  - 2=No
  - 3=Refused

A.48 Hepatitis B Complete Series (ever)

- **Description**: Hepatitis B complete series received ever
- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement)**: See Audit Logic for definition of Hepatitis B vaccines.
- **Audit Logic**: Data is scanned for hepatitis B vaccine any time prior to the Audit date. HEP B (3 DOSE SERIES) is determined by:
  - CVX codes:
    - 8 HEP B, ADOLESCENT OR PEDIATRIC
    - 42 HEP B, ADOLESCENT/HIGH RISK IN
- 43 HEP B, ADULT
- 44 HEP B, DIALYSIS
- 45 HEP B, NOS
- 51 HIB-HEP B
- 102 DTP-HIB-HEP B
- 104 HEP A-HEP B
- 110 DTaP-Hep B-IPV
- 132 DTaP-IPV-HIB-HEP B, historical
- 146 DTaP,IPV,Hib,HepB
- 193 Hep A-Hep B, pediatric/adolescent

- CPT codes contained in the BGP HEPATITIS CPTS taxonomy: 90636, 90723, 90731, 90740, 90743, G0010, Q3021, Q3023
- HEP B (2 DOSE SERIES) is determined by: CVX code 189 Hep B, adjuvanted

  - Vaccinations must be given at least 20 days apart. If the appropriate number are found (two for the two dose series or three for the three dose series) a value of 1 - Yes is assigned.
  
  - If less than the required number of vaccines are found, the system will look for an Immune Contraindication in the Immunization contraindications file. If it is found, a value of 4 - Immune is assigned. The system then looks for evidence of disease: Problem List or V POV of [BGP HEP EVIDENCE] Taxonomy. If it is found, a value of 4 - Immune is assigned.
  
  - If the required number of vaccinations are not found and immunity or evidence of disease is not found, the system searches for a refusal documented in the past year. If one is found, then a value of 3 – Refused is assigned. Refusal definitions: Immunization Package refusal or PCC refusal of the above listed CVX or CPT codes.
  
  - If none of the above are found, a value of 2 - No is assigned.

- **Audit Report:** Immunization section:
  
  - Hepatitis B complete series – ever
  - Refused - Hepatitis B
  - Immune - Hepatitis B

- **Audit Export Field Name and Details:** HEPBVAX:
  
  - 1=Yes
  - 2=No
  - 3=Refused
A.49 A1C

- **Description:** Hemoglobin A1c test performed during the Audit period

- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** The date, test name and result of the last A1c test is displayed. See Audit Logic for the definition of an A1c test.

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

  Individual Audit: The date and result of test are displayed.

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

- **Audit Export Field Name and Details:**
  - HBA1C
  - HBA1CDATE
    - Most recent in the report period
    - When exported, all characters that are not a number or a "," are stripped from the value. For example, if the value is <7.0, 7.0 is exported.
A.50 Total Cholesterol

- **Description:** Most recent Total Cholesterol value

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

- **Audit Logic:** The last lab test with a result in the year prior to the Audit date that is a member of the DM AUDIT CHOLESTEROL TAX taxonomy or the BGP TOTAL CHOLESTEROL LOINC taxonomy is found in V LAB.

- **Audit Report:** Not reported

- **Audit Export Field Name and Details:** CHOLVALUE All characters other than numbers and "." are stripped from the value which is then rounded to the closest whole number and truncated to a total of three characters with zero decimal digits.

A.51 HDL Cholesterol

- **Description:** Most recent HDL Cholesterol value

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

- **Audit Logic:** The last lab test with a result in the year prior to the Audit date that is a member of the DM AUDIT HDL TAX taxonomy or the BGP HDL LOINC CODES taxonomy is found in V LAB

- **Audit Report:** HDL cholesterol section: If result is blank OR first digit is not a number, then counted in the "Not tested or no valid result" category. For example, if the value is “cancelled”.
  - In females
    - HDL < 50 mg/dl
    - HDL ≥ 50 mg/dl
    - Not tested or no valid result
  - In males
    - HDL < 40 mg/dl
    - HDL ≥ 40 mg/dl
    - Not tested or no valid result
- **Audit Export Field Name and Details:** HDLVALUE All characters that are not numbers or ",," are stripped from the value which is then rounded to the closest whole number and truncated to a total of three characters with zero decimal digits.

## A.52 LDL Cholesterol

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

## A.53 Triglyceride Value (mg/dl)

- **Description:** Most recent Triglyceride value
- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** The date, test name and result of the last Triglyceride test is displayed. See Audit Logic for the definition of a Triglyceride test.
- **Audit Logic:** The last lab test with a result in the year prior to the Audit date that is a member of the DM AUDIT TRIGLYCERIDE TAX taxonomy or the BGP TRIGLYCERIDE LOINC CODES taxonomy is found in V LAB. Only tests with a result are used; tests with a result containing "CANC" or "COMMENT" are also skipped.
- **Audit Report:** Triglycerides section: If the result is blank OR first digit is not a number then counted in the "Not tested or no valid result" category. For example, if the value is "cancelled".
− TG <150 mg/dl
− TG 150-499 mg/dl
− TG 500-999 mg/dl
− TG ≥1000 mg/dl
− Not tested or no valid result

Auditor Export Field Name and Details: TRIGVALUE
All characters other than numbers and "." are stripped from the value and which is then rounded to the closest whole number and truncated to a total of 3 characters with 0 decimal digits.

A.54 Serum Creatinine

Description: Most recent Serum Creatinine value

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

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

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

Audit Report: Not reported

Audit Export Field Name and Details: CREATVALUE
All characters other than numbers and "." are stripped from the value which is truncated to a total of four characters with two decimal digits.

A.55 eGFR

Description: Most recent Estimated GFR value

How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement): The date, test name and result of the last eGFR test is displayed. See Audit Logic for the definition of an eGFR test.
• **Audit Logic:** For patients that are 18 or older, the last lab test in the year prior to the Audit date that is a member of the BGP GPR A ESTIMATED GFR TAX or the BGP ESTIMATED GFR LOINC taxonomy is found. For the individual Audit, the actual value that is in V LAB is displayed.

If there is no estimated GFR found in V LAB but there is a creatinine value found, the Estimated GFR is calculated using the Modified Diet in Renal Disease (MDRD) formula for eGFR.

• **Audit Report:** Kidney Evaluation section: If the first character of the value is ">" it goes into $\geq 60$ ml/min. Otherwise, all characters other than numbers and "." are stripped and the resulting value is placed in the following categories:
  - eGFR $\geq 60$
  - eGFR 30-59
  - eGFR 15-29
  - eGFR <15
  - Not tested or no valid result

Also used in the CKD Stage section.

• **Audit Export Field Name and Details:** EGF RVALUE

All characters other than numbers or "." are stripped from the value which is truncated to a total of 4 characters with 1 decimal digit.

A.56 **Quantitative Urine Albumin Creatinine Ratio Value**

• **Description:** Most recent Quantitative Urine Albumin Creatinine Ratio (UACR) value

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

• **Audit Logic:** The system looks for a test contained in the DM AUDIT QUANT UACR lab taxonomy or DM AUDIT A/C RATIO LOINC taxonomy, if found and the test has a valid numeric result then the result of the test is assigned to UACR value.

If the test found does not have a valid numeric result, then the system will look for a urine microalbumin test on the same visit date. If found, the result of that test is evaluated. If the result contains a < symbol or the words "less than," a value of 5 is assigned to UACR value. If the result contains a '>' symbol or contains the words "greater than" a value of 999 is assigned to UACR value.

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

• **Audit Report:** Kidney Evaluation section:
− Urine albumin excretion - normal: <30 mg/g
− Urine albumin excretion increased: 30-300 mg/g
− Urine albumin excretion increased: >300 mg/g
− Not tested or no valid result
Also used in the CKD Stage section.

• **Audit Export Field Name and Details:** UPACRVAL

All non-numeric characters are stripped from the value.

