EHRA
HIMSS ELECTRONIC HEALTH RECORD ASSOCIATION

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April 13, 2026

Dr. Thomas Keane
National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Keane,

On behalf of our nearly 30 member companies, the HIMSS Electronic Health Record (EHR) Association appreciates the opportunity to provide feedback on the draft United States Core Data for Interoperability (USCDI) Version 7. As the national trade association of EHR developers, we are committed to advancing interoperable health IT that supports high-quality, efficient, and patient-centered care delivery. We support the continued evolution of USCDI to expand the availability of standardized health data; however, we also emphasize the importance of ensuring that new data elements and classes are adopted in a manner that is feasible, well-aligned with industry readiness, and mindful of the cumulative burden on health IT developers and the providers they support.

The EHR Association continues to support the ongoing expansion of USCDI. However, we note a significant and growing concern that not all EHR systems capture every data element across USCDI, particularly as its scope expands across diverse care settings. To reduce unnecessary burden and promote more accurate and meaningful data exchange, we recommend that ONC clearly acknowledge within the USCDI framework that not all data elements are relevant to every EHR implementation and avoid certification requirements that assume comprehensive data capture across all settings.

As always, we stand ready to continue collaborating with ONC and other relevant stakeholders to expand USCDI and other issues important to advancing safe, interoperable, standards-based health IT. Our specific comments follow.

Sincerely,

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Chair, EHR Association
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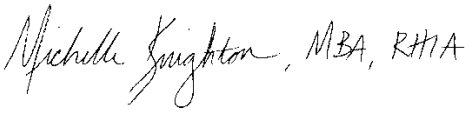

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Established in 2004, the Electronic Health Record (EHR) Association is comprised of 27 companies that supply the vast majority of EHRs to physicians' practices and hospitals across the United States. The EHR Association operates on the premise that the rapid, widespread adoption of EHRs will help improve the quality of patient care as well as the productivity and sustainability of the healthcare system as a key enabler of healthcare transformation. The EHR Association and its members are committed to supporting safe healthcare delivery, fostering continued innovation, and operating with high integrity in the market for our users and their patients and families. The EHR Association is a partner of HIMSS. For more information, visit www.ehra.org.

Adverse Events

The EHR Association has concerns regarding the proposed inclusion of "Adverse Event" and "Adverse Event Outcome" as discrete USCDI data elements. The definitions of adverse events and associated outcomes are not consistently established or applied across health IT systems and vary significantly depending on context, such as clinical care versus research settings. In many cases, these data are not captured within the EHR at all, but instead reside in separate systems, such as clinical trial management platforms. Additionally, there are limited mature specifications and implementation guidance available to support consistent representation and exchange of this information.

Given these challenges, we recommend that ONC defer inclusion of Adverse Event Outcome until the industry has developed more consistent documentation standards, relevant FHIR profiles have matured, and clear guidance is established regarding the appropriate scope and use of this data element.

Clinical Notes

The EHR Association supports the inclusion of additional referral-related content within USCDI; however, we have questions regarding the relationship between the proposed "Referral Note" data element and the existing Referral Order data class. As currently defined, a standalone Referral Note may be duplicative of the referral order itself. It is unclear whether this element is intended to represent the clinical rationale accompanying a referral or a distinct clinical document separate from the referral order. In practice, many systems do not maintain a separate referral note but instead include relevant clinical context directly within the referral order or as part of a general clinical note.

We recommend that ONC clarify the distinction between the Referral Note and Referral Order data elements, including whether a Referral Note must be associated with a structured Referral Order. If the intent is to capture the clinical narrative supporting a referral, we suggest explicitly scoping this element as an attachment or addendum to the referral order rather than as a standalone note, to better align with real-world system design and workflows.

Diagnostic Imaging

The EHR Association has significant concerns regarding the readiness of the proposed "Diagnostic Imaging Reference" data element for inclusion in USCDI v7. While we support the broader goal of improving access to and exchange of diagnostic imaging, the current state of standards, implementation guidance, and industry alignment does not yet support consistent, secure, and interoperable use of this element.

