

THSA

Texas Health Services Authority

# TEXAS INTEROPERABILITY COLLABORATIVE

## September 9, 2026

# TOPICS OF DISCUSSION

1. Welcome
2. Antitrust Policy
3. August 12, 2026, Summary
4. Lisa Nelson & Phil Beckett – Common Language for Document-Based Exchange
5. News
6. Priorities / Work Group Status Updates
    - C-CDA Content
    - Direct Message Adoption – ADT (Event Notification)
    - National Network Adoption / Public Health Reporting
    - Immunization Registry /IMMTRAC2
    - Newborn Informatics
    - Behavioral Health Barriers to Interoperability
    - Data Usability
    - Medication Reconciliation
    - Laboratory Data Normalization
    - Prior Authorization
    - Death Notification



# ANTITRUST POLICY STATEMENT

"The Texas Health Services Authority (THSA) was created by the Texas Legislature to establish statewide health information exchange capabilities."

The members of this meeting will not play any role in the competitive decisions among HIE competitors, nor will they in any way restrict competition of HIE in Texas. Rather, this meeting serves as a forum for a free and open discussion of diverse opinions in how to implement HIE in Texas.

The members of this meeting recognize the possibility that this meeting could be viewed as a forum for anti-competitive conduct. Therefore, this policy statement clearly and unambiguously supports strict compliance with all state and federal antitrust laws.

Section 182.101(a)(1), Health and Safety Code

HEALTH AND SAFETY CODE CHAPTER 182. ELECTRONIC EXCHANGE OF HEALTH INFORMATION (texas.gov)

Compliance with antitrust laws and the guidance provided in the policy statement is a shared responsibility among all meeting members.

If a member of the meeting appears to violate any portion of this statement, please politely interject by requesting that we seek additional counsel before proceeding further.

If the behavior persists, please recommend that we move on to a different agenda item.

If the behavior still persists at that point, the meeting may be terminated immediately.

# Virtual Cybersecurity Symposium – Recordings THSA website

- Kimberly A Brown, **FBI Cybersecurity**
- Dr. Susan Fenton, UT Houston – **Health IT Cyberthreats and Resiliency**
- Scott Trevino & Ryan Gonzalez, Trimedx – **Real-world Challenges Securing Medical Devices**
- Phil Beckett – **PULSE Supporting Clinicians Access to Medications and Patient History**
- Don Taylor – **AI Cybersecurity Governance**
- Steve Ordahl, Microsoft Health and Live Sciences – **Microsoft's Cybersecurity Defenses**
- Phil Beckett, Scott Stuewe, Direct Trust, Greg Garcia, Health Sector Cybersecurity Working Group, and Dr. Diane Dolezel, Texas State - **SecureTexas, Partnerships for Cyber Workforce Development**
- Jim St Clair moderating a panel discussion with Lori Kelly, Amgen Nathan Lesser, Children's National, Zak Pantelli, GSK and Stephen Craig, NY Presbyterian on **Post Quantum Remediation – Making the 2031 deadline**

# Texas Health and Human Services Commission – Volunteer Opportunities

**Deadline Extended: for the Sickle Cell Task Force**

**Applications Due: September 14, 2026**

If you're interested in issues related to sickle cell disease and sickle cell trait, you may want to apply to be a member of the Sickle Cell Task Force.

The Texas Health and Human Services Commission executive commissioner will appoint members to the committee to serve a term expiring August 31, 2027 or 2028.

Advisory committee news posted – Members Sought for the Sickle Cell Task Force

If you qualify, submit your application through the advisory application link.

# Texas Health and Human Services Commission – Volunteer Opportunities

**Deadline Extended: for the Behavioral Health Advisory Committee**

**Applications Due: September 14, 2026**

The Texas Health and Human Services Commission (HHSC) is seeking qualified applicants to serve on the Behavioral Health Advisory Committee (BHAC). If you're interested in improving mental health and substance use services and programs across Texas, we encourage you to apply.

The HHSC executive commissioner will appoint members to the committee to serve terms expiring on August 31, 2028, and 2029.

Advisory committee news posted – Behavioral Health Advisory Committee Application for Membership application letter.

If you qualify, submit your application through the advisory application link.

# Texas Health and Human Services Commission – Volunteer Opportunities

**Members Sought for the Palliative Care Interdisciplinary Advisory Council**

The Texas Health and Human Services Commission (HHSC) is seeking qualified applicants to serve on the Palliative Care Interdisciplinary Advisory Council (PCIAC). The Texas Health and Human Services Commission (HHSC) executive commissioner will appoint members to the council to serve a term expiring December 31, 2029, or 2030.

**Applications are due by 11:59 p.m., October 1, 2026.**

HHSC will evaluate applicants based on their qualifications, relevant experience, and interest in serving on the council. The agency also seeks members who reflect the geographic diversity of Texas.

**How to apply:**

Review the Palliative Care Interdisciplinary Advisory Council Application for Membership application letter to find out who the council is seeking as representatives and if you qualify.

If you meet the qualifications, submit your application through the HHSC Advisory Committee Application Portal.

# Texas Health and Human Services Commission – Volunteer Opportunities

**Members Sought for the Hospital Payment Advisory Committee**

If you're interested in Texas hospital financing policies and programs, including disproportionate share hospitals, uncompensated care, and directed payment programs you may want to apply to be a member of the Hospital Payment Advisory Committee (HPAC). The Texas Health and Human Services Commission (HHSC) executive commissioner will appoint members to the committee to serve a term expiring December 31, 2032.

**Applications are due by 11:59 p.m., October 1, 2026.**

HHSC will consider the applicants' qualifications, background, and interest in serving on the committee and will choose committee members who represent the geographic diversity of all Texans.

**How to apply:**

Review the Hospital Payment Advisory Committee Application for Membership application letter to find out who the committee is seeking as representatives and if you qualify.

If you meet the qualifications, submit your application through the HHSC Advisory Committee Application Portal.

# USCDI V7 & STANDARDS BULLETIN 26-2

USCDI v7 introduces 31 new data elements and two new data classes. This version strengthens support for patient safety, nutrition care, and administrative burden reduction in alignment with national health and wellness priorities to Make America Healthy Again.

The accompanying Standards Bulletin 26-2 describes ONC's continued expansion of USCDI and reflects ONC's consideration of submissions for new data elements and comments on previously submitted data elements.

[USCDI-Version-7-July-2026.pdf]

## New Data Elements Added to USCDI v7

**Data Elements Not Currently Referenced in ONC Health IT Certification**

- Accommodation
- Adverse Event Condition +
- Adverse Event Outcome
- Allergy Intolerance Criticality
- Appointment
- Diagnostic Imaging Reference +
- Healthcare Agent +
- Medication Administration +
- Medical Device Order +
- Nutrition Assessment +
- Nutrition Order +
- Reason Not Performed +
- Referral Note
- Referral Order +
- Specimen Collection Method
- Tobacco and Nicotine Product Use

**Certified EHRs are required to be a V3 – But you can ask for more.**

# CMS 2027 PHYSICIAN FEE SCHEDULE PROPOSED RULE

**The CY 2027 PFS Proposed Rule includes proposals for the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs), as well as several Requests for Information (RFIs).**

Specifically, we're proposing policies that:

- Move towards the full implementation of MIPS Value Pathways (MVPs).
- Focus on prevention and wellness in patient care.
- Reduce administrative burden.
- Promote more meaningful participation that drives quality and value.

**2027 Policy Proposal Highlights**

**Key QPP policies that we are proposing in the CY 2027 Medicare PFS Proposed Rule include:**

- Sunsetting the traditional MIPS reporting option after the 2028 performance year.
- Introducing 3 new MVPs for the 2027 performance year that are related to diabetic disease, hypertension, and hospitalists, and modifying all 27 previously finalized MVPs.
- Replacing the outcome/high-priority measure requirement for the quality category with a new MIPS core measure requirement.
- Revising the MIPS Promoting Interoperability performance category reporting requirements in the CY 2026, 2027, and 2028 reporting periods.
- Modifying the APM Performance Pathway Plus (APP Plus) quality measurement set and introducing a new collection type: Medicare Electronic Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare eCQMs).
- Applying Qualifying APM Participant (QP) and Partial QP determinations at the Taxpayer Identification Number/National Provider Identifier (TIN/NPI) level instead of the NPI level.

**Comments due by September 14, 2026**

**How Do I Comment on the CY 2027 Proposed Rule?**

The proposed rule includes directions for submitting comments within the 60-day comment period. When commenting, refer to file code: CMS-1848-P.

We don't accept FAX transmissions.

Use 1 of the 3 following ways to officially submit your comments:

- **Electronically:** regulations.gov
- **Regular mail:** Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1848-P, P.O. Box 8016, Baltimore, MD 21244-8016.
- **Express or overnight mail:** Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1848-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

2026-14327.pdf (SECURED)

# USCDI V8 Open for Comments

**C-CDA Workgroup will comment on the value of Past Medical History –**
**Is there anything that you believe needs including or defining more in the shared electronic medical record**

With the publication of **USCDI v7**, ONC begins the next cycle to update USCDI to Version 8. The **ONDEC** submission system is open and accepting recommendations for data elements. ONC has updated the comment feature on the USCDI data element pages, making it easier to post comments on multiple data elements. In addition to proposals for new data elements, ONC invites feedback on existing data elements via the commenting feature on the **USCDI data element pages**.

