

## **CCDA DATA PORTABILITY USERS GUIDE**

V10 - January 2016



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# CCDA DATA PORTABILITY

This document provides information about extracting data and generating a CCDA file for a patient from the eClinicalWorks software.

## What is Data Portability?

Data Portability enables users to create a set of export summaries electronically for all patients using EHR technology formatted according to the Consolidated CDA (CCDA) standards. These export summaries represent the most current clinical information about each patient and include, at a minimum, the Common Meaningful Use (MU) Data Set and the following data: encounter diagnosis, immunizations, cognitive status, functional status, ambulatory setting, referral reason, and the referring or transitioning provider's name and office contact information.

**Note:** The Common MU Data Set information consists of the following information: patient name, gender, DOB, race, ethnicity, preferred language, smoking status, problems, medications, medication allergies, procedures, lab tests and results, vitals (height, weight, BP, and BMI), care plan (including goals and instructions), and care team members.

Data Portability within eClinicalWorks has been enhanced to allow users to select patient records prior to exporting the CCDA. The previous functionality used a scheduled job to create CCDAs after hours and save them in a predetermined folder (Client Server). eClinicalWorks has since enhanced the feature to create a set of export summaries and to allow the user to download the file without navigating to the predetermined location. This has been deployed to all eClinicalWorks Cloud customers and is available to all eClinicalWorks Client Server practices as a patch named Data Portability.

## How Does Data Portability Apply to Practices?

The following two examples are common scenarios in which Data Portability is used:

- Practices must extract data and generate a file to submit to a registry for an incentive program
- Patient records must be transferred when a provider moves to another practice

# Data Portability Workflow

To access the enhanced Data Portability feature:

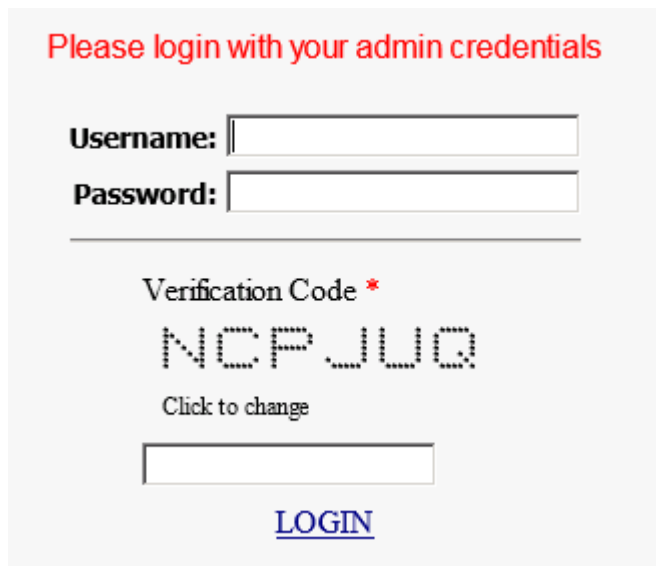
1. From the *Reports* menu, click *Report Console*.

The Reports window opens.

2. From the Utilities section, click *Data Portability*.

A pop-up window opens asking for admin credentials to access this report.

3. Enter your admin credentials and the verification code.
4. Click *Login*:



Please login with your admin credentials

**Username:**

**Password:**

---

**Verification Code \***

NCFJUQ

Click to change

[LOGIN](#)

The Data Portability window opens.

5. Select an option from the *Show* drop-down list to change the number of entries that are displayed on the window:

**Data Portability**

Show **10** entries

☐ ALL ☐ 10 ☐ 25 ☐ 50 ☐ 100

Search:

	First Name	Last Name	DOB
<input type="checkbox"/>	TEMPLATES	T	01/01/1980
<input type="checkbox"/>	Frank	Faulkner	08/27/1930
<input type="checkbox"/>	Ella	Farrell	12/02/1949
<input type="checkbox"/>	Chad	Heilman	05/11/1954
<input type="checkbox"/>	Kristin	Criss	10/31/1993
<input type="checkbox"/>	Dale	Alcantar	06/29/1976
<input type="checkbox"/>	Gary	Spates	01/28/1989
<input type="checkbox"/>	Amanda	Oliva	02/25/1964
<input type="checkbox"/>	John	Valdes	08/05/1938
<input type="checkbox"/>	Andrew	Childs	03/19/1932

Showing 1 to 10 of 393 entries

Previous **1** 2 3 4 5 ... 40 Next

[Generate CCDA's for Selected Patients](#)

6. (Optional) Enter information in the *Search* field to filter the list of patients displayed on this window by either name or date of birth.
7. Check the box(es) next to the patient record(s) you want to generate for the CCDA. All patients can be selected at once by checking the *ALL* box at the top-left corner of the window (this selects all patients on all pages and can take a significant amount of time to process):

**Data Portability**

Show **10** entries

☐ ALL ☐ 10 ☐ 25 ☐ 50 ☐ 100

Search: **John**

	First Name	Last Name	DOB
<input checked="" type="checkbox"/>	John	Valdes	08/05/1938
<input type="checkbox"/>	John	Kinzer	06/27/1971
<input checked="" type="checkbox"/>	John	Stones	02/14/1976
<input type="checkbox"/>	Nelson	Johnson	07/01/1957
<input type="checkbox"/>	Test	Johnson	01/01/1989

Showing 1 to 10 of 393 entries

Previous **1** 2 3 4 5 ... 40 Next

[Generate CCDA's for Selected Patients](#)

8. Click *Generate CCDA's for Selected Patients*.

[Generate CCDA's for Selected Patients](#)

A progress message for the generated CCDAs displays:

### Data Portability

CCDA's for 2 patients are being processed. After processing is complete you will be able to download a Compressed file which will contain CCDA's for the selected patients.

The process will take approximately Days:0 Hours:0 Minutes:0 Seconds:6 to generate 2 CCDA

Note: The automated schedule job to generate the CCDA's will start after hours and it will generate the CCDA's in batches. The system will process 10000 CCDA's per batch.

Click [here](#) to view CCDA generation progress (0% Completed)

Click [here](#) to cancel current job and start over

**Note:** CCDAs are generated in batches. For the files to be generated successfully, a scheduled job must be created for this process to run after hours. Check back at least 24 hours after clicking the *Generate CCDA's for Selected Patients* button. If the progress still stands at 0% after 24 hours, contact eClinicalWorks Support.

9. (Optional) To view more information on the CCDA generation progress, click the first *here* link.
10. (Optional) To cancel this job and start over, click the second *here* link.

If the CCDA is successfully generated, one of the following messages displays:

- ◆ eCW Cloud message:

### Data Portability

Your requested data is now ready for download.

Start Over

Completed

Download

- ◆ Non-eCW Cloud message:



If the CCDA is not successfully generated, the following message displays:

### Data Portability

Your requested data is now ready for download.

Start Over

No CCDA available

Patients with no encounter

Show  entries

Search:

First Name	Last Name	DOB
Marie	Roop	01/12/1931

Showing 1 to 1 of 1 entries

Previous  Next

Unable to generate CCDA's for below patients

Show  entries

Search:

First Name	Last Name	DOB
No data available in table		

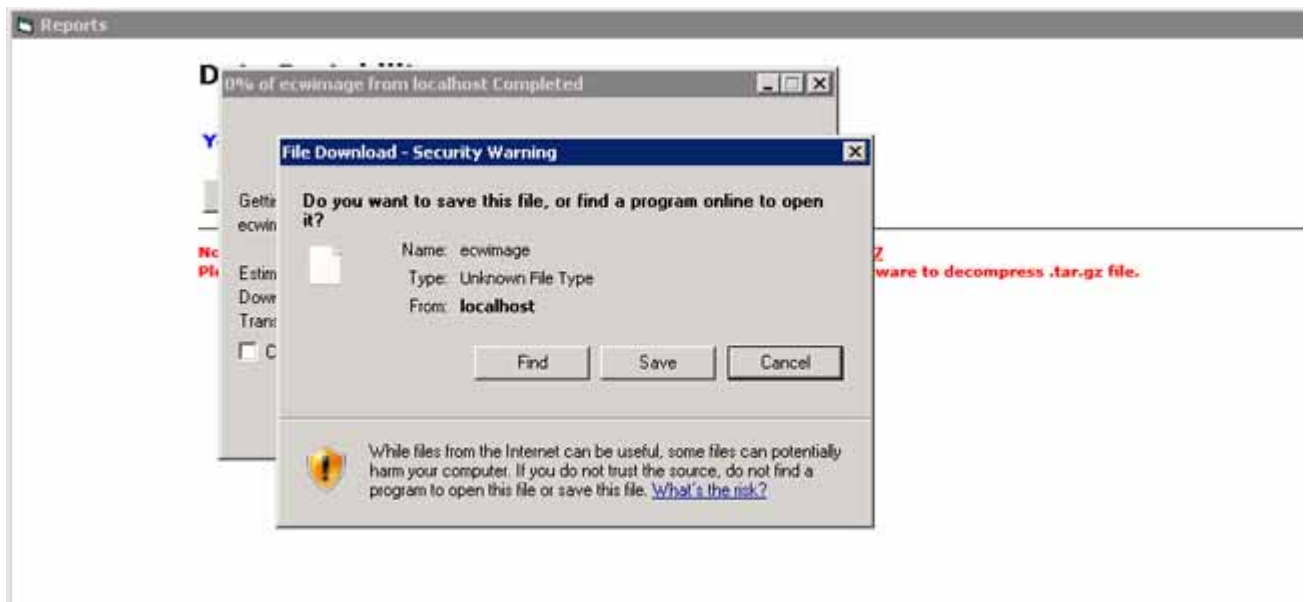
Showing 0 to 0 of 0 entries

Previous Next

Note: The requested information will only be available until: 2016-02-14 10:04:48  
Please append .tar.gz to the file downloaded. You will need a decompression software to decompress .tar.gz file.

11. Click *Download*.

The File Download window opens:

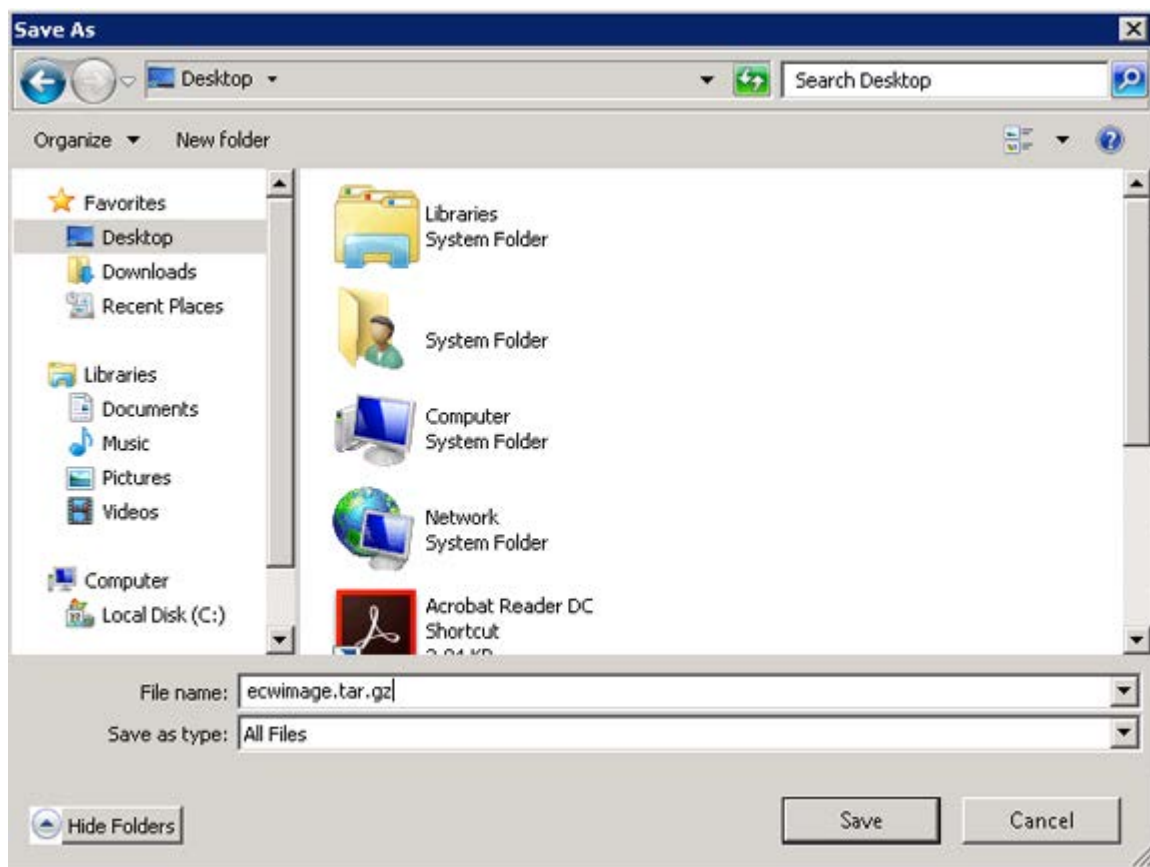


12. Click *Save*.

The Save As window opens:



13. Navigate to the location where you want to save this file, add *.tar.gz* to the end of the file name, then click *Save*:



This file is saved to the specified location.