We urge ONC to withdraw the Diagnostic Imaging Reference data element from USCDI v7 pending resolution of feedback received through the Diagnostic Imaging Interoperability Standards and Certification Request for Information (RFI) and further maturation of supporting standards. The

Association looks forward to continued collaboration with ONC and the broader healthcare community on this topic as it evolves, but we do not believe it is sufficiently mature for inclusion at this time.

Facility Information

The EHR Association is generally supportive of including "Facility Telecom" as a USCDI data element. To support effective implementation and promote more consistent and meaningful exchange of this information, we recommend that ONC clarify the intended use and scope of the Facility Telecom element – specifically, which types of contact information are expected (e.g., scheduling, clinical, administrative) and how this aligns with existing capabilities in FHIR US Core.

Health Status Assessments: Nutrition Assessment

The EHR Association recommends additional clarity before including the proposed "Nutrition Assessment" data element, given concerns regarding the scope of required structured data capture across all EHR types. Nutrition assessments are not universally captured in a structured, discrete format across care settings. In many ambulatory-focused EHR systems, this information – if collected – is often documented in free text, scanned documents, or linked PDFs rather than in standardized data fields. Requiring structured capture across all certified health IT would impose a disproportionate burden on systems not designed to support this workflow.

Additionally, nutrition-related information may be documented in multiple ways, including formal assessments, unstructured clinical notes, or as part of patient-provider conversations. Given this variability, we recommend that ONC allow for text or other less discrete responses from EHRs that do not collect this, ensuring alignment with real-world documentation practices and minimizing unnecessary implementation burden.

Health Status Assessments: Tobacco Use

The EHR Association acknowledges the proposed "Tobacco Use" data element as an evolution of the existing Smoking Status data element and supports efforts to capture substance use information more comprehensively. However, we recommend that ONC consider renaming this element to reflect its full scope more accurately (e.g., "Tobacco and Nicotine Product Use") or, at a minimum, explicitly clarify in the usage notes that non-tobacco nicotine products are included.

Immunizations

The EHR Association recommends additional clarification regarding the proposed "Immunization Record Source" data element in three areas. First, we request that ONC clarify the definition to distinguish between where an immunization was administered and where it was documented, as these concepts are not always equivalent in practice. Next, we recommend replacing the term "external record" with "historical" to better align with FHIR US Core terminology, which differentiates between data originating from the administering organization and data reported secondarily by a third party. Finally, we request clarification on how this element relates to existing Provenance data elements, which may already capture aspects of source information.

Medication Administration

The EHR Association has concerns regarding the proposed "Medication Administration" data element. As currently defined, this element appears to conflate clinically documented administration events (e.g., a nurse administering a medication in an inpatient setting) with patient-reported or outpatient medication use. In non-inpatient settings, "administration" is difficult to verify; while EHRs can document that a medication was prescribed or dispensed, confirmation of administration often relies on patient self-report. Additionally, detailed Medication Administration Record (MAR) data – including timing, dosing events, and route – is highly complex and may introduce risk of misrepresentation if exchanged without sufficient context.

We recommend that ONC clarify that the Medication Administration data element applies specifically to provider-administered medications in clinical settings and explicitly excludes patient-reported adherence. We further recommend acknowledging that this information is primarily relevant to inpatient settings and that not all EHRs serve as the system of record for this data.

Finally, ONC should clearly distinguish between a prescription (MedicationRequest) and confirmed administration (MedicationAdministration), as these are separate FHIR resources for good reason. The scope of exchanged data should be limited to confirmed administration events.

Medication Dispense Quantity

The EHR Association supports adding this information to USCDI but has concerns regarding the scope and clarity of the proposed "Medication Dispense Quantity" data element. As currently described, the proposal appears to conflate the quantity of medication intended to be dispensed (as indicated in a prescription) with the quantity actually dispensed in a specific event. These are fundamentally different clinical concepts—one representing intent (e.g., FHIR MedicationRequest) and the other representing an event (e.g., FHIR MedicationDispense). Ambiguity between these concepts could lead to inconsistent implementation across systems.

We recommend that ONC clarify whether this data element refers to the prescribed dispense quantity or the actual amount dispensed and align the definition with the corresponding FHIR resources. To avoid conflation with prescribing intent, we suggest scoping this element to the confirmed dispense event quantity.

