



Version: V9.1

## **§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

VertexDr 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 CCD for Single Patient:-

- In the patient’s chart, *File Menu* and select *Export CCD...*
- In the *Patient Continuity of Care Export* window select the requested sections and options and choose **OK**

**Jeremy V Bates JR (NKDA)**  
 43 Year Old Male Birth Date: 8/1/1980 Next Visit: None In Wait List: No Consent: Unspecified  
 MRN: 0000850201 Account: 8502/1  
 Address: 1357 AMBER DR BEAVERTON, OR 97006  
 Home Phone: (555) 723-1544  
 Work Phone: Other Phone: Directives: Advanced directives not on file [View](#)

**Patient Chart Summary**  
 The chart summary provides a comprehensive overview of the entire patient chart.

**Chart Summary**

**Encounters**  
 7/22/2015 (Active) - Office Visit  
[View all encounters](#)

**Allergies**  
 (NKDA)  
[View all allergies](#)

**Problem List**

Date	Description	Code	Condition
7/22/2015	ENCNTR FOR GENERAL ADULT MEDICAL EXAM W/O ABNORMAL FINDINGS	D:200.00	Acute

[View problem details](#)

**Medications**

Patient Created: 1/5/2018 Patient Last Changed: 11/7/2023

**Patient CCD Export**  
 Select which parts of the patient's chart to export in a Continuity of Care document.

**Patient Information**  
 Patient Name: BATES JR, JEREMY V  
 Encounters: All Encounters

**Chart Sections**

<input checked="" type="checkbox"/> All Sections	<input checked="" type="checkbox"/> Plan Of Care
<input checked="" type="checkbox"/> Allergies	<input checked="" type="checkbox"/> Problem List
<input checked="" type="checkbox"/> Encounters	<input checked="" type="checkbox"/> Procedures
<input checked="" type="checkbox"/> Family History	<input checked="" type="checkbox"/> Results (Orders)
<input checked="" type="checkbox"/> Functional Status	<input checked="" type="checkbox"/> Social History
<input checked="" type="checkbox"/> Immunizations	<input checked="" type="checkbox"/> Vital Signs
<input checked="" type="checkbox"/> Instructions	
<input checked="" type="checkbox"/> Medications	
<input checked="" type="checkbox"/> Payers (Guarantors/Insurance)	

**Export Options**

Also create "Human Readable" document  
 Send in a secure e-mail  
 Send to the Patient Portal

**OK** **Cancel**

### Clinical Data – Bulk Patient Export

Steps to Export CCD for Patient Population:

- From the Main window of VertexDr, Navigate to the *File Menu* and navigate to *Export CCD(s) for Patients*
- Fill out the entries for **Output Options** and any other desired options
- Click the **OK** button
- A **ZIP file** will be *downloaded* with CCD in **XML** format.

The screenshot shows the VertexDr application interface. The 'File' menu is open, and 'Export CCD for Patient(s)...' is selected. The desktop background features a 'My Desktop' widget with a pie chart showing the following data:

Category	Percentage	Count
PatientMessages	50.00%	136
Messages	47.43%	128
Vials Awaiting Approval	1.10%	3
Tasks	0.37%	1
Documents	1.10%	3

The 'VertexDr Patient(s) CCD Exporter' dialog box contains the following sections:

- Report Options:** Radio buttons for 'Client, Provider, Location', 'Patient Select', and 'All'.
- Output Options:**
  - Output Directory: [Text Field]
  - Error Log: [Text Field]
  - Referral Reason: [Text Field]
  - From Date: [Dropdown]
  - To Date: 11/10/2023
  - Days Prior: [Text Field]
  - Last Account #: [Text Field]
  - Create "Human Readable" document
  - Create Route Docs
  - Send to HIE: HIE: [Dropdown]
- Individual Selections:**
  - Clients: All
  - Providers: All
  - Locations: All

