FY2020 Effectiveness Measures Guide

The Ryan White HIV/AIDS Program (RWHAP) is a public health program that empowers people with HIV (PWH) to achieve their best health. While health can be defined and measured differently, as an HIV public health program, health outcomes are framed through the HIV care continuum (HCC). The key measure of success is empowering Ryan White clients to achieve viral suppression. When viral suppression is achieved, the chances of transmitting the virus sexually is essentially zero.[1] In turn, increasing population viral suppression rates prevents new HIV infections.

This document describes the effectiveness measures for subrecipients[2] contracted through Hennepin County Public Health's RWHAP for fiscal year 2020 (FY2020). In the outcome grid of the RWHAP contract, subrecipients will find the following performance measures, called an indicator in the contract. Additional information, including a numerator and denominator, are provided in this document that are not found in the contract.

Figure 1: HIV care continuum stages. Credit: Health Resources and Services Administration[3]

[1] Undetectable = Untransmittable (U=U). Minnesota Department of Health. https://www.health.state.mn.us/diseases/hiv/prevention/uu/index.html

[2] Subrecipient is the Health Resources and Services Administration (HRSA) term for contracted provider. Provider and subrecipient will be used interchangeably in this document.

[3] HRSA is the federal funder of the Ryan White HIV/AIDS Program.

Targeted Testing (Early Intervention Services Only)

Subrecipients providing early intervention services will be measure on their ability to identify and test clients within the populations defined in the Early Identification of Individuals with HIV/AIDS (EIIHA)[4] work plan. To meet the expected targeted testing value of 75%, HIV tests can be conducted within any of these demographics:

- African American MSM,
- Hispanic MSM,
- African-born men,
- African-born women, or
- Transgender (any race/ethnicity).

This shift in focus was driven by subrecipient and community feedback. While programs are still encouraged, and often contracted, to focus on specific populations, tests for individuals identified as high risk of exposure that result in case findings are public health successes. As a reminder, event testing should not be geared towards general testing (even within a population) or with the goal of reducing HIV stigma.

In previous fiscal years, the positivity rate measured the effective use of public-funded HIV testing resources. Systemwide analyses reveal positivity rates vary considerably across subrecipients, often due to the random distributions of case findings. Example: If a subrecipient conducts 50 tests and finds 2 case findings vs 0 case findings in a quarter, the positivity rate looks amazing at 4%, though it was only a difference of 2 case findings. While the positivity rate will be evaluated from a system level by HCPH, it will not be used at a subrecipient level.

Definition: Targeted Testing

Targeted Testing Terminology	Defined
Indicator	Percentage of Eligible Persons tested who are in the targeted demographic(s) of African American MSM, Hispanic MSM, African-born men, African-born women, or transgender (any race/ethnicity).
- Indicator Explained	Eligible Persons is any client you conduct an HIV test with.
- Numerator	The number of HIV tests conducted with clients in the defined demographic groups.
- Denominator	The total number of HIV tests conducted.
Who Applied to	Eligible Persons
Time of Measure	Annual
Data Source	EvaluationWeb
Obtained By	Provider

[4] EIIHA is annual governmental and community collaboration, required by Ryan White funding, to coordinate efforts to identify people unaware of their HIV status .

Targeted Testing Terminology	Defined
Performance Goal	75%

Case Findings

- Case Finding Newly Diagnosed – Individuals unaware of their status and newly diagnosed.
- Case Finding Out of Care – Individuals who have not had a medical appointment in the last six months (or one year if virally suppressed).

Linkage to care

Linkage to care is defined by the HIV/AIDS Bureau (HAB)[5] as "Percentage of patients, regardless of age, who attended a routine HIV medical care visit within 1 month of HIV diagnosis." In addition to measuring linkage to care for newly diagnosed clients, Hennepin County Public Health (HCPH) and its subrecipients track linkage to care for out of care case findings.

Outreach services were merged with early intervention services beginning this fiscal year.

Linkage to Care for newly diagnosed clients

The numbers presented here represents all case findings of HCPH's funded subrecipients, regardless of geography. Though, most of these clients live within the Minneapolis-St. Paul Transitional Grant Area (MSP-TGA). The date ranges represent when a case finding was identified.