### A.57 Local Questions

• **Description:** Single digit 1-9 Locally defined data element

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

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

• **Audit Report:** Not reported

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

### A.58 Extended Local Question

• **Description:** Extended Local Question Locally defined data element

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

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

• **Audit Report:** Not reported

• **Audit Export Field Name and Details:** LOCALEXT character (max length=50) This field may be left blank for all patients if the facility does not choose to populate it.
Appendix B: Audit Export (Data) File Definition

IHS Diabetes Care & Outcomes Audit
Data Export File Specifications for 2020

B.1 General Information

- Data File Format: Delimited text, with the following general requirements:
  - Delimiter must be the caret (^) symbol, not a tab, space, or any other character.
  - Line 1 contains the Audit field names in the order they appear below.
  - Lines 2 and beyond contain the data, with each line representing a single record/patient.
  - All records must contain a value or a place holder for all fields. If there is no value for a field (because data are missing or due to skip pattern), the place holder is one blank space between the delimiters (i.e., ^ ^).
- Data Fields: A list of the fields for Audit 2020 and basic details/requirements for each can be found on subsequent pages of this document. Extracting accurate data for many fields requires additional information, some of which is available in the Audit documentation. Other information is specific to the health record system being used and must be determined locally, including documentation of medications and education.
- Additional Information and Resources:
  - Audit webpages: https://www.ihs.gov/diabetes/audit/
  - Contact the Audit team via email: diabetesaudit@ihs.gov
### B.2 List of Fields

