



RESOURCE AND PATIENT MANAGEMENT SYSTEM

Consolidated Clinical Data Architecture

(BCCD)

Addendum to User Manual

Version 1.0 Patch 1
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Preface

This document outlines changes associated with Consolidated Clinical Data Architecture (CCDA) BCCD v1.0, p1. It is submitted as a supplement to the CCDA BCCD v1.0 package. The specifications within this document serve as a guide for staff who produce Consolidated Clinical Document (CCD) documents and extracts on selected patients and patient visit. The scope of this document is limited to CCDA BCCD v1.0 p1 and assumes that the site has already loaded patches up through EHR p13.

Please review these changes and add a copy of them to any printed documentation your site may be using for CCDA BCCD v1.0. The changes cited within this document will be integrated into future versions of the software and manuals and will no longer be considered an addendum at the time of the next release.

1.0 Introduction

1.1 Summary of Changes

1.1.1 Patch # 1

BCCD v1.0 p1 delivers the following CCD generation updates:

- Modified extraction criteria for display of Referrals on the CCD (RQMT_141).
- Modified extraction criteria for display of Lab/Panel Tests on the CCD (RQMT_142).

The modifications above pertain to CCDA background processing and have no impact on current Electronic Health Record (EHR) end-user functionality. These modifications are specific to CCDs that are generated (by the user) from within the EHR CCD documents sent to the Health Information Exchange are impacted by the change is the list criteria for referrals.

2.0 Patch #1 Changes

2.1 CCD Generation in EHR

The CCD data extraction process is a component of CCDA generation that pulls relevant RPMS data (from BMW Classes) when a user submits a CCD document request from within an EHR session. EHR contains end-user controls and navigation allowing authorized users to view/customize/print the CCD document (containing pertinent clinical, demographic, and administrative data for a specific patient covering one or more healthcare encounters).

As part of a separate function (outside of EHR), end-users can generate a data portability extract which contains CCD data in structured extensible markup language (XML) form when viewed using a published style-sheet.

2.2 Reduce Number of CCD Pages

In BCCD v1.0, users requested to reduce the number of pages on the generated CCD to improve the readability and usability of CCD content. From these requests, subject matter experts determined that particular listings of data in CCD subsections could be shorted by modifying BCCD extract logic. Among other measures to reduce the number of CCD pages, the team determined the two functional modifications that comprise this patch:

- Reduce the listing of referrals to other providers contained in the “Plan of Care” subsection by altering the current CCD extract logic which pulls referral data from BMW Classes.
- Reduce the listing of lab and panel tests in the “Recent Lab Tests” subsection by altering the current extract logic which pulls lab/panel data from BMW Classes.

2.3 Modified criteria for display of Referrals

As part of current functionality (BCCD v1.0), the CCD generation extracts all referrals to other providers (“referrals”) associated with a patient visit without consideration the past Referral Date. The generated CCD lists qualifying instances pulled from the RPMS referral files (RCIS REFERRALS, V REFERRAL) which are displayed under the “Reason to other Providers” heading within the Plan of Care section.

Patch 1 modifications to the data extract component of CCD generation limit the selection criteria for referrals. As a result of this change, the CCD document will only display qualifying referrals dated one year from the current date (where a date exists for either the expected appointment or the actual appointment). This modification applies to both visit settings (ambulatory and inpatient) and impacts display of referral data on the Transition of Care and Clinical Summary documents, and Data Portability extract. This change also impacts CCD documents that are sent to the HIE.

The content, form and nomenclature of referral instances appearing under “Referrals to other Providers” within the Plan of Care section of the CCDA will remain unchanged.

2.4 Modified criteria for display of Lab Tests/Panels with results

Patch 1 modifications to the data extract component of CCD generation limit the selection criteria for lab tests as described below. The generated CCD will continue to list all qualifying instances with a lab result pulled from the RPMS data files (V LAB) for display within the CCDA subsection entitled “Recent Lab Tests.” The CCD document will display qualifying lab tests as follows:

- **Clinical Summary document.** Display only those labs resulted in the past 15 days (based on the “Specimen Collection Date”) from the date of the clinical summary. The document will exclude all labs resulted during an inpatient stay.
- **Transition of Care document & Data Portability extract:**
 - **Ambulatory Visits.** Will only display the last two results for each test and panel in the past 30 days (based on the “Specimen Collection Date”).
 - **Inpatient Visits.** Will only display the initial test and panel at admission and the most recent lab test and panel (if they are the same, then extract and display once).

The content, form and nomenclature of lab test/panel instances appearing under the “Recent Lab Tests” section of the CCDA remain unchanged.

Glossary

BMW Classes

A set of relational data stores that contain source clinical, demographic, and administrative data for a specific patient covering one or more healthcare encounters.

Continuity of Care Document

Represents an artifact that takes the form of a document (in the case of a Clinical Summary or Transition of Care), or a data extract (Data Portability Export). The CCD contains clinical, demographic, and administrative data for a patient as specified by the CDA standard. The CCD consists of XML intended to specify the encoding, structure, and semantics of a patient summary clinical document for exchange (See CCDA).

Consolidated Clinical Document Architecture

Describes the HL7 Clinical Document Architecture (CDA) standard, specifically relating to the CCD specification. The CDA specifies that the content of the document consists of a mandatory textual part (which ensures human interpretation of the document contents) and optional structured parts (for software processing). CCDs will contain pertinent clinical, demographic, and administrative data for a specific patient covering one or more healthcare encounters. It also provides a means for one healthcare practitioner, system, or setting to aggregate all of the pertinent data about a patient and forward it to another practitioner, system, or setting to support the continuity of care.

Acronym List

Acronym	Meaning
BCCD	RPMS namespace associated with CCDA in EHR
CCD	Consolidated Clinical Document
CCDA	Consolidated Clinical Data Architecture
CDA	Clinical Document Architecture
EHR	Electronic Health Record
IHS	Indian Health Service
RPMS	Resource and Patient Management System
XML	Extensible Markup Language

Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

Phone: (888) 830-7280 (toll free)

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