## 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
<b>Patient Demographics/Information</b>			
Patient Name	patient/name		-
Sex	patient/administrativeGenderCode	2.16.840.1.113883.5.1	AdministrativeGender
Date of Birth	patient/birthTime		
Race	patient/raceCode	2.16.840.1.113883.6.23 8	Race & Ethnicity - CDC
Ethnicity	patient/ethnicGroupCode	2.16.840.1.113883.6.23 8	Race & Ethnicity - CDC
Preferred Language	patient/languageCommunication/languageCode		
<b>Provider's name and office contact information</b>			
Performer	documentationOf/serviceEvent/performer/assignedEntity/assignedPerson/name		
Performer	documentationOf/serviceEvent/performer/assignedEntity/telecom		
Performer	documentationOf/serviceEvent/performer/assignedEntity/addr		
<b>Date and Location of visit [2.16.840.1.113883.10.20.22.2.22.1 : 2015-08-01]</b>			
Encounter	entry/encounter/effectiveTime/@value		
Encounter	entry/encounter/participant/participantRole/addr		
<b>Chief Complaint and Reason for visit [2.16.840.1.113883.10.20.22.2.13 : 2014-06-09]</b>			
Patient visit details/complaints			
<b>Encounters [2.16.840.1.113883.10.20.22.2.22.1 : 2015-08-01]</b>			
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			
<b>Immunizations [2.16.840.1.113883.10.20.22.2.2.1 : 2015-08-01]</b>			
Vaccine	2.16.840.1.113883.10.2 0.22.4.52: 2015-08-01	2.16.840.1.113883.12.2 92 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			
<b>Instructions [2.16.840.1.113883.10.20.22.2.45 : 2014-06-09]</b>			
Patient Instructions/FollowupReasons	2.16.840.1.113883.10.2 0.22.4.20: 2014-06-09	2.16.840.1.113883.6.96	SNOMED
<b>Treatment Plan [2.16.840.1.113883.10.20.22.2.10 : 2014-06-09]</b>			
(Diagnostic tests pending, Future appointments, Referrals to other providers, Future scheduled tests, Recommended patient decision aids)			
Planned Observation	2.16.840.1.113883.10.2 0.22.4.44: 2014-06-09	2.16.840.1.113883.6.1	LOINC
Planned Date	2.16.840.1.113883.10.2 0.22.4.40: 2014-06-09 2.16.840.1.113883.10.2 0.22.4.39: 2014-06-09 2.16.840.1.113883.10.2 0.22.4.121		
<b>Social History [2.16.840.1.113883.10.20.22.2.17 : 2015-08-01]</b>			
Social History Observation	2.16.840.1.113883.10.2 0.22.4.78: 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
<b>Problems [2.16.840.1.113883.10.20.22.2.5.1 : 2015-08-01]</b>			
Problem	2.16.840.1.113883.10.2 0.22.4.3: 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			
<b>Medications [2.16.840.1.113883.10.20.22.2.1.1 : 2014-06-09]</b>			
Medication	2.16.840.1.113883.10.2 0.22.4.16: 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			
<b>Medication Allergies [2.16.840.1.113883.10.20.22.2.6.1 : 2015-08-01]</b>			
Substance	2.16.840.1.113883.10.2 0.22.4.30: 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
<b>Laboratory Tests</b>			
Test Code			
Code System		2.16.840.1.113883.6.1	LOINC
Name			
Date			
<b>Laboratory Information</b>			
Lab Name			
Lab Address			
Test Report Date			
Test Performed			
Specimen Source			
<b>Laboratory value(s)/result(s) [2.16.840.1.113883.10.20.22.2.3.1 : 2015-08-01]</b>			
Result Type	2.16.840.1.113883.10.2 0.22.4.1: 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
<b>Vitals [2.16.840.1.113883.10.20.22.2.4.1 : 2015-08-01]</b>			
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			
<b>Goal [2.16.840.1.113883.10.20.22.2.60]</b>			
Goal	2.16.840.1.113883.10.2 0.22.4.121		
Value			
Date			
<b>Procedures [2.16.840.1.113883.10.20.22.2.7.1 : 2014-06-09]</b>			
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 or HCPCS
Date			
<b>Care team member(s) [2.16.840.1.113883.10.20.22.2.500 : 2019-07-01]</b>			
Care Giver Name	2.16.840.1.113883.10.2 0.22.4.500: 2019-07-01		
Specialty			
Date			
<b>Reason for Referral [1.3.6.1.4.1.19376.1.5.3.1.3.1 : 2014-06-09]</b>			
Reason for visit	2.16.840.1.113883.10.2 0.22.4.140	2.16.840.1.113883.6.96	SNOMED
<b>Medical Equipment [2.16.840.1.113883.10.20.22.2.23 : 2014-06-09]</b>			
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			
<b>Mental Status [2.16.840.1.113883.10.20.22.2.56 : 2015-08-01]</b>			
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			
<b>Functional Status [2.16.840.1.113883.10.20.22.2.14 : 2014-06-09]</b>			
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
<b>Health Concern [2.16.840.1.113883.10.20.22.2.58 : 2015-08-01]</b>			
Concern / Observation	2.16.840.1.113883.10.2 0.22.4.132:2015-08-01	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 be 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

VertexDr 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).