Purpose

EHI export promotes access, exchange, and use of health information to facilitate electronic access to single patient and patient population health information in cases such as a patient requesting their information, or a health care provider switching health IT systems.

How to Use this File

This document outlines the requirements and steps for opening and viewing the exported CCDA file(s).

Accessing a single patient export CCDA file

When the CCDA download export is initiated, the file will be downloaded directly to your system's configured folder. The file will be stored as an XML file, which can be opened in a browser or Excel. When opening in Excel, select "open as an XML" when prompted, and Excel will generate the appropriate schema.

Accessing the exported CCDA file(s)

In order to open your exported CCDA folder you will need to follow the steps below:

1. Locate the exported zip folder on your local device
2. Access the zipped folder containing the CCDA exports
3. Unzip the entire folder and extract all the files to your preferred file location
4. View the file(s) exported in the unzipped folder in the preferred file location selected in step 3.
5. Click on the patient's CCDA file to open the XML file

CCDA Format

The following section will be contained within your exported patient level CCDA if the data is available, if not that section will not have details.

- Header Section:
    - Document-level metadata, including information about the patient, document creation time, and the document's unique identifier.
- Allergies and Intolerances Section:

    - Information about the patient's allergies and intolerances.
- Problems Section:
    - Information about the patient's current and historical health problems or diagnoses.
- Medications Section:
    - Details about the medications the patient is currently taking or has taken in the past.
- Procedures Section:
    - Information about medical procedures or surgeries that the patient has undergone.
- Results Section:
    - Laboratory results and other diagnostic test results.
- Vital Signs Section:
    - Information about the patient's vital signs, such as heart rate, blood pressure, temperature, etc.
- Social History Section:
    - Patient's social history, including details about lifestyle, occupation, and other relevant factors.
- Family History Section:
    - Information about the health history of the patient's family members.
- Immunizations Section:
    - Details about the patient's immunization history.
- Encounters Section:
    - Information about healthcare encounters, including visits to healthcare providers.
- Plan of Care Section:
    - Information about the care plan, including goals and instructions for the patient's care.
- Functional and Cognitive Status Section:
    - Details about the patient's functional and cognitive status.
- Advance Directives Section:
    - Information about any advance directives or healthcare preferences expressed by the patient.
- Medical Equipment Section:
    - Details about any medical equipment used or prescribed for the patient.