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The Whoosh: Innovative Data Exchange, Saving Time, Improving HIV Care Coordination

Case Study: NYC Jails

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with thanks to RDE/ecompas: Jesse Thomas, Anusha Dayananda, Jean-Felix Lanoue & Alyse Rokita

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Publication Acknowledgement / Disclaimer

These projects are/were supported by the Health Resources and Services Administration (HRSA)) of the U.S. Department of Health and Human Services (HHS):

- Enhancing Linkages to HIV Primary Care and Services in Jail Settings, 2007-2012
- Culturally Appropriate Interventions of Outreach, Access and Retention among Latino(a) Populations, 2013-2018
- System-level Workforce Capacity Building for Integrating HIV Primary Care in Community Health Care Settings, 2014-2018

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Case Study #1: NYC Jails

- Goals: Effective collaboration, communication and system coordination
- Solution: Build data exchange program to led to process efficiencies and quality improvements for federal reporting and patient care coordination
- Results: Transfer of over 66 million data elements imported from electronic health record to the Transitional Care Management System, over the last three years saving time and improving service coordination.
- Partner Access: To simplify coordination and tracking efforts.
- Dissemination and Replication: Activities in Puerto Rico
- Outcomes and Lessons Learned

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SPNS, NYC Correctional Health Services & Puerto Rico

Jail Linkages: NYC site found Latino/as less likely to remain engaged in care 6m after incarceration.

Latino Initiative: NYC CHS found most Latinos/as in local jails are of PR origin; need culturally appropriate resources after incarceration.

Workforce Capacity: NYC CHS Latino Initiative partner, One Stop Career Center of PR, to build collaboration & coordination with corrections and engage key stakeholders; NYC CHS/Reentry & Continuity Services develops workforce capacity in PR by training employment services staff in Transitional Care Coordination (TCC) intervention.

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Community Partners

SPNS Project	CHS Data Sharing Partners
Jail Linkages	Exponents Fortune Society Palladia, Inc. Women's Prison Association
Latino Populations	Fortune Society
Workforce Capacity	Fortune Society One Stop Career Center – PR

The Fortune Society remains a Ryan White Part A community partner offering a 'one-stop' model of coordinated care where non-medical case management, housing assistance, substance use and mental health treatment, and employment and social services are provided after incarceration – with online access to TCMS

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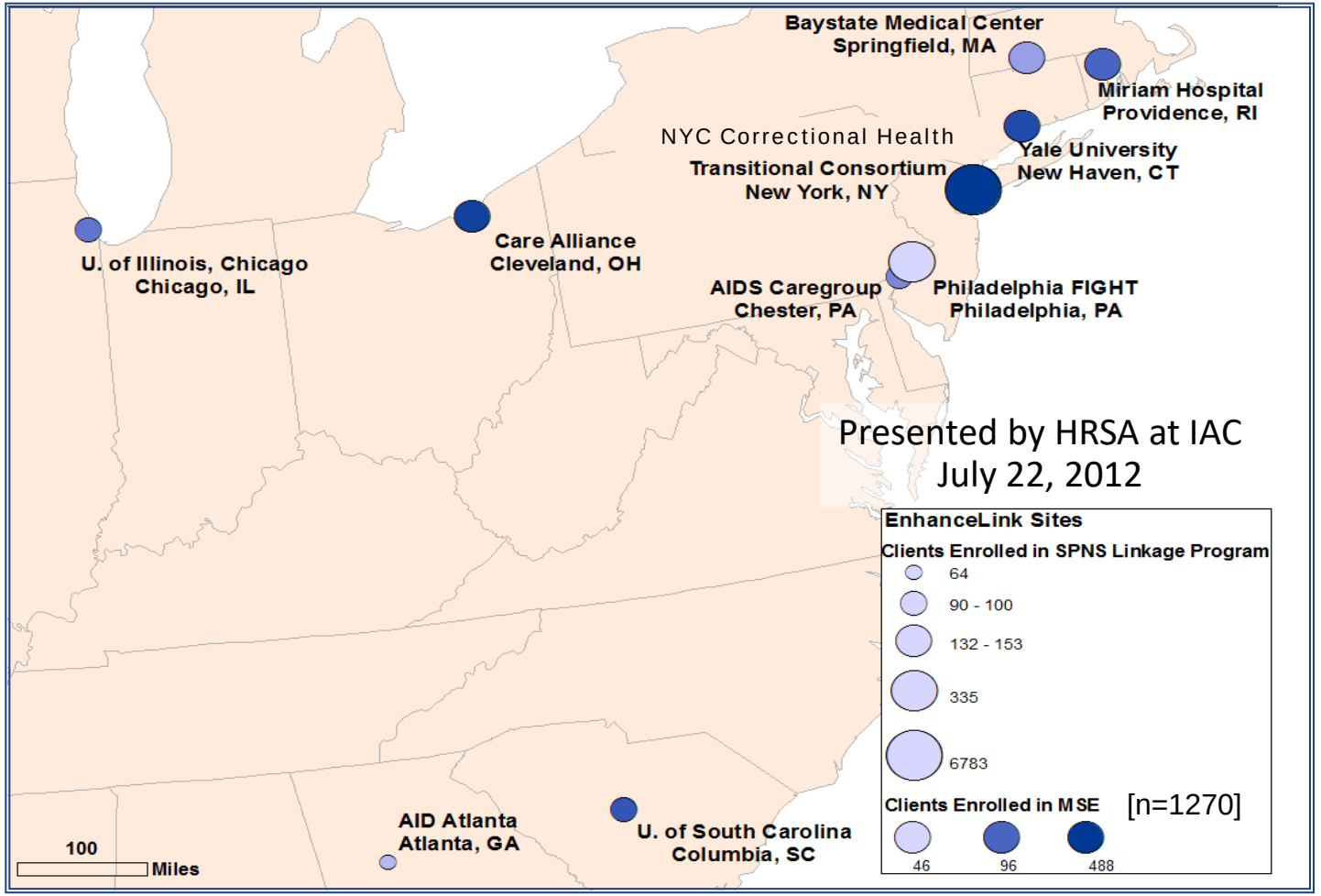
SPNS Jail Linkages

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.



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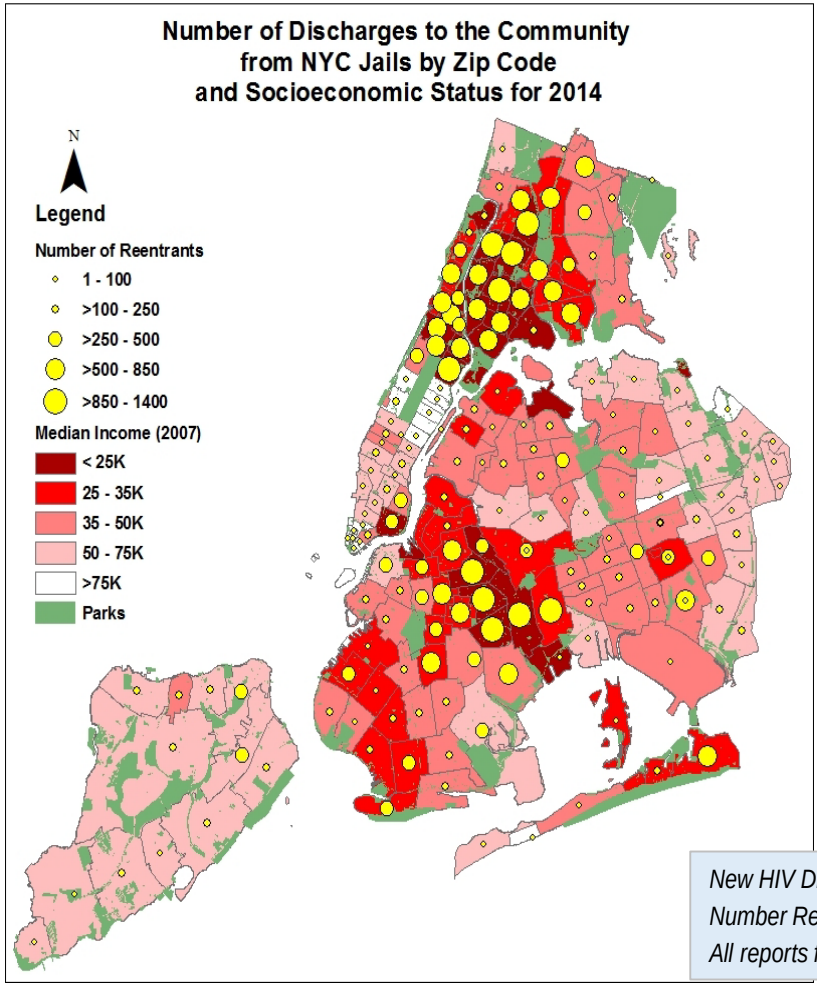
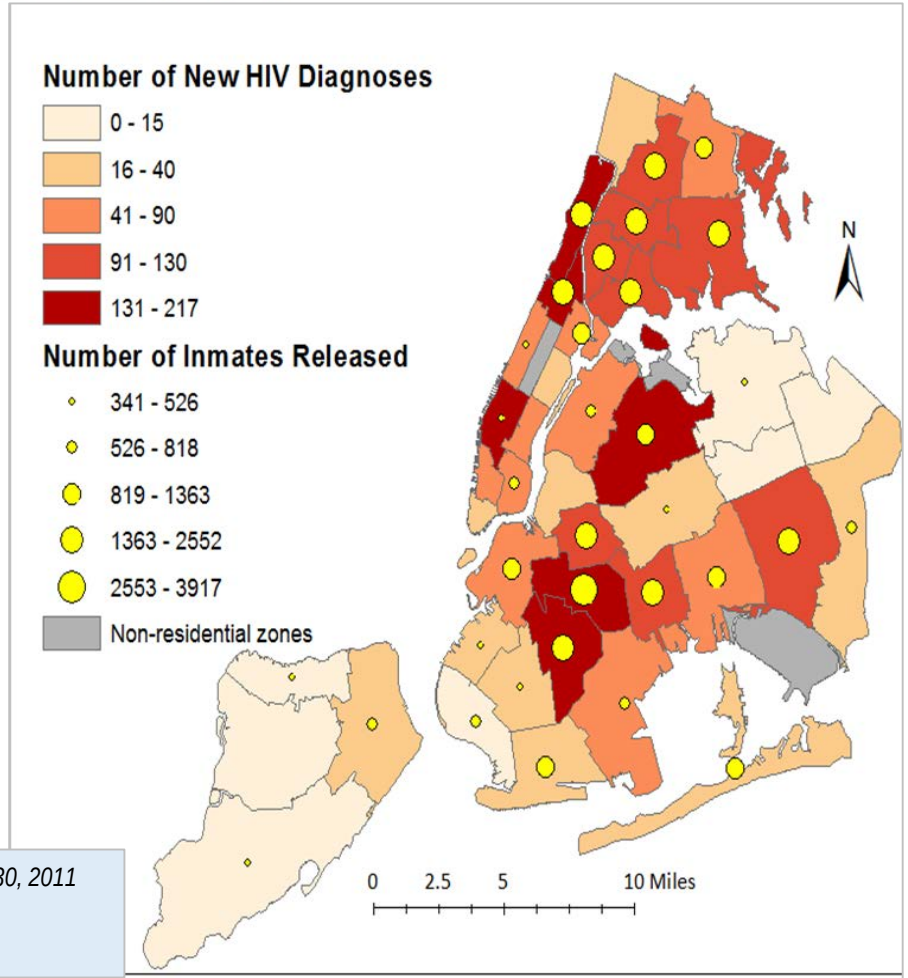
Incarceration & HIV in NYC





