EHI Export Documentation

Export Zip File Content:

Contains a Folder with the patient(s) name and record number with the following folder structure:

- PatientName PatientLastName – Record Number
- Readme
    - AuthorizationDocuments
    - PatientDocuments

File	Description
ReadMe.txt	Contains a weblink to this document.
CCD.XML	Consolidated-CDA documents formated as C-CDA R2.1: C-CDA Templates for Clinical Notes R2.1 Companion Guide, Release 2
PatientRecord.XML	Contains all the Electronic Heatlh Information of the patient that's not captured in a CCD document.
PatientFinancialData.XML	Contains all the financial information of the patient stored in our systems.

Accessing the Export Module

Users can access the Data Export functionality within the Evolution EHR through the designated export module. This module has been developed to manage the complexities of large-scale data exports, seamlessly accommodating the export needs for an individual patient, multiple patients, or the entire patient database within our system.

Applying Patient Data Filters

The export module, users have the ability to filter and select patient data based on several criteria:

- **Dates**: Filter by either Discharge Date or Admission Date to target specific patient records.
- **Patient Type**: Select patients based on their categorization within the system.
- **Patient Name and Last Name**: Search and select patients using their first and last names.
- **Patient Insurance**: Filter patients based on their insurance provider.

Data Visualization and Selection

Upon applying the filters, the queried data will be displayed in a user-friendly grid on the Evolution Export Module interface. This visualization allows users to:

- Inspect patient data visually.
- Select individual patients.
- Choose all patients displayed in the current query.

Note: Data visualization is not available when selecting the 'All Patients' export option.

4. Initiating the Export Process

After finalizing the selection of patients, the export process can be initiated. Evolution EHR will retrieve the relevant EHI, ensuring that the data aligns with the applied filters. The system will then proceed to compile and export the data, maintaining high standards of accuracy and security.

5. Securing and Retrieving Exported Data

The exported data for each patient will be stored in a secure folder, organized into individual ZIP files of each patient for ease of management. Users will be notified upon the completion of the export process and can then access the secured folder to retrieve the exported files.

PatientRecord.XML Dictionary

1. **Encoding and Declaration**: The document starts with an XML declaration specifying the encoding and version.
2. **Root Element**: The root element is **<PATIENT_RECORD>**, which contains all the patient-related information.
3. **Demographic Information (<DEMOGRAPHICINFO>) Section**:
    - The demographic information is logically divided into several sub-sections, each focusing on specific aspects of the patient's profile. These sub-sections ensure that detailed and categorized patient information is clearly organized and easily accessible. Below are the descriptions of the sub-sections and their respective fields:

Personal Information (<PERSONAL_INFORMATION>):
Contains core identifying details about the patient, such as name, date of birth, gender, and other demographic attributes.

Field Name	Description
RECORDNUMBER	The unique identifier for the patient record
PATNAME	Full name of the patient
BIRTHDATE	Date of birth of the patient
SEXATBIRTH	Sex assigned at birth
AGE	Age of the patient
SOCSECURITYNUM	Social security number
RACE	Patient's race (with a CODE attribute)
ETHNICITY	Patient's ethnicity (with a CODE attribute)
RELIGION	Patient's religion (with a CODE attribute)
SPOKENLANG	Spoken language (with a CODE attribute)
MARITALSTATUS	Marital status (with a CODE attribute)

Health Information (<HEALTH_INFORMATION>):
Captures key medical details, including the patient's blood type, height, weight, and lifestyle factors like smoking and alcohol use.

Field Name	Description
BLOODTYPE	Blood type of the patient
HEIGHT	Height of the patient
WEIGHT	Weight of the patient
HIPAAACKNOWLEDGE	HIPAA acknowledgment status
ALCOHOLFREQUENCY	Frequency of alcohol consumption
SMOKEFREQUENCY	Frequency of smoking (with a CODE attribute)

Encounter Information (<ENCOUNTER_INFORMATION>):
Stores information related to the patient's medical encounters, such as account number, admission details, admitting and attending doctors, diagnosis codes, and insurance information.

Field Name	Description
ACCOUNTNUMBER	Account number associated with the encounter
PATIENTTYPE	Type of patient (CATEGORY and CODE attributes)
ADMISSIONDATETIME	Date and time of admission
ADMITTINGDOCTOR	ID of the admitting doctor
ATTENDDOCTOR	ID of the attending doctor
PRIVACYREQUESTED	Privacy request status
VISITSALLOWED	Status on whether visits are allowed
ADMITDXDIAGNOSIS	Admitting diagnosis (with CODE attribute)
PRIMARYDXDIAGNOSIS	Primary diagnosis (with CODE attribute)
PROCEDURE	Code of the procedure performed
INSURANCEPLAN	Insurance plan details (ID, CODE, NAME attributes)
CONTRACTNUM	Contract number for the insurance
LASTLOCATION	Last location details (COSTCENTERNUM attribute)
ROOMBEDNO	Room and bed number
DISPOSITION	Disposition status (CODE and STANDARDCODE attributes)

Contact Information (<CONTACT_INFORMATION>):
Focuses on the patient's residential and postal addresses, phone numbers, and next of kin details, ensuring that communication-related data is readily available.

Subsection: PATIENT

Field Name	Description
RESIDENTIAL	Residential address of the patient
POSTAL	Postal address of the patient
PHONENUMBER	Phone number details (residential and mobile)

Subsection: NIE

Field Name	Description
NAME	Name of the next of kin (NIE)
RELATIONSHIP	Relationship to the patient (with CODE attribute)
PHONENUMBER	Mobile phone number of the next of kin

