

eLTSS Testing at HL7 Connectathon 25

Initial Report Out







Agenda

- 1. Purpose of eLTSS Testing
- 2. PACIO-eLTSS Track Use Case
- 3. Pacio-eLTSS Testing Architecture
- 4. Scene 1
- 5. Scene 2
- 6. Scene 3
- 7. Scene 4
- 8. Scene 5
- 9. Outcomes
- 10. Lessons Learned
- 11. Acknowledgements



Purpose of eLTSS Testing

- Implement and test the eLTSS FHIR IG within a variety of independently developed systems
- Integrate the eLTSS IG with a production case management system and share data from that system with an independent server
- Utilize the eLTSS IG in conjunction with other FHIR IGs to support the aggregation of data
- Exchange eLTSS care plans among disparate health IT (HIT) systems and clients, and display care plans in a consumable format for care providers, beneficiaries, and family members
- Dynamically update eLTSS Care Plan data and share that update among systems



PACIO-eLTSS Use Case

SCENE 1: Home with LTSS	SCENE 2: Hospital	SCENE 3: SNF	SCENE 4: Home with HHA	SCENE 5: Patient and Family Access
Day 1 (7/6/20): Betsy is at home receiving LTSS. SW assesses her and documents Care Plan, Goals into in the CM EHR on 7/6/ 2020 at 1300. Betsy is functionally independent without the use of assistive devices. Day 2 (7/7/20): Betsy experiences an acute onset of right sided weakness (with drift), facial palsy (partial paralysis of lower face), blurry vision with mild aphasia and dysarthria. She calls 911 for help and an ambulance transports her to the hospital.	 Day 2 (7/7/20): Hospital admits Betsy at 1500. Upon assessment by the Neurologist, Betsy is found to have an occlusion of the L MCA. MD documents ischemic stroke and a list of current medications on 7/7/20 at 1532. The care team decides to follow conservative management, since too much time has elapsed to effectively administer TPA. Day 3 (7/8/20): PAC assessments are pulled from Pseudo DEL for PT and OT to complete (1) functional assessments at 1600 and (2) SLP to complete MMSE and MoCA 1732. Day 4 (7/9/20): Betsy's condition significantly worsens resulting in complete right sided paralysis, worsening dysarthria and dysphagia. The care team decides to perform a mechanical thrombectomy. Betsy's condition improves after the thrombectomy with right sided weakness improving as well as the dysarthria and dysphagia. Day 6 (7/10/20): PAC assessments are pulled from Pseudo DEL for (1) SLP to complete MOCA and MMSE at 1216 and (2) functional assessments at 1434. PT, OT and SLP recommend rehab in a SNF. Day 7 (7/11/20): MD updates medication list on day of discharge at 7/11/20 OS42 by MD. Hospital discharges Betsy to SNF soon after. 	 Day 7 (7/11/20): SNF admits Betsy to the SNF at 1130. PT/SLP complete a medication review and assessments (Nursing Comprehensive on the MDS) by 1632. Day 8 (7/12/20):OT completes assessments (Nursing Comprehensive on the MDS) at 1115 Day 9-26 (7/13/20 -7/30/20): During the SNF admission, Betsy's condition continues to improve. Day 27 (8/1/20): PT/SLP complete the MDS discharge assessment, which shows improvement in function and cognition. However, Betsy requires home health services and a continuation of her home and community based services as she returns to her baseline function/cognition. SNF discharges Betsy to home. 	Day 27 (8/1/20): Betsy is now at home receiving both HHA and HCBS. The HHA admission nurse is able to view the patients transition summary to inform patients care and set therapy goals. Day 28 (8/2/20): PT assesses Betsy and completes the admission OASIS assessment (includes FASI information).	Day 1-28: Betsy shares her medical record with her adult son and daughter who are able to view her information at any point. Additionally Betsy is able to use the mobile app to inform her daily activities.
Social Worker Social Worker Social Worker enters LTSS Care Plan & goals CM EHR	Multi-D team conducts assessments Multidisciplinary team Multidisciplinary team Multidisciplinary team Multidisciplinary team MD enters diagnosis and discharge medications SLP enters cognitive assessments PT/OT enters functional assessments	Multi-D team conducts assessments Multidisciplinary team SLP enters cognitive assessments FT/OT enters functional Assessments	RN validates Information from Transition Summary and Care Plan Patient Patient FASI information Documented RN views Transition Summary	Patient Patient Patient reviews Core Plan Potient reviews Core Plan Mobile App

HHA EHR



PACIO-eLTSS Track Testing Architecture





Scene 1 FEI Blue Compass Data Entry

Ms. Betsy Smith Johnson receives home community-based services (HCBS) services at home. A social worker documents eLTSS data, including care plan and goals in FEI's Blue Compass Mississippi system.

LTSSMississippi - Local	Anconymous User (On behait of: DOM Admin, Jyoth) Organization Unit: Missessiepi Dirition of Medicael					Message Center (?)	Menu	Account
G Home At People I≣ My Lists	Alerts 💵 Assignments 🖾 Reports 🗄 Program Wartist 📴 Person's	Details						
Betsy Smith-Johnson	Person's Profile Overview							
 Age: 69 ID: 123456ABC DOB: 11/01/1959 							F	Expand All
* Person's Profile	Degracantation				Vere			-
Profile Overview	>							
Personal Summary	Representative				Edit Deleto			
Attachments	Full Name.	Charles Johnson	Current Durable Power of	No				
Medicaid Source Info	Relationship	Child/Step Child	Alterney Centact					
	Primary Phone	(210) 222-3333	Current Case Manager or Service Coordinator Contact	No				
 Case management 	Address.	100 Montana St, San Antonio, TX	Current Physician	No				
Screening and Assessment	Compared Server	75203	Current Emergency Contact	Yes				
A Annalizations	Guardian of Presenter	No.						
* Applications	Serionale	No						
Programs	Current Representative	Pavee No						
+ B2I	Current Power of Attorn Contact:	ey No O						
	Representative				Edit Delete			
Offline Forms	Fut Name	Debra Johnson	Current Darable Prever of	No				
	Relationship	Child/Step Child	Attornoy Centact					
	Primary Phone	(410) 444-6555	Current Case Manager or	No				
	Address	333 W Camden St, Baltimore,	Current Physician	No				
		MD 21201	Current Enversance Contact	No				
	Guardian of Person	No	and an an a group and an					
	Guardan di Piopeny.	NO NO						
	Current Pervacantative	Davier No						
	Current Power of Atom Contect	ey No O						
	Advanced Dire	ctives			Edit			
	Lock In Code				Vew			
3.4 =	Goals		المراجع والمستعدية		Manage			
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2278.3 ×1								



Scene 1 FEI Blue Compass Data Transmission Using the eLTSS IG

• FEI pushed Betsy's eLTSS care plan through their FHIR façade infrastructure





Scene 1 Data from a case management system is received by a FHIR server

Betsy's care plan bundle is posted on Altarum's Care Coordinator Server





Scene 1 The transferred care plan can now be viewed on the FHIR server

Altarum's portal displays the care plan sent by FEI Systems

📥 ALTARUM	✓ Patient: 1	> Patient: 1
ඬ Home	Name: Betsy Smith-Johnson ID: clients-b579880c-ad30-429f-947f-7ded6f674f19	> Related Person: 1
Q. Search	Phone: 210-222-1111 Phone: betsy.johnson@woohoo.com	
Server Viewer	Gender: female Birthdate: 1950-11-01	
🕄 Broker	Address: 111 Maple Ct, San Antonio, Texas, 78212 Link: https://fhirconnect.altarum.org/hapi-fhir-jpaserver-eltss-CC/fhir/Patient/clients-b579880c-	
Profiles	ad30-4291-9471-7ded6/674119	
Admin	> Goal: 1	
	> Contract: 1	
	> Observation: 2	
	> ServiceRequest: 2	
	> RiskAssessment: 1	
	> RelatedPerson: 1	
	> Practitioner: 1	
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Scene 1 A data transfer tool is used to move a complete eLTSS data collection to another server

Altarum's eLTSS data tool was used to efficiently move a complete collection of eLTSS data to Patient Centric Solutions' data hub

/ ALTARUM	🤙 FHIR VUHR			Admin
 ☑ Home Q. Search ☑ Server Viewer ☑ Broker 	Profile: eLTSS Profile Source: eLTSS CC Target: DATA HUB	Sec Ad	arch ID: patientBSJ1 tions: Search Ocar Thirmson ba	54%
 Profiles Admin 	Type \$	Count 🖨	Profile	
<		II whove.com is sharing your screen. Stop sharing	Hide	



Scene 2 Clinical and assessment data are aggregated with eLTSS data in the data hub

Betsy's clinical data was imported to the data hub from a pseudo HIE, and her assessment data was added from the MITRE PAC assessment app. This data was successfully aggregated with the eLTSS data on the hub and displayed in Patient Centric Solutions Transitions of Care app.

Transitions	of Ca	re						HOME CONT	ACT US LC	GOUT
Patient Demographics	08/02/	2020 Mobili	ty – Admission Perf	formance Sk	y Harbor Home Hea	Ith Services	8810 Old S Antonio, TX	ky Harbor, San (78242	Luna Baskins, Physiotherapi	st
Medications	08/30/	2020 Mobili	ty - Discharge Perf	ormance Sk	y Harbor Home Hea	lth Services	8810 Old S Antonio, T	ky Harbor, San (78242	Scott Dumble Physiotherapi	, st
Allergies	Question	07/08/2020 San Antonio General Hospital Mobility – Admission Performance	07/08/2020 San Antonio General Hospital Mobility – Discharge Goal	07/10/2020 San Antonio General Hospital Mobility – Discharge Performance	07/11/2020 Happy Nursing Facility Mobility – Admission Performance	07/11/2020 Happy Nursing Facility Mobility - Discharge Goal	08/01/2020 Happy Nursing Facility Mobility – Discharge Performance	08/02/2020 Sky Harbor Home Health Services Mobility – Admission Performance	08/30/2020 Sky Harbor Home Health Services Mobility – Discharge Performance	Trend
Vital Signs	Roll left and right	Substantial/maximal Assist	Partial/moderate Assist	Partial/moderate Assist	Partial/moderate Assist	Supervision or touching assistance	Supervision or touching assistance	Supervision or touching assistance	Independent	
Conditions	Sit to lying	Substantial/maximal Assist	Partial/moderate Assist	Partial/moderate Assist	Partial/moderate Assist	Setup or clean-up assistance	Setup or clean-up assistance	Setup or clean-up assistance	Independent	
Lab Results	Lying to sitting on side of bed	Substantial/maximal Assist	Partial/moderate Assist	Partial/moderate Assist	Partial/moderate Assist	Setup or clean-up assistance	Setup or clean-up assistance	Setup or clean-up assistance	Independent	
Assessments	Sit to stand	Substantial/maximal Assist	Partial/moderate Assist	Partial/moderate Assist	Partial/moderate Assist	Supervision or touching assistance	Supervision or touching assistance	Supervision or touching assistance	Independent	
Care Plan	Chair/bed- to-chair transfer	Dependent	Substantial/maximal Assist	Substantial/maximal Assist	Substantial/maximal Assist	Partial/moderate Assist	Partial/moderate assistance	Partial/moderate assistance	Independent	
	Toilet transfer	Not attempted due to medical condition or safety concerns	Substantial/maximal Assist	Substantial/maximal Assist	Substantial/maximal Assist	Partial/moderate Assist	Partial/moderate assistance	Partial/moderate assistance	Independent	
Patient Centric Solutions, Inc $@$ 2019	Car	Not attempted due to medical condition	Dependent	Not attempted due to medical condition	Not attempted due to medical condition	Partial/moderate	Partial/moderate	Partial/moderate	Supervision or touching	



Scene 3 A client displays the care plan

Betsy is admitted to the SNF. From the SNF, a clinician used the Transitions of Care client, by Patient Centric Solutions, to access both clinical data and the eLTSS care plan from the hub to inform care.

Transitions	of Care									HO	ME CONTACT U	S LC	GOUT
Patient Demographics	Author:Mark PlannerFundingTexas DepartSource:7430 Louis P	, phone: (22 ment of Co asteur Dr, S	10) 555 1221 mmunity Hea an Antonio, 1	llth FX 78229									
Medications	Strengths: Description												
Allergies	Independent walking with cane.												
Immunizations	Description Accessing the ICWP Waiver for her	current servic	e needs, and wo	ould like to	remain on	ICWP and continue	e with her cu	rrent serv	ices.				
Vital Signs	Goals: Description	Lifecycle Sta	tus Plan										
Conditions	Improve balance skills Dance at son's upcoming wedding	Accepted Accepted	Perform ex Work on m	ercises to i obility to d	mprove bal ance at son	ance skills 's upcoming wedd	ling						
Lab Results	Description Needs transportation		Clinical Status Active	Verificatio	n Status C	ategories ssessed Need							
Assessments	Needs health / nutrition education Depression (on treatment) Needs physical exercises	for diabetes	Active Active Active	Confirmed Confirmed	A Li A	ssessed Need ssessed Need ssessed Need							
Care Plan	Activities:							Cost		Total			
	Description Bath tub wall rail, each			Intent	Start Date	End Date	Frequency	per Unit	# Units	cost per service	Performer	Location	Status
Patient Centric Solutions, Inc © 2019	(self-directed) Non-emergency transportation; en (Service provider will provide a ren the trip, and will call when an theo	counter/trip hinder the bus	iness day befor	e Plan	07/01/20	20 12/31/2020 20 12/31/2020	2 trips per 1 month	60	10	600	The Transporter, Inc., phone: (210) 555 1313	In Home	Active



Scene 3 A separate server receives both eLTSS and PACIO data from a data hub

The Altarum data tool is used to pull both the eLTSS and PACIO data from the Data Manager to a SNF server to inform her care

/ ALTARUM	🔞 FHIR VUHR			Admin
යා Home Q. Search	Profile: eLTSS Profile	Search	h ID: patientBSJ1	
Server Viewer	Source: DATA HUB	✓ Action	ns: Search Clear Transact	
🖪 Broker	Target: PACIO SNF	✓ Progre	ess: Gathering resources	0%
 Profiles Admin 	Type ©	Count 🖨	Profile	
		No Dala De		
<		whova.com is sharing your screen. Stop sharing	Hide	



Scene 3 eLTSS data is moved into and displayed by a care coordinator app

Betsy's data was pulled into and displayed by MITRE's SNF Care Coordinator application





Scene 3 eLTSS data is dynamically updated using a care coordinator app

A goal was added to Betsy's care plan using MITRE's SNF Care Coordinator app

Goal Edit		}], "code": { "coding": [
ld	not yet assigned	"system": "http://snomed.info/sct", "code": "183301007", "display": " Physical exercises (regime/there
Subject	Patient/patient8531], "text": "Needs physical exercises"
Description text (for the codeable concept)	Stroke Education	<pre>}, "subject": { "reference": "Patient/patientES31"</pre>
Lifecyclestatus	proposed v	} }
Priority	high-priority >	D, [2020-09-11T14:43:57.432378 #16584] DEBUG : Par response with {klass: , format: application/fhir+jsor e: 2003
		<pre>[#PTHR.:COMODOUGDIDJOERS gitAll, @Axtension @system="http://terminology.hl7.org/CodeSystem/condi clinical", @version=nil, @code="active", @display=nil erselected=nil>][#<fhir::coding:0x000000001d127f10 @j<br="">, @extension=[], @system="http://terminology.hl7.org/ ystem/condition-clinical", @version=nil, @code="active display=n1l, @userSelected=nil>][#<fhir::coding:0x000 1d816948 @id=nil, @extension=[], @system="http://terminology.hl7.org/CodeSystem/condition-clinical", @version=ni code="active", @display=nil, @userSelected=nil>][#<fh oding:0x00000001d85d0c8 @id=nil, @extension=[], @system="http://terminology.hl7.org/CodeSystem/condition-clini- @version=nil, @code="active", @display=nil, @userSelected=nil>][#<fh oding:0x0000001d85d0c8 @id=nil, @extension=[], @system="http://terminology.hl7.org/CodeSystem/condition-clini- @version=nil, @code="active", @display=nil, @userSelected=nil>][#<fh oding:0x0000001d85d0c8 @id=nil, @extension=[], @system="http://terminology.hl7.org/CodeSystem/condition-clini- @version=nil, @code="active", @display=nil, @userSelected=nil>][#</fh </fh </fh </fhir::coding:0x000 </fhir::coding:0x000000001d127f10></pre>



Scene 3 eLTSS update is pushed from an app into the SNF server

Betsy's new goal was shared with Altarum's eLTSS+PACIO SNF FHIR server

A Home	Server Hi	story				🔲 Server: Local Tester 👻	O Source Code	About This Server
Options				^	<pre>content-location: https://fhirconnect.altarum.org/hapi-fhir-jpaserver-elt connection: Keep-alive content-type: application/fhir+jsonycharast=UTF-8</pre>	tes-CC/fhir/Bundle/d8fd0961-2628-4c77-sc	1-676a76a9de24	
Encoding	(default) XML	JSON		Result Body	Bundle contains 20 / 218 entries			
Summary	(default) On (none) true	Off text data	count	(44760 bytes)	ID		Updated	
Server					Read CarePlan/careplan1/_history/2		14:44:31	
Server Hom	e/Actions				Read Def Goal/302/_history/1		14:44:07	
					Read C Update Location/location1/_history/2		14:10:26	
Resource	s				Read Dr Update Questionnaire/questionnaire1/_history/2		14:10:26	
SearchPara	neter 75				Read Update Practitioner/planner1/_history/1		14:10:25	
StructureDet	finition (44)				Read Dpdate Condition/need4/_history/1		14:10:25	
ValueSet					Read DruceRequest/service1/_history/1		14:10:25	
Vancoci en					Read Defate Condition/need3/_history/1		14:10:25	
CodeSystem	0				Read Depart Practitioner/caremgr1/_history/1		14:10:25	
Practitioner	0				Read @ Update Observation/pref1/_history/1		14:10:25	
ServiceRequ	uest 🕞				Read Order Condition/need2/_history/1		14:10:25	
Observation	0				Read DenviceRequest/service2/_history/1		14:10:25	
					Read Drate EpisodeO/Care/episode1/_history/1		14:10:25	
CapabilitySt	atement				Read 12 Undate QuestionnaireResponse/questionnaireresponse1/_history/1		14:10:25	

https://fhirconnect.altarum.org/hapi-fhir-jpaserver-eltss-CC/history-server?serverId=home&pretty=true&limit=



Scene 3 eLTSS update pushed from the SNF server to the data hub

Betsy's new goal was pushed to the Patient Centric Solutions data hub and displayed in the Patient*Share* app

PatientShe	are					НОМЕ	CONTACT US
Patient Demographics			Bets	y Smith–Johnson			
Medications	Care Plan Careplan2 Description: Weather Emerge	ncy: A shelf-stable m	Category Assess Plan eal is delivered to Meals On W	Start Date heels clients. It is to be eaten	End Date	Status Active ation. Weather meals are	donated by the
Allergies	Sheboygan Servi Intent: Plan	ce Club.	Access Plan			Active	
Immunizations	Description: A service and su Intent: Plan	pport plan that outlin	es Betsy's assessed needs, go	als, strengths, preferences, ar	nd services/providers to meet th	nose needs and goals.	
Vital Signs	Goals: Description	Lifecycle Status Plan					
Conditions	Improve balance skills Dance at son's upcoming wedding Stroke Education	Accepted Accepted Proposed					
Lab Results		,,					
Assessments							
Care Plan							
Patient Centric Solutions, Inc © 2019							



Scene 4 eLTSS data is pushed from data hub to an HHA application

Betsy returns home from the SNF and receives HHA and HCBS care. Her care plan is forwarded to the HHA

HHA Psei	udo EHR				
Betsy Smith	Johnson's Services a Betay Smith- Johnson Full A service and support plan that obtlines Betsy's assessed needs, goals, strengths, preferences, and services/providers to meet those needs and goals.	and Supports Plan	Conditions Needs transportation Needs health / nutrition Depression (on treatme Needs physical exercise	education for diabetes int) es	
Time Period	05/01/2020 - 12/31/2020		Improve balance skills		
Status	active		Dance at son's upcomin	ng wedding	
Intent	plan				
Activities Perform exerc	cises to improve balanc	e skills	Supporting info	Able to manage her bills.	



Scene 5 The care plan is displayed in a patient facing application

Betsy and her son Charles were able to view her care plan using Patient Centric Solutions Patient*Share* application

PatientSha	re										НОМЕ	CONTA	CT US
Patient Demographics	Author:Mark Planner, pFundingTexas DepartmSource:7430 Louis Pas	ohone: (210 ent of Com teur Dr, Sa)) 555 imunit n Anto	1221 y Health nio, TX	h 7822	29							
Medications	Strengths: Description Able to manage her bills.												
Allergies	Independent walking with cane.												
Immunizations	Description Accessing the ICWP Waiver for her of	current servic	e need:	s, and wo	ould lik	e to remain o	n ICWP and c	ontinue v	vith her cu	irrent ser	vices.		
Vital Signs	Description Improve balance skills	Lifecycle Sta Accepted	ifecycle Status Plan Accepted Perform exercises to improve balance skills										
Conditions	Dance at son's upcoming wedding Addresses:	Accepted	Wo	ork on mo	obility	to dance at se	on's upcomin	g weddin	g				
Lab Results	Description Needs transportation Needs health / nutrition education	for diabetes	Clinica Active Active	al Status	Verific Confi Confi	cation Status rmed rmed	Categories Assessed Ne Assessed Ne	ed ed					
Assessments	Depression (on treatment) Needs physical exercises		Active Active		Confi Confi	rmed rmed	Assessed Ne Assessed Ne	ed ed					
Care Plan	Description		Intent	Start Da	ite	End Date	Frequency	Cost per Unit	# Units	Total cost per service	Performer	Location	Status
	Bath tub wall rail, each (self-directed)		Plan	05/01/2	2020	12/31/2020	1 install				Charles Johnson, son	In Home	Active
atient Centric Solutions, Inc © 2019	Non-emergency transportation; en (Service provider will provide a rem business day before the trip, and w	counter/trip inder the ill call when	Plan	07/01/2	2020	12/31/2020	2 trips per 1 month	60	10	600	The Transporter, Inc., phone: (210) 555 1313		Active



Outcomes

- eLTSS data stored in FEI System's Blue Compass Mississippi system was pushed through a FHIR façade and received in Altarum's eLTSS Care Coordinator server. The case management system used in this demonstration is a development version of a production system used by the state of Mississippi.
- The eLTSS care plan was displayed in a reader-friendly manner in Altarum's FHIR VUHR client
- eLTSS data was effectively and rapidly "pushed" from Altarum's eLTSS server to a Patient Centric Solutions data hub using Altarum's FHIR Broker Tool. This tool supported the efficient delivery of a complete eLTSS dataset of 35 resources
- eLTSS data was aggregated with clinical data imported from a pseudo HIE into the hub effectively combining clinical and non-clinical data within a single server
- eLTSS data was aggregated with PACIO functional and cognitive assessment data within the hub, representing the successful integration of three different FHIR IGs
- At the SNF, the clinician used the Transitions of Care client, by Patient Centric Solutions, to access both clinical data and the eLTSS care plan from the hub to inform care



Outcomes

- eLTSS and PACIO data, were efficiently "pulled" from the data hub into Altarum's eLTSS+PACIO SNF FHIR server. This server also demonstrated the successful integration of three separate IGs
- eLTSS care plan was pulled into MITRE's Care Coordinator application, displayed in that application, and dynamically updated using that application. The update was then pushed to Altarum's eLTSS+PACIO SNF FHIR server, and from there it was pushed to the data hub.
- eLTSS care plan was pulled from the data hub to MITRE's HHA EHR system and displayed
- SMART on FHIR clients and authentication requirements were utilized in the display of eLTSS data
- Demonstrated eLTSS and PACIO data moving from numerous systems across facilities using the FHIR API for both read and write scenarios
- The patient and her family caregivers were able to access her data as she moved across the continuum of care.



Lessons Learned

- Working with real world systems provides real world challenges such as patient matching, reconciling different approaches to storing and sharing data using FHIR, and recognizing that systems may not support the complete set of data specified in an IG
- Relying on FHIR's \$everything operation to share care plan data has some limitations. This operation can only capture resources that have direct references to the patient resource. Additionally, by pulling all information related to a patient, this operation could result in the sharing of extraneous information. Finally, some FHIR servers may not have activated support for operation.
- In a production environment, application functionality certification will be critical to maintain accurate data
- Data can be effectively shared using the FHIR API. Customized data transfer tools, such as the one developed and demonstrated by Altarum at this event, can also facilitate the exchange of comprehensive care plans.



Acknowledgements

This testing and outcomes could not have been possible without the dedicated engagement of the project's connectathon partners





SOLUTIONS TO ADVANCE HEALTH



