2021-06-30 CDS Design Meeting

Agenda June 30, 2021

Desired Outcome: CDS Design Team understands desired functionality, requirements, and challenges to building a CDS tool that can be integrated into EHR systems.

1. Statement of Purpose for the CDS Tool
2. Partner Introductions
3. Summary of Guideline Development by Alphora
4. Questions from CDS Design Team

Partner Talking Points

Desired Outcome: CDS Design Team understands desired functionality, requirements, and challenges to building a CDS tool that can be integrated into EHR systems.

1. Introduce your team - 1 min
2. Tell your health center's story - where you are, whom you serve - 1min
3. Talk to us about your system and your data - (How are these captured [e.g. POC, patient-input, MA/PA/Nurse/NP/Physician)? How is the data stored[e.g. structured, unstructured, paper-based, electronic abstraction?] Where is the data stored? - 3 min
    a. HIV test refusal
    b. External history of HIV test
    c. PrEP counseling and/or referrals

RESOURCES

Project Teams

NACHC Informatics Team	Alphora	AllianceChicago	El Rio	Fenway	Montefiore	Ohio ACHC
Julia Skapik Clinician SME, familiar with EHR Pedro B Carneiro Data Scientist familiar with EHR, HIV Data Raymonde Uy Physician SME on Informatics John Gresh Data Management Andrea Price Project Manager	Bryn Rhodes Sean Wheelright Zack Austin	Andrew Hamilton Shelly Sital Dr. Timothy Long (Clinical SME/User), the Director of Nursing, HIV Care Team, Medical Assistants, and Lab Director For most of the technical components, that would be AllianceChicago staff (Clinical Informatics). At the health center, it would be the EMR manager who would ensure the order was created correctly for the SME user to utilize in-house. Shannon Pohl	Sudha Nagalingam, MD- Clinician SME, Familiar with EHR Greg Raglow, MD- Physician SME Informatics Dustin Holloway, MPH- Data Management /Analytcis Erin Dougherty, MPH- Grants Management Erika Solis- HIV Care Coordinator	Clinical Champions - Dr. Alex Gonzalez, Medical Director Dr. Ami Multani, Medical Director of Infectious Disease Dr. Brian Bakofen, Medical Population Health Technical Leads Juwan Campbell, Programmer /Analyst Corinne Fournier, Clinical Informatics Analyst Sy Gitin, Clinical Data Specialist Chris Grasso, AVP for Informatics +	Viraj Patel, MD, MPH – Project lead and SME on clinical care for HIV prevention and treatment Uriel Felson, MD, MS – Project leadership team and SME on clinical care for HIV prevention and treatment Sharon Rikin, MD, MS – Project leadership team and SME on quality improvement in health systems Robert Beil, MD Debjyoti Datta, MBBS, MPH – Project coordinator Helen Farren – EPIC IT Analyst responsible for Adult Medicine Michael Rinke, MD – Stakeholder for quality improvement at primary care sites Vanessa Protamo, MD -- Stakeholder for clinical care at primary care sites Manuja Mather, MD – Medical Director and Champion for one primary care site Tamara Nawar, MD – CHampion for one primary care site	Tiffany White Ashley Ballard Lindsay Weaver **Lower Lights CHC** Dr. Lynnette Palmer, Quality Director, familiar with EHR Richard Harris, Data Analyst, familiar with EHR **Southeast CHC** Nick Nelson, MPH, NP-C SME advisor, familiar with the EHR Dr. Dana Vallangeon (OACHC CMO, also is a part-time provider at Southeast)
EHR		AthenaPractice	Transitioning from NextGen to Epic	AthenaHealth	Epic	NextGen ▪ SE will be upgrading this year, might have differences in system. Azara Population Health Center

AllianceChicago Workflows

AllianceChicago CDS Worksheet

1.Briefly describe the current approach to measuring and supporting the care team in HIV testing and follow up in your organization.

In our clinical content in athenaPractice, there are CDS tools that alert the provider whether or not the patient should have an HIV screening or for routine testing in the general population. This is in the adult preventative care form and other forms such as the prenatal clinical content. It is always on the flow sheets to see the results if the HIV test was completed. There are order sets that allow individual providers to check one box for STI testing, which includes HIV, Hep-B, Hep-C, gonorrhea, chlamydia and syphilis.

