



Department
of Health

AIDS
Institute

2026
Review
of 2025
Care

ATTENTION

The official deadline
for submission is
May 20, 2026.

Processing of
submissions will begin
on May 1, 2026.

2026 Organizational HIV Treatment Cascade Review of Care Provided in 2025

PROGRAM OVERVIEW AND INSTRUCTIONS FOR REPORTING VIA THE
HEALTH COMMERCE SYSTEM

NYS DOH QUALITY OF CARE PROGRAM

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Overview and General Guidance

Background of the Organizational HIV Treatment Cascade

Ensuring that all people with HIV receive high-quality medical care remains a top priority in combating the HIV/AIDS epidemic in the United States, yet achieving this goal remains a challenge. For providers to have an accurate understanding of the quality of care they deliver to people with HIV in their organizations, they must be able to collect, analyze, and visualize data on their performance. The HIV Treatment Cascade, when applied to a clinic population, allows providers to better identify gaps along the care continuum, from linkage and engagement in care to viral suppression. This represents a key strategy in our ongoing efforts to end the HIV epidemic in New York State. The Organizational HIV Treatment Cascade provides health care institutions with a standardized tool to:

1. Monitor the extent and quality of care being delivered to all people with HIV seen at an organization, and not just those who are actively engaged in their HIV program.
2. Identify gaps in the sequence of steps between diagnosis and viral suppression.
3. Develop data-driven plans to assess and improve gaps within an organization's care continuum through quality improvement (QI) activities.
4. In addition, organizational HIV treatment cascade data are integrated into New York State regional quality improvement collaboratives and quality learning networks to drive our collective efforts and progress toward ending the epidemic.

This reporting system was created with the needs of healthcare providers in mind, providing expedited feedback related to the care of all people with HIV who touch the organization. A Microsoft Excel submission template automates data validation and analysis, allowing providers to view gaps in care with a few clicks. (Users who do not have access to Excel can use free, opensource alternative spreadsheet programs to enter and submit the data. Some other functions may not be available.) Through the secure collection of patient-level data, results are compiled individually for each organization as well as across the State. The required data fields are aligned with those mandated by Ryan White Services Report (RSR) and offer analytical insights into demographic factors that are associated with viral suppression.

New York State organizations that provide medical care to people with HIV are expected to complete this template and submit it to the New York State Department of Health AIDS Institute via the Health Commerce System; submissions that pass validation checks will be incorporated into a secure AIDS Institute database.

All submissions will be reviewed by an AIDS Institute Quality Coach and Data Analyst. Approval will involve a review of an organization's adherence to required submission components described in these instructions and a satisfactory analysis of cascade data leading to a responsive quality improvement plan. Feedback will be provided to guide the integration of the cascades into organizations' ongoing quality management programs.

Data Use Policies

Validated submissions are stored on a secure server within the AIDS Institute. To review submissions and provide advice regarding ongoing quality improvement work, our Quality of Care Coaches use a dedicated intranet application to view aggregated results and the statements about methodology, key findings, quality improvement projects and consumer involvement as well as a list of quality tools used by the submitting organization. Quality of Care Program data management staff and affiliated data systems developers have secure access as well to patient-level data. This allows for ongoing web application development and close review of submissions for any data integrity concerns.

Organization- and clinic-level results are available for each participating organization within their data template. To put these results into context for the participants and identify statewide trends, the Quality of Care Program scores and analyzes the data collected from all providers. The Program then develops quality improvement profiles specific to each participating organization and annual benchmark and quality improvement activity reports. With the permission of the submitting organization, we post profiles for organizations with exemplary quality improvement work on the New York State Ending the Epidemic Dashboard. After Executive Deputy Commissioner clearance but without additional provider approval, we also post key indicator results, with facility identifiers, on the Health Data NY website.

To advance the public health objectives of the AIDS Institute, the Program occasionally uses the aggregated data for research studies. Recent work has included a regression analysis of the patient- and facility-level factors associated with immediate initiation of antiretroviral medication. Other planned research includes review of outcomes specific to more elderly patients. Some of this work may involve matching these data with other identified data collected by the AIDS Institute to inform collaborative studies. These projects typically do not involve attribution of particular participating organizations, and we will review research results with any named organizations before submitting anything for publication.

Finally, within the constraints of specific data use agreements and without provision of any patient identifying information, we may share data reports and summaries with the New York City Department of Health and Mental Hygiene and other public health agencies.

The Reporting System for Review of Care Provided in 2025

Data Template

Prior to 2019, organizations were asked to collect and validate their data to create organizational treatment cascades manually: one for newly diagnosed/new-to-care patients and two for previously diagnosed patients. Guidance was provided through a document and coaching, but data validation, cascade design, and construction were carried out by the organizations using their own resources.

This year, the New York State Department of Health HIV Quality of Care Program is continuing to use the **Excel submission template** created in 2019 (for review of care provided in 2018) where the following tasks are performed in one place (asterisks designate automated features):

- 1) patient-level data collection
- 2) data sorting*
- 3) data validation*
- 4) scoring of cascade indicators*
- 5) generation of charts depicting scored cascade indicators*
- 6) scoring of patient-level data*

- 7) generation of a patient-level scored data report*
- 8) generation of a pivot-table report*
- 9) generation of analytical data for chi-square tests and logistic regression analyses*

The template will also store the following written statements:

- 10) field-specific responses to data validation warnings
- 11) methodology (general and specific to frailty/functional status screening)
- 12) key findings
- 13) planned quality improvement (QI) projects
- 14) updates on previous quality improvement (QI) projects
- 15) consumer involvement

All healthcare organizations participating in this review are asked to appoint a person responsible for submitting the template on their organization's behalf. When all elements of the template are filled out and completed, the template must then be uploaded via the **Health Commerce System**, a secure file-sharing platform, for final processing and storage on a secure DOH data server. The organization's Coach should be notified via direct email (i.e., outside of the Health Commerce System, and without any attachments) when templates are submitted.

New for This Year's Review

The most significant change this year is the addition of two new fields:

- Sexual Orientation
- ARV Mode

Both of these apply to all patients although an NA option is available for ARV Mode when the patient did not receive antiretroviral medications in 2025. A full list of the options for each of these fields is provided in Appendix 1.

Related to the inclusion of a Sexual Orientation field, we have consolidated two options for the HIV Exposure Risk: heterosexual exposure (MSM) and exposure between men who have sex with men (MSM) have been replaced with a single option for sexual exposure (SEXUAL). Of note, this new option would also apply to patients who do not identify as either a heterosexual person or a gay man but were exposed to HIV through sexual contact.

Another significant change is modification of the frailty indicator that we piloted in the last review:

- **This indicator is now required.**
- Eligibility is now all patients enrolled in care, regardless of whether they were established in care or new to the organization (so either ACTEST or ACTNEW for Enrollment), who were at least 51 years old by the end of the review period or who acquired HIV through perinatal transmission and were at least at 31 years old by the end of the review period.
- To reflect the nature of the acceptable screens, the indicator has been renamed to Frailty or Functional Status Screening.
- The distinction between recommended and other screens has been removed so the options are simply NO, YES, UK or NA. However, please see Appendix 4 for some suggested screens.

Other changes of note include:

- We added an additional option for Insurance (ESSENTIAL) for patients who are covered by any of the NYS Essential Plans. See Appendix 2 for additional guidance on making selections for the Insurance field.
- On the Statements worksheet, we have added a 2nd methodology statement specific to the use of frailty and functional status screens.
- On the Control Panel worksheet, we have added breakout data for results by sexual orientation and mode of ARV (injection, oral, or both). Corresponding changes have also been made to the Charts, Scored Data, Pivot Table and Data Analysis worksheets.

Process Diagram

A schematic overview of the Organizational HIV Treatment Cascade Review is laid out on the next page in **Figure 1: Overview of Organizational Treatment Cascade Data Collection and Reporting**. Template users may refer to the flow diagram for a bird's eye view of the data sorting and reporting process. For a breakdown of patient-level outcome reporting requirements, users may refer to **Figure 2: Diagnosis Status and Reporting of Antiretroviral Treatment, Viral Suppression, Resistance Testing and Frailty/Functional Status Screening**.

[Instructions continue on the next page.]

Figure 1: Overview of Organizational Treatment Cascade Data Collection and Reporting

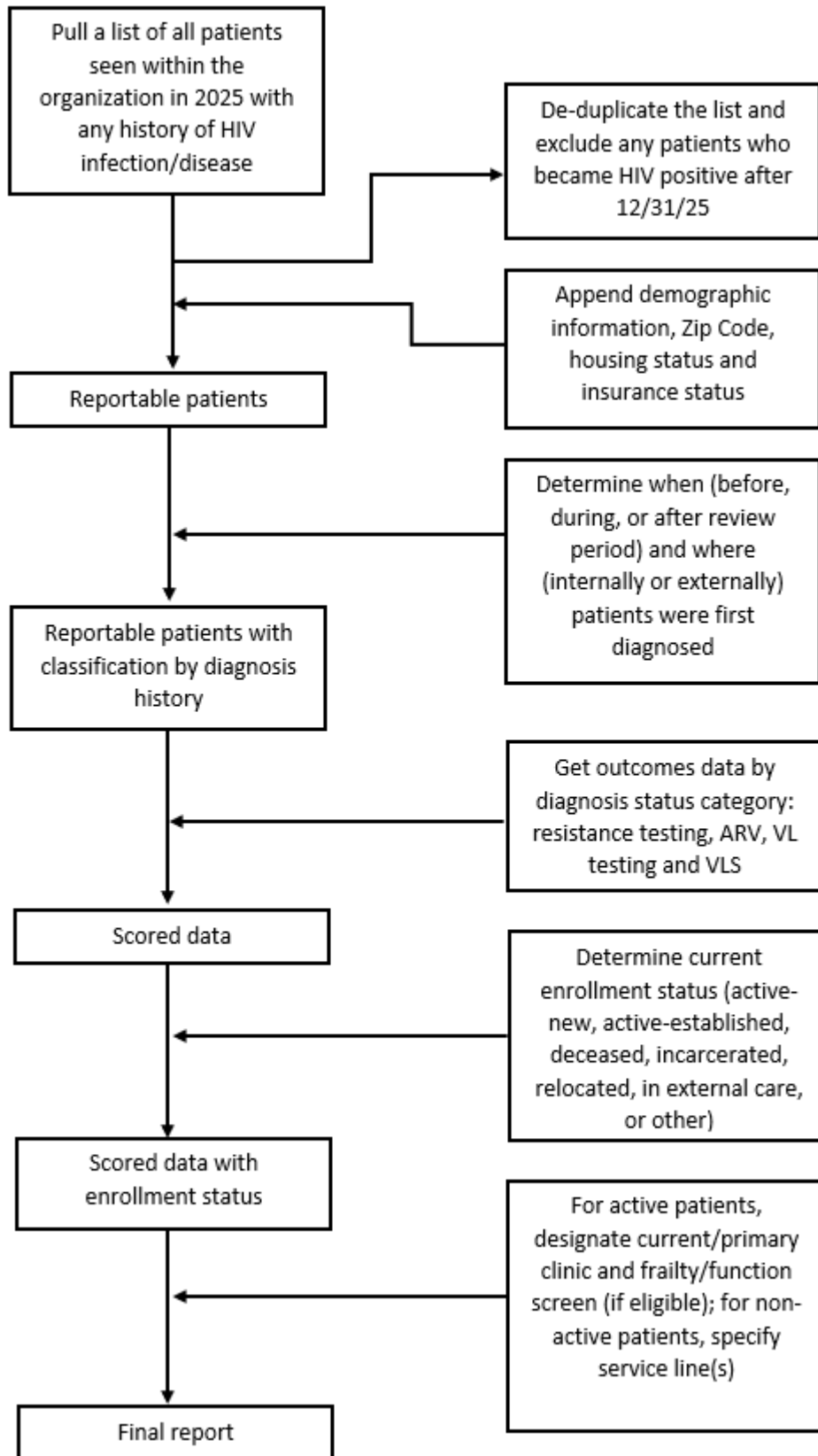
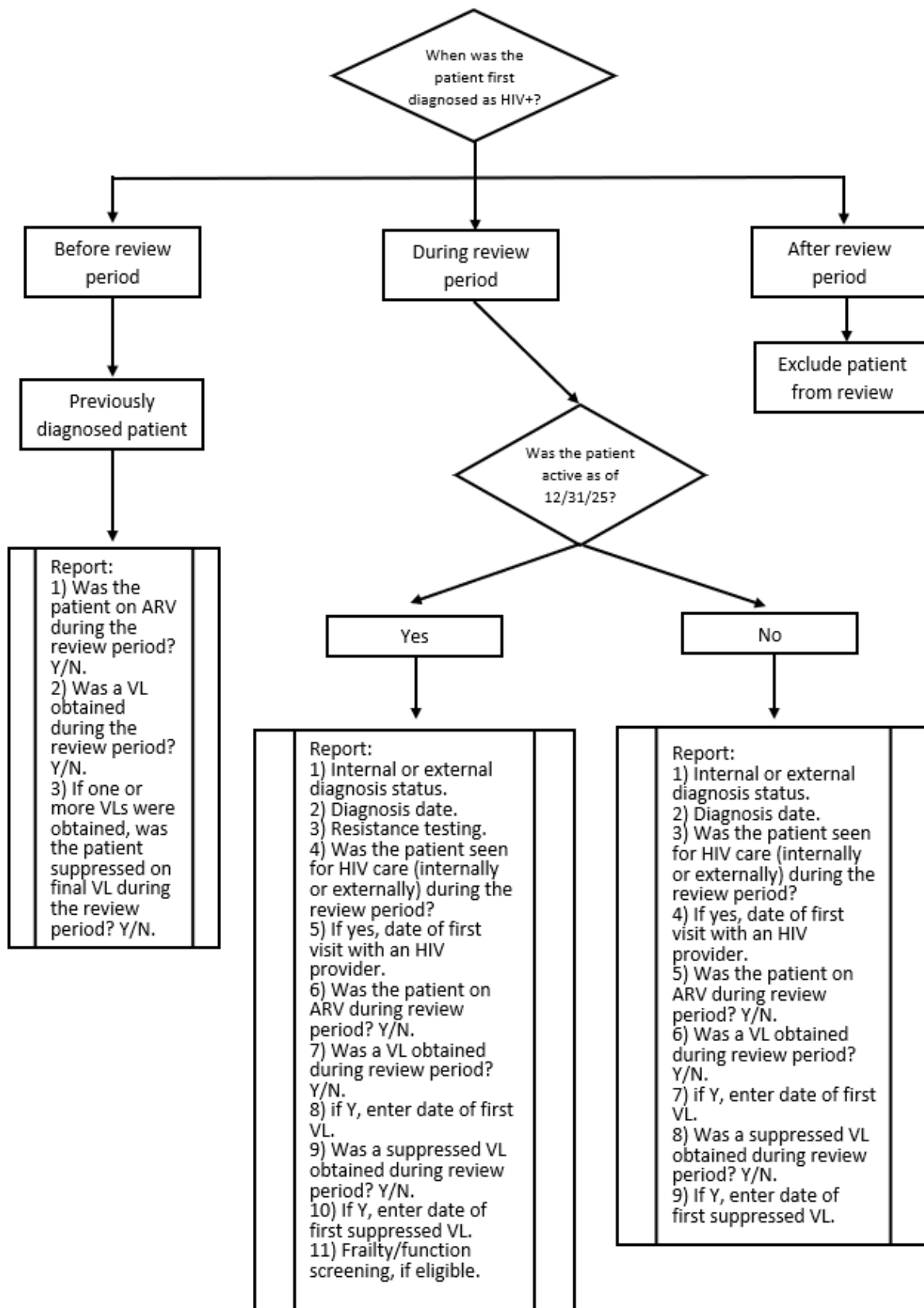


Figure 2: Diagnosis Status and Reporting of Antiretroviral Treatment, Viral Suppression, Resistance Testing and Frailty/Functional Status Screening



Visualizing Cascade Indicator Results and Charts

Indicator eligibility is dependent on care status. Please see the care status chart in Appendix 9 and the indicator scoring table in Appendix 10 for details.

Please note that all individuals with HIV who were seen at the organization in 2025 should be included in the patient-level submission, including those who died during the review period or were incarcerated, relocated or confirmed to be receiving ongoing HIV care at another site as of the end of the review period.

The Cascade Data Template will automatically generate reports and cascades as follows:

- **Newly Diagnosed Patients:** One cascade will automatically be generated for all patients diagnosed in 2025 who had at least one medical or medically supportive care visit within the organization.
 - *Linked-to-Care:* All patients diagnosed with HIV at the organization in 2025 who were linked to care within 3 calendar days from date of diagnosis (and before the end of the review year). A patient is considered to have been linked to medical care if the individual attended a routine HIV medical visit with a treating physician¹ or if the patient was prescribed antiretroviral medication following a positive diagnosis.
 - *Antiretroviral Therapy:* All newly diagnosed patients who were prescribed antiretroviral therapy, other than pre- or post-exposure prophylaxis in 2025. Eligible patients include those enrolled in care (“active”) or are of unknown care status as of the end of the review period.
 - *Baseline Resistance Testing:* All newly diagnosed patients enrolled in HIV care with a record of a baseline resistance test within the review year.
 - *Viral Load Testing:* All newly diagnosed patients with a recorded viral load test within 91 days from diagnosis (and before the end of the review year). Eligible patients include those enrolled in care (“active”) or of unknown care status as of the end of the review period.
 - *Viral Suppression:* All newly diagnosed patients with viral load <200 copies/mL within 91 days from diagnosis (and before the end of the review year). Eligible patients include those enrolled in care (“active”) or of unknown care status as of the end of the review period.

- **Other New-to-Care Patients:** One cascade will automatically be generated for all patients who were diagnosed prior to 2025 but were new to an organization’s HIV clinical care program (or returning after not being seen or having a viral load test in the 2 prior calendar years), having had at least one visit with a medical provider who had the capacity to prescribe antiretroviral medication in 2025.
 - *Antiretroviral Therapy:* All other new-to-care patients who were prescribed antiretroviral therapy in 2025. Eligible patients include those enrolled in care as of the end of the review period.
 - *Viral Load Testing:* All other new-to-care patients with a recorded viral load during the review period. Eligible patients include those enrolled in care as of the end of the review period.

¹ A routine HIV medical visit is defined as any clinical care visit with a clinician with antiretroviral therapy prescribing privileges where management of HIV disease is discussed. People with HIV are considered successfully linked if they attend this initial medical visit, irrespective of whether antiretroviral therapy is initiated during that visit.

- *Viral Suppression*: All other new-to-care patients with a viral load <200 copies/mL at last viral load test of 2025. Eligible patients include those enrolled in care as of the end of the review period.
- **Other Previously Diagnosed Patients**: Two cascades will automatically be generated for all other previously diagnosed patients.
 - **Open Caseload**: All previously diagnosed patients who received any services from the organization within 2025, except those who were new to care in 2025 (or returning after two or more years) or who were deceased, incarcerated, relocated outside NYS, or confirmed to be in care elsewhere by the end of the year.
 - *Antiretroviral Therapy*: All open patients who were prescribed antiretroviral therapy in 2025.
 - *Viral Load Testing*: All open patients with a recorded viral load test in 2025.
 - *Viral Suppression*: All open patients with a viral load <200 copies/mL at last viral load test of 2025.
 - **Established Active Caseload**: All previously diagnosed patients who received HIV clinical care services from a medical provider with the capacity to prescribe antiretroviral medications within the organization in 2025, except those new to care in 2025.
 - *Antiretroviral Therapy*: All established active patients who were prescribed antiretroviral therapy during 2025.
 - *Viral Load Testing*: All established active patients with a documented viral load test in 2025.
 - *Viral Suppression*: All established active patients with a viral load <200 copies/mL at last test of 2025.
- **Older Patient Caseload**: While we have been reporting breakout data by age for antiretroviral therapy, viral load testing and viral suppression, we have recently added an assessment of frailty/functional status screening among older patients. This applies only to patients enrolled in care, and the age cutoff (at end of year) is 51 years or older for most patients but 31 years or older for patients who acquired HIV perinatally.

Other features of the cascade data:

- Automated drill down of established active caseload by key characteristics: this will help identify ongoing disparities in clinical outcomes among subpopulations of people with HIV enrolled in an organization's HIV primary care program.
- We automate calculation of the active caseload, prescription of antiretroviral therapy, receipt of a viral load test, and viral suppression rate for each of these subgroups.
- Service delivery points for non-active caseload: to better target re-engagement interventions among people with HIV without evidence of ongoing HIV care, organizations will be expected to report the **service delivery points** visited by open-caseload people with HIV who did **not** receive HIV primary care services within the organization (and who were not receiving external HIV care, incarcerated, relocated or deceased as of the end of the review period). In other words, organizations will be expected to report the delivery points at which non-active open caseload patients received services.
 - Report service delivery points for non-active patients.
 - We automate calculation of how many non-active patients were seen at each delivery point.
 - Service delivery points include:
 - Emergency Department/Urgent Care
 - Inpatient care, including intensive care unit, surgery, and psychiatric care.

- Primary care (outside of HIV clinic(s))
- Faculty practice HIV care
- Non-HIV specialty care such as cardiology, pulmonology, etc.
- Reproductive health services
- Mental and behavioral health services
- Dental services
- Supportive services
- Other (please specify)

Reporting Methodology

For cascades to be understood by internal and external stakeholders, the methodology underlying their construction should be transparently reported. Organizations will therefore be expected to provide detailed answers to the following questions:

First section:

- ✓ What sources of data were used for the patient level data?
- ✓ How were service delivery points determined and verified for non-active open caseload patients?
- ✓ How were patients determined to be deceased, relocated outside New York State, incarcerated, or in care at an outside organization?
- ✓ How were date of diagnosis, first care date, first viral load date and first suppressed viral load date determined for the newly diagnosed patients?
- ✓ How were patients newly diagnosed internally distinguished from those externally diagnosed?
- ✓ What are the limitations specific to each data source?
- ✓ Who participated in the review? How were front-line staff involved?

Second section: Please provide information on the screening tool(s) used and how patients were selected for frailty/functional status screening.

Key Findings

This description should cite specific data from the cascades and explain how these indicate any suboptimal outcomes in the context of internal, state, and/or national HIV treatment performance goals.

- ✓ A detailed description of significant gaps in care that are revealed during the review year, as well as any disparities that emerge through disaggregation of outcomes by key characteristics.
- ✓ A narrative description of changes (if any) between the 2024 and 2025 cascade results.
- ✓ Include a description of quality improvement interventions that were tested throughout 2025.
- ✓ Explain if there were any barriers that were faced when implementing the quality improvement

interventions. In addition, describe how the improvement plan was modified in response to changes.

- ✓ Were the stated goals achieved by the end of 2025?

Developing a Quality Improvement Plan

Organizations will be asked to submit an analysis and quality improvement plan that uses the identified outcomes gaps in the cascades to develop a formal strategy that addresses these gaps. This plan should feature **an analysis of significant gaps, as well as disparities that emerged through disaggregation of outcomes by key characteristics**. The results of the Organizational HIV Treatment Cascades should be incorporated into an organization's broader improvement activities regarding HIV treatment. At a minimum, each organization's improvement plan should include the following:

- ✓ At least one and up to three specific, measurable, and time-bound improvement goals that specifically address the gaps in established active, new to care or newly diagnosed cascade results with the indicators that your organization will focus upon. Numerical goals described as percentages should consider what the actual net improvement will be based on that percentage (e.g., a 5% goal for 20 patients only represents a difference of one patient).
- ✓ Each improvement goal should have a detailed description of proposed action steps (including how and by when these steps will be measured and assessed) and a roster of staff members responsible for implementation.
- ✓ A list of organization staff, including the HIV medical director, who will be responsible for execution of the proposed improvement plan. If applicable, organizations should also list any institutional or external partnerships that will be leveraged to implement the proposed improvement plan.
- ✓ A plan to disseminate the cascades to all relevant stakeholders (e.g., display of cascades in clinics for staff and patients to see, dissemination to organization leadership). Organizations will be strongly encouraged to include regional HIV quality conferences, meetings, and webinars (e.g., New York Links meetings) as potential forums for dissemination of their cascades and improvement plans.

Consumer Involvement

Each organization must provide an explanation of how consumers were engaged in the process of developing the quality improvement plan based on the data in the cascades.

- ✓ Explain how consumers were given the opportunity to learn about the methodology used to define each indicator and construct each bar on treatment cascades, including how the numerator and denominator were derived.

[Instructions continue on the next page.]

