



RESOURCE AND PATIENT MANAGEMENT SYSTEM

Diabetes Management System

(BDM)

User Manual

Version 2.0 Patch 19
February 2026

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Preface

This manual has been developed for physicians, mid-level practitioners, nurses, pharmacy clinicians, case managers, and diabetes coordinators responsible for the care of American Indian and Alaska Native (AI/AN) people with diabetes. It provides instructions for:

- The setup and maintenance of the Resource and Patient Management System (RPMS) Diabetes Management System, including:
 - Taxonomies for Medications, Lab Tests, Health Factors, and Education Topics.
 - Identifying patients with a diagnosis of diabetes for local registers.
 - Identifying those health care providers who will be allowed to use the system for monitoring patients with diabetes.
- Setting up automatic notification for patients newly diagnosed with diabetes or diabetes complications.
- Conducting an electronic Diabetes Audit.
- Evaluating the care of patients with prediabetes.
- Generating a variety of reports for patient and program management.

1.0 Introduction

Within American Indian and Alaska Native populations, diabetes exacts a great toll in both morbidity and mortality. The **Diabetes Management System (DMS)** of the IHS Resource and Patient Management System (RPMS) provides a unique capability for improving the care and management of patients with this significant health problem.

The Diabetes Management System is continually reviewed and updated to reflect current standards of care for patients with diabetes. The Diabetes Management System is designed to provide the capability to monitor the overall effectiveness of diabetes care and education using an automated audit system and as a supplement to the Case Management System and Patient Care Component (PCC) Management Reports.

Long-standing features of the Diabetes Management System include:

- A Diabetes Register using the PCC Case Management System.
- Standard nomenclature for documenting diabetes exams and education in the Electronic Health Record (EHR) or on PCC forms.
- Tools for conducting Diabetes Audits, including reports for an individual patient, a search template of patients, the entire IHS Diabetes Register at a facility, or a random sample of patients from the Register.
- Case Management System report options.
- E-mail bulletins identifying newly diagnosed diabetes patients or those with new complications.

In addition, the system provides for:

- Automatic installation of the IHS Diabetes Register if it has not already been installed at a site.
- Simplified population of taxonomies for medications, laboratory tests, education topics, and health factors required by the Diabetes Management System.
- A Diabetes Patient Care Summary.
- Entry of a Register as the Subject for QMan searches.
- A menu of follow-up reports for identifying patients with unmet standards of care measures.
- Management and tracking of patients with prediabetes.
- Installation of the IHS Prediabetes Register is available.
- Prediabetes Registry report tools that include reports for an individual patient, a search template of patients, or the entire register of patients.

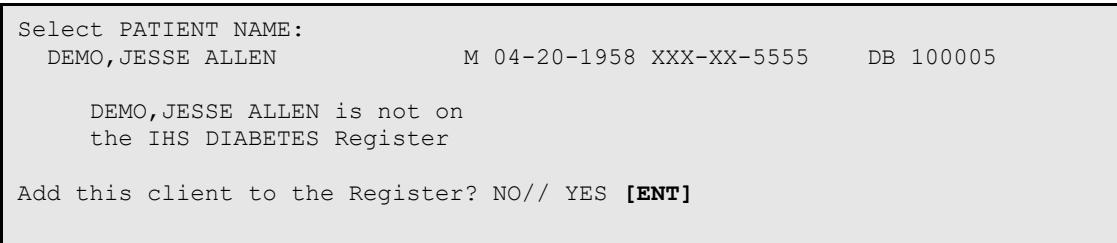
- Prediabetes Patient Care Summary

2.0 System Navigation

Throughout this manual, sample computer dialogues are included to illustrate the performance of various steps. Within these dialogues, computer-generated text appears in gray-shaded boxes. User responses in the dialog appear in bold type.

Note: This manual does not contain any real patient data. All patient-related information in computer-generated text, tables, figures, and images throughout this manual contain demo data only.

You will be required to press the Enter key to accept the default values and enter data. Within the sample computer dialogues that appear in this manual, the Enter key will be indicated as [ENT] (Figure 2-1).



Select PATIENT NAME:
DEMO, JESSE ALLEN M 04-20-1958 XXX-XX-5555 DB 100005

DEMO, JESSE ALLEN is not on
the IHS DIABETES Register

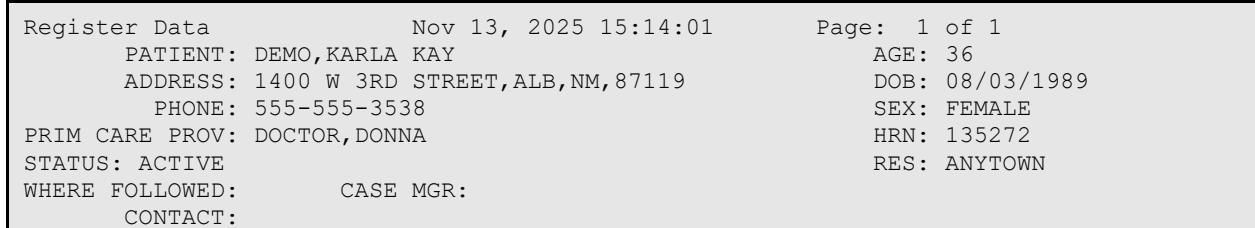
Add this client to the Register? NO// YES [ENT]

Figure 2-1: Enter Key indicated as [ENT]

List Manager (ListMan)

This version of the Diabetes Management System uses a screen display called **List Manager** screen to display options for review and entry of data. Data displays in a window-type screen. Menu options for editing, displaying, or reviewing the data display at the bottom of the window. You cannot use the mouse for pointing and clicking to select a menu option. Additional menu options for displaying, printing, or reviewing data can be viewed by typing two question marks (??) at the “Select Option” prompt. Entering the symbol or letter mnemonic for an action at the Select Action prompt will result in the indicated action.

Note: In the example ListMan (Figure 2-2), two question marks (??) have been typed at the “Select Action” prompt to display the list of secondary options available to the user.



Register Data Nov 13, 2025 15:14:01 Page: 1 of 1
PATIENT: DEMO, KARLA KAY AGE: 36
ADDRESS: 1400 W 3RD STREET, ALB, NM, 87119 DOB: 08/03/1989
PHONE: 555-555-3538 SEX: FEMALE
PRIM CARE PROV: DOCTOR, DONNA HRN: 135272
STATUS: ACTIVE RES: ANYTOWN
WHERE FOLLOWED: CASE MGR:
CONTACT:

ENTRY DATE: NOV 13, 2022	LAST EDITED:
DIAGNOSIS: TYPE 2	
COMMENTS:	
LOCAL OPTION:	
LOCAL OPTION TEXT:	
- Previous Screen QU Quit ?? for More Actions 1 Register Status 7 Local Option Entry 13 Print Letter 2 Where Followed 8 Last Visit 14 PREDM Care Summary (PPCS) 3 Case Manager 9 Review Appointments 15 PREDM Assessment of Care (PDMC) 4 Client Contact 10 DM Audit Status Q Quit 5 DX/Date of Onset 11 Health Summary 6 Comments 12 DM Care Summary (DPCS) Select Action: Quit//??	
The following actions are also available: + Next Screen < Shift View to Left PS Print Screen - Previous Screen FS First Screen PL Print List UP Up a Line LS Last Screen SL Search List DN Down a Line GO Go to Page ADPL Auto Display(On/Off) > Shift View to Right RD Re Display Screen Q Quit	
Enter RETURN to continue or '^' to exit:	

Figure 2-2: Sample ListMan screen

Table 2-1: Menu Options

Menu Option	Description
+	In a display that fills more than one page, typing a plus sign (+) at Select Action displays the next full screen
-	If you reviewed several screens in a display, return to the previous screen(s) by typing a hyphen (-) at Select Action .
↑	Press the up-arrow key at Select Action to move back one line at a time.
↓	Press the down-arrow key at Select Action to move forward one line at a time.
→	Press the right-arrow key at Select Action to move the screen display to the right.
←	Press the left-arrow key at Select Action to move to the left.
FS	In a multi-page display type FS at Select Action to return to the First Screen of the display.
LS	In a multi-page display, type LS at Select Action to go to the Last Screen in the display.
GO	If you know which page of a multi-screen display you want to review, type GO at Select Action to go directly to that screen.
RD	Type RD at Select Action to redisplay the screen.
PS	Type PS to print what is currently displayed on the screen to a selected device.
PL	Type PL to print an entire single or multi-screen display (called a List) to a selected device.

Menu Option	Description
SL	Typing SL prompts you to enter a word that you want to search for in the List. Type the word to search for and press Enter to display any entries containing that word. For example, if you were many pages into a patient's face sheet and wanted to know the patient's age, you can type SL, AGE , and press Enter to return to the age entry.
ADPL	Auto display (On/Off) —Selecting this option allows the user to either display or hide the list of menu options at the bottom of the screen.
QU	Entering QU at Select Action closes the screen and returns you to the menu.

Note: All other RPMS conventions are applicable.

For certain types of data fields, primarily those that utilize lists of possible entries—such as facilities, diagnoses, communities, or patients—press the space bar, Enter, to insert the last entry used for that field.

Use the caret (^) to exit from a particular activity or data entry sequence. Typing the caret (^) at any prompt will return you to the proceeding prompt or menu level. Use the caret also to exit from long data displays such as vendor lists that involve many screens.

Any time a possible answer is followed by double forward slashes (//), pressing the Enter key will default to the entry (Figure 2-3) displayed. If an alternative response is desired, it must be typed after the double slashes (//).

```
Enter new result? Y// [ENT]
New Result: 153
Enter new result? Y// N [ENT]
Enter new patient? Y//
```

Figure 2-3: Accepting a default entry

Typing one, two, or three question marks (?, ??, or ???) will display Help options at any data point entry caption.

Typing three question marks (???) at the prompt for selecting a menu option will display a brief summary of each of the options in that menu.

2.1 System Requirements

Consult v2.0 p19 installation notes file for RPMS system requirements and Visual DMS special requirements.

2.2 Security Keys

System users will require the following Security Keys:

Diabetes Management System

- BDMZMENU—This key allows access to the main **Diabetes Management System** menu.
- BDMZ REGISTER MAINTENANCE—This key allows access to the **Register Maintenance** menu option which includes Patient Management and Register reports.

Case Management System

- ACMZMENU—This key allows access to the **Case Management System** main menu.

PCC Management Reports

- APCLZMENU—This key allows access to the **PCC Management Reports** main menu.

QMan

- AMQQZMENU—This key allows access to **QMAN**.
- AMQQZCLIN—This key allows access to clinical data in **QMAN**.

Health Summary (Generate Multiple Health Summaries)

- APCHSMGR—This key allows the user to create health summary types. This is only necessary if the user wants to create a summary type that differs from the DIABETES STANDARD type.

Automatic notification of the case manager or diabetes coordinator of all newly diagnosed cases of diabetes enhances effective use of the Diabetes Management System. VA FileMan can be used for setting up the Diabetes Mail group and identifying members of the mail group who should receive the bulletins. A brief overview of setting up notification bulletins for patients newly diagnosed with diabetes, or diabetes complications, is provided in Appendix A.

3.0 The IHS Diabetes Registers

The standard **IHS Diabetes Register** is a tool for maintaining a list of your patients with diabetes, their disease type, complications, family members, and case review dates. The register facilitates the addition, inactivation, and removal of patients from the list; entry of data to be monitored for patients on the list; printing of case summaries; generation of reports; and retrieval of virtually all clinical data entered into the PCC for patients on the list.

The Standard **IHS Diabetes Register** is installed automatically with installation of the Diabetes Management System (BDM v1.0) if not already present. Because this is v2.0 p19, all updates through p19 must be installed. It provides a core set of data items with predefined lists and standard definitions. It also permits you to establish your own lists and definitions in support of these data items. The **IHS Diabetes Register** helps simplify the process of creating a Case Management-based register, but you are in no way limited to this core set of data items and the lists that accompany them. Remember that you always have access to all existing PCC demographic and clinical data without keeping these items in the Diabetes Register.

You may want to create additional registers. Using the **Create Register** option in the **Case Management System**, you may create new registers or change the name of the existing register, perhaps to maintain multiple registers for communities or facilities within a single service unit. However, in order for the Diabetes Management System to work with a register, the word Diabetes must be in the name of the register. If you change the name of an existing register, you will be asked if you want to re-index files. You must answer **Yes**.

Note: Additional security keys may be needed to create registers.

The following data items (Table 3-1) are automatically included in the **IHS Diabetes Register**:

Table 3-1: IHS Diabetes Register data items

IHS Diabetes Register Data Items
Register Status
Where Followed
Case Manager
Contact (patient contact)
Diagnosis
Comments
Local Option
Local Option Text

Upon installation of the **Diabetes Management System**, the **Case Management System** is no longer required for entry of the diabetes-related data items in the list above. However, if you elect to maintain data elements that are not contained in the list above, you must enter those data elements using the data entry option in the **Case Management System** (Figure 3-1).

The following diagnoses are available when the register is established. The register manager can modify these to add other diagnoses, if desired. This can be done using the Case Management System's options for creating and/or modifying a register.

NO.	DIAG
1	GESTATIONAL DM
2	IMPAIRED GLUCOSE TOLERANCE
3	TYPE 1
4	TYPE 2

Which DIAGNOSIS(S) : (1-4) :

Figure 3-1: IHS Diabetes Register Diagnosis Information

3.1 IHS Prediabetes Register

The **IHS Prediabetes Register** is a tool for maintaining a list of patients with prediabetes. This register is designed to be used in the **Diabetes Management System (DMS)** under **Register Maintenance (RM)**. A **Prediabetes Menu** was added to the **DMS** in v2.0 p17.

See Appendix E for information on the Prediabetes Menu items including:

- Installation of the Prediabetes Register
- Prediabetes Patient Care Summary
- Assessment of Prediabetes Care (individual report)
- Prediabetes Health Care Status (cumulative report)
- Specific Prediabetes taxonomies for reports

4.0 Package Operation

The **Register Maintenance** option of the main menu is used for customizing the **Diabetes Management System** to meet the needs of your program. Before you begin using the **Diabetes Register**, you must define members of the Diabetes Team who will be using the Register, identify the patients who will be included in the Register, run various reports such as a Master List.

Each of the options within the **Register Maintenance** menu will be described in this section and examples will be given on how to use the option.

- To select the **Register Maintenance** menu, type **RM** at the “Select Diabetes Management System Option” prompt (Figure 4-1).

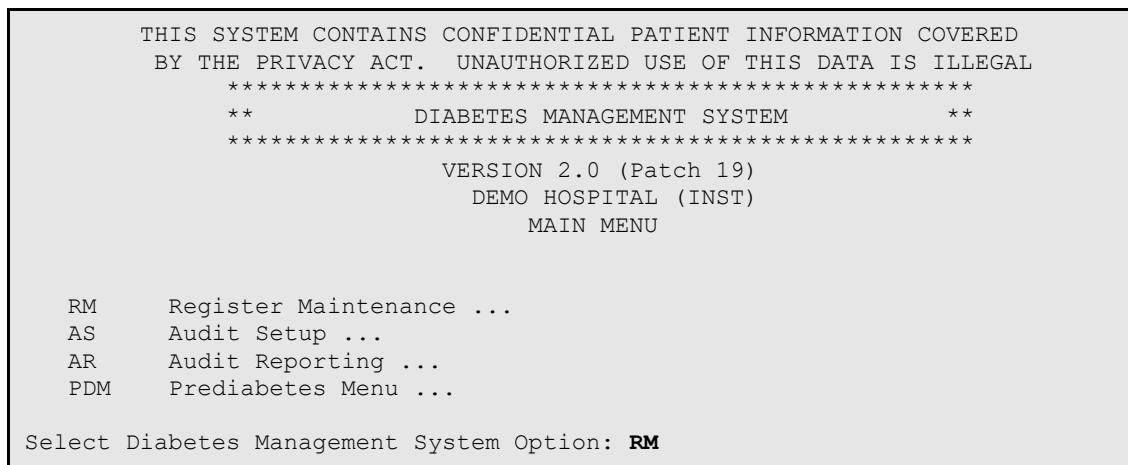


Figure 4-1: Selecting the RM option

4.1 User Setup (US)

User Setup allows you to identify those members of the Diabetes Team who will be allowed access to the Register. For security reasons, only users with Manager Authority (having the BDMZ REGISTER MAINTENANCE key) can add other authorized users. A sample dialog for adding authorized users (Figure 4-2) is provided.

Adding a New Authorized User to a Diabetes Register

```

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 19)
DEMO HOSPITAL (INST)
REGISTER MAINTENANCE

RM      Register Management ...
PM      Patient Management
CGM     Enter/Edit Continuous Glucose Monitoring Data
DMU     Update Diabetes Patient Data
AP      Add Patients from Template
DEL     Delete Patient from the Register
LM      Letter Management ...
RR      Register Reports ...
DPCS    Display a Patient's DIABETES CARE SUMMARY
Select Register Maintenance Option: RM

```

Figure 4-2: Navigating to User Setup

1. Type **US** at the “Select Register Maintenance Option” prompt from the **Register Management** menu (Figure 4-3).
2. Select the register to which you would like to add or remove an authorized user from.
3. Type **1 (Add/Remove DMS Authorized Users)** at the “Which one” prompt.
4. Type the user’s name at the “Select NEW User” prompt. If the system detects that the person is not currently an authorized user, it adds them immediately.
5. This process can be repeated until all authorized users of the Register have been added.

```

**          DIABETES MANAGEMENT SYSTEM          **
*****
VERSION 2.0 (Patch 19)
DEMO HOSPITAL
REGISTER MANAGEMENT

US      User Setup
FS      Flow Sheet Setup

Select DIABETES Register
No. Register Name          # Active # members  Last patient update
                           members

-----  -----
1  DEMO DIABETES REGISTER   535      539      11/09/2025
2  2020 KDS DIABETES REGISTER   13      13      10/26/2025
3  IHS DIABETES             553      556      09/11/2025
4  DEMO DIABETES REGISTER   29      29      10/05/2025

```

Which REGISTER: (1-7) :
REGISTER: IHS DIABETES
Select one of the following:
1 Add Authorized User to the IHS DIABETES register
2 List Current Authorized Users
3 Remove an Authorized User from the register
Which one: 1
Select NEW User: DEMO,CHRIS CD
DEMO,CHRIS is now an Authorized User of the IHS DIABETES register.

Figure 4-3: Adding a new user to DMS

Listing Current Authorized Users of a Diabetes register

1. Type **US** at the “Select Register Maintenance Option” prompt from the **Register Maintenance** menu.
2. Select the register to which you would like to add or remove an authorized user from.
3. Type **2** (List Current Authorized Users) at the “Which one” prompt.

The system will display a list of current **Authorized** users (Figure 4-4).

Current DMS Authorized Users	Manager Authority
-----	-----
DEMO,BENJAMIN P	YES
DEMO,BETSY	YES
DEMO,CHRIS	

Figure 4-4: Listing the current DMS users

Remove an Authorized User from a Diabetes register

1. Type **US** at the “Select Register Maintenance Option” prompt from the **Register Maintenance** menu.
2. Type **3** (Remove an Authorized User from the register) at the “Which one” prompt.
3. At the select user prompt, enter the name of the person you wish to remove as an authorized user.

4.2 Add Patients from Search Template (AP)

This option allows you to add patients with a diagnosis of diabetes to the **Diabetes Register** as a group. It may also be used to periodically add a template of patients newly diagnosed with diabetes. This process will not result in duplication of patients already in the Register.

Adding to the template

1. Type **AP** at the “Select Register Maintenance Option” prompt (Figure 4-5).

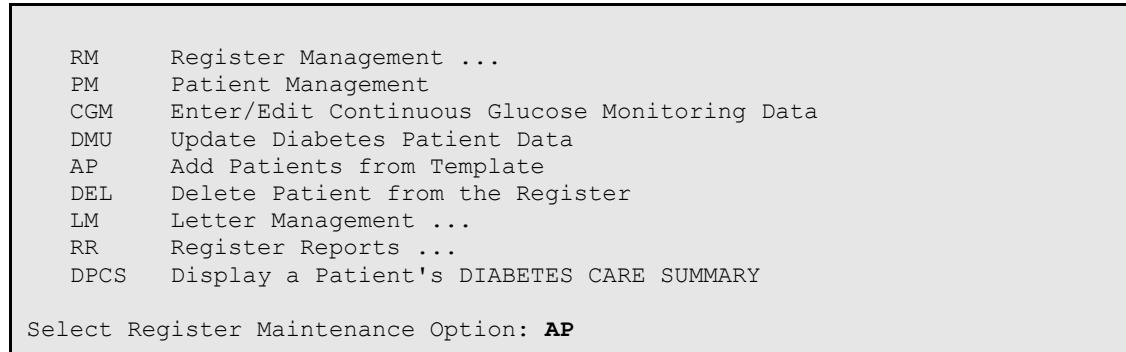


Figure 4-5: Adding to the template (step 1)

2. Type the name of the template of patients, which is to be added to the **Register** at the “Which Search Template” prompt.
3. Type **YES** or **NO** at the “Is that what you want?” Prompt (Figure 4-6). If you type **YES**, the patients will be added in an Active Status.

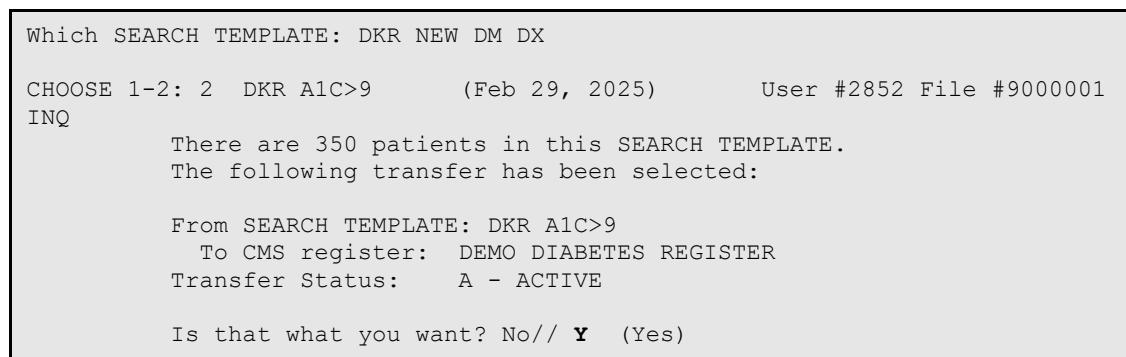


Figure 4-6: Adding to the template (steps 2-3)

5.0 Entering/Deleting Patients on the Diabetes Register

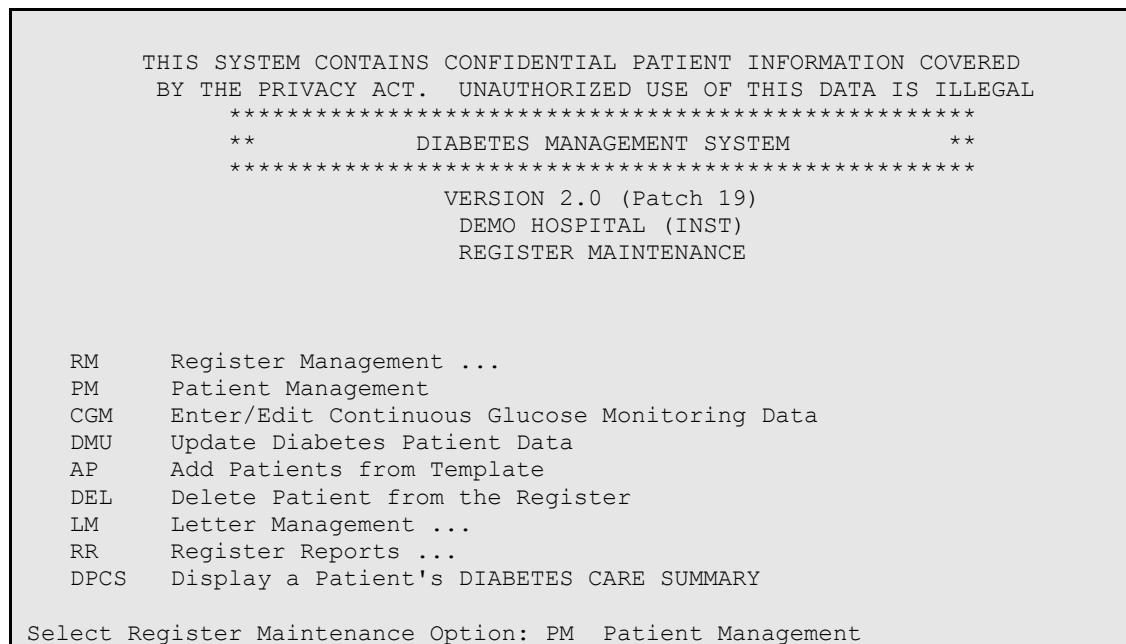
There are two ways to add patients to the **Diabetes Register**:

- Enter patients manually, one at a time, using the PATIENT MANAGEMENT option.
- Transfer patients from a QMan-generated search template.
 - **QMan** is a menu option in **PCC Management Reports** and cannot be accessed from the **Diabetes Management System** menu. To access **QMAN**, you will need access to the **PCC Management Reports** menu and three additional security keys. See your Site Manager for assignment of the following security keys and access to the **PCC Management Reports** menu.
 - AMQQZMEN
 - AMQQZCLIN
 - AMQQZRPT

Each of the standard methods for entering patients into the Diabetes Register is described in Section 5.1 through Section 5.4.

5.1 Entering Patients Manually

Enter the chart number or name (Last Name,First Name) of the patient to be added to the Register. If the patient is not currently a member of the Register, you will be prompted to add the patient. See the example in Figure 5-1.



Select PATIENT NAME: DEMO, LAURA MARIAN	F 07-12-1988 XXX-XX-3297 TST 133250
DEMO, LAURA MARIAN is not on the DEMO DIABETES REGISTER	
Add this client to the Register? NO// Y	

Figure 5-1: Entering patients manually

As soon as the Enter key has been pressed, the following screen will display (Figure 5-2) and you may begin to display, edit, or print data on this patient.

Register Data	Nov 13, 2025 15:14:01	Page: 1 of 1
PATIENT: DEMO, KARLA KAY	AGE: 36	
ADDRESS: 1400 W 3RD STREET, ALB, NM, 87119	DOB: 08/03/1989	
PHONE: 555-555-3538	SEX: FEMALE	
PRIM CARE PROV: DOCTOR, DONNA	HRN: 135272	
STATUS: ACTIVE	RES: ANYTOWN	
WHERE FOLLOWED:		
CASE MGR:		
CONTACT:		
ENTRY DATE: NOV 13, 2025	LAST EDITED:	
DIAGNOSIS: TYPE 2		
COMMENTS:		
LOCAL OPTION:		
LOCAL OPTION TEXT:		
- Previous Screen QU Quit ?? for More Actions		
1 Register Status	7 Local Option Entry	13 Print Letter
2 Where Followed	8 Last Visit	14 PREDM Care Summary (PPCS)
3 Case Manager	9 Review Appointments	15 PREDM Assessment of Care (PDMC)
4 Client Contact	10 DM Audit Status	Q Quit
5 DX/Date of Onset	11 Health Summary	
6 Comments	12 DM Care Summary (DPCS)	
Select Action: Quit//??		
The following actions are also available:		
+ Next Screen	< Shift View to Left	PS Print Screen
- Previous Screen	FS First Screen	PL Print List
UP Up a Line	LS Last Screen	SL Search List
DN Down a Line	GO Go to Page	ADPL Auto
Display(On/Off)		
> Shift View to Right	RD Re Display Screen	Q Quit
Enter RETURN to continue or '^' to exit:		

Figure 5-2: Entering patients manually, screen 2

5.2 Transferring Patients from a QMan-Generated Search Template

This two-step process allows you to quickly identify all diabetes patients who are active at your facility based on PCC data and load them into your **IHS Diabetes Register**. For active IHS User population statistics, patients are generally considered to be active if they have had one or more visits for diabetes in the past three years. For the purposes of diabetes care, more stringent criteria that more closely resembling GPRA criteria may be desired.

Each facility may have different criteria for identifying the patients who will be added to the template. In the following example, the search criteria used are that the patient had at least one diagnosis of diabetes codes as identified in the taxonomy **SURVEILLANCE DIABETES**, lived in the service unit area (GPRA taxonomy of communities), and had at least two visits to primary care clinics (**01 [GENERAL], 06 [DIABETIC], 13 [INTERNAL MEDICINE], 20 [PEDIATRIC], 24 [WELL CHILD], 28 [FAMILY PRACTICE]**) in the last three years. This may result in patients inadvertently being added to the Register because of miscoding, but they can be easily recognized by age or chart review and removed.

Note: Your facility may already have a taxonomy of communities in the service area used in GPRA reports. The site manager would know the name of this taxonomy.

The specific **QMan** dialogue (Figure 5-3) to accomplish this search follows. User responses and instructions are in **bold** type.

```
***** SEARCH CRITERIA *****

Subject: LIVING PATIENTS
Attribute of Living Patients: DX
Enter DX: [SURVEILLANCE DIABETES]

ICD codes in this range =>
[QMan lists all codes in the taxonomy]
Enter Another DX: [ENT]
Want to save this group for future use? NO
First condition of Diagnosis: SINCE
Exact Date: (Enter the date 3 years ago)
Next condition of Diagnosis: AT LEAST
Value: 1
Next condition of Diagnosis: [ENT]
Attribute of Living Patients: COMMUNITY[ENT]
Community: GPRA COMMUNITIES [ENT]
Members of GPRA Taxonomy =>

ADAIR
AFTON
BARTLESVILLE
BIXBY
BROKEN ARROW
CATOOSA
```

CHELSEA
CLAREMORE
JAY
LOCUST GROVE
MIAMI
PRYOR
SAPULPA

Enter ANOTHER COMMUNITY: **[ENT]**

The following have been selected =>

ADAIR
AFTON
BARTLESVILLE
BIXBY
BROKEN ARROW
CATOOSA
CHELSEA
CLAREMORE
JAY
LOCUST GROVE
MIAMI
PRYOR
SAPULPA

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

Computing Search Efficiency

Rating.....

.....

Subject of search: PATIENTS
ALIVE TODAY
CURRENT COMMUNITY (ADAIR/AFTON...)

Attribute of LIVING PATIENTS: **VISIT**

SUBQUERY: Analysis of multiple VISITS

First condition of "VISIT": **CLINIC**

Enter CLINIC: [BGP PRIMARY CARE CLINICS

Members of BGP PRIMARY CARE CLINICS Taxonomy =>

GENERAL
DIABETIC
INTERNAL MEDICINE
PEDIATRIC
WELL CHILD
FAMILY PRACTICE
Enter ANOTHER CLINIC: **[ENT]** (Enter additional Primary Care Clinics)

The following have been selected =>
GENERAL
DIABETIC
INTERNAL MEDICINE
PEDIATRIC
WELL CHILD
FAMILY PRACTICE

```
Want to save this CLINIC group for future use? No// [ENT] (No)

Next condition of "VISIT": DURING THE PERIOD
Exact starting date: 1/1/25 (JAN 01, 2025)
Exact ending date: 12/31/25 (DEC 31, 2025)

Subject of subquery: VISIT
CLINIC (DIABETIC/INTERNAL MED...)
BETWEEN JAN 1, 2025 and DEC 31, 2025@23:59:59

Next condition of "VISIT": AT LEAST
Enter the value that goes with AT LEAST _ EXIST; e.g., AT LEAST _ EXIST 3,
AT LEAST _ EXIST 10, etc.
Value: 2

Subject of subquery: VISIT
CLINIC (DIABETIC/INTERNAL MED...)
BETWEEN JAN 1, 2025 and DEC 31, 2025@23:59:59
AT LEAST 2 EXIST

Next condition of "VISIT": [ENT]

Computing Search Efficiency Rating.....

Subject of search: PATIENTS
ALIVE TODAY
CURRENT COMMUNITY (ADDAIR/AFTON...)
DIAGNOSIS (250.01/250.11...)
Subject of subquery: VISIT
CLINIC (DIABETIC/INTERNAL MED...)
BETWEEN JAN 1, 2025 and DEC 31, 2025@23:59:59
AT LEAST 2 EXIST

Attribute of LIVING PATIENTS: [ENT]

*** 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: 4 - Store Results of Search in FileMan Template

Enter the name of the search template: PTS FOR IHS DM REGISTER

Are you adding 'PTS FOR IHS DM REGISTER' as a new sort template? YES
Description: [ENT]

Want to run this task in background? NO
```

Figure 5-3: Transferring Patients from a QMan-Generate Search Template

QMan will then display each patient that matches the specified criteria as it stores the patients in the template called **PTS FOR IHS DM REGISTER**. When finished, the number of patients stored is displayed.

A site setting up the Register for the first time may choose to include or exclude different attributes in selecting patients to transfer. For example, by selecting the additional attribute of Community, you may limit the patients in the Register only to the communities in your service population. Another way of delimiting the group of patients to be included in the template is to select **DX of [SURVEILLANCE DIABETES]** as an attribute with no time limitations, and then selecting VISIT with limiting conditions of clinics and time frames. Other sites may choose to restrict the patients in the template even more by selecting a QMan attribute of Classification and limiting the Class to Indian/Alaska Native.

For the next step of loading the patients into your Register, exit **QMan** and return to the Diabetes Management System main menu.

1. Type **RM** the “Select Diabetes Management System Option” prompt in the **Register Maintenance** menu option.
2. Type **AP** at the “Select Register Maintenance Option” prompt (Figure 5-4).

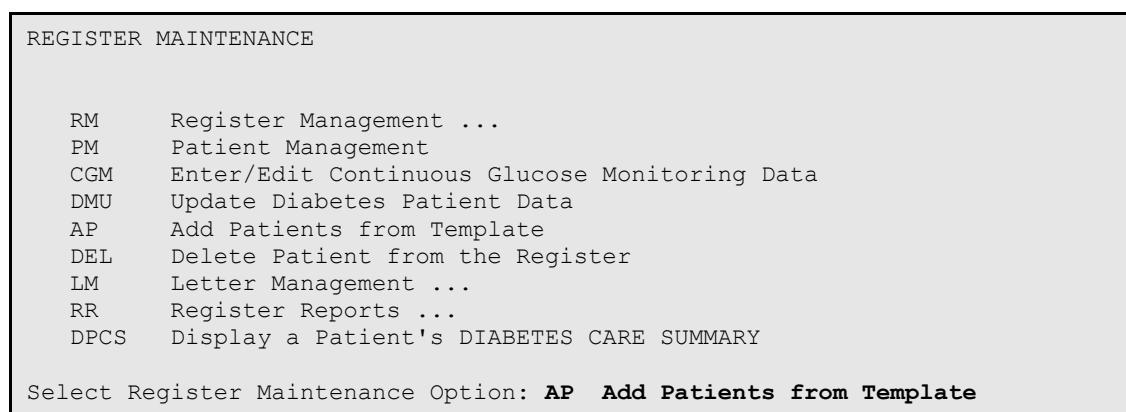
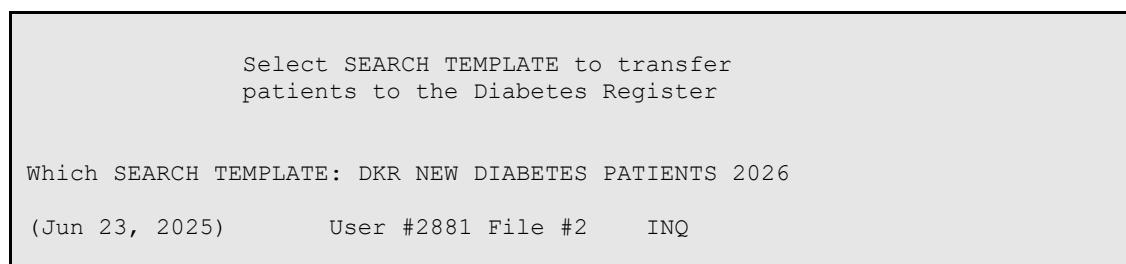


Figure 5-4: Transferring Patients from a Qman-Generated Search Templates (steps 1-2)

3. Type **PTS FOR IHS DIABETES REGISTER** at the “Which Search Template” prompt (Figure 5-5). If the transfer is approved the system will then move all of the patients from the search template into the IHS Diabetes Register and assign them the status of **ACTIVE**.



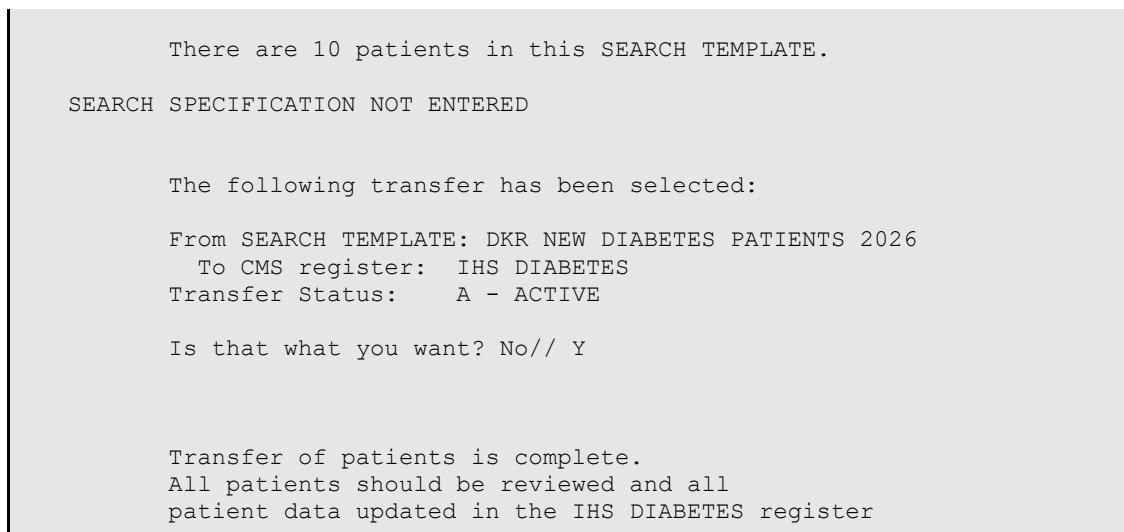


Figure 5-5: Transferring Patients from a Qman-Generated Search Template (step 3)

When this process is complete, you should review the patients transferred into the register to determine their appropriateness. You may delete patients or change their status to **Inactive**, **Transient**, **Unreviewed**, **Deceased**, **Lost to Followup**, **Non-IHS**, or **Noncompliant** using the **Edit Register Data** option under the **Patient Management** menu.

5.3 Deleting Patients from the Register

This option may be used to remove a patient from the Register if the patient is no longer active, is deceased, or has moved. The recommendation is to use this option only to remove patients from the Register if they do not have a diagnosis of diabetes. Other patients may be moved into a different Status category as opposed to deleting them. Deleting a patient from the Register results in the loss of any data that may have been stored in the Register for that patient including diagnosis, date of onset, complications, date of onset of complications, or date added to the register.

To delete a patient from the register (Figure 5-6), type **DEL** at the “Select Diabetes Management System Option” prompt. When prompted, type the chart number or name of the patient to be deleted from the register. You will be warned that all data on that patient will be removed from the **IHS Diabetes Register**. If you are certain, type **YES**. The dialogue will indicate that deletion of that patient from the **IHS Diabetes Register** is complete.

```
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 19)
DEMO HOSPITAL (INST)
REGISTER MAINTENANCE
```

RM	Register Management ...
PM	Patient Management
CGM	Enter/Edit Continuous Glucose Monitoring Data
DMU	Update Diabetes Patient Data
AP	Add Patients from Template
DEL	Delete Patient from the Register
LM	Letter Management ...
RR	Register Reports ...
DPCS	Display a Patient's DIABETES CARE SUMMARY

Select Register Maintenance Option: DEL [ENT]

Figure 5-6: Deleting patients from the register

5.4 Periodic Addition of New Cases to Your Register

After your register is installed and your initial group of patients has been entered, enter newly diagnosed cases using the manual entry process described. It is critical that the local Diabetes Coordinator is notified as new patients are diagnosed or move into the service area. There are several mechanisms to identify patients newly diagnosed with diabetes, but no mechanism exists for adding patients automatically to the Register. The three methods of identification are described below.

Notation on Health Summary or Case Summary

Some facilities use the **PCC Health Summary** and/or the **Case Management System Case Summary** as turn-around documents. Following review of the **Health Summary** or **Case Summary**, the provider may make notations on the summary regarding new diabetes cases or new diabetes complications and forward the summary to the Diabetes Coordinator for updating the register.

QMan Search

Using **QMan**, you can print a list of newly diagnosed cases or new complications since your last update of the register. The list should be reviewed by the Diabetes Coordinator and appropriate entries made in the register. The following **QMan** dialogue (Figure 5-7) is used to find new cases or complications. User responses and instructions are in **bold** type.

***** SEARCH CRITERIA *****	
Subject: LIVING PATIENTS	
Attribute of Living Patients: DX	
ENTER DX: [SURVEILLANCE DIABETES]	
Enter Another DX: [ENT]	
Want to save this group for future use? YES	
Enter name for this taxonomy: DM & COMPLICATIONS CODES	
First condition of Diagnosis: FIRST	
How many? 1	
Next condition of Diagnosis: SINCE	

```

Exact Date: (Enter date you last updated register with new cases and/or
complications.)
Next condition of Diagnosis: [ENT]
Attribute of Living Patients: [ENT]

*** 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: 2 - Print Results
Device: (Enter printer device number.)

```

Figure 5-7: Qman search

After you have printed the results of your **QMan** search, you can review charts and manually add the patients on your list to the **Diabetes Register** using the **PM Patient Management** menu option.

Mailman Bulletin

Each time a diagnosis of diabetes or one of the standard complications is entered into the **PCC**, a program will determine if this is a new case or new complication for the patient at your facility. If it is new, a Bulletin will be generated in the RPMS Mailman System announcing the new case. See the example in Figure 5-8.

```

Subj: DM NEW CASE [#6732] 19 November 2025 13:10 20 Lines
From: POSTMASTER in 'IN' basket. Page 1 **NEW**
-----
Patient Name: TEST, PATIENT
Chart No.: HC 27689 DOB: 10/12/1953

This patient was seen on NOV 18, 2025 @14:04 at IHS FACILITY
with the following diagnosis:

ICD10 Code: E10.9 ICD Description: DM UNCOMPL/T-II/NIDDM,UNCONTR
Provider Stated: DM TYPE 2 - UNCONTROLLED
Patient's Community: IHS COMMUNITY
Patient's Service Unit: IHS SERVICE UNIT
Patient's Tribe: NON-INDIAN BENEFICIARY
Tribal Blood Quantum: NONE

Patient's Health Records:
This is the first time that this patient has been seen for the diabetes
diagnosis listed above. Please take appropriate follow up action.

Select MESSAGE Action: IGNORE (in IN basket) / /

```

Figure 5-8: MailMan bulletin

The **Bulletin**, or **Mail Message**, will be automatically routed to the local Diabetes Coordinator. Each time the coordinator signs on to RPMS, they will be notified that new mail messages are waiting to be read. If you are not already using Mailman within your facility, you will need to discuss this capability with your Site Manager.

Note: See Appendix A for directions on setting up this automatic notification system.

6.0 Patient Management

The **IHS Diabetes Register** has been designed to minimize the data entry required for maintenance. One key to achieving this goal is to optimize the use of data entered through the **PCC** process (Figure 6-1). Another key is to limit the non-PCC data maintained in the register to as few items as possible and to limit items that require infrequent updating after initial entry into the register.

All data items are entered or modified on the **Patient Screen** that is displayed when the **PM Patient Management** option is selected. To initiate an interactive session, enter the patient's name or chart number.

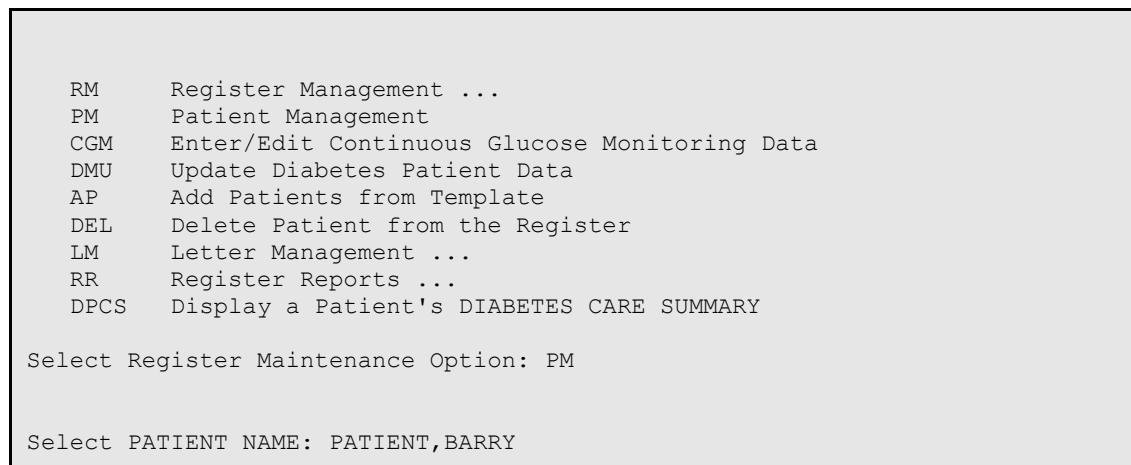
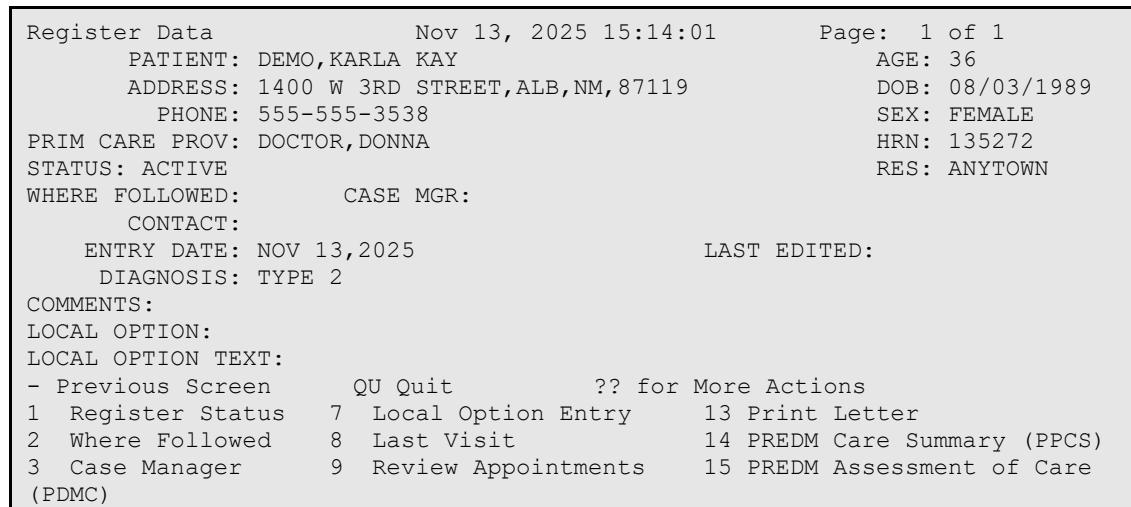


Figure 6-1: Selecting the PM options

6.1 Edit Register Data

If the patient is a new addition to the **Register**, only demographic data from **Registration** will display as shown in Figure 6-2.



```

4 Client Contact 10 DM Audit Status           Q  Quit
5 DX/Date of Onset 11 Health Summary
6 Comments          12 DM Care Summary (DPCS)
Select Action: Quit// 1

The following actions are also available:
+  Next Screen      < Shift View to Left  PS  Print Screen
-  Previous Screen  FS  First Screen       PL  Print List
UP  Up a Line        LS  Last Screen       SL  Search List
DN  Down a Line      GO  Go to Page        ADPL Auto
Display(On/Off)
>  Shift View to Right  RD  Re Display Screen  Q  Quit

Enter RETURN to continue or '^' to exit:

```

Figure 6-2: Selecting the PM option

Very few data items are included in the register itself. These items should be entered when you add patients to the register and modified as needed.

You may enter data into each field beginning with the **Status** field. Press Enter after recording data or press Tab to move through the fields to be edited.

Typing one question mark (?) at each field will display the choices or the type of data to be entered:

- **STATUS:** Use 1 to select **Register Status**.
 - **A** Active—Patients who receive their primary health care at your facility and who have had care at your facility within the last year.
 - **I** Inactive—Patients not seen within the last two years.
 - **T** Transient—Patients seen at your clinic within the past year who do not receive their primary diabetes care at your facility but only visit your 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 who are deceased. Note that this status will be automatically updated if a date of death is recorded in Registration. However, if a patient's status is changed to deceased in the Register, the patient registration file is not automatically updated.
 - **N** Non-IHS—Non-AI/AN patients who receive their diabetes care at your facility.
 - **L** Lost to Follow-up—patients seen at your facility within the past two years but who have not had a visit in the last year.
 - **N** Noncompliant—Patients with repeated documented refusals of recommended services.

Note: Most of the register reports include only active patients.

- **WHERE FOLLOWED:** (Optional)–**2 Where Followed**–If the service unit has one or more field clinics, health clinics, or health stations, it may be of value identifying the facility where the patient routinely goes for health care.
- **CASE MGR:** (Optional)–**3 Case Manager**–This is the nurse or health care provider that has been assigned or has assumed responsibility for managing a patient’s health care.
- **CONTACT:** (Optional)–**4 Client Contact**–Type the **Name of Contact**. This is a free text entry of 1–30 characters to identify an alternative contact if a patient does not have a telephone.
- **ENTRY DATE:** This date is entered automatically when the patient is added to the Register. You may override this date with a date from your records.
- **LAST EDITED:** This field is filled automatically by the system with the date you or another authorized system user last entered or modified any data.
- **DIAGNOSIS:** Enter the **Diabetes** diagnosis from the list. Make sure that the same **Diabetes** diagnosis is on the patient’s **Integrated Problem List (IPL)**, so that other clinicians can see it.
- **ONSET DATE:** Enter the **Date of Onset** for the **Diabetes** diagnosis. Make sure that the Date of Onset is also documented on the patient’s **Integrated Problem List (IPL)**, so that other clinicians can see it.

If you want to return to a field to modify the data, you may type a caret (^) followed by the name of that field or caption to return. When all data is entered, at the “Command” prompt, type S and press Enter to save your entries. Then, type E and press Enter to exit the **Edit Register Data** option.

6.2 Adding Diagnosis

To add or modify a **Diagnosis** for a patient (Figure 6-3), choose **5 Diagnosis** from the menu screen. You will have the option to edit an existing Diagnosis, add a new Diagnosis, or delete a Diagnosis.

Register Data	Nov 16, 2025 14:20:36	Page: 1 of 1
PATIENT:	TEST, PATIENT TEN	AGE: 18
ADDRESS:		DOB: 01/01/2000
PHONE:		HRN: 123456
PRIM CARE PROV:		RES: TOPPENISH
CY		
STATUS:	ACTIVE	
WHERE FOLLOWED:		
CASE MGR:		
CONTACT:		
ENTRY DATE:	NOV 14, 2025	LAST EDITED: NOV 16, 2025
DIAGNOSIS:	(NO DIAGNOSIS ON FILE FOR THIS PATIENT)	
COMMENTS:		
LOCAL OPTION:		
LOCAL OPTION TEXT:		

```

- Previous Screen      QU Quit      ?? for More Actions
1 Register Status     7 Local Option Entry 13 Print Letter
2 Where Followed      8 Last Visit   14 PREDM Care Summary (PPCS)
3 Case Manager         9 Review Appointments 15 PREDM Assessment of Care
4 Client Contact       10 DM Audit Status Q Quit
5 DX/Date of Onset    11 Health Summary
6 Comments             12 DM Care Summary (DPCS)

Select Action: Quit// 5

```

Figure 6-3: Adding Diagnosis—screen 1

In the patient example given, **Prediabetes** is currently listed. Another Diagnosis will be added, **Type 2** (Figure 6-4).

```

Register Diagnoses          Nov 16, 2025 08:10:58      Page: 1 of 1
Make sure that the date of onset is also documented on the
patient's problem list so other clinicians can see it.
Problem list entries can be modified using EHR.

DIABETES RELATED PROBLEMS ON THE PROBLEM LIST
PROB # DX           PROVIDER NARRATIVE           DATE OF ONSET
STATUS

-----
None on file

Register Diagnosis
NO. Diagnosis           ONSET DATE
--- -----
1   Prediabetes          NOV 15,2023

- Previous Screen      QU Quit      ?? for More Actions
1 Add Diagnosis        2 Edit Diagnosis 3 Delete Diagnosis
Select Action: Quit// 1

```

Figure 6-4: Adding Diagnosis—screen 2

You will be given the choice of entering one or more of the following Diagnoses (Figure 6-5).

Note: This display is the **Diagnosis List** created under **Register Maintenance**. This list will differ for each register type as this list is site customizable.

```

NO.  DIAG
--- -----
1   GESTATIONAL DM
2   IMPAIRED GLUCOSE TOLERANCE
3   TYPE 1
4   TYPE 2
Which DIAGNOSIS(S) : (1-4) :

```

Figure 6-5: Adding Diagnosis—screen 3

When prompted for **Which DIAGNOSIS (1-4)**, enter the number.

To add **Onset Date** and other details for each **Diagnosis**, choose option **2-Edit**.

You will be prompted to choose the number of the **Diagnosis** you want to edit (Figure 6-6). A window displays with prompts for **DATE OF ONSET, SEVERITY**. Use the Tab key to move between fields. To display the list of **Diagnosis Severity**, at the caption **SEVERITY**, type one question mark (?). A list of four choices will be displayed for you to select from. **Diagnosis Severity** is not a required entry.

N	NORMAL		
M	MILD		
MO	MODERATE		
S	SEVERE		
Diagnosis			
NO.	Diagnosis	ONSET	DATE
---	---	---	---
1	Type 2	NOV 2020	
- Previous Screen QU Quit ?? for More Actions 1 Register Status 7 Local Option Entry 13 Print Letter 2 Where Followed 8 Last Visit 14 PREDM Care Summary (PPCS) 3 Case Manager 9 Review Appointments 15 PREDM Assessment of Care 4 Client Contact 10 DM Audit Status Q Quit 5 DX/Date of Onset 11 Health Summary 6 Comments 12 DM Care Summary (DPCS) Select Action: Quit// [ENT]			

Figure 6-6: Diagnosis selection

6.3 Add Case Comments

Free-text case comments may be added to the Register indicating either nursing care plans, patient history or other information relevant to a patient's care. Select option **6 Comments** (Figure 6-7).

Register Data	Nov 13, 2025 15:14:01	Page: 1 of 1
PATIENT:	DEMO, KARLA KAY	AGE: 36
ADDRESS:	1400 W 3RD STREET, ALB, NM, 87119	DOB: 08/03/1989
PHONE:	555-555-3538	SEX: FEMALE
PRIM CARE PROV:	DOCTOR, DONNA	HRN: 135272
STATUS:	ACTIVE	RES: ANYTOWN
WHERE FOLLOWED:	CASE MGR:	
CONTACT:		
ENTRY DATE:	NOV 13, 2025	LAST EDITED:
DIAGNOSIS:	TYPE 2	
COMMENTS:		
LOCAL OPTION:		
LOCAL OPTION TEXT:		
- Previous Screen QU Quit ?? for More Actions 1 Register Status 7 Local Option Entry 13 Print Letter 2 Where Followed 8 Last Visit 14 PREDM Care Summary (PPCS) 3 Case Manager 9 Review Appointments 15 PREDM Assessment of Care (PDMC) 4 Client Contact 10 DM Audit Status Q Quit		

```

5  DX/Date of Onset 11 Health Summary
6  Comments          12 DM Care Summary (DPCS)
Select Action: Quit// 6

The following actions are also available:
+  Next Screen          <  Shift View to Left    PS  Print Screen
-  Previous Screen       FS   First Screen        PL  Print List
UP  Up a Line            LS   Last Screen        SL  Search List
DN  Down a Line          GO   Go to Page        ADPL Auto
Display(On/Off)
>  Shift View to Right  RD   Re Display Screen  Q   Quit

Enter RETURN to continue or '^' to

```

Figure 6-7: Adding Case Comments—screen 1

To add Comments, select option **1 Edit Comments**. A window will open displaying the patient's name (Figure 6-8). To enter free-text comments, press Enter at the "Comments" prompt to open a word-processing field.

```

PATIENT: DEMO,BARRY

(Press the Enter key to edit COMMENTS or <TAB> to skip.)
COMMENTS: [ENT]

Exit      Save      Refresh
Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND:                                     Press <PF1>H for help      Insert

```

Figure 6-8: Adding Case Comments—screen 2

Enter free-text comments (Figure 6-9) just as you would using any word processor. The lines will wrap automatically. Press F1 followed by the H key to display all the options for editing text.

```

==[ WRAP ]===[ INSERT ]=====< CASE COMMENTS >===== [ <PF1>H=Help ]=====
This 36 year old patient was brought in by his wife because of recent
excessive weight loss, lack of energy, and loss of appetite. By his own
account, he is a heavy drinker and smoker. He is employed as a long
distance driver for a trucking firm. DKR 05/2/03

```

Figure 6-9: Adding Case Comments—screen 3

Neither the date of the comment entry nor the identity of the person entering the text is stored with a comment. Therefore, it is recommended that any comment entry be accompanied by date and initials. When all comments have been entered, press the F1 key (**PF1**) followed by E to close the word processing window. You may save and exit from the comment option by typing **S** and pressing Enter, followed by typing **E** and pressing Enter. Exit the **Comment** window by typing **Q** to Quit or pressing Enter.

Note: The **Case Summary** is the only option that allows display of case comments entered via this menu option.

6.4 Local Option Entry

The local option entry may be edited by selecting **7 Local Option Entry**. Enter **0-9** at the prompt then enter the appropriate text.

6.5 Last Visit

The last visit the patient has made to your healthcare facility may be displayed by selecting **8 Last Visit**. All visit-related data for that date displays, including purpose of visit, providers, measurements, exams, and labs.

6.6 Review Appointments

To review future appointments for a patient, select **9 Review Appointments**. This option will display future appointments only if the RPMS Scheduling Package is used at your facility.

6.7 DM Audit Status

The status of compliance with the IHS Diabetes Standards of Care can be monitored at any time for a single patient by selecting **10 Audit Status**. You will be prompted to enter a date. 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. This allows the provider to determine which standards of diabetes care have not been met prior to the date of this visit. Future dates may be used.

6.8 Health Summary

The **Health Summary** for the patient may be displayed by selecting **11 Health Summary**. You will be prompted for **Health Summary Type** and may select any of the standard **IHS distributed Health Summaries** or a custom site-developed **Health Summary**. All of the secondary menu options discussed in Table 2 1 of this manual may be used for searching, displaying, or printing data from this health summary.

6.9 DM Care Summary (DPCS)

The **Diabetes Patient Care Summary (DPCS)** (Figure 6-10) for the patient may be displayed by selecting option **12 DM Care Summary (DPCS)**. The display of the DPSC may require several screens, therefore the display and print options described in Table 2-1 may be used. Typing two question marks **(??)** will display the choices.

OUTPUT BROWSER	Nov 01, 2025 14:22:37	Page: 1 of 5
***** CONFIDENTIAL PATIENT INFORMATION [LAB] Nov 01, 2025 *****		
DIABETES PATIENT CARE SUMMARY	Report Date: 11/01/2025	
Patient: DEMO, JANE		HRN: 127259

Age: 24 (DOB 07/04/2000) CLASS/BEN: INDIAN/ALASKA NATIVE	Sex: FEMALE Designated PCP: MOORE, LORI
Date of DM Diagnosis: 12/04/2023 (Problem List) Diabetes type: (1 or 2): 1	
BMI: 28.7 Last Height: 62.00 inches Last Weight: 157 lbs	03/07/2025 03/07/2025
Tobacco Use: Last Screened: 03/07/2025 Current Status: Not a Current user PREVIOUS (FORMER) SMOKER 03/07/2025 Tobacco cessation counseling/education received in the past year:	

Figure 6-10: Adding Case Comments screen—3

6.10 PREDM Care Summary (PPCS)

Use **option (#14)** if you are working with a **Prediabetes Register** and would like to review the patient's **Prediabetes Care Summary**. Refer to Appendix E for additional information.

6.11 PREDM Assessment of Care (PDAR)

Use **option (#15)** if you are working with a **Prediabetes Register** and would like to review the patient's **Prediabetes Assessment of Care document**. Refer to Appendix E for additional information.

7.0 Continuous Glucose Monitoring Data (CGM)

An option is available on the **Register Maintenance** menu to provide a means for a user to enter data from a **Continuous Glucose Monitoring** device. This chapter describes the steps to enter CGM data.

Type **RM** (Register Maintenance) at the “Select Diabetes Management System Option” prompt (Figure 7-1).

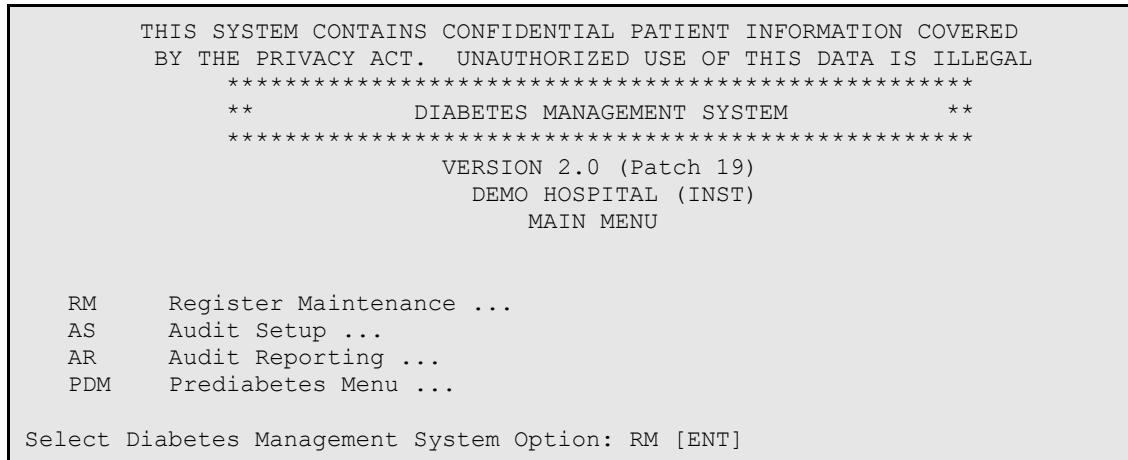
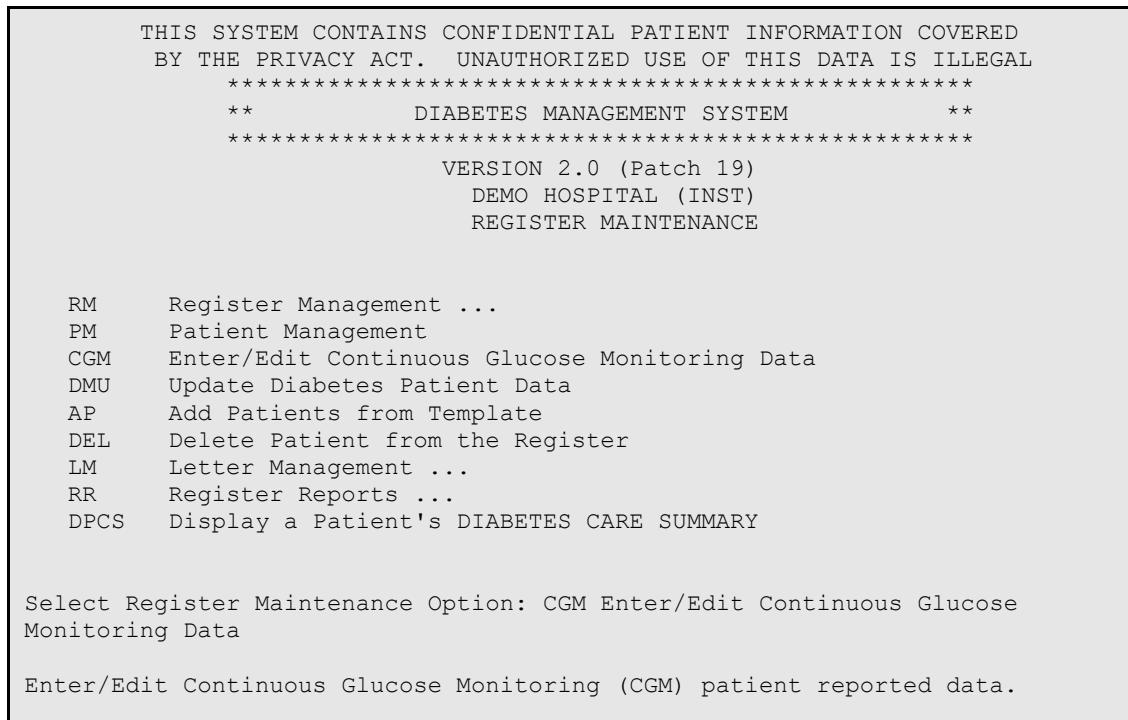


Figure 7-1: Navigating to Enter/Edit CGM Data from Main Menu

Type **CGM** at the “Select Register Maintenance Option” prompt (Figure 7-2).



```
Select PATIENT NAME: DEMO, DONNA SUE [ENT]
          <A>   F 11-10-1986 XXX-XX-5139   TST 137711
          Ok? Yes// [ENT]
```

Figure 7-2: Entering Patient Name

At **Select PATIENT NAME**, Enter the patient's name or HRN.

The system will display a history of all of the CGM data that has been entered for this patient (Figure 7-3).

```
View/Update CGM Data      Sep 01, 2025 12:13:15      Page:  1 of  1
CGM Data on File for: DEMO, DONNA SUE
HRN: 137711   FEMALE   DOB: Nov 10, 1986

1) Report Date: SEP 01, 2025  Report Date Range: SEP 01, 2025-SEP 13, 2025
   Duration (Days): 13          GMI: 7.0%           Time in Range (TIR): 55%
   Target Range: 70-180 mg/dL

2) Report Date: AUG 28, 2025  Report Date Range: AUG 21, 2025-AUG 28, 2025
   Duration (Days): 7          GMI: 9.1%           Time in Range (TIR): 90%
   Target Range: 70-180 mg/dL

      ?? for more actions + next screen - prev screen
A   Add CGM Data   X   Delete CGM   Q   Quit
M   MODIFY CGM     DP   DPCS
Select Item(s): Quit//
```

Figure 7-3: CGM Data Display and Actions

If the patient has no previous CGM data entered only patient information will be displayed as shown in Figure 7-4.

```
View/Update CGM Data      Sep 03, 2025 12:13:15      Page:  1 of  1
CGM Data on File for: DEMO, DONNA SUE
HRN: 137711   FEMALE   DOB: Nov 10, 1986

      ?? for more actions + next screen - prev screen
A   Add CGM Data   X   Delete CGM   Q   Quit
M   MODIFY CGM     DP   DPCS
Select Item(s): Quit//
```

Figure 7-4: CGM Data Display and Actions with no CGM data entered

Actions displayed to **Add CGM Data**, **Modify CGM**, **Delete CGM**, and display of the **Diabetes Patient Summary** to view entered CGM data are described in the following sections.

7.1 A—Add CGM Data

This action allows the user to enter a new set of data from the CGM device.

Users will be prompted to enter **Report Date** (date of entry), **Report Start Date**, **Report End Date**, **Glucose Management Indicator (GMI)** value, **Time in Target Range (TIR)** value, and **Target Range** for **Low** and **High** values.