14. Navigate to the file to access it using the following process:

- a. Open the zipped file with either WinZip or 7-Zip (e.g., in 7-Zip, right-click on the saved file, mouse over 7-Zip to open a drop-down list, then click *Extract Here* from the drop-down list):



**Note:** WinRAR will NOT open the zipped file.

A second zipped file is extracted.

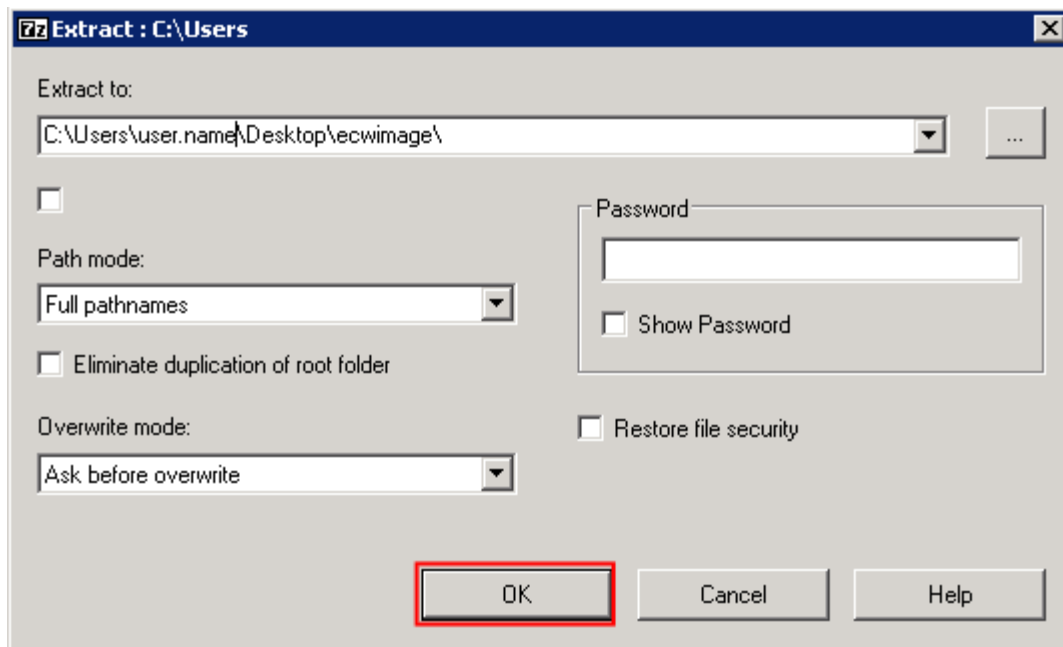
- b. Open the second zipped file using the same process, except click *Extract files...* in the last step instead of *Extract Here*:



**Note:** Because of the size of the file being downloaded, it is necessary to double zip the file to improve speed and save space.

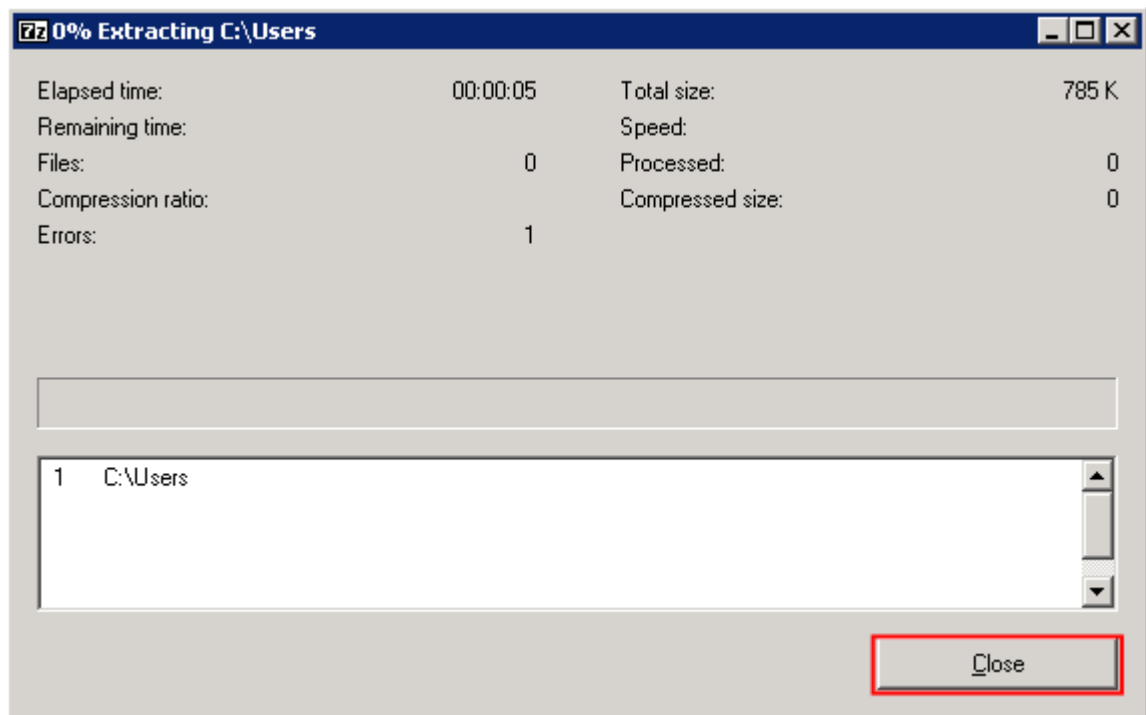
The Extract window opens.

- c. Click *OK*:



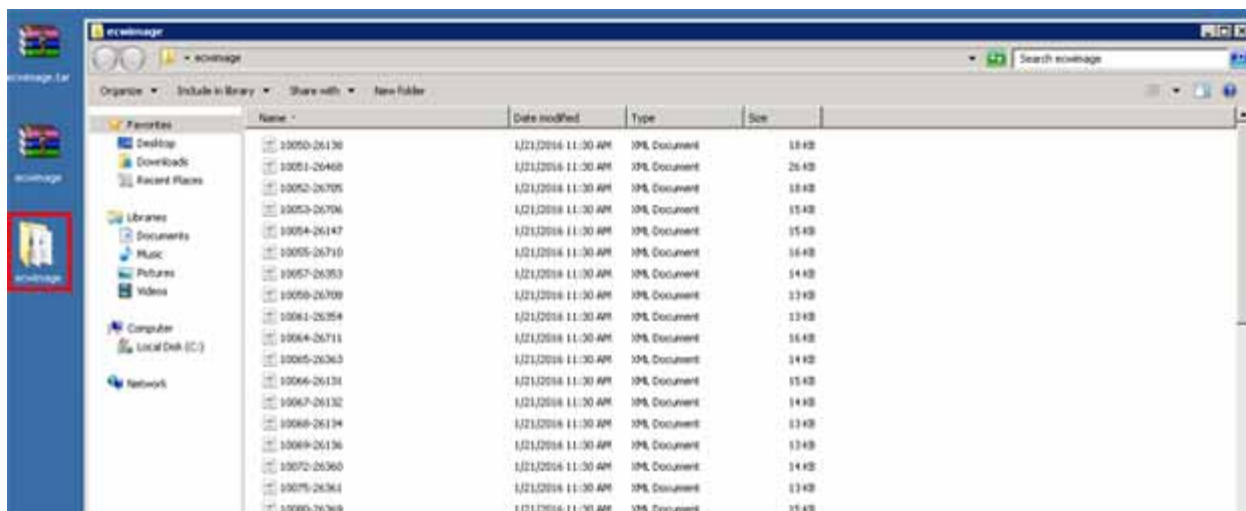
The extraction progress window opens.

- d. Click *Close*:



The extraction progress window closes and a folder is extracted.

- e. Double-click the folder to access all the files from the download:



15. (Optional) Click *Start Over* to start this process over.

### Data Portability

Your requested data is now ready for download.

Download

Start Over

**Note:** The requested information will only be available until: **2016-03-26 09:20:18**  
Please append .tar.gz to the file downloaded. You will need a decompression software (recommended software is WinZip or 7-Zip) to decompress .tar.gz file.  
Please note that WinRAR will not decompress the (.tar.gz) file.

## eClinicalWorks Data Entry

For valid CCDA file creation, the following sections of the patient demographics and Progress Notes must be filled out and mapped (if applicable) prior to generating the CCDA:

- Patient Demographics
- Patient Race, Ethnicity, and Preferred Language
- Preferred Language Community Mapping
- Social History - Tobacco Use
- Social History Community Mapping
- Preventive Medicine - Care Plan
- Preventive Medicine Community Mapping
- Immunizations
- Immunizations CVX Mapping
- Assessments - Encounter Diagnosis and Problems
- Allergies/Intolerance - Medication Allergies
- Current Medication

- Family History
- Vitals
- Configure Vitals Mapping
- Treatment - Order Labs and Results
- Linking LOINC Codes with Labs
- Treatment - Outgoing Referral
- Circle of Care Team Members
- HPI - Cognitive and Functional Status
- HPI Community Mapping

**Note:** Data entry included in the CCDA is most commonly performed from the following areas within eClinicalWorks: Patient Hub, jelly beans, right chart panel (ICW), and Telephone Encounters

## Patient Demographics

To document the demographics for a patient:

1. From the Patient Information window, enter information in the *Last Name*, *First Name*, and *Date of Birth* fields.
2. To record the patient's sex, click the More (...) button next to the Sex field and select a sex from the window that pops up:

**Patient Information**

**Personal Info**

Account No  Prefix  **PCP**

**Last Name\***  Suffix  Referring Provider

**First Name\***  MI  **Rendering Provider/Primary Care Giver**

Previous Name

Address Line 1

Address Line 2

City  **Validate**

State  Zip  Country

Home Phone  Cell No

Work Phone  Ext

(statements will be addressed to responsible party)

**Responsible Party**

Name

Relation  (None Selected)

Last Appt

Date Of Birth\*  (mm/dd/yyyy) Age:

Gestational Age

**Sex\***   Female ☐ Transgender

Marital Status

Social Security  **Parent Info**

Employer Name

Emp Status  (None Selected)

Student Status  (None Selected)

**Emergency Contact**

Acct Balance

Patient

Next Appt

3. Click **OK**.

## Patient Race, Ethnicity, and Preferred Language

To document the race, ethnicity, and preferred language for a patient:

1. From the Patient Information window, click *Additional Info*.
2. To record the patient's race, click the More (...) button next to the Race field and select a race from the window that pops up.
3. Select an option from the *Ethnicity* drop-down list.
4. To record the patient's language, select an option from the *Language* drop-down list, or click the More (...) button next to the Language field and select an option from the window that pops up:

The screenshot shows a patient information form. The 'Race' field has a 'More (...)' button. The 'Ethnicity' field is a drop-down menu. The 'Language' field is a drop-down menu with a 'More (...)' button. Other fields include 'Birth Order' (0), 'VFC Eligibility', 'Employer Address' (Address Line 1, Address Line 2, City, State, Zip), 'Mail Order Member ID', 'Plan Type' (None Selected), 'Deceased' checkbox, 'Default Facility' (with a 'Clr' button), 'MRN(External System)', 'Default Lab Company' (None), 'Default DI Company' (None), 'Translator' checkbox, 'Exclude From Registry Search' checkbox, 'Use Street Address for Prescription' checkbox, and a 'Registered On' timestamp of 09/17/2015 (10:52:56.0).

5. Click *OK*.

## Preferred Language Community Mapping

To map preferred language:

1. From the *Community* menu, mouse over *Mappings* to open a drop-down list, then click *Language*.  
The ISO Language Code Mapper window opens.
2. Enter the name of a language in the left *Search* field and click a language in the Language Name section on the left.
3. Enter the ISO name of a language in the right *Search* field click the ISO in the ISO Name section on the right that corresponds to the language selected from the Language Name column on the left.
4. Click *Map*.

