

2015 Certification Criterion

Transition of Care – Receive and Reconcile

Medicare Promoting Interoperability (Meaningful Use) Objective:

- <u>Measure</u>: Health Information Exchange: Support Electronic Referral Loops by Receiving and Reconciling Health Information. Hospitals have three options when attesting to the HIE Objective:
 - Option 1: Submit data for the HIE Send and HIE Receive Measures
 - Option 2: Bi-directional Exchange (requires an automated CCDA Interface)
 - Option 3: Exchange with TEFCA (requires partnership with CommonWell or another certified QHIN)
- <u>Measure</u>: For at least one electronic summary of care received for patient encounters during the EHR reporting period for which an eligible hospital is the receiving party of a transition of care or referral, or for patient encounters during the EHR reporting period in which the eligible hospital has never before encountered the patient, the eligible hospital conducts clinical information reconciliation for medications, problems, and allergies.
- Possible Points: 15
- <u>Medicare Exclusion</u>: None

NOTE: The hospital denominator will show the number of electronic summary of care (CCDA) records received and imported using CEHRT for patient encounters during the EHR reporting period. The numerator is met when clinical information reconciliation is completed using CEHRT for the following three clinical information sets: Medication, Medication Allergy, and Current Problem List.

NOTE: Clinical Reconciliation must be performed after the summary of care is imported.

Importing Documents

There are THREE methods for importing CCDA documents:

- Import from Inbox: Importing CCDA documents received via direct messaging.
- <u>Querying an HIE/HIN</u>: Importing CCDA documents from an HIE/HIN using an interface.
- <u>Querying CommonWell</u>: Importing CCDA documents from CommonWell.



Importing a CCDA via Import from Inbox

Importing a CCDA is the only way to update the denominator for the hospital measure Health Information Exchange: Support Electronic Referral Loops by Receiving and Incorporating Health Information.

To import a CCDA that was delivered in a direct message, the user will need to access the Health Information Resource application via the patient's chart.

1. In Web Client, select Charts > select patient > Health Information Resource > Import from Inbox.

WALKER, JOHN HENRY	Discharged: 3/29/2024	Visit #: 70001592 @ HALL1	No Behavioral Alerts	<u>Δ!</u>	
DOB: 05/05/1979 (44)	Code Status: Assume Full Code	Weight: 0 kg. (0.0g = 0 lbs 0.0 oz)	Chief Complaint: N/A	Attending Physician: EVIDENT- 2107 FAC 0002	
Birth Sex: Male Not Specifi	ed Advanced Directive: Unknown	Height: 0.00 in.	CrCI: N/A		
Clinical History	💲 Import from Inbox 👌 Patient Medical Summaries 🔍	Patient Referral/Transition of Care 🛛 Dinical Reconcile 🤱	Portal Management		
Reports and Attachments	Health Information Resource				
Order Entry	Health Information Resource	ф Туре	Last Query	Available Documents	φ
Verify Orders	CommonWell	HIE			
MAR	IMS_TESTING	HIE			
Documentation	myCPSI	Links			
	WVHIN	Links			
Notes	Lexicomp	Links			
Console					
Health History					
Health Information Resource					
Temporary Registration					
Plan of Care					
Communication					
Charges					
Location Maintenance					
Demographics					
Visit History					

2. The screen will list documents that match the selected patient. The patient matching is based on the patient's first name, middle name, last name, suffix, previous name, date of birth, address, phone numbers and birth sex.

If no document displays based on the automatic patient matching, select the **View Document Queue** – **All** button to view all documents in the Inbox for the Direct address. To return to the matched set of documents, select the **View Document Queue** – **Match** button.

NOTE: Import from Inbox can also be access through Charts, or through a POC Virtual Chart tab.

