RESOURCE AND PATIENT MANAGEMENT SYSTEM

Uniform Data System Reporting System for CY 2011

(BUD)

User Manual

Version 6.0
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Office of Information Technology (OIT)
Division of Information Resource Management
Albuquerque, New Mexico

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Preface

This manual contains the user's guide for the Resource and Patient Management System (RPMS) Uniform Data System (UDS) Reporting System for calendar year 2011.

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

> **Note:** Submit 2011 Uniform Data System data by February 15, 2012 in order to assure adequate time for review and correction of data errors prior to final submission. Changes to these data will be permitted until March 31, 2012.

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

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

Rules of Behavior

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

1.0 About This Manual

This manual provides user instructions for the Resource and Patient Management System (RPMS) Uniform Data System (UDS) Reporting System for calendar year (CY) 2011. The chapters included in the manual cover these main system components:

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

1.1 Key Changes for Version 6.0

1.1.1 Menu Changes

- Reports Menu Changes
  - Renamed option "M"
    From: Multiple/ALL Tables Zip through 7
    To: Multiple/ALL Tables Zip through 9D
  - Added option "4"
    4 Table 4: Selected Patient Characteristics
  - Added option "9D"
    9D Table 9D: Patient-Related Revenue (Totals Only)
  - Added option "DR"
    DR Table 9D: Patient-Related Revenue (Delimited Rept)
- MU Menu Changes
- LST Submenu Changes
  - Renamed option "LST"
    From: LST1 Lists for Tables Zip Code, 3A&3B, 5, and 6A
    To: LST1 Lists for Tables Zip Code, 3A&3B, 4, 5, and 6A
  - LST1 Submenu Changes

- Added option “IPPL”
  IPPL Income Percent of Poverty Level (Table 4)
- Added option “PMIS”
  PMIS Principle Third Party Medical Insurance (Table 4)
- Added option “CHAR”
  CHAR Characteristics of Special Populations (Table 4)

- LST2 Submenu Changes
  - Added option “WAC1”
    WAC1 All Patients 2-17 w/WT Assessment & Counseling
  - Added option “WAC2”
    WAC2 All Patients 2-17 w/o WT Assessment & Counseling
  - Added option “AWS1”
    AWS1 All Patients 18+ w/BMI & over/underweight w/plan
  - Added option “AWS2”
    AWS2 All Patients 18+ w/o BMI or w/o follow-up plan
  - Added option “TUA1”
    TUA1 All Patients 18+ w/tobacco use assessment
  - Added option “TUA2”
    TUA2 All Patients 18+ w/o tobacco use assessment
  - Added option “TCI1”
    TCI1 All Pts 18+ smokers/tobacco user w/intervention
  - Added option “TCI2”
    TCI2 All Pts 18+ smokers/tobacco user w/o intervention
  - Added option “APT1”
    APT1 All Asthma Pts 5-40 w/Asthma Therapy Medication
  - Added option “APT2”
    APT2 All Asthma Pts 5-40 w/o Asthma Therapy Medication

- LST3 Submenu Changes

- Renamed option "DMR2"

  From: DMR2 All DM Pts w/A1c >=7 & <=9 by Race & Hisp Identity
  To: DMR2 All DM Pts w/A1c >=7 & <8 by Race & Hisp Identity

- Renamed option "DMR3"

  From: DMR3 All DM Patients w/A1c >9 by Race & Hisp Identity
  To: DMR3 All DM Pts w/A1c >=8 & <=9 by Race & Hisp Identity

- Added option "DMR4"

  DMR4 All DM Pts w/o A1c or >9 by Race & Hisp Identity

1.1.2 Table Name Changes

- Added Tables

  Table 4– Characteristics of Special Populations (Table 4)
  Table 9D– Characteristics of Special Populations (Table 9D)

1.1.3 Changes Applicable to All Tables and Patient Lists

- Added Patient Classification Selection for Reports and Patient Lists

1.1.4 Table 4– Selected Patient Characteristics

Added this new table which reports data on selected characteristics of health center patients (i.e., income as a percent of poverty level, principal third party medical insurance source, managed care utilization, and characteristics of targeted special populations).

1.1.5 Table 6B–Quality of Care Indicators

- Updated Section C (Childhood Immunizations) as follows:
  - Include two (2) Hepatitis A shots
  - Include two (2) or three (3) Rotavirus shots
  - Include two (2) influenza shots
- Added Section E: Weight Assessment and Counseling for Children and Adolescents
- Added Section F: Adult Weight Screening and Follow-up
- Added Section G1: Tobacco Use Assessment

- Added Section G2: Tobacco Cessation Intervention
- Added Section H: Asthma Pharmacological Therapy

1.1.6 Table 7–Health Outcomes and Disparities

- Updated table format
- Updated Section C (Diabetes By Race and Hispanic/Latino Identity) as follows:
  - Included column 3d: Patients with HBA1c >= 7% and < 8%
  - Included column 3e: Patients with HBA1c >= 8% and <= 9%

1.1.7 Table 9D– Characteristics of Special Populations (Table 4)

Added this new table which collects information on charges, collections, supplemental payments, contractual allowances, self-pay sliding discounts, and self-pay bad debt write-off.

2.0 Introduction

Indian Health Service (IHS) RPMS UDS Reporting is intended for use by Tribal or urban health facilities receiving grant funds for primary care system development programs administered by the Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA). The RPMS UDS Reporting System provides passive extraction of patient and visit data from the RPMS to produce 9 of the 11 UDS reports. For each of the seven reports, RPMS UDS also produces lists of all patients and related visits that are counted in the reports.

Note: The UDS 2011 reports are due to BPHC on or before February 15, 2012 in order to assure adequate time for review and correction of data errors prior to final submission. Changes to these data will be permitted until March 31, 2012.

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

2.1 About the BPHC Uniform Data System (UDS)

The BPHC UDS is an integrated reporting system used by all grantees of the following primary care programs administered by the Bureau of Primary Health Care, Health Resources and Services Administration:

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

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

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

See the Quick Reference Guide for relevant excerpts. Additional information can be obtained from the following Web site: http://www.bphc.hrsa.gov/uds/.

2.2 RPMS UDS Reporting System Overview

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

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

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

- LST1–Lists for Tables Zip Code, 3A&3B, 4, 5, and 6A
  - Patient list by zip code, used with the ZIP table
  - Patient list with age and gender information about the patient and a list of all visits for the patient during the report period, used with Table 3A
  - Patient list with Hispanic Identity and race information about the patient and a list of all visits for the patient during the report period, used with Table 3B
  - Patient List used with Table 4, Income As A Percent Of Poverty Level section (Number of patients with an Income as A Percent of Poverty Level (i.e., =<100%, 101-150%, 151-200%, >200%, Unknown))

  - Patient List used with Table 4, Principle Third Party Medical Insurance Source section (Number of patients with or without a Principle Third Party Medical Insurance Source)
  - Patient List used with Table 4, Characteristics - Special Populations section (Number of patients with Characteristics of Special Populations (i.e., migrant workers, seasonal workers, homeless, school based health center patient, or a veteran))
  - Provider list categorized by BPHC-defined categories to assist in manual calculations of Table 5 Column A (Staffing FTEs)
  - Patient list categorized by UDS-defined service categories (primary provider code) and showing all patients with visits to that provider type during the report period, used with Table 5, Columns B (Visits) and C (Patients)
  - Patient list showing visits to whom the primary provider was uncategorized (i.e., did not map to the BPHC-defined categories), used with Table 5, Columns B (Visits) and C (Patients)
  - Patient list categorized by selected diagnoses (primary POV) and other services, used with Table 6A
- LST2–Lists for Table 6B
  - Patient list by age that had pregnancy-related visits during the past 20 months with at least one pregnancy-related visit during the report period, used with Table 6B.
  - Patient list of two-year-old patients who had their first visit prior to their second birthday, had a medical visit during the report period, and have all required childhood immunizations, used with Table 6B.
  - Patient list of two-year-old patients who had their first visit prior to their second birthday, had a medical visit during the report period, and list the immunizations still needed to complete all required childhood immunizations, used with Table 6B.
  - Patient list of all female patients ages 24–64 who have not had a hysterectomy, had a medical visit during the report period, were first seen in the clinic by their 65th birthday, and had a Pap test in the past three years, used with Table 6B.
  - Patient list of all female patients ages 24–64 who have not had a hysterectomy, had a medical visit during the report period, were first seen in the clinic by their 65th birthday, and *did not* have a Pap test in the past three years, used with Table 6B.
  - Patient list of all children and adolescents ages 2-17 who had a medical visit during the report period, were first seen ever by the grantee prior to their 17th birthday, and had BMI documented and counseling for nutrition and physical activity during the report period, used with Table 6B.

  - Patient list of all children and adolescents ages 2-17 who had a medical visit during the report period, were first seen ever by the grantee prior to their 17th birthday, and *did not* have BMI documented or counseling for nutrition and physical activity during the report period, used with Table 6B.
  - Patient list of all adults age 18 or older who had a medical visit during the report period and had BMI documented and if overweight or underweight, a follow-up plan documented, used with Table 6B.
  - Patient list of all adults age 18 or older who had a medical visit during the report period and *did not* have BMI documented or if overweight or underweight, *did not* have a follow-up plan documented, used with Table 6B.
  - Patient list of all adults age 18 or older who had a medical visit during the report period, at least two medical visits ever, and had tobacco use assessed during the report period or the year prior, used with Table 6B.
  - Patient list of all adults age 18 or older who had a medical visit during the report period, at least two medical visits ever, and *did not* have tobacco use assessed during the report period or the year prior, used with Table 6B.
  - Patient list of all adults age 18 or older who had a medical visit during the report period, at least two medical visits ever, used tobacco products within the past 24 months, and who received tobacco cessation counseling or smoking cessation agents during the report period or the year prior, used with Table 6B.
  - Patient list of all adults age 18 or older who had a medical visit during the report period, at least two medical visits ever, used tobacco products within the past 24 months, and who *did not* receive tobacco cessation counseling or smoking cessation agents during the report period or the year prior, used with Table 6B.
  - Patient list of all patients ages 5-40 with a diagnosis of mild, moderate or severe persistent asthma who had a medical visit during the report period, at least two medical visits ever, who received a prescription for or provided inhaled corticosteroid or an accepted alternative medication, used with Table 6B.
  - Patient list of all patients ages 5-40 with a diagnosis of mild, moderate or severe persistent asthma who had a medical visit during the report period, at least two medical visits ever, who *did not* receive a prescription for or provided inhaled corticosteroid or an accepted alternative medication, used with Table 6B.

- LST3–Lists for Table 7
  - Patient list of patients that had pregnancy-related visits during the past 20 months, with at least one pregnancy-related visit during the report period, and who have been diagnosed with HIV, used with Table 7 Section A.

- Patient list by race and Hispanic or Latino identity of patients that had pregnancy-related visits during the past 20 months, with at least 1 pregnancy-related visit during the report period, used with Table 7 Section A.
- Patient list by race and Hispanic or Latino identity of patients ages 18 to 85 years old who have had two medical visits during the report period and were diagnosed with hypertension before June 30 of the report period, used with Table 7 Section B.
- Patient list by race and Hispanic or Latino identity of patients ages 18 to 85 years old who have had two medical visits during the report period, were diagnosed with hypertension before June 30 of the report period, and who have controlled blood pressure (<140/90 mm Hg) during the report period, used with Table 7 Section B.
- Patient list by race and Hispanic or Latino identity of patients ages 18 to 85 years old who have had two medical visits during the report period, were diagnosed with hypertension before June 30 of the report period, and who do not have controlled blood pressure (<140/90 mm Hg) during the report period, used with Table 7 Section B.
- Patient list by race and Hispanic or Latino identity of patients ages 18 to 75 years old who have had two medical visits during the report period, with a diagnosis of Type I or Type II diabetes anytime through the end of the report period, and without a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes, used with Table 7 Section C.
- Patient list by race and Hispanic or Latino identity of patients ages 18 to 75 years old who have had two medical visits during the report period, with a diagnosis of Type I or Type II diabetes anytime through the end of the report period, and without a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes and with a most recent hemoglobin A1c of less than 7%, used with Table 7 Section C.
- Patient list by race and Hispanic or Latino identity of patients ages 18 to 75 years old who have had two medical visits during the report period, with a diagnosis of Type I or Type II diabetes anytime through the end of the report period, and without a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes and with a most recent hemoglobin A1c greater than or equal to 7% and less than 8%, used with Table 7 Section C.
- Patient list by race and Hispanic or Latino identity of patients ages 18 to 75 years old who have had two medical visits during the report period, with a diagnosis of Type I or Type II diabetes anytime through the end of the report period, and without a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes and with a most recent hemoglobin A1c greater than or equal to 8% and less than or equal to 9%, used with Table 7 Section C.

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

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

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

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

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

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

3.0 Manager Utilities for System Setup

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

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

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

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

Also included is one medication taxonomy: BUD DIABETES MEDS TAX. This taxonomy is used as one of two methods to identify patients with diabetes in Table 7. It is prepopulated by NDC, as indicated in Excel spreadsheet *UDS 2011 Medication Taxonomies* and users are able to add and/or remove drugs as necessary.

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

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

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

> **Note**: After typing each command, you must press the Enter key.

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

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

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

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

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

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

3. Type **UD11** at the "Select RPMS Uniform Data Systems (UDS) Reporting System Option" prompt to access the 2011 version of the software.

```
                  ******************************************
                  **     RPMS UNIFORM DATA SYSTEM (UDS)     **
                  ******************************************
                             DEMO INDIAN HOSPITAL
                                 Version 6.0

   UD11   UDS 2011 ...
   UD10   UDS 2010 ...
   UD09   UDS 2009 ...
   UD08   UDS 2008 ...
   UD07   UDS 2007 ...
   UD06   UDS 2006 ...
   UD05   UDS 2005 ...
   UD04   UDS 2004 ...
   UD03   UDS 2003 ...

Select RPMS Uniform Data Systems (UDS) Reporting System Option:  UD11
   <Enter>  UDS 2011 ...
```

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

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

```
Type MU at the "Select UDS 2011 Option" prompt.
                  ****************************************
                  **     RPMS UNIFORM DATA SYSTEM (UDS)     **
                  **                 2011                   **
                  ****************************************
                             DEMO INDIAN HOSPITAL
                                 Version 6.0

   REP    Reports ...
   MU     Manager Utilities ...

Select UDS 2011 Option:  MU <Enter>  Manager Utilities ...
```

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

4. The Manager Utilities menu displays (Figure 3-4).

```
                    ************************************
                    **  RPMS UNIFORM DATA SYSTEM (UDS)  **
                    **      2011 Manager Utilities      **
                    ************************************
                             DEMO INDIAN HOSPITAL
                                 Version 6.0

   SET    Update/Review Site Parameters
   LST    Patient and Provider Lists Main Menu ...
   STP    Create Search Template of Patients on Table 3A
   TAX    Update Taxonomies for Use with UDS 2011

Select Manager Utilities Option:
```

Figure 3-4: Manager Utilities menu

3.1 Site Parameters Setup (SET)

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

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

3.1.1 Locations

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

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

The BPHC UDS Manual states:

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

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

Table 3-1. Examples of Site Locations

[Site Name] Health Center	Exclude?
XYZ Clinic	
ABC Hospital	
XYZ High School	
School Unspecified	
Ambulance	Y
CHS Hospital	
[Site Name] A/SA Program	
Regional Treatment Center	
Office	
CHS Physician Office	
Home	
Nursing Home	
CHS Other	Y
Other	Y

[i] BPHC Uniform Data System Manual, 2011 Revision, p. 7.

[Site Name] Health Center	Exclude?
Undesignated Locations	Y

3.1.2 Adding New Parameters

Follow these steps to set up your site parameters.

1. Type **SET Update/Review Site Parameters** at the "Select Manager Utilities Option" prompt on the 2011 Manager Utilities menu (Figure 3-4). An explanation of the Site Parameters function displays (Figure 3-5).

```
***  Update/Review UDS 2011 Site Parameters ***

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

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

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

Select UDS 11 SITE PARAMETERS SITE NAME:
```

Figure 3-5: Site Parameters screen

2. Type the name of your site location at the "Select UDS 10 Site Parameters Site Name" prompt.

   a. If multiple names match what you typed, a list displays. Type the corresponding number of the correct site name.

   b. If you enter a site name that has not been previously entered, the system will prompt you, "Are you adding '[SITE NAME]' as a new UDS 10 SITE PARAMETERS (the XTH)?" Type **Y** (Yes) if you want to add the new site or **N** (No).

3. Type in the site UDS Identification Number (assigned by BPHC) at the "UDS NO." prompt, if you know it; otherwise, press the Enter key to skip this prompt.

4. The Update UDS Visit Locations screen displays. If this is a new site, the Locations list will be blank.

```
Select UDS 11 SITE PARAMETERS SITE NAME: san carlos
     1   SAN CARLOS           PHOENIX            SAN CARLOS       01
     2   SAN CARLOS TRIBE     PHOENIX TRIBE/638  SAN CARLOS       80
CHOOSE 1-2: 1 <Enter> SAN CARLOS     PHOENIX            SAN CARLOS       01
```

```
Are you adding 'SAN CARLOS' as a new UDS 11 SITE PARAMETERS (the 1ST)? No//
Y <Enter> (Yes)

Update UDS Visit Locations    Dec 23, 2011 11:09:47     Page:  0 of 0
------------------------------------------------------------------------------
Site Name: SAN CARLOS
Enter all locations to be included in the UDS report.

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

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

Figure 3-6: Site Parameters Setup, Steps 2–5

5. You can (1) add individual locations one at a time or (2) add the entire group of locations associated with the site and refine the list by deleting individual locations. See Section 3.1.1, "Locations" for a more detailed description about site locations.

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

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

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

Update UDS Visit Locations
Dec 23, 2011 11:19:13          Page:    1 of    1
------------------------------------------------------------------------------
Site Name: SAN CARLOS
Enter all locations to be included in the UDS report.

1) AMBULANCE
2) BYLAS
3) CHS HOSPITAL
4) CHS OTHER
5) CHS PHYSICIAN OFFICE
6) HOME
7) NURSING HOME
```

```
8) OFFICE
9) OTHER
10) SAN CARLOS
11) SCHOOL UNSPECIFIED
12) UNDESIG LOCS

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

Figure 3-7: Adding All SU Locations

7. Type **R** (Remove Visit Location from List) at the "Select Item(s)" prompt to delete a location.

8. Type the number(s) corresponding to the location name(s) you want to remove at the "Which item(s)" prompt. To delete multiple locations, type individual numbers separated by commas or hyphens. To delete location numbers 1, 3, and 7 through 9, type **1,3,7–9**. Do not use spaces between the comma separators.

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

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

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

Update UDS Visit Locations    Dec 23, 2011 11:26:58          Page:   1 of 1
------------------------------------------------------------------------------
Site Name: SAN CARLOS
Enter all locations to be included in the UDS report.

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

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

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

10. You will return to the Update/Review Site Parameters screen. If you want to add or edit another site, with associated UDS identification number and locations, type **Y** (Yes) at the "Do you want to add/edit another site?" prompt.

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

11. If you enter a site name that has not been previously entered, the system will prompt you, "Are you adding '[SITE NAME]' as a new UDS 10 SITE PARAMETERS (the XTH)?" Type **Y** (Yes) or **N** (No).

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

```
Do you want to add/edit another site? N// Y <Enter>  YES
Select UDS 10 SITE PARAMETERS SITE NAME: kanakANAK HOSPITAL       ALASKA
TRIBE/638   BRISTOL BAY       01
         ...OK? Yes// Y <Enter>  (Yes)

Are you adding 'KANAKANAK HOSPITAL' as a new UDS 10 SITE PARAMETERS (the
2ND)? No// Y <Enter>  (Yes)
UDS NO.:
```

Figure 3-9: Entering another site name

3.1.3 Updating Locations or Other Site-Related Data

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

1. Type the site name at the "Select UDS 10 Site Parameters Site Name" prompt.
2. To change the UDS ID number, type in a different number at the "UDS No." prompt. If the ID number is correct as displayed in the default, press the Enter key to accept the default value.
3. The current site location list displays. Type **A** (Add) or **R** (Remove) to add or delete a location.
4. When you have finished updating the locations, type **Q** to Quit.

3.2 Taxonomies

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

On UDS Table 6A Selected Diagnoses and Services Rendered, BPHC defines standard national codes (International Classification of Diseases, Ninth Revision [ICD-9], Current Procedural Terminology [CPT], and ADA) to identify the diagnoses and services provided to a grantee site's users. Using standard national codes ensures comparable data within the agency as well as to external organizations.

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

RPMS UDS also uses lab taxonomies for these four tests that need to be populated by each individual site, BGP HIV TEST TAX, BGP PAP SMEAR TAX, BUD HEPATITIS B TEST and BUD HEPATITIS C TEST. Taxonomies are used to mitigate the variations in RPMS medical terminology that is not standardized across each facility, such as laboratory tests or medications. This means that you can compare one site's Pap smear data to another site, even though the same term is not used for the Pap smear laboratory test.

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

Other RPMS software, including the Diabetes Management System and the Clinical Reporting System (CRS), uses taxonomies. If your site is using CRS, then the Human Immunodeficiency Virus (HIV) Test and Pap Smear taxonomies are most likely already populated with your site's laboratory test names. BUD HEPATITIS B TEST and BUD HEPATITIS C TEST are new to UDS 2011 and may need to be prepopulated prior to first use.

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

[ii] BPHC Uniform Data System Manual, 2011 Revision, pp. 44-45.

3.2.1 Taxonomy Setup (TAX)

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

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

BUD HEPATITIS B TEST and **BUD HEPATITIS C TEST** were new to UDS 2010 and may need to be prepopulated prior to first use, if not already done so for UDS 2010. Work with your laboratory staff to identify and assign tests to these two taxonomies.

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

In addition to the lab taxonomies, RPMS UDS uses one medication taxonomy to identify patients with diabetes: BUD DIABETES MEDS TAX. The RPMS UDS software will load the prepopulated taxonomy. Users are able to add and/or remove drugs as necessary.

1. Type **TAX** at the "Select Manager Utilities Option" prompt from the 2011 Manager Utilities menu.

2. The UDS Taxonomy Update menu displays with the two taxonomies used by UDS (Figure 3-10).

```
UDS TAXONOMY UPDATE         Dec 23, 2011 12:08:36     Page:    1 of 1
TAXONOMIES TO SUPPORT UDS REPORTING
* Update Taxonomies

1)  BGP PAP SMEAR TAX                  LAB
2)  BGP HIV TEST TAX                   LAB
3)  DM Audit HGB A1C Tax               LAB
4)  BUD HEPATITIS B TESTS              LAB
5)  BUD HEPATITIS C TESTS              LAB
6)  BUD DIABETES MEDS TAX              DRUG

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

Figure 3-10: UDS Taxonomy Update menu

3. Type **S** to select the lab test taxonomy you want to review or populate.

4. Type the number of the lab test taxonomy you want to review or populate, either **1** (BGP PAP SMEAR TAX), **2** (BGP HIV TEST TAX), **3** (DM AUDIT HGB A1C TAX), **4** (BUD HEPATITIS B TEST) or **5** (BUD HEPATITIS C TEST).

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

```
UDS LAB TAXONOMY UPDATE       Dec 23, 2011 12:08:45      Page:    1 of    1
Updating the BGP PAP SMEAR TAX taxonomy

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

Figure 3-11: UDS Lab Taxonomy Update screen

5. Type **A** to add a laboratory test to the taxonomy.

6. Type the name of the laboratory test at the "Which Lab Test" prompt. Depending on the test name, several types of lab tests specific to your site might display.

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

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

Figure 3-12: Adding Tests to a Lab Taxonomy

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

```
UDS LAB TAXONOMY UPDATE       Dec 23, 2011 12:09:15      Page:    1 of    1
Updating the BGP PAP SMEAR TAX taxonomy

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

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

Figure 3-13: Completed Lab Taxonomy

8. When all tests have been added to the taxonomy, type **Q** to quit and return to the UDS Taxonomy Update menu.

9. To add to or review tests for another taxonomy, repeat Steps 3–9. Otherwise, type **Q** to return to the Manager Utilities menu.

4.0 Report Definitions and Logic Example

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

4.1 BPHC UDS Manual Definitions

4.1.1 Definition of Patients

"Patients are individuals who have at least one visit during the reporting year …" As described in the BPHC definition of a patient: "The *Universal Report* includes all patients who have at least one visit during the year within the scope of activities supported by *any* BPHC grant covered by the UDS. On Tables 3A, 3B, 4, 6A, 6B and 7 of the Universal Report, each patient is counted once and only once, even if s/he received more than one type of service (e.g., medical, dental, enabling, etc.) or receives services supported by more than one BPHC grant…"

"Persons who only receive services from large-scale efforts such as immunization programs, screening programs, and health fairs are not counted as patients. Persons whose only service from the grantee is a part of the WIC program are not counted as patients."[iii]

4.1.2 Definition of Visits

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

Further elaborations of the definitions and criteria for defining and reporting visits are included below.

[iii] BPHC Uniform Data System Manual, 2011 Revision, p. 10.

1. To meet the criterion for *"independent professional judgment,"* the provider must be acting on his/her own when serving the patient and not assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history or drawing a blood sample *is not* credited with a separate visit. Independent judgment implies the use of the professional skills associated with the profession of the individual being credited with the visit and unique to that provider or other similarly or more intensively trained providers.

2. To meet the criterion for "*documentation*," the service (and associated patient information) must be recorded in written or electronic form. The patient record does not have to be a full and complete health record in order to meet this criterion. For example, if an individual receives services on an emergency basis and these services are documented, the documentation criterion is met even though some portions of the health record are not completed. Screenings at health fairs, immunization drives for children or the elderly and similar public health efforts *do not* result in visits regardless of the level of documentation.

3. When a behavioral health provider (i.e., a mental health or substance abuse provider) renders services to several patients simultaneously, the provider can be credited with a visit for each person only if the provision of services is noted in *each* person's health record. Such visits are generally limited to behavioral health services. Examples of such non-medical "group visits" include: family therapy or counseling sessions and group mental health counseling during which several people receive services and the services are noted in each person's health record. In such situations, *each* patient is normally billed for the service. Medical visits must be provided on an individual basis. Patient education or health education classes (e.g., smoking cessation) are not credited as visits.

