



CCD® Integrated Continuity Of Care and Personal Health Records Bank

The Continuity of Care Document (CCD) is an electronic document exchange standard for sharing patient summary information. Summaries include the most commonly needed pertinent information about current and past health status in a form that can be shared by all computer applications, including web browsers, electronic medical record (EMR) and electronic health record (EHR) software systems. *CCD Interoperability is the ability for computer systems to exchange information and be able to use that information.*

CCD will allow **patient health data** to be easily transported from one platform to another, intact and with integrity, so that better decisions can positively impact care, health, and the costs of achieving them.

In addition, CCD act as **CDA (Clinical Document Architecture)** stores or moves clinical documents between medical systems. Documents are things like discharge summaries, progress notes, history and physical reports, prior lab results, etc. The CDA uses XML for encoding of the documents and breaks down the document in generic, unnamed, and non-template sections.

The Continuity of Care Document meets ASTM International and Health Level 7 (HL7). The specific content and scope of the Continuity of Care Document was determined by another specification, ASTM's Continuity of Care Record (CCR), an XML-based specification for patient summary data.

The CCR is intended to provide consulting physicians with the information necessary to participate in a patient's care.

Upon patient request, patient discharge, referral or transfer, produce a Continuity of Care Document (CCD) Serves as a minimum data set to supplement – not replace - the medical record

CCD improving quality of care, reducing risk and liability and helping to monitor protocol compliance. CCD is a key step in integrating the healthcare enterprise.

CCD Templates* include:

1. Problems	6. Advance directives	11. Vital signs
2. Procedures	7. Alerts	12. Functional stats
3. Family history	8. Medications	13. Results
4. Social history	9. Immunizations	14. Encounters
5. Payers	10. Medical equipment	15. Plan of care

Value Added to Hospital, emergency rooms and clinics

- Single-Click access to all problems, procedures, medications, alerts, and other data on your patients.
- Quick access to see if prescribed medications have been filled
- Interoperability and seamless information exchange
- Instant information about whether the patient is being treated by other physicians, and for what reasons
- Closely ties in with federal initiatives for interoperability

“Specializing In The Standardization Of Global Healthcare Management”