2018 ANNUAL RYAN WHITE HIV/AIDS PROGRAM SERVICES REPORT (RSR) INSTRUCTION MANUAL

HIV/AIDS Bureau
Division of Policy and Data
Health Resources and Services Administration
U.S. Department of Health and Human Services
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WHAT'S NEW FOR 2018

(Last Updated: November 29, 2018)

New in 2018 are changes to the Grantee Contract Management System (GCMS) and updates on the Provider Report. These changes are listed below:

1. The data synchronization process has been streamlined in the GCMS.
2. Three questions regarding the treatment of opioid-use disorders have been added to the Provider Report's Program Information section.
3. The service categories within the Provider Report's service delivery sites section have been updated to reflect changes in the Service Category Descriptions and Program Guidance section of **Policy Clarification Notice 16-02: Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds**.

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BACKGROUND

(Last Updated: November 29, 2018)

The Ryan White HIV/AIDS Program (RWHAP), first authorized by the U.S. Congress in 1990, is administered by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration's (HRSA) HIV/AIDS Bureau (HAB).[1] HRSA's RWHAP uses dynamic data-driven and innovative approaches to provide a comprehensive system of care to achieve optimal health outcomes for people living with HIV (PLWH). RWHAP funds are provided to cities, States, and local community-based organizations that provide HIV medical care treatment and essential support services to approximately half-a-million people in the United States living with diagnosed HIV infection. A smaller but equally critical portion of RWHAP funds are used to fund technical assistance, clinical training, and the development of innovative models of HIV care.

Of the nearly one million people living with diagnosed HIV in the United States, more than 50 percent receive high-quality HIV medical care, treatment, and support services from HRSA RWHAP each year. HRSA RWHAP has developed a comprehensive system of care and treatment that provides the foundation for ending the HIV epidemic in the United States. RWHAP is critical to ensuring that low-income uninsured or underserved PLWH are linked to medical care, are retained in medical care, and are prescribed antiretroviral medications, and have achieved viral suppression. HIV treatment is a recognized form of prevention. HRSA RWHAP works toward four national HIV health outcome goals:

1. Reducing new infections,
2. Increasing access to care and improving health outcomes for PLWH,
3. Reducing HIV-related disparities and health inequities, and
4. Achieving a more coordinated national response to the HIV epidemic.

HRSA RWHAP has been increasingly successful in achieving improved outcomes along the HIV care continuum.[2] HRSA RWHAP Services Report (RSR) client-level data demonstrates annual improvements in viral suppression, from 69.5 percent of clients achieving viral suppression in 2010 to 84.9 percent in 2016. HRSA RWHAP seeks to continue improving rates of viral suppression; this improves the quality and length of life for PLWH and prevents HIV transmission.

HRSA HAB regularly monitors program performance to demonstrate accountability and impact. It also integrates performance measurement into long-term programmatic plans to ensure its programs support HRSA strategies.

[1] The Ryan White HIV/AIDS Treatment Extension Act of 2009—Title XXVI of the Public Health Service Act, as amended—the Ryan White HIV/AIDS Program legislation. https://HRSA HAB.hrsa.gov/aboutHRSA HAB/legislation.html.

[2] HIV/AIDS Bureau HIV Performance Measures. **https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio.**

RECIPIENT/SUBRECIPIENT REPORTING REQUIREMENTS

(Last Updated: November 29, 2018)

Federal regulations explicitly state that grant recipients must monitor and report program performance to ensure they are using their Federal grant program funds in accordance with program requirements.[3]

Title 45 CFR § 75.342(a), monitoring and reporting program performance:

> The non-Federal entity is responsible for oversight of the operations of the Federal award supported activities. The non-Federal entity must monitor its activities under Federal awards to assure compliance with applicable Federal requirements and performance expectations are being achieved. Monitoring by the non-Federal entity must cover each program, function or activity. See also §75.352.

The Federal regulations additionally impose subrecipient monitoring requirements. See 45 CFR § 75.352(d):

> All pass-through entities must: . . . . (d) Monitor the activities of the subrecipient as necessary to ensure that the subaward is used for authorized purposes, in compliance with Federal statutes, regulations, and the terms and conditions of the subaward; and that subaward performance goals are achieved.

Likewise, HRSA, HHS, and Congress hold HRSA HAB responsible for monitoring and reporting the program performance of its recipients and its subrecipients, the RWHAP service providers. HRSA HAB has established the following reporting requirements for RWHAP-fund recipients accordingly.

Additional information on a covered entity's use or disclosure of protected health information without the written authorization of the individual to a public health authority is in 45 CFR 164.512 at: **https://www.gpo.gov/fdsys/pkg/CFR-2011-title45-vol1/pdf/CFR-2011-title45-vol1-sec164-512.pdf**

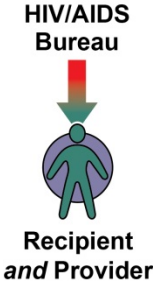
[3] The rules and requirements that govern the administration of HHS grants are set forth in the regulations found in the Uniform Administrative Requirements, Cost Principles and Audit Requirements for HHS Awards, 45 CFR part 754.342(a) and 75.352(d).

RECIPIENT AND SUBRECIPIENT RELATIONSHIPS

(Last Updated: November 29, 2018)

Recipients and subrecipients work together to quickly and easily submit the RSR. Figures 1–4 offer illustrations and definitions of recipient and subrecipient relationships.

Figure 1. Recipient-Provider

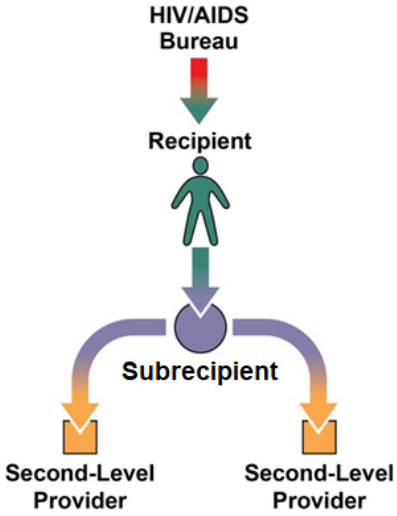


A recipient-provider, which is a service provider that also is a recipient, must complete a Recipient Report and a Provider Report. A recipient-provider of core medical or support services must also upload client-level data.

Figure 2. Subrecipient

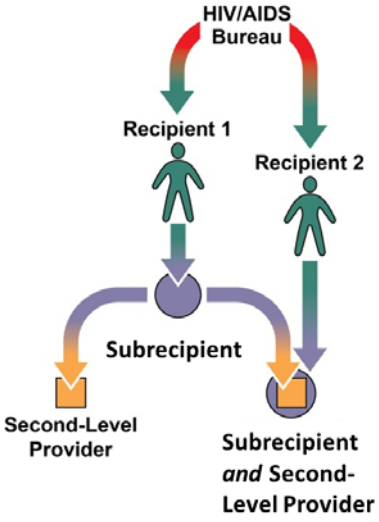
A service organization that has a contract with a recipient is considered a subrecipient. A subrecipient must complete a Provider Report and, if it provides core medical or support services, upload client-level data.

Figure 3. Second-Level Provider



Occasionally, recipients will use an administrative agent to award and/or monitor the use of their RWHAP funds. In this situation, the administrative agent (or fiscal intermediary service provider) is the recipient's subrecipient. When the recipient's subrecipient (administrative agent or fiscal intermediary provider) enters into a contract with another provider to use the recipient's funds to deliver services, that provider is considered a second-level provider to the recipient. A second-level provider must complete a Provider Report and, if it provides core medical or support services, upload client-level data.

Figure 4. Multi-Level Provider



If a service organization is a multilevel provider (a second-level provider to one recipient and a subrecipient to another recipient), it must complete a single Provider Report and, if it provides core medical or support services, upload client-level data. The provider must include client data for ***all*** its RWHAP contracts.

RECIPIENT/SUBRECIPIENT EXEMPTIONS

Service organizations may be exempt* from completing their own Provider Report and Client Report at the recipient's discretion if any of the following apply to them:

- They submit only vouchers or invoices for payment (e.g., a taxicab company that only provides transportation services),
- They do not see clients on a regular and sustained basis (e.g., on an emergency basis only),
- They offer services to clients on a "fee-for-service" basis,
- They provide only laboratory services to clients,
- They received less than $10,000 in RWHAP funding during the reporting period (January 1—December 31),
- They see a small number (1–25 patients) of RWHAP clients,
- They did not provide services during the reporting period (January 1—December 31),
- They are no longer funded by the recipient, and/or
- They are no longer in business.

*HRSA HAB recommends that an exempted subrecipient have the reason and approval for an exemption in writing from its recipient.

Service providers that only provide laboratory services and no other services are exempt from this reporting requirement. However, HRSA HAB requires service providers that offer laboratory services among other services to report laboratory service data under Outpatients/Ambulatory Health Services, even if a client only received the laboratory services and no other service.

If a recipient exempts a subrecipient from submitting a Provider Report or Client Report, this does not exempt the recipient from collecting and submitting data for that subrecipient. If a recipient exempts a subrecipient, the recipient must ensure that the subrecipient's data are reported to HRSA HAB. See page 12 for instructions on marking a subrecipient as exempt in the RSR system. For a recipient to exempt a subrecipient, it does the following:

- Completes a Provider Report and uploads client-level data in the exempted subrecipient's name. In this case, recipients do not select the "Exempt" check box;
- Reports the exempted subrecipient's data with its agency's RSR data. In this case, all recipients must select the "Exempt" box; or
- Includes the second-level provider's data in the subrecipient's Provider Report. In this case, the recipient WILL select the "Exempt" checkbox for the second-level provider.

Not all subrecipients are eligible to receive a reporting exemption:

- Recipient-providers may not be given an exemption.
- Multilevel providers may not be given an exemption.
- A multiply funded subrecipient may be given an exemption only if all its recipients agree to the exemption.

FREQUENTLY ASKED QUESTIONS ABOUT RECIPIENT/SUBRECIPIENT RELATIONSHIPS AND REPORTING REQUIREMENTS

I have several subrecipients that delivered services to RWHAP-eligible clients during the reporting period. I have decided to give one of them an exemption from submitting an RSR Provider Report and client-level data. How should I report the data for the exempt subrecipient?

If you exempt a subrecipient from submitting an RSR Provider Report and client-level data, you are required to submit the data to HRSA HAB on behalf of the subrecipient. There are three options for accomplishing this:

1. Complete the subrecipient's RSR Provider Report and upload client-level data into the subrecipient's report.
2. Direct your subrecipient to complete the report on a second-level subrecipient's behalf. If you or your subrecipient will be completing the report, DO NOT indicate that the subrecipient is exempted from reporting.

   Note: Subrecipients cannot access a second-level provider's report if the subrecipient (1) is not a recipient AND (2) also funds the subrecipient.
3. Report the exempted subrecipient's data with your agency's RSR data. In this instance, you WILL select the exempt option in your Recipient Report. See page **4** for instructions on marking a subrecipient as exempt in the RSR system.

What if a subrecipient receiving funding from multiple RWHAP Parts is given an exemption from reporting by one recipient but not another?

Subrecipients must be exempted from reporting by all of their recipients. If your subrecipient has other recipients, you will need to coordinate with the other recipient(s) to ensure that all recipients have indicated that the subrecipient is exempted. If one or more of a subrecipient's recipients does not agree to exempt the subrecipient, the subrecipient will still need to complete the RSR Provider Report.

I have a subrecipient that has been exempted by all recipients that fund the agency. Why is there a report in "Not Started" status for the agency?

If a subrecipient has been exempted by all recipients that fund the agency, all recipients will still be required to submit a "blank" report for the agency. See page **26** for instructions.

We are funded for outpatient ambulatory health services, and we provide laboratory services. Are we exempt from reporting the laboratory services?

