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February 15, 2018

The Honorable Donald Rucker, MD,
National Coordinator for Health Information Technology,
US Department of Health and Human Services
200 Independence Ave. SW
Washington, DC, 20201

Comments submitted electronically at: exchangeframework@hhs.gov

Re: DRAFT US Core Data for Interoperability (USCDI) and Proposed Expansion Process

Dear Dr. Rucker:

The Alliance for Nursing Informatics (ANI) and The American Nurses Association (ANA) appreciate the opportunity to comment as nursing stakeholders on the DRAFT US Core Data for Interoperability (USCDI) and Proposed Expansion Process. We provide comments to the related ONC's Draft Trusted Exchange Framework and Common Agreement (TEFCA) in a separate comment letter.

The Alliance for Nursing Informatics (ANI), cosponsored by AMIA & HIMSS, advances nursing informatics leadership, practice, education, policy and research through a unified voice of nursing informatics organizations. We transform health and healthcare through nursing informatics and innovation. ANI is a collaboration of organizations that represents more than 5,000 nurse informaticists and brings together 25 distinct nursing informatics groups globally. ANI crosses academia, practice, industry, and nursing specialty boundaries and works in collaboration with the more than 3 million nurses in practice today.

The American Nurses Association (ANA) is the premier organization representing the interests of the nation's 3.6 million registered nurses. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. ANA is at the forefront of improving the quality of health care for all.

As the most honest and ethical profession[1], Nurses play a significant role in advancing a robust ecosystem of health information exchange and make major contributions to improving our nation's population health[2]. We are well prepared to support collaboration with others to achieve expectations

[1] Gallop Poll, December, 2017, "Nurses Keep Healthy Lead as Most Honest, Ethical Profession", retrieved from: http://news.gallup.com/poll/224639/nurses-keep-healthy-lead-honest-ethical-profession.aspx
[2] Robert Wood Johnson Foundation (September, 2017) *Catalyst for Change: Harnessing the Power of Nurses to Build Population Health for the 21st Century*, retrieved from: https://www.rwjf.org/content/dam/farm/reports/reports/2017/rwjf440286

set in the 21st Century Cures Act for interoperability in health information technology (health IT) that sets an expectation that **ALL** of a patient's health information that is stored electronically will be able to be exchanged, and:

a) Enables the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user;

b) Allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law; and

c) Does not constitute information blocking as defined in section 3022(a).

ANI and ANA support the **DRAFT US Core Data for Interoperability (USCDI) and Proposed Expansion Process** and offer **two overall recommendations** plus a series of more granular comments.

ANI and ANA Recommendations

1. Adequate Pilot Testing

Given the recognition that the technical work to prepare the data class for inclusion in the USCDI could take 12, 18, or 24 months to complete, including certain candidate data classes remaining in this status for 2 to 3 years, the industry will require adequate pilot testing to assure readiness for adoption. Pilot testing will need to include:

a) Technical readiness within the EHR, other sources of EHI, including novel data sources

b) Clinical workflow readiness with a focus on effective care coordination across representative settings (e.g. acute care, emergency care, long term care, home care, behavioral health, schools)

c) Education readiness for Individuals and their authorized caregivers with a focus on safety in care transitions and ease of access/exchange

2. Include Nursing and Consumer representation in the TEFCA and USCDI FACA Workgroups

We recognize that the USCDI and proposed expansion process requires the industry to collectively work towards defining the data that needs to be exchangeable. Additionally, work will be required to prioritize the development of technical standards and implementation guidance to support the exchange of such data, and, ultimately, to implement and adopt those capabilities for robust person-centered health exchange at the point of care, across diverse care settings. Effectively achieving a predictable, transparent, and collaborative process for achieving those goals calls for engagement by diverse stakeholders, including consumer health advocates and nurses.

ANI and ANI will provide letters of support for nursing informatics experts to serve in these roles.

