eClinicalWorks

CCDA Data Portability Users Guide

V10 - January *2016*

CONTENTS

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*.

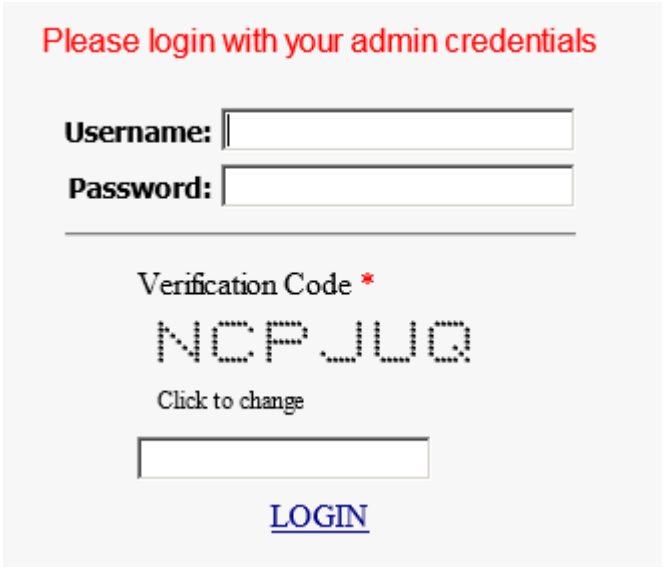
   The Reports window opens.

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*:



The Data Portability window opens.

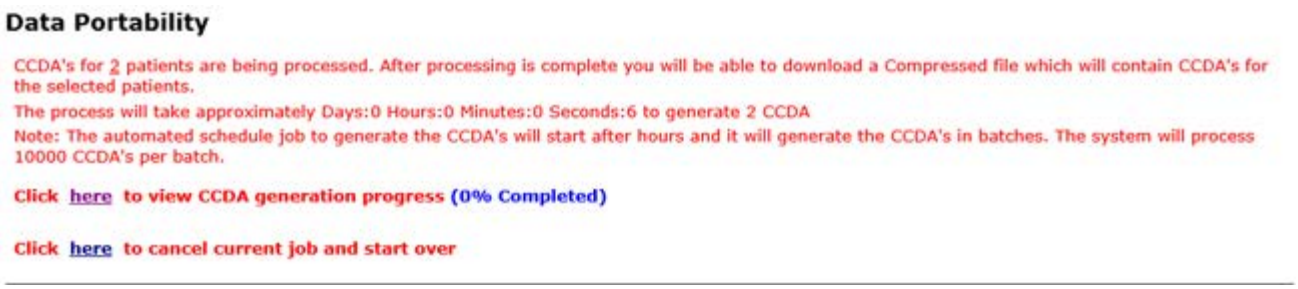
5. Select an option from the *Show* drop-down list to change the number of entries that are displayed on the window:

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):

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

A progress message for the generated CCDAs displays:



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.

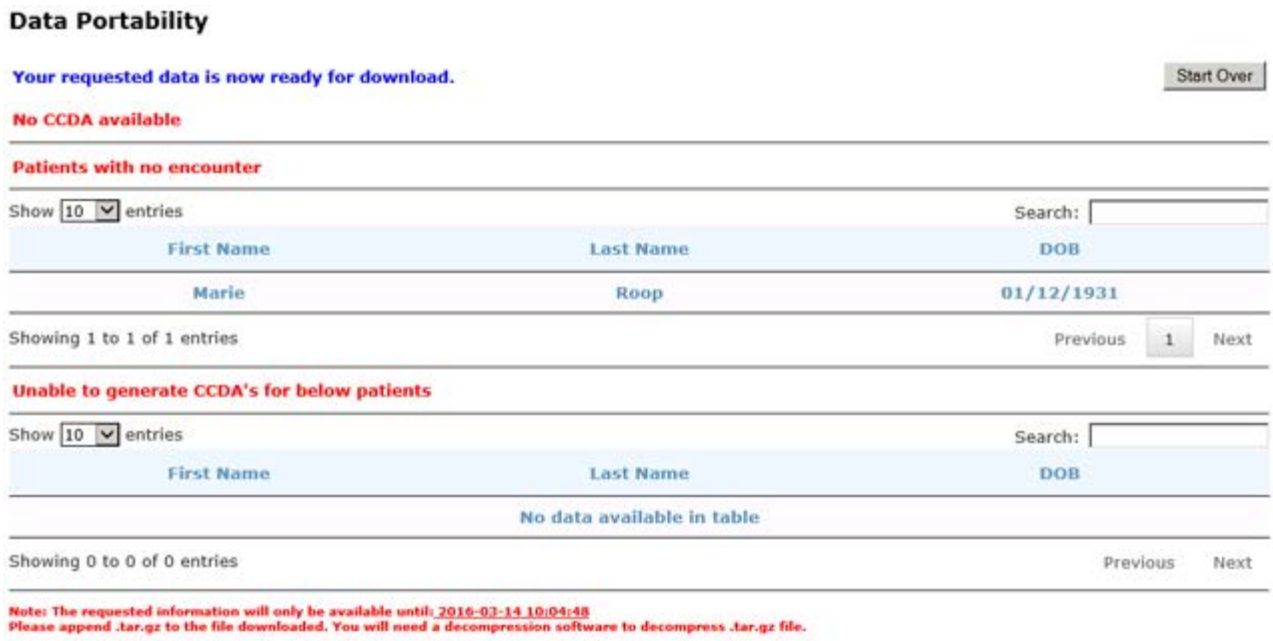
9. *(Optional)* To view more information on the CCDA generation progress, click the first *here* link.
10. *(Optional)* To cancel this job and start over, click the second *here* link.

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

- eCW Cloud message:

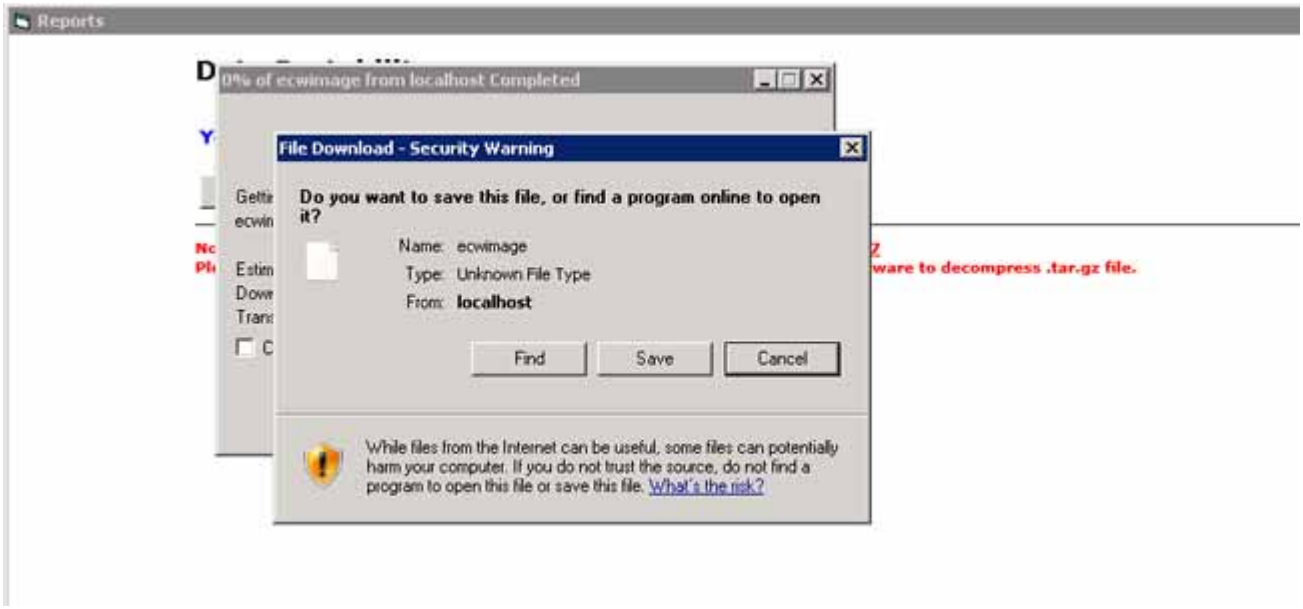
- Non-eCW Cloud message:

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



11. Click *Download*.

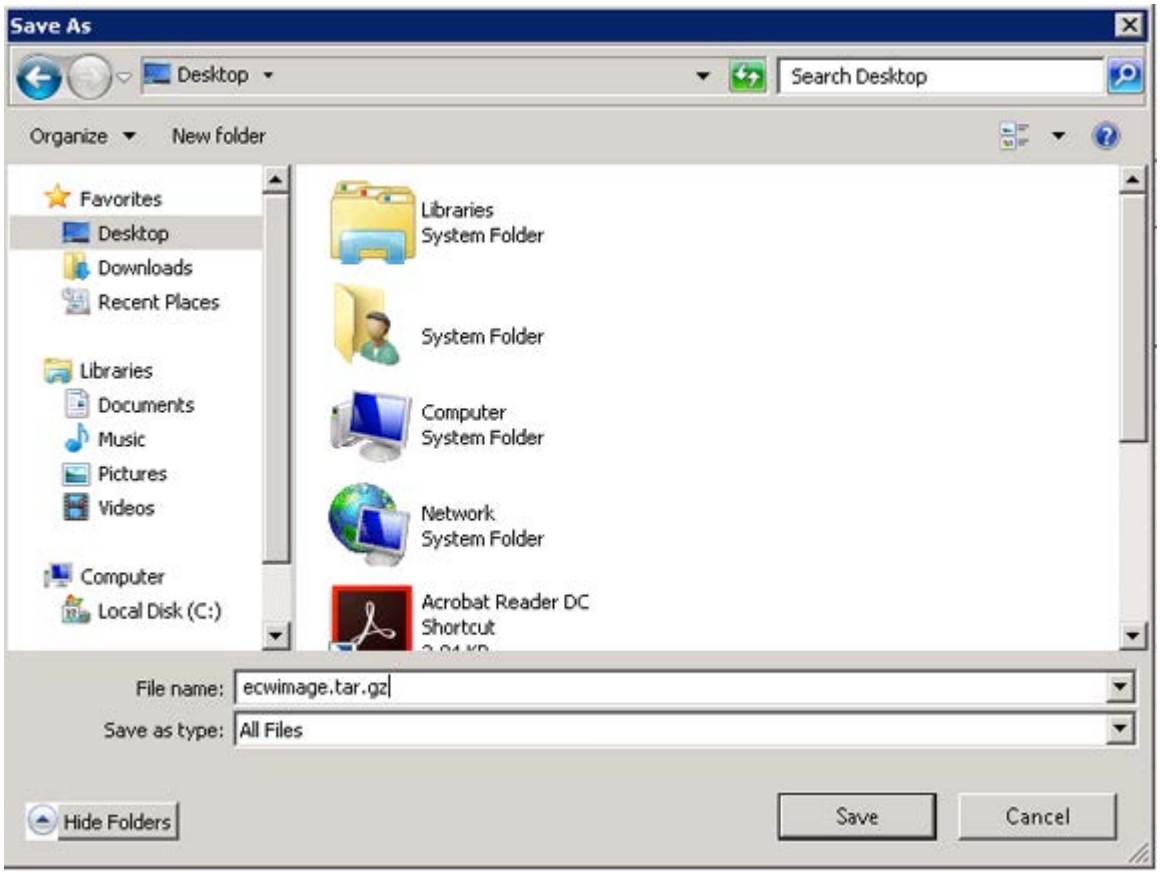
The File Download window opens:



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.

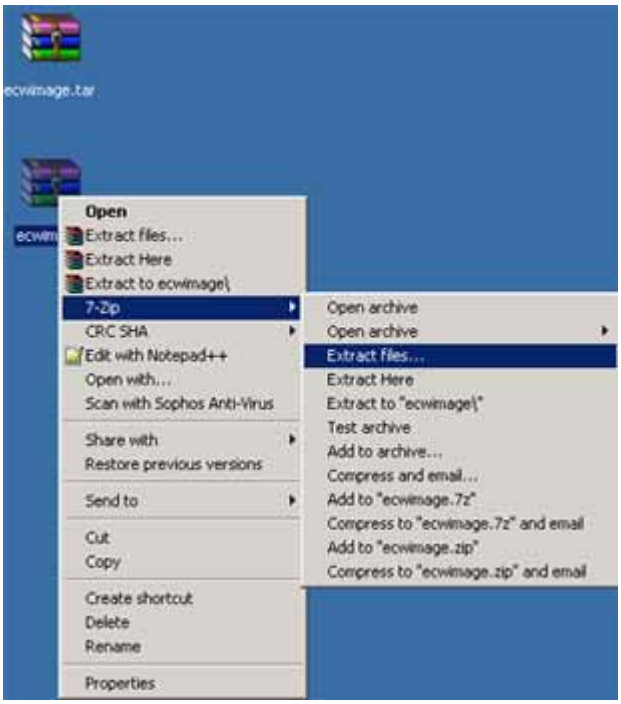
14. Navigate to the file to access it using the following process:

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.

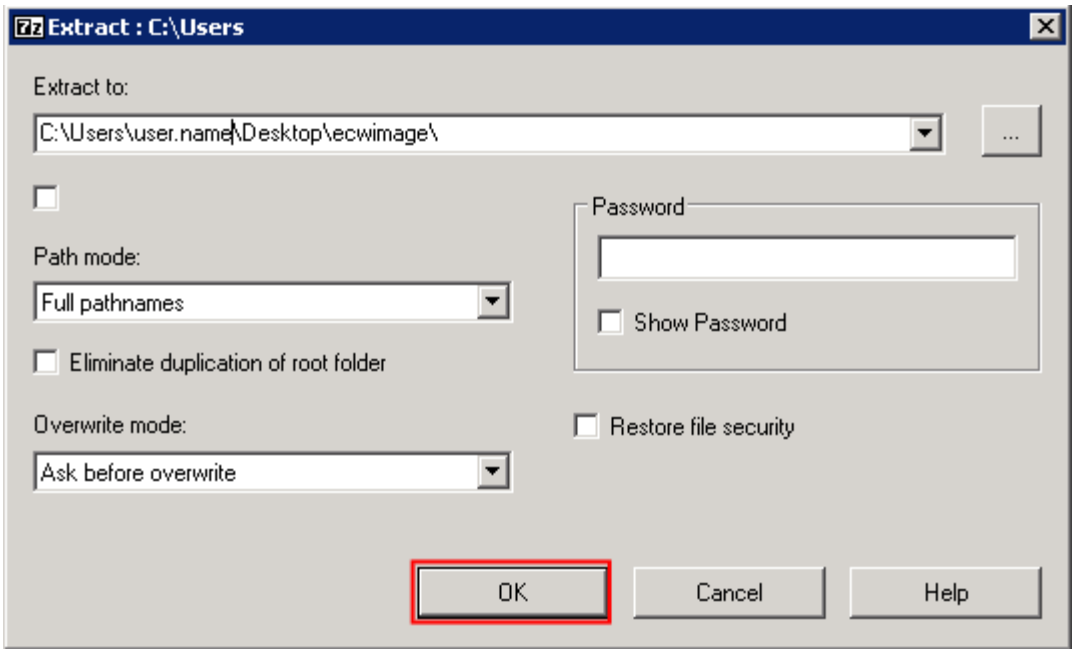
b. Open the second zipped file using the same process, except click *Extract files...* in the last step instead of *Extract Here*:



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

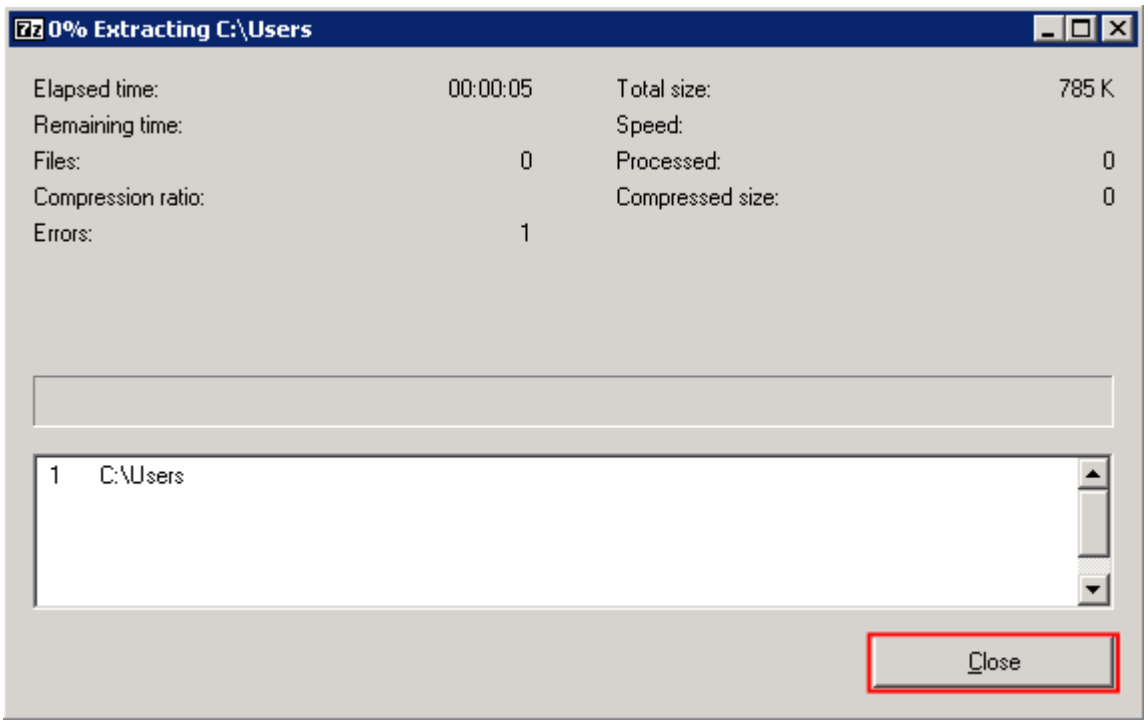
The Extract window opens.