Laboratory services are considered an activity of the Outpatient Ambulatory Health Services category. Therefore, the recipient would report laboratory service data under Outpatient Ambulatory Health Service, even if a patient only received the laboratory services, and no other Outpatient Ambulatory Health Service activity was included.

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For the purposes of reporting, RWHAP-funded services are divided into three groups:

1. Administrative and technical services,
2. Core medical services, and
3. Support services.

Descriptions for all RWHAP services are in the **Policy Clarification Notice (PCN) 16-02,** Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds.

CHECKING THE CLIENT-LEVEL DATA XML FILE

(Last Updated: **November 29, 2018)**

The Check Your XML Feature allows subrecipients to confirm that the XML file complies with RSR client-level data schema and to review data quality prior to submitting client-level data. Subrecipients are also able to check their client-level data to identify any data validations that need to be addressed before submission. The Check Your XML feature is available to users before the RSR Recipient Report opens.

For detailed instructions on how to access and use the Check Your XML feature, refer to the materials on the TargetHIV website at **https://targethiv.org/library/rsr-check-your-xml-feature**. Instructions on how to import client-level data are on page 26 of this manual.

Uploading client-level data in the Check Your XML feature DOES NOT meet the requirement for data reporting. A client-level data file must be uploaded using the "import client-level data" link in the RSR Provider Report to meet the reporting requirement.

RSR RECIPIENT REPORT

(Last Updated: November 29, 2018)

Each recipient of record completes a separate Recipient Report for each RWHAP grant the recipient receives from HRSA. For example:

- An agency with only a RWHAP Part A grant will complete one Recipient Report.
- An agency with RWHAP Part C and D grants will complete two Recipient Reports—one for its RWHAP Part C grant and another for its RWHAP Part D grant.

The Grantee Contract Management System

All RWHAP contract information is stored in the GCMS. The GCMS uses information from your previous RSR submissions, the Consolidated List of Contracts, and/or the Program Terms Report to populate your RSR Recipient Report with all the elements necessary to complete the RSR, such as subrecipient relationships and funded services. You will not be required to synchronize any changes to the RSR Recipient Report if the subrecipient and service information populated from the GCMS are correct. However, if the data that populate in the Recipient Report are incorrect, edit the information in the GCMS and integrate your changes into your RSR via the Synchronize step on the Program Information page of the RSR Recipient Report.

Instructions on how to synchronize information into your RSR Recipient Report are on page 12 of the manual.

Instructions for Completing the Recipient Report

Step One: Access the GCMS

Recipients and recipient-providers only: Log in to the HRSA electronic handbooks (EHBs) site at **https://grants.hrsa.gov/webexternal** and navigate to your Performance Reports. There are several methods of accessing the RSR Report in the EHBs interface. An instructional video and slides are on the TargetHIV website: **https://targethiv.org/library/completing-grantee-contract-management-system-gcms**. Start at slide 6.

Hover your mouse over the "Grants" tab on the top-left side of the screen to show a drop-down menu. On the drop-down menu, under "Submissions," select "Work on Performance Report." On the bottom of the Submissions - All page, under "Submission Name," locate your most recent RSR submission Find your 2018 RSR Deliverable and click "Start" or "Open." On the left side of the screen, under the Navigation panel, select "Search Contracts" to navigate to the GCMS.

If you need help navigating the EHBs to find your annual RSR, call the HRSA Contact Center at 1-877-464-4772.

Step Two: Verify your contracts in the GCMS

In the GCMS, enter the date range for your submission as the search criteria. For example, for the 2018 RSR, enter "1/1/2018" in the Range Start Date field or select the date from the calendar, and "enter 12/31/2018" in the Range End Date Field or select the date from the calendar.

Contracts listed in the GCMS should match the actual agreements you have in place with your subrecipients. For the purpose of the RSR, contracts include formal contracts, memoranda of understanding, or other agreements. Each subrecipient listed and the corresponding services it is funded to provide will be copied into your RSR Recipient Report when it is created.

You will need the information listed below for each of your contracts.

Contract Information

1. Contract Start Date: Enter the start date by typing into the box or selecting the date from the calendar.
2. Contract End Date: Enter the end date by typing into the box or selecting the date from the calendar.
3. Enter the Contract Reference number (if applicable): This item is for your reference and is not required for you to enter the contract.
4. Contract Execution: Select "Yes" if the contract has been signed and executed.
5. Is this agency serving as a consortia, fiscal intermediary provider, administrative agent, or lead agency for this contract? Select "Yes" or "No." If you select "Yes," specify consortia, fiscal intermediary provider, administrative agent, or lead agency in question 5a that appears after you select "Yes."
6. Is this agency a subcontractor or second-level provider? Select "Yes" or "No." If you select "Yes," select the provider's fiscal intermediary from the drop-down menu in question 6a that appears after you select "Yes."

Service Information

7. Does this agency provide direct client services? Select "Yes" or "No."
8. If applicable, select the administrative and technical services that are funded for this contractor. Select all that apply:

    - Planning and evaluation
    - Administrative or technical support
    - Fiscal intermediary support
    - Other fiscal services
    - Technical assistance
    - Capacity development
    - Quality management

9. If applicable, indicate the core medical and essential support services that are funded for this contract by selecting the "Update Services" button. A screen will pop up with the list of services. Enter the award amount(s) using only whole numbers for each service that the subrecipient was funded to deliver, regardless of whether the subrecipient actually used the funding. To review the service definitions, refer to page 6.

    - Once you have entered all the contract information, click the "Done Updating Services" link. Then click "Save" at the bottom of the main page.

The GCMS does not capture funding amounts allocated to administrative and technical services.

- After you have verified that all contracts listed are correct, you are ready to complete the RSR Recipient Report.

Editing Contracts in the GCMS

If you need to make modifications to your list of service provider contracts displayed, click the "Edit/Remove" link at the right side of the table to open the desired contract. Make the edits and click "Save."

The GCMS is used to populate multiple HRSA HAB deliverables. Only delete a contract from the GCMS if you no longer have a contract in place during the reporting period. If a specific contract is exempt from RSR reporting, use the exempt feature in the RSR Recipient Report. See page 4 for exemption instructions.

Adding Contracts in the CGMS

If you determine a contract is missing for one of your subrecipients after you first perform a search, add the new contract:

1. Click the "Add Contract" button below the search results table.
2. Search for the organization by registration code, name, or city/state.
3. Locate the subrecipient in the results table and click "Add" under the action column.
4. Complete questions 1–9.

Ensure all contracts within the submission period are accurate and present in the GCMS before proceeding to Step Three.

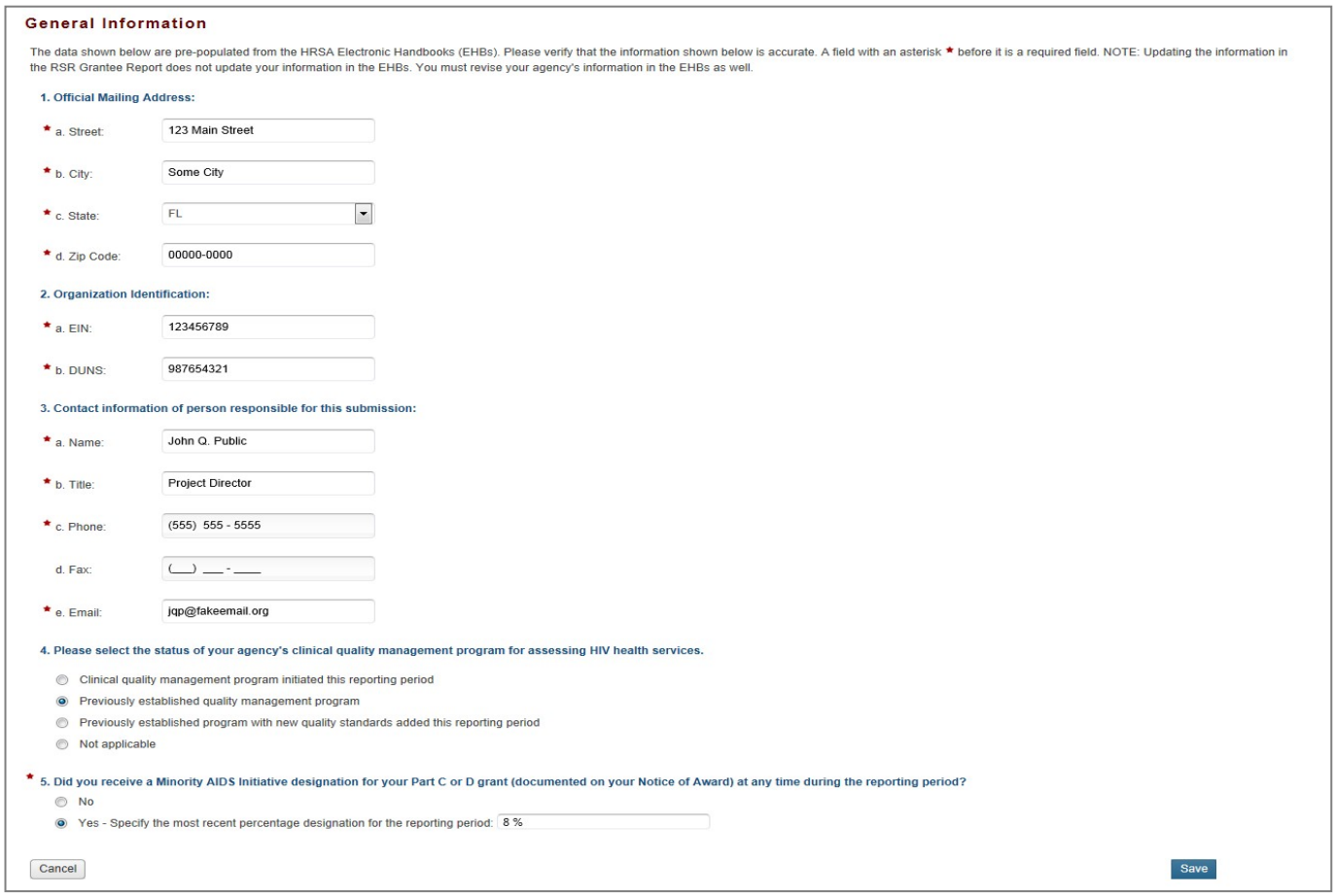
If you need help locating/adding a subrecipient to the GCMS, call Data Support at 1-888-640-9356 or e-mail RyanWhiteDataSupport@wrma.com.

Step Three: Open and complete your RSR Recipient Report

Once all contracts from the submission period are in the GCMS, under the Inbox heading in the left Navigation panel, select the "Recipient Report" link. Create or open your Recipient Report by clicking the envelope icon under the "Action" column. You will be redirected to the RSR Recipient Report General Information page.

General Information

Figure 5. RSR Recipient Report Online Form: Screenshot of the General Information Section



Items 1–3 show the information on the Recipient Report prepopulated from your notice of award (NOA). These fields are editable, and you should also update your agency's information on your NOA:

1. Official Mailing Address
   a. Street
   b. City
   c. State
   d. ZIP Code
2. Organization Identification
   a. EIN
   b. DUNS
3. Contact information of person completing this form (fillable item). This will be the primary contact person for RSR matters.
   a. Name
   b. Title
   c. Phone
   d. Fax
   e. Email
4. Select the status of your agency's clinical quality management program for assessing HIV health services (select only one):
   - Clinical quality management program initiated this reporting period,
   - Previously established clinical quality management program,
   - Previously established program with new quality standards added this reporting period, or
   - Not applicable.

