



Health IT Advisory
Committee

Draft USCDI Version 7

February 19, 2026



Core Principles



Comprises a core set of data needed to **support patient care** and **facilitate patient access** using health IT

Establishes a consistent baseline of data for other use cases

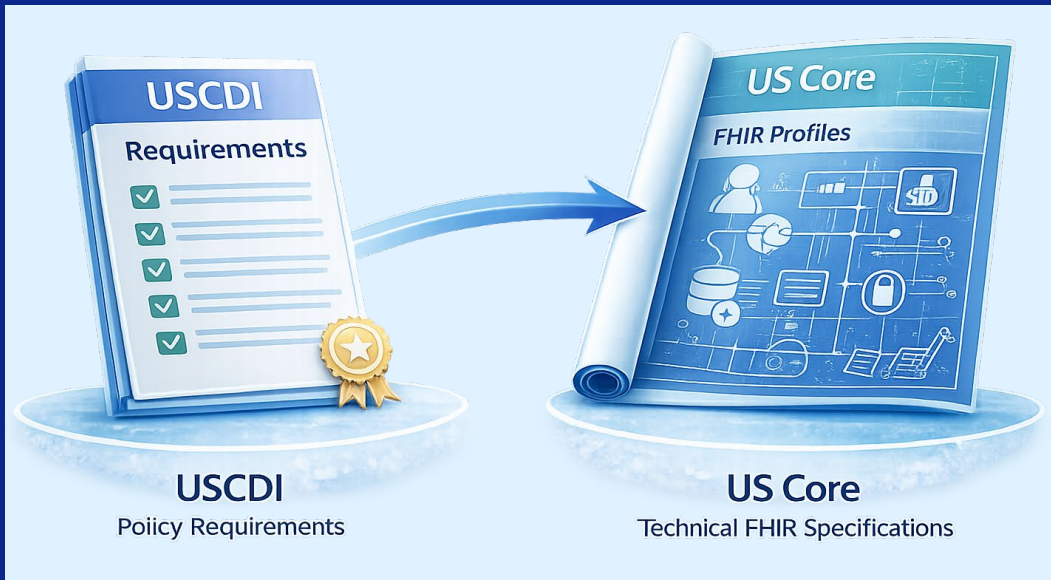
Expands over time via a predictable, transparent, and collaborative **public** process

Why USCDI Matters

- ONC Cures Act Final Rule established USCDI v1 in 2020, and replaced the Common Clinical Data Set
- USCDI serves as the baseline data set for the ONC Certification Program
- USCDI also defines required data for other uses, such as CMS Patient Access and Payer-to-Payer API, TEFCA, and California Data Exchange Framework (v2)
- USCDI v5 was included in 2025 [Standards Version Advancement Process \(SVAP\)](#) standards
 - SVAP allows health IT developers to voluntarily update their products to newer versions of standards

[*Health Data, Technology, and Interoperability: Certification Program Updates, Algorithm Transparency, and Information Sharing](#)

USCDI Data Elements Are Part of the Interoperability Ecosystem



Through certification requirements, ASTP/ONC ensures that health IT developers build and maintain the technical capability to exchange USCDI data elements.

USCDI: Transparent, Predictable, Collaborative

USCDI v1 includes 52 data elements and is required by Cures Act Final Rule and added data classes clinical notes and provenance, and data elements pediatric vital signs and address

USCDI v3 expanded to 94 data elements and is required in HTI-1, effective January 1, 2026

USCDI v5 is included the 2025 SVAP Standards, released May 2025

Draft USCDI v7 includes 156 data elements, including 30 proposed additions, to advance interoperability, released in January 2026

