

Standard Specification for Continuity of Care Record (CCR)¹

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1. Scope

1.1 The Continuity of Care Record (CCR) is a core data set of the most relevant administrative, demographic, and clinical information facts about a patient's healthcare, covering one or more healthcare encounters.² It provides a means for one healthcare practitioner, system, or setting to aggregate all of the pertinent data about a patient and forward it to another practitioner, system, or setting to support the continuity of care.

1.1.1 The CCR data set includes a summary of the patient's health status (for example, problems, medications, allergies) and basic information about insurance, advance directives, care documentation, and the patient's care plan. It also includes identifying information and the purpose of the CCR. (See 5.1 for a description of the CCR's components and sections, and [Annex A1](#) for the detailed data fields of the CCR.)

1.1.2 The CCR may be prepared, displayed, and transmitted on paper or electronically, provided the information required by this specification is included. When prepared in a structured electronic format, strict adherence to an XML schema and an accompanying implementation guide is required to support standards-compliant interoperability. The Adjunct³ to this specification contains a W3C XML schema and [Annex A2](#) contains an Implementation Guide for such representation.

1.2 The primary use case for the CCR is to provide a snapshot in time containing the pertinent clinical, demographic, and administrative data for a specific patient.

1.2.1 This specification does not speak to other use cases or to workflows, but is intended to facilitate the implementation

of use cases and workflows. Any examples offered in this specification are not to be considered normative.⁴

1.3 To ensure interchangeability of electronic CCRs, this specification specifies XML coding that is required when the CCR is created in a structured electronic format.⁵ This specified XML coding provides flexibility that will allow users to prepare, transmit, and view the CCR in multiple ways, for example, in a browser, as an element in a Health Level 7 (HL7) message or CDA compliant document, in a secure email, as a PDF file, as an HTML file, or as a word processing document. It will further permit users to display the fields of the CCR in multiple formats.

1.3.1 The CCR XML schema or .xsd (see the Adjunct to this specification) is defined as a data object that represents a snapshot of a patient's relevant administrative, demographic, and clinical information at a specific moment in time. The CCR XML is not a persistent document, and it is not a messaging standard.

NOTE 1—The CCR XML schema can also be used to define an XML representation for the CCR data elements, subject to the constraints specified in the accompanying Implementation Guide (see [Annex A2](#)).

1.3.2 Using the required XML schema in the Adjunct to this specification or other XML schemas that may be authorized through joint efforts of ASTM and other standards development organizations, properly designed electronic healthcare record (EHR) systems will be able to import and export all CCR data to enable automated healthcare information transmission with minimal workflow disruption for practitioners. Equally important, it will allow the interchange of the CCR data between otherwise incompatible EHR systems.

1.4 *Security*—The data contained within the CCR are patient data and, if those data are identifiable, then end-to-end CCR document integrity and confidentiality must be provided

¹ This specification is under the jurisdiction of ASTM Committee E31 on Healthcare Informatics and is the direct responsibility of Subcommittee E31.25 on Healthcare Data Management, Security, Confidentiality, and Privacy.

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² A CCR is not intended to be a medical-legal clinical or administrative document entered into a patient's record, but may in specific use cases be used in such a manner, provided that accepted policies and procedures in adding such data to a patient's record are followed. A personal health record, with the information under the control of the patient or their designated representative, would be an example of such a use case, as would be importation into an electronic health record system, a data repository, or a registry.

³ Available from ASTM International Headquarters. Order Adjunct No. ADJE2369. Original adjunct produced in 2006.

⁴ Since the CCR is a core data set of selected, relevant information, it is not a discharge summary, that is, it does not include all of a patient's health information that would be routinely recorded at the time of discharge, nor is it the transfer of an entire patient record.

⁵ The required XML may be as represented in the Adjunct to this specification or [Annex A2](#) or other XML representation made possible through joint efforts of ASTM and other standards development organizations.