Patient Data Export

09/18/2024 9:00 am EDT

In the event you need to export the patient data from your DrChrono account, you will need to work with your account manager to complete the process. If you do not remember your account manager's contact information you can email accountmanager@drchrono.com.

This article will describe the steps involved, what data can be exported, and what data can not be exported.

Step-by-Step Process

1. Contact your Account Manager and let them know if you would like DrChrono to process your data export.
2. Your Account Manager will send over a contract addendum and any related fees will need to be collected.
3. Once the contract addendum is signed and your fees are collected, our data team will be notified to start the extraction process (the standard timeline is 4-8 weeks but may take longer depending upon the total amount of practice data and/or if there are any custom export requirements).
4. Once the process is complete, the shared point of contact will receive access to a secure Box.com account where the data is stored.
5. You will need to download the data from the Box.com account into your own secure Cloud or local storage. Your access to the Box folder will expire after sixty (60) days and the data will be deleted.

What data can be exported?

- Patients
  - Basic patient demographics, medications, allergies, problem list, clinical notes, documents, images
  - Includes patients in “Inactive” or “Deceased”, Insurance History, Patient Payments
- Appointments
  - Will include all data associated with the appointment, such as the clinical note, time, patient data, reason for visit, assigned provider, vitals, and associated ICD-10 codes
- Clinical Notes
  - Will include ALL clinical notes ever created (locked version only)
- Documents
- Lab Results (Manual Entry, Quest/LabCorp)
- Integration Lab Results (ex. HealthGorilla)
- Onpatient Messages (to/from patient, including attachments)
- Faxes and referrals connected to DrChrono's patient records
- CCDA Files

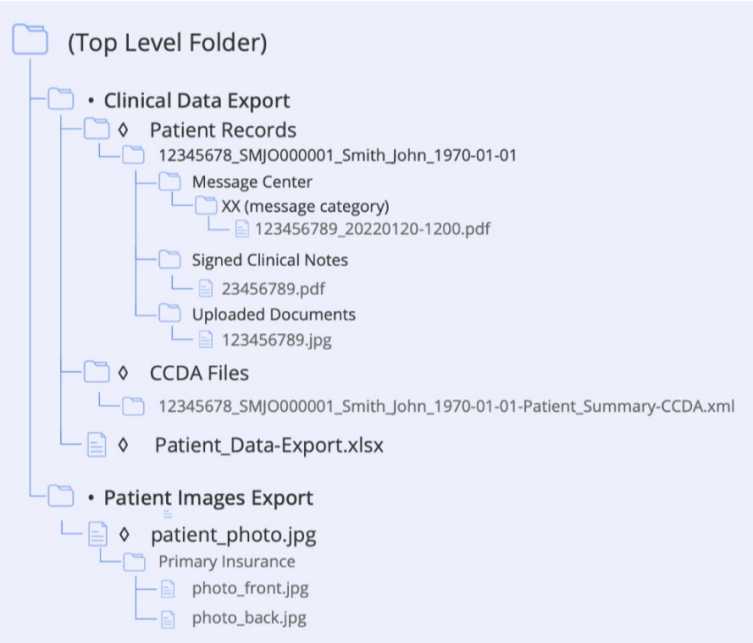
What can not be exported?

- Account settings
- Staff accounts and permissions
- Unlocked clinical notes
- Meaningful Use/CQM data
- Custom CDS rules
- OnPatient Check-In Form Settings
- Persistent OnPatient / Check-In Data

- Persistent Clinical Note Settings
- Copyable previous notes
- Signed patient consent forms
- Real-time insurance eligibility data
- Billing/Payment/Balance data
- Recurring appointment series
- Charge Codes (CPT, HCPCS, Custom codes, etc.)
- Patient credit card information
- Custom patient payment
- Patient groups
- Offices
- Authorizations
- Lab favorites
- Tasks
- Faxes (not connected to patient records)
- Inventory

