## HOPE Center's 2016 ETE Dashboard Submission

**St. John's Riverside Hospital's HOPE Center is a NYS-DOH DAC (Designated AIDS Center) dedicated to providing comprehensive care in a compassionate, professional, respectful and ethical manner to every HIV-positive patient and his or her family. We offer excellence in HIV-related medical care, mental health, counseling & testing, dental care and case management with special concern for the underserved and low-income individuals living with HIV. Working with our clients to continually improve our care, we are open to new ideas, directions and initiatives to effectively respond to the needs of individuals living with or at risk of HIV in our communities. We are leaders in the fight for the lives of those who have this virus.**

**The main "Gap in Care" revealed in our Cascade was the large number of HIV+ individuals who have "touched" our healthcare system, and are unknown to our HIV program. We identified 563 individuals with a HIV/AIDS diagnosis that have an unknown disposition through a custom report designed by our Information Services and Technology (IST) Department to retrieve data from the hospital's Electronic Medical Record (EMR) known as "Meditech."**

**We found that 79% percent of the individuals under the "open cases" were admitted to our Behavioral Health Services (BHS) because of our close proximity to the city border and because our facility's BHS outreach efforts is focused in the boroughs. We learned that 95% of those individuals reside in NYC and return to NYC upon completion of treatment. The remaining 21% of "open cases" touched our system through Emergency Room visits, inpatient admissions or the use of ancillary services at one of our sites and sixty (47%) of them were also found to be NYC residents.**

**Ultimately, we found that only 15% of HIV+ individuals that were served in our healthcare system (and not already known to our HIV services) actually reside in Westchester County. Due to our hospital's EMR limitation, we are currently not alerted when these individuals "touch" the system. We recognize that this inability to track these individuals affects Governor Cuomo's Ending the Epidemic three-point plan. Not being able to track these individuals limits our ability to assess their compliance with the required HIVQUAL indicators (e.g., antiretroviral therapy medication; adherence to ARV therapy).**

**We recognize that there are several barriers (e.g., funding; time constraints; and EMR) to ensure this level of contact with individuals not necessarily "known" to our program. Nevertheless, we developed the following goals to address gaps concerning the HIV + individuals who "touch" our hospital system:**

1. **HOPE Center plans to engage in conversations with other internal departments (such as BHS and ED); and explore ways of identifying those HIV+ individuals that reside in Westchester and being notified that they are on the units.**
2. **HOPE Center will also support the facilities' inpatient services (med/surg and BHS) with resources available in NYC for HIV + individuals.**

**Progress/next steps with our open patients:**

**For the past two months, the HOPE Center has had an Outreach Care Manager stationed in SJRH's Emergency Department (ED). The staff member has been meeting with the high utilizers of the ED in an effort to connect them with appropriate community services or Health Homes Care Management. In addition, he has been tasked with reaching out to known HIV+ individuals to ensure that they are connected to care. If the individual is not, the Outreach Care Manager then facilitates a referral for treatment.**

**A percentage of the "open" patients/cases identified being HIV+ and residing in Westchester County have received treatment in one of BHS's programs. We will set up a meeting with BHS's Director of Intake and Admissions in order to explore how we can develop the means of identifying HIV+ Westchester County residents that enter our inpatient BHS. BHS underwent some administrative upheaval in 2017 because their AVP resigned during the earlier part of the year and the VP retired at the end of December. We will work on scheduling the meeting within the new two months (by the end of March 2018). Diane Anderson and Maria Sariol will facilitate the discussion.**