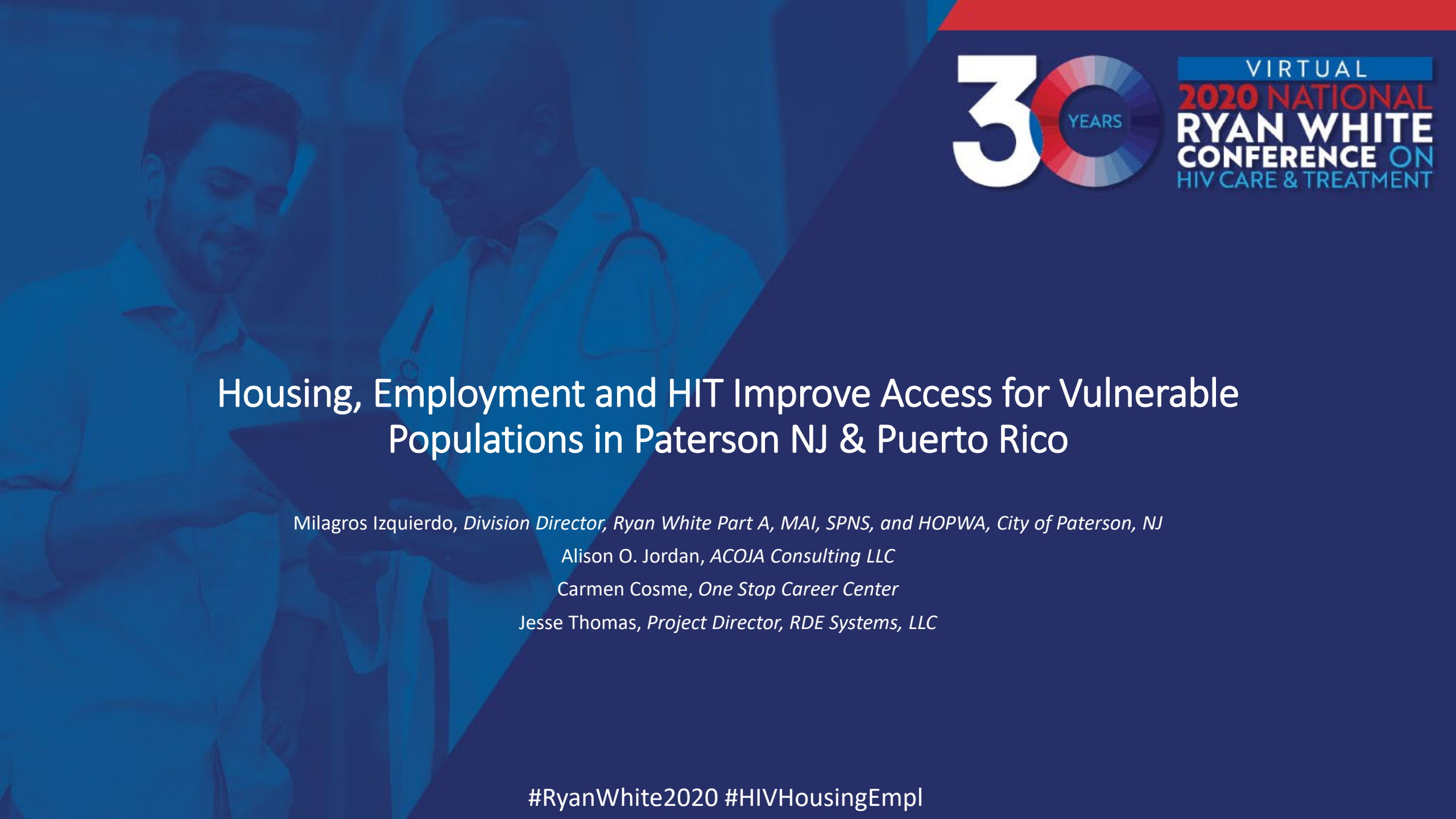


VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Housing, Employment and HIT Improve Access for Vulnerable Populations in Paterson NJ & Puerto Rico

Milagros Izquierdo, *Division Director, Ryan White Part A, MAI, SPNS, and HOPWA, City of Paterson, NJ*

Alison O. Jordan, *ACOJA Consulting LLC*

Carmen Cosme, *One Stop Career Center*

Jesse Thomas, *Project Director, RDE Systems, LLC*

#RyanWhite2020 #HIVHousingEmpl

Disclosures

- The City of Paterson, Department of Human Services has 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 AffinityCE/Professional Education Services Group in cooperation with HRSA and LRG. PESG, HRSA, LRG and all accrediting organization do not support or endorse any product or service mentioned in this activity.
- PESG, HRSA, and LRG staff as well as planners and reviewers have no relevant financial or nonfinancial interest to disclose.
- Commercial Support was not received for this activity.

Obtaining CME/CE Credit

If you would like to receive continuing education credit for this activity, please visit:

http://ryanwhite.cds.pesgce.com

Learning Objectives

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

1. Understand how a paradigm of health information and data exchange can **free up time better spent on client care and quality improvement** through interactive use of mobile audience engagement tools.

2. Describe how to adopt and adapt innovative strategies and approaches, implement web-based resources to achieve federal compliance and improve quality management, and **increase access to care for vulnerable populations** including people unstably housed with history of incarceration.

3. I**dentify key collaborative partners** in developing innovative approaches to coordinated care including housing, employment, community reentry, corrections, transportation and healthcare systems.

Presentation Outline

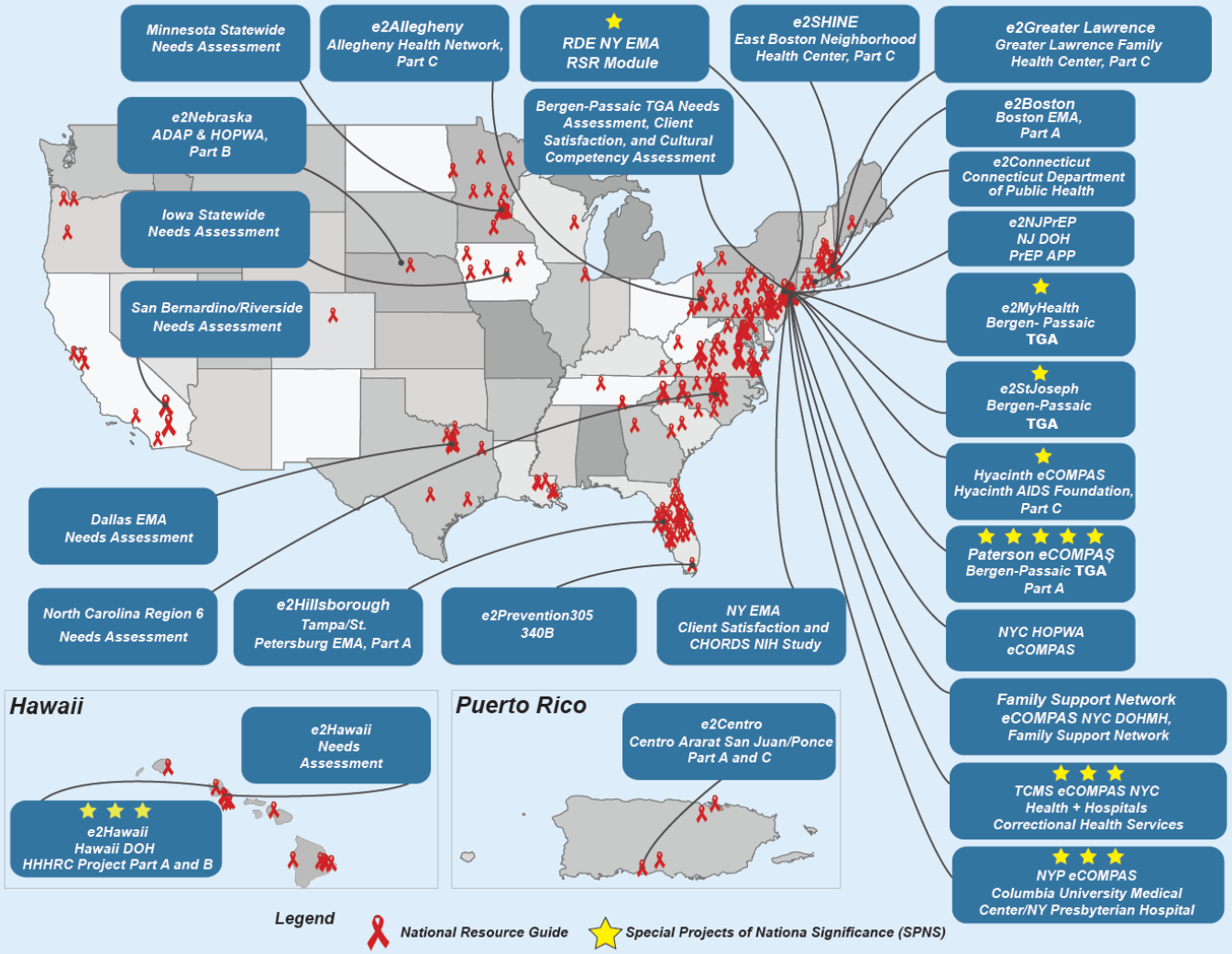
1. Introductions
2. Overview: Special Projects of National Significance (SPNS) innovations
3. Transitional Care Coordination, an evidence-informed intervention
4. Case Study #1: Pay it Forward - Integration in Puerto Rico
5. Case Study #2: Smart Care Management - City of Paterson, New Jersey
6. Lessons Learned & Recommendations

Welcome and Introductions

Synthesizing National Lessons Learned

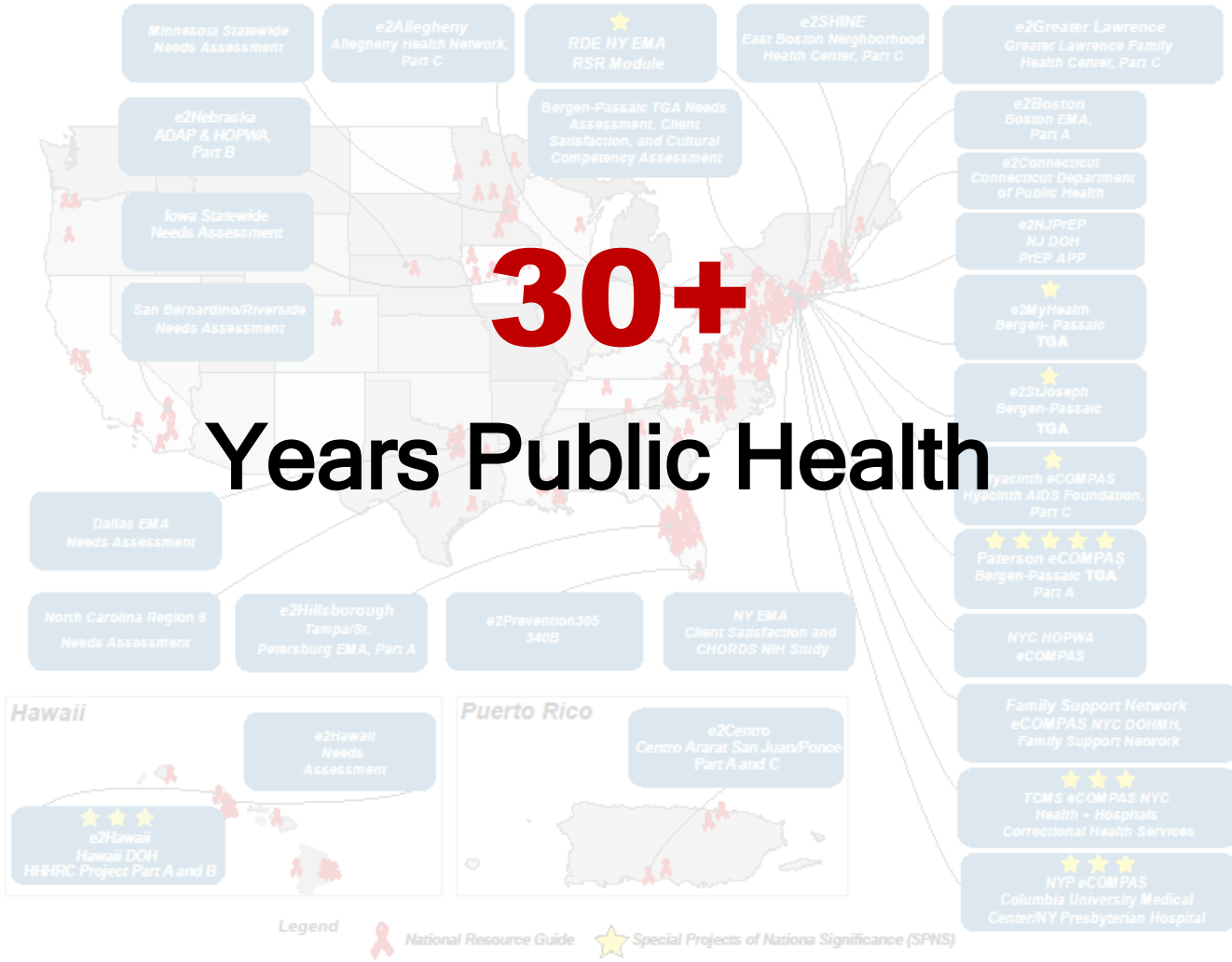
Programs

- ✓ CDC Prevention
- ✓ HRSA A,B,C,D
- ✓ HRSA ADAP
- ✓ HRSA SPNS
- ✓ HRSA AETC
- ✓ HUD HOPWA
- ✓ NIH
- ✓ ONC



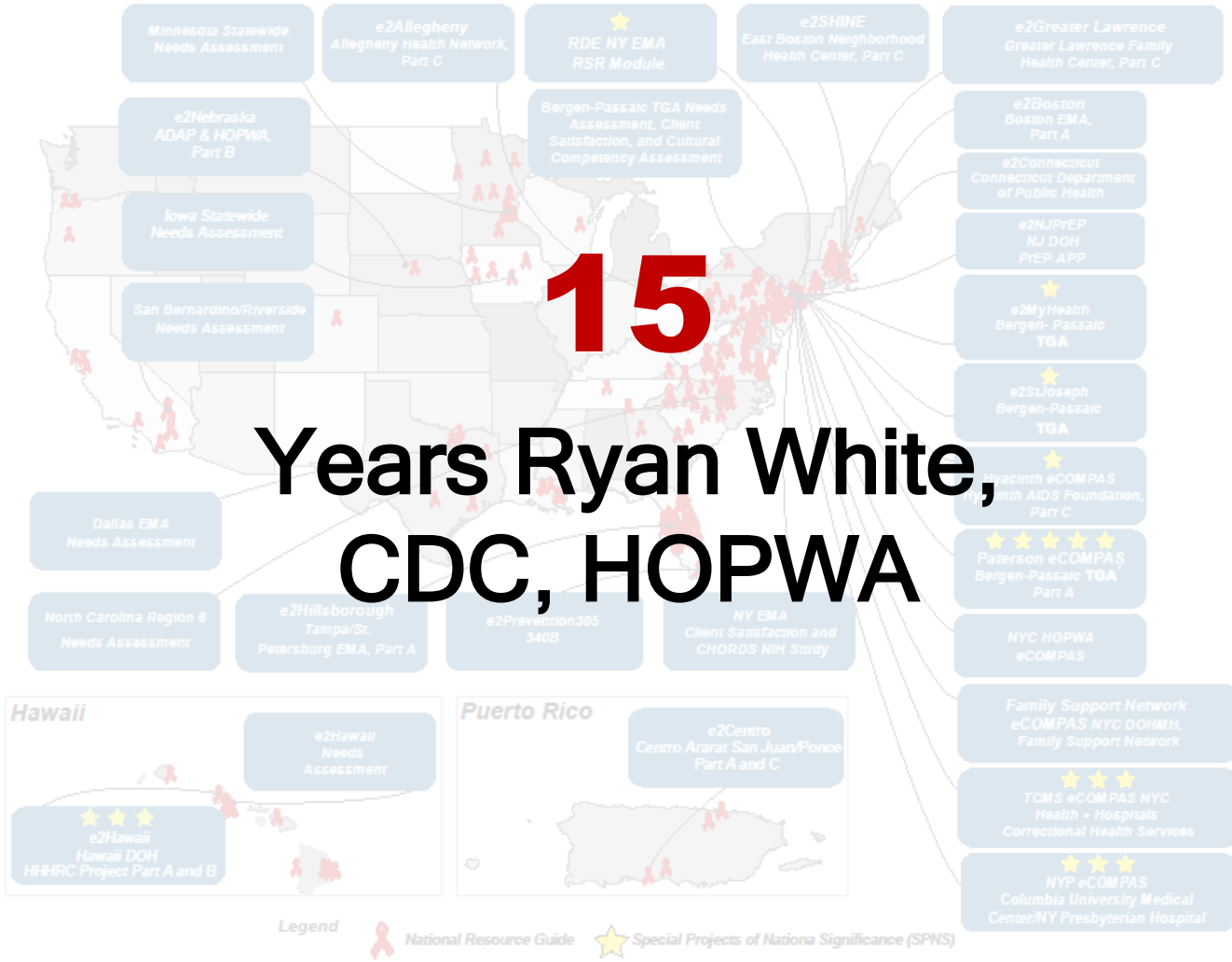
Users

- ✓ Recipients
- ✓ Sub-Recipients
- ✓ Public Health
- ✓ Human Services
- ✓ Health Networks
- ✓ Hard Reduction
- ✓ Clinics
- ✓ CBOs
- ✓ Planning Commissions
- ✓ Clients & Patients