4. A visit might take place in the health center or at any other approved site in which project-supported activities are carried out. Examples of other sites and locations include mobile vans, hospitals, patients' homes, schools, nursing homes, homeless shelters, and extended care facilities. Visits also include contacts with patients who are hospitalized, where health center medical staff member(s) follow the patient during the hospital stay as physician of record or where they provide consultation to the physician of record provided they are being paid by the grantee for these services and the patient is billed either for the specific service or through a global fee. A reporting entity may not count more than one inpatient visit per patient per day regardless of how many clinic providers see the patient or how often they do so.

5. Such services as drawing blood, collecting urine specimens, performing laboratory tests (including pregnancy tests and PPDs), taking X-rays, giving immunizations or other injections, and filling/dispensing prescriptions do not constitute visits, regardless of the level or quantity of supportive services.

6. Under certain circumstances, a patient may have more than one visit with the health center in a day. The number of visits per service delivery location per day is limited as follows. Each patient may have, at a maximum:

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

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

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

7. A provider may be credited with no more than one visit with a given patient in a single day, regardless of the types or number of services provided.

8. The visit criteria *are not* met in the following circumstances:

   - When a provider participates in a community meeting or group session that is *not* designed to provide clinical services. Examples of such activities include information sessions for prospective patients, health presentations to community groups (high school classes, Parent Teacher Association (PTA), etc.), and information presentations about available health services at the center.

- When the only health service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program (e.g., a health fair).
- When a provider is primarily conducting outreach and/or group education sessions, not providing direct services
- When the *only* services provided are lab tests, x-rays, immunizations or other injections, Tb tests or readings and/or prescription refills
- Services performed under the auspices of a Women, Infants, and Children (WIC) program or a WIC contract."[iv]

4.1.3 Definition of Providers

"A provider is the individual who assumes primary responsibility for assessing the patient and documenting services in the patient's record. Providers include only individuals who exercise independent judgment as to the services rendered to the patient during a visit. Only one provider who exercises independent judgment is credited with the visit, even when two or more providers are present and participate." [v] The BPHC UDS 2011 Manual contains a chart listing typical health facility staff with Provider/Non Provider categories designated.

4.2 RPMS General Definitions and Logic for All UDS Reports

4.2.1 Definition of Patients

RPMS UDS reporting defines "patients" as:

1. Any patient whose name is not "DEMO,PATIENT", "PATIENT,UDS" or "PATIENT,CRS", *and* whose name must *not* be included in the RPMS demo/test search patient template named "RPMS DEMO PATIENT NAMES," *and* who has one or more visits during the time period specified (quarter or full calendar year). Visits are documented face-to-face contacts between a patient and a provider who exercises independent judgment in providing services to the patient. This determination is made in Section 4.2.2.1 below.

2. Each patient is to be counted only once, regardless of the number or types of services received.

[iv] BPHC Uniform Data System Manual, 2011 Revision, p. 8.

[v] BPHC Uniform Data System Manual, 2011 Revision, pp. 9-10.

4.2.2 Definition of Visits

4.2.2.1 Definition of All Visits for a Qualified Patient

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

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

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

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

[vi] BPHC Uniform Data System Manual, 2011 Revision, p. 7

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

Table 4-1. Excluded Clinic Codes and Clinic Description

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

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

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

6. Must have only one other health visit for each type of other health provider per day. For example, a patient may have visits with a nutritionist, podiatrist, and optometrist on the same day but may not have two visits with a nutritionist on the same day because they provide the same type of care. If a patient has two or more visits to the same type of provider on the same day, the first visit is kept and the subsequent visits are removed. An exception to this rule occurs when the patient is seen in multiple different locations. In this case, each of the visits would count if the patient sees different providers in the different locations. However, if the patient sees the same provider in different locations, then only the first visit would be counted. A second exception to this rule occurs if the Service Category is I for an inpatient visit. All I visits will be counted, whether or not it is to the same type of provider on the same day. Refer to Appendix D: RPMS Provider Codes Mapping to UDS Service Category for Table 5 for provider codes included for each category of care.

7. Must have only one enabling service visit for each type of enabling provider per day. For example, a patient may have a visit with a case manager and a visit with a health educator on the same day but may not have two visits with a case manager on the same day because they provide the same type of care. If a patient has two or more visits to the same type of provider on the same day, the first visit is kept and the subsequent visits are removed. An exception to this rule occurs when the patient is seen in multiple different locations. In this case, each of the visits would count if the patient sees different providers in the different locations. However, if the patient sees the same provider in different locations, then only the first visit would be counted. A second exception to this rule occurs if the Service Category is I for an inpatient visit. All I visits will be counted, whether or not it is to the same type of provider on the same day. Refer to Appendix D: RPMS

Provider Codes Mapping to UDS Service Category for Table 5 for provider codes included for each category of care.

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

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

1. *Must be a "complete" PCC visit*; that is, have a primary provider with a nonblank discipline code and a coded purpose of visit (POV) and the POV must not be equal to .9999 (uncoded). This meets the BPHC definition: "Visits are defined as documented, face-to-face contacts between a patient and a provider who exercises independent professional judgment in the provision of services to the patient. To be included as a visit, services rendered must be documented in a chart…."

2. *Must not have an RPMS Service Category of Historical Event (E) or Inpatient Visit (I).*

3. *Must not have an excluded clinic code*. The following RPMS clinic codes shown in Table 4-2 do not fit the BPHC definition of a visit for these tables.

Table 4-2. Excluded Clinic Codes and Clinic Description

Clinic Code	Clinic Description
12	Immunization
63	Radiology
76	Laboratory Services
91	Teleradiology

4.2.3 Definition of Providers

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

4.3 RPMS UDS Logic Example

The following example demonstrates how RPMS UDS selects patients and visits for CY2011 for all tables and associated patient lists.

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

- Our Hospital
- Satellite A
- Satellite B
- Home

4.3.1 Determine if Patient Meets RPMS Definition of a Patient

1. Each patient on the RPMS computer is reviewed. Any patient whose name is "DEMO,PATIENT" or whose name is included in the RPMS demo/test search patient template named "RPMS DEMO PATIENT NAMES" is excluded and all processing stops for that patient. For all other patients, processing continues with Step 2.

2. Determine if patient has at least one RPMS visit that meets the BPHC criteria in Visit List 2, as shown in Section 4.3.2 below.

4.3.2 Determine if Patient's Visits Meet the RPMS Definition of Visits

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

Table 4-3. Patient Mary Jones Has 10 visits That Were Found in RPMS for CY2011, And That Comprise the All Visits List.

Visit Date	Location	Service Category	Clinic	Prov Disc	Dx	Services
1/5/2011@9am	Our Hospital	Amb	01-General	71-Internist (Jones)	381.01	
1/5/2011@11am	Our Hospital	Amb	01-General	71-Internist (Jones)	381.01	
1/5/2011@4pm	Our Hospital	Amb	01-General	71-Internist (Smith)	293.01	
3/1/2011@12pm	IHS Clinic ABC	Amb	30-Emergency Medicine	00-Physician	692.02	
4/1/2011@3pm	Satellite A	Chart review	01-General	01-Nurse (Begay)	250.00	
4/5/2011@12pm	Our Hospital	Tele. Call	01-General	01-Nurse (Adams)	250.00	
6/1/2011@3pm	Our Hospital	Amb	01-General	00-Physician	V72.3	Pap
6/4/2011@4pm	Our Hospital	Amb	63-Radiology	76-Radiologist	V76.12	Mammogram
8/1/2011@1pm	Other	Event				Flu shot given

Visit Date	Location	Service Category	Clinic	Prov Disc	Dx	Services
						at Costco
9/20/2011@2pm	Our Hospital	Amb	39-Pharmacy	09-Pharmacist	V25.2	Given BCPs

2. The above list of visits is reviewed, and all visits that would not be used in *any* table calculation are removed from the list. The visits must meet *all* of the following criteria:

   a. Must be to a location specified by the site in the Setup option.

   b. Must be one of the following RPMS Service Categories: Ambulatory (A), Hospitalization (H), Day Surgery (S), Observation (O), Telemedicine (M), Nursing Home (R), Historical Event (E), or In-hospital (I).

   c. Must *not* have one of the following clinic codes, which are excluded from UDS reporting:

Table 4-4. Excluded Clinic Codes and Clinic Description

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

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

e. Must not be more than one medical, one dental, one mental health, and one substance abuse visit on the same day, unless the patient sees different providers in different locations or the Service Category is I.

f. Must not be more than one other health visit for each type of other health provider on the same day, unless the patient sees different providers in different locations or the Service Category is I.

g. Must not be more than one enabling service visit for each type of enabling provider on the same day, unless the patient sees different providers in different locations or the Service Category is I.

3. After applying this criteria, the following seven visits were removed:

- 1/5/2011 @11am visit because the patient already had a visit on the same day to the same provider (person) (i.e., Dr. Jones)
- 1/5/2011 @4pm visit because the patient already have a visit on the same day to a medical provider (i.e., Dr. Jones)
- 3/1/2011 visit due to location (IHS Clinic ABC) not specified in the Setup option
- 4/1/2011 visit due to Chart Review service category
- 4/5/2011 visit due to Telephone Call service category
- 8/1/2011 visit due to location (Other) not included in Setup and also due to Historical Event service category
- 9/20/2011 visit due to clinic code of Pharmacy

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

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

Visit Date	Location	Service Category	Clinic	Prov Disc	Dx	Services
1/5/2011@9am	Our Hospital	Amb	01-General	71-Internist (Jones)	381.01	
6/1/2011@3pm	Our Hospital	Amb	01-General	00-Physician	V72.3	Pap
6/4/2011@4pm	Our Hospital	Amb	63-Radiology	76-Radiologist	V76.12	Mammogram

4. Visit List 1 is now reviewed for the visits that are eligible to be counted in Tables Zip Code, 3A, 3B, 5 and the Selected Diagnoses section (Lines 1–20d) of Table 6A. The following *additional* criteria are applied:

a. Must be a complete visit (have a primary provider with a nonblank discipline code and coded POV, where the POV is not equal to .9999).

b. Must not have an RPMS Service Category of Historical Event (E) or Inpatient (I).

c. Visit must *not* have one of the following clinic codes:

- 12 Immunization
- 63 Radiology
- 76 Laboratory Services
- 91 Teleradiology

5. After applying the criteria, the following visit was removed:

- 6/4/2011 visit due to clinic code of Radiology.

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

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

Visit Date	Location	Service Category	Clinic	Prov Disc	Dx	Services
1/5/2011@9am	Our Hospital	Amb	01-General	71-Internist (Jones)	381.01	
6/1/2011@3pm	Our Hospital	Amb	01-General	00-Physician	V72.3	Pap

6. To recap:

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

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

5.1 Overview

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

The following reports are produced:

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

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

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

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

  - Patient list of all adults age 18 or older who had a medical visit during the report period, at least two medical visits ever, and did not have tobacco use assessed during the report period or the year prior, used with Table 6B.
  - Patient list of all adults age 18 or older who had a medical visit during the report period, at least two medical visits ever, used tobacco products within the past 24 months, and who received tobacco cessation counseling or smoking cessation agents during the report period or the year prior, used with Table 6B.
  - Patient list of all adults age 18 or older who had a medical visit during the report period, at least two medical visits ever, used tobacco products within the past 24 months, and who did not receive tobacco cessation counseling or smoking cessation agents during the report period or the year prior, used with Table 6B.
  - Patient list of all patients ages 5-40 with a diagnosis of mild, moderate or severe persistent asthma who had a medical visit during the report period, at least two medical visits ever, who received a prescription for or provided inhaled corticosteroid or an accepted alternative medication, used with Table 6B.
  - Patient list of all patients ages 5-40 with a diagnosis of mild, moderate or severe persistent asthma who had a medical visit during the report period, at least two medical visits ever, who did not receive a prescription for or provided inhaled corticosteroid or an accepted alternative medication, used with Table 6B.
- LST3–Lists for Table 7
  - Patient list of patients that had pregnancy-related visits during the past 20 months, with at least one pregnancy-related visit during the report period, and who have been diagnosed with HIV, used with Table 7 Section A.
  - Patient list by race and Hispanic or Latino identity of patients that had pregnancy-related visits during the past 20 months, with at least one pregnancy-related visit during the report period, used with Table 7 Section A.
  - Patient list by race and Hispanic or Latino identity of patients ages 18 to 85 years old who have had two medical visits during the report period and were diagnosed with hypertension before June 30 of the report period, used with Table 7 Section B.
  - Patient list by race and Hispanic or Latino identity of patients ages 18 to 85 years old who have had two medical visits during the report period, were diagnosed with hypertension before June 30 of the report period, and who have controlled blood pressure (<140/90 mm Hg) during the report period, used with Table 7 Section B.

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

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

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

This chapter describes the logic for each of the seven reports and how to run the reports from the Reports menu option on the RPMS UDS Reporting System main menu.

> **Note:** It is strongly recommended that sites run the Staff List (option ST from the 2011 Reports menu) first and review and edit providers and related provider codes for accuracy prior to running any other reports.

5.2 Report Descriptions

5.2.1 Patient by Zip Code

This table reports the number of patients by their zip code as entered in patient registration.

5.2.1.1 Logic for Patients by Zip Code Table

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

- This report includes all patients who have at least one visit for the specified time period that meets the visit definition criteria. The total number of patients on this table should equal the number of total unduplicated patients on Tables 3A, 3B, and 4.[vii]
- The patient's zip code is obtained from patient registration.
- The table will be sorted in ascending order by zip code, with the total number of patients having an address with that zip code.
- Zip codes with a count of patients less than 0.1% (0.001) of the total population will be included in the Other Zip Codes category.
- Patients who do not have a zip code value in patient registration are included in the Unknown Residence category.
- Since there is no way of determining if a patient is homeless or a migrant, all patients without a zip code will be placed in the Unknown Residence category.

[vii] BPHC Uniform Data System Manual, 2011 Revision, p. 15.

Table 5-1: Example of BPHC UDS Patients by Zip Code[viii]

ZIP Code	Patients
Other Zip Codes	
Unknown Residence	
TOTAL	

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

Table 3A provides demographic data on BPHC grantee site patients, by age and gender. The patient's age is calculated on June 30 of the reporting period. "…[I]nclude as patients all individuals receiving at least one face-to-face visit for services … within the scope of any of the programs covered by UDS. Regardless of the scope or volume of services received, each patient is to be counted only once on Table 3A and only once in *each* of the two sections of Table 3B: ethnicity and race and language, if applicable."[ix]

5.2.2.1 Logic for Table 3A

The report categorizes all patients who met the RPMS definition of a patient by age and gender. The patient's age is calculated as of June 30, 2011 by subtracting the date of birth from June 30, 2011. If the patient was born after June 30, 2011 and before the end of the calendar year being reported, the age is calculated as "Under age 1" (Line 1). The patient's gender is also determined. The patient is placed in the appropriate line of Table 3A (see Table 5-2).

[viii] BPHC Uniform Data System Manual, 2011 Revision, p. 16.

[ix] BPHC Uniform Data System Manual, 2011 Revision, p. 17.

Table 5-2: Example of BPHC UDS Table 3A Patients by Age and Gender[x]

Age Groups		Male Patients (a)	Female Patients (b)
Number of Patients			
1	Under age 1		
2	Age 1		
3	Age 2		
4	Age 3		
5	Age 4		
6	Age 5		
7	Age 6		
8	Age 7		
9	Age 8		
10	Age 9		
11	Age 10		
12	Age 11		
13	Age 12		
14	Age 13		
15	Age 14		
16	Age 15		
17	Age 16		
18	Age 17		
19	Age 18		
20	Age 19		
21	Age 20		
22	Age 21		
23	Age 22		
24	Age 23		
25	Age 24		
26	Ages 25–29		
27	Ages 30–34		
28	Ages 35–39		
29	Ages 40–44		
30	Ages 45–49		
31	Ages 50–54		
32	Ages 55–59		
33	Ages 60–64		
34	Ages 65–69		
35	Ages 70–74		
36	Ages 75–79		

[x] BPHC Uniform Data System Manual, 2011 Revision, p. 22.

Age Groups		Male Patients (a)	Female Patients (b)
Number of Patients			
37	Ages 80–84		
38	Age 85 and over		
39	**Total Patients** (Sum Lines 1-38)		

5.2.2.2 Logic for Table 3B

The report categorizes all patients who met the RPMS definition of a patient by Hispanic or Latino identity, race, and language. The report uses the logic described below (see Table 5-3)

1. The patient's Race, Classification/Beneficiary, and Ethnicity values from RPMS Patient Registration are examined and are categorized by the logic shown in Table 5-1 below. Unless otherwise noted, both the patient's [race or classification/beneficiary] and the [ethnicity] values are used to determine the patient's placement in the table

Table 5-3. Map to Table 3B (Patients By Hispanic Or Latino Identity/Race/Language)

Map to Table 3B, Race Line # and Ethnicity Column	RPMS Race or Classification/ Beneficiary Value	RPMS Ethnicity Value
Line 1–Asian		
Hispanic/Latino (Column A)	A–Asian	H–Hispanic or Latino
Not Hispanic/Latino (Column B)		N–Not Hispanic or Latino U–Unknown by Patient D–Declined to Answer–or– Ethnicity value is blank
Unreported/Refused to Report (Column C)		
Line 2a–Native Hawaiian		
Hispanic/Latino (Column A)	H–Native Hawaiian or Other Pacific Islander	H–Hispanic or Latino
Not Hispanic/Latino (Column B)		N–Not Hispanic or Latino U–Unknown by Patient D–Declined to Answer–or– Ethnicity value is blank
Unreported/Refused to Report (Column C)		
Line 2b–Other Pacific Islander		
Hispanic/Latino (Column A)	5–Pacific Islander (old code)	H–Hispanic or Latino

Map to Table 3B, Race Line # and Ethnicity Column	RPMS Race or Classification/ Beneficiary Value	RPMS Ethnicity Value
Not Hispanic/Latino (Column B)		N–Not Hispanic or Latino U–Unknown by Patient D–Declined to Answer–or– Ethnicity value is blank
Unreported/Refused to Report (Column C)		
Line 2–Total Hawaiian/Pacific Islander		
Sum Lines 2a and 2b	N/A	N/A
Line 3–Black/African American		
Hispanic/Latino (Column A)	B–Black or African American 2–Hispanic, Black[xi]	H–Hispanic or Latino
Not Hispanic/Latino (Column B)	B–Black or African American 4–Black, Not of Hispanic Origin[xii]	N–Not Hispanic or Latino U–Unknown by Patient D–Declined to Answer-or- Ethnicity value is blank
Unreported/Refused to Report (Column C)	B–Black or African American	
Line 4–American Indian/Alaska Native		
Hispanic/Latino (Column A)	3–American Indian or Alaska Native	H–Hispanic or Latino
Not Hispanic/Latino (Column B)	Z–American Indian or Alaska Native-Old (old code) -or- RPMS Classification/Beneficiary Value	N–Not Hispanic or Latino U–Unknown by Patient D–Declined to Answer-or- Ethnicity value is blank
Unreported/Refused to Report (Column C)	01–Indian/Alaska Native	
Line 5–White		
Hispanic/Latino (Column A)	W–White 1–Hispanic, White[xiii]	H–Hispanic or Latino

[xi] This Race value does not require an Ethnicity value in order to determine the patient's ethnicity; rather, both the patient's race and ethnicity are determined from the Race value.

[xii] Ibid.

[xiii] Ibid.

Map to Table 3B, Race Line # and Ethnicity Column	RPMS Race or Classification/ Beneficiary Value	RPMS Ethnicity Value
Not Hispanic/Latino (Column B)	W–White 6–White, Not of Hispanic Origin	N–Not Hispanic or Latino U–Unknown by Patient D–Declined to Answer-or-Ethnicity value is blank
Unreported/Refused to Report (Column C)	W–White	
Line 6–More than One Race		
Leave blank since there is no such Race code in RPMS	N/A	N/A
Line 7–Unreported/Refused to Report		
Hispanic/Latino (Column A)	D–Declined to Answer U–Unknown by Patient 7–Unknown Race value is blank	H–Hispanic or Latino
Not Hispanic/Latino (Column B)		N–Not Hispanic or Latino
Unreported/Refused to Report (Column C)		U–Unknown by Patient D–Declined to Answer -or-Ethnicity value is blank
Line 8–Total Patients		
Sum Lines 1, 2, and 3–7	N/A	N/A
Line 9–Patients Best Served in a Language Other than English		
Leave blank since this data is currently not collected in RPMS	N/A	N/A

Table 5-4: Patients by Hispanic or Latino Identity/Race/Language [xiv]

Patients by Race		Hispanic/Latino (A)	Not Hispanic/Latino (B)	Unreported/ Refused to Report (C)	Total (D)
NUMBER OF PATIENTS					
1.	Asian				
2a.	Native Hawaiian				
2b.	Other Pacific Islander				
2.	**Total Hawaiian/Pacific Islander (Sum Lines 2a + 2b)**				

[xiv] BPHC Uniform Data System Manual, 2011 Revision, Table 3B, p. 23

Patients by Race		Hispanic/Latino (A)	Not Hispanic/Latino (B)	Unreported/ Refused to Report (C)	Total (D)
3.	Black/African American				
4.	American Indian/Alaska Native				
5.	White				
6.	More than one race				
7.	Unreported / Refused to Report				
8.	**Total Patients (Sum Lines 1+2 + 3 to 7)**				

Patients by Language		Number (A)
NUMBER OF PATIENTS		
9.	**Patients Best Served in a Language Other Than English**	

5.2.3 Table 4 Selected Patient Characteristics

Table 4, Selected Patient Characteristics provides descriptive data on selected characteristics of health center patients. Table 4 is included in both the Universal Report and Grant Reports[xv].

Cross Table Check: The sum of Table 3A, Line 39, Column A + B (total patients by age and gender) must equal Table 3B, Lines 8 column D (total patients by race and Hispanic/Latino identity); Table 4, Line 6 (total patients by income); and Table 4 Line 12, Column A + B (total patients by medical insurance status). The sum of Table 3A, Lines 1-20, Column A + B (total patients age 0-19 years) must equal Table 4, Line 12, Column A (total patients age 0-19 years).

[xv] BPHC Uniform Data System Manual, 2011 Revision, *Instructions for Table 4*, p. 24

5.2.3.1 Income as a Percent of Poverty Level (Lines 1-6):

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

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

5.2.3.2 Principal Third Party Insurance Source (Lines 7 -12)

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

- Patients are divided into two age groups (Column A) 0 - 19 and (Column B) age 20+.
- Primary patient medical insurance is divided into seven types as follows:
  - Uninsured (Line 7): This line lists those patients who do not have medical insurance.
  - Medicaid (Line 8a, 8b, and 8)
  - CHIP (Line 8b or 10b):
  - Medicare (Line 9)
  - Other Public Insurance (Line 10a)
  - Other Public (CHIP) (Line 10b)
  - Private Insurance (Line 11)

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

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

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

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

This section on "characteristics" asks for a count of patients from targeted special populations. There are five characteristic categories defined by BPHC and are described below.[xvi]

- **Migrant Agricultural Workers and Their Dependents (Line 14)**

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

- **Seasonal Agricultural Workers and Their Dependents (Line 15)**

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

[xvi] BPHC Uniform Data System Manual, 2011 Revision, p. 28.

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

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

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

- **Homeless (Lines 17-23)**

  Defined as patients who lack housing (without regard to whether the individual is a member of a family), including individuals whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations, and individuals who reside in transitional housing. BPHC defines homeless in the following categories[xvii].

  - Homeless Shelter
  - Transitional
  - Doubling Up
  - Street
  - Other
  - Unknown

- **School-Based Health Center Patients (Line 24)**

  A school-based health center is a health center located on or near school grounds, including pre-school, kindergarten, and primary through secondary schools, that provides on-site comprehensive preventive and primary health services. BPHC requires these programs to have a clinic code of 22.

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

- **Veterans (Line 25)**

  Veterans are defined as patients served who have been discharged from the uniformed services of the United States.

[xvii] BPHC Uniform Data System Manual, 2011 Revision, p. 29.

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

Table 4 Logic

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

DU UDS 2011 DEMO INDIAN HOSPITAL Page 1
UDS No. 000001 Date Run: Dec 15, 2011
Reporting Period: Jan 01, 2011 through Dec 31, 2011

TABLE 4 - SELECTED PATIENT CHARACTERISTICS

CHARACTERISTIC		NUMBER OF PATIENTS (a)
INCOME AS PERCENT OF POVERTY LEVEL		
1.	100% and below	7
2.	101 - 150%	12
3.	151 - 200%	21
4.	Over 200%	61
5.	Unknown	37,265
6.	TOTAL (SUM LINES 1 - 5)	37,366

PRINCIPAL THIRD PARTY MEDICAL INSURANCE SOURCE		0-19 YEARS OLD (a)	20 AND OLDER (b)
7.	None/Uninsured	5,820	13,465
8a.	Regular Medicaid (Title XIX)	5,143	1,287
8b.	CHIP Medicaid	0	0
8.	TOTAL MEDICAID (LINE 8A + 8B)	5,143	1,287
9.	MEDICARE (TITLE XVIII)	4	2,833
10a.	Other Public Insurance Non-CHIP (specify)	0	0
10b.	Other Public Insurance CHIP	0	0
10.	TOTAL PUBLIC INSURANCE (LINE 10a + 10b)	0	0
11.	PRIVATE INSURANCE	3,016	5,798
12.	TOTAL (SUM LINES 7+8+9+10+11)	13,983	23,383

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

DU UDS 2011 DEMO INDIAN HOSPITAL Page 2
UDS No. 000001 Date Run: Dec 15, 2011
Reporting Period: Jan 01, 2011 through Dec 31, 2011

TABLE 4 - SELECTED PATIENT CHARACTERISTICS

MANAGED CARE UTILIZATION

	MEDICAID (a)	MEDICARE (b)	OTHER PUBLIC INCLUDING MEDICAID CHIP (c)	NON-PRIVATE (d)	TOTAL (e)
13a. Capitated Member					
13b. Fee-for-service					
13c. TOTAL MEMBER MONTHS					

CHARACTERISTICS - SPECIAL POPULATIONS		NUMBER OF PATIENTS - (a)
14. Migrant	(330g grantees only)	0
15. Seasonal	(330g grantees only)	0
16. TOTAL MIGRANT/SEASONAL AGRICULTURAL WORKER OR DEPENDENT	(ALL GRANTEES REPORT THIS LINE)	0
17. Homeless Shelter	(330g grantees only)	0
18. Transitional	(330g grantees only)	0
19. Doubling Up	(330g grantees only)	0
20. Street	(330g grantees only)	0
21. Other	(330g grantees only)	0
22. Unknown	(330g grantees only)	0
23. TOTAL HOMELESS	(ALL GRANTEES REPORT THIS LINE)	0
24. TOTAL SCHOOL BASED HEALTH CENTER PATIENTS	(ALL GRANTEES REPORT THIS LINE)	1
25. TOTAL VETERANS	(ALL GRANTEES REPORT THIS LINE)	798

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

5.2.4 Table 5- Staffing and Utilization

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

BPHC defines different types of provider and facility staff for each of the seven major staff service categories. For example, Medical Care Services includes physicians, nurse practitioners, physician assistants, nurses, certified nurse midwives, laboratory and X-ray personnel and other medical personnel. See Appendix C: BPHC Service Category Definitions for Table 5 for more detailed definitions.

