

# Reconcile Incoming Transitions of Care (CDA)

Last Modified on 03/14/2023 12:48 pm EDT



OP sets **all defaults to share all information** Any individual decisions by Practice-users to restrict information sharing (access, use, or exchange) are the responsibility of the Practice in the implementation of its 21st Century Cures Act Information Blocking policies and procedures for its Practice and patients.

Version 21.0

## About

The reconciling of a CDA and management of external documents begins with a Direct Message received in the Unread External tab of the Message Center. Direct Messages may be a CDA, an embedded PDF within a CDA, or a Zip folder that contains many different files. Reconciling CDAs allows users to compare the clinical information in a patient's chart with the information provided in the CDA file. A permission of **Admin\_Data\_Reconciliation** is required to perform the Clinical Data Reconciliation.

There are currently three clinical areas available for incorporation:

- Problems
- Allergies
- Medications

## Direct Message: Zip file

1. Navigate to the Direct Message: **Main Navigation Panel > External > Unread External tab** Messages will not be associated with a patient (non-patient message).
2. Select the message; all files within the Zip folder will be displayed.

#	Date Entered	Date/Time of Message	Spoke With	Sender	Recipient(s)	
1	09/07/2022 04:54 am	09/07/2022 08:56 am		kevin@test.directproject.net	Demo Doctor	

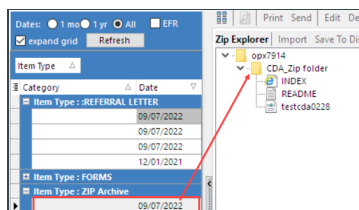
3. Click the **CDA** icon to view the patient's name. The Clinical Document Review and Reconciliation window open.
4. Click **OK** in the Warning message that displays stating that there is no patient associated with the document.
5. Obtain the patient's name from the document and choose one of the workflows listed below.

**Note:** If the patient is new to the Practice, create the patient record before proceeding.

- **Select Patient and Reconcile CDA from the Clinical Document Review and Reconciliation Window.**
    - a. Select the **Patient Search** button and search for and select the patient.
    - b. The CDA options display, proceed to **Reconcile a Referral Transition of Care**
    - c. Once the CDA is reconciled, proceed to step 6.
  - **Select Patient from the message.**
    - a. Close the Clinical Document Review and Reconciliation window.
    - b. From the message, click in the name field, select the **Patient Search** button and search for and select the patient.
    - c. Proceed to step 6.
6. Navigate to **Documents** in the Patient Chart. All files in the Zip folder have been saved as individual documents in the Referral Letter Item Type.
  7. Select each document to Edit or Delete from the Patient record. To reconcile the CDA, proceed to **Reconcile a Referral Transition of Care**.

**Note:** In Document Management an Item Type of ZIP Archive is created that contains the original files. To view the contents of the Zip folder

1. Click on the line item with the date of the message, the Zip Explorer opens.



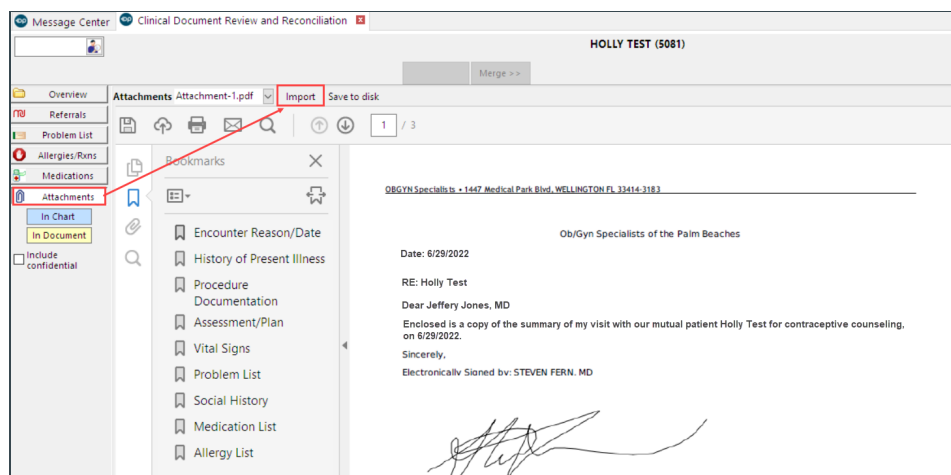
2. Click on a document to view.
3. (Optional) For existing files not previously saved to the patient record, you may select the file in the Zip Explorer and click the **Import** button. Once imported you can edit or reconcile the CDA. Optionally, you may click **Save to Disk** if not importing to the patient record at this time and save to your system.