ONC encourages the community to engage and collaborate. The open comment period ends **Monday, September 28, 2026, at 11:59 PM ET.**

ONC is targeting release of Draft USCDI v8 in January 2027.

# HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE

The HITAC will recommend to the National Coordinator for Health IT policies, standards, implementation specifications, and certification criteria relating to the implementation of a health information technology infrastructure, nationally and locally, that advances the electronic access, exchange, and use of health information.

The Meetings are open to the public.

[HITAC - ONC - Office of the National Coordinator for Health Information Technology]

Meetings:

- September 14, 2026 – Annual Report Workgroup
- September 24, 2026 – Health IT Advisory Committee
- November5, 2026 – Health IT Advisory Committee

# Leading Edge Acceleration Projects

**Area of Interest 3: Assess laboratory interoperability gaps to improve the adoption and use of standard terminology among small, independent laboratories.**

**THSA, C3HIE, TORCH and Dallas County Public Health are partnering to apply for this grant.**

**The subject matter expertise of the Laboratory workgroup will be key.**

**Letter of Intent submitted: 6.27.2026.**

**Application submitted: 7.16.2026.**

**Anticipated award date: 09.26.2026**

Texas Health Informatics Alliance

**Sixth Annual Texas Health Informatics Alliance Conference**
**ALL IN: From Innovation to Impact – Implementing Trustworthy Health Informatics Across Texas**
**September 18, 2026**
**Location: UNT Frisco Landing**

The University of Texas Arlington (UTA), The University of Texas Health Science Center at Houston (UTHealth Houston), Texas State University (TXST), Texas Woman's University (TWU), UT Southwestern Medical Center (UTSW), and the University of North Texas (UNT) are pleased to share that registration for the **Sixth Annual Texas Health Informatics Alliance Conference "ALL IN - From Innovation to Impact: Implementing Trustworthy Health Informatics Across Texas"** is now open. This in-person event will bring together the health informatics community across Texas to share research, innovations, and real-world applications that improve healthcare delivery and outcomes. This year, it will be hosted as an in-person conference on Friday, **September 18, from 8 a.m. to 4:30 p.m. CDT at UNT Frisco Landing Campus, 12995 Preston Rd. Frisco, TX 75033.**

The Sixth Annual Texas Health Informatics Alliance conference is dedicated to advancing trustworthy, ethical, and impactful health informatics implementation across Texas.

**THIA 2026 Agenda** (see link below or attached PDF)

https://cihi.uta.edu/texas-health-informatics-alliance/thia-2026/agenda-thia-2026/

**THIA 2026 Registration**

https://cihi.uta.edu/texas-health-informatics-alliance/thia-2026/registration-thia-2026/

The registration fee is $100 and includes a continental breakfast and boxed lunch as well as parking.

# Maternal Health Plugathon – Cosponsored HL7 & IHE Arlington, VA at George Mason University

IHE North America Connectathon Week
October 12-16, 2026
George Mason University Campus
Arlington, VA




Review the Plugathon plan on Confluence

Join us to test real-world interoperability capabilities for communicating information across the continuum of maternal care—before, during, and after deliver.

IHE PLUGATHON ARLINGTON OCTOBER 2026

MATERNAL HEALTH PLUGATHON
OCTOBER 15–16, 2026
Arlington, VA · George Mason University Campus

## MATERNAL HEALTH PLUGATHON

*Better Information. Safer Mothers. Healthier Families.*

A hands-on testing event maturing the ONC USCDI+ Maternal Health data elements and improving document-based exchange for maternal health — connecting providers, payers, vendors, and public health across the care continuum. Held during IHE North America Connectathon Week.

### TESTING FOCUS

- Test as a Content Creator/Consumer, Sender/Receiver, or Query Initiator/Responder
- Query & retrieve maternal health documents (e.g., OB Flowsheet, Antepartum Summary)
- Exchange documents via CDA and Direct Secure Messaging (e.g., Pregnancy Notification - Risk Assessment, Maternal Discharge Summary)
- Trigger bi-directional workflows from real clinical events (admission, discharge)

### WHO SHOULD ATTEND

- Healthcare providers & health systems
- EHR and health IT vendors
- Payers and health information exchanges (HIEs)
- Public health agencies & standards developers
- Testing Tools provided for Observers who want hands-on experience

HL7 CDA
An HL7 International Standard

**REGISTER TODAY**

Early Bird $750 · by Aug 14 · Code EARLY26
*Space is limited — register early*



Scan to Register

More to Come!
GET INVOLVED

The Interoperability Progressive Standards Usability Program

October 20-21, 2026
DirectTrust Annual Conference
Kansas City, MO

October 21, 2026
Maternal Health Data Summit
Kansas City, MO

November 17, 2026
Sequoia Project Data Usability Taking Root
Virtual Workshop

January 2027
HL7 Working Group
Virtual Meeting

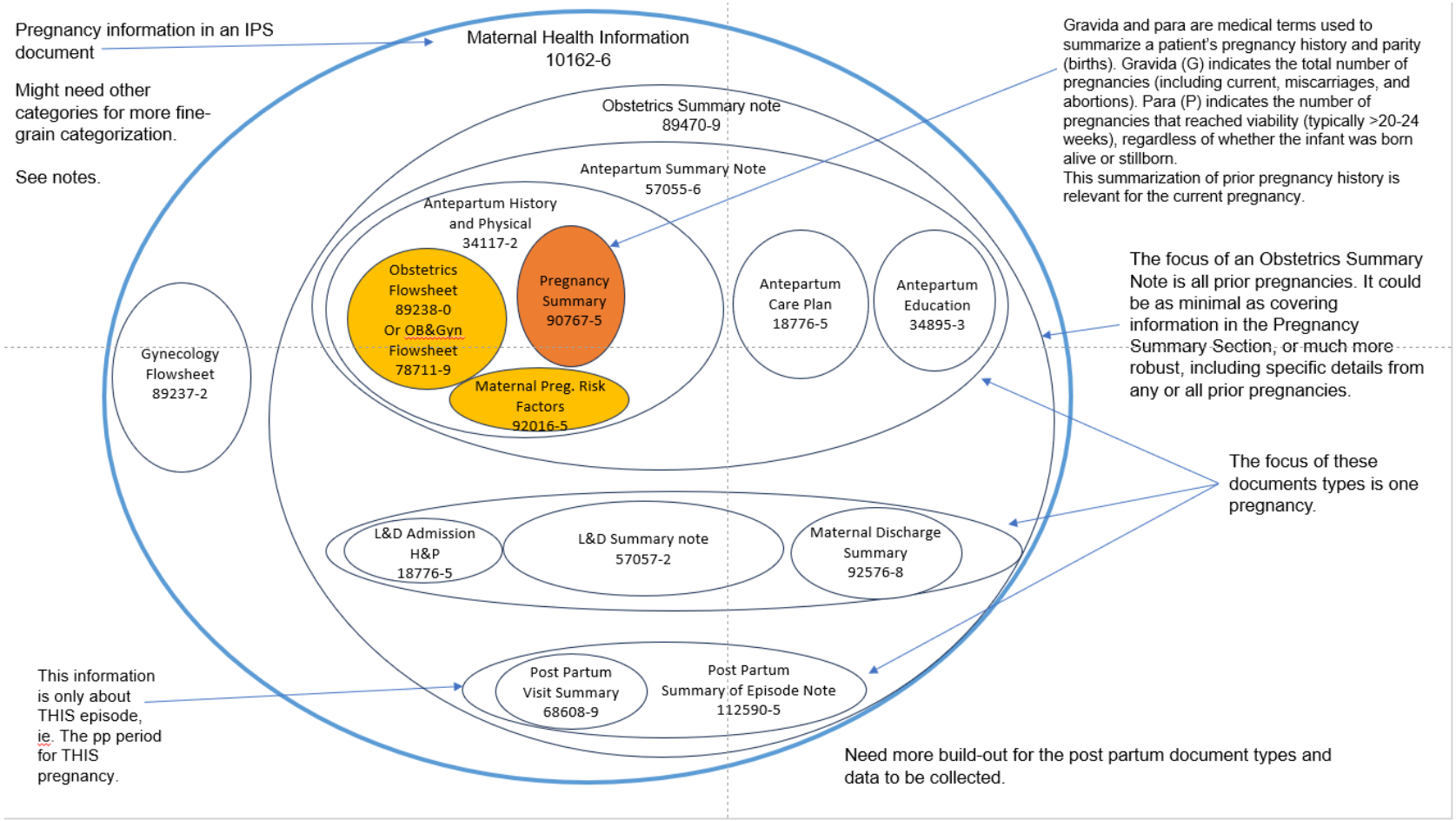
February 2027
IHE Working Group
Oakbrook, IL

April 2027
HIMSS Annual Conference
Chicago, IL

*Small-scale tests of change using a continuous quality improvement Plan-Do-Study-Act cycle*

