ONC Office of the National Coordinator for Health Information Technology

Draft USCDI Version 7

USCDI United States Core Data for Interoperability

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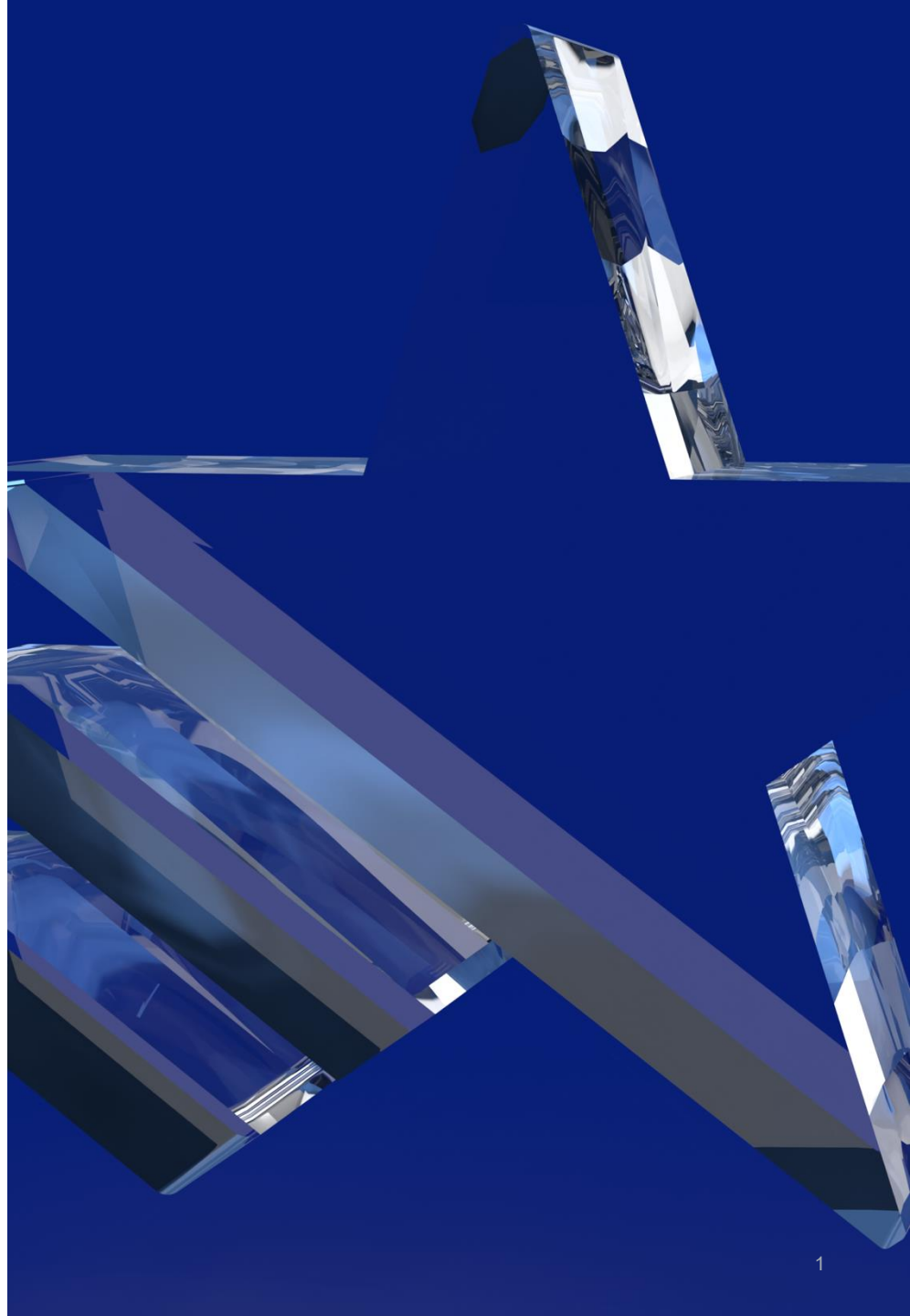
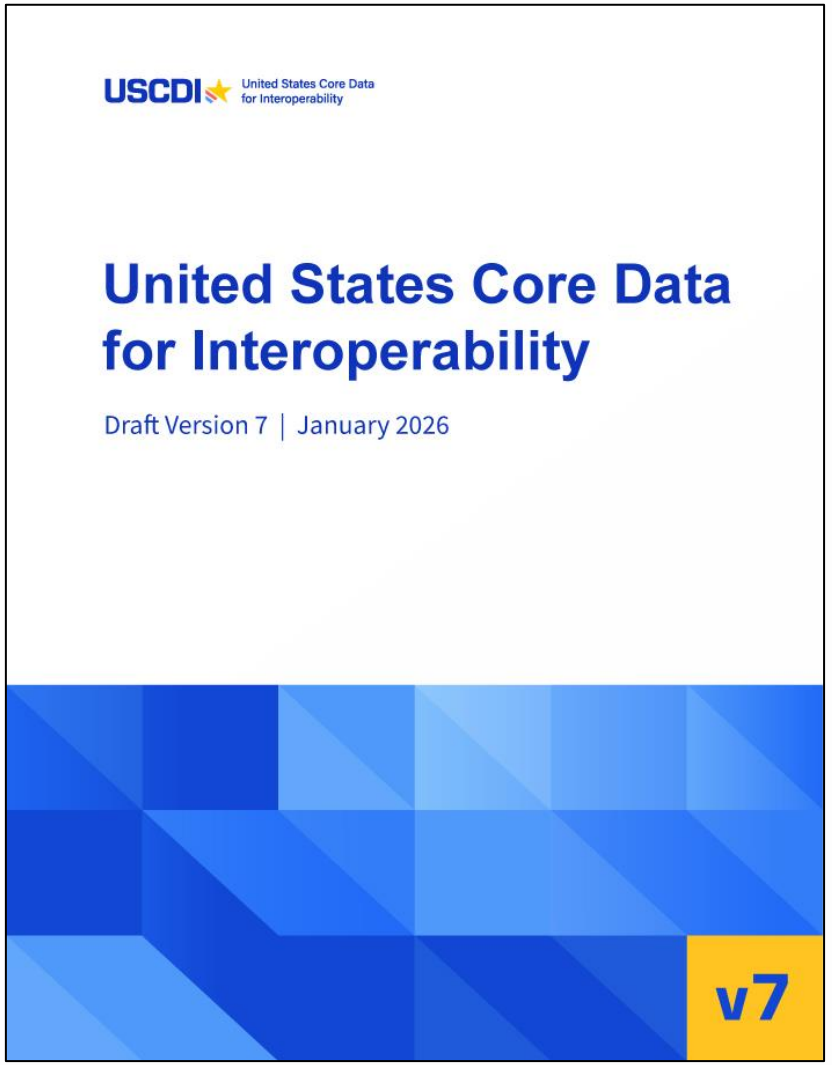