PatientInfo XML Format

```
<DEMOGRAPHICINFO>
        <PERSONAL_INFORMATION>
            <RECORDNUMBER/>
            <PATNAME/>
            <BIRTHDATE/>
            <SEXATBIRTH/>
            <AGE/>
            <SOCSECURITYNUM/>
            <RACE CODE=""/>
            <ETHNICITY CODE=""/>
            <RELIGION CODE=""/>
            <SPOKENLANG CODE=""/>
            <MARITALSTATUS CODE=""/>
        </PERSONAL_INFORMATION>
        <HEALTH_INFORMATION>
            <BLOODTYPE/>
            <HEIGHT/>
            <WEIGHT/>
            <HIPAAACKNOWLEDGE/>
            <ALCOHOLFREQUENCY/>
            <SMOKEFREQUENCY CODE=""/>
        </HEALTH_INFORMATION>
        <ENCOUNTER_INFORMATION>
            <ACCOUNTNUMBER/>
            <PATIENTTYPE CATEGORY="" CODE=""/>
            <ADMISSIONDATETIME/>
            <ADMITTINGDOCTOR ID=""/>
            <ATTENDDOCTOR ID=""/>
            <PRIVACYREQUESTED/>
            <VISITSALLOWED/>
            <ADMITDXDIAGNOSIS CODE=""/>
            <PRIMARYDXDIAGNOSIS CODE=""/>
            <PROCEDURE CODE=""/>
            <INSURANCEPLAN ID="" CODE="" NAME="">
                <CONTRACTNUM/>
            </INSURANCEPLAN>
            <LASTLOCATION COSTCENTERNUM="">
                <ROOMBEDNO/>
            </LASTLOCATION>
            <DISPOSITION CODE="" STANDARDCODE=""/>
        </ENCOUNTER_INFORMATION>
        <CONTACT_INFORMATION>
            <PATIENT>
                <RESIDENTIAL>
                    <ADDRESS>
                        <ADDRESS1/>
                        <ADDRESS2/>
                        <CITY/>
                        <STATE/>
                        <COUNTRY/>
                        <ZIPCODE/>
                    </ADDRESS>
                </RESIDENTIAL>
                <POSTAL>
                    <ADDRESS>
                        <ADDRESS1/>
                        <CITY/>
                        <STATE/>
                        <COUNTRY/>
                        <ZIPCODE/>
                    </ADDRESS>
                </POSTAL>
                <PHONENUMBER>
                    <RESIDENTIAL/>
                    <MOBILE/>
                </PHONENUMBER>
            </PATIENT>
            <MOTHER NAME=""/>
            <NIE NAME="">
                <RELATIONSHIP CODE=""/>
```

4. **Authorizations (<Authorizations>) Section**:

The **Authorizations** section contains information about the patient's legal authorizations, including directives, authorized persons, and associated documentation. This section is vital for recording legal consents, patient directives, and the involvement of designated contacts in decision-making processes. Each authorization has details about its category, type, status, and related documents or images

Field	Description
ID	Unique identifier for the authorization.
CATEGORY	Category of the authorization (e.g., medical, financial).
TYPE	Type of authorization (e.g., directive, consent).
STATUS	Status of the authorization (e.g., active, revoked).
DIRECTIVENAME	Name or title of the directive or legal document.
IMAGE	BASE64 Representation of the image.
NOTIFIED	Indicates if the patient has been notified about the authorization.
REVISEDON	Date when the authorization was last revised.
CREATEDBY	The user ID of the individual who created the authorization record.
CREATEDON	Date when the authorization record was created.
HASDOCUMENT	Indicates whether a related document exists for this authorization.
TRANSID	Transaction ID for tracking the authorization document's image.
MODE	Mode in which the document was captured (e.g., scanned, imported).
DOCUMENTTYPE	The type of document associated with the authorization (e.g., consent form, living will).
NAME	Name of the document related to the authorization.
EXTENSION	The file extension of the document (e.g., PDF, DOCX).
RELATIONSHIP	Describes the relationship between the patient and the authorized person (e.g., spouse, parent).

Subsection: Image

The **IMAGE** subsection holds details regarding any documents or images related to the authorization. This could be scanned documents, imported files, or other types of images associated with the patient's authorizations.

Field	Description
TRANSID	Transaction ID for tracking the image or document related to the authorization.
MODE	Mode of capture for the document (e.g., scanned, imported).
DOCUMENTTYPE	The type or category of document related to the authorization (e.g., living will, consent form).
ID	Unique identifier for the type of document.
NAME	Name of the file related to the authorization (e.g., "Living_Will_2023").
EXTENSION	File extension of the document (e.g., PDF, DOCX).

Subsection: AuthorizedBy

The **AUTHORIZEDBY** subsection contains details about the individual or entity authorized by the patient to make decisions on their behalf. This ensures proper identification of the person involved in legal or medical matters.

Field	Description
RELATIONSHIP	The relationship code between the patient and the authorized person (e.g., spouse, parent).

Authorization XML Format Sample:

```
<AUTHORIZATIONS>
        <AUTHORIZATION ID="" CATEGORY="" TYPE="" STATUS="">
            <DIRECTIVENAME/>
            <NOTIFIED/>
            <REVISEDON/>
            <CREATEDBY USERID=""/>
            <CREATEDON/>
            <HASDOCUMENT/>
            <IMAGE TRANSID="" MODE="">
                <DOCUMENTTYPE ID=""/>
                <NAME EXTENSION=""/>
            </IMAGE>
        </AUTHORIZATION>
        <AUTHORIZATION ID="" CATEGORY="" TYPE="" STATUS="">
            <DIRECTIVENAME/>
            <AUTHORIZEDBY>
                <RELATIONSHIP CODE=""/>
            </AUTHORIZEDBY>
            <NOTIFIED/>
            <REVISEDON/>
            <CREATEDBY USERID=""/>
            <CREATEDON/>
            <HASDOCUMENT/>
        </AUTHORIZATION>
    </AUTHORIZATIONS>
```

Care Plans (<CAREPLANS>) Section:

The **CAREPLANS** section records detailed information about a patient's care plans, including the status of the plans, who assigned them, the focus of the plans, and the results. Each care plan is represented with multiple key elements, including the name of the care plan, status, assigned personnel, and focus areas. Focus areas represent specific aspects of patient care, with associated roles and outcomes.

Main Section: Careplans

Field	Description
GROWNNAME	The overarching name of the care plan group. Represents the broader care strategy for the patient.
SEQID	A unique sequence identifier for each care plan.
CAREPLANNAME	The name of the specific care plan, such as "Diabetes Management" or "Hypertension Control."
STATUS	The current status of the care plan. Possible values include "Active", "Completed", "Ongoing", etc.
ASSIGNEDBY	The person or entity that assigned the care plan, typically a doctor or healthcare provider.
ASSIGNEDON	The date when the care plan was assigned.

REVIEWEDON	The date when the care plan was last reviewed, if applicable.