New HIV Diagnoses as reported to NYC DOHMH HIV/AIDS Registry (HARS) by June 30, 2011
Number Released to Community reported by NYC DOC.
All reports for CFY2010 (July 1, 2009 to June 30, 2010).

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NYC Intervention: Transitional Care Coordination

Purpose: To design, implement, and evaluate innovative methods for linking persons living with HIV (PLWH) in jail settings, to community-based HIV primary care and services

Highlights:

- NYC CHS: 1/10 sites; ~40% of total enrolled
- Evaluate and disseminate NYC Transitional Care Coordination model
- Added court liaison role

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Transitional Care Services

Identify population – use electronic health records

Engage client – access to housing areas

Conduct assessment – universal tool

Screen for Benefits – DSS is a partner

Arrange discharge medications – 7 days + Rx

Coordinate post-release plan – Primary care, social service orgs, Courts, attorneys, treatment providers

Facilitate continuity of care

- Aftercare letters / transfer medical information using HIE
- Make appointments / walk-in arrangements
- Arrange transportation / accompaniment

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Access to Care

non-medical case management strategies to facilitate access to care

- Case conferencing
- Medical Summary / Medications
- Accompaniment / Transport
- Community Case Manager
- Directly Observed Connections
- Patient Navigation / Care Coordination

https://targethiv.org/ihip/tools-tips-providing-transitional-care-coordination

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SPNS Jail Linkages Outcomes*

Indicator	NYC CHS [N=555]		All Sites [N=1270]	
Clinical Care				
CD 4 (mean)	↑	(372 to 419)	↑	(416 to 439)
vL (mean)	↓	(52,313 to 14,044)	↓	(39,642 to 15,607)
Undetectable vL	↑	(11% to 22%)	↑	(9.9% to 21.1%)
Engagement in Care				
# Taking ART	↑	(62% to 98%)	↑	(57% to 89%)
ART Adherence	↑	(86% to 95%)	↑	(68% to 90%)
Avg # ED visits p/p	↓	(.60 to .2)	↓	(1.1 to .59)
Basic Needs				
Homeless	↓	(23% to 4.5%)	↓	(36.2% to 19.2%)
Hungry	↓	(20.5% to 1.75%)	↓	(37.4% to 14.1%)

79% linkage to care rate after incarceration

*from 6 months prior to index incarceration to 6 months after baseline incarceration

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Jail Linkages: Access to Community Services

- 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 by field services team; 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 use and mental health treatment, and employment and social services.

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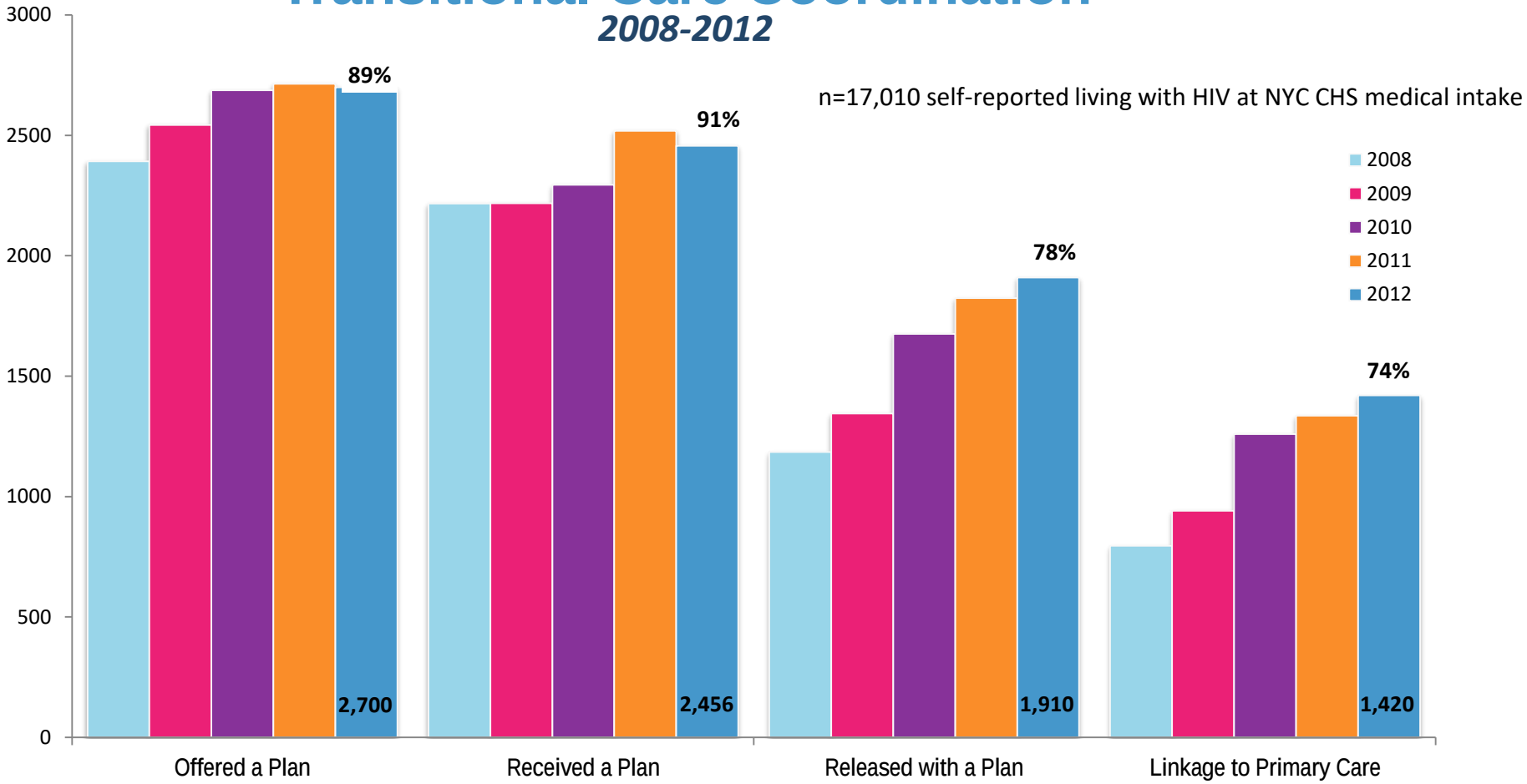
Transitional Care Coordination