Case Finding Type	Jan 1, 2018 – Dec 31, 2018	Jan 1, 2019 – Oct 31, 2019	FY2020 Expectation
Newly Diagnosed (Clinical)	88% (22/25)	91% (30/33)	90%
Newly Diagnosed (Community)	71% (15/21)	100% (13/13)	90%

[5] Housed within Health Resources and Services Administration (HRSA), the federal funder of the Ryan White HIV/AIDS Program. You can find the full list of HAB defined measures here: https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio

Definition: Linkage to care for newly diagnosed clients

Linkage to Care Terminology	Defined
Indicator	Percentage of Eligible Persons who attend an HIV medical care appointment within 30 days of diagnosis.
- Indicator Explained	As noted in the table above, linkage to care is measured separately for clinical and community case findings (Eligible Persons). All case findings for The Aliveness Project are community case findings. Minnesota Community Care and Red Door will need to determine if a newly diagnosed patient is a community or clinical case finding. Newly diagnosed (clinical): initial HIV diagnosis identified in a clinical setting Newly diagnosed (community): initial HIV diagnosis identified through community outreach. HCPH can provide further guidance if the distinction is unclear.
- Numerator	Number of clients who attended a routine HIV medical care visit within 30 days of the case finding date. The case finding date is the date of diagnosis.
- Denominator	Number of clients identified as a newly diagnosed case findings.
Who Applied to	Eligible Persons
Time of Measure	Annual
Data Source	CAREWare
Obtained By	Provider
Performance Goal	90%

Linkage to Care for out of care/previously diagnosed clients

The numbers presented here represents all case findings of HCPH's funded subrecipients, regardless of geography. Though, most of these clients live within the Minneapolis-St. Paul Transitional Grant Area (MSP-TGA). The date ranges represent when a case finding was identified.

Case Finding Type	Jan 1, 2018 – Dec 31, 2018	Jan 1, 2019 – Oct 31, 2019	FY2020 Expectation
Out of Care/Previously Diagnosed	76% (44/58)	80% (31/39)	90%
Data to Care[6]	83% (5/6)	75% (6/8)	90%

Definition: Linkage to care for out of care/previously diagnosed clients

Linkage to Care Terminology	Defined
Indicator	Percentage of Eligible Persons who know their HIV status and have not been in for an HIV medical appointment in the past 6 months who are reconnected to care within 30 days of determination.
- Indicator Explained	Beginning in FY2020, case findings (Eligible Persons) for out of care/previously diagnosed clients will be separated into clinical vs community in the same manner as newly diagnosed case findings. Newly diagnosed (clinical): case finding is identified at a clinical visit Newly diagnosed (community): case finding is identified through community outreach. HCPH can provide further guidance on a if the distinction is unclear.
- Numerator	Number of clients who attended a routine HIV medical care visit within 30 days of the case finding date.
- Denominator	Number of clients identified as a case finding.
Who Applied to	Eligible Persons
Time of Measure	Annual
Data Source	CAREWare
Obtained By	Provider
Performance Goal	90%

[6] The Data to Care program utilizes HIV surveillance data to reach out to people with HIV who are out of care. This work can only be conducted by public health departments. This program is responsible for this work in Hennepin County only.

Retention in Care

Retention in care is defined as a Ryan White client having evidence of at least one HIV medical appointment in the measurement year. The following table presents systemwide outcomes for the Minneapolis-St. Paul Transitional Grant Area.

