National Association for the Support of Long Term Care

Insight • Advocacy • Action

April 14, 2021

Micky Tripathi, PhD, MPP
National Coordinator for Health Information Technology
U.S. Department of Health & Human Services (HHS)
Office of the National Coordinator for Health Information Technology (ONC)
330 C Street, SW
Room 7033A
Washington, DC 20201

Electronic Submission to HealthIT.gov/ISA

RE: Draft US Code for Data Interoperability Version 2

Dear Mr. Tripathi:

The National Association for the Support of Long Term Care (NASL) appreciates the opportunity to share our comments with the HHS Office of the National Coordinator for Health Information Technology (ONC) regarding the *Draft US Code for Data Interoperability Version 2 (Draft USCDI v2).*

NASL is a trade association representing the providers of ancillary care and services and products to the long term and post-acute care (LTPAC) sector. NASL members include rehabilitation therapy companies; providers of clinical laboratory services and portable x-ray; suppliers of complex medical equipment and other specialized supplies; and health information technology (health IT) companies that develop and distribute full clinical electronic medical records (EMRs), billing and point-of-care health IT systems and other software solutions serving the majority of LTPAC providers (*i.e.,* assisted living, home health, inpatient rehabilitation facilities, long term care hospitals and skilled nursing facilities). NASL is a founding member of the Long Term & Post-Acute Care Health IT Collaborative, which formed in 2005 to advance health IT issues by encouraging coordination among provider organizations, policymakers, vendors, payers and other stakeholders.

NASL is pleased to submit these comments and welcomes the opportunity to work with ONC in further developing and expanding the standardized set of health data classes and elements contained in the US Code for Data Interoperability (USCDI) that are essential for nationwide, interoperable health information exchange. We appreciate that ONC is setting a baseline dataset that will foster greater health data exchange, which in turn will improve care for all Americans nationwide.

1444 I ("Eye") Street, NW
Suite 301
Washington, DC 20005

202.803.2385
www.NASL.org
@NASLdc

We understand that the ONC adopted the USCDI Version 1 as a standard in the *Cures Act Final Rule* last May and requires its use for certain *2015 Edition Cures Update* certification criteria. To be clear, there is no federal government requirement for long term and post-acute care providers (LTPAC) to use certified health IT nor is sharing patient health information electronically part of long term care facilities' Requirements for Participation in Medicare. Nonetheless, NASL and our health IT members, which serve the majority of the LTPAC sector, support interoperability and continue to be active participants in a variety of federal health IT initiatives and to share our insights with ONC and other federal agencies such as the Centers for Medicare & Medicaid Services (CMS).

NASL is well aware of the intersections of the USCDI and the information blocking provisions of the *Cures Act Final Rule*. We also appreciate ONC's efforts to ensure that standards like the USCDI are used to align interoperability requirements and national priorities across the federal government as well as industry-based initiatives such as Carequality and CommonWell. As the nation recovers from the COVID-19 pandemic, we believe that necessary changes to our nation's public health infrastructure demand greater use of health IT and standardized data.

> ***NASL recommends that the ONC expand its role as the nation's coordinator of health IT to encourage federal agencies such as CMS and the Centers for Disease Control & Prevention (CDC) to reflect federal health IT standards in implementing and issuing policy that will advance interoperability while maintaining the privacy of patient health information and security of the health data on which we all rely.***

Overview

NASL appreciates that the ONC recognized the ongoing burden that COVID-19 has placed not only on health care staff serving on the frontlines, but on the resources available to health IT developers that support them. The ONC's measured approach of including data elements in USCDI Version 2 that would impose minimal new development burden and complement existing data elements in the USCDI is especially welcomed by those operating in the LTPAC sector.

As longtime advocates working to advance interoperability, we agree that standards are needed now. Yet, the glaring gaps in adoption and use of health IT across the healthcare spectrum and the need to focus health IT resources on implementing new reporting requirements due to COVID-19 has us questioning if the pace of review set by the ONC and its USCDI Task Force is too rapid to allow for relevant input from all stakeholders. In order to provide the best input that we can, NASL focused our comments largely on the new data classes and data elements in the USCDI Version 2.

NASL and its members also have interest in and expertise with many of the proposed data classes and data elements that are captured in Level 2, Level 1 and Comment sections of the draft USCDI (see DRAFT USCDI – Level 2, Level 1, Comment chart below). For example, NASL members have expertise with various patient assessment instruments (*e.g.,* the Minimum Data Set (MDS) 3.0) that

are referenced in the Social Determinants of Health Data Class found in Level 2 of USCDI v2 as well as the proposed data class for "Functioning" listed under the Comment Level of the USCDI v2. In fact, NASL and many of our members were involved in developing quality measures around mobility and self-care, which are listed as potential data elements for the Functioning Data Class. We strongly urge ONC to consult with NASL and our LTPAC colleagues who have unique and in-depth understanding of the use of such data elements. Those elements cited below are a primary concern for LTPAC providers.