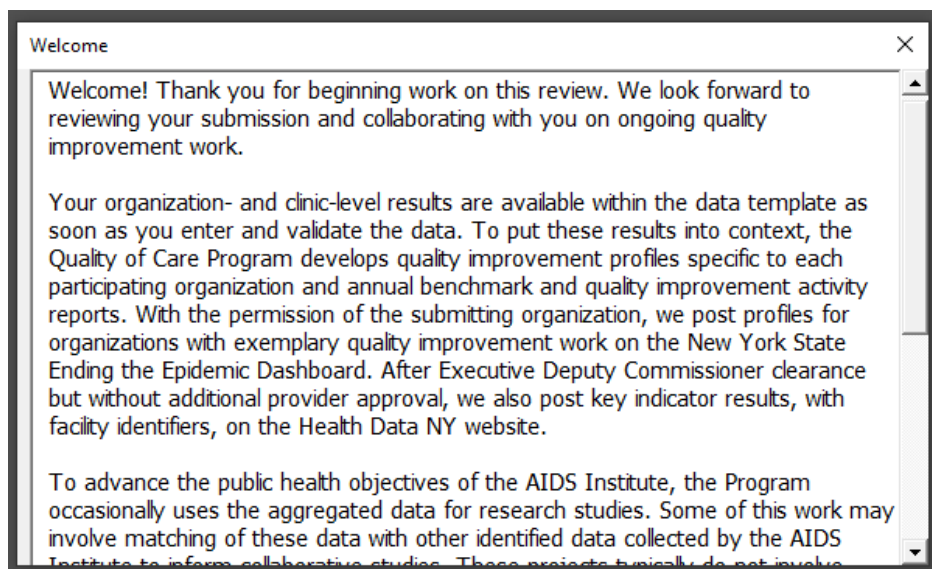
Use of the Data Reporting Template

NOTICE: The browser-based versions of Office/Excel 365 do not support Excel macros. Template users must use a desktop version of Excel and enable macros for the template to function properly. For security reasons, users are strongly cautioned not to use versions prior to Excel 2010. Use of earlier versions, including Excel 2007, is not supported and may also be incompatible with some of the macros in the template.

Overview

The Excel submission template is password protected. To unlock the template, primary contacts at the organization should use the password provided to them by the Quality of Care Program staff.

PLEASE NOTE: When the template is opened for the first time, a welcome screen (see screenshot below) will be displayed. This provides general information about the collection, reporting and subsequent use of treatment cascade data. Click on the “X” in the top right corner to close this form after you have read the welcome message. See the earlier portions of this guidance document for more information about our data use policies.



The template consists of 11 worksheets whose tabs are located at the bottom of the spreadsheet. They are listed below in order from left to right:

- **Preliminary_Information**
 - Year of review period (preset).
 - Select name of organization from drop-down menu.
 - Enter name of person submitting data.
 - Enter email address of person submitting data.
 - Enter name of person who authorized submission.
 - Enter email address of person who authorized submission.

- Clinic list with name and code will appear after organization is selected from drop-down menu.
- **Patient_Data_Template**
 - Top half contains a menu of allowed values to select from, along with definitions of abbreviations (i.e. TGW = transgender woman).
 - Bottom half contains a table with one row per patient to be filled in based on the values listed in the menu directly above.
 - Use the horizontal scroll bar to navigate between columns.
 - Certain cells may be filled in using drop-down menus.
 - Multiple selection is possible as needed (see Entering Patient-Level Data section of this document).
 - Dates should be typed in using the format *m/*d/yyyy (e.g., 3/5/2025 rather than 03/05/2025).
- **QI_Tools**
 - List of quality improvement tools for use in planning QI projects.
 - Select YES or NO from drop-down menu to state whether tools were or will be used.
 - References for information about these QI tools are provided on the template.
- **Statements**
 - Follow the prompts in the template when entering written statements for the following sections:
 - Methodology (now in two sections)
 - Analysis and Key Findings
 - Planned QI Projects Based on Current Findings (up to three)
 - After running the “Score Indicators” macro via the Control Panel, select an indicator from the drop-down menu for each QI project entered.
 - 2025 rates for each indicator will be automatically calculated and appear next to the indicator selected. Enter the 2026 goal for each indicator as an integer that represents the targeted percentage (e.g., “90” to specify a goal of 90%).
 - Consumer Involvement
- **Control_Panel**
 - 2 buttons facilitate data entry:
 - “Hide Patient Data Template Headers” enables viewing more data entry rows.
 - Can be cleared by clicking the “Restore Patient Data Template Headers” button.
 - 8 buttons automate error checking:
 - “Check Patient Data for Errors” highlights errors and warnings in the Patient_Data_Template worksheet.
 - Can be cleared by clicking the “Clear Patient Data Error Counts” button.
 - “Check for Duplicated Patients” highlights duplicated and possibly duplicated patients.
 - Can be cleared by clicking the “Clear Duplicated Patient Count” button.
 - “Check for Other Errors” highlights missing information on the Preliminary_Information worksheet, empty statement fields, unspecified QI tools and missing explanations for patient-data warnings. This should be done as a final check after validating and analyzing the data, specifying use of QI tools and entering all requested responses on the Statements sheet.
 - Can be cleared by clicking the “Clear Other Errors” button.
 - 8 buttons automate data scoring:

- Scored data appear only after “Generate Scored Patient-Level Data” is clicked.
 - Scored data disappear after “Clear Scored Patient-Level Data” is clicked.
- **Pivot_Table**
 - Presents a PivotTable report in which the fields, including diagnosis and enrollment status, demographic information, housing, risk factor, insurance, linkage status, ARV status, VL testing, suppression status and frailty/functional status screen can be added and removed as desired to isolate subgroups and view areas to improve (do not check the Defer Layout Update box as this will lead to formatting problems).
 - The PivotTable report appears only after “Generate PivotTable Report” button is clicked.
 - The PivotTable report disappears after “Remove PivotTable Report” button is clicked.
- **Data_Analysis**
 - This spreadsheet of binary data representing various patient characteristics and outcomes (antiretroviral therapy, testing, viral suppression and frailty/functional status screening) among all previously diagnosed (prior to 2025) active patients provides an opportunity for exploring any disparities among these patients. Choices include simple chi-square tests and more elaborate regression analyses. This sheet can also be used as a “scratchpad” for other analyses of your data.
 - Data only appear after “Generate Analytical Data” button is clicked.
 - Data are erased after “Clear Analytical Data” button is clicked.
- **Indicator_Definitions**
 - Lists and defines indicators, formal and informal, and how they are calculated.
 - Example: For the indicator “Antiretroviral therapy among open patients,” the numerator is “Eligible patients for whom *arv* = ‘YES’” and denominator is “All patients for whom enrollment equals ‘ACTEST’ or ‘OTH’ and diagnosis equals ‘PREV’ or ‘UK.’”
- **Field_Descriptions_&_Validation**
 - Lists field name, corresponding validation rules and warnings, and special formatting/values accepted.
 - If an input violates one of the “Validation Rules,” it will be highlighted in red on the applicable worksheet after checking for errors using the control panel buttons.
 - If an input fulfills a condition in the “Other Warnings” category, it will be highlighted in yellow on the applicable worksheet after checking for errors using the control panel buttons.

[Instructions continue on the next page.]

Data Collection and Validation

Collecting Patient-Level Data

Appendix 1 gives the required patient-level information for this year's review, along with field types and allowed values that may be entered in the template. The mechanism for collecting this information will depend on your medical information systems, data reporting software, and procedures you have in place for validating your data. Please see below for suggestions on how to enter the data into the template.

"Exclusions"

In some previous reviews, patients who were deceased, incarcerated, or confirmed to be in external care by the end of the measurement year were excluded from the HIV organizational treatment cascades. In this review, as in recent years, **they are included in the reporting** but identified under the enrollment category in the Patient Data Template and assigned the following values (see Appendix 1 for a complete table of fields values, Appendix 9 for a general glossary of terms and Appendix 10 for indicator scoring details):

- DEC (= died during the review period)
- INC (= incarcerated as of end of review period)
- RELOC* (= relocated out of New York State during the review period)
- EXTCARE* (= confirmed to be receiving ongoing HIV care at another site as of end of the review period)

*NOTE: In order to categorize patients as 'RELOC' or 'EXTCARE,' providers should have confirmation that the patient is in fact relocated out of New York State or receiving ongoing HIV care at another site. For the latter, confirmation entails having the name of the external provider on record. However, while organizations should have the name of the external provider for their own purposes, the review program is not asking for it to be submitted as part of the cascade data.

The only patients with HIV who should be excluded when filling out the Patient Data Template are those who were first diagnosed as having HIV after 12/31/25 or who had no medical or medically supportive care visits in 2025.

Entering Patient-Level Data

Go to the "Patient_Data_Template" tab listed at the bottom of the spreadsheet. The patient data template consists of two parts:

- In the upper half, a menu consisting of all possible values to select from, along with definitions of abbreviations (i.e. TGW = transgender woman). If desired, this section can be compressed by clicking the "Hide Patient Data Template Headers" button on the Control Panel sheet.
- In the bottom half, a table with one row per patient to be filled in based on the options listed in the menu directly above. Here, the filtering tool may be used to select different subgroups of patients to view at any one time.

Recommended way to fill in patient information:

- Review the list of possible values for each category in the Patient Data Template to ensure consistency.
- Set up patient information in a separate blank Excel file, following the same format as the Patient Data Template, including number and order of columns.
- Copy the cells in the external Excel spreadsheet. In the Patient Data Template, paste the information using the “Values (V)” option.
- Any input that does not fit the values defined by the template will be highlighted when checking for errors. These can be easily corrected using drop-down menus for the cells that have them (if there are only a few errors) or repeating the above steps.

How to fill in patient information manually:

- Fill out one row per patient.
- Use the horizontal scroll bar to navigate between columns.
- For cells that have a drop-down menu, click the down arrow to reveal the menu and then select a category. Refer to the menu above for definitions of terms.
 - To select multiple values for a field (e.g., ASIAN and NHPI for Race), simply repeat this action as many times as needed (once per value).
 - To clear the cell, left click on the cell and hit ‘Delete’ on the keyboard.
- For cells that do not have a drop-down menu, type in the information directly.
 - When entering dates, use the following format: *m/*d/yyyy (i.e., month and day without leading zeros and a four-digit year).

Removing empty rows:

- Empty rows beneath the patient-level data are fine, but any empty rows above or within the included patients will be flagged by the validation process and would cause errors in the scoring. These empty rows can occur if you realize that a patient should not have been included (e.g., misdiagnosed with HIV) or the data are pasted in the wrong location (not at the very top of the available space).
- To delete these rows:
 - Select all the data cells in the applicable row(s) and click the Delete key on your keyboard. (Selecting the row, as opposed to the applicable cells, is not possible due to data protection outside the designated fields.)
 - Click the “Delete Empty Rows” button in the top left corner of this spreadsheet.

Using the Filtering Tool

The filtering tool allows you to select one or more categories of patient information to be viewed at one time.

To pick which categories you would like to view, click on a down arrow located in one of the column headings at the start of the patient information rows (see **Image 1** below). A list will appear with checkboxes, which you can click to include or exclude categories that exist under the heading.

For example, checking the box for ACTEST under the “enrollment” heading will restrict the list to all established active patients. Subsequently checking the box for YES under “vl_test_review_year” will further restrict the list of patients to those who are established active *and* received a viral load test in the review year.

Be sure to choose “Select all” or “Clear Filter From [‘enrollment’]” when you are finished filtering for particular categories to restore the full patient list.

Image 1: Using the Filtering Tool.

All Patients		Active Patients
insurance Single-select	enrollment Single-select	clinic_code Single-select
MEDICAID	ACTNEW (= active, new to clinic during review period or returning after not being seen the previous two years, continuing in program)	
MEDICARE	ACTEST (= active, seen prior to the review period, continuing in program)	
DUALELG (= Medicaid & Medicare)	DEC (= died during the review period)	
PRIVATE (= Individual or employer-based private insurance)	INC (= incarcerated as of end of review period)	
VA (= Veteran's Administration)	RELOC (= relocated out of New York State during the review period)	
ADAP (= AIDS Drug Assistance Program (primary care))	EXTCARE (= confirmed to be receiving ongoing HIV care at another site as of end of the review period)	
OP (= other plan)	OTH (= other status, not enrolled in care at your organization)	
NONE		
UK (= unknown)		

insurance	enrollment	clinic_code
PRIVATE	ACTNEW	GPC
PRIVATE	ACTNEW	DFH
PRIVATE	ACTNEW	GPC
ADAP	INC	
PRIVATE	ACTNEW	KC
PRIVATE	ACTNEW	KC
PRIVATE	ACTNEW	GPC
PRIVATE	ACTNEW	DFH
PRIVATE	ACTEST	KC

Filtering can also be done using the fill color for cells, rather than the values in them, to make the selection. This can be especially helpful when validating the data. If you filter the patient data by the values in the Data Alerts column, you will see any rows with one or more errors or warnings, but if you filter by color on a particular field, you will just see the patients who have alerts for that field. In the example below (Image 2), we are detecting errors in the Birth Sex column by filtering on red cells. (The errors here are due to the entry of “UNK” instead of “UK” to record a person whose birth sex was unknown.)

Image 2: Filtering by Color.

zip	birth_sex	gender
		F
		M
		F
		X
		M
		X
		M
		M
		M
		F
		M
		M

Using the Sorting Tool

Unless you have fewer than 100 patients and are entering everything “by hand,” we recommend that you use another Excel file (or comparable spreadsheet) as an initial staging area before copying and pasting your processed data “as values” into the template. That initial spreadsheet would typically have all of the columns that are included in the Patient Data Template sheet in the final template and perhaps a few others for data manipulation. Using Excel’s standard data manipulation tools on the Data tab, the patients can be filtered and sorted as needed to organize and review the data. However, there may be times when it is helpful to sort the data after they have been entered into the data submission template. That cannot be done in the standard way given the constraints imposed in the template to ensure data integrity. However, we have incorporated a feature on the Control Panel sheet to enable sorting of the patients on the Patient Data Template sheet. It is important to note that sorting is only reversible if the data are already sorted by some combination of the fields on the template and not some other factor (e.g., the order they were first seen in your clinic, or by some patient ID other than MRN, etc.). We always recommend saving the file, perhaps with a new name, before sorting.

The data sorting tool has no initial selections:

Sort Patients

Select at least 1 and up to 5 fields, specifying ascending or descending for each. Then click on the Sort Patients button.

Field 1	SELECT TO INCLUDE	Order	Ascending
Field 2	SELECT TO INCLUDE	Order	Ascending
Field 3	SELECT TO INCLUDE	Order	Ascending
Field 4	SELECT TO INCLUDE	Order	Ascending
Field 5	SELECT TO INCLUDE	Order	Ascending

Sort Patients

To sort the patients, select the fields to be used and whether each field should be applied in ascending or descending order. The first field will determine initial sorting, and any subsequent fields will define sorting within each value for the first field. For instance, if you sort by gender, last name and date of birth as pictured below, all of the female patients will be placed before all of the male patients, and within each gender group the patients will be sorted by last name, with the oldest patient listed first if two or more patients have the same last name.

Sort Patients

Select at least 1 and up to 5 fields, specifying ascending or descending for each. Then click on the Sort Patients button.

Field 1	<input type="text" value="gender"/>
Order	<input type="text" value="Ascending"/>
Field 2	<input type="text" value="last_name"/>
Order	<input type="text" value="Ascending"/>
Field 3	<input type="text" value="dob"/> ▼
Order	<input type="text" value="Ascending"/>
Field 4	<input type="text" value="SELECT TO INCLUDE"/>
Order	<input type="text" value="Ascending"/>
Field 5	<input type="text" value="SELECT TO INCLUDE"/>
Order	<input type="text" value="Ascending"/>

After clicking on the Sort Patients button, you will be cautioned about the potential irreversibility of the sorting as described above. If you have saved the file and are sure that you want to sort the patients, click on the Proceed to Sort button:

Please Back Up Data Before Sorting ✕

It is highly recommended to backup your data before sorting. In particular, please note that sorting is **IRREVERSIBLE** if your data are not ordered using these field options or if sorted using more than 5 fields.

Also, any filters applied to data validation or date fields will need to be reapplied manually after the sort (other filters will be automatically restored).

If you have not saved your data, please click on **CANCEL** and do that before sorting.

CANCEL

PROCEED TO SORT

Also of note:

1. Any data validation markup and tallies (for patient data errors or duplicate patients) will be cleared prior to sorting, and any filters applied to these columns (A and B) on the Patient Data Template will need to be reapplied manually after sorting.
2. Any date-based filters (except "UK" or blank) will also need to be reapplied manually.
3. Any other filters will be automatically reapplied afterwards.

Data Validation

Go to the “Control_Panel” tab listed at the bottom of the workbook. The second, third and fifth buttons in the “Do” and “Undo” columns on this worksheet are used for validation and will check the data for any patient data errors, duplicated patients, and other errors including missing preliminary information and empty statement fields.

Checking patient data for errors:

- Click on the button labeled “Check Patient Data for Errors.” A pop-up window will direct you back to the Patient Data Template worksheet, where errors are now highlighted in **red** and warnings are highlighted in **yellow**. In addition, an “_ERR_” message will appear in the first column of the worksheet, labeled “Data Alerts.”
 - **Red** indicates that the data input violates the validation rules and must be corrected. To see the explanation of an error, go to the “Field_Descriptions_&_Validation” worksheet and review the “Validation Rules” column.
 - **Yellow** indicates that the data input may be faulty due to an error in that or other related fields. For an explanation, go to the “Field_Descriptions_&_Validation” worksheet and review the “Other Warnings” column.
- To view the number and location of errors and warnings, see the “Patient Data Error Count” and “Duplicated Patients & Other Errors” tables in the Control Panel tab (see below regarding checking for duplicated patients).

How to determine if errors are fixed:

- After correcting any number of highlighted cells, return to the Control Panel and hit the “Check for Errors” button again to obtain the new highlighting.
- Error checking will not update automatically when changes are made. To refresh highlighting after making changes, click “Check for Errors” again.
- To clear the error highlighting, click “Clear Patient Data Error Counts.”

Checking for duplicated patients:

- Click on the button in the Control Panel labeled “Check for Duplicated Patients.” A count of errors and warnings will appear in the “Duplicated Patients and Other Errors” table on the same page. A pop-up window will also direct you back to the Patient Data Template worksheet, where errors are colored in **red** and warnings are colored in **magenta**. In addition, an “_ERR_” message will appear in the second column of the Patient Data Template worksheet, labeled “Dup. Alerts.”
 - When one patient is possibly duplicated, an error message will appear next to both matching rows. This means that two errors in the “Dup. Alerts” column will refer to one duplicated patient.
 - **Errors** are marked when two or more patients are matching in 5 out of 5 categories: first name, middle initial, last name, date of birth, and medical record number (optional). If the medical record number (MRN) is not included, errors are marked for 4 matching categories out of 4.
 - **Warnings** are issued when two or more patients are matching in 4 out of 5 (or 3 out of 4, excluding the MRN) of the previously listed categories.

Checking for other errors:

- “Other errors” refers to missing preliminary information, empty statement fields, missing responses to questions about fields with warnings (see below) and unspecified QI tools.
- After clicking on the “Check for Other Errors” button, a count of errors will appear in the “Duplicated Patients and Other Errors” table on the same page. If errors are shown, you must go to the appropriate tabs to ensure that all required information is entered into the submission template.

Responding to Warnings

In recent cascade reviews we have emphasized that all warnings should be reviewed and corrections made where applicable and practical. However, we realize that there are reasons why some information may not be available or appear to be “contradictory.” We have relied on post-submission communication between the participating organization and AIDS Institute staff (Quality Coach and Data Analyst) to ascertain the nature of problems, what has been done to address them and whether anything further can be done. This has often proven time consuming for everyone involved. To expedite this process, we are now requesting an explanatory comment within the template itself, on the Control Panel sheet, which will be available to the Coach and Data Analyst as they review the submission.

After the data have been validated and any possible problems addressed, enter a comment for any field with one or more warnings identified (i.e., if a cell in the range N4:N41 has a number greater than zero, then a corresponding comment should be entered in the applicable cell in the range O4:O41). These comments should be sufficiently detailed so as to provide an understanding of data limitations and decisions but should not reference particular patients. See the example here for the general sense of this. Your comments will depend on the nature of your patient data and its limitations.

Patient Data Error Count			
Field Name	Errors	Warnings	Response to Warnings
first_name	0	0	
last_name	0	0	
middle_initial	0	0	
dob	0	0	
mrn	0	0	
zip	0	0	
birth_sex	0	13	Sex at birth is not available for our patients who transferred from the recently closed clinic in
gender	0	13	Some of our patients who were classified as male at birth identify as "female," rather than as "transgender."
ethnicity	0	0	
hispanic_subgroup	0	0	
race	0	0	
asian_subgroup	0	0	
nhpi_subgroup	0	0	
language	0	0	
other_language_specify	0	0	
housing	0	0	
hiv_risk	0	0	
insurance	0	0	
medicaid_number	0	0	
enrollment	0	0	
clinic_code	0	0	
service_line	0	0	
other_service_specify	0	0	
diagnosis	0	0	
arv	0	0	
vl_test_review_year	0	0	
diagnosis_date	0	0	
resistance_test	0	0	
hiv_clinic_visit	0	0	
hiv_clinic_visit_date	0	0	
arv_initiation_date	0	0	
suppressed_ever_review_year	0	0	
first_vl_date_newly_dx	0	0	
first_suppressed_date_newly_dx	0	0	
suppressed_final_review_year	0	0	

Tips for Reviewing and Responding to Warnings

Important General Points:

1. At the extreme right of the tabs on the bottom of the template, there is a Field Descriptions and Validation worksheet. This contains detailed information about all the reasons for every possible error or warning identified in the validation process. This information is also available as Appendix 3 of these instructions.
2. Warnings identified for one field are often related to entries in another field (e.g., the relationship between Sex at Birth and Current Gender or between Insurance and Medicaid Number), and what has been identified as a warning may actually reflect an inaccurate value in the other field.
3. While the reasons for some warnings may be obvious, it is important to examine all fields for the possibility that other factors, including possible data errors, may be involved.
4. Even when the explanation is straightforward, some statement should be entered for each field where any warnings are displayed.
5. These responses can be brief but should contain meaningful information regarding the reason for the warnings (e.g., “Many of our Hispanic patients do not identify as another race,” rather than “Missing data for Race”).
6. However, **no information (besides row number in the template) that could be used to identify specific patients should be included in these responses.** That includes patient names, medical record numbers, birth dates and other exact dates such as date of diagnosis. If necessary to make a point about, for instance, missing information for patients diagnosed late in the year, a generalized statement or approximate dates (year or month but not day) should be used instead.

Guidance Related to Certain Specific Fields:

- **DOB:** All patients reported as being under 5 years old or over 90 at the end of the review period are flagged as warnings in this field. This serves two purposes: a chance to confirm that the dates are correct, and a reminder that only certain values are likely to apply for these patients, especially those related to gender identification and exposure risk. So, an appropriate response could be along the lines of this: “Dates of birth for these 5 individuals were confirmed in our electronic medical record system. Entries for current gender are age appropriate. The pediatric patients are reported as perinatally diagnosed, and the other two patients had sexual exposure risks. No problems were identified.”
- **Birth Sex and Current Gender:** An entry other than “UK” (unknown) is required for at least one of these fields; an error will be generated otherwise. Warnings for these fields relate to “contradictory” information. While the data may appropriately reflect patient choice (e.g., female designation at birth but currently identifying as “male,” rather than “transgender man”), these warnings can also identify data entry or transcription errors (e.g., confusion of “transgender man” and “transgender woman”). So, an appropriate entry might be, “After correction of one mistake, the three remaining warnings relate to patients who were assigned a male identity at birth but identify as female, rather than transgender.”
- **Sexual Orientation:** The only warnings will be for unknown values among patients enrolled in care. If you do not have this information for some patients, please just enter a brief explanation in the Response to Warnings section of the Control Panel worksheet.