3. Double-click on the CCDA in the Document List to view the CCDA.



_	WALKER, JOHN HENRY		Discharged: 3	29/2024	Visit #: 70001592 🛛 HA	ш	No Behavioral Alerts		∆!	
2	DOB: 05/05/1979 (44)		Code Status: A	ssume Full Code	Weight: 0 kg. (0.0g = 0	lbs 0.0 oz)	Chief Complaint: N/A		Attending Physician: EVIDENT- 2107 FAC 0002	
	Birth Sex: Male <u>Not Specifi</u> manscriptions Clinical History	_	Advanced Dire	tive: Unknown e-All 📀 Delete 🔒 Clinical Reconcile 🗆	Height: 0.00 in.		CrCI: N/A			
	Reports and Attachments	Patient Detail						_		
	Order Entry	First Name:	ЛОНИ	Sear Document List	h:	Name ~ Sort	Date ~	O Ascending O Desc	ending	
1	Verify Orders	Middle Name: Last Name:	HENRY WALKER	WALKER JOHN HENRY		OB: 05/05/1979			Sex: M	
	MAR	Suffix: Previous Name:		Date: 05/01/2024 Time: 13:50		om Address: test@cpsi.hin.us			Type: Patient Summary 2.1	
1	Documentation	Date of Birth:	05/05/1979	WALKER JOHN HENRY Date: 05/01/2024 Time: 13:50		OB: 05/05/1979 om Address: test@cpsi.hin.us			Sex: M Type: TEXT	
	Notes	Sex: Address 1:	Male 123 SYCAMORE STREET							
	Console	Address 2: City:	MOBILE							
	Health History Health Information Resource	State: Zip Code:	AL 36695							
	Temporary Registration	Home: Business:								
		Mobile:								
	Plan of Care									
1	Communication									
	Charges									
	Location Maintenance									
	Demographics									
,	Visit History									

- 4. Once the CCDA is selected, the action bar provides a few options:
 - <u>Import</u>: This option allows users to import the CCDA so the information from the CCDA can be reconciled. Importing the CCDA places the patient in the denominator. Once **Import** has been selected, a copy of the imported CCDA is saved in Electronic File Management. Once **Import** is selected, it is not possible to cancel the import.
 - **Print:** This option allows users to print the CCDA to a specific printer, to the user's workstation, or to a PDF.
 - <u>View XML</u>: This option allows users to view the XML of the CCDA.
 - <u>View Errors</u>: This option allows users to review any errors, warning, or information regarding the document validation display.



WALKER, JOHN HENRY DOB: 05/05/1979 (44) Birth Sex: Male <u>Not Spr</u>		Discharged: 3/2 Code Status: As Advanced Direct	ssume Full Code	Visit #: <u>70001592</u>	No Behavioral Alerts Chief Complaint: N/A CrCl: N/A	Attending Physician: EVIDENT-2107 FAC 0002	
Clinical History	💠 🛞 Im		L 🔍 View HTML 🔍 View Errors				
Reports and Attachments	Patient Detail		Document				
Order Entry	First Name: Middle Name:	JOHN HENRY	EVIDENT- 2107 FAC 00	002 🖿 C	ontinuity of Care Document (CCD)	🛗 Created On May 01, 2024 1	3:50
Verify Orders MAR	Last Name: Suffix: Previous Nam	WALKER	Preferences: Of	JOHN HENRY WALKER		Admission Date: Discharge Date: Mar 29, 2024 12:04 Mar 29, 2024 02:10	0
Documentation	Date of Birth:	05/05/1979	 Functional Status 			Visit Reason: No Information	
Notes	Sex: Address 1:	Male 123 SYCAMORE STREET	 Immunization 	Contact Info	Demographics	Encounter Care Team	
Console	Address 2: City:	MOBILE	✓ Mental Status	FUNCTIONAL STATUS	Back To Top	_	0
Health History	State:	AL	✓ Results	TONCHONAL STATUS	Back to top		•
Health Information Resource	Zip Code: Home:	36695	 Social History 	No Data Found			
Temporary Registration	Business: Mobile:		✓ Vital Signs				_
Plan of Care			 Medications Assessment 	IMMUNIZATION	Back To Top	-	8
Communication			 Hospital Discharge Instructions 	No Data Found			
Location Maintenance			Reason For Referral Procedures	MENTAL STATUS	Back To Top	-	0
Demographics			✓ Implants	No Data Found			
Visit History			 Problems 	✓ Provenance			

