

THSA

TEXAS HEALTH SERVICES AUTHORITY

TEXAS INTEROPERABILITY COLLABORATIVE

November 11, 2026

TOPICS OF DISCUSSION

1. Welcome
2. Antitrust Policy
3. October 14, 2026, Summary
4. Dr. Joseph Schneider, UTSW & Wendy Mizell and Crystal Chambers / THR – AHIMA 2026 Naming Framework and implementing Standardized Newborn Naming Convention
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



Veterans Day – Thank you to the People Who have Served in the United States Armed Forces



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.

THSA is undergoing Sunset Review

Sunset Review Recommendations published on November 6, 2026. Page 171, ISSUE 9: The State has a Continuing Need for THSA but with Certain Change

Public Input: Public Input Form | Texas Sunset Advisory Commission

Public hearings on December 2 and 3, 2026. Anyone can listen and provide public comments. Link below for participation.

Sunset Commission Meetings | Texas Sunset Advisory Commission

Sequoia Project Data Usability Implementation Guide – MAY BE Moved will know more

Sequoia Project will be putting out a new Data Usability Implementation Guide 2.1 on 11.05.2026. There will be a workshop on 11.17.2026.

Didi Davis offered the THSA Collaborative, guest participation in the workshop.

https://attendee.gotowebinar.com/register/3766816243398317660

AHIMA26 is the free code to attend.

Sequoia Project Consumer Engagement Strategy Workgroup "Simplifying Data Access for Better Patient Experience"



Simplifying Data Access for Better Patient Experience Submission - The Sequoia Project

TEFCA Update

The Department of Veterans Affairs and Department of War Join the TEFCA® Network

Last week, ONC and HHS announced that the U.S. Department of Veterans Affairs and the Department of War have joined the Trusted Exchange Framework and Common Agreement™ (TEFCA®). This will expand secure, timely health information exchange for America's veterans and warfighters, especially those who receive care in multiple locations. Launched in 2023, TEFCA continues to improve care coordination and ensure health information moves securely when and where it is needed.

HHS Welcomes the Department of Veterans Affairs and Department of War to the TEFCA® Network, Expanding Secure, Timely Health Information Exchange for America's Veterans and Warfighters - ONC - Office of the National Coordinator for Health Information Technology

HTI – 5 FINALIZED

HTI-5 Final Rule - ONC - Office of the National Coordinator for Health Information Technology

Information Session held on October 29, 2026.

HTI-5_Final_Rule_info-session_10_29-2026_508.pdf


SPOTLIGHT

ICYMI: HTI-5 is Here

ONC and HHS recently released the Health Data, Technology, and Interoperability: ONC Deregulatory Actions to Unleash Prosperity (HTI-5) Final Rule. It advances administration initiatives by significantly reducing administrative burden for health IT developers participating in the ONC Health IT Certification Program and is projected to save more than $1.5 billion in regulatory costs. Ultimately, HTI-5 frees up resources for health IT developers, offering flexibility and support in pursuing innovations that enhance user experiences for patients and clinicians.

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:

- November 5, 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.

THSA did not receive the Grant but a great organization – Regenstrief Institute Did!

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.**
3. ARC & HCA – Epic / Meditech - Continuing to work together.
4. ARC & Ascension –Epic / Oracle & Athena – Continuing to work together.
5. Lack of standardization on C-CDA Doc Types Shared is impacting interoperability.
6. **Standardized Consult Doc Content is complete.**
7. **Closed Loop Referrals remains a focus.**
8. **Discussed Prior Authorization efforts.**
9. **TEFCA Adoption: BSW, Catalyst, Children's Dallas, United Regional, & THR.**

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 - Done**
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. BSW clinicians provided additional elements. Vetted with Collaborative Aug & Sept 2026