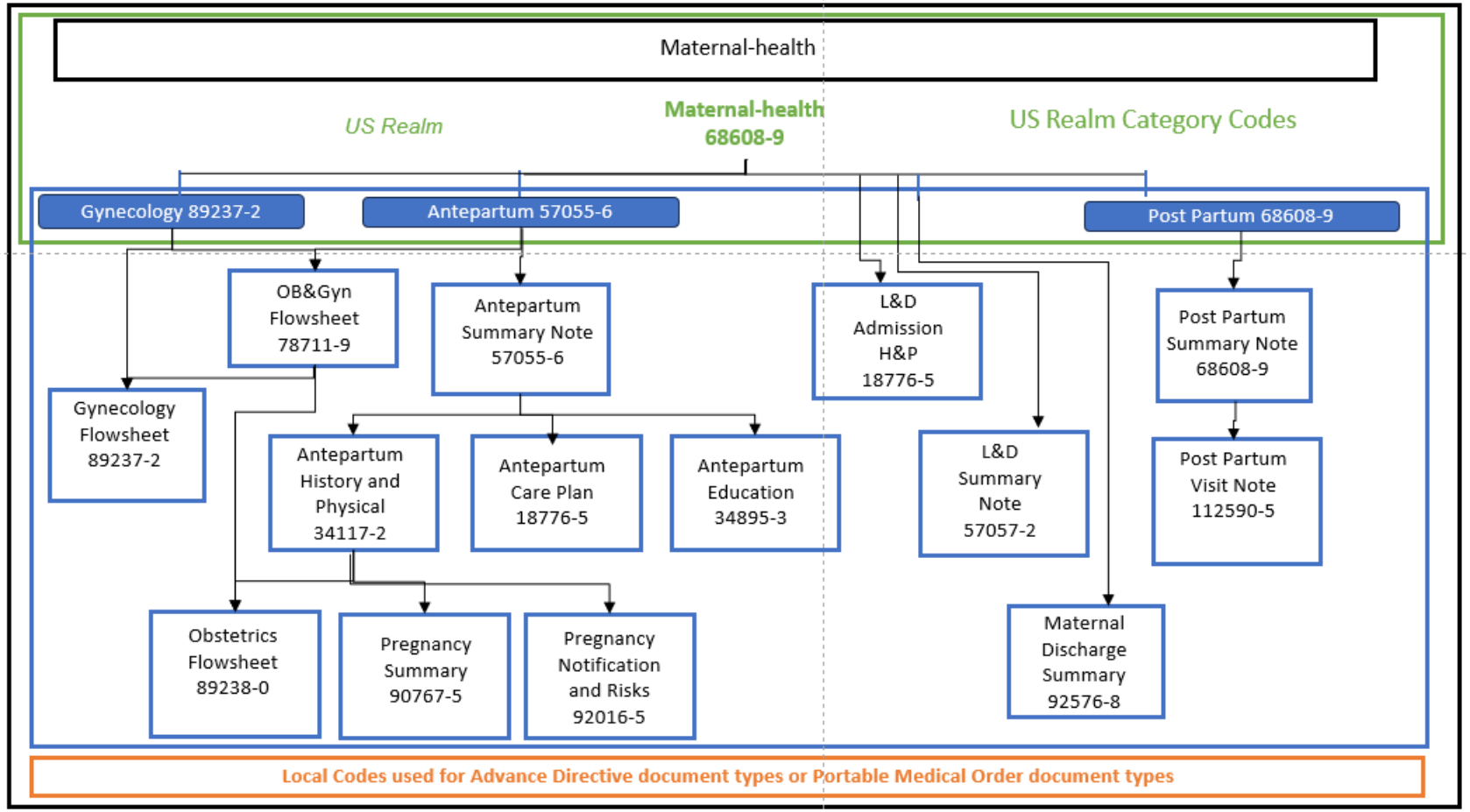
Learn More

# Maternal Health will be a Focus



STANDARDIZED DOCUMENT CLASSIFICATION

# DOCUMENT ONTOLOGY HIERARCHY




5/12/2025

***L0 Dimension: UV Realm Category codes do not utilize the LOINC Document Ontology.***

**L1 Domain: US Category classifications for Maternal Health document types (LOINC)**

**L2 Category: Standard types of Maternal Health documents (LOINC).**

**Local codes for Maternal document types.**

# C-CDA STANDARDIZATION

**Problem:**

**Inconsistent CCDA content is impacting transitions of care in the Texas community.**

Although C-CDA was implemented to make data transfer between various EMR/EHR easier, that is not always the case. CCDA data received by the clinical community is inconsistent creating frustration with the community and lack of trust in the data received. Clinicians have vocalized that data transfer between different EMR / EHR vendors and organizations is inconsistent. When sending patient information from one group to another, fax or printed papers are still used. Even if the electronic method of the transfer is used, topics/parts that are filled may differ between organizations. There are policy requirements for CCDA and transitions of care but the application is inconsistent across the ecosystem as such not optimally supporting transitions of care between various healthcare providers.




**The final goal of this project is to recommend clinical content to be included in the C-CDA that can be implemented as a standard throughout Texas.**

This project aims to identify and suggest a modification to various parts of the CCDA that will benefit transitions of care. We are also targeting to pick components of CCDA that can be made standard so that there is parity between all the patient data transferred between varied health care organizations.

# C-CDA standardization

**Work-Group Members:**

- Austin Regional: Dr. Manish Naik, Kaitlyn Theiss, & Maggie Felger (Epic)
- Texas Health Resources: Jennifer Glass (Epic)
- UT Austin: Dr. Micheal Auth (Athena & Oracle)
- Ascension Health: Glenn McManus, Phil Kwang, & Ashleigh Miller DuChamp (Oracle)
- United Regional: Kortney Kouns and Sheryl Sledge (Epic)
- Children's Dallas: Christian Agwumaro (Epic)
- Epic: Karl Zelle
- Oracle: Jeff Sum
- HCA: Dr Bill Rice, MD, & Dr. Bill Gregg
- Sequoia Project / Carequality: Didi Davis
- CommonWell: Paul Wilder
- HHSC: Jeff Leung, Willis Gibson, Jason Setters, & Sasha Robey
- BSW: Susan Bradshaw (Epic)
- Meditech – Nick Meyers and John
- PointClickCare – Robin Roberts & Stephen Hill (PCC)
- Health Services North Texas – Karishma Patel (eCW)

**Actions**

Focus on the balance of sharing clinically pertinent information and cognitive overload with sharing too much. Will develop best practice recommendation

1. **Participating in Sequoia Project Data Usability Taking Root initiative.**
2. Maternal Health: Antepartum Summary Progress Note Document. HSNT & THR – LOINC Code being used by eCW updated to 89238-0 for OB Flowsheet. **No records have been faxed since this change on 12.11.2025. Working on Epic Chart Review inclusion, moving to C-CDA instead of PDF and use of DSM to send. Efforts a focus for HL7 / IHE Plugathon.**
3. ARC & HCA –Continuing to review and work together.
4. ARC & Ascension –Epic / Oracle & Athena. Deep dive into metadata on date underway.
5. Transfer Summary C-CDA work completed. Recommending adoption.
6. Lack of standardization on C-CDA Doc Types Shared is impacting interoperability. Education by Lisa Nelson on Doc Types and Categories with LOINC Codes.
7. **Discussion on identifying orgs sending PDFs instead of electronic and working with these orgs.**
8. **Standardizing Consult Doc type underway.**

# EFFECTIVE USE OF CODES, THSA C-CDA

**Problem: Interpretation of LOINC Code Assignment for C-CDAs varies resulting with inability to electronically ingest data in a consistent manner. Ask your EHR vendor if the respond to queries, receive via query or send these Document Types. If not ask that they do so.**

**2.4.5.** Document Level Clinical Notes

***2.4.5.1.*** The HL7 C-CDA Templates for Clinical Notes R2.1 Companion Guide, Release 4.1, section 2.7.1, describes how clinical note types are identified using LOINC terminology and identifies the most commonly used note types in Table 8. C-CDA Content Creators SHOULD support creation of C-CDA documents.

2.4.5.1.1. Document Level Clinical Notes SHOULD use the most general LOINC code from C-CDA Templates for Clinical Notes R2.1 Companion Guide, Release 4.1, section 2.7.1, Table 8 as document type code.

2.4.5.1.2. Document Level Clinical Notes SHOULD include a more specific LOINC code from the Complete Note Type Value Set in C-CDA Templates for Clinical Notes R2.1 Companion Guide, Release 4.1, section 2.7.1 Table 8 as a translation of the main code.

***2.4.5.2.*** C-CDA Content Creators SHOULD support inclusion of narrative clinical note information in structured sections of C-CDA documents.

The LOINC terminology includes thousands of different clinical note types. These codes can be used at the document, section, or entry level to categorize the type of clinical note information being shared. To focus the industry, the Argonaut participants and the Department of Veterans Affairs contributed their most commonly used note types to develop the following list of most frequently created clinical note documents.

| | |
|---|---|
| **Consultation Note** | **11488-4** |
| **Discharge Summary** | **18842-5 - Done** |
| History and Physical | 34117-2 |
| Procedure Note | 28570-0 |
| Progress Note | 11506-3 |
| Imaging Narrative | 18748-4 |
| Laboratory Narrative Note | 11502-2 |
| Summary of Episode | 34133-9 |
| **Transfer Summary** | **18761-7 – Done** |

# CONSULT NOTE CLINICAL CONTENT - 11488-4

Validated with HIM Professionals that these are the elements traditionally included and those required by CMS and Joint Commission.

