## **ONC Update 2025: Immunizations & Family History**

Last modified on 07/29/2025 1:20 pm EDT

To align with the latest ONC Health IT Certification (HTI-1) requirements, DrChrono has implemented updates to ensure compliance with **United States Core Data for Interoperability (USCDI) Version 3**. The update focuses specifically on enhancing how **Immunization** and **Family History** data are captured, structured, and exchanged within the platform.

## **Why This Update Matters**

- Improves Data Integrity: Promotes consistent use of structured formats and standardized vocabularies (e.g., CVX codes for immunizations, SNOMED CT for family history).
- Enhances Interoperability: Facilitates accurate data exchange between healthcare organizations, public health registries, and third-party applications.
- **Supports Clinical Decision-Making**: Enables more complete and reliable patient histories, informing better clinical outcomes.

## **What Has Changed**

To support USCDI v3 compliance, the following changes were implemented:

- Immunization Data Enhancements
- Family History Data Enhancements

Let's take a closer look!

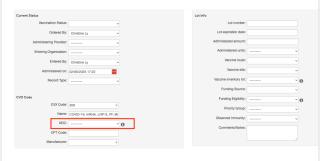
## **Immunizations**

Requirement	Update	
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When the user clicks on the NDC dropdown field, there will be a list of updated sale and use NDCs that the user can select from based on the CVX code entered.

To document a vaccine record:

- Open a patient chart
- Click on the Immunization patient chart tab
- Select a Vaccine from the dropdown
- Click on the Select Vaccines button
- Complete Step 2: Review and Sign by signing a consent form or skipping this step
- On the Step 3: Record Vaccinations, scroll down to the CVX field



When the user is typing in characters into the CVX field, a dropdown of updated results will appear based on the most relevant search results.

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Update the list of CVX codes in the database and dropdown options

Update the list of NDCs in the database and dropdown

options



Learn more about Immunizations.

Requirement	Update		
Update the list of SNOMED CT codes in the database and dropdown options	The user will be able to select from the most up to date list of SNOMED CT codes when documenting a family member's observations  To document an observation for a family member:  • Open a patient chart		
	<ul> <li>Click on the Family History patient chart tab</li> <li>Click on the +Add Family Member button</li> <li>Input desired information for that family member</li> <li>Click the Save button</li> <li>Click on the Action button next to the family member in the table</li> <li>Click on the + Add Observation button</li> <li>Type in data into the clinical observation search field and select the corresponding SNOMED CT code</li> <li>Click on the Save button</li> </ul>		
	Add Observation ×		
	Clinical observation Search in SNOMED CT collection  Age (optional)		
	Observation Age ID SnoMED Concept		
	Diabetic sensory polyneuropathy 127011001 Pelete Delete		
	Diabetic peripheral angiopathy 10 127014009		
	Close		