- **Asian Subgroup and NHPI Subgroup:** These values are often unknown, and entry of “UK” will not generate a warning. There can be confusion, however, around the distinction between Asian and Native Hawaiian/Pacific Islander patients. Also, patients of mixed racial background (e.g., white and Asian) may also have entries here without a corresponding entry included in the Race field (“ASIAN” in this case). These warnings should usually be fixable and not require a comment after the corrections have been made.
- **Other Language Specify:** There are two reciprocal reasons for warnings here: (i) an entry of “OTH” (other) was made in the Language field but the Other Language Specify field was left blank; (ii) the entry for Language was something other than “OTH” (i.e., one of the 12 most common languages, which are included in the picklist for Language), but there is also an entry in the Language field. In the first instance, the solution is to add the patient’s (uncommon) primary language in Other Language Specify or to enter “UK” if this is unknown. In the second case, the problem is typically one of interpretation: we are asking for the name of the patient’s primary language if not one of the 12 most common, but users may enter instead the patient’s second language. This can be addressed by removing these entries. If that poses a burden, a response to the warning might be “Patient’s second language entered in this field.”
- **HIV Risk:** The most common warning for this field relates to missing information among patients enrolled in care. However, it is important to check another possibility: other exposure risks (e.g., “IDU”) are combined with perinatal exposure (“PERI”). This is usually the result of combining information about recent or current behavior with information about original exposure risk, which is what we are seeking to determine.
- **Medicaid Number:** These warnings are generated when a Medicaid number is entered for patients who are not specified in Insurance as either receiving either “MEDICAID” or “DUALELG” coverage. This may reflect the collection of information about both primary and secondary insurance or simply a missed entry in the Insurance field. These problems should typically be fixable, but if any warnings remain please explain the particular reason (without identifying specific patients except, where helpful, the relevant row numbers in the template).
- **Clinic Code, Service Line and Other Service Specify:** Entries for Clinic Code that do not correspond to the codes for your clinics or non-standard entries for Service Line will generate an error. Warnings for these fields relate to missing or apparently contradictory information. For Clinic Code, warnings are generated for non-active patients (i.e., Enrollment does not equal “ACTNEW” or “ACTEST”) because the intention is to specify where patients are receiving ongoing HIV care, not where they otherwise “touched the system” (as this is handled separately). For Service Line, warnings are generated when entries are made but not required (Enrollment not equal to “OTH”). This reflects the fact that we have information about where the patients are in HIV care (within the reporting organization or externally), and we do not need the “point of contact” information to facilitate linkage to HIV care. Warnings related to Other Service Specify can also be for unrequested information on patients in care or for missing information when Service Line is “OTH.” Please try to align data collection with the intention of these fields. Where that is not practical, please investigate for any possible errors within the warnings and then describe what happened (along the lines of what is mentioned here).
- **HIV Clinic Visit Date and Resistance Test:** Warnings are generated when responses are entered for patients for whom the data are not requested. For HIV Clinic Visit Date, this would be any patient not specified as being diagnosed with HIV during the reporting period. For Resistance Test, the request is even more specific: newly diagnosed patients who are enrolled in care by the end of the year. In both cases, the problem should be fixable through removal of inapplicable data.

- ARV Mode: The only warnings will be for unknown values among patients enrolled in care. If you do not have this information for some patients, please just enter a brief explanation in the Response to Warnings section of the Control Panel worksheet.
- ARV Initiation Date, First VL Date and First Suppressed VL Date: As in the case above, warnings are generated when data are entered for patients not diagnosed with HIV during the review year. This should be fixable through removal of unrequested data. However, **all warnings for First Suppressed VL Date should be given close attention by a clinician familiar with HIV care** as there are two other types of warnings that may be generated for this field: (i) the date entered is before, on, or less than 7 days after the date entered for ARV Initiation Date and (ii) the date entered is less than 7 days after the diagnosis date. There are various reasons why these entries may actually be accurate, including treatment outside your medical organization prior to first visit within the organization, seroconversion among patients who had been receiving pre- or post-exposure prophylaxis, or patients who prove to be “elite controllers.” However, it is also possible that one or more of these fields is incorrect for some patients. Of note, the ARV Initiation Date should reflect prescription of medication intended as a complete treatment regimen, not continuation of pre- or post-exposure prophylaxis. It is also important to check that the Diagnosis Date reflects the first time the patient was diagnosed with HIV, not the administration of routine in-house confirmatory testing for externally diagnosed patients. Once all cases have been reviewed, please make any necessary corrections and then describe the reasons for any remaining warnings in the response for this field.
- Suppressed Final Viral Load: There are two reasons for warnings in this field: (i) “YES” or “NO” responses for newly diagnosed patients (as this indicator does not apply to them) and (ii) entries of “NO” or “UK” for patients who did not have a viral load test during the review year (since “NA” is expected instead). The first case should be fixable through removal of unrequested data. The latter case can be handled by substituting “NA” or adding a note in the response mentioning that “UK” was used instead (“NO” would not be an appropriate entry as this cannot be known if the patient was not tested).
- Frailty or Functional Status Screen: Any errors would relate to missing or spurious entries for eligible patients. Of note, eligibility is restricted to active patients (enrolled in HIV care), and the age cutoff depends on whether the patient was perinatally infected (≥ 31 years old by 12/31/25) or acquired HIV otherwise (≥ 51 years old by 12/31/25). Any warnings would relate to inclusion of data for patients who are not eligible.

Data Analysis

Calculating Indicator Scores

When all patient-level data have been entered correctly, go to the “Control_Panel” worksheet and click on the “Score Indicators” button. The newly calculated scores will appear in tables on the same page, while the corresponding graphs will appear in the “Charts” worksheet.

Generated charts

- Bar graph showing cascade indicators
- Pie chart showing linkage of internally diagnosed patients
- Bar graphs showing cascade results among subgroups of established active patients including:

- Age
- Gender*
- Sexual Orientation
- Race
- Ethnicity
- HIV risk factor
- Housing status
- Insurance status
- Bar graph showing cascade results by clinic for established active patients
- Bar graph showing service line encounters among unknown-status patients

*Based on the 'current gender' field, not 'sex at birth.'

The indicator scores will not automatically update themselves when the data are updated. Click on the "Clear Indicator Scoring" button to erase the previous calculations when changes to the patient-level data have been made. Then click the "Score Indicators" button again.

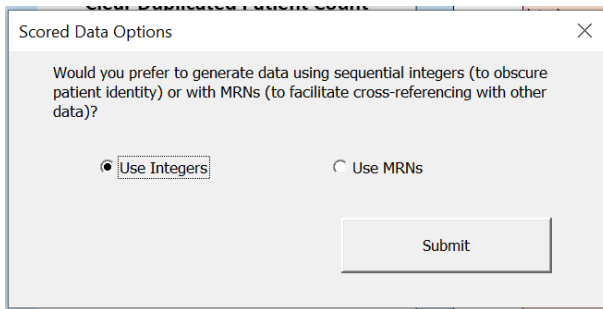
Generating the Patient-Level Scored Data Report

When all patient-level data have been entered correctly, go to the "Control_Panel" worksheet and click on the "Generate Scored Patient-Level Data" button. The newly generated report will appear in the "Scored_Data" worksheet.

"Diagnosis and Enrollment Status" is determined based on input from the Patient Data Template. Definitions of terms within this category are provided in a table in Appendix 9, which is also located in the "Indicator Definitions" worksheet.

The Scored Patient-Data Report also appends information on demographics, primary language spoken at home, housing, HIV risk factor, insurance, linkage if applicable, antiretroviral therapy status, viral load testing in review year, suppression status and frailty/functional status screen, if applicable, for each patient. Providers can use the Scored Patient-Data Report as a quick reference tool for finding individual patients' status, and a copy of this information, without patient identifiers, can be used to conduct further analyses such as logistic regression. The filtering options on this sheet are especially useful for selecting which patient subgroups are displayed after the report has been generated.

To enable confidential sharing of patient information in quality improvement-related contexts, the Scored Patient-Level Data Report identifies each patient by a number instead of their name and birth date, yet keeps patients listed in the same order as the Patient Data Template in case reference is necessary. Alternatively, there is an option to display the patient's medical record number as an identifier for cross-referencing with other data sources:



Generating the PivotTable Report

The PivotTable Report can only be generated after the Scored Patient-Data Report has been generated. Go to the “Control_Panel” worksheet and click on the “Generate PivotTable Report” button. The newly generated PivotTable will appear in the “Pivot_Table” worksheet.

The PivotTable allows the user to adjust the variables included in the report by selecting or removing different fields shown on the right-hand side of the Excel worksheet (**Figure 3**). This way, the user can identify gaps in care anywhere along the HIV organizational treatment cascade, for any group or subset of population. Depending on the fields selected (which match the fields in the Scored Patient-Level Data Report), a count of patients will appear under different categories. To arrange the fields in the table, drag the fields into boxes labeled “Filters,” “Columns,” “Rows,” and/or “Values,” also shown on the right-hand side of the worksheet.

Do not check the “Delay Layout Update” box as that will result in problems when the table is automatically reformatted.

Figure 3: PivotTable Worksheet

Count of Patient ID	Sexual Orientation	Suppression Status	Excluded (same day VL5)	Not applicable	Not suppressed in 91 days	Not suppressed on final VL	Not tested in 91 days	Not tested in year	Suppressed in 91 days	Suppressed on final VL
Female	Asexual		3		4		14		27	
	Bisexual		7		9		16		31	
	Gay or Lesbian		6		8		18		31	
	Other		5		1		17	1	27	
	Straight		67	2	94		185	8	487	
Female Total			88	2	116		250	9	597	
Gender X	Asexual		3		1		4		9	
	Bisexual		2		2		11	1	19	
	Gay or Lesbian		16		18	1	31	2	61	
	Other		1	1	2		9		17	
	Straight		18		23		34	1	95	
Gender X Total			40	1	46	1	89	4	201	
Male	Asexual		12		14		37	4	69	
	Bisexual		29		25		53	4	121	
	Gay or Lesbian		107	9	127	2	324	13	553	
	Other		22	1	22		72	5	107	
	Straight		61	2	63	1	160	3	272	
Male Total			231	14	251	3	647	29	1,233	
Other	Straight								1	
Other Total									1	
Transgender Man	Other								2	
	Straight		1						2	
Transgender Man Total			1						3	
Transgender Woman	Asexual				1				1	
	Bisexual								3	
	Gay or Lesbian		2						6	
	Other		1		1				2	
	Straight		1						2	
Transgender Woman Total			1		4				15	
Grand Total			1	366	17	417	4	1003	42	1940

Additional Analysis of Previously Diagnosed Active Patients

Additional analytical data can only be generated after the Scored Patient-Data Report has been generated. Go to the “Control_Panel” worksheet and click on the “Generate Analytical Data (Prev. Dx. Active Patients)” button. The newly generated analytical data will appear in the “Data_Analysis” worksheet.

Two methods of analyzing outcomes among these patients are provided on this worksheet: chi-square tests of difference between a subpopulation and all other patients, and logistic regression to examine the outcomes while considering multiple patient characteristics simultaneously. Please see Appendix 7 for additional information about these tests.

Statistical tests

Quick Overview of Options and Use

- 1) While options are provided analyzing antiretroviral prescription and viral load testing, this may not be informative if all or almost all patients were tested and treated. Most often, you will want to select “Viral Suppression” as there is typically a significant number of unsuppressed patients, at least within larger organizations. If you have a significant number of older patients, you may want to analyze these results as well.
- 2) For both tests, a P value of less than 0.05 is conventionally deemed to be “statistically significant,” but for purposes of data exploration it is more helpful to think generally along the lines of “the smaller the number, the more likely it’s not due to chance.”
- 3) Choosing a test:
 - a. If you want to compare the outcome for one group against that for all other patients, use the chi-square test tool. This is typically most useful when the group in question comprises a large but not overwhelming percentage of your patients. For instance, if about half of your patients are Hispanic, selecting this option from the Population of Interest could be informative. Likewise, you may want to use this test to compare Black and non-Black patients, those over or under 50, etc.
 - b. If you want to take more than one factor into consideration at a time, use the logistic regression tool, preferably after having identified candidate factors using the chi-square test tool. This is most useful if you have a medium to large caseload or a relatively low percentage of suppressed patients. The results are displayed in terms of the P value mentioned above and a coefficient for the regression equation. Details regarding the latter are provided in Appendix 7, but it’s helpful to keep two basic ideas in mind: positive values (greater than 0) are indicative that the factor in question increases the likelihood of the outcome being analyzed while negative values (less than 0) suggest that the factor decreases the likelihood; and (ii) the greater the magnitude (absolute value), the stronger the effect. See the Detailed Instructions immediately below for further guidance.

Detailed Instructions

To perform a simple chi-square test (see Figure 4), do the following:

- 1) Select the outcome of interest from the drop-down list. The choices are ARV prescription during the review period (“ARV Therapy”), viral load test during the review period (“VL Testing”), suppression on final viral load during the review period (“Viral Suppression”) or frailty/functional status screening (“Frailty or Function Screen”). Patients who were not tested during the review period are included in the calculations for suppression and counted as unsuppressed.

- 2) Select the population of interest from the drop-down list. This list includes all the patient-characterizing data entered for the review with some simplification to avoid very small patient subgroups.
- 3) Click on the “Run Chi-square Test” button. Even with large caseloads, the chi-square statistic and corresponding p value should be generated quickly. P values less than 0.05 are conventionally treated as statistically significant, but this is somewhat arbitrary. Additional insight may be obtained by including seemingly important factors in a logistic regression analysis (see below for instructions and Appendix 7 for additional information).

Figure 4: Chi-square Test

OUTCOME OF INTEREST			Viral Suppression				
POPULATION OF INTEREST			Established in Care			Run Chi-square Test	
			Population	Other Patients			
		Outcome = True	1611	121			
		Outcome = False	277	52		Chi square	P value
		Expected True	1587	145		27.9669	0.00000012
		Expected False	301	28			

To perform a regression analysis (see Figure 5), do the following:

- 1) When first using this feature after reopening the workbook (or after encountering any problems), you need to load and initialize the Solver add-in that is bundled with Excel. You can do this by clicking on the “Initialize Solver” button.
- 2) Select the outcome of interest from the drop-down list. The choices are ARV prescription during the review period (“ARV Therapy”), viral load test during the review period (“VL Testing”), suppression on final viral load during the review period (“Viral Suppression”) or frailty/functional status screening (“Frailty or Function Screen”. Patients who were not tested during the review period are included in the calculations for suppression and counted as unsuppressed.
- 3) Choose the factors you want to include in the analysis by changing the values in the blue boxes to "Include" (clear selections individually or with the "Reset All to 'Exclude'" button).
- 4) Click on the "Run Regression Analysis" button. If you observe the left side of the status bar at the bottom of the Excel window, you will see updates as Solver tries to minimize the value for the negative sum of the log likelihood function (cell H42), which in turn optimizes the values for the coefficients. Depending on the complexity of the regression, it may take several seconds for this process to complete. A message box will then be displayed to let you know if Solver converged on a solution. If so, estimated coefficients for all included factors will be displayed as well as the p value for each. If at least 100 patients are included in the analysis, the Gini statistic—a measure of how well these factors distinguish the patients who are likely to have the desired outcome from those who are not—will also

be reported. Here are some indications that you may need to adjust your analysis to get meaningful results (or do not use this tool at all if you have a small caseload):

- The P value for the factor in a regression analysis conducted without inclusion of other factors differs considerably from that seen in the chi-square test for the same factor (some minor variation is expected due to rounding of small numbers within the calculation).
- One coefficient is much larger (positive or negative) than the others, especially if this is for a group that has very few patients who were not suppressed (or tested or on ARV, as the case may be).
- Adding or removing one group greatly changes the results for other factors.

See Appendix 7 for additional information about how to interpret these results.

Figure 5: Logistic Regression

Check Results for Multiple Groups Using Logistic Regression Analysis

OUTCOME OF INTEREST	Viral Suppression		Initialize Solver							
To run a regression analysis (see Instructions for more detail): 1) When first opening the file (or after encountering a problem), click on the "Initialize Solver" button and wait for a response (takes a few seconds). 2) Select the desired outcome measure (ARV, Testing or VLS). 3) Choose the factors you want to include in the analysis by changing the values in the blue boxes to "Include" (clear selections individually or with the "Reset All to 'Exclude'" button). 4) Click on the "Run Regression Analysis" button (depending on the complexity of the regression, it may take several seconds to complete).			Run Regression Analysis							
			Reset All to "Exclude"							
		INTERCEPT	PRE-DEFINED FACTORS							
Parameter Estimates			Established in Care	Under 25	Over 50	Birth Female	Birth Male	Transgender	Gay or Lesbian	Straight or Heterosexual
	Coefficient	0.8689492	0.89241905		0.2401117		0.007219181		-0.19135	-0.1890219
	P > z (Wald)	0.0004776	7.8307E-07		0.0520254		0.962274849		0.273904	0.282523947
	Gini Score	0.0783148	Include	Exclude	Include	Exclude	Include	Exclude	Include	Include

Other uses of this spreadsheet

- 1) Additional patient characterizing data can be added to the right of the data that are generated automatically. These additional values should also be binary (0 or 1) and align with the corresponding patients. This entails matching the patient on this sheet with the position of the patient in the Patient Data Template sheet (discounting the first 7 rows without patient data). For example, if you have data on current substance use among all previously diagnosed active patients, you could add it to the first user-defined column as seen in **Figure 6** (1 = Yes; 0 = No). Alternatively, you can paste the Data Analysis data to another Excel file, join the data with other data elements using medical record numbers, and then paste everything back into the Data Analysis sheet. In either case, any data elements included in this fashion become available for chi-square tests or logistic regression as previously described.
- 2) You can use the "Scratch Pad" area of this worksheet for any additional calculations as desired. This can include data from this worksheet or others. To include values from other worksheets, use the "bang operator" (an exclamation point). So, for instance, to assign a cell on this sheet the value of the

percentage of male established active patients who were virologically suppressed, you would enter “=Control_Panel!\$M\$60” in the formula bar with the target cell selected.

Figure 6: Adding User-Defined Values

USER-DEFINED FACTORS						
Private Ins.	ADAP	Substance Use	TBD	TBD	TBD	TBD
1	0	1				
0	0	0				
1	0	0				
1	0	1				
0	0	1				
0	0	1				
0	0	0				
0	1	0				
0	0	1				
0	1	0				
0	0	0				
0	0	0				

Using Data for Quality Improvement

Written Statements

The written statements may be either typed directly or typed in an external document and copied and pasted into the text boxes in the “Statements” worksheet. Responses may not exceed the character limits but must provide detailed answers to the prompts given in the template. Detailed checklists for these fields are provided in the introductory and data-submission sections of this guidance document.

Statements:

- Methodology Statement
- Analysis and Key Findings Statement – *Must include results for specific patient subpopulations whose outcomes fall short of expectations for the organization.*
- Descriptions of at least one and up to three QI projects
- Consumer Involvement Statement

Submission of the Template

NOTICE: Do **not** use old versions of Internet Explorer (IE 10 or earlier) to upload the data submission template in the Health Commerce System.

Overview

1: Health Commerce System Registration

The cascade review will require the submission of patient-level data into a secure database through the Health Commerce System. To ensure a fully confidential process, organizations will need to identify appropriate staff to use the Health Commerce System for data submission.

Registration Process

- 1) Identify someone at the organization responsible for submitting the data. While only one upload is needed per organization, you may wish to identify a backup person as well.
- 2) Provide Health Commerce System access for these staff:
 - a) If your organization is already registered to use the Health Commerce System, contact the organization's Health Commerce System Coordinator to register additional staff as needed.
 - b) If the organization does not have a Health Commerce System Coordinator or you do not know if the organization has a Health Commerce System coordinator, you can contact the Health Commerce Accounts Management Unit directly at camusupp@health.ny.gov or by calling them at 866-529-1890.

Please see Appendix 6 for additional details about the Health Commerce System.

2: Review and Validation of the Template

A thorough review of your template data prior to submission is essential to ensuring the validity of the patient data and the integrity of the other elements. The Control Panel worksheet has several macros for this purpose, and prior to submission these should all be run. It is also critical that the results be shared among quality improvement staff at your organization and that the completion of the statements related to methodology, key findings, quality improvement projects and consumer involvement reflect the input of that group.

3: Health Commerce System Submission

Submissions are due by May 20, 2026. Submissions should be uploaded via the [Organizational Treatment Cascade Data Upload application](#) in the Health Commerce System site. **DO NOT EMAIL, MAIL OR FAX PATIENT LEVEL DATA.** In addition, **DO NOT USE OLD VERSIONS OF INTERNET EXPLORER (IE 10 or earlier)** when accessing the upload application. Please see Appendix 6 for additional details.

4: Ongoing Coaching

Program staff will provide one-on-one technical assistance to organizations with significant needs. Beginning in April 2026, organizations will be requested, where circumstances permit, to provide their assigned Quality

Coach with regular updates. These updates should include reports of progress on data collection in addition to ongoing quality improvement activities to address gaps and disparities in cascade outcomes. Once the data are submitted, Coaches will follow-up with organizations on a quarterly basis.

Before You Submit - A Checklist

To avoid immediate rejection of your submission due to data errors or extensive back and forth with the AIDS Institute regarding other questions or problems, it is critical that you review the following before submitting your data:

1. Confirm that the contact information you have entered into the Preliminary Information worksheet aligns with our expectations
 - a. **The Submitter and Approver should both be individuals known to the Quality of Care Program.**
 - b. The emails for these individuals should be work addresses (not personal accounts) that match those we use when sending broadcast emails.
 - c. The Submitter will receive feedback on the submission and should be willing to serve as a liaison between the rest of the medical organization and the Quality of Care Program.
 - d. **The Approver should be someone with medical oversight for HIV care and have been established with us in this capacity. Ideally, this will be HIV Medical Director for the organization.**
 - e. If you have any questions about the above, please reach out to your Quality Coach or our general email account, qocreviews@health.ny.gov. As always, do NOT attach the template to any email communications.
2. Run all three error-checking macros on the Control Panel worksheet.
 - a. "Check Patient Data for Errors":
 - i. Any "errors" that are identified must be corrected on the Patient Data Template worksheet. After making the corrections, rerun this macro to make sure that there are no errors (you should see a value of zero in all cells from M4 to M41 on the Control Panel). Even a single error will cause the submission to be rejected.
 - ii. Please review all "warnings." While these may just reflect the limits of your data, some may bring attention to problems that can be corrected. After making all possible corrections, enter an explanatory comment for any fields that have one or more warnings (i.e., for any cell in N4 to N41 on the Control Panel that has a value greater than zero, enter a comment in the corresponding cell in the range O4 to O41).
 - b. "Check for Duplicated Patients":
 - i. Any "errors" must be corrected. These are patients that match exactly on name, date of birth and medical record number. Review any duplicated records, identify the most complete one (or combine information), and delete the data for the remaining records for that patient. When you have done this for all sets of duplicated records, use the Delete Empty Rows button on the Patient Data Template worksheet to eliminate the gaps resulting from deletion.

- ii. Any “warnings” should be reviewed. These are patients who match on all but one field for first name, middle initial, last name, date of birth and medical record number. The most common situations are two or more patients with the same name but different medical record numbers and patients who are identical except for spelling of some portion of their name. Both of these most likely represent true duplicates and, if so, should be addressed as per the above instructions for errors.
- c. “Check for Other Errors,” which may identify problems on one or more of these sheets:
 - i. Preliminary Information: Make sure that you have selected the name of your organization from the drop-down list and have entered the name and work email address for the person submitting the data (primary contact for review) and the person who has reviewed and approved the submission (“authorized approver” as identified and provided previously to the AIDS Institute).
 - ii. QI Tools: Make sure that you have made an explicit selection of “YES” or “NO” for each of the nine QI tools (do not leave blank to represent “NO”).
 - iii. Statements:
 1. Make sure that you have entered a response for each of the statement fields (Methodology 1 and 2, Analysis and Key Findings, and Consumer Involvement).
 2. In the second Methodology statement, please include language in the about how patients were selected for frailty/functional status screening and which screening tool(s) was/were used.
 3. At least one QI project is required, and for each QI project that is entered please check the following:
 - a. Indicator has been selected from the drop-down list.
 - b. The goal for this indicator in 2026 has been specified using an integer value (e.g., “90” to represent a rate of 90% in 2026). This rate should be equal to or, preferably, higher than the rate for 2025 and reflect the goal for the entire eligible population (e.g., all established active patients), not just those who will be receiving a QI intervention.
 - c. You have entered a description of the quality improvement project(s) to achieve this goal including some specifics on the activities and the patient groups that will be included. Goals for specific subpopulations can be entered here.
 - iv. Control Panel: Make sure that you have entered an explanatory comment for any field where one or more patient data warnings were identified.
3. Review your patient counts and indicator results for signs of possible data scoring errors or omissions.
 - a. Are any of the indicator rates exactly 0% or 100%? If so, could this reflect a data coding error?
 - b. Are any of the rates much lower or higher than you would expect? If so, can you discern the reason for the difference? If the difference is real, please explain in your Key Findings.
 - c. Are the average and median times to antiretroviral initiation and viral suppression among newly diagnosed patients about what you would expect? If not, could there be a problem with any of the related date fields (diagnosis date, antiretroviral initiation date and first suppressed viral load)?