The **Target Range** for **Low** and **High** values have default values. **Target Range Low Value** is set at **70 mg/dL**. **Target Range High Value** is set at **180 mg/dL**. These values can be modified by the user, as needed. Prompts for required responses and instructions are in **bold** type (Figure 7-5).

```

REPORT DATE: [Enter Date]
REPORT PERIOD START DATE: [Enter Date]
REPORT PERIOD END DATE: [Enter Date]
DURATION (DAYS): [Type a number between 3 and 100, 0 decimal digits]
GMI-GLUCOSE MGMT INDICATOR%:[Type a number between 2 and 20, 2 decimal digits]
TIME IN TARGET RANGE(TIR)%:[Type a number between 0 and 100, 2 decimal digits]
TARGET RANGE LOW VALUE(mg/dL): 70// [ENT] to use default or change value
TARGET RANGE HIGH VALUE(mg/dL): 180// [ENT] to use default or change value

```

Figure 7-5: Prompts from entering CGM data

An example of entered data is shown below in Figure 7-6.

```

REPORT DATE: T (SEP 01, 2025)
REPORT PERIOD START DATE: 09/01/2025 (Sep 1, 2025)
REPORT PERIOD END DATE: 09/13/2025 (SEP 13, 2025)
DURATION (DAYS): 13
GMI-GLUCOSE MGMT INDICATOR%: 7
TIME IN TARGET RANGE(TIR)%: 55
TARGET RANGE LOW VALUE(mg/dL): 70// 70
TARGET RANGE HIGH VALUE(mg/dL): 180// 180

```

Figure 7-6: Example of entered CGM data

7.2 M—Modify CGM

This action allows the user to edit an existing set of data from the CGM device. The same prompts will appear as above when adding CGM data (Figure 7-7)

```

View/Update CGM Data          Sep 20, 2025 22:28:24          Page: 1 of 1
CGM Data on File for: DEMO, DONNA SUE
HRN: 137711      FEMALE      DOB: Nov 10, 1986

1) Report Date: SEP 01, 2025      Report Date Range: SEP 01, 2025-SEP 13, 2025
   Duration (Days): 13          GMI: 7.0%          Time in Range (TIR): 55%
   Target Range: 70-180 mg/dL
2) Report Date: SEP 18, 2025      Report Date Range: SEP 01, 2025-SEP 15, 2025

```

```

Duration (Days): 14 GMI:10% Time in Range (TIR):50%
Target Range: 70- 180 mg/dL
3) Report Date: AUG 11, 2025 Report Date Range: AUG 01, 2025-AUG 11, 2025
Duration (Days): 10 GMI: 7.2% Time in Range (TIR): 50%
Target Range: 70-180 mg/dL

Enter ?? for more actions
A Add CGM Data X Delete CGM Q Quit
M MODIFY CGM DP DPCS

Select Item(s): Quit// M MODIFY CGM
Select CGM Patient Data: (1-3): 2
REPORT DATE: SEP 18,2025// 09/23/2025 (SEP 23, 2025)
REPORT PERIOD START DATE: SEP 1,2025// 09/13/2025 (SEP 01, 2025)
REPORT PERIOD END DATE: SEP 15,2025// 09/23/2025 (SEP 11, 2025)
DURATION (DAYS): 14// 10
GMI - GLUCOSE MGMT INDICATOR %: 10// 7.2
TIME IN TARGET RANGE (TIR) %: 50// 60
TARGET RANGE LOW VALUE(mg/dL): 70// [ENT]
TARGET RANGE HIGH VALUE(mg/dL): 180// [ENT]

```

Figure 7-7: Modifying CGM data

7.3 X—Delete CGM

This action to delete a CGM entry that was entered in error. You will be asked to provide a reason for the deletion (Figure 7-8).

```

View/Update CGM Data Sep 20, 2025 22:28:24 Page: 1 of 1
CGM Data on File for: DEMO, DONNA SUE
HRN: 137711 FEMALE DOB: Nov 10, 1986

1) Report Date: SEP 01, 2025 Report Date Range: SEP 01, 2025-SEP 13, 2025
Duration (Days): 13 GMI: 7.0% Time in Range (TIR): 55%
Target Range: 70-180 mg/dL
2) Report Date: SEP 23, 2025 Report Date Range: SEP 13, 2025-SEP 23, 2025
Duration (Days): 10 GMI:7.2% Time in Range (TIR):60%
Target Range:70-180 mg/dL
3) Report Date: AUG 11, 2025 Report Date Range: AUG 01, 2025-AUG 11, 2025
Duration (Days): 10 GMI: 7.2% Time in Range (TIR): 50%
Target Range: 70-180 mg/dL

Enter ?? for more actions
A Add CGM Data X Delete CGM Q Quit
M MODIFY CGM DP DPCS
Select Item(s): Quit// X Delete CGM
Select CGM Patient Data: (1-3): 3
Are you sure you want to delete this CGM entry? N// YES
REASON FOR DELETION: ?
Choose from:
D DUPLICATE
E ENTERED IN ERROR
O OTHER
REASON FOR DELETION: E ENTERED IN ERROR
DELETION COMMENT: [FREE TEXT COMMENT]

```

Figure 7-8: Deleting a CGM Entry

7.4 DP—Diabetes Patient Care Summary

This action allows the user to display the patient's **Diabetes Patient Care Summary**. The CGM data will display below the lab data (See Figure 7-9).

```
Continuous Glucose Monitoring (CGM) (most recent data)
GMI 7.2%      09/23/2025  GLUCOSE MANAGEMENT INDICATOR
DURATION: 10 DAYS
TARGET RANGE: 70-180 mg/dL
TIR 60%      09/23/2025  TIME IN TARGET RANGE
```

Figure 7-9: Diabetes Patient Care Summary (DPCS)

8.0 Register Reports (RR)

Numerous reports can be generated from the **IHS Diabetes Register** through the **Diabetes Management System's Register Reports** option (Figure 8-1). These reports contain a combination of demographic data, clinical data from the PCC, and register data that you have entered.

To generate reports of your register data, use the **RR Register Reports** option (Figure 8-1) on the **Diabetes Management System** main menu.

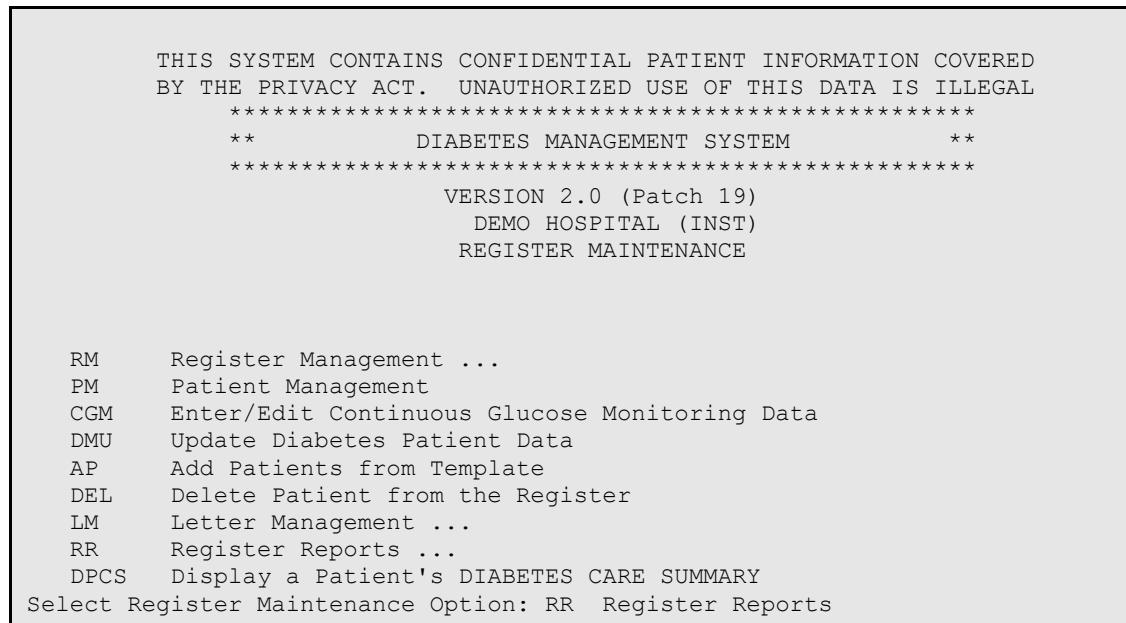
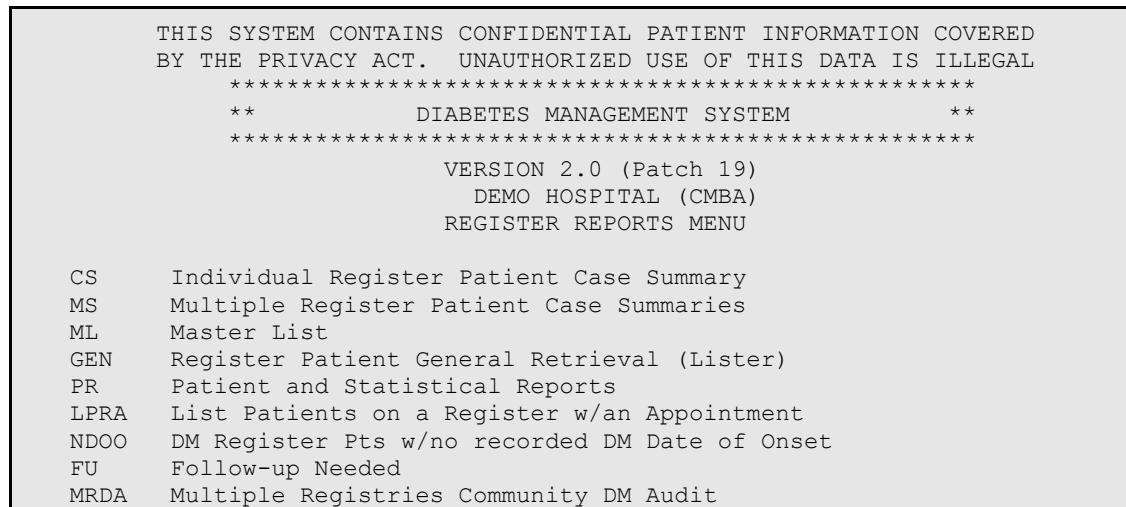


Figure 8-1: Selecting the RR option

By selecting **RR Register Reports** you can choose to display or print register data in a number of different ways. The reports listed in Figure 8-2 are available.



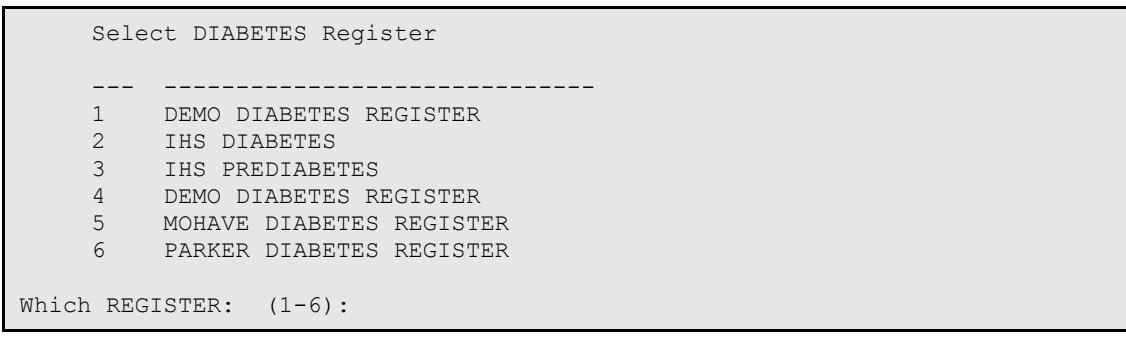


Select Register Reports Option:

Figure 8-2: Register Reports Menu

8.1 Individual Register Patient Case Summary (CS)

The **Case Summary** displays or prints all data contained in the **Diabetes Management System** for a single patient. For the **IHS Diabetes Register** (Figure 8-3), this includes demographic information, register status data, diabetes diagnosis, complications, review dates, and any case comments that have been entered. The **Case Summary** also includes the patient's PCC Problem List. To produce an individual **Case Summary**, select the **Individual Case Summary** menu option and enter the patient's name or chart number. The **Case Summary** is generated instantaneously. You have the option of including a **PCC Health Summary** at the end of the **Case Summary**. For this report, you may retrieve data for all patients on the **Diabetes Register** regardless of status.



Select DIABETES Register

1	DEMO DIABETES REGISTER
2	IHS DIABETES
3	IHS PREDIABETES
4	DEMO DIABETES REGISTER
5	MOHAVE DIABETES REGISTER
6	PARKER DIABETES REGISTER

Which REGISTER: (1-6):

Figure 8-3: Select Register

8.2 Multiple Register Patient Case Summaries (MS)

This option allows you to produce **Case Summaries** for all patients or a subset of patients in your **IHS Diabetes Register**. After selecting the option, you will be asked to specify a sorting order for the **Case Summaries**. You may sort by **Patient (alphabetical order)**, **Community of Residence**, **Facility where Followed**, **Case Manager**, or **Next Review Date** (Figure 8-4 and Figure 8-5).

After selecting the sort order, you will specify whether to retrieve data for everyone in the register or for a subset of patients. For example, if you select **Community** for the sort order, you can print all patients in the register grouped by community, or you can choose a specific community in order to print only those patients within that particular community. Likewise, if you select **Next Review Date** as your sort order, you can specify a time period and list only those patients whose next review date falls in that range or list all patients in the register in the order of their next review date. This option retrieves only active patients. All other patients are excluded. You may save your report results in a search template for later data retrievals.

```

DEMO HOSPITAL (CMBA)
DEMO, SKIP

DIABETES REGISTER MULTIPLE PATIENTS SUMMARIES

This report will print patient summaries for a selected set of patients.
You may select individual patients by name/HRN or you may select a group
of patients by any combination of the following attributes:- Register
Status
- Community of Residence
- Case Manager
- Where Followed
- Next Review Date

Enter the Name of the Register: DEMO DIABETES REGISTER

Select one of the following:

I           Individual Patient Names/HRNs
A           Group of Patients by Attribute

Select Patients By: I// individual Patient Names/HRNs
Select PATIENT NAME: demo
1  DEMO, ALISTER LANE      <A>  M 05-20-1980 XXX-XX-4693  TST 124625
2  DEMO, ASHLEY            <A>  F 02-25-1930 XXX-XX-5631  TST 114649
3  DEMO, BENJAMIN SR       M 08-06-2012 XXX-XX-9932  TST 893856
4  DEMO, DEJON              M 11-27-2002 XXX-XX-0095  TST 115569
5  DEMO, FERN               <A>  M 01-01-1960 XXX-XX-1230  TST 142601
ENTER '^' TO STOP, OR
CHOOSE 1-5: 2
DEMO, ASHLEY                <A>  F 02-25-1930 XXX-XX-5631  TST 114649
Select PATIENT NAME:

Include PCC HEALTH SUMMARY? NO//  

DEVICE: HOME//  Virtual

```

Figure 8-4: Multiple Register Patient Case Summaries Prompts

```

***** CONFIDENTIAL PATIENT INFORMATION *****
***** DEMO DIABETES REGISTER *****
CLIENT: DEMO, ASHLEY                         CHART: 114649
                                                 PRIMARY CARE PROVIDER: DEMO, DONNA
                                                 AGE: 94 YRS
                                                 COMMUNITY: PARKER
                                                 HOME PHONE: 555-555-9833
DOB: FEB 25, 1930
CONTACT: NOT STATED
***** INSURANCE INFORMATION *****
INSURANCE          NUMBER      SUFF COV  EL DATE  SIG DATE END
DATE

***** PATIENT INFORMATION *****
STATUS: ACTIVE                                CASE PRIORITY: NOT STATED
REGISTER PRV: NONE ASSIGNED                  INIT ENTRY: FEB 8, 2022
CASE MANAGER: NONE ASSIGNED                 WHERE FLWD: NOT STATED
PUB HLTH NRS: NONE ASSIGNED

End of report for ASHLEY DEMO
Press <ENTER> to continue.....

```

Figure 8-5: Patient Summary

8.3 Master List (ML)

The **Diabetes Management Master List** (Figure 8-6 and Figure 8-7) produces a list of patients the user selects. Selections include **Register Status**, **Age**, **Community of Residence**, **Sex**, **Case Manager**, and **Where Followed**.

The report displays the patient's **Chart Number**, **Name**, **Case Manager**, **Last visit date**, **Last Review Date**, and **Next Review Date**.

You can sort the list by **Patient Name** (alphabetical order), **Age**, **Community of Residence**, **Case Manager**, **Public Health Nurse**, **Sex**, **Status** (see Note below), or **Facility where Followed**. You may also sort by a combination of these register items, for example, alphabetical order by **Patient Name by Community**. The report output may be stored in a search template to be used for additional data retrievals.

Note: **Inactive, Transient, Unreviewed, Deceased, Lost to Follow up, Non-IHS, and Noncompliant** patients are included when the **Master List** is sorted by **Status**. If you choose to sort patients by **Status**, you may list patients for one or more of the status categories. This is the only report in **Diabetes Management**, other than **Individual Case Summary** and **General Retrieval** that displays patients who are not classified as Active.

<p>DEMO HOSPITAL (CMBA) DEMO, SKIP</p> <p>DIABETES REGISTER MASTER LIST</p> <p>This report will list all patients on the Diabetes Register. You will be able to select which patients will be included on the list based on any of the following:</p> <ul style="list-style-type: none">- Register Status- Age- Community of Residence- Sex- Case Manager- Where Followed <p>Enter the Name of the Register: DEMO DIABETES REGISTER Do you want to select register patients with a particular status? Y// ES Select status: A// ACTIVE Select another status:</p> <p>Would you like to restrict the master list by Patient age range? NO//</p> <p>Select one of the following:</p> <table><tr><td>O</td><td>One particular Community</td></tr><tr><td>A</td><td>All Communities</td></tr><tr><td>S</td><td>Selected Set of Communities (Taxonomy)</td></tr></table>	O	One particular Community	A	All Communities	S	Selected Set of Communities (Taxonomy)
O	One particular Community					
A	All Communities					
S	Selected Set of Communities (Taxonomy)					

Include Patients: A// 11 Communities

Select one of the following:

M	MALES
F	FEMALES
U	UNKNOWN
A	ALL SEXES

Include which Patient(s): A// LL

Do you want to select register patients with a particular CASE MANAGER? N//
O

Do you want to select patients with a particular facility WHERE FOLLOWED?
N// O

This list can be sorted by a primary and optionally a secondary sort value.

Select one of the following:

P	Patient Name
S	Register Status
A	Age
C	Community
G	Sex
M	Case Manager
W	Where Followed

Select Primary Sort Value: Patient Name

You can optionally sort by a second sort value. If you do not pick a secondary sort value it will default to patient name.

Select one of the following:

S	Register Status
A	Age
C	Community
G	Sex
M	Case Manager
W	Where Followed

Select Secondary Sort Value: Age

Should patients meeting the above criteria that have a Date of Death documented in patient registration be included in the list? N//

Select one of the following:

P	Print the List
B	Browse the List on the Screen
S	Save as a Search Template

Output Type: B// 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// Include ALL Patients

Figure 8-6: Diabetes Register Master List Prompts

OUTPUT BROWSER		Nov 12, 2025 14:33:47	Page:	1 of 3					
***** CONFIDENTIAL PATIENT INFORMATION *****									
SHS	1	Page							
DEMO HOSPITAL (CMBA)									
DIABETES REGISTER MASTER LIST									
Total number of patient selected for this report: 34									
HRN	PATIENT	CASE MANAGER	LAST VISIT	LAST REVIEW	NEXT REVIEW				
894038	DEMO, CARRIE		12/01/23						
101465	DEMO, MARIE		11/04/25	01/23/25	04/24/26				
106581	DEMO, PHYLLIS N		02/07/25						
890625	DEMO, MONICA		12/15/23						
115425	DEMOA, GARRETT WILLIA		10/19/25						
+>>>	Enter ?? for more actions								
+>>>	+ NEXT SCREEN	- PREVIOUS SCREEN	Q QUIT						
Select Action: +//									

Figure 8-7: Diabetes Register Master List Output

8.4

Register Patient General Retrieval (Lister) (GEN)

This report produces a list of patients on the **Diabetes Register** by the criteria that you choose. The report format is extremely flexible; you can specify the selection criteria, the data items to be printed, and the sorting order. You can print a detailed patient list or just counts of those patients that match the criteria you select. The first page of the report output is a summary page that displays the selection criteria, print items, and sort variable that you have requested.

Note: Only the items selected as a **Component Item** of your **Register** will appear as a choice of selection.

After selecting the **report** option, enter the name of a previously defined report or press Enter to bypass the first prompt. Then, in three separate steps, you will be prompted to identify your selection criteria, data items to print for each patient, and the sorting order. All of the selections are listed in Figure 8-8. You may save the selected variables for future use by entering **YES** when prompted to save them and then naming the report template.

If you design a report that is 80 characters or fewer in width, it can be displayed on the screen or printed. If your report is 81 to 132 characters wide, it must be printed on a printer capable of producing 132-character lines or a printer set up for condensed print.

Selection Criteria

REGISTER: IHS DIABETES	USER: USER, DEMO																																																									
<p>The Patients displayed can be SEARCHED based on any of the following criteria:</p> <table border="0"> <tr> <td>1) Patient Name</td> <td>14) Class/Beneficiary</td> <td>27) Next Review</td> </tr> <tr> <td>Date</td> <td></td> <td></td> </tr> <tr> <td>2) Patient Sex</td> <td>15) Cause of Death</td> <td>28) Where PT</td> </tr> <tr> <td>Followed</td> <td></td> <td></td> </tr> <tr> <td>3) Patient DOB</td> <td>16) Medicare Eligibility</td> <td>29) Date Last</td> </tr> <tr> <td>Edited</td> <td></td> <td></td> </tr> <tr> <td>4) Birth Month</td> <td>17) Medicaid Eligibility</td> <td>30) Register</td> </tr> <tr> <td>Provider</td> <td></td> <td></td> </tr> <tr> <td>5) Patient Age</td> <td>18) Prvt Ins Eligibility</td> <td>31) Care-Plan</td> </tr> <tr> <td>Comment</td> <td></td> <td></td> </tr> <tr> <td>6) Patient DOD</td> <td>19) Primary Care Provide</td> <td>32) Complications</td> </tr> <tr> <td>7) Mlg Address-State</td> <td>20) Register Status</td> <td>33) Complication</td> </tr> <tr> <td>Comment</td> <td></td> <td></td> </tr> <tr> <td>8) Mlg Address-Zip Code</td> <td>21) Initial Entry Date</td> <td>34) Diagnoses</td> </tr> <tr> <td>9) Living Patients</td> <td>22) Inactivation Date</td> <td>35) Date of Onset</td> </tr> <tr> <td>10) Chart Facility</td> <td>23) Case Priority</td> <td>36) Recall Date</td> </tr> <tr> <td>11) Patient Community</td> <td>24) Case Manager</td> <td></td> </tr> <tr> <td>12) Patient Tribe</td> <td>25) PHN</td> <td></td> </tr> <tr> <td>13) Eligibility Status</td> <td>26) Last Review Date</td> <td></td> </tr> </table>		1) Patient Name	14) Class/Beneficiary	27) Next Review	Date			2) Patient Sex	15) Cause of Death	28) Where PT	Followed			3) Patient DOB	16) Medicare Eligibility	29) Date Last	Edited			4) Birth Month	17) Medicaid Eligibility	30) Register	Provider			5) Patient Age	18) Prvt Ins Eligibility	31) Care-Plan	Comment			6) Patient DOD	19) Primary Care Provide	32) Complications	7) Mlg Address-State	20) Register Status	33) Complication	Comment			8) Mlg Address-Zip Code	21) Initial Entry Date	34) Diagnoses	9) Living Patients	22) Inactivation Date	35) Date of Onset	10) Chart Facility	23) Case Priority	36) Recall Date	11) Patient Community	24) Case Manager		12) Patient Tribe	25) PHN		13) Eligibility Status	26) Last Review Date	
1) Patient Name	14) Class/Beneficiary	27) Next Review																																																								
Date																																																										
2) Patient Sex	15) Cause of Death	28) Where PT																																																								
Followed																																																										
3) Patient DOB	16) Medicare Eligibility	29) Date Last																																																								
Edited																																																										
4) Birth Month	17) Medicaid Eligibility	30) Register																																																								
Provider																																																										
5) Patient Age	18) Prvt Ins Eligibility	31) Care-Plan																																																								
Comment																																																										
6) Patient DOD	19) Primary Care Provide	32) Complications																																																								
7) Mlg Address-State	20) Register Status	33) Complication																																																								
Comment																																																										
8) Mlg Address-Zip Code	21) Initial Entry Date	34) Diagnoses																																																								
9) Living Patients	22) Inactivation Date	35) Date of Onset																																																								
10) Chart Facility	23) Case Priority	36) Recall Date																																																								
11) Patient Community	24) Case Manager																																																									
12) Patient Tribe	25) PHN																																																									
13) Eligibility Status	26) Last Review Date																																																									
<p><Enter a list or a range. E.g. 1-4,5,20 or 10,12,20,30> <<HIT RETURN to conclude selections or bypass screens>></p>																																																										
<p>Select Patients based on which of the above: (1-36):</p>																																																										

Figure 8-8: Register Patient General Retrieval (Lister)—screen 1

After pressing Enter to use all the patients in the **Register** or entering specific selection criteria, you can choose to select (Figure 8-9 and Figure 8-10) one of the following:

- **T**—Total Count Only
- **S**—Sub-counts and Total Count
- **D**—Detailed Patient Listing
- **F**—Delimited Export File

If the delimited export file option is chosen, a file name will be assigned by the system. This file will be written and reside on the main RPMS server. Make a note of the file name as you will have to request that your site manager retrieve this file for you. If you choose to continue, you can select from the list of fields to be included in the file. The resulting file can be imported into Excel, ACCESS, SAS, or other programs used for data analysis.

Choose Type of Report: D// F Delimited Export File

I am going to create a file called ACM612.5 which will reside in

the C:\EXPORT directory.
 Actually, the file will be placed in the same directory that the data export files 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:

***** ACM612.5 *****

The records that are generated will be '^' delimited. The fields will be the fields you select in the next screen and will be in the order that you select them.

Do you want to continue?? Y// [ENT]

REGISTER: IHS DIABETES USER: USER,DEMO
 PRINT Data Items Menu

1) Patient Name	15) Patient Tribe	29) PHN
2) Patient Chart #	16) Eligibility Status	30) Last Review Date
3) Patient Sex	17) Class/Beneficiary	31) Next Review Date
4) Patient DOB	18) Cause of Death	32) Where PT Followed
5) Birth Month	19) Medicare Eligibility	33) Date Last Edited
6) Patient Age	20) Medicaid Eligibility	34) Client Contact
7) Patient DOD	21) Prvt Ins Eligibility	35) Register Provider
8) Mlg Address-Street	22) Patient's Last Visit	36) Care-Plan Comment
9) Mlg Address-State	23) Primary Care Provide	37) Complication
10) Mlg Address-City	24) Register Status	38) Diagnoses
11) Mlg Address-Zip Code	25) Initial Entry Date	39) Date of Onset
12) Home Phone	26) Inactivation Date	40) Recall Date
13) Mother's Name	27) Case Priority	
14) Patient Community	28) Case Manager	

<Enter a list or a range. E.g. 1-4,5,18 or 10,12,18,30>
 <<HIT RETURN to conclude selections or '^' to exit>>

Select print item(s): (1-40):
 Select print item(s): (1-40):
 Items selected for flat file output:
 Patient Name
 Patient Chart #
 Patient Sex
 Patient DOB
 Classification/Beneficiary

Would you like to select additional PRINT criteria? NO//

Figure 8-9: Register Patient General Retrieval (Lister)—screen 2

REGISTER: IHS DIABETES USER: USER,DEMO
 PRINT Data Items Menu

The following data items can be selected to be output to a '^' delimited file.
 Choose the data items in the order you want them to be output.

1) Patient Name	12) Home Phone	23) Inactivation Date
2) Patient Chart #	13) Mother's Name	24) Case Priority
3) Patient Sex	14) Patient Community	25) Case Manager
4) Patient DOB	15) Patient Tribe	26) PHN
5) Birth Month	16) Eligibility Status	27) Last Review Date
6) Patient Age	17) Class/Beneficiary	28) Next Review Date
7) Patient DOD	18) Cause of Death	29) Where PT Followed
8) Mlg Address-Street	19) Patient's Last Visit	30) Date Last Edited
9) Mlg Address-State	20) Primary Care Provide	31) Client Contact
10) Mlg Address-City	21) Register Status	32) Register Provider

```

11) M1g Address-Zip Code 22) Initial Entry Date
    <Enter a list or a range. E.g. 1-4,5,18 or 10,12,18,30>
    <<HIT RETURN to conclude selections or '^' to exit>>
Select print item(s): (1-32):

```

Figure 8-10: Register Patient General Retrieval (Lister)—screen 3

If you do not select a sort criterion, the file will be sorted alphabetically by **Patient Name**.

If the option to print a **Total Count** is chosen, the total number of patients meeting the search criteria is displayed. If the option for **Sub-counts** and **Total Counts** is chosen, you will be prompted to indicate how you would like to have the counts sorted. For example, if you would like to do a count of your diabetes register patients sorted by community, you can press Enter on the search screen, then select **Community** on the **sort** screen. The resulting report would display total and sub-counts as shown in Figure 8-11.

```

REPORT SUMMARY

CMS REGISTER PATIENT Selection Criteria:
Items selected for flat file output:
Patient Name
Patient Chart #
Patient Sex
Patient DOB
Classification/Beneficiary

CMS REGISTER PATIENT SORTING Criteria:
CMS REGISTER PATIENTS will be sorted by: Patient Name

DEVICE: HOME// Virtual

CMS File being generated.....
DOS File Being Created'
Please Standby - Copying Data to DOS File X:\EXPORT\ACM2963.4

```

Figure 8-11: Register Patient General Retrieval (Lister)—screen 4

If the option for a detailed patient listing is chosen, you will be prompted to identify which data items to print and how you would like them sorted. Print items are shown in Figure 8-12.

PRINT Data Items Menu			
1) Patient Name	15) Patient Tribe	29) PHN	
2) Patient Chart #	16) Eligibility Status	30) Last Review Date	
3) Patient Sex	17) Class/Beneficiary	31) Next Review Date	
4) Patient DOB	18) Cause of Death	32) Where PT Followed	
5) Birth Month	19) Medicare Eligibility	33) Date Last Edited	
6) Patient Age	20) Medicaid Eligibility	34) Client Contact	

7) Patient DOD	21) Prvt Ins Eligibility	35) Register Provider
8) Mlg Address-Street	22) Patient's Last Visit	36) Care-Plan Comment
9) Mlg Address-State	23) Primary Care Provide	37) Complications
10) Mlg Address-City	24) Register Status	38) Complication Com
11) Mlg Address-Zip Code	25) Initial Entry Date	39) Diagnoses
12) Home Phone	26) Inactivation Date	40) Date of Onset
13) Mother's Name	27) Case Priority	41) Recall Date
14) Patient Community	28) Case Manager	

<Enter a list or a range. E.g. 1-4,5,18 or 10,12,18,30>
<<HIT RETURN to conclude selections or '^' to exit>>

Select print item(s): (1-41):

Figure 8-12: Print items

Note: Only one sort criterion may be used.

Sort Criteria are shown in Figure 8-13.

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

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

Figure 8-13: Sort Criteria

Note: The numbers of the **Select**, **Sort**, and **Print** items will correspond to the actual data item structure of the diabetes register that you have created. The data items will be limited to those you have included in your register and those available from the PCC database.

For more information about using this report option, refer to the *Case Management (Version 2.0) User's Manual*.

8.5 Patient and Statistical Reports (PR)

The **Statistical Reports** option (Figure 8-14) produces patient lists or counts. It includes reports for the following seven categories:

Note: Only **Active** patients are included in this report.

- **Register Data**
- **Complications**
- **Diagnoses**
- **Family Members**
- **PCC Problem List**
- **Case Review Date**
- **Case Comments**

```
*****
DEMO DIABETES REGISTER
*****
STATISTICAL REPORTS

1) REGISTER DATA          5) PCC PROBLEM LIST
2) COMPLICATIONS          6) CASE REVIEW DATE
3) DIAGNOSES               7) CASE COMMENTS
4) FAMILY MEMBERS

Report Option ==>
```

Figure 8-14: Statistical Reports

Most reports can be sorted by **Patient Name**, **Community**, **Facility where Followed**, **Age**, **Sex**, or a combination of these options (Figure 8-15). Additionally, you can be selective in specifying which patients to retrieve. For example, you can select to retrieve only patients with a specific diagnosis or complication, then sort the list by any of the above factors. By indicating the patients you want to retrieve and the sorting variables, you can generate a specific report, for example, all patients with major amputations who live in Santa Fe and are between the ages of 40 and 50.

```
*****
DEMO DIABETES REGISTER
*****
REPORT SORTING UTILITY

The DIAGNOSES report can be sorted by one or more of the following
attributes. '<==' indicates a mandatory selection.

1) AGE                      5) SEVERITY
2) CURRENT COMMUNITY        6) SEX
3) DIAGNOSIS                7) WHERE FOLLOWED
4) PATIENT
```

Your choice:

Figure 8-15: Reports Sorting Utility

When you request these reports, you will be asked whether you want a Patient or Statistical report. By responding with **P**, for patient, the system will generate a patient listing. A response of **S**, for statistical, will result in a display of counts without a patient listing.

You will also be asked whether you want to store the output from the report in a search template. If you respond **YES**, you will be asked to enter a name for the template. The name may be up to 30 characters long. After naming the template, the report will be generated and the patients will be stored in a template for use in QMan retrievals, as specified in Section 9.0. In Figure 8-16, a report is generated for all patients with Type 2 diabetes and stored as a search template for further queries.

Note: All patients in the **Register** must have an assigned diagnosis to generate an accurate report.

```
Your choice: 3  DIAGNOSIS

Do you want to sort by a particular DIAGNOSIS? No// Y  (Yes)

Which DIAGNOSIS: TYPE 2

Within DIAGNOSIS, want to sort by another attribute? No//  (No)

'P'atient or 'S'tatistical report? ==> Patient

Store Report Result as Search Template? NO// YES

Search Template: TYPE 2 DM PTS
Are you adding 'TYPE 2 DM PTS' as a new SORT TEMPLATE? No// Y  (Yes)

An unduplicated patient list resulting from this report
will be stored in the.....>

      ** TYPE 2 DM PTS  ** Search Template.

A brief report will be printed after the search template is complete.
You must enter a device for this report OR you may queue at this time.

DEVICE: HOME//  Virtual

...HMM, JUST A MOMENT PLEASE...
CMS DIAGNOSIS FOR THE CLIENT STATISTICS          NOV 12, 2025  17:01      PAGE 1
      DIAGNOSIS
-----
COUNT      1
```

End of report. Strike <CR> to continue.

Figure 8-16: Patient and statistical report

8.6 List Patients on a Register w/an Appointment (LPRA)

This option (Figure 8-17) permits the diabetes coordinator to review appointments for has occurred. This option only works if the facility uses the **RPMS Scheduling Package**. Select the **LPRA List Patients on a Register w/an Appointment** option. Enter the beginning date for appointment review and the ending date.

This option will print a list of all patients on a register e.g. Diabetes Register) who have an appointment in a date range in any clinic or in a selected set of clinics.

You will be asked to enter the name of the register, the date range of the appointments and the clinic names if selecting a set of clinics.

Enter the Name of the Register: **DEMO DIABETES REGISTER**

Enter Beginning Appointment Date: 10/1/2025 (OCT 01, 2025)
Enter Ending Appointment Date: 12/31/2025 (DEC 31, 2025)

Select one of the following:

A ANY Clinic
S One or more selected Clinics

Include patients with Appointments to: A// **[ENT]** NY Clinic

Select one of the following:

P PRINT the List
B BROWSE the List on the Screen

Output Type: B// PRINT the List

Select one of the following:

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

Demo Patient Inclusion/Exclusion: E// Include ALL Patients
DEVICE: HOME// Virtual

Figure 8-17: Listing patient appointments

The report displays as shown in Figure 8-18.

SHS

Sep 12, 2025

Page 1

PATIENTS ON THE DEMO DIABETES REGISTER WITH AN APPOINTMENT

Appointment Dates: Oct 01, 2025 to Dec 31, 2025 CLINICS: ANY			
HRN	PATIENT NAME	CLINIC NAME	DATE
TIME			

999999	PATIENT, BARRY	DIABETIC CLINIC	OCT 12, 2025 10:00
888888	PATIENT, RAE	INTERNAL MEDICINE (P	NOV 12, 2025 08:15
End of report. PRESS ENTER:			

Figure 8-18: Listing patient appointments—screen 2

8.7 DM Register Pts w/no recorded DM Date of Onset (NDOO)

When calculating the duration of diabetes for Audit reports, 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 date of the Audit. 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. A report to identify those patients on the Register who do not have a date of onset recorded may be run by selecting the NDOO DM Register Pts w/no recorded DM Date of Onset option (Figure 8-19).

When calculating the duration of diabetes for Audit reports, 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 date of the Audit. 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. A report to identify those patients on the Register who do not have a date of onset recorded may be run by selecting the **NDOO DM Register Pts w/no recorded DM Date of Onset** option (Figure 8-19).

DEMO HOSPITAL (CMBA) User, Demo
This report will list patients who are on the Diabetes Register who do not have a date of diagnosis recorded in either the Register or on the problem list.
Enter the Name of the Register: DEMO DIABETES REGISTER Do you want to select register patients with a particular status? Y// ES Which status: A// [ENT] ACTIVE
Select one of the following: P PRINT the List B BROWSE the List on the Screen
Output Type: B// PRINT the List
Select one of the following: I Include ALL Patients

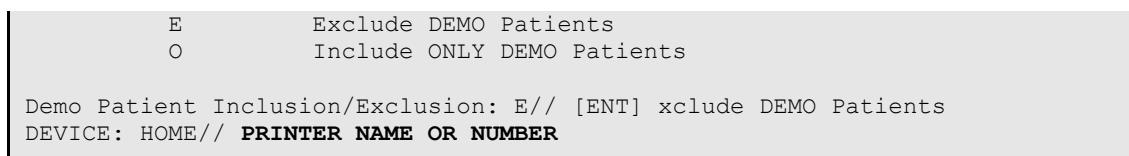


Figure 8-19: DM Register PTs with no recorded DM Date of Onset

The resulting report (Figure 8-20) not only lists those patients with no date of onset recorded but also identifies whether the patients have a diagnosis of diabetes on the active problem list.

***** CONFIDENTIAL PATIENT INFORMATION *****						
SHS Page 1						
DEMO HOSPITAL (CMBA)						
DIABETES REGISTER PATIENTS WITH NO RECORDED DATE OF ONSET OF DIABETES						
Patients on the DEMO DIABETES REGISTER						
PATIENT NAME	HRN	DOB		LAST DM DX	#DM DXS	DM ON PL
-----	-----	-----	-----	-----	-----	-----
DEMO, MONICA	890625	Jan 19, 1957	F	Mar 03, 2017	67	YES
DEMO, AARON V	144227	May 07, 1993	M		0	NO
DEMO, BRAZ	103193	Sep 07, 2010	M		0	NO
DEMO, JESSICA	101578	Jul 10, 1957	F	Nov 12, 2023	14	NO
DEMO, CHRISTIAN JA	135554	Nov 19, 1989	M		0	NO
DEMO, DANIEL MICHA	135205	Feb 10, 1986	M		0	NO
DEMO, RHIANNON RAIN	144277	Jan 20, 1995	F	Oct 28, 2017	4	NO
TEST, AMY	679458	Dec 23, 1934	F	Jan 06, 2023	3	YES
TEST, DONNA	13976	Feb 17, 1954	F	Dec 29, 2018	1	NO
End of report. HIT RETURN:						

Figure 8-20: DM Register PTs with no recorded DM Date of Onset—report sample

Once these patients are identified, the charts may be reviewed or the patients queried to determine the date or estimated date of onset. An actual date, a month and a year, or just a year can be used as a date of onset when updating Register data.

8.8 Follow-up Needed (FU)

The Follow-up Needed report option allows you to identify members of the Register who are delinquent in receiving or have never had exams, procedures, patient education, immunizations, vaccines, or lab tests. A report of those patients identified as requiring follow-up may be generated, custom letters may be generated, or both a report and letters may be generated.

You can choose to generate the report for all members of the **Register**, only **Active patients**, **Inactive patients**, **Transient patients**, **Unreviewed patients**, **Non-IHS patients**, **Noncompliant**, or **Deceased patients**. The report can be generated for all members of the **Register**, a template of patients, or patients with specific diagnoses. In addition, the report may be sorted by community, where the patients are followed, or by their register provider. In the following examples (Figure 8-21 and Figure 8-22), a report on active patients in the **Register** who do not have a foot exam on record in the past year will be generated by selecting the **FU Follow-up Needed** option.

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

1	ALL Exams/Procedures-----		
11	Foot Exam	12	Eye Exam
14	Depression Screening	18	Dental Exam
2	ALL Patient Education-----		
21	Nutrition	22	Physical Activity
23	General Info		
3	ALL Immunizations/Vaccines-----		
31	Seasonal Flu Shot	32	Pneumococcal
33	Td/Tdap	34	TB Test
35	Hepatitis B	36	Shingrix (Age >=50)
37	RSV (Age >=50)		
4	ALL Lab Tests-----		
41	LDL Cholesterol	42	HDL Cholesterol
43	Cholesterol	44	Triglyceride
45	Creatinine	46	Hemoglobin A1c
47	Estimated GFR	48	Quant UACR
49	Hepatitis C Screening		

Type 'ALL' to include ALL Follow-up Needed
Which Report:

Which Report: 1

Select one of the following:

1	Use Register Members
2	Use A Search Template

Which Group: Use Register Members// **[ENT]**

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
NON	Noncompliant
Z	All Register Patients

Which patients: Active// **[ENT]**

Select the Diabetes Diagnosis for this report

Select one of the following:

1	Type 1
2	Type 2
3	Type 1 & Type 2
4	Gestational DM
5	Prediabetes
6	All Diagnoses

Which Diagnosis: All Diagnoses// 2 Type 2 **<<Note: If a Register Diagnosis has not been assigned to all patients, you must choose 6 All Diagnoses for an accurate report. >>**

Include list of patient's upcoming appointments? NO// **[ENT]**

Print the Follow-up Report/Letters by

Select one of the following:

1	Community
2	Primary Provider
3	Where Followed

Which one: Community// **[ENT]** **<<Press Enter to select ALL Communities >>**

(Press <ENTER> to select ALL Communities

Which Community:

Communities Selected:

ALL

Select one of the following:

1	Follow-up Report
2	Follow-up Letter
3	Both

Which one: Follow-up Report// **[ENT]**

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

DEVICE: HOME// **<< Enter name or number of printer >>**

Figure 8-21: Using the FU option—screen 1

The resulting report displays the community, patient names, chart numbers, and the last foot exam. Only those patients who have not had a foot exam in the past year or are due for a foot exam within the next 30 days are displayed. The report is sorted alphabetically by patient name within each community. Each of the follow-up reports can be limited to patients within a specific community or followed by a specific primary provider. To better coordinate the patients' care, an option to display future appointments is also included in the report.

FOLLOW-UP REPORT		Nov 12, 2025 18:29:5		Page: 1 of 1		
DEMO DIABETES REGISTER Register - Active Patients				Page: 1		
Follow-up Report: FOOT EXAM						
(For ** TYPE 2 ** Diabetics Only.)						
(For Patients due now or within the next 30 days)						
REPORT DATE: NOV 12, 2025						
COMMUNITY	PATIENT	HRN	STATUS			
AJO	PATIENT, AMANDA	101422	*NO*	FOOT EXAM on record.		
AJO	PATIENT, JILL	101476	*NO*	FOOT EXAM on record.		
AKCHIN	PATIENT, ALLISON	101387	*NO*	FOOT EXAM on record.		
ANEGRAM	PATIENT, DARLENE	101240	last	FOOT EXAM JUL 13, 2022		
ANEGRAM	PATIENT, JENNIFER	101321	last	FOOT EXAM OCT 10. 2023		
ARTESA	PATIENT, LAURA	100089	*NO*	FOOT EXAM on record.		
ARTESA	PATIENT, MAUDE	100047	*NO*	FOOT EXAM on record.		
BIG FIELDS	PATIENT, LRAINE	100266	last	FOOT EXAM AUG 13, 2023		

- Previous Screen Q Quit ?? for More Actions

Select Action:Quit//

Figure 8-22: Using the FU option—screen 2

8.9

Multiple Registries Community DM Audit (MRDA)

This report will search two or more **Diabetes Registers** (Figure 8-23) to combine a list of patients from a particular community. Choose **MRDA** from the **Register Reports** menu.

DEMO HOSPITAL (INST)
DEMO, LORI
MULTIPLE REGISTER COMMUNITY DIABETES AUDIT
This report will search two or more Diabetes Registers to combine a list of patients from a particular community. You can run the audit just for the subset of patients who live in a particular community.
Do you wish to continue? Y// ES =>> Answer Y to continue
In order for the 2025 DM AUDIT Report to find all necessary data, several

taxonomies must be established. The following taxonomies are missing or have no entries:
 LABORATORY TEST taxonomy [BGP HEP C TESTS TAX] contains a panel test: HEPATITIS C PROFILE and should not.
 DRUG taxonomy [DM AUDIT AMYLIN ANALOGUES] has no entries
 DRUG taxonomy [DM AUDIT COLESEVELAM DRUGS] has no entries
 DRUG taxonomy [DM AUDIT GLP-1 ANALOG DRUGS] has no entries
 LABORATORY TEST taxonomy [DM AUDIT HGB A1C TAX] contains a panel test: HGB A1c (R) and should not.
 DRUG taxonomy [DM AUDIT SGLT-2 INHIBITOR DRUGS] has no entries
 DRUG taxonomy [DM AUDIT SULFONYLUREA-LIKE] has no entries
 End of taxonomy check. HIT RETURN:

Select DIABETES Register

No.	Register Name	# Active members	# members	Last patient update
1	DEMO DIABETES REGISTER	535	539	11/09/2025
2	2020 KDS DIABETES REGISTER	13	13	10/26/2025
3	IHS DIABETES	553	556	09/11/2025
4	DEMO DIABETES REGISTER	29	29	10/05/2025
5	PARKER DIABETES REGISTER	1,002	1,012	10/03/2025
6	SDPI NON DIABETES	158	158	10/04/2025

This response must be a list or range, e.g., 1,3,5 or 2-4,8

Select Diabetes Register(s): (1-6): 3,6 => Choose the registers by number per the instructions above.

You have selected the following register(s):

IHS DIABETES
 SDPI NON DIABETES

Is this correct? Y//

Do you want to select register patients with a particular status? Y// ES
 Select status: A// ACTIVE
 Select another status:

Limit the patients who live in a particular community ? N// YES

Select COMMUNITY NAME: PARKER
 PARKER LA PAZ ARIZONA 285 0415285

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// Indian/Alaskan Native (Classification 01)

There are 443 individual patients in those registers that meet this criteria.

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: 12312025 (DEC 31, 2025)

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//
xclude Pregnant Patients
okay, hold on...this may take a few minutes..

There are 443 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// LL 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) **>> Choose the output type**

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

Select one of the following:

- P PRINT Output
- B BROWSE Output on Screen

Do you wish to: B//

Samples of the various outputs can be found in Appendix D

Figure 8-23: Multiple Registries Community DM Audit

9.0 Retrieval of Clinical Data from the PCC for Patients in the IHS Diabetes Register

Both **PCC Management Reports** and **QMan** can be used to retrieve a variety of data for patients in the IHS Diabetes Register.

9.1 PCC Management Reports

Use the Body Mass Index (BMI) Reports tool in **PCC Management Reports** to follow patients with diabetes. You can run the reports on all the patients in your Register or selected groups based on search templates using the **Patient and Statistical Report** option or QMan. In the following example (Figure 9-1), a **BMI** report will be run on the **TYPE 2 DM PTS** template. Begin by selecting the **BMI** menu option from the main **PCC Management Report** menu.

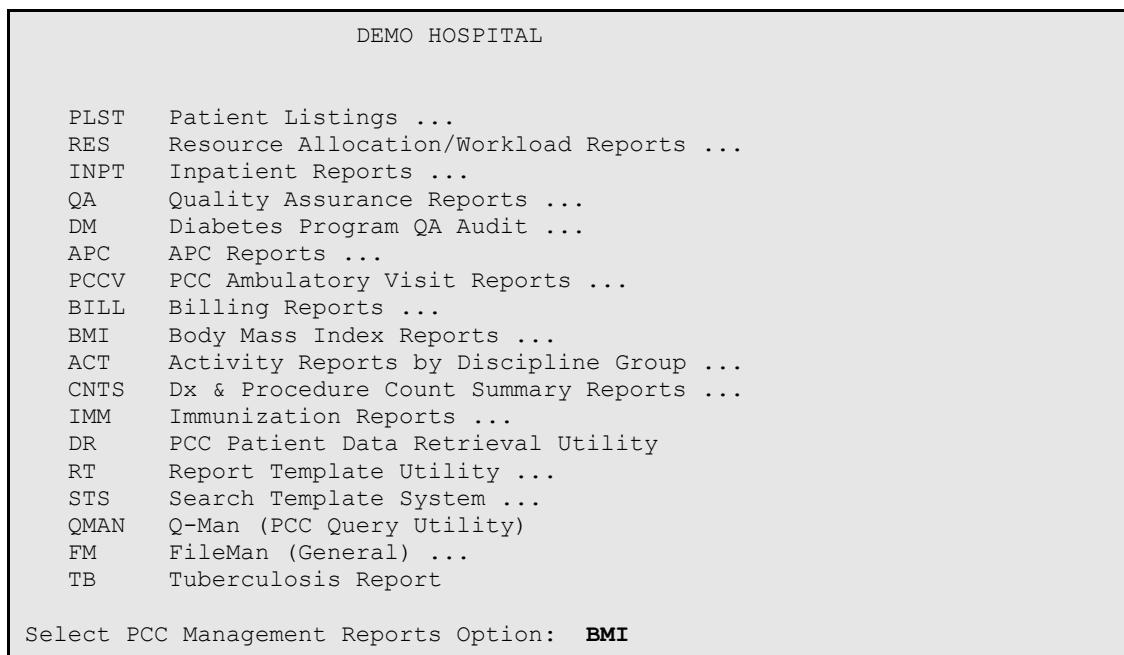
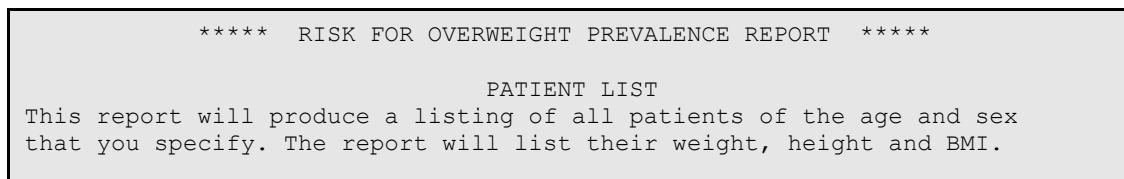


Figure 9-1: PCC management reports

There are several different report options for displaying Body Mass Index, but for the purpose of this example, a list of patients with height, weight and BMI sorted by BMI will display (Figure 9-2). Therefore, the **Listing of Patients with Height/Weight/BMI (LPAT)** option has been selected.



Select one of the following:

S Search Template of Patients
P Search All Patients

Select List : Search Template of Patients [ENT]

Enter Visit SEARCH TEMPLATE name: **TYPE 2 DM PTS**
(Sep 27, 2025) User #605 File #9000001

Select one of the following:

M Males
F Females
B Both

Report should include: B// [ENT]

Do you wish to include ONLY Indian/Alaska Native Beneficiaries? N// Y

Enter a Range of Ages (e.g. 5-12) [HIT RETURN TO INCLUDE ALL RANGES]: **[ENT]**

No age range entered. All ages will be included.

Select one of the following

R Report (Printed or Browsed)
S Sort Template

Type of Output: R// [ENT]

Select one of the following:

P Patient Name
A Age of Patient
B BMI

Sort the report by: P// **B**

Do you wish to suppress patient identifying data (name, chart #)? N// **[ENT]**
DEVICE: HOME// Enter Printer number

Figure 9-2: PCC management reports—screen 2

The resulting report is displayed in Figure 9-3.

DKR DEMO HOSPITAL Page 1
 OVERWEIGHT/OBESITY PREVALENCE REPORT
 PATIENT LISTING

Report includes: MALES & FEMALES / ALL AGES
 Report Includes: INDIAN/ALASKA NATIVES ONLY
 Search Template of Patients: DM TYPE 2 PTS

PATIENT NAME	HRN #	DATE OF			AGE	SEX	BMI	>=	>=
		HEIGHT	WEIGHT	WEIGHT				NHANES	NHANES
PATIENT, BARR	100005	63.8	222.1	01/24/25	33	M	39.6	N	Y

PATIENT, SALLY 100000 64.0 333.0 08/07/25 47 F 58.9 N Y

Figure 9-3: PCC management reports—screen 3

9.2 QMan

QMan, the **PCC query** tool, provides virtually unlimited access to PCC clinical data for patients in your **IHS Diabetes Register**. Many of the follow-up reports formerly requiring QMan to generate are now available through the **Follow-up Report** menu option of the **Diabetes Management System**.

When using **QMan**, all of the patients in your **Register** may be used as the subject of your query by entering **REGISTER** as the subject and **IHS Diabetes** (or the name of your local diabetes register) when prompted for a Register. You may also use QMan for retrieving clinical data on specific subsets of the patients in your register. These subsets of patients are referred to as cohorts or search templates.

You can use the **Master List** or **Patient and Statistical Reports** option to create templates of patients. Both of these options are accessed from the **Register Reports** menu in the **Diabetes Management System**. Using these report-generating options, you can create a template of all patients in your register, all active patients, patients in selected age groups or communities, patients with selected diagnoses or complications, or patients in other categories as needed.

Important: If you are sorting by diagnosis, each patient in the Register must have been assigned a diagnosis or the resulting report will be invalid.

The process for generating templates is described in Section 8.5.

Formal **QMan** training for Diabetes Coordinators is essential to optimize use of the link between the **Diabetes Register** and the **PCC**. Instructions on using QMan are not provided in this manual. The remainder of this section provides QMan dialogue for producing three QMan outputs. These outputs are representative of the many QMan searches of PCC clinical data that are available.

9.2.1 Using Register as the Subject of a Search

In this example, a list of the last Hemoglobin A1C for each patient in the Register will be created. User responses and instructions are in **bold** type.

1. Type **REGISTER** at the “What is the subject of your search” prompt.
2. Type the **name** of your **Register** at the “Which CMS Register” prompt.
3. Type the **Status** of the patients at the “Which Patients” prompt.

4. Type the **Diabetes Diagnosis** of the patients for this report at the “Which Diagnosis” prompt.

Remember, you may only select a specific diagnosis if all of your patients have been assigned a Register diagnosis.

5. Type the desired **attribute** at the “Attribute of IHS Diabetes Register” prompt (Figure 9-4).

What is the subject of your search? LIVING PATIENTS // **REGISTER**
Which CMS REGISTER: **IHS DIABETES**
Select the Patient Status for this report

- 1 Active
- 2 Inactive
- 3 Transient
- 4 Unreviewed
- 5 Deceased
- 6 Non-IHS
- 7 All Register

Which patients: 1// **[ENT]**

Select the Diabetes 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 Diagnosis: All Diagnoses//

Attribute of IHS DIABETES REGISTER: **A1C**

Figure 9-4: Using Register as the Subject of a Search (steps 1-4)

6. Type the **first condition** at the “First condition of attribute” prompt.
7. Type the **value** at the “Value” prompt.
8. Type another condition or press Enter to continue at the “Next condition of attribute” prompt.
9. Type a selection from the **QMan Output Options** at the “Your Choice” prompt.
10. If a clinical attribute was chosen, choose between values of the clinical attribute, an extended display of the values, or unduplicated patients by typing a number for the selection at the “Your Choice” prompt (Figure 9-5).

SUBQUERY: Analysis of multiple HEMOGLOBIN A1CS
First condition of "HEMOGLOBIN A1C": **LAST**

```

Enter the value which goes with LAST; e.g., LAST 3, LAST 10,
etc.
Value: 1
Next condition of "HEMOGLOBIN A1C": [ENT]

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

You have 3 options for listing HEMOGLOBIN A1C RESULTS =>

1) List every RESULTS meeting search criteria.
2) List every RESULTS and EXPANDED LAB REPORT meeting search
   criteria.
3) List all PATIENTS with RESULTS you specified, but DO NOT list
   individual RESULTS or EXPANDED LAB REPORT (FASTEST OPTION!!)
   (Displays UNDuplicated list of PATIENTS)
Your choice (1-3): 1// [ENT]

```

Figure 9-5: Using Register as the Subject of a Search (Steps 5-9)

A section of the resulting report displays as shown in Figure 9-6.

PATIENTS	DEMO	A1C	A1C DATE
	NUMBER	%	
PATIENT, SALLY*	100010	13.3 H	JAN 12, 2025
PATIENT, BARRY	100035	10.8 H	SEP 22, 2025
PATIENT, RUTH	100383	6.5	DEC 1, 2019
PATIENT, MEGAN	100557	4.5	JUL 13, 2022
PATIENT, BARBARA	100643	7.8 H	DEC 1, 2023
PATIENT, MAXINE	100771	10.0 H	DEC 1, 2021
PATIENT, DARLENE	101240	8.4 H	JUL 13, 2025
PATIENT, ROSE	101599	6.0	JUL 13, 2023
PATIENT, BARRY	101860	7.2 H	DEC 1, 2022

Figure 9-6: Using Register as the subject of a search—sample report

9.2.2 Using a Template of Patients with Diabetes as an Attribute

In this example, a search will be made using the **Type 2 DM Patients** template as an attribute and a query will be made to determine which of them have not been seen in the dental clinic in the last year. To use a template of patients as an attribute, begin by identifying your search subject as LIVING PATIENTS. When you are prompted for an Attribute of the patients, type the left bracket symbol ([) followed by the name of your template, and close it with a right bracket symbol (]): **[TYPE 2 DM PTS]**. You will then be given four options related to your template. Select option 1 to indicate that the patients to be searched must be members of your template.

The following **QMan** examples (Figure 9-7 and Figure 9-8) will produce the list of patients who have not been seen in the Dental Clinic in the last year. User responses and instructions are in bold type.

1. Type the **subject** of your search at the “What is the subject of your search” prompt.
2. Type the **attribute** at the “Attribute” prompt.
3. Type a **number** for the selection list at the “Your Choice” prompt.

What is the subject of your search? LIVING PATIENTS // **[ENT]**

Attribute: **[TYPE 2 DM PTS**

Select one of the following =>

1) LIVING PATIENTS must be a member of the TYPE 2 DM PTS cohort
 2) LIVING PATIENTS must NOT be a member of the TYPE 2 DM PTS cohort
 3) Select a random sample of the TYPE 2 DM PTS cohort
 4) Count the number of entries in the TYPE 2 DM PTS cohort

Your choice (1-4): 1// **[ENT]**

Figure 9-7: Using a Template of Patients with Diabetes as an Attribute (steps 1-3)

4. Type an **attribute** at the next “Attribute” prompt.
5. Type the first **condition** of the attribute, **During**, at the “First Condition/Attribute of VISIT” prompt.
6. Type the **date** or the **date one year ago** at the “Exact Date” prompt.
7. Type the next **condition** at the Next Condition/Attribute of Visit prompt.
8. Type the name of the **clinic**, **Dental**, at the “Clinic” prompt.
9. Type the **name** of another clinic or press the Enter key to continue at the next “Enter Clinic” prompt.

10. Type the next **condition**, **NULL**, at the “Next Condition/Attribute of Visit” prompt. Null means that the patient has not had a dental clinic visit in the past year.
11. Type the next **condition** or press Enter to continue at the “Next Condition/Attribute of Visit” prompt.
12. Type the next **attribute** or press Enter to continue at the “Next Attribute” prompt.
13. Type the **number** for the selection of **QMan Output Options** at the “Your Choice” prompt.

```

Attribute: VISIT
First Condition/Attribute of VISIT: SINCE
Exact Date: T-365
Next Condition/Attribute of VISIT: CLINIC
Enter Clinic: DENTAL
Enter Clinic: [ENT]
Next Condition/Attribute of VISIT: NULL
Next Condition/Attribute of VISIT: [ENT]
Next Attribute: [ENT]

* * 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
    [ETC.]

Your Choice: DISPLAY// 1

```

Figure 9-8: Using a Template of Patients with Diabetes as an Attribute (steps 4-13)

QMan will display the patients (Figure 9-9) in your cohort who have not visited the dental clinic in the past year. A dash (-) in the **Visit** column indicates that no visit to the dental clinic within the designated time frame has occurred.

PATIENTS (Alive)	DEMO	VISIT NUMBER
PATIENT, RAE*	100003	-
PATIENT, SALLY*	100010	-
PATIENT, BARRY	100035	-
Total: 3		

Figure 9-9: Using a template of patients with diabetes as an attribute—sample

10.0 Diabetes Audit

Each year since 1986, the IHS Division of Diabetes Treatment and Prevention has coordinated a medical records review of American Indian and Alaska Native diabetes patients from IHS, tribal, and urban (I/T/U) facilities. The Audit measures 80–90 different items, some reflecting the process of diabetes care and others reflecting diabetes outcomes. The **Diabetes Management System** allows you to either partially or fully automate the process of gathering data for the **Annual Diabetes Audit**.

Refer to Appendix D for details on **DMS Audit** tools.

Additional information about the Audit is available on the Division of Diabetes website: <https://www.ihs.gov/diabetes/audit/>

11.0 Health Summary Tools for Diabetes Care

The tools described below: **Diabetes Patient Care Summary, Educational Assessment, Refusals, and DM Health Maintenance Reminders**, can be included on any type of Health Summary. However, it is strongly recommended that they be added to the routinely used adult health summary at your facility. At most facilities that would be the Adult Regular Health Summary or a locally developed version of the Adult Regular Summary. This recommendation is made so that these important diabetes care reminders are seen by providers at all visits, such as Diabetes Clinic, Primary Care Clinics, Specialty Clinics, Urgent Care, and Emergency Room.

11.1 Diabetes Standard Summary

The **Diabetes Standard Summary** is special type of health summary for patients with diabetes. There are several ways to display the **Diabetes Standard Summary** for a patient with diabetes. At the main **Diabetes Management System** menu, select **RM Register Maintenance** and then **PM Patient Management**. In the **Patient Management** dialog, option **11** enables you to select a **Health Summary** type. When prompted for a health summary type, enter **DIABETES STANDARD**. The **Health Summary** is displayed on the terminal screen. This option permits the user to use the minus (-), plus (+), up-arrow, and down-arrow keys to scroll through the **Health Summary** or to review various items of interest.

This Health Summary is similar to the **Adult Regular Summary** except that it includes a **Diabetes Patient Care Summary** at the end of the report. The **Diabetes Patient Care Summary** provides an overview of all **IHS Diabetes Standards of Care** for that patient. It is triggered by the presence of a problem of Diabetes on the Active Problem list or a diagnosis of Diabetes in the last year by a primary provider. The **Diabetes Standard Health Summary** should be routinely printed by Health Records staff for all diabetes clinic visits.

An option can be set to automatically print the **Diabetes Standard Health Summary** for patients with Diabetes regardless of when or where the health summary is printed. The **Update Health Summary Site Parameters** option is included under the **Health Summary Maintenance Menu**. Instructions for setting up this feature are provided below.

1. In the **Health Summary Maintenance Menu**, select **HSSP Update Health Summary Site** parameters.
2. Identify the name of your facility.
3. Type **YES** at the “Auto-switch to DM Summary” prompt.
4. At the “Default DM Health Summary Type” prompt (Figure 11-1), type **DIABETES STANDARD**.

```
Select HEALTH SUMMARY SITE PARAMETERS SITE NAME: DEMO HOSPITAL [ENT]
SITE NAME: DEMO HOSPITAL// [ENT]
AUTO-SWITCH TO DM SUMMARY: YES [ENT]
DEFAULT DIABETES SUMMARY TYPE: DIABETES STANDARD [ENT]
```

Figure 11-1: Default DM Health Summary Type: Diabetes Standard

11.2 Diabetes Patient Care Summary

The **Diabetes Patient Care Summary** (Figure 11-2), also referred to as the **Diabetes Supplement**, provides a complete review of the patient's care in relation to the IHS Diabetes Standards of Care. It includes virtually all data items used by the **Diabetes Management System Audit**. It is intended to alert providers to Diabetes Standards of Care for which the patient is deficient each time the patient is seen, thus encouraging providers to attend to these needs prospectively during the course of the year. See Figure 11-2 for an example.

For more details, refer to Appendix D for the logic and clinical data as it relates to the **Diabetes Audit**.

```
***** CONFIDENTIAL PATIENT INFORMATION [LB] Oct 24, 2025 *****
DIABETES PATIENT CARE SUMMARY Report Date: 10/24/2025

Patient: DEMO,BRENDA ANN HRN: 101439
Age: 49 (DOB 01/16/1973) Sex: FEMALE
CLASS/BEN: INDIAN/ALASKA NATIVE Designated PCP:

Date of DM Diagnosis: 03/01/2019 (Problem List)
Diabetes type: (1 or 2): 2

BMI: 25.0 Last Height: 65.00 inches 10/06/2025
Last Weight: 150 lbs 10/06/2025

Tobacco Use:
Last Screened: 10/06/2025
Current Status: Current user CURRENT SMOKER, SOME DAY 10/06/2025
Tobacco cessation counseling/education received in the past year:
Yes 10/06/2025 CPT G9458

Electronic Nicotine Delivery Systems (ENDS)
Last Screened: Never
Current Status:

HTN Diagnosed ever: Yes
CVD Diagnosed ever: No
Last 3 BP: 120/90 10/06/2025

ACE Inhibitor or ARB prescribed (in past 6 months): No
Aspirin or Other Anti-platelet/Anticoagulant prescribed (past 6 months):
Yes 10/06/2025 ASPIRIN 325MG EC
Statin prescribed (in past 6 months): No

Exams (in past 12 months):
Foot: Yes 10/06/2025 CPT: G0245
Eye: Yes 10/06/2025 Diabetic Eye Exam
Dental: No
```

Depression:			
Screened in past year: Yes - DX: Z13.32 10/06/2025			
Active diagnosis in past year: No			
Immunizations:			
Influenza vaccine (since August 1st): Yes 10/06/2025			
Pneumococcal [PCV15, PCV20, PCV21, or PPSV23] (ever): Yes 02/02/2024			
Td/Tdap/DTAP/DT (in past 10 yrs): Yes 10/06/2024			
Tdap (ever): Yes 10/06/2024			
Hepatitis B complete series (ever): No			
Shingrix/RZV complete series (ever): No			
Respiratory syncytial virus (RSV) vaccine (ever): Yes 07/21/2025			
Tuberculosis (TB):			
TB diagnosis (latent or active) documented ever: No			
Last Documented TB Test: Skin test (PPD) 09/30/2024			
TB Test Result: Positive 9/30/24 Reading: 30 Result: P			
TB Treatment initiated (isoniazid, rifampin, rifapentine, others): No			
Hepatitis C (HCV)			
Diagnosed with HCV ever: No			
Screened for HCV ever: No			
Retinopathy Diagnosed (ever): No			
Amputation			
Lower extremity (ever), any type (e.g., toe, partial foot, above or below knee): No			
Laboratory Results (most recent):	RPMS LAB TEST NAME		
A1C: 8.2	10/06/2025 HA1C-DEHR		
Next most recent A1C:			
Serum Creatinine:			
eGFR: 55 mL/min	04/03/2025 ESTIMATED GFR		
Quantitative UACR 30 mg/g	04/03/2025 ALBUMIN/CREATININ		
Total Cholesterol: 220	10/06/2025 TOTAL CHOLESTEROL		
LDL Cholesterol: 100	10/06/2025 LDL CHOLESTEROL		
HDL Cholesterol: 45	10/06/2025 HDL CHOLESTEROL (R)		
Triglycerides: 120	10/06/2025 TRIGLYCERIDE (R)		
Continuous Glucose Monitoring (CGM) (most recent data)			
GMI 8% 09/03/2025 GLUCOSE MANAGEMENT INDICATOR			
DURATION: 10 days			
TARGET RANGE: 70-180 mg/dL			
TIR 90% 09/03/2025 TIME IN TARGET RANGE			
Education Provided (in past yr):			
Last Dietitian Visit (ever):			
DM-EXERCISE 10/06/2025			
DM-NUTRITION 10/06/2025			
DEMO, BRENDA ANN	DOB: 1/16/1973 Chart #DB 101439		

Figure 11-2: Diabetes Patient Care Summary

Normally the **Patient Care Summary** prints after the **Flow Sheet** on the **Diabetes Standard Health Summary**. In the **Patient Management** dialog, the option **12 DM Care Summary (DPCS)** allows the user to display the **DPCS** to the terminal. This option permits the user to use the minus (-), plus (+), up-arrow, and down-arrow keys to scroll through the **DPCS** or to return to review various items. Some facilities choose to print these for each patient with diabetes prior to a clinic appointment and highlight overdue items as a reminder for the provider seeing the patient.