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

Table 5-5: Example of BHPC UDS Table 5, Staffing And Utilization[xix]

Personnel by Major Service Category		FTEs (a)	Clinic Visits (b)	Patients (c)
1	Family Physicians			
2	General Practitioners			
3	Internists			
4	Obstetrician/Gynecologists			
5	Pediatricians			
6				
7	Other Specialty Physicians			
8	**Total Physicians (Lines 1–7)**			

[xviii] BPHC Uniform Data System Manual, 2011 Revision, *Instructions for Table 5*, p. 33.

[xix] BPHC Uniform Data System Manual, 2011 Revision, Table 5, p. 43.

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

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

5.2.4.1 ST Staffing List (Column A)

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

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

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

This option lists all providers with whom patients had visits and the provider was noted as the primary provider in RPMS. RPMS UDS software has mapped the RPMS provider discipline codes to the BPHC UDS definitions (see Appendix D:RPMS Provider Codes Mapping to UDS Service Category for Table 5–5). Any staff members with associated provider discipline codes that are not included in the BPHC service categories are identified at the bottom of the report as “Unidentified Provider

Category". The system does not count visits with unmapped provider discipline codes toward visits or patients for Table 5 Column B or C.

In Figure 5-1, "Nurse Assistant, Larry" is currently categorized as Provider Code 15 Other. He should be recoded to Code 22 Nurse Assistant.

```
***** CONFIDENTIAL PATIENT INFORMATION, COVERED BY THE PRIVACY ACT *****
   DU                          Dec 15, 2011                        Page 1

                    ***  BPHC Uniform Data System (UDS)  ***
             Personnel List for Table 5 Column A, By Service Category
                              DEMO HOSPITAL
                   Reporting Period: Jan 01, 2011 to Dec 31, 2011
-------------------------------------------------------------------------------

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

PROVIDER NAME                       PROVIDER CODE                        FTE
-------------------------------------------------------------------------------

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

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

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

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

Figure 5-3: Sample Staff List by BPHC Categories

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

Columns B and C document the number of visits provided and patients served, as categorized by BPHC service categories. There are seven major service categories and the limits for Column B (Clinic Visits) as defined by BPHC are described below.[xx]

- Medical Care Services (Line 15). A patient may have one medical visit per day (e.g., visit with a physician, nurse practitioner, physician's assistant, certified nurse midwife, or nurse).
- Dental Services (Line 19). A patient may have one dental service visit per day (visit with a dentist or hygienist).

[xx] BPHC Uniform Data System Manual, 2011 Revision, p. 39.

- Other Professional Services (Line 22). A patient may have one "other health" visit *for each type of "other health" provider* (e.g., visit with a nutritionist *and* a visit with a podiatrist *and* a visit with a speech therapist, all on the same day as long as the person providing the services is not the same provider).
- Vision Services (Line 22d). A patient may have one eye exam/vision service visit per day (e.g., visit with an ophthalmologist, eye care specialist, optometrist, contract optometrist, optometric assistant or optometry student).
- Enabling Services (Line 29). A patient may have one enabling service visit per day *for each type of "enabling service" provider* (e.g., visit with a case manager *and* a visit with a family planning counselor, both on the same day as long as the person providing the services is not the same provider).
- Mental Health Services (Line 20). A patient may have one mental service visit per day (e.g., visit with a psychiatrist, psychologist, or medical social worker).
- Substance Abuse Services (Line 21). A patient may have one substance abuse service visit per day (e.g., visit with an alcoholism/substance abuse counselor, family therapist, or mental health).

The Bureau of Primary Health Care (BPHC) UDS Manual defines visits as ". . . documented, face-to-face contacts between a patient and a provider who exercises independent professional judgment in the provision of services to the patient".[xxi] The blocked out areas in Column B (see Table 5-5) indicate staff categories whose visits are *not* counted.

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

Column C displays the unduplicated number of patients who received the visits displayed in Column B. A patient is defined as "an individual who has had at least one visit during the reporting year".[xxii] (Section 4.2 discusses definitions and logic in more detail.)

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

[xxi] BPHC Uniform Data System Manual, 2011 Revision, p. 6.

[xxii] BPHC Uniform Data System Manual, 2011 Revision, p. 39.

Table 5 Logic

RPMS UDS reviews every visit (see Section 4.2.2) for patients who meet the RPMS UDS definition of a patient. Based on the PRIMARY PROVIDER discipline code, the visit is tabled according to the RPMS UDS to BPHC UDS mapping logic (see Appendix D: RPMS Provider Codes Mapping to UDS Service Category for Table 5–5). For example, a visit with Primary Provider Code 70 Cardiologist is counted toward Line 7 Other Specialty Physicians. If the primary provider discipline code does not fit into any of the BPHC categories, a separate line at the bottom of the report is listed with the number of visits that did not map to a category.

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UDS No. 000001 Date Run: Dec 15, 2011
Reporting Period: Jan 01, 2011 through Dec 31, 2011

TABLE 5-STAFFING AND UTILIZATION

	PERSONNEL BY MAJOR SERVICE CATEGORY	FTEs (a)	CLINIC VISITS (b)	PATIENTS (c)
1.	Family Physicians		3,841	********
2.	General Practitioners		72,668	********
3.	Internists		1,507	********
4.	Obstetrician/Gynecologists		7,950	********
5.	Pediatricians		1,043	********
7.	Other Specialist Physicians		2,318	********
8.	Total Physicians (Lines 1-7)		89,327	********
9a.	Nurse Practitioners		21,354	********
9b.	Physician Assistants		6,723	********
10.	Certified Nurse Midwives		7,901	********
10a.	Total NP, PA, and CNMs (Lines 9a-10)		35,978	********
11.	Nurses		16,116	********
12.	Other Medical Personnel		********	********
13.	Laboratory Personnel		********	********
14.	X-Ray Personnel		********	********
15.	Total Medical Care (Lines 8 + 10a through 14)		141,421	34,272
16.	Dentists		11,438	********
17.	Dental Hygienists		1	********

18.	Dental Assistants, Aides, Technicians	********	********
19.	Total Dental Services (Lines 16-18)	11,439	6,110

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

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UDS No. 000001 Date Run: Dec 15, 2011
Reporting Period: Jan 01, 2011 through Dec 31, 2011

TABLE 5-STAFFING AND UTILIZATION

	PERSONNEL BY MAJOR SERVICE CATEGORY	FTEs (a)	CLINIC VISITS (b)	PATIENTS (c)
20a.	Psychiatrists		1,075	********
20a1.	Licensed Clinical Psychologists		9	********
20a2.	Licensed Clinical Social Workers		9	********
20b.	Other Licensed Mental Health Providers		5	********
20c.	Other Mental Health Staff		2,385	********
20.	Mental Health Services (Lines 20a-c)		3,483	870
21.	Substance Abuse Services		1,409	631
22.	Other professional services (specify__)		8,357	3,780
22a.	Ophthalmologists		1,715	********
22b.	Optometrists		5,281	********
22c.	Other Vision Care Staff		********	********
22d.	Total Vision Services (Lines 22a-c)		7,029	4,321
23.	Pharmacy Personnel		********	********
24.	Case Managers		3	********
25.	Patient and Community Education Specialists		8	********
26.	Outreach Workers		********	********
27.	Transportation Staff		********	********
27a.	Eligibility Assistance Workers		********	********
27b.	Interpretation Staff		********	********

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

```
  DU     UDS 2011           DEMO INDIAN HOSPITAL                      Page 3
UDS No.  000001                                      Date Run: Dec 15, 2011
Reporting Period:  Jan 01, 2011 through Dec 31, 2011

                       TABLE 5-STAFFING AND UTILIZATION
-------------------------------------------------------------------------------
                                                    FTEs    CLINIC   PATIENTS
                                                            VISITS
PERSONNEL BY MAJOR SERVICE CATEGORY                  (a)      (b)        (c)
-------------------------------------------------------------------------------
28.   Other Enabling Services
          (specify__)                                        ********   ********
_______________________________________________________________________________
29.       Total Enabling Services
          (Lines 24-28)                                        11         34
_______________________________________________________________________________
29a.      Other Programs/ Services
          (specify__)                                        ********   ********
_______________________________________________________________________________
30a.  Management and Support
      Staff                                                  ********   ********
_______________________________________________________________________________
30b.  Fiscal and Billing Staff                               ********   ********
_______________________________________________________________________________
30c.  IT Staff                                               ********   ********
_______________________________________________________________________________
30.       Total Administrative Staff
          (Lines 30a-30c)                                    ********   ********
_______________________________________________________________________________
31.   Facility Staff                                         ********   ********
_______________________________________________________________________________
32.   Patient Support Staff                                  ********   ********
_______________________________________________________________________________
33.       TOTAL ADMINISTRATION AND FACILITY
          (TOTAL LINES 30+31+32)                             ********   ********
_______________________________________________________________________________
34.       GRAND TOTAL: (TOTAL LINES
          (15+19+20+21+22d+22+23+29+29a+33)                  173,525    ********
_______________________________________________________________________________

209 visits did not fit into any of the above categories
```

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

5.2.5 Table 6A Selected Diagnoses and Services Rendered

Table 6A reports the number of visits and patients for 26 selected diagnoses and 22 services rendered, e.g., laboratory tests, mammograms. The system reports visits where the requested diagnosis is the *primary* diagnosis only. For services, all specified diagnostic or procedure codes are counted, even when more than one test or preventive service was documented during the same visit. For example, if an HIV test and a Pap smear were conducted during the same visit, each would be counted in the appropriate report line. Additionally for services only, tests or services found on both completed and "orphan" visits are counted and so are services documented as historical events.

Table 6A does not reflect the full range of diagnoses and services offered by a BPHC grantee facility, but rather those that are prevalent among BPHC patients and/or are considered key indicators.

Diagnoses include:

- HIV (symptomatic and asymptomatic)
- Tuberculosis
- Syphilis and other sexually transmitted diseases
- Hepatitis B
- Hepatitis C
- Asthma
- Chronic bronchitis and emphysema
- Abnormal breast findings, female
- Abnormal cervical findings
- Diabetes mellitus
- Heart disease (selected)
- Hypertension
- Contact dermatitis and other eczema
- Dehydration
- Exposure to heat or cold
- Overweight and obesity
- Otitis media and eustachian tube disorders
- Selected perinatal medical conditions
- Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive)–does not include sexual or mental development; nutritional deficiencies
- Alcohol related disorders
- Other substance abuse disorders (excluding tobacco use disorders)
- Tobacco use disorder
- Depression and other mood disorders
- Anxiety disorders including post-traumatic stress disorder (PTSD)
- Attention deficit and disruptive behavior disorders

- Other mental disorders, excluding drug or alcohol dependence (includes mental retardation)

Services include:

- HIV tests
- Hepatitis B test
- Hepatitis C test
- Mammogram
- Pap test
- Selected immunizations: (Hepatitis A, Hemophilus Influenza B (HiB), Pneumococcal, Diptheria, Tetanus, Pertussis (DTaP) (DTP) (DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatitis B Child)
- Seasonal flu vaccine
- H1N1 flu vaccine
- Contraceptive management
- Health supervision of infant or child (ages 0 through 11)
- Childhood lead test screening (9 to 72 months)
- Screening, Brief Intervention, and Referral (SBIRT)
- Smoke/tobacco counseling; Smoking cessation treatment
- Comprehensive and intermediate eye exams
- Dental: Emergency Services
- Dental: Oral Exams
- Dental: Prophylaxis–adult or child
- Dental: Sealants
- Dental: Fluoride Treatment–adult or child
- Dental: Restorative Services
- Dental: Oral Surgery (extractions and other surgical procedures)
- Dental: Rehabilitative Services (Endo, Perio, Prostho, Ortho)

5.2.5.1 Logic for Diagnoses

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

Table 5-6: Table 6A BPHC Codes for Tests and Preventative Services [xxiii]

Diagnostic Category		Applicable ICD-9-CM Code	Number of Visits by Primary Diagnosis (A)	Number of Patients with Primary Diagnosis (B)
Selected Infectious and Parasitic Diseases				
1, 2.	Symptomatic and Asymptomatic HIV	042.xx; 079.53; V08		
3.	Tuberculosis	010.xx–018.xx		
4.	Syphilis and other sexually transmitted diseases	090.xx–099.xx		
4.a	Hepatitis B	070.20; 070.22; 070.30; 070.32		
4.b	Hepatitis C	070.41; 070.44, 070.51; 070.54, 070.70; 070.71		
Selected Diseases of the Respiratory System				
5.	Asthma	493.xx		
6.	Chronic bronchitis and emphysema	490.xx–492.xx		
Selected Other Medical Conditions				
7.	Abnormal breast findings, female	174.xx; 198.81; 233.0x; 238.3; 793.8x		
8.	Abnormal cervical findings	180.xx; 198.82; 233.1x; 795.0x		
9.	Diabetes mellitus	250.xx; 648.0x; 775.1x		
10.	Heart disease (selected)	391.xx–392.0x 410.xx–429.xx		

[xxiii] BPHC Uniform Data System Manual, 2011 Revision, p. 49

Diagnostic Category		Applicable ICD-9-CM Code	Number of Visits by Primary Diagnosis (A)	Number of Patients with Primary Diagnosis (B)
11.	Hypertension	401.xx–405.xx		
12.	Contact dermatitis and other eczema	692.xx		
13.	Dehydration	276.5x		
14.	Exposure to heat or cold	991.xx–992.xx		
14a.	Overweight and obesity	278.00–278.02; V85.xx excluding V85.0, V85.1, V85.51; V85.52		
Selected Childhood Conditions				
15.	Otitis media and eustachian tube disorders	381.xx–382.xx		
16.	Selected perinatal medical conditions	770.xx; 771.xx; 773.xx; 774.xx–779.xx (excluding 779.3x)		
17.	Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive)--does not include sexual or mental development; Nutritional deficiencies	260.xx–269.xx; 779.3x; 783.3x–783.4x;		

Table 5-7: Table 6A BPHC Codes for Tests and Preventative Services [xxiv]

Diagnostic Category		Applicable ICD-9-CM Code	Number of Visits by Primary Diagnosis (A)	Number of Patients with Primary Diagnosis (B)
Selected Mental Health and Substance Abuse Conditions				
18.	Alcohol related disorders	291.xx; 303.xx; 305.0x; 357.5x		
19.	Other substance related disorders (excluding tobacco use disorders)	292.1x–292.8x; 304.xx; 305.2x–305.9x; 357.6x; 648.3x		
19a.	Tobacco use disorder	305.1		
20a.	Depression and other mood disorders	296.xx; 300.4; 301.13; 311.xx		

[xxiv] BPHC Uniform Data System Manual, 2011 Revision, p. 50

Diagnostic Category		Applicable ICD-9-CM Code	Number of Visits by Primary Diagnosis (A)	Number of Patients with Primary Diagnosis (B)
20b	Anxiety disorders including PTSD	300.0x; 300.2x, 300.3; 308.3; 309.81		
20c	Attention deficit and disruptive behavior disorders	312.8x; 312.9x; 313.81; 314.xx		
20d	Other mental disorders, excluding drug or alcohol dependence (includes mental retardation)	290.xx; 293.xx–302.xx (excluding 296.xx, 300.0x; 300.2x, 300.3; 300.4; 301.13); 306.xx–319.xx (excluding 308.3, 309.81; 311.xx; 312.8x; 312.9x; 313.81; 314.xx)		

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

5.2.5.2 Logic for Diagnostic Tests, Screening, and Preventive Services

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

For Column B (Number of Patients), the logic counts each patient who had at least one visit during the calendar year for the specified tests/screening. If the patient had two or more different tests during the same visit, the patient would count once for each separate test/screening/service. For service categories, BPHC identifies CPT, ICD-9, and ADA codes. See Table 5-8 below for the BPHC-defined codes.

Table 5-8: Example of Table 6A BPHC Codes for Tests and Preventative Services [xxv]

Service Category		Applicable ICD-9-CM or CPT-4 Code(s)	Number of Visits (A)	Number of Patients (B)
Selected Diagnostic Tests/Screening/Preventive Services				
21.	HIV test	**CPT-4:** 86689; 86701–86703; 87390-87391		
21.a	Hepatitis B test	**CPT-4:** 86704; 86706; 87515–87517		
21.b	Hepatitis C test	**CPT-4:** 86803–86804; 87520-87522		
22.	Mammogram	**CPT-4:** 77052, 77057 OR **ICD-9:** V76.11; V76.12		
23.	Pap Test	**CPT-4:** 88141–88155; 88164–88167; 88174–88175 **OR** **ICD-9:** V72.3; V72.31; V76.2		
24.	Selected Immunizations: Hepatitis A, Hemophilus Influenza B (HiB), Pneumococcal, Diptheria, Tetanus, Pertussis (DTaP) (DTP) (DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatitis B Child)	**CPT-4:** 90633–90634; 90645–90648; 90670; 90696–90702; 90704–90716; 90718–90723 90743–90744; 90748		
24a	Seasonal Flu vaccine	**CPT-4**: 90655–90662		
24b	H1N1 Flu vaccine	**CPT-4**: 90663; 90470		
25.	Contraceptive management	**ICD-9**: V25.xx		
26.	Health supervision of infant or child (ages 0 through 11)	**CPT-4**: 99391–99393; 99381–99383;		
26a.	Childhood lead test screening (9 to 72 months)	**CPT-4**: 83655		
26b.	Screening, Brief Intervention, and Referral (SBIRT)	CPT-4: 99408–99409		

[xxv] BPHC Uniform Data System Manual, 2011 Revision, pp. 50-51

Service Category		Applicable ICD-9-CM or CPT-4 Code(s)	Number of Visits (A)	Number of Patients (B)
26c.	Smoke and tobacco use cessation counseling	**CPT-4**: 99406 and 99407; S9075		
26d.	Comprehensive and intermediate eye exams	**CPT-4**: 92002; 92004; 92012; 92014		
Selected Dental Services				
27.	I. Emergency Services	**ADA:** D9110		
28.	II. Oral Exams	**ADA:** D0120; D0140; D0145; D0150; D0160; D0170; D0180		
29.	Prophylaxis - adult or child	**ADA:** D1110; D1120		
30.	Sealants	**ADA:** D1351		
31.	Fluoride treatment - adult or child	**ADA:** D1203; D1204; D1206		
32.	III. Restorative Services	**ADA:** D21xx–D29xx		
33.	IV. Oral Surgery (extractions and other surgical procedures)	**ADA:** D7111; D7140; D7210; D7220; D7230; D7240; D7241; D7250; D7260; D7261; D7270; D7272; 7280		
34.	V. Rehabilitative services (Endo, Perio, Prostho, Ortho)	**ADA:** D3xxx; D4xxx; D5xxx; D6xxx; D8xxx		

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

RPMS UDS has expanded the logic for each test/service category as defined in Table 5-9.

Table 5-9: Expanded Logic for Each Test/Service Category

Test/Service	RPMS Logic
HIV test	**V LAB:** LOINC taxonomy BGP HIV TEST LOINC CODES, site-defined taxonomy BGP HIV TEST TAX **V CPT:** 86689; 86701-86703; 87390-87391 (BPHC-defined)
Hepatitis B test	**V LAB:** site-defined taxonomy BUD HEPATITIS B TEST **V CPT:** 86704; 86706; 87515-87517 (BPHC-defined)
Hepatitis C test	**V LAB**: site-defined taxonomy BUD HEPATITIS C TEST **V CPT:** 86803-86804; 87520-87522 (BPHC-defined)
Mammogram	**V RADIOLOGY:** CPT codes 77052; 77057 (BPHC-defined) **V CPT:** 77052; 77057 (BPHC-defined) **V POV:** ICD V76.11; V76.12 (BPHC-defined) **Women's Health:** Any procedure called MAMMOGRAM SCREENING, MAMMOGRAM DX BILAT, or MAMMOGRAM DX UNILAT
Pap Test(s)	**V LAB:** Any laboratory test of PAP SMEAR, site-defined taxonomy BGP PAP SMEAR TAX, LOINC taxonomy BGP PAP LOINC CODES **V CPT:** 88141-88155; 88164-88167; 88174-88175 (BPHC-defined) **V POV:** ICD V72.3; V72.31; V76.2 (BPHC-defined) **Women's Health:** Any procedure called PAP SMEAR **V HCPCS:** G0101, G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091
Selected Immunizations: Hepatitis A, Hemophilus Influenza B (HiB), Influenza virus, Pneumococcal, Diphtheria, Tetanus, Pertussis (DTaP) (DTP) (DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatitis B Child	**V CPT:** 90633-90634; 90645–90648; 90670; 90696–90702; 90704–90716; 90718-90723; 90743–90744; 90748 (BPHC-defined) **V IMMUNIZATION:** CVX Codes 83 HEP A PED, 84 HEP A PED, 104 HEP A-HEP B, 46 HIB, 47 HIBTITER, 48 ACTHIB, 49 PEDVAXHIB, 130 DTap-IPV, 120 DTap-Hib-IPV, 20 DTAP, 01 DTP, 28 DT PED, 106 DTAP 5Pertussis, 107 DTAP NOS, 02 OPV, 89 POLIO, NOS, 03 MMR, 04 MR, 05 MEASLES, 06 RUBELLA, 07 MUMPS, 38 RUBELLA/MUMPS, 09 Td-ADULT, 138 Td (adult), 139 Td (adult) NOS, 10 IPV, 11 Pertussis, 21 VARICELLA, 94 MMRV, 113 TD (ADULT) PRESERVATIVE FREE, 115 TDAP, 22 DTP-HIB, 50 DTap-Hib, 110 DTap-HepB-IPV, 43 HEP B ADULT, 08 HEP B PED, 42 HEP B Adolescent, 44 HEP B, DIALYSIS, 45 HEP B NOS, 51 HepB-Hib, 102 DTP-HIB-HEP B, 132 DTaP-IPV-HIB-HEP B historical, 31 HEP A PED, 52 HEP A, 85 HEP A NOS, 17 HIB NOS, 33 PNEUMO PPV23, 100 PNEUMO PED, 109 PNEUMO NOS, 133 PNEUMO PCV13
Seasonal Flu Vaccine	**V CPT:** 90655-90662 (BPHC-defined) **V IMMUNIZATION:** 15 INFLUENZA PED, 16 INFLUENZA, WHOLE, 111 INTRANASAL INFLUENZA, 135 Influenza High Dosage, 140 Influenza, seasonal, injectable, preservative free, 141 Influenza, seasonal, injectable

Test/Service	RPMS Logic
H1N1 Flu Vaccine	**V CPT:** 90663; 90470 (BPHC-defined) **V IMMUNIZATION:** 125 Novel Influenza-H1N1-09, Nasal, 126 Novel influenza-H1N1-09, preservative-free, 127 Novel influenza-H1N1-09, 128 Novel influenza-H1N1-09, all formulations
Contraceptive Management	**V POV:** V25.xx (BPHC-defined)
Health Supervision of infant or child (ages 0 through 11)	For any visit for patients 0-11 as of June 30: **Clinic code:** 24 (Well Child) or 57 (EPSDT [Early and Periodic Screening, Diagnosis and Treatment]) **V CPT:** 99381-99383, 99391-99393 (BPHC-defined)
Childhood lead test screening (9 to 72 months)	**V CPT:** 83655 (BPHC-defined)
Screening, Brief Intervention, and Referral (SBIRT)	**V CPT:** 99408-99409 (BPHC-defined) **Patient Education Code:** AOD-INJ
Smoke/tobacco counseling; Smoking cessation treatment	**V CPT:** 99406 and 99407; S9075 (BPHC-defined) **Patient Education Code:** Containing "TO-", "-TO", "-SHS", 305.1
Comprehensive and intermediate eye exams	**V CPT:** 92002, 92004, 92012, 92014 (BPHC-defined)
Dental: I. Emergency Services	**ADA:** 9110 (BPHC-defined) **V CPT:** D9110
Dental: II. Oral Exams	**ADA:** 0120, 0140, 0145, 0150, 0160, 0170, 0180 (BPHC-defined) **V CPT:** D0120, D0140, D0145, D0150, D0160, D0170, D0180
Prophylaxis–adult or child	**ADA:** 1110, 1120 (BPHC-defined) **V CPT:** D1110, D1120
Sealants	**ADA:** 1351 (BPHC-defined) **V CPT:** D1351
Fluoride treatment–adult or Child	**ADA:** 1203, 1204, 1206 (BPHC-defined) **V CPT:** D1203, D1204, D1206
Dental: III. Restorative Services	**ADA:** 21xx–29xx (BPHC-defined) **V CPT:** D21xx–D29xx

Test/Service	RPMS Logic
Dental: IV. Oral Surgery (extractions and other surgical procedures)	**ADA:** 7111, 7140, 7210, 7220, 7230, 7240, 7241, 7250, 7260, 7261, 7270, 7272, 7280 (BPHC-defined) **V CPT:** D7111, D7140, D7210, D7220, D7230, D7240,D7241, D7250, D7260, D7261,D7270, D7272, D7280
Dental: V. Rehabilitative services (Endo, Perio, Prostho, Ortho)	**ADA:** 3xxx, 4xxx, 5xxx, 6xxx, 8xxx (BPHC-defined) **V CPT:** D3xxx, D4xxx, D5xxx, D6xxx, D8xxx

Figure 5-5 through Figure 5-9 (which follow) show a sample RPMS UDS Table 6A report.

DU UDS 2011 DEMO INDIAN HOSPITAL Page 1
UDS No. 000001 Date Run: Dec 15, 2011
Reporting Period: Jan 01, 2011 through Dec 31, 2011

TABLE 6A-
SELECTED DIAGNOSES AND SERVICES RENDERED

DIAGNOSTIC CATEGORY	Applicable icd-9-cm code	Number of Visits by prim dx (a)	# of Pts w/this prim Dx (b)
1,2. Symptomatic and Asymptomatic HIV	042,079.53, V08	47	29
3. Tuberculosis	010.xx-018.xx	5	5
4. Syphilis and other sexually transmitted diseases	090.xx-099.xx	56	43
4a. Hepatitis B	070.20, 070.22, 070.30 070.32	27	21
4b. Hepatitis C	070.41, 070.44, 070.51 070.54, 070.70, 070.71	327	128
SELECTED DISEASES OF THE RESPIRATORY SYSTEM			
5. Asthma	493.xx	2,274	1,421
6. Chronic bronchitis and emphysema	490.xx-492.xx	1,562	1,349

SELECTED OTHER MEDICAL CONDITIONS				
7.	Abnormal breast findings, female	174.xx; 198.81; 233.0x 238.3; 793.8x	154	60
8.	Abnormal cervical findings	180.xx; 198.82; 233.1x; 795.0x	892	597
9.	Diabetes mellitus	250.xx; 648.0x; 775.1x	11,645	2,590
10.	Heart disease (selected)	391.xx-392.0x 410.xx-429.xx	1,973	928
11.	Hypertension	401.xx-405.xx	6,373	2,773

Figure 5-7: Sample RPMS UDS Report for Table 6A, Page 1

DU UDS 2011 DEMO INDIAN HOSPITAL Page 2
UDS No. 000001 Date Run: Dec 15, 2011
Reporting Period: Jan 01, 2011 through Dec 31, 2011

TABLE 6A-
SELECTED DIAGNOSES AND SERVICES RENDERED

	DIAGNOSTIC CATEGORY	Applicable icd-9-cm code	Number of Visits by prim dx (a)	# of Pts w/this prim Dx (b)
12.	Contact dermatitis and other eczema	692.xx	1,294	1,111
13.	Dehydration	276.5x	99	93
14.	Exposure to heat or cold	991.xx-992.xx	15	15
14a.	Overweight and obesity	278.00-278.02, V85.xx excluding V85.0, V85.1, V85.51, V85.52	294	231
	SELECTED CHILDHOOD CONDITIONS			
15.	Otitis Media and eustachian tube disorders	381.xx-382.xx	5,734	3,785
16.	Selected perinatal medical conditions	770.xx; 771.xx; 773.xx 774.xx-779.xx excluding 779.3x	260	177
17.	Lack of expected normal physical development (such as delayed milestone; failure to gain weight; failure to thrive)-does not include sexual or mental development; Nutritional deficiencies	260.xx-269.xx; 779.3x 783.3x-783.4x	160	56

