# Introduction

## Overview

The Patient Summary and Referral/Transition of Care Summary (Continuity of Care Document) documents may be accessed from different locations in the software.

### Medical Records

The system will automatically generate and add a Patient Summary and Referral/Transition of Care Summary to the Print Electronic Record list when a visit is created.

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number**

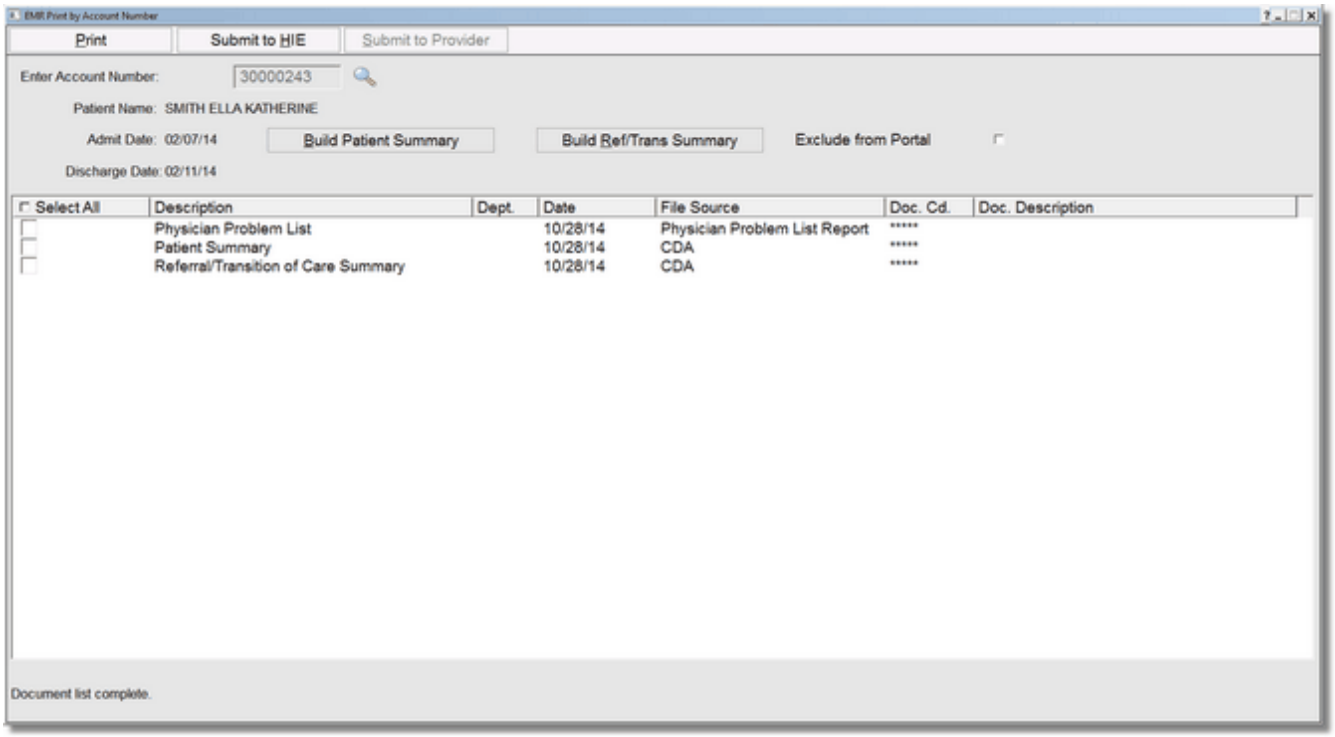



**Figure 1.1 EMR Print by Account Number**

Select the **Exclude from Portal** option to deny a patient or authorized representative viewing of the Patient Summary or Referral/Transition of Care documents within the Patient Portal. The default for this field is blank which allows the Patient Summary or Referral/Transition of Care documents within the Patient Portal. This field may also be selected by the physician from HIR (Health Information Resource).

To view the CCD, select **Build Patient Summary** or **Build Ref/Trans Summary**. The same data elements pull to both documents. The CCD may also be viewed by double-clicking the CCD from the

Print Electronic Record list.

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary**

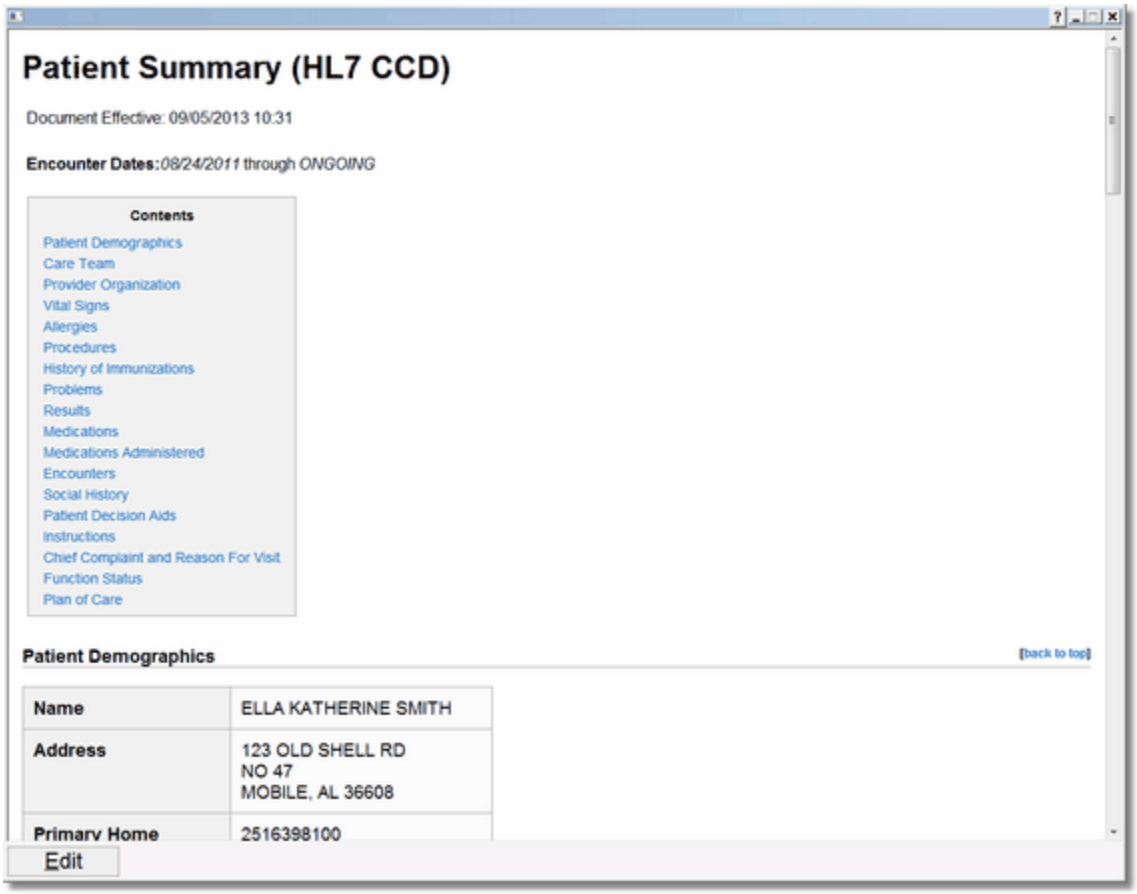



**Figure 1.2 Patient Summary (HL7 CCD)**

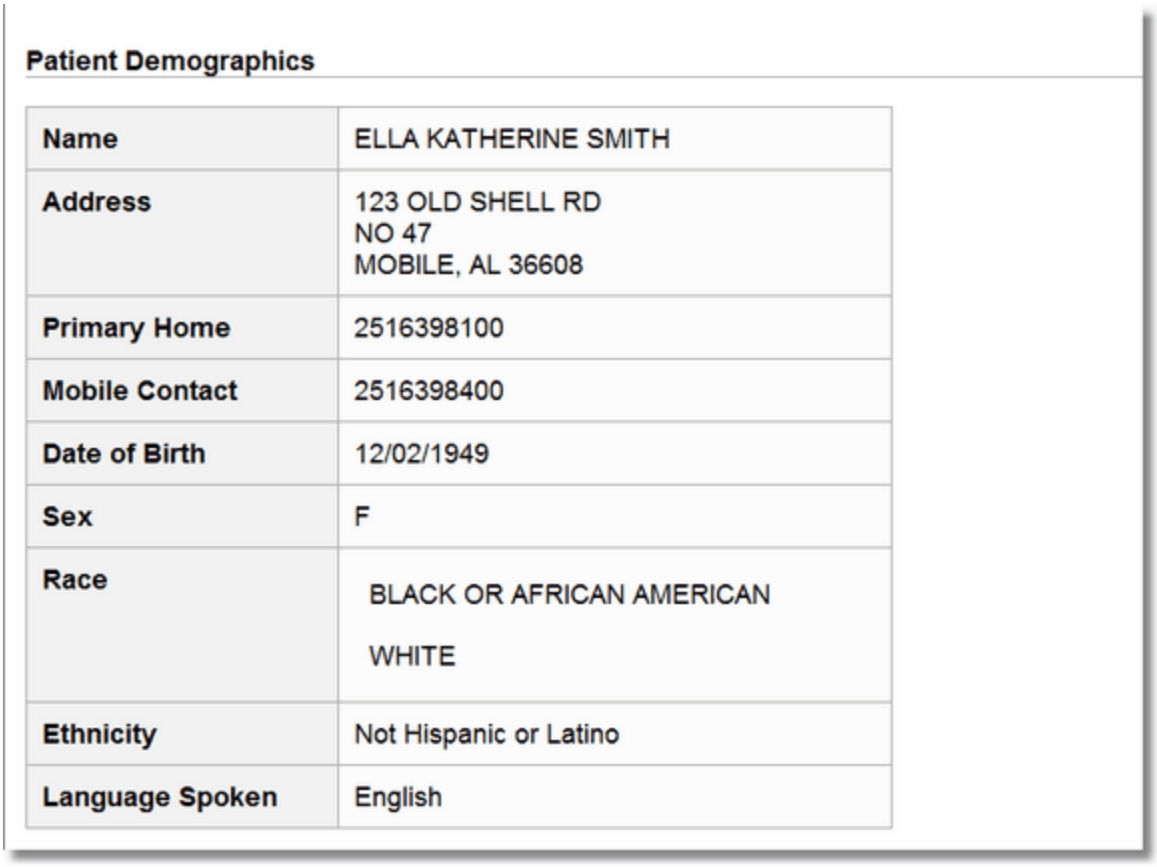
- **Document Effective:** Displays the date and time the CCD was generated
- **Encounter Dates:** Displays the dates of service
- **Contents:** Gives a list of hyperlinks to the different sections of the CCD. The **back to top** option will take the user to the top of the CCD to select another section.

# Contents

## Patient Demographics

The Patient Demographics section of the CCD reflects the patient's demographic information entered on the Patient tab on the Registration and ADT screen. "Unknown" will display if no information is entered for a field or section.

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Patient Demographics**



**Patient Demographics**

| | |
|---|---|
| **Name** | ELLA KATHERINE SMITH |
| **Address** | 123 OLD SHELL RD<br>NO 47<br>MOBILE, AL 36608 |
| **Primary Home** | 2516398100 |
| **Mobile Contact** | 2516398400 |
| **Date of Birth** | 12/02/1949 |
| **Sex** | F |
| **Race** | BLACK OR AFRICAN AMERICAN<br>WHITE |
| **Ethnicity** | Not Hispanic or Latino |
| **Language Spoken** | English |

**Figure 1.3 Patient Summary (HL7 CCD)**

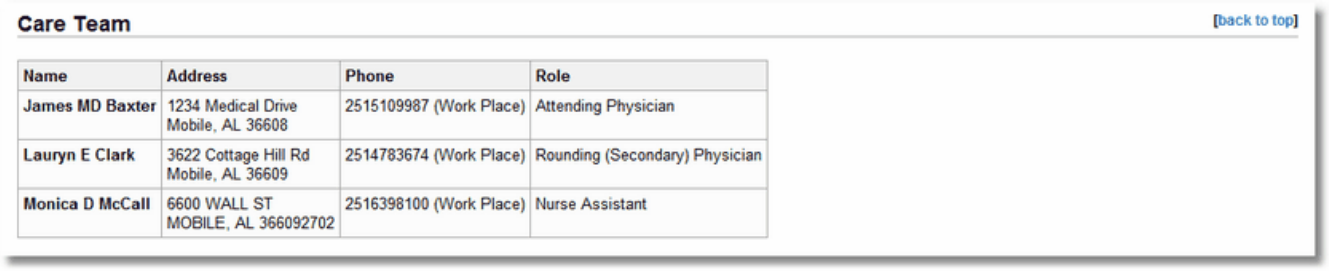
- **Name:** Pulls from the Patient tab on the Registration and ADT screen
- **Address:** Pulls from the Patient tab on the Registration and ADT screen
- **Primary Home:** Pulls from the Patient tab on the Registration and ADT screen
- **Mobile Contact:** Pulls from the Patient tab on the Registration and ADT screen
- **Date of Birth:** Pulls from the Patient tab on the Registration and ADT screen
- **Sex:** Pulls from the Patient tab on the Registration and ADT screen
- **Race:** Pulls from the Patient tab on the Registration and ADT screen. The CCD can display up to five races.
- **Ethnicity:** Pulls from the Patient tab on the Registration and ADT screen
- **Language Spoken:** Pulls from the Patient tab on the Registration and ADT screen

***NOTE**: The Race and Ethnicity codes must be associated with a Meaningful Use value code in the respective business office table in order to pull to the CCD.*

## Care Team

The Care Team section of the CCD reflects the people involved in the patient's care.

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Care Team**



Care Team [back to top]

| Name | Address | Phone | Role |
|---|---|---|---|
| James MD Baxter | 1234 Medical Drive Mobile, AL 36608 | 2515109987 (Work Place) | Attending Physician |
| Lauryn E Clark | 3622 Cottage Hill Rd Mobile, AL 36609 | 2514783674 (Work Place) | Rounding (Secondary) Physician |
| Monica D McCall | 6600 WALL ST MOBILE, AL 366092702 | 2516398100 (Work Place) | Nurse Assistant |

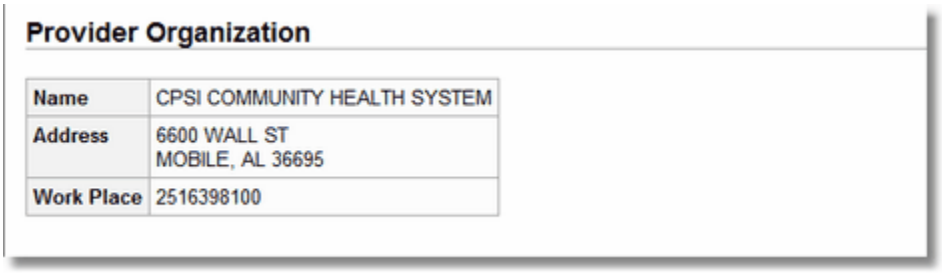
**Figure 1.4 Patient Summary (HL7 CCD)**

- **Name:** Pulls the name of the person caring for the patient
- **Address:** Pulls from the Physician table for physicians. Pulls the provider organization address from the 999999 Physician table for nurses.
- **Phone:** Pulls from the Physician table for physicians. Pulls the provider organization address from the 999999 Physician table for nurses.
- **Role:** Pulls according to the role responsibility during patient care

## Provider Organization

The Provider Organization section of the CCD reflects the facility's contact information entered in the 999999 Physician table.

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Provider Organization**



**Provider Organization**

| | |
|---|---|
| **Name** | CPSI COMMUNITY HEALTH SYSTEM |
| **Address** | 6600 WALL ST<br>MOBILE, AL 36695 |
| **Work Place** | 2516398100 |

**Figure 1.5 Patient Summary (HL7 CCD)**

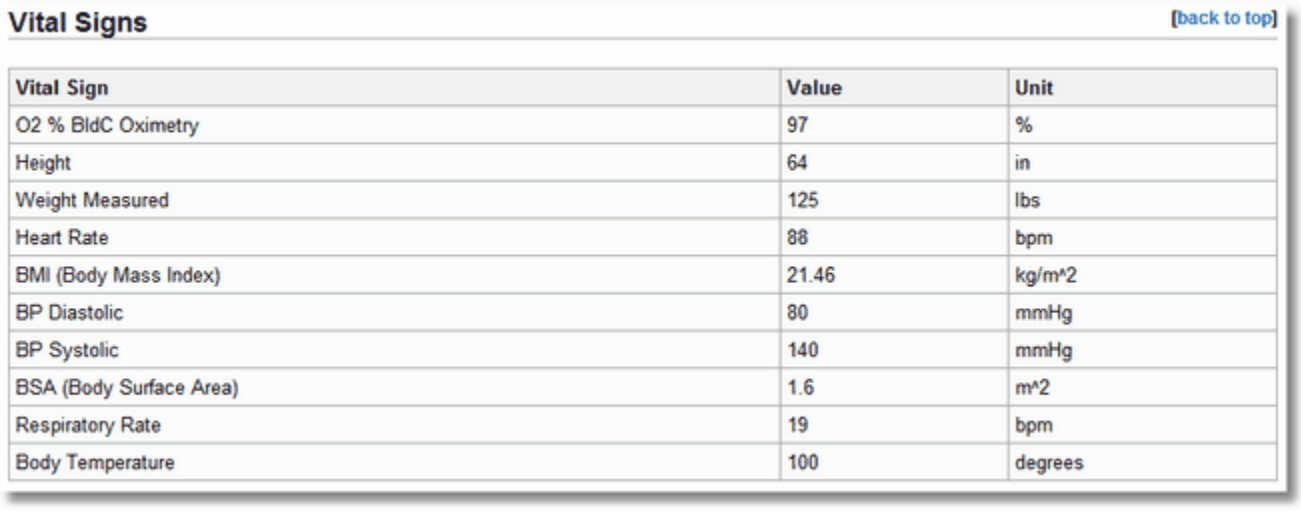
- **Name:** Pulls from the 999999 Physician table - Physician Group Information
- **Address:** Pulls from the 999999 Physician table - Physician Group Information
- **Work Place:** Pulls from the 999999 Physician table - Physician Group Information

## Vital Signs

The Vital Signs section of the CCD reflects vital sign values and units documented via Point of Care Flow Charts, Electronic Forms and/or Clinical Information. Body Mass Index (BMI) and Body Surface Area (BSA) values and units are automatically calculated by the system and are displayed in this section as well.

If a specific vital sign is not documented, the description does not pull to the display area. "Unknown" will display if no information is entered for the section.

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Vital Signs**



**Vital Signs** [back to top]

| Vital Sign | Value | Unit |
|---|---|---|
| O2 % BldC Oximetry | 97 | % |
| Height | 64 | in |
| Weight Measured | 125 | lbs |
| Heart Rate | 88 | bpm |
| BMI (Body Mass Index) | 21.46 | kg/m^2 |
| BP Diastolic | 80 | mmHg |
| BP Systolic | 140 | mmHg |
| BSA (Body Surface Area) | 1.6 | m^2 |
| Respiratory Rate | 19 | bpm |
| Body Temperature | 100 | degrees |

**Figure 1.6 Patient Summary (HL7 CCD)**

- **Vital Sign:** if documented during the stay, the following vital signs will populate this section:
  - O2 Sat
  - Height
  - Weight
  - Pulse
  - BMI (Body Mass Index) - automatically calculated
  - BP Diastolic
  - BP Systolic
  - BSA (Body Surface Area) - automatically calculated
  - Respirations
  - Temperature

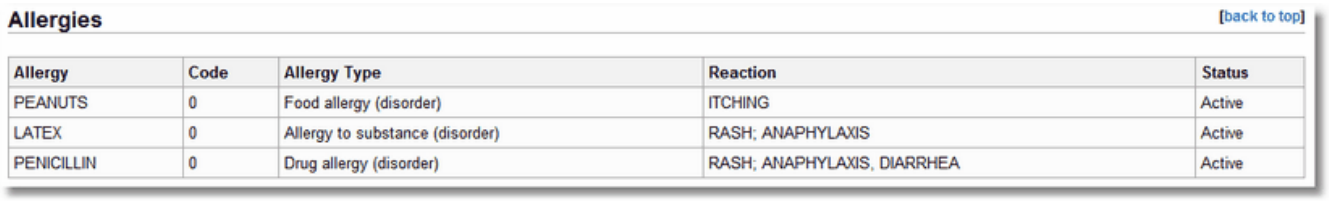
- **Value:** Pulls from POC Flow Charts, Electronic Forms and/or Clinical Information

- **Units:** Pulls from POC Flow Charts, Electronic Forms and/or Clinical Information

## Allergies

The Allergies section of the CCD reflects the patient's documented drug, food and environmental allergies. "Unknown" will display if no information is entered for the section.

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Allergies**



**Allergies** [back to top]

| Allergy | Code | Allergy Type | Reaction | Status |
|---|---|---|---|---|
| PEANUTS | 0 | Food allergy (disorder) | ITCHING | Active |
| LATEX | 0 | Allergy to substance (disorder) | RASH; ANAPHYLAXIS | Active |
| PENICILLIN | 0 | Drug allergy (disorder) | RASH; ANAPHYLAXIS, DIARRHEA | Active |

**Figure 1.7 Patient Summary (HL7 CCD)**

- **Allergy:** Displays the description of the allergy

- **Code:** Will display the RxNorm Code in a future release

- **Allergy Type:** Displays the allergy type including Allergy to Substance (Environmental), Drug Allergy and/or Food Allergy

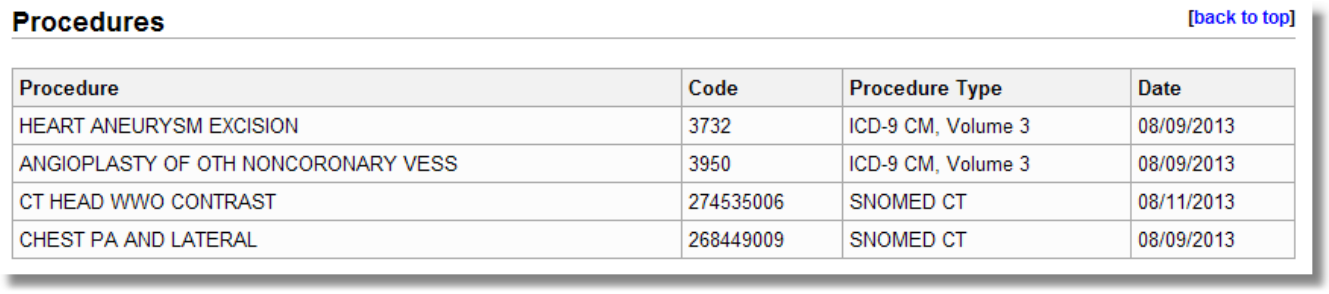
- **Reaction:** Displays the reaction to the allergen

- **Status:** Only active allergies will display.

## Procedures

The Procedures section of the CCD reflects the procedure codes from page 2 of the DRG Grouper and Maintenance screen as well as ancillary procedures.

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Procedures**



**Procedures** [back to top]

| Procedure | Code | Procedure Type | Date |
|---|---|---|---|
| HEART ANEURYSM EXCISION | 3732 | ICD-9 CM, Volume 3 | 08/09/2013 |
| ANGIOPLASTY OF OTH NONCORONARY VESS | 3950 | ICD-9 CM, Volume 3 | 08/09/2013 |
| CT HEAD WWO CONTRAST | 274535006 | SNOMED CT | 08/11/2013 |
| CHEST PA AND LATERAL | 268449009 | SNOMED CT | 08/09/2013 |

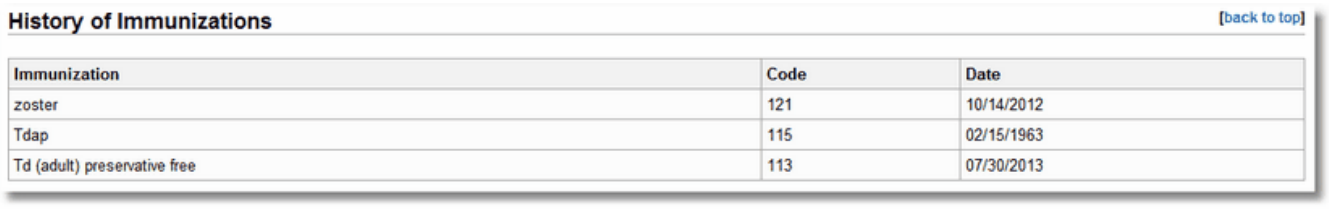
**Figure 1.8 Patient Summary (HL7 CCD)**

- **Procedure:** Pulls from the DRG Grouper and Maintenance screen, page 2, ICD description and/or the Item Master Description, page 1 if the SNOMED Coded is loaded on page 5 of the Item Master
- **Code:** Pulls from the DRG Grouper and Maintenance screen, page 2, ICD and/or the SNOMED Code on page 5 of the Item Master
- **Procedure Type:** Pulls the type of procedure and/or Snomed.
- **Date:** Pulls from the DRG Grouper and Maintenance screen, page 2, Proc-Dt (Procedure Date). Procedures pulling from ancillary orders show the schedule date.

## History of Immunizations

The History of Immunizations section of the CCD reflects the patient's immunizations documented historically and/or administered via Point of Care Pharmacy. "Unknown" will display if no information is entered for the section.

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **History of Immunizations**



**History of Immunizations** [back to top]

| Immunization | Code | Date |
|---|---|---|
| zoster | 121 | 10/14/2012 |
| Tdap | 115 | 02/15/1963 |
| Td (adult) preservative free | 113 | 07/30/2013 |

**Figure 1.9 Patient Summary (HL7 CCD)**

- **Immunization:** Displays the short description of the immunization
- **Code:** Displays the CVX Code for the immunization
- **Date:** Displays the date the immunization was administered

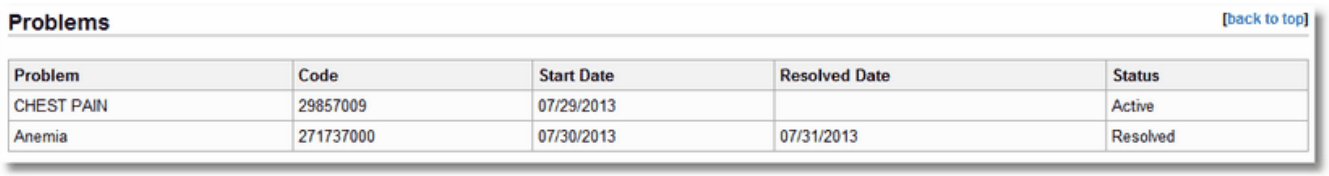
## Problems

The Problems section of the CCD reflects problems documented via the Physician Problem List. Problems are included on the summary as follows:

- All problems with an active status are included on the summary by default.
- Problems that are initiated and resolved during the current stay are included on the summary by default.
- Problems that were initiated during a previous stay but resolved during the current stay are not included on the summary by default but may be included on the summary using the Edit option discussed in the next section.

"Unknown" will display if no information is entered for the section.

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Vital Signs**



**Problems** [back to top]

| Problem | Code | Start Date | Resolved Date | Status |
|---|---|---|---|---|
| CHEST PAIN | 29857009 | 07/29/2013 | | Active |
| Anemia | 271737000 | 07/30/2013 | 07/31/2013 | Resolved |

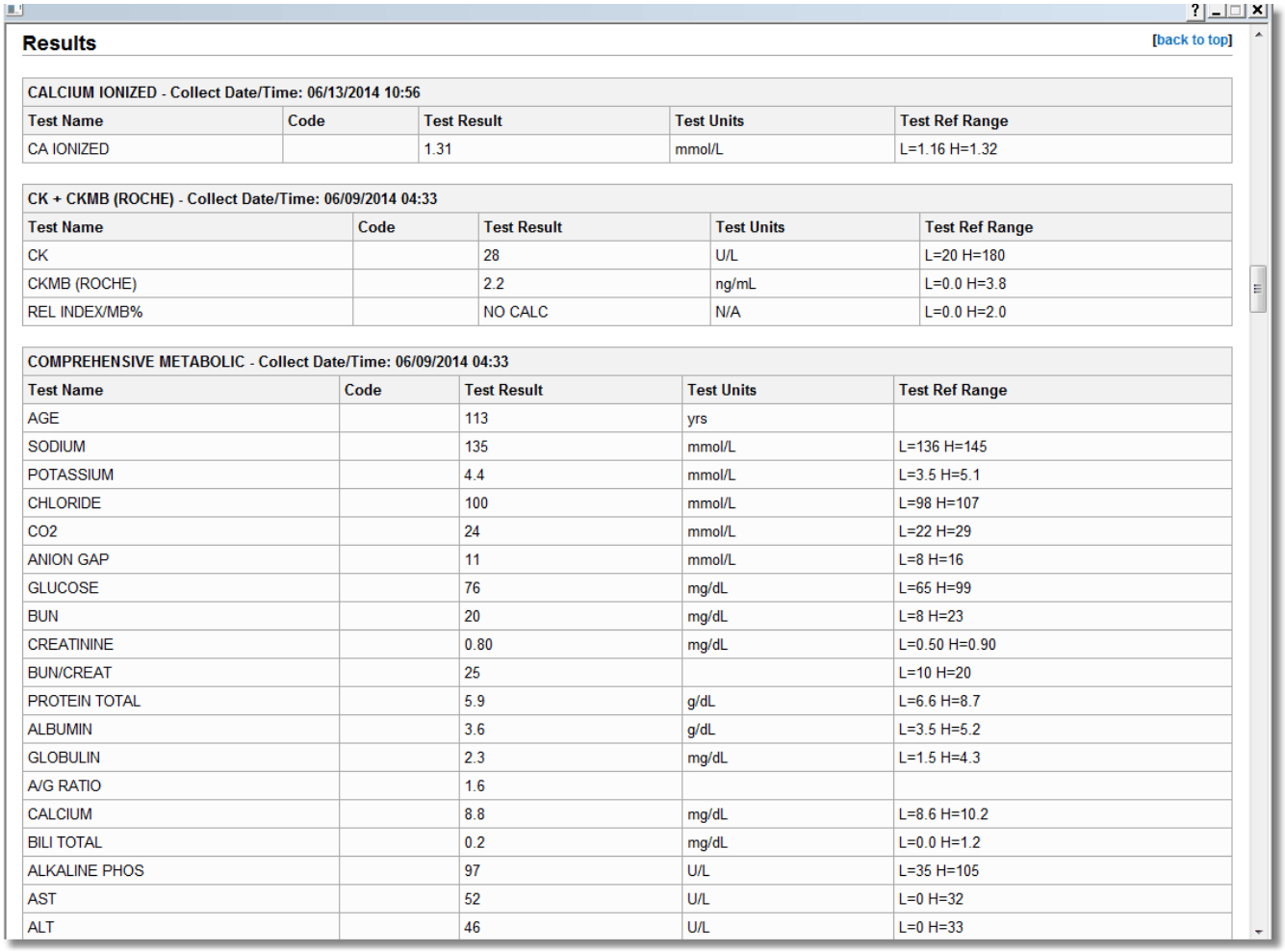
**Figure 1.10 Patient Summary (HL7 CCD)**

- **Problem:** Displays the description of the problem
- **Code:** Displays the SNOMED code for the problem
- **Start Date:** Displays the diagnosis date documented for the problem
- **Resolved Date:** Displays the resolved date documented for the problem
- **Status:** Displays the status documented for the problem

## Results

The Results section of the CCD displays any Laboratory tests and results.

Select **Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > Results**



**Results** [back to top]

CALCIUM IONIZED - Collect Date/Time: 06/13/2014 10:56

| Test Name | Code | Test Result | Test Units | Test Ref Range |
|---|---|---|---|---|
| CA IONIZED | | 1.31 | mmol/L | L=1.16 H=1.32 |

CK + CKMB (ROCHE) - Collect Date/Time: 06/09/2014 04:33

| Test Name | Code | Test Result | Test Units | Test Ref Range |
|---|---|---|---|---|
| CK | | 28 | U/L | L=20 H=180 |
| CKMB (ROCHE) | | 2.2 | ng/mL | L=0.0 H=3.8 |
| REL INDEX/MB% | | NO CALC | N/A | L=0.0 H=2.0 |

COMPREHENSIVE METABOLIC - Collect Date/Time: 06/09/2014 04:33

| Test Name | Code | Test Result | Test Units | Test Ref Range |
|---|---|---|---|---|
| AGE | | 113 | yrs | |
| SODIUM | | 135 | mmol/L | L=136 H=145 |
| POTASSIUM | | 4.4 | mmol/L | L=3.5 H=5.1 |
| CHLORIDE | | 100 | mmol/L | L=98 H=107 |
| CO2 | | 24 | mmol/L | L=22 H=29 |
| ANION GAP | | 11 | mmol/L | L=8 H=16 |
| GLUCOSE | | 76 | mg/dL | L=65 H=99 |
| BUN | | 20 | mg/dL | L=8 H=23 |
| CREATININE | | 0.80 | mg/dL | L=0.50 H=0.90 |
| BUN/CREAT | | 25 | | L=10 H=20 |
| PROTEIN TOTAL | | 5.9 | g/dL | L=6.6 H=8.7 |
| ALBUMIN | | 3.6 | g/dL | L=3.5 H=5.2 |
| GLOBULIN | | 2.3 | mg/dL | L=1.5 H=4.3 |
| A/G RATIO | | 1.6 | | |
| CALCIUM | | 8.8 | mg/dL | L=8.6 H=10.2 |
| BILI TOTAL | | 0.2 | mg/dL | L=0.0 H=1.2 |
| ALKALINE PHOS | | 97 | U/L | L=35 H=105 |
| AST | | 52 | U/L | L=0 H=32 |
| ALT | | 46 | U/L | L=0 H=33 |

**Figure 1.11 Patient Summary (HL7 CCD)**

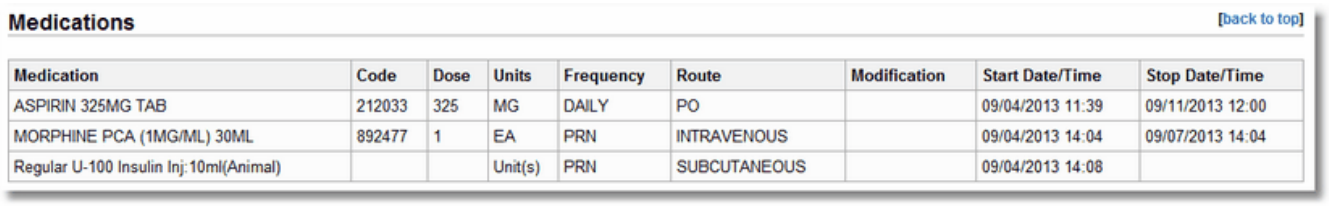
- **Test Name:** Displays the description of the result field
- **Code:** Displays the LOINC code for the result field if added to the Reference Range Table for the result
- **Test Result:** Displays the results for the test performed
- **Test Units:** Displays the Units defined in the Reference Range Table for the result where applicable
- **Test Ref Range:** Displays the reference range values for each test

## Medications

The Medications section of the CCD reflects the patient's active medications on the Pharmacy Profile, home medications entered via Medication Reconciliation that are not associated with an active medication, and medications entered using Prescription Writer. "Unknown" will display if no

information is entered for the section.

