



Version: V6.1

§170.315(b)(10) Electronic Health Information export- Documentation

This document describes the details for §170.315(b)(10) Electronic Health Information export

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Overview

Capella EHR meets the certification criterion §170.315(b)(10) Electronic Health Information export by implementing the CCD Export for Single Patient and Bulk Export. This helps the clinical users to generate the Clinical Care Document for a single patient or for a group of patients in accordance with the standards specified in § 170.205(a)(4) HL7® Implementation Guide for CDA Release 2 Consolidation CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use Release 2.1 C-CDA 2.1, August 2015, June 2019 (with Errata) and

To achieve this, we have implemented,

Single Patient Export and Bulk Patient Export in the CCD format which can be printed in Adobe PDF format.

Ability to download the Images / Clinical notes on demand and can be printed in Adobe PDF format.

a. Single Patient Export

The screenshot shows a web interface titled "Clinical Summary". It features a "Data To Be Displayed" section with a sub-section "Automatically Displayed" containing "Patient details and Demographics" and "Provider name and contact Information". Below this is an "Encounter Details" section with a grid of checkboxes for various data points, all of which are checked. The checkboxes include: Reason Of Visit, Vitals, Clinical Instruction, Immunizations, Mental Status, Care Plan, Laboratory Test(s), Smoking Status, Allergy, Functional Status, Procedure(s), Laboratory Values/Results, Encounter, Goals, Assessment, Medication, Medications Administered During visit, Treatment Plan, Problem List, Reason for Referral, Implants, Health Concern, Lab Test, Laboratory Information, and Diagnostics Tests Pending, Future Scheduled Tests, and Patient Decision Aids. At the bottom of the selection area is a "Check All" checkbox. To the right are four buttons: "Launch API" (blue), "Generate Care Note" (blue), "Generate CCD" (green), and "Clear All" (red). Below the selection area is a "Send Summary" section with a "Recipient" text box, a "+" icon, a "Message" text box, and an "Attachment" link. A "Send" button is located at the bottom right of the form.

- The user can select one or more sections to be printed in the CCD of the Patient.
- Generate CCD button will print the Care document in Adobe PDF Format which is human readable as well as in CCD format

Patient Chart Clinical Summary

Patient	[REDACTED]		
Date of Birth	[REDACTED]	Sex	[REDACTED]
Race	Declined to specify		
Contact info	Primary Home: [REDACTED]	Ethnicity	[REDACTED]
		Patient IDs	684267 2,16,840,1,113883,8375
Document Id	2023060041103 2,16,840,1,113883,8375		
Document Created:	June 1, 2023, 04:11:03 +0500		
Performer (attending physician)	[REDACTED]		
Author	Dr. PHY, S. TEST, M.D.		
Contact info	Work Place: [REDACTED]		
Author	Capella EHR v6.1		
Contact info	Work Place: [REDACTED]		
Entered by	MAL1		
Contact info	Work Place: [REDACTED]		
Legal authenticator	[REDACTED]		
Contact info	[REDACTED]		
Document maintained by	TEST FACILITY		
Contact info	Work Place: [REDACTED]		
Preferred Language	English		

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b. Bulk Export

Bulk Export

Select Date Of Service Range

From Date: 03-Jul-2023 To Date: 03-Sep-2023

Provider: [REDACTED] Show All Physicians **Get**

Select	Patient Account #	Patient Name	DOB	Gender	DOS
<input type="checkbox"/>	684267	[REDACTED]	[REDACTED]	[REDACTED]	7/6/2023 11:29:58 PM
<input type="checkbox"/>	534070	[REDACTED]	[REDACTED]	[REDACTED]	7/11/2023 5:20:38 AM
<input type="checkbox"/>	534070	[REDACTED]	[REDACTED]	[REDACTED]	7/13/2023 11:41:49 PM
<input type="checkbox"/>	534070	[REDACTED]	[REDACTED]	[REDACTED]	7/13/2023 11:37:00 PM
<input type="checkbox"/>	534070	[REDACTED]	[REDACTED]	[REDACTED]	7/14/2023 6:14:43 AM

Generate **Close**

Export Scheduler

Destination Path: [REDACTED]

Non Recurring Recurring

Non Recurring

Export Date: 03-Sep-2023

Time: 11:18 PM

Recurring

Start Date: 03-Sep-2023

Time: 11:18 PM

Frequency: [REDACTED]

- The user can select more than one patient based on the Provider or Appointments
- Generate CCD button will print the Care document in Adobe PDF Format which is human readable as well as in CCD format for all the selected patients.