c. Click *OK*:



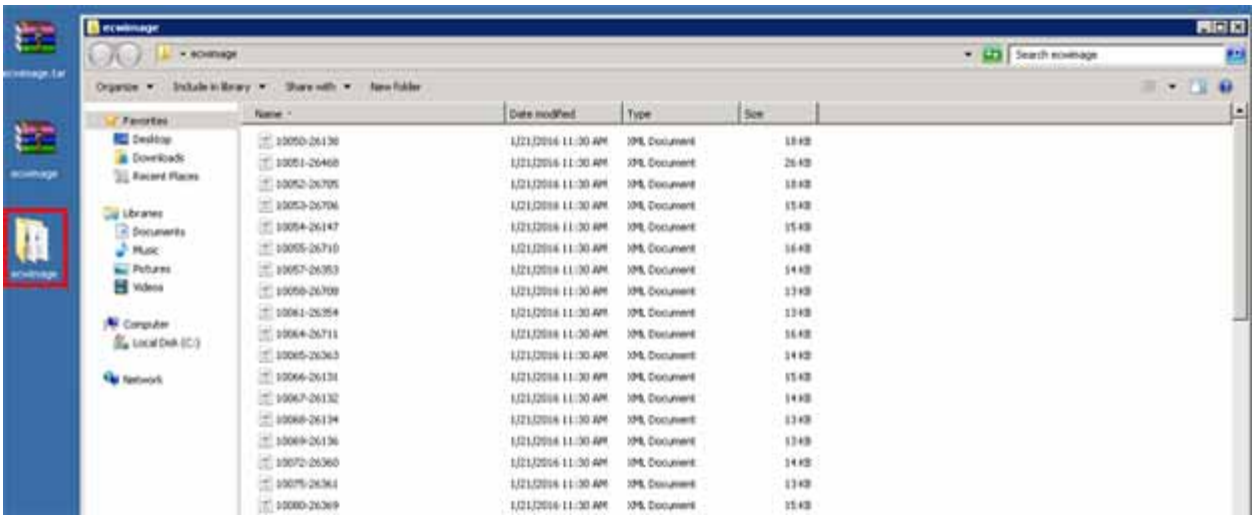
The extraction progress window opens.

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.

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

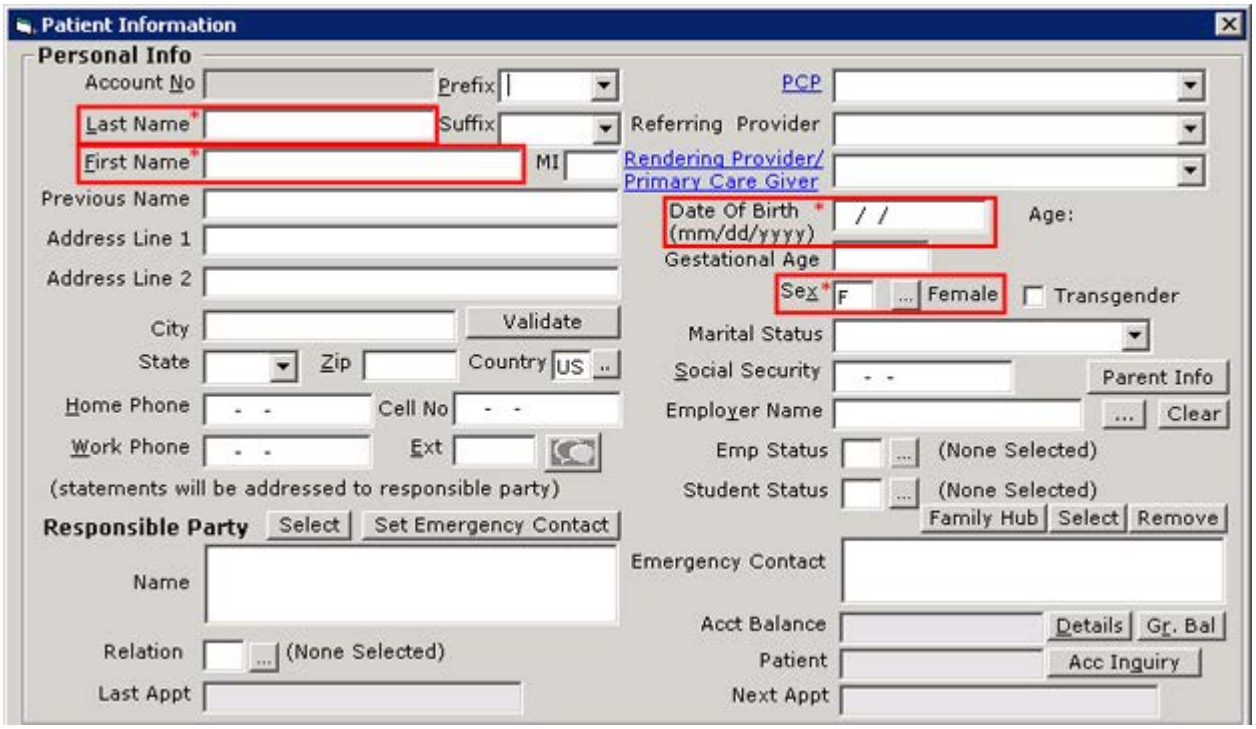
- Family History
- Vitals
- Configure Vitals Mapping
- Treatment - Order Labs and Results
- Linking LOINC Codes with Labs
- Treatment - Outgoing Referral
- Circle of Care Team Members
- HPI - Cognitive and Functional Status
- HPI Community Mapping

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:

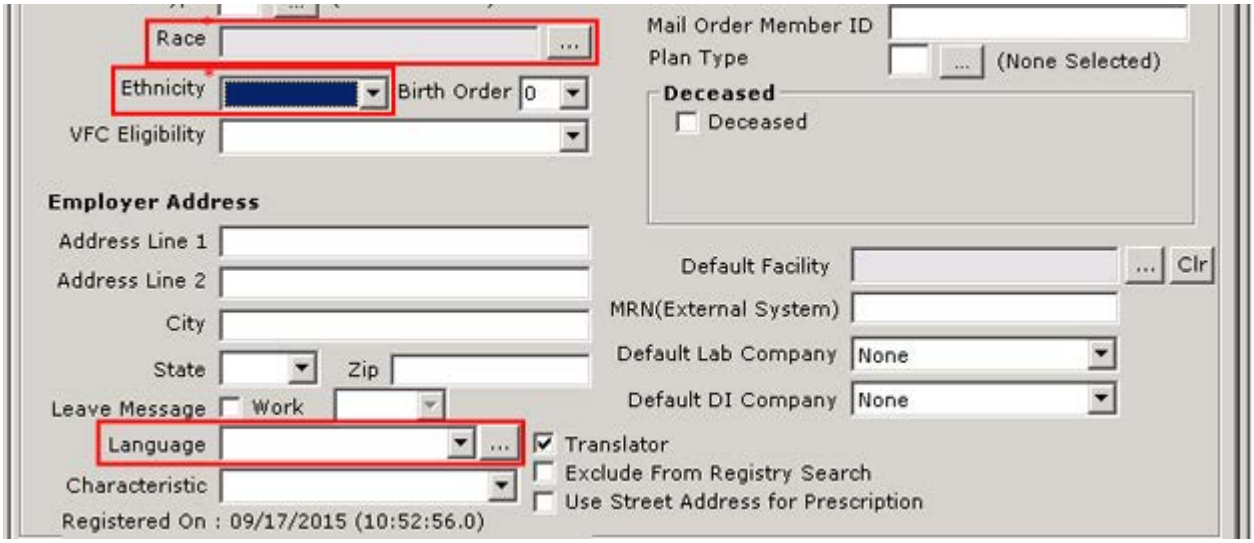


3. Click *OK*.

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:



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*.

5. Repeat steps 2-4 for all desired languages:

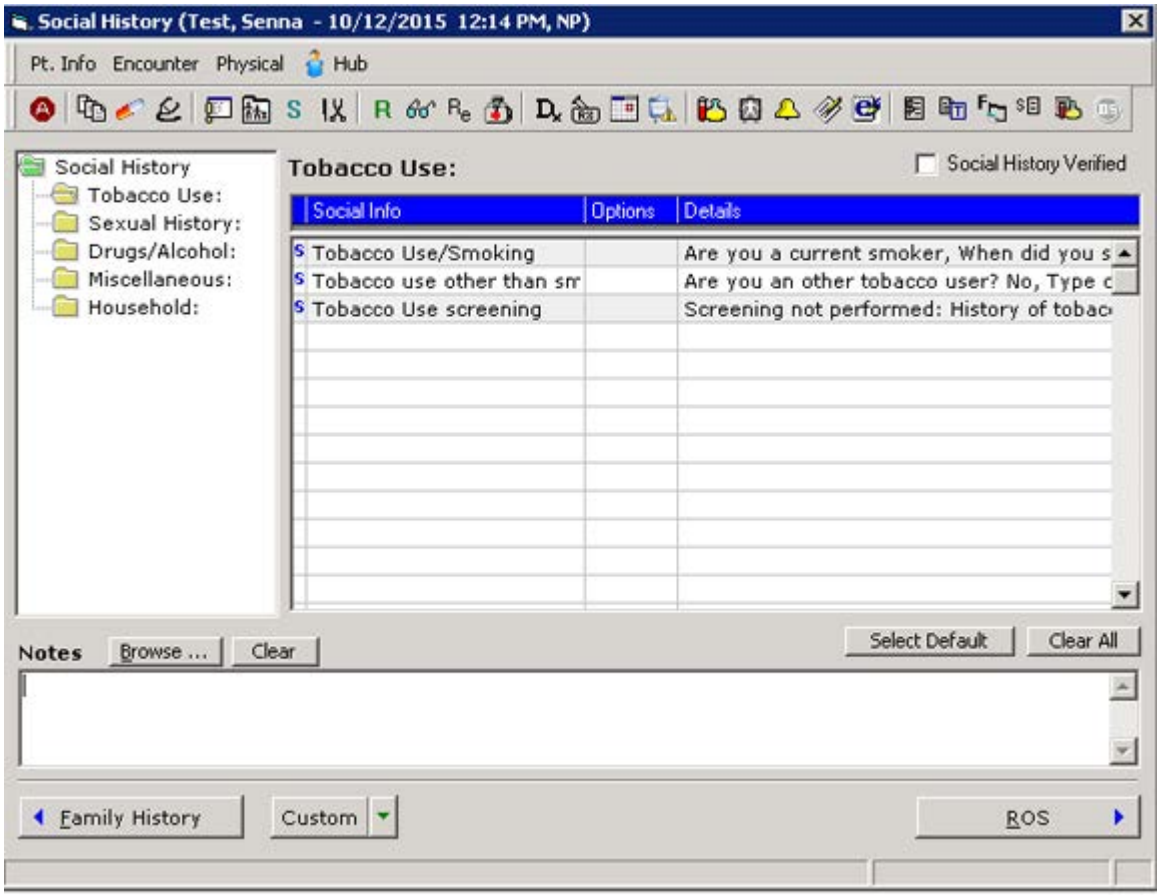
Note: If a language is accidentally mapped to an incorrect ISO name, select that language and ISO name and click *UnMap*.

Social History - Tobacco Use

To document the Tobacco Use of a patient:

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

   The Social History window opens:



2. Click in the Details column for the *Tobacco Use/Smoking* row.

   The Social History Notes window opens with the Structured tab selected.

3. 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:

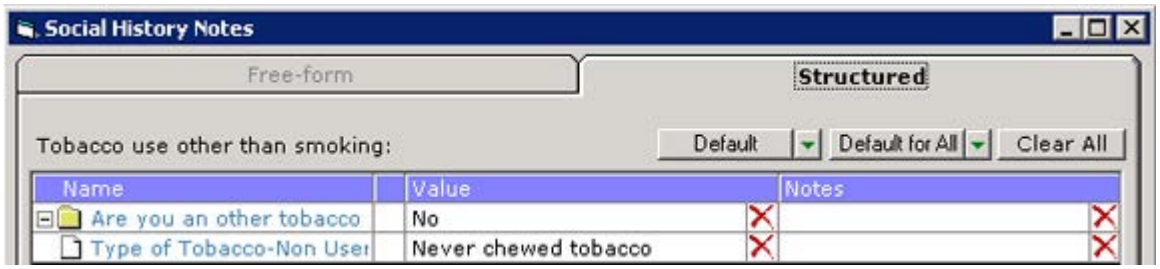
1. From the Progress Notes window, click *Social History*.

   The Social History window opens.

2. Click in the Details column for the *Tobacco use other than smoking* row.

   The Social History Notes window opens with the Structured tab selected.

3. Enter information in the Value column for both the *Are you an other tobacco user* and the *Type of Tobacco-Non User* rows:



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

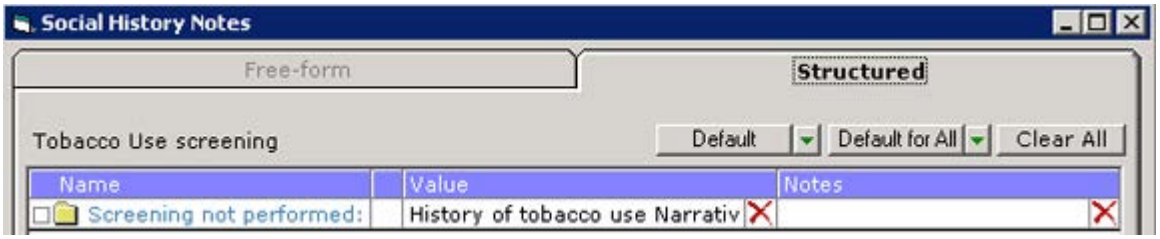
1. From the Progress Notes window, click *Social History*.

   The Social History window opens.

2. Click in the Details column for the *Tobacco use screening* row.

   The Social History Notes window opens with the Structured tab selected.

3. Enter information in the Value column for the *Screening not performed* row:



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):

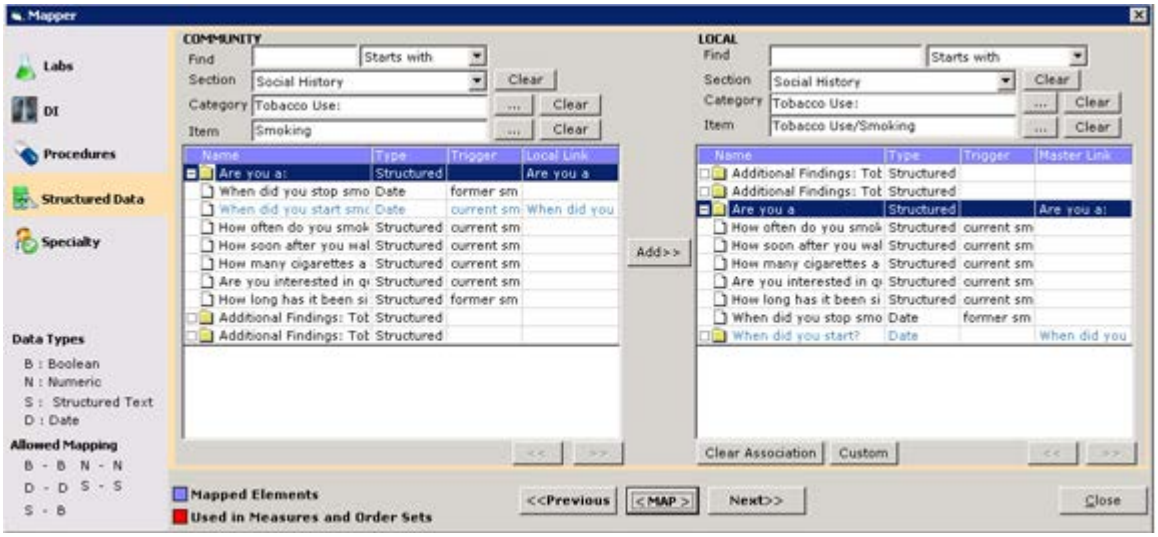
   a. From the *Section* drop-down list, select *Social History*.

