COMMUNITY HEALTH CARE ASSOCIATION of New York State

Set Your Lunch on FHIR

Lunch and Learn Series Session 2: FHIR 101

Thurs. Jun 18, 2026

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Set your Lunch on FHIR

Session 2 ~ FHIR 101

June 17, 2026

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Next Level Health Innovations

Scenario:

A new patient arrives for an appointment and says the following:

> “The hospital portal lets me share my record with other providers using this QR code. If you scan it, I think you can pull my meds, labs, and visit notes right into your system.
>
> Can someone here help me do that so I don’t have to do a bunch of paperwork?”

Who in your organization would handle that request (front desk, nurse, provider, IT, HIE team, etc.?) and what steps or questions would you need to go through to decide whether you can safely use that QR code-based FHIR/API connection in your workflows?

Q4.1: Current FHIR/API Tool Usage		
Response Category	Count	Percentage
Not currently using FHIR	19	24%
Bulk FHIR data submissions	8	10%
Population health reporting	19	24%
eCQM extraction	13	17%
Referral management	11	14%
No response	8	10%

Q4.3: Technical Standards Used for Data Exchange		
Standard	Count	Percentage
HL7 v2	33	45%
FHIR (excluding non-FHIR APIs)	6	8%
APIs (non-FHIR)	16	22%
Unsure	10	14%
No response	8	11%

Q4.4: Interest in Piloting FHIR-Based Workflows with CHCANYS		
Response	Count	Percentage
Yes	19	36%
No	11	21%
Unsure	15	28%
No response	8	15%

Q4.5.a: FHIR Knowledge Level (1=None, 5=Full Understanding)		
Level	Count	Percentage
1 (No knowledge)	6	11%
2	10	19%
3	19	36%
4	8	15%
5 (Full understanding)	2	4%
No response	8	15%
Average Score	2.78	

Total Respondents	45

Review of Where New York State Health Centers are as a Network

24% “not currently using FHIR,” but similar percentage using population health reporting and eCQM extraction.

For those who know, most report using HL7 v2 and non-FHIR APIs for data exchange.

Average FHIR knowledge 2.78, plus many reporting they are unsure.

Choosing Realistic FHIR Use Cases for Your Health Center

Huge health center challenge: Determining whether better ways of defining, accessing, and/ or exchanging data would address the root of any particular challenge.

Question to ask	What the Question Can Reveal	Example
Is the data already captured in the EHR or another system?	Whether the use case is realistic ***now*** or depends on better data collection ***first***	PRAPARE data may be captured inconsistently across sites
Is it clear who would use the information?	Whether someone can act on the information once exchanged	QI team owns dashboards; care management owns panel outreach
Does the vendor support the needed FHIR capability?	Whether this is mostly internal setup or a vendor dependency	EHR supports SMART on FHIR apps but not Bulk FHIR export
Is the exchange partner ready?	Whether the barrier is outside the health center's control	Payer prior auth API not fully operational until 2027
Is there a clear operational benefit?	Whether the effort is worth prioritizing	Less manual chart review for quality improvement

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High Value Use Cases Identified by Health Centers

Are you doing or looking into any of these? How so?

Population Health/ Dashboards

Many are already using Azara and similar tools, sometimes FHIR enabled.

FHIR and FHIR Bulk Data creates a more standardized, scalable extract path over time.

Social Need Screening/ PRAPARE

PRAPARE and other social need screens can be represented using FHIR.

If these are aligned to USCDI SDOH data elements it could set you up for future payer use of SDOH for risk management and care coordination, and you may already be doing this!

Patient Facing Apps

EHR vendors' SMART on FHIR use plus ONC/ CMS rules make patient access via apps a reality, particularly through things like Apple Health and portal apps.

Some patients may even be moving to AI health apps.

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Health Center Pilots and Implementations

NYHER 1115 Waiver / Social Care Networks FHIR use case

New York's Health Equity Reform 1115 waiver funds Social Care Networks that must deploy FHIR-enabled IT platforms within 90 days to exchange health-related social needs (HRSN) screenings, closed-loop referrals, and eligibility data via the SHIN-NY HIE.

Envisions bidirectional, HL7 FHIR-based exchange between health centers, social service platforms (e.g., CBO networks), managed care plans, and the SHIN-NY data lake to support care coordination, reporting, and evaluation. https://www.zeomega.com/blog/nys-1115-waivers-the-future-of-healthcare-data-exchange

Aligning health and housing through an interoperable shared e–care plan

FHIR-enabled shared e-care plan that connects a health center and community-based organizations to manage social and medical needs together. It replaces ad hoc phone/email coordination with a web-based referral and tracking system that supports closed-loop referrals, better follow-up, and easier SDOH data collection.

FHIR was used to operationalize cross-sector care coordination between CHCs and CBOs, with referrals flowing directly from the EHR into a shared application.
https://pmc.ncbi.nlm.nih.gov/articles/PMC11972701/

System Relationships

Front end systems

User Interfaces that request or display data.

Application/ FHIR Layer

Back end systems

Internal source systems like EHR, billing, lab, and clinical databases.

External systems

Outside organizations or services that exchange data through FHIR or connected interfaces.

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Example of Remote Patient Monitoring Implementation

Example

A patient with hypertension uses a Bluetooth blood pressure cuff at home. The cuff sends the reading to a companion app, the app posts the result to the RPM platform, and the platform converts it into a FHIR Observation tied to that patient. If the systolic value crosses a threshold, the care team gets an alert in the EHR or RPM inbox, and a nurse may follow up with a message or call.

Device reading arrives from the remote monitoring device (e.g., from home).

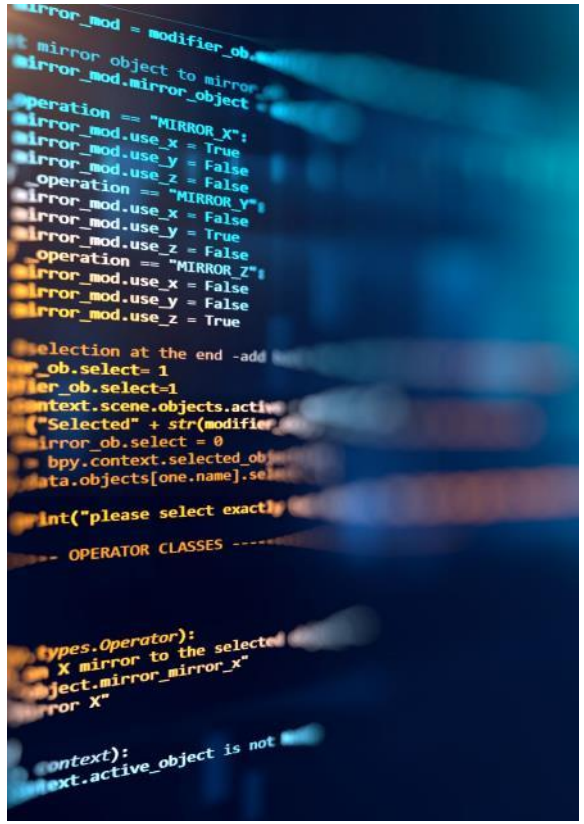
Middleware maps it to a FHIR Observation.

The system links the observation to the right patient and device.

The EHR pulls it in, subscribes to it, or shows it through an embedded SMART on FHIR app.

Let's Look at a Detailed Example

- `GET [base]/Observation?code=4548-4&patient=123` is a FHIR search for **Observation** resources that match both the LOINC code 4548-4 and the patient with id 123. In practice, this returns that patient's HbA1c observations when the server supports standard Observation search parameters.
- Break that down
  - `GET [base]/Observation` means a search on the Observation endpoint. The corresponding post back would be `POST [base]/Observation`
  - `code=4548-4` filters to observations whose code is LOINC 4548-4, commonly used for HbA1c in the US.
  - `patient=123` filters to observations associated with Patient/123, assuming the server supports the patient search parameter on Observation.
- What is this used for?
  - A typical use case is retrieving a patient's HbA1c results for diabetes monitoring. The result set would usually include final, preliminary, or other observations depending on what the server stores and how it indexes the search.



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What are examples of where this exists? And how are they defined?

- **US Core Implementation Guide (IG)**: the foundation for U.S. clinical interoperability and the minimum set of constraints on FHIR resources used across many workflows, including primary care.
  - Used to define a minimum standard for the US, other countries have their own version (like UK Core exists as well)
- **QI Core Implementation Guide**: used for quality measurement and clinical data representation on top of FHIR/US Core, which matters for primary care reporting and performance measurement. (Moving towards US Quality Core)
  - Used for defining quality reporting for CMS, NCQA, etc.
- **Da Vinci Project guides**: Accelerator created IGs for value based care making them especially relevant to primary care organizations participating in care coordination, coverage, and utilization workflows.
- **SMART on FHIR**: commonly used to launch apps inside EHRs, which is useful for primary care decision support, screening tools, and workflow apps.
  - Allows apps to work with different EHRs, has learning community: https://good-neighbor.smarthealthit.org/
- **Argonaut Scheduling**: useful if your primary care use case includes appointment booking and scheduling interoperability.

These IGs are not necessarily something that you need to read, but are something that vendors build upon.

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So, how does all of this touch health centers?

It may not just yet, but it means there is a lot of movement toward FHIR as key infrastructure.

- Beyond provider-to-provider/ provider-to-patient exchange which has fairly clear value, CMS is implementing payer-focused requirements to stand up FHIR APIs for Patient Access, Provider Access, Payer-to-Payer data exchange, and Prior Authorization by January 1, 2027.
    - The intended results are more streamlined electronic prior authorization, smoother access to patient claims and clinical data across payers, and a standardized FHIR-based workflow that can reduce administrative burden and improve care coordination.
- It also standardizes the underlying technology around FHIR R4, USCDI, SMART on FHIR, Bulk Data, while recommending Da Vinci and CARIN implementation guides to reduce burden and improve interoperability.
    - Many of these are things health centers are already somewhat familiar with (or at least have some relationship to)– where do you know of these existing?

The important question of the moment: Where could standardized data exchange reduce manual work, improve data quality, or support a current, important workflow?

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Scenario:

One of your Medicaid MCOs notifies you that starting in 2027, all high-volume prior auth will be supported via a FHIR Prior Authorization API.

They ask: ‘Can your EHR integrate with our FHIR endpoints?’

What questions would you ask your vendor?

Which FHIR pathway are we dealing with?

If you are thinking about…	You are probably dealing with…	What to Consider
Patients using apps to access or share their own data	**Patient Access / SMART on FHIR**	Is this already supported by the EHR or portal? What does the patient control?
Prior authorization, payer care coordination, payer data sharing, or claims/clinical data exchange	**Payer APIs**	Which payer? Which API? Where in the workflow?
Referrals, care coordination, clinical data exchange with hospitals, HIEs, CBOs, or other providers	**Provider-to-provider exchange built on the FHIR Standard and Provider APIs**	Who is the partner? What data is needed? Is there a shared IG or platform? What's the governance structure?
Dashboards, panel management, QI, or reporting	**Internal or vendor-supported FHIR/Bulk FHIR**	Can the EHR or population health platform expose the right data reliably?

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If you could move *one* FHIR effort forward in the next 12–18 months, which would you pick?

What assistance would be most helpful? What do you need?

Actions to Take Following this Session

Learn more about what others have done through available case studies: https://good-neighbor.smarthealthit.org/case-studies/

These case studies include great tips.

Identify *one* FHIR-related capability you want to confirm in your primary EHR/ health IT system.

Identify *one* workflow (population health, SDOH, prior auth, referrals) that you would nominate as your health center's first or next FHIR-enabled use case if someone were to ask.

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