- Background: United States Core Data for Interoperability
- Draft USCDI Version 7: Development Overview
- What’s New in Draft USCDI v7
- Questions & Discussion

US Core Data for Interoperability (USCDI)

The minimum dataset of the health care delivery system



Core Principles

USCDI

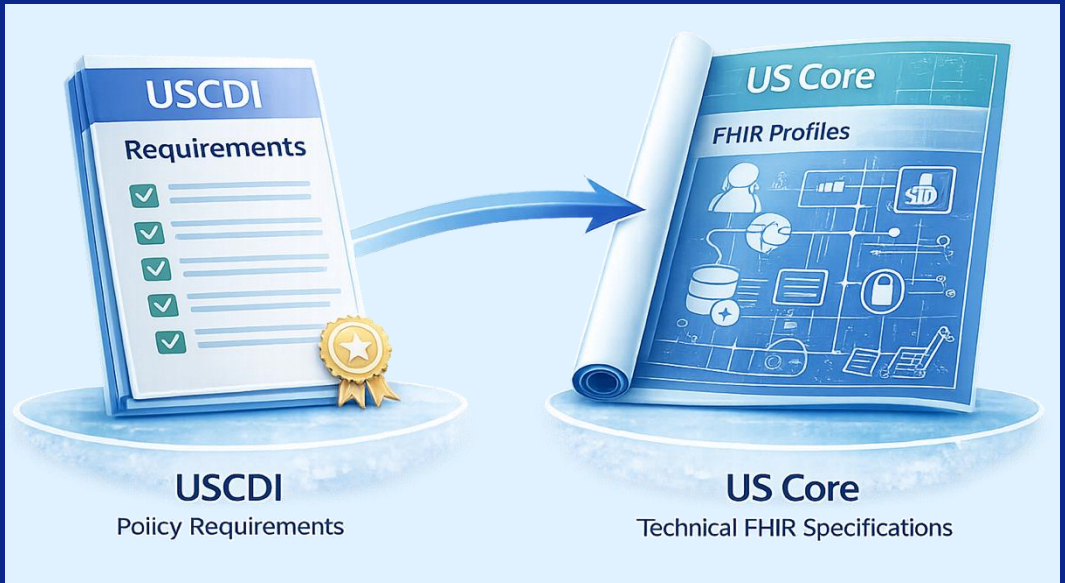
- Comprises a core set of data needed to **support patient care** and **facilitate patient access** using health IT
- Establishes a consistent baseline of data for other use cases
- Expands over time via a predictable, transparent, and collaborative **public** process

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, ONC ensures that health IT developers build and maintain the technical capability to exchange USCDI data elements.