<table>
<thead>
<tr>
<th>Order</th>
<th>Field Name</th>
<th>Description</th>
<th>Timeframe</th>
<th>Format/Values/Units</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>AUDITDATE</td>
<td>Ending date of the Audit period - 12/31/2019 for Annual Audit 2019</td>
<td>N/A</td>
<td>MM/DD/YYYY</td>
<td>N/A</td>
</tr>
<tr>
<td>2.</td>
<td>FACILITYNA</td>
<td>Name or abbreviation for the facility</td>
<td>N/A</td>
<td>Character</td>
<td>Character (max length=20)</td>
</tr>
<tr>
<td>3.</td>
<td>REVIEWER</td>
<td>Reviewer's initials</td>
<td>N/A</td>
<td>Character</td>
<td>Character (max length=3)</td>
</tr>
<tr>
<td>4.</td>
<td>STATE</td>
<td>Postal abbreviation for last known state of residence</td>
<td>N/A</td>
<td>Character</td>
<td>Character (max length=2) If the patient's address is outside of the US (e.g., in Canada), leave blank.</td>
</tr>
<tr>
<td>5.</td>
<td>MOB</td>
<td>Month of birth</td>
<td>N/A</td>
<td># with value 1-12</td>
<td>N/A</td>
</tr>
<tr>
<td>6.</td>
<td>YOB</td>
<td>Year of Birth</td>
<td>N/A</td>
<td>YYYY</td>
<td>N/A</td>
</tr>
<tr>
<td>7.</td>
<td>SEX</td>
<td>Gender</td>
<td>N/A</td>
<td># field with:</td>
<td># field with: 1=Male 2=Female 3=Unknown</td>
</tr>
<tr>
<td>8.</td>
<td>DODX</td>
<td>Date of diabetes diagnosis</td>
<td>N/A</td>
<td>MM/DD/YYYY</td>
<td>If only year is known, use value 07/01/yyyy. If only month and year are known, use 15 for the day. Leave blank if year or entire date is unknown.</td>
</tr>
<tr>
<td>9.</td>
<td>DMTYPE</td>
<td>Diabetes type</td>
<td>N/A</td>
<td># field with:</td>
<td># field with: 1=Type 1 2=Type 2 (or uncertain)</td>
</tr>
<tr>
<td>10.</td>
<td>TOBSCREEN</td>
<td>Screened for tobacco use</td>
<td>Audit period</td>
<td># field with: 1=Yes</td>
<td># field with: 1=Yes 2=No</td>
</tr>
<tr>
<td>11.</td>
<td>TOBACCO</td>
<td>Tobacco use status</td>
<td>Most recent</td>
<td># field with: 1=Current user</td>
<td># field with: 1=Current user 2=Not a current user 3=Not documented</td>
</tr>
<tr>
<td>12.</td>
<td>TOBCOUNSEL</td>
<td>Tobacco cessation counseling received</td>
<td>Audit period</td>
<td># field with: 1=Yes</td>
<td>Leave blank if value for TOBACCO is not 1=Current user</td>
</tr>
<tr>
<td>Order</td>
<td>Field Name</td>
<td>Description</td>
<td>Timeframe</td>
<td>Format/Values/Units</td>
<td>Comments</td>
</tr>
<tr>
<td>-------</td>
<td>----------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>13.</td>
<td>ENDSSCREEN</td>
<td>Screened for electronic nicotine delivery system (ENDS) use during Audit period</td>
<td>Audit period</td>
<td># field with: 1=Yes 2=No</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>ENDSSTATUS</td>
<td>ENDS use status</td>
<td>Most recent</td>
<td># field with: 1=Current user 2=Not a current user 3=Not documented</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>FEET</td>
<td>Last recorded height - feet part</td>
<td>Last ever</td>
<td># with up to 2 decimal places</td>
<td>Combine with INCHES</td>
</tr>
<tr>
<td>16.</td>
<td>INCHES</td>
<td>Last recorded height - inches part</td>
<td>Last ever</td>
<td># with up to 2 decimal places</td>
<td>Total or in combination with FEET</td>
</tr>
<tr>
<td>17.</td>
<td>WEIGHT</td>
<td>Weight in lbs</td>
<td>Audit period, most recent</td>
<td># with 0 decimal places</td>
<td>Truncate to nearest pound</td>
</tr>
<tr>
<td>18.</td>
<td>HTNDX</td>
<td>Hypertension diagnosed</td>
<td>Ever</td>
<td># field with: 1=Yes 2=No</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>SYST1</td>
<td>Most recent systolic blood pressure (mmHg)</td>
<td>Audit period</td>
<td># with 0 decimal places</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>DIAST1</td>
<td>Most recent diastolic blood pressure (mmHg)</td>
<td>Audit period</td>
<td># with 0 decimal places</td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>SYST2</td>
<td>Next most recent systolic blood pressure BP (mmHg)</td>
<td>Audit period</td>
<td># with 0 decimal places</td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>DIAST2</td>
<td>Next most recent diastolic blood pressure (mmHg)</td>
<td>Audit period</td>
<td># with 0 decimal places</td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>SYST3</td>
<td>Third most recent systolic blood pressure (mmHg)</td>
<td>Audit period</td>
<td># with 0 decimal places</td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>DIAST3</td>
<td>Third most recent diastolic blood pressure (mmHg)</td>
<td>Audit period</td>
<td># with 0 decimal places</td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>FOOTEXAM</td>
<td>Complete diabetic foot exam</td>
<td>Audit period</td>
<td># field with: 1=Yes 2=No</td>
<td></td>
</tr>
<tr>
<td>Order</td>
<td>Field Name</td>
<td>Description</td>
<td>Timeframe</td>
<td>Format/Values/Units</td>
<td>Comments</td>
</tr>
<tr>
<td>-------</td>
<td>------------</td>
<td>-----------------------------------------------------------</td>
<td>-----------------</td>
<td>---------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>26.</td>
<td>EYEEEXAM</td>
<td>Dilated retinal exam or retinal imaging exam</td>
<td>Audit period</td>
<td># field with:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1=Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2=No</td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>DENTALEXAM</td>
<td>Dental exam including examination of teeth and gingiva</td>
<td>Audit period</td>
<td># field with:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1=Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2=No</td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>DEPDX</td>
<td>Active diagnosis of depression</td>
<td>Audit period</td>
<td># field with:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1=Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2=No</td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>DEPSCREEN</td>
<td>Screened for depression</td>
<td>Audit period</td>
<td># field with:</td>
<td>Leave blank if value for DEPDX is not</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1=Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2=No</td>
<td>2=No</td>
</tr>
<tr>
<td>30.</td>
<td>DIETINSTR</td>
<td>Nutrition education</td>
<td>Audit period</td>
<td># field with:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1=Yes by RD</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2=Yes by non-RD</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3=Yes by RD &amp; non-RD</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4=None</td>
<td></td>
</tr>
<tr>
<td>31.</td>
<td>EXERCISE</td>
<td>Physical activity education</td>
<td>Audit period</td>
<td># field with:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1=Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2=No</td>
<td></td>
</tr>
<tr>
<td>32.</td>
<td>DMEDUC</td>
<td>Diabetes education other than nutrition and physical activity</td>
<td>Audit period</td>
<td># field with:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1=Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2=No</td>
<td></td>
</tr>
<tr>
<td>33.</td>
<td>TXNONE</td>
<td>None of the listed diabetes medications prescribed</td>
<td>As of the end</td>
<td># field with:</td>
<td>-If this item=1:Yes, then all other TX fields should=2:No.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>of the Audit</td>
<td>1=Yes</td>
<td>-If all other TX fields=2:No, then this item should=1:Yes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>period</td>
<td>2=No</td>
<td></td>
</tr>
<tr>
<td>34.</td>
<td>TXINSUL</td>
<td>Prescribed any insulin</td>
<td>As of the end</td>
<td># field with:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>of the Audit</td>
<td>1=Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>period</td>
<td>2=No</td>
<td></td>
</tr>
<tr>
<td>Order</td>
<td>Field Name</td>
<td>Description</td>
<td>Timeframe</td>
<td>Format/Values/Units</td>
<td>Comments</td>
</tr>
<tr>
<td>-------</td>
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<td>-----------------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>35.</td>
<td>TXMETFORM</td>
<td>Prescribed metformin</td>
<td>As of the end of the Audit period</td>
<td># field with:</td>
<td>Includes Glucophage, others</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1=Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2=No</td>
<td></td>
</tr>
<tr>
<td>36.</td>
<td>TXSUREA</td>
<td>Prescribed a sulfonylurea</td>
<td>As of the end of the Audit period</td>
<td># field with:</td>
<td>Includes glyburide, glipizide, others</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1=Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2=No</td>
<td></td>
</tr>
<tr>
<td>37.</td>
<td>TXDPP4</td>
<td>Prescribed a DPP4 inhibitor</td>
<td>As of the end of the Audit period</td>
<td># field with:</td>
<td>Includes Sitagliptin (Januvia), Saxagliptin</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1=Yes</td>
<td>(Onglyza), Linagliptin (Tradjenta),</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2=No</td>
<td>Alogliptin (Nesina)</td>
</tr>
<tr>
<td>38.</td>
<td>TXGLP1MED</td>
<td>Prescribed an injectable GLP-1 agonist</td>
<td>As of the end of the Audit period</td>