DRAFT USCDI – Level 2, Level 1, Comment		
Social Determinants of Health	**Functioning**	**Laboratory**
Assessment	Domestic Life/ Instrumental Activities of Daily Living (IADLs)	Laboratory Result Status
Goals	ECOG	Laboratory Result Value
Interventions	Kanefsky	Laboratory Results: Date & Timestamps
Outcomes	Mental Function	Laboratory Test Performed Date
Problems/Health Concerns	Mobility	Laboratory Test/Panel Code
	Self-care	

Care Team Member(s) Data Class, USCDI v2

DRAFT USCDI v2 – § Care Team Member(s) Data Class	
The specific person(s) who participate or are expected to participate in the care team.	
New Data Element	**Applicable Standard(s)**
§ Provider Name	Name of person with responsibility for delivering health care or related services
§ Provider Identifier	An identifier that applies to the person in this role

NASL reviewed the two, new, proposed data elements of Provider Name and Provider Identifier within the Care Team Member Data Class. Whether the descriptions listed are incomplete or the application of the use case to post-acute care settings makes it seem so, our review raised several questions. The description for Provider Name appears to require an individual's name to be noted in the health record, whereas the Provider Identifier appears to require a unique identifier that is applicable only to professional health care providers. The Use Case Description for both Provider Name and Provider Identifier are identical and offer no indication regarding specific clinical care provided to the patient by a particular healthcare professional. Applying either use case to a post-

acute care setting would require some refinement or modification to allow for multiple individuals – each of whom have separate and distinct responsibilities in caring for the patient – to be entered into the record in what appears to be a single field.

Provider Name

The Provider Name data element does not specify a standard format for listing a provider's name, nor does it specify which category of provider should be captured. Are multiple formats acceptable in listing a provider's name (*e.g.,* would either First Name_Last Name and/or First Initial_Last Name be acceptable)? Should the Provider Name data element capture the name(s) of physicians, nurses, physical therapists (PTs), occupational therapists (OTs), speech language pathologists (SLPs), physical therapy assistants (PTAs), occupational therapy assistants (OTAs) or other clinicians?

> ***NASL recommends that the ONC more clearly define the Provider Name data element. Perhaps a data dictionary or other reference guide, such as using the same formatting as is used for the Patient Demographics data class, could be cited in the USCDI to impart a more complete definitions that align with or link to the applicable standards.***

The use case description notes that, "Elements of this class are required for federal and other financial claims and reporting programs." Is there some linkage between documenting clinical care and naming of providers that would not be part of the clinical care team, yet part of a patient's care team?

NASL also found the reference to data collection related to "quality of care and safety reporting, financial information, consultation and referral, and discovery of services that may be needed for future care" confounding. Does the Provider Name data element refer to the facility where the patient receives care? Alternatively, if Provider Name refers to an individual care provider, does it require that the name of every person who attends to a patient for any reason be itemized in the health record?

Provider Identifier

It appears that the Provider Identifier data element could require that a unique identifier such as a National Provider Identifier (NPI) be recorded for each credentialed health care professional responsible for a specific treatment. What would be the intent of using an NPI as the Provider Identifier?

The use of an NPI as the Provider Identifier raised additional questions. First, does the USCDI v2 require the use of an NPI attributed to an individual provider or does it require citing an organizational NPI such as a facility's NPI? If an organization's NPI is used, would it apply to all care team members? If the Provider Identifier requires that individual NPIs be recorded, then the ONC should allow sufficient time for providers who do not have an NPI presently to obtain one. If

that is the case, then CMS also would need time to expand significantly its NPI assignment process to accommodate the influx of additional providers requesting NPIs.

It is not clear how this use case would be applied in a post-acute care setting. Even if every provider who interacts with a patient has an NPI, modifications may be needed to account for workflows that are unique to the post-acute care sector where patients are treated by more than one rehabilitation therapist (*e.g.,* PT, OT, SLP) during the course of a day. In such instances, progress notes on a patient's therapy may be split or shared by different therapists.

We question if the use of NPIs is intended to track a provider's documentation rather than reflect patient-centric documentation. Shifting from the current system for capturing clinical documentation about a patient may require a fundamental or significant data model shift. NASL believes that any such change would represent a substantial burden and would do little to improve care.

Post-acute care settings employ a variety of care team members, including certified nursing assistants and home health aides who do not have NPIs. Does the ONC intend to use this new Provider Identifier to reflect the input of both credentialed and non-credentialed caregivers who do not have specified clinical roles, but who provide critical support and assistance to an individual patient, especially in the individual's home?

