April 13, 2026

U.S. Department of Health and Human Services
Office of the Deputy Secretary
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201.

Re: United States Core Data for Interoperability (USCDI) Draft Version 7

Submitted electronically at: https://isp.healthit.gov/united-states-core-data-interoperability-uscdi#draft-uscdi-v7

Dear Deputy Secretary O'Neill:

As nursing stakeholders, the Alliance for Nursing Informatics (ANI) is pleased to offer comments on the **United States Core Data for Interoperability (USCDI) Draft Version 7.**

The Alliance for Nursing Informatics (ANI), cosponsored by the American Medical Informatics Association (AMIA) and the Healthcare Information and Management Systems Society (HIMSS), advances nursing informatics leadership, practice, education, policy, and research through a unified voice of nursing informatics organizations. We transform health and healthcare through nursing informatics and innovation. ANI is a collaboration of organizations representing more than 25,000 nurse informaticists and bringing together 29 distinct nursing informatics groups globally. ANI crosses academia, practice, industry, and nursing specialty boundaries and collaborates with more than 4 million nurses in practice today.

ANI appreciates the opportunity to comment on the USCDI Draft Version 7. ANI strongly supports ASTP's continued commitment to expanding standardized, interoperable health data exchange and commends the thoughtful, stakeholder-informed process used to develop Draft v7. The proposed additions across 30 data elements represent meaningful progress for nursing informatics, patient safety, and care coordination. Of the new and revised elements, six data classes are of particular significance to nursing practice and informatics: Adverse Events, Care Team Members, Encounter Information, Healthcare Information Attributes, Immunizations, and Medications. We offer the following class-level and element-specific comments below.

1. Adverse Events (New Data Class): ANI strongly supports the introduction of Adverse Events as a new USCDI data class. This addition represents a long-overdue formal acknowledgment of

nursing's central role in patient safety surveillance.[1] Registered nurses are the primary detectors, reporters, and documenters of adverse events across virtually all care settings, and the absence of a standardized, interoperable adverse event data class has long undermined cross-organizational patient safety data exchange. Standardizing both Adverse Event and Adverse Event Outcome will enable structured documentation to follow patients across care transitions, which is a critical gap in post-acute and transitional care settings where nursing leads handoff workflows. We advocate for vocabulary guidance that extends beyond the currently specified SNOMED CT to encompass nursing-sensitive adverse event categories, including patient falls, pressure injury staging events, and medication errors,[2] and we encourage ONC to provide implementation guidance that supports embedded, point-of-care adverse event capture rather than reliance on siloed safety reporting systems.[3]

2. Care Team Members — Healthcare Agent: ANI strongly supports the addition of Healthcare Agent to the Care Team Members data class, recognizing it as among the most clinically impactful proposals in Draft v7. The ability to identify and rapidly contact a legally authorized healthcare decision-maker, particularly during emergent situations, is a core nursing responsibility that is currently hampered by the lack of structured, interoperable data on this role. We note, however, a concern regarding the use of the term "agent" in this context. As AI-enabled systems, autonomous software agents, and agentic workflows become increasingly prevalent in health information technology, the term "agent" risks semantic confusion in implementation contexts where it may be interpreted as referring to an AI agent rather than a human proxy. ANI recommends that ONC consider the term "healthcare proxy" or similar unambiguous language in implementation guidance and value set documentation to preserve clarity as the terminology landscape evolves. We also recommend that systems capturing Healthcare Agent data include structured fields for contact information, scope of authority, and activation status to ensure this element delivers its full clinical utility, particularly in palliative care and intensive care settings.

3. Encounter Information — Appointment: ANI strongly supports the addition of Appointment as a new data element within the Encounter Information class. The distinction between a planned appointment and a completed encounter is clinically and operationally significant: it is precisely the information gap that limits nurses, care managers, and transitional care teams from placing individual care events within a longitudinal care plan context. Interoperable appointment data enables care coordinators and nurse navigators to identify upcoming visits across primary care, specialty, and behavioral health settings, supporting proactive gap closure and adherence outreach. This element also carries important health equity implications, as patterns of missed or rescheduled appointments, when captured in a standardized and interoperable form, can signal social determinants of health barriers such as transportation access, work schedule constraints, or childcare needs, enabling nursing-led outreach to address these upstream factors.[4] We recommend that implementation guidance clarify the

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[1] Shever, L.L. (2011). The impact of nursing surveillance on failure to rescue. *Research and Theory for Nursing Practice*, 25(2), 107–126