Subsection Table: Focus

Each care plan may include one or more focus areas, which represent specific objectives or tasks within the overall care plan. The FOCUS subsection tracks each of these areas and their status.

Field	Description
SEQID	A unique sequence identifier for the specific focus area within the care plan.
FOCUSNAME	The name of the focus area, such as "Blood Sugar Control" or "Physical Therapy."
ROLENAME	The role responsible for managing the focus area, such as "Endocrinologist" or "Physical Therapist."
STATUS	The current status of the focus area, such as "Ongoing" or "Resolved."
PRIORITY	The priority level of the focus area, typically ranked as "Low", "Medium", or "High."

Subsection Table: Results

Each focus area may have one or more results, which represent the desired or achieved outcomes within that focus area. The RESULT subsection captures this information.

Field	Description
SEQID	A unique sequence identifier for the result.
RESULTNAME	The name of the result, such as "Achieve Target Blood Sugar Levels" or "Full Mobility Restored."
STATUS	The current status of the result, such as "In Progress", "Completed", or "Not Met."

CarePlan section XML Format Sample

```
<CAREPLANS>
    <GROWNNAME ID=""/>
    <CAREPLAN SEQID="">
        <CAREPLANNAME ID=""/>
        <STATUS ID=""/>
        <ASSIGNEDBY USERID=""/>
        <ASSIGNEDON/>
        <FOCUS SEQID="">
            <FOCUSNAME ID=""/>
            <ROLENAME ID=""/>
            <STATUS ID=""/>
            <PRIORITY/>
            <RESULT SEQID="">
                <RESULTNAME ID=""/>
                <STATUS ID=""/>
            </RESULT>
            <RESULT SEQID="">
                <RESULTNAME ID=""/>
                <STATUS ID=""/>
            </RESULT>
        </FOCUS>
        <FOCUS SEQID="">
            <FOCUSNAME/>
            <ROLENAME ID=""/>
            <STATUS ID=""/>
            <PRIORITY/>
            <NOTE/>
            <TARGETEDON/>
            <REVIEWEDON/>
            <RESULT SEQID="">
                <RESULTNAME/>
                <STATUS ID=""/>
                <RESULTNOTE/>
            </RESULT>
        </FOCUS>
    </CAREPLAN>
</CAREPLANS>
```

5. **Consults and Referrals (<CONSULTS_REFERRALS>) Section**:

The **CONSULTS_REFERRALS** section provides detailed records of consultations and referrals made for a patient. Each referral includes the purpose of the referral, priority level, referring provider, and any related health issues or diagnoses.

Main Table: CONSULT_REFERRAL

This table includes key information about each referral or consultation request.

Field	Description
TRANSID	A unique transaction ID for each consultation or referral.
DATE	The date on which the referral or consultation request was made.
PURPOSE	The purpose or reason for the referral, such as "Specialist Consultation" or "Diagnostic Test."
PRIORITY	The urgency of the referral, often marked as "Routine," "Urgent," or "Emergency."
REFERREDBY	The healthcare provider or facility who initiated the referral, with a unique REFERRALID.
CONSULTEDBY	The provider or consultant who is receiving the referral, used in specific cases where applicable.
PROVIDER	The specialist or provider who is handling the consultation or referral.
CREATEDBY	The user ID of the individual who created the referral record in the system.
CREATEDON	The date and time when the referral record was created.

Subsection Table: HEALTHISSUES

Each referral may include one or more health issues or diagnoses that prompted the referral. These health issues help guide the specialist or receiving provider in understanding the patient's current medical needs.

Field	Description
DIAGNOSISORPROBLEM	The diagnosis or problem that led to the referral, with the associated medical code (CODE) and name (NAME).

Subsection Table: COMMENTS

In some referrals, comments or notes might be added to provide additional context about the referral.

Field	Description
COMMENTS	Any additional comments or information added regarding the referral or consultation.

Consult and Referrals XML format sample

```
<CONSULTS_REFERRALS>
        <CONSULT_REFERRAL TRANSID="" DATE="">
            <PURPOSE/>
            <PRIORITY/>
            <REFERREDBY REFERRALID=""/>
            <PROVIDER/>
            <HEALTHISSUES>
                <DIAGNOSISORPROBLEM CODE="" NAME=""/>
            </HEALTHISSUES>
            <COMMENTS/>
            <CREATEDBY USERID=""/>
            <CREATEDON/>
        </CONSULT_REFERRAL>
</CONSULTS_REFERRALS>
```

6. **Diet (<DIETS >) Section**:

Section Introduction: DIETS

The **DIETS** section captures information regarding the dietary plans or recommendations prescribed to a patient. Each DIET entry includes details such as the type of diet, description, attending doctor, and any relevant comments or notes. It also records the user who created the dietary plan and the date it was entered into the system.

Main Table: DIET

This table documents the main details of each dietary recommendation or plan for the patient.

Field	Description
ID	A unique identifier for each diet plan or entry.
TYPE	The type of diet prescribed, such as "Low Sodium," "Diabetic," "Vegan," etc.
DESCRIPTION	A more detailed explanation or description of the diet plan.
DOCTOR	The name of the doctor who prescribed or recommended the diet.
COMMENTS	Any additional comments or notes relevant to the diet plan.
CREATEDBY	The user ID of the individual who created the diet entry in the system.
CREATEDON	The date and time when the diet plan was entered into the system.

Subsection: DOCTOR

This subsection records details of the doctor responsible for prescribing or managing the patient's diet.

Field	Description
DOCTOR	Name of the doctor who is in charge of overseeing or prescribing the patient's diet.

Diet Section XML Format Sample

```
<DIETS>
    <DIET ID="" TYPE="">
        <DESCRIPTION/>
        <DOCTOR/>
        <COMMENTS/>
        <CREATEDBY USERID=""/>
        <CREATEDON/>
    </DIET>
</DIETS>
```

7. **Documents (<Documents>) Section**:

   - Contains information about documents, including document name, creation date, creator, and document address.
   - The creation date should be converted to ISO 8601 format.
   - Documents saved at PatientDocuments Folder

Field	Description
DocumentEntry	An array containing details of document-related entries.
documentName	The name or title of the document (e.g., "MedicalReport.pdf").
CreatedDate	The date when the document was created (ISO 8601 format).
CreatedBy	The name of the individual who created the document.
DocumentAddress	The file path or location where the document is stored.
TemplateID	An identifier for the document template, if applicable.
PATACCTNUM	The patient's account number, if applicable.
RTFDATA	Base64-encoded content of the document, if applicable.
CHANGEDBY	The name of the individual who made changes to the document.
CHANGEDON	The date and time when changes were made to the document (ISO 8601 format).
SIGNEDBY	The name of the individual who signed the document, if applicable.
SIGNEDON	The date and time when the document was signed (ISO 8601 format), if applicable.
RESIGNEDBY	The name of the individual who re-signed the document, if applicable.
RESIGNEDON	The date and time when the document was re-signed (ISO 8601 format), if applicable.

