NextServices, Inc.

enki EHR

170.315(b)(10) Electronic Health Information Export

Version 1

Date: 11/21/2023

Usage: This guide is intended to be used by enki EHR users for understanding the content of date exported from the "EHI Export" module in accordance with certification criteria 170.315(b)(10) Electronic Health Information Export. The material in this guide may not be reused or reproduced for any purpose other than its intended use.

170.315(b)(10) Electronic Health Information Export: Enables users to create an export file(s) with all or a single patient's electronic health information.

Overview:

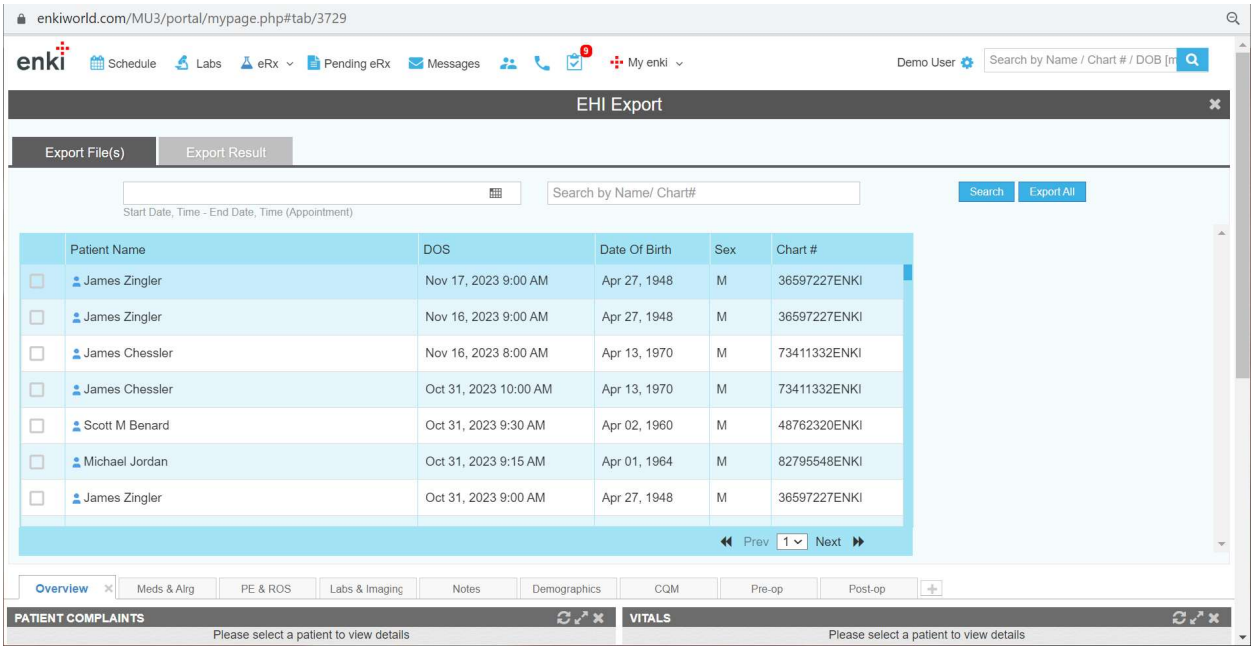
This document describes the EHR (Electronic Health Record) module developed in accordance with the ONC guidelines for health information export, as outlined at https://www.healthit.gov/test-method/electronic-health-information-export. The module is designed to facilitate the efficient and standardized export of patient health information.

The exported data is readily accessible and can be integrated into various healthcare systems for analysis, reporting, and continued patient care.

The module strictly adheres to ONC guidelines, ensuring that the export process is compliant with current healthcare information standards.

EHI Export module in enki:

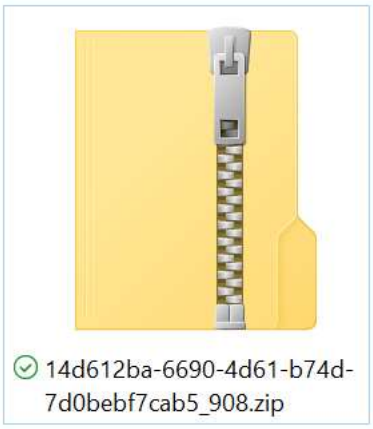
To access the export module in enki, navigate to “EHI Export” option under “My enki”



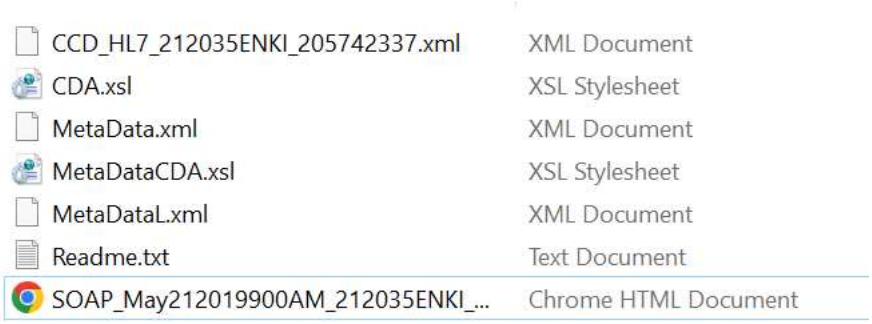
Users can export single/multiple/all patient medical information based on controls and filters available in the module. Users can identify a set of patients based on start/end date and time of the appointment or by locating a specific patient based on patient’s name or chart number (patient unique identifier).

Exported Data Format:

Each export can be downloaded as a bundle of record(s) as a single compressed (zip) file from the **Export Result** tab of the **EHI Export** module.



The exported bundle (patient record zip) contains a set of files as shown in the below image.