Data Classes in Draft USCDI V1.	
Questions	**ANI and ANA Comments & Recommendations**
1: Overall *The same data classes referenced by the 2015 Edition CCDS definition.*	• The CCDS set is a good start on data needed for interoperability but the required values (or value sets) for the coded questions need to be pointed to or defined. • "Assessment and Plan of Treatment" is considered one data class, and should be divided into two classes. • We recommend that "Education" be added as a data class. • We recommend that "Gender Identity and/or Expression" be added as a data class.
2. Clinical Notes *Clinical Notes are composed of structured (pick-list and/or check the box) and unstructured (free text) data. The free text portion of the clinical note may include the assessment, diagnosis, plan of care and evaluation of plan, patient teaching and other relevant data points. Clinical notes data was most often identified by clinicians as the data they sought but were often missing when they engaged in interoperable exchange.*	• We support the addition of Clinical Notes. • We need to better define types of notes. See LOINC for examples of clinical note types. • We need the ability to capture clinical note by role, diagnosis and specialty. • One of the most valuable types of clinical notes for care coordination and patient safety include a variety of care plans. Care plans may exist as notes, as flow sheets, as reports, and as a combination of structured and unstructured data. Clinical Notes may be clinical provider and/or patient facing. We ask for clarification. Those currently being exchanged, including with School Nurses and Care Managers, may be labeled as Longitudinal Care Plan (LPOC), Asthma Action Plan, the Adaptive Care Plan, to name a few.
3. **Provenance** *Provenance describes the metadata, or extra information about data, that can help answer questions such as when and who created the data*.	• Provenance (who, what, when, where) is not yet defined. • Care team members, across diverse settings, such as School Nurses, need to be included • Individuals (patients) need to be included in Provenance
4. Industry Timeline *The Draft TEF proposes that QHINs and their Participants must update their data format and/or API to include new data classes added to the USCDI not less than 12 months after the data class has been officially added. We request comment on the feasibility of this timeframe.*	• Considering if the timeline is reasonable, Nurse Informaticists and HIT support teams will need continued education on APIs and new FHIR-based standards. • Regional resources may need to be available, similar to the Regional Extension Centers of the past, to support settings with under-developed HIT adoption, including limited HIT education resources. • Intentional industry commitment will be needed to prioritize and devote the resources necessary to position these data classes for promotion to the USCDI as soon as practical.

USCDI Candidate and Emerging Data Classes Under Consideration	
Questions	**ANI and ANA Comments & Recommendations**
1. Public Input *We request public comment on the initial assignment of the data classes in the candidate and emerging sections as well as additional characteristics or attributes that should be considered in determining a data class' status, especially, whether a data class should be promoted to candidate status. We also request comment on additional data classes that should be added to either list, removed, or moved from one status to another.* *These classes span a wide variety of use cases and target populations — including behavioral health, long term and post-acute care (LTPAC), individual access, public health, emergency medical services (EMS), pediatrics, social determinants of health, transitions of care, provider directory services, and clinical quality measures (CQMs).*	We applaud and recommend that ONC continue to gain broad public input. We encourage ONC to concurrently align the data classes with existing and/or emerging quality, public health and other incentive program reporting. We strongly recommended clear inclusivity in language and data attribution to nurses and other care providers in inter-professional teams.

USCDI 2019 v2	*See Table 2: USCDI Candidate Status Data Classes*
Admission and Discharge Dates and Locations	• Monitor current work being done to assess and measure High Frequency Utilization, by CMS and others innovating in complex high-risk care. This work may add locations of health and social service that are significant to the longitudinal patient story, as well as add exchange partners.
Cognitive Status	• Cognitive Function needs to represent changes over time
Encounter	• Edit for clear inclusivity in language and data attribution to nurses and other care providers in inter-professional teams.
Discharge Instructions	• Expand definition, care by authorized care providers (e.g. family care)
Family Health History	• Concur as written
Functional Status	• We support prioritizing this data class • Represents most significant determinant of mortality, morbidity and capacity for self and other care • Functional status is also inter-disciplinary, common need to all clinical roles (e.g. Nurse, Physical Therapist, Speech Language Pathologist)

USCDI Candidate and Emerging Data Classes Under Consideration	
Questions	**ANI and ANA Comments & Recommendations**
Gender Identity	• We recommend that "Gender Identity and/or Expression" be added as a data class. • Prioritize, and reconsider for V1
Pediatric Vital Signs	Concur as written
Pregnancy Status	Concur as written
Reason for Hospitalization	Concur as written
USCDI 2020 v3	*See Table 2: USCDI Candidate Status Data Classes*
Care Provider Demographics	• Edit for clear inclusivity in language and data attribution to nurses and other care providers in inter-professional teams.
Care Team Members Contact Information	• We encourage consideration of how dynamic these fields will be over time, especially for the Individual and authorized caregivers accessing and finding this information useful.
Care Team Members Roles/Relationships	• Edit for clear inclusivity in language and data attribution to nurses and other care providers in inter-professional teams. • Consider how this is sourced in EHR versus PHR, and how patient's updates are inclusive in the Exchange.
Diagnostic Imaging Reports (DIR)	• Edit for clear inclusivity in language and data attribution to nurses and other care providers in inter-professional teams.
USCDI 2021 v4	*See Table 2: USCDI Candidate Status Data Classes*
Individual Goals and Priorities	• Concur as written • We encourage ONC to continue to align language with other initiatives, like NCQA, in developing person centered goals and measurement of person centered outcomes.
Practitioner Responsible for Care	• Concur as written
Provider Goals and Priorities	• Edit for clear inclusivity in language and data attribution to nurses and other care providers in inter-professional teams.
Reason for Referral	• Concur as written
Referring or Transitioning Provider's Name and Contact Information	• Concur as written

