

Agastha Enterprise Healthcare Software

Version: 20.1

§170.315(b)(10) Electronic
Health Information export-
Documentation

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10/3/2023

Overview

Agastha EHR meets the certification criterion §170.315(b)(10) Electronic Health Information export by implementing the FHIR Export for Single Patient and Bulk Export. Based on specific user roles, clinical users with assigned rights can generate the FHIR export for a single patient, for a group of patients or for the entire patient population in accordance with the standards specified in 45 CFR 164.501

What Is EHI?

Electronic Health Information (EHI) refers to “electronic protected health information” (ePHI) to the extent that it would be included in a designated record set as defined in [45 CFR 164.501](#). EHI does not include psychotherapy notes as defined in 45 CFR 164.501 or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. The EHI definition represents the same ePHI that an individual would have the right to access under the [HIPAA Privacy Rule](#). (For additional information about the definition of EHI, we refer readers to the [Understanding Electronic Health Information \(EHI\) fact sheet](#)).

Under the Data Portability Export as seen below:

Data Portability/Export

Date of Service Date Range Previous Month None

Date Range AI - PI

All patients
 Provider patients
 Patient accounts

Comments

Users with assigned roles have the option to do the following exports:

- Single Patient Export

Data Portability/Export

Date of Service Date Range Previous Month None

Date Range AI - PI

All patients
 Provider patients
 Patient accounts

- Group of Patients EHI Export

Data Portability/Export

Date of Service Date Range Previous Month None

Date Range AI - PI

All patients
 Provider patients
 Patient accounts

- Patient Population EHI Export

Data Portability/Export

Date of Service Date Range Previous Month None

Date Range AI - PI

All patients
 Provider patients
 Patient accounts

FHIR®

All export files use the FHIR JSON format for any resource that will allow the FHIR export format. FHIR is a standard for health care data exchange, published by HL7®. Agastha Supports [HL7® Version 4.0.1 FHIR® Release 4, October 30, 2019](#), [FHIR® US Core Implementation Guide STU V3.1.1](#), [HL7 FHIR Bulk Data export](#).

Refer to <http://hl7.org/fhir/> for more information.

At this time, the resources using FHIR are:

- [Allergy Intolerance](#)
- [Care Plan](#)
- [Care Team](#)
- [Condition](#)
- [Device](#)
- [Diagnostic Report](#)
- [Document Reference](#)
- [Encounter](#)
- [Goal](#)
- [Immunization](#)
- [Location](#)
- [Medication](#)
- [Medication Request](#)
- [Observation](#)
- [Organization](#)
- [Patient](#)
- [Practitioner](#)
- [Procedure](#)
- [Provenance](#)

- [Related Person](#)
- [Service Request](#)

All the other resources are currently exported using the standard JSON format.

Resource Description

Name	Description
Allergy Intolerance	Risk of harmful or undesirable physiological response which is specific to an individual and associated with exposure to a substance.
Care Plan	Describes the intention of how one or more practitioners intend to deliver care for a particular patient, group or community for a period of time, possibly limited to care for a specific condition or set of conditions.
Care Team	The Care Team includes all the people and organizations who plan to participate in the coordination and delivery of care.
Condition	A clinical condition, problem, diagnosis, or other event, situation, issue, or clinical concept that has risen to a level of concern.
Device	This resource describes the properties (regulated, has real time clock, etc.), administrative (manufacturer name, model number, serial number, firmware, etc.), and type (knee replacement, blood pressure cuff, MRI, etc.) of a physical unit (these values do not change much within a given module, for example the serial number, manufacturer name, and model number). An actual unit may consist of several modules in a distinct hierarchy and these are represented by multiple Device resources and bound through the 'parent' element.
Diagnostic Report	The findings and interpretation of diagnostic tests performed on patients, groups of patients, products, substances, devices, and locations, and/or specimens derived from these. The report includes clinical context such as requesting provider information, and some mix of atomic results, images, textual and coded interpretations, and formatted representation of diagnostic reports. The report also includes non-clinical context such as batch analysis and stability reporting of products and substances.

Document Reference	A reference to a document of any kind for any purpose. While the term "document" implies a more narrow focus, for this resource this "document" encompasses any serialized object with a mime-type, it includes formal patient-centric documents (CDA), clinical notes, scanned paper, non-patient specific documents like policy text, as well as a photo, video, or audio recording acquired or used in healthcare. The DocumentReference resource provides metadata about the document so that the document can be discovered and managed. The actual content may be inline base64 encoded data or provided by direct reference.
Encounter	An interaction between a patient and healthcare provider(s) for the purpose of providing healthcare service(s) or assessing the health status of a patient. Encounter is primarily used to record information about the actual activities that occurred, where Appointment is used to record planned activities.
Goal	Describes the intended objective(s) for a patient, group or organization care, for example, weight loss, restoring an activity of daily living, obtaining herd immunity via immunization, meeting a process improvement objective, etc.
Immunization	Describes the event of a patient being administered a vaccine or a record of an immunization as reported by a patient, a clinician or another party.
Location	Details and position information for a place where services are provided and resources and participants may be stored, found, contained, or accommodated.
Medication	This resource is primarily used for the identification and definition of a medication, including ingredients, for the purposes of prescribing, dispensing, and administering a medication as well as for making statements about medication use.
Medication Request	An order or request for both supply of the medication and the instructions for administration of the medication to a patient. The resource is called "MedicationRequest" rather than "MedicationPrescription" or "MedicationOrder" to generalize the use across inpatient and outpatient settings, including care plans, etc., and to harmonize with workflow patterns.
Observation	Measurements and simple assertions made about a patient, device or other subject.
Organization	A formally or informally recognized grouping of people or organizations formed for the purpose of achieving some form of collective action. Includes companies, institutions, corporations, departments, community groups, healthcare practice groups, payer/insurer, etc.

Patient	Demographics and other administrative information about an individual or animal receiving care or other health-related services.
Practitioner	A specific set of Roles/Locations/specialties/services that a practitioner may perform, or has performed at an organization during a period of time.
Procedure	An action that is or was performed on or for a patient, practitioner, device, organization, or location. For example, this can be a physical intervention on a patient like an operation, or less invasive like long term services, counseling, or hypnotherapy. This can be a quality or safety inspection for a location, organization, or device. This can be an accreditation procedure on a practitioner for licensing.
Provenance	Provenance of a resource is a record that describes entities and processes involved in producing and delivering or otherwise influencing that resource. Provenance provides a critical foundation for assessing authenticity, enabling trust, and allowing reproducibility. Provenance assertions are a form of contextual metadata and can themselves become important records with their own provenance. Provenance statement indicates clinical significance in terms of confidence in authenticity, reliability, and trustworthiness, integrity, and stage in lifecycle (e.g. Document Completion - has the artifact been legally authenticated), all of which may impact security, privacy, and trust policies.
Related Person	Information about a person that is involved in a patient's health or the care for a patient, but who is not the target of healthcare, nor has a formal responsibility in the care process.
Service Request	A record of a request for service such as diagnostic investigations, treatments, or operations to be performed.

Support

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