Exported file details:

The module exports patient data in a structured format, encapsulated in three distinct files along with additional metadata files and stylesheets.

1. Readme.txt File:

Purpose: This file serves as a guide to the exported data, providing essential information for users to understand and utilize the data correctly.

Contents: It contains a hyperlink directing users to the documentation that details the format and structure of the exported data. This is critical for ensuring proper interpretation and use of the data.

2. C-CDA File:

Format: HL7 Clinical Document Architecture (CDA). The specifications of the C-CDA R2.1 format can be found at https://www.hl7.org/ccdasearch/ or https://hl7-c-cda-examples.herokuapp.com/sections

Purpose: This file contains patient data formatted in HL7 C-CDA (Consolidated CDA) standard, ensuring interoperability and consistency in data representation.

Contents: It includes comprehensive patient information such as demographics, clinical notes, medications, lab results, and other relevant health data.

Compliance: The exported C-CDA complies with USCDI Version 1 requirements which can be found at https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi

3. Clinical (SOAP) Notes:

Format: PDF (Portable Document Format).

Purpose: The inclusion of clinical (SOAP) notes provides detailed insights into each patient's medical history and treatment plans.

Contents: These notes are a critical component of patient records, offering healthcare providers a concise and organized view of patient interactions and care plans.

Each section of the note is described below:

Patient Information: This section typically includes details such as the patient's name, chart number, date of birth, race, ethnicity, preferred language, and other demographic information. It helps healthcare providers identify the patient and understand important contextual factors that may impact their healthcare.

Referral and Doctor Information: This section lists the healthcare providers involved in the patient's care, including the referring doctor, the attending physician, and other consultants. It may also include information about who saw the patient and who is responsible for the care plan.

History of Present Illness (HPI): This is a detailed narrative description of the patient's current complaint or symptoms. The HPI includes the onset, duration, intensity, frequency, quality, and factors that aggravate or relieve the symptoms. It is crucial for understanding the patient's current health issue.

Vitals: Documentation of vital signs like blood pressure, heart rate, temperature, height, weight, and respiratory rate.

Billing & Coding: This area includes codes for insurance billing purposes. It typically contains ICD (International Classification of Diseases) codes for diagnoses and CPT (Current Procedural Terminology) codes for any procedures performed.

Active Medication List: Lists all medications the patient is currently taking, including prescription drugs, over-the-counter medicines, and supplements. This information is essential for monitoring drug interactions and understanding the patient's treatment regimen.

Problem List: This section is a compilation of the patient's ongoing and past health issues. It is an organized inventory of illnesses, injuries, and other factors affecting the patient's health. This section is crucial for tracking the patient's health status over time.

Chief Complaint(s): This subsection records the primary reason(s) the patient is seeking medical attention. It is usually a brief statement or two summarizing the patient's main concerns or symptoms.

History (Hx): This part provides a detailed account of the patient's medical, surgical, family, smoking and social history. It includes past medical conditions, treatments, hospitalizations, allergies, family health history, lifestyle factors, and other relevant historical information.

Diagnosis: The healthcare provider's determination of the patient's condition, based on the assessment. This section includes specific medical terms or ICD codes representing the patient's health issues.

Care Plan: Details the planned treatment or management strategies for the patient. This may include medications, therapies, lifestyle changes, follow-up appointments, and referrals to specialists.

SOAP Note:

Subjective: The patient's description of their symptoms or concerns. This is what the patient reports about their condition.

Objective: Objective findings from the healthcare provider's examination, including vital signs, physical exam findings, lab results, and imaging studies.

Assessment: The healthcare provider's interpretation of the subjective and objective findings, leading to a diagnosis or a differential diagnosis.

Plan: The proposed treatment plan based on the assessment. This includes medications, procedures, lifestyle advice, and follow-up plans.

Functional Status: Information about the patient’s ability to perform daily activities and their level of independence. This can include mobility, cognitive function, and other activities of daily living.

Cognitive Status: An assessment of the patient's mental functions, including memory, orientation, and problem-solving abilities.

Physical Exam: Breast, Cardiovascular, Constitutional, Ear, Extremities, Eyes, Gastrointestinal, Head, Lymphatic, Mouth, Musculoskeletal, Neck, Nose, Psychiatric, Rectal, Respiratory, Skin, Integumentary, Abdomen, Genitourinary, Others: These are all specific areas of focus during a physical examination, where the healthcare provider assesses each part for signs of disease or abnormality.

Review Of System: Allergic/Immunologic, Cardiovascular, Constitutional, EENMT (Eyes, Ears, Nose, Mouth, Throat), Endocrine, Gastrointestinal, Hematologic/Lymphatic, Integumentary, Musculoskeletal, Neurological, Psychiatric, Reproductive, Respiratory, Urological: This is a systematic approach to reviewing the patient's symptoms and signs across various bodily systems to identify any additional problems.

Immunizations: This section documents the patient's immunization history. It includes details of vaccines received, dates of immunization, and any reactions to vaccines. This information is crucial for preventive healthcare and is often required for school, employment, and certain travel purposes.

Procedures: Here, any medical or surgical procedures the patient has undergone are recorded. This includes the type of procedure, the date it was performed, the outcome, and any relevant details about the procedure. This information helps in understanding the patient's medical history and in planning future care.

Reason for Referral: This section explains why the patient was referred to a specialist or for a specific service. It provides context for the current healthcare visit and helps the receiving healthcare provider understand what specific issues or concerns need to be addressed.

Disclaimer: This section often states that the document was generated with certain technology (like voice recognition) and advises on the potential for errors.

Support Information:

Our dedicated support team is here to help you with any assistance, queries, or feedback regarding enki EHI Export module. You can reach us through the following channels:

Email ID: support@nextservices.com