In addition, it is unclear from reviewing these proposed additions to the USCDI if all of the data elements can be mapped to existing provider health IT systems without significant effort or overhaul of underlying data structure. Are proposals to track provider-specific data intended to be used outside of the context of a patient's record? The roles and personas in FHIR resources are not clearly delineated nor aligned with current facility workflows and practice. We request further clarification in order to accurately assess impact of adding these data elements to the USCDI.

Encounter Information Data Class, USCDI v2

DRAFT USCDI v2 – Encounter Information Data Class	
An episode defined by an interaction between a healthcare provider and the subject of care in which healthcare-related activities take place.	
New Data Element	**Applicable Standard(s)**
§ Encounter Type	An identifiable grouping of healthcare-related activities characterized by the entity relationship between the subject of care and a healthcare provider. This data element specifies the classification of encounter that has occurred for a patient, for example an inpatient admission, an observation stay, or an office visit and the specific type of encounter such as a follow-up visit, or encounter for a procedure.

§ Encounter Diagnosis	An identifiable grouping of healthcare-related activities characterized by the entity relationship between the subject of care and a healthcare provider. This data element specifies the classification of encounter that has occurred for a patient, for example an inpatient admission, an observation stay, or an office visit and the specific type of encounter such as a follow-up visit, or encounter for a procedure.
§ Encounter Time	SNOMED International, Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®) U.S. Edition, September 2020 Release International Classification of Diseases ICD-10-CM 2021

Encounter Type

The proposed USCDI v2 definition for an Encounter Type describes multiple "encounters" when applied to the post-acute setting. Clinically appropriate and feasible clarifications are needed to ensure accurate and complete health records. Specific guidance is needed regarding the type and frequency of Encounter Type information in the health record. For example, "An identifiable grouping of healthcare-related activities characterized by the entity relationship between the subject of care and a healthcare provider" could apply to the entire period of time a patient is being treated in a skilled nursing facility (SNF). In contrast, the description, "This data element specifies the classification of encounter that has occurred for a patient, for example an inpatient admission, an observation stay or an office visit and the specific type of encounter such as a follow-up visit, or encounter for a procedure," could be extrapolated to apply to any number of post-acute events such as multiple rehabilitation treatments in a single day, or a single attending physician visit in a SNF, or a single wound specialist treatment.

Encounter Time

Encounter Time requires the date and time associated with the encounter to be recorded. Clarification of the definition of what constitutes an encounter in the post-acute care sector may require a corresponding update or clarification to the descriptions of Encounter Time. A requirement to document both the date and time of every service a patient receives in every post-acute setting is excessive and burdensome. Doing so would not add to the quality of the clinical documentation, nor foster improvements in positive outcomes for patients. Unlike a single visit to a physician's office or surgery while in a hospital, post-acute clinical care occurs throughout the day and treatments may be split or shared among care team members (*e.g.,* PT and PTA or OT and OTA may treat a patient/ resident together or at different times of the day).

NASL seriously questions how to define an encounter in the context of a post-acute care setting. Should an encounter be based on a patient's admission or discharge, the entire stay in a skilled nursing facility, or only the portion of a patient's stay under Medicare Part A? During a nursing home stay, many providers deliver care and services for the resident in addition to the care provided

by the nursing facility itself. Physicians providing a service to a resident bill Medicare directly. Rehab therapy provided to a resident on a Part A stay is considered part of the Part A episodic payment. If the resident is not on a Part A stay but is receiving Part B services such as rehab therapy, the facility is required by CMS to bill Medicare on behalf of the rehab therapy company (*i.e.,* this is called consolidated billing). Another example of complexity to consider is how interrupted stays would be addressed where a patient leaves the nursing facility for an observation stay or inpatient stay in the hospital and returns to the nursing facility, or when the payer source changes. While the descriptions of Encounter Type, Encounter Diagnosis and Encounter Time differ, all rely on an identical Use Case Description. How does this single Use Case Description facilitate distinct and accurate health record information by various clinicians involved in a patient's care?

NASL agrees with comments posted by Dan Vreeman who states, "Encounter time periods have a lot of complexity in the context of post-acute care settings (with different perspectives from payment and clinical views) that may not be fully captured here."

The current definitions of Encounter are hospital- and physician office-centric and not easily adapted for application to reflect care provided in post-acute care settings. A PACIO Project workgroup led by one of NASL's members has been working to define a standard way to use the FHIR resources for Encounter, Episode Of Care, Assessment and Clinical Impression. It is clear from that effort that requiring the use of the Encounter Data Class (or the FHIR resource, Encounter) for the same activities as acute and ambulatory represents a considerable burden and could mean a complete rewrite of long term care software workflows. We believe that a simpler definition of Encounter is needed – one that matches how HL7 v2 ADT messages are used today. For LTPAC settings, a typical encounter may initiate with a patient's admission to a care setting and end with the patient's discharge from that setting. Since LTPAC patients sometimes have what CMS has termed "an interrupted stay," where the patient leaves and then returns to a facility as occurs when a patient is transported to an emergency department for treatment of an acute condition. We recommend that such interrupted stays (*i.e.,* involving a patient's transfer from and return to a facility) mark the end of one encounter and the beginning of another encounter, especially if the patient does not return to the same facility or to the same level of care.