Draft USCDI Version 7: Development Overview

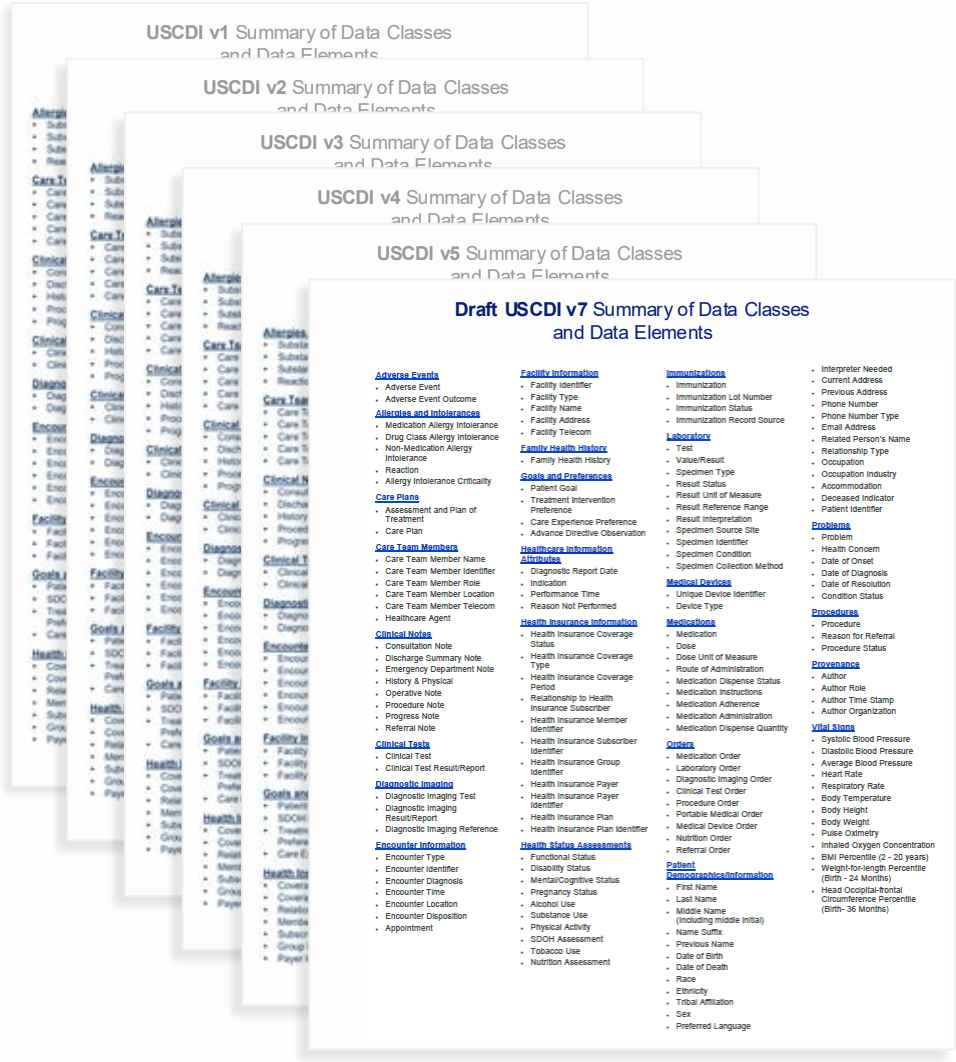
USCDI: Transparent, Predictable, Collaborative

