



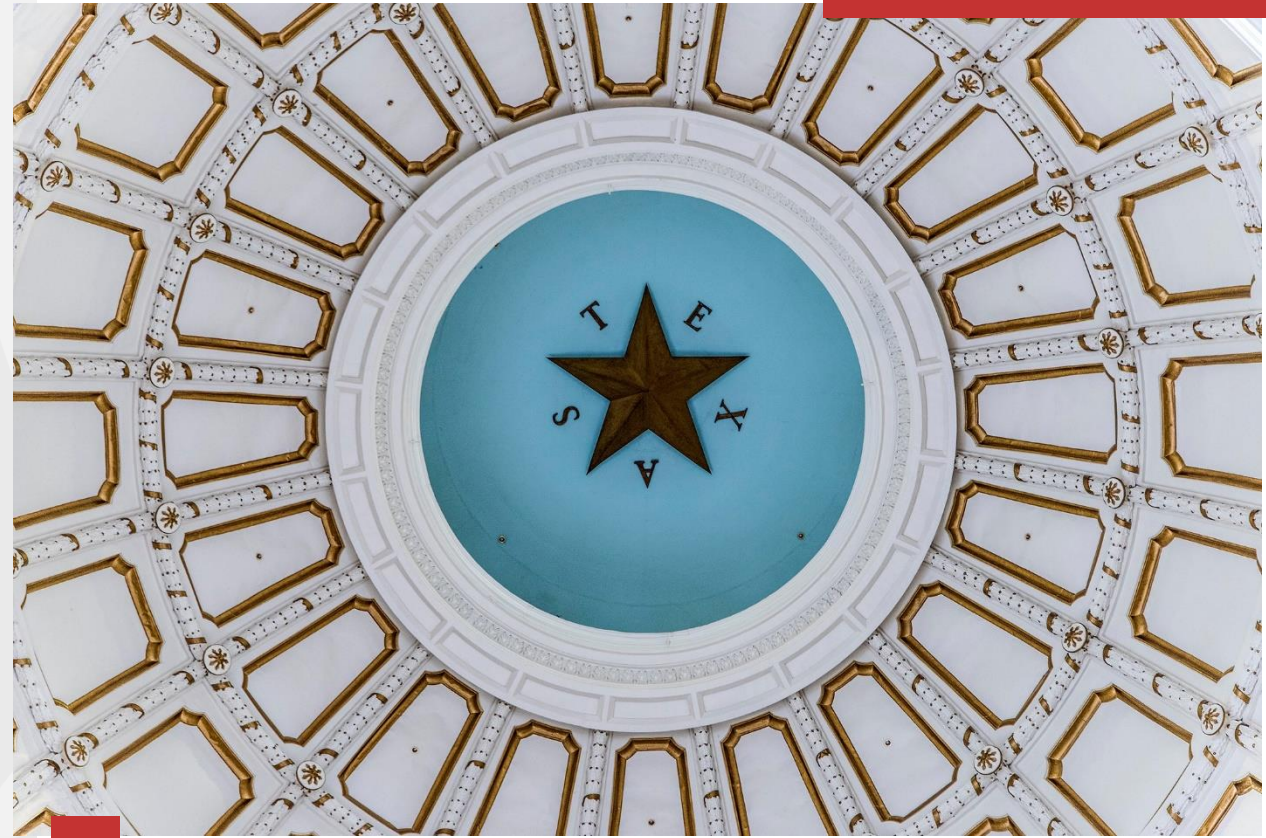
Texas Interoperability Collaborative

Learning Objectives

1. Demonstrate of awareness of the Texas Health Services Authority Interoperability Collaborative
2. Describe barriers to interoperability in Texas
3. Apply THSA Interoperability Collaborative recommendations and efforts to solve operational problems

TEXAS HEALTH SERVICES AUTHORITY

- Created in 2007 by the Texas Legislature as the public/private entity to promote and coordinate electronic health information exchange in the State of Texas
- Operates three major functions: (1) HIETexas -- electronic health information exchange platform, (2) SECURETexas – a privacy and security certification program and (3) Texas Interoperability Collaborative
- Governed by a 12-member board of directors, appointed by the Texas Governor and confirmed by the Texas Senate. Two ex-officio members representing state health agencies also sit on the board



[Section 182.101\(a\)\(1\), Health and Safety Code](#)
[HEALTH AND SAFETY CODE CHAPTER 182. ELECTRONIC EXCHANGE OF HEALTH INFORMATION \(texas.gov\)](#)

TEXAS INTEROPERABILITY COLLABORATIVE

- May, 2021 THSA convened a multidisciplinary, vendor agnostic collaborative including the complete continuum of care that will serve the State with improved care delivery, streamlining administrative processes, and cost control realized through trusted cooperation
- The Collaborative will serve to address the challenges with timely, trusted data exchange across multiple public and private healthcare venues, public health, and vendor platforms
- Meets monthly, virtually with all members of the healthcare sector invited to participate



We've been busy!

May 2021
HIMSS Regional Launch

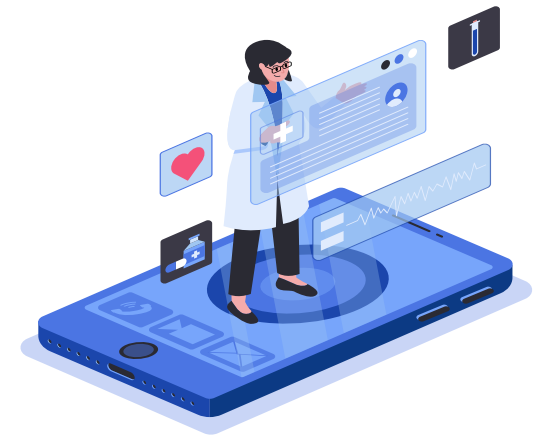
2022
C-CDA Content
Direct Message Adoption
National Network Adoption / Public Health Reporting
Immunization Registry
21st Century Cures
Standardizing Newborn Screening

2023
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Standardizing Newborn Screening Reporting
Telehealth & Sharing Information
Death Registry - Real time data
**September 2023
Interoperability Symposium**

2024
C-CDA Content
Direct Message Adoption
National Network Adoption / Public Health Reporting
Immunization Registry
Standardizing Newborn Screening Reporting
Telehealth & Sharing Information
Death Registry - Real time data
**June 7, 2024
Interoperability Symposium**

AN INTEROPERABILITY SHORT STORY

HEALTH INFORMATION EXCHANGE IS BROKEN



Minimal, sporadic information - Clinic defaulted Carequality set up to query at 48 hours pending patients. The clinic contacts pending patients at 72 hours and confirms appointments.

- **Adjust query settings to maximize information available to clinicians; changed to “confirmed” and “pending” appointment query**

Sending and sharing obstetric records electronically but the hospital is calling asking for a fax - Hospital labor and delivery team calling clinic for faxed records because they could not find electronically. Hospital looked and records were electronically received as an abstract with no identifying data, not showing as an OB Record or displaying document source.