Service Activity	Jan 1, 2018 – Dec 31, 2018	Jul 1, 2018 – Jun 30 2019	FY2020 Expectation
Early Intervention Services	Early intervention services is measured for linkage to care, not retention in care.		
Food Bank/Home-Delivered Meals	See below by service activity.		
- Food Shelf	98.4% (671/682)	96.4% (694/720)	98%
- Home-delivered Meals	98.7% (301/305)	97.1% (402/414)	98%
- On-site Meals	96.7% (763/789)	95.4% (882/925)	98%
Health Education/Risk Reduction	97.8% (227/232)	98.3% (238/242)	98%
Home and Community-based Health Services	<100	<100	98%
Housing	<100	<100	98%
Legal Services	97.6% (279/286)	96.4% (293/304)	98%
Medical Case Management	97.4% (1,910/1,961)	97.7% (2,347/2,402)	98%
Medical Case Management: Adult Foster Care	<100	<100	98%
Medical Case Management: Treatment Adherence	99.8% (549/550)	99.6% (540/542)	98%
Medical Nutrition Therapy	98.5% (464/471)	98.6% (427/433)	98%
Medical Transportation Services	99.0% (1,421/1,436)	98.6% (1,566/1,588)	98%
Mental Health Services	98.8% (579/586)	98.3% (468/476)	98%
Outpatient/ambulatory Health Care Services (OAHS)†	100% (921/921)	100% (1,020/1,020)	n/a
Psychosocial Support Services	99.6% (243/244)	99.1% (213/215)	98%
Substance Abuse: Outpatient	98.0% (289/295)	97.7% (303/310)	98%

† By definition, all OAHS clients are retained in care. OAHS is measured on ART prescription and viral suppression.

Definition: Retention in Care

Retention in Care Terminology	Defined
Indicator	Percentage of Eligible Persons who have attended an HIV medical appointment in the past 12 months as evidenced by a viral load, CD4 count, or Form I medical appointment date documented in CAREWare.
- Indicator Explained	Eligible Persons are Ryan White clients served during the time of measure. The retention in care rate will be measured on a rolling 12 month period for quarterly reports. Since retention in care is consistently high across service activities, the subrecipient will be asked to provide retention in care for their entire program, not by funding source or service activity.
- Numerator	Number of Ryan White clients in the defined group who have evidence of at least one HIV medical appointment in the measurement year
- Denominator	Number of Ryan White clients in the defined group who received at least one Ryan White service in the measurement year
Who Applied to	Eligible Persons
Time of Measure	Annual
Data Source	CAREWare, eHARS[7]
Obtained By	Provider
Performance Goal	98%

[7] eHARS is the acronym for enhanced HIV/AIDS reporting system. This is the HIV surveillance system used by the Minnesota Department of Health. In line with the Health Commissioner's order, select lab values from the surveillance system are uploaded to CAREWare for Ryan White clients.

ART Prescription (OAHS only)

HRSA continues to require ART prescription as a performance measure for outpatient/ambulatory health care service (OAHS). When receiving ART prescription data directly from the OAHS subrecipient, HCPH recognized ART prescription rates are essentially 100%. Documenting ART prescriptions in CAREWare demonstrates to the Ryan White federal funder that great HIV work is happening here in Minnesota.

Despite the reality being nearly 100%, there have been historical issues of documenting ART prescriptions in CAREWare. In 2019, ART prescription data completeness was a focus of the CAREWare team. While complete 2019 data is not yet available (as of April 22, 2020), preliminary analysis shows vast improvements in data completeness. HCPH appreciates OAHS subrecipients' efforts with the CAREWare team to improve this data completeness.

Definition: ART Prescription

ART Prescription Terminology	Defined
Indicator	Percentage of Eligible Persons, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the past twelve months.
- Indicator Explained	Eligible Persons are any clients who received an OAHS service. ART Prescription will be measured on a rolling 12-month period for quarterly reports.
- Numerator	The number of Ryan White clients who have an ART prescription documented in CAREWare.
- Denominator	The total number of Ryan White clients who received OAHS services.
Who Applied to	Eligible Persons
Time of Measure	Annual
Data Source	CAREWare
Obtained By	Provider
Performance Goal	98%

Viral Suppression

Viral suppression is the ultimate measure of success in the Ryan White HIV/AIDS Program. The following table presents systemwide outcomes for the Minneapolis-St. Paul Transitional Grant Area. HIV viral loads in CAREWare are uploaded from eHARS and by Ryan White funded outpatient/ambulatory health service (OAHS) subrecipients. The percentage missing indicates the percentage of Ryan White clients that do not have a documented viral load in CAREWare. Clients without a viral load are not included in the denominator. This contrasts with the definition used by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH). For this reason, viral suppression rates released by MDH for the statewide HIV care continuum are *not* comparable to the percentages found here.