- Repeat steps 2-4 for all desired languages:



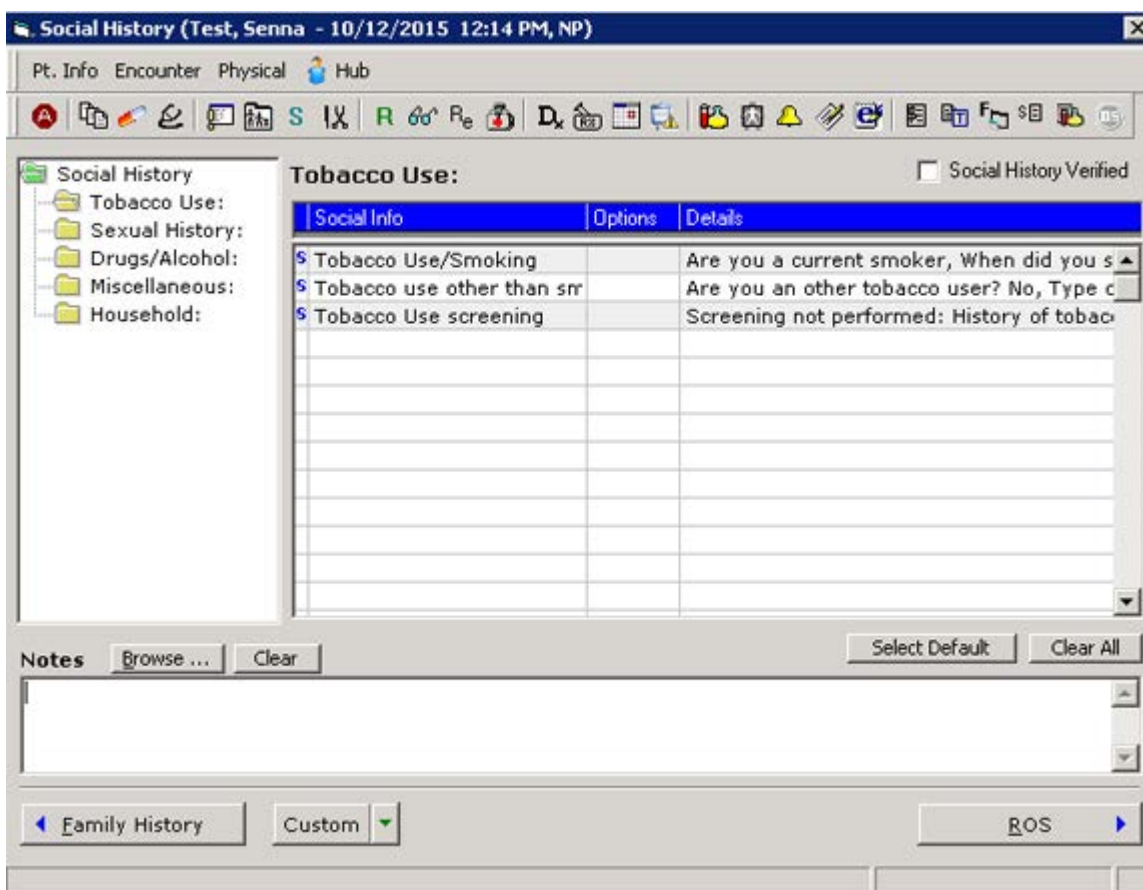
**Note:** If a language is accidentally mapped to an incorrect ISO name, select that language and ISO name and click *UnMap*.

## Social History - Tobacco Use

To document the Tobacco Use of a patient:

- From the Progress Notes window, click *Social History*.

The Social History window opens:





- Click in the Details column for the *Tobacco Use/Smoking* row.  
The Social History Notes window opens with the Structured tab selected.
- Enter information in the Value column for the *Are you a* row.

**Note:** Tobacco Use can also be entered through a Smart Form and will be included on the CCDA.

#### To document Other Tobacco Use for a patient:

- From the Progress Notes window, click *Social History*.  
The Social History window opens.
- Click in the Details column for the *Tobacco use other than smoking* row.  
The Social History Notes window opens with the Structured tab selected.
- Enter information in the Value column for both the *Are you an other tobacco user* and the *Type of Tobacco-Non User* rows:

The screenshot shows the 'Social History Notes' window with the 'Structured' tab selected. The title bar reads 'Social History Notes'. Below the tabs, there are buttons for 'Default', 'Default for All', and 'Clear All'. The main section is titled 'Tobacco use other than smoking:'. Below this is a table with three columns: 'Name', 'Value', and 'Notes'.

Name	Value	Notes
Are you an other tobacco	No	
Type of Tobacco-Non User	Never chewed tobacco	

#### To document Tobacco Use Screening Not Performed for a patient (if applicable):

- From the Progress Notes window, click *Social History*.  
The Social History window opens.
- Click in the Details column for the *Tobacco use screening* row.  
The Social History Notes window opens with the Structured tab selected.
- Enter information in the Value column for the *Screening not performed* row:

The screenshot shows the 'Social History Notes' window with the 'Structured' tab selected. The title bar reads 'Social History Notes'. Below the tabs, there are buttons for 'Default', 'Default for All', and 'Clear All'. The main section is titled 'Tobacco Use screening'. Below this is a table with three columns: 'Name', 'Value', and 'Notes'.

Name	Value	Notes
Screening not performed:	History of tobacco use Narrativ	

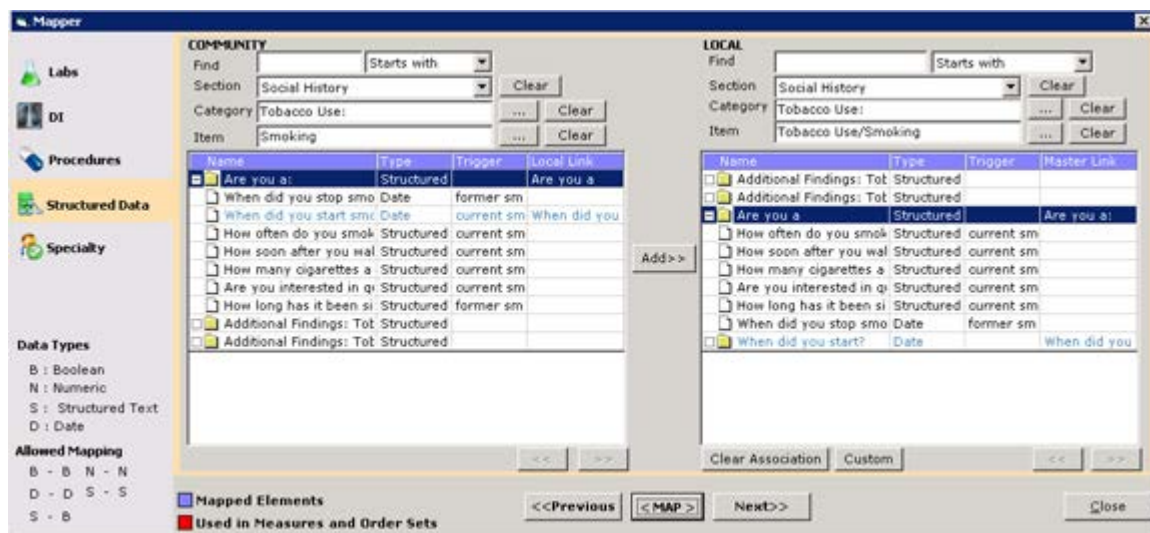
**Note:** Data entered into Social History in a Telephone Encounter via the Patient Hub or T jelly bean is also included in the CCDA.



# Social History Community Mapping

To map the social history structured data:

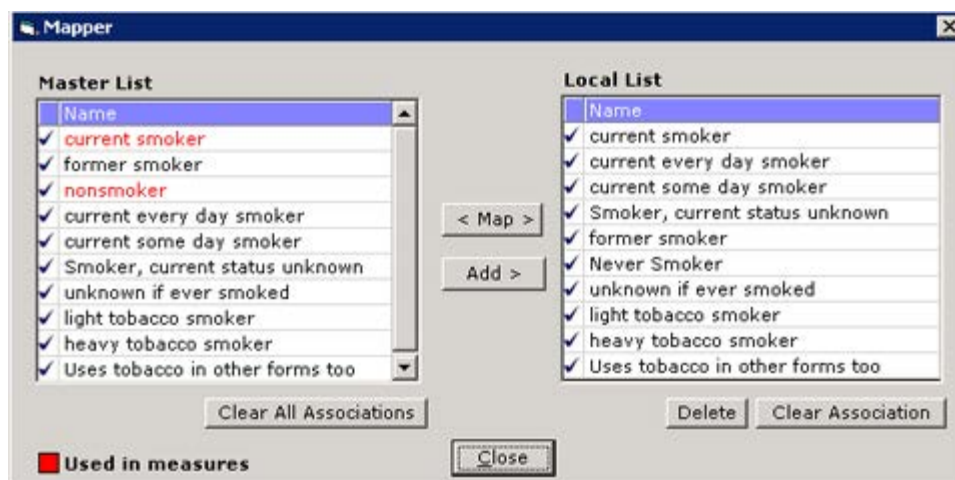
1. From the *Community* menu, click *Mappings*.  
The Mapper window opens.
2. Click the *Structured Data* tab in the left pane.  
The Structured Data options display on the right.
3. Select the following on the left, Community side:
  - a. From the *Section* drop-down list, select *Social History*.
  - b. From the *Category* drop-down list, select *Tobacco Use*.
  - c. From the *Item* drop-down list, select *Smoking*.
4. Select the following on the right, Local side (this is customizable and the office should choose the appropriate options for where the Tobacco information has been created, which may differ from the options below):
  - a. From the *Section* drop-down list, select *Social History*.
  - b. From the *Category* drop-down list, select *Tobacco Use*.
  - c. From the *Item* drop-down list, select *Tobacco Use/Smoking*.
5. Click *Are you a:* on the left and the right.
6. Click *< Map >*:



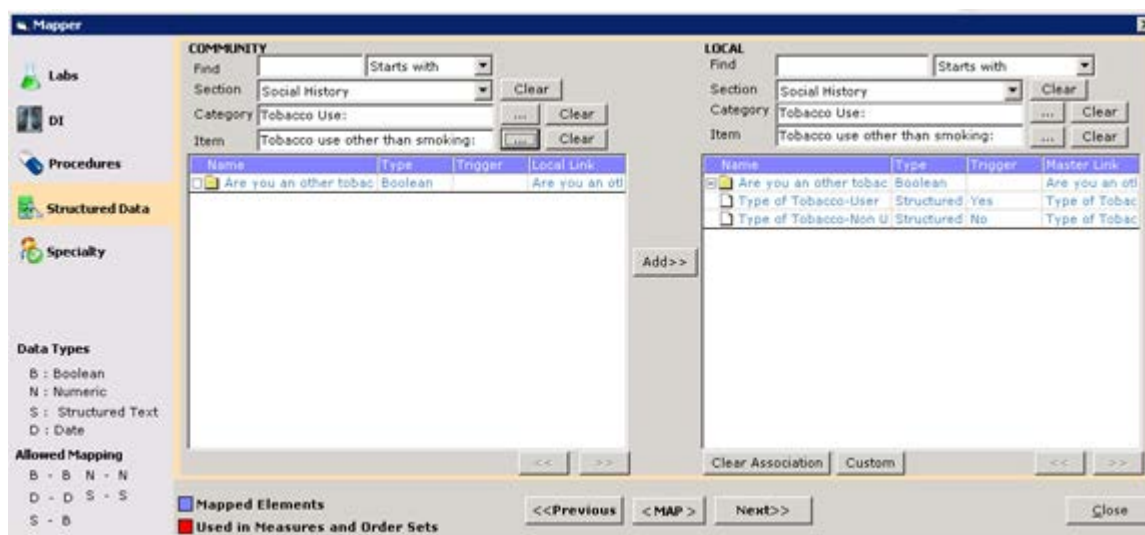
A second Mapper window opens.

