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.

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**HIV CARE CONTINUUM:**

The series of steps a person with HIV takes from initial diagnosis through their successful treatment with HIV medication

- Diagnosed with HIV
- Engaged or Retained in Care
- Linked to Care
- Achieved Viral Suppression
- Prescribed Antiretroviral Therapy

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

<table>
<thead>
<tr>
<th>Targeted Testing Terminology</th>
<th>Defined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>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).</td>
</tr>
<tr>
<td>- Indicator Explained</td>
<td>Eligible Persons is any client you conduct an HIV test with.</td>
</tr>
<tr>
<td>- Numerator</td>
<td>The number of HIV tests conducted with clients in the defined demographic groups.</td>
</tr>
<tr>
<td>- Denominator</td>
<td>The total number of HIV tests conducted.</td>
</tr>
<tr>
<td>Who Applied to</td>
<td>Eligible Persons</td>
</tr>
<tr>
<td>Time of Measure</td>
<td>Annual</td>
</tr>
<tr>
<td>Data Source</td>
<td>EvaluationWeb</td>
</tr>
<tr>
<td>Obtained By</td>
<td>Provider</td>
</tr>
</tbody>
</table>

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\(^4\) EIIHA is annual governmental and community collaboration, required by Ryan White funding, to coordinate efforts to identify people unaware of their HIV status.
<table>
<thead>
<tr>
<th>Targeted Testing Terminology</th>
<th>Defined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Goal</td>
<td>75%</td>
</tr>
</tbody>
</table>

**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.

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

\(^5\) 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**

<table>
<thead>
<tr>
<th>Linkage to Care Terminology</th>
<th>Defined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Percentage of Eligible Persons who attend an HIV medical care appointment within 30 days of diagnosis.</td>
</tr>
</tbody>
</table>

- **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.

<table>
<thead>
<tr>
<th>Case Finding Type</th>
<th>Jan 1, 2018 – Dec 31, 2018</th>
<th>Jan 1, 2019 – Oct 31, 2019</th>
<th>FY2020 Expectation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of Care/Previously Diagnosed</td>
<td>76% (44/58)</td>
<td>80% (31/39)</td>
<td>90%</td>
</tr>
<tr>
<td>Data to Care⁶</td>
<td>83% (5/6)</td>
<td>75% (6/8)</td>
<td>90%</td>
</tr>
</tbody>
</table>

**Definition: Linkage to care for out of care/Previously diagnosed clients**

<table>
<thead>
<tr>
<th>Linkage to Care Terminology</th>
<th>Defined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>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.</td>
</tr>
<tr>
<td>- Indicator Explained</td>
<td>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.</td>
</tr>
<tr>
<td>- Numerator</td>
<td>Number of clients who attended a routine HIV medical care visit within 30 days of the case finding date.</td>
</tr>
<tr>
<td>- Denominator</td>
<td>Number of clients identified as a case finding.</td>
</tr>
<tr>
<td>Who Applied to</td>
<td>Eligible Persons</td>
</tr>
<tr>
<td>Time of Measure</td>
<td>Annual</td>
</tr>
<tr>
<td>Data Source</td>
<td>CAREWare</td>
</tr>
<tr>
<td>Obtained By</td>
<td>Provider</td>
</tr>
<tr>
<td>Performance Goal</td>
<td>90%</td>
</tr>
</tbody>
</table>

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.

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

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

<table>
<thead>
<tr>
<th>Retention in Care Terminology</th>
<th>Defined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>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.</td>
</tr>
</tbody>
</table>

- **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

<table>
<thead>
<tr>
<th>Who Applied to</th>
<th>Eligible Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time of Measure</td>
<td>Annual</td>
</tr>
<tr>
<td>Data Source</td>
<td>CAREWare, eHARS&lt;sup&gt;7&lt;/sup&gt;</td>
</tr>
<tr>
<td>Obtained By</td>
<td>Provider</td>
</tr>
<tr>
<td>Performance Goal</td>
<td>98%</td>
</tr>
</tbody>
</table>

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<sup>7</sup> 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**

<table>
<thead>
<tr>
<th>ART Prescription Terminology</th>
<th>Defined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>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.</td>
</tr>
<tr>
<td>- Indicator Explained</td>
<td>Eligible Persons are any clients who received an OAHS service. ART Prescription will be measured on a rolling 12-month period for quarterly reports.</td>
</tr>
<tr>
<td>- Numerator</td>
<td>The number of Ryan White clients who have an ART prescription documented in CAREWare.</td>
</tr>
<tr>
<td>- Denominator</td>
<td>The total number of Ryan White clients who received OAHS services.</td>
</tr>
<tr>
<td>Who Applied to</td>
<td>Eligible Persons</td>
</tr>
<tr>
<td>Time of Measure</td>
<td>Annual</td>
</tr>
<tr>
<td>Data Source</td>
<td>CAREWare</td>
</tr>
<tr>
<td>Obtained By</td>
<td>Provider</td>
</tr>
<tr>
<td>Performance Goal</td>
<td>98%</td>
</tr>
</tbody>
</table>
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.

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

<table>
<thead>
<tr>
<th>Viral Suppression Terminology</th>
<th>Defined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>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.</td>
</tr>
<tr>
<td>- Indicator Explained</td>
<td>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.</td>
</tr>
<tr>
<td>- Numerator</td>
<td>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</td>
</tr>
<tr>
<td>- Denominator</td>
<td>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.</td>
</tr>
<tr>
<td>Who Applied to</td>
<td>Eligible Persons</td>
</tr>
<tr>
<td>Time of Measure</td>
<td>Annual</td>
</tr>
<tr>
<td>Data Source</td>
<td>CAREWare, eHARS</td>
</tr>
<tr>
<td>Obtained By</td>
<td>Provider</td>
</tr>
<tr>
<td>Performance Goal</td>
<td>Health education/risk reduction: 86%</td>
</tr>
<tr>
<td></td>
<td>Housing: 86%</td>
</tr>
<tr>
<td></td>
<td>Medical case management, including adult foster care: 91%</td>
</tr>
<tr>
<td></td>
<td>Medical case management: treatment adherence: 94%</td>
</tr>
<tr>
<td></td>
<td>Medical nutrition therapy: 94%</td>
</tr>
<tr>
<td></td>
<td>Mental health services: 93%</td>
</tr>
<tr>
<td></td>
<td>Outpatient/ambulatory health services: 94%</td>
</tr>
<tr>
<td>Viral Suppression Terminology</td>
<td>Defined</td>
</tr>
<tr>
<td>------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Substance abuse: outpatient services: 86%</td>
<td></td>
</tr>
</tbody>
</table>

**Contact**

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

Ryan White HIV/AIDS Program  
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