11.3 Prediabetes Patient Care Summary

The **Prediabetes Patient Care Summary** was updated in BDM v2.0 p17. It must be added under health summary maintenance as a supplement type to any health summaries that are routinely used at your health care facility. Printing of this supplement is triggered by a diagnosis of **Prediabetes, Impaired Fasting Glucose, or Impaired Glucose Tolerance** on the active problem list or made by a primary care provider in the past year. It will not be printed if the patient has a diagnosis of diabetes on the active problem list or a primary provider has used a diagnosis of diabetes in the past year. This supplement was designed as a tool for displaying data items that are important in following patients who may be predisposed to developing diabetes. An example of a **Prediabetes Patient Care Summary** is provided in Figure 11-3.

```
***** CONFIDENTIAL PATIENT INFORMATION [LAB] Nov 07, 2025 *****
PREDIABETES PATIENT CARE SUMMARY                                         Report Date: Nov 07, 2025

Patient: DEMOPATIENT,CHARLES                                         HRN: 142692
Age: 29 (DOB 11/23/1993)                                         Sex: MALE
CLASS/BEN: INDIAN/ALASKA NATIVE                                     Designated PCP: NURSE, BARBARA A R N

Diagnosis
Problem List (Date of Diagnosis)
Impaired Fasting Glucose      (Date of Onset not recorded)
Prediabetes                  (Feb 01, 2023)

Diagnosis first recorded in PCC (Used as POV):
Impaired Fasting Glucose      Mar 02, 2020
Prediabetes                    Aug 04, 2023

BMI: 27.1  Last Height: 72.00 inches  08/04/2025
                                         Last Weight: 200 lbs      08/04/2025

Tobacco Use:
Last Screened: 08/04/2025
Current Status: Current user CURRENT SMOKER, SOME DAY 08/04/2025
Tobacco cessation counseling/education received in the past year:
Yes 08/04/2025 TO-QT

HTN Diagnosed ever: No
Last 3 BP:      120/76  08/04/2025
                130/88  12/05/2022
                108/65  05/01/2012
```

Statin prescribed (in past 6 months): No		
Laboratory Results (most recent):		
A1C:	6.2 %	08/04/2025 HEMOGLOBIN A1C
Next most recent A1C:	5.6 %	03/02/2020 HEMOGLOBIN A1C
Last Fasting Glucose:	110 mg/dL	08/04/2025 GLUCOSE (CCDA)
Last 75 GM 2 hour Glucose:	150	08/04/2025 Glucose, Imp.GTT.2 Hr
Quantitative UACR:	15 mg/g	08/04/2025 ..ALBUMIN/CREATININE
Total Cholesterol:	200 mg/dL	08/04/2025 CHOLESTEROL (POCT)
LDL Cholesterol:	90 mg/dL	08/04/2025 LDL CHOLESTEROL
HDL Cholesterol:	50 mg/dL	08/04/2025 HDL CHOLESTEROL
Triglycerides:	300 mg/dL	08/04/2025 TRIGLYCERIDE (POCT)
Education Provided (in past yr):		
Last Dietitian Visit (ever):		
DM-DISEASE PROCESS	09/27/2025	
DM-MEDICAL NUTRITION THERAPY	12/05/2025	DEMO, RODNEY MD
DM-NUTRITION	09/27/2025	
DEMOPATIENT, CHARLES	DOB: 11/23/1993	Chart #TST 142692

Figure 11-3: Prediabetes Patient Care Summary

11.4 Other Health Summary Components

There are two other health summary components that may be useful for diabetes care:

- **Medications**—Displays medications for the patient.
- **Laboratory Data**—Displays lab tests and results for the patient.

These components may be added using the **Create/Modify a Summary Type** menu option under **Health Summary Maintenance**. A segment of a health summary showing these components is displayed in Figure 11-4.

----- EDUCATIONAL ASSESSMENT -----	
Most recent Health Factor recorded.	
Learning Preference: LEARNING PREFERENCE-VIDEO Sep 09, 2025	
Readiness to Learn: READINESS TO LEARN-UNRECEPTIVE Sep 09, 2025	
Barriers to Learning: BARRIERS TO LEARNING-NO BARRIERS Sep 09, 2025	
----- PATIENT REFUSALS FOR SERVICE (max 10 visits or 2 years) -----	
--	
Jun 23, 2023 SCREENING MAMMOGRAM (RADIOLOGY EXAM)	
Refusal Type: REFUSED SERVICE	
Jun 22, 2022 ECG SUMMARY (EKG)	
Refusal Type: REFUSED SERVICE	
*** END CONFIDENTIAL PATIENT INFORMATION -- 6/28/2025 2:07 PM [CMI]	

Figure 11-4: Educational Assessment and Refusals of Service Components

Appendix A Bulletin System for Notification of Newly Diagnosed Patients

The **RPMS MailMan** system can be used to generate bulletins to members of a Diabetes Team, so that newly diagnosed diabetes patients, those with new complications, those with abnormal fasting glucose values, or those with abnormal 2-hour glucose tolerance test results are not lost to follow-up. The bulletins are added automatically to the facility Bulletin file during installation of the PCC Management Reports Package. Refer to the *PCC Management Reports* documentation to add them manually, if they are not available.

The bulletins are:

- **APCL DIABETES REG COMPLICATION**
- **APCL DIABETES REG NEW CASE**
- **APCL IFG NOTIFICATION**

Note: You must have Fasting Glucose lab tests added as members to the **DM AUDIT FASTING GLUCOSE** lab test taxonomy.

- **APCL IGT NOTIFICATION**

Note: You must have the 2 Hr Post 75 Gm Glucose test added as a member to the **DM AUDIT 75GM 2HR GLUCOSE** lab test taxonomy.

Seek assistance from your local IT staff if you do not have FileMan security to set up a new **Mail Group**, **Add Members**, and add that **Mail Group** to the **PCC Management Reports Bulletins**.

It is currently recommended that only the bulletins for patients newly diagnosed with **Diabetes**, **IGT**, or **IFG** be set up. If the complications on the complication list have been appropriately linked to **ICD-9** or **ICD-10** codes, the patients on the Diabetes Register will automatically be updated with their complications via provider POV recording and data entry coding.

A **Mail Group** for the **Diabetes Team** (Figure A-1) may already exist on your system. If not, one may be set up as follows:

VA Fileman Version 21.0

Select VA FileMan Option: **Enter or Edit File Entries**

INPUT TO WHAT FILE: MAIL GROUP//
EDIT WHICH FIELD: ALL//

```

Select MAIL GROUP NAME: DIABETES TEAM
Are you adding 'DIABETES TEAM' as a new MAIL GROUP (the 17TH)? No// Y (Yes)
  MAIL GROUP COORDINATOR: USER,DAVID K           DKR
Select MEMBER: USER,BETTY           BM
  Are you adding 'USER,BETTY' as a new MEMBER (the 1ST for this MAIL GROUP)? No// Y
  (Yes)
Select MEMBER: USER,DAVID K
  Are you adding 'USER,DAVID' as a new MEMBER (the 2ND for this MAIL GROUP)? No// Y
  (Yes)
DESCRIPTION:
  No existing text
  Edit? NO//Y
===[ WRAP ]===[ INSERT ]=====< DESCRIPTION >===== [ <PF1>H=Help ]=====
THIS GROUP RECEIVES BULLETINS FOR NEWLY DIAGNOSED DIABETICS AND THOSE WITH NEW
COMPLICATIONS.

TYPE: PRIVATE
ORGANIZER: USER,DAVID K
COORDINATOR: USER,DAVID K
Select AUTHORIZED SENDER:
ALLOW SELF ENROLLMENT?: NO
REFERENCE COUNT:
LAST REFERENCED:
RESTRICTIONS: 0

```

Figure A-1: Setting up a Mail Group for the Diabetes team

Additional entries to the **Mail Group** may be made for remote members outside the local facility but will require assistance from the IHS National Mailman Coordinator.

Once the **Mail Group** and members have been defined, all that remains is assigning this **Mail Group** (Figure A-2) to the desired APCL Bulletins:

```

VA Fileman Version 21.0

Select VA FileMan Option: Enter or Edit File Entries

INPUT TO WHAT FILE: BULLETIN
EDIT WHICH FIELD: ALL// [ENT]

Select BULLETIN NAME: APCL
  1  APCL DIABETES REG COMPLICATION
  2  APCL DIABETES REG NEW CASE
CHOOSE 1-2: 2 APCL DIABETES REG NEW CASE
NAME: APCL DIABETES REG NEW CASE Replace
SUBJECT: DM NEW CASE// [ENT]
Select MAIL GROUP: DIABETES TEAM
Are you adding 'DIABETES TEAM' as a new MAIL GROUP (the 1ST for this BULLETIN)
? No// Y
Select MAIL GROUP:
DESCRIPTION:
This bulletin will be sent to diabetes control officer when a patient is seen for
the first time for a dm diagnosis

  Edit? NO// 
MESSAGE: . . .
  . . .
was seen on |3| at |15|

```

with the following diagnosis:
ICD10 Code: |1| ICD Description: |8|
Provider Stated: |4|
This is the first time that this patient has been seen for the diabetes diagnosis listed above. This patient/visit may require your follow-up. Please review the patient's medical record at your earliest convenience for further information.

Edit? NO// **[ENT]**

Figure A-2: Assigning a Mail Group to the desired APCL Bulletins

Repeat the process for the bulletins **APCL DIABETES REG COMPLICATION**, **APCL IFG NOTIFICATION**, and **APCL IGT NOTIFICATION**.

To be sure that the bulletin system works correctly, add a new diabetes complication as a Purpose of Visit to a DEMO, PATIENT in your facility database. If the **Mail Groups** and **Bulletins** have been set up correctly, you should see, within a few minutes of entering the complication as a Purpose of Visit, a notice that you have a new mail message when signing on to RPMS.

Appendix B Word Processing Commands

This appendix lists the commands used in the **ScreenMan** word processing fields. These commands can be accessed at any time in the word processing screen by pressing F1 (PF1 on some keyboards) followed by the H key.

B.1 Summary of Key Sequences

Navigation

Incremental movement	Arrow keys
One word left and right	<Ctrl-J> and <Ctrl-L>
Next tab stop to the right	<Tab>
Jump left and right	<PF1><Left> and <PF1><Right>
Beginning and end of line	<PF1><PF1><Left> and <PF1><PF1><Right>
Screen up or down	<PF1><Up> and <PF1><Down> or: <PrevScr> and <NextScr>
Top or bottom of document	<PF1>T and <PF1>B
Go to a specific location	<PF1>G

Figure B-1: Navigation options

Exiting/Saving Options	
Exit and save text	<PF1>E
Quit without saving	<PF1>Q
Exit, save, and switch editors	<PF1>A
Save without exiting	<PF1>S

Figure B-2: Exiting/Saving

Deleting

Character before cursor	<Backspace>
Character at cursor	<PF4> or <Remove> or <Delete>
From cursor to end of word	<Ctrl-W>
From cursor to end of line	<PF1><PF2>
Entire line	<PF1>D

Figure B-3: Deleting options

Settings/Modes

Wrap/nowrap mode toggle	<PF2>
Insert/replace mode toggle	<PF3>
Set/clear tab stop	<PF1><Tab>
Set left margin	<PF1>,
Set right margin	<PF1>.
Status line toggle	<PF1>?

Figure B-4: Settings/Modules options

Formatting

Join current line to next line	<PF1>J
Reformat paragraph	<PF1>R

Figure B-5: Formatting options (1)

Finding

Find text	<PF1>F or <Find>
Find next occurrence of text	<PF1>N
Find/Replace text	<PF1>P

Figure B-6: Formatting options (2)

Cutting, Copying, and Pasting

Select (Mark) text	<PF1>M at beginning and end of text
Unselect (Unmark) text	<PF1><PF1>M
Delete selected text	<Delete> or <Backspace> on selected text
Cut and save to buffer	<PF1>X on selected text
Copy and save to buffer	<PF1>C on selected text
Paste from buffer	<PF1>V
Move text to another location	<PF1>X at new location
Copy text to another location	<PF1>C at new location

Figure B-7: Cutting, Copying, and Pasting options

Appendix C Visual DMS

A graphical user interface (GUI) or Windows-based version is available for the **Diabetes Management System (DMS)** software. The GUI version of the software contains most of the existing functionality of the traditional **Roll and Scroll RPMS** application, including patient management, register maintenance, running reports, and running the **Diabetes Audit**.

To avoid redundancy, this Appendix only includes the steps for using the **Visual DMS** and does not include background information, such as how to use the patient management list manager, set up taxonomies, add or delete users, or run reports. This information is included in other sections of this manual.

C.1 Getting Started

1. After the **DMS GUI** is installed, a shortcut will appear on the Windows desktop that is labeled **Visual DMS** (Figure C-1). Double-click that icon to open the **DMS GUI**.

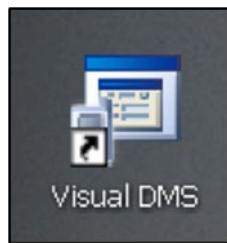


Figure C-1: Visual DMS shortcut

2. The program window (Figure C-2) will display briefly before you are prompted to enter an **RPMS server** and **port**.



Figure C-2: Visual DMS splash window

3. On the **Visual DMS Login** dialog (Figure C-3), select the **RPMS Server** from the drop-down menu that you would like to connect to and enter your **Access Code** and **Verify Code**. Click **OK**.

Note: This information will be saved and will not need to be changed unless you select a different server.

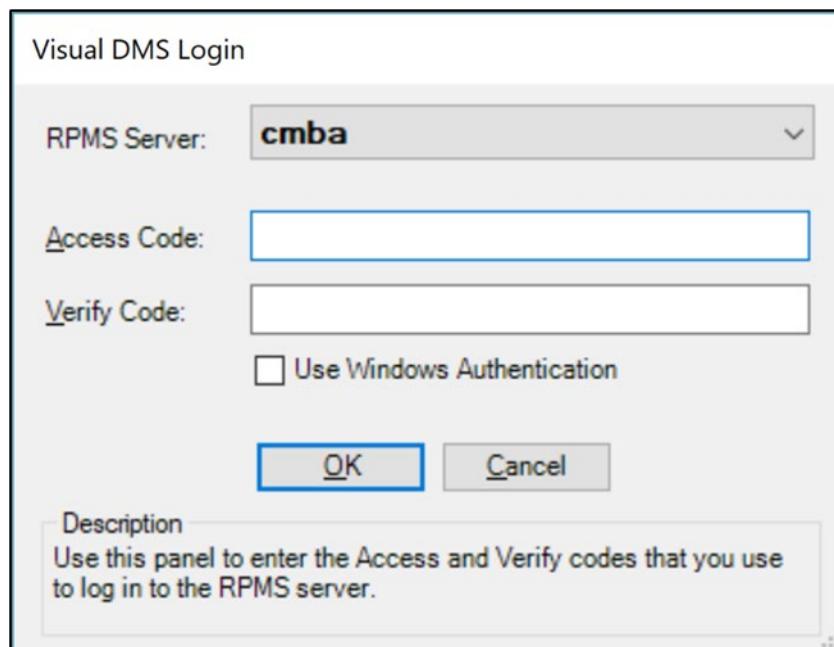


Figure C-3: Visual DMS Login dialog

4. If you are a multidivisional site, the following dialog will display. Select the appropriate **Division** (Figure C-4) from the list displayed.

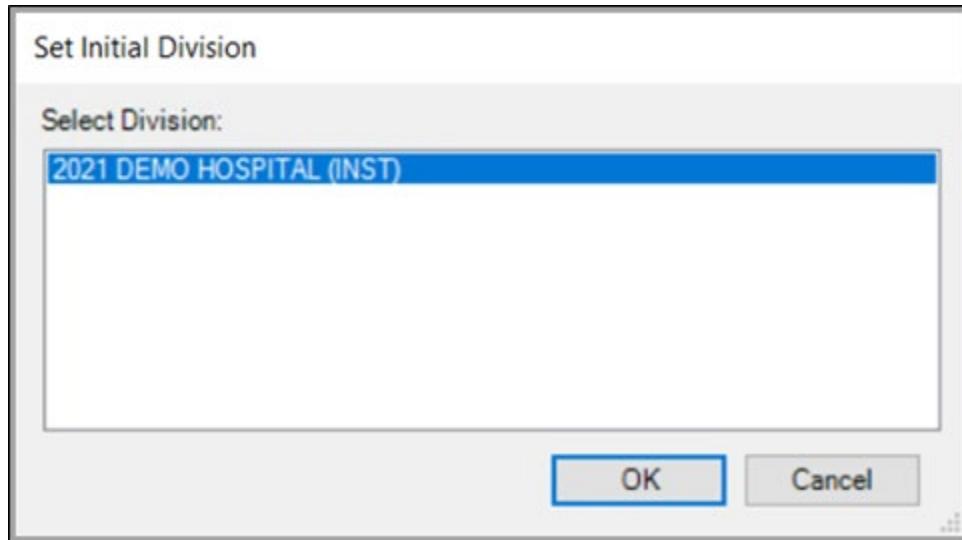


Figure C-4: Select Initial Division dialog

5. A list of **Diabetes Registers** that you are an authorized user for displays. Select the **Register Name** (Figure C-5) that you want to use.



Register Name	Active Members	Members	Last Patient Update
2017 DIABETES REGISTER	556	561	10/22/2024
2020 KDS DIABETES REGISTER	28	28	11/23/2022
2024 DIABETES REGISTER	83	83	11/16/2023
IHS DIABETES	560	563	11/25/2023
IHS PRE-DIABETES	133	133	11/17/2023
LORI'S DIABETES REGISTER	37	38	01/11/2024
MOHAVE DIABETES REGISTER	110	110	05/18/2004
PARKER DIABETES REGISTER	1,002	1,013	06/07/2022

Figure C-5: Select Register list dialog

6. The **Visual DMS** window (Figure C-6) opens and displays the main menu.

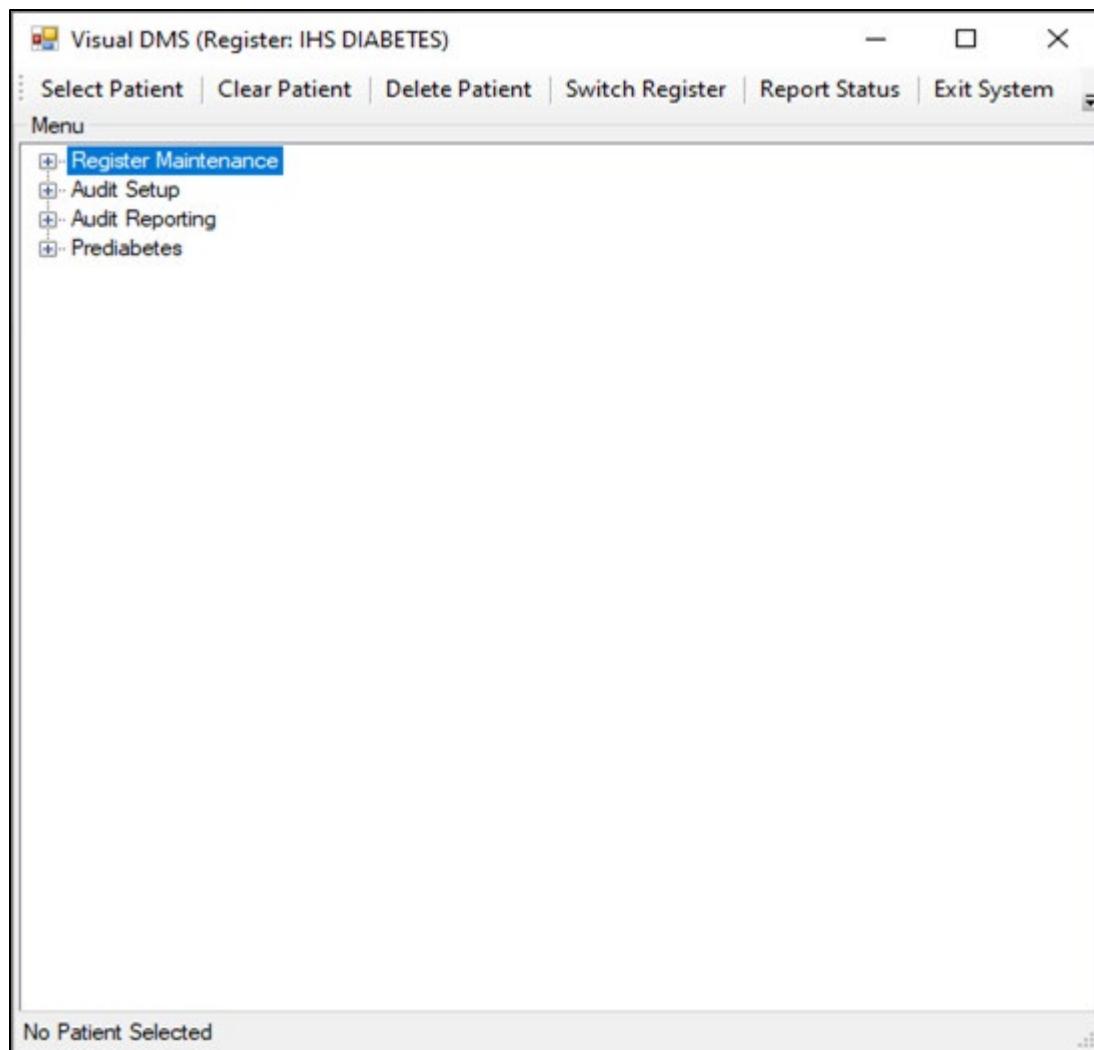


Figure C-6: Visual DMS main menu dialog

7. Select a **Register** to begin using either the listed options or select from the toolbar at the top of the window.

The name of the **Register** that you are currently using displays in the title bar of the window.

The window can be enlarged by either clicking on the box in the upper right corner of the screen or using the mouse to resize. To use the mouse, point it at the lower right-corner of the screen, hold down the left mouse button, and drag to resize the window.

A plus sign (+) in a box preceding a menu item indicates more menu options in that category. Display the options by clicking the plus sign.

C.2 Toolbar Options

There are seven toolbar options and four main menu options. The seven toolbar options are described in the following sections.

C.2.1 Select Patient

1. Click the **Select Patient** button to select a patient and use any of the **Patient Management** options. Patients can be identified by:
 - **Last Name**
 - **First Name**
 - **Date of Birth**
 - **Chart Number**
2. Click the **Display** button or press Enter to view a list of matching patients (Figure C-7). If the list is too long to display on a single page, use the scroll bar or click the **More** button to view additional names.
3. Select a name in the list to select a patient.

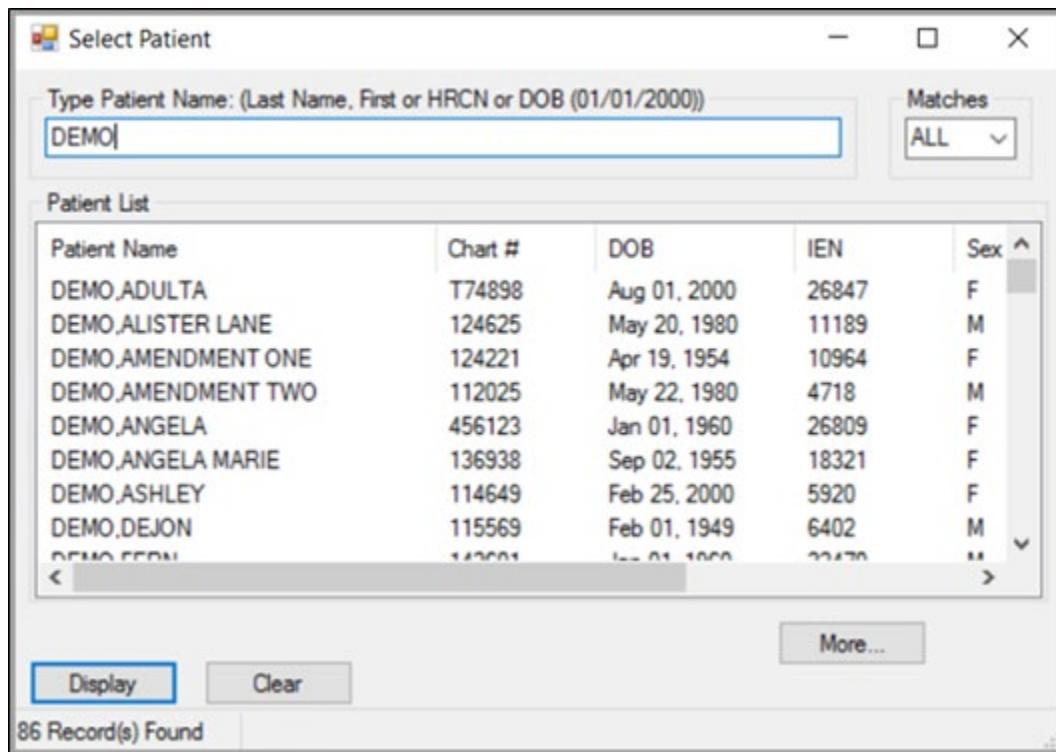


Figure C-7: Select Patient dialog

If you select a patient who is not currently a member of the **Register**, you will be asked if you want to add the patient to the **Register**.

4. Click **Yes** to add the patient.

If you click the **Select Patient** toolbar button while working on another patient, a warning box will ask if you want to switch patients.

5. Click **Yes** to switch or **No** to continue working with the same patient.

The **Register** that you are currently working with will always displays in the title bar at the top of the window (Figure C-8). If you have a patient currently selected, their identifying information is displayed in the gray bar at the bottom of the window.

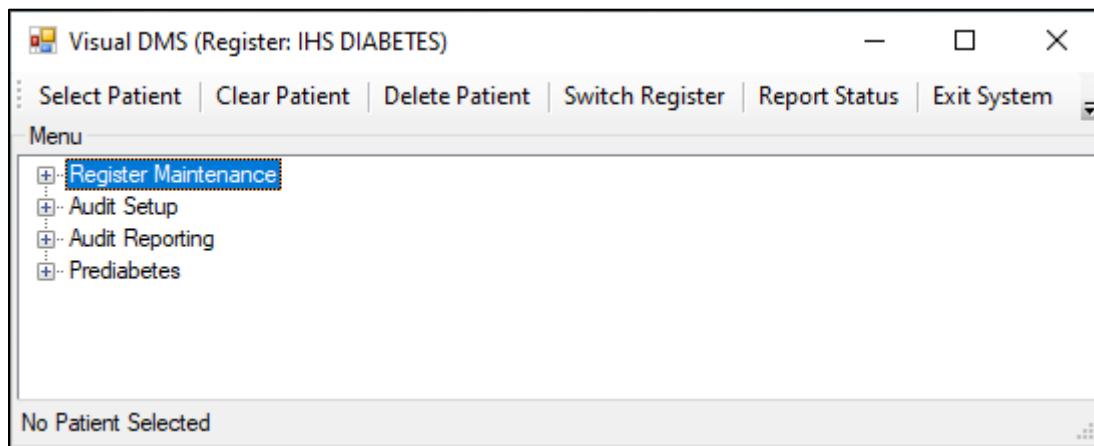


Figure C-8: Visual DMS with patient selected dialog

C.2.2 Delete Patient

To delete a patient from the **Register**, click the **Delete Patient** option. If you click this option while working with a patient (the name displayed at bottom of the window), the program will assume that you want to delete this patient. Click **Yes** to delete this patient.

If no patient is selected and you click the **Delete Patient** option, you will be prompted to identify the patient you want to delete (patient's Last Name, First Name, Chart Number, or Date of Birth). Select the patient to immediately delete the record from the **Register**.

Warning: Deletion is *final*. Any Register data associated with this patient will be deleted as well.

C.2.3 Switch Register

If you are an authorized user of other **Registers**, click this toolbar option to switch to another **Register**. Select the **Register Name** you want to view from the displayed list.

C.2.4 Report Status

Click the **Report Status** button to display any reports that are currently running or that have been completed. You can select a report name to automatically open it in Microsoft Word. Reports can be printed or saved as with any other Word document. If a report is no longer needed, delete it by selecting the check box in front of the report and then clicking the **Delete** button on the toolbar.

C.2.5 Exit System

Clicking the **Exit System** button on the toolbar will result in the display a pop-up dialog asking **Are You Sure You Want to Exit?**. Click **Yes** or **No** as appropriate. Click the **X** in the upper-right corner of the window to exit.

C.2.6 Help

Click the **Help** button on the toolbar to display the online help. Help is also available on each applicable form.

C.2.7 About

Click the **About** button on the toolbar to display the current version of **Visual DMS**. Click **OK** to close the window.

C.3 Menu Options

There are three main menu options in **Visual DMS** that correspond to the traditional **RPMS Diabetes Management System** menu options.

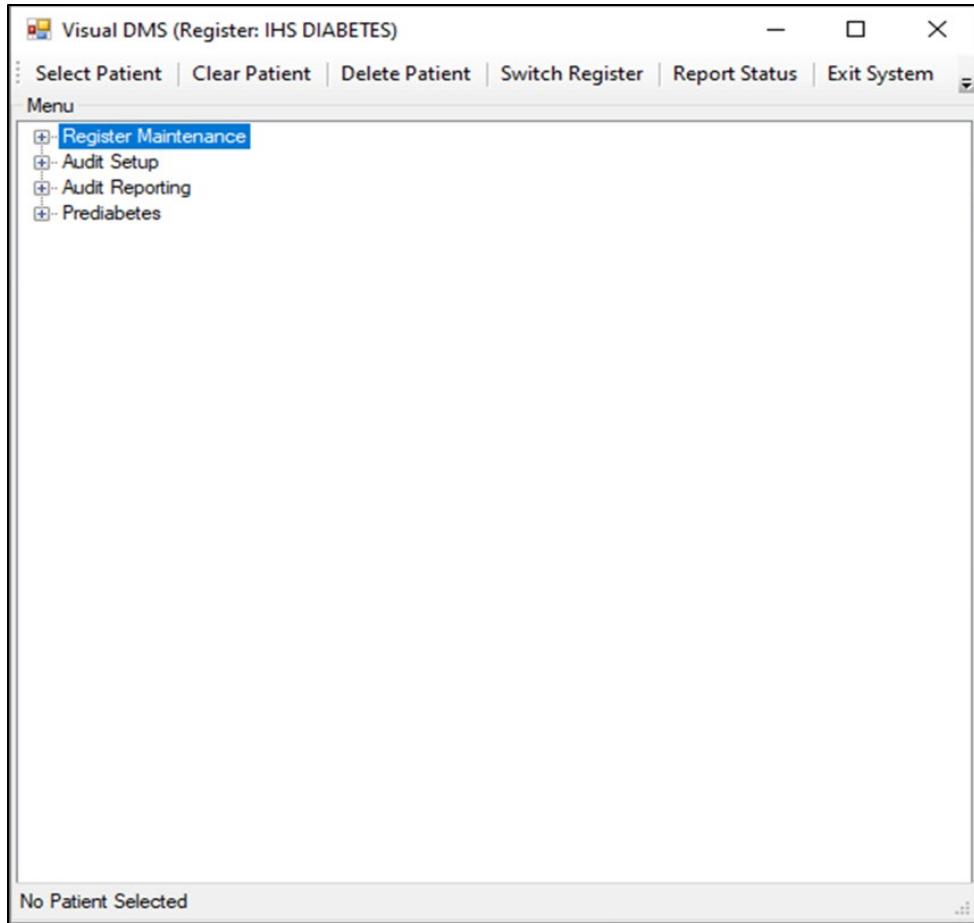


Figure C-9: Visual DMS main menu dialog

C.3.1 Register Maintenance

1. Open the **Register Maintenance Menu** by clicking the plus sign (+) in front of **Register Maintenance**.
2. A submenu (Figure C-10) will display with the following options: **Register Management**, **Enter/Edit Continuous Glucose Monitoring Data**, **Patient Management**, **Update Patient Data**, **Add Patients from Template**, and **Register Reports**. These options correspond to the same menu options in RPMS.

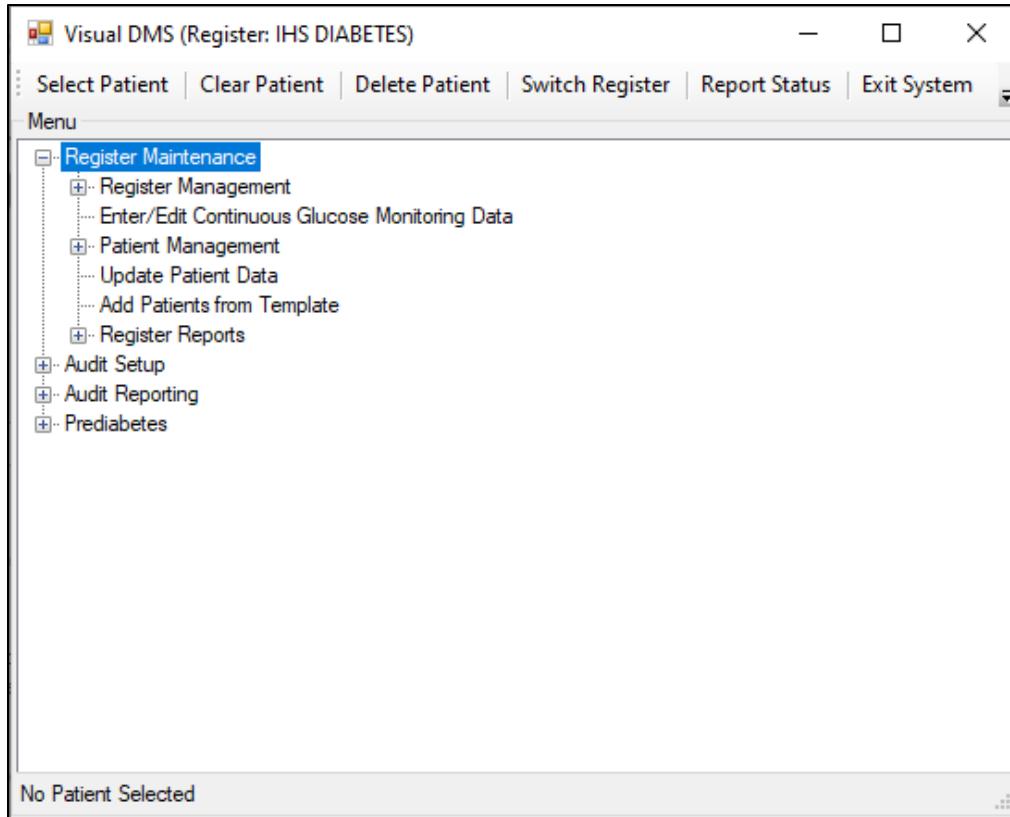


Figure C-10: Register Maintenance Menu option dialog

3. The **Patient Management** options are disabled until a patient is selected using the **Select Patient** option on the toolbar. The selected patient's name is displayed in the gray bar at the bottom of the window.

Note: Menu options will be described separately in their own section.

4. When finished with the **Register Maintenance Menu**, click the minus sign (-) in front of **Register Maintenance** to close the menu.

C.3.1.1 Register Management

Click the plus sign (+) in front of **Register Management** to expand this menu. The only available option is **User Setup**.

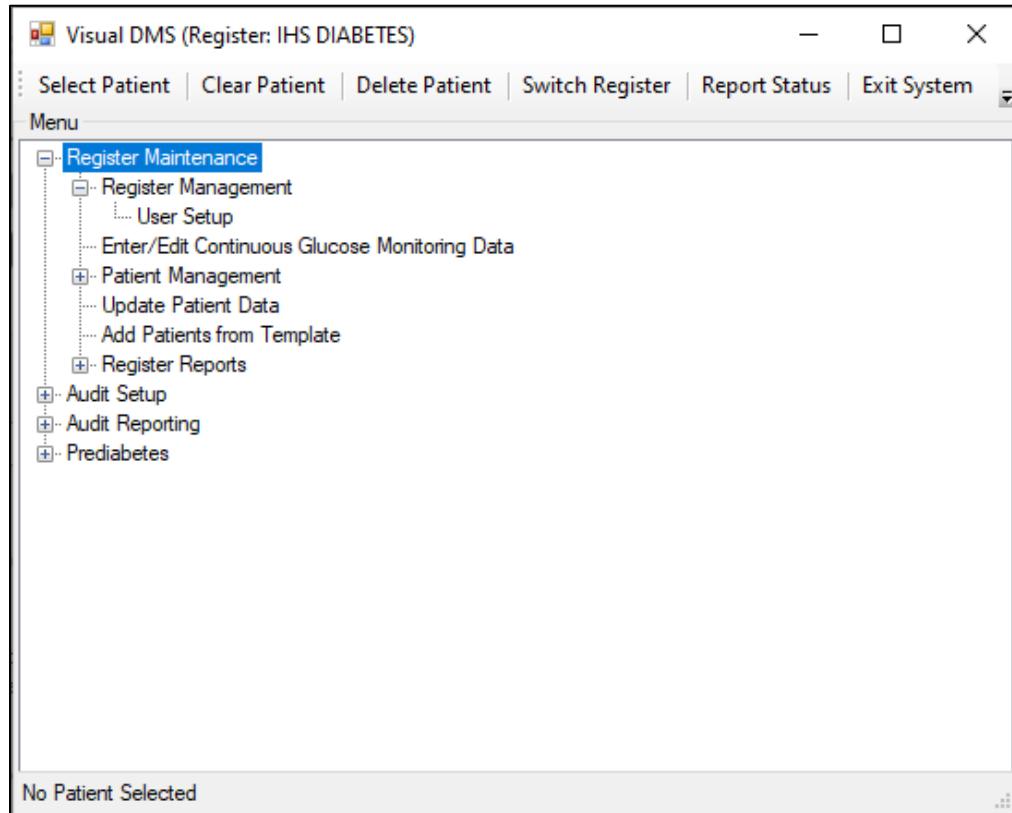


Figure C-11: Register Management menu option dialog

C.3.1.2 User Setup

Click **User Setup** to review current authorized users (Figure C-12) of the **Register** and update the user list.

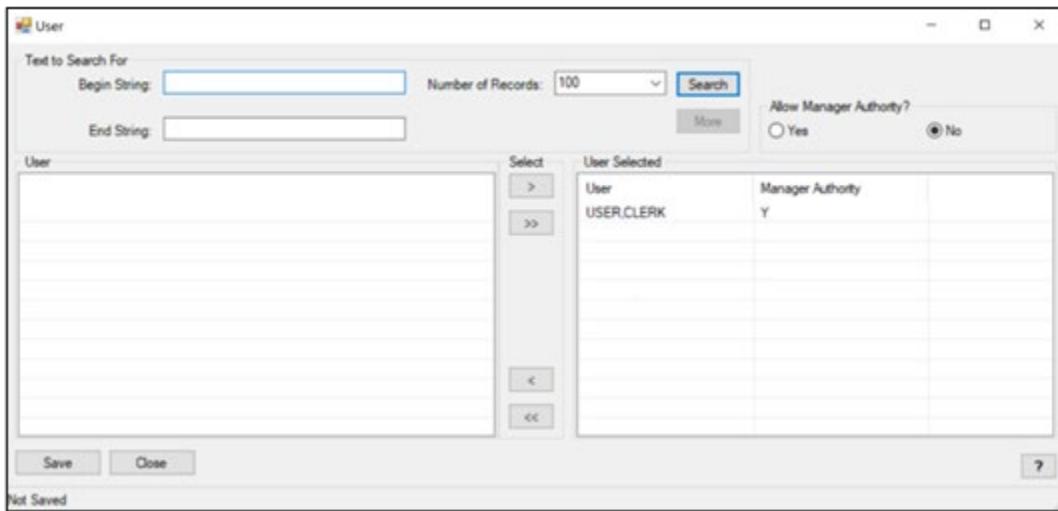


Figure C-12: User Selection dialog

Current users of the **Register** will be listed in the **User Selected** list. Those who have Manager authority will have a **Y** in the **Manager Authority** column.

1. If additional authorized users are to be added to the **Register**, type the first few letters of that user's last name in the **Begin String** box. A list of matching entries displays.
 - Either click and drag a user's name from the **User** list to the **User Selected** list or select the user and click the right arrow (**>**) to move them into the **User** list.
 - If user(s) are to be removed from the **User Selected** list, either drag their name back to the **User** list or select their name and click the left arrow (**<**).
2. If a user is to be given manager authority, click the **Yes** button under **Allow Manager Authority?**, and then click the user's name. Manager authority may be removed in a similar manner, by clicking the **No** button under **Allow Manager Authority?** and then click the name(s) of user(s) who will not be allowed manager authority.
3. When the list of authorized users has been updated, click the **Save** button to save changes. Close the **User** window.

C.3.1.3 Enter/Edit Continuous Glucose Monitoring Data

This option allows the user to enter data from a patient's continuous glucose monitoring device. The information will be stored and can be viewed using this option. The most recent data will be displayed on the **Diabetes Patient Care Summary (DPCS)**.

Select the patient using the **Select Patient** item on the menu bar. Click on the **Enter/Edit Continuous Glucose Monitoring Data (CGM)**. The following screen will pop up and display any existing CGM data on file for the patient:

Report Date	Report Start	Report End	Duration	GMI	TIR	Target Low	Target High
09/18/2025	09/18/2025	08/11/2025	10	7.2	50	70	180
08/28/2025	08/21/2025	08/28/2025	7	9.1	90	70	180

Figure C-13: CGM DATA

- **Add** a new CGM entry

This action allows the user to enter a new set of data from the CGM device.

Users will be prompted to enter **Report Date** (date of entry), **Report Start Date**, **Report End Date**, **Glucose Management Indicator (GMI)** value, **Time in Target Range (TIR)** value and **Target Range** for **Low** and **High** values.

The **Target Range** for **Low** and **High** values have default values. **Target Range Low Value** is set at **70** mg/dL. **Target Range High Value** is set at **180** mg/dL. These values can be modified by the user, as needed. Prompts for required responses and instructions are in bold type

Allowable values:

- **REPORT DATE:** [Enter Date]
- **REPORT PERIOD START DATE:** [Enter Date]
- **REPORT PERIOD END DATE:** [Enter Date]
- **DURATION (DAYS):** [Type a number between 3 and 100, 0 decimal digits]

- **GMI-GLUCOSE MGMT INDICATOR%:** [Type a number between 2 and 20, 2 decimal digits]
- **TIME IN TARGET RANGE (TIR)%:** [Type a number between 0 and 100, 2 decimal digits]
- **TARGET RANGE LOW VALUE (mg/dL):** Enter a number from 70 to 180 or skip to accept the default
- **TARGET RANGE HIGH VALUE (mg/dL):** Enter a number from 70 to 180 or skip to accept the default.

When you are finished entering the data, click **Save**.

Continuous Glucose Monitoring

Report Date: Thursday, October 16, 2025

Report Period Start Date: Thursday, October 16, 2025

Report Period End Date: Thursday, October 16, 2025

Duration: [empty]

GMI-Glucose Mgmt Indicator %: [empty]

Time in Target Range (TIR) %: [empty]

Target Range Low Value (mg/dL): 70

Target Range High Value (mg/dL): 180

DEMO,DONNA SUE Chart: 137711 Sex: F

Save Close

Figure C-14: CGM Data Entry Window

- **Edit an existing CGM entry**
 - This action allows the user to edit a set of data from the CGM device. Click on the entry that is to be changed and then click on the Edit button. See Add a new CGM entry for details on entering the data. Click **Save** when done.
- **Delete a CGM entry**

- This action allows the user to delete a set of CGM data that has been entered in error. Click on the entry to be deleted and then click on the **Delete** button. You will be asked to enter a reason for the deletion (**Entered in Error**, **Duplicate**, or **Other**). You may enter a comment if needed. Click Save to complete the deletion.

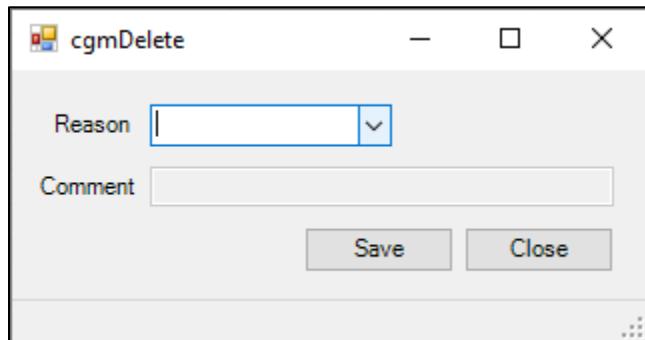


Figure C-15: CGM DATA Delete Window

C.3.2 Patient Management

Click the plus sign (+) next to **Patient Management** to open the **Patient Management** menu (Figure C-16).

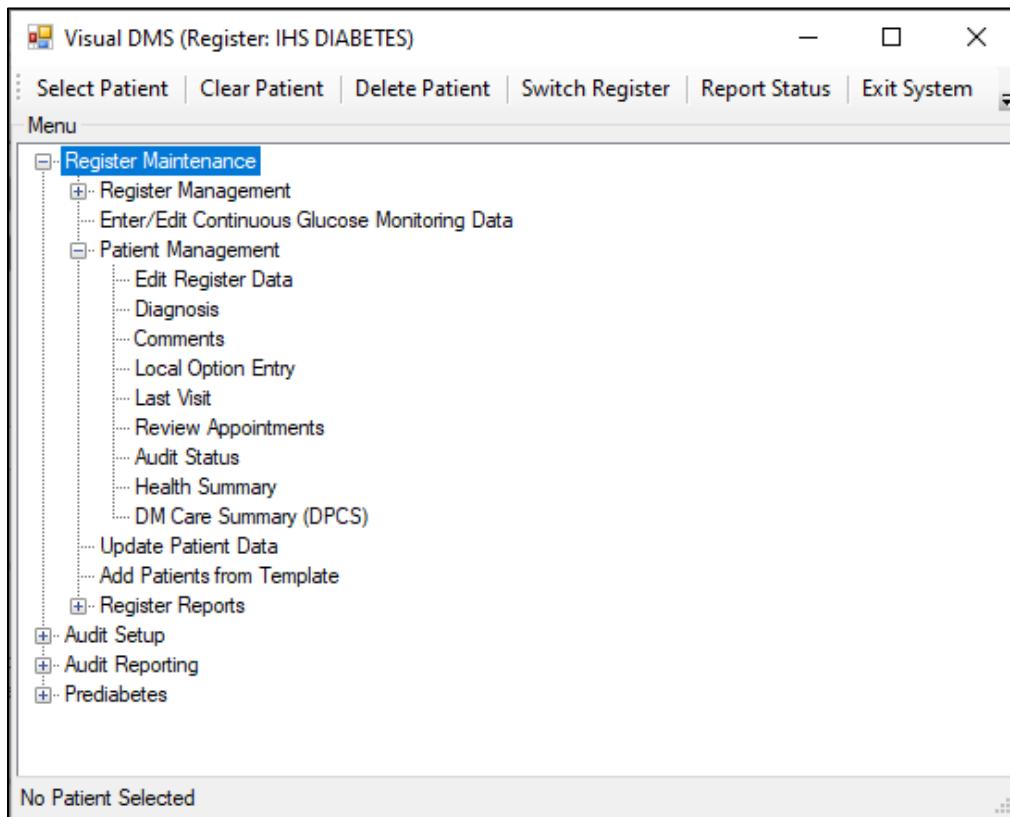


Figure C-16: Patient Management options dialog

C.3.2.1 Edit Register Data

1. Use the **Patient Profile** dialog (Figure C-17) to change **Register Status**, **Where Followed**, **Case Manager**, **Contact**, **Last Review**, and **Next Review Date**.

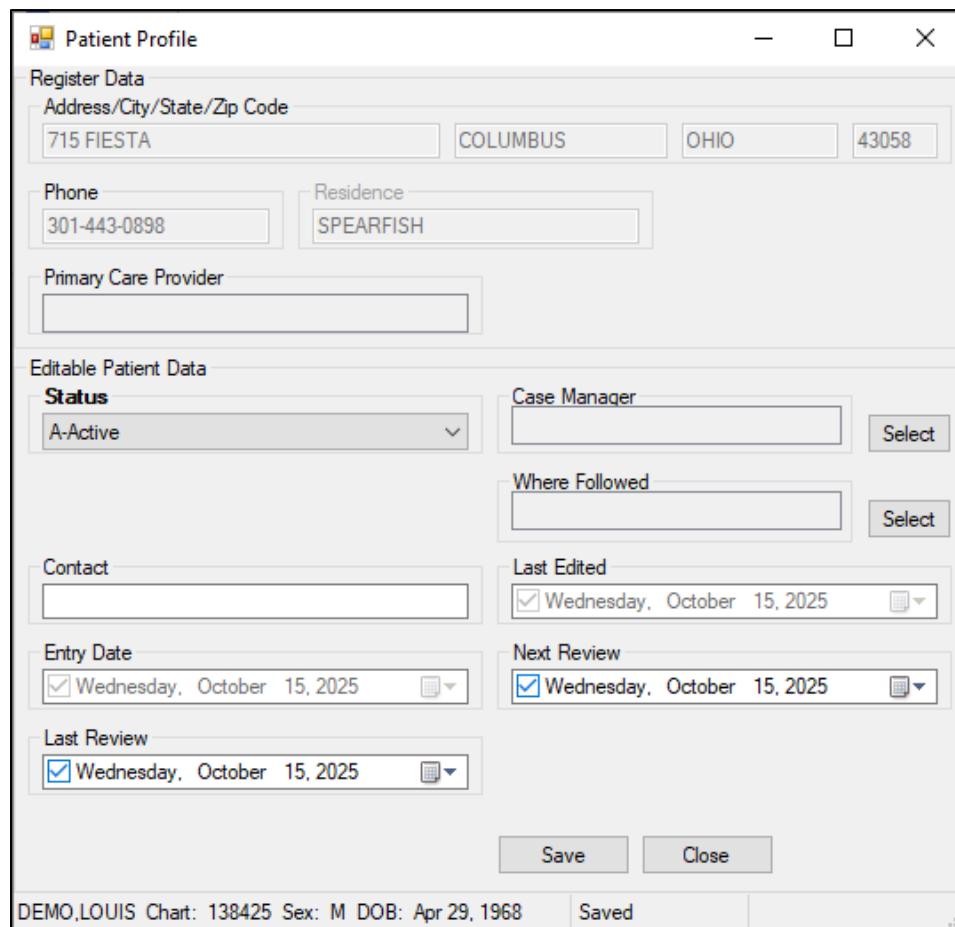


Figure C-17: Patient Profile dialog

2. Change **date fields**, as needed, by clicking the **date** (month, day, or year) and using the up or down arrows to change the month, date, or year.
 - The date and year can also be changed by typing the desired new date or year to replace the one displayed.
 - Alternatively, click the **arrow** to open a calendar and browse to a date by scrolling, using the right and left arrows. Click a **date** on the calendar to select it.
3. The **Contact** field is a free-text field in which to enter patient contact information.
4. Click the **Select** button to the right of the **Case Manager** field to display a list. Browse the list to find the desired entry and select it.

5. The **Where Followed** field requires a match on the name of a facility. Type the first few letters of the facility name in the **Begin String** box and click **Search**.
6. Click the name of the facility where the patient is followed.
7. When all data entry is complete, click **Save** to exit. Click the **X** in the upper right corner of the window to close the **Patient Profile** dialog and stop editing the register data.

C.3.2.2 Diagnosis

Click the **Diagnosis** menu option to open the **Diagnosis** dialog.

If your site also utilizes **Certified EHR (Electronic Health Record)** and the **Integrated Problem List (IPL)** (Figure C-18), the diagnoses entered here with date of onset should also be entered into the IPL, so that all clinicians will be aware of the diagnoses.

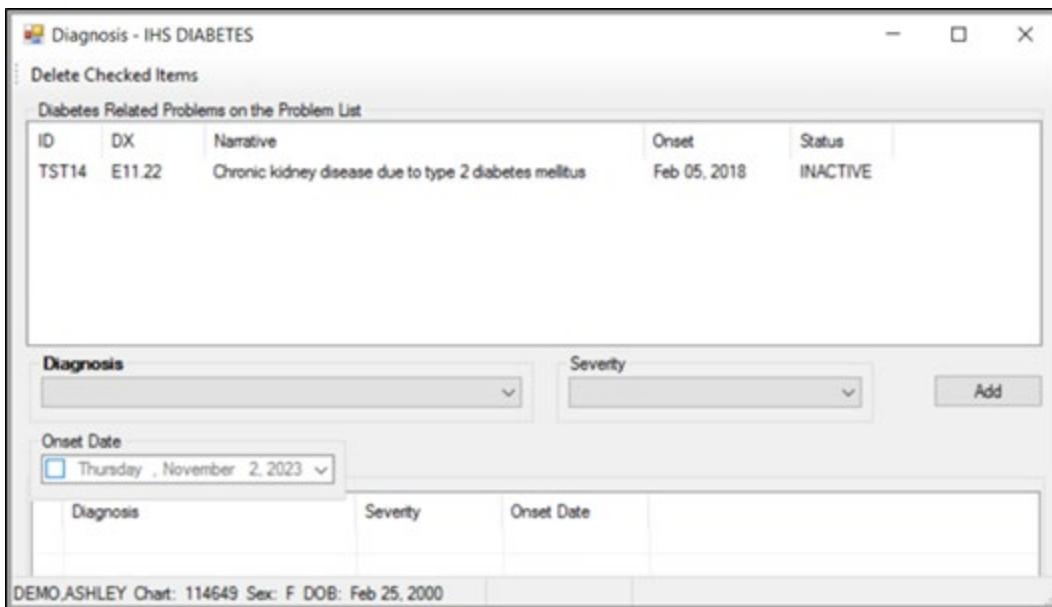


Figure C-18: Diagnosis dialog

1. To add a new diagnosis, select a **Diagnosis** from the list.
2. Select the severity from the **Severity** list and enter an **Onset** date.
3. Click **Add** to add it to the **Diagnosis** list box.
4. To delete a diagnosis, select the **check box** next to it and click the **Delete Checked Items** button.
5. Click **Yes** to proceed at the **Delete Diagnosis Confirmation** dialog (Figure C-19) or click the **X** in the upper-right corner to close it.

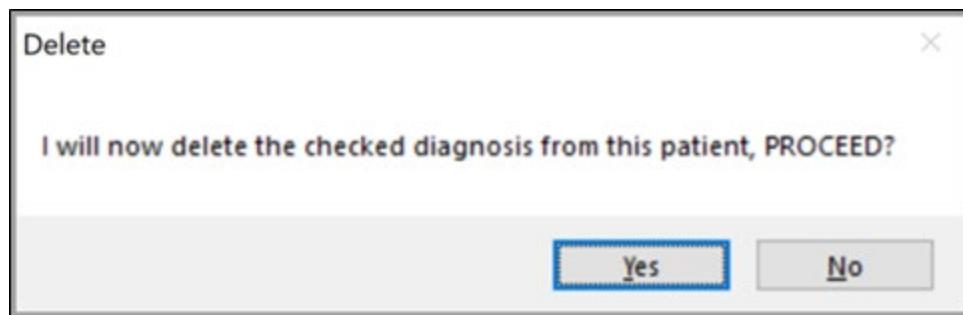


Figure C-19: Delete Diagnosis Confirmation dialog

C.3.2.3 Comments

1. Enter case comments by clicking the **Comments** option. The **Additional Comments** dialog (Figure C-20) displays.

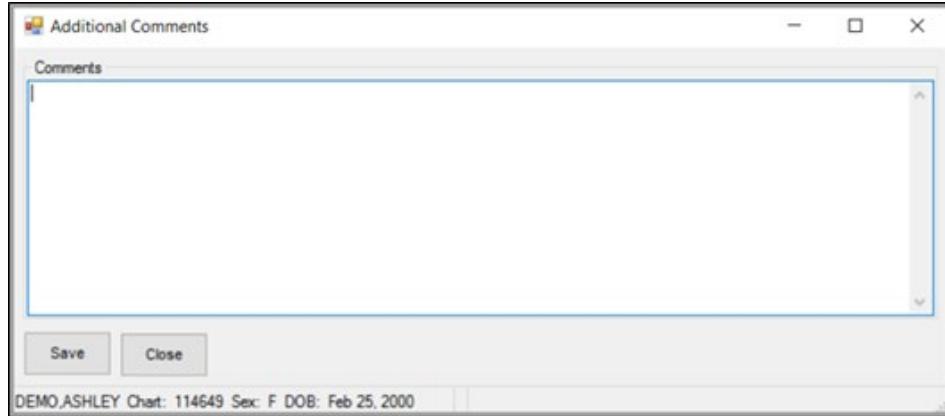


Figure C-20: Additional Comments dialog

2. Enter any comments and click **Save** when the entry is complete. The **Not Saved** text in the gray bar at the bottom of the window is replaced by **Saved**.
3. Close the dialog by clicking the **X** in the window's upper-right corner or click **Close**.

C.3.2.4 Local Option Entry

1. Click the **Local Option Entry** menu option to open the **Local Option Entry** dialog.
2. Enter the **DM Audit Local Option** code and text click **OK** to save.
3. Click **Close** or close the dialog to exit the **Local Option Entry** form (Figure C-21).

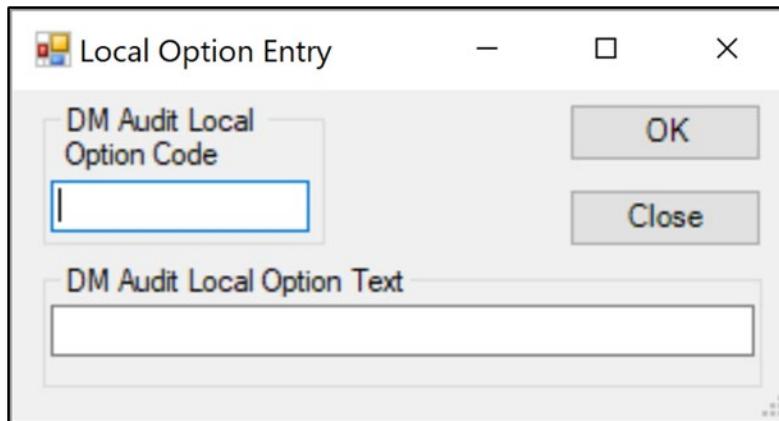


Figure C-21: Local Option Entry dialog

C.3.2.5 Last Visit

1. Display the patient's last visit by clicking the **Last Visit** menu option.

The **Last Visit** record (Figure C-22) will open in Microsoft Word. Users can browse or print the visit record, as needed.

2. When the record review is complete, close the **Word** window by clicking the **X** in the upper-right corner.

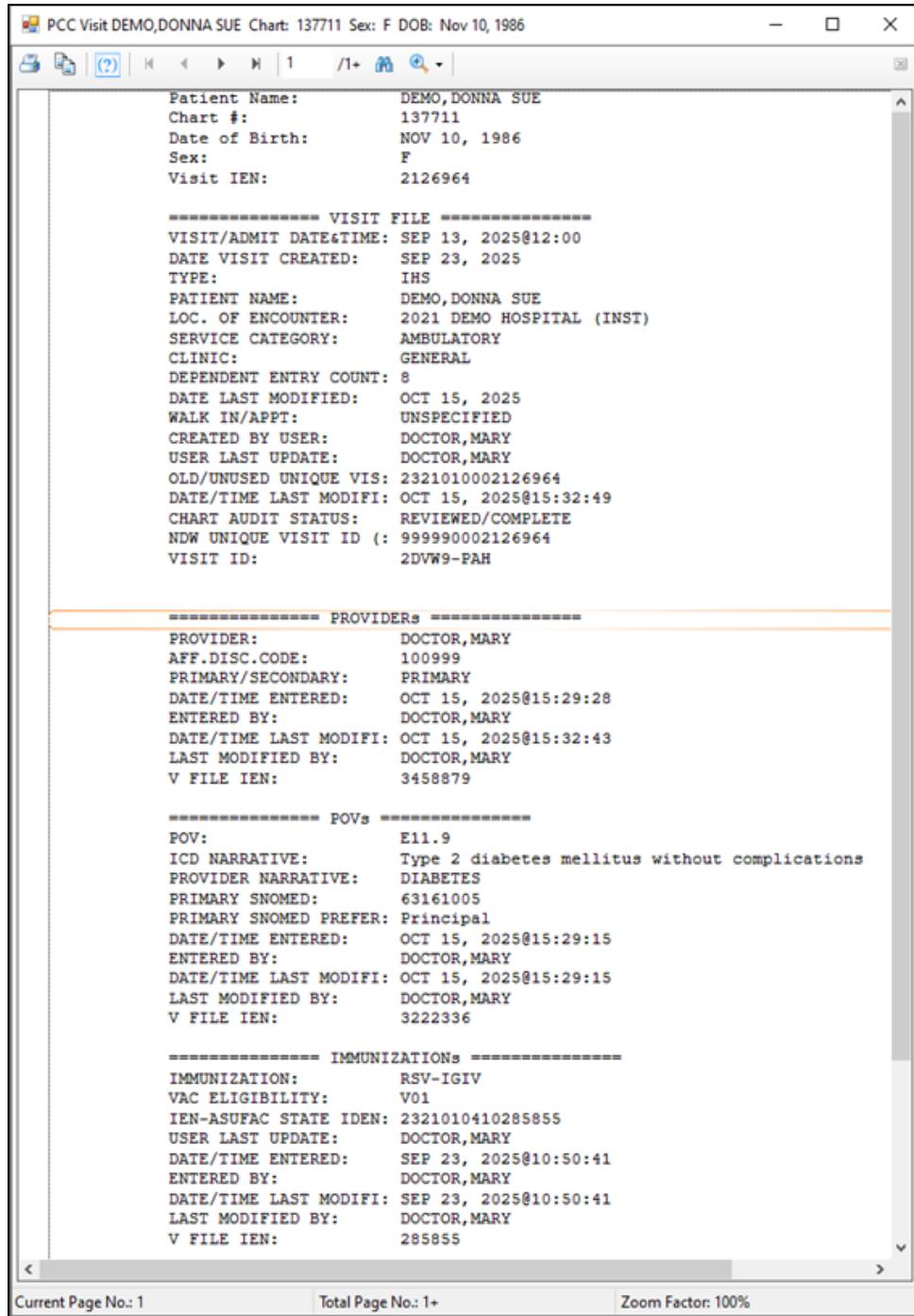


Figure C-22: Last Visit display window

C.3.2.6 Review Appointments

1. Click the **Review Appointments** menu option to display a list of scheduled appointments (Figure C-23) for the selected patient.
 - This list will only include appointments made in the **IHS Scheduling** or **PIMS Scheduling** modules.
 - The list will be displayed in a **Crystal Reports** document. The user can browse or print the list as needed.
2. Close the **Crystal Reports** document by clicking the **X** in the upper-right corner when the review is complete.

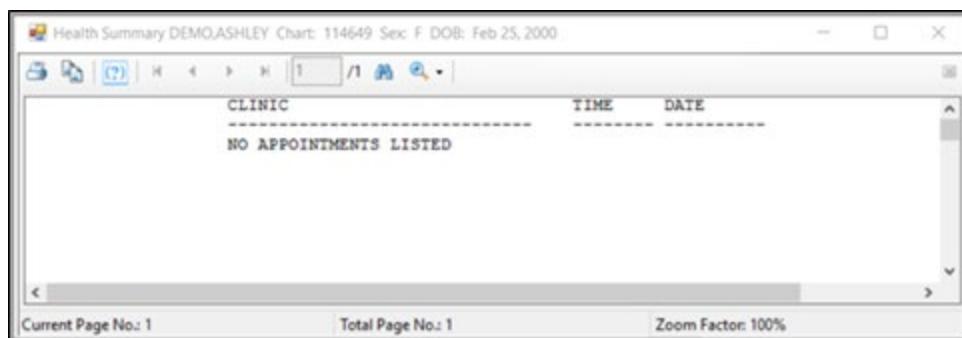


Figure C-23: Review appointments window

C.3.2.7 Audit Status

1. Click the **Audit Status** menu option to display the **Audit Status** dialog (Figure C-24).

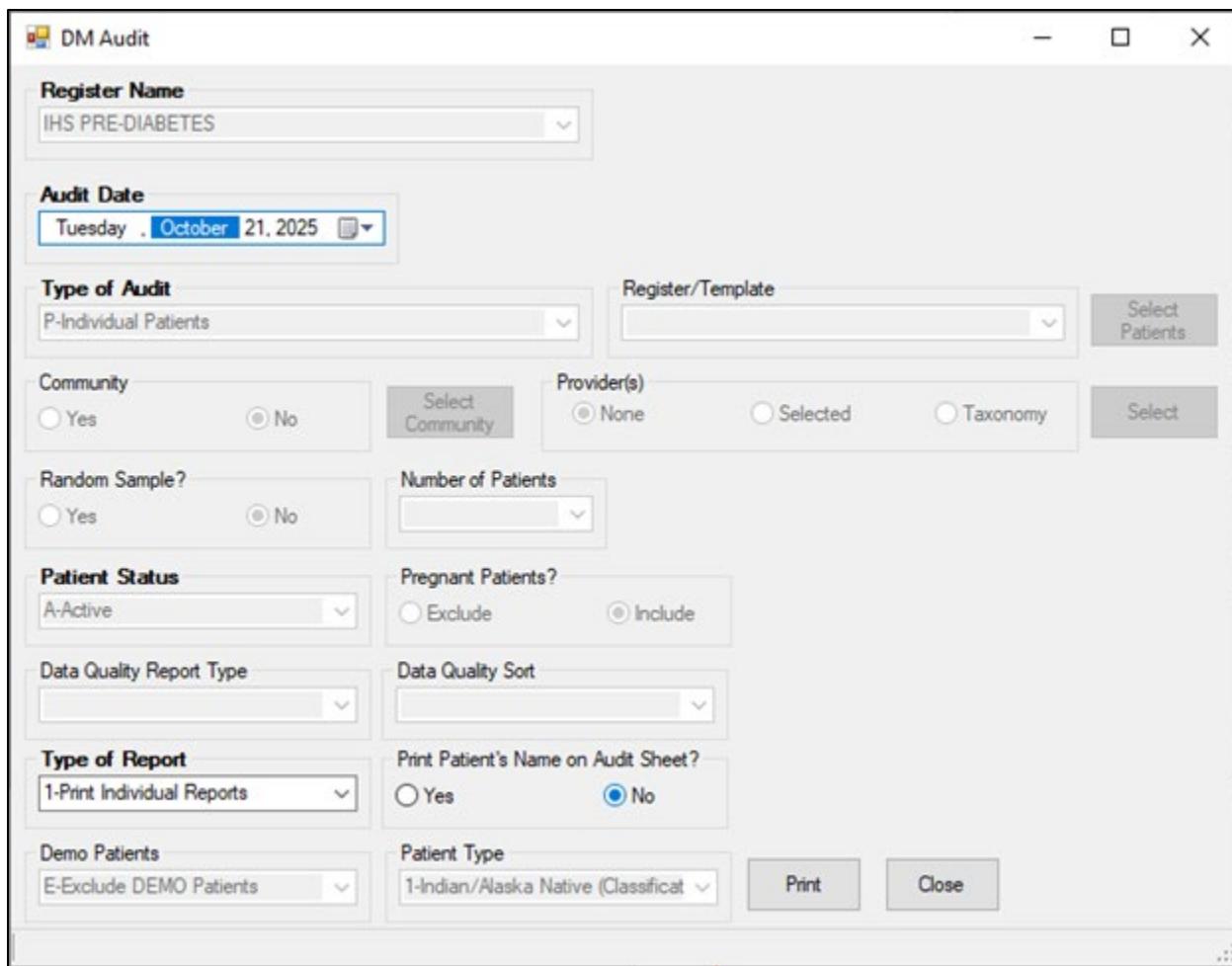


Figure C-24: DM Audit dialog

2. When the window for setting the **Audit** options opens, use the calendar to select the **Audit Date** or change it by typing in a new day, month, and/or year in the date box.
3. When entries are complete, click the **Print** button. The **Audit** will display in a **Crystal Reports** document (Figure C-25).
4. Browse or print the **Audit**, as needed.
5. When the review is complete, close the **Crystal Reports** document by clicking the **X** in the upper right corner.