2008-2012



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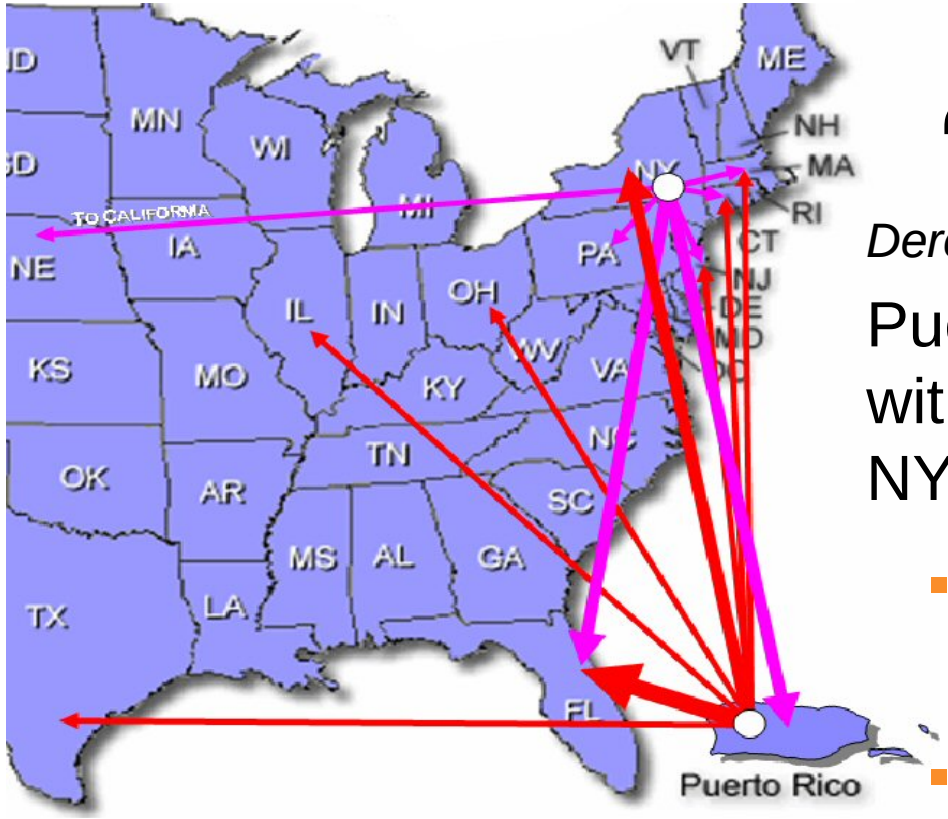
SPNS LATINO ACCESS INITIATIVE

SPNS Latino Access Initiative

Purpose: to design, implement, and evaluate innovative methods to identify Latinos/as who are at high risk or living with HIV and improve their access, timely entry, and retention in quality HIV primary care.

- 10 Sites
  - 4 = Puerto Rican ancestry/origin
  - 6 = Mexican ancestry/origin
- Evaluation and Technical Assistance Center: University of California at San Francisco



"Air Bridge"

Deren et al. 2007 found:

Puerto Ricans living with HIV seek care in NYC

- 62% of NYC-based Puerto Ricans had lived in PR
- 42% of PR-based had lived in NYC

Transnationalism[5]

Processes by which immigrants forge and sustain *multi-stranded relations* that link their societies of origin and settlement. Transnationalism impacts *migrants' cultural reference points* and sources of emotional and practical support, discrimination, social stigma, beliefs about health, access to health care and health care practices.

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Intersection of HIV/AIDS & Incarceration in Puerto Rico

Puerto Rico (PR) has the 5th highest rate of new HIV diagnoses in the U.S.

PR has the 3rd highest rate of people living with HIV

PR has a high prison population rate (303 per 100,000):

- 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

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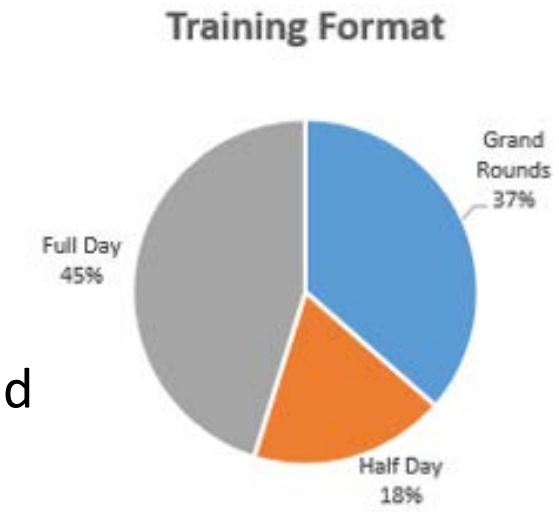
SPNS LATINO ACCESS INITIATIVE

NYC CHS Demonstration Project

Objective: Develop culturally competent providers and resources

1) Cultural competency training for NYC CHS and community providers at all levels

- 3 Formats
  - Grand rounds for physicians, nurse practitioners
  - Half day for nurses, social workers
  - Full day for care coordinators, patient navigators
- Trainings delivered to:
  - Over 60 community partner agencies
  - Over 450 participants: 47% jail-based; 53% community-based
- Sustained through online webinar series with CDC CEUs



2) Match clients/patients to care coordinators of PR origin

- Linkage agreements with providers in NYC and PR

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Provider Training

SPNS LATINO ACCESS INITIATIVE

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 are available (CME, CNE, CHEC and CEU)
http://www.bxconsortium.org/cewebinarseries.html

Webinar 1:

Curriculum Purpose, Overview, and Target Audience

Module I: Increasing Health Care Utilization among Latino/a HIV Patients

- Key Concepts:
  - Cultural Competence
  - Transnationalism
  - The Socioecological Model
  - Understanding Latino/a Culture
- The Cultural Formulation Framework
- Transnationalism in HIV Care
- The DECIDE Model
- Shared Decision Making

Webinar 2:

Key Concepts: The U.S. Latino/a Population

Module II: Overview of HIV/AIDS among Latino/as

- The National HIV/AIDS Strategy
- HIV Epidemic in the United States
- The HIV Care Continuum

Module III: HIV/AIDS and Incarceration among Latino/as: Interconnected Epidemics

- HIV/AIDS and Incarceration
- Case Study: Hector

www.bxconsortium.org/CEWebinarSeries

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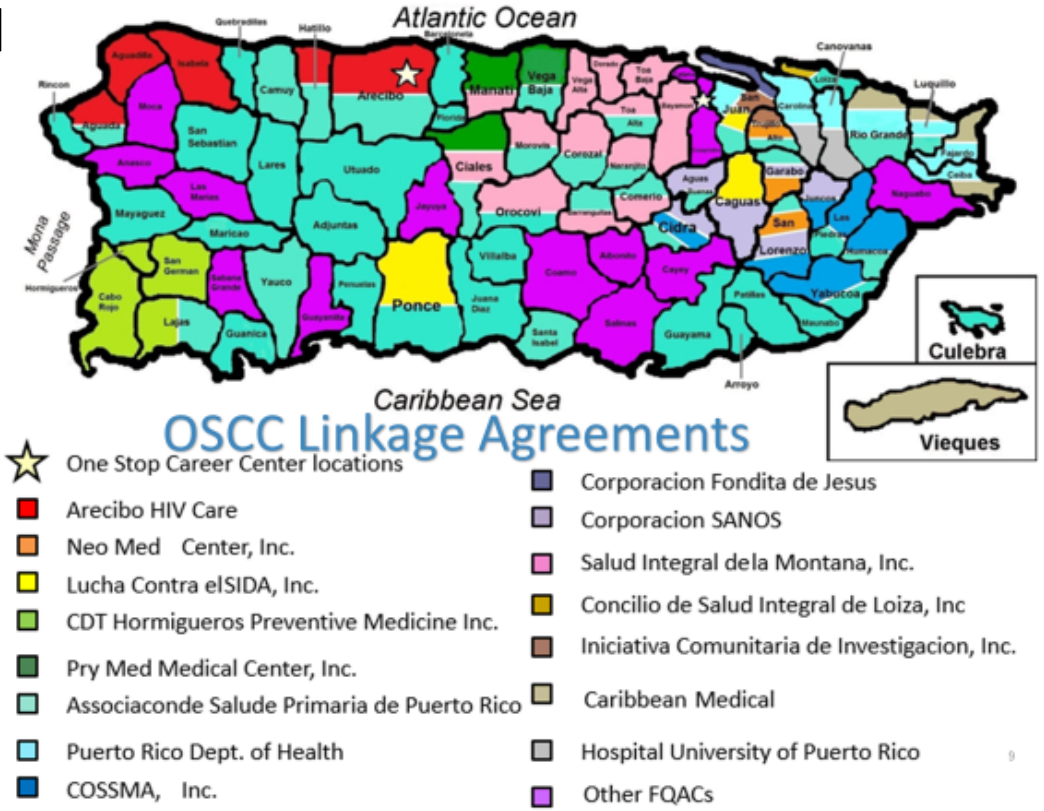
SPNS LATINO ACCESS INITIATIVE

Latino Access: Collaboration Outcomes

- Over 60 MOUs with services 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



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SPNS Workforce Capacity Building Initiative

Purpose: To design, implement, and evaluate system-level strategies to increase organizations' workforce capacities and achieve efficient and sustainable service delivery practices that both optimize human resources and improve quality outcomes.

