



April 17, 2023

The Honorable Micky Tripathi, PhD, MPP
Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
330 C Street SW, 7th Floor
Washington, D.C. 20201

RE: Draft U.S. Core Data for Interoperability (USCDI) Version 4

Dear National Coordinator Tripathi:

On behalf of the 56,000 members of the American Society of Anesthesiologists (ASA), I am pleased to provide comment to the Office of the National Coordinator for Health Information Technology (ONC) on its draft U.S. Core Data for Interoperability (USCDI) Version 4. ASA supports ONC's efforts to promote interoperability through a nationwide standardized dataset. We understand this goal is served by an emphasis on breadth and wide applicability in the selection of data classes and elements. We hope to work with ONC to find solutions that will allow for more seamless implementation of USCDI and greater interoperability for anesthesiologists and other specialists.

Consistent and seamless intercommunication and interoperability of electronic medical devices, electronic health records (EHRs), and other patient documentation can lead to important advances in patient safety and quality of care. For the clinical workflows of anesthesiologists, increasing efficiency and reducing the burdens of recording and reporting data will be crucial in supporting these advances.

Below, we provide specific feedback on data classes and elements within the draft Version 4 dataset.

Data Element: "Substance (Non-Medication)"

We are concerned that the definition of this new element under the "Allergies and Intolerances" data class is misaligned with the way allergies are widely reported by physicians and other health care professionals, which could lead to confusion and inaccurate reporting. The element defines the reportable substances as "believed to cause a harmful or undesired physiologic response following exposure." However, medical professionals will often list substances as allergens to serve as a surrogate or to ensure a patient avoids exposure to a class of agents. As an example, a peanut allergy may be listed for a patient with a tree nut allergy. Other examples include listing latex as an allergen for spina bifida patients and listing succinylcholine and/or sevoflurane for malignant hyperthermia patients to avoid exposures and adverse reactions. In these scenarios, clear reporting helps prevent medical errors.

We support the development of this new element as a means of providing more comprehensive methods for reporting intolerances to non-pharmacologic substances but have some concerns about how the element will be utilized in practice. We recommend working closely with physicians and other stakeholders to align this element with current best practices in recording and reporting allergies and intolerances.

Data Element: "Encounter Identifier"

For anesthesiologists, being able to link pre-anesthesia assessments with the surgeon's medical history and physical assessments would be an interoperability use case with significant clinical benefits. These

assessments contain clinical information about a patient that cannot be found in other records. There is some existing functionality to create these links, but clear definitions from ONC would be beneficial. Some EHR vendors provide functionality to support direct linkage of anesthesia preoperative, intraoperative, and postoperative documents as a nested “encounter.” ASA requests further clarification on the definition of “encounter” and recommends accommodating nested encounters. We recommend that ONC define a method that can effectively link encounters within a nested relationship, for example surgical encounters nested within a hospitalization encounter.

Data Element: “Functional Status”

We support use of the “Functional Status” data element as an important interoperability component for planning anesthetic care. We request clarification on how specific terms from the proposed terminologies and standards (SNOMED and LOINC) will be selected as the basis for this element. The element’s submission page references SNOMED and LOINC as the applicable standards and alludes to the large number of different assessment instruments currently available without much detail on how they would be incorporated. Additionally, we recommend guidance on how to incorporate widely used standardized assessment tools for measuring functional status that are not currently included in LOINC, including the Fried Frailty Index and the Duke Activity Status Index.

Data Element: “Unique Device Identifier”

As currently defined, this element does not include information about when a device was implanted or removed. For class 2 devices like pacemakers and defibrillators, it’s important that any reporting of specific unique device identifier (UDI) data can be easily associated with the first report of that UDI. We recommend expanding the element’s definition to ensure appropriate patient history and context are captured.

Data Elements: “Race” and “Ethnicity”

ASA requests more information on how the reporting of these elements can be implemented. The “Centers for Disease Control and Prevention (CDC) Race and Ethnicity Code Set Version 1.2” is listed as a required standard for both elements, but with over 900 distinct items in this code set, it is unclear if many hospitals or EHR systems are using these codes currently. We recommend working with CDC and the Centers for Medicare & Medicaid Services (CMS) to better define the element and the ways it can be implemented.

Data Element: “Time of Procedure”

Timing can be crucial in understanding the care provided to a patient and the complexities of a given surgical case. However, this element as currently defined may not be broadly applicable to medical specialties such as anesthesia. For anesthesia care, the time of induction and the time that a patient is brought out of anesthesia are both important elements on a patient’s chart and the anesthesia record. “Anesthesia Start Time” and “Anesthesia End (Finish) Time” are well-defined elements that are used in quality measures and billing. Such elements would be appropriate and clinically relevant to include within USCDI. This information is directly relevant to patient safety and quality of care and is not captured within the definition of the “Time of Procedure” element. Because of its clinical importance, we ask ONC to provide guidance on how anesthesiologists may be able to promote interoperability in timing data, either through USCDI or other tools.

Data Element: “Average Blood Pressure”

This measure requires specification of “the relevant time period of measurements.” ONC should more clearly define the time period and number of blood pressure observations required for documentation.

We also recommend expanding this measure to capture the method of blood pressure measurement (e.g., manual auscultation, invasive monitor, wearable device) and the context of this measurement (e.g., operating room, office setting, emergency room, intensive care unit, hospital ward). Environmental factors can affect blood pressure readings and the subsequent management of anesthetic care. Additional information on these factors would guide the effective clinical use of this data element.

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Thank you for your consideration of our comments. ASA welcomes the opportunity to speak with ONC further about our feedback and collaborate on how best to promote interoperability. Please contact Matthew Goldan, ASA Regulatory Affairs Operations Associate (m.goldan@asahq.org), for questions or further information.

Sincerely,

A handwritten signature in cursive script that reads "Michael Champeau MD".

Michael W. Champeau, MD, FAAP, FASA
President
American Society of Anesthesiologists