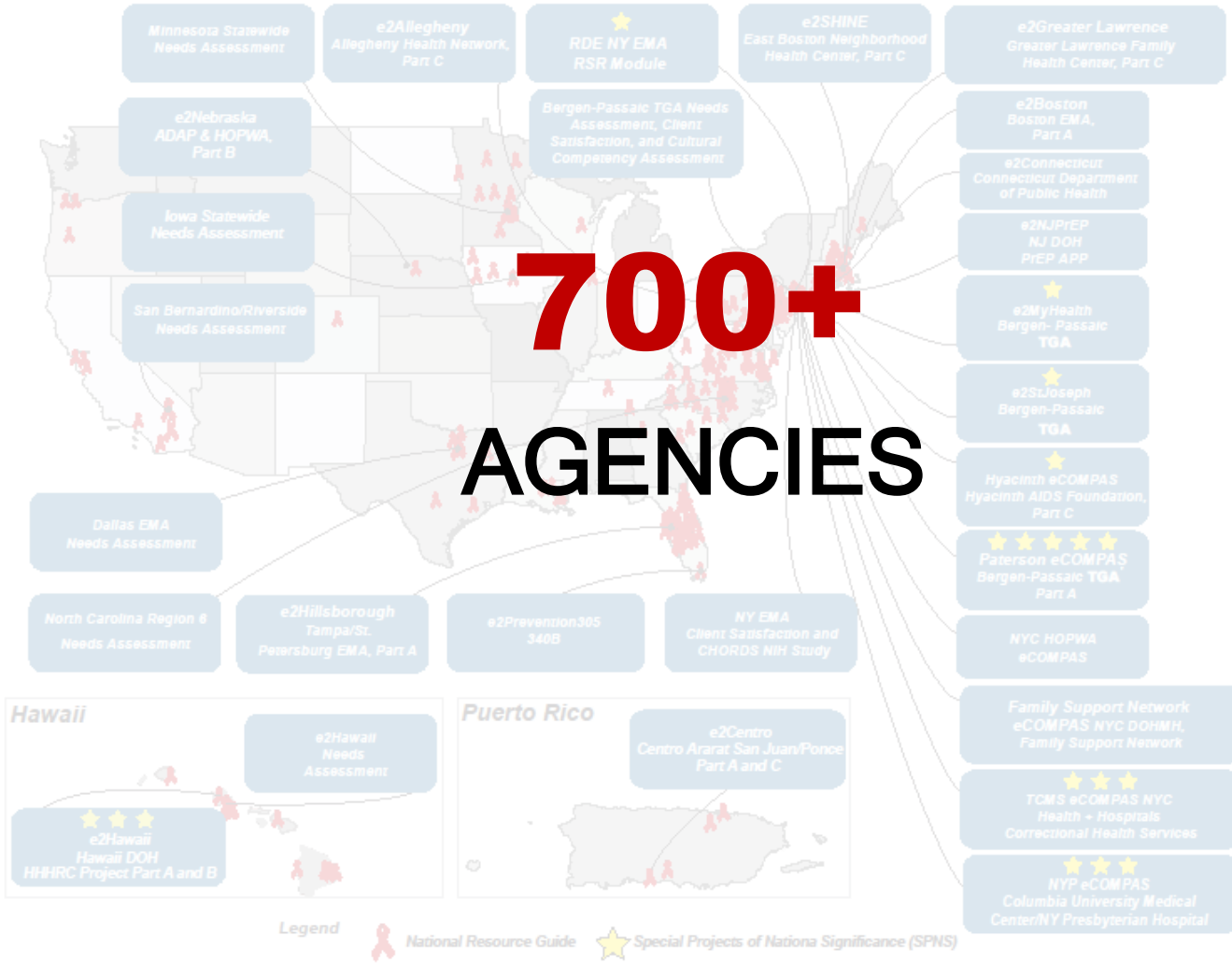
30+

Years Public Health



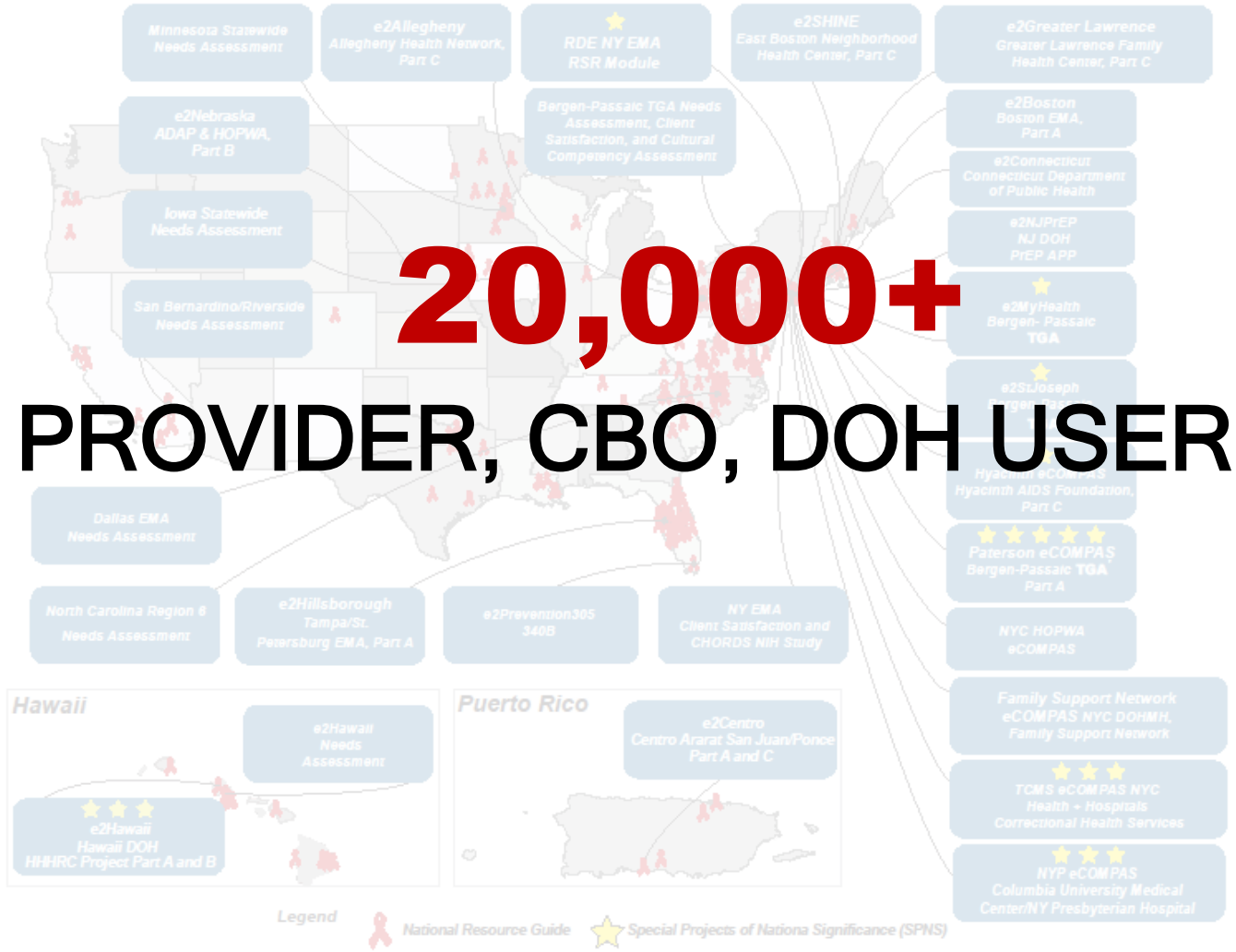
15

Years Ryan White, CDC, HOPWA



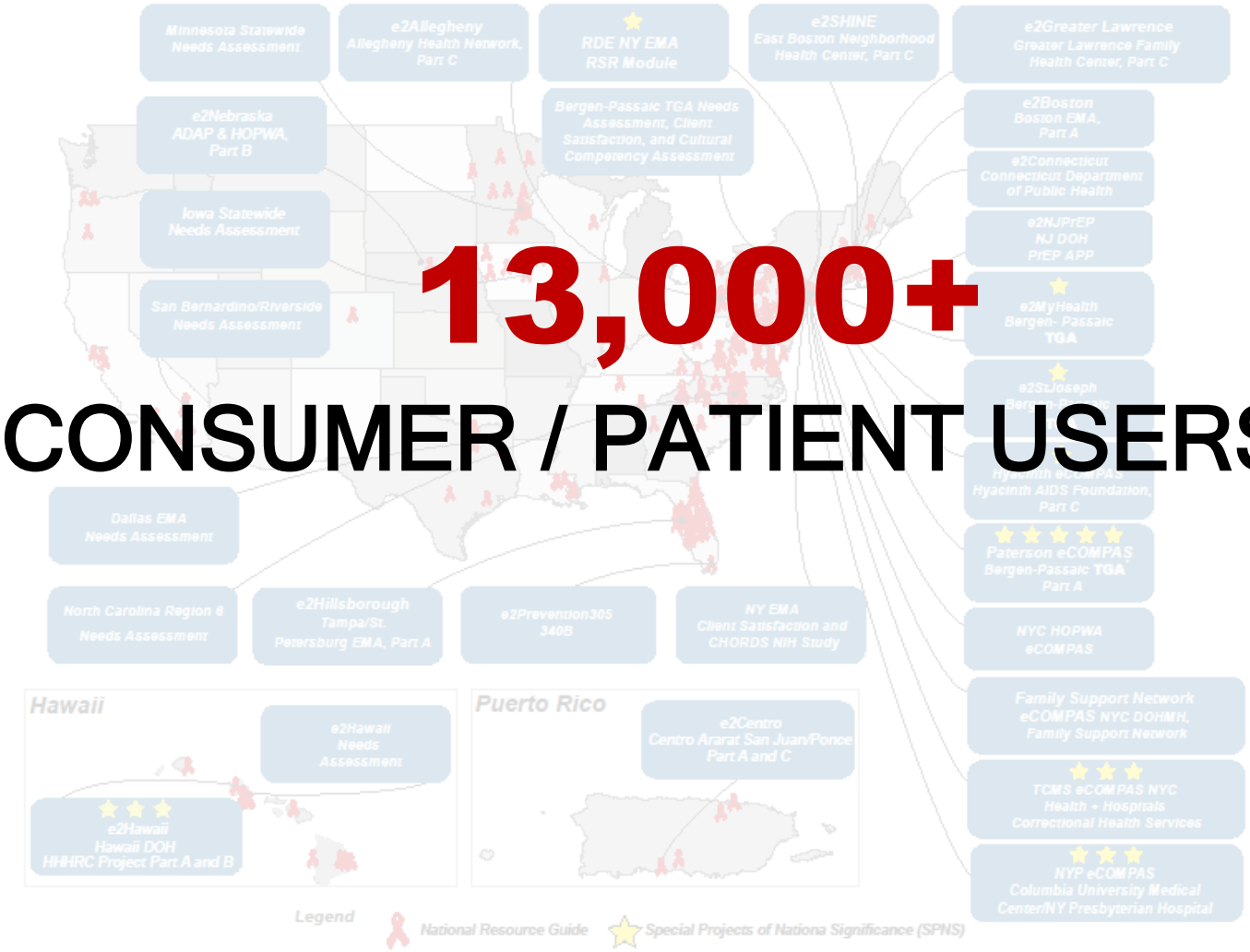
700+

AGENCIES



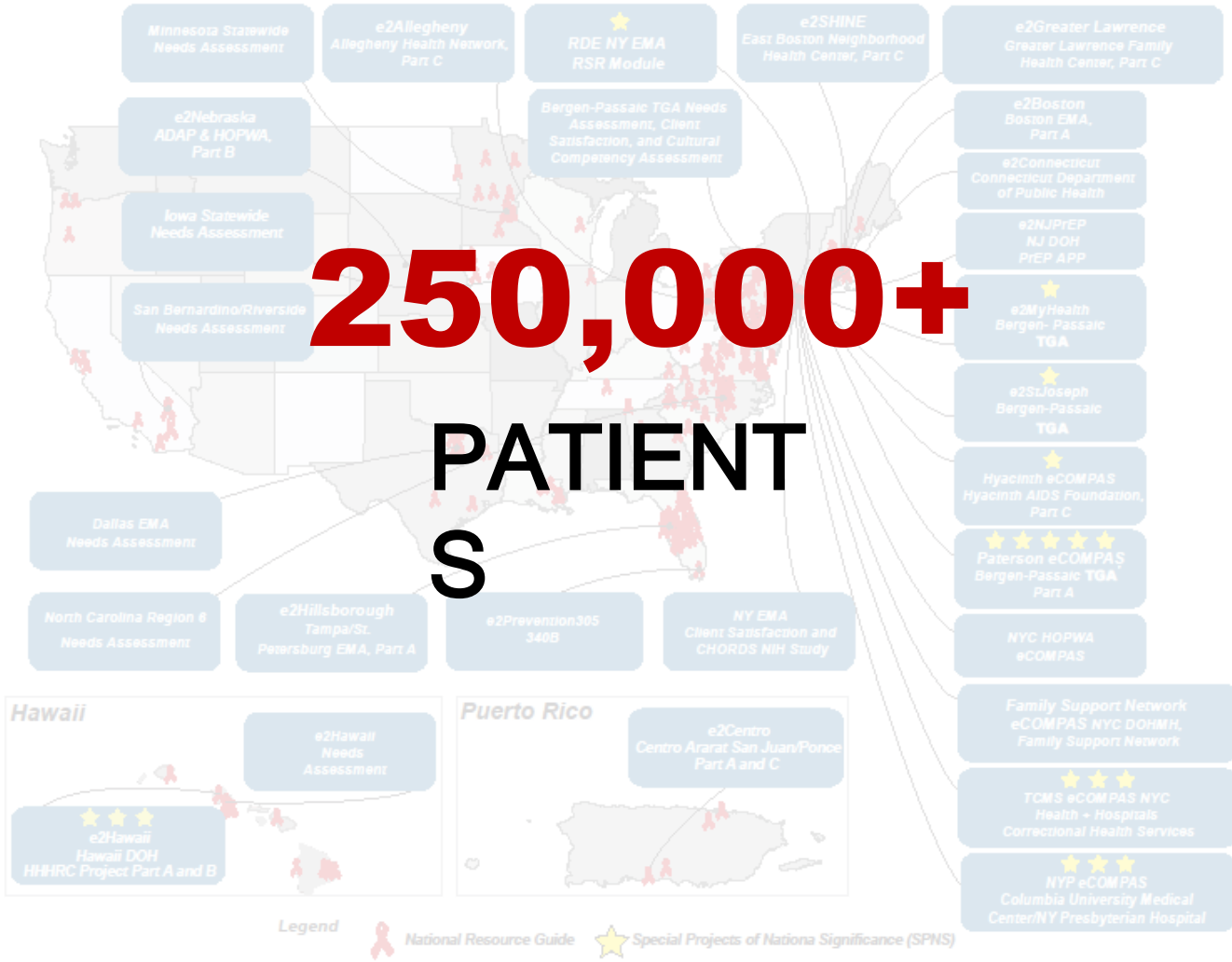
20,000+

PROVIDER, CBO, DOH USERS



13,000+

CONSUMER / PATIENT USERS



250,000+

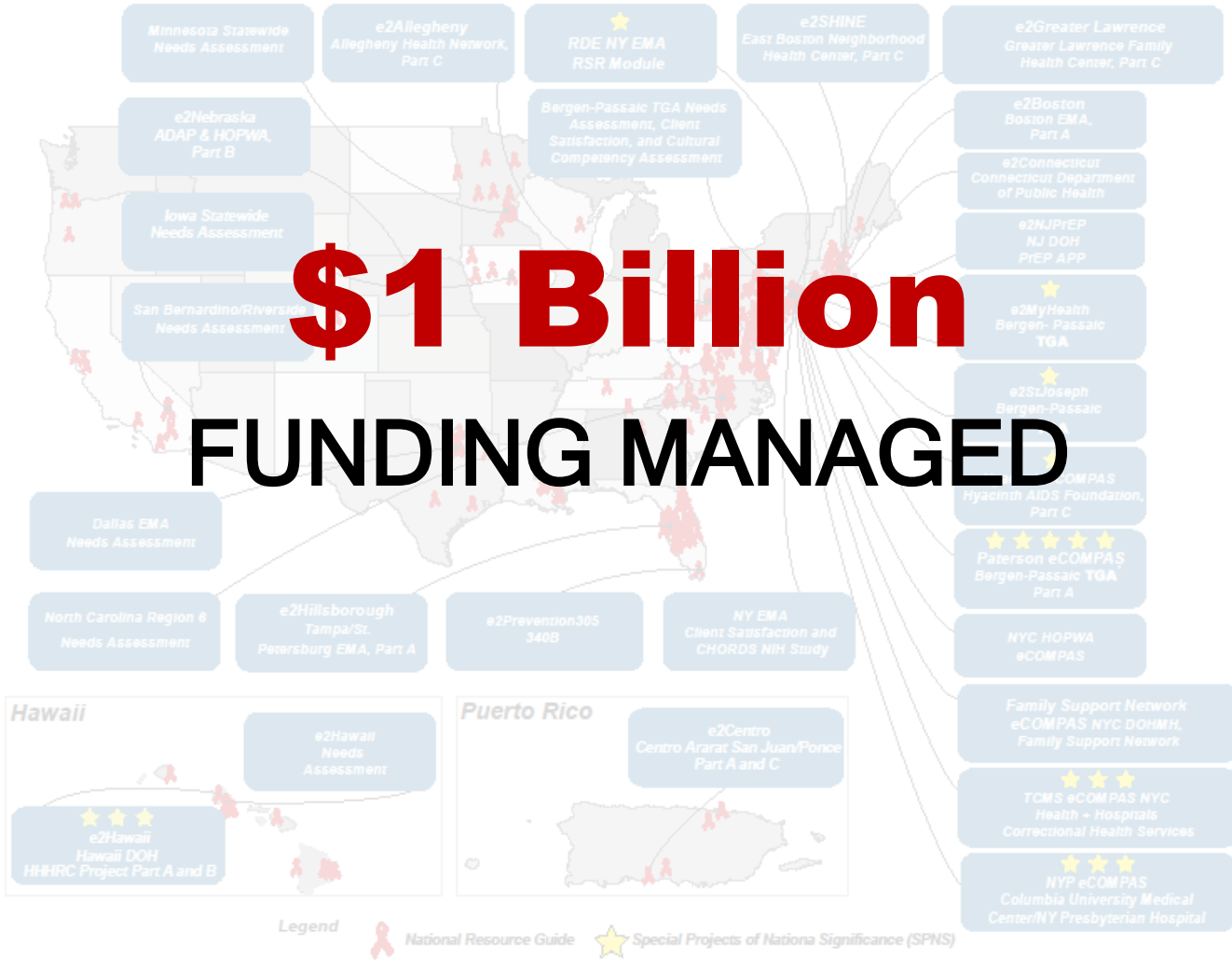
PATIENTS

Security and Privacy are #1

+

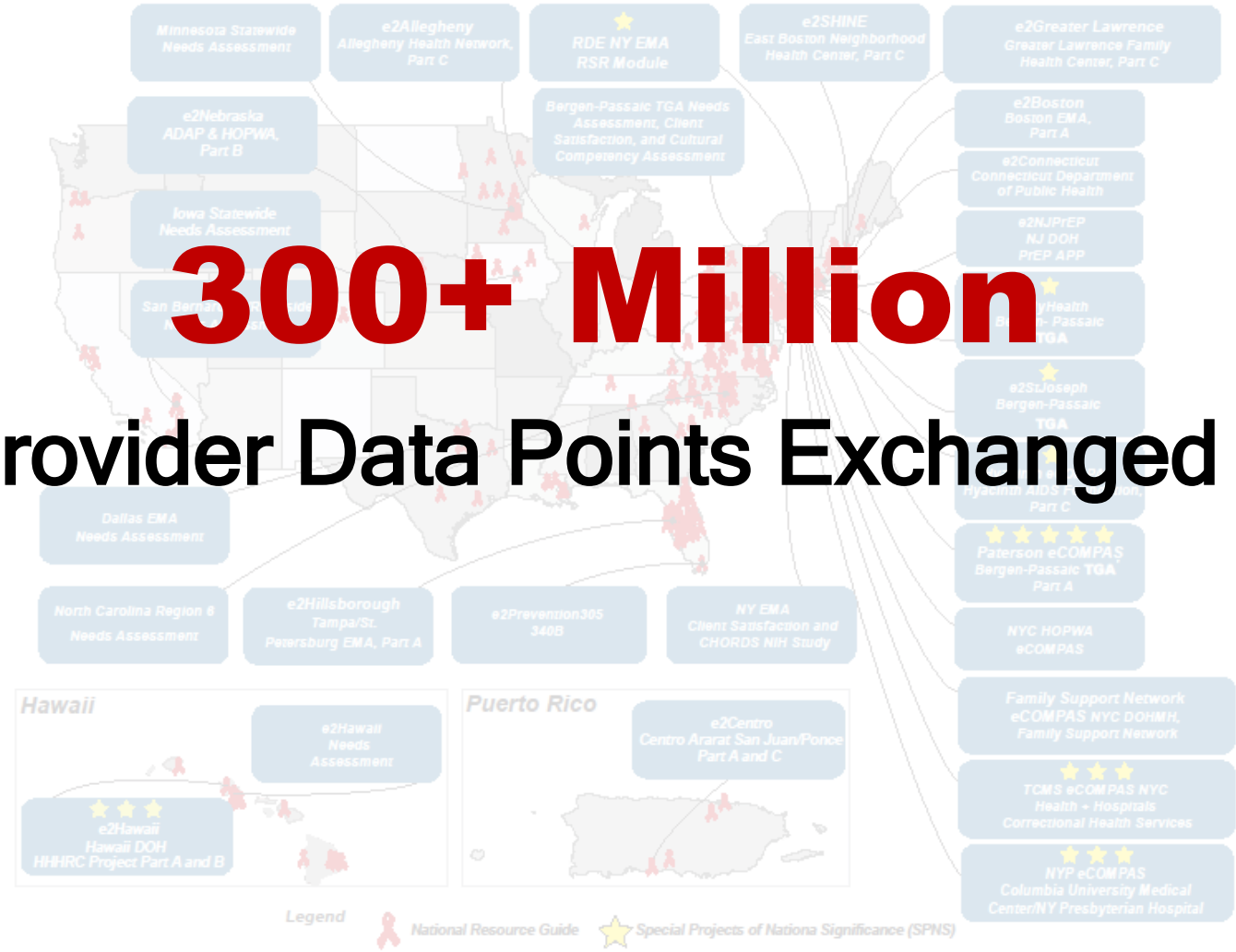
e2 LKM

eCOMPAS Advanced Encryption



$1 Billion

FUNDING MANAGED

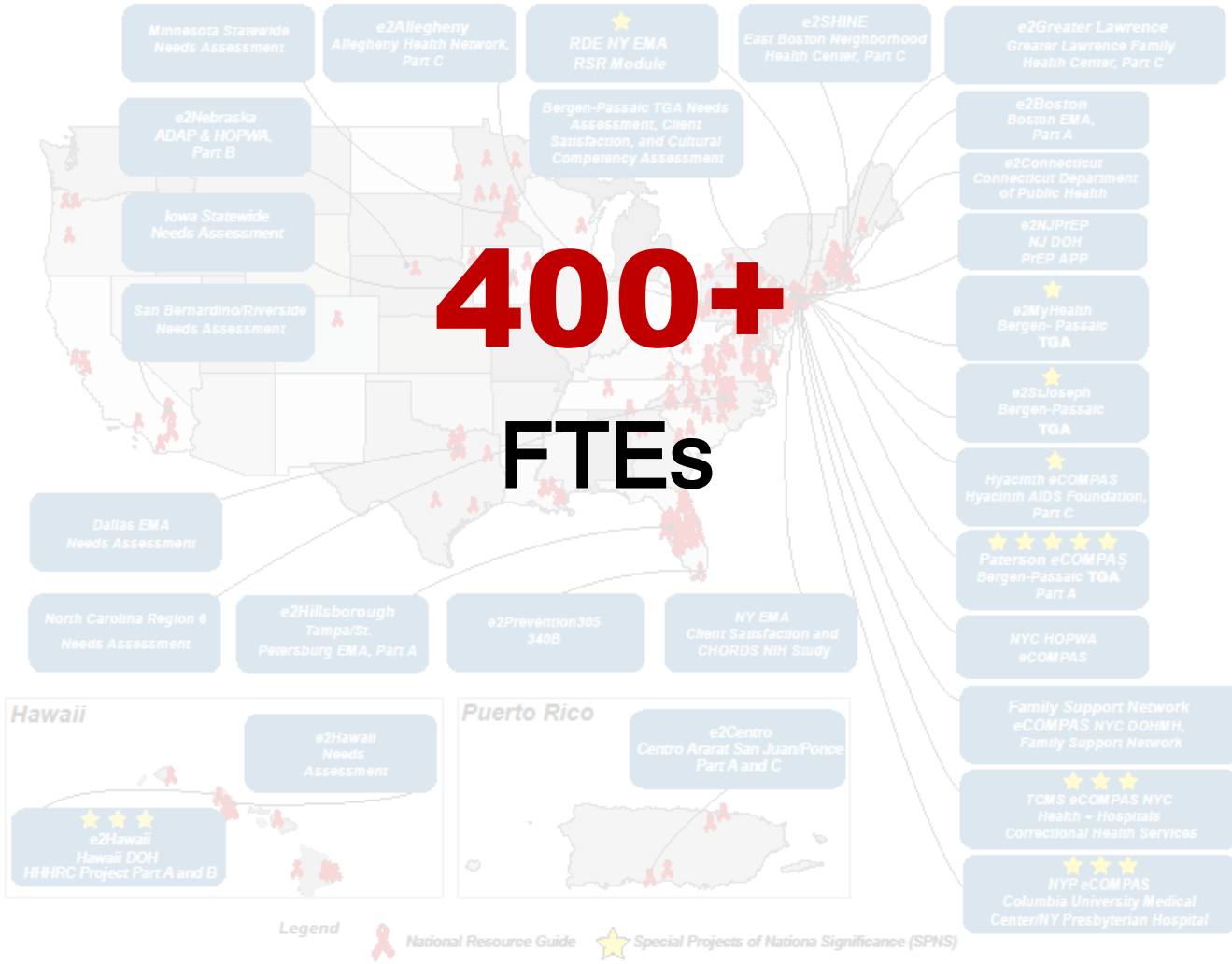


300+ Million

Provider Data Points Exchanged

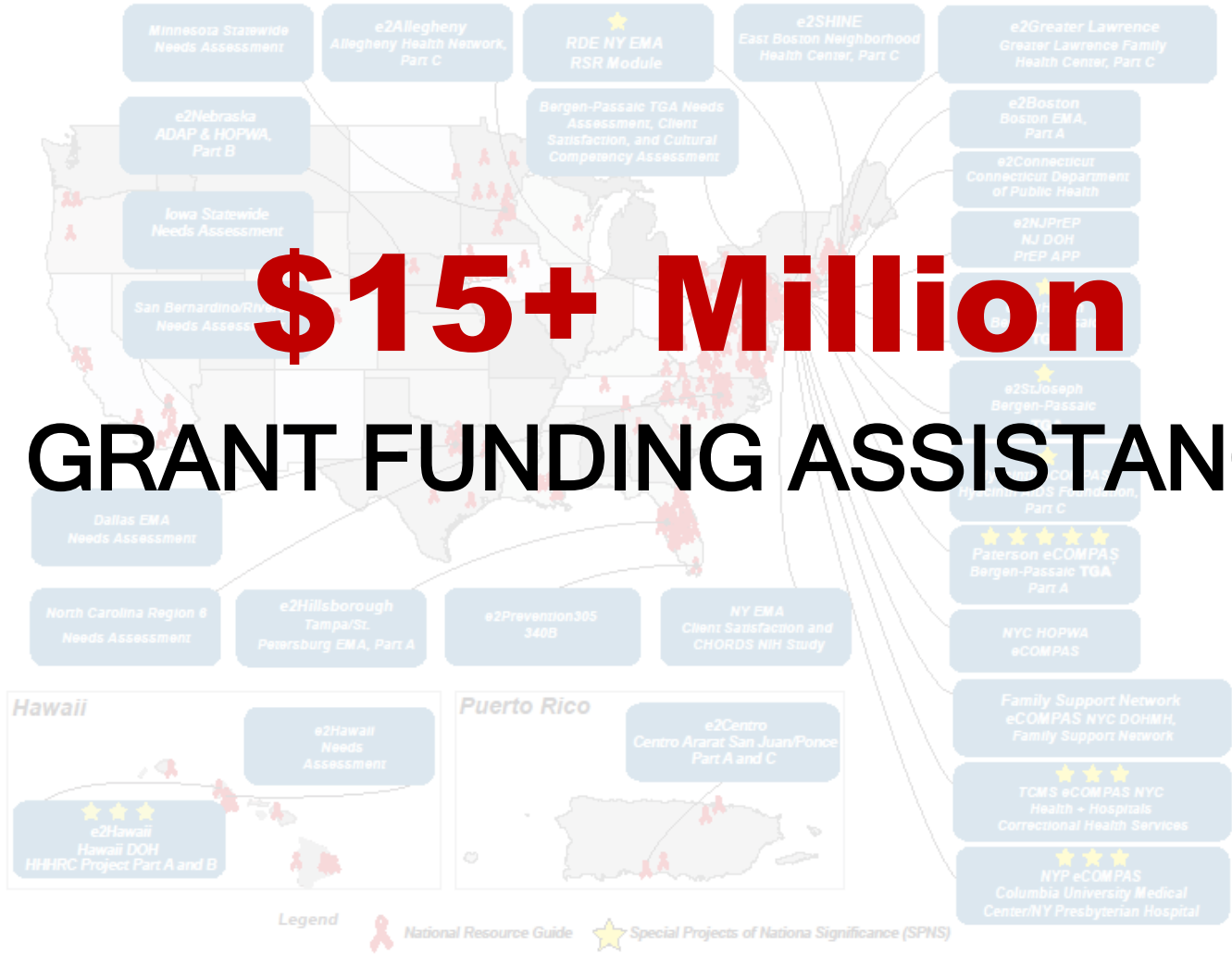
805,000+

HOURS SAVED


Minnesota Statewide Needs Assessment
e2Allegheny Allegheny Health Network, Part C
RDE NY EMA RSR Module
e2SHINE East Boston Neighborhood Health Center, Part C
e2Greater Lawrence Greater Lawrence Family Health Center, Part C
e2Nebraska ADAP & HOPWA, Part B
Bergen-Passaic TGA Needs Assessment, Client Satisfaction, and Cultural Competency Assessment
e2Boston Boston EMA, Part A
e2Connecticut Connecticut Department of Public Health
Iowa Statewide Needs Assessment
e2NJPrEP NJ DOH PrEP APP
San Bernardino/Riverside Needs Assessment
e2MyHealth Bergen- Passaic TGA
e2StJoseph Bergen-Passaic TGA
Hyacinth eCOMPAS Hyacinth AIDS Foundation, Part C
Dallas EMA Needs Assessment
Paterson eCOMPAS Bergen-Passaic TGA Part A
NYC HOPWA eCOMPAS
North Carolina Region 6 Needs Assessment
e2Hillsborough Tampa/St. Petersburg EMA, Part A
e2Prevention305 340B
NY EMA Client Satisfaction and CHORDS NIH Study
Family Support Network eCOMPAS NYC DOHMH, Family Support Network
TCMS eCOMPAS NYC Health + Hospitals Correctional Health Services
NYP eCOMPAS Columbia University Medical Center/NY Presbyterian Hospital
Hawaii
e2Hawaii Needs Assessment
e2Hawaii Hawaii DOH HHHRC Project Part A and B
Puerto Rico
e2Centro Centro Ararat San Juan/Ponce Part A and C
Legend
National Resource Guide
Special Projects of National Significance (SPNS)

400+

FTEs



$15+ Million

GRANT FUNDING ASSISTANCE

19 SPNS PROJECTS

Evaluate Impact of HIT on Care

e Networks of Care

Capacity building grants*

Parts A & B

Parts C & D

All Parts

HIT for ADAP

HIT for HIV Care Continuum

SMAIF HIEs for Care Engagement

SMAIF HIV Care & Housing Data Integration

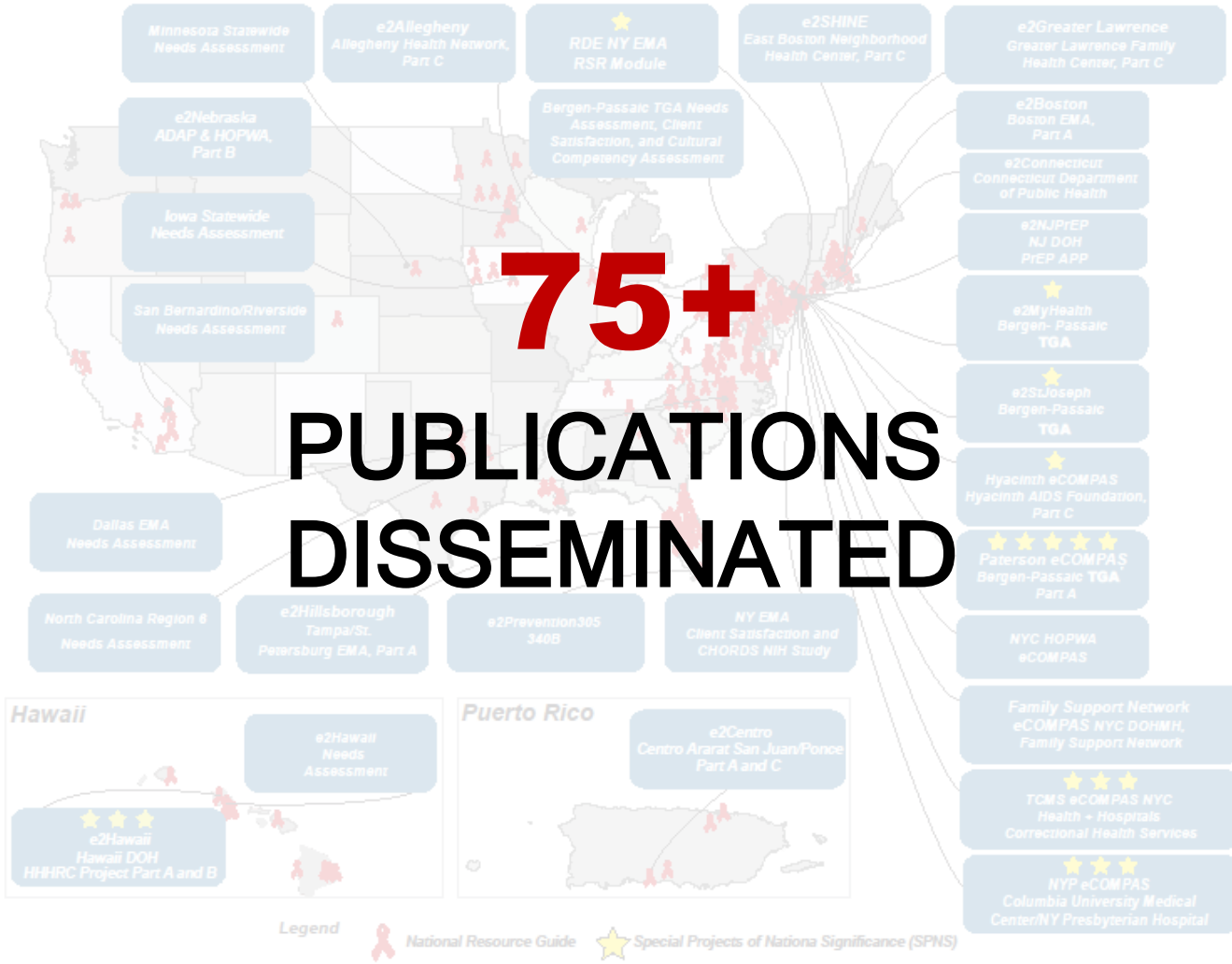
Direct clinic IT investments:

Medical Home for HIV+ Homeless

Practice Transformation HIV Primary Care

Evidence-Informed Interventions

Social Media HIV Care Continuum



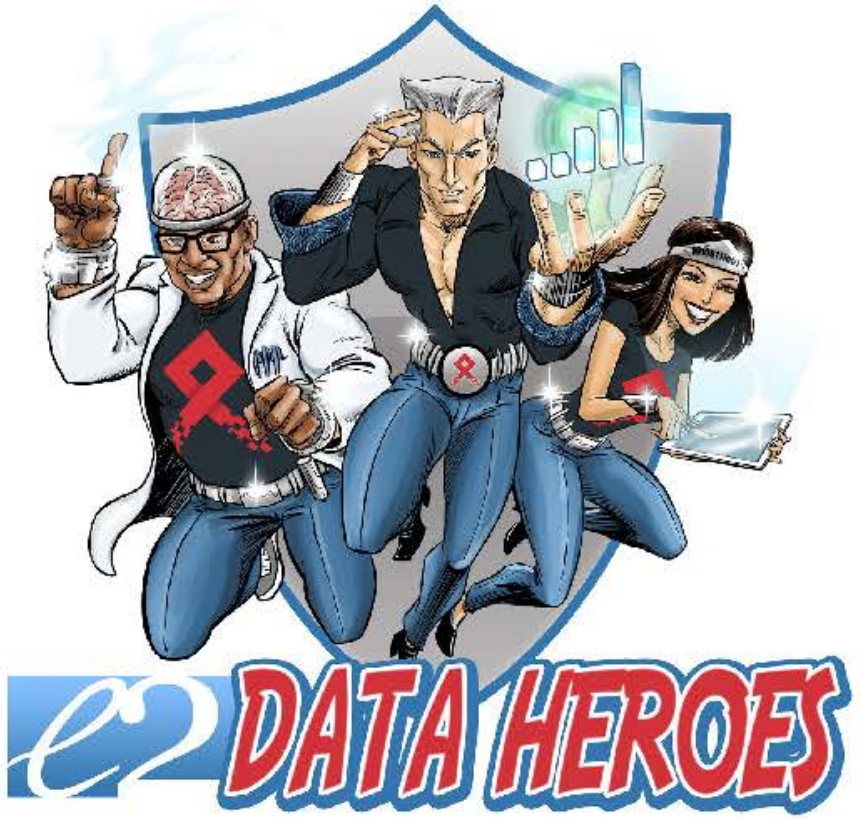
75+

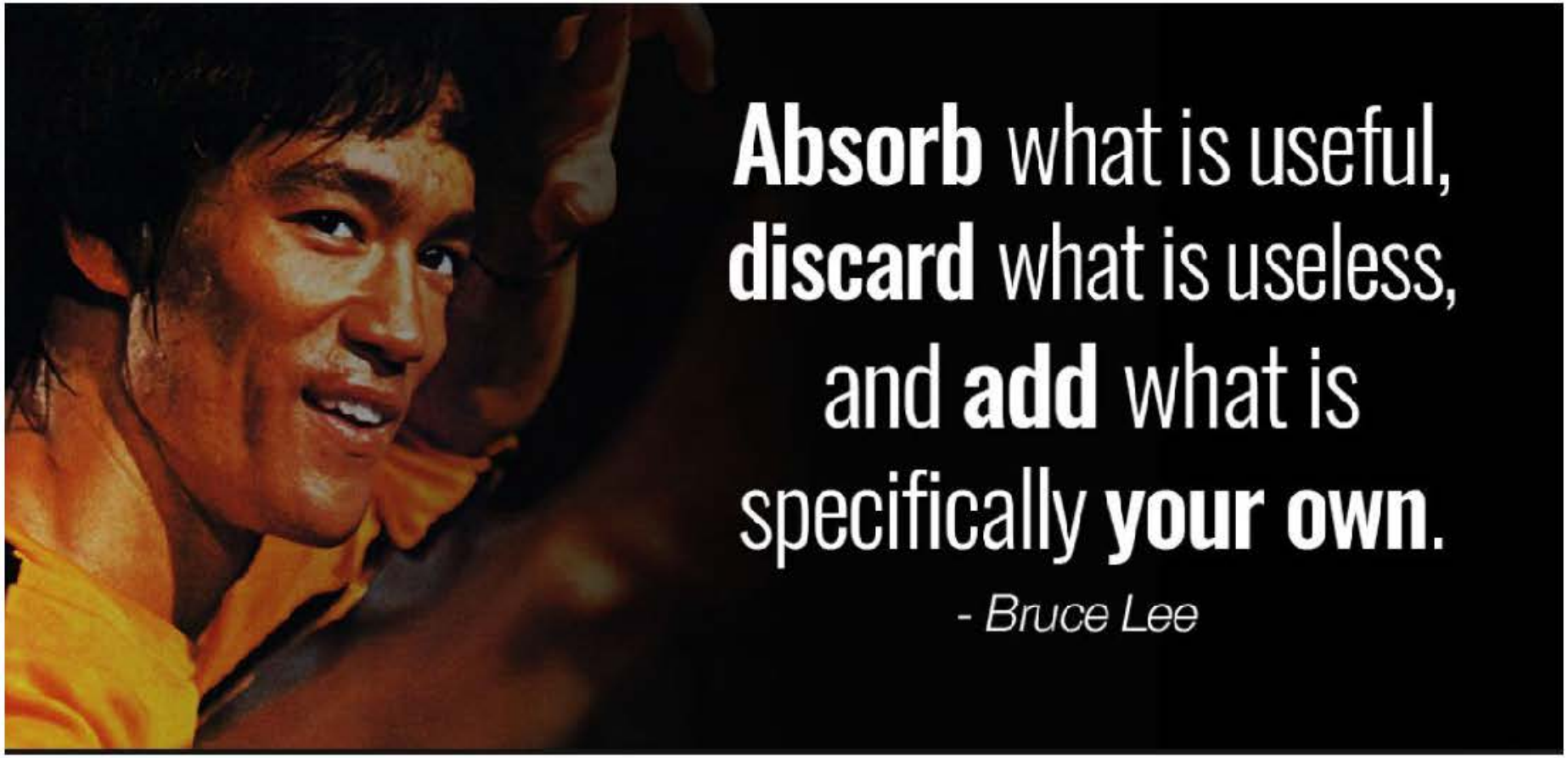
PUBLICATIONS DISSEMINATED

VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

#	Title	Presenters/Panelists	Presenters	Date and Time
1	Housing, Employment, and Quality Improvement for Incarcerated Populations - Paterson, NJ, and Puerto Rico. (Session #16238)	Bergen-Passaic NJ TGA; Puerto Rico One Stop Career Center; RDE Systems	Millie Izquierdo; Carmen Cosme Pitre; Alison Jordan; Jesse Thomas	Wednesday, August 12 2:30pm - 4:00pm (Subject to change)
2	How to Share and Leverage Data: Learn from Three Diverse Clinics: Puerto Rico, Boston and Pennsylvania. (Session #16252)	Centro-Ararat, Puerto Rico; East Boston Neighborhood Health Center, Boston; RDE Systems	Marianella De La Cruz Fraticelli; Elisa Sosa; Jesse Thomas	Wednesday, August 12 2:30pm - 4:00pm (Subject to change)
3	Avoiding the Data System Black Holes: Stakeholder-driven design to increase data integration and reduce administrative burden. (Session #16205)	Connecticut Department of Public Health; RDE Systems	Mukhtar Mohamed; Michael Ostapoff; Daniel Hulton; Jesse Thomas	Thursday, August 13 2:30 pm - 4:00pm (Subject to change)
4	Practice transformation, data analytics, and quality improvement: Addressing HIV/HCV and opioid use disorder in NYC. (Poster Presentation #15892)	Columbia Presbyterian University / New York Presbyterian; RDE Systems	Mila Gonzalez Davila; Susan Olender; Megan Urry; Kenneth Ruperto; Jesse Thomas	Thursday, August 13 4pm - 4:25pm (Subject to change)
5	Actuating Care in Iowa, Dallas, TX, and NJ Using Multilingual, Evidence-Based Needs Assessments. (Session #16211)	Dallas EMA; Bergen-Passaic NJ TGA; Iowa State AIDS Program; RDE Systems	Justin Henry; Millie Izquierdo; Katie Herting; Jesse Thomas	Friday, August 14 11:00am - 12:30pm (Subject to change)
6	Innovative Automation in data management, claims processing and electronic billing which saves time and costs! (Session #15910)	Tampa-St. Petersburg EMA; RDE Systems	Aubrey Arnold; Onelia Pineda; Jesse Thomas	TBD

