Understanding C-CDA Export Data in DrChrono

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You can export patient data in C-CDA (Consolidated Clinical Document Architecture) format in bulk, and download or view it individually. The data is formatted in XML format and can also be viewed as a PDF when you export it individually.

Clinical notes will only appear in the CCDA file based on the form type selected for the form. Form types MUST be associated with a form for the clinical note generated text to appear in the CCDA file.

CCDA Version Settings | Viewing C-CDA Data | C-CDA Document Components

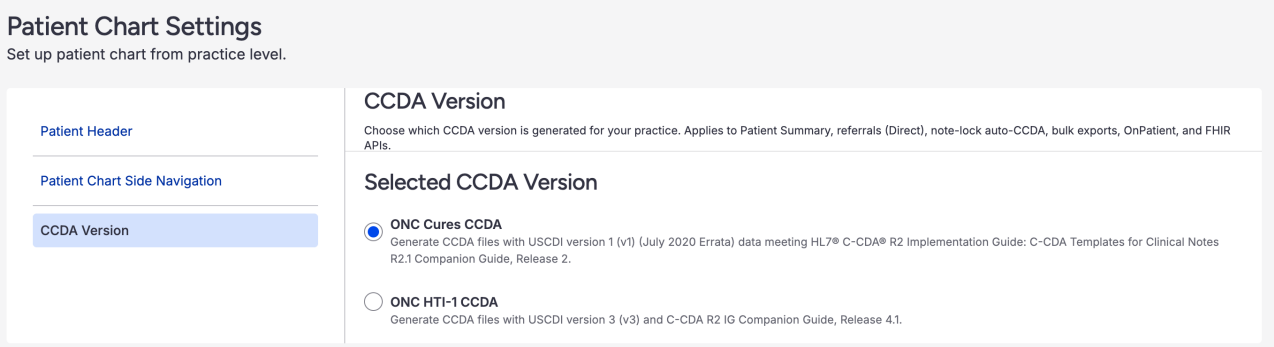
CCDA Version Settings

DrChrono now supports two CCDA versions that can be configured in your account settings:

- **ONC Cures CCDA** (Default): Generates CCDA files using the current format
- **ONC HTI-1 CCDA**: Generates CCDA files with USCDI v3 and HTI-1 ONC updates, including enhanced data elements for interoperability

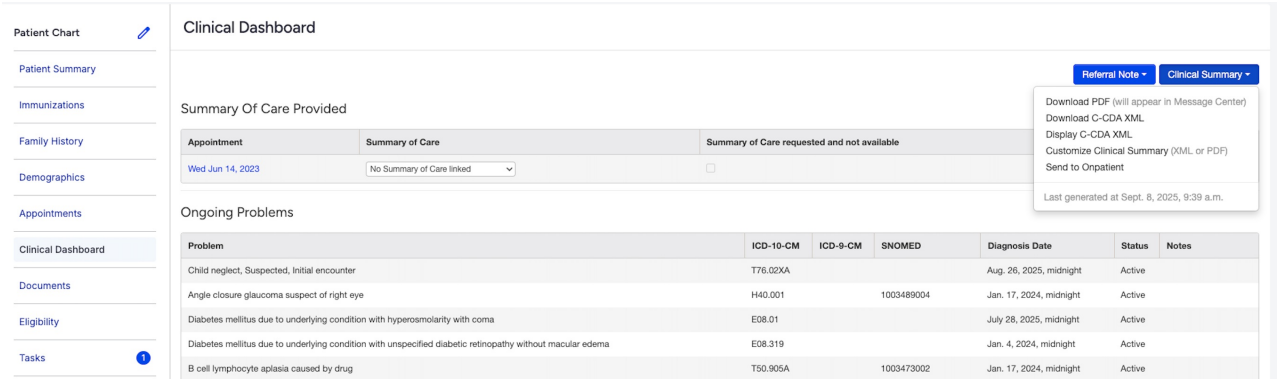
To change your CCDA version:

1. Navigate to **Account > Practice Settings > Patient Chart Settings**
2. Select **CCDA Version**
3. Choose your preferred version



Viewing C-CDA Data

There are two easy ways to view what is included in a C-CDA export from the patient's chart under the Clinical Dashboard section. You can select **Download PDF** or **Display C-CDA XML** from the Clinical Summary dropdown.



C-CDA Document Components

Patient Health Summary

Contains the demographic information of the patient as well as the provider, care team members (performer), and practice information. For more information on adding care team members, see our article **here**.