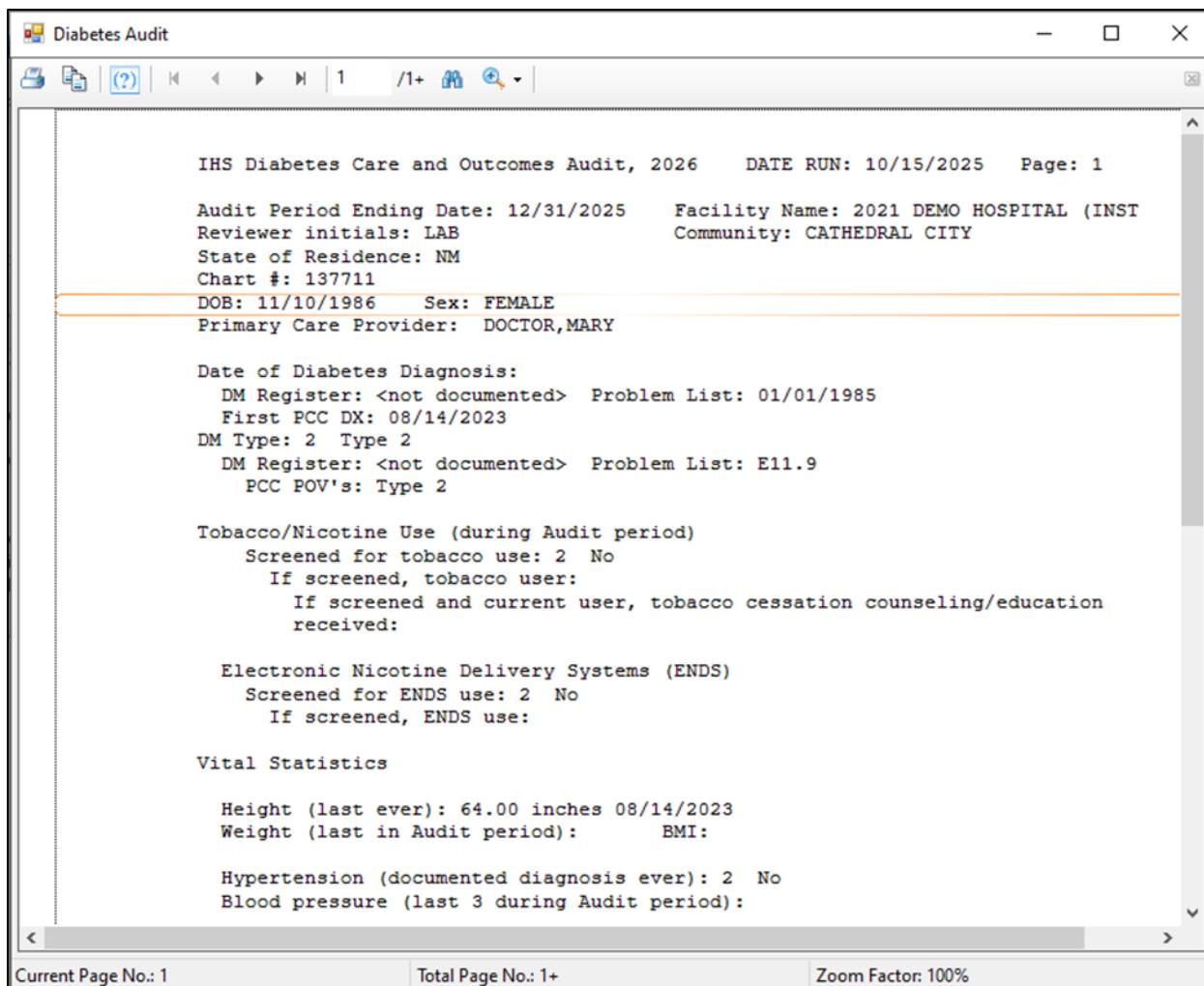


Figure C-25: Individual Audit window

C.3.2.8 Health Summary

1. Click the **Health Summary** option to open **Health Summary** window (Figure C-26).
2. Click the arrow next to **Health Summary Type** to display the available choices.

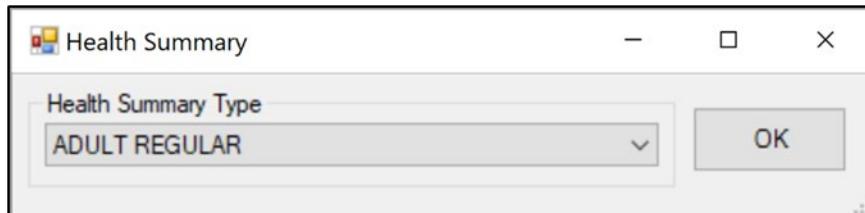


Figure C-26: Health Summary dialog

3. Select a **Health Summary Type** and click **OK**.

The **Health Summary** (Figure C-27) displays in **Crystal Reports**. Browse or print the health summary as needed.

4. Click the **X** in the upper right corner to close the **Health Summary** dialog.

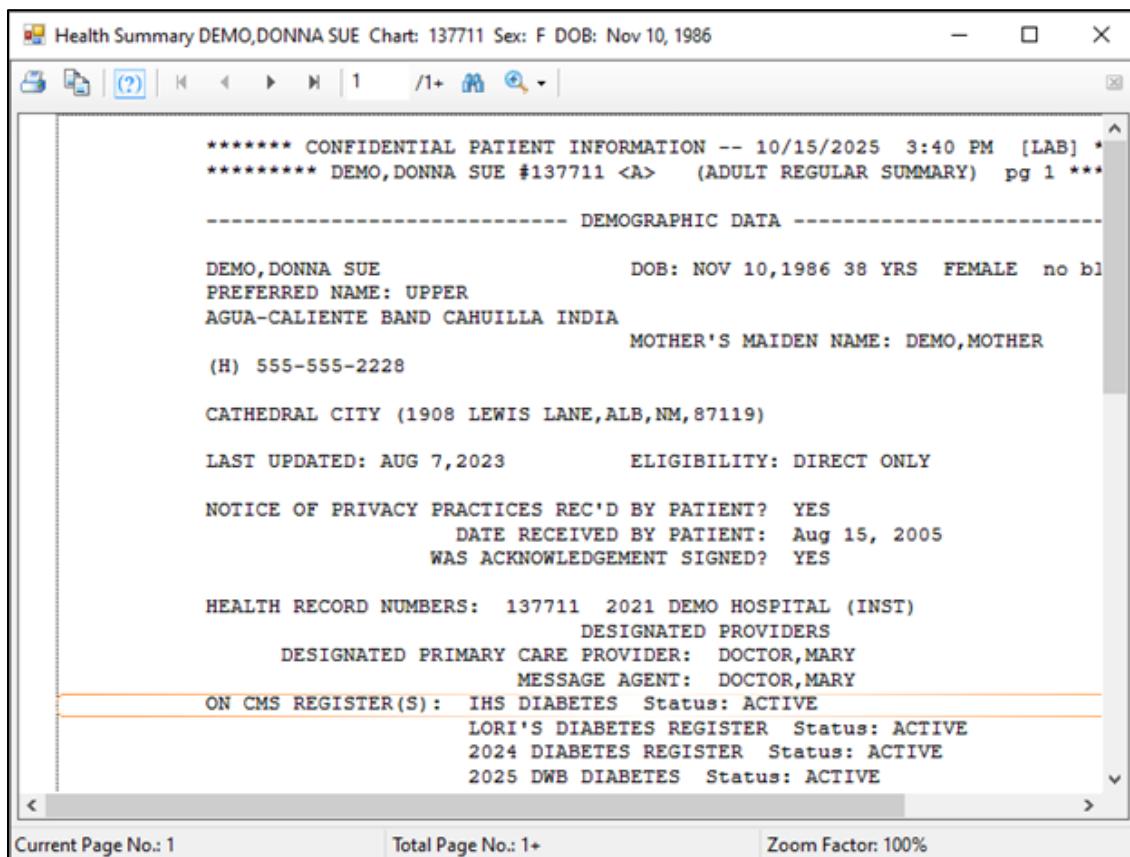


Figure C-27: Health Summary display window

C.3.2.9 DM Care Summary (DPCS)

1. Click the **Diabetes Care Summary (DPCS)** menu item to open **Diabetes Care Summary (DPCS)**.

A **Crystal Reports** document (Figure C-28) will open, displaying the summary.

2. Click the X in the upper-right corner to close the **Crystal Reports** document.

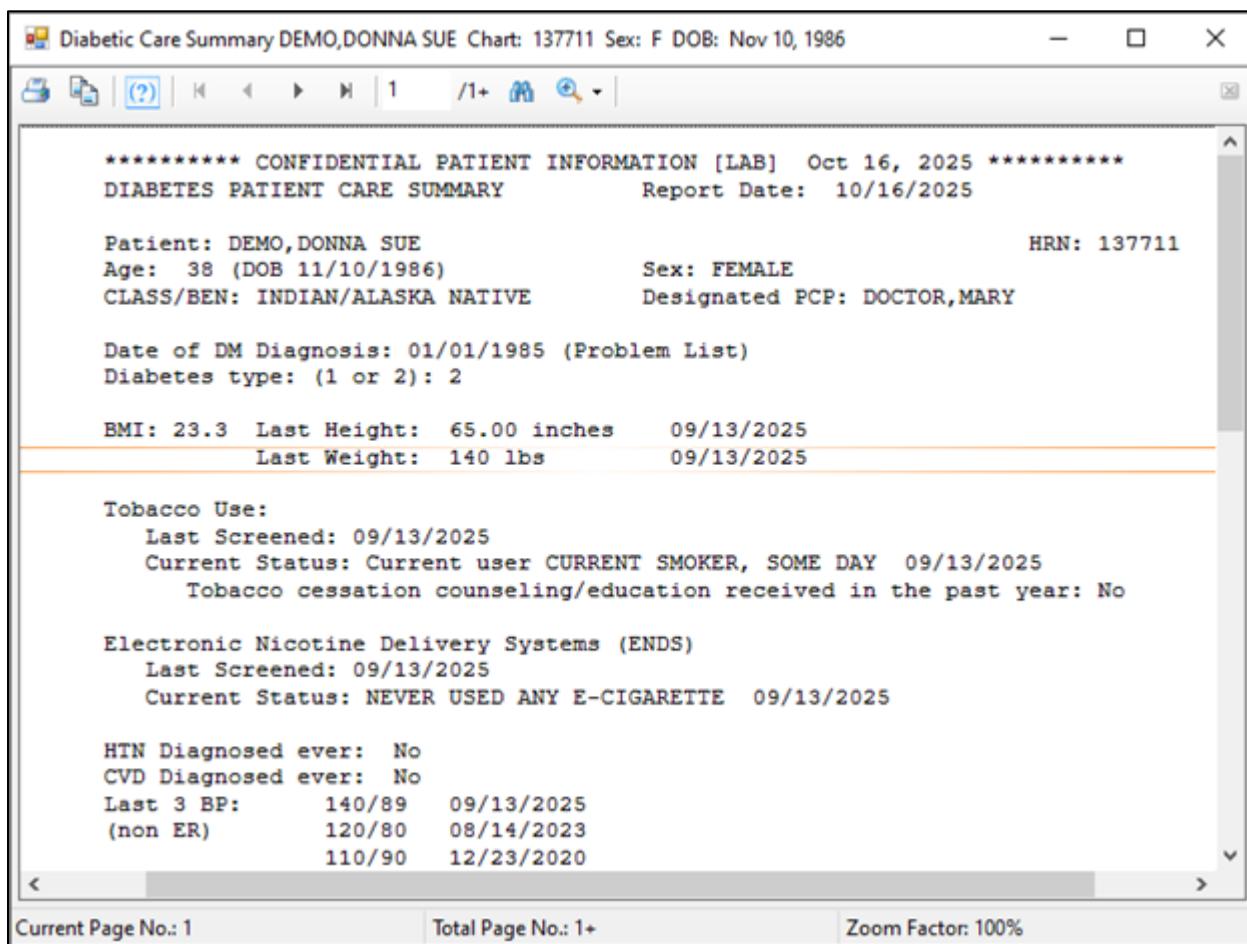


Figure C-28: DM Care Summary display window

C.3.3 Add Patients from Search Template

1. Click the **Add Patients from Search Template** menu option, if you have a template of patients that you want to add to the **Register**.

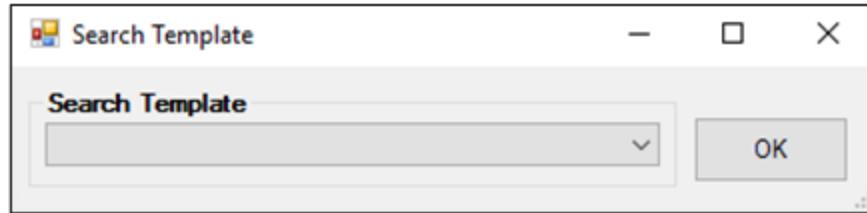


Figure C-29: Search Template dialog

2. Click the arrow next to the **Search Template** (Figure C-29) to view a list of available templates.
3. Select the desired template and click **OK**.

A pop-up window will display indicating if the patients have been added successfully.

4. Click **OK** to close the pop-up window.

C.3.4 Register Reports

Click the plus sign (+) in front of **Register Reports** to display the **Register Reports** options (Figure C-30). No patient needs to be selected to run reports.

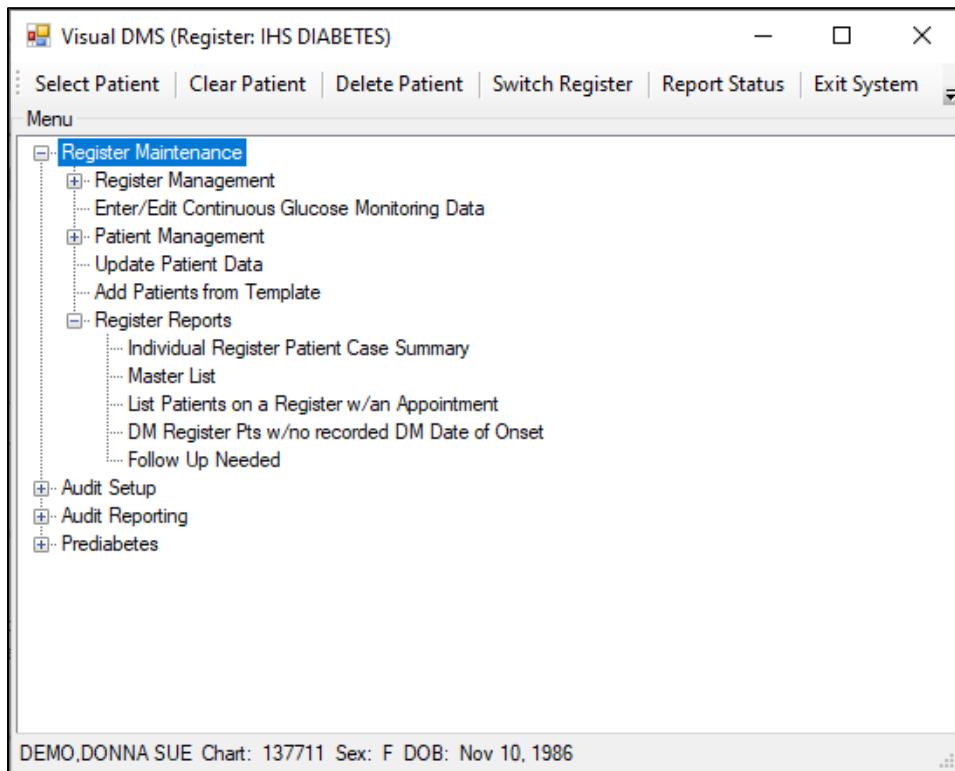


Figure C-30: Register Reports menu options dialog

C.3.4.1 Individual Register Patient Case Summary

1. To review the **Individual Case Summary**, click the **Individual Register Patient Case Summary** menu (Figure C-31) option.

The case summary will display as a Microsoft Word document that the user can browse or print.

2. Close the document when the review is complete.

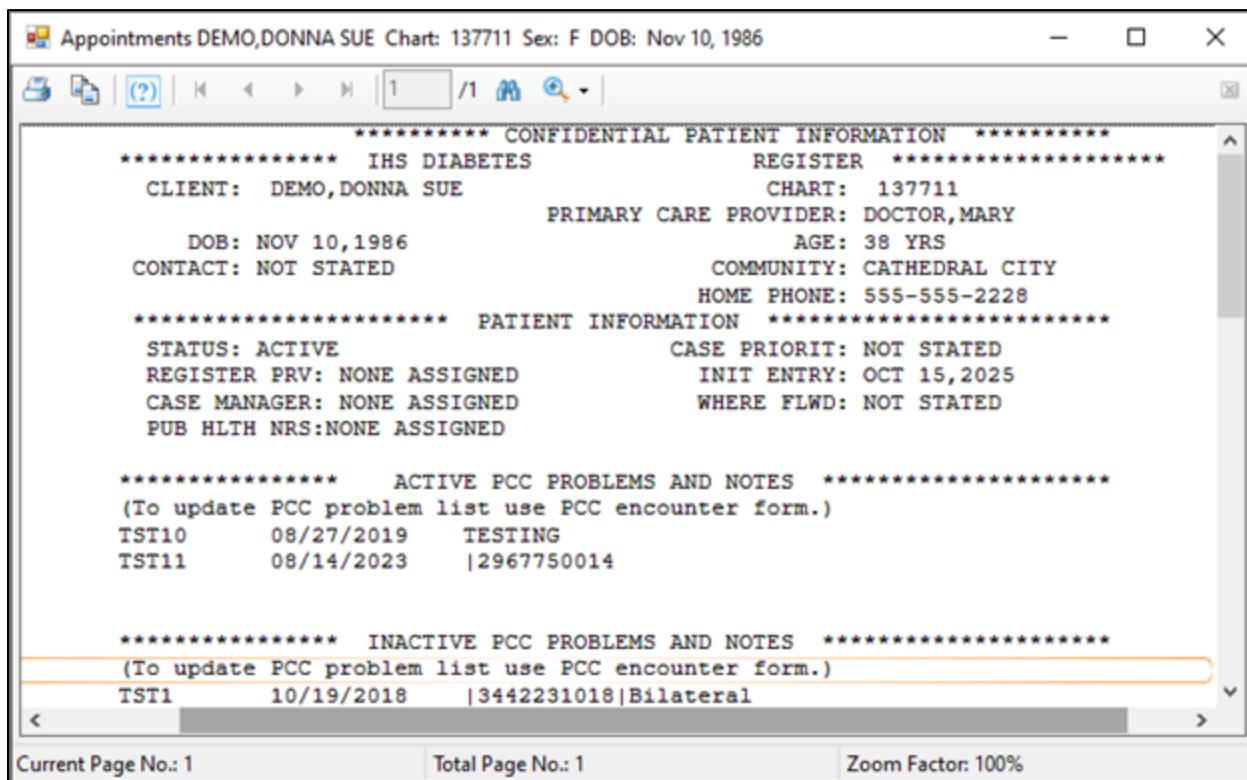


Figure C-31: Individual Register Case Summary

C.3.4.2 Master List

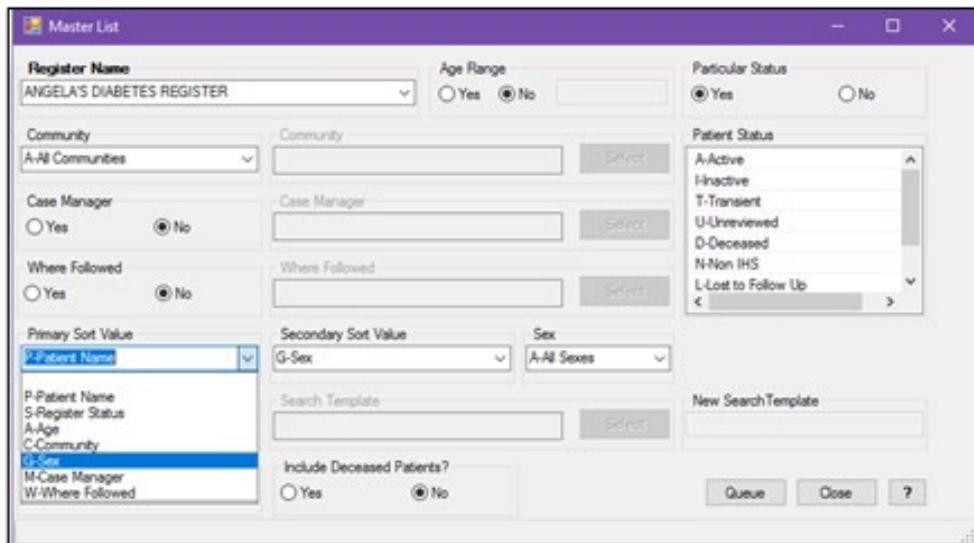


Figure C-32: Master List parameters dialog

1. Click the **Master List** menu item to open the **Master List** dialog (Figure C-32).
2. Select the **Register Name** from the list and specify any other parameters you would like to use.
3. Click **Queue** to queue the report.
4. Once the report is queued to run, click the **Report Status** option (Figure C-33) on the main window toolbar to review the report progress.

Report Status Check						
Refresh Delete Checked Items Close						
Name	User	Start Time	End Time	Option	Report Status	
<input type="checkbox"/> 2881.67499.42308	DOCTOR,MARY	Oct 21, 2025@11:45:09		2026 Data Quality Report	RUNNING	
<input type="checkbox"/> 28813251015.121922	DOCTOR,MARY	Oct 15, 2025@12:19:22	Oct 15, 2025@12:19:24	Master List	COMPLETED	
<input type="checkbox"/> 28813251015.121759	DOCTOR,MARY	Oct 15, 2025@12:17:59		Master List	RUNNING	
<input type="checkbox"/> 2881.67459.40182	DOCTOR,MARY	Sep 11, 2025@11:09:42	Sep 11, 2025@11:09:45	DM 2026 Pre-Diabetes Audit	COMPLETED	
<input type="checkbox"/> 2881.67459.39561	DOCTOR,MARY	Sep 11, 2025@11:06:01	Sep 11, 2025@11:06:03	Follow-Up Needed	COMPLETED	
<input type="checkbox"/> 2881.67459.39880	DOCTOR,MARY	Sep 11, 2025@11:04:40	Sep 11, 2025@11:04:43	Follow-Up Needed	COMPLETED	
<input type="checkbox"/> 2881.67459.39843	DOCTOR,MARY	Sep 11, 2025@11:04:03	Sep 11, 2025@11:04:07	Follow-Up Needed	COMPLETED	
<input type="checkbox"/> 2881.67459.37097	DOCTOR,MARY	Sep 11, 2025@10:18:17	Sep 11, 2025@10:18:20	2026 Diabetes Program Audit	COMPLETED	
<input type="checkbox"/> 2881.67408.52986	DOCTOR,MARY	Jul 22, 2025@14:43:06	Jul 22, 2025@14:43:17	SDPI RKM Report	COMPLETED	
<input type="checkbox"/> 2881.67408.51654	DOCTOR,MARY	Jul 22, 2025@14:20:54	Jul 22, 2025@14:27:59	2025 Diabetes Program Audit	COMPLETED	
<input type="checkbox"/> 2881.67408.51589	DOCTOR,MARY	Jul 22, 2025@14:19:49	Jul 22, 2025@14:20	2025 Diabetes Program Audit	COMPLETED	
<input type="checkbox"/> 2881.66813.42458	DOCTOR,MARY	Dec 05, 2023@11:47:38	Dec 05, 2023@11:47:33	DM 2024 Pre-Diabetes Audit	COMPLETED	

Figure C-33: Report Status Check dialog

5. Select a report to review it.

The report will be displayed in a **Crystal Reports** document that the user can save or print.

6. When review of the report is complete, close the **Crystal Reports** document by clicking the **X** in the upper right corner.

If a report is no longer needed, select the check box to the right of the report name. Then, click the **Delete Checked Items** option on the toolbar to delete all checked reports.

C.3.4.3 List Patients on a Register with an Appointment

This report will allow you to print a list of patients on a **Register** with appointments within a specified date range in all or in selected clinics.

1. Begin by clicking the **List Patients on a Register with an Appointment** menu option.
2. When the **List Patients on Register with an Appointment** window (Figure C-34) opens, click the down arrow next to the **Register Name** box to display a list of **Registers**.
3. Select the desired **Register** for the report.

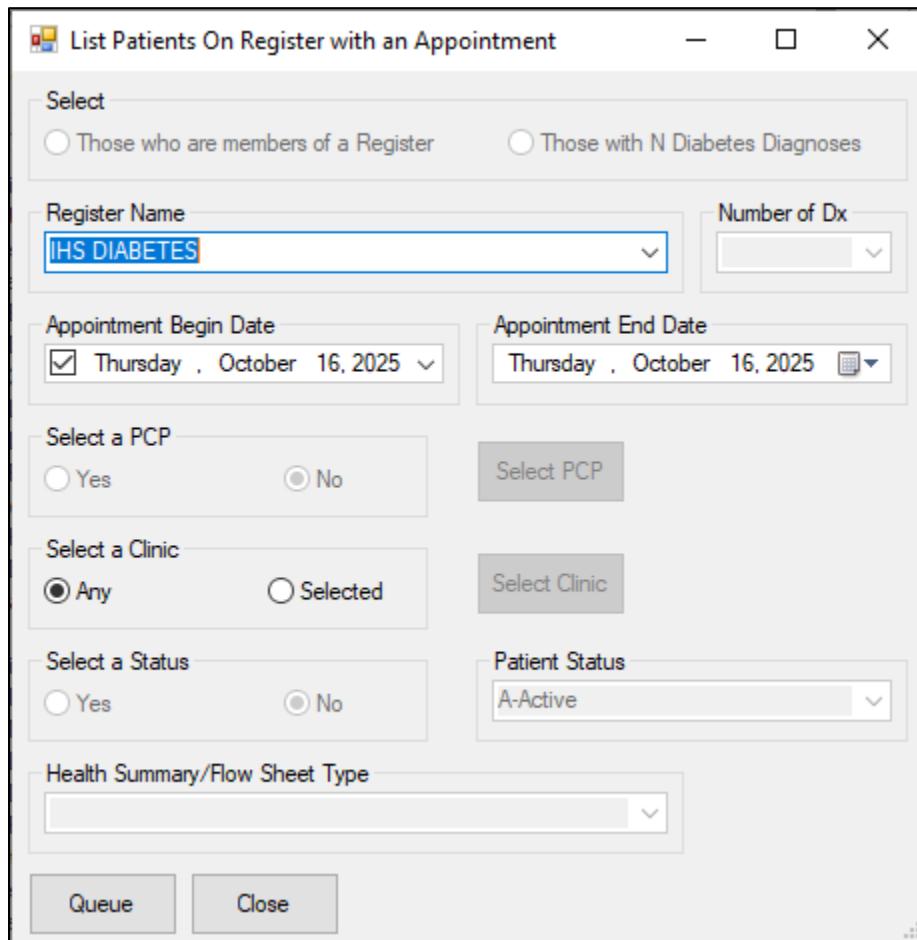


Figure C-34: List Patients on Register with an Appointment window

4. Click the down arrow next to the **Appointment Begin Date** or **Appointment End Date** to select a date. The month, day, or year may be changed by clicking on each and using the up or down arrows to set the date.

5. If you want to see all appointments, regardless of clinic, select **Any** under **Select a Clinic**. If you want to only review appointments for one or more particular clinics, click the **Select Clinic** button.
 - a. Type the first three letters of the clinic with a scheduled appointment in the beginning string box.
 - b. When the list of matching clinics displays, the desired clinic may be highlighted and dragged into the column on the right. You may also highlight the clinic and click the right arrow (>) button to move the clinic into the right column.
 - c. When all desired clinics have been added to the **Clinic Selected List**, click the **Save** button.
6. Click the **Queue** button to run the report. A pop-up window will notify you that the report has been queued.
7. Close the pop-up window by clicking the **X** in the upper right corner.
8. The report status can be checked by clicking the **Report Status** button on the toolbar. See Section C.3.4.2 for complete instructions.

C.3.4.4 DM Register Pts with no Recorded DM Date of Onset

This report identifies patients on the **Register** who do not have a date of onset of diabetes recorded in RPMS.

1. Begin by clicking the menu option, **DM Register Pts with No Recorded DM Onset** (Figure C-35). A window will display that allows selection of the **Register** to be reviewed and identify, if necessary, the status of the patients who will be reviewed for the report.

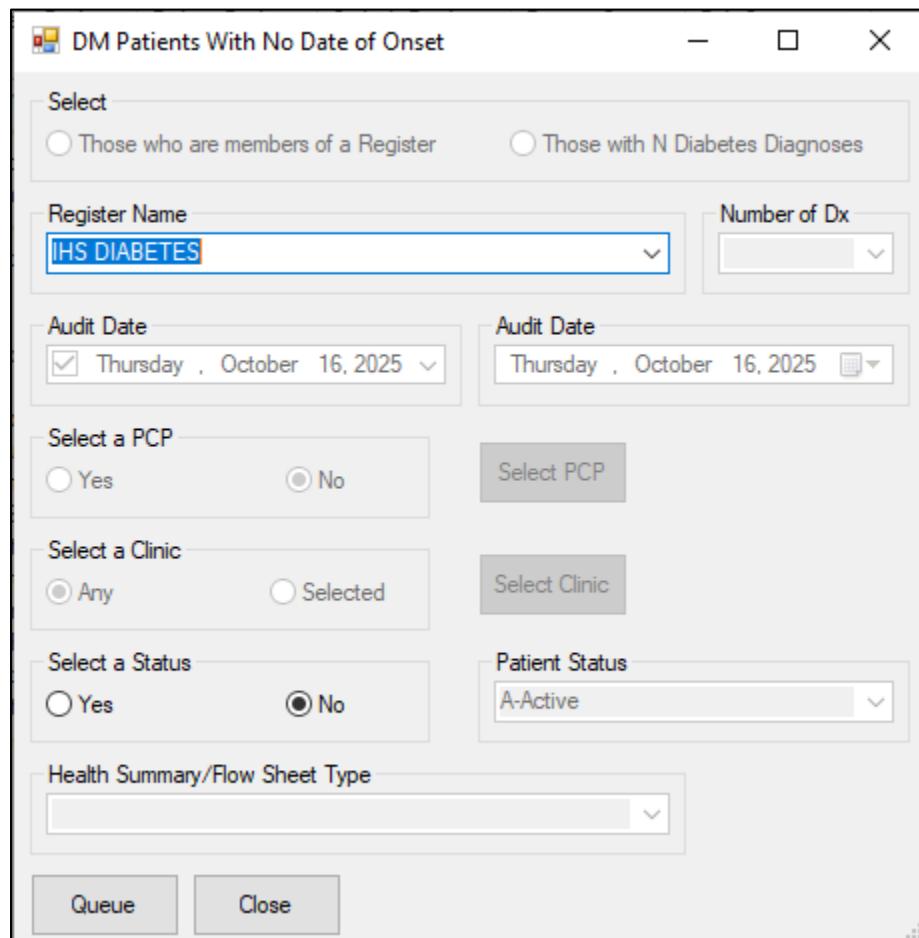


Figure C-35: DM Patients with No Date of Onset dialog

2. Click the arrow next to **Register Name**. Select a **Register Name** from the list displayed.
3. Click **Yes** or **No** in the **Select a Status** box.
4. Use the arrow next to the **Patient Status** box to display the list of statuses. Click to select the desired status.

5. Click the **Queue** button to run the report. A pop-up window will notify you that the report has been queued. Close the pop-up window by clicking the **X** in the upper-right corner.
6. The report status can be checked by clicking the **Report Status** button on the toolbar. See Section C.3.4.2 for complete instructions.

C.3.4.5 Follow Up Needed

This option will allow the user to generate a report of patients that are due now or within the next 30 days for specific diabetes care needs.

1. Begin by clicking the **Follow up Needed** menu option. The **Follow Up Report** dialog displays (Figure C-36).

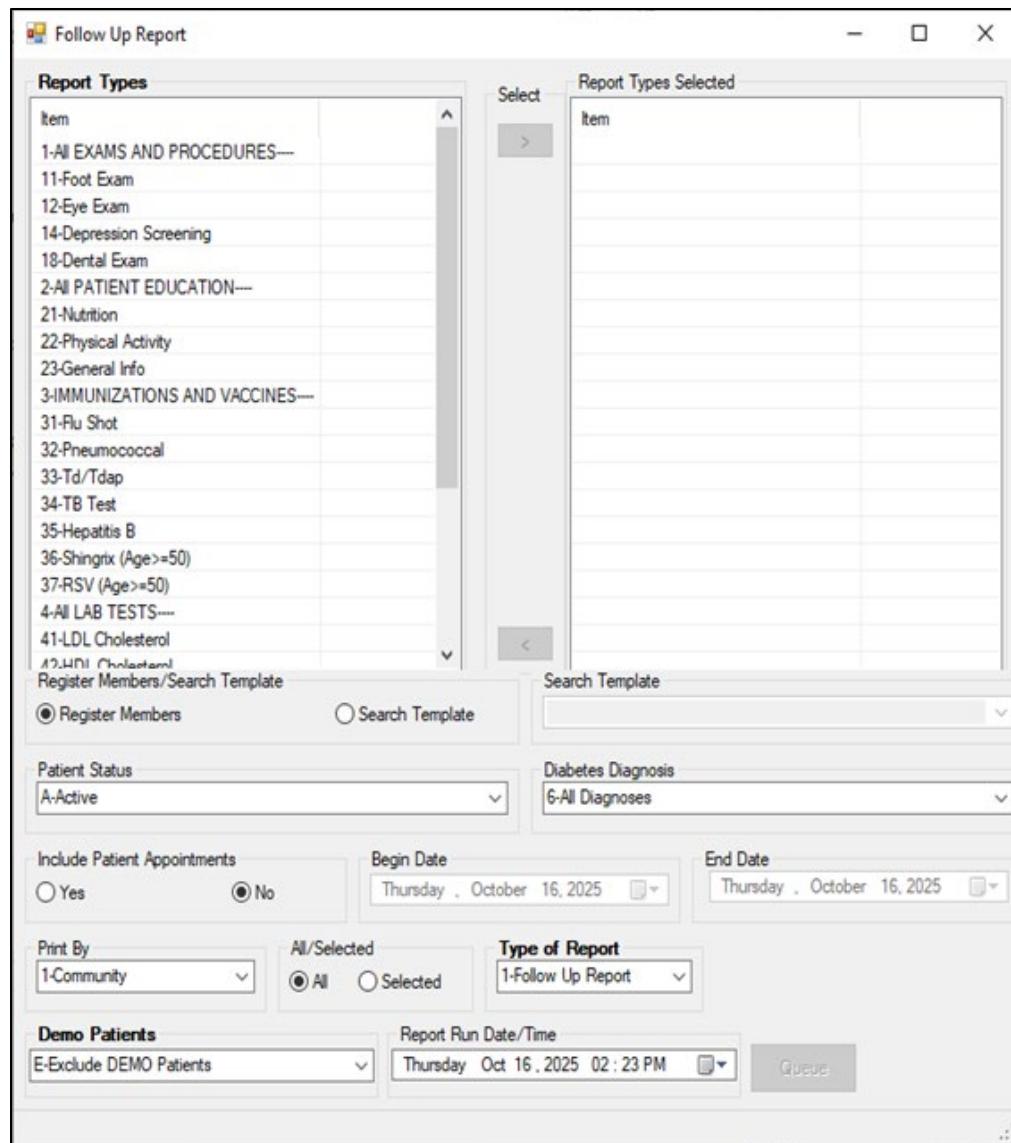


Figure C-36: Follow Up Report dialog

2. Identify which follow-up report is needed. Either highlight the option in the **Report Types** list and click the arrow to move it to the **Reports Type Selected** box or drag it from the list on the left to the list on the right.

3. Determine whether the report will be run for members of your **Register** or for a preselected group of patients stored in a search template. If **Search Template** is chosen, use the list of search templates to identify the desired search template of patients for the report.
4. Select the **Patient Status** for the report.
5. Select the **Diabetes Diagnosis** for the report.
6. If you are using the **IHS Scheduling Package** or **PIMS**, determine whether you want to see a list of appointments for patients on the report by selecting **Yes** or **No** in the **Include Patient Appointments** box.
7. If you want to see scheduled appointments, indicate the beginning and end dates using the calendars. Click the arrow to change the month or day or use the up- and down-arrow keys.
8. The report may be printed by **Community**, **Primary Provider**, or **Where Followed**. Make your selection by using the arrow next to the Print by box and clicking the desired selection.
 - If **Print By Community** is selected, you may choose all or individual communities.
 - If **Selected Communities** is selected, a window will open where the first few letters of the desired community may be chosen by typing them in the **Begin String box** (Figure C-37).
9. Click the right-arrow (>) button to move the desired community into the **Communities Selected** box. This process may be repeated as many times as necessary to identify all communities to be included in the report.
10. When all communities have been selected, click the **Save** button. Close the **Community** window.

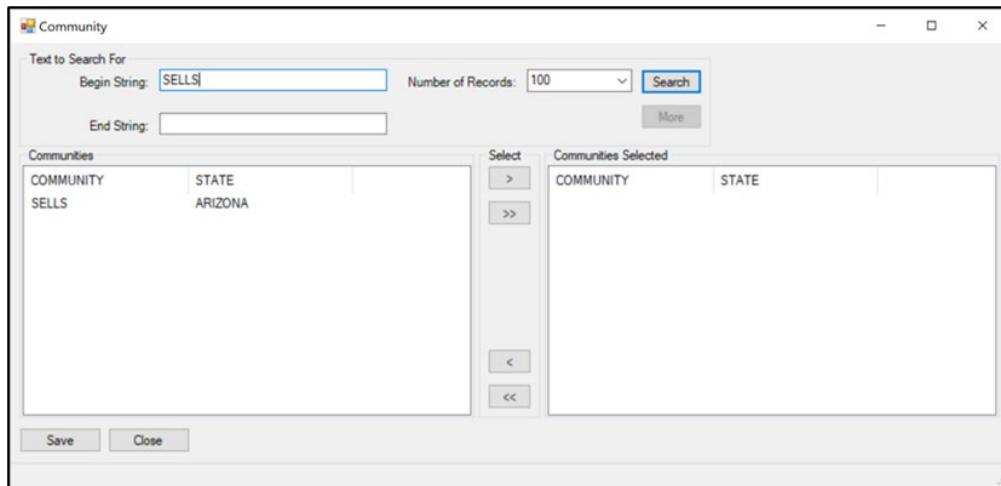


Figure C-37: Community dialog

11. Click the box next to **Type of Report** to select the **Follow Up Report**.
12. Select the **Report Run Date/Time** from the calendar.
13. When all desired options have been selected, click the **Queue** button to initiate the report generation.
14. Once the report is queued to run, click the **Report Status** option on the toolbar of the main window to review the progress of the report.

C.3.5 Audit Setup

Click the plus sign (+) next to the **Audit Setup Menu** option (Figure C-38) to open the submenu.

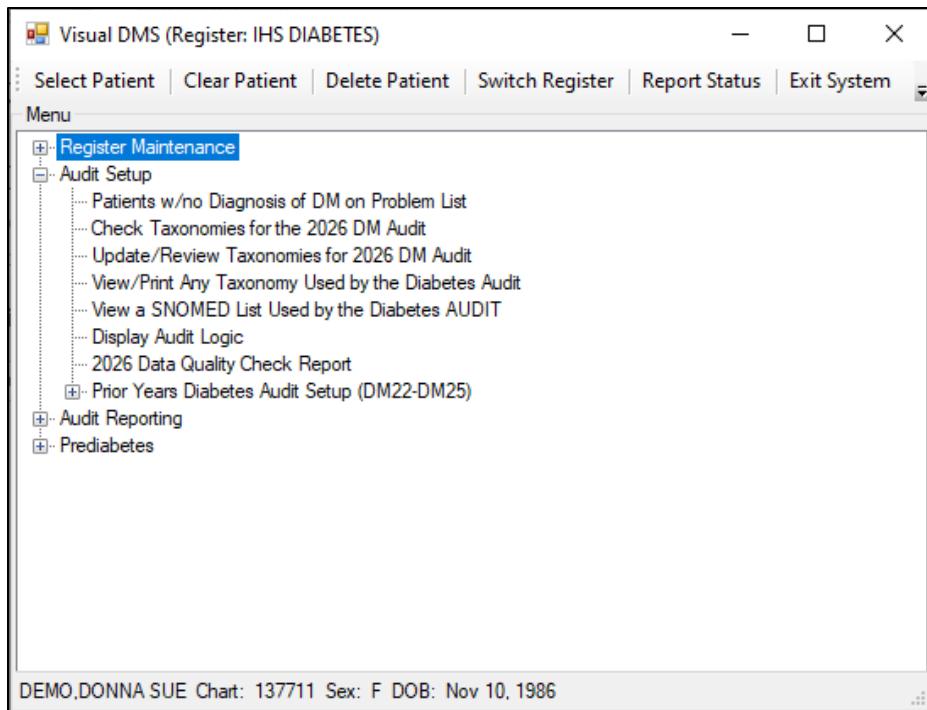


Figure C-38: Audit Setup options dialog

C.3.5.1 Patients w/no Diagnosis of DM on Problem List

This report identifies patients who do not have a diagnosis of diabetes on their problem list but are on your register or have a certain number of diabetes diagnosis codes.

1. Click the Patients with No DX of DM on Problem List menu option (Figure C-39).

A window opens that allows you to define the report criteria.

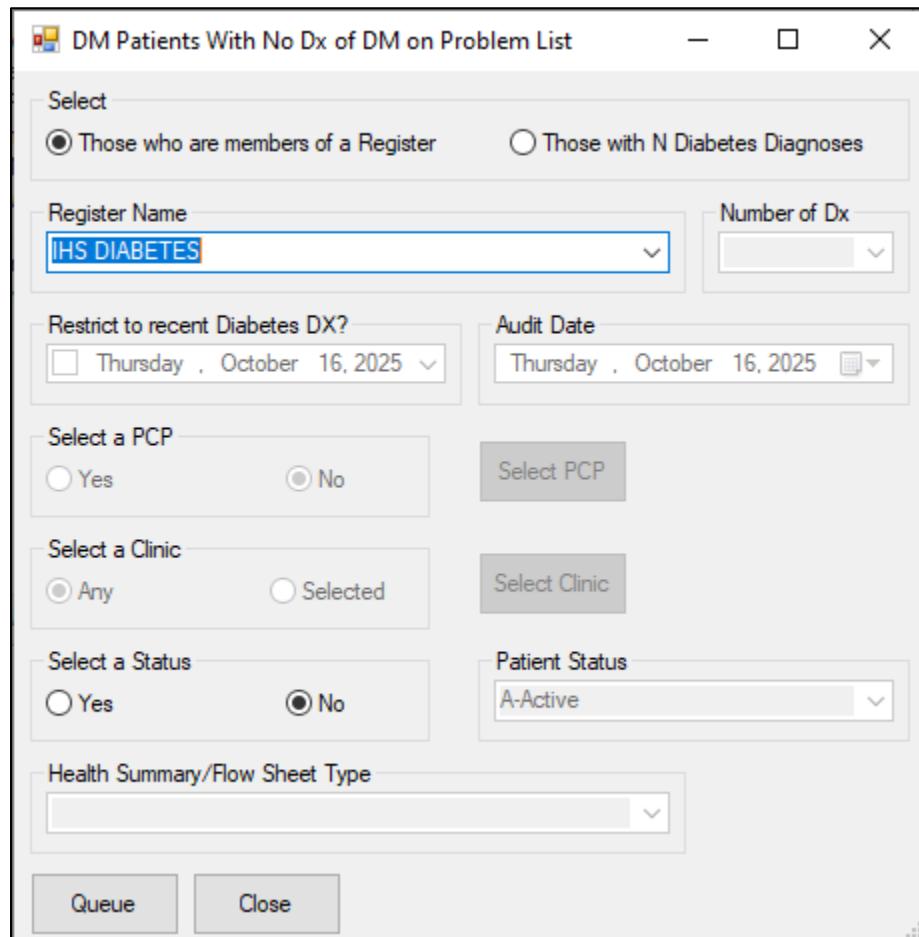


Figure C-39: DM Patients with No DX of DM on Problem List menu

2. Click either **Those who are members of a Register** or **Those with N Diabetes Diagnoses**. N refers to the number of diabetes diagnoses a patient has had.
3. If you select **Those with N Diabetes Diagnoses**, you will need to select the **Number of Dx**. If you select **Those who are members of a Register**, you will need to select a **Register Name**.

4. To restrict your list to only those patients whose most recent diabetes diagnosis is since a certain date, click the down arrow next to the **Restrict to Recent Diabetes DX?** to select a date.
5. Select the desired date of how far back you want to look at diagnoses. You can also select the month, date, or year and use the up or down arrows to change those entries.
6. When your selections are completed, click the **Queue** button. A pop-up window will notify you that the report has been queued. Close the pop-up window by clicking the **X** in the upper right corner.
7. You can check the report status by clicking on the **Report Status** button on the toolbar.

C.3.5.2 Check Taxonomies for the 2026 DM Audit

1. Click the **Check Taxonomies for the 2026 DM Audit** menu option (Figure C-40) to determine whether any taxonomies have not been populated. The result of the taxonomy check will display in a result box.
2. Close the box by clicking the **X** in the upper-right corner.

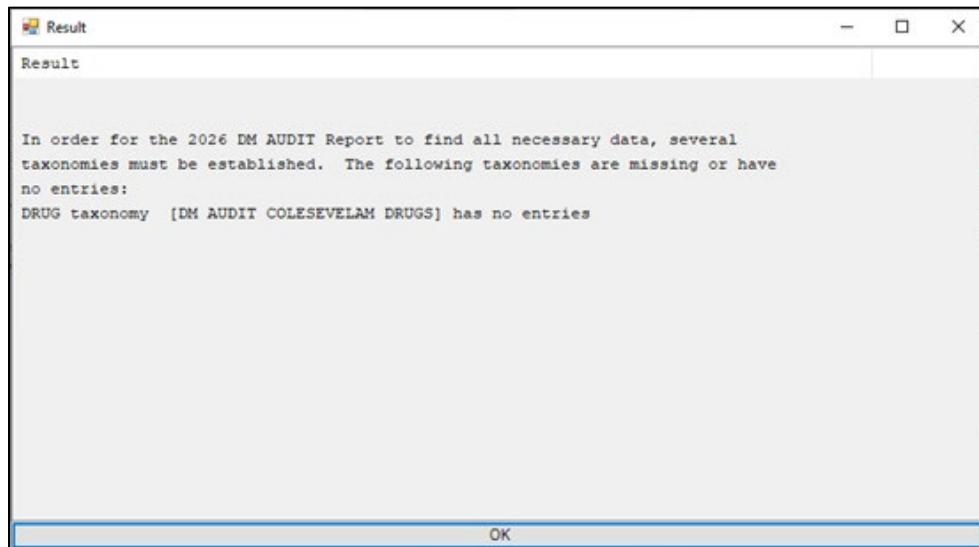


Figure C-40: Check Taxonomies for the 2026 DM Audit Results window

C.3.5.3 Update/Review Taxonomies for 2026 DM Audit

1. Click Update/Review Taxonomies menu option for 2026 DM Audit dialog (Figure C-41) to open the taxonomy update window.

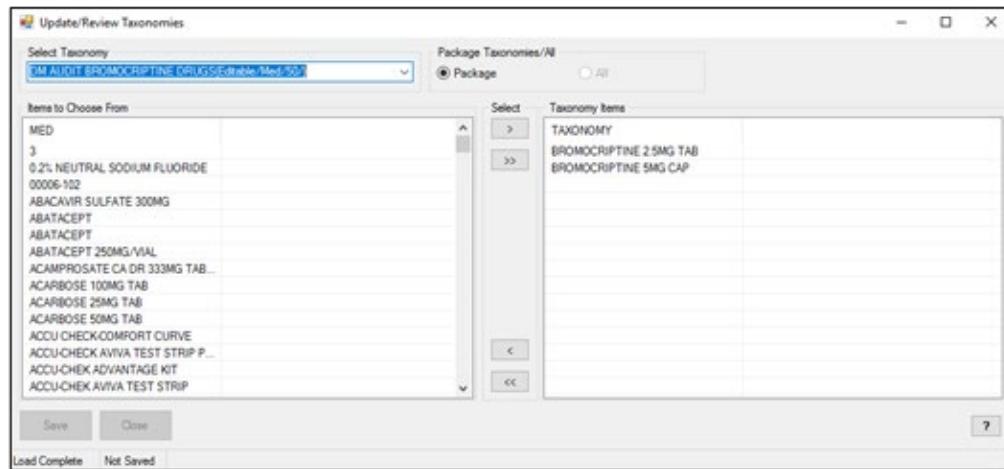


Figure C-41: Update/Review Taxonomies for 2026 DM Audit dialog

2. Select a taxonomy that you want to update from the list.
3. Select the items you want in the taxonomy from the left column titled **Items to Choose From** and click the right-arrow (>) button to move them to the **Taxonomy Items** column on the right, click **Save**.
4. To remove an item from the taxonomy, select the item(s) to remove in the **Taxonomy Items List View** and click the left-arrow (<) button to remove them. Click **Save**.
5. Click **Close** or the **X** to exit.

C.3.5.4 View/Print Any Taxonomy Used by the Diabetes Audit

1. Click the **View/Print Any Taxonomy** used by the **Diabetes Audit**.
2. Select the **Audit Year and Taxonomies** (Figure C-42) to print. Click **Print**.

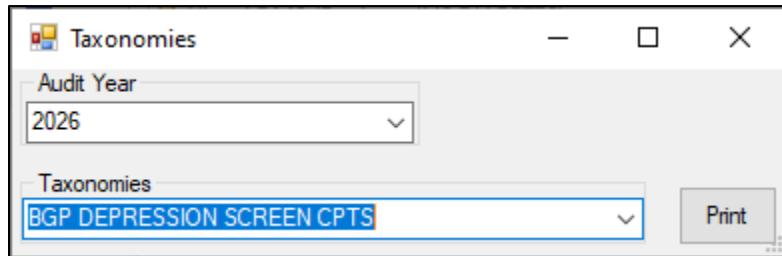


Figure C-42: Audit and Taxonomy Selection dialog

The taxonomy is displayed in **Crystal Reports** (Figure C-43).

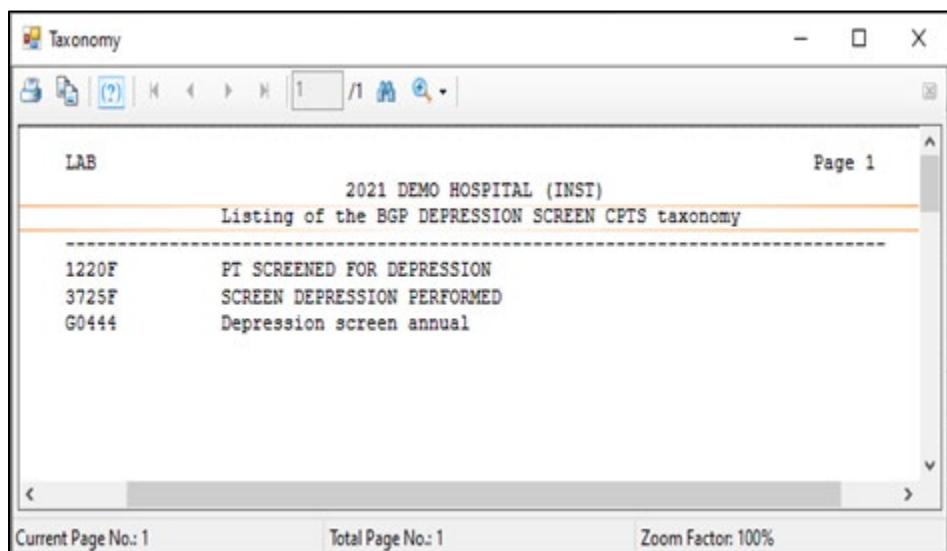


Figure C-43: Taxonomy Listing window

3. Click **Close** or the **X** to exit.

C.3.5.5 View a SNOMED List Used by the Diabetes AUDIT

1. Click the **View a SNOMED List Used by the Diabetes AUDIT** (Figure C-44).
2. Select the **Audit Year** and **SNOMED Lists** to print. Click **Print**.

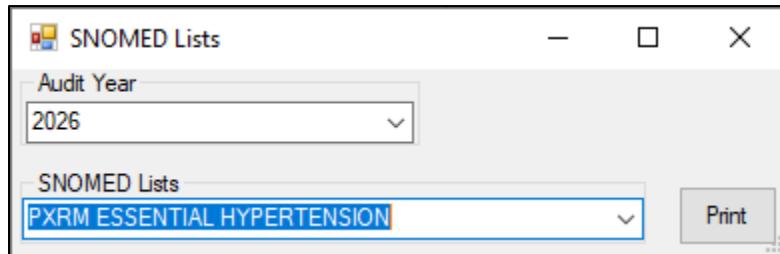


Figure C-44: Audit Year and SNOMED List Selection dialog

The **SNOMED** list displays in **Crystal Reports** (Figure C-45).

3. Click the **X** to close the display.

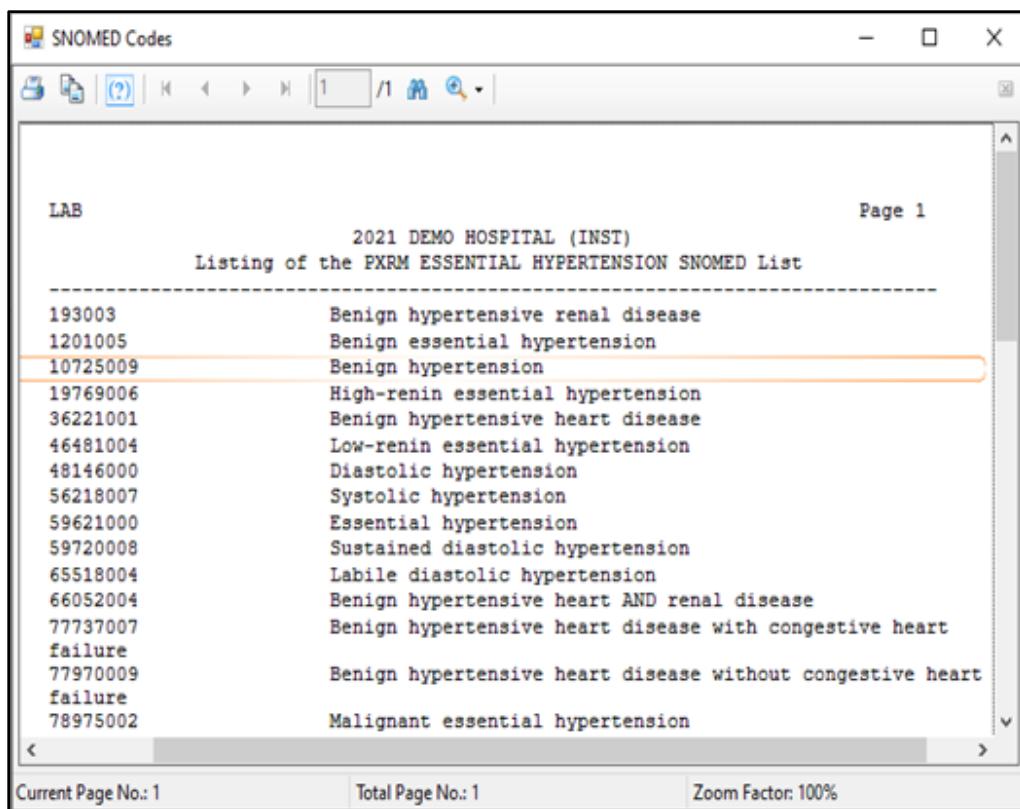


Figure C-45: SNOMED List sample window

C.3.5.6 Display Audit Logic

1. Click the **Display Audit Logic** (Figure C-46) menu option.
2. Select the **Audit Year** from the list.

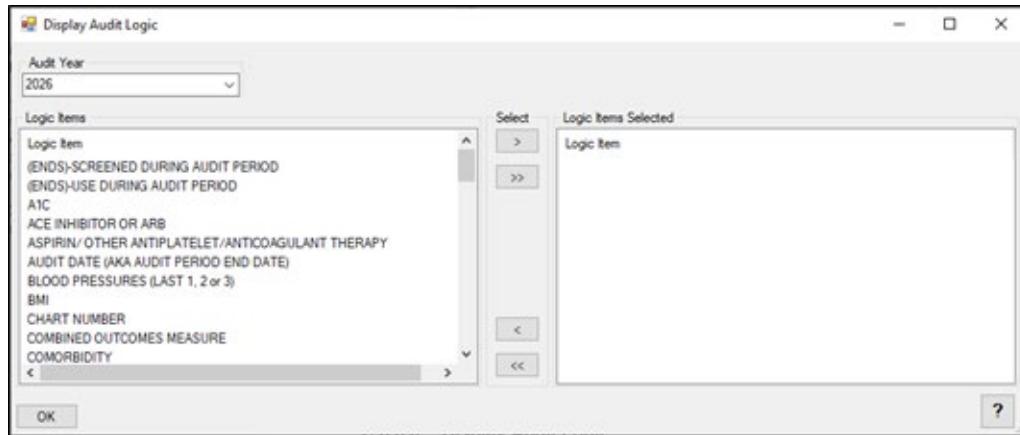


Figure C-46: Display Audit Logic options dialog

3. Select the **Logic Item** you want to display from the **Logic Items** list and click the right-arrow (>) button. To display all Logic Items, click the double right-arrow (>>) button. Click **OK**.
4. The result is displayed in **Crystal Reports** (Figure C-47). Click the **X** in the upper-right corner to close the display.

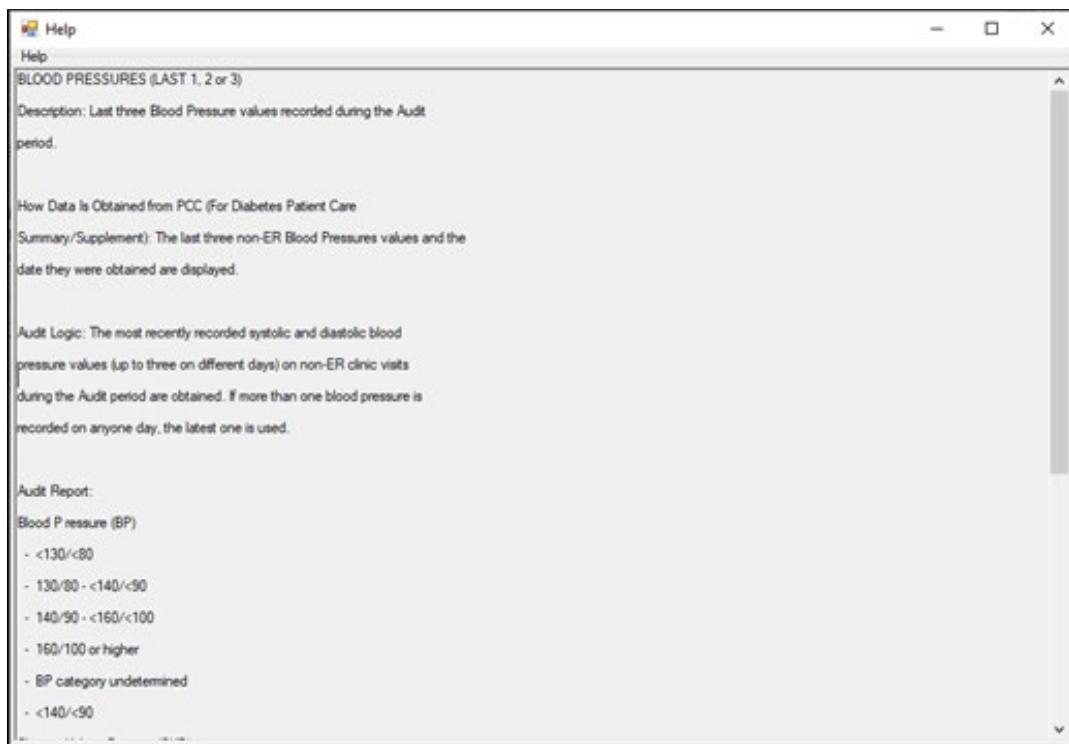


Figure C-47: Display Audit Logic window

C.3.5.7 2026 Data Quality Check Report

1. Click the **2026 Data Quality Check Report** menu item to display the **Taxonomy Check** (Figure C-48). Before the **Audit** window opens, a taxonomy check will run, and the results will display on the screen.
2. Close the **Taxonomy Check Result** screen.

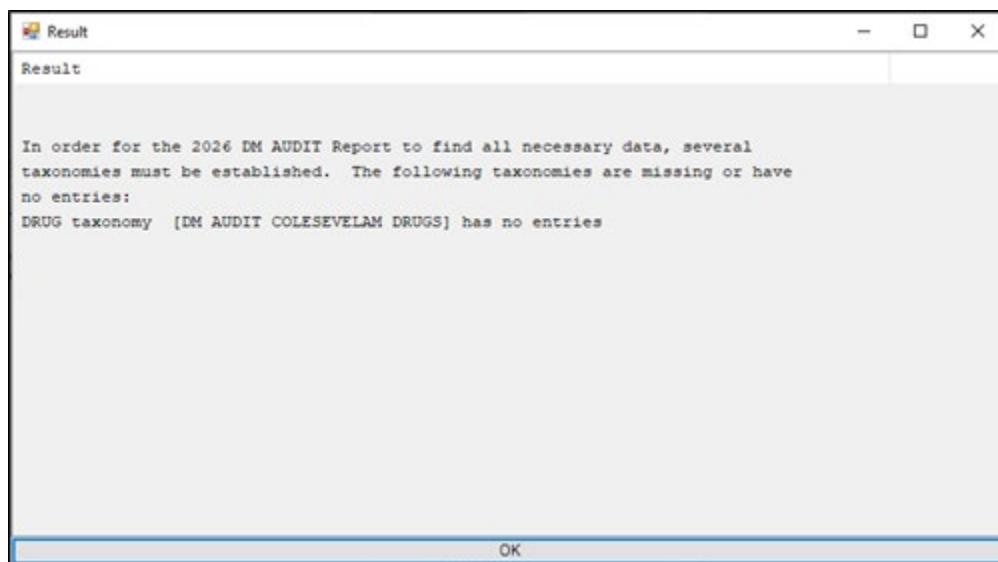


Figure C-48: Taxonomy Check Results window

3. The **Data Quality Report** dialog (Figure C-49) displays.

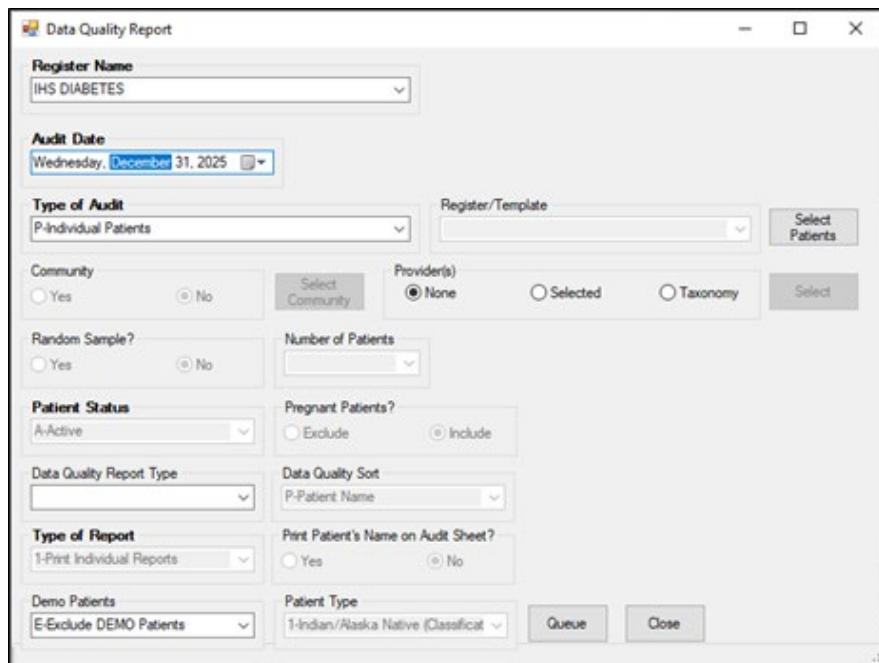


Figure C-49: Data Quality Report parameters dialog

4. Select a **Register Name** from the box, the **Audit Date** from the calendar, the **Type of Audit**, and any other options.
5. Click **Queue**.
6. The report is queued. Use the **Report Status Toolbar** button from the main menu to view a list of reports (Figure C-50). Click to display the report.