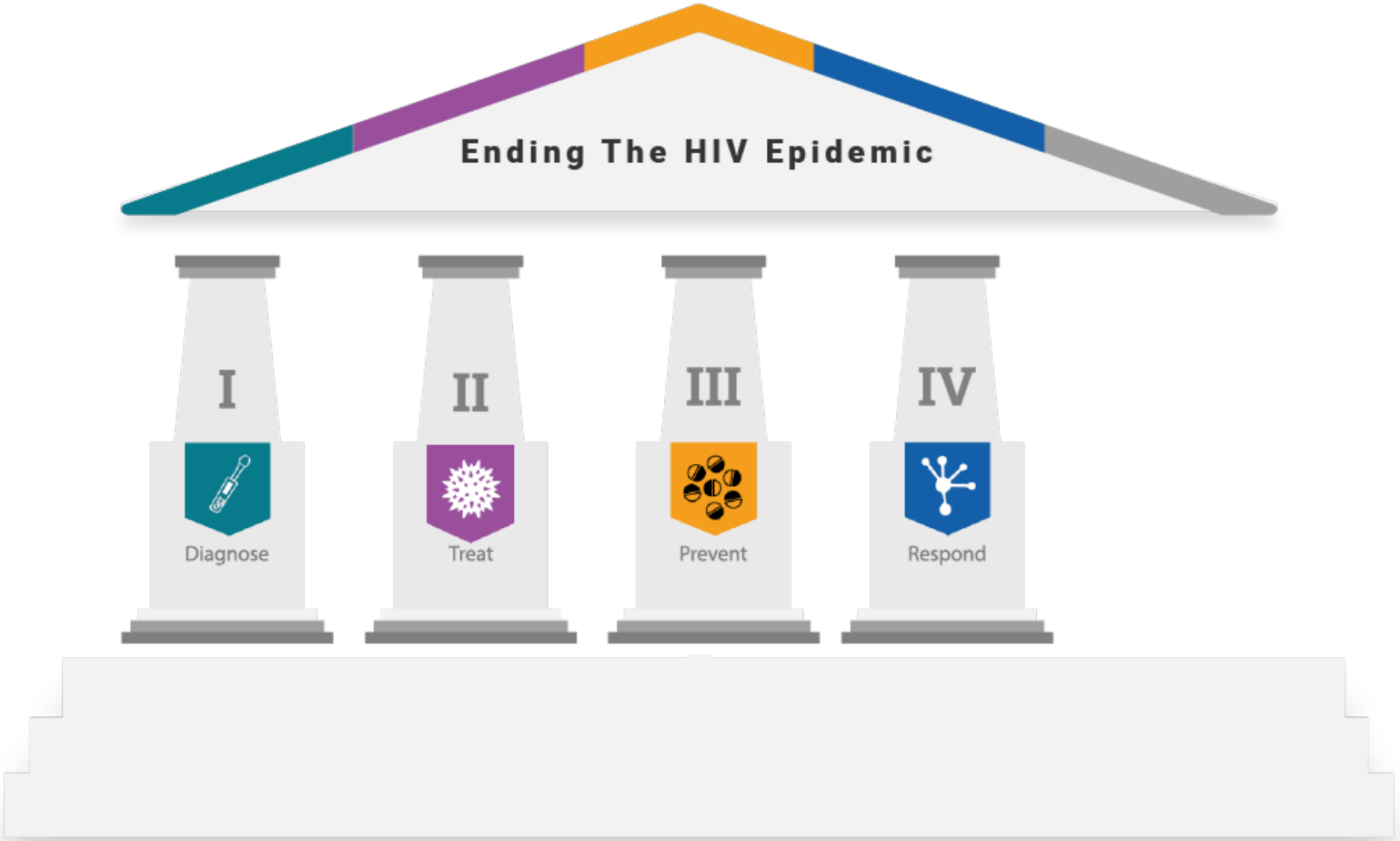
VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT




Absorb what is useful,
discard what is useless,
and add what is
specifically your own.
- Bruce Lee

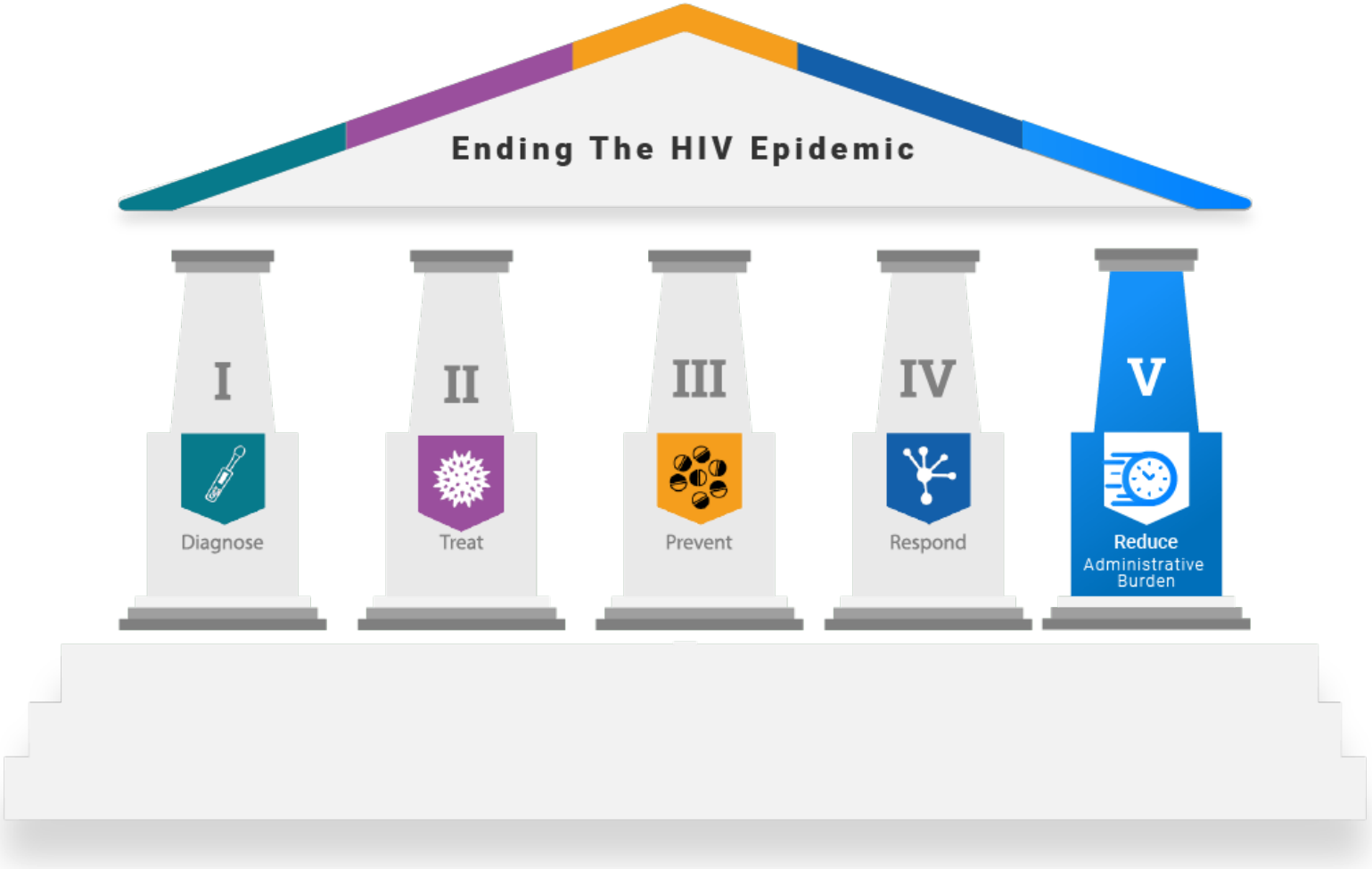
30 Years of Innovating Care, Optimizing Public Health, Ending the HIV Epidemic

VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT



Source: Four Pillars: Ending the HIV Epidemic: A Plan for America, HIV.gov

30 Years of Innovating Care, Optimizing Public Health, Ending the HIV Epidemic



Source: Four Pillars: Ending the HIV Epidemic: A Plan for America, HIV.gov

Reducing Administrative Burden

- Time is our finite resource
- Reduce staff stress, burnout, and turnover
- Burden → empowerment

Right Data & Right Tools

- Quality
- Actionable
- Useful + Usable

Who are you?

An interactive poll

Interactive Poll

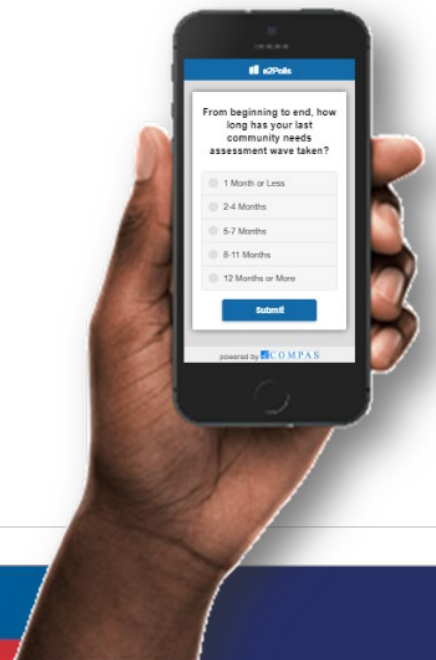
VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

e2Polls.com

Code: **SPNS**

Join us on e2Polls.com/SPNS

Access Code: **SPNS**



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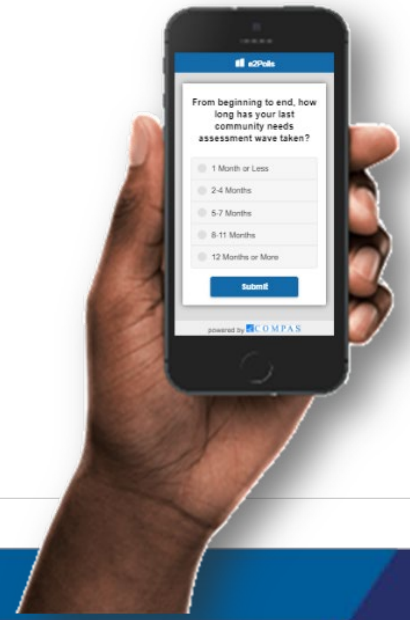
Interactive Poll

VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

e2Polls.com Code: **SPNS**

Join us on e2Polls.com/SPNS

Access Code: **SPNS**



Provided for free by RDE Red

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RDE.org/Red

Acknowledgments

City of Paterson

ACOJA Consulting

One Stop Career Center of Puerto Rico

NYC Correctional Health Services

RDE Systems

HRSA

ACOJA Consulting - Who We Are

ACOJA Consulting LLC is a NYC-certified M/WBE and internationally recognized team skilled in strategic planning and guidance for health and human services, public health research, and government programs.

ACOJA Consulting – Who We Are

Content Expertise

Alternatives to Incarceration | Case Management | Community Outreach
Correctional Public Health | Court Health Liaison | Discharge Planning
Employment Services | Government Purchasing | Harm Reduction | Health Education
Health Homes | HIV Services | Housing Assistance | Linkages to Care | Patient Navigation
| **Transitional Care Coordination** |

Services-at-a-Glance

Technical assistance and support for health and human services, correctional health and justice systems, government agencies and university research centers serving vulnerable populations.

Strategic Planning + Sustainability

Housing, employment and health integration
From pilot project to renewable funding
Improve outcomes & reduce costs

Change Management

Performance-based outcomes
Information Technology solutions
Grant writing and project management

Research Translation

Evaluation, publication & dissemination
Health outcome measures & program evaluations
Peer reviewed publications & presentations

Training + Technical Assistance

Integrating Evidence-informed interventions
Curricula development and dissemination
Project implementation and evaluation

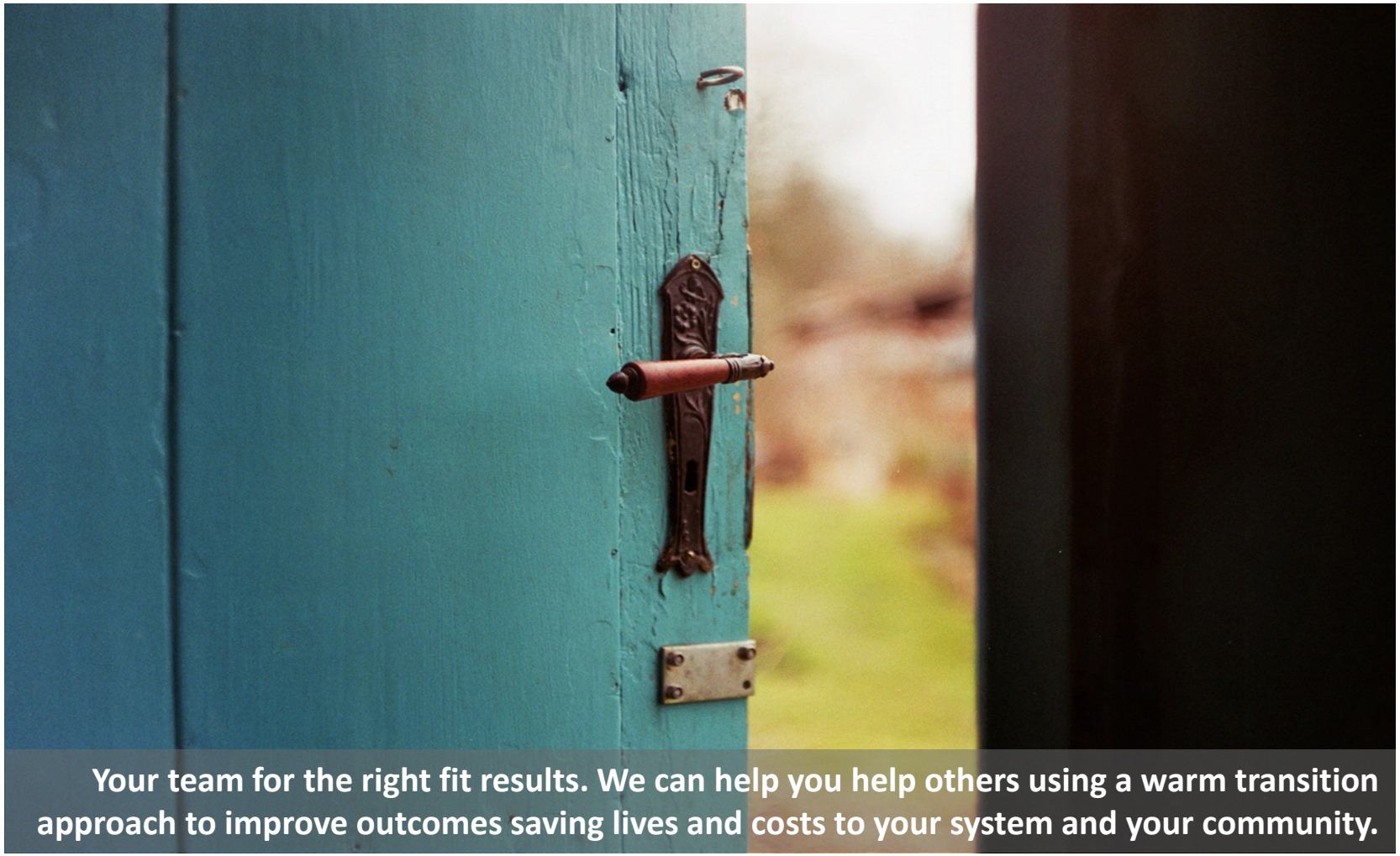
Population Management

HIV, HCV and SUD Care Management
Vulnerable population interventions
Jail visitor opiate overdose reversal

Building Collaboratives

Online mapping resource directory
Innovative approaches to networks of care
Event planning: health fairs, retreats, convenings

Opening Doors…



Your team for the right fit results. We can help you help others using a warm transition approach to improve outcomes saving lives and costs to your system and your community.

CLIENTS & PARTNERS

PRIMARY CARE DEVELOPMENT CORPORATION

Abt ASSOCIATES

COPE HEALTH SOLUTIONS

AIDS United

NOW POW

healthcare Vesta

BU School of Social Work
Center for Innovation in Social Work & Health

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ARC ANALYTICS FOR RISK CONTRACTING

ACOJA "has participated in key strategy meetings for the design of the evaluation study… an active participant providing resources to us as the multisite evaluation center and to the local demonstration sites... Ms. Cruzado helped us draft a manuscript outlining the lessons learned for this intervention to the American Journal of Public Health." -Serena Rajabiun, Boston University, Research Assistant Professor

ACOJA "agreed to give presentations about Re-entry and Continuity to our NYC HIV Planning Group and at the NYC H+H HIV Annual Conference. They were densely packed with stats and actionable info for the respective groups. [The ACOJA] consulting website is full of great resources. Glad to have met and learn from her expertise." -Nathalie Abejero, MPH | Data & Quality Improvement

ACOJA - "my 'go-to' expert on systems and policies related to the complex interface of health and corrections… Their "experience and depth of knowledge are fairly indispensable. This is a critical area of work; the dynamic health care landscape changes that are imminent will be well informed by this work." -Tracie M. Gardner, VP of Policy Advocacy, Legal Action Center

ACOJA "has the ability to create a vision; articulate that vision to obtain by-in from a diverse group; and develop the systems and tools to implement and monitor the outcomes of that vision."
-Stanley Richards,
Executive Vice President at The Fortune Society, Inc.

www.acojaconsulting.com

…Making a Difference

Training, technical assistance and technical support using innovative approaches for results that make an impact.

Purpose of SPNS

Develop innovative models of HIV treatment

Quickly respond to emerging needs of clients

Source: Johanna L. Goderre, MPH

Key SPNS Initiatives

Correctional Health [2007-2012]	Ten sites found 79% of participants linked to care after incarceration with improved health outcomes.
Latino Initiative [2013-2018]	NYC site found most ethnic minorities in local jails are of PR origin; identified resources for culturally appropriate care and linkages after incarceration.
Workforce Capacity [2014-2018]	NYC Latino Initiative partner, One Stop Career Center of PR, a housing and employment services agency, built a community collaborative & adapted the Transitional Care Coordination intervention.
Housing & Employment [2019-2021]	Various interventions across the U.S. – all have enrolled people with recent histories of incarceration

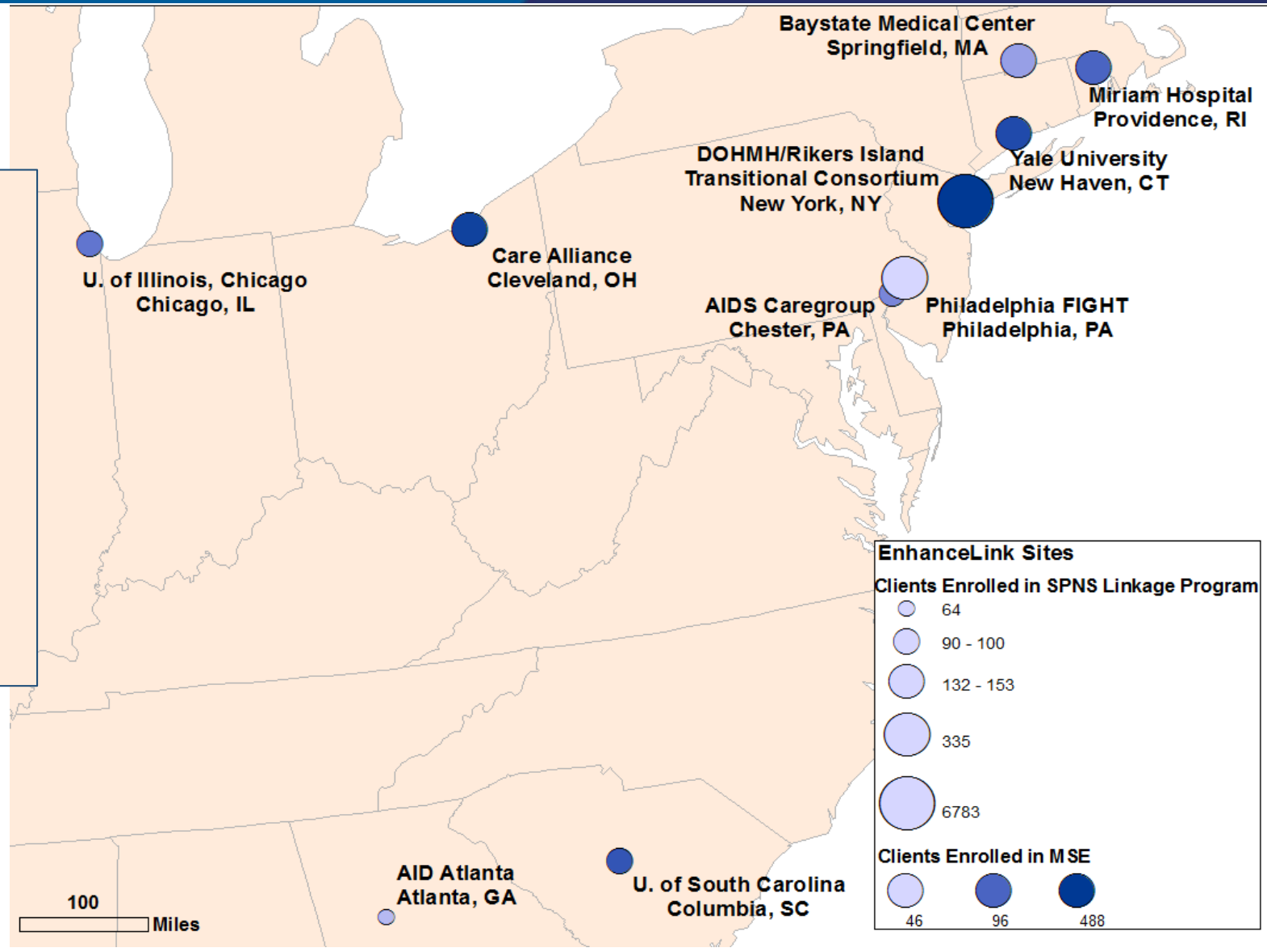
SPNS Correctional Health Initiative

Ten Demonstration Sites

(2007-2012)

Facilitate linkage to primary care for HIV patients leaving local jails:

- Identify HIV patients in custody
- Initiate transitional services in jail
- Facilitate post-release linkage to primary care and community services.



Correctional Health Initiative in NYC

- Along with primary medical care, Jail Linkages clients were also connected to:
  - Medical case management (53%)
  - Substance abuse treatment (52%)
  - Housing services (29%)
  - Court advocacy (18%)

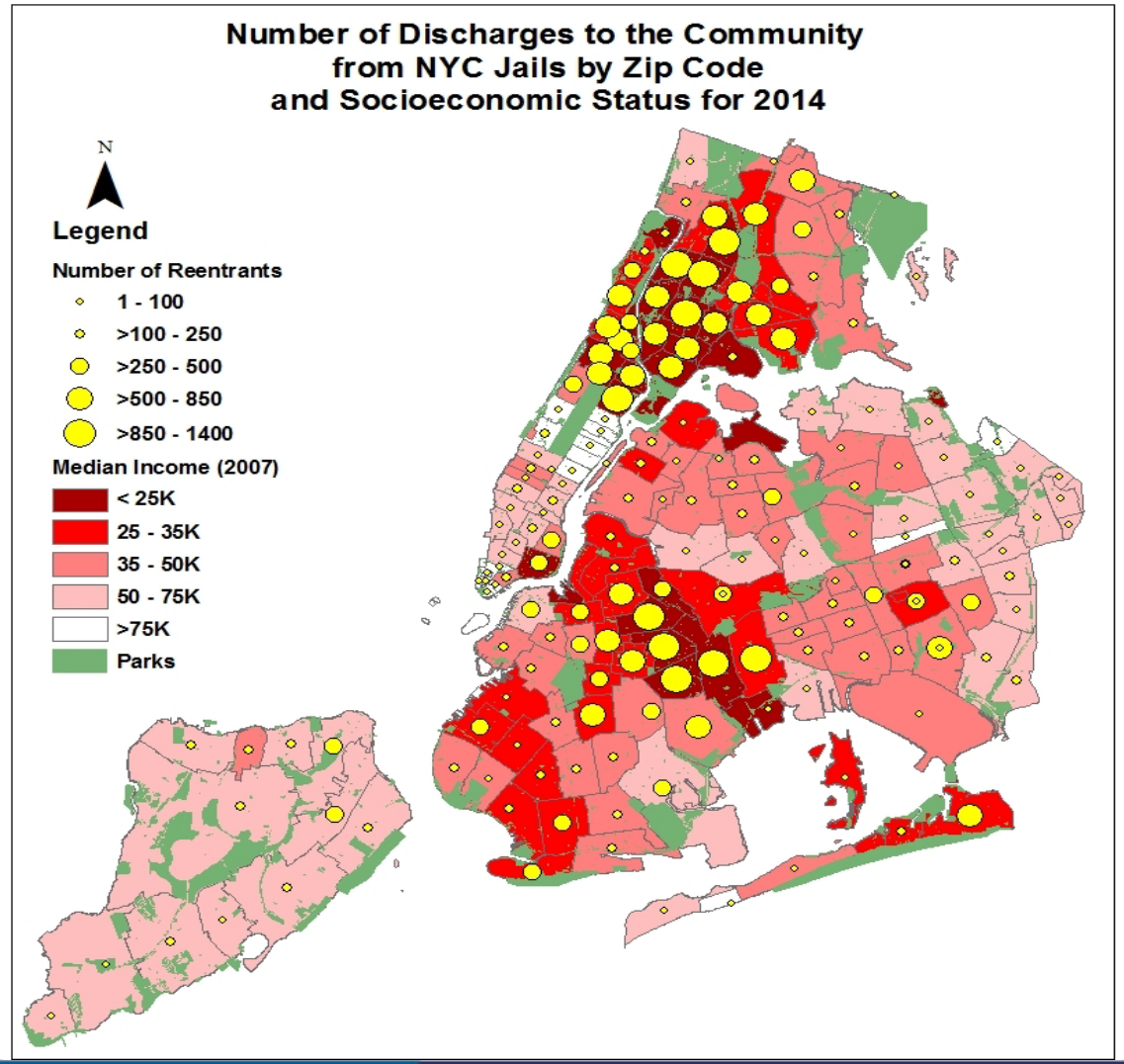
- Approximately 65% of clients accept the offer of accompaniment and / or transport to their medical appointment.