Workgroup added these additional elements

**Can you support this as the minimum for Consult Note?**

- Encounter Date / time
- Care Team Member / Attending Name
- Attending Name
- Patient Identification
- Reason for Referral
- Past Medical History (Not a USCDI concept)
- Current Medications
- Allergies & Intolerances
- History of Present Illness
- Review of Systems
- Social and Family History
- Physical Examination
- Test Results (Radiology, Laboratory, Cardiology, Pulmonary, Neurology, Nephrology)
- Diagnosis
- Treatment Plan / Assessment & Plan
- Problem List

# USCDI V8 Comments

Will comment on the value of Past Medical History as a concept for USCDI V8.

# OB Flowsheet – LOINC Codes

**eCW LOINC code 89238-0 for OB Flowsheet.**

The LOINC code is the data normalizer that allows the OB Flowsheet to display in the electronic medical record. You will want to check with your EHR vendors to see how they handle this LOINC code.

**Epic does not include 89238-0 as part of their standard document request, however the organizations can add the LOINC Code 89238-0.**

Epic Hospitals - QAN **8057994 – Development tracking with links included for the workaround to add LOINC Code. Contact your CareEverywhereTS. The build took about 30 minutes; the instructions are very clear.**

**Not retroactive but you can do an update, and the information is available as an OB Flowsheet.**

# DIRECT MESSAGING

**Problem:**

Adoption and use of Direct messaging as a secure communication platform is affecting access to clinical information for the direct care clinicians. In the process of establishing Direct messaging, administrative steps and processes need to be streamlined to avoid the use of manual workarounds, including fax machines, for communication between health care entities.

**Work-Group Members:**

Ascension: Glenn McManus, & Phillip Kwang

CHRISTUS: David Gano

Baylor Scott & White: Susan Bradshaw & Dr. Craig Kneten

UTSW: Anita Heard

Children's Dallas: Christian Agwumaro & John Archibald

Texas Medical Association: Shannon Vogel

UT Austin: Dr. Michael Auth

UT Houston: Tracy Swoboda & Diana Canales

THR: Jennifer Glass

UT San Antonio: Mudathir Mohamed

University Health: Dr. Mysti Schott

# DIRECT MESSAGING

**ACTIONS TAKEN:**

1. Closed Loop Referrals is a focus. Discussion on developing standards for PRAPARE for non-medical drivers of health. Community based organization referrals and management difficulty with different platforms, standards and the state referral that is required in a grant is not the same as CMS. This is creating duplicate work for organizations. Developing a FAQ to share with the community.
2. Directory Management and inclusion of hospital or department Direct Addresses. Epic is working with Lisa Nelson, DirectTrust.
3. Sharing HL7 definitions for ADT Messages. Recommending that all organizations follow HL7 definitions.
4. **Use of DirectSecure Messaging to close the loop between antepartum to post partum. Clinicians caring for mother antepartum are not consistently receiving information on birth. IHE Plugathon**
5. **Closed Loop Referrals including Directory Management for access to Direct Addresses for referrals is a focus.**



# Ascension Looking for Pilot Partners on Adopting Direct Secure Messaging

Ascension uses Oracle for their inpatient facility. Oracle inpatient facility has the ability flip fax number to Direct Address.

Ascension is doing some piloting with Harbor Health.

If interested contact: Glenn McManus - ggmcmanus@ascension.org

# CLOSED LOOP REFERRALS

Problem: The amount of time that it should take to provide feedback to the referring organization is undefined, making it difficult to manage expectations

Capture of non-medical drivers of health screening is being completed by diverse disciplines. While Prepare seems to be the NMDH tool used, the disciplines using the tool are diverse with different interpretations.

Access to a Direct Address is inconsistent. Community based organizations do not have Direct Addresses.

**Discussion C-CDA Workgroup too.**

**Should we work on standardizing?**

- Content, time standards – what else?
- Use of departments rather than Names for referrals?
- Sending referrals to rehab services, DME, etc.
- Engaging community-based organizations – i.e. food banks, clothing distributors, homeless shelters, etc.

# NATIONAL NETWORK ADOPTION GOALS

**Encourage adoption of national networks across Texas to support patient record query retrieve.**

- Achieve goals of better access, improved patient satisfaction, and high quality and economical care with care coordination that relies on robust patient data sharing. Better care management is achieved with robust interoperability.
- ***Create a circle of providers surrounding an individual that is interconnected via interoperability allowing the management of care to reach its most effective stage.***



# NATIONAL NETWORKS

carequality

the sequoia project

eHealth Exchange

DirectTrust

www.DirectTrust.org

**eCR - CDC**

commonwell HEALTH ALLIANCE

**Work-Group:**

- Amy McLarty – Children's Dallas
- Dr. Phil Huang – Dallas County Public Health
- Susan Bradshaw – BSW
- Roxanne Barrera –Tenet
- Dr. Joseph Schneider – UTSW / Parkland

**Actions Taken:**

Concentrating efforts on understanding what are the barriers to joining a national network.

1. **Group is focusing on eCR and data quality. The group discussed the relationship between ImmTrac2 data quality and eCR. Requesting ImmTrac2 Team discuss at next Immunization / ImmTrac2 Workgroup meeting.**

2. **Group is recommending that organizations attend the following national network open meetings.**

- https://rce.sequoiaproject.org/events-webinars-and-sessions/
- Events - eHealth Exchange

**Sequoia Project as the Review Coordinator Entity for TEFCA and the eHealth Exchange that is a national network and QHIN.**

# National Network Awareness

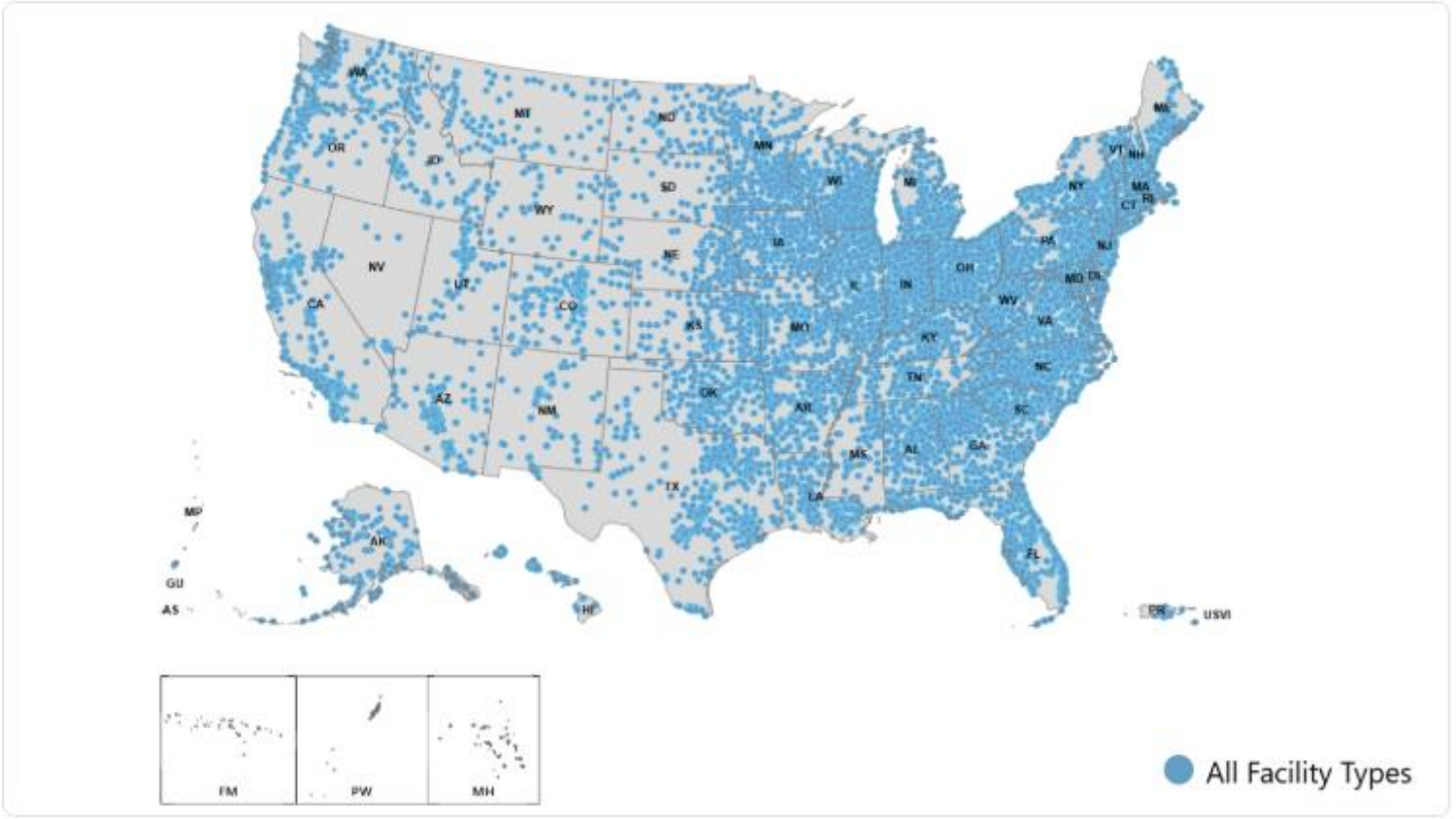
**Workgroup is recommending that organizations attend the following national network open meetings.**

- https://rce.sequoiaproject.org/events-webinars-and-sessions/
- Events - eHealth Exchange

# Electronic Case Reporting

As of August 3, 2026 more than 65,360 facilities in all 50 states and three territories are actively sending electronic initial case reports to public health using eCR. Reports that meet the reporting criteria for multiple jurisdictions are sent to each jurisdiction at the same time.