CCD Output Format

Standard Referenced:

§ 170.205(a)(4) HL7® Implementation Guide for CDA Release 2 Consolidation CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use Release 2.1 C-CDA 2.1, August 2015, June 2019 (with Errata)

Sections in the CCD output

Data Elements	XPATH / Entry	Code System	Code System Name
Patient Demographics/Information			
Patient Name	ClinicalDocument/recordTarget/patientRole/patient/name		-
Sex	ClinicalDocument/recordTarget/patientRole/patient/administrativeGenderCode/@code	2.16.840.1.113883.5.1	Administrative Gender
Date of Birth	ClinicalDocument/recordTarget/patientRole/patient/birthTime/@value		
Race	ClinicalDocument/recordTarget/patientRole/patient/raceCode/@code	2.16.840.1.113883.6.238	Race & Ethnicity - CDC
Ethnicity	ClinicalDocument/recordTarget/patientRole/patient/ethnicGroupCode/@code	2.16.840.1.113883.6.238	Race & Ethnicity - CDC
Preferred Language	ClinicalDocument/recordTarget/patientRole/patient/languageCommunication/languageCode/@code		
Current Address	ClinicalDocument/recordTarget/patientRole/addr		
Previous Address	ClinicalDocument/recordTarget/patientRole/addr/useablePeriod		
Phone Number	ClinicalDocument/recordTarget/patientRole/telecom/@value		
Email Address	ClinicalDocument/recordTarget/patientRole/telecom/@value		
Provider's name and office contact information			
Performer Name	ClinicalDocument/documentationOf/serviceEvent/performer/assignedEntity/assignedPerson/name		
Performer Phone Number	ClinicalDocument/documentationOf/serviceEvent/performer/assignedEntity/telecom/@value		
Performer Address	ClinicalDocument/documentationOf/serviceEvent/performer/assignedEntity/addr		

Data Elements	XPATH / Entry	Code System	Code System Name
Care team member(s)			
Care Giver Name	ClinicalDocument/documentationOf/serviceEvent/performer/assignedEntity/assignedPerson/name		
Specialty	ClinicalDocument/documentationOf/serviceEvent/performer/assignedEntity/code		
Phone Number	ClinicalDocument/documentationOf/serviceEvent/performer/assignedEntity/telecom		
Address	ClinicalDocument/documentationOf/serviceEvent/performer/assignedEntity/addr		
Related Person [2.16.840.1.113883.10.20.22.5.8: 2023-05-01]			
Related Person Name	ClinicalDocument/participant/associatedEntity/associatedPerson/name		
Medication Allergies [2.16.840.1.113883.10.20.22.2.6.1 : 2015-08-01]			
Substance	ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/observation/participant/participantRole/playingEntity/code/@displayName	2.16.840.1.113883.6.88	RxNorm
Reaction	ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/observation/entryRelationship/observation/value/@displayName	2.16.840.1.113883.6.96	SNOMED
Severity	ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/observation/entryRelationship/observation/value/@displayName	2.16.840.1.113883.6.96	SNOMED
Status	ClinicalDocument/component/structuredBody/component/section/entry/act/status/@code	2.16.840.1.113883.6.96	SNOMED
Medications [2.16.840.1.113883.10.20.22.2.1.1 : 2014-06-09]			
Medication	ClinicalDocument/component/structuredBody/component/section/entry/substanceAdministration/consumable/manufacturedProduct/manufacturedMaterial/code/@displayName	2.16.840.1.113883.6.88 and 2.16.840.1.113883.6.69 (translation code)	RxNorm and NDC
Route	ClinicalDocument/component/structuredBody/component/section/entry/substanceAdministration/routeCode/@code		