DISMISSEDBY	The name of the individual who dismissed the document, if applicable.
DISMISSEDON	The date and time when the document was dismissed (ISO 8601 format), if applicable.
DISMISSEDREASON	The reason for dismissing the document, if applicable.
RETRACTIONBY	The name of the individual who retracted the document, if applicable.
RETRACTIONON	The date and time when the document was retracted (ISO 8601 format), if applicable.
RETRACTIONREASON	The reason for retracting the document, if applicable.

Documents Section XML Sample

```
<Documents>
        <DocumentEntry>
            <documentName>MedicalReport.pdf</documentName>
            <CreatedDate>2023-11-22</CreatedDate>
            <CreatedBy>Dr. Smith</CreatedBy>
            <DocumentAddress>/path/to/MedicalReport.pdf</DocumentAddress>
        </DocumentEntry>
        <!-- Add more DocumentEntry elements as needed -->
        <DocumentEntry>
            <!-- Another Document entry goes here -->
        </DocumentEntry>
    </Documents>
```

8. **Education Section (<EDUCATIONS>) Section**:

The **EDUCATIONS** section documents educational interventions or instructions provided to the patient, which may include disease education, treatment guidance, or lifestyle advice. Each EDUCATION entry captures essential information such as the type of education, the topic or subject covered, how it was delivered, and the patient's response to the education. It also tracks the healthcare professional who provided the education and the date and time it was given.

Main Table: EDUCATION

Field	Description
ID	A unique identifier for each education entry.
CLASSIFICATION	The type of education provided, such as "Disease Education," "Medication Instruction," etc.
SUBJECT	The specific topic or subject covered during the education session (e.g., diabetes management).
ICDX	The ICD code associated with the education, if relevant to the diagnosis or treatment.
ORAL_GIVEN	Indicates whether the education was delivered orally.
RESPONSE	The patient's response or reaction to the education provided.
COMMENT	Any additional notes or comments related to the educational session.

GIVENBY	The user ID of the healthcare professional who provided the education, along with their role or type.
GIVENON	The date and time when the education was given to the patient.

Subsection: GIVENBY

Field	Description
USERID	The unique ID of the healthcare professional who provided the education.
USERTYPE	The role or type of healthcare professional, such as nurse, doctor, or dietitian.

Education Section XML Format Sample

```
<EDUCATIONS>
    <EDUCATION ID="" CLASSIFICATION="" SUBJECT="">
        <ICDX/>
        <ORAL_GIVEN/>
        <RESPONSE/>
        <COMMENT/>
        <GIVENBY USERID="" USERTYPE=""/>
        <GIVENON/>
    </EDUCATION>
</EDUCATIONS>
```

9. **Epidemiology (<EPIDEMIOLOGIES >) Section**:

The **EPIDEMIOLOGIES** section contains detailed records of the patient's epidemiological history, including the medical disorders they have experienced, the status of these conditions, and any preventive or management notes. This section is useful for tracking the spread, origin, and course of diseases and how they relate to public health.

Main Table: EPIDEMIOLOGY

Field	Description
CODE	A code representing the specific medical disorder (ICD or other classification).
MEDDISORDER	A description or name of the medical disorder.
STATUS	The current status of the medical disorder (e.g., Active, Resolved).
PREVENTIVENOTE	Any preventive measures or notes related to the epidemiological condition.
COMMENTS	Additional comments or observations about the medical disorder.
REPORTEDON	The date when the epidemiological condition was reported.
CREATEDBY	The ID of the user who documented the epidemiological condition.
CREATEDON	The date and time when the entry was created.

Subsection: CREATEDBY

This subsection contains the details of the user who documented the epidemiological entry.

Field	Description
USERID	The unique ID of the user who created the epidemiology entry.

Epidemiology Section XML Format Sample

```
<EPIDEMIOLOGIES>
    <EPIDEMIOLOGY CODE="" MEDDISORDER="" STATUS="">
        <PREVENTIVENOTE/>
        <REPORTEDON/>
        <CREATEDBY USERID=""/>
        <CREATEDON/>
    </EPIDEMIOLOGY>
    <EPIDEMIOLOGY CODE="" MEDDISORDER="" STATUS="">
        <COMMENTS/>
        <REPORTEDON/>
        <CREATEDBY USERID=""/>
        <CREATEDON/>
    </EPIDEMIOLOGY>
</EPIDEMIOLOGIES>
```

10. **Intake Output Log (<INTAKEANDOUTPUTS >) Section**:

The **INTAKEANDOUTPUTS** section in the XML document captures the intake and output details for a patient during specific periods, typically recorded during shifts and summarized over the day. Each entry in this section provides a breakdown of various intakes (e.g., fluids, medications) and outputs (e.g., urine, feces) logged by different providers, along with the total intake and output calculated per shift and per day.

Table: INTAKEANDOUTPUTS

Field	Description
INTAKEANDOUTPUT	The parent element for each intake and output record per date, including shifts and summaries.
DATE	The date on which the intake/output data is recorded.

Table: SHIFT

Field	Description
NUMBER	The shift number or identifier for the intake/output record.
PERIOD	Time period covered by the shift (e.g., "Morning", "Night").

Table: DETAIL

Field	Description
INTAKE	Contains individual intake entries (fluids, food, etc.).
OUTPUT	Contains individual output entries (urine, feces, etc.).

Subsection: INTAKE (within DETAIL)

Field	Description
ITEM	Represents a specific intake item (e.g., fluid, medication) during the shift.
NAME	Name of the intake item (e.g., "Water", "IV Fluids").
LIOID	An identifier for the intake item.
QUANTITY	The amount or volume of the intake.
LOGGED	Information on each instance the intake was logged.
NOTE	Optional notes regarding the intake (e.g., special instructions).
PROVIDEDBY	The ID of the provider who logged the intake.
PROVIDEDON	The timestamp when the intake was logged.

