UI Health Public Feedback: Draft USCDI Version 7

To: Assistant Secretary for Technology Policy (ASTP) / ONC

Date: April 3, 2026

Subject: Formal Organizational Feedback on Draft USCDI Version 7

UI Health appreciates the opportunity to provide feedback on the Draft USCDI Version 7. As an organization currently managing the transition across USCDI versions while preparing for significant 2027 mandates, our focus is on ensuring that data standards are technically mature, clinically relevant, and supportive of administrative efficiency.

I. Strategic Alignment: CMS Interoperability & Prior Authorization Rule

UI Health emphasizes that the "mechanical necessity" of the Health Insurance Information data class is the most critical component of the v7 proposal. This class directly aligns with the CMS-0057-F Final Rule requirements for January 1, 2027.

- **Data Class:** Health Insurance Information (**Existing**)
- **New Data Elements (v7):** *Health Insurance Plan Identifier, Health Insurance Payer, Health Insurance Plan, Health Insurance Coverage Period*.
- **Organizational Position:** Strong Support.
- **Executive Rationale:** To meet the 2027 mandate for automated, electronic Prior Authorization APIs, healthcare systems must be able to programmatically identify plan-specific requirements. Standardizing these elements reduces the administrative friction caused by manual payer portal navigation. Without a standardized Plan Identifier, the move toward real-time authorization remains an aspirational goal rather than an operational reality.

II. Support for High-Utility Clinical Data (Allergy Intolerance)

UI Health strongly supports the addition of elements that are already widely captured and provide immediate clinical value.

- **Data Class:** Allergies and Intolerances **(Existing)**
- **New Data Element (v7):** Allergy Intolerance Criticality

- **Executive Rationale:** This element—defined as the estimate of potential clinical harm or seriousness—is widely captured and exchanged today. Its inclusion in USCDI v7 is highly useful across nearly all clinical contexts, particularly in emergency and acute care settings where rapid assessment of risk is required.

III. Patient Safety & Clinical Maturity

We support the expansion of patient safety data but caution against standards that lack the nuance required for high-reliability healthcare workflows.

- **Data Class:** Adverse Events (**New**)
- **New Data Elements (v7):** *Adverse Event, Adverse Event Outcome*.
- **Organizational Position:** Support with Recommendation.
- **Requirement:** We recommend adding an "Adverse Event Actuality" or "Timing" element
- **Executive Rationale:** Distinguishing an actual event from a "near-miss" is vital for proactive safety protocols and quality benchmarking. Furthermore, the Adverse Event Outcome must be explicitly mapped to SNOMED CT or ICD-10-CM to ensure interoperability across clinical datasets.

IV. Mitigating Implementation Burden & Data Redundancy

UI Health prioritizes Lean methodologies to ensure efficiency and data integrity. We urge the ASTP to avoid data elements that create duplicative effort for technical and clinical staff.

- **Data Class:** Encounter Information (**Existing**)
- **New Data Element (v7):** *Appointment*.
- **Organizational Position:** Concern Regarding Redundancy.
- **Executive Rationale:** As currently proposed, Appointment lacks the discrete specificity required for effective exchange. Since Encounter Type and Time are already established elements, an "Appointment" element must be defined with unique metadata (e.g., specific scheduling status or future-dated intent). Without this clarity, it risks being a duplicative burden with negligible clinical utility.

V. Regulatory Reporting & Quality Measures

The standardization of healthcare attributes is essential for "non-iterative" reporting for MIPS, HQR, and TJC programs

- **Data Class:** Healthcare Information Attributes (**New**)
- **New Data Element (v7):** *Reason Not Performed*.
- **Organizational Position:** Strong Support.
- **Executive Rationale:** This element directly impacts eCQMs such as VTE-1 and VTE-2. Standardizing this allows for automated patient exclusions, eliminating the need for manual chart abstraction.
- Indication: We support the requirement of SNOMED CT and ICD-10-CM for this element. It provides the standardized "medical necessity" justification required for specialty measures like TJC PC-02 (C-Birth) and protects clinician scores for measures like MIPS #005 (Heart Failure) by providing discrete evidence for care decisions.
- Performance Time: Critical for precision in "Hospital Harm" measures (e.g., CMS816), ensuring accurate window attribution for medication-induced events.

VI. Behavioral Health & Social Realities

- **Data Class:** Health Status Assessments (**Existing**)
- **Revised Data Element (v7):** *Tobacco Use* (Replaces v6 **Smoking Status**).
- **Organizational Position:** Support.
- **Executive Rationale:** This shift reflects the current reality of the healthcare industry and patient behavior, specifically regarding the prevalence of electronic nicotine delivery systems. This is a mature transition that aligns with modern clinical documentation standards.

VII. Bridging the Gap: Medication Reconciliation (Med Rec)

UI Health notes that while Draft v7 expands the "event" data for medications, it still lacks a discrete framework for the reconciliation process, which is a critical safety failure point during transitions of care.

- **Data Class:** Medications (**Existing**)
- **New Data Elements (v7):** *Medication Administration, Medication Dispense Quantity.*
- **Organizational Position:** Support with Gap Identification**.**
- **Executive Rationale:** We support the addition of Medication Administration and Medication Dispense Quantity as they provide the necessary data points for a clinical review. However, for these to be effective in a high-reliability setting, ASTP must define a "Medication Reconciliation" status or attribute.
- **Impact:** Standardizing the *outcome* of a Med Rec event (e.g., "Validated," "Discrepancy Identified") ensures that the next provider in the care continuum knows the list is accurate. Without this, we are exchanging more data without exchanging the "trust" that the medication list has been verified.

VIII. Addressing the Documentation Burden (Clinician Wellness)

UI Health remains deeply concerned with the cumulative documentation burden placed on nurses and providers. While we support the inclusion of new data classes, we urge the ASTP to prioritize **data reuse** over **data entry**.

- **Executive Position:** The addition of 30+ new elements must not translate to 30+ new fields for a clinician to click.
- **Rationale:** Every new USCDI requirement risks worsening "EHR fatigue." We advocate for standards that allow for automated derivation—where data captured during a standard clinical workflow (e.g., a nurse scanning a med or a provider entering an order indication) is mapped "behind the scenes" to these USCDI elements. Standards should serve the clinician, not the other way around.

IX. Final Recommendation on Implementation

UI Health recommends a 24-month stabilization window following the finalization of USCDI v7. This allows sufficient time to align technical infrastructure without disrupting active 2027 regulatory compliance projects.

In summary, USCDI v7 is a vital bridge to the 2027 regulatory landscape. By focusing on discrete, high-utility data that supports automated reporting and reduces manual documentation, we can move toward a system that prioritizes patient care over administrative overhead.