Patient Medical Summaries (CCDA)

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Chapter 1 Introduction

1.1 Attestation Disclaimer

Meaningful Use attestation confirms the use of a certified Electronic Health Record (EHR) to regulatory standards over a specified period of time. TruBridge Meaningful Use certified products, recommended processes, and supporting documentation are based on TruBridge's interpretation of the Meaningful Use 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.

Chapter 2 Overview

The Patient Medical Summaries are clinical documents that include basic medical information to ensure safe and secure healthcare. It includes general patient demographic information and a basic medical summary consisting of allergies, medical problems, medical implants, recent surgeries and medications. This information is intended to provide essential electronic patient health information to other health providers for the continuity of care of the patient. This information is also intended to provide patients with information about their medical encounter including updated medication list, updated vitals, procedures, clinical instructions, medications administered, follow up information and lab results.

NOTE: *Facilities outside of the United States may choose a date format of MMDDYY, DDMMYY, or YYMMDD to be used on all date fields in the Patient Medical Summaries Application. Where four-digit dates display, a date format of MMDD, DDMM or MMDD, respectively, will be used. Whichever date format is selected will be reflected in all date fields and column displays throughout the application. A TruBridge Representative should be contacted in order for the date format to be changed.*

Chapter 3 Patient Medical Summaries

3.1 Accessing Patient Summaries

The Patient Medical Summaries may be accessed from different locations:

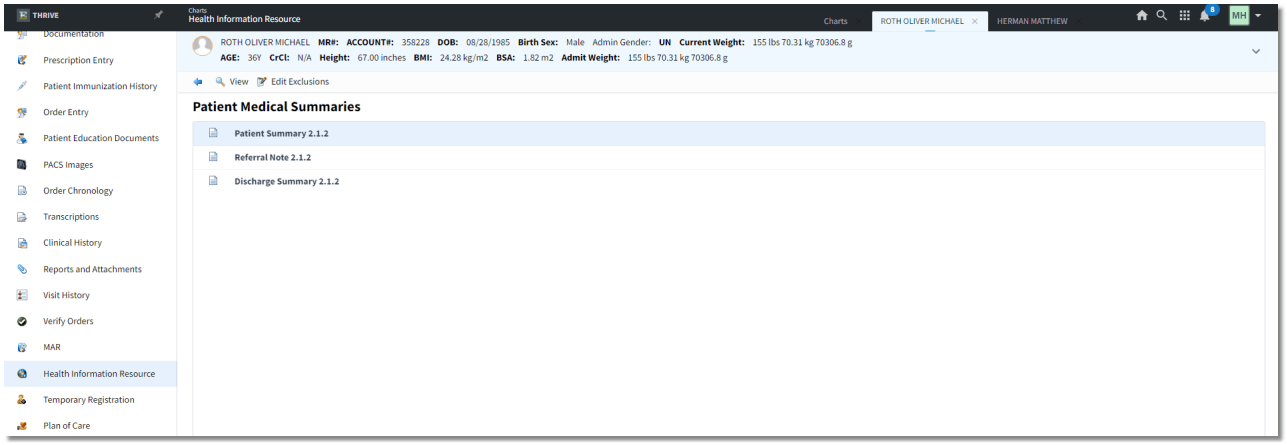
- **Health History:** Select Patient Account > Health History > New > Referral/Transition of Care > Patient Medical Summaries
- **Communication:** Select Patient Account > Communication > Referral/Transition of Care > New > Patient Medical Summaries
- **Health Information Resource:** Select Patient Account > Health Information Resource > Patient Medical Summaries
- **POC:** Select POC Whiteboard > Patient. The Patient Medical Summaries may be added to any of the available tabs on the virtual chart. See the POC Setup user guide for additional information on adding the Patient Medical Summaries.
- **Medical Records:** Select System Menu > Patient Account # > Medical Records > Print Electronic Record > Account Number or Medical Record Number > Patient Medical Summaries

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

3.2 Types of Summaries

There are three predefined medical summary options available for specified needs according to Promoting Interoperabiity. To access a single summary, highlight the desired summary and select **View**.

Select **Patient Account > Health Information Resource > Patient Medical Summaries**



Patient Medical Summaries

The following options are displayed:

	Includes:	
Patient Summary 2.1.2	• Patient Demographics • Care Team • Provider Organization • Functional Status • Immunization • Mental Status • Results • Social History • Vital Signs • Medications • Assessment • Hospital Discharge Instructions • Reason For Referral	• Procedures • Implants • Problems • Allergies and Adverse Reactions • Plan of Treatment • Encounters • Goals • Health Concerns Section • Personal Care Team Section • Consultation Notes • History and Physical Notes • Progress Notes
Referral Note 2.1.2	• Patient Demographics • Care Team • Provider Organization • Functional Status • Immunization • Mental Status • Results • Social History • Vital Signs • Assessment • Hospital Discharge Instructions • Reason For Referral • Medications	• Procedures • Implants • Problems • Allergies and Adverse Reactions • Plan of Treatment • Encounters • Goals • Health Concerns Section • Personal Care Team Section • Consultation Notes • History and Physical Notes • Progress Notes
Discharge Summary 2.1.2	• Patient Demographics • Care Team • Provider Organization • Functional Status	• Procedures • Implants • Problems

- Immunization
- Mental Status
- Results
- Social History
- Vital Signs
- Assessment
- Hospital Discharge Instructions
- Reason For Referral
- Hospital Course
- Medications
- Allergies and Adverse Reactions
- Plan of Treatment
- Encounters
- Goals
- Discharge Medications
- Discharge Diagnosis
- Health Concerns Section
- Personal Care Team Section
- Consultation Notes
- History and Physical Notes
- Progress Notes

NOTE: *The Referral Note 2.1.2 is only required for Eligible Providers (EP) and the Discharge Summary 2.1.2 is only required for Eligible Hospitals. An EP or eligible hospital must verify current problem list, current medication list, and current medication allergy list are not blank and include the most recent information known by the EP or hospital at the time of generating the CCDA.*

The following options are available on the action bar:

- **View:** Allows the selected Patient Medical Summary to display within the Patient Medical Summaries - Document View screen. This option is enabled once a document has been selected. For additional information on viewing a document please see View 6. TIP: To view a document, you can also double-click to view the Patient Medical Summaries - Document View screen.

- **Edit Exclusions:** Allows certain parts of the Patient Medical Summary to be excluded from the document and/or the patient portal. This option is enabled once a document has been selected. For additional information, see Edit Exclusions 34.

Chapter 4 View

The Patient Medical Summaries - CCDA allows the documentation to be submitted to the provider or HIE. The documentation may also be printed or copied to portable media.

Select **Patient Account > Health Information Resource > Patient Medical Summaries > Patient Summary 2.1.2 > View**

The screen displays the facility name and the date the CCDA was created. Pulls from the Physician table for physicians. Pulls the provider organization address from the 999999 Physician table for nurses.

The following options are available from the task bar:

- **Submit to Provider:** Allows direct messaging of a single Patient Medical Summary. Please see Submit to Provider 10 for more information.
- **Submit to HIE (Health Information Exchange):** Allows a single Patient Medical Summary to be transmitted. Please see Submit to HIE 12 for more information.
- **Copy to Portable Media:** The media may be given to a patient electronically by selecting **Portable Media**. At this point, select CD Drive or insert a flash drive to copy media. The steps to download data to a CD are dependent on the type of operating system.
- **Print:** Once the desired documents are selected, they may be printed. Select a print option.
- **View Errors:** Provides a display of any errors, warnings and information regarding the transmission of Patient Medical Summaries for Model-Driven Health Tools (MDHT) Conformance and Office of the National Coordinator for Health Information Technology (ONC) Conformance. Transmission Errors will be the default display, but radio buttons for Errors, Warnings and Info allow the user to view another selected group. If no information is returned for a specific section, the screen should display one of the following: "No Errors", "No Warnings", or "No Info".
- **View XML:** Creates an XML version of the document for review.
- **View HTML:** Allows the CCDA to display in the HTML view instead of displaying it in the Viewer. When selected and the HTML view is displayed the option then displays as **View CDA Viewer**. When View CDA Viewer is selected, the CCDA is then displayed in the Viewer. All export options will remain the same whether the CCDA is displayed in the Viewer or the HTML view.

NOTE: *The default display for the CCDA is the Viewer. This may be changed so that the HTML view is the default by selecting the* ***Use CCDA HTML View*** *check box within the Department Tables in Table Maintenance. Please see the Table Maintenance - Control User Guide for additional information.*

NOTE: *If the following actions are taken on an edited Patient Medical Summary, an entry will display in Electronic File Management: Submit to Provider, Submit to HIE, Copy to Portable Media, and Print.*

The following patient information will display:

- **Name:** Pulls the First, Middle and Last Name from the Patient tab on the Registration and ADT screen. The Suffix will pull when added to the Suffix field in the patient's Additional Information in Additional Demographics.
- **Sex:** Pulls the patient's gender from the Patient tab on the Registration and ADT screen
- **Date of Birth:** Pulls the patient's date of birth from the Patient tab on the Registration and ADT screen
- **Admission Date/Time and Discharge Date/Time:** Pulls the admit date/time and discharge date/time from the Stay tab on the Registration and ADT screen or AR Hospital - Visit Screen for TruBridge Provider EHR.