Service Activity	Jan 1, 2018 – Dec 31, 2018	Jul 1, 2018 – Jun 30 2019	FY2020 Expectation
Early Intervention Services	Early intervention services is measured for linkage to care only, not viral suppression.		
Food Bank/Home-delivered Meals	See below by service activity.		
- Food Shelf	88.5% (531/600), 12.0% missing	87.8% (539/614), 9.8% missing	n/a
- Home-delivered Meals	91.2% (250/274), 10.2% missing	92.2% (273/296), 8.9% missing	n/a
- On-site Meals	89.3% (615/689), 12.7% missing	88.9% (675/759), 10.5% missing	n/a
Health Education/Risk Reduction	82.4% (169/205), 11.6% missing	83.9% (167/199), 8.7% missing	86%
Home and Community-based Health Services	<100	<100	n/a
Housing	<100	<100	86%
Legal Services	94.3% (246/261), 8.7% missing	91.4% (224/245), 10.6% missing	n/a
Medical Case Management	88.1% (1,530/1,737), 11.4% missing	89.4% (1,572/1,758), 9.2% missing	91%
Medical Case Management: Adult Foster Care	<100	<100	91%
Medical Case Management: Treatment Adherence	91.0% (487/535), 2.7% missing	92.4% (476/515), 4.1% missing	94%
Medical Nutrition Therapy	92.6% (402/434), 7.9% missing	86.5% (269/311), 5.2% missing	94%
Medical Transportation Services	88.3% (1,176/1,332), 7.2% missing	87.7% (1,137/1,297), 7.1% missing	n/a
Mental Health Services	89.6% (506/565), 3.6% missing	91.2% (392/430), 5.1% missing	93%
Outpatient/ambulatory Health Care Services	92.7% (833/899), 2.4% missing	91.3% (887/972), 4.1% missing	94%
Psychosocial Support Services	88.9% (208/234), 4.1% missing	91.9% (181/197), 4.4% missing	n/a

Service Activity	Jan 1, 2018 – Dec 31, 2018	Jul 1, 2018 – Jun 30 2019	FY2020 Expectation
Substance Abuse: Outpatient	80.8% (214/265), 10.2% missing	83.9% (239/285), 5.9% missing	86%

How were viral suppression expectations determined?

For housing services, 86% is the systemwide viral suppression rate for clients who are temporarily housed.

If the viral suppression rate was less than 85%, the expectation took the higher percentage of the two time periods and added 2%, then rounded to an integer value.

If viral suppression was greater than 85%, the expectation took the higher percentage of the two time periods and added 1.5%, then rounded to an integer value. Since Medical Case Management: Adult Foster Care serves less than 100 clients, it was decided to mirror the 91% for Medical Case Management.

Definition: Viral Suppression

Viral Suppression Terminology	Defined
Indicator	Percentage of Eligible Persons, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at their last HIV viral load test during the past twelve months.
- Indicator Explained	Eligible Persons are Ryan White clients served during the time of measure. The viral suppression rate will be measured on a rolling 12 month period on quarterly reports.
- Numerator	Number of Ryan White clients in the defined group with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year
- Denominator	Number of Ryan White clients in the defined group who received at least one Ryan White service in the measurement year and have a documented viral load in CAREWare. Clients without a documented viral load in CAREWare should be excluded from the denominator.
Who Applied to	Eligible Persons
Time of Measure	Annual
Data Source	CAREWare, eHARS
Obtained By	Provider
Performance Goal	Health education/risk reduction: 86% Housing: 86% Medical case management, including adult foster care: 91% Medical case management: treatment adherence: 94% Medical nutrition therapy: 94% Mental health services: 93% Outpatient/ambulatory health services: 94%

Viral Suppression Terminology	Defined
	Substance abuse: outpatient services: 86%

Contact

If you have additional questions or comments, please reach out to your contract manager.

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