<td># field with:</td>
<td>Includes Exenatide (Byetta, Bydureon),</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1=Yes</td>
<td>Liraglutide (Victoza), Albiglutide</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2=No</td>
<td>(Tanzeum), Dulaglutide (Trulicity), Lixisenatide</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Adlyxin), Semaglutide (Ozempic)</td>
</tr>
<tr>
<td>39.</td>
<td>TXSGLT2</td>
<td>Prescribed an SGLT2 inhibitor</td>
<td>As of the end of the Audit period</td>
<td># field with:</td>
<td>Includes Canagliflozin (Invokana), Dapagliflozin</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1=Yes</td>
<td>(Farxiga), Empagliflozin (Jardiance), Ertugliflozin</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2=No</td>
<td>(Steglatro)</td>
</tr>
<tr>
<td>40.</td>
<td>TXGLIT</td>
<td>Prescribed Pioglitazone [Actos] or rosiglitazone [Avandia]</td>
<td>As of the end of the Audit period</td>
<td># field with:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1=Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2=No</td>
<td></td>
</tr>
<tr>
<td>41.</td>
<td>TXACARB</td>
<td>Prescribed Acarbose [Precose] or miglitol [Glyset]</td>
<td>As of the end of the Audit period</td>
<td># field with:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1=Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2=No</td>
<td></td>
</tr>
<tr>
<td>42.</td>
<td>TXSUREALK</td>
<td>Prescribed Repaglinide [Prandin] or Nateglinide [Starlix]</td>
<td>As of the end of the Audit period</td>
<td># field with:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1=Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2=No</td>
<td></td>
</tr>
<tr>
<td>43.</td>
<td>TXAMYLIN</td>
<td>Prescribed injectable Amylin analog [Symlin]</td>
<td>As of the end of the Audit period</td>
<td># field with:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1=Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2=No</td>
<td></td>
</tr>
<tr>
<td>44.</td>
<td>TXBROMO</td>
<td>Prescribed Bromocriptine [Cycloset]</td>
<td>As of the end of the Audit period</td>
<td># field with:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1=Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2=No</td>
<td></td>
</tr>
<tr>
<td>Order</td>
<td>Field Name</td>
<td>Description</td>
<td>Timeframe</td>
<td>Format/Values/Units</td>
<td>Comments</td>
</tr>
<tr>
<td>-------</td>
<td>------------------</td>
<td>--------------------------------------------</td>
<td>------------------------</td>
<td>--------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>45.</td>
<td>TXCOLESEV</td>
<td>Prescribed Colesevelam [Welchol]</td>
<td>As of the end of the Audit period</td>
<td># field with: 1=Yes 2=No</td>
<td></td>
</tr>
<tr>
<td>46.</td>
<td>ACE</td>
<td>Prescribed an ACE inhibitor or ARB</td>
<td>As of the end of the Audit period</td>
<td># field with: 1=Yes 2=No</td>
<td></td>
</tr>
<tr>
<td>47.</td>
<td>ASPIRIN</td>
<td>Prescribed aspirin or other antiplatelet/ anticoagulant therapy</td>
<td>As of the end of the Audit period</td>
<td># field with: 1=Yes 2=No</td>
<td></td>
</tr>
<tr>
<td>48.</td>
<td>LLSTATIN2</td>
<td>Prescribed a statin drug</td>
<td>As of the end of the Audit period</td>
<td># field with: 1=Yes 2=No 3= Allergy/intolerance/ contraindication</td>
<td>-Look for yes, then allergy or intolerance or contraindication, then no.</td>
</tr>
<tr>
<td>49.</td>
<td>CVDDX</td>
<td>Diagnosed cardiovascular disease (CVD)</td>
<td>Ever</td>
<td># field with: 1=Yes 2=No</td>
<td></td>
</tr>
<tr>
<td>50.</td>
<td>TBTESTDONE2</td>
<td>Skin (PPD) or blood test for tuberculosis (TB) done with valid result</td>
<td>Ever</td>
<td># field with: 1=Skin test (PPD) 2=Blood test (QFT-GIT, T-SPOT) 3=Unknown/not offered</td>
<td></td>
</tr>
<tr>
<td>51.</td>
<td>TBTESTRSLT2</td>
<td>TB test result</td>
<td>Ever</td>
<td># field with: 1=Positive 2=Negative 3=Unknown</td>
<td>Leave blank if value for TBTESTDONE is not 1=Skin test or 2=Blood test</td>
</tr>
<tr>
<td>52.</td>
<td>TBINHTX2</td>
<td>Isoniazid treatment complete</td>
<td>Ever</td>
<td># field with: 1=Yes 2=No 3=Unknown</td>
<td>Leave blank if value for TBTESTRSLT2 is not 1=Positive</td>
</tr>
<tr>
<td>53.</td>
<td>TBTESTDATE</td>
<td>Date of last TB test</td>
<td>Ever</td>
<td>mm/dd/yyyy</td>
<td>Leave blank if value for TBTESTRSLT2 is not 2=Negative</td>
</tr>
<tr>
<td>Order</td>
<td>Field Name</td>
<td>Description</td>
<td>Timeframe</td>
<td>Format/Values/Units</td>
<td>Comments</td>
</tr>
<tr>
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<td>---------------------</td>
<td>----------</td>
</tr>
<tr>
<td>54</td>
<td>HCVDX</td>
<td>Diagnosed hepatitis C (HCV)</td>
<td>Ever</td>
<td># field with: 1=Yes 2=No</td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>HCVSCREEN2</td>
<td>Screened for HCV at least once</td>
<td>Ever</td>
<td># field with: 1=Yes 2=No</td>
<td>New for 2019 Replaces HCVSCREEN</td>
</tr>
<tr>
<td>56</td>
<td>RETINOPDX</td>
<td>Diagnosed retinopathy</td>
<td>Ever</td>
<td># field with: 1=Yes 2=No</td>
<td></td>
</tr>
<tr>
<td>57</td>
<td>LEA</td>
<td>Lower extremity amputation, any type (e.g., toe, partial foot, above or below knee)</td>
<td>Ever</td>
<td># field with: 1=Yes 2=No</td>
<td>New for 2019 See Audit Instructions and DMS Audit Logic for more information</td>
</tr>
<tr>
<td>58</td>
<td>FLUVAX</td>
<td>Influenza vaccine</td>
<td>Audit period</td>
<td># field with: 1=Yes 2=No 3=Refused</td>
<td></td>
</tr>
<tr>
<td>59</td>
<td>PNEUMOVAX</td>
<td>Pneumococcal vaccine</td>
<td>Ever</td>
<td># field with: 1=Yes 2=No 3=Refused</td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>TD</td>
<td>Tetanus (Td, Tdap, DTaP, or DT) vaccine</td>
<td>Past 10 years</td>
<td># field with: 1=Yes 2=No 3=Refused</td>
<td></td>
</tr>
<tr>
<td>61</td>
<td>TDAP</td>
<td>Tdap vaccine</td>
<td>Ever</td>
<td># field with: 1=Yes 2=No 3=Refused</td>
<td></td>
</tr>
<tr>
<td>Order</td>
<td>Field Name</td>
<td>Description</td>
<td>Timeframe</td>
<td>Format/Values/Units</td>
<td>Comments</td>
</tr>
<tr>
<td>-------</td>
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<td>-------------------------------</td>
<td>------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>62.</td>
<td>HEPBVAX</td>
<td>Hepatitis B complete series</td>
<td>Ever</td>
<td># field with:</td>
<td>Either complete 2-dose series or complete 3-dose series counts</td>
</tr>
<tr>
<td>63.</td>
<td>HBA1C</td>
<td>HbA1c test result (%)</td>
<td>Most recent in Audit period</td>
<td># with one decimal place</td>
<td></td>
</tr>
<tr>
<td>64.</td>
<td>HBA1CDATE</td>
<td>Date of most recent HbA1c</td>
<td>Most recent in Audit period</td>
<td>MM/DD/YYYY</td>
<td></td>
</tr>
<tr>
<td>65.</td>
<td>CHOLVALUE</td>
<td>Total cholesterol value</td>
<td>Most recent in Audit period</td>
<td># with 0 decimal places</td>
<td></td>
</tr>
<tr>
<td>66.</td>
<td>HDLVALUE</td>
<td>HDL cholesterol value (mg/dl)</td>
<td>Most recent in Audit period</td>
<td># with 0 decimal places</td>
<td></td>
</tr>
<tr>
<td>67.</td>
<td>LDLVALUE</td>
<td>LDL cholesterol value (mg/dl)</td>
<td>Most recent in Audit period</td>
<td># with 0 decimal places</td>
<td></td>
</tr>
<tr>
<td>68.</td>
<td>TRIGVALUE</td>
<td>Triglyceride value (mg/dl)</td>
<td>Most recent in Audit period</td>
<td># with 0 decimal places</td>
<td></td>
</tr>
<tr>
<td>69.</td>
<td>CREATVALUE</td>
<td>Serum creatinine value (mg/dl)</td>
<td>Most recent in Audit period</td>
<td># with up to 2 decimal places</td>
<td></td>
</tr>
<tr>
<td>70.</td>
<td>EGFRVALUE</td>
<td>Estimated GFR (eGFR) value</td>
<td>Most recent in Audit period</td>
<td># with one decimal place</td>
<td>- Use documented value, if available.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- If no eGFR value is available, but serum creatinine value is, calculate as: eGFR (mL/min/1.73 m²) = 175 × (Scr)^-1.154 × (Age)^-0.203 × (0.742 if female)</td>
</tr>
<tr>
<td>71.</td>
<td>UPACRVAL</td>
<td>Quantitative urine albumin:creatinine ratio (UACR) value (mg/g)</td>
<td>Most recent in Audit period</td>
<td># with up to 2 decimal places</td>
<td></td>
</tr>
<tr>
<td>Order</td>
<td>Field Name</td>
<td>Description</td>
<td>Timeframe</td>
<td>Format/Values/Units</td>
<td>Comments</td>
</tr>
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<td>-----------</td>
<td>---------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>72.</td>
<td>LOCAL</td>
<td>Local question</td>
<td>N/A</td>
<td>#, single digit, 1-9</td>
<td>This field may be left blank for all patients if the facility does not choose to populate it.</td>
</tr>
<tr>
<td>73.</td>
<td>LOCALEXT</td>
<td>Extended local question</td>
<td>N/A</td>
<td>Character (max length=50)</td>
<td>This field may be left blank for all patients if the facility does not choose to populate it.</td>
</tr>
<tr>
<td>74.</td>
<td>AGE</td>
<td>Patient age in years at time of AUDITDATE</td>
<td>N/A</td>
<td># with maximum of 3 digits and no decimal places</td>
<td>Calculate as: integer part of difference in days between AUDITDATE and date of birth, divided by 365.25</td>
</tr>
</tbody>
</table>
Appendix C: Data Quality Error Report Error Definitions