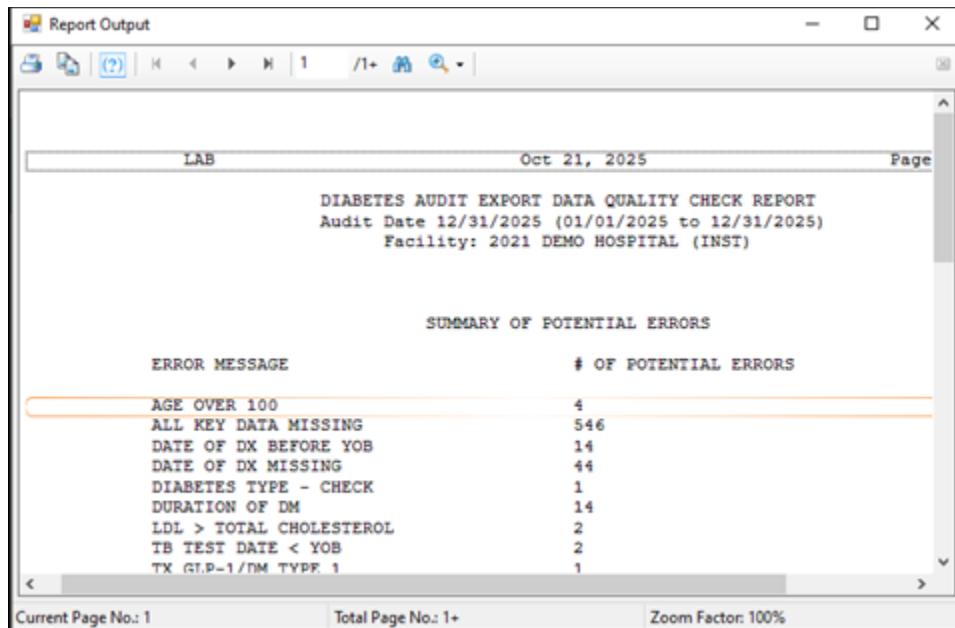


Figure C-50: Data Quality Check Report window

C.3.5.8 Prior Years Diabetes Audit Setup (DM21–DM24)

1. Click the plus sign (+) next to **Prior Years Diabetes Audit Setup (DM22–DM25)** to open the menu (Figure C-51).

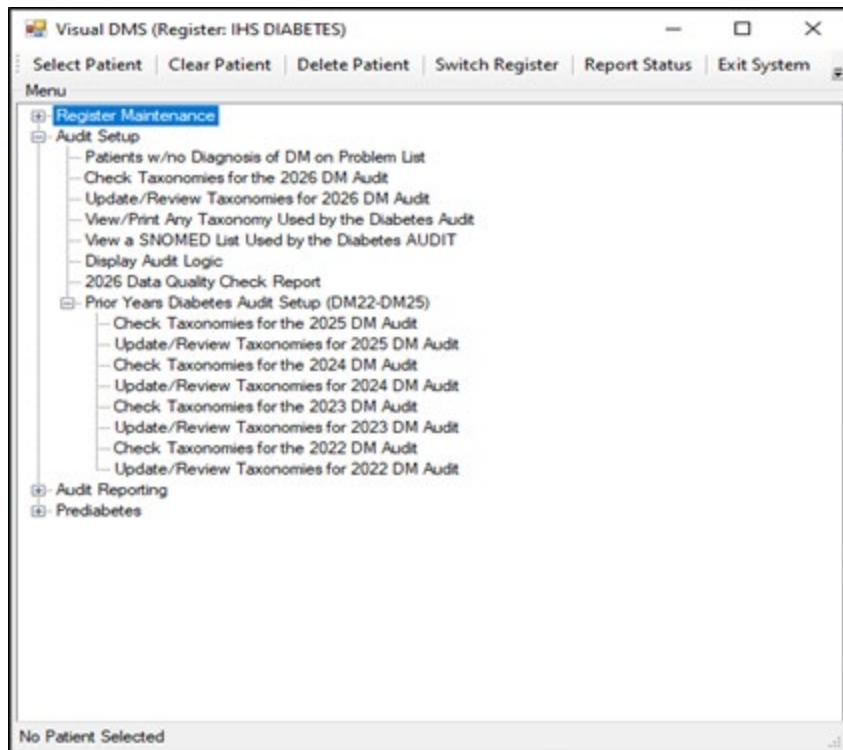


Figure C-51: Prior Years Options window

2. Select any of the menu options. The options work the same as the **Check Taxonomies for the 2026 DM Audit** and **Update/Review Taxonomies for the 2026 DM Audit**.

C.3.6 Audit Reporting

Click the plus sign (+) in front of **Audit Reporting** (Figure C-52) to open this menu.

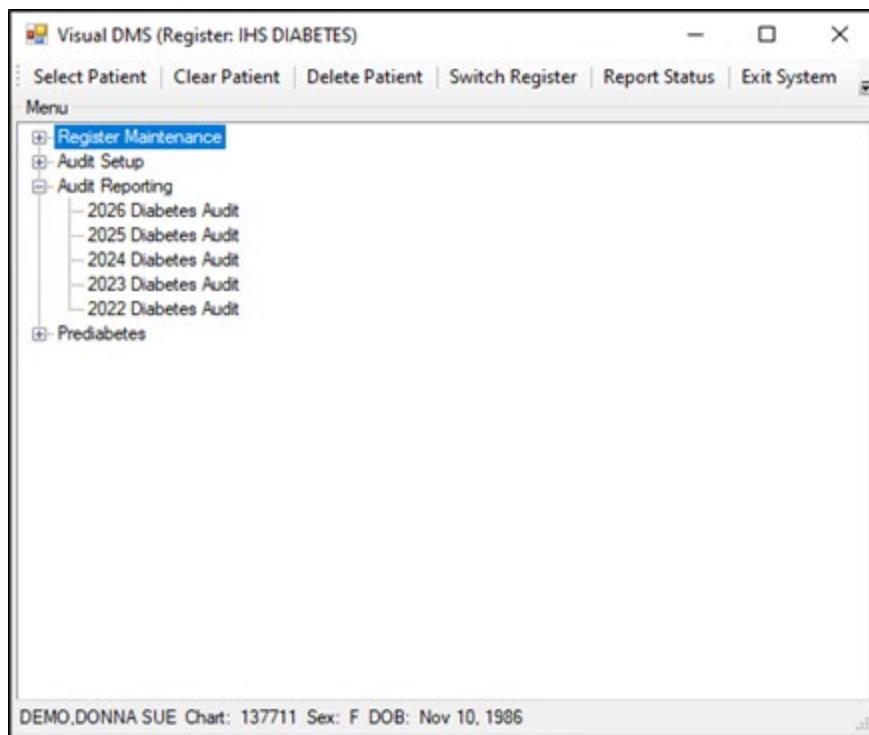


Figure C-52: Audit Reporting options window

C.3.6.1 2026 Diabetes Audit

1. Click the **2026 Diabetes Audit** menu option (Figure C-53) to run the 2026 Audit. Before the Audit window opens, a taxonomy check will run, and the results will display on the screen.

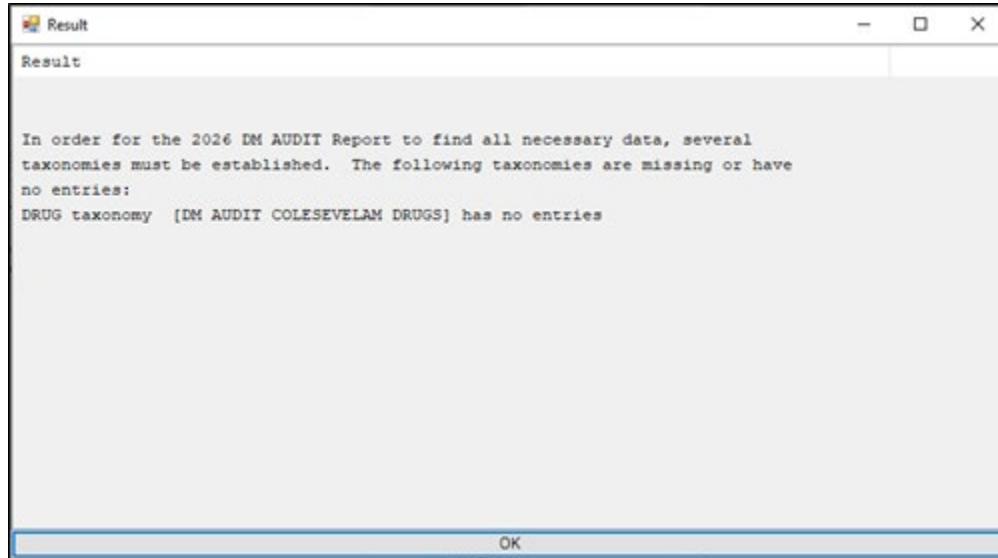


Figure C-53: Taxonomy Check Results window

2. Close the **Taxonomy Check Result** window. The **DM Audit** dialog will open (Figure C-54).

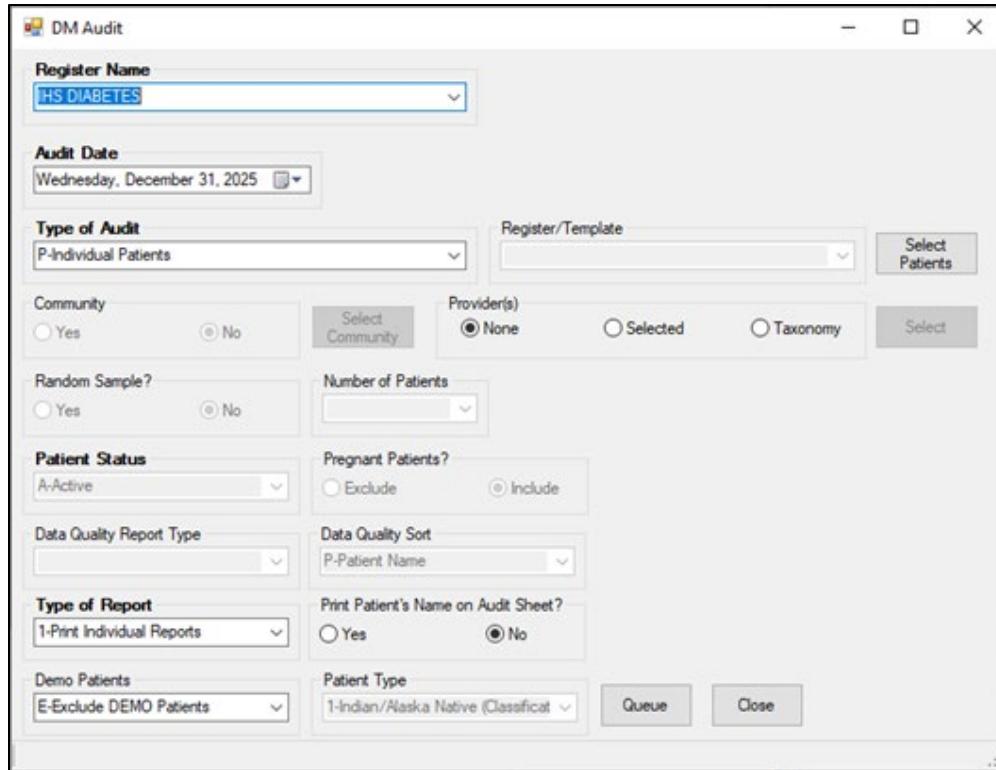


Figure C-54: Diabetes Audit options dialog

3. Select a **Register Name** from the list of available Registers.
4. Select the **Audit Date** from the calendar. Alternatively, use the up or down arrow keys to select the month, day, or year to change the **Audit Date**.
5. Select the **Type of Audit**:
 - **P-Individual Patients**
 - **S-Search Template of Patients**
 - **C-Members of a CMS Register**
 - **E-E Audit (predefined set of patients)**
6. If you choose **Individual Patients**, click the **Select Patients** button that highlights when this option is selected.
 - Enter patients one at a time by chart number, last name, first name, or date of birth on the patient selection screen.
 - If you only enter a last name, the entire list of matching patients may be displayed by clicking on the **Display** button.

7. Select the patients you want to include in the Audit. Their names will appear on the **Patients Selected** window. Repeat the process until all desired patients are identified.
8. Click the **Save** button when the list is complete.
 - If you choose **Search Template of Patients**, select the desired template from the **Register/Template** list.
 - If you choose **Members of a CMS Register**, select the desired register from the **Register/Template** list.
 - If you choose **E Audit**, indicate if you want Only ACTIVE members of the register selected and select a **Community Taxonomy**.
 - If you want to run the **Audit** on patients that live in a particular community, click **Yes** in the **Select Community** box. A window will display to type the first few letters of the community's name in the **Begin String** box. When the list of communities is displayed, select the desired community.
 - If you want to run the **Audit** by either a **Provider**, **Selected Providers**, or a **Taxonomy of Providers**, click the appropriate button in the **Provider(s)** box. Then, click the **Select** button to select providers or the taxonomy you want to use. A window will open where you can type the first few letters of the primary care provider's last name in the **Begin String** box. When the list of providers displays, click the desired provider's name, then the right-arrow button. Repeat if multiple providers are desired. If selecting a Taxonomy, a list of taxonomies will display.
 - If you want to run the **Audit** on **Members of a CMS Register**, you may answer **Yes** or **No** in the **Select a Random Sample?** box. If you select Yes, you will be prompted to enter the Number of Patients.
9. Use the **Patient Status** box to identify the status of the patients to be included in the Audit.
10. Use the **Pregnant Patients?** box to indicate whether pregnant patients should be included or excluded.
11. Select the **Type of Report** you want to run:
 - **1–Print Individual Reports**
 - **2–Create Audit Export File**
 - **3–Cumulative Audit Only**
 - **4–Both Individual and Cumulative Audit**
 - **5–SDPI RKM Report**
12. Choose whether to exclude **Demo Patients**.

13. Select **Patient Type**.
14. When all selections are made for the DM Audit, click the **Queue** button. A pop-up window will notify you that the report has been queued.
15. Close the pop-up window by clicking the **X** in the upper right corner.
 - The report status may be checked by clicking the Report Status button on the toolbar.
 - The **Individual** or **Cumulative Audit** may be opened by clicking the report when it shows a status of complete. This will open in a **Crystal Reports** document.
16. The report can be printed or browsed. The document may be closed when review is complete by clicking the **X** in the upper right corner.

C.3.6.2 2022–2025 Diabetes Audit

This Audit has the same functionality as the 2025 Diabetes Audit. See Appendix D for complete instructions.

C.3.7 Prediabetes Reports

Prediabetes Audit functionality (Figure C-55) has been restored and redesigned to allow users to review the **Prediabetes Patient Care Summary**, **Prediabetes Assessment of Care**, and **Prediabetes Health Status Reports**.

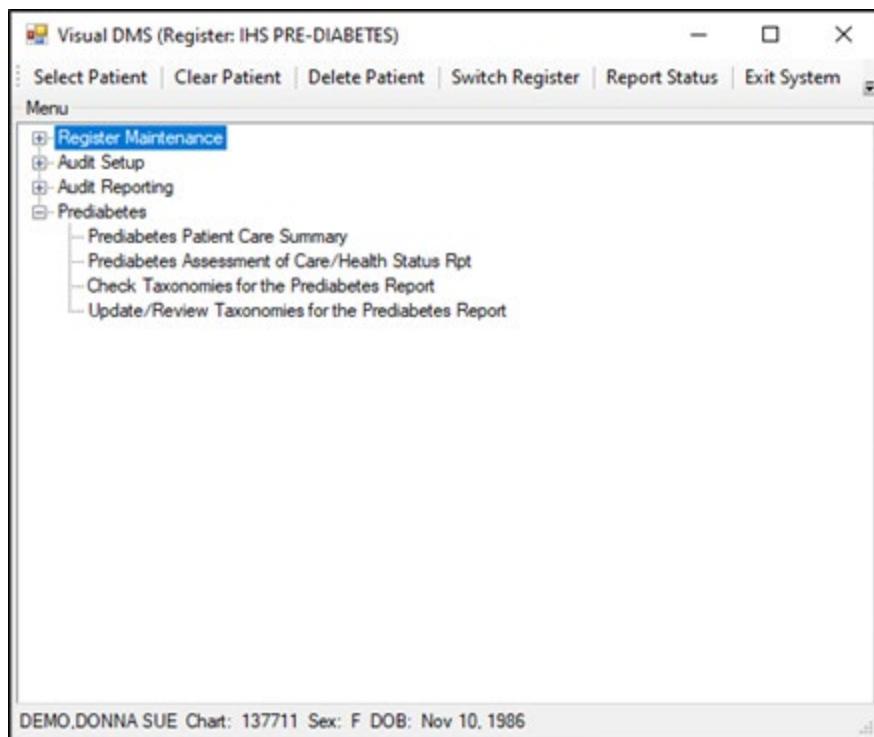


Figure C-55: Prediabetes Audit Functionality window

C.3.7.1 Prediabetes Patient Care Summary

1. Click the **Prediabetes Care Summary (DPCS)** menu item (Figure C-56) to open **Prediabetes Care Summary (DPCS)**.

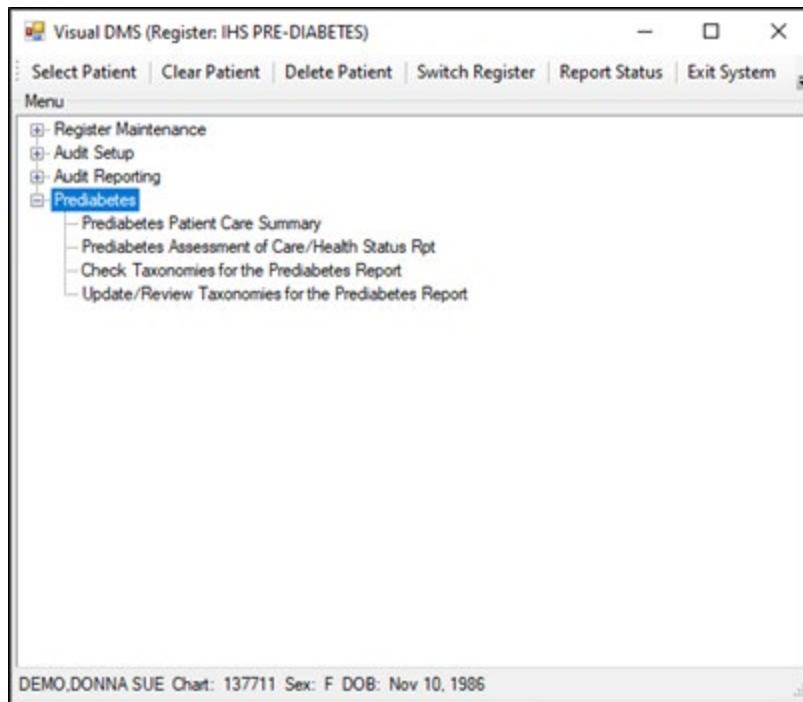


Figure C-56: Prediabetes Care Summary (DPCS) menu item

A **Crystal Reports** document (Figure C-57) opens displaying the **Summary**.

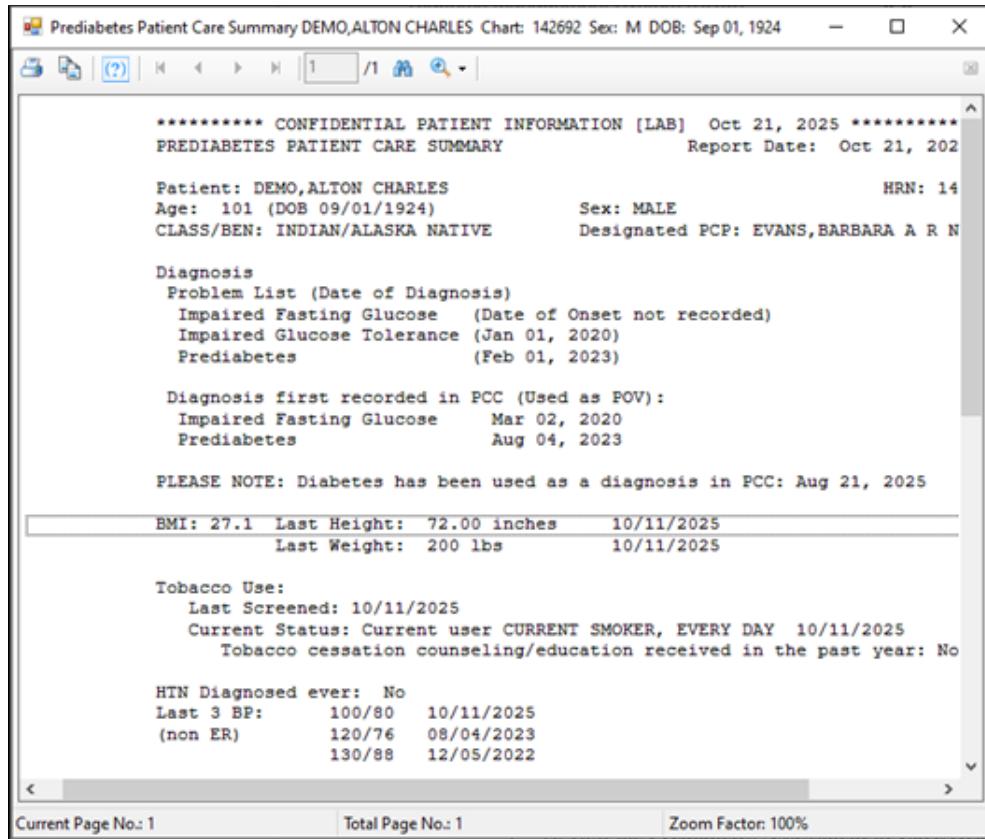


Figure C-57: Crystal Reports Summary screen

2. Click the X in the upper-right corner to close the **Crystal Reports** document.

C.3.7.2 Prediabetes Assessment of Care/Health Status Report

1. To view the **Prediabetes Assessment of Care/Health Status Report**, click on the menu option to run the **2026 Prediabetes Assessment of Care Report**.

Before the **Assessment** window opens, a taxonomy check will run, and the results dialog will display (Figure C-58).

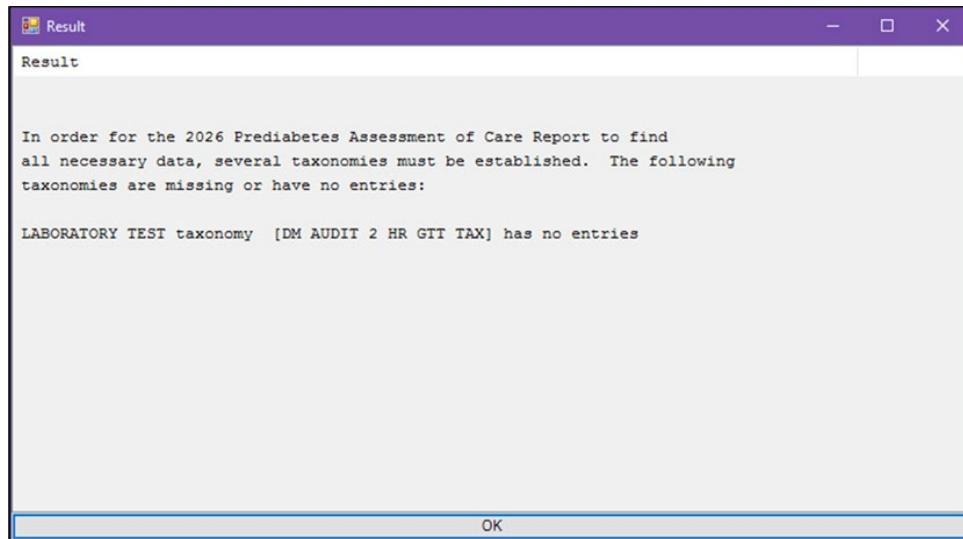


Figure C-58: Taxonomy Check Results window

2. Close the **Taxonomy Check Result** window. The **Pre-diabetes Report** dialog (Figure C-59) opens.

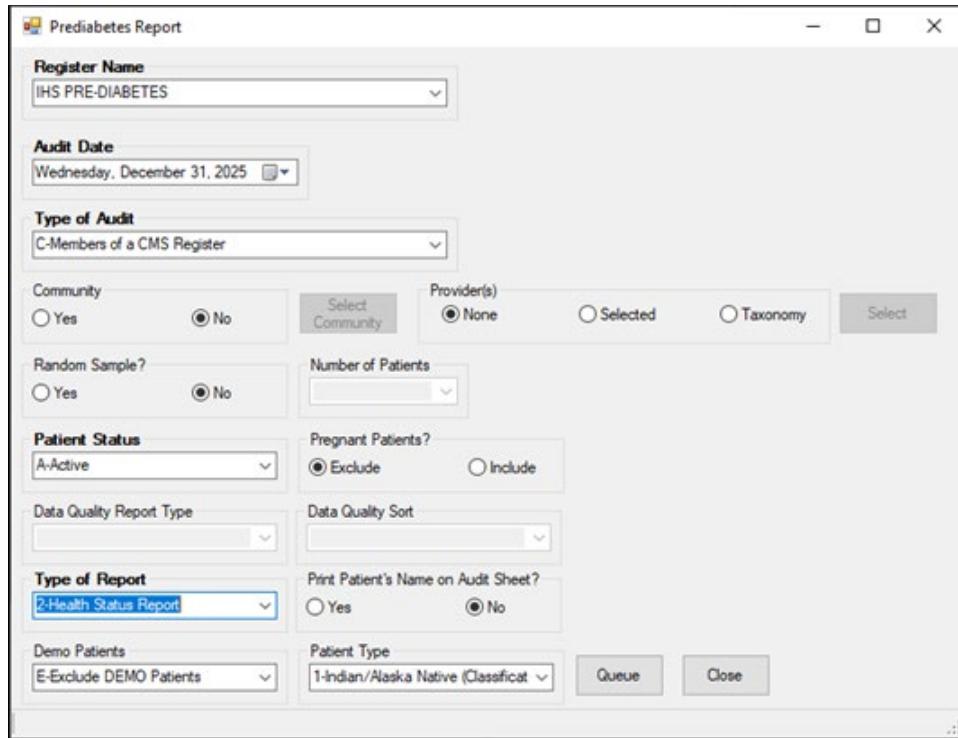


Figure C-59: Prediabetes Audit dialog

3. Select a **Register Name** from the list of available registers.
4. Select the **Audit Date** from the calendar. Alternatively, use the up or down-arrow keys to select the month, day, or year to change the **Audit Date**.
5. Select the **Type of Audit**:
 - **P-Individual Patients**
 - **S-Search Template of Patients**
 - **C-Members of a CMS Register**
6. If you select **Individual Patients**, click the **Select Patients** button that is highlighted when this selection is made.
7. Enter patients one at a time by **chart number, last name, first name, or date of birth** on the **Patient Selection** dialog.
 - If you only enter a last name, the entire list of matching patients may be displayed by clicking on the **Display** button.
8. Select the patients who you want to include in the Audit. Their names will appear on the **Patients Selected** window. Repeat the process until all desired patients are identified.
9. Click the **Save** button when the list is complete.

10. If you choose **Search Template of Patients**, select the desired template from the **Register/Template** list.

- If you choose **Members of a CMS Register**, select the desired register from the **Register/Template** list.
- If you want to run the **Audit** on patients that live in a particular community, click **Yes** in the **Select Community** box. A window will display where you can type the first few letters in the community's name in the **Begin String** box. When the list of communities is displayed, select the desired community.
- If you want to run the **Audit** by either a **provider**, **selected providers**, or a **taxonomy of providers**, click the appropriate button in the **Provider(s)** box. Click the **Select** button to select providers or the taxonomy you want to use. A window will open where you can type the first few letters of the primary care provider's last name in the **Begin String** box. When the list of providers displays, click the desired provider's name, then the right-arrow button. Repeat if multiple providers are desired. If selecting a **Taxonomy**, a list of taxonomies will be displayed.
- If you choose to run the **Audit** on **Members of a CMS Register**, you may answer **Yes** or **No** in the **Select a Random Sample?** box. If you select **Yes**, you will be prompted to enter the **Number of Patients**.

11. Use the **Patient Status** box to identify the status of the patients to be included in the **Audit**.

12. Use the **Pregnant Patients?** box to indicate whether pregnant patients should be included or excluded.

13. Select the **Type of Report** you want to run:

- **1–Print Individual Reports**
- **2–Cumulative Audit Only**
- **3–Both Individual and Cumulative Audit**

14. Choose whether to exclude **Demo Patients**.

15. Select **Patient Type**.

16. When all selections are made for the **Audit**, click the **Queue** button. A pop-up window will notify you that the report has been queued. Close the pop-up window by clicking the **X** in the upper-right corner.

- The report status may be checked by clicking the **Report Status** button on the toolbar.
- The **Individual** or **Cumulative Audit** may be opened by clicking the report when it shows a status of complete.

It will open in a **Crystal Reports** document (Figure C-60).

17. The report can be printed or browsed. The document may be closed when review is complete by clicking the X in the upper-right corner.

The screenshot shows a 'Report Output' window with the following details:

Report Title: PREDIABETES HEALTH STATUS OF PATIENTS - RPMS

Report Period: Dec 31, 2024 to Dec 31, 2025

Hospital: 2021 DEMO HOSPITAL (INST)

Summary: 134 patients were reviewed. Unless otherwise specified, time period for each item is the 12-month Audit Period.

Table Data:

	# of Patients	# Considered	Percent
	(Numerator)	(Denominator)	
Sex			
Male	41	134	31%
Female	93	134	69%
Unknown	0	134	0%
Age			
<15 yrs	0	134	0%
15-44 yrs	42	134	31%
45-64 yrs	54	134	40%
65 yrs and older	38	134	28%
Classification			
Prediabetes	3	134	2%
Impaired Fasting Glucose	66	134	49%
Impaired Glucose Tolerance	44	134	33%
Duration of Prediabetes			
<1 year	0	134	0%
<10 years	0	134	0%

Page Information:

- Current Page No.: 1
- Total Page No.: 1+
- Zoom Factor: 100%

Figure C-60: Report Output window

C.3.7.3 Check Taxonomies for the Prediabetes Report

1. Click the **Check Taxonomies for the Prediabetes Report** menu option to determine whether any taxonomies have not been populated. The result of the taxonomy check will be displayed in a result box (Figure C-61).
2. Close the box by clicking the X in the upper-right corner.

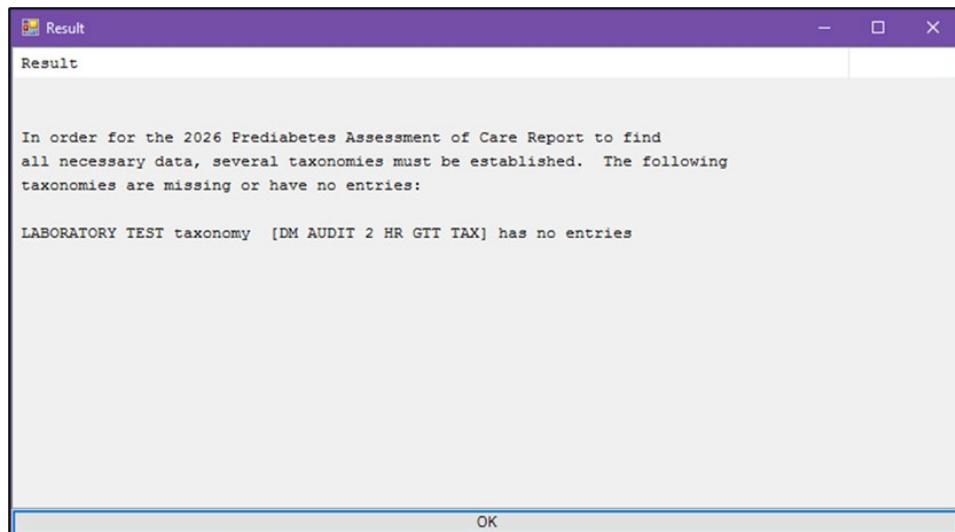


Figure C-61: Taxonomy Check Displayed in a result box

C.3.7.4 Update/Review Taxonomies for the Prediabetes Audit

1. Click the menu option **Update/Review Taxonomies for Prediabetes Audit** (Figure C-62) to open the taxonomy update window.

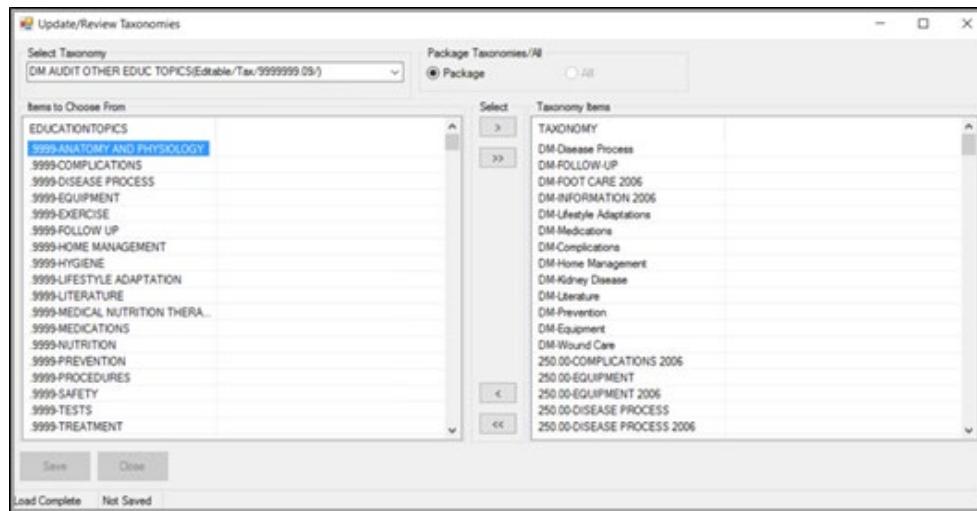


Figure C-62: Update/Review Taxonomies for Prediabetes Audit dialog

2. Select a taxonomy that you want to update from the list.
3. Select the items you want in the taxonomy from the **Items to Choose From** column and click the right-arrow (>) button to move them to the **Taxonomy Items** column on the right.
4. Click **Save**.
5. To remove an item from the taxonomy, select the item(s) to remove in the **Taxonomy Items List View** and click the left-arrow (<) button to remove them.
6. Click **Save**.
7. Click **Close** or the **X** to exit.

Appendix D 2026 Diabetes Audit

The **Diabetes Management System (DMS)** can be used to conduct a **Diabetes Audit**, including creation of Audit data files and reports. This section focuses on the **DMS** menu options used to prepare for and conduct an **Audit**.

The general steps for conducting an Audit are:

1. Complete the 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:

- The **Audit Setup** menu includes tools for Audit preparation.
- The **Audit Reporting** menu includes tools for creating Audit data files and reports.

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

DMS Main Menu

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

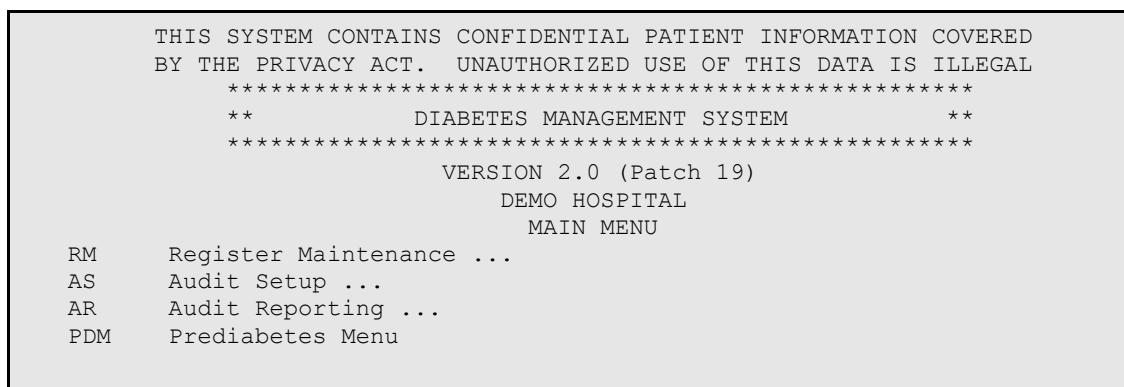


Figure D-1: RPMS DMS main menu screen

Visual DMS (Figure D-2) includes the same options to prepare for and conduct an **Audit**.

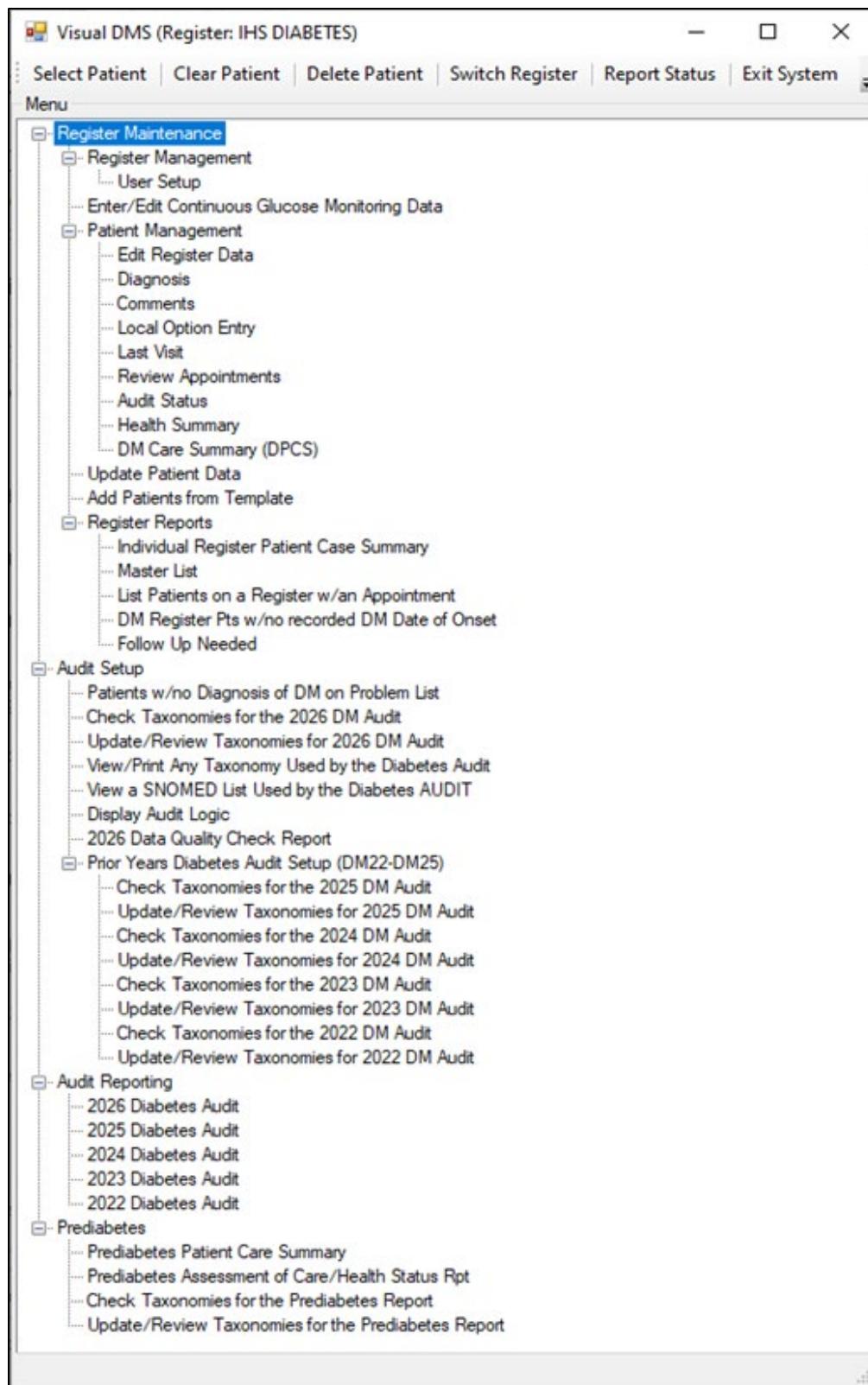


Figure D-2: Visual DMS menu dialog

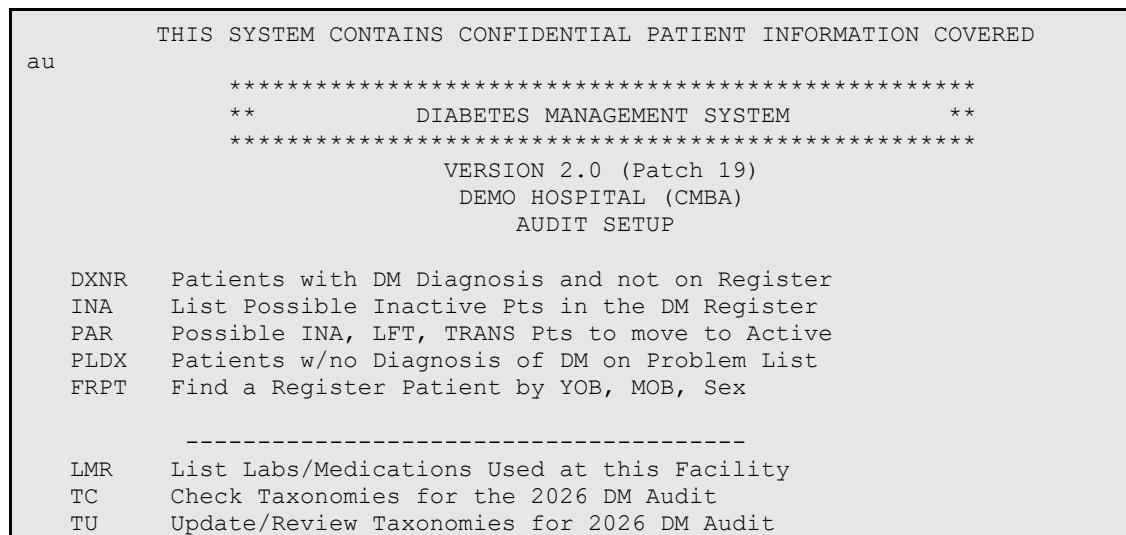
D.1 Audit Setup—Prepare for an Audit

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 D.3 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. Deleting 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 eligible patients with diabetes.
2. Review and update taxonomies for medications and laboratory tests as needed (see Section D.4).
3. Run and review a **Data Quality Check** report. Make corrections as appropriate. See Section D.5 for additional information.

D.2 Audit Setup Menu

The Audit Setup (AS) menu provides reports and utilities used to prepare for conducting an Audit. Details of AS menu options are provided in Figure D-3 and Figure D-4.



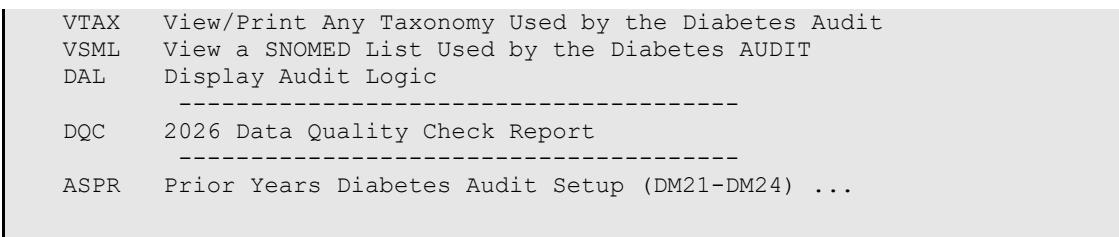


Figure D-3: Audit Setup menu

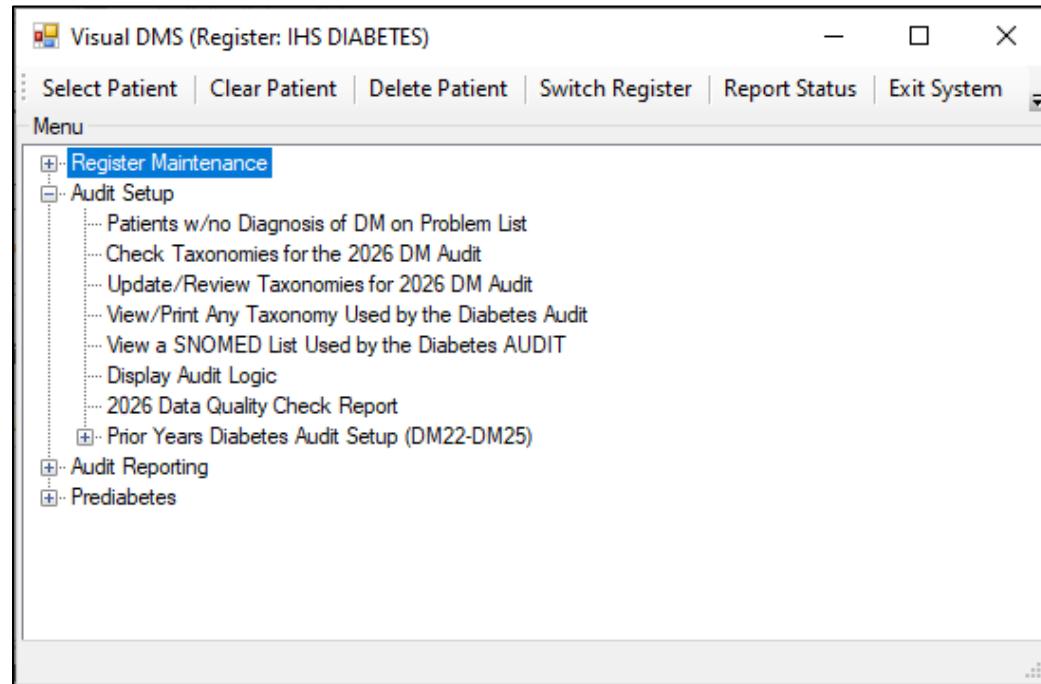


Figure D-4: Visual DMS Audit Setup menu

D.3 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 2026 Annual Diabetes Audit:

1. First, identify patients who meet all of the following criteria:
 - Have a diagnosis of diabetes mellitus.
 - Are American Indian or Alaska Native.
 - Have at least one visit (in person or Telehealth) with a diabetes diagnosis as a purpose of visit to any of the following clinics during the one-year Audit period (numbers in parentheses are IHS-specific clinic codes):
 - **General (01)**
 - **Diabetic (06)**

- **Internal Medicine (13)**
- **Pediatric (20)**
- **Well Child (24)**
- **Family Practice (28)**
- **Chronic Disease (50)**
- **Endocrinology (69)**
- **Pharmacy Primary Care Clinic (D5)**

2. Then, exclude patients who:

- Received the majority of their primary care during the Audit period outside of your facility.
- Are currently on dialysis *and* received the majority of their primary care during the Audit period at the dialysis unit.
- Have died before the end of the Audit period.
- Were pregnant during any part of the Audit period.
- Have prediabetes (as determined by documented diagnosis or impaired fasting glucose [IFG], impaired glucose tolerance [IGT], or elevated A1C level).
- Have moved—permanently or temporarily.

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 D.3.1 for guidance in reviewing and updating the **Diabetes Register**.

D.3.1 Using the Diabetes Register for the 2026 Diabetes Audit

The **Diabetes Register** may be used for the 2026 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 (AMQQMENU)** tools and **DMS** reports below can help identify patients in the Diabetes Register who should and should not be included in the Audit. Contact your site manager if you do not know how to access QMAN.

- Section D.3.1.1 describes how to find patients in the **Register** who have a **Register Diagnosis of Prediabetes or Gestational Diabetes Mellitus (GDM)** and should not be included in the **Audit**.

- Section D.3.1.2 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: This report is only available in traditional **DMS**, not **Visual DMS**.

- Section D.3.1.3 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: This report is only available in traditional **DMS**, not **Visual DMS**.

- Section D.3.1.4 describes how to use the **PAR List Possible INA, LTF, TRANS Pts to move to Active** report to list patients on the register with a status of **Inactive, Lost to Follow-up, or Transient to be reviewed** for potential to move to Active status.

Note: This report is only available in traditional **DMS**, not **Visual DMS**.

- Section D.3.1.5 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 2026 Annual Audit, the IHS Division of Diabetes requires review of the care provided during the calendar year ending December 31, 2025. Reports identifying patients with an active status should be run for the time period between 1/1/2025 and 12/31/2025.

D.3.1.1 Identify IHS Diabetes Register Patients with GDM or Prediabetes Using QMAN

The **IHS Diabetes Register** allows entry of **GDM** and **Prediabetes** 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 **Prediabetes**.

The **QMAN** search shown in Figure D-5 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 **Impaired Glucose Tolerance**. 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**.

```

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 D-5: QMAN search to identify patients with Register Diagnosis of GDM

Figure D-6 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
-----
PATIEN,DEMO I* 29693
Total: 1
```

Figure D-6: QMAN Search results

Note: A patient whose name is marked with an asterisk (*) might have an alias.

D.3.1.2 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 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 (Figure D-7), 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: 1/1/25 (JAN 01, 2025)

Enter Ending Visit Date: 12/31/25 (DEC 31, 2025)

Figure D-7: 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 (Figure D-8), type the ending date and press Enter.

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

Figure D-8: 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: B// BROWSE the List on the Screen

Figure D-9: Enter the output type

7. At the “Output Type” prompt (Figure D-9), 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 D-10: Prompt to include or exclude demo patients

8. At the “Demo Patient Inclusion/Exclusion” prompt (Figure D-10), 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 shown in Figure D-11:

OUTPUT BROWSER Nov 17, 2025 12:00:26 Page: 1 of 26 ***** CONFIDENTIAL PATIENT INFORMATION ***** DR Page 1 DEMO HOSPITAL Patients NOT on the DEMO HOSPITAL DIABETES Register with at least 3 visits with a DX of Diabetes between Jan 01, 2025 and Dec 31, 2025 PATIENT NAME HRN DOB COMMUNITY LAST VISIT # DM LAST DM DXS DX ----- DEMO, RACHEL PATIENT 100019 03/28/1941 LAKE HAVSU 03/20/25 3 03/20/24 DEMOPATIENT, NEOMI 888885 03/15/1955 KINGMAN 03/22/25 3 03/22/24 PATIENTDEMO, CARLEE 122222 11/12/1993 PARKER 04/03/25 3 02/27/24 DEMO-CARTER, PATIENT A 144444 05/25/1977 PARKER 03/27/25 4 03/19/25 + Enter ?? for more actions >>> + NEXT SCREEN - PREVIOUS SCREEN Q QUIT Select Action: +//
--

Figure D-11: Report of patients not on the Diabetes register that have a diabetes diagnosis

D.3.1.3 INA–List Possible Inactive Pts in the DM Register

The **INA List Possible Inactive Pts in the DM Register** option (Figure D-12) 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. Begin by selecting AS Audit Setup . . .

Type INA to initiate the report for Possible Inactive Patients

Enter the name of the Register that is to be reviewed for inactive patients.

Select A for patients on the Register with a Register status of ACTIVE.

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 or other locally defined clinic(s).

Enter the beginning and ending dates for searching for a visit to one or more of these primary care clinics. Note that the 2026 Annual Audit is for the time frame between January 1, 2025 and December 31, 2025. To be considered as an active patient, there should be at least one documented visit to a primary care clinic during that time frame.

Choose the option to Browse the list. Note the number of pages in the report in the upper right hand corner of the screen.

Figure D-12: Report option details

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 D-13:

AS AUDIT SETUP . . .

Select Reports Option: INA List Possible Inactive Pts in the DM Register

DEMO HOSPITAL
DEMO, DOROTHY

This report will list patients who are on the diabetes register who have not had a visit to a set of primary care clinics in a date range defined by the user.
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 69

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: 1/1/25 (JAN 01, 2025)

Enter Ending Visit Date: 12/31/25 (DEC 31, 2025)

Select one of the following:

P	PRINT the List
B	BROWSE the List on the Screen

Output Type: B// 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						
OUTPUT BROWSER Dec 31, 2025 12:25:21 Page: 1 of 48						
***** CONFIDENTIAL PATIENT INFORMATION *****						
DR	Page 1					
DEMO HOSPITAL						
Patients on the IHS DIABETES Register without a visit between Jan 01, 2025 and Dec 31, 2025						
PATIENT NAME	HRN	STATUS	CASE MANAGER	LAST VISIT	# DM DXS	LAST DM DX

DEMO, MARIE	999490	ACTIVE		03/22/2019	158	02/22/2022
DEMOA, CHANTEL	999991	ACTIVE		05/17/2005	18	02/08/2005
DEMOB, LAYLA GABRIELL	999992	ACTIVE		08/09/2010	4	08/09/2010
DEMOC, PHYLLIS N	999993	ACTIVE		04/10/2019	124	04/10/2019
DEMOD, CARLA	999994	ACTIVE		11/05/2004	0	
DEMOF, ILLYANA	999995	ACTIVE		10/29/1993	1	10/27/2021
+ Enter ?? for more actions					>>>	
+ NEXT SCREEN	-	PREVIOUS SCREEN		Q	QUIT	
Select Action: +//						

Figure D-13: INA List Possible Inactive Pts in the DM Register report

D.3.1.4 PAR-Possible INA, LTF, TRANS Pts to move to Active

The **PAR Possible INA, LTF, TRANS Pts to move to Active** option can be used to identify patients in the diabetes register with a status of **Inactive (INA)**, **Lost to follow-up (LTF)**, or **Transient (TRANS)**, to be reviewed for possible move to **Active** status. Patients on this list can be changed to **Active** in the register so they will be included in the **Audit**. This option will provide a report based on register status, visit time frame, and clinic(s). The BGP Primary Care Clinics or other locally determined clinics can be used.

The steps to running this report are:

1. Select the register to use.
2. Indicate which status(s) to look for.
3. Indicate which clinics to search for.
4. Indicate the visit date range.
5. Indicate whether to print the report or browse it on the screen.
6. Indicate whether to include Demo patients.

If browsing, the report can be eventually printed using the **PL** command.

```
AS AUDIT SETUP . . .

Select Reports Option: PAR Possible INA, LFT, TRANS Pts to move to Active

Select DIABETES Register
No. Register Name          # Active # members  Last patient update
                           members

-----
1  2017 DIABETES REGISTER      370      376  11/23/2022
2  IHS DIABETES                658      708  07/24/2025
3  IHS PREDIABETES             214      214  10/02/2024
Which REGISTER: (1-3): 2

Select the Patient Status for this report
1) INACTIVE
2) TRANSIENT
3) LOST TO FOLLOW-UP
You can enter a list (e.g. 1, OR 1,2) or a range (e.g. 1-3)
Which status(s) should be included: (1-3): //1,2,3

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: CHRONIC DISEASE

Enter ANOTHER CLINIC: ENDOCRINOLOGY

Enter ANOTHER CLINIC: PHARMACY PRIMARY CARE CLINIC

Enter ANOTHER CLINIC: <enter>

The following have been selected =>

GENERAL
DIABETIC
INTERNAL MEDICINE
PEDIATRIC
WELL CHILD
FAMILY PRACTICE
.....CHRONIC DISEASE
ENDOCRINOLOGY
PHARMACY PRIMARY CARE CLINIC

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

Enter the time frame to look for visits.

Enter Beginning Visit Date: **01/01/2025** (JAN 01, 2025)
Enter Ending Visit Date: **12/31/2025** (DEC 31, 2025)

Select one of the following:

P PRINT the List
B BROWSE the List on the Screen

Output Type: B// **B 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// **E**

***** CONFIDENTIAL PATIENT INFORMATION *****

LAB

Page 1

2013 DEMO HOSPITAL (CMBB)
Patients on the IHS DIABETES Register
with a visit between Jan 01, 2025 and Dec 31, 2025
who do not currently have a status of Active.

PATIENT NAME	HRN	STATUS	LAST VISIT	# DM DXS	LAST DM DX	CLINIC CODE

DEMO, MARY JANE	1233	INACTIVE	07/31/2025	43	07/31/2025	01

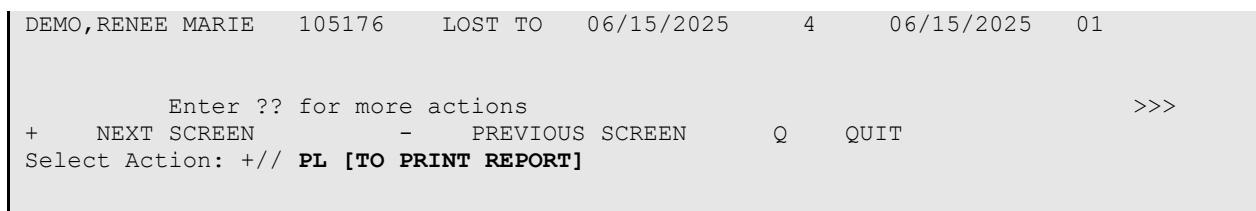


Figure D-14: PAR–Possible INA, LTF, TRANS Pts to move to Active example dialog

D.3.1.5 Update Patient Register Status

Based on the output from the INA and PAR reports, if there are patients that need to have their status in the register changed, their register status may be updated using the Patient Management tool in the DMS Register Maintenance menu.

How to Edit Register Status in DMS

1. Open the **RM–Register Maintenance** menu of **DMS**.
2. Open the **Patient Management** option (Figure D-15).

Register Data	Nov 01, 2025 13:14:24	Page: 1 of 1
PATIENT: DEMO, MARY JANE	AGE: 55	
ADDRESS: P.O. BOX 234, ALB, NM, 87119	DOB: 05/13/1963	
PHONE: 555-555-4811	HRN: 105176	
PRIM CARE PROV: DOCTOR, MICHAEL J	RES: TUCSON	
STATUS: ACTIVE		
WHERE FOLLOWED:		
CASE MGR: DEMO, LORI ANN		
CONTACT:		
ENTRY DATE: DEC 6, 2016	LAST EDITED: OCT 4, 2025	
DIAGNOSIS: TYPE 2	ONSET DATE: FEB 1, 1978	
COMMENTS:		
LOCAL OPTION:		
LOCAL OPTION TEXT:		
- Previous Screen Q Quit ?? for More Actions 1 Register Status 7 Local Option Entry 13 Print Letter 2 Where Followed 8 Last Visit 14 PREDM Care Summary (PPCS) 3 Case Manager 9 Review Appointments 15 PREDM Assessment of Care 4 Client Contact 10 DM Audit Status Q Quit 5 DX/Date of Onset 11 Health Summary 6 Comments 12 DM Care Summary (DPCS) Select Action: Quit//		

Figure D-15: Select Register Status (1)

3. At the “Select Action” prompt (Figure D-16), type **1** and press Enter.

STATUS: ACTIVE//

Figure D-16: Updating the status

4. 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.

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 D-17).

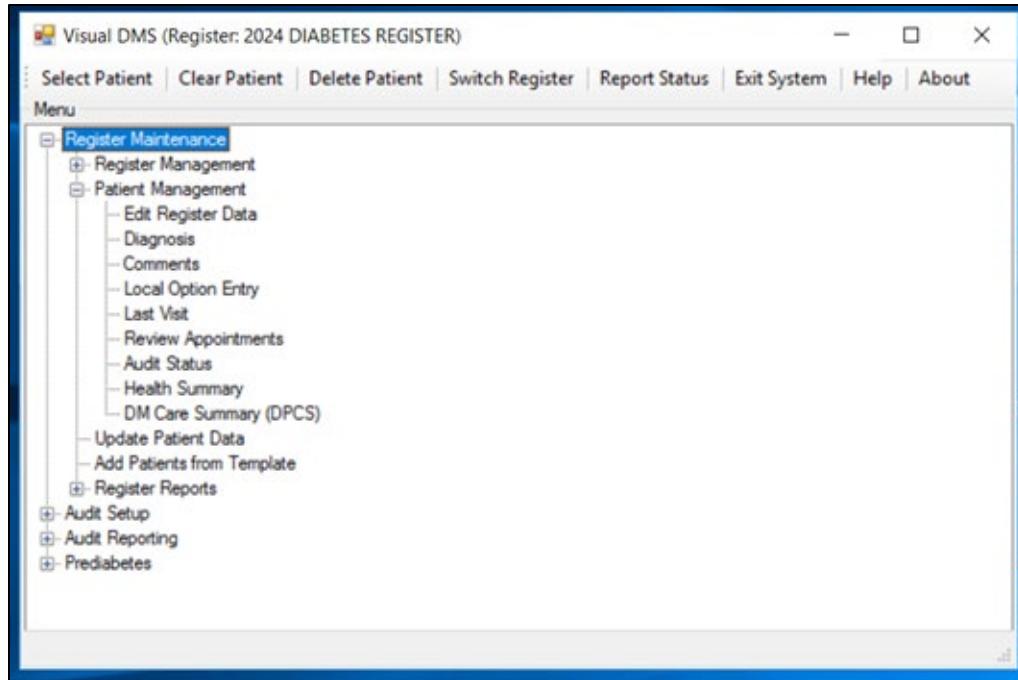


Figure D-17: Selecting Edit Register Data from the Patient Management menu

3. Click **Edit Register Data**. The **Patient Profile** (Figure D-18) displays.

Patient Profile

Register Data

Address/City/State/Zip Code

1908 LEWIS LANE ALB NEW MEXICO 87119

Phone

555-555-2228

Residence

CATHEDRAL CITY

Primary Care Provider

DOCTOR,MARY

Editable Patient Data

Status

A-Active

Case Manager

Select

Where Followed

Select

Contact

Last Edited

Thursday, October 16, 2025

Entry Date

Wednesday, October 15, 2025

Next Review

Thursday, October 16, 2025

Last Review

Thursday, October 16, 2025

Save Close

DEMO,DONNA SUE Chart: 137711 Sex: F DOB: Nov 10, 1986 Saved

Figure D-18: Patient Profile Screen Display

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.

D.3.1.6 PLDX–Patients with No Diagnosis of DM on Problem List

This report (Figure D-19) identifies patients who do not have a problem list diagnosis of diabetes. In addition, these patients will not have the 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 D-19: Patients with No Diagnosis of DM on Problem List

The resulting report (Figure D-20) 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.

***** CONFIDENTIAL PATIENT INFORMATION *****					
DKR Page 1					
DEMO HOSP					
PATIENTS WITH NO DIAGNOSIS OF DIABETES ON PROBLEM LIST					
Patients on the IHS DIABETES Register					
PATIENT NAME	HRN	DOB	LAST DM DX	# OF DM DXS	
PATIENT, AMANDA	101500	Sep 19, 1985	F Jan 01, 2025	1	
PATIENT, BARNEY	101988	Aug 08, 1996	M Jun 18, 2025	1	
PATIENT, BRANDON	101867	May 06, 1996	M Jun 18, 2025	1	
PATIENT, GRANT	101857	Jan 30, 1995	M Jun 18, 2025	1	
PATIENT, GREG	101738	May 16, 1992	M Jun 18, 2025	1	
PATIENT, JENNIFER	100044	Jul 19, 1938	F Jan 13, 2023	1	

Figure D-20: Patients with No Diagnosis of DM on Problem List, reports sample

D.3.2 Create a Template of Patients for the 2026 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 **2026 Annual Diabetes Audit**.

Users can run the **QMAN** search using either the general patient population (see Section D.3.2.1) or the **Diabetes Register** (see Section D.3.1). 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.

D.3.2.1 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 D-21 through Figure D-23).