Patient Health Summary

Patient	Peter Abbott		
Patient Previous Name			
Date of birth	January 27, 1984	**Sex**	Male
Race	Unknown	**Ethnicity**	Not Hispanic or Latino
Contact info	Primary Home: 225 Schilling Circle ave Apt 345 Hunt Valley, MD 21031, US Tel (Primary Home): +1(443)-909-0636	**Previous Address**	address not available
Preferred Language	Other		
Patient IDs	105148754 2.16.840.1.113883.3.7621 443-64-5188 2.16.840.1.113883.4.1		
Document Created	December 4, 2025, 16:25:56, EST		
Care provision	from September 22, 2022, 11:13:30, EST to December 4, 2025, 16:25:56, EST		
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Document Header Information

The document header includes essential patient identification and administrative information:

Administrative Gender Code: Patient sex is expressed using SNOMED CT codes:

- Male (248153007)
- Female (248152002)
- Other/Unknown (184115007)

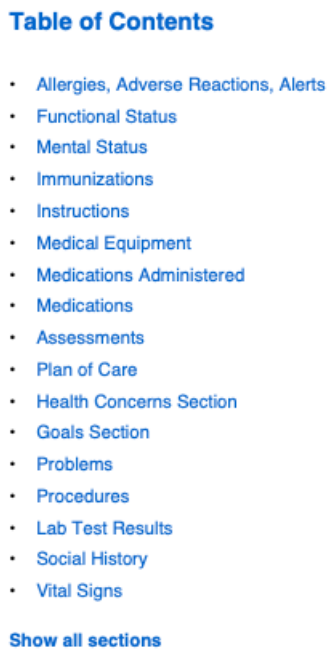
Language Communication: Patient's preferred language using ISO 639-2 alpha-3 codes (e.g., "eng" for English)

Provenance Information: Each clinical entry (problems, medications, allergies, procedures, immunizations, SDOH observations) includes author information showing:

- Author name (first and last)
- Author NPI
- Authoring date/time
- Represented organization name

Table of Contents

Table of Contents is a good way to see the data included in the C-CDA file. This information is pulled from the patient chart and clinical documentation. While in the PDF and Display C-CDA XML views, you can click on any section in the Table of Contents to jump to that section.



Clinical Data Sections

Allergies and Adverse Reactions

Allergies, Adverse Reactions, Alerts

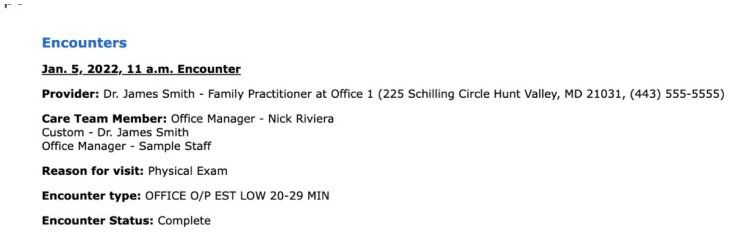
Type	Substance	Reaction	Status	Date	Severity
Drug Allergy (416098002)	Class of drugs: benzodiazepine (16047007)	Allergic headache	Active	12/21/2022	
Drug Allergy (416098002)	Class of drugs: sulfa drug (372788003)	Headache	Active	12/13/2022	
Drug Allergy (416098002)	penicillin (7984)	Hives	Active	11/03/2020	None
Drug Allergy (416098002)	d00170 aspirin (1191)	Hives	Active	11/03/2020	None
Drug Allergy (416098002)	penicillin (7984)	Hives	Active	11/03/2020	None
Drug Allergy (416098002)	d00170 aspirin (1191)	Hives	Active	11/03/2020	None
Drug Allergy (416098002)	d00118 sulfADIAZINE (10171)	None	Active	09/23/2022	
Drug Allergy (416098002)	penicillin (7984)	Hives	Active	10/13/2021	Was allergic since a child.
Drug Allergy (416098002)	Non-Drug Allergy: Cats ()	Shortness of breath/difficulty breathing	Active	10/13/2021	From allergy test.
Drug Allergy (416098002)	Non-Drug Allergy: Milk ()	Hives	Active	10/13/2021	
Drug Allergy (416098002)	d00170 aspirin (1191)	Hives	Active	10/13/2021	

Allergy data can be entered on the web in the patient's chart, in the clinical note, or through the iPad or iPhone EHR app.