View Larger




Healthcare Facilities sending reports with Electric Case Reporting

[Healthcare Facilities Live for eCR | eCR | CDC]

# IMMUNIZATION REGISTRY CHARTER



ImmTrac 2
Texas Immunization Registry

**9.1 million Texans' immunization records.**
**33,000 organizations store them in 1 place.**

**Goal:**

- Assure ImmTrac2 data is trusted
- Identify a means to correct identified data integrity issues
- Create a sharing opportunity so that other health care providers can learn from others and streamline implementation.
- Collaboratively work together to streamline the ImmTrac2 on-boarding process and post production operations.

**Objectives:**

1. Create a FAQ and lessons learned document to share with the community
2. Work-Group and ImmTrac2 to collaborate on recommendations for improvements or changes including but not limited to technology, communication, policy or website. DSHS must follow the state change management process
3. We will follow THSA Texas Interoperability Charter including anti-trust requirements

# IMMUNIZATION REGISTRY

**Work-Group:**

- Dr. Mujeeb Basit, UTSW
- Barbara Ray, Texas Health Resources
- Dr. Paul Bassel & Susan Bradshaw, Baylor Scott and White
- David Whitman & Heather Stevenson, Children's Dallas
- Prageet Sachdev, Lilian Obwoge, Steve Eichner, Kevin Allen, David Walker, Arthur Lara, & Tim White, DSHS
- Carolyn Marshall, Ascension
- Dr. Scott Wilson, Rachel Haro, Rachel Cunningham, and Tim Tracy, Texas Children's
- Dr. Phil Huang, Dallas County Public Health
- Diana Canales & Brittney Townsend, UT Houston
- Dr. Joe Schneider, UTSW / Parkland
- Justin Lopez, CUC
- Wendy Ward, Immunization Partnership
- Cayla Huon, Harris Methodist
- Rachel Hauser, TMA

**Actions Taken:**

1. Reports for additional aid with resolving issues – Please request from DSHS.
3. Project underway to accept 2 consents (Adult and disaster). This is in planning at DSHS. Survey of impact sent to EHR vendors. ImmTrac2 team evaluating feedback.
4. Access to test and production ImmTrac2 site is available but requires coordination.
5. Pilot Project with American Immunization Registry announced.
6. **Consents and timing issues with consents continue to be a topic of discussion.**
7. **Workgroup continues to enjoy open discussion and problem solving.**
8. **Workgroup is focusing on data integrity.**

# NEWBORN INFORMATICS

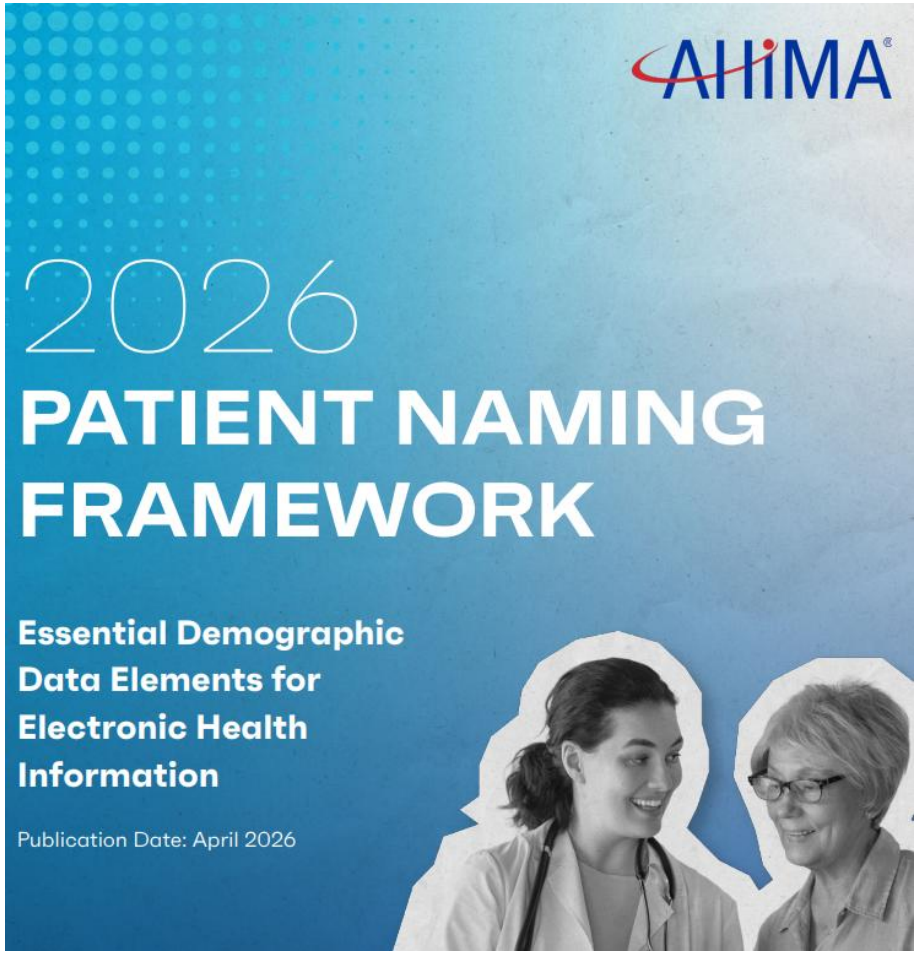
**Work Group Members:**

- Dr. Joseph Schneider – Parkland & UTSW
- Dr. Paul Bassel, Dr. Rob Jones, & Susan Bradshaw – Baylor Scott & White
- Craig Newman, J Michael Consulting
- Dr. Jermaine Hurling, Dell
- Dr. Scott Watson & Dr. Regine Fortunov, Texas Children's
- Dr. Phil Bernard, Dr. Lisa Scheid & Jimmie Glorioso, Dallas Children's
- Dr. Charlie Shumate, Birth Defects Registry
- Dr. Ashley Antipolo, Cook Children's
- Dr. Raghu Puttagunta, Driscoll Children's
- Dr. Rajegowda – United Regional
- Dr. Antonio Hernandez, UT San Antonio

## Actions:

- **Patient Matching with newborns:** 4.29.2025 Press Release Standardize Newborn Naming Convention, THSA and NAHAM agreed to follow AHIMA and Newborn Informatics Recommendation. Communication development in process. Worked collaboratively with NAHAM and AHIMA on AHIMA Framework – to be updated with THSA recommendation in Dec 2025 or Jan 2026. Dr. Schneider and THSA continue to share the standard both in the state and nationally. **Dr. Schneider is working with Epic & Meditech on standard adoption The plan is to work with other vendors.**
- **Group is discussing standards for screening for biliary atresia. Dr. Schneider is looking into the return on investment for standardizing.**
- **NB Naming Standard and Dr. Schneider's national efforts.**
- **NB Naming Standard recommendations for statewide adoption September 18, 2026 eHAC.**

# AHIMA's Newborn Naming Framework




| First Name Field | Middle Name Field | Last Name Field |
|---|---|---|
| **Singleton** | | |
| GIRLMaria | | Lopez |
| BOYMaria | | Lopez |
| BABYMaria | | Lopez |
| **Multiples** | | |
| GIRL1Katherine | | Miller-Smith |
| BOY2Katherine | | Miller-Smith |
| BABY3Katherine | | Miller-Smith |
| BOY4Katherine | | Miller-Smith |

*BABY when sex is undetermined

2026_patientframingnetwork.pdf

# Why is a Temporary Newborn Naming Standard important?

- Supports electronic real-time access to clinical records for newborns
- Impacts annually approximately 390K Live Births, 11K Multiple Births & 1000 newborns with life threatening disorders identified by newborn screening with 45.8% Medicaid
- Delays in care delivery; i.e. emergency transfers between facilities with receiving physicians' accessing birth medical records and / or newborn screening failures with pediatricians or PCPs unable to access results with potential patient harm i.e. hypothyroid with brain cell loss
- Burden of faxing documents and searching through faxed documents
- Survey of 27 hospitals revealed 23 different temporary newborn naming conventions

Texas Health Data - Live Births

Newborn Screening Program | Texas DSHS

Medicaid coverage of births: Texas, 2019-2024 | PeriStats | March of Dimes

# Newborn Informatics –Streamlining



Standardized newborn naming conventions allow the medical record to flow seamlessly with the patient. This information is critical for the pediatrician, PCP, or neonatologist supporting this fragile population.

Estimate: 1.5 hours of administrative work to acquire the medical record when a standardizing naming convention is not utilized for a neonatology transfer.

