talkEHR

Version: V1.0

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

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

CareCloud

Contents

Overview

talkEHR support **§170.315(b)(10) Electronic Health Information export** by using CCD Export for Single Patient and Bulk Export as per the standards specified in § 170.205(a)(4) HL7® Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm) and Patient demographic/insurance, appointments, Billing information and documents export in pdf format.

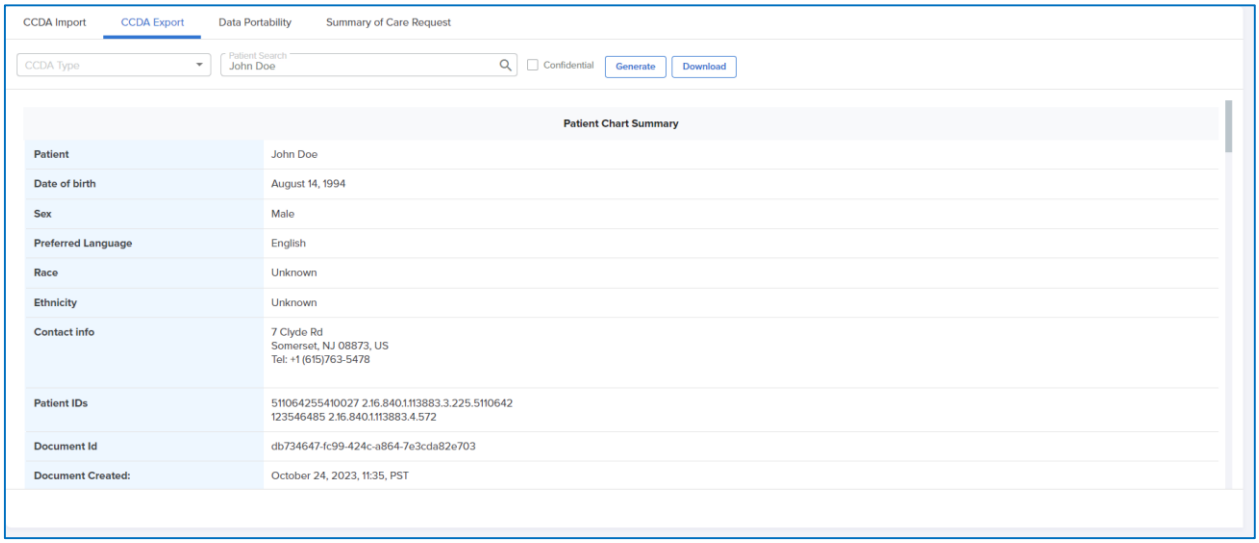
Here are the detailed formats and structures we offer

- Clinical Data (Single Patient Export and Bulk Patient Export in the xml/html format)
- Patient Demographic, Insurance, Appointments, Provider-to-patient messages, and Billing Data in pdf format
- Documents (signed progress notes, available lab results, radiology reports, and any other scanned or uploaded document export in pdf format)

Clinical Data – Single Patient Export

Steps to Export CCDA for Single Patient:-

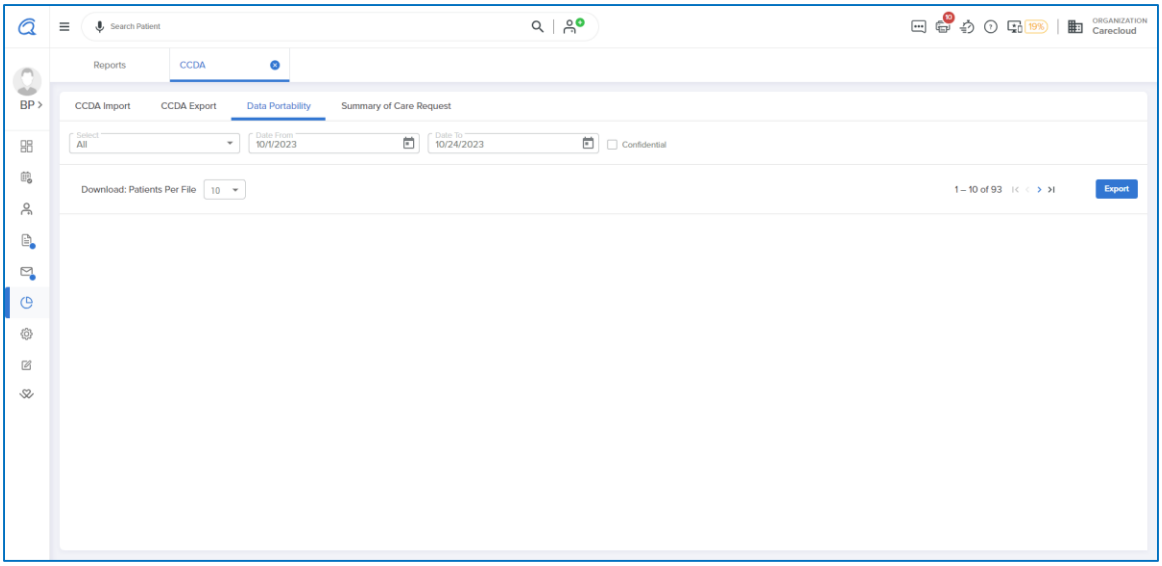
- In CCDA Report, *Navigate* to the CCDA Export Tab
- Select the CCDA Type
- Search and select the patient
- *Click* the **Generate** button to *generate* CCDA
- Once the CCDA is generated, *Click* the **Download** button to *download* the CCDA in **XML** format.

