OFFICE OF THE CHIEF RESEARCH INFORMATION OFFICER

4/3/24

From: Oregon Health & Science University (OHSU), Office of the Chief Research Information Officer

Re: Comments on USCDI V5, Submitted to: https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi#draft-uscdi-v5

OHSU is a moderate sized Tier 1 Academic Health Center, serving all of Oregon and Southwest Washington. OHSU has a strong history of informatics innovation coupled with a pragmatic approach to sustainability of our HIT systems, including our Epic EHR, which was installed in 2008.

In our work in advancing Health Information Exchange, we have found the 21st Century Cures Act and its subsequent rules to be helpful in considering strategy, especially in terms of our strategic collaborations and innovation. We have more than 30 FHIR applications currently installed and are preparing for additional requests from a variety of sources. One of the major barriers to seeing the benefits of these applications has been the lack of consistent interoperability of the underlying data. USCDI represents a major step forward – and we have seen progress as v1-3 have been moved towards adoption.

However, we continue to see significant gaps. First, the lack of clear and prioritized vocabulary mappings has led to substantial confusion. The cost of mapping is substantial; large economies of scale could be created by the major EHR vendors actively transitioning their proprietary coding systems to mapped and standardized systems. However, many data domains are perceived as optional, and the lack of clear guidance has led to challenges in setting strategy. A simple example of this is Medication Form - Per HL7 Medication Form the terminology binding is SNOMED, but USCDI does not insist on this binding, leading to a confusion around IV, oral, and topical forms for key applications, which limit their accuracy and success.

Similarly, the variability in LOINC code mappings for Laboratory tests, the variation in Order mappings for Service Requests (such as referrals), and the variability in Procedure mappings have led to decreased ability to use these in innovations and for recipients of the data to make sense of the current quality of care.

Prioritizing the key areas to require USCDI v5 standardization would help immensely, especially where these data are planned to be used for quality measurement, public health, or other large-scale assessments. Quality assessments for interoperability would be highly useful in planning and selection of strategic efforts.

With warm regards,

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