Please 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

Consult Note – LOINC 11488-4

Clinical Content	Template OID	LOINC Code
Date / Time	Header Element	Header Element
Attending Name	Header Element	Header Element
Patient Identification	Header Element	Header Element
Reason for Referral	1.3.6.1.4.1.19376.1.5.3.1.3.1	42349-1
History of Present Illness	1.3.6.1.4.1.19376.1.5.3.1.3.4	10164-2
Chief Complaint and Reason for Visit	2.16.840.1.113883.10.20.22.2.13	46239-0
Signs & Symptoms (Review of Systems)	1.3.6.1.4.1.19376.1.5.3.1.3.18	10187-3
Past Medical History	2.16.840.1.113883.10.20.22.2.20	11348-0
Family History	2.16.840.1.113883.10.20.22.2.15	10157-6
Social History	2.16.840.1.113883.10.20.22.2.17	29762-2
Current Medications	2.16.840.1.113883.10.20.22.2.1.1	10160-0
Allergies and Intolerances	2.16.840.1.113883.10.20.22.2.6.1	48765-2
Physical Exam	2.16.840.1.113883.10.20.2.10	29545-1
Results (Test Results)	2.16.840.1.113883.10.20.22.2.3.1	30954-2
Assessment (Diagnosis)	2.16.840.1.113883.10.20.22.2.8	51848-0
Plan of Treatment	2.16.840.1.113883.10.20.22.2.10	18776-5
Problem List	2.16.840.1.113883.10.20.22.2.5.1	11450-4

Discharge Summary Clinical / Technical Mapping LOINC 18842-5

Contents	TemplateID OID (Object Identifier)	LOINC Code	Subsection
Discharge Summary	2.16.840.1.113883.10.20.22.1.8	18842-5	
Discharge Summary Narrative (Hospital Course)	2.16.840.1.113883.10.20.22.2.64	8648-8	
Medications, last dose and schedule	2.16.840.1.113883.10.20.22.2.1.1	10160-0	
Allergies	2.16.840.1.113883.10.20.22.2.6.1	48765-2	
Admission Diagnosis	2.16.840.1.113883.10.20.22.2.43	46241-6	
Discharge Diagnosis	2.16.840.1.113883.10.20.22.2.24	11535-2	
Procedures: including Interventional Radiology, Cardiac Cath, operative procedures	2.16.840.1.113883.10.20.22.2.7.1	47519-4	
Diagnostic Imaging – Advanced imaging for example: MRI, CT, PET, Nuclear Imaging, Ultrasound, Echo, & Venous Doppler	2.16.840.1.113883.10.20.22.2.3.1	30954-2	18748-4
Laboratory – Recommend 1st and last laboratory result for every test. On those rare tests – they are only done once so would be included (ANA Rheumatoid)	2.16.840.1.113883.10.20.22.2.3.1	30954-2	11502-2
Consultations	2.16.840.1.113883.10.20.22.2.42	18841-7	
Assessment & Plan	2.16.840.1.113883.10.20.22.2.9	51847-2	
Active Problem List	2.16.840.1.113883.10.20.22.2.5.1	11450-4	

Transfer Summary Clinical / Technical Mapping LOINC - 18761-7

Contents	TemplateID OID (Object Identifier)	LOINC Code	Subsection
Transfer Reason – Course of care	2.16.840.1.113883.10.20.22.2.64	8648-8	
Medications, last dose and schedule	2.16.840.1.113883.10.20.22.2.1.1	10160-0	
Allergies	2.16.840.1.113883.10.20.22.2.6.1	48765-2	
Admission Diagnosis	2.16.840.1.113883.10.20.22.2.43	46241-6	
Discharge Diagnosis	2.16.840.1.113883.10.20.22.2.24	11535-2	
Procedures: including Interventional Radiology, Cardiac Cath, operative procedures	2.16.840.1.113883.10.20.22.2.7.1	47519-4	
Diagnostic Imaging – Advanced imaging for example: MRI, CT, PET, Nuclear Imaging, Ultrasound, Echo, & Venous Doppler	2.16.840.1.113883.10.20.22.2.3.1	30954-2	18748-4
Laboratory – Recommend 1st and last laboratory result for every test. On those rare tests – they are only done once so would be included (ANA Rheumatoid)	2.16.840.1.113883.10.20.22.2.3.1	30954-2	11502-2
Consultations	2.16.840.1.113883.10.20.22.2.42	18841-7	
Assessment – Do we collapse into Transfer Reason?	2.16.840.1.113883.10.20.22.2.8	51848-0	
Active Problem List	2.16.840.1.113883.10.20.22.2.5.1	11450-4	

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. **Closed Loop Referrals:**
   - **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.**
   - **Closing the Loop between Hospitals and Physicians with Community Based Organizations referrals is a focus.**

5. Organization and Department Direct Addresses – Referral hospital needs to send referrals and is having difficulty locating



Access to Direct Addresses Issue

Rural Hospital is attempting to locate Health System Direct Addresses for referral partners and is unable to find a Direct Address. This is impacting their ability to implement closed loop referrals, streamlining their referral process and moving away from faxing to meet CMS interoperability metrics.

