

THSA

Texas Health Services Authority

TEXAS INTEROPERABILITY COLLABORATIVE

June 10, 2026

TOPICS OF DISCUSSION

1. Welcome
2. Antitrust Policy
3. May 13, 2026, Summary
4. SME Speaker
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



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
August 26, 2026

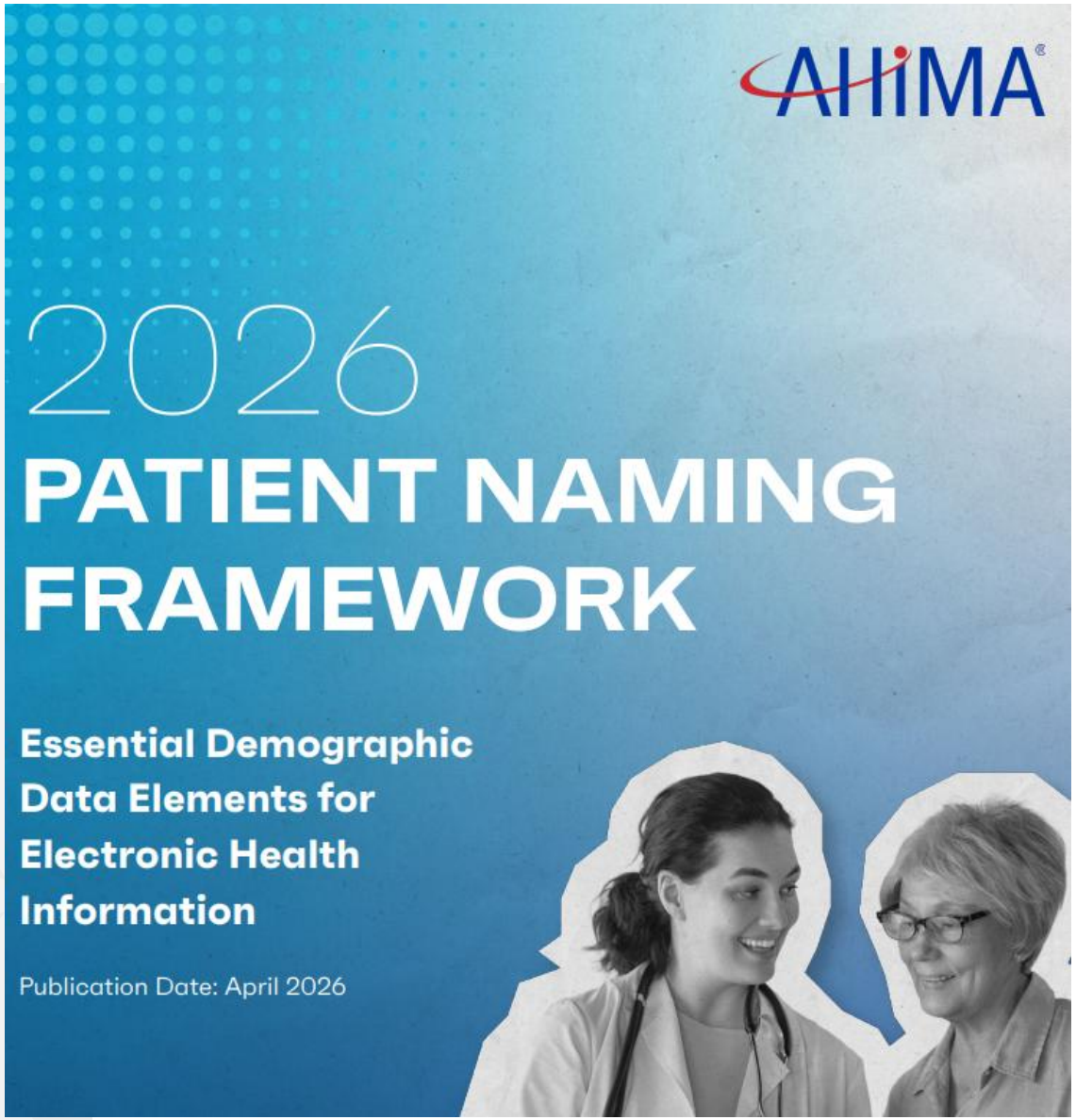
- Phil Beckett, CEO for Texas Health Services Authority – SecureTexas, Partnerships for Cyber Workforce Development
- Supervisory Special Agent Nathan Hopp, FBI Dallas' Cyber Squad
- Dr. Susan Fenton, UT Houston – Health IT Cyberthreats and Resiliency
- Scott Trevino & Ryan Gonzalez, Trimedx – Real-world Challenges Securing Medical Devices
- Steve Ordahl, Microsoft Health and Live Sciences – Microsoft's Cybersecurity Defenses
- Don Taylor, UT Dallas – AI Cybersecurity Governance
- PULSE –Supporting Clinicians Access to Medications and Patient History

THSA's Newborn Informatics Workgroup contributed heavily to this publication. Dr. Joe Schneider and Susan Bradshaw actively participated in the workgroup.

Organizations should work with your health information management team members to review and adopt.