7. Click the options that correspond to each other in the Master List and the Local List sections.
8. Click *< Map >*.

9. Repeat steps 7-8 for all options:

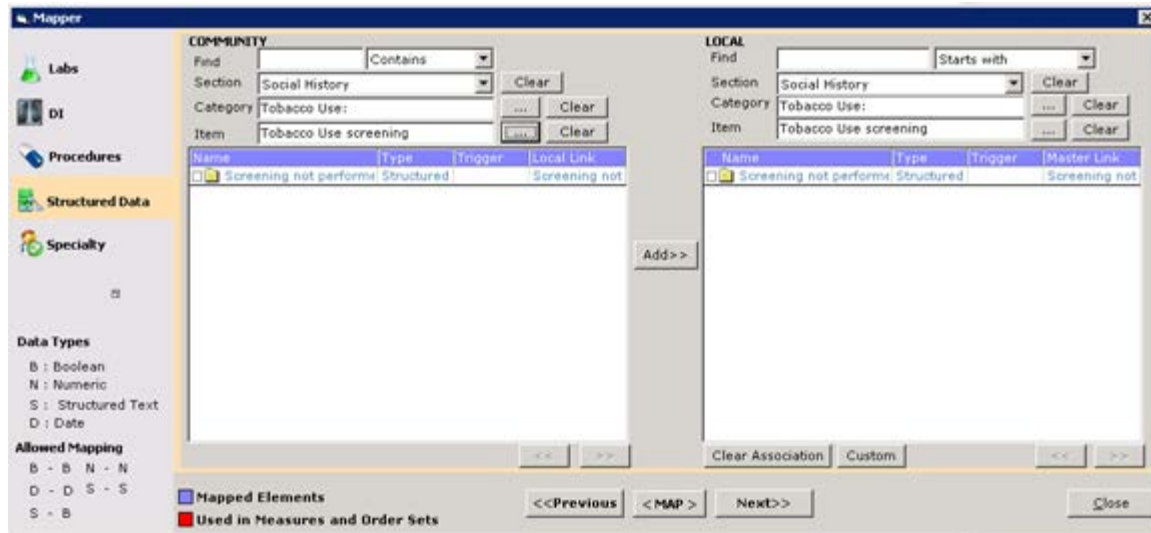


10. Close the second Mapper window.
11. From the *Item* drop-down lists on both sides of the Mapper window, select *Tobacco use other than smoking*.
12. Click *Are you an other tobacco user* in the Community and Local sections.
13. Click < Map >:



14. From the *Item* drop-down lists on both sides of the Mapper window, select *Tobacco Use Screening*.
15. Click *Screening not performed* in the Community and Local sections.

16. Click < Map >:



## Preventive Medicine - Care Plan

To document Weight Management for a patient:

1. From the Progress Notes window, click *Preventive Medicine*.  
The Preventive Medicine window opens.
2. Click *Care Plans* in the left pane.  
The Care Plans symptoms display in the right pane.
3. Click in the *Notes* column for the *Weight Management* row.  
The Preventive Notes window opens with the Structured Data tab selected.
4. Enter information for the *Goals* and *Instructions* structured data items:

The Preventive Notes window shows the 'Structured' tab selected. It contains a table with the following data:

Name	Value	Notes
Goals:	Weight Loss	
Instructions:	Diet and exercise information	

To document Chronic Care Management for a patient:

1. From the Progress Notes window, click *Preventive Medicine*.  
The Preventive Medicine window opens.
2. Click *Care Plans* in the left pane.  
The Care Plans symptoms display in the right pane.
3. Click in the *Notes* column for the *Chronic Care Management* row.  
The Preventive Notes window opens with the Structured Data tab selected.

4. Enter information for the *Goals* and *Instructions* structured data items:

The screenshot shows the 'Preventive Notes' window with the 'Structured' tab selected. The section is 'Chronic Care Management'. The table below shows the structured data:

Name	Value	Notes
Goals:	Asthma management	
Instructions	Resources and instructions pro	

To document Smoking Cessation for a patient:

1. From the Progress Notes window, click *Preventive Medicine*.  
The Preventive Medicine window opens.
2. Click *Care Plans* in the left pane.  
The Care Plans symptoms display in the right pane.
3. Click in the *Notes* column for the *Smoking* row.  
The Preventive Notes window opens with the Structured Data tab selected.
4. Enter information for the *Goals* and *Instructions* structured data items:

The screenshot shows the 'Preventive Notes' window with the 'Structured' tab selected. The section is 'Smoking'. The table below shows the structured data:

Name	Value	Notes
Goal:	Smoking Cessation	
Instructions:	Resources and instructions pro	

To document Preventative Health information for a patient:

1. From the Progress Notes window, click *Preventive Medicine*.  
The Preventive Medicine window opens.
2. Click *Care Plans* in the left pane.  
The Care Plans symptoms display in the right pane.
3. Click in the *Notes* column for the *Preventive Medicine* row.  
The Preventive Notes window opens with the Structured Data tab selected.
4. Enter information for the *Goals* and *Instructions* structured data items:

The screenshot shows the 'Preventive Notes' window with the 'Structured' tab selected. The section is 'Preventative Medicine'. The table below shows the structured data:

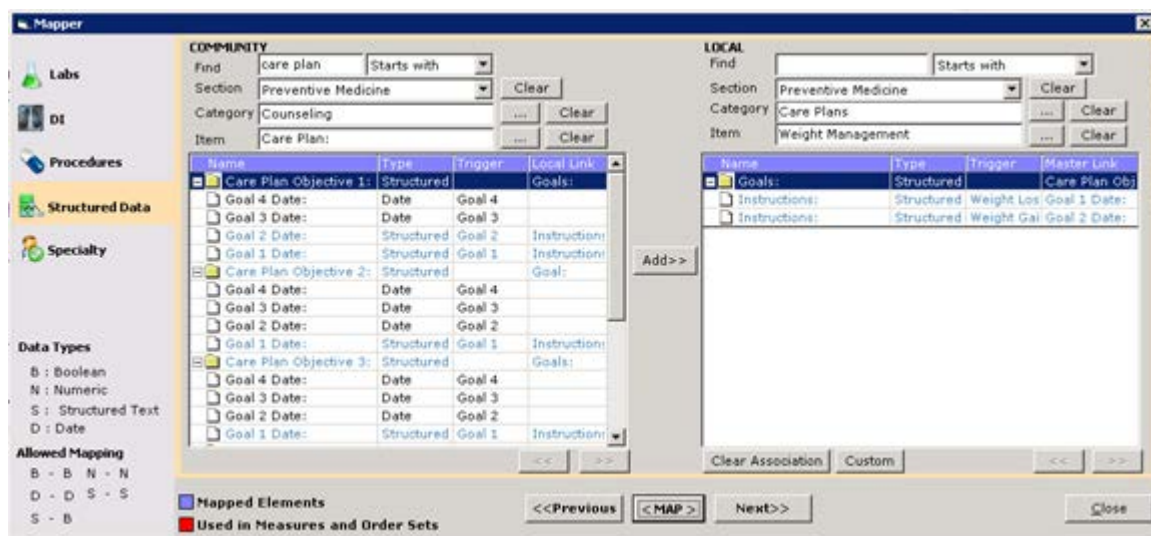
Name	Value	Notes
Preventative Health	Annual Pap Smear, Biennial Sc	
Instructions	0	
Instructions	0	
Instructions	0	

**Note:** Data entered in the Preventive Medicine section from a Telephone Encounter via the Patient Hub or Tjelly bean is also included in the CCDA.

# Preventive Medicine Community Mapping

To map the preventive medicine structured data:

1. From the *Community* menu, click *Mappings*.  
The Mapper window opens.
2. Click the *Structured Data* tab in the left pane.  
The Structured Data options display on the right.
3. Select the following on the left, Community side:
  - a. From the *Section* drop-down list, select *Preventive Medicine*.
  - b. From the *Category* drop-down list, select *Counseling*.
  - c. From the *Item* drop-down list, select *Care Plan*.
4. Select the following on the right, Local side (this is customizable and the office should choose the appropriate options for where the Care Plan information has been created, which may differ from the options below):
  - a. From the *Section* drop-down list, select *Preventive Medicine*.
  - b. From the *Category* drop-down list, select *Care Plans*.
  - c. From the *Item* drop-down list, select *Weight Management*.
5. Click *Care Plan Objective 1* in the left Community pane.
6. Click *Goals* in the right Local pane.
7. Click *< Map >*:

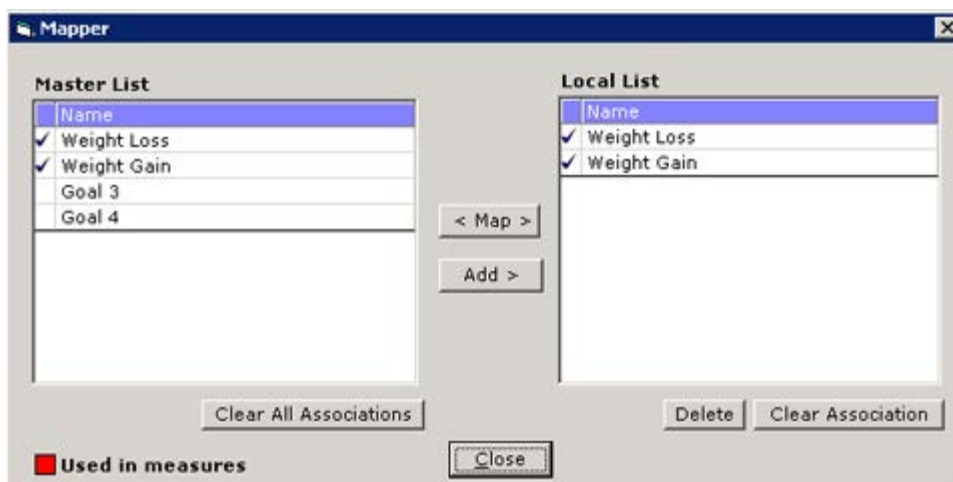


A second Mapper window opens.

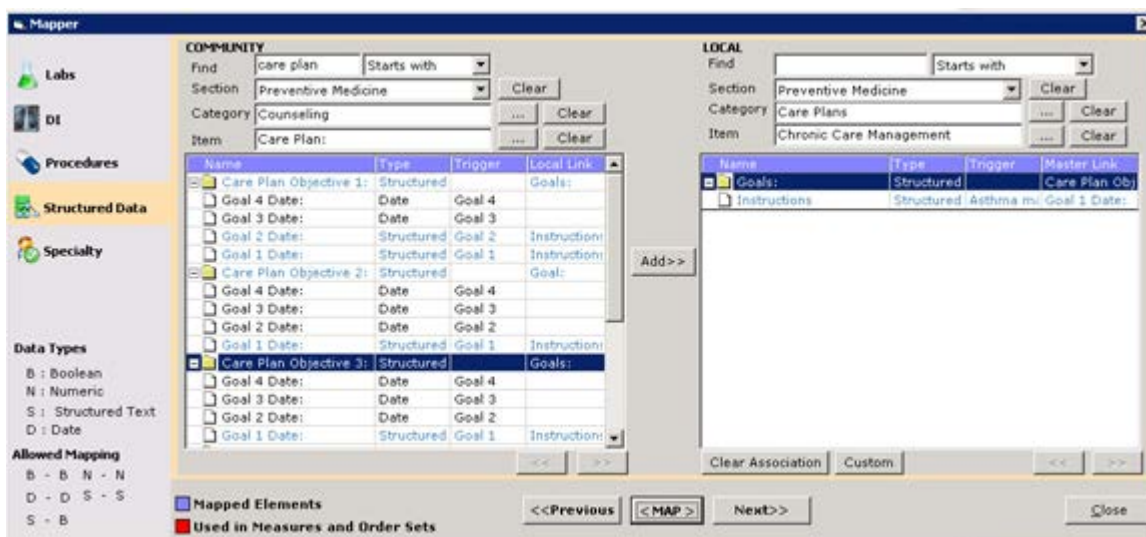
8. Click the *Weight Loss* options in the Master List and the Local List sections and then click *< Map >*.



9. Click the *Weight Gain* options in the Master List and the Local List sections and then click *< Map >*:



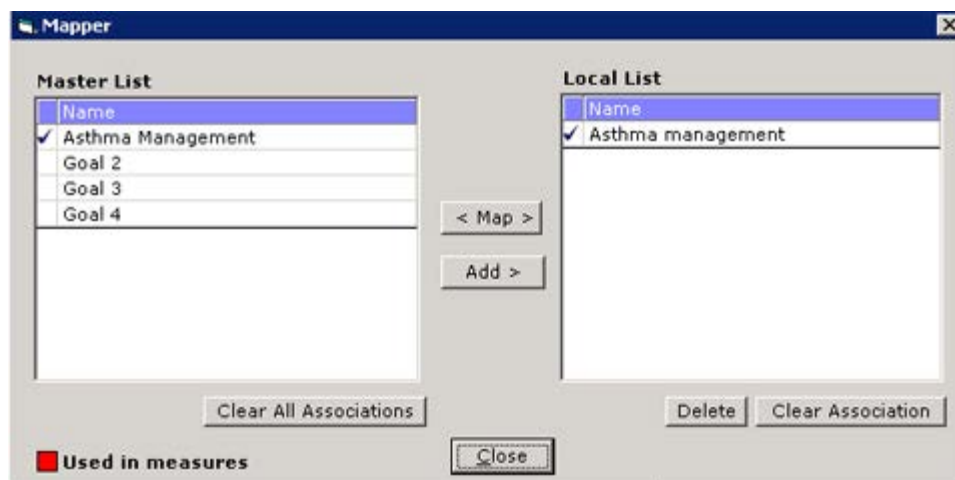
10. Close the second Mapper window.
11. From the *Item* drop-down list in the Local pane of the Mapper window, select *Chronic Care Management*.
12. Click *Care Plan Objective 3* in the Community section on the left.
13. Click *Goals* in the Local section on the right.
14. Click *< Map >*:



The second Mapper window opens.