- d. In areas where other reporting (internal quality reports, Ryan White extracts, etc.) indicates that your outcomes have changed, do you see something similar reflected in these data?
 - e. Are the number of established active patients by clinic and demographic category about what you would expect? If not, could this reflect a data coding error?
 - f. Are the outcomes among these groups about what you would expect? If not, can you determine the reason for the unexpected results? If it is not a coding issue, please explain it in Key Findings.
 - g. Do you have a mix of internally and externally diagnosed patients, or is it just one or the other? If all patients are reported as internally diagnosed, are you capturing the original diagnosis date for all patients (as intended) or the time when a subsequent confirmatory test was performed?
 - h. Do the relative number of newly diagnosed, other new to care and established in care patients seem right to you? If not, could some patients have been misclassified (e.g., other new to care patients reported as newly diagnosed)?
 - i. Are your caseloads by our various categories (newly diagnosed, other new to care, established in care, “excused,” and unknown) similar to those for the previous review? If not, do you know of a reason for the change?
 - j. Is the denominator for “open patients” significantly larger than that for “established active patients”? If not, are you including all of the patients seen within your organization but not for HIV-specific care?
 - k. Do the service line counts seem right to you and consistent with previous reviews? If not, do you know what may have changed?
4. Review your statements for completeness and appropriate content.
- a. Do any of your statements include mention of specific patients, peer workers, etc.? This is mostly to occur in the Consumer Involvement section but should be checked generally, and any such references should be removed.
 - b. Does your Methodology statement provide sufficient detail so that people without access to your medical system can understand how you obtained, processed and reviewed the data? Does it address any limitations to your data and your decisions about how to address these?
 - c. **Does your Key Findings statement compare results for 2025 to those for 2024 and highlight areas of significant change? Do you analyze the changes and areas of lower than desired performance by specific patient subpopulations (i.e., were the results driven by outcomes for certain patient groups)?**
 - d. Do your QI projects set ambitious but reasonable goals? Do the descriptions for the projects include a timeline and relate how activities will be tailored to the needs of particular patient subpopulations?
 - e. Does your Consumer Involvement statement convey both what has been done to involve consumers in QI and your plans to involve them in the future?
 - f. Have you provided information about data warnings that will allow the AIDS Institute to assess the completeness and accuracy of your data? These statements should not reference particular patients but rather describe categorical problems such as reasons for missing demographic information or lack of access to medical record systems outside the HIV clinic.

File Naming Conventions

The submission template is distributed with a name such as “QOC Cascade Template_8.00_PRODUCTION_[Update Date]” or “QOC Cascade Template_8.01[or higher]_PRODUCTION_BLANK_[Update Date]”. When your completed template is ready for submission, rename the file by prefacing this with your organization’s name in caps along with the submission date, and then save it. (If the file name is too long, you can delete “PRODUCTION...” as in the example below.)

Example:

GREATER_NYC_HEALTHCARE_2026-06-15_QOC Cascade Template_8.00

If you have questions about this, please reach out to us at qocreviews@health.ny.gov WITHOUT attaching the template to the correspondence.


Your template is now ready to be uploaded to the Health Commerce System.

[Instructions continue on the next page.]

How to Upload the Template to the Health Commerce System²

Step 1: Log into the Health Commerce System (<https://commerce.health.state.ny.us/>) with your user ID and password. **Please note that your User ID should be all lowercase characters to ensure proper functionality in subsequent steps.**

PLEASE LOGIN TO BEGIN USING THE HEALTH COMMERCE SYSTEM (HCS)


Health Commerce System

User ID

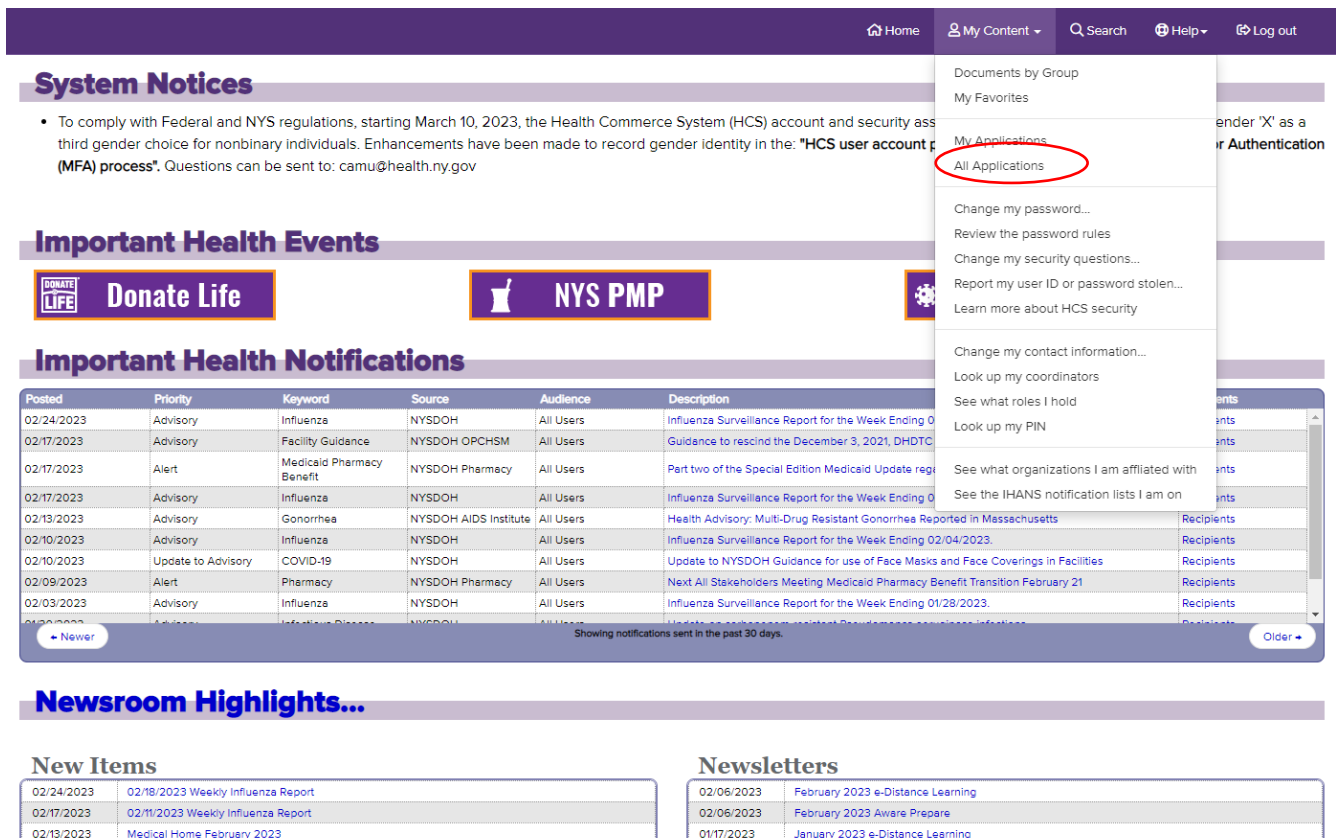
Password

[Forgot Your User ID or Password](#) Remember User ID

LOGIN

[Don't Have An Account? Sign Up Here](#)

Step 2: Go to “All Applications” listed under the “My Content” tab.



The screenshot shows the Health Commerce System dashboard. At the top right, the 'My Content' dropdown menu is open, and 'All Applications' is circled in red. The dashboard includes sections for System Notices, Important Health Events (with 'Donate Life' and 'NYS PMP' buttons), Important Health Notifications (a table of notifications), and Newsroom Highlights (with 'New Items' and 'Newsletters' sub-sections).

Posted	Priority	Keyword	Source	Audience	Description
02/24/2023	Advisory	Influenza	NYSDOH	All Users	Influenza Surveillance Report for the Week Ending 02/20/2023
02/17/2023	Advisory	Facility Guidance	NYSDOH OPCHSM	All Users	Guidance to rescind the December 3, 2021, DHDTC
02/17/2023	Alert	Medicaid Pharmacy Benefit	NYSDOH Pharmacy	All Users	Part two of the Special Edition Medicaid Update regu
02/17/2023	Advisory	Influenza	NYSDOH	All Users	Influenza Surveillance Report for the Week Ending 0
02/13/2023	Advisory	Gonorrhoea	NYSDOH AIDS Institute	All Users	Health Advisory: Multi-Drug Resistant Gonorrhoea Reported in Massachusetts
02/10/2023	Advisory	Influenza	NYSDOH	All Users	Influenza Surveillance Report for the Week Ending 02/04/2023.
02/10/2023	Update to Advisory	COVID-19	NYSDOH	All Users	Update to NYSDOH Guidance for use of Face Masks and Face Coverings in Facilities
02/09/2023	Alert	Pharmacy	NYSDOH Pharmacy	All Users	Next All Stakeholders Meeting Medicaid Pharmacy Benefit Transition February 21
02/03/2023	Advisory	Influenza	NYSDOH	All Users	Influenza Surveillance Report for the Week Ending 01/28/2023.

² See Appendix 6 for more information about Health Commerce System policies and contact information for support.

Step 3: Click on the letter “Q” and then “Quality of Care Program Data Submission.”

Application Name	Acronym	P
QARR Query System		
Quality of Care Program Data Submission	SFT	


Step 4: Click the button labeled “Quality of Care Program Data Submission.”

Quality of Care Program Data Submission

Purpose

To facilitate annual and ad hoc quality reviews, this data transfer utility enables secure submission to the AII medical organizations providing clinical care to individuals in New York State living with HIV and (ii) other data care organizations serving this population.

Instructions

1. Click the button to launch the application

2. Complete the **Multi-Factor Authentication** process
3. Enter a **Subject**
4. Enter **Notes**
5. Click the **Upload Files** link
 - Click **Add File**
 - Browse and click on the file(s) you want to upload
 - Click **Open**
 - Click **Upload**
 - Click **Close**
6. You have the option to check **Delivery Receipt(s)**
7. Click **Send**

For technical issues, please contact hinweb@health.ny.gov

Step 5: Complete the multifactor authentication process.

Instructions

- Please enter the code received from your SMS message on your registered phone number.
- You will have [2 minutes] from now [2024-04-04 at 03:50:15 EDT] to enter the code.
- You will be logged out of HCS after 3 unsuccessful attempts.

Verification Code

AUTHENTICATE

Please note that **this needs to be completed very quickly (within 2 minutes)** so it will be important to have on hand the device where you will receive the text that contains the authentication code.

Updated Health Commerce System Policy (3/13/2025): “If you are using a non-shared device, you can select the option to remember your device when being challenged for your MFA code. You will not be challenged for MFA for 30 days and will receive an email to indicate your selection. Please note if you clear your internet browser cookies and history, or use a different browser, the next time you access an application with MFA you will be challenged for an MFA code.” The Quality of Care Program recommends that you **do not** use this option unless you are certain that nobody else will use your computer or laptop.

Step 6: Fill in the “Subject” heading with the name of your organization and the quality initiative for which you are submitting (i.e., Annual Organizational Cascade Review).

Step 7: Enter a message in the free-text box. This is required before clicking the “Send” button. You can enter comments for our attention here (**do not include any protected health information**) or simply specify the review period (e.g., “This is our submission for the review of care provided in 2025.”).

[Instructions continue on next page.]

Step 8: Click "Upload Files," then click "Browse" to select the data file from storage.

To Quality of Care Program Data Submission **Add Cc/Bcc**

Subject Greater NYC Healthcare - Organizational Treatment Cascade Submission

This is our initial submission of data for care provided in 2025. Please let me know if you have any questions.

Options for this package

- Secure message body
- Delivery receipt(s)
- Prevent "Reply All"
- Prevent all replies
- Package expires after: 14 days

Classification

Select classification label

File attachments (It is recommended that you password protect or encrypt files that contain PHI/PII)

Drop files to upload or **Upload Files** dialog

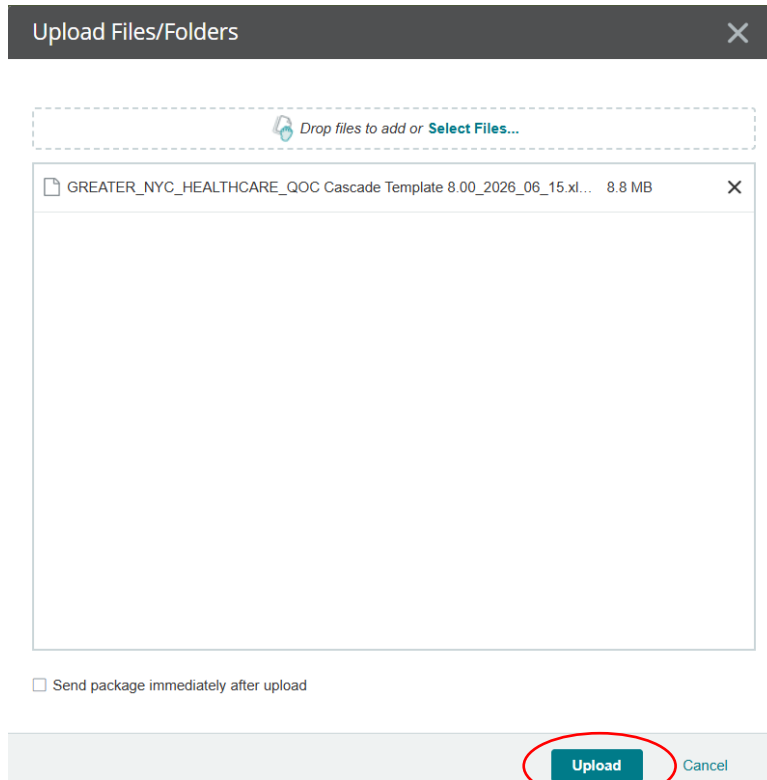
Upload Files ✕

Drop files to add or **Browse...**

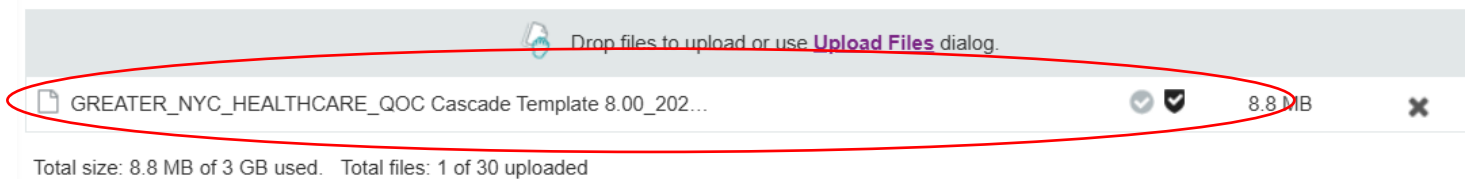
Send package immediately after upload

Upload **Cancel**

Step 9: Click “Upload” once the template file has been chosen, and then “Close.” The title of the Excel file will appear in the file attachments section with two checkmarks when it has been successfully uploaded. This just indicates the file has been attached; **you must proceed through Step 11 to submit the file to the AIDS Institute.** (When submitting organizational treatment cascade data, the template is already password protected so no additional password or encryption is needed.)



File attachments (It is recommended that you password protect or encrypt files that contain PHI/PII)



Step 10: Make sure that the addressee (To line) has not been changed; see screenshot for Steps 8 and 11. DO NOT include other addresses on the To, CC or BCC lines as this will allow others to download your submission. If you want, it is permissible to check the Delivery Receipt box on the right side of the screen.

[Instructions continue on next page.]

Step 11: Click the “Send” button at the top to officially submit your template via the Health Commerce System.

The screenshot shows an email composition window. At the top, there are buttons for 'Send' (circled in red), 'Discard', 'Save Draft', and a menu icon. Below these are fields for 'To' (Quality of Care Program Data Submission) and 'Subject' (Greater NYC Healthcare - Organizational Treatment Cascade Submission). The main body of the email contains the text: "This is our initial submission of data for care provided in 2025. Please let me know if you have any questions." Below the body is a section for 'File attachments' with a note: "(It is recommended that you password protect or encrypt files that contain PHI/PII)". One attachment is visible: "GREATER_NYC_HEALTHCARE_QOC Cascade Template 8.00_202..." (8.8 MB). On the right side, there are 'Options for this package' (Secure message body, Delivery receipt(s), Prevent "Reply All", Prevent all replies, Package expires after: 14 days) and a 'Classification' dropdown menu.

Please note that the submission will need to be downloaded to a secure DOH data server and processed by the QOC Review team before you receive confirmation of your submission; this may take a few days, depending on the volume of submissions. When your submission has been processed, an email will be sent to the “submitter” with a copy to the “authorized approver” and the Quality Coach for your organization. This email will provide the status of the data validation process. If any errors are detected, a detailed list will be provided, and you will be asked to correct them and resubmit the template. Successful submissions will be incorporated into an analytical database on the data server.

After automated data validation has been successful, your submission will be qualitatively reviewed by your organization’s Quality Coach and the Data Analyst before final approval by the Quality of Care Program. You may be asked to resubmit your template to address any concerns raised during these reviews. Please reach out to your Coach to discuss the status of your submission.

Appendixes

Appendix 1: Patient-Level Data Elements

Patient Information	Variable Name	Applies To	Field Type	Allowed Values	Guidance
First name	first_name	All patients	Text	Up to 50 characters	For transgender patients or others who have changed their first name, enter just the patient's current name (nothing in parenthesis, etc.).
Last name	last_name	All patients	Text	Up to 80 characters	For any patients who have changed their name, enter just the current name. For married patients or anyone else who uses two last names, enter their current legal name if known.
Middle initial	middle_initial	All patients	Text	Single character	Recommended for full deduplication of patient list but can be blank if needed.
Date of birth	dob	All patients	Date	*m/*d/yyyy	
Medical record number	mrn	All patients	Text	Up to 50 characters	Optional
Zip Code	zip	All patients	Text	5 numerical characters entered as text	Mark 'UK' if unknown or 'NA' if not applicable (i.e., a patient who has never been domiciled in the United States).
Sex at birth	birth_sex	All patients	Single selection	F (= female), I (= intersex), M (= male), UK (= unknown)	Mark 'UK' if unknown, but sex at birth and current gender cannot both be unknown.
Current gender	gender	All patients	Single selection	F (= female), M (= male), TGM (= transgender man), TGW (= transgender woman), X (= gender X), OTH (= transgender other, non-binary, gender non-conforming, other), UK (= unknown)	Mark 'UK' if unknown, but sex at birth and current gender cannot both be unknown.
Sexual orientation	sexual_orientation	All patients	Single selection	A (= asexual), B (= bisexual), G (= gay or lesbian), S (= straight or heterosexual), OTH (= other sexual orientation including queer or pansexual), NS (= not sure or questioning), UK (= unknown)	Mark 'UK' if unknown.
Ethnicity	ethnicity	All patients	Single selection	H (= Hispanic or Latino/Latina), NH (= non-Hispanic/Latino/Latina), UK (= unknown)	Mark 'UK' if unknown.
Hispanic subgroup	hispanic_subgroup	Hispanic patients	Multiple selection (as needed, comma separated)	CA (= Central American), CU (= Cuban), D (= Dominican), M (= Mexican, Mexican American or Chicano/Chicana), PR (= Puerto Rican), SA (= South American), SP (= Spanish), OH (= other Hispanic, Latino/Latina, Spanish Origin), UK (= unknown), NA (= not applicable as patient is not Hispanic)	Mark 'NA' if patient is not Hispanic, 'UK' if unknown.
Race	race	All patients	Multiple selection (as needed,	ASIAN, AIAN (= American Indian or Alaska Native), B (= Black or African American), , NHPI (= Native Hawaiian or Pacific Islander), W (= White), UK (= unknown)	Mark 'UK' if unknown (warning issued if 'UK' and <i>enrollment</i> = ACTNEW or ACTEST).

			comma separated)		
Asian subgroup	asian_subgroup	Asian patients	Multiple selection (as needed, comma separated)	AI (= Asian Indian), BAN (= Bangladeshi), BUR (= Burmese), CAM (= Cambodian), CHI (= Chinese), FIL (= Filipino), HM (= Hmong), IND (= Indonesian), JP (= Japanese), KOR (= Korean), LAO (= Laotian), MAL (= Malaysian), NEP (= Nepalese), PK (= Pakistani), SL (= Sri Lankan), TA (= Taiwanese), TH (= Thai), TI (= Tibetan), V (= Vietnamese), OA (= other Asian), UK (= unknown), NA (= not applicable)	Mark 'NA' if patient is not Asian, 'UK' if unknown.
NHPI subgroup	nhpi_subgroup	Native Hawaiian / Pacific Islander patients	Multiple selection (as needed, comma separated)	F (= Fijian), G (= Guamanian), H (= Hawaiian), S (= Samoan), T (= Tongan), OPI (= other Pacific Islander), UK (= unknown), NA (= not applicable)	Mark 'NA' if patient is not Native Hawaiian or Pacific Islander, 'UK' if unknown.
Primary language	language	All patients	Single selection	ARABIC, BENGALI, BURMESE, CHINESE, CREOLE (= Haitian Creole), ENGLISH, FRENCH, HINDI, ITALIAN, JAPANESE, KOREAN, NEPALI, POLISH, RUSSIAN, SPANISH, URDU, YIDDISH, OTH (= other language), UK (= unknown)	Primary language spoken at patient's home, if known. Enter 'UK' if unknown.
Other language specification	other_language_specify	Patients who speak a language not on list	Text	Up to 50 characters	Enter language name or description for patients whose primary language spoken at home is not one of choices for Primary Language. Leave blank if not applicable.
Housing status	housing	All patients	Single selection	S (= stable / permanent), T (= temporary), US (= unstable), UK (= unknown)	Temporary housing is defined as a short-term arrangement with family or friends, transitional housing or temporary institutional placement including substance abuse treatment facilities and psychiatric hospitals. Unstable housing is defined as living in emergency shelters, jail/prison or places not meant for human habitation. Mark 'UK' if unknown.
HIV exposure risk	hiv_risk	All patients	Multiple selection (as needed, comma separated)	BLOOD (= blood transfusion/blood products), HEMO (= hemophilia/coagulation disorder), IDU (= injecting drug use, PERI (= perinatal transmission), SEXUAL (= sexual exposure), OTH (= other), UK (= unknown)	Patient's HIV exposure risk factor(s); mark 'UK' if unknown (warning issued if 'UK' and <i>enrollment</i> = ACTNEW or ACTEST). Please note: (i) With the separate collection of sexual orientation, sexual exposure has replaced previous recording of heterosexual or MSM exposure. (ii) This field is for reporting, using established categories, of the most likely way(s) the patient was exposed to HIV at the time of infection and is not necessarily intended to reflect the patient's current gender identity or recent substance use history. Provider judgment, in conjunction with patient input, should be used as necessary to determine which option(s) to use for this and related fields.
Insurance	insurance	All patients	Single selection	ADAP (= AIDS Drug Assistance Program (Primary Care)), DUALELG (= Medicaid & Medicare), ESSENTIAL (=NYS Essential Plan), MEDICAID, MEDICARE, PRIVATE (= individual or employer-based private insurance other than an Essential Plan), VA (= Veteran's	Primary insurance on last status check during the review period; mark 'UK' if unknown (warning issued if 'UK' and <i>enrollment</i> = ACTNEW or ACTEST). See Appendix 2 for additional guidance.