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Medications**



Medications [back to top]

| Medication | Code | Dose | Units | Frequency | Route | Modification | Start Date/Time | Stop Date/Time |
|---|---|---|---|---|---|---|---|---|
| ASPIRIN 325MG TAB | 212033 | 325 | MG | DAILY | PO | | 09/04/2013 11:39 | 09/11/2013 12:00 |
| MORPHINE PCA (1MG/ML) 30ML | 892477 | 1 | EA | PRN | INTRAVENOUS | | 09/04/2013 14:04 | 09/07/2013 14:04 |
| Regular U-100 Insulin Inj:10ml(Animal) | | | Unit(s) | PRN | SUBCUTANEOUS | | 09/04/2013 14:08 | |

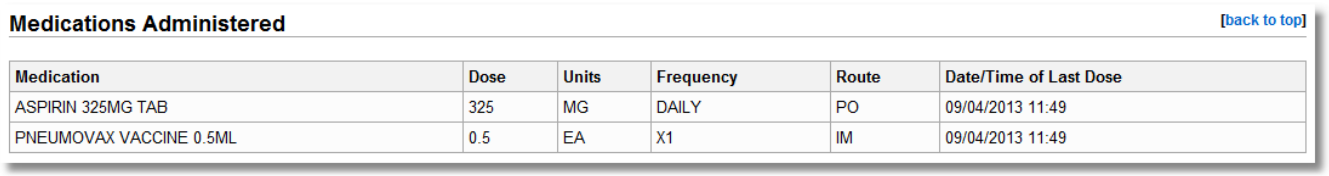
**Figure 1.12 Patient Summary (HL7 CCD)**

- **Medication:** Displays the description of the medication
- **Code:** Displays the NDC number for the medication if available
- **Dose**: Displays the ordered dose for the medication
- **Units:** Displays the ordered units for the medication
- **Frequency:** Displays the ordered frequency for the medication
- **Route:** Displays the ordered route for the medication
- **Modification**: Displays modifications to instructions if entered via Prescription Writer
- **Start Date/Time**: Displays the start date and time for the order
- **Stop Date/Time**: Displays the stop date and time for the order if entered

## Medications Administered

The Medications Administered section of the CCD reflects the patient's medications administered via Diabetic Record, EMAR and Med-Verify. "Unknown" will display if no information is entered for the section.

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Medications Administered**



**Medications Administered** [back to top]

| Medication | Dose | Units | Frequency | Route | Date/Time of Last Dose |
|---|---|---|---|---|---|
| ASPIRIN 325MG TAB | 325 | MG | DAILY | PO | 09/04/2013 11:49 |
| PNEUMOVAX VACCINE 0.5ML | 0.5 | EA | X1 | IM | 09/04/2013 11:49 |

**Figure 1.13 Patient Summary (HL7 CCD)**

- **Medication:** Displays the description of the medication administered
- **Dose:** Displays the last dose documented as given for the medication
- **Units:** Displays the last units documented for the administration
- **Frequency:** Displays the ordered frequency for the medication administered
- **Route:** Displays the ordered route for the medication administered
- **Date/Time of Last Dose**: Displays the date and time of the last administration for the medication

## Encounters

The Encounters section of the CCD reflects the patient's principal diagnosis.

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Encounters**

**Encounters** [back to top]

| Encounter Diagnosis | Diagnosis Code |
|---|---|
| AC MYOC INF OF ANTERLAT WAL INI CAR | 41001 |

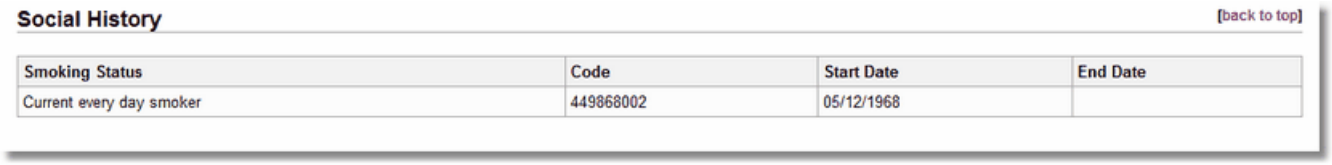
**Figure 1.14 Patient Summary (HL7 CCD)**

- **Encounters Diagnosis:** Pulls from the DRG Grouper and Maintenance screen, page 1, principal diagnosis code description
- **Diagnosis Code:** Pulls from the DRG Grouper and Maintenance screen, page 1, principal diagnosis code

## Social History

The Social History section of the CCD reflects the patient's Smoking Status entered on the Patient tab on the Registration and ADT screen. "Unknown" will display if no information is entered for a field or section.

Select **Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > Social History**


Social History [back to top]

| Smoking Status | Code | Start Date | End Date |
|---|---|---|---|
| Current every day smoker | 449868002 | 05/12/1968 | |

**Figure 1.15 Patient Summary (HL7 CCD)**

- **Smoking Status:** Pulls from the Patient tab on the Registration and ADT screen
- **Code (Snomed Code):** Pulls from the Patient tab on the Registration and ADT screen
- **Start Date:** Pulls from the Patient tab on the Registration and ADT screen
- **End Date:** Pulls from the Patient tab on the Registration and ADT screen

***NOTE**: Based on the response entered in the Smoker field on the Patient tab on the Registration and ADT screen; a smoke **Start Date** and/or smoke **End Date** may pull to the CCD. If **Never** or **Unknown if ever smoked** is selected, neither Start Date nor End Date will pull to the CCD. If **Current every day smoker**, **Current some day smoker**, **Smoker/current status unknown**, **Heavy tobacco smoker** or **Light tobacco smoker** is selected, the Start Date will pull to the CCD. If **Former smoker** is selected, both Start Date and End Date will pull to the CCD.*

## Patient Decision Aids

The Patient Decision Aids section of the CCD reflects the Patient Education Documents recorded as being given to the patient. "Unknown" will display if no information is entered for the section.

Select **Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > Patient Decision Aids**


Patient Decision Aids [back to top]

| Patient Decision Aid |
|---|
| Chronic Hypertension |
| Blood urea nitrogen measurement |

**Figure 1.16 Patient Summary (HL7 CCD)**

- **Patient Decision Aids**: Displays the title of the Patient Education Document given to the patient

## Instructions

The Instructions section of the CCD reflects information pertinent to discharge. "Unknown" will display if no information is entered for the section.

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Instructions**

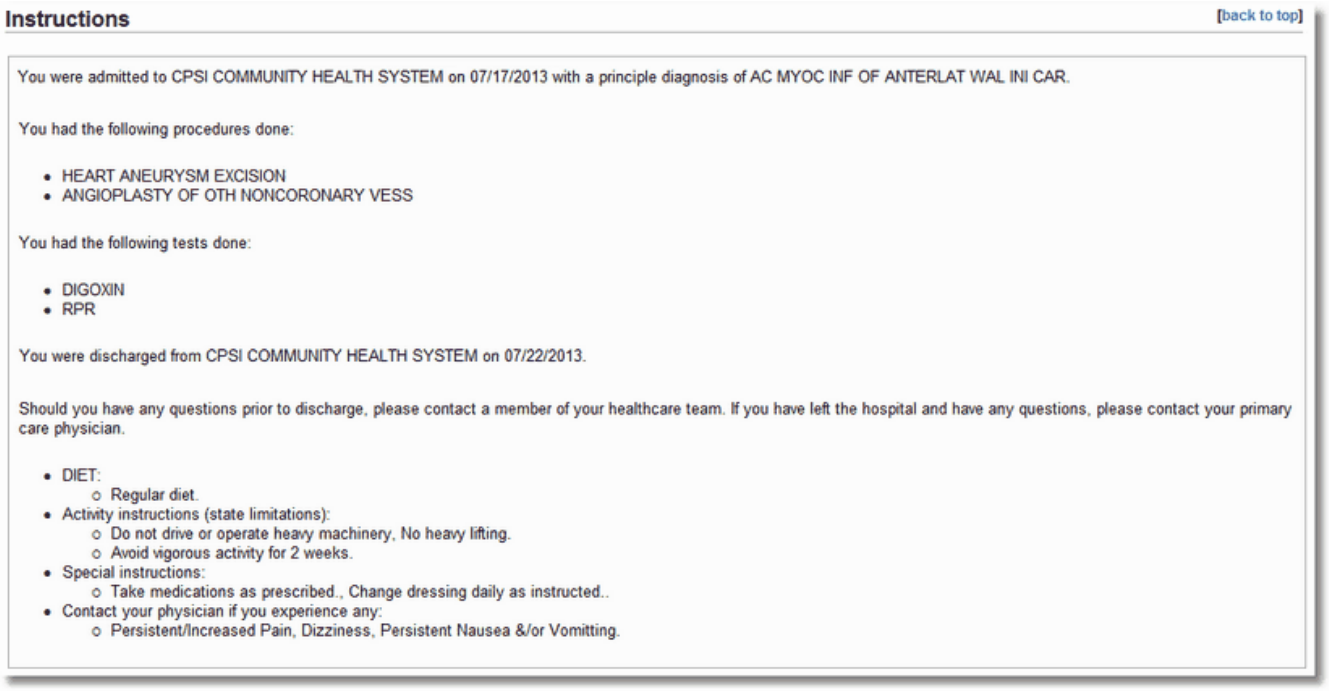


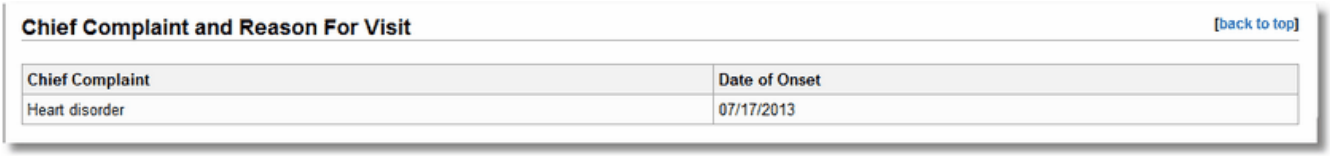

**Figure 1.17 Patient Summary (HL7 CCD)**

- The first section displays the facility name, admission date and principle diagnosis, which pulls from the DRG Grouper and Maintenance screen, page 1, principal diagnosis code description.
- The second section displays procedures performed which pull from the DRG Grouper and Maintenance screen, page 2, ICD description.
- The third section displays tests performed which includes resulted lab items.
- The fourth section displays the facility name and discharge date.
- The fifth section displays a patient reminder to seek assistance if needed.
- The sixth section displays the patient's discharge instructions as documented via Point of Care.

## Chief Complaint and Reason For Visit

The Chief Complaint and Reason for Visit section of the CCD reflects the chief complaint information entered on the Clinical tab on the Registration and ADT screen.

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Chief Complaint and Reason For Visit**



**Chief Complaint and Reason For Visit** [back to top]

| Chief Complaint | Date of Onset |
|---|---|
| Heart disorder | 07/17/2013 |

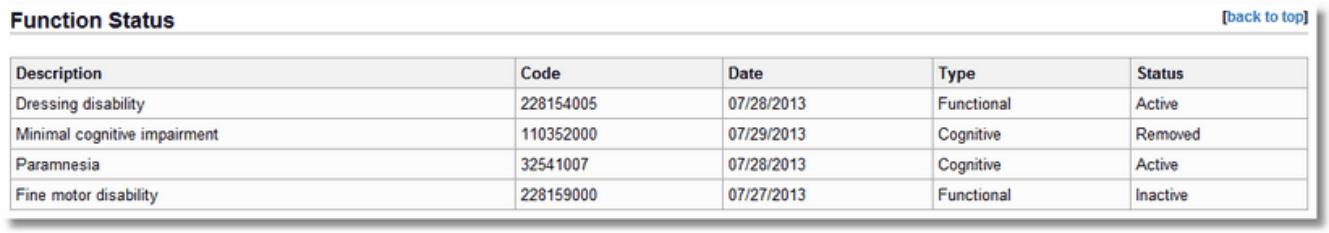
**Figure 1.18 Patient Summary (HL7 CCD)**

- **Chief Complaint:** Pulls from the Clinical tab on the Registration and ADT screen
- **Date of Onset:** Pulls from the Chief Complaint entry screen on the Clinical tab on the Registration and ADT screen.

## Function Status

The Function Status section of the CCD reflects the patient's functional and/or cognitive status as entered via the Health History application. "Unknown" will display if no information is entered for the section.

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Function Status**



**Function Status** [back to top]

| Description | Code | Date | Type | Status |
|---|---|---|---|---|
| Dressing disability | 228154005 | 07/28/2013 | Functional | Active |
| Minimal cognitive impairment | 110352000 | 07/29/2013 | Cognitive | Removed |
| Paramnesia | 32541007 | 07/28/2013 | Cognitive | Active |
| Fine motor disability | 228159000 | 07/27/2013 | Functional | Inactive |

**Figure 1.19 Patient Summary (HL7 CCD)**

- **Description:** Displays the description of the impairment documented from the Health History Application-Functional/Cognitive Status section
- **Code:** Displays the SNOMED Code associated with the impairment
- **Date:** Displays the Onset Date for the impairment documented
- **Type:** Displays the type of impairment documented, Functional or Cognitive
- **Status:** Displays the status of the impairment including Active, Inactive, No Impairment and/or Removed

## Plan of Care

The Plan of Care section of the CCD reflects problems, goals and instructions as entered via the physician's Plan of Care application. "Unknown" will display if no information is entered for the section.

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Plan of Care**

**Plan of Care** [back to top]

| Care Plan Entries |
|---|
| Problem: Broken skin [SNOMED: 247442005] |
| Goal: Wound care management [SNOMED: 385942004] |
| Instructions: Anti-Pressure Mattress, Turn every 2 hours |
| Problem: Alteration in comfort: pain [SNOMED: 20361002] |
| Goal: Pain relief [SNOMED: 182970005] |
| Instructions: Re-position patient |

**Figure 1.20 Patient Summary (HL7 CCD)**

- **Problem:** Displays the problem description and SNOMED Code
- **Goal:** Displays the goal description and SNOMED Code documented for the problem
- **Instructions:** Displays the instructions documented for the goal

# Edit

## Section Edits

The Patient Summary and Referral/Transition of Care Summary may be edited by selecting the **Edit** option.

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary**

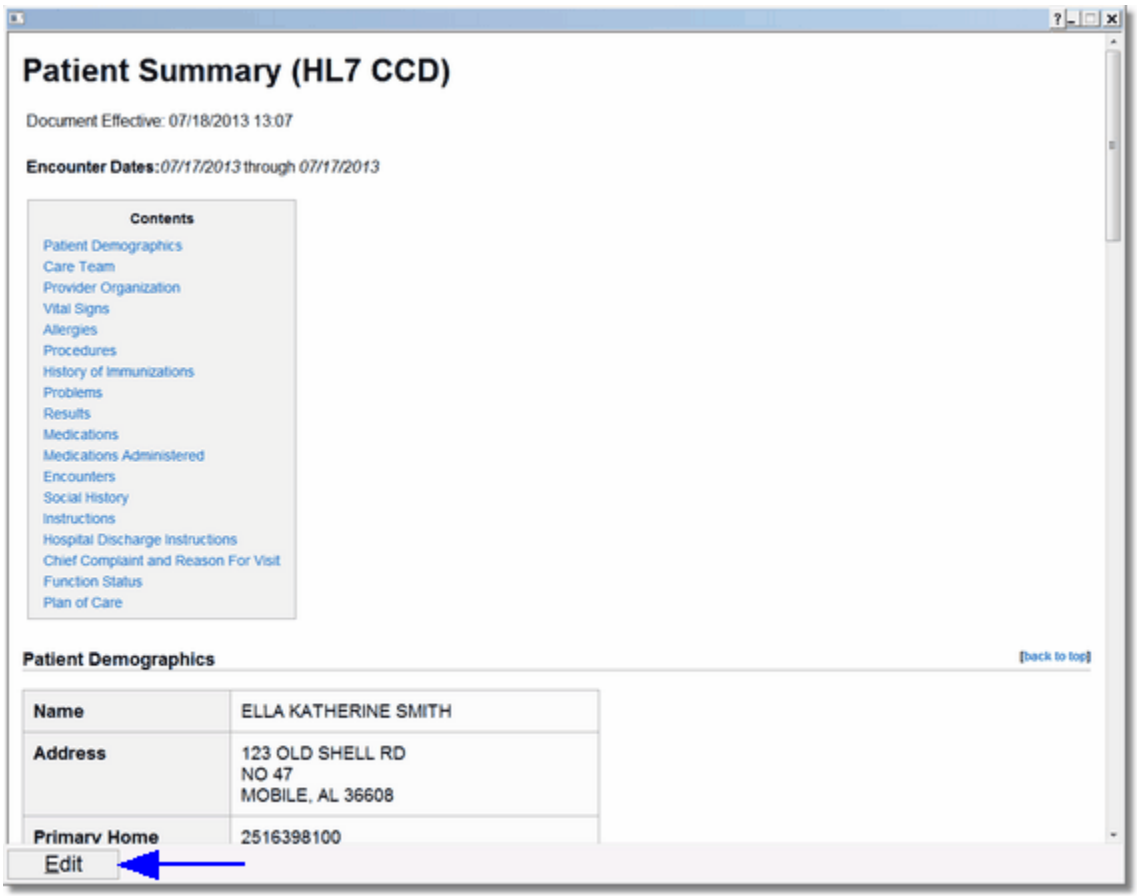



**Figure 1.21 Patient Summary (HL7 CCD)**

Once the **Edit** option has been selected, a list of all the sections of the CCD will display. The CCD may be edited to exclude an entire section or individual components of a section.

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Edit**

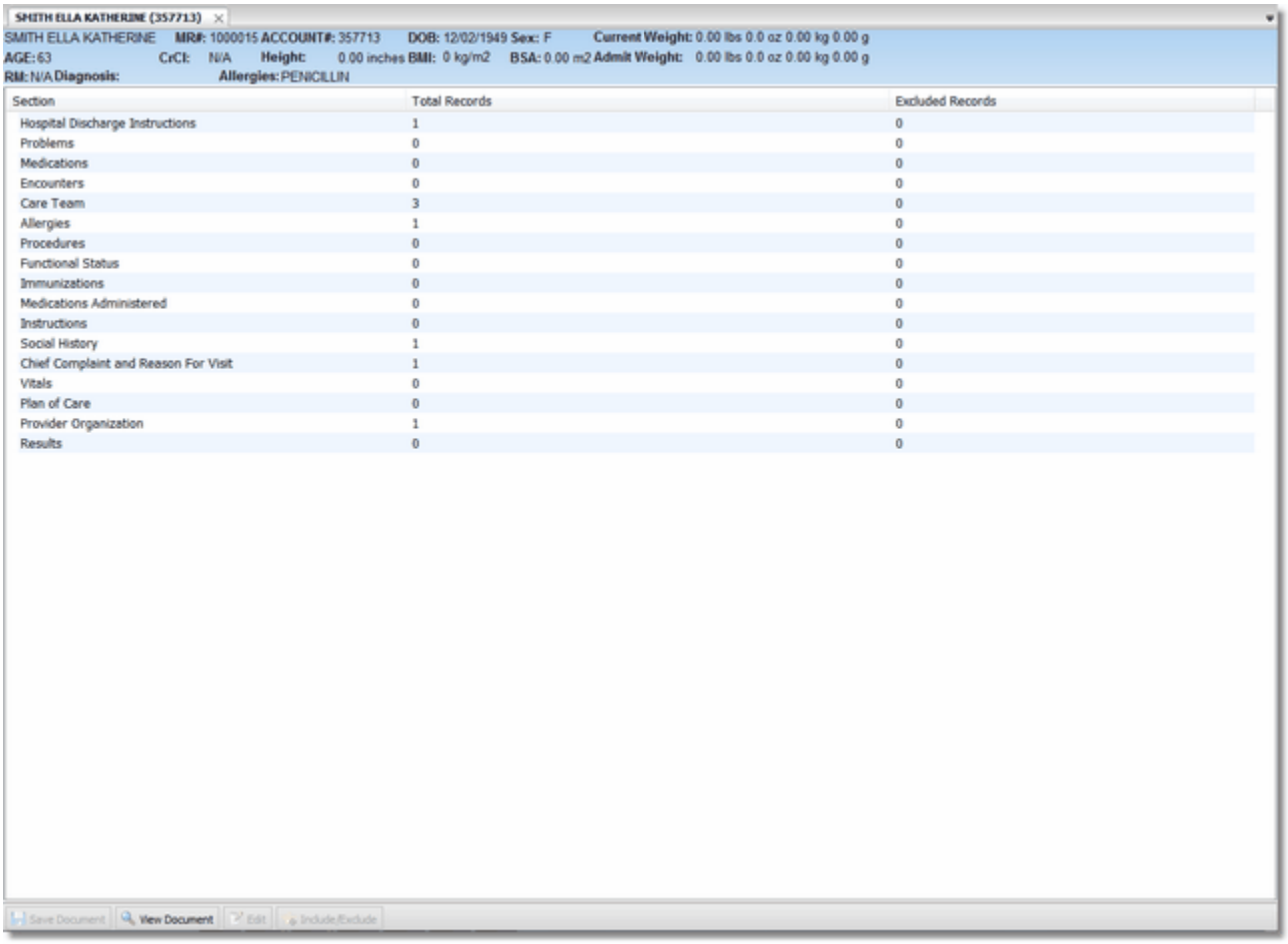



**Figure 1.22 Patient Summary (HL7 CCD)**

- **Section:** Section of the CCD
- **Total Records:** Total number of records included in the section of the CCD
- **Excluded Records:** Number of records excluded in the section of the CCD
- **View Document:** Select this option from the action bar to view the attached CCD

To exclude an entire section, highlight the section to be excluded. Once the section is highlighted, select **Include/Exclude** on the action bar**.** The Excluded Records column will now display ALL for the excluded section. Select **Save Document** to save the changes. "Unknown" will pull to the CCD for the excluded section.

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Edit**

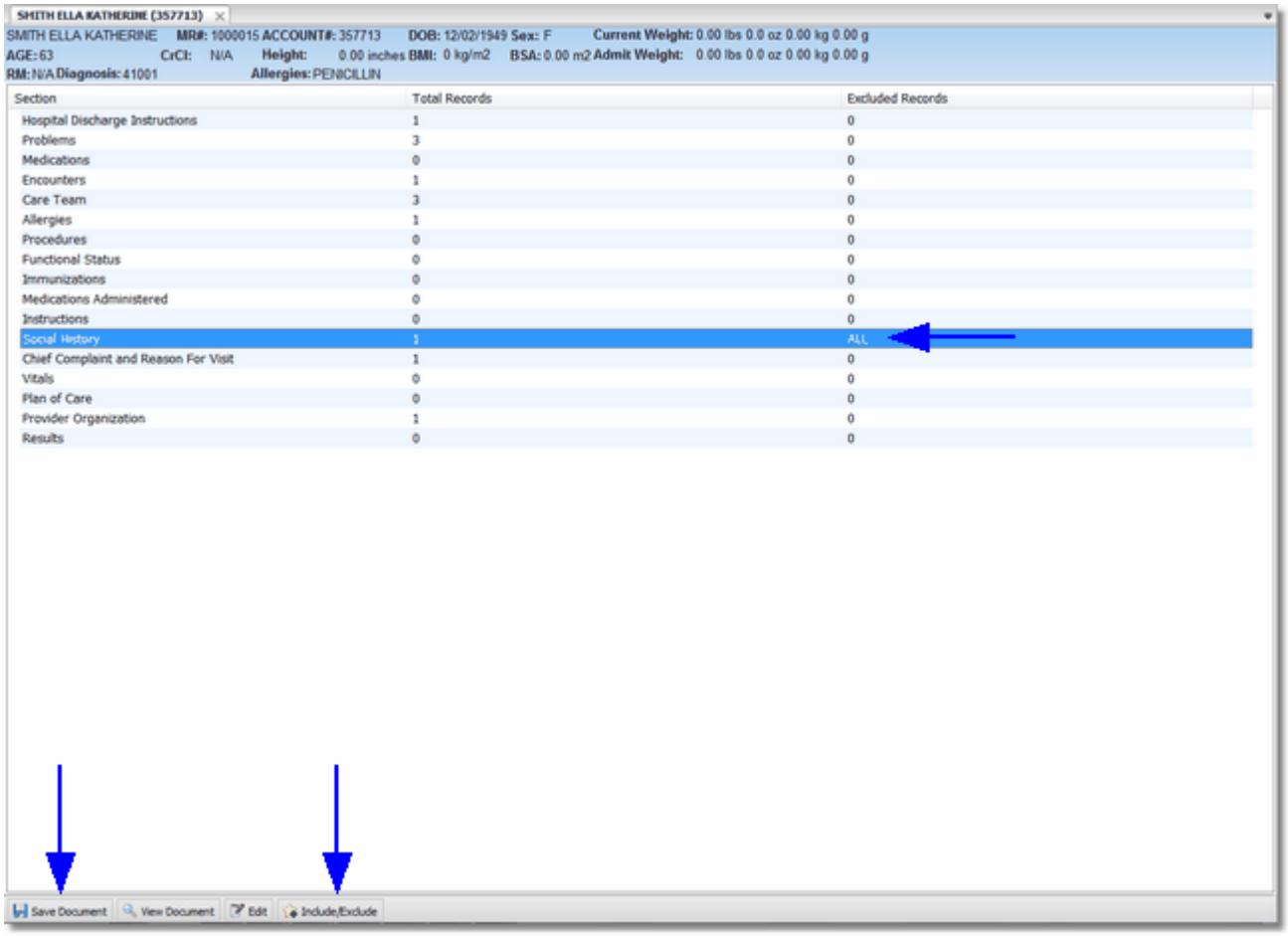



**Figure 1.23 Patient Summary (HL7 CCD)**

The process to exclude individual components of a section changes depending on the information contained in the section. Reference the section needing to be edited for the steps.

When the Patient Summary or Referral/Transition of Care Summary is edited, a copy of the document will be saved in Electronic File Management. The document will have a file type of Clinical Document Arch (Clinical Document Architecture). The Patient Summary will be saved with a description of z_CCDA:Patient Summary, and the Referral/Transition of Care Summary will be saved with a description of z_CCDA:Referral/Transition. The Electronic File Management audit log will be updated with the date, time and employee name when the document is saved.

Select **Hospital Base Menu** > **Patient Account #** > **Electronic File Management**

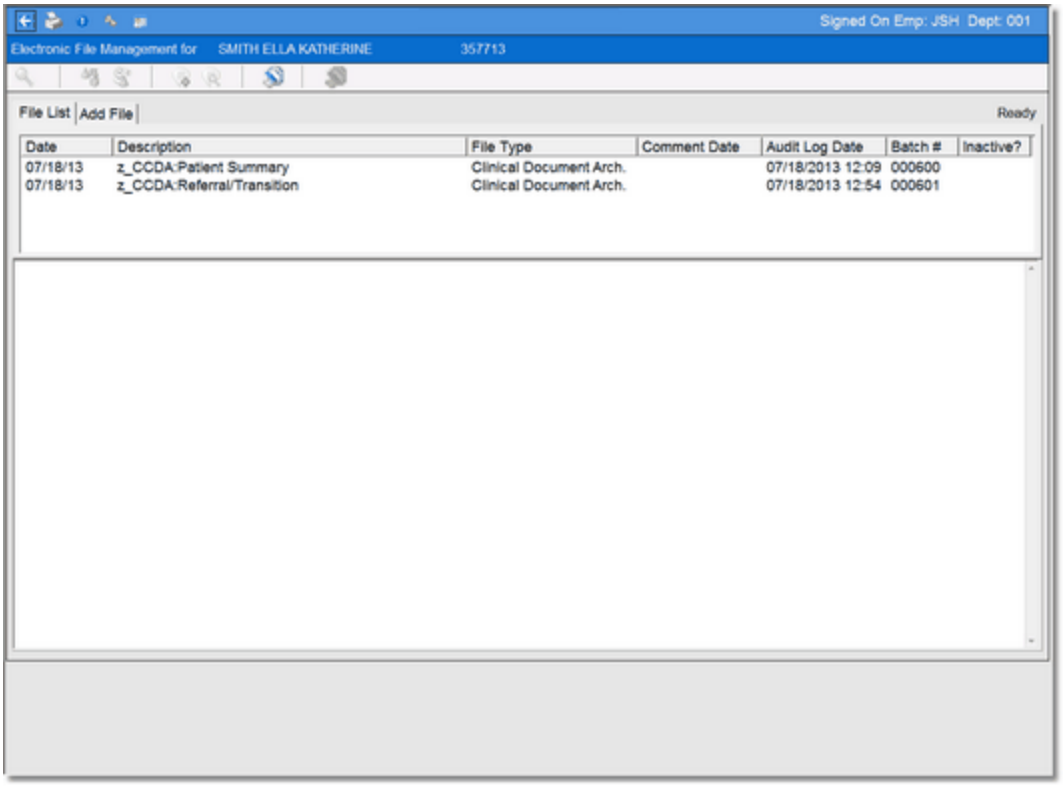



**Figure 1.24 Electronic File Management**

## Hospital Discharge Instructions

At this time, individual components of the Hospital Discharge Instructions section may not be excluded. See Section Edits 15 for excluding the entire section.

## Problems

Follow the steps below to edit the Problems section of the CCD.

To exclude individual problems, highlight the **Problems** section. Once the section is highlighted, select **Edit** on the action bar**.**

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Edit**

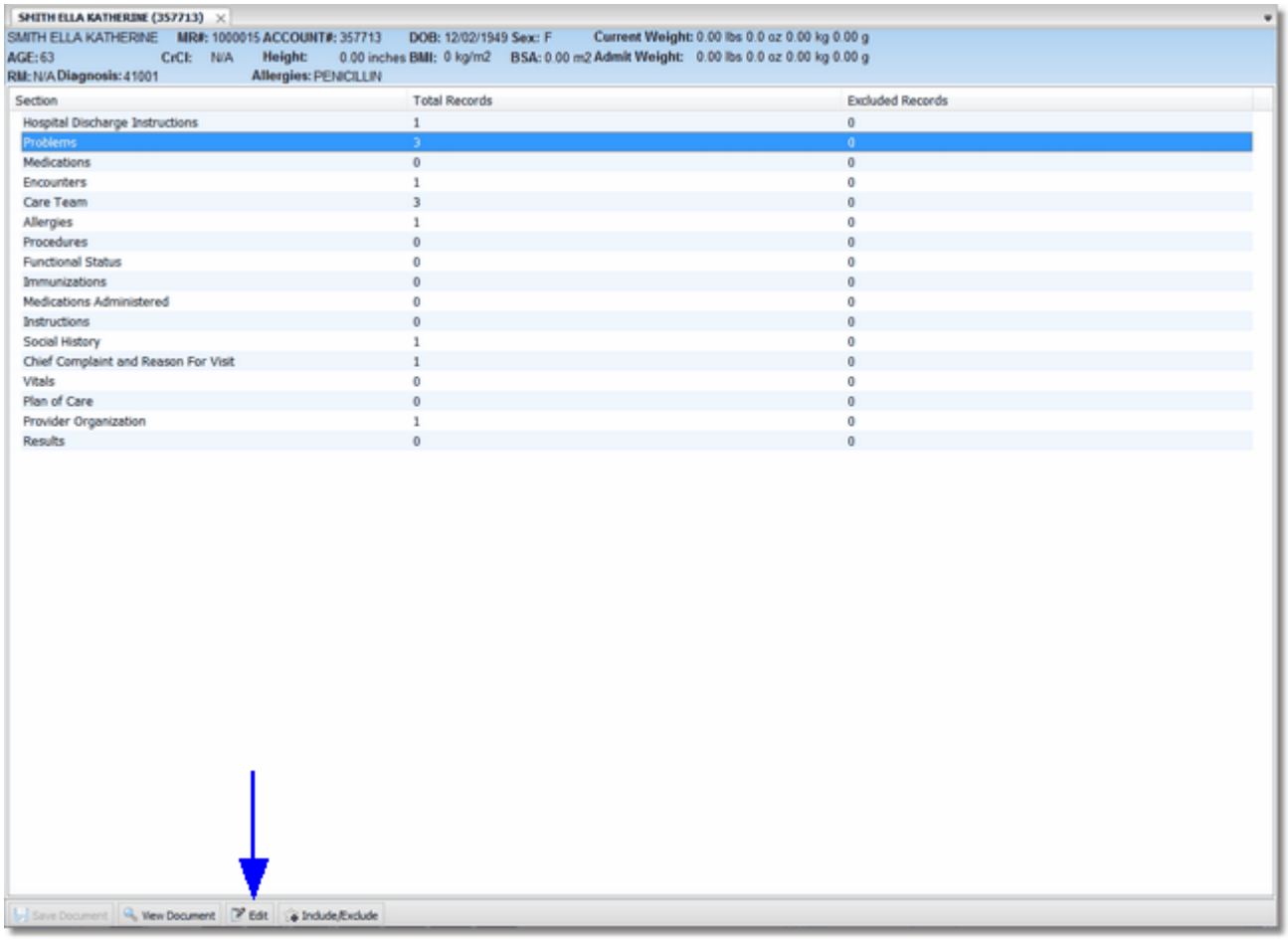



**Figure 1.25 Patient Summary (HL7 CCD)**

Once **Edit** is selected, the individual problems will display. Highlight the problem to exclude. Multiple problems may be selected by holding down the Ctrl key and selecting the desired problems. When all problems are highlighted, select **Include/Exclude.** Select the  **back arrow** to return to the list of the sections of the CCD.

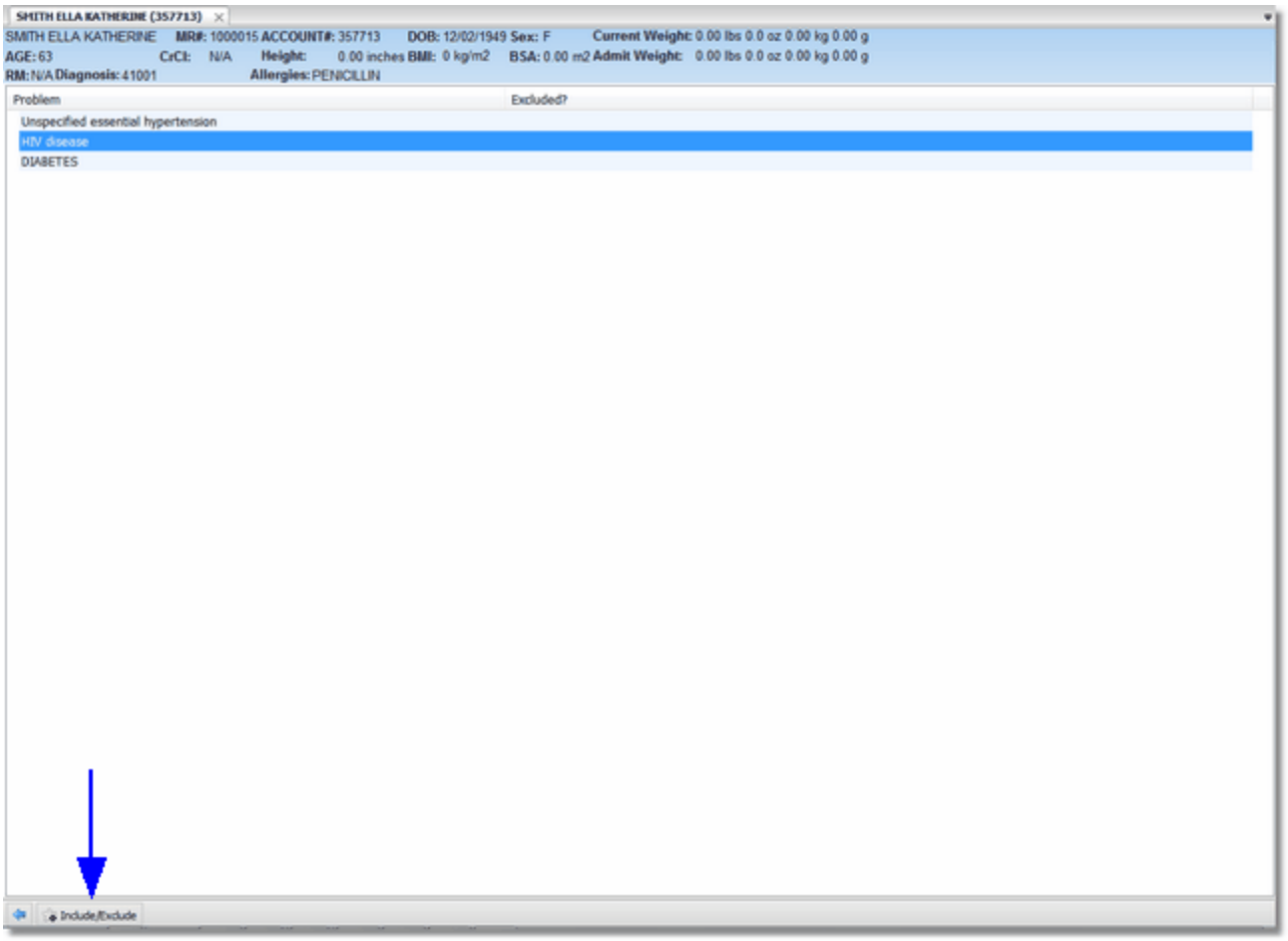



**Figure 1.26 Patient Summary (HL7 CCD)**

The Excluded Records column will now display the number of problems excluded from the section. Select **Save Document** to save the changes.