Problems Data Class, USCDI v2

DRAFT USCDI v2 – § Problems Data Class	
Information about a condition, diagnosis, or other event, situation, issue, or clinical concept that is documented.	
New Data Element	**Applicable Standard(s)**
§ Problems	USCDI v1 – SNOMED International, Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®) U.S. Edition, September 2019 Release

	Draft USCDI v2 – SNOMED International, Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®) U.S. Edition, September 2020 Release.
§ Date of Diagnosis	A date field associated with each diagnosis on a patient's problem list and/or medical diagnosis history to capture the date a patient first had the diagnosis. One could imagine, in the future, supplementing this with additional data elements for capturing identifying information for the individual making this determination, their role (physician vs. other healthcare professional, etc.), institution, some categorization of the basis for the determination (symptoms, signs, laboratory abnormality, etc.)
§ Date of Resolution	Date field associated with a past/resolved medical problem, typically coded using ICD, which specifies the date that the problem resolved.

Date of Resolution

The Date of Resolution data element within the Problems Data Class requires considerable clarification. How is a "date of resolution" defined? Whether treating routine, acute conditions such as the flu where a patient seeks treatment, but does not require follow up, or treating chronic conditions where there is no resolution but rather an ongoing need to maintain function (*e.g.,* therapy), there may not be a "date of resolution."

The USCDI cites SNOMED as the applicable standard for reporting on problems. Post-acute care utilizes diagnosis codes to identify the patient's need for care and CPT codes to describe the care that is provides. These codes are required by CMS for all post-acute care medical records and billing as well. How would such a discrepancy be addressed?

As we found in working with diagnoses under USCDI v1, there is no backwards compatibility between ICD-10 codes and SNOMED. We are required to use ICD-10 coding under the Patient Driven Payment Model (PDPM) recently implemented by CMS. Perhaps clinical decision support tools that use SNOMED could be incorporated into LTPAC health IT systems on a go-forward basis. Even so, any historical data alignment would rely on imperfect, manual mapping solutions that could lead to discrepancies when reconciling problems derived from SNOMED in the future.

Date of Diagnosis

The applicable standard for the Date of Diagnosis data element requires a date field for each diagnosis. In post-acute care, the service provider rarely knows the exact date of the diagnosis as it may have been assigned even before a patient is admitted to a hospital, upon admission to the hospital or at some point during the patient's hospitalization. Many post-acute care patients and residents have longstanding or chronic conditions such as Parkinson's disease, arthritis or Chronic Obstructive Pulmonary Disease (COPD) that are treated when the condition is exacerbated. The

initial Date of Diagnosis might serve as a reference point; however, it is not likely to provide any real rationale to inform decisions about the patient's needs, service provided or the duration of treatment. The Date of Resolution data element is a bit anathema to post-acute care, where chronic conditions remain chronic rather than fully resolved. For these patients, the ability to function within one's chosen environment may be more of an "accommodation" rather than a "resolution."

Diagnostic Imaging Class, USCDI v2

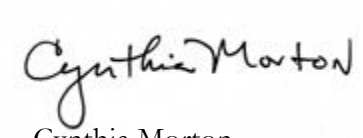
DRAFT USCDI v2 – § Diagnostic Imaging Data Class	
Information about a condition, diagnosis, or other event, situation, issue, or clinical concept that is documented.	
New Data Element	**Applicable Standard(s)**
§ Diagnostic Imaging Order	Logical Observation Identifiers Names and Codes (LOINC®) Database version 2.69
§ Diagnostic Imaging Report	Logical Observation Identifiers Names and Codes (LOINC®) version 2.69
§ Diagnostic Imaging Narrative *Contains a consulting specialist's interpretation of diagnostic imaging data.*	Diagnostic Imaging Study (LOINC® code 18748-4) ** Diagnostic Imaging Narrative Data Element – Reclassified from Clinical Notes Data Class to NEW Diagnostic Imaging Data Class.*

NASL agrees with the creation of a new data class for Diagnostic Imaging and reclassifying the Diagnostic Imaging Narrative Data Element from the Clinical Notes Data Class to the new Diagnostic Imaging Data Class. We also believe it would be helpful to clarify the difference between the Diagnostic Imaging Narrative and Diagnostic Imaging Report.

NASL welcomes the opportunity to continue reviewing additional data elements for inclusion in USCDI Version 2 and future iterations of the standard.

Thank you for your consideration of our comments.

Sincerely,



Cynthia Morton
Executive Vice President