Data Export Details

The data export will consist of the following data structure:



Format Details

1. **Clinical Data Export**: Contains extracted clinical data.
   - Patient Records: Contains one folder for each respective patient, labeled as {id}_{chart_id}_{lastname}_{firstname}_{dob}. Inside each of these folders exist these directories
     - Message Center: Containing one folder for each message center value/category found for the patient, and the corresponding files (categories shown below)
     - (See Below)

Value	Description
“GP”	Generated PDF
“GC”	Generated CSV
“GZ”	Generated ZIP
“IF”	Incoming Fax
“OF”	Outgoing Fax
“IL”	Incoming Labs
“IR”	Inbound Referrals
“OR”	Outbound Referrals
“IE”	Incoming eRx
“OA”	Online Appointments
“PO”	Patient Onboarding
“PI”	Patient Incoming Message
“PM”	Patient Outgoging Message
“OO”	Demo Meeting Message
“OD”	Outbound Direct Message
“ID”	Inbound Direct Message

        - Labeled as {message.id}_{message.received_at}.ext (where ext can be many extensions)
        - Signed Clinical Notes: Contains PDF notes, labeled as {appointment.id}.pdf; metadata for these files is referenced in the Signed Clinical Notes workbook of Patient_Data_Export.xlsx
        - Uploaded Documents: Contains all files (reflected individually) uploaded to Patient Documents, labeled as {document.id}.pdf
- CCDA Files: XML-based Consolidated Clinical Documentation Architecture (CCDA) summary files. There should exist one file for each unique patient.
- Patient_Data_Export.xlsx: A multi-worksheet Excel workbook file containing one sheet for each category of data provided in the export. (Important: Message Center Contents, Signed Clinical Notes, XML files, and uploaded documents have their metadata referenced here, depicting the file’s reflected patient, file date, absolute path to the file, and tags/categories. This allows users to easily locate and identify any file provided in the dataset.)

2. Patient Images Export

- Contains one directory for each patient, labeled as {id}_{chart_id}_{lastname}_ {firstname}_{dob} . Within each directory may exist the following:
    - patient_photo.jpg: The patient’s profile photo
    - Primary Insurance: (also Secondary and Tertiary) contains front/back insurance card images for each insurance priority, if available.
- patient_images_index.csv: A reference file for all images downloaded in the Patient Images Export directory, similar to Patient_Data_Export.xlsx detailed above.

The data detailed above is converted into a password-protected archive (.zip) file and shared with you via Box.

Data Point	Description	Extract Format
Signed (Locked) Clinical Notes	Pulls only the final locked copy *(Neither revisions, nor amendments are extractable at this time due to API limitations.)*	PDF*, referenced by Signed Clinical Notes workbook of Export XLSX Format: {appt.id}_ClinicalNote_{appt.scheduled_time}.pdf Example: 65478932_CinicalNote_20171002-1300.pdf
Documents	Any and all items uploaded to Patient Documents, downloaded in its original formatting.	Various file types* (such as MP4, PDF, PNG, TIF, JPG, etc) referenced by Uploaded Documents workbook of Export XLSX. Format: {doc.id}_{doc.date}.ext Example: 150857740_2017-11-28.pdf
CCDA/xml Summary File	One file per patient, containing detailed/ structured patient data such as: • Demographics • Encounter details (appointments, some notes) • Medications • Allergies • Problems • Vaccine Records • Lab Results (Integrations only)	
Lab Results	Legacy/non-integration lab results manually entered into a patient's record.	CSV/XLSX
Message Center Contents	Any and all message center items attached to patients, including but not limited to: • Inbound/Outbound Faxes • Inbound/Outbound Referrals • eRx Refill Requests • direct messages • generated files (such as reports run on a single patient) (Note: unattached message center items are not exported)	Various file types, referenced by Message Center Contents workbook of Export XLSX. Format: {msg.id}_{msg.datetime}.ext Example: 21859840_20171003-1544.pdf