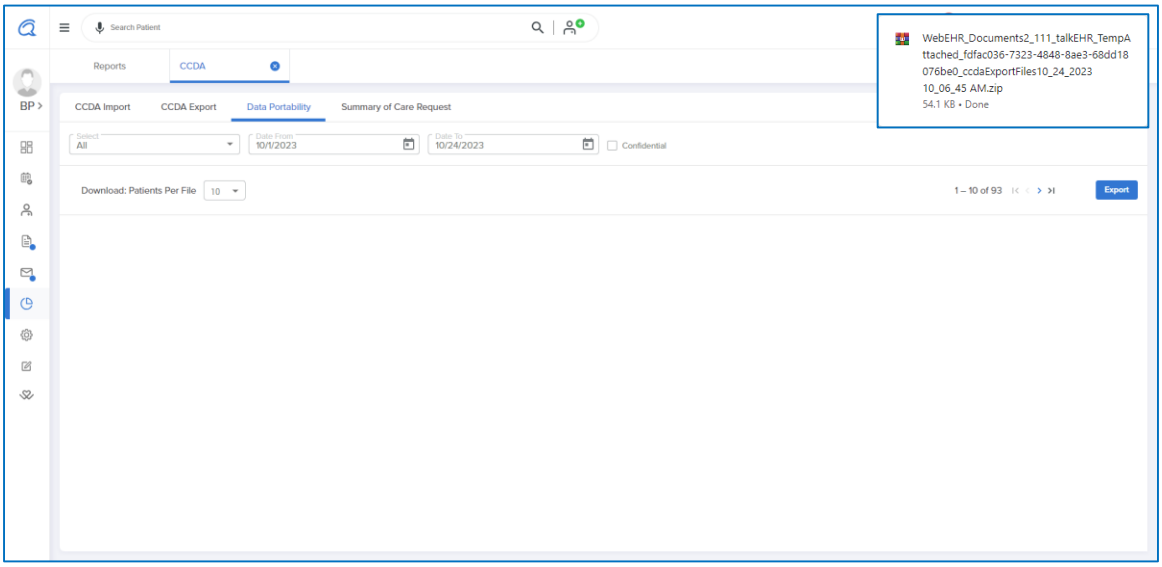


Clinical Data – Bulk Patient Export

Steps to Export CCDA for Patient Population:

- In the CCDA Report, *Navigate* to the Data Portability Tab
- *Select* the **Date Range**
- *Click* the **Export** button
- A **ZIP file** will be *downloaded* with CCDA in **XML** format.