- **Include an identifier (facility name, document type) on documentation shared with Carequality so documents can be ingested into receiving EHR in appropriate context (i.e. Obstetric records)**

Not getting PCP notices on hospital admissions, discharges or transfers - The clinic was not receiving ADT encounter notifications or direct messages sent to the providers due to no published Direct Address. EHR offered Direct Messaging.

- **Implement Direct Secure Messaging and check to make sure HISP is participating in DirectTrust Bundle**

C-CDA STANDARDIZATION

Problem:

Inconsistent C-CDA content is impacting transitions of care in the Texas community

- C-CDA was implemented to make data transfer between EHRs easier, however that is not always the case
- C-CDA data received by the clinical community is inconsistent, thus creating frustration and lack of trust in the data received
- Clinicians vocalized that data electronically transferred between different EHR vendors and organizations is inconsistent



C-CDA STANDARDIZATION

Work-Group Members:

- **Austin Regional**
- **Texas Health Resources**
- Driscoll
- UT Austin
- Titus Regional
- **Ascension Health**
- United Regional
- Children's Dallas
- Epic
- Oracle / Cerner
- NextGen
- MedHost
- **HCA**
- Sequoia Project
- CommonWell
- **Health Services North Texas**

Community Contributions:

1. Instructions on C-CDA content validation
2. Developed recommendation for minimum content Discharge Summary C-CDA
 - HL7 Structured Documents – **“you raised the bar on C-CDAs”**
 - Sequoia Project Data Usability Implementation Guide included Discharge Summary C-CDA recommendation, Appendix B
3. Improvements to electronic sharing of information between Epic and Cerner facilitated by Austin Regional and Ascension
4. Improvements to electronic sharing of information between Epic and Meditech facilitated by Austin Regional and Saint David's
5. Improvements to electronic sharing of information between eCW and Epic facilitated by Health Services of North Texas and THR

C-CDA CURRENT PROJECTS

1. Encouraging adoption of minimum content Discharge Summary C-CDA
2. Standardizing laboratory results C-CDA content via Data Usability Laboratory Tiger Team
3. Commented on USCDIV5 to add Prenatal Document to required Clinical Notes
4. Collaboration between Ascension and ARC and THR and HSNT continue
5. **Focus on the balance of sharing clinically pertinent information and cognitive overload with sharing too much. Developing best practice recommendations**
6. De-duplication of Problems, Allergies, Medications and Immunizations – Sharing Data Usability Implementation Guide asking everyone to get with their vendors, encourage adoption and see where they are on the journey

DISCHARGE C-CDA MINIMUM CONTENT RECOMMENDATION

It is recognized that this is not perfect but a beginning. Clinicians can query for additional information when needed – this recommendation is to meet the majority of clinician needs. The list is organized by priority of content

Each organization is asked to work with their EHR vendor and information technology teams to send and receive the Discharge C-CDA Content

Organizations receiving the Discharge C-CDA can use a style sheet to display content

Discharge C-CDA Content

1. Discharge Summary Narrative (aka Hospital Course)
2. Discharge Medications
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. On those rare tests – they are only done once so would be included (ANA Rheumatoid)
9. Consultations
10. Assessment & Plan (includes future orders for follow-up with PCP and diagnostic tests)
11. Problem List

IMMUNIZATION REGISTRY WORK GROUP

ImmTrac2
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:

- UTSW
- Texas Health Resources
- Baylor Scott and White
- Children's Dallas
- Hazel Chappell, ishca health, Inc.
- DSHS
- Ascension
- University of Houston
- Texas Children's
- Dallas County Public Health
- Kelsey Seybold
- UT San Antonio
- Tenet
- Community Care
- Central Health

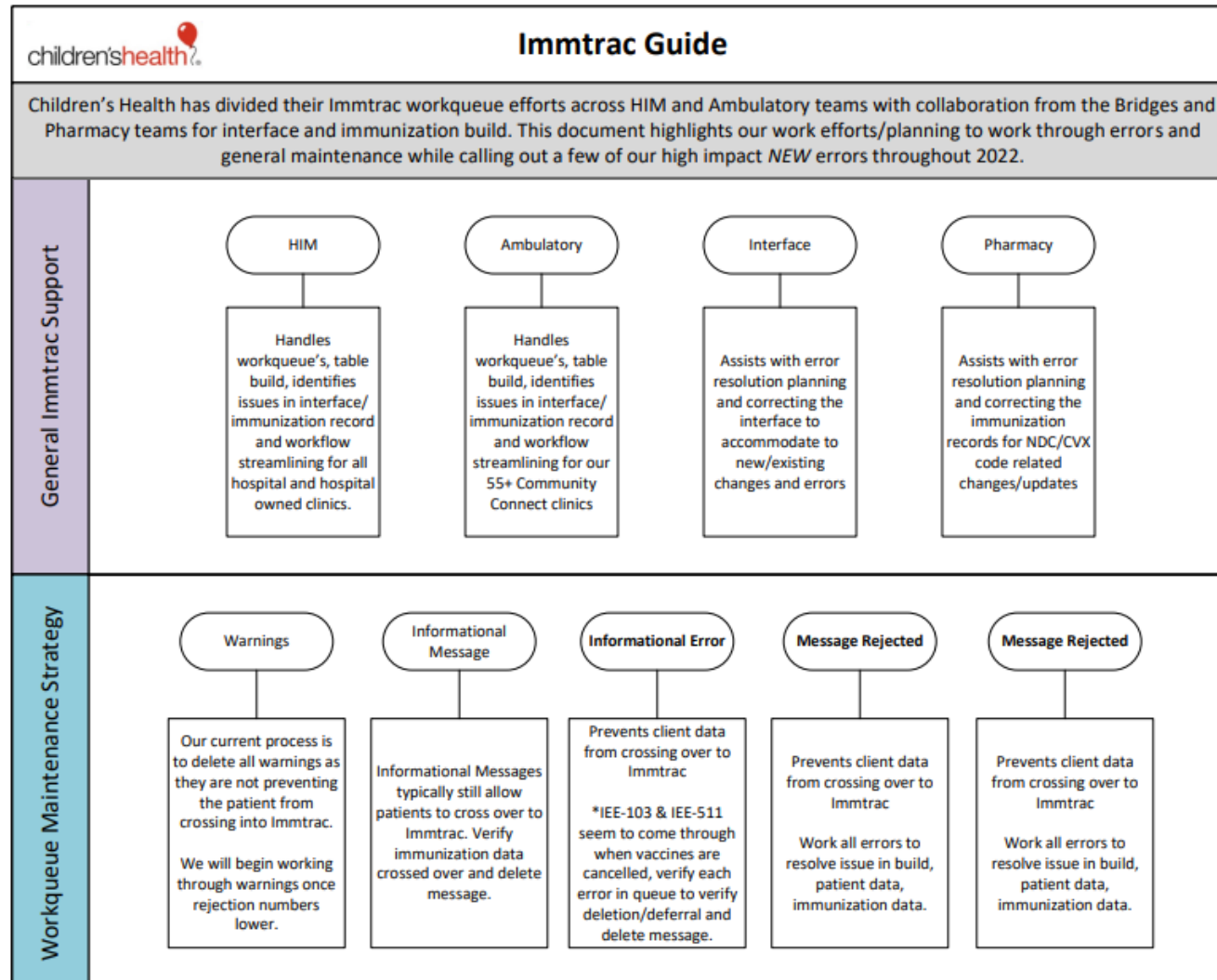
Community Contributions:

1. FAQ to assist organizations with IMMTRAC2 onboarding shared by IMMTRAC2 Team
2. Epic Bridges Report to assist organizations with prioritization of error correction
3. Issue Resolution Guide
4. Identified patient matching opportunities
5. Stakeholder feedback body for IMMTRAC2
4. Primer for staff recording patient names

Current Projects:

1. Working closely with IMMTRAC2 Team on issue resolution

ISSUE RESOLUTION GUIDE



TEXAS IMMUNIZATION REGISTRY – CONSENT & DATA EXCHANGE FAQs



Table of Contents

Consent Practices 7

1. What is the process of sending consent affirmation to the immunization registry? 7

2. What does patient consent to participation in ImmTrac2 entail? 7

3. Does registry consent have to be obtained with each immunization to store each immunization, or is consent held for vaccinations in perpetuity?..... 8

4. How often should consent be collected? What is required by the state? 8

5. At what age can patients consent to ImmTrac2 participation as an adult? .. 8

6. Why might vaccination records among patients among young adults be unavailable? What is an ImmTrac2 Pending Adult client?..... 9

7. Are electronic consent forms accepted by the registry? 9

8. Can healthcare entities add to the consent form?..... 9

9. How is consent affirmation submitted to the registry?..... 9

10. Can the state accept immunization data prior to receiving a patient’s ImmTrac2 consent? 10

11. Should schools need to collect and report registry consent?..... 10

12. Can hospitals send ImmTrac2 consent affirmation through IDNS or HIEs? 11

13. How can a healthcare organization see if a patient is still assigned to them? 11

14. How can a healthcare organization validate if a patient has had standard or disaster consent affirmation submitted for them?..... 11

15. How does patient matching operate in ImmTrac2? 12

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

Many providers are unaware or unable to view the direct messages they are receiving so much of what is being sent is not being meaningfully received

THSA's Nine Recommendations for a Better Direct Secure Messaging Experience

01



Include NPI in Directory Entries

Confirm your Health Information Service Provider (HISP) has National Provider IDs (NPIs) for your organization and providers.

02



List Direct Address on Fax Cover Sheet

Update the language on your Fax Cover sheet to indicate you'd prefer communication via Direct and your Direct address(es).

03



Use Message Routing

Avoid unintended consequences by routing the messages to the appropriate team member to manage through workflow Direct addresses, or other use of technology.

04



Encourage Referral Partners to Adopt Direct

Reach out to your common referral partners and encourage them to use Direct Secure Messaging for your communication.

05



Include your Direct Address on All External Communication

Anywhere that you list your office phone or fax number, include your Direct address.

06



Verify NPI Compliance in Your Database

Check if your organization's physician database has a NPI for all Primary Care Providers you refer to for ease of lookup for clinician matching.

07



Use the ONC's Project US@ address format

Ensure addresses are entered in a standardized format by using the Project US@ guidance.

08



Routinely Synchronize your Provider Directory

Develop a schedule for reconciling and updating your organization's Directory.

09



Adopt Policy and be a Good Partner

Establish Policy Guidelines for reviewing and updating your Directory data quality and routinely publish your provider directory; inform EHR/HISP technology partners of any changes.

DIRECT MESSAGING

Parallel paths including: Communication, Data integrity and Happy Path Development

Work-Group Members:

- CHRISTUS
- CommonSpirit
- Baylor Scott & White
- UTSW
- Children's Dallas
- Texas Medical Association
- UT Austin
- Baylor College of Medicine
- UT Houston
- UT San Antonio
- Ascension

Community Contributions:

1. Outreach efforts:

- Texas Medical Association published several articles
- Published in Applied Clinical Informatics. Presented internationally at MedInfo on Directory Management and AMIA Informatics Conference on the value of Directory Maintenance
- Tracy Swoboda wrote blog for LinkedIn and Texas MGMA sent to their members
- Krista Fox, UT Houston developed social media outreach for Twitter and LinkedIn
- Developed definitions for Instant Messages, Direct Secure Messaging and Admission, Discharge, Transfer (ADT Notifications)
- Working with Community on adopting DSM including vendors

2. Policy on Provider Directory, & instructions on how to update NPPES (national registry)

3. Encouraging adoption of DirectTrust Event Notification Standard

Current Projects:

1. TIM+ Instant Messaging Project with DirectTrust, Cerner, Inpriva and Ascension being led by Dr. Michael Auth
2. Direct Messaging one pager under development

IMPROVING TRANSITIONS OF CARE – DIRECT MESSAGING

Clinicians are burdened receiving messages that should be routed to other team members. Care is delayed from needless hand-offs.

1. Validate with the organization that is sending Event Notifications for you that they are following the DirectTrust Standard
2. Work with EHR vendor to route incoming messages to appropriate personnel, many EHR vendors are capable of routing incoming messages when they contain **Context**
3. Help your clinicians by adhering to DirectTrust Event Notification standard



BENEFITS

- **Shortest path to compliance** with CMS ADT Conditions of Participation
- **Creates near real-time visibility** to status changes of patient's care
- **Improves communication between providers** about shared patients for a stronger continuum of care
- **Empowers care teams** to make informed decisions and positively impact patient care
- **Includes Context** to enable message routing to the appropriate person on the care team

PROVIDER DATABASE DICTIONARY (PROVIDER DIRECTORY) POLICY

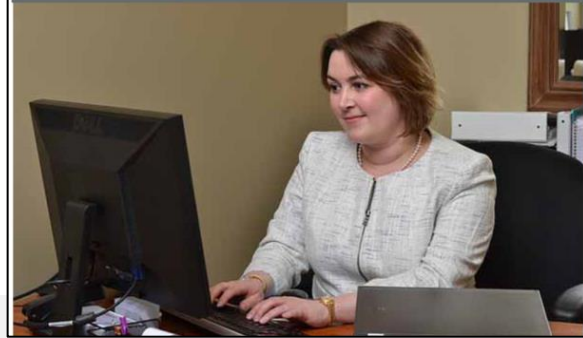
Clinical information should be provided to clinical care providers in a timely and efficient manner without requiring human intervention. Direct Secure Messaging is an encrypted communication technology that is available to the broadest healthcare delivery audience and is available to organizations large and small.