Data Elements	XPATH / Entry	Code System	Code System Name
Dose	ClinicalDocument/component/structuredBody/component/section/entry/substanceAdministration/doseQuantity/@value		
Start Date	ClinicalDocument/component/structuredBody/component/section/entry/substanceAdministration/effectiveTime/low/@value		
End Date	ClinicalDocument/component/structuredBody/component/section/entry/substanceAdministration/effectiveTime/high/@value		
Status	ClinicalDocument/component/structuredBody/component/section/entry/substanceAdministration/statusCode/@code		
Problems [2.16.840.1.113883.10.20.22.2.5.1 : 2015-08-01]			
Problem	ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/observation/value/translation/@displayName	2.16.840.1.113883.6.96 and 2.16.840.1.113883.6.3 (translation code)	SNOMED and ICD10
Concern Status	ClinicalDocument/component/structuredBody/component/section/entry/act/status/@code		
Diagnosis date	ClinicalDocument/component/structuredBody/component/section/entry/act/effectiveTime/low/@value		
Encounters [2.16.840.1.113883.10.20.22.2.22.1 : 2015-08-01]			
Encounter Code and Code Description	ClinicalDocument/component/structuredBody/component/section/entry/encounter/code/@code	2.16.840.1.113883.6.12	CPT
Diagnosis	ClinicalDocument/component/structuredBody/component/section/entry/encounter/entryRelationship/observation/value/translation/@code	2.16.840.1.113883.6.96 and 2.16.840.1.113883.6.3 (translation code)	SNOMED and ICD10
Service Delivery Location	ClinicalDocument/component/structuredBody/component/section/entry/encounter/participant/participantRole/playingEntity/name		
Date Recorded	ClinicalDocument/component/structuredBody/component/section/entry/encounter/effectiveTime/@value		
Immunizations [2.16.840.1.113883.10.20.22.2.2.1 : 2015-08-01]			
Vaccine	ClinicalDocument/component/structuredBody/component/section/entry/substanceAdministration/consumable/code/@code	2.16.840.1.113883.12.292 and 2.16.840.1.113883.	CVX and CPT-4

Data Elements	XPATH / Entry	Code System	Code System Name
		6.12 (translation code)	
Date	ClinicalDocument/component/structuredBody/component/section/entry/substanceAdministration/effectiveTime/@value		
Status	ClinicalDocument/component/structuredBody/component/section/entry/substanceAdministration/statusCode/@code		
Vitals [2.16.840.1.113883.10.20.22.2.4.1 : 2015-08-01]			
Observation Code	ClinicalDocument/component/structuredBody/component/section/entry/organizer/component/observation/code/@code	2.16.840.1.113883.6.1	LOINC
Observation Date/Time	ClinicalDocument/component/structuredBody/component/section/entry/organizer/component/observation/effectiveTime/@value		
Social History [2.16.840.1.113883.10.20.22.2.17 : 2015-08-01]			
Description Code	ClinicalDocument/component/structuredBody/component/section/entry/observation/value/@code	2.16.840.1.113883.6.96	SNOMED
Dates Observed	ClinicalDocument/component/structuredBody/component/section/entry/observation/effectiveTime/@value		
Procedures [2.16.840.1.113883.10.20.22.2.7.1 : 2014-06-09]			
Procedure Code	ClinicalDocument/component/structuredBody/component/section/entry/procedure/code/@code	2.16.840.1.113883.6.12 or 2.16.840.1.113883.6.96 or 2.16.840.1.113883.6.13	CPT-4 or SNOMED or HCPCS
Date	ClinicalDocument/component/structuredBody/component/section/entry/procedure/effectiveTime/@value		
Laboratory Tests			
Test Code	ClinicalDocument/component/structuredBody/component/section/text/table/tbody/tr/td[1]		
Code System	ClinicalDocument/component/structuredBody/component/section/text/table/tbody/tr/td[2]	2.16.840.1.113883.6.1	LOINC
Name	ClinicalDocument/component/structuredBody/component/section/text/table/tbody/tr/td[3]		
Date	ClinicalDocument/component/structuredBody/component/section/text/table/tbody/tr/td[4]		