- 85% of those who were not known to be linked to care were found through community outreach; 30% re-incarcerated.

"An ideal community partner offers a 'one-stop' model of coordinated care in which primary medical care is linked with medical case management, housing assistance, substance abuse and mental health treatment, and employment and social services."

– Alison O Jordan, LCSW &
Lawrence Ouellet, PhD

Correctional Health is Public Health



Why Jails?

Structural Racism: Over 70% of people return to the communities with the greatest socioeconomic and health disparities after incarceration.

Jordan AO, Cohen LR, Harriman G, Teixeira, PA, Cruzado-Quinones J, Venters H, Transitional Care Coordination in New York City Jails: Facilitating Linkages to Care for People with HIV Returning Home from Rikers Island, AIDS Behav Oct 2013

TOOLS + TIPS FOR PROVIDING TRANSITIONAL CARE COORDINATION

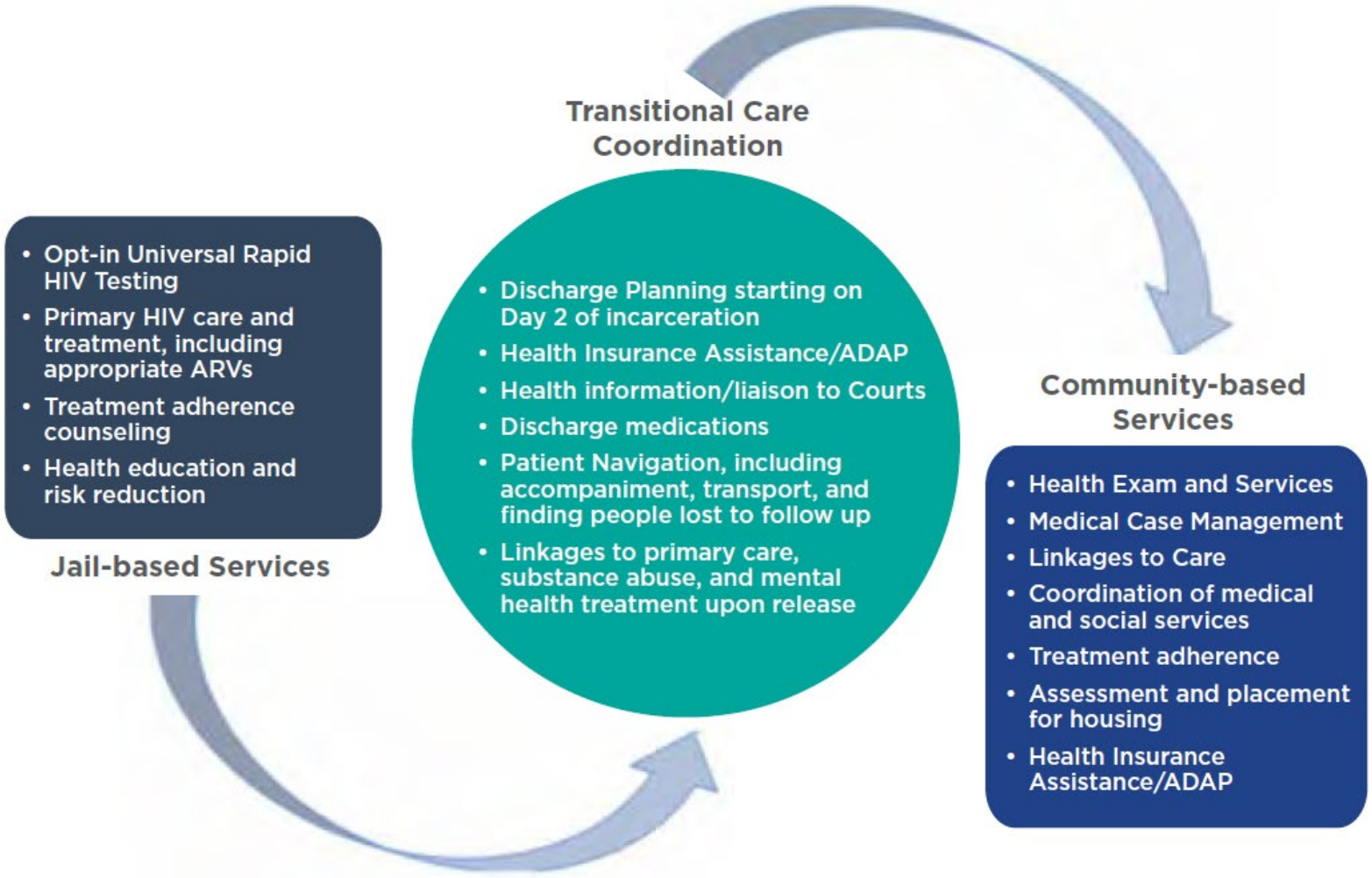
HANDBOOK

Synthesizes program planning, implementation, and lessons learned, offering strategic approaches to:

- implement, expand, and refine care coordination work.
- negotiate and form partnerships to improve health outcomes.
- identify medical alternatives to incarceration.
- improve continuity from jail to community healthcare.
- benefit health and hospital care, public health, HIV services, substance use and mental health, and jail

It can take just one individual to initiate improvement and one team to sustain it.

Transitional Care Coordination



https://www.acojaconsulting.com/providing-transitional-care-coordination-handbook

Improving Health Outcomes

Transitional Care Coordination results:

- **Fewer visits to the emergency department,** from 0.60 per person in the 6 months prior to baseline to .20 visits at follow-up
- **Housing instability and food insecurity decreased** from over 20% at baseline to less than 5% at follow-up.
- Individuals also self-reported **feeling in better general health.**

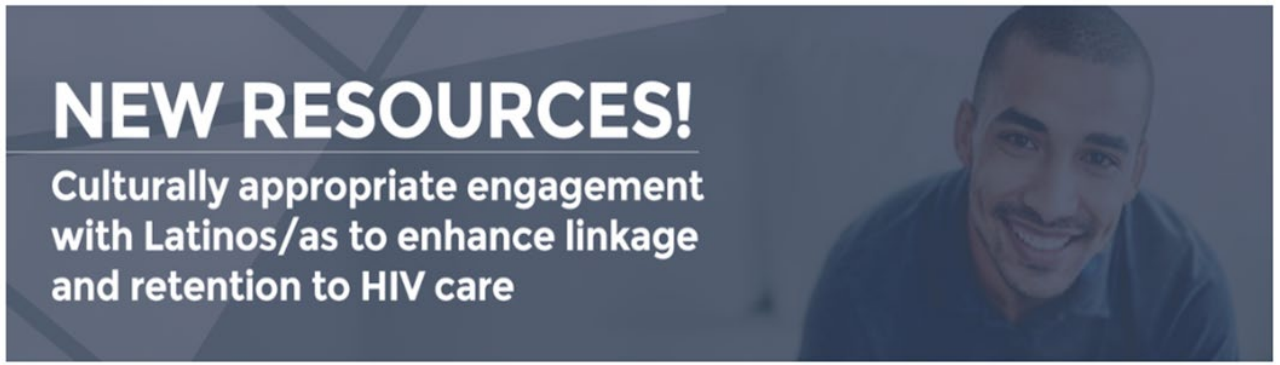
SPNS Latino Initiative in NYC

VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Key Topic Areas

- Transnationalism
- Puerto Rican & Latino Culture
- Cultural Competency
- Strategies for Improving Care
- Also: Interactive activities

This webinar series is available for health and social service professionals! Continuing Education credits for physicians, nurses, Certified Health Educators as well as general CE is available. (CME, CNE, CHEC and CEU)
http://www.bxconsortium.org/cewebinarseries.html



A webinar series about Culturally Appropriate Engagement and Service Delivery with Latino/as to Enhance Linkage and Retention to HIV Primary Care – including a Transnational Case Study for Puerto Ricans is now available for health and social service professionals! This Continuing Education activity is for physicians, nurses and Certified Health Educators, as well as other health and social service professionals. Accreditation for physicians, nurses, and Certified Health Educators as well as general CE is available (CME, CNE, CHEC and CEU).

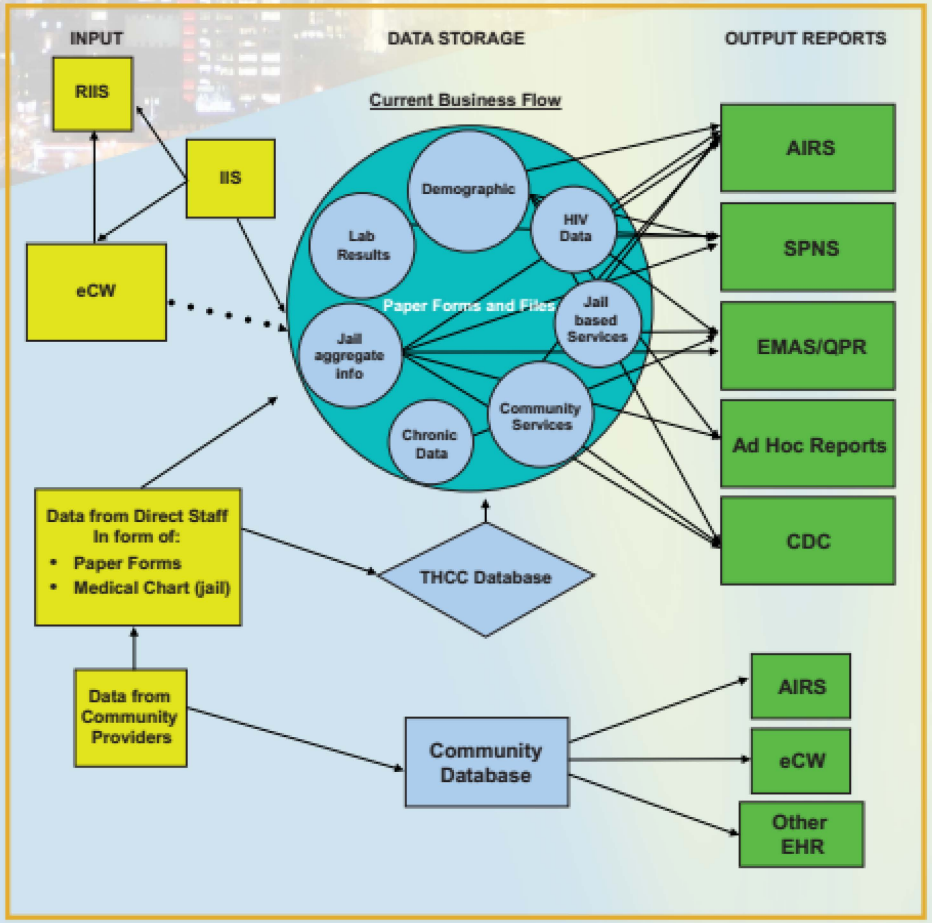
This curriculum explains how to use four key frameworks which, when integrated, allow for the development of a provider-level strategy to improve the HIV primary care patient outcomes for Latinos/as who are incarcerated or have a history of incarceration. The case study provides a sub-analysis of transnationalism among Puerto Ricans.

These frameworks include:

1. **Cultural Formulation,** which analyzes cultural factors that affect clinical encounters, especially when the healthcare provider does not share the same cultural background as the patient.
2. **Transnationalism,** which represents the process by which immigrants forge and sustain multi-stranded social relations with their country/place of origin. It affect the social field of individuals, which includes their group identity, daily activities, neighborhoods/communities, economic opportunities, and social and political behaviors.
3. **DECIDE**, a six-step process for decision making.
4. **Shared Decision Making**, a strategy where patients and providers build a consensus on the treatment plan and agree on the steps necessary to implement it.

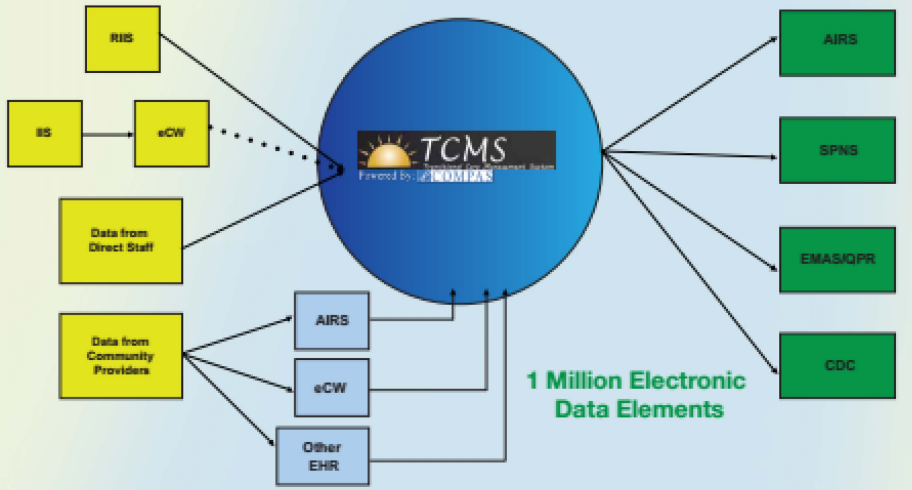

TCMS
Transitional Care Management System
"Warm Transitions - Support Linkages To Care To Improve Community Health"
NYC Health
Login
Username
Password
Log in
This is a secured web connection. All data is protected by the highest level of Internet encryption (SSL).
eCOMPAS © 2015 RDE Systems, LLC. All rights reserved

Before



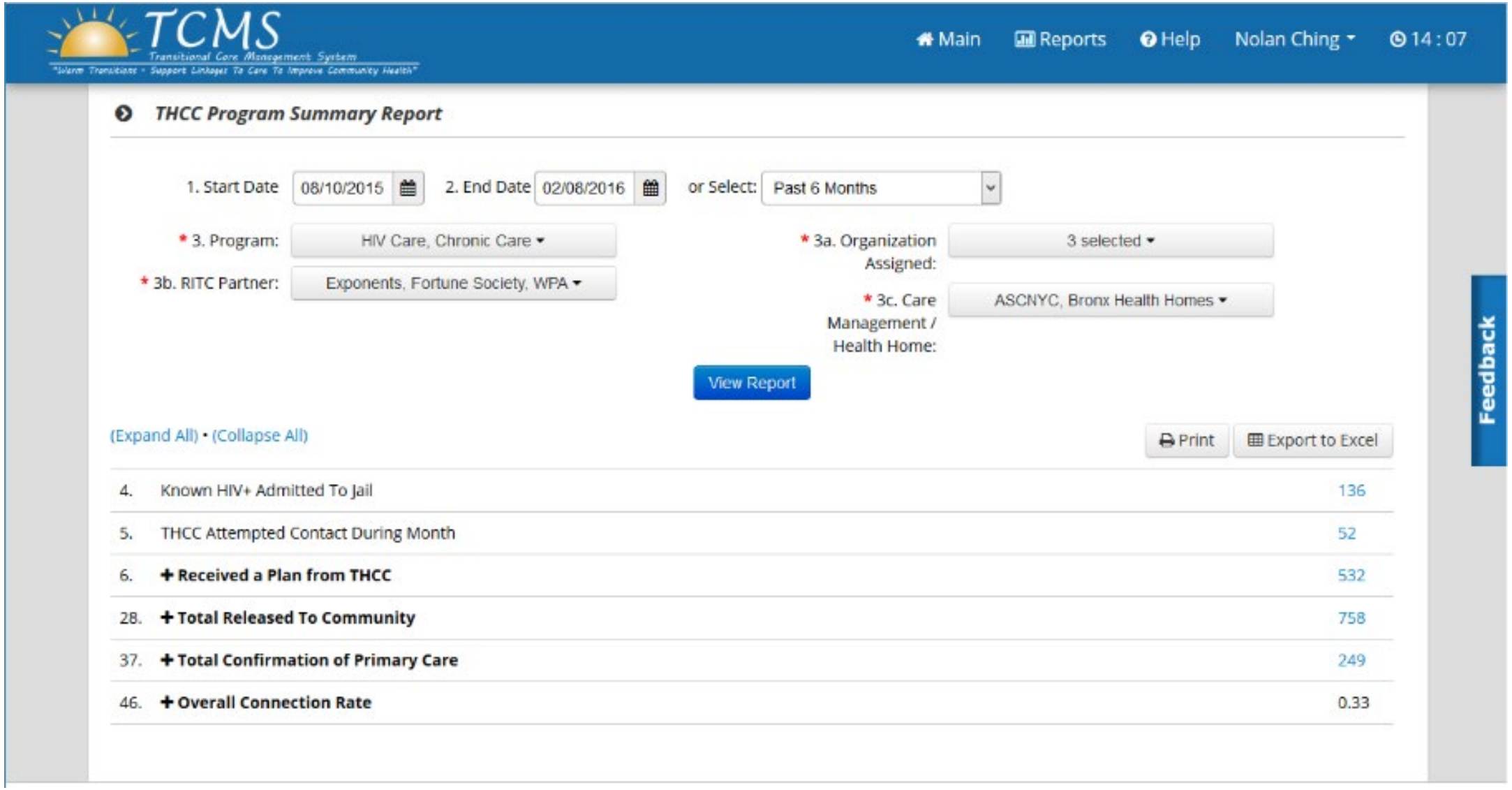
- ✗ Time spent on entering data into multiple excel sheets hence less effective and lower efficiency
- ✗ Time spent on cleaning up errors in multiple excel sheets
- ✗ Double data entry
- ✗ Communication back and forth on data clean up
- ✗ No ability to monitor real time activities

After

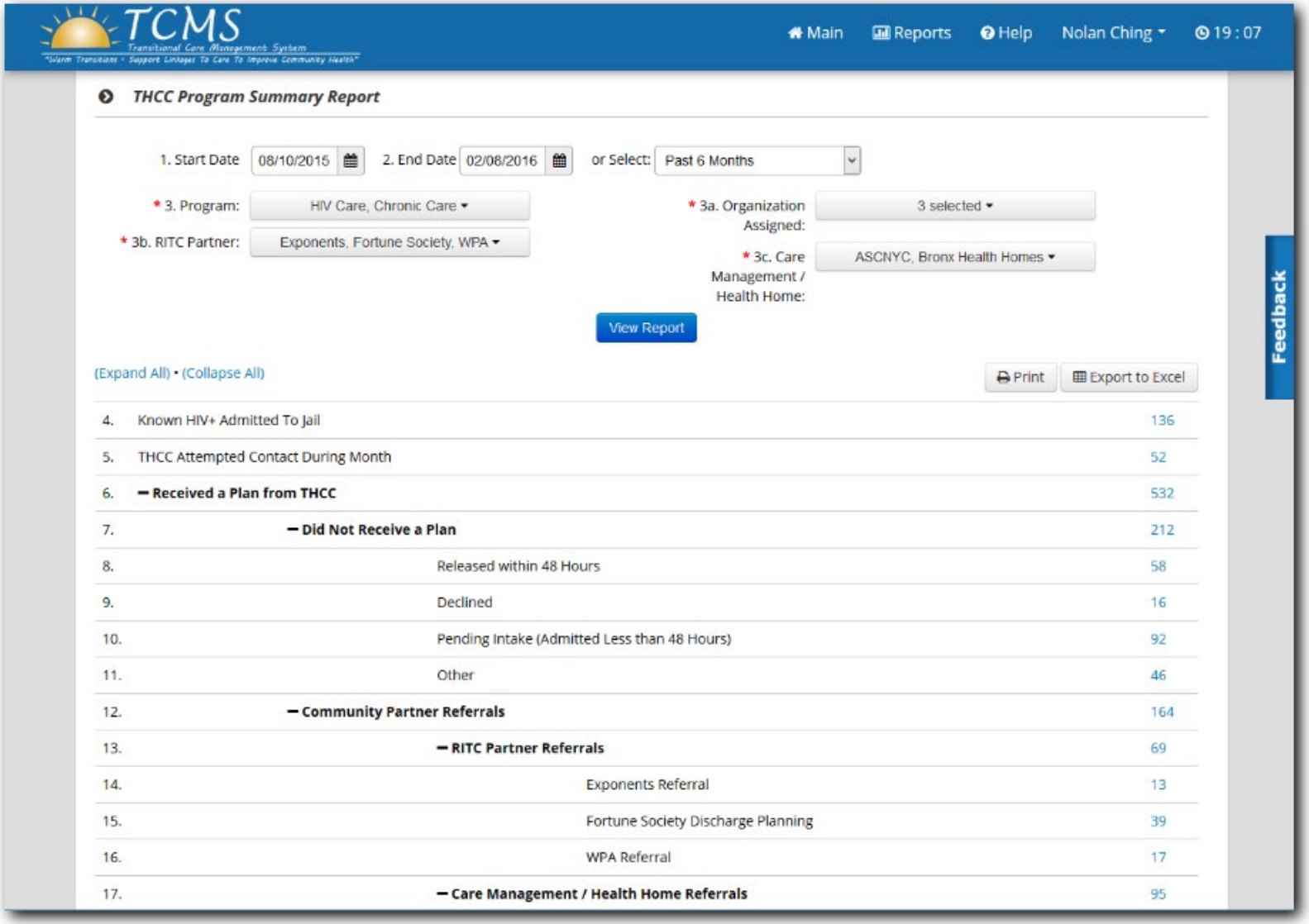


- ✓ No more paper/excel sheets thus improved effectiveness and efficiency
- ✓ Work smarter and not harder
- ✓ Projected to redirect 10-15% from admin to direct service delivery
- ✓ One Stop to access all information
- ✓ No more double data entry, direct data integration from EMR
- ✓ Instant access to management reports
- ✓ Accountability of community partners

Actionable eCOMPAS Management Reports with Drill Downs



Collapse-expand feature



4.	Known HIV+ Admitted To Jail	136
5.	THCC Attempted Contact During Month	52
6.	**– Received a Plan from THCC**	532
7.	**– Did Not Receive a Plan**	212
8.	Released within 48 Hours	58
9.	Declined	16
10.	Pending Intake (Admitted Less than 48 Hours)	92
11.	Other	46
12.	**– Community Partner Referrals**	164
13.	**– RITC Partner Referrals**	69
14.	Exponents Referral	13
15.	Fortune Society Discharge Planning	39
16.	WPA Referral	17
17.	**– Care Management / Health Home Referrals**	95

16.		WPA Referral	17
17.		**– Care Management / Health Home Referrals**	95
18.		ASCNYC Referral	24
19.		Bronx Health Home Referral	71
20.	**– Community Partner Enrolled**		156
21.		**– RITC Partner Enrolled**	60
22.		Exponents Enrolled	34
23.		Fortune Society Discharge Planning Enrolled	22
24.		WPA Enrolled	4
25.		**– Care Management / Health Home Enrolled**	96
26.		ASCNYC Enrolled	49
27.		Bronx Health Home Enrolled	47
28.	**– Total Released To Community**		758
29.		THCC Released To Community	250
30.		**– RITC Partner Released To Community**	183
31.		Exponents Released	25
32.		Fortune Released	92
33.		WPA Released	66
34.		**– Care Management / Health Home Released to Community**	323
35.		ASCNYC Released	147
36.		Bronx Health Home Released	176
37.	**– Total Confirmation of Primary Care**		249
38.		THCC Confirmation of Primary Care	54
39.		**– RITC Partner Confirmation of Primary Care**	119

Feedback

35.		ASCNYC Released	147
36.		Bronx Health Home Released	176
37.	**− Total Confirmation of Primary Care**		249
38.	THCC Confirmation of Primary Care		54
39.	**− RITC Partner Confirmation of Primary Care**		110
40.		Exponents Confirmation of Primary Care	26
41.		Fortune Confirmation of Primary Care	50
42.		WPA Confirmation of Primary Care	34
43.	**− Care Management / Health Home Confirmation of Primary Care**		85
44.		ASCNYC Confirmation of Primary Care	42
45.		Bronx Health Home Confirmation of Primary Care	43
46.	**− Overall Connection Rate**		0.33
47.	THCC Connection Rate		0.22
48.	**− RITC Partner Connection Rate**		0.89
49.		Exponents Connection Rate	0.98
50.		Fortune Connection Rate	0.54
51.		WPA Connection Rate	0.52
52.	**− Care Management / Health Home Connection Rate**		0.26
53.		ASCNYC Connection Rate	0.27
54.		Bronx Health Home Connection Rate	0.24

Client Drill downs

46.	**− Overall Connection Rate**		0.33
47.		THCC Connection Rate	0.22
48.		**− RITC Partner Connection Rate**	0.89
49.		Exponents Connection Rate	0.98
50.		Fortune Connection Rate	0.54
51.		WPA Connection Rate	0.52
52.		**− Care Management / Health Home Connection Rate**	0.26
53.		ASCNYC Connection Rate	0.27
54.		Bronx Health Home Connection Rate	0.24

Client Drilldown for #6

NYSID	First Name	Last Name	
05516129H	JUAN	BARBAR	View
06788858M	RODRIGUEZ	PALACIOS	View
03350088P	NYASIA	MACK	View
00017229Z	INOLISSA	COTTINI	View
04894332K	CARLOS	ULLAH	View

Feedback

The Whoosh!

"Data is 'whooshed' from the EMR to TCMS eCOMPAS every day, ***saving time, reducing double data entry, and maintaining data consistency****. TCMS eCOMPAS now manages data for over* ***18,000 patients;*** *and an* ***average of over 1.8 million records (16 million data elements)*** *are fed through this data transfer annually."*

Alison O. Jordan, LCSW
former Senior Director
Reentry & Continuity Services
NYC Correctional Health Services

Thank you RDE, we can hear The Whoosh!

The Whoosh!

*"RDE has been a **great partner, providing excellent support, proactive problem-solving, and being responsive** to our IT needs… **RDE has worked seamlessly with IT operations across organizations** to facilitate a smooth migration and uninterrupted operation and data feeds.* ***RDE is a knowledgeable, competent, and responsive HIT partner**."*

Jeffrey Herrera
Senior Director
Information Technology

Thank you RDE, we can hear The Whoosh!

NYC Correctional Health Services

Carmen G. Cosme Pitre
Executive Director

ONE STOP Career Center of Puerto Rico, Inc.
Ayudando a Forjar Caminos

Who We Are

One Stop Career Center of Puerto Rico, Inc. (OSCCPR) is a private non-profit organization (501) (c) (3), incorporated in November 2000, with state and federal tax exemption. We offer services to young people and adults across the island with a commitment to develop and help strengthen community structures.

Our initiatives aim to impact the areas of greatest need of the population such as housing, education, employment, health and legal services. Offering service programs that can integrate and offer alternatives to communities in need.

In addition, we believe in the importance of collaborations between organizations, with the aim of bringing more and better services to the participants.

What We Do

ONE STOP HOUSING AGENCY

Advisory Agency and Financial Capacity

Advice for first purchase, prevention of loss and reverse mortgages.

ONE STOP JOB PLACEMENT

Job Placement and Retention

Training in social and labour integration and job placement for persons who have had problems with the justice system or have been displaced. The removal of criminal records, if it qualifies.

HIV

HEALTH

Case Management Services and connection to health services for people who have committed a crime and are HIV patients.

LEGAL SERVICES ONE STOP

LEGAL SERVICES

Legal advice and representation for people over 50 years of age who are in the process of losing their home or at risk of losing their home.

ONE STOP

Career Center of Puerto Rico, Inc.
Ayudando a Forjar Caminos

TRAINING

Short-term workshops and training

HOUSING COUNSELING PROGRAM

One Stop Career Center of PR in coordination with the Department of Housing of Puerto Rico provides advisory services to people affected by hurricanes Irma and/or Maria.

OSCCPR Partners

citi
CitiCommunityDevelopment.com

UNIDOSUS
AFFILIATE

EQUAL HOUSING OPPORTUNITY

GOBIERNO DE PUERTO RICO

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF PRISONS

ELTON JOHN AIDS FOUNDATION

DEPARTMENT OF LABOR
UNITED STATES OF AMERICA

FUNDACIÓN
FONDO DE ACCESO A LA JUSTICIA, INC.

hispanicfederation

Estadisticas.pr

cfpb Oficina para la Protección Financiera del Consumidor

FEDERAL TRADE COMMISSION · UNITED STATES OF AMERICA · MCMXV

FUNDACIÓN COMUNITARIA
DE PUERTO RICO

Case Study #1: Puerto Rico

ONE STOP Career Center of Puerto Rico, Inc.

Ayudando a Forjar Caminos

HIV & Incarceration in PR

- Puerto Rico (PR) has the 5th highest rate of new HIV diagnoses in the U.S.[1]
- PR has the 3rd highest rate of people living with HIV[1]
- PR has a high prison population rate (303 per 100,000):[2]
  - Over 11,000 incarcerated individuals
  - 98% are men in 7 correctional centers
  - 6.9% of people incarcerated in PR are living with HIV
- Puerto Ricans living with HIV and coming home after incarceration often need assistance, including housing, employment and transportation, to access available HIV care in Puerto Rico

1. *CDC HIV Surveillance Report 2014, excludes DC (rates are per 100,000)*
2. *Rodriquez-Diaz CE, Rivera-Negron RM, Clatts MC, Myers JJ. 2014. Health Care Practices and Associated Service Needs in a Sample of HIV-Positive Incarcerated Men in Puerto Rico: Implications for Retention in Care. J Int Assoc Provid AIDS Care.*

SPNS Latino Initiative Training

VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Key Topic Areas

- Transnationalism
- Puerto Rican & Latino Culture
- Cultural Competency
- Strategies for Improving Care
- Also: Interactive activities

A webinar series about Culturally Appropriate Engagement and Service Delivery with Latino/as to Enhance Linkage and Retention to HIV Primary Care – including a Transnational Case Study for Puerto Ricans is now available for health and social service professionals! This Continuing Education activity is for physicians, nurses and Certified Health Educators, as well as other health and social service professionals. Accreditation for physicians, nurses, and Certified Health Educators as well as general CE is available (CME, CNE, CHEC and CEU).

