AHIMA Comments on US Core Data for Interoperability Draft Version 2
April 15, 2021

General comments

AHIMA sees the aspirational nature for the USCDI to encompass data classes such as provider directories, that are priorities for interoperability but may not technically meet the definition of EHI. As the USCDI expands, so too will EHI with new classes of health information increasingly used for decision making. Because the standards development process may lag slightly as those data classes and elements are added to the USCDI, this makes a USCDI "superset" aspirational.

As USCDI continues to expand, categories within the USCDI may become helpful or necessary. For example, health information could be one category. Sub-categories of health information may subsequently include clinical, administrative, and billing information. Other categories may be purpose-of-use related.

AHIMA believes that as actors transition in 2022 to the EHI definition no longer limited to the EHI identified by the data elements represented in the USCDI, a standardized understanding of what data elements are EHI, and situations where certain data elements are out of scope, would be valuable to many stakeholders. This includes documentation and maintenance of these standardized understandings so they will be readily accessible to stakeholders. Along these lines, we suggest that ONC consider housing this information with other USCDI information on the ONC website.

We also encourage ONC to consider including data elements that support the COVID-19 vaccination process as part of USCDI v2.

Proposed USCDI v2 Data Classes and Data Elements

Care Team Members

AHIMA asks ONC to clarify the relationship between "Provider Name" and the existing "Care Team Member(s)" data element currently in USCDI v1. It is unclear how these two data classes relate to each other given that providers are generally members of the care team.

Diagnostic Imaging

AHIMA suggests that ONC clarify the scope of the Diagnostic Imaging Report. It is unclear whether the Diagnostic Imaging Report is intended to solely be the documentation of the test itself and how it distinguishes from Diagnostic Imaging Narrative.

Encounter Information

Further clarification is needed regarding the definition of "Encounter Type." For patients who might be transferred to multiple times during a single inpatient stay, it is unclear whether classification of the encounter should be based on admission, where the patient spends the most time, etc.

AHIMA also suggests that ICD-10-CM is the appropriate standard for "Encounter Diagnosis." The concept of an "encounter," or "primary," or "discharge" diagnosis are not necessarily applicable to SNOMED-CT, given that SNOMED is a terminology that simply represents clinical concepts. We also seek clarification as to whether SNOMED CT, US Edition, March 2021 Release should be the applicable standard or if it should be SNOMED CT, US Edition, September 2020 Release.

AHIMA also recommends that additional clarification is needed regarding the scope of "Encounter Time." Does encounter time refer to when the clinician is face-to-face with the patient? Is it intended to include time outside of seeing the patient face-to-face such as when the clinician is reading medical record documentation, reviewing test results, or consulting other clinicians? Further clarification is needed as to what is meant by "date and time associated with the encounter for clinical context."

Problems

"Date of Diagnosis" and "Date of Resolution" are both important data elements to be included in USCDI v2, however, we are concerned about their subsequent interpretation, use, and maintenance—particularly in instances when patients experience multiple encounter locations, which in turn could lead to data quality and integrity concerns.

Level 2 Data Classes and Data Elements

Patient Demographics

AHIMA encourages the inclusion of additional patient demographic data elements in the USCDI. Many of these elements are immensely helpful in improving patient identification and matching including, but not limited to, "Mother's Maiden Name" and "Multiple Birth Order."

"Gender Identity" and "Sexual Orientation" are also critical data elements that should be added to USCDI v2. We believe are important to not only improve the delivery of culturally competent care for LGBTQ patients, but to address health disparities and inequities in the LGBTQ patient population.

Problems

AHIMA recommends that ONC clarify that the applicable standard for "Problems, defined by ICD-10-CM terminology standards" should be ICD-10-CM, not ICD-10. Additionally, the link to the standard should be the Centers for Disease Control and Prevention's National Center for Health Statistics' website (https://www.cdc.gov/nchs/icd/icd10cm.htm), not the World Health Organization's website, to reflect the US clinical modification.

More generally, we recognize the rationale for including ICD-10-CM as a standard for the "Problems" data element, since this code set is in such widespread use; however, we have concerns about using ICD-10-CM to describe patient "problems." Because ICD-10-CM is a classification and not a terminology, some problems fall under an "other" or "unspecified" ICD-10-CM category, resulting in a problem being identified, for example, as "other disorder of the musculoskeletal system." This appear problematic, as "problems" are not commonly described in such terms. Furthermore, ICD-10-CM may not at times provide the level of specificity needed to describe a problem as is possible in SNOMED.

Thank you for the opportunity to provide comments. Should you have any additional questions, please contact Lauren Riplinger, Vice President, Policy & Government Affairs at lauren.riplinger@ahima.org or 202.839.1218.