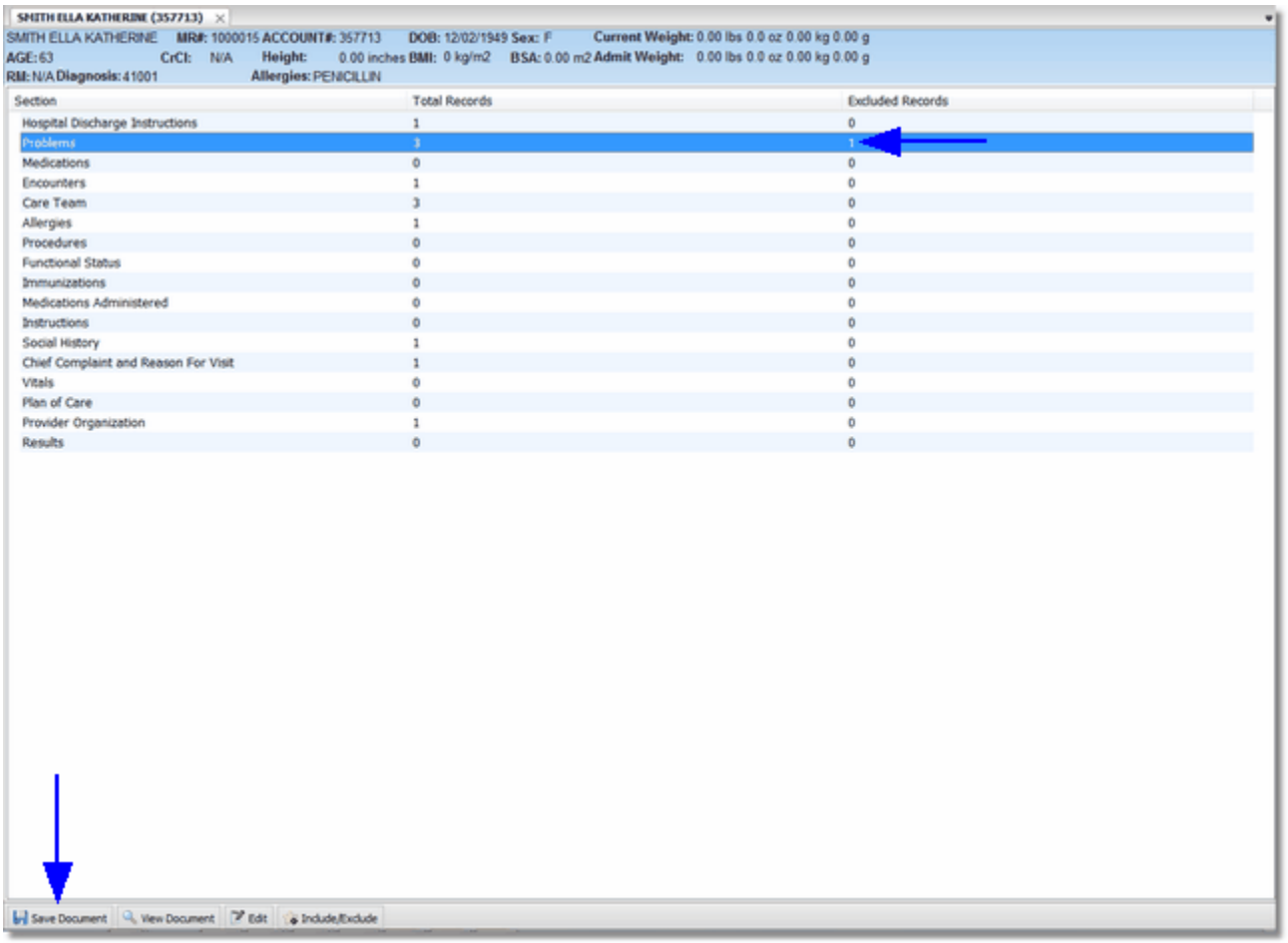



**Figure 1.27 Patient Summary (HL7 CCD)**

***NOTE**: If a problem has a resolved date less than or equal to the discharge date, the problem will be automatically excluded from displaying on the CCD.*

## Medications

Follow the steps below to edit the Medications section of the CCD.

To exclude individual medications, highlight the **Medications** section. Once the section is highlighted, select **Edit** on the action bar**.**

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Edit**

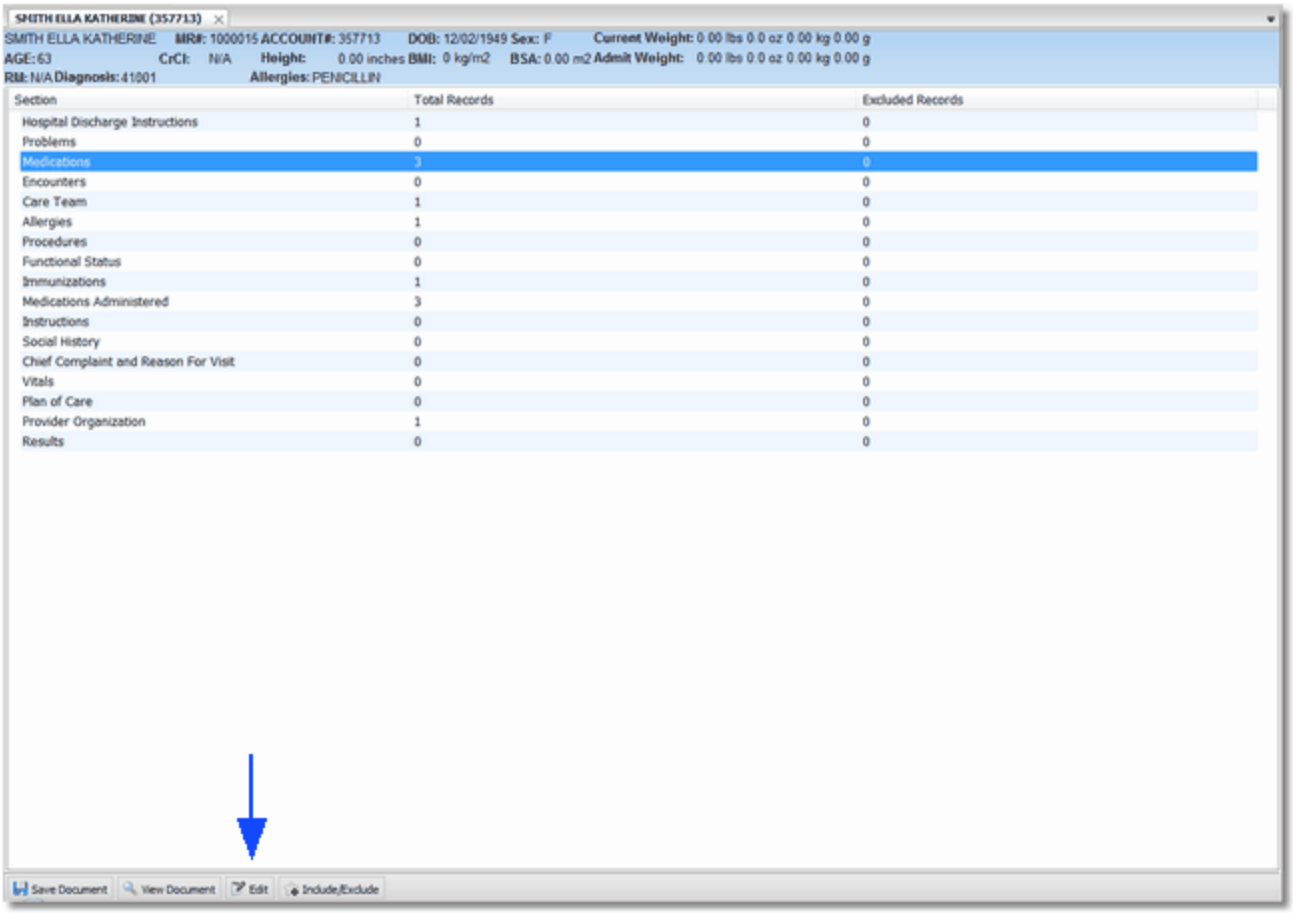



**Figure 1.28 Patient Summary (HL7 CCD)**

Once **Edit** is selected, the individual medications will display. Highlight the medication to exclude. Multiple medications may be selected by holding down the Ctrl key and selecting the desired medications. When all medications are highlighted, select **Include/Exclude.** Select the  **back arrow** to return to the list of the sections of the CCD.

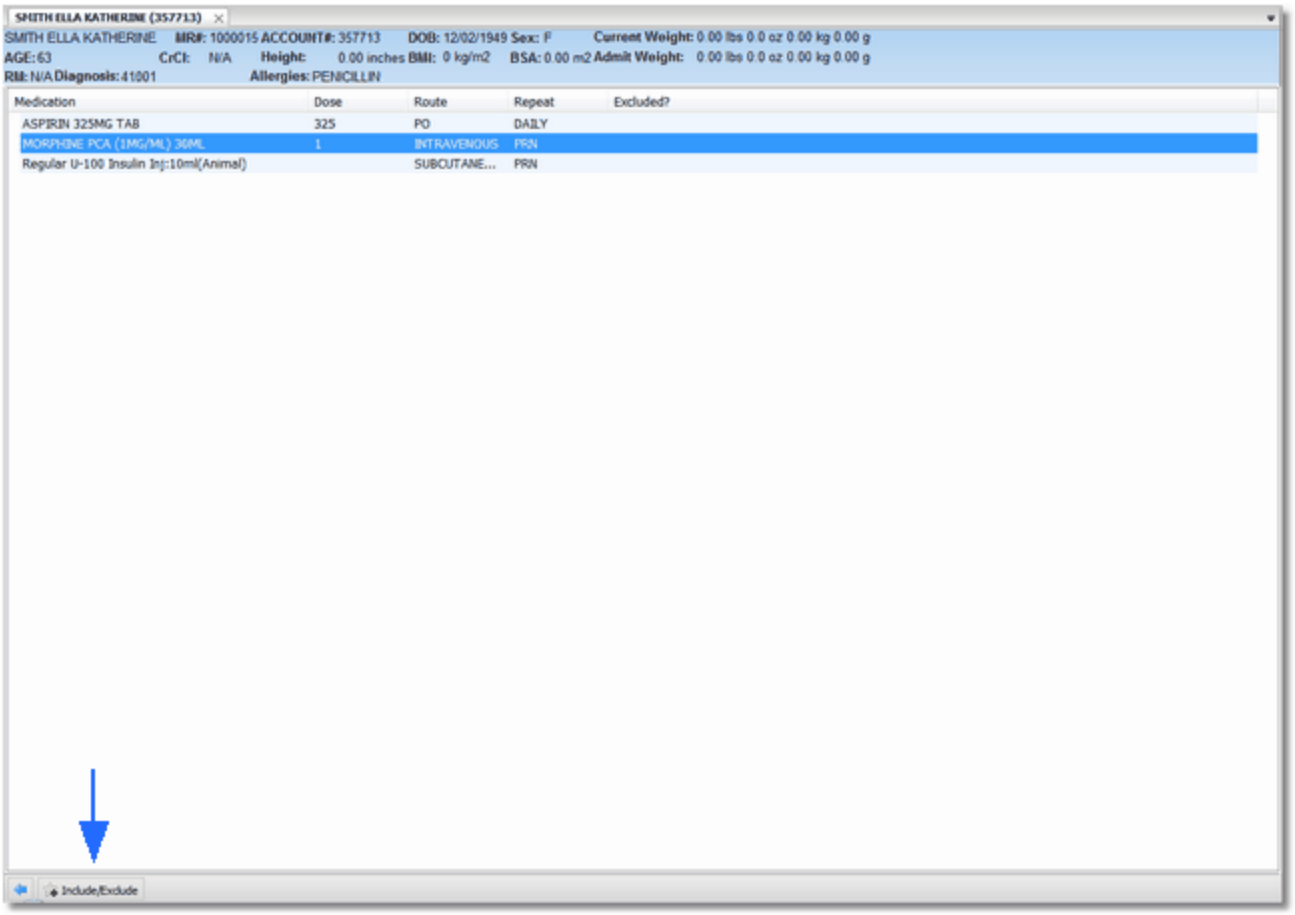



**Figure 1.29 Patient Summary (HL7 CCD)**

The Excluded Records column will now display the number of medications excluded from the section. Select **Save Document** to save the changes.

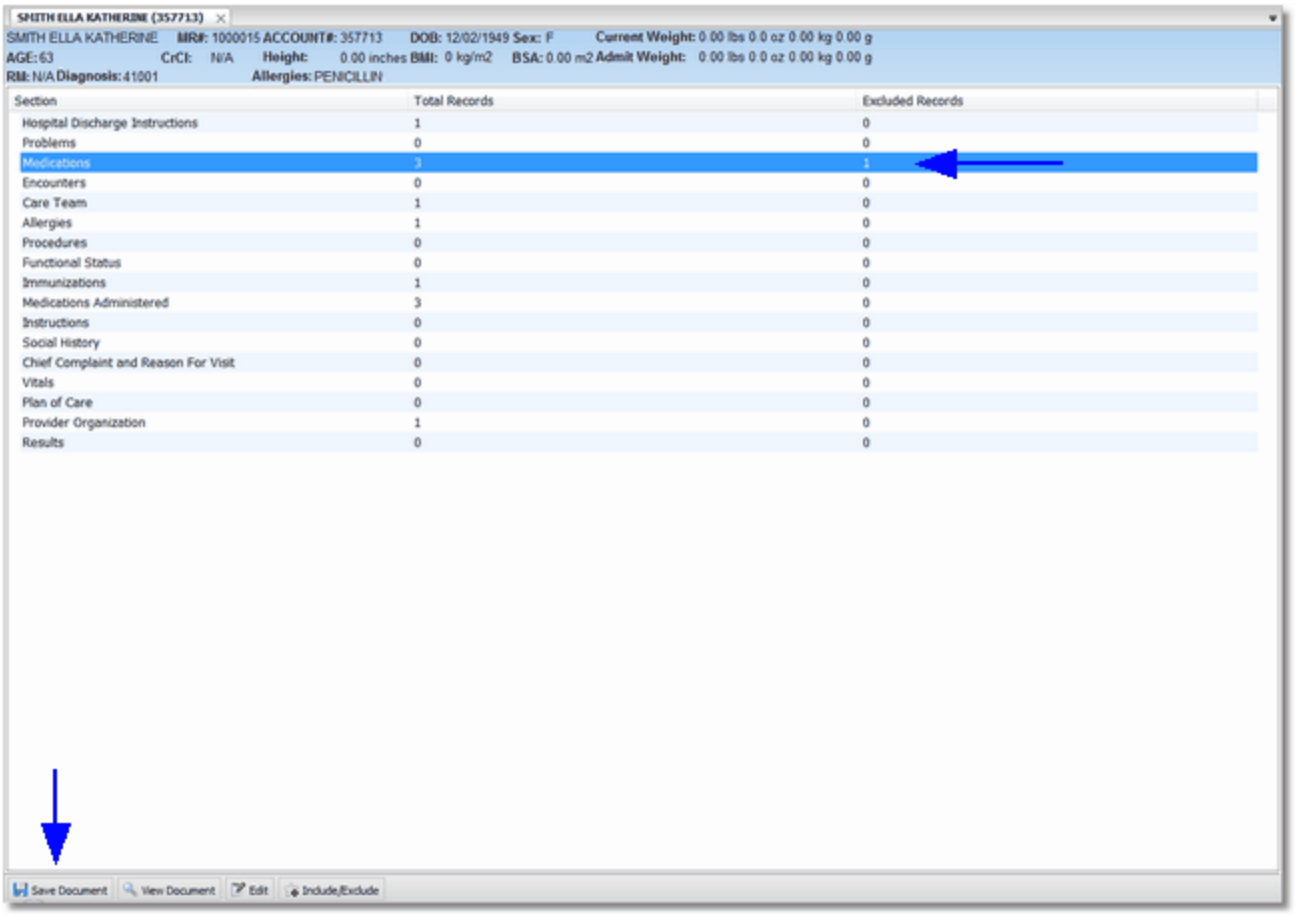



**Figure 1.30 Patient Summary (HL7 CCD)**

## Encounters

Follow the steps below to edit the Encounters section of the CCD.

To exclude individual components of the Encounters section, highlight the **Encounters** section. Once the section is highlighted, select **Edit** on the action bar**.**

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Edit**

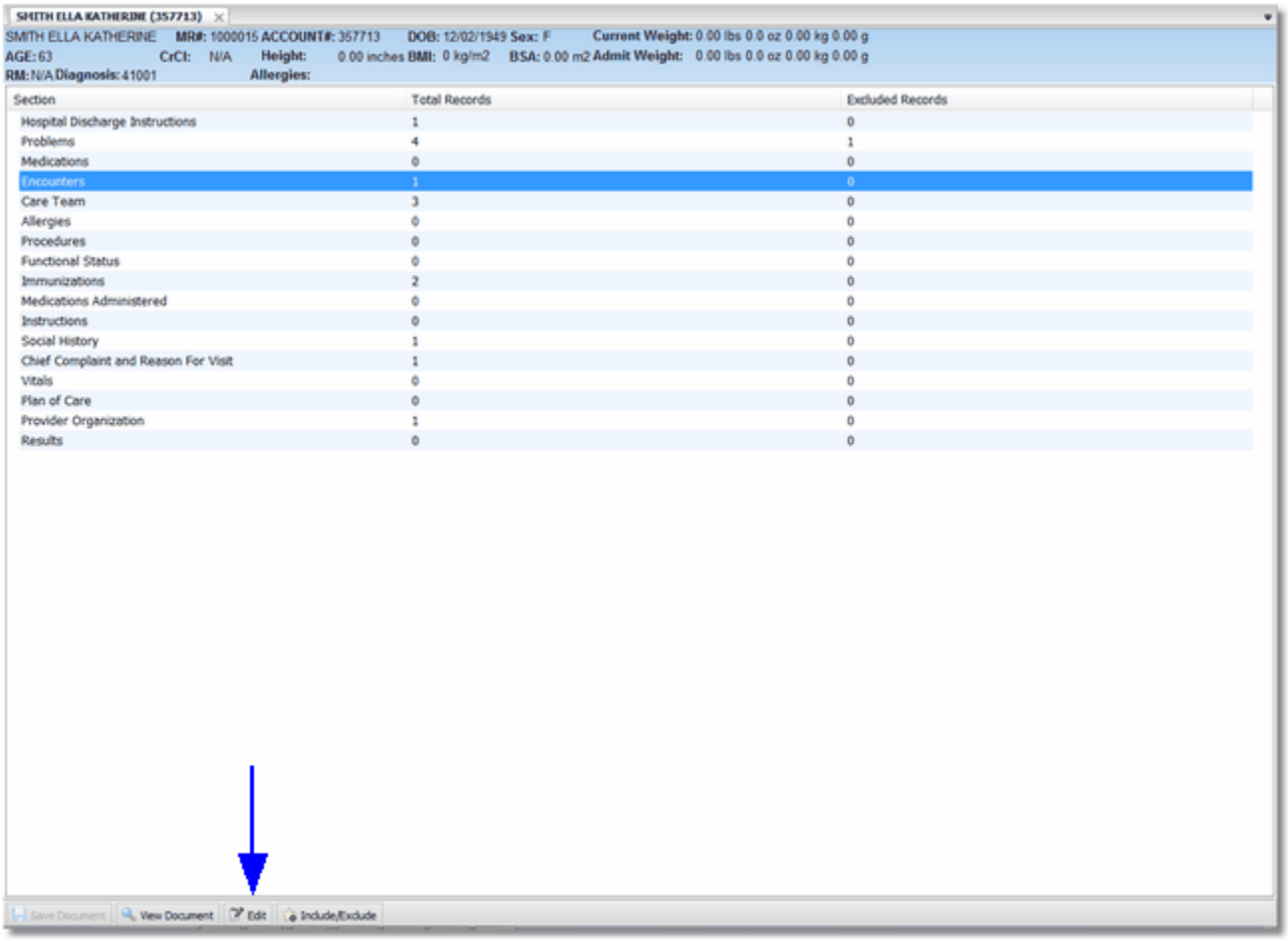



**Figure 1.31 Patient Summary (HL7 CCD)**

Once **Edit** is selected, the individual components of the Encounters section will display. Highlight the component to exclude. Once the component is highlighted, select **Include/Exclude.** Select the  **back arrow** to return to the list of the sections of the CCD.

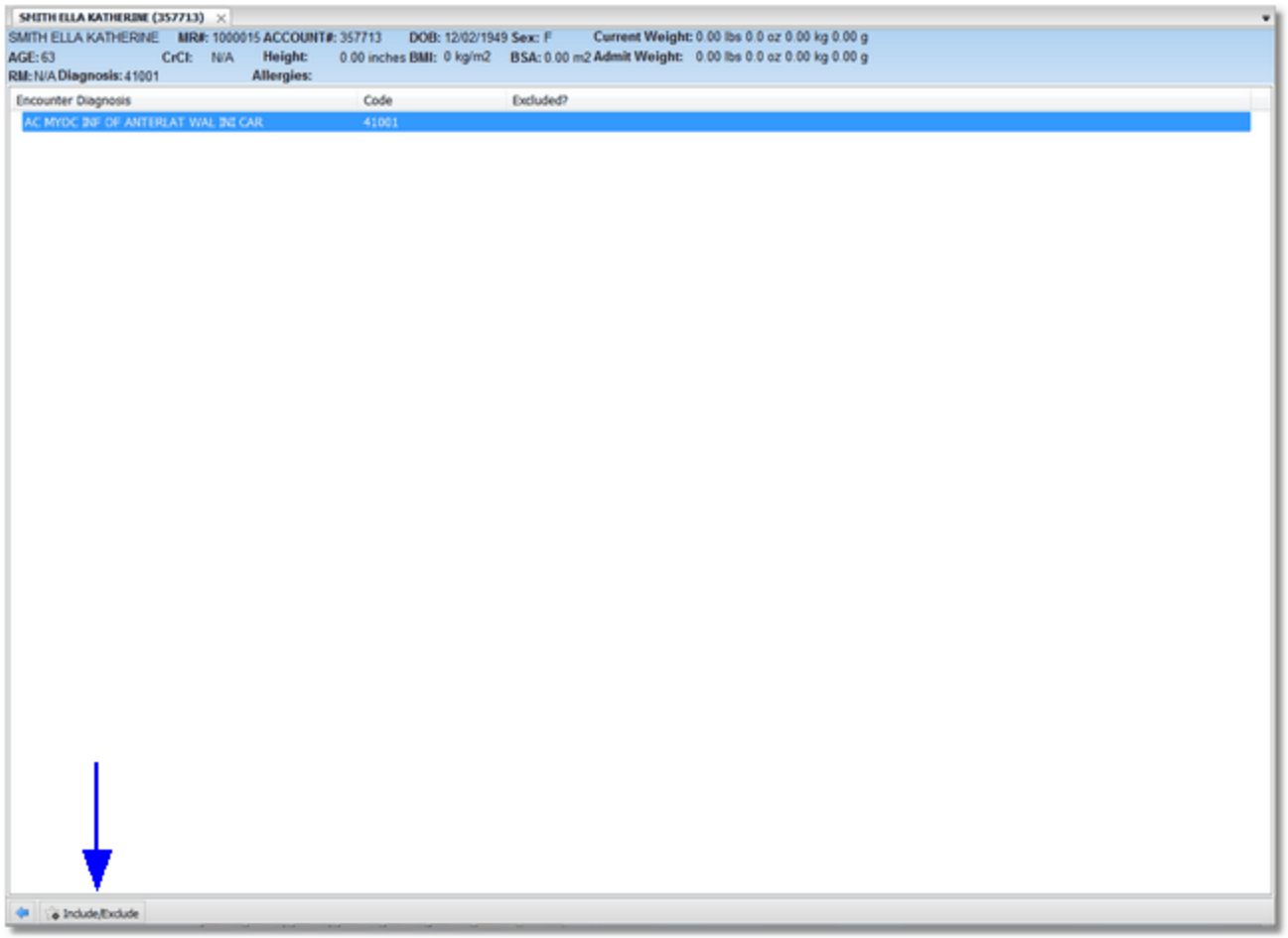



**Figure 1.32 Patient Summary (HL7 CCD)**

The Excluded Records column will now display the number of components excluded from the Encounters section. Select **Save Document** to save the changes.

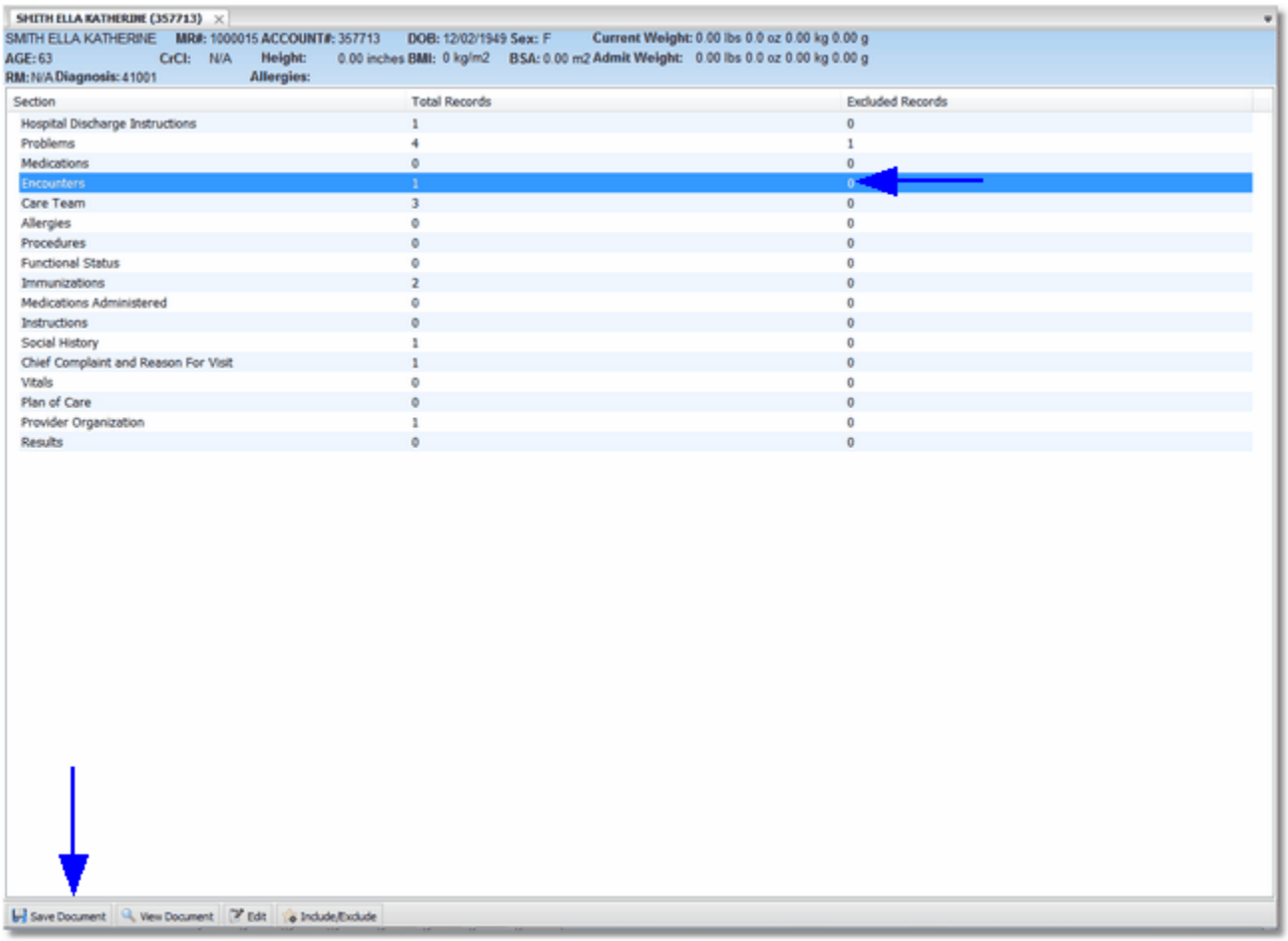



**Figure 1.33 Patient Summary (HL7 CCD)**

## Care Team

There are three editing options available for the Care Team section of the CCD:

1. Individual care team members may be excluded from the CCD.
2. Care team members information may be modified on the CCD.
3. Care team members may be added to the CCD.

To exclude individual care team member, highlight the **Care Team** section. Once the section is highlighted, select **Edit** on the action bar.

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Edit**

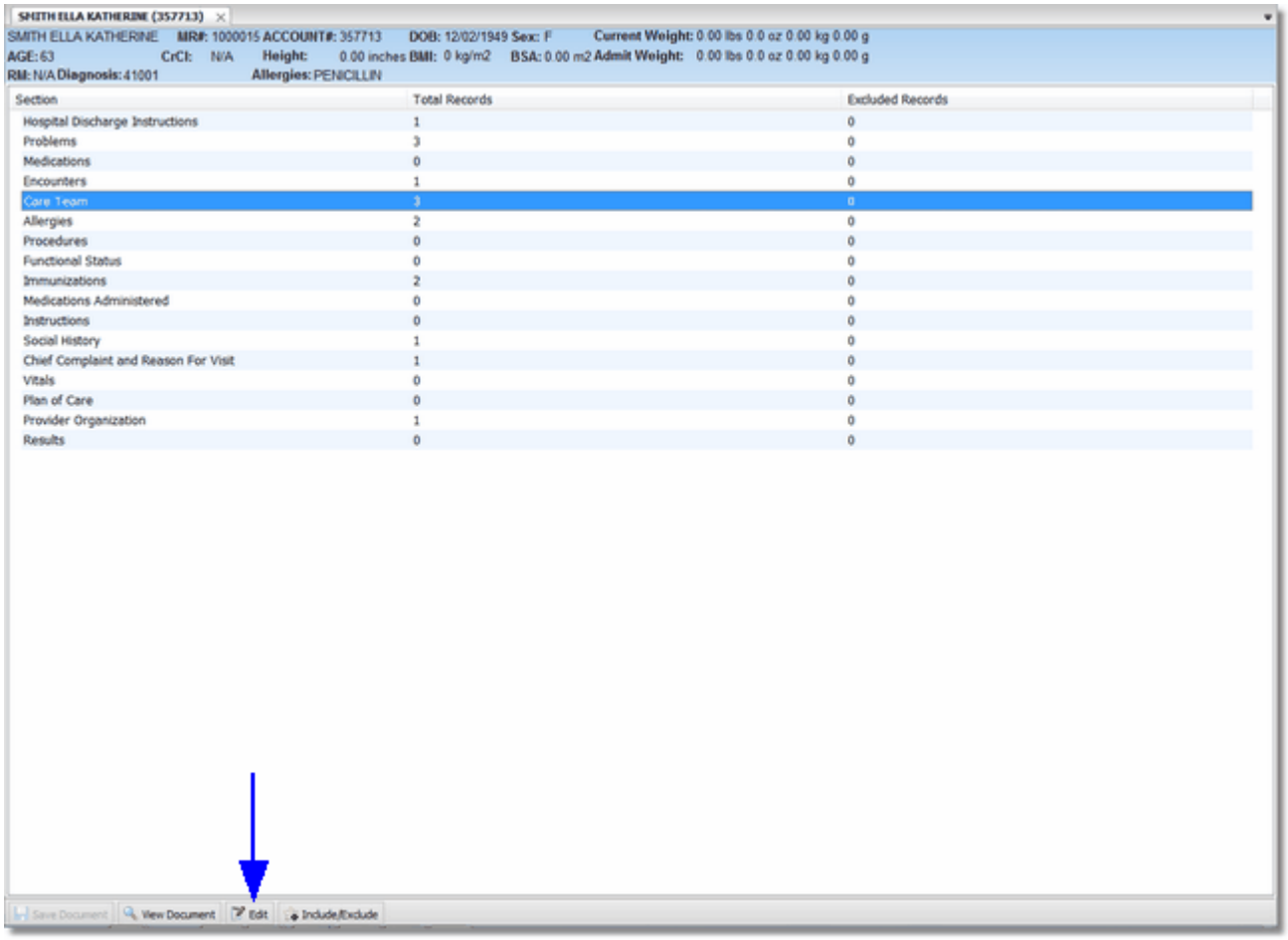



**Figure 1.34 Patient Summary (HL7 CCD)**

Once **Edit** is selected, the individual care team members will display. Highlight the care team member to exclude. Once the care team member is highlighted, select **Include/Exclude.** Select the  **back arrow** to save the information and return to the list of the sections of the CCD.

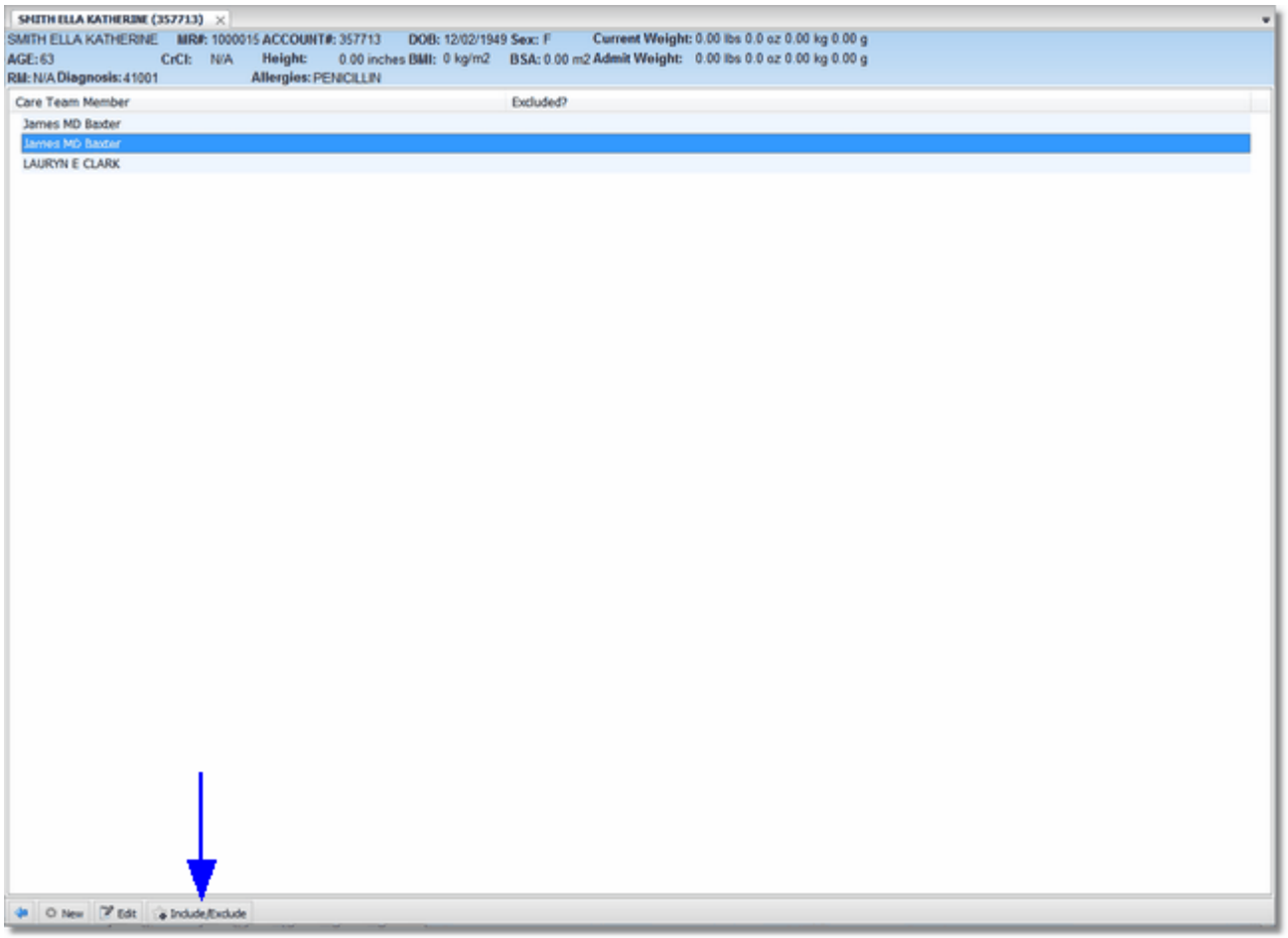



**Figure 1.35 Patient Summary (HL7 CCD)**

The Excluded Records column will now display the number of care team members excluded from the section. Select **Save Document** to save the changes.