   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* >:

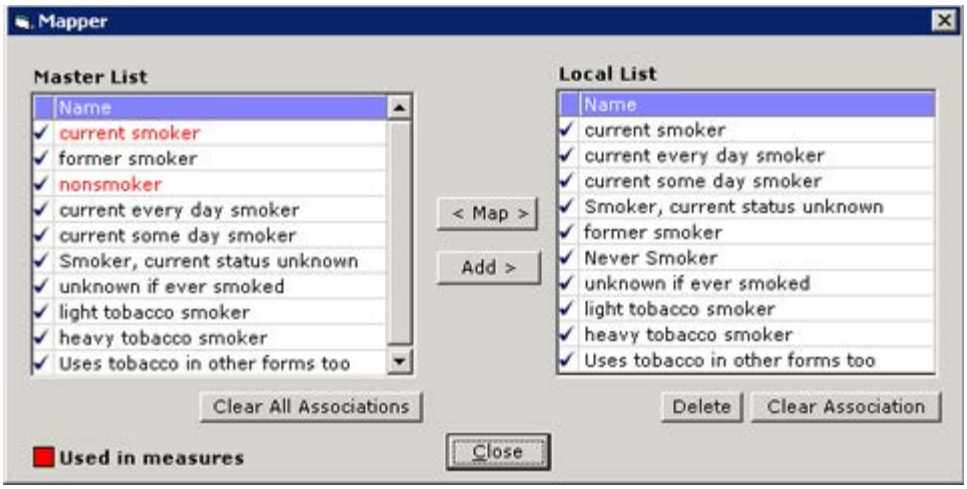


   A second Mapper window opens.

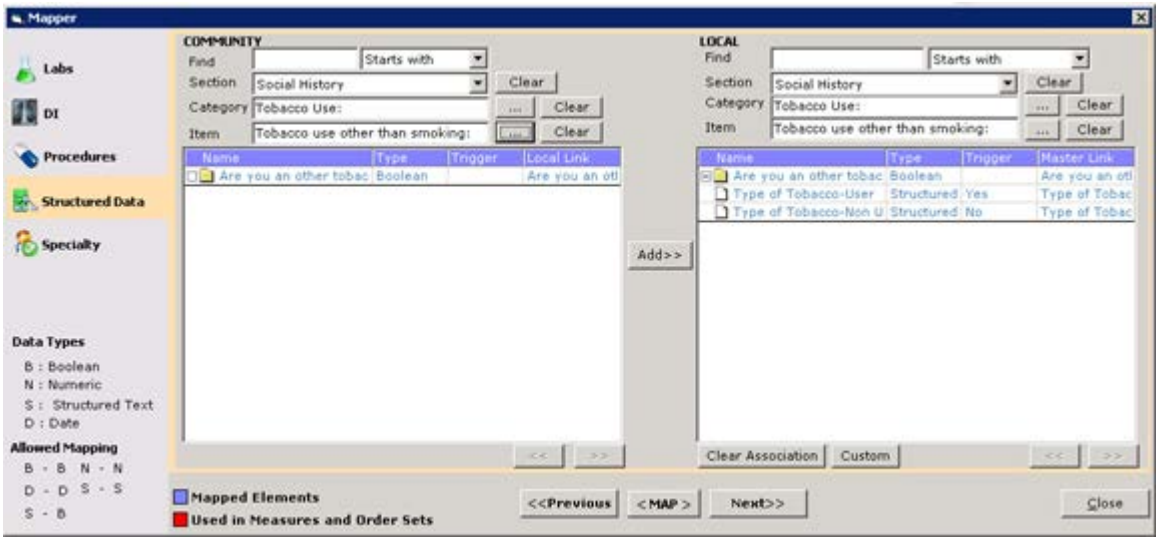
7. Click the options that correspond to each other in the Master List and the Local List sections.

8. Click < *Map* >.

9. Repeat steps 7-8 for all options:

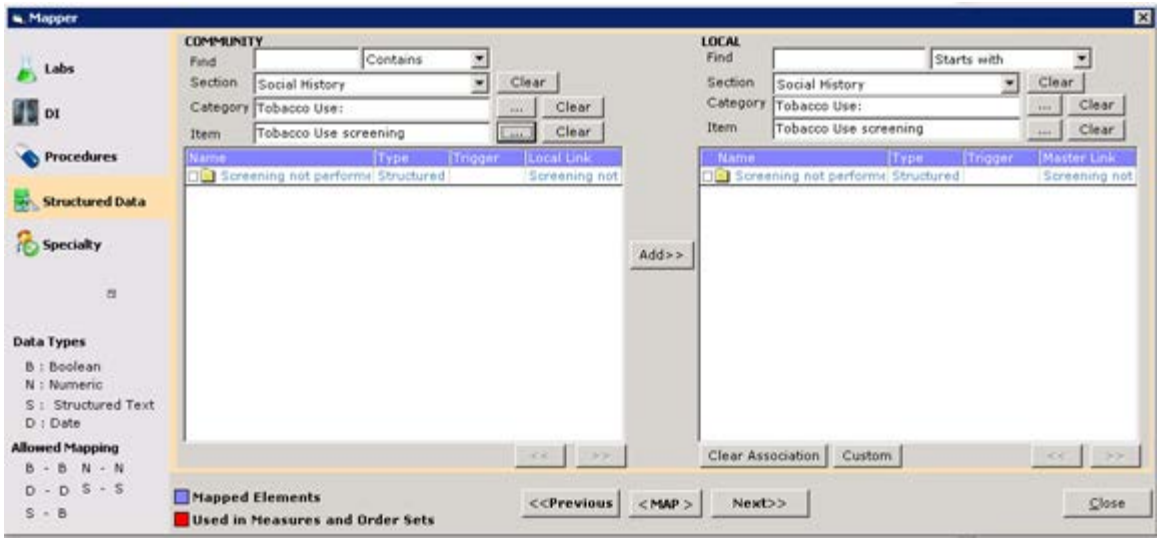


10. Close the second Mapper window.
11. From the *Item* drop-down lists on both sides of the Mapper window, select *Tobacco use other than smoking*.
12. Click *Are you an other tobacco user* in the Community and Local sections.
13. Click < *Map* >:



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.

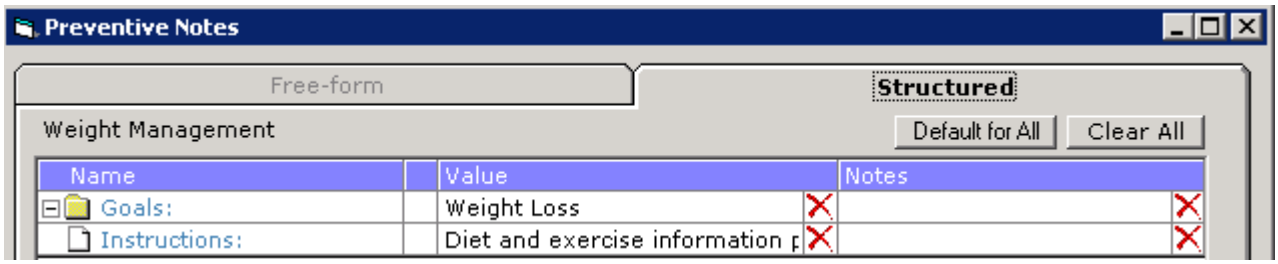
2. Click *Care Plans* in the left pane.

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:



To document Chronic Care Management for a patient:

1. From the Progress Notes window, click *Preventive Medicine*.

The Preventive Medicine window opens.

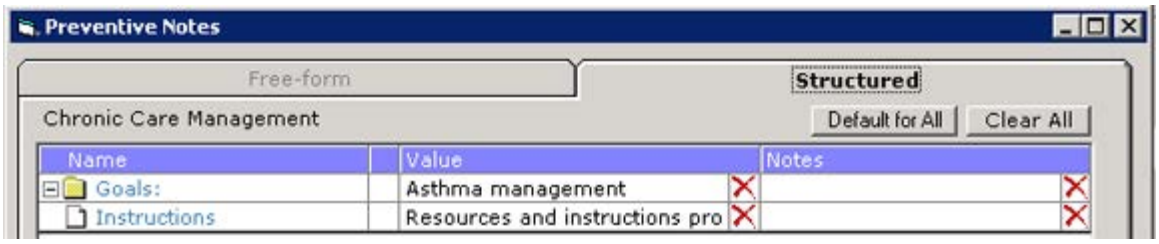
2. Click *Care Plans* in the left pane.

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:



To document Smoking Cessation for a patient:

1. From the Progress Notes window, click *Preventive Medicine*.

   The Preventive Medicine window opens.

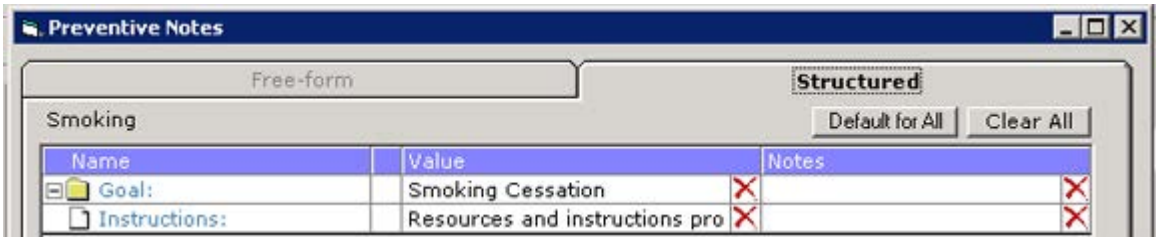
2. Click *Care Plans* in the left pane.

   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:



To document Preventative Health information for a patient:

1. From the Progress Notes window, click *Preventive Medicine*.

   The Preventive Medicine window opens.

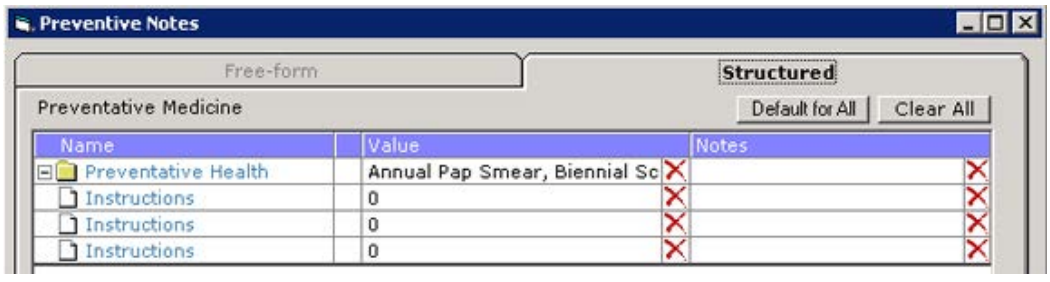
2. Click *Care Plans* in the left pane.

   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:



Note: Data entered in the Preventive Medicine section from a Telephone Encounter via the Patient Hub or *T* jelly 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*.

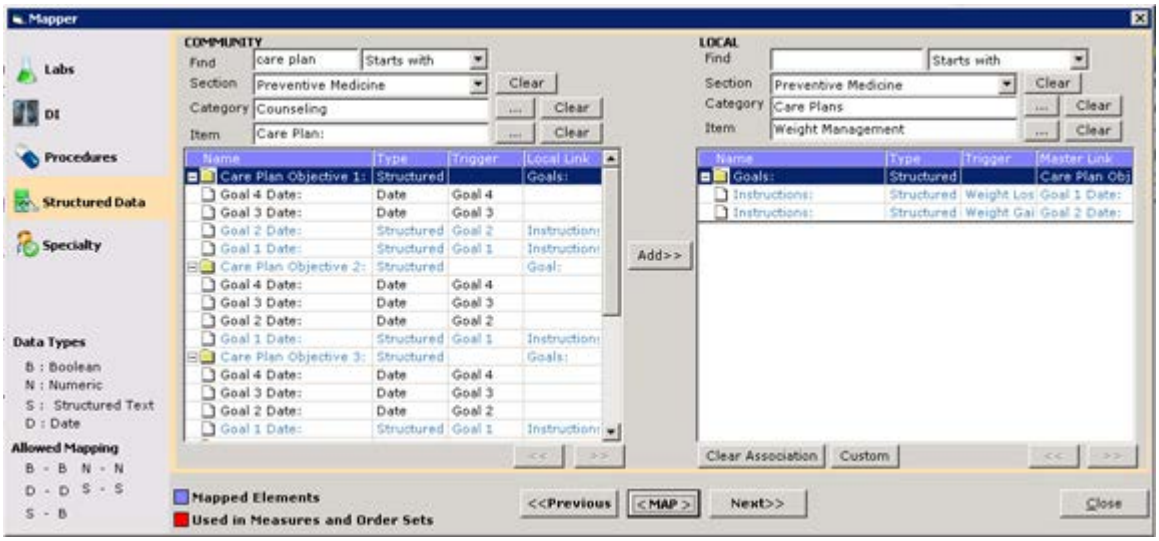
   b. From the *Category* drop-down list, select *Care Plans*.

   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.

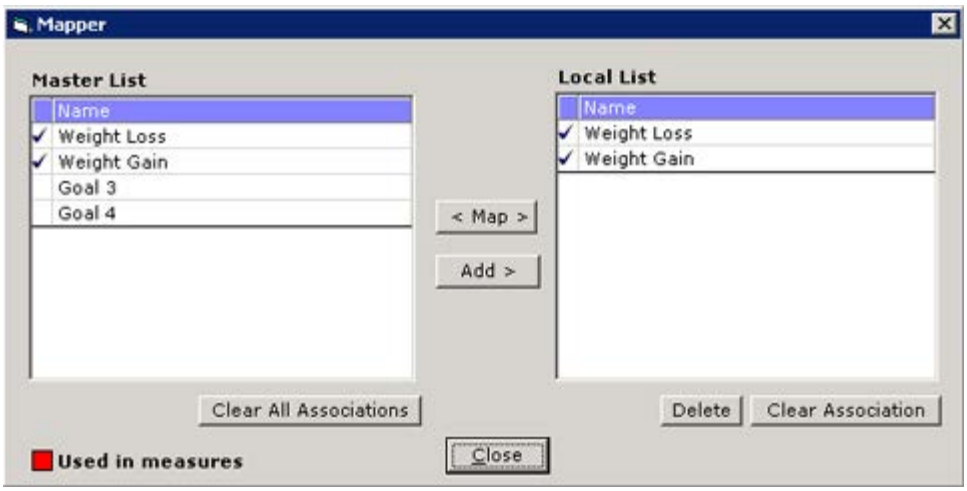
7. Click < *Map* >:



   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* >:



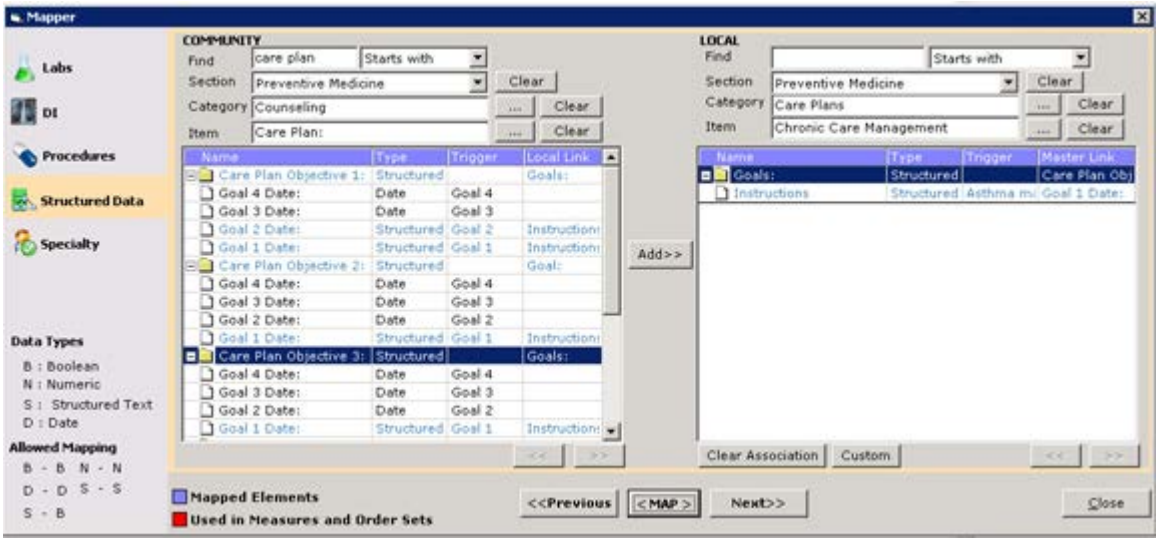
10. Close the second Mapper window.

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.

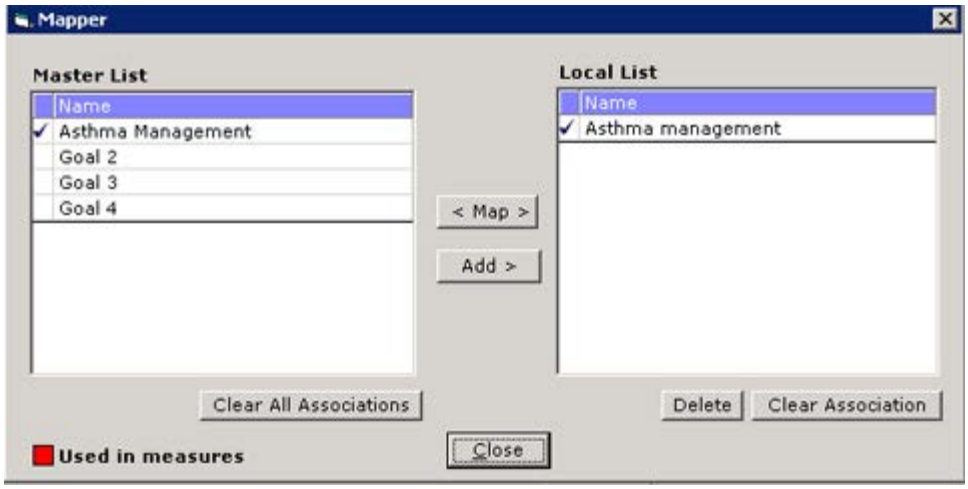
14. Click < *Map* >:



The second Mapper window opens.