- adult
- embedded in well child care
- in prenatal care workflow, embedded in perinatal care

2. Talk about the process you would have to engage in to design and get care team buy in for the design of content and interfaces to support HIV testing and follow up guidelines and workflow improvements.

It would be interesting to design a new workflow where during intake the care team screens the patient for diabetes, HIV, etc. This could include standing orders that automatically order the HIV test to be a part of bloodwork that is being requested. Nursing staff in addition to the provider is then in the workflow ordering the tests. There may also be Point of Care testing for HIV or the regular testing completed by the intake person. This would be additional responsibility placed on those care team members, but then it reduces the burden on the provider (especially as this is then routine, and the provider may be occupied with other more urgent screenings). We should be making HIV testing as one of the routine processes.

3. Identify the team, including titles, who would work on this project from the clinical and technical sides. Who are the technical leads? Are there any external vendors? Clinical SMEs and users? Other leaders/champions?

Dr. Timothy Long (Clinical SME/User), the Director of Nursing, HIV Care Team, Medical Assistants, and Lab Director.

For most of the technical components, that would be AllianceChicago staff (Clinical Informatics). At the health center, it would be the EMR manager who would ensure the order was created correctly for the SME user to utilize in-house.

4. Discuss your technical path to implement new tools or significant improvements to your EHR/pop health tools to support HIV testing and follow up. Include approvals, costs, impacts, testing, vendor involvement if any. If there are unanswered questions you need to answer, OK to list here.

The technical path involved the following milestones:

- **Discovery**: Reviewed the existing HIV testing clinical decision support technical programming logic against the US PSTF clinical guidance recommendations
- **Design**: Created prototypes of an updated HIV testing clinical decision support technical logic and user interface design.
- **Development**: Updated HIV testing clinical decision support technical programming logic.
- **Testing**: Tested the technical updates
- **Deployment**: Deployed the updated HIV testing clinical decision support to EHR clinical content subscribers. Created electronic wraparound support materials for marketing and communication, to reinforce best-practices of HIV testing clinical decision support available in the EHR and highlighting the technical updates deployed to Health Centers.

These stages of our technical path – Discovery, Design, Development, Testing, and Deployment – are indicative of our standard informatics processes for health IT software solutions, based on healthcare user experience best-practices. Stakeholders involved included internal AllianceChicago clinical, implementation, and technical Subject Matter Experts, as well as external Health Center clinical Subject Matter Experts. This team of cross-functional expertise enabled the translation of the USPSTF recommendations into real-world CDS solutions and workflow recommendations. These stakeholders were informed and engaged at each stage, to ensure the project was on course and approving next steps for the overall jobs-to-be-done.

a. Do you have a portal where you can use FHIR applications inside your EHR? Yes: https://mydata.athenahealth.com/home

a. Do you have a CDS engine to build content in your EHR?

Yes – clinical decision support (CDS) can be built within the EHR application we use, involving product-specific programming capabilities enabled by the vendor. In addition, we have experience in CDS development integration projects where we connect the EHR to CDS engines outside the EHR application, for real-time referencing of outside CDS guidance while the user is within the EHR experience.

El Rio Health
Clinical Workflow

Post-visit/Care Coordination:
• Current – Coordinate via phone services
• Future –
o Referral for PrEP – if at risk and HIV negative, and need for further evaluation using the EMR
o Referral to Special Immunology Associates (SIA) HIV Clinic if the patient tests positive.

Described are the opportunities to engage with a patient around the clinic encounter.

Pre-visit:
• Current State - Not applicable.
• Future State – Review care gaps – patients need HIV screening.

