Continuity of Care: Tracking Patients Across Health Plans and Clinical Settings

Basic Information and Some Examples of Applications

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Director HIV/AIDS, Kaiser Permanente
Disclosures

- I am an employee of Kaiser Permanente
  - All opinions expressed are my own
  - But I do think we (KP) do a pretty darn good job at this!
- I will not be discussing any medications during my talk
  - Except to say that most are too expensive and pharma needs to lower their prices!
- I am not a health informaticist!
Setting the Stage

1. Describe Kaiser Permanente
   a) Nationally
   b) Kaiser Permanente Mid-Atlantic States (where most of my examples come from)

2. Our data systems
   a) The “front end”—what our health care system professionals and patients see
   b) The “back end”—and how we can make it all fit together data-wise

3. How the data systems mesh together
   a) Within KP
   b) With multiple systems
Kaiser Permanente (KP)

- **Our Mission:** To provide high-quality, affordable health care services and to improve the health of our members and the communities we serve
- Integrated delivery system (hospitals, clinicians, pharmacies, lab, x-ray, etc.) and financing
- Operates like a mini-“national health system”
  - Single funding stream with global budget
  - Accountable for total health of a population

KP defines the integrated model of health care financing and delivery through its unique partnership among hospitals, health plan, and medical group: *contractual* and *exclusive*
Fast Facts: KP Mid-Atlantic

- Cover much of Maryland, Washington, DC, and Northern Virginia
- >670,000 members
- Over 1,300 Mid-Atlantic Permanente Medical Group physicians
- About 6,000 employees
- 30+ medical facilities
  - Hub and spoke → 5 hubs
- Core hospitals at which KPMAS physicians directly care for members
- 24 hours / 7 days / 365 days care available
- Fully supported by Comprehensive electronic health record (EHR)
The KP Model—Technology Driven

Kaiser Permanente model: Highly coordinated care through state-of-the-art technology and the area’s largest multi-specialty physician group practice

**KP Health Connect**
- Secure Web-Based
- Universal Access
- Real Time
- Linked to Delivery System
- Electronic Ordering
- Digital Imaging
- Secure Messaging

**KP.org and My Health Manager**

**Population Management Tools**
- Disease registries
- Risk stratification
- Identification of subgroups needing care
- Patient management tools
- Targeted panel lists
- Inreach- Prompts, reminders for clinicians
- Outreach- Letters and automated telephone outreach to members
- Monitoring and process improvement measures and reports
First Key Concept—The Medical Record Number

- All is based on the patient’s Medical Record Number (MRN)
  - Uniquely derived number for each patient
  - Is NOT related to any patient attribute intentionally (i.e., SSN, date of birth, gender, etc.)
  - BUT is considered as group A PHI (same as name, SSN)
  - Requires patients to know this number too!

- However, MRN is not coordinated across KP regions
  - Thus, patients can have multiple MRN
  - MAJOR LIMITATION (especially for linking patients across regions)
  - Further, without SSN, cannot get most death data
  - Or easily link outside of KP

- NOTE: Other systems use SSN, DOB, etc.
  - However, potential disclosure and HIPAA rules
KP HealthConnect  Our EHR—The “front end”

- From any computer with an internet connection, our physicians can view x-rays (or any other radiology image) with the member moments after the film is taken.

- Epic®-based
kp.org—our patient website—also “front end”

- From any computer with an internet connection, Kaiser Permanente members can:
  - Email their Permanente doctor’s office
    - Including their doctor
  - Schedule appointments
  - Fill prescriptions
  - View lab test results
  - Print immunization records
  - View own medical record
  - Get their list of medications

- Nationwide, millions of Kaiser Permanente members are using this convenient, time-saving technology.
Population Health Built-in: The Front End

Automatic prompts at every visit in every department

- Care Gap Identification
- Immediate electronic action / order placement / booking to address
- Systematized workflows / Smart Sets
- Document the **Right** Info

### Medical vitals:
- blood pressure
- temperature
- pulse

**plus**

- BMI
- Smoking
- Exercise
- Alcohol

**EXAMPLE**

Patient visit to Ophthalmologist can prompt for needed mammogram

We’ll Get Back to this…
Population Health Built-in: The Back End

All members with a chronic condition are automatically “enrolled” in disease management programs.