Allergy Information Includes:

- Allergen/substance
- Reaction
- Severity (Mild, Moderate, Severe)
- Verification status (Unconfirmed, Confirmed, Refuted, Entered-in-error)
- Active or Inactive status

Encounters



Encounters

Jan. 5, 2022, 11 a.m. Encounter

Provider: Dr. James Smith - Family Practitioner at Office 1 (225 Schilling Circle Hunt Valley, MD 21031, (443) 555-5555)

Care Team Member: Office Manager - Nick Riviera
Custom - Dr. James Smith
Office Manager - Sample Staff

Reason for visit: Physical Exam

Encounter type: OFFICE O/P EST LOW 20-29 MIN

Encounter Status: Complete

The encounter data includes:

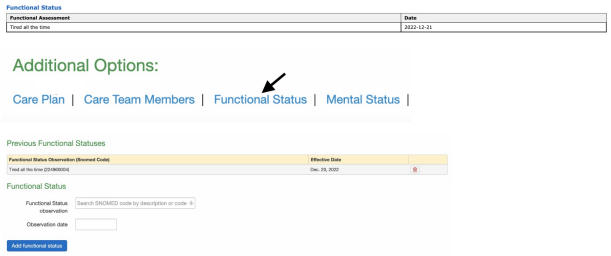
- Date of service and appointment time
- Location
- Provider
- Care team members
- Reason for visit
- Encounter type

The encounter data can be entered in various places in DrChrono on the web or EHR app.

Family History

Family History information can be entered into the patient's chart on the web. Navigate to Family History on the left-side menu. Select +Add Family Member. Once the family member is added, select +Add Observation to enter the data.

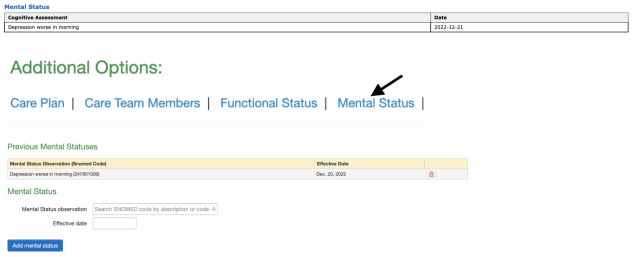
Functional Status



Functional status assessments can be entered in the patient's chart by scrolling down to the Functional Status section under the Clinical Dashboard tab.

Important: Functional status data uses SNOMED CT codes from the Problem List where Problem Type = Functional Status. This information appears in the Functional Status Section of the CCDA, not in the Problem List section.

Mental Status



Mental status assessments can be entered in the patient's chart by scrolling down to the Mental Status section under the Clinical Dashboard tab.

> Cognitive status data uses SNOMED CT codes from the Problem List where Problem Type = Cognitive Status. This information appears in the Mental Status Section of the CCDA, not in the Problem List section.

Immunizations

Immunization data can be entered into the patient's chart by navigating to the **Immunizations** tab on the left-side menu. For information on entering immunizations see our article here.

Instructions

Instructions information can be entered in the Clinical Dashboard of the patient chart. Scroll down to **Care Plan** under the Additional Options section. When entering the instruction details, select **Patient Clinical Instructions** from the Plan Type menu.

Medical Equipment

Medical Equipment information can be entered into the patient's chart on the web under the **Implantable Devices** section. Click **Add Implantable Device**, enter the device information, and **Save**.

Medications

Medication data can be entered in multiple areas and ways:

- Entered medication manually in the patient's chart or clinical note on the web or EHR app
- Data sync with SureScripts
- Reconciliation data with a C-CDA import
- Sending a prescription through the send eRx feature on the web or EHR app

Medications Administered

Medications Administered data can be entered on the web or EHR app by selecting **Administered During Visit** from the Order Status dropdown menu when entering or editing medication info.

Insurance Providers

The Insurance Providers section is populated by the primary and secondary insurance information in the patient's chart.

Insurance Information Includes:

- Insurance provider details
- **Coverage Type**: Insurance plan type (e.g., Medicare, Medicaid, Commercial)
- **Coverage Role Type**: Patient relationship to subscriber (e.g., Self, Spouse, Child, Other)

Both Coverage Type and Coverage Role Type are captured from the patient's Demographics > Insurance section.