15. Click the *Asthma Management* options in the Master List and the Local List sections.

16. Click < Map >:



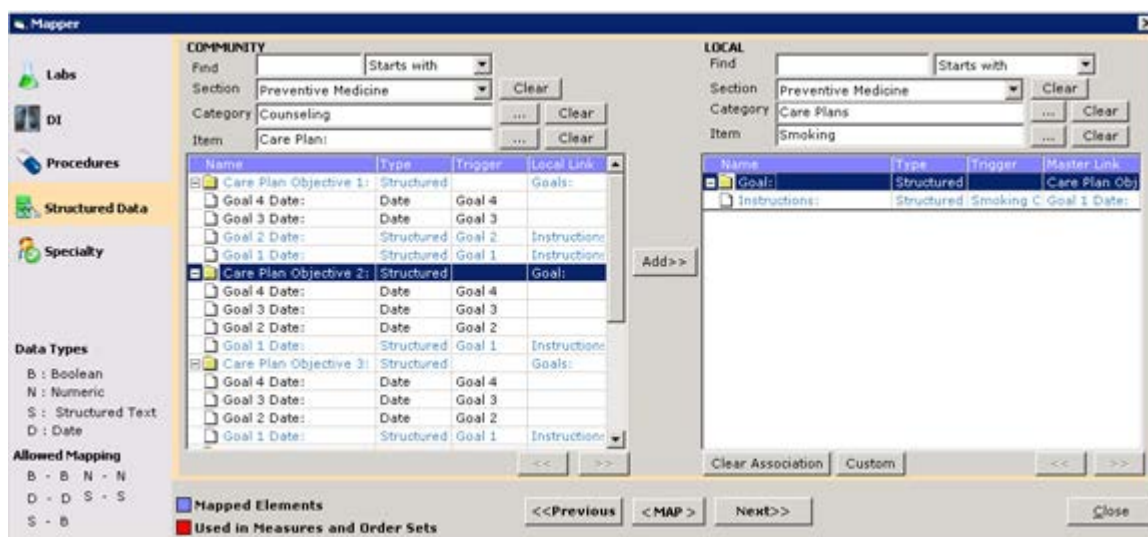
17. Close the second Mapper window.

18. From the *Item* drop-down list in the Local section on the right, select *Smoking*.

19. Click *Care Plan Objective 2* in the Community section on the left.

20. Click *Goals* in the Local section on the right.

21. Click < Map >:

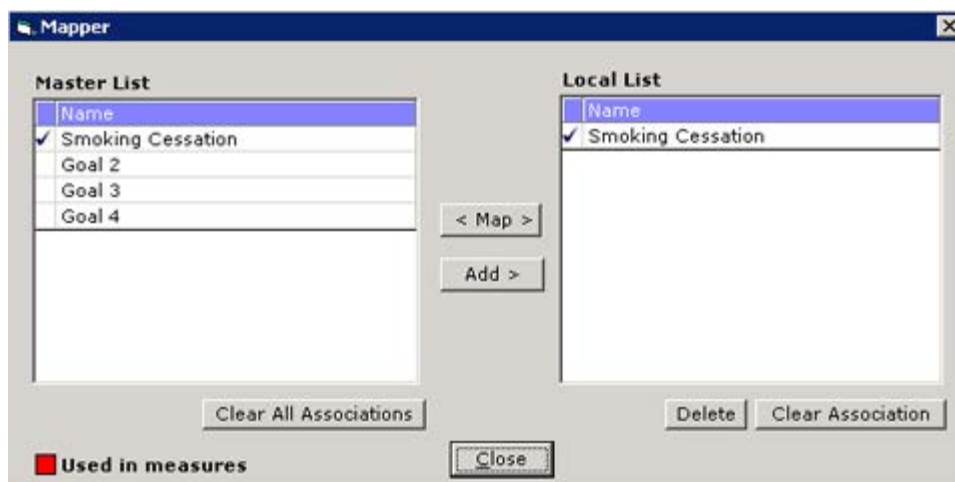


The second Mapper window opens.

22. Click the *Smoking Cessation* options in the Master List and the Local List sections.



23. Click < Map >:



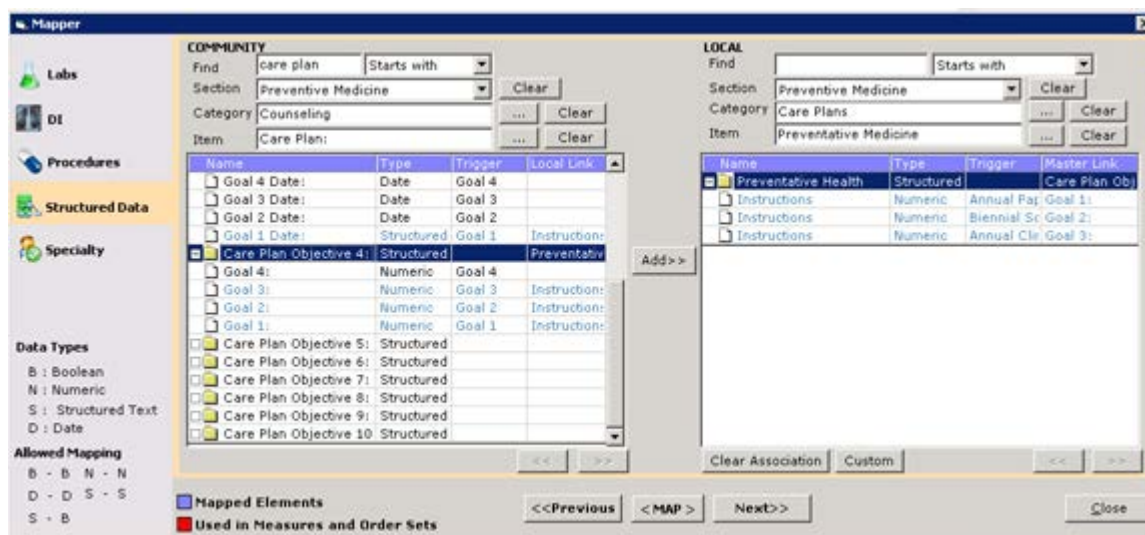
24. Close the second Mapper window.

25. From the *Item* drop-down list in the Local section on the right, select *Preventive Medicine*.

26. Click *Care Plan Objective 4* in the Community section on the left.

27. Click *Preventive Health* in the Local section on the right.

28. Click < Map >:

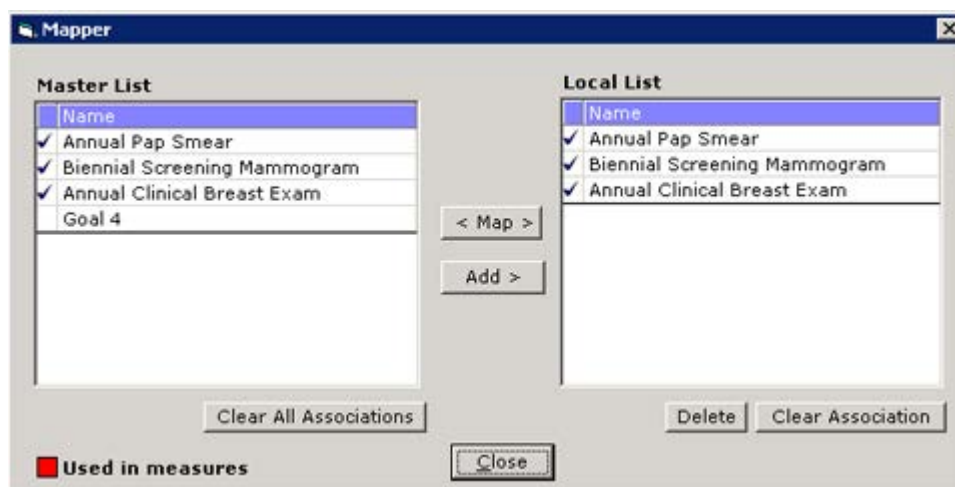


The second Mapper window opens.

29. Click the *Annual Pap Smear* options in the Master List and the Local List sections and then click < Map >.

30. Click the *Biennial Screening Mammogram* options in the Master List and the Local List sections and then click < Map >.

31. Click the *Annual Clinical Breast Exam* options in the Master List and the Local List sections and then click *< Map >*:

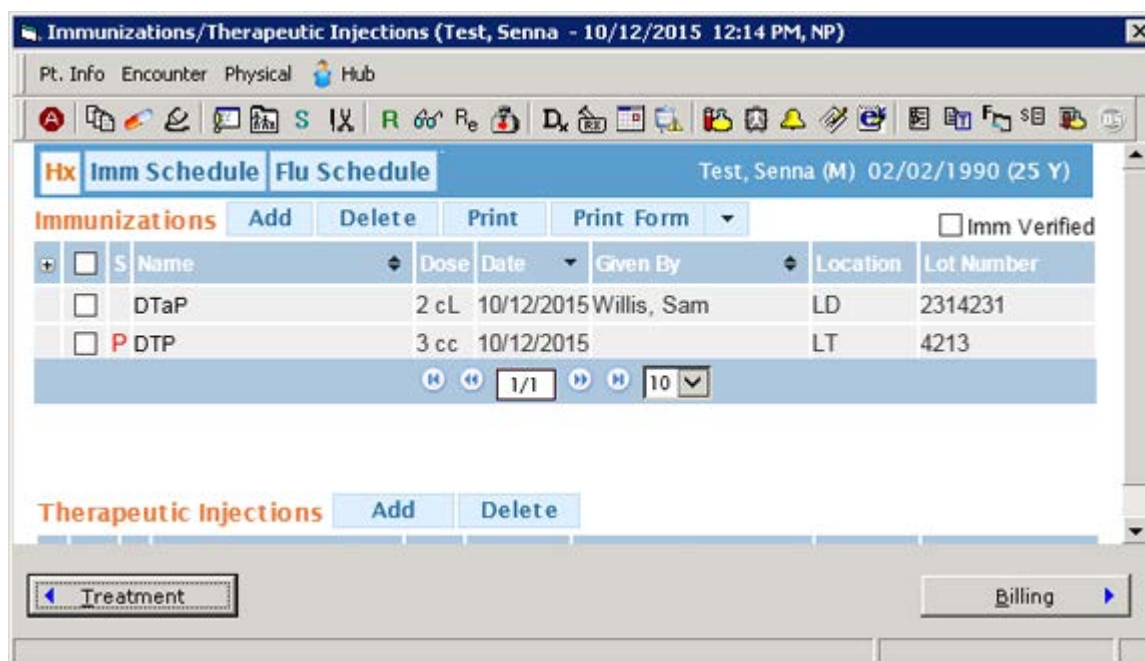


## Immunizations

To document immunizations for a patient:

1. From the Progress Notes window, click *Immunizations*.

The Immunizations window opens:



2. Click *Add*.  
The Immunization Details window opens.
3. Click an immunization in the left pane.
4. Enter information in the data fields on the right side of the window.