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

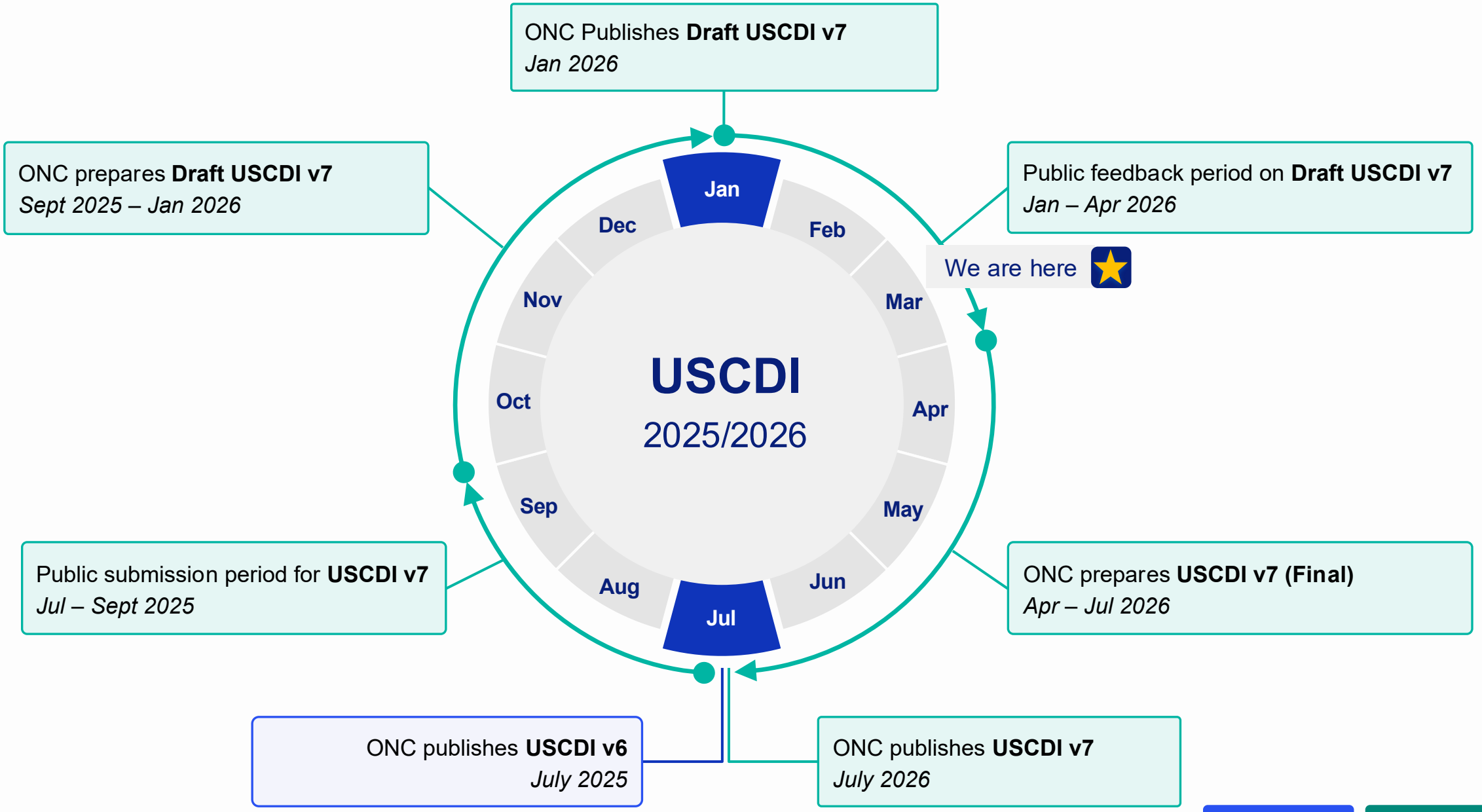
USCDI v3 expanded to 92 data elements and is required in HTI-1, effective January 1, 2026 (Note: Enforcement discretion until March 1, 2026)

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


ONC Publishes **Draft USCDI v7**
Jan 2026
ONC prepares **Draft USCDI v7**
Sept 2025 – Jan 2026
Public feedback period on **Draft USCDI v7**
Jan – Apr 2026
We are here
Public submission period for **USCDI v7**
Jul – Sept 2025
ONC prepares **USCDI v7 (Final)**
Apr – Jul 2026
ONC publishes **USCDI v6**
July 2025
ONC publishes **USCDI v7**
July 2026
Jan
Feb
Mar
Apr
May
Jun
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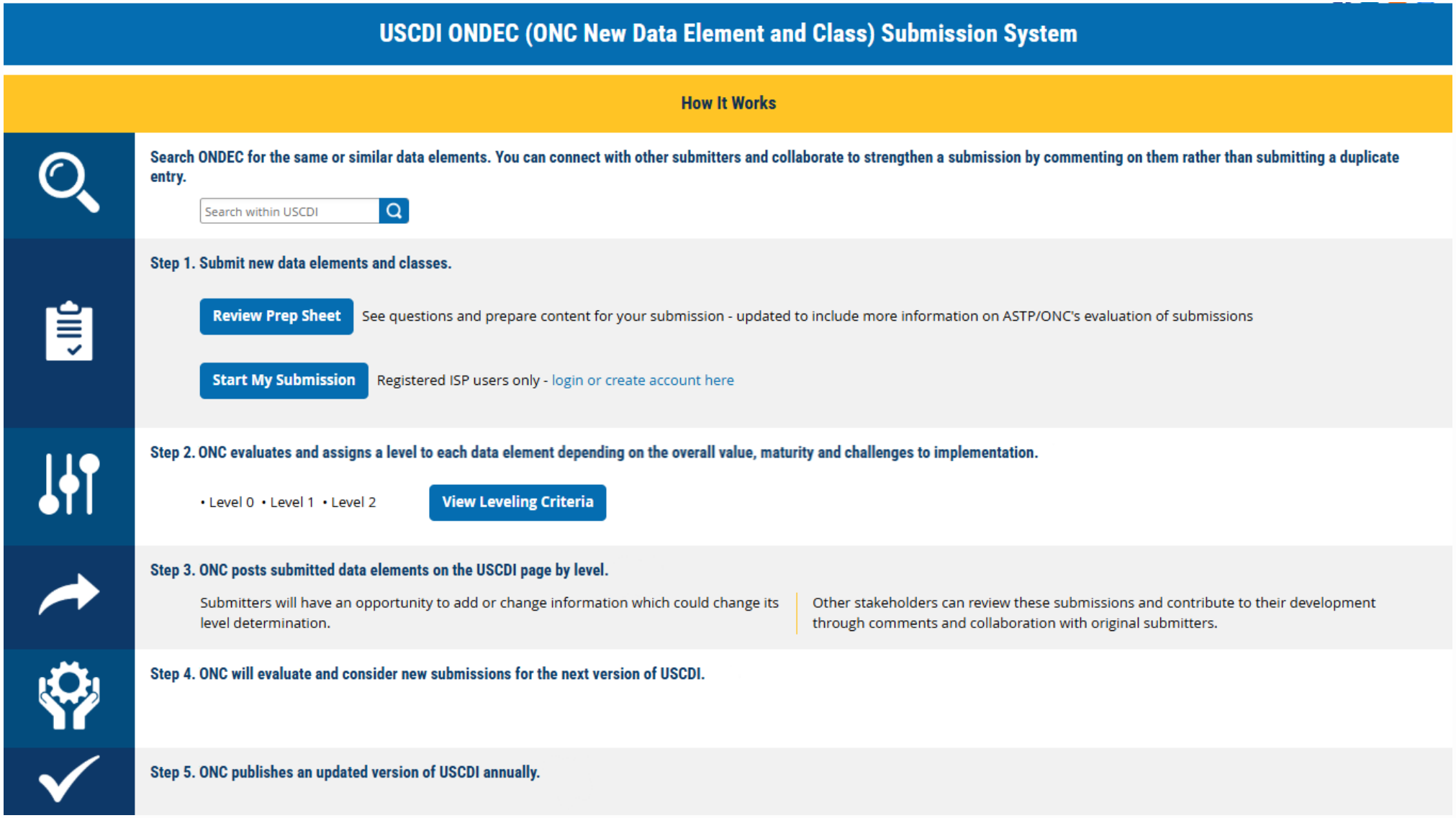
Dec
USCDI
2025/2026
USCDI v6
USCDI v7