This curriculum explains how to use four key frameworks which, when integrated, allow for the development of a provider-level strategy to improve the HIV primary care patient outcomes for Latinos/as who are incarcerated or have a history of incarceration. The case study provides a sub-analysis of transnationalism among Puerto Ricans.

These frameworks include:

1. **Cultural Formulation,** which analyzes cultural factors that affect clinical encounters, especially when the healthcare provider does not share the same cultural background as the patient.
2. **Transnationalism,** which represents the process by which immigrants forge and sustain multi-stranded social relations with their country/place of origin. It affect the social field of individuals, which includes their group identity, daily activities, neighborhoods/communities, economic opportunities, and social and political behaviors.
3. **DECIDE**, a six-step process for decision making.
4. **Shared Decision Making**, a strategy where patients and providers build a consensus on the treatment plan and agree on the steps necessary to implement it.

This webinar series is available for health and social service professionals! Continuing Education credits for physicians, nurses, Certified Health Educators as well as general CE credits (CME, CNE, CHEC and CEU) http://www.bxconsortium.org/cewebinarseries.html

SPNS Workforce Capacity

One Stop Career Center of Puerto Rico (OSCC)

- Partnership with PR Department of Correction Supports individuals coming home after incarceration
  - Job training and placement
  - Clear criminal records
  - Case management
  - Housing assistance
  - Eviction prevention
  - Life skills training

Workforce Capacity Expansion

- HIV outreach and education in jails / prisons
- Transitional Care Coordination
- Mapping linkages to care
- Interactive Resource Guide

Powered by: eCOMPAS®

Steps to Implementation

Identify staff:

- ✓ Train staff in TCC
- ✓ State certified HIV counselors

Transportation:

- ✓ Transportation Service
- ✓ Identify sustainable funding

Coordinate with Corrections:

- ✓ Access to correctional facilities
- ✓ Patient health records

Engage Key Stakeholders:

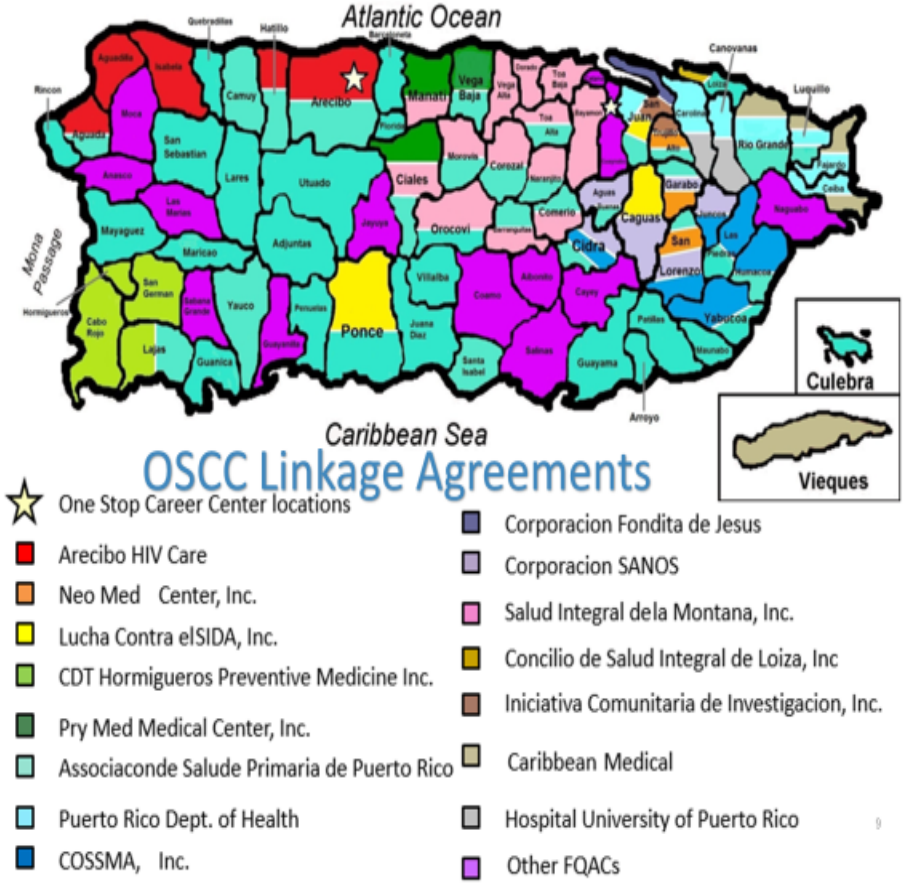
- ✓ Establish Linkage Agreements and a Consortium
- ✓ Sustain using Resource Guide

Workforce Capacity Building

- Build on SPNS Latino Initiative to enhance collaboration and coordination among providers
- Train employment and housing specialists in Transitional Care Coordination
  - HIV education and risk reduction
  - Outreach & engagement
  - Transitional care planning
  - Coordination with service providers
  - Patient navigation after incarceration
- Conduct SPNS local evaluation
- Secure reliable transportation for clients
- Sustain collaborative and service delivery

Collaboration Outcomes

- Over **60 MOUs** with service providers across PR to address housing, primary care, employment, and other social services
- Government and community partners launched Island-wide consortium to address needs of HIV+ clients transitioning to community after incarceration
  - **Community providers** – medical care, including HIV Primary Care, housing, substance use treatment, syringe exchange, support services, care management.
  - **Federal agencies** – Ryan White, US DOJ
  - **PR Department of Correction and Rehabilitation**



HIV Primary Care in PR

Program Outcomes

- OSCC staff working in 13/32 correctional facilities in PR
- Prevention education/risk reduction sessions provided at jail orientations to identify potential clients (n=360)
- 69 enrolled and completed baseline
  - All received transitional care coordination
  - 10 additional served as part of pilot
- 58 returned to community after incarceration
  - 54 of 58 eligible (93%) linked to HIV primary care and other services after incarceration
  - All 10 (100%) pilot participants linked to care

Housing & Employment

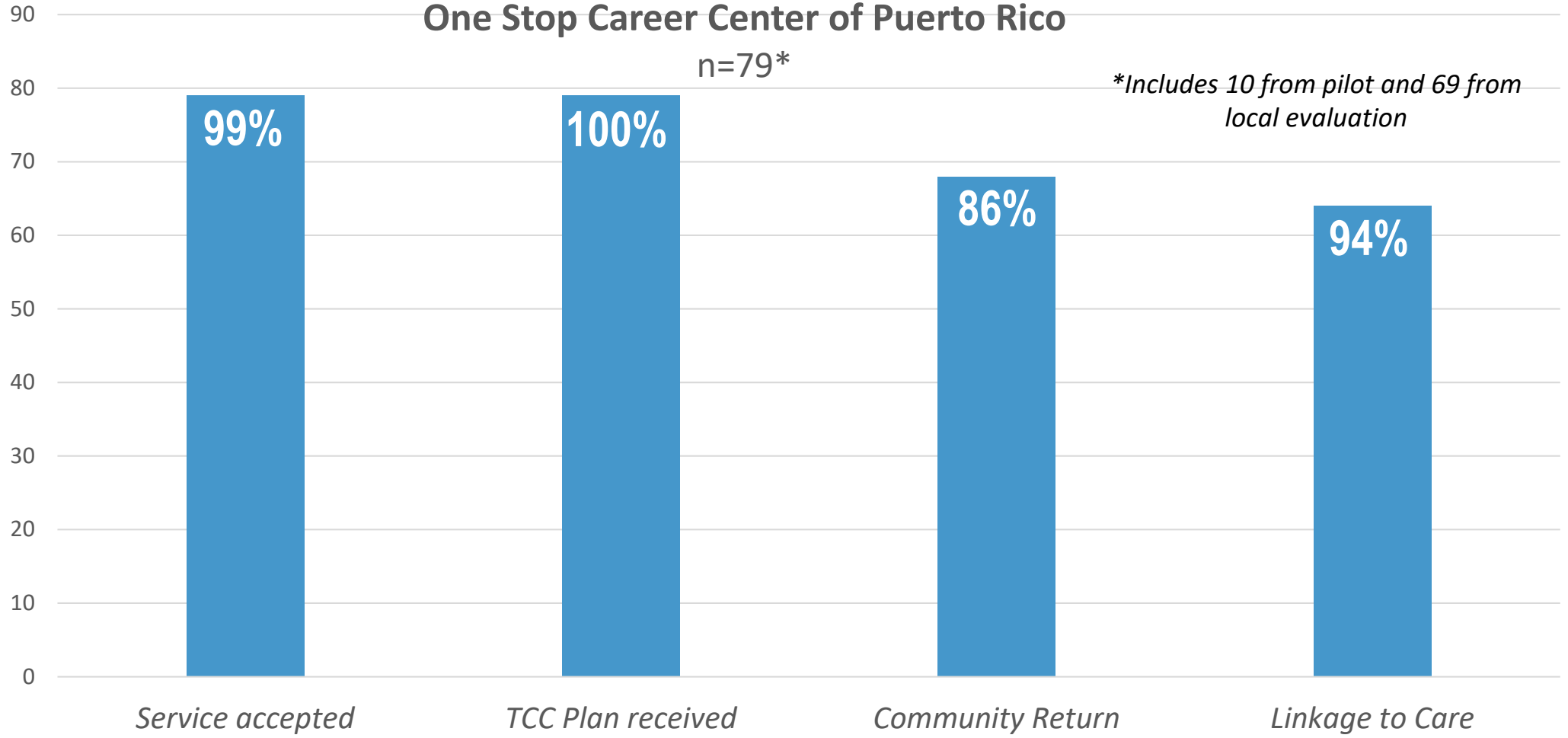
Housing: 22

- 19 transitional
- 5 permanent

Job readiness: 15

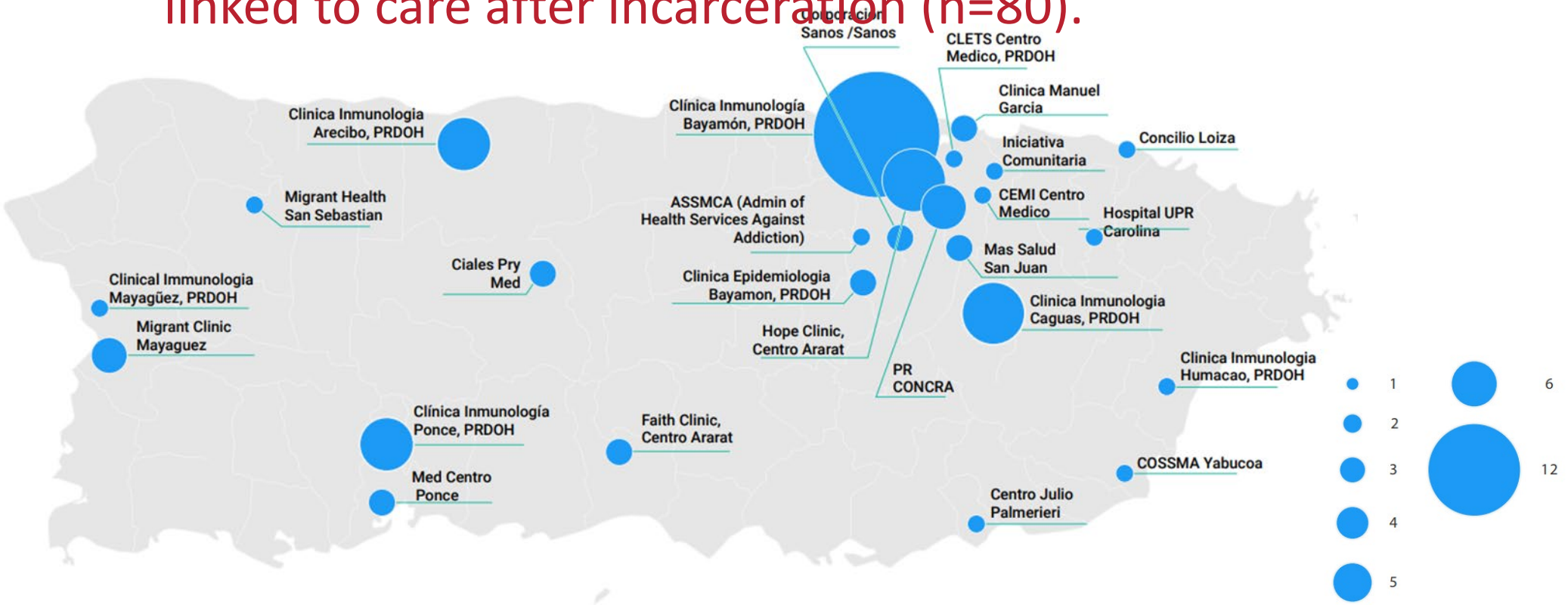
- 12 employed;
- 1 volunteer;
- 2 seeking employment

Transitional Care Coordination Cascade



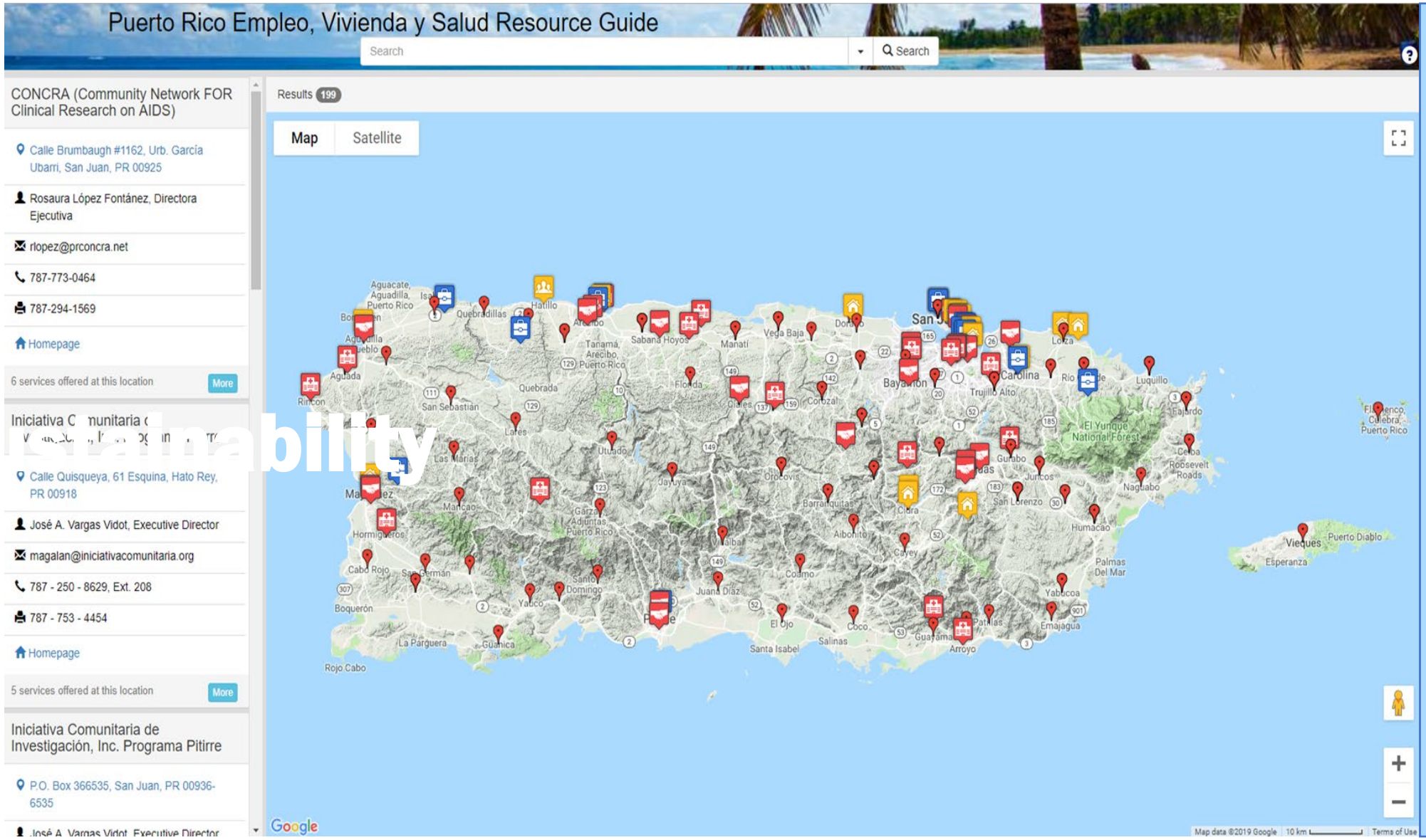
Mapping Linkages to Care in Puerto Rico

94% of people returning home with a transitional care plan linked to care after incarceration (n=80).



ONE STOP

Most people linked to care after incarceration were seen at Ryan White Part B and C clinics, with others followed by Federally Qualified Health Centers. Access to care was facilitated in all regions across Puerto Rico.



The Puerto Rico Employment, Housing and Health Resource Guide is available at no cost to network providers through RDE eCOMPAS and includes icons that depict available services, such a hospital for medical care, a house for housing and a suitcase for employment services and a handshake for care coordination.

https://nrg.e-compas.com/pr/

Implementation Challenges

- Identifying right fit programs: personal relationships v. formal expertise
- Proposal evaluation methodology favors existing programs
- Formal authority/documents from predecessors are insufficient to gain buy-in
- Culture of corrections varies by location/jurisdiction
- Opening/closing of programs absent formal communication system
- Frequent turnover and changes in local government leadership
- Poor local economy, lack of affordable housing/shelters
- Hurricane Maria…

Hurricane Maria Relief Efforts

OSCC received hurricane relief funding and found clients after Hurricane Maria to assess need and arrange for:

- Medications
- Housing
- Food, drinking water, clothes and other needs
- Assistance with FEMA application
- Placement in transitional housing / treatment

OSCC Executive Director and staff secure & distribute food and essentials

Overcoming Challenges

Manati

After Hurricane Maria

Brenda Rosario

February 2019

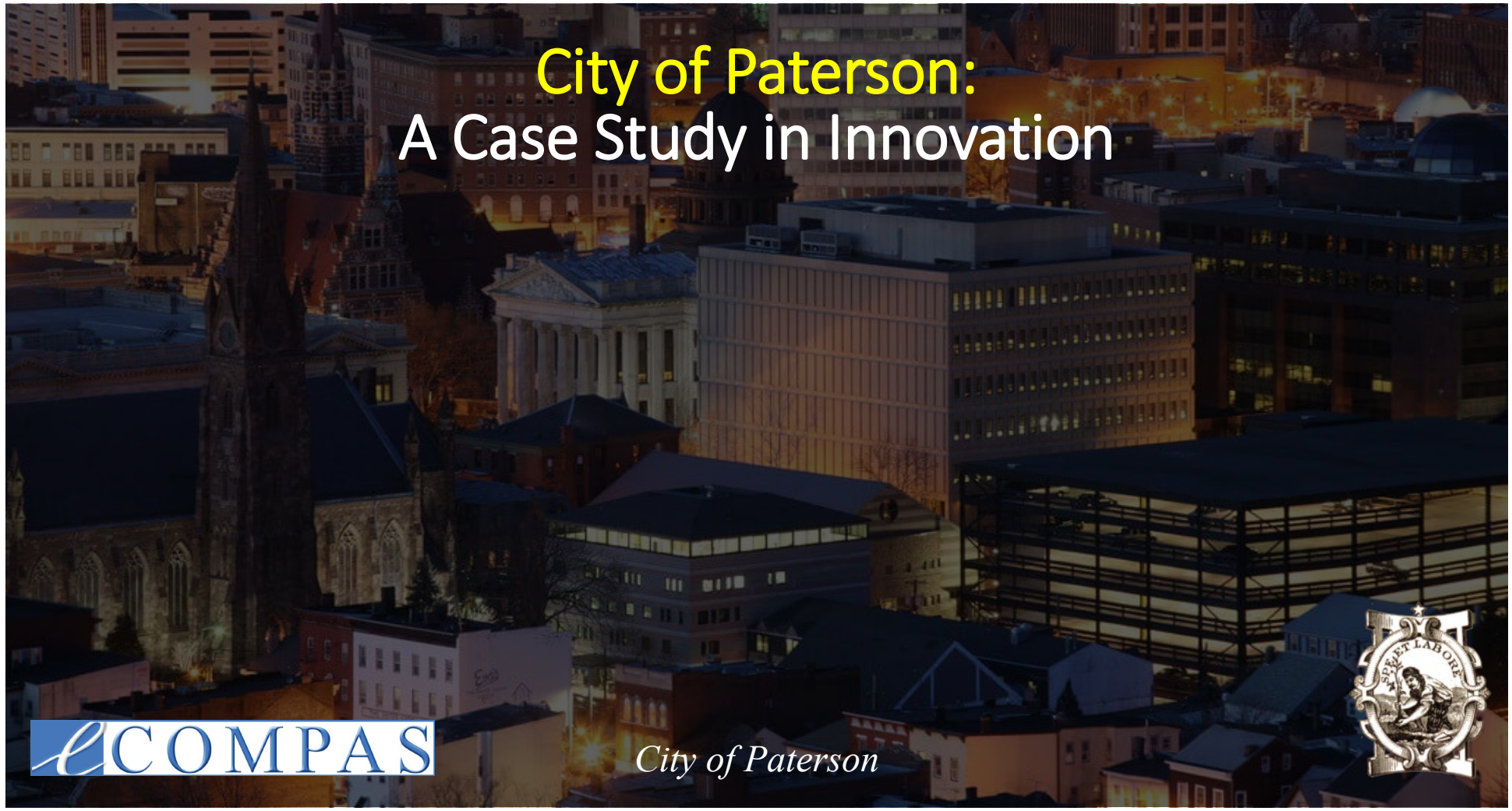
Alison O Jordan

Lessons Learned & Recommendations

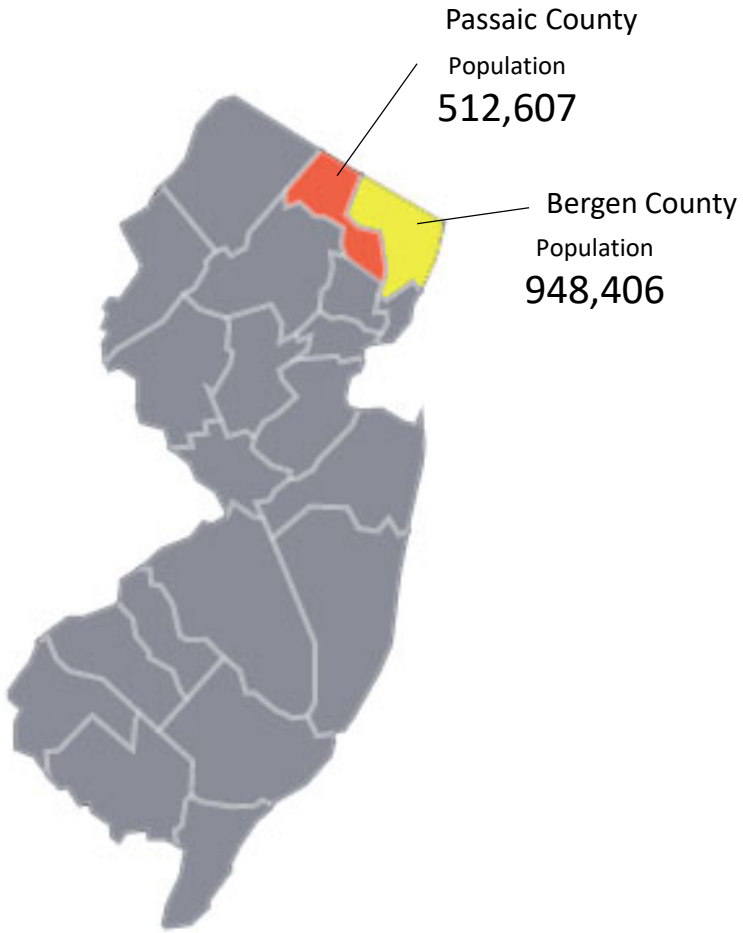
1. Networking with other agencies & jurisdictions identified core organizations and champions
2. Local community/ faith-based organization (CBO) leadership pooled resources + worked with government staff to establish best practices to facilitate continuity of care
3. Coordination & collaboration between Ryan White service network and local CBOs improved access for those out of care.
4. Pre-established relationships led to formal agreements & created synergy among medical and support service providers (housing, employment, substance use)
5. OSCC participation on HIV Planning Council facilitated coordination with key stakeholders
6. Annual convening of stakeholders helped create strategies to address population needs
7. Maintain relationships and linkage agreements
8. Transitional Consortium maintained core leadership, supported relationships & leveraged resources to coordinate care
9. Engaging client during incarceration fosters relationships to endure after incarceration
10. Transportation access ensures linkage to care after incarceration

Jesse Thomas

Case Study #2: Paterson NJ


City of Paterson:
A Case Study in Innovation
eCOMPAS
City of Paterson
STREET LABORE

Introduction



Coordinating systems through eHIE

COMPAS

SPNS Improving HIV Health Outcomes through the Coordination of Supportive Employment and Housing Services

2017-2020

IN A NUTSHELL

We are enhancing Housing and Employment services, workflows, tracking and coordination within the Bergen-Passaic TGA for improved client outcomes.

Project Goals

Bergen-Passaic Housing and Employment SPNS: Changing Lives – A Client Story

A client story…

- "I was basically **blind**, I didn't know what to do, I **didn't have hope**. Sometimes I just **didn't feel like trying**."
  - Diagnosed with HIV in 2014
  - She was homeless, working several part-time jobs, going to school for GED
  - "There were lots of **ups and downs** in my life and **nowhere to go** for help, mentally or financially."
  - Living in the shelter made her realize she wanted to be in a **better place**
  - "My doctors suggested CAPCO but **I wasn't ready**."

How SPNS and CAPCO Helped

- SPNS and CAPCO Helped
  - Found current job through temp agency & case management, transportation assistance, emotional support
  - "Tisa (Smith) was a **friend**, and she helped me talk through problems. It made me feel like other people wanted better for me, and I wanted better for me too."

- "Every conversation we had, I felt **comfortable**, I felt **at ease**. Everything about it was a **blessing** and I wouldn't be here today without it. **Thank you**."

- "I would tell somebody else about this program if they needed help."

The Results: "Things take time and it was well worth it."

- Stably housed.
  - Studio apartment close to transportation.
  - "I love it. It's affordable and comfortable for me and my lifestyle. I like my privacy. It fits me."
- Finding success at work.
  - Full-time employment since September 2019.
  - "My boss said I'm a solid worker."
  - "**I love what I do**, I make good pay and benefits."
- "Having my own place made me want to keep my job because now I have responsibilities and it feels good. A year ago it wasn't like that. **Now I feel like I'm in a good place physically and mentally**."
- Adherence and viral suppression.
  - "I'm still **undetected**."
- Looking to the Future.
  - "I don't want to just exist, I want to be somebody."
  - "I want to go back to school but I couldn't do school and have a full-time job before."

Bergen-Passaic Housing and Employment SPNS: Changing Lives

How did we get there?

Big Picture Themes

- The Power and Challenge of electronic coordination, monitoring, and tracking.
- Partnership: Being flexible and creative, transforming barriers into win-win arrangements.
- Smart Care Management

Partnership

1. HRSA SPNS
2. RDE eCOMPAS
3. Buddies of NJ
4. Team Management
5. CAPCO
6. Bergen Family Center
7. Straight & Narrow
8. Bergen-Passaic Housing Authority
9. Homeless Shelter Network
10. Bergen Housing Authority
11. City of Passaic
12. Other Ryan White, medical and housing providers
13. Department of Education (DOE)
14. Division of Vocational Rehabilitation Services (DVRS)
15. One Stop Career Center
16. Passaic County Jail
17. Department of Parole
18. Department of Probation
19. Bergen-Passaic library
20. County colleges
21. NJ Reentry Program

Boston University, Evaluation & Technical Assistance Provider,
HRSA/SPNS Initiative Improving HIV Health Outcomes through the
Coordination of Supportive Housing & Employment Services

THE HIV, HOUSING & EMPLOYMENT PROJECT

CITY OF PATERSON NEW JERSEY

BOSTON UNIVERSITY

New Referral Partners

1. Hackensack Housing Authority
2. Bergen County One-Stop Career
3. Passaic County One Stop Career
4. County of Passaic Board of Social Services
5. Division of Vocational Rehabilitation Services
6. Paterson Library
7. Passaic County Community College
8. Eva's Village (Main Facility)
9. Eva's Kitchen
10. Eva's Men's Shelter
11. Eva's Women's Shelter
12. Eva's Hope Residence for Mothers and Children
13. Family Promise of Passaic County
14. Father English Community Center
15. Hispanic Information Center
16. Hispanic Multi-Purpose Service Center
17. Passaic Information Center
18. Passaic County Women's Center
19. Paterson Coalition for Housing
20. Paterson Task Force
21. Path Program for Passaic County
22. Case Management for Mentally Ill and Homeless
23. Salvation Army of Passaic
24. St. Joseph's Hospital
25. St. Paul's Community Development Corporation
26. St. Peter's Haven
27. Strengthen Our Sisters
28. Youth Consultation Services

SMART CARE MANAGEMENT

Leverages evidence-informed models of coordinated care in which HIV primary care is linked with case management, housing assistance, substance use and mental health treatment, as well as legal, employment and social services.