Medical Device Order

The EHR Association requests clarification on the scope of the proposed "Medical Device Order" data element across different device categories. Medical device orders vary significantly in clinical complexity and workflow. For example, ordering an implantable device, such as a pacemaker, involves a multi-step process that includes referral, implantation, post-procedure documentation, and device registry entry. In contrast, ordering a CPAP machine follows a simpler workflow more closely aligned with standard durable medical equipment ordering. These differences materially affect how EHR systems capture and exchange this data.

We recommend that ONC provide explicit guidance on how the Medical Device Order element should be applied to implantable and non-implantable devices to ensure consistent, practical implementation across care settings.

Nutrition Order

The EHR Association requests clarification on the scope and applicability of the proposed "Nutrition Order" data element across EHR types. Nutrition orders vary widely, ranging from clinical dietary prescriptions in inpatient settings to nutritional supplement recommendations in ambulatory care. Not all EHR systems – particularly those serving ambulatory-only practices – are designed to capture structured nutrition orders. Additionally, the cited examples span a broad range of complexities, from total parenteral nutrition (TPN) and enteral nutrition to general dietary recommendations.

We recommend that ONC clarify the minimum scope of the Nutrition Order element and specify which care settings are expected to support it. Requirements should reflect the clinical and workflow context of each setting and should not impose structured documentation requirements on EHRs that do not routinely support nutrition ordering workflows.

Referral Order

The EHR Association supports the inclusion of the proposed "Referral Order" data element and requests additional clarity regarding its scope. Provider-authored requests for care services are broadly documented in EHR systems; however, the scope of Referral Order spans a wide spectrum – from medical specialty referrals to social and community services to home health – each with distinct workflows and data structures. Not all EHR systems support all referral types, and the clinical context and acuity vary significantly across these categories.

We recommend that ONC clearly delineate the scope of the Referral Order element, specifying whether it applies solely to medical specialty referrals or also includes social services and community-based referrals. Relevant implementation guide specifications should provide sufficient detail to support appropriate handling of each referral type within its respective workflow context.

Accommodation

The EHR Association requests clarification on the definition and codification of the proposed "Accommodation" data element. As currently defined, the element appears to describe a patient's disability status or functional limitation (e.g., limited mobility) rather than the specific accommodations provided (e.g., wheelchair-accessible exam room). There is no established, finite value set for accommodations, and it is unclear whether EHRs are expected to capture disability status, accommodation type, or both.

We recommend that ONC clarify whether this data element is intended to capture disability status, accommodation requirements, or both, and provide a defined value set or reference vocabulary to support consistent implementation.

Deceased Indicator

The EHR Association supports the inclusion of a "Deceased Indicator" as a USCDI data element and recognizes its clinical and administrative importance for patient safety and care coordination. We strongly support improving the exchange of this information.

However, we note a practical challenge related to data currency. EHR systems are not always notified in a timely or reliable manner when a patient passes away outside of the healthcare system (e.g., at home or in a non-affiliated facility). As a result, this field may not consistently reflect the most current or accurate status across implementations.

We recommend that ONC acknowledge in the usage notes that the Deceased Indicator may not always represent real-time or fully accurate information, and that implementers should not rely on this field as a definitive record of patient death without appropriate verification processes in place.

Healthcare Information Attributes

The EHR Association has concerns regarding the proposed "Healthcare Information Attributes" data class, as it introduces data elements without clear guidance on where they should be applied. While these elements appear intended to be broadly applicable across USCDI, in practice, they are not relevant to all data classes or elements, which may lead to inconsistent implementation.

For example, "Performance Time" may apply to certain clinical activities, such as procedures or medication administration, but not to all elements of care. "Indication," while expanded beyond medications, does not logically extend to all data classes. "Diagnostic Report Date" and "Reason Not Performed" are similarly more appropriate for specific clinical contexts, such as laboratory, imaging, or procedures, rather than universally across USCDI.

We recommend that ONC assign these data elements to the specific data classes where they are most applicable. If that is not feasible, we suggest clearly defining the scope of each element to indicate where it should be used.

More broadly, we suggest that USCDI would benefit from closer alignment with FHIR as a modeling framework. Leveraging FHIR would improve conceptual consistency, clarify relationships between data elements, and help identify gaps prior to inclusion, ultimately supporting more effective and interoperable data exchange.