Julia Skapik, MD, MPH, FAMIA

Chief Medical Information Officer

National Association of Community Health Centers

7501 Wisconsin Ave, Suite 1100W

Bethesda, MD 20814

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Micky Tripathi, PhD, MPP

National Coordinator

Office of the National Coordinator for Health Information Technology (ONC)

Department of Health and Human Services

Hubert Humphrey Building, Suite 729

200 Independence Avenue SW Washington, DC 20201

Re**:** Draft United States Core Data for Interoperability Version 5 (Draft USCDI v5)

Dear Dr. Tripathi:

The National Association of Community Health Centers (NACHC) welcomes the opportunity to submit comments onONC’s Draft United States Core Data for Interoperability Version 5 (Draft USCDI v5), and to participate in advancing USCDI. NACHC has for more than five decades been a leader in providing high-quality, culturally competent health and wellness care for the nation’s most vulnerable people with the least access to care serving 29 million patients annually through 12,000 sites. NACHC’s member health centers (Federally Qualified Health Centers (FQHCs) and look-alikes) and partner organizations Primary Care Association (PCA) and Health Center-Controlled Networks (HCCN) are the largest national primary care network providing high quality culturally responsible care to the nations underserved.

We encourage ONC and its federal partners to push HIT developers and vendors to implement USCDI and its extensions to improve data standardization that supports data extraction, public health reporting and research that informs legislation and regulation. NACHC has been working with partner health centers and across industry to understand challenges to the deployment of USCDI requirements and implementation of the data capture and quality it requires. Community health centers routinely have experienced certified systems that are not in practice, conformant to all the certified functionalities and data requirements and are often the last customers to receive updates to conform to new requirements. We believe that more effort to ensure that underserved communities and health equity populations receive timely access to these important advances in data standardization and interoperability is a key component to addressing health disparities and improving digital health access.

Additional support for critical areas of primary care services in USCDI are key for advancing national strategic priorities like reducing maternal morbidity and mortality, ending the HIV and Hepatitis C epidemics, addressing gender-affirming and reproductive health care, addressing social determinants and drivers of health (SDOH) and improving care coordination. Ending the exception around implanted reproductive health devices would address a longstanding inequity around interoperability and data exchange for intrauterine devices (IUDs) and implanted contraceptives and NACHC urges ONC to consider this step. Support for a comprehensive data model centered around the pregnancy and postpartum episodes would better support care teams in primary care obstetrics; this approach is already implemented in several health center-controlled networks and has led to better and more accurate data on pregnancy outcomes including the actual delivery date, which is needed to drive timely patient follow-up and quality improvement efforts. Improving required laboratory metadata and enriching social history elements around risk behaviors could allow more comprehensive sharing of data on HIV and Hepatitis C status that drives the respective care cascades for these infectious conditions.

Finally, we encourage ONC to treat SDOH as a cross-cutting data class rather than a unique one, in that SDOH includes existing and emerging data elements across multiple data classes present in USCDI, such as demographics, health status, social needs, social history and diagnoses. A filtering element in USCDI could allow data elements to be designated both in the class in which they reside and as elements required to support social needs and services.

Additional data elements in USCDI widen the scope of agreement for a common representation of data, with standards widely available and accessible, supporting semantic aggregation for research and interoperability. We recognize the value of USCDI and USCDI+ in advancing clinical data interoperability, standards, and definitions in addressing our challenges with data capture, extraction, analytics, reuse, and workflow. However, the creation of new domains in USCDI+ does potentially create a risk for lack of alignment across this important program. NACHC encourages ONC to require all USCDI+ data elements to at a minimum, be aligned to the content in the core USCDI standard. Ideally, new metadata elements and content in USCDI+ would then be pushed through to the USCDI standard over time.

NACHC encourages ONC to consider going farther to build formal data models and to extend required metadata in USCDI in advance of comment periods to avoid the spread of comments which fail to have the specificity needed to ensure machine to machine readability. Creating and optimizing bidirectional test environments for the successful testing of USCDI and USCDI+ as well as sample datasets are likely to assist and accelerate the process for implementation and would be of strong interest and utility in the health center community. These could become updates to the EHR certification protocols and also foster more conformant data tools and products in the community.

NACHC looks forward to the ongoing maturity of this program and appreciates the opportunity to provide comments.

 Sincerely,

 

 Julia Skapik, MD, MPH, FAMIA

 CMIO

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