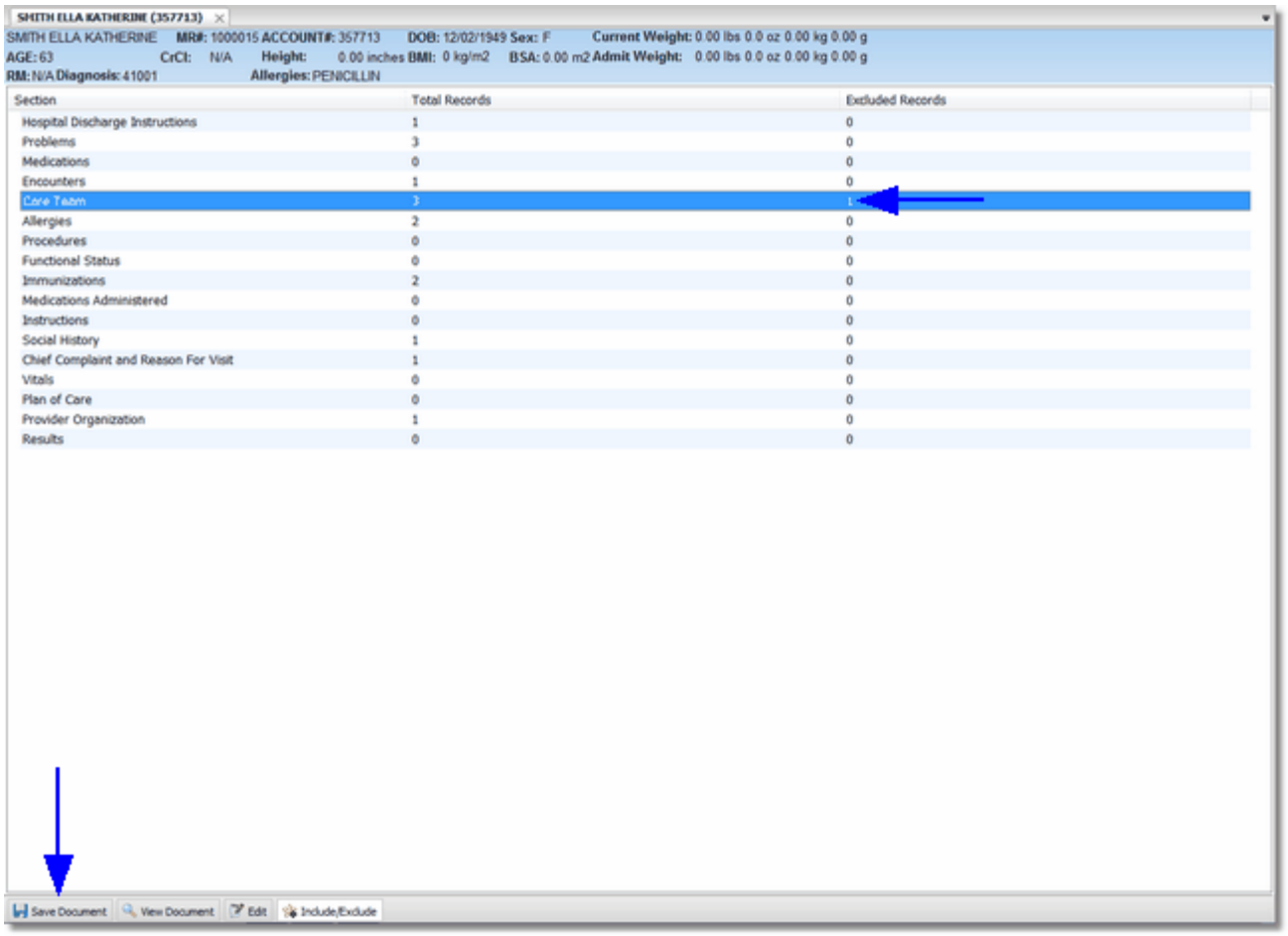



**Figure 1.36 Patient Summary (HL7 CCD)**

To edit a care team member's information, highlight the care team member. Once the care team member is highlighted, select **Edit** on the action bar.

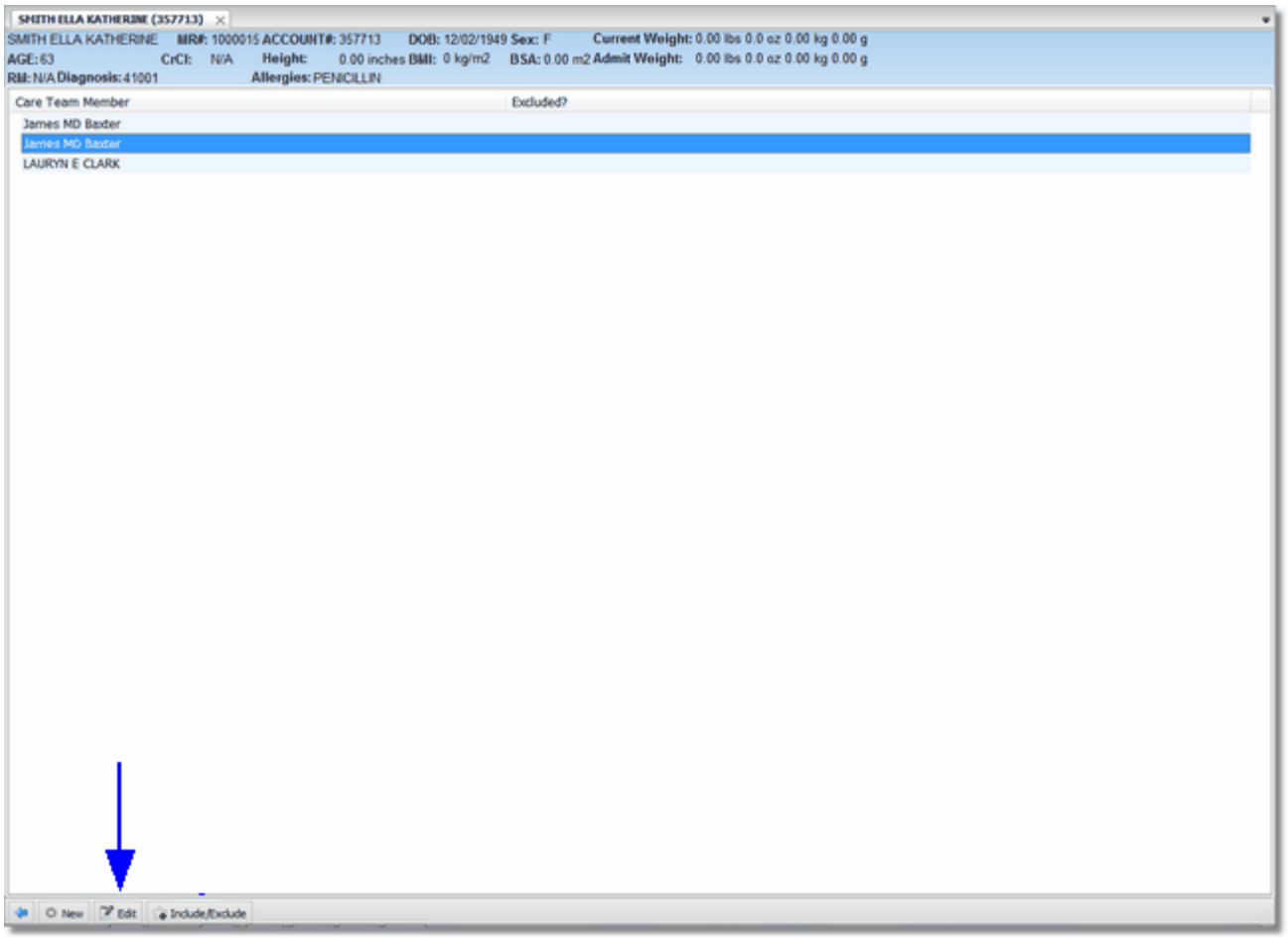



**Figure 1.37 Patient Summary (HL7 CCD)**

Once **Edit** is selected, the individual care team member's information will display. The care team member's name and type cannot be changed. When all the necessary corrections have been made select the  **back arrow** to save the information and return to the list of care team members.

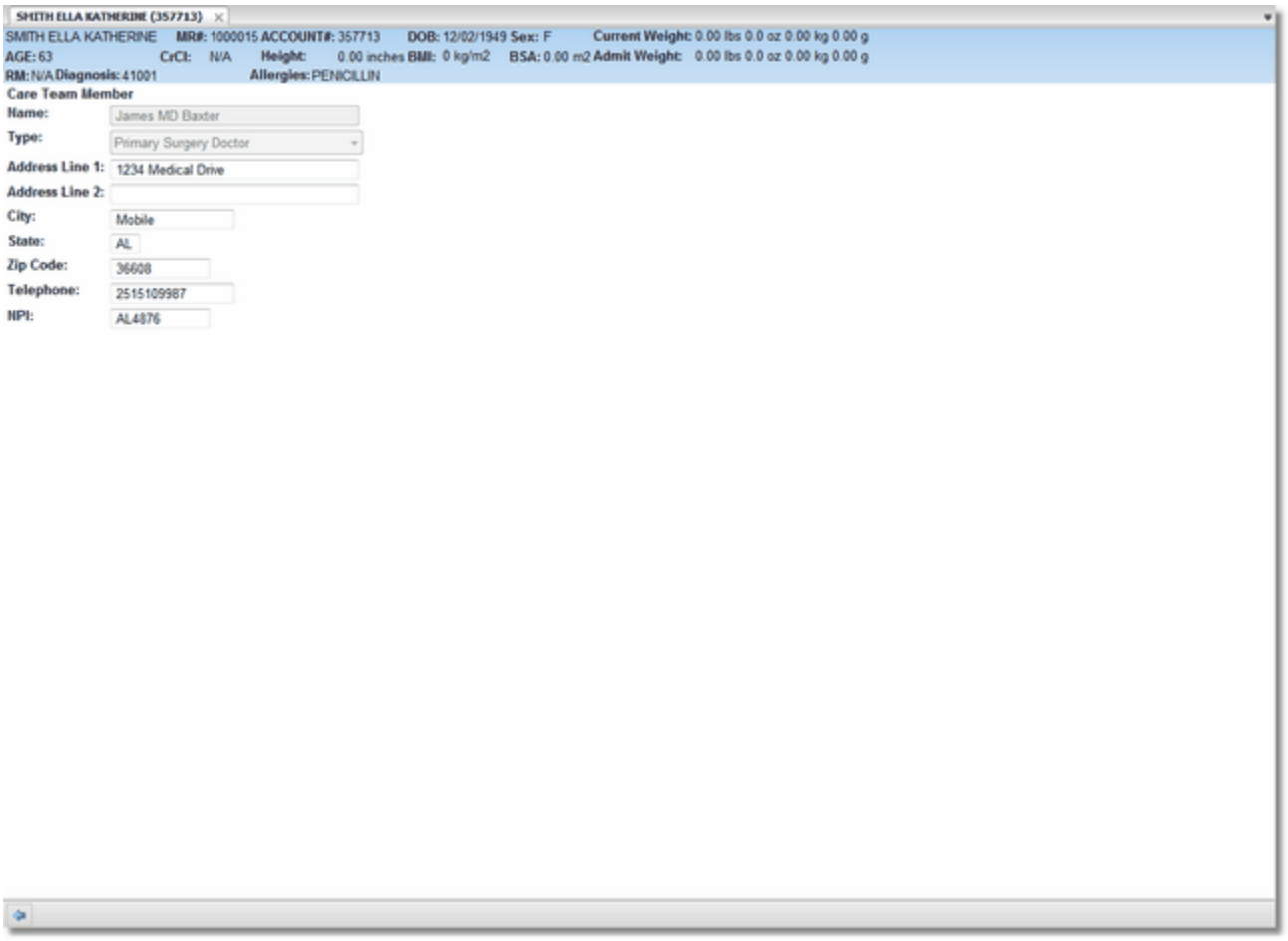



**Figure 1.38 Patient Summary (HL7 CCD)**

To add a care team member, select **New** on the action bar.

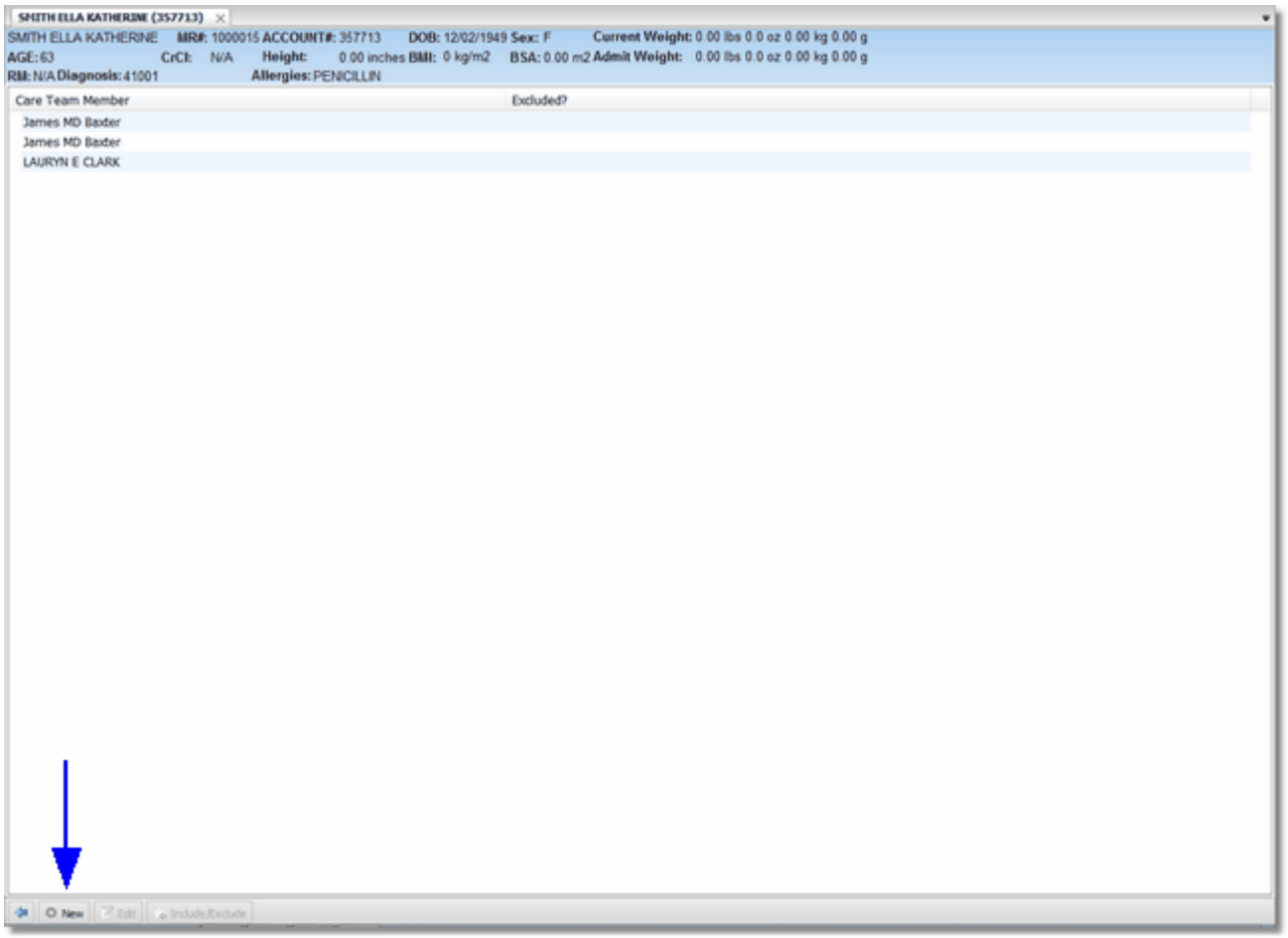



**Figure 1.39 Patient Summary (HL7 CCD)**

Once **New** is selected, the care team member's information may be entered. Select the  **back arrow** to save the information and return to the list of care team members.

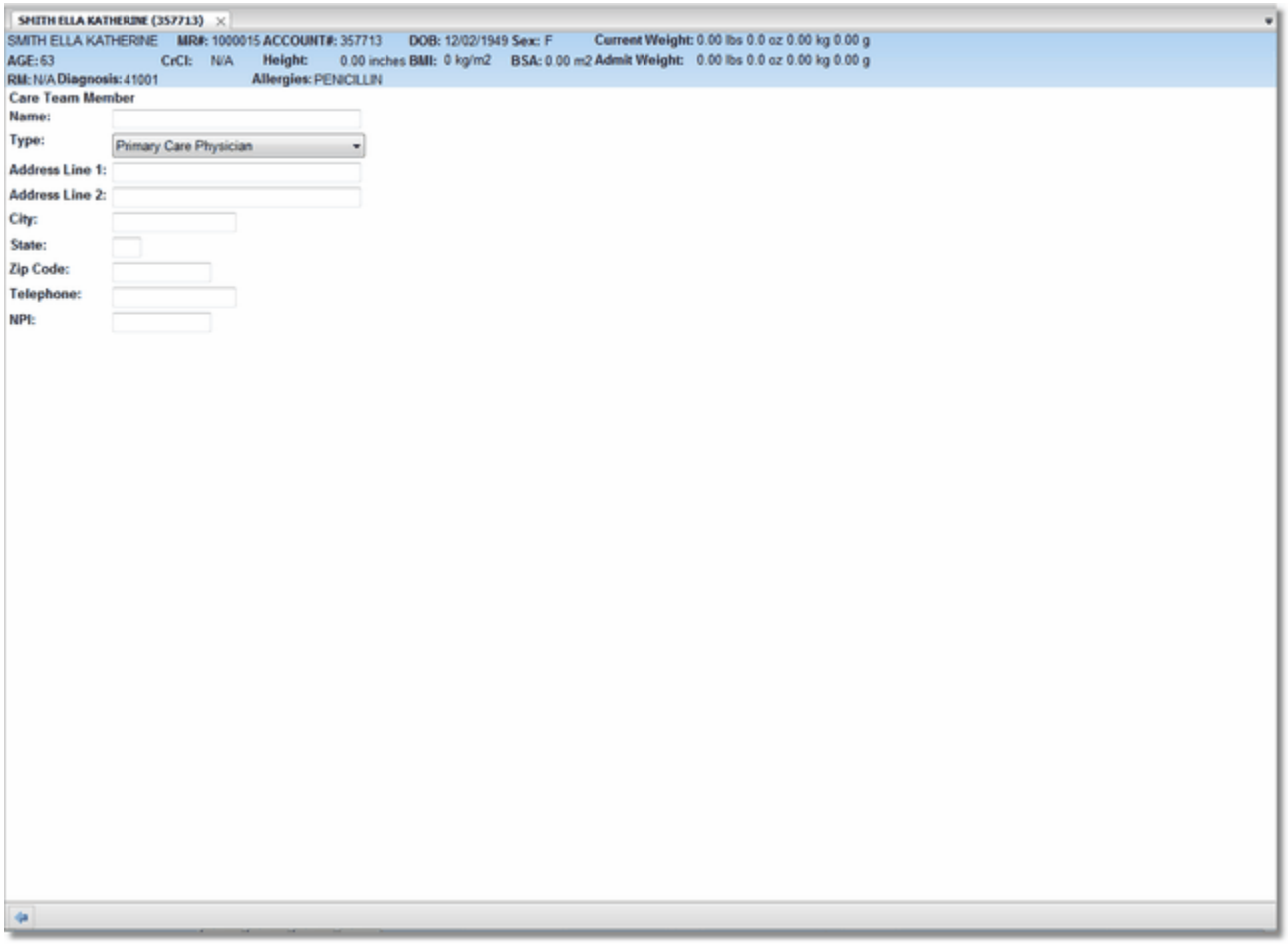



**Figure 1.40 Patient Summary (HL7 CCD)**

## Allergies

Follow the steps below to edit the Allergies section of the CCD.

To exclude individual allergies, highlight the **Allergies** section. Once the section is highlighted, select **Edit** on the action bar**.**

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Edit**

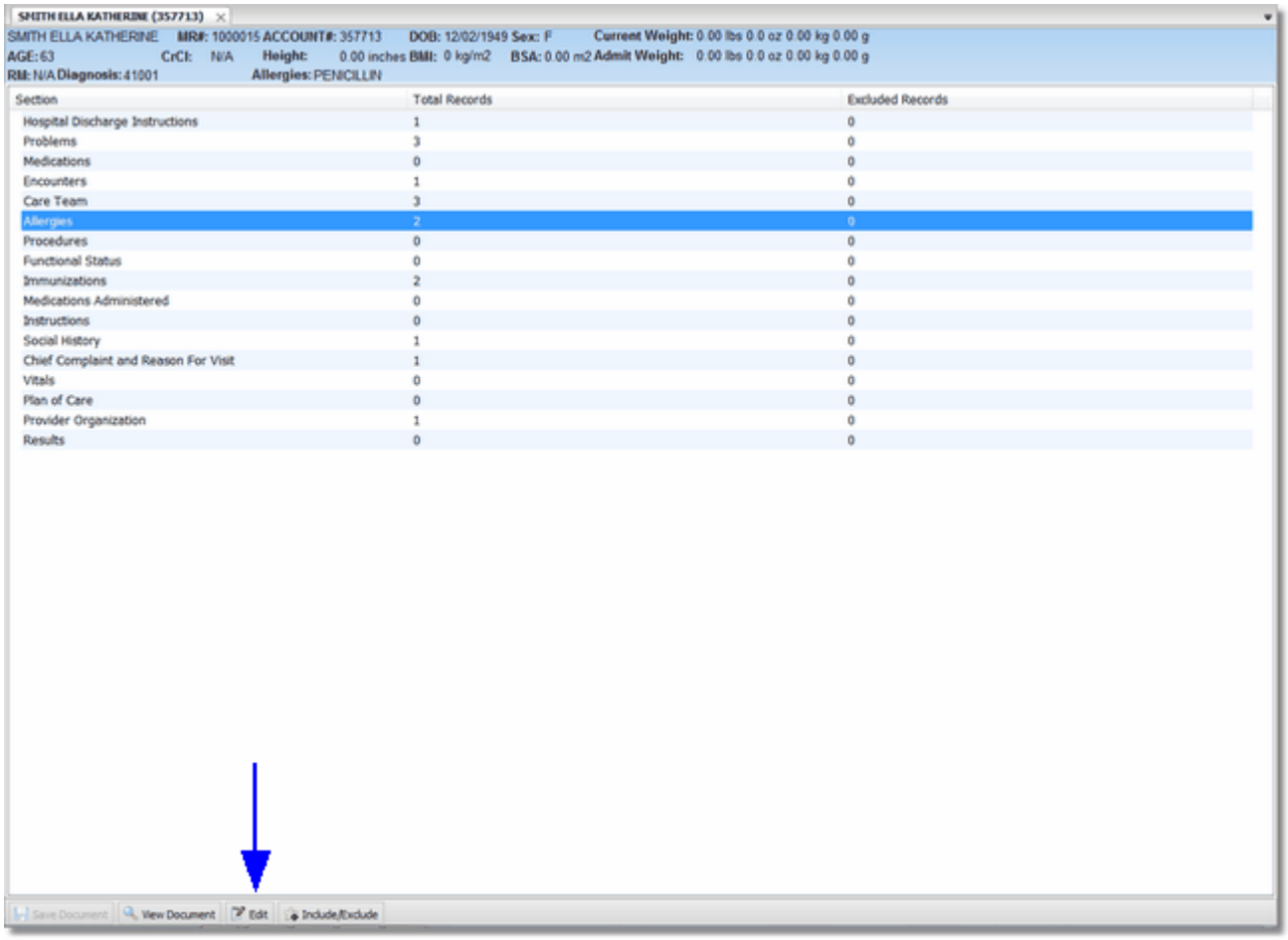



**Figure 1.41 Patient Summary (HL7 CCD)**

Once **Edit** is selected, the individual allergies will display. Highlight the allergy to exclude. Multiple allergies may be selected by holding down the Ctrl key and selecting the desired allergies. When all allergies are highlighted, select **Include/Exclude.** Select the  **back arrow** to return to the list of the sections of the CCD.

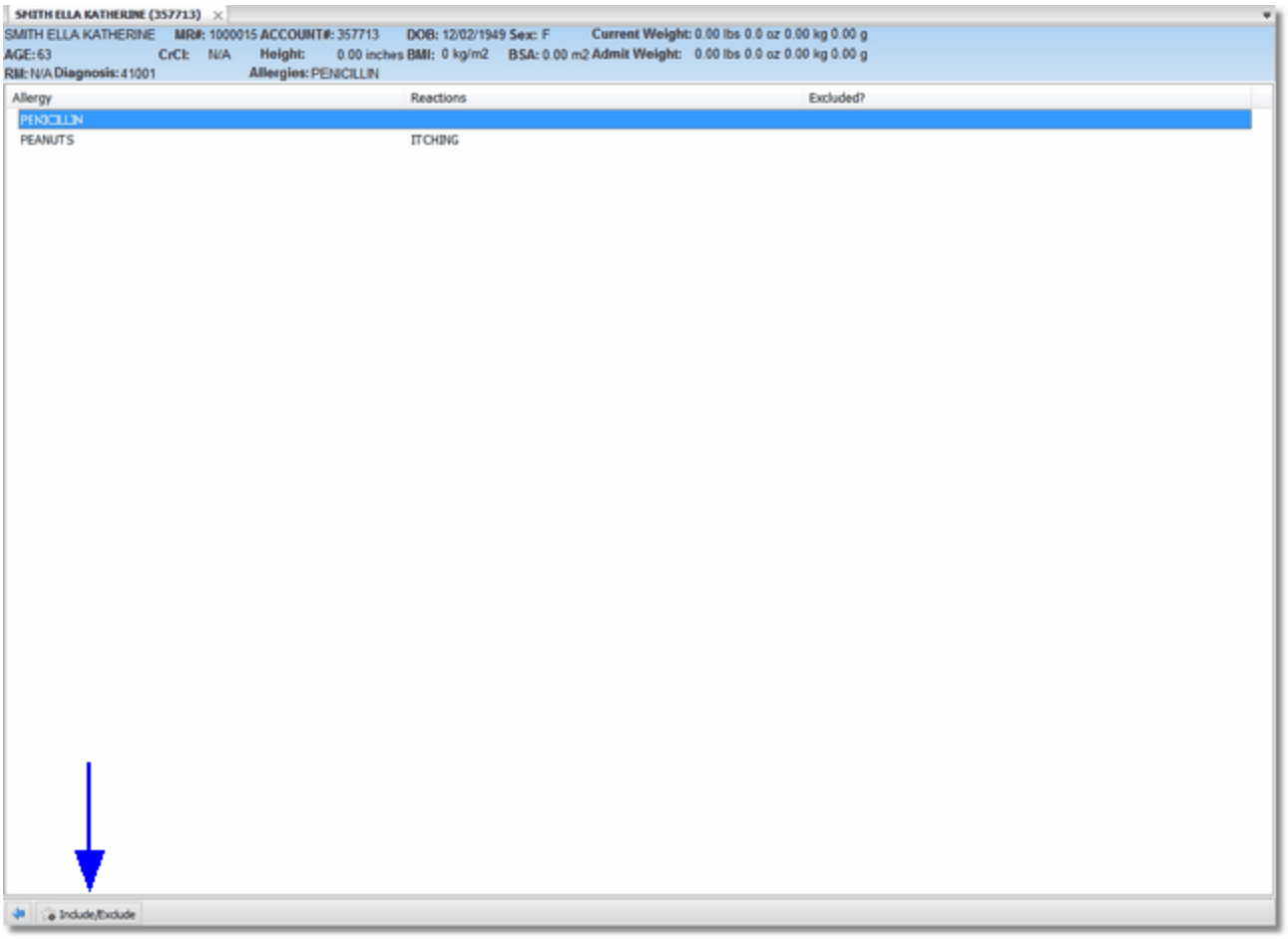



**Figure 1.42 Patient Summary (HL7 CCD)**

The Excluded Records column will now display the number of allergies excluded from the section. Select **Save Document** to save the changes.

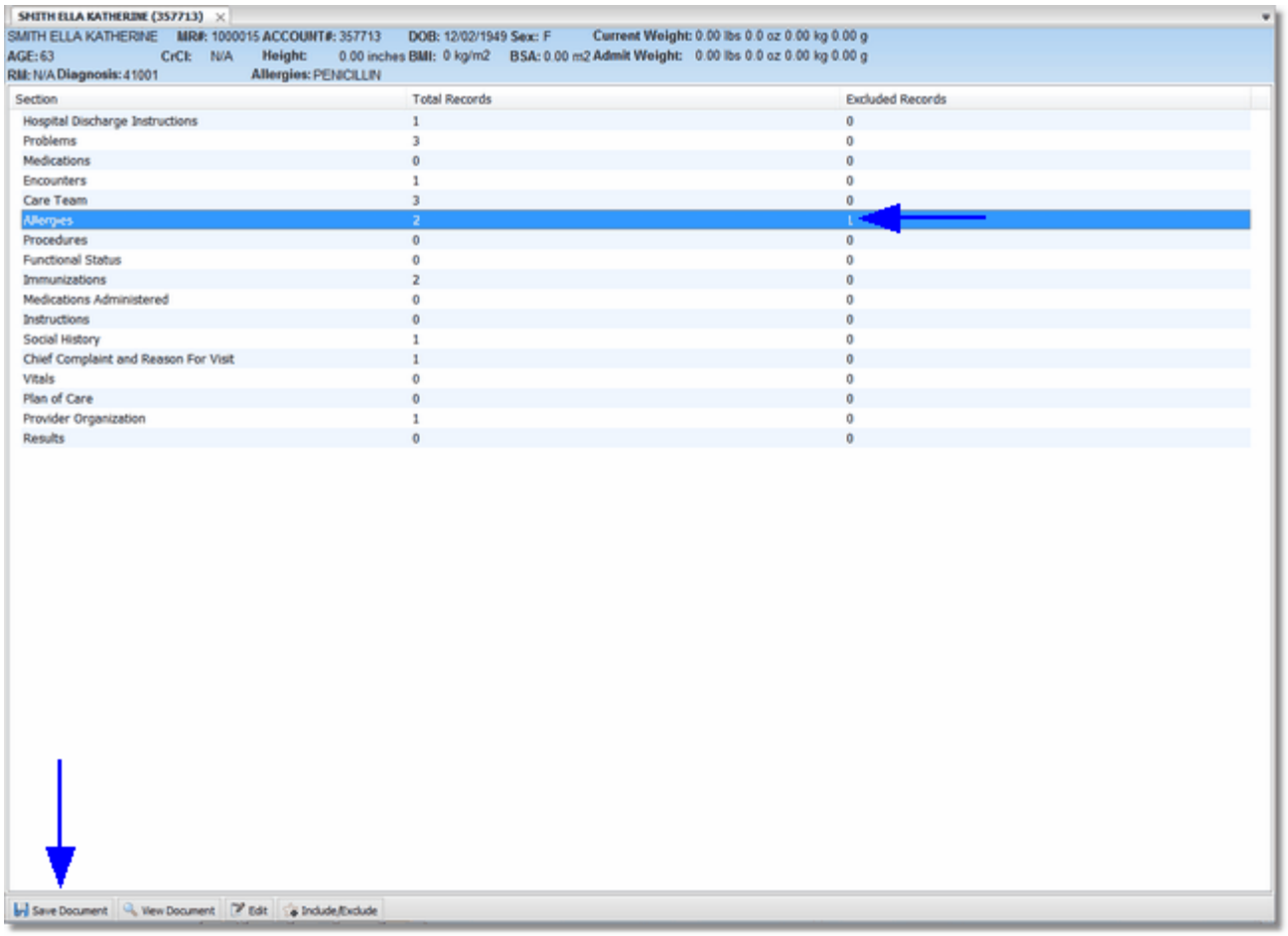



**Figure 1.43 Patient Summary (HL7 CCD)**

## Procedures

Follow the steps below to edit the Procedures section of the CCD.

To exclude individual procedures, highlight the **Procedures** section. Once the section is highlighted, select **Edit** on the action bar**.**

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Edit**

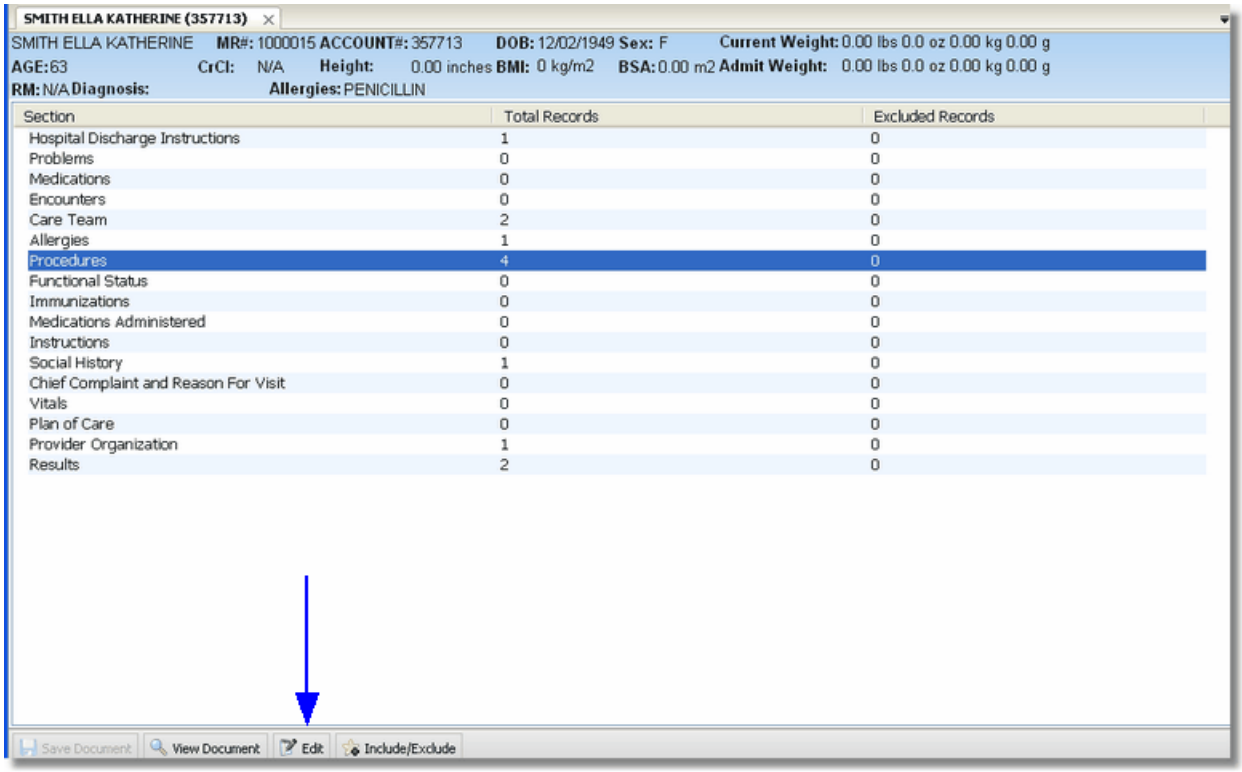



**Figure 1.44 Patient Summary (HL7 CCD)**

Once **Edit** is selected, the individual procedures will display. Highlight the procedures to exclude. Multiple procedures may be selected by holding down the Ctrl key and selecting the desired procedures. When all procedures are highlighted, select **Include/Exclude.** Select the  **back arrow** to return to the list of the sections of the CCD.