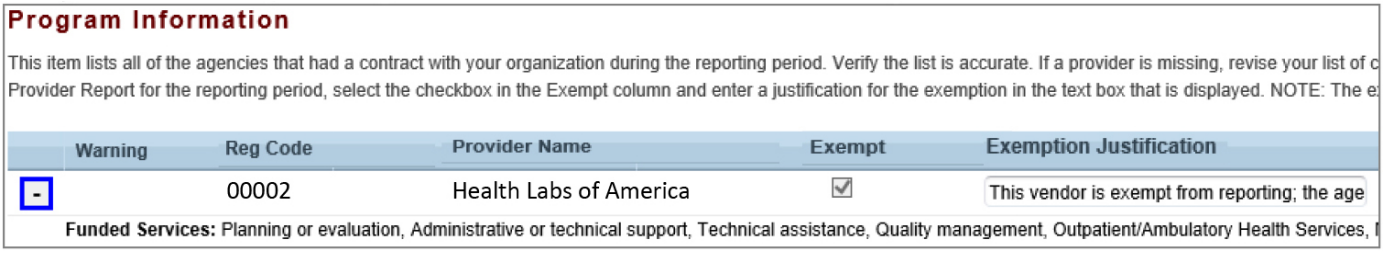
Every RWHAP agency that provides core medical services is required to have a clinical quality management program to assess how HIV health services provided to patients by medical providers and/or medical case managers under the grant are consistent with the most recent **HHS guidelines** for HIV treatment. For further information on quality management, refer to the resources at **https://hab.hrsa.gov/deliverhivaidscare/qualitycare.html**.

5. **RWHAP Part C and D Recipients Only:** Indicate whether your agency received Minority AIDS Initiative (MAI) funding during the reporting period. If your agency did receive MAI funding, specify the most recent percentage designation for the reporting period.

Click "Save" on the bottom right of the page.

Program Information

Figure 6. RSR Recipient Report Online Form: Screenshot of the Program Information Section



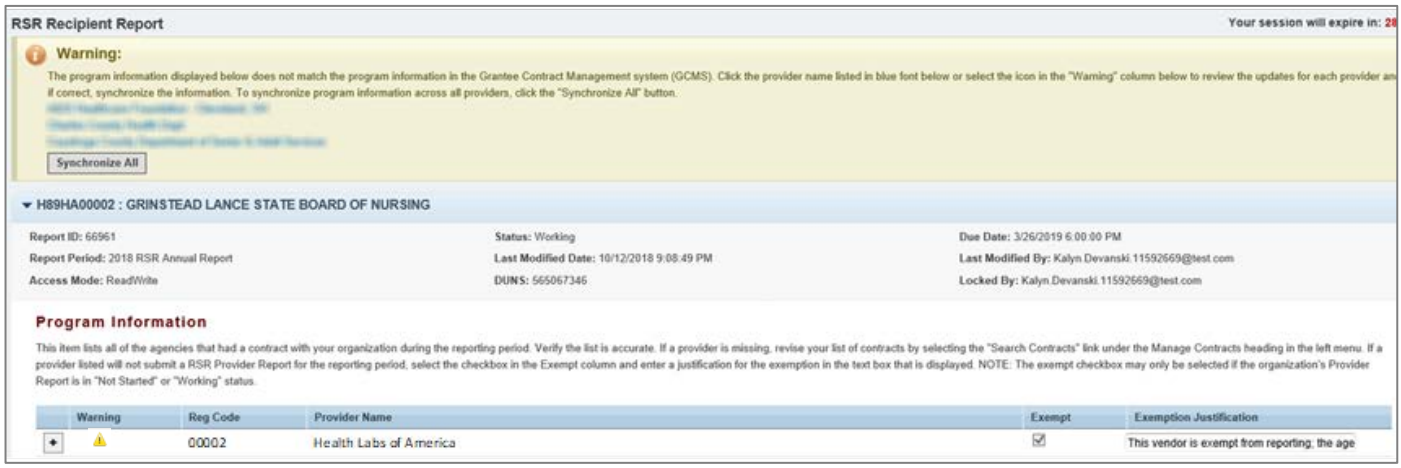
On the left Navigation panel, select "Program Information." Review the list of your service providers that were active during the reporting period.

- Select the "Expand/Collapse" icon to view the services you funded for each subrecipient. The list should display all the services that were funded, regardless of whether the subrecipient actually delivered the service.
- If you need to exempt a subrecipient from reporting, check the box in the "Exempt" column, and enter a brief explanation for the exemption. **Please Note:** If a subrecipient has other recipients in addition to you, all its recipients must check "Exempt" for the subrecipient to be considered exempt from reporting. If one or more recipient(s) chooses not to exempt the subrecipient, the provider must complete the Provider Report and should include data for all programs. Refer to page 4 for a list of exemption criteria.
- If all the information displayed is correct, click "Save" at the bottom of the page, and move on to Step 4 (Validate and Certify your RSR Recipient Report).

Synchronizing Changes to Your RSR Recipient Report

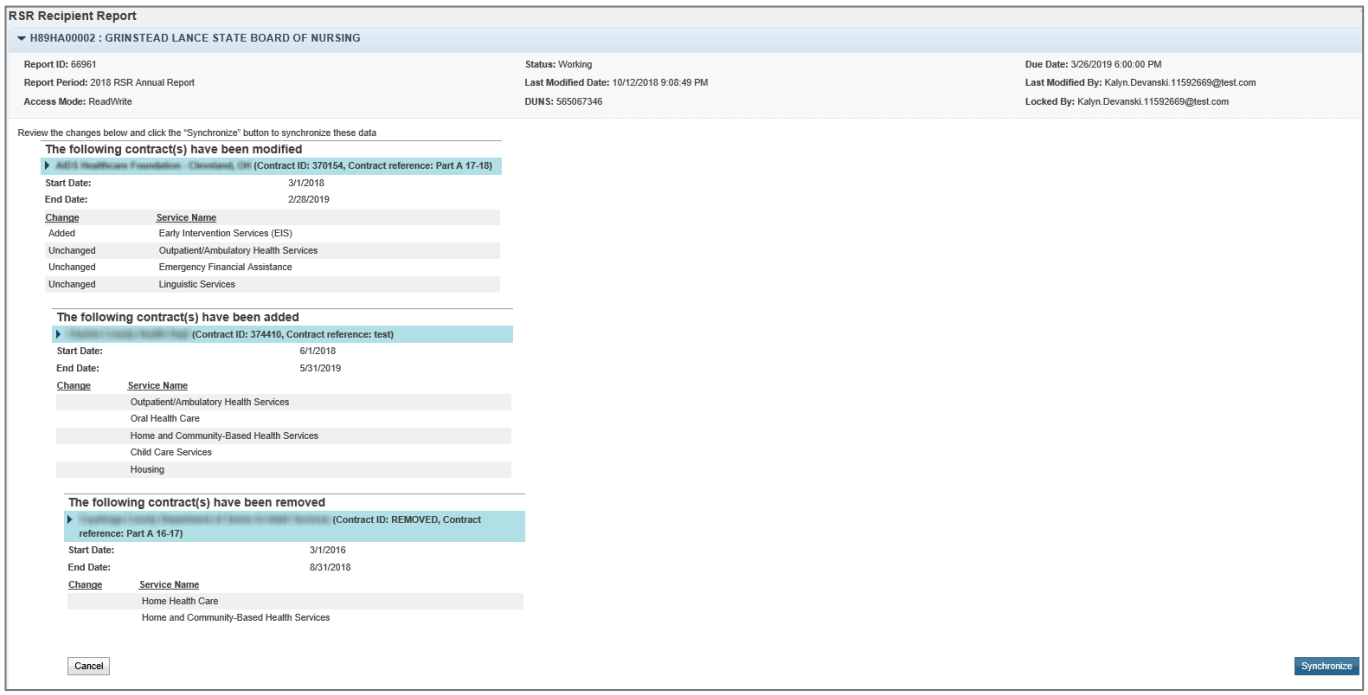
If you edit contracts in the GCMS after you start your Recipient Report, synchronize the changes so that they appear in your RSR report. To access the "Synchronize" feature, click "Program Information" in the left Navigation panel. A Warning message will appear that contains links for each subrecipient with contract edits.

Figure 7. RSR Recipient Report Online Form: Screenshot of the Program Information Section with Synchronization Warning



- Click "Synchronize All" in the Warning message box at the top of the page to synchronize program information across providers.
- Alternatively, click on either the blue link in the Warning message box or the icon in the Warning column to review the contract modifications. **Please note**: If you added a new subrecipient contract in the GCMS, you will not see that subrecipient in your list; you must select the link with the subrecipient name in the Warning at the top of the page.

Figure 8. RSR Recipient Report Online Form: Screenshot of the Synchronization Confirmation Section



- Review the list of changes you made to the subrecipient contract(s). To accept the changes and update the data in your Recipient Report, click "Synchronize" at the bottom of the page.
- Synchronize your Recipient Report to incorporate any changes you made in the GCMS. Changes are not visible to subrecipients until they have been synchronized.

Step Four: Validate and certify your RSR Recipient Report

Once your Recipient Report is complete and correct, validate your Recipient Report by selecting "Validate" in the Navigation panel on the left. Allow the system to validate for a few minutes, and then refresh the page by selecting "Validate" again. Once the system displays your validation results, it will sort validation problems into three categories: Errors, Warnings, and Alerts. Errors must be fixed. If your Recipient Report triggers a validation error, revise your Recipient Report. You cannot certify your Recipient Report with errors. Warnings require that you add a comment; however, you should address warnings to prevent your project officer from returning the report to you. Alerts are informational and do not need to be addressed.

To add a comment to a warning, select "Add Comment" under the "Actions" column to the right of the warning validation. A new window will appear for you to enter your comment. When finished, select "Save" at the bottom of the text box. In your comment, you can explain why the warning is inaccurate or erroneous. The comment does not change the information in your report.

Indicate that you have completed data entry for your RSR Recipient Report by clicking "Certify" in the Navigation panel on the left. Enter a comment in the text box, and check the box under the comment box indicating that you certify that the information is accurate. Make an effort to certify your RSR Recipient Reports as soon as possible after the RSR Web System opens. Subrecipients cannot submit their RSR Provider Report and client-level data until their recipient(s) certify their RSR Recipient Report(s).

You will need to request a decertification if you need to make edits to your Recipient Report Program Information after it has been certified.

Step Five: Accept Provider's Reports (after subrecipients have submitted their report)

When your subrecipient(s) have submitted their RSR Provider Report and client-level data, it is your responsibility to review the reports.

- Navigate to each subrecipient's RSR by using the Provider Report inbox or searching for the subrecipient using the search feature in the left Navigation panel. Open the Provider Report by selecting the envelope icon in the "Action" column.
- Review:
  - Provider Report
  - Upload Confirmation Report validation
  - Completeness Report
  - Validation comments the subrecipient has made

Use the links on the left to either "Submit/Accept" or "Return for Changes."

- If you fund a single subrecipient with more than one grant, such as RWHAP Parts C and D grants, accept the report from both grant folders before the Provider Report will advance to "Submitted" status.

For Exempted Subrecipients Only: If all recipients have exempted a subrecipient, "Create" the Provider Report, and use the "Submit/Accept" link to submit a blank provider report. However, the recipient will need to complete the Service Delivery section of the Provider Report prior to submitting it.

- Your RSR Recipient Report will not advance to "Submitted" status until you have accepted ALL of your providers' reports.

If you need help completing your Recipient Report or reviewing your providers' reports, contact RWHAP Data Support at 1-888-640-9356 or RyanWhiteDataSupport@wrma.com.

FREQUENTLY ASKED QUESTIONS ABOUT THE RSR RECIPIENT REPORT

My subrecipient is multiply funded. Does it have to submit multiple RSR Provider Reports?
No. Subrecipients only submit one RSR Provider Report, even if they are multiply funded. Their RSR Provider Report should include data for all their RWHAP funds.

We are a RWHAP Part C and D recipient; we are also a RWHAP Part A subrecipient. We do not have RWHAP Part C or D subrecipients. We use all our funds to deliver HIV counseling and testing and core medical and support services. What components of the RSR do I have to complete?
To complete your RSR, submit two RSR Recipient Reports, one for your RWHAP Part C grant and another for your RWHAP Part D grant. Complete one RSR Provider Report that includes data on all the services your agency is funded to deliver. Finally, submit client-level data that includes one record for each eligible client that received a service visit during the reporting period.