**NICU Transfer : ½ hour of Neonatologist time at $96 + 1 hour of APNs & RN at $60 = $156**

# Adopting Standardized Newborn Naming

- Texas Health Resources, live
- Dallam-Hartley, live
- John Peter Smith, live
- Parkland Health, live

**Organizations discussing: UTSW, Baylor Scott & White, Children's Dallas and Driscoll.**
**If you are implementing or considering – Please let Katherine know.**
**Katherine presented June TxHIMA Conference.**
**Dr. Schneider presenting at Kentucky Epic User Group.**
**Dr. Schneider discussed with Joint Commission. Meditech, and Epic.**

**Interoperability Workgroup of E-Health Advisory Committee is recommending for adoption.**

# BEHAVIORAL HEALTH BARRIERS TO INTEROPERABILITY

Clearly communicating the data needs for the care continuum is important. Sewing up the wrap around services for these patients and coordinating to establish a medical home is critical.

What are salient for continuum of care? Working together on interoperability for this population would be helpful. What are the needed data elements and what are the constraints?

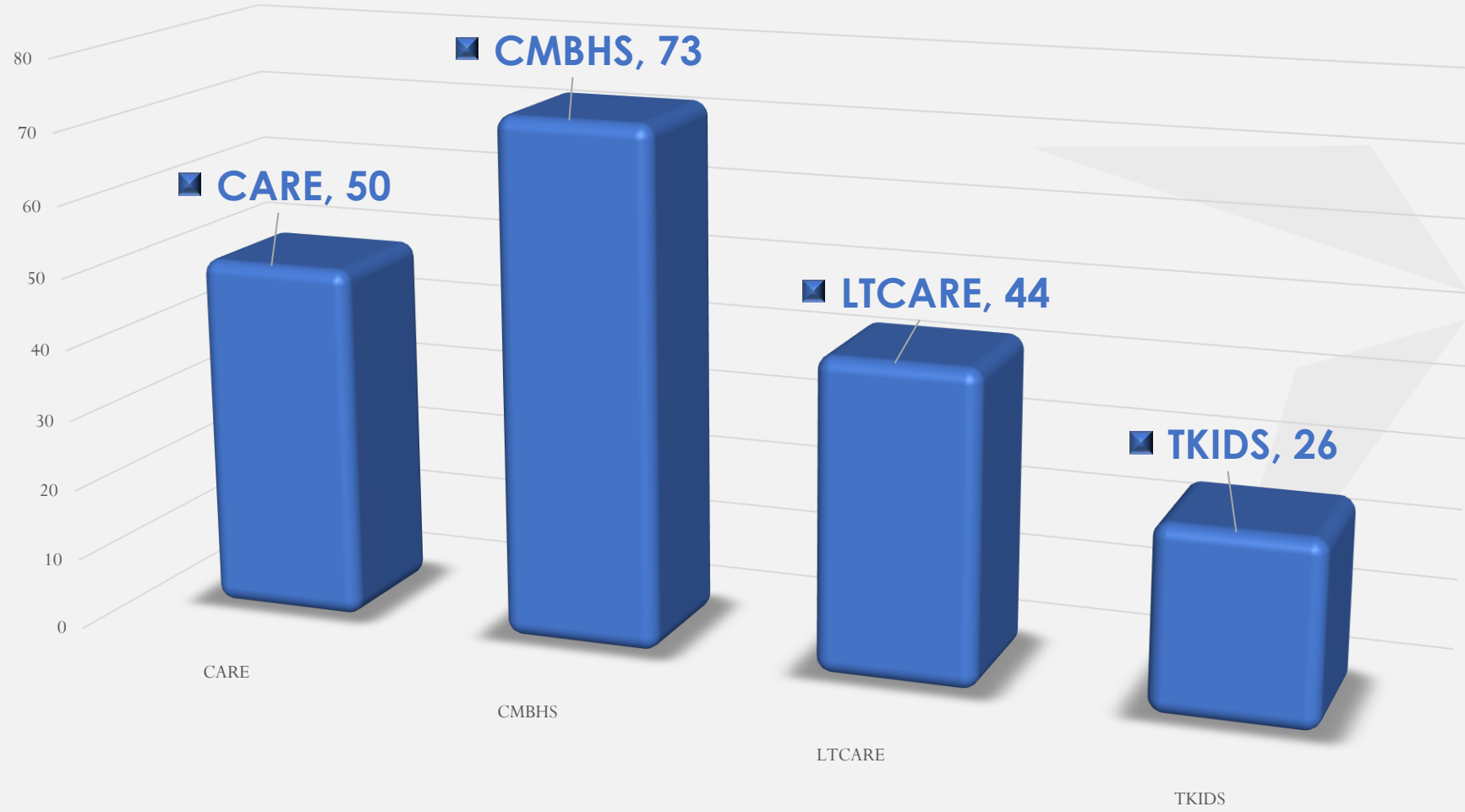
There was agreement from all participants that access to the information for the care continuum is important.

Actions:

1. Developed content needed for behavioral health transitions of care.
2. Non-Medical Drivers of Health – discussion on screening and then what happens once the screening is completed. What are the different platforms? How do we close the loop?
3. Group is focusing on decreasing duplicate data entry. Initial focus will be on demographics included in the CMBHS Client Profile. The data included in the client profile can be electronically sent via HL7. Three organizations were committed to eliminating manual data entry. THSA contacting DSHS to determine next step to electronically sending this data. Students providing preliminary HL7 mapping.

# NUMBER OF FORMS IN EACH SYSTEM

Starting with Demographics




There are 37 LMHA and LMBHorganizations serving Texans impacted.

# IMPACT



For 1,000 patients with 5 forms per patient, in 3 systems the total time spent would equal **908 working days or 0.44 FTE** at a cost of **$52,663.03.**

# DATA USABILITY WORKGROUP

Membership:

Catalyst: Sam Echols, Hannah Chirwa, Tina Clark & Emily Szoke

HCA: John Milano & Nick Meyers

BSW: Susan Bradshaw

THR: Jennifer Glass

TMA: Shannon Vogel

PCC: Neal Sampson & Jennifer Quereau

THSA: Phil Beckett & Katherine Lusk

Actions: Evaluation of Discharge C-CDA and moving from fax request to C-CDA receipt. Catalyst is working with Baylor Scott & White & Athena to understand more.

**Charter:**

**The Current Challenge**
We are currently experiencing a high volume of patient records flowing in from multiple Health Information Exchange (HIE) vendors, resulting in duplicate documentation—particularly for hospital visits. At present, we are receiving approximately **48,600 documents per day**, which contributes to clinical inefficiencies and unnecessary provider burden.

**Our Objective**
Our goal is to streamline this data exchange process so that only **clinically relevant and actionable information** reaches providers. This will ensure they have exactly what they need to make informed care decisions. This will support better outcomes and improved efficiency.

**Impact on Patient Care**
By refining what data is delivered and how, providers will be able to focus on **timely, relevant information**, reducing overload and improving patient safety. This will enhance the overall patient experience and support more coordinated, high-quality care.

**Goal of This Conversation**
Today, our aim is to explore opportunities for collaboration and improvement—particularly in refining how patient data is filtered and delivered across HIE connections. We are eager to identify practical next steps and actionable solutions that can be implemented through this partnership.

# PHARMACISTS' ROLE IN MEDICATION RECONCILIATION TO ENHANCE INTEROPERABILITY

1. Texas Children's
2. Children's Dallas
3. United Regional
4. Cook Children's
5. Midland Health
6. THR
7. DHR
8. Driscoll
9. NCPCP
10. UT San Antonio
11. HEB
12. Lake Hills Pharmacy
13. Texas Pharmacy Association

**Actions Taken:**

- No more Free Text. Agreed that we could focus on this space and make a difference.
- Survey completed on why free text was reviewed.
- Epic developers attended 7.21.2026 to discuss Epic and Sigs.
- Revised Sig recommendation for antithrombotic agents based on feedback from NCPDP and workgroup consensus. There were hospital, commercial and free-standing pharmacists involved in the discussion. Participants taking back to their respective organizations to discuss barriers to implementation.
- Katherine, Phil and Jobby presented at the Texas Pharmacy Association Conference on interoperability value for Pharmacies.
- **Group decision made – Theoretically agree that standardization is optimal, however we are not going to pursue moving forward with this recommendation due to the barriers discussed above. We are going to focus on increased awareness regarding Sig Hygiene.**

# LABORATORY TEST DATA NORMALIZATION TO SUPPORT INTEROPERABILITY –

## The Power of the Possible

Co-Chairs: Dr. Nainish Shah & Dr. Eric Salazar

- **One laboratory test at a time to prove that this can be done. Started with hemoglobin A1C. Create a scalable, repeatably path for adoption. Next will be hemoglobin & hematocrit.**
- **Epic and PointClickCare discussing electronic exchange of laboratory tests. Pilot organizations to work with Epic and PointClickCare underway.**
- **Discussion on commenting on RFIs**

**Trending laboratory test results across the care continuum is desirable, requiring a unique value or LOINC code to be assigned to the laboratory result. The LOINC code assignment is based on methodology and test.**

Problem: Not all organizations have LOINC codes associated with all laboratory tests. Organizations may associate LOINC codes to a portion of laboratory tests.

