April 15, 2021

Micky Tripathi, Ph.D. M.P.P.
National Coordinator for Health Information Technology
Office of the National Coordinator
U.S. Department of Health and Human Services
330 C ST SW
Mary Switzer Building; Mail Stop 7033A
Washington, D.C. 20201

Via Electronic Submission

Re: United States Core Data for Interoperability Draft Version 2

Dear National Coordinator Tripathi:

The LexisNexis Risk Solutions business ("LexisNexis") is pleased to submit comments to the Office of the National Coordinator for Health Information Technology (ONC) regarding the United States Core Data for Interoperability (USCDI) Draft Version 2. We appreciate the considerable work that ONC has undertaken and continues to do to set a foundation for broader sharing of electronic health information to support patient care.

Our comments regarding USCDI V2 are focused on a proposed addition to Care Team Member(s). We wish to share our expertise related to the use of physician specialty encoding in a manner that translates well across the industry.

LexisNexis Risk Solutions harnesses the power of data and advanced analytics to provide insights that help businesses and governmental entities reduce risk and improve decisions to benefit people around the globe. In healthcare, LexisNexis provides advanced understanding of providers and patients to health care insurers, providers, pharmacies, life sciences companies, and government agencies, to enable better patient outcomes, more effective care coordination, improved patient data privacy and security, innovative research and development, and operational efficiency.

LexisNexis maintains and commercializes a database including all healthcare providers and health organizations in the US, totaling 11 million plus entities, including, physicians, advanced practice providers, behavioral health professionals, hospitals, and other facilities, etc. To create and maintain this dataset, we draw upon numerous, varied sources on an ongoing basis. One challenge is to normalize the way that different

providers and other organizations characterize the different types of Physician Specialty. As we source data from across the industry, we find wide variation across the industry in the structure and domain of possible values (as one example, ENT vs otorhinolaryngologists). There is also significant confusion around the use of sub-specialties (pediatric oncology) as either subsets of other specialties (pediatrics or medical oncology) or when considered a specialization on its own.

While these variations have been difficult in the past, it has not been a critical problem because the people primarily using these data values have been other healthcare personnel who can read the different terms (Family Practice vs Primary Care or Interventional Radiologists vs Radiologists) and have a knowledgebase that allows them to interpret them correctly. But the utilization of the USCDI as a normalizing agent for the access and use of the data by patients will cause this problem to be more acute. Ordinary people who are not healthcare experts will have great difficulty navigating the variation in provider specialty coding that occurs today. Imagine someone looking for a specialist to treat vein issues. How can they be expected to know whether they need a Vascular Surgeon, or a Phlebologist, or a Cardiovascular Surgeon?

LexisNexis believes that any new specialty designation for healthcare providers should follow the standards set forth by WPS Government Health Administrators (see WPS). This includes both the structure of the data and the values within and their curation of changes to the values over time.

Generally, there are two specialty formats known in the industry: 1) AMA Specialty designations and 2) Taxonomies provided by WPS. Therefore, as we drew upon our 20 years of experience in working with this data, we considered 3 options: AMA, WPS or something new.

AMA: The AMA specialties are more generic and represent more easily understood specialty values for consumers. However, it is only for a subset of providers (AMA members) and does not provide the granularity supported by WPS. For those reasons we do not recommend them as a standard.

WPS: These standards have been adopted since the onset of the NPPES database and are continually updated as new specialties evolve. They support both Individual and Organizations and because they are tied to the NPPES database, companies have built their processes around them. They are multi-tiered which can enable users to design their classifications at different levels dependent on their use cases. Taxonomies can also be mapped to AMA specialties or something similar.

Something new: with the complexities that interoperability presents, changing specialty types would add another challenge that is not needed. The WPS standards fit the needs of the market.

We also evaluated the various State License files, which also provide us Specialty codes, but they vary so much from board to board that a standard is not achievable.

Conclusion
We are encouraged by the V2 enhancements to the USCDI. We believe this effort to strengthen standardization for nationwide, interoperable health information exchange, will have broader applicability and facilitate the usability of data beyond the siloes of the current healthcare system. The USCDI can be a rationalizing force in how we share data across all populations and types of stakeholders and a normalization in the way we discuss physician specialty is badly needed. We hope this comment helps ONC and HL7 in their work to promote meaningful interoperability.

Should you have any questions or if we can be of assistance, please feel free to contact me at (706) 338-8024 or jay.sultan@lexisnexisrisk.com, or Julien Nagarajan, Manager, Government Affairs Mid-Atlantic & US Health Policy, at (202) 403-7346 or julien.nagarajan@relx.com.

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