```
SELECTED MENTAL HEALTH AND SUBSTANCE ABUSE CONDITIONS
_____________________________________________________________________________
                                  291.xx; 303.xx;
18.  Alcohol related disorders    305.0x, 357.5x            198           122
_____________________________________________________________________________
19.  Other substance related      292.1x-292.8x
      disorders (excluding tobacco 304.xx, 305.2x-305.9x
      use disorders)              357.6x, 648.3x            148            99
_____________________________________________________________________________
19a. Tobacco use disorder         305.1                      74            72
_____________________________________________________________________________
```

Figure 5-8: Sample RPMS UDS Report for Table 6A, Page 2

```
  DU     UDS 2011           DEMO INDIAN HOSPITAL                    Page 3
UDS No.  000001                                  Date Run: Dec 24, 2011
Reporting Period:  Jan 01, 2011 through Dec 31, 2011

                                TABLE 6A-
                    SELECTED DIAGNOSES AND SERVICES RENDERED
-----------------------------------------------------------------------------
                                  Applicable   Number of    # of Pts
                                  icd-9-cm     Visits by    w/this prim
                                  code         prim dx        Dx
DIAGNOSTIC CATEGORY                                (a)             (b)
-----------------------------------------------------------------------------
20a. Depression and other mood    296.xx, 300.4
      disorders                   301.13, 311.xx          3,424          961
_____________________________________________________________________________
20b. Anxiety disorders including  300.0x, 300.2x, 300.3
      PTSD                        308.3, 309.81             961          401
_____________________________________________________________________________
20c. Attention Deficit and        312.8x, 312.9x,
     disruptive behavior disorders 313.81, 314.xx           636          183
_____________________________________________________________________________
                                  290.xx
                                  293.xx-302.xx
                                  (excluding 296.xx
20d. Other mental disorders,      300.0x, 300.2x, 300.3
      excluding drug or alcohol   300.4, 301.13);
      dependence
      (includes mental            306.xx-319.xx (excluding 308.3,
       retardation)               309.81, 311.xx, 312.8x,
                                  312.9x, 313.81,
                                  314.xx)                   896          444
_____________________________________________________________________________
```

Figure 5-9: Sample RPMS UDS Report for Table 6A, Page 3

```
  DU     UDS 2011           DEMO INDIAN HOSPITAL                    Page 4
UDS No.  000001                                  Date Run: Dec 15, 2011
Reporting Period:  Jan 01, 2011 through Dec 31, 2011

                                TABLE 6A-
                    SELECTED DIAGNOSES AND SERVICES RENDERED
-----------------------------------------------------------------------------
                                  Applicable   Number of    # of Pts
                                  icd-9-cm     Visits by     w/this prim
                                  code         prim dx        Dx
DIAGNOSTIC CATEGORY                                (a)             (b)
-----------------------------------------------------------------------------

SELECTED DIAGNOSTIC TESTS/SCREENING/PREVENTIVE SERVICES
_____________________________________________________________________________
```

21. HIV Test	CPT-4: 86689; 86701-86703 87390-87391 LOINC & site- defined taxonomies	1,031	991
21a. Hepatitis B test	CPT-4: 86704, 86706, 87515-87517 or VLab [BUD HEPATITIS B TESTS]	654	622
21b. Hepatitis C test	CPT-4: 86803-86804, 87520-87522 or VLab [BUD HEPATITIS C TESTS]	683	637
22. Mammogram	CPT-4: 77052, 77057 ICD-9: V76.11, V76.12 WH Mammogram Screening WH Mammogram DX Bilat WH Mammogram DX Unilat	750	644
23. Pap Test	CPT-4: 88141-88155, 88164-88167, 88174-88175 ICD-9: V72.3, V72.31, V76.2 VLab Pap Smear; WH Pap Smear; LOINC & site defined taxonomies	5,216	4,502
24. Selected immunizations; Hepatitis A, Hemophilius Influenza B (HIB), Pneumococcal, Diphtheria, Tetanus, Pertussis (DTap) (DTP)(DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatitis B Child	CPT-4: 90633-90634 90645-90648 90670, 90696-90702 90704-90716, 90718-90723 90743-90744, 90748 CVX: 31,52,83-84,85,104,17,22 46-47,48-49,50-51,102,120,132 33, 109,133,01,09,11 20,22,28,50,106,107,110,113 115,130,132,138,139,03-07 38,94,02,10,89,21,94,08,42 43,44,45	5,733	4,307

Figure 5-10: Sample RPMS UDS Report for Table 6A, Page 4

DU UDS 2011 DEMO INDIAN HOSPITAL Page 5
UDS No. 000001 Date Run: Dec 15, 2011
Reporting Period: Jan 01, 2011 through Dec 31, 2011

TABLE 6A-
SELECTED DIAGNOSES AND SERVICES RENDERED

DIAGNOSTIC CATEGORY	Applicable icd-9-cm code	Number of Visits by prim dx (a)	# of Pts w/this prim Dx (b)
24a. Seasonal Flu vaccine	CPT-4: 90655-90662, CVX: 16, 111, 135, 140, 141	814	808
24b. H1N1 Flu vaccine	CPT-4: 90663; 90470	20	17
25. Contraceptive Management	ICD-9: V25.xx	4,185	2,328
26. Health supervision of infant	Clinic code 24, 57;		

or child (ages 0-11)	CPT-4: 99381-99383, 99391-99393	2,758	1,551
26a. Childhood lead test screening (9-72 months)	CPT-4: 83655	1	1
26b. Screening, Brief Intervention and Referral (SBIRT)	CPT-4: 99408-99409 Pat Ed: AOD-INJ	11	9
26c. Smoke and tobacco use cessation counseling	CPT-4: 99406 and 99407; S9075; Pat Ed: TO-*; -TO*, *-SHS; 305.1	3,549	2,371
26d. Comprehensive and intermediate eye exams	CPT-4: 92002, 92004, 92012, 92014	239	234
SELECTED DENTAL SERVICES			
27. I. Emergency Services	ADA: 9110 CPT-4: D9110	222	213
28. II. Oral Exams	ADA: 0120, 0140, 0145, 0150 0160, 0170, 0180; CPT-4: D0120 D0140, D0145, D0150, D0160 D0170, D0180	6,851	5,209
29. Prophylaxis-adult or child	ADA: 1110, 1120, CPT-4: D1110, D1120	454	438
30. Sealants	ADA: 1351; CPT-4: D1351	469	407

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

DU UDS 2011 DEMO INDIAN HOSPITAL Page 6
UDS No. 000001 Date Run: Dec 15, 2011
Reporting Period: Jan 01, 2011 through Dec 31, 2011

TABLE 6A-
SELECTED DIAGNOSES AND SERVICES RENDERED

DIAGNOSTIC CATEGORY	Applicable icd-9-cm code	Number of Visits by prim dx (a)	# of Pts w/this prim Dx (b)
31. Fluoride treatment- adult or child	ADA: 1203, 1204, 1206 CPT-4: D1203, D1204 D1206	932	790
32. III. Restorative Services	ADA: 21xx-29xx CPT-4: D21xx-D29xx	2,178	1,558
33. IV. Oral Surgery (extractions and other surgical procedures)	ADA: 7111, 7140, 7210, 7220 7230, 7240, 7241, 7250, 7260 7261, 7270, 7272, 7280 CPT-4: D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7270, D7272, D7280	1,581	1,439