CITY OF PATERSON NEW JERSEY

ACOJA CONSULTING
OPENING DOORS...MAKING A DIFFERENCE

powered by

Powered by: rde RDE Systems S®

SCM Goals

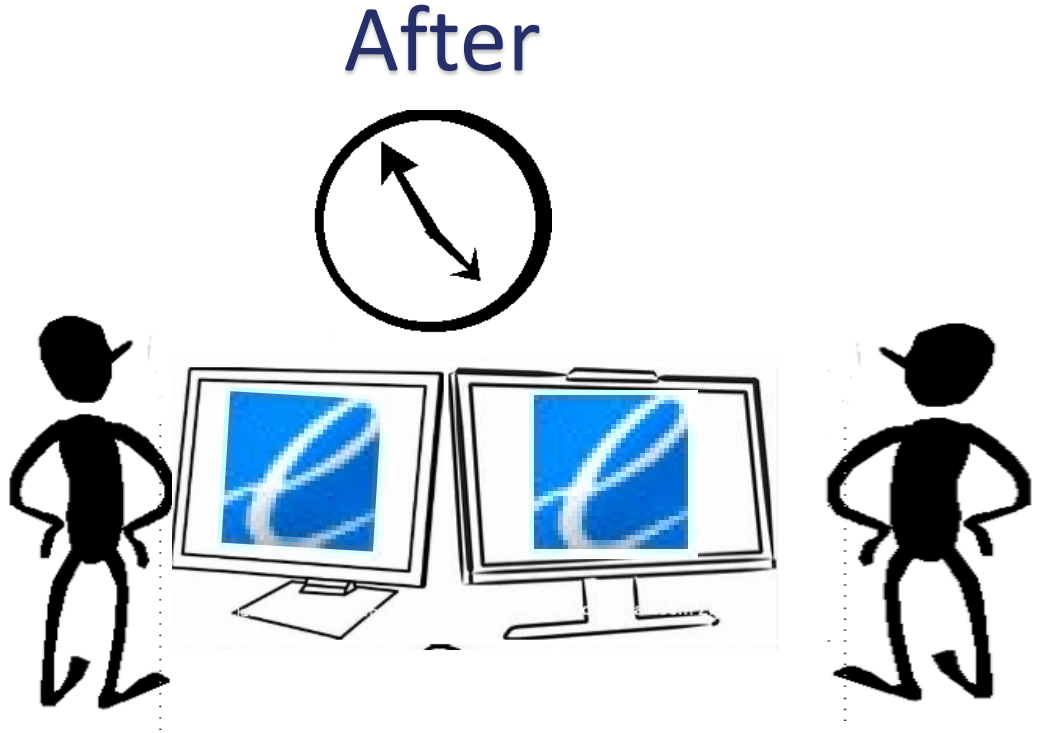
- Coordinated approach to identify population, deliver needed services and improve health outcomes
- Self sustainability with continuous quality improvement.

Applying IT solutions to care management to achieve goals and objectives

OBJECTIVES

- Use technology, resources and coordinated network of care to address changing needs and number who know their COVID-19 status.
- Engagement in healthcare services and treatment.
- Facilitate access to social determinant of health including housing and employment.

IMPACT OF THE INTERVENTION



CITY OF PATERSON NEW JERSEY

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What is Smart Care Management?

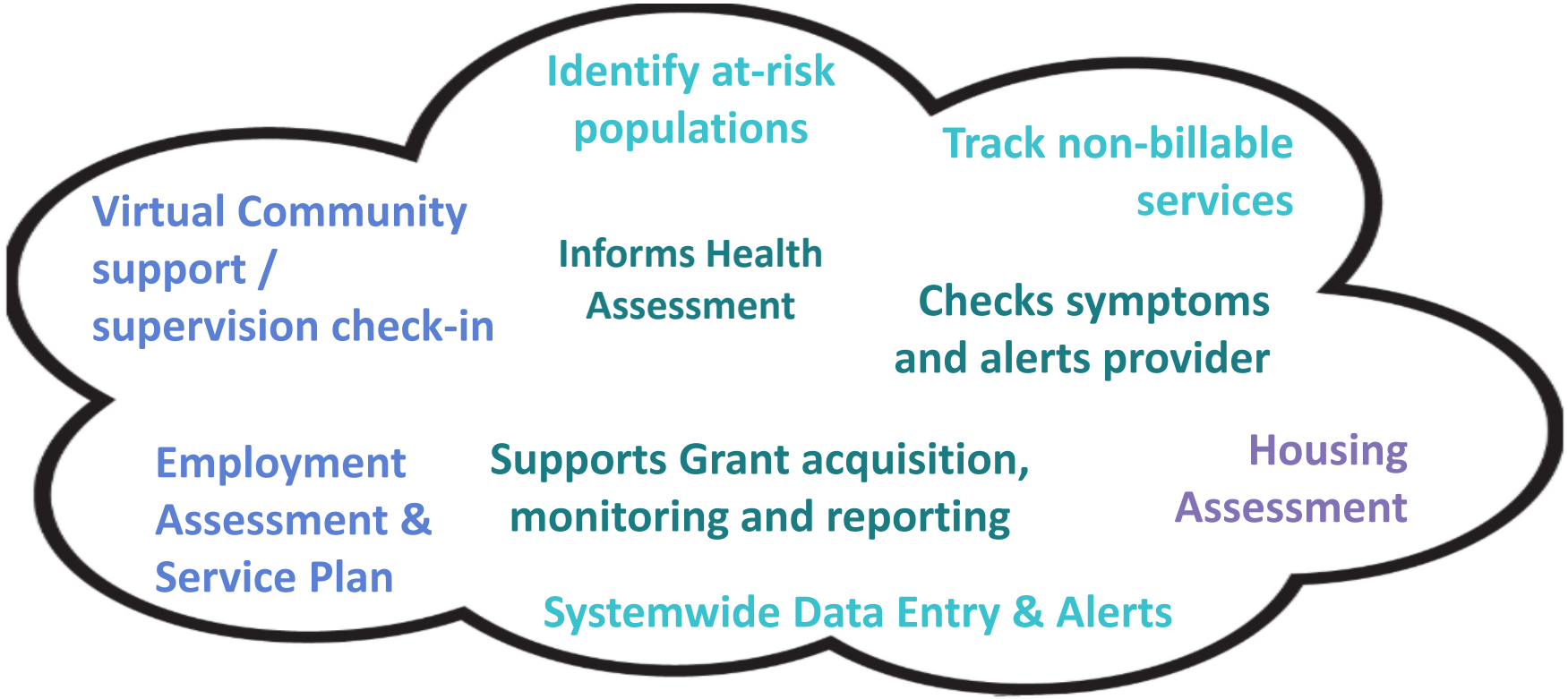
Smart Care Management is a strategic systems approach to facilitate needed access to care and services.

Smart Care Management leverages existing health, social and support services to improve population health outcomes.

Smart Care Management uses Health Information Technology solutions for quality management and more.

Smart Care Management includes strategic planning and program development, service integration, and outcome reporting for quality improvement and population health management.

How is it Smart?



Supports teamwork– working smarter, not harder to coordinate care & services

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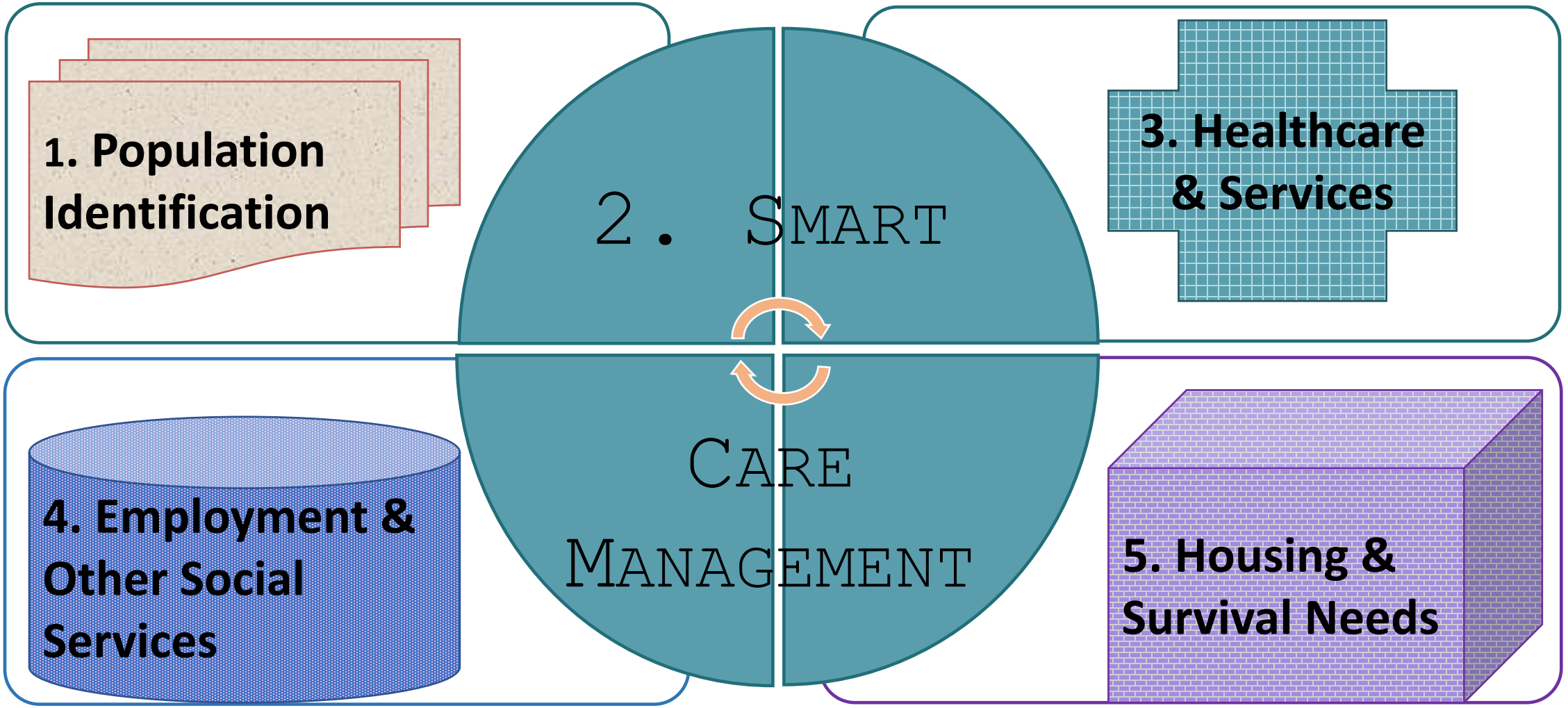
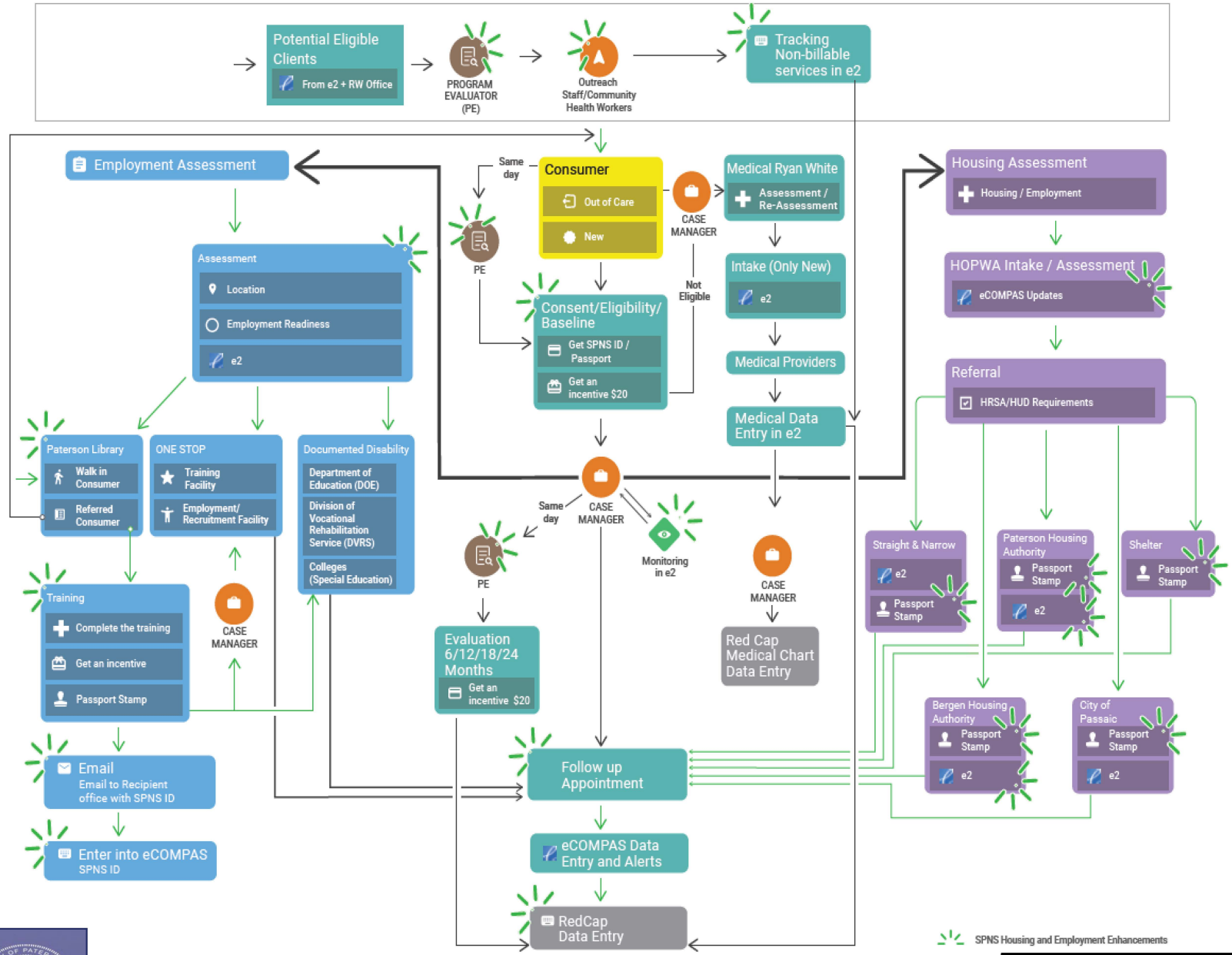
Five Core Elements



Five Core Elements Defined

1. **Population Identification:** determine new and out of care clients, identify at risk populations and service needs
2. **Smart Care Management:** facilitate engagement in care; coordinate care among service providers
3. **Healthcare & Services:** identify risk factors, education and awareness, facilitate access to care, treatment and support
4. **Housing & Survival Services:** identify, provide and enhance access to needed resources toward stable shelter and food security
5. **Employment and other Social Services**: integrate income, employment, legal and other social services

PATERSON SPNS HOUSING & EMPLOYMENT WORKFLOW - PROPOSED (AFTER)



CITY OF PATERSON NEW JERSEY

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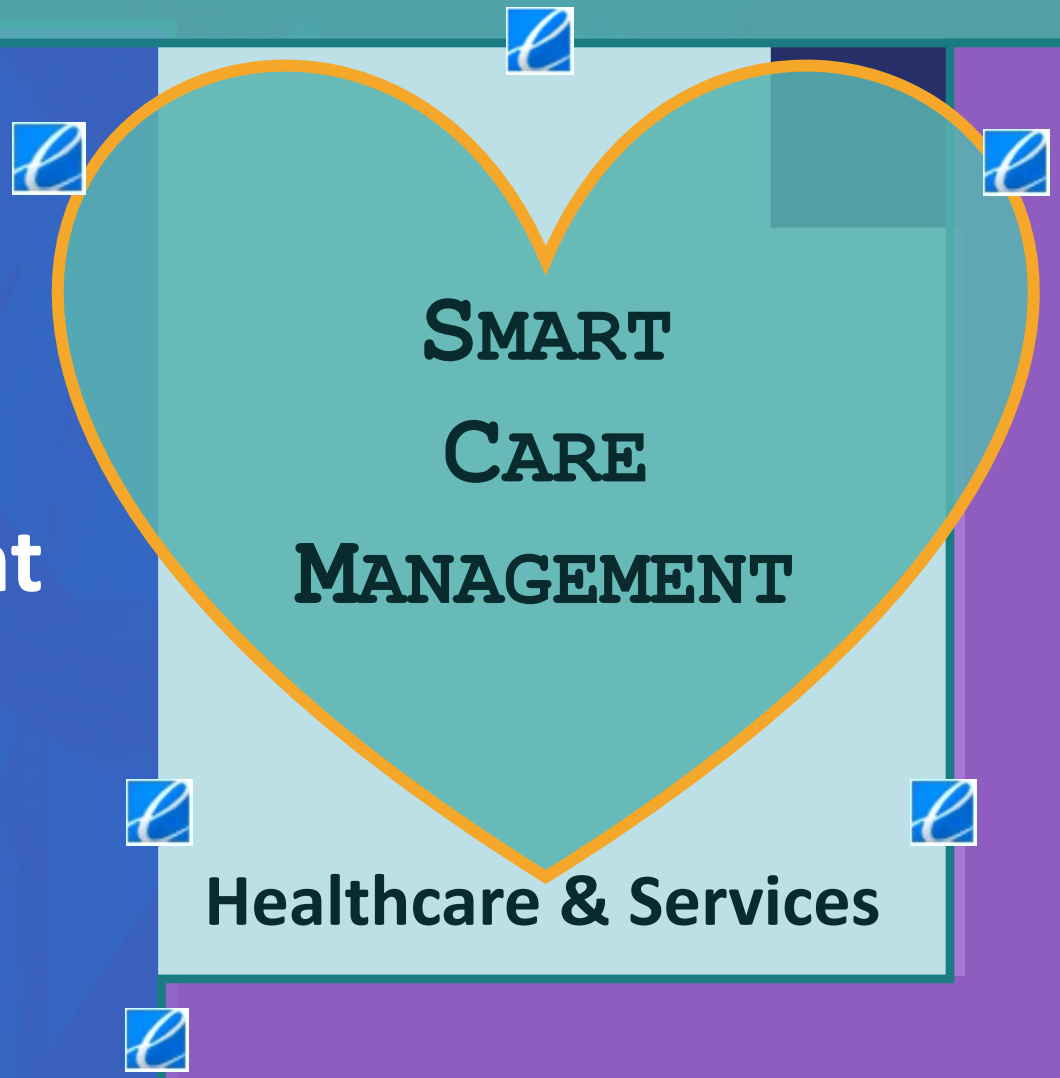
Population Identification



Employment & Social Services

Housing & Survival Services

VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

30 YEARS

The Benefits of SMART CARE MANAGEMENT

e2 supports teamwork – working smarter, not harder to coordinate care and services

Smart Care Management
Benefits of the Intervention

- Streamlined, coordinated system facilitates improved data collection and reporting
- Quality management process improvements, including identification of service reporting gaps, facilitates more accurate assessments and improved service plans
- Improved coordination of case management activities among case managers, community health workers, housing and employment specialists
- Collaborations between the RW service network and community based organizations leverage resources and improves information sharing.
- Improved information sharing leads to improved outcome documentation

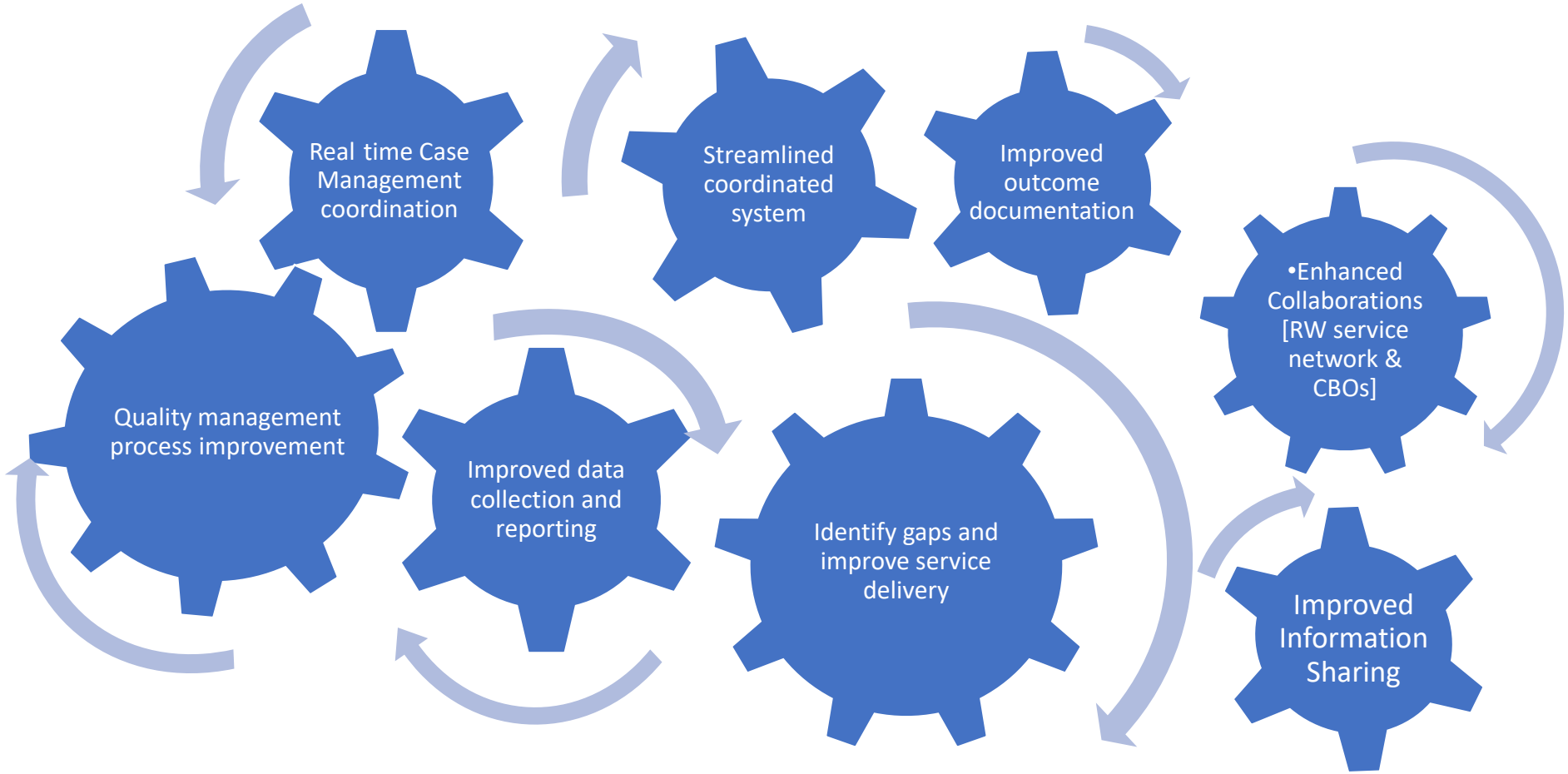
CITY OF PATERSON NEW JERSEY

ACOJA CONSULTING OPENING DOORS...MAKING A DIFFERENCE

Powered by: COMPAS®

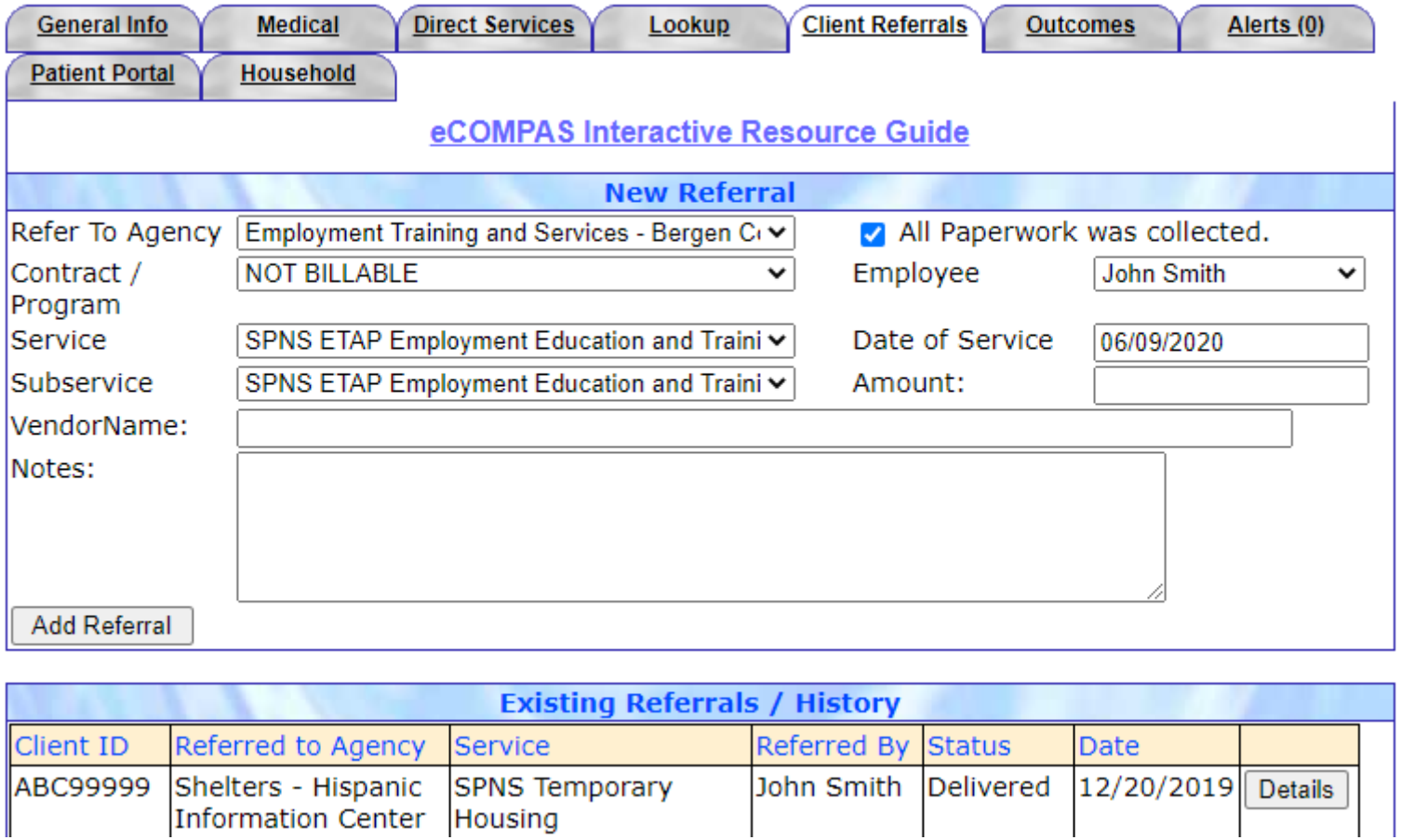
Smart Care Management

Data-driven Process Improvement



Leveraging Technology and Data

Electronic Referrals in e2



12,000

Referrals Made in eCOMPAS

One-Click CAPER in e2

1. HOPWA Performance Planned Goal and Actual Outputs

	HOPWA Assistance	HOPWA Funds	
	Number of Households	HOPWA Budget	HOPWA Actual
HOPWA Housing Subsidy Assistance			
1. Tenant-Based Rental Assistance [?]	0	$0.00	$0.00
2a. Permanent Housing Facilities [?]	0	$0.00	$0.00
2b. Transitional/Short-term Facilities [?]	0	$0.00	$0.00
4. Short-Term Rent, Mortgage and Utility Assistance [?]	0	$0.00	$0.00
5. Permanent Housing Placement Services [?]	0	$0.00	$0.00
6. Adjustments for duplication (subtract)	0		
7. Total HOPWA Housing Subsidy Assistance [?]	**0**	**$0.00**	**$0.00**
Supportive Services			
11a. Supportive Services provided by project sponsors /subrecipient that also delivered HOPWA housing subsidy assistance [?]	0	$0.00	$0.00
11b. Supportive Services provided by project sponsors /subrecipient that only provided supportive services [?]	0	$0.00	$0.00
12. Adjustment for duplication (subtract)	0		
13. Total Supportive Services [?]	**0**	**$0.00**	**$0.00**
Grant Administration and Other Activities			
19. Project Sponsor Administration (maximum 7% of portion of HOPWA grant awarded)		$0.00	$0.00
20. Total Grant Administration and Other Activities [?]		**$0.00**	**$0.00**
Total Expended			
21. Total Expenditures for Program Year [?]		**$0.00**	**$0.00**

Housing and Employment Alerts in e2

Type	Upcoming Alerts	Past-Due Alerts	Recommendation
Total number of clients eligible for employment and training referral to Paterson Library [?]	8	N/A	Refer the client to Paterson Library and add the service referral in the Referrals screen.
Total number of clients eligible for employment and training referral to Bergen County One Stop [?]	26	N/A	Refer the client to Bergen County One Stop and add the service referral in the Referrals screen.
Total number of clients eligible for employment and training referral to Passaic County One Stop [?]	8	N/A	Refer the client to Passaic County One Stop and add the service referral in the Referrals screen.
Total number of clients eligible for DVR referral [?]	3	N/A	Refer the client to DVRs and add the service referral in the Referrals screen.
Client referred for Employment Training to One-Stop Centers and pending service delivery and Referral close out. [?]	0	0	Follow up with Client or the Referred agency and mark the Referral as Complete.
Client referred for Employment Training to Paterson Library and pending service delivery and Referral close out. [?]	0	0	Follow up with Client or the Referred agency and mark the Referral as Complete.
Client referred for Employment Training to DVR and pending service delivery and Referral close out. [?]	0	0	Follow up with Client or the Referred agency and mark the Referral as Complete.
Client referred to a Shelter. Pending Referral close out. [?]	0	1	Follow up with Client or the Shelter they were referred to and mark the Referral as Complete.
HOPWA Services Delivered by the agency. Follow up appointment date missing. [?]	0	N/A	Schedule a follow up appointment with the client. Go to Service Entry screen, edit the service and add the next appointment date.