Problems

Problem (ICD-10) data can be entered through various paths on both the web and EHR app versions of DrChrono. Some examples are:

- Patient's chart > Problem List
- Appointment window > Billing > ICD-10 Codes
- iPhone > Patient Menu > Problems
- iPad > Visit > Assessment or Billing Information

Problem Information Includes:

- Problem code (ICD-10)
- Problem description
- **Status**: Active, Recurrence, Relapse, Inactive, Remission, Resolved
- **Verification Status**: Unconfirmed, Provisional, Differential, Confirmed, Refuted, Entered-in-error
- Effective dates (start and end dates)

The following problem types are **NOT i**ncluded in the Problem List section of the CCDA:

- Functional Status (appears in Functional Status Section)
- Cognitive Status (appears in Mental Status Section)
- Pregnancy Status (appears in Social History Section)
- Smoking Status (appears in Social History Section)

Procedures

Similar to problems, procedure data (CPT and HCPCS codes) have various points of entry in DrChrono. Some examples include:

- Appointment window > Billing > CPT and/or HCPCS Codes
- Billing > Live Claims Feed > Date of Service > Line Item Transactions
- View Clinical Note > Billing
- iPad/iPhone EHR App > Visit > Billing > CPT and/or HCPCS

Codes for both Problems and Procedures can be entered manually or through billing profiles, the billing pick list, or by adding codes to your clinical forms.

Lab Tests and Results

Lab test data is entered by sending lab orders or entering the data manually. The data can be found in the patient's chart under **Lab Orders**.

Lab results can be found in the patient chart under **Lab Orders**. Data can be entered manually or through an integration with our lab partners.

Lab Result Information Includes:

- Test name (LOINC code)
- Result value
- Unit of measure
- Reference range
- Status
- Effective date/time

Clinical Tests and Results

Clinical test and result data can be captured using the Clinical Test & Result form element in Form Builder. This

data appears in the Results section of the CCDA.

Clinical Test Information Includes:

- Clinical Test Name (LOINC code)
- Clinical Test Result (numeric or text value)
- Date performed
- Customized notes

Assessments

Assessments section includes any information entered into the assessment section of the H&P or SOAP forms. This information can be entered on the web version or through the EHR app for iPad or iPhone.

Social History Section

Social History captures important social determinants of health and patient background information.

Smoking Status

Data Sources:

- Patient chart under Demographics > Smoking Status (most recent status)
- Active problems in Problem List that match Smoking Status Value Set codes
- Smoking-related SNOMED codes in the billing attachment section of forms

Only the most recent smoking status is included in the CCDA.

Birth Sex

Birth sex of the patient based on the Sex entered under the Demographics tab.

Pregnancy Status

Data Sources:

- Active problems in Problem List that match Pregnancy Value Set codes
- Pregnancy-related SNOMED codes in the billing attachment section of forms

Pregnancy status appears in the Social History section using the Pregnancy Observation template, not in the Problem List.

Tribal Affiliation

Patient's tribal affiliation can be captured using codes from the TribalEntityUS value set (579 options available).

Data Includes:

- Tribal entity code and name
- Effective date when tribal affiliation was observed

Occupation and Occupation Industry

Occupation Information Includes:

- Occupation name (SOC code)

- Occupation start date
- Occupation end date (optional)

Occupation Industry Information Includes:

- Industry name (NAICS code)
- Industry start date
- Industry end date (optional)

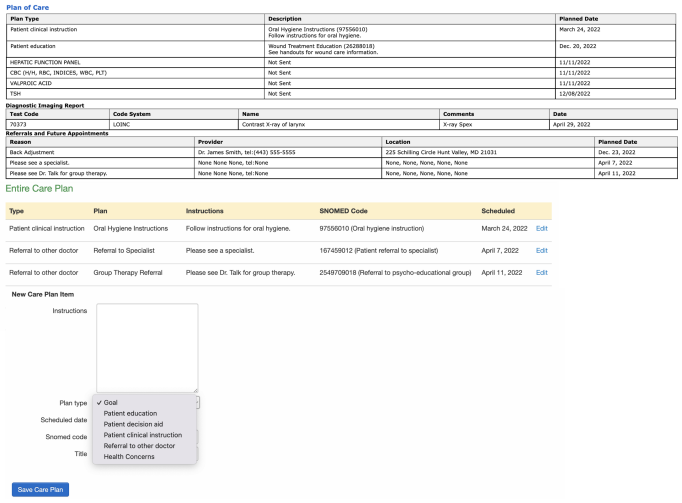
LOINC Assessments

Social Determinants of Health (SDOH) assessments using LOINC codes are included in the Social History section. These structured assessments capture:

- Assessment name (Parent LOINC code)
- Assessment date
- Questions (LOINC codes)
- Answers (coded responses)
- Scores per question (when applicable)

Plan of Care Section

Plan of care is populated by care plan data entered in the patient's chart by scrolling down to the**Care Plan** section under the Clinical Dashboard tab.