Provider Database Dictionary Data Elements: Data should be complete, accurate, timely and include the following at minimum:

- Legal name as documented on medical license
- Physical Address – US Postal Service format (Project US@)
- National Provider Identifier (NPI) #
- Phone #
- Direct Secure Messaging address(es)
- Physical address and NPI # should be tied to the Direct Secure Messaging address
- Specialty identification using NUCC Taxonomy Code

OUTREACH

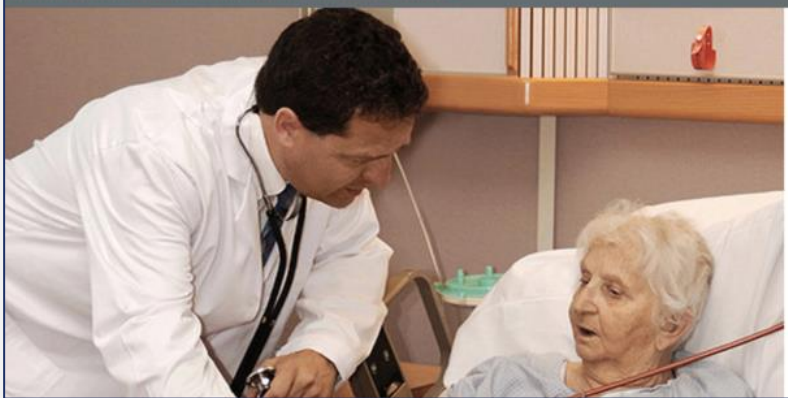
Direct Messaging Can Help You Comply With Federal Information-Sharing Law



“What is a Direct Address for Direct Secure Messaging of Health Information Exchange?”

A Direct Address is the core element to foster a connection across different electronic health record networks when attempting to build the secure means of electronic communication for referrals, transitions of care, or to receive notifications of patient admission, discharge or transfer.

Hospitals Required to Send Admit, Discharge, Transfer Notices to Physicians



- Contact your EHR vendor or Health Information Service Provider (HISP) to obtain your Direct Secure Messaging address

- Log into NPPES and select "Health Information Exchange"

- Select "Direct Messaging Address" as Endpoint type and enter Direct Secure Messaging address

- Place "Direct" as Endpoint Use

- Enter the practicing address in the Endpoint location field

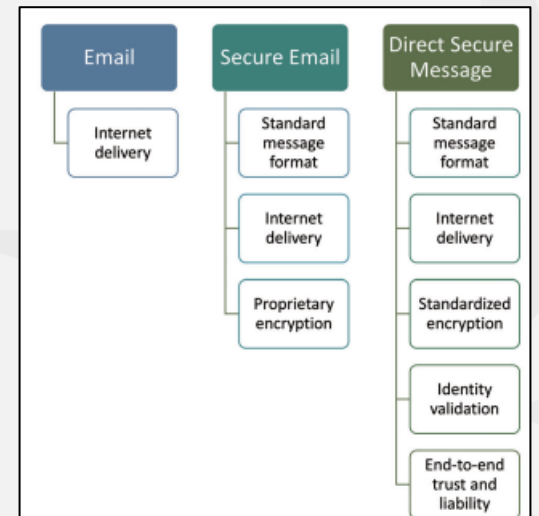


Fig. 1 Email versus Direct Secure Messaging: what's the difference?

DIRECT MESSAGING DEFINITIONS

Instant Messages: Conversation, can be included in legal medical record but not necessarily. Real-time communication. Has presence, if application turned on, sender will know when they send a message if the message was received. Sender / Receiver have a “handle”

Direct Secure Messaging: Sends a one-way message in a secure manner to a Direct Address that is uniquely identified by the provider’s NPI. This is integrated into the EHR workflow and used for referrals and sending clinical information such as consultations, discharge summaries, etc. The message is not urgent but can be consumed in the normal work day. Sender / Receiver has a Direct Address

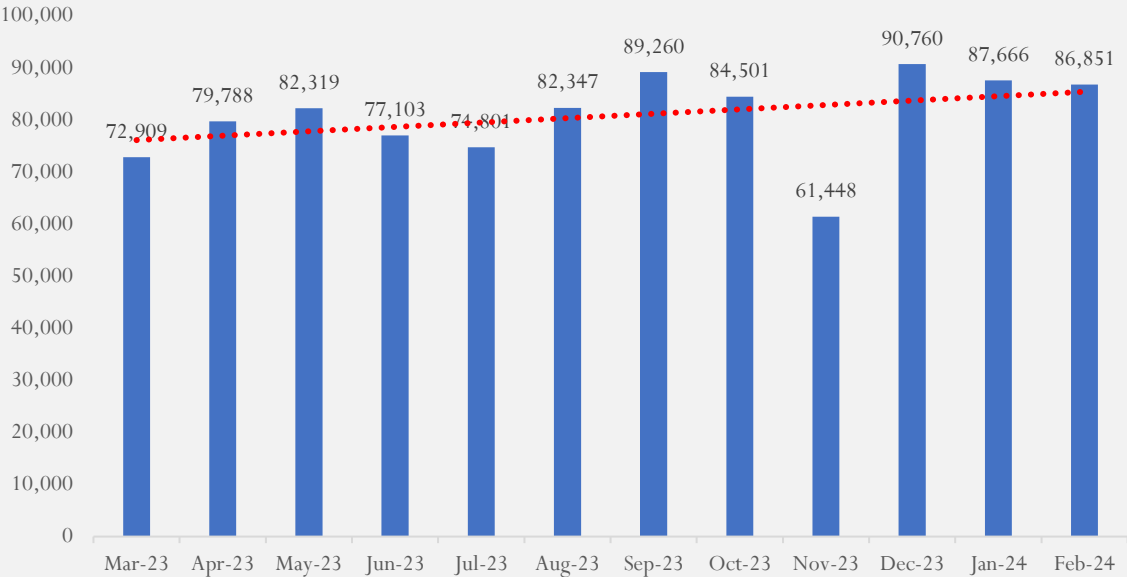
Admission Discharge Transfer (ADT) Event Notifications – This is a CMS requirement to notify the patient identified PCP and others with treatment relationships either by **Direct Secure Messaging or FHIR** of an emergency room, inpatient or observation encounter. The three required elements are: Patient Name, treating practitioner name and sending institution name at admission, discharge and transfer. Some Organizations include more info in the message to make it more meaningful for example: chief complaint, diagnoses, and payer information

Oracle / Cerner - Lessons Learned – Interoperability for CommonWell and Direct Secure Message

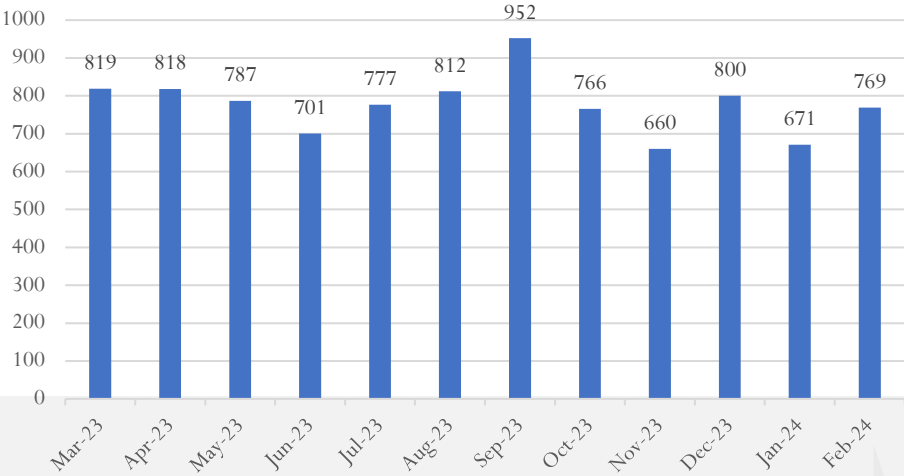
- **Location Information**
 - Identify all locations that produce ADTs i.e. register and discharge patients as well as document patient care information
 - Acute care facilities
 - Ambulatory facilities
 - Including specialty clinics located within hospital walls but have their own ORG ID and utilize the same EMR
- **Registration**
 - Workflow
 - PCP identification and process to get new providers not in the system added to be selectable in the future
 - Consent to share health information workflow
 - Where is this documented?
 - Is this a required field?
 - Does it carry over from encounter to encounter and at different facilities?
 - Review the set up and backend configuration. Some organizations have a Consent to Share PHI and a separate CommonWell Consent to Share. Determine if your state law and your hospital organization's regulatory body will allow you to combine these into one consent.
 - Encounter Types used at all locations
 - Acute and Ambulatory
 - Discharge timing for encounter types
 - Do any encounter types auto discharge at a later time i.e. 2 days after admission for Clinic and Day Surgery encounters
 - Newborn naming
 - Review workflow and put a system in place to make sure these names are updated from "Baby Boy Smith" to the patient name within 48 -72 hours before they see their PCP so the PCP can see the patient information in CommonWell
 - Patient linking (CommonWell)
 - Auto linking may not occur due to demographic information inconsistencies - First name, Last name, DOB, gender and 5 number zip code must match 100%
 - Manual linking will be required to pull in outside information
 - Review workflow and determine what positions should do this, how and when in their workflow.

Direct Messaging THSA Network

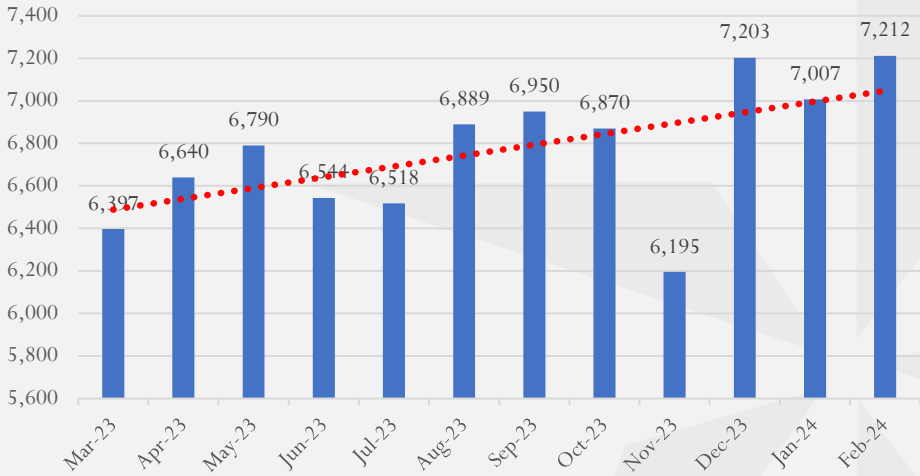
Message Volume



New PCP Direct Addresses



Unique PCPs



TRUSTED INSTANT MESSAGING TIM +

Problem: There is a need for immediate contact between care providers. Clinicians cannot communicate instantaneously across platforms.

Example: Complex cancer patient where ED is trying to reach the cancer patient's primary care provider or oncologist to ask about changing medications

DirectTrust Connection: April 24, 2023

Trusted Instant Messaging (TIM+) is a protocol that:

- Secure real-time communications
- Among trusted Identification proofed electronic endpoints referred to as a “handle”
- Handles are universally unique
- Identity is Federated
- Endpoints are dynamically discoverable
- Works regardless of organizational boundaries
- Messages are end-to-end encrypted

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

Fax, paper hand-offs and telephone calls are used to support the complete continuum of care in Texas Hospitals.



INCREASING ADOPTION OF NATIONAL NETWORKS



eHealth Exchange



eCR - CDC



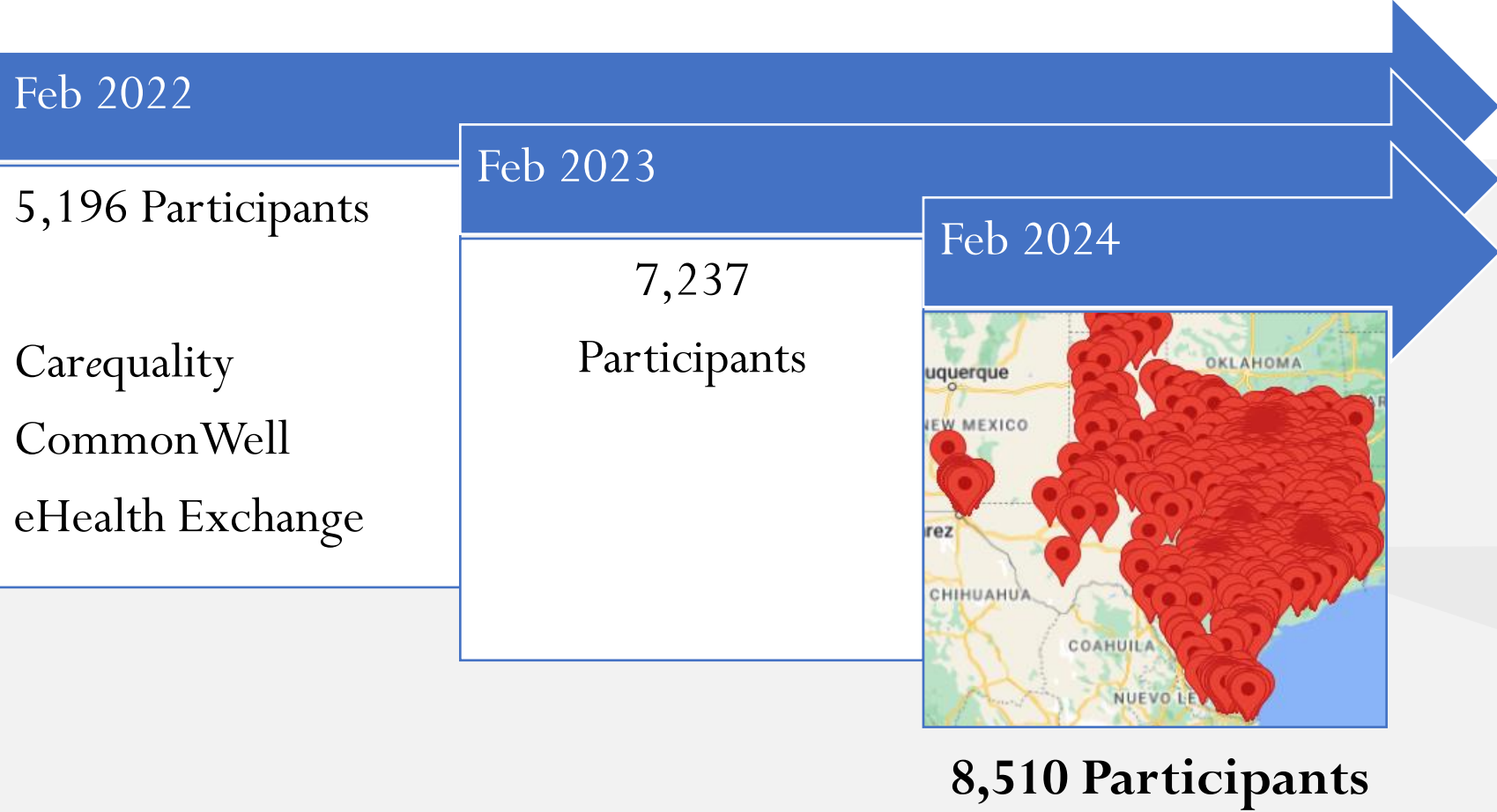
Work Group:

- Children's Dallas
- Texas Hospital Association
- Dallas County Public Health
- RAC
- Baylor Scott & White
- Tenet

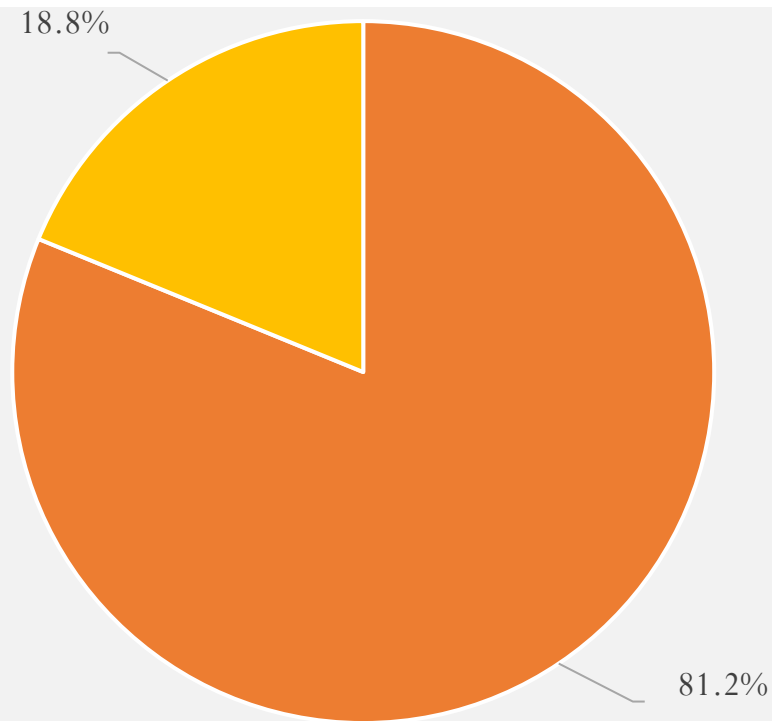
Community Contributions:

1. Outreach to vendors and all members of healthcare ecosystem
2. Resource Summary with links
3. Participation Public Health Steering Committee for eCR
4. Focused sessions for Inpatient and Ambulatory CMS Promoting Interoperability Requirements

TEXAS NATIONAL NETWORK ADOPTION



NATIONAL NETWORK USE TEXAS HOSPITALS

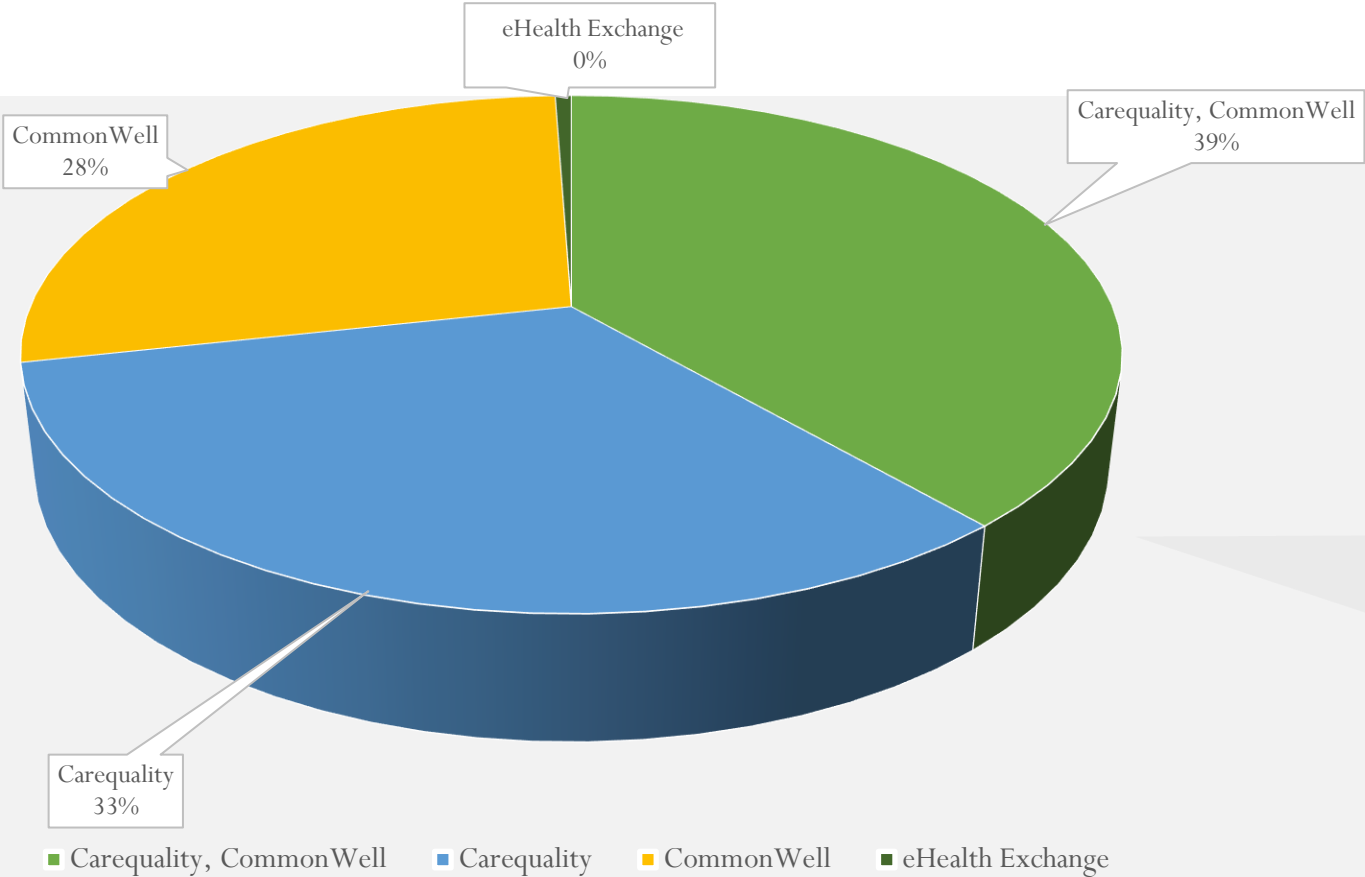


The 18.8% comprises primarily Behavioral Health Hospitals and one EHR vendor.

Thank you
Baraah Elsaadi,
Texas State Student

DEEPER DIVE

Connected to National Network Carequality, CommonWell & eHealth Exchange



** eHealth Exchange 3 hospitals are connected to the eHealth Exchange but not CommonWell or Carequality*

Thank you
Baraah Elsaadi,
Texas State Student

21ST CENTURY WORK-GROUP

21st Century Cures Act

- Definition of electronic health information (EHI) as determined by designated record set and USCDI
- Information Blocking

Members:

- Baylor Scott and White
- Texas Health Information Management Association
- Connally Memorial
- UT Houston
- United Regional
- Texas Medical Association
- Omnipoint Health
- Children's Dallas

Community Support:

1. Rita Bowen, Sequoia Secretary spoke to Collaborative on what she was seeing nationally
2. Rani Perez, R1RCM spoke to the group on 21st Century Cures Act and the front-line with information blocking
3. List of resources
4. Check-list for 21st Century Cures Act
5. Sample Information Blocking Policy

Work-group met goals and dissolved 10.2023

- ❑ **Who's Needed On the Team:** Health Information Management (Medical Records), Privacy/Security & Compliance, Legal, Clinical Informatics, and Information Technology.
- ❑ **What's Step 1:** Review current processes in order to make recommendations for changes and facilitate compliance with 21st Century Cures Act.
- ❑ **Next Step:** Review the complete list of document types within your EHR and determine if you can or will share electronically (based on Exceptions).
- ❑ **Work With Your EHR Vendor:** Make sure you understand how you can electronically and automatically share information with your patients to meet the intent of the 21st Century Cures Act.
- ❑ **Review Policies:** Including but not limited to: Designated Record Set (HIPAA) and Legal Medical Record (be sure there is a definition of Electronic Health Information – HealthIT.gov). Include the exceptions to not share and the definitions in your policy.

<https://www.healthit.gov/topic/information-blocking/understanding-electronic-health-information-ehi>

https://www.healthit.gov/sites/default/files/page2/2021-12/Understanding_EHI.pdf

***You will have changes along the way as you learn more, make sure that you have a means to archive the decisions that you made along the way. Designate an individual to track the decisions.*

- ❑ **Understand Exceptions:** Have a means to indicate in the EHR when an exception is used, what the exception is, and why. Educate the community, clinicians, and other vital affiliates of the entity on the exceptions.
- ❑ **Single Note Holding:** Make sure an individual note can be marked to not share electronically in your EHR. This can be an exception.
- ❑ **Monitor Notes:** Track any notes that are held/not shared to assure all providers understand process and procedure and circumstances. Provide feedback and training if notes that are not shared do not meet allowed exceptions.
- ❑ **Release of Information:** Review how you currently handle requests for Release of Information. Consider your options for things like centralizing, electronic requesting “portals”, and electronic delivery. Remember EHI includes any/all information used in clinical decision making and could sometimes include billing information.
- ❑ **Patient Portal Access:** Review your current policies and procedures for patients requesting access to their Patient Portal (including proxy and minor access).
- ❑ **Review External Applications:** Review any interfaces or internal applications (e.g. digital imaging, cardiac testing) to ensure you are getting all EHI. Is it duplicate data?
- ❑ **Keep Up-To-Date:** Designate someone to monitor 21st Century Cures Act.

[Information Blocking | HealthIT.gov](#) & [HealthIT.gov](#)

21ST CENTURY CURES CHECKLIST

- This is not an all-inclusive list but will get you well on the way
- Staying up to date on requirements, understanding your vendors capabilities and flexibility are key

PURPOSE: To facilitate compliance with the Information Blocking Regulations of the 21st Century Cures Act. To give patients control over their own health information by giving them unimpeded access to their data and records. This is intended to increase their engagement in care, increase safety, and decrease costs. The implementation of this policy will advance interoperability and support the access, exchange, and use of electronic health information.

POLICY: It is the intent of the organization to comply with the 21st Century Cures Act, which prohibits healthcare providers, health information technology (IT), developers, health information networks (HINs) and health information exchanges (HIEs) from impermissible interfering with the access, exchange or use of electronic health information (EHI). The 21 Century Cures Act provides National Institute of Health with the flexibility and resources needed to accomplish its mission to improve the health the health of Americans. The cures act defines practices that constitute information blocking and authorized the Secretary of Health and Human Service to identify reasonable and necessary activities that do not constitute information blocking (referred to as “exceptions”)

PROCEDURE – The sample procedures were pulled directly from Health Information Technology, Evaluation and Quality Center Website –

Disclaimer: Information blocking forms become part of the record and can be reviewed by OIG during an investigation. The HITEQ Center and related entities are not liable for any direct or indirect consequences resulting from information given herein and advises legal counsel review of these and all forms prior to use.

The HITEQ Center project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of awards totaling \$779,625 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

Appendix material can be found at the following link:

[HITEQ Center - Sample Information Blocking policies, procedures, and templates](#)

1. Conduct Initial Information Blocking Risk Assessment (Appendix A) as part of the organizational record, and update annually thereafter.
2. For any organizational practices that appear on the list of suspected practices for [Information Blocking](#) (Appendix A, Section VI).
 - a) Record the exact practice and current workflow, and assess whether any of the [21st Century Cures Act ONC exceptions](#) apply using *Appendix D: Information Blocking Exceptions* and other references.
 - b) For any practices that are reviewed where no exceptions apply, cannot be modified, and is/are necessary, document that the organization does not intend for the practice to result in information blocking.
3. Develop/review policy/ procedure for reviewing/fulfilling requests for information.
 - a) Ensure that process is non-discriminatory and expedient.
 - b) Ensure that electronic and physical information requests are consistent in terms of consent, privacy, and legal requirements.
4. Develop a process for documenting exceptions to requests
 - a) Ensure that process aligns with the eight possible exceptions, noting that five allow for not fulfilling the request while the other three refer to procedures for fulfilling requests.
 - b) Use other HITEQ information blocking process resources, including *Appendix D: information blocking exceptions*
5. Implement documentation for exceptions on a case-by-case basis
6. Develop a process for responding to requests, either where information will be shared and access maintained or where the request will not be fulfilled, and the reason needs to be communicated.
7. Review and adopt information blocking complaint procedures (*Appendix E*)
 - a) Use *Appendix G* as a template for investigation workflow.
 - b) Use *Appendix H* to document the investigation.
8. Document complaints, incidents, and related responses and/ or actions
 - a) Use *Appendix F - Incidence Response Log* to document this.

STANDARDIZING NEWBORN SCREENING REPORTING

Problem: Despite standardized values for Blood Spot, Hearing Test Results and Critical Congenital Heart Disease Results are displayed in a wide variety of ways
Variation is a problem for 1) clinicians who practice in multiple hospitals and 2) efficient and effective health information exchange

Goal: Improve the usability and safety of newborn screening displays that clinicians see in EMRs, by standardizing and reducing variation:

- Blood Spot – Screen for ~60 disorders and the screening is done at the state
- Critical Congenital Heart Disease – Texas law requires screening but not reporting of screening. Requirement is for reporting of confirmed cases
- Hearing – The TEHDI Information System has identifiable data on all newborns born in a hospital. About 1/3 of the hospitals use an IHE technical profile (NANI) to send the information



NEWBORN SCREENING REPORTING

Work Group Members:

- Parkland, UTSW & Children's
- Baylor Scott & White
- PerkinElmer
- Altarum
- Dell Children's
- Texas Children's
- DSHS



Community Contributions:

1. Newborn Screening Reporting being tackled in 3 concept buckets:
 - Data and Reporting Standardization
 - Transmitting data through C-CDAs
 - Using eCR for Critical Congenital Heart Disease
2. eCR holds promise for Critical Congenital Heart Disease by automating capture, standardizing the process and eliminating administrative burden
3. Collaboration with DSHS Birth Defects Registry

Current Projects:

1. Developing CCHD potential trigger elements to share with APHL and State for eCR. Outreach & research underway
2. Exploring adoption of eCR for Newborn Screening reporting beyond CCHD
3. Exploring standardization of reporting within EHRs
4. Exploring inclusion of automated state reporting i.e. blood spots to all clinicians rather than birthing hospital

TELEHEALTH AND PCPS

Problem: 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
- 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

Environmental scanning and exploration continues

Actions underway:

1. Continued contacts with National Telehealth Professional organizations for discussion
2. Met with TCHAT on 11.30.2023 with Dr. Lakey and Dr. Williams. [Texas Child Health Access Through Telemedicine \(TCHAT\) – TCMHCC \(utsystem.edu\)](https://utsystem.edu/tchat) **This group is encouraging electronic notification of the PCP**
3. Engaged Texas Medical Association HIT Committee in the discussion
4. Met with TexLa Telehealth Resource Center housed at Texas Tech on 1.23.2024 with Derrick Ramsey, TexLA providing overview at the May 2024 Collaborative Meeting

DEATH REGISTRY – STATE

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.

Actions Taken:

- Reviewed Texas Government Code 552.115 that guides release of information by the Vital Statistics
- Epic Developers confirmed potential & interest in working with Texas
- Met with CDC/DDPHSS/NCHS/DVS to understand CDC involvement with Death Registry to explore opportunities to standardize nationally. The value of a national effort for death reporting with a feedback loop was acknowledged. This would allow the vendor community to support and provide the standardization needed for all communities to understand the efficacy of treatment with respect to outcomes.
- **Engaged Texas Medical Association HIT Committee in advocacy discussion on updating Texas Government Code 552.115. Positive response and value appreciated.**
- **Engaged Texas Hospital Association in the advocacy discussion on updating Texas Government Code 552.115.**

Interoperability Symposium, June 7, 2024

No cost, virtual platform – everyone invited.

- **Didi Davis**, VP, Informatics, Conformance & Interoperability **The Sequoia Project®** -TEFCA and Data Usability Taking Root Initiative
- **Kathryn Wickenhauser**, Senior Director of Community Strategy, **DirectTrust** – Common Conveyance, Standards and the Directory Integrity Project
- **Liz Johnson**, FCHIME, RN-BC, FAAN, CHCIO, Courtesy of THIA - HT1 Overview
- **Mac McMillan**, CEO Emeritus, **CynergisTek** – Artificial Intelligence, Are you prepared?
- **Lucille Palenapa**, Senior Health Informatics Specialist, Texas Department of State Health Services – eCR Status Update
- **Steve Eichner**, Health IT Policy Director, Texas Department of State Health Services. **HITAC**, co-lead Interoperability Sub-Committee. Office of National Coordinator, Health Information Technology Advisory Committee

THSA COLLABORATIVE CALL TO ACTION

- Join US!
- Adopt our recommendations
- Help us with smiling Clinicians who are receiving trusted information in a timely manner!



THSA COLLABORATIVE 2023 ACHIEVEMENTS

- **Standardizing C-CDA Content:** Discharge Summary C-CDA recommendation adopted by Sequoia Project Data Usability and has moved through the HL7 Structured Documents for a Jan 2024 vote on inclusion with technical standards. Group is currently working on recommending standardizing laboratory result data.
- **Direct Message Adoption:** CMS requires hospitals to notify patient identified PCPs. CMS data requirements are minimal resulting with in-actionable data. Work-group is educating and encouraging adoption of DirectTrust ADT standard that allows messages to be routed based on context to relieve pressure on PCP and allow all to work at the top of their license.
- **National Network Adoption / Public Health Reporting:** Encouraging adoption of National Networks & eCR continues. Researching barriers to adoption of national networks.
- **21st Century Cures:** Developed & shared with the community: Preparedness Checklist, Sample Information Blocking Policy, Alert to the community of suspect behavior and information resources.
- **Immunization Registry / IMMTRAC2:** Collaboration to resolve issues, remove barriers and improve communication for bi-direction immunization registry. Primer developed by Grand Canyon Student on capturing patient names and shared with community.
- **Standardizing Newborn Screening Reporting:** Working with CDC and Vital Statistics to leverage eCR for standardized electronic capture of Congenital Critical Heart Defects(CCHD). Developed DRAFT CCHD display with community vetting underway.
- **Telehealth & Sharing Information:** Stakeholders communicated that PCPs are not receiving notifications. Contacting telehealth organizations to discuss the value of sharing clinical information both for the telehealth provider and the PCP. Engaged Texas Medical Association HIT Committee for participation.
- **Death Registry - Real time data:** Goal is to eliminate inappropriate and unnecessary contact with a decedent's family, minimize cost and to increase ability to evaluate clinical impact of programs. Engaged Texas Medical Association HIT Committee for participation.

CONTACT INFORMATION

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