What we have learned:

1. **Not all healthcare organizations have an Organizational Direct Address. Many are working on how to operational implement and who will be responsible.**
2. **Organizations that do have an Organizational Direct Address if they use SureScripts as their HISP – SureScripts does not share Direct Addresses unless there is an NPI in the Directory.**

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.

Discussion on standardizing has started.

- 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.**
2. **Discussion on the difficulty with quality reporting for national organizations due to different federal and state requiremednts.**

3. 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.

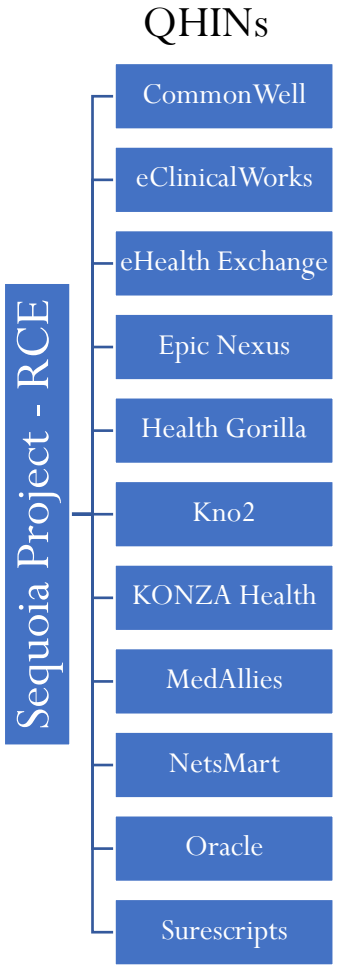
TRUSTED EXCHANGE FRAMEWORK & COMMON AGREEMENT (TEFCA)

TEFCA™ Trusted Exchange Framework and Common Agreement

Goal is to assure electronic health information is safely exchanged between all stakeholders in a cost-effective manner in support of the 21st Century Cures Act. TEFCA data sharing use cases includes treatment, payment, health care operations, public health, government benefits determination, and individual access.

ONC TEFCA RECOGNIZED COORDINATING ENTITY

Sequoia Project is the Recognized Coordinating Entity (RCE) for Office of National Coordinator (ONC) governing TEFCA & overseeing Qualified Health Information Networks (QHINs). Organizations can join a QHIN of their choice. QHINs must exchange at no cost however QHINs can charge participants to participate.



the sequoia project

November 2026

- 11 Designated QHINs & 2 Candidate QHINS
- **24,500 organizations with over 2B shared documents**
- Data Sharing use cases: Treatment, Government Benefits and Individual Access are live
- Treatment defined
- Individual access live 3rd Qtr. 2026 with QHINs working cooperatively to stabilize.