Check in:
• Current - Sexual Orientation/Gender Identity (SOGI) data is assessed via kiosks
• Future - Same

Rooming:
• Current - Care gap review is conducted by the Medical Assistant, and a standing order is in place for HIV
opt out testing for patients ages 16-21 years.
• Future - Care Gap review to be conducted by the Medical Assistant with a standing order for all patients
ages 16 +

MD/Clinician Extender visit:
• Current - Care Gap review; order HIV testing after discussion.
• Future:
o Discussion regarding sexual history and assess for STDs
o Consideration for Pre-exposure Prophylaxis (PrEP) if it fits the criteria

Post-visit with staff (in clinic):
• Current - Direct to the Laboratory if ordered.
• Future - Same, plus add note to the post-visit summary that HIV screening is recommended/due (when applicable)

Pharmacist:
• Current – Not applicable. The Pharmacist is not involved in HIV opt-out testing.
• Future - nothing/not applicable

Proposed Intervention

We would like a streamlined approach to HIV counseling and testing – currently we are using the care guidelines (alerts in the medical record system. Our referral process – for PrEP vs HIV positive results – includes using the EMR (currently we use telephone and encrypted text services). We would like built-in order sets in the EMR – that could help with STD evaluation /Sexual history / PrEP order sets etc.

El Rio CDS Worksheet

1.Briefly describe the current approach to measuring and supporting the care team in HIV testing and follow up in your organization.

- Part of “care guidelines” a one-time check box for patients 18-65 years old – serves as a reminder for providers to perform HIV testing when they are seeing the patient
- Results are scored in a program – “Relevant” – where providers can see the percent of patients in their panel who have been tested, as well as the list of patients who have not been tested from their panel.
- Patients are assigned to a provider panel – based on who they have seen for the last three encounters.

2. Talk about the process you would have to engage in to design and get care team buy in for the design of content and interfaces to support HIV testing and follow up guidelines and workflow improvements.

- A Weitzman initiative was started four years ago – to make HIV testing mandatory at least 1 time for individuals 18-65 years old.
- Need for ongoing training with STI testing and management, considerations for PrEP
- Some of these trainings – occur during “Lunch and Learn” sessions and Operational Meetings
- As company is set to transition to EPIC – new workflows and teams are being created to set up new guidelines and templates

4. Discuss your technical path to implement new tools or significant improvements to your EHR/pop health tools to support HIV testing and follow up. Include approvals, costs, impacts, testing, vendor involvement if any. If there are unanswered questions you need to answer, OK to list here.

A. *Do you have a portal where you can use FHIR applications inside your EHR?*

- With our current Nextgen we do NOT have the FHIR technical capabilities to do this. We are working with EPIC on this as part of our Implementation workflow analysis.

B. *Do you have a CDS engine to build content in your EHR?*

- We are working with EPIC on this as part of our Implementation workflow analysis

Fenway Clinical and Data Workflows - TBD

Fenway CDS Worksheet

1.Briefly describe the current approach to measuring and supporting the care team in HIV testing and follow up in your organization.

Monthly reports are distributed that aggregate the number of tests completed as well as HIV positive tests. The reports are stratified by different demographics (e.g., age, race, ethnicity, gender, etc.).

Care teams conduct daily huddles for patients seen that day. The huddles review any clinical services that a patient is due for (e.g., HIV test, depression screen, etc.) The huddle forms are accessible in the patient's charts.

2. Talk about the process you would have to engage in to design and get care team buy in for the design of content and interfaces to support HIV testing and follow up guidelines and workflow improvements.

We have several workgroup and team meetings that provide an opportunity to discuss workflow improvements. There is a weekly clinical computing meeting that consists of clinical and technical staff. Additionally, we have a monthly HIV meeting where clinical issues and workflows are discussed.

4. Discuss your technical path to implement new tools or significant improvements to your EHR/pop health tools to support HIV testing and follow up. Include approvals, costs, impacts, testing, vendor involvement if any. If there are unanswered questions you need to answer, OK to list here.

- Any changes to our EHR include an approval process by both clinical and technical leads. Depending on the complexity, this may require external vendor support. The costs associated with this can vary from a few hundred dollars to a few thousand dollars.
- Changes to ancillary products (e.g., population management tool) to our EHR, require conversations with external vendors. The modifications require commitment by the vendor as well as prioritization within their work queue. Costs associated with changes varies.