```
34.  V. Rehabilitative services
      (Endo, Perio, Prostho, Ortho)ADA: 3xxx, 4xxx, 5xxx
                                   6xxx, 8xxx
                                   CPT-4: D3xxx, D4xxx, D5xxx
                                   D6xxx, D8xxx            1,851         1,320
```

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

5.2.6 Table 6B Quality of Care Indicators

Table 6B reports the number of patients with selected quality of care indicators, (prenatal care, childhood immunizations, pap smears). These indicators are "process measures" which means that they document services which are thought to be correlated with and serve as a proxy for good long-term health outcomes.

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

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

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

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

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

[xxvi] BPHC Uniform Data System Manual, 2011 Revision, p. 53

[xxvii] BPHC Uniform Data System Manual, 2011 Revision, p. 53

The BPHC UDS Manual defines trimesters as described below:[xxviii]

- **First Trimester**–Women who received prenatal care during the reporting period and whose first visit occurred when they were estimated to be pregnant anytime through the end of the 13th week after conception.
- **Second Trimester**–Women who received prenatal care during the reporting period and whose first visit occurred when they were estimated to be between the start of the 14th week and through the 26th week after conception
- **Third Trimester**–Women who received prenatal care during the reporting period and whose first visit occurred when they were estimated to be 27 weeks or more after conception.

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

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

> **Note:** The definition of pregnancy is defined in Section 5.2.6.

5.2.6.2 Logic for Section C: Childhood Immunizations

This section (Table 6B Line 10) reports on the number of children with at least one medical visit during the reporting period, who had their second birthday during the reporting period, and who were first seen ever by the grantee prior to their second birthday and the number of those children who were fully immunized. **Note:** Those children whose only service was receipt of a vaccination and who never received other medical services are not to be counted as patients on the demographic tables and are not included in the universe for this table.

[xxviii] BPHC Uniform Data System Manual, 2011 Revision, pp. 53-54

A child is fully immunized if he/she has been vaccinated or there is documented evidence of contraindication for the vaccine or a history of illness for *all* of the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1 Varicella, 4 Pneumococcal conjugates, 2 Hepatitis A, 2 or 3 Rotavirus, and 2 Influenza prior to or on his/her second birthday. This includes patients who received the vaccines, had a contraindication to a vaccine(s), and/or had a documented history of the illness(es).

> **Note**: Detailed patient lists can be produced from the List menu option within the Manager Utilities for "All Patients Age 2 w/All Child Immunizations" (MU/LST/LST2/CIM1) and "All Patients Age 2 w/o All Child Immunizations" (MU/LST/LST2/CIM2) to assist sites with verifying the information reported by RPMS UDS.

Dosage and types of immunization definitions:

- **Four doses of DTP/DTaP:** (1) 4 DTaP/DTP; (2) 1 DTaP/DTP and 3 DT; (3) 1 DTaP/DTP and 3 each of Diphtheria and Tetanus; (4) 4 DT and 4 Pertussis; or (5) 4 each of Diphtheria, Tetanus, and Pertussis. The patient must have received the 4 doses of DTaP on or after 42 days of age and before the child's second birthday.
- **Three doses of IPV:** The three polio vaccinations (IPV) with different dates of service must be received on or after 42 days of age and before the child's second birthday.
- **One dose of MMR:** (1) MMR; or (2) 1 each of Measles, Mumps, and Rubella. The measles, mumps and rubella (MMR) vaccination must be received on or before the child's second birthday.
- **Three doses of HIB:** The three H influenza type B (HiB) vaccination, with different dates of service must be received on or after 42 days of age and before the child's second birthday.
- **Three doses of Hep B:** The hepatitis B vaccinations, with different dates of service must be received on or before the child's second birthday.
- **One dose of Varicella:** The chicken pox vaccination with a date of service falling must be received on or after the child's first birthday and on or before the child's second birthday.
- **Four doses of Pneumococcal:** The four pneumococcal conjugate vaccinations must be received on or before child's second birthday.
- **Two doses of Hepatitis A:** The two Hepatitis A vaccinations, with different dates of service must be received on or before the child's 2nd birthday.
- **Two or three doses of Rotavirus:** The two or three Rotavirus vaccinations, with different dates of service must be received on or after 42 days of age and before the child's 2nd birthday.

- **Two doses of Influenza:** The two Influenza vaccinations, with different dates of service must be received on or after 180 days of age and before the child's 2nd birthday.

Contraindications

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

For immunizations where required number of doses is >1, only one contraindication is necessary on or before the patient's second birthday to be counted as receiving all immunization(s) for the contraindicated vaccine. The patient may or may not have previously received an immunization(s) for the contraindicated vaccine. For example, if there is a single contraindication for Hib, the patient will be counted as receiving the required number of doses for Hib. See Table 5-10 below for specific contraindication definitions.

> **Note:** Contraindications should be looked for as far back as possible in the patient's history but prior to the patient's 2nd birthday

Table 5-10: Table 6B Section C Childhood Immunizations BPHC Contraindications [xxix]

Childhood Immunizations, Contraindications Definitions		
Vaccine	**Contraindication and BPHC-Specified Applicable ICD-9-CM Code(s)**	**Other Codes to Check (IHS-Specified Codes)**
All Vaccines	Allergic reaction to the vaccine or its components: ICD-9: 999.4	Immunization Package contraindication of "Anaphylaxis" for any of the vaccines listed below
DTaP/DTP	Encephalopathy: ICD-9 323.5* AND (E948.4 or E948.5 or E948.6)	
Varicella and MMR	Immunodeficiency, including genetic (congenital) immunodeficiency syndromes: ICD-9 279.* HIV-infected or household contact with HIV infection: ICD-9 V08, 042, 079.53 Cancer of lymphoreticular or histiocytic tissue: ICD-9 200.*-202.* Multiple myeloma: ICD-9 203.0*, 203.1*, 203.8* Leukemia: ICD-9 204.*-208.*	

[xxix] BPHC Uniform Data System Manual, 2011 Revision, pp. 58-59

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

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

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

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

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

5.2.6.5 Number of Patients Immunized, Column (C)

This column contains the number of children from column b who have received all of the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1Varicella, 4 Pneumococcal conjugates, 2 Hepatitis A, 2 or 3 Rotavirus, and 2 Influenza prior to or on their second birthday. RPMS UDS counts any of the following as documenting compliance for a given vaccine: evidence of the antigen, contraindication for the vaccine, documented history of the illnesses, or a seropositive test result. For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), find evidence of all the antigens. See Table 5-11 below for the BPHC-defined and IHS-specific codes.

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

Table 5-11: Table 6B Section C Childhood Immunizations BPHC-Defined[xxx] and IHS-Specific Codes

Childhood Immunizations Definitions		
Vaccine	**BPHC-Specified Applicable ICD-9-CM and CPT-4 Code(s)**	**Other Codes to Check (IHS-Specified Codes)**
DTaP/DTP	**CPT:** 90698, 90700, 90701, 90720, 90721, 90723 **ICD-9:** 99.39	**Immunization (CVX):** 1, 20, 22, 50, 102, 106, 107, 110, 120, 130, 132
Diphtheria and Tetanus (DT)	**CPT:** 90702	**Immunization (CVX):** 28
Diphtheria	**CPT:** 90719 **ICD-9:** 99.36 Evidence of disease: POV or PCC Problem List (active or inactive) **ICD-9:** V02.4, 032	
Tetanus	**CPT:** 90703 **ICD-9:** 99.38 Evidence of disease: POV or PCC Problem List (active or inactive) **ICD-9:** 037	**Immunization (CVX):** 35, 112

[xxx] BPHC Uniform Data System Manual, 2011 Revision, p. 60

Childhood Immunizations Definitions		
Vaccine	**BPHC-Specified Applicable ICD-9-CM and CPT-4 Code(s)**	**Other Codes to Check (IHS-Specified Codes)**
Pertussis	**ICD-9:** 99.37 Evidence of disease: POV or PCC Problem List (active or inactive) **ICD-9:** 033	**Immunization (CVX):** 11
IPV	**CPT:** 90698, 90713, 90723 **ICD-9:** 99.41 Evidence of disease: POV or PCC Problem List (active or inactive) **ICD-9:** V12.02, 045	**Immunization (CVX):** 10, 89, 110, 120, 130, 132
MMR	**CPT:** 90707, 90708, 90710 **ICD-9:** 99.45 Evidence of disease: POV or PCC Problem List (active or inactive) **ICD-9:** 055	**Immunization (CVX):** 3, 94
Measles	**CPT:** 90705, 90708 **ICD-9:** 99.45 Evidence of disease: POV or PCC Problem List (active or inactive) **ICD-9:** 055	**Immunization (CVX):** 5
Mumps	**CPT:** 90704, 90710 **ICD-9:** 99.46 Evidence of disease: POV or PCC Problem List (active or inactive) **ICD-9:** 072	**Immunization (CVX):** 7
Rubella	**CPT:** 90706, 90707, 90708, 90710 **ICD-9:** 99.47 Evidence of disease: POV or PCC Problem List (active or inactive) **ICD-9:** 056	**Immunization (CVX):** 6
Hib	CPT: 90645, 90646, 90647, 90648, 90698, 90720, 90721, 90748 Evidence of disease: POV or PCC Problem List (active or inactive) **ICD-9:** 038.41, 041.5, 320.0, 482.2	**Immunization (CVX):** 17, 22, 46-49, 50-51, 102, 120, 132
Hepatitis B	**CPT:** 90723, 90740, 90744, 90747, 90748 Evidence of disease: POV or PCC Problem List (active or inactive) **ICD-9:** VO2.61, 070.2, 070.3	**Immunization (CVX):** 8, 42- 45, 51, 102, 104, 110, 132
Varicella	**CPT:** 90710, 90716 Evidence of disease: POV or Problem List (active or inactive) **ICD-9:** 052, 053	**Immunization (CVX):** 21, 94
Pneumococcal Conjugate	**CPT:** 90669,90670	**Immunization (CVX):** 33, 100, 109, 133

Childhood Immunizations Definitions		
Vaccine	**BPHC-Specified Applicable ICD-9-CM and CPT-4 Code(s)**	**Other Codes to Check (IHS-Specified Codes)**
Hepatitis A	**CPT:** 90633-90634, 90730 (old code) Evidence of disease: POV or Problem List (active or inactive) **ICD-9:** 070.0, 070.1	**Immunization (CVX):** 31, 83, 84, 85
Rotavirus	**2-dose series: CPT:** 90681 **3-dose series: CPT:** 90680 **ICD-9:** 008.61	**2-dose series: Immunization (CVX):** 119 **3-dose series: Immunization (CVX):** 74, 116, 122
Influenza	**CPT:** 90654-90655, 90657, 90660-90662 **ICD-9:** 99.52	**Immunization (CVX):** 15, 16, 88, 111, 135, 140, 141

5.2.6.6 Logic for Section D: Cervical Cancer Screening

This section (Table 6B Line 11) reports on the number of women 24–64 years of age who have not had a hysterectomy and who have a cervix and the number of those women who received one or more documented Pap tests during the report period or during the two years prior to the report period and who had at least one medical visit during the reporting year. Because of the difficulty in obtaining records from third parties, it is likely that a number of women will not be able to be counted as compliant, even though the grantee has referred the patient for services[xxxi].

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

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

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

[xxxi] BPHC Uniform Data System Manual, 2011 Revision, p. 61

Exclusions

Women who have had a hysterectomy and who have no residual cervix and for whom the administrative data does not indicate a Pap test was performed. Look for evidence of a hysterectomy as far back as possible in the patient's history, through either administrative data or medical record review. See Table 5-12 below for specific Hysterectomy definitions.

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

Table 5-12: Table 6B Section D Pap Test Exclusion BPHC-defined[xxxii] and IHS-specific Codes

Pap Test Exclusion Definitions	
BPHC-Specified Applicable ICD-9-CM And CPT-4 Code(S)	**Other Codes to Check (IHS-Specified Codes)**
CPT: 51925, 56308, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58550, 58551, 58552-58554, 58951, 58953-58954, 58956, 59135 **ICD-9:** 68.4-68.8, 618.5	**Women's Health:** Any procedure called Hysterectomy

Number Of Charts Sampled or EHR Total, Column (B)

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

[xxxii] BPHC Uniform Data System Manual, 2011 Revision, p. 62

Number Of Patients Tested, Column (C)

This column contains the number of women who received one or more Pap tests and met all of the criteria in a 3-year period from 2009 through 2011. Documentation in the medical record must include a note indicating the date the test was performed and the result of the finding. The Pap test may have been performed at the reporting or another facility. Patients whose charts note a referral to a third party but which do not include a copy of the laboratory report or a report of some form from the clinician/clinic that provided the test, or unsubstantiated statements from patients which cannot be backed up with documentation are not included in the count.[xxxiii] See Table 5-13 below for specific Pap test definitions.

Table 5-13: Table 6B Section D Pap Test BPHC-Defined[xxxiv] and IHS-Specific Codes

Pap Test Definitions	
BPHC-Specified Applicable ICD-9-CM and CPT-4 Code(s)	**Other Codes to Check (IHS-Specified Codes)**
CPT: 88141-88145, 88148, 88150, 88152-88155, 88164-88167, 88174-88175	**V Lab:** Any lab test of PAP SMEAR, site-defined taxonomy BGP PAP SMEAR TAX, LOINC taxonomy BGP PAP LOINC CODES
ICD-9: 91.46	**Women's Health:** Any procedure called PAP SMEAR

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

This section (Table 6B Line 12) reports on the number of patients 2[xxxv]–17 years of age with a documented BMI percentile, counseling for nutrition, and counseling for physical activity during report period. **NOTE: All the elements must be documented in the report year**.

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

[xxxiii] BPHC Uniform Data System Manual, 2011 Revision, p. 63

[xxxiv] BPHC Uniform Data System Manual, 2011 Revision, p. 63

[xxxv] BPHC Uniform Data System Manual, 2011 Revision, p. 63: This measure commonly refers to patients who are two years old, however the specific compliance criteria is that they have the required services "within one year after reaching two years . . ." This means that a patient who is two (or two and a half) years old on December 31 and has not had the required counseling still has six months to a year to meet the criteria for compliance. Hence the use of "three years" as the criteria.

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

This column includes all patients who were born between January 1, 1994 and December 31, 2008, were first seen by the grantee prior to their 17th birthday and had at least one medical visit during the reporting period.

Exclusions

Pregnant patients.

Charts Sampled or EHR Total, Column (B)

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

Number Of Patients With Counseling and BMI Documented, Column (C)

This column contains the number of patients who had a documented Body Mass Index (BMI) percentile documented, a documented counseling for nutrition, and a documented counseling for physical activity during the report period. **NOTE: The BMI is an actual percentile recorded; not just a BMI or Height + Weight.** See tables below for specific definitions.

Table 5-14: Table 6B Section E BMI BPHC-Defined[xxxvi]

BMI Definitions
BPHC-Specified Applicable ICD-9-CM Code(s)
ICD-9: V85.5x (V85.51, V85.52, V85.53, V85.54)

Table 5-15: Table 6B Section E Counseling for Nutrition BPHC-Defined[xxxvii] and IHS-Specific Codes

Counseling for Nutrition Definitions	
BPHC-Specified Applicable CPT-4 Code(s)	Other Codes to Check (IHS-Specified Codes)
CPT: 97802-97804	**Patient Education:** Codes ending "-N" (Nutrition) or "-MNT" (or old code "-DT" (Diet)) or containing 97802-97804

[xxxvi] BPHC Uniform Data System Manual, 2011 Revision, p. 64

[xxxvii] BPHC Uniform Data System Manual, 2011 Revision, p. 64

Table 5-16: Table 6B Section E Counseling for Nutrition BPHC-Defined[xxxviii] and IHS-Specific Codes

Counseling for Physical Activity Definitions	
BPHC-Specified Applicable ICD-9-CM Code(s)	**Other Codes to Check (IHS-Specified Codes)**
ICD-9: V65.41	**Patient Education:** Codes ending "-EX" (Exercise) or containing V65.41

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

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

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

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

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

Exclusions

Pregnant or terminally ill patients. Terminal illness must be documented on or within 6 months prior to the last visit during the report period with ICD-9 code V66.7.

Charts Sampled or EHR Total, Column (B)

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

[xxxviii] BPHC Uniform Data System Manual, 2011 Revision, p. 64

Number Of Patients With BMI Charted and Follow-Up Plan Documented As Appropriate, Column (C)

This column contains the number of patients who had a documented Body Mass Index (BMI) percentile documented on the last visit during the report period or on any visit within the last 6 months of the last visit during the report period, and had a follow-up plan documented if the patient was overweight or underweight. **NOTE: The BMI is an actual percentile recorded; not just a BMI or Height + Weight.** See tables below for specific definitions.

Table 5-17: Table 6B Section F BPHC-Defined[xxxix] Overweight/Underweight

Overweight/Underweight Definitions		
	Age 18-64	**Age 65+**
Overweight	BMI =>25	BMI =>30
Underweight	BMI < 18.5	BMI <22

Table 5-18: Table 6B Section F Follow-Up Plan for Overweight/Underweight IHS-Specific Codes

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

5.2.6.9 Logic for Section G1: Tobacco Use Assessment

This section (Table 6B Line 14) reports on the number of patients 18 years of age or older who were queried about any and all forms tobacco use at least once within 24 months (the report period or the prior year).

> **Note:** Detailed patient lists can be produced for "All Patients 18+ w/tobacco use assessment" (MU/LST/LST2/TUA1) and "All Patients 18+ w/o tobacco use assessment" (MU/LST/LST2/TUA2) to assist sites with verifying the information reported by RPMS UDS.

[xxxix] BPHC Uniform Data System Manual, 2011 Revision, p. 65

Total Patients Age 18 and Over, Column (A)

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

Charts Sampled or EHR Total, Column (B)

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

Number Of Patients Assessed for Tobacco Use, Column (C)

This column contains the number of patients who were queried about any and all forms tobacco use at least once within 24 months (the report period or the prior year). Tobacco Use Assessment requires documentation that provider or support staff asked patient if they used tobacco and the patient's response. See tables below for specific definitions.

Table 5-19: Table 6B Section G1 Tobacco Use Assessment BPHC-Defined[xl] and IHS-Specific Codes

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

5.2.6.10 Logic for Section G2: Tobacco Cessation Intervention

This section (Table 6B Line 15) reports on the number of patients 18 years of age or older who were identified as users of any and all forms of tobacco during the report period or the prior year, who received tobacco use intervention (cessation counseling and/or pharmacological intervention), and who had at least one medical visit during the report period, and with at least two medical visits ever.

[xl] BPHC Uniform Data System Manual, 2011 Revision, p. 66

> **Note:** Detailed patient lists can be produced for "All Pts 18+ smokers/tobacco user w/intervention" (MU/LST/LST2/TCI1) and "All Pts 18+ smokers/tobacco users w/o intervention" (MU/LST/LST2/TCI2) to assist sites with verifying the information reported by RPMS UDS.

Total Patients with Diagnosed Tobacco Dependence, Column (A)

This column includes all patients who were age 18 and older as of December 31 of the report period, were ever seen after their 18th birthday, who were identified as a tobacco user at some point during the prior twenty four months who had at least one medical visit during the reporting period and at least two medical visits ever. See table below for tobacco use definition.

Table 5-20: Table 6B Section G2 Tobacco Users BPHC-Defined[xli] and IHS-Specific Codes

Tobacco Users Definitions	
BPHC-Specified Applicable ICD-9-CM Code(s) and CPT-4 Code(s)	**Other Codes to Check (IHS-Specified Codes)**
CPT: 1034F, 1035F **ICD-9:** 305.1, 649.00-649.04	**Health Factors:** TOBACCO (SMOKING) and TOBACCO (SMOKELESS – CHEWING/DIP) categories: Current Smokeless, Cessation-Smoker, Cessation-Smokeless, Current Smoker, status unknown, Current smoker, every day, or Current smoker, some day

Charts Sampled or EHR Total, Column (B)

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

Number Of Patients Advised to Quit, Column (C)

This column contains the number of patients who received documented tobacco cessation counseling or smoking cessation agents during the report or prior year. Tobacco Cessation Intervention requires documentation that provider or appropriate staff provided cessation counseling and/or documentation of prescription written or drug dispensed (may include OTC medications). See tables below for specific definitions.

[xli] BPHC Uniform Data System Manual, 2011 Revision, p. 67

Table 5-21: Table 6B Section G2 Tobacco Cessation Intervention BPHC-Defined[xlii] and IHS-Specific Codes

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

5.2.6.11 Logic for Section H: Asthma Pharmacological Therapy

This section (Table 6B Line 16) reports on the number of patients 5-40 years of age with a diagnosis of persistent asthma (either mild, moderate, or severe) who were prescribed either the preferred long term control medication or an acceptable alternative pharmacological therapy during the report period.

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

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

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

Exclusions

The following patients will be excluded from the denominator:

- Patients with an allergic reaction to asthma medications.

[xlii] BPHC Uniform Data System Manual, 2011 Revision, pp. 67-68

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

Table 5-22: Table 6B Section H Persistent Asthma BPHC-Defined[xliii] Codes

Persistent Asthma Definitions
BPHC-Specified Applicable ICD-9-CM Code(s) and CPT-4 Code(s)
CPT: 1038F, 4015F **ICD-9:** 493.x

Charts Sampled or EHR Total, Column (B)

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

Number Of Patients with Acceptable Plan, Column (C)

This column contains the number of patients who were prescribed preferred long-term control medication or an acceptable alternative pharmacologic therapy during the report. **NOTE: Requires documentation that medication was prescribed or dispensed.**

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

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

Acceptable Alternative Pharmacologic Therapy: Acceptable Alternative Pharmacologic Therapy is defined in the medication taxonomies BGP PQA CONTROLLER MEDS Medications. (Medications are: Cromolyn, Leukotriene Modifier (Zafirlukast, Zileuton, Montelukast), Nedocromil, Theophylline).

[xliii] BPHC Uniform Data System Manual, 2011 Revision, p. 69

DU UDS 2011 DEMO INDIAN HOSPITAL Page 1
UDS No. 000001 Date Run: Dec 15, 2011
Reporting Period: Jan 01, 2011 through Dec 31, 2011

TABLE 6B-QUALITY OF CARE INDICATORS

(NO PRENATAL CARE PROVIDED? CHECK HERE: X)

SECTION A: AGE CATEGORIES FOR PRENATAL PATIENTS
(GRANTEES WHO PROVIDE PRENATAL CARE ONLY)

DEMOGRAPHIC CHARACTERISTICS OF PRENATAL CARE PATIENTS

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

SECTION B-TRIMESTER OF ENTRY INTO PRENATAL CARE

	TRIMESTER OF FIRST KNOWN VISIT FOR WOMEN RECEIVING PRENATAL CARE DURING REPORTING YEAR	WOMEN HAVING FIRST VISIT WITH GRANTEE (a)	WOMEN HAVING FIRST VISIT WITH ANOTHER PROVIDER (b)
7	First Trimester		
8	Second Trimester		
9	Third Trimester		

Figure 5-13: Sample RPMS UDS Report for Table 6B Page 1

DU UDS 2011 DEMO INDIAN HOSPITAL Page 2
UDS No. WWH Date Run: Dec 15, 2011
Reporting Period: Jan 01, 2011 through Dec 31, 2011

TABLE 6B-QUALITY OF CARE INDICATORS

SECTION C-CHILDHOOD IMMUNIZATION

	CHILDHOOD IMMUNIZATION	TOTAL NUMBER PATIENTS WITH 2ND BIRTHDAY DURING MEASUREMENT YEAR (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS IMMUNIZED (c)
10	Number of children who have received required vaccines who had their 2nd birthday during measurement year	783	783	27

(on or prior to December 31)			

SECTION D - CERVICAL CANCER SCREENING

PAP TESTS	TOTAL NUMBER OF FEMALE PATIENTS 24-64 YEARS OF AGE (a)	NUMBER CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS TESTED (c)
11 Female patients aged 24-64 who received one or more Pap tests to screen for cervical cancer	9,147	9,147	4,107

SECTION E - WEIGHT ASSESSMENT AND COUNSELING FOR CHILDREN AND ADOLESCENTS

CHILD AND ADOLESCENT WEIGHT ASSESSMENT AND COUNSELING	TOTAL PATIENTS AGED 3 - 17 ON DECEMBER 31 (a)	CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH COUNSELING AND BMI DOCUMENTED (c)
12 Children and adolescents aged 3 - 17 with a BMI percentile, and counseling on nutrition and physical activity documented for the current year	8,452	8,452	42

Figure 5-14: Sample RPMS UDS Report for Table 6B Page 2

DU UDS 2011 DEMO INDIAN HOSPITAL Page 3
UDS No. WWH Date Run: Dec 15, 2011
Reporting Period: Jan 01, 2011 through Dec 31, 2011

TABLE 6B-QUALITY OF CARE INDICATORS

SECTION F - ADULT WEIGHT SCREENING AND FOLLOW-UP

ADULT WEIGHT SCREENING AND FOLLOW-UP	TOTAL PATIENTS 18 AND OVER (a)	CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH BMI CHARTED AND FOLLOW-UP PLAN DOCUMENTED AS APPROPRIATE (c)
13 Patients aged 18 and over with (1) BMI charted and (2) follow-up plan documented if patients are overweight or	12,473	12,473	1,059

underweight			

SECTION G1 - TOBACCO USE ASSESSMENT

TOBACCO ASSESSMENT	TOTAL PATIENTS 18 AND OVER (a)	CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS ASSESSED FOR TOBACCO USE (c)
14 Patients queried about tobacco use one of more times in the measurement year or prior year	15,624	15,624	13,276

Figure 5-15: Sample RPMS UDS Report for Table 6B Page 3

DU UDS 2011 DEMO INDIAN HOSPITAL Page 4
UDS No. WWH Date Run: Dec 15, 2011
Reporting Period: Jan 01, 2011 through Dec 31, 2011

TABLE 6B-QUALITY OF CARE INDICATORS

SECTION G2 - TOBACCO CESSATION INTERVENTION

TOBACCO CESSATION INTERVENTION	TOTAL PATIENTS WITH DIAGNOSED TOBACCO DEPENDENCE (a)	CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS ADVISED TO QUIT (c)
15 Tobacco users aged 18 and above who have received cessation advise or medication	7,504	7,504	2,591

SECTION H - ASTHMA PHARMACOLOGICAL THERAPY

ASTHMA TREATMENT PLAN	TOTAL PATIENTS AGED 5 - 40 WITH PERSISTENT ASTHMA (a)	CHARTS SAMPLED OR EHR TOTAL (b)	NUMBER OF PATIENTS WITH ACCEPTABLE PLAN (c)
16 Patients aged 5 through 40 diagnosed with persistent asthma who have an acceptable pharmacological treatment plan	1,348	1,348	543

Figure 5-16: Sample RPMS UDS Report for Table 6B Page 4

5.2.7 Table 7 Health Outcomes and Disparities

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

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

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

5.2.7.1 Logic HIV Positive Pregnant Women

This section of the table reports the total number of pregnant women served by the facility who have had at least 2 positive HIV diagnosis anytime through the end of the report period, with at least 2 pregnancy related visits during the past 20 months with no documented miscarriage or abortion occurring after the second pregnancy related visit and during the past 20 months and with at least 1 medical visit during the report period. All grantees are to report the total number of HIV positive pregnant women served by the health center in column (i) *regardless* of whether or not they provide prenatal care services.[xliv]

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

HIV Positive Pregnant Definitions:

- **Pregnancy:** (1) POV or Problem List diagnosis: V22.0–V23.9, V72.42, 640.* –649.*, 651.* –676.*

[xliv] BPHC Uniform Data System Manual, 2011 Revision, p. 75

- **Miscarriage:** (1) POV: 630, 631, 632, 633*, 634*, (2) CPT 59812, 59820, 59821, 59830
- **Abortion:** (1) POV: 635*, 636* 637*, (2) CPT: 59100, 59120, 59130, 59136, 59150, 59151, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, S2260–S2267, (3) ICD-9 Procedure: 69.01, 69.51, 74.91, and 96.49
- **HIV:** (1) POV: 042, 042.0–044.9 (old codes), 079.53, V08, or 795.71

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

BPHC UDS Manual states that Section A (Table 7 Columns 1a – 1d), only grantees that provide or assume primary responsibility for some or all of a patient's prenatal care services, whether or not the grantee does the delivery, are required to complete this section. All prenatal care patients who delivered during the reporting period, and all children born to them, are to be reported.[xlv]

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

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

Deliveries Performed By Grantee Provider (Line 2)

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

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

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

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

[xlv] BPHC Uniform Data System Manual, 2011 Revision, p. 76

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

> **Note**: This line is not reported by the race/Hispanic/Latino identity of the women delivered. The definition of pregnancy is defined in Section 5.2.6.

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

This section of the table reports by race and Hispanic/Latino identity the number of patients 18 to 85 years old diagnosed with hypertension any time before June 30th of the report period and who had at least 2 medical visits during the reporting period and the number of those patients who have controlled blood pressure (less than 140/90– systolic 140/diastolic 90).

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

Total Hypertensive Patients (Column 2a)

Report the total number of patients by race and Hispanic/Latino identity who are age 18–85, had 2 medical visits during the report period, been diagnosed with Hypertension prior to June 30th of the report period. BPHC describes Hypertension evidenced by an ICD-9 code of 401.xx–405.xx. It does not matter if Hypertension was treated or is currently being treated.[xlvii]

Number Of Charts Sampled Or EHR Total (Column 2b)

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

[xlvi] BPHC Uniform Data System Manual, 2011 Revision, p. 78

[xlvii] Ibid

Patients with HTN Controlled (Column 2c)

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

> **Note:** Under no circumstances may a grantee report more hypertensive Hispanic/Latinos or individuals from any given race on Table 7 Column 2a than reported on Table 3B.
>
> Under most circumstances Column H will be zero. Use Column H only if you specifically ask a patient their race and whether or not they are Hispanic/Latino and they specifically refuse to answer the questions. Those who do provide their race but do not check that they are Hispanic/Latino on an intake form should be considered non-Hispanic/Latino.[xlviii]

Blood Pressure Definitions:

- **Actual Blood Pressure Measurement:** Most recent blood pressure measurement during the report period < 140/90. If both the systolic and diastolic measurements are not less than 140/90, the values are considered not controlled and are not to be included in the count.
- **CPT II Code Indicating Controlled Blood Pressure:** Systolic3074F, 3075F, or 3077F *with* Diastolic: 3078F or 3079F. Systolic and diastolic values do not have to be recorded on the same day. The combinations shown below represent BP <140/90:
  - CPT 3074F (Most recent systolic BP <130 mm Hg) *and* 3078F (Most recent diastolic BP <80 mm Hg)
  - CPT 3074F (Most recent systolic BP <130 mm Hg) *and* 3079F (Most recent diastolic BP 80-89 mm Hg)
  - CPT 3075F (Most recent systolic BP 130-139 mm HG) *and* 3078F (Most recent diastolic BP <80 mm Hg)
  - CPT 3075F (Most recent systolic BP 130-139 mm HG) *and* 3079F (Most recent diastolic BP 80–89 mm Hg)

[xlviii] BPHC Uniform Data System Manual, 2011 Revision, p. 79

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

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

This section of the table reports by race and Hispanic/Latino identity the number of patients 18 to 75 years old diagnosed with Type I or Type II diabetes and whose most recent hemoglobin (HbA1c) was less than or equal to 9% and without a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes and who had at least two medical visits during the report period. Results are to be reported in three categories: less than 7% (good control); greater than or equal to 7% and less than 8%; greater than or equal to 8% and less than or equal to 9%; and greater than 9% (poor control).

Total Patients With Diabetes (Column 3a)

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

BPHC describes Diabetes evidenced by an ICD-9 code of 250.xx, 648.0 or from pharmacy data (those who were dispensed insulin or oral hypoglycemics/antihyperglycemics.[l] These medications will be defined with medication taxonomy BUD DIABETES MEDS TAX (see spreadsheet UDS 2011 Medication Taxonomies) and are prepopulated during the install of RPMS UDS.

Exclusions

- Patients who do not have two visits with a diagnosis of diabetes during the report period or the year prior to the report period *and* have been diagnosed with polycystic ovaries during the report period. Polycystic ovaries defined as (POV or Problem List) 256.4.

[xlix] BPHC Uniform Data System Manual, 2011 Revision, p. 80

[l] Ibid

- Patients who have been diagnosed with gestational diabetes (POV or Problem List 648.8*) or steroid-induced diabetes (POV or Problem List 962.0 or 251.8) during the report period.

Number Of Charts Sampled Or EHR Total (Column 3b)

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

Total Patients With HbA1c < 7% (Column 3c)

Report the total number of patients by race and Hispanic/Latino identity who are age 18–85, had 2 medical visits during the report period, been diagnosed with Diabetes any time prior to the end of the report period whose most recent HbA1c was less than 7%.

Total Patients With 7% <= HbA1c < 8% (Column 3d)

Report the total number of patients by race and Hispanic/Latino identity who are age 18–85, had 2 medical visits during the report period, been diagnosed with Diabetes any time prior to the end of the report period whose most recent HbA1c was greater than or equal to 7% but less than 8%.

Total Patients With 8% <= HbA1c <= 9% (Column 3e)

Report the total number of patients by race and Hispanic/Latino identity who are age 18–85, had 2 medical visits during the report period, been diagnosed with Diabetes any time prior to the end of the report period whose most recent HbA1c was greater than or equal to 8% but less than or equal to 9%.

Total Patients With HbA1c > 9% OR No Test During Year (Column 3f)

Report the total number of patients by race and Hispanic/Latino identity who are age 18–85, had 2 medical visits during the report period, been diagnosed with Diabetes any time prior to the end of the report period whose most recent HbA1c was greater than 9% or who did not receive a HbA1c test during the report period or whose test results were missing.

> **Note:** Under no circumstances may a grantee report more diabetic Hispanic/Latinos or individuals from any given race in Column 3a than reported on Table 3B.
>
> Under most circumstances Column h will be zero. Use Column h only if you specifically ask a patient their race and whether or not they are Hispanic/Latino and they specifically refuse to answer the questions. Those who do provide their race but do not check that they are Hispanic/Latino on an intake form should be considered non-Hispanic/Latino.li

Hemoglobin A1c Definitions:

- **CPT:** 83036, 83037, 3044F-3046F:
  - CPT 83036 and 83037 indicate tests with no result and will be included in the A1c >9% numerator (Column 3f)
  - CPT 3044F indicates an A1c level <7% and will be included in Column 3c
  - CPT 3045F indicates an A1c level 7%-9% and will be included in Column 3e
  - CPT 3046F indicates an A1c level >9% and will be included in Column 3f
- LOINC taxonomy; or site-populated taxonomy DM AUDIT HGB A1C TAX
  - A1cs documented by LOINC or with a lab test included in lab taxonomy DM AUDIT HGB A1C TAX will be reported in the appropriate category according to the A1c result.

> **Note**: Detailed patient lists can be produced from the List menu option within the Manager Utilities for "All DM Patients by Race & Hisp Identity" (MU/LST/LST3/DM/DMR), "All DM Patients w/A1c<7 by Race & Hisp Identity" (MU/LST/LST3/DM/DMR1), "All DM Patients w/A1c >=7 and <8 by Race & Hisp Identity" (MU/LST/LST3/DM/DMR2), "All DM Patients w/A1c >=8 and <=9 by Race & Hisp Identity" (MU/LST/LST3/DM/DMR3), and "All DM Patients w/A1c >9 by Race & Hisp Identity" (MU/LST/LST3/DM/DMR4) to assist sites with verifying the information reported by RPMS UDS.

[li] BPHC Uniform Data System Manual, 2011 Revision, p. 81

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  DU     UDS 2011           DEMO INDIAN HOSPITAL                    Page 1
UDS No.  000001                                    Date Run: Dec 15, 2011
Reporting Period:  Jan 01, 2011 through Dec 31, 2011
Population:  All (both Indian/Alaskan Natives and Non 01)

                  TABLE 7 - HEALTH OUTCOMES AND DISPARITIES
  SECTION A: DELIVERIES AND BIRTH WEIGHT BY RACE AND HISPANIC/LATINO ETHNICITY
_____________________________________________________________________________

0    HIV Positive Pregnant Women**********************************|  11
_____________________________________________________________________________
2    Deliveries Performed by Grantee's Providers******************|
_____________________________________________________________________________
     |                 |Prenatal Care| Live Births:| Live Births:| Live Births:
     |                 | Patients Who| <1500 grams | 1500-2499   | =>2500 grams
Line |  Race and       |  Delivered  |             | grams       |
 #   |  Ethnicity      | During the  |             |             |
     |                 |   Year      |             |             |
     |                 |   (1a)      |   (1b)      |   (1c)      |   (1d)
_____|_________________|_____________|_____________|_____________|_____________
Hispanic/Latino
_____________________________________________________________________________
1a   | Asian           |             |             |             |
_____|_________________|_____________|_____________|_____________|_____________
1b1  | Native Hawaiian |             |             |             |
_____|_________________|_____________|_____________|_____________|_____________
1b2  | Pacific Islander|             |             |             |
_____|_________________|_____________|_____________|_____________|_____________
1c   | Black/African   |             |             |             |
     | American        |             |             |             |
_____|_________________|_____________|_____________|_____________|_____________
1d   | American Indian/|             |             |             |
     | Alaska Native   |             |             |             |
_____|_________________|_____________|_____________|_____________|_____________
1e   | White           |             |             |             |
_____|_________________|_____________|_____________|_____________|_____________
1f   | More than One   |             |             |             |
     | Race            |             |             |             |
_____|_________________|_____________|_____________|_____________|_____________
1g   | Unreported/     |             |             |             |
     | Refused         |             |             |             |
     | to Report Race  |             |             |             |
_____|_________________|_____________|_____________|_____________|_____________
     | Subtotal        |             |             |             |
     | Hispanic/Latino |             |             |             |
_____|_________________|_____________|_____________|_____________|_____________
```

Figure 5-17: Sample RPMS UDS Report for Table 7 Page 1

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DU     UDS 2011           DEMO INDIAN HOSPITAL                    Page 2
UDS No.  000001                                    Date Run: Dec 15, 2011
Reporting Period:  Jan 01, 2011 through Dec 31, 2011
Population:  All (both Indian/Alaskan Natives and Non 01)

                  TABLE 7 - HEALTH OUTCOMES AND DISPARITIES
  SECTION A: DELIVERIES AND BIRTH WEIGHT BY RACE AND HISPANIC/LATINO ETHNICITY
_____________________________________________________________________________
     |                 |Prenatal Care| Live Births:| Live Births:| Live Births:
     |                 | Patients Who| <1500 grams | 1500-2499   | =>2500 grams
Line |  Race and       |  Delivered  |             | grams       |
 #   |  Ethnicity      | During the  |             |             |
     |                 |   Year      |             |             |
     |                 |   (1a)      |   (1b)      |   (1c)      |   (1d)
```

Non-Hispanic/Latino					
1a	Asian				
1b1	Native Hawaiian				
1b2	Pacific Islander				
1c	Black/African American				
1d	American Indian/ Alaska Native				
1e	White				
1f	More than One Race				
1g	Unreported/ Refused to Report Race				
	Subtotal Non-Hispanic/Latino				
Unreported/Refused to Report Ethnicity					
h	Unreported/ Refused to Report Race and Ethnicity				
i	Total				

Figure 5-18: Sample RPMS UDS Report for Table 7 Page 2

```
DU     UDS 2011           DEMO INDIAN HOSPITAL                    Page 3
UDS No.  000001                                  Date Run: Dec 15, 2011
Reporting Period:  Jan 01, 2011 through Dec 31, 2011
Population:  All (both Indian/Alaskan Natives and Non 01)

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

#	Race and Ethnicity	Total Hypertensive Patients (2a)	Charts Sampled or EHR Total (2b)	Patients with HTN Controlled (2c)
Hispanic/Latino				
1a	Asian	0	0	0
1b1	Native Hawaiian	0	0	0
1b2	Pacific Islander	0	0	0
1c	Black/African American	0	0	0
1d	American Indian/ Alaska Native	4	4	3
1e	White	0	0	0

1f	More than One Race	0	0	0
1g	Unreported/ Refused to Report Race	0	0	0
	Subtotal Hispanic/Latino	4	4	3

Figure 5-19: Sample RPMS UDS Report for Table 7 Page 3

DU UDS 2011 DEMO INDIAN HOSPITAL Page 4
UDS No. 000001 Date Run: Dec 15, 2011
Reporting Period: Jan 01, 2011 through Dec 31, 2011
Population: All (both Indian/Alaskan Natives and Non 01)

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

#	Race and Ethnicity	Total Hypertensive Patients (2a)	Charts Sampled or EHR Total (2b)	Patients with HTN Controlled (2c)
Non-Hispanic/Latino				
1a	Asian	0	0	0
1b1	Native Hawaiian	0	0	0
1b2	Pacific Islander	0	0	0
1c	Black/African American	0	0	0
1d	American Indian/ Alaska Native	5,181	5,181	2,464
1e	White	0	0	0
1f	More than One Race	0	0	0
1g	Unreported/ Refused to Report Race	0	0	0
	Subtotal Non-Hispanic/Latino	5,181	5,181	2,464
Unreported/Refused to Report Ethnicity				
h	Unreported/ Refused to Report Race and Ethnicity	31	31	17
i	Total	5,216	5,216	2,484

Figure 5-20: Sample RPMS UDS Report for Table 7 Page 4

DU UDS 2011 DEMO INDIAN HOSPITAL Page 5
UDS No. 000001 Date Run: Dec 15, 2011
Reporting Period: Jan 01, 2011 through Dec 31, 2011
Population: All (both Indian/Alaskan Natives and Non 01)

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

#	Race and Ethnicity	Total Patients with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with Hba1c <7% (3c)	Patients with 7%<= Hba1c <8% (3d)	Patients with 8%<= Hba1c <=9% (3e)	Patients with Hba1c >9% Or No Test During Year (3f)
Hispanic/Latino							
1a	Asian	0	0	0	0	0	0
1b1	Native Hawaiian	0	0	0	0	0	0
1b2	Pacific Islander	0	0	0	0	0	0
1c	Black/African American	0	0	0	0	0	0
1d	American Indian/ Alaska Native	3	3	0	0	0	3
1e	White	0	0	0	0	0	0
1f	More than One Race	0	0	0	0	0	0
1g	Unreported/ Refused to Report Race	0	0	0	0	0	0
	Subtotal Hispanic/Latino	3	3	0	0	0	1,677

Figure 5-21: Sample RPMS UDS Report for Table 7 Page 5

DU UDS 2011 DEMO INDIAN HOSPITAL Page 6
UDS No. 000001 Date Run: Dec 15, 2011
Reporting Period: Jan 01, 2011 through Dec 31, 2011
Population: All (both Indian/Alaskan Natives and Non 01)

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

#	Race and Ethnicity	Total Patients with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with Hba1c <7% (3c)	Patients with 7%<= Hba1c <8% (3d)	Patients with 8%<= Hba1c <=9% (3e)	Patients with Hba1c >9% Or No Test During Year (3f)
Non-Hispanic/Latino							

1a	Asian	0	0	0	0	0	0
1b1	Native Hawaiian	0	0	0	0	0	0
1b2	Pacific Islander	0	0	0	0	0	0
1c	Black/African American	0	0	0	0	0	0
1d	American Indian/ Alaska Native	3,460	3,460	1,102	423	272	1,663
1e	White	0	0	0	0	0	0
1f	More than One Race	0	0	0	0	0	0
1g	Unreported/ Refused to Report Race	0	0	0	0	0	0
	Subtotal Non-Hispanic/Latino	3,460	3,460	1,102	423	272	1,677
Unreported/Refused to Report Ethnicity							
h	Unreported/ Refused to Report Race and Ethnicity	14	14	1	0	2	11
i	Total	3,477	3,477	1,103	423	274	1,677

Figure 5-22: Sample RPMS UDS Report for Table 7 Page 6

5.2.8 Table 9D Patient-Related Revenue

Table 9D, Patient-Related Revenue collects information on charges, collections, supplemental payments, contractual allowances, self-pay sliding discounts, and self-pay bad debt write-off. Table for is included only in the Universal Report[lii].