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

16. Click < *Map* >:



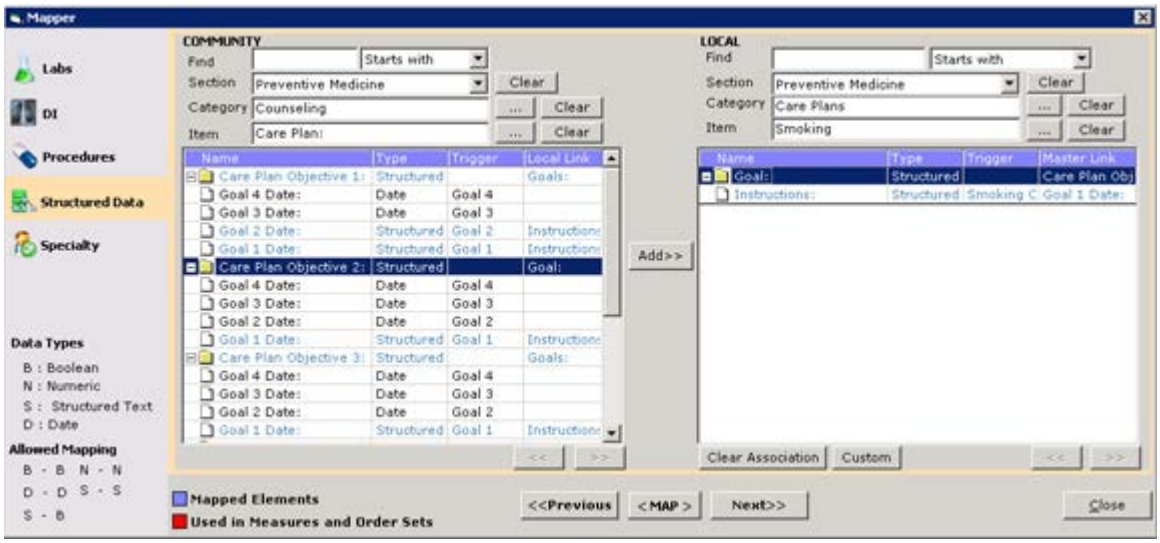
17. Close the second Mapper window.

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.

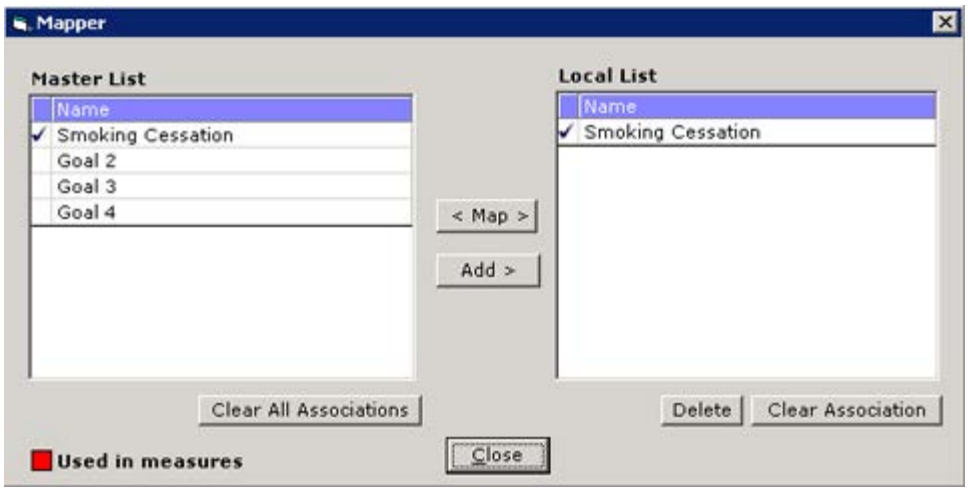
21. Click < *Map* >:



The second Mapper window opens.

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

23. Click < *Map* >:



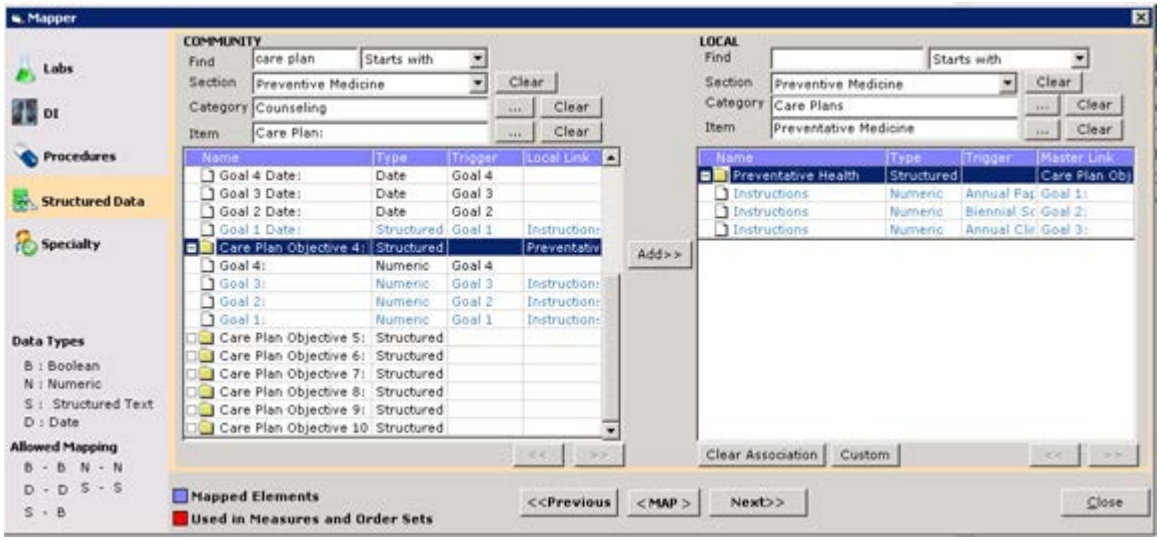
24. Close the second Mapper window.

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* >:

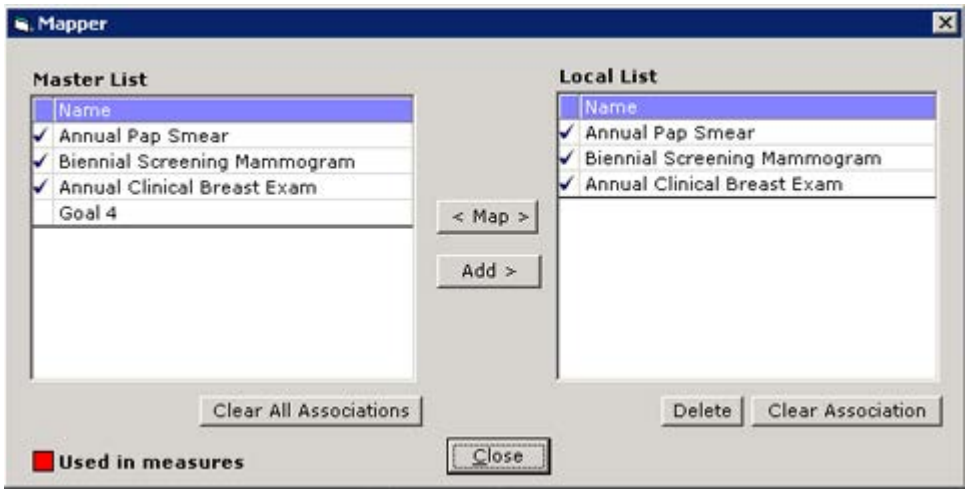


The second Mapper window opens.

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* >:

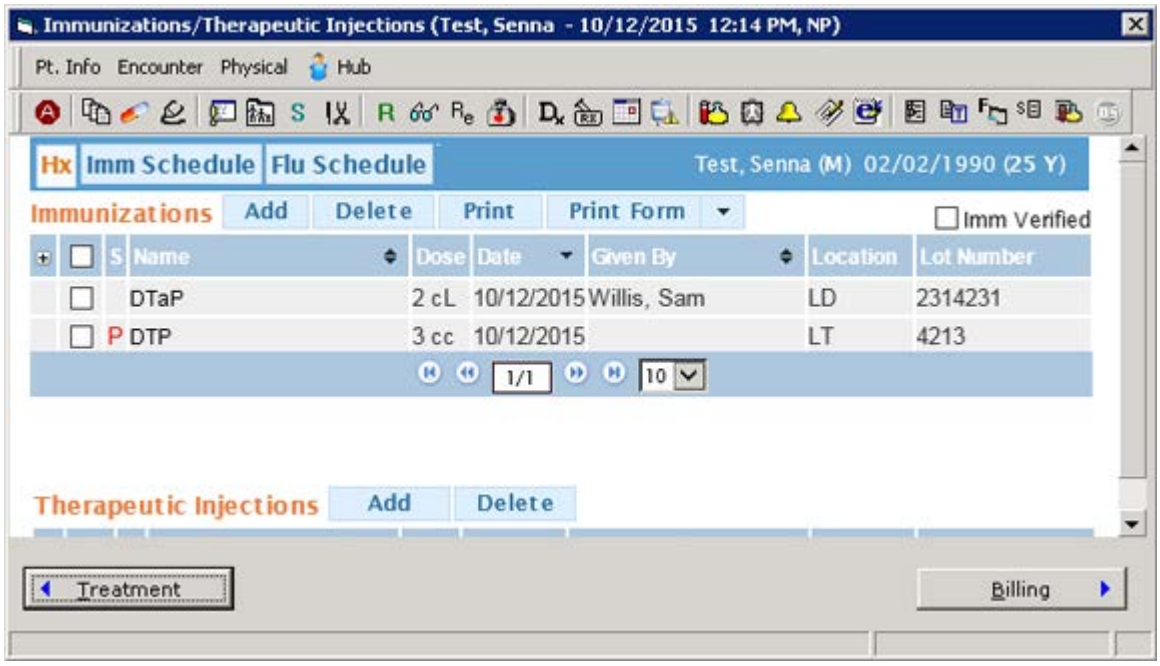


Immunizations

To document immunizations for a patient:

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

The Immunizations window opens:



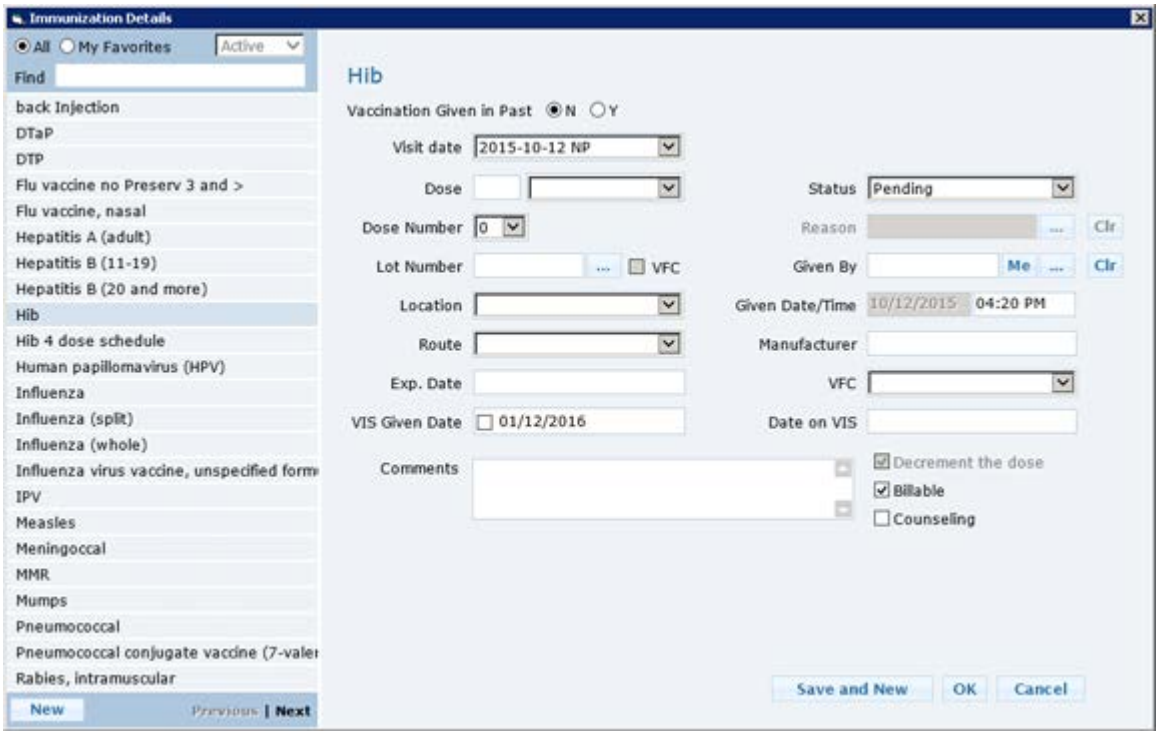
2. Click *Add*.

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.

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



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

Immunizations CVX Mapping

To map the immunization CVX codes:

1. From the *EMR* menu, mouse over *Immunizations/Therapeutic Injections* to open a drop-down list, then click *Immunizations/Therapeutic Injections*.

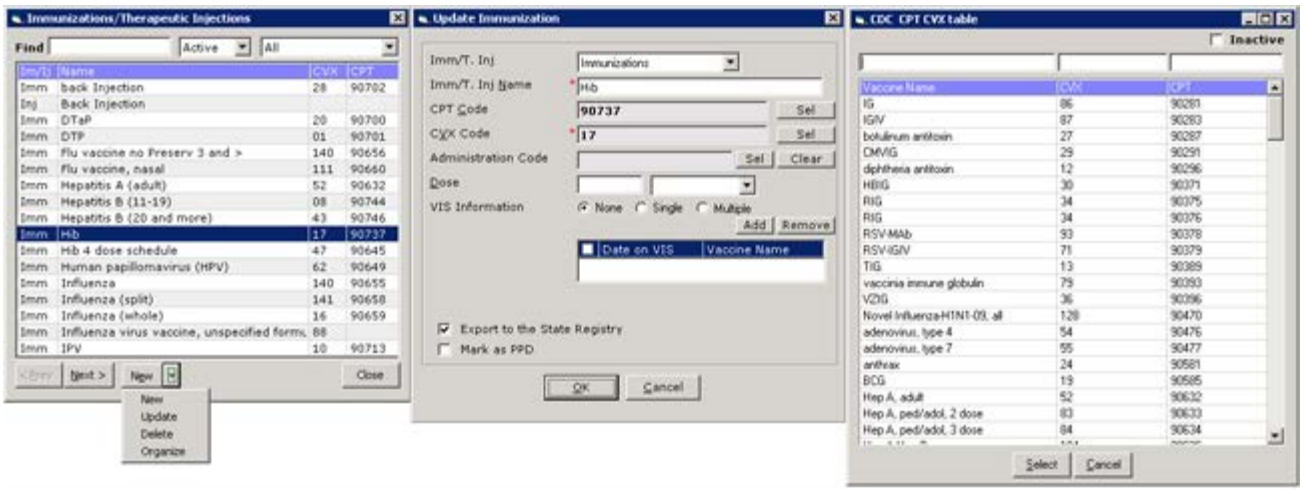
   The Immunizations/Therapeutic Injections window opens.
2. Click an immunization from the list.
3. Click the green arrow icon next to the New button to open a drop-down list, then click *Update*.

   The Update Immunization window opens.
4. Click *Sel* next to the CVX Code field.

   The CDC CPT CVX Table window opens.
5. Click a CVX code and click *Select*.

   The CDC CPT CVX Table window closes.