Population health tools allow us to identify members in need of outreach. The program is owned by the member’s primary care team, not a 3rd party.

- **Disease registries**
  - Not opt in or out
  - Algorithms
  - Physician definition
  - Enriched with clinical data, not simply claims

- **Search/Query on demand**
  - Each PCP has access
  - Drive outreach calls, letters, email

- **Robust Health Ed tools**
  - Classes, Coaches, etc.
  - Complete Care Journal
KP HIV Overall Program Strategy: ...as a learning organization

Multidisciplinary care team model

Generating QI programs from recognized gaps

Shared electronic health record and HIV registry for panel management

Testing guidelines and interregional care guidelines

Practice Improvement

Research

Provider Education

Policy
So, Data Coordination is Key

- Demonstrate “garbage in, garbage out.”
- Data Management is Complex
- No such thing as a simple data request.
- Data is time consuming, and requires expertise.
  — Administrators don’t get this…
Why Even Simple Data Requests are Complex
But all is coordinated via the MRN

MAS Regional Legacy Systems

MAS Data Warehouse

MAS Regional Oracle Applications

National Systems

National Insurance Solution

HealthConnect

Teradata

Legend

Data Files
Weekly Feed
Daily Feed
Hourly Feed
Real Time Interface

MAS Data Feeds
Thursday, March 23, 2006
Development of KPMAS Data Warehouse: Example in Effort; Each Region Has Own “Data Warehouse”
HCSRN Virtual Data Warehouse
The Analyst’s Toolkit—But again, the MRN is key!
But We Can Also Coordinate this Across Systems--HCSRN

Figure R2. Health Care Systems Research Network Member Institutions
The Virtual Data Warehouse Used by all members of KP and HCSRN

How we do such research

Note that there are other models, including PCORnet Common Data Model
Similar principles for NA-ACCORD

Figure R3. Virtual Data Warehouse Data Domains

<table>
<thead>
<tr>
<th>Implemented Across HSCRN</th>
<th>Implemented in KP Regions</th>
<th>Planned</th>
</tr>
</thead>
</table>

Note: The diagram shows various data domains and attributes relevant to the Virtual Data Warehouse, including Encounter, Procedures, Providers, Tumors, Death, Cause of Death, Demographics, Cancer Demographics, Census Location, Encounters, Encounters ID, Encounter Type, Dates of Service, Facility, Department, DBC, Provider ID, Provider ID, Specialty, Birth Year, Gender, Race, Year Graduated, Diagnosis (ICD-9), Primary DRG, Primary Diagnosis Date, Procedure Type, Procedure Code, Provider ID, Diagnosis (ICD-0), Diagnosis Date, NAMC/RES variables, Death, Date of Death, Source, Cause of Death, Type of Cause, Source, Race, Ethnicity, Diagnosis, Malignant Neoplasm, Invasive Carcinoma, In situ Carcinoma, Carcinoma, Invasive Malignant Neoplasm, In situ Malignant Neoplasm, Carcinoma In Situ, Prostate Cancer, Lung Cancer, Breast Cancer, Colon Cancer, Diabetes, Hypertension, Heart Disease, Smoking Status, Primary Care Clinic, Primary Care Provider, Social History, Person ID, Encounter ID, Date, Education, Drug History, Alcohol History, Tobacco History, Sexual History, Vital Signs, Person ID, Encounter ID, Measurement Date, Blood Pressure, Pulse, Height, Weight, Head Circumference, Lab Results, Person ID, Order Date, Collection Date, Result Date, Test Name, Test Location, LOINC Code, Test Result, Unit, Normal Range, Range, Ordering Provider, Department, Facility, Row ID, Lab Notes, NASI ID, Result Notes, Netty type, Line, Bone Mineral Density, Provider ID, Reported Race/Ethnicity, Imputed Race/Ethnicity.
NA-ACCORD Collaboration

- 130,000 HIV-infected persons in the cohort; >1 million person-years of follow-up time; reflects the North American epidemic demographically
- Productive collaboration:
  - Over 60 national and international presentations
  - Over 40 papers published
  - 10 other federal grants using this resource