NOTE: Because there is no way to distinguish between non-managed care, capitated managed care, and fee-for-service managed care in RPMS, only the totals lines (3, 6, 9, 12, and 14) and line 13 will be calculated. Table 9D: Patient-Related Revenue (Delimited Rept) can be used to help sites complete this table.

[lii] BPHC Uniform Data System Manual, 2011 Revision, *Instructions for Table 9D*, p. 96

5.2.8.1 Rows – Payor Categories and Form of Payment

There are five payor categories defined by BPHC and are described below. Except for Self Pay, each category has three sub-groupings: non-managed care, capitated managed care, and, fee-for-service managed care.

- **Medicaid (Lines 1-3)**

  All services billed to and paid for by Medicaid (Title XIX) regardless of whether they are paid directly or through a fiscal intermediary or an HMO. The following is included in the counts for these lines:

  – Medicaid (Title XIX)
  – Children's Health Insurance Program (CHIP) paid through Medicaid.
  – Cross-over services that are reclassified to Medicaid after initial submission to Medicare are reported here.

- **Medicare (Lines 4 – 6)**

  All services billed to and paid for by Medicare (Title XVIII) regardless of whether they are paid directly or through a fiscal intermediary or an HMO.

- **Other Public (Lines 7 – 9)**

  All services billed to and paid for by State or local governments through programs other than indigent care programs. The following is included in the counts for these lines:

  – CHIP when it is paid for through commercial carriers. (See above if CHIP is paid through Medicaid.)
  – Family planning programs such as Breast and Cervical Cancer Control Programs (BCCCP) with various state names, other dedicated state or local programs, and state insurance plans.

  Reporting on state or local indigent care programs that subsidize services rendered to the uninsured is as follows:

  – Report all charges for these services and collections from patients as "self-pay" (line 13 columns a and b of this table);
  – Report all amounts not collected from the patients as sliding discounts or bad debt write-off, as appropriate, on line 13 columns e and f of this table; and
  – Report collections from the associated state and local indigent care programs on Table 9E and specify the program paying for the services. State/local indigent care programs are reported on line 6a on that table.

  Do not classify anything as an indigent care program without first reviewing this in a UDS Training Program or with the UDS Help line.

- **Private (Lines 10 – 12)**

  All services billed to and paid for by commercial or private insurance companies and *do not* include any services that fall into one of the other payor categories. The following is included in the counts for these lines:

  – Insurance purchased for public employees or retirees such as Tricare, Trigon, the Federal Employees Insurance Program, Workers Compensation, etc.
  – Contract payments from other organizations who engage the clinic on a fee-for-service or other reimbursement basis such as a Head Start program that pays for annual physical exams at a contracted rate, or a school, jail, or large company that pays for provision of medical care at a per-session or negotiated rate.

- **Self pay (Line 13)**

  – All services and charges where the responsible party is the patient, including charges for indigent care programs. **NOTE:** This includes the reclassified co-payments, deductibles, and charges for uncovered services for otherwise insured individuals which become the patient's personal responsibility.

5.2.8.2 Columns: Charges, Payments and Adjustments related to services delivered (Reported on a cash basis) Definitions

Because RPMS does not collect data for c-c4 and sites may use different codes for columns e and f, only columns a, b, and d will be calculated.

- **Column a: Full charges this period**

  This column records the total charges for each payor source. This should always reflect the full charge (per the fee schedule) for services rendered to patients in that payor category.

- **Column b: Amount collected this period**

  This column records the amount of net receipts for the year on a cash basis, regardless of the period in which the paid for services were rendered.

- **Column c: Retroactive Settlements, Receipts or Paybacks**

  This column gives details on cash receipts or payments for FQHC reconciliation, managed care pool distributions, payments from managed care withholds, and paybacks to FQHC or HMOs are reported in Columns c1 - c4.

- **Column c1: Collection of Reconciliation/Wrap around, Current Year**

  This column lists details on cash receipts or payments for FQHC reconciliation, managed care pool distributions, payments from managed care withholds, and paybacks to FQHC or HMOs are reported in Columns c1 - c4.

- **Column c2: Collection of Reconciliation/Wrap around, Previous Years**

  This column displays FQHC cash receipts from Medicare and Medicaid that cover services provided during previous reporting periods.

- **Column c3: Collection of other retroactive payments including risk pool/incentive/withhold**

  This column displays other cash payments including managed care risk pool redistribution, incentives, and withholds, from any payor. These payments are only applicable to managed care plans.

- **Column c4: Penalty/Payback**

  This column lists payments made to FQHC payors because of overpayments collected earlier and payments made to managed care plans (e.g., for over-utilization of the inpatient or specialty pool funds).

- **Column d: Allowances**

  This column displays allowances that are granted as part of an agreement with a third-party payor.

- **Column e: Sliding Discounts**

  This column lists reductions to patient charges based on the patient's ability to pay, as determined by the grantee's sliding discount schedule.

- **Column f: Bad Debt Write Off**

  This column lists only bad-debts from patients are recorded on this table.

Table 9D Logic

RPMS UDS reviews every visit (see Section 4.2.2) for patients who meet the RPMS UDS definition of a patient. This report includes A/R transactions for patients who are considered to be "UDS" patients (patients included in Table 3A) during the report period.

```
  DU     UDS 2011           DEMO INDIAN HOSPITAL                      Page 1
UDS No.  000001                                      Date Run: Dec 15, 2011
Reporting Period:  Jan 01, 2011 through Dec 31, 2011

  TABLE 9D - PATIENT-RELATED REVENUE (SCOPE OF PROJECT ONLY)

_____________________________________________________________________________

                                      FULL                AMOUNT
                                    CHARGES             COLLECTED
                                    THIS PERIOD         THIS PERIOD
PAYOR CATEGORY                        (a)                 (b)
_____________________________________________________________________________
```

1.	Medicaid Non-Managed Care		
2a.	Medicaid Managed Care (capitated)		
2b.	Medicaid Managed Care (fee-for-service)		
3.	TOTAL MEDICAID (LINES 1+2A+2B)	9,556,755	7,135,855
4.	Medicare Non-Managed Care		
5a.	Medicare Managed Care (capitated)		
5b.	Medicare Managed Care (fee-for-service)		
6.	TOTAL MEDICARE (LINES 4+5A+5B)	5,576,063	2,157,718
7.	Other Public including Non-Medicaid CHIP (Non) Managed Care)		
8a.	Other Public including Non-Medicaid CHIP (Managed Care Capitated)		
8b.	Other Public including Non-Medicaid CHIP (Managed Care fee-for-service)		
9.	TOTAL OTHER PUBLIC (LINES 7+8A+8B)	0	0

Figure 5-23: Sample RPMS UDS Table 9D, page 1

DU UDS 2011 DEMO INDIAN HOSPITAL Page 2
UDS No. 000001 Date Run: Dec 15, 2011
Reporting Period: Jan 01, 2011 through Dec 31, 2011

TABLE 9D - PATIENT-RELATED REVENUE (SCOPE OF PROJECT ONLY)

	PAYOR CATEGORY	FULL CHARGES THIS PERIOD (a)	AMOUNT COLLECTED THIS PERIOD (b)
10.	Private Non-Managed Care		
11a.	Private Managed Care (capitated)		
11b.	Private Managed Care (fee-for-service)		

12.	TOTAL PRIVATE (LINES 10+11A+11B)	11,807,201	1,596,821
13.	Self Pay	0	0
14.	TOTAL (LINES 3+6+9+12+13)	26,940,019	10,890,393

Figure 5-24: Sample RPMS UDS Table 9D, page 2

DU UDS 2011 DEMO INDIAN HOSPITAL Page 3
UDS No. 000001 Date Run: Dec 15, 2011
Reporting Period: Jan 01, 2011 through Dec 31, 2011

TABLE 9D - PATIENT-RELATED REVENUE (SCOPE OF PROJECT ONLY)

		RETROACTIVE SETTLEMENTS, RECEIPTS AND PAYPACKS (c)			
	PAYOR CATEGORY	COLLECTION RECONCILIATION/WRAP AROUND CURRENT YEAR (c1)	COLLECTION OF RECONCILIATION/WRAP AROUND PREVIOUS YEARS (c2)	COLLECTION OF OTHER RETROACTIVE PAYMENTS INCLUDING RISK POOL/ INCENTIVE/ WITHHOLD (c3)	PENALTY/ PAYBACK (c4)
1.	Medicaid Non-Managed Care				
2a.	Medicaid Managed Care (capitated)				
2b.	Medicaid Managed Care (fee-for-service)				
3.	TOTAL MEDICAID (LINES 1+2A+2B)				
4.	Medicare Non-Managed Care				
5a.	Medicare Managed Care (capitated)				
5b.	Medicare Managed Care (fee-for-service)				
6.	TOTAL MEDICARE (LINES 4+5A+5B)				
7.	Other Public including Non-Medicaid CHIP (Non) Managed Care)				
8a.	Other Public including Non-Medicaid CHIP (Managed Care Capitated)				

```
     Other Public including
8b.  Non-Medicaid CHIP
     (Managed Care fee-for-service)
_____________________________________________________________________________
         TOTAL OTHER PUBLIC
9.        (LINES 7+8A+8B)
_____________________________________________________________________________
```

Figure 5-25: Sample RPMS UDS Table 9D, page 3

```
  DU     UDS 2011           DEMO INDIAN HOSPITAL                    Page 4
UDS No.  000001                                  Date Run: Dec 15, 2011
Reporting Period:  Jan 01, 2011 through Dec 31, 2011

  TABLE 9D - PATIENT-RELATED REVENUE (SCOPE OF PROJECT ONLY)

_____________________________________________________________________________
               RETROACTIVE SETTLEMENTS, RECEIPTS AND PAYPACKS (c)
                                                  COLLECTION OF
                                    COLLECTION    OTHER
                          COLLECTION RECONCILIA   RETROACTIVE
                          RECONCILIA TION/WRAP    PAYMENTS     PENALTY/
                          TION/WRAP  AROUND       INCLUDING    PAYBACK
                          AROUND     PREVIOUS     RISK POOL/
                          CURRENT    YEARS        INCENTIVE/
                          YEAR                    WITHHOLD
PAYOR CATEGORY               (c1)         (c2)         (c3)         (c4)
_____________________________________________________________________________
     Private Non-Managed
10.  Care
_____________________________________________________________________________
     Private Managed Care
11a. (capitated)
_____________________________________________________________________________
     Private Managed Care
11b. (fee-for-service)
_____________________________________________________________________________
           TOTAL PRIVATE
12.    (LINES 10+11A+11B)
_____________________________________________________________________________

13.  Self Pay
_____________________________________________________________________________
14.          TOTAL
     (LINES 3+6+9+12+13)
_____________________________________________________________________________
```

Figure 5-26: Sample RPMS UDS Table 9D, page 4

```
  DU     UDS 2011           DEMO INDIAN HOSPITAL                    Page 5
UDS No.  000001                                  Date Run: Dec 15, 2011
Reporting Period:  Jan 01, 2011 through Dec 31, 2011

  TABLE 9D - PATIENT-RELATED REVENUE (SCOPE OF PROJECT ONLY)

_____________________________________________________________________________

                                          SLIDING        BAD DEBT
                                ALLOWANCES DISCOUNTS      WRITE OFF
PAYOR CATEGORY                     (d)         (e)           (f)
_____________________________________________________________________________
```

1.	Medicaid Non-Managed Care	
2a.	Medicaid Managed Care (capitated)	
2b.	Medicaid Managed Care (fee-for-service)	
3.	TOTAL MEDICAID (LINES 1+2A+2B)	0
4.	Medicare Non-Managed Care	
5a.	Medicare Managed Care (capitated)	
5b.	Medicare Managed Care (fee-for-service)	
6.	TOTAL MEDICARE (LINES 4+5A+5B)	0
7.	Other Public including Non-Medicaid CHIP (Non) Managed Care)	
8a.	Other Public including Non-Medicaid CHIP (Managed Care Capitated)	
8b.	Other Public including Non-Medicaid CHIP (Managed Care fee-for-service)	
9.	TOTAL OTHER PUBLIC (LINES 7+8A+8B)	0

Figure 5-27: Sample RPMS UDS Table 9D, page 5

DU UDS 2011 DEMO INDIAN HOSPITAL Page 6
UDS No. 000001 Date Run: Dec 15, 2011
Reporting Period: Jan 01, 2011 through Dec 31, 2011

TABLE 9D - PATIENT-RELATED REVENUE (SCOPE OF PROJECT ONLY)

	PAYOR CATEGORY	ALLOWANCES (d)	SLIDING DISCOUNTS (e)	BAD DEBT WRITE OFF (f)
10.	Private Non-Managed Care			
11a.	Private Managed Care (capitated)			
11b.	Private Managed Care (fee-for-service)			

```
            TOTAL PRIVATE
12.    (LINES 10+11A+11B)           5,170,927
_____________________________________________________________________

13.  Self Pay                             0
_____________________________________________________________________
14.           TOTAL
     (LINES 3+6+9+12+13)           18,534,279
_____________________________________________________________________
```

Figure 5-28: Sample RPMS UDS Table 9D, page 6

5.3 How to Run Reports

> **Note:** Before any reports are run, the system manager must identify all visit locations that should be counted toward your site's UDS reporting in the Site Parameters Setup. Your report will have no values if no locations are defined. (See Section 3.1.1 Locations to identify all visit locations that are eligible.)

To begin:

1. From the UDS 2011 Main Menu, type **REP** at the "Select UDS 2011 Option" prompt.

```
                  ******************************************
                  **     RPMS UNIFORM DATA SYSTEM (UDS)     **
                  **                  2011                  **
                  ******************************************
                              DEMO INDIAN HOSPITAL
                                  Version 6.0

   REP    Reports ...
   MU     Manager Utilities ...

Select UDS 2011 Option: REP <Enter>  Reports
```

Figure 5-29: UDS 2011 Main Menu

```
The UDS 2011 Reports menu displays (Figure 5-24).
                     ************************************
                     **  RPMS UNIFORM DATA SYSTEM (UDS)  **
                     **           2011 Reports           **
                     ************************************
                              DEMO INDIAN HOSPITAL
                                  Version 6.0

   Z      Patients by Zip Code
   3A     Table 3A: Patients by Age and Gender
   3B     Table 3B: Patients by Hisp Identity/Race/Language
   4      Table 4: Selected Patient Characteristics
   ST     Table 5 (a): Staffing List only (column A)
   5      Table 5 (b&c): Staffing and Utilization (cols b&c)
```

```
   6A     Table 6A: Selected Diagnoses and Services Rendered
   6B     Table 6B: Quality of Care Indicators
   7      Table 7: Health Outcomes and Disparities
   9D     Table 9D: Patient-Related Revenue (Totals Only)
   DR     Table 9D: Patient-Related Revenue (Delimited Rept)
   M      Multiple/ALL Tables Zip through 9D
Select Reports Option:
```

Figure 5-30: UDS 2011 Reports Menu

2. Type the number or letter corresponding to the report you want to run at the "Select Reports Option" prompt.

3. A description of the report you have requested displays (Figure 5-25)

```
                              DEMO INDIAN HOSPITAL
                                    UDS 2011

UDS searches your database to find all visits and related patients
during the time period selected. Based on the UDS definition, to be
considered
a patient the patient must have had at least one visit meeting the following
criteria:
   -must be to a location specified in your visit location setup
   -must be to Service Category Ambulatory (A), Hospitalization (H), Day
      Surgery (S), Observation (O), Telemedicine (M), Nursing home visit
(R),
      or In-Hospital (I) visit
   -must NOT have an excluded clinic code (see User Manual for a list)
   -must have a primary provider and a coded purpose of visit


TABLE 5 (b&c):  STAFFING AND UTILIZATION
This report will produce UDS Table 5 that itemizes visits and patients
(columns b and c only) by primary provider discipline.
Enter your site:
```

Figure 5-31: Running UDS Reports, Steps 3–4, selecting one report

4. If you select the "M Multiple/ALL Tables Zip through 7" option, a second menu of report choices displays. Type the numbers of the reports you want to run at the "Include Which Tables" prompt, separated by commas or hyphens. For example, to select Tables 1, 3 and 4, type **1,3–4** with no spaces between entries.

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

```
UDS Table Selection

     1   Patients by Zip Code
     2   Table 3A: Patients by Age and Gender
     3   Table 3B: Patients by Hispanic or Latino Identity/Race/Language
     4   Table 4: Selected Patient Characteristics
     5   Table 5 (a): Staffing List only (column A)
```

```
     6   Table 5 (b&c): Staffing and Utilization (cols b&c)
     7   Table 6A: Selected Diagnoses and Services Rendered
     8   Table 6B: Quality of Care Indicators
     9   Table 7: Health Outcomes and Disparities
     10  Table 9D: Patient-Related Revenue (Totals Only)
     11  Table 9D: Patient-Related Revenue (Delimited Rept)
     12  Multiple/ALL Tables Zip through 9D                Include which
Tables:  (1-12): 1// 1,3-4 <Enter>
```

Figure 5-32: Running UDS Reports, Step 5, selecting multiple reports

5. If Tables 6B or 7 are selected, Type **Y** or **N** at the "Does your facility provide prenatal care? N//" prompt. If Tables 6B or 7 is *not* selected, skip to Step 7.

6. Enter your site name at the "Enter your site" prompt.

7. The system will check to see if all taxonomies are present and will display a message. If all taxonomies are present, press the Enter key to continue. If all taxonomies are not present and you want to cancel the report, type a caret (^) and then follow the steps in Section 3.2.1 to edit the taxonomies.

8. Enter the calendar year for the report; for example, 2011.

9. Type in the number corresponding to the time period (quarter or full year) for the report.

10. Select the Patient Classification to be used for the report.

11. If Table 9D: Patient-Related Revenue (Delimited Report) enter a filename for the delimited report at the "You have selected to create a delimited output file for Table 9D. Enter a filename for the delimited output (no more than 40 characters):" prompt. If Table 9D: Patient-Related Revenue (Delimited Report) is *not* selected, skip to Step 13.

12. Type in the name of the printer or electronic file to which you want the report to print.

```
Enter your site:    DEMO INDIAN HOSPITAL
Checking for Taxonomies to support the 2011 UDS Report...

All taxonomies are present.

End of taxonomy check.  PRESS ENTER: <Enter>

Enter the Calendar Year.  Use a 4 digit year, e.g. 2003, 2007
Enter Calendar Year:  2011 <Enter>  (2011)

     Select one of the following:

          1         1st Quarter (January 1-March 31)
          2         2nd Quarter (April 1-June 30)
          3         3rd Quarter (July 1-September 30)
          4         4th Quarter (October 1-December 31)
          F         Full Calendar Year (January 1-December 31)
```

```
Choose the time period to report on: F// <Enter>  1st Quarter (January 1-
March 31)

Your report will be run for the time period: Jan 01, 2011 to Mar 31, 2011

     Select one of the following:

          1         Indian/Alaskan Native (Classification 01)
          2         Not Indian Alaskan/Native (Not Classification 01)
          3         All (both Indian/Alaskan Natives and Non 01)

Select Beneficiary Population to include in this report: 1//
Indian/Alaskan Native (Classification 01)

You have selected to create a delimited output file for Table 9D. Enter a
filename for the delimited output (no more than 40 characters):
DemoDelimited9DReport

When the report is finished your delimited output will be found in the
Q:\ directory.  The filename will be DemoDelimited9DReport.txt

DEVICE: HOME//
```

Figure 5-33: Running UDS Reports, Steps 6–12, selecting the Time Period

6.0 Patient Lists

For each report, RPMS UDS can also produce a corresponding list of patients and visits that are counted in the report. These lists can be used by a site to either verify data for accuracy or assist you with calculating reports where the data is not automatically calculated (e.g., Table 5 Column A (FTEs), Table 6B Sections A & B, Table 7 Section A) and to use as report backup for an auditor. Lists include:

- LST1–Lists for Tables Zip Code, 3A&3B, 4, 5, and 6A
  - Patient List by zip code
  - Patient list with age and gender information about the patient and a list of all visits for the patient during the report period, used with Table 3A.
  - Patient list with Hispanic Identity and race information about the patient and a list of all visits for the patient during the report period, used with Table 3B.
  - Patient List used with Table 4, Income As A Percent Of Poverty Level section (Number of patients with an Income as A Percent of Poverty Level (i.e. =<100%, 101-150%, 151-200%, >200%, Unknown))
  - Patient List used with Table 4, Principle Third Party Medical Insurance Source section (Number of patients with or without a Principle Third Party Medical Insurance Source)
  - Patient List used with Table 4, Characteristics - Special Populations section (Number of patients with Characteristics of Special Populations (i.e. migrant workers, seasonal workers, homeless, school based health center patient, or a veteran))
  - Staffing (Provider) List categorized by BPHC-defined categories to assist in manual calculations of Table 5 Column A (FTEs)
  - Patient List categorized by UDS-defined service categories (primary provider code) used with Table 5, Columns B (Visits) and C (Patients)
  - Patient List of visits for patients to whom the provider was uncategorized (i.e. did not map to the BPHC-defined categories), used with Table 5, Columns B (Visits) and C (Patients)
  - Patient List categorized by selected diagnoses (primary POV) and other services, used with Table 6A

The Visits with Uncategorized Primary Providers list report produces a list of visits that are not counted toward Table 5 Column B (Visits), allowing sites to re-categorize the provider code, if necessary.

- LST2–Lists for Table 6B

- Patient list by age that had pregnancy-related visits during the past 20 months with at least 1 pregnancy-related visit during the report period, used with Table 6B
- Patient list of two-year-old patients who had their first visit prior to their second birthday, had a medical visit during the report period, and have all required childhood immunizations, used with Table 6B
- Patient list of two-year-old patients who had their first visit prior to their second birthday, had a medical visit during the report period, and list the immunizations still needed to complete all required childhood immunizations, used with Table 6B
- Patient list of all female patients ages 24–64 who have not had a hysterectomy, had a medical visit during the report period, were first seen in the clinic by their 65th birthday, and had a Pap test in the past three years, used with Table 6B
- Patient list of all female patients ages 24–64 who have not had a hysterectomy, had a medical visit during the report period, were first seen in the clinic by their 65th birthday, and *did not* have a Pap test in the past 3 years, used with Table 6B
- Patient list of all children and adolescents ages 2-17 who had a medical visit during the report period, were first seen ever by the grantee prior to their 17th birthday, and had BMI documented and counseling for nutrition and physical activity during the report period, used with Table 6B.
- Patient list of all children and adolescents ages 2-17 who had a medical visit during the report period, were first seen ever by the grantee prior to their 17th birthday, and did not have BMI documented or counseling for nutrition and physical activity during the report period, used with Table 6B.
- Patient list of all adults age 18 or older who had a medical visit during the report period and had BMI documented and if overweight or underweight, a follow-up plan documented, used with Table 6B.
- Patient list of all adults age 18 or older who had a medical visit during the report period and did not have BMI documented or if overweight or underweight, did not have a follow-up plan documented, used with Table 6B.
- Patient list of all adults age 18 or older who had a medical visit during the report period, at least two medical visits ever, and had tobacco use assessed during the report period or the year prior, used with Table 6B.
- Patient list of all adults age 18 or older who had a medical visit during the report period, at least two medical visits ever, and did not have tobacco use assessed during the report period or the year prior, used with Table 6B.