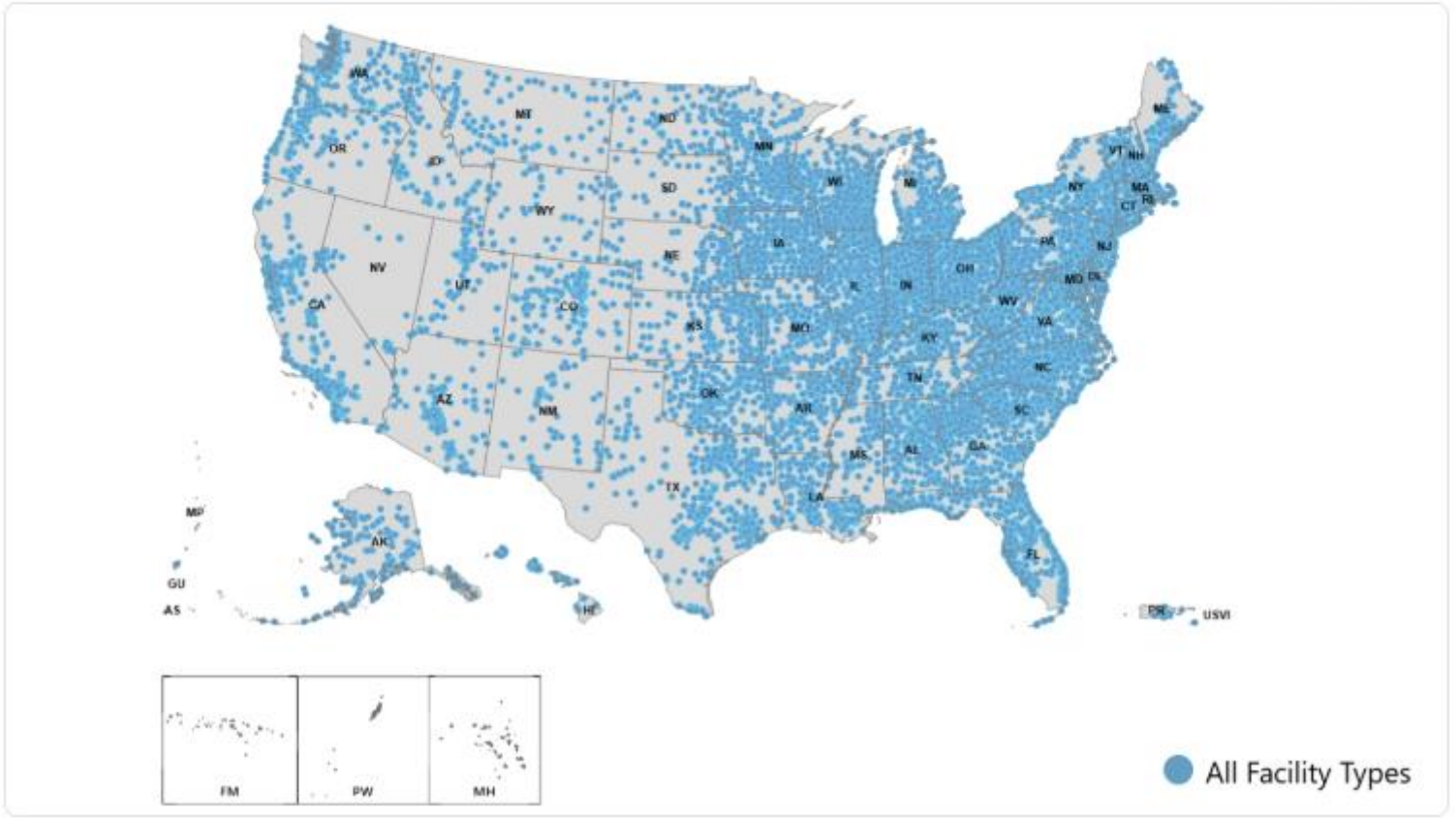
08.03.2026 – 65,360 facilities

Electronic Case Reporting

Facilities throughout the United States

As of October 6, 2026 more than 65,750 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 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 underway.
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. Guidance on errors from Immtrac2 Team.**

IMR-129 & IMR 128 Error

IMR-129 and IMR-128 are associated with CVX, NDC, CPT and MVX code misalignment in the provider EHR systems, which were not synchronized with CDC-published code sets mapping. CDC published code set mapping is the source of truth, and CDC code-set mappings must be up to date and accurately mapped in both the Texas IIS and provider EHR systems.

How to resolve: maintain up-to-date CDC-published code sets (CVX, NDC, MVX) and accurate mappings in the provider EHR systems.
Please refer to the CDC site link for the CDC-published code sets mapping: IIS | Code Sets | NDC | Vaccines | CDC.
Downloadable versions of the NDC Consolidated Crosswalk are available on the site.

This is a one-time fix in the provider EHR system. Again, the provider may please double-check with your EHR vendor whether the provider's EHR system is hosted internally to the provider organization or shared across multiple providers.

