EHR Your Way has the capability of exporting Electronic health information as CCDA and PDF documents.

Practice administrator can give access to the list of users to generate Electronic health information as CCDA and PDF documents. The standards used to generate the Patient Electronic health information are based on the HL7 Implementation Guide for CDA release 2: Consolidate CDA Template for Clinical Notes, Draft Standard for Trial use, Release 2.1. EHR Your Way will generate the complete Electronic health information as CCDA and PDF (computable).

Single Patient Data Export:

User can select quantity of data required by selecting the date range, sections required for the clinical data and attachments or documents which include all electronic health information.

Step 1: Open Chart → Navigate to Chart Left folders – CCDA → Data Export

Step 2: Select Date range and sections required to generate CCDA. User can navigate to Attachments and select required documents to export them in PDF format. These PDF includes all scanned clinical and administrative documents for the patients. User has ability to select which document must be exported along with CCDA.

Step 3: click export button and select the path on the computer to save the data.

The exported zip file will have the CCDA readable format, xml and other clinical data as PDF documents.
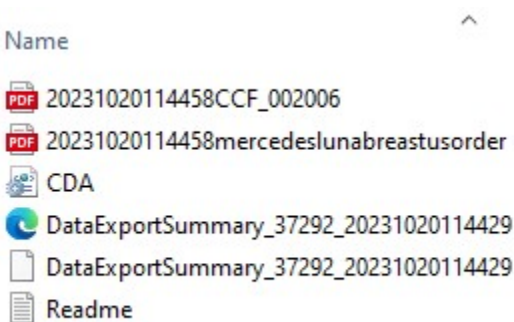
Bulk Export:

The user who has ability to perform Data export of EHI will have the folder on the Dashboard as "Data Export". User can choose the list of patients for whom Data export to be performed and select the path to save the data. This export will have the CCDA readable format, xml and PDF documents zip files by patient.

Below screenshot will help understand how to Select the patients and generate the CCDA.

Multiple Patient Data Export:

Dashboard→Generate Clinical Message (CCDA) for Multiple Patients

Step1: Click on CCDA from dashboard left folders.
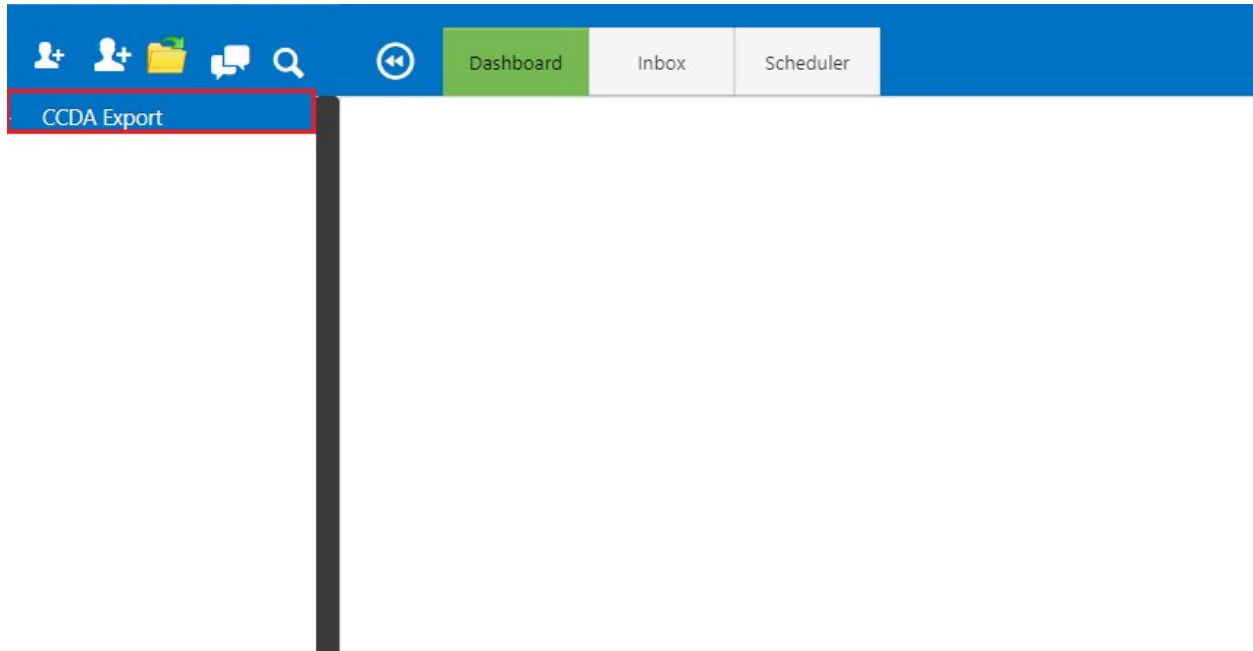
Step 2: Select "Data Export" from the drop down.