One of my subrecipients receives funds to provide AIDS Drug Assistance Program (ADAP) services only. Will this subrecipient submit an RSR?
No. This subrecipient is not required to submit an RSR. When a contract is created for a subrecipient, at least one non-ADAP service must be specified. Recipients should exclude subrecipients (and/or subrecipients' contracts) that are exclusively funded to provide only ADAP services from their Recipient Reports.

Our organization contributes RWHAP Part A Eligible Metropolitan Area/Transitional Grant Area funds and/or RWHAP Part B Base Funds for ADAP. Should I include a contract with the State (or its ADAP contractor) on my contract list?
Yes, a contract should be entered into the GCMS for the respective contract period. The State (or its ADAP contractor) may be exempted from reporting on the Program Information section of the RSR Recipient Report.

I am a recipient and have a contract with a fiscal intermediary. Do I list second-level subrecipient services in the fiscal intermediary contract?
No. You must create a contract for the fiscal intermediary in the GCMS. On question 4 of the contract, indicate that the subrecipient is a fiscal intermediary. Then, create a separate contract for the second-level subrecipient. Under question 5 in the GCMS, indicate "Yes," and select the fiscal intermediary that funds the organization.

The services listed for one of my subrecipients are not correct. Where can I edit the services?
You can make modifications to the contract in the GCMS. Select "Search Contracts" to enter the GCMS, search and select the subrecipients, make updates as necessary, and synchronize your report. As a reminder, verify contracts BEFORE starting the Recipient Report to avoid the need to synchronize the data.

I have already certified my Recipient Report, and I am no longer able to make any changes. What do I need to do?
You are not able to make changes to your Recipient Report while it is in "Certified" status. You will need to "request decertification" using the link on the left Navigation panel. Once your request is

approved, you will be able to make changes, revalidate, and recertify your report. Please contact Data Support at 1-888-640-9356 or **RyanWhiteDataSupport@wrma.com** for assistance with requesting a decertification.

What does it mean if a contract has been signed and executed, and do I need to check off the box if the contract is with my own agency?
A contract is signed and executed if there is an agreement/arrangement in place to provide services with RWHAP funding. An agency should mark that its contract has been executed even if the contract is self-funded.

Why hasn't my Provider Report moved into "Submitted" status even though the report has been accepted?
A Provider Report will only be moved to "Submitted" status if all funding grant recipients have accepted the report. If you are self-funded through multiple program Parts (e.g., your agency receives Part C and Part D funding), the report must be accepted under both grants.

RSR SERVICE PROVIDER REPORT

(Last Updated: November 29, 2018)

An organization that provides RWHAP services to PLWH could fill any and all the roles noted on page 6. At the same time, the organization might be:

- A recipient-provider,
- A subrecipient provider, or
- A second-level subrecipient provider.

For the purposes of the Provider Report, all these entities are referred to as "providers." They all provide client-level data about their services (unless exempted).

The Provider Report is a collection of basic information about both the provider and the services the provider delivered under each of its RWHAP contracts.

All agencies that provide RWHAP-funded services must complete one Provider Report using the RSR web system. Multiply funded providers will include information from all RWHAP Parts under which the agency is funded in one Provider Report.

Unless exempted, all provider agencies are expected to complete their own reports to confirm that their data accurately reflect their program and the quality of care their agency provides. A full explanation of exempting providers is in the section **Recipient/Subrecipient Reporting Requirements** on page 2.

Instructions for Completing the Provider Report

Step One: Open the Provider Report.

Recipient-providers: Access the RSR web system via the EHBs by logging in to the EHBs at **https://grants.hrsa.gov/webexternal**, and navigate to your Performance Reports. There are several methods of accessing the RSR in the EHBs interface, including through the following:

Hover your mouse over the "Grants" tab, also on the top-left of the screen to show a drop-down menu. On this drop-down menu, under "Submissions," select "Work on Performance Report." On the bottom of the Submissions - All page, under "Submission Name," locate your most recent RSR submission Find your 2018 RSR Deliverable and click "Open" or "Edit." On the left side of the screen, under the Inbox heading, select "Provider Report." Use the envelope icon in the Action column to access your Provider Report.

If you need help navigating the EHBs to find your annual RSR, call the HRSA Contact Center at 1-877-464-4772.

Providers Only: To access the RSR system, go to **https://performance.hrsa.gov/hab/RegLoginApp/Admin/Login.aspx**. Enter your user name and password, and click "Log In." If you have submitted the Provider Report in the past, you do not need to reregister in the system. If you are a new RSR system user, you will need your agency's registration code to create a user name and password. You will automatically be taken to the first page of your Provider Report.

To obtain your registration code, contact your recipient or Data Support at 1-888-640-9356. If you need help logging into or registering to use the RSR system, call Data Support at 1-888-640-9356.

Step Two: Complete the Provider Report

On the left Navigation panel, find "Provider Report Navigation." It has five links: General Information, Program Information, Service Information, HC&T Information, and Import Client-level Data. Complete each section before validating and submitting the report.

General Information

Confirm the following information. This information is populated from your organization's profile. The provider's organization information should be entered in the General Information section regardless of whether the recipient completed the Provider Report. Use the "Update" link highlighted in red below to modify as needed.

Figure 9. RSR Provider Report Online Form: Screenshot of General Information

Organization Details:

- Organization Name (editable for service "Provider Only" organizations)
- Tax ID/EIN
- DUNS
- Mailing Address

Provider Profile Information

Subrecipient Type (select only one): Select the provider type that best describes your agency.

- **Hospital or university-based clinic** includes ambulatory/outpatient care departments or clinics, emergency rooms, rehabilitation facilities (physical, occupational, speech), hospice programs, substance use disorder treatment programs, sexually transmitted diseases clinics, HIV/AIDS clinics, and inpatient case management service programs.
- **Publicly funded community health center** includes community health centers, migrant health centers, rural health centers, and homeless health centers.
- **Publicly funded community mental health center** is a community-based agency, funded by local, State, or Federal funds, that provides mental health services to low-income people.
- **Other community-based service organization** includes nonhospital-based organizations, HIV/AIDS service and volunteer organizations, private nonprofit social service and mental health organizations, hospice programs (home and residential), home health care agencies, rehabilitation

programs, substance use disorder treatment programs, case management agencies, and mental health care providers.

- **Health department** includes State or local health departments.
- **Substance use disorder treatment center** is an agency that focuses on the delivery of substance misuse treatment services.
- **Solo/group private medical practice** includes all health and health-related private practitioners and practice groups.
- **Agency reporting for multiple fee-for-service providers** is an agency that reports data for more than one fee-for-service provider (e.g., a State operating a reimbursement pool).
- **People Living with HIV(PLWH) coalition** includes organizations that provide support services to individuals and families affected by HIV and AIDS.
- **VA facility** is a facility funded through the U.S. Department of Veterans Affairs.
- **Other provider type** is an agency that does not fit the agency types listed above. If you select "Other facility," you must provide a description.

Section 330 funding received: funds community health centers, migrant health centers, and health care for the homeless? Section 330 of the Public Health Service Act supports the development and operation of community health centers that provide preventive and primary health care services, supplemental health and support services, and environmental health services to medically underserved areas/populations. Indicate if you received such funding during the reporting period.

- Yes
- No
- Unknown

Ownership Type (select only one):

- **Public/local** is an organization funded by a local government entity and operated by local government employees. A local health department is an example.
- **Public/State** is an organization funded by a State government entity and operated by State government employees. A State health department is an example.
- **Public/Federal** is an organization funded by the Federal Government and operated by Federal Government employees. A VA hospital is an example.
- **Private, nonprofit** is an organization owned and operated by a private not-for-profit entity. A nonprofit health clinic is an example.
- **Private, for-profit** is an organization owned and operated by a private entity, even though it may receive government funding. A privately owned hospital is an example.
- **Unincorporated** is an agency that is not incorporated.
- **Other** is an agency other than those listed above.

Faith-Based Organization (indicate whether your organization considers itself faith based):

- Yes
- No

Categories that best describe the agency's racial/ethnic characteristics. Select all that apply:

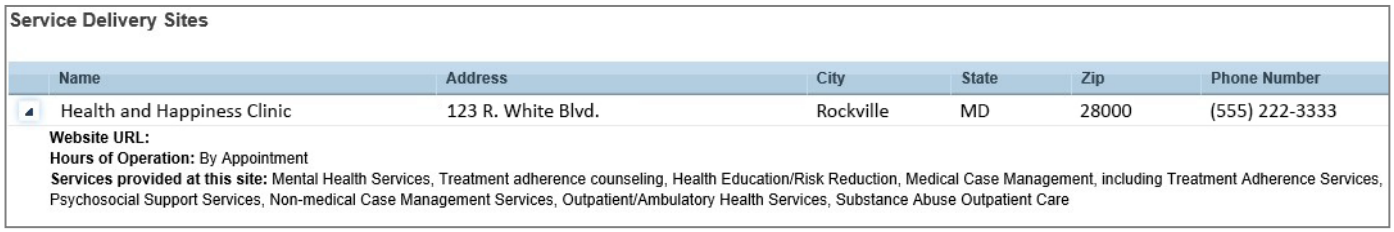
- Agency in which racial/ethnic minority group members make up more than 50 percent of the agency's board members.
- Agency in which more than 50 percent of the professional staff members in direct HIV services are racial/ethnic minority group members.
- Solo or group private health care practice in which more than 50 percent of the clinicians are racial/ethnic minority group members.
- Other "traditional" provider that has historically served racial/ethnic minority clients but does not meet any of the criteria above.
- Other type of agency or facility.

Service Delivery Sites

If the provider delivers client services, at least one service delivery site should be listed, even when the service delivery address matches the provider mailing address. The service categories have been updated to match **Policy Clarification Notice 16-02**. If you are a recipient and have exempted providers, you are still responsible for completing this section of their report.

Review the information in the table for accuracy. Use the "Edit" link to make changes to site information and modify delivered services at each agency. Use the "Add a Site" button to add additional service delivery sites.

Figure 10. RSR Provider Report Online Form: Screenshot of the Service Delivery Sites



Follow the on-screen prompts to enter the information into the "Add/Edit a New Service Delivery Site" screen. The Hours of Operation field is a text field, so you can enter anything, such as "By appointment only," to complete this item. Once you enter all the required information, select "Save" at the bottom of the screen.

Program Information

1) **Contact Information of person responsible for this submission.** Verify that the contact information is correct and make any necessary changes.
2) **Report the number of paid staff, in full-time equivalents (FTEs), funded by RWHAP during the given reporting period.** Enter up to two decimal places. Enter a zero if there are no paid staff.

How to Calculate FTEs

Count each staff member who works full time (at least 35–40 hours per week) on RWHAP as one FTE. Full-time employees who regularly work overtime should not be counted as more than one FTE.

If a percentage of each staff member's time is being funded (e.g., part-time employees or full-time employees who spend only a portion of their time on HIV care), add the percentages to calculate the total. For example: An agency uses program funds to support two physicians, one full time (1.0 FTE) and another

part time (0.50 FTE); a nurse practitioner full time (1.0 FTE); a dentist part time (0.20 FTE); and two case managers, one part time (0.75 FTE) and another full time (1.0 FTE). This agency would report 4.45 FTEs in Item 10 of its Service Provider Report.