One example of a mismatched code set error shown up in October is given below.
1. 19515-0822-52 (CVX 140) ---------- Sale NDC 11, sending MVX code SKB instead of IDB
2. 19515-0822-41 (CVX 140) ---------- Use NDC 11, sending MVX code SKB instead of IDB

Prageet recommended that any providers who are receiving an IMR-128 and IMR-129 should send the actual message (after removing the PHI information), so the IIS team can test the message on their end and review the source of the error. Providers should refer to IIS | Code Sets | NDC | Vaccines | CDC for the updated codes before submitting the vaccines. In addition, if providers are submitting codes that have been end dated, then they should report it as historical and not as a new vaccine.

Consent Error

1. Does the provider EHR system support the PD1 segment?

2. Does the PD1-12 and PD1-13 populate with correct Texas consent codes (TXA, TXY, TXD) when sending registry consent along with the immunization record (VXU message)? TXY for minor consent, TXA for adult consent, and TXD for disaster consent.

3. If the 'registry consent' message (AFF) is sent separately, does the AFF message send prior to the administered immunization record message (VXU)?

4. Does the 'registry consent' capture in the EHR system prior to sending the immunization record (VXU) to ImmTrac2? In other words whether patient check-in process completed prior to vaccine administration event?

NEWBORN INFORMATICS

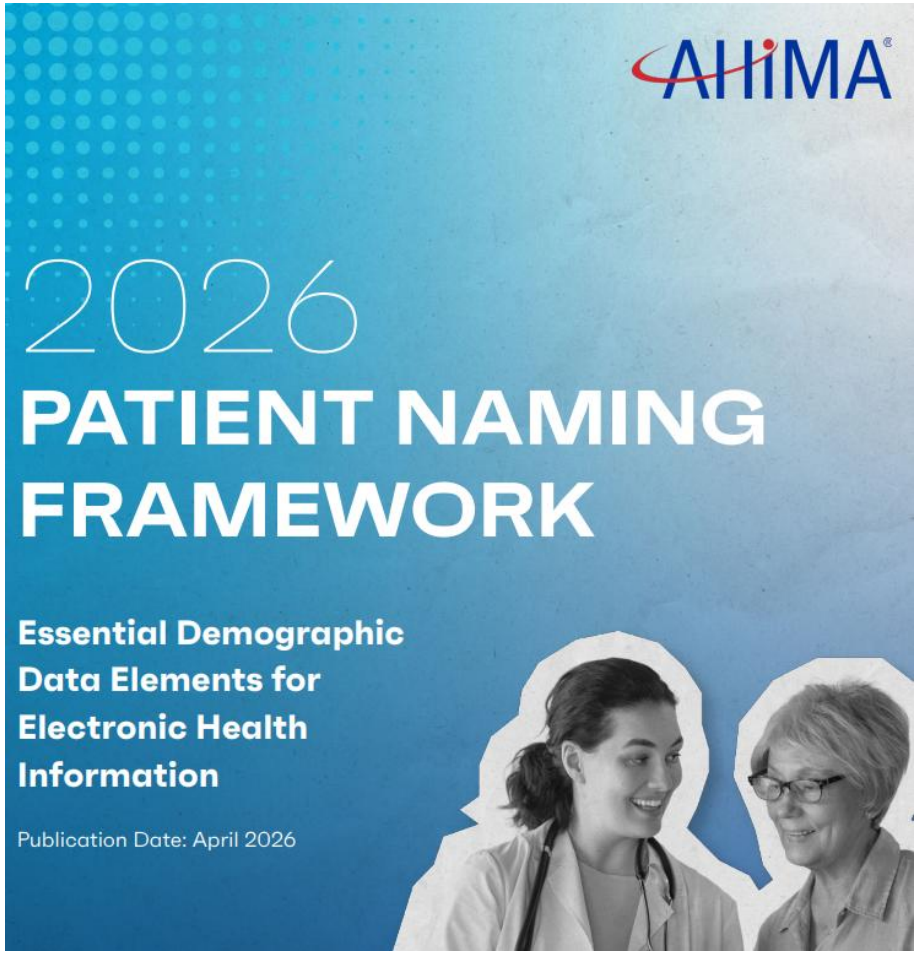
Work Group Members:

- 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 & EHRA 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 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, BSW and UTSW have working projects

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, Epic and EHRA.

Interoperability Workgroup of E-Health Advisory Committee recommended for adoption to HHSC.

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?