Step 3: Select Date range, Provider and click on "Go" button.

Step 4: Select the patients and click on Move icon.

Generate Clinical Message (CCDA) for Multiple Patients

| Data Export ▾ | 09/01/2023 🗓 | 10/11/2023 🗓 | Kumara Prathipati, ... ▾ |
| Show All Appts of Patient ▾ | Search Patient Name | | DOB 🗓 | Go |

Appt. Date	Patient Name	Gender	DOB	➡
09/06/2023 09:00 AM		Female	03/01/1944	➡
09/23/2023 08:30 AM		Female	05/12/1955	➡
09/25/2023 09:45 AM		Female	05/12/1955	➡
09/29/2023 10:15 AM		Female	05/12/1955	➡
10/07/2023 08:00 AM		Female	05/12/1955	➡
09/27/2023 11:00 AM		Female	06/27/1980	➡
09/19/2023 01:00 PM		Male	11/02/1978	➡

Step 5: Multiple patients will be moved successfully to right side.

Step 6: Click on "Next" button.

Step 7: Clinical messages will be generated shortly.

Step 8: Clinical Messages will be generated successfully for multiple patients and this export gives all selected patient CCDA readable formats, xml and pdf documents.

Step 9: Click on "Save & Export File(s)" button.

CCDA Format:

The CCDA format is build basedon the standards mentioned in the HL7 Implementation Guide for CDA® Release 2:Consolidated CDA Templates for Clinical Notes (US Realm) Draft Standard for Trial Use Release 2.1 Draft Standard for Trial Use August 2015. Section wise Data templates and Xpath are mentioned in the below table.

Section Name	Data Element	Entry/xpath	Code System
Demographics	Patient Name	patient/name	NA
	Date of Birth	patient/birthTime	2.16.840.1.113883.5.1
	Race	patient/raceCode	2.16.840.1.113883.6.238
	Ethnicity	patient/ethnicGroupCode	2.16.840.1.113883.6.238

	Sex	patient/adminstrativeGenderCode	
	Preferred Language	patient/languageCommunication/languageCode	
	AuthorInformation	author/time	
		author/assignedAuthor/assignedPerson/name	
	custodian	custodian/assignedCustodian/representedCustodianOrganization/name	
		custodian/assignedCustodian/representedCustodianOrganization/addr	
	Encompassing encounter	componentOf/encompassingEncounter/effectiveTime	
		componentOf/encompassingEncounter/encounterParticipant	
		componentOf/encompassingEncounter/location	
Reason for Visit	Reason for Visit	component/text	
Encounter	EncounterCode	Entry template id: 2.16.840.1.113883.10.20.22.4.49: 2015-08-01	2.16.840.1.113883.6.12
	Encounter Diagnosis	entryRelationship template id: 2.16.840.1.113883.10.20.22.4.4:2015-08-01	SNOMED : 2.16.840.1.113883.6.96

			and ICD 10: 2.16.840.1.113883.6.3
Medication Allergies	Allergies Section	2.16.840.1.113883.10.20.22.2.6.1:2015-08-01	
	Entry	Entry: 2.16.840.1.113883.10.20.22.4.30: 2015-08-01	
	Substance	2.16.840.1.113883.10.2 0.22.4.30: 2015-08-01	Rx Norm: 2.16.840.1.113883.6.88
	Reaction		SNOMED: 2.16.840.1.113883.6.96
	Severity		SNOMED: 2.16.840.1.113883.6.96
	Status		SNOMED: 2.16.840.1.113883.6.96
Medication Information	Medication Section	2.16.840.1.113883.10.20.22.2.1.1: 2014-06-09	
	Consumable	component/section/entry/substanceAdministration /consumable	Rx Norm: 2.16.840.1.113883.6.88
Problem or Conditions	Problems Section	2.16.840.1.113883.10.20.22.2.5.1:2015-08-01	SNOMED: 2.16.840.1.113883.6.96 Transalation: ICD 10: 2.16.840.1.113883.6.3
	Problem	component/section/entry/act/entryRelationship/o bservation/Value	