New USCDI Data Elements: Where Do They Come From?

- Public Feedback – Submissions through ONDEC
- Technically mature & broadly applicable data elements
- USCDI+ Domains

USCDI ONDEC Submission System



Level Criteria Language

USCDI Data Element Leveling Criteria

Return to ONDEC

ONC evaluates all submissions and assigns a level based on four criteria.

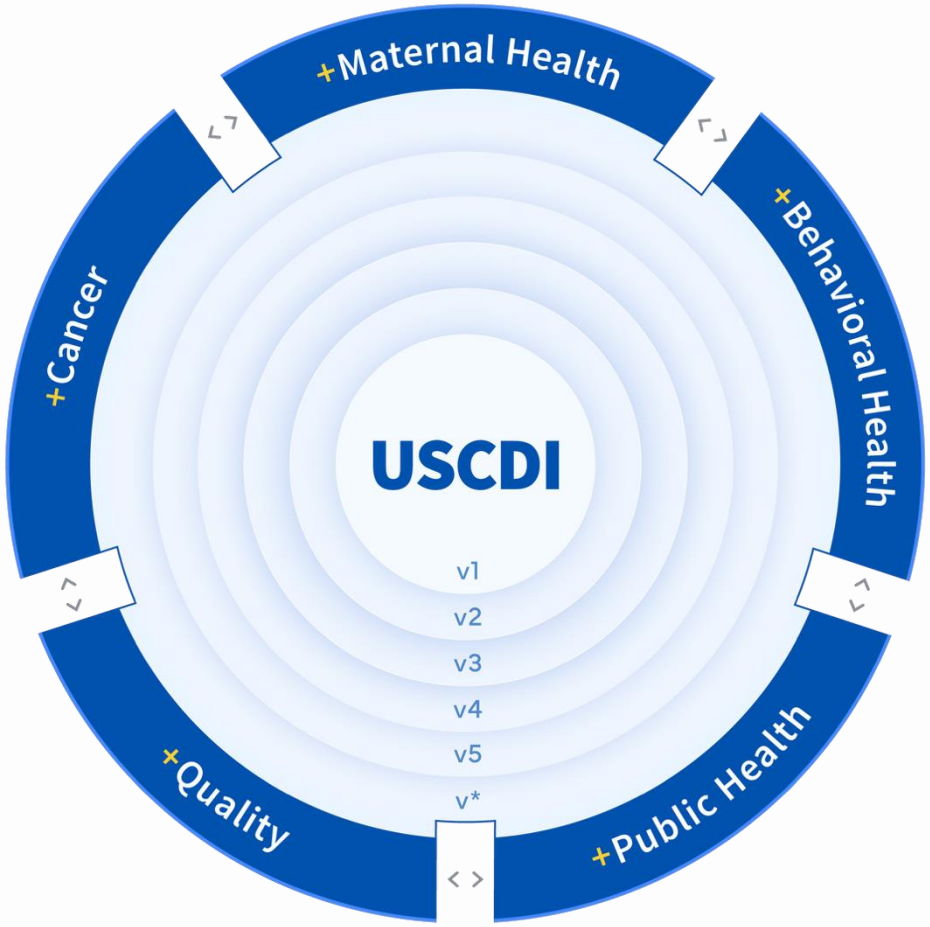
- Level 2 data elements are most mature and are considered for future versions of USCDI.
- Level 1 and Level 0 determinations are used to identify areas of additional work needed to meet the criteria for a higher level and consideration for future versions of USCDI.