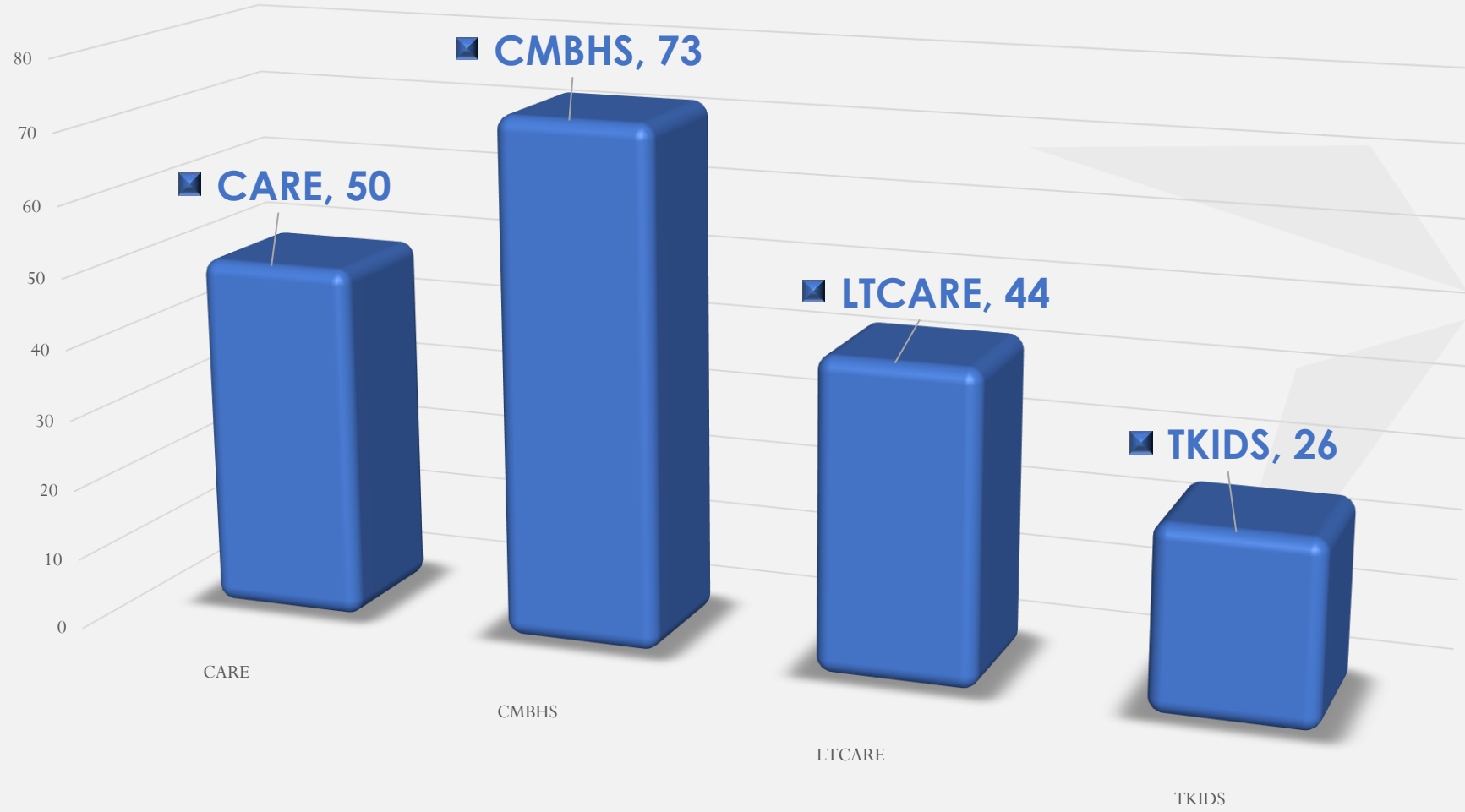
There was agreement from all participants that access to the information for the care continuum is important.

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.
4. Mapping completed by students.
5. 10.23.2026 Reached out to HHSC to discuss eliminating duplicate data entry.

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.

Opportunities Identified

1. Ability to query for discharge summary C-CDA
2. **Timely access to Direct Secure Messaging Addresses – How often are organizations updating and sharing their directories? Clinicians are receiving faxes when DSM is preferred communication.**
3. **Catalyst will share physicians and DSM address to help organizations quickly update.**

Catalyst requires a structured Discharge Summary C-CDA to respond to quality metrics data imbedded in the discharge summary. Without a structured document, the review must be done manually.

Work underway to identify the gaps and resolve. These efforts should help all Athena, Epic and Meditech clients.

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.**

MESSAGE SENT 10.22.2026

This message was not sent to Epic or Oracle because we heard from members of the Medication Reconciliation Workgroup that there was a Notes Field available.

The message was sent to the following EHR vendors: Athena, eCW, NextGen, Azalea, PointClickCare, Medhost, Trubridge, AXXESS, MatrixCare, Streamline, Meditech, Netsmart, and WellSky. I have contacts within these EHR organizations.

I will also share this information at the Collaborative Meeting on 11.11.2026 8 am and ask that the members contact their vendors and request as well.

Dear E.H.R. vendors -

Texas Health Services Authority Medication Reconciliation Workgroup consists of Pharmacists working to improve the medication reconciliation workflow. An identified issue is extraneous information included in the SIG i.e., instructions to another pharmacist, information that should be included in the Note Field. Pharmacists are entering information in the SIG because they are not certain if the downstream EHR will receive the Note information for the Pharmacist. When a refill request comes back, the notes in the SIGs are there requiring manual intervention. Our understanding is that in **NCPDP Script version 2017071 (and the forthcoming named standard version 2023011) the Notes field is optional however we are recommending that vendors include with new prescriptions or all transactions.**

http://www.ncpdp.org/standards-development-process.aspx [ncpdp.org]

In an abundance of caution, before we encourage increased use of the Medication Notes Fields – we are reaching out to the EHR vendor community and let you know the issue and encourage you to include a **Notes Field** with your SIGs.

We appreciate your support in helping to improve patient safety and allowing organizations to fully leverage technology at hand.

Messages Received –
Use Note Field for Instructions with SIG

Organizations are not consistently using the Note Field in the structured SIG to provide instructions to downstream pharmacists or clinicians. They are doing this because they are not sure that all the **receiving organizations** will receive the Note. The same information in the wrong field comes back to the organizations for refills. This requires additional steps to reconcile the medication.

Clarification Received: Surescripts has a certification requirement that all receivers must be able to display the Note, and that if sent the sender must display the Note before sent. There is not technical reason to enter instructions outside of the Note field with the SIG.

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.**
- **Developing a "How To Guide" for Hemoglobin A1C as a starter**
- **BSW joined workgroup**

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.

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

- 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.
- **GOAL: 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 published clinical documentation criteria and asked that this workgroup adopt.**
- **The workgroup selected 9 procedural tests from AHIP and is asking hospitals to implement.**

Consideration for Texas Pilot – Clinical Content

1. MRI Head (Brain) and Neck W/WO Contrast (Page 18)
2. CT Head (Page 10)
3. Echocardiogram (Page 15)
4. Diagnostic Cardiac Catheterization (Page 24)
5. Cochlear implants (Page 31)
6. CT Abdomen pelvis w contrast (Page 12)
7. MRI Lumbar Spine WO Contrast (Page 21)
8. CT Chest W/WO Contrast (Page 9)
9. Total Knee Arthroscopy (Page 36)

PRIOR AUTHORIZATION STANDARDS

AHIP Links

Health Plans' Efforts to Standardize Electronic Prior… - AHIP

Resources -

Prior-Authorization-Documentation-Standards_Clinical-Documentation-Codes.pdf

Prior-Authorization-Documentation-Standards_Provider-Facing-Prompts-Codes.pdf

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.
- **If you are a Trauma 1 facility and have not yet been contacted by DSHS to begin the implementation – Let Katherine know and she will connect you with THA members who may be able to help.**

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

- 11.05.2026 – THSA Sunset Report published
- 12.02 & 12.03.2026 THSA Sunset Review Public Hearing Sunset Commission Meetings | Texas Sunset Advisory Commission
- 12.09.2026 Karishma Patel, HSNT and Jennifer Glass / Evan Riley, THR – The Maternal Health Journey
- 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.
- 03.10.2027 Lucille Palenapa, DSHS & Paul Grunenfeld, DSHS – Texas and Electronic Case Reporting

CONTACT INFORMATION

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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**

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