

### Introduction

The Continuity of Care Document (CCD) is built using HL7 Clinical Document Architecture (CDA) elements and contains data that is defined by the ASTM Continuity of Care Record (CCR). It is used to share summary information about the patient within the broader context of the personal health record.

The CCD was formed through a joint collaboration between Health Level 7 and ASTM International as a way to address the divide between those who have adopted HL7 CDA and those who have adopted ASTM CCR. It was endorsed by CCHIT as part of their EHR certification requirements in June 2008, and is predicted to drive the use of electronic exchange for clinical data.

CCD is compatible with any document or standard that uses RIM-based specifications, including new versions of HL7, new types of public safety reports, IHE specifications, HITSP specifications and CDISC. Because of its small fixed XML tag set, CCD can be universally rendered as HTML or PDF without requiring specialized communication efforts.

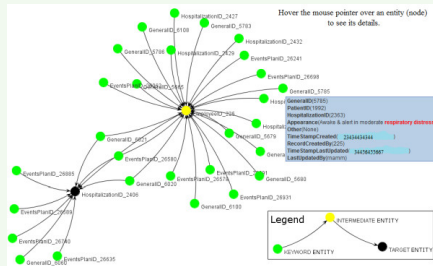
The CCD specification contains U.S. specific requirements; its use is therefore limited to the U.S. The U.S. Healthcare Information Technology Standards Panel has selected the CCD as one of its standards. CCDs are quickly becoming one of the most ubiquitous and thorough means of transferring health data on patients as each can contain vast amounts of data based on the standard format, in a relatively easy to use and portable file.

### CCD Templates

CCD uses a detailed set of constraints (or templates) for CDA elements. The templates define how to use CDA elements to communicate clinical data, but the scope of the data within the templates is determined by the CCR. CCD Templates include:

- Header
- Purpose
- Problems
- Procedures
- Family history
- Social history
- Payers
- Advance directives
- Alerts
- Medications
- Immunizations
- Medical equipment
- Vital signs
- Functional stats
- Results
- Encounters
- Plan of care

### CCDA XML



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Published 3rd February, 2016.

Last updated 10th May, 2016.

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