- Click *OK* to save this information and close this window or click *Save and New* to save this information and enter another immunization:

**Immunization Details**

☒ All ☐ My Favorites Active

Find:

back Injection  
DTaP  
DTP  
Flu vaccine no Preserv 3 and >  
Flu vaccine, nasal  
Hepatitis A (adult)  
Hepatitis B (11-19)  
Hepatitis B (20 and more)  
**Hib**  
Hib 4 dose schedule  
Human papillomavirus (HPV)  
Influenza  
Influenza (split)  
Influenza (whole)  
Influenza virus vaccine, unspecified form  
IPV  
Measles  
Meningococcal  
MMR  
Mumps  
Pneumococcal  
Pneumococcal conjugate vaccine (7-valent)  
Rabies, intramuscular

**Hib**

Vaccination Given in Past: ☒ N ☐ Y

Visit date:

Dose:

Dose Number:

Lot Number:  ☐ VFC

Location:

Route:

Exp. Date:

VIS Given Date:

Status:

Reason:

Given By:

Given Date/Time:

Manufacturer:

VFC:

Date on VIS:

Comments:

☒ Decrement the dose  
☒ Billable  
☐ Counseling

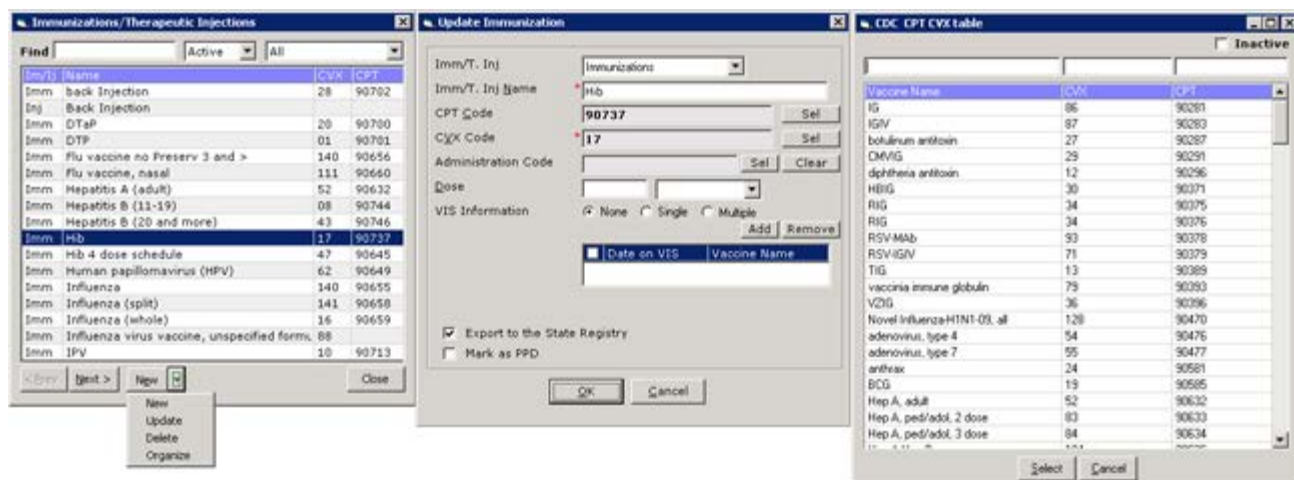
**Note:** Data entered in the Immunizations section from a Telephone Encounter via the Patient Hub or Tjelly bean is also included in the CCDA.

## Immunizations CVX Mapping

To map the immunization CVX codes:

- From the *EMR* menu, mouse over *Immunizations/Therapeutic Injections* to open a drop-down list, then click *Immunizations/Therapeutic Injections*.  
The Immunizations/Therapeutic Injections window opens.
- Click an immunization from the list.
- Click the green arrow icon next to the New button to open a drop-down list, then click *Update*.  
The Update Immunization window opens.
- Click *Set* next to the CVX Code field.  
The CDC CPT CVX Table window opens.
- Click a CVX code and click *Select*.  
The CDC CPT CVX Table window closes.

- Click *OK* on the Update Immunization window:

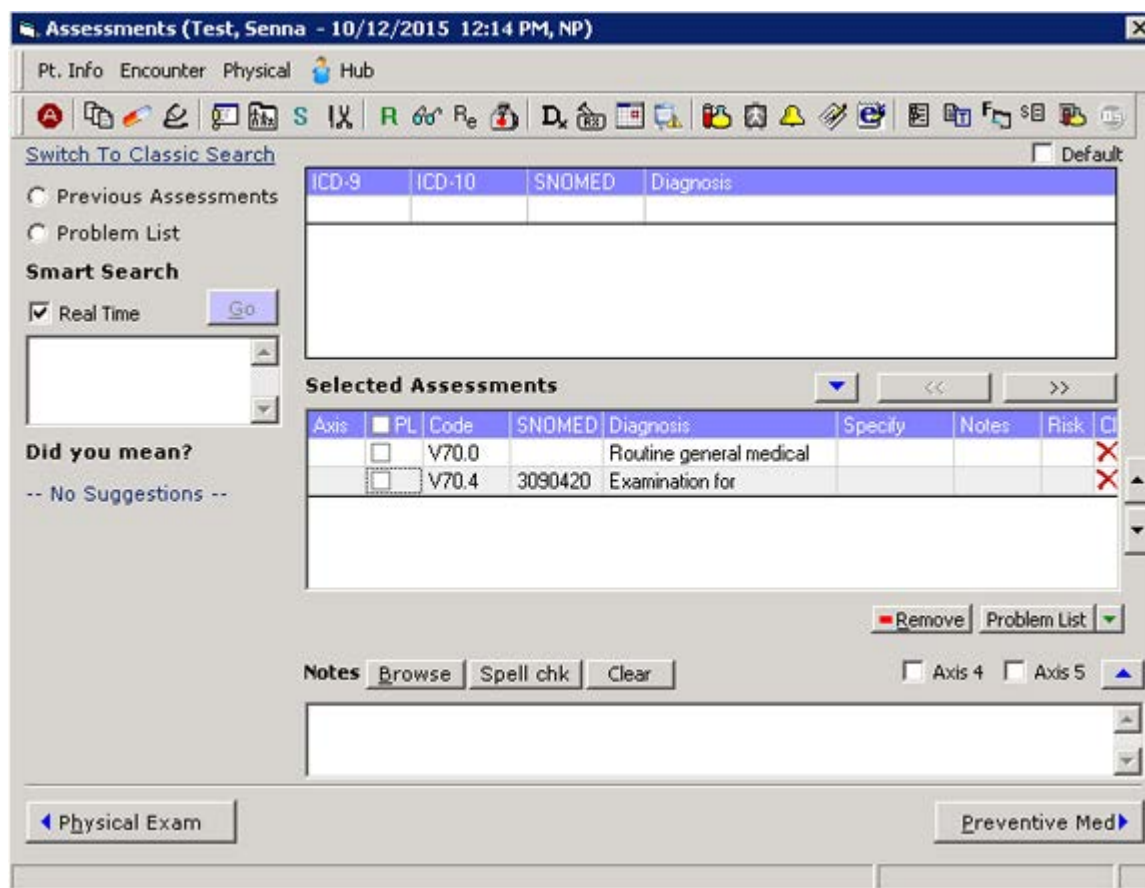


## Assessments - Encounter Diagnosis and Problems

To document the assessments for a patient:

- From the Progress Notes window, click *Assessments*.

The Assessments window opens:



- Type a code or description into the *Smart Search* field.



If the Real Time box is checked, assessments that match the entered text display in real time.

3. Click a diagnosis in the list on the right.
4. Check the box in the *PL* column next to the diagnosis you want to add to the Problem List:

**Assessments (Test, Senna - 10/12/2015 12:14 PM, NP)**

Pt. Info Encounter Physical Hub

Switch To Classic Search

Previous Assessments  
Problem List  
Smart Search

☒ Real Time

diabe

Did you mean?  
-- No Suggestions --

**IMO**

ICD-9	ICD-10	SNOMED	Diagnosis
250.00	E11.9	73211009	Diabetes
250.00	E13.9	426875007	Diabetes 1.5, managed as type 1
250.00	E13.9	426875007	Diabetes 1.5, managed as type 2
250.00	E11.9	73211009	Diabetes education, encounter for
648.00	024.919	199223000	Diabetes in pregnancy
648.03	024.919	199227004	Diabetes in undelivered pregnancy

**Selected Assessments**

Axis	PL	Code	SNOMED	Diagnosis	Specify	Notes	Risk	C
	<input type="checkbox"/>	V70.0		Routine general medical				X
	<input type="checkbox"/>	V70.4	3090420	Examination for				X
	<input checked="" type="checkbox"/>	250.00	7321100	Diabetes				X

**Notes**

☐ Axis 4 ☐ Axis 5

**Note:** Data entered in the Assessments or Problem List sections from a Telephone Encounter via the Patient Hub or Tjelly bean is also included in the CCDA.

## Allergies/Intolerance - Medication Allergies

To document medication allergies for a patient:

1. From the Progress Notes window, click *Allergies/Intolerance*.

The Allergies/Intolerance window opens:

No	History	ICD Code	PL
1	Saber shin	090.5	<input type="checkbox"/>

Structured/N	Agent/Substance	Reaction	Type	Status
Structured	12 Hour Nasal	anaphylaxis	Allergy	Active
Structured	12 Hour Cold	HIV-Infected	Side Effects	Active
Structured	14-Count Warmer	Leukemia	Allergy	Active

2. Click the *Browse Rx*.

The Find Rx window opens.

3. Click a medication category in the Rx Category pane on the left.

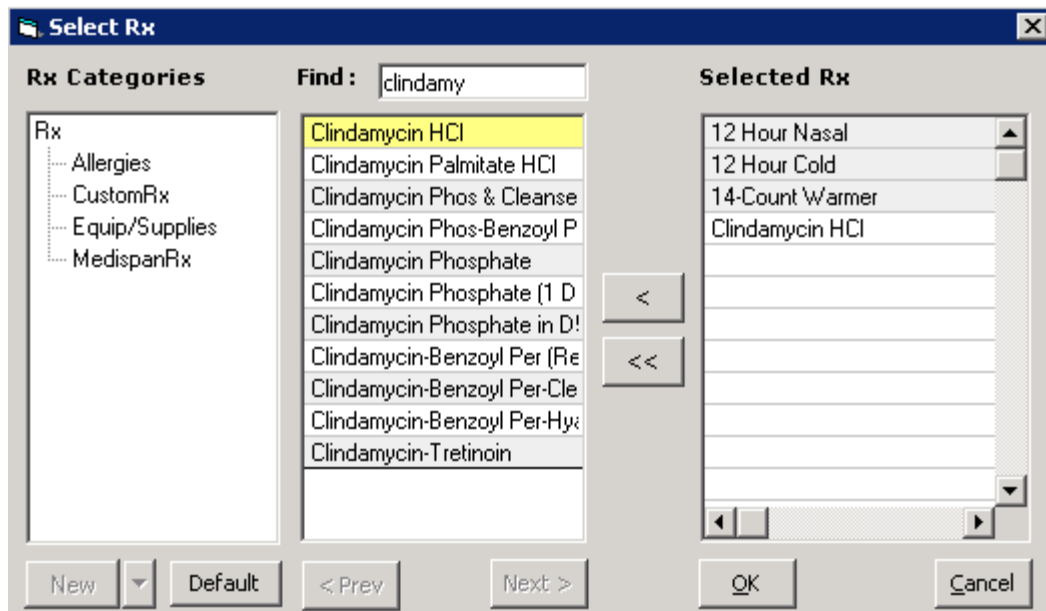
4. Type the name of a medication into the *Find* field.

The medications that in the selected Rx category that match the entered text display in the center pane in real time.

5. Click a medication in the center pane.

The available formulations for the selected medication populate in the Selected Rx pane on the right.

- Click the formulation of the medication in the Selected Rx pane on the right:



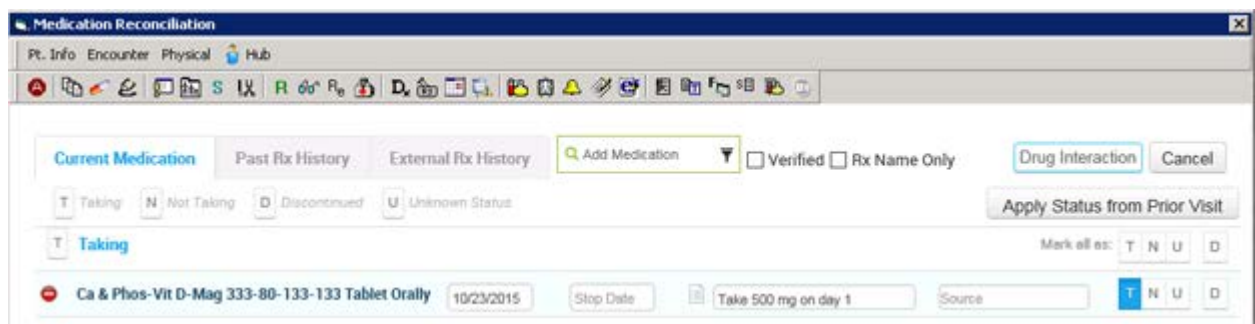
**Note:** Data entered in the Allergies/Intolerance section from a Telephone Encounter via the Patient Hub or Tjelly bean is also included in the CCDA.

## Current Medication

To document the current medications for a patient:

- From the Progress Notes window, click *Current Medication*.

The Medication Reconciliation window opens:



- Type the name of a medication in the *Add Medication* field.  
The medications that match the entered text display in a pop-up pane beneath the Add Medication field in real time.
- Click a medication from this pop-up pane.  
The available formulations for this medication display in a drop-down list.
- Select a formulation of this medication from the drop-down list.



5. Check the *Verified* box:

History  ☒ Verified ☐ Rx Name Only

<input checked="" type="checkbox"/> Rx	Metformin & Diet Manage Prod
<input checked="" type="checkbox"/> Rx	Metformin HCl
<input checked="" type="checkbox"/> Rx	MetFORMIN HCl ER
<input checked="" type="checkbox"/> Rx	MetFORM
<input checked="" type="checkbox"/> Rx	MetFORM

Source

500 MG Tablet Extended Release 24 Hour 1 tablet with evening meal  
Orally Once a day

750 MG Tablet Extended Release 24 Hour 1 tablet with evening meal  
Orally Once a day

**Note:** Data entered in the Current Medications section from a Telephone Encounter via the Patient Hub or Tjelly bean is also included in the CCDA.