25 Collaborating Cohorts in Canada and US (>200 sites)
Participants from: 47 US states and D.C., 1 US territory, and 5 Canadian Provinces

Slides courtesy of Richard Moore, JHM
NA-ACCORD Data Elements

- Demographic
- Clinical
  - Clinical diagnoses
  - Laboratory
  - Medications
  - Procedures (some)
  - Hospitalization and Ambulatory visits
  - Health Insurance
- Cause of death

Data transmitted from each participating cohort to a central data core, data transmitted in a standardized fashion, combined with data from other cohorts for analyses

www.naaccord.org
@NAACCORD
Some Examples of How We Use This—Back End and Front End
Mid-Atlantic Permanente Research Institute

- Our mission is to advance medical knowledge and improve the quality of care and health of our patients and communities we serve by conducting innovative scientific and clinical research.

**Hepatitis C Cascade of Care**
Kaiser-Permanente, Mid-Atlantic States, 2003–2015

- Screening
- Confirmation
- Staging Fibrosis
- Linkage to Care
- Cure
- Hepatitis C Virus (HCV) Seroconversion and Linkage to Care in a Large Health Care System 2015 American Association for the Study of Liver Diseases

**Original Research & Contributions**
Expanding Access to Care and Improving Quality in the Mid-Atlantic States Safety-Net Clinics: Kaiser Permanente’s Community Ambassador Program

- Mindy R. Call, Matthew Day, Michael A. Herberg, MD, MAS, FACW, FACSP, Bernadette C. Loeb, MD, MSHS

**Clinical and Epidemiologic Research**
The HIV Care Cascade Measured Over Time and by Age, Sex, and Race in a Large National Integrated Care System

- Michael Alan Herberg, MD, MAS
- Leo Bartemeier Hurley, MPH
- Daniel Benjamin Klein, MD
- William James Towne, MD
- Peter Kadlecik, MD
- Diana Antonski, MD
- Miguel Mogyoros, MD
- Philip Sigmund Bricman, MD
- Carol Louisa Remmers, PhD
- Rebecca Claire Gambalese, MPH
- Jackie Blair, MBA
- Courney Georgland Ellis, BS
- Michael Jonor Silverberg, PhD
How does MAPRI contribute to the Value Equation?

1. Study quality measurement and quality improvement
   - Examples include HIV and HCV

2. Provide access to clinical trials
   - Internalizing care
   - Gaining access to the latest in medical care
   - Improve the care for these patients

3. Study new programs in care
   - Studying the ongoing implementation of HCV screening and early treatment pathway
   - Studied our new “Exchange” patients
   - Sickle cell transitions program
     - Improving Transitions from Pediatrics to Adult Heme-Onc

4. Registry Development with Intentional Clinical Applications

5. Monitoring Drug Safety
   - “Sentinel” work with FDA
   - Raltegravir Study (with TPMG and SCPMG)
How We’re Working with KPMAS Daily

- **Registry Work:**
  - Use of Tableau enhanced HIV physician reports is helping to shape data driven care
  - Development of Clinical Disease Registries are being used by operations for targeting patients for case management
  - Working with Population Care Management to develop enhanced Diabetes registry—in progress
  - Development of CKD, COPD, HCV, HBV, Sickle Cell Registries—all with clinical component and provider reports
    - Including HCV reports for clinical pharmacy

- **Disease Registries within MAPRI**
  - HIV
  - HCV
  - HBV
  - CKD and ESRD
  - COPD
  - CHF
  - Congenital Heart Disease
  - Rheumatoid Arthritis
  - Sickle Cell
  - Tumor

- **In Development**
  - Asthma
  - Diabetes
  - Cirrhosis
How We’re Working with KPMAS Daily (2)

- Data Driven Visual Analytics
  - Development of basic query tools and analytics for physician leaders
  - Introduce novel Visual Analytics for population insights
Interactive HIV Physician Centric Actionable Dashboard

- To improve physician performance
- Quickly identify and close care gap

Using Data for HIV Quality Metrics and Improvement

Engagement in Care and Factors Affecting Such Outcomes

Diagnosis → Linkage to Care → Retention in Care → Antiviral Prescription and Adherence → Outcomes

Patient factors ← Provider factors ← System-level Factors

Medication factors

Retention in care ↓ Antiviral receipt and adherence

Health system utilization

Adapted from Mugavero, 2011
How often do patients need to be seen?