<table>
<thead>
<tr>
<th>ERROR</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>REVIEWER INITIALS MISSING</td>
<td>Review initials are missing. IT staff should update the NEW PERSON entry and add initials for the reviewer.</td>
</tr>
<tr>
<td>MONTH OF BIRTH NOT VALID</td>
<td>Month of birth is invalid. Check this patient's DOB in patient registration.</td>
</tr>
<tr>
<td>YEAR OF BIRTH MISSING</td>
<td>Year of Birth is missing. Check this patient's DOB in patient registration.</td>
</tr>
<tr>
<td>GENDER NOT VALID</td>
<td>Gender of patient is missing or is invalid. Check this patient's gender in patient registration.</td>
</tr>
<tr>
<td>DATE OF DX BEFORE YOB</td>
<td>Date of Diabetes Diagnosis is before year of birth.</td>
</tr>
<tr>
<td>DATE OF DX &gt; AUDIT DATE</td>
<td>Date of Diabetes diagnosis is after the audit date.</td>
</tr>
<tr>
<td>DATE OF DX = AUDIT DATE</td>
<td>Date of Diabetes Diagnosis is equal to the audit date.</td>
</tr>
<tr>
<td>DIABETES TYPE MISSING</td>
<td>Diabetes Type is missing. Update the patient's DM register status.</td>
</tr>
<tr>
<td>DIABETES TYPE INVALID</td>
<td>Diabetes Type is invalid. Value must be 1 or 2. Update the patient's diabetes type in the diabetes register.</td>
</tr>
<tr>
<td>TOBACCO SCREEN IS MISSING</td>
<td>Tobacco Screen in past year is missing.</td>
</tr>
<tr>
<td>TOBACCO SCREEN IS INVALID</td>
<td>Tobacco Screen is invalid, must be 1 for Yes, 2 for No.</td>
</tr>
<tr>
<td>TOBACCO USE IS INVALID</td>
<td>Tobacco Use value is invalid, must be a 1, 2 or 3.</td>
</tr>
<tr>
<td>TOBACCO USE IS MISSING</td>
<td>Tobacco Use is missing.</td>
</tr>
<tr>
<td>TOBACCO COUNSEL INVALID</td>
<td>Tobacco Use is 1-Yes. Tobacco Counsel Must be 1 or 2; it cannot be blank.</td>
</tr>
<tr>
<td>TOBACCO COUNSEL INVALID</td>
<td>Tobacco Use Status is 2-No or 3-Undocumented. Tobacco Counsel should be blank.</td>
</tr>
<tr>
<td>ENDS SCREEN MISSING</td>
<td>ENDS Use Screen is missing.</td>
</tr>
<tr>
<td>ENDS USE STATUS MISSING</td>
<td>ENDS Use Status is missing.</td>
</tr>
<tr>
<td>HEIGHT IN FEET LOW FOR AGE &gt;18</td>
<td>Height in feet value is unusually low (less than 4). Check patient's last Height value.</td>
</tr>
<tr>
<td>HEIGHT IN FEET LOW FOR AGE &lt;19</td>
<td>Height in feet is unusually low for patient under 19 years old. Value is less than 2, check patient's last height value.</td>
</tr>
<tr>
<td>HEIGHT IN FEET HIGH AGE &lt;10</td>
<td>Height Value is high (greater than 5) for patient age under 10. Check the patient's last height value.</td>
</tr>
<tr>
<td>HEIGHT IN FEET HIGH FOR AGE &gt;9</td>
<td>Height is high (over 6) for patient under the age of 9. Check the patient's last height value.</td>
</tr>
<tr>
<td>HEIGHT INCHES IS &lt;0</td>
<td>Height in inches is blank or less than zero. Check patient's last height value.</td>
</tr>
<tr>
<td>HT INCHES &gt;12, FEET ENTERED</td>
<td>Height in feet is entered, inches cannot be greater than 12.</td>
</tr>
<tr>
<td>ERROR</td>
<td>DEFINITION</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>WEIGHT IS NOT A WHOLE NUMBER</td>
<td>Weight in lbs must be a whole number. No decimals.</td>
</tr>
<tr>
<td>WEIGHT LESS THAN 80, AGE &gt;17</td>
<td>Weight is less than 80 lbs and patient is over 17 years old. Check the patient's last weight value. If accurate, no action necessary.</td>
</tr>
<tr>
<td>HYPERTENSION DX NOT VALID</td>
<td>Hypertension diagnosed value is not a 1–Yes or a 2–No.</td>
</tr>
<tr>
<td>SYSTOLIC 1 VALUE &lt;50 OR &gt;250</td>
<td>Systolic 1 value is less than 50 or greater than 250. Check value and change if necessary.</td>
</tr>
<tr>
<td>SYSTOLIC 2 VALUE &lt;50 OR &gt;250</td>
<td>Systolic 2 value is less than 50 or greater than 250. Check value and change if necessary.</td>
</tr>
<tr>
<td>SYSTOLIC 3 VALUE &lt;50 OR &gt;250</td>
<td>Systolic 3 value is less than 50 or greater than 250. Check value and change if necessary.</td>
</tr>
<tr>
<td>DIASTOLIC 1 &lt;30 OR &gt;140</td>
<td>Diastolic 1 is less than 30 or greater than 140. Check value.</td>
</tr>
<tr>
<td>DIASTOLIC 2 &lt;30 OR &gt;140</td>
<td>Diastolic 2 is less than 30 or greater than 140. Check value.</td>
</tr>
<tr>
<td>DIASTOLIC 3 &lt;30 OR &gt;140</td>
<td>Diastolic 3 is less than 30 or greater than 140. Check value.</td>
</tr>
<tr>
<td>FOOT EXAM NOT VALID</td>
<td>Foot Exam value must be 1 or 2.</td>
</tr>
<tr>
<td>EYE EXAM NOT VALID</td>
<td>Eye Exam value must be 1 or 2.</td>
</tr>
<tr>
<td>DENTAL EXAM NOT VALID</td>
<td>Dental Exam value must be 1 or 2.</td>
</tr>
<tr>
<td>DEPRESSION ACTIVE DIAGNOSIS</td>
<td>Depression Active on the Problem List must be 1 or 2.</td>
</tr>
<tr>
<td>DEP SCREEN MUST BE BLANK</td>
<td>Depression Screen value must be blank if Depression on the Problem List is a 1–Yes.</td>
</tr>
<tr>
<td>DEP SCREEN BLANK/DEP DX = NO</td>
<td>Depression Screen must not be blank if Depression Dialysis field is 2–No.</td>
</tr>
<tr>
<td>DEPRESSION SCREEN NOT VALID</td>
<td>Depression Screen value not valid. Must be blank, 1, or 2.</td>
</tr>
<tr>
<td>DIET INSTRUCTION NOT VALID</td>
<td>Diet Instruction does not equal 1, 2, 3, or 4.</td>
</tr>
<tr>
<td>EXERCISE EDUCATION NOT VALID</td>
<td>Exercise Education value must be 1 or 2.</td>
</tr>
<tr>
<td>OTHER EDUCATION NOT VALID</td>
<td>Other Education value must be 1 or 2.</td>
</tr>
<tr>
<td>TX NONE IS INVALID</td>
<td>TX None must be 1 or 2.</td>
</tr>
<tr>
<td>TX INSULIN NOT VALID</td>
<td>TX insulin must be 1 or 2.</td>
</tr>
<tr>
<td>TX SULFONYLUREA INVALID</td>
<td>TX Sulfonylurea value must be 1 or 2.</td>
</tr>
<tr>
<td>TX SULFONYLUREA/DM TYPE 1</td>
<td>Value for this treatment inconsistent with DM Type 1; check medications and DM Type.</td>
</tr>
<tr>
<td>TX SUFONYLUREA LIKE INVALID</td>
<td>TX Sulfonylurea like therapy must be 1 or 2.</td>
</tr>
<tr>
<td>TX SUFONYLUREA LIKE/DM TYPE 1</td>
<td>Value for this treatment inconsistent with DM Type 1, check medications and DM Type.</td>
</tr>
<tr>
<td>TX METFORMIN INVALID</td>
<td>TX Metformin value must be 1 or 2.</td>
</tr>
<tr>
<td>ERROR</td>
<td>DEFINITION</td>
</tr>
<tr>
<td>------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>TX METFORMIN/DM TYPE 1</td>
<td>TX Metformin inconsistent with DM Type 1. Check medications and DM Type.</td>
</tr>
<tr>
<td>TX ACARBOSE INVALID</td>
<td>TX Acarbose must be 1 or 2.</td>
</tr>
<tr>
<td>TX ACARBOSE/DM TYPE 1</td>
<td>TX Acarbose inconsistent with DM Type 1. Check medications and DM Type.</td>
</tr>
<tr>
<td>TX GLITAZONE INVALID</td>
<td>TX Glitazone must be 1 or 2.</td>
</tr>
<tr>
<td>TX GLITAZONE/DM TYPE 1</td>
<td>TX Glitazone therapy value inconsistent with DM Type 1. Check the patient's medications and DM Type.</td>
</tr>
<tr>
<td>TX GLP-1 INVALID</td>
<td>TX GLP-1 value must be 1 or 2.</td>
</tr>
<tr>
<td>TX GLP-1/DM TYPE 1</td>
<td>TX GLP-1 inconsistent with DM Type 1. Check the patient's medications and DM Type.</td>
</tr>
<tr>
<td>TX DPP4 INVALID</td>
<td>TX DPP4 must be 1 or 2.</td>
</tr>
<tr>
<td>TX DPP4/DM TYPE 1</td>
<td>TX DPP4 inconsistent with DM Type 1. Check the patient's medications and DM Type.</td>
</tr>
<tr>
<td>TX AMYLIN INVALID</td>
<td>TX Amylin therapy inconsistent with DM Type 1.</td>
</tr>
<tr>
<td>TX BROMO INVALID</td>
<td>TX Bromocriptine must be 1 or 2.</td>
</tr>
<tr>
<td>TX BROMO/DM TYPE 1</td>
<td>Tx Bromocriptine therapy inconsistent with DM Type 1. Check the patient's medications and DM Type.</td>
</tr>
<tr>
<td>TX COLESEV INVALID</td>
<td>TX Colesevelam therapy inconsistent with DM Type 1. Check the patient's medications and DM Type.</td>
</tr>
<tr>
<td>TX SLGT2 INVALID</td>
<td>TX SLGT2 inhibitor therapy inconsistent with DM Type 1. Check the patient's medication and DM Type.</td>
</tr>
<tr>
<td>ACE INHIBITOR INVALID</td>
<td>ACE Inhibitor value must be 1 or 2.</td>
</tr>
<tr>
<td>ASPIRIN INVALID</td>
<td>Aspirin value must be 1 or 2.</td>
</tr>
<tr>
<td>CVD DX INVALID</td>
<td>CVD Dx value must be 1 or 2.</td>
</tr>
<tr>
<td>TB TEST DONE INVALID</td>
<td>TB Test Done must be 1, 2, or 3.</td>
</tr>
<tr>
<td>TB TEST RESULT INVALID</td>
<td>TB Test Result must be a 1–Positive, 2–Negative or 3–Unknown.</td>
</tr>
<tr>
<td>TB RESULT/TB TEST INCONSISTENT</td>
<td>TB Test Result must be blank if the TB Test Done value is 3-Unknown.</td>
</tr>
<tr>
<td>TB TX/TB TEST RESULT</td>
<td>If TB Test result is 1–Positive, TB Treatment must not be blank.</td>
</tr>
<tr>
<td>TB TX/TB TEST NEGATIVE</td>
<td>If TB Test Result is not 1–Positive, TB must be blank.</td>
</tr>
<tr>
<td>TB TX INVALID</td>
<td>TB Treatment must be a value of 1, 2, 3, or blank.</td>
</tr>
<tr>
<td>TB TEST DATE &lt; YOB</td>
<td>Date of TB Test is earlier than year of birth.</td>
</tr>
<tr>
<td>TB TEST DATE &gt; AUDIT DATE</td>
<td>Date of TB Test is after audit date.</td>
</tr>
<tr>
<td>TB TEST DATE/TB TEST RESULT</td>
<td>TB Test date should be blank if TB Test Result is 2–Negative.</td>
</tr>
<tr>
<td>TB TEST RESULT/TB TEST DATE</td>
<td>TB Test date should not be blank if TB Test Result is 2.</td>
</tr>
<tr>
<td>HEPATITIS C DX INVALID</td>
<td>Hepatitis C Diagnosis must be 1 or 2.</td>
</tr>
<tr>
<td>ERROR</td>
<td>DEFINITION</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>RETINOPATHY INVALID</td>
<td>Retinopathy Diagnosis must be 1 or 2.</td>
</tr>
<tr>
<td>FLU VACCINE INVALID</td>
<td>Flu vaccine value must be 1, 2, or 3.</td>
</tr>
<tr>
<td>PNEUMOVAX INVALID</td>
<td>Pneumovax Value must be 1, 2, or 3.</td>
</tr>
<tr>
<td>TD INVALID</td>
<td>TD value must be 1, 2, or 3.</td>
</tr>
<tr>
<td>TDAP INVALID</td>
<td>TDAP value must be 1, 2, or 3.</td>
</tr>
<tr>
<td>HEP B VACCINE INVALID</td>
<td>Hepatitis B Vaccine value must be 1, 2, 3 or 4.</td>
</tr>
<tr>
<td>HBAIC TEST RESULT &lt;4 OR &gt;18</td>
<td>HbA1c value is less than 4 or greater than 18; check value and if accurate no action necessary.</td>
</tr>
<tr>
<td>HBA1C DATE &gt; AUDIT DATE</td>
<td>Date of HbA1c is after the audit date.</td>
</tr>
<tr>
<td>HBA1C BEFORE AUDIT BEGIN DATE</td>
<td>HbA1c date is before audit begin date.</td>
</tr>
<tr>
<td>HBA1C DATE &gt; YOB</td>
<td>HbA1c date is before year of birth.</td>
</tr>
<tr>
<td>HBA1C DATE &lt;20 DAYS BEFORE DOO</td>
<td>HbA1c date is more than 20 days prior to the date of onset. Check both values; if they are accurate no action is necessary.</td>
</tr>
<tr>
<td>TOTAL CHOLESTEROL &lt;70 OR &gt;500</td>
<td>Total Cholesterol Value is less than 70 or greater than 500. Check the value; if accurate no action necessary.</td>
</tr>
<tr>
<td>HDL VALUE &lt;12 OR &gt;140</td>
<td>HDL Value is less than 12 or greater than 140. Check the value; if accurate no action necessary.</td>
</tr>
<tr>
<td>HDL &gt; TOTAL CHOLESTEROL</td>
<td>HDL value is greater than the Total Cholesterol value. Check both values; if accurate, no action necessary.</td>
</tr>
<tr>
<td>LDL VALUE &lt;10 OR &gt;300</td>
<td>LDL value is less than 10 or greater than 300. Check the value; if accurate, no action necessary.</td>
</tr>
<tr>
<td>LDL &gt; TOTAL CHOLESTEROL</td>
<td>LDL value is greater than the Total Cholesterol. Check both values; if accurate, no action necessary.</td>
</tr>
<tr>
<td>TRIGLYCERIDE &lt;25 OR &gt;4000</td>
<td>Triglyceride value is less than 25 or greater than 4000. Check the value; if accurate, no action necessary.</td>
</tr>
<tr>
<td>CREATININE VALUE &lt;0.3 OR &gt;15</td>
<td>Serum Creatinine value is less than .3 or greater than 15. Check the value; if accurate, no action necessary.</td>
</tr>
<tr>
<td>EGFR VALUE &lt;5 OR &gt;250</td>
<td>eGFR value is less than 5 or greater than 250. Check the value; if accurate, no action necessary.</td>
</tr>
<tr>
<td>UACR VALUE &gt; 20,000</td>
<td>Quantitative urine albumin creatinine value is greater than 20,000. Check the value; if accurate, no action necessary.</td>
</tr>
<tr>
<td>BMI &lt;16 OR &gt;80</td>
<td>BMI is less than 16 or greater than 80. Check values and if necessary correct HT/WT. If value is correct, no action is necessary.</td>
</tr>
<tr>
<td>DURATION OF DM</td>
<td>Duration of Diabetes is less than zero or greater than the patient's age.</td>
</tr>
<tr>
<td>ALL KEY DATA MISSING</td>
<td>Data is missing for all key fields: weight, blood pressure, A1c, LDL, UACR.</td>
</tr>
<tr>
<td>AGE OVER 100</td>
<td>Age of the patient is greater than 100. Check to be sure this patient should be included in the audit.</td>
</tr>
<tr>
<td>ERROR</td>
<td>DEFINITION</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>HEIGHT TOTAL &lt;48 AGE&gt;17</td>
<td>Age of patient is greater than 17 and total height is less than 48</td>
</tr>
<tr>
<td></td>
<td>inches. Check the DOB and height value.</td>
</tr>
<tr>
<td>HEIGHT TOTAL &lt;24 AGE&lt;18</td>
<td>Age of patient is less than 17 and total height in inches is less</td>
</tr>
<tr>
<td></td>
<td>than 24 inches. Check the DOB and height value.</td>
</tr>
<tr>
<td>HEIGHT TOTAL &gt;60 AGE &lt;10</td>
<td>Age of patient is less than 10 and height in total inches is greater</td>
</tr>
<tr>
<td></td>
<td>than 60. Check the DOB and height value.</td>
</tr>
<tr>
<td>HEIGHT TOTAL &gt;84 AGE &gt;9</td>
<td>Age of patient is greater than 9 and total height is greater than</td>
</tr>
<tr>
<td></td>
<td>84. Check the DOB and height value.</td>
</tr>
<tr>
<td>HEIGHT IN FEET MISSING</td>
<td>Height in feet is missing, inches is present. Check patient's last</td>
</tr>
<tr>
<td></td>
<td>height value.</td>
</tr>
<tr>
<td>AGE LESS THAN 1</td>
<td>Age is less than 1, check DOB and audit date.</td>
</tr>
</tbody>
</table>
Appendix D: Sample Audit Report