Alerts Drilldown

Housing and Employment Alerts

Type	Upcoming Alerts	Past-Due Alerts	Recommendation
Total number of clients eligible for employment and training referral to Paterson Library [?]	8	N/A	Refer the client to Paterson Library and add the service referral in the Referrals screen.
Total number of clients eligible for em Be [?]	26	N/A	Refer the client to Bergen County One Stop and add the service referral in the Referrals screen.
To em Pa			Refer the client to Passaic County One Stop and add the service referral in the Referrals screen.
To DV			Refer the client to DVRs and add the service referral in the Referrals screen.
Client referred for Employment Training to One-Stop Centers and pending service delivery and Referral close out. [?]	0	0	Follow up with Client or the Referred agency and mark the Referral as Complete.

Upcoming - Eligible for Bergen County One Stop [Anchor for Printing] [Close]

AAF035324 ACF753710 ADM060619 AMF793919 BAM762012 CMM819408 CPM268127 CTM789211 ECM323202 ETM658205 GSM119706 GTM143705 GWF792616 HSM679719 HTM193628 IKF327528 IMM907002 JHM347310 JJM066429 JPM646306 JPM897905 JRM844010 NHM902524 SDF999622 SRF049401 TWM756109

In-Sight, In-Mind

Basic Information

ID:	**ABC9999**	Status:	Active	First Name:	John	Last Name:	Smith
SSN:	999-99-9999	Gender:	Male	Birth Date:	01/01/1800	Age:	99

Last MD Visit(Part A) 07/18/07
HIV Care Provider: None / Out of Care

Alerts: refresh
Inactive for 6 mo
Med Case Plan Due
Case Plan Due

General Info | Medical | Direct Services | Lookup | Client Referrals | Outcomes | Alerts (1) | Patient Portal | Household

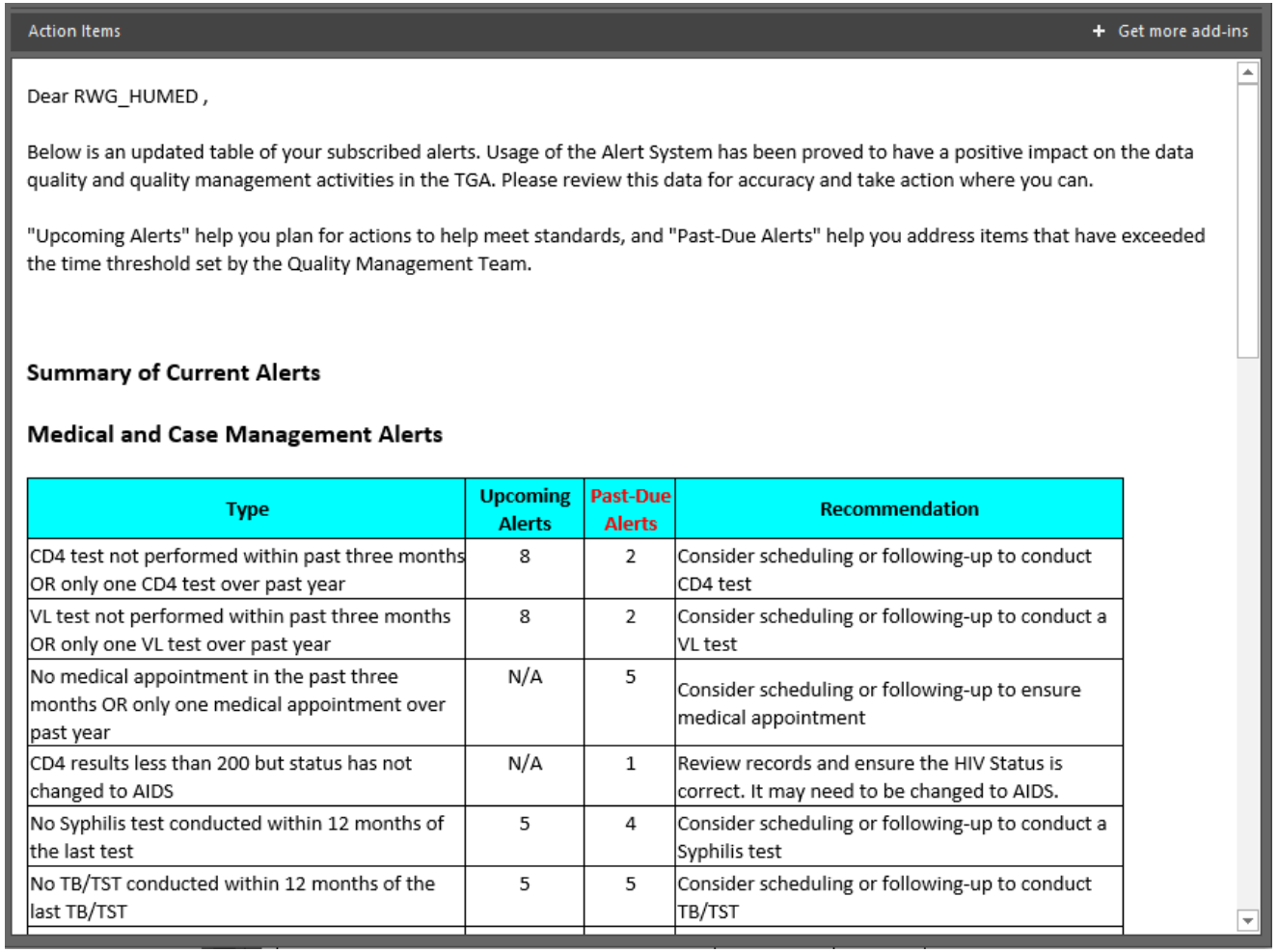
Past Due Alerts

Alert Name	Recommendation
Client has not received any services in the past 6 months	Review client records and try to reconnect them to services or mark as inactive.

Upcoming Alerts

Alert Name	Recommendation
Client's case management plan has not been updated in the past 6 months.	Consider scheduling a case management session to update the case management plan.
Client's medical case management plan has not been updated in the past 6 months.	Consider scheduling a case management session to update the medical case management plan.
Client eligible for employment and training referral to Paterson Library	Refer the client to Paterson Library and add the service referral in the Referrals screen.

Proactive Weekly Email Alerts



Action Items + Get more add-ins

Dear RWG_HUMED ,

Below is an updated table of your subscribed alerts. Usage of the Alert System has been proved to have a positive impact on the data quality and quality management activities in the TGA. Please review this data for accuracy and take action where you can.

"Upcoming Alerts" help you plan for actions to help meet standards, and "Past-Due Alerts" help you address items that have exceeded the time threshold set by the Quality Management Team.

Summary of Current Alerts

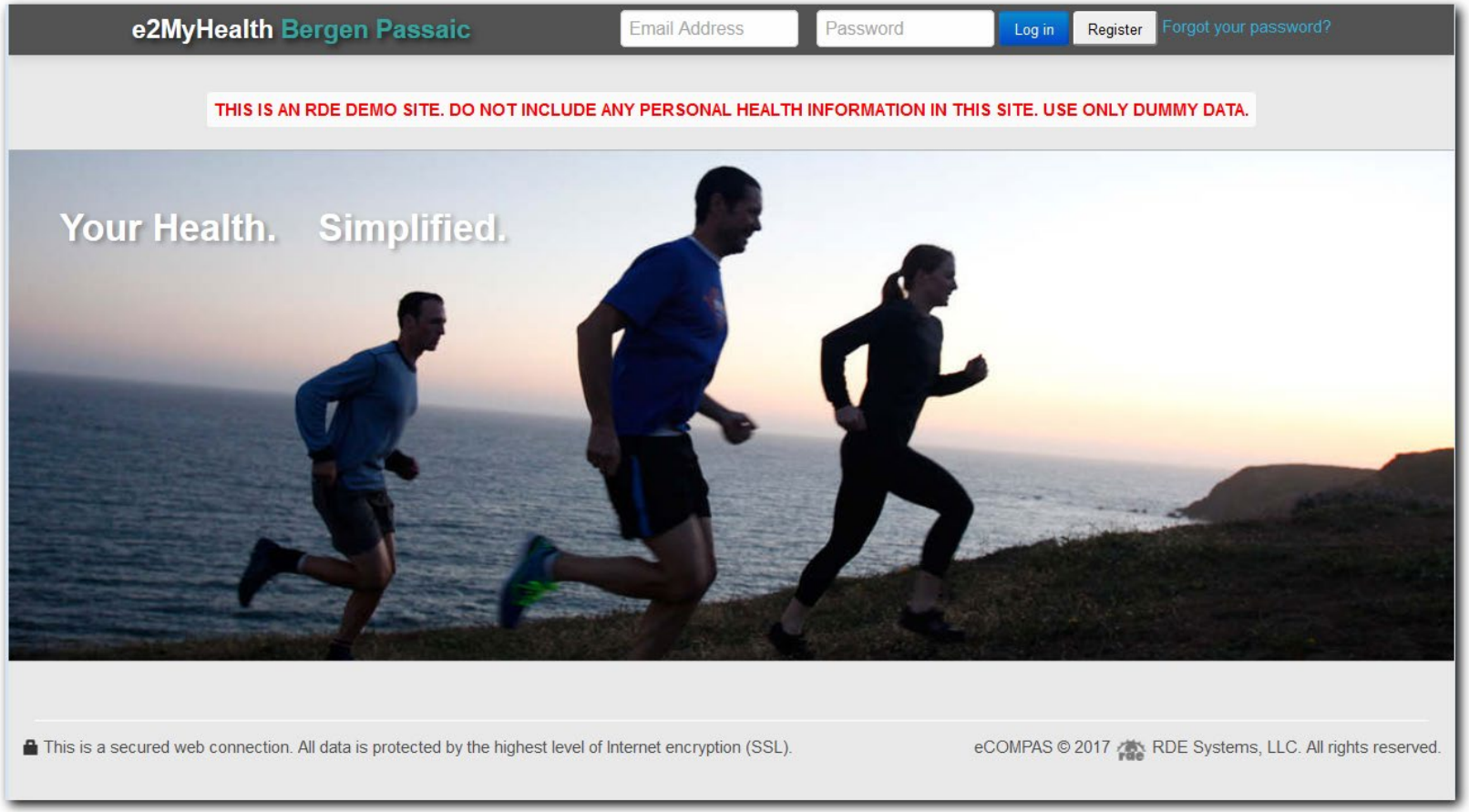
Medical and Case Management Alerts

Type	Upcoming Alerts	Past-Due Alerts	Recommendation
CD4 test not performed within past three months OR only one CD4 test over past year	8	2	Consider scheduling or following-up to conduct CD4 test
VL test not performed within past three months OR only one VL test over past year	8	2	Consider scheduling or following-up to conduct a VL test
No medical appointment in the past three months OR only one medical appointment over past year	N/A	5	Consider scheduling or following-up to ensure medical appointment
CD4 results less than 200 but status has not changed to AIDS	N/A	1	Review records and ensure the HIV Status is correct. It may need to be changed to AIDS.
No Syphilis test conducted within 12 months of the last test	5	4	Consider scheduling or following-up to conduct a Syphilis test
No TB/TST conducted within 12 months of the last TB/TST	5	5	Consider scheduling or following-up to conduct TB/TST

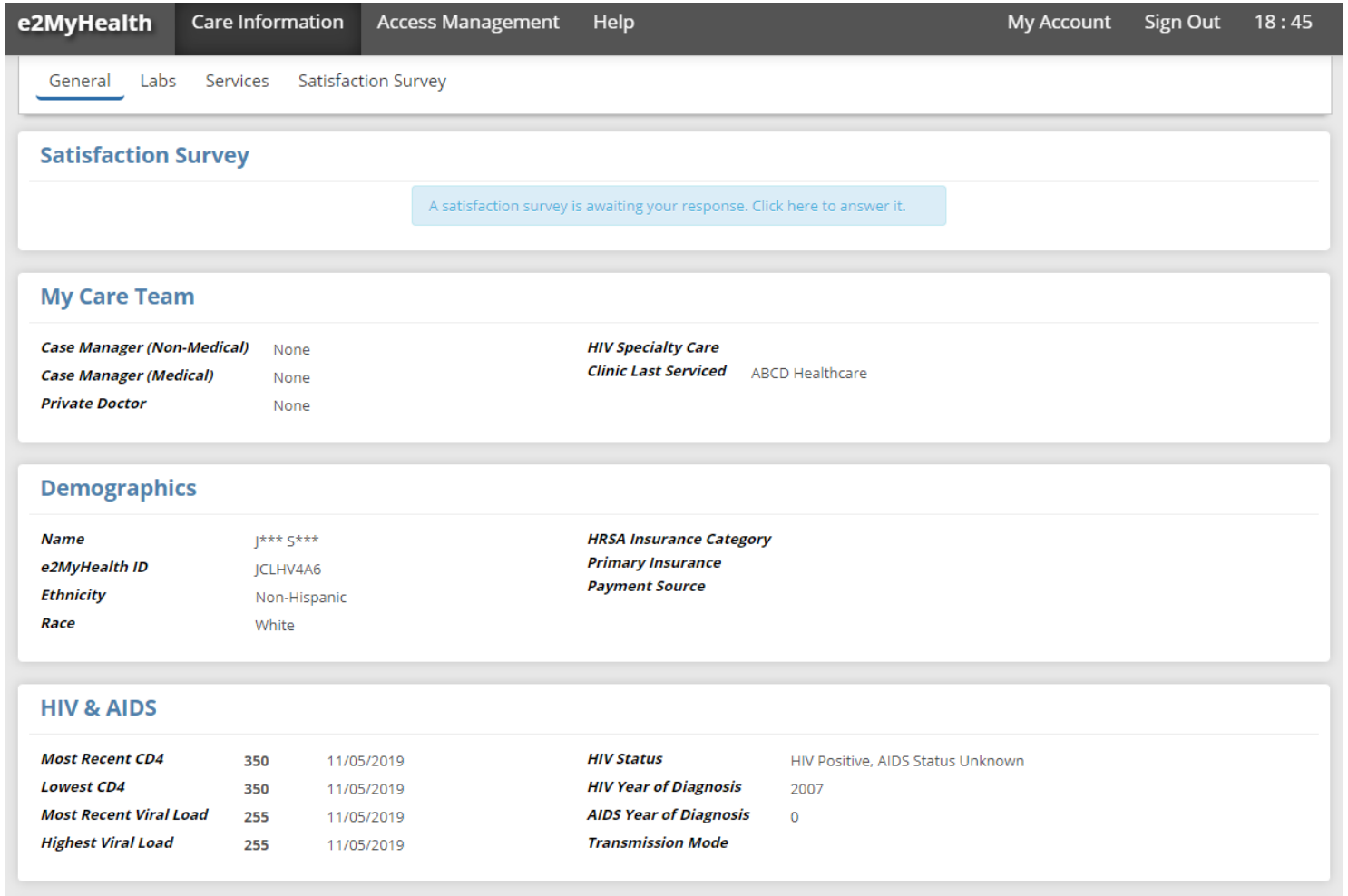
11,370

Alerts module was accessed in eCOMPAS

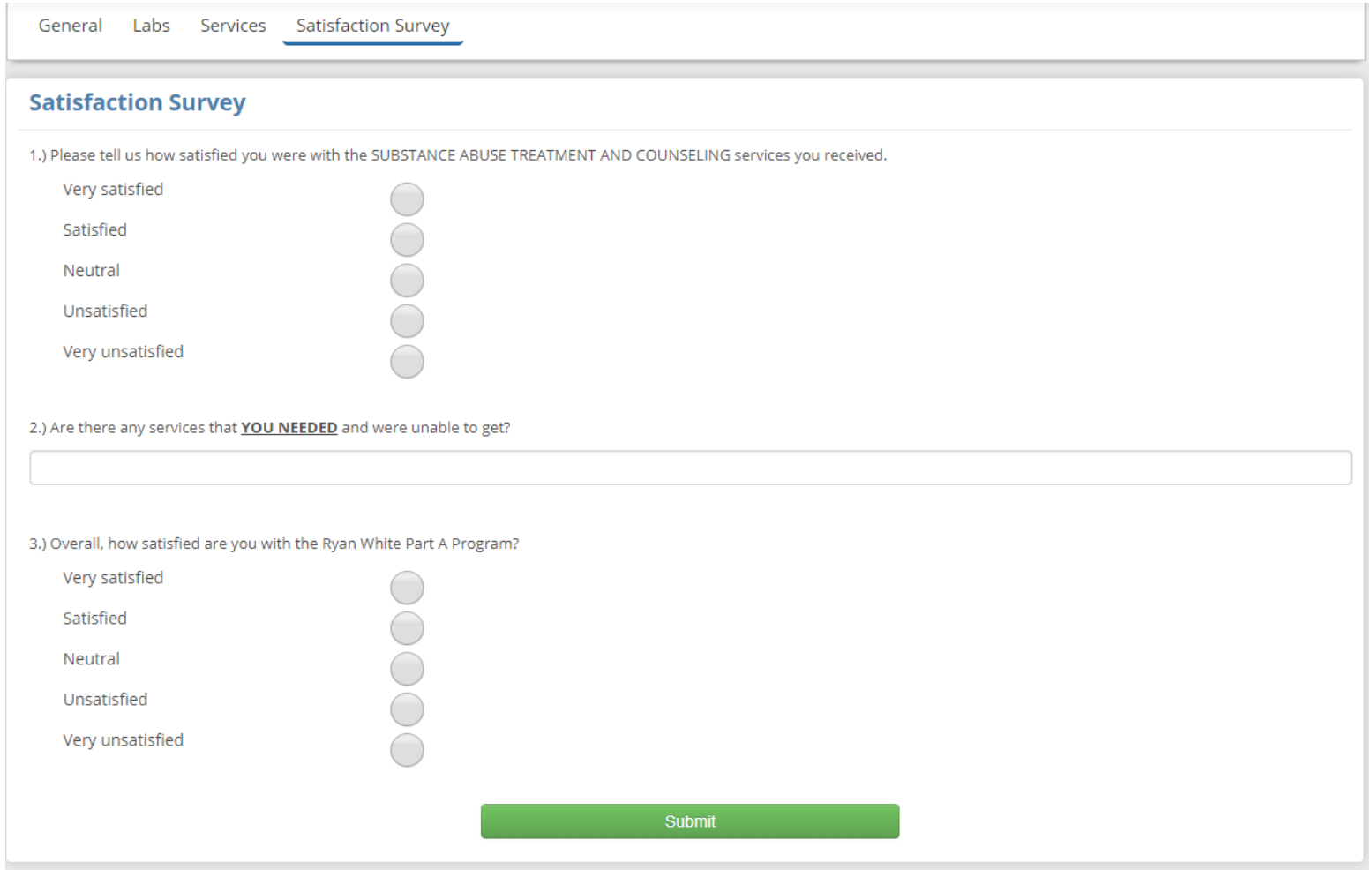
Bergen Passaic e2MyHealth



e2MyHealth


e2MyHealth
Care Information
Access Management
Help
My Account
Sign Out
18 : 45
General
Labs
Services
Satisfaction Survey
Satisfaction Survey
A satisfaction survey is awaiting your response. Click here to answer it.
My Care Team
Case Manager (Non-Medical) None
Case Manager (Medical) None
Private Doctor None
HIV Specialty Care
Clinic Last Serviced ABCD Healthcare
Demographics
Name J*** S***
e2MyHealth ID JCLHV4A6
Ethnicity Non-Hispanic
Race White
HRSA Insurance Category
Primary Insurance
Payment Source
HIV & AIDS
Most Recent CD4 350 11/05/2019
Lowest CD4 350 11/05/2019
Most Recent Viral Load 255 11/05/2019
Highest Viral Load 255 11/05/2019
HIV Status HIV Positive, AIDS Status Unknown
HIV Year of Diagnosis 2007
AIDS Year of Diagnosis 0
Transmission Mode

Eliciting Client Feedback Survey



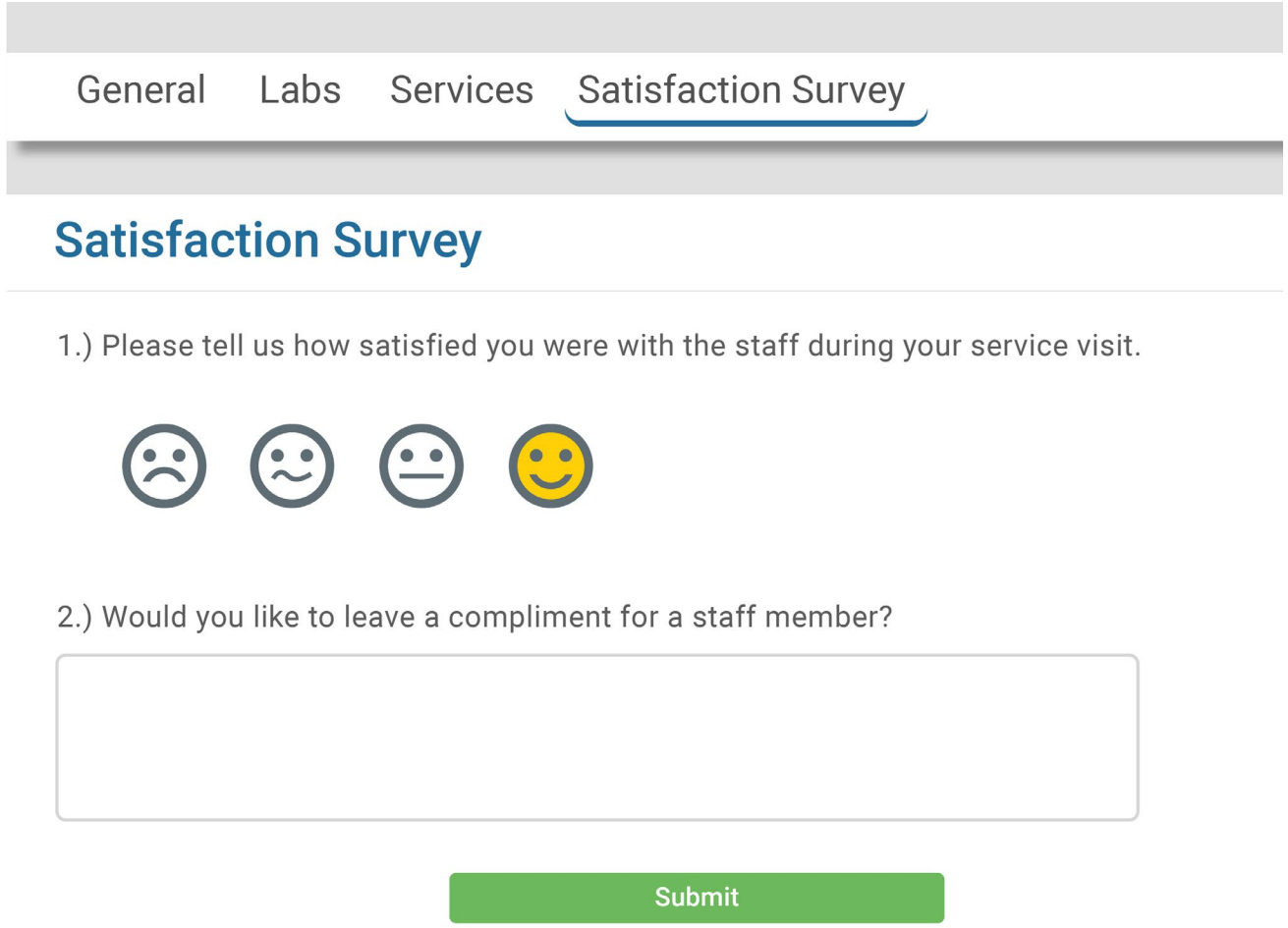
CSS Survey – Future Vision

General Labs Services Satisfaction Survey

Satisfaction Survey

1.) Please tell us how satisfied you were with the staff during your service visit.

CSS Survey – Future Vision



CSS Survey Client Emails

eCOMPAS

Hello,

You have been invited to participate in the Client Satisfaction Survey beasuse you have recently received the following services from your Ryan White Part A provider:

- Case Management Community
- Treatment Adherence
- Non-Medical Case Management

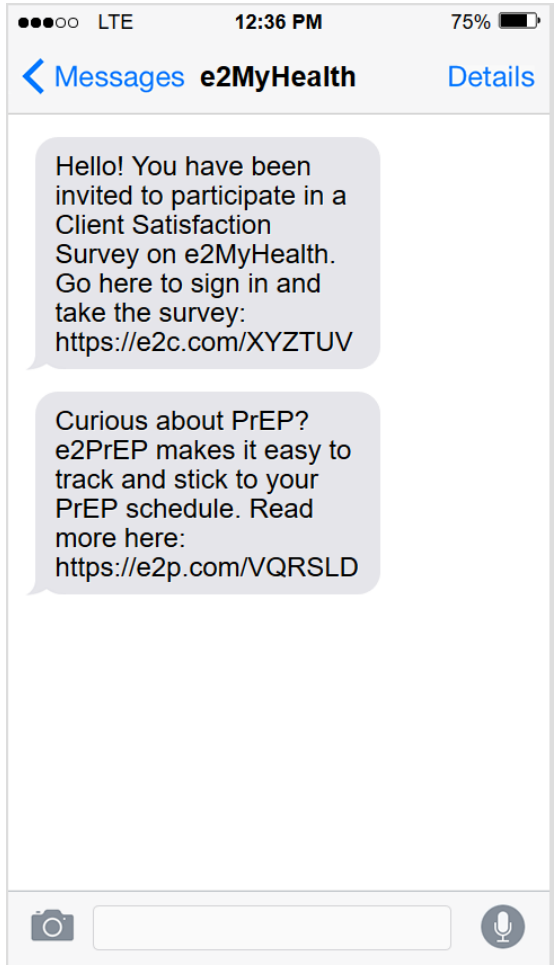
Please complete the survey by following the link below and logging into your My Health Profile account. The survey will only take about 5 minutes to complete and all survey responses are confidential.

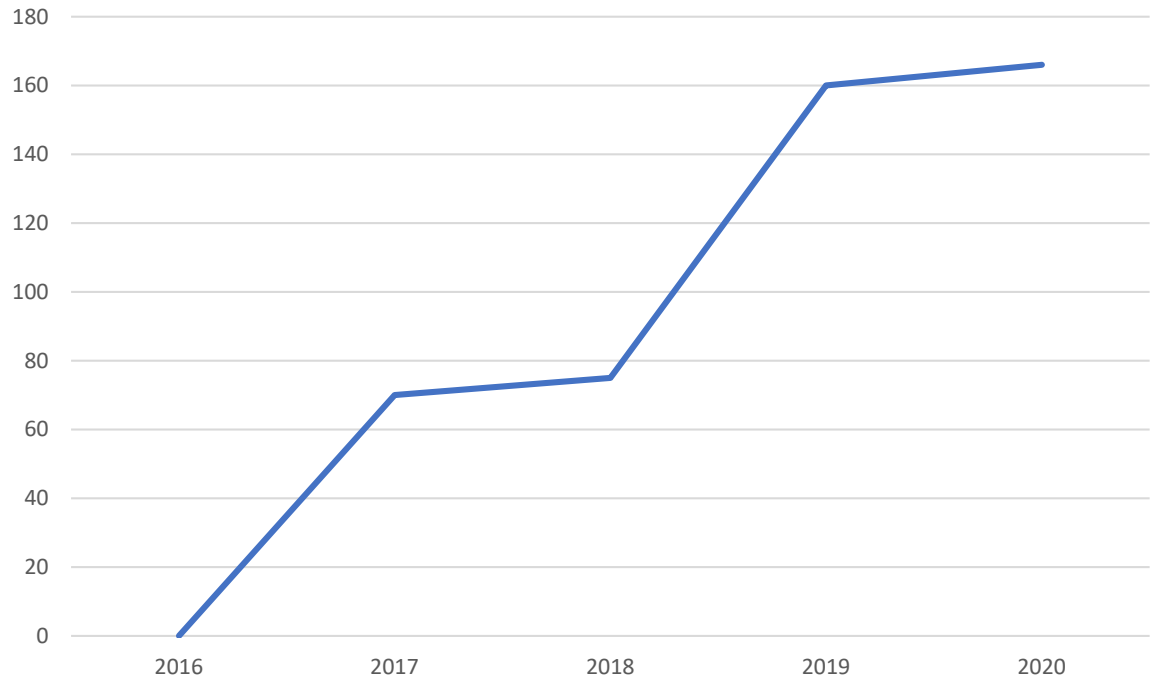
Go to My Health Profile →

If you have any questions, please email support@e-compas.com and we will be happy to help.