[2] Montalvo, I. (2007). The National Database of Nursing Quality Indicators (NDNQI). *OJIN: Online Journal of Issues in Nursing*, 12(3)

[3] Classen, D.C., Resar, R., Griffin, F., et al. (2011). 'Global Trigger Tool' shows that adverse events in hospitals may be ten times greater than previously measured. *Health Affairs*, 30(4), 581–589

[4] Kheirkhah, P., Feng, Q., Travis, L.M., Tavakoli-Tabasi, S., & Sharafkhaneh, A. (2016). Prevalence, predictors and economic consequences of no-shows. *BMC Health Services Research*, 16, 13

distinction between Appointment and the existing Encounter Time element to prevent conflation of scheduled versus completed care events in downstream data models and analytics.

4. Healthcare Information Attributes — Reason Not Performed: ANI strongly supports the addition of Reason Not Performed to the Healthcare Information Attributes data class and considers it one of the most critical additions in Draft v7 for nursing documentation integrity. Nurses routinely document clinical omissions, including medications refused by patients, procedures deferred due to clinical deterioration, and immunizations contraindicated, yet this documentation has historically been captured as free text in nursing notes or not at all in a structured, interoperable format. The absence of a standardized Reason Not Performed element systematically distorts quality measure performance reporting, causing clinically justified omissions to appear as failures of care and creating inequitable quality measurement outcomes for providers and health systems with higher-acuity or more complex patient populations. ANI advocates for explicit vocabulary specification for this element and requests that the reference value set include nursing-specific reason codes such as patient refusal, clinical contraindication, patient not present, and patient condition precluding the intervention.

5. Immunizations — Immunization Status & Immunization Record Source: ANI strongly supports the addition of both Immunization Status and Immunization Record Source to the Immunizations data class. Immunization administration is a foundational nursing function across virtually every care setting, and these two elements together address distinct but complementary clinical needs. Immunization Status enables point-of-care clinical decision support for nurses administering vaccines, surfacing whether a patient's status for a given vaccine is current, overdue, or contraindicated; this information is critical to preventing both duplicate vaccinations and missed immunization opportunities. Immunization Record Source is equally important: knowing whether a record originates from a patient's self-report, a state immunization information system (IIS), an imported EHR record, or a directly administered dose enables nurses to apply appropriate clinical judgment about data reliability. These elements are particularly significant for patients who receive immunizations across multiple settings, which may include primary care, retail pharmacy, occupational health, and school health, where care coordination across systems is essential to maintaining an accurate and complete immunization history.

6. Medications — Route of Administration & Medication Dispense Quantity: ANI strongly supports the addition of Route of Administration and Medication Dispense Quantity to the Medications data class, and regards both as essential elements of comprehensive, safe medication documentation. Nurses, as the primary administrators of medications in virtually all inpatient and many ambulatory settings, are responsible for verifying and documenting the correct route for every administration, and the absence of this element in prior USCDI versions represented a meaningful gap in interoperable medication data. Together, these elements advance the completeness and clinical utility of interoperable medication records and reduce risk at care transitions where incomplete medication data is a leading contributor to preventable adverse drug events.[5] ANI further advocates for implementation guidance that

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[5] Forster, A.J., Murff, H.J., Peterson, J.F., Gandhi, T.K., & Bates, D.W. (2003). The incidence and severity of adverse events affecting patients after discharge from the hospital. *Annals of Internal Medicine*, 138(3), 161–167

addresses nursing-specific medication administration record (MAR) documentation nuances, including PRN administration, dose modifications, and route changes, to ensure these elements are implemented in ways that reflect actual nursing workflow.

In conclusion, ANI commends ASTP for a substantive and clinically meaningful Draft USCDI v7 and appreciates the opportunity to provide comment during this public review period. The proposed additions across the six data classes addressed above collectively advance the visibility and interoperability of nursing-generated data and strengthen the foundation for patient safety, care coordination, and health equity in nationwide health information exchange.

Sincerely,

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The Alliance for Nursing Informatics (ANI), cosponsored by AMIA & HIMSS, advances nursing informatics leadership, practice, education, policy, and research through a unified voice of nursing informatics organizations. We transform health and healthcare through nursing informatics and innovation. ANI is a collaboration of organizations representing more than 25,000 nurse informaticists and bringing together 29 distinct nursing informatics groups globally. ANI crosses academia, practice, industry, and nursing specialty boundaries and collaborates with more than 4 million nurses in practice today. Contact ANI.