```
***** 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
Enter ANOTHER CLINIC: PHARMACY PRIMARY CARE CLINIC
Enter ANOTHER CLINIC: CHRONIC DISEASE

The following have been selected =>
GENERAL
DIABETIC
INTERNAL MEDICINE
PEDIATRIC
WELL CHILD
FAMILY PRACTICE
ENDOCRINOLOGY
PHARMACY PRIMARY CARE CLINIC
CHRONIC DISEASE
Want to save this CLINIC group for future use? No//<ENTER> (No)

Next condition of "VISIT": DURING THE PERIOD           VISIT ATTRIBUTES
Exact starting date: 1/1/25 (JAN 01, 2025)
Exact ending date: 12/31/25 (DEC 31, 2025)

Subject of subquery: VISIT
CLINIC (GENERAL/DIABETIC...)
```

```

BETWEEN JAN 1,2025 and DEC 31,2025@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 JAN 1,2025 and DEC 31,2025@23:59:59

Attribute of LIVING PATIENTS: DX           DIAGNOSES

Enter DX: [SURVEILLANCE DIABETES]

```

Figure D-21: 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 D-22: Code Listing

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

```

(THIS 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: 1/1/25 (JAN 01, 2025)
Exact ending date: 12/31/25 (DEC 31, 2025)

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

```

```
Subject of search: PATIENTS
ALIVE TODAY
    Subject of subquery: VISIT
    CLINIC (GENERAL/DIABETIC...)
    BETWEEN JAN 1,2025 and DEC 31,2025@23:59:59
    DIAGNOSIS (250.01/250.11...)
    Subject of subquery: DIAGNOSIS
    BETWEEN JAN 1,2025 and DEC 31,2025@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 2026
Are you adding 'DM AUDIT 2026' 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:

Want to run this task in background? No// <ENTER>  (No)

...HMM, JUST A MOMENT PLEASE...
```

PATIENTS (Alive)	DEMO H NUMBER	ICD CODE	VISIT
<hr/>			
DEMOG, ABE	999996	+	+
DEMOH, MICKEY*	999997	+	+
DEMOJ, JANE*	999998	+	+
DEMOK, AMY *	999999	+	+
DEMOM, SHANE	999910	+	+
DEMO, JESSICA*	999911	+	+
DEMOO, ALEXANDRI	999912	+	+
DEMOPAT, RHIANNON	999913	+	+
TEST, AMY	999914	+	+

Figure D-23: Audit Template

Note: FileMan users: This template will be attached to IHS's Patient file.

D.3.2.2 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 Figure D-24 through Figure D-26.

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//12/31/25 (DEC 31, 2025)
Computing Search Efficiency Rating.....

Subject of search: PATIENTS
MEMBER OF 'IHS DIABETES REGISTER-4104' COHORT ALIVE AS OF DEC 31, 2025

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 BGP PRIMARY CARE CLINICS Taxonomy =>
GENERAL
DIABETIC
INTERNAL MEDICINE
PEDIATRIC
WELL CHILD
FAMILY PRACTICE

Enter ANOTHER CLINIC:

The following have been selected =>

GENERAL
DIABETIC
INTERNAL MEDICINE
PEDIATRIC
WELL CHILD
FAMILY PRACTICE

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

Next condition of "VISIT": DURING THE PERIOD           VISIT ATTRIBUTES
Exact starting date: 1/1/2025 (JAN 01, 2025)
Exact ending date: 12/31/2025 (DEC 31, 2025)

Subject of subquery: VISIT
CLINIC (GENERAL/DIABETIC...)
BETWEEN JAN 1,2025 and DEC 31,2025@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 D-24: 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.

<>E10.42

Figure D-25: 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: 1/1/25 (JAN 01, 2025)
Exact ending date: 12/31/25 (DEC 31, 2025)

Next condition of "DIAGNOSIS": 

Computing Search Efficiency Rating

Subject of search: PATIENTS
ALIVE TODAY
Subject of subquery: VISIT
CLINIC (GENERAL/DIABETIC...)
BETWEEN JAN 1,2025 and DEC 31,2025@23:59:59
DIAGNOSIS (250.01/250.11...)
Subject of subquery: DIAGNOSIS
BETWEEN JAN 1,2025 and DEC 31,2025 @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 2025
Are you adding 'DM AUDIT 2026' 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...

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:

Want to run this task in background? No// <ENTER> (No)

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

PATIENTS (Alive)	2103 D ICD CODE	VISIT NUMBER #
---------------------	-----------------	-------------------

DEMOQ, NKITA	100006	+	+
DEMOR, ARON*	100007	+	+
DEMOS, MARIE*	100008	+	+
DEMOT, ADRIANN*	100009	+	+
DEMOU, SHANELI	100010	+	+
DEMOV, JESSICA*	100011	+	+
DEMOV, ALEXANDRI	100012	+	+
DEMOX, RHIANNON	100014	+	+

Figure D-26: QMAN search demonstrating how to create a template of patients for the Audit

D.4 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 D-27 are referenced in the 2026 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 2025 Annual Audit, they must be reviewed and updated again before running the 2026 Annual Audit as new medications may have been added to the pharmacy formulary or new lab tests offered.

DM AUDIT TAXONOMY UPDATE	Oct 26, 2025 16:26:19	Page: 1 of 1
TAXONOMIES TO SUPPORT 2026 DIABETES AUDIT REPORTING		
* Update Taxonomies		

1) BGP CMS SMOKING CESSATION MEDS	DRUG
2) BGP CREATINE KINASE TAX	LABORATORY TEST
3) BGP ECQM TOB CESSATION MEDS	DRUG

4)	BGP GPRA ESTIMATED GFR TAX	LABORATORY TEST
5)	BGP HEP C TESTS TAX	LABORATORY TEST
6)	BGP PQA STATIN MEDS	DRUG
7)	DM AUDIT ACARBOSE DRUGS	DRUG
8)	DM AUDIT ACE INHIBITORS	DRUG
9)	DM AUDIT ALT TAX	LABORATORY TEST
10)	DM AUDIT AMYLIN ANALOGUES	DRUG
11)	DM AUDIT ANTIPLT/ANTICOAG RX	DRUG
12)	DM AUDIT ASPIRIN DRUGS	DRUG
13)	DM AUDIT AST TAX	LABORATORY TEST
14)	DM AUDIT BROMOCRIPTINE DRUGS	DRUG
15)	DM AUDIT CHOLESTEROL TAX	LABORATORY TEST
16)	DM AUDIT COLESEVELAM DRUGS	DRUG
17)	DM AUDIT CREATININE TAX	LABORATORY TEST
18)	DM AUDIT DIET EDUC TOPICS	EDUCATION TOPICS
19)	DM AUDIT DPP4 INHIBITOR DRUGS	DRUG
20)	DM AUDIT EXERCISE EDUC TOPICS	EDUCATION TOPICS
21)	DM AUDIT GLITAZONE DRUGS	DRUG
22)	DM AUDIT GLP-1 RECEPT AGONISTS	DRUG
23)	DM AUDIT HDL TAX	LABORATORY TEST
24)	DM AUDIT HGB A1C TAX	LABORATORY TEST
25)	DM AUDIT INSULIN DRUGS	DRUG
26)	DM AUDIT LDL CHOLESTEROL TAX	LABORATORY TEST
27)	DM AUDIT METFORMIN DRUGS	DRUG
28)	DM AUDIT OTHER EDUC TOPICS	EDUCATION TOPICS
29)	DM AUDIT QUANT UACR	LABORATORY TEST
30)	DM AUDIT SGLT-2 INHIBITOR DRUG	DRUG
31)	DM AUDIT STATIN DRUGS	DRUG
32)	DM AUDIT SULFONYLUREA DRUGS	DRUG
33)	DM AUDIT SULFONYLUREA-LIKE	DRUG
34)	DM AUDIT TB LAB TESTS	LABORATORY TEST
35)	DM AUDIT TB MEDS	DRUG
36)	DM AUDIT TIRZEPATIDE DRUGS	DRUG
37)	DM AUDIT TRIGLYCERIDE TAX	LABORATORY TEST

Figure D-27: Audit user-populated taxonomies

D.4.1 LMR—List Labs or Medications Used at this Facility

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

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 want to list” prompt, type **L** (LAB TESTS) and press Enter.
4. Type the **beginning** and **ending** dates for the report (1/1/25 and 12/31/25 for the 2026 Annual Diabetes Audit), pressing Enter after each.

5. At the “Do you want 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 D-28 .

Oct 31, 2025				Page 1
LAB TESTS Used at DEMO HOSPITAL				
Date Range: Jan 01, 2025 - Dec 31, 2025				
LAB TEST NAME TAXONOMIES	IEN	# DONE	UNITS	RESULT
HDL	244	1		40
DM AUDIT HDL TAX				
LDL	901	1		120
DM AUDIT LDL CHOLESTEROL TAX				
ALBUMIN/CREATININE RATIO	9034	1		3
DM AUDIT QUANT UACR				
ANION GAP	1160	2		
BASIC METABOLIC PANEL	9999068	2		
C DIFF A+B E/A (R)	9999195	3		
CALCIUM	180	2		
CHLORIDE	178	2		
CHOLESTEROL	183	1		240
DM AUDIT CHOLESTEROL TAX				
CO2	179	2		
CREATININE	173	3		0.6
DM AUDIT CREATININE TAX				
CRYSTALS, FLUID	9999199	1		
CULTURE, HSV RAPID (R)	9999198	1		
CYCLIC CITRULLINATED PEPTIDE A	9999172	1		
DIAGNOSIS:	9999089	3		WITHIN NORMAL LIMITS
DILANTIN	210	1		
ESTIMATED GFR	9999103	3		>60
BGP GPRA ESTIMATED GFR TAX				
FERRITIN (SQ)	9999175	2		
FREE T3	9999176	1		
GLUCOSE	175	5	mg/dL	145
H PYLORI AG EIA	9999183	2		
H. PYLORI AG EIA	9999177	1		
HEMOGLOBIN	3	1	g/dL	5.0
LEAD	262	1	mcg/dL	6.7
LIPASE (R)	200	1	U/L	456

Figure D-28: 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 (7/1/25 and 12/31/25 for the 2026 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 D-29:

MEDICATIONS (DRUGS) Used at DEMO HOSPITAL		
Date Range: Jul 01, 2025 - Dec 31, 2025		
MEDICATION/DRUG NAME	IEN	# DONE
TAXONOMIES		
ACARBOSE 25MG TAB	84472	4
DM AUDIT ACARBOSE DRUGS		
ACETAMINOPHEN 325MG TAB	263	3
ACETAMINOPHEN WITH CODEINE 30M	342	301
ACETAMINOPHEN/CODEINE 12MG/5M	3958	5
ACETAZOLAMIDE 250MG TABS	638	2
ACETIC ACID 2% HC 1% OTIC	2810	13
ACETIC ACID 2% OTIC SOL	3868	1
ACYCLOVIR 200MG CAP	83978	7
ACYCLOVIR 800MG TAB	84481	2
ALBUTEROL 2MG TAB	84348	2
ALBUTEROL 4MG TAB	84333	5
ALBUTEROL INHALER 17GM	3769	247
ALBUTEROL REFILL	84459	1
ALBUTEROL SOL 0.5%	84042	66
ALBUTEROL SULFATE SYRUP 2MG/5M	84061	20
ALENDRONATE SODIUM 10MG TAB	84444	1
ALLEGRA	84422	8
ALLOPURINOL 100MG TABS	1391	10
ALLOPURINOL 300MG TAB	3740	27
ALUMINUM ACETATE SOLN TAB	83607	1
AMANTADINE 100MG CAP	1606	3
AMIODARONE 200MG TAB	84092	17
AMITRIPTYLINE 25MG TAB	1639	100
AMLODIPINE BESYLATE 10MG TAB	84337	34
AMLODIPINE BESYLATE 2.5MG TAB	84335	2
AMLODIPINE BESYLATE 5MG TAB	84336	22
AMOXICILLIN 250MG CAP	4601	7
AMOXICILLIN 250MG/5ML	83611	78
AMOXICILLIN 500MG CAP	84024	135
AMOXICILLIN/CLAVULENATE 400MG/	84434	20
ANTIPYRINE/BENZOCAINE OTIC SOL	83614	19
ASCORBIC ACID 500MG TAB	1642	421
ASPIRIN 325MG E.C. TAB UD	84291	1
DM AUDIT ASPIRIN DRUGS		
ASPIRIN 325MG TAB	276	310
DM AUDIT ASPIRIN DRUGS		
ASPIRIN 650MG E.C. TAB	83618	113

DM AUDIT ASPIRIN DRUGS		
ASPIRIN 81MG TAB	83620	8
DM AUDIT ASPIRIN DRUGS		
ATENOLOL 25MG TAB	84328	42
ATENOLOL 50MG TAB	84329	301
ATORVASTATIN 40MG TABLETS	84416	7
DM AUDIT STATIN DRUGS		
ATORVASTATIN 80MG TABLETS	84503	8
DM AUDIT STATIN DRUGS		
ATROPINE SULFATE 0.4MG/1ML	2545	1

Figure D-29: Sample Report of Drugs Prescribed during the last six months of the Audit period

D.4.2 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 individual values such as A1C, LDL, HDL, or eGFR 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 Tirzepatide [Mounjaro], then the DM AUDIT TIRZEPATIDE DRUGS 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 considered comprehensive.

D.4.2.1 Drug Taxonomies

Table D 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/prescribed as outside medications.

Combination drugs should be added to the taxonomy for each of the components of that drug. For example, Empagliflozin and metformin (Synjardy, Synjardy XR) should be included in both the SGLT-2 inhibitor taxonomy (for empagliflozin) and the metformin taxonomy.

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 D-1: DM Audit Drug Taxonomies

Taxonomy	Drugs—Note: Bold font used to indicate drug in class relevant to Taxonomy
DM AUDIT ACE INHIBITORS Note: This taxonomy includes both ACE inhibitors and angiotensin II receptor blockers (ARBs). Also included are angiotensin receptor-neprilysin inhibitor/ARB combos (ARNi/ARB) and other combination medications.	ACE INHIBITORS Amlodipine and benazepril (Lotrel) Amlodipine and perindopril (Prestalia) Benazepril (Lotensin) Benazepril and hydrochlorothiazide (Lotensin HCT) Captopril Captopril and hydrochlorothiazide Enalapril (Vasotec, Epaned) Enalapril and diltiazem (Teczem) Enalapril and felodipine (Lexxel) Enalapril and hydrochlorothiazide (Vaseretic) Fosinopril (Monopril) Fosinopril and hydrochlorothiazide (Monopril HCT) Lisinopril (Prinivil, Zestril, Qbrelis) Lisinopril and hydrochlorothiazide (Prinzide, Zestoretic) Moexipril (Univasc) Moexipril and hydrochlorothiazide (Uniretic) Perindopril (Aceon) Quinapril (Accupril) Quinapril and hydrochlorothiazide (Accuretic) Ramipril (Altace) Trandolapril (Mavik) Trandolapril and verapamil (Tarka) ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs) Amlodipine and olmesartan (Azor)

Taxonomy	Drugs—Note: Bold font used to indicate drug in class relevant to Taxonomy
-	Amlodipine and Amlodipine and valsartan (Exforge) Amlodipine, valsartan and hydrochlorothiazide (Exforge HCT) Azilsartan (Edarbi) Azilsartan and chlorthalidone (Edarbyclor) Candesartan (Atacand) Candesartan and hydrochlorothiazide (Atacand HCT) Eprosartan (Teveten) Eprosartan and hydrochlorothiazide (Teveten HCT) Irbesartan(Avapro) Irbesartan and hydrochlorothiazide (Avalide) Losartan (Cozaar) Losartan and hydrochlorothiazide (Hyzaar) Nebivilol and valsartan (Byvalson) Olmesartan (Benicar) Olmesartan , amlodipine, and hydrochlorothiazide (Tribenzor) Olmesartan and hydrochlorothiazide (Benicar HCT) Telmisartan (Micardis) Telmisartan and amlodipine (Twynsta) Telmisartan and hydrochlorothiazide (Micardis HCT) Valsartan (Diovan, Prexxartan) Valsartan and hydrochlorothiazide (Diovan HCT) ANGIOTENSIN RECEPTOR-NEPRILYSIN INHIBITOR/ARB COMBINATIONS (ARNi/ARB) Sacubitril and valsartan (Entresto)
DM AUDIT ACARBOSE DRUGS	Acarbose (Precose) Miglitol (Glyset)
DM AUDIT AMYLIN ANALOGUES	Pramlinitide (Symlin)

Taxonomy	Drugs—Note: Bold font used to indicate drug in class relevant to Taxonomy
DM AUDIT ANTIPLT/ANTICOAG THERAPY	<p>Antiplatelet Drugs</p> <p>Any non-aspirin anti-platelet product including Cilostazol (Pletal) Clopidogrel (Plavix) Dipyridamole (Persantine) Prasugrel (Effient) Ticagrelor (Brilinta) Ticlopidine (Ticlid) Vorapaxar (Zontivity)</p> <p>Anticoagulants</p> <p>Apixaban (Eliquis) Dabigatran etexilate (Pradaxa) Dalteparin (Fragmin) Edoxaban (Savaysa) Enoxaparin (Lovenox) Fondaparinux (Arixtra) Rivaroxaban (Xarelto) Warfarin (Coumadin)</p>
DM AUDIT ASPIRIN DRUGS	Any Aspirin (ASA) or Aspirin containing product Aspirin and dipyridamole (Aggrenox)
DM AUDIT BROMOCRIPTINE DRUGS	Bromocriptine 0.8 mg (Cycloset)
DM AUDIT COLESEVELAM DRUGS	Colesevelam (Welchol)
DM AUDIT DPP-4 INHIBITOR DRUGS	<p>Alogliptin (Nesina) Alogliptin and metformin (Kazano) Alogliptin and pioglitazone (Oseni) Linagliptin (Tradjenta) Empagliflozin and linagliptin (Glyxambi) Empagliflozin. linagliptin and metformin (Trijardy XR) Linagliptin and metformin(Jentadueto, Jentadueto XR) Sitagliptin (Januvia, Zituvio) Ertugliflozin and sitagliptin (Steglujan) Sitagliptin and metformin (Janumet, Janumet XR, Zituvimet) Sitagliptin and simvastatin (Juvisync) Saxagliptin (Onglyza) Dapagliflozin and saxagliptin (Qtern) Dapagliflozin, saxagliptin and metformin (Qternmet XR) Saxagliptin and metformin (Kombiglyze XR)</p>

Taxonomy	Drugs—Note: Bold font used to indicate drug in class relevant to Taxonomy
DM AUDIT GLITAZONE DRUGS (a.k.a.: Thiazolidinediones)	Alogliptin and pioglitazone (Oseni) Pioglitazone (Actos) Pioglitazone and metformin (ActoPlus Met, ActoPlus Met XR) Pioglitazone and glimepiride (Duetact) Rosiglitazone (Avandia) Rosiglitazone and metformin (Avandamet)
DM AUDIT GLP-1 RECEPT AGONISTS	Dulaglutide (Trulicity) Exenatide (Byetta, Bydureon, Bydureon BCise) Insulin degludec and liraglutide (Xultophy) Insulin glargine and lixisenatide (Soliqua) Liraglutide (Victoza, Saxenda) Lixisenatide (Adlyxin) Semaglutide (Ozempic, Rybelsus, Wegovy)
DM AUDIT INSULIN DRUGS	<p>Any Insulin product in Drug File: Insulin aspart (Novolog, Fiasp, Kirsty), Insulin aspart-szjj (Merilog), Insulin glulisine (Apidra), Insulin lispro (Humalog, Admelog), Insulin lispro-aabc (Lyumjev), Insulin REG, (, Humulin R, Humulin R U-500, Novolin R);, Insulin degludec (Tresiba); Insulin detemir (Levemir); Insulin glargine (Lantus, Rezvoglar, Toujeo), Insulin glargine-aglr (Basaglar), Insulin glargine-yfgn (Semglee), Insulin NPH (Novolin N, Humulin N);</p> <p>Inhaled Insulin: (Affreza)</p> <p>Pre-Mixed Insulins: 70/30: NPH/REG (Humulin 70/30, Novolin 70/30), Aspart Protamine/Aspart (Novolog Mix 70/30), Degludec/Aspart (Ryzodeg 70/30) 75/25: Lispro protamine/Lispro (Humalog Mix 75/25); 50/50: Lispro protamine/Lispro (Humalog Mix 50/50)</p> <p>Insulin Combinations: Insulin degludec and liraglutide (Xultophy), Insulin glargine and lixisenatide (Soliqua)</p>

Taxonomy	Drugs—Note: Bold font used to indicate drug in class relevant to Taxonomy
DM AUDIT METFORMIN DRUGS	Alogliptin and metformin (Kazano) Canagliflozin and metformin (Invokamet, Invokamet XR) Dapagliflozin and metformin (Xigduo XR) Dapagliflozin, saxagliptin and metformin (Qternmet XR) Empagliflozin, linagliptin and metformin (Trijardy XR) Empagliflozin and metformin (Synjardy, Synjardy XR) Ertugliflozin and metformin (Segluromet) Glipizide and metformin (Metaglip) Glyburide and metformin (Glucovance) Linagliptin and metformin (Jentadueto, Jentadueto XR) Metformin (Glucophage, Fortamet, Glumetza, Riomet) Metformin extended release (Glucophage XR, Glumetza) Pioglitazone and metformin (ActoPlus Met, ActoPlus Met XR) Repaglinide and metformin (PrandiMet) Rosiglitazone and metformin (Avandamet) Saxagliptin and metformin (Kombiglyze XR) Sitagliptin and metformin (Janumet, Janumet XR)
DM AUDIT SGLT-2 INHIBITOR DRUGS	Bexagliflozin (Brenzavvy) Canagliflozin (Invokana) Canagliflozin and metformin (Invokamet, Invokamet XR) Dapagliflozin (Farxiga) Dapagliflozin and metformin (Xigduo XR) Dapagliflozin and saxagliptin (Qtern) Dapagliflozin , saxagliptin and metformin (Qternmet XR) Empagliflozin (Jardiance) Empagliflozin and metformin (Synjardy, Synjardy XR) Empagliflozin and linagliptin (Glyxambi) Empagliflozin , linagliptin and metformin (Trijardy XR) Ertugliflozin (Steglatro) Ertugliflozin and metformin (Segluromet) Ertugliflozin and sitagliptin (Steglujan) Sotagliflozin (Inpefa)

Taxonomy	Drugs—Note: Bold font used to indicate drug in class relevant to Taxonomy
DM AUDIT STATIN DRUGS	Amlodipine and atorvastatin (Caduet) Atorvastatin (Atorvaliq, Lipitor) Ezetimibe and atorvastatin (Liptruzet) Ezetimibe and simvastatin (Vytorin) Fluvastatin (Lescol, Lescol XL) Lovastatin (Mevacor, Altocor, Altoprev) Niacin XR and lovastatin (Advicor) Niacin XR and simvastatin (Simcor) Pravastatin (Pravachol) Pitavastatin (Livalo, Zypitamag) Rosuvastatin (Crestor, Ezallor) Rosuvastatin and ezetimibe (Roszet) Simvastatin (Zocor) Sitagliptin and simvastatin (Juvisync)
DM AUDIT SULFONYLUREA DRUGS	Acetohexamide (Dymelor) Chlorpropamide (Diabinese) Glimepiride (Amaryl) Glipizide (Glucotrol, Glucotrol XL) Glipizide and metformin (Metaglip) Glyburide (Diabeta, Micronase, Glynase, Glynase PresTab, Glycron) Glyburide and metformin (GlucoVance) Pioglitazone and glimepiride (Duetact) Tolazamide (Tolinase) Tolbutamide (Orinase)
DM AUDIT SULFONYLUREA-LIKE DRUGS	Nateglinide (Starlix) Repaglinide (Prandin) Repaglinide and metformin (PrandiMet)
DM AUDIT TIRZEPATIDE DRUGS	Tirzepatide (Mounjaro, Zepbound)
DM AUDIT TB MEDS	Bedaquiline (Sirturo) Ethambutol (Myambutol) Isoniazid (INH) Isoniazid and Rifampin (IsonaRif) Pretomanid (Dovprela) Pyrazinamide Rifabutin (Myobutin) Rifampin (Rifadin) Rifampin and isoniazid (Rifamate) Rifampin, isoniazid and pyrazinamide (Rifater) Rifapentine (Priftin)

D.4.2.2 Laboratory Test Taxonomies

Table D-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.

With the advent of reference laboratory interfaces and Point of Care result entry, there is considerable variation in test nomenclature. Solicit assistance from laboratory 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.

Table D-2: DM Audit Laboratory Test Taxonomies

Taxonomy	Tests
BGP GPRA ESTIMATED GFR TAX	Estimated GFR, Calculated GFR, _GFR, Estimated, _GFR Non-African American, EST GFR, eGFR, eGFRcr SerPIBld CKD-EPI 2021, eGFRcr-cys SerPIBld CKD-EPI 2021, GFR Cystatin C-based formula/1.73 sq M (S/P/Bld), GFR Creatinine, Cystatin C and Urea-based formula (CKD)/1.73 sq M (S/P/Bld)
BGP CREATINE KINASE TAX	CK, CPK, Creatine Kinase, Total CK
DM AUDIT ALT TAX	ALT, SGPT
DM AUDIT CHOLESTEROL TAX	Cholesterol, Total Cholesterol, _Cholesterol, POC Cholesterol
DM AUDIT HDL TAX	HDL, HDL Cholesterol, POC HDL Cholesterol, _HDL Cholesterol
DM AUDIT HGB A1C TAX	Hemoglobin A1C, A1C, HGB A1C, HBA1C, HA1C, POC HEMOGLOBIN A1C, _A1C
DM AUDIT LDL CHOLESTEROL TAX	LDL, Direct LDL, LDL Cholesterol, LDL Cholesterol (calc), POC LDL Cholesterol, _LDL Cholesterol
DM AUDIT QUANT UACR TAX	Quantitative Albumin/Creatinine Ratio measured in actual numeric values (mg/g Creatinine). Look for tests A/C, A:C, Albumin/Creatinine, _A/C, -A/C, asterisk (*)A/C. Note: Check with your laboratory supervisor to confirm that the tests added to this taxonomy reflect true quantitative test values.
DM AUDIT TB LAB TESTS	QFT-G, T SPOT-TB, Quantiferon GOLD, Quantiferon-TB Gold Plus (QFT-Plus)

Taxonomy	Tests
DM AUDIT TRIGLYCERIDE TAX	Triglyceride, POC Triglyceride, _Triglyceride
BGP HEP C TESTS TAX	Hepatitis C tests

Figure D-30 shows a **Health Summary** sample with the name of the taxonomy that the test is included in noted underneath the lab test.

HGB A1C-GLYCO (R)	01/16/23	5.7	%	4.3-6.1
DM AUDIT HGB A1C				
LIPID PROFILE (R)	01/16/23			
HDL CHOLESTEROL (R)	01/16/23	44	MG/DL	40-125
DM AUDIT HDL CHOLESTEROL				
TRIGLYCERIDE (R)	01/16/23	109	MG/DL	30-150
DM AUDIT TRIGLYCERIDE				
LDL CHOLESTEROL (R)	01/16/23	97	MG/DL	0-130
DM AUDIT LDL CHOLESTEROL				
CHOLESTEROL (R)	01/16/23	163	MG/DL	100-200
DM AUDIT CHOLESTEROL				
CHOL/HDL RATIO (R)	01/16/23	3.70	RATIO	0.00-4.44
COMPREHENSIVE-14 METABOLIC (R)	01/16/23			
AST (SGOT) (R)	01/16/23	18	U/L	0-40
ALT (SGPT) (R)	01/16/23	15	U/L	0-40
BUN (R)	01/16/23	11	MG/DL	5-19
ALBUMIN (R)	01/16/23	4.2	GM/DL	3.9-5.0
CHLORIDE (R)	01/16/23	104	MMOL/L	96-108
BILIRUBIN, TOTAL (R)	01/16/23	0.9	MG/DL	0.1-1.0
ALKALINE PHOS (R)	01/16/23	76	U/L	28-110
SODIUM (R)	01/16/23	139	MMOL/L	135-145
CALCIUM (R)	01/16/23	8.9	MG/DL	8.5-10.5
POTASSIUM (R)	01/16/23	5.6 (H)	MMOL/L	3.5-5.5
PROTEIN, TOTAL (R)	01/16/23	7.7	GM/DL	6.7-8.3
GLUCOSE RANDOM (R)	01/16/23	68 (L)	MG/DL	70-100
M-ALB/CREAT RATIO (R)	01/22/23			
_MICROALB, RANDOM	01/22/23	<5.0	MG/L	0.0-20.0
ALB/CREAT RATIO	01/22/23	29	MG/G	0.0-30.0
DM AUDIT QUANT UACR				

Figure D-30: Health Summary with recommended taxonomy placement

D.4.3 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 **2026** as the Audit year. A list of the taxonomies used in the 2026 Diabetes Audit display (Figure D-31).

Note: 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 on an RPMS printer. Figure D-32 shows a sample of the taxonomy contents for the creatinine kinase test.

DM AUDIT TAXONOMY VIEW	Nov 02, 2025 11:31:16	Page:	1 of 8
TAXONOMIES TO SUPPORT 2026 DIABETES AUDIT REPORTING			
* View Taxonomies			
1) BGP ABORTION PROCEDURES	ICD OPERATION/PROCEDURE		
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 BREASTFEEDING DXS	ICD DIAGNOSIS		
8) BGP CABG CPTs	CPT		
9) BGP CABG DXS	ICD DIAGNOSIS		
10) BGP CABG PROCS	ICD OPERATION/PROCEDURE		
11) BGP CMS SMOKING CESSATION MEDS	DRUG		
12) BGP CPT ABORTION	CPT		
13) BGP CPT FLU	CPT		
14) BGP CPT FOOT EXAM	CPT		
15) BGP CPT MISCARRIAGE	CPT		
16) BGP CREATINE KINASE LOINC	LAB LOINC		
+ Enter ?? for more actions			
S Select Taxonomy to View	Q Quit		
Select Action:+/			

Figure D-31: Taxonomy list for Diabetes Audit

DKR	Page 1
DEMO HOSPITAL	
Listing of the BGP CREATINE KINASE LOINC taxonomy	
2157-6	CREATINE KINASE:CCNC:PT:SER/PLAS:QN
24335-2	CREATINE KINASE PANEL: - :PT:SER/PLAS:QN
50756-6	

Figure D-32: Sample of a Taxonomy for Creatine Kinase LOINC Codes

D.4.4 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**.

3. When prompted for the year, type **2026**.

The **SNOMED Lists** used in the **2026 Diabetes Audit** will display (Figure D-33 and Figure D-34).

4. Type **S** to indicate a selection will be made.

5. Enter the number preceding the **SNOMED List** of interest. The contents of the **SNOMED List** may be browsed on the screen or printed to an RPMS printer.

```
DM AUDIT SNOMED LIST VIEW      Nov 02, 2025 11:30:36      Page: 1 of 1
SNOMED LISTS TO SUPPORT 2026 DIABETES AUDIT REPORTING
* View SNOMED Lists

1) BREASTFEEDING PATIENT ED
2) PXRM BGP CURRENT TOBACCO
3) PXRM BGP DM ATK AMP
4) PXRM BGP DM BTK AMP
5) PXRM BGP DM RETINOPATHY
6) PXRM BGP TOBACCO SCREENED
7) PXRM BGP TOBACCO SMOKELESS
8) PXRM BGP TOBACCO SMOKER
9) PXRM BQI TUBERCULOSIS
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 D-33: Selecting a SNOMED LIST in the Diabetes Audit

```
OUTPUT BROWSER      Dec 11, 2025 10:51:50      Page: 1 of 5
BHS      Page 1
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
232022008      Proliferative diabetic retinopathy with new vessels on
232023001      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 D-34: Browsing a selected SNOMED LIST used in the Diabetes Audit

D.5 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 the **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 Audit Export (Data) file to the WebAudit.

The **Data Quality Check Report** (Figure D-35) 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.

```

DXNR  Patients with DM Diagnosis and not on Register
INA   List Possible Inactive Pts in the DM Register
PAR   Possible INA, LFT, TRANS Pts to move to Active
PLDX  Patients w/no Diagnosis of DM on Problem List
FRPT  Find a Register Patient by YOB, MOB, Sex
-----
LMR   List Labs/Medications Used at this Facility
TC    Check Taxonomies for the 2026 DM Audit
TU    Update/Review Taxonomies for 2026 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   2026 Data Quality Check Report
-----
ASPR  Prior Years Diabetes Audit Setup (DM22-DM25) ...
```

Figure D-35: Audit Setup Menu

Figure D-36 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 2026 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 SGLT-2 INHIBITOR DRUGS] has no entries
DRUG taxonomy [DM AUDIT SULFONYLUREA-LIKE] has no entries
End of taxonomy check. HIT RETURN: <Enter>

ASSESSMENT OF DIABETES CARE, 2026

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: 12/31/25 (DEC 31, 2025)

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> LL Patients selected so far

Select one of the following:

S SUMMARY OF ERRORS ONLY
P PATIENT LIST ONLY
B BOTH A SUMMARY AND PATIENT LIST

Type of Report: B BOTH A SUMMARY AND PATIENT LIST

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> xclude DEMO Patients

Select one of the following:

P PRINT Output
B BROWSE Output on Screen

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

Figure D-36: Running a Data Quality Check Report

If you choose **Summary of Errors Only**, the output will be a tally of the errors found. If you choose **Patient List Only**, a list of patients with errors will display. You can also choose **Both a Summary and a Patient List** and both will display.

The **RPMS Data Quality Check** report may also be used to identify patients with errors. The **RPMS Data Quality Check** report includes the patient's name and chart. Use **FRPT Find a Register Patient** by YOB, MOB, and Sex in the **AS Audit Setup** menu.

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 D-37.

```
Device: HOME// Q <Enter> QUEUE TO PRINT ON
Device: P171 <Enter>
Start Date/Time: T@2000 <Enter>
Device: P180
```

Figure D-37: Device prompt

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

A sample **2026 Data Quality Check Report** is displayed in Figure D-38.

LAB	Nov 03, 2025	Page 1				
DIABETES AUDIT EXPORT DATA QUALITY CHECK REPORT						
Audit Date 12/31/2025 (01/01/2025 to 12/31/2025)						
Facility: DEMO HOSPITAL (CMBA)						
SUMMARY OF POTENTIAL ERRORS						
ERROR MESSAGE	# OF POTENTIAL ERRORS					
AGE OVER 100	1					
ALL KEY DATA MISSING	25					
BMI <16 OR >80	2					
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					
PATIENT NAME HRN DOB SEX AGE VALUE ERR TYPE						
DEMOA, CHARLENE	111111	12/06/1985	F	27		POTENTIAL
						ERROR: ALL KEY DATA MISSING-Data is missing for all key fields: weight, blood pressure, A1c, 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.						
DEMOM, 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.						

Figure D-38: Sample Data Quality check Report

The **RPMS Data Quality Check** report may also be used to identify the patients with errors. The **RPMS Data Quality Check** report includes the patient's name and chart. Use **FRPT Find a Register Patient** by YOB, MOB, and Sex in the **AS Audit Setup** menu.

D.6 2026 Audit Tools

Instructions for creating and submitting a Diabetes Audit data file are provided in the Audit 2026 Instructions that can be found on the Audit website:
<https://www.ihs.gov/diabetes/audit/audit-resources/>.

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

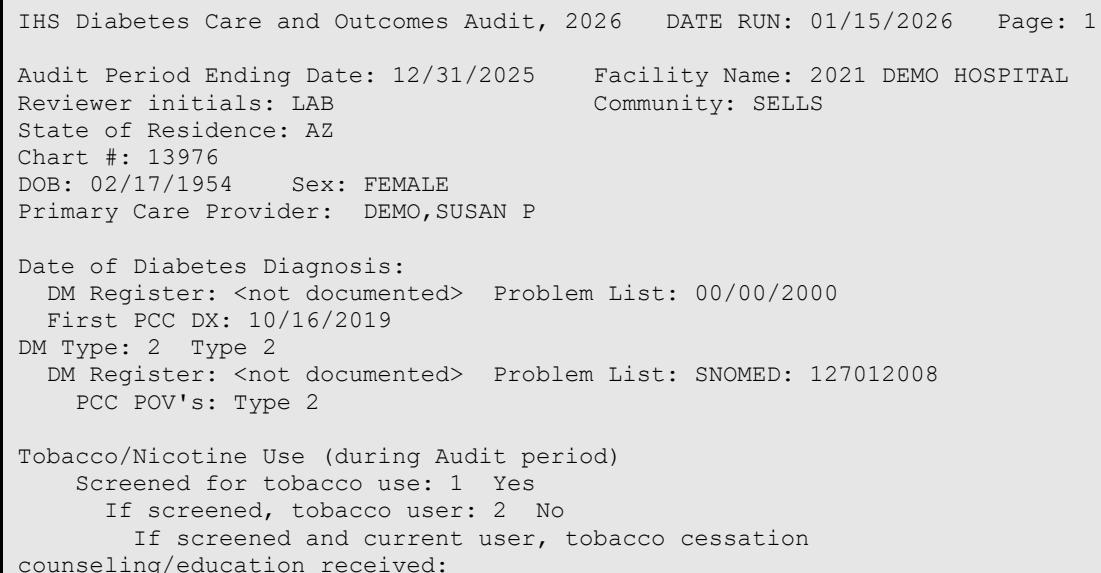
Output options include an individual **Audit**, **Audit Report**, **SDPI RKM Report**, and **Audit Export (Data)** file. Even those doing manual **Audits** may find it useful to print individual **Audits** that most likely have some information on them, such as measurements.

D.6.1 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, refer to Section C.3.7. 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, select your diabetes register. Then in **Register Data**, type **10 (DM 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 individual Audit, 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 D-39.



IHS Diabetes Care and Outcomes Audit, 2026 DATE RUN: 01/15/2026 Page: 1

Audit Period Ending Date: 12/31/2025 Facility Name: 2021 DEMO HOSPITAL
Reviewer initials: LAB Community: SELLS
State of Residence: AZ
Chart #: 13976
DOB: 02/17/1954 Sex: FEMALE
Primary Care Provider: DEMO, SUSAN P

Date of Diabetes Diagnosis:
DM Register: <not documented> Problem List: 00/00/2000
First PCC DX: 10/16/2019
DM Type: 2 Type 2
DM Register: <not documented> Problem List: SNOMED: 127012008
PCC POV's: Type 2

Tobacco/Nicotine Use (during Audit period)
Screened for tobacco use: 1 Yes
If screened, tobacco user: 2 No
If screened and current user, tobacco cessation
counseling/education received:

Electronic Nicotine Delivery Systems (ENDS)
 Screened for ENDS use: 2 No
 If screened, ENDS use:

Vital Statistics

Height (last ever): 65.00 inches 10/15/2025
 Weight (last in Audit period): 150 lbs 10/15/2025 BMI: 25.0

Hypertension (documented diagnosis ever): 1 Yes
 Blood pressure (last 3 during Audit period): 150/99 mm Hg 10/15/2025

Examinations (during Audit period)

Foot (comprehensive or "complete", including evaluation of sensation and vascular status): 1 Yes 10/15/2025 Diabetic Foot Exam
 Eye (dilated exam or retinal imaging): 1 Yes 07/17/2025 Diabetic Eye Exam
 Dental: 1 Yes 07/07/2025 Dental Exam

Depression

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

Education (during Audit period)

Nutrition: 2 Yes (Non RD) NRD: DM-N 10/15/2025
 Physical activity: 1 Yes DM-EXERCISE 10/15/2025
 Other diabetes: 1 Yes E11.9-L 10/15/2025

IHS Diabetes Care and Outcomes Audit, 2025 DATE RUN: 01/15/2025 Page: 2
 Audit Period Ending Date: 12/31/2025
 CHART #: 13976 DOB: Feb 17, 1954 SEX: FEMALE

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

ACE Inhibitor or ARB
 Prescribed (as of the end of the Audit period):
 1 Yes 10/15/2025 LOSARTAN 25MG TAB

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

Statin Therapy
 Prescribed (as of the end of the Audit period):
 1 Yes 10/15/2025 ATORVASTATIN 40MG TAB

Cardiovascular Disease (CVD)
 Diagnosed (ever): 1 Yes - DX 05/21/2018 | 07/06/2016

Tuberculosis (TB)
 TB diagnosis (latent or active) documented (ever): 2 No
 TB test done (most recent): 3 No test documented
 TB test result:
 If TB diagnosis documented or TB result 'Positive', treatment initiated (isoniazid, rifampin, rifapentine, others):
 If TB result 'Negative', test date:

Hepatitis C (HCV)
 HCV diagnosed (ever): 2 No
 If not diagnosed with HCV, screened at least once (ever):
 1 Yes 01/23/2017 HEPATITIS C Antibody (R)

Retinopathy
 Diagnosed (ever): 2 No

IHS Diabetes Care and Outcomes Audit, 2025 DATE RUN: 01/15/2025 Page: 3
 Audit Period Ending Date: 12/31/2025
 CHART #: 13976 DOB: Feb 17, 1954 SEX: FEMALE

Amputation
 Lower extremity (ever), any type (e.g., toe, partial foot, above or below knee): 1 Yes - 07/01/2015 PROCEDURE: 84.11

Immunizations
 Influenza vaccine (during Audit period): 1 Yes 06/18/2025
 Pneumococcal [PCV15, PCV20, PCV21, or PPSV23] (ever): 1 Yes 07/17/2023
 Td, Tdap, DTaP, or DT (in past 10 years): 1 Yes 10/15/2024
 Tdap (ever): 1 Yes 10/15/2024
 Hepatitis B complete series (ever): 1 Yes
 Shingrix/RZV complete series (ever): 1 Yes
 Respiratory syncytial virus (RSV) vaccine (ever): 1 Yes 07/21/2025

Laboratory Data (most recent result during Audit period)
 A1C: 7.0 % 04/03/2025 HEMOGLOBIN A1C
 Total Cholesterol: 220 mg/dL 04/03/2025 CHOLESTEROL (Q)
 HDL Cholesterol: 52 mg/dL 04/03/2025 HDL CHOLESTEROL
 LDL Cholesterol: 110 mg/dL 04/03/2025 LDL CHOLESTEROL
 Triglycerides: 109 mg/dL 04/03/2025 TRIGLYCERIDE
 eGFR: 55 mL/min 04/03/2025 ESTIMATED GFR
 Quantitative UACR: 30 mg/g 04/03/2025 ALBUMIN/CREATININ

COMBINED: Meets ALL: A1C <8.0, statin prescribed, mean BP <130/80
 2 No A1C: <7.0; statin prescribed: Yes; Mean BP: 145/89

Local Questions

Select one:

Text:

Figure D-39: Individual Audit sample

D.6.2 Audit Report

The **Audit Report** summarizes all of the **Audit** data items for a selected group of patients. The **Audit Report** can be either queued using the **DM26** option in **Visual DMS** or run from the traditional RPMS menu. It is highly recommended that the **2026 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 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 Export (Data) 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 D.4 for more information.

Figure D-40 shows the steps for generating an **Audit Report**.

```

Diabetes Management System ...
AR Audit Reporting ...
DM26 2026 Diabetes Audit

Select 2026 Diabetes Program Audit Option: DM26 Run 2026 Diabetes Program
Audit

In order for the 2026 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 SGLT-2 INHIBITOR DRUGS] has no entries
DRUG taxonomy [DM AUDIT SULFONYLUREA-LIKE] has no entries
End of taxonomy check. HIT RETURN: <Enter>

Select DIABETES Register
  No. Register Name          # Active # members Last patient update
                                members
  -----
  1  MY DIABETES REGISTER      37      40      02/07/2020
  2  IHS DIABETES             552      555     11/14/2025
  3  CLINIC DIABETES REGISTER  29       29      10/05/2019
  4  DEMO DIABETES REGISTER    1,002    1,012    10/03/2019

```

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: 12/31/25 (DEC 31, 2025)

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 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 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> LL 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

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

Select one of the following:

P      PRINT Output
B      BROWSE Output on Screen

Do you wish to: B// BROWSE Output on Screen
```

Figure D-40: 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 D-41.

```
Device: HOME// Q <Enter> QUEUE TO PRINT ON

Device: P171 <Enter>
Start Date/Time: T@2000 <Enter>
Device: P180
```

Figure D-41: Device prompt

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

A sample 2026 Audit Report is displayed in Section D.14.

D.6.3 Audit Export (Data) File

IHS recommends that the **Annual Audit** includes 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 2025 Instructions and in Section D.2. 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 **DM26 (2026 Diabetes Audit)** and follow the prompts as shown in the script in Figure D-42.

```
DM26 2026 Diabetes Audit

In order for the 2026 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 SGLT-2 INHIBITOR DRUGS] has no entries
DRUG taxonomy [DM AUDIT SULFONYLUREA-LIKE] has no entries
End of taxonomy check. HIT RETURN: <Enter>

Select DIABETES Register
No. Register Name          # Active # members Last patient update
                           members
-----
1  MY DIABETES REGISTER      37      40      02/07/2025
2  IHS DIABETES             552     555     11/14/2025
3  CLINIC DIABETES REGISTER  29      29      10/05/2025
4  DEMO DIABETES REGISTER   1,002    1,012    10/03/2025
5  ANOTHER DIABETES REGISTER 158     158     10/04/2025

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: 12/31/25 (DEC 31, 2025)

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 542 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> LL 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): DM 2026 AUDIT

I am going to create a file called dm 2026 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 2026 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 dm 2026 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> xclude DEMO Patients

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

Requested Start Time: NOW//T@2000

```

Figure D-42: 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.

D.6.4 SDPI RKM 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 **DM26 (2026 Diabetes Audit)** and follow the prompts as shown in the script in Figure D-43.

```

Select Audit Reporting Option: DM26  Run 2026 Diabetes Program Audit

In order for the 2026 DM AUDIT Report to find all necessary data, several
taxonomies must be established. The following taxonomies are missing or have
no entries:
LABORATORY TEST taxonomy  [BGP CREATINE KINASE TAX] contains a panel test: SQL C
KMB 5030 and should not.
DRUG taxonomy  [DM AUDIT AMYLIN ANALOGUES] has no entries
DRUG taxonomy  [DM AUDIT COLESEVELAM DRUGS] has no entries
DRUG taxonomy  [DM AUDIT SGLT-2 INHIBITOR DRUGS] has no entries
DRUG taxonomy  [DM AUDIT SULFONYLUREA-LIKE] has no entries
End of taxonomy check. HIT RETURN: <Enter>

Select DIABETES Register
  No. Register Name          # Active # members Last patient update
                                members
  -----
  1  2017 DIABETES REGISTER      37      40    02/07/2025
  2  IHS DIABETES              552      555   11/14/2025
  3  CLINIC DIABETES REGISTER    29      29    10/05/2025
  4  DEMO DIABETES REGISTER     1,002    1,012  10/03/2025
  5  ANOTHER DIABETES REGISTER   158      158   10/04/2025

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: 12/31/25  (DEC 31, 2025)

```

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 1002 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 980 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> LL 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> xclude DEMO Patients

Select one of the following:

P           PRINT Output
B           BROWSE Output on Screen

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

Figure D-43: Running an SDPI RKM Report

The SDPI RKM Report is displayed in Figure D-44.

LAB	Dec 31, 2025	Page 1
IHS Diabetes Care and Outcomes Audit - RPMS SDPI Required Key Measures Report for 2026 (01/01/2025 to 12/31/2025) Facility: DEMO HOSPITAL (INST) Annual Audit/SDPI Reporting		
620 patients were audited		
----- # of # Percent Patients Considered (Numerator) (Denominator)		
***NOTE: 6 Patients were not included in this report because their date of onset was after the Audit end period date.		
Aspirin or Other Antiplatelet Therapy in Cardiovascular Disease (CVD) In patients with diagnosed CVD, aspirin 216 304 71% or other antiplatelet/anticoagulant therapy currently prescribed		
Blood Pressure (BP) Control BP <130/<80 mmHg 266 620 43% (one value or mean of 2 or 3 values)		
Chronic Kidney Disease Screening and Monitoring In age >=18 years, 231 596 39% both quantitative UACR and eGFR done		
Dental Exam Dental exam received 240 620 39%		
Depression Screening Screened and/or active diagnosis during Audit period 474 620 76%		

Diabetes-Related Education				
Any diabetes topic (nutrition, physical activity, or other)	470	620	76%	
Eye Exam - Retinopathy Screening				
Eye exam - dilated exam or retinal imaging	304	620	49%	
Foot Exam				
Foot exam - comprehensive or complete	191	620	31%	
LAB	Dec 31, 2025		Page 2	
<p>IHS Diabetes Care and Outcomes Audit - RPMS SDPI Required Key Measures Report for 2026 (01/01/2025 to 12/31/2025) Facility: DEMO HOSPITAL (INST) Annual Audit/SDPI Reporting</p>				
620 patients were audited				
	# of Patients	# (Numerator)	Percent	
		Considered (Denominator)		
Glycemic Control				
A1C <8.0%	213	620	34%	
Hepatitis C (HCV) Screening				
In age => 18 years, screened for HCV ever or HCV diagnosed ever	181	596	30%	
Immunizations: Hepatitis B				
Hepatitis B complete series - ever or immune to hepatitis B	439	620	71%	
Immunizations: Influenza				
Influenza vaccine during report period	364	620	59%	
Immunizations: Pneumococcal				
Pneumococcal vaccine (PCV15, PCV20, PCV21 or PPSV23) - ever	508	620	82%	
Immunizations: Tetanus/Diphtheria				
Td/Tdap/DTap/DT - past 10 years	573	620	92%	
Lipid Management in Cardiovascular Disease				
In patients age 40-75 years and/or with diagnosed CVD, statin currently prescribed*	205	515	40%	
*Excludes patients with an allergy, intolerance, or contraindication				
Nutrition Education				
Nutrition education - by any provider (registered dietitian and/or other)	286	620	46%	
Physical Activity Education				
Physical activity education	202	620	33%	
Tobacco Use Screening				
Screened for tobacco use during report period	514	620	83%	

LAB	Dec 31, 2025	Page 3
IHS Diabetes Care and Outcomes Audit - RPMS SDPI Required Key Measures Report for 2026 (01/01/2025 to 12/31/2025) Facility: DEMO HOSPITAL (INST) Annual Audit/SDPI Reporting		
620 patients were audited		

# of Patients Considered (Numerator) (Denominator)		
Tuberculosis (TB) Screening TB test done ever or TB diagnosed ever		
457 620 74%		

Figure D-44: Sample SDPI RKM Report

D.7 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 **2026 Audit Instructions** and Section D.2 of this manual.
6. Click the **Submit** button.
7. Select **Upload** file for this facility from the onscreen menu or click **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 the **Choose File** button and navigate to your data file, then click the **Open** button.
11. Click 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 2026 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 2026 Instructions**.

D.8 Import the Audit Export (Data) File to Excel (Optional)

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 2026 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 D.6.3 provides details about the Audit Export file format and field definitions.

Figure D-45 shows a sample **Audit Export** file opened in Notepad.

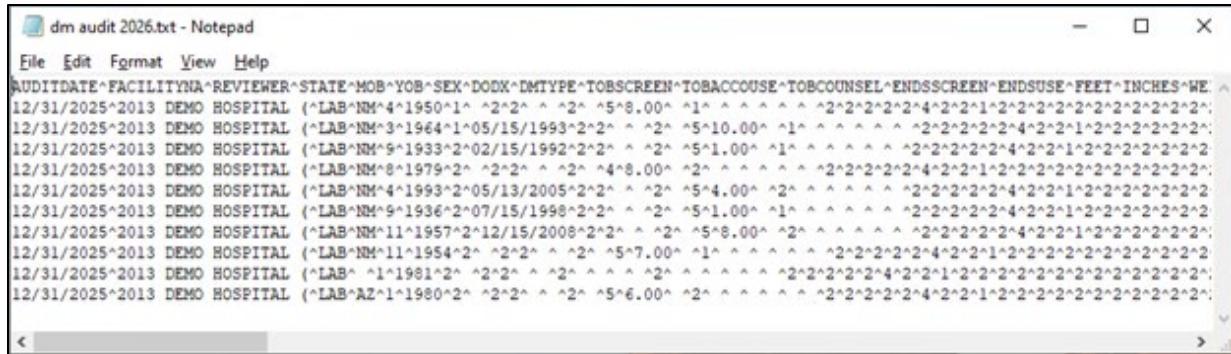


Figure D-45: Sample Audit Export file displayed in Notepad

To import a file into Excel:

1. Open Excel and select a blank workbook (Figure D-45).
2. Click **File**, then **Open**; browse to the folder containing the **Audit Export** file.

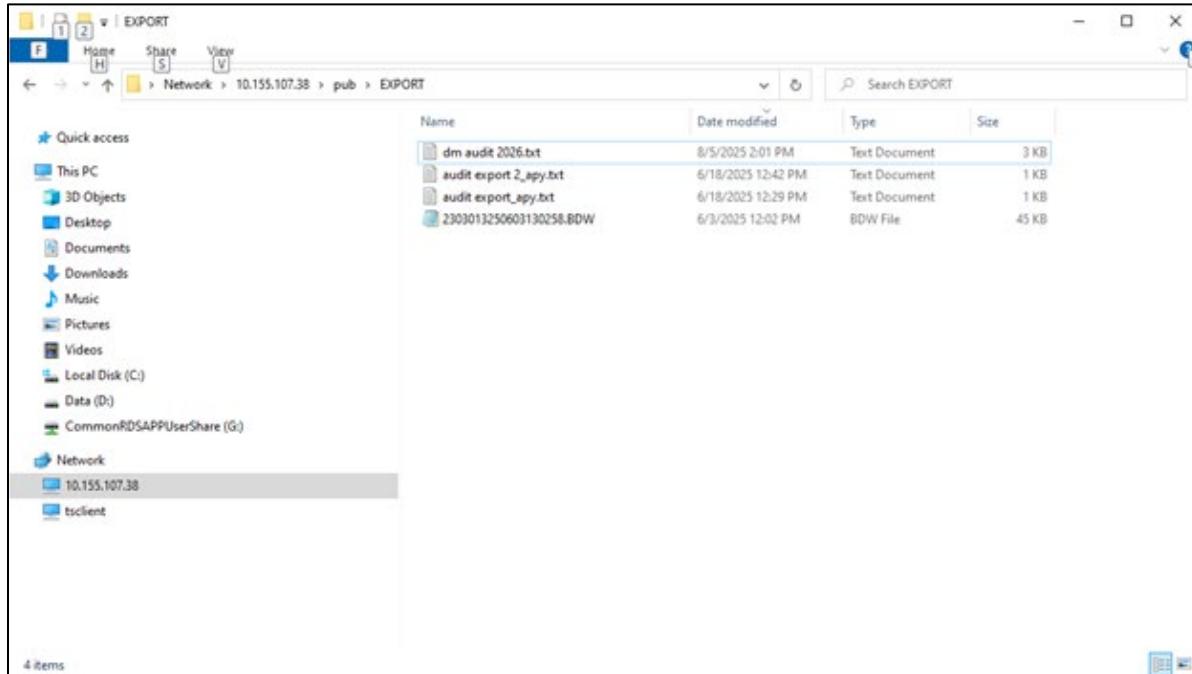


Figure D-46: Navigating to the Audit Export file

3. Change the file type from **All Excel Files** to **All Files** (Figure D-45). 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 D-47) displays.

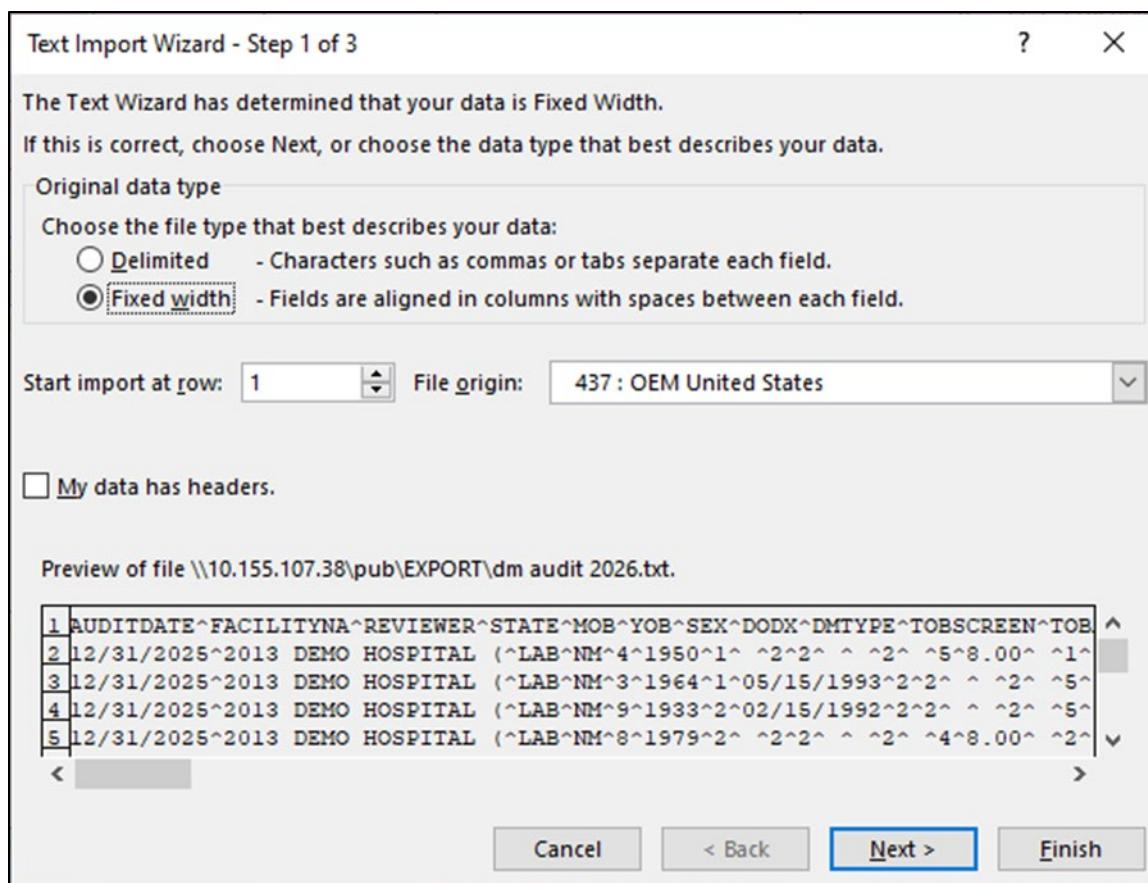


Figure D-47: Text Import Wizard Step 1 of 3 dialog

6. If the **Text Import Wizard** does not correctly identify that this is a delimited file, select the **Delimited** option button. Also, select the **My data has headers** check box.
7. Click **Next**. The **Text Import Wizard–Step 2 of 3** dialog (Figure D-48) displays.

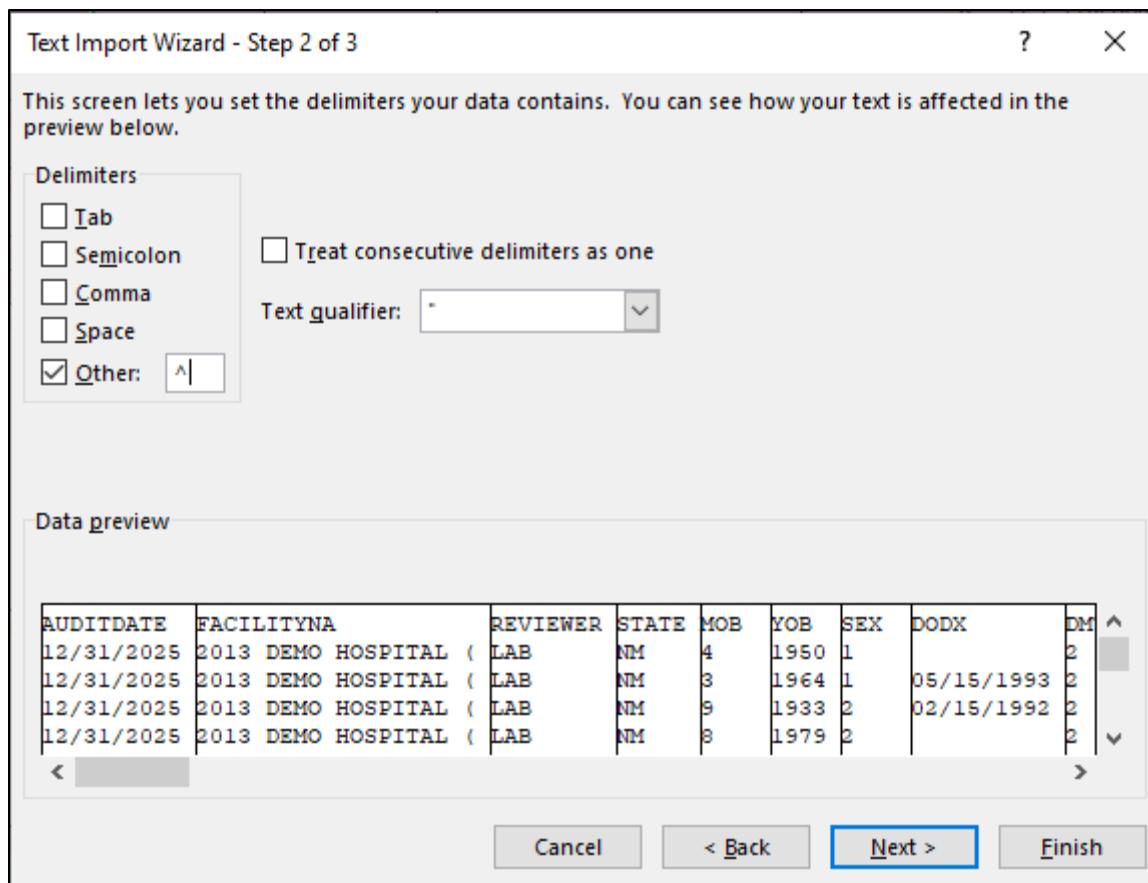


Figure D-48: Text Import Wizard Step 2 of 3 dialog

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.

D.9 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 D.6.2). 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 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 **RPMS Data Quality Check** report may also be used to identify the patients with errors. Running this report is described in Section D.5. The RPMS Data Quality Check report includes the patient's name and chart number. The Year and Month of Birth, Sex, and Date of Diagnosis may all be used to identify the patient via **iCare** and/or **FRPT Find a Register Patient** in the **AS Audit Setup Menu**.
 - 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. (See Section 8.4 for additional detail on this functionality):

- By **Date of Diagnosis**
- By **Register Status, Sex, Year, and Month of Birth**

D.10 Display 2026 Diabetes Audit Logic

The logic for the **2026 Diabetes Audit** is provided under the **DAL** menu option in the **AS–Audit Setup** menu, as shown in Figure D-49.

1. At the **Diabetes Management Systems** menu, type **AS** and press Enter.
2. At the “Select DMS Audit Item Descriptions Audit Year” prompt, type **2026** for the Audit year and press Enter to display the item list.

DM AUDIT ITEM DESCRIPTION	Nov 07, 2025 16:26:32	Page:	1 of 2
1) AUDIT DATE (AKA AUDI	21) FOOT EXAM - COMPLETE	41) RETINOPATHY (DIAGNOS	
2) FACILITY NAME	22) EYE EXAM (dilated ex	42) LOWER LEG AMPUTATION	
3) REVIEWER INITIALS	23) DENTAL EXAM	43) INFLUENZA VACCINE DU	
4) STATE OF RESIDENCE	24) DEPRESSION SCREENING	44) Pneumococcal Vaccine	
5) CHART NUMBER	25) DEPRESSION AN ACTIVE	45) RSV - Respiratory sy	

6)	DATE OF BIRTH (DOB)	26)	NUTRITION INSTRUCTION	46)	Td, Tdap, DTap, or D
7)	SEX	27)	PHYSICAL ACTIVITY IN	47)	Tdap EVER
8)	PRIMARY CARE PROVIDE	28)	DM EDUCATION (OTHER)	48)	HEPATITIS B COMPLETE
9)	DATE OF DIABETES ONS	29)	DIABETES THERAPY	49)	SHRINGRIX COMPLETE S
10)	DM TYPE	30)	ACE INHIBITOR OR ARB	50)	A1C
11)	TOBACCO - SCREENED D	31)	ASPIRIN/ OTHER ANTIP	51)	TOTAL CHOLESTEROL
12)	TOBACCO USE STATUS	32)	STATIN THERAPY	52)	HDL CHOLESTEROL
13)	TOBACCO CESSATION CO	33)	CVD	53)	LDL CHOLESTEROL
14)	(ENDS) -SCREENED DURI	34)	TUBERCULOSIS (TB) DI	54)	TRIGLYCERIDES
15)	(ENDS) -USE DURING AU	35)	TB TEST DONE	55)	Estimated Glomerular
16)	HEIGHT	36)	TB TEST RESULT	56)	QUANTITATIVE URINE A
17)	WEIGHT	37)	TB RESULT POSITIVE,	57)	COMBINED OUTCOMES ME
18)	BMI	38)	TB RESULT NEGATIVE,	58)	e-GFR and UACR
19)	HYPERTENSION DOCUMENT	39)	HEPATITIS C - HCV Di	59)	COMORBIDITY +

Enter ?? for more actions

S Select Item A Display All Items Q Quit

Select Action: +//

Figure D-49: 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.

Section D.11.1.1 provides a complete listing of the logic for all Audit items.

D.11 Audit Resources

- The complete DMS v2.0 p19 User Manual (bdm_0200.19u.pdf) can be found on the RPMS website <https://www.ihs.gov/rpms/applications/clinical/> under the Diabetes Management System (BDM) group.
- Diabetes Audit 2026 information can be found on the IHS Division of Diabetes website: <https://www.ihs.gov/diabetes/audit/>.
- IHS Diabetes Standards of Care and Resources for Clinicians and Educators can be found on the IHS Division of Diabetes website: <https://www.ihs.gov/diabetes/clinician-resources/soc/>.

D.11.1 2026 Diabetes Audit Logic

Note: 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 2026 DM Audit) menu option under the **AS** menu option of the **Diabetes Management System** menu.

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

D.11.1.1 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

D.11.1.2 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, 2025, data are reviewed for the year prior to this date (January 1–December 31, 2025).
- **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 01/01/2025 to 12/31/2025.)
- **Audit Export Field Name and Details:** AUDITDATE MM/DD/YYYY

D.11.1.3 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).

D.11.1.4 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 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.

D.11.1.5 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

D.11.1.6 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.

D.11.1.7 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 and not uploaded to the WebAudit.

D.11.1.8 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.
- **Audit Export Field Names and Details:** MOB and YOB.

Only the month and year of birth are included and can be uploaded to WebAudit.

D.11.1.9 Sex

- **Description:** Patient's sex
- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** Male, Female or Unknown, from patient registration.
- **Audit Logic:** Sex of patient. Obtained from data entered through patient registration. Male, Female, or Unknown.
- **Audit Report:** Sex—Male, Female, Unknown.
- **Audit Export Field Name and Details:** SEX.
 - 1=Male
 - 2=Female
 - 3=Unknown

D.11.1.10 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 and not uploaded into the WebAudit.

D.11.1.11 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.

For the selected date: if year only documented, 0701 is used for month/day; if month/year are documented 15 is used for the day.
- **Audit Logic:** The diabetes onset date. This date is used in the calculation of the duration of diabetes. The system obtains the date from three different dates in the following order:
 - The date of onset from the Diabetes Register.
 - The earliest date of onset from all diabetes related problems on the problem list. The problem list is scanned for all problems in the ICD diagnosis code ranges defined in the SURVEILLANCE DIABETES taxonomy or SNOMED code defined in PXRM DIABETES SNOMED subset.
 - The first recorded diagnosis (POV) of diabetes in PCC. ICD codes: SURVEILLANCE DIABETES taxonomy.
- **Audit Report:** Duration of Diabetes: When calculating the duration of diabetes, the earliest date of the 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.

Note: The first diagnosis date from POV is not used.

Audit Report categories for Duration of Diabetes:

- < 1 year
- < 10 years
- \geq 10 years
- Diagnosis date not recorded

- **Audit Export Field Name and Details:** DODX

The earliest date found from the Diabetes register or the problem list is included.
Format: MM/DD/YYYY.

D.11.1.12 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 2, 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 Export (Data) File and Audit Report. For the individual Audit, **Not Documented** is displayed.
- **Audit Report:** Diabetes Type:
 - Type 1
 - Type 2
- **Audit Export Field Name and Details:** DMTYPE
 - 1=Type 1, 2=Type 2 (or uncertain)

D.11.1.13 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 below. The last screening done ever is displayed, it does not have to be from the audit period.
- **Audit Logic:** If any of the following items are documented during the Audit period, then a value of 1=Yes is assigned. Otherwise, a value of 2=No is assigned.
 - Any Health Factor for category Tobacco [C004], TOBACCO (SMOKING) [C017], TOBACCO (SMOKELESS–CHEWING/DIP) [C016], ECIGARETTES [C019], TOBACCO (EXPOSURE) [C015]
 - POV or Problem List entry where the status is not Inactive or Deleted:–ICD-10: F17.2*, O99.33*, Z71.6, Z72.0, Z87.891 [BGP TOBACCO DXS]– SNOMED data set PXRM BGP TOBACCO SCREENED (Problem List only)
 - Dental code 1320 or D1320
 - Patient Education codes containing “TO-”, “-TO”, “-SHS,” 305.1, 305.1* (old codes), 649.00 through 649.04, V15.82, F17.2*, O99.33*, Z71.6, Z72.0, Z87.891, D1320, 99406, 99407, G0030, 1034F, 1035F, 1036F, 1000F, 4000F, 4001F, G9016, G9275, G9276, G9458, or SNOMED 408939007 or data set PXRM BGP TOBACCO SCREENED
 - CPT D1320, 99406, 99407, G0030, G9016, G9275, G9276, G9458, 1034F (Current Tobacco Smoker), 1035F (Current Smokeless Tobacco User), 1036F (Current Tobacco Non-User), 1000F (Tobacco Use Assessed), 4000F, 4001F [BGP TOBACCO SCREEN CPTS]
- **Audit Report:** Value is used in the Tobacco and Nicotine Use section of the Audit Report.
- **Audit Export Field Name and Details:** TOBSCREEN.
 - 1=Yes
 - 2=No

D.11.1.14 Tobacco Use

- **Description:** Tobacco use during the Audit period.
- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** Audit Logic below is applied, but not limited to Audit period. Current use (Yes or No) is determined and displayed, along with last documented of the items in the Audit Logic.
- **Audit Logic:** If tobacco screening is 1=Yes, then tobacco use documented in the audit period is searched for. If any of the following items are found, then a value of 1=Yes is assigned. Otherwise, a value of 2=No is assigned.
 - **Health Factors:** Current Smokeless [F003]; Current Smoker and Smokeless [F030]; Current Smoker, status unknown [F002]; Current smoker, every day [F108]; Current smoker, some day [F109]; Heavy Tobacco Smoker [F121]; Light Tobacco Smoker [F122]
 - **Diagnosis (POV or Problem List entry where the status is not Inactive or Deleted):**
 - ICD-10: F17.2*0, F17.2*3, F17.2*8, F17.2*9, O99.33*, Z71.6, Z72.0 [BGP TOBACCO USER DXS]
 - ICD-10: F17.200, F17.203 through F17.210, F17.213 through F17.219, F17.290, F17.293 through F17.299, O99.33* [BGP GPRA SMOKING DXS]
 - SNOMED data set PXRM BGP CURRENT TOBACCO (Problem List only)
 - SNOMED data set PXRM BGP TOBACCO SMOKER (Problem List only)
 - ICD-10: F17.220, F17.223 through F17.229 [BGP GPRA SMOKELESS DXS]
 - SNOMED data set PXRM BGP TOBACCO SMOKELESS (Problem List only)
 - **CPT Codes**
 - CPT 99406, 99407, 1034F, 1035F, 4000F, 4001F, G9016, G9276, G9458 [BGP TOBACCO USER CPTS]
 - CPT 99406, 99407, G9016 [BGP SMOKER CPTS]
 - CPT 1035F [BGP SMOKELESS TOBACCO CPTS]
- **Audit Report:** Value is used in the Tobacco and Nicotine Use and CVD sections.
- **Audit Export Field Name and Details:** TOBACCOUSE
 - 1=Yes, 2=No

D.11.1.15 Tobacco Cessation Counseling

- **Description:** If the patient is a tobacco user, were they provided cessation counseling during the audit period.
- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** Audit Logic below is applied. Any cessation counseling found in the past 12 months from the date the summary is run. If counseling is found, Yes is displayed along with a description of what was found, otherwise No is displayed.
- **Audit Logic:** If screened for tobacco use and tobacco use is 1=Yes, then counseling documented in the audit period is searched for. If any of the following items are found, then a value of 1=Yes is assigned. Otherwise, a value of 2=No is assigned.
 - Patient education codes containing TO-, -TO, -SHS, 305.1, 305.1* (old codes), 649.00 through 649.04, V15.82, F17.2*, O99.33*, Z71.6, Z72.0, Z87.891, D1320, 99406, 99407, 4000F, G0030, G9016, G9458, or SNOMED data set PXRM BGP TOBACCO SCREENED.
 - Clinic code 94 (tobacco cessation clinic)
 - Dental code 1320
 - CPT D1320, 99406, 99407, G0030, G9016, G9458, 4000F
 - POV ICD-10: Z71.6
 - Prescription for Tobacco Cessation Aid—Any of the following documented anytime during the Report Period:
 - Prescription for medication in the site-populated BGP CMS SMOKING CESSATION MEDS or the BGP ECQM TOB CESSATION MEDS taxonomies that does not have a comment of RETURNED TO STOCK
 - Prescription for any medication with name containing “NICOTINE PATCH,” “NICOTINE POLACRILEX,” “NICOTINE INHALER,” “NICOTINE NASAL SPRAY” that does not have a comment of RETURNED TO STOCK.
 - CPT 4001F
- **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 TOBACCOUSE is not 1=Yes

D.11.1.16 Electronic Nicotine Delivery Systems (ENDS) Screening

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

D.11.1.17 Electronic Nicotine Delivery System (ENDS) Use

- **Description:** ENDS use during the Audit period.
- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** The last documented health factor in the category E CIGARETTES is found and displayed. If none are found **Never** is displayed.
- **Audit Logic:** If ENDS screening is **1=Yes**, then ENDS use documented in the audit period is searched for.
If Health Factor Current E-cigarette user w/nicotine [F124] is found during Audit period, 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:** ENDSUSE
 - **1=Yes**
 - **2=No**

D.11.1.18 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 ($BMI \geq 30.0$)
 - Height or weight missing
 - Severely obese ($BMI \geq 40.0$)
- **Audit Export Field Names and Details:**
 - FEET (combine with INCHES or blank)
 - 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.