## Direct Message: Embedded PDF

1. Navigate to the Direct Message: **Main Navigation Panel > External > Unread External tab** Messages will not be associated with a patient (non-patient message).
2. Select the message.
3. Click the **CDA** icon to open the Clinical Document Review and Reconciliation window.

Date Entered	Date/Time of Message	Spoke With	Sender	Recipient(s)
09/15/2022 09:52 am	09/15/2022 01:55 pm		kevin@test.directproject.net	Demo Doctor

4. Click **OK** in the Warning message that displays stating that there is no patient associated with the document.
5. Click the **Patient Search** button and search for and select the patient.
6. Click the **Attachments** button to view the document.
7. Click the **Import** button.



**Note:** Optionally, you may click **Save to Disk**, if not importing to the patient record at this time, and save to your system.

8. A Confirmation window displays that the document was successfully imported into OP, click **Yes** to open the document.
9. The document opens in the Manage Documents window. Follow your Practice policy on completing the information in the Documents Details panel.
10. Navigate to the Patient Chart and select **Documents**. All documents can be viewed in the Referral Letter Item Type.
11. (Optional) Select each document to Edit or Delete from the Patient record. To reconcile the CDA, proceed to **Reconcile a Referral Transition of Care**.

## Reconcile a Referral Transition of Care

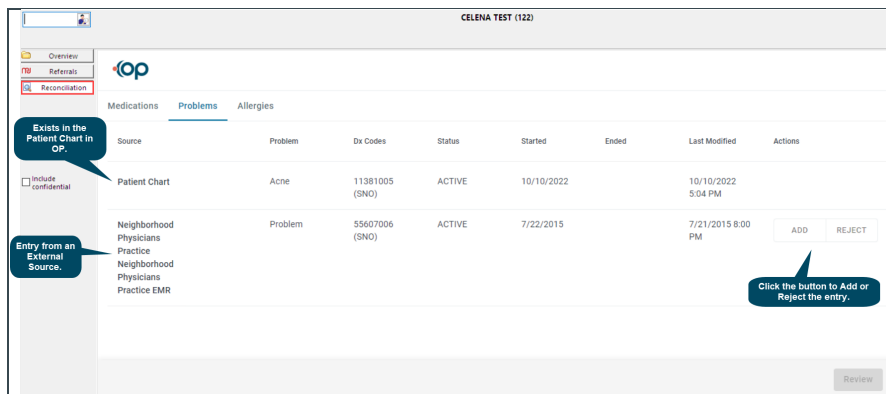
When the Clinical Document Review and Reconciliation window opens, the **Overview** tab is displayed. The user can continue reviewing and reconciling the CDA. A permission of **Admin\_Data\_Reconciliation** is required to perform the Clinical Data Reconciliation.

1. Review the **Overview** tab, this tab serves as a face sheet for the CDA.
2. (Optional) Attach the referral:
  - a. Click the **Referrals** button.
  - b. Click the **paper clip** button on the referral to attach the document. A line is created in the grid indicating that the referral has been associated.

Create TOC		<input checked="" type="checkbox"/> show all responses			
Date	Note	Referring MD	ICD 10	ICD 10 Desc	Status
9/11/2019	Evaluation of unresolved pneumonia.	Roger Provider MD			PENDING

- If a Referral/Transition of Care has not been created, the **Create TOC** button should be used to open the Referral/Transition of Care window to enter the information and attach the document.

3. Reconcile the CDA:
  - a. Click the **Reconciliation** tab, the Medications tab is selected. If an error message displays, click here for further details.
  - b. Review the information in the window, and click the **Add** or **Reject** button.



The screenshot shows the 'Reconciliation' window for 'CELENA TEST (122)'. The 'Problems' tab is active. A table lists two problem entries:

Source	Problem	Dx Codes	Status	Started	Ended	Last Modified	Actions
Patient Chart	Acne	11381005 (SNO)	ACTIVE	10/10/2022		10/10/2022 5:04 PM	
Neighborhood Physicians Practice Neighborhood Physicians Practice EMR		55607006 (SNO)	ACTIVE	7/22/2015		7/21/2015 8:00 PM	ADD REJECT

Callouts in the image indicate: 'Exists in the Patient Chart in OP' for the first row, 'Entry from an External Source' for the second row, and 'Click the button to Add or Reject the entry' pointing to the 'ADD' and 'REJECT' buttons.

**Note:** Any entry with a Source of:

- **Patient Chart:** The entry exists in the patient record.
- **Office Practicum:** The entry is a duplicate and exists in the patient record and the CDA. You must make a decision to Add or Reject the entry.