6. Click *OK* on the Update Immunization window:

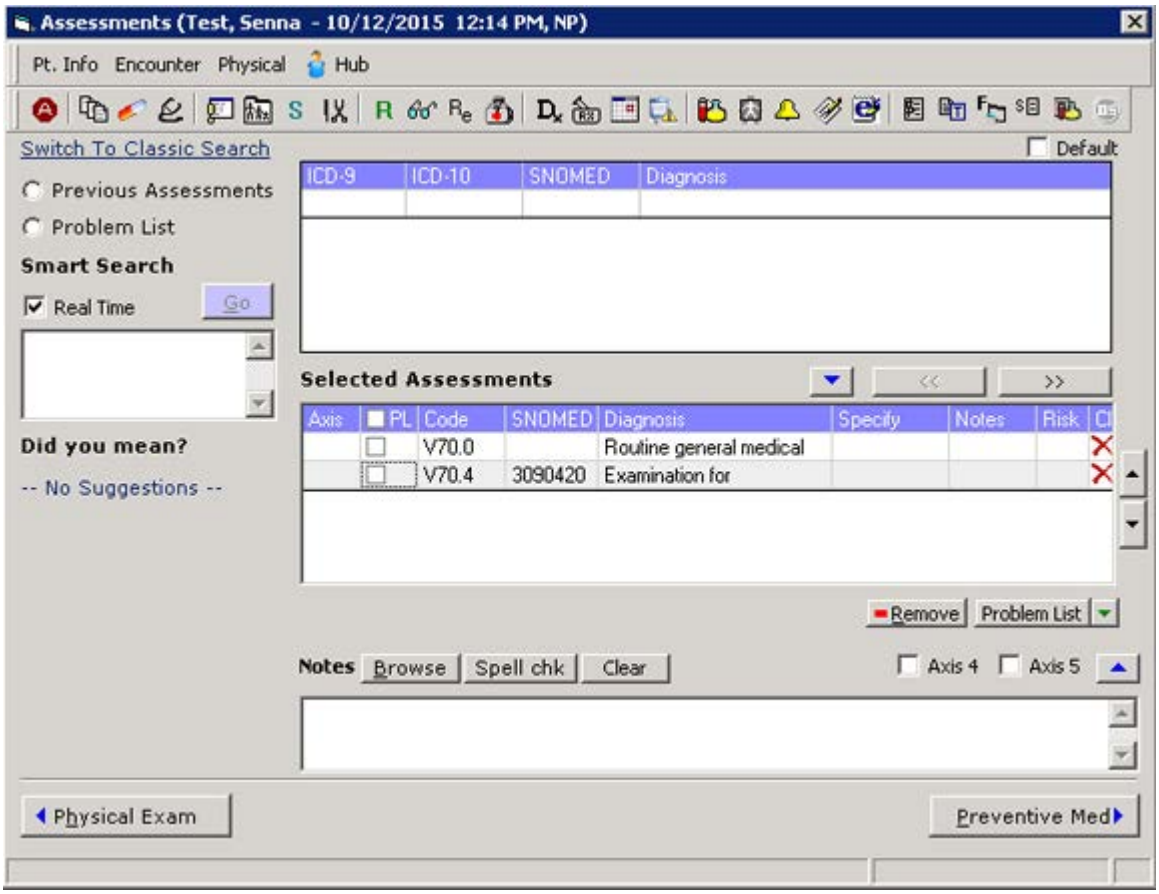


Assessments - Encounter Diagnosis and Problems

To document the assessments for a patient:

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

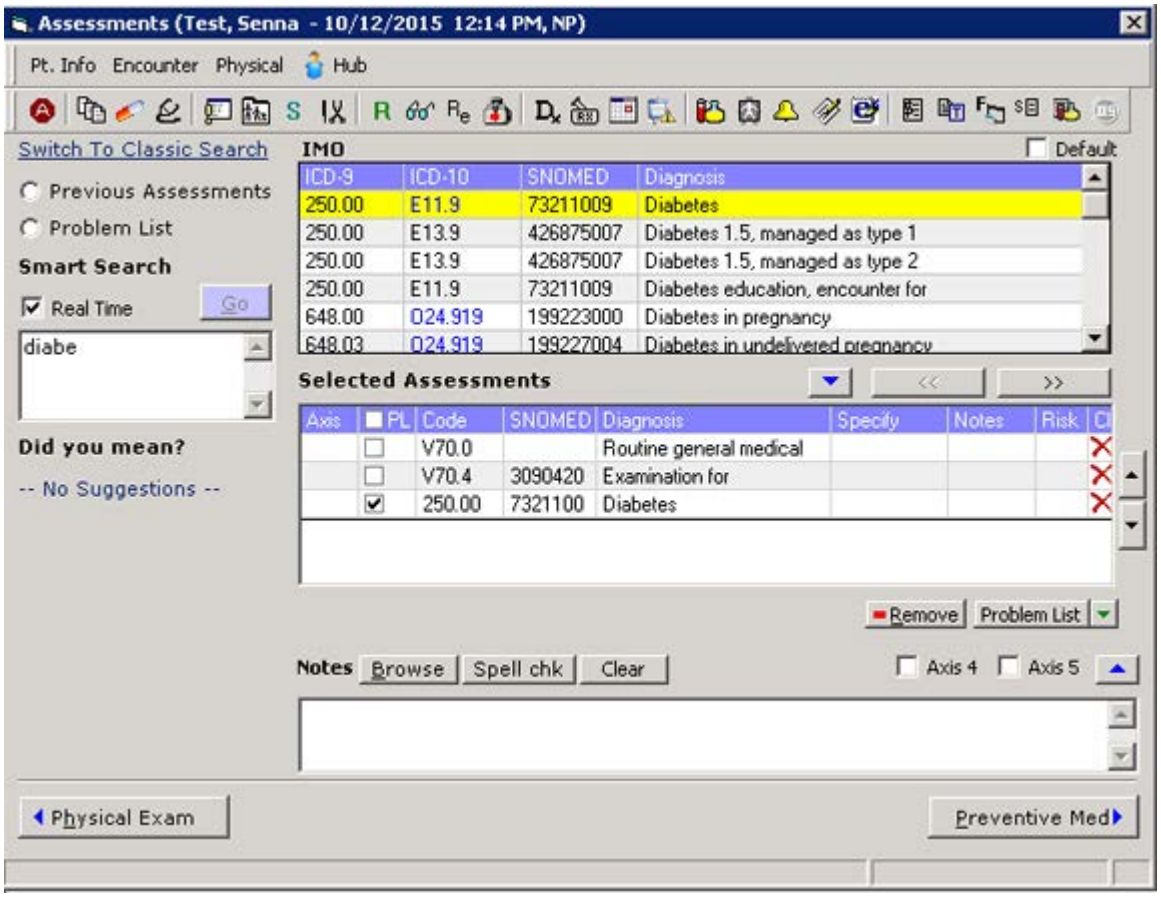
   The Assessments window opens:



2. 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:



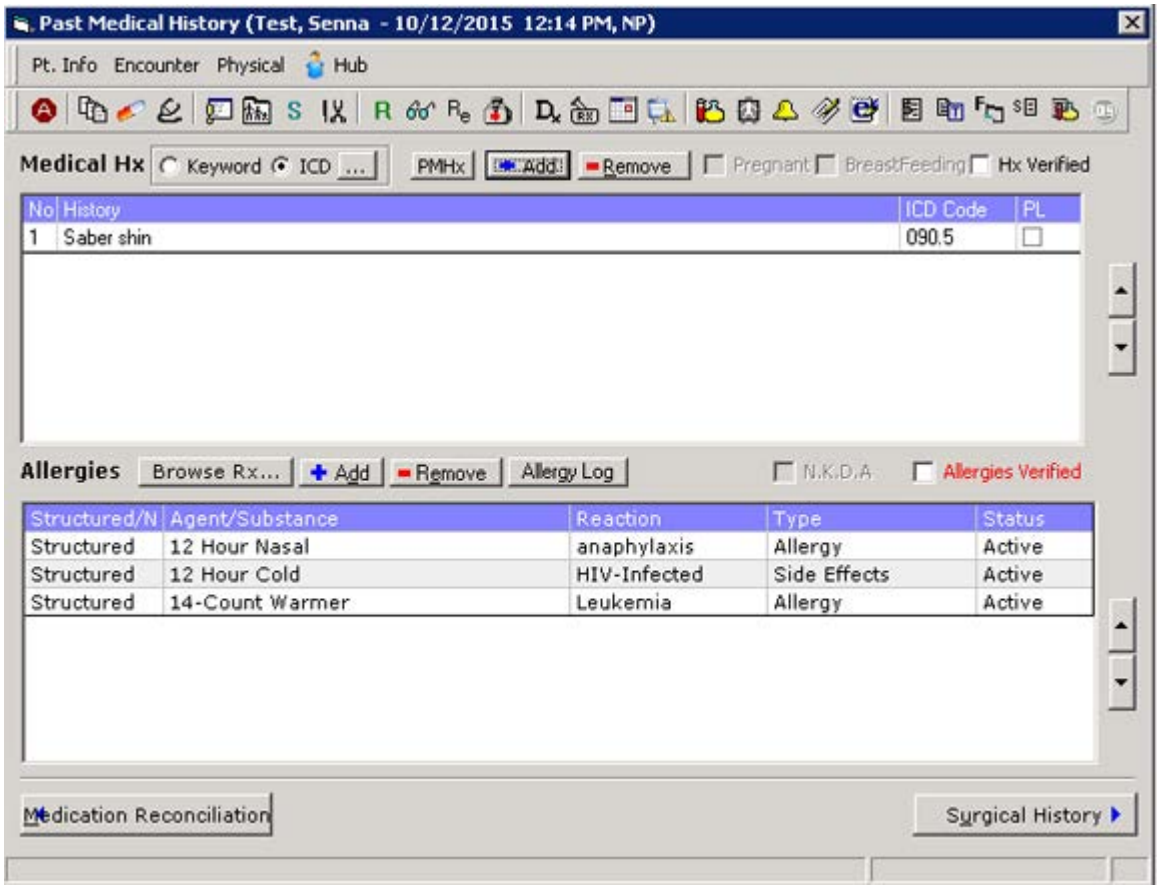
Note: Data entered in the Assessments or Problem List sections from a Telephone Encounter via the Patient Hub or *T* jelly bean is also included in the CCDA.

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:



2. Click the *Browse Rx*.

   The Find Rx window opens.

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

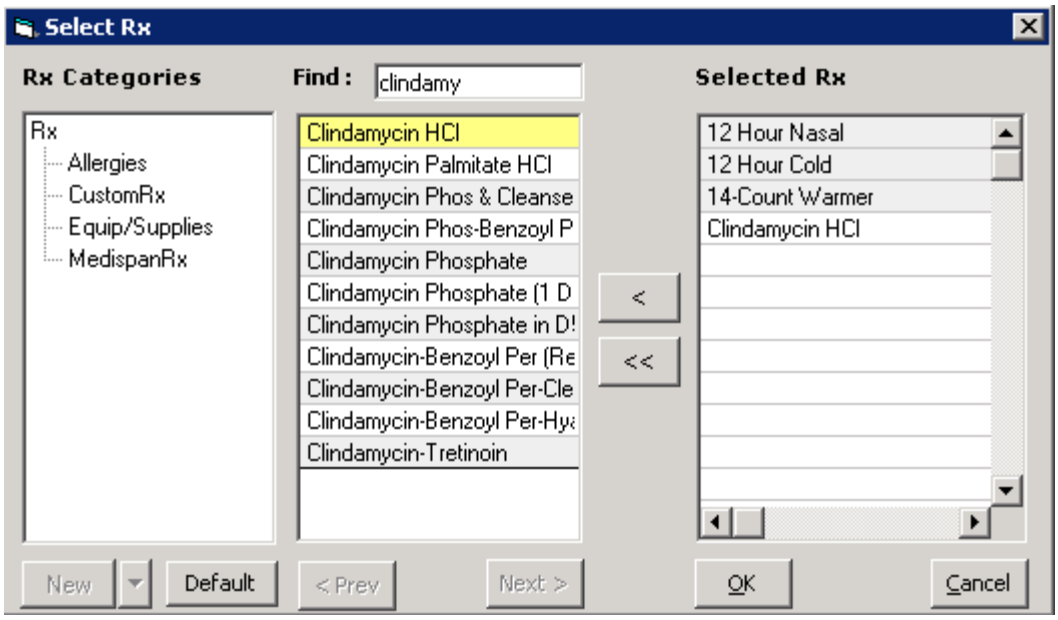
4. Type the name of a medication into the *Find* field.

   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.

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



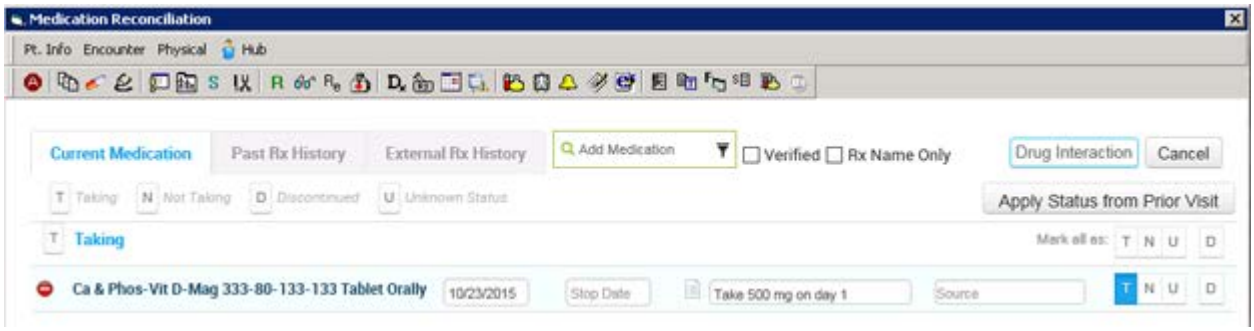
Note: Data entered in the Allergies/Intolerance section from a Telephone Encounter via the Patient Hub or *T* jelly bean is also included in the CCDA.

Current Medication

To document the current medications for a patient:

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

   The Medication Reconciliation window opens:



2. Type the name of a medication in the *Add Medication* field.

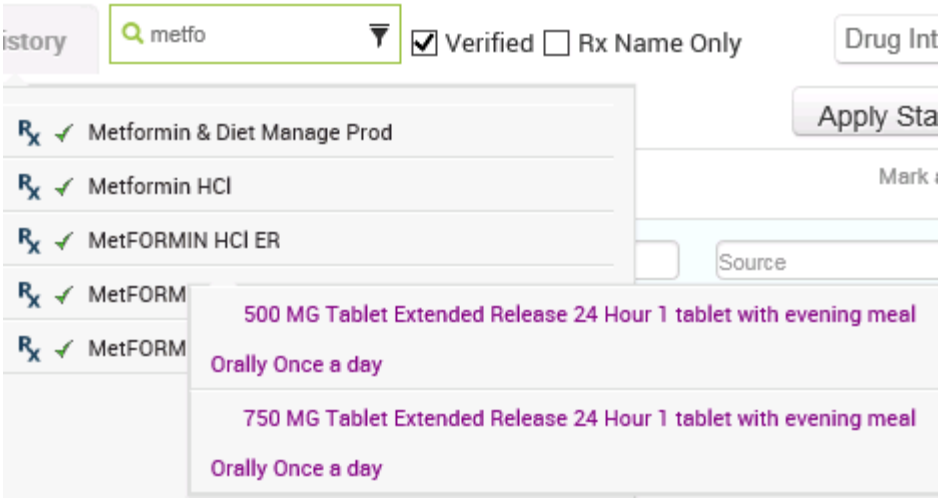
   The medications that match the entered text display in a pop-up pane beneath the Add Medication field in real time.

3. Click a medication from this pop-up pane.

   The available formulations for this medication display in a drop-down list.

4. Select a formulation of this medication from the drop-down list.

5. Check the *Verified* box:



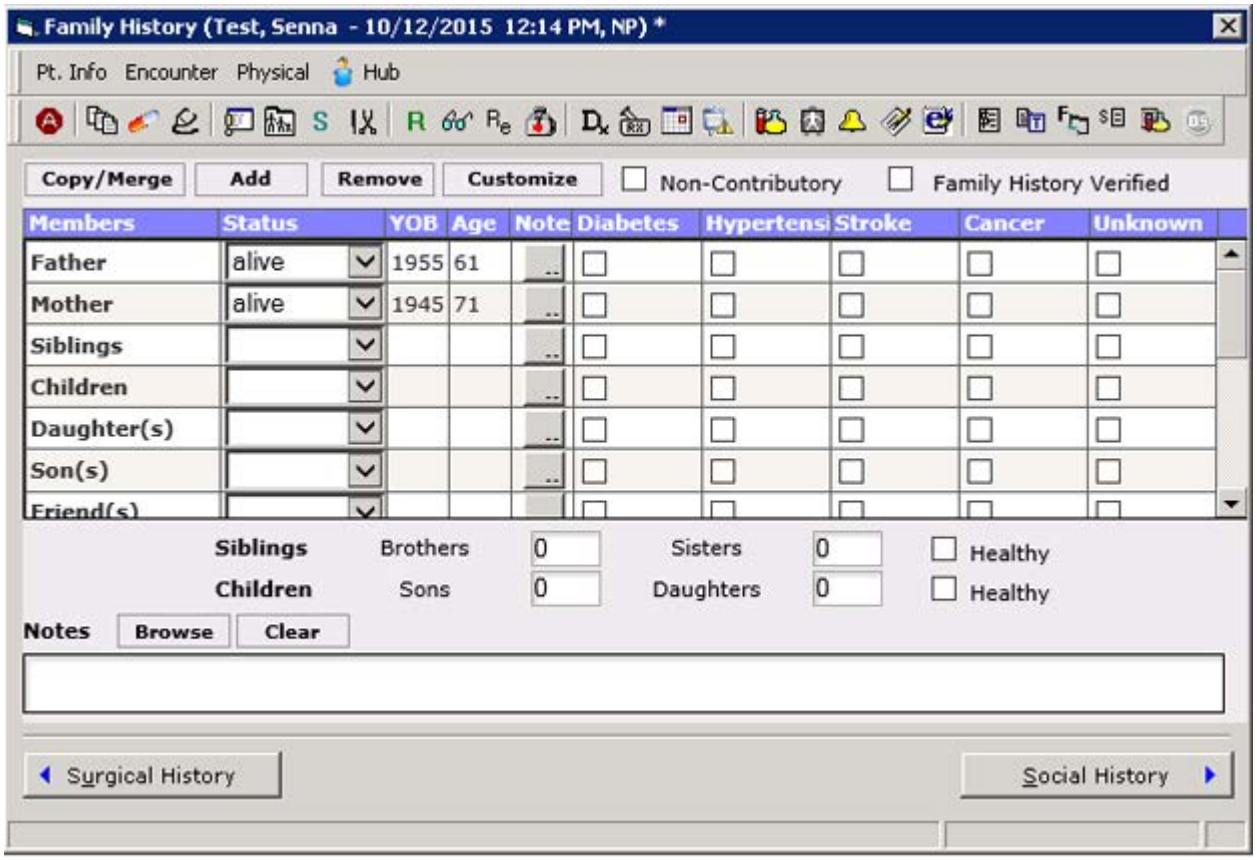
Note: Data entered in the Current Medications section from a Telephone Encounter via the Patient Hub or *T* jelly bean is also included in the CCDA.