D.11.1.19 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 assigned to a 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:** WEIGHT
Last recorded weight during the Audit period, truncated to the nearest whole pound.

D.11.1.20 Body Mass Index

- **Description:** Calculated BMI
- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** BMI is calculated as:
$$\text{BMI} = (\text{weight}/[\text{height} * \text{height}]) \times 703$$
 where:
 - weight=the last weight (in lbs).
 - height=the last height (in inches) recorded any time.If the patient has a pregnancy diagnosis on the date of the weight, the BMI is not calculated or displayed.
If the patient is < 19 years of age the height and weight must be on the same day or the BMI is not calculated.
- **Audit Logic:** BMI is calculated as:
$$\text{BMI} = (\text{weight}/[\text{height} * \text{height}]) \times 703.$$
 - weight=the last weight (in lbs.) documented during the Audit period.
 - height=the last height (in inches) recorded any time before the Audit date.
- **Audit Report:** Body Mass Index (BMI) Category:
 - Normal (BMI < 25.0)
 - Overweight (BMI 25.0–29.9)
 - Obese (BMI \geq 30.0)
 - Height or weight missing
 - Severely obese (BMI \geq 40.0)
- **Audit Export Field Name and Details:** Not included and not uploaded into the WebAudit.

D.11.1.21 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 <130/<80
 - Diagnosed hypertension and mean BP <140/<90
 - Diagnosed hypertension and ACE inhibitor or ARB currently prescribed.
- Also used when determining diabetes related conditions.
- **Audit Export Field Name and Details:** HTNDX
 - 1=Yes
 - 2>No

D.11.1.22 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 the same day, the latest one is used.
- **Audit Report:**

Blood Pressure (BP)

 - <130/<80
 - 130/80–<140/<90
 - 140/90–<160/<100
 - 160/100 or higher
 - BP category undetermined
 - <140/<90
 - Cardiovascular Disease (CVD) section
 - CVD and mean BP <130/<80
 - CVD and mean BP <140/<90
 - Chronic Kidney Disease (CKD) section
 - CKD and mean BP <130/<80
 - CKD and mean BP <140/<90
- **Audit Export Field Name and Details:** The blood pressure values are exported but mean blood pressure is not.
 - SYST1
 - DIAST1
 - SYST2
 - DIAST2
 - SYST3
 - DIAST3

D.11.1.23 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, G0245, G0246, and G9226 in V CPT [Taxonomy: BGP CPT FOOT EXAM]
 - A visit on which a podiatrist (provider class codes 33=PODIATRIST, 84=PEDORTHIST or 25=CONTRACT PODIATRIST) that is not a DNKA visit is searched for in the year prior to the Audit date. If found, it is not assumed the exam was done so the term “maybe” is displayed with the date of the visit.
 - A visit to clinic 65=PODIATRY or B7=Diabetic Foot clinic that is not a DNKA is searched for in the year prior to the Audit date. If found, it is not assumed the exam was done so the term “maybe” is displayed with the date of the visit.
- **Audit Logic:** The logic used in determining if a comprehensive or complete foot exam has been done is as follows:
 - A documented DIABETIC FOOT EXAM, COMPLETE (CODE 28) is searched for in the year prior to the Audit date. This is recorded in V Exam. If found, no other processing is done, an exam is assumed to have been done.
 - CPT codes 2028F, G0245, G0246, and G9226 in V CPT [Taxonomy: BGP CPT FOOT EXAM]
 - If found, no other processing is done.
 - If any of the above is found, a value of 1=Yes is assigned.
 - If none of the above are found, the value is 2=No.
- **Audit Report:** In the Exam section of the Audit report. Foot exam—comprehensive
- **Audit Export Field Name and Details:** FOOTEXAM:
 - 1=Yes
 - 2=No

D.11.1.24 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 are found, the value 2-No is assigned.
- **Audit Report:** In the Exam section of the Audit report. Eye exam–dilated or retinal imaging.
- **Audit Export Field Name and Details:** EYEEXAM
 - 1=Yes, 2>No

D.11.1.25 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 below. For the DPSC if nothing is found using that logic then the system will look for the following:
 - 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.
 - 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 with IHS Dental Tracking Code 0000 or 0190
 - A visit with RPMS Dental codes/ADA CDT 0110 through 0390, 0415 through 0471, 0601 through 0603, 0999 through 9974, 9995, 9996, 9999, D0120 through D0389, D0415 through D0470, D0701 through D0804, D0999 through D9974, D9995, D9996, D9999
 - A visit with RPMS Dental codes/ADA CDT 0110 through 0390, 0415 through 0471, 0601 through 0603, 0999 through 9974, 9995, 9996, 9999, D0120 through D0389, D0415 through D0470, D0701 through D0804, D0999 through D9974, D9995, D9996, D9999
 - A visit on which a CPT code from the BGP DENTAL VISIT CPT CODES taxonomy was recorded.
 - A visit for which the ICD10 POV is: Z01.20, Z01.21, Z13.84, Z29.3 [BGP DENTAL VISIT DXS]
 - 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

D.11.1.26 Depression Active Diagnosis

- **Description:** Does patient have depression as an active diagnosis during the Audit period?
- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** See Section D.10.
- **Audit Logic:** The PCC and BH systems are reviewed for at least two visits with any of the following in the year prior to the Audit date.
 - Diagnosis (POV) contained in the BGP MOOD DISORDERS
 - Behavioral Health Problem Codes 14 or 15
 - If two POVs are found, then the value assigned is 1=Yes.
 - If not, then a value of 2=No is assigned.
- **Audit Report:** Depression section:
 - Active diagnosis during Audit period
 - Screened and/or active diagnosis during Audit period
 - Also used to determine if depression is a diabetes related condition.
- **Audit Export Field Name and Details:** DEPDX2
 - 1=Yes
 - 2=No

D.11.1.27 Depression Screening

- **Description:** Was patient screened for depression in the audit period?
- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** See Section D.10.
- **Audit Logic:** The PCC and Behavioral health databases are reviewed for any of the following documented in the past year:
 - Exam 36 or Behavioral Health Module Depression Screening.
 - Diagnosis–V POV, V79.0, Z13.3*, [BGP DEPRESSION SCRN DXS].
 - Measurement of PHQ2, PHQ9, PHQ-T, EPDS.
 - Behavioral Health Module Diagnosis (POV) of 14.1.
 - CPT codes 1220F, 3725F or G0444 in PCC or Behavioral Health. Taxonomy: [BGP DEPRESSION SCREEN CPTS] and CPT 96127.
 - If any of the above is found, then a value of 1=Yes is assigned. If not, then a value of 2=No is assigned.
- **Audit Report:** Depression section:
 - Screened during Audit period
 - Screened and/or active diagnosis during Audit period
- **Audit Export Field Name and Details:** DEPSCREEN2
 - 1=Yes
 - 2=No

D.11.1.28 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 Section D.10 for nutrition education, physical activity education and other DM education.
- **Audit Logic:**
 - 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.
 - A visit to clinic 67–DIETARY clinic that is not a DNKA is searched for in the year prior to the Audit date. If found, and visit doesn't have the provider codes 29, 07, 34, then Other is assigned.
 - If the visit does not have one of the above providers but has a Diagnosis of [BGP DIETARY SURVEILLANCE DXS] then Other is assigned.
 - If the visit has a CPT documented of 97802, 97803, 97804, G0270, G0271 then RD is assigned.
 - If the visit contains any of the following education topics:
 - Topic in the DM AUDIT DIET EDUC TOPICS taxonomy
 - Topic ending in-N
 - Topic ending in-DT
 - Topic ending in-MNT
 - Topic beginning with MNT-
 - Topic beginning with DNCN-
 - The V Patient Education entry is examined:
 - If the provider documented in that entry is a Dietitian or Nutritionist, the RD is assigned.
 - If the provider is blank or not a dietitian/nutritionist, then Other is assigned.
 - At this point:
 - If RD is assigned and Other is not then the value assigned is 1=RD.
 - If RD and Other is assigned then the value assigned is 3=Both RD & Other.

- If Other is assigned and RD is not then the value assigned is 2=Other.
 - Processing stops if a value is assigned.
 - If none of the above is documented, the value 4=None is assigned.
- **Audit Report:** Diabetes-Related Education.
 - Nutrition–by any provider (RD and/or other)
 - Nutrition–by RD
- **Audit Export Field Name and Details:** DIETINSTR
 - 1=Yes by RD
 - 2=Yes by non-RD
 - 3=Yes by both RD & non-RD
 - 4=None

D.11.1.29 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 Section D.10 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 Z71.82 taxonomy BGP EXERCISE COUNSELING DXS
 - 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

D.11.1.30 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 Section D.10 for nutrition education, physical activity education and other DM education.
- **Audit Logic:** All education topics documented in the year prior to the Audit date are examined.
 - If any topic meets the following criteria, then the value assigned is 1=Yes:
 - Topic does not end in -EX, -N, -DT, or -MNT.
 - Topic does not begin with MNT-.
 - Topic is a member of the **DM AUDIT OTHER EDUC TOPICS** taxonomy OR the topic begins with one of the following:
 - **DM-** (e.g., DM-L)
 - **DMC-** (e.g., DMC-L)
 - An **ICD Diagnosis** code that is a member of the **SURVEILLANCE DIABETES** taxonomy (e.g., 250.00-L, E10.51-L)
 - A **Diabetes SNOMED** code (e.g., 46635009-L)
 - If no patient education topic matching the above criteria is found, then all visits documented during the report period are examined. If any visit meets the following criteria, then a value of 1=Yes is assigned:
 - If the visit has a CPT documented of 95249, 95250, 95251, 98960, 98961, 98962, 99605, 99606, G0109, G0108.
 - If clinic code is **A1 (DIABETES EDUCATION-INDIVIDUAL)**, **60 (EDUCATION CLASSES)**, or **98 (DIABETES EDUCATION-GROUP)**
 - **Audit Report:** Diabetes-Related Education Other diabetes education.
 - **Audit Export Field Name and Details:** DMEDUC:
 - 1=Yes
 - 2=No

D.11.1.31 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 one fill in the past six months.)
 - If no V Medication is found, the Prescription file (file 52) is searched for any drug in the taxonomy of drugs being searched for. The prescription number must begin with an X (an X indicates that the prescription was e-prescribed). If the prescription begins with an X the following calculation is done:
 - Days' supply times (# of refills +1) (this is the total number of days the prescription covers)
 - Number of days calculated above + issue date (this is the last date the prescription covers) - If the date calculated above is greater than the Audit date minus 180 days it is assumed the patient was taking that medication in the six months prior to the end of the Audit date.
 - If no medications are found in the searches shown above the system will look for any EHR Outside Medication that fits into one of medication categories. EHR Outside Medications are found in the V Medication file and have a value in the EHR Outside Medication field and no discontinued date. The system will go back 10 years to find one of these medications.

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

Table D-3: Diabetes Therapy Taxonomy Names

Therapy	Taxonomy Name(s)
Insulin	DM AUDIT INSULIN DRUGS
Metformin	DM AUDIT METFORMIN DRUGS
Sulfonylurea	DM AUDIT SULFONYLUREA DRUGS
DPP-4 inhibitor	DM AUDIT DPP-4 INHIBITOR DRUGS

Therapy	Taxonomy Name(s)
GLP-1 receptor agonist	DM AUDIT GLP-1 RECEPT AGONISTS
SGLT-2 inhibitor	DM AUDIT SGLT-2 INHIBITOR DRUGS
Pioglitazone, rosiglitazone	DM AUDIT GLITAZONE DRUGS
Tirzepatide	DM AUDIT TIRZEPATIDE DRUGS
Acarbose, miglitol	DM AUDIT ACARBOSE DRUGS
Repaglinide, Nateglinide	DM AUDIT SULFONYLUREA-LIKE
Pramlintide	DM AUDIT AMYLIN ANALOGUES
Bromocriptine	DM AUDIT BROMOCRIPTINE DRUGS
Colesevelam	DM AUDIT COLESEVELAM DRUGS

- **Audit Report:** Diabetes Treatment section.
 - Number of diabetes medications currently prescribed.
 - Diabetes meds currently prescribed, alone or in combination:
 - Insulin
 - Metformin
 - Sulfonylurea
 - DPP-4 inhibitor
 - GLP-1 receptor agonist
 - SGLT-2 inhibitor
 - Pioglitazone or rosiglitazone
 - Tirzepatide [Mounjaro, Zepbound]
 - Acarbose or miglitol
 - Repaglinide or Nateglinide
 - Pramlintide
 - Bromocriptine
 - Colesevelam
- **Audit Report:** Cardiovascular Disease (CVD) section.
 - CVD and GLP-1 receptor agonist currently prescribed
 - CVD and SGLT-2 inhibitor currently prescribed
 - CVD and GLP-1 receptor agonist and/or SGLT-2 inhibitor currently prescribed
- **Audit Report:** Chronic Kidney Disease (CKD) section.
 - CKD and GLP-1 receptor agonist currently prescribed

- CKD and SGLT-2 inhibitor currently prescribed
- CKD and GLP-1 receptor agonist and/or SGLT-2 inhibitor currently prescribed
- **Audit Export Field Name and Details:** See Section D.10.
 - If any med is found in a category, value=1 for the corresponding field, otherwise value=2.
 - If no meds are found value=1 for TXNONE.
 - TXNONE
 - TXINSUL
 - TXMETFORM
 - TXSUREA
 - TXDPP4
 - TXGLP1MED
 - TXSGLT2
 - TXGLIT
 - TXTIRZEP
 - TXACARB
 - TXSUREALK
 - TXAMYLIN
 - TXBROMO
 - TXCOLESEV

D.11.1.32 ACE Inhibitor or ARB

- **Description:** Was an ACE Inhibitor or ARB prescribed to the patient at 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 and angiotensin receptor blockers (ARBs) 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 currently prescribed

- Chronic Kidney Disease (CKD) section:
 - CKD and ACE inhibitor or ARB currently prescribed
- Audit Export Field Name and Details: ACE:
 - **1**=Yes
 - **2**=No

D.11.1.33 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:
 - Cardiovascular Disease (CVD) section:
 - CVD and aspirin or other antiplatelet/anticoagulant therapy currently prescribed.
- **Audit Export Field Name and Details:** ASPIRIN
 - 1=Yes
 - 2=No

D.11.1.34 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)
 - C) "Statin" or "Statins" contained within Problem List or in Provider Narrative field

For any POV ICD-9: 995.0-995.3, V14.8; ICD-10: Z88.8.

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.
 - Contraindications to Statins defined as any of the following:
 - Pregnancy (see definition below)
 - Breastfeeding, defined as POV ICD-9, V24.1; ICD-10: Z39.1 or breastfeeding patient education codes BF-BC, BF-BP, BF-CS, BF-EQ, BF-FU, BF-HC, BF-ON, BF-M, BF-MK, or BF-N during the Report Period.
 - Acute Alcoholic Hepatitis, defined as POV ICD-9: 571.1; ICD-10: K70.10, K70.11 during the Report Period.
 - NMI (not medically indicated) refusal for any statin at least once during the Report Period.
 - Pregnancy Definition: At least two visits during the Audit Period with Documented codes in the following taxonomies:

- BGP PREGNANCY DIAGNOSES 2; BGP PREGNANCY ICD PROCEDURES; BGP PREGNANCY CPT CODES where the provider is not a CHR (Provider code 53). Pharmacy-only visits (clinic code 39) will not count toward these two visits. If the patient has more than two pregnancy-related visits during the Report Period, the Audit will use the first two visits in the Report Period. The patient must not have a documented miscarriage or abortion occurring after the second pregnancy-related visit. Miscarriage definition: Codes documented that are contained in the following taxonomies: BGP MISCARRIAGE/ABORTION DXS; BGP ABORTION PROCEDURES; BGP CPT ABORTION; BGP CPT MISCARRIAGE.
- **Audit Report:** Statin Prescribed section
 - Yes*
 - Allergy, intolerance, or contraindication
 - These three items also reported:
 - In patients with diagnosed CVD
 - In patients age 40–75 years
 - In patients with diagnosed CVD and/or age 40–75 years
- **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**.

D.11.1.35 Cardiovascular Disease

- **Description:** CVD Diagnosed Ever?
- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** See Section D.10.
- **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 <130/<80
 - CVD and mean BP <140/<90
 - CVD and not current tobacco user
 - CVD and aspirin or other antiplatelet/anticoagulant therapy currently prescribed
 - CVD and GLP-1 receptor agonist currently prescribed
 - CVD and SGLT-2 inhibitor currently prescribed
 - CVD and GLP-1 receptor agonist and/or SGLT-2 inhibitor currently prescribed
 - CVD and statin currently prescribed*
- **Audit Export Field Name and Details:** CVDDX

- **1**=Yes
- **2**=No

D.11.1.36 Tuberculosis (TB) (latent or active) diagnosis (ever)

- **Description:** Was Tuberculosis (TB) (latent or active) diagnosed ever?
- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** Any health factor in the TB STATUS category is found, if one is found that health factor is displayed. If no health factor found, then the problem list and purpose of visits are examined for any that are contained in the DM AUDIT TUBERCULOSIS DXS diagnosis taxonomy or the PXMR BQI TUBERCULOSIS SNOMED subset. If one is found, it is displayed.
- **Audit Logic:** If the patient has a TB health factor recorded, TB on the problem list, or any diagnosis of TB documented in the PCC, a 1–Yes is assigned. If none of these are found, a value of 2 - No is assigned. Definition of diagnosis:
 - TB Health Factor—any health factor in the TB STATUS category.
 - Problem list diagnosis and Purpose of visit in the DM AUDIT TUBERCULOSIS DXS taxonomy or the PXRM BQI TUBERCULOSIS SNOMED subset.
- **Audit Report:** Tuberculosis (TB) Status section:
 - TB diagnosis documented and/or positive test result
 - If not diagnosed, TB test done (skin test or blood test)
 - TB test done ever or TB diagnosed ever
 - If TB diagnosis documented and/or positive test result, treatment initiated
 - If TB negative test result, was test done after diabetes diagnosis
- **Audit Export Field Name and Details:** TBDX
 - 1=Yes
 - 2>No

D.11.1.37 TB Test Done (Most Recent)

- **Description:** In patients with no diagnosis of Tuberculosis (TB) Was a TB test done ever? Skin Test; Blood test; No test documented.
- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** TB—Last Documented Test. The date of the last documented TB test is displayed along with what type of test was done. See Section D.10 for TB Test definition.
- **Audit Logic:** If there is not a TB diagnosis documented, a TB test is searched for in the following way:
 - All recorded PPD entries and TB lab tests using the DM AUDIT TB LAB TESTS TAX prior to the Audit date are gathered. If at least one is found the latest one is used, if it is a Skin test then 1—Skin test (PPD) is assigned, if it is a lab test then 2—Blood Test is assigned.
 - If no TB test is found, then the value is 3 - No test documented.
- **Audit Report:** Tuberculosis (TB) Status section:
 - TB diagnosis documented and/or positive test result
 - If not diagnosed, TB test done (skin test or blood test)
 - TB test done ever or TB diagnosed ever
 - If TB diagnosis documented and/or positive test result, treatment initiated
 - If TB negative test result, was test done after diabetes diagnosis
- **Audit Export Field Name and Details:** TBTESTDONE3
 - 1=Skin test (PPD)
 - 2=Blood test (QFT-GIT, T-SPOT)
 - 3=No test documented
 - **Blank** if TBDX is not 2=No.

D.11.1.38 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 Section D.10 for TB Test definition.
- **Audit Logic:** If there is not a TB diagnosis documented and a TB test was done, the test result is determined in the following way:
 - All recorded PPD entries and TB lab tests using the DM AUDIT TB LAB TESTS TAX prior to the Audit date are gathered.
 - If at least one is found the latest one is used.
 - If it is a Skin test and the reading or result is Positive (reading >9), then it is assigned as 1=Positive.
 - If reading or result of last PPD is negative, then the value is 2=Negative.
 - If the test type is a blood test then the result of the test is examined:
 - If it is Positive then 1=Positive is assigned.
 - If it is Negative then 2=Negative is assigned.
 - If the results are Null the value 3=No result documented is assigned.
 - If no result is found, then the value assigned is 3=No result documented.
- **Audit Report:** Tuberculosis (TB) Status section:
 - TB diagnosis documented and/or positive test result
 - If not diagnosed, TB test done (skin test or blood test)
 - TB test done ever or TB diagnosed ever
 - If TB diagnosis documented and/or positive test result, treatment initiated
 - If TB negative test result, was test done after diabetes diagnosis
- **Audit Export Field Name and Details:** TBTESTRSLT2
 - 1=Positive
 - 2=Negative
 - 3=No result documented
 - Leave **blank** if value for TBTESTDONE3 is not 1 or 2

D.11.1.39 TB Treatment

- **Description:** If TB diagnosed ever and/or result positive, was treatment initiated?
- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** See Section D.10 for definition of treatment initiated. The value of the last TB Health factor or medication displayed.
- **Audit Logic:** If TB diagnosis documented ever is YES or the value of the TB Test result is POSITIVE, then the last TB health factor and TB medication taxonomy are looked at for determining TB Treatment status. The last recorded TB Health factor is displayed. The TB Health factors are:
 - TB-TX COMPLETE
 - TB-TX INCOMPLETE
 - TB-TX UNKNOWN
 - TB-TX UNTREATED
 - TB-IN PROGRESSThe value assigned is based on the last recorded health factor or prescription of any medication from the TB medication taxonomy (DM AUDIT TB MEDS/DM AUDIT TB DRUG NDC) ever:
 - TX COMPLETE: 1=Yes
 - TX INCOMPLETE: 1=Yes
 - TX UNTREATED: 2=No
 - TX IN PROGRESS: 1=Yes
 - TX UNKNOWN: 3=Unknown
 - TB medication prescribed 1=Yes
- **Audit Report:** Tuberculosis (TB) Status section:
 - TB diagnosis documented and/or positive test result
 - If not diagnosed, TB test done (skin test or blood test)
 - TB test done ever or TB diagnosed ever
 - If TB diagnosis documented and/or positive test result, treatment initiated
 - If TB negative test result, was test done after diabetes diagnosis
- **Audit Export Field Name and Details:** TBINHTX2
 - 1=Yes
 - 2=No
 - 3=Unknown
 - Leave **blank** if value for TBDX is not 1=Yes or TBTESTRSLT2 is not 1=Positive

D.11.1.40 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 Section D.10 for TB Test Done for definition of a TB test.
For the selected date: if year only documented, 0701 is used for month/day; if month/year are documented 15 is used for the day.
- **Audit Logic:** If the value of TB test result is **NEGATIVE**, then the date of the last TB test is displayed.
- **Audit Report:** Tuberculosis (TB) Status: If negative TB test, test done after diabetes diagnosis.
- **Audit Export Field Name and Details:** TBTESTDATE MM/DD/YYYY
 - Leave **blank** if value for TBTESTRSLT2 is not 2=Negative.

D.11.1.41 Hepatitis C (HCV) Diagnosis

- **Description:** Hepatitis C (HCV) diagnosis ever
- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** See Section D.10.
- **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
 - HCV test done ever or HCV diagnosed ever
- **Audit Export Field Name and Details:** HCVDX
 - 1=Yes
 - 2>No

D.11.1.42 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 Section D.10. 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 \geq 18 years, screened ever
 - HCV test done ever or HCV diagnosed ever
- **Audit Export Field Name and Details:** HCVSCREEN2
 - **1=Yes**
 - **2=No**
 - **Blank** if value for HCV is not **2=No**

D.11.1.43 Retinopathy Diagnosis

- **Description:** Retinopathy diagnosed ever?
- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** See Section D.10. The date of the diagnosis is displayed.
- **Audit Logic:** If retinopathy is on the problem list or the patient has had at least one visit with a diagnosis of retinopathy ever, then it is assumed that they have been diagnosed with retinopathy and a value of 1=Yes is assigned. Otherwise, a value of 2=No is assigned.

Taxonomy used: BGP DM RETINOPATHY DX

SNOMED List: PXRM BGP DM RETINOPATHY

- **Audit Report:** Retinopathy Diagnosed ever. Also used in calculation of diabetes-related conditions.
- **Audit Export Field Name and Details:** RETINOPDX
 - 1=Yes
 - 2=No

D.11.1.44 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 Section D.10.
- **Audit Logic:** The patient's electronic record is scanned for documentation of any of the following items:
 - The purpose of visits is scanned for any diagnosis in the BGP DM BTK AMP DXS or the BGP DM ATK AMP DXS taxonomies. If a diagnosis is found a value of 1=Yes is assigned.
 - The problem list is scanned for a diagnosis in the BGP DM BTK AMP DXS or BGP DM ATK AMP DXS taxonomies or a SNOMED in the PXRM BGP DM BTK AMP or PXRM BGP DM ATK AMP SNOMED subsets.
 - The procedures are scanned for a procedure in the BGP DM BTK AMP PROCS or BGP DM ATK AMP PROCS taxonomies.
 - The CPT codes are scanned for a CPT in the BGP DM BTK AMP CPTS or BGP DM ATK AMP CPTS taxonomies.

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

- **Audit Report:** Lower Extremity Amputation, any type ever (e.g., toe, partial foot, above or below knee).
Also used in calculation of diabetes-related conditions
- **Audit Export Field Name and Details:** LEA
 - 1=Yes
 - 2=No

D.11.1.45 Influenza Vaccine

- **Description:** Influenza vaccine received during the Audit Period
- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** See Section D.10 for definition of Influenza vaccine. The date of the vaccine since August 1st is displayed. If no documented Influenza vaccine is found, a search is done for a documented refusal or contraindication, if found, it is displayed.
- **Audit Logic:** The patient's data is scanned for an influenza vaccine in the 12 months prior to the Audit date. Influenza vaccine is determined by:
 - Immunization CVX codes: See BGP FLU IZ CVX CODES taxonomy.
 - Immunization CVX code: 333 (Influenza, live, trivalent, intranasal, self/caregiver admin, PF)
 - CPT codes: BGP CPT FLU
 - If any of the above are found, a value of 1=Yes is assigned.
 - If none of the above are found, a value of 2=No is assigned.
- **Audit Report:** Immunization section: Influenza vaccine during Audit period.
- **Audit Export Field Name and Details:** FLUVAX2:
 - 1=Yes
 - 2=No

D.11.1.46 Pneumococcal Vaccine

- **Description:** Pneumococcal vaccine [PCV15, PCV20, PCV21, or PPSV23] vaccine (ever)
- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** See Section D.10 for the definition of a pneumococcal vaccine. The date of the last pneumococcal vaccine is displayed. If no documented vaccine is found a search is done for a documented refusal or contraindication, if found, it is displayed.
- **Audit Logic:** Data is scanned for pneumococcal vaccine any time prior to the Audit date. A pneumococcal vaccine is determined by:
 - Immunization CVX codes:
 - BGP PCV15 CVX CODES:
 - 215 PNEUMOCOCCAL CONJUGATE PCV15
 - BGP PCV20 CVX CODES:
 - 216 PNEUMOCOCCAL CONJUGATE PCV20
 - BGP PCV21 CVX CODES:
 - 327 PNEUMOCOCCAL CONJUGATE PCV21
 - BGP PPSV23 CVX CODES:
 - 33 PNEUMOCOCCAL POLYSACCHARIDE PPSV23
 - 109 PNEUMOCOCCAL, NOS
 - Diagnoses: V03.82 (Note: There are no ICD-10 codes.)
 - Immunization CPT codes:
 - BGP PCV15 CPT CODES:
 - 90671
 - BGP PCV20 CPT CODES:
 - 90677
 - BGP PCV21 CPT CODES:
 - 90684
 - BGP PPSV23 CPT CODES:
 - 90732, G0009, G8115 (old code), G9279
 - If any of the above is found, a value of 1=Yes is assigned.
 - If none of the above are found, a value of 2>No is assigned.
- **Audit Report:** Immunization section:
 - Pneumococcal vaccine [PCV15, PCV20, PCV21, or PPSV23]–ever

- **Audit Export Field Name and Details:** PNEUMO

- 1=Yes
- 2=No

D.11.1.47 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 Section D.10 for the definition of the vaccines. The date of the last vaccine is displayed. If no documented vaccine is found a search is done for a documented refusal or contraindication, if found, it is displayed.
- **Audit Logic:** Immunizations are scanned for any tetanus vaccine in the 10 years prior to the Audit date. Logic used to find a TD vaccine: Immunization CVX codes: DM AUDIT TD CVX CODES (listed below)
 - 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
 - 146 DTAP,IPV,HIB,HEPB
 - 196 Td-LF, NOS
 - 198 DTP-HbH5
- CPT codes:
 - 90696, 90697, 90714, 90715, 90718 Taxonomy DM AUDIT TD CPTS
- If any of the above are found, a value of **1=Yes** is assigned.
- If none of the above are found, a value of **2=No** is assigned.
- **Audit Report:** Immunization section:

- Td/Tdap/DTaP/DT—past 10 years
- **Audit Export Field Name and Details: TD2**
 - 1=Yes
 - 2=No

D.11.1.48 Tdap (Ever)

- **Description:** Tdap given ever
- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** See Section D.10 for the definition of Tdap. The date of the last Tdap is displayed. If no documented vaccine is found, a search is done for a documented refusal or contraindication, which if found, is displayed.
- **Audit Logic:** Immunizations are scanned for a Tdap vaccine ever. A Tdap vaccine is determined by:
 - CVX code 115 Tdap
 - CPT code 90715
 - If either of the above is found, a value of 1=Yes is assigned. If neither is found, a value of 2=No is assigned.
- **Audit Report:** Immunization section:
 - Tdap-ever
- **Audit Export Field Name and Details:** TDAP2
 - 1=Yes
 - 2=No

D.11.1.49 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 Section D.10 for definition of Hepatitis B vaccines. If no documented vaccine is found, a search is done for an immune contraindication which, if found, is displayed.
- **Audit Logic:** Data is scanned for Hepatitis B vaccine any time prior to the Audit date.

HEP B (3 DOSE SERIES) is determined by:

- CVX codes:
 - 8 HEP B, ADOLESCENT OR PEDIATRIC
 - 42 HEP B, ADOLESCENT/HIGH RISK IN
 - 43 HEP B, ADULT
 - 44 HEP B, DIALYSIS
 - 45 HEP B, NOS
 - 51 HIB-HEP B
 - 102 DTP-HIB-HEP B
 - 104 HEP A-HEP B
 - 110 DTaP-Hep B-IPV
 - 132 DTaP-IPV-HIB-HEP B, historical
 - 146 DTaP,IPV,Hib,HepB
 - 193 Hep A-Hep B, pediatric/adolescent
 - 220 HEP B, recombinant, 3-antigen, AI(OH)3
- CPT codes contained in the BGP HEPATITIS CPTS taxonomy:
90636, 90697, 90723, 90731, 90739, 90740, 90743, 90744, 90745, 90746, 90747, 90748, 90759, G0010, Q3021, Q3023.
- HEP B (2 DOSE SERIES) is determined by: CVX code 189 Hep B, adjuvanted.
- Vaccinations must be given at least 20 days apart. If the appropriate number is found (two for the two-dose series, three for the three-dose series, or a combination of one dose of the two dose vaccine with two doses of the three dose vaccine) a value of 1=Yes is assigned.

- If less than the required number of vaccines are found, the system will look for an Immune Contraindication in the Immunization contraindications file. If it is found, a value of 3=Immune is assigned. The system then looks for evidence of disease: Problem List or V POV of [BGP HEP EVIDENCE] Taxonomy. If it is found, a value of 3=Immune is assigned.
- If none of the above are found, a value of 2=No is assigned.

- **Audit Report:** Immunization section:
 - If not immune, hepatitis B complete series—ever
 - Immune—hepatitis B
 - Hepatitis B complete series ever or immune to hepatitis B
- **Audit Export Field Name and Details:** HEPBVAX2:
 - 1=Yes
 - 2=No
 - 3=Immune

D.11.1.50 Shingrix (recombinant zoster vaccine, RZV) Complete Series (Ever)

- **Description:** Shingrix complete series received ever.
- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** See Section D.10. If no documented vaccine is found, a search is done for a documented refusal or contraindication, if found, it is displayed.
- **Audit Logic:** Data is scanned for Shingrix vaccine any time prior to the Audit date. Shingrix vaccine is determined by documentation of 2 doses:
 - CPT Code 90750
 - CVX Code 187, zoster recombinant
- **Audit Report:** Immunization section:
 - In patients age ≥ 50 years Shingrix complete series—ever
- **Audit Export Field Name and Details:** SHINGLESVAX:
 - **1**=Yes
 - **2**=No

D.11.1.51 Respiratory syncytial virus (RSV) vaccine (Ever)

- **Description:** RSV vaccine received ever.
- **How Data Is Obtained from PCC (For Diabetes Patient Care Summary/Supplement):** See Section D.10. If no documented vaccine is found, a search is done for a documented refusal or contraindication, if found, it is displayed.
- **Audit Logic:** Data is scanned for RSV vaccine any time prior to the Audit date. An RSV vaccine is determined by:
 - CPT Codes
 - 90679 RSV VACC PREF RECOMB ADJT IM
 - 90678 RSV VACC PREF BIVALENT IM
 - 90683 RSV VACC mRNA LIPID NANO IM
 - CVX Codes
 - 303 RSV RESPIRATORY SYNCYTIAL VIRUS VACCINE, RECOMBINANT
 - 305 RSVbv RESPIRATORY SYNCYTIAL VIRUS VACCINE, BIVALENT, PRO
 - 326 RSVpf RESPIRATORY SYNCYTIAL VIRUS VACCINEmRNA, INJECTABLE, PRE
- **Audit Report:** Immunization section:
 - In patients age ≥ 50 years at increased risk: RSV vaccine—ever
- **Audit Export Field Name and Details:** RSVVAX:
 - 1=Yes
 - 2=No

D.11.1.52 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 Section D.10 for the definition of an A1C test.

For the selected date: if year only documented, 0701 is used for month/day; if month/year are documented 15 is used for the day.
- **Audit Logic:** All lab tests in the V LAB file in the year prior to the Audit date are found using the DM AUDIT HGB A1C TAX taxonomy and the BGP HGBA1C LOINC CODES taxonomies. Only tests that have a result are used, if the result of the V LAB is blank, contains "CANC" or contains "COMMENT" the V Lab is skipped.

Individual Audit: The date and result of test are displayed.
- **Audit Report:** Blood Sugar Control section:
 - If result contains ">" counted in ≥ 11.0 category.
 - If result contains "<" counted in <7.0 category.
 - Otherwise, everything is stripped from the value except numbers and ". ". If remaining value is something other than a number, counted in the "Not tested or no valid result" category.
 - If remaining value is numerical, it is counted in the appropriate category(ies):
 - A1C <7.0
 - A1C 7.0-7.9
 - A1C 8.0-8.9
 - A1C 9.0-9.9
 - A1C 10.0-10.9
 - A1C ≥ 11.0
 - Not tested or no valid result
 - A1C <8.0
 - A1C >9.0
- **Audit Export Field Name and Details:**
 - HBA1C.
 - HBA1CDATE.

- When exported, all characters that are not a number or a "." are stripped from the value. For example, if the value is <7.0, 7.0 is exported. A maximum of 4 digits are exported.
- Date is in MM/DD/YYYY format.

D.11.1.53 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 Section D.10 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 that is then rounded to the closest whole number and truncated to a total of three characters with zero decimal digits. Rounding is done by adding .5 to the result and sending the non-decimal portion.
 - E.g., Value in RPMS is 100.1, then .5 is added to get 100.6; then 100 is sent to the audit
 - E.g., Value in RPMS is 100.5; then .5 is added to get 101.0; then 101 is sent to the audit

D.11.1.54 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 Section D.10 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 \geq 50 mg/dL
 - Not tested or no valid result
 - In males
 - HDL < 40 mg/dL
 - HDL \geq 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 that is then rounded to the closest whole number and truncated to a total of three characters with zero decimal digits. Rounding is done by adding .5 to the result and sending the non-decimal portion.
 - E.g., Value in RPMS is 45.1; then .5 is added to get 45.6; then 45 is sent to the audit
 - E.g., Value in RPMS is 60.5; then .5 is added to get 61.0; then 61 is sent to the audit

D.11.1.55 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 Section D.10 for the definition of a LDL Cholesterol test.
- **Audit Logic:** The last lab test with a result in the year prior to the Audit date that is a member of the DM AUDIT LDL CHOLESTEROL TAX taxonomy or the BGP LDL LOINC CODES taxonomy is found in V LAB. Tests with a result containing "CANC" are ignored.
- **Audit Report:** LDL cholesterol section:

If the first digit of the result is not a number, then counted in the "Not tested or no valid result" category. For example, if the value is "UNK."

- LDL <100 mg/dL
- LDL 100-189 mg/dL
- LDL >=190 mg/dL
- Not tested or no valid result

- **Audit Export Field Name and Details:** LDLVALUE

All characters that are not numbers or "." are stripped from the result value that is then rounded to the closest whole number and truncated to a total of three characters with zero decimal digits. Rounding is done by adding .5 to the result and sending the non-decimal portion.

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

D.11.1.56 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 Section D.10 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 \geq 1000 mg/dL
 - Not tested or no valid result
- **Audit Export Field Name and Details:** TRIGVALUE
All characters other than numbers and "." are stripped from the value that is then rounded to the closest whole number and truncated to a total of 4 characters with 0 decimal digits. Rounding is done by adding .5 to the result and sending the non-decimal portion.
 - E.g., Value in RPMS is 100.1; then .5 is added to get 100.6; then 100 is sent to the audit
 - E.g., Value in RPMS is 100.5; then .5 is added to get 101.0; then 101 is sent to the audit

D.11.1.57 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 Section D.10 for the definition of a Serum Creatinine test.
- **Audit Logic:** N/A
- **Audit Report:** N/A
- **Audit Export Field Name and Details:** Not included and not uploaded to the WebAudit.

D.11.1.58 Estimated Glomerular Filtration Rate (eGFR)

- **Description:** Most recent eGFR 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 Section D.10 for the definition of an eGFR test.
- **Audit Logic:** For patients that are 18 or older, the last lab test in the year prior to the Audit date that is a member of the BGP GPRA ESTIMATED GFR TAX or the BGP ESTIMATED GFR LOINC taxonomy is found. For the individual Audit, the actual value that is in V LAB is displayed.
- **Audit Report:** Kidney Evaluation section: If the first character of the value is ">," it goes into ≥ 60 mL/min. Otherwise, all characters other than numbers and "." are stripped from the value that is then rounded to the closest whole number and truncated to a total of 3 characters with 0 decimal digits. Rounding is done by adding .5 to the result and sending the non-decimal portion to the audit.
 - E.g., value in RPMS is 29.2; then .5 is added to get 29.7; then 29 is sent to the audit
 - E.g., value in RPMS is 29.5; then .5 is added to get 30.0; then 30 is sent to the audit
 - The resulting value is placed in the following categories:
 - eGFR ≥ 60 mL/min
 - eGFR 30-59 mL/min
 - eGFR 15-29 mL/min
 - eGFR < 15 mL/min
 - Not tested or no valid result
- Also used in the CKD Stage section.
- **Audit Export Field Name and Details:** EGFRVALUE
All characters other than numbers or "." are stripped from the value that is truncated to a total of 5 characters with 1 decimal digit.

D.11.1.59 Quantitative Urine Albumin-to-Creatinine Ratio (UACR) Value

- **Description:** Most recent 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 Section D.10 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 BGP QUANT UACR LOINC taxonomy, if found and the test has a valid numeric result then the result of the test is assigned to UACR value.
 - Result reporting: For the individual Audit, the resulting value is displayed.
- **Audit Report:** Kidney Evaluation section:
 - UACR - normal: <30 mg/g
 - UACR increased: 30-300 mg/g
 - UACR increased: >300 mg/g
 - Not tested or no valid resultAlso used in the CKD Stage section.
- **Audit Export Field Name and Details:** UPACRVAL
 - All non-numeric characters are stripped from the value.

D.11.1.60 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.

D.11.1.61 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.

D.12 Audit Export (Data) File Specifications for 2026

This section includes the IHS Diabetes Care and Outcomes Audit Data File Specifications for 2026.

D.12.1 General Information

1. Data File Format: Delimited text, with the following general requirements.
 - a. Delimiter must be the ^ symbol, not a tab, space, or any other character.
 - b. Line 1 contains the Audit field names in the order they appear below.
 - c. Lines 2 and beyond contain the data, with each line representing a single record/patient.
 - d. All records must contain a value or a placeholder for all fields. If there is no value for a field (because data are missing or due to skip pattern), the placeholder is one blank space between the delimiters (i.e., ^ ^).
2. Data Fields:
 - a. A list of Audit 2026 fields (Table D-4) and basic details/requirements for each is provided on subsequent pages of this document.
 - b. Extracting accurate data for many fields requires additional information, some of which is available in the Audit documentation.
 - c. Other information is specific to the health record system being used and must be determined locally, including documentation of medications and education.
3. Additional Information and Resources
 - a. Audit website: <https://www.ihs.gov/diabetes/audit/>
 - b. Contact the Audit team via email: diabetesaudit@ihs.gov

D.12.2 List of Audit Data Fields

Table D-4: List of fields

Order	Field Name	Description	Timeframe	Format/Values/Units	Comments
1	AUDITDATE	Ending date of the one year Audit period: 12/3/2025 for Annual Audit 2026	N/A	Mm/dd/yyyy	<no date>
2	FACILITYNA	Name or abbreviation for the facility	N/A	Character (max length=20)	For confirmation purposes only, the WebAudit will automatically supply and display the name.
3	REVIEWER	Reviewer's initials	N/A	Character (max length=3)	<no data>
4	STATE	Postal abbreviation for last known state of residence	N/A	Character (max length=2)	Do not populate if patient's address is outside of the US (e.g., in Canada)
5	MOB	Month of birth	N/A	# with value 1-12	<no data>
6	YOB	Year of birth	N/A	yyyy	<no data>
7	SEX	Sex	N/A	# field with: 1=Male 2=Female 3=Unknown	<no data>
8	DODX	Date of diabetes diagnosis	N/A	Mm/dd/yyyy	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.
9	DMTYPE	Diabetes type	N/A	# field with: 1=Type 1 2=Type 2 (or uncertain)	<no data>

Order	Field Name	Description	Timeframe	Format/Values/Units	Comments
10	TOBSCREEN	Screened for tobacco use	Audit period	# field with: 1=Yes 2=No	<no data>
11	TOBACCOUSE	Tobacco use	Audit period	# field with: 1=Yes 2=No	Populate only if TOBSCREEN value is 1=Yes.
12	TOBCOUNSEL	Tobacco cessation counseling/education received	Audit period	# field with: 1=Yes 2=No	Populate only if TOBSCREEN value is 1=Yes and TOBACCO TOBACCOUSE value is 1=Yes.
13	ENDSSCREEN	Screened for electronic nicotine delivery system (ENDS) use during Audit period	Audit period	# field with: 1=Yes 2=No	ENDS include: vapes, vaporizers, vape pens, hookah pens, electronic cigarettes (e-cigarettes or e-cigs), and e-pipes. Limit to nicotine for Audit.
14	ENDSUSE	ENDS use	Audit period	# field with: 1=Yes 2=No	Populate only if ENDSSCREEN value is 1=Yes. ENDS include: vapes, vaporizers, vape pens, hookah pens, electronic cigarettes (e-cigarettes or e-cigs), and e-pipes. Limit to nicotine for Audit
15	FEET	Last recorded height - feet part	Last ever	# with 0 decimal places	If height is provided as feet and inches, be sure to provide a value for both fields: FEET and INCCHES.

Order	Field Name	Description	Timeframe	Format/Values/Units	Comments
16	INCHES	Last recorded height - inches part	Last ever	# with up to 2 decimal places	If height is provided as total in inches only, FEET field should not be populated (i.e., do not submit 0 or any other value). Round to 2 decimal places, if necessary.
17	WEIGHT	Weight in lbs	Most recent in Audit period	# with 0 decimal places	Truncate to nearest whole pound.
18	HTNDX	Hypertension diagnosed	Ever	# field with: 1=Yes 2>No	<no data>
19	SYST1	Most recent systolic blood pressure (mmHg)	Audit period	# with 0 decimal places	<no data>
20	DIAST1	Most recent diastolic blood pressure (mmHg)	Audit period	# with 0 decimal places	<no data>
21	SYST2	Next most recent systolic blood pressure (mmHg)	Audit period	# with 0 decimal places	<no data>
22	DIAST2	Next most recent diastolic blood pressure (mmHg)	Audit period	# with 0 decimal places	<no data>
23	SYST3	Third most recent systolic blood pressure (mmHg)	Audit period	# with 0 decimal places	<no data>
24	DIAST3	Third most recent diastolic blood pressure (mmHg)	Audit period	# with 0 decimal places	<no data>
25	FOOTEXAM	Complete diabetic foot exam including evaluation of sensation and vascular status	Audit period	# field with: 1=yes 2>No	<no data>
26	EYEEEXAM	Dilated retinal exam or retinal imaging exam	Audit period	# field with: 1=Yes 2>No	<no data>

Order	Field Name	Description	Timeframe	Format/Values/Units	Comments
27	DENTALEXAM	Dental exam conducted by a dental professional including examination of teeth and gingiva	Audit period	# field with: 1=Yes 2=No	<no data>
28	DEPSCREEN2	Screened for depression	Audit period	# field with: 1=Yes 2=No	<no data>
29	DEPDX2	Active diagnosis of depression	Audit period	# field with: 1=Yes 2=No	<no data>
30	DIETINSTR	Nutrition education	Audit period	# field with: 1=Yes by RD 2=Yes by non-RD 3=Yes by both RD & non-RD 4=None	<no data>
31	EXERCISE	Physical activity education	Audit period	# field with: 1=Yes 2=No	<no data>
32	DMEDUC	Diabetes education other than nutrition and physical activity	Audit period	# field with: 1=Yes 2=No	<no data>
33	TXNONE	None of the listed diabetes medications prescribed	As of the end of the Audit period	# field with: 1=Yes 2=No	If Value for this field=1:Yes, then all other TX field should=2:No. If all other TX field=2:No, then value for this field should=1:Yes.
34	TXINSUL	Prescribed any insulin	As of the end of the Audit period	# field with: 1=Yes 2=No	<no data>

Order	Field Name	Description	Timeframe	Format/Values/Units	Comments
35	TXMETFORM	Prescribed metformin	As of the end of the Audit period	# field with: 1=Yes 2=No	Includes Glucophage, others
36	TXSUREA	Prescribed a sulfonylurea	As of the end of the Audit period	# field with: 1=Yes 2=No	Includes glipizide, glyburide, glimepiride
37	TXDPP4	Prescribed a DPP-4 inhibitor	As of the end of the audit period	# field with: 1=Yes 2=No	Includes alogliptin (Nesina), linagliptin (Tradjenta), saxagliptin (Onglyza), sitagliptin (Januvia)
38	TXGLP1MED	Prescribed a GLP-1 receptor agonist	As of the end of the audit period	# field with: 1=Yes 2=No	Includes dulaglutide (Trulicity), exenatide (Byetta, Bydureon), liraglutide (Victoza, Saxenda), lixisenatide (Adlyxin), semaglutide (Ozempic, Rybelsus, Wegovy)
39	TXSGLT2	Prescribed an SGLT-2 inhibitor	As of the end of the audit period	# field with: 1=Yes 2=No	Includes bexagliflozin (Brenzavvy), canagliflozin (Invokana), dapagliflozin (Farxiga), empagliflozin (Jardiance), ertugliflozin (Steglatro), sotagliflozin (Inpefa)
40	TXGLIT	Prescribed pioglitazone [Actos] or rosiglitazone [Avandia]	As of the end of the audit period	# field with: 1=Yes 2=No	<no data>
41	TXTIRZEP	Prescribed tirzepatide [Mounjaro, Zepbound]	As of the end of the audit period	# field with: 1=Yes 2=No	<no data>
42	TXACARB	Prescribed acarbose [Precose] or miglitol [Glyset]	As of the end of the audit period	# field with: 1=Yes 2=No	<no data>

Order	Field Name	Description	Timeframe	Format/Values/Units	Comments
43	TXSUREALK	Prescribed repaglinide [Prandin] or nateglinide [Starlix]	As of the end of the Audit period	# field with: 1=Yes 2=No	<no data>
44	TXAMYLIN	Prescribed injectable pramlintide [Symlin]	As of the end of the Audit period	# field with: 1=Yes 2=No	<no data>
45	TXBROMO	Prescribed bromocriptine [Cycloset]	As of the end of the Audit period	# field with: 1=Yes 2=No	<no data>
46	TXCOLESEV	Prescribed colesevelam [Welchol]	As of the end of the Audit period	# field with: 1=Yes 2=No	<no data>
47	ACE	Prescribed an ACE inhibitor or ARB	As of the end of the Audit period	# field with: 1=Yes 2=No	Commonly prescribed medications include: ACE Inhibitors: benazepril (Lotensin), captopril, enalapril (Vasotec, Epaned), fosinopril, lisinopril (Zestril), ramipril (Altace), ARBs: candesartan (Atacand), irbesartan (Avapro), losartan (Cozaar), telmisartan (Micardis), olmesartan (Benicar), valsartan (Diovan, Prexxartan)

Order	Field Name	Description	Timeframe	Format/Values/Units	Comments
48	ASPIRIN	Prescribed aspirin or other antiplatelet/ anticoagulant therapy	As of the end of the Audit period	# field with: 1=Yes 2=No	Commonly prescribed medications include: Antiplatelets: aspirin, aspirin/dipyridamole (Aggrenox), cilostazol (Pletal), clopidogrel (Plavix), prasugrel (Effient), ticagrelor (Brilinta) Anticoagulants: apixaban (Eliquis), dabigatran (Pradaxa), edoxaban (Savaysa), enoxaparin (Lovenox), rivaroxaban (Xarelto), warfarin (Coumadin)
49	LLSTATIN2	Prescribed a statin therapy	As of the end of the Audit period	# field with: 1=Yes 2=No 3=Allergy/intolerance/ contraindications	Look for yes, then allergy or intolerance or contraindication, then no. Commonly prescribed medications include: atorvastatin, fluvastatin, lovastatin, pitavastatin, pravastatin, rosuvastatin, simvastatin
50	CVDDX	Diagnosed cardiovascular disease (CVD)	Ever	# field with: 1=Yes 2=No	Includes coronary artery disease (CAD), hypertensive heart disease, heart failure, cardiomyopathy, heart dysrhythmias, valvular heart disease, stroke, and/or peripheral vascular disease.
51	TBDX	Tuberculosis (TB) diagnosis (latent or active) documented (ever)	Ever	# field with: 1=Yes 2=No	<no data>

Order	Field Name	Description	Timeframe	Format/Values/Units	Comments
52	TBTESTDONE3	Most recent skin (PPD) or blood test for tuberculosis (TB) with valid result	Most recent ever	# field with: 1=Skin test (PPD) 2=Blood test (QFT-GIT, T-SPOT) 3=No test documented	Populate only if TBDX value is 2 =No. If more than one test is documented, use the most recent.
53	TBTESTRSLT2	TB test result	Most recent	# field with: 1=Positive 2=Negative 3=No result documented	Populate only if TBDX value is 2=No and TBTESTDONE3 value is 1=Skin test or 2=Blood test.
54	TBINHTX2		Ever	# field with: 1=Yes 2>No 3=Unknown	Populate only if TBDX value is 1=Yes or (TBDX value is 1=No and TBTESTDONE3 value is 1=Skin test or 2=Blood test and TBTESTRSLT2 value is 1=Positive).
55	TBTESTDATE	Date of last TB Test	Ever	Mm/dd/yyyy	Populate only if TBDX value is 2=No and TBTESTDONE3 value is 1=Skin test or 2=Blood test and TBTESTRSLT2 is 2=Negative. 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.
56	HCVDX	Diagnosed hepatitis C (HCV)	Ever	# field with: 1=Yes 2>No	<no data>

Order	Field Name	Description	Timeframe	Format/Values/Units	Comments
57	HCVSCREEN2	If not diagnosed with HCV, screened for HCV at least once	Ever	# field with: 1=Yes 2=No	Populate only if HCVDX value is 2=No. Screening is performed using the Hepatitis C antibody (anti-HCV) test.
58	RETINOPDX	Diagnosed retinotherapy	Ever	# field with: 1=Yes 2=No	<no data>
59	LEA	Lower extremity amputation, any type (e.g., toe, partial foot, above or below knee)	Ever	# field with: 1=Yes 2=No	<no data>
60	FLUVAX2	Influenza vaccine	Audit period	# field with: 1=Yes 2=No	<no data>
61	PNEUMO	Pneumococcal vaccine (PCV15, PCV20, PCV21 or PPSV23)	Ever	# field with: 1=Yes 2=No	<no data>
62	TD2	Tetanus (Td, Tdap, DTaP, or DT) vaccine	Past 10 years	# field with: 1=Yes 2=No	<no data>
63	TDAP2	Tdap vaccine	Ever	# field with: 1=Yes 2=No	<no data>

Order	Field Name	Description	Timeframe	Format/Values/Units	Comments
64	HEPBVAX2	Hepatitis B complete series	Ever	# field with: 1=Yes 2>No 3=Immune	Either complete 3-dose series or complete 2-dose series counts. [Series is also complete if 3 doses are given – using a combination of a two-dose vaccine with the three-dose vaccines] 3-dose series includes: Engerix-B®, PreHevbrío®, Recombivax HB®, and Twinrix® vaccines. 2-dose series includes: Heplisav-B® vaccine.
65	SHINGLESVAX	Shingrix/recombinant zoster vaccine (RZV) complete series	Ever	# field with: 1=Yes 2>No	Complete series for Shingrix is 2 doses. Note: Zostavax vaccine does not count for this item.
66	RSVVAX	Respiratory syncytial virus (RSV) vaccine	Ever	# field with: 1=Yes 2>No	<no data>
67	HBA1C	HbA1c text result (%)	Most recent in Audit period	# with 1 decimal place	<no data>
68	HBA1CDATE	Date of most recent HbA1c	Most recent in Audit period	Mm/dd/yyyy	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.

Order	Field Name	Description	Timeframe	Format/Values/Units	Comments
69	CHOLVALUE	Total cholesterol value (mg/dL)	Most recent in Audit period	# with 0 decimal places	Round to 0 decimal places, if necessary.
70	HDLVALUE	HDL cholesterol value (mg/dL)	Most recent in Audit period	# with 0 decimal places	Round to 0 decimal places, if necessary.
71	LDLVALUE	LDL cholesterol value (mg/dL)	Most recent in Audit period	# with 0 decimal places	Round to 0 decimal places, if necessary.
72	TRIGVALUE	Triglyceride value (mg/dL)	Most recent in Audit period	# with 0 decimal places	Round to 0 decimal places, if necessary.
73	EGFRVALUE	Estimated GFR (eGFR) value	Most recent in Audit period	# with 1 decimal place	Use documented value, if available. Round to 1 decimal place, if necessary
74	UPACRVAL	Quantitative urine albumin/creatinine ratio (UACR) value (mg/g)	Most recent in Audit period	# with up to 2 decimal places	Round to 2 decimal places, if necessary.
75	LOCAL	Local question	N/A	#, single digit, 1-9	This field may be left blank for all patients if the facility does not choose to populate it.
76	LOCALEXT	Extended local question	N/A	Character (max length=50)	This field may be left blank for all patients if the facility does not choose to populate it.
77	AGE	Patient age in years at time of AUDITDATE	N/A	# 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

D.13 Data Quality Error Report Error Definitions

Table D-5: Error Report Definitions

Error	Definition
REVIEWER INITIALS MISSING	Review initials are missing. IT staff should update the NEW PERSON entry and add initials for the reviewer.
MONTH OF BIRTH NOT VALID	Month of birth is invalid. Check this patient's DOB in patient registration.
YEAR OF BIRTH MISSING	Year of Birth is missing. Check this patient's DOB in patient registration.
AGE LESS THAN 1	Age is less than 1, check DOB and audit date.
AGE OVER 100	Age of the patient is greater than 100. Check to be sure this patient should be included in the audit.
SEX NOT VALID	Sex of patient is missing or is invalid. Check this patient's sex in patient registration.
DATE OF DX MISSING	Date of Diabetes Diagnosis is missing
DATE OF DX BEFORE YOB	Date of Diabetes Diagnosis is before year of birth.
DATE OF DX SAME AS DOB	Date of Diabetes Diagnosis equal to DOB. Check both dates.
DATE OF DX > AUDIT DATE	Date of Diabetes diagnosis is after the audit date.
DATE OF DX =AUDIT DATE	Date of Diabetes Diagnosis is equal to the audit date.
DIABETES TYPE MISSING	Diabetes Type is missing.
DIABETES TYPE - CHECK	Diabetes Type 2 is unusual in young children. Check Diabetes Type is DMTYPE=2 and AGE is less than or equal to 5 yrs.
TOBACCO SCREEN IS MISSING	Tobacco Screen in past year is missing.
TOBACCO SCREEN IS INVALID	Tobacco Screen is invalid, must be 1=Yes, 2=No.
TOBACCO USE IS INVALID	Tobacco Use value is invalid, must be a 1 or 2.
TOBACCO USE IS MISSING	Tobacco Use is missing.
TOBACCO COUNSEL INVALID	Tobacco Use is 1=Yes. Tobacco Counsel Must be 1 or 2; it cannot be blank.
TOBACCO COUNSEL INVALID	Tobacco Use Status is 2=No. Tobacco Counsel should be blank.

Error	Definition
ENDS SCREEN MISSING	ENDS Use Screen in past year is missing.
ENDS SCREEN INVALID	ENDS Screen value is invalid, must be a 1 or 2.
ENDS USE STATUS MISSING	ENDS Use Status is missing.
ENDS USE STATUS INVALID	ENDS Use value is invalid, must be a 1 or 2.
HEIGHT IN FEET LOW FOR AGE >18	Height in feet value is unusually low (less than 4). Check patient's last Height value.
HEIGHT IN FEET LOW FOR AGE <19	Height in feet is unusually low for patient under 19 years old. Value is less than 2, check patient's last height value.
HEIGHT IN FEET HIGH AGE <10	Height Value is high (greater than 5) for patient age under 10. Check the patient's last height value.
HEIGHT IN FEET HIGH FOR AGE <9	Height is high (over 6) for patient under the age of <9. Check the patient's last height value.
HEIGHT INCHES IS <0	Height in inches is blank or less than zero. Check patient's last height value.
HEIGHT INCHES >12, FEET ENTERED	Height in feet is entered, inches cannot be greater than 12.
HEIGHT TOTAL <48 AGE>17	Age of patient is greater than 17 and total height is less than 48 inches. Check the DOB and height value.
HEIGHT TOTAL <24 AGE<18	Age of patient is less than 17 and total height in inches is less than 24 inches. Check the DOB and height value.
HEIGHT TOTAL >60 AGE <10	Age of patient is less than 10 and height in total inches is greater than 60. Check the DOB and height value.
HEIGHT TOTAL >84 AGE >9	Age of patient is greater than 9 and total height is greater than 84. Check the DOB and height value.
HEIGHT IN FEET MISSING	Height in feet is missing, inches is present. Check patient's last height value.
WEIGHT IS NOT A WHOLE NUMBER	Weight in lbs must be a whole number. No decimals.
WEIGHT LESS THAN 80, AGE >17	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.
WEIGHT LESS THAN 50, AGE <18	Weight is less than 50 lbs and patient is under 18 years old. Check the patient's last weight value. If accurate, no action necessary.

Error	Definition
HYPERTENSION DX NOT VALID	Hypertension diagnosed value is not a 1–Yes or a 2–No.
SYSTOLIC 1 VALUE <50 OR >250	Systolic 1 value is less than 50 or greater than 250. Check value and change if necessary.
SYSTOLIC 2 VALUE <50 OR >250	Systolic 2 value is less than 50 or greater than 250. Check value and change if necessary.
SYSTOLIC 3 VALUE <50 OR >250	Systolic 3 value is less than 50 or greater than 250. Check value and change if necessary.
DIASTOLIC 1 <30 OR >140	Diastolic 1 is less than 30 or greater than 140. Check value.
DIASTOLIC 2 <30 OR >140	Diastolic 2 is less than 30 or greater than 140. Check value.
DIASTOLIC 3 <30 OR >140	Diastolic 3 is less than 30 or greater than 140. Check value.
FOOT EXAM NOT VALID	Foot Exam value must be 1 or 2.
EYE EXAM NOT VALID	Eye Exam value must be 1 or 2.
DENTAL EXAM NOT VALID	Dental Exam value must be 1 or 2.
DEPRESSION ACTIVE DIAGNOSIS	Depression Active Diagnosis must be 1 or 2.
DEPRESSION SCREEN NOT VALID	Depression Screen value not valid. Must be blank, 1, or 2.
NUTRITION EDUCATION NOT VALID	Nutrition education does not equal 1, 2, 3, or 4.
PHYSICAL ACTIVITY EDUCATION NOT VALID	Physical Activity Education value must be 1 or 2.
OTHER DIABETES EDUCATION NOT VALID	Other Diabetes Education value must be 1 or 2.
TX NONE IS INVALID	TX None must be 1 or 2.
TX INSULIN NOT VALID	TX insulin must be 1 or 2.
TX INSULIN/DM TYPE 1	Value for this treatment inconsistent with DM Type 1; check medications and DM Type if DM TYPE=1 and TXINSUL=2
TX SULFONYLUREA INVALID	TX Sulfonylurea value must be 1 or 2.
TX SULFONYLUREA/DM TYPE 1	Value for this treatment inconsistent with DM Type 1; check medications and DM Type.
TX SULFONYLUREA LIKE INVALID	TX Sulfonylurea like therapy must be 1 or 2.
TX SULFONYLUREA LIKE/DM TYPE 1	Value for this treatment inconsistent with DM Type 1, check medications and DM Type.
TX METFORMIN INVALID	TX Metformin value must be 1 or 2.

Error	Definition
TX METFORMIN/DM TYPE 1	TX Metformin may be inconsistent with DM Type 1. Check medications and DM Type.
TX ACARBOSE INVALID	TX Acarbose must be 1 or 2.
TX ACARBOSE/DM TYPE 1	TX Acarbose inconsistent with DM Type 1. Check medications and DM Type.
TX GLITAZONE INVALID	TX Glitazone must be 1 or 2.
TX GLITAZONE/DM TYPE 1	TX Glitazone therapy inconsistent with DM Type 1. Check the patient's medications and DM Type.
TX GLP-1 INVALID	TX GLP-1 value must be 1 or 2.
TX GLP-1/DM TYPE 1	TX GLP-1 may be inconsistent with DM Type 1. Check the patient's medications and DM Type.
TX DPP-4 INVALID	TX DPP4 must be 1 or 2.
TX DPP-4/DM TYPE 1	TX DPP4 inconsistent with DM Type 1. Check the patient's medications and DM Type.
TX AMYLIN INVALID	TX Amylin must be 1 or 2.
TX BROMO INVALID	TX Bromocriptine must be 1 or 2.
TX BROMO/DM TYPE 1	Tx Bromocriptine therapy inconsistent with DM Type 1. Check the patient's medications and DM Type.
TX COLESEV INVALID	TX Colesevelam must be 1 or 2.
TX COLESEV/DM TYPE 1	TX Colesevelam therapy inconsistent with DM Type 1. Check the patient's medications and DM Type.
TX SLGT2 INVALID	TX SGLT2 must be 1 or 2.
TX SLGT2/DM TYPE 1	TX SLGT2 inhibitor therapy may be inconsistent with DM Type 1. Check the patient's medication and DM Type.
TX TIRZEP INVALID	TX TIRZEP must be 1 or 2.
TX TIRZEP/DM TYPE 1	TX TIRZEP inconsistent with DM Type 1. Check the patient's medications and DM Type.
ACE INHIBITOR INVALID	ACE Inhibitor value must be 1 or 2.
ASPIRIN INVALID	Aspirin value must be 1 or 2.
CVD DX INVALID	CVD Dx value must be 1 or 2.
TB DIAGNOSIS INVALID	TB Diagnosis must be 1 or 2.
TB TEST DONE INVALID	TB Test Done must be 1, 2, or 3.
TB DIAGNOSIS/TB TEST DONE INCONSISTENT	TB Test Done must be blank if the TB Diagnosis value is 1-Yes.

Error	Definition
TB TEST RESULT INVALID	TB Test Result must be 1, 2, or 3.
TB RESULT/TB TEST INCONSISTENT	TB Test Result must be blank if the TB Test Done value is 3-No test documented.
TB TX/TB TEST RESULT	If TB Diagnosis is 1-Yes or TB Test result is 1-Positive, TB Treatment must not be blank.
TB TX/TB TEST NEGATIVE	If TB Diagnosis is not 1-Yes or TB Test Result is not 1-Positive, TB Treatment must be blank.
TB TX INVALID	TB Treatment must be a value of 1, 2, 3, or blank.
TB TEST DATE < YOB	Date of TB Test is earlier than year of birth.
TB TEST DATE > AUDIT DATE	Date of TB Test is after audit date.
TB TEST DATE/TB TEST RESULT	TB Test date should be blank if TB Test Result is not 2-Negative.
TB TEST RESULT/TB TEST DATE	TB Test date should not be blank if TB Test Result is 2.
HEPATITIS C DX INVALID	Hepatitis C Diagnosis must be 1 or 2.
HEPATITIS C SCREEN INVALID	Hepatitis C Screen must be 1 or 2.
RETINOPATHY INVALID	Retinopathy Diagnosis must be 1 or 2.
LEA INVALID	Lower extremity amputation (LEA) must be 1 or 2.
FLU VACCINE INVALID	Flu vaccine value must be 1 or 2.
PNEUMOCOCCAL VACCINE INVALID	Pneumococcal vaccine value must be 1 or 2.
TD2 INVALID	TD value must be 1 or 2.
TDAP INVALID	TDAP value must be 1 or 2.
SHINGLES VACCINE INVALID	Shingles vaccine value must be 1 or 2.
HEP B VACCINE INVALID	Hepatitis B Vaccine value must be 1, 2, or 3.
RSV VACCINE INVALID	Respiratory syncytial virus vaccine value must be 1 or 2.
HBA1C TEST RESULT <4 OR >18	HbA1c value is less than 4 or greater than 18; check value and if accurate no action necessary.
HBA1C DATE > AUDIT DATE	Date of HbA1c is after the audit date.
HBA1C BEFORE AUDIT BEGIN DATE	HbA1c date is before audit begin date.
HBA1C DATE < YOB	HbA1c date is before year of birth.
HBA1C DATE >20 DAYS BEFORE DOO	HbA1c date is more than 20 days prior to the date of onset. Check both values; if they are accurate no action is necessary.