## Family History

To document the family history for a patient:

1. From the Progress Notes window, click *Family History*.

The Family History window opens:

**Family History (Test, Senna - 10/12/2015 12:14 PM, NP) \***

Pt. Info Encounter Physical Hub

Copy/Merge Add Remove Customize ☐ Non-Contributory ☐ Family History Verified

Members	Status	YOB	Age	Note	Diabetes	Hypertensi	Stroke	Cancer	Unknown
Father	alive	1955	61	..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	alive	1945	71	..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings				..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children				..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daughter(s)				..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Son(s)				..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friend(s)				..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Siblings Brothers 0 Sisters 0 ☐ Healthy

Children Sons 0 Daughters 0 ☐ Healthy

Notes Browse Clear

Surgical History Social History

2. Select an option from the *Status* drop-down list for each family member.
3. Type the year in which each family member was born in the *YOB* field for each family member.
4. Check the box(es) for any applicable medical issues for each family member (Diabetes, Hypertension, Cancer, and Unknown):

**Family History (Test, Senna - 10/12/2015 12:14 PM, NP) \***

Pt. Info Encounter Physical Hub

Copy/Merge Add Remove Customize ☐ Non-Contributory ☐ Family History Verified

Members	Status	YOB	Age	Note	Diabetes	Hypertensi	Stroke	Cancer	Unknown
Father	alive	1955	61	..	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	alive	1945	71	..	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Note:** Data entered in the Family History section from a Telephone Encounter via the Patient Hub or Tjelly bean is also included in the CCDA.

## Vitals

To document the vitals for a patient:

1. From the Progress Notes window, click *Vitals*.

The Vitals window opens:

Date	HR(/min)	BP(mm Hg)	Ht(in)	Wt(lbs)	BMI(Index)	RR(/min)	Oxygen sat	Peds
10/12/2015	34		70	264.55	37.95			
10/07/2015								
10/06/2015								
10/05/2015								
09/17/2015	80		70	160	22.96			
09/15/2015	70		60	150	29.29			
09/14/2015	60		50	140	39.37			

2. Enter the height, weight, BMI, BP (if applicable), and any other necessary vital signs in the appropriate columns:

Date	HR(/min)	BP(mm Hg)	Ht(in)	Wt(lbs)	BMI(Index)	RR(/min)	Oxygen sat	Peds
10/12/2015 *	34	115/80	70	264.55	37.95			

**Note:** Data entered in the Vitals section from a Telephone Encounter via the Patient Hub or Tjelly bean is also included in the CCDA.

## Configure Vitals Mapping

To configure vitals mapping:

1. From the *EMR* menu, mouse over *Vitals* to open a drop-down list, then click *Configure Vitals*.  
The Configure Vitals window opens.
2. For all desired local vitals on the left, select an option from the *Standard Vital Type* drop-down list(s) on the right.

3. Click *OK*:

Name	Standard Vital Type	Mand...	Display...
Len-cm		<input type="checkbox"/>	<input type="checkbox"/>
Len-in		<input type="checkbox"/>	<input type="checkbox"/>
Length		<input type="checkbox"/>	<input type="checkbox"/>
Purvi		<input type="checkbox"/>	<input type="checkbox"/>
Temp	Temperature	<input type="checkbox"/>	<input checked="" type="checkbox"/>
HR	Heart Rate	<input type="checkbox"/>	<input checked="" type="checkbox"/>
BP	Blood Pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Ht	Height	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Wt	Weight	<input type="checkbox"/>	<input checked="" type="checkbox"/>
BMI	BMI	<input type="checkbox"/>	<input checked="" type="checkbox"/>
RR	Respiratory Rate	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Oxygen sat %	Oximetry	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Peak Flow	Peak Flow	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Pain scale	Pain Scale	<input type="checkbox"/>	<input checked="" type="checkbox"/>
HC	Head Circumference	<input type="checkbox"/>	<input checked="" type="checkbox"/>

☒ Automatically carry forward height from previous visit after certain age

Age for male  Age for female

☐ Automatically calculate hypertension and prehypertension for BP

☐ Enable WHO Growth Charts for 0 to 2 Years (uses CDC when unchecked)  
(Note: From 2 to 20 years eCW uses CDC data as recommended by CDC)

☐ Enable Down's Syndrome Growth Charts  
(Note: Growth chart data for children with Down Syndrome provided with permission from www.growthcharts.com. Percentiles are approximate; use at your own discretion)

Qualifiers Associate CPT Migrate OK Cancel

## Treatment - Order Labs and Results

To document ordering labs for a patient:

1. From the Progress Notes window, click *Treatment*.

The Treatment window opens:

2. Click *Browse* in the Labs section.  
The Manage Orders window opens.
3. Enter the name of a lab in the Lookup field.  
The labs that match the entered text display in the pane beneath the Lookup field in real time.

4. Click a lab from this pane:

The screenshot shows the 'Manage Orders' window in eClinicalWorks. The window is divided into several sections:

- Current Meds**: A tab at the top.
- Add New Rx**: A tab at the top.
- Add New Order**: A tab at the top.
- Assessments**: A section on the left with a search bar and a list of assessments. The search bar contains 'cbd'. The list shows 'V70.0 Routine general m' and 'V70.4 Examination for m'.
- Lab Company**: A dropdown menu set to 'All'.
- Order Name**: A list of search results showing 'CBC' and 'CBC W Auto Differential panel in Blood'.
- Lab Companies**: A list of lab companies, including 'MU2.S.1'.
- Today's Orders**: A table showing orders for today. The table has columns for 'H', 'S', 'F', 'IH', 'Description', 'Dx', and 'Order Date'. The table contains two rows: 'Amylase, Seru...' and 'CBC w Differe...'. The 'Order Date' for the second row is '10/31/2015'.
- Future Orders**: A section for future orders, currently empty.
- CC Results To**: A dropdown menu at the bottom left.
- Buttons**: 'Quick Transmit', 'Quick Print', 'Add', 'Bill To Physician Account', and 'Add Standing Orders' at the bottom.



The Lab Results window opens:

To document lab results for a patient (manually):

1. Open a lab order.
2. Enter lab results in the yellow grid.
3. Check the *Received* box.
4. Select the date on which these results were received from the *Date* drop-down list in the Results section:

**Note:** Data entered in the Labs section from the *L* jelly bean or right chart panel (ICW), or on a Telephone Encounter via the Patient Hub or *T* jelly bean is also included in the CCDA.

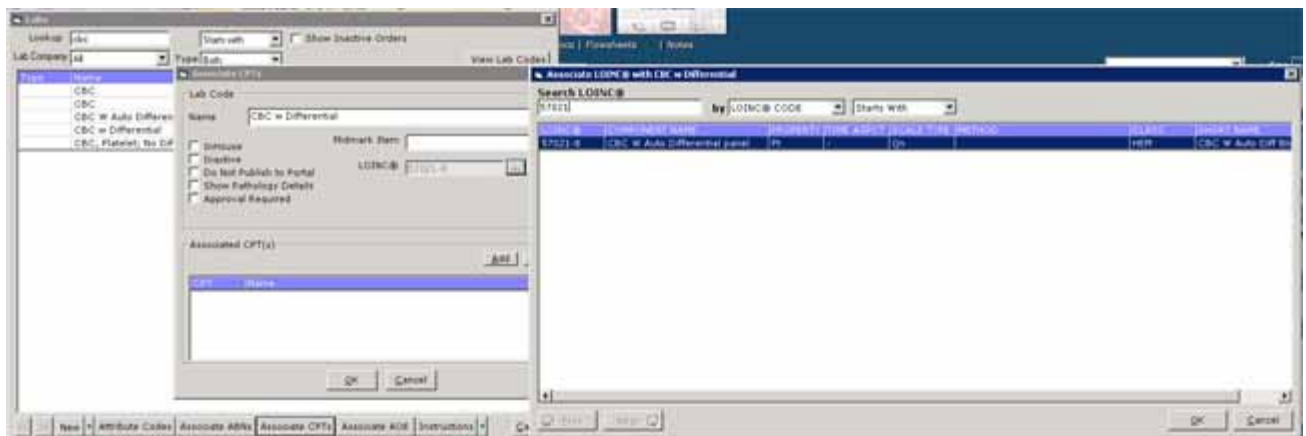
**Note:** Practices with a lab interface that automatically populate the *Result* and *Received Date* fields do not need to be entered manually on the Lab Results window.



## Linking LOINC Codes with Labs

To link LOINC codes to labs:

1. From the *EMR* menu, mouse over *Labs, DI & Procedures* to open a drop-down list, then click *Labs*.  
The Labs window opens.
2. Highlight a lab, then click *Associate CPTs*.  
The Associate CPTs window opens.
3. Click the More (...) button next to the LOINC field.  
The Associate LOINC window opens.
4. Enter a LOINC code in the Search LOINC field.  
The LOINC codes that match the entered text are filtered on this window in real time.
5. Highlight a LOINC code and click *OK*:



## Treatment - Outgoing Referral

To document ordering an outgoing referral for a patient:

1. From the Progress Notes window, click *Treatment*.

The Treatment window opens:

The screenshot shows the 'Treatment' window for patient 'Test, Senna' on 10/12/2015 at 12:14 PM. The window has a title bar and a menu bar with 'Pt. Info', 'Encounter', 'Physical', and 'Hub'. Below the menu bar is a toolbar with various icons. The main area is divided into several sections: 'Rx Cur Rx' with 'Add' and 'Remove' buttons, 'Education' and 'Formulary' tabs, and a 'Generate Hx By' section with radio buttons for 'Id', 'Code', and 'Group'. Below these are tabs for 'Routine general medi', 'Examination for medi', and 'Others'. A table with columns for 'Name', 'Strength', 'Formul', 'Take', 'Route', 'Frequency', 'Duration', 'Disp', 'Refill', 'Auth', 'AWP', 'Stop Dz', and 'No' is present. Below the table are three sections: 'Labs' (Amylase, Serum), 'Diagnostic Imaging', and 'Procedures', each with a 'Browse...' button. At the bottom, there are buttons for 'Notes', 'Clinical Notes', 'Browse...', 'Spell chk', 'Clr', 'Outgoing Referral', 'eClniSense', 'Add Info', 'New Action', 'Preventive Med', 'Print Orders', 'Send Rx', 'Allergies', 'Interaction', and 'CDSS'.

2. Click *Outgoing Referral*.

The Referral (Outgoing) window opens.

3. Click More (...) next to the Provider field in the Ref To section to select the provider to whom this referral is being made.
4. Select an option from the Specialty drop-down list in the Ref To section to select the specialty of the provider to whom this referral is being made.

5. Enter all other applicable data for this referral:

**Referral (Outgoing)**

Patient: Test, Senna (10443) [Sel] [Info] [Hub]

Insurance: [Sel] [Pt Ins] POS: 11

Ref From: Willis, Sam [Ref To: Provider: Lung, George [Pref] [Clear] Specialty: Cardiology]

Facility From: Test Facility [Facility To: Dr. Lung [Clear]

Auth Code: [Auth Type: [End Date: 11/04/2016]

Start Date: 11/04/2015 [Assigned To: Willis, Sam [Unit Type: V (VISIT)]

Referral Date: 11/04/2015 [Status: ☒ Open ☐ Consult Pending ☐ Addressed]

Open Cases: [N] [Priority: Routine]

Appt Date: 11/11/2015 [Received Date: 01/13/2016]

**Diagnosis / Reason** [Visit Details] [Notes] [Structured Data]

**Reason** [Add] [Browse] [Remove]

Sl. No	Description
1	Pulmonary function tests

**Diagnosis** [Previous Dx] [Add] [Remove]

Code	Name
V70.0	Routine general medical examination at a h

**Procedures** [Add] [Remove]

Code	Name
------	------

[Scan] [Attachments (2)] [Logs] [OK] [Cancel] [Send Referral]

**Note:** Data entered in the Outgoing Referral section from the *R* jelly bean, or on a Telephone Encounter via the Patient Hub or *T* jelly bean, is also included in the CCDA.

## Circle of Care Team Members

To document Circle of Care team members:

1. From the Patient Information window, click *Additional Info*.  
The Patient Information - Additional Information window opens.
2. Click the *Circle of Care* tab at the bottom of the window.

The Circle of Care options display:

Circle Name	Description
CareTeam	

- Click *Add* to create a new circle or highlight an existing circle and click *Update*.