Care Plan

Care Plan Information Includes:

- Goal name and description
- Associated codes (SNOMED or LOINC)
- Target date
- Status (e.g., active, not started)
- Objectives (when applicable)
- Interventions and instructions
- Related problems

Planned Procedures

Planned procedures can be captured using the Planned Procedure form element in Form Builder.

Planned Procedure Information Includes:

- Procedure name and code (SNOMED CT or CPT)
- Planned date
- Status

Additional Plan of Care Components

The Plan of Care section also includes:

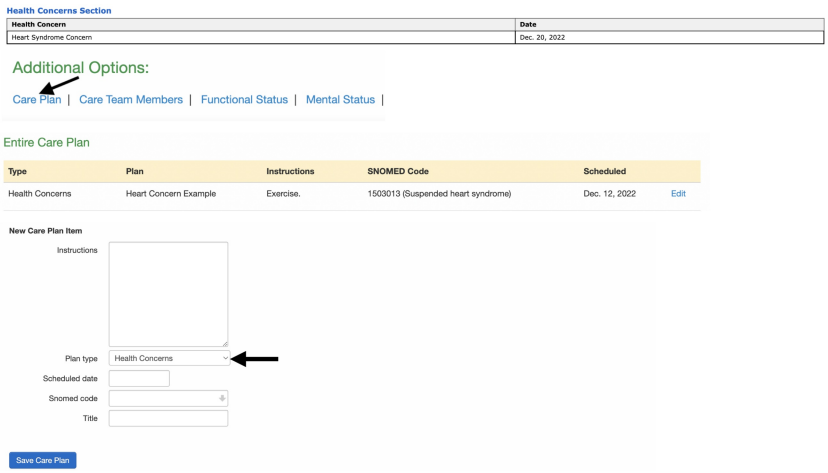
- Patient Education
- Patient Instructions
- Pending lab tests
- Diagnostic Imaging Reports
- Future Appointments
- Referrals

Diagnostic Imaging Reports

Diagnostic Imaging Report data can be entered in the patient's chart by selecting the**Imaging Orders** tab and **+ Add New Order** and entering the details. Imaging orders use LOINC codes to identify the type of imaging study.

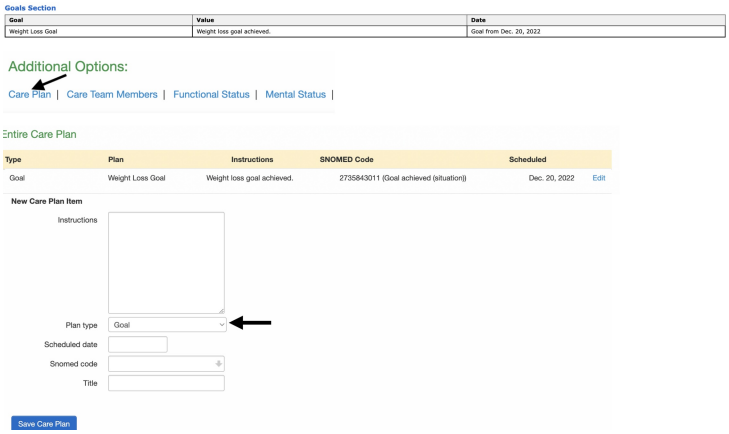
Health Concerns

Health Concerns data can be entered into the patient's chart by scrolling down to the**Care Plan** section under the Clinical Dashboard tab.



Goals

Goals data can be entered into the patient's chart by scrolling down to the**Care Plan** section under the Clinical Dashboard tab.



Care Team Section

Care Team information captures the collaborative care providers involved in the patient's treatment.

Care Team Member Information Includes:

- Member name (first and last)
- Care team role (e.g., Primary Care Physician, Specialist, Nurse)
- Care team identifier (NPI or other unique ID)
- Member status (Active, Inactive)
- Effective dates

Care team members can be added and managed through the patient's chart. For more information on adding care team members, see our article here.

Vital Signs

Vital Signs data can be entered in the appointment window, in the clinical note, or through the iPhone or iPad EHR app.

If pediatric vital percentiles are used, they will be included in the C-CDA.