Subsection: OUTPUT (within DETAIL)

Field	Description
ITEM	Represents a specific output event (e.g., urine, feces).
NAME	Name of the output item (e.g., "Urine", "Stool").
LIOID	An identifier for the output item.
QUANTITY	The amount or volume of the output.
LOGGED	Information on each instance the output was logged.
NOTE	Optional notes regarding the output.
PROVIDEDBY	The ID of the provider who logged the output.
PROVIDEDON	The timestamp when the output was logged.

Table: TOTALPERSHIFT

Field	Description
INTAKEN	The total intake volume recorded during the shift.
OUTTAKEN	The total output volume recorded during the shift.
DIFFERENCE	The difference between intake and output during the shift.

Table: TOTALPERDAY

Field	Description
INTAKEN	The total intake volume recorded during the day.
OUTTAKEN	The total output volume recorded during the day.
DIFFERENCE	The difference between intake and output over the entire day.

Intake and Output XML Format Sample

```
<INTAKEANDOUTPUTS>
    <INTAKEANDOUTPUT DATE="">
        <SHIFT NUMBER="" PERIOD="">
            <DETAIL>
                <INTAKE>
                    <ITEM NAME="" LIOID="">
                        <QUANTITY/>
                        <LOGGED ID="">
                            <QUANTITY/>
                            <PROVIDEDBY USERID=""/>
                            <PROVIDEDON/>
                        </LOGGED>
                        <LOGGED ID="">
                            <QUANTITY/>
                            <PROVIDEDBY USERID=""/>
                            <PROVIDEDON/>
                        </LOGGED>
                    </ITEM>
                    <ITEM NAME="" LIOID="">
                        <QUANTITY/>
                        <LOGGED ID="">
                            <QUANTITY/>
                            <NOTE/>
                            <PROVIDEDBY USERID=""/>
                            <PROVIDEDON/>
                        </LOGGED>
                        <LOGGED ID="">
                            <QUANTITY/>
                            <NOTE/>
                            <PROVIDEDBY USERID=""/>
                            <PROVIDEDON/>
                        </LOGGED>
                    </ITEM>
                    <ITEM NAME="" LIOID="">
                        <QUANTITY/>
                        <LOGGED ID="">
                            <QUANTITY/>
                            <PROVIDEDBY USERID=""/>
                            <PROVIDEDON/>
                        </LOGGED>
                        <LOGGED ID="">
                            <QUANTITY/>
                            <NOTE/>
                            <PROVIDEDBY USERID=""/>
                            <PROVIDEDON/>
                        </LOGGED>
                    </ITEM>
                </INTAKE>
                <OUTPUT>
                    <ITEM NAME="" LIOID="">
                        <QUANTITY/>
                        <LOGGED ID="">
                            <QUANTITY/>
                            <PROVIDEDBY USERID=""/>
                            <PROVIDEDON/>
                        </LOGGED>
                    </ITEM>
                </OUTPUT>
            </DETAIL>
            <TOTALPERSHIFT>
                <INTAKEN/>
                <OUTTAKEN/>
                <DIFFERENCE/>
            </TOTALPERSHIFT>
        </SHIFT>
        <TOTALPERDAY>
            <INTAKEN/>
            <OUTTAKEN/>
            <DIFFERENCE/>
        </TOTALPERDAY>
    </INTAKEANDOUTPUT>
</INTAKEANDOUTPUTS>
```

11. **Clinical Documents (<CLINICALDOCUMENTS >) Section**:

The **CLINICALDOCUMENTS** section provides a detailed log of clinical documents related to the patient. Each document is recorded within a specific class, containing metadata such as the template used, creation and modification information, and rich text data (RTFDATA) that contains the content of the document. This section supports various types of clinical documentation, including assessments, medical procedures, and other clinical events signed by medical professionals.

Table: CLINICALDOCUMENTS

Field	Description
CLASS	Represents a category or grouping of clinical documents, identified by an ID and class name.
CLINICALDOCUMENT	Holds information about each clinical document within a class.

Subsection: CLASS

Field	Description
ID	Identifier for the class of clinical documents (e.g., "99" for a specific type).
CLASS	The name of the clinical document class (e.g., "ALL").

Subsection: CLINICALDOCUMENT (within CLASS)

Field	Description
TRANSID	Transaction ID for the clinical document.
TEMPLATE ID	Identifier for the template used in this clinical document.
RTFDATA	Rich text format data that includes the clinical content in a structured, formatted manner.
CREATEDBY	Information about the user who created the document, including their user ID and credentials.
CREATEDON	Date and time when the clinical document was created.
CHANGEDBY	Information about the user who modified or updated the document, including their user ID.
CHANGEDON	Date and time when the clinical document was last modified.
SIGNEDBY	Information about the user who electronically signed the document, including their user ID.
SIGNEDON	Date and time when the clinical document was signed.

Clinical Documents Section XML Sample

```
<ClinicalDocuments>
        <DocumentEntry>
            <TemplateID>1001</TemplateID>
            <PATACCTNUM>987654321</PATACCTNUM>
            <RTFDATA>Base64EncodedStringHere</RTFDATA>
            <CREATEDBY>Dr. Alice Smith</CREATEDBY>
            <CREATEDON>2023-11-21T10:00:00</CREATEDON>
            <CHANGEDBY>Nurse John Doe</CHANGEDBY>
            <CHANGEDON>2023-11-22T15:30:00</CHANGEDON>
            <SIGNEDBY>Dr. Emily Johnson</SIGNEDBY>
            <SIGNEDON>2023-11-23T09:20:00</SIGNEDON>
            <RESIGNEDBY>Nurse Michael Brown</RESIGNEDBY>
            <RESIGNEDON>2023-11-24T11:45:00</RESIGNEDON>
            <DISMISSEDBY>Dr. David Wilson</DISMISSEDBY>
            <DISMISSEDON>2023-11-25T14:10:00</DISMISSEDON>
            <DISMISSEDREASON>Change in patient condition</DISMISSEDREASON>
            <RETRACTIONBY>Admin Lisa Green</RETRACTIONBY>
            <RETRACTIONON>2023-11-26T16:55:00</RETRACTIONON>
            <RETRACTIONREASON>Patient request</RETRACTIONREASON>
        </DocumentEntry>
        <!-- Additional DocumentEntry elements as needed -
</ClinicalDocuments>
```

12. **Scales (<Scales>) Section**:
    The **SCALES** section contains a variety of standardized assessments used to evaluate a patient's condition. Each sub-section (such as **AUDITC**, **BRADEN**, **BRADENQ**, **HARK**, **HDS**, **NHANES**, **PHQ9**, and **OTHERS**) represents a different type of assessment or scale. These scales are comprised of multiple **QUESTIONED** elements, which collect responses from the patient or clinician about specific questions related to the patient's condition.