Imported CCDA documents can be viewed in the following locations:

- Web Client > Charts > Reports and Attachments > Med Rec
- Web Client > System Menu > POC Access > POC Virtual Chart > Images > Imported CCDA will have a Document Origin of Imported
- Web Client > System Menu > Medical Records > Acct Number > Electronic File Management

Importing a CCDA via an HIE Query

Importing a CCDA via an HIE/HIN (Health Information Network) query is another way to include the patient in the denominator of the measure. The hospital must have an interface to an HIE/HIN that can actively query CCDAs to meet this measure.

- 1. In_Web Client, select Health Information Resource > Select the HIE > View CCDA > Import.
- 2. Double-click on the HIE to query. Once selected, the EMR will automatically query the HIE for any CCDA documents for the previous three months.



Ет	HRIVE Charts Health Information Resou	rce			charts < WALKER JOHN HENRY X 🏫 🤍 🏭 👾 🚾 🗸
0	WALKER, JOHN HENRY DOB: 05/05/1979 (44) Birth Sex: Male <u>Not Specifi</u>	Discharged: <u>3/29/2024</u> Code Status: Assume Full Code Advanced Directive: Unknown	Visit #: <u>70001592</u>	No Behavioral Alerts Chief Complaint: N/A CrCL: N/A	Attending Physician: EVIDENT-2107 FAC 0002
99 191	Order Entry Verify Orders	Import from Inbox Patient Medical Summaries Health Information Resource	Patient Referral/Transition of Care 🍃 Clinical Reconcile 🙇 Portal	Management	
8	MAR	Health Information Resource	ф Туре	Last Query	
	Documentation	CommonWell	HIE		
<u>9</u> 2	Notes	IMS_TESTING	HIE		
	Console	WVHIN	Links		
۲	Health History	Lexicomp	Links		
۲	Health Information Resource				
*	Temporary Registration				
.8	Plan of Care				
6	Communication				
ø	Charges				
*	Location Maintenance				
<u></u>	Demographics				
2	Visit History				
	Patient Summary Apple Health app data				
1	Apple Realth app data				
_	<				<

Т	HRIVE Health Information Resource	e			Charts × WALKER JOHN HENRY × 🛧 🔍 🎬 🎝 🕅	VG 🖵
6	WALKER, JOHN HENRY	Discharged: 3/29/2024	Visit #: 70001592	😢 No Behavioral Alerts	<u> </u>	60
2	y	Code Status: Assume Full Code	Weight: 0 kg. (0.0g = 0 lbs 0.0 oz)	Chief Complaint: N/A	Attending Physician: EVIDENT- 2107 FAC 0002	Q
,	Birth Sex: Male Not Specifier	Advanced Directive: Unknown	Height: 0.00 in.	CrCl: N/A		
2	Order Entry	•				
	Verify Orders	Health Information Exchange				
e	MAR	List Health Information Exchange Documents - From Date: 02	01/2024 To Date: 05/01/2024 Go			
<u>9</u> 2	Documentation					
9	Notes					
	Console	Document Title	Type	Authoring Institution 🔶 Stored In	¢	
۲	Health History	Continuity of Care Document	Patient Summary 01/10/20	UC Davis Health IMS_TESTING		
۲	Health Information Resource	Aggregated CCD	Patient Summary 05/01/20	DOD-VA IMS_TESTING		
&	Temporary Registration	Medical Record Import	Patient Summary 11/01/20	SacValley MedShare IMS_TESTING		
.8	Plan of Care					
8	Communication					
ø	Charges					
4	Location Maintenance					
	Demographics					
±.	Visit History					
	Patient Summary					4
	Apple Health app data					
-						
https://l	2107.cpsi.com/?arid=1&facid=2&	patient=70001592&op=launch_charts_usher/patient_7				<

NOTE: The date range to query can be manually changed.

If a document is returned, it will be available in the Inbox to View and Import (refer to screen shot shown above). If a document is not returned, the database has stored that a query was performed. Importing a document will include the patient in the measure denominator.



