Draft USCDI V2

What we are doing today:
• SDWG Convened a task force to review USCDI V2 Draft for its implications for C-CDA
  - Documents Here (HL7 Confluence): [USCDI CDA Related Topics](#)
• Goals:
  - Review Task Force Discussions
  - Encourage similar or additional comments to be submitted by you or your organization
  - Get your opinion on the task force discussions

USCDI Draft V2 and C-CDA

Summary of Discussions
2021-MAR
Discussions Focused On:

- **Problems - Data of Diagnosis and Date of Resolution**
- **Diagnostic Imaging - Narrative vs Report**
- **Encounter Information - Encounter Diagnosis, etc.**
- **Care Team**

**Deadlines:**
- Submit to HL7 Policy Advisory Committee (PAC): March 19, 2021 (This Friday)
- Submit to ONC: April 15, 2021

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Date of Diagnosis and Date of Resolution

**General Conclusions:**
- Need to bring in 2 more dateTime elements IF Date of Diagnosis and Resolution are brought in:
  - Onset Date
  - Recorded Date
- Note: For Onset, diagnosis and resolution date systems SHALL allow recording of past dates
- Need to provide more precise definitions for each dateTime element
- Need to provide guidance on how C-CDA can represent all
  - The committee feels

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Comments to Submit/Take-aways

- Submit precise definitions and examples for:
  - Diagnosis Date
  - Resolution Date
  - Onset Date
- **Recorded Date**
- SDWG needs to provide guidance for representing:
  - Diagnosis and diagnosis date
  - Onset date of (problem/finding/symptom)
  - Recorded Date
  - How?: C-CDA Examples Task Force/Companion Guide updates
### Diagnosis Dates - Additional Notes

- In Example task force / Companion Guide
  - Consider if current modeling can handle
  - Or do we need extensions
  - What about existing documents and the rep of same
    - Is it new/should the same be adhered to?
  - A note about “recordedDate” as a new USCDI data element: this data element was not submitted to ONC and therefore not a candidate for addition.
  - Recommendation: IN USCDI V2 add text that states that though recorded date (system recorded date) is often currently the only date available, and the desire is to move to the clinically relevant dates of:
    - Diagnosis Date
    - Resolution Date
    - Onset Date
  - Provenance – should capture recorded date (and is USCDI v1 Data element)

- Please see Word Document "Diagnosis Related Dates"

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### Diagnostic Imaging – Narrative vs Report

- General Conclusions:
  - In USCDI V1 only narrative was required
  - V2 adds Narrative and Report as separate Data elements
  - Confusion among USCDI V2 readers as clinically and from standards perspective both elements will be in a single report
  - Report and Narrative should be collapsed into 1 data element
  - New Data element needs precise definition
    - Current submitted definition focuses entirely on LOINC
    - Discrete imaging data is "more than just LOINC"
    - C-CDA Diagnostic Imaging Report is:
      - Not highly used
      - Likely outdated
      - Contains highly detailed DICOM Object Catalogue requirements and terminology issues

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### Diagnostic Imaging – Narrative vs Report – cont.

- General Conclusions:
  - In Diagnostic Imaging the result and the report are the same
  - It is unclear in Report what is meant by Discrete Data
    - LOINC codes and result values?
      - Always quantifiable?
      - Conclusion – test explanation?
      - Conclusion – "normal/abnormal" etc.
    - Does discrete data also mean radiologic data that may or may not be useful to primary clinicians
    - SOP Instance Observation
    - Referenced frames observation
  - We did not talk about Diagnostic Imaging Order.
Comments to Submit/Take-aways

- Submit recommendation that Diagnostic Imaging Narrative and Report be collapsed into single data element
- Provide precise definition for this collapsed data element
  - Provide precise definition for what “discrete data” means within this context
  - LOINC codes and result values?
  - "Always quantifiable?"
  - Conclusion – text explanation
  - Conclusion or encoded interpretation – “normal” “abnormal”? Does discrete data also mean radiologic data that may or may not be useful to primary clinician
  - OP Instance Observation
  - Referenced frames observation

DI Report vs Narrative Additional Notes

- Narrative SHALL be present
  - Includes impression narrative
- Structured Data Elements
  - Procedure Performed (LOINC)
- What is the workflow around this?
  - From a certification perspective who is the report generator?
  - RIS – creates the report
  - Many EHRs do not create this report
  - CCD summary (for example might state have an observation – but reference out to the rad report
  - Comment
    - A general EHR won’t be creating a rad report
    - Are RIS certified by ONC?
    - Encoded Observations procedure within an encounter or summary document will reference out to the actual report

Encounter Information

- General Conclusions:
  - Clarity is needed wrt:
    - Encounter Diagnosis
    - Reason for Visit
    - Chief Complaint
    - Principle Diagnosis
  - Primary Diagnosis
- Comment
  - Even if just adding “encounter diagnosis” – need definition for all of the above terms
  - The task force feels CMS should provide these definitions
Care Team

- Need to recognize that all care givers are not formal health professionals and will not have an NPI
- This needs to be asserted in the Care Team Data class
- Security and access info concerns:
  - Security as it exists today and from a standards perspective for role based "Access control" is set up as if all the Care team is part of one enterprise
  - If we want to bring in community/family care giver and multi providers, access issue need to be resolved
- Security and access wrt Care Team Suggestion/comment:
  - Significant changes are needed within clinical applications, paradigm shifts and standards guidance

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Thanks for your input!!!