3) **Select the status of your agency's clinical quality management program for assessing HIV core medical services** (select only one):

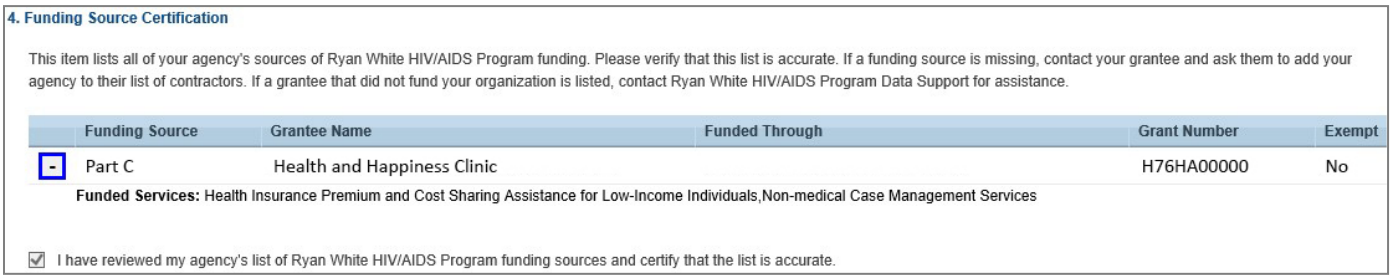
- Clinical quality management program initiated this reporting period,
- Previously established clinical quality management program,
- Previously established program with new quality standards added this reporting period, or
- Not applicable.

Further information on clinical quality management is in **PCN 15-02**, available on the HRSA HAB website. After reviewing and updating the information on this page of the Service Provider Report (if necessary), save the data and advance to the "HIV Counseling and Testing" section of the Provider Report.

Funding Source Certification

4) This item lists all your agency's sources of RWHAP funding. Verify this list is accurate by checking the box under the funding source table. If a funding source is missing or services listed are inaccurate, contact your recipient and ask it to add your agency to its list of contractors. If a recipient that did not fund your organization is listed, contact RWHAP Data Support for assistance.

Figure 11. RSR Provider Report Online Form: Screenshot of the Funding Source Certification



Opioid-Use Treatment

5) **Within your organization/agency, identify the number of physicians, nurse practitioners, or physician assistants who obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat opioid use disorder with medications (medication assisted treatment [MAT], e.g., buprenorphine, naltrexone) specifically approved by the U.S. Food and Drug Administration (FDA).** Enter the number of the abovementioned staff who obtained the waiver. Enter zero if none of the abovementioned staff obtained the waiver.

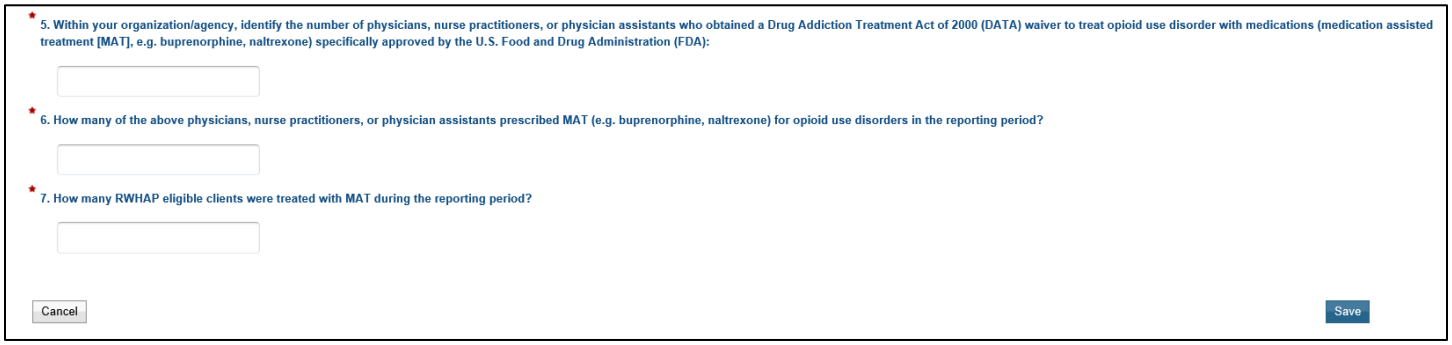
6) **How many of the above physicians, nurse practitioners, or physician assistants prescribed MAT (e.g., buprenorphine, vivitrol) for opioid use disorders in the reporting period?** Enter the number of the abovementioned staff who prescribed MAT. Enter zero if none of the abovementioned staff prescribed MAT.

7) **How many RWHAP clients were treated with MAT during the reporting period?** Enter the number of clients treated. Enter zero if no clients were treated.

For questions 5 and 6, providers should report information on all providers in the unit or subunit of their organization that are funded to provide RWHAP services (regardless of whether that unit or subunit is specifically funded to provide MAT through RWHAP).

For question 7, providers should report all RWHAP eligible clients who were treated with MAT during the reporting period in the unit or subunit of their organization funded to provide RWHAP services.

Figure 12. RSR Provider Report Online Form: Screenshot of the Opioid Reporting Questions

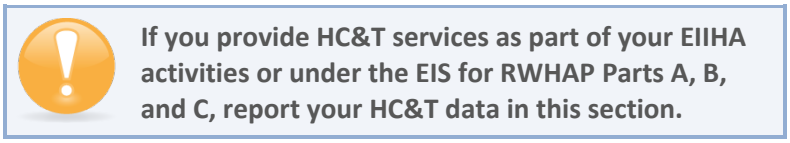


Service Information

8) Review the services funded by your recipient(s). This is populated from the services indicated as funded by your recipient(s) in its Recipient Report(s). This list includes ALL RWHAP funding sources covered by the RSR. Your agency should select any service category that was delivered using RWHAP funds during the reporting period. If a service category is missing, contact the appropriate recipient.

HC&T Information

If your agency used RWHAP funding to provide HC&T services during the given reporting period, complete this section. Report ALL individuals who received the service at your agency during the reporting period, regardless of funding source. Complete this section if RWHAP funds are only used for staff salaries.



9) **Did your organization use RWHAP funds to provide HIV Counseling and Testing services during the reporting period?** Indicate "Yes" or "No."

10) **Number of individuals tested for HIV**: Indicate the number of people tested using an FDA-approved test during the reporting period.

11) **Of those tested**, **number who tested NEGATIVE**: Indicate the number who tested NEGATIVE for HIV during the reporting period.

12) **Number who tested NEGATIVE and received post-test counseling**: Of the number specified in Item 11, indicate the number who received HIV post-test counseling.

13) **Of those tested**, **number who tested POSITIVE**: Of the total number tested, indicate how many tested positive for HIV during the reporting period.

14) **The number who tested POSITIVE and received post-test counseling**: Of the number specified in Item 13, indicate how many received HIV-post-test counseling immediately following the test or returned for counseling at a later date.

15) **Of those who tested POSITIVE**, **number referred to HIV medical care**: Of the total number who tested positive for HIV, indicate how many were referred to HIV medical care.

Step Three: Complete the Client-Level Data Report: Import client-level data (if applicable)

If you provide core medical or support services, upload a client-level data file to complete your Provider Report. The Client-Level Data Report is a collection of RWHAP client records that must be submitted in a properly formatted client-level data XML (eXtensible Markup Language) file. To learn how to upload the client-level data XML file, see page 26.

Step Four: Validate your RSR Provider Report and client-level data

Validate your Provider Report by clicking "Validate" on the left Navigation panel in the "Provider Report Actions" section.

If you have questions about a specific data validation check, contact Data Support at 1-888-640-9356.

Your validation results may return three types of report validation results: Errors, Warnings, or Alerts.

- Correct errors before you submit your Provider Report. If the errors are triggered by the Provider Report, correct the information entered. If the errors are triggered by the client-level data, correct the data file and re-upload it to the system. Be sure to clear the old file by using the "Clear Clients" feature in the left Navigation panel before uploading the corrected data file. When you have finished updating your data, validate your report again.
- Correct warnings if possible or enter a comment explaining the data. To submit your Provider Report with warnings, write a comment for all the warnings that cannot or should not be fixed by clicking the "Add Comments" link under the Action column in your validation report. Do not include personal health information (PHI) when entering warning comments.
- Alerts are informative and intended to help you identify potential issues in your data collection and reporting processes. You can submit your report with alerts.

Your data system contains PHI that includes, but is not limited to, client names, addresses, DOB, SSN, dates of service, and URNs generated for your organization's client-level data XML file. To ensure client confidentiality, you must be compliant with all relevant Federal regulations. Protect this information the same way you protect all client data. For additional information, visit the HHS Office of Civil Rights Health Information Privacy webpage. Do not disclose sensitive information in your reporting comments. Refer to **https://www.hhs.gov/ocr/privacy** for additional information about client confidentiality and privacy.

Step Five: Submit your data

When you are satisfied that your Provider Report is complete, submit it and client-level data by clicking "Submit" in the left Navigation panel and following the instructions on your screen.

Your RSR Provider Report will proceed to either "Review" or "Submitted" status. If your report advances to "Submitted" status, you are done. If your report advances to "Review" status, one or more RWHAP funders must review and accept the report before it will advance to "Submitted" status. If you have questions about the status of your RSR, contact Data Support at 1-888-640-9356.

FREQUENTLY ASKED QUESTIONS ABOUT THE RSR PROVIDER REPORT

Do providers receiving funding from multiple RWHAP Parts complete multiple Provider Reports?
No. Each subrecipient will submit only one Provider Report including data from all RWHAP Parts under which the agency is funded.

Are providers we do not have formal contracts with required to submit data?
For the purpose of the RSR, "contracts" include formal contracts, memoranda of understanding, or other agreements. Data must be reported for all providers that delivered RWHAP services.

Do providers need to submit a Provider Report and client-level data if they do not serve any clients, submit only vouchers, only serve clients on a fee-for-service basis, or receive a small amount of funding from my grant?
Each provider listed on your contract lists will be required to complete an RSR Provider Report unless all of its RWHAP funders have marked it as exempted. Data are still required of all providers that delivered RWHAP services. Please refer to page 4 to review how to report for an exempted provider.

Do second-level providers have to submit Provider Reports?
Yes, both first- and second-level providers need to complete Provider Reports. Second-level providers will see the name of their RWHAP funders and the name of their fiscal intermediary, the agency through which it receives funding, in their contracts list.

I have a lot of providers and have set an early submission deadline so I have time to review their submissions. But one of my providers is multiply funded, and the other recipient told my provider that it does not need to submit its data until HRSA HAB's recommended submission deadline. I really need my provider to submit its data early. What do I do?
Contact your provider's other RWHAP funder(s), preferably before the report submission period begins, to coordinate your deadlines. Taking the time up front to agree on the submission deadlines that all the provider's RWHAP funders will enforce will help ensure a smooth submission process. If your provider is also a recipient, be sure to negotiate an early submission deadline that is agreeable to both of you. Project officers can be helpful in these decisions and can suggest due dates for Recipient Reports.

How do I report a service that I delivered that does not appear in my Provider Report?
If you receive Ryan White funds to deliver a service that is not populated in your Provider Report, contact your RWHAP recipient to add the service(s) on its Recipient Report. If you did not receive RWHAP funds to deliver the service, do not mark it in your Provider Report.

When completing the new opioid-use treatment questions in the Provider Report, should we count providers covered under a subcontract?
Yes, include subcontract providers.

If our agency has a separate non-RHWAP-funded program that provides MAT for opioid use, do we need to report on these clients?
No, only report all RWHAP-eligible clients who were treated with MAT during the reporting period in the unit or subunit of their organization funded to provided RHWAP services.

For the opioid-use treatment questions about how many clients were treated with MAT during the reporting period, should we include the RWHAP-eligible patients who received MAT at an outside organization?
No, only report RWHAP-eligible clients who were treated with MAT during the reporting period in the unit or subunit of their organization funded to provide RWHAP services.

Is question 7 under the opioid-use treatment questions asking how many clients the organization has prescribed MAT treatment to? Or are the questions asking how many clients of the organization have been prescribed MAT treatment (regardless of who prescribed it)? Some of our provider agencies do not prescribe MAT treatment, but clients they serve are on MAT treatment prescribed elsewhere.
Question 7 asks how many clients were treated with MAT during the reporting period. Providers should report all RWHAP-eligible clients who were treated with MAT in the unit or subunit of their organization funded to provide RWHAP services during the reporting period.