				Administration), OP (= other plan), NONE, UK (= unknown)	
Medicaid number	medicaid_number	Patients whose primary insurance is MEDICAID or DUALELG	Text	Eight characters in this sequence: two letters, five numbers, and one letter. See guidance in next column for other options.	Also applies to dual-eligible patients (those also covered through Medicare). Mark 'NA' for patients with other primary insurance, 'NS' if number is in a non-standard format and the 8-character CIN cannot be extracted, 'UK' if unknown.
Enrollment status (as of the end of the review period, was the patient established in care, new to care, deceased, incarcerated, relocated, in external care, or other?)	enrollment	All patients	Single selection	ACTEST (= active, seen prior to the review period, continuing in program), ACTNEW (= active, new to clinic during review period or returning after not being seen the previous two years, continuing in program), DEC (= died during review period), EXTCARE (= confirmed to be receiving ongoing HIV care at another site as of end of the review period), INC (= incarcerated as of end of review period), RELOC (= relocated out of New York State during the review period), OTH (= other status, not enrolled in care at your organization)	For ACTEST, the patient must (1) have had during the two years immediately prior to the review period at least one HIV medical care visit at your clinic or at least one viral load test performed within or reported to your organization; and (2) have had at least one HIV medical care visit at your clinic during the review period; and (3) not be analytically excludable due to death during the review period or incarceration, relocation outside of NYS or ongoing external HIV care within NYS as of the end of the review period. For ACTNEW, the patient must (1) have NOT had during the two years immediately prior to the review period any HIV medical care visits at your clinic nor any viral load tests performed within or reported to your organization; and (2) have had at least one HIV medical care visit at your clinic during the review period; and (3) not be analytically excludable due to death during the review period or incarceration, relocation outside of NYS or ongoing external HIV care within NYS as of the end of the review period. Patients who died during the review period, relocated outside of NYS during the review period or who were receiving ongoing external HIV care or were incarcerated as of the end of the review period should be included in the reported data but will be excluded from most indicator scoring. These patients should be classified as DEC, RELOC, EXTCARE or INC, respectively. All other patients should be entered as 'OTH' (other status).
Clinic (where was the patient enrolled in care?)	clinic_code	New or established active patients	Single selection	Must match one of the clinic codes we have defined for your organization.	If seen at multiple sites, location where seen most often or, if tied, where seen last. Leave blank if not applicable (<i>enrollment</i> does <u>not</u> equal ACTEST or ACTNEW).
Service line (where was the patient seen within your system?)	service_line	Unknown-status patients (enrollment = 'OTH')	Multiple selection (as needed, comma separated)	DS (= dental services), ED (= emergency department/urgent care), FACHIV (= faculty practice HIV care outside HIV clinic(s)), IP (= inpatient care, including ICU, surgery and psychiatric care), MBHS (= outpatient mental and behavioral health services), NHSC (= non-HIV specialty care such as cardiology, pulmonology, neurology, ambulatory surgery,	Leave blank if not applicable. Include all applicable services, but only list each one once. For example, a patient with one inpatient stay, two dental appointments and three visits to the emergency department should be listed as "IP, DS, ED", not "IP, DS, DS, ED, ED, ED".

				etc.), PC (= primary care provided outside of your HIV clinic(s)), RHS (= reproductive health services), SS (= supportive services), OTH (= other)	
Service line specifics	other_service_specify	Patient seen on "other" service	Text	Up to 200 characters	Enter a brief description of any service line that does not match one of the predefined categories. Leave blank if not applicable.
Diagnosis status (when was the patient diagnosed, and if during the review period, where?)	diagnosis	All patients	Single selection	NEWEXT (= externally diagnosed during the review period), NEWINT (= internally diagnosed during the review period), PREV (= diagnosed prior to the review period), UK (= unknown)	Mark 'UK' if unknown.
Was the patient on ARV (besides PrEP or PEP) during review period?	arv	All patients	Single selection	NO, YES, UK (= unknown)	For "YES": At least one prescription for ARV therapy, concurrent with or following diagnosis and during the review period, from any provider (within your medical organization or outside).
How was ARV provided?	arv_mode	All patients on ARV	Single selection	INJECTION, ORAL, BOTH, UK (= unknown), NA (= not applicable as patient was not on ARV therapy)	Enter 'BOTH' if patient received at least one prescription for both oral and injection medication during the review year. <u>Enter 'UK' only if patient was known to be on some ARV medication but not known whether this was delivered orally or by injection.</u> Enter 'NA' if patient was not on any ARV medication during the review year.
Was a VL test obtained during the review period?	vl_test_review_year	All patients	Single selection	NO, YES, UK (= unknown)	Mark 'UK' if unknown. Must be on or after diagnosis date for newly diagnosed patients (see related fields below).
Diagnosis date	diagnosis_date	Newly diagnosed patients	Date	*m/*d/yyyy	Enter the <u>earliest</u> available date when any of these events occurred: (i) HIV-1 and/or HIV-2 antibodies detected on antibody differentiation immunoassay (date of report) (ii) Acute HIV-1 infection detected on HIV-1 NAT (date of report) (iii) Second positive rapid HIV test (different manufacturer than for first test) conducted (iv) Date when treating physician entered a diagnosis of HIV disease or initiated ARV therapy on a presumptive diagnosis of HIV disease For externally diagnosed patients, this date should be when the external provider made the initial diagnosis (as specified above) if that can be determined. If necessary, this can be estimated using the assumed date of the first positive test.
Resistance test (among newly diagnosed patients enrolled in HIV care)	resistance_test	Newly diagnosed patients	Single selection	NO, YES, UK (= unknown), NA (= not applicable)	Qualifying events include a resistance test performed within your organization or documentation of an external test performed during the review period. Mark 'NA' if patient is not enrolled in care (<i>enrollment</i> does not equal 'ACTNEW') or was previously diagnosed.

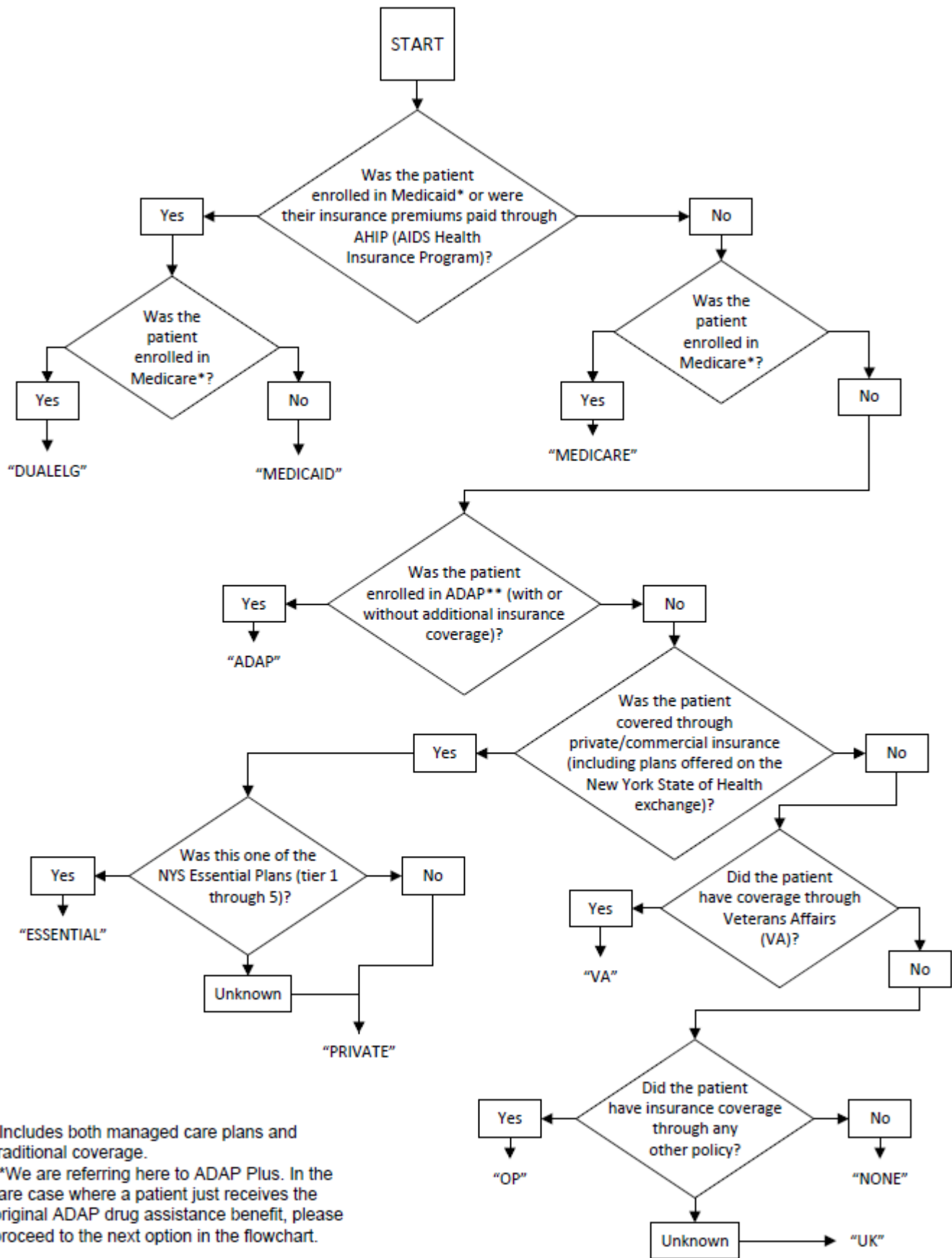
Was the patient seen for HIV care during review period?	hiv_clinic_visit	Newly diagnosed patients	Single selection	NO, YES, UK (= unknown), NA (= not applicable)	Qualifying events include an HIV medical care visit at your clinic or at an external provider following your referral for external care. Mark 'UK' if unknown, 'NA' if patient was previously diagnosed.
If yes, date of first visit with an HIV provider	hiv_clinic_visit_date	Newly diagnosed patients	Date	*m/*d/yyyy	Enter the <u>earliest</u> available date <u>on or after diagnosis date</u> and during the review period when either of these events occurred: (i) First HIV medical care visit at one of your clinics (ii) First HIV medical care visit at another medical organization following your referral for external care Date cannot be before the diagnosis date. Leave blank if diagnosis status is unknown or previously diagnosed or if the patient was not seen for HIV care during the review period.
Date of ARV initiation	arv_initiation_date	Newly diagnosed patients	Date	*m/*d/yyyy	Enter the date of the first known ARV prescription during the review period (other than PEP) that was <u>not prior to date of diagnosis or first visit within your medical organization (can be before first visit to HIV clinic)</u> . Date cannot be before the diagnosis date. Leave blank if diagnosis status is unknown or previously diagnosed or if the patient was not prescribed ARV therapy during the review period.
Was a suppressed viral load obtained during the review period?	suppressed_ever_review_year	Newly diagnosed patients	Single selection	NO, YES, UK (= unknown), NA (= not applicable)	Mark 'UK' if unknown, 'NA' if patient was previously diagnosed or not tested. For 'YES', at least one suppressed viral load must have occurred on or after diagnosis date and by end of the review period (see related fields below).
Date of first VL test during review period	first_vl_date_newly_dx	Newly diagnosed patients	Date	*m/*d/yyyy	Enter the earliest available documented date, <u>not prior to date of diagnosis or first visit within your medical organization (can be before first visit to HIV clinic)</u> , when a viral load test result was reported. Date cannot be before the diagnosis date. Leave blank if diagnosis status is unknown or previously diagnosed.
Date of first suppressed VL	first_suppressed_date_newly_dx	Newly diagnosed patients	Date	*m/*d/yyyy	Enter the earliest available documented date, not prior to date of diagnosis or first visit within your medical organization, when a viral load test result of less than 200 copies/mL (or "undetectable" based on a test with a threshold of sensitivity less than 200 copies/mL) was reported. Date cannot be before the date of first VL test. Leave blank if a suppressed viral load was not obtained during the review period.
Was the patient suppressed on final VL test during the review period?	suppressed_final_review_year	Previously diagnosed patients	Single selection	NO, YES, UK (= unknown), NA (= not applicable as the patient was newly diagnosed or not tested during the review period)	Mark 'UK' if unknown, 'NA' if patient is newly diagnosed or was not tested.

<p>Was a frailty or functional status screen performed during the review period?</p>	<p>frailty_or_function_screen</p>	<p>Older patients</p>	<p>Single selection</p>	<p>NO, YES, UK (= unknown), NA (= not applicable as the patient was not eligible based on age or enrollment status)</p>	<p>Newly modified and required indicator for 2025 Review. Eligibility is limited to patients enrolled in HIV care who were (a) at least 51 years old as of end of review period or (b) at least 31 years old as of end of review period and acquired HIV through perinatal transmission. These screens should be done using a published (and preferably validated) tool designed for gaining insight into a patient’s frailty or functional status. In-house modification of the tool to suit the needs of your clinic is acceptable, but the screening should be more substantive than routine medical monitoring such as BMI calculations. Suggested frailty screens include FRAIL scale, Gérontopôle Frailty Screening Tool, Dalhousie Clinical Frailty Scale and Rockwood Frailty Index. Suggested functional status screens include the modified ICOPE screen, Timed Up and Go (TUG) screen and the Instrumental Activities of Daily Living (IADL) screens such as the Lawton IADL.</p>
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Appendix 2: Guidance on Entering Values in the Insurance Field

- Determinations should be made based on last status check during the review year (2025). If insurance was not checked during the review year, enter “UK” (unknown).
- Please follow the flowchart on the next page to determine which category applies.
- The policy covering the individual should be entered regardless of who the primary holder of the policy may be. For example, someone who is covered by their spouse’s work-related insurance would have private/commercial insurance.
- For patients classified as “MEDICAID” or “DUALELG”, there is a follow-up field for the Medicaid number. This is an 8-character sequence in the form of two letters, five numbers and one final letter. It should be available for all patients enrolled in Medicaid, but it may need to be extracted from a longer value that contains additional information about the Medicaid policy.
- “OP” (other plan) will typically apply to few if any of your patients. One possible example would be worker’s compensation coverage that provides health benefits when an employee is not normally covered by commercial insurance offered by the employer.

[Continues on next page.]



Appendix 3: Data Validation Details

Field Name	Data Length	Special Formatting / Values	Validation Rules	Warnings Will Be Issued
first_name	VARCHAR(50)		(i) Field cannot be blank (ii) Entry cannot be longer than 50 characters	
last_name	VARCHAR(80)		(i) Field cannot be blank (ii) Entry cannot be longer than 80 characters	
middle_initial	CHAR(1)		(i) Field must either be blank or exactly one character in length	
dob	DATE	mm/dd/yyyy	(i) Field cannot be blank (ii) Value must be a date, preferably in *m/*d/yyyy format (iii) Date cannot be before '01/01/1900' (iv) Date cannot be after last day of the review period	(i) If patient was under 5 years old or over 90 years old by the end of the review period
mrn	VARCHAR(50)		(i) Entry cannot be longer than 50 characters	(i) If blank
zip	VARCHAR(5)	Five-digit Zip Code or UK (= unknown) or NA (= not applicable, if patient has never been domiciled in the United States)	(i) Field cannot be blank (ii) Entry must be 'UK', 'NA' or consist of five numerical characters entered as text (to allow for values that begin with one or more zeros)	(i) If 'UK' or 'NA' and <i>housing</i> = 'S'
birth_sex	VARCHAR(2)	F (= female), I (= intersex), M (= male), UK (= unknown)	(i) Field cannot be blank (ii) Entry must match one of the allowable values (iii) Entry for this field and for <i>gender</i> cannot both equal 'UK'	(i) If 'UK' (ii) If <i>birth_sex</i> = 'F' and <i>gender</i> = 'M' or 'TGW' (iii) If <i>birth_sex</i> = 'M' and <i>gender</i> = 'F' or 'TGM'
gender	VARCHAR(5)	F (= female), M (= male), TGM (= transgender man), TGW (= transgender woman), X (= gender X), OTH (= transgender other, non-binary, gender non-conforming, other), UK (= unknown)	(i) Field cannot be blank (ii) Entry must match one of the allowable values (iii) Entry for this field and for <i>birth_sex</i> cannot both equal 'UK'	(i) If 'UK' (ii) If <i>birth_sex</i> = 'F' and <i>gender</i> = 'M' or 'TGW' (iii) If <i>birth_sex</i> = 'M' and <i>gender</i> = 'F' or 'TGM'

sexual_orientation	VARCHAR(3)	A (= asexual), B (= bisexual), G (= gay or lesbian), S (= straight or heterosexual), OTH (= other sexual orientation including queer or pansexual), NS (= not sure or questioning), UK (= unknown)	(i) Field cannot be blank (ii) Entry must match one of the allowable values	(i) If 'UK' and enrollment = 'ACTNEW' or 'ACTEST'
ethnicity	VARCHAR(2)	H (= Hispanic or Latino/Latina), NH (= non-Hispanic/Latino/Latina), UK (= unknown)	(i) Field cannot be blank (ii) Entry must match one of the allowable values	(i) If 'UK' and enrollment = 'ACTNEW' or 'ACTEST'
hispanic_subgroup	VARCHAR(12)	CA (= Central American), CU (= Cuban), D (= Dominican), M (= Mexican, Mexican American or Chicano/Chicana), PR (= Puerto Rican), SA (= South American), SP (= Spanish), OH (= other Hispanic, Latino/Latina, Spanish Origin), UK (= unknown), NA (= not applicable as patient is not Hispanic)	(i) Field cannot be blank or 'NA' if ethnicity = 'H' (ii) Entry cannot be longer than 25 characters (iii) After parsing by commas and stripping blanks, each token must match one of the allowed values (iv) 'UK' and 'NA' cannot be combined with other tokens	(i) If not blank or 'NA' and ethnicity does not equal 'H'
race	VARCHAR(25)	ASIAN, AIAN (= American Indian or Alaska Native), B (= Black or African American), , NHPI (= Native Hawaiian or Pacific Islander), W (= White), UK (= unknown)	(i) Field cannot be blank (ii) Entry cannot be longer than 25 characters (iii) After parsing by commas and stripping blanks, each token must match one of the allowed values (iv) 'UK' cannot be combined with other tokens	(i) If 'UK' and enrollment = 'ACTNEW' or 'ACTEST'
asian_subgroup	VARCHAR(40)	AI (= Asian Indian), BAN (= Bangladeshi), BUR (= Burmese), CAM (= Cambodian), CHI (= Chinese), FIL (= Filipino), HM (= Hmong), IND (= Indonesian), JP (= Japanese), KOR (= Korean), LAO (= Laotian), MAL (= Malaysian), NP (= Nepalese), PK (= Pakistani), SL (= Sri Lankan), TA (= Taiwanese), TH	(i) Field cannot be blank or 'NA' if race contains 'ASIAN' (as a distinct token) (ii) Entry cannot be longer than 40 characters (iii) After parsing by commas and stripping blanks, each token must match one of the allowed values (iv) 'UK' and 'NA' cannot be combined with other tokens	(i) If not blank or 'NA' and race does not contain 'ASIAN' as a distinct token

		(= Thai), TI (= Tibetan), V (= Vietnamese), OA (= other Asian), UK (= unknown), NA (= not applicable)		
nhpi_subgroup	VARCHAR(25)	F (= Fijian), G (= Guamanian), H (= Hawaiian), S (= Samoan), T (= Tongan), OPI (= other Pacific Islander), UK (= unknown), NA (= not applicable)	(i) Field cannot be blank or 'NA' if <i>race</i> contains 'NHPI' (as a distinct token) (ii) Entry cannot be longer than 25 characters (iii) After parsing by commas and stripping blanks, each token must match one of the allowed values (iv) 'UK' and 'NA' cannot be combined with other tokens	(i) If not blank or 'NA' and race does not contain 'NHPI' as a distinct token
language	VARCHAR(8)	ARABIC, BENGALI, BURMESE, CHINESE, CREOLE (= Haitian Creole), ENGLISH, FRENCH, HINDI, ITALIAN, JAPANESE, KOREAN, NEPALI, POLISH, RUSSIAN, SPANISH, URDU, YIDDISH, OTH (= other language), UK (= unknown)	(i) Field cannot be blank (ii) Entry must match one of the allowable values	
other_language_specify	VARCHAR(50)		(i) Entry cannot be longer than 200 characters	(i) If field is blank and <i>language</i> = 'OTH' (ii) If field is not blank and <i>language</i> does not = 'OTH'
housing	VARCHAR(2)	S (= stable/permanent), T (= temporary), US (= unstable), UK (= unknown)	(i) Field cannot be blank (ii) Entry must match one of the allowable values	(i) If 'UK' and enrollment = 'ACTNEW' or 'ACTEST'
hiv_risk	VARCHAR(40)	BLOOD (= blood transfusion/blood products), HEMO (= hemophilia/coagulation disorder), IDU (= injecting drug use), PERI (= perinatal transmission), SEXUAL (= sexual exposure), OTH (= other), UK (= unknown)	(i) Field cannot be blank (ii) Entry cannot be longer than 40 characters (iii) After parsing by commas and stripping blanks, each token must match one of the allowed values (iv) 'UK' cannot be combined with other tokens	(i) If 'UK' is an included token and enrollment = 'ACTNEW' or 'ACTEST' (ii) If 'PERI' is combined with other tokens

insurance	VARCHAR(8)	ADAP (= AIDS Drug Assistance Program (Primary Care)), DUALELG (= Medicaid & Medicare), ESSENTIAL (= NYS Essential Plan), MEDICAID, MEDICARE, PRIVATE (= individual or employer-based private insurance other than Essential Plan), VA (= Veteran's Administration), OP (= other plan), NONE, UK (= unknown)	(i) Field cannot be blank (ii) Entry must match one of the allowable values	(i) If 'UK' and <i>enrollment</i> = 'ACTNEW' or 'ACTEST'
medicaid_number	VARCHAR(8)	Eight characters in this sequence: two letters, five numbers, and one letter. NA for patients with other primary insurance, NS if number is in a non-standard format and the 8-character CIN cannot be extracted, UK if unknown.	(i) If <i>insurance</i> = 'MEDICAID' or 'DUALELG', cannot be blank and must either be 'NS' (non-standard format), 'UK' or an eight-character entry in the form of two letters, five numbers, and one final letter	(i) If not blank or 'NA' and <i>insurance</i> does not equal 'MEDICAID' or 'DUALELG'
enrollment	VARCHAR(6)	ACTEST (= active, seen prior to the review period, continuing in program), ACTNEW (= active, new to clinic during review period or returning after not being seen the previous two years, continuing in program), DEC (= died during review period), EXTCARE (= confirmed to be receiving ongoing HIV care at another site as of end of the review period), INC (= incarcerated as of end of review period), RELOC (= relocated out of New York State during the review period), OTH (= other status, not enrolled in care at your organization)	(i) Field cannot be blank (ii) Entry must match one of the allowable values	

clinic_code	VARCHAR(10)		(i) If <i>enrollment</i> = 'ACTNEW' or 'ACTEST', field cannot be blank (ii) If <i>enrollment</i> = 'ACTNEW' or 'ACTEST', value must match one of the clinic codes in our predefined list for the submitting organization	(i) If field is not blank and <i>enrollment</i> does not equal 'ACTNEW' or 'ACTEST'
service_line	VARCHAR(50)	"DS (= dental services), ED (= emergency department/urgent care), FACHIV (= faculty practice HIV care outside HIV clinic(s)), IP (= inpatient care, including ICU, surgery and psychiatric care), MBHS (= outpatient mental and behavioral health services), NHSC (= non-HIV specialty care such as cardiology, pulmonology, neurology, ambulatory surgery, etc.), PC (= primary care provided outside of your HIV clinic(s)), RHS (= reproductive health services), SS (= supportive services), OTH (= other)	(i) Entry cannot be longer than 50 characters (ii) After parsing by commas and stripping blanks, each token must match one of the allowed values (iii) If <i>enrollment</i> equals 'OTH' field cannot be blank	(i) If field is not blank and <i>enrollment</i> does not equal 'OTH'
other_service_specify	VARCHAR(200)		(i) Entry cannot be longer than 200 characters	(i) If field is blank and 'OTH' is an included token for <i>service_line</i> (ii) If field is not blank and <i>enrollment</i> does not equal 'OTH'
diagnosis	VARCHAR(6)	NEWINT (= internally diagnosed during the review period), NEWEXT (= externally diagnosed during the review period), PREV (= diagnosed prior to the review period), UK (= unknown)	(i) Field cannot be blank (ii) Entry must match one of the allowable values (iii) Cannot be 'NEWINT' or 'NEWEXT' if <i>enrollment</i> = 'ACTEST'	
arv	VARCHAR(3)	YES, NO, UK (= unknown)	(i) Field cannot be blank (ii) Entry must match one of the	(i) If 'UK' and <i>enrollment</i> = 'ACTNEW' or 'ACTEST'

			allowable values (iii) Must equal 'YES' if <i>arv_initiation_date</i> is not blank	
arv_mode	VARCHAR(9)	INJECTION, ORAL, BOTH, UK (= unknown), NA (= not applicable as patient was not on ARV therapy)	(i) Field cannot be blank (ii) Entry must match one of the allowable values (iii) Cannot be 'NA' if <i>arv</i> = 'YES' (iv) Must be 'NA' if <i>arv</i> is not equal to "YES"	i) If 'UK' and enrollment = 'ACTNEW' or 'ACTEST'
vl_test_review_year	VARCHAR(3)	YES, NO, UK (= unknown)	(i) Field cannot be blank (ii) Entry must match one of the allowable values	i) If 'UK' and <i>enrollment</i> = 'ACTNEW' or 'ACTEST'
diagnosis_date	DATE	mm/dd/yyyy	(i) If field is not blank, value must be a date, preferably in *m/*d/yyyy format (ii) If <i>diagnosis</i> equals 'NEWINT' or 'NEWEXT': (a) Field cannot be blank (b) Date cannot be outside of the review period (iii) If <i>diagnosis</i> = 'PREV', field must be blank or prior to the review period (iv) If <i>diagnosis</i> = 'UK', field must be blank	
resistance_test	VARCHAR(3)	YES, NO, UK (= unknown), NA (= not applicable as the patient was not newly diagnosed or not enrolled in care)	(i) If <i>diagnosis</i> equals 'NEWINT' or 'NEWEXT' and <i>enrollment</i> equals 'ACTNEW': (a) Field cannot be blank (b) Value must match one of the allowable values other than 'NA'	(i) If <i>diagnosis</i> = 'PREV' or 'UK' or <i>enrollment</i> does not equal 'ACTNEW' and field is not blank and not equal to 'NA'
hiv_clinic_visit	VARCHAR(3)	YES, NO, UK (= unknown), NA (= not applicable as the patient was not newly diagnosed)	(i) If <i>diagnosis</i> equals 'NEWINT' or 'NEWEXT': (a) Field cannot be blank (b) Value must match one of the allowable values other than 'NA' (c) If <i>enrollment</i> = "ACTNEW" or <i>hiv_clinic_visit_date</i> is not blank, value must be 'YES'	(i) If <i>diagnosis</i> = 'PREV' or 'UK' and field is not blank and not equal to 'NA'

hiv_clinic_visit_date	DATE	mm/dd/yyyy	<p>(i) If field is not blank, value must be a date, preferably in *m/*d/yyyy format</p> <p>(ii) If <i>diagnosis</i> equals 'NEWINT' or 'NEWEXT' and <i>hiv_clinic_visit</i> = 'YES':</p> <p>(a) Field cannot be blank</p> <p>(b) Date cannot be before that entered in <i>diagnosis_date</i></p> <p>(c) Date cannot be after the end of the review period</p>	(i) If <i>diagnosis</i> = 'PREV' or 'UK' and field is not blank
arv_initiation_date	DATE	mm/dd/yyyy	<p>(i) If field is not blank, value must be a date, preferably in *m/*d/yyyy format</p> <p>(ii) If <i>diagnosis</i> equals 'NEWINT' or 'NEWEXT' and <i>arv</i> = 'YES':</p> <p>(a) Field cannot be blank</p> <p>(b) Date cannot be before that entered in <i>diagnosis_date</i></p> <p>(c) Date cannot be after the end of the review period</p>	(i) If <i>diagnosis</i> = 'PREV' or 'UK' and field is not blank
suppressed_ever_review_year	VARCHAR(3)	YES, NO, UK, NA (= not applicable as the patient was diagnosed prior to the review period or was not tested during the review period)	<p>(i) If <i>diagnosis</i> equals 'NEWINT' or 'NEWEXT':</p> <p>(a) Field cannot equal 'NA' if <i>vl_test_review_year</i> = 'YES'</p> <p>(b) Entry must match one of the allowable values</p> <p>(c) If <i>vl_test_review_year</i> does not equal 'YES', this field cannot be 'YES'</p>	(i) Entry of 'NO' or 'UK' if <i>vl_test_review_year</i> does not equal 'YES'
first_vl_date_newly_dx	DATE	mm/dd/yyyy	<p>(i) If field is not blank, value must be a date, preferably in *m/*d/yyyy format</p> <p>(ii) If <i>diagnosis</i> equals 'NEWINT' or 'NEWEXT' and <i>vl_test_review_year</i> = 'YES':</p> <p>(a) Field cannot be blank</p> <p>(b) Date cannot be before date entered in <i>diagnosis_date</i></p> <p>(c) Date cannot be after the end of the review period</p>	(i) If <i>diagnosis</i> = 'PREV' or 'UK' and field is not blank