All other Source entries are new from the CDA. You will make a decision to add or reject the entry by selecting the Add or Reject button.

- c. Click the **Problems** and **Allergies** tab and click the Add or Reject button for entries new to the patient record.
- d. Click the **Review** button. The Review window displays entries that will be added to the patient record and have been rejected.

× Review
Finalize

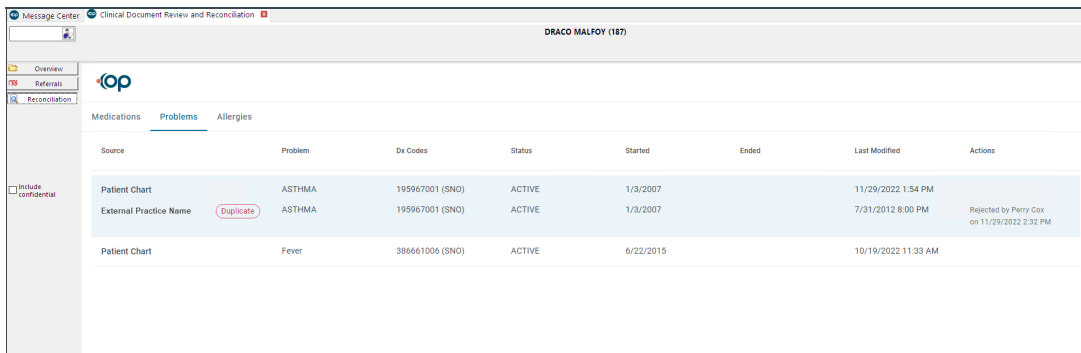
**Add Records**

Source	Type	Title	Dates	Last Modified
Get Well Clinic Henry Seven	Allergy	Codeine	5/1/2006 -	4/30/2006 8:00 PM

**Reject Records**

Source	Type	Title	Dates	Last Modified
Get Well Clinic Henry Seven	Problem	Pneumonia	8/6/2012 -	8/5/2012 8:00 PM

e. Click the **Finalize** button. When complete a Success message displays. You can now see what data you have accepted and rejected (and who performed the reconciliation) in the **Action** column:

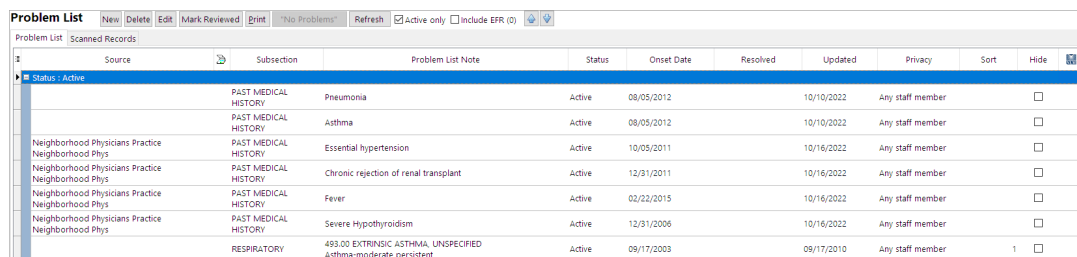


Source	Problem	Dx Codes	Status	Started	Ended	Last Modified	Actions
Patient Chart	ASTHMA	195967001 (SNO)	ACTIVE	1/3/2007		11/29/2022 1:54 PM	
External Practice Name	<span style="border: 1px solid red; border-radius: 50%; padding: 2px;">Duplicate</span> ASTHMA	195967001 (SNO)	ACTIVE	1/3/2007		7/31/2012 8:00 PM	Rejected by Perry Cox on 11/29/2022 2:32 PM
Patient Chart	Fever	386661006 (SNO)	ACTIVE	6/22/2015		10/19/2022 11:33 AM	

f. Close the Clinical Document Review and Reconciliation window.

4. Click the **Mark Reviewed** button (if accessed from Document Management) or mark the message **Read** (if accessed from the Message Center).