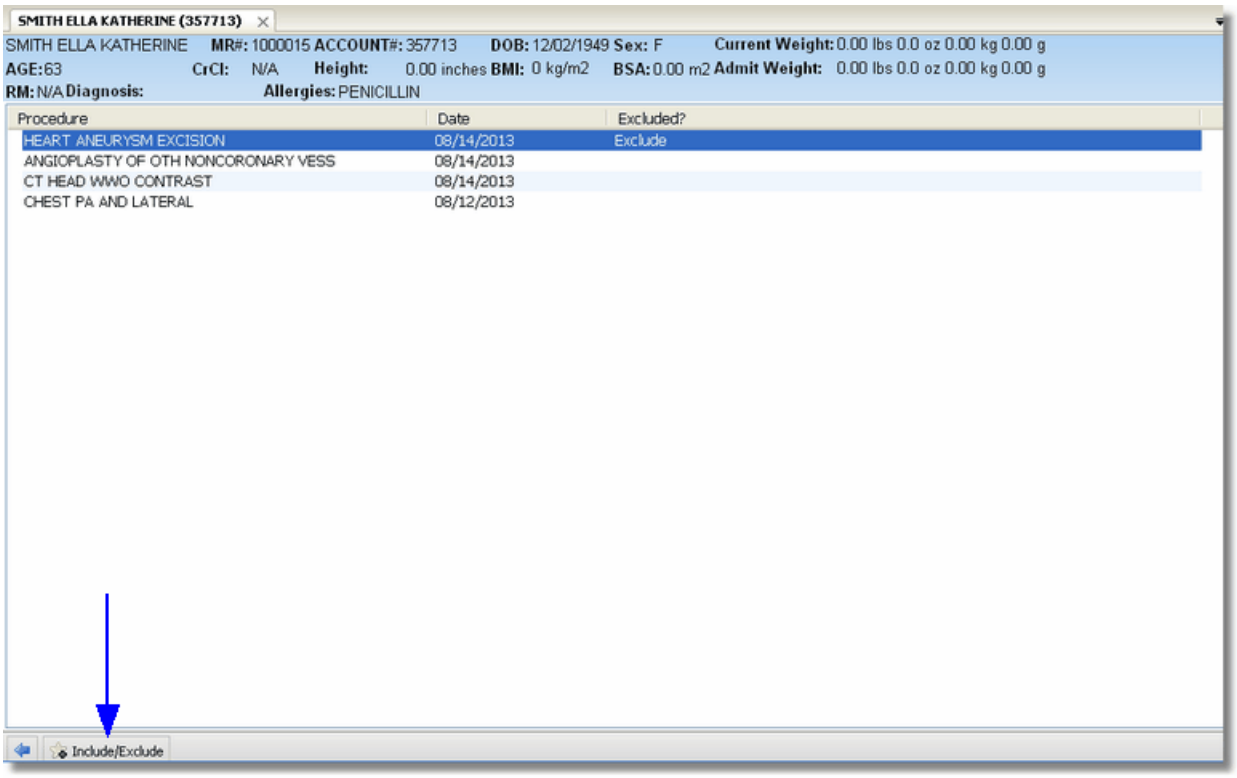



**Figure 1.45 Patient Summary (HL7 CCD)**

The Excluded Records column will now display the number of procedures excluded from the section. Select **Save Document** to save the changes.

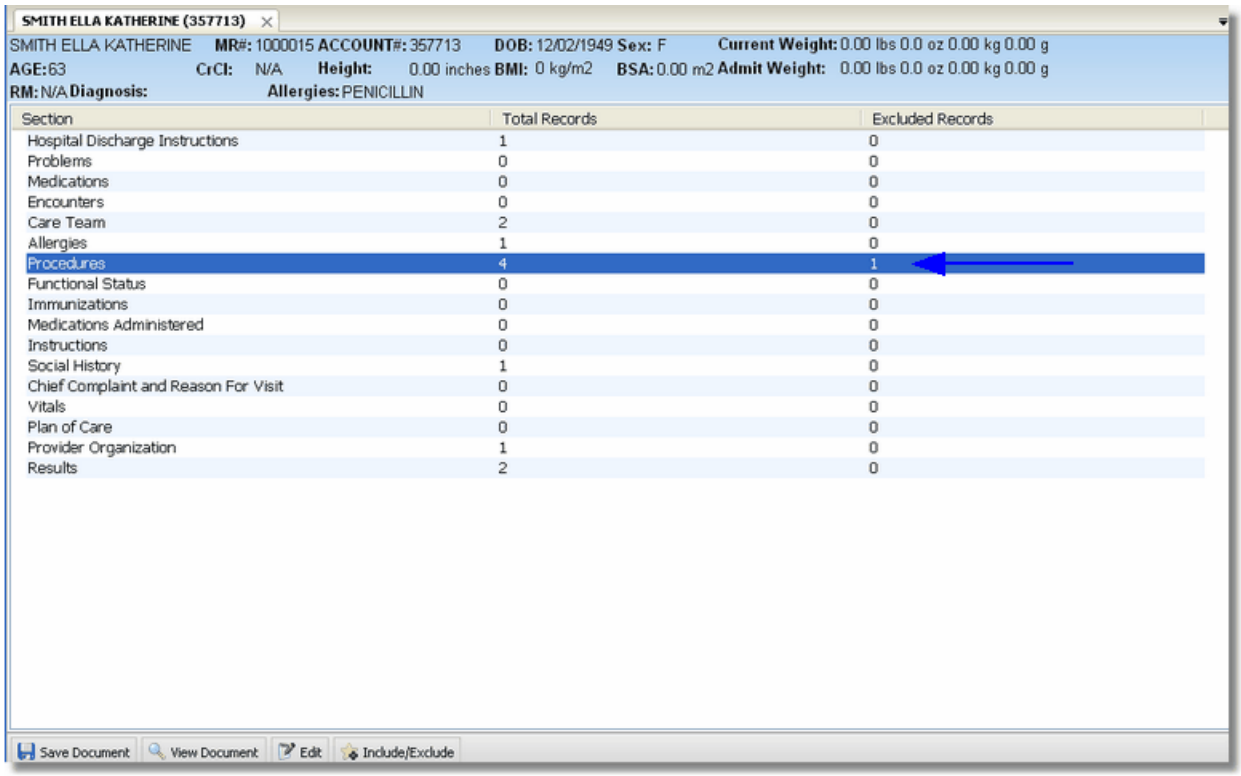



**Figure 1.46 Patient Summary (HL7 CCD)**

## Functional Status

Follow the steps below to edit the Functional Status section of the CCD.

To exclude an individual status, highlight the **Functional Status** section. Once the section is highlighted, select **Edit** on the action bar**.**

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Edit**

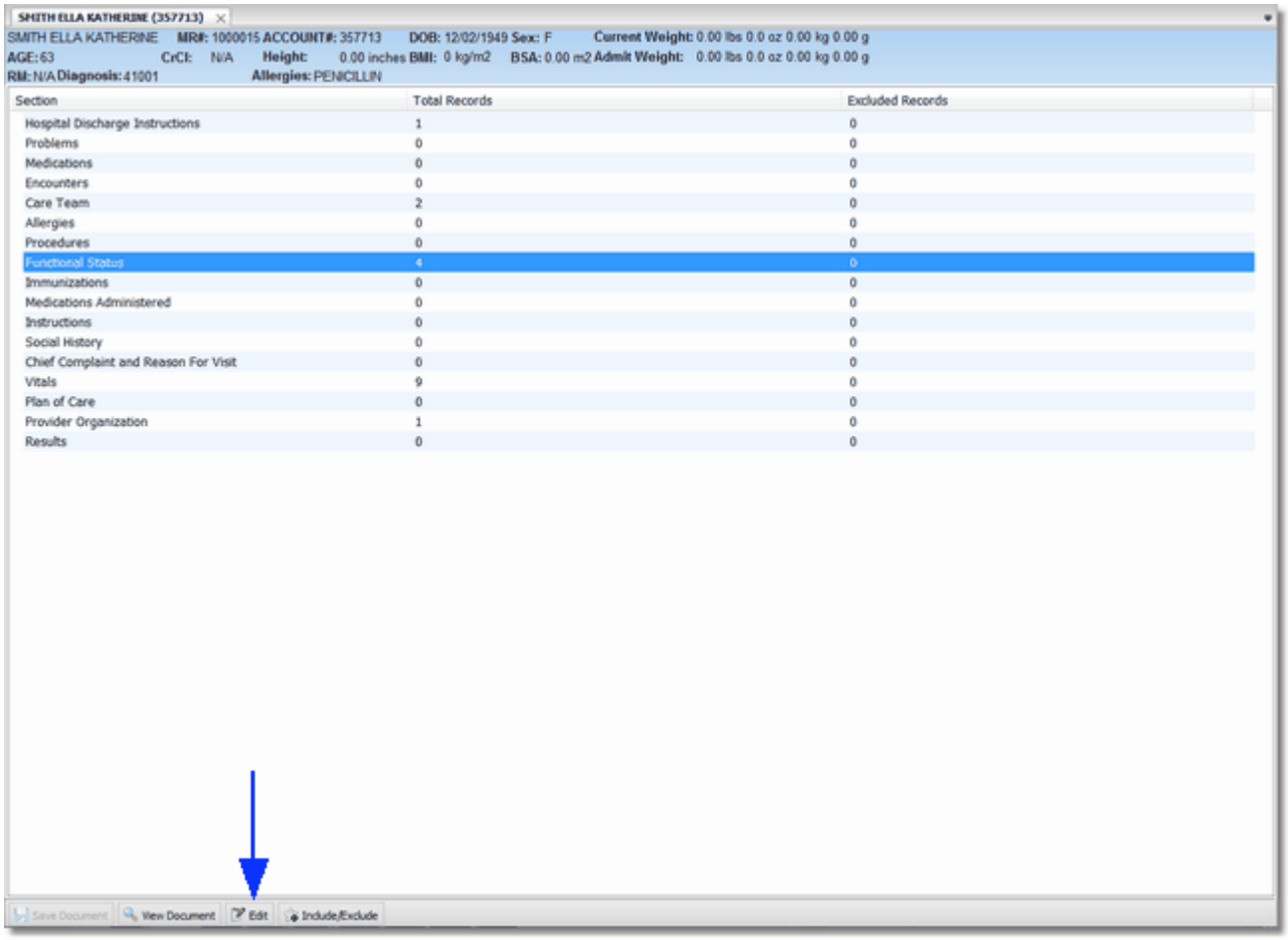



**Figure 1.47 Patient Summary (HL7 CCD)**

Once **Edit** is selected, the individual impairments will display. Highlight the impairment to exclude. Multiple impairments may be selected by holding down the Ctrl key and selecting the desired entries.

When all impairments are highlighted, select **Include/Exclude.** Select the  **back arrow** to return to the list of the sections of the CCD.

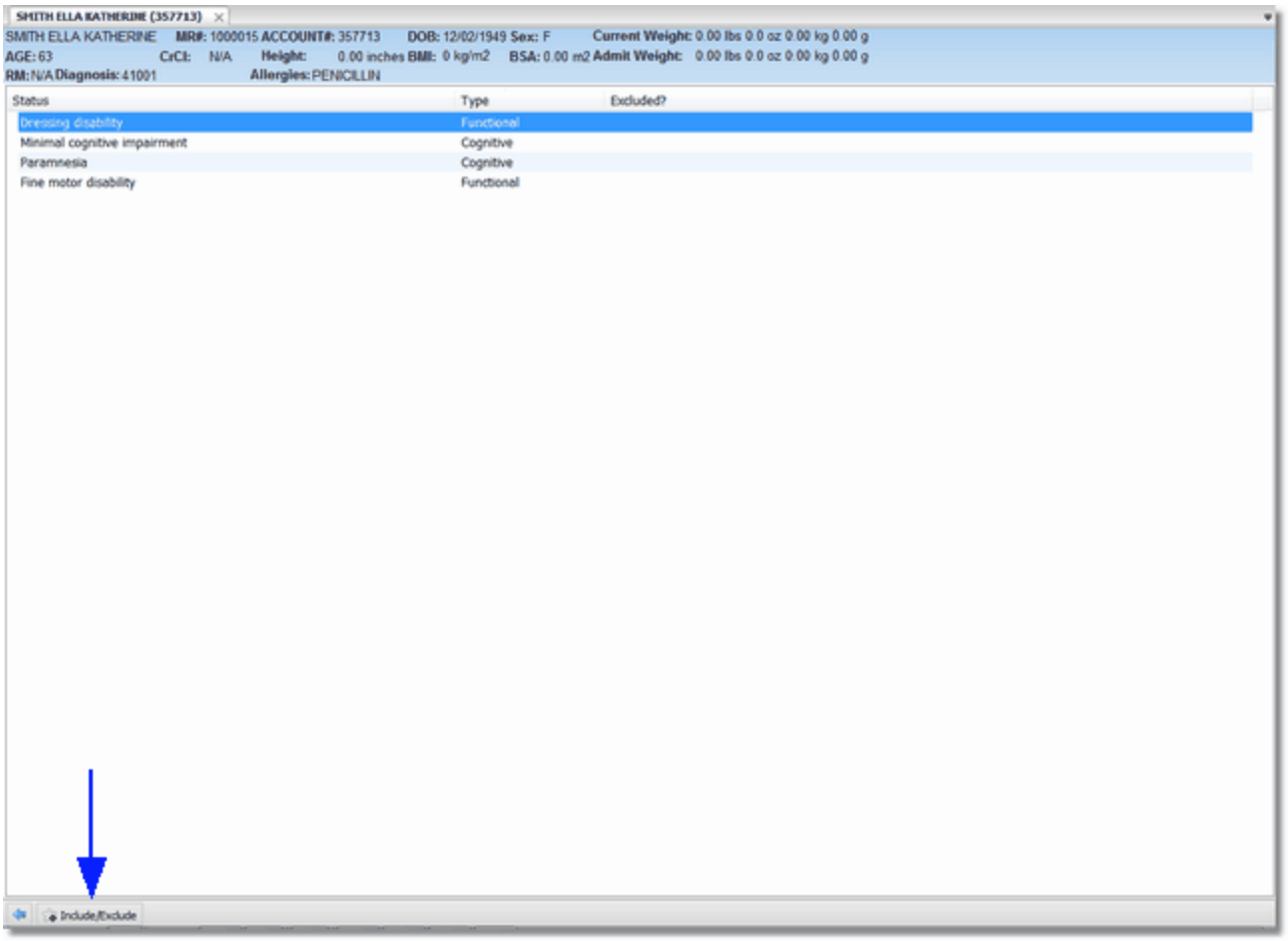



**Figure 1.48 Patient Summary (HL7 CCD)**

The Excluded Records column will now display the number of impairments excluded from the section. Select **Save Document** to save the changes.

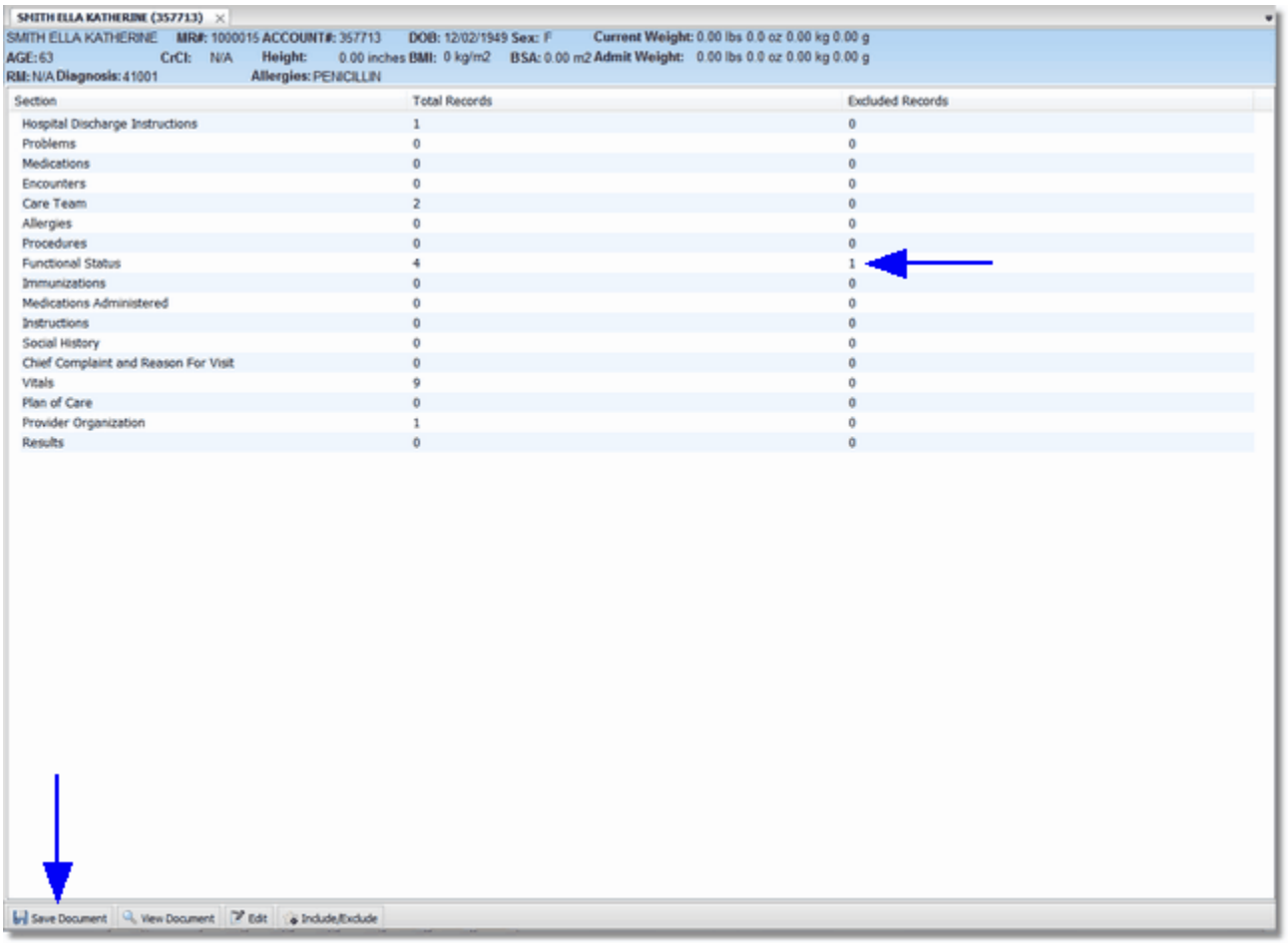



**Figure 1.49 Patient Summary (HL7 CCD)**

## Immunizations

Follow the steps below to edit the Immunizations section of the CCD.

To exclude individual immunizations, highlight the **Immunizations** section. Once the section is highlighted, select **Edit** on the action bar**.**

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Edit**

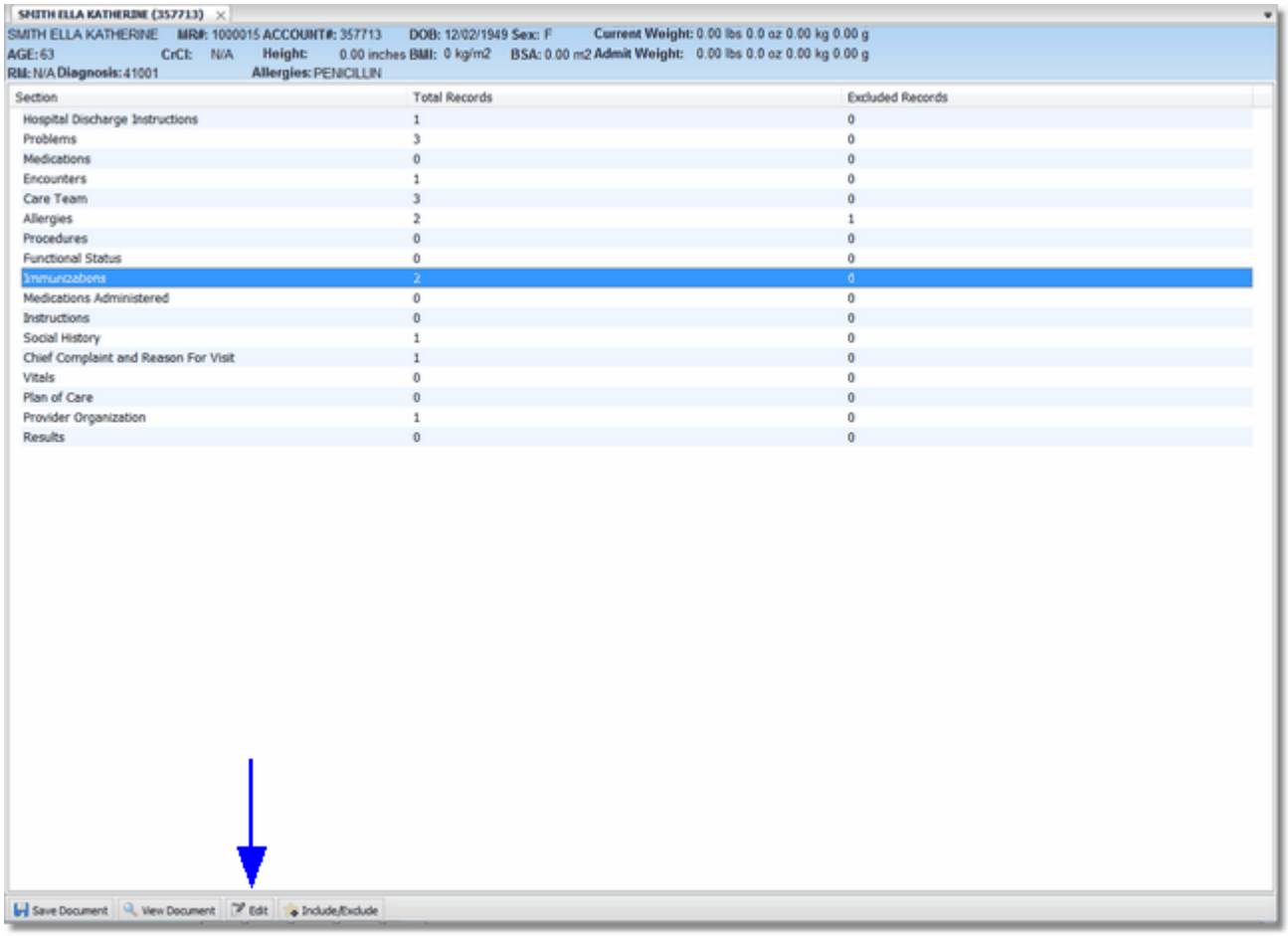



**Figure 1.50 Patient Summary (HL7 CCD)**

Once **Edit** is selected, the individual immunizations will display. Highlight the immunization to exclude. Multiple immunizations may be selected by holding down the Ctrl key and selecting the desired immunizations. When all immunizations are highlighted, select **Include/Exclude.** Select the  **back arrow** to return to the list of the sections of the CCD.

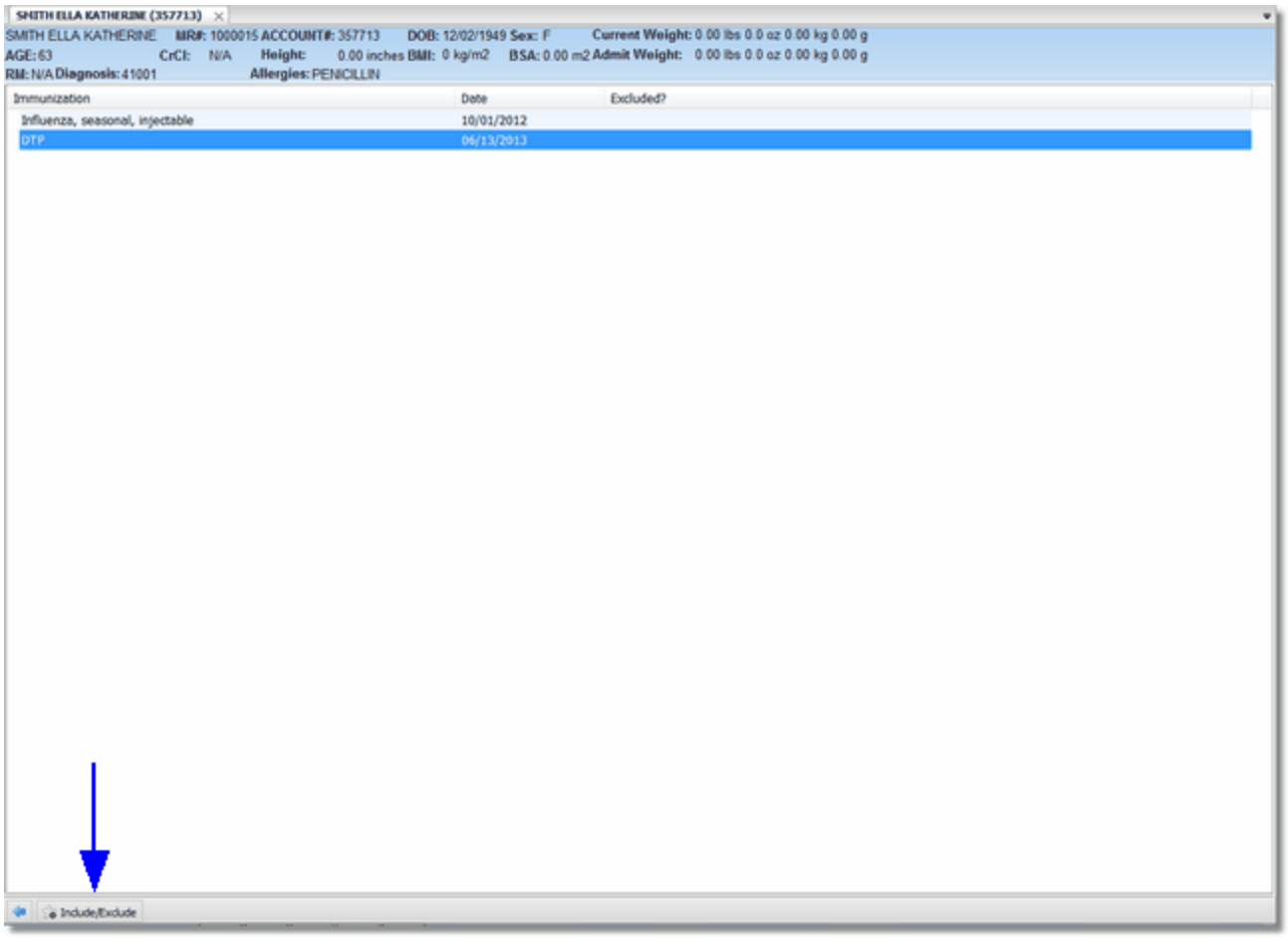



**Figure 1.51 Patient Summary (HL7 CCD)**

The Excluded Records column will now display the number of immunizations excluded from the section. Select **Save Document** to save the changes.

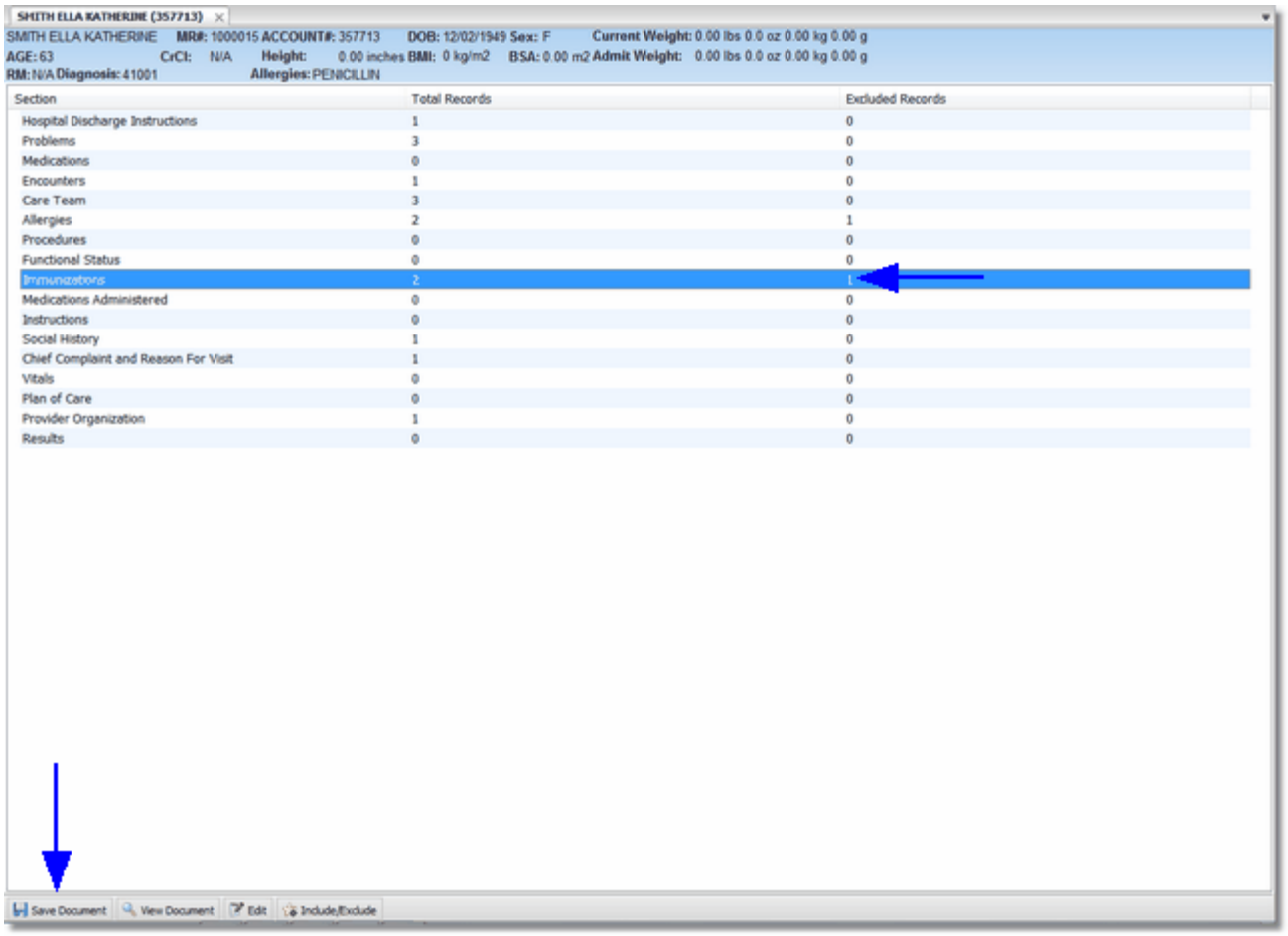



**Figure 1.52 Patient Summary (HL7 CCD)**

## Medications Administered

Follow the steps below to edit the Medications Administered section of the CCD.

To exclude individual medication administrations, highlight the **Medications Administered** section. Once the section is highlighted, select **Edit** on the action bar**.**

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Edit**

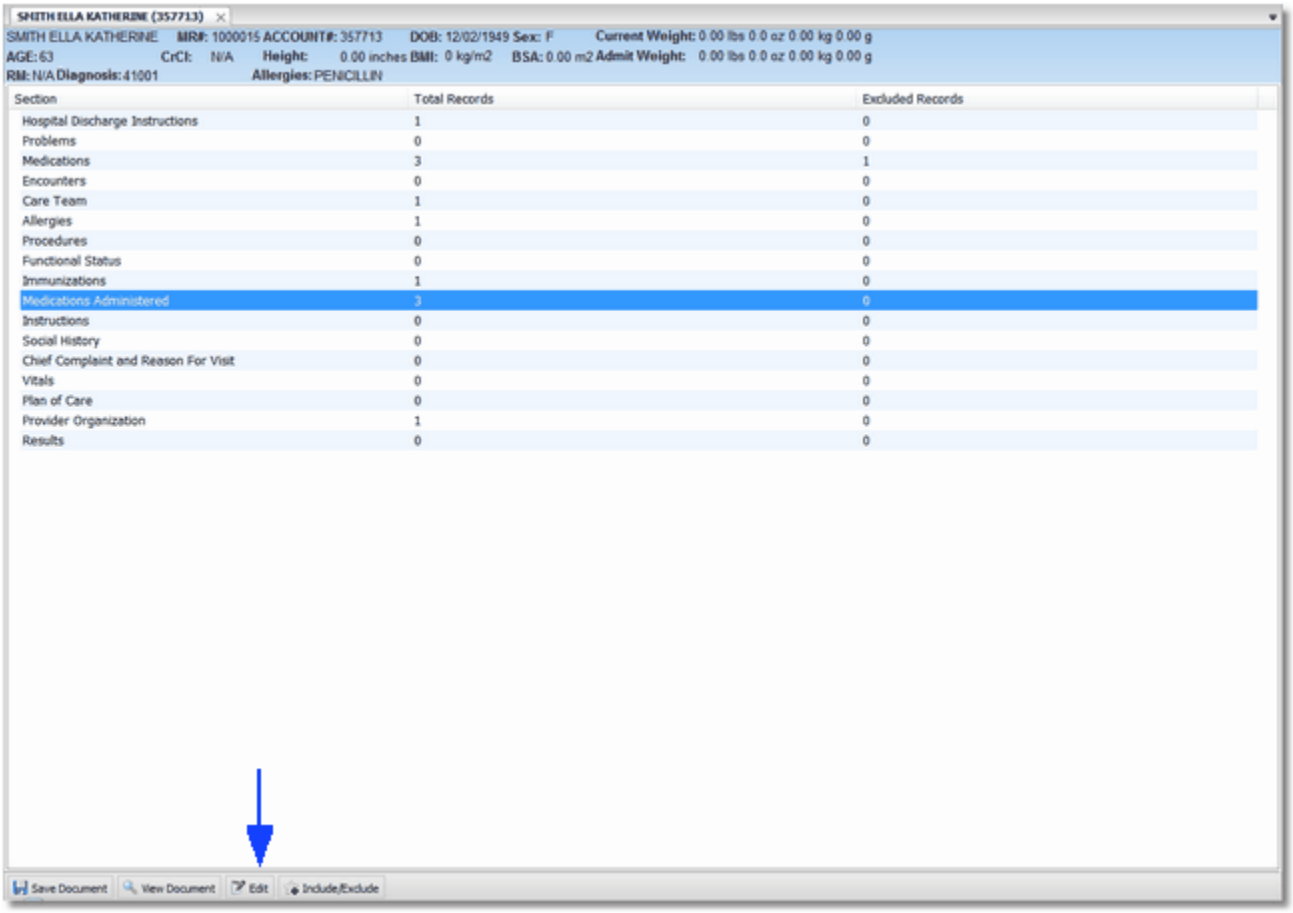



**Figure 1.53 Patient Summary (HL7 CCD)**

Once **Edit** is selected, the individual medication administrations will display. Highlight the medication administration to exclude. Multiple medication administrations may be selected by holding down the Ctrl key and selecting the desired items. When all administrations are highlighted, select **Include/ Exclude.** Select the  **back arrow** to return to the list of the sections of the CCD.