			(iii) If <i>vl_test_review_year</i> does not equal 'YES' this field must be blank	
first_suppressed_date_newly_dx	DATE	mm/dd/yyyy	<p>(i) If field is not blank, value must be a date, preferably in *m/*d/yyyy format</p> <p>(ii) If <i>diagnosis</i> equals 'NEWINT' or 'NEWEXT' and <i>suppressed_ever_review_year</i> = 'YES':</p> <p>(a) Field cannot be blank</p> <p>(b) <i>First_vl_date_newly_dx</i> cannot be blank and date of first suppressed VL cannot be before date entered in <i>first_vl_date_newly_dx</i></p> <p>(c) Date cannot be after the end of the review period</p> <p>(iii) If <i>suppressed_ever_review_year</i> does not equal 'YES' or 'NA' this field must be blank</p>	<p>(i) If <i>diagnosis</i> = 'PREV' or 'UK' and field is not blank</p> <p>(ii) If date entered for this field is before, on, or less than 7 days after the date entered for <i>arv_initiation_date</i></p> <p>(iii) If date entered for this field is less than 7 days after date entered for <i>diagnosis_date</i></p>
suppressed_final_review_year	VARCHAR(3)	YES, NO, UK, NA (= not applicable as the patient was newly diagnosed or not tested during the review period)	<p>(i) If <i>diagnosis</i> equals 'PREV' or 'UK':</p> <p>(a) Field cannot be blank or 'NA' if <i>vl_test_review_year</i> = 'YES'</p> <p>(b) Entry must match one of the allowable values</p> <p>(ii) If VL Test Review Year != 'YES', cannot be 'YES'</p>	<p>(i) Any non-blank entry besides 'NA' or 'UK' if <i>diagnosis</i> does not equal 'PREV' or 'UK'</p> <p>(ii) Entry of 'NO' or 'UK' if <i>vl_test_review_year</i> does not equal 'YES'</p>
frailty_or_function_screen	VARCHAR(3)	NO, YES, UK (= unknown), NA (= not applicable as the patient was not eligible based on age or enrollment status)	<p>(i) If not blank, must match one of the allowable values</p> <p>(ii) If <i>Enrollment</i> = 'ACTEST' or <i>Enrollment</i> = 'ACTNEW' and patient was at least 51 as of end of review period, this field cannot be blank or 'NA'</p> <p>(iii) If <i>Enrollment</i> = 'ACTEST' or <i>Enrollment</i> = 'ACTNEW', patient was at least 31 as of end of review period and <i>HIV_risk</i> includes "PERI", this field cannot be blank or 'NA'</p>	<p>(i) Enrollment is neither 'ACTEST' nor 'ACTNEW', and field is not blank or 'NA'</p> <p>(ii) Enrollment is either 'ACTEST' or 'ACTNEW' but the patient is below the age thresholds, and field is not blank or 'NA'</p>

Appendix 4: Suggested Frailty and Functional Status Screens

The indicator has been expanded to include use of either frailty or functional status screens. These screens should be done using a published (and preferably validated) tool designed for gaining insight into a patient's frailty or functional status. In-house modification of the tool to suit the needs of your clinic is acceptable, but the screening should be more substantive than routine medical monitoring such as BMI calculations. While, so long as it meets the aforementioned criteria, the screening tool used is up to each organization, we have included examples of acceptable tools recommended by our quality advisory committee medical experts. We have also identified three functional status screens that can be helpful in managing the care of older people living with HIV. Other screens that meet the criteria mentioned above are also acceptable. As described in the preceding instructions, we are assessing the screening for all patients enrolled in HIV care who were either at least 51 years old by the end of the review period or who were at least 31 years old and had acquired HIV perinatally.

Frailty Screens

FRAIL Questionnaire

- Fatigue: Are you fatigued?
- Resistance: Cannot walk up 1 flight of stairs?
- Aerobic: Cannot walk 1 block?
- Illnesses: Do you have more than 5 illnesses?
- Weight Loss: Have you lost more than 5% of your weight in the past 6 months?

3 or Greater = Frailty

1 or 2 = Prefrail

Reference: Morley et al. Journal of Nutrition, Health and Aging. 2012 Jul;16(7):601-8. PMID: 22836700 PMC4515112

Gérontopôle Frailty Screening Tool

- Living alone?
- Involuntary weight loss in the past 3 months?
- Fatiguability from the past 3 months?
- Mobility difficulties for the past 3 months?
- Memory complaints?
- Slow gait speed (> 4 seconds for 4 meters)

Frailty = At least one, plus "gestalt" assessment

Reference: Subra et al. Journal of Nutrition, Health and Aging. 2012 doi: 10.1007/s12603-012-0391-7.

[Appendix continues on the next page.]



Top Tips to help you use the Clinical Frailty Scale

The Clinical Frailty Scale (CFS) was designed to summarise the results of a Comprehensive Geriatric Assessment. It's now commonly being used as a triage tool to make important clinical decisions, so it is imperative that it is used correctly.

#1 It's all about the baseline
If the person you are assessing is acutely unwell, score how they were 2 weeks ago, not how they are today.

#2 You must take a proper history
The CFS is an objective clinical assessment tool. Frailty must be sensed, described, and measured - not guessed.

#3 Trust, but verify
What the person you are assessing says is important, but should be cross-referenced with family/carers. **The CFS is a judgement-based tool**, so you must integrate what you are told, what you observe, and what your professional clinical experience tells you from dealing with older adults

#4 Over-65s only
The CFS is not validated in people under 65 years of age, or those with stable single-system disabilities. However, documenting how the person moves, functions, and has felt about their health may help to create an individualised frailty assessment.

#5 Terminally ill (CFS 9)
For people who appear very close to death, the current state (i.e. that they are dying) trumps the baseline state.

#6 Having medical problems does not automatically increase the score to CFS 3
A person who isn't bothered by symptoms and whose condition(s) doesn't limit their lives can be CFS 1 or 2 if they're active and independent.

#7 Don't forget "vulnerable" (CFS 4)
People in this category are not dependent (though they may need assistance with heavy housework), but often complain of "slowing down". They're becoming sedentary, with poor symptom control.

#8 Dementia doesn't limit use of the CFS
Decline in function in people living with dementia follows a pattern similar to frailty: mild, moderate and severe dementia generally map to CFS 5, 6 and 7 respectively. If you don't know the stage of dementia, follow the standard CFS scoring.

#9 Drill down into changes in function
When considering more complex activities of daily living (such as cooking, managing finances, and running the home) the focus is on *change* in function. A person who has always relied on someone else to perform a particular activity should not be considered dependent for that activity if they've never had to do it before and may not know how.

Kenneth Rockwood, Sherri Fay, Olga Theou & Linda Dykes
v2.0 5 June 2020



Reference: Rockwood K, Theou O. "Using the Clinical Frailty Scale in allocating scarce health care resources." Canadian Geriatrics Journal. 2020;23:254-259.

Frailty Index (Accumulation of Deficits)

Scored as a percentage positive of a list of deficits. This is only feasible if it can be programmed into the electronic health record system. See online reference for additional details.

Reference: <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0201394>

Functional Status Screens

Modified ICOPE Screen

A version of the World Health Organization’s Integrated Care for Older People screening instrument that has been adapted for the needs of HIV care providers.

Patient Name & DOB:	Screener Name:	Screening Complete? <input type="checkbox"/>	Date:
MODIFIED WHO ICOPE SCREENING TOOL			
<i>Assess fully any domain with a checked box.</i>			
MEMORY	1. Remember three words: flower, door, rice (for example)		
	2. Orientation in time and space: What is the month, day, and year today? Where are you now (home, clinic, etc.)?	<input type="checkbox"/>	Wrong to either question or doesn't know
	3. Recalls all three words?	<input type="checkbox"/>	No
MOBILITY	1. Are you able to get around without difficulty?	<input type="checkbox"/>	No
	2. Do you require durable (e.g., cane, walker) medical equipment for moving around?	<input type="checkbox"/>	Yes
	3. <i>*In Person Only* Chair rise test: Rise from the chair five times without using arms. Did the person complete 5 chair rises within 14 seconds?</i>	<input type="checkbox"/>	No
NUTRITION	1. Weight: Have you unintentionally lost more than 3kg/6.6lbs over the last three months?	<input type="checkbox"/>	Yes
	2. Appetite: Have you experienced loss of appetite?	<input type="checkbox"/>	Yes
	3. Are you able to eat without difficulty?	<input type="checkbox"/>	No
VISION	1. Are you having trouble seeing, even when wearing glasses or contacts?	<input type="checkbox"/>	Yes
	2. Have you had an eye exam in the last 12 months?	<input type="checkbox"/>	No
HEARING	1. Are you having trouble hearing, even with hearing assistance (e.g., hearing aids)?	<input type="checkbox"/>	Yes
	2. <i>*In Person Only* Hears whispers (whisper test) OR Screening audiometry result is 35 dB or less OR Passes automated app-based digits-in-noise test</i>	<input type="checkbox"/>	No
MOOD	1. Over the past two weeks, have you been bothered by:		
	- Feeling down, depressed, or hopeless?	<input type="checkbox"/>	Yes
	- Little interest or pleasure in doing things?	<input type="checkbox"/>	Yes
	- Feeling lonely or isolated?	<input type="checkbox"/>	Yes
NOTES	Space for other comments.		

Reference: https://quality.aidsinstituteny.org/QualManage/QualManage/QM_Aging_and_Long_term_Survivors_En

Timed Up and Go (TUG) Screen

An easy to administer and validated mobility and fall-risk test developed in 1991 and based on a more comprehensive test, the Get-Up and Go Test.

ASSESSMENT

Timed Up & Go (TUG)

Purpose: To assess mobility

Equipment: A stopwatch

Directions: Patients wear their regular footwear and can use a walking aid, if needed. Begin by having the patient sit back in a standard arm chair and identify a line 3 meters, or 10 feet away, on the floor.

① Instruct the patient:

When I say "Go," I want you to:

1. Stand up from the chair.
2. Walk to the line on the floor at your normal pace.
3. Turn.
4. Walk back to the chair at your normal pace.
5. Sit down again.

NOTE:
Always stay by the patient for safety.

② On the word "Go," begin timing.

③ Stop timing after patient sits back down.

④ Record time.

Time in Seconds: _____

An older adult who takes ≥ 12 seconds to complete the TUG is at risk for falling.

CDC's STEADI tools and resources can help you screen, assess, and intervene to reduce your patient's fall risk. For more information, visit www.cdc.gov/steady

Patient _____

Date _____

Time _____ AM PM

OBSERVATIONS

Observe the patient's postural stability, gait, stride length, and sway.

Check all that apply:

- Slow tentative pace
- Loss of balance
- Short strides
- Little or no arm swing
- Steadying self on walls
- Shuffling
- En bloc turning
- Not using assistive device properly

These changes may signify neurological problems that require further evaluation.



Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

2017



Stopping Elderly Accidents, Deaths & Injuries

References:

<https://www.cdc.gov/steady/media/pdfs/STEADI-Assessment-TUG-508.pdf>

<https://academic.oup.com/ageing/article/37/4/442/40977>

[Appendix continues on next page.]

Lawton Instrumental Activities of Daily Living

One of several screens that assess a person's ability to perform "real life" tasks such as using the phone and managing transportation and food preparation needs.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE (IADL)

M.P. Lawton & E.M. Brody

Rationale

This tool is valuable for evaluating patients with early-stage disease, both to assess the level of disease and to determine the patient's ability to care for him- or herself. At a higher level of functioning are the instrumental activities of daily living (IADLs). Whereas basic activities of daily living (ADLs) diminish in the late-middle and later phases of the illness, IADLs diminish earlier. Performance of IADLs requires mental as well as physical capacity. The IADL scale measures the functional impact of emotional, cognitive, and physical impairments. Only four IADLs are used when determining if an individual is eligible to receive personal care service. If an individual is eligible for personal care services, he/she may receive assistance with IADLs that are not considered when determining the eligibility for personal care services, but have been scored a 1 or 2. IADLs are scored based on what an individual can do rather than what he/she is doing. IADLs should be scored based on how an individual usually performs a task.

Ability to Use Telephone

1. Operates telephone on own initiative; looks up and dials numbers.....1
2. Dials a few well-known numbers.....1
3. Answers telephone, but does not dial.....1
4. Does not use telephone at all.....0

Shopping

1. Takes care of all shopping needs independently.....1
2. Shops independently for small purchases0
3. Needs to be accompanied on any shopping trip0
4. Completely unable to shop0

Food Preparation

1. Plans, prepares, and serves adequate meals independently.....1
2. Prepares adequate meals if supplied with ingredients.....0
3. Heats and serves prepared meals or prepares meals but does not maintain adequate diet0
4. Needs to have meals prepared and served0

Housekeeping

1. Maintains house alone with occasion assistance (heavy work).....1
2. Performs light daily tasks such as dishwashing, bed making.....1
3. Performs light daily tasks, but cannot maintain acceptable level of cleanliness1
4. Needs help with all home maintenance tasks1
5. Does not participate in any housekeeping tasks.....0

Laundry

1. Does personal laundry completely.....1
2. Launders small items, rinses socks, stockings, etc1
3. All laundry must be done by others0

Mode of Transportation

1. Travels independently on public transportation or drives own car1
2. Arranges own travel via taxi, but does not otherwise use public transportation.....1
3. Travels on public transportation when assisted or accompanied by another.....1
4. Travel limited to taxi or automobile with assistance of another0
5. Does not travel at all0

Responsibility for Own Medications

1. Is responsible for taking medication in correct dosages at correct time1
2. Takes responsibility if medication is prepared in advance in separate dosages.....0
3. Is not capable of dispensing own medication.....0

Ability to Handle Finances

1. Manages financial matters independently (budgets, writes checks, pays rent and bills, goes to bank); collects and keeps track of income.....1
2. Manages day-to-day purchases, but needs help with banking, major purchases, etc1
3. Incapable of handling money0

Reference: https://www.dementiaresearch.org.au/wp-content/uploads/2016/06/Lawton_IADL_Scale.pdf

Appendix 5: Resources for Information on Out-of-Care Patients

Medical organizations participating in the treatment cascade reviews are encouraged to make use of the New York City and New York State HIV surveillance systems to obtain additional information on patients who may be lost to follow up.

New York City: Providers can browse to this website for the City's HIV Care Status Report System, <https://nyc.gov/site/doh/health/health-topics/aids-hiv-care-status-reports-system.page>, and follow the instructions there. The website provides various pdfs related to standard requests and contact information for urgent requests. A medical license number will be required.

New York State: Providers with a Health Commerce System account can log into that website, <https://commerce.health.state.ny.us>, and browse to the HIV/AIDS Provider Portal: My Content -> All Applications -> H -> HIV/AIDS Provider Portal. Users with a medical license number will see a link for "Out of Care Inquiry," and clicking on that should provide instructions for how to do so. If there are any questions or problems, providers can reach out to the Bureau of HIV / AIDS Epidemiology (BHAEE) at 518-474-4284 or via email at eprfhelp@health.ny.gov.

[Appendixes continue on next page.]

Appendix 6: Health Commerce System Policies & Procedures

Login Page for Health Commerce System: <https://commerce.health.state.ny.us>

Contact Information for Commerce Accounts Management Unit (CAMU)

Phone number: 866-529-1890

Fax number: 518-486-2249

Email: camusupp@health.ny.gov

Mail:

New York State Department of Health
Commerce Accounts Management Unit (CAMU) Supervisors
800 North Pearl Street, Room 214
Albany, NY 12204-1899

Multi-Factor Authentication – Governor’s Office Communication, 8/16/23

Effective August 23, 2023, the Health Commerce System implemented Multi-Factor Authentication (MFA) functionality for the secure file transfer functionality in the Health Commerce System (HCS). Multi-Factor Authentication adds an additional layer of security to the application to ensure security and compliance. All users are required to use MFA to access the Quality of Care Program’s data upload application in the HCS. Users who have not already done so are strongly encouraged to set up MFA as soon as possible to ensure continuity of access.

Users **with** a New York State driver’s license or non-driver photo ID can set up their own MFA:

- Click My Content on the top navigation bar and select “All Applications.”
- Click the “M” tab, then “MFA Enrollment” and complete the required fields.
- Step-by-step directions can be found here: <https://bit.ly/userMFA>

Users **without** a New York State driver’s license or non-driver photo ID must have their MFA set up by their HCS Coordinator using the Coordinator’s Update Tool. HCS Coordinators without a New York State driver’s license or non-driver photo ID must have their MFA completed by a different HCS Coordinator at their organization.

If you do not know your HCS Coordinator or if you need help adding new HCS Coordinators for your organization, contact the Commerce Accounts Management Unit (see above).

Network Requirements for Accessing Health Commerce System (HCS) – Governor’s Office Communication, 8/22/23

This section is intended for network administrators, particularly firewall and proxy security administrators in organizations that need to access the Health Commerce System (HCS). It will help you configure your network to support the secure connection to the HCS. It primarily focuses on the network requirements of accessing HCS from Internet browser via HTTPS. Most organizations deploy an internet firewall, or internet proxy and

firewall, to restrict and control the HTTP based traffic that leaves and enters their network. Follow the firewall and proxy guidance below to enable access to the HCS from your network.

First try testing. The HCS User Acceptance Testing (UAT) website is accessible on the internet at <https://uatcommerce.health.state.ny.us/>. No need to login/authenticate. No further action needed if you can reach the login page of the UAT HCS website. If you are not able to reach the UAT HCS login page, continue below for guidance on ensuring network access for your users.

If you are using a firewall only, note that filtering HCS traffic using IP addresses is NOT recommended, as the IP addresses used by HCS are dynamic and may change at any time. The IP addresses also are not used exclusively by HCS but also by other customers of our service provider.

If your firewall supports URL filtering, configure the firewall to allow the HCS destination URLs listed below. An * shown at the beginning of a URL (e.g., *.health.ny.gov) indicates that services in the top-level domain and all subdomains must be accessible, which will also help to ensure that users in your organization can access other DOH systems in addition to HCS.

- *.health.ny.gov
- *.health.state.ny.us

If your firewall does not support URL filtering and you must use IP filtering, configure the firewall to allow the HCS destination IPs listed here, but please notice that the IP addresses used by HCS are dynamic and may change at any time, therefore you need to continuously review and update your firewall accordingly.

<https://commerce.health.state.ny.us/public/ipapp/>

If you have any questions or issues, please contact hcsoutreach@health.ny.gov.

[Appendixes continue on next page.]

Appendix 7: Statistical Tests Provided on the Data Analysis Worksheet

Chi-square Tests

Data presented in the form of a frequency table are often analyzed for significant variation using a chi-square test. This is done in a series of steps:

- 1) The row and column totals are calculated for the table.
- 2) Using these totals, the number of results that would be expected for each cell if there were no correlation between the columns (i.e., that the number of results in the cell would equal the product of the percentage of values in that row and the percentage of values in that column) is calculated. For example, in Figure A1, the formula for cell D23 is “=(SUM(D21, E21)/SUM(D21:E22))*SUM(D21, D22)” (combining steps 1 and 2 and rearranging the order of the operands).
- 3) The chi-square statistic is then calculated by summing the squared differences of the observed and expected values divided by the number of expected. The squaring ensures that these values will be positive, and the larger the sum the greater the discrepancy from expectations if the outcome were not correlated with membership in the group under consideration. In this case, the formula for cell G23 is “=POWER(D21 - D23,2)/D23 + POWER(E21 - E23,2)/E23 + POWER(D22 - D24,2)/D24 + POWER(E22 - E24,2)/E24.”
- 4) The probability of observing a value this large (or larger) by chance is then calculated by seeing where the value falls in the chi-square distribution. Excel has a built-in function for this, and the formula for cell H23 is “=CHISQ.DIST.RT(G23,1).” Half of the probability (in this case, the relatively small value of $0.03549361/2 = 0.017746807$ or about 1.77%) is for a chi-square value at least this great due to an excess of “true” values, and the other half is for a chi-square value this great due to a deficit of “true” values. It is conventional to treat any (total) p value less than 0.05 as statistically significant, but this is an arbitrary threshold. It is perhaps better to think of this number as falling on a spectrum of confidence, especially when retrospectively reviewing data outside of a formal study design.

Figure A1: Chi-square Calculations

	A	B	C	D	E	F	G	H
17								
18	OUTCOME OF INTEREST			VLS				
19	POPULATION OF INTEREST			Hispanic			Run Chi-square Test	
20				Population	Other Patients			
21			Outcome = True	1820	4093			
22			Outcome = False	271	716		Chi square	P value
23			Expected True	1792	4121		4.4213	0.03549361
24			Expected False	299	688			

Logistic Regression

Regression analysis is process for quantifying the impact of one or more independent variables on an outcome of interest (the dependent variable). For instance, if one had access to data about blood pressure that included the age of each patient, it would be possible to plot a “regression line” for the expected pressure based on age. This line would be defined by a formula: $\text{Pressure} = \text{Intercept} + (x * \text{Age})$, where “x” is a coefficient that defines the slope of the line. Determining this formula entails finding a value for x that maximizes the “fit” of the line to the data points. This is typically done by minimizing the sum of the squared vertical distances between each of the points and the line.

While it is harder to visualize, this process can be extended mathematically to multiple dimensions. So, if one also had the sex and body mass index (BMI) of each patient, it would be possible to define a “best fit” formula for all three factors: $\text{Pressure} = \text{Intercept} + (x * \text{Age}) + (y * \text{Sex}) + (z * \text{BMI})$, where y and z are coefficients for Sex and BMI, and Sex could be coded as male = 0, female = 1, or vice versa.

The above are examples of linear regression. When the relationship between an independent variable and the outcome is non-linear, it may be possible to transform the data first by exponentiating each value (e.g., looking at blood pressure as a function of, among other things, the square root of BMI). However, when we want to predict the probability that something will occur, we are confronted with a more fundamental problem: the probability of an event can never be greater than 100%!

