CCD - Continuity of Care Document

The Continuity of Care Document (CCD) is built using HL7 Clinical Document Architecture (CDA) elements and contains data that is defined by the ASTM Continuity of Care Record (CCR). It is used to share summary information about the patient within the broader context of the personal health record.

The CCD was formed through a joint collaboration between Health Level 7 and ASTM International as a way to address the divide between those who have adopted HL7 CDA and those who have adopted ASTM CCR. It was endorsed by CCHIT as part of their EHR certification requirements in June 2008, and is predicted to drive the use of electronic exchange for clinical data.

CCD is compatible with any document or standard that uses RIM-based specifications, including new versions of HL7, new types of public safety reports, IHE specifications, HITSP specifications and CDISC. Because of its small fixed XML tag set, CCD can be universally rendered as HTML or PDF without requiring specialized communication efforts.

CCD uses a detailed set of constraints (or templates) for CDA elements. The templates define how to use CDA elements to communicate clinical data, but the scope of the data within the templates is determined by the CCR.

CCD Templates* include:

1. Header
2. Purpose
3. Problems
4. Procedures
5. Family history
6. Social history
7. Payers
8. Advance directives
9. Alerts
10. Medications
11. Immunizations
12. Medical equipment
13. Vital signs
14. Functional stats
15. Results
16. Encounters
17. Plan of care

*excludes supporting templates

Additional information can be found on the HL7 Standards resource site and in Corepoint Health's Resource Center:

- HL7 Continuity of Care Document Quick Start Guide (blog post)
- HL7 CCD Topic Category (blog)
- Continuity of Care Document white paper (PDF)

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