Family History

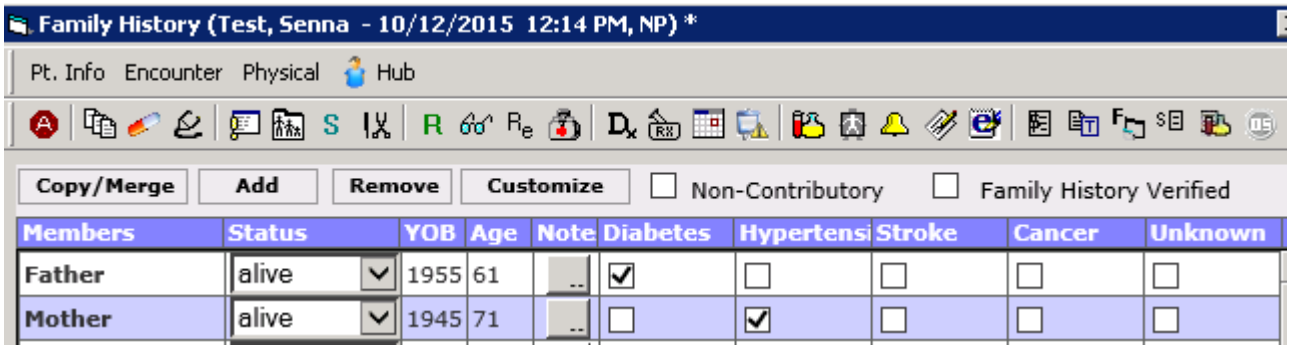
To document the family history for a patient:

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

   The Family History window opens:



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):



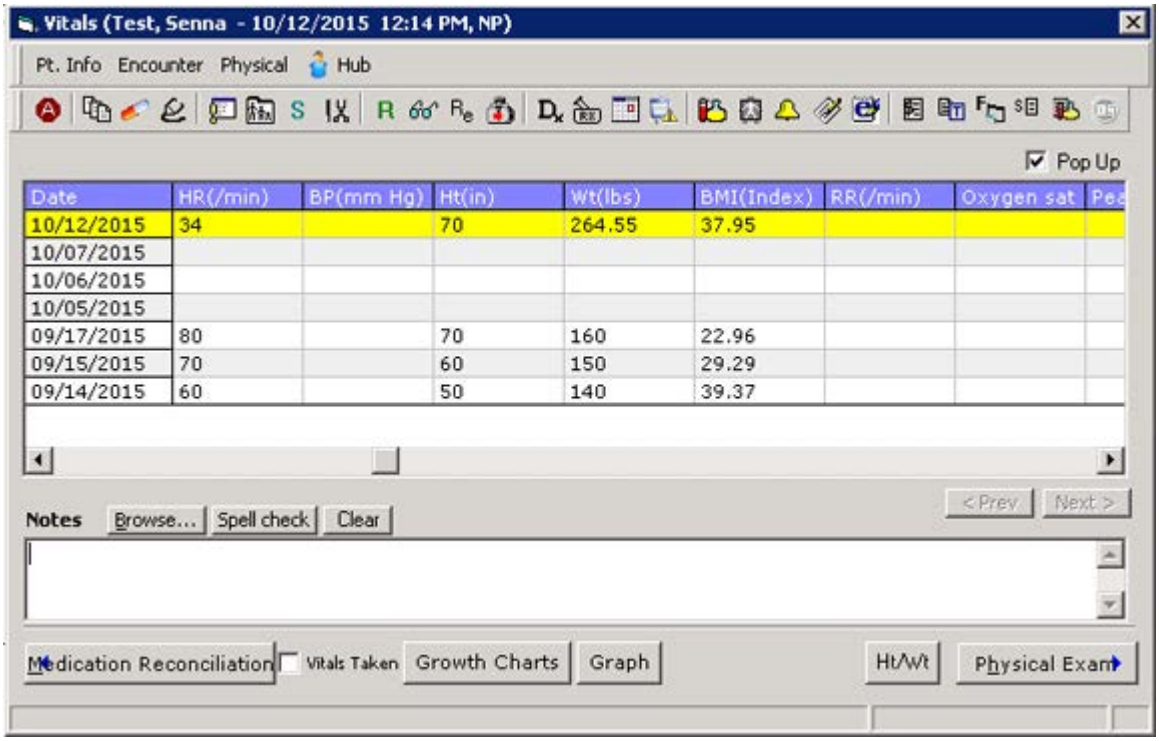
Note: Data entered in the Family History section from a Telephone Encounter via the Patient Hub or *T* jelly bean is also included in the CCDA.

Vitals

To document the vitals for a patient:

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

   The Vitals window opens:



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	Pea
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 *T* jelly bean is also included in the CCDA.

Configure Vitals Mapping

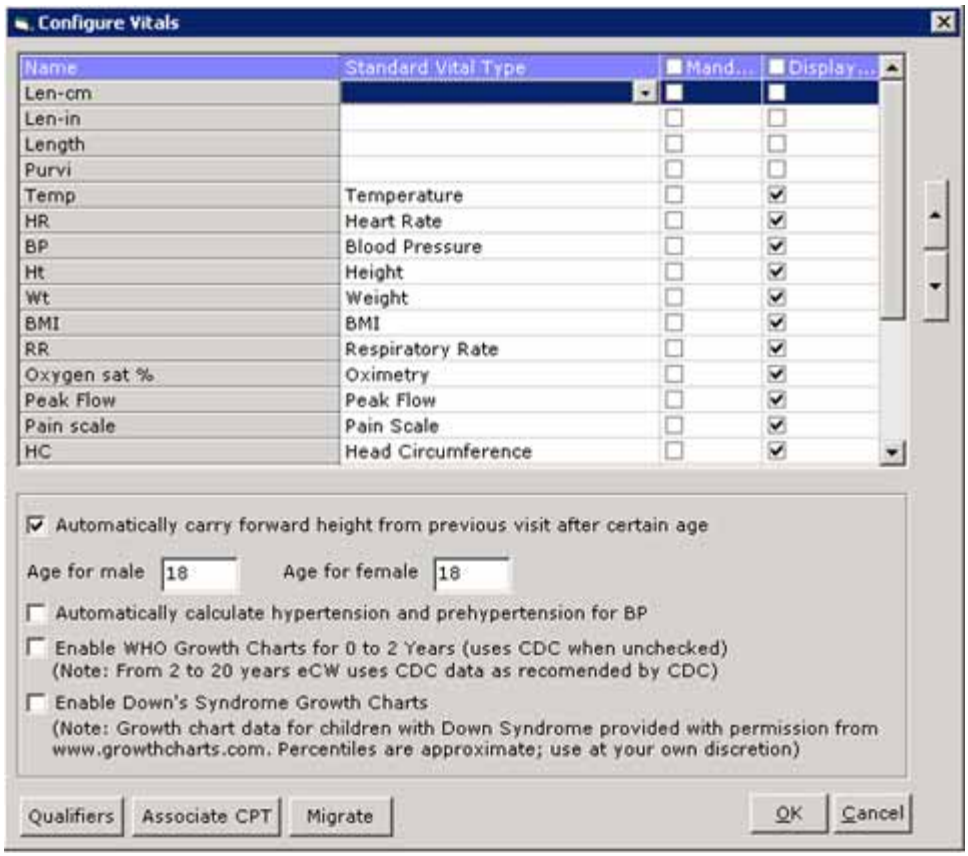
To configure vitals mapping:

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*:

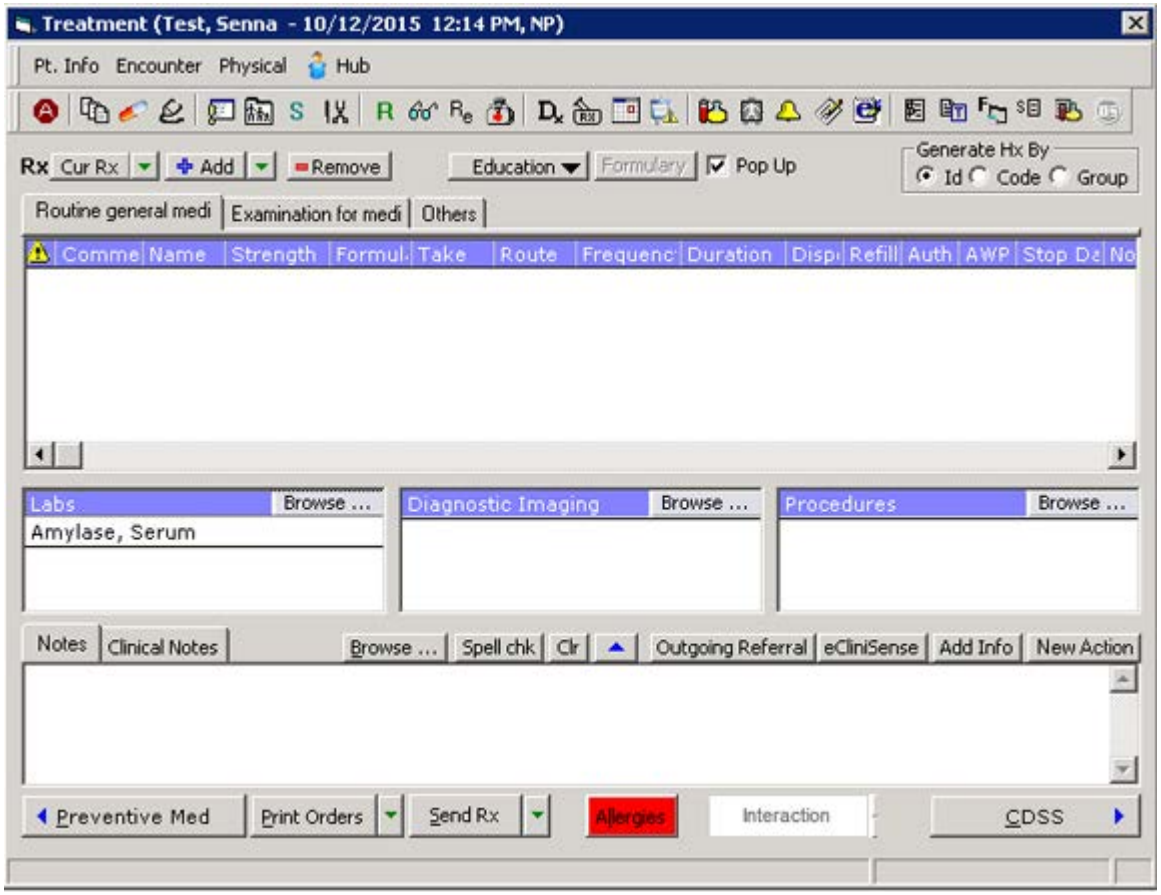

Configure Vitals
Name
Standard Vital Type
Mand...
Display...
Len-cm
Len-in
Length
Purvi
Temp
Temperature
HR
Heart Rate
BP
Blood Pressure
Ht
Height
Wt
Weight
BMI
BMI
RR
Respiratory Rate
Oxygen sat %
Oximetry
Peak Flow
Peak Flow
Pain scale
Pain Scale
HC
Head Circumference
Automatically carry forward height from previous visit after certain age
Age for male 18
Age for female 18
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 recomended 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:



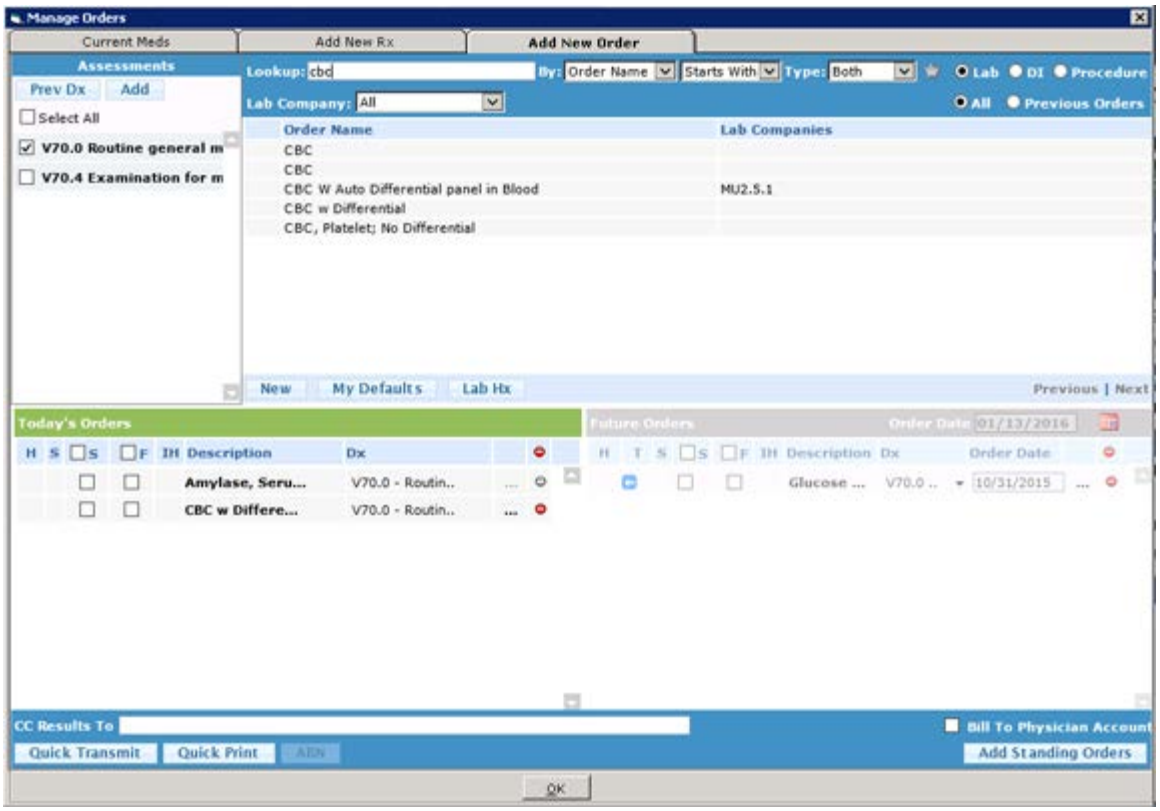
2. Click *Browse* in the Labs section.

   The Manage Orders window opens.

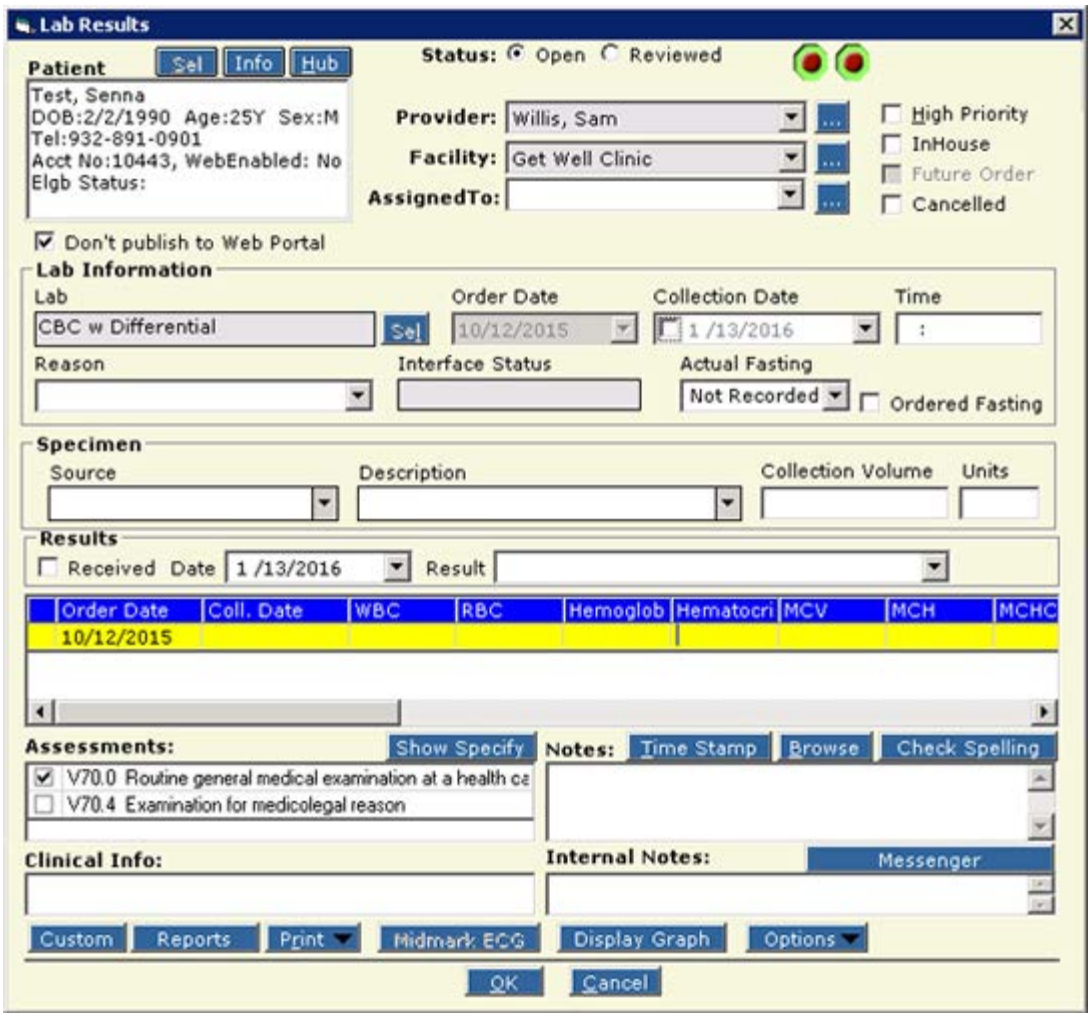
3. Enter the name of a lab in the Lookup field.