To address this, logistic regression estimates the natural log of the odds of an occurrence in terms of an intercept value and parameter estimates for various factors that may affect the likelihood of that occurrence. The odds of, for instance, viral suppression can be calculated from this equation, where both sides of the initial regression equation have been exponentiated: $\text{Odds} = e^{(a + B_1 \text{Age} + B_2 \text{Housing} + \dots + B_N \text{Race})}$, where a is the intercept estimate and the various Bs are all of the parameter estimates for factors such as age, housing status, race, etc.

Since the odds of the suppression (continuing this example) are defined as the probability of suppression divided by the probability that the patient was not suppressed (i.e., $1 - \text{probability of suppression}$), algebraic rearrangement yields the following equation for the probability of suppression: $\text{Probability} = \text{Odds} / (\text{Odds} + 1)$.

Using these two equations allows for estimation of the probability of suppression for any patient. With this relationship defined, the parameters for the logistic regression equation are chosen by maximizing the (negative) value for the log of the “likelihood function.” This function quantifies the probability that we would observe the values seen in the data, and maximizing it is analogous to the “least squares” fitting process described for linear regression.

Since the odds of suppression equal an expression in the form of $e^{(a + B_1 X + B_2 Y + \dots + B_N Z)}$, any parameters B_1, B_2, \dots etc. that are greater than 0 increase the odds and, in turn, the probability of suppression. Conversely, parameters that are less than 0 decrease the odds and therefore the probability of suppression.

So, if the outcome is “good” (e.g., viral suppression), parameters that are positive are associated with a greater likelihood of a “good” outcome. However, it is important to view each parameter in relation to others, particularly where they are mutually exclusive. For instance, if the parameter for the influence of being on Medicaid is modestly positive, this is not really “good” if the other insurance options are also included and the parameter estimates for these are larger positive values.

It is also important to consider the statistical significance of these estimates. In other words, what is the probability of finding a result of this magnitude if the true coefficient value were zero. There are various ways to do this. The Excel template estimates these p values by calculating the Wald statistic for each coefficient.

These calculations are too complicated to explain in detail here. In short, this involves calculating the covariance-variance matrix for the intercept and all of the coefficients, taking the square root of the variances to find the standard error for each factor, dividing the coefficients by their standard errors, and then looking up a p value for this ratio from a table of chi-square distributed values. These estimates are more reliable when the number of patients is relatively large.

Even if the selected parameters are statistically significant, they may not explain much of the variation between patients who are likely to have the good outcome and those who are not. One measure of the degree to which the available information accounts for the differences in outcomes is the Gini coefficient. This metric, commonly used as a measure of economic inequity, can vary from 0 to 1 and measures how quickly the desired outcome accrues to the “haves” (in this case, patients with characteristics such as greater age that are associated with viral suppression, etc.) versus the “have nots.” When considering the reported Gini coefficient, it is important to bear in mind that it is being calculated for the fitted data. It is likely that the value would be lower for a new, random sample of patients.

While “conventional” logistic regression is a powerful tool, more nuanced insights can be obtained from hierarchical logistic regression. In this process, individuals are treated as members of groups, and the parameter estimates can vary from group to group. The relevant analysis for the data in the template would be patients enrolled in separate clinics within the same organization. A full hierarchical analysis is not possible with the functionality built into the template, but it is possible to add clinics as an additional factor in the user-defined fields.

For a more robust analysis, the user of the template would do well to consider investigating the organization’s data in dedicated statistical software. There are a variety of both commercial and open source programs available. There are also several statistical add-ins for Excel that may be of interest to the program’s analytical staff. Please contact our own Data Analyst at qocreviews@health.ny.gov for suggested resources.

[Appendixes continue on next page.]

Appendix 8: Frequently Asked Questions

Template & Health Commerce System

1. Q: Will organizations be receiving a guidance document to accompany the Excel template?

A: Yes, a guidance document (this one) will be distributed to all providers. It also contains instructions specific to the use of the template and the process for submitting the data.

2. Q: How should the data be entered into the template?

A: Detailed instructions will be distributed with the template (in this document). Though the process may vary from site to site, we hope that most sites will be able to extract data from sources such as electronic medical records using data definitions and structure the information so that it can be copied and pasted into the template.

3. Q: Will it be possible to freeze the columns and rows on the template to better view the spreadsheet?

A: Where applicable, the spreadsheets in the template will have Excel's freeze-pane features enabled already; however, you will not be able to adjust these settings. Spreadsheets with line-item data will also allow for filtering so you can focus on subgroups of patients as needed, and the patient data template worksheet has a feature to hide the header rows so more data rows can be seen.

4. Q: Will the indicators be on a separate worksheet from the template?

A: This guidance document and data definition document, which describes the indicators, will be distributed; however, all reporting will be done using the template, which will also define the indicators in terms of the underlying data elements.

5. Q: Do organizations need their own Health Commerce System login to upload their Excel template?

A: Organizations will need to be registered for Health Commerce System use. However, if your organization is already registered you can see whoever manages that account at your site (your Health Commerce System Coordinator) to obtain access. Otherwise, you can contact the Health Commerce Accounts Management Unit directly at camusupp@health.ny.gov or by calling them at 866-529-1890.

6. Q: Is the drill-down data automated on the template once the data is inputted?

A: Yes. For unknown-status patients, the service delivery site for each patient will need to be entered using a drop-down set of choices or another service category that you specify. Similarly, providers will need to enter patient characteristics that will be used for the analysis, particularly, of active patients. To drill down the data, the template user clicks a button, and the template automatically generates active-patient cascades based on the patient characteristics data and a table with the number of non-active patients seen per service line.

7. Q: Will organizations receive the template with their specific site IDs defined?

A: Yes. Each provider organization will have a pre-defined list of clinic names and corresponding abbreviations. This requires selection of your organization's name on the Preliminary Information worksheet in the template. The abbreviations can then be used on the Patient Data Template worksheet to specify where "active" patients were enrolled in care within your organization.

8. Q: Can the data be uploaded to the Health Commerce System before an improvement plan is written?
A: No, organizations should analyze their data and develop a plan, which is submitted on the same template with the patient data and methodology statement. Coaches will review your plans and work with you to improve them if needed.
9. Q: Why does the Excel template start with inputting the first name of the patient?
A: Patient level information is required. This will help to track errors in the review process as well as identifying subgroups of patients on whom to focus your QI work. Also, the AIDS Institute would like the information to ensure that all patients are engaged in care. Please see the data use policies described in this reference guide.
10. Q: Can we copy and paste data into the Excel template?
A: Yes, so long as your organization has the capability to generate the applicable reports. This should be done “as values” if that option is available. If you do not use Excel, there are open source alternatives that can be used. Please contact us via our group email account, qocreviews@health.ny.gov, for more information about this.
11. Q: Is there a specific application on the Health Commerce System for which you will need to register?
A: There is a specific application on the Health Commerce System site for uploading your data (see submission instructions in this document for details), but you only need to register for general access to Health Commerce System. To do so, you will need to contact your local Health Commerce System Coordinator. If you do not have a Coordinator, you can contact the Health Commerce Accounts Management Unit directly at camusupp@health.ny.gov or by calling them at 866-529-1890.
12. Q: Is there a particular spreadsheet that organizations will need to populate, or should they make their own spreadsheet using the format outline in the guidance document?
A: There is an Excel reporting template. In most cases, we recommend that you organize the data on another Excel spreadsheet first, and then copy and paste (“as values”) into the template. See the template use instructions in this document for more detailed information about this.
13. Q: On the Statements tab of the template, we have different projects and goals at each of our networked HIV clinics. Where should I enter the clinic associated with the QI project listed?
A: Indicate in the QI plan whether each activity will be conducted at all your HIV clinics or specify which clinics will participate.
14. Q: I have never used PivotTables and would like to learn more about how to use them for quality improvement. Are there resources and/or technical assistance available for programs interested in using this function within the template?
A: Step-by-step directions on how to use the PivotTable feature are included in the template use instructions within this guide.

15. Q: I would like to know the viral suppression rate for all patients enrolled in HIV primary care at my organization. Is there a field within the control panel that calculates this? If not, how would I go about this?

A: Suppression rates for all previously diagnosed active patients are included with other results on the Control Panel sheet. Viral suppression on last viral load of the year is not collected for newly diagnosed patients. An organization would need to collect this data separately and include it in the viral suppression calculation for all patients.

16. Q: Can you please summarize the differences between the 2024 performance review elements and this year's (2025) performance review?

A: We have updated the frailty screening indicator, which is now required, and added fields for specifying each patient's sexual orientation and for distinguishing oral and injectable ARV therapy. See the What's New section of these instructions for other minor changes.

17. Q: What is meant by *newly diagnosed linkage ineligible*?

A: Patients who are diagnosed at an external organization are not eligible for the linkage indicator at the reporting organization.

18. Q: We have more than a thousand people with HIV receiving services at our organization. Do you have recommendations for simplifying the process of assigning enrollment status to these patients?

A: Keeping a patient list that you regularly update can help to minimize the amount of work for each review.

19. Q: I scored the indicators, and it seemed like some of the numerators and denominators were off. We realized that some of the patients with "OTH" in the enrollment column should actually be marked as active patients, and we want to change this where applicable. Which table should I look at to see just our 'active' people?

A: If you use the "Generate Scored Patient Data" command on the Control Panel, you will have patient-level results that you can filter by various categories, including enrollment status. Use the auto-filter drop-down lists on that worksheet to do that. You can then match the patients on that sheet with those in the Patient Data Template sheet by medical record number.

20. Q: I am pasting the patient level data unto the QOC template. However, the instructions stated that the information should be pasted using the "Values (V)" option. Can you let me know where I can find this on the template?

A: After copying the text and selecting the target cell for pasting, you can go to the Home tab in the template file, and there should be a clipboard icon in the top left corner. Below that, there's a very small triangle. If you click on that, you get a menu of different options. Hover your cursor over them to see the one for pasting values.

Documenting and Categorizing Patients

1. Q: What do you mean when you refer to 'active' patients?

A: 'Active' patients are those enrolled in HIV care at your organization as of the end of the review period. Among patients diagnosed prior to the review period in this group, we distinguish between

patients who were in care at your organization prior to the review period ('established active') or who started or resumed care after an absence of two or more years ('other new to care'). Newly diagnosed patients may also be 'active' if they enrolled in care at your organization (regardless of where they were diagnosed). Appendix 1 and Appendix 9 for additional information about patient caseloads.

2. Q: Does a patient need to have a viral load test or ARV prescription to be designated as 'active'?
A: No! While a viral load test may maintain a patient's 'established active' status (see Appendix 1), neither a viral load test nor an ARV prescription is a prerequisite of being an active patient. This distinction is fundamental to the notion of a cascade of care as we distinguish first whether someone is enrolled in care, then the testing and treatment they received, and finally the suppression outcome. If a viral load test is made a requirement, then the initial distinction is lost and the indicator rate for testing among active patients would automatically be 100%. Likewise, while almost all patients enrolled in care are treated with antiretroviral medication, there may be delays in ARV prescription for various reasons among new-to-care patients, and established patients may on occasion be off ARVs.
3. Q: When developing our QI plan, should we focus only on the patients we care for or everyone?
A: You should review the results for all patient groups to identify any gaps in care. This may include variations in care outcomes among your newly diagnosed, active new and established patients and/or limited documentation of patient outcomes among non-active patients (including deceased, incarcerated, relocated, in external care, or 'other' status).
4. Q: What categories do patients fall into who had a preliminary point of care positive test, then got lost to follow up and were eventually confirmed in 2026?
A: Exclude this patient from the review (i.e., do not enter on spreadsheet) as they were not known to have HIV before the end of the review period.
5. Q: Is it only medical visits or does any visit at all in the building count? Like social work, therapy, etc.
A: Any HIV+ patient who was seen for a visit to support their medical care should be included. Thus, patients seen just for social work visits should be included as this was in support of their mental and, perhaps, physical health.
6. Q: What about telemedicine visits? Do they count?
A: Yes, throughout the review process you can treat a telemedicine visit as equivalent to an in-person visit with the same provider. This applies to determination as to whether a patient was seen at all in 2025 (and belongs on the spreadsheet) and whether they were seen for management of HIV disease, which in turn defines whether someone is an "active" patient and, for newly diagnosed patients, when they were linked to care. Similarly, if a visit specific to HIV care occurs outside of the HIV clinic (e.g., at an inpatient bed), that can also be used as the date of first HIV care for a newly diagnosed patient.
7. Q: Is 3-day linkage only for newly diagnosed patients or also other new to clinic patients?
A: The linkage indicator only applies to patients newly diagnosed internally, either as inpatients or ambulatory patients. However, the date of first HIV care should also be reported for patients externally diagnosed during the review period as we also analyze viral suppression with this date in mind. Antiretroviral prescription after diagnosis is also an acceptable linkage to care indication. Whichever

comes first, the linkage to HIV care or antiretroviral prescription after HIV diagnosis, will be used for the linkage indicator for internally diagnosed patients. No linkage information is necessary for previously diagnosed patients even if they were new to the clinic in 2025.

8. Q: Aren't the numerators in the indicator scoring referring to active patients on antiretroviral therapy?
A: As in previous cascade reviews, there are multiple sets of indicators for the different patient populations. Some apply just to the established active patients, but others look at outcomes for the broader "open patient" population, and we also analyze results among those newly diagnosed or new-to-care at your organization.

9. Q: I don't have documentation of a diagnosis date for HIV+ patients coming in for surgery, etc. What should I enter for newly diagnosed patients when I don't have the date?
A: If you have information that allows you to approximate the date, please do so. For instance, "HIV diagnosis in March" could be translated to a diagnosis date of 3/15/25. However, if you have no documentation besides a generalized note that the patient was diagnosed, you cannot be sure that they really were diagnosed during the review period. In this case, change the diagnosis status to 'UK.'

10. Q: If I put 'UK' for Ethnicity or Race, do I put 'UK' or 'NA' for the Hispanic, Asian and NHPI subgroup fields?
A: Put 'NA' for the applicable patient subgroup if you don't know for sure if they are Hispanic, Asian or Native Hawaiian/Pacific Islander.

11. Q: A patient was diagnosed externally but we had to run the antibody test here to confirm. Are they still considered externally diagnosed?
A: Yes. We are looking for the time and location where a physician first diagnosed the patient with HIV disease.

12. Q: We might not have up-to-date viral load test results for patients who are not ours.
A: If you have information for the current review period, please enter it. However, it's fine to enter 'UK' if you don't have current testing results.

13. Q: One patient did not follow up with an HIV medical visit until Jan. 2026. (Unable to enter that date on template without having an error.)
A: If the patient wasn't seen until 2026, then they weren't linked in 2025. That's OK; we must draw the line somewhere. The expectation is not necessarily to see 100% "scores" but to collect the data in a consistent way that allows for quality improvement activities. When you analyze the results, you can examine reasons why patients may not have been linked within the specified timeframe.

14. Q: I do not understand the formula for “Viral load testing for newly diagnosed patients.” A person newly diagnosed in 2025 and new to care at my clinic may have a viral load test completed more than 91 days after diagnosis. Shouldn’t the countdown for externally diagnosed patients be based on *hiv care date* and *first vl date newly dx* instead?

A: We discussed this internally as we were developing the template and decided to stick with a definition that matched the Ending the Epidemic indicator for newly diagnosed patients regardless of site of diagnosis. So, we’re scoring this as suppression within 91 days of the diagnosis date. We understand that it may be difficult or impossible to achieve suppression within this timeframe if someone is delayed in presenting to your clinic. We, therefore, also use the HIV care date and antiretroviral initiation date to calculate alternative measures (see the Indicator Definitions spreadsheet in the template). As usual with our quality improvement reviews, the aim is not necessarily 100% scores but an understanding of where there is (or is not) room for improvement.

15. Q: Please confirm if the Clinic Code field should be blank if the enrollment status for a patient is either EXTCARE or OTH?

A: Yes, the Clinic Code field should be left blank in the circumstances you mention. It’s only for patients enrolled in HIV care in your organization as of the end of 2025 (whether newly or previously diagnosed).

16. Q: For patients who identify as Hispanic/Latino for their ethnicity, which option should we be selecting for Race? Many of our Hispanic patients don’t identify as White, African American, or any of the other Race options. There is no “other race” option which is what most of our Hispanic patients have chosen. I’m not sure that unknown would be the correct option either.

A: This depends on the information you have in your records for each patient. If you have separate information about race, please enter that. Otherwise, enter ‘UK’ for unknown race. This will be flagged as a warning, but that’s OK. We’ll still have the information that they’re Hispanic, which is what we used to capture when we combined race and ethnicity. In general, these options are a result of aligning with HRSA categories to streamline the review process as best as possible for providers. The details may change as these policies evolve.

17. Q: The Control Panel is reporting errors because I left these fields blank for established patients:

- *Diagnosis date*
- *Hiv care date*
- *Arv initiation date*
- *First vl date newly dx*
- *First suppressed date newly dx*

Should we be entering NA for these instead? The instructions say to leave them blank for all but newly diagnosed patients.

A: It is appropriate to leave these date fields blank for patients who were diagnosed prior to the review period. Please check that you have correct values for *Diagnosis* (“PREV”) and *Enrollment* (“ACTEST”).

18. Q: For patients who are only seen for a health homes visit (i.e., no medical care at all) – should we include them in our extract?

A: Our “rule of thumb” is that all HIV+ patients who were seen for any service related to their physical or mental health should be included in the review. This would typically include patients seen in a health-home setting but might exclude, for instance, patients seen only for transportation services. All active patients must have had at least one HIV clinical care visit in the review year. All established active patients must also have had a minimum of one HIV clinical care visit or one viral load test in the 24-month period preceding the review year.

19. Q: As I am going through the open caseload, we have a lot of patients who see an HIV provider in the community, and I had been marking them “EXTCARE” for Enrollment; however, I believe the intent of EXTCARE is actually more like the old “transfer of care” from HIVQual, right? EXTCARE would be someone who was seen at our HIV clinic but then was confirmed to have transferred to another provider outside the organization?

A: The intention is along the lines of “transfer.” However, it’s possible that someone might get HIV services elsewhere but continue to be seen for other medical care at the organization under review. The standard we’ve used for “EXTCARE” is “confirmed ongoing HIV care at another provider where the name of that provider is documented.” So, depending on what you mean by “see an HIV provider in the community,” this could apply, or they could be unknown status (Enrollment = “OTH”) patients (i.e., meaning it is unknown if their external care is ongoing).

Newly Diagnosed Cascade / New-to-Care Cascade

1. Q: Is a patient considered newly diagnosed if they were previously diagnosed but are new to living within the United States?

A: No, they might be considered new to care if they started care at the site during the review year. The patient is considered newly diagnosed if the original date of diagnosis, wherever it was made, was during the review period (2025).

2. Q: Are patients who are new to an organization in 2025 but diagnosed in a different year considered previously diagnosed?

A: These patients have their own category, Other New to Care, which is distinguished by the combination of responses in the *diagnosis* and *enrollment* fields. They are not included in calculations for the open or established active patient cascades.

3. Q: For the diagnosis date for newly diagnosed patients, should you use the date on which the results of the confirmatory test were provided to the patient?

A: If that is the policy of your site. Our formal definition is the earliest available date when any of these events occurred:

(i) HIV-1 and/or HIV-2 antibodies detected on antibody differentiation immunoassay (date of report).

(ii) Acute HIV-1 infection detected on HIV-1 nucleic acid test (date of report).

(iii) Second positive rapid HIV test (different manufacturer than for first test) conducted.

(iv) Date when treating physician entered a diagnosis of HIV disease or initiated antiretroviral therapy on a presumptive diagnosis of HIV disease.

4. Q: For the newly diagnosed data, should we include both individuals diagnosed internally and externally in 2025 and exclude those individuals diagnosed in a previous year but new to us in 2025?

A: All patients with HIV should be included in the template. You will use the *diagnosis* field to distinguish those who were newly diagnosed in 2025. Newly diagnosed patients are defined as any patient diagnosed for the first time in 2025 (whether at your organization or elsewhere). All patients internally diagnosed will be included in the 3-day linkage measure. All newly diagnosed patients will be included in the on-antiretroviral therapy, viral load testing and viral suppression measures unless they are linked to an external clinic (or were deceased, relocated, receiving ongoing external HIV care, or incarcerated as of the end of the review period). Other new-to-care patients are defined as those patients who were diagnosed prior to 2025 but were seen for the first time at your site in 2025 (or re-entered care in 2025 after two or more years absence without reported viral load). These patients will be distinguished through an entry of ACTNEW in the *enrollment* field and PREV in the *diagnosis* field.

5. Q: If a patient is returning to an organization after 2 years but was established in care with another HIV provider, is the patient considered new-to-care?

A: Yes. So, if the patient was seen in your organization prior to 2023, not seen by you in 2023 and 2024 (nor reported viral load in those years), but then returned in 2025, they would be considered new to care, regardless of whatever care they received externally in 2023 and 2024.

6. Q: If a primary care physician who is going to follow up with a patient makes an appointment for a week and the confirmatory test results are returned on day 3 and the patient shows up on day 7, what type of linkage is this considered? Is the patient linked from day 1 or is this now a post day 7 linkage? And, what if the confirmatory test is returned on a Saturday, and the patient is not seen until, for instance, Tuesday?

A: Days to linkage will be measured using date arithmetic so it will be the day from diagnosis to linkage to care without exception. However, antiretroviral therapy prescription is now an acceptable measure of linkage to care. Therefore, if a patient receives antiretroviral therapy prescription before attending an HIV clinical visit, the date they receive the antiretroviral therapy prescription is considered the linkage date. If a patient receives HIV-specific medical care before being prescribed antiretroviral therapy, the date of that care is considered the linkage date. The date of diagnosis is defined as per answers to other questions in this document. Linkage is defined as the date of the patient's HIV-specific medical care or antiretroviral therapy prescription on or following the date of diagnosis. Linkage will also be measured in other intervals (7 days, 30 days, 90 days).

7. Q: For patients who were diagnosed or new to care near the end of the reporting year (2025), should providers pull their viral load recorded in 2026?

A: No, all data must be from 2025. We understand that this may result in some patients not meeting indicator criteria. In light of this, in addition to the official indicator (all newly diagnosed patients), we also report suppression rates within 91 days just for patients diagnosed in the first 9 months of the review year.

Service Line

1. Q: What should be written in the Service Line specifics?

A: In the *service_line* field, there is a drop-down list to select the service line(s) where the patient was seen and an “other” choice if an applicable option is not available in the drop-down list. The specification of this other service should be made in the *other_service_specify* field, and this should be a brief description (up to 200 characters) of the nature of that service. If a patient was seen multiple times on a service, only one entry for that service is required. **Do not include highly detailed or otherwise sensitive information in this field.**

2. Q: How do patients from the agency (e.g., HIV + housing program) but not from the clinic fit into the service line questions?

A: People with HIV who are not established HIV clinic patients are considered open inactive patients. There is a dropdown list, associated with *service_line* field, to select the general area of care where these patients accessed services from your organization. The goal is to understand where patients who are not in care are touching the system so that you can strengthen efforts in those areas to engage patients into care. Depending on the nature of your housing program, this could be classified as supportive services (“SS” code) or other service (“OTH” code), with “housing services” specified in the follow-up question.

3. Q: Under Service Lines, what is meant by “supportive services”?

A: Supportive services are non-medical services meant to provide support for patients; case management, nutrition and transportation are examples of supportive services.

4. Q: Do Service Lines apply to the open and active caseload?

A: This field will apply to certain open patients but not active patients. Service line information is only needed for patients who are not enrolled in HIV care at your organization and not known to be in care elsewhere, deceased, incarcerated or relocated by the end of the review period (i.e., for unknown-status patients). Care elsewhere entails documentation in your electronic medical record system of the HIV care provider (person’s name or name of organization), and relocation entails documentation in your electronic medical record system of the location (state outside of New York or foreign country) where the patient moved.

5. Q: Under Service Lines, is “PC (primary care outside of your HIV clinic(s))” and “FACHIV (faculty practice HIV care outside HIV clinic(s))” the same thing as HIV care being external?

A: If the patient is known to be receiving ongoing care external to your entire organization (i.e., the documented name of individual provider or providing organization is known), that is specified in the *enrollment* field as “EXTCARE.” Entry of service line data is only for the “open non-active” patients (see previous question).

6. Q: For HIV+ clients who participate in programs such as psychotherapy, adult day health care and OASAS, but are not seen for primary care at the organization, are they to be included in the total number of patients seen in 2025? If so, are they classified as “EXTCARE” (external care) or “OTH” (other) and then marked as “MBHS” (mental and behavioral health services) or “SS” (supportive services) or “OTH” (other) in the Service Line variable?

