Inclusion of Interprofessional Terminology Standards in Electronic Health Records

Position Statement of the American Nursing Informatics Association Board of Directors

Authors: Susan A. Matney, PhD, RNC-OB, FAAN and Tess Settergren, MHA, MA, RN-BC

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Purpose

The purpose of this position statement is to affirm the American Nursing Informatics Association's (ANIA) support for development and use of terminology standards for nursing and interprofessional electronic health record (EHR) documentation, in order to support data-driven practice and to enable interoperability, patient-centered outcomes measurement, and the generation of nursing knowledge and wisdom across the continuum of health and health care.

Statement of ANIA Position

The American Nursing Informatics Association advocates the use of terminology standards to support safe, efficient, and effective continual use of the data and information in health information technology systems, including point of care clinical decision support, outcomes measurement, the patient-centered longitudinal plan of care, cross-organizational research and other healthcare-related purposes. Therefore, in alignment with the Office of the National Coordinator for Health Information Technology (ONC) and the American Nurses' Association (ANA), the ANIA recommends:

1. All healthcare organizations incorporate the ONC Interoperability Standards for nursing data in clinical systems. This will require a strong collaboration among personnel with expertise in nursing/interprofessional practice (i.e., the clinical experts), clinical informatics, and clinical system vendors.
2. If other ANA-recognized terminologies and classifications or local terms and codes are used in information systems, they must be mapped to LOINC and SNOMED Clinical Terms.

Background

Nursing terminologies define and code concepts in an organized way to represent nursing knowledge and support nursing practice (ANA, 2018). Interoperability of data and information in electronic health record systems is of critical importance to achieving the quadruple aim of healthcare: better care, improved population health, decreased healthcare costs, and clinician satisfaction. Interoperability of EHR data and information includes both common semantics and syntax—standardized coding of the data within the messaging structure is critical to achieve comparability and exchange of nurse-generated data across information systems. The

ONC updated interoperability standards for nursing data elements in 2017 (https://www.healthit.gov/isa/):

- Logical Observations Identifiers Names and Codes (LOINC©) code are used for observations and outcomes expressed as measures.
- SNOMED Clinical Terms© are used for problems/diagnoses, findings, interventions, and observed outcomes that represent assertions.

References

American Nurses Association (2018). Position statement: Inclusion of recognized terminologies supporting nursing practice within electronic health records and other health information technology solutions. Retrieved from: https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/Inclusion-of-Recognized-Terminologies-Supporting-Nursing-Practice-within-Electronic-Health-Records/

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