Patient outcomes depend on a complete medical record and to obtain – you need to match patient records across the continuum. Technology can make a difference, but accurate data is key.

2026_patientframingnetwork.pdf



CMS Interoperability Standards & Prior Authorization for Drugs Proposed Rule – Request for Comments due 6.15.2026

Centers for Medicare & Medicaid Services (CMS) continues its efforts to improve prior authorization so patients and providers can benefit from a more expeditious, transparent, and reliable process. Today, CMS released the 2026 CMS Interoperability Standards and Prior Authorization for Drugs proposed rule (CMS-0062-P).

2026 CMS Interoperability Standards and Prior Authorization for Drugs Proposed Rule (CMS-0062-P) | CMS

Federal Register :: Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability Standards and Prior Authorization for Drugs for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges

Regulations.gov

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.**
3. ARC & HCA –Continuing to review and work together.
4. ARC & Ascension –Epic / Oracle & Athena. Group has included the Ascension clinics that use Athena in the discussion. 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. Decision made that we would start with encouraging adoption of HL7 C-CDA Documents and build content.**
7. **Review of referral C-CDA documents underway to support closed loop referrals.**

Respond to Query

Document Type	LOINC	Epic	Athena	eCW	Streamline	NetsMart	NextGen	Meditech
Consultation Note	11488-4	X			X	X		X
Consult Note	34109-9				Customers configure			
Physician Consulting Progress Note	28569-2	X						
Discharge Summary	18842-5	X				X		X
History and Physical	34117-2	X				X		X
Operative Note	11504-8	X						
Procedure Note	28570-0	X						X
Progress Note	11506-3	X				X		X
Imaging Narrative	18748-4	X						X
Laboratory Narrative Note	11502-2							X
Pathology Procedure Note	34122-2							
Pathology Study	11526-1							X
Summary of Episode	34133-9					X	X	X
Transfer Summary	18761-7							
Continuity of Care Document	72232-2	**34133-9**	X					X
OB Flowsheet	89238-0			X				
Referral Note	57133-1	X						X
Care Plan	52521-2							X
Overall Plan of Care	18776-5	X						
Electronic Case Report	55751-2							X
National Health Care Surveys	75619-7							X
Emergency Department Summary	11303-5	X						
Patient Health Summary	34133-9	X						
Constellation Update	71482-4	X						
Patient Reported Information	34133-9	X						
190-2015 CCDS CCd	83910-0	X						
								Create & Supply

Query for Documents

Document Type	LOINC	Epic	Athena	eCW	Streamline	NetsMart	NextGen	Meditech
Consultation Note	11488-4		x		x			x
Consult Note	34109-9	Setting can be changed by organizations.			Not core but customers configure	Query for any documents available. Must be returned in CDA .xml format		Query for all documents and don't filter by type. Only incorporate the Documents indicated above.
Discharge Summary (Discharge Summarization Note)	18842-5		x		3.2026 No Texas Clients using - available & used by others			x
History and Physical	34117-2							x
Procedure Note	28570-0							x
Progress Note	11506-3						x	x
Imaging Narrative	18748-4							x
Laboratory Narrative Note	11502-2							
Pathology Procedure Note	34122-2							
Pathology Study	11526-1							
Summary of Episode	34133-9						x	x
Transfer Summary	18761-7							
Continuity of Care Document	72232-2	Non-Epic Organizations	x					
Ambulatory Summary			x					
Summarization of Episode Note			x					
Summary of Episode Note			x					
Hospital Encounter			x					
Physician Hospital Discharge Summary			x					
Hospital Discharge Summary	34105-7		x					
Emergency Department Discharge Summary	81218-0		x					
Enhanced Discharge Summary (outpatient)	81242-0		x					
Discharge Summary			x					
OB Flowsheet	89238-0	Org must set up						
Dialysis Summary Note	87236-6						x	
Referral Note	57133-1							x

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**

TRANSFER SUMMARY C-CDA

Care transfers occur from a multitude of different scenarios and the information in inconsistent creating delays in care delivery. Standardization of the minimum clinical content provided will improve care delivery.

This is a minimum clinical content recommendation.

Transfer Summary LOINC 18761-7.

Clinical Content

1. Transfer Reason – Course of care
2. Medications, last dose and schedule
3. Allergies
4. Admission Diagnosis
5. Discharge Diagnosis
6. Procedures: including Interventional Radiology, Cardiac Cath, operative procedures
7. Diagnostic Imaging – Advanced imaging for example: MRI, CT, PET, Nuclear Imaging, Ultrasound, Echo, & Venous Doppler
8. Laboratory – Recommend 1st and last laboratory result for every test
9. Consultations
10. Assessment
11. Active Problem List

Transfer Summary Document C-CDA – 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.	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	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	

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.