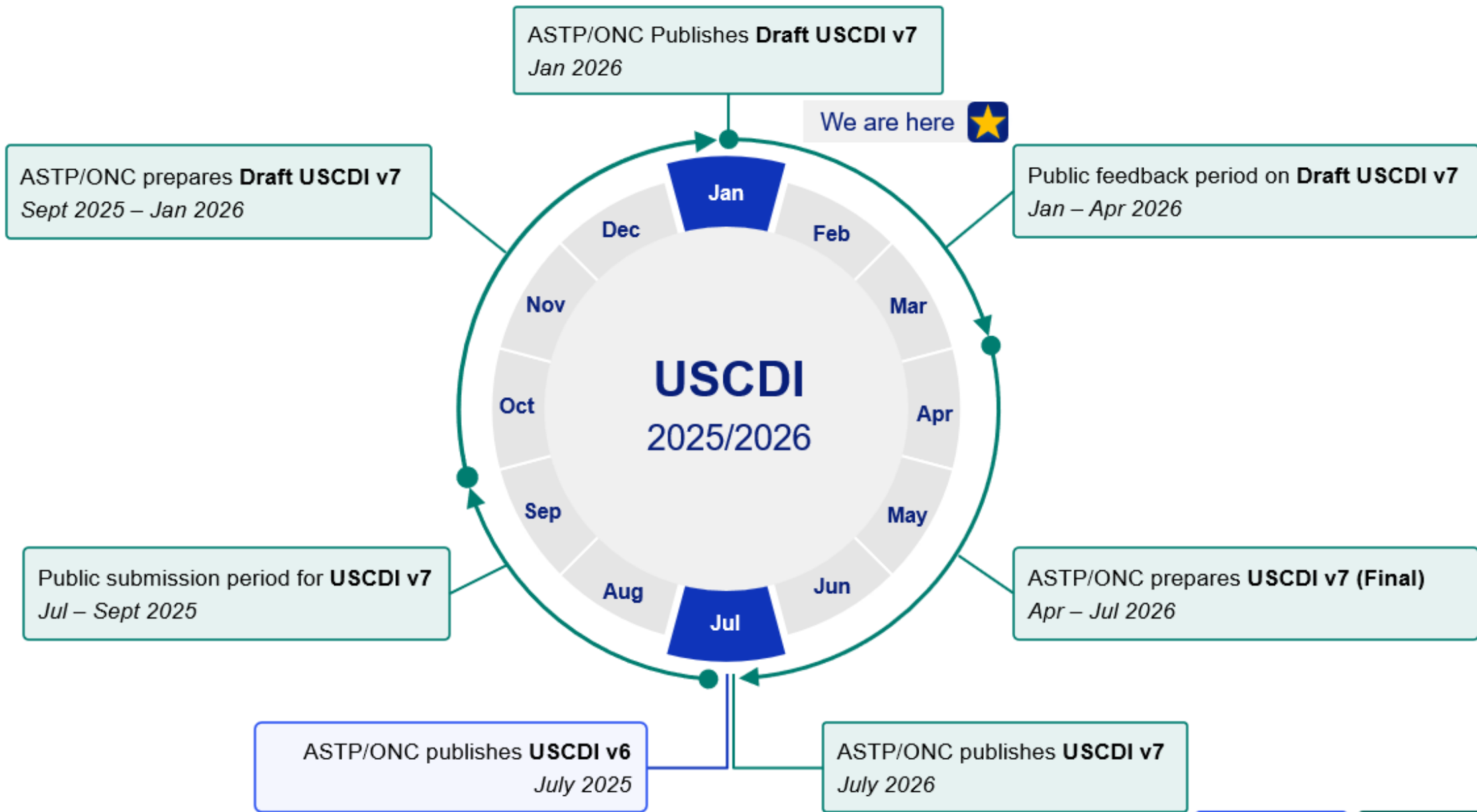
[*Health Data, Technology, and Interoperability: Patient Engagement, Information Sharing, and Public Health Interoperability Proposed Rule](#)

The image displays a stack of six documents representing the evolution of USCDI (Unified Clinical Data Interoperability) standards. The documents are titled as follows:

- USCDI v1 Summary of Data Classes and Data Elements
- USCDI v2 Summary of Data Classes and Data Elements
- USCDI v3 Summary of Data Classes and Data Elements
- USCDI v4 Summary of Data Classes and Data Elements
- USCDI v5 Summary of Data Classes and Data Elements
- Draft USCDI v7 Summary of Data Classes and Data Elements

The 'Draft USCDI v7' document is the most detailed, listing a wide array of data classes and elements. Key categories include:

- Adverse Events**: Adverse Event, Adverse Event Outcome
- Allergies and Intolerances**: Medication Allergy Intolerance, Drug Class Allergy Intolerance, Non-Medication Allergy Intolerance
- Care Plans**: Assessment and Plan of Treatment, Care Plan
- Clinical Notes**: Consultation Note, Discharge Summary Note, Emergency Department Note, History & Physical, Operative Note, Procedure Note, Progress Note, Referral Note
- Diagnostic Imaging**: Diagnostic Imaging Test, Diagnostic Imaging Result/Report, Diagnostic Imaging Reference
- Health Status Assessments**: Functional Status, Disability Status, Mental/Cognitive Status, Pregnancy Status, Alcohol Use, Substance Use, Physical Activity, SDOH Assessment, Tobacco Use, Nutrition Assessment
- Immunizations**: Immunization, Immunization Lot Number, Immunization Status, Immunization Record Source
- Laboratory**: Test, Value/Result, Specimen Type, Result Status, Result Unit of Measure, Result Reference Range, Result Interpretation, Specimen Source Site, Specimen Identifier, Specimen Condition, Specimen Collection Method
- Medications**: Medication, Dose, Dose Unit of Measure, Route of Administration, Medication Dispense Status, Medication Instructions, Medication Adherence, Medication Administration, Medication Dispense Quantity
- Orders**: Medication Order, Laboratory Order, Diagnostic Imaging Order, Clinical Test Order, Procedure Order, Portable Medical Order, Medical Device Order, Nutrition Order, Referral Order
- Provenance**: Author, Author Role, Author Time Stamp, Author Organization
- Vital Signs**: Systolic Blood Pressure, Diastolic Blood Pressure, Average Blood Pressure, Heart Rate, Respiratory Rate, Body Temperature, Body Height, Body Weight, Pulse Oximetry, Inhaled Oxygen Concentration, BMI Percentile (2 - 20 years), Weight-for-length Percentile (Birth - 24 Months), Head Occipital-frontal Circumference Percentile (Birth - 36 Months)



USCDI v6

USCDI v7

Draft USCDI Version 7

Draft USCDI v7 – 30 Proposed New Data Elements

New Adverse Events	Allergies and Intolerances	Care Team Members
Adverse Event + Adverse Event Outcome	Allergy Intolerance Criticality	Healthcare Agent +
Clinical Notes	Diagnostic Imaging	Encounter Information
Referral Note	Diagnostic Imaging Reference +	Appointment
Facility Information	New Healthcare Information Attributes	Health Insurance Information
Facility Telecom + S	Reason Not Performed + Diagnostic Report Date + S	Health Insurance Coverage Period + S Health Insurance Payer S Health Insurance Plan + S Health Insurance Plan Identifier + S
Health Status Assessments	Immunizations	Laboratory
Nutrition Assessment + Tobacco Use	Immunization Status + S Immunization Record Source + S	Specimen Collection Method
Medical Devices	Medications	Orders
Device Type + S	Medication Administration + Medication Dispense Quantity + S	Medical Device Order + Nutrition Order + Referral Order
Patient Demographics/Information	Problems	Procedures
Accommodation Deceased Indicator + Patient Identifier + S	Condition Status + S	Procedure Status + S

Proposed Data Elements

Adverse Events and Safety

Allergy Intolerance Criticality

Estimate of the potential clinical harm, or seriousness, of a reaction to an identified substance.

Reason Not Performed

Explanation or justification provided when an order or practice guideline is not carried out.

Usage note: Should be included with a procedure, immunization, and medication.

New Data Class: Adverse Events

New Data Class: Adverse Events

Adverse Event

A change to patient condition that could be an unintended effect of clinical interventions.

- Standard: SNOMED

Adverse Event Outcome

Result or impact of an adverse event.

Examples include but are not limited to hospitalized, recovered, recovered with sequelae, and death.

- Supports patient safety monitoring
- Enables quality improvement and reporting
- Improves awareness of prior adverse events across care settings

Proposed Data Elements Care Coordination & Patient Context

Appointment

A planned healthcare event for a future date/time.

Usage note: Created, tracked and managed for planned participation. An appointment may be called a future encounter and may result in one or more Encounters.

Healthcare Agent

Individual legally authorized to make healthcare decisions on behalf of a patient.

Accommodation

Modifications, tools, technologies, and other supports necessary to access care.

- Standard: SNOMED
-

Deceased Indicator

Indicates if the person is deceased or not.

Care Coordination Across the Health Ecosystem

Referral Order

Provider-authored request to another provider, specialist, or organization for care services.