- Resetting the standard definition of retention in care

KP HIV Care Cascade 2010-2012

Subsequent stage is dependent on prior stage

Cannot determine undiagnosed in our system.

Horberg, et. Al., AIDS, Patient Care, and STDs; 2015
But Methodology Matters!

Subsequent stage is **NOT dependent** on prior stage

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnosed</strong></td>
<td>16,816</td>
<td>17,711</td>
<td>18,249</td>
</tr>
<tr>
<td><strong>Linked to care</strong></td>
<td>17,213</td>
<td>17,589</td>
<td>13,165</td>
</tr>
<tr>
<td><strong>Retained in care</strong></td>
<td>14,131</td>
<td>14,576</td>
<td>13,975</td>
</tr>
<tr>
<td><strong>Filled ART ≥3 months</strong></td>
<td>15,926</td>
<td>13,953</td>
<td>15,130</td>
</tr>
<tr>
<td><strong>HIV RNA &lt;200/mL</strong></td>
<td>13,519</td>
<td>14,688</td>
<td>15,650</td>
</tr>
</tbody>
</table>

Increase from prior stage is possible

Horberg, et. Al., *AIDS, Patient Care, and STDs;* 2015
Can Stratify by Demographics: by Gender

<table>
<thead>
<tr>
<th>Percent Success</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linked to Care</td>
<td>97.2</td>
<td>97.3</td>
<td>96.3</td>
</tr>
<tr>
<td>Retained in Care</td>
<td>77.8</td>
<td>79.4</td>
<td>79.2</td>
</tr>
<tr>
<td>Filled ART ≥3 Months</td>
<td>84.4</td>
<td>86.5</td>
<td>88.6</td>
</tr>
<tr>
<td>Viral Suppression</td>
<td>81.7</td>
<td>84.3</td>
<td>86.4</td>
</tr>
</tbody>
</table>

- **Men %**: 97.2, 97.3, 96.3, 77.8, 79.4, 79.2, 84.4, 86.5, 88.6, 81.7, 84.3, 86.4
- **Women %**: 96.2, 96.2, 97.1, 81.6, 82.4, 84.6, 74.8, 77.5, 82.1, 71.5, 74.4, 81.4

"Diagnosed" here is 100% by definition for all sub-populations, not included here.

Horberg, et. al., AIDS, Patient Care, and STDs; 2015
Can Stratify by Demographics: by Age

KP HIV Cascade 2010 - 2012 Stratified by Age Range
"Diagnosed" here is 100% by definition for all sub-populations, not included here

<table>
<thead>
<tr>
<th>Year</th>
<th>Linked to Care</th>
<th>Retained in Care</th>
<th>Filled ART ≥3 Months</th>
<th>Viral Suppression</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>95.8</td>
<td>76.8</td>
<td>69.8</td>
<td>64.6</td>
</tr>
<tr>
<td>2011</td>
<td>95.8</td>
<td>77.9</td>
<td>75.5</td>
<td>69.4</td>
</tr>
<tr>
<td>2012</td>
<td>94.9</td>
<td>77.4</td>
<td>78.5</td>
<td>73.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age Range</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age &lt;35; %</td>
<td>96.9</td>
<td>97.2</td>
<td>96.1</td>
</tr>
<tr>
<td>Age 35 - 54; %</td>
<td>97.7</td>
<td>97.7</td>
<td>97.3</td>
</tr>
<tr>
<td>Age 55+; %</td>
<td>97.7</td>
<td>97.7</td>
<td>97.3</td>
</tr>
</tbody>
</table>

Horberg, et. Al., AIDS, Patient Care, and STDs; 2015
HIV Care Cascade by Race/Ethnicity

Significant (p<0.05): *-for race/ethnicity as categorical variable or as sub-group compared to all other sub-groups; †-Latino compared with Black

Linked to Care
- No significant difference.

Retained in Care*
- Latinos have significantly better retention.

Filled ART ≥3 months*
- Whites have significantly greater ART use, but Latinos more than Blacks and Asians.