CCD Output Format

Standard Referenced:

- § 170.205(a)(4) HL7® Implementation Guide for CDA® Release 2: Consolidated CDA Templates for Clinical Notes (US Realm), Draft Standard for Trial Use Release 2.1, August 2015

Sections in the CCD output

Data Elements	XPATH / Entry	Code System	Code System Name
Patient Demographics/Information			
Patient Name	patient/name		-
Sex	patient/administrativeGenderCode	2.16.840.1.113883.5.1	AdministrativeGender
Date of Birth	patient/birthTime		
Race	patient/raceCode	2.16.840.1.113883.6.238	Race & Ethnicity - CDC
Ethnicity	patient/ethnicGroupCode	2.16.840.1.113883.6.238	Race & Ethnicity - CDC
Preferred Language	patient/languageCommunication/languageCode		
Provider's name and office contact information			
Performer	documentationOf/serviceEvent/performer/assignedEntity/assignedPerson/name		
Performer	documentationOf/serviceEvent/performer/assignedEntity/telecom		
Performer	documentationOf/serviceEvent/performer/assignedEntity/addr		
Date and Location of visit [2.16.840.1.113883.10.20.22.2.22.1 : 2015-08-01]			
Encounter	entry/encounter/effectiveTime/@value		
Encounter	entry/encounter/participant/participantRole/addr		
Chief Complaint and Reason for visit [2.16.840.1.113883.10.20.22.2.13 : 2014-06-09]			
Patient visit details/complaints			
Encounters [2.16.840.1.113883.10.20.22.2.22.1 : 2015-08-01]			
Encounter Code and Code Description	2.16.840.1.113883.10.20.22.4.49: 2015-08-01	2.16.840.1.113883.6.12	CPT
Performer			

Data Elements	XPATH / Entry	Code System	Code System Name
Diagnosis		2.16.840.1.113883.6.96 and 2.16.840.1.113883.6.3 (translation code)	SNOMED and ICD10
Location			
Date			
Immunizations [2.16.840.1.113883.10.20.22.2.2.1 : 2015-08-01]			
Vaccine	2.16.840.1.113883.10.20.22.4.52: 2015-08-01	2.16.840.1.113883.12.292 and 2.16.840.1.113883.6.12 (translation code)	CVX and CPT-4
Date			
Status			
Route		2.16.840.1.113883.3.26.1.1	National Cancer Institute (NCI) Thesaurus
Site		2.16.840.1.113883.6.96	SNOMED
Manufacturer			
Dose			
Lot Number			
Notes			
Instructions [2.16.840.1.113883.10.20.22.2.45 : 2014-06-09]			
Patient Instructions/FollowupReasons	2.16.840.1.113883.10.20.22.4.20: 2014-06-09	2.16.840.1.113883.6.96	SNOMED
Treatment Plan [2.16.840.1.113883.10.20.22.2.10 : 2014-06-09]			
(Diagnostic tests pending, Future appointments, Referrals to other providers, Future scheduled tests, Recommended patient decision aids)			
Planned Observation	2.16.840.1.113883.10.20.22.4.44: 2014-06-09	2.16.840.1.113883.6.1	LOINC
Planned Date	2.16.840.1.113883.10.20.22.4.40: 2014-06-09 2.16.840.1.113883.10.20.22.4.39: 2014-06-09 2.16.840.1.113883.10.20.22.4.121		
Social History [2.16.840.1.113883.10.20.22.2.17 : 2015-08-01]			
Social History Observation	2.16.840.1.113883.10.20.22.4.78: 2014-06-09	2.16.840.1.113883.6.1	LOINC
Description		2.16.840.1.113883.6.96	SNOMED
Dates Observed		-	-

Data Elements	XPATH / Entry	Code System	Code System Name
Problems [2.16.840.1.113883.10.20.22.2.5.1 : 2015-08-01]			
Problem	2.16.840.1.113883.10.20.22.4.3: 2015-08-01	2.16.840.1.113883.6.96 and 2.16.840.1.113883.6.3 (translation code)	SNOMED and ICD10
Status			
Active date			
Medications [2.16.840.1.113883.10.20.22.2.1.1 : 2014-06-09]			
Medication	2.16.840.1.113883.10.20.22.4.16: 2014-06-09	2.16.840.1.113883.6.88 and 2.16.840.1.113883.6.69 (translation code)	RxNorm and NDC
Directions			
Start Date			
End Date			
Status			
Medication Allergies [2.16.840.1.113883.10.20.22.2.6.1 : 2015-08-01]			
Substance	2.16.840.1.113883.10.20.22.4.30: 2015-08-01	2.16.840.1.113883.6.88	RxNorm
Reaction		2.16.840.1.113883.6.96	SNOMED
Severity		2.16.840.1.113883.6.96	SNOMED
Status		2.16.840.1.113883.6.96	SNOMED
Laboratory Tests			
Test Code			
Code System		2.16.840.1.113883.6.1	LOINC
Name			
Date			
Laboratory Information			
Lab Name			
Lab Address			
Test Report Date			
Test Performed			
Specimen Source			
Laboratory value(s)/result(s) [2.16.840.1.113883.10.20.22.2.3.1 : 2015-08-01]			
Result Type	2.16.840.1.113883.10.20.22.4.1: 2015-08-01	2.16.840.1.113883.6.1	LOINC
Result Value			
Relevant Reference Range			
Interpretation			
Date			