- CHS builds capacity of PR housing & employment services agency to transform service delivery to people living with HIV after incarceration:
  - Client-Level: Provide transitional care coordination services to people returning to community from prison/jail
  - Organization-level: transform employment/housing services CBO to deliver transitional care
  - System-level: transform broader system to meet needs of people returning to community after incarceration

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Community Partner

One Stop Career Center of Puerto Rico (OSCC)

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

www.onestopcareerpr.org

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

Workforce Capacity Expansion

- HIV education in jails / prisons
- Transitional care coordination facilitates linkage to care
- Transportation to access care after incarceration

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Results: Transitional Care Coordination in PR

- 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 interviews
  - All receiving 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 services: 22

- 19 transitional
- 5 permanent

Job readiness: 15

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

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NYC CHS Workforce Collaborators

- NYC Correctional Health Services
  - Transitional Care Coordination model
  - Critical Skills for Collaboration
  - ACASI survey administration
- One Stop Career Center of Puerto Rico
  - Intervention Implementation
  - Leads Transitional Consortium
- Puerto Rico Department of Health
  - HIV/AIDS 101/ HIV Prevention
  - Basic Principles of Rapid HIV Testing
  - Sexually Transmitted Infections 101
  - Crisis Intervention
  - HIV/AIDS Stigma
- Florida/Caribbean AIDS Education and Training Center
  - HIV and Incarceration
- Programa Sigue Adelante –
  - You are the tool to achieve equity
- Collaborative Institutional Training Initiative (CITI)
  - Human subjects research
- University of Puerto Rico (local evaluator / co-PI)
  - Training / oversight for local program evaluation
  - Data review / quality assurance
  - Publication / dissemination

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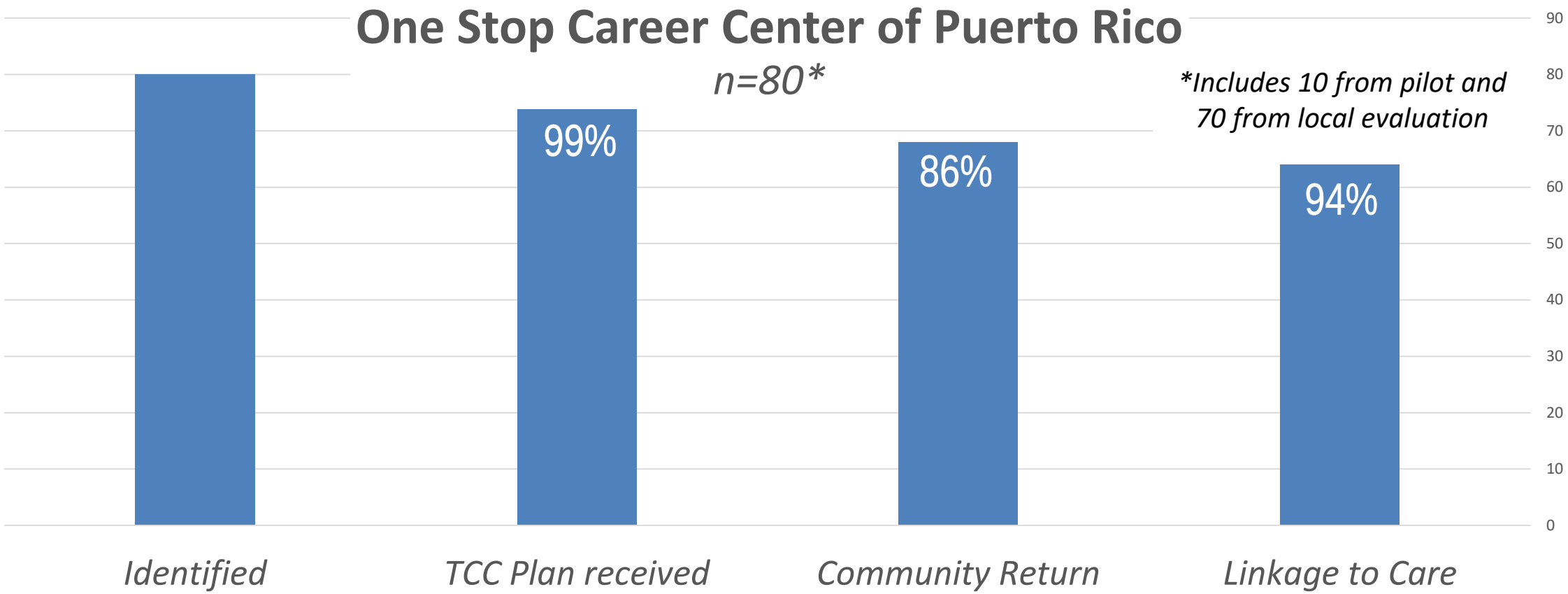
Transitional Care Coordination Cascade



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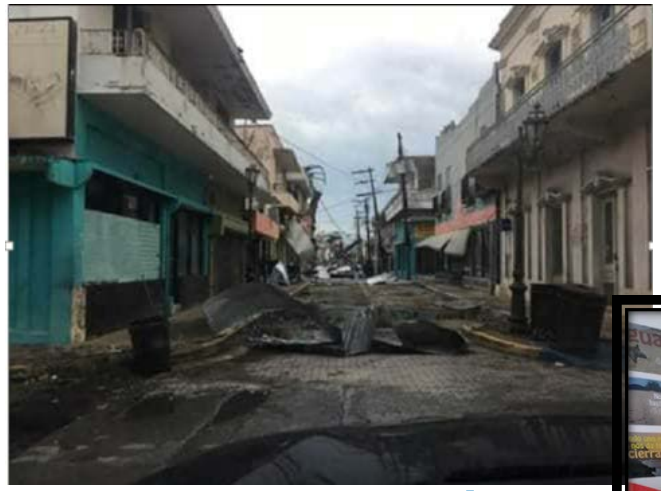
Implementation Challenges

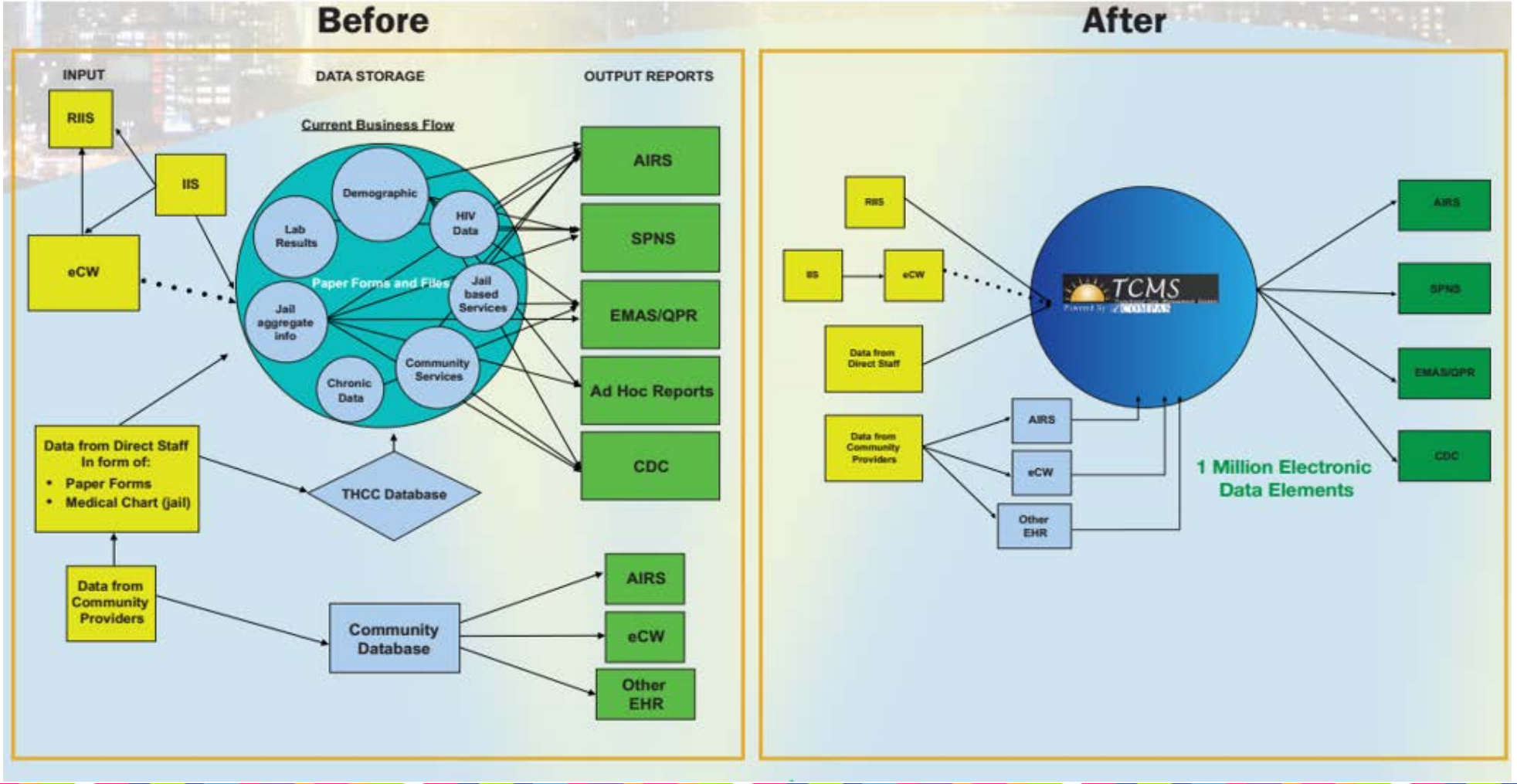
- Identifying right fit programs: personal relationships v. formal expertise
- Proposal evaluation methodology favors existing programs
- Formal authority/documents from predecessors are insufficient to gain buy-in
- Culture of corrections varies by location/jurisdiction
- Opening/closing of programs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