  - Patient list of all adults age 18 or older who had a medical visit during the report period, at least two medical visits ever, used tobacco products within the past 24 months, and who received tobacco cessation counseling or smoking cessation agents during the report period or the year prior, used with Table 6B.
  - Patient list of all adults age 18 or older who had a medical visit during the report period, at least two medical visits ever, used tobacco products within the past 24 months, and who did not receive tobacco cessation counseling or smoking cessation agents during the report period or the year prior, used with Table 6B.
  - Patient list of all patients ages 5-40 with a diagnosis of mild, moderate or severe persistent asthma who had a medical visit during the report period, at least two medical visits ever, who received a prescription for or provided inhaled corticosteroid or an accepted alternative medication, used with Table 6B.
  - Patient list of all patients ages 5-40 with a diagnosis of mild, moderate or severe persistent asthma who had a medical visit during the report period, at least two medical visits ever, who did not receive a prescription for or provided inhaled corticosteroid or an accepted alternative medication, used with Table 6B.
- LST3–Lists for Table 7
  - Patient list of patients that had pregnancy-related visits during the past 20 months, with at least one pregnancy-related visit during the report period, and who have been diagnosed with HIV, used with Table 7 Section A
  - Patient list by race and Hispanic or Latino identity of patients that had pregnancy-related visits during the past 20 months, with at least one pregnancy-related visit during the report period, used with Table 7 Section A
  - Patient list by race and Hispanic or Latino identity of patients ages 18 to 85 years old who have had two medical visits during the report period and were diagnosed with hypertension before June 30 of the report period, used with Table 7 Section B
  - Patient list by race and Hispanic or Latino identity of patients ages 18 to 85 years old who have had two medical visits during the report period, were diagnosed with hypertension before June 30 of the report period, and who have controlled blood pressure (<140/90 mm Hg) during the report period, used with Table 7 Section B
  - Patient list by race and Hispanic or Latino identity of patients ages 18 to 85 years old who have had two medical visits during the report period, were diagnosed with hypertension before June 30 of the report period, and who do not have controlled blood pressure (<140/90 mm Hg) during the report period, used with Table 7 Section B

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

Patient lists are run from the Manager Utilities menu option. Because patient lists might be hundreds or even thousands of pages long, depending on the size of a site's patient population, the menu options are "hidden" where casual users will not run them by accident.

Note: It is strongly recommended that patient lists be printed to an electronic file since they may be hundreds or thousands of pages long.

6.1 Patient List Definitions

6.1.1 ZIP–All Patients w/Visits by Zip

This report lists all patients counted toward the Zip Code Table who have at least one visit for the specified time period that meets the visit definition criteria. Sorted by patients descending, community, gender, and name, this report lists all patients that fit the definition.

6.1.2 USVA–All Patients w/Visits, By Age and Gender (Tables 3A)

This report lists all patients who have at least one visit for the specified time period that meets the visit definition criteria. Sorted by community, age, and gender and lists all visits that fit the definition. Age is calculated as of June 30th of the report year.

6.1.3 USVR–All Pts w/Visits, by Hispanic or Latino Identity & Race (Table 3B)

This report lists all patients by Hispanic or Latino Identity/Race/Language who have at least one visit for the specified time period that meets the visit definition criteria. Sorted by race/Hispanic identity, age, gender, and community and lists all visits that fit the definition. Age is calculated as of June 30th of the report year.

6.1.4 IPPL–Income Percent of Poverty Level (Table 4)

This report lists all patients with an income percent of poverty level (=<100%, 101-150%, 151-200%, >200%, Unknown) who have at least one visit for the specified time period that meets the visit definition criteria. Sorted by Income as Percent of Poverty Level, community, age, and gender and lists all visits that fit the definition.

6.1.5 PMIS–Principle Third Party Medical Insurance (Table 4)

This report lists all patients and the type of medical insurance the patient had as of the patient's last visit, if any, during the report period and who have at least one visit for the specified time period that meets the visit definition criteria. Sorted by Principle Third Party Medical Insurance, community, age, and gender and lists all visits that fit the definition.

6.1.6 CHAR–Characteristics of Special Populations (Table 4)

This report lists all patients who are migrant workers, seasonal workers, homeless, school based health center patient, or a veteran during the report period and who have at least one visit for the specified time period that meets the visit definition criteria. Sorted by Special Characteristics, community, age, and gender and lists all visits that fit the definition.

6.1.7 PROV–Provider/Staff List (Table 5 Column A)

This report provides a list of all providers and other facility staff who are documented in RPMS and with whom patients had visits during the report period where the provider was the primary provider, categorized by BPHC-UDS-defined service categories. You should use this list to manually calculate FTEs for each staff category to document in Table 5 Column A (FTEs).

6.1.8 SER–All Patients By Service Category (Table 5, Columns B and C)

This report lists all patients and related eligible visits, categorized by BPHC UDS-defined service categories (primary provider code) and sorted by community, age, and gender. See Appendix D: RPMS Provider Codes Mapping to UDS Service Category for Table 5–5 for how UDS disciplines are mapped to RPMS provider codes.

6.1.9 UCP–Visits w/Uncategorized Primary Provider (Table 5, Columns B and C)

This report provides a list of patients who had visits during the specified calendar year to providers who were not mapped to any BPHC major service category and sorted by community, age, and gender. (See Appendix D: RPMS Provider Codes Mapping to UDS Service Category for Table 5–5 for details of how RPMS provider codes are mapped to UDS service categories.)

6.1.10 DIAG–All Patients by Selected Primary Diagnosis (Table 6A)

This report provides a list of patients who had visits during the report period, had a specified primary diagnosis, had a specified diagnostic test or screening performed, or who had a specified dental service performed and sorted by community, age, and gender.

6.1.11 M–Multiple/ALL Lists Zip through 6A

This report enables the user to run all lists or to select multiple lists to run for the Zip Code, 3A, 3B, 5, and 6A tables.

6.1.12 PRGA–All Pregnant Patients by Age (Table 6B Sections A & B)

This report provides a list of patients by age that had pregnancy-related visits during the past 20 months, with at least one pregnancy-related visit during the report period, sorted in age brackets by age. You should use this list to manually calculate Sections A & B (Lines 1–9).

6.1.13 CIM1–All Patients Age 2 w/All Child Immunizations (Table 6B Section C)

This report provides a list of two year old patients who had their first visit prior to their 2nd birthday, had a medical visit during the report period, and have all required childhood immunizations (4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1 Varicella, and 4 Pneumococcal conjugate) sorted by last name. Age is calculated as of December 31.

6.1.14 CIM2–All Patients Age 2 w/o All Child Immunizations (Table 6B Section C)

This report provides a list of two year old patients who had their first visit prior to their 2nd birthday, had a medical visit during the report period, and list the immunizations still needed to complete all required childhood immunizations (4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1 Varicella, and 4 Pneumococcal conjugate) sorted by last name. Age is calculated as of December 31.

6.1.15 PAP1–All Female Patients w/Pap Test (Table 6B Section D)

This report provides a list of all female patients ages 24–64 who have not had a hysterectomy, had a medical visit during the report period, were first seen in the clinic by their 65th birthday, and had a Pap test in the past 3 years sorted by age and last name. Age is calculated as of December 31.

6.1.16 PAP2–All Female Patients w/o Pap Test (Table 6B Section D)

This report provides a list of all female patients ages 24–64 who have not had a hysterectomy, had a medical visit during the report period, were first seen in the clinic by their 65th birthday, and did not have a Pap test in the past 3 years sorted by age and last name. Age is calculated as of December 31.

6.1.17 WAC1–All Patients 2-17 w/WT Assessment & Counseling (Table 6B Section E)

This report provides a list of all patients ages 2-17 who have documented BMI percentile, counseling for nutrition, counseling for physical activity, had a medical visit during the report period, and were first ever seen in the clinic by their 17th birthday sorted by age and last name. Age is calculated as of December 31. **Note:** The patient must turn three during the report period; therefore, patients in this list will range from the age of 3-17.

6.1.18 WAC2–All Patients 2-17 w/o WT Assessment & Counseling (Table 6B Section E)

This report provides a list of all patients ages 2-17 who does not have documented BMI percentile, or counseling for nutrition, or counseling for physical activity, had a medical visit during the report period, and were first ever seen in the clinic by their 17th birthday sorted by age and last name. Age is calculated as of December 31. **Note:** The patient must turn three during the report period; therefore, patients in this list will range from the age of 3-17.

6.1.19 AWS1–All Patients 18+ w/BMI & over/underweight w/plan (Table 6B Section F)

This report provides a list of all patients 18 years and older who have documented BMI percentile on the last visit during the report period or on any visit within the last 6 months of the last visit during the report period, and are overweight or underweight, and patient had a follow-up plan documented, had a medical visit during the report period, and were ever seen after their 18th birthday sorted by age and last name. Age is calculated as of December 31.

6.1.20 AWS2–All Patients 18+ w/o BMI or w/o follow-up plan (Table 6B Section F)

This report provides a list of all patients 18 years and older who does not have documented BMI percentile on the last visit during the report period or on any visit within the last 6 months of the last visit during the report period, or who are not overweight or underweight, or does not have a follow-up plan documented, had a medical visit during the report period, and were ever seen after their 18th birthday sorted by age and last name. Age is calculated as of December 31.

6.1.21 TUA1–All Patients 18+ w/tobacco use assessment (Table 6B Section G1)

This report provides a list of all patients 18 years and older who were queried about any and all forms tobacco use one or more times during the report period or the prior year, had at least one two medical visit during the report period, and with at least two medical visits ever, and were ever seen after their 18th birthday sorted by age and last name. Age is calculated as of December 31.

6.1.22 TUA2–All Patients 18+ w/o tobacco use assessment (Table 6B Section G1)

This report provides a list of all patients 18 years and older who were queried not about any and all forms tobacco use one or more times during the report period or the prior year, had at least one medical visit during the report period, and with at least two medical visits ever, and were ever seen after their 18th birthday sorted by age and last name. Age is calculated as of December 31.

6.1.23 TCI1–All Pts 18+ smokers/tobacco user w/intervention (Table 6B Section G2)

This report provides a list of all patients 18 years or older who are documented smokers or tobacco users and who received documented advice to quit smoking or tobacco use during the report, had at least two medical visits ever, had a medical visit during the report period, and were ever seen after their 18th birthday sorted by age and last name. Age is calculated as of December 31.

6.1.24 TCI2–All Pts 18+ smokers/tobacco users w/o intervention (Table 6B Section G2)

This report provides a list of all patients 18 years or older who are documented smokers or tobacco users and who have not received documented advice to quit smoking or tobacco use during the report, had at least two medical visits ever, had a medical visit during the report period, and were ever seen after their 18th birthday sorted by age and last name. Age is calculated as of December 31.

6.1.25 APT1–All Asthma Pts 5-40 w/Asthma Therapy Medication (Table 6B Section H)

This report provides a list of all patients 5-40 years of age with an active diagnosis of persistent asthma (either mild, moderate, or severe) who were prescribed either the preferred long term control medication or an acceptable alternative pharmacological therapy during the report period, had at least two medical visits ever, and had a medical visit during the report period sorted by age and last name. Age is calculated as of December 31.

6.1.26 APT2–All Asthma Pts 5-40 w/o Asthma Therapy Medication (Table 6B Section H)

This report provides a list of all patients 5-40 years of age with an active diagnosis of persistent asthma (either mild, moderate, or severe) who were not prescribed either a preferred long term control medication or an acceptable alternative pharmacological therapy or patients 5-40 years of age without an active diagnosis of persistent asthma who were prescribed either the preferred long term control medication or an acceptable alternative pharmacological therapy during the report period, had at least two medical visits ever, and had a medical visit during the report period sorted by age and last name. Age is calculated as of December 31.

6.1.27 M6B–Multiple/ALL Lists for Table 6B

This report enables the user to run all lists or to select multiple lists to run for Table 6B.

6.1.28 PRGH–All Pregnant Patients w/HIV (Table 7 HIV Positive Pregnant Women)

This report provides a list of patients that had pregnancy-related visits during the past 20 months, with at least one pregnancy-related visit during the report period, and who have been diagnosed with HIV sorted by age and last name. Age is calculated as of June 30.

6.1.29 PRGR–All Pregnant Patients by Race & Hisp Identity (Table 7 Section A)

This report provides a list of all pregnant patients by race and Hispanic or Latino identity, with most recent pregnancy related visits during the past 20 months, with at least one pregnancy-related visit during the report period sorted by race/Hispanic identity, community, age and last name. Age is calculated as of June 30. You should use this list to manually calculate Sections A (Lines 1-5).

6.1.30 MPRG–Multiple/ALL Lists for Pregnant Patients (Table 7 HIV Positive Pregnant Women & Section A)

This report enables the user to run all lists or to select multiple lists to run for Table 7 HIV Positive Pregnant Women Line and Section A (Deliveries and Birth Weight By Race and Hispanic/Latino Identity, Lines 1–5).

6.1.31 HTR–All HTN Patients by Race & Hisp Identity (Table 7 Section B)

This report provides a list by race and Hispanic or Latino identity of all patients' ages 18 to 85 years old who have had two medical visits during the report period and were diagnosed with hypertension anytime before June 30 of the report period. The list displays the patient's most recent hypertension diagnosis before June 30 of the report period sorted by race/Hispanic identity, community, age and last name. Age is calculated as of December 31.

6.1.32 HTCR–All HTN Pts w/Contr BP by Race & Hisp Identity (Table 7 Section B)

This report provides a list by race and Hispanic or Latino identity of all patients ages 18 to 85 years old who have had two medical visits during the report period and were diagnosed with hypertension anytime before June 30 of the report period and who have controlled blood pressure (<140/90 mm Hg) during the report period. The list displays the patient's last blood pressure (<140/90 mm Hg) sorted by race/Hispanic identity, community, age and last name. Age is calculated as of December 31.

6.1.33 HTUR–All HTN Pts w/Uncont BP by Race & Hisp Identity (Table 7 Section B)

This report provides a list by race and Hispanic or Latino identity of all patients ages 18 to 85 years old who have had two medical visits during the report period and were diagnosed with hypertension anytime before June 30 of the report period and who do not have controlled blood pressure (<140/90 mm Hg) during the report period. The list displays the patient's last blood pressure results or no blood pressure taken sorted by race/Hispanic identity, community, age and last name. Age is calculated as of December 31.

6.1.34 MHT–Multiple/ALL Lists for HTN Patients (Table 7 Section B)

This report enables the user to run all lists or to select multiple lists to run for Table 7 Section B (Hypertension By Race and Hispanic/Latino Identity, Lines 6–8).

6.1.35 DMR–All DM Patients by Race & Hisp Identity (Table 7 Section C)

This report provides a list by race and Hispanic or Latino identity of all patients ages 18 to 75 years old who have had two medical visits during the report period, and were diagnosed with Type I or Type II diabetes anytime through the end of the report period, and without a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes sorted by race/Hispanic identity, community, age and last name. Age is calculated as of December 31.

6.1.36 DMR1–All DM Patients w/A1c <7 by Race & Hisp Identity (Table 7 Section C)

This report provides a list by race and Hispanic or Latino identity of all patients ages 18 to 75 years old who have had two medical visits during the report period, and were diagnosed with Type I or Type II diabetes anytime through the end of the report period, and without a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes and whose most recent hemoglobin A1c of less than 7% sorted by race/Hispanic identity, community, age and last name. Age is calculated as of December 31.

6.1.37 DMR2–All DM Pts w/A1c >=7 & <8 by Race & Hisp Identity (Table 7 Section C)

This report provides a list by race and Hispanic or Latino identity of all patients ages 18 to 75 years old who have had two medical visits during the report period, and were diagnosed with Type I or Type II diabetes anytime through the end of the report period, and without a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes and whose most recent hemoglobin A1c is >=7% and <8% sorted by race/Hispanic identity, community, age and last name. Age is calculated as of December 31.

6.1.38 DMR3–All DM Pts w/A1c >=8 & <=9 by Race & Hisp Identity (Table 7 Section C)

This report provides a list by race and Hispanic or Latino identity of all patients ages 18 to 75 years old who have had two medical visits during the report period, and were diagnosed with Type I or Type II diabetes anytime through the end of the report period, and without a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes and whose most recent hemoglobin A1c is >=8% and <=9% sorted by race/Hispanic identity, community, age and last name. Age is calculated as of December 31.

6.1.39 DMR4–All DM Patients w/o A1c or >9 by Race & Hisp Identity (Table 7 Section C)

This report provides a list by race and Hispanic or Latino identity of all patients ages 18 to 75 years old who have had two medical visits during the report period, and were diagnosed with Type I or Type II diabetes anytime through the end of the report period, and without a diagnosis of polycystic ovaries, gestational diabetes, or steroid-induced diabetes and whose most recent hemoglobin A1c is >9%, or did not have a result, or the patient did not have an A1c test during the report period sorted by race/Hispanic identity, community, age and last name. Age is calculated as of December 31.

6.1.40 MDM–Multiple/ALL Lists for DM Patients (Table 7 Section C)

This report enables the user to run all lists or to select multiple lists to run for Table 7 Section C (Diabetes By Race and Hispanic/Latino Identity, Lines 9–13).

6.2 How to Run Patient and Provider Lists

RPMS UDS will produce both the summary table report and the corresponding patient list. This will enable you to directly compare summary results with the RPMS data that is current at the time the report is run.

1. From the main RPMS UDS 2011 main menu, type **MU** (Manager Utilities).
2. From the Manager Utilities menu, type **LST** at the "Select Manager Utilities Option" prompt.

```
                    ************************************
                    **  RPMS UNIFORM DATA SYSTEM (UDS)  **
                    **      2011 Manager Utilities      **
                    ************************************
                             DEMO INDIAN HOSPITAL
                                 Version 6.0

   SET    Update/Review Site Parameters
   LST    Patient and Provider Lists Main Menu ...
   STP    Create Search Template of Patients on Table 3A
   TAX    Update Taxonomies for Use with UDS 2011

Select Manager Utilities Option:  LST <Enter>  Patient and Provider Lists
Main Menu
```

Figure 6-1: Manager Utilities menu

3. The 2011 Patient and Provider Lists menu is displayed. Type **LST1** to view the available lists for Tables Zip Code, 3A, 3B, 4, 5 and 6A (Figure 6-2).

```
                    ************************************
                    **  RPMS UNIFORM DATA SYSTEM (UDS)  **
                    ** 2011 Patient and Provider Lists  **
                    ************************************
                             DEMO INDIAN HOSPITAL
                                 Version 6.0

   LST1   Lists for Tables Zip Code, 3A&3B, 4, 5, and 6A ...
   LST2   Lists for Table 6B ...
   LST3   Lists for Table 7 ...

Select Patient and Provider Lists Main Menu Option: LST1 <Enter>
```

Figure 6-2: 2011 Patient and Provider Lists menu

4. The list options are displayed. Type the letter corresponding to the individual patient list you want to produce, or type **M** to select more than one list.

```
              ************************************************
              **          RPMS UNIFORM DATA SYSTEM (UDS)        **
              **         2011 Patient and Provider List         **
              **  Lists for Tables Zip Code, 3A&3B, 5, and 6A   **
              ************************************************
                             DEMO INDIAN HOSPITAL
                                 Version 6.0


   ZIP    All Patients w/Visits by Zip
   USVA   All Pts w/Visits, by Age & Gender (3A)
   USVR   All Pts w/Visits, by Hispanic Identity & Race (3B)
   IPPL   Income Percent of Poverty Level (Table 4)
   PMIS   Principle Third Party Medical Insurance (Table 4)
   CHAR   Characteristics of Special Populations (Table 4)
   PROV   Provider/Staff List (Table 5 col A)
   SER    All Patients by Service Category (Table 5 col B&C)
   UCP    Visits w/Uncategorized Primary Prov (Table 5 B&C)
   DIAG   All Patients by Selected Primary DX (Table 6A)
   M      Multiple/ALL Lists Zip through 6A

Select Lists for Tables Zip Code, 3A&3B, 5, and 6A Option:
```

Figure 6-3: Lists for Tables Zip Code, 3A&3B, 5 and 6A menu

5. A message is displayed (Figure 6-4) advising you that the list may be very long and that it is best to print the list to a file. Press the Enter key to continue.

6. A patient list description and definition displays (Figure 6-4).

```
Select Lists for Tables Zip Code, 3A&3B, 4, 5, and 6A Option: USVA <Enter>
All Pts w/Visit, by Age & Gender (3A)

                             DEMO INDIAN HOSPITAL
                                   UDS 2011
NOTE: Patient lists may be hundreds of pages long, depending on the size of
your patient population.  It is recommended that you run these reports at
night and  print to an electronic file, not directly to a printer.

Press Enter to Continue: <Enter>
```

```
The Patient List option documents the individual patients and visits that
are counted and summarized on each Table report (main menu
option REP).  The summary Table report is included at the beginning of each
List report.
UDS searches your database to find all visits and related patients
during the time period selected. Based on the UDS definition, to be counted
as a patient, the patient must have had at least one visit meeting the
following criteria:
   -must be to a location specified in your visit location setup
   -must be to Service Category Ambulatory (A), Hospitalization (H), Day
      Surgery (S), Observation (O), Telemedicine (M), Nursing home visit
(R),
      or In-Hospital (I) visit
   -must NOT have an excluded clinic code (see User Manual for a list)
   -must have a primary provider and a coded purpose of visit


ALL PATIENTS BY AGE & GENDER (Tables 3A)
This report lists all patients who have at least one visit for the specified
time period that meets the visit definition criteria. Sorted by community,
age, and gender and lists all visits that fit the definition. Age is
calculated as of June 30th of the report year.
```

Figure 6-4: Running a Patient List, Steps 3–6

7. If you selected M Multiple/All Lists Zip through 6A, another list will be displayed (Figure 6-5). Type in the numbers corresponding to the patient lists you want to produce, using commas or hyphens to separate the entries. For example, to select Lists 1, 2, 3 and 5, type **1–3,5**.

> **Note:** Do *not* use spaces between entries.

```
UDS Patient and Provider List Selection

     1   All Patients w/Visits by ZIP
     2   All Patients w/Visits, by Age & Gender (Tables 3A)
     3   All Patients w/Visits, by Hispanic or Latino Identity & Race (Table
3B)
     4   Income Percent of Poverty Level (Table 4)
     5   Principle Third Party Medical Insurance Source (Table 4)
     6   Characteristics of Special Populations (Table 4)
     7   Provider/Staff List (Table 5 col A)
     8   All patients by Service Category (Table 5 col B&C)
     9   All Visits w/Uncategorized Primary Prov (Table 5 col B&C)
     10  All Patients by Selected Primary Diagnosis (Table 6A)
     11  ALL Patient Lists for LST1 -Sub Menu
Include which Lists:  (1-11): 1// 1-3,5 <Enter>
```

Figure 6-5: Selecting Multiple Lists

8. Enter your site name at the “Enter your site” prompt.

9. The system will check to see if all taxonomies are present and will display a message. If all taxonomies are present, press the Enter key to continue. If all taxonomies are not present and you want to cancel the report, type a caret (^) and then follow the steps in Section 3.2.1 to edit the taxonomies.

10. Type the calendar year at the "Enter Calendar Year" prompt.

11. Type the number or letter corresponding to the time period for the report (quarters or full calendar year) at the "Choose the time period to report on" prompt.

12. RPMS UDS will provide a final reminder that the reports may take time to run and include several hundred pages. To exit from the menu now, type **Y** (Yes) at the "Do You Want to Exit This Program Now?" prompt. To proceed with the report, type **N** (No).