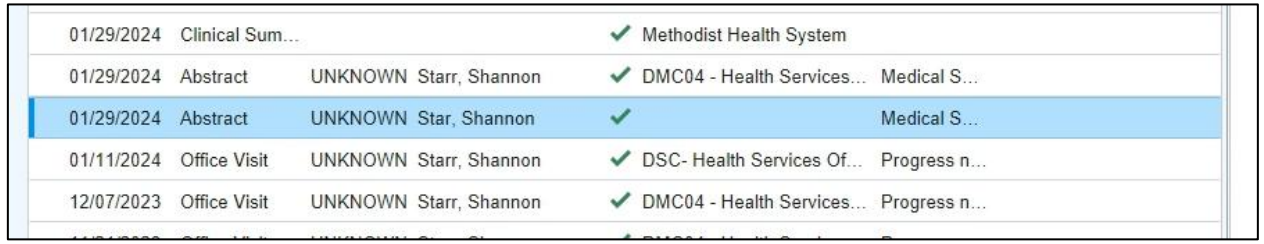
Epic does not include 89238-0 as part of their standard document request, however the organizations can add the LOINC Code 89238-0.

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.

OB FLOWSHEET

Patient presents in labor to hospital. Labor and Delivery calls and requests faxed documents.
Document Name nor Source can be seen.



01/29/2024	Clinical Sum...			✓ Methodist Health System	
01/29/2024	Abstract	UNKNOWN	Starr, Shannon	✓ DMC04 - Health Services...	Medical S...
01/29/2024	Abstract	UNKNOWN	Star, Shannon	✓	Medical S...
01/11/2024	Office Visit	UNKNOWN	Starr, Shannon	✓ DSC- Health Services Of...	Progress n...
12/07/2023	Office Visit	UNKNOWN	Starr, Shannon	✓ DMC04 - Health Services...	Progress n...

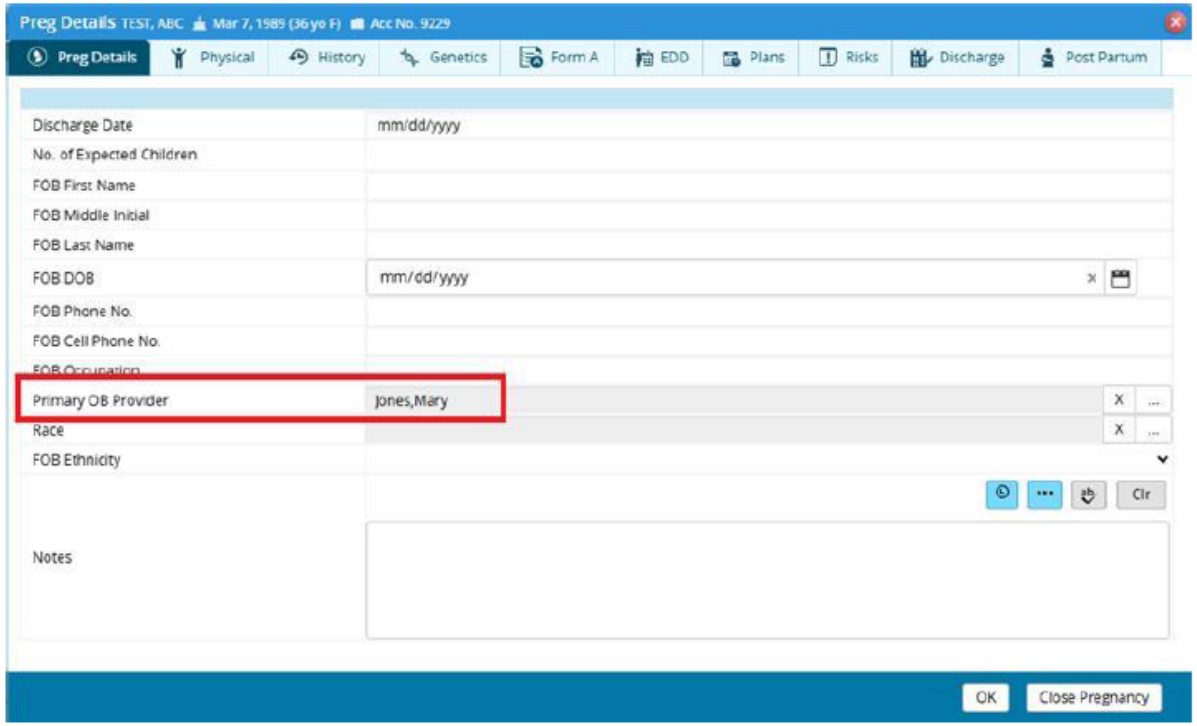
Training provided to staff and Data Provenance including **Document Name and Source are seen at receiving organization.**

eCW LOINC Code 89238-0 = OB Flowsheet

Specialty	Providers	Source	Title	Description
Certified Nur...	Guillory, Synceera	✓ DSC- Health Services Of North Texas Inc	OB-Flowsheet	
Certified Nur...	Guillory, Synceera	✓ DSC- Health Services Of North Texas Inc	Progress note	
Certified Nur...	Fisher, Abbie	✓ DSC- Health Services Of North Texas Inc	Progress note	
Certified Nur...	Guillory, Synceera	✓ DSC- Health Services Of North Texas Inc	Progress note	

In eCW OB Flowsheet, here are the recommended fields to be populated for data to show up meaningfully on the receiving end.