Manati

OSCC Executive Director and staff secure & distribute food and essentials

SPNS Jail Linkages: Making the Case



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SPNS Jail Linkages: Making the Case

Challenges	Solutions
✗ Time spent on entering data into multiple excel sheets hence less effective and lower efficiency	✓ No more paper/excel sheets thus improved effectiveness and efficiency
✗ Time spent on cleaning up errors in multiple excel sheets	✓ Work smarter and not harder
✗ Double data entry	✓ Projected to redirect 10-15% from admin to direct service delivery
✗ Communication back and forth on data clean up	✓ Partners can access information with consent on file
✗ No ability to monitor real time activities	✓ No more double data entry, direct data integration from EMR
	✓ Instant access to management reports
	✓ Accountability of community partners

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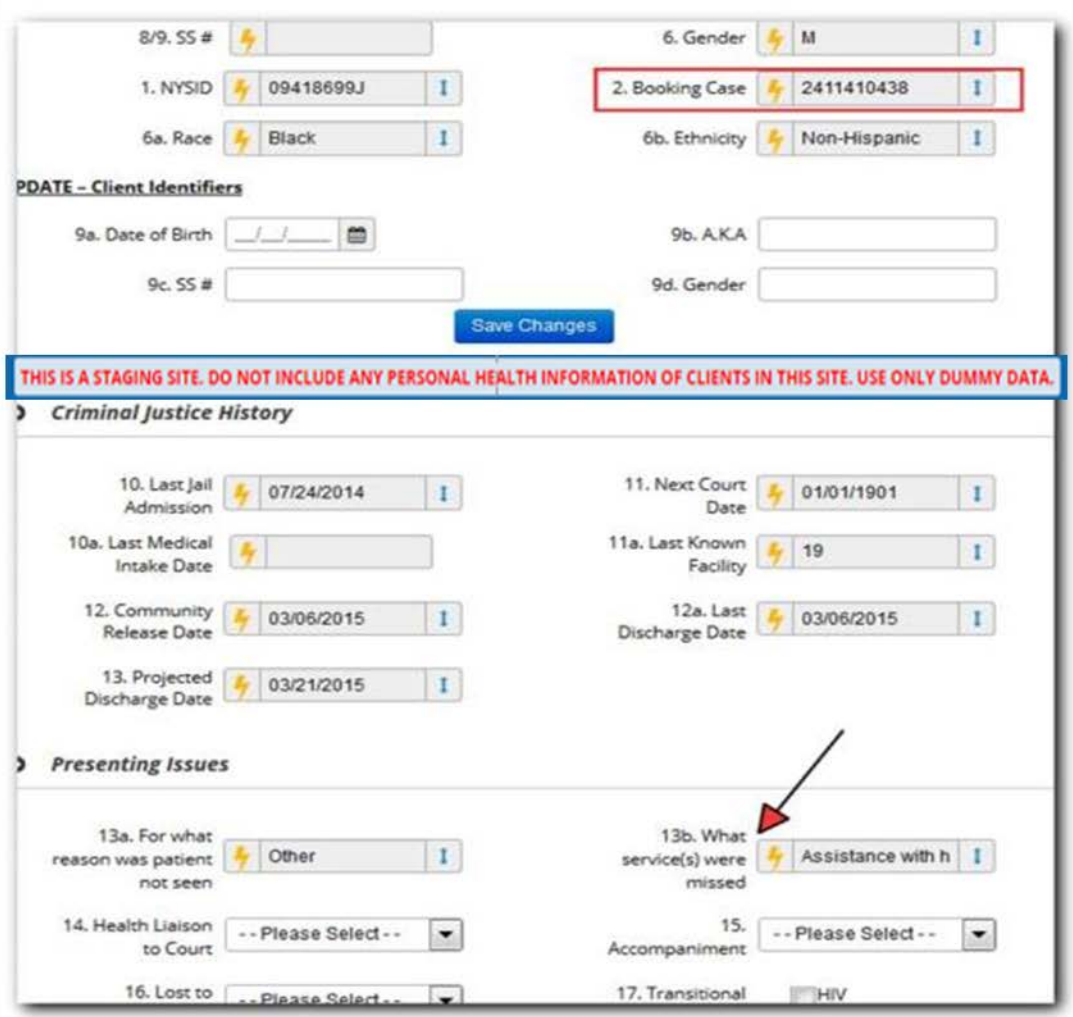
The Whoosh! … eHR to eCOMPAS data flow

Every lightning bolt represents a data element that is "Whooshed" from NYC CHS electronic health record (EHR) into TCMS



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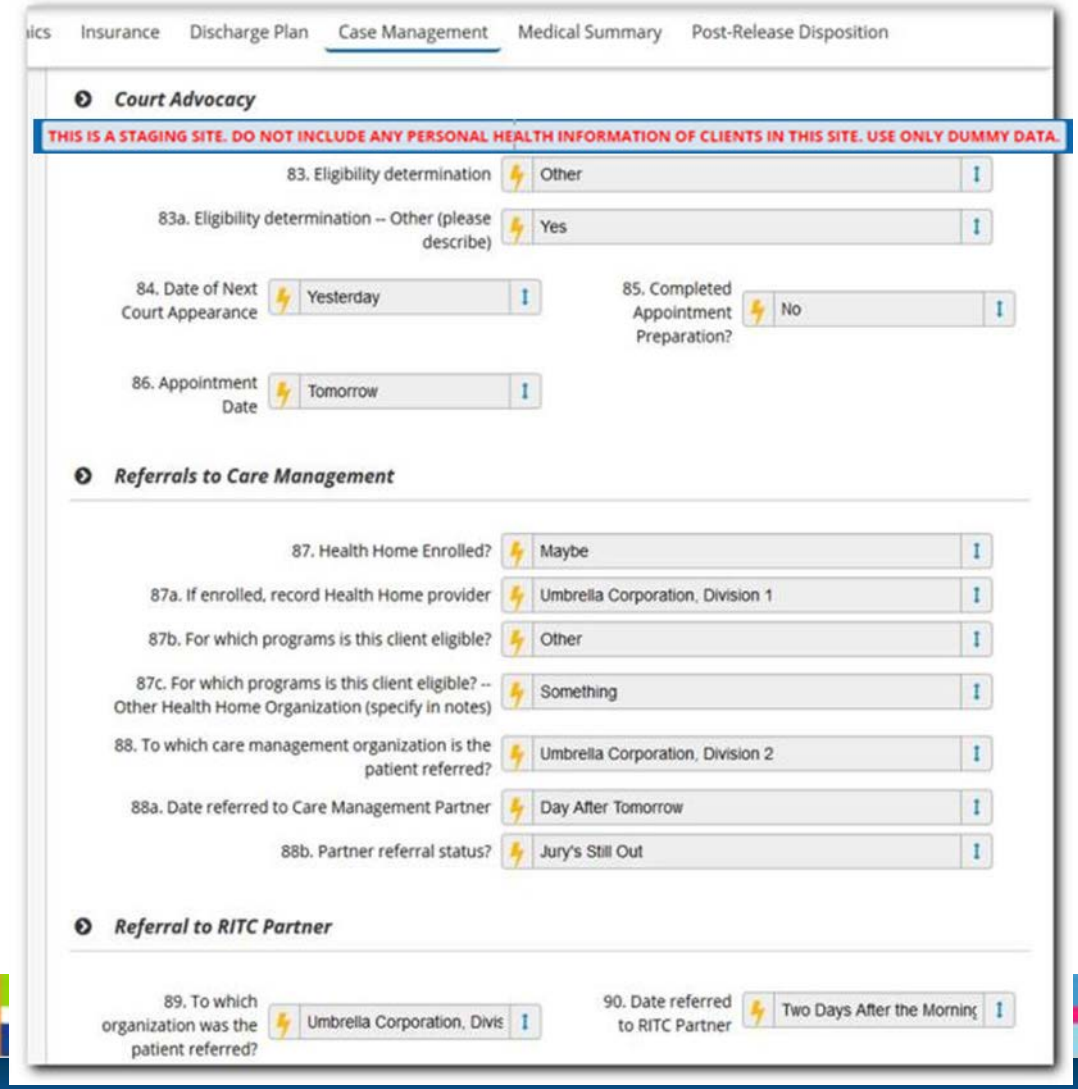
The Whoosh! … Transitional Care Management System

TCMS collects data and, through an interface, imports meaningful data points for the end user.



TCMS facilitates coordinated care management with multiple service providers and facilitates cross-system collaboration.