LOINC code association with a laboratory test is completed in a multitude of ways:

1) Organizations may associate based on test manufacturer reference material

2) Pathologist may assign

3) Laboratory LIS team may assign

4) Outsourced laboratory organizations may assign LOINC codes absorbed by EHR

When local codes are used instead of LOINC or no LOINC - clinical communication is impacted with the longitudinal medical record. Availability and / or accuracy may be an impediment.

**The end-point is that organizations can ingest laboratory results from external organizations.**

**A single line for external laboratory results is better than now, but the end-goal is results on the same line for clinicians for trending.**

Identify laboratory test using community feedback, Measureands, and Sequoia Project Data Usability Laboratory Priorities

**Roll-out Plan**

1. Laboratory test and LOINC determined
2. Share Lab test and LOINC with workgroup for vetting
3. Share Lab test and LOINC with entire collaborative for vetting
4. Recommend that organizations update laboratory directory with LOINC code
5. **Communication tool for top 3-5 EHRs on how to ingest the external laboratory test result with "LOINC" code into clinician's workflow.**

**Update laboratory survey for additional detail**

**Next laboratory tests will be Hemoglobin and Hematocrit**

**Inviting organizations that use Oracle, Trubridge and Meditech to participate.**

# Hgb A-1C Laboratory Test Mapping - Everyone who has replied (Sept Meeting) stated they are using 4548-4 LOINC Code for Hemoglobin A1C.

**Check with your pathologist and / or laboratory leadership – We can start one at a time to normalize lab across Texas.**

A meeting of instrument manufacturers (presumably including Japanese) in Milan, Italy, December 12, 2007, agreed (among other items) that: -All manufacturers should implement worldwide the traceability to the IFCC reference system for Hgb -A1c. -All new instruments sold after January 1st, 2011 will report (as a result of an Hgb A1c test) both SI (mmol/mol - no decimals) and NGSP derived units (percentage - one decimal), in agreement with the Consensus Statement. Note they only committed to supporting protocol (1) and (2)

**4548-4** - NGSP - the long-standing protocol used in the US and most other countries since the DCCT study (http://www.ngsp.org/factors.asp)

**59261-8** – LOINC has defined 59261-8 (Hemoglobin A1c/Hemoglobin. Total in Blood) by IFCC protocol. IFCC - designated as a Reference Method or RM (http://www.ifcchba1c.net/)

NGSP: National Glycohemoglobin Standardization Program

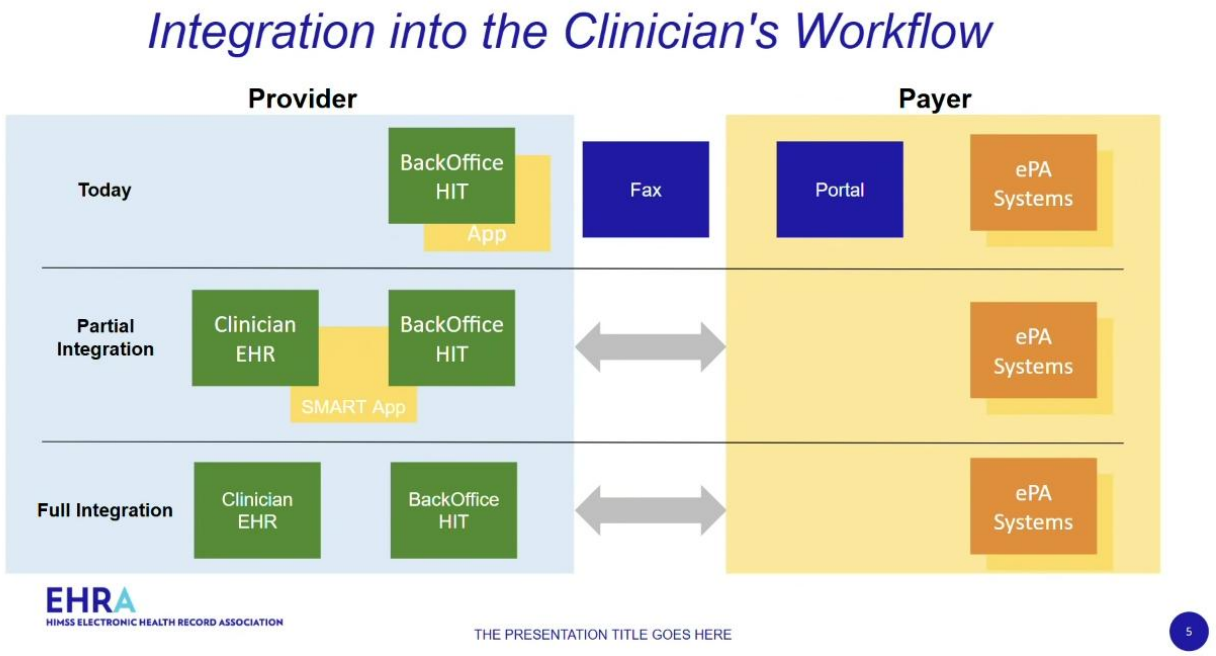
IFCC: International Federation of Clinical Chemistry

# Prior Authorization Workgroup - Launched

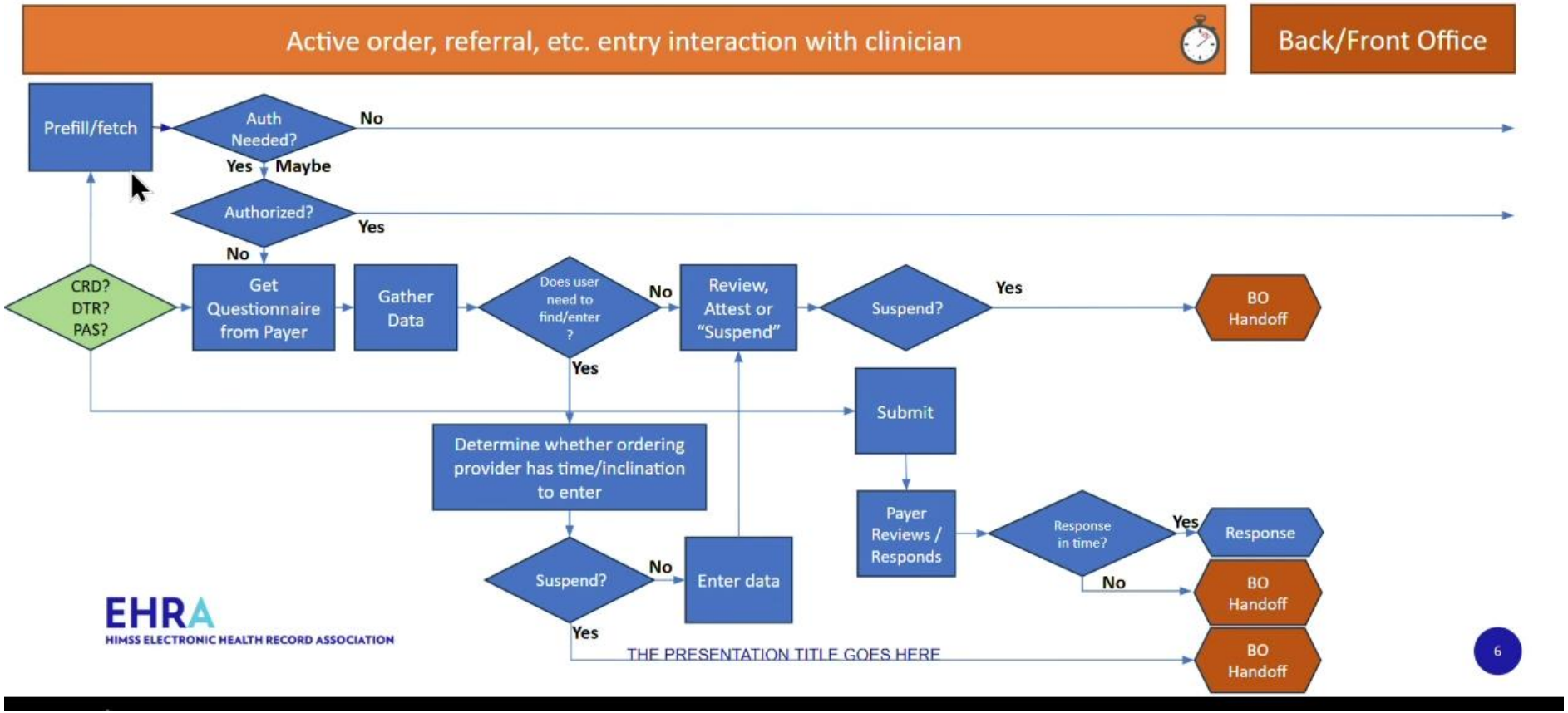
- Center for Medicare and Medicaid Services Interoperability and Prior Authorization Final Rule (CMS-0057-F) calls upon health information exchange to improve prior authorization processes through policies and technology while maintaining the patient as the focus by January 1, 2027. The requirements include implementing Health Level 7 (HL7) application programing interfaces (APIs) to streamline the prior authorization process impacting payers, patients, and providers.
- Participation will be limited to organizations providing services in Texas. All facets of prior authorization both in the public and private sector are open for discussion. This workgroup will serve to support the launch of CMS-0057-F across Texas by supporting sharing of lessons learned, best practices, standards adoption, testing outcomes, readiness status, and gap analysis.
- **Discussion – Standardize minimum content for authorization.**
- **AHIP (Danielle Lloyd) and EHRA (Hans Buitendijk) attended the 7.09.2026 Meeting to discuss national efforts to standardize minimum content for authorization. AHIP and EHRA will publish clinical documentation pre-fetch soon. Asked that this Workgroup start here and share across our community.**