Figure D-1 displays a sample Cumulative Audit Report over several pages.

<table>
<thead>
<tr>
<th>LAB</th>
<th>Oct 24, 2019</th>
<th>Page 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>IHS Diabetes Care and Outcomes Audit - RPMS Audit</td>
<td>Audit Report for 2020 (Audit Period 01/01/2019 to 12/31/2019)</td>
<td></td>
</tr>
<tr>
<td>Facility: 2019 DEMO HOSPITAL (INST)</td>
<td>Annual Audit</td>
<td></td>
</tr>
<tr>
<td>28 patients were audited</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th># of Patients</th>
<th># Considered</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>(Numerator)</td>
<td>(Denominator)</td>
</tr>
<tr>
<td>Male</td>
<td>11</td>
<td>28</td>
</tr>
<tr>
<td>Female</td>
<td>17</td>
<td>28</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th># of Patients</th>
<th># Considered</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20 years</td>
<td>3</td>
<td>28</td>
<td>11%</td>
</tr>
<tr>
<td>20-44 years</td>
<td>9</td>
<td>28</td>
<td>32%</td>
</tr>
<tr>
<td>45-64 years</td>
<td>7</td>
<td>28</td>
<td>25%</td>
</tr>
<tr>
<td>&gt;=65 years</td>
<td>9</td>
<td>28</td>
<td>32%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diabetes Type</th>
<th># of Patients</th>
<th># Considered</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>Type 2</td>
<td>28</td>
<td>28</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duration of Diabetes</th>
<th># of Patients</th>
<th># Considered</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1 year</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>&lt;10 years</td>
<td>5</td>
<td>28</td>
<td>18%</td>
</tr>
<tr>
<td>&gt;=10 years</td>
<td>15</td>
<td>28</td>
<td>54%</td>
</tr>
<tr>
<td>Diagnosis date not recorded</td>
<td>8</td>
<td>28</td>
<td>29%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Body Mass Index (BMI) Category</th>
<th># of Patients</th>
<th># Considered</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal (BMI&lt;25.0)</td>
<td>1</td>
<td>28</td>
<td>4%</td>
</tr>
<tr>
<td>Overweight (BMI 25.0-29.9)</td>
<td>1</td>
<td>28</td>
<td>4%</td>
</tr>
<tr>
<td>Obese (BMI &gt;=30.0)</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>Height or weight missing</td>
<td>26</td>
<td>28</td>
<td>93%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Severe obesity (BMI &gt;=40.0)</th>
<th># of Patients</th>
<th># Considered</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not tested or no valid result</td>
<td>26</td>
<td>28</td>
<td>93%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Blood Sugar Control</th>
<th># of Patients</th>
<th># Considered</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1C &lt;7.0</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>A1C 7.0-7.9</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>A1C 8.0-8.9</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>A1C 9.0-9.9</td>
<td>1</td>
<td>28</td>
<td>4%</td>
</tr>
<tr>
<td>A1C 10.0-10.9</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>A1C &gt;=11.0</td>
<td>1</td>
<td>28</td>
<td>4%</td>
</tr>
</tbody>
</table>

| Not tested or no valid result | 26 | 28 | 93% |

| A1C <8.0 | 0 | 28 | 0% |
| A1C >9.0 | 2 | 28 | 7% |

LAB | Oct 24, 2019 | Page 2 |
## Blood Pressure (BP) - Based on one value or mean of two or three values

<table>
<thead>
<tr>
<th>Blood Pressure Range</th>
<th># of Patients (Numerator)</th>
<th># of Considered Patients (Denominator)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;140/&lt;90</td>
<td>2</td>
<td>28</td>
<td>7%</td>
</tr>
<tr>
<td>140/90 - &lt;160/&lt;100</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>160/100 or higher</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>BP category undetermined</td>
<td>26</td>
<td>28</td>
<td>93%</td>
</tr>
</tbody>
</table>