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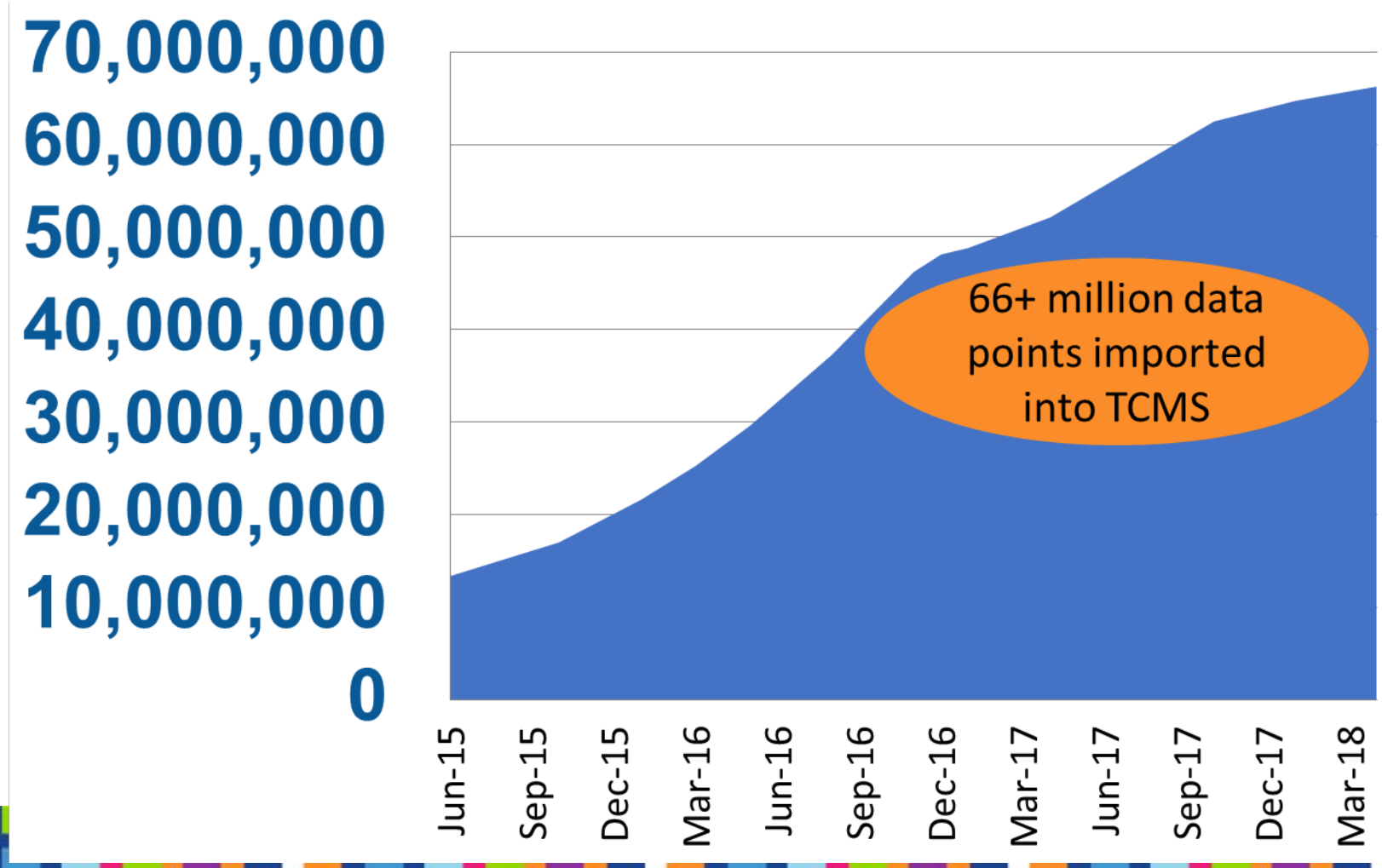
Process Outcome: TCMS Data Feeds (the Whoosh!)



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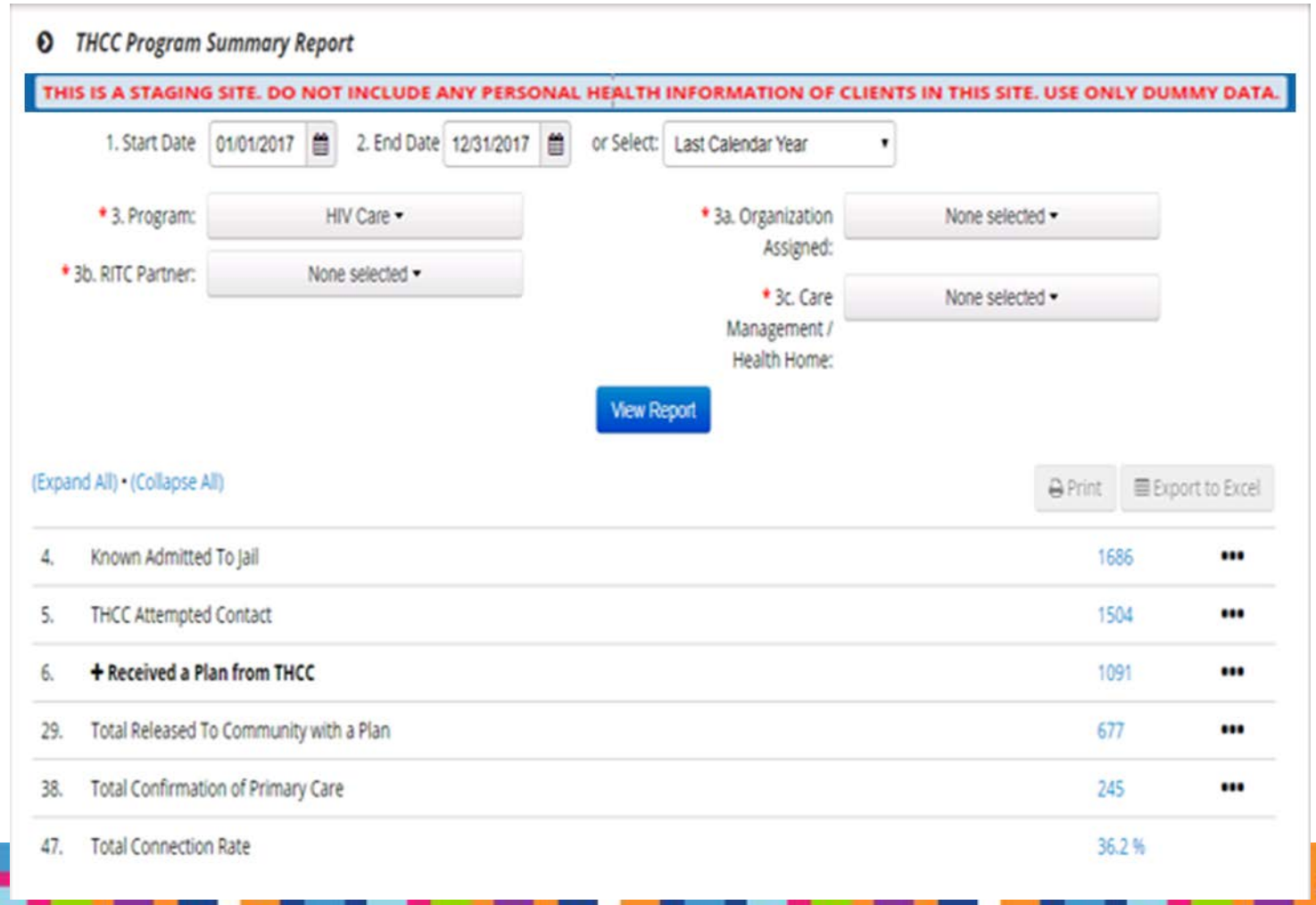
Results: Program Management Summary Report



