Mass Health Data Consortium
Annual Update

Sept 8, 2021
Welcome

Attestation update

ENS Framework

Consolidated Clinical Gateway & AWS update

E-POLST Project

Strategic Planning Update

Future of public health reporting

Conclusion
• As the state-sponsored, statewide health information exchange (HIE) for Massachusetts, the **Mass HIway will continue its mission to enable health information exchange by all providers in the Commonwealth regardless of affiliation, location, or differences in technology.**

• The Mass HIway has been, and will continue to be, designed through an open and inclusive planning and decision-making process. M.G.L. Chapter 118I designated a multi-stakeholder **Health Information Technology Council (HIT Council)** which provides input and advice regarding the Mass HIway directly to the EOHHS Secretary.

• Additionally, a new **Digital Health Information Exchange Taskforce** has been established. The purpose of the taskforce is to align the Mass HIway, MassHealth and EOHHS Partner agencies to further cross-agency coordination and enable digital transformation to meet strategic goals and promote health IT policies and initiatives through open, transparent and accountable processes.
The 2021 attestation window is condensed due to extended 2020 deadline; the 2021 forms went live on August 2, 2021 and are due October 31, 2021.

2021 attestation:

- Because the 2020 attestation deadline was extended due to COVID-19, there is a shorter turnaround for 2021 attestation.
- The 2021 attestation forms went live on the HIway’s website on August 2, 2021.
- This year, the submission deadline is Oct. 31.
- Provider Organizations (POs) are attesting to calendar year 2020 use cases.
- As with 2020 attestation, 2021 attestation features three forms:
  - Year 3/4 form (medium/large medical ambulatory practices, small/large community health centers)
  - Year 5 form (acute care hospitals): hospitals will attest to ADT submission
  - HIE Exception Form (POs that did not meet connection requirement)
Attestation 2021 timeline:

- **Dec. 31, 2020:** Use case implementation deadline for 2021 attestation
- **May-July 2021:** HIway outreach and education regarding 2021 connection requirement and attestation process leading up to webform launch (email outreach, updated website material, webinars, direct PO contact)
- **July:** HIway attestation webform testing
- **August:** HIway attestation/exception webforms go live and start accepting submissions
- **Oct. 31:** Deadline for attestation/exception submissions
- **November:** HIway reaches out to POs that have not submitted
- **Winter 2022:** When it seems that submissions have stopped, HIway closes webform

The annual attestation webforms are live for all provider organizations to submit their attestation information.
The Mass HIway has added DirectTrust HISP-to-HISP exchange to meet the HIway connection requirement through sub-regulatory guidance.

**Background**

- Mass HIway converted to HIway 2.0 (a HISP) in order to connect to DirectTrust, a national framework for Direct Message
- During our last meeting, the Council was supportive of DirectTrust HISP-to-HISP Direct Message exchange as it leverages existing infrastructure

**Technical advantage**

- DirectTrust replaces 1:1 contracting for security/privacy and replaces it with a common agreement for security/privacy for HISP users and DirectTrust users
- A user of a DirectTrust HISP can securely send messages to a user of any other DirectTrust HISP without any additional contracting

**Business advantage**

- Providers will have additional opportunities to meet the connection requirement with DirectTrust Direct Messaging
- Providers may use EHR-native Direct Message capabilities instead adding an extra connection to the HIway Direct Message System
Statewide ENS Framework
EOHHS ENS Initiative goal:
• Supporting timely statewide Event Notification Services (ENS) across the Commonwealth in order to improve health care delivery, quality, and coordination

EOHHS guiding principles:
• Universal access - Promoting data sharing within an ENS framework to increase accessibility to ENS for providers of all sizes
• Streamline provider experience - Crafting ENS framework to allow single point of submission and single point of reception of ADT data
• Improve notification timing - Improving timing for flow of data (real/near-real time)
The Statewide ENS Framework was implemented in April 2021

Design
- Regulatory
- RFA

Development
- Certification
- Connecting

Implementation
- Go Live
ADT-Based Care Collaboration Network

CollectiveMedical offers a cost-effective solution that ensures hospitals, psychiatric hospitals, and critical access hospitals are completely compliant, without the need for any additional intermediary service providers.