Importing a CCDA via CommonWell

CommonWell can be used to query and import CCDA documents for the HIE – Receive and Reconcile measure. If your facility is not a member of CommonWell, you can locate signup details on TruLearn.

The steps to Querying CommonWell are identical to Querying an HIE. In Web Client, select Health Information Resource > Select CommonWell > View CCDA > Import.

WALKER, JOHN HENRY DOB: 05/05/1979 (44) Birth Sex: Male <u>Not Specifi</u>	Discharged: 3/29/2024 Code Status: Assume Full Code Advanced Directive: Unknown	Visit #: 70001592	No Behavioral Alerts Chief Complaint: N/A CrCl: N/A	Attending Physician: EVIDENT-2107 FAC 0002	
Reports and Attachments	💲 Import from Inbox 🛛 🎍 Patient Medical Summaries 🔍 Pati	ent Referral/Transition of Care 🛛 🍃 Clinical Reconcile 💈 Portal Mar	nagement		
Order Entry	Health Information Resource				
Verify Orders	Health Information Resource	💠 Туре	💠 🛛 Last Query	💠 🛛 wailable Documents	÷
MAR	CommonWell	HIE			
Documentation	IMS_TESTING	HIE	05/01/2024 14:08		
Notes		<u>5145</u>			
Console	WVHIN	Links			
Health History	Lexicomp	Links			
Health Information Resource					
Temporary Registration					
Plan of Care					
Communication					
Charges					
Location Maintenance					
Demographics					
Visit History					
Patient Summary					

Performing Clinical Reconciliation

All three Clinical Reconciliations may be performed in Health Information Exchange > Clinical Reconcile, or within their respective applications, and **all three reconciliations must be performed for the patient to meet the measure numerator**.

Reconciling Allergies

- 1. In Web Client, select Charts > Select Patient > Allergies.
 - Imported allergies are listed under the **Imported Medication Allergies** column. Existing allergies are listed under the **Current Medication Allergies** column.
 - **Associate Like Items** will automatically associate imported and current allergies based on the RxNorm code. Users can also manually associate and remove associations.



econcile Medication Allergies			
ported Medication Allergies	Current Medication Allergies	Pending Action	
Ampicillin Isocion: Hives Statu: Active as: Modified: 42/22/2015 Source: Neighborhood Physicians Practice		Import New	
Penicillin G benzathine	PENICILLIN G		
Reaction. Hiven	Reaction Hives		
Status: Active	Status: Active		
ast Modified 02/22/2015 Source: Neighborhood Physicians Practice	Last Modified 05/23/2017 Source: Neighborhood Physicians Practi		

- Additional options include the ability to Import New, Keep Existing, or Remove.
 - **Import New:** This option will mark the selected imported allergy with a pending action of Import New, which will add that allergy to the patient's allergy list upon reconciling.
 - **Keep Existing:** This option will mark the selected current allergy with a pending action of Keep Existing, which will retain that allergy on the patient's allergy list upon reconciling.
 - **Remove:** This option will mark either an import or current allergy with a pending action of Remove. If an imported allergy has Remove selected, that allergy will be deleted upon reconciling (and not become part of the patient's allergy list). If a current allergy has Remove selected, that allergy will be removed from the patient's allergy list upon reconciling.
- 2. Once all items on the screen have been addressed, the **Review** button will become available. To proceed, select **Review**.



econcile Medication Allergies			
ported Medication Allergies	Current Medication Allergies	Pending Action	
Ampicillin		Import New	
Reaction: Hives		1.1.2.2.2.2.2.4.4.4.4.4.4.4.4.4.4.4.4.4.	
Status: Active			
Last Modified 02/22/2015			
Source Neighborhood Physicians Practice			
Penicillin G benzathine	PENICILUN G	Keep Existing	
Reaction: Hives	Reaction: Mives	the second	
Status: Active	Status: Active		
Last Modified @2/22/2015	Last Modified 05/23/2017		
Source: Neighborhood Physicians Practice	Source: Neighborhood Physicians Practi		

