CDA CCD and C32 Descriptions

Clinical Document Architecture (CDA) is an HL7 document markup standard that specifies the structure and semantics of "clinical documents" for the purpose of exchange. CDA documents define their machine processable meaning from the HL7 Reference Information Model (RIM) and use the HL7 Version 3 Data Types. CDA is a flexible XML-based clinical document architecture. CDA itself is not a specific document, but can be used to express many types of documents.

A CDA document can contain many data sections, all of which contain narrative text, and some of which contain structured data elements, some of which are coded.

There are many types of CDA documents, including CCD, XDS-M, Discharge Summary (HITSP C48), History and Physical (HITSP C48), Lab Report (HITSP C37), etc.

Comparison of CCR/CCD and CDA Documents

This spreadsheet illustrates a range of content that may be in CDA documents. Many more CDA document types could be listed, e.g., Care Record Summary, Healthcare Associated Infection Reports, Personal Healthcare Monitoring Report, Operative Note, Antepartum Summary, Emergency Department Referral, Nursing Triage Note, and Immunization Summary. These are specified by HL7 or IHE and follow the same patterns. Many CDA document types are in recommendations from the HIT Standards Committee.

Continuity of Care Document (CCD) describes constraints on the HL7 Clinical Document Architecture. Release 2 (CCD) specifies interchange, in accordance with requirements set forth in ASTM E2369-95a Standard Specification for Continuity of Care Record (CCR). It is intended as an alternate implementation to the one specified in ASTM ADJE2369 for those institutions or organizations committed to implementation of the HL7 Clinical Document Architecture. The Continuity of Care Record (CCR) is a core data set of the most relevant administrative, demographic, and clinical information facts about a patient's healthcare, covering one or more healthcare encounters. It provides a means for one healthcare practitioner, system, or setting to aggregate all of the pertinent data about a patient and forward it to another practitioner, system, or setting to support the continuity of care.

CCD is just one type of CDA document. Other types of CDA documents can contain some of the same CCD sections, but different sections as well.

 HITSP CDA Content Modules (C83) describes a library of sections that can be combined into various CDA document types. In addition, a document type can include additional sections, even those not a part of it. So for example a CCD could add a Reason for Referal section added and still be a valid CCD. In addition, the sections in C83 can contain structured data, described as "Entry Content Modules" that are being assembled into a "HITSP Data Dictionary" that describes the data elements and the constraints (optionality, repetition, and value sets) for each data element.

 HITSP C32. The HITSP Summary Document Using HL7 Continuity of Care Document (CCD) Component describes the content component summarizing a consumer's medical status for the purpose of information exchange. The content may include administrative (e.g., registration, demographics, insurance, etc.) and clinical (problem list, medication list, allergies, test results, etc.) information. Any specific use of this Component by another HITSP specification may constrain the content further based upon the requirements and context of the document exchange. This specification defines content in order to promote interoperability between participating systems. Any given system creating or consuming the document may contain much more information than conveyed by this specification. Such systems may include Personal Health Records (PHRs), EHRs (Electronic Health Records), Practice Management Applications and other persons and systems as identified and permitted.