EMERGING Data Classes	
Data Class	**ANI and ANA Comments & Recommendations**
EMERGING Status	*See Table 3: USCDI Emerging Status Data Classes*
Advanced Care Planning	• **Advance Directive** ○ Consider as part of "In Case of Emergency" Bundle • **Power of Attorney and name of Person** • **Physician Orders for Life Sustaining Treatment Form (POLST)**
Alive Status/Date of Death	• Concur as written
Care Provider Education/Licenses	• We do not support inclusion of Tax Identification Number (TIN)
Communication Facilitators	• Consider as part of "In Case of Emergency" Bundle
Minor Consent	• Consider needs and issues for exchanging this data class and its relationship to minor status emancipation
Disability Status	• Concur as written
Durable Medical Equipment	• Edit for clear inclusivity in language and data attribution to nurses and other care providers in inter-professional teams.
ESI/Electronic endpoint (for each organization, individual, relationship, system)	• Concur as written
Health Insurance Information	• Concur as written
Minor Status Emancipation	• Will need consistency and alignment across EHRs, and personal m-health tools, patient portals and usability for the Individual and care teams
Personal Representative	• Clearly define difference between Personal Representative and Authorized Caregiver
Social, psychological and behavioral data • Education • Overall Financial Strain • Social	• Add Adverse Childhood Events (ACE) • The class labeled Overall Financial Strain requires some definition modification. Sources of strain are complex, interdependent and may relate to other factors not listed, such as depression, employment, alcohol and/or drug use. (*Encompasses both the subjective sense of strain as the result of economic difficulties and the specific sources of strain, including employment insecurity,*

EMERGING Data Classes	
Data Class	**ANI and ANA Comments & Recommendations**
Connection/Support and Isolation • Exposure to Violence • Employment Status • Depression • Stress • Physical Activity • Alcohol Use • Veteran's Status/Military History	*income insecurity, housing insecurity, transportation insecurity, and food insecurity.*) • Drug use is missing
Reconciled Medication List	• Recommend date/time/location of last Medication Reconciliation
Special Instructions or Precautions for Ongoing Care	• Concur as written
Travel Status/History	• Concur as written
Weight –Based Dosing	• Concur as written

What is Missing?

We note emphasis across health care setting to track and measure "Gaps in Care", as well as the standard development community supporting adoption of GiC standard.

In closing, we encourage the ONC to frame the context of the USCDI and expansion process in terms of its impact on population health and incremental movement towards **ALL** electronic health information being available and exchangeable for individuals, QHINs and participants. We urge the ONC and working committees to continually ask and evaluate:

a) What data categories and classes, if exchanged easily, will make the most difference to improving individual and population health for our nation's citizens?

b) What difference is the type of data (classes and individual items in the exchange) making to Individuals and their authorized caregivers, for care coordination across transitions of care, time and settings?

c) How will the additional emerging, candidate and required data classes contribute to the person's longitudinal comprehensive health story/record?

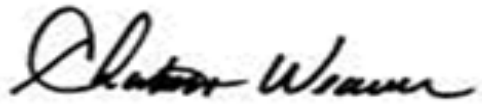
d) How is each annual cycle of USCDI data class determination (emerging, candidate and required) contributing to the Cures Act requirement that **all** electronic health information from a patient's record be available?

We invite the ONC to continue to recognize the unique and important role of nursing in creating and exchanging health data. Relevant to the USCDI, ANA has previously stated in comments on "Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Draft Version 1.0," dated April 2, 2015:

> "Registered nurses are pivotal in identifying patient-centered problems (e.g., incontinence, functional status) through standardized screening and assessments and compiling data. They provide information to other clinicians and are an essential source of information for patients, families and other caregivers. Registered nurses also have a critical role in documenting health information in current electronic health records (EHR) and providing care coordination in multiple roles, including during care transitions between units in acute care and across all care settings. Utilization of terminologies (and standards) that support nursing practice and patient-centered care will ensure that the steps articulated in this roadmap will result in data that informs comprehensive patient-centered care. Data collected by nurses and entered in the EHR ensures the capture of the contributions of registered nurses, the largest group of healthcare professionals. The promise of data analytics to improve patient care and outcomes will not be fully achieved without the inclusion of this data."

ANI and ANA commend ONC on this effort and look forward to continued engagement. We thank you for the opportunity to provide comments.

Sincerely,



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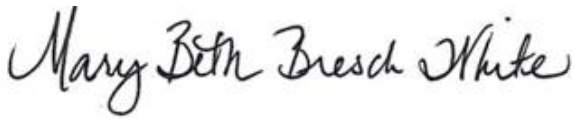

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