— *The eCOMPAS Team at RDE Systems.*

CSS Survey – Future Vision





Consumer Enrollment in e2MyHealth

HIV Care Continuum

HIV Care Continuum Dashboard

End Date: 12/31/2019

Report Type: SPNS ETAP

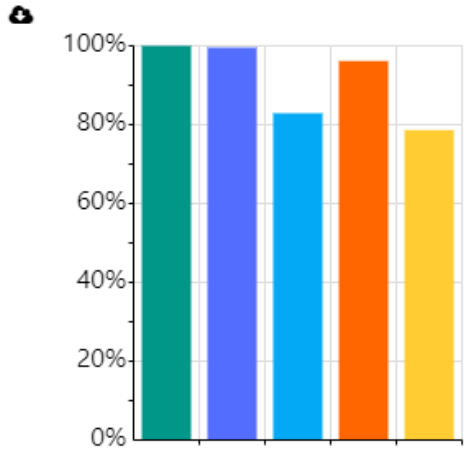
Run Report

Measurement Year: 01/01/2019 - 12/31/2019
24-Month Measurement Period: 01/01/2018 - 12/31/2019

This is the latest version of the CCT Dashboard
Click Here to see the previous version of this report

Summary | Graphical View | Tabular View

Bergen-Passaic Ryan White Part A (3 clinics) HIV Care Measures

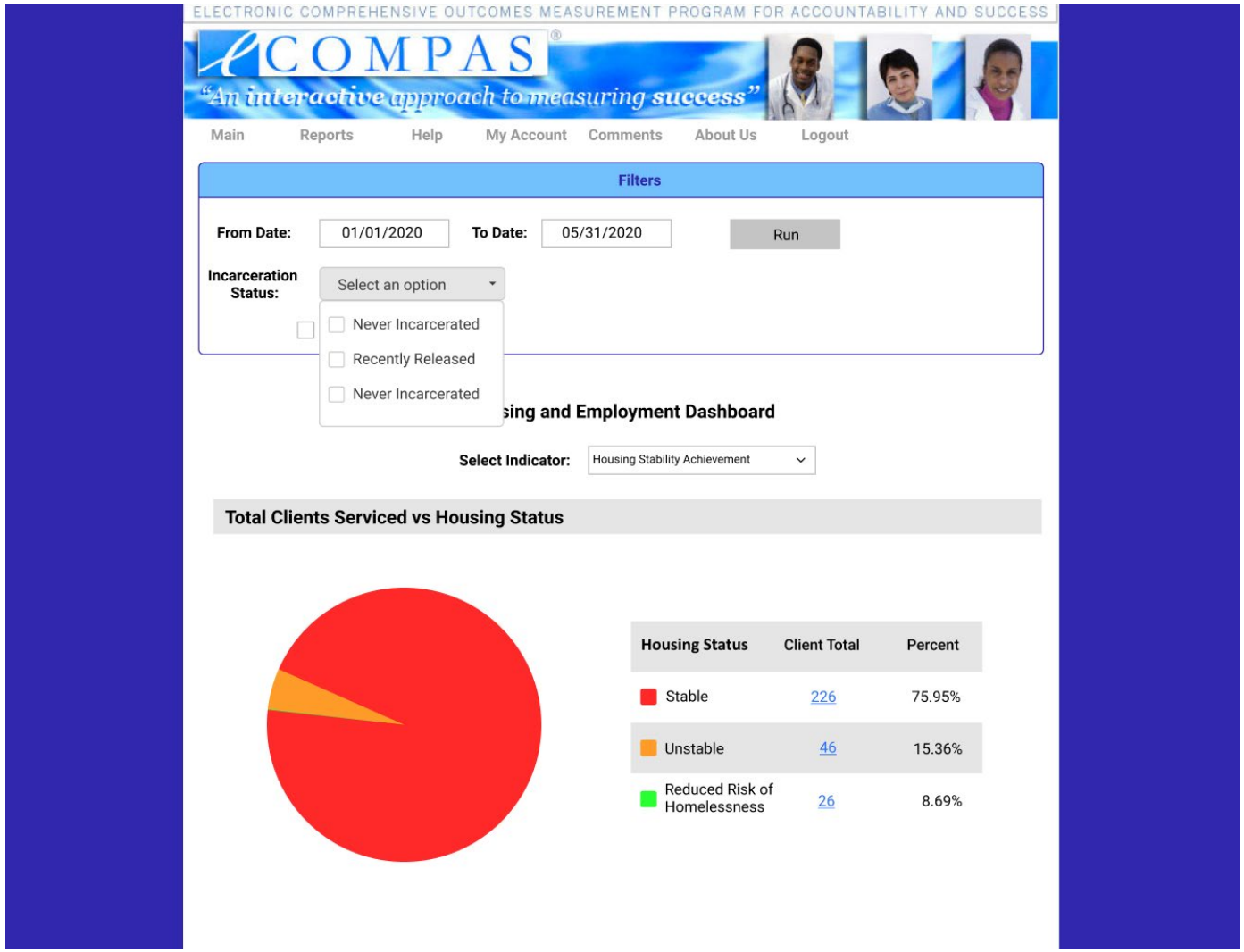


Summary Table [?]		
Enrolled	234	100.00%
Linked to Care	233	99.57%
Retained in Care	194	82.91%
Rx of ARV Therapies	225	96.15%
VL Suppressed	184	78.63%

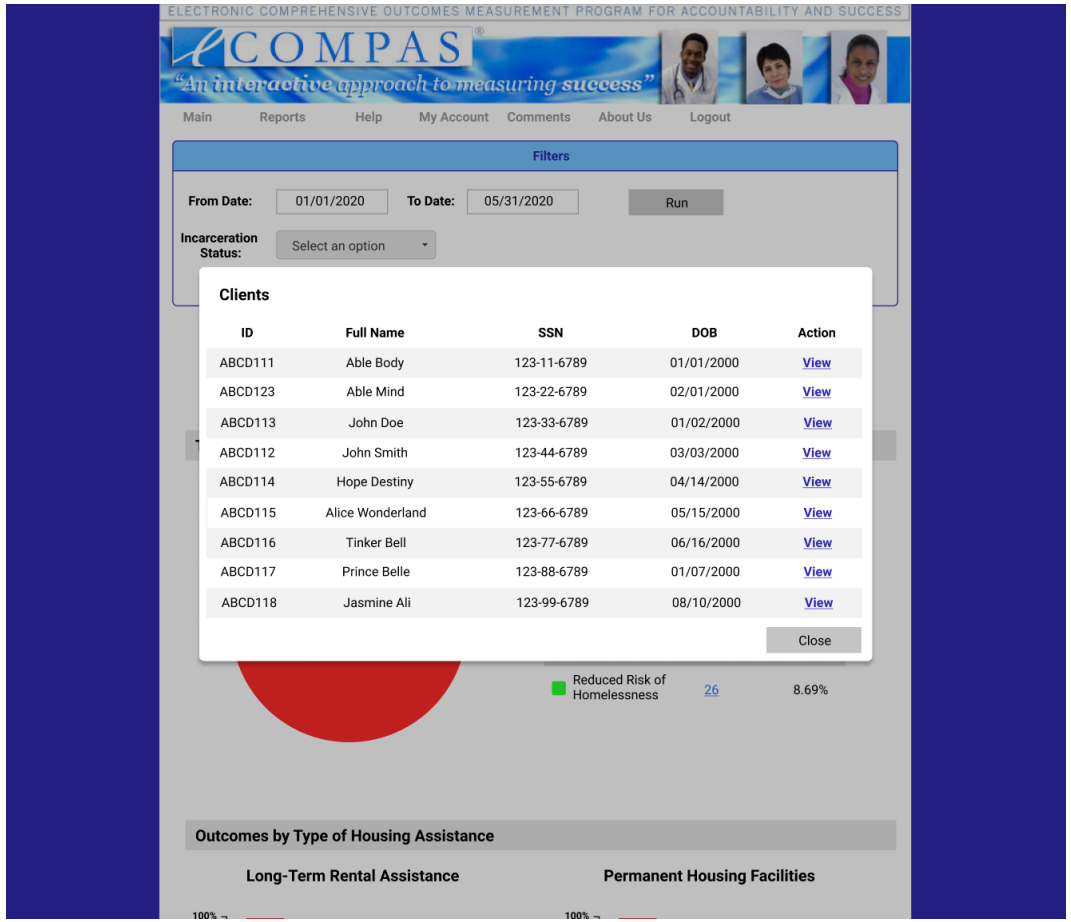
Bergen-Passaic Ryan White Part A (3 clinics) HIV Care Measures: by Service

	Enrolled		Linked to Care		Retained in Care		Rx of ARV Therapies		VL Suppressed	
Outpatient/Ambulatory Health Services	234	100.00%	233	99.57%	194	82.91%	225	96.15%	184	78.63%
Medical Case Management	118	100.00%	118	100.00%	104	88.14%	115	97.46%	98	83.05%
Mental Health Services	6	100.00%	6	100.00%	5	83.33%	3	50.00%	3	50.00%
Oral Health Care	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Early Intervention Services (EIS)	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%

Future Vision – Housing Dashboard



Future Vision – Housing Dashboard

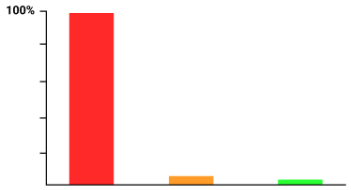


Future Vision – Housing Dashboard

Future Vision – Housing Dashboard

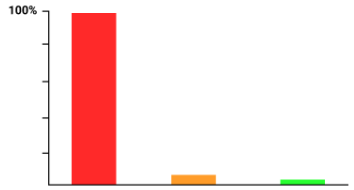
Outcomes by Type of Housing Assistance

Long-Term Rental Assistance



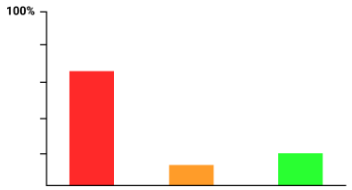
Housing Status	Client Total	Percent
Stable	142	95.94%
Unstable	5	3.38%
Reduced Risk of Homelessness	1	0.07%

Permanent Housing Facilities



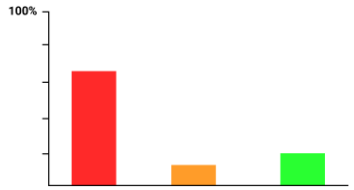
Housing Status	Client Total	Percent
Stable	75	93.75%
Unstable	4	5.00%
Reduced Risk of Homelessness	1	1.25%

Transactional/Short-Term Housing Facilities



Housing Status	Client Total	Percent
Stable	21	65.63%
Unstable	4	12.50%
Reduced Risk of Homelessness	7	21.87%

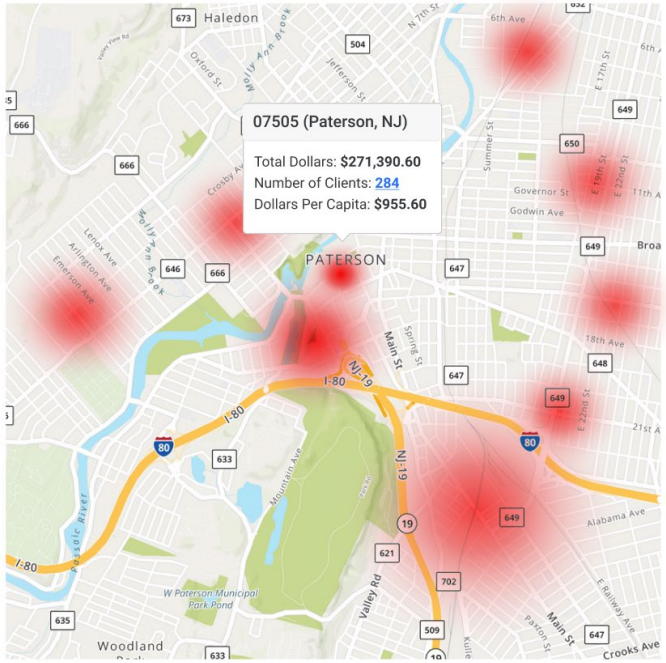
Short-Term Rent, Mortgage & Utility Assistance



Housing Status	Client Total	Percent
Stable	18	47.37%
Unstable	2	5.26%
Reduced Risk of Homelessness	18	47.37%

Future Vision – Housing Dashboard

Total Housing Subsidy Dollars Per ZIP Code

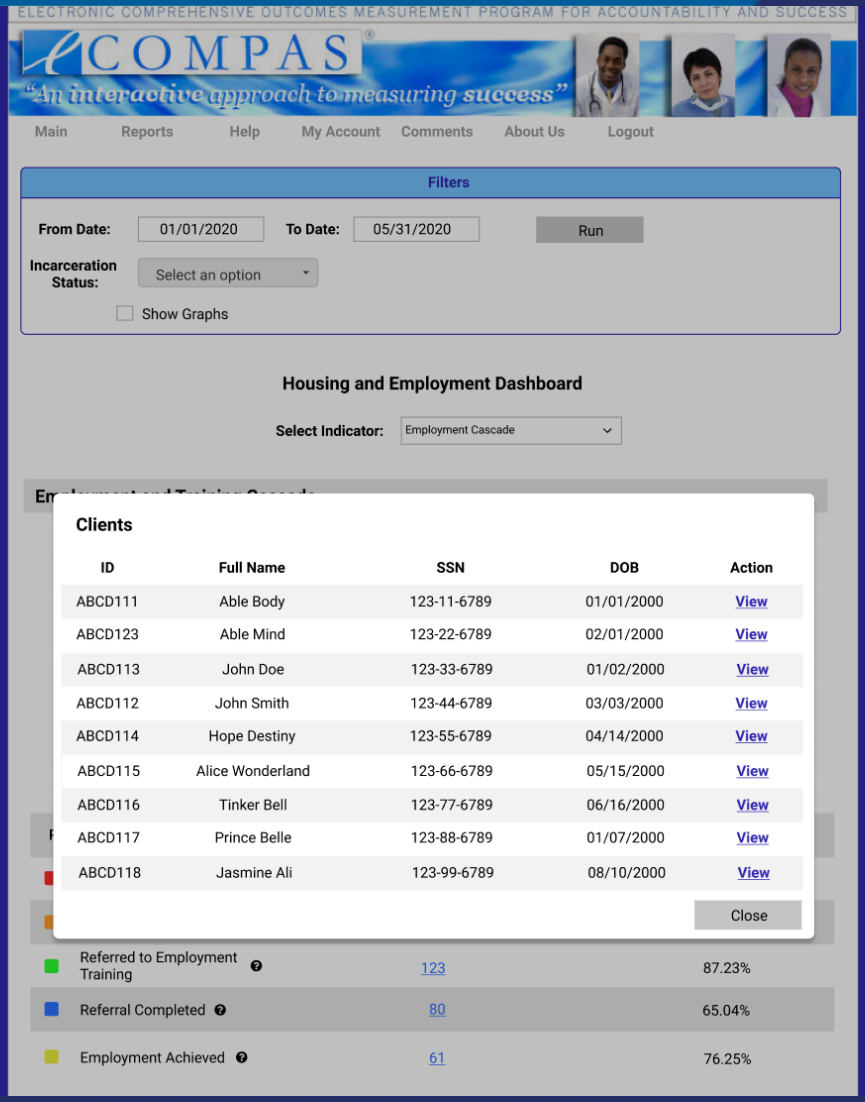


ZIP Code	Total Subsidy Dollars	Number of Clients	Dollars Per Capita
07505 (Paterson, NJ)	$271,390.60	284	$955.60
07501 (Paterson, NJ)	$260,435.40	277	$940.20
07504 (Paterson, NJ)	$259,538.80	302	$859.40
07514 (Paterson, NJ)	$195,626.34	234	$836.01
07513 (Paterson, NJ)	$174,611.78	206	$847.63
07522 (Paterson, NJ)	$162,307.60	196	$828.10

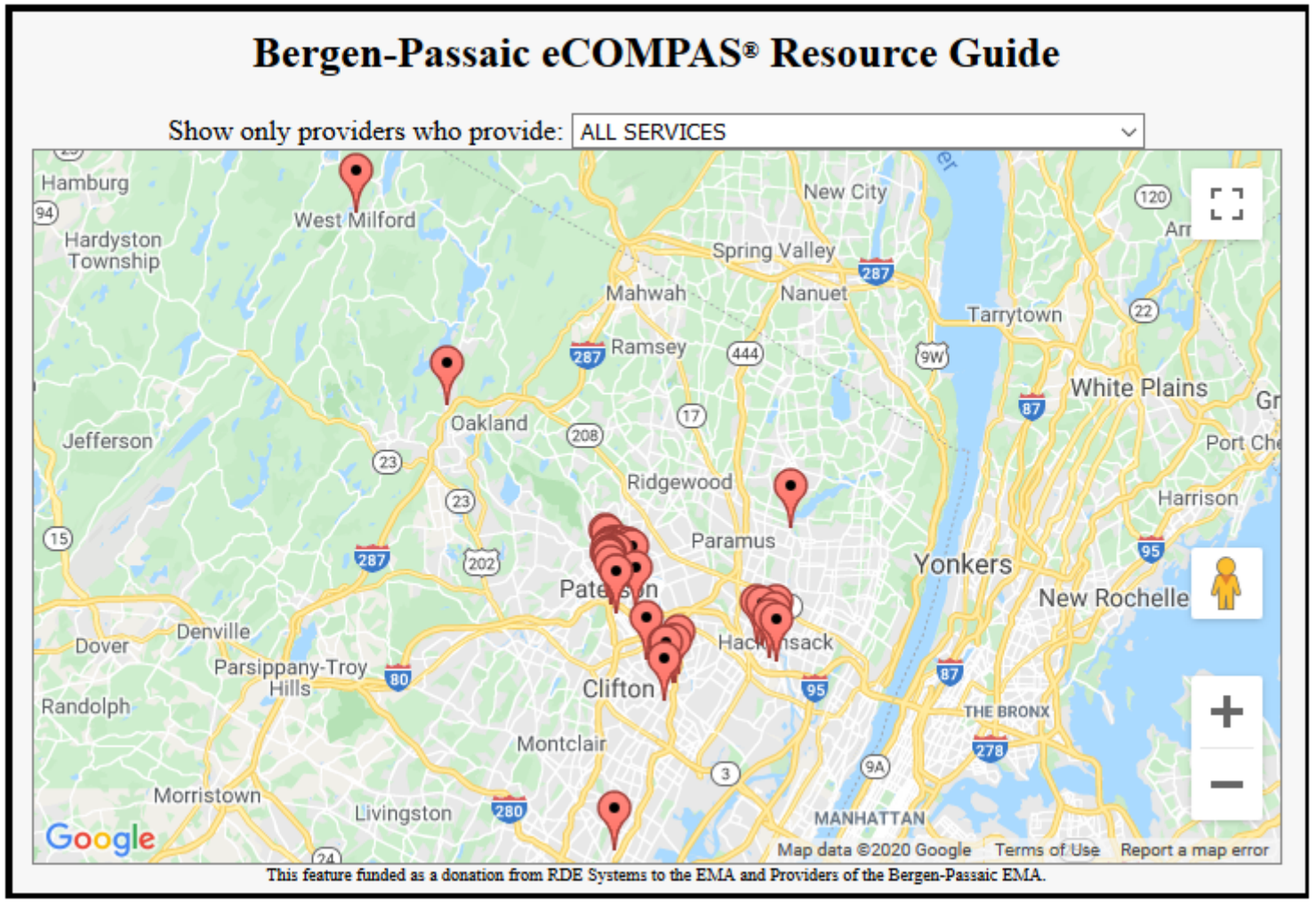
« 1 2 3 »

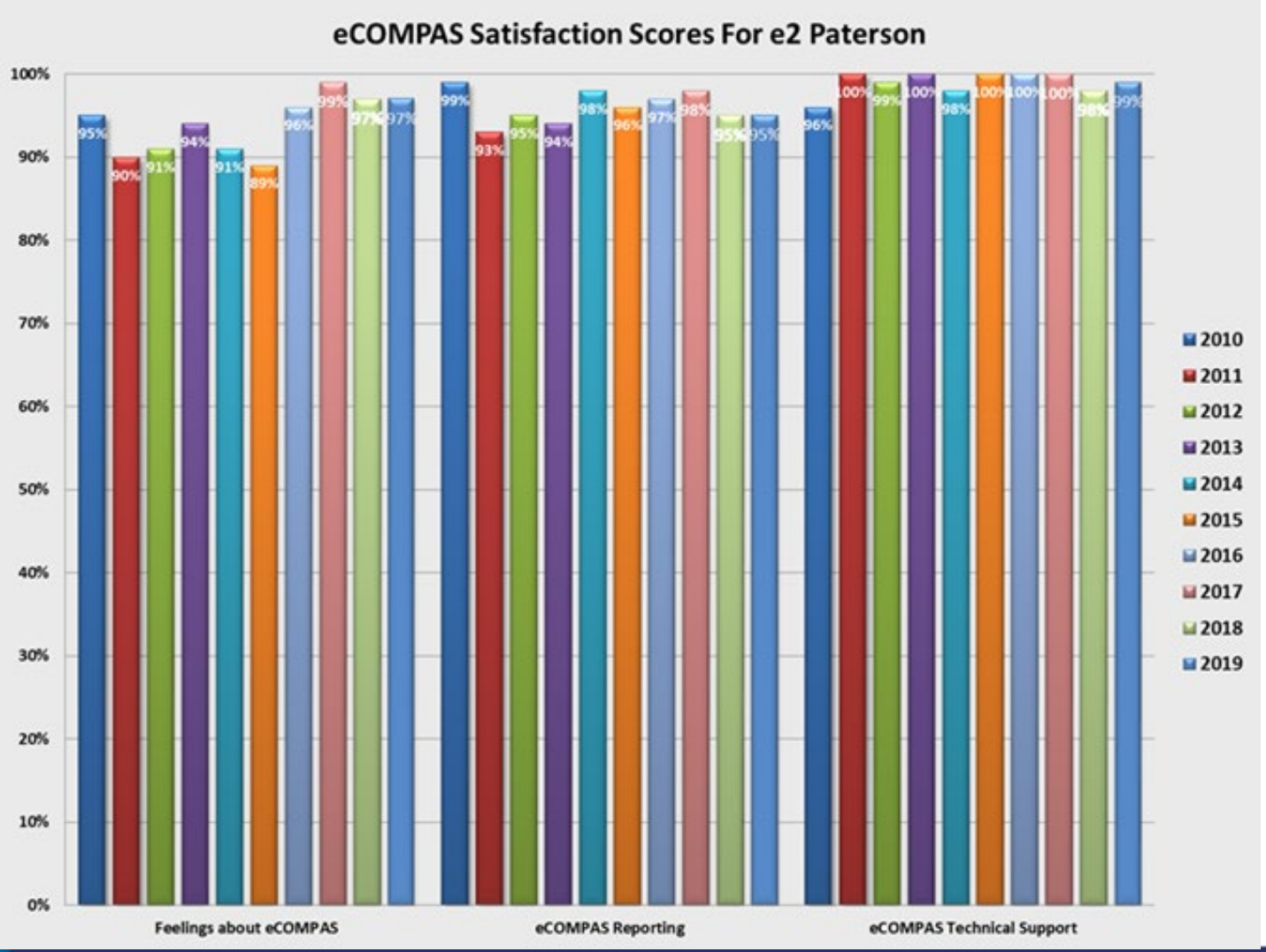
Future Vision – Employment Dashboard

Future Vision – Employment Dashboard



Online Resource Guide




eCOMPAS Satisfaction Scores For e2 Paterson
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
95% 90% 91% 94% 91% 89% 96% 99% 97% 97%
99% 93% 95% 94% 98% 96% 97% 98% 95% 95%
96% 100% 99% 100% 98% 100% 100% 100% 98% 99%
Feelings about eCOMPAS
eCOMPAS Reporting
eCOMPAS Technical Support
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019

Case Manager Experience

- **Experience with the housing and employment SPNS project**
  - **It was enlightening** finding services for clients
  - We provided job services
  - Barriers such as COVID-19 and client drug addiction was challenging
- **Success Stories**
  - One client was homeless and is now doing quite well
  - Got **over 12 people housed**
  - Had a plan for clients to be self-sufficient
  - Leveraging the City's HOPWA program was a strength and benefit
- **Working with the SPNS Team (Recipient, RDE, and Partners)**
  - It is a good experience
  - Team work - **we did the best we can**
  - This will be a sustainable program

Tisa Nicole Smith
Medical Case Manager
CAPCO Resource Inc.

CAPCO

Whatever-It-Takes Partnership

"I was **so proud** to be a part of this project and connecting people living with HIV/AIDS to employment. Assisting others in obtaining successful employment was a passion of mine before I started working at RDE Systems and I was so happy to be part of this group to **advance the project goals** and assist with weekly follow-ups."

Alyse Rokita
Executive Assistant

RDE Red

COMPAS

City of Paterson HOPWA

- HOPWA program is housed in City of Paterson and overseen by Director Mizquierdo
- Federal HOPWA dollars leveraged for SPNS Project and non-SPNS clients
- Ongoing

The Story of the Family of Six…

Benefits of SPNS carry over to Non-SPNS Clients!

- Referrals as valuable to the SPNS mission and local mission
- A result from SPNS-inspired partnership and technical capacity development
  - This is in-grant SPNS replication!
- More than 10 families saved from becoming homeless
- 10 received gainful employment and 8-9 families are still employed, even after COVID-19
- 5-6 were eligible, received, and reported back on the helpful education, skills development, and job training provided as a result of the initiative
- Interviews and increased understanding and connection between community and City of Paterson

Sustainability & Reducing Administrative Burden

- Manual data entry into REDCap research system and IRB requirements constrained the project.
- Entering in services & medical fields for hundreds of client every year.
- Approximately 270 hours a year spent on double data entry will be eliminated after research requirements are lifted which will strengthen sustainability.
- More seamless and automated methods allow for this project to continue with sustainability without the additional research requirements for paperwork to help reduce administrative burden.

Conclusions

- System Innovations – Cross-program integration, electronic referral expansion, visual dashboards with drill downs
- Partnership – Flexibility, Win-Win, Patience
- Impact – Consumers and those that serve them deserve the best
- Feasibility – You Can Do it!
- Sustainability – Through strategic systems capacity development and unwavering leadership, administrative burden can be reduced to sustain.

A heartfelt thanks…..

VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

What's Going on @SPNS

HRSA

AN UPDATE FROM THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH RESOURCES AND SERVICES ADMINISTRATION, HIV/AIDS BUREAU, SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE

OCTOBER 2012

Leveraging Health Information Technology to Improve Access to and Quality of HIV/AIDS Care

People living with HIV/AIDS (PLWHA) tend to be more mobile than the general population and may seek care from multiple providers. As a result, assessing the complete HIV disease and care history of PLWHA can be next to impossible, particularly because few clinics nationwide have the capacity to exchange patient records securely online.

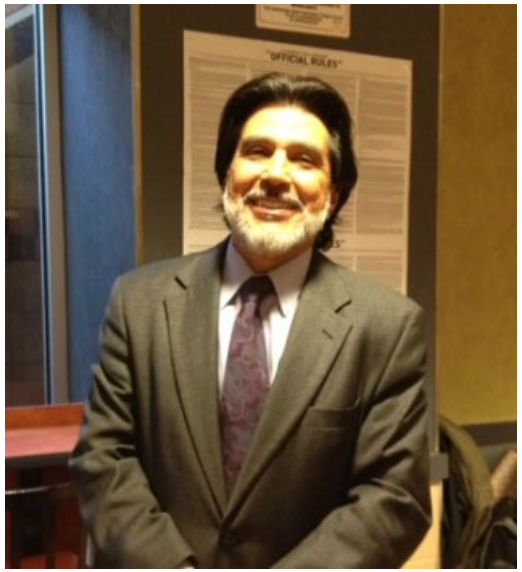
The consequences of incomplete records can be significant. Doctors may find themselves treating clients who have long histories of HIV treatment as being new to care and thus request redundant lab tests and medications. PLWHA—particularly those dealing with common HIV coinfections and comorbidities, such as sexually transmitted diseases, hepatitis, tuberculosis, substance use disorders, and mental health issues[1-5]—may be wary of telling their doctor that they have been in care at another clinic or have previously fallen out of care. Others may believe that their new doctor has access to their records.

Electronic Medical Records, Health Information Exchanges, and SPNS

To enable clinicians to better serve PLWHA who frequent different providers, the Ryan White HIV/AIDS Program, administered by the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB), has supported the development and implementation of health information technology (HIT) innovations, most notably through HAB's Special Projects of National Significance (SPNS) Program.

From 2007 to 2011, the SPNS Information Technology Networks of Care Initiative (Networks of Care Initiative) promoted the enhancement and evaluation of existing health information electronic network systems to serve PLWHA in underserved communities. Six demonstration sites (see box, p. 2) were funded for 4 years to demonstrate the benefits of updating electronic medical record (EMR) databases to securely share patient information online with other providers and ancillary points of service, such as mental health clinics and pharmacies. Known as health information exchange (HIE), this technology enables secure transmission of information across disparate database systems, enabling users to update patient records in real time. As Wayne Steward, who served as co-principal investigator with Janet Myers of the Networks of Care Initiative's Evaluation and Support Center, explains, each site used different customizations to achieve the same result: "The Initiative helped bolster the operations of existing systems so that providers could communicate electronically across locations, hence the idea of health information

Especially,
Adan Cajina
Chief, Demonstration and Evaluation Branch



Thank you from all of us on the Paterson SPNS Team…

How can we accomplish ambitious goals?

How can we accomplish ambitious goals?

One bite at a time.

Thank you for your time!

VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

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Career Center of Puerto Rico, Inc.
Ayudando a Forjar Caminos

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Jesse@rdesystems.com

RDE Red

Free and innovative resources to end the epidemic

www.RDE.org/Red