ELECTRONIC HEALTH INFORMATION (EHI) EXPORT (§170.315(B)(10)

This document describes the Electronic Health Information (EHI) Export capability in ScriptSure Cloud eRx. The exports allow users to create a zip file of an individual patient, or all patients contained in the practice. This page describes the types of exports that are available, the format of the exports, and additional details that are specific to its structures.

WHAT IS EHI?

EHI is electronic protected health information (ePHI) to the extent that it would be included in a designated record set (DRS) (other than psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding), regardless of whether the group of records is used or maintained by or for a HIPAA covered entity.

EHI EXPORT USE CASES

1. **Practice export** enables export of all patient data belonging to a practice. This export can be used when transferring to another vendor, or to replicate data for an existing application. The bulk export requires that the DAW Systems, Inc. technical staff transfer the data to the client once the export is completed. This is due to large amount of data that these exports can contain; often they require a long time to run and are very large.
2. **Single patient export** is useful when patients request their health information for personal reasons, or to share with another prescriber. This export is downloaded to the browser at the time of the request.

Note: All export data is considered Protected Health Information (PHI) and requires that all guidelines be used to ensure that the information is encrypted and stored appropriately after download.

EHI EXPORTS TYPE

ScriptSure offers comprehensive and structured data in the C-CDA format.

The following list of patient documentation will be exported in this format:

1. Patient Demographics
2. Practice Demographics
3. Allergy Information
4. Medication History Information
5. Diagnosis / Problem Information
6. Encounter Information
7. Vitals Information
8. Subjective Information

Note: The **SOAP note** (an acronym for **subjective**, **objective**, **assessment**, and **plan**) is a method of documentation employed by healthcare providers to write out notes in a patient's chart, along with other common formats. Documenting patient encounters in the medical records is an integral part of practice workflow starting with appointment scheduling, patient check-in and exam, documentation of notes, check-out, and rescheduling. Additionally, it serves as a general cognitive framework for physicians to follow as they assess their patients. Unfortunately, the C-CDA does not have a dedicated section that is used to communicate the notes to an

external system or individual. As a result, the SOAP notes have been included in the Subjective section of the C-CDA document.

Each SOAP note will appear with a Date, User and Doctor Name in the header of the note. Additionally, each section of the note (i.e. Chief Complaint, Subjective, Objective, Assessment and Plan) are included under the header. The user may opt to include the patients Current Medications, Allergies, Orders and additional Addendums to the note at the end of the traditional SOAP narrative.

EHI EXPORTS FILE

The export will be a zip file that contains a directory with the name ***ccda***. Under the directory there will be an individual C-CDA document for each patient. The naming convention for those documents is the ScriptSure Patient Identification number followed by the file extension of **.xml.**