RNA <200/mL at Last Measure*
- Whites have significantly greater viral suppression, but Latinos more than Blacks and Asians.

Horberg, et. Al., AIDS, Patient Care, and STDs; 2015
But Can Also Do for HCV—KPMAS Data

Hepatitis C Cascade of Care
Kaiser-Permanente, Mid-Atlantic States, 2003-2015

1. Screening
Antibody (Ab) Testing

- n = 123,572
- 19% of adults

2. Confirmation
RNA/Genotype Testing

- n = 3,643†
- 86% of Ab+

3. Staging
Fibrosis Measurement (FIB-4)

- N = 3,076
- 93% of RNA+

4. Linkage to Care
GI/ID Referral or TX

- Elevated ALT‡
- Black
- Hispanic
- HIV

5. Cure
SVR

6. Hepatocellular Carcinoma f/u
(Cirrhotics)

LEGEND
* Absolute number with Confirmatory Testing
† Derived from Ab+
‡ Elevated Alanine Transaminase – defined as 2 consecutive measures >60 IU/L
§ Gastroenterology (GI)/Infectious Disease (ID)
1 Ref: Whites
2 Ref: Specialty
3 Ref: Never Used
4 Ref: DC/Suburban MD

For Screening: Hepatitis C in KPMAS

- >5,100 active members with HCV in 2015
  - >10,000 in recent past have had HCV (active or former KP members)
- <10% have ever been treated for HCV
  - Fortunately, ~25-30% have cleared the virus (RNA -, don’t need treatment)
- 40% have not had recent labs or been evaluated by GI
- We are now diagnosing about 90-100 new cases monthly with increased testing

Clinical Infectious Diseases Advance Access published March 10, 2016

Streamlining Screening to Treatment: The Hepatitis C Cascade of Care at Kaiser Permanente Mid-Atlantic States

M. Cabell Jonas, Carla V. Rodriguez, Jacquelyn Red, Dana A. Sloane, Bradley J. Winston, and Bernadette C. Loftus

Mid-Atlantic Permanente Medical Group, Mid-Atlantic Permanente Research Institute, and Gastroenterology Department, Mid-Atlantic Permanente Medical Group, Rockville, Maryland, and Permanente Medical Group, Oakland, California
Hepatitis C Cascade of Care in KPMAS

.HCVPATHWAY

At-Risk Born 1945-1965

MD places 'HCV Antibody & Protocol Order Panel (0210117)' or clicks BPA to initiate screening pathway
Learn More: .HCVPATHWAY

HCV Antibody POSITIVE

Automatic Confirmation Tests (no action needed):
- HCV RNA
- HBsAg
- HIV 1 & 2

HCV RNA POSITIVE / HBsAg POSITIVE

HCV Care Coordinator
- Communicates HCV diagnosis to patient
- Orders additional HCV Labs and Fibroscan

Coordinator Offers:
- Informational video
- Educational sheets

Physician communicates HCV RNA negative results to patient, and counsels patient on risk reduction .HCVABPOSVLNEG

HCV RNA NEGATIVE

HIV +

MD refers patient to Infectious Disease

.END

.HCVNEG

HCV Assessment Labs
- HAV (hepatitis A) Total
- HBsAb
- HCV Genotype
- Hepatic Function Panel
- Ferritin
- Iron, TIBC% saturation
- Prothrombin with INR
- TSH
- CBC
- Creatinine
- Anti-mitochondria
- Anti-smooth muscle
- Anti-nuclear antibody-IFA
- Fibroscan

Coordination communicates final results to patient. Patient referred based on Fibrosis Stage:
- F0, F1, F2, F3, F4

Treatmet options assessed

Screening Pathway Ends (manage in GI)

Activity carried out by the HCV Care Coordinator

Activity carried out by the ordering or consulting physician

.F2-4 GI REFERRAL

Comorbidities, Abnormal Results, or >F2 stage

.F0-1 PRIMARY CARE REFERRAL

Health Maintenance Alert for Annual Tests:
- Fibroscan, CBC, Hepatic Function Panel, Alpha-Fetoprotein

Treatment Deferred

Questions?
Clinical: Dr. Michael Horberg 301-852-9307 (cell) or the GI Chiefs
Operational: Cabell Jonas, PhD 202-594-7836 (cell)
Hepatitis C Care Coordinator: Linda Steeby 703-674-7684