1. Primary OB Provider: This is present under the 'Preg List' section of the OB Flowsheet.



2. Primary Service Location for the Primary OB Provider: This is present under Admin -> Providers ('Admin' from left navigation band).



If your organization delivers babies – Please share with your eCW referral partners.

HSNT and THR have shown that it works!

You can have a complete OB Flowsheet when the patient is admitted.

Thank you eCW for sharing!

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. **Evaluated discontinuing sending of ADT encounter notifications when patient moves from ED status to Observation status. Notification not required by CMS. Feedback is that notifications are useful.**
5. **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.**



CMS Hospital Required Encounter Notification
Recommending all Orgs follow HL7 Definitions.

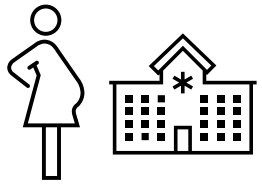
Goal: Facilitation of Care Coordination

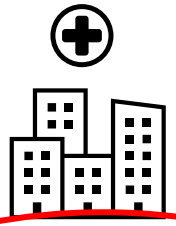
Required: Registered in ED, admitted as inpatient, discharged from ED or IP, transferred from ED or IP and status changes from IP to OP and OP to IP.

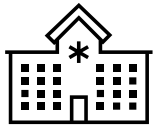
HL7 Definitions:

- A01 – Admit / visit notification: An A01 event is to be used for "Admitted" patients only. An A01 event is sent as a result of a patient undergoing the admission process which assigns the patient to a bed. It signals the beginning of a patient's stay in a healthcare facility. It includes short stay.
- A04 – Register a patient: An A04 event signals that a patient has arrived or checked in as a one-time, or recurring outpatient and is not assigned to a bed. One example might be its use to signal the beginning of a visit to the Emergency Room. Note that some systems refer to these events as outpatient registrations or emergency admissions.
- A03 – Discharge of a patient
- A06 – Status change from Outpatient to (Observation or ED) to Inpatient
- A07 – Status change from Inpatient to Outpatient (ED or Observation)

ANTEPARTUM (PRENATAL) INFORMATION JOURNEY











Where we started

Prenatal care begins. Documentation is completed in certified EHR that participates with a national network.

Mom preregisters at delivery site – EHR queries & retrieves available documents.

Mom arrives at delivery site when laboring. Delivery site has many "abstract" documents in EHR but cannot locate needed information.

Staff call the answering service who calls the clinic to request faxed prenatal documents.

Clinic staff stop other work and fax prenatal record.

Fax received and search begins for the pertinent information from the month's long care received at the clinic.

Child delivered and mother is discharged with support needed for formula, housing and transportation.

Better Care Experience	Higher Quality Care	Reduced Costs	Less Burden	Improved Maternal Health Outcomes

May 2026

Prenatal care begins. Documentation is in certified EHRs that participate with a national network.

At 36 weeks a Direct Message with Antepartum Summary Progress Note Document is sent to the delivery facility.

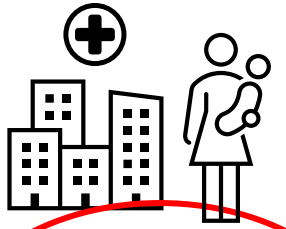
The ASPND is clearly labeled and available with needed discrete prenatal data.

Patient arrives in labor and information is ready and available for clinicians in the EHR.

OB Flowsheet, LOINC 89238-0 is available for query response but no DSM is sent

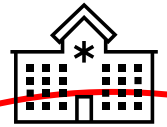
Child delivered and mother is discharged with support needed for feeding, housing and transportation.

POST-PARTUM INFORMATION JOURNEY

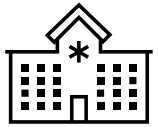


Current State

Child delivered and Mother / Child discharged from birth center



Clinic does not know about delivery and post-partum visit is dependent on patient scheduling a visit or clinic manually following up with the patient.



Post-partum visit is scheduled, and clinic staff query for delivery records.



Post-partum visit occurs.

Better Care Experience	Higher Quality Care	Reduced Costs	Less Burden	Improved Maternal Health Outcomes

May 2026

Post-partum care begins. Documentation is in certified EHRs that participate with a national network.

DSM message with labor and delivery record sent to prepartum care site.

OB Flowsheet, LOINC 89238-0 is available for query response but no DSM is sent

Child delivered and mother is discharged with support needed for feeding, housing and transportation.

At delivery, record locator service is accessed establishing a treatment relationship with DSM address.

Patient arrives in labor and information is ready and available for clinicians in the EHR.