    Each **SCALE** contains one or more **QUESTIONED** sets, which in turn contain **ANSWERED** items representing individual questions and responses. The results from these assessments contribute to understanding the patient's medical needs, functional capabilities, and potential risk factors.

SCALE Table

Field	Description
ID	Unique identifier for the scale.
NAME	The name of the scale, representing the specific assessment being conducted (e.g., AUDITC, BRADEN, etc.).

QUESTIONED Table

Field	Description
ID	Unique identifier for the assessment session within the scale.

PERFORMEDBY	The ID and name of the individual who performed the assessment.
PERFORMEDON	The date and time when the assessment was conducted.
SCORE	The final score or result derived from the answers provided.

ANSWERED Table

Field	Description
QUESTION ID	Unique identifier for the specific question being answered.
SEQID	Sequence number for the question in the assessment.
QUESTION	The question asked in the assessment.
ANSWER ID	Unique identifier for the answer provided.
VALUE	The value or score assigned to the answer.
ANSWER	The detailed description of the response.

Subtables for Specific Scales

AUDITC (Alcohol Use Disorders Identification Test - Consumption)

This scale assesses a patient's alcohol consumption habits. Each question evaluates a different aspect of alcohol use, such as frequency and quantity.

Field	Description
QUESTION ID	Unique identifier for each question in the AUDITC scale.
SEQID	Sequence number of the question in the test.
ANSWER ID	Unique identifier for the answer provided.
VALUE	The score value assigned to the answer (e.g., 0 for none, higher for more frequent consumption).
ANSWER	The detailed answer provided (e.g., how often they consume alcohol).

BRADEN (Pressure Ulcer Risk Assessment)

The BRADEN scale measures a patient's risk for developing pressure ulcers based on various factors such as mobility, nutrition, and moisture exposure.

Field	Description
QUESTION ID	Unique identifier for each question in the BRADEN scale.
SEQID	Sequence number of the question.
ANSWER ID	Unique identifier for the answer provided.
VALUE	The score value assigned to the answer (e.g., 1-4 scale).
ANSWER	The descriptive answer to the question.
DESCRIPTION	Additional details provided about the answer.

BRADENQ (Pediatric Risk Assessment)

This is the pediatric version of the BRADEN scale, designed to assess pressure ulcer risk in children.

Field	Description
QUESTION ID	Unique identifier for each question.
SEQID	Sequence number of the question.
ANSWER ID	Unique identifier for the answer provided.
VALUE	The score assigned to the answer.
DESCRIPTION	Additional description of the answer.

HARK (Domestic Abuse Screening)

The HARK scale screens for experiences of domestic violence and abuse. Each question seeks to determine whether the patient has experienced various forms of abuse.

Field	Description
QUESTION ID	Unique identifier for the question.
SEQID	Sequence number of the question.
ANSWER ID	Unique identifier for the answer provided.
VALUE	The score or response to the question.
ANSWER	A descriptive response.

HDS (Health Deficiency Screening)

The HDS scale assesses health deficiencies, including lifestyle habits, pre-existing conditions, and more.

Field	Description
QUESTION ID	Unique identifier for each question in the HDS scale.
SEQID	Sequence number of the question.
ANSWER VALUE	The specific value for the answer provided (e.g., Yes/No, or numerical score).

NHANES (National Health and Nutrition Examination Survey)

The NHANES scale collects health and nutritional data.

Field	Description
QUESTION ID	Unique identifier for each question.
SEQID	Sequence number of the question.
ANSWER VALUE	The value provided in response to the question.
DESCRIPTION	Additional descriptive details for the answer.

PHQ9 (Patient Health Questionnaire - Depression Screening)

The PHQ9 scale is used to screen for depression and assess the severity of the patient's symptoms.

Field	Description
QUESTION ID	Unique identifier for each question.
SEQID	Sequence number of the question.
ANSWER ID	Unique identifier for the answer provided.
VALUE	The value assigned to the answer (e.g., 0 for no symptoms, higher for more severe symptoms).
ANSWER	A detailed description of the response to the question.

Subtables for ANSWERED Section

Each **ANSWERED** element captures responses to a specific question.

Field	Description
QUESTION ID	Unique identifier for each question.
SEQID	Sequence number of the question.
ANSWER ID	Unique identifier for the answer.
VALUE	The score or value provided in response.
ANSWER	A detailed description of the answer.

Scales Section XML Sample

```
<SCALES>
    <OTHERS>
        <SCALE ID="65" NAME="RISK PAIN">
            <QUESTIONED ID="68">
                <ANSWERED>
                    <QUESTION ID="2888" SEQID="1">1. HOW MUCH PAIN DO YOU FEEL
TODAY?</QUESTION>
                    <ANSWER ID="2129" VALUE="10">UNIMAGINABLE,
UNSPEAKBLE</ANSWER>
                </ANSWERED>
                <ANSWERED>
                    <QUESTION ID="2889" SEQID="2">2. WHEN START THE
PAIN?</QUESTION>
                    <ANSWER ID="2133" VALUE="0">I DON'T REMEMBER</ANSWER>
                </ANSWERED>
                <PERFORMEDBY USERID="54">PREFIX GUILLERMO F CARRASQUILLO
CARRASQUILLO SUFIX, DEGREE, LIC: 9688</PERFORMEDBY>
                <PERFORMEDON>07/20/2022 04:52PM</PERFORMEDON>
                <SCORE>10</SCORE>
            </QUESTIONED>
        </SCALE>
    </OTHERS>
</SCALES>
```

PatientFinancialData.XML Dictionary

1. **Encoding and Declaration**: The document starts with an XML declaration specifying the encoding and version.