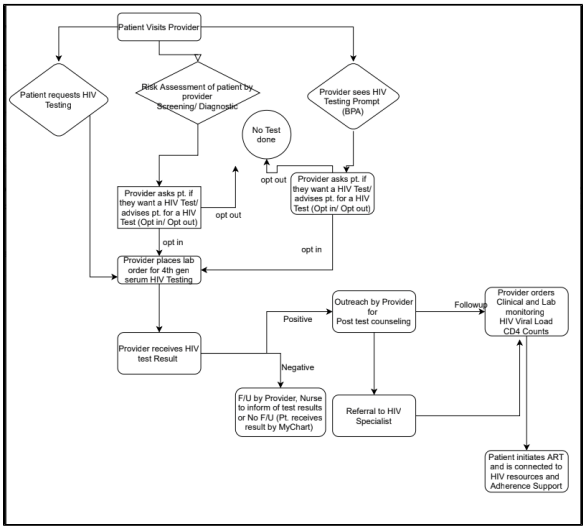
Do you have a portal where you can use FHIR applications inside your EHR?

- Yes, we currently have other FHIR applications integrated with our EHR

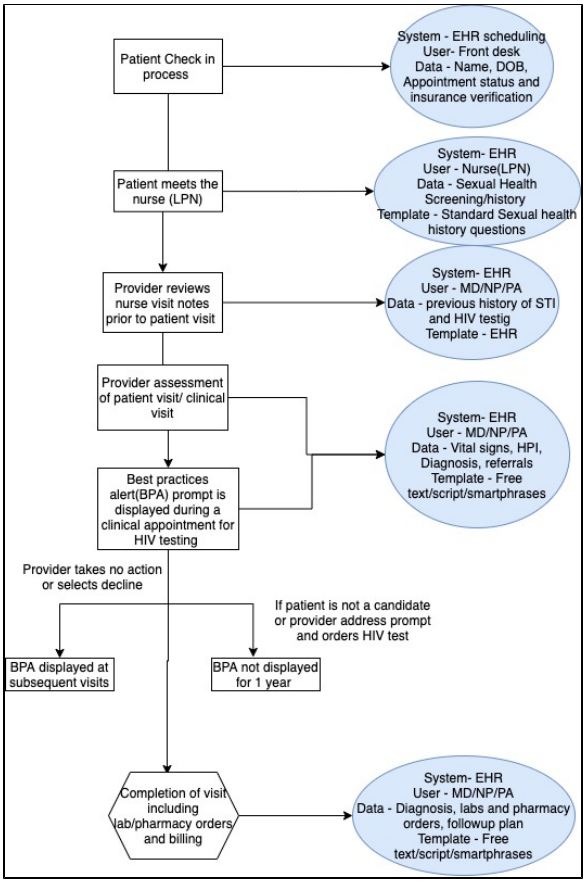
Do you have a CDS engine to build content in your EHR?

- Yes, but not a very sophisticate rules engine

Montefiore Clinical Workflow



Montefiore Data Workflow



Montefiore CDS Worksheet

1. Briefly describe the current approach to measuring and supporting the care team in HIV testing and follow up in your organization.

The current approach to supporting the care team in HIV testing is – Best Practice Advisory (BPA) Prompts. We have an established multidisciplinary network of HIV providers in primary care, developing comprehensive program for HIV prevention with PrEP

There is a Best Practice Advisory - but one of 100 BPAs. This is for patients 18-65.

2. Talk about the process you would have to engage in to design and get care team buy in for the design of content and interfaces to support HIV testing and follow up guidelines and workflow improvements.

Meeting with primary care quality improvement (QI) committee – Describing the problem (showing data about relative low testing rate)

Making BPA more user friendly – Discuss BPA modification or other types of CDS à get feedback from the committee

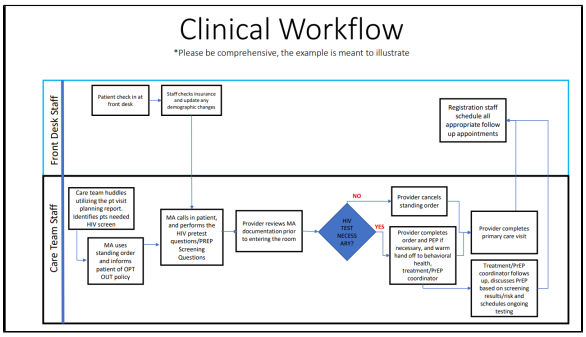
Talking to IT Team for adult ambulatory EPIC care – discussing feasibility and modifications

4. Discuss your technical path to implement new tools or significant improvements to your EHR/pop health tools to support HIV testing and follow up. Include approvals, costs, impacts, testing, vendor involvement if any. If there are unanswered questions you need to answer, OK to list here.