Data Elements	XPATH / Entry	Code System	Code System Name
Laboratory value(s)/result(s) [2.16.840.1.113883.10.20.22.2.3.1 : 2015-08-01]			
Result Code	ClinicalDocument/component/structuredBody/component/section/entry/organizer/component/observation/code/@code	2.16.840.1.113883.6.1	LOINC
Result Value	ClinicalDocument/component/structuredBody/component/section/entry/organizer/component/observation/value		
Relevant Reference Range	ClinicalDocument/component/structuredBody/component/section/entry/organizer/component/observation/referenceRange/observationRange/text		
Date	ClinicalDocument/component/structuredBody/component/section/entry/organizer/component/observation/effectiveTime/@value		
Medical Equipment [2.16.840.1.113883.10.20.22.2.23 : 2014-06-09]			
Implanted Device Code	ClinicalDocument/component/structuredBody/component/section/entry/procedure/participant/participantRole/playingDevice/@code	2.16.840.1.113883.6.96	SNOMED
UDI	ClinicalDocument/component/structuredBody/component/section/entry/procedure/participant/participantRole/id/extension		
Treatment Plan [2.16.840.1.113883.10.20.22.2.10 : 2014-06-09]			
Planned Observation	ClinicalDocument/component/structuredBody/component/section/entry/observation/code/@code	2.16.840.1.113883.6.1	LOINC
Planned Date	ClinicalDocument/component/structuredBody/component/section/entry/observation/effectiveTime/@value		
SDOH Assessment [2.16.840.1.113883.10.20.22.2.17 : 2015-08-01 2.16.840.1.113883.10.20.22.4.38 : 2015-08-01 2.16.840.1.113883.10.20.22.4.38 : 2022-06-01]			
Assessment code	ClinicalDocument/component/structuredBody/component/section/entry/observation/entryRelationship/observation/code/@code	2.16.840.1.113883.6.1	LOINC
Assessment Status	ClinicalDocument/component/structuredBody/component/section/entry/observation/entryRelationship/observation/statusCode/@code		
Assessment Date	ClinicalDocument/component/structuredBody/component/section/entry/observation/entryRelationship/observation/effectiveTime/@Value		

Data Elements	XPATH / Entry	Code System	Code System Name
Assessment Value	ClinicalDocument/component/structuredBody/component/section/entry/observation/entryRelationship/observation/value/@value		
Assessment Questions - Loinc Code	ClinicalDocument/component/structuredBody/component/section/entry/observation/entryRelationship/observation/entryRelationship/observation/code/@code		
Assessment Questions - Value Code	ClinicalDocument/component/structuredBody/component/section/entry/observation/entryRelationship/observation/entryRelationship/observation/value/@code		
SDOH Intervention [2.16.840.1.113883.10.20.22.2.10 : 2014-06-09, 2.16.840.1.113883.10.20.22.4.41 : 2014-06-09 2.16.840.1.113883.10.20.22.4.41 : 2022-06-01]			
Intervention Code	ClinicalDocument/component/structuredBody/component/section/entry/procedure/code/@code	2.16.840.1.113883.6.96	SNOMED
Proposed Date	ClinicalDocument/component/structuredBody/component/section/entry/procedure/effectiveTime/@value		
SDOH Goal [2.16.840.1.113883.10.20.22.2.60 2.16.840.1.113883.10.20.22.4.121 : 2022-06-01]			
SNOMED Code	ClinicalDocument/component/structuredBody/component/section/entry/observation/value/@code	2.16.840.1.113883.6.96	SNOMED
SDOH Health Concern [2.16.840.1.113883.10.20.22.2.58 : 2015-08-01 2.16.840.1.113883.10.20.22.4.132 : 2015-08-01 2.16.840.1.113883.10.20.22.4.132 : 2022-06-01]			
Problem SNOMED Code	ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/observation/value/@code	2.16.840.1.113883.6.96	SNOMED
Concern Status	ClinicalDocument/component/structuredBody/component/section/entry/act/statusCode/@code		
Reason for Referral [1.3.6.1.4.1.19376.1.5.3.1.3.1 : 2014-06-09]			
Referral Code	ClinicalDocument/component/structuredBody/component/entry/act/code/@code	2.16.840.1.113883.6.96	SNOMED
Referral Reason	ClinicalDocument/component/structuredBody/component/entry/act/code/@displayName		
Functional Status [2.16.840.1.113883.10.20.22.2.14 : 2014-06-09]			