CollectiveMedical combines data from sources spanning the care continuum, including ADT, continuity of care documents (CCD), claims data, prescription drug histories (PDMP/PMP), imaging, and more, to give insights into patients’ activities.

CollectiveMedical also supports the CMS-9115-F ADT alert requirements.

To visit website, click here.
Advanced E-Notifications System

PatientPing delivers real-time notifications whenever your patients experience care events, whether they are at a hospital, ED, or post-acute (SNF, LTACH, HHA, IRF, hospice)

Pings (alerts) allow you to scale how you manage your patient populations. Pings can be embedded within your existing workflow systems or used natively through our web and mobile user experience

PatientPing also supports the CMS-9115-F ADT alert requirements

To visit website, click here
ENS: Next steps

Attestation

• Acute care hospitals will attest to ADT submission through the annual connection requirement attestation process

Long-term items to explore

• **Increase ENS access** – Assess other entities’ access to the Statewide ENS Framework as either submitters or receivers.
• **Expand ADT use cases** – Review other use cases related to ADTs
  • Ex. Bed finding/bed availability
• **# of vendors** – After stabilization, explore expanding the number of vendors participating in the ENS Framework
Consolidated Clinical Gateway & AWS update
We successfully migrated the Clinical Gateway nodes to the AWS cloud!

Consolidated Clinical Gateway High Level Architecture

CCG Phase 1:
- Live Dates
  - MCR 3/22/21
  - CBHI 3/24/21
  - CLPPP 3/27/21
  - Syndromic 4/1/21

CCG Phase 2:
- Live Dates
  - ELR 5/22/21
  - IEATS 5/26/21
  - MIIS 5/29/21
With the Direct Standards almost 10+ years old the Mass HIway team is researching the Application Programming Interface services that can be developed for the Provider community message transport. The HIway team sees the growth of these services in the overall health information exchange industry and those services applicability to the Clinical Gateway Nodes.

Some of the benefits and features this project include:

• Provide synchronous response services to increase query responses time

• Provide foundation for FHIR transported over Restful APIs

• APIs will be able to support the growth of messages traversing to the CG nodes

• Restful and SOAP services will be built, with a preference for Restful services

• A Clinical Gateway API is already in place with MIIS CDC WSDLs
ePOLST update
ePOLST: Design timeline

~2 Months
Assess the Current State & Conduct Stakeholder Engagement
- Conduct interviews and focus groups
- Conduct benchmarking against e-registries in other states
- Prepare a Current State Assessment presentation

~2 Months
Prepare a Future State Blueprint
- Draft a future state blueprint
- Develop IT system technical and functional requirements

~5-6 Months
Draft RFP and Provide Procurement Support
- Draft RFP
- Support bidders’ Q&A and any presentations or follow-up
- Draft recommendation memo
- Provide bidder selection support
ePOLST assessment: Interviews and focus groups

MA State Government
• EOEAA
• EOHHS
• DPH OEMS
• MeHI

MA Process Owners
• Coalition for Serious Illness Care
• HPCFM
• Honoring Choices
• Beth Israel Deaconess
• Ariadne Labs
• Massachusetts Hospital Association

Benchmarking States
• Oregon Center for Ethics in Health Care
• Maine POLST
• NY MOLST

Additional Subject Matter Experts
• National POLST
• UMass Boston
• Reliant Medical Group Physician Group
• Archdiocese of Boston

14 Focus Groups representing 5 care settings:
Hospitals, PCP, SNF, Hospices, and EMS (128 participants)

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<th>Day</th>
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ePOLST assessment: Stakeholder feedback paradigm

People

Technology  Process
ePOLST assessment: Stakeholder feedback on people

- **MOLST is just one component in a multi-party, long-term relationship**
  - Physician-patient; Goals of Care focus
  - Social workers, nurses, aides, EMT/paramedics
  - Patient relatives, agents, guardians

- **Goals of care conversations difficult to conduct**
  - Clinicians typically not trained in these topics
  - Patients have little background on MOLST (or any end-of-life-related topic) → cultural challenge
  - PCPs have very limited time

- **Current approach challenging for all stakeholders, particularly EMS**
  - Form issues
  - Issues related to honoring the form

- **Process**
  - “Often, it is the social worker who is having the conversation and filling out the form.”
  - “It is not only about talking to the patient, but also about talking to the family, proxy, guardian...”

- **Technology**
  - “The MOLST conversation takes years to master.”
  - “The public and clinicians need to be educated so patients and families understand the form.”
  - “Goals of Care conversations cannot be conducted as part of an annual; we don’t have time.”

- **People**
  - “Our frustration is with incomplete forms or not having the form readily available.”
  - “Sometimes families do not understand the form and tells us to revoke it.”

Source: Stakeholder Focus Groups
ePOLST assessment: Stakeholder feedback on process

- **Current process 100% paper-based and manual**
  - Patient wishes not honored accurately, consistently

- **Current process does not result in trustworthy forms**

- **Care setting workflows around MOLST are inconsistent**

- **Lack of alignment with National POLST**

- **Current process does not fully support health equity**
  - Languages
  - Level of literacy

- “I still cannot believe that most MOLST forms exist on an 11x8.5 piece of paper…”

- “We have a ton of patients with 10 MOLST forms.”

- “What constitutes a complete MOLST form varies from care setting to care setting.”

- “We would love to be aligned with the National Form.”

- “It’s very hard to explain the MOLST form with its current wording, patients do not understand it… The words scare them…”

Source: Stakeholder Focus Groups
ePOLST assessment: Stakeholder feedback on technology

- Some interoperability with EMRs
- No form validation capability
- No audit or update capability
- No reporting capability
- No interoperability with ambulance systems
- No interoperability across care settings
- No transferability state-to-state

Source: Stakeholder Focus Groups

- “The new registry has to be interoperable with our EMR systems... we need one source of truth...”
- “We try to manually check our forms... it’s not perfect.”
- “We have the ability to upload MOLST forms into our EMR but we don’t because we are concerned about version control.”
- “We would love to leverage MOLST data if it was available. It would also be helpful for comparison purposes, across states and within states.”
- “The MOLST form has to be transferable across states and health care settings.”
ePOLST blueprint: Current state
MOLST process

- Conduct (multiple) goals of care
  Clinician / Social Worker

- Complete MOLST form and sign (or verbal consent)
  Clinician / Patient / Proxy

- Manually validate form
  Admin Staff

- Add form to patient chart and/or upload to EMR
  Admin Staff

- Retrieve MOLST as needed
  Provider / Patient

- Details of conversations are generally not captured

- The definition of a valid form varies from setting to setting

- In some cases, hospitals still write a corresponding medical order

- Forms are not validated consistently

- In most settings, version control issues lead to lack of trust in the form

- Patients may have numerous MOLST forms
ePOLST blueprint: Future state ePOLST process

Electronically capture goals of care conversation, create and submit POLST form

Clinician / Patient

Automatically validate form

System/Admin Staff

Valid Form?

Yes

Retrieve from electronically as needed

Provider / Patient

No

Review form and fix issues

Clinician

• Including multiple input methods (e.g., fax, e-mail)

• Ability to flag whether a healthcare proxy is present and activated

• Interoperability with EMR

• Portal access for all users (patient, proxy, provider, etc.)
ePOLST blueprint: Future state ePOLST system map

POLST Signors
- Hospitals
- Hospices
- Skilled Nursing
- PCP
- Assisted Living

Cloud Based POLST eRegistry

Automatic Validation

System Interoperability
- EHR / EMR
- RVRS Death Records
- EMS / MATRIS

POLST Users
- EMS
- Patient / Family / Proxy
ePOLST: Next steps

- Draft RFR (incl. business requirements)
- Secure CMS approval
- Post RFR on Commbuys
- Award contract
Mass HIway Strategic Planning
• Predicated on the idea that HIE services and programs are necessary to support care quality and care coordination, the Mass HIway has been broadly supported and subsidized by dedicated public funds from Massachusetts and the Federal Government.
• However, recognizing that state and federal government do not have the ability to maintain the current financial burden, the management and continued renewal of the Mass HIway infrastructure will require an evaluation and alignment of services and programs and a new financial model which is equitable and leverages both public and private funding.
• The Mass HIway is evaluating and establishing strategies which will build consensus and commitments for services and programs and a sustainable financial model for the Mass HIway, drawing support from the stakeholders who benefit from it as well as from the State, which recognizes the critical role it plays.
Federal funding through the **ARRA HITECH Act will be ending on September 30, 2021**. Primary funding for Mass HIway HIE services and programs will shift from HITECH to activities covered under the Medicaid Enterprise Systems (MES).

This shift will include reduced Federal Financial Participation (FFP) rates and a change in cost allocation **reducing the federal match** from 86% to 14%.

The combined effect results in a **significant revenue** gap for the Mass HIway in SFY22 and beyond.

The HIway Direct Messaging services and supports are **not sustainable** with the current cost model and reduction of federal revenues that had provided high subsidy levels.

**EOHHS is developing strategies to manage the impact of the federal revenue loss to ensure existing and future health IT investments can be sustained.**
Federal revenue reduction: Mitigation Strategies

To programatically **manage the impacts of the federal reduction**, the HIway will execute on the following 3 **strategies** **over a multi-year timeline**

### Strategy 1
**Evaluate Direct Messaging Services**
- Evaluate options and set strategy immediately for a transition of the HIway Direct Messaging System by SFY24

### Strategy 2
**Accelerate Clinical Gateway Development**
- Fast track planned API development to enable provider alternatives for public health exchanges by SFY23

### Strategy 3
**Reduce Program Outreach Activity**
- Reduce near-term Program & Outreach activities immediately (Oct 21) with potential to restore activity in SFY24
Federal revenue reduction: Mitigation Strategies

Subsidization of HIway Direct Messaging System is unsustainable long-term due to the reduction in federal revenues for HIT

Strategy 1: The Mass HIway is evaluating options for the future of HIway Direct Messaging Services

Option 1: Develop Sustainability Plan
- Vendor contract negotiations
- Explore new agency contributions, funding streams and participant growth
- Evaluate feasibility of participant fee increase (~2-3x)
- Build stakeholder consensus and commitment

Option 2: Retire DM Services
- Transition to viable market alternatives for HISP-DM services
- Promote DirectTrust as interoperability solution
- Establish 2 year glide path for providers to transition
- Update policy and regulations

Sep 2021

Finalize DM Strategy
Planning & Communication
Policy Alignment
Transition Activity Support
## Utilization Perspectives
- Groups are using HIway DM because it is required, easy, and affordable.
- HIway DM is heavily integrated into quality reporting and clinical workflows.
- Changing DM service would cause significant disruption and have an adverse impact on providers.
- Use of HIway DM affords provider groups the agility to manage unique HIE scenarios.

## Rate Increase Reaction
- Strong reaction, some shock to potential cost increase.
- Groups may be receptive and able to tolerate an increase of **1.5-2x**, but not **7-10x**.
- Multiple groups have or would consider Surescripts as an alternative HISP for provider-to-provider exchanges.
- Comparable HISP-DM costs need to be quantified and compared to potential rate increase.

## Provider Comments
- “DM has become a utility type service that is important for all and should be subsidized.”
- “We are using it for certain exchanges because of regulations.”
- “If DM is a vital tool for Interoperability goals and objectives, then investments needed.”
- “Need to consider impact to smaller provider groups, ensure there is planning and communication to minimize disruption and support transition.”

## Next Steps
- Soliciting stakeholder feedback to address CMS and State funding, other funding options, participant expansion and vendor contract renegotiations.
- Mass HIway to convene round-table discussions to build consensus and commitment on rate increase and/or transition planning.
Timeline

**SFY22**
- Jul ‘21: Begin CCG API development (Existing part of AWS Migration)
- **Aug ’21: Strategic Planning & Stakeholder Engagement**
- Oct ‘21: HITECH Act funding ends
  - Activity reductions (including outreach)
- Oct ‘21: Announce HIway Direct Messaging *Strategy*
  - Activities focus on dev-ops and transition work

**SFY23**
- Jan ‘22: Regulatory amendments to conform with state technology changes
- Jul ‘22: API pathways to CCG live
  - Providers to begin transition to CCG APIs pathways

**SFY24**
- Sep ‘23: HIway Direct Messaging *transition* complete (~24 months lead time)
- Oct ‘23: Programmatic work expands
  - Restore outreach via technology *transition* savings
Future of Public Health Reporting
The HIway recognizes the industry will be moving to the new federal interoperability standards

- Recent regulations and FHIR accelerators are removing barriers to clinical data & creating demand through Value-Based Care
- The Mass HIway can position itself to capitalize on these trends and become aligned with leading FHIR interoperability platforms

**Regulations**

Starting in March 2020 and extending through 2023, ONC & CMS Regulations to prevent information blocking, mandate FHIR APIs for providers and payers and to empower consumers as data owners

**FHIR Momentum**

Since 2010, FHIR standards have matured. Industry is now coalescing around HL7 FHIR standard with adoption accelerating

Mass HIway April 2021 Survey indicates 70% of respondents are interested in a FHIR API to the Clinical Gateway for Public Health Reporting

**Shift to Value-Based Care**

Since 2008, there has been an ongoing shift from FFS to VBC, which incentivizes stakeholders to share more data to improve outcomes and lower costs
HL7 FHIR & API Standards

HL7 FHIR
- Defines resources (e.g., allergy info) and APIs to access them
- Resources can be bundled into documents/messages
- Logically compatible with HL7 v2 and C-CDAs
- Enables app integration using SMART on FHIR standard

API Standards
- Robust information exchange for many purposes
- Built on Web technology, security, and communities
Primary review of HIE information sources were combined with secondary HIE surveys to give an approximation of FHIR capabilities in the HIE market.
FHIR API: Mass HIway Options

FHIR API initiative

FHIR API to Clinical Gateway

- Moderate Value & Moderate Complexity / Effort
- FHIR API is component of new CG gateway architecture
- Message transformation to/from back-end registry systems

Technical components (ex. Amazon Web Services, Rhapsody engine) of the Clinical Gateway Nodes could be leveraged for other FHIR API initiatives

Potential FHIR API options for Mass HIway to explore

FHIR API to Provider Directory

- Higher Value & Lower Complexity / Effort
- Potential alignment-support for CMS-ONC requirements
- Development of API capability is a component Mass HIway - Orion contract

FHIR Exchange / Routing Services

- Undefined Value & Higher Complexity / Effort
- Potential alignment with ONC FAST initiative and efforts
- Assess Mass HIway technology capability gaps

HL7-FHIR Broker / Message Transformation

- Undefined Value & Higher Complexity / Effort
- Potentially leverage new technical capabilities gained from CCG FHIR transformation services
- Need to identify interested organizations and use cases
Gather and consolidate stakeholder feedback related to FHIR API services and use cases

Identify interested providers and organizations and use cases for

1. FHIR API access to Consolidated Clinical Gateway (CCG)
2. FHIR API access to Provider Directory

Complete FHIR API solution scoping and scaling options and assess Mass HIway technology and capability gaps

Develop framework of options and opportunities to align proposed FHIR API solution(s) with the CMS & ONC requirements on regulated entities
Q15: Do you have any interest in a Fast Healthcare Interoperability Resources (FHIR) API to the Mass HIway Clinical Gateway (Public Health reporting)?

**Questions from targeted Mass HIway April 2021 PD & FHIR API Survey**

Q16: If yes, which Clinical Gateway node would you be interested in?

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<thead>
<tr>
<th>Clinical Gateway Node</th>
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<tr>
<td>MIIS – Massachusetts Immunization Information System</td>
<td>100.00%</td>
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<td>Syndromic – Syndromic Surveillance Program</td>
<td>81.82%</td>
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<tr>
<td>ELR – Electronic Lab Reporting</td>
<td>54.55%</td>
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<tr>
<td>CLPPP – Childhood Lead Poison Prevention Program</td>
<td>27.27%</td>
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<td>MCR – Massachusetts Cancer Registry</td>
<td>18.18%</td>
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<td>I-EATS – Includes the Opioid Treatment and TB Reporting Programs</td>
<td>9.09%</td>
</tr>
<tr>
<td>CBHI – Children’s Behavioral Health Initiative</td>
<td>9.09%</td>
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**QUICK STAT:** In Massachusetts, the top EHR vendors in the state have FHIR API capability and represent approximately 85% of the provider market and 100% of the hospital EHR market in the state.
The Clinical Gateway API and FHIR Integration project will implement and maintain secure, standards-based APIs with FHIR integration by redesigning the current state architecture and data systems and revising business and technical processes and related support efforts.

The intent of this project is to develop a foundation for a common API infrastructure that can be used for multiple public health use cases instead of establishing multiple ‘purpose-built solutions’, each with their own unique infrastructure.

Where possible, the effort will align with the industry API infrastructure work being developed for activities beyond public health, so that public health needs, service delivery and costs can be optimized.
Develop Application Programming Interface (API) and FHIR Integration to the Clinical Gateway as a foundation for public health reporting initiatives

Key project objectives:

- Build an alternative pathway to current Direct Messaging reporting
- Maintain processing and routing of existing registry messages (HL7 & Other Payloads)
- Create an environment to enable providers to send and receive messages in real time (Synchronous method)
- Add support for multiple channels to send and receive data (RESTFUL Web Services and SOAP Services)
- Implement FHIR integration and authentication protocols to support enhanced security and business functionality
- Publish specifications for the provider and developer community
Consolidate Clinical Gateway High Level Architecture

Future State
- Web service (New)
  - Synchronous
  - SOAP / REST API
  - HL7 / FHIR / Other Payload
- Direct (Orion Communicate)
  - Asynchronous
  - XDR / SMIME
  - HL7 / Other Payload

Current State
- Gateway

AWS
- Consolidated Clinical Gateway (Shared Rhapsody Instances)
  - CBHI
  - CLPPP
  - SYNDROMIC
  - MCR
  - IEATS
  - ELR
  - MIIS
  - Other

Application backend
- MCR
- CLPPP
- CDC (BioSense)
- MIIS
- ELR
- CBHI
- EIM/ESM
1. Providers will send HL7 message using REST/SOAP or FHIR bundle using REST service to the Gateway URL
2. Gateway will setup the REST/SOAP endpoints and accept the REST or SOAP calls
3. Gateway will authenticate by username & password using AIMS. OAuth will replace AIMS for FHIR-REST APIs once evaluated and developed
4. Once the authentication is complete, Gateway will route messages to the specific CG Node
5. CG node will perform validations and send message to Backend Application
6. If HL7 FHIR, will validate the FHIR message
7. If necessary, will convert the FHIR bundle resource to a HL7 or whichever format backend application expects
8. Backend application will send the response to the providers
CCG API & FHIR Development Timeline

Sep 2021

Architecture and Design

• Complete Architecture & Design
• Build Proof of Concept (POC) for the APIs

Sep 2021 - Dec 2021

API Development & Deployment

• Develop the REST & SOAP APIs
• Publish API Specifications
• Deploy changes (Live)

Jan 2022 – Jun 2023

FHIR Development & Onboarding

• Develop FHIR Integration
• Authentication Protocols
• Onboarding to APIs

Sep 2023

Transition from Direct Messaging

• Complete Transitions from Direct Messaging