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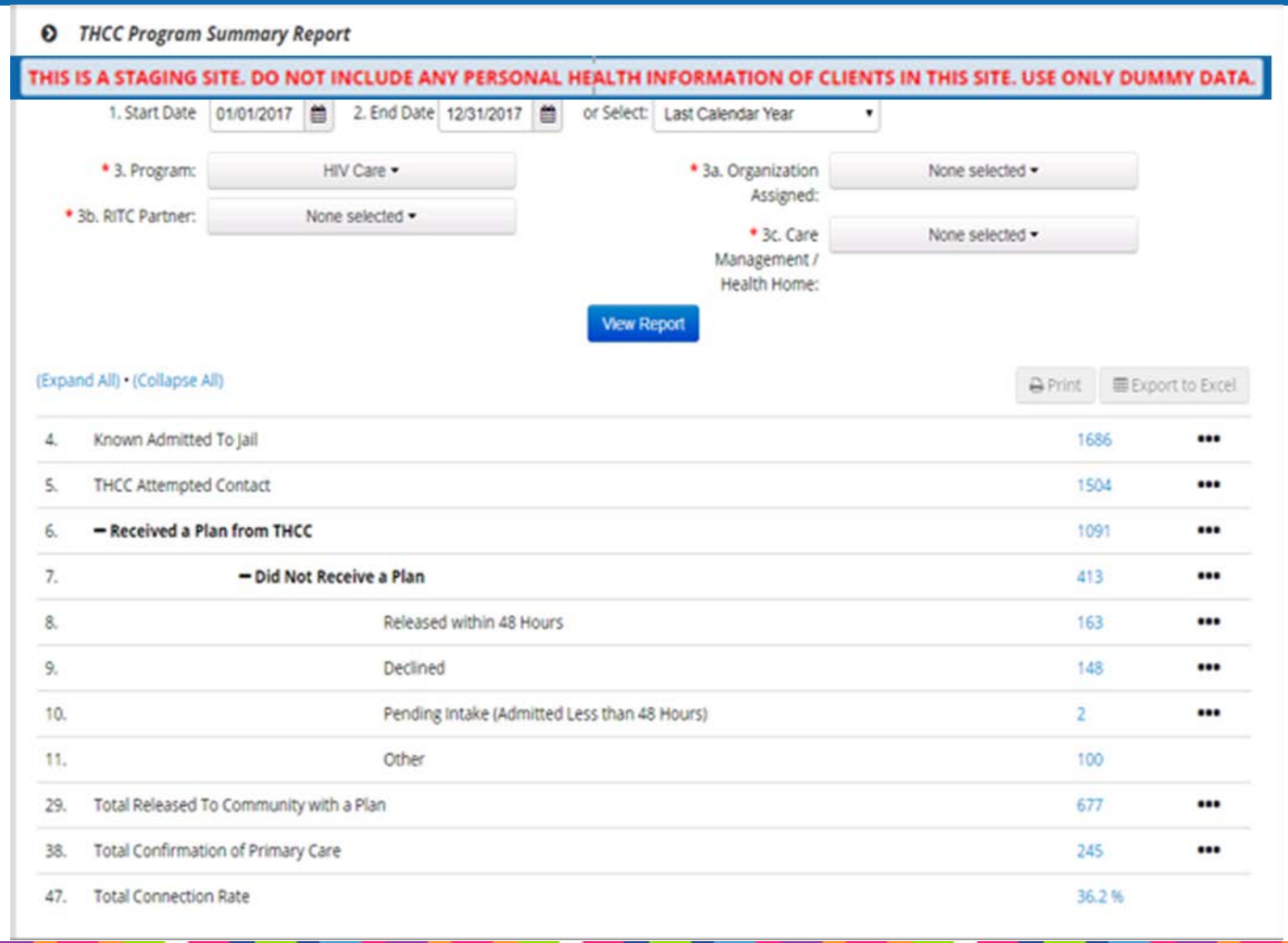
Quality Improvement: Collapse-expand feature



THCC Program Summary Report

THIS IS A STAGING SITE. DO NOT INCLUDE ANY PERSONAL HEALTH INFORMATION OF CLIENTS IN THIS SITE. USE ONLY DUMMY DATA.

1. Start Date 01/01/2017 2. End Date 12/31/2017 or Select: Last Calendar Year

* 3. Program: HIV Care

* 3a. Organization Assigned: None selected

* 3b. RITC Partner: None selected

* 3c. Care Management / Health Home: None selected

View Report

(Expand All) • (Collapse All) Print Export to Excel

4.	Known Admitted To Jail	1686	•••
5.	THCC Attempted Contact	1504	•••
6.	**– Received a Plan from THCC**	1091	•••
7.	**– Did Not Receive a Plan**	413	•••
8.	Released within 48 Hours	163	•••
9.	Declined	148	•••
10.	Pending Intake (Admitted Less than 48 Hours)	2	•••
11.	Other	100	
29.	Total Released To Community with a Plan	677	•••
38.	Total Confirmation of Primary Care	245	•••
47.	Total Connection Rate	36.2 %	

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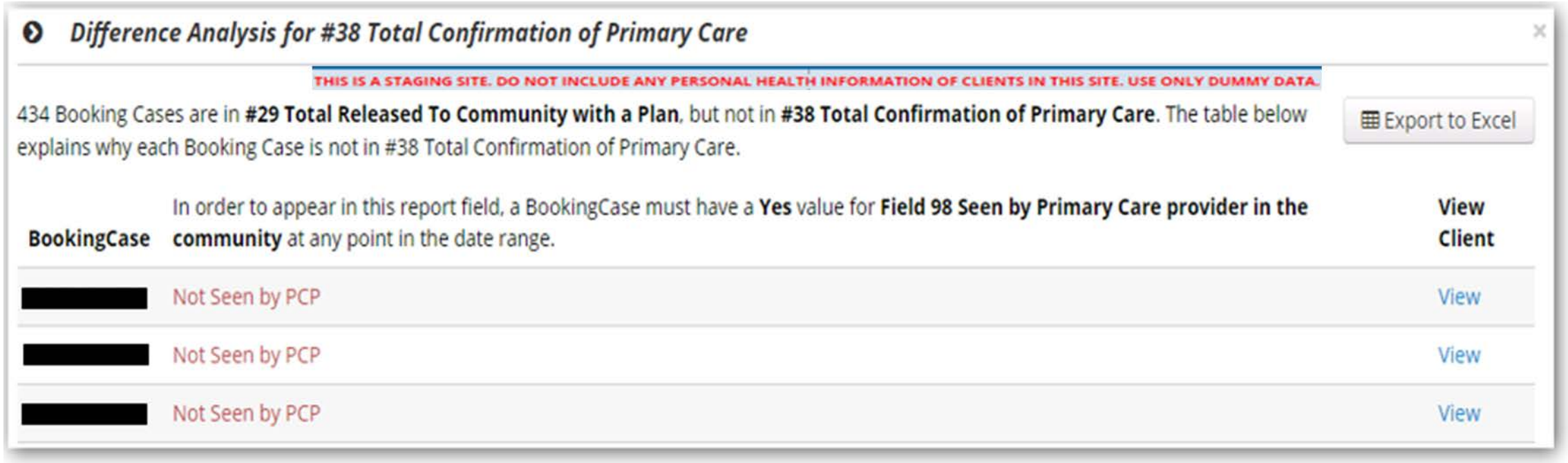
Actionable Data: Exceptions Report

TCMS Exceptions Report helps NYC CHS easily find list of clients NOT in the indicator. Reasons are listed so next steps can be taken to document community access to care:



Difference Analysis for #38 Total Confirmation of Primary Care

THIS IS A STAGING SITE. DO NOT INCLUDE ANY PERSONAL HEALTH INFORMATION OF CLIENTS IN THIS SITE. USE ONLY DUMMY DATA.

434 Booking Cases are in **#29 Total Released To Community with a Plan**, but not in **#38 Total Confirmation of Primary Care**. The table below explains why each Booking Case is not in #38 Total Confirmation of Primary Care.

Export to Excel

BookingCase	In order to appear in this report field, a BookingCase must have a **Yes** value for **Field 98 Seen by Primary Care provider in the community** at any point in the date range.	View Client
[redacted]	Not Seen by PCP	View
[redacted]	Not Seen by PCP	View
[redacted]	Not Seen by PCP	View

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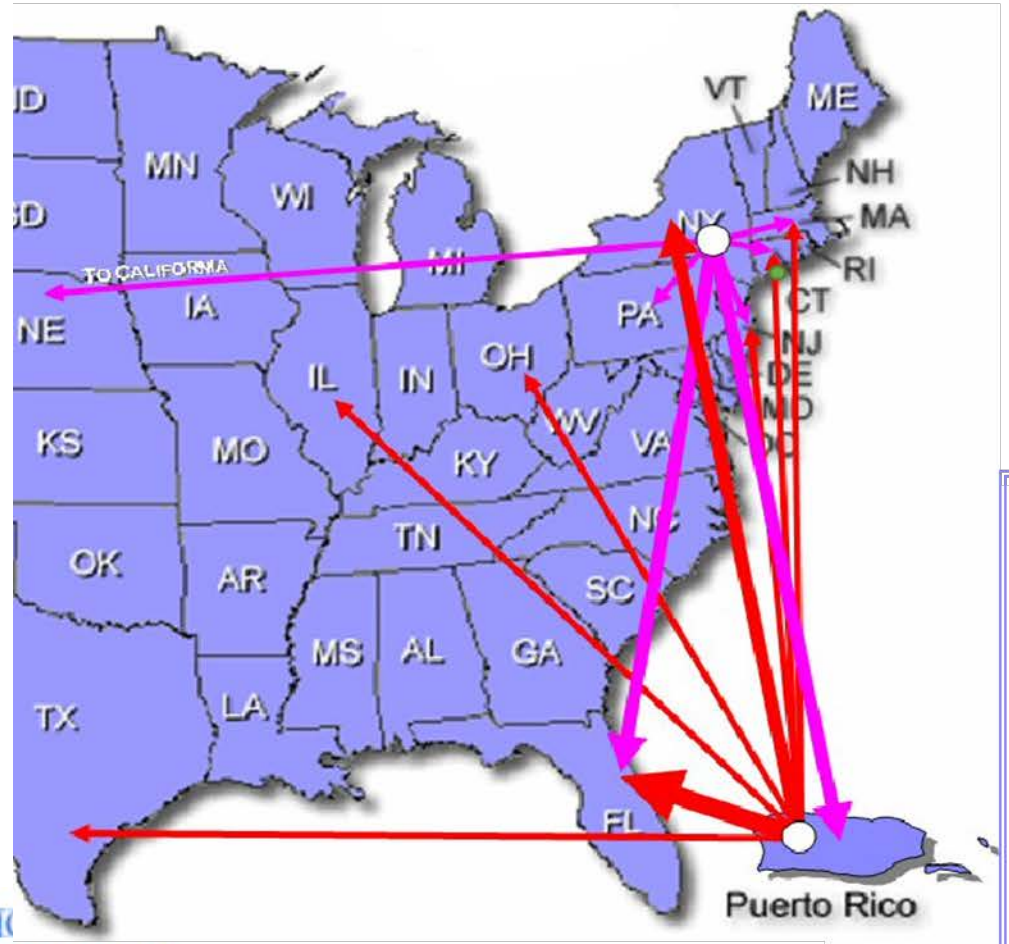
SPNS Latino & Workforce: Air Bridge Challenge