# Complexities of Prior Auth Automation

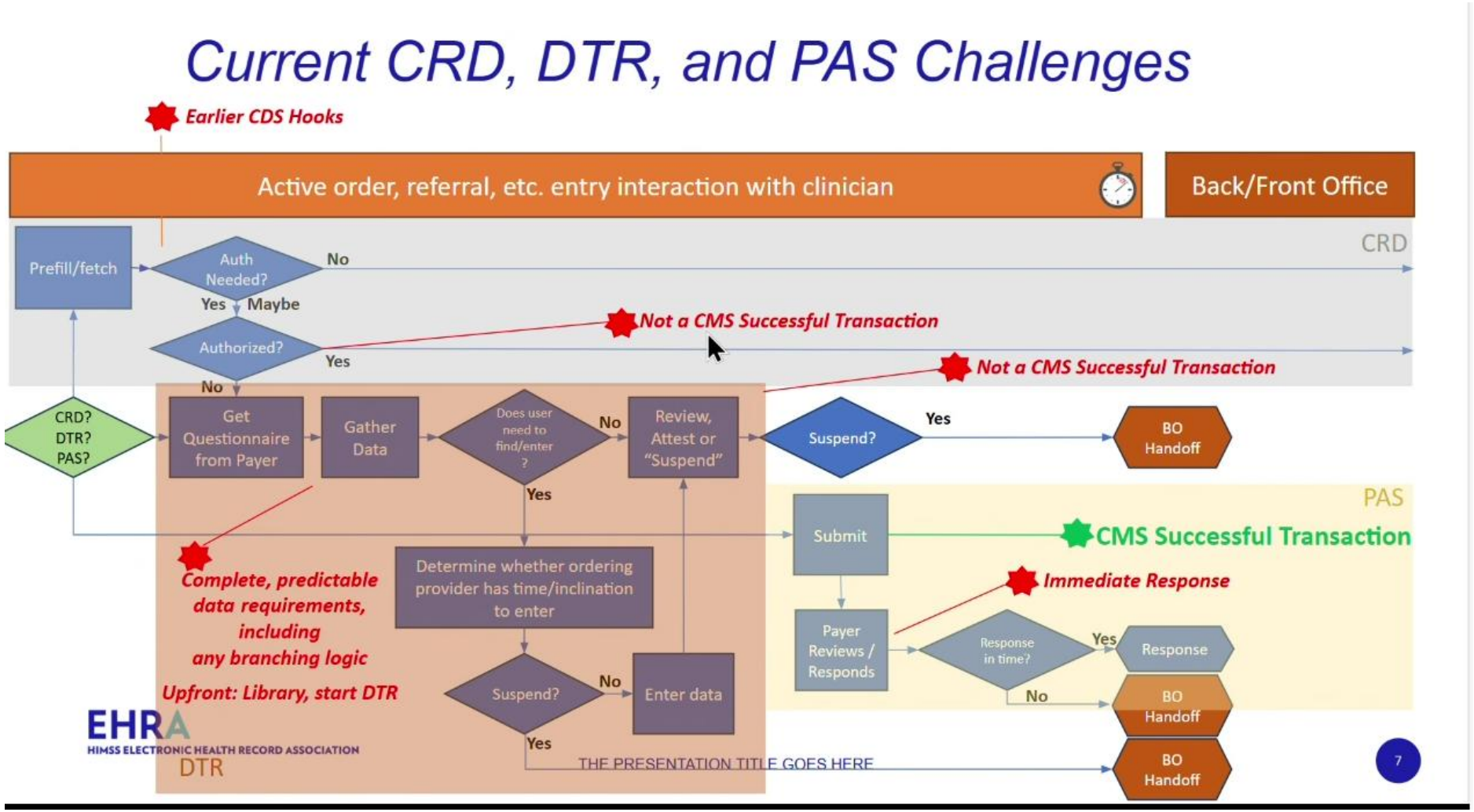
- Today prior-authorization mostly involves faxes, portals, and phones to manage the process. The goal is to integrate this into the BackOffice and ultimately, as much as practical, the clinician's clinical workflow.
- The process is complex, starting with submitting essential data (prefetch) to understand whether an authorization is needed.



# Optimum Flow for Authorization in Clinical Workflow



# Current CRD, DTR, and PAS Challenges




Acronyms: CRD - Coverage Requirements Discovery, DTR - Documentation Template Rules, PAS - Prior Authorization Support

# Specific Data Elements being considered for pre-fetch

## Prefetch Data Points to Determine if Prior Authorization is Needed

- **Patient Information**
  - Full name
  - Date of birth
  - Address and contact information
  - [Reserve for potential clinical extension]
- **Subscriber or member Information (if different than patient)**
  - Subscriber full name
  - Subscriber number + extension code
  - Member identification number + extension code, if different
  - Group number, if applicable
  - Relationship of patient to subscriber
- **Ordering Provider Information**
  - Full name
  - Practice or facility name
  - Provider address
  - National Provider Identifier (NPI) or equivalent identifier
  - Tax Identification Number (TIN), when required
- **Rendering Provider Information**
  - Full name
  - Practice or facility name
  - Provider address
  - National Provider Identifier (NPI) or equivalent identifier
  - Tax Identification Number (TIN), when required
- **Service Information**
  - Service location name and address, if different than rendering provider address
  - Request Date
  - Date(s) of Service
  - Authorization Type
    - Place of Service Code
    - Type of Bill (NUBC)
  - Service Type Code
  - Level of Service Code (Urgency)
  - Diagnosis Code(s) (ICD-10 CM)
  - Procedure Code(s) (CPT or HCPCS; ICD-10-PCS), including modifiers where applicable
  - Units of Service

- Required
- Preferred
- If unavailable, impacts accuracy

**Confidential Draft – Do Not Circulate**

# DEATH REGISTRY – STATE

**Problem: Inappropriate and unnecessary contact with a decedent's family regarding follow-up appointments or prescription renewals.**

Work-Group Members:

- Dr. Brett Moran, Parkland – Leading
- Lois Marchand, DHR Hospital System
- Roberto Haddad, DHR Hospital System
- Bianca Radney, THR

**Actions Taken:**

- Senate Bill 1467 approved at Senate and House. Governor 06.22. 25 with 9.01.25 effective date.
- Encouraging organizations to reach out to their EHR vendors on roadmap to take advantage of automation. Katherine has communicated to EHR vendors the opportunity.
- State is working with the Texas Hospital Association.
- **Texas Hospital Association communicated: "Texas Hospital Association is working through hospital government relations staff on contacts for legal, IT and primary contact for a MOU. DSHS will contact the hospital for next steps.**

# Automated, Electronic Access to Current Death Registry Data

**Situation:** Healthcare individual practitioners / entities' lack of knowledge of patient death leads to several problems:

Repeated trauma to the families of decedents with inappropriate and unnecessary contact regarding post-discharge care, follow-up appointments, or prescription renewals.

Potential for inappropriate medication refills and gaps in care.

Privacy concerns with open patient portals or identity fraud.

Failed Healthcare facility quality improvement activities related to patient outcomes and efforts to improve care for future residents of the State.

**Background:** Healthcare entities (individual practitioners and healthcare organizations) have no access to State data on deaths of patients for whom they have a care relationship. The absence of this data lends to blind spots in healthcare, such as measuring effectiveness of treatment, outcomes of care, and opportunities for improvement in both.

# TELEHEALTH AND PCPS

Problem: Concern PCPs were not receiving copies of notes when their patients were seen by national telehealth organizations.

Informal Survey completed:

- Clinicians have access to telehealth notes when the telehealth services are conducted by their providers. Many organizations have telehealth services available through their health system and their patients use.
- Clinicians are often not aware when patients seek telehealth services outside of their health system. They become aware when a patient tells them.
- PCPs do not appear to be routinely receiving visit notes from national Telehealth organizations (Teladoc, Doctor on Demand or Accolade). Responses from three PCP networks – Austin, Denton and Houston.

**Actions:**

1. Exploration continues with national telehealth professional organizations for discussion.
2. Engaged Texas Medical Association HIT Committee and Texas Hospital Association in the discussion.
3. Met with TexLa Telehealth Resource Center housed at Texas Tech on 1.23.2024. Texas Child Health Access Through Telemedicine (TCHATT) – TCMHCC (utsystem.edu)
4. TexLA Telehealth Resource Center and Texas Child Health Access Through Telemedicine (TCHATT) are encouraging sharing of information.
5. Little progress has been made however hope is not lost.

# Community Happenings

- 09.18.2026 Texas Health Informatics Alliance, Frisco, Texas
- 10.14.2026 Brittany Henson – The American Heart Association
- 11.11.2026 Dr. Joseph Schneider – AHIMA 2026 Naming Framework
- e-Health Advisory Council – Public Quarterly meeting to advise the Texas Health and Human Services Commission Texas Health and Human Services Commission (govdelivery.com) – To sign up to receive notifications from HHSC for example for CHIRP but there are others.

# CONTACT INFORMATION

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