The Contact Information, Patient Demographics and Care Team may be selected to display additional patient information. Please see Patient Demographics 7 and Care Team 15 for more information. Once reviewed, select the option again to hide the information panel.

To view all sections of the document, use the scroll bar on the right side of the screen. To return to the top of the document, select the **Back To Top** option on each individual section. Selecting the name of any section from the left side navigation panel will jump directly to that section. Users may also choose the order in which sections display in the CCDA Viewer. To change the order of the sections, the user will select the section from the table of contents and drag it up or down to the desired location.

Sections may also be removed or minimized. To **Minimize** a section, select the minus sign on the desired section. To display the minimized section again, select the plus sign. To **Remove** a section, select the 'X' icon on the desired section. Removed sections will display a grey check mark in the navigation menu on the left. To add a section back, select the grey check mark next to the section name. The check mark will then display green, this is the default setting for a section.

Any changes are temporary and the standard defaults will be applied each time a new document is generated, unless the changes are saved to a Preference. Please see Preferences 15 for additional information. Also be aware that any changes made to the document view are not saved on documents printed, copied to Portable Media, submitted to HIE, nor Submitted to Provider. Users must still edit and save documents, via the Edit Exclusions 34 option on the previous screen.

4.1 Patient Demographics

The Patient Demographics section of the CCDA reflects the patient's contact and demographic information entered within Patient tab on the Registration and ADT screen.

Select **Patient Demographics** to jump to the patient demographic information section of the document.

- **Name:** Displays the patient's name.

- **Alternate Name:** Pulls the patient's alternate name listed in their additional patient demographics. Alternate Name will only display within the demographics tab if the patient has an alternate name(s) listed.
- **Address:** Pulls the patient's address information from the Patient tab on the Registration and ADT screen.
- **Previous Address:** Pulls the patient's previous address if available within Address History of Health History
- **Primary Number (home/cell):** Pulls the patient's home and mobile numbers from the Patient tab on the Registration and ADT screen.
- **Email:** Pulls the patient's email from the Patient tab on the Registration and ADT screen.
- **Date of Birth:** Pulls the patient's date of birth from the Patient tab on the Registration and ADT screen.
- **Administrative Gender:** Pulls the patient's administrative gender from the Person Profile.
- **Race:** Pulls from the Patient tab on the Registration and ADT screen. The CCDA can display up to five races.
- **Marital Status:** Pulls from the Patient tab on the Registration and ADT screen.
- **Ethnicity:** Pulls from the Patient tab on the Registration and ADT screen.
- **Secondary Ethnicity:** Pulls from the Patient tab on the Registration and ADT screen.
- **Language Spoken:** Pulls the full language description from the Patient tab on the Registration and ADT screen.
- **Religion:** Pulls from the Patient tab on the Registration and ADT screen.

NOTE: *The Race and Ethnicity codes must be associated with a Promoting Interoperability value code in the Race Codes table and Ethnicity Codes table in Table Maintenance - Patient Intake in order to pull to the CCDA.*

4.2 Care Team

The Care Team section of the Patient Medical Summaries reflects the care team members involved in the patient's care. The listing includes the name, address (work), phone (work) and role (provider, nurse, pharmacist, employee, etc) for the facility, physicians and employees.

Select **Care Team** to jump to the Care Team section of the document and view the medical staff associated with the visit.

The Care Team Members will pull from the following places within TruBridge to the Patient Medical Summaries.

Office Contact:

The name and phone number will pull from Office Contact Information on the MU tab of the 999999 Physician Table for the hospital and TP EHR clinics that are separate facilities. The address will pull from Page 1 of the 999999 Physician Table. If the TP EHR clinic is a department of the hospital, the address will pull from the Clinic Code Table and the name and phone number will pull from the Office Contact Information in the Clinic Code Table in Business Office Table Maintenance.

Provider:

The Provider's Name, Address and Phone Number will pull from Physician Information Page 1 of the Physicians table in Clinical Table Maintenance. The Role may be Attending, Secondary, Primary, Consulting, Hospitalist, Hospitalist of Record or Transferring Provider. If there is no address or phone information in the Physician table, the system will pull the organization address and phone number from the 999999 Physician Table.

- Any provider listed within the Care Team which may be accessed from the following locations:
  - From the Hospital Base Menu > Master Selection > Account > Census > Stay Tab > Care Team.
  - From Charts > Account > Demographics > Care Team.
- Providers listed as the Attending, Second, Primary Care or Consulting (multiple available) from the Diagnosis/Physicians tab in Clinical Information on the Patient Function screen.
- Providers listed at the Attending, Second, Primary Care or Consulting (multiple available) from the Demographics option on POC Flowcharts.
- The Provider of Care from Patient Location Maintenance for EDIS and TruBridge Provider EHR. If the Provider of Care is changed or removed from the field, they will remain on the Care Team.
- When an Outbound Referral is created the Attending Physician will be listed as the Transferring Provider.
- The Patient's Physician added to the Procedure in the Medical Records Grouper.

Employees:

The employee Name and Role will pull from the user login in System Administration. The organization address and phone number will pull from Page 1 of the 999999 Physician Table.

- Selecting the plus (+) on a selected patient from Census tab on the POC Whiteboard.
- The Nurse field in Patient Location Maintenance for EDIS and TruBridge Provider EHR. If a nurse is changed or removed from the field they will remain on the Care Team.
- Employees added to the Care Team in the Demographics application.
- From the Patient List option on the POC Whiteboard when the **Add to My Patients** option is used to create a unique patient list.
- From the Patient List option on the Hospital Base menu when the **Add to My Patients** option is used to create a unique patient list.

NOTE: *Participants Care Team Members is currently TruBridge Use Only.*

4.3 Provider Organization

The Provider Organization section of the Patient Medical Summaries displays the Name, Address and Phone Number of the facility. This information pulls from the Test Physician 999999 in the Physician Table.

4.4 Submit to Provider

When the **Submit to Provider** option is selected for transmittal of the CCDA document to another provider of care, a message screen will display.

NOTE: *If a CCDA document is viewed, printed, exchanged through HIE Interface or submitted via Submit to Provider and Release of Information is updated, 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 CCDA document will be saved with the title that is associated with document in the CCDA Image Title table. If there is not a CCDA Image title associated, the Image title Table will display to choose a title. See* *Image Title Table* 11 *for additional information.* *The Electronic File Management audit log will be updated with the date, time and employee name when the document is saved.*

The email address that pulls to the **From** field will follow the hierarchy listed below:

1. The system will determine the patient's location. For example, inpatients will be associated with a nursing station. The nursing station will be linked to a department.
2. If the department has a clinic code loaded on page 5 of the Department table, the system will pull the email address loaded in the **Direct Address** field in the Clinic Table for the listed clinic code.
3. If the department does not have a clinic code loaded on page 5 of the Department table, the system will pull the email address loaded in the **Direct Address** field on page 5 of the 999999 Physician table.
4. If there is not a location for the patient. For example, outpatients would not have a location. The system will pull the email address loaded in the **Direct Address** field on page 5 of the 999999 Physician table.

The provider's direct email address may be entered in the **To** field. This field will accept multiple direct email addresses. Select the **magnifying glass icon** to search the Referring Physician table for the provider's direct email address.

A subject may be entered in the **Subject** field.

The **Message** box is a free text box.

The attached CCDA document may be viewed by selecting **View Attachment** from the action bar.

The email may be sent by selecting the **Send** option on the action bar. Once an email has been sent to another provider of care, the CCDA Transmission Log will be updated with the patient information and a status of Pending. The log will be updated again once a notification is received that the transmission was a success or a failure. Refer to the Audit System documentation for more information regarding the CCDA Transmission Log.

Select **Patient Account > Health Information Resource > Patient Medical Summaries > CCDA Document > View or Edit > Submit to Provider**

Submit to Provider

Image Title Table

When a CCDA document is selected to be viewed, printed or exchanged through HIE Interface, Submit to Provider or Copy to Portable Media, a copy of the document will be saved in Electronic File Management. If there is not an image title associated with the selected CCDA document in the CCDA Image Title table, within Business Office - Table Maintenance area, the Image Title table will display. Please see the Table Maintenance - Business Office user guide for the CCDA Image Title setup to bypass the Image Title table.

Select the **Image Title** that should be associated with the CCDA document.

Select **OK**.

After the image title is selected, then the Submit to Provider screen, Submit to HIE screen, Print screen or Copy to Portable Media screen will display.

4.5 Submit to HIE

The **Submit to HIE** option may be selected for transmittal of the CCDA document.