13. Type in the name of the printer or electronic file at the "Device" prompt.

> **Note:** It is recommended that patient lists be printed to electronic files, as they may be several hundred or thousands of pages long, depending on the size of the facility's patient population.

```
Enter your site:    DEMO INDIAN HOSPITAL
Checking for Taxonomies to support the UDS Report...

All taxonomies are present.
End of taxonomy check.  PRESS ENTER: <Enter>

Enter the Calendar Year.  Use a 4 digit year, e.g. 2003, 2007
Enter Calendar Year:  2011 <Enter>  (2011)

     Select one of the following:

          1         1st Quarter (January 1-March 31)
          2         2nd Quarter (April 1-June 30)
          3         3rd Quarter (July 1-September 30)
          4         4th Quarter (October 1-December 31)
          F         Full Calendar Year (January 1-December 31)

Choose the time period to report on: F// F <Enter>  Full Calendar Year
(January 1-December 31)

Your report will be run for the time period: Jan 01, 2011 to Dec 31, 2011
Depending on the size of your database, this report may take 2-4 hours to
run and produce patient reports that are hundreds of pages long.  It is
recommended that these reports be run at night and printed to an electronic
file, rather than directly to a printer.
Do you want to exit this program now? N// NO <Enter>

DEVICE: HOME//
```

Figure 6-6: Running a Patient List, Steps 8–13

6.3 Create Search Template of Patients on Table 3A

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

1. From the main RPMS UDS 2011 main menu, type **MU** (Manager Utilities).
2. From the Manager Utilities menu, type **STP** at the "Select Manager Utilities Option" prompt.

```
                    ************************************
                    **  RPMS UNIFORM DATA SYSTEM (UDS)  **
                    **      2011 Manager Utilities      **
                    ************************************
                             DEMO INDIAN HOSPITAL
                                 Version 6.0

   SET    Update/Review Site Parameters
   LST    Patient and Provider Lists Main Menu ...
   STP    Create Search Template of Patients on Table 3A
   TAX    Update Taxonomies for Use with UDS 2011

Select Manager Utilities Option:  STP <Enter>  Create Search Template of
Patients on Table 3A
```

Figure 6-7: Manager Utilities menu

3. The information screen is displayed, as shown below in Figure 6–8.

```
                              DEMO INDIAN HOSPITAL
                                   UDS 2011

UDS searches your database to find all visits and related patients
during the time period selected. Based on the UDS definition, to be
considered a patient the patient must have had at least one visit meeting
the following criteria:
   -must be to a location specified in your visit location setup
   -must be to Service Category Ambulatory (A), Hospitalization (H), Day
      Surgery (S), Observation (O), Telemedicine (M), Nursing home visit
(R),
      or In-Hospital (I) visit
   -must NOT have an excluded clinic code (see User Manual for a list)
   -must have a primary provider and a coded purpose of visit

PRESS ENTER: <Enter>
TABLE 3A:  PATIENTS BY AGE AND GENDER WITH SEARCH TEMPLATE CREATION

This option will create a search template of all patients who meet
the definition of a patient above and who are included in UDS Table 3A.
You may use this search template in other applications (QMAN, PGEN)
to assist you in completing UDS tables not produced by the IHS/RPMS UDS
application.

Patients must have at least one visit during the selected time period,
```

```
as defined above.  Age is calculated as of June 30th of the year you
select.

This option will also produce UDS Table 3A, an itemization of users
(patients) by age and gender.

Enter your site:
```

Figure 6-8: Creating a Search Template

4. Enter your site name at the "Enter your site" prompt.
5. The system will check to see if all taxonomies are present and will display a message. If all taxonomies are present, press the Enter key to continue. If all taxonomies are not present and you want to cancel the report, type a caret (^) and then follow the steps in Section 3.2.1 to edit the taxonomies.
6. Enter the calendar year for the report; for example, 2011.
7. Type in the number corresponding to the time period (quarter or full year) for the report.
8. Enter the name of an existing search template that will be overwritten or the name of a new search template that will be created.
9. Type in the name of the output device for the report.

```
Enter your site: DEMO INDIAN HOSPITAL
Checking for Taxonomies to support the 2011 UDS Report...

All taxonomies are present.

End of taxonomy check.  PRESS ENTER: <Enter>

Enter the Calendar Year.  Use a 4 digit year, e.g. 2003, 2007
Enter Calendar Year:  2011 <Enter> (2011)

     Select one of the following:

          1         1st Quarter (January 1-March 31)
          2         2nd Quarter (April 1-June 30)
          3         3rd Quarter (July 1-September 30)
          4         4th Quarter (October 1-December 31)
          F         Full Calendar Year (January 1-December 31)

Choose the time period to report on: F// <Enter>  1st Quarter (January 1-
March 31)

Your report will be run for the time period: Jan 01, 2011 to Mar 31, 2011

* You may enter an existing Template Name or Save results in a New Template
*
Patient Search Template: MYSEARCHTEMPLATE
  Are you adding 'MYSEARCHTEMPLATE' as a new SORT TEMPLATE? No// Y  (Yes)

     An unduplicated PATIENT list resulting from this report
     will be stored in the MYSEARCHTEMPLATE Search Template.
```

```
DEVICE: HOME//
```

Figure 6-9: Creating a Search Template, Steps 4–9

Appendix A: RPMS Rules of Behavior

The Resource and Patient Management (RPMS) system is a United States Department of Health and Human Services (HHS), Indian Health Service (IHS) information system that is ***FOR OFFICIAL USE ONLY***. The RPMS system is subject to monitoring; therefore, no expectation of privacy shall be assumed. Individuals found performing unauthorized activities are subject to disciplinary action including criminal prosecution.

All users (Contractors and IHS Employees) of RPMS will be provided a copy of the Rules of Behavior (RoB) and must acknowledge that they have received and read them prior to being granted access to a RPMS system, in accordance IHS policy.

- For a listing of general ROB for all users, see the most recent edition of *IHS General User Security Handbook* (SOP 06-11a).
- For a listing of system administrators/managers rules, see the most recent edition of the *IHS Technical and Managerial Handbook* (SOP 06-11b).

Both documents are available at this IHS Web site: http://security.ihs.gov/.

The ROB listed in the following sections are specific to RPMS.

A.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).

A.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.

A.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.

A.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.

A.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.

A.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.

A.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).

A.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.

A.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.

A.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.

A.1.10 Session Timeouts

RPMS system implements system-based timeouts that back 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.

A.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.

A.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.

A.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.

A.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.

A.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.

Appendix B: Quick Reference Guide

Follow these steps to implement the Resource and Patient Management System (RPMS) Uniform Data System (UDS) Reporting System. The section numbers listed in parentheses refer to appropriate sections in the RPMS UDS User Manual.

1. Load software on your RPMS server.
2. To open the software on your computer, type **UDS** at your RPMS main menu prompt.
3. Review the BPHC definitions of "visit" and determine which RPMS location codes should be included in your UDS reporting. Most locations probably should be included; examples of locations *not* to include are "Ambulance" and "Other." (Sections 4.1.2 and 3.1.1)
4. Consult with laboratory staff to identify lab tests that need to be included in the HIV Test, the Pap Smear, the DM Audit HGB A1C Tax, the Hepatitis B test and the Hepatitis C test taxonomies. (Section 3.2)
5. Set your site parameters: Enter site name, UDS identification number, if known; and associated location codes (MU/SET menu options). (Section 3.1)

> **Note:** It is recommended that you use the "S Add All SU locations" option to add all locations associated with the site, and then delete those few that you don't need.

6. Set up lab taxonomies for HIV Test, Pap Smear, DM Audit HGB A1C Tax, Hepatitis B test and Hepatitis C test (MU/TAX menu options). (Section 3.2.1)
7. Run the Staff List (Table 5) first (REP/ ST menu option). Review the list of providers and ensure that all staff is coded correctly. (Section 6.2)
8. Update your Provider file in RPMS if necessary. Rerun the Staff List (Table 5) report again to ensure correct coding.
9. Run the eight Reports (REP menu option). (Section **5.0**)
10. Review the results to identify any RPMS data issues. If you think the summary reports are substantially inaccurate (e.g., total patients or visits are too low or too high), run and review associated patient lists (MU/LST/ menu options) to verify that the correct site is selected, and that all appropriate locations have been identified in the Site Parameters file (MU/SET menu options).

> **Note:** Depending on the size of your RPMS database, patient lists may take 1–2 hours to run and may print out hundreds or thousands of pages. It is recommended to print the reports to an electronic file and to run the report overnight. (Section 6.0)

11. Update RPMS as needed.
12. Ensure that data entry has completed entering all visit data through December 31, prior to running final reports.
13. For final reports, run the reports only (not the patient lists) (REP menu option). (Section **5.0**)
14. To complete Column A on Table 5, run the Staff List report from the MU/LST/LST1/ menu and manually calculate your FTEs by BPHC-defined provider categories. (Section 6.2)
15. Manually enter your summary data from the RPMS UDS reports into your BPHC UDS software.
16. To complete Section A & B of Table 6B, run the PRGA report from the MU/LST/LST2/ menu and manually calculate your prenatal care patients. (Section 6.2)
17. To complete Section A of Table 7, run the PRGR report from the MU/LST/LST3/PRG/ menu and manually calculate your deliveries and birth weight patients by race and Hispanic/Latino identity. (Section 6.2)

Appendix C: BPHC Service Category Definitions for Table 5

C.1 Personnel by Major Service Category

Staff is distributed into categories that reflect the types of services they provide. Major service categories include: medical care services, dental services, mental health services, substance abuse services, other professional health services, vision services, pharmacy services, enabling services, other program related services staff, and administration and facility. Whenever possible, the contents of major service categories have been defined to be consistent with definitions used by Medicare.[liii] The following summarizes the personnel categories; a detailed list is in Appendix C.

- Medical Care Services (Lines 1–15)
  - Physicians–M.D.s and D.O.s, except psychiatrists, pathologists, and radiologists. Naturopaths and chiropractors are not counted here.
  - Nurse Practitioners
  - Physician Assistants
  - Certified Nurse Midwives
  - Nurses–registered nurses, licensed practical and vocational nurses, home health and visiting nurses, clinical nurse specialists, and public health nurses
  - Laboratory Personnel–pathologists, medical technologists, laboratory technicians and assistants, phlebotomists
  - X-ray Personnel–radiologists, X-ray technologists, and X-ray technicians
  - Other Medical Personnel–medical assistants, nurse's aides, and all other personnel providing services in conjunction with services provided by a physician, nurse practitioner, physician assistant, certified nurse midwife, or nurse. Staff who support the quality assurance/Electronic Health Records (EHR) program. Medical records and patient support staff are not reported here.

> **Note**: Quality Assurance Personnel–Individuals in any or all of the above positions may be involved in Quality Assurance and EHR activities. They will be classified on the line that describes their main responsibility.

- Dental Services (Lines 16–19)

[liii] BPHC Uniform Data System Manual, 2011 Revision, p. 25.

- Dentists–general practitioners, oral surgeons, periodontists, and pediodontists
- Dental Hygienists
- Other Dental Personnel–dental assistants, aides, and technicians

- **Mental Health Services (Lines 20a, a1, a2, b, c and 20)**

> **Note**: Behavioral health services include both mental health and substance abuse services. Centers using the "Behavioral Health" designation need to divide their staff between lines 20 and 21 as appropriate.

- Psychiatrists (Line 20a)
- Licensed Clinical Psychologists (Line 20a1)
- Licensed Clinical Social Workers (line 20a2)
- Other Licensed Mental Health Providers (Line 20b)–Psychiatric social workers, psychiatric nurse practitioners, family therapists, behavioral health nurse practitioners, behavioral analysts, and other licensed Masters Degree prepared clinicians.
- Other Mental Health Staff (Line 20c)–Unlicensed individuals providing counseling, treatment or support services related to mental health professionals

- **Substance Abuse Services (Line 21)**–Psychiatric nurses, psychiatric social workers, mental health nurses, clinical psychologists, clinical social workers, and family therapists, behavioral health nurse practitioners and other individuals providing counseling and/or treatment services related to substance abuse.

> **Note**: Behavioral health services include both mental health and substance abuse services. Centers using the "Behavioral Health" designation need to divide their staff between lines 20 and 21 as appropriate.

- **All Other Professional Health Services (Line 22)**–Occupational and physical therapists, nutritionists, podiatrists, naturopaths, chiropractors, acupuncturists, and other staff professionals providing health services.

> **Note**: WIC nutritionists and others working in WIC programs are reported on Line 29a, Other Programs and Services Staff.

- **Vision Services (Line 22a–22d)**–Ophthalmologist, Eye Care Specialist, Optometrist, Contract Optometrist, Optometric Assistant and Optometry Student providing vision services.

- **Pharmacy Services (Line 23)**–Pharmacists (including clinical pharmacists), pharmacist assistants and others supporting pharmaceutical services. Note that effective 2006, the time (and cost) of individuals spending all or part of their time in assisting patients to apply for free drugs from pharmaceutical companies are to be classified as "Eligibility Assistance Workers" on Line 27a.
- **Enabling Services (Lines 24–29)**
- **Case Managers (Line 24)**–Staff who provide services to aid patients in the management of their health and social needs, including assessment of patient medical and/or social services needs, and maintenance of referral, tracking and follow-up systems. Case managers may provide eligibility assistance, if performed in the context of other case management functions. Staff may include nurses, social workers and other professional staff who are specifically allocated to this task during assigned hours, but not when it is an integral part of their other function. Care/Referral Coordinators are considered Case Managers.
  - **Patient and Community Education Specialists (Line 25)**–Health educators, family planning specialists, HIV specialists, and others who provide information about health conditions and guidance about appropriate use of health services that are not otherwise classified under outreach.
  - **Outreach Workers (Line 26)**–Individuals conducting case finding, education or other services to identify potential clients and/or facilitate access/referral of clients to available services.
  - **Eligibility Assistance Workers (Line 27a)**–All staff providing assistance in securing access to available health, social service, pharmacy and other assistance programs, including Medicaid, Women, Infants, and Children (WIC), Supplemental Security Income (SSI), food stamps, Temporary Assistance for Needy Families (TANF), and related assistance programs.
  - **Personnel Performing Other Enabling Service Activities (Line 28)**–All other staff performing services as enabling services, not described here. There is a "specify" field that must be used to describe what these staff are doing.
  - **Interpretation Staff (Line 27b)**–Staff whose *full time or dedicated time* is devoted to translation and/or interpretation services. *Do not include* that portion of the time of a nurse, medical assistant or other support staff who provides interpretation or translation during the course of their other activities.
- **Other Program Related Services Staff (Line 29a)–**Some grantees, especially "umbrella agencies," operate programs which, while within their scope of service, are not directly a part of the listed medical, dental, behavioral or other health services. These include WIC programs, job training programs, head start or early head start programs, shelters, housing programs, child care, etc. The staff for these programs are reported under Other Programs and Related Services. The cost of these programs is reported on Table 8A on Line 12. There is a "specify" field that must be used to describe what these staff are doing.

- **Administration and Facility (Lines 30a–30c, 30-32 and 33)**
  - **Management and Support Staff (Line 30a)**–Management team including Chief Executive Officer, *Chief Financial Officer*, Chief Information Officer and Chief Medical Officer, other administrative staff and administrative office support (secretaries, administrative assistants, file clerks, etc.) for health center operations within the scope of the grant. Report only that portion of the management team's full-time equivalent corresponding to the management function.
  - **Fiscal and Billing Staff (Line 30b)**–Staff performing accounting and billing functions in support of health center operations for services performed within the scope of the grant, *excluding the Chief Financial Officer*.
  - **IT Staff (Line 30c)**–Technical information technology and information systems staff supporting the maintenance and operation of the computing systems that support clinical and administrative functions performed within the scope of the grant. Staff managing an EHR/EMR system are reported on Line 30c, but design of medical forms, data entry and analysis of EHR data are part of the medical functions reported on Lines 1–15.
  - **Facility (Line 31)**–Staff with facility support and maintenance responsibilities, including custodians, housekeeping staff, security staff, and other maintenance staff.
  - **Patient Services Support Staff (Line 32)**–Intake staff and medical/patient records. Eligibility assistance workers are reported on Line 27a, not here.

Note: The Administration and Facility category for this report is more comprehensive than that used in some other program definitions and includes *all* personnel working in a BPHC supported program, whether or not that individual's salary was supported by the BPHC grant or other funds included in the scope of the project.

Appendix D: RPMS Provider Codes Mapping to UDS Service Category for Table 5

Line	Personnel by Major Service Category	IHS Provider Code	Column B
1	Family Physicians	80 Family Practice	Y
2	General Practitioners	00 MD 18 Contract Physician 44 Tribal Physician 45 Osteopathic Medicine 15 Other AND must have Location Name beginning with “CHS” (e.g. CHS Office)	Y
3	Internists	71 Internal Medicine	Y
4	Obstetrician/ Gynecologists	72 OB/GYN 41 Contract OB/GYN	Y
5	Pediatricians	75 Pediatrician	Y
7	Other Specialty Physicians	82 Anesthesiologist 70 Cardiologist 86 Dermatologist 68 Emergency Room Physician B2 Endocrinologist B1 Gastroenterologist A9 Hepatologist 64 Nephrologist 85 Neurologist B6 Neurosurgeon B4 Oncologist–Hematologist 73 Orthopedist 74 Otolaryngol B5 Pulmonologist B3 Rheumatologist A1 Sports Medicine Physician 77 Surgeon 78 Urologist	Y
9a	Nurse Practitioners	21 Nurse Practitioner 16 Pediatric Nurse Practitioner	Y
9b	Physician Assistants	11 Physician Assistant	Y
10	Certified Nurse Midwives	17 Nurse Midwife	Y
11	Nurses	01 Clinic RN 32 Contract Public Health Nurse 05 Licensed Practical Nurse 13 Public Health Nurse 14 School Nurse	Y

Line	Personnel by Major Service Category	IHS Provider Code	Column B
12	Other Medical Personnel (providing services in conjunction with services provided by physician, nurse practitioner, PC, nurse, nurse midwife)	47 CRNA 38 EMT/Paramedic 03 Health Aide C3 Medical Assistant 20 Medical Student 22 Nurse Assistant 27 Student Nurse B8 Surgical Technician	
13	Laboratory Personnel	A2 Medical Technologist 23 Laboratory Technician 83 Pathologist	
14	X-ray personnel	76 Radiologist 59 X-ray Technician 87 Ultrasound Technician	
16	Dentists	52 Dentist	Y
17	Dental Hygienists	46 Dental Hygienist	Y
18	Dental Assistants, Aides and Technicians	60 Dental Assistant 61 Dental Lab 54 Dental Assistant (prenatal) B7 Dental Health Aide Therapist	
20a	Psychiatrists **Note:** For Table 5, Columns B & C, count only visits and associated patients for listed Provider Codes *that do not have* POV 303.*, 304.*; 305.*, or Behavioral Health System (BHS) Problem Codes 27-30 (i.e., any visits/patients who are *not* included in Line 21 definition below).	49 Contract Psychiatrist 81 Psychiatrist	Y
20a1	Licensed Clinical Psychologists	50 Contract Psychologist 12 Psychologist	Y
20a2	Licensed Clinical Social Worker	63 Contract Social Worker 62 Licensed Clinical Social Worker D5 Licensed Clinical Social Worker	Y

Line	Personnel by Major Service Category	IHS Provider Code	Column B
20b	Other Licensed Mental Health Providers **Note:** For Table 5, Columns B & C, count only visits and associated patients for listed Provider Codes *that do not have* POV 303.*, 304.*; 305.* (i.e., any visits/patients who are *not* included in Line 21 definition below).	D1 Behavioral Health Nurse Practitioner D2 Behavior Analyst D4 Licensed Professional Counselor 96 Family Therapist A6 In School Therapist 95 Mental Health (Master only) 92 Psychotherapist	Y
20c	Other Mental Health Staff **Note:** For Table 5, Columns B & C, count only visits and associated patients for listed Provider Codes *that do not have* POV 303.*, 304.*; 305.* (i.e., any visits/patients who are *not* included in Line 21 definition below.)	C5 Behavioral Health Student C9 Behavioral Health Aide/Practitioner A7 Domestic Violence Counselor 06 Medical Social Worker 94 Mental Health (BA/BS only) 19 Mental Health Technician	Y
21	Substance Abuse Services **Note:** *Except for Provider Code 48 Alcoholism/Sub Abuse Counselor*, for Table 5, Columns B & C, count only visits and associated patients for listed Provider Codes *and* any POV 303.*, 304.*; 305.* *Provider Code 48 does not require a specific POV*.	C5 Behavioral Health Student C9 Behavioral Health Aide/Practitioner D1 Behavioral Health Nurse Practitioner 48 Alcoholism/Sub Abuse Counselor 49 Contract Psychiatrist 50 Contract Psychologist 63 Contract Social Worker A7 Domestic Violence Counselor 96 Family Therapist A6 In School Therapist 62 Licensed Medical Social Worker 06 Medical Social Worker 19 Mental Health Technician 94 Mental Health (BA/BS only) 95 Mental Health (Master only) 81 Psychiatrist 12 Psychologist 92 Psychotherapist	Y

Line	Personnel by Major Service Category	IHS Provider Code	Column B
22	Other Professional Services	A3 Naturopath Doctor A4 Naturopath Physician A5 Acupuncturist 28 Audiologist 89 Audiology Health Technician 43 Audiometric Technician 69 Chiropractor C8 Community Health Aide/Practitioner 24 Contract Optometrist 25 Contract Podiatrist 84 Pedorthist 99 Dietetic Technician 29 Dietitian 55 Disease Control Program 02 Environmental Health 36 Eye Care Specialist C7 Fitness Specialist C6 Massage Therapist 97 Nutrition Technician 07 Nutritionist 90 Occupational Therapist 31 Optometric Assistant 08 Optometrist 65 Optometry Student 51 Papago Nutrition Program 10 Physical Therapist C2 Physical Therapy Technician 33 Podiatrist 26 Respiratory Therapist C4 Respiratory Therapy Technician 39 Speech Therapist 58 Speech Ther-Discontinue 42 Speech/Language Path 93 Traditional Medicine Practitioner 34 Tribal/Contract Nutritionist B9 Chaplain D3 Early Childhood Intervention Specialist	Y
22a	Ophthalmologist	79 Ophthalmologist	Y
22b	Optometrist	08 Optometrist 24 Contract Optometrist	Y

Line	Personnel by Major Service Category	IHS Provider Code	Column B
22c	Optometric Assistant	31 Optometric Assistant 36 Eye Care Specialist 65 Optometry Student	
23	Pharmacy Personnel	67 Clinical Pharmacy Specialist 09 Pharmacist 30 Pharmacy Practitioners A8 Pharmacy Tech C1 Pharmacy Student	
24	Case Managers	66 Case Managers	Y
25	Patient and Community Education Specialists	04 Health Educator 37 Family Planning Counselor	Y
26	Outreach workers	53 Community Health Representative 35 Outreach Workers	
27	Transportation staff	40 Ambulance Driver	
27a	Eligibility Assistance Workers	None	
27b	Interpretation Staff	None	
28	Other Enabling Services	91 PHN Driver/Interpreter	
29a	Other Programs and Services	None	
30a	Management and Support Staff	57 Administrative	
30b	Fiscal and Billing Staff	None	
30c	IT Staff	None	
31	Facility Staff	98 Food Service Supervisor	
32	Patient Support Staff (e.g., medical records, intake)	88 Coding/Data Entry 56 Health Records	
35	Unassigned	15 Other (if Location Name does not begin with “CHS”) Any qualifying visit where the primary provider code is not included above	

Glossary

AI/AN

Abbreviation for American Indian and Alaska Natives.

ASUFAC Number

Area Service Unit Facility; unique identifier for each facility within IHS. is comprised of a six-digit number where the first 2 digits identify the Area, the next 2 digits identify the Service Unit, and the last 2 digits identify the Facility.

BPHC

Bureau of Primary Health Care.

CPT Codes

One of several code sets used by the healthcare industry to standardize data, allowing for comparison and analysis. Current Procedural Terminology was developed and is updated annually by the American Medical Association and is widely used in producing bills for services rendered to patients. CPTs include codes for diagnostic and therapeutic procedures, and specify information that differentiates the codes based on cost. CPT codes are the most widely accepted nomenclature in the United States for reporting physician procedures and services for federal and private insurance third-party reimbursement. UDS searches for CPT and other codes as specified in the logic definition to determine if a patient meets a denominator or numerator definition.

CRS

The Clinical Reporting System (CRS) is a component of the Resource and Patient Management System (RPMS) software suite. CRS provides sites with the ability to report on GPRA and developmental clinical performance measures from local RPMS databases.

CY

The abbreviation for calendar year, January through December.

Device

A device that either displays or prints information.

Enter Key

Used interchangeably with the Return key. Press the Enter key to show the end of an entry such as a number or a word. Press the Enter key each time you respond to a computer prompt. If you want to return to the previous screen, simply press the Enter key without entering a response. This will take you back 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.

File

A set of related records or entries treated as a single unit.

FileMan

The database management system for RPMS.

FY

Abbreviation for fiscal year. The fiscal year for the federal government is October 1 through September 30.

Health Record Number (HRN)

Each facility assigns a unique number within that facility to each patient. Each HRN with its facility ASUFAC identification make a unique identifier within all of IHS.

HRSA

Health Resources and Services Administration.

ICD Codes

One of several code sets used by the healthcare industry to standardize data. The International Classification of Disease is an international diagnostic coding scheme. In addition to diseases, ICD also includes several families of terms for medical-specialty diagnoses, health status, disablements, procedure and reasons for contact with healthcare providers. IHS currently uses ICD-9 for coding. UDS searches for ICD and other codes as specified in the logic definition to determine if a patient meets a denominator or numerator definition.

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.

Logic

The detailed definition, including specific RPMS fields and codes, of how the software defines for the Uniform Data System a patient and a patient's visits and denominators and numerators.

LOINC

Logical Observations, Identifiers, Names, and Codes. A standard coding system originally initiated for Laboratory values, the system is being extended to include non-laboratory observations (vital signs, electrocardiograms, etc.). Standard code sets are used to mitigate variations in local terminologies for lab and other healthcare procedures, e.g., Glucose or Glucose Test. IHS began integrating LOINC values into RPMS in several pilot sites in 2002.

Mandatory

Required. A mandatory field is a field that must be completed before the system will allow you to continue.

Menu

A list of choices for computing activity. A menu is a type of option designed to identify a series of items (other options) for presentation to the user for selection. When displayed, menu-type options are preceded by the word "Select" and followed by the word "option" as in Select Menu Management option: (the menu's select prompt).

Mnemonic

A short cut that designated to access a particular party, name, or facility.

Namespace

A unique set of alpha characters assigned by the Database Administrator, which uniquely identifies package components; for example, BUD is the namespace for the RPMS Unified Data System (UDS).

Option

As an item on a menu, an option provides an opportunity for users to select it, thereby invoking the associated computing activity. Options may also be scheduled to run in the background, non-interactively, by TaskMan.

Performance Measure

Performance measures are definitions of specific measurable objectives that can demonstrate progress toward the goals stated in the strategic and/or performance plans of an organization. An example of a performance measure is: Maintain at the previous year's level the proportion of eligible women who have had a pap smear documented within the past three years.

Queuing

Requesting that a job be processed at a later time rather than within the current session.

Receipt Dates

The date that the party received the information

Receiving Party

The person or organization that is receiving the information.

Sequential

Arranged in a particular order.

Site Specific

Particular to a specific site.

STAT

Immediately.

Tagged

Marked with a specific identifier.

Taxonomy

Taxonomies are groupings of functionally related data elements, such as specific codes, code ranges, or terms, that are used by various RPMS applications to find data items in the Patient Care Component (PCC) to determine if a patient meets a certain criteria. To ensure comparable data within the agency as well as to external organizations, as much Uniform Data System (UDS) logic as possible is based on standard national codes, such as CPTs or ICD-9. For terminology that is not standardized across each facility, such as lab tests or medications, UDS uses taxonomies that can be populated by each individual facility with its own codes.

UCI

User Class Identification; a computing area

Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

Phone: (505) 248-4371 or (888) 830-7280 (toll free)

Fax: (505) 248-4363

Web: http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm

E-mail: support@ihs.gov