- 3. Selecting **Review** takes the user to a final pending list. The selected pending action will appear in the **Pending Action** column.
- 4. Once the list has been visually verified, select **Reconcile** to reconcile the data into the patient's chart.

nding Allergy Li	st				
FinalList ⊜ R	amoved Only 🗇 All				
cription	Reactions	Status	Last Modified	Source	Panding Action
rpicifin	Hives	Active	02/22/2015	Neighborhood Physicians Practice	Import New
ENCILIN G	Hives	Active	45/23/2017	Neighborhood Physicians Practi	Keep Existing



Reconciling Medications and Problems

Reconciling Medications and Problems follows the same process as Reconciling Allergies.

<u>Path to Reconcile Medications</u>: In Web Client, select Charts > Select Patient > Medication Reconciliation or Prescription Entry (or Clinical Reconcile in Health Information Resource).

- Imported medications will be listed under the **Imported Home Medications** column. The existing medications will be listed under the **Current Home Medications** column.
- Users can Associate Like Items, manually associate, remove associations, Import New, Keep Exist, or Remove.
- The list is reviewed for accuracy and then reconciled into the patient's chart.

<u>Path to Reconcile Problems</u>: In Web Client, select Charts > Select Patient > Problem List (or Clinical Reconcile in Health Information Resource).

- Imported problems will be listed under the **Imported Problems** column. The existing problems will be listed under the **Current Problems** column.
- Users can Associate Like Items, manually associate, remove associations, Import New, Keep Exist, or Remove.
- The list is reviewed for accuracy and then reconciled into the patient's chart.



Setup

Setup for PIX (HIE) Query

If the hospital has an interface that can <u>actively query</u> an HIE for CCDA documents <u>and retrieve</u> the CCDA documents, the **Yes** radio button for **HIE with Query and Response** must be set on the MU page of test physician 999999.

If the hospital does not have an HIE in its area <u>OR</u> if the HIE interface is not yet operational in the TruBridge EHR for the facility, the **No** radio button will be set. Only when the HIE interface is operational should the **HIE with Query and Response** field be set to Yes.

Path to set up PIX Query access in the hospital: Web Client > Tables > Clinical > Physicians > Test Physician 999999 > MU page > HIE with Query and Response



Setup for Image Titles

In order for the CCDA documents to upload correctly into the EHR, the HIE Image Titles and CCDA Image Titles need to be set up.

Recommended Image Titles to set up:

- Patient Summary
- Referral Note
- Discharge Summary
- Unspecified Document



Recommended Setup for HIE Image Titles:

- Currently Used: Select this checkbox.
- Image Deletion Allowed: Select this checkbox.
- **ChartLink Tab:** Select Med Rec (Medical Records). This is where the imported document will display within Reports and Attachments.
- **Clinical History:** This is an optional field. If you want the imported document to display in Clinical History, then select the MR checkbox.
- Page Properties: Use the default settings.

Path to set up the HIE Image Titles: Web Client > Tables > Business Office > Images: Titles



Use the settings below to set up your CCDA Image Title and select **Save**. Repeat the process for all CCDA Image Titles recommended.





There are four document types to which image titles need to be associated:

- CCD
- Discharge Summary
- Referral Note
- Unspecified Document

IMPORTANT! Each document type needs to have its own specific image title so that the EMR can accurately store the document in Print EMR based on the document OID.

To associate the image title, select the magnifying glass next to the document type. The list of image titles will appear. Highlight the image title and select **OK**. The image title will now be associated with that document type.



F	THRIVE Business Office	A Q # [™] W
R	Accounting Tables	radiig: Truggidge community Hospital v
R	Business Office	Business Office
8 8 8 8 8 8	Patient Intake Clinical Control HIM Patient Summary Trubridge Services	Beater Office Image Charge Statutate Category Codes Titles Charge Statutate Titles Charge Statutate Debetay Nove Reasons Collar Statutate Debetay Nove Reasons P Releted Statutate Debetay Nove Reasons P Releted Statutate Debetay Nove Reasons P Releted Statutate Category Codes Petater Statutate Category Codes P Releted Statutate Category Codes Petater Statutate Category Codes P Releted Statutate Category Codes Petater Statutate Category Codes Collace Codes Petater Statutate Category Codes Collace Codes Petater Statutate Category Reasons Collace Codes Statutate Petater Statutate Category Reasons P Collace Codes Statutate Petater Statutate Category Reasons P Collace Codes Statutate Category Reasons Petater Statutate Category Reasons P Collace Codes Statutate Category Reasons Petater Friendy Statutate Category Reasons <tr< th=""></tr<>
	<	P Control Billing Codes P Review Codes P Medical Necessity Settings P Popting Code Costmalk P P ecR New Settings P P CDSM Vendor Table

The facility's CCDA Image Titles setup should look similar to the example below.

THRIVE CCDA Image Titles		Table Maintenance	CCDA Image Titles \times	n 🤉 🏭 🚰 🚾 -
CCDA Image Titles	🔹 🔛 Save			
	CCDA Image Titles			
	CCD: Set Patient Summary			
	Discharge Summary: Referral Note: Referral Note: Referral Summary			
	Unspecified Document: Unspecified Documents			
<				



Frequency Crosswalk Setup

<u>Path to set up Frequency Crosswalk</u>: Web Client > Tables > Clinical > Clinical Reconciliation: Frequency Crosswalk



Frequencies are typically represented by a period of time and a unit of time (such as 8H for eight hours, 1D for once a day, 2WK for every other week, etc.) or by an event code that represents certain times of day (AC for before measures, HW for bedtime, etc.). Once the values have been entered, the appropriate prescription frequency must be associated to it.

- It is possible for the period of time to be represented by a decimal instead of a whole number (0.5D or 12H can both be used for a medication to be taken twice a day).
- It is also possible to have a frequency with both period/units and an event code (1H and PC for taking a medication 1 hour after meals).
- PRN medications have a special section in the CCDA indicating the frequency is PRN instead of standard. To accommodate this, separate records must be created for the standard frequency and the PRN frequency. For example, a frequency of four times a day could be represented by 6H, and a frequency of four times a day as needed could be represented by 6H and the PRN box checked.

Select the CCDA Value lookup to associate a CCDA Value with the frequency.



Select New.

acility 58 : f10 MPE	MR IN HOSPITAL			
Search:				
CCDA Period Value	CCDA Unit Value	Event Code	Prescription Entry Frequency	PRN
8	н		EVERY 8 HOURS	No
0.25	D		FOUR TIMES A DAY	No
12	н		EVERY 12 HOURS	No
1	WK		WEEKLY	No
0.33	D		THREE TIMES A DAY	No
24	н		EVERY 24 HOURS	No
2	D		EVERY OTHER DAY	No
6	н		EVERY 6 HOURS	No
4	н		EVERY 4 HOURS	No
4	н		AS NEEDED EVERY 4HRS	Yes
1	MO		Monthly	No
1	D		DAILY	No
1	н	AC	Before Meals	No
0.5	D		TWO TIMES A DAY	No
		AC	Before Meals	No

Clinical Info	rmation Reconciliation Frequency Maintenance
Facility 58 : f10	PEMR IN HOSPITAL
CCDA Period Val	e:
CCDA Unit Value	

Complete the fields on the Clinical Information Reconciliation Frequency Maintenance screen:

- CCDA Period Value: This is a free text field that will allow the user to enter a valid period value.
 - For example: 0.5, 1 2, 4, 6, 8, 12
 - If the Frequency is "every 2 hours," the CCDA Period Value would be 2.
- **CCDA Unit Value:** This is a free text field that will allow the user to enter a unit value. This can be upper or lower case.
 - For example: D, H, MO, WK
 - If the frequency is "every 2 hours," the CCDA Unit Value would be H.
- Event Code: This is a free text field, but will likely not be used often.
 - For Example: HS, AC, PC
 - HW = Bedtime, AC, = Before Meals, PC = After meals
- **Prescription Entry Frequency:** The user can select the search icon to open the Prescription Entry Frequencies table and select a frequency. The selected frequency populates into the text box.



• **PRN:** Selecting this check box will make the frequency PRN.



Route Crosswalk Setup

<u>Path to set up Route Crosswalk</u>: Web Client > Tables > Clinical > Clinical Reconciliation: Route Crosswalk





Select New.

acility 58 : f10 M	MPEMR IN HOSPITAL		
Search:		NCIT Code ~	
NCIT Code	NCIT Description		Prescription Entry Route
C38304	TOPICAL		TOPICAL
C38211	EXTRA-AMNIOTIC		GINGIVAL
C38272	INTRAUTERINE		INTRAUTERINE
C38216	RESPIRATORY (INHALATION)		INHALATION
C38193	BUCCAL		LEFT EAR
C38267	INTRATHECAL		INTRATHECAL
C38288	ORAL		BY MOUTH
C38192	AURICULAR (OTIC)		RIGHT EAR
C38238	INTRADERMAL		INTRADERMAL
C28161	INTRAMUSCULAR		INTRAMUSCULAR
C38299	SUBCUTANEOUS		SUBCUTANEOUS
C38300	SUBLINGUAL		SUBLINGUAL
C38209	ENTERAL		NASAL
C38210	EPIDURAL		EPIDURAL

	rmation Reconciliation Route Maintenance
acility 58 : f10 M	PEMR IN HOSPITAL
VCIT Code:	
NCIT Description:	
	Route: 🔍

Complete the fields on the Clinical Information Reconciliation Route Maintenance screen:

- NCIT Code: Select the search icon to select an NCIT code.
- **NCIT Description:** Once an NCIT code is selected, the description of the code will populate this field.
- **Prescription Entry Route:** Select the search icon to be taken to the Prescription Entry Routes table to select a route.

Select Update.



🛃 Update 🙆 Delete	
Clinical Information Reconciliation Route Maintenance Facility 58 : f10 MPEMR IN HOSPITAL	
NCIT Code:	C38288
NCIT Description:	ORAL
	ute: 🔍 BY MOUTH

Unit Crosswalk Setup

Path to set up Unit Crosswalk: Web Client > Tables > Clinical > Clinical Reconciliation: Unit Crosswalk





Select New.

	dit 🛛 🧬 Refresh		
Search:		UCUM Code ~	
UCUM Code	UCUM Description		Prescription Entry Unit
{tbl}	tablets		TABLET
mg	MilliGram [SI Mass Units]		MILLIGRAMS
mL	MilliLiter [SI Volume Units]		MILLILITER
g	gram		GRAM
[tsp_us]	teaspoon		TEASPOON
[drp]	drop		DROP
[tbs_us]	tablespoon		TABLESPOON
ueq/mL	MicroEquivalentsPerMilliLiter		MILLIEQUIVALENT
L	liter		LITER
U	Unit		UNIT

Clinical Information Reconciliation Unit Maintenance Facility 58 : f10 MPEMR IN HOSPITAL	
UCUM Description:	
Prescription Entry U	nit: 🔍

Complete the fields on the Clinical Information Reconciliation Unit Maintenance screen:

- UCUM Code: Select the search icon to select a UCUM code.
- **UCUM Description:** Once a UCUM code is selected, the description will populate in this field.
- **Prescription Entry Unit:** Select the search icon to be taken to the Prescription Entry Units table to select a unit.

Select Update.



Attestation Disclaimer:

Promoting Interoperability attestation confirms the use of a certified Electronic Health Record (EHR) to regulatory standards over a specified period of time. TruBridge Promoting Interoperability certified products, recommended processes, and supporting documentation are based on TruBridge's interpretation of the Promoting Interoperability regulations, technical specifications, and vendor specifications provided by CMS, ONC, and NIST. Each client is solely responsible for its attestation being a complete and accurate reflection of its EHR use during the attestation period and that any records needed to defend the attestation in an audit are maintained. With the exception of vendor documentation that may be required in support of a client's attestation, TruBridge bears no responsibility for attestation information submitted by the client.