Submitters can provide updates with additional information to justify a higher level and consideration.

	Criterion #1 Maturity - Current Standards	Criterion #2 Maturity - Current Use	Criterion #3 Maturity - Current Exchange	Criterion #4 Use Case(s) - Breadth of Applicability
LEVEL 2	Data element is represented by a terminology standard or SDO-balloted technical specification or implementation guide.*	Data element is captured, stored, or accessed in multiple production EHRs or other HIT modules from more than one developer.	Data element is electronically exchanged between more than two production EHRs or other HIT modules of different developers using available interoperability standards.	Use cases apply to most care settings or specialties.
LEVEL 1	Data element is represented by a terminology standard or SDO-balloted technical specification or implementation guide.*	Data element is captured, stored, or accessed in at least one production EHR or HIT module.	Data element is electronically exchanged between two production EHRs or other HIT modules using available interoperability standards.	Use cases apply to several care settings or specialties.
LEVEL 0	Data element is not represented by a terminology standard or SDO-balloted technical specification or implementation guide.	Data element is captured, stored, or accessed in limited settings such as a pilot or proof of concept demonstration.	Data element is electronically exchanged in limited environments, such as connectathons or pilots.	Use cases apply to a limited number of care settings or specialties, or data element represents a specialization of other, more general data elements.

*Maturity-Standard criterion is the same for Level 1 and Level 2. Data elements meeting this level of maturity will be assigned Level 2 for this criterion.

United States Core Data Interoperability (USCDI)+



Extending Beyond the USCDI

Unique program and use case-specific data needs are sometimes not fully met by USCDI.

ONC's USCDI+ initiative helps government and industry partners build on USCDI to support specific program needs.

Applies USCDI processes for submission and harmonization while focusing on programmatic priorities.

Seeks to leverage programs and authorities across HHS to drive adoption

USCDI+ Initiatives

	Quality	Cancer	Behavioral Health	Public Health
	Harmonized data for quality measurement and reporting.	Real-world data for cancer care, trials, and registries.	Data for mental health and substance use disorder programs.	Data elements for case reporting, lab exchange, and situational awareness.
Impact	**Aligns with CMS eCQMs, HRSA UDS modernization, and FHIR-based reporting.**	**Enhances trial matching, irAE tracking, and registry data collection.**	**Supports SAMHSA grantees, reduces reporting burden, improves data quality.**	**Supports CDC's OPHDST and public health interoperability across jurisdictions.**

USCDI+ Quality: Standardizing Digital Quality Measurement

Purpose

- Establishes **standardized, interoperable data elements** for digital quality measurement and reporting, aligning federal and non-federal quality programs.

Dual Release Structure

- **USCDI+ Quality V1 (Final):** Implementation-ready elements supporting eCQMs
- **Quality Overarching:** Strategic roadmap for future development

Development Approach

- **Six Core Criteria:** Community Input • Readiness • Policy Alignment • Measure Relevance • Harmonization • Standards Alignment
- **Engagement for Draft V1:** 30+ commenters | 400+ comments

