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

ethizo EHR

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Contents

Overview

ethizo EHR's share data functionality empowers users to export Electronic Health Information (EHI) from the ethizo system in the form of an "export zip" file. This file comprises data in both machine-readable and human-readable formats, fully compliant with §170.315(b)(10) - Electronic Health Information export of the ONC 2015 Edition Cures Update Certification Criteria.

Here are the detailed formats and structures we offer

- Clinical Data in CDA Format (Clinical Document Architecture)
- Patient Demographics and Insurance Details (CSV, Separated)
- Appointments (CSV, Separated)
- Documents (Scanned Documents like PDF, JPG, PNG File Formats)

Clinical Data – Single Patient Export

Steps to Export CCDA for Single Patient:

- Log in with your secure credentials to access ethizo EHR.
- Use the search bar to select a specific patient.
- Navigate to the "Share Data" option in the left menu.
- Choose the specific sections you wish to include in the export.
- Click the "Process" button to generate the export file.
- The system will prompt you to enter an email address or phone number for file delivery.
- Based on your preference, the system will generate a secure link through email/ text message. Clicking this link will generate another email/text message with a secure token, granting access to the patient's record.
- User can now access and download a zip folder contains CCDA in XML, CSV and PDF format EHI data.

Clinical Data – Bulk Patient Export

Steps to Export CCDA for Patient Population:

- Log in with your secure credentials to access ethizo EHR.
- From top right menu go to “Quick Links”.
- Navigate to the "Share Data" option in the left menu.
- From filters choose EHI export request for single or bulk patients
- Choose the specific sections you wish to include in the export.
- Click the "Process" button to generate the export file.
- The system will prompt you to enter an email address or phone number for file delivery.
- Based on your preference, the system will generate a secure link. Clicking this link will generate a secure token, granting access to the patient's record.
- User can now access and download a zip folder contains multiple zip folders, and each compressed folder contains CCDA (XML), CSV and PDF format EHI data.

1. Clinical Data in CDA Format (Clinical Document Architecture)

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	2.16.840.1.113883.10.22.4.3: 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	2.16.840.1.113883.10.22.4.16: 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	2.16.840.1.113883.10.22.4.30: 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	2.16.840.1.113883.10.22.4.1: 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			

2. Patient Demographics and Insurance Details

CSV Format ("," Separated): This file offers a comprehensive view of demographics and insurance details, structured for clarity and ease of access.

3. Appointments

CSV Format ("," Separated): This file offers a comprehensive view of all future appointments details, structured for clarity and ease of access.

4. Documents (Scanned Documents like PDF, JPG, PNG File Formats)

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

Organizational Structure:

All these documents are sorted and indexed within the respective patient chart number folders. If there are specific categories or types for these documents (e.g., Lab Reports, Radiology, Scanned Receipts, etc.), they will reside in their respective category subfolder within the primary patient folder.

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