1 Infectious Disease physician completes HCV workup concurrent with HIV treatment
Ordering the Pathway

✓ Best Practice Alert for Baby Boomers
  • If your patient is a Baby Boomer and is eligible, order the new screening pathway by clicking the BPA and placing the order inside.
  • BPA fires in Adult Primary Care, GI, ID, and OBGYN

✓ Within the STI (sexually transmitted infections) Screening Order Set and Adult Health Assessment The new HCV screening pathway replaces the single HCV Ab test in these two Order Sets

![Image of data: 30,260 HCV Antibody and Protocol Order Panel screening orders (as of Feb 2016) - 776 patients diagnosed with chronic HCV, 76.9% of patients with chronic HCV received a Fibroscan]
Ordering for Baby Boomers – Preventive Screening: Click Visit Navigator → Best Practice at Left

Place the order
STI Screening Order Set
Adult Health Assessment Order Set

12/31/2015 visit with Genova, Frank J (M.D.) for Office Visit

- Allergies: Not on file
- Last Vitals: BP: P: R: H: W: H:
- BMI: BSA: 

SmartSets
- Adult Health Assessment

GUIDELINES & EVIDENCE BASED SUMMARIES

PROGRESS NOTES

Please review and update Patient Level Data, including allergies, problem list, medications, immunizations, and history section (PMH, FSH, FH, SH)

- Progress Notes
  - HA, ADULT MALE WITHOUT NORMAL EXAM DEFAULTED
  - HA, ADULT MALE WITH NORMAL EXAM DEFAULTED
  - RIGHT CLICK TO ADD PERSONAL DOCUMENTATION

ORDERS - LAB

- LABORATORY FOR ADULT HA
  - STD & HEPATITIS C SCREENING (One time Hepatitis C testing is recommended for all adults born between 1945 and 1965. One time Hepatitis B testing is recommended for all adults born in high prevalence areas and their children. This includes Southeast Asia and China, sub-Saharan Africa, Eastern Europe and parts of South America.)
  - Use the HCV Antibody and Protocol Order Panel for routine Hepatitis C screening. Pathway automatically tests for HCV RNA (viral load) if HCV Ab positive. If Ab and RNA positive, he Hepatitis C Coordinator will place additional orders including fibroscac
    - OC AND CHLAMYDIA DNA PROBE, URINE
    - OC AND CHLAMYDIA DNA PROBE, PRINT
    - SYPHILIS IGM
    - HIV 1/2 ANTIBODY
    - HEPATITIS B PANEL (HEPB 0 4G, HEPB S A, HEPB CORE KM)
    - HCV ANTIBODY AND PROTOCOL ORDER PANEL

- FUTURE LAB, 6 WKS
- FUTURE LAB, 6 MOS
- VACCINE TITERS
- OTHER VACCINES
The Next Frontier?—Putting the Data at the Provider’s Fingertips
--And Making Them Use It!

Population Health Built-in
PROACTIVE CARE DRIVEN BY TECHNOLOGY

Automatic prompts at every visit in every department

- Care Gap Identification
- Immediate electronic action / order placement / booking to address
- Systematized workflows / Smart Sets
- Document the Right Info

Medical vitals:
- blood pressure
- temperature
- pulse
plus
- BMI
- Smoking
- Exercise
- Alcohol

EXAMPLE
Patient visit to Ophthalmologist can prompt for needed mammogram

What if we did this for HIV?
To Improve Kidney Health among Patients Using ART or PrEP

**Figure 3: Simulation of CDST for ART**

**Figure 4: Simulation of CDST for PrEP**
Concluding Thoughts

- Need to think about the back end as well as the front end of the EHR
- The EHR is a powerful tool
  - But need to know how to use it
- Data across systems is not only coming—it’s here!
- HIPAA is not a small issue
- It has wide application for HIV and HCV
  - For screening, care improvement, quality measurement
- You need a Health Informaticist for best results
“Working together, I am confident that we can stop the spread of HIV and ensure that those affected get the care and support they need.”

--President Barack Obama

Strive only for the best. Be proud. The great work continues. Thank you