NOTE: *If a CCDA document is viewed, printed, exchanged through HIE Interface or submitted via Submit to Provider and Release of Information is updated, 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 CCDA document will be saved with the title that is associated with document in the CCDA Image Title table. If there is not a CCDA Image title associated in the Image Title table, a list will display to choose a title. See* *Image Title Table* 11 *for additional information. The Electronic File Management audit log will be updated with the date, time and employee name when the document is saved.*

Upon selecting the **Submit to HIE** option, the system will display one of the following submission statuses:

1. **All Submitted Successfully**: The submission attempt was successful.
2. **Submission Error, Please Check Exchange Configuration**: There is an issue with all active exchanges.
3. **Partial Submission Success**: The document was successfully submitted to one or more exchanges. However, the document was not transmitted to one or more exchanges.
4. **No HIEs Enabled, No Submissions Performed**: No exchanges have been set up.
5. **An Unknown Error Occurred, Please Check Exchange Configuration**: There is an unspecified issue with one or more of the active exchanges.
6. **Submission Failed, Patient is not Set to Allow HIE Sharing**: The HIE Shared Data field on the Stay tab on the Registration and ADT screen is set to **N**. If this field is answered **N**, the information will not be shared and therefore not transmitted.

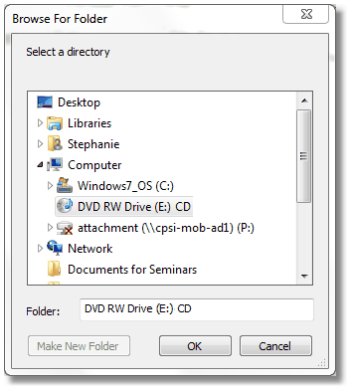
NOTE: *It is the responsibility of the facility to ensure proper encryption of the PDF file that is emailed.*

4.6 Copy to Portable Media

Once **Copy to Portable Media** is selected, the Browse for Folder box is displayed. Select a CD Drive or insert a flash drive to copy media. The steps to download data to a CD are dependent on the type of operating system. Refer to the document Instructions for Downloading to Portable Media which details steps for Windows XP, Vista and Windows 7 operating systems.

NOTE: *If a CCDA document is viewed, printed, exchanged through HIE Interface or submitted via Submit to Provider and Release of Information is updated, 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 CCDA document will be saved with the title that is associated with the document in the CCDA Image Title table. If there is not a CCDA Image title associated in the Image Title Table, a list will display to choose a title. See* *Image Title Table* 11 *for additional information. The Electronic File Management audit log will be updated with the date, time, and employee name when the document is saved.*

Select **Patient Account > Health Information Resource > Patient Medical Summaries > CCDA Document > View or Edit > Copy to Portable Media**



Browse for Folder

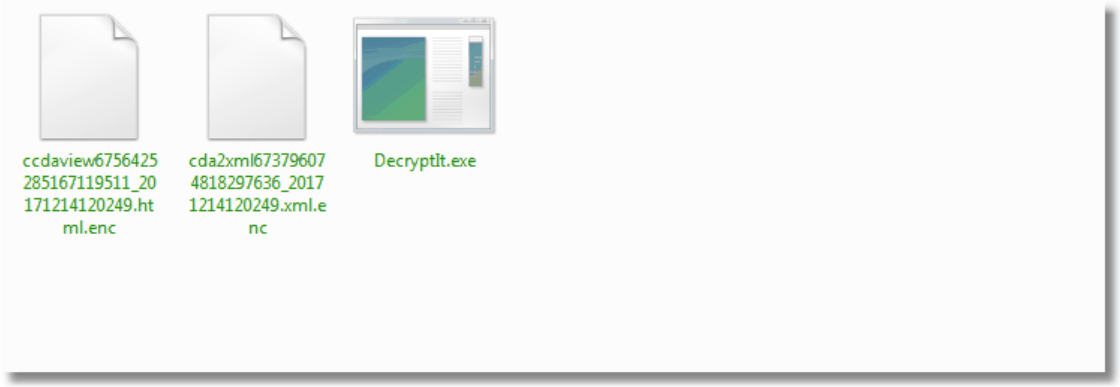
This will allow the hospital to encrypt the data before providing it to the patient. Enter an encryption key as designated by the patient or hospital. The encryption key may be up to 32 characters in length. TruBridge recommends the encryption key be relayed verbally to the requestor and not documented alongside the portable media.

Select **Patient Account > Health Information Resource > Patient Medical Summaries > CCDA Document > View or Edit > Copy to Portable Media > Folder or Portable Media**

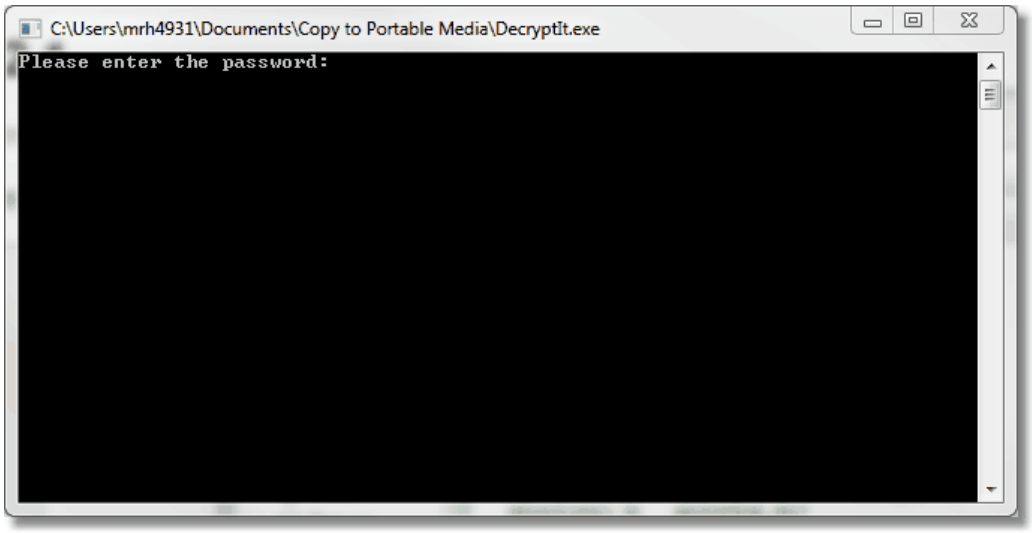
After the encryption key is entered select **OK** to complete the Copy to Portable Media or **Cancel** to end the Copy to Portable Media without saving. Selecting **OK** will display a notification of "Submitted!" and then select **OK** to close the notification. If **Cancel** is selected, the notification "Invalid password, file not encrypted!" will display.

Retrieving the file from Portable Media - Data Encrypted

When the patient inserts the flash drive in the PC, temporary files will display that cannot be read. The patient will need to select the DecryptIt file and enter the encryption code provided by the facility.



USB Thumb Drive Directory



DecryptIt.exe

At this point, an PDF file will be created allowing the patient to view the medical record.

NOTE: *If the Patient Medical Summary is downloaded to Portable Media, it will automatically load and display once the encryption code is entered.*

4.7 Print

Selecting the **Print** option from the action bar will allow the selected CCDA document to be printed.

NOTE: *If a CCDA document is viewed, printed, exchanged through HIE Interface or submitted via Submit to Provider and Release of Information is updated, 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 CCDA document will be saved with the title that is associated with document in the CCDA Image Title table. If there is not a CCDA Image title associated in the Image Title Table, a list will display to choose a title. See* *Image Title Table* 11 *for additional information. The Electronic File Management audit log will be updated with the date, time and employee name when the document is saved.*

1. Select **Print**.The Select a printer screen is displayed.
2. Select the **Workstation** option from action bar may be selected to print the CCDA document to the workstation printer or choose a printer from the list.
3. Select **OK**.

Selecting **View** will display the CCDA document.

4.8 View XML

Selecting **View XML** displays the XML format of the Summary document. Click the **X** to close the view.

4.9 View CDA Viewer

Selecting **View CDA Viewer** displays the document in the CDA Viewer, which allows you to select preferences 15 and edit the display of the document.

Preferences

Once a document is displayed in the viewer, users can create customized viewing preferences.

Select **Patient Account > Health Information Resource > Patient Medical Summaries > Patient Summary 2.1.2 > View**

To Create a Preference:

1. To hide any section, select the green check mark next to the section name. This will turn the check mark gray and hide the section from the display. A gray check mark identifies the section as hidden.

2. Place the sections in the desired order by selecting the section and dragging it up or down to the desired location.

3. Once the desired sections are hidden and in the selected order, select "No Preference" in the name field and delete the "No Preference" title.

4. Enter the name of the preference.

5. Select the green plus sign to save the preference. Once the preference is created, a message will flash in the top right corner of the CCDA Viewer stating "Success. A new preference layout created".

To Edit a Preference:

1. Select the preference to be edited from the Preferences drop-down.

2. Once selected, add or remove any sections or change the display order of the sections.

3. Once all changes have been made, select the pencil icon to finalize the edits on that preference. Once the preference is edited, a message will flash in the top right corner of the CCDA Viewer stating "Success. This preference has been modified".