Social History	Social History Section	2.16.840.1.113883.10.20.22.2.17: 2015-08-01	
	Observation	2.16.840.1.113883.10.20.22.4.78: 2014-06-09	LOINC: 2.16.840.1.113883.6.1
	Value		SNOMED: 2.16.840.1.113883.6.96
Vitals	Vitals Section	2.16.840.1.113883.10.20.22.2.4.1: 2015-08-01	
	Observation	2.16.840.1.113883.10.20.22.4.26: 2015-08-01	SNOMED: 2.16.840.1.113883.6.96
			LOINC: 2.16.840.1.113883.6.1
Immunizations	Immunizations Section	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	CVX: 2.16.840.1.113883.12.292
	Route		National Cancer Institute (NCI) Thesaurus: 2.16.840.1.113883.3.26.1.1
	Dose		
Procedures	Procedures Section	2.16.840.1.113883.10.20.22.2.7.1: 2014-06-09	
	Observation	2.16.840.1.113883.10.20.22.4.13: 2014-06-09	SNOMED: 2.16.840.1.113883.6.96
Plan of Treatment	Plan of Treatment Section	2.16.840.1.113883.10.20.22.2.10: 2014-06-09	
	Observation	2.16.840.1.113883.10.20.22.4.44: 2014-06-09	LOINC: 2.16.840.1.113883.6.1

Functional Status	Functional Status Section	2.16.840.1.113883.10.20.22.2.14: 2014-06-09	
	Observation	2.16.840.1.113883.10.20.22.4.67: 2014-06-09	
Mental Status	Mental Status Section	2.16.840.1.113883.10.20.22.2.56: 2015-08-01	
	Observation	2.16.840.1.113883.10.20.22.4.74: 2015-08-01	
Medical Equipmen t	Medical Equipment Section	2.16.840.1.113883.10.20.22.2.23: 2014-06-09	
	Observation	2.16.840.1.113883.10.20.22.4.14: 2014-06-09	SNOMED: 2.16.840.1.113883. 6.96
Goals	Goals Section	2.16.840.1.113883.10.20.22.2.60	
	Goal	2.16.840.1.113883.10.20.22.4.121	
Health Concerns	Health Concerns Section	2.16.840.1.113883.10.20.22.2.58: 2015-08-01	
	Observation	2.16.840.1.113883.10.20.22.4.132: 2015-08-01	SNOMED: 2.16.840.1.113883. 6.96
Care Team	Care Team Section	2.16.840.1.113883.10.20.22.2.500: 2022-06-01	
History and Physical Exam Note	History and Physical Exam Notes Section	2.16.840.1.113883.10.20.22.2.65: 2016-11-01	
	Notes	2.16.840.1.113883.10.20.22.4.202: 2016-11-01	LOINC: 34117-2

Progress Notes	Progress Notes Section	2.16.840.1.113883.10.20.22.2.65: 2016-11-01	
	Notes	2.16.840.1.113883.10.20.22.4.202: 2016-11-01	LOINC: 11506-3
Procedure Notes	Procedure Notes Section	2.16.840.1.113883.10.20.22.2.65: 2016-11-01	
	Notes	2.16.840.1.113883.10.20.22.4.202: 2016-11-01	LOINC: 28570-0
Consultation Notes	Consultation Notes Section	2.16.840.1.113883.10.20.22.2.65: 2016-11-01	
	Notes	2.16.840.1.113883.10.20.22.4.202: 2016-11-01	LOINC: 11488-4
Discharge Summary	Discharge Summary Section Notes	2.16.840.1.113883.10.20.22.2.65: 2016-11-01 2.16.840.1.113883.10.20.22.4.202: 2016-11-01	LOINC: 18842-5
Imaging Narrative	Imaging Narrative Section Notes	2.16.840.1.113883.10.20.22.2.65: 2016-11-01 2.16.840.1.113883.10.20.22.4.202: 2016-11-01	LOINC: 18748-4
Pathology Report Narrative	Pathology Report Narrative Notes	2.16.840.1.113883.10.20.22.2.65: 2016-11-01 2.16.840.1.113883.10.20.22.4.202: 2016-11-01	LOINC: 60570-9

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