TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

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National Coordinator for Health Information Technology
Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
330 C St. SW; Floor 7
Washington, DC 20201

Submitted via ONC's USCDI webpage

RE: Comments on United States Core Data for Interoperability Draft Version 5

Dear Dr. Tripathi,

On behalf of the Texas Medical Association (TMA) and our more than 57,000 physician and medical student members, we thank you for the opportunity to comment on the United States Core Data for Interoperability (USCDI) Draft Version 5.

TMA recognizes the benefit of standardizing data elements to facilitate interoperability of patient information and appreciates the steps the Office of the National Coordinator for Health Information Technology (ONC) is taking to advance data sharing. TMA urges ONC to define applicable vocabulary standards as part of the standardized process to ensure that disparate systems are exchanging data elements with a common language.

Of the 13 new data elements, eight do not have a correlating vocabulary standard. If ONC adopts the newly proposed data elements, there will be a total of 127 data elements, 54 of which will not have a correlating vocabulary standard. Without vocabulary standards, electronic health record (EHR) vendors can choose their preferred vocabulary standard, which inhibits interoperability. TMA encourages ONC to work with EHR vendors to reach consensus on vocabulary standards for each USCDI data element. Before advancing additional vendor requirements, ONC should conduct testing among certified EHR vendors to ensure the data is interoperable between disparate systems.

While TMA agrees with the addition of many of the proposed data elements, it is important for ONC to understand that not all elements are applicable to all medical specialties. EHRs should have the ability to suppress fields that are not applicable, and thus reduce EHR clutter with the goal of improving EHR usability. This will reduce EHR complexity that can lead to physician frustration and burnout.

For many years, TMA has advocated for universal use of extensible markup language (XML) or a similar standard (e.g., Fast Healthcare Interoperability Resources, or FHIR) as a way of exchanging meaningful health data, as is used in accounting and other industries. Universal common encoding of all data elements could permit disparate systems to share and consume information much more easily. Information consumed by a receiving EHR could be placed correctly within the system to give it meaning and make it useful. Requiring

this kind of data-element tagging as part of USCDI has the potential to rapidly advance ONC's interoperability goals while decreasing user burden. Standardized encoding of all data elements supports physicians who desire changing EHRs by making it possible to seamlessly move from one EHR to another at little to no cost.

Additionally, ONC should consider collecting data on how well various organizations are adapting to and complying with use of new data elements. This should include Qualified Health Information Networks (QHINs) and Health Information Exchanges (HIEs) to understand if the USCDI v1 data elements can all be exchanged seamlessly and without additional user effort.

Specific data elements
TMA also offers for ONC's consideration the following feedback on specific data elements of USCDI Version 5.

- *Immunization Lot Number:* This data element should not be adopted until there is a correlating vocabulary standard.

- *Advance Directive Observation:* This data element should not be adopted until there is a correlating vocabulary standard.

- *Sex Parameter for Clinical Use:* This data element should not be adopted until there is a correlating vocabulary standard.

- *Orders:* ONC should not adopt "Orders" as a new data class or a new data element. Not only does it not have a correlating vocabulary standard, but physicians' EHRs are already filled with many orders. This includes orders never completed by the patient; some which are complete with results delivered; and others that fall into the "intent to treat" category. The number of orders is so voluminous that adding yet another data element adds additional noise that is not necessarily actionable. For example, why do physicians need to see orders for tests that are completed with results delivered?

- *Name to use:* This data element should not be adopted until there is a correlating vocabulary standard.

- *Pronoun:* This data element should not be adopted until there is a correlating vocabulary standard.

- *Author (Provenance):* This data element should not be adopted until there is a correlating vocabulary standard.

- *Author Role (Provenance):* This data element should not be adopted until there is a correlating vocabulary standard.

TMA appreciates the opportunity to provide feedback on USCDI Version 5. Any questions may be directed to Shannon Vogel, associate vice president of health information technology, by emailing shannon.vogel@texmed.org or calling (512) 370-1411.

Sincerely,

Richard "Rick" W. Snyder, II, MD
President
Texas Medical Association