Data Elements	XPATH / Entry	Code System	Code System Name
Assessment Code	ClinicalDocument/component/structuredBody/component/section/entry/organizer/component/observation/value/@code	2.16.840.1.113883.6.96	SNOMED
Assessment Date	ClinicalDocument/component/structuredBody/component/section/entry/organizer/component/observation/effectiveTime/@value		
CUBS Disability Code	ClinicalDocument/component/structuredBody/component/section/entry/observation/value/@code	2.16.840.1.113883.6.1	LOINC
Disability Assessment Question Code	ClinicalDocument/component/structuredBody/component/section/entry/observation/entryRelationship/observation/code/@code	2.16.840.1.113883.6.1	LOINC
Disability Assessment Answer Code	ClinicalDocument/component/structuredBody/component/section/entry/observation/entryRelationship/observation/value/@code	2.16.840.1.113883.6.1	LOINC
Mental Status [2.16.840.1.113883.10.20.22.2.56 : 2015-08-01]			
Assessment Code	ClinicalDocument/component/structuredBody/component/section/entry/observation/value/@code	2.16.840.1.113883.6.96	SNOMED
Assessment Date	ClinicalDocument/component/structuredBody/component/section/entry/observation/effectiveTime/@value		
Basic Occupation [2.16.840.1.113883.10.20.22.2.17 : 2015-08-01 2.16.840.1.113883.10.20.22.4.503 : 2023-05-01]			
Occupation Code	ClinicalDocument/component/structuredBody/component/section/entry/observation/value/@code	2.16.840.1.114222.4.5.327	Occupational Data for Health (ODH)
Occupation Industry Code	ClinicalDocument/component/structuredBody/component/section/entry/observation/entryRelationship/observation/value/@code	2.16.840.1.114222.4.5.327	Occupational Data for Health (ODH)
Tribal Affiliation [2.16.840.1.113883.10.20.22.2.17 : 2015-08-01 2.16.840.1.113883.10.20.22.4.506 : 2023-05-01]			

Data Elements	XPATH / Entry	Code System	Code System Name
Code	ClinicalDocument/component/structuredBody/component/section/entry/observation/value/@code	2.16.840.1.113883.5.140	TribalEntityUS
Pregnancy Status [2.16.840.1.113883.10.20.22.2.17 : 2015-08-01 2.16.840.1.113883.10.20.15.3.8]			
Code	ClinicalDocument/component/structuredBody/component/section/entry/observation/value/@code	2.16.840.1.113883.6.96	SNOMED
Health Insurance Information [2.16.840.1.113883.10.20.22.2.18 : 2015-08-01]			
Coverage Status	ClinicalDocument/component/structuredBody/component/section/entry/act/effectiveTime/@value		
Coverage Type	ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/act/code/@code	2.16.840.1.113883.3.221.5	Source of Payment Typology (PHDSC)
Relationship To Subscriber	ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/act/participant/participantRole/code/@code	2.16.840.1.113883.5.111	
Member Identifier	ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/act/participant/participantRole/id/@extension - typeCode="COV"		
Subscriber Identifier	ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/act/participant/participantRole/id/@extension - typeCode="HLD"		
Group Identifier	ClinicalDocument/component/structuredBody/component/section/entry/act/entryRelationship/act/entryRelationship/act/text		