A: These patients should be included in the review. Patients who are receiving ongoing HIV primary care externally would be classified as “EXTCARE” for *enrollment*. Otherwise, they would be classified as “OTH” (unknown care status) for *enrollment*, and the *service_line* entry would depend on the nature of the care that was provided.

7. Q: For a service that could go under either “MBHS” (mental and behavioral health services) or “SS” (supportive services), should the provider determine the best fit for said service? For example, is an Opiate Treatment Program (OTP) considered “OTH (other)” or “MHBS (outpatient mental and behavioral health services)”?

A: Yes, use your best judgment in these cases. If more than one service was provided, each should be included, classifying them to the best of your ability or entering “OTH” for *service_line* and providing details in *other_service_specify*. If needed, it’s possible to combine a predefined service category such as “MBHS” with “OTH” in the *service_line* field. For this example, it depends on the nature of your OTP and who is providing the services. It may be appropriate to classify this as a mental and behavioral health service, but you can use “OTH (other)” to specify alternatives if indicated.

Viral Suppression

1. Q: For newly diagnosed patients, does the 91 days start after you have received lab confirmation?

A: It is 91 days from the date when the patient was diagnosed as previously defined.

2. Q: What should you do if the patient does not have a viral load test in 91 days?

A: These patients will be treated as not virally suppressed within 91 days.

3. Q: Are only patients with a viral load test in 91 days included in the denominator for viral suppression?

A: No, all newly diagnosed patients are in the denominator. If there is no viral load result, they are considered not virally suppressed.

Technical Problems

1. Q: I’m trying to enter patient medical record numbers into the Excel sheet, but it keeps translating them to hashtags. The number has plenty of room to fit so I’m not sure what the error is.

A: Please make sure that the cells you are pasting into are currently formatted as text (not general or number). Then when you copy and paste as values it should be OK. If you continue to have problems, you may want to paste everything (as values) into a clean copy of the file.

2. Q: I am having an issue with the Excel template. I am copying the names from my Excel sheets into the secured template. I have entered other names before, but now I am getting an error message, stating that this is a secure document and I need a password to enter the information on the sheet. However, I have opened the sheet with the given password, but now it is not allowing me to paste.

A: This could be because the number of columns you are trying to paste exceeds the non-protected space in the worksheet or you are entering data below the rows reserved for data entry (8 through 20007). The former can happen if you copy additional columns or start the paste in the wrong column; the latter can occur if you have filtered the data in a way that removes blanks.

3. Q: I'm having problems manipulating the data inside the Excel file.

A: Many of the cells in the template are protected to prevent changes that could jeopardize the integrity of the data. This includes individual cells as well as entire rows and columns that cannot be edited or deleted. If you have many changes to make, you may be better served by copying everything into a separate file, making the edits there, and then pasting the resulting content (as values) into another blank copy of the template.

4. Q: When I complete the Statements section, information entered, although less than the 8000-character limit, does not show completely. Should I be doing something else?

A: What you are doing is fine. Even if it does not show completely in the blue text box, all the text will appear line by line in the thin white text box above the worksheet if you click on it and scroll through it. You can do this to double check that all the text in a cell is intact. If the formatting of the cell has changed, you can also right click on the blue cell where you've entered data, select Format Cells and then the Alignment tab, check the Wrap Text box and click on OK.

5. Q: We are wondering why the linkage chart did not populate. Granted, there were only three newly diagnosed patients in 2025, and one of these was diagnosed externally.

A: This indicator only applies to patients internally diagnosed during the review period, and it's possible there may be problems with the data entered for these patients. For this and all questions regarding scoring, please check the Indicator Definitions spreadsheet to make sure that the patients are truly eligible for the indicator/measure under consideration. You can also check the Field Descriptions & Validation sheet to check for any related data entry errors.

6. Q: I copied some of my data in my cascade and it is now locked, and I can't take it out.

A: It's possible you may be entering the wrong password. Please double check, including making sure you do not have Caps Lock engaged. If you cannot remember the password, please contact us at qocreviews@health.ny.gov.

7. Q: I am experiencing some difficulty with validating a few errors in my data.

A: Please see the Field Descriptions & Validation spreadsheet (far right tab at the bottom of the template) for a list of reasons why these and other fields could be marked as errors.

8. Q: I am not able to use the template on my computer at work. I sent the template to the IT department and a copy was made of the template and I was able to add some of the patient names onto the template. However, when I tried to check for errors in the control panel, I am receiving this error notice: “cannot run the macro copy of QOC cascade template.”

A: Macros need to be enabled for the commands on the Control Panel to work. If you cannot obtain permission from your IT staff to do that, please contact us at qocreviews@health.ny.gov, and we can arrange for secure transfer of the file to review the data for you.

Miscellaneous

1. Q: How do you find out who the Coach for your organization’s cascade review is?

A: See Appendix 11 at the end of this document for a list of these Coaches by region. If you have any questions about this, please contact qocreviews@health.ny.gov.

2. Q: For patients who describe their race as “Other”, which is an option in some EHRs, should they be reported as “Unknown”?

A: If no other information is available, yes. The code for this in the *race* field is “UK.”

3. Q: Would an MCO plan be considered as “other plan”?

A: The intention is to capture information about who is paying for coverage. So, for instance, Medicaid Managed Care would be coded as “MEDICAID.” Other coverage administered by Medicaid (e.g., AIDS Health Insurance Program, or AHIP) would also be coded as “MEDICAID.” Other managed care would likely be “PRIVATE.” If nothing fits, classification as Other Plan (“OP” code in *insurance* field) is acceptable. See Appendix 2 for more information about these decisions.

4. Q: When should the “ADAP” code be used for the insurance field?

If the patient is enrolled in ADAP, then “ADAP” is the appropriate selection, regardless of any other insurance the patient may have.³ See the flowchart in Appendix 2 for guidance about the insurance field.

5. Q: Is there a definition as to what is classified as “Temporary” housing or is it what you choose to put in that category based on the data we collect in that area?

A: This is defined as a short-term arrangement with family or friends, transitional housing or temporary institutional placement including substance abuse treatment facilities and psychiatric hospitals. If you do not have structured data that match this definition, make the assessment to the best of your ability with whatever housing status data you can obtain.

6. Q: I see (for instance) 20 patient-data errors, but when I filter on the patients with errors there are only (say) 15 rows. What’s happening here?

A: The validation process counts the number of field-level errors. Some patients may have multiple independent errors. In other cases, one error may result in validation failure for more than one field. As the errors are addressed, the error count will go down, and when it reaches zero no more patients will be flagged for errors.

³ In the rare case where a patient’s drug costs are covered through the original AIDS Drug Assistance Program but the patient does not receive ADAP Plus (medical care is covered through another plan), then another category would apply.

7. Q: Is the HIV Organizational Treatment Cascade Review the same as HIVQUAL, or is it something different?
A: The organizational treatment cascade review replaced HIVQUAL, which is no longer a component of the annual quality review.
8. Q: What is done for patients who are homeless for part of the year—do you choose the last status of the year?
A: Yes, but use your best judgement. If, for instance, a patient was homeless for most of the review period and got housing in the last week of December, consider what status best describes the patient.
9. Q: What clinic code should be used for a patient that has been seen at multiple clinics throughout the year?
A: The clinic where the patient was seen most often (or last clinic where the patient was seen if a tie).
10. Q: For a patient (for example, someone receiving methadone) who received HIV care at one point in 2025 but by the end of the calendar year was receiving HIV care outside of the organization, which indicators would apply? Does it matter if the patient was newly diagnosed in 2025?
A: Patients who were in care elsewhere as of the end of the review period will be excluded from the calculations for all formal indicators with one exception: for those who were diagnosed internally in 2025, the linkage indicator will apply. However, entry of some response for the antiretroviral therapy indicator and the applicable viral load testing and viral suppression fields is required for all patients; a response of “UK (unknown)” is acceptable where needed.
11. Q: In describing our QI projects, how should we refer to retrospective reviews?
A: It’s usually easiest to refer to the time when care was provided. So, reviews that are conducted in 2026 with 2025 data are most often referred to as the ‘2025 cascades.’ To be more explicit, the review can also be referred to as ‘the 2026 cascade review of care provided in 2025.’
12. Q: I’ve seen that you’ve distributed a new version of the template for the current review. Currently, I am working on the data entry, using a previous version of the template for this review. Can they be merged without the loss of already entered data?
A: Yes, you can easily transition at any point from the file you’ve been using to a new template. With both files open, select all the cells with data from the Patient Data Template sheet in the original template. On the Home menu for that file, select Copy. Then, in the new file, select the first data entry cell (C8, assuming you have data beginning with first names). On the Home menu for that file, click on the drop-down arrow below the Paste icon and select the “Paste as Values (V)” option.

[Appendixes continue on next page.]

Appendix 9: Glossary

Care Status Categories for Indicator Eligibility					
		Diagnosis Field			
		NEWINT = internally diagnosed during the review period	NEWEXT = externally diagnosed during the review period	PREV = diagnosed prior to the review period	UK = unknown
Enrollment Field	ACTNEW = active, new to clinic during review period, continuing in program	"Newly diagnosed active - linkage eligible"	"Newly diagnosed active - linkage ineligible"	"Other new to care"	
	ACTEST = active, seen prior to the review period, continuing in program				"Established active"
	DEC = died during review period	"Linkage only"	"Excused - newly diagnosed"	"Excused - previously diagnosed"	
	INC = incarcerated as of end of review period				
	RELOC = relocated out of New York State during the review period				
	EXTCARE = confirmed to be receiving ongoing HIV care at another site as of end of the review period				
OTH = other status, not enrolled in care at your organization	"Newly diagnosed of unknown status - linkage eligible"	"Newly diagnosed of unknown status - linkage ineligible"	"Open non-active"		

Previously diagnosed patients: Patients diagnosed with HIV before the measurement year.

Open patients: Previously diagnosed patients who were not incarcerated at the end of the measurement year, deceased by the end of the measurement year, or confirmed to be in-care elsewhere at the end of the measurement year, and excluding those new to care in 2025 or returning after an absence of at least two years (no visits or viral loads).

Established active patients: Open patients who received medical services in the HIV program of the organization during the measurement year and were still enrolled in care at the end of the year.

Newly diagnosed patients: Patients first diagnosed with HIV within the measurement year.

Linkage to care: A newly diagnosed patient is considered to have been linked to medical care in a timely fashion if the individual, subsequent to initial diagnosis of HIV disease, either received an antiretroviral

prescription or attended a routine HIV medical visit within three calendar days of the diagnosis date (and before the end of the review year).

Other new-to-care patients: Patients who were diagnosed prior to the review period but were new to an organization's HIV program, and patients who were seen prior to 2025, not seen (nor viral load reported) in 2023 or 2024, but then returned in 2025.

Non-active non-“excused” patients: Patients who (1) have had contact with a healthcare organization during the measurement year but were not seen by the HIV clinical program during that year and (2) who cannot be confirmed to have died by the end of the year, to be in care elsewhere by the end of the year, relocated outside New York State, or to be incarcerated at the end of the year. These patients should be included in the review and will be counted in most of the indicator scoring.

“Excused” patients: Patients who (1) have had contact with a healthcare organization during the measurement year but were not seen by the HIV clinical program during that year and (2) who can be confirmed to have died by the end of the year, to be in care elsewhere by the end of the year, relocated outside New York State, or to be incarcerated at the end of the year. These patients should be included in the review but will not be counted in most of the indicator scoring.

Viral suppression: Previously diagnosed patients are considered virally suppressed when their last viral load test conducted in 2025 returned a value of less than 200 copies/mL. Newly diagnosed patient viral suppression must occur within 91 days of diagnosis (any suppressed test during this time period, not last).

Older patients: This refers to a specific group of patients eligible for the frailty/functional status screen indicator: active patients who were at least 51 years old by the end of the review period or who were at least 31 years old by the end of the review period and had acquired HIV perinatally.

[Appendixes continue on next page.]

Appendix 10: Indicator Scoring

See Glossary (Appendix 9) for definition of terms.

Measure	Formal Indicator?	Numerator	Denominator (by patient status)	Denominator (scoring details)
ARV therapy among open patients	Yes	Eligible patients for whom arv = 'YES'	"Established active" and "Open non-active"	All patients for whom (i) enrollment equals 'ACTEST' or 'OTH' and (ii) diagnosis equals 'PREV' or 'UK'
VL testing among open patients	Yes	Eligible patients for whom vl_test_reivew_year = 'YES'	"Established active" and "Open non-active"	All patients for whom (i) enrollment equals 'ACTEST' or 'OTH' and (ii) diagnosis equals 'PREV' or 'UK'
Viral suppression among open patients	Yes	Eligible patients for whom vl_test_reivew_year = 'YES' and suppressed_final_review_year = 'YES'	"Established active" and "Open non-active"	All patients for whom (i) enrollment equals 'ACTEST' or 'OTH' and (ii) diagnosis equals 'PREV' or 'UK'
ARV therapy among established active patients	Yes	Eligible patients for whom arv = 'YES'	"Established active"	All patients for whom (i) enrollment equals 'ACTEST' and (ii) diagnosis equals 'PREV' or 'UK'
VL testing among established active patients	Yes	Eligible patients for whom vl_test_reivew_year = 'YES'	"Established active"	All patients for whom (i) enrollment equals 'ACTEST' and (ii) diagnosis equals 'PREV' or 'UK'
Viral suppression among established active patients	Yes	Eligible patients for whom vl_test_reivew_year = 'YES' and suppressed_final_review_year = 'YES'	"Established active"	All patients for whom (i) enrollment equals 'ACTEST' and (ii) diagnosis equals 'PREV' or 'UK'
ARV therapy among newly diagnosed patients	Yes	Eligible patients for whom arv = 'YES'	"Newly diagnosed active - linkage eligible", "newly diagnosed active - linkage ineligible", "Newly diagnosed of unknown status - linkage eligible" and "Newly diagnosed of unknown status - linkage ineligible"	All patients for whom (i) enrollment equals 'ACTNEW' or 'OTH' and (ii) diagnosis equals 'NEWINT' or 'NEWEXT'
VL testing among newly diagnosed patients	Yes	Eligible patients for whom vl_test_review_year = 'YES' and first_vl_date_newly_dx is no more than 91 days after diagnosis_date (with both in the review period)	"Newly diagnosed active - linkage eligible", "newly diagnosed active - linkage ineligible", "Newly diagnosed of unknown status - linkage eligible" and "Newly diagnosed"	All patients for whom (i) enrollment equals 'ACTNEW' or 'OTH' and (ii) diagnosis equals 'NEWINT' or 'NEWEXT'

			of unknown status - linkage ineligible"	
Viral suppression among newly diagnosed patients	Yes	Eligible patients for whom vl_test_review_year = 'YES' and suppressed_ever_review_year = 'YES' and first_suppressed_date_newly_dx is no more than 91 days after diagnosis_date (with both during the review period)	"Newly diagnosed active - linkage eligible", "newly diagnosed active - linkage ineligible", "Newly diagnosed of unknown status - linkage eligible" and "Newly diagnosed of unknown status - linkage ineligible"; further restricted to patients whose first suppressed viral load was after (not on) the date of diagnosis	All patients for whom (i) enrollment equals 'ACTNEW' or 'OTH' and (ii) diagnosis equals 'NEWINT' or 'NEWEXT'; further restricted to patients whose first suppressed viral load was after (not on) the date of diagnosis
Resistance testing among newly diagnosed patients	Yes	Eligible patients for whom resistance_test = 'YES'	"Newly diagnosed active - linkage eligible" and "newly diagnosed active - linkage ineligible"	All patients for whom (i) enrollment equals 'ACTNEW' and (ii) diagnosis equals 'NEWINT' or 'NEWEXT'
3-day linkage of internally diagnosed patients	Yes	Eligible patients for whom hiv_clinic_visit = 'YES' and hiv_clinic_visit_date is no more than 3 days after diagnosis_date (with both during the review period) OR arv = 'YES' and arv_initiation_date is no more than 3 days after diagnosis_date	"Newly diagnosed active - linkage eligible", "Linkage only" and "Newly diagnosed of unknown status - linkage eligible"	All patients for whom (i) enrollment does not equal 'ACTEST' and (ii) diagnosis equals 'NEWINT'
7-day linkage of internally diagnosed patients	No	Eligible patients for whom hiv_clinic_visit = 'YES' and hiv_clinic_visit_date is no more than 7 days after diagnosis_date (with both during the review period) OR arv = 'YES' and arv_initiation_date is no more than 7 days after diagnosis_date	"Newly diagnosed active - linkage eligible", "Linkage only" and "Newly diagnosed of unknown status - linkage eligible"	All patients for whom (i) enrollment does not equal 'ACTEST' and (ii) diagnosis equals 'NEWINT'
30-day linkage of internally diagnosed patients	No	Eligible patients for whom hiv_clinic_visit = 'YES' and hiv_clinic_visit_date is no more than 30 days after diagnosis_date (with both during the review period) OR arv = 'YES' and arv_initiation_date is no more than 30 days after diagnosis_date	"Newly diagnosed active - linkage eligible", "Linkage only" and "Newly diagnosed of unknown status - linkage eligible"	All patients for whom (i) enrollment does not equal 'ACTEST' and (ii) diagnosis equals 'NEWINT'

90-day linkage of internally diagnosed patients	No	Eligible patients for whom hiv_clinic_visit = 'YES' and hiv_clinic_visit_date is no more than 90 days after diagnosis_date (with both during the review period) OR arv = 'YES' and arv_initiation_date is no more than 90 days after diagnosis_date	"Newly diagnosed active - linkage eligible", "Linkage only" and "Newly diagnosed of unknown status - linkage eligible"	All patients for whom (i) enrollment does not equal 'ACTEST' and (ii) diagnosis equals 'NEWINT'
ARV therapy among other new-to-care patients	Yes	Eligible patients for whom arv = 'YES'	"Other new to care"	All patients for whom (i) enrollment equals 'ACTNEW' and (ii) diagnosis equals 'PREV' or 'UK'
VL testing among other new-to-care patients	Yes	Eligible patients for whom vl_test_reivew_year = 'YES'	"Other new to care"	All patients for whom (i) enrollment equals 'ACTNEW' and (ii) diagnosis equals 'PREV' or 'UK'
Viral suppression among other new-to-care patients	Yes	Eligible patients for whom vl_test_reivew_year = 'YES' and suppressed_final_review_year = 'YES'	"Other new to care"	All patients for whom (i) enrollment equals 'ACTNEW' and (ii) diagnosis equals 'PREV' or 'UK'
Frailty or functional status screen among older patients	Yes	Eligible patients for whom frailty_or_function_screen = 'YES'	"Established active" and "Other new to care", restricted to patients who were (a) at least 51 years old by the end of the review period or (b) at least 31 years old by the end of the review period and who had acquired HIV through perinatal transmission	All patients for whom (i) enrollment equals 'ACTEST' or 'ACTNEW' and (ii) (DOB prior to 1/1/1995 and hiv risk = PERI) OR DOB prior to 1/1/1975
ARV therapy among all previously diagnosed active patients	No	Eligible patients for whom arv = 'YES'	"Established active" and "Other new to care"	All patients for whom (i) enrollment equals 'ACTEST' or 'ACTNEW' and (ii) diagnosis equals 'PREV' or 'UK'
VL testing among all previously diagnosed active patients	No	Eligible patients for whom vl_test_reivew_year = 'YES'	"Established active" and "Other new to care"	All patients for whom (i) enrollment equals 'ACTEST' or 'ACTNEW' and (ii) diagnosis equals 'PREV' or 'UK'
Viral suppression among all previously diagnosed active patients	No	Eligible patients for whom vl_test_reivew_year = 'YES' and suppressed_final_review_year = 'YES'	"Established active" and "Other new to care"	All patients for whom (i) enrollment equals 'ACTEST' or 'ACTNEW' and (ii) diagnosis equals 'PREV' or 'UK'
Suppression within 91 days among patients newly diagnosed during the first 9	No	Eligible patients for whom vl_test_review_year = 'YES' and suppressed_ever_review_year = 'YES' and first_suppressed_date_newly_dx is	"Newly diagnosed active - linkage eligible", "newly diagnosed active - linkage ineligible", "Newly diagnosed of	All patients for whom (i) enrollment equals 'ACTNEW' or 'OTH' and (ii) diagnosis equals 'NEWINT' or 'NEWEXT'; further restricted to patients who were diagnosed

months of the review year		no more than 91 days after diagnosis_date (with both during the review period)	unknown status - linkage eligible" and "Newly diagnosed of unknown status - linkage ineligible"; further restricted to patients who were diagnosed on or before October 1st, allowing at least 91 days for suppression to occur, and whose first suppressed viral load was after (not on) the date of diagnosis	on or before October 1st, allowing at least 91 days for suppression to occur, and whose first suppressed viral load was after (not on) the date of diagnosis
Suppression within 91 days of initiation of HIV care for newly diagnosed patients	No	Eligible patients for whom vl_test_review_year = 'YES' and suppressed_ever_review_year = 'YES' and first_suppressed_date_newly_dx is no more than 91 days after hiv_clinic_visit_date or arv_initiation_date, whichever came first (with both during the review period)	"Newly diagnosed active - linkage eligible" and "Newly diagnosed active - linkage ineligible" ; further restricted to patients who initiated HIV care (visit or ARV) prior to first suppressed viral load	All patients for whom (i) enrollment equals 'ACTNEW' and (ii) diagnosis equals 'NEWINT' or 'NEWEXT' and (iii) first_suppressed_date_newly_dx is after whichever occurred first, hiv_clinic_visit_date or arv_initiation_date
Ever suppressed during review period among newly diagnosed patients	No	Eligible patients for whom vl_test_review_year = 'YES' and suppressed_ever_review_year = 'YES' and first_suppressed_date_newly_dx is during the review period	"Newly diagnosed active - linkage eligible", "Newly diagnosed active - linkage ineligible", Newly diagnosed of unknown status - linkage eligible" and "Newly diagnosed active - linkage ineligible"	All patients for whom (i) enrollment equals 'ACTNEW' or 'OTH' and (ii) diagnosis equals 'NEWINT' or 'NEWEXT'
Average time to suppression among suppressed newly diagnosed patients	No	Average of the number of days from diagnosis to suppression for all eligible patients	"Newly diagnosed active - include linkage", "Newly diagnosed active - no linkage", "Newly diagnosed of unknown status - linkage eligible" and "Newly diagnosed active - linkage ineligible"; further restricted to patients who had a suppressed VL during the review period	All patients for whom (i) enrollment equals 'ACTNEW' or 'OTH' and (ii) diagnosis equals 'NEWINT' or 'NEWEXT' and (iii) vl_test_review_year = 'YES' and (iv) suppressed_ever_review_year = 'YES' and (v) first_suppressed_date_newly_dx is after diagnosis_date and during the review period
Median time to suppression among	No	Median of the number of days from diagnosis to suppression for all eligible patients	"Newly diagnosed active - include linkage", "Newly diagnosed active - no linkage",	All patients for whom (i) enrollment equals 'ACTNEW' or 'OTH' and (ii) diagnosis equals 'NEWINT' or 'NEWEXT' and (iii)

suppressed newly diagnosed patients			"Newly diagnosed of unknown status - linkage eligible" and "Newly diagnosed active - linkage ineligible"; further restricted to patients who had a suppressed VL during the review period	vl_test_review_year = 'YES' and (iv) suppressed_ever_review_year = 'YES' and (v) first_suppressed_date_newly_dx is after diagnosis_date and during the review period
Average time to ARV initiation among newly diagnosed patients initiated on ARV during the review period	No	Average of the number of days from diagnosis to ARV initiation for all eligible patients	"Newly diagnosed active - include linkage", "Newly diagnosed active - no linkage", "Newly diagnosed of unknown status - linkage eligible" and "Newly diagnosed active - linkage ineligible"; further restricted to patients who received an ARV prescription during the review period	All patients for whom (i) enrollment equals 'ACTNEW' or 'OTH' and (ii) diagnosis equals 'NEWINT' or 'NEWEXT' and (iii) arv = 'YES' and (iv) arv_initiation_date is during the review period and not prior to diagnosis_date
Median time to ARV initiation among newly diagnosed patients initiated on ARV during the review period	No	Median of the number of days from diagnosis to ARV initiation for all eligible patients	"Newly diagnosed active - include linkage", "Newly diagnosed active - no linkage", "Newly diagnosed of unknown status - linkage eligible" and "Newly diagnosed active - linkage ineligible"; further restricted to patients who received an ARV prescription during the review period	All patients for whom (i) enrollment equals 'ACTNEW' or 'OTH' and (ii) diagnosis equals 'NEWINT' or 'NEWEXT' and (iii) arv = 'YES' and (iv) arv_initiation_date is during the review period and not prior to diagnosis_date

Appendix 11: NYS Quality Coaches by Region

Region	Treatment Cascade Questions	
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Bronx	Dan Belanger	daniel.belanger@health.ny.gov
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