2. **Patient Account Section**: Holds the primary account information of the patient, including basic admission details.

Field Name	Description
INVOICENUM	Unique invoice number
MEDRECNUM	Medical record number
PATACCTNUM	Patient account number
PATCATEGORY	Category of the patient (e.g., OPD, IPD)
ADMISSIONDATETIME	Date and time of admission
DISCHARGEDATETIME	Date and time of discharge
ADMISSIONTYPE	Type of admission (e.g., Emergency, Routine)
ADMITTEDFROM	Code indicating where the patient was admitted from
PATIENTTYPECODE	Code representing the type of patient
PATSTARTILLNESS	Date when the illness started
EMPLOYMENTRELATED	Indicator if related to employment
ACCIDENTRELATED	Indicator if related to an accident
OTHERACCIDENTRELATED	Indicator for other accident-related issues
PATREFERRALNUM	Referral number for the patient
TYPEOFBILL	Type of bill (e.g., hospital, clinic)
STATEMENTFROM	Statement start date
STATEMENTTO	Statement end date

3. **Demographics Section:** Contains detailed demographic information of the patient.

Field Name	Description
PATLASTNAME	Patient's last name
PATMATLASTNAME	Patient's maternal last name
PATFIRSTNAME	Patient's first name
PATMIDNAME	Patient's middle name
PATADDR1	Patient's primary address
PATADDR2	Secondary address line
PATCITY	City of residence
PATSTATE	State of residence
PATZIPCODE	ZIP code of residence
PATBIRTHDATE	Patient's date of birth
PATGENDER	Gender of the patient
PATHOMEPHONE	Home phone number
PATMARITALSTATUS	Marital status
PATEMPLOYER	Employer's name
PATSOCSECNUM	Social security number

4. **Financial Section -** Provides a summary of financial balances related to the patient's account.

Field Name	Description
INVBALANCE	Total invoice balance
INVPAYTOTAL	Total amount paid
INVPENDBALANCE	Pending balance after payments

5. **Diagnoses Section**: Lists all diagnoses associated with the patient's visit.

Field Name	Description
DXINDICATOR	Indicator of diagnosis type (P, S, etc.)
DXCODE	Diagnosis code (e.g., J00)
DXDESC	Description of the diagnosis
DXPOA	Indicator of present on admission
CODESET	Code set used for diagnosis

6. **Procedures Section**: Details of medical procedures performed on the patient.

Field Name	Description
OPCODE	Procedure code
OPINDICATOR	Indicator of type of procedure
OPDATE	Date of the procedure
OPDESC	Description of the procedure

7. **ValueCodes Section**: Contains value codes and amounts related to the patient's account and billing.

Field Name	Description
CODE	Value code
AMOUNT	Amount associated with the value code

8. **Conditions Section**: Lists any conditions related to the patient's treatment or billing.

Field Name	Description
CONDITION	Condition code
DESC	Description of the condition

9. **Insurances Section**: Insurance details associated with the patient's account.
    a. PlanDetails Subsection

Field Name	Description
PLANID	Insurance plan ID
PLANNAME	Name of the insurance plan
PLANADDR1	Address line 1 of the insurance plan
PLANADDR2	Address line 2 of the insurance plan
PLANCITY	City of the insurance plan

PLANSTATE	State of the insurance plan
PLANCOUNTRY	Country of the insurance plan
PLANZIPCODE	ZIP code of the insurance plan

b. ContractDetails Subsection

Field Name	Description
PATCONTRACTNUM	Patient's contract number with the insurance
RELATIONSHIPTOHOLDER	Relationship of patient to the policyholder
HOLDERCONTRACTNUM	Contract number of the policyholder
EFFECTIVEDATE	Effective date of the insurance
EXPIRATIONDATE	Expiration date of the insurance
MEDICARETYPE	Type of Medicare if applicable

c. HolderDetails Subsection

Field Name	Description
HOLDERPATLASTNAME	Policyholder's last name
HOLDERMATLASTNAME	Policyholder's maternal last name
HOLDERFIRSTNAME	Policyholder's first name
HOLDERMIDDLENAME	Policyholder's middle name
HOLDERBIRTHDATE	Policyholder's birth date
HOLDERGENDER	Gender of the policyholder
HOLDEREMPLOYER	Policyholder's employer

d. GroupDetails Subsection

Field Name	Description
GROUPNUM	Insurance group number
GROUPNAME	Name of the insurance group

e. FinancialDetails Subsection

Field Name	Description
REVENUECODE	Revenue code for billing
BALANCE	Insurance balance
PAYTOTAL	Total amount paid by insurance
PENDBALANCE	Pending balance of insurance

f. ProviderDetails Subsection

Field Name	Description
PROVIDERNUM	Provider number
REPNAME	Representative name for billing

g. AdditionalInfo Subsection

Field Name	Description
IPDPOS	Inpatient place of service code
OPDPOS	Outpatient place of service code
PRN2NDCARR	Indicator for secondary carrier
EXSECPROV	Indicator for secondary provider
GROUPREV	Indicator for group revenue
INCREFDOC	Indicator for including referring doctor
INCPATREFNUM	Included patient reference number
PPS	Indicator for Prospective Payment System
FLD81_TAXO	Taxonomy field 81
SEND_ADD_REMARKS	Indicator for additional remarks
SEND_QUAL_FLD14	Indicator for qualifier in field 14
SUPADT	Indicator to suppress admission date/time
SUPF18	Indicator to suppress field 18 in form
SUPRESS_UB04_FLD_69	Suppress field 69 in UB04 form
SUPRESS_UB04_FLD_70	Suppress field 70 in UB04 form

10. Doctors Section: Information about doctors who attended to the patient.

Field Name	Description
DOCTORID	Unique identifier of the doctor
TYPE	Type of doctor (e.g., Attending, Consulting)
DOCTORFIRSTNAME	First name of the doctor
DOCTORMIDNAME	Middle name of the doctor
DOCTORLASTNAME	Last name of the doctor
DOCTORMATLASTNAME	Maternal last name of the doctor
UPINNUMBER	UPIN number of the doctor
LICENSE	Doctor's license number
TAXONOMYCODE	Taxonomy code of the doctor

a. DoctorProvider Subsection

Field Name	Description
PLANID	Insurance plan ID associated with the doctor
SEQUENCE	Sequence number
IDTYPE	Type of provider ID
PROVIDERNUM	Provider number

