



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

RE: Comments on [United States Core Data for Interoperability Draft Version 2](#)

Dear Dr. Tripathi,

On behalf of the Texas Medical Association (TMA) and our more than 55,000 physician and medical student members, we thank you for the opportunity to comment on the United States Core Data for Interoperability (USCDI) Draft Version 2.

TMA offers the following feedback on specific elements of USCDI v. 2:

Encounter Information

Except for time of birth, which is already used nationally and is reasonably well-defined, TMA recommends holding “Encounter Information” in a draft state until standards are developed for the concepts in this category. The comments below illustrate how the lack of standards can generate data that are not comparable across organizations and are therefore meaningless.

Encounter Time TMA recommends the Office of the National Coordinator (ONC) use a national standard to appropriately define “Encounter Time” so that all electronic health records (EHRs) capture it in a standardized manner. For example, in an ambulatory setting, “Encounter Time” could have many possible starting points such as:

- The appointment time;
- The time when the patient is called back from the waiting room;
- The time when the patient enters the exam room;
- The time when the medical assistant or physician, or both, start the note; and
- The time when the physician enters the exam room.

There also are many possible ending times, e.g., the time when:

- The appointment was scheduled to end,
- The patient checks out of the visit,
- The patient or the physician leaves the exam room, and
- The note is signed.

Telemedicine visits have their own set of questions about starting and stopping times.

Note that in an ambulatory practice, the patient's note may be started by the medical assistant interviewing the patient and gathering vitals.

Regardless of how ONC finalizes the encounter time calculation, the time capture should happen automatically within the workflow without requiring any type of manual start and stop.

Encounter Type TMA recommends ONC specify a *useful* national standard to appropriately define "Encounter Type" so that all EHRs capture it in a standardized manner. The HL7/SNOMED Value Set referenced (www.hl7.org/fhir/us/core/ValueSet-us-core-encounter-type.html) does not meet our definition of useful as it has approximately 170 different "Types," many of which mix in the concept of diagnosis and other concepts such as place of service. Before adding this field, it needs much more standardization work.

Encounter Diagnosis By the use of the singular "Diagnosis," is ONC referring to a single value for this element? Unfortunately, there are often multiple diagnoses in a single encounter. So at a minimum, if more than one diagnosis should be entered, the term needs to be plural. If it is only one diagnosis, what are the guidelines for which diagnosis to choose? If a patient is being followed for anxiety and diabetes, to enter only one of these as the encounter diagnosis would be misleading.

General TMA believes that without standardization, each organization will choose its own definition of "Encounter Time," "Encounter Type," and "Encounter Diagnosis," and the result will be a Tower of Babel. Keeping these concepts in a draft state until there are well-defined and well-used standards is necessary for future data quality.

Problems

Date of Diagnosis, Date of Resolution Once again, it is critically important that use of these fields be standardized and crystal clear to the EHR user. "Date of Diagnosis" and "Date of Resolution" may not always be accurate in EHR systems. The "Date of Diagnosis" may simply be the date the problem was added to the Problems list. The same applies to "Date of Resolution" – that may simply be the date the diagnosis was "cleaned" from the Problems list.

By ignoring the date of onset (as opposed to diagnosis), ONC risks creating a misleading picture of the natural history of problems. "Onset" can precede "diagnosis" by years.

Importantly, these data elements should be automatically entered upon the creation of the "Problem," preferably through its inclusion in a physician note, with the ability to modify them. Also, they should not be required fields, as these dates are not always known. Likewise, in cases where the exact dates are not clinically significant (e.g., the dates associated with an ingrown toenail), systems should have the ability to enter the year of onset, diagnosis, and resolution rather than specific dates.

General The relationships between "Encounter Diagnosis," "Problems," "Health Concerns," and prior medical/surgical history is ill-defined in the USCDI, with the latter not being included at all. This can cause significant workflow and safety issues, especially when health information is exchanged. For example, is it ONC's intention that the Problems list contain all current and prior Encounter Diagnoses and vice versa? (TMA advises that it should not, since "problems" and "diagnoses" are different concepts). Also, since "prior medical/surgical history" is not part of the USCDI, does ONC want all the information ordinarily included in this history to be on the "Problems" list? If not, how will prior medical and surgical history be communicated in health information exchange? It is easy to see that the same data could be replicated in four different

places – “anxiety” could be an “Encounter Diagnosis,” a “Problem,” a “Health Concern,” and a prior medical history if prior episodes had been resolved. *These relationships urgently need to be clarified so we can share meaningful information. In addition, no matter what is eventually decided, double-entry and data duplication should be avoided at all times.*

Wherever possible, structured data and standardized codes should be encouraged, but the option for free text needs to be preserved as not everything can be captured in codes.

“Health Concerns” should be patient-entered and controlled outside of the EHR, if ONC truly cares about patients having input to their care. While it is a USCDI Version 1 element, TMA questions the value of “Health Concerns” since the data are not standardized and are simply a physician’s interpretation of what the patient – or someone else in the patient’s family – is concerned about. It rapidly could be the dumping ground for all sorts of useless information, similar to the problem list in many organizations.

Diagnostic Imaging Order

It seems that having the imaging order information is to avoid duplication of an imaging study when one is already planned. Depending on the lag time between when the patient is seen and the data are generated, and then the patient seen by another physician, this may or may not be useful, and that information would likely be part of a progress note. ONC may consider a broader category that may include other scheduled testing or procedures to avoid more than just imaging duplication.

Care Team Members

Name The release of an individual’s name can be dangerous in certain cases. Organizations should have the ability to suppress this data element where appropriate, e.g., in emergency departments.

General The use of the word “provider” should slowly be eliminated in ONC’s vocabulary. While it is widely used, it is so nonspecific as to be effectively useless. Virtually anyone or anything can be a “provider” – for example, in one organization, the IT staff are called “IT providers.” The term is also offensive to many physicians. TMA strongly recommends the use of the word “clinician” where ONC is referring to health care individuals providing care. This recognizes they are human beings with a specific level of training.

As a general comment, the USCDI is increasingly becoming loaded with unstructured data. This may be challenging to share in the near term if the narratives cannot be attached to a continuity of care document (CCD).

TMA appreciates the opportunity to provide. Any questions may be directed to Shannon Vogel at TMA by emailing shannon.vogel@texmed.org or calling (512) 370-1411.

Sincerely,



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Texas Medical Association