



April 13, 2026

The Honorable Thomas Keane, MD, MBA
National Coordinator for Health Information Technology and Assistant Secretary for Technology Policy (ASTP)
Office of the National Coordinator for Health Information Technology (ONC)
U.S. Department of Health and Human Services
Submitted electronically at healthit.gov

RE: Draft Version 7 of the United States Core Data for Interoperability

Dear Dr. Keane:

On behalf of Allina Health, I am writing in response to the Draft Version 7 of the United States Core Data for Interoperability (USCDI) standards. Overall, we appreciate the office of the Assistant Secretary for Technology Policy's (ASTP) continued efforts with stakeholder outreach to help progress toward standardizing certain data elements in pursuit of an improved interoperable exchange of health information. Our brief comments seek clarity on newly proposed data elements.

Allina Health, an integrated health system, is dedicated to the prevention and treatment of illness and enhancing the greater health of individuals, families, and communities throughout Minnesota and western Wisconsin. We serve our communities by providing exceptional care as we prevent illness, restore health, and provide comfort to all who entrust us with their care - regardless of race, color, national origin, sex, age, or disability. As a nonprofit health care system with 28,000 employees, Allina Health cares for patients from beginning to end-of-life through our 90+ clinics, 12 hospital campuses, 13 retail pharmacies, specialty care centers and specialty medical services providing home care, senior transitions, hospice care, and emergency medical transportation services.

Reason Not Performed

We appreciate the intent behind including "Reason Not Performed" to enhance clinical context and support care coordination. However, we offer comments regarding the feasibility and clarity of this data element as currently defined.

In practice, reasons for not performing an order, procedure, or intervention are often documented in unstructured clinical notes rather than captured in a discrete field. Additionally, there are many

real-world scenarios where a standardized “reason not performed” field may not align well with clinical workflows. For example, patient-driven factors - such as declining an immunization or not adhering to pre-procedure instructions - may not fit neatly into a discrete, codified field.

We encourage ASTP to further clarify the intended use cases and purpose of this element, including whether it is meant to capture clinician-driven decisions, patient-driven decisions, or both. Additional guidance on scope, standardization, and workflow integration would improve feasibility and consistency. Consideration should also be given to whether this information can be reliably captured in a structured format across diverse care settings.

Accommodation

We support efforts to improve the capture of patient needs that impact access to care. However, the current definition of “Accommodation” is too broad and lacks sufficient specificity for consistent implementation.

The term could encompass a wide range of supports, including clinical accommodations (e.g., medical/surgical or obstetric needs), language services, disability-related accommodations, therapeutic supports, financial assistance, or community-based services. Without clearer boundaries, it is difficult to determine what is in scope for capture as a discrete data element.

We recommend that ASTP further define the intended scope and use cases for this element and clarify whether specific categories of accommodations are expected to be captured. As currently defined, the breadth of this concept may limit consistent data capture and interoperability. Additional guidance on how this element should be standardized and operationalized within workflows would be helpful.

Healthcare Agent

We recognize the value of capturing a healthcare agent to support care decision-making when patients are unable to speak, advocate, or make decisions for themselves. However, we have concerns regarding the operational and legal complexity of implementing this data element as a discrete field.

Currently, this information is not always discretely captured and would require new system build and workflow development. More importantly, the designation of a healthcare agent can change over time and may vary depending on the availability and validity of legal documentation (e.g., advance directives, power of attorney). Accurately capturing and maintaining this information would require robust verification processes, clear policies, and ongoing updates.

Frontline clinical and administrative staff may not be well-positioned to validate legal authority or ensure that documentation is current and accurate. This introduces potential risks related to data

accuracy and legal compliance. Additionally, maintaining up-to-date information would likely require significant operational resources.

We encourage ASTP to consider the implementation burden associated with this element and provide additional guidance on verification standards, documentation requirements, and update processes. A phased or optional approach may be more appropriate until workflows and standards are more fully developed.

Diagnostic Imaging Reference

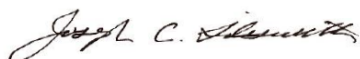
We appreciate and support the intent to improve access to imaging studies through a “Diagnostic Imaging Reference.” However, in current workflows, imaging references are not typically captured as discrete data elements within the EHR. Instead, access is facilitated through embedded functionality, with underlying identifiers and links managed dynamically.

Feasibility will depend on how this element is defined. Standard identifiers such as accession numbers or DICOM Study Instance UIDs could be implemented, as they are already widely used. In contrast, requiring a persistent, externally resolvable link would be challenging, as such links are often system-specific, security-dependent, and not stable across environments. We recommend that ASTP clarify the intended use case(s) and prioritize a flexible approach focused on standardized identifiers, with links treated as optional and context dependent.

Conclusion

On behalf of Allina Health, we appreciate the opportunity to provide feedback on USCDI Draft v7 and support the continued advancement of interoperability. As new data elements are considered, we encourage ASTP to prioritize clarity of purpose, standardization maturity, and real-world implementation feasibility to ensure that expanded data exchange delivers meaningful clinical and operational value. Please feel free to contact us with any questions.

Sincerely,



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