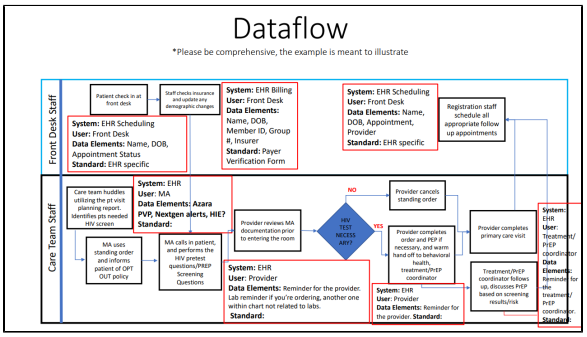
IT/EPIC Ticket/request à reviewed in Adult Medicine IT request prioritization meetings - prioritized and assigned to analysts for final approval by Matt Berger, MD

1. Do you have a portal where you can use FHIR applications inside your EHR? – Not Known
2. Do you have a CDS engine to build content in your EHR? - Yes

Ohio ACHC Clinical Workflow



Ohio ACHC Data Workflow



Ohio PCA CDS Worksheet

HIV CDS Objectives	Southeast Health
Standing Orders or Pre-Built order sets in EHR	· Don't currently have a standing order for HIV Screening · Need to figure out how standing orders can be built into HER (Shawn) or clarify for nurses, could be an MA as well- how they do standing orders · Standing order could be based on the identification of certain risk factors, scores on risk assessment questionnaire, or patient request. · Might have a SO already for HIV, need to check on this.
Utilize Patient Visit Planning/ Huddle Reports	· SE would start with patients here in the huddle. · HIV screening flag turned on in Azara 5/18 /21. Staff is already familiar with this.
Identify opportunities or decision support in your EHR specific to different staff members	· Providers: a pop-up reminder during the lab ordering process for patients that are due for the once in a lifetime screening · Risk assessment module that could give a score for individual patients and could prompt a high risk reminder for someone who needs additional HIV testing. Risk assessment would need to be built and then set for every 90 days for example. Currently have a risk assessment for HIV- tied to recommending PrEP. · Nurses/MAs: Pop up/flag in the check out section that lists the orders placed by the provider · Note- this is ideal, not sure what all is possible

HIV CDS Objectives	Lower Lights Christian Health Center
Standing Orders or Pre-Built order sets in EHR	· MA to be able to automatically order an HIV test if it's left off a lab order. Current alerts and flags are old and do not disappear when the test is ordered. Possible that Nextgen does not pick up on all alerts. Azara PVP alert fills in here.
Utilize Patient Visit Planning/ Huddle Reports	· Azara PVP alert is on for HIV Lifetime Screening at LL. Azara report will not help with lab only visit because its not an appointment.
Identify opportunities or decision support in your EHR specific to different staff members	· Not sure that Nextgen can pick up on test needing to be ordered. Visit types of telehealth, lab visit etc. · There is a screening summary section in Nextgen that HIV could maybe be added to and checked off like other preventative screenings (PAP, mammogram, hearing). Can review drug use and other risk factors here as well that could inform screening.
Utilize EHR tools such as system alerts and patient reminders to alert staff of patient who meet eligibility criteria	· Currently have an alert for HIV already but it doesn't work well and isn't updated so is often incorrect. Providers do not use for HIV specifically.
Identify the frequency of EHR alerts (annually for some, more often for others). Include optional overrides	· Just once for the HIV Lifetime screening. Not sure about the high risk for HIV alert in HER because they can't really configure the lifetime one at this time. Would want 90 days retest if this could be configured. · Maybe can turn on an alert in Azara for this? Not sure about OUD HIV Measure or others. · PrEP risk assessment from Columbia University