Error	Definition
TOTAL CHOLESTEROL <70 OR >500	Total Cholesterol Value is less than 70 or greater than 500. Check the value; if accurate no action necessary.
HDL VALUE <12 OR >140	HDL Value is less than 12 or greater than 140. Check the value; if accurate no action necessary.
HDL > TOTAL CHOLESTEROL	HDL value is greater than the Total Cholesterol value. Check both values; if accurate, no action necessary.
LDL VALUE <10 OR >300	LDL value is less than 10 or greater than 300. Check the value; if accurate, no action necessary.
LDL > TOTAL CHOLESTEROL	LDL value is greater than the Total Cholesterol. Check both values; if accurate, no action necessary.
TRIGLYCERIDE <25 OR >4000	Triglyceride value is less than 25 or greater than 4000. Check the value; if accurate, no action necessary.
EGFR VALUE <5 OR >250	eGFR value is less than 5 or greater than 250. Check the value; if accurate, no action necessary.
QUANTITATIVE UACR VALUE > 20,000	Quantitative urine albumin creatinine value is greater than 20,000. Check the value; if accurate, no action necessary.
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.
DURATION OF DM	Duration of Diabetes is less than zero or greater than the patient's age.
ALL KEY DATA MISSING	Data is missing for all key fields: weight, blood pressure, A1C, LDL, UACR.

D.14 Sample Audit Report

Figure D-50 displays a sample Audit Report over several pages.

LAB	Jan 21, 2026	Page 1
IHS Diabetes Care and Outcomes Audit - RPMS Audit Audit Report for 2026 (Audit Period 01/01/2025 to 12/31/2025) Facility: DEMO HOSPITAL (INST) Annual Audit 959 patients were audited Unless otherwise specified, time period for each item is the 12-month Audit		

Period	# of Patients	# Considered	Percent		
	(Numerator)	(Denominator)			
*** NOTE: 10 Patients were not included in this report because their date of onset was after the Audit period end date.					
Sex					
Male	389	959	41%		
Female	570	959	59%		
Unknown	0	959	0%		
Age					
<20 years	36	959	4%		
20-44 years	144	959	15%		
45-64 years	402	959	42%		
=65 years	377	959	39%		
Diabetes Type					
Type 1	34	959	4%		
Type 2	925	959	96%		
Duration of Diabetes					
<1 year	5	959	1%		
<10 years	79	959	8%		
=10 years	506	959	53%		
Diagnosis date not recorded	374	959	39%		
Body Mass Index (BMI) Category					
Normal (BMI<25.0)	53	959	6%		
Overweight (BMI 25.0-29.9)	123	959	13%		
Obese (BMI >=30.0)	398	959	42%		
Height or weight missing	385	959	40%		
Severely obese (BMI >=40.0)	121	959	13%		
Blood Sugar Control					
A1C <7.0	126	959	13%		
A1C 7.0-7.9	87	959	9%		
A1C 8.0-8.9	68	959	7%		
A1C 9.0-9.9	55	959	6%		
A1C 10.0-10.9	40	959	4%		
A1C >=11.0	100	959	10%		
Not tested or no valid result	483	959	50%		
A1C <8.0	213	959	22%		
A1C >9.0	189	959	20%		
LAB	Jan 21, 2026		Page 2		
IHS Diabetes Care and Outcomes Audit - RPMS Audit					
Audit Report for 2026 (Audit Period 01/01/2025 to 12/31/2025)					
Facility: DEMO HOSPITAL (INST)					
Annual Audit					
959 patients were audited					
Unless otherwise specified, time period for each item is the 12-month Audit Period					

	# of Patients	# Considered	Percent		
	(Numerator)	(Denominator)			
Blood Pressure (BP) - Based on one value or mean of two or three values					
<130/<80	266	959	28%		
130/80 - <140/<90	162	959	17%		
140/90 - <160/<100	115	959	12%		
160/100 or higher	31	959	3%		
BP category undetermined	385	959	40%		

<140/<90	428	959	45%		
Hypertension					
Diagnosed ever	712	959	74%		
Diagnosed hypertension and mean BP <130/<80	232	712	33%		
Diagnosed hypertension and mean BP <140/<90	378	712	53%		
Diagnosed hypertension and ACE inhibitor or ARB currently prescribed.	392	712	55%		
Tobacco and Nicotine Use					
Tobacco use					
Screened	514	959	54%		
If screened, user	93	514	18%		
If user, counseled	55	93	59%		
Electronic nicotine delivery system (ENDS) use					
Screened	0	959	0%		
If screened, user	0	0	0%		

User of both tobacco and ENDS*	0	0	0%		
User of tobacco and/or ENDS*	0	0	0%		
*Excludes patients not screened for both tobacco and ENDS use					
LAB	Jan 21, 2026		Page 3		
IHS Diabetes Care and Outcomes Audit - RPMS Audit					
Audit Report for 2026 (Audit Period 01/01/2025 to 12/31/2025)					
Facility: DEMO HOSPITAL (INST)					
Annual Audit					
959 patients were audited					
Unless otherwise specified, time period for each item is the 12-month Audit Period					

	# of Patients	# Considered	Percent		
	(Numerator)	(Denominator)			
Diabetes Treatment					
Number of diabetes meds currently prescribed					
None	523	959	55%		
One medication	154	959	16%		
Two medications	109	959	11%		
Three medications	104	959	11%		
Four or more medications	69	959	7%		
Diabetes meds currently prescribed, alone or in combination					
Insulin	331	959	35%		

Metformin [Glucophage, others]	261	959	27%	
Sulfonylurea [glipizide, glyburide, others]	231	959	24%	
DPP-4 inhibitor [alogliptin (Nesina), linagliptin (Tradjenta), saxagliptin (Onglyza), sitagliptin (Januvia)]	134	959	14%	
GLP-1 receptor agonist [dulaglutide (Trulicity), exenatide (Byetta, Bydureon), liraglutide (Victoza, Saxenda), lixisenatide (Adlyxin), semaglutide (Ozempic, Rybelsus, Wegovy)]	3	959	0%	
SGLT-2 inhibitor [bexagliflozin (Brenzavvy), canagliflozin, (Invokana), dapagliflozin (Farxiga), empagliflozin (Jardiance), ertugliflozin (Steglatro), sotagliflozin (Inpefa)]	0	959	0%	
Pioglitazone [Actos] or rosiglitazone [Avandia]	0	959	0%	
Tirzepatide [Mounjaro, Zepbound]	0	959	0%	
Acarbose [Precose] or miglitol [Glyset]	2	959	0%	
Repaglinide [Prandin] or nateglinide [Starlix]	0	959	0%	
Pramlintide [Symlin]	0	959	0%	
Bromocriptine [Cycloset]	0	959	0%	
Colesevelam [Welchol]	0	959	0%	
LAB	Jan 21, 2026		Page 4	
IHS Diabetes Care and Outcomes Audit - RPMS Audit Audit Report for 2026 (Audit Period 01/01/2025 to 12/31/2025) Facility: DEMO HOSPITAL (INST) Annual Audit 959 patients were audited Unless otherwise specified, time period for each item is the 12-month Audit Period				
	# of Patients	# Considered (Numerator)	Percent	
Statin Prescribed (Currently)				
Yes*	216	929	23%	
Allergy, intolerance, or contraindication	30	959	3%	
In patients with diagnosed CVD				
Yes*	127	371	34%	
Allergy, intolerance, or contraindication	21	392	5%	

In patients age 40-75 years			
Yes*	176	659	27%
Allergy, intolerance, or contraindication	19	678	3%
In patients with diagnosed CVD and/or age 40-75 years			
Yes*	205	774	26%
Allergy, intolerance, or contraindication	25	799	3%
*Denominator excludes patients with an allergy, intolerance, or contraindication.			
Cardiovascular Disease (CVD)			
CVD diagnosed ever	392	959	41%
CVD and mean BP <130/<80	129	392	33%
CVD and mean BP <140/<90	202	392	52%
CVD and not tobacco user*	223	270	83%
*Excludes patients not screened for tobacco use			
CVD and aspirin or other antiplatelet/anticoagulant therapy currently prescribed	216	392	55%
CVD and GLP-1 receptor agonist currently prescribed	1	392	0%
CVD and SGLT-2 inhibitor currently prescribed	0	392	0%
CVD and GLP-1 receptor agonist and/or SGLT-2 inhibitor currently prescribed	1	392	0%
CVD and statin currently prescribed*	127	371	34%
*Denominator excludes patients with an allergy, intolerance, or contraindication.			

LAB

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IHS Diabetes Care and Outcomes Audit - RPMS Audit
 Audit Report for 2026 (Audit Period 01/01/2025 to 12/31/2025)
 Facility: DEMO HOSPITAL (INST)
 Annual Audit
 959 patients were audited
 Unless otherwise specified, time period for each item is the 12-month Audit Period

	# of Patients	# Considered (Numerator)	Percent (Denominator)
Retinopathy			
Diagnosed ever	0	959	0%
Lower Extremity Amputation			
Any type ever (e.g., toe, partial foot, above or below knee)	58	959	6%
Exams			
Foot exam - comprehensive or complete	191	959	20%
Eye exam - dilated exam or retinal imaging	287	959	30%
Dental exam	240	959	25%
Diabetes-Related Education			
Nutrition - by any provider (RD and/or other)	286	959	30%
Nutrition - by RD	154	959	16%
Physical activity	202	959	21%

Other diabetes education	438	959	46%		

Any of above	472	959	49%		
Immunizations					
Influenza vaccine during Audit period	364	959	38%		
Pneumococcal vaccine (PCV15, PCV20, PCV21 or PPSV23) - ever	626	959	65%		
Td/Tdap/DTap/DT - past 10 years	642	959	67%		
Tdap - ever	533	959	56%		
If not immune, hepatitis B complete series - ever	493	955	52%		
Immune - hepatitis B	4	959	0%		
Hepatitis B complete series ever or immune to hepatitis B	497	959	52%		
In patients age >=50 years	110	700	16%		
Shingrix/recombinant zoster vaccine (RZV) series - ever					
In patients age >=50 years at increased risk Respiratory syncytial virus (RSV) vaccine - ever	60	700	9%		
Depression					
Screened during Audit period	474	959	49%		
Active diagnosis during Audit period	0	959	0%		
Screened and/or active diagnosis during Audit period	474	959	49%		

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IHS Diabetes Care and Outcomes Audit - RPMS Audit					
Audit Report for 2026 (Audit Period 01/01/2025 to 12/31/2025)					
Facility: DEMO HOSPITAL (INST)					
Annual Audit					
959 patients were audited					
Unless otherwise specified, time period for each item is the 12-month Audit Period					
# of Patients # Considered Percent					
(Numerator) (Denominator)					

Lipid Evaluation - Note these results are presented as population level CVD risk markers and should not be considered treatment targets for individual patients.					
LDL cholesterol	374	959	39%		
LDL <100 mg/dL	277	959	29%		
LDL 100-189 mg/dL	96	959	10%		
LDL >=190 mg/dL	1	959	0%		
Not tested or no valid result	585	959	61%		
HDL cholesterol	377	959	39%		
In females					
HDL <50 mg/dL	118	570	21%		
HDL >=50 mg/dL	108	570	19%		
Not tested or no valid result	344	570	60%		
In males					
HDL <40 mg/dL	67	389	17%		
HDL >=40 mg/dL	84	389	22%		
Not tested or no valid result	238	389	61%		

Triglycerides [1]	377	959	39%
Trig <150 mg/dL	200	959	21%
Trig 150-499 mg/dL	165	959	17%
Trig 500-999 mg/dL	12	959	1%
Trig >=1000 mg/dL	0	959	0%
Not tested or no valid result	582	959	61%
Kidney Evaluation			
Estimated Glomerular Filtration Rate (eGFR) to assess kidney function (In age >=18 years)	499	928	54%
eGFR >=60 mL/min	334	928	36%
eGFR 30-59 mL/min	108	928	12%
eGFR 15-29 mL/min	23	928	2%
eGFR < 15 mL/min	34	928	4%
eGFR Not tested or no valid result	429	928	46%
LAB	Jan 21, 2026	Page 7	
IHS Diabetes Care and Outcomes Audit - RPMS Audit			
Audit Report for 2026 (Audit Period 01/01/2025 to 12/31/2025)			
Facility: DEMO HOSPITAL (INST)			
Annual Audit			
959 patients were audited			
Unless otherwise specified, time period for each item is the 12-month Audit Period			
	# of Patients	# Considered (Numerator)	Percent (Denominator)
Quantitative Urine Albumin-to-Creatinine Ratio (UACR) to assess kidney damage	238	959	25%
UACR - normal: <30 mg/g	124	238	52%
UACR increased:			
30-300 mg/g	88	238	37%
>300 mg/g	26	238	11%
Not tested or no valid result	721	959	75%
In patients age >=18 years, eGFR and UACR	231	928	25%
Chronic Kidney Disease (CKD) (In age >=18 years)			
CKD [2]	242	928	26%
CKD [2] and mean BP <130/<80	104	242	43%
CKD [2] and mean BP <140/<90	168	242	69%
CKD [2] and ACE inhibitor or ARB currently prescribed	174	242	72%
CKD [2] and GLP-1 receptor agonist currently prescribed	1	242	0%
CKD [2] and SGLT-2 inhibitor currently prescribed	0	242	0%
CKD [2] and GLP-1 receptor agonist and/or SGLT-2 inhibitor currently prescribed	1	242	0%
CKD Stage			
Normal: eGFR >=60 mL/min and UACR <30 mg/g	94	928	10%
Stages 1 and 2: eGFR >=60 mL/min and UACR >=30 mg/g	77	928	8%
Stage 3: eGFR 30-59 mL/min	108	928	12%

Stage 4: eGFR 15-29 mL/min	23	928	2%
Stage 5: eGFR <15 mL/min	34	928	4%
Undetermined	592	928	64%
Tuberculosis (TB) Status			
TB diagnosis documented ever and/or positive test result ever	58	959	6%
If not diagnosed, TB test done ever (skin test or blood test)	523	927	56%
TB test done ever or TB diagnosed ever	555	959	58%
If TB diagnosis documented and/or positive test result, treatment initiated ever	8	58	14%
If most recent TB test result was negative, was test done after diabetes diagnosis	245	356	69%
LAB	Jan 21, 2026	Page 8	
IHS Diabetes Care and Outcomes Audit - RPMS Audit			
Audit Report for 2026 (Audit Period 01/01/2025 to 12/31/2025)			
Facility: DEMO HOSPITAL (INST)			
Annual Audit			
959 patients were audited			
Unless otherwise specified, time period for each item is the 12-month Audit Period			
	# of Patients	# Considered	Percent
	(Numerator)	(Denominator)	
Hepatitis C (HCV)			
Diagnosed HCV ever	27	959	3%
In patients not diagnosed with HCV and age \geq 18 years, screened ever	181	901	20%
In age \geq 18 years, screened for HCV ever or HCV diagnosed ever	208	928	22%
Combined Outcome Measure			
Patients age \geq 40 years meeting ALL of the following criteria: A1C <8.0 , Statin currently prescribed* and mean BP $<130/<80$	37	810	5%
*Denominator excludes patients with a statin allergy, intolerance, or contraindication			
Diabetes Related Conditions (In age \geq18 years)			
Severely obese (BMI \geq 40)	119	928	13%
Hypertension diagnosed ever	700	928	75%
CVD diagnosed ever	380	928	41%
Retinopathy diagnosed ever	0	928	0%
Lower extremity amputation ever (any type (e.g., toe, partial foot, above or below knee)	57	928	6%
Active depression diagnosis during Audit period	0	928	0%
CKD stage 3-5	165	928	18%
Number of diabetes related conditions			
Diabetes only	189	928	20%

Diabetes plus:				
One	282	928	30%	
Two	281	928	30%	
Three	133	928	14%	
Four	37	928	4%	
Five or more	6	928	1%	

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 Quantitative UACR >=30

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IHS Diabetes Care and Outcomes Audit - RPMS Audit
 Audit Report for 2026 (Audit Period 01/01/2025 to 12/31/2025)
 Facility: DEMO HOSPITAL (INST)

Annual Audit

959 patients were audited

Unless otherwise specified, time period for each item is the 12-month Audit Period

# of Patients	# Considered	Percent
(Numerator)	(Denominator)	

Abbreviations

A1C = hemoglobin A1c (HbA1c)
 ACE inhibitor = angiotensin converting enzyme inhibitor
 ARB = angiotensin receptor blocker
 BMI = body mass index
 BP = blood pressure
 DPP-4 inhibitor = dipeptidyl peptidase 4 inhibitor
 DT = diphtheria and tetanus
 DTaP = diphtheria, tetanus, and acellular pertussis
 CKD = chronic kidney disease
 CVD = cardiovascular disease
 eGFR = estimated glomerular filtration rate
 ENDS = electronic nicotine delivery systems
 GLP-1 receptor agonist = glucagon-like peptide-1 receptor agonist
 HCV = hepatitis C virus
 HDL = high-density lipoprotein
 LDL = low-density lipoprotein
 RD = registered dietitian
 SGLT-2 inhibitor = sodium-glucose co-transporter-2 inhibitor
 TB = tuberculosis
 Td = tetanus and diphtheria
 Tdap = tetanus, diphtheria, and acellular pertussis
 Trig = triglycerides
 UACR = urine albumin-to-creatinine ratio

Figure D-50: Sample Cumulative Audit Report

Appendix E Prediabetes Register and Reports

The **IHS Prediabetes Register** is a tool for maintaining a list of patients with prediabetes. This register is designed to be used in the **Diabetes Management System (DMS)** under **Register Maintenance (RM)**. A **Prediabetes Menu** has been added to the **DMS** v2.0 p17.

The **Prediabetes Menu** (Figure E-1) displays access to the Prediabetes Register and Reports.

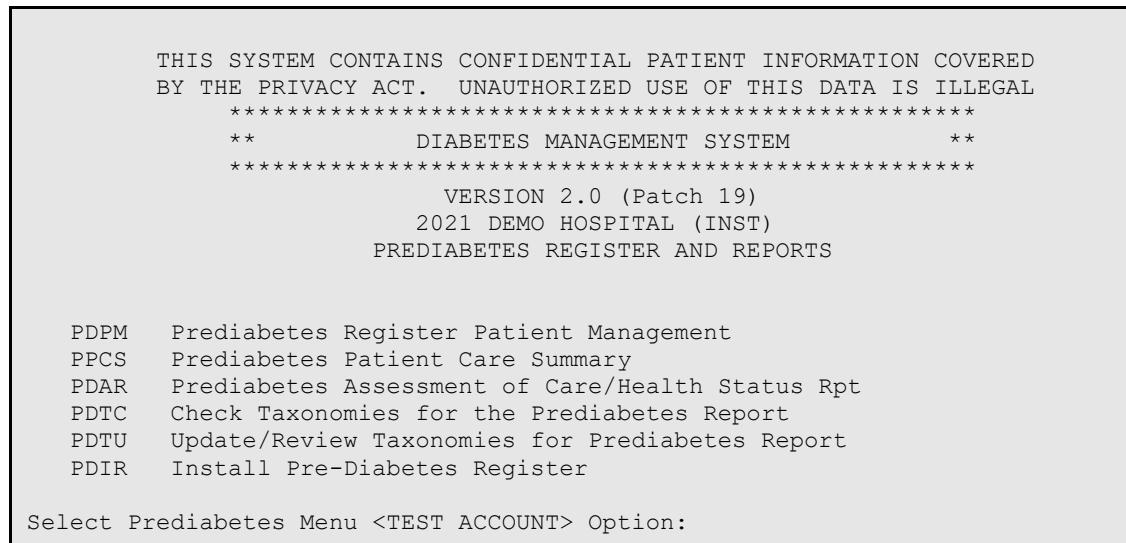


Figure E-1: Prediabetes Menu

E.1 Prediabetes Menu Items

The **Prediabetes Menu** items described in this section include:

- Installation of the Prediabetes Register
- Prediabetes Patient Care Summary
- Assessment of Prediabetes Care (individual report)
- Prediabetes Health Care Status (cumulative report)
- Prediabetes Report Taxonomies

To access the **Prediabetes Menu**, select **Prediabetes Register (PDM)** (Figure E-2) on the **DMS** main menu.



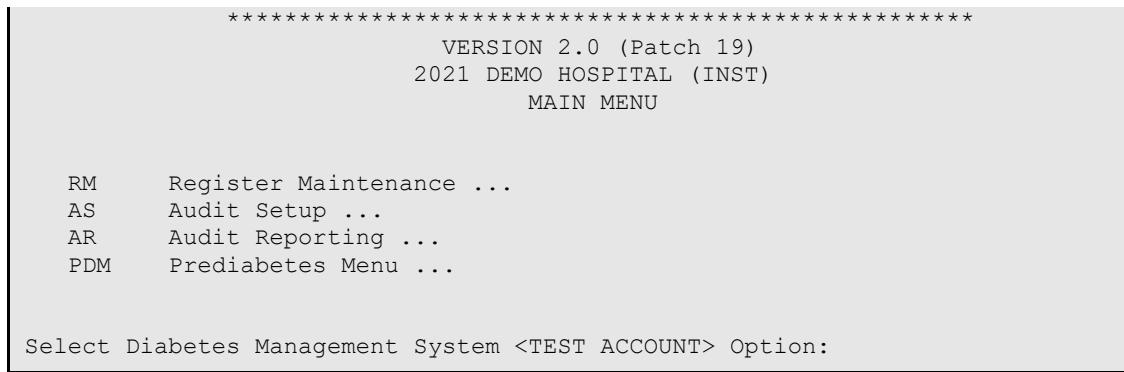


Figure E-2: Selecting the PDM option

E.1.1 Installation of the IHS Prediabetes Register

The **IHS Prediabetes Register** can be installed through **DMS** using the **Install Prediabetes Register (PDIR)** option on the **Prediabetes Menu** (Figure E-3).

The **IHS Prediabetes Register** uses the same functionalities described for the **IHS Diabetes Register**.

If a **Prediabetes Register** already exists, the user is provided with directions on how to update the existing Register with the IHS standards. It provides a core set of data items with predefined lists and standard definitions. It also permits you to establish your own lists and definitions in support of these data items. The **IHS Prediabetes Register** helps simplify the process of creating a Case Management-based register, but you are in no way limited to this core set of data items and the lists that accompany them. Remember that you always have access to all existing PCC demographic and clinical data without keeping these items in the **Diabetes Register**.

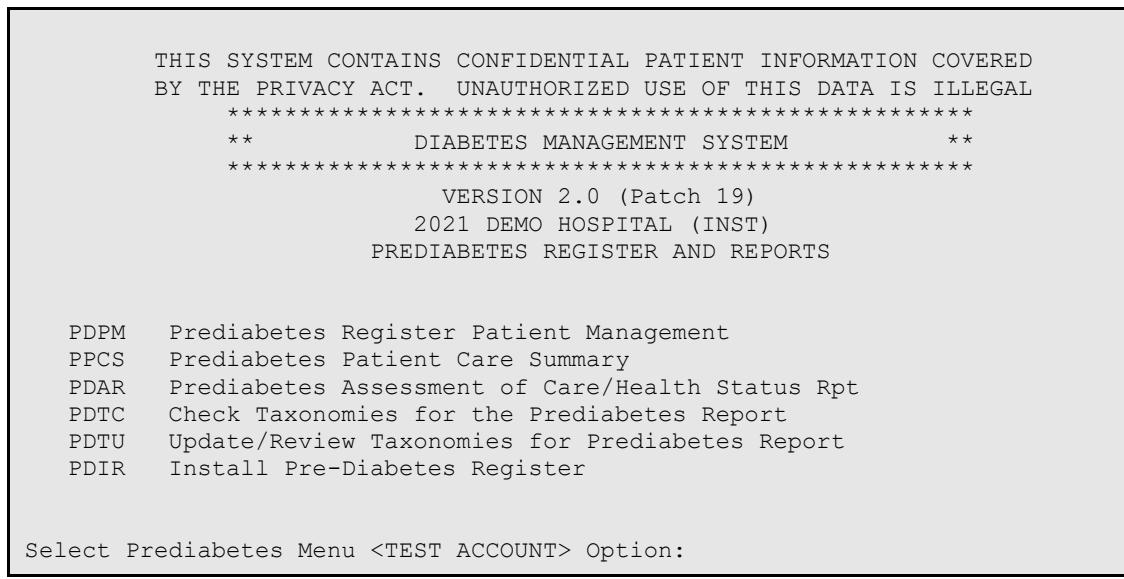


Figure E-3: Prediabetes Menu

Once the **IHS Prediabetes Register** (Figure E-4) is installed it becomes available to use in **DMS–Register Maintenance**. Once installed it cannot be installed again.

Select DIABETES Register		# Active	# members	Last patient member
No.	Register Name			
update				
1	IHS DIABETES	558	561	09/27/2023
2	IHS PRE-DIABETES	130	130	10/02/2023
3	2024 DIABETES REGISTER	35	36	09/15/2023
4	DEMO DIABETES REGISTER	1,002	1,013	06/07/2022
5	SDPI NON DIABETES	158	158	10/04/2018

Which REGISTER: (1-5):

Figure E-4: Prediabetes Register

Note: To Add Authorized Users for the IHS Prediabetes Register go to Register Management Menu, then User Setup (US). See Section 4.0.

E.2 Prediabetes Patient Care Summary (PPCS)

The **Prediabetes Patient Care Summary** was updated in BDM v2.0 p17. It must be added under health summary maintenance as a supplement type to any health summaries that are routinely used at your health care facility.

Printing of this supplement is triggered by a diagnosis of **Prediabetes, Impaired Fasting Glucose, or Impaired Glucose Tolerance** on the active problem list or made by a primary care provider in the past year. It will not print if the patient has a diagnosis of diabetes on the active problem list or a primary provider has used a diagnosis of diabetes in the past year as a purpose of visit.

This summary was designed as a tool for displaying data items that are important in following patients who may be predisposed to developing diabetes. An example of a **Prediabetes Patient Care Summary** is provided in Figure E-5.

***** CONFIDENTIAL PATIENT INFORMATION [LAB] Jan 03, 2026 *****	
PREDIABETES PATIENT CARE SUMMARY Report Date: Jan 03, 2026	
Patient: DEMO, ALTON CHARLES	HRN: 142692
Age: 29 (DOB 11/23/1993)	Sex: MALE
CLASS/BEN: INDIAN/ALASKA NATIVE	Designated PCP: NURSE, BARBARA A R N
Diagnosis	
Problem List (Date of Diagnosis)	
Impaired Fasting Glucose	(Date of Onset not recorded)
Prediabetes	(Feb 01, 2023)

Diagnosis first recorded in PCC (Used as POV):		
Impaired Fasting Glucose Mar 02, 2020		
Prediabetes Aug 04, 2023		
BMI: 27.1 Last Height: 72.00 inches 08/04/2025		
Last Weight: 200 lbs 08/04/2025		
Tobacco Use:		
Last Screened: 08/04/2023		
Current Status: Current user CURRENT SMOKER, SOME DAY 08/04/2025		
Tobacco cessation counseling/education received in the past year:		
Yes 08/04/2025 TO-QT		
HTN Diagnosed ever: No		
Last 3 BP: 120/76 08/04/2025		
(non ER) 130/88 12/05/2023		
108/65 05/01/2023		
Statin prescribed (in past 6 months): No		
Laboratory Results (most recent):		
A1C: 6.2 % 08/04/2025 HEMOGLOBIN A1C		
Next most recent A1C: 5.6 % 03/02/2020 HEMOGLOBIN A1C		
Last Fasting Glucose: 110 mg/dL 08/04/2025 GLUCOSE (CCDA)		
Last 75 GM 2 hour Glucose: 150 08/04/2025 SQL Glucose, Imp.GTT.2 Hr		
Quantitative UACR: 15 mg/g 08/04/2025 ..ALBUMIN/CREATININE RATIO		
Total Cholesterol: 200 mg/dL 08/04/2025 CHOLESTEROL (POCT)		
LDL Cholesterol: 90 mg/dL 08/04/2025 LDL CHOLESTEROL (POCT)		
HDL Cholesterol: 50 mg/dL 08/04/2025 HDL CHOLESTEROL (POCT)		
Triglycerides: 300 mg/dL 08/04/2025 TRIGLYCERIDE (POCT)		
Education Provided (in past yr):		
Last Dietitian Visit (ever):		
DM-DISEASE PROCESS 09/27/2025		
DM-MEDICAL NUTRITION THERAPY 12/05/2025 NURSE, RENEE		
DM-NUTRITION 09/27/2025		
DEMO, ALTON CHARLES		DOB: 11/23/1993
Chart #TST 12345		

Figure E-5: Prediabetes Patient Care Summary

E.3 Prediabetes Assessment of Care and Health Status Reports

Prediabetes Reports can be generated for an individual patient, a template of patients, the entire **IHS Prediabetes Register** at a facility, or for a random sample of patients from the Register. The **Prediabetes Assessment of Care** (individual report) and the **Prediabetes Health Status Report** (cumulative) are modeled after the Diabetes Audit reports.

E.4 Prediabetes Assessment of Care–Individual Report

The **Prediabetes Assessment of Care (PDAR)** (Figure E-6) provides a report for individual patients during a 12-month reporting period.

This report will display all diagnoses documented in the **Prediabetes Register** for this patient. The date of onset recorded will also be displayed.

In addition, the system searches for a diagnosis of diabetes on the problem list and in the purpose of visits recorded for the patient. If a diagnosis is found, it is displayed along with the date of the diagnosis.

IHS Prediabetes Assessment of Care, 2026	DATE RUN: 01/20/2026	Page: 1
Report Period Ending Date: 12/31/2025		
Reviewer initials: LAB	Facility Name: 2021 DEMO HOSPITAL (INST)	
State of Residence: NM	Community: RIVERSIDE	
Chart #: 142692		
DOB: 11/23/1993	Sex: MALE	
Primary Care Provider: NURSE, BARBARA A R N		
Diagnosis		
Problem List (Date of Diagnosis)		
Impaired Fasting Glucose	(Date of Onset not recorded)	
Prediabetes	(Feb 01, 2023)	
Diagnosis first recorded in PCC (Used as POV):		
Impaired Fasting Glucose	Mar 02, 2020	
Prediabetes	Aug 04, 2023	
Tobacco/Nicotine Use (during Report period)		
Screened for tobacco use: 1	Yes	
If screened, tobacco user: 1	Yes CURRENT SMOKER, SOME DAY 08/04/2025	
If screened and current user, tobacco cessation counseling/education received: 1	Yes 08/04/2025 TO-QT	
Vital Statistics		
Height (last ever): 72.00 inches	08/04/2025	
Weight (last in Report period): 200 lbs	08/04/2025	BMI: 27.1
Hypertension (documented diagnosis ever): No		
Blood pressure (last 3 during Report period): 120/76 mm Hg 08/04/2025		
Education (during Report period)		
Nutrition:	Yes (Non RD) NRD: DM-N 09/27/2025	
Physical activity:	No	
Other education:	Yes DM-DP 09/27/2025	
Medication Therapy prescribed (as of the end of the Report period):		
X 1	None of the following	
2	Metformin [Glucophage, others]	
3	SGLT-2 inhibitor [bexagliflozin (Brenzavvy), canagliflozin (Invokana), dapagliflozin (Farxiga), empagliflozin (Jardiance), ertugliflozin (Steglatro), sotagliflozin (Inpefa)]	
4	GLP-1 receptor agonist [dulaglutide (Trulicity), exenatide (Byetta, Bydureon), liraglutide (Victoza, Saxenda), lixisenatide (Adlyxin),	

semaglutide (Ozempic, Rybelsus, Wegovy)]
 5 Tirzepatide [Mounjaro, Zepbound]
 6 Pioglitazone [Actos] or rosiglitazone [Avandia]
 7 Acarbose [Precose] or miglitol [Glyset]

Statin Therapy

Prescribed (as of the end of the Report period): 2 No

IHS Assessment of Prediabetes Care, 2026 DATE RUN: 01/20/2026 Page: 2
 Audit Period Ending Date: 12/31/2025
 CHART #: 142692 DOB: Nov 23, 1993 SEX: MALE

Laboratory Data (most recent result during Report period)

A1C:	6.2 %	08/04/2025	HEMOGLOBIN A1C
Next most recent A1C:	5.6 %	03/02/2025	HEMOGLOBIN A1C
Fasting Glucose:	110 mg/dl	08/04/2025	GLUCOSE (CCDA)
75 Gm 2 hour Glucose:	150 mg/dl	08/04/2025	SQL Glucose, Imp.GT
Total Cholesterol:	200 mg/dL	08/04/2025	CHOLESTEROL (POCT)
LDL Cholesterol:	90 mg/dL	08/04/2025	LDL CHOLESTEROL (PO)
HDL Cholesterol:	50 mg/dL	08/04/2025	HDL CHOLESTEROL (PO)
Triglycerides:	300 mg/dL	08/04/2025	TRIGLYCERIDE (POCT)
Quantitative UACR:	15 mg/g	08/04/2025	..ALBUMIN/CREATININ

Local Questions

Select one:

Text:

Figure E-6: Prediabetes Assessment of Care

E.5 Prediabetes Health Status Report—Cumulative Report

The **Prediabetes Health Status Report (PDAR)** (Figure E-7) provides a cumulative report for a template of patients, an entire Prediabetes Register, or a random sample of patients from the Register during a 12-month reporting period.

LAB	Jan 03, 2026	Page 1																																				
*** PREDIABETES HEALTH STATUS OF PATIENTS - RPMS *** (Report Period: Jan 01, 2025 to Dec 31, 2025) 2021 DEMO HOSPITAL (INST)																																						
127 patients were reviewed Unless otherwise specified, time period for each item is the 12-month Audit Period																																						
<hr/> <table> <thead> <tr> <th></th> <th># of Patients</th> <th># Considered (Numerator)</th> <th>Percent</th> </tr> </thead> <tbody> <tr> <td>Sex</td> <td></td> <td></td> <td></td> </tr> <tr> <td> Male</td> <td>37</td> <td>127</td> <td>29%</td> </tr> <tr> <td> Female</td> <td>90</td> <td>127</td> <td>71%</td> </tr> <tr> <td> Unknown</td> <td>0</td> <td>127</td> <td>0%</td> </tr> </tbody> </table> <hr/> <table> <thead> <tr> <th>Age</th> <th># of Patients</th> <th># Considered (Numerator)</th> <th>Percent</th> </tr> </thead> <tbody> <tr> <td>18-29</td> <td>37</td> <td>127</td> <td>29%</td> </tr> <tr> <td>30-39</td> <td>90</td> <td>127</td> <td>71%</td> </tr> <tr> <td>40-49</td> <td>0</td> <td>127</td> <td>0%</td> </tr> </tbody> </table> <hr/>				# of Patients	# Considered (Numerator)	Percent	Sex				Male	37	127	29%	Female	90	127	71%	Unknown	0	127	0%	Age	# of Patients	# Considered (Numerator)	Percent	18-29	37	127	29%	30-39	90	127	71%	40-49	0	127	0%
	# of Patients	# Considered (Numerator)	Percent																																			
Sex																																						
Male	37	127	29%																																			
Female	90	127	71%																																			
Unknown	0	127	0%																																			
Age	# of Patients	# Considered (Numerator)	Percent																																			
18-29	37	127	29%																																			
30-39	90	127	71%																																			
40-49	0	127	0%																																			

<15 yrs	7	127	6%		
15-44 yrs	66	127	52%		
45-64 yrs	46	127	36%		
65 yrs and older	8	127	6%		
Classification					
Prediabetes	1	127	1%		
Impaired Fasting Glucose	62	127	49%		
Impaired Glucose Tolerance	41	127	32%		
Duration of Prediabetes					
<1 year	0	127	0%		
<10 years	0	127	0%		
>=10 years	95	127	75%		
Diagnosis date not recorded	32	127	25%		
Body Mass Index (BMI) Category					
Normal (BMI<25.0)	8	127	6%		
Overweight (BMI 25.0-29.9)	23	127	18%		
Obese (BMI >=30.0)	64	127	50%		
Height or weight missing	32	127	25%		

Severely obese (BMI >=40.0)	30	127	24%		
Blood Sugar Control					
A1C <5.7	12	127	9%		
A1C 5.7-6.4	25	127	20%		
A1C >=6.5	1	127	1%		
Not tested or no valid result	89	127	70%		
LAB	Jan 03, 2026		Page 2		
*** PREDIABETES HEALTH STATUS OF PATIENTS - RPMS ***					
(Report Period: Jan 01, 2025 to Dec 31, 2025)					
2021 DEMO HOSPITAL (INST)					
127 patients were reviewed Unless otherwise specified, time period for each item is the 12-month Audit Period					

# of Patients # Considered Percent					
(Numerator) (Denominator)					
Blood Pressure (BP) - Based on one value or mean of two or three values					
<120/<70	10	127	8%		
120/70 - <130/<80	34	127	27%		
130/80 - <140/<90	26	127	20%		
140/90 or higher	25	127	20%		
BP category Undetermined	32	127	25%		
Hypertension					
Diagnosed ever	49	127	39%		
Tobacco and Nicotine Use					
Tobacco use					
Screened	73	127	57%		
If screened, user	10	73	14%		
If user, counseled	10	10	100%		

Prediabetes Treatment			
Metformin [Glucophage, others]	1	127	1%
GLP-1 receptor agonist [dulaglutide (Trulicity), exenatide (Byetta, Bydureon), liraglutide (Victoza, Saxenda), lixisenatide (Adlyxin), semaglutide (Ozempic, Rybelsus, Wegovy)]	0	127	0%
SGLT-2 inhibitor [bexagliflozin (Brenzavvy), canagliflozin, (Invokana), dapagliflozin (Farxiga), empagliflozin (Jardiance), ertugliflozin (Steglatro), sotagliflozin (Inpefa)]	0	127	0%
Pioglitazone [Actos] or rosiglitazone [Avandia]	0	127	0%
Tirzepatide [Mounjaro, Zepbound]	0	127	0%
Acarbose [Precose] or miglitol [Glyset]	0	127	0%
LAB	Jan 03, 2026		Page 3
*** PREDIABETES HEALTH STATUS OF PATIENTS - RPMS *** (Report Period: Jan 01, 2025 to Dec 31, 2025) 2021 DEMO HOSPITAL (INST)			
127 patients were reviewed Unless otherwise specified, time period for each item is the 12-month Audit Period			
# of Patients # Considered Percent			
(Numerator) (Denominator)			
Statin Prescribed (Currently)			
Yes*	7	119	6%
Allergy, intolerance, or contraindication	8	127	6%
*Denominator excludes patients with an allergy, intolerance, or contraindication.			
Lipid Evaluation - Note these results are presented as population level CVD risk markers and should not be considered treatment targets for individual patients.			
LDL cholesterol	25	127	20%
LDL <100 mg/dL	17	127	13%
LDL 100-189 mg/dL	8	127	6%
LDL >=190 mg/dL	0	127	0%
Not tested or no valid result	102	127	80%
HDL cholesterol	25	127	20%
In females			
HDL <50 mg/dL	9	90	10%
HDL >=50 mg/dL	6	90	7%

Not tested or no valid result	75	90	83%
In males			
HDL <40 mg/dL	4	37	11%
HDL >=40 mg/dL	6	37	16%
Not tested or no valid result	27	37	73%
Triglycerides [1]	25	127	20%
Trig <150 mg/dL	15	127	12%
Trig 150-499 mg/dL	10	127	8%
Trig 500-999 mg/dL	0	127	0%
Trig >=1000 mg/dL	0	127	0%
Not tested or no valid result	102	127	80%
LAB	Jan 03, 2026	Page 4	
*** PREDIABETES HEALTH STATUS OF PATIENTS - RPMS ***			
(Report Period: Jan 01, 2025 to Dec 31, 2025)			
2021 DEMO HOSPITAL (INST)			
127 patients were reviewed Unless otherwise specified, time period for each item is the 12-month Audit Period			

# of Patients # Considered (Numerator) (Denominator) Percent			
Quantitative Urine Albumin-to-Creatinine Ratio (UACR) to assess kidney damage			
UACR - normal: <30 mg/g	6	7	86%
UACR increased:			
30-300 mg/g	1	7	14%
>300 mg/g	0	7	0%
Not tested or no valid result	120	127	94%
Footnotes			
[1] For triglycerides: >150 is a marker of CVD risk, not a treatment target; >1000 is a risk marker for pancreatitis.			

Figure E-7: Prediabetes Health Status Report

E.6 Prediabetes Report Taxonomies

The **Prediabetes Reports** are modeled after the diabetes audit reports and use most of the existing **Diabetes Audit Logic and taxonomies** (see Appendix D).

The **last Fasting Glucose** and **last 75 Gm 2-hour Glucose** are reported only on the **Prediabetes Patient Care Summary** and the **Prediabetes Assessment of Care**. These lab taxonomies should be reviewed and updated locally in addition to those for the **Diabetes Audit**. See Section D.4 for guidance in reviewing and updating Lab Taxonomies.

E.6.1 Lab Taxonomies

E.6.1.1 Fasting Glucose

The **last Fasting Glucose** test in the **V LAB** file are found. The taxonomy used to find these tests is the **DM AUDIT FASTING GLUCOSE TESTS** lab taxonomy. If no test in that taxonomy is found, then the **V LAB** file is searched for a **LOINC** code in the **DM AUDIT FASTING GLUC LOINC** code taxonomy.

Note: Do not include Point of Care testing.

E.6.1.2 75 GM 2-Hour Glucose

The last lab test in the year prior to the audit date that is a member of the **DM AUDIT 75GM 2HR GLUCOSE** taxonomy is found in **V LAB**. If no test in that taxonomy is found, then the **V LAB** file is searched for a **LOINC** code in the **DM AUDIT 75GM 2HR LOINC** code taxonomy (Figure E-8).

Note: Do not include 2-Hour Oral Glucose Tolerance Test in Pregnancy.

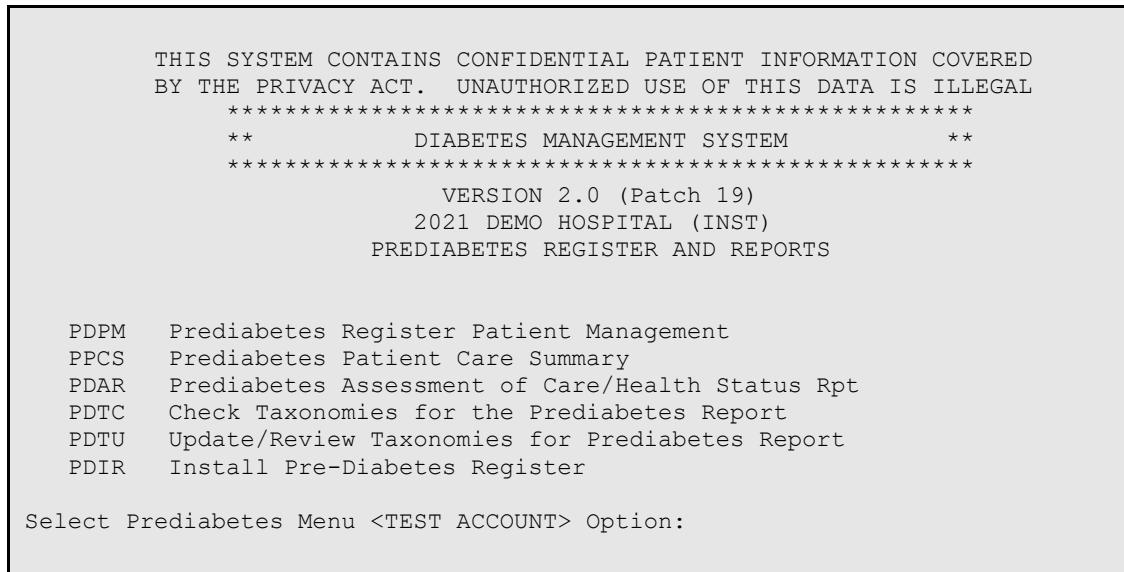


Figure E-8: Prediabetes Menu (PDTU)

Additional Modifications for Prediabetes reporting is noted in the following sections.

E.6.2 Prediabetes Diagnosis Classifications

E.6.2.1 Prediabetes

The system first looks at the problem list for a documented problem with **ICD-10 code R73.03—PREDIABETES**. If one is found, it will display **Problem List** with the date of onset, if the date of onset is documented. The system then looks at all of a patient's purpose of visits for the code **R73.03**. If it finds one, it displays the date of the earliest one found.

E.6.2.2 Impaired Fasting Glucose

The system first looks at the problem list for a documented problem with **ICD-9 code 790.21** or **ICD-10-code R73.01–IMPAIRED FASTING GLUCOSE**. If one is found, it will display a **Problem List** with the date of onset, if the date of onset is documented. The system then looks at all of a patient's purpose of visits for codes **790.21** or **R73.01**. If it finds one, it displays the dates of the earliest one found.

E.6.2.3 Impaired Glucose Tolerance

The system first looks at the problem list for a documented problem with **ICD-9 code 790.22** or **ICD-10 code R73.02–IMPAIRED GLUCOSE TOLERANCE**. If one is found, it will display Problem List with the date of onset, if the date of onset is documented. The system then looks at all of a patient's purpose of visits for codes **790.22** or **R73.02**. If it finds one, it displays the date of the earliest one found.

E.6.3 Medication Therapy

The following medications are reported in the **Prediabetes Reports**:

- Metformin
- SGLT-2 Inhibitor
- GLP-1 Receptor Agonist
- Tirzepatide
- Pioglitazone
- Acarbose

See Table E-1 for **Medication List** and **Taxonomy Name(s)**.

The list of medications is displayed on the **Prediabetes Assessment of Care** and **Prediabetes Health Status Reports**—an X designates the medication(s) prescribed.

Table E-1: Prediabetes Medication Therapy Taxonomy Names

Medication List	Taxonomy Name(s)
Metformin	DM AUDIT METFORMIN DRUGS
GLP-1 receptor agonist	DM AUDIT GLP-1 RECEPT AGONISTS
SGLT-2 inhibitor	DM AUDIT SGLT-2 INHIBITOR DRUGS
Pioglitazone, rosiglitazone	DM AUDIT GLITAZONE DRUGS
Tirzepatide	DM AUDIT TIRZEPATIDE DRUGS
Acarbose, miglitol	DM AUDIT ACARBOSE DRUGS

Appendix F Rules of Behavior

The Resource and Patient Management (RPMS) system is a United States Department of Health and Human Services (HHS), Indian Health Service (IHS) information system that is ***FOR OFFICIAL USE ONLY***. The RPMS system is subject to monitoring; therefore, no expectation of privacy shall be assumed. Individuals found performing unauthorized activities are subject to disciplinary action including criminal prosecution.

All users (Contractors and IHS Employees) of RPMS will be provided a copy of the Rules of Behavior (ROB) and must acknowledge that they have received and read them prior to being granted access to a RPMS system, in accordance IHS policy.

- For a listing of general ROB for all users, see the most recent edition of *IHS General User Security Handbook* (SOP 06-11a).
- For a listing of system administrators/managers rules, see the most recent edition of the *IHS Technical and Managerial Handbook* (SOP 06-11b).

Both documents are available at this IHS website:

<https://home.ihs.gov/security/index.cfm>.

Note: Users must be logged on to the IHS D1 Intranet to access these documents.

The ROB listed in the following sections are specific to RPMS.

F.1 All RPMS Users

In addition to these rules, each application may include additional ROBs that may be defined within the documentation of that application (e.g., Dental, Pharmacy).

F.1.1 Access

RPMS users shall:

- Only use data for which you have been granted authorization.
- Only give information to personnel who have access authority and have a need to know.
- Always verify a caller's identification and job purpose with your supervisor or the entity provided as employer before providing any type of information system access, sensitive information, or nonpublic agency information.
- Be aware that personal use of information resources is authorized on a limited basis within the provisions *Indian Health Manual* Part 8, "Information Resources Management," Chapter 6, "Limited Personal Use of Information Technology Resources."

RPMS users shall not:

- Retrieve information for someone who does not have authority to access the information.
- Access, research, or change any user account, file, directory, table, or record not required to perform their *official* duties.
- Store sensitive files on a PC hard drive, or portable devices or media, if access to the PC or files cannot be physically or technically limited.
- Exceed their authorized access limits in RPMS by changing information or searching databases beyond the responsibilities of their jobs or by divulging information to anyone not authorized to know that information.

F.1.2 Information Accessibility

RPMS shall restrict access to information based on the type and identity of the user. However, regardless of the type of user, access shall be restricted to the minimum level necessary to perform the job.

RPMS users shall:

- Access only those documents they created and those other documents to which they have a valid need-to-know and to which they have specifically granted access through an RPMS application based on their menus (job roles), keys, and FileMan access codes. Some users may be afforded additional privileges based on the functions they perform, such as system administrator or application administrator.
- Acquire a written preauthorization in accordance with IHS policies and procedures prior to interconnection to or transferring data from RPMS.

F.1.3 Accountability

RPMS users shall:

- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Log out of the system whenever they leave the vicinity of their personal computers (PCs).
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local Information System Security Officer (ISSO)
- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.
- Abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior, and information technology (IT) information processes.

F.1.4 Confidentiality

RPMS users shall:

- Be aware of the sensitivity of electronic and hard copy information and protect it accordingly.
- Store hard copy reports/storage media containing confidential information in a locked room or cabinet.
- Erase sensitive data on storage media prior to reusing or disposing of the media.
- Protect all RPMS terminals from public viewing at all times.
- Abide by all Health Insurance Portability and Accountability Act (HIPAA) regulations to ensure patient confidentiality.

RPMS users shall not:

- Allow confidential information to remain on the PC screen when someone who is not authorized to that data is in the vicinity.
- Store sensitive files on a portable device or media without encrypting.

F.1.5 Integrity

RPMS users shall:

- Protect their systems against viruses and similar malicious programs.
- Observe all software license agreements.
- Follow industry standard procedures for maintaining and managing RPMS hardware, operating system software, application software, and/or database software and database tables.
- Comply with all copyright regulations and license agreements associated with RPMS software.

RPMS users shall not:

- Violate federal copyright laws.
- Install or use unauthorized software within the system libraries or folders.
- Use freeware, shareware, or public domain software on/with the system without their manager's written permission and without scanning it for viruses first.

F.1.6 System Logon

RPMS users shall:

- Have a unique User Identification/Account name and password.

- Be granted access based on authenticating the account name and password entered.
- Be locked out of an account after five successive failed login attempts within a specified time period (e.g., one hour).

F.1.7 Passwords

RPMS users shall:

- Change passwords a minimum of every 90 days.
- Create passwords with a minimum of eight characters.
- If the system allows, use a combination of alpha-numeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.
- Change vendor-supplied passwords immediately.
- Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts or batch files).
- Change passwords immediately if password has been seen, guessed, or otherwise compromised, and report the compromise or suspected compromise to their ISSO.
- Keep user identifications (IDs) and passwords confidential.

RPMS users shall not:

- Use common words found in any dictionary as a password.
- Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user's name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).
- Share passwords/IDs with anyone or accept the use of another's password/ID, even if offered.
- Reuse passwords. A new password must contain no more than five characters per eight characters from the previous password.
- Post passwords.
- Keep a password list in an obvious place, such as under keyboards, in desk drawers, or in any other location where it might be disclosed.
- Give a password out over the phone.

F.1.8 Backups

RPMS users shall:

- Plan for contingencies such as physical disasters, loss of processing, and disclosure of information by preparing alternate work strategies and system recovery mechanisms.
- Make backups of systems and files on a regular, defined basis.
- If possible, store backups away from the system in a secure environment.

F.1.9 Reporting

RPMS users shall:

- Contact and inform their ISSO that they have identified an IT security incident and begin the reporting process by providing an IT Incident Reporting Form regarding this incident.
- Report security incidents as detailed in the *IHS Incident Handling Guide* (SOP 05-03).

RPMS users shall not:

- Assume that someone else has already reported an incident. The risk of an incident going unreported far outweighs the possibility that an incident gets reported more than once.

F.1.10 Session Timeouts

RPMS system implements system-based timeouts that kick users out of a prompt after no more than 5 minutes of inactivity.

RPMS users shall:

- Utilize a screen saver with password protection set to suspend operations at no greater than 10 minutes of inactivity. This will prevent inappropriate access and viewing of any material displayed on the screen after some period of inactivity.

F.1.11 Hardware

RPMS users shall:

- Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
- Keep an inventory of all system equipment.
- Keep records of maintenance/repairs performed on system equipment.

RPMS users shall not:

- Eat or drink near system equipment.

F.1.12 Awareness

RPMS users shall:

- Participate in organization-wide security training as required.
- Read and adhere to security information pertaining to system hardware and software.
- Take the annual information security awareness.
- Read all applicable RPMS manuals for the applications used in their jobs.

F.1.13 Remote Access

Each subscriber organization establishes its own policies for determining which employees may work at home or in other remote workplace locations. Any remote work arrangement should include policies that:

- Are in writing.
- Provide authentication of the remote user through the use of ID and password or other acceptable technical means.
- Outline the work requirements and the security safeguards and procedures the employee is expected to follow.
- Ensure adequate storage of files, removal, and nonrecovery of temporary files created in processing sensitive data, virus protection, and intrusion detection, and provide physical security for government equipment and sensitive data.
- Establish mechanisms to back up data created and/or stored at alternate work locations.

Remote RPMS users shall:

- Remotely access RPMS through a virtual private network (VPN) whenever possible. Use of direct dial in access must be justified and approved in writing and its use secured in accordance with industry best practices or government procedures.

Remote RPMS users shall not:

- Disable any encryption established for network, internet, and Web browser communications.

F.2 RPMS Developers

RPMS developers shall:

- Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.
- Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.
- Only access information or code within the namespaces for which they have been assigned as part of their duties.
- Remember that all RPMS code is the property of the U.S. Government, not the developer.
- Not access live production systems without obtaining appropriate written access and shall only retain that access for the shortest period possible to accomplish the task that requires the access.
- Observe separation of duties policies and procedures to the fullest extent possible.
- Document or comment all changes to any RPMS software at the time the change or update is made. Documentation shall include the programmer's initials, date of change, and reason for the change.
- Use checksums or other integrity mechanism when releasing their certified applications to assure the integrity of the routines within their RPMS applications.
- Follow industry best standards for systems they are assigned to develop or maintain and abide by all Department and Agency policies and procedures.
- Document and implement security processes whenever available.

RPMS developers shall not:

- Write any code that adversely impacts RPMS, such as backdoor access, "Easter eggs," time bombs, or any other malicious code or make inappropriate comments within the code, manuals, or help frames.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

F.3 Privileged Users

Personnel who have significant access to processes and data in RPMS, such as, system security administrators, systems administrators, and database administrators, have added responsibilities to ensure the secure operation of RPMS.

Privileged RPMS users shall:

- Verify that any user requesting access to any RPMS system has completed the appropriate access request forms.
- Ensure that government personnel and contractor personnel understand and comply with license requirements. End users, supervisors, and functional managers are ultimately responsible for this compliance.
- Advise the system owner on matters concerning information technology security.
- Assist the system owner in developing security plans, risk assessments, and supporting documentation for the certification and accreditation process.
- Ensure that any changes to RPMS that affect contingency and disaster recovery plans are conveyed to the person responsible for maintaining continuity of operations plans.
- Ensure that adequate physical and administrative safeguards are operational within their areas of responsibility and that access to information and data is restricted to authorized personnel on a need-to-know basis.
- Verify that users have received appropriate security training before allowing access to RPMS.
- Implement applicable security access procedures and mechanisms, incorporate appropriate levels of system auditing, and review audit logs.
- Document and investigate known or suspected security incidents or violations and report them to the ISSO, Chief Information Security Officer (CISO), and systems owner.
- Protect the supervisor, superuser, or system administrator passwords.
- Avoid instances where the same individual has responsibility for several functions (i.e., transaction entry and transaction approval).
- Watch for unscheduled, unusual, and unauthorized programs.
- Help train system users on the appropriate use and security of the system.
- Establish protective controls to ensure the accountability, integrity, confidentiality, and availability of the system.
- Replace passwords when a compromise is suspected. Delete user accounts as quickly as possible from the time that the user is no longer authorized system. Passwords forgotten by their owner should be replaced, not reissued.

- Terminate user accounts when a user transfers or has been terminated. If the user has authority to grant authorizations to others, review these other authorizations. Retrieve any devices used to gain access to the system or equipment. Cancel logon IDs and passwords and delete or reassign related active and backup files.
- Use a suspend program to prevent an unauthorized user from logging on with the current user's ID if the system is left on and unattended.
- Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator's database.
- Shall follow industry best standards for systems they are assigned to and abide by all Department and Agency policies and procedures.

Privileged RPMS users shall not:

- Access any files, records, systems, etc., that are not explicitly needed to perform their duties
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

Glossary

Amputation

To cut a limb from the body.

Caret (^)

A caret, also known as a circumflex, up-hat, or hat, is used as a piece delimiter in a global. The caret is denoted as “^” and typed by pressing Shift-6 on the keyboard.

CRS

Clinical Reporting System: A RPMS program for running standard reports for facility or service unit performance on GPRA indicators.

CVA

Short for Cerebrovascular accident, also known as a stroke.

Default Response

A suggested response that can be activated simply by pressing the Return key. For example: "Do you really want to quit? No//." Pressing the Return key tells the system you do not want to quit. "No// is considered the default response.

Device

The name of the printer you want the system to use when printing information. Home means the computer screen.

Diabetes

Referring to Diabetes Mellitus, a variable disorder of carbohydrate metabolism caused by a combination of hereditary and environmental factors and usually characterized by inadequate secretion or utilization of insulin, by excessive urine production, by excessive amounts of sugar in the blood and urine, and by thirst, hunger, and loss of weight.

Discharge

To release a patient from care.

DOB

Date of Birth.

DOS

Date of Service.

Enter Key

Used interchangeably with the Return key. Press Enter to show the end of an entry such as a number or a word. Press Enter each time you respond to a computer prompt. If you want to return to the previous screen, press Enter without entering a response. This will return you to the previous menu screen. The Enter key on some keyboards is shown as the Return Key. Whenever you see [ENT] or the Enter key, press the Enter or Return key.

Export

To format data so it can be used by another application.

Fields

Fields are a collection of related information that comprises a record. Fields on a display screen function like blanks on a form. For each field, you will find a prompt requesting specific types of data. There are nine basic field types in RPMS programs, and each collects a specific type of information.

File

A set of related records or entries treated as a single unit.

FileMan

The database management system for RPMS.

Free Text Field

This field type will accept numbers, letter, and most of the symbols on the keyboard. There may be restrictions on the number of characters you are allowed to enter.

Full Screen Editor

A word processing system used by RPMS. In many ways, the Full Screen Text Editor works just like a traditional word processor. The lines wrap automatically, the up, down, right, and left arrows move the cursor around the screen, and a combination of uppercase and lowercase letters can be used.

Global

In MUMPS, global refers to a variable stored on disk (global variable) or the array to which the global variable may belong (global array).

GPRA Indicators

The Government Performance and Results Act (GPRA) requires Federal agencies to report annually on how the agency measured up against the performance targets set in its annual Plan. IHS GPRA indicators include measures for clinical prevention and treatment, quality of care, infrastructure, and administrative efficiency functions.

Hypertension

High arterial blood pressure.

I/T/U

Abbreviation referring to all IHS direct, tribal, and urban facilities. Using the abbreviation, I/T/U generally means that all components of the Indian health care system are being referred to.

ICD Codes

One of several code sets used by the healthcare industry to standardize data. The International Classification of Disease is an international diagnostic coding scheme. In addition to diseases, ICD also includes several families of terms for medical-specialty diagnoses, health status, disablements, procedure and reasons for contact with healthcare providers. IHS currently uses ICD-9 for coding.

iCare

Population management software used with IHS Electronic Health Record to view patient information using customizable panels.

Imminent

Almost or ready to occur.

Interfaces

A boundary where two systems can communicate.

Kernel

The set of MUMPS software utilities that function as an intermediary between the host operating system and application packages, such as Laboratory and Pharmacy. The Kernel provides a standard and consistent user and programmer interface between application packages and the underlying MUMPS implementation. These utilities provide the foundation for RPMS.

Line Editor

A word-processing editor that allows the user to edit text line by line.

Logic

The detailed definition, including specific RPMS fields and codes, of how the software defines a denominator or numerator.

MailMan

Short for Mail Manager, MailMan is a VA-based utility that facilitates messaging for a number of RPMS packages.

Mandatory

Required. A mandatory field is a field that must be completed before the system will allow you to continue.

Menu

A list of choices for computing activity. A menu is a type of option designed to identify a series of items (other options) for presentation to the user for selection. When displayed, menu-type options are preceded by the word “Select” and followed by the word “option” as in Select Menu Management option: (the menu’s select prompt).

Myocardial Infarction

Also known as a MI or heart attack; infarction of the myocardium that results typically from coronary occlusion, that may be marked by sudden chest pain, shortness of breath, nausea, and loss of consciousness, and that sometimes results in death.

Mnemonic

A short cut or code that is designated to access a particular menu option, data entry option, name, or facility.

Namespace

A unique set of two to four alpha characters that are assigned by the database administrator to a software application.

Narrative Description

A detailed description given using words rather than codes.

Option

An entry in the Option file. As an item on a menu, an option provides an opportunity for users to select it, thereby invoking the associated computing activity. Options may also be scheduled to run in the background, non-interactively, by TaskMan.

Outpatient Treatment

Treatment that occurs within a medical facility that does not involve an overnight stay.

Prompt

A field displayed onscreen indicating that the system is waiting for input. Once the computer displays a prompt, it waits for you to enter some specific information.

Provider

One who provides direct medical care to a patient (i.e., physician, nurse, physician's assistant, pharmacy clinician).

Provider Codes

Codes that are assigned at the time a provider is added as a new user to RPMS and denotes the provider's discipline.

QMan

Short for Query Manager.

Queuing

Requesting that a job be processed at a later time rather than within the current session.

Return key

Press the Return key to indicate the end of an entry such as a number or a word. Press the Return key each time you respond to a computer prompt. If you want to return to the previous screen, press the Return key without entering a response. This will take you back to the previous menu screen. The Return key on some keyboards is shown as the Enter Key. Whenever you see [RET] or the Return key, press the Return or Enter Key.

Retinopathy

Any of various noninflammatory disorders of the retina including some that cause blindness.

Routine

A program or sequence of instructions called by a program that may have some general or frequent use. MUMPS routines are groups of program lines that are saved, loaded, and called as a single unit via a specific name.

RPMS

Resource and Patient Management System; a suite of software packages used by IHS.

Select

To choose one option from a list of options.

Site Manager

The person in charge of setting up and maintaining the RPMS System at the facility or area level.

Submenu

A menu that is accessed through another menu.

Taxonomy

Grouping of functionally related data elements.

Text Editor

A word processing program that allows you to enter and edit text.

Triage

Sorting patients by the urgency of their need for care.

Type 1 Diabetes

Diabetes of a form that usually develops during childhood or adolescence and is characterized by a severe deficiency of insulin secretion resulting from atrophy of the islets of Langerhans and causing hyperglycemia and a marked tendency toward ketoacidosis. Also called insulin-dependent diabetes, insulin-dependent diabetes mellitus, juvenile diabetes, juvenile-onset diabetes, type 1 diabetes mellitus.

Type 2 Diabetes

Diabetes mellitus of a common form that develops especially in adults and most often in obese individuals and that is characterized by hyperglycemia resulting from impaired insulin utilization coupled with the body's inability to compensate with increased insulin production. Also called adult-onset diabetes, late-onset diabetes, maturity-onset diabetes, non-insulin-dependent diabetes, non-insulin-dependent diabetes mellitus, type 2 diabetes mellitus.

Utility

A callable routine line tag or function. A universal routine usable by anyone.

Variable

A character or group of characters that refers to a value. MUMPS recognizes 3 types of variables: local variables, global variables, and special variables. Local variables exist in a partition of the main memory and disappear at sign-off. A global variable is stored on disk, potentially available to any user. Global variables usually exist as parts of global arrays.

Walk-In

A patient who walks into a medical facility seeking care but who does not have an appointment.

Word Processing Field

This is a field that allows the user to write, edit, and format text for letters, MailMan messages, etc.

Acronym List

Acronym	Meaning
A1C	Hemoglobin A1c (HbA1c)
ACE Inhibitor	Angiotensin Converting Enzyme Inhibitor
ARB	Angiotensin Receptor Blocker
ASUFAC	Area, Service Unit, and Facility
BDM	Namespace for the Diabetes Management System
BGP	Namespace for the Clinical Reporting System
BMI	Body Mass Index
BP	Blood Pressure
CKD	Chronic Kidney Disease
CRS	Clinical Reporting System
CVA	Cerebrovascular Accident
CPT	Current Procedural Terminology
CVD	Cardiovascular Disease
DAL	Display Audit Logic
DM	Diabetes Mellitus
DMS	Diabetes Management System
DMU	Update Diabetes Patient Data
DOB	Date of Birth
DOS	Date of Service
DPCS	Diabetes Patient Care Summary
DPP-4 Inhibitor	Dipeptidyl Peptidase-4 Inhibitor
eGFR	Estimated Glomerular Filtration Rate
EHR	Electronic Health Record
ENDS	Electronic Nicotine Delivery System
GDM	Gestational Diabetes Mellitus
GEN	General Retrieval Report
GLP-1 Receptor Agonist	Glucagon-like Peptide 1 Receptor Agonist
GPRA	Government Performance and Results Act
GUI	Graphical User Interface
HCV	Hepatitis C Virus
HDL	High-Density Lipoproteins
HTN	Hypertension

Acronym	Meaning
ICD	International Classification of Disease
IFG	Impaired Fasting Glucose
IGT	Impaired Glucose Tolerance
IHS	Indian Health Service
IT	Information Technology
LDL	Low-Density Lipoproteins
LMR	Lists, Labs, or Medications used at this Facility
LOINC	Logical Observation Identifiers Names and Codes
MI	Myocardial Infarction
NDC	National Drug Code
PCC	Patient Care Component
POC	Point of Care
RD	Registered Dietitian
RML	Master List Report
RPMS	Resource and Patient Management System
SDPI	Special Diabetes Program for Indians
SGLT-2 Inhibitor	Sodium-glucose Cotransporter 2 Inhibitor
SNOMED	Systematized Nomenclature of Medicine
TB	Tuberculosis
TD	Tetanus and Diphtheria
TDAP	Tetanus, Diphtheria, and Pertussis
TRIG	Triglycerides
UACR	Urine Albumin-to-Creatinine Ratio
VA	Veteran's Administration

Contact Information

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

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