Examples include but are not limited to referral orders to a wound care specialist and to a podiatrist.

Referral Note

Narrative summary requesting an opinion advice or service from a clinician.

Examples include but are not limited to primary care referral to dermatology, dentistry, and acupuncture

- Standard: LOINC, At minimum: 57133-1

- Supports the referral workflow
- Reduced redundant communication
- Improved coordination across specialties and organizations

Proposed Data Elements Clinical Care

Medical Device Order

Provider-authored request for medical devices.

Examples include but are not limited to therapeutic footwear, insulin infusion pump, and continuous positive airway pressure (CPAP) machine.

Specimen Collection Method

Technique or procedure used to obtain a specimen.

Examples include but are not limited to venipuncture, swab, biopsy, aspiration, and catheter collection.

Medication Administration

Information about the event of a patient consuming or otherwise being given a medication.

Examples include but are not limited to swallowing a tablet, administering an injection, and a long running infusion.

Nutrition Assessment

Assessment of a person's dietary intake.
Standard: LOINC

Nutrition Order

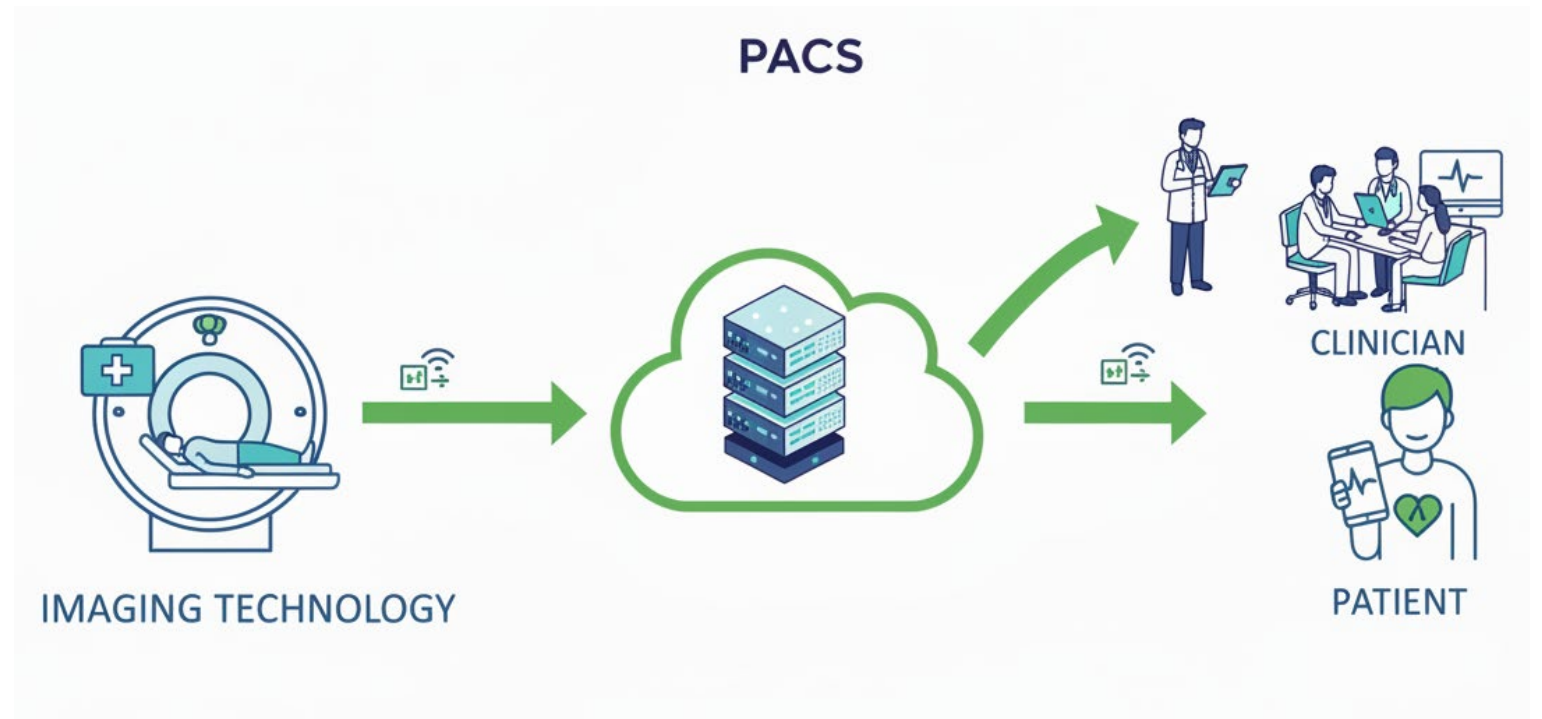
Provider-authored request for therapeutic diet, nutrition support, and nutrition to promote and maintain health.