Utilize EHR tools such as system alerts and patient reminders to alert staff of patient who meet eligibility criteria	· Color change or a flag for different staff. MA or provider can review- Not sure if this is possible. · We currently do NOT have a preventative maintenance dashboard. If our update has one, then HIV screening could be on this and the frequency could be based on other risk factors that would be identified in the chart, possible through an HIV risk assessment questionnaire.
Identify the frequency of EHR alerts (annually for some, more often for others). Include optional overrides	· Once for all patients · Every 3 months for people that have an opiate use disorder dx · Every 3 months for people with a high risk sexual behavior diagnosis
Use EMR and Azara to monitor patients with HIV dx	· The HIV/PrEP care manager and RN team currently use a self-made registry to follow HIV positive patients · A registry pulled from the EHR has been requested from data management · Azara would be great to use, but need HIV module? Review the measure list for the HIV add on module.
EMR Templates /AVS for education on PrEP	· Would need to create an HIV risk assessment template. · Need to find out if Nextgen update will have something that would work for risk assessment or any other PrEP specific modules etc. · If there was an HIV risk assessment template, then a certain score could trigger a pop-up for HIV testing every 3 months or a pop up to offer PrEP.
OTHER NOTES	Might use risk assessment or pop up for HepC as well as HIV.

Use EMR and Azara to monitor patients with HIV dx	· HIV coordinator gets referral for positive HIV patients (refer to Equitas for txt). Not an alert or notification coming up for HIV dx. · HIV reports in Azara and can see who is newly diagnosed. · Would want an alert for a patient that has HIV if possible.
EMR Templates /AVS for education on PrEP	· Nextgen has a pt. education tab where you can add whatever you'd like for the MA to print off. Not sure about the PrEP education. Providers use different resources. · Could load better HIV and PrEP info in there and more languages are needed.
OTHER NOTES	· . Care Guidelines- providers do not want to use so it isn't turned on. Can't be personalized by providers.

Sources for the objectives:

WHO: https://apps.who.int/iris/bitstream/handle/10665/324745/WHO-CDS-HIV-19.5-eng.pdf

HITEQ: https://hiteqcenter.org/Resources/Priority-Topics/Ending-the-HIV-Epidemic/Strategies-for-Increasing-HIV-Screening/increasing-hiv-screening-rates-at-your-health-center

Recording is here.

Discussion Questions

Q	Item	Notes	Action Items

1.	**What would you like a Clinical Decision Support routine to do?**
	
	Shared goals:
	
	▪ Improve the quality and quantity of HIV risk factor data capture, HIV testing data (external, internal and historical), HIV test opt-out
	▪ Grab low-burden opportunities to add the HIV test – include self-referral, standing and automated/renewing test orders
	▪ Use the HIV risk factor data to expand opportunities for HIV prevention and PrEP counseling/access
		▪ A number of providers across different departments, has to work across, is currently in different places and the info on HIV testing is presented to them in different places - AC
		▪ Would like to see wide standards - SMART on FHIR - El Rio (28:45)
		▪ Make decisions, select out patients and refer them to Northern Lights (OAPCA)
		▪ Different pathways for high risk vs lifetime screening patients-- more information is needed for the high risk patients
		  ▪ **Probably significant patients are missed by current approach-- both the prospective and retrospective screening approaches**
		  ▪ **Capture for some of the risk factors is challenging**
		  ▪ Risk scoring tool is used by some-- the approach may need to be modified because CDC approach is not inclusive or patient-centered enough-- some centers capture this on paper
		  ▪ Investigate existing electronic templates including lower lights template
		  ▪ Sexual Orientation Gender Identity (SOGI) data collection approach in CDC tool may miss patients at risk
		  ▪ Asked in check in and in questionnaires
		  ▪ Missing data may be high especially in non-LGBTQ oriented settings – may be related to privacy concerns
		▪ CDS should be aimed at the provider/care team goal to the person from the data and system
		  ▪ Prompt for ordering is easier
		  ▪ Age-driven guideline is also more attainable
		  ▪ **Would like for CDS to drive prompts/discussion of PrEP**
		  ▪ **Consider to create an order for unscreened patient when lab test entered or ALLOW PATIENT TO DO IT**
		  ▪ "Side-car" prompt HIV testing when doing other STI testing
		  ▪ prompt HIV testing when other STI testing comes back positive.
		▪ Implementation approach should be encompassed after the base IG content incorporates all the endpoints
		  ▪ System agnostic but the workflow and trigger/action combinations have to be there to allow it to be used by any future partners or a direct implementation of the code
		▪ **Dashboarding for user responses and missing data**
		▪ Normalize lab tests and HIV testing historical data into the testing framework and definitions
		  ▪ Include query for external data?
		▪ Automate processing as much as possible and simplify work stream to minimize clicks and patient effort
		  ▪ Provider fatigue should be a primary endpoint but also patient fatigue (being asked lots and lots of questions, research, data entry)
		▪ Ask patients what they experience in their own data capture and screening-- is the data presentation appropriate?
		  ▪ Consider sensitivity of data and opportunities to progressively capture the data and allow patients to directly provide it
		  ▪ Opt out
		▪ Is there an opportunity to consolidate other use cases with HIV screening? Are some patients being over-approached or over-sampled?
		  ▪ TURN OFF alerts at the right time-- automate the approach, be able to snooze them and why (example - patient refused on X date)
		