Next Steps

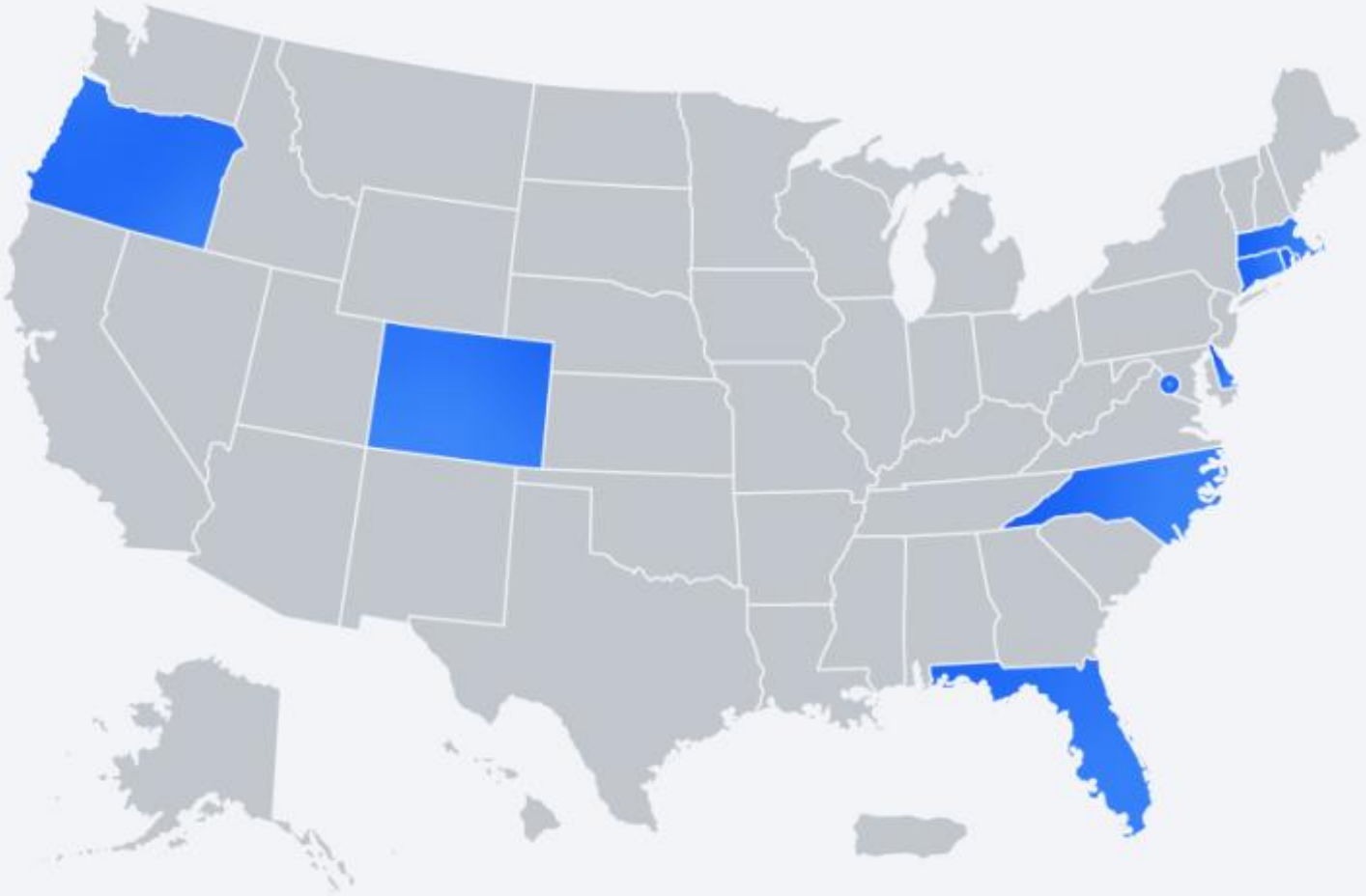
- Federal partner coordination on implementation
- **Draft V2 open for comment until March 17, 2026**
- Ongoing evaluation of challenges and priorities

USCDI+ Behavioral Health: New Pilot Projects Launched

9
Pilots

$300-$690k
Awards

45
Exchange Partners



What’s New in Draft USCDI v7

Draft USCDI v7

Adverse Events
- Adverse Event NEW
- Adverse Event Outcome NEW

Allergies and Intolerances
- Medication Allergy Intolerance
- Drug Class Allergy Intolerance
- Non-Medication Allergy Intolerance
- Reaction
- Allergy Intolerance Criticality NEW

Care Plans
- Assessment and Plan of Treatment
- Care Plan

Care Team Members
- Care Team Member Name
- Care Team Member Identifier
- Care Team Member Role
- Care Team Member Location
- Care Team Member Telecom
- Healthcare Agent NEW

Clinical Notes
- Consultation Note
- Discharge Summary Note
- Emergency Department Note
- History & Physical
- Operative Note
- Procedure Note
- Progress Note
- Referral Note NEW

Clinical Tests
- Clinical Test
- Clinical Test Result/Report

Diagnostic Imaging
- Diagnostic Imaging Test
- Diagnostic Imaging Result/Report
- Diagnostic Imaging Reference NEW

Encounter Information
- Encounter Type
- Encounter Identifier
- Encounter Diagnosis
- Encounter Time
- Encounter Location
- Encounter Disposition
- Appointment NEW

Facility Information
- Facility Identifier
- Facility Type
- Facility Name
- Facility Address
- Facility Telecom NEW

Family Health History
- Family Health History

Goals and Preferences
- Patient Goal
- Treatment Intervention Preference
- Care Experience Preference
- Advance Directive Observation

Healthcare Information Attributes
- Diagnostic Report Date NEW
- Indication
- Performance Time
- Reason Not Performed NEW

Health Insurance Information
- Health Insurance Coverage Status
- Health Insurance Coverage Type
- Relationship to Health Insurance Subscriber
- Health Insurance Member Identifier
- Health Insurance Subscriber Identifier
- Health Insurance Group Identifier
- Health Insurance Payer Identifier
- Health Insurance Coverage Period NEW
- Health Insurance Payer NEW
- Health Insurance Plan NEW
- Health Insurance Plan Identifier NEW

Health Status Assessments
- Functional Status
- Disability Status
- Mental/Cognitive Status
- Pregnancy Status
- Alcohol Use
- Substance Use
- Physical Activity
- SDOH Assessment
- Tobacco Use NEW
- Nutrition Assessment NEW

Immunizations
- Immunization
- Immunization Lot Number
- Immunization Status NEW
- Immunization Record Source NEW