   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:

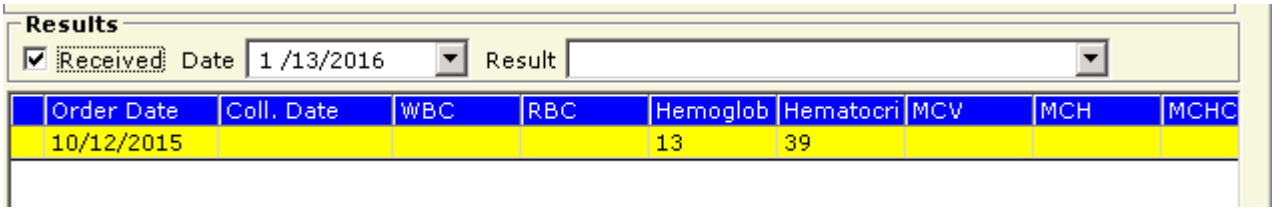


The Lab Results window opens:



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:

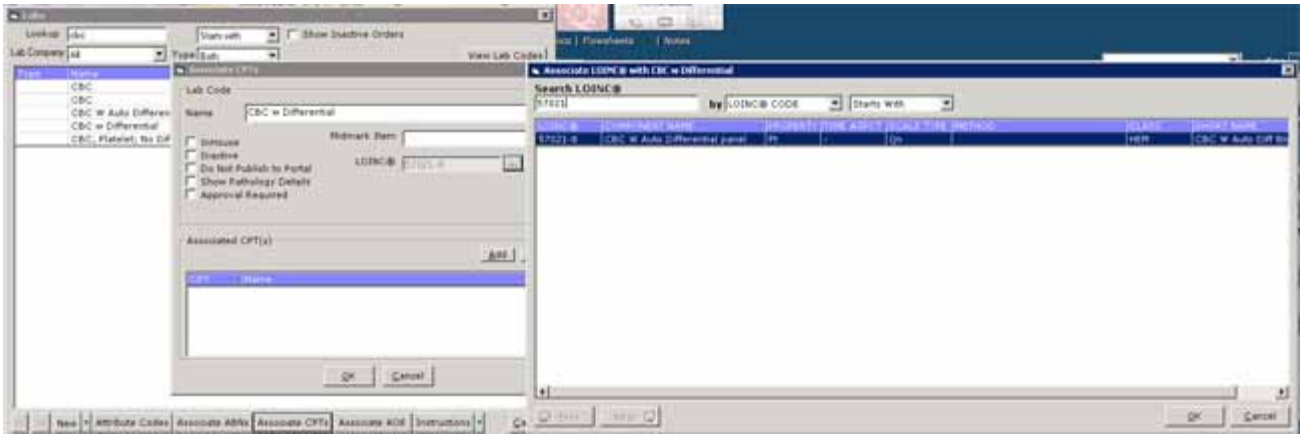
1. From the *EMR* menu, mouse over *Labs, DI & Procedures* to open a drop-down list, then click *Labs*.

   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*:

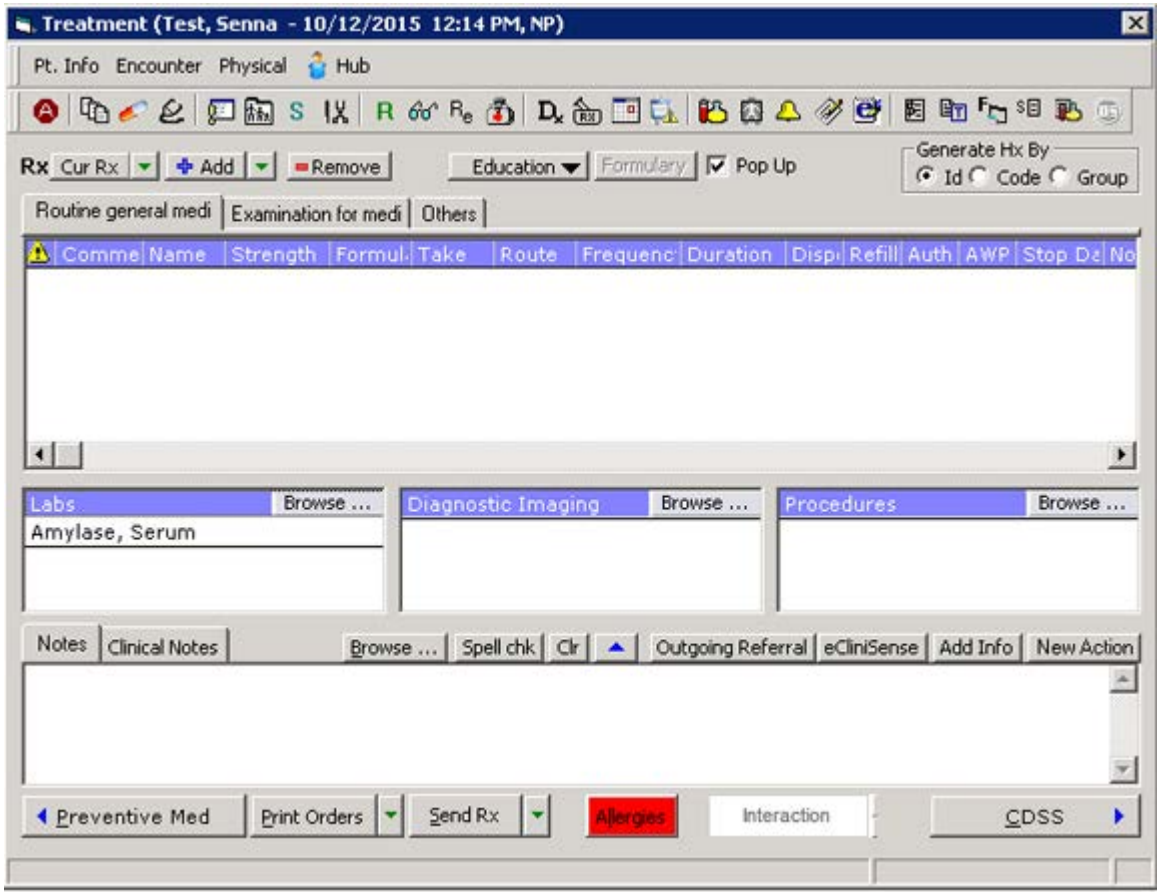


Treatment - Outgoing Referral

To document ordering an outgoing referral for a patient:

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

   The Treatment window opens:



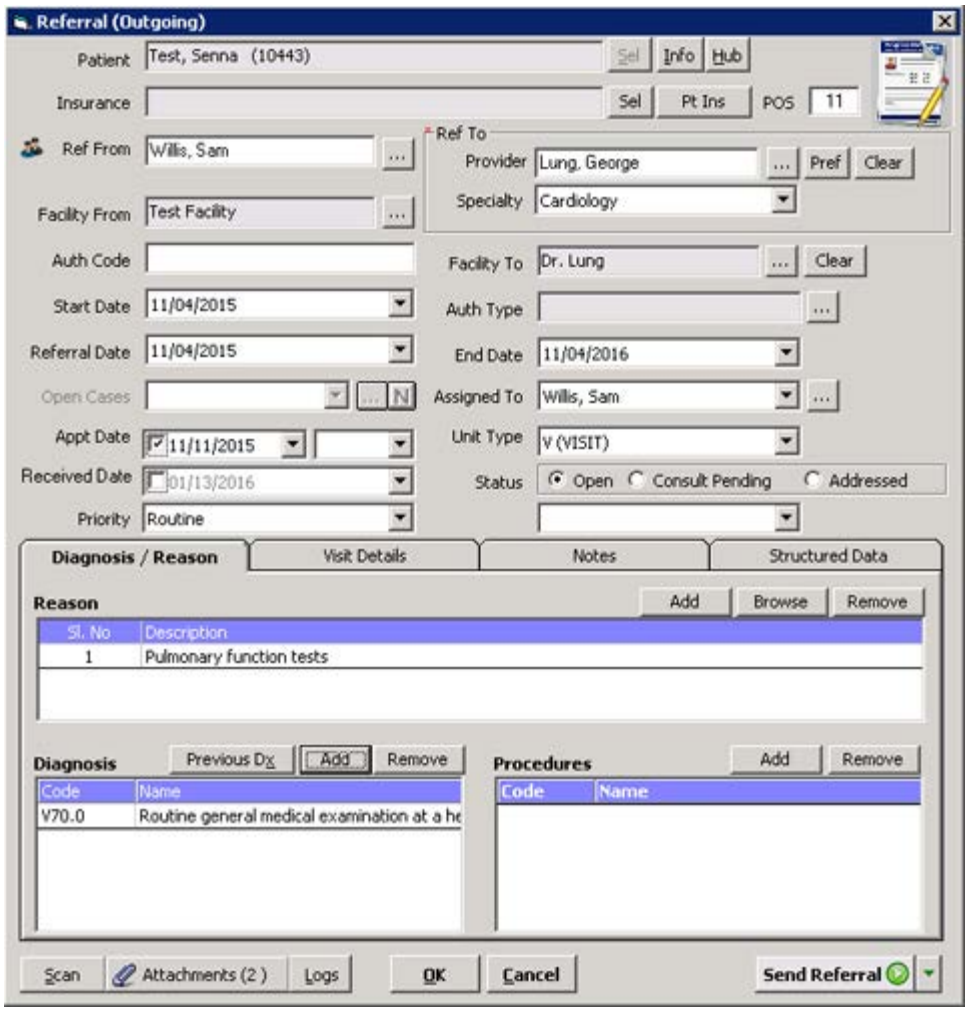
2. Click *Outgoing Referral*.

   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:



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.

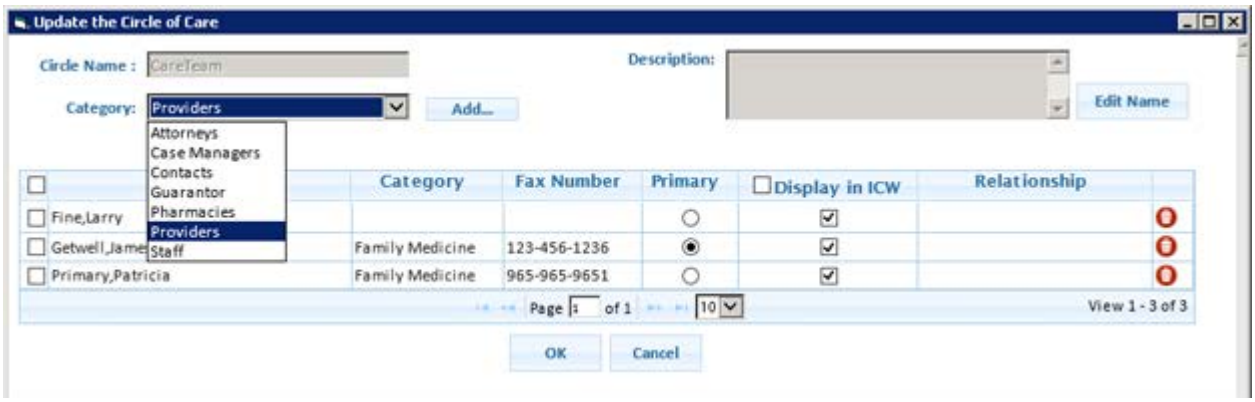
2. Click the *Circle of Care* tab at the bottom of the window.

The Circle of Care options display:

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

   The Circle of Care window opens.

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



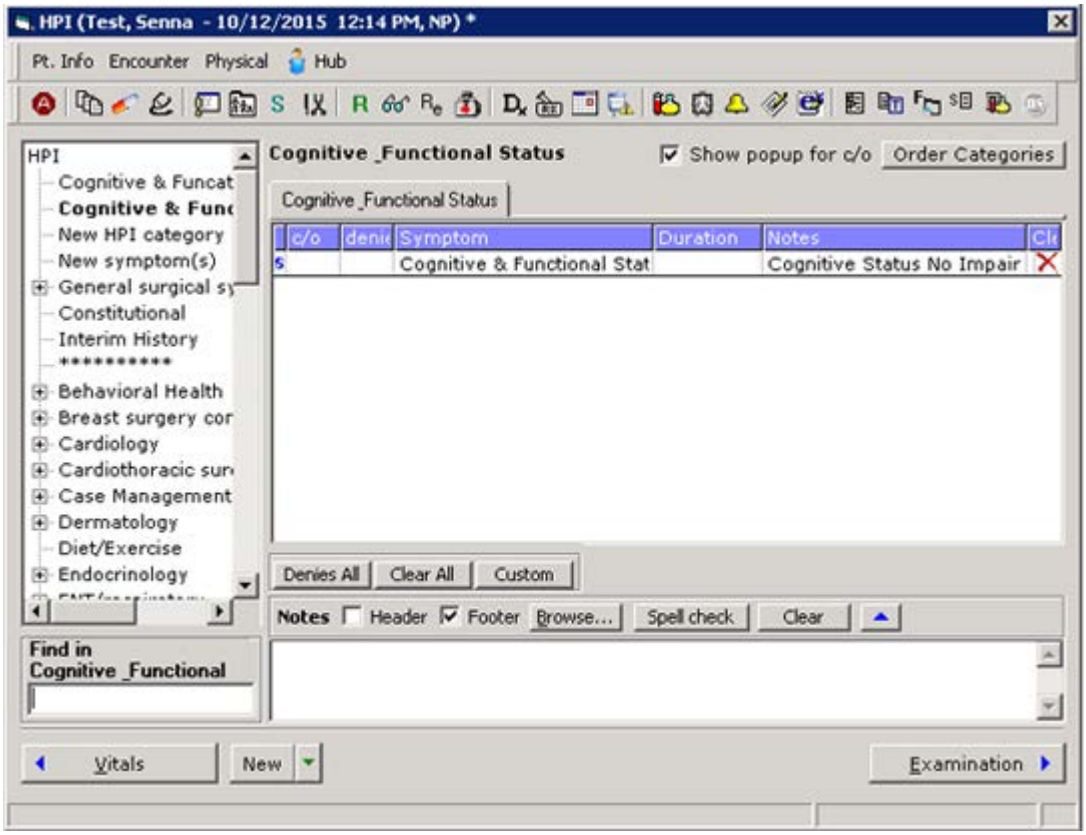
Note: Data entered into the Circle of Care section in the right chart panel (ICW) on the Patient Hub or in the Progress Notes is also be included in the CCDA.

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:



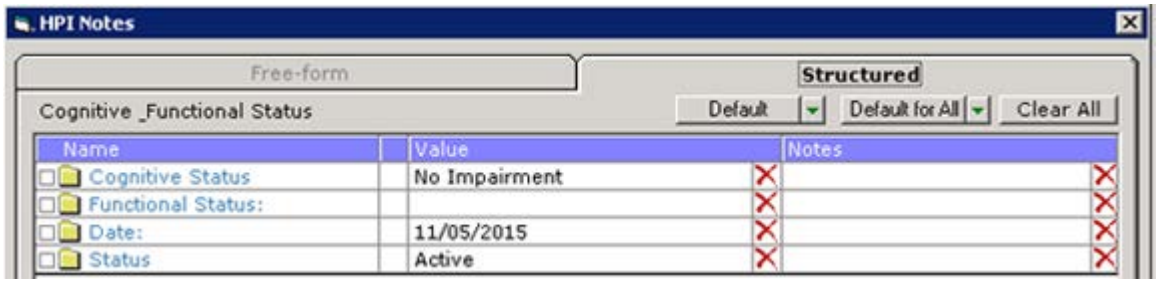
2. Click the *Cognitive & Functional Status* option in the left pane.

   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 *T* jelly 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*.