		▪ When we talk about high risk, we can gauge "high risk" according to a risk assessment tool	

2.	**Discussion with the technical ppl on what their protocols are for integrating the CDS into their system** 1. What is the process to implement a change in your EHR? a. Can your internal team make changes to the EHR? Are they limited or not? b. What is the timeframe to deploy? c. What approvals and tests are needed? d. Do you have to rely on the vendor to make changes? 2. Does your EHR currently support Fast Healthcare Interoperability Resources or some other software portal? If not, do you have another way to integrate new software tools into the EHR?	Ohio: ▪ Some sites (LL) may not have the ability to make changes directly– hosted EHR with hospital system ▪ SE: need to go through vendor-- have a big upgrade coming out-- not sure about expanded functionality (OSIS/NextGen)-- may incur cost ▪ What is the process to implement a change in your EHR? Depending on the change we go through Mount Carmel then possibly have to also work with NextGen. 1. Can your internal team make changes to the EHR? We can make suggestions for things to be changed, but no actual changes come straight from us. 2. What is the timeframe to deploy? It would depend on what all needs to change and who is affected. 3. What approvals and tests are needed? Mount Carmel really works on this. 4. Do you have to rely on the vendor to make changes? Yes ▪ Does your EHR currently support Fast Healthcare Interoperability Resources or some other software portal? If not, do you have another way to integrate new software tools into the EHR? I will check with Mount Carmel we do have a patient portal if that is what you are asking. Montefiore: ▪ TBD Fenway: ▪ Some level of customization at the EHR level-- require coordination across clinical/technical team ▪ PopHealth tool requires working with the vendor for changes ▪ Cost variable depending on the implementation effort El Rio: ▪ November 1 (post-Epic transition): training MD builders who can implement changes after technical team approval-- post-November implementation date (likely 2022) AllianceChicago: ▪ Support FHIR apps in EHR, are able to build native CDS into product, close relationship with Athena, timing unclear depending on approach and scope (AthenaPractice) ▪ Will require testing and approval	
3.	**Data form and manner including whether you capture:** i. HIV test refusal ii. External history of HIV test iii. PrEP counseling and/or referrals		
4.	**Follow Up/Next Steps**	☐ Goal statement draft ☐ Staged implementation plan/timeline ☐ CDC Risk Scoring Criteria and QI it ☐ Generic CDS flow documents for feedback on opportunities to act ☐ Follow up on SOGI and Gender Harmony timing and content ☐ Coding of the non-diagnosis or testing risk items?	
5.	**Parking lot for later**		
	CDC is the project sponsor - what is their main focus?	Who gets tested and how frequently?	
	As a non-IT person -- can you help me understand what is the ask for our local IT/Epic team once the FHIR code is developed? How is it delivered to an institution, how does an analyst integrate into the EHR, what kind of validation do they need to do?		