**Note:** A Source column is available to add that displays the External Source. This column is available in the Medication, Allergies, and Problem list windows of the Patient's Chart. Example:



Source	Subsection	Problem List Note	Status	Onset Date	Resolved	Updated	Privacy	Sort	Hide
	PAST MEDICAL HISTORY	Pneumonia	Active	08/05/2012		10/10/2022	Any staff member		<input type="checkbox"/>
	PAST MEDICAL HISTORY	Asthma	Active	08/05/2012		10/10/2022	Any staff member		<input type="checkbox"/>
Neighborhood Physicians Practice	PAST MEDICAL HISTORY	Essential hypertension	Active	10/05/2011		10/16/2022	Any staff member		<input type="checkbox"/>
Neighborhood Physicians Practice	PAST MEDICAL HISTORY	Chronic rejection of renal transplant	Active	12/31/2011		10/16/2022	Any staff member		<input type="checkbox"/>
Neighborhood Physicians Practice	PAST MEDICAL HISTORY	Fever	Active	02/22/2015		10/16/2022	Any staff member		<input type="checkbox"/>
Neighborhood Physicians Practice	PAST MEDICAL HISTORY	Severe Hypothyroidism	Active	12/31/2006		10/16/2022	Any staff member		<input type="checkbox"/>
Neighborhood Phys	RESPIRATORY	493.00 EXTRINSIC ASTHMA, UNSPECIFIED Asthma-moderate persistent	Active	09/17/2009		09/17/2010	Any staff member	1	<input type="checkbox"/>

Version 20.18

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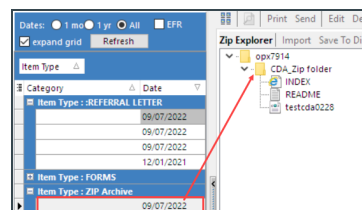
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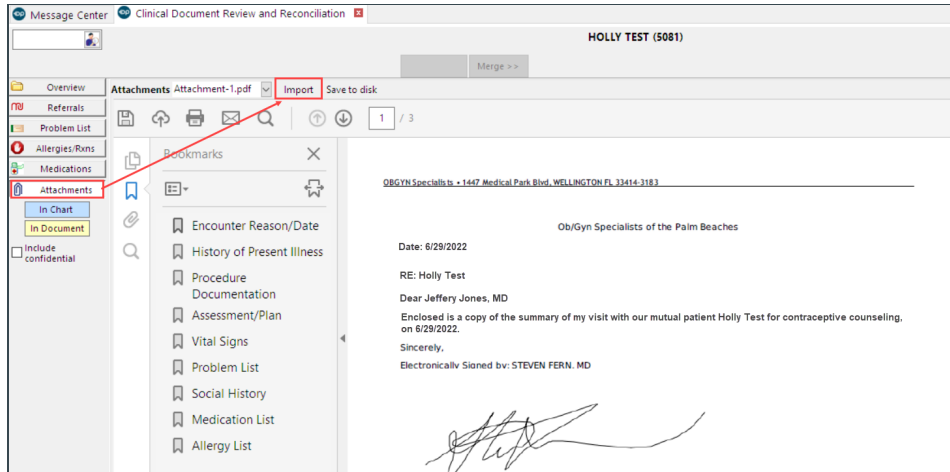
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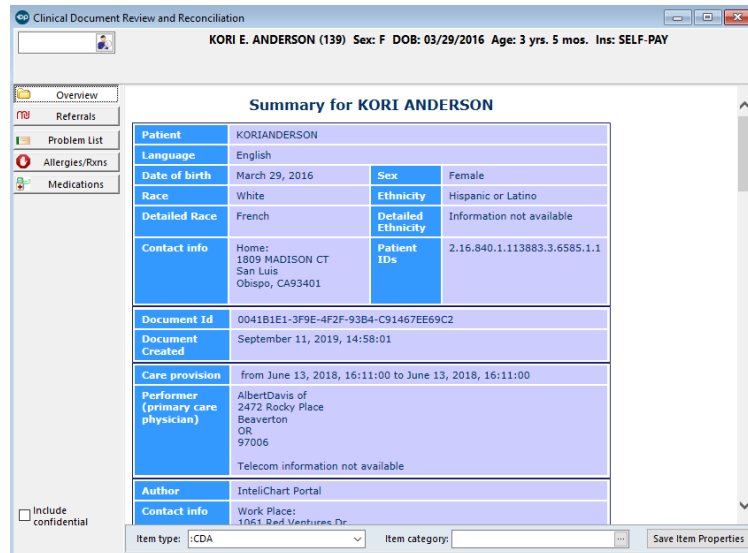


**Note:** Optionally, you may click **Save to Disk**, if not importing to the patient record at this time, and save to your system.

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## Reconcile a Referral Transition of Care

When the Clinical Document Review and Reconciliation window opens, the Overview tab is displayed. The user can continue with reviewing and reconciling the CDA.