PatientFinancialData.XML Sample:

```
<?xml version="1.0" encoding="UTF-8"?>
<PatientAccount INVOICENUM="140704" MEDRECNUM="0000000324" PATACCTNUM="2011200321"
PATCATEGORY="OPD" ADMISSIONDATETIME="2015-09-17T10:34:00" DISCHARGEDATETIME="2015-09-
18T08:19:00" ADMISSIONTYPE="Emergency" ADMITTEDFROM="2" PATIENTTYPECODE="2"
PATSTARTILLNESS="2014-09-02T00:00:00" EMPLOYMENTRELATED="0" ACCIDENTRELATED="0"
OTHERACCIDENTRELATED="0" PATREFERRALNUM="REF1234" TYPEOFBILL="131"
STATEMENTFROM="09/17/2015" STATEMENTTO="09/18/2015">
    <Demographics>
        <Patient PATLASTNAME="CARRASQUILLO" PATMATLASTNAME="CARRASQUILLO2"
PATFIRSTNAME="NESTOR" PATMIDNAME="I" PATADDR1="PORTAL PRUEBA PRUEBA FISICA"
PATADDR2="PORTAL PRUEBA PRUEBA FISICA2" PATCITY="SAN JUAN" PATSTATE="PR"
PATZIPCODE="00925" PATBIRTHDATE="1963-01-01T00:00:00" PATGENDER="M"
PATHOMEPHONE="7876202474" PATMARITALSTATUS="S" PATEMPLOYER="COMPANÍA DE FOMENTO
INDUSTRIAL" PATSOCSECNUM="222222222" />
    </Demographics>
    <Financial>
        <Balance INVBALANCE="125.00" INVPAYTOTAL="0.00" INVPENDBALANCE="125.00" />
    </Financial>
    <Diagnoses>
        <Diagnosis DXINDICATOR="P" DXCODE="J00" DXDESC="ACUTE NASOPHARYNGITIS [COMMON
COLD]" DXPOA=" " CODESET="0" />
        <Diagnosis DXINDICATOR="S" DXCODE="J0140" DXDESC="ACUTE PANSINUSITIS,
UNSPECIFIED" DXPOA=" " CODESET="0" />
    </Diagnoses>
    <Procedures>
        <Procedure OPCODE="0B110F4" OPINDICATOR="S" OPDATE="2015-09-17" OPDESC="Excision
of Right Lung Lobe, Percutaneous Endoscopic Approach" />
        <Procedure OPCODE="0FJD8ZZ" OPINDICATOR="S" OPDATE="2015-09-18"
OPDESC="Inspection of Large Intestine, Via Natural or Artificial Opening Endoscopic" />
    </Procedures>
    <ValueCodes>
        <ValueCode CODE="A1" AMOUNT="100.00" />
        <ValueCode CODE="B2" AMOUNT="50.00" />
    </ValueCodes>
    <Conditions>
        <Condition CONDITION="R52" DESC="Pain, unspecified" CODESET="0" />
        <Condition CONDITION="M54.5" DESC="Lower back pain" CODESET="0" />
    </Conditions>
    <Insurances>
        <Insurance COORDINATENUM="1">
            <PlanDetails PLANID="227" PLANNAME="First Plus Medicare Advantage"
                 PLANADDR1="PO Box 144090" PLANADDR2=""
                 PLANCITY="Arecibo" PLANSTATE="PR" PLANCOUNTRY="Puerto Rico"
PLANZIPCODE="00966" />
            <ContractDetails PATCONTRACTNUM="123601010" RELATIONSHIPTOHOLDER="18"
                     HOLDERCONTRACTNUM="123601010" EFFECTIVEDATE="2013-09-18T00:00:00"
                     EXPIRATIONDATE="2016-09-17T00:00:00" MEDICARETYPE="" />
            <HolderDetails HOLDERPATLASTNAME="CARRASQUILLO"
HOLDERMATLASTNAME="CARRASQUILLO2"
                   HOLDERFIRSTNAME="NESTOR" HOLDERMIDDLENAME="IVAN"
HOLDERBIRTHDATE="1963-01-02T00:00:00"
                   HOLDERGENDER="M" HOLDEREMPLOYER="" />
            <GroupDetails GROUPNUM="" GROUPNAME="" />
            <FinancialDetails REVENUECODE="0450" BALANCE="105.00" PAYTOTAL="0.00"
PENDBALANCE="105.00" />
            <ProviderDetails PROVIDERNUM="1154391415" REPNAME="FACTURACION REPRESENTANTE
2DO PISO" />
```

```
            <AdditionalInfo IPDPOS="21" OPDPOS="11" PRN2NDCARR="0" EXSECPROV="0"
GROUPREV="0"
                    INCREFDOC="0" INCPATREFNUM="0" PPS="0" FLD81_TAXO=""
                    SEND_ADD_REMARKS="0" SEND_QUAL_FLD14="0" SUPADT="0" SUPF18="1"
                    SUPRESS_UB04_FLD_69="0" SUPRESS_UB04_FLD_70="0" />
        </Insurance>
    </Insurances>
    <Doctors>
        <Doctor DOCTORID="1444" TYPE="A" DOCTORFIRSTNAME="CARMEN" DOCTORMIDNAME="R"
DOCTORLASTNAME="BALLESTER" DOCTORMATLASTNAME="FRANK" UPINNUMBER="" LICENSE="L13454"
TAXONOMYCODE="111NI0900X">
            <DoctorProvider PLANID="227" SEQUENCE="1" IDTYPE="XX"
PROVIDERNUM="1234567990" />
        </Doctor>
        <Doctor DOCTORID="1444" TYPE="C" DOCTORFIRSTNAME="CARMEN" DOCTORMIDNAME="R"
DOCTORLASTNAME="BALLESTER" DOCTORMATLASTNAME="FRANK" UPINNUMBER="" LICENSE="L13454"
TAXONOMYCODE="111NI0900X">
            <DoctorProvider PLANID="227" SEQUENCE="1" IDTYPE="XX"
PROVIDERNUM="1234567990" />
        </Doctor>
    </Doctors>
</PatientAccount>
```