Partner Profiles in Brief (These are estimates and do not need to match the data pulls. The timeframe is any time frame that is convenient for you)

	HIV Prevalence/New Infections per year /percent of pop that lives with HIV	**Demographics (however you define them - your categories)**					**Substance Abuse Profile/Rate**
		Race	***Ethnicity***	***Gender Identity***	***Sex Assigned at Birth***	***Sexual Orientation***	
Alliance Chicago							
El Rio	Percent of Health Center Population Living with HIV/AIDS: 1.5% (2019) New HIV Diagnoses in 2019: 62 (this number includes new infections diagnosed within the organization and outside referrals to El Rio SIA upon a positive HIV diagnosis outside of our El Rio system)	2% - Asian 0.08% - Native Hawaiian 0.16% - Other PI 4.45% - African American 7.26% - American Indian 80.87% - White 0.99% - More than one Race 4.38% - Unreported /Refused All Race Data: UDS, 2019	57% Hispanic /Latinx (UDS, 2019) 42% Non-Hispanic (UDS, 2019) 1% Refused (UDS, 2019)	0.55% - Transgender (UDS, 2019)	41%-Male (UDS, 2019) 59%-Female (UDS, 2019)	3.1%-Lesbian, Gay, Bisexual (UDS, 2019) 1.7% - Other /Something Else (UDS, 2019)	3.95% Other Substance-related Disorders (excluding tobacco) and Alcohol-related Disorders (UDS, 2019)
Fenway							
Montefiore	HIV prevalence: 5% (among ED patients, based on 2015 ED serosurvey) New infxns/year: 69 (2018, DOHMH attributed these 69 new diagnoses to Monte) Bronx: HIV prevalence: 2.2% (2019, DOHMH) New infxns/year: 466 (2019, DOHMH) % of population living with HIV: 2.2% (as above)	35.64% Black or African American 29.87% White 0.85% Native American 3.01% Asian	48.38% of the population were Hispanic or Latino of any race. 14.5% were whites, not of Hispanic origins.	19% of those who took the survey identified as transgender or gender nonconforming		35% identified as gay 26% as lesbian 20 % as bisexual	

Ohio	**Lower Lights CHC** Health Center Patients living with HIV - 0.19% (21 pts) New HIV Dx: UDS 2020 **Southeast CHC** Health Center Patients living with HIV - 0.46% (37 pts) New HIV Dx: 10 (HIV Linkage to Care measure) 2020 UDS Data	**Lower Lights CHC** 2% Asian 1% Other PI 22% Black/AA 49% White 14% more than one race 12% Unreported /Refused 2020 UDS Data **Southeast CHC** 0.8% Asian 0.05% Native Hawaiian 0.05% Other PI 30.8% Black/AA 0.4% AI/AN 62.2% White 3.1% More than one race 2.6% Unreported /Refused 2020 UDS Data	**Lower Lights CHC** 15% Hispanic /Latino 77% Non Hispanic Latino 8% Unreported /Refused 2020 UDS Data **Southeast CHC** 2.2% Hispanic /Latino 97.5% Non Hispanic Latino 0.3% Unreported /Refused 2020 UDS Data	**Lower Lights CHC** 0.18% Transgender 2020 UDS Data **Southeast CHC** 0.73% Transgender 2020 UDS Data	**Lower Lights CHC** 3894 (36%) Male, 5664 (53 %) Femal e 2020 UDS Data **Southeas t CHC** 3977 (50.2%) assigned male 3737 (49.7%) assigned female 2020 UDS Data	**Lower Lights CHC** Lesbian /gay (1%) Bisexual (0. 8%) Something else /don't know (15%) 2020 UDS Data **Southeast CHC** 3.1% Lesbian /gay 4.6% Bisexual 1.1% Something else/don't know 2020 UDS Data	**Lower Lights CHC** 6.0% Other Substance-related disorders (excluding tobacco use and alcohol-related disorders) **Southeast CHC** 26.2% Other Substance-related disorders (excluding tobacco use and alcohol-related disorders) 2020 UDS Data