If age >=60 years, <150/<90

### Hypertension

- Diagnosed ever: 19 (68%)
- Diagnosed hypertension and mean BP <140/<90: 1 (5%)
- Diagnosed hypertension and ACE inhibitor or ARB prescribed: 1 (5%)

### Tobacco and Nicotine Use

- Tobacco use screening during Audit period:
  - Screened: 3 (11%)
  - Not screened: 25 (89%)

- Tobacco use status:
  - Current tobacco user: 15 (54%)
    - In current users, cessation counseling/education received:
      - Yes: 2 (13%)
      - No: 13 (87%)
  - Not a current tobacco user: 9 (32%)
  - Tobacco use not documented: 4 (14%)

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

- Screened: 3 (11%)
- Not screened: 25 (89%)

- ENDS use status:
  - Current ENDS user: 3 (11%)
  - Not a current ENDS user: 9 (32%)
  - ENDS use not documented: 16 (57%)

- Current user of both tobacco and ENDS: 1 (4%)
- Current user of tobacco and/or ENDS: 17 (61%)
## Patients Considered (Numerator) (Denominator)

### Diabetes Treatment

#### Number of diabetes meds currently prescribed

<table>
<thead>
<tr>
<th>Type of Treatment</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>27</td>
<td>28</td>
<td>96%</td>
</tr>
<tr>
<td>One medication</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>Two medications</td>
<td>1</td>
<td>28</td>
<td>4%</td>
</tr>
<tr>
<td>Three medications</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>Four or more medications</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Treatment Type</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>Metformin [Glucophage, others]</td>
<td>1</td>
<td>28</td>
<td>4%</td>
</tr>
<tr>
<td>Sulfonylurea [glipizide, glyburide, others]</td>
<td>1</td>
<td>28</td>
<td>4%</td>
</tr>
<tr>
<td>DPP4 inhibitor [Alogliptin (Nesina), Linagliptin (Tradjenta), Saxagliptin (Onglyza), Sitagliptin (Januvia)]</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>GLP-1 agonist [Dulaglutide (Trulicity), Exenatide (Byetta, Bydureon), Liraglutide (Victoza), Semaglutide (Ozempic)]</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>SGLT-2 inhibitor [Canagliflozin, (Invokana), Dapagliflozin (Farxiga), Empagliflozin (Jardiance), Ertugliflozin (Steglatro)]</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>Pioglitazone [Actos] or rosiglitazone [Avandia]</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>Acarbose [Precose] or miglitol [Glyset]</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>Repaglinide [Prandin] or Nateglinide [Starlix]</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>Amylin analog [Symlin]</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>Bromocriptine [Cycloset]</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>Colesevelam [Welchol]</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>Statin Prescribed</td>
<td># of Patients</td>
<td>Considered (Numerator)</td>
<td>Percent</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------</td>
<td>------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Yes*</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>Allergy, intolerance, or contraindication</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>In patients with diagnosed CVD</td>
<td>0</td>
<td>13</td>
<td>0%</td>
</tr>
<tr>
<td>Yes*</td>
<td>0</td>
<td>13</td>
<td>0%</td>
</tr>
<tr>
<td>Allergy, intolerance, or contraindication</td>
<td>0</td>
<td>13</td>
<td>0%</td>
</tr>
<tr>
<td>In patients age 40-75 years</td>
<td>0</td>
<td>13</td>
<td>0%</td>
</tr>
<tr>
<td>Yes*</td>
<td>0</td>
<td>13</td>
<td>0%</td>
</tr>
<tr>
<td>Allergy, intolerance, or contraindication</td>
<td>0</td>
<td>13</td>
<td>0%</td>
</tr>
<tr>
<td>In patients with diagnosed CVD and/or age 40-75 years</td>
<td>0</td>
<td>19</td>
<td>0%</td>
</tr>
<tr>
<td>Yes*</td>
<td>0</td>
<td>19</td>
<td>0%</td>
</tr>
<tr>
<td>Allergy, intolerance, or contraindication</td>
<td>0</td>
<td>19</td>
<td>0%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Cardiovascular Disease (CVD)</th>
<th># of Patients</th>
<th>Considered (Numerator)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVD diagnosed ever</td>
<td>13</td>
<td>28</td>
<td>46%</td>
</tr>
<tr>
<td>CVD and mean BP &lt;140/&lt;90</td>
<td>0</td>
<td>13</td>
<td>0%</td>
</tr>
<tr>
<td>CVD and not current tobacco user</td>
<td>6</td>
<td>13</td>
<td>46%</td>
</tr>
<tr>
<td>CVD and aspirin or other antiplatelet/anticoagulant therapy prescribed</td>
<td>0</td>
<td>13</td>
<td>0%</td>
</tr>
<tr>
<td>CVD and statin prescribed*</td>
<td>0</td>
<td>13</td>
<td>0%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Retinopathy</th>
<th># of Patients</th>
<th>Considered (Numerator)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosed ever</td>
<td>4</td>
<td>28</td>
<td>14%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lower Extremity Amputation</th>
<th># of Patients</th>
<th>Considered (Numerator)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any type ever (e.g., toe, partial foot, above or below knee)</td>
<td>8</td>
<td>28</td>
<td>29%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exams</th>
<th># of Patients</th>
<th>Considered (Numerator)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foot exam - comprehensive</td>
<td>3</td>
<td>28</td>
<td>11%</td>
</tr>
<tr>
<td>Eye exam - dilated or retinal imaging</td>
<td>3</td>
<td>28</td>
<td>11%</td>
</tr>
<tr>
<td>Dental exam</td>
<td>1</td>
<td>28</td>
<td>4%</td>
</tr>
</tbody>
</table>

LAB Oct 24, 2019

IHS Diabetes Care and Outcomes Audit - RPMS Audit Audit Report for 2020 (Audit Period 01/01/2019 to 12/31/2019) Facility: 2019 DEMO HOSPTAL (INST) Annual Audit 28 patients were audited

<table>
<thead>
<tr>
<th>Diabetes-Related Education</th>
<th># of Patients</th>
<th>Considered (Numerator)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition - by any provider (RD and/or other)</td>
<td>2</td>
<td>28</td>
<td>7%</td>
</tr>
<tr>
<td>Nutrition - by RD</td>
<td>0</td>
<td>28</td>
<td>0%</td>
</tr>
<tr>
<td>Physical activity</td>
<td>2</td>
<td>28</td>
<td>7%</td>
</tr>
<tr>
<td>Other diabetes education</td>
<td>1</td>
<td>28</td>
<td>4%</td>
</tr>
</tbody>
</table>
Any of above                                      2          28         7%

Immunizations
Influenza vaccine during Audit period            3          28        11%
    Refused - Influenza vaccine                   0          28         0%
Pneumococcal vaccine - ever                     21         28        75%
    Refused - Pneumococcal                       1          28         4%
Td/Tdap/DTap/DT - past 10 years                  17         28        61%
    Refused - Td/Tdap/DTap/DT                    0          28         0%
Tdap - ever                                     20         28        71%
    Refused - Tdap                              0          28         0%
Hepatitis B complete series - ever               21         27        78%
    Refused - Hepatitis B                      0          27         0%
    Immune - Hepatitis B                       1          28         4%

Depression
Active problem/diagnosis
Yes                                            4          28        14%
No                                             24         28        86%

In patients without active depression, screened for depression during Audit period:
Screened                                        1          24         4%
Not screened                                    23         24        96%

Lipid Evaluation – Note these results are presented as population level CVD risk markers and should not be considered treatment targets for individual patients.
| Trig 150-499 mg/dl | 0  | 28  | 0% |
| Trig 500-999 mg/dl | 0  | 28  | 0% |
| Trig >=1000 mg/dl  | 0  | 28  | 0% |
| Not tested or no valid result | 27  | 28  | 96% |

**Kidney Evaluation**

| eGFR to assess kidney function (In age >=18 years) | 0  | 27  | 0% |
| eGFR >=60 ml/min | 0  | 27  | 0% |
| eGFR 30-59 ml/min | 0  | 27  | 0% |
| eGFR 15-29 ml/min | 0  | 27  | 0% |
| eGFR < 15 ml/min | 0  | 27  | 0% |
| eGFR Not tested or no valid result | 27  | 27  | 100% |