RSR CLIENT-LEVEL DATA REPORT

(Last Updated: November 29, 2018)

Client-level data must be submitted for all providers who used RWHAP funds to provide core medical or support services directly to clients during the reporting period. Unless exempted from reporting, all provider agencies must complete their own reports to confirm that their data accurately reflect their program and the quality of care their agency provides. A full explanation of exempting providers is in **Recipient/Subrecipient Reporting Requirements** on page 2.

Importing the Client-Level Data XML File to the Provider Report

Providers need to extract the client-level data from their systems into the proper XML format before the data can be submitted to HRSA HAB. Software applications that manage and monitor HIV clinical and supportive care can export the data in the required XML format. A list of RSR-ready vendor systems that can generate the RSR client-level data XML file is on the TargetHIV website at **https://targethiv.org/library/rsr-ready-data-systems-vendor-information**. If your organization uses a custom-built data collection system, you have two options:

1. Write a program that extracts the data and inserts it into an XML file that conforms to the rules of the RSR XML schema. Obtain the schema from HRSA HAB at **https://targethiv.org/library/ryan-white-services-report-rsr-data-dictionary-and-xml-schema-implementation-guide-client**. This list is updated every year.
2. Use TRAX to create your client-level data XML file. TRAX was developed to help recipients and providers that do not use CAREWare, a provider data import, or other RSR-ready vendor system to create their client-level data XML file.

If you need help generating or modifying your XML file, contact the DART Team at data.ta@caiglobal.org.

To upload a client-level data XML file, open your RSR Provider Report. From within the RSR Provider Report, click the "Import Client-level Data" link in the Provider Report Navigation panel on the left. Follow the on-screen instructions.

Each file uploaded into the RSR system goes through an automatic schema validation check. If the file is noncompliant, the RSR system rejects the file, and a complete list of error messages will be displayed. Download the list as a text file and use it to fix the client-level data in your source system.

Generate and review the Upload Completeness Report from the left Navigation panel before submitting the data.

Data files must be uploaded to the RSR Provider Report. Uploading to the Check Your XML feature does not meet the reporting requirements.

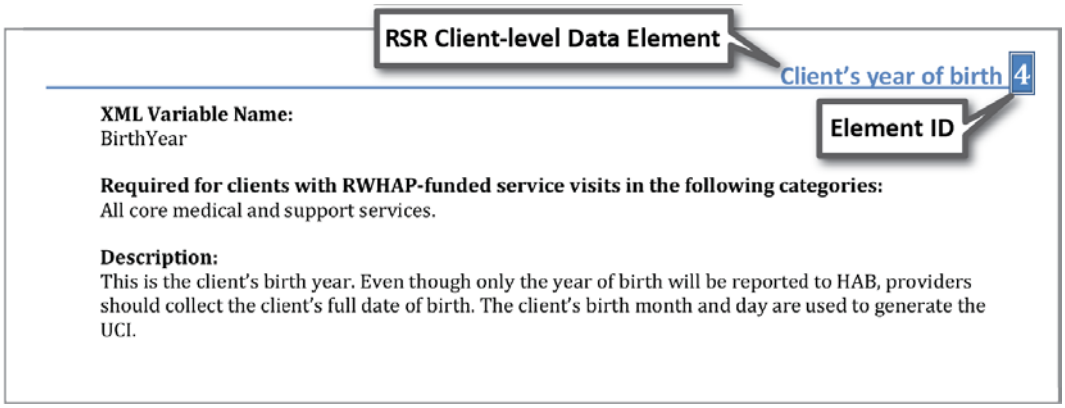
Client-Level Data Elements

The client report should contain one record for each client who was eligible and received RWHAP core medical services or support services during the reporting period. The data elements reported per client are determined by the specific RWHAP services your agency is funded to provide. See the chart in **Appendix A. Required Client-Level Data Elements for RWHAP Services** on page 51 to determine which client-level data elements to report for a client.

Up to 60 data elements may be reported for each client; they include the following:

- Unique Client Identifier (eUCI),
- Demographic information,
- The core medical and support services received, and
- Clinical information if the client received outpatient/ambulatory medical care services.

Figure 13. Screenshot of Client-Level Data Element and Element ID



This section outlines the data fields that may be submitted in the client-level data XML file. Each description includes the following:

Element ID: Each data element has been assigned a value for convenient referencing between this document and the RSR data dictionary available at **https://targethiv.org/library/ryan-white-services-report-rsr-data-dictionary-and-xml-schema-implementation-guide-client**.

RSR Client-Level Data Element: A brief description of the client-level data element being collected.

XML Variable Name: The data elements have been assigned a variable name in the RSR data dictionary as the way to label data in the RSR client-level data XML file. The variable name is provided for convenient referencing between this document and the RSR data dictionary.

Required for clients with service visits in the following categories: The data elements that must be reported for your clients are based on the type of services your agency is RWHAP-funded to provide. Report the data element for all clients who meet your eligibility criteria for the RWHAP-funded service, regardless of payer.

Description: A detailed discussion, if required, of the variable and responses that may be reported for the variable. This section defines the responses allowed for the data element.

Frequently asked questions about this data element: Where applicable, answers are provided to the questions recipients and providers ask the most about the data element.

System Variables

RSR system's unique provider ID SV2

XML Variable Name:
ProviderID

Description:
The unique provider organization identifier assigned through the RWHAP Data Report (RDR) or RSR web application.

RSR system's unique provider registration code SV3

XML Variable Name:
RegistrationCode

Description:
The unique provider registration code is automatically generated when the provider is entered into the RSR web system provider directory. It is the same code that providers use when they create an account in the RSR web system.

Client's encrypted Unique Client Identifier SV4

XML Variable Name:
ClientUci

Required for clients with service visits in the following categories:
All core medical and support services

Description:
To protect client information, an encrypted UCI (eUCI) is used for reporting Ryan White client data. Using eUCIs allows HRSA HAB to deduplicate the clients and obtain a more accurate count of the clients' RWHAP services.

Note: Your data system contains PHI that includes, but is not limited to, client names, addresses, DOB, SSN, dates of service, and URNs generated for your organization's client-level data XML file. To ensure client confidentiality, you must be compliant with all relevant Federal regulations. Protect this information the same way you protect all client data. For additional information, visit the HHS Office of Civil Rights Health Information Privacy web page. Do not disclose sensitive information in your reporting comments. Refer to **https://www.hhs.gov/ocr/privacy** for additional information about client confidentiality and privacy.

To learn more about the eUCI, including rules on how to construct the UCI before encryption, view the resources available on the TargetHIV website at https://targethiv.org/library/encrypted-unique-client-identifier-euci-application-and-user-guide.

Guidelines for Collecting and Recording Client Names

Develop business rules/operating procedures outlining the method by which client names are collected and recorded. For example:

- Enter the client's entire name as it normally appears on documentation such as a driver's license, birth certificate, passport, or Social Security card.
- Follow the naming patterns, practices, and customs of the local community or region (e.g., for Hispanic clients living in Puerto Rico, record both surnames in the appropriate order).
- Avoid using nicknames (e.g., do not use Becca if the client's first name is Rebecca).
- Avoid using initials.

Instruct providers and staff on how to enter their client's names. This is especially true when clients receive services from multiple providers in a network. To avoid false duplicates, client names must be entered in the same way at each provider location so that the client has the same eUCI.

FREQUENTLY ASKED QUESTIONS ABOUT THIS DATA ELEMENT

What if I am missing data elements that compose the eUCI?
If you are missing data elements required for the eUCI, do everything possible to obtain those data elements. They are required for each client. This effort will improve not only the quality of data linking but also patient care and case management.

Demographic Data

Up to 16 demographic data elements may be reported for each client. Determine which demographic data elements are required for a particular client by looking at **Appendix A. Required Client-Level Data Elements for RWHAP Services** on page 51.

Client's vital enrollment status at the end of this reporting period 2

XML Variable Name:
EnrollmentStatusID

Required for clients with service visits in the following categories:

- Outpatient/ambulatory health services
- Medical case management
- Nonmedical case management

Description:
This is the client's vital enrollment status at the end of the reporting period. Response categories for this data element are:

- *Active*—The client is enrolled as of the end of the reporting period.
- *Referred*—The client is not enrolled as of the end of the reporting period due to referral to another program for services.
- *Removed*—The client is disenrolled from the program due to violation of rules.
- *Incarcerated*—The client is disenrolled from the program because he or she is serving a criminal sentence in a Federal, State, or local penitentiary, prison, jail, reformatory, work farm, or similar correctional institution (whether operated by the government or a contractor).
- *Relocated*—The client is disenrolled from the program because he or she has moved out of the agency's service area.
- *Deceased*

FREQUENTLY ASKED QUESTIONS ABOUT THIS DATA ELEMENT

How do I report a client who is no longer receiving services?
Each agency must determine its own guidelines for classifying a client's vital enrollment status. If a client is no longer active at the end of the reporting period, choose one of the alternate response options. HRSA HAB recommends that these policies be in writing and applied at all providers within a recipient agency. HRSA HAB understands that different recipients may have different policies in the same geographic area.

What if a client falls into more than one category (e.g., active and incarcerated)?
If the client received services during the reporting period and you expect the client to continue to receive services from your program, report the client as "Active." If the client is not "Active" in your agency's program, choose the category that explains why the client is no longer active.

Our agency stopped receiving RWHAP funding during the reporting period. How do I report enrollment status for our clients?
HRSA HAB recommends that providers report the vital enrollment status associated with the client at the time funding ended.

Client's year of birth 4

XML Variable Name:
BirthYear

Required for clients with service visits in the following categories:
All core medical and support services

Description:
This is the client's birth year. Even though only the year of birth will be reported to HRSA HAB, collect the client's full date of birth as the client's birth year, month, and day are used to generate the UCI. The value must be on or before all service dates for the client. This is a variable that is used for the eUCI. The RSR System will reject any XML file with client records that do not include the client's year of birth.

Reporting Client Race and Ethnicity

Office of Management and Budget (OMB) Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity provides a minimum standard for maintaining, collecting, and presenting data on race and ethnicity for all Federal reporting purposes. The standards were developed to provide a common language for uniformity and comparability in the collection and use of data on race and ethnicity by Federal agencies.

The standards have five categories for data on race: American Indian or Alaska Native; Asian, Black, or African American; Native Hawaiian or Other Pacific Islander; and White. There are two categories for data on ethnicity: Hispanic or Latino and Not Hispanic or Latino. In addition, identification of ethnic and racial subgroups is required for the categories of Hispanic/Latino, Asian, and Native Hawaiian/Pacific Islander. The racial category descriptions, defined in October 1997, are required for all Federal reporting as mandated by the OMB.

HRSA HAB is required to use the OMB reporting standard for race and ethnicity. However, service providers should feel free to collect race and ethnicity data in greater detail. If the agency chooses to use a more detailed collection system, the data collected must be organized so that any new categories can be aggregated into the standard OMB breakdown.

RWHAP providers are expected to make every effort to obtain and report race and ethnicity based on each client's self-report. Self-identification is the preferred means of obtaining this information. Providers should not establish criteria or qualifications to use to determine a particular person's racial or ethnic classification, nor should they specify how someone should classify himself or herself.

Client's self-reported ethnicity 5

XML Variable Name:
EthnicityID

Required for clients with service visits in the following categories:
All core medical and support services

Description:
The client's ethnicity based on his or her self-report.

These are the response category options:

- *Hispanic/ Latino/a*—A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be synonymous with "Hispanic or Latino." If a client identifies as Hispanic/Latino/a or Spanish origin, choose all Hispanic subgroups that apply in ID 68.
- *Non-Hispanic/Latino/a*—A person who does not identify his or her ethnicity as "Hispanic or Latino."