Data Elements	XPATH / Entry	Code System	Code System Name
Vitals [2.16.840.1.113883.10.20.22.2.4.1 : 2015-08-01]			
Observation	2.16.840.1.113883.10.2 0.22.4.26: 2015-08-01	2.16.840.1.113883.6.1	LOINC
Observation Date/Time			
Goal [2.16.840.1.113883.10.20.22.2.60]			
Goal	2.16.840.1.113883.10.2 0.22.4.121		-
Value			
Date			
Procedures [2.16.840.1.113883.10.20.22.2.7.1 : 2014-06-09			
Procedure	2.16.840.1.113883.10.2 0.22.4.14: 2014-06-09	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 orHCPCS
Date			
Care team member(s) [2.16.840.1.113883.10.20.22.2.500 : 2019-07-01]			
Care Giver Name	2.16.840.1.113883.10.2 0.22.4.500: 2019-07-01		
Specialty			
Date			
Reason for Referral [1.3.6.1.4.1.19376.1.5.3.1.3.1 : 2014-06-09]			
Reason for visit	2.16.840.1.113883.10.2 0.22.4.140	2.16.840.1.113883.6.96	SNOMED
Medical Equipment [2.16.840.1.113883.10.20.22.2.23 : 2014-06-09]			
Implanted Device	2.16.840.1.113883.10.2 0.22.4.14: 2014-06-09	2.16.840.1.113883.6.96	SNOMED
GMDN PT Description			
Mental Status [2.16.840.1.113883.10.20.22.2.56 : 2015-08-01]			
Assessment	2.16.840.1.113883.10.2 0.22.4.74: 2015-08-01		
Assessment Date			
Results		2.16.840.1.113883.6.96	SNOMED
Comments			
Functional Status [2.16.840.1.113883.10.20.22.2.14 : 2014-06-09]			
Assessment	2.16.840.1.113883.10.2 0.22.4.67: 2014-06-09		
Assessment Date			
Results		2.16.840.1.113883.6.96	SNOMED
Comments			

Data Elements	XPATH / Entry	Code System	Code System Name
Health Concern [2.16.840.1.113883.10.20.22.2.58 : 2015-08-01]			
Concern / Observation	2.16.840.1.113883.10.20.22.4.132: 2015-08-01	2.16.840.1.113883.6.96	SNOMED
Status			
Date			

Patient Demographic/Insurance

PDF format - This file offers a comprehensive view of demographics and insurance details, structured for clarity and ease of access

Advance Directive

PDF format - This file offers a comprehensive view of Advance Directive, structured for clarity and ease of access

Appointments

PDF format - This file offers a comprehensive view of appointments, structured for clarity and ease of access

Provider-to-Patient Messages

PDF format - This file offers a comprehensive view of messages, structured for clarity and ease of access

Billing Data (Claim)

PDF format - This file offers a comprehensive view of billing data (CPT, ICD, Modifier), structured for clarity and ease of access

Within the application's 'Reports' section, clients have the option to export Appointments, Patients Demos, and Insurance details, patient messages and claim data in pdf Format.

Documents

This includes signed progress notes, available lab results, radiology reports, and any other scanned or uploaded document in the patient's record. They can exported in **PDF format**

Organizational Structure

The files created by the export are saved to a folder specified by the user. Documents can be sorted and categorized as per their Type, e.g., Lab Reports and Imaging etc. Each type of document can further be sorted into its respective sub-types.

FHIR Data Export

talkEHR FHIR server creates a single-patient FHIR resource Document Reference and supports FHIR Bulk Data EHI Export for patient population as described in § 170.315(b)(10)(ii).

Export Files are created in a Timely Fashion

Practice administrator can give access to the list of users to generate Electronic health information.
A user of the Product can perform an electronic health information (EHI) export for at any time the user chooses without developer assistance and that the export files are created in a timely fashion.

For further information contact: hello@carecloud.com or call 877-342-7517