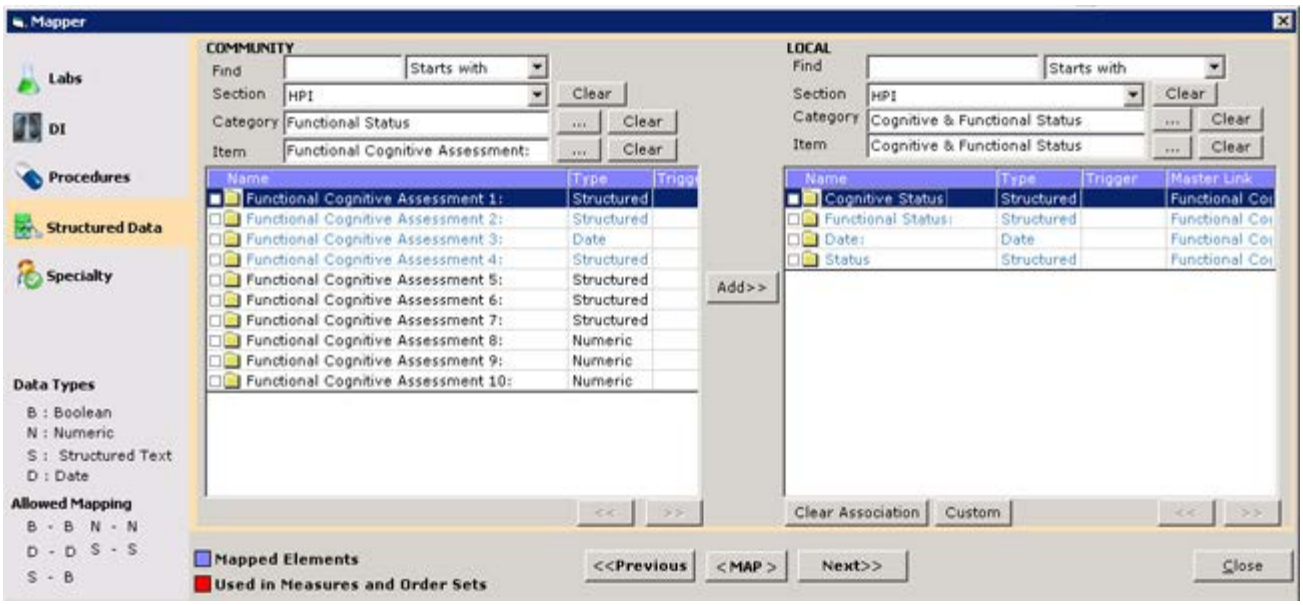
   b. From the *Category* drop-down list, select *Cognitive & Functional Status*.

   c. From the *Item* drop-down list, select *Cognitive & Functional Status*.

5. Click *Functional Cognitive Assessment 1* in the left Community pane.

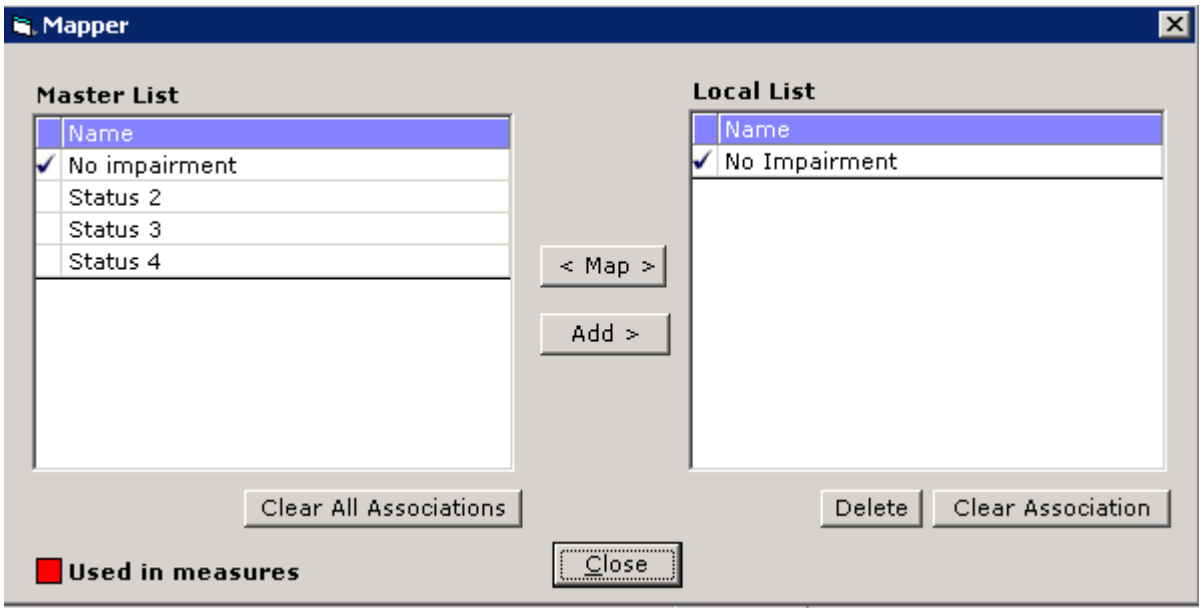
6. Click *Cognitive Status* in the right Local pane.

7. Click < *Map* >:



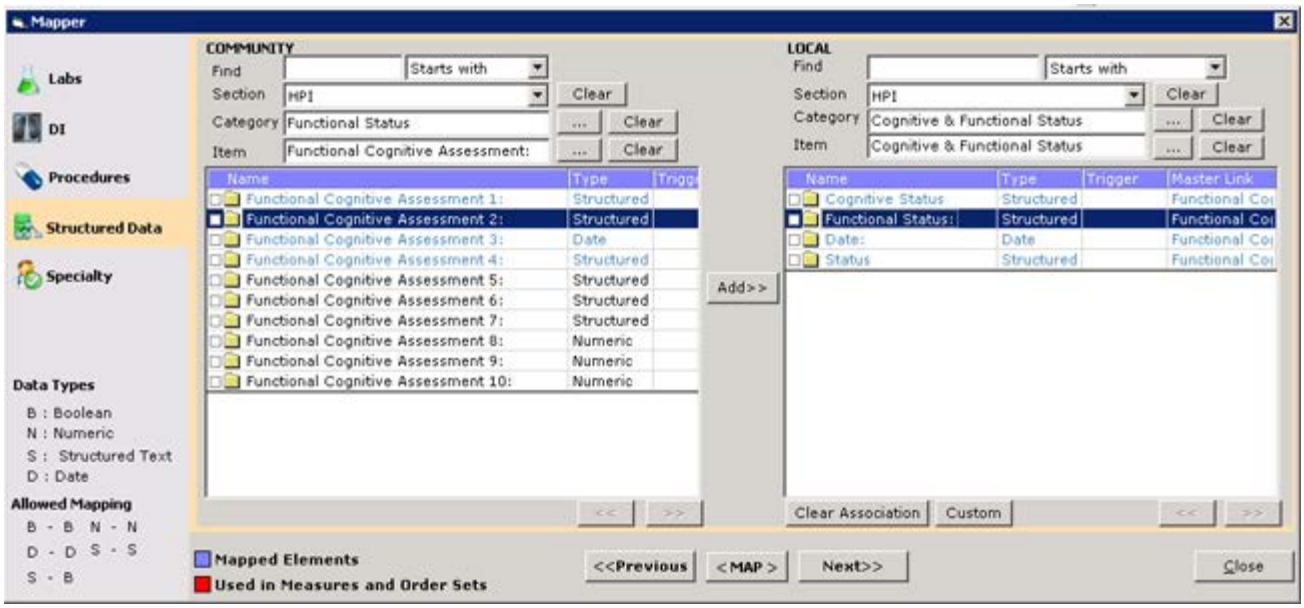
A second Mapper window opens.

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



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.

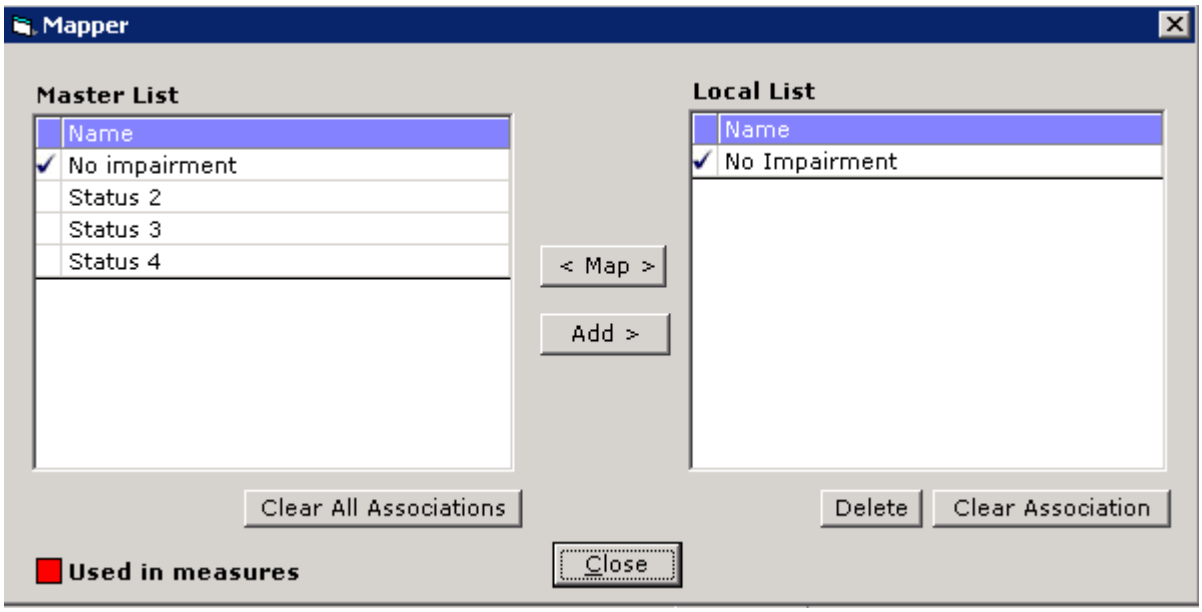
13. Click < *Map* >:



A second Mapper window opens.

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

15. Click < *Map* >:

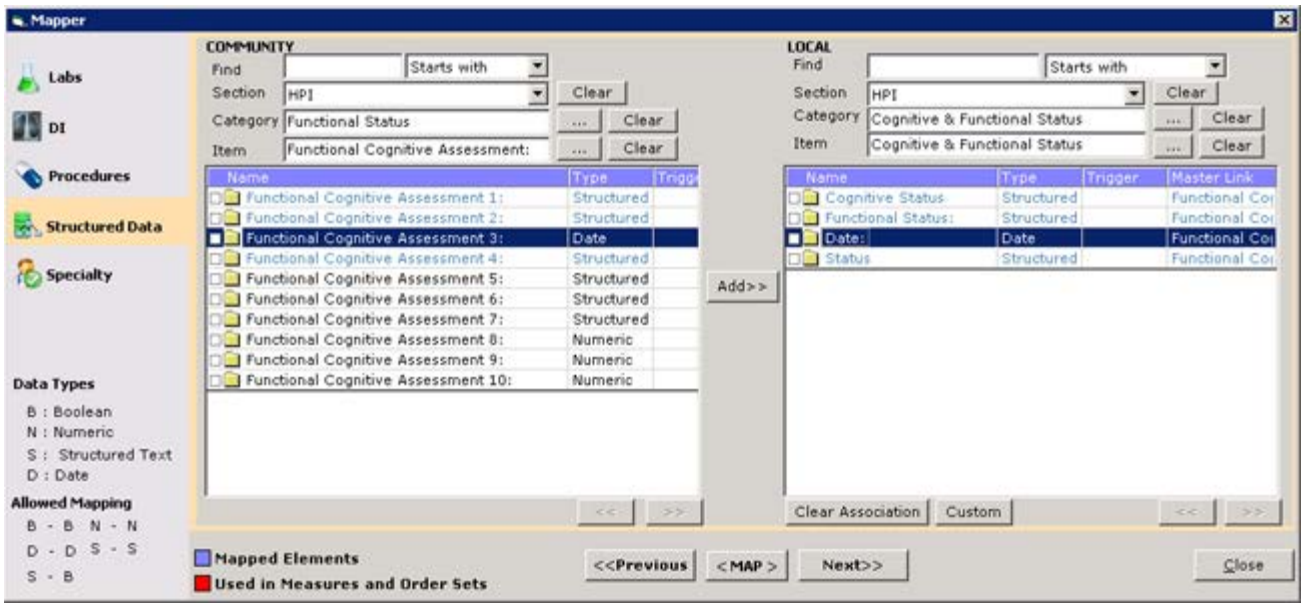


16. Close the second Mapper window.

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

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

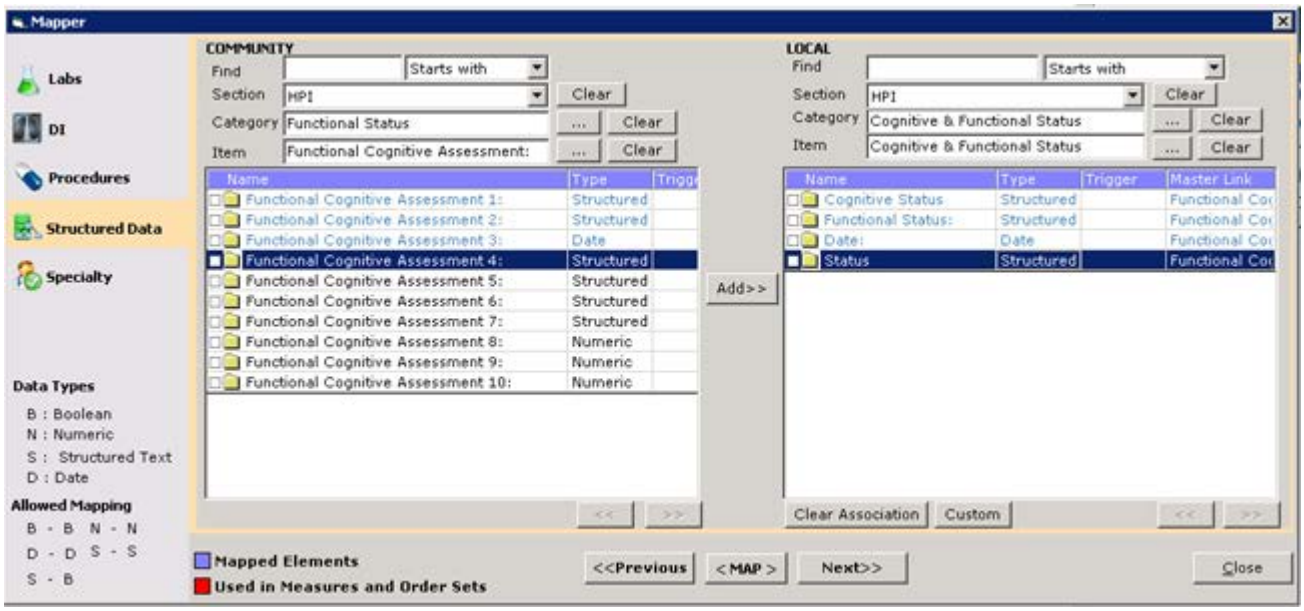
19. Click < *Map* >:



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

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

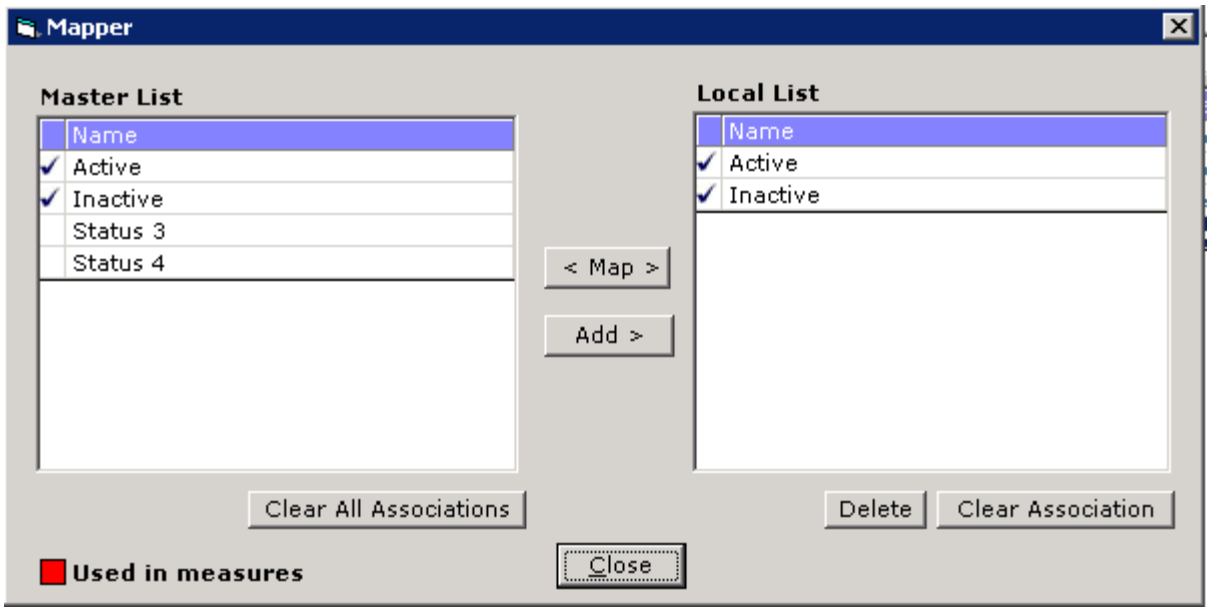
22. Click < *Map* >:



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

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