**Clinical Document Review and Reconciliation**  
**KORI E. ANDERSON (139) Sex: F DOB: 03/29/2016 Age: 3 yrs. 5 mos. Ins: SELF-PAY**

**Summary for KORI ANDERSON**

<b>Patient</b>	KORIANDEKSON		
<b>Language</b>	English		
<b>Date of birth</b>	March 29, 2016	<b>Sex</b>	Female
<b>Race</b>	White	<b>Ethnicity</b>	Hispanic or Latino
<b>Detailed Race</b>	French	<b>Detailed Ethnicity</b>	Information not available
<b>Contact info</b>	Home: 1809 MADISON CT San Luis Obispo, CA93401	<b>Patient IDs</b>	2.16.840.1.113883.3.6585.1.1
<b>Document Id</b>	0041B1E1-3F9E-4F2F-93B4-C91467EE69C2		
<b>Document Created</b>	September 11, 2019, 14:58:01		
<b>Care provision</b>	from June 13, 2018, 16:11:00 to June 13, 2018, 16:11:00		
<b>Performer (primary care physician)</b>	AlbertDavis of 2472 Rocky Place Beaverton OR 97006 Telecom information not available		
<b>Author</b>	IntelChart Portal		
<b>Contact info</b>	Work Place: 3.063_Rad_Mentures.Dr.		

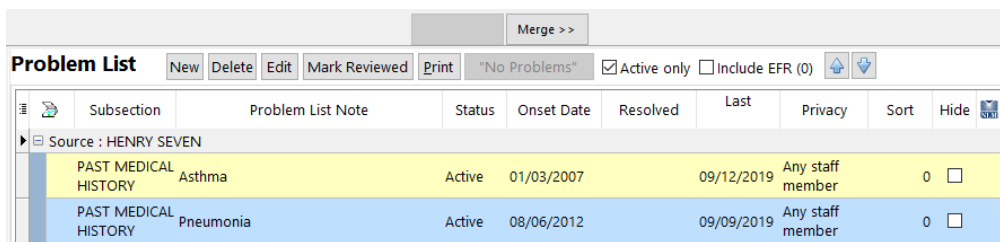
Item type: CDA Item category: Save Item Properties

1. Review the Overview tab. This tab serves as a face-sheet for the CDA.
2. Attach the CDA to a referral:
  - a. Click the **Referrals** tab.
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Create TOC		<input checked="" type="checkbox"/> show all responses				
Date	Note	Referring MD	ICD 10	ICD 10 Desc	Status	
9/11/2019	Evaluation of unresolved pneumonia.	Roger Provider MD			PENDING	

- If a Referral/Transition of Care has not been created, the **Create TOC** button should be used to open the Referral/Transition of Care window to enter the Transition information. Once that entry is saved, the CDA may be attached.

3. Review the **Problem List** section of the report.
  - a. Click the **Problem List** tab.
  - b. Review the information provided where clinical information that already existed in the patient's chart is displayed with a **blue** background, and new clinical information is displayed with a **yellow** background.



Subsection	Problem List Note	Status	Onset Date	Resolved	Last	Privacy	Sort	Hide
PAST MEDICAL HISTORY	Asthma	Active	01/03/2007		09/12/2019	Any staff member	0	<input type="checkbox"/>
PAST MEDICAL HISTORY	Pneumonia	Active	08/06/2012		09/09/2019	Any staff member	0	<input type="checkbox"/>

4. Choose which information should be incorporated into the patient's chart:
  - a. Select the new clinical information displayed with a yellow background.
  - b. Click the **Merge >>** button.
  - c. In the Action column, select from the following options:
    - **Ignore:** This is the default for new clinical data.
    - **Add:** Adds the data from the document to the patient's chart.
    - **Retain:** This is the default for the clinical information that already existed in the patient's chart.
    - **Remove:** When regarding new data, this does not incorporate the data into the patient's chart. When regarding

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existing patient chart data, this removes data from the patient's chart. An example of when this would be done could be if a specialist provided a more granular description of the patient's problem/diagnosis.

5. *(Optional)* Edit the following columns, as needed: Status, Onset Date, Resolved, Privacy, Sort Order, and Hide.
  6. Click the **Review >>** button to review the patient's new Problem List.
  7. If the Problem List is acceptable as is, click the **Submit** button (**an irreversible action**), and confirm you want to merge the data. If a change needs to be made, click the **<< Merge** button to return to the previous screen.
  8. Repeat the steps above for the Allergies/Rxns and Medications tabs of the report (as applicable).
  9. Close the Clinical Document Review and Reconciliation window.
  10. Click the **Mark Reviewed** button (if accessed from Document Management) or mark the message **Read** (if accessed from the Message Center).
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