**Urine Albumin:Creatinine Ratio (UACR)**

| Urine Albumin:Creatinine Ratio (UACR) to assess kidney damage | 1  | 28  | 4% |
| Urine albumin excretion - normal: <30 mg/g | 0  | 1  | 0% |
| Urine albumin excretion increased: | 30-300 mg/g | 0  | 1  | 0% |
| >300 mg/g | 1  | 1  | 100% |
| Not tested or no valid result | 27  | 28  | 96% |

**In patients age >=18 years, eGFR and UACR**

| Urine Albumin:Creatinine Ratio (UACR) to assess kidney damage | 0  | 27  | 0% |

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

| Chronic Kidney Disease (CKD) (In age >=18 years) | 1  | 27  | 4% |
| CKD [2] | 1  | 1  | 100% |
| CKD [2] and mean BP <140/<90 | 1  | 1  | 100% |
| CKD [2] and ACE Inhibitor or ARB prescribed | 1  | 1  | 100% |

**CKD Stage**

| Normal: eGFR >=60 ml/min and UACR <30 mg/g | 0  | 27  | 0% |
| Stages 1 and 2: eGFR >=60 ml/min and UACR >=30 mg/g | 0  | 27  | 0% |
| Stage 3: eGFR 30-59 ml/min | 0  | 27  | 0% |
| Stage 4: eGFR 15-29 ml/min | 0  | 27  | 0% |
| Stage 5: eGFR <15 ml/min | 0  | 27  | 0% |
| Undetermined | 27  | 27  | 100% |

**Tuberculosis (TB) Status**

| Tuberculosis (TB) Status | 21  | 28  | 75% |
| TB Test done ever (skin or blood) | 18  | 21  | 86% |
| If test done, skin test | 3  | 21  | 14% |
| If test done, blood test | 5  | 21  | 24% |
| If positive TB test, treatment completed | 0  | 5  | 0% |
| If negative TB test, test done after diabetes diagnosis | 10  | 16  | 63% |
Diabetes Related Conditions (In age >=18 years)

<table>
<thead>
<tr>
<th>Condition</th>
<th># of Patients</th>
<th># Considered</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe obesity (BMI &gt;=40)</td>
<td>0</td>
<td>27</td>
<td>0%</td>
</tr>
<tr>
<td>Hypertension diagnosed ever</td>
<td>18</td>
<td>27</td>
<td>67%</td>
</tr>
<tr>
<td>Current tobacco user</td>
<td>14</td>
<td>27</td>
<td>52%</td>
</tr>
<tr>
<td>CVD diagnosed ever</td>
<td>13</td>
<td>27</td>
<td>48%</td>
</tr>
<tr>
<td>Retinopathy diagnosed ever</td>
<td>4</td>
<td>27</td>
<td>15%</td>
</tr>
<tr>
<td>Lower extremity amputation ever (any type)</td>
<td>7</td>
<td>27</td>
<td>26%</td>
</tr>
<tr>
<td>Active Depression</td>
<td>4</td>
<td>27</td>
<td>15%</td>
</tr>
<tr>
<td>CKD stage 3-5</td>
<td>0</td>
<td>27</td>
<td>0%</td>
</tr>
</tbody>
</table>

Footnotes

[1] For triglycerides: >150 is a marker of CVD risk, not a treatment target; >1000 is a risk marker for pancreatitis.

[2] Chronic Kidney Disease (CKD): eGFR <60 or UACR >=30
<table>
<thead>
<tr>
<th>Abbreviations</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1C = hemoglobin A1c (HbA1c)</td>
</tr>
<tr>
<td>ACE inhibitor = angiotensin converting enzyme inhibitor</td>
</tr>
<tr>
<td>ARB = angiotensin receptor blocker</td>
</tr>
<tr>
<td>BMI = body mass index</td>
</tr>
<tr>
<td>BP = blood pressure</td>
</tr>
<tr>
<td>DT = diphtheria and tetanus</td>
</tr>
<tr>
<td>DTaP = diphtheria, tetanus, and pertussis</td>
</tr>
<tr>
<td>CKD = chronic kidney disease</td>
</tr>
<tr>
<td>CVD = cardiovascular disease</td>
</tr>
<tr>
<td>eGFR = estimated glomerular filtration rate</td>
</tr>
<tr>
<td>ENDS = electronic nicotine delivery systems</td>
</tr>
<tr>
<td>HCV = hepatitis C virus</td>
</tr>
<tr>
<td>HDL = high-density lipoprotein</td>
</tr>
<tr>
<td>LDL = low-density lipoprotein</td>
</tr>
<tr>
<td>RD = registered dietitian</td>
</tr>
<tr>
<td>TB = tuberculosis</td>
</tr>
<tr>
<td>Td = tetanus and diphtheria</td>
</tr>
<tr>
<td>Tdap = tetanus, diphtheria, and pertussis</td>
</tr>
<tr>
<td>Trig = triglycerides</td>
</tr>
<tr>
<td>UACR = urine albumin-to-creatinine</td>
</tr>
</tbody>
</table>

Figure D-1: Sample 2020 Cumulative Audit Report
## Acronym List

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASUFAC</td>
<td>Area, Service Unit, and Facility</td>
</tr>
<tr>
<td>BDM</td>
<td>Namespace for the Diabetes Management System</td>
</tr>
<tr>
<td>BGP</td>
<td>Namespace for the Clinical Reporting System</td>
</tr>
<tr>
<td>CKD</td>
<td>Chronic Kidney Disease</td>
</tr>
<tr>
<td>CRS</td>
<td>Clinical Reporting System</td>
</tr>
<tr>
<td>CPT</td>
<td>Current Procedural Terminology</td>
</tr>
<tr>
<td>CVD</td>
<td>Cardiovascular Disease</td>
</tr>
<tr>
<td>DAL</td>
<td>Display Audit Logic</td>
</tr>
<tr>
<td>DM</td>
<td>Diabetes Mellitus</td>
</tr>
<tr>
<td>DMS</td>
<td>Diabetes Management System</td>
</tr>
<tr>
<td>DMU</td>
<td>Update Diabetes Patient Data</td>
</tr>
<tr>
<td>DOB</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>DPCS</td>
<td>Diabetes Patient Care Summary</td>
</tr>
<tr>
<td>eGFR</td>
<td>Estimated Glomerular Filtration Rate</td>
</tr>
<tr>
<td>EHR</td>
<td>Electronic Health Record</td>
</tr>
<tr>
<td>ENDS</td>
<td>Electronic Nicotine Delivery System</td>
</tr>
<tr>
<td>GDM</td>
<td>Gestational Diabetes Mellitus</td>
</tr>
<tr>
<td>GEN</td>
<td>General Retrieval Report</td>
</tr>
<tr>
<td>GPRA</td>
<td>Government Performance and Results Act</td>
</tr>
<tr>
<td>HDL</td>
<td>High-Density Lipoproteins</td>
</tr>
<tr>
<td>HTN</td>
<td>Hypertension</td>
</tr>
<tr>
<td>ICD</td>
<td>International Classification of Disease</td>
</tr>
<tr>
<td>IFG</td>
<td>Impaired Fasting Glucose</td>
</tr>
<tr>
<td>IGT</td>
<td>Impaired Glucose Tolerance</td>
</tr>
<tr>
<td>IHS</td>
<td>Indian Health Service</td>
</tr>
<tr>
<td>IT</td>
<td>Information Technology</td>
</tr>
<tr>
<td>LDL</td>
<td>Low-Density Lipoproteins</td>
</tr>
<tr>
<td>LMR</td>
<td>Lists, Labs, or Medications used at this Facility</td>
</tr>
<tr>
<td>LOINC</td>
<td>Logical Observation Identifiers Names and Codes</td>
</tr>
<tr>
<td>NDC</td>
<td>National Drug Code</td>
</tr>
<tr>
<td>PCC</td>
<td>Patient Care Component</td>
</tr>
<tr>
<td>POC</td>
<td>Point of Care</td>
</tr>
<tr>
<td>RML</td>
<td>Master List Report</td>
</tr>
<tr>
<td>Acronym</td>
<td>Meaning</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>RPMS</td>
<td>Resource and Patient Management System</td>
</tr>
<tr>
<td>SDPI</td>
<td>Special Diabetes Program for Indians</td>
</tr>
<tr>
<td>SNOMED</td>
<td>Systematized Nomenclature of Medicine</td>
</tr>
<tr>
<td>UACR</td>
<td>Urine Albumin/Creatinine Ratio</td>
</tr>
</tbody>
</table>
Contact Information

If you have any questions or comments regarding this distribution, please contact the IHS IT Service Desk.

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Web: https://www.ihs.gov/itsupport/
Email: itsupport@ihs.gov