Examples include but are not limited to cardiac diet, Mediterranean diet, whole food diet, clear liquid diet, enteral nutrition, and nutritional supplement.

Diagnostic Imaging Reference

The information that can be used to access a diagnostic imaging study.

Examples include but are not limited to imaging study endpoint weblink, unique identifiers, and contextual information needed to retrieve a diagnostic imaging study.



Tobacco Use

Assessment of a patient's tobacco product use behaviors. Tobacco products may include smokeless tobacco, cigarette tobacco, cigars, pipe tobacco, waterpipes (or hookah), nicotine pouches, nicotine gum, e-cigarettes, and other electronic nicotine delivery systems.

Examples include but are not limited to duration and frequency of use, mode of consumption, and type of product used.

Standard: LOINC, SNOMED CT

Expanded definition captures information about a patient's use of tobacco and nicotine products



Revised

Aligns with FDA definition of tobacco use, including e-cigarettes, vaping devices, and smokeless tobacco

- ✓ Enables more complete risk assessment
- ✓ Supports targeted cessation interventions
- ✓ Improves public health surveillance of evolving product use



New Data Class: Healthcare Information Attributes

Reason Not Performed **NEW**

Explanation or justification provided when an order or practice guideline is not carried out.

Usage note: Should be included with a procedure, immunization, and medication.

Indication

Sign, symptom, or medical condition that is the reason for a care activity.

Usage note: Indication may be included with a procedure, medication, and an order.

Diagnostic Report Date **NEW**

Date and time a report containing test results or clinical interpretation was made available to providers.

Performance Time

Time and/or date a care activity is performed.

Examples include but are not limited to vaccine and medication administration times, surgery start time, time ultrasound performed, and laboratory specimen collection time.

Proposed Data Elements – Already supported in Certified HIT

13 proposed data elements are already supported in certified health IT

- These improvements can be realized with minimal additional implementation burden

Facility Telecom
Diagnostic Report Date
Health Insurance Coverage Period
Health Insurance Payer
Health Insurance Plan
Health Insurance Plan Identifier
Immunization Status

Immunization Record Source
Device Type
Medication Dispense Quantity
Patient Identifier
Condition Status
Procedure Status

Draft USCDI v7 Updates to Existing Data Elements and Classes

Data Element Names Revised

- Diagnostic Imaging Result/Report
- Health Concern
- Health Insurance Coverage Status
- Health Insurance Coverage Type
- Health Insurance Group Identifier
- Health Insurance Member Identifier
- Health Insurance Payer Identifier
- Health Insurance Subscriber Identifier
- Immunization
- Immunization Lot Number
- Medication
- Medication Dispense Status
- Patient Goal
- Problem
- Procedure
- Relationship to Health Insurance Subscriber
- Specimen Condition
- Test
- Value/Result

Data Element Definitions Revised

- Author Role
- Discharge Summary Note
- Indication
- Patient Goal
- Performance Time
- Problem
- Procedure

Data Elements Reclassified

- Health Concern
- Indication
- Performance Times

Applicable Standards Added

- Health Insurance Coverage Type
- Tobacco Use
- Patient Goal
- Pregnancy Status

Data Class Definition Revised

- Medical Devices

Consolidated into Another Data Element

- SDOH Goals
- SDOH Interventions
- SDOH Problems/Health Concerns

Data Class Name Revised

- Care Plans

ASTP/ONC requests public feedback on Draft USCDI v7

Feedback period open until:

April 13, 2026, at 11:59 pm ET

- Are the proposed data elements **being exchanged today** in health IT systems?
- Are these data elements **broadly usable** across health use cases and specialties?
- Should any **data element names or definitions be revised**?
- Are there other widely exchanged **data elements missing** from the USCDI floor?

[ONDEC](#) is open and accepting data element recommendations

Questions?