Frequently Asked Questions

What Standards and APIs does the Healthcare API Server support?

Our Healthcare API Server implements APIs using the HL7® FHIR® Standard for Trial Use Release 2, and the HL7® Consolidated CDA (C-CDA) Implementation Guide Release 2.1, and can support other HL7® CDA® Release 2.0 based document formats.

The Healthcare API Server supports access to system configuration, clinical and administrative data using the HL7® FHIR® standard. It includes operations defined using GE Healthcare extensions to the FHIR standard to create clinical documents using the HL7 Consolidated CDA Release 2.1 standard.

What is a Resource?

In Internet terms, a resource is an information item that can be accessed over the web through a URL (Uniform Resource Locator). It is the basic content associated with a RESTful API.

What API Resources are available to access System Configuration Data?

System Configuration data includes access to the following FHIR resources:

Resource	Read	Search
metadata	√	
	√	√
	√	√
	√	√
Medication	√	√
OperationDefinition	√	
	√	√
	√	√
	√	√

ValueSet	√	√

What API Resources are available to access Clinical Data?

Clinical data includes access to the following FHIR resources:

Resource	Read	Search
AllergyIntolerance	√	√
CarePlan	√	√
	√	√
	√	√
	√	√
DocumentReference*	√	√
	√	√
	√	√
	√	√
	√	√
	√	√
	√	√
	√	√
	√	√
	√	
	√	√
	√	√
	√	√

What API Resources are available to access Administrative and Financial Data?

Administrative data includes access to the following FHIR resources and operations:

Resource	Read	Search	Create	Update	Delete
	√	√	√	√	
	√	√	√		
	√	√	√		√
	√	√	√	√	
	√	√	√	√	
	√	√	√	√	
RelatedPerson	√	√	√	√	
Schedule	√	√			
Slot	√	√			

What vocabularies does the Healthcare API Server use?

Standard vocabularies are used when the provider workflow uses standard items from lists configured in the product, or in some cases where free text matches the preferred description from standardized terminology.

- **Problems** and **Family** History can be coded using SNOMED® CT, ICD-10-CM and ICD-9-CM
- **Lab Results**, **Vital Signs**, **Social History** and other observations are coded using LOINC® for the observation type, and SNOMED CT for certain kinds of results.
- **Medications** are coded using RxNORM and National Drug Codes (NDC).
- **Allergies** can be coded using RxNORM for medication allergies, and reactions can be coded to SNOMED CT.
- **Immunizations** can be coded to CVX and RxNORM.
- Procedures can be coded using CPT®, SNOMED CT, and LOINC codes.

What is FHIR®?

FHIR is a standard being developed by Health Level 7 International that describes the information contained within Electronic Health Record systems as information resources available through RESTful, internet accessible resources. More information about FHIR can be found at http://www.hl7.org/fhir.

What are CDA®, CCD® and CCD-A?

Clinical Document Architecture Release 2, or CDA is an information exchange standard, from Health Level 7 International. CDA allows clinical data to be exchanged in Extensible Markup Language (XML) formats that contain both human and machine readable data using tags similar HTML, but meeting healthcare specific content requirements.

The Continuity of Care Document (CCD) Implementation Guide, also published by HL7 defines how to exchange the relevant and pertinent information supporting continuity of care for patients being referred or transferred to other care providers or settings. It uses CDA as the base standard, and implements the information requirements of the ASTM Continuity of Care Record.

The Consolidated CDA Implementation Guide includes the current version of CCD as well as other clinical document templates that support exchange of information required to coordinate patient care.

What do I do if I find a problem?

GE Customers, Value Added Resellers and participants in the GE Partner program should contact product support to address issues found during testing. NOT SURE WHAT ELSE TO SAY HERE