# Determining if Continuity of Care Documents are Part of the Health Record

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Continuity of care is front and center in healthcare today as a mechanism for reducing costs and improving patient care. The ability for information to seamlessly flow from one care setting to another is a critical component to the success of healthcare. The new standard in healthcare is that the right health information is accessible, at the right place, by the right person, at the right time. The continuity of care document (CCD) holds the promise of capturing, abstracting, and moving important key documentation elements to the next point of care.

Since the creation of the CCD depends upon the ability of abstracting data from various systems, the chart completion process has never been more important. Confirmation that the data has satisfied all health information management principles for completion before it is repurposed is paramount. The ability to track the data being parsed will only increase in importance, especially from an information governance and accounting of disclosures perspective. Data being repurposed as well as received from an outside organization for treatment must be considered and defined in the designated record set and consistently upheld throughout all scenarios.

## Defining the CCD and Why It's Important

The CCD is a summary created from existing clinical information in an electronic health record (EHR) and is based on Health Level Seven (HL7) and ASTM standards. The primary use is to provide a representation of the patient's documentation at one particular point in time. The CCD contains a summary of data elements from a core data set, covering one or more encounters, consisting of the most relevant administrative, demographic, and clinical information about a patient's healthcare.

The CCD provides the following benefits to providers:

- Allows physicians to send electronic health information to other providers without loss of meaning
- Provides a "snapshot in time," containing a summary of the pertinent clinical, demographic, and administrative data for a specific patient
- Supports the ability to represent professional society recommendations, national clinical practice guidelines, standardized data sets, etc.[1]

CCDs provide a standard way to share this picture of a patient's treatment. CCDs are especially useful for referrals, transfers, and emergency room visits. However, it is important to note this is not a complete health record. Certified EHR vendors must ensure their systems have the capability of generating a CCD and allow EHRs to utilize the CCD format to display critical clinical information from other providers. Currently in health information exchanges (HIEs) this is the most common format in which healthcare information is shared.

## Managing CCDs' Sensitive Information

Organizations will need a process to ensure that the CCD does not contain sensitive information that the patient did not approve to share. Based on state and federal laws, there are data elements that need to be protected from routine release without a specific authorization from the patient.

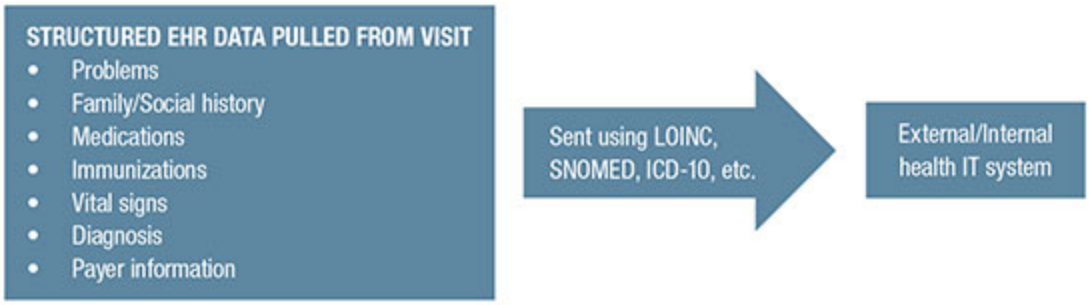
There are ongoing federal efforts to address segmenting sensitive data elements. The goal of one federal effort, the S&I Framework Initiative: Data Segmentation for Privacy (DS4P), is to "enable the implementation and management of varying disclosure policies in an electronic health information exchange environment in an interoperable manner."[2] Six pilot projects

are currently working in a real-world environment. These projects, run by the Office of the National Coordinator for Health IT's (ONC's) Office of Standards and Interoperability, are: VA/SAMSHA, SATVA, Netsmart, Jericho/UT Austin, GNDHIE, and Teradact.

In addition, sensitive information that is received will need to be marked as such so that it is not re-disclosed without specific authorization. Some EHR systems allow the user to identify those sections to include in a CCD, but the result of excluding the sensitive information may be a nearly empty CCD. For example, lab results and medications can indirectly reveal a sensitive condition. Excluding those two sections from the CCD would eliminate much useful information. Some patients who want all their health information protected may not be good candidates for the CCD.

### What Information Does the CCD Cover?

The CCD is a structured template based on HL7 language that includes elements that communicate demographic and clinical data. There are different templates that can be defined for medication, problem lists, advance directives, etc.




## Is the CCD Part of the Legal Health Record?

When is the CCD a part of the legal health record? Organizations will need to define when and if a CCD is considered part of the legal health record. The CCD abstracts data from areas that should already be defined in the organization's legal health record and designated record set. Since this is an abstract of data elements derived from existing data, organizations may consider excluding the CCD from the legal health record.

However, the organization will need the ability to track the data elements that were abstracted for the CCD and track where it was sent. This is important for evidentiary purposes. Organizations may want to keep a copy of exactly what was sent to have that snapshot for accounting of disclosures purposes.

Conversely, if you received a CCD from another healthcare entity and it is used for treatment, organizations will want to define the CCD in the desginated record set. Organizations will need to determine if this will also be defined in the legal health record. Organizations should define this in a way that is consistent with how they have defined outside records that come into their electronic systems and are then used for treatment.

The CCD is an important way to transport documentation to enhance overall continuity of care. Organizations should evaluate the various parts of the CCD to ensure these are defined in the legal health record.

## Notes

1. Health Level Seven International. "HL7/ASTM Implementation Guide for CDAA R2–Continuity of Care Document (CCDA) Release 1." http://www.hl7.org/implement/standards/product_brief.cfm?product_id=6.
2. S&I Framework. "Data Segmentation for Privacy Charter and Members." http://wiki.siframework.org/Data+Segmentation+for+Privacy+Charter+and+Members.

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