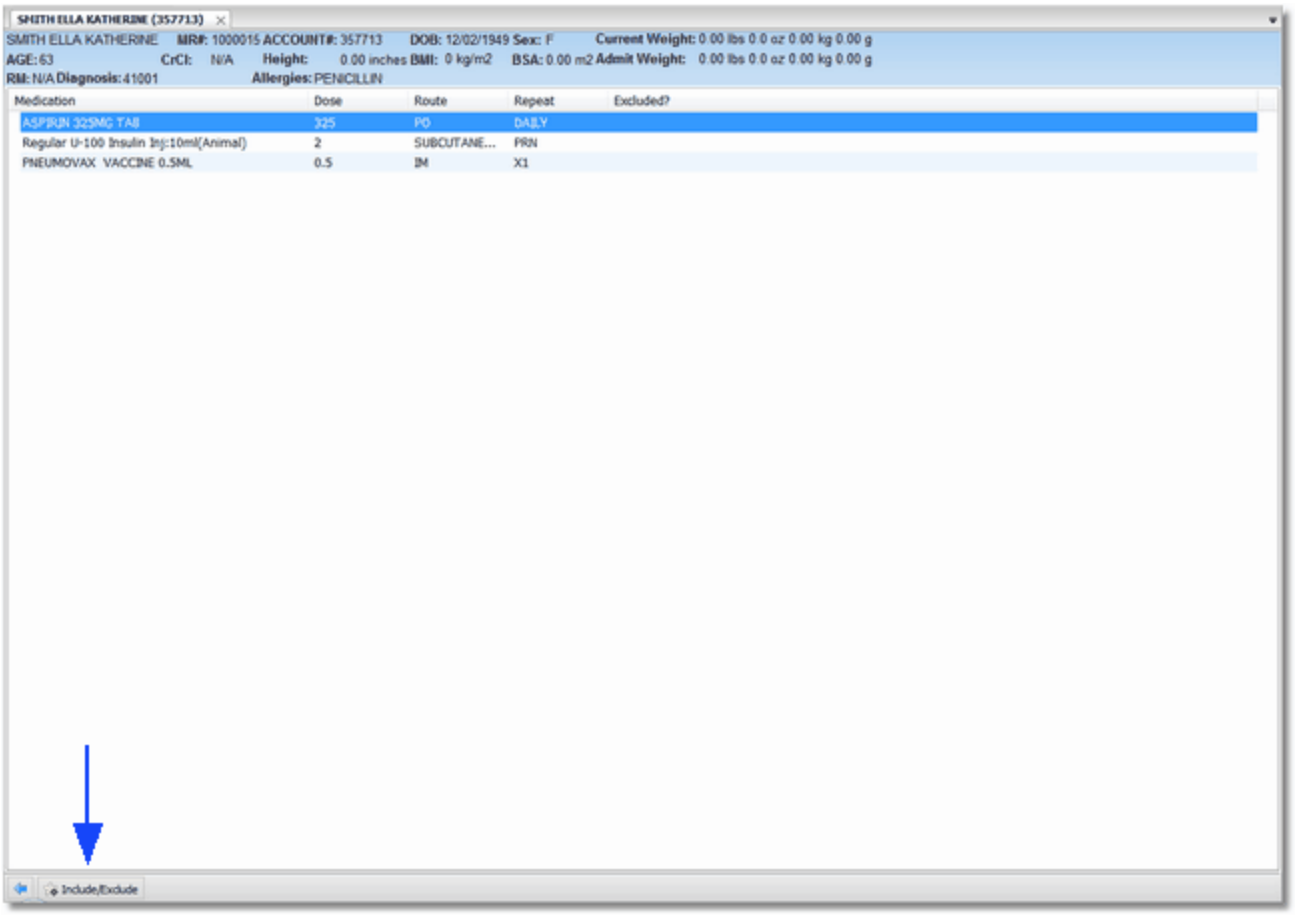



**Figure 1.54 Patient Summary (HL7 CCD)**

The Excluded Records column will now display the number of medication administrations excluded from the section. Select **Save Document** to save the changes.

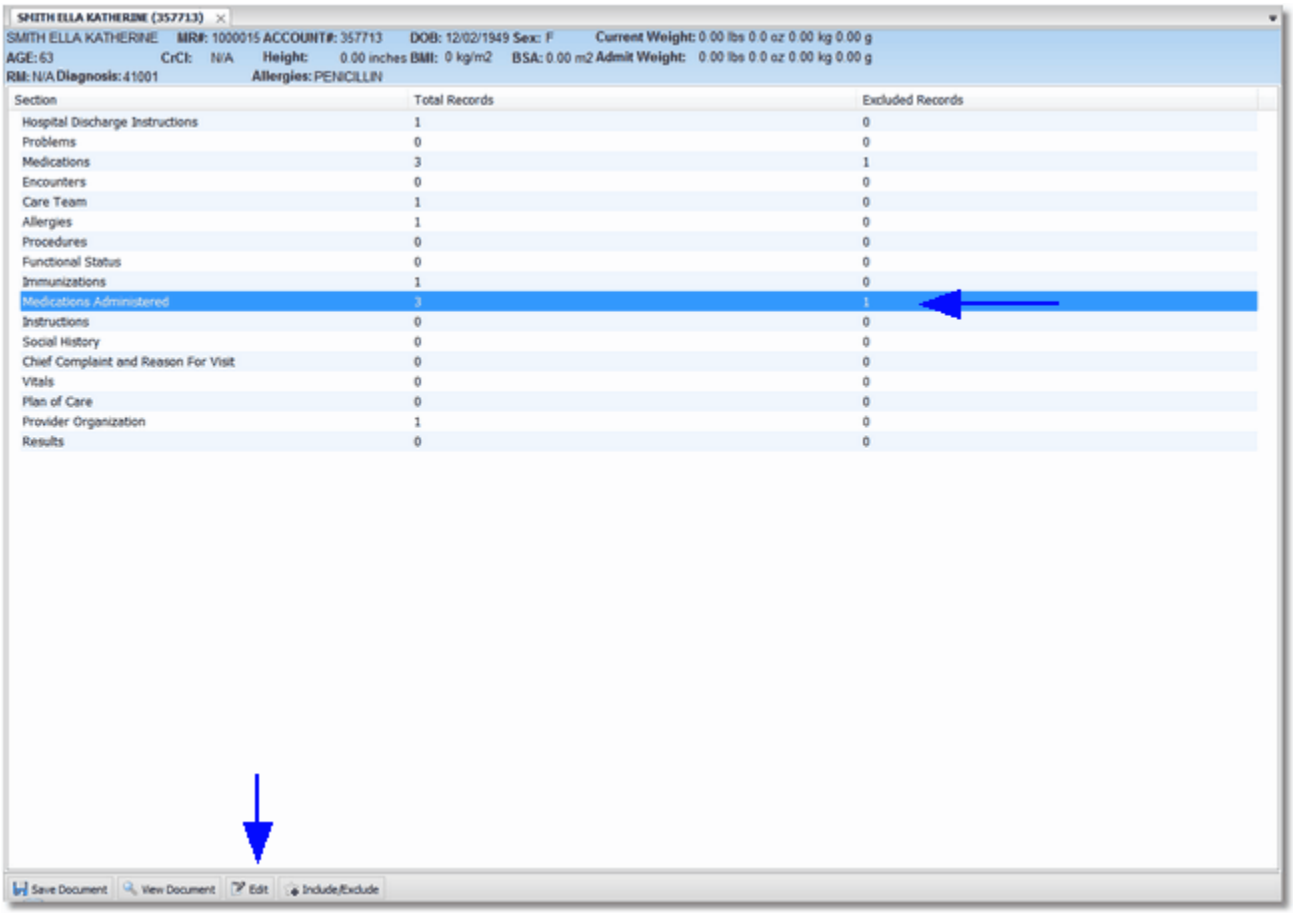



**Figure 1.55 Patient Summary (HL7 CCD)**

## Instructions

At this time, individual components of the Instructions (Patient Decision Aids) section may not be excluded. See Section Edits 15 for excluding the entire section.

## Social History

Follow the steps below to edit the Social History section of the CCD.

To exclude individual components of the Social History section, highlight the **Social History** section. Once the section is highlighted, select **Edit** on the action bar**.**

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Edit**

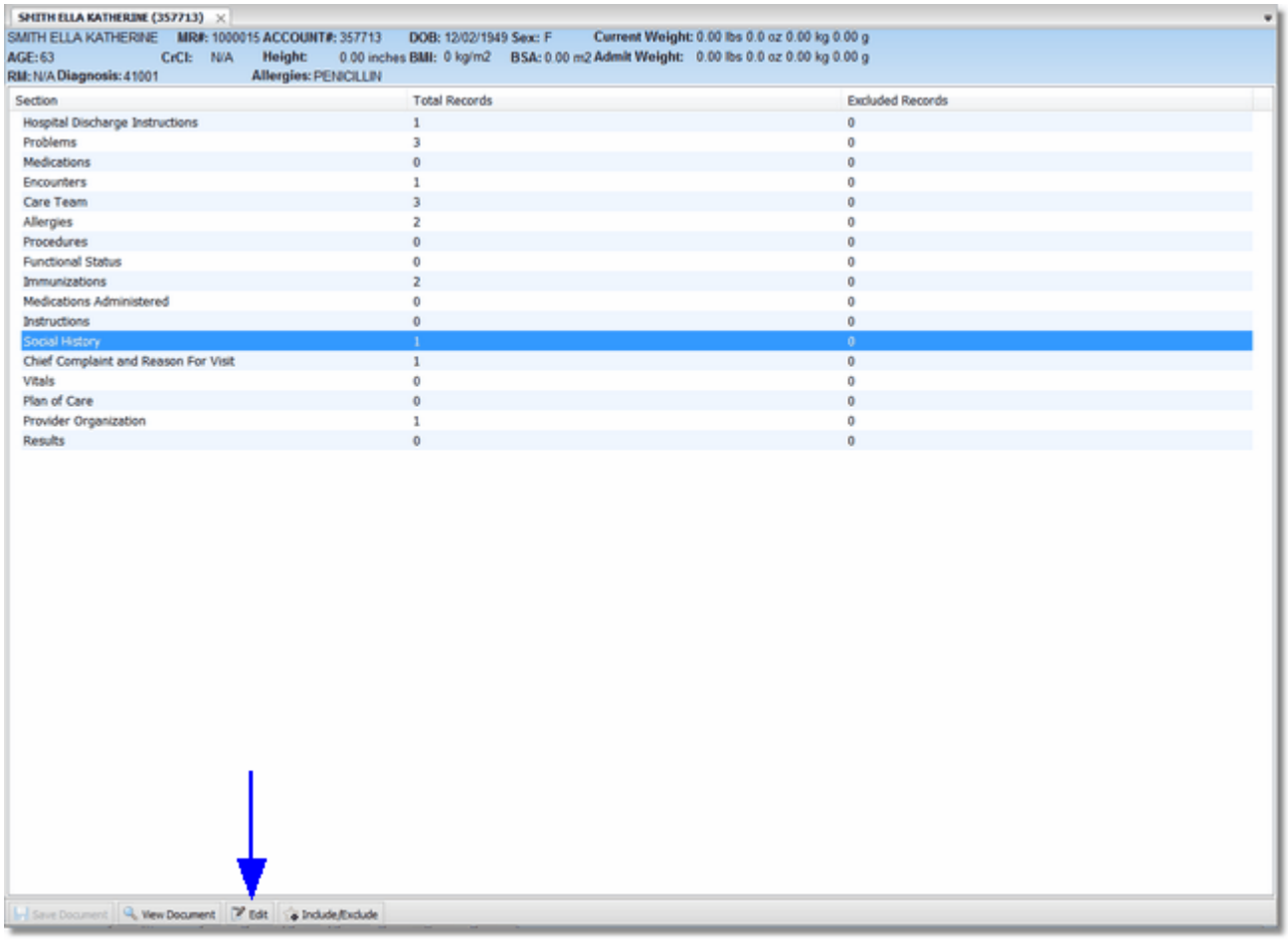



**Figure 1.56 Patient Summary (HL7 CCD)**

Once **Edit** is selected, the individual components of the Social History section will display. Highlight the component to exclude. Once the component is highlighted, select **Include/Exclude.** Select the  **back arrow** to return to the list of the sections of the CCD.

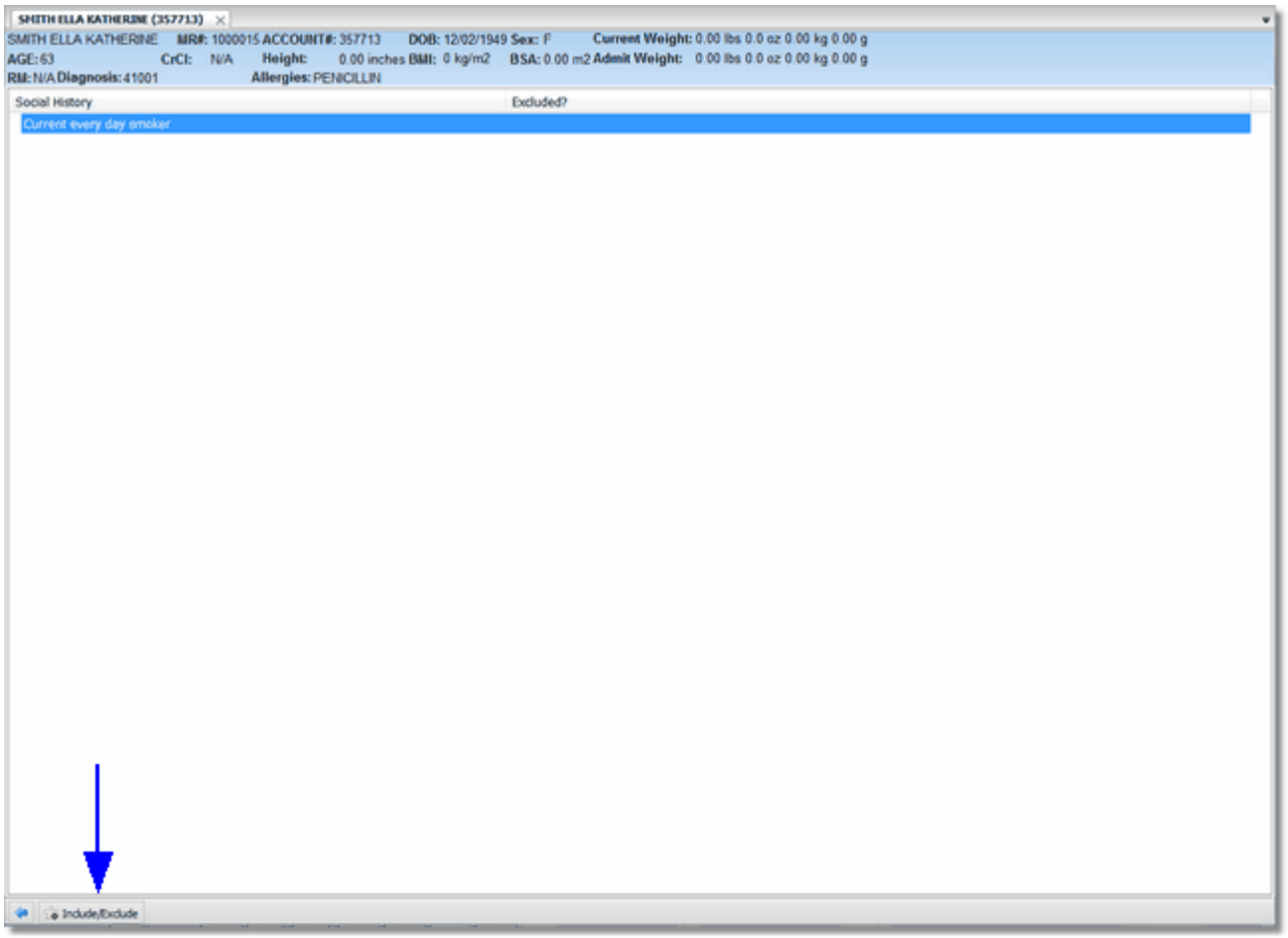



**Figure 1.57 Patient Summary (HL7 CCD)**

The Excluded Records column will now display the number of components excluded from the Social History section. Select **Save Document** to save the changes.

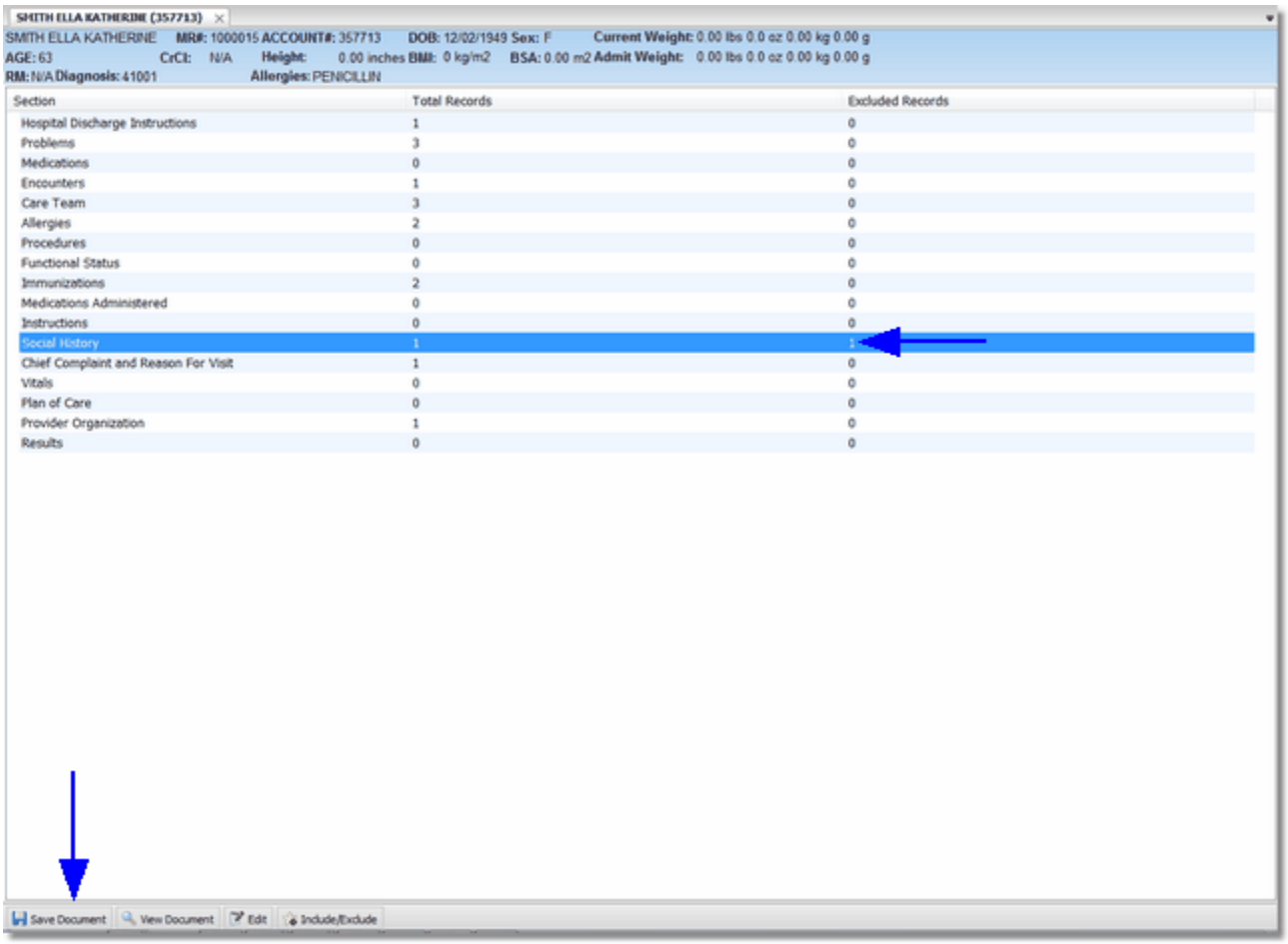



**Figure 1.58 Patient Summary (HL7 CCD)**

## Chief Complaint and Reason For Visit

Follow the steps below to edit the Chief Complaint and Reason For Visit section of the CCD.

There are two editing options available for the Chief Complaint and Reason for Visit section of the CCD:

1. The Chief Complaint and Reason for Visit may be excluded from the CCD.
2. The Chief Complaint and Reason for Visit information may be modified on the CCD.

To exclude the Chief Complaint, highlight the **Chief Complaint and Reason For Visit** section. Once the section is highlighted, select **Edit** on the action bar.

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Edit**

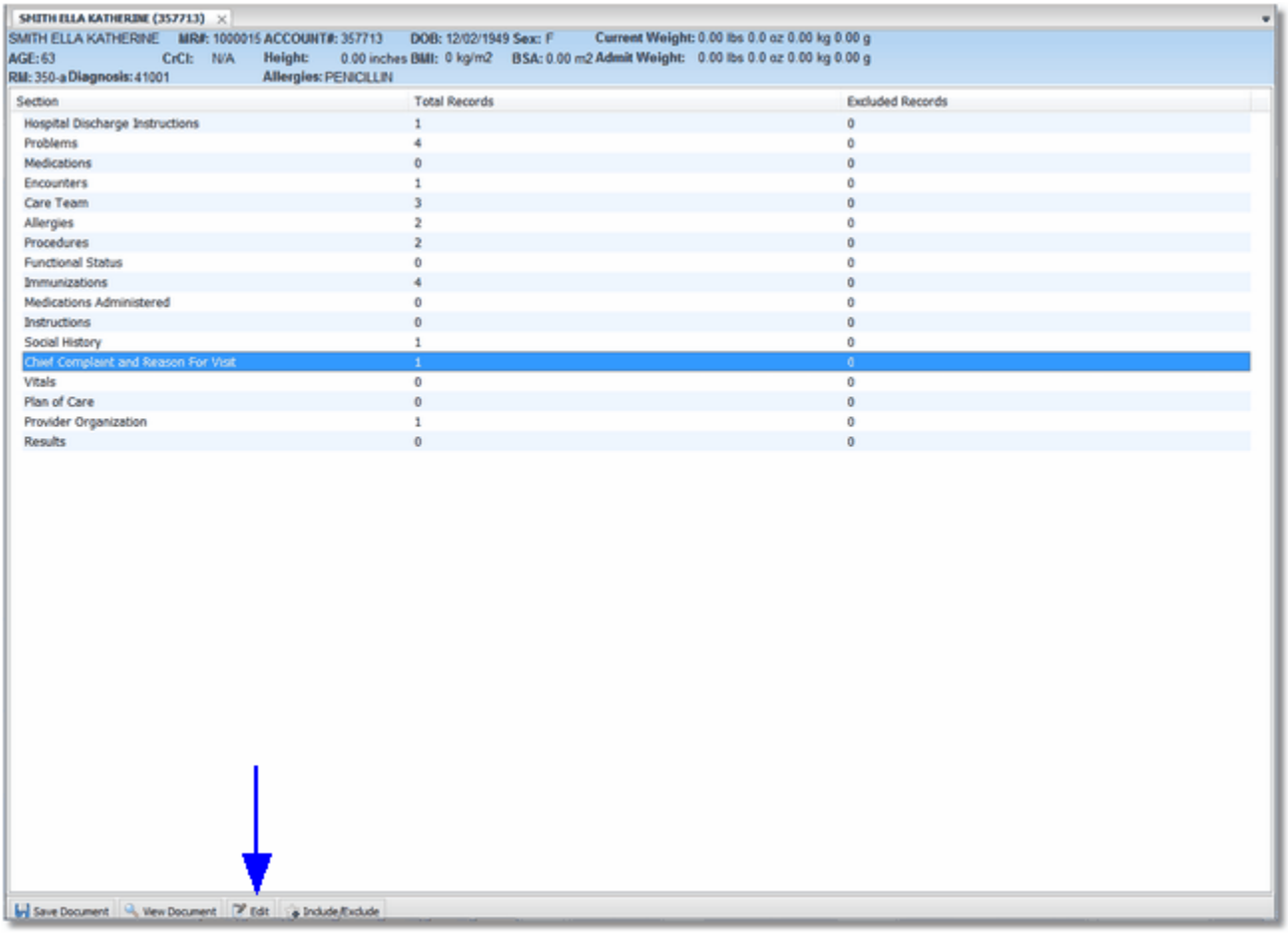



**Figure 1.59 Patient Summary (HL7 CCD)**

Once **Edit** is selected, the Chief Complaint will display. Highlight the Chief Complaint. Once the Chief Complaint is highlighted, select **Include/Exclude.** Select the  **back arrow** to save the information and return to the list of the sections of the CCD.

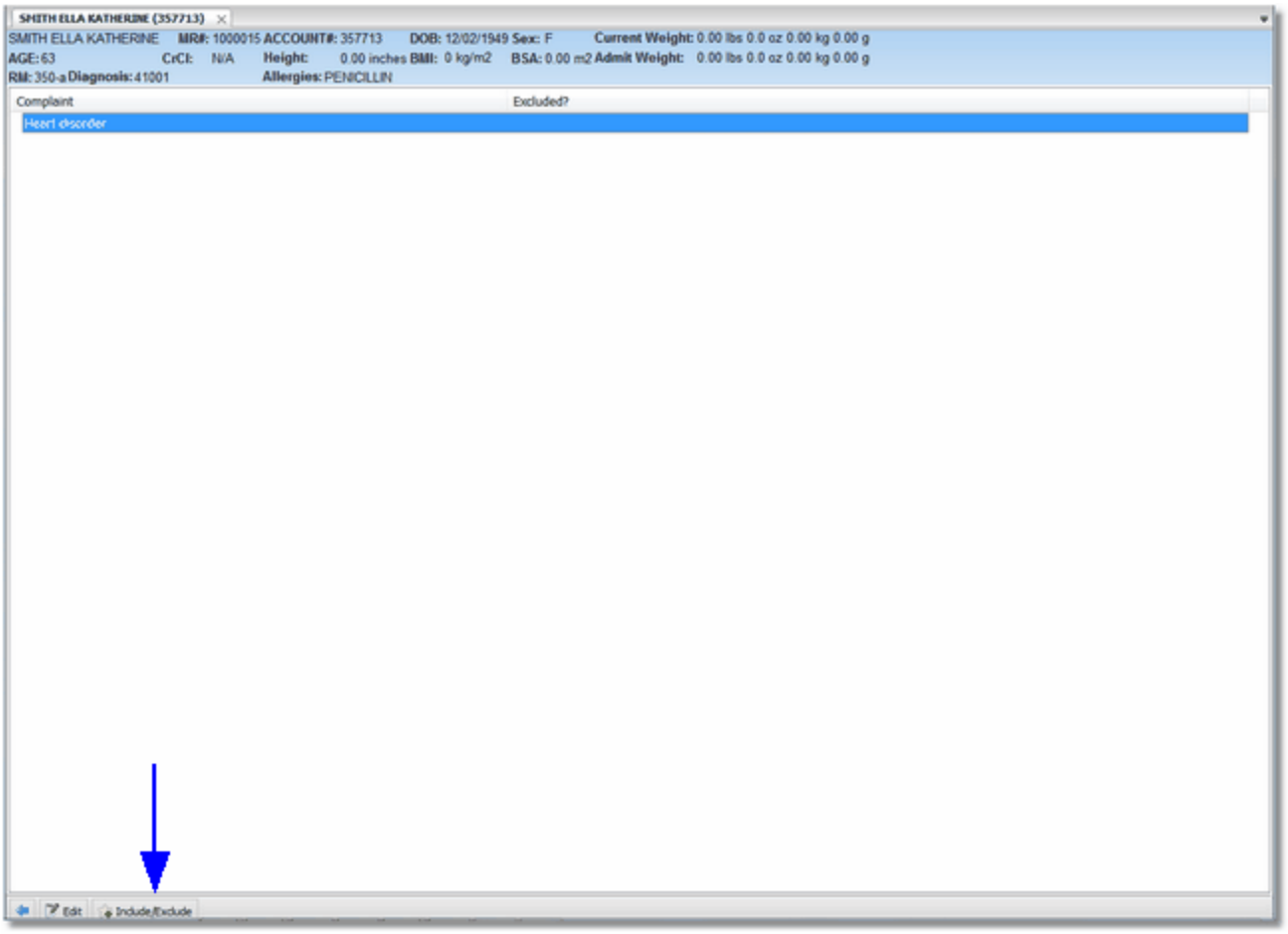



**Figure 1.60 Patient Summary (HL7 CCD)**

The Excluded Records column will now display the Chief Complaint and Reason for Visit were excluded from the section. Select **Save Document** to save the changes.

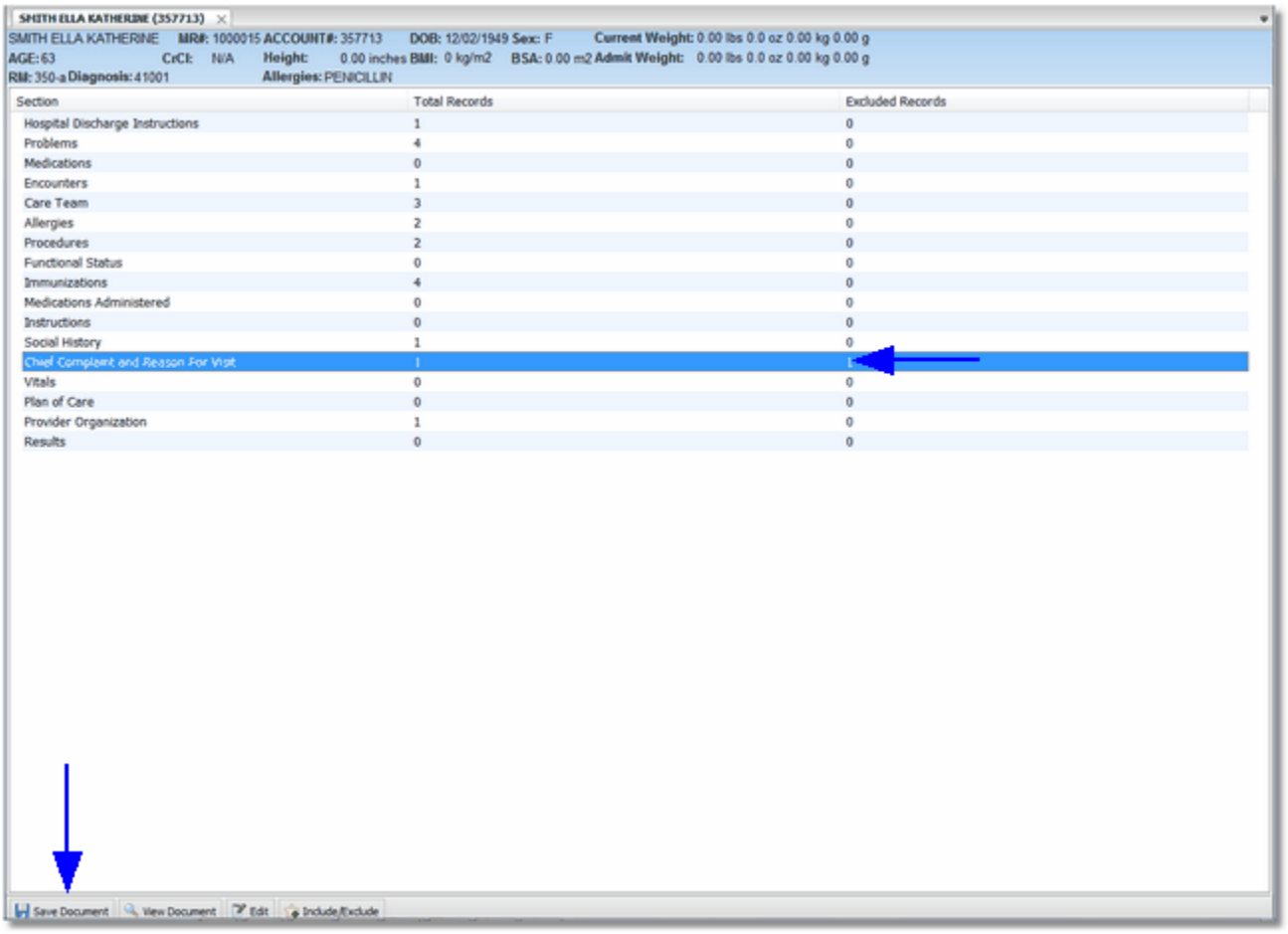



**Figure 1.61 Patient Summary (HL7 CCD)**

To edit the Chief Complaint, highlight the Chief Complaint. Once the Chief Complaint is highlighted, select **Edit** on the action bar.

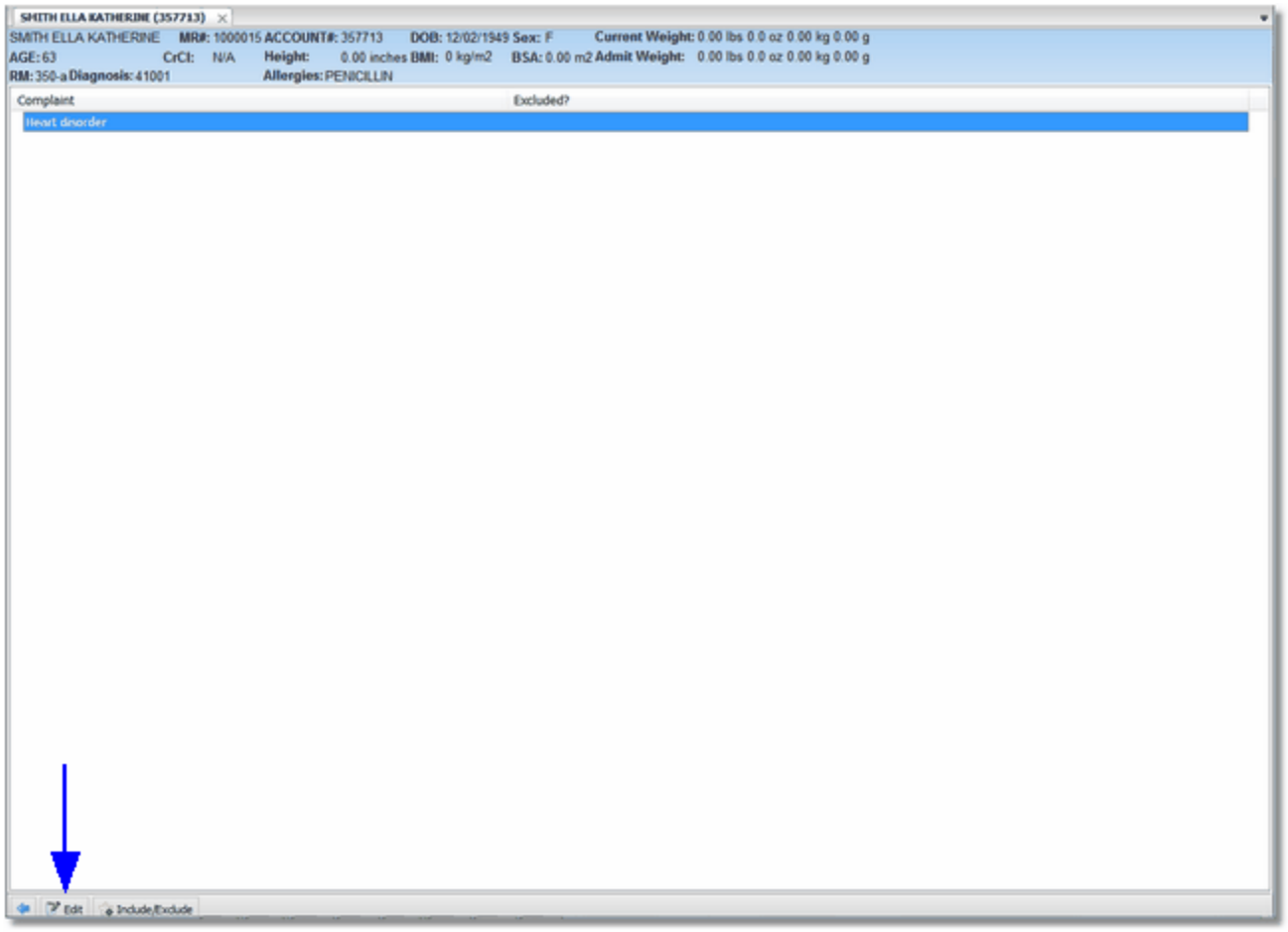



**Figure 1.62 Patient Summary (HL7 CCD)**

Once **Edit** is selected, the Chief Complaint will display. When all the necessary corrections have been made, select the  **back arrow** to save the information and return to the list displaying the Chief Complaint.

