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April 12, 2023

Micky Tripathi, PhD, MPP  
National Coordinator for Health Information Technology  
Office of the National Coordinator (ONC)  
U.S. Department of Health and Human Services  
330 C St. SW., Mary Switzer Building, Office 7009A  
Washington, DC 20201

***RE: Draft United States Core Data for Interoperability (USCDI) Version 4***

Dear Dr. Tripathi:

The Association of American Medical Colleges (AAMC) appreciates the opportunity to provide feedback on the Draft USCDI Version 4 (v4) health data classes and constituent data elements as part of ongoing efforts to improve the interoperability of critical health information and systems.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members comprise all 157 accredited U.S. medical schools; 13 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and nearly 80 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals across academic medicine, including more than 191,000 full-time faculty members, 95,000 medical students, 149,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened the AAMC's U.S. membership and expanded its reach to international academic health centers.

The AAMC shares the ONC's commitment to improving interoperability and to ensuring that patients and providers can seamlessly access, exchange, and use electronic health information to improve clinical care and outcomes. Efforts to standardize data for interoperability should prioritize information that is critical for delivering high quality care that meets patients' needs as they move through the health care system, and that supports their broader health goals outside of the health care system. At the same time, it is critical to also protect the privacy and security of patient's sensitive health information. Many of our member institutions were early adopters of electronic health records (EHRs) and remain committed to continuous improvements to interoperability to support the delivery of high-quality health care for all patients. Advancing interoperable data sets is also critical for research and population health, including developing

evidence-based solutions meet health equity goals. Feedback in response to specific draft data classes and elements follow.

### ***Facility Information – Facility Identifier, Facility Type, and Facility Name***

The AAMC supports new data elements to better identify facilities through a new Facility Information data class for interoperable information exchange. We note that none of these new data elements (Facility Identifier, Facility Type, and Facility Name) have applicable vocabulary standards nor detailed definitions. We have some suggestions that might help improve the draft elements by providing clarity. First, Facility Identifier is defined as a “sequence of characters representing a physical place of available services or resources.”<sup>1</sup> We recommend that the Facility Identifier be more specifically tied to a publicly available federal ID number. Regarding the Facility Type, the draft provides some examples, but it does not account for documenting different types of available services or resources within a facility. For example, it includes laboratory or pharmacy which are separate facilities to a hospital but does not clarify documentation standards for a laboratory or pharmacy that is part of a hospital. Finally, the draft USCDI v4 notes that Facility Name would be defined as “word or words by which a facility is known,”<sup>2</sup> appearing to give great flexibility to the author of the data. This definition could be insufficient as identifying information for a patient or other provider, as it might mean different things to different people. For example, there are similar names for hospitals across the nation in addition to names that are similar for facilities within a system that one might not easily distinguish the precise facility. Additionally, there are rebranding efforts in healthcare leading to changes in facility names.<sup>3</sup> We suggest that the ONC consider whether there are more clear approaches for better defining each of these elements that can support both patient understanding of data included in their records and provider understanding of a patient’s information and ability to follow-up with another facility.

### ***Goals – Treatment Intervention Preferences and Care Experience Preferences***

The AAMC supports standardized data elements that allow for the documentation and exchange of data to be used for a patient’s individual goals for their care. We urge the ONC to coordinate with CMS on potential use cases of these data elements for quality reporting purposes. Advance care planning is often used as a quality metric of communication and care coordination within Medicare and private payer value-based alternative payment models. Measurement of advance care plans (ACPs) is often through extraction of data from a provider’s EHR, and largely considered a burdensome exercise. Could these two data elements be used to document an ACP in an interoperable format, and reduce reporting burden for providers? Additionally, does the

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<sup>1</sup> [United States Core Data for Interoperability Draft Version 4](#), Page 14 (January 2023).

<sup>2</sup> *Ibid.*

<sup>3</sup> See, Naomi Diaz, [Hospital, health system rebrands of 2022](#), Becker’s Health IT (December 2022), tracking the many name changes over the course of last year.

ONC envision allowing the patient to periodically review and confirm, or even author this information directly, to ensure it continues to best represent their preferences?

### ***Health Status Assessments – Alcohol Use and Substance Use***

The proposed “alcohol use” and “substance use” data elements within the health status assessments data class are critical data points, especially considering the national mental and behavioral health crisis and the opioid epidemic, for the USCDI to help improve the interoperability of such key information. If finalized, we ask ONC to incorporate additional policy standards for implementation to ease data segmentation for privacy (DS4P), in line with federal privacy regulations for maintaining the confidentiality of substance use disorder information. Currently there is insufficient DS4P within EHR systems, which can significantly limit the electronic exchange of patient records with sensitive substance use information due to federal privacy regulations designed to protect sensitive information. We urge the ONC to provide additional definitional context on these draft USCDI data elements relative to supporting DS4P standards to improve the interoperable exchange of patient information to support care and treatment for patients who use alcohol and/or other substances.

### ***Medications – Medication Adherence***

The AAMC understands the critical clinical importance of understanding how a patient adheres with their provider’s prescribed use of medications. The draft defines the element as “medication is consumed according to instructions,” with non-exhaustive examples as “taking as directed, taking not as directed, and not taking.” However, there may be concerns with the term and the limited examples for the definition that, as drafted, might not meet broader health information sharing goals for patient-centeredness.<sup>4</sup> The AAMC suggests that at a minimum the definition is broadened to recognize inclusion of information regarding a patient’s ability to take prescribed medications may be constrained by other factors. Additionally, we recommend that the ONC consider additional guidance within the definition to support patient engagement, for example that free text be used to better contextualize a patient’s concordance with the prescribed treatment.

### ***Procedures – Time of Procedure***

The AAMC supports the addition of “Time of Procedure” as a new data element for the Procedures data class. However, we recommend that greater specificity be added to the applicable vocabulary standard for software coding purposes to ensure appropriate translation across systems. For example, the term could be defined to the DateTime standard, stored in Coordinated Universal Time, and then translated by the EHR to a given end user’s local time

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<sup>4</sup> See, S. Chakrabarti, “[What’s in a name? Compliance, adherence and concordance in chronic psychiatric disorders](#),” World J Psychiatry 4(2): 30-36 (2014), noting that studies “over the past few decades have emphasized the importance of patients’ perspectives in medication-taking, based on their own beliefs, their personal circumstances, the information and resources available for them.”

zone. This is critical for accurate time capture necessary for patient safety, especially in the early post-procedure recovery timeframe when information might be shared across the patient's providers, potentially across time zones.

### ***Vital Signs – Average Blood Pressure***

The AAMC supports the addition of “average blood pressure” as a new data element for the Vital Signs data class as it could assist the sharing of accurate blood pressure measurement, which in turn is essential for driving clinical decisions. However, we suggest that the definition be revised to “the average” of two or more blood pressure readings in a specified time period instead of “the mean value.” This would reduce the potential for confusion between “mean value” and the clinical term “mean arterial pressure.”

### **Conclusion**

We thank the ONC for the opportunity to provide input on the draft USCDI v4. We would be happy to work with you on any of the issues discussed above or other topics relating to interoperability that involve the academic medicine community. Please contact my colleague Phoebe Ramsey ([pramsey@aamc.org](mailto:pramsey@aamc.org)) with any questions about these comments.

Sincerely,



Jonathan Jaffery, MD, MS, MMM  
Chief Health Care Officer

cc: David Skorton, MD, AAMC President and CEO