RESOURCE AND PATIENT MANAGEMENT SYSTEM

Consolidated Clinical Data Architecture

(BCCD)

Addendum to User Manual

Version 1.0 Patch 8
April 2019

Office of Information Technology
Division of Information Resource Management
Albuquerque, New Mexico
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Preface

This document outlines changes associated with Consolidated Clinical Data Architecture (CCDA) BCCD v1.0, patch 8. 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 Continuity of Care Documents (CCD) and extracts on selected patients and patient visits. The scope of this document is limited to CCDA BCCD v1.0 p8 and assumes that the site has already loaded Electronic Health Record (EHR) patches through EHR v1.1 p24.

Please review these changes and add a copy of them to any printed documentation your site may be using for CCDA BCCD v1.0.
1.0 Introduction

BCCD v1.0 p8 delivers the following updates:

- The Care Team logic is updated to allow a provider to display as both the discharge planner and the case manager. (Change request [CR] 05254)

- If a patient is merged between the time a document is requested and the time it is generated, the document will not be generated. (CR 05270)

- Spaces in medication status codes have been replaced with underscores. (CR 05971)

- Previously, if the extract encountered an error, the application would not switch from processing Health Information Exchange (HIE) uploads if a new request was received from EHR. This behavior has been fixed, so requests from EHR are given priority over HIE uploads. (CR 06927)

- An option to display a CCDA application status report has been added. (CR 07585)

- The CCDA purge process was not deleting some child objects. The purge has been corrected. The patch post-install process will delete the previously undeleted objects. (CR 08765)

- A setting is added to the Edit CCDA Clinical Site Parameters to enable displaying the smoking status last documented date. The label for the date is updated for clarity. (CR 08771)

- Transitions of Care and Data Portability documents now include discharge instructions for notes in which the name contains “Discharge Instructions.” (CR 08827)

- Discharge instructions have been added to documents for observation (“O”) and day-surgery (“S”) visits. (CR 08828)

- Historical medications have been added to the document to assist in identifying medications that have been used to treat chronic conditions. (CR 08849)

- Smoking status “HF F006” has been added to the narrative as SNOMED 228524006 (“Exposed to tobacco smoke at home”). (CR 08896)

- Previously, requesting a data portability document for a patient who has no provider visit and for whom the most recent visit was deleted caused an error. This defect has been corrected. (CR 08927)

- Allergies that did not have an allergy code were erroneously omitted from the coded data. This issue has been corrected. (CR 08990)
• The encounter ID element contained the facility ID. The values have been corrected, so the encounter ID element contains the visit ID, and the encounter location element contains the facility ID. (CR 09845)

• The code for the Ojibwe language has been corrected from “obi” to “oji” in the stylesheet. (CR 09846)

• Previously, if the visit location name was not extracted, the application would generate an <INVALID OREF> error. This has been corrected. (CR 10033)

• The extract for visit information has been modified so that it no longer uses an index that is not populated for merged or deleted visits. (CR 10034)

• Changes in Ensemble caused the application to encounter errors in Ensemble versions beyond 2012.2. The code has been modified to work in newer versions of Ensemble. (CR 10370)
2.0 User Manual (UM) Updates

2.1 UM Section 1.2: Hospital Discharge Instructions
Hospital discharge instructions now display for observation ("O") and day surgery ("S") visits, in addition to inpatient visits.

2.2 UM Section 2.1: CCDA Menu Options
The CCDA menu now includes the following options:
- Edit CCDA Site Parameters [BCCD EDIT SITE PARAMETERS]
- Edit CCDA Clinical Site Parameters [BCCD EDIT CLINICAL PARAMETERS]
- Generate CCD for a single patient [BCCD GEN ONE]
- Generate CCD documents for all patients in RPMS [BCCD GEN ALL]
- Generate CCDA documents for a specified date range [BCCD GEN CCD DATE RANGE]
- Manage CCDA transmissions [BCCD MGR]
- View and Purge Error Documents [BCCD ERROR PURGE]
- Display the CCDA application status report [BCCD APP STATUS]

2.3 UM Section 3.1: Edit CCDA Clinical Site Parameters
The Edit CCDA Clinical Site Parameters option now contains a fourth parameter: Display the Last Smoking Status Document Date.

The Display the Last Smoking Status Document Date parameter is set to No by default. If it is set to Yes, the Social History section of the document will display the smoking status last documented date.

2.4 UM Section 3.4: CCDA Application Status Report
Section 3.4 is a new addition to the manual and contains information about the new CCDA application status report option.

The STAT (Display the CCDA Application Status Report) option can be used to display a report summarizing various information about the state of the CCDA application, as well as information about the most recent pull, push, and error messages. The intent of the report is to provide support personnel with a snapshot of the application. It is not intended to be used by site managers, and no information is provided to assist site managers with interpreting the report.
When the user runs the report, it will ask whether to display the report with page breaks. If the user intends to view the report on the screen, it is recommended that the user selects to insert page breaks. If the user is running the report to copy and paste information for the support team, the user may prefer to not use page breaks.

A sample report is shown in Figure 2-1.
Due to different rules surrounding patient DFNs, some sites may want to prevent DFNs from displaying on the report. To suppress DFNs site-wide, go to RPMS programmer mode and run the following command:

```
DO DFNOFF^BCCDSTAT
```

To clear the setting and re-enable DFNs on the report, go to RPMS programmer mode and run the following command:

```
DO DFNCLR^BCCDSTAT
```

2.5 UM Section 6.0: Medications

The Medications section on CCDA documents now includes historical medications from the past five years.
# Acronym List

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Term Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCD</td>
<td>Continuity of Care Documents</td>
</tr>
<tr>
<td>CCDA</td>
<td>Consolidated Clinical Data Architecture</td>
</tr>
<tr>
<td>CR</td>
<td>Change Request</td>
</tr>
<tr>
<td>EHR</td>
<td>Electronic Health Care</td>
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<tr>
<td>HIE</td>
<td>Health Information Exchange</td>
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<td>IHS</td>
<td>Indian Health Service</td>
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<tr>
<td>RPMS</td>
<td>Resource and Patient Management System</td>
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<tr>
<td>SNOMED</td>
<td>Systemized Nomenclature of Medicine Clinical Terms</td>
</tr>
<tr>
<td>UM</td>
<td>User Manuals</td>
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</tbody>
</table>
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)
Web: https://www.ihs.gov/helpdesk/
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