The Circle of Care window opens.

- (Optional) If this is a new circle, enter a name in the *Circle Name* field.
- Select an option from the Category drop-down list.
- Click *Add*.
- Select an appropriate option from the list.
- Click *OK*:

	Category	Fax Number	Primary	<input type="checkbox"/> Display in ICW	Relationship
<input type="checkbox"/> Fine, Larry			<input type="radio"/>	<input checked="" type="checkbox"/>	
<input type="checkbox"/> Getwell, James	Family Medicine	123-456-1236	<input checked="" type="radio"/>	<input checked="" type="checkbox"/>	
<input type="checkbox"/> Primary, Patricia	Family Medicine	965-965-9651	<input type="radio"/>	<input checked="" type="checkbox"/>	

**Note:** Data entered into the Circle of Care section in the right chart panel (ICW) on the Patient Hub or in the Progress Notes is also be included in the CCDA.

## HPI - Cognitive and Functional Status

To document cognitive and functional status for a patient:

1. From the Progress Notes window, click *HPI*.

The HPI window opens:

2. Click the *Cognitive & Functional Status* option in the left pane.  
The symptoms related to the Cognitive & Functional Status option displays in the right pane.
3. Click in the Notes column for the *Cognitive & Functional Status* symptom row.  
The HPI Notes window opens with the Structured tab displayed.
4. Enter values for the *Cognitive Status*, *Functional Status*, *Date*, and *Status* structured data options:

**Note:** Data entered in the HPI section from a Telephone Encounter via the Patient Hub or Tjelly bean is also included in the CCDA.

## HPI Community Mapping

To map the HPI structured data:

1. From the *Community* menu, click *Mappings*.  
The Mapper window opens.
2. Click the *Structured Data* tab in the left pane.  
The Structured Data options display on the right.
3. Select the following on the left, Community side:
  - a. From the *Section* drop-down list, select *HPI*.
  - b. From the *Category* drop-down list, select *Functional Status*.
  - c. From the *Item* drop-down list, select *Functional Cognitive Assessment*.
4. Select the following on the right, Local side (this is customizable and the office should choose the appropriate options for where the Care Plan information has been created, which may differ from the options below):
  - a. From the *Section* drop-down list, select *HPI*.
  - b. From the *Category* drop-down list, select *Cognitive & Functional Status*.
  - c. From the *Item* drop-down list, select *Cognitive & Functional Status*.
5. Click *Functional Cognitive Assessment 1* in the left Community pane.
6. Click *Cognitive Status* in the right Local pane.



7. Click *< Map >*:

The Mapper window is divided into two main sections: **COMMUNITY** and **LOCAL**. Both sections have search filters for Find, Section, Category, and Item. The **COMMUNITY** section shows a list of 'Functional Cognitive Assessment' items (1-10) with their types (Structured, Date, Numeric). The **LOCAL** section shows 'Cognitive Status' and 'Functional Status' items. A central 'Add >' button is used to map elements. At the bottom, there are navigation buttons: '<<Previous', '<MAP>', 'Next>>', and 'Close'. A legend on the left indicates 'Mapped Elements' (blue square) and 'Used in Measures and Order Sets' (red square).

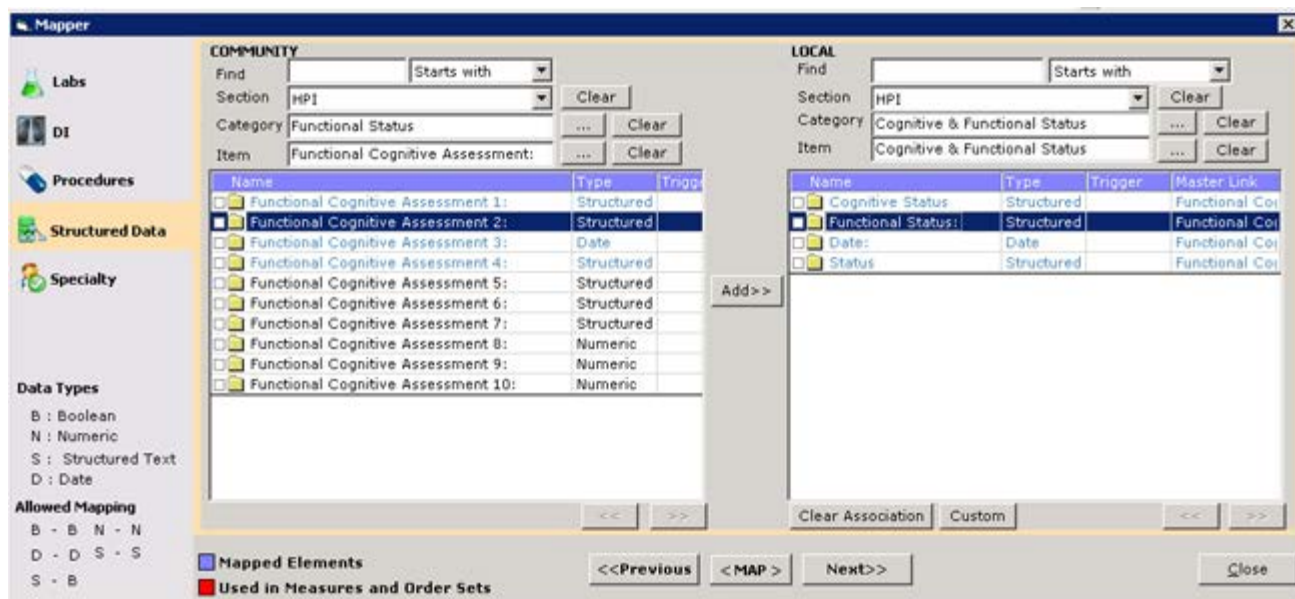
A second Mapper window opens.

8. Click the *No Impairment* options in the Master List and the Local List sections.  
9. Click *< Map >*:

The second Mapper window shows two lists: **Master List** and **Local List**. Both lists have a 'Name' column. In the Master List, 'No impairment' is selected with a checkmark. In the Local List, 'No Impairment' is selected with a checkmark. A central '< Map >' button is used to map the selected items. Below the lists are buttons for 'Add >', 'Clear All Associations', 'Delete', 'Clear Association', and 'Close'. A legend at the bottom indicates 'Used in measures' (red square).

10. Close the second Mapper window.  
11. Click *Functional Cognitive Assessment 2* in the Community section on the left.  
12. Click *Functional Status* in the Local section on the right.

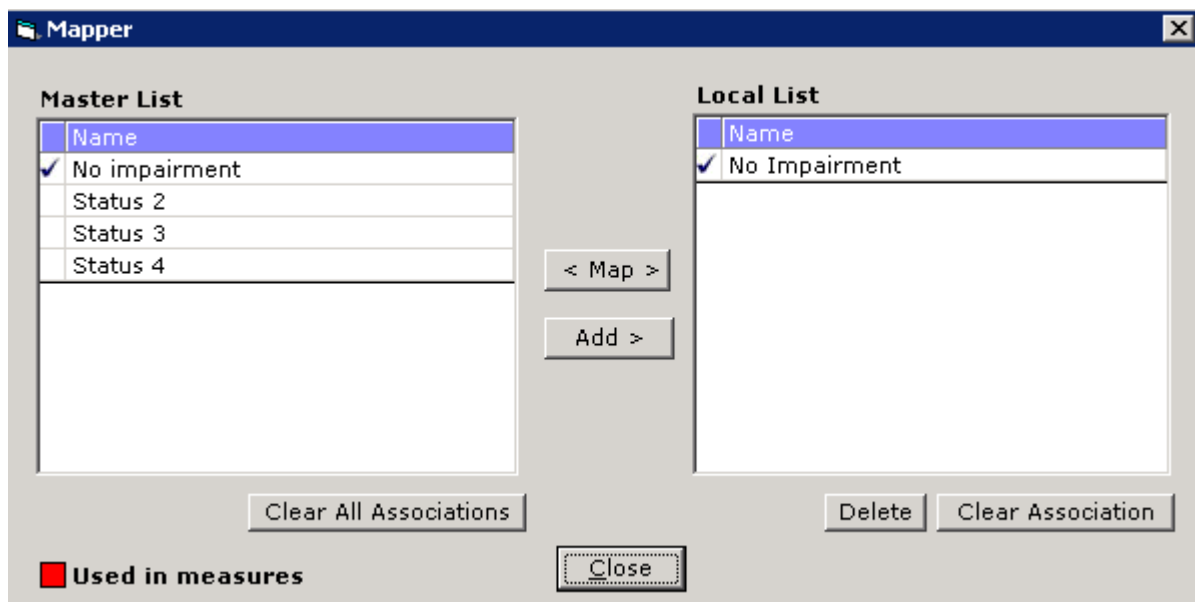
13. Click < Map >:



A second Mapper window opens.

14. Click the *No Impairment* options in the Master List and the Local List sections.

15. Click < Map >:



16. Close the second Mapper window.

17. Click *Functional Cognitive Assessment 3* in the Community section on the left.

18. Click *Date* in the Local section on the right.

19. Click < Map >:

The Mapper window displays two main sections: COMMUNITY and LOCAL. The COMMUNITY section on the left includes a sidebar with categories like Labs, DI, Procedures, Structured Data, and Specialty. Below these are Data Types (B: Boolean, N: Numeric, S: Structured Text, D: Date) and Allowed Mapping options. The main list in the COMMUNITY section shows 'Functional Cognitive Assessment 4' selected. The LOCAL section on the right has a similar structure but with 'Status' selected. The bottom navigation bar contains buttons for '<<Previous', '<MAP>', 'Next>>', and 'Close'. The '<MAP>' button is highlighted.

20. Click *Functional Cognitive Assessment 4* in the Community section on the left.

21. Click *Status* in the Local section on the right.

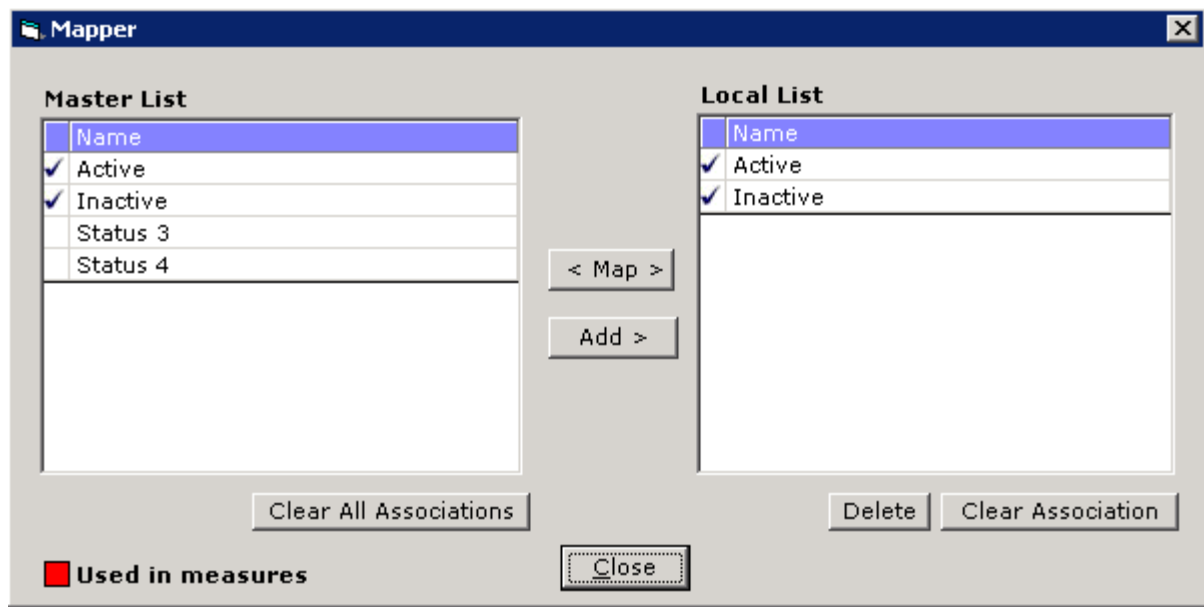
22. Click < Map >:

This screenshot is identical to the previous one, showing the Mapper window with 'Functional Cognitive Assessment 4' selected in the COMMUNITY section and 'Status' selected in the LOCAL section. The '<MAP>' button in the bottom navigation bar remains highlighted.

The second Mapper window opens.

23. Click the *Active* in the Master List and the Local List sections and then click < Map >.

24. Click the *Inactive* options in the Master List and the Local List sections and then click < Map >:



## Transferring the File

Please contact the vendor or the third party for whom the file is being created for details regarding how to transfer the file.



# APPENDIX A: NOTICES

## Trademarks

### eClinicalWorks®

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