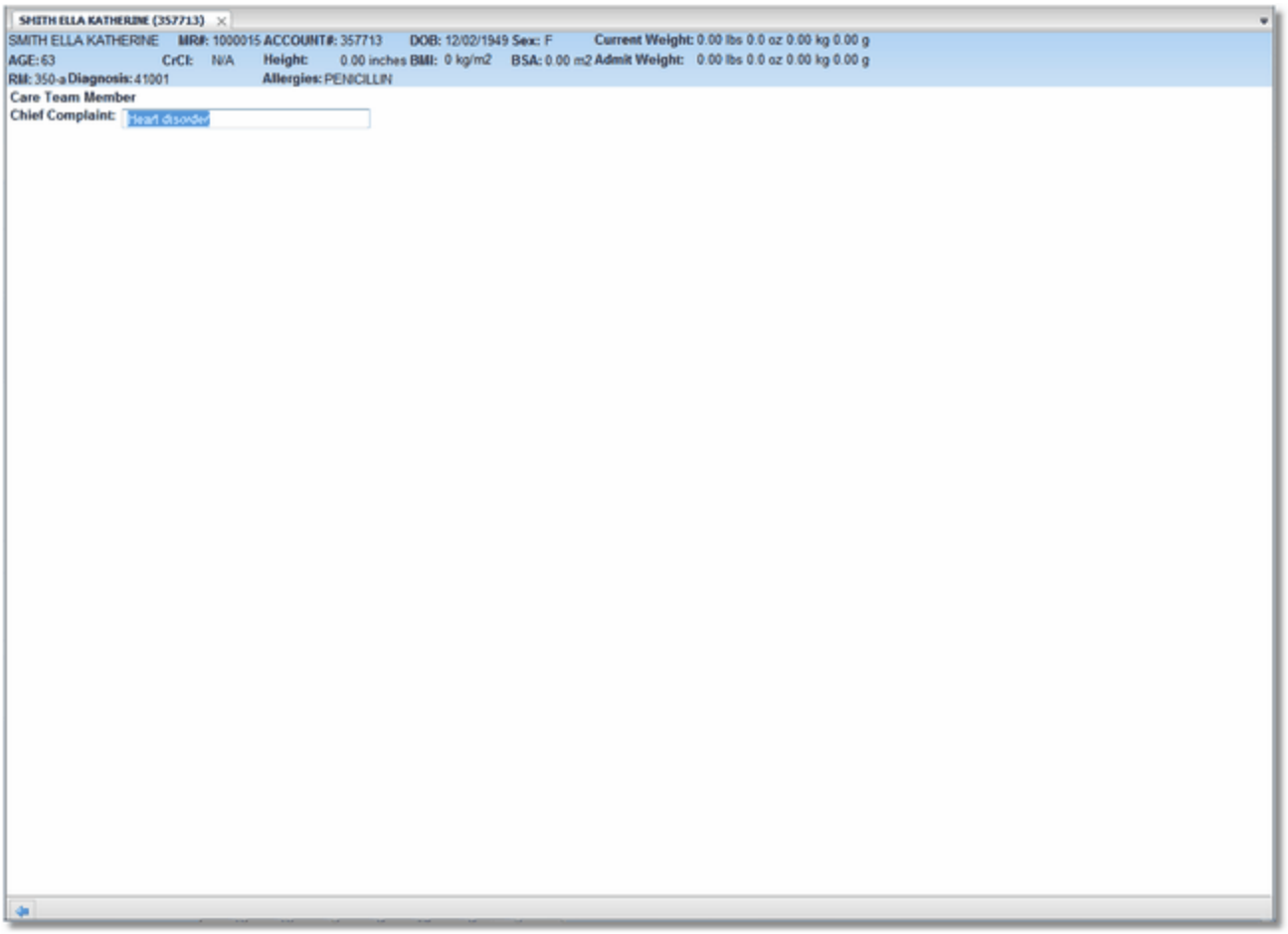



**Figure 1.63 Patient Summary (HL7 CCD)**

## Vitals

Follow the steps below to edit the Vitals section of the CCD.

To exclude individual vital signs, highlight the **Vitals** section. Once the section is highlighted, select **Edit** on the action bar**.**

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Edit**

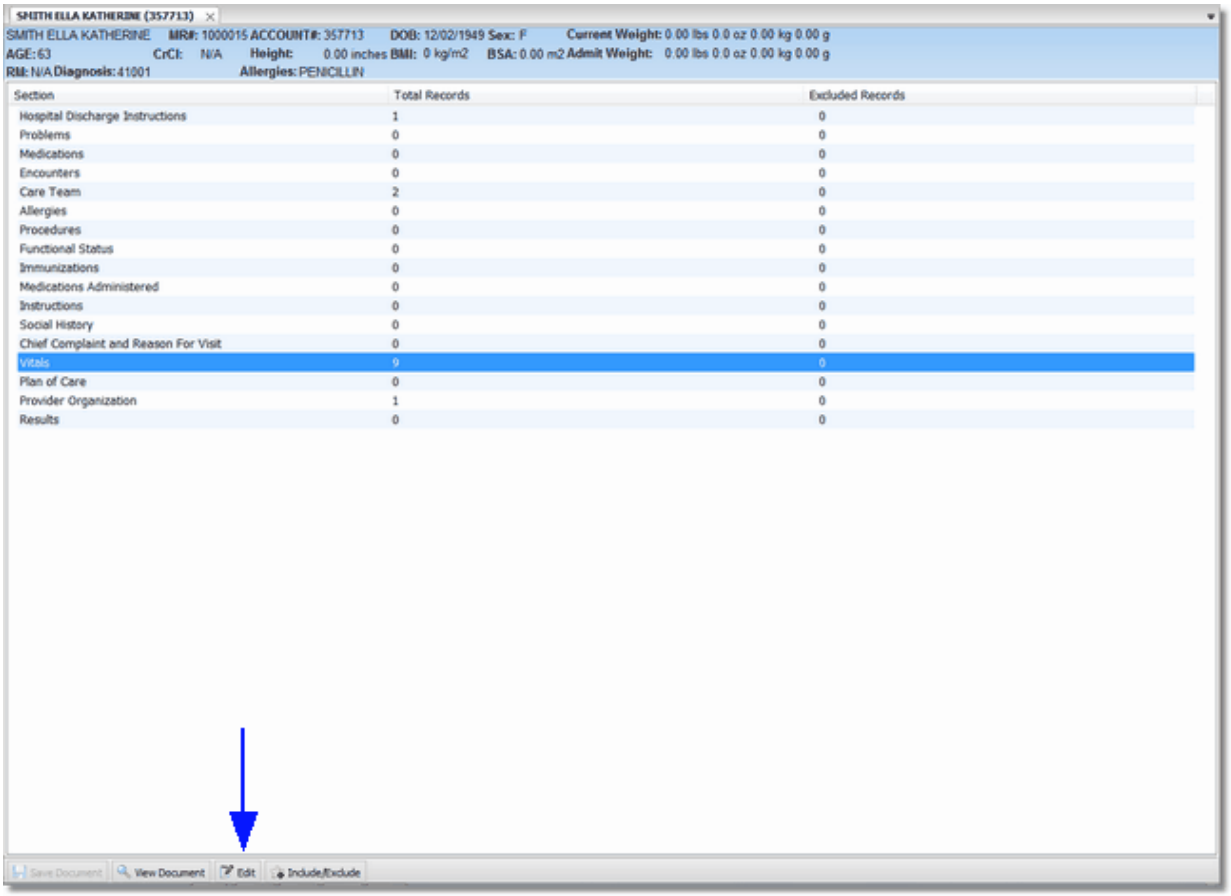



**Figure 1.64 Patient Summary (HL7 CCD)**

Once **Edit** is selected, the vital sign groups will display. Highlight the vital sign group to exclude. Multiple vital sign groups may be selected by holding down the Ctrl key and selecting the desired entries. When all vital sign groups are highlighted, select **Include/Exclude.** Select the  **back arrow** to return to the list of the sections of the CCD.

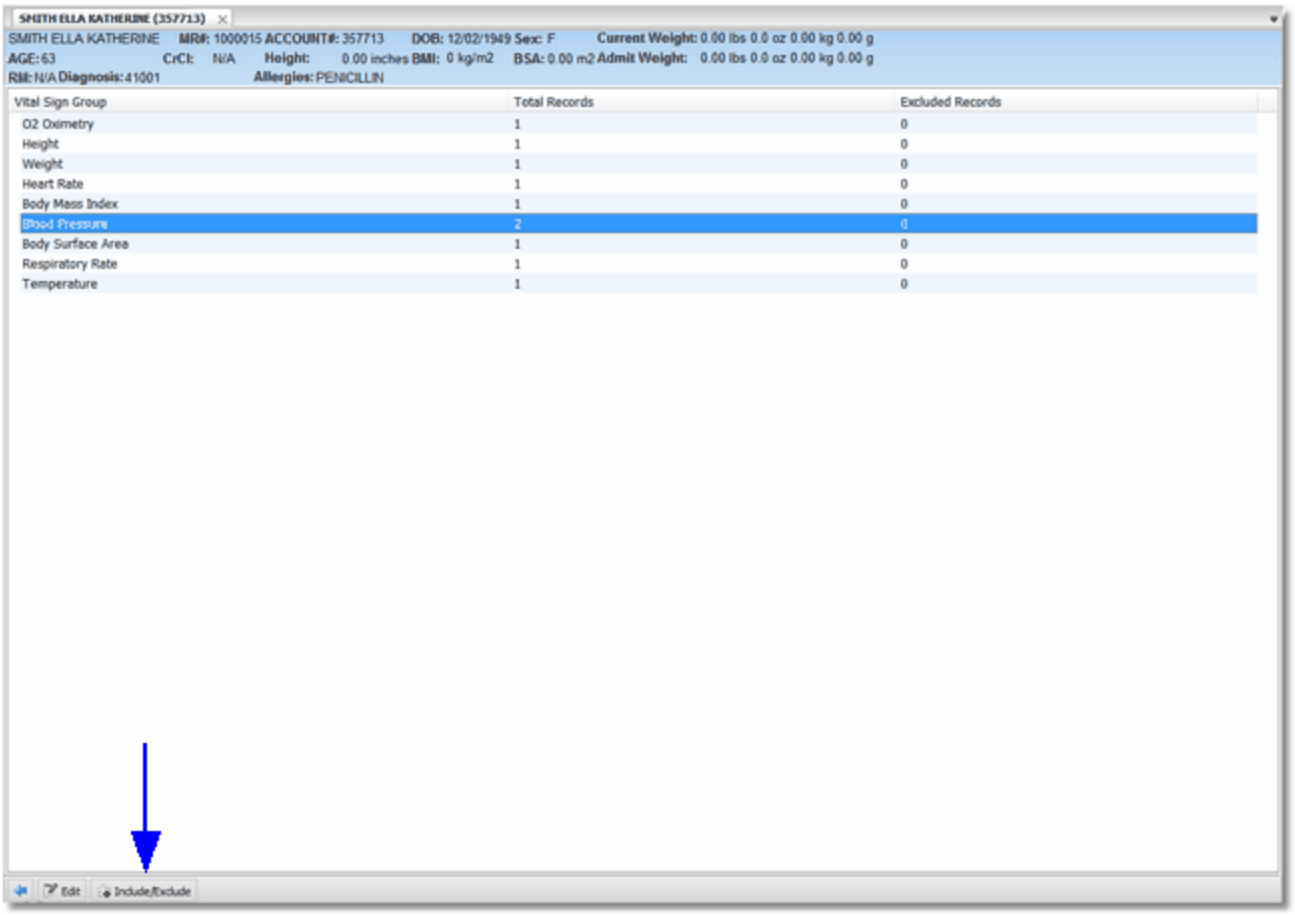



**Figure 1.65 Patient Summary (HL7 CCD)**

Each vital sign group may contain multiple records. To exclude an individual record within a group, select the group then **Edit**. Highlight the vital sign to exclude. Multiple vital signs may be selected by holding down the Ctrl key and selecting the desired entries. When all vital signs are highlighted, select **Include/Exclude.** Select the  **back arrow** to return to the list of vital sign groups.

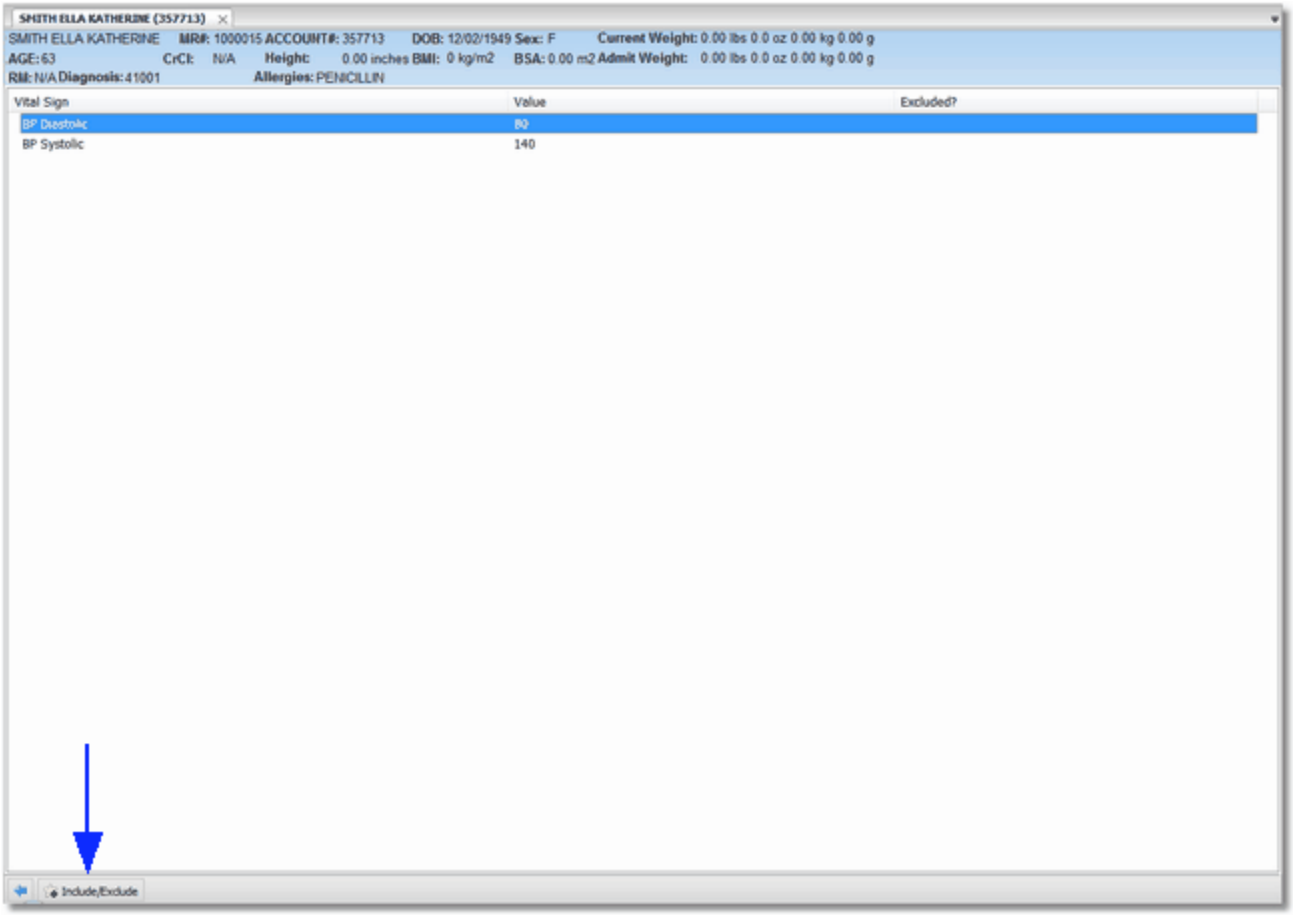



**Figure 1.66 Patient Summary (HL7 CCD)**

The Excluded Records column will now display the number of vital signs excluded from the section. Select **Save Document** to save the changes.

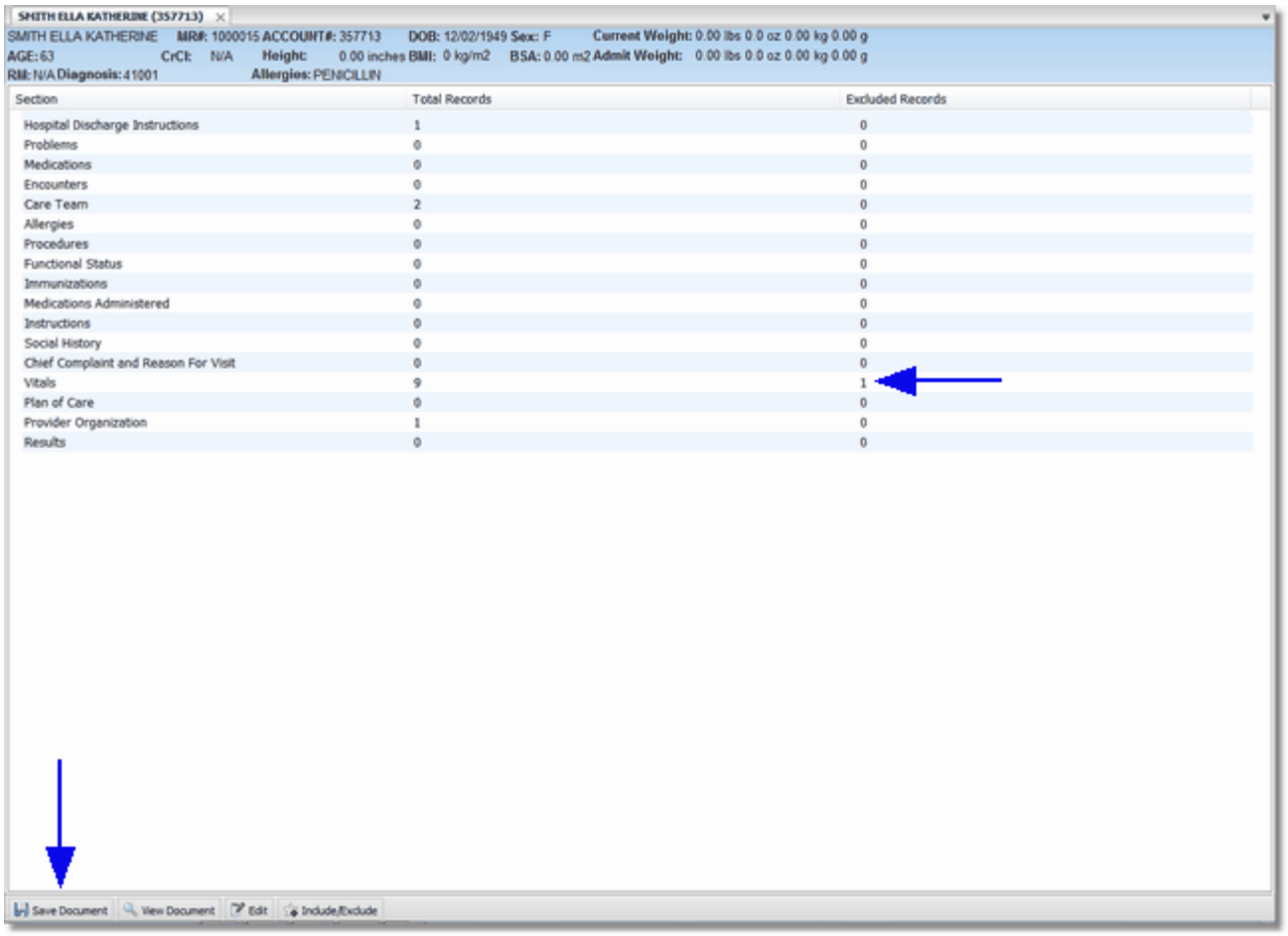



**Figure 1.67 Patient Summary (HL7 CCD)**

## Plan of Care

Follow the steps below to edit the Plan of Care section of the CCD.

To exclude individual problems along with the associated goals and instructions, highlight the **Plan of Care** section. Once the section is highlighted, select **Edit** on the action bar**.**

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Edit**

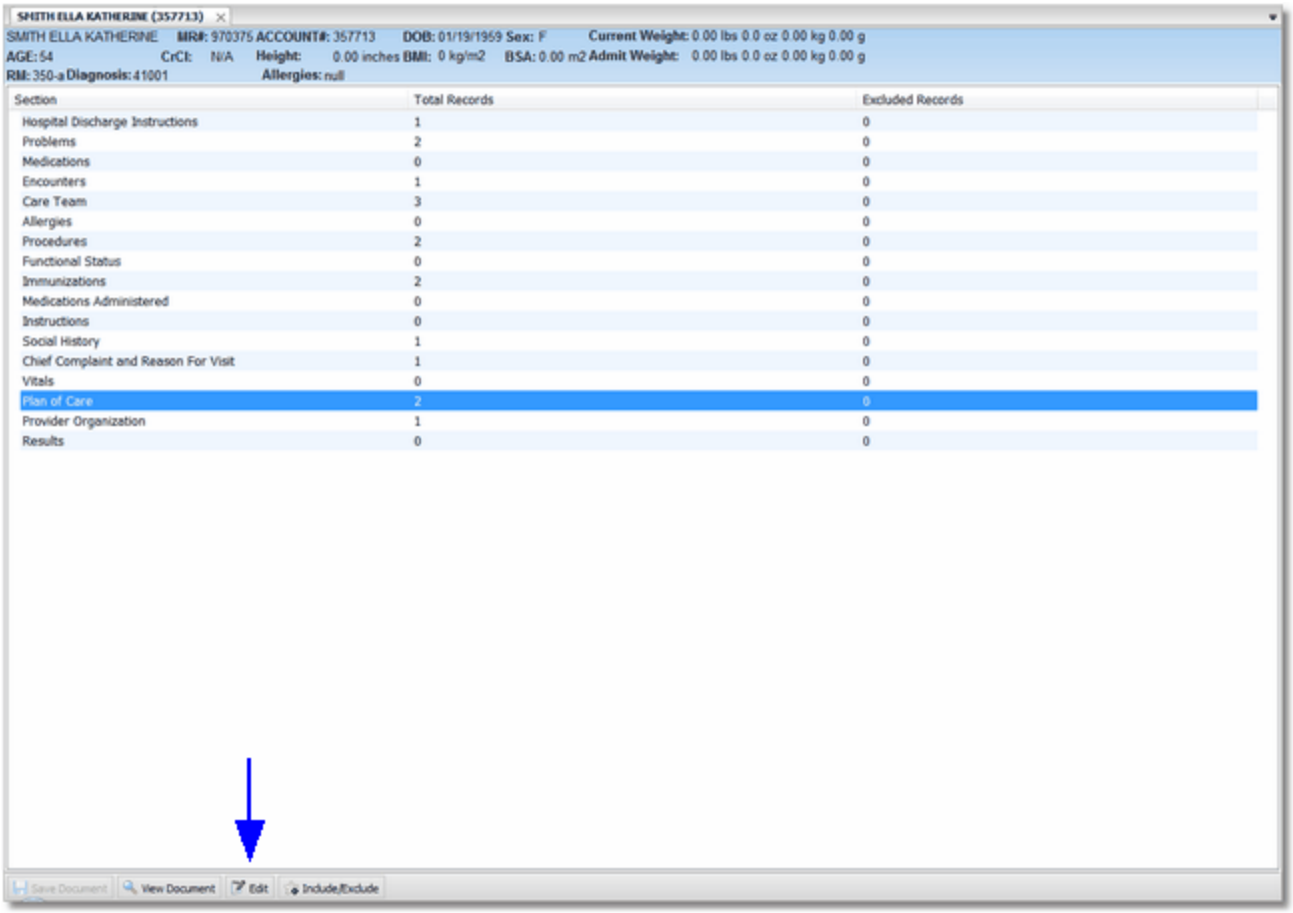



**Figure 1.68 Patient Summary (HL7 CCD)**

Once **Edit** is selected, the individual problems will display. Highlight the problem to exclude. Multiple problems may be selected by holding down the Ctrl key and selecting the desired problems. When all problems are highlighted, select **Include/Exclude.** Select the  **back arrow** to return to the list of the sections of the CCD.

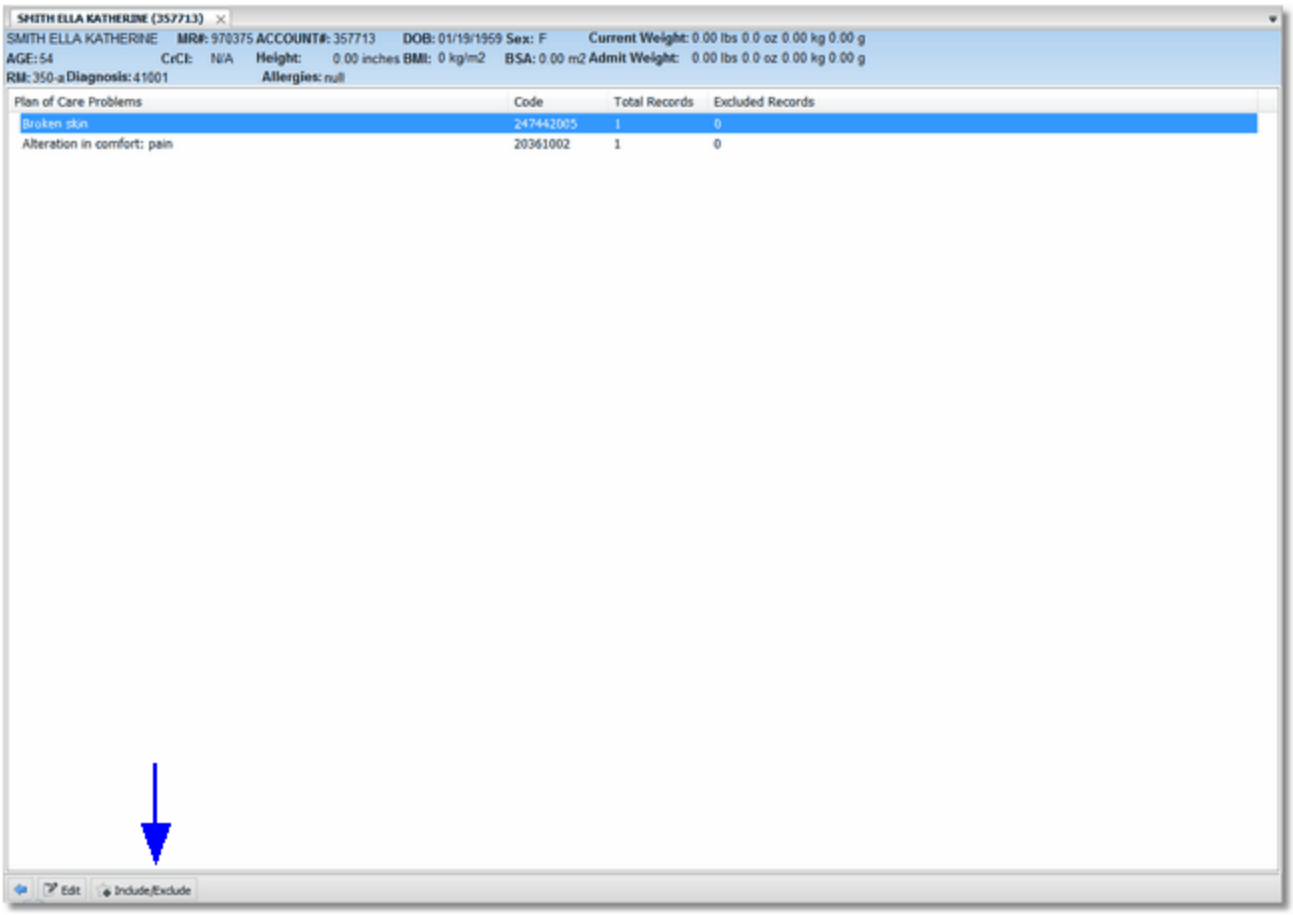



**Figure 1.69 Patient Summary (HL7 CCD)**

The Excluded Records column will now display the number of problems excluded from the section. Select **Save Document** to save the changes.

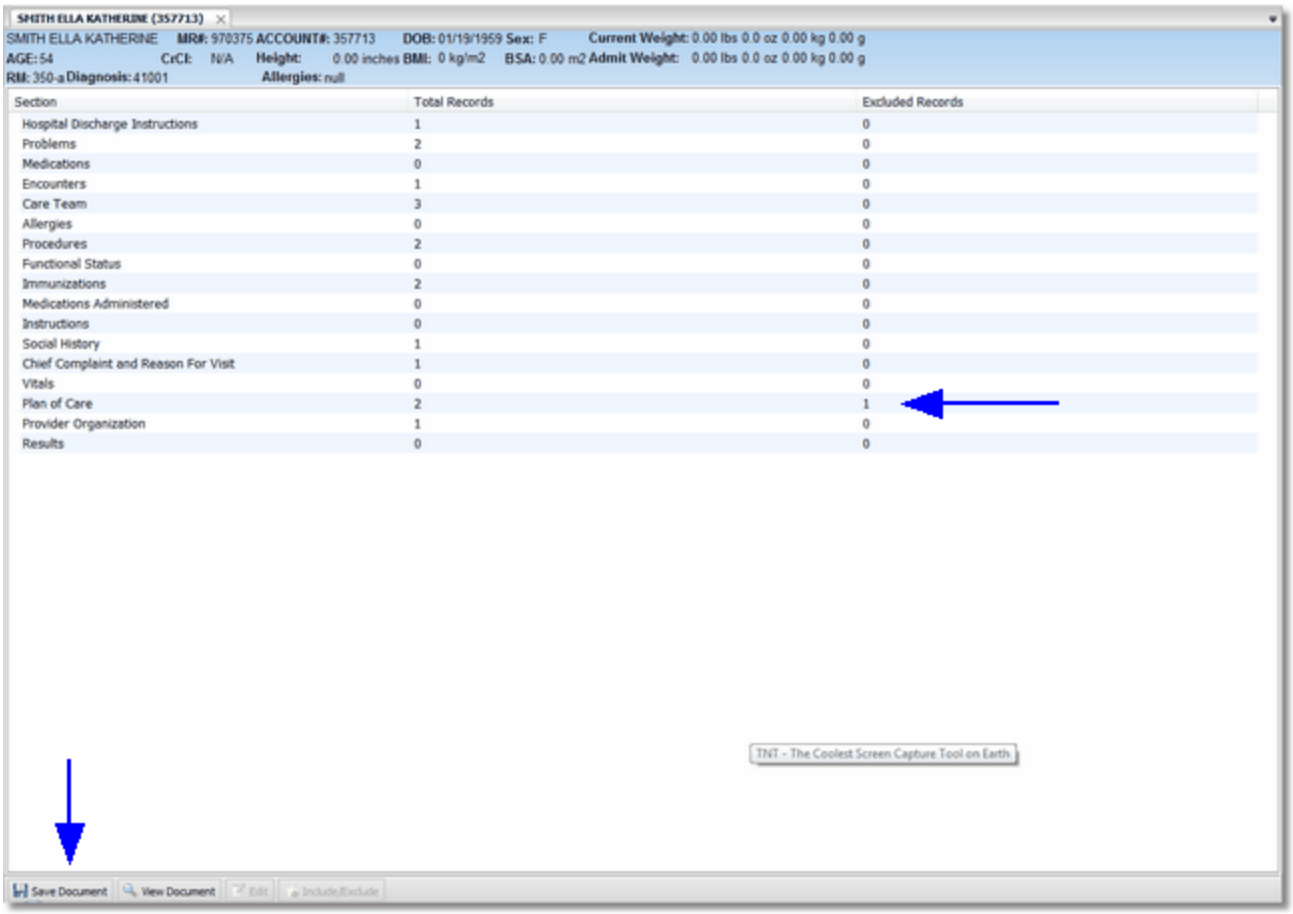



**Figure 1.70 Patient Summary (HL7 CCD)**

To edit a goal and the associated instructions, highlight the problem. Once the problem is highlighted, select **Edit** on the action bar.

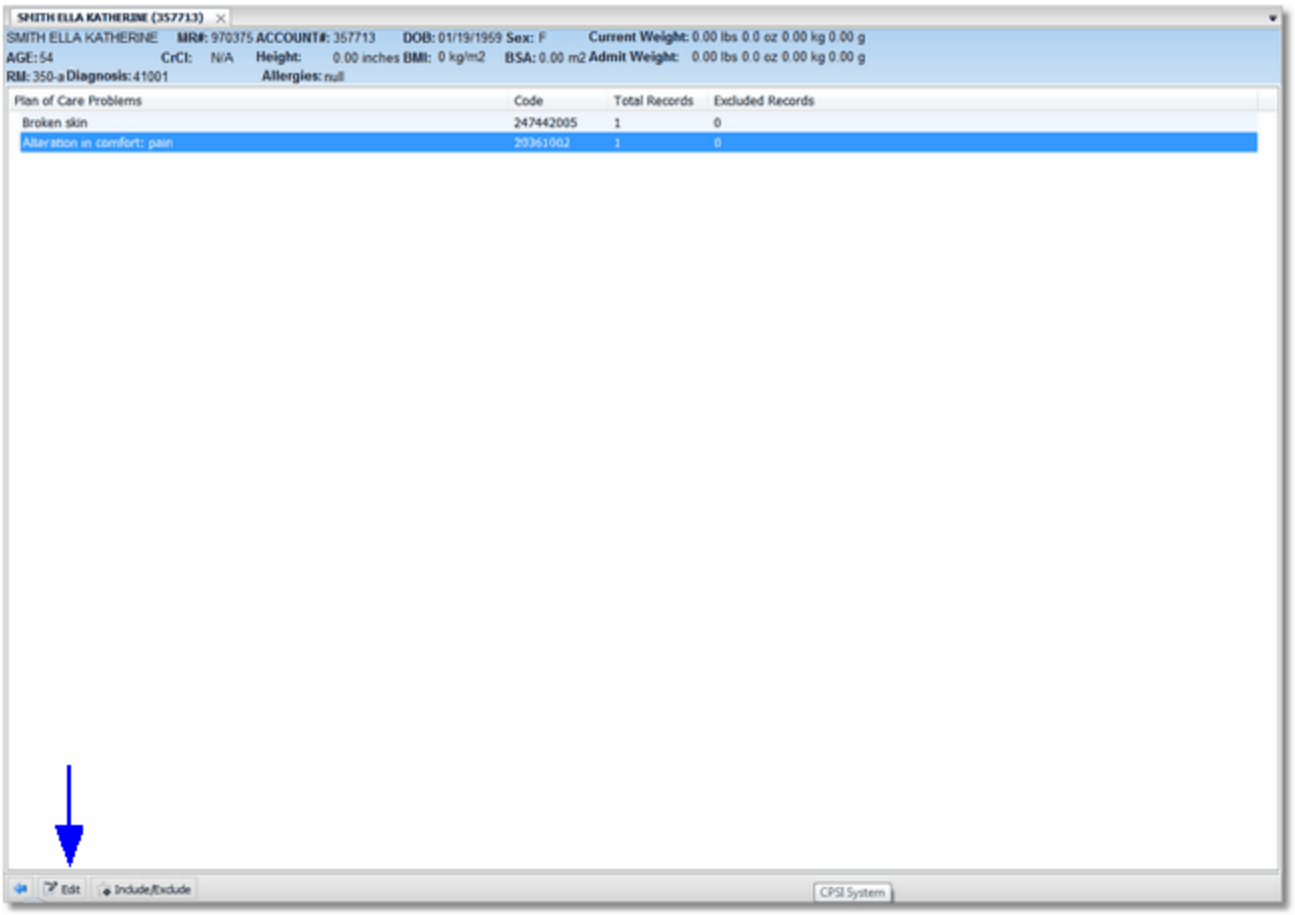



**Figure 1.71 Patient Summary (HL7 CCD)**

Once **Edit** is selected, the goals and instructions for the selected problem will display. Highlight the goal to exclude. Multiple goals may be selected by holding down the Ctrl key and selecting the desired goals. When all goals are highlighted, select **Include/Exclude.** Select the  **back arrow** to return to the list of the sections of the CCD.