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 NEW

Medical Devices
- Unique Device Identifier
- Device Type NEW

Medications
- Medication
- Dose
- Dose Unit of Measure
- Route of Administration
- Medication Dispense Status
- Medication Instructions
- Medication Adherence
- Medication Administration NEW
- Medication Dispense Quantity NEW

Orders
- Medication Order
- Laboratory Order
- Diagnostic Imaging Order
- Clinical Test Order
- Procedure Order
- Portable Medical Order
- Medical Device Order NEW
- Nutrition Order NEW
- Referral Order NEW

Patient Demographics/ Information
- First Name
- Last Name
- Middle Name (Including middle initial)
- Name Suffix
- Previous Name
- Date of Birth
- Date of Death
- Race
- Ethnicity
- Tribal Affiliation
- Sex
- Preferred Language
- Interpreter Needed
- Current Address
- Previous Address
- Phone Number
- Phone Number Type
- Email Address
- Related Person's Name
- Relationship Type
- Occupation
- Occupation Industry
- Accommodation NEW
- Patient Identifier NEW
- Deceased Identifier NEW

Problems
- Problem
- Health Concern
- Date of Onset
- Date of Diagnosis
- Date of Resolution
- Condition Status NEW

Procedures
- Procedure
- Reason for Referral
- Procedure Status NEW

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)

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.

Nutrition Assessment

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

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.

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.

Medication Administration

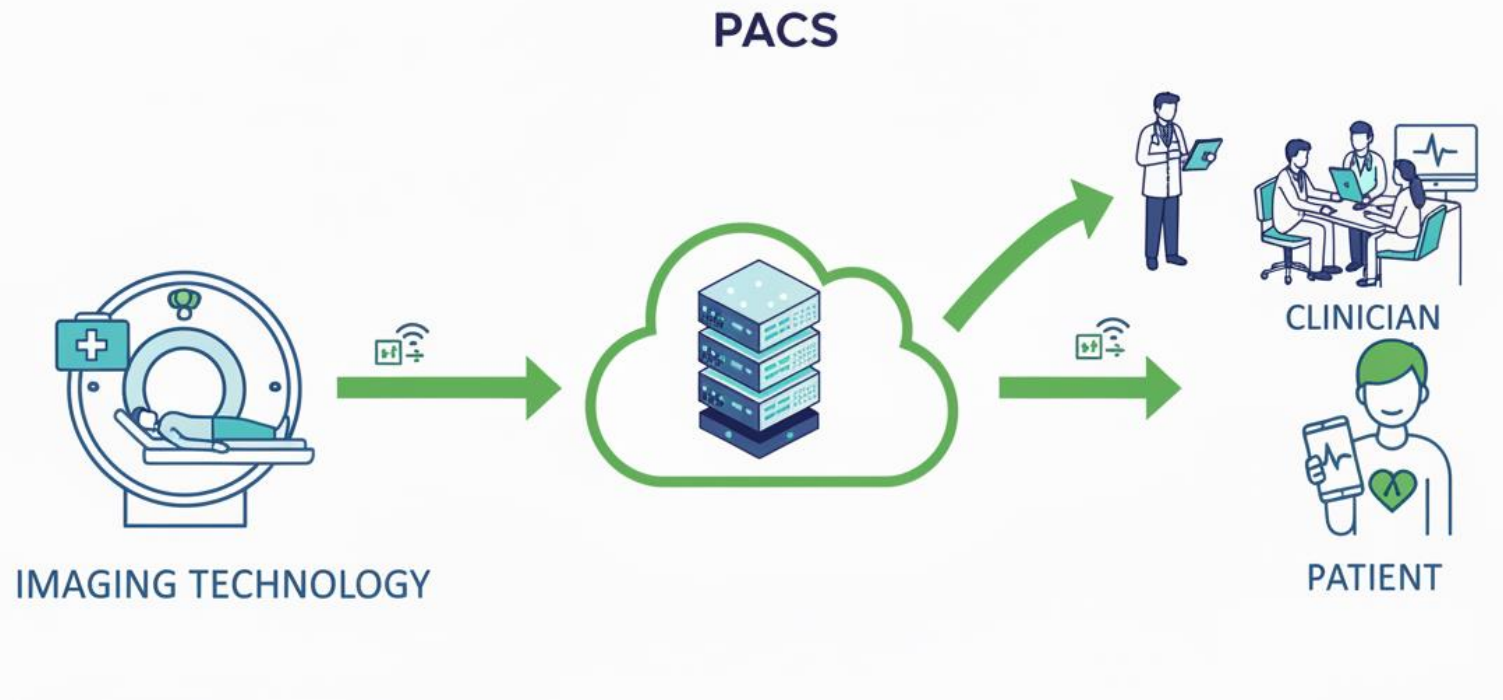
Information about the event of a patient consuming or otherwise being given a medication.

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

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.

Diagnostic Report Date NEW

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

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.

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

HHS | ONC

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