Client Report Hispanic subgroup 68

XML Variable Name:
HispanicSubgroupID

Required for clients if EthnicityID is Hispanic/Latino(a) or Spanish origin with service visits in the following categories:
All core medical and support services

Description:
If the response to ID 5, client's self-reported ethnicity, is "Hispanic/Latino/a," indicate the client's Hispanic subgroup (choose all that apply).

These are the response category options:

- Mexican, Mexican American, Chicano/a
- Puerto Rican
- Cuban
- Another Hispanic, Latino/a or Spanish origin

Client's self-reported race 6

XML Variable Name:
RaceID

Required for all clients with service visits in the following categories:
All core medical and support services

Description:
This is the client's race based on his or her self-report. **NOTE:** Multiracial clients should select all categories that apply.

- *American Indian or Alaska Native*—A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- *Asian*—A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. If a client identifies as Asian, choose all Asian subgroups that apply in ID 69.
- *Black or African American*—A person having origins in any of the black racial groups of Africa.
- *Native Hawaiian or Pacific Islander*—A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. If a client identifies as Native Hawaiian/Pacific Islander, choose all Native Hawaiian/Pacific Islander subgroups that apply in ID 70.
- *White*—A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Client report Asian subgroup 69

XML Variable Name:
AsianSubgroupID

Required for clients if RaceID is Asian with service visits in the following categories:
All core medical and support services

Description:
If the response to ID 6, client's self-reported race, is "Asian," indicate the client's Asian subgroup (choose all that apply).

These are the response category options:
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian

Client Report Native Hawaiian/Pacific Islander (NHPI) subgroup 70

XML Variable Name:
NHPISubgroupID

Required for clients if RaceID is Native Hawaiian/Pacific Islander with service visits in the following categories:
All core medical and support services

Description:
If the response to ID 6, client's self-reported race, is "Native Hawaiian or Other Pacific Islander," indicate the client's Native Hawaiian/Pacific Islander subgroup (choose all that apply).

- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander

Client's current self-reported gender 7

XML Variable Name:
GenderID

Required for clients with service visits in the following categories:
All core medical and support services

Description:
Indicate the client's gender (the socially and psychologically constructed, understood, and interpreted set of characteristics that describe the current sexual identity of an individual) based on his or her self-report. Gender cannot be missing; one of the options below must be reported for current gender. This is a variable that is used for the eUCI.

- *Male*—An individual with strong and persistent identification with the male gender.
- *Female*—An individual with strong and persistent identification with the female gender.
- *Transgender Male to Female*—An individual whose sex assigned at birth was male but identifies their gender as female, regardless of the status of social gender transition or surgical and hormonal sex reassignment processes.
- *Transgender Female to Male*—An individual whose sex assigned at birth was female but identifies their gender as male, regardless of the status of social gender transition or surgical and hormonal sex reassignment processes.
- *Transgender Other*—An individual who identifies as transgender but does not identify with the other transgender options and/or does not identify with the binary positions of male/female. These individuals may or may not engage in social gender transition or surgical and hormonal sex reassignment processes (e.g., gender nonconforming, genderqueer, nonbinary, gender fluid, bigender).
- *Unknown*—Indicates the client's gender category is unknown or was not reported or does not fit within one of the available options.

Client sex at birth 71

XML Variable Name:
SexAtBirthID

Required for clients with service visits in the following categories:
All core medical and support services

Description:

The biological sex assigned to the client at birth.

- Male
- Female

Client's annual household income category 9

XML Variable Name:
PovertyLevelID

Required for clients with service visits in the following categories:

- Outpatient/ambulatory health services
- Medical case management
- Nonmedical case management

Description:
This is the client's income in terms of the percent of the Federal poverty level at the end of the reporting period. The response categories for this data are:

- Below 100 percent of the Federal poverty level
- 100–138 percent of the Federal poverty level
- 139–200 percent of the Federal poverty level
- 201–250 percent of the Federal poverty level
- 251–400 percent of the Federal poverty level
- 401–500 percent of the Federal poverty level
- More than 500 percent of the Federal poverty level

If your organization collects this information early in the reporting period, it is not necessary to collect it again at the end of the reporting period (although changes should be documented). Report the latest information on file for each client.

There are two slightly different versions of the Federal poverty measure—the poverty thresholds (updated annually by the U.S. Bureau of the Census) and the poverty guidelines (updated annually by HHS). For more information on poverty measures and to see the most recent HHS Poverty Guidelines, go to **https://aspe.hhs.gov/poverty/index.shtml**.

If your agency already uses the U.S. Bureau of the Census poverty thresholds to calculate this data element, continue to use the poverty thresholds to report these data. Otherwise, HRSA HAB recommends (and prefers) that you use the HHS poverty guidelines to collect and report these data.

Client's housing status 10

XML Variable Name:
HousingStatusID

Required for clients with service visits in the following categories:

- Outpatient/ambulatory health services
- Medical case management
- Nonmedical case management
- Housing services

Description:
This data element is the client's housing status at the end of the reporting period. There are three response categories for this data element:

- Stable Permanent Housing
- Temporary Housing
- Unstable Housing

Stable Permanent Housing includes the following:

- Renting and living in an unsubsidized room, house, or apartment
- Owning and living in an unsubsidized house or apartment

- Unsubsidized permanent placement with families or other self-sufficient arrangements
- Housing Opportunities for Persons with AIDS (HOPWA)-funded housing assistance, including Tenant-Based Rental Assistance or Facility-Based Housing Assistance, but not including the Short-Term Rent, Mortgage and Utility Assistance Program.
- Subsidized, non-HOPWA, house or apartment, including Section 8, the HOME Investment Partnerships Program, and public housing.
- Permanent housing for formerly homeless persons, including Shelter Plus Care, the Supportive Housing Program, and the Moderate Rehabilitation Program for SRO Dwellings.
- Institutional setting with greater support and continued residence expected (psychiatric hospital or other psychiatric facility, foster care home or foster care group home, or other residence or long-term care facility).

Temporary Housing includes the following:

- Transitional housing for homeless people
- Temporary arrangement to stay or live with family or friends
- Other temporary arrangement such as a RWHAP housing subsidy
- Temporary placement in an institution (e.g., hospital, psychiatric hospital or other psychiatric facility, substance use disorder treatment facility, or detoxification center)
- Hotel or motel paid for without emergency shelter voucher

Unstable Housing Arrangements include the following:

- Emergency shelter or a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for humans, including a vehicle, an abandoned building, a bus/train/subway station/airport, or anywhere outside.
- Jail, prison, or a juvenile detention facility
- Hotel or motel paid for with emergency shelter voucher

These definitions are based on:

- HOPWA Program, Annual Progress Report, Measuring Performance Outcomes, form HUD-40110-C
- McKinney-Vento Act, Title 42 US Code, Sec. 11302, General definition of homeless individual

Client's HIV/AIDS status 12

XML Variable Name:
HivAidsStatusID

Required for clients with service visits in the following categories:

- Outpatient/ambulatory health services
- Medical case management
- Nonmedical case management

Description:
This data element is the client's HIV status at the end of the reporting period. For HIV-affected clients with unknown HIV status, leave this value blank. The response categories for this element are:

- *HIV-negative* (affected)—Client has tested negative for HIV, is an affected partner or family member of an individual who is HIV positive, and has received at least one support service during the reporting period.

HIV-affected clients are clients who are HIV negative or have an unknown HIV status. An affected client must be linked to a client who has HIV.

- *HIV-positive, not AIDS*—Client has diagnosed HIV but has not been diagnosed with AIDS.
- *HIV-positive, AIDS status unknown*—Client has diagnosed HIV. It is not known whether the client has diagnosed AIDS.
- *CDC-defined AIDS*—Client has HIV and meets the CDC AIDS case definition for an adult or child. **NOTE:** Once a client has AIDS, he or she always is counted in the CDC-defined AIDS category regardless of changes in CD4 counts.
- *HIV-indeterminate* (infants <2 years only)—A child under the age of 2 years whose HIV status is not yet determined but was born to a woman living with HIV.

Once an HIV-indeterminate (infants <2 years only) client is confirmed HIV negative, he or she must be reclassified as an HIV-affected client.

FREQUENTLY ASKED QUESTIONS ABOUT THIS DATA ELEMENT

What is the operational definition of AIDS?
HRSA HAB uses the current CDC surveillance case definition for Acquired Immunodeficiency Syndrome for national reporting. For additional information, see:

- **https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5710a1.htm**
- **https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6303a1.htm**

Client's risk factor for HIV 14

XML Variable Name:
HivRiskFactorID

Required for clients with service visits in the following categories:

- Outpatient/ambulatory health services
- Medical case management
- Nonmedical case management

Description:
This data element is the client's initial risk factor for HIV transmission. Report all the response categories that apply. It is primarily based on self-report.

- Male-to-male sexual contact cases include men who report sexual contact with other men (i.e., homosexual contact) and men who report sexual contact with both men and women (i.e., bisexual contact).
- Injection drug use cases include clients who report receiving an injection, either self-administered or by another person, of a drug that was not prescribed by a physician for this person. The drug itself is not the source of the HIV infection but rather the sharing of syringes or other injection equipment (e.g., cookers and cottons), which can result in transmission of bloodborne pathogens such as HIV.
- Hemophilia/coagulation disorder cases include clients with delayed clotting of the blood.
- Heterosexual contact cases include clients who report specific heterosexual contact with an individual known to have, or to be at high risk for, HIV infection (e.g., an injection drug user or a man who has sex with men).

- Receipt of transfusion of blood, blood components, or tissue cases include transfusion-transmitted HIV through receipt of infected blood or tissue products given for medical care.
- Mother with/at risk for HIV infection (perinatal transmission) cases include transmission from mother to child during pregnancy. This category is exclusively for infants and children infected by mothers who are HIV positive or at risk.
- Risk factor not reported or not identified above. This category also refers to HIV-affected clients.

FREQUENTLY ASKED QUESTIONS ABOUT THIS DATA ELEMENT

How do we report risk factors not listed above?
Risk factors that are not expressly stated above—occupational exposure, prison tattoos, etc.—should be reported under risk factor not reported or not identified above.

RWHAP providers are expected to make every effort to obtain and report HIV risk factor(s) based on each client's self-report. Self-identification is the preferred means of obtaining this information.

Client's medical insurance 15

XML Variable Name:
MedicalInsuranceID

Required for clients with service visits in the following categories:

- All core medical services
- Medical case management
- Nonmedical case management

Description:
Report all sources of health care coverage the client had for any part of the reporting period (select one or more).

- Private—Employer
- Private—Individual
- Medicare is a health insurance program for people ages 65 years and older, some disabled people ages 64 years and younger, and people with end-stage renal disease (permanent kidney failure treated with dialysis or a transplant).
- Medicaid, CHIP, or other public plan
- Veterans Health Administration (VA), military health care (TRICARE), and other military health care
- Indian Health Service
- No insurance/uninsured means the client did not have health insurance at some time during the reporting period. HRSA HAB classifies clients who have no way to pay for medical expenses other than with RWHAP funds as uninsured.
- Other plan means client has an insurance type other than those listed above. An example of other plan would be a company that chooses to "self-insure" and pay the medical expenses of its employees directly as they are incurred rather than purchasing health insurance for its employees to use.

FREQUENTLY ASKED QUESTIONS ABOUT THIS DATA ELEMENT

How should a provider report clients who have private insurance but use RWHAP funds to pay their copay and/or deductible?
If the client has private insurance, select the corresponding response option. Select all responses that apply.