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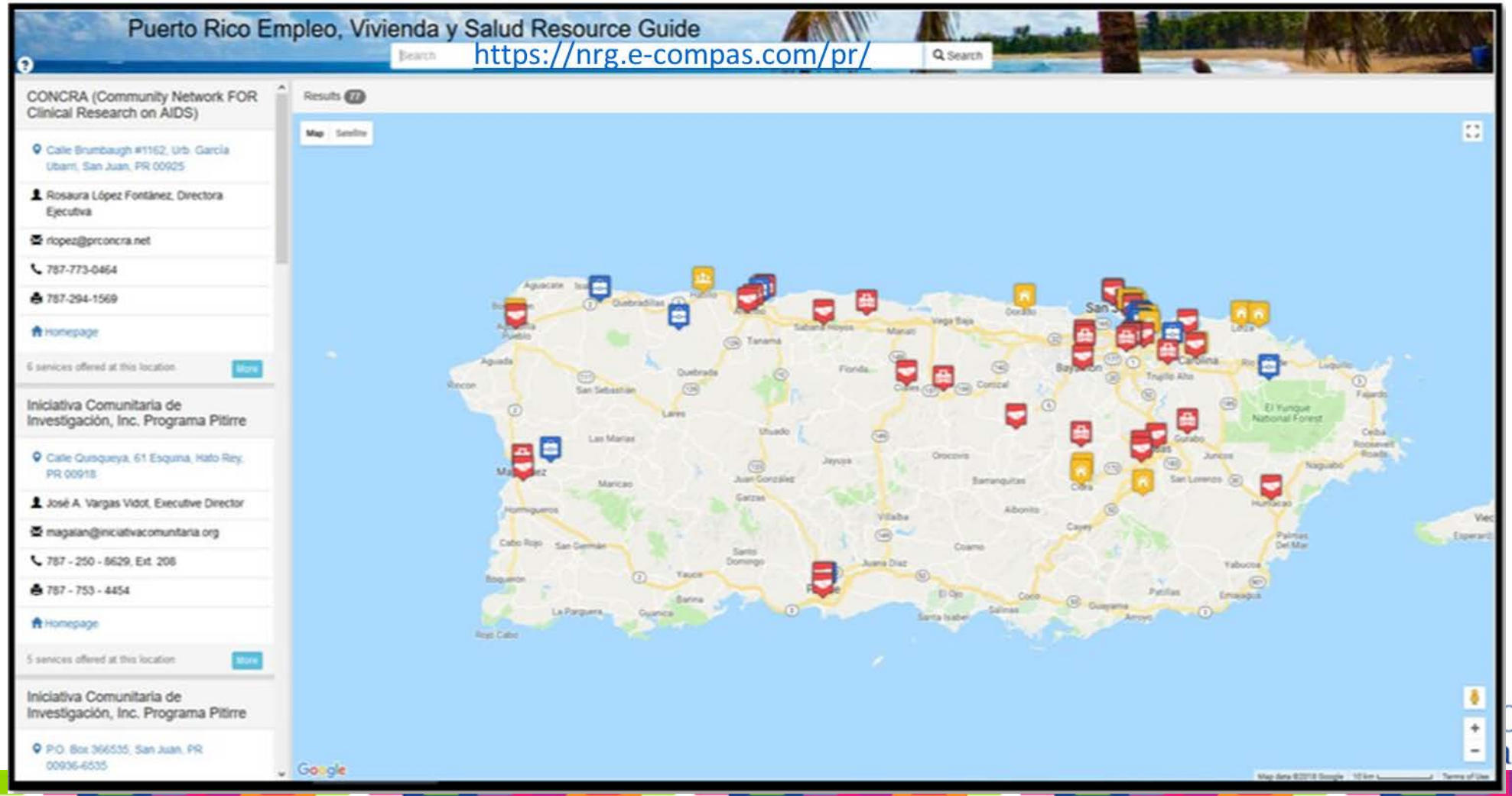
SPNS Latino & Workforce: Air Bridge Solution



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SPNS Workforce Capacity Building

Where were people linked to care after incarceration?

The right fit program – primarily PRDOH RW Part B and Part C Health Clinics

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Linkages to Care in Puerto Rico

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Lessons Learned

1. Networking with other agencies & jurisdictions identified core organizations and champions
2. Pooling resources + working with government helps establish best practices to facilitate continuity of care
3. Coordination & collaboration between Ryan White service network and local CBOs improves access for those out of care.
4. Build on established relationships, develop formal agreements, create synergy among medical & service programs (housing, employment, mental health / substance use)
5. Participate & engage with RW HIV Planning Council key stakeholders
6. Annual convening of stakeholders helps create strategies to address population needs
7. Data systems integration helps improve care coordination, data reporting & quality management
8. Transitional Consortium leadership supports relationships & leverages resources to coordinate care
9. Engaging client during incarceration fosters relationships to endure after incarceration
10. Transportation access helps ensure linkage to care after incarceration

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Collaborations

Inform and inspire:

- ❑ Best practices
- ❑ Cost analyses

Marry Creative Ideas & Practical Solutions to Wicked Problems

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6. Tinsley M, Spaulding AC, Altice F, Strauss IH. *Enhancing Linkages to Primary Care & Services in Jail Settings, A Critical HIV/AIDS Bureau Initiative,* International AIDS Conference, June 22, 2012

Thank you!

COMPAS

NYC HEALTH+ HOSPITALS
Correctional Health Services

2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Wrap Up / Lessons Learned Discussion

e2Poll:
Did we meet your learning objectives?

National, State and EMA-level Insights: Leveraging Partnerships & Data Systems for Program Monitoring and Outcomes. (#Session ID 11077)
Health HIV; Louisiana Office of Public Health; Tampa-St. Petersburg EMA;
RDE Systems
Wed. 10:30 a.m.-12:00 p.m.Room: Chesapeake C
1

Actuating Care in Iowa, Dallas, TX, and Paterson, NJ Using Multilingual, Evidence-Based Needs Assessments. (#Session ID 13019)
Iowa State AIDS Program; Dallas BMA; Bergen – Passaic NJ TGA;
RDE Systems
Wed. 1:30 p.m.-3:00 p.m. Room: National Harbor 8
2

The Whoosh: Innovative Data Exchange, Saving Time, Improving HIV Care Coordination- NYC Jails and Boston. (#Session ID 13002)
INYC Health + Hospitals – Correctional Health Services; Boston Public Health Commission, HIV/AIDS Services Division;
RDE Systems
Wed. 4:00 p.m.-5:30 p.m. Room: Maryland B 4/5/6
3

Bridging the Data (Systems) Divide! Integrating Data Systems for Better HIV reporting and Care Coordination. (#Session ID 11079)
Boston Medical Center; Parkland Health & Hospital System; Northeast/Caribbean AETC; University of Puerto Rico;
RDE Systems
Thurs. 10:30 a.m.-12:00 p.m. Room: National Harbor 4/5
4

Learnings from Implementation and Integration of Interventions from the SPNS Latino Transnational Initiative. (#Session ID 13008)
University of Puerto Rico; HRSA; AIDS Foundation of Chicago;
RDE Systems
Thurs. 10:30 a.m.-12:00 p.m. Room: Chesapeake 1/2/3
5

Emerging Issues, Part A & B Resource Trends, and Using RWHAP Funds Efficiently by Saving Time and Money. (#Session ID 11047)
HRSA; Tampa-St. Petersburg EMA;
RDE Systems
Thurs. 1:30 p.m.-3:00 p.m. Room: Maryland C
6

Improving HIV Outcomes in Rural and Urban Settings: A Tale of Two Emergency Department Strategies. (#Session ID 11084)
Columbia University/ New York Presbyterian; University of Nebraska Medical Center; ECU Brody School of Medicine;
RDE Systems
Thurs. 4:00 p.m.- 5:30 p.m. Room: Chesapeake 6
7

SPNS Systems Innovations and Consumer Empowerment: Paterson, NJ. (#Session ID 12786)
Bergen – Passaic NJ TGA;
RDE Systems
Fri. 8:30 a.m.-10:00 a.m. Room: National Harbor 15
8

How to Share and Leverage Data in Good Times and in Bad. (#Session ID 12796)
Centro-Ararat, Puerto Rico; East Boston Neighborhood Health Center, Boston; Allegheny Health Network, Pennsylvania; RDE Systems
Fri. 10:15 a.m.-11:45 a.m. Room: Chesapeake 1/2/3
9

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