THSA
Texas Health Services Authority

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
- Juan Nanez – PHIX
- Dr. Joseph Schneider – UTSW / Parkland

Actions Taken:

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

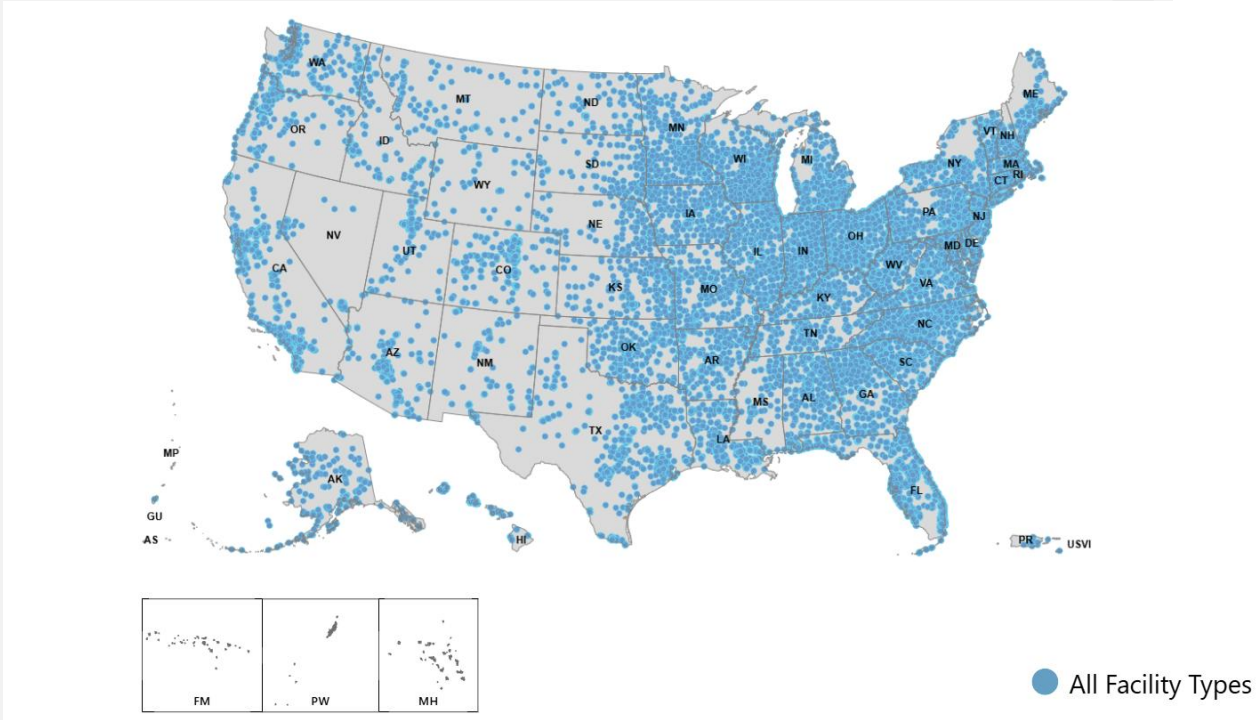
1. **Group is focusing on eCR and data quality. Dr. Schneider shared information from the National Council of Public Health on eCR for birth defects surveillance.**

"Conclusions: eCR may be a viable source for timely potential case identification and may also facilitate timelier referral to social services among eligible cases. eCR data files are not standardized across facilities, lack critical variables permitting examination of birth defect risk factors, and are generally not a comprehensive resource for all pertinent data related to a birth defect case." Inviting national experts to speak to Collaborative.

2. **Exploring TEFCA query treatment types and definitions.**

ELECTRONIC CASE REPORTING

As of April 6, 2026, more than 61,400 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.



- Altera Paragon (in limited jurisdictions only)
- Altera Sunrise
- athenahealth athenaOne (athenaClinicals and athenaHHS)
- athenahealth athenaPractice
- eClinical Works
- Epic
- Flatiron OncoEMR
- Greenway Health Intergy
- Greenway Health Prime Suite
- McKesson/Ontada iKnowMed
- Medhost eCR 1.0
- Meditech Expanse
- Modernizing Medicine EMA
- NextGen Enterprise
- Oracle Cerner Ambulatory
- Oracle Cerner Millennium
- Oracle Cerner CommunityWorks
- Premier Inc. TheraDoc
- TruBridge EHR
- Veradigm - Veradigm EHR

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.**

ImmTrac2 Pilot Project with American Immunization Registry Association

Goal: Texas IIS participated in a pilot project with American Immunization Registry Association. The goal of project is to use the Measurement and Initiative Data at Rest framework to better understand and surface data quality variation across EHR systems, with a focus on practical, jurisdiction-informed approaches that can support analysis, improvement, and peer learning. Data at Rest (DAR) is the measurement of data residing in the immunization information system (IIS) database regardless of how it arrived there. Through participation in this pilot, Texas IIS will be able to generate report cards on how each EHR system performs on the completeness, validity and latency of reporting the immunization data.

NEWBORN INFORMATICS

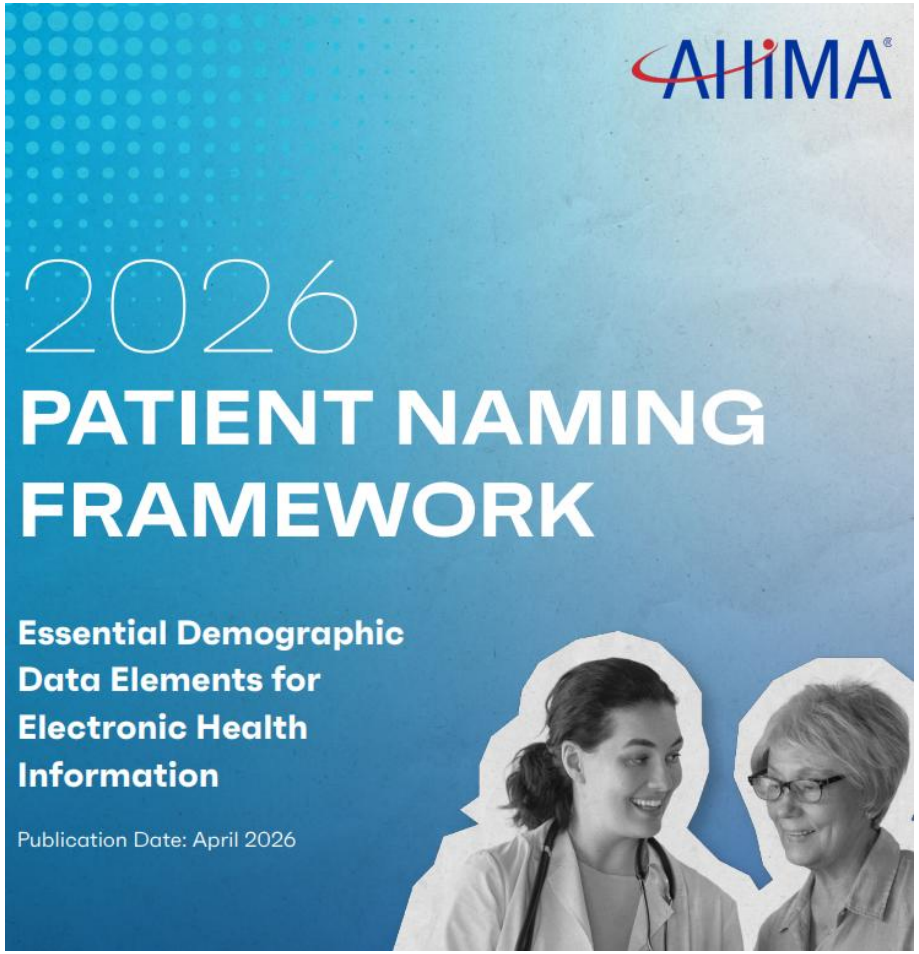
Work Group Members:

- 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

Actions:

- DRAFT for CCHD consolidated by Dr. Schneider on hold.
- Dr. Fortunov, Texas Children's focus on Electronic laboratory results for samples sent to the State on patients under treatment at a facility i.e. NB transferred to a NICU or followed by PCP or specialist. Difficulty with tracking prematurity screening (blood spot, CCHD & hearing) as the results are sent back to birthing hospital and not provided to clinicians caring for the child. Standardize data capture & harmonize data exchange.
- Fetal medicine documentation needs under discussion.
- **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 on standard adoption The plan is to work with other vendors.**
- Data normalization for newborn screening results under discussion – how do we standardize.
- Texas Children's shared ability for Epic to share discrete data from birth history (mother's record) to newborn.
- **Group is discussing standards for screening for biliary atresia. More discussions with each organization. How can they improve this process. Outreach to West Texas for involvement.**

AHIMA's Newborn Naming Policy



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 – Committed, but discussing

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

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?

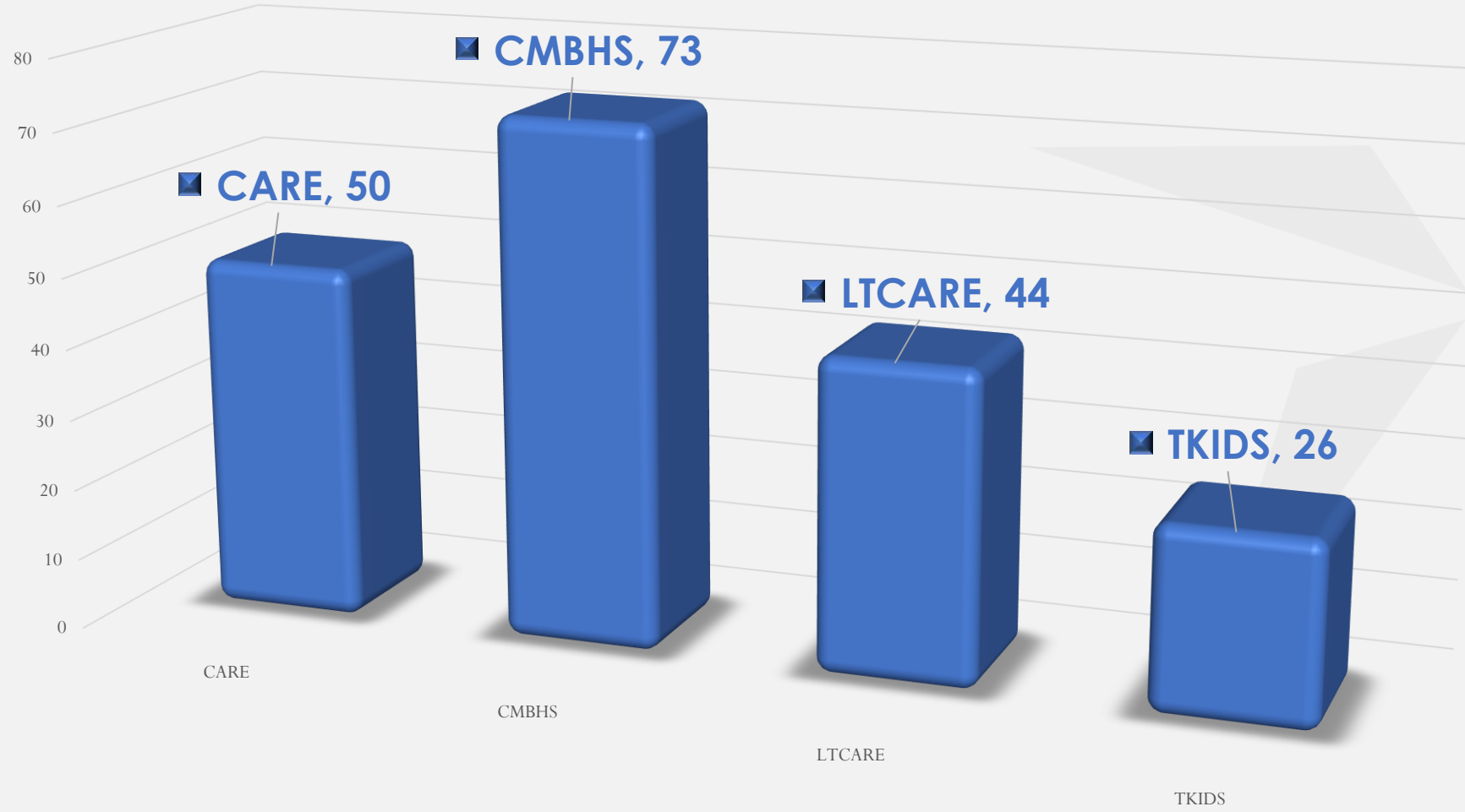
There was agreement from all participants that access to the information for the care continuum is important.

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 will focus on decreasing duplicate data entry.

NUMBER OF FORMS IN EACH SYSTEM

Starting with Demographics



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

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.

Data Usability

- Inconsistencies with LOINC codes for query and response to query. This led to further discussion that was continued at the C-CDA workgroup.
- Differing verbiage between disciplines has been identified as a barrier. Lisa Nelson and Phil Beckett put together a presentation to improve.

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

Actions Taken:

- ADT Notifications and Pharmacists potential – January meeting.
- Charter completed.
- ISMP Med Safety Alert & Targeted Medication Safety Best Practices for Hospitals are the baseline.
- **No more Free Text. Agreed that we could focus on this space and make a difference.**
- **Survey completed on why free text was reviewed.**
- **Developed standard language for oral antithrombotic agents.**
- **Next step - Vetting with community, receiving feedback and finalizing.**

Improving Medication Safety using ISMP Best Practice Recommendations

- Standardizing medication reconciliation is a huge endeavor, but we can incrementally make a difference.
- Starting with ISMP High Risk Medications – anticoagulants – No Free Text.
- Free Text lends itself to transcription errors, dosing errors and bypasses safety features imbedded in the EHR. Clinical decision support tools cannot be leveraged. Reviewing dosing becomes more complicated by requiring manual dosing. Doses can be missed. Translation issues for non-English speaking people.

Decreasing Free Text

- To move forward with decreasing use of free text – we need to use the same language in the sigs
- Sigs need to be in plane language so the paper discharge instructions, the portal and the label on bottle all match
- Support for transitions of care is key

Ask of Community – Can you support the sigs below?

Understanding that there are alternate routes, this may not be appropriate for pediatrics or patients with enteral feeding tubes

- apixaban – one tablet by mouth twice daily
- clopidogrel 75 mg - one tablet by mouth daily
- dabigatran – one capsule by mouth daily or one capsule by mouth twice a day
- rivaroxaban – one tablet by mouth daily or one tablet by mouth twice a day
- Edoxaban – one tablet by mouth daily
- Brilinta – one tablet by mouth twice a day

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

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.
- Next Meeting: 6.11.2026 with a goal to finalize charter.

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.**
- **Awaiting feedback from State on management. Will regroup when announced.**
- **State is working with the Texas Hospital Association who has communicated that this is complex and everyone is working towards assuring the information is available to the Texas Hospitals as required by law.**

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

- 06.10 – 06.12.2026 – TxHIMA Annual Conference, Georgetown
- 7.08.2026 – Prageet Kaang, ImmTrac2 Director, Interoperability Unit on Patient Active / Inactive (PAIS) Program
- 08.12.2026 – Shaily Krishan, CSTE & Joel Hartsell, aphl – eCR
- 08.26.2026 – THSA Cybersecurity Symposium
- 09.09.2026 Lisa Nelson & Phil Beckett – Common Language for Document-Based Exchange
- 09.18.2026 Texas Health Informatics Alliance, Frisco, Texas
- 10.14.2026 Brittany Henson – The American Heart Association
- 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

info@THSA.org
Katherine.Lusk@THSA.org
Phil.Beckett@THSA.org

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC)

Meeting from 9 am to 2 pm – Virtual open to everyone
Scheduled - May 7, 2026, September 24, 2026 & November 5, 2026

The Health Information Technology Advisory Committee (HITAC) was established by the 21st Century Cures Act (P.L. 114-255) and is governed by the provisions of the Federal Advisory Committee Act (FACA), P.L. 92-463, as amended, 5 U.S.C. App. 2, which sets forth standards for the formation and use of federal advisory committees. The HITAC will recommend to the Assistant Secretary for Technology Policy and 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. HITAC unifies the roles of, and replaces, the Health Information Technology Policy Committee and the Health Information Technology Standards Committee that were in existence before the date of the enactment of the 21st Century Cures Act.

Meetings are open to the public: HITAC Calendar | HealthIT.gov

Consideration - Hospitals not sending notifications when patients changed from ED to Observation status

Feedback Received: Notifications useful for ED to Observation.

CMS does not require an ADT encounter notification for status changes from ED to Observation. Is this notification inflating the in-basket with minimal value?

"However, while the requirements do not prohibit a hospital from electing to send a patient event notification when a patient is transferred to one inpatient services unit of the hospital to another, the requirements finalized in this rule are based on a change in the patient's status from outpatient to inpatient, and not necessarily on the physical location of the patient."

Notifications would continue for ED Registration and Discharge in Observation Status.

Is there an unintended consequence?

Designated QHINs

commonwell® HEALTH ALLIANCE

eClinicalWorks PRISMANet

eHealth Exchange™

Epic Nexus

HEALTH GORILLA®

Kno2®

KONZA HEALTH
The Connections to Make a Difference

MEDALLIES®

Netsmart

ORACLE Health
Information Network, Inc.™

surescripts
Health Information Network

ImmTrac2 – Multiple Consents

Many EHR vendors responded. ImmTrac2 team is evaluating responses.

ImmTrac2 Team is working on options to collect multiple Texas consents in the PD1-12 segment. This will allow providers to collect during one point of care and sent them to ItS within one VXU message.

Concerns:

What impact this will have on EHR vendors?

Will the EHR vendors be able to configure their systems to allow for this change?

Sent to EHR Vendors 4.01.2026

The Texas Immunization Registry is working on options to collect multiple Texas Immunizations consents in the PD1-12 segment. This will allow providers to collect multiple consents during one point of care and send them to ImmTrac2 within one VXU message.

They are concerned with the impact to the EHR vendors. What impact will this have on your product? Will you be able to configure your system to allow for this change? How much effort will this take?

Are there concerns, considerations, or recommendations that you would like to share with the Texas Department of State Health Services, Texas Immunization Registry?

Your help during this discovery phase is much appreciated.

Laboratory Survey Responses

1. **What is your Hemoglobin A1C test manufacturer**. Siemens (3), Abbott (3), Bio-Rad (1)
2. **What is your Hemoglobin A1C instrument model.** DCA Vantage (3), Afinon 2 (2), Cobas (1), D-100 (1)
3. **Names used for Hemoglobin A1C**. HEMOGLOBIN A1C FOR SCREENING, DIAGNOSIS, AND MONITORING; HEMOGLOBIN A1C-POC FOR MONITORING ONLY; Hemoglobin A1C, Siemens Hemoglobin A1c (HbA1c); Hgb A1C L/C in CPSI, HEMOGLOBIN A1C FOR SCREENING, DIAGNOSIS, AND MONITORING; HEMOGLOBIN A1C-POC FOR MONITORING ONLY; Hemoglobin A1C, HgbA1C; glycohemoglobin, Hemoglobin A1C-HPLC;A1C-HPLC
4. **What is the sample type**: Whole blood venous (4) Capillary (2)
5. **Unit of measure**: percentage (5)
6. **LOINC Code.** 4548-4 (4)
7. **Data Interoperability**: Captured discretely (order, result, specimen, etc);Encoded with LOINC;Shared electronically as discrete data (not fax, pdf);Test maintained/updated to latest standards (https://www.govinfo.gov/content/pkg/CMR-HE1-00196380/pdf/CMR-HE1-00196380.pdf);Shareable with HL7 V2 and/or FHIR and/or CCDA;EHR changes name received from LIS; Shareable with HL7 V2 and/or FHIR and/or CCDA; Shared electronically as discrete data (not fax, pdf);Captured discretely (order, result, specimen, etc);Encoded with LOINC;Shareable with HL7 V2 and/or FHIR and/or CCDA;Test maintained/updated to latest standards (https://www.govinfo.gov/content/pkg/CMR-HE1-00196380/pdf/CMR-HE1-00196380.pdf); Shared electronically as discrete data (not fax, pdf);Captured discretely (order, result, specimen, etc);Encoded with LOINC;Shareable with HL7 V2 and/or FHIR and/or CCDA;
8. **Lab Information System:** Epic (3), Trubridge (1), Clinisys / Orchard (1)
9. **EHR Vendor**: Epic (4), Trubridge (1)