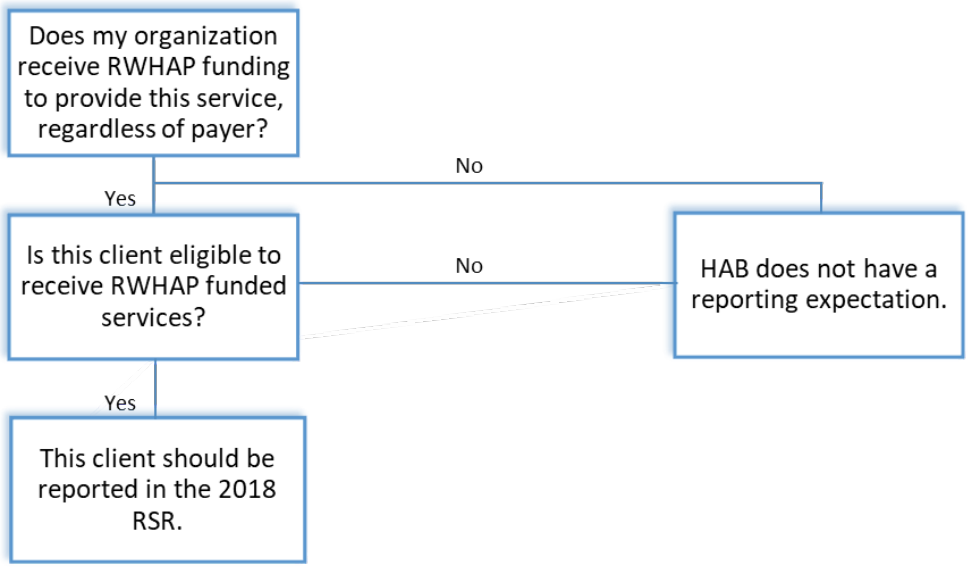
How should a provider report a client who has insurance for part of the reporting period but has no insurance at a different point in the same reporting period?
If the client has insurance for part of the reporting period, select the corresponding response option AND select "No Insurance." Select all responses that apply.

How should a provider report a client who is covered by COBRA?
Insurance reporting is based on who is paying the premium for the insurance. When a client is covered by COBRA, the client is responsible for payment, and insurance status should be reported as "Private–Individual."

RWHAP-Eligible Service Data

For the next set of data elements, report clients eligible to receive RWHAP-funded services whether or not they actually received the services. Do not report clients who received services that your agency is not funded by RWHAP to deliver. To determine whether to report a client, refer to the decision tree in Figure 14.

Figure 14. Eligible Scope Decision Tree



For example, you have two clients, Aaron and Robert, who are eligible to receive RWHAP services. Your agency is funded by RWHAP to provide OAHS and medical case management services. You also provide housing services but do not receive RWHAP funds to deliver housing services.

Aaron receives OAHS, but his visits are paid for from a non-RWHAP funding source. As Aaron is eligible to receive RWHAP funds to cover his care, he should be reported on the RSR.

Robert only receives housing services. Robert would not be reported on the RSR because your agency is not funded by RWHAP to deliver housing services.

FREQUENTLY ASKED QUESTIONS ABOUT ELIGIBLE SCOPE

How do I determine which clients are eligible for RWHAP?
Requirements for RWHAP are set at the RWHAP-recipient level. Contact your RWHAP funder to determine your site's eligibility requirements.

How do I know if I should report a client?
You should report a client if:

1) The client is RWHAP eligible, and
2) The client received a service that your agency was funded by RWHAP to deliver in 2018.

How does eligible scope affect clients with high-deductible insurance plans?
RWHAP assists all eligible PLWH. Clients with high-deductible plans are likely to need RWHAP for assistance with deductibles and later in the year. Eligible scope allows providers to collect client data prior to these PLWH being enrolled in the program and to provide a complete picture of the client's care. Please review **PCN 16-02** for allowable uses of RWHAP funds to assist clients.

What do I report if a client has a gap in eligibility? For example, a client is eligible from January to July and has service visits in January and December. Which visits do we count?
If the client moves in and out of eligibility, report services that were within the period of eligibility (Items 16–45). If an OAHS client moves in and out of eligibility and the agency is RWHAP funded for OAHS, report the services (ID 16) within the period of eligibility AND all the clinical data elements (including OAHS visit dates ID 48) from the ENTIRE year.

Should I report client-level data from HOPWA clients?
Yes. HRSA HAB is working with the U.S. Department of Housing and Urban Development to demonstrate how coordinated data can improve clinical outcomes. This Special Projects of National Significance initiative started in 2016 and will help inform data collection for future RSRs.

HIV diagnosis year 72

XML Variable Name:
HIVDiagnosisYearID

Required for new clients if HivAidsStatusID is not HIV-negative or HIV-indeterminate (infants <2 years only) with service visits in the following categories:

- Outpatient/ambulatory health services
- Medical case management
- Nonmedical case management

Description:
If the response to ID 12 is not "HIV-negative" or "HIV-indeterminate (infants <2 years only)," indicate the client's year of HIV diagnosis, if known.

HIV Diagnosis Year:

- yyyy (must be less than or equal to the reporting period year)

FREQUENTLY ASKED QUESTIONS ABOUT ELIGIBLE SCOPE

How do we determine what a new client is?
Each agency must determine its own guidelines for determining whether clients are new.

Core medical service visits delivered 16, 18–19, 21–27

XML Variable Name:
ClientReportServiceVisits

- Service Visit
- ServiceID (see Table 1)
- Visits (number of visits [1–365] the client received in the service category indicated)

Required for clients with service visits in the following categories:
Recipients of at least one core medical service, per client, as listed in Table 1.

Description:
Report the number of core medical service visits the client received while he or she was eligible for RWHAP. Remember, for each day, only one service visit per category may be reported for the RSR—even if the client receives more than one service in a particular category during the day.

Example 1: During her visit with the dentist on June 19, Jane Doe receives five services: a dental exam, a cleaning, a filling, X-rays, and a fluoride treatment. In this situation, even though Jane received five services, the provider will only report one oral health care service visit for that day.

Example 2: On December 7, John Doe has a medical visit with his physician, meets with his medical case manager, and participates in an individual counseling session with his psychologist in the morning. Later that day, he also participates in a group counseling session. Even though John received four services, the provider will report only three service visits for that day: one mental health service visit, one medical case management service visit, and one outpatient/ambulatory health service visit.

Core medical services (IDs 16, 18–19, 21–27) should be reported only for HIV-positive and HIV-indeterminate (infants <2 years) clients. HIV-negative clients who receive HIV counseling and testing services as part of EIS for RWHAP Parts A, B, and C should only be reported in the HIV Counseling and Testing section of the Provider Report.

The definitions for the **RWHAP core medical services** are in the **PCN 16-02** on the HRSA HAB website.

Table 1. RWHAP Core Medicare Services Definitions

ELEMENT ID	Service Category	ServiceID
16	Outpatient ambulatory health services	ID 8
18	Oral health care	ID 10
19	Early intervention services	ID 11
21	Home health care	ID 13
22	Home and community-based health	ID 14
23	Hospice	ID 15
24	Mental health services	ID 16

ELEMENT ID	Service Category	ServiceID
25	Medical nutrition therapy	ID 17
26	Medical case management (including treatment adherence services)	ID 18
27	Substance use disorder outpatient care	ID 19

Core medical and support services delivered 17, 20, 28–44, 75

XML Variable Name:
ClientReportServiceDelivered

- ServiceDelivered
- ServiceID (see Table 2)
- DeliveredID (2—Yes)

Description:
Report whether or not eligible clients received these core medical and support services during the reporting period. The definitions for the **RWHAP support services** are in the **PCN 16-02** on the HRSA HAB website.

Table 2. RWHAP Core Medical Services and Support Services Definitions

Element ID	Service Category	ServiceID
Core Medical Services		
17	AIDS pharmaceutical assistance (LPAP, CPAP)	ID 9
20	Health insurance premium and cost-sharing assistance for low-income individuals	ID 12
Support Services		
28	Nonmedical case management services	ID 20
29	Child care services	ID 21
31	Emergency financial assistance	ID 23
32	Food bank/home-delivered meals	ID 24
33	Health education/risk reduction	ID 25
34	Housing	ID 26
36	Linguistic services	ID 28
37	Medical transportation	ID 29
38	Outreach services	ID 30
40	Psychosocial support services	ID 32
41	Referral for health care and support services	ID 33
42	Rehabilitation services	ID 34
43	Respite care	ID 35
44	Substance use disorder services (residential)	ID 36
75	Other professional services	ID 42

Clinical Information

The final group of data elements collected in the client-level data XML file are the clinical information data elements. All providers who received RWHAP funding to provide outpatient/ambulatory health services are required to report clinical information.

Clinical information is required for HIV-positive clients who received an outpatient/ambulatory medical care visit. Clinical information is *not* required to be reported for HIV-indeterminate (infants <2 years only) clients.

Data provided in this section will help HRSA HAB assess to what extent RWHAP is meeting patient care and treatment standards according to **HHS HIV treatment guidelines**.

Client received HIV risk-reduction screening/counseling 46

XML Variable Name:
RiskScreeningProvidedID

Required for HIV-positive clients with service visits in the following categories:
Outpatient/ambulatory health services

Description:
Indicate (Yes/No) if HIV risk-reduction screening and/or counseling was provided to the client during this reporting period. HIV risk-reduction screening and counseling refers to a short questionnaire administered by a clinician to identify patients at risk for HIV followed by counseling about ways to reduce their risk.

Date client's first HIV outpatient/ambulatory health service visit 47

XML Variable Name:
FirstAmbulatoryCareDate

Required for HIV-positive clients with service visits in the following categories:
Outpatient/ambulatory health services

Description:
Report the date of the client's first HIV outpatient/ambulatory health service visit with this provider. When responding to this ID, keep these points in mind:

- The visit must meet the RWHAP definition of an outpatient/ambulatory health services visit.
- You are not expected to resort to unreasonable measures to locate this information in your files. If you are unable to identify the first date of service, report the earliest date available in your records.
- This visit may have occurred before the start of the reporting period.
- This visit may or may not be a RWHAP-funded visit.
- The date of first HIV outpatient/ambulatory health service visit does not change in subsequent reports.

Dates of the client's outpatient/ambulatory health service visits 48

XML Variable Name:
ClientReportAmbulatory
- Service
- ServiceDate

Required for HIV-positive clients with service visits in the following categories:
Outpatient/ambulatory health services

Description:
Report all dates (MM/DD/YYYY) of the client's outpatient/ambulatory health service visits in this provider's HIV care setting with a clinical care provider during the reporting period, regardless of the payer. A clinical care provider is a physician, physician assistant, clinical nurse specialist, nurse practitioner, or other health care professional who is certified in his or her jurisdiction to prescribe antiretroviral therapy. The number of outpatient ambulatory health service visit dates reported for this ID should be equal to or greater than the number of visits reported in ID 16.

NOTE: The visits should meet the RWHAP definition of an outpatient/ambulatory health services visit.

Client's CD4 test 49

XML Variable Name:
ClientReportCd4Test
- Count
- ServiceDate

Required for HIV-positive clients with service visits in the following categories:
Outpatient/ambulatory health services

Description:
Report the value and test date for all CD4 count tests administered to the client during the reporting period. The CD4 cell count measures the number of T-helper lymphocytes per cubic millimeter of blood. It is a good predictor of immunity. As CD4 cell count declines, the risk of developing opportunistic infections increases. The test date is the date the client's blood sample is taken, not the date the results are reported by the lab.

Client's viral load test 50

XML Variable Name:
ClientReportViralLoadTest
- Count
- ServiceDate

Required for HIV-positive clients with service visits in the following categories:
Outpatient/ambulatory health services

Description:
Report the value and test date for all viral load tests administered to the client during the reporting period. Viral load is the quantity of HIV RNA in the blood and is a predictor of disease progression. Test results are expressed as the number of copies per milliliter of blood plasma. The test date is the date the client's blood sample is taken, not the date the results are reported by the lab. If a viral load

count is undetectable, report the lower bound of the test limit. If the lower bound is not available, report zero.

Client prescribed PCP prophylaxis 51

XML Variable Name:
PrescribedPcpