Innovative Special Project of National Significance (SPNS): Fusing Part A, B, C, & D Data for *MyCareContinuum* Dashboard and Empowering Consumers with an Award-Winning Low-Health-Literacy Patient Portal

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Disclosures

The City of Paterson, Department of Human Services, New York Presbyterian Hospital and New Solutions, Inc. have no financial interest to disclose.

Jesse Thomas works as Project Director for RDE System Support Group, LLC.

This continuing education activity is managed and accredited by Professional Education Services Group in cooperation with HSRA and LRG. PESG, HSRA, LRG and all accrediting organization do not support or endorse any product or service mentioned in this activity.

PESG, HRSA, and LRG staff has no financial interest to disclose.

Learning Objectives

At the conclusion of this activity, the participant will be able to:

1. **Recognize how a paradigm of fusing disparate data sources across funding silos can enhance quality improvement.**
2. **Describe how to replicate and adapt strategies and tools to implement novel approaches to impacting the outcomes along the HIV Care Continuum.**
3. **Identify, analyze and evaluate the pitfalls and benefits of implementing health information exchange, including the adoption of federal Office of the National Coordinator (ONC) standards.**

Introduction

Coordinating systems through eHIE

Introduction

City of Paterson Department of Health and Human Resources Ryan White Grants Division

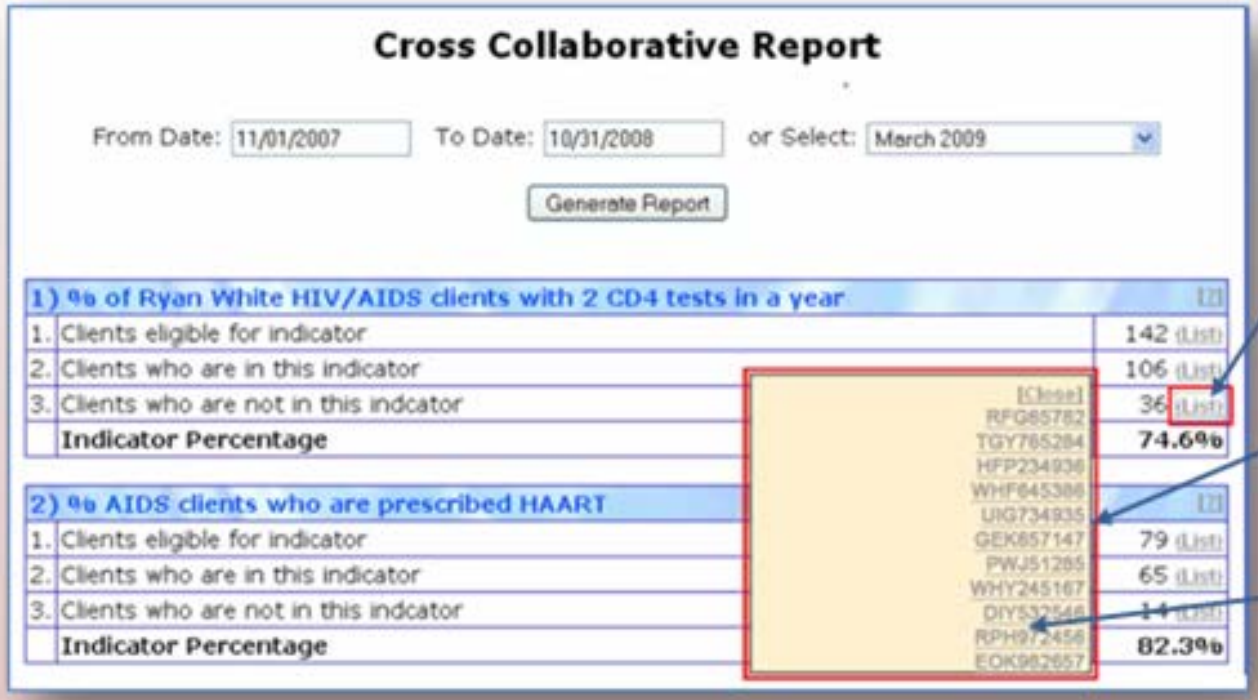
- **In existence since 1994**
- **Services located across two counties and concentrated in the epicenters of Paterson, Passaic and Hackensack**
- **Ryan White Programs and Providers**
  - **16 Ryan White Part A**
  - **4 Minority AIDS Initiative (MAI)**
  - **6 HOPWA sub-recipients**

Our Story

Building on SPNS Electronic Exchange of Health Information - Networks of Care

Using Data to Impact Process and Health Outcomes

eCOMPAS Interactive Quality Reporting



1. *User clicks on the number of clients NOT in the numerator.*
2. *A list of clients pops up.*
3. *Staff drill-down to each client record and use it as a tool for follow-up.*

Agency Alerts

Search | Bulk/Group | Referrals | Outreach | Useful Links | Tracker | QM (799)

Alerts | Alert Subscriptions | Journaling

Summary of Current Alerts

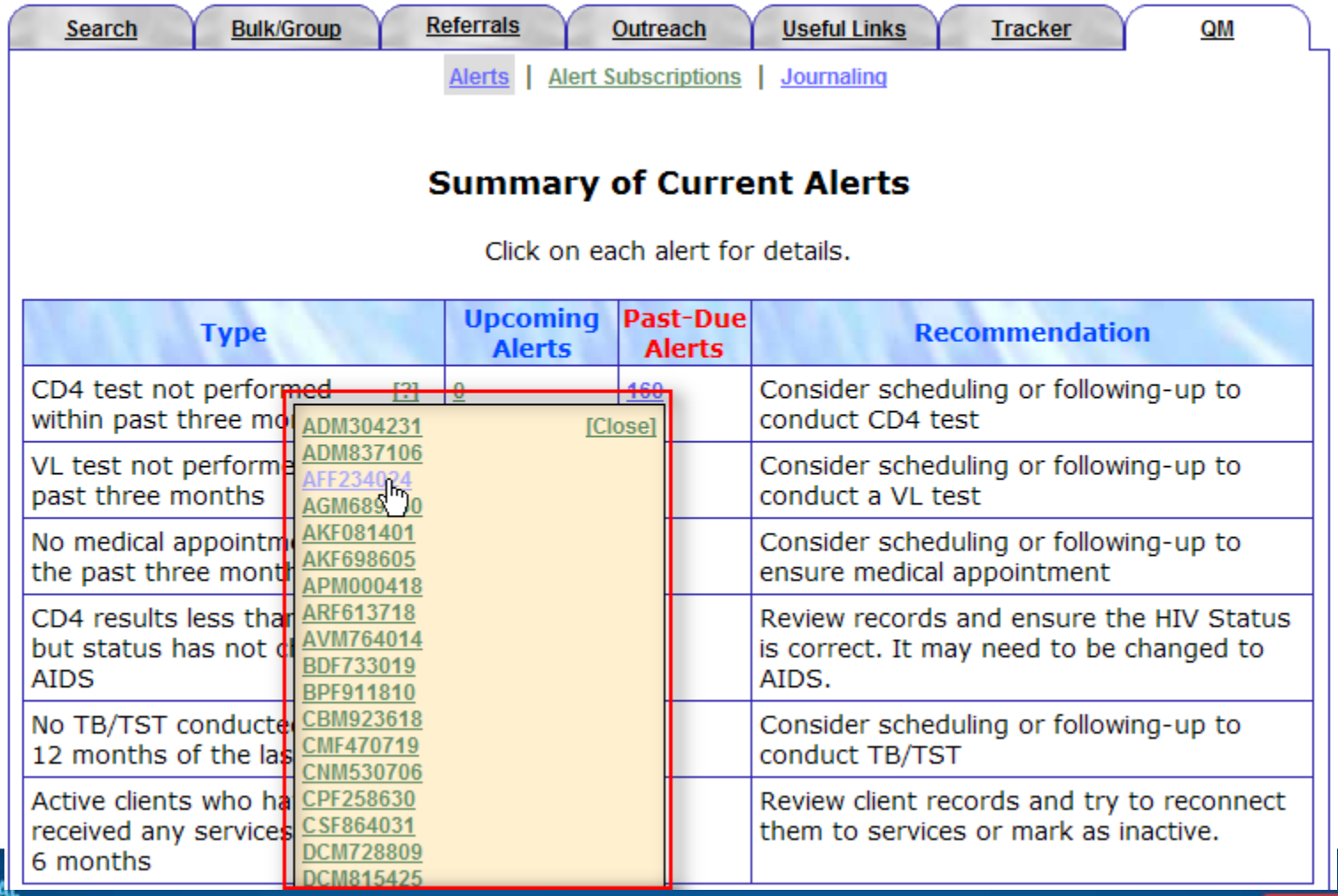
Click on each alert for details.

Type	Upcoming Alerts	Past-Due Alerts	Recommendation
CD4 test not performed within past three months [?]	0	160	Consider scheduling or following-up to conduct CD4 test
VL test not performed within past three months [?]	0	164	Consider scheduling or following-up to conduct a VL test
No medical appointment in the past three months [?]	N/A	168	Consider scheduling or following-up to ensure medical appointment
CD4 results less than 200 but status has not changed to AIDS [?]	N/A	7	Review records and ensure the HIV Status is correct. It may need to be changed to AIDS.
No TB/TST conducted within 12 months of the last TB/TST [?]	N/A	122	Consider scheduling or following-up to conduct TB/TST
Active clients who have not received any services in the past 6 months [?]	N/A	178	Review client records and try to reconnect them to services or mark as inactive.

All recommendations assume that you first ensure that the data (e.g., CD4 test date and value) has been entered into eCOMPAS.

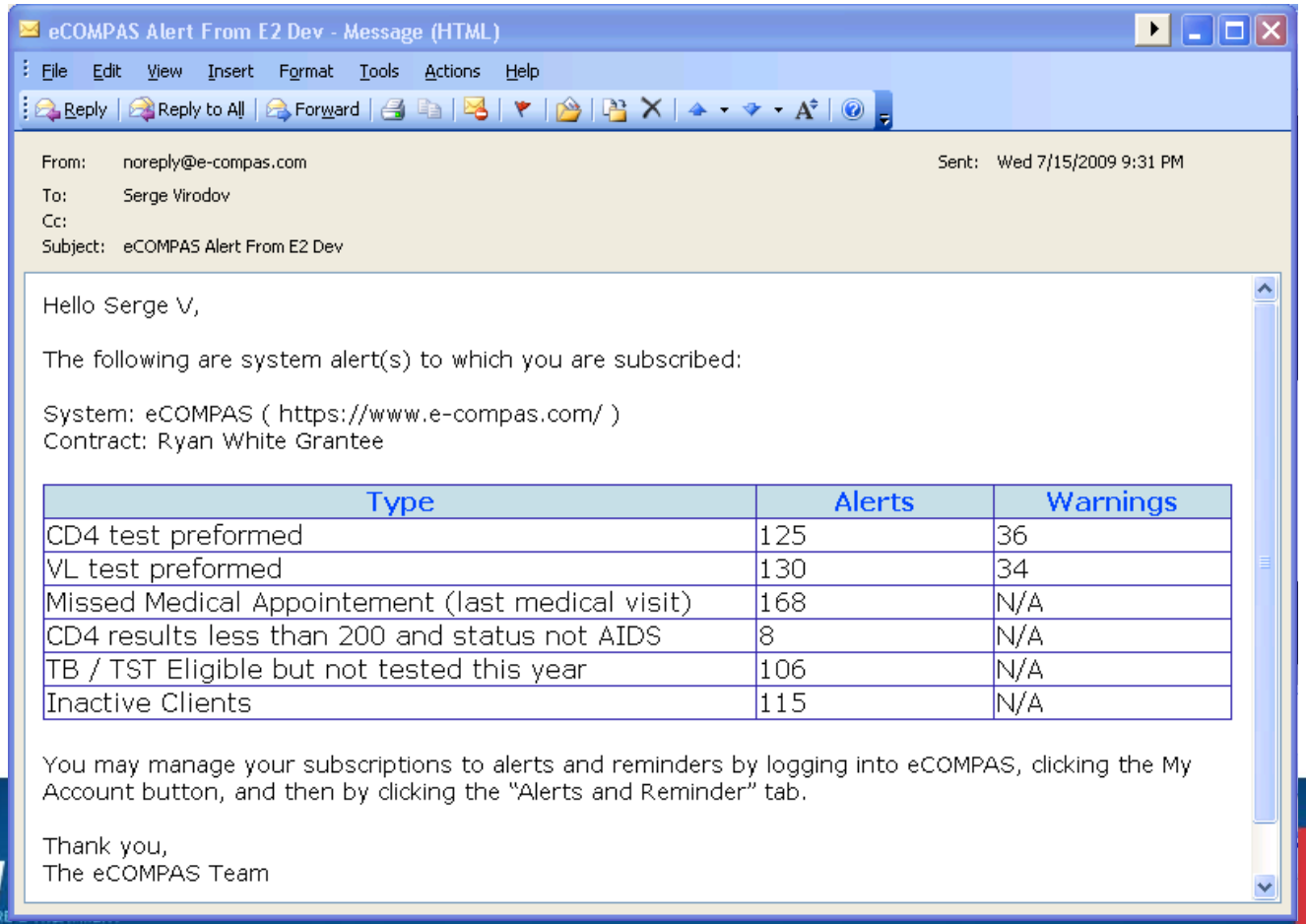
If you wish to suggest a new alert click here

Agency Alerts Drilldown



Email Alerts

- Proactive, regular, *push* notification
- Supervisors are more likely to read email



eCOMPAS Alert From E2 Dev - Message (HTML)

File Edit View Insert Format Tools Actions Help

Reply | Reply to All | Forward

From: noreply@e-compas.com
Sent: Wed 7/15/2009 9:31 PM
To: Serge Virodov
Cc:
Subject: eCOMPAS Alert From E2 Dev

Hello Serge V,

The following are system alert(s) to which you are subscribed:

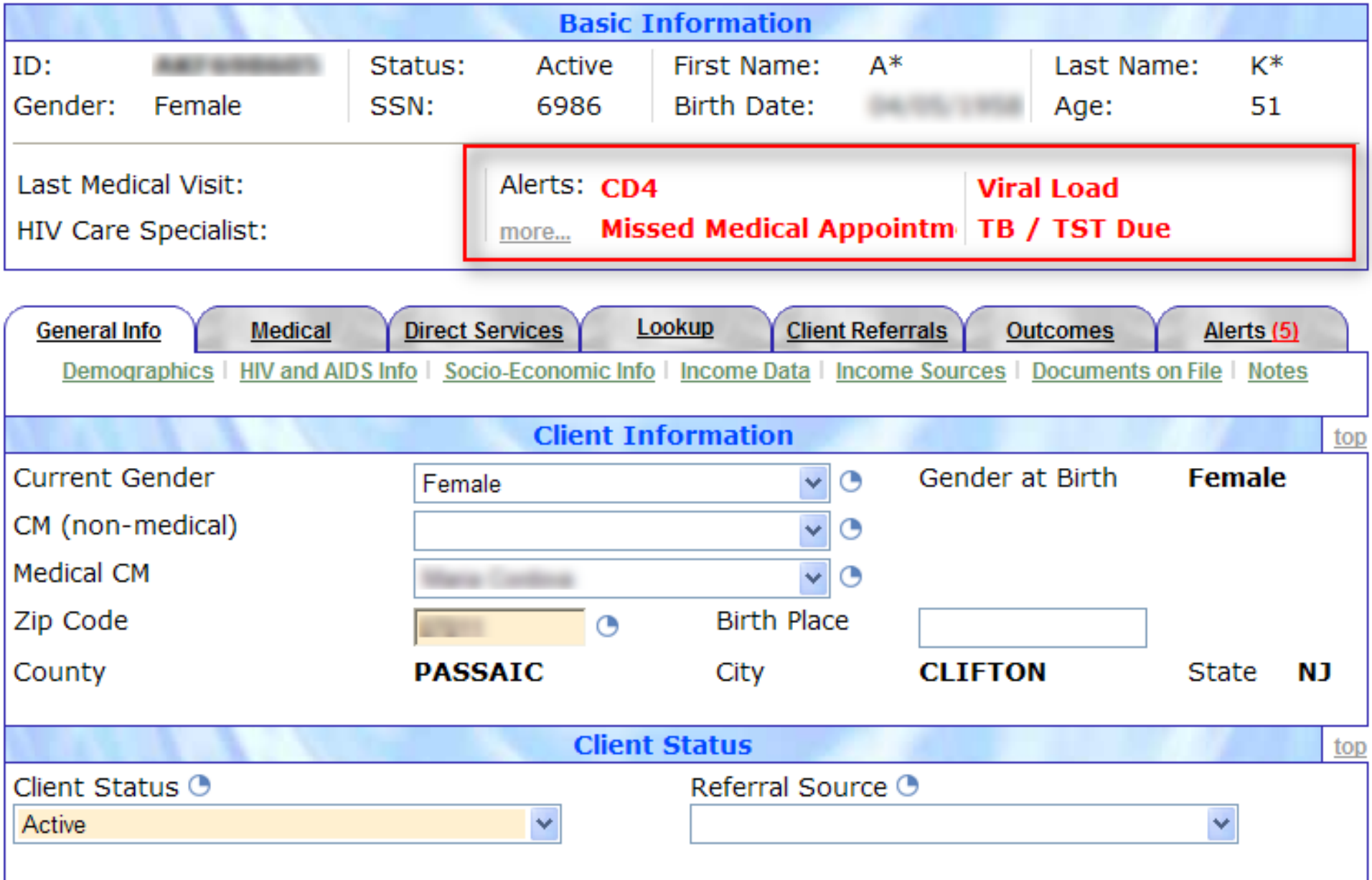
System: eCOMPAS (https://www.e-compas.com/)
Contract: Ryan White Grantee

Type	Alerts	Warnings
CD4 test preformed	125	36
VL test preformed	130	34
Missed Medical Appointement (last medical visit)	168	N/A
CD4 results less than 200 and status not AIDS	8	N/A
TB / TST Eligible but not tested this year	106	N/A
Inactive Clients	115	N/A

You may manage your subscriptions to alerts and reminders by logging into eCOMPAS, clicking the My Account button, and then by clicking the "Alerts and Reminder" tab.

Thank you,
The eCOMPAS Team

Linked to Exact Screen



Basic Information

ID:	[redacted]	Status:	Active	First Name:	A*	Last Name:	K*
Gender:	Female	SSN:	6986	Birth Date:	[redacted]	Age:	51

Last Medical Visit:

HIV Care Specialist:

Alerts: **CD4** **Viral Load**

more... **Missed Medical Appointm** **TB / TST Due**

General Info | Medical | Direct Services | Lookup | Client Referrals | Outcomes | Alerts (5)

Demographics | HIV and AIDS Info | Socio-Economic Info | Income Data | Income Sources | Documents on File | Notes

Client Information

top

Current Gender	Female		Gender at Birth	**Female**	
CM (non-medical)					
Medical CM	[redacted]				
Zip Code	[redacted]	Birth Place			
County	**PASSAIC**	City	**CLIFTON**	State	**NJ**

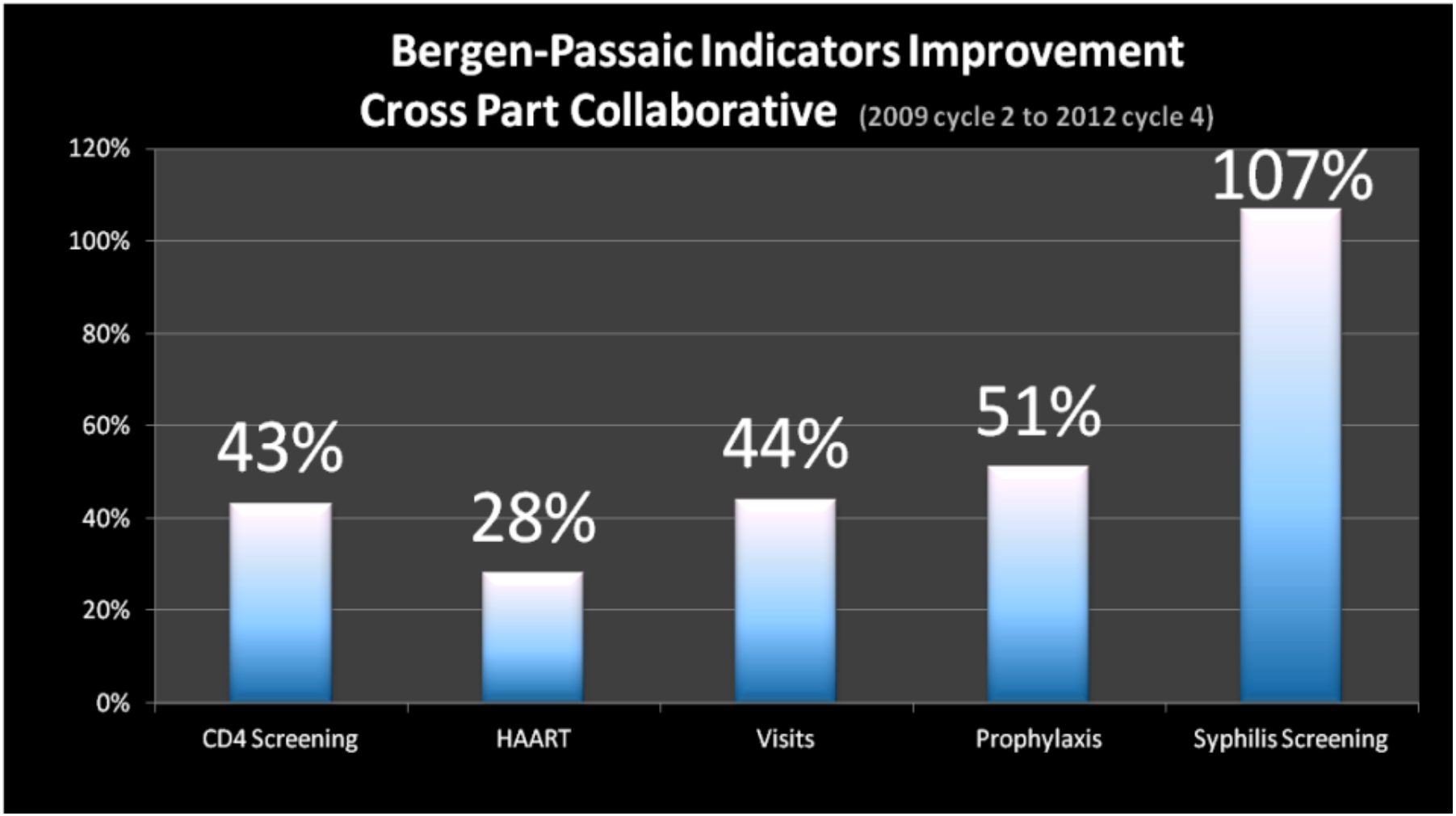
Client Status

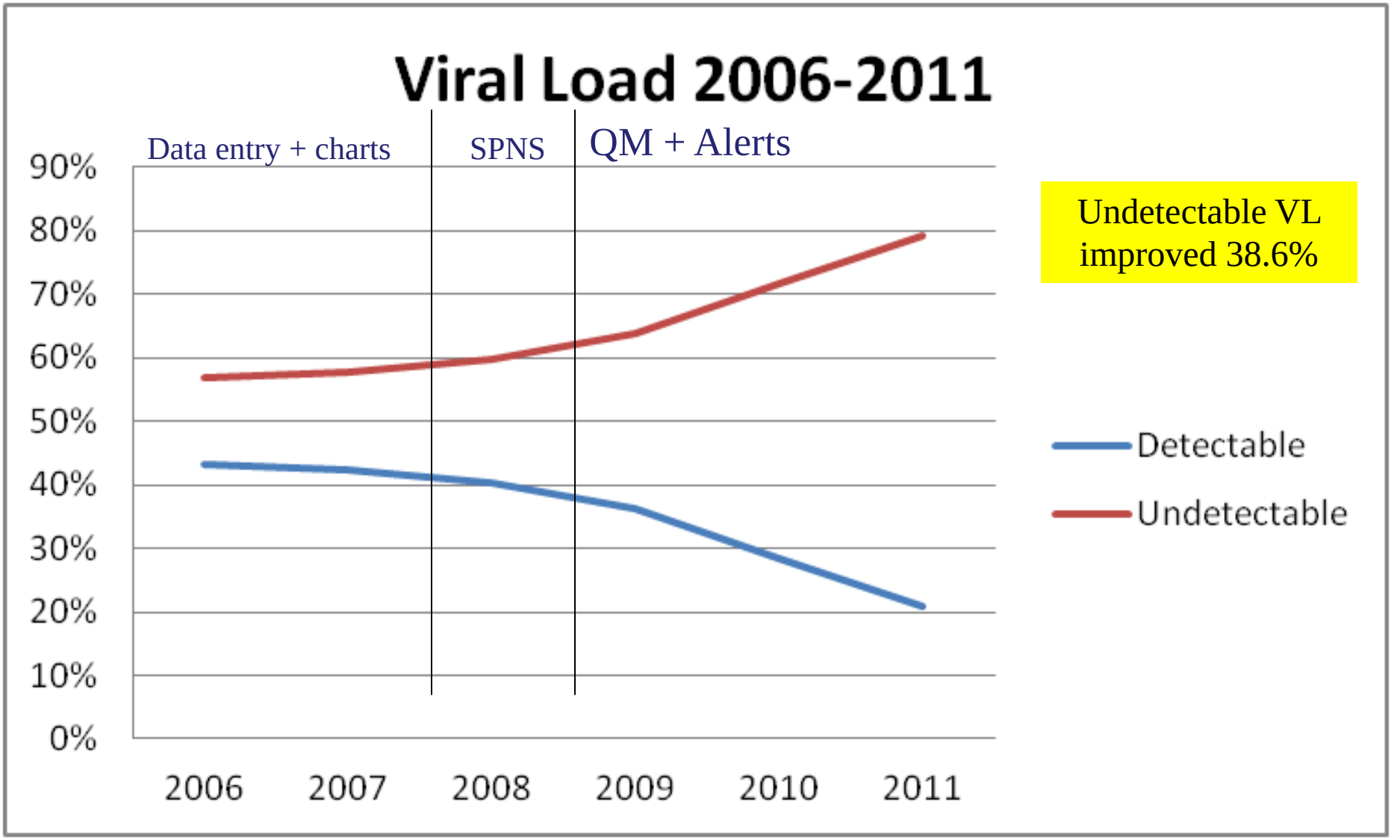
top

Client Status: Active

Referral Source:

Outcomes


Bergen-Passaic Indicators Improvement
Cross Part Collaborative (2009 cycle 2 to 2012 cycle 4)
120%
100%
80%
60%
40%
20%
0%
43%
28%
44%
51%
107%
CD4 Screening
HAART
Visits
Prophylaxis
Syphilis Screening



2006-2007 prior to SPNS, all medical patients

Electronic health information technology as a tool for improving quality of care and health outcomes for HIV/AIDS patients

- Patricia H. Virga, Bonggyu K. Jin, Jesse Thomas, Sergey Virodov

Highlights

▶ Health information technology (HIT) is shown to benefit quality of care for HIV/AIDS patients.

▶ An easy-to-use system responsive to users' needs effectively facilitates rigorous application of quality improvement methods.

▶ HIT can lead to improved health outcomes for HIV/AIDS patients.

Abstract

Purpose

This paper presents research on the interplay of health information technology (HIT), quality improvement and progression of health status. The purpose of the research was to determine whether electronic exchange of health information impacts quality of care and, by extension, health outcomes of patients with HIV/AIDS. The research was supported as a demonstration project under the Information Technology Networks of Care Initiative sponsored by the U.S. Health Resources and Services Administration, HIV/AIDS Bureau, Special Projects of National Significance (SPNS). The City of Paterson, New Jersey, Department of Health and Human Services administered the project as the grant recipient, secured and managed through the City of Paterson's Ryan White Part A Program of Bergen and Passaic Counties.

Methods

We implemented a web-based health information support system, e2, to facilitate rigorous quality improvement activities associated with care and treatment of HIV/AIDS patients. We used e2 to monitor patient care in the clinic setting. We observed five quality and two health status indicators relating to the care of 263 HIV/AIDS medical patients at three HIV/AIDS medical clinics from 2008 to 2010. The quality indicators conformed to HIV/AIDS Bureau (HAB) Groups 1 and 2 definitions of two or more CD4 T-cell counts performed in the measurement year, AIDS patients prescribed HAART, two or more medical visits in the measurement year, PCP prophylaxis administered to AIDS patients with CD4 T-cell counts <200, and adults screened for syphilis within the measurement year. CD4 T-cell count and viral load suppression indicators were used as health status indicators. Frequency analysis and logistic

International Journal of Medical Informatics, August 2012

(from left to right) Denise Cobia, Pat Virga, Jesse Thomas, Millie Izquierdo, Jimease Green, Maria Cordova, Doug Mendez, Pricilla Moschella, Jerry Dillard, Ellen McNamara, Larry Rodgers, Blanca Roman, Anthony Fazzinga, Sandra Murillo, Maryann Collins, Irene Panagiotis, Serge Virodov, Chantia Douglas, Kathy Lebron.

SPNS 2014 Program Goal

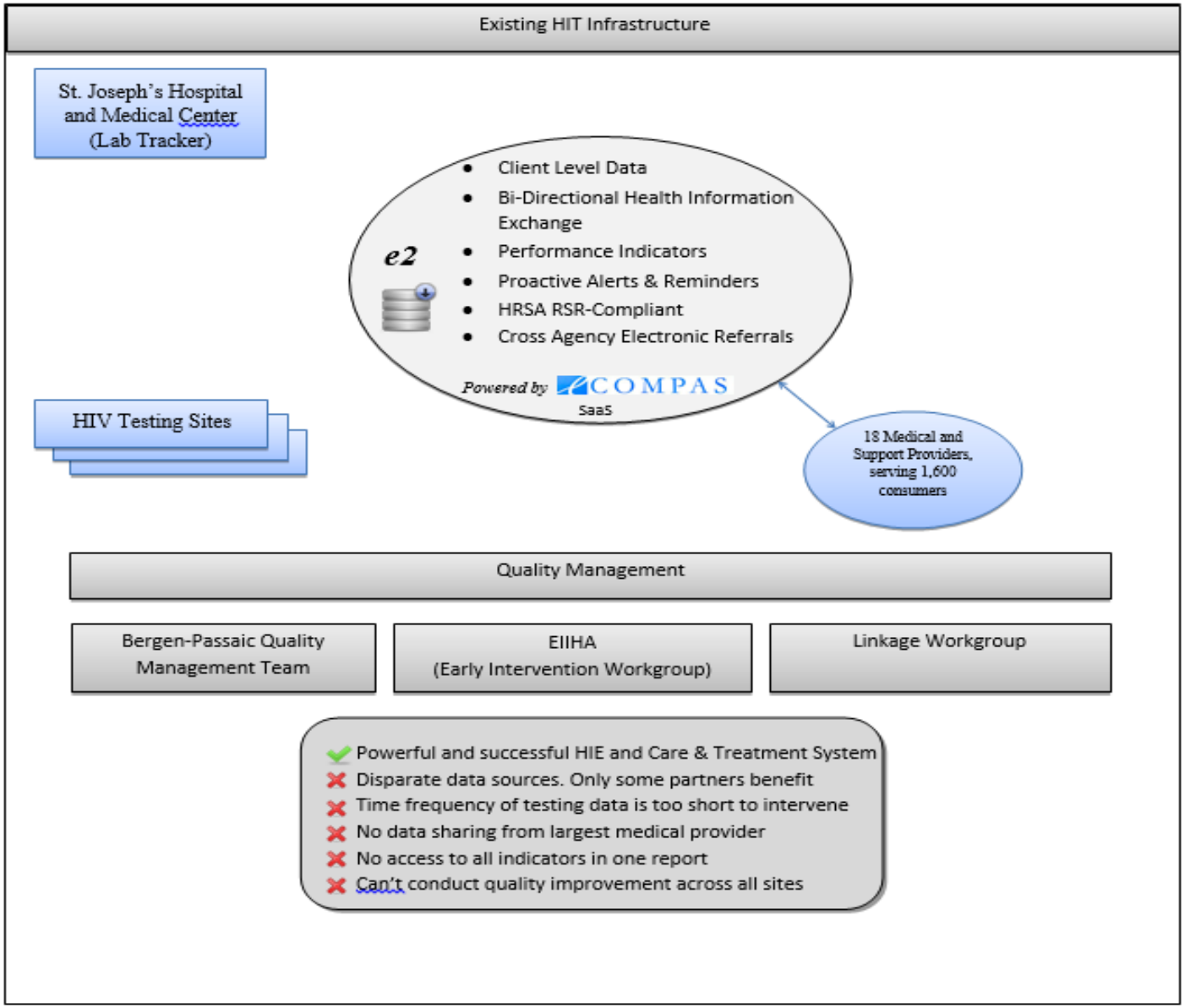
Create a coordinated regional system of HIV/AIDS medical services, joining outreach, HIV testing, early intervention and HIV medical providers to ensure that all individuals at risk for HIV have access to HIV testing, timely disclosure of test results, and rapid linkage to medical care, access to ARV therapy and sustained viral suppression.

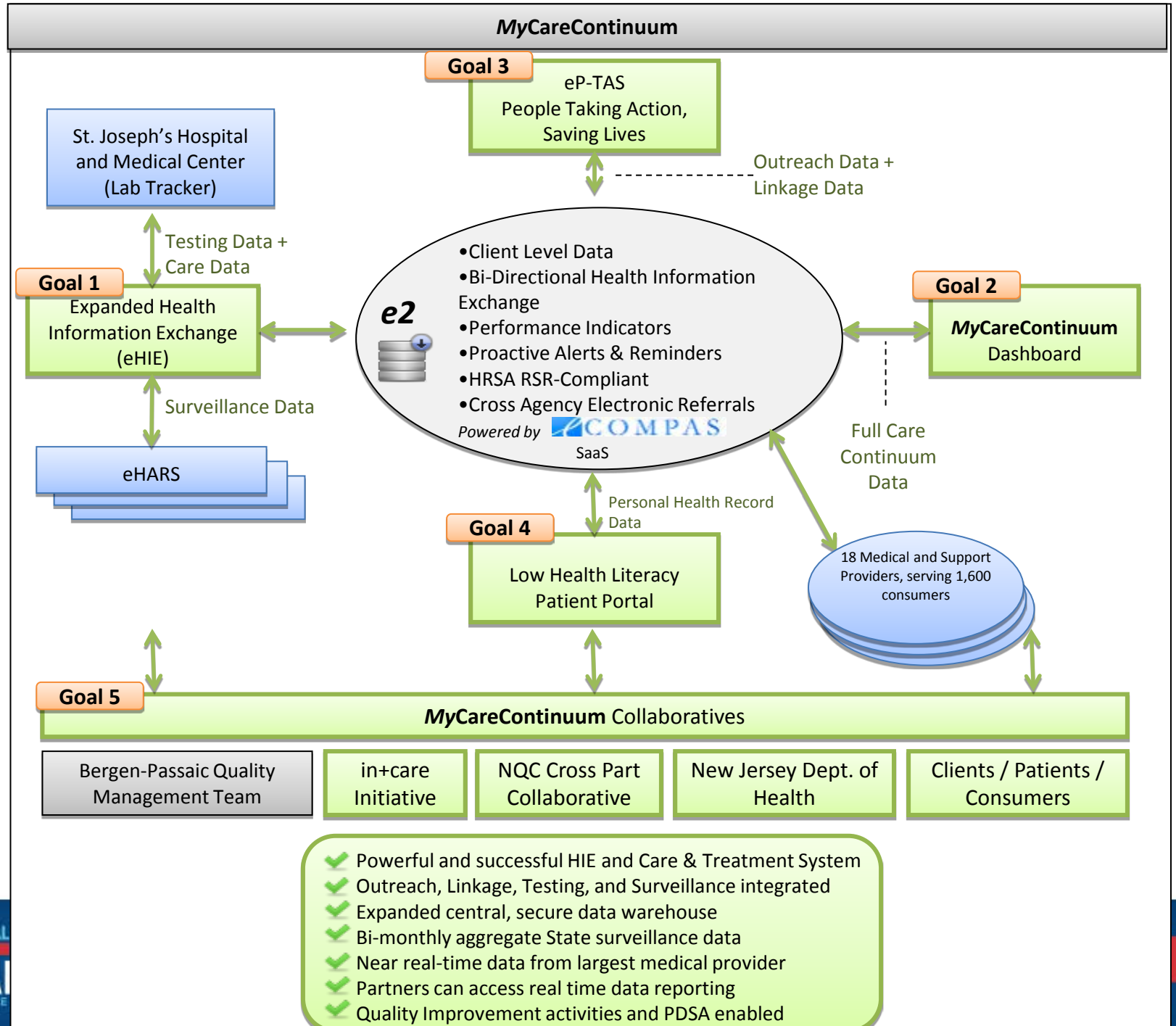
Objectives

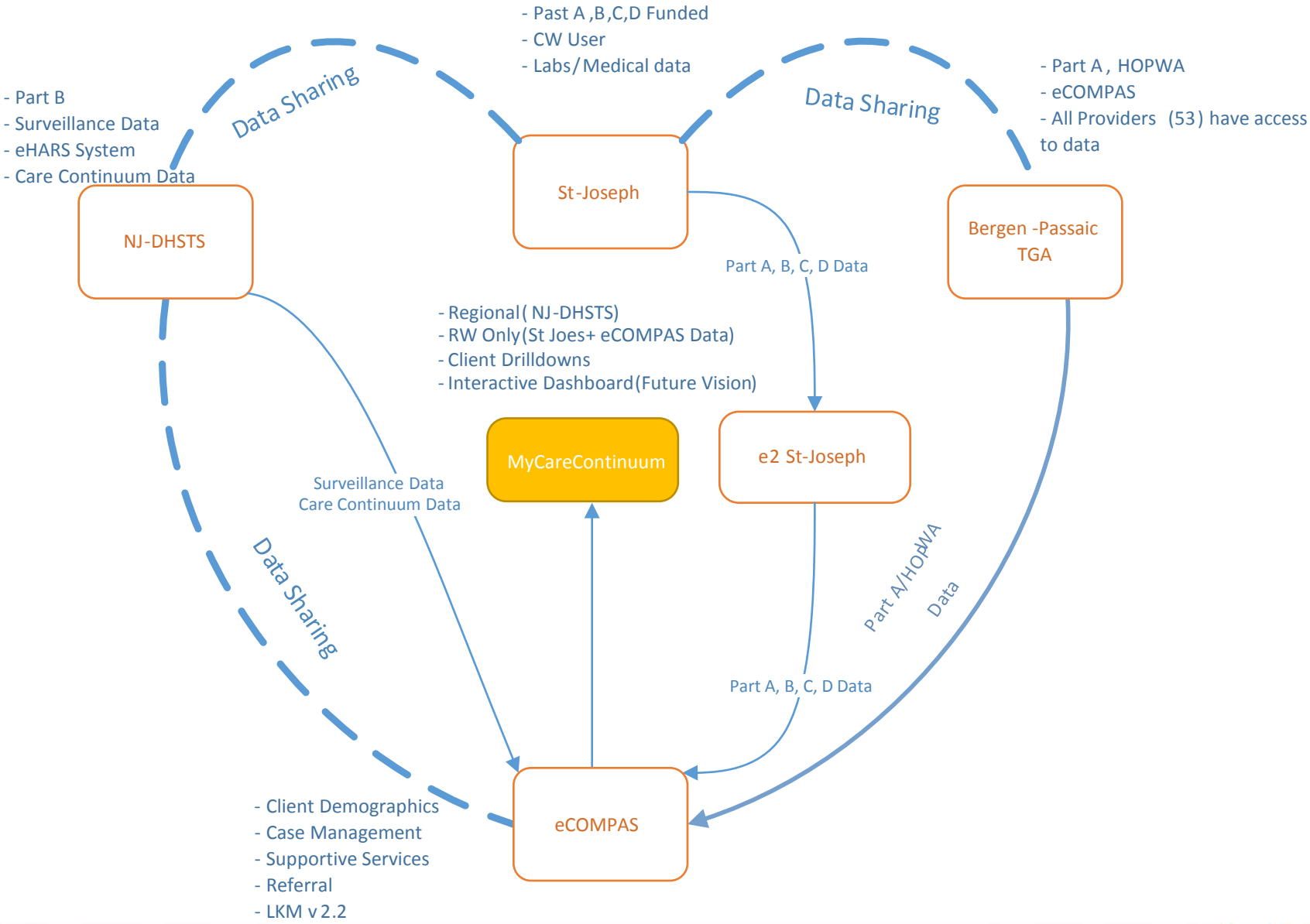
- Construct the Regional (RWHAP) and Local HIV Care Continuum as an interactive Continuum that allows the user to view any sub-section desired.
- Import data from NJ-DHSTS (Part B) into eCOMPAS
- Import data from St. Joseph's Hospital and Medical Center HIV Services (Part A, C and D) into eCOMPAS

Project Components

Project Components of The Bergen-Passaic MyCareContinuum SPNS Project	HIV Care Continuum Stage				
	1. Diagnosis	2. Linkage to Care	3. Retention in Care	4. Prescribed ART	5. Virally Suppressed
1. eHIE	X	X	X	X	X
2. MyCareContinuum Dashboard	X	X	X	X	X
3. eP-TAS	X	X			
4. Low Health Literacy Patient Portal			X		X
5. MyCareContinuum Collaboratives	X	X	X	X	X


Existing HIT Infrastructure
St. Joseph's Hospital and Medical Center (Lab Tracker)
e2
Client Level Data
Bi-Directional Health Information Exchange
Performance Indicators
Proactive Alerts & Reminders
HRSA RSR-Compliant
Cross Agency Electronic Referrals
Powered by COMPAS
SaaS
HIV Testing Sites
18 Medical and Support Providers, serving 1,600 consumers
Quality Management
Bergen-Passaic Quality Management Team
EIIHA (Early Intervention Workgroup)
Linkage Workgroup
Powerful and successful HIE and Care & Treatment System
Disparate data sources. Only some partners benefit
Time frequency of testing data is too short to intervene
No data sharing from largest medical provider
No access to all indicators in one report
Can't conduct quality improvement across all sites


MyCareContinuum
Goal 3
eP-TAS
People Taking Action, Saving Lives
Outreach Data + Linkage Data
St. Joseph's Hospital and Medical Center (Lab Tracker)
Testing Data + Care Data
Goal 1
Expanded Health Information Exchange (eHIE)
Surveillance Data
eHARS
e2
•Client Level Data
•Bi-Directional Health Information Exchange
•Performance Indicators
•Proactive Alerts & Reminders
•HRSA RSR-Compliant
•Cross Agency Electronic Referrals
Powered by COMPAS
SaaS
Goal 2
MyCareContinuum Dashboard
Full Care Continuum Data
Personal Health Record Data
Goal 4
Low Health Literacy Patient Portal
18 Medical and Support Providers, serving 1,600 consumers
Goal 5
MyCareContinuum Collaboratives
Bergen-Passaic Quality Management Team
in+care Initiative
NQC Cross Part Collaborative
New Jersey Dept. of Health
Clients / Patients / Consumers
Powerful and successful HIE and Care & Treatment System
Outreach, Linkage, Testing, and Surveillance integrated
Expanded central, secure data warehouse
Bi-monthly aggregate State surveillance data
Near real-time data from largest medical provider
Partners can access real time data reporting
Quality Improvement activities and PDSA enabled


- Past A ,B,C,D Funded
- CW User
- Labs/Medical data
- Part B
- Surveillance Data
- eHARS System
- Care Continuum Data
- Part A , HOPWA
- eCOMPAS
- All Providers (53) have access to data
Data Sharing
Data Sharing
Data Sharing
NJ-DHSTS
St-Joseph
Bergen -Passaic TGA
Part A, B, C, D Data
- Regional(NJ-DHSTS)
- RW Only(St Joes+ eCOMPAS Data)
- Client Drilldowns
- Interactive Dashboard(Future Vision)
MyCareContinuum
e2 St-Joseph
Surveillance Data
Care Continuum Data
Part A/HOPWA Data
Part A, B, C, D Data
- Client Demographics
- Case Management
- Supportive Services
- Referral
- LKM v 2.2
eCOMPAS

Goal 1: eHIE – Part C/D provider data import

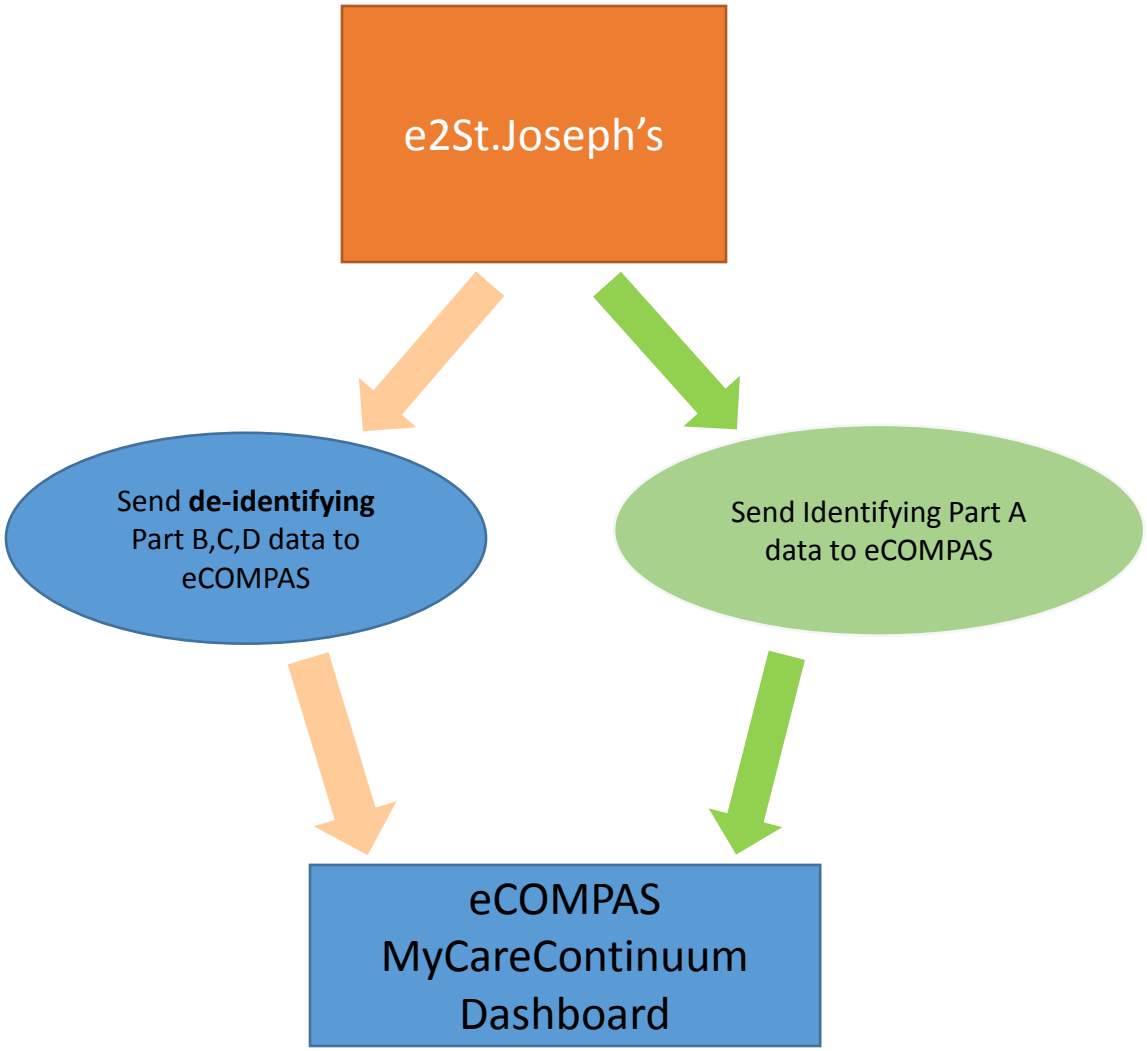
Objectives

- Import data from St. Joseph's Hospital & Medical Center HIV Services (Part A, B,C and D) into eCOMPAS
- Construct the Ryan White HIV Care Continuum for the MyCareContinuum Dashboard
- Reduce double data entry

Hi!

HIE

eHIE


e2St.Joseph's
Send **de-identifying** Part B,C,D data to eCOMPAS
Send Identifying Part A data to eCOMPAS
eCOMPAS MyCareContinuum Dashboard

Barriers and mitigation

Challenges

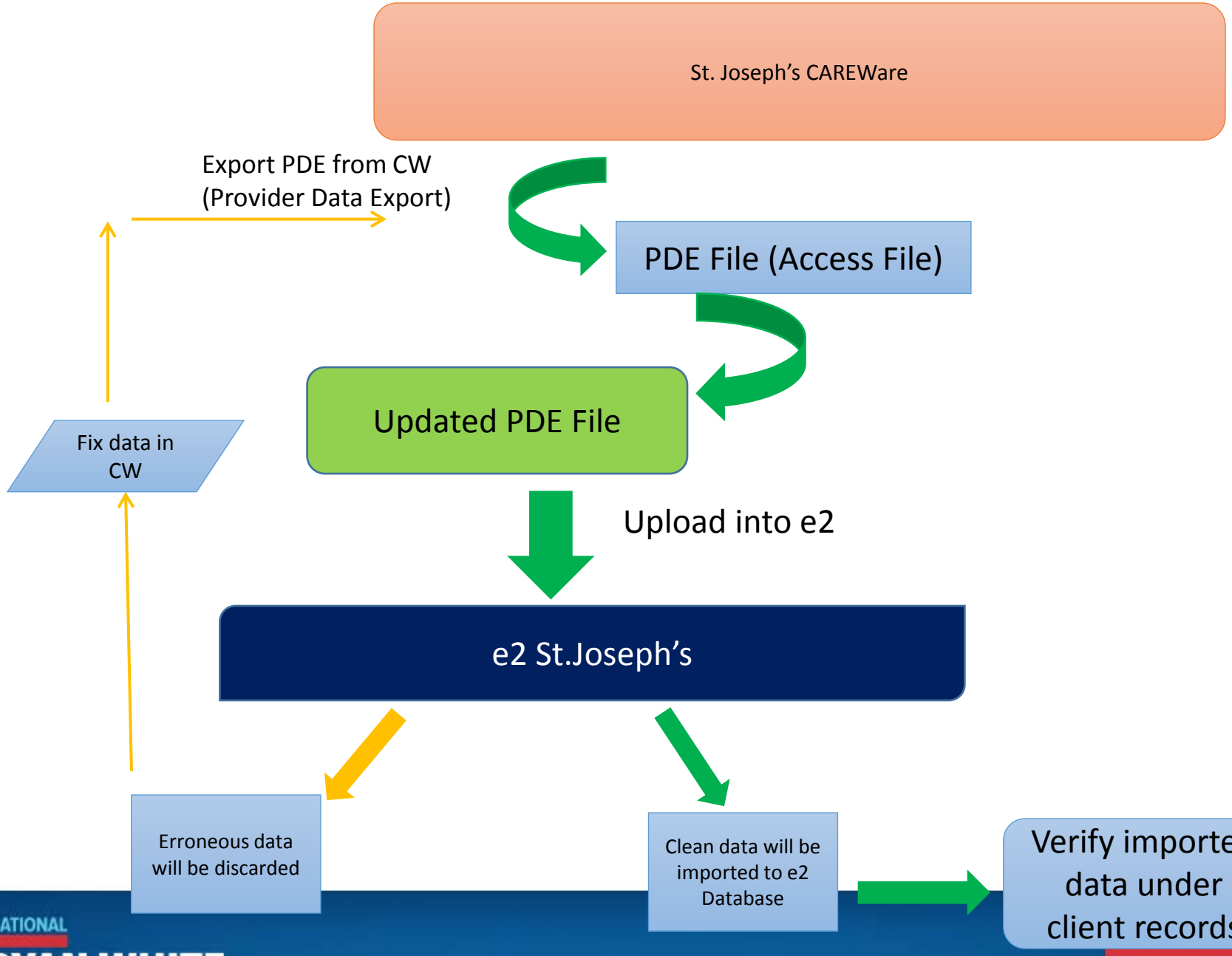
- Data exchange delayed - St. Joseph had their biggest move the hospital has ever seen.
- St. Joseph's data system (Aviga) was discontinued. Team was deciding on a new data system.
- St. Joseph's had to migrate historic data to the new data system selected – CAREWare
- Staff was new to CAREWare and had a learning curve.
- Approvals and confidentiality agreement.
- Matching algorithms

Mitigation

- SPNS team requested sample data sets from St. Joseph's as a first step.
- SPNS team is flexible on format, detail and timeframes.
- Care Continuum dashboard prototype built from aggregate data in parallel.
- Current status: Re-use eCOMPAS model System's CAREWare Data import using PDE (Provider Data Export)
- Proposed a win-win idea to import data into a intermediary site.

Success

- For the first time, RWHAP Part B provider agrees to explore sharing CLD with Part A Grantee.
- Collaboration with St. Joseph's data team to receive sample client level data.
- With PDE data import, prevent Part A double data entry.
- Data sharing and data import design.
- Sample CW file received.


St. Joseph's CAREWare
Export PDE from CW
(Provider Data Export)
PDE File (Access File)
Updated PDE File
Fix data in
CW
Upload into e2
e2 St.Joseph's
Erroneous data
will be discarded
Clean data will be
imported to e2
Database
Verify imported
data under
client records

Current Status and Next Steps

- Meetings/webinars between SPNS team and St. Joseph's team to finalize PDE template and final specifications.
- Data import design has been shared with St. Joseph's team.
- RDE will give St. Joseph's team access to e2Virginia's demo site
- Once specs are final and agreements in place, implementation will begin and prototype will be deployed for alpha testing

Benefits to the TGA

- Expanded central, secure data warehouse
- Construct the *My*CareContinuum Dashboard
- Allows broader analysis of Care Continuum indicators
- Supports planning, quality care and collaboration
- Supports coordination across the TGA in accordance with the Integrated Prevention and Care Plan
- Improve Patient Outcomes

Benefits to St. Joseph's

- Reduce double data entry
- Access to Part A Quality Program
- Potential cross part reports

eHIE- Data Import from NJ-DHSTS (eHARS)

Objectives

- Construct the Regional HIV Care Continuum in accordance with SPNS objectives, i.e. an interactive Continuum that allows the user to view any sub-section desired.
- Institute a bi-directional data exchange between eCOMPAS and eHARS.
- Focus limited resources on clients who are truly out of care
- Successful collaboration with NJ-DHSTS

Barriers and Mitigation

Challenges

- Coordinating with NJDHSTS to receive client level eHARS data.
- Client matching between eCOMPAS and eHARS.
- Establishing Data Exchange Agreement.
- Reviewing protocols and confidentiality policy.
- NJDHSTS requirement to perform client matches before data exchange.
- City of Paterson not compatible with NJDHSTS requirements for full client match

Mitigation

- SPNS team engaged in multiple conference calls with key data personnel.
- SPNS team proposed a matching algorithm using common elements between eHARS and eCOMPAS.
- Proposed a win-win idea to send Part A data to the State for matching and eHARS supplementation.
- Pilot test for 100 clients
- Use random Reference ID to identify matching clients to comply with client confidentiality.
- Expanding eCOMPAS to have the ability to capture full first and last names using advanced encryption model (LKMv2.1 -Local Key Model)

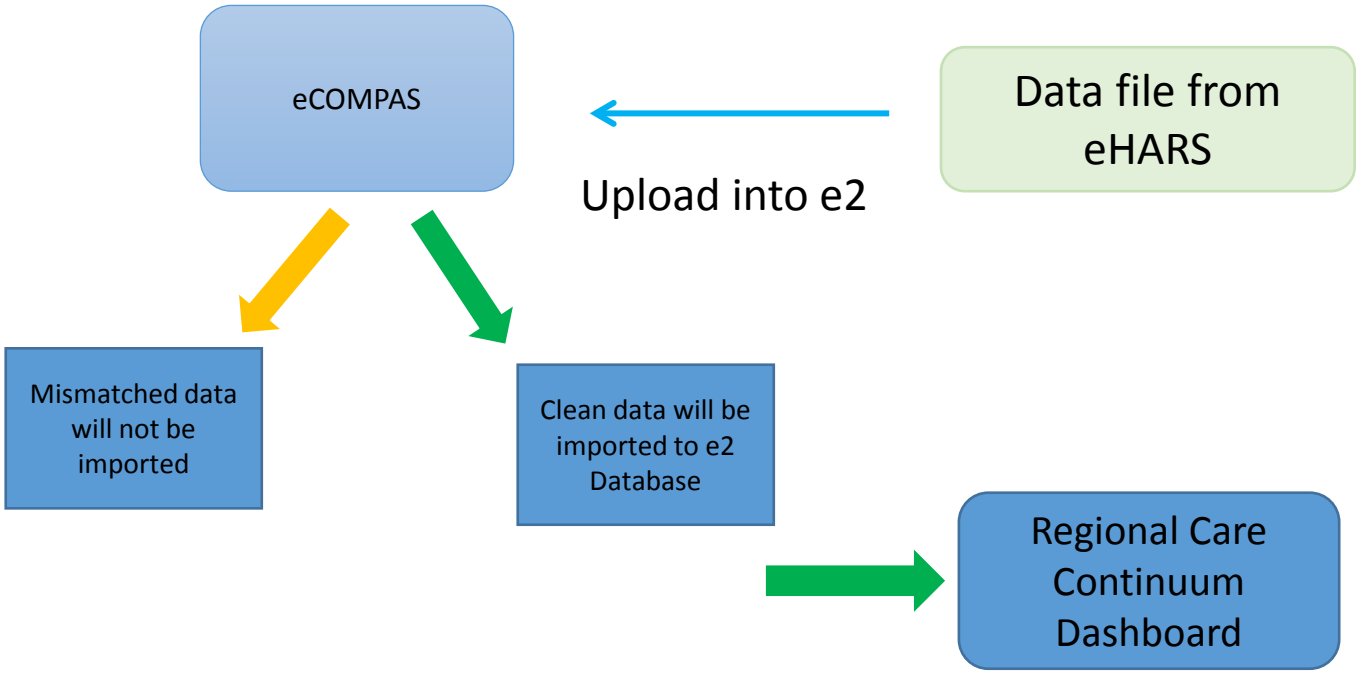
Success

- For the first time, NJ-DHSTS agrees to collaborate on Data Exchange.
- SPNS team continue to collaborate with NJ-DHSTS with the intention to succeed.
- If eHARS is missing data, the data exchange will help NJ-DHSTS complete eHARS data.
- eCOMPAS users can enter and track full first and last names with advanced encryption model (LKMv2.1 -Local Key Model)

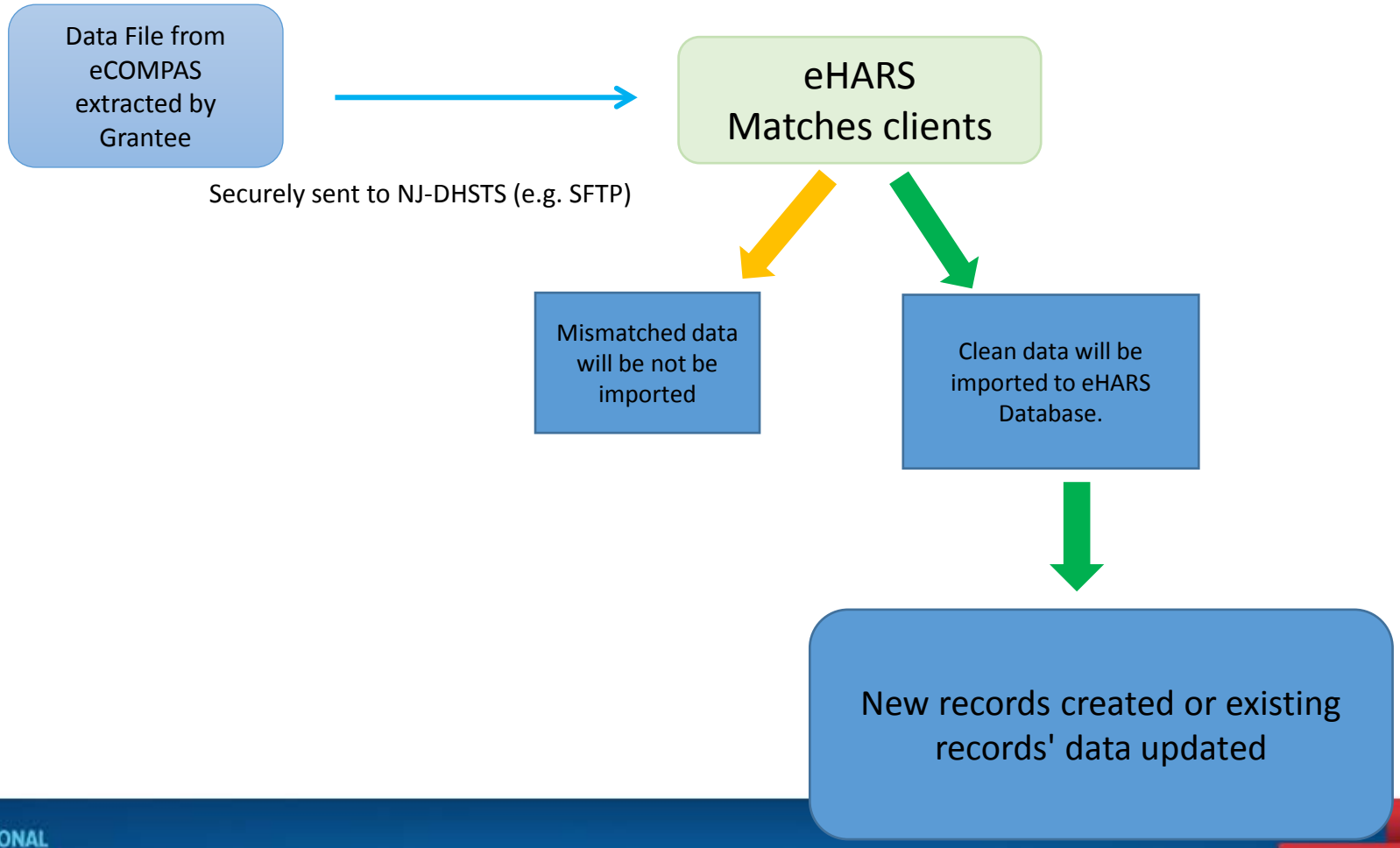
Coordinating with NJ-DHSTS to receive client level eHARS data.

- 100 clients pilot is complete
  - Full match between eCOMPAS and eHARS
- SPNS team and NJ-DHSTS continue to identify mutual benefits of client level data exchange and care continuum
- Consensus and agreement
- Data exchange design

Data Exchange TGA's Perspective



Data Exchange NJ-DHSTS' Perspective



Benefits to the TGA

- **Expanded central, secure data warehouse**
- **Construct the *My*CareContinnum Dashboard**
- **Track Out of Care Patients using the Data from eHARS**

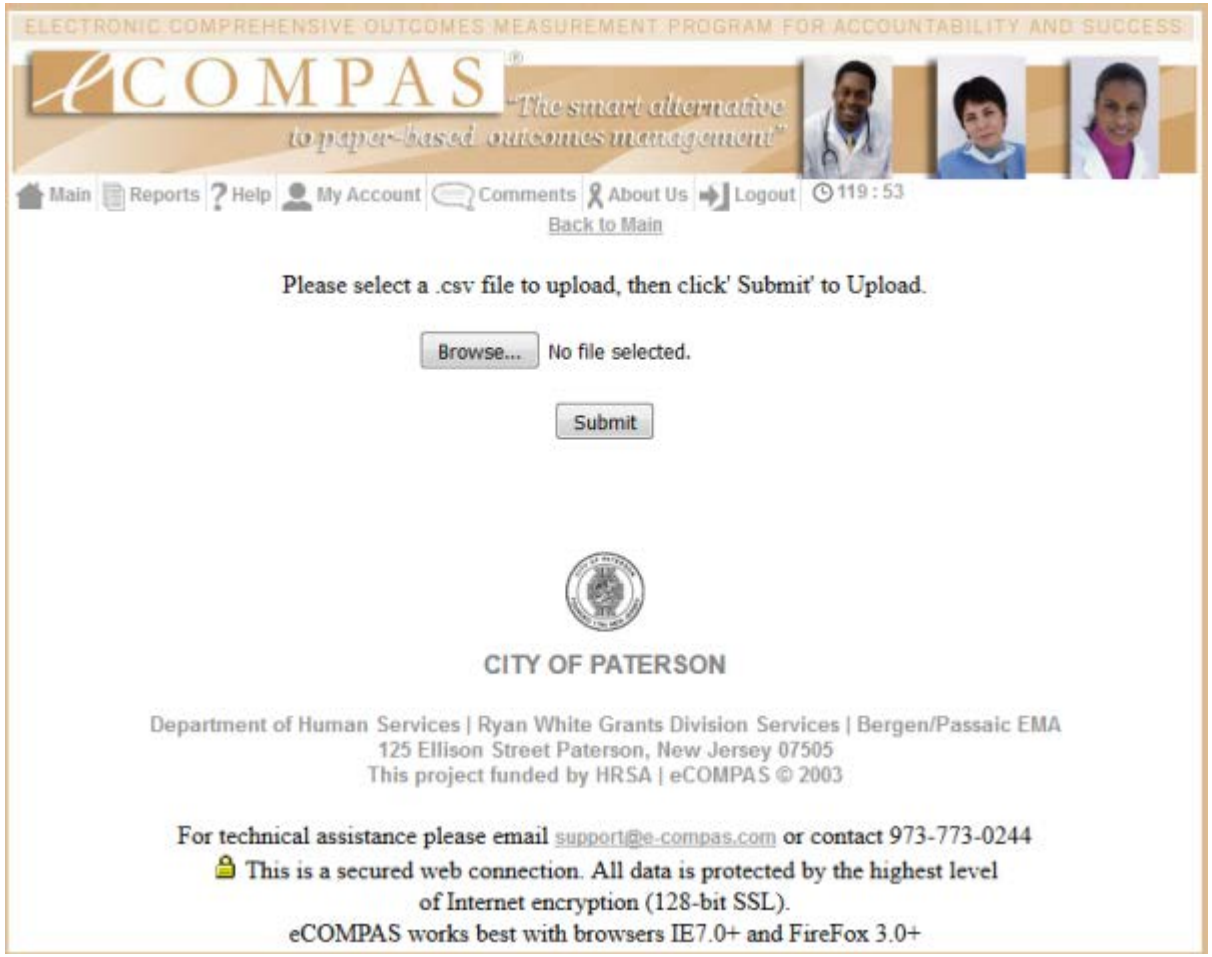
Benefits to NJ-DHSTS

- **Expand eHARS data sources**
- **Facilitate an Out of Care list**
- **Replicate Data Exchange model with other EMA/TGAs.**

Current Status and Next Steps

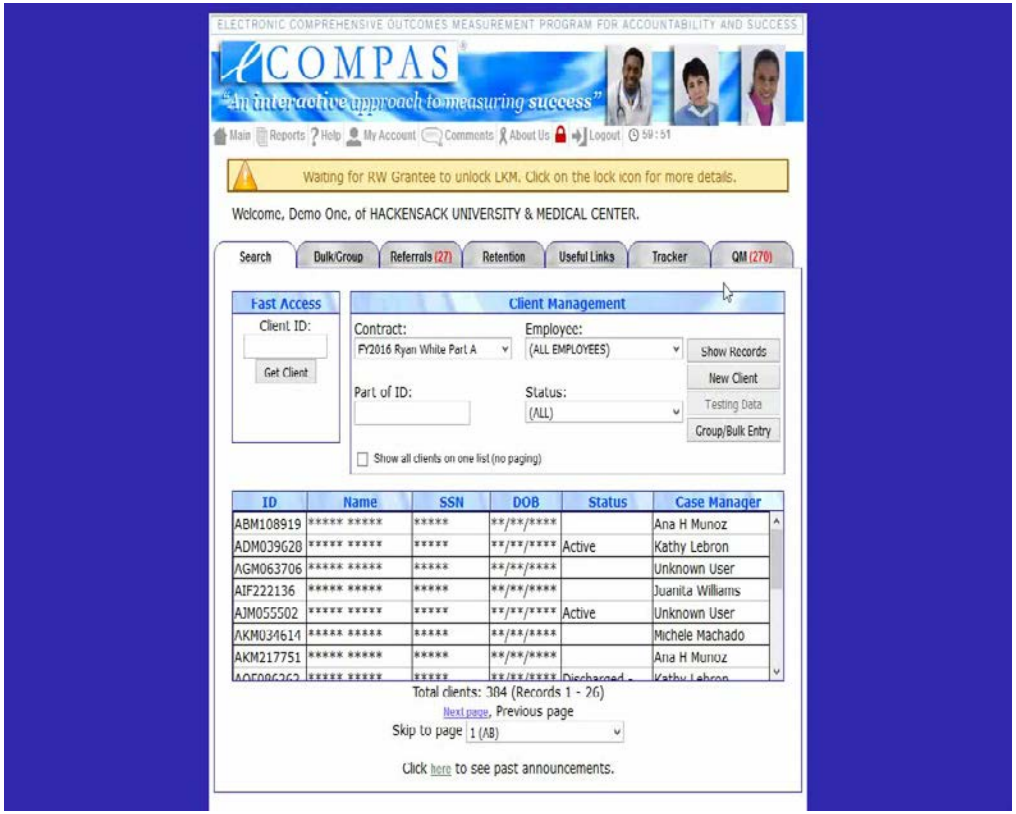
- Data agreement executed.
- 100 pilot records delivered to NJ-DHSTS and all records match.
- Decision point – Further collaboration under discussion.
- LKMv2.1 implementation in eCOMPAS in progress.

Prototype

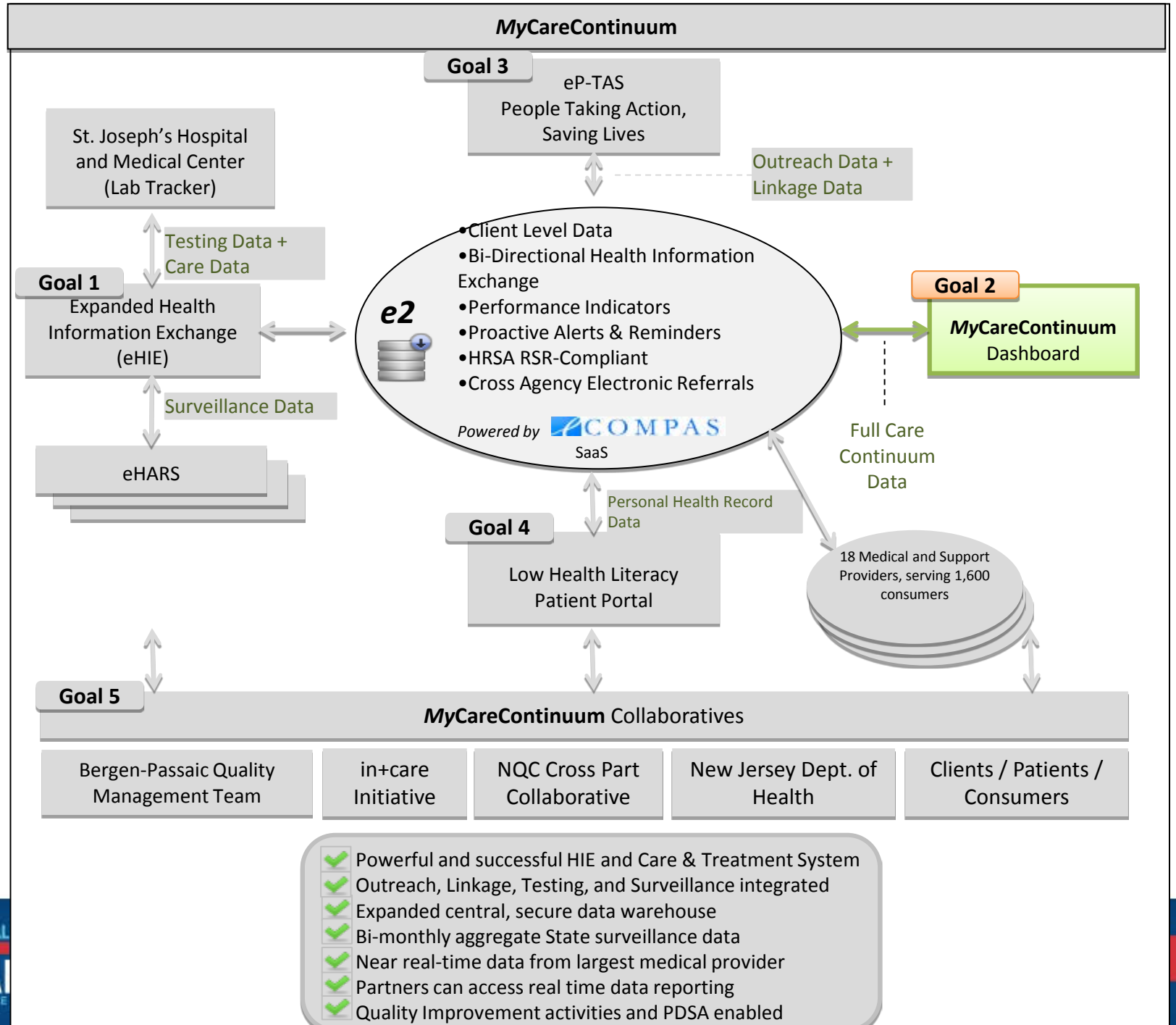

ELECTRONIC COMPREHENSIVE OUTCOMES MEASUREMENT PROGRAM FOR ACCOUNTABILITY AND SUCCESS
eCOMPAS
"The smart alternative to paper-based outcomes management"
Main
Reports
Help
My Account
Comments
About Us
Logout
119 : 53
Back to Main
Please select a .csv file to upload, then click' Submit' to Upload.
Browse...
No file selected.
Submit
CITY OF PATERSON
Department of Human Services | Ryan White Grants Division Services | Bergen/Passaic EMA
125 Ellison Street Paterson, New Jersey 07505
This project funded by HRSA | eCOMPAS © 2003
For technical assistance please email support@e-compas.com or contact 973-773-0244
This is a secured web connection. All data is protected by the highest level of Internet encryption (128-bit SSL).
eCOMPAS works best with browsers IE7.0+ and FireFox 3.0+

Paterson eCOMPAS LKMv2

- Link to file



Goal 2: *My*CareContinuum Dashboard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Bi-monthly aggregate State surveillance data
Near real-time data from largest medical provider
Partners can access real time data reporting
Quality Improvement activities and PDSA enabled

Objective

- Construct the HIV Care Continuum from testing and treatment data specific to the Bergen-Passaic TGA
- Provide a tool to coordinate and improve quality of HIV actions leading to optimal viral load suppression
- Provide break-down and drill-down capabilities to enhance analysis, planning, quality improvement and decision-making

Constructing the HIV Care Continuum

- General requirements
- Indicators and definitions
- Data harvesting
- Demographic variables
- Interactive prototypes

Two HIV Care Continua

- **Regional – utilizes eHARS data from NJ-DHSTS Office of Epidemiology**
- **RWHAP – utilizes eCOMPAS data from the Part A and Part C/D databases**

Each has its own data set, definitions, limitations and challenges

Definitions and Data Sources

Regional HIV Care Continuum

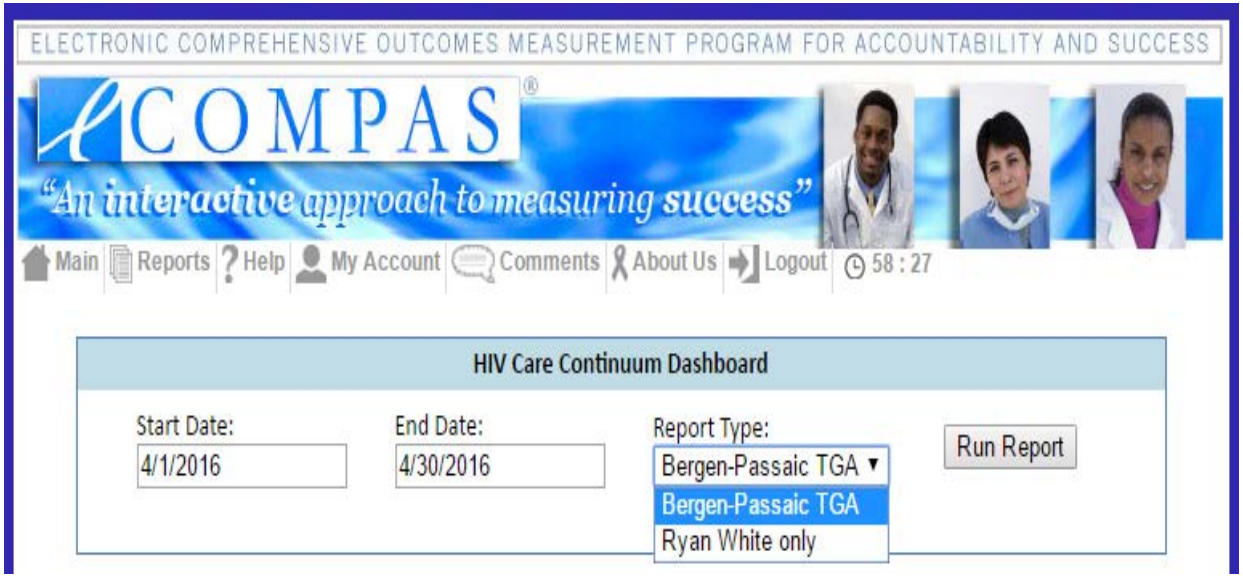
- HIV Diagnosed: PLWH diagnosed in Bergen or Passaic County as of 12/31/2014; excludes deceased and persons no longer living in NJ. Source: NJ-DHSTS eHARS Surveillance System.
- Linked to Care: Received least one CD4, VL test or medical visit in 12 months ending 12/31/2014. Source: NJ-DHSTS eHARS Surveillance System.
- Retained in Care: Received two or more medical visits, CD4 or VL test at 60 days apart in 12 months ending 12/31/2014. Source: NJ-DHSTS eHARS Surveillance System.
- ARV Therapy: Numerator = Patients in Bergen-Passaic RWHAP clinics prescribed ARV in CY 2014 as recorded in patient medical record; includes St. Joseph's Comprehensive Care Center. Denominator = Total patients enrolled in RHWAP clinics from 2010 to 2014. Excludes deceased patients. Source: eCOMPAS information system; NJ-Cross Part Collaborative (NJ-CPC) bi-monthly reports for St. Joseph's Comprehensive Care Center.
- Viral Load Suppression: Patients with <200mL achieved at last measurement in CY 2014. Source: NJ-DHSTS eHARS Surveillance System.
- Age cohorts13-18, 19-24, 55-64, 65+ are estimated based on 2010 eHARS and 2014 NJ-CPC summarized reports.

RWHAP HIV Care Continuum

- HIV Diagnosed: PLWH enrolled in RWHAP since 2010. Source: eCOMPAS information system; NJ-Cross Part Collaborative (NJ-CPC) bi-monthly report for St. Joseph's Comprehensive Care Center.
- Linked to Care: Received least one CD4, VL test or medical visit in 12 months ending 12/31/2014. Source: eCOMPAS information system; NJ-Cross Part Collaborative (NJ-CPC) bi-monthly report for St. Joseph's Comprehensive Care Center.
- Retained in Care: Received two or more medical visits, CD4 or VL test at 60 days apart in 12 months ending 12/31/2014. Source: eCOMPAS information system; NJ-Cross Part Collaborative (NJ-CPC) bi-monthly report for St. Joseph's Comprehensive Care Center.
- ARV Therapy: Numerator = Patients in Bergen-Passaic RWHAP clinics prescribed ARV in CY 2014 as recorded in patient medical record; includes St. Joseph's Comprehensive Care Center. Denominator = Total patients enrolled in RHWAP clinics from 2010 to 2014. Excludes deceased patients. Source: eCOMPAS information system; NJ-Cross Part Collaborative (NJ-CPC) bi-monthly report for St. Joseph's Comprehensive Care Center.
- Viral Load Suppression: Patients with <200mL achieved at last measurement in CY 2014. Source: eCOMPAS information system; NJ-Cross Part Collaborative (NJ-CPC) bi-monthly report for St. Joseph's Comprehensive Care Center.
- Age cohorts 13-18, 19-24, 55-64, 65+ are estimated based on 2014 NJ-CPC reports.

Demo


ELECTRONIC COMPREHENSIVE OUTCOMES MEASUREMENT PROGRAM FOR ACCOUNTABILITY AND SUCCESS
COMPAS
"An interactive approach to measuring success"
Main
Reports
Help
My Account
Comments
About Us
Logout
50 : 11
Welcome, John Other, of BUDDIES OF NJ.
Search
Bulk/Group
Referrals (319)
Retention
Useful Links
Tracker
QM (369)
Dashboard
Fast Access
Client ID:
Get Client
Client Management
Contract:
FY2016 Ryan White Part A
Employee:
(ALL EMPLOYEES)
Show Records
New Client
Testing Data
Group/Bulk Entry
Part of ID:
Status:
(ALL)
Show all clients on one list (no paging)


ELECTRONIC COMPREHENSIVE OUTCOMES MEASUREMENT PROGRAM FOR ACCOUNTABILITY AND SUCCESS
eCOMPAS®
"An interactive approach to measuring success"
Main
Reports
Help
My Account
Comments
About Us
Logout
58 : 27
HIV Care Continuum Dashboard
Start Date:
4/1/2016
End Date:
4/30/2016
Report Type:
Bergen-Passaic TGA
Bergen-Passaic TGA
Ryan White only
Run Report

HIV Care Continuum Dashboard

Start Date: 01/01/2015

End Date: 12/31/2015

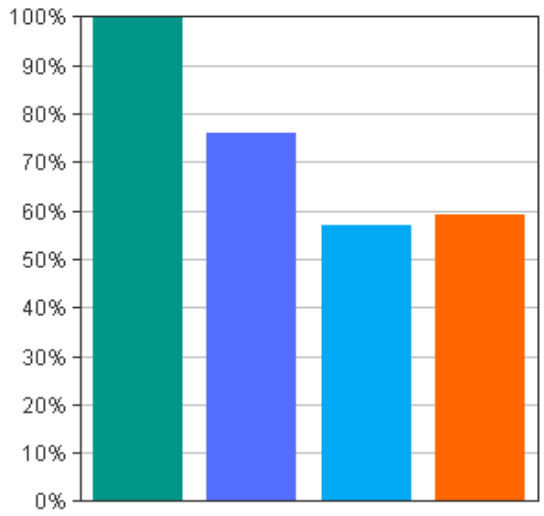
Report Type: Bergen-Passaic TGA

- Bergen-Passaic TGA
- Ryan White only

Run Report

Summary | Graphical View | Tabular View

Bergen-Passaic TGA HIV Care Measures



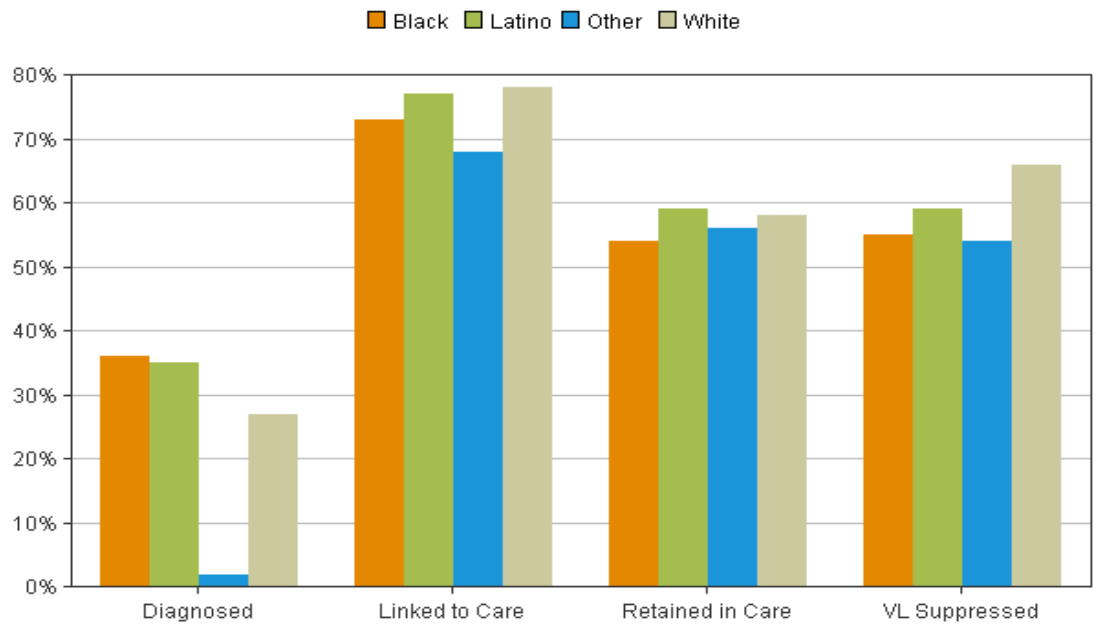
Summary Table		[?]
Positively Diagnosed	3397	100.00%
Received HIV Care	2568	75.60%
Continiously Retained in Care	1927	56.73%
Virally Suppressed	2013	59.26%
Study Population		3397

HIV Care Continuum Dashboard

Start Date: 01/01/2015 End Date: 12/31/2015 Report Type: Bergen-Passaic TGA Run Report

Summary | Graphical View | Tabular View

Bergen-Passaic TGA HIV Care Measures: by Race/Ethnicity



Summary | Graphical View | Tabular View

Bergen-Passaic TGA HIV Care Measures: by Race/Ethnicity

	Diagnosed		Linked to Care		Retained in Care		ARV Therapy		VL Suppressed	
Black	1602	36.67%	956	59.68%	666	41.57%	577	56.35%	545	34.02%
Latino	1534	35.11%	903	58.87%	648	42.24%	509	76.89%	620	40.42%
Other	84	1.92%	52	61.90%	30	35.71%	8	66.67%	32	38.10%
White	1149	26.30%	773	67.28%	473	41.17%	143	48.31%	552	48.04%

Summary

In (Received HIV Care)

dummy1234 dummy1234 dummy1234 dummy1234 dummy1234
dummy1234 dummy1234 dummy1234 dummy1234 dummy1234
dummy1234 dummy1234 dummy1234 dummy1234 dummy1234

										uppressed
0-12										0.00%
13-24										20.00%
25-34										35.68%
35-44										34.92%
45-54										38.29%
55 and older	1604	36.71%	1047	65.27%	739	46.07%	393	89.52%	750	46.76%

Bergen-Passaic TGA HIV Care Measures: by Gender

	Diagnosed		Linked to Care		Retained in Care		ARV Therapy		VL Suppressed	
Female	1481	33.90%	946	63.88%	680	45.91%	490	58.54%	627	42.34%
Male	2888	66.10%	1738	60.18%	1137	39.37%	747	65.47%	1122	38.85%

Benefits

- Truly innovative tool to help providers assess the continuum
- Data available from all the testing sites within the region and outside the Part A network
- HIV Positive clients identified in and outside Part A network
- Date of first medical visit available to determine if clients are in care anywhere within the State
- Medication data available to determine ART in RWHAP network
- Viral load data will help identify clients who are Virally Suppressed

Barriers and mitigation

Challenges

- Data Transfer through eHIE (expanded Health Information Exchange)
- Specifications
- Data consistencies across disparate databases at the small area

Mitigation

- Draft specifications built based on samples from NJ/NY Care Continuum models and Continuum of HIV Care Guidance for Local Analyses
- Mock-ups built based on the draft specs
- Functional prototype built with aggregate data in parallel while eHIE is in progress
- Data analysis and design

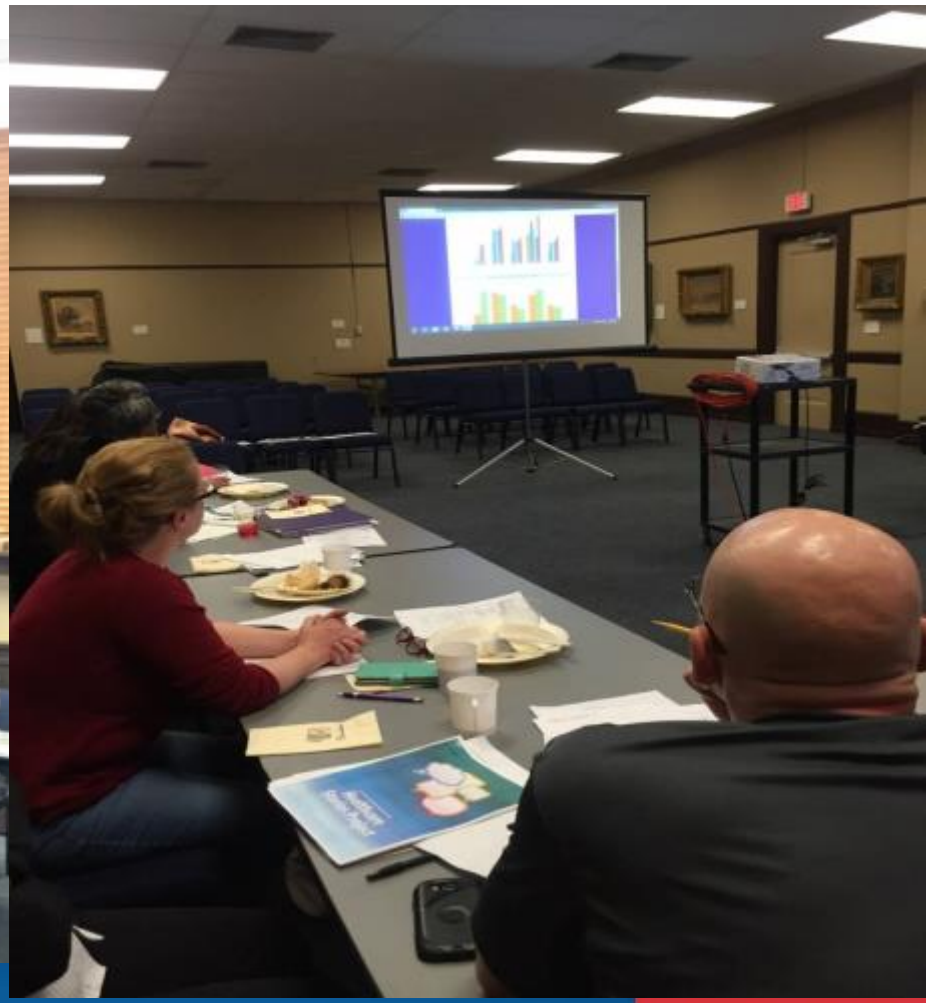
Success

- SPNS team was able to get a head start and were able to develop prototype of the dashboard.
- First prototype built with current summarized data
- Prototype demonstrated to Providers and Consumers at the Quarterly Quality Management Meeting on 4/18/2016.
- Valuable feedback from the QM meeting gathered and reviewed by SPNS team.
- 2015 aggregate data harvested and prototype update

Current Status and Next Steps

- Demonstrated the prototype to consumers and providers at the Quarterly Quality Management meeting on 4/18/2016
- Demonstrated the prototype to consumers and providers at Integrated Prevention and Care Planning Workshop on 8/17/2016
- Valuable discussion and feedback collected
- Next steps: Enhancements to the prototype
- Interactive dashboard

Bergen-Passaic
Quality Management Team
Studying the HIV Care Continuum



Feedback from Consumers and Providers

eCOMPAS

eCOMPAS Stakeholder Input Form

As you may know, users and stakeholders like to drive the development and enhancement of eCOMPAS right from the start. Your input is always welcome and appreciated. Please take a moment to help us again.

Name: Agency: Position:

1. Please list your top favorite features from today's demonstration and how it can help you provide better services, better oversight, save time, improve data quality, etc.

2. Please list any creative or constructive ideas you have to make today's new features better to meet your needs in serving your clients or managing your program. How would they help you?

Feedback from Consumers and Providers

Agency	Name	Please list your top favorite features from today's demonstration and how it can help you provide better service, better oversight, save time, improve data quality, etc.	Please list any creative or constructive ideas you have to make today's new features better to meet your needs in serving your clients or managing your program. How they would help you?	Additional Comments or Questions:
Paterson Counseling Center	Rosalyn Liebholder	Stimulating to view health and tools assessing literacy. The new addition to the eCOMPAS adds very good information. The correlation of office visits to suppression of HIV was intriguing. The discussion of the two medical visits being skewed), the switch between Medical and Ryan White was interesting. The concept of the patient portal on eCOMPAS and explanation was very good. Consumers input and ideas are interesting and the discussion was stimulating (about meeting today). Liked the health literacy improvement idea to educate patients in insurance literacy, health literacy, meeting the client where they are at.	Can develop a survey of questions to ascertain health improvement literacy. Tools (TOFLA) and further discussion would help case managers/providers/clinicians. Clients seem to grasp the Depression scale easily. To improve medical treatment compliance by continuing to reach out, understand the client, continue to be persistent, contacting the client, continue providing excellent services medical, mental health, case management. To continue to provide a supportive and caring stance with patients. To provide education and prevention services to the client.	N/A
CAPCO	Linda	Patient Portal. Health Insurance Literacy.	Do Outreach find out why clients are falling out of care, try to come up with a plan to get them back in care and stay.	N/A
Hackensack University Medical Center	Irene Panagiotis	N/A	Need ability to use referral tab to enter referrals to outside of RW agencies.	N/A

Quality Management Team 2016

Thank You!

Contact Us

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Collaborator: **Dr. Peter Gordon**, MD, Medical Director Comprehensive Health Program, NY Presbyterian

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Thank you Mayor Jose “joey” Torres,
Chief Elected Official
Ryan White Program
City of Paterson

CITY OF PATERSON