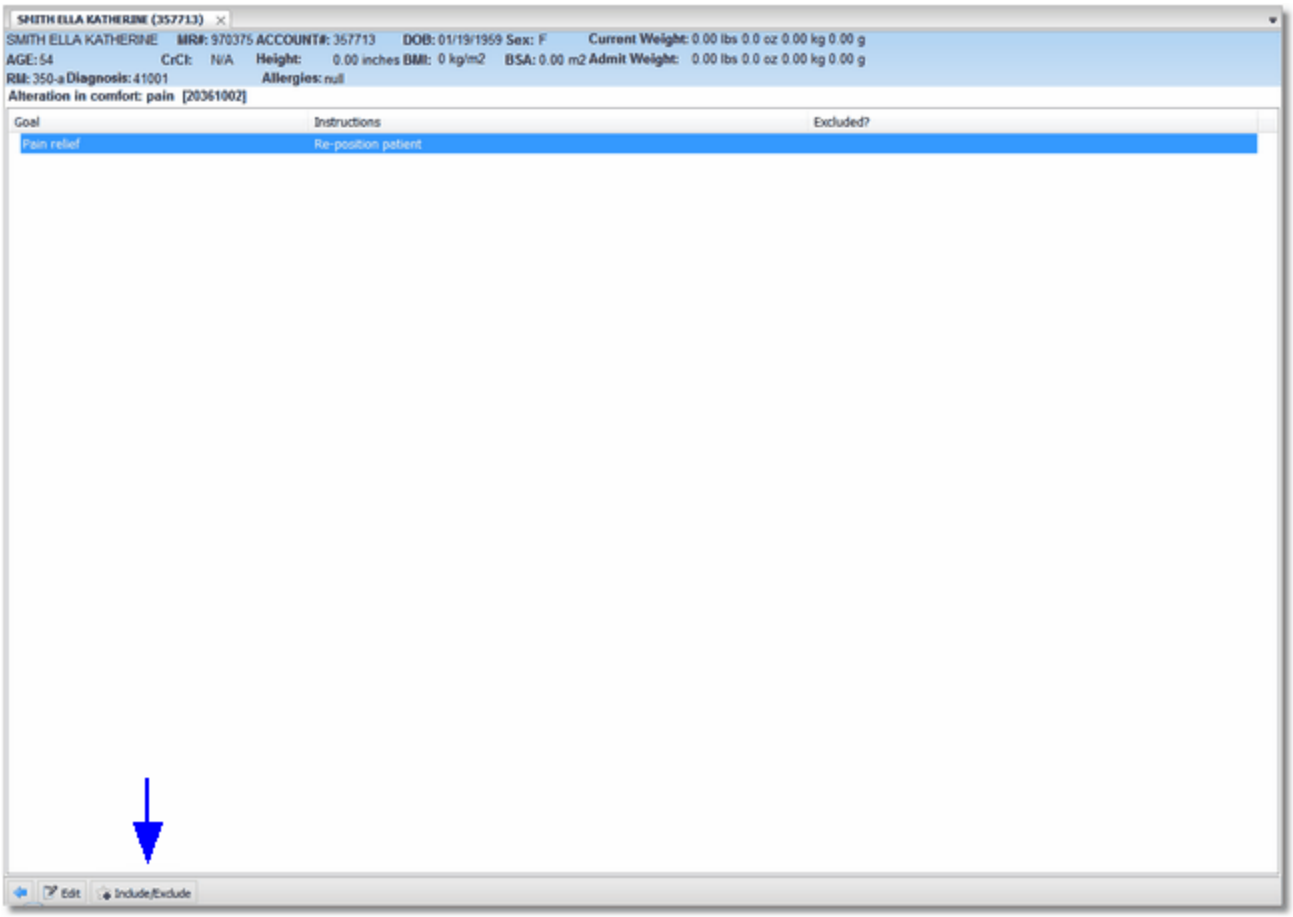



**Figure 1.72 Patient Summary (HL7 CCD)**

To edit the instructions associated with a goal, highlight the goal then select **Edit** from the action bar.

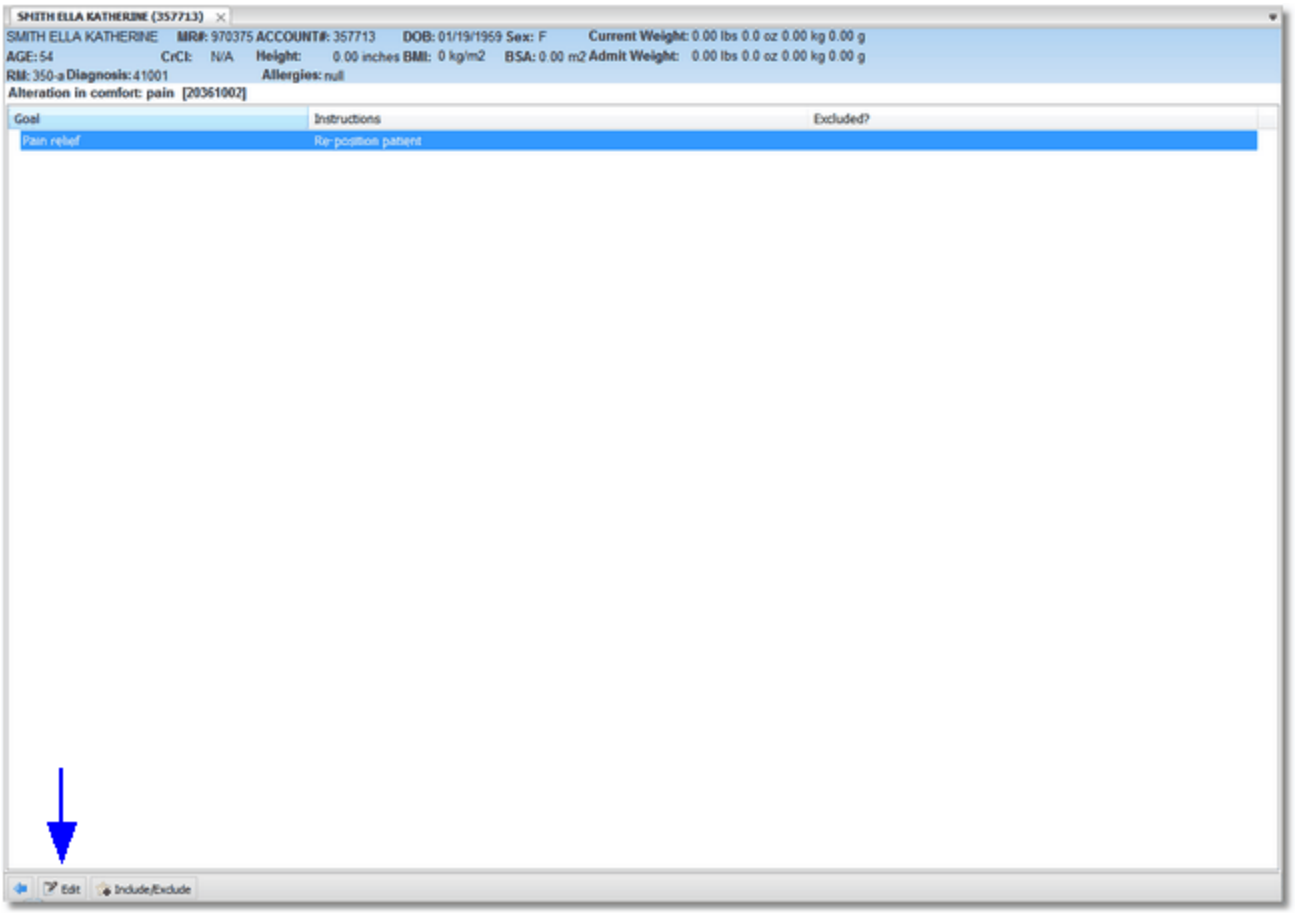



**Figure 1.73 Patient Summary (HL7 CCD)**

Modify the instruction field as needed. Select the  **back arrow** to save the information and return to the list of goals.

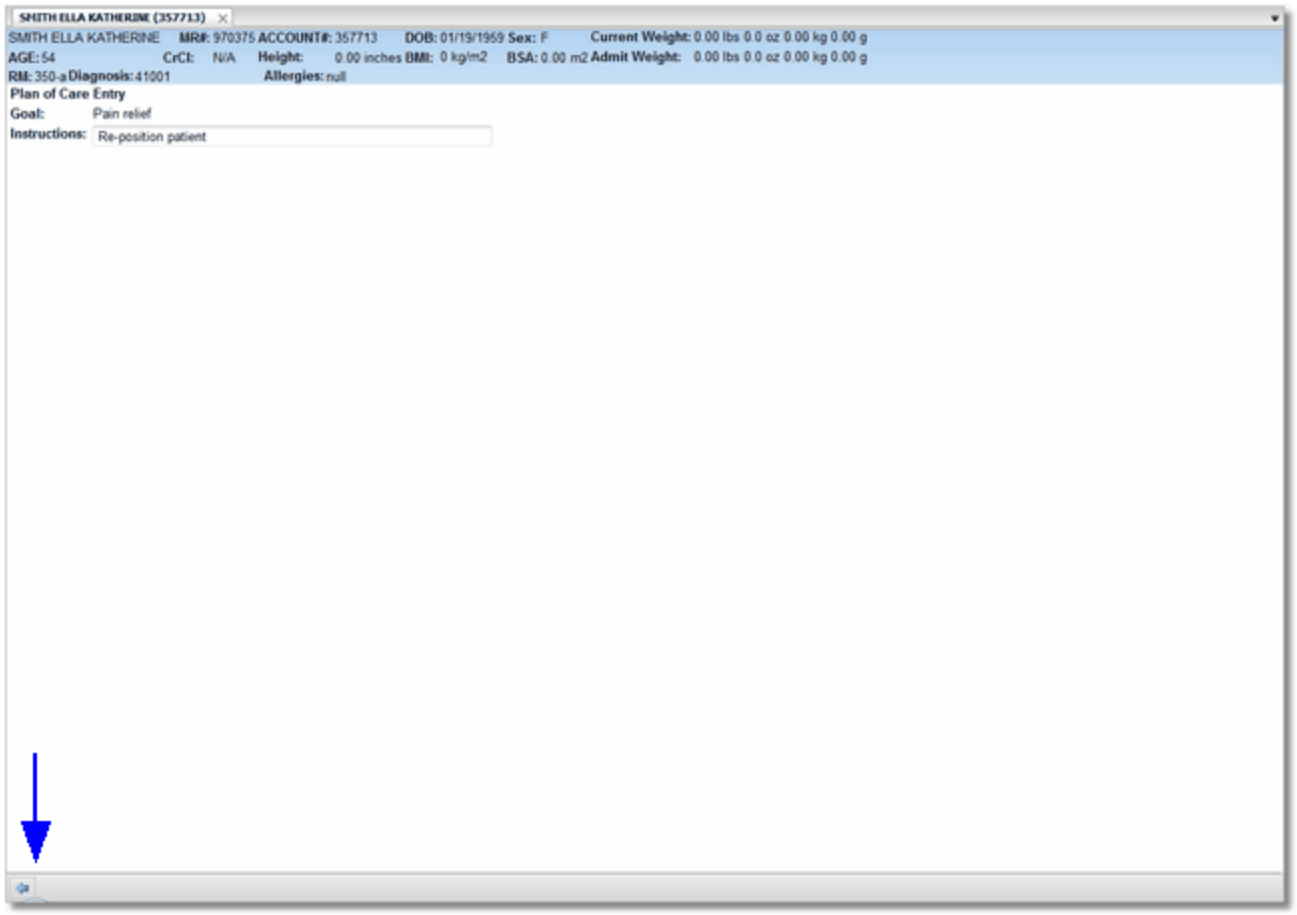



**Figure 1.74 Patient Summary (HL7 CCD)**

## Provider Organization

To edit the section, highlight the **Provider Organization** section. Once the section is highlighted, select **Edit** on the action bar**.**

Select **Hospital Base Menu** > **Master Selection** > **Medical Records** > **Print Electronic Record** > **Account Number** > **Build Patient Summary** > **Edit**

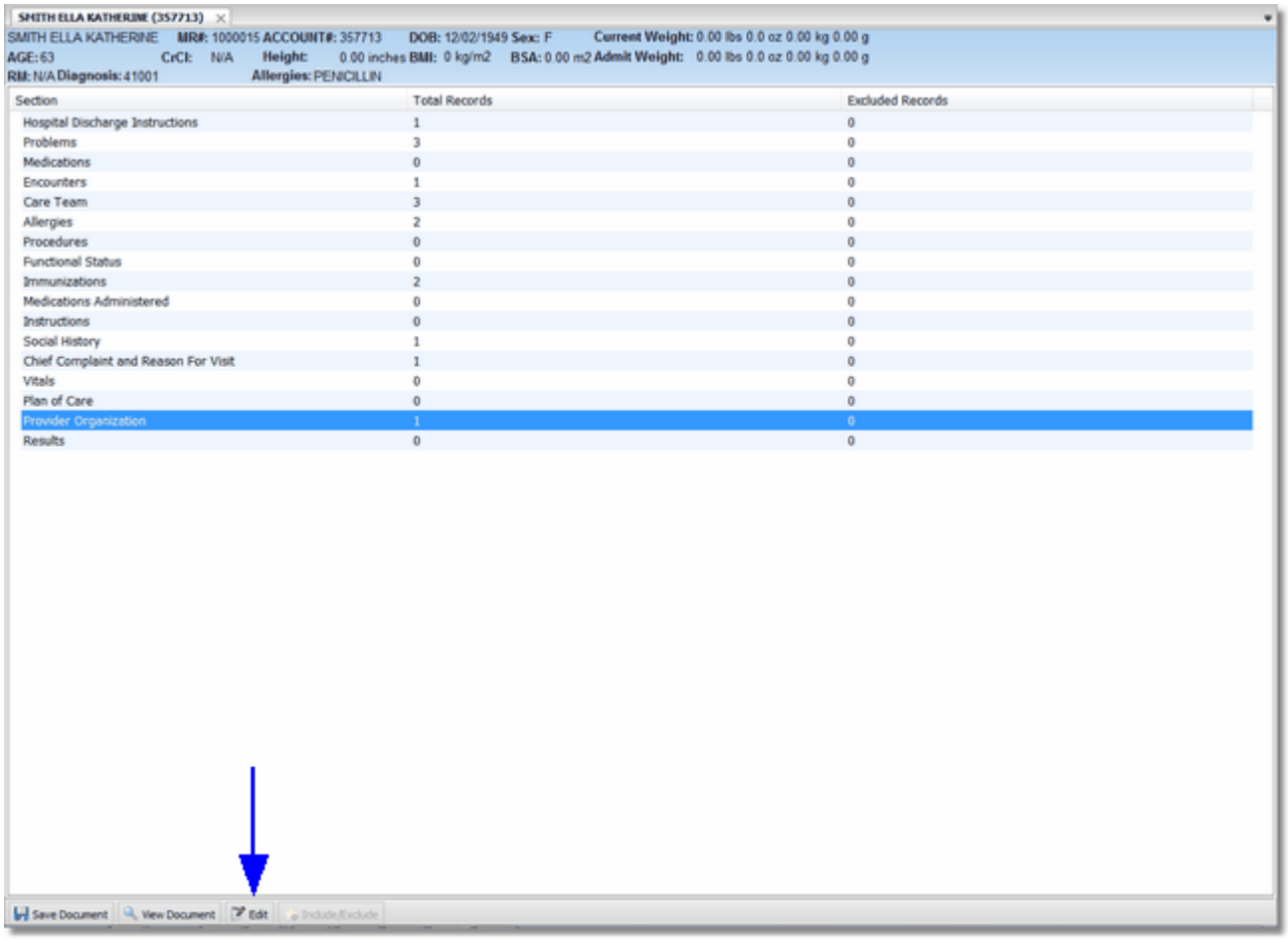



**Figure 1.75 Patient Summary (HL7 CCD)**

Once **Edit** is selected, the Provider Organization information will display. Only the address and phone number information may be modified. When all necessary corrections have been made, select the  **back arrow** to save the information and return to the list of the sections of the CCD.

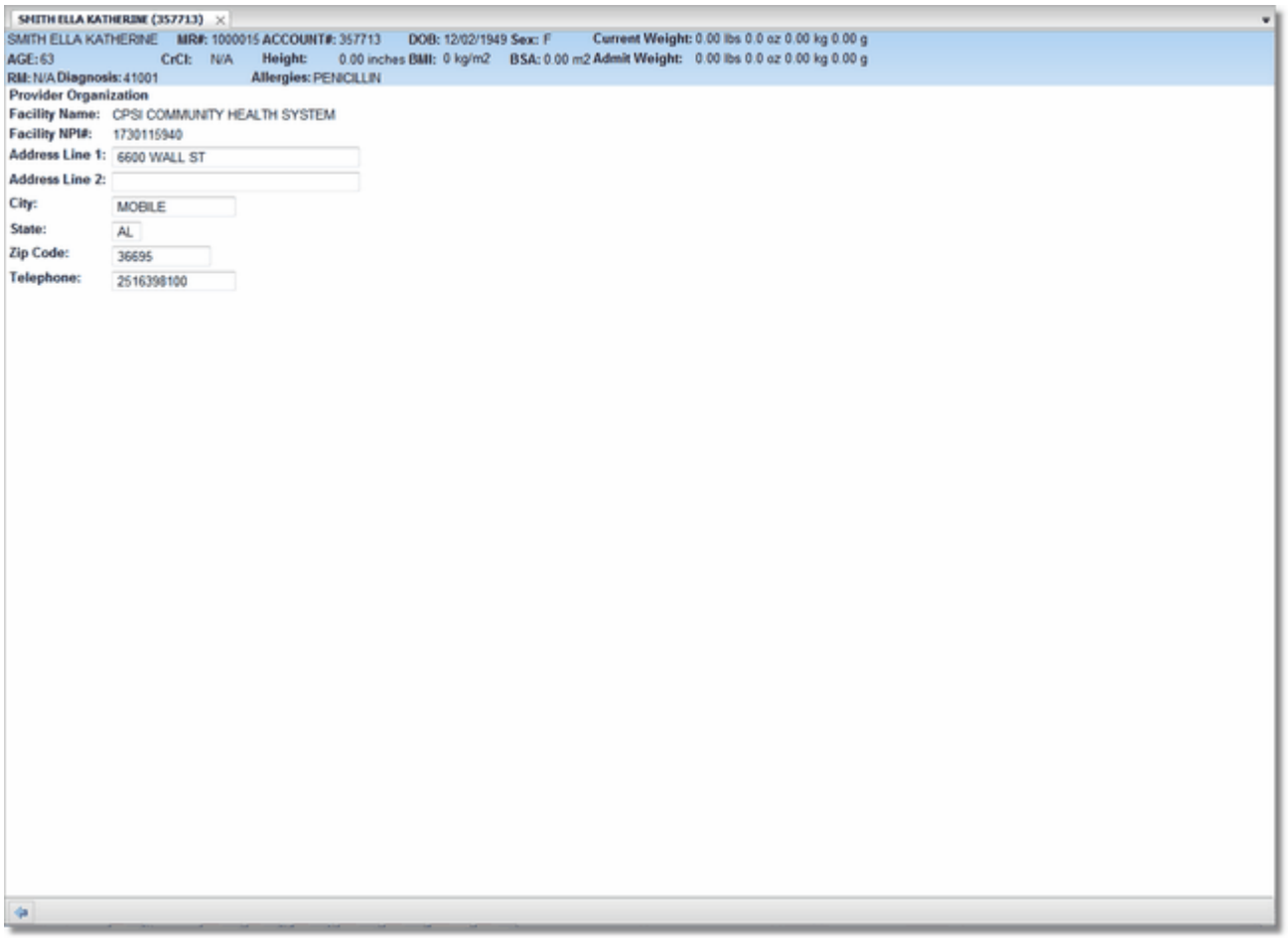



**Figure 1.76 Patient Summary (HL7 CCD)**

## Results

Follow the steps below to edit the Results section of the CCD.

To exclude individual results, highlight the **Results** section. Once the section is highlighted, select **Edit** on the action bar**.**

Select **Hospital Base Menu > Master Selection > Medical Records > Print Electronic Record > Account Number > Build Patient Summary > Edit**

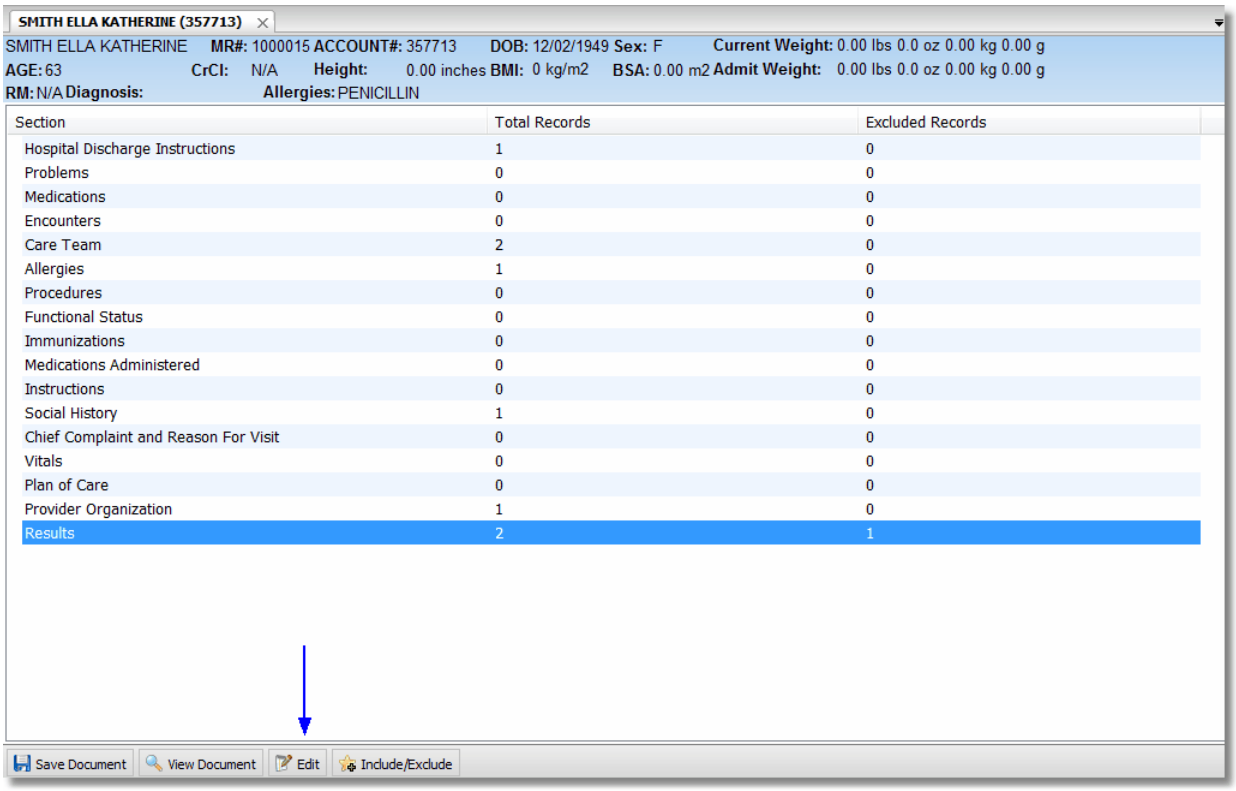



**Figure 1.77 Patient Summary (HL7 CCD)**

Once **Edit** is selected, the individual results will display. Highlight the test to exclude. Multiple tests may be selected by holding down the Ctrl key and selecting the desired procedures. When all procedures are highlighted, select **Include/Exclude.** Select the  **back arrow** to return to the list of the sections of the CCD.

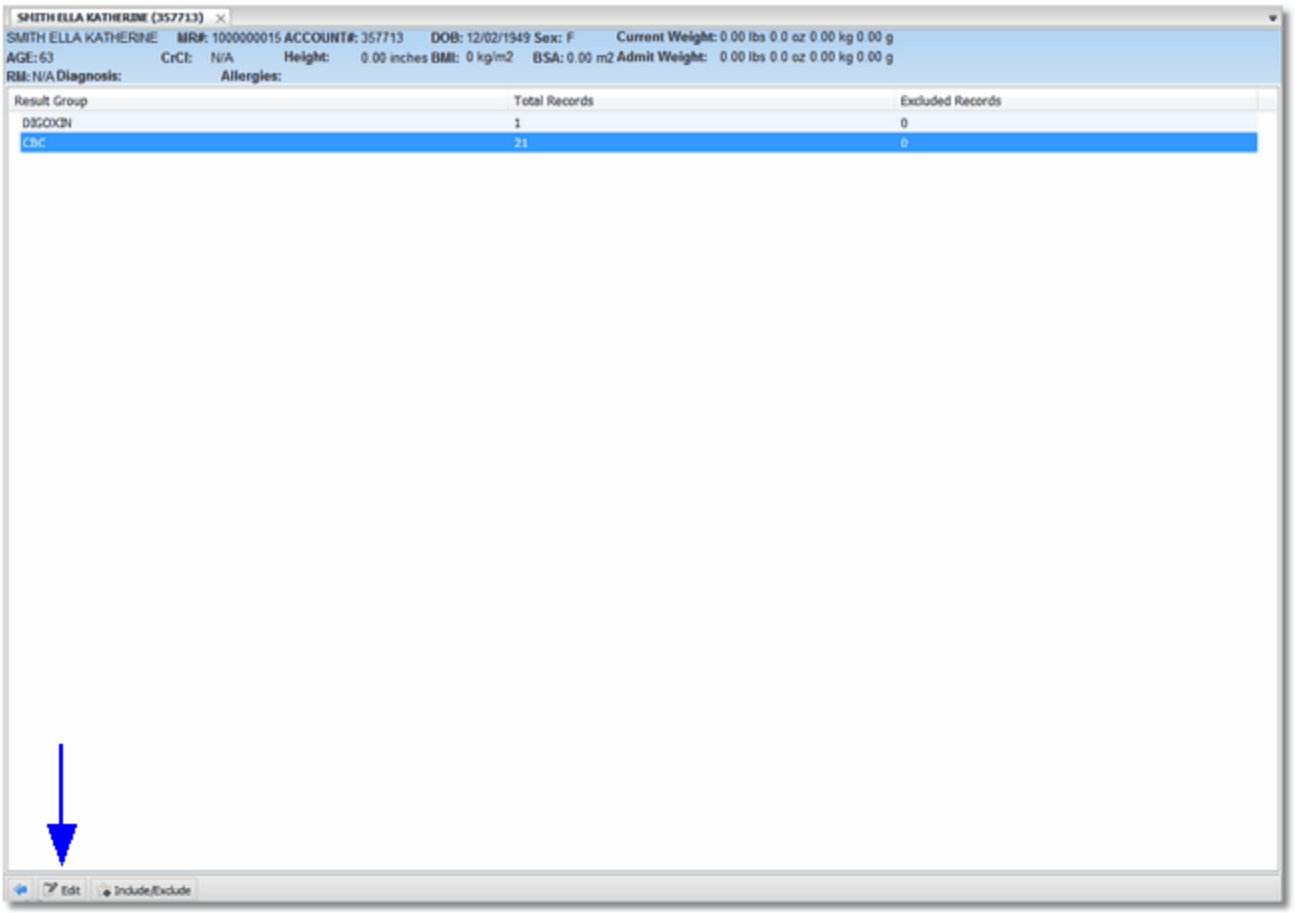



**Figure 1.78 Patient Summary (HL7 CCD)**

Each result group may contain multiple records. To exclude an individual record within a group, select the group then **Edit**. Highlight the result to exclude. Multiple results may be selected by holding down the Ctrl key and selecting the desired entries. When all results are highlighted, select **Include/ Exclude.** Select the  **back arrow** to return to the list of vital sign groups.

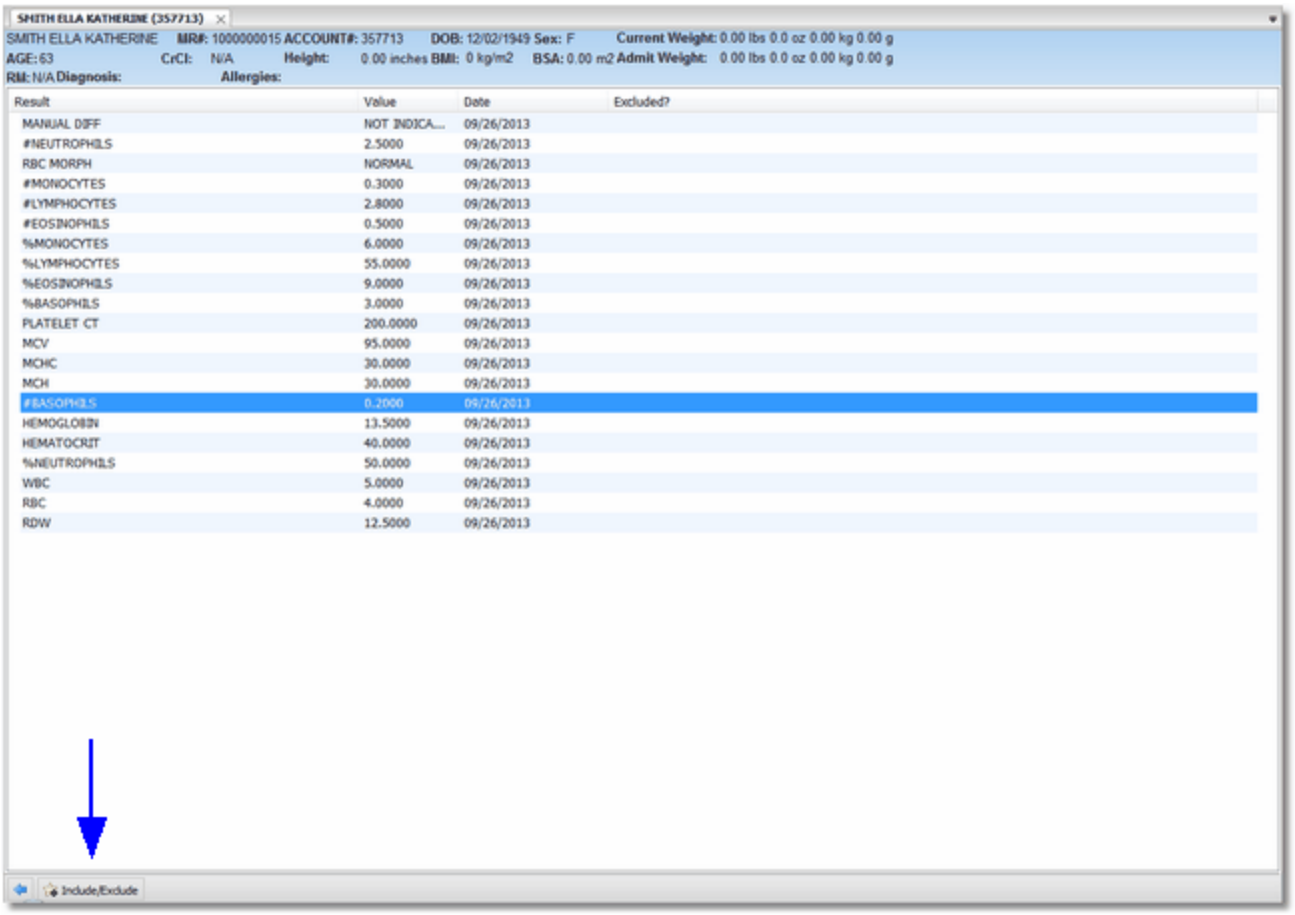



**Figure 1.79 Patient Summary (HL7 CCD)**

The Excluded Records column will now display the number of tests results excluded from the section. Select **Save Document** to save the changes.

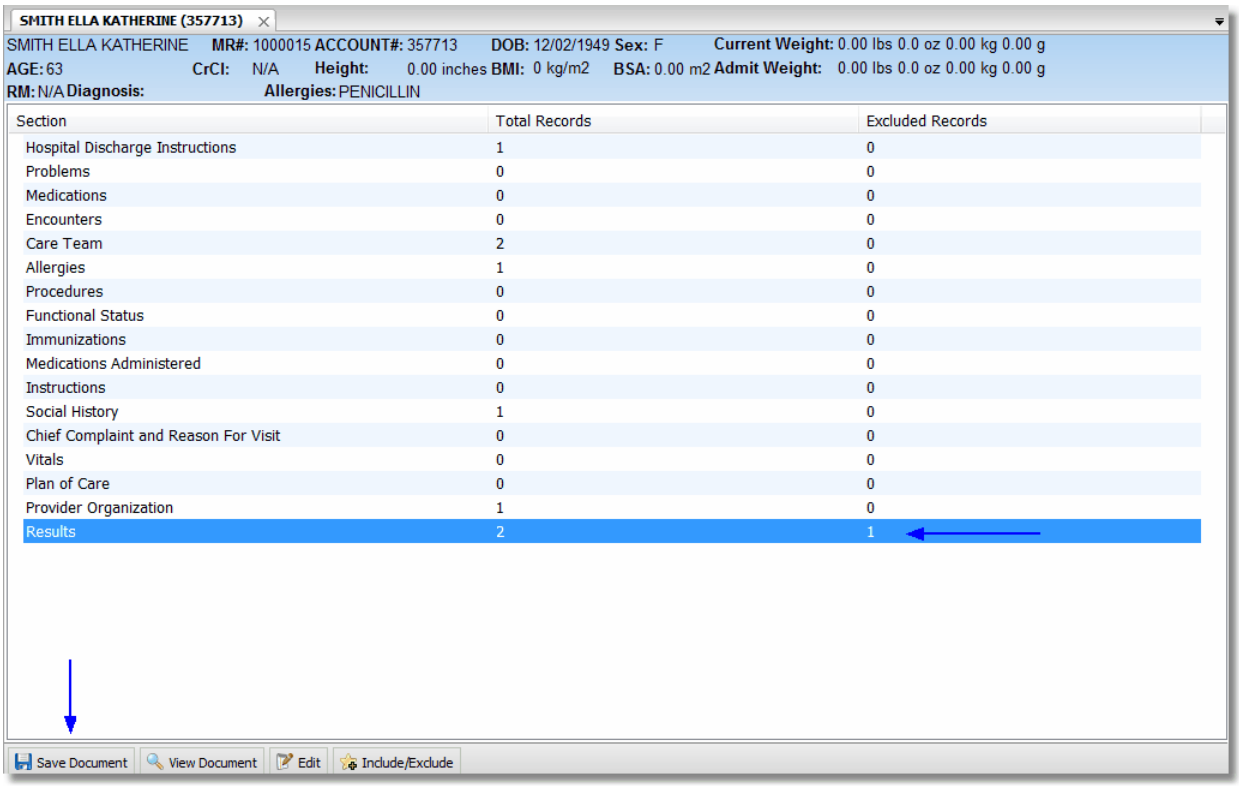



**Figure 1.80 Patient Summary (HL7 CCD)**