Deleting a Preference:

1. Select the preference to delete from the Preferences drop-down.

2. Then select the garbage can icon to delete the selected preference. A prompt will display to confirm the preference will be deleted. The users will select "Yes" to delete the preference and "No" to keep the preference. (Highlight/point to **Yes and No** options on the confirmation pop-up. Select **Yes**). Once the preference is deleted, a message will flash in the top right corner of the CCDA Viewer stating "Success: This preference has been deleted".

Default Preferences:

Default Preferences may also be set up for the CCDA Viewer. The default preference for the document viewer will be "No Preferences". The user may set another title as a default preference.

To set up a default preference:

1. Select the Preferences drop-down.

2. In the list of preferences, select the grey star icon next to the desired default preference. This will set that preference as the default, turning the star gold. This default preference will load each time the user accesses the document viewer screen.

At any time, the user can select the grey star next to any title in order to change their default preference. To reset the "No Preference" as the default, select the gold star next to the current default preference. This will turn it back to grey.

Sections included in the Preference that are note included in the document will display with a no symbol icon  in the header of the table of contents and 'Section Not Included in this Document' will display within the section.

The "i" icon  will display within the table of contents if the section has information available but section is not included within the applied preference. Once the section is saved to the applied preference, the "i" icon will no longer display.

NOTE: *All preferences are specific to the current UBL. Preferences cannot be shared nor copied to other UBLs.*

4.10 View Errors

This will allow any errors, warnings or information to display that may have generated via the CCDA validator while importing a CCDA or exporting a CCDA. This is a view only screen and any errors, warnings or information that displays does not affect the document when importing or exporting.

The following radio buttons will display:

- **Errors**: Displays all errors from the MDHT Conformance section and ONC Conformance section. This is the default selection.

- **Warnings**: Displays all warnings from the MDHT Conformance section and ONC Conformance section.
- **Info**: Displays all info from the MDHT Conformance section and ONC Conformance section.

***NOTE**: If no information is returned for a specific section, the text will display one of the following: No Errors if the Errors radio button was selected, No Warnings if the Warnings radio button was selected and No Info if the Info radio button was selected.*

The action bar is as follows:

- **Back Arrow**: Allows the user to return to the previous screen.

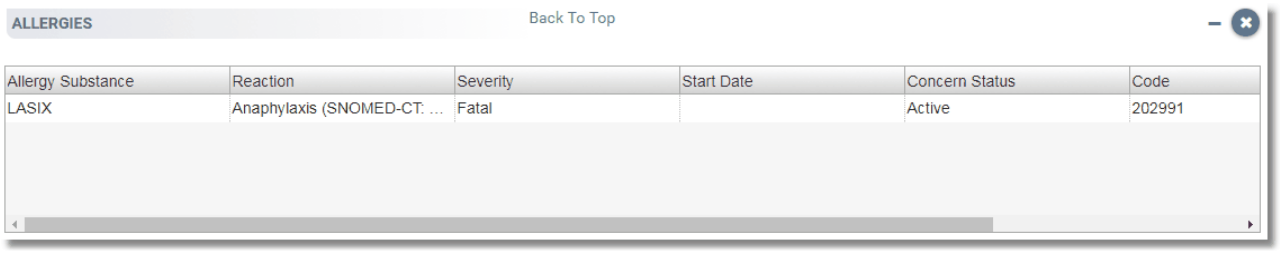
4.11 Content

Allergies and Adverse Reactions

The Allergies and Adverse Reactions section of the Patient Medical Summaries reflects the patient's active drug, food and environmental allergies. "No Data Found" will display if no information is entered for the section. "No Known Drug Allergies" will display when selected for documentation.

***NOTE:** Current medication allergies must be fulfilled for Meaningful Use standards.*

Select **Patient Account** > **Health History** > **New** > **Referral/Transition of Care** > **Patient Medical Summaries** > **Patient Summary 2.1.2** > **Allergies**



Allergies

- **Allergy Substance:** Displays the description of the allergy
- **Reaction:** Displays the reaction to the allergen and the associated SNOMED code.
- **Severity:** Displays the severity of the reaction to the allergen
- **Start Date:** Displays the Onset Date of the allergen. If no Onset Date is entered the field will be blank.

- **Concern Status:** Only active allergies display
- **Code:** Displays the allergy code.
- **Code System:** Displays the code system used for the identification of the allergen.

Assessment

The Assessment section of the Patient Medical Summaries is an overall evaluation of the patient visit. "No Data Found" will display if no information is entered for the section.

Select **Patient Account** > **Health History** > **New** > **Referral/Transition of Care** > **Patient Medical Summaries** > **Patient Summary 2.1.2** > **Assessment**

Assessment

The Assessment section of the CCDA includes:

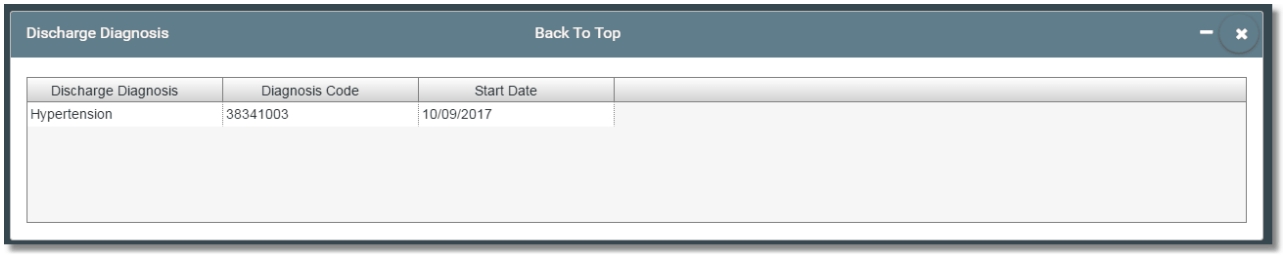
- Active problems entered or documented against, in the Problem List.
- On inpatients the Assessment section consists of the last signed Progress Note.
- On patients in the EDIS department or TPEHR clinic, the Assessment section contains all documentation entered on the Assessment section of a document within the Documentation application. This includes the predefined information within the document, and information added from Charting Options or Quick Add text boxes. Information retracted or amended will not be included.
- On patients with a signed Note that includes the Patient Medical Summaries filter Assessment, any documentation within the Assessment filter will display.

Discharge Diagnosis

NOTE: *This topic is only available on the Discharge Summary 2.1.2.*

The Discharge diagnosis section of the CCDA reflects the patient's principal diagnosis. "No Data Found" will display if no information is entered for the section.

Select **Patient Account** > **Health History** > **New** > **Referral/Transition of Care** > **Patient Medical Summaries** > **Patient Summary 2.1.2** > **Discharge Diagnosis**



Discharge Diagnosis

- **Discharge Diagnosis:** Pulls the description of the principal diagnosis from the Diagnosis screen in the Medical Records Grouper."
- **Diagnosis Code:** Displays the SNOMED Code associated with the principal diagnosis code from the Diagnosis screen in the Medical Records Grouper.
- **Start Date:** Pulls from the admission date of the visit.

Discharge Medications

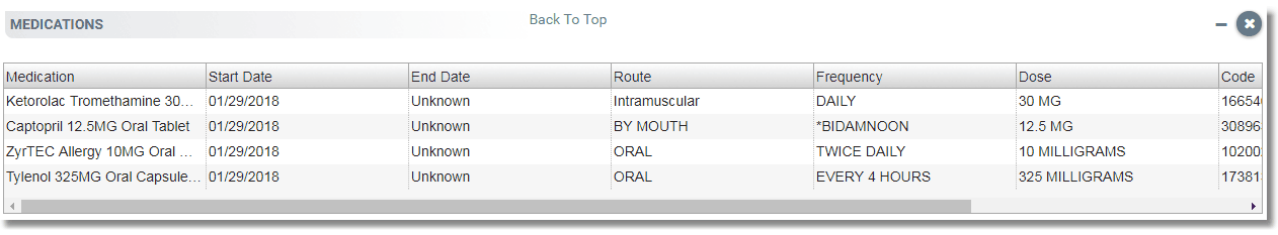
NOTE: *This is topic is only available on the Discharge Summary 2.1.2. If the Discharge Medications is included in a preference but the Discharge Summary 2.1.2 is not the selected summary, the viewer preference listing will display the no symbol icon*  *and 'Section Not Included in this Document' will display within the section.*

The Discharge Medications section of the Patient Medical Summaries reflects all of the patient's active medications, prescriptions entered within Prescription Entry and those administered via Diabetic Record, EMAR and Med-Verify. "No Data Found" will display if no information is entered for the section.

The "i" icon  will display within the section preference listing if the section has information available but section is not included within the applied preference

NOTE: *Prescriptions created when continuing active medications via discharge reconciliation may look like duplicates because the active medications will also be pulling.*

Select **Patient Account > Health History > New > Referral/Transition of Care > Patient Medical Summaries > Patient Summary 2.1.2 > Discharge Medications**



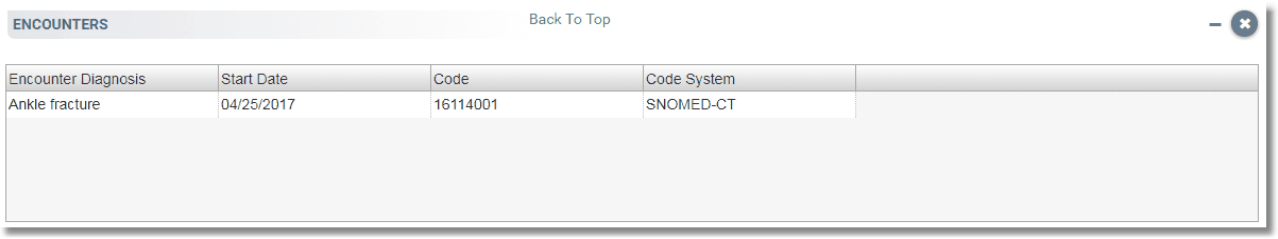
Discharge Medications

- **Medication:** Displays the description of the medication.
- **Start Date:** Displays the date the medication was started.
- **End Date:** Displays the date the medication was stopped. "Unknown" will display if a Stop Date has not been entered for the medication.
- **Route:** Displays the ordered route for the medication.
- **Frequency:** Displays the ordered frequency for the medication.
- **Dose:** Displays the ordered dose for the medication.
- **Code:** Displays the drug code.
- **Code System:** Displays the code system used for the identification of the medication.

Encounters

The Encounters section of the CCDA reflects the patient's principal diagnosis. "No Data Found" will display if no information is entered for the section.

Select **Patient Account** > **Health History** > **New** > **Referral/Transition of Care** > **Patient Medical Summaries** > **Patient Summary 2.1.2** > **Encounters**



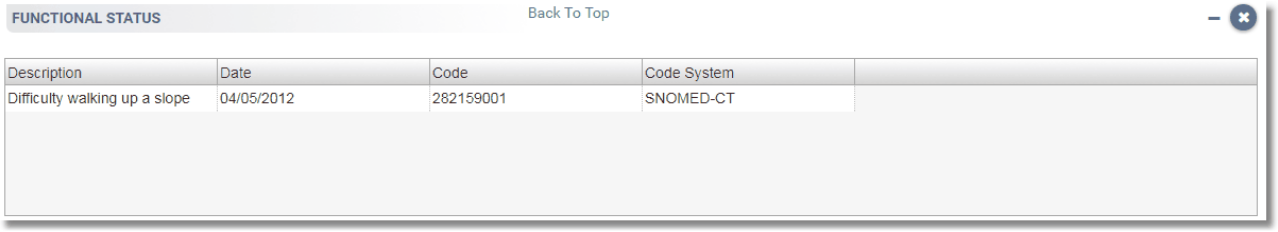
Encounters

- **Encounter Diagnosis:** Pulls the description of the principal diagnosis from the Diagnosis screen in the Medical Records Grouper."
- **Start Date:** Pulls from the admission date of the visit.
- **Code:** Displays the SNOMED Code associated with the principal diagnosis code from the Diagnosis screen in the Medical Records Grouper
- **Code System:** Displays the code system used for the identification of the principal diagnosis impairment

Functional Status

The Functional Status section of the Patient Medical Summaries reflect the patient's active functional status as entered in the Functional/Cognitive Status in the Health History application. "No Data Found" will display if no information is entered for the section or if **No Impairment** is documented within the application.

Select **Patient Account** > **Health History** > **New** > **Referral/Transition of Care** > **Patient Medical Summaries** > **Patient Summary 2.1.2** > **Function Status**



Functional Status

- **Description:** Displays the description of the impairment documented from the Health History Application-Functional/Cognitive Status section
- **Date:** Displays the Onset Date for the impairment documented
- **Code:** Displays the SNOMED Code associated with the impairment
- **Code System:** Displays the code system used for the identification of the functional impairment

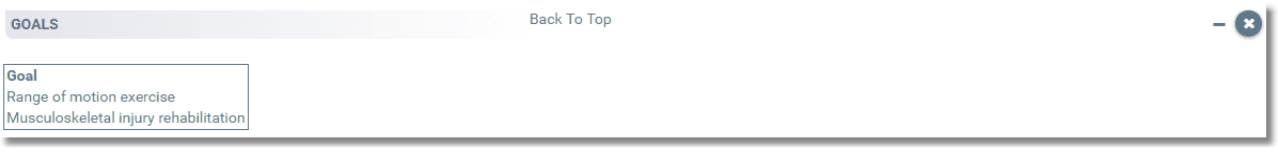
NOTE: *Entries with a status of removed will not display.*

Goals

The Goals Section of the Patient Medical Summaries will reflect the description of any patient goal entered via the Plan of Care application for the current patient visit. "No Data Found" will display if no information is entered for the section.

All goal descriptions will pull to this section with date of entry.

Select **Patient Account** > **Health History** > **New** > **Referral/Transition of Care** > **Patient Medical Summaries** > **Patient Summary 2.1.2** > **Goals Section**



Goals Section

Health Concerns Section

The Health Concerns Section of the Patient Medical Summaries will reflect any linked health concerns entered within Health History. "No Data Found" will display if no information is entered for the section. "Related Problem" may pull problems from the Problem List and any text entered in the "Other Concerns" section of Health Concerns in Health History will display in the "Comment" section.

Select **Patient Account > Health History > New > Referral/Transition of Care > Patient Medical Summaries > Patient Summary 2.1.2 > Health Concerns Section**

Health Concerns Section

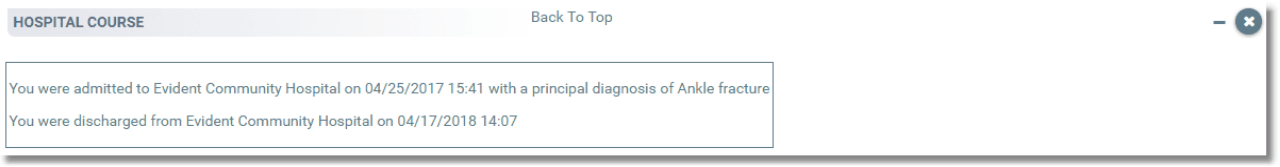
Hospital Course

NOTE: *This topic is only available on the Discharge Summary 2.1.2. If the Hospital Course is included in a preference but the Discharge Summary 2.1.2 is not the selected summary, the viewer preference listing will display the no symbol icon*  *and 'Section Not Included in this Document' will display within the section.*

The "i" icon  will display if the section has information available but section is not included within the applied preference.

The Hospital Course section displays the facility name, admission date/time, principle diagnosis and the discharge date/time from the facility. The principle diagnosis pulls from the DRG Grouper and Maintenance screen, page 1, principal diagnosis code description. On patients with a signed Note that includes the Patient Medical Summaries filter Hospital Course, any documentation within the Hospital Course filter will display.

Select **Patient Account > Health History > New > Referral/Transition of Care > Patient Medical Summaries > Discharge Summary 2.1.2 > Hospital Course**

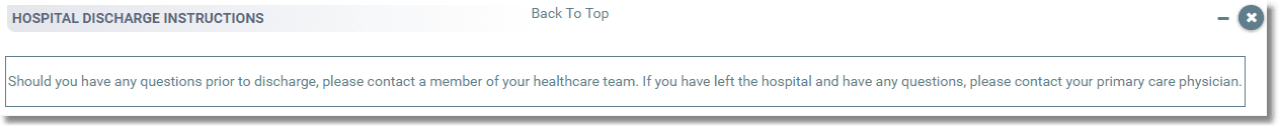


Hospital Course Section

Hospital Discharge Instructions

The Instructions section of the CCDA reflects information pertinent to discharge. "No Data Found" will display if no information is entered for the section.

Select **Patient Account > Health History > New > Referral/Transition of Care > Patient Medical Summaries > Discharge Summary 2.1.2 > Hospital Course**



Hospital Discharge Instructions Section

The Hospital Discharge Instructions section displays a hard coded patient reminder to seek assistance from the healthcare team or Primary Care Physician if needed.

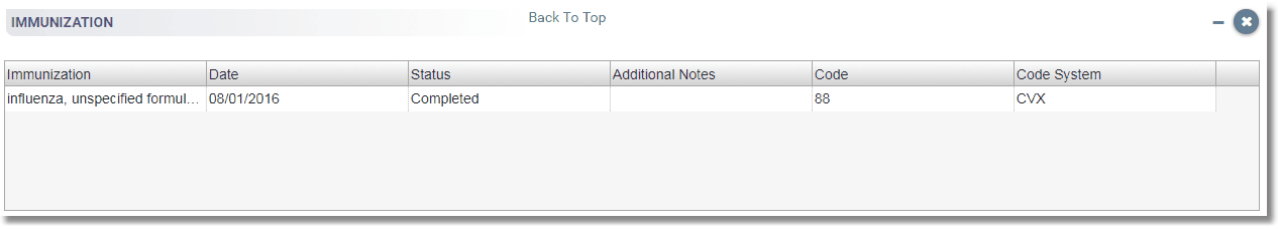
The patient's discharge instructions will display as documented via Point of Care Flow Charts, Documentation sections that are set to pull the CCDA Discharge Instructions and Physician Documentation sections that are set up with Action drop down menu set to Instructions and the Pull to drop down menu set to CDA Instructions.

Immunization

The Immunization section of the Patient Medical Summaries reflects the patient's immunizations that have been administered, added, omitted or excluded via the MAR, Patient Immunization History or Point of Care Pharmacy. "No Data Found" will display if no information is entered for the section.

NOTE: *Immunizations given from the MAR and then amended will not pull to the Immunization section.*

Select **Patient Account > Health History > New > Referral/Transition of Care > Patient Medical Summaries > Patient Summary 2.1.2 > Immunization**



Immunization

- **Immunization:** Displays the description of the immunization.
- **Date:** Displays the date the immunization was administered.
- **Status:** Displays if the immunization is "Completed", "Cancelled" or the reason not administered description if the immunization is Omitted.

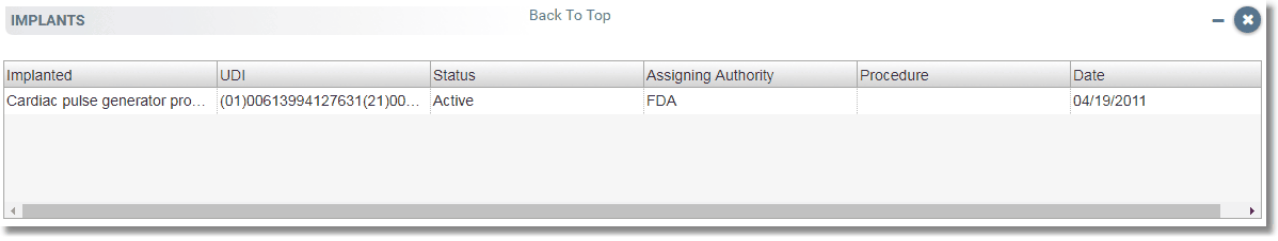
NOTE: *Excluded immunizations will display the Reason Not Administered SNOMED description in the Status column. If the SNOMED does not exist, the Omit Reason will display. If neither the SNOMED or Omit Reason are present, "Removed" will display in this column.*

- **Additional Notes:** Displays the Omit Description, if available.
- **Code:** Displays the CVX Code for the immunization.
- **Code System:** Displays the code system used for the identification of the immunization.

Implants

The Implant section of the Patient Medical Summaries will display all Active implants on the patient record. "Inactive" and "Entered in Error" will not display. "No Data Found" will display if no information is entered for the section.

Select **Patient Account** > **Health History** > **New** > **Referral/Transition of Care** > **Patient Medical Summaries** > **Patient Summary 2.1.2** > **Implants**



Implants

- **Implanted:** A procedure added when documenting an implantable device in Health History.

- **UDI:** A unique device identifier (UDI) in human and machine readable form. The UDI contains the Device Identifier (DI) and Product Identifiers (PI).
- **Status:** Active and Inactive statuses will display. Entered in Error will not display.
- **Assigning Authority:** The assigning authority is hard coded in the Patient Medical Summaries. It is the agency responsible for assigning unique device identifiers to implanted devices. It will always be the FDA for TruBridge Patient Medical Summaries.
- **Procedure:** Displays the Procedure associated with the implant in Health History if entered.
- **Date:** Displays the Procedure Date from the Implant entry in Health History.
- **Lot Number:** Displays the lot or batch number within which a device was manufactured.
- **Serial Number:** Displays the serial Number of the device.

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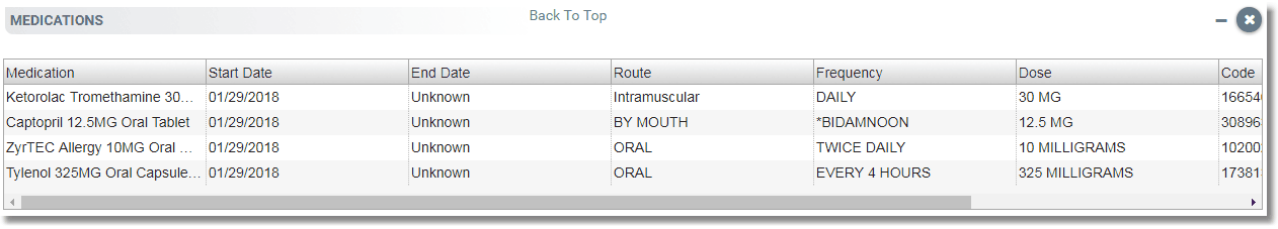
- **Manufacturing Date:** Displays the date the specific device was manufactured
- **Expiration Date:** Displays the expiration date of the device.
- **Distinct ID Code:** Displays the distinct identification code indicates the product contains or consists of human cells or tissues (HCT/P's) that are intended for implantation, transplantation, infusion or transfer into a human recipient and the Donation Identification Number. This will only be available on HCT/P implants.
- **Brand Name:** Displays the proprietary, trade or brand name of the medical device as used in device labeling or in the catalog.
- **Model Number:** Displays the version or model found of the device label or accompanying packaging used to identify a category or design of a device.

Medications

The Medications section of the Patient Medical Summaries reflects all of the patient's active medications, prescriptions entered within Prescription Entry and those administered via Diabetic Record, EMAR and Med-Verify. "No Data Found" will display if no information is entered for the section.

NOTE: *Prescriptions created when continuing active medications via discharge reconciliation may look like duplicates because the active medications will also be pulling.*

Select **Patient Account** > **Health History** > **New** > **Referral/Transition of Care** > **Patient Medical Summaries** > **Patient Summary 2.1.2** > **Medications**



Medications

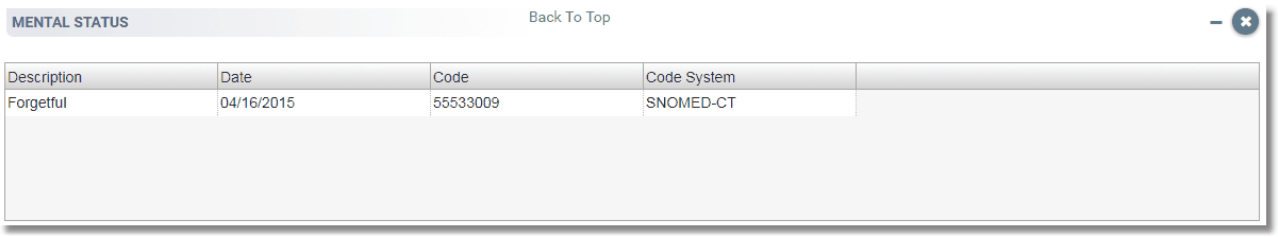
- **Medication:** Displays the description of the medication.
- **Start Date:** Displays the date the medication was started.
- **End Date:** Displays the date the medication was stopped. "Unknown" will display if a Stop Date has not been entered for the medication.
- **Route:** Displays the ordered route for the medication.
- **Frequency:** Displays the ordered frequency for the medication.
- **Dose:** Displays the ordered dose for the medication.
- **Code:** Displays the drug code.
- **Code System:** Displays the code system used for the identification of the medication.
- **Instructions:** Displays the ordered instructions for the medication.

NOTE: *Prescriptions that have a Stop Date/Time that is equal to or equal to the Admit Date/Time will display when the Patient Medical Summary is generated.*

Mental Status

The Mental Status section of the Patient Medical Summaries reflect the patient's active cognitive status as entered in the Functional/Cognitive Status in the Health History application. "No Data Found" will display if no information is entered for the section or if **No Impairment** is documented within the application.

Select **Patient Account** > **Health History** > **New** > **Referral/Transition of Care** > **Patient Medical Summaries** > **Patient Summary 2.1.2** > **Mental Status**



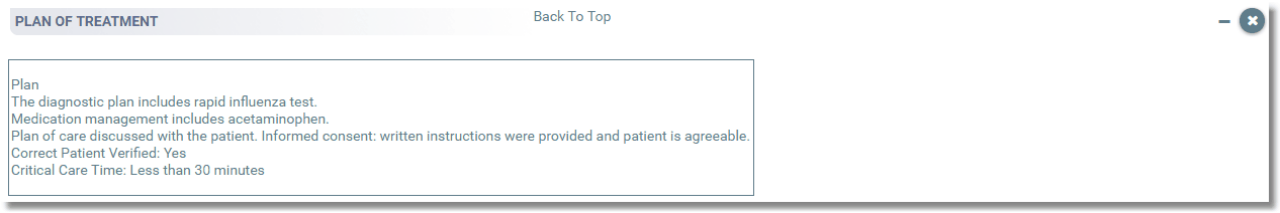
Mental Status

- **Description:** Displays the description of the impairment documented from the Health History Application-Functional/Cognitive Status section
- **Date:** Displays the Onset Date for the impairment documented
- **Code:** Displays the SNOMED Code associated with the impairment
- **Code System**: Displays the code system used for the identification of the mental impairment

Plan of Treatment

The Plan of Treatment section of the Patient Medical Summaries contains the current and future treatment plan for the current patient visit. "No Data Found" will display if no information is entered for the section.

Select **Patient Account** > **Health History** > **New** > **Referral/Transition of Care** > **Patient Medical Summaries** > **Patient Summary 2.1.2** > **Plan of Treatment**



Plan of Treatment

This section contains information entered in the following:

- Physical Assessment Flowchart questions that have Plan selected in the "Print to:" section in flowchart setup and have been documented against.
- The Plan of Treatment section contains all documentation entered on the Plan section of a document within the Documentation application, except for information retracted or amended.
- On patients with a signed Note that includes the Patient Medical Summaries filter Plan, any documentation within the Plan filter will display.
- Lab orders that have not been resulted with the scheduled date and LOINC code.
- Outbound Referrals from the Referral Transition of Care screen.
- Future appointments from Updated Scheduling.

Problems

The Problems section of the Patient Medical Summaries reflect problems documented within the Physician Problem List. "No Data Found" will display if no information is entered for the section. Problems are included on the summary as follows:

- All problems with an active status.
- Problems that are initiated and resolved during the current stay.
- Problems that were initiated during a previous stay but resolved during the current stay.
- Problems with a status of "Entered in Error" will not display on the summary.

NOTE: *Current problems must be fulfilled for Meaningful Use standards.*

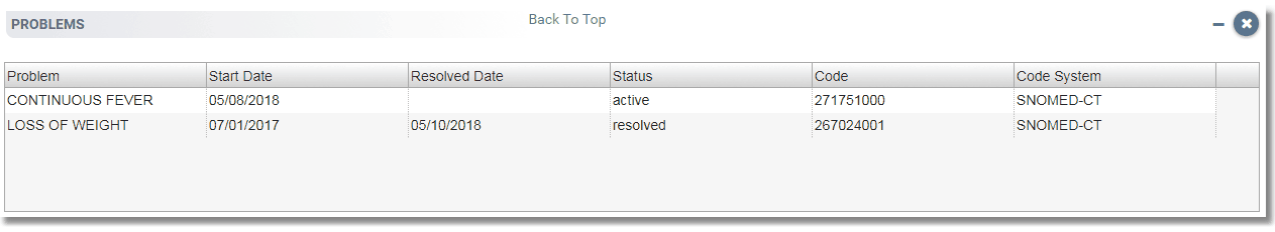
No Active Problems

When No Active Problems are selected for documentation within the Problem List, this will display as the active problem.

Problems

- **Problem:** Displays the description of the problem entered in the Problem List.
- **Start Date:** Displays the Onset Date documented in the Problem List.
- **Resolved Date:** Displays the resolved date documented for the problem.
- **Status:** Displays the status documented for the problem; active statuses or resolved status.
- **Code:** Displays the SNOMED code for the problem.
- **Code System:** Displays the code system used for the identification of the problem entered.

Select **Patient Account > Health History > New > Referral/Transition of Care > Patient Medical Summaries > Patient Summary 2.1.2 > Problems**

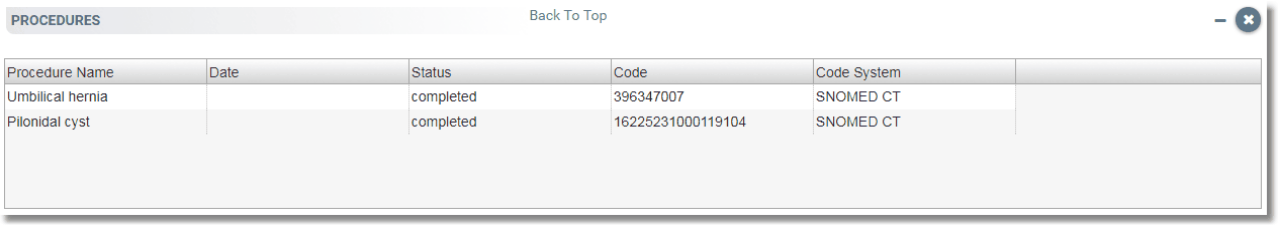


Problems

Procedures

The Procedures section of the Patient Medical Summaries reflects the procedure codes entered in the Grouper Procedure screen as well as ancillary and implant procedures. "No Data Found" will display if no information is entered for the section.

Select **Patient Account** > **Health History** > **New** > **Referral/Transition of Care** > **Patient Medical Summaries** > **Patient Summary 2.1.2** > **Procedures**



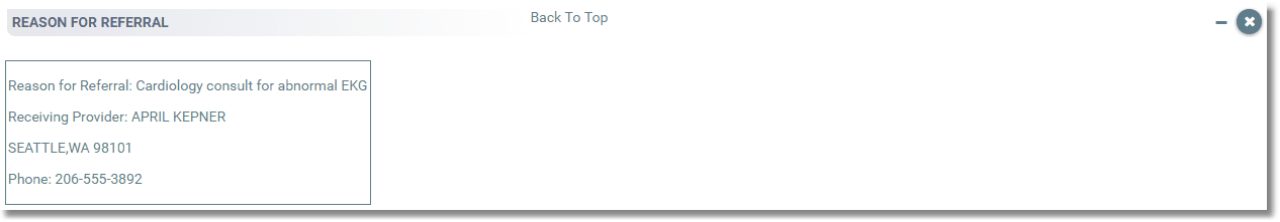
Procedures

- **Procedure:** Pulls procedures from the following:
  - The ICD description of procedures added in the Grouper Procedure screen.
  - The Item Master Description, page 1 of ancillary orders if the SNOMED Code is loaded on page 5 of the Item Master.
  - Associated procedures added when documenting an implantable device in Health History.
- **Procedure Name:** Pulls the procedure description.
- **Date:** Pulls from the DRG Grouper and Maintenance screen, page 2, Proc-Dt (Procedure Date). Procedures pulling from ancillary orders show the schedule date.
- **Status:** Displays the status of the procedure.
- **Code:** Pulls from the DRG Grouper and Maintenance screen, page 2, ICD and/or the SNOMED Code on page 5 of the Item Master.
- **Code System:** Displays the code system used for the identification of the procedure entered.

Reason for Referral

The Reason for Referral section of the Patient Medical Summaries, displays information from the Health History application. "No Data Found" will display if no information is entered for the section.

Select **Patient Account** > **Health History** > **New** > **Referral/Transition of Care** > **Patient Medical Summaries** > **Patient Summary 2.1.2** > **Reason for Referral**



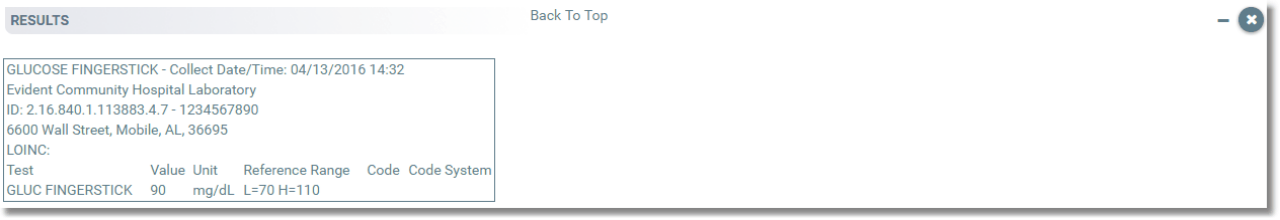
Reason for Referral

The summary will display Reason for Referral, Receiving Provider name, city, state, zip code and phone number, as well as the scheduled Appointment Date entered in the Referral/Transition of Care.

Results

The Results section of the Patient Medical Summaries displays any laboratory results and order transcriptions. "No Data Found" will display if no information is entered for lab tests and results.

Select **Patient Account > Health History > New > Referral/Transition of Care > Patient Medical Summaries > Patient Summary 2.1.2 > Results**



Results

The name of the lab test will display followed by the Collect Date and Time of the resulted lab test. The name and the address where the lab test was performed will also display.

NOTE: *If the CLIA number is present, the address will pull from the Performing Lab table in Table Maintenance - Control. If the CLIA number is not present, the address will pull from the Clinic Code associated with the department number. If there is not a Clinic Code, the address will pull from the Global Physician 999999.*

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

- **Code System:** Displays the code system used for the identification of the test result.

NOTE: *If a LOINC code is not present, but a SNOMED code is, the SNOMED will display. If a LOINC and SNOMED code are present on the test, the LOINC code will override the SNOMED. If neither a LOINC or SNOMED code is present, a CPT code will pull.*

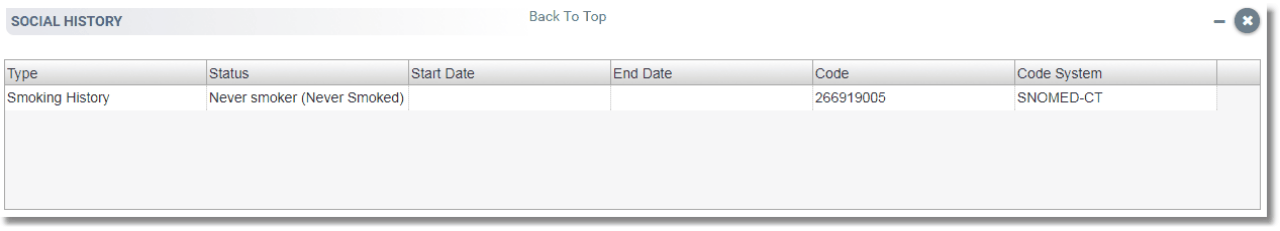
Order Transcriptions will display the order description followed by the completed date and time. The body of the transcription will display with the transcription and electronic signature data.

NOTE: *Results will not include Microbiology Results or results that have been canceled/removed. Only signed Radiology orders will display.*

Social History

The Social History section of the Patient Medical Summaries reflects the patient's Smoking History, Birth Sex, Sexual Orientation, and Gender Identity from the Social History section of Health History. The information in Health History pulls from the Patient tab on the Registration and ADT screen. "No Data Found" will display if no information is entered for the section.

Select **Patient Account** > **Health History** > **New** > **Referral/Transition of Care** > **Patient Medical Summaries** > **Patient Summary 2.1.2** > **Social History**



Social History

- **Type:** Pulls the type of information that will display from the Social History section of Health History. The different types are Smoking History, Birth Sex, Sexual Orientation, or Gender Identity.

- **Status:** For Smoking History, Sexual Orientation, or Gender Identity, pulls the patient's current and any historical Status from the Social History section of Health History. For Birth Sex, will pull the entry within the Birth Sex field of on the Patient tab on the Registration and ADT screen. If Non-Binary is selected within Social History-Sexual History, this will display as "Identifies as non-conforming gender" within the Status column for Gender Identity.

- **Start Date:** For Smoking History, pulls start date from the Social History-Drug Use section of Health History. For Birth Sex, the patient's date of birth will pull from the Patient tab on the Registration and ADT screen. For Sexual Orientation or Gender Identity, pulls the date it was entered within the Social History section of Health History.

- **End Date:** Pulls from the Social History-Drug Use section of Health History.

- **Code:** Displays the SNOMED code for the associated smoking status.

- **Code System:** Displays the code system used for the identification of the problem entered.

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 CCDA. If* ***Never*** *or* ***Unknown if ever smoked*** *is selected, neither Start Date nor End Date will pull to the CCDA. 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 CCDA. If* ***Former smoker*** *is selected, both Start Date and End Date will pull to the CCDA.*

Vital Signs

The Vital Signs section of the Patient Summaries 2.1.2 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. "No Data Found" will display if no information is entered for the section.

Select **Patient Account** > **Health History** > **New** > **Referral/Transition of Care** > **Patient Medical Summaries** > **Patient Summary 2.1.2** > **Vital Signs**

Vital Sign	Value	Unit	Date/Time	Recent/Initial?	Code	Code
Body Mass Index	29.68	kg/m2	11/14/2017 06:10	Inital	39156-5	LOI
Systolic Blood Pressure	120	mm[Hg]	11/14/2017 06:13	Most Recent	8480-6	LOI
Diastolic Blood Pressure	72	mm[Hg]	11/14/2017 06:13	Most Recent	8462-4	LOI
Systolic Blood Pressure	120	mm[Hg]	11/14/2017 06:10	Inital	8480-6	LOI

Vital Signs

- **Vital Sign:** The following initial and most recent vital signs will populate this section:
  - Body Mass Index measured in Kilogram Square Meter (kg/m2) is automatically calculated
  - Systolic Blood Pressure measured in Millimeters or Mercury (mm[Hg])
  - Diastolic Blood Pressure measured in Millimeters or Mercury (mm[Hg])
  - Body Surface Area measured in Square Meter (m2) is automatically calculated
  - Head Circumference measured in Centimeters (cm)
  - Height measured in inches (in)
  - O2 Saturation measured as a percentage (%)
  - Pulse measured in heart beats per minute (/min)
  - Respiration measured in breaths per minute (/min)
  - Temperature measured in Fahrenheit (F)
  - Weight measured in pounds (lbs)

- **Value:** Displays the vital value documented

- **Unit:** Displays the unit of measurement for the vital

- **Date/Time:** Displays the date and time the vital was documented

- **Recent/Initial?:** Displays if the vital was the Initial or Most Recent entry
- **Code:** Displays the associated SNOMED code
- **Code System:** Displays the code system used for the identification of the vital

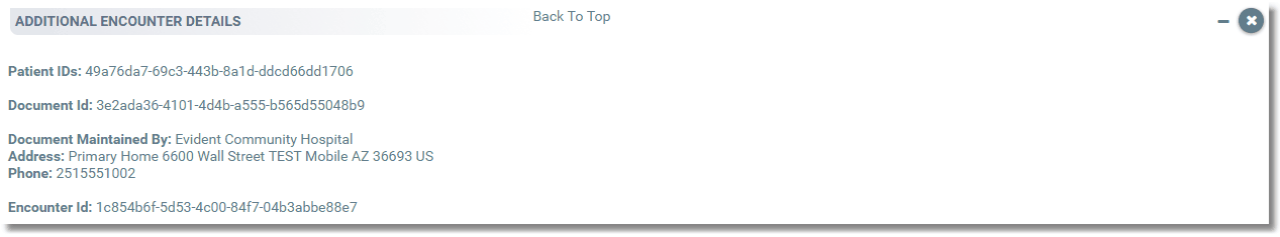
Additional Encounter Details

NOTE: *Currently this section is TruBridge Use Only*

Additional Encounter Detail will display the Encounter ID, Location ID, Encounter Type, Care Provision Start and End Dates/Time, Signed By, Legal Authenticator, Document ID, Document Maintained By, Responsible Party, Information Recipient, Informant, Entered By, Author, Patient IDs, and Admission Date. "No Patient Data Reported" will display if no information is entered for the section. This section will default to the bottom of the list of sections.

The "i" icon  will display if the section has information available, but the section is not included within the applied preference.

Select **Patient Account** > **Health History** > **New** > **Referral/Transition of Care** > **Patient Medical Summaries** > **Patient Summary 2.1.2** > **Additional Encounter Details**



Additional Encounter Details

Clinical Notes

The Clinical Notes section of the Patient Medical Summaries will displays clinical documentation that is associated to a LOINC code within the Clinical Note Classification Reporting Table within the Control area of Tables. For more information on setting up clinical documentation with a LOINC code see the Table Maintenance - Control user guide.

Personal Care Team Section

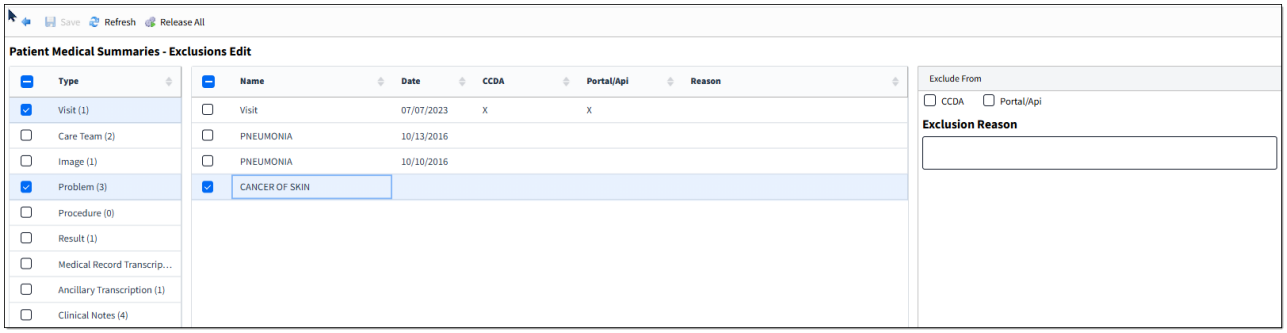
The Personal Care Team Section will display the patient's personal care team outside of the facility. This will pull the primary care and consulting physicians set up within the Care Team Event Notification and will also display the Office Contact from the 99999 physician or the clinic code table.

Chapter 5 Edit Exclusions

5.1 Edit Exclusions

Sections within the Patient Medical Summary may be edited to exclude individual records of a section. Selecting **Exclusions Edit** option will launch the Patient Medical Summaries - Exclusions Edits screen. Each record within the section will display and the user may choose which records to exclude from the section. This is a multi-select screen allowing more than one record to be chosen at a time.

Select **Patient Account > Health Information Resource > Patient Medical Summaries > Patient Summary 2.1.2 > Edit Exclusions**



Patient Medical Summaries - Edit Exclusion

The Edit screen will display two columns. The first column displays the section type and each record for that section. The second column will display a record's name, date, if excluded from the CCDA or Portal/Api and the reason. An 'X" will display within the CCDA and Portal/Api column if the record is set to not display.

When a record is selected the following **Exclude From** options will display:

- **CCDA:** Select this option to set the exclusion to be excluded from the CCDA. This option is not available when Clinical Notes is selected.
- **Patient (Portal/API):** Select this option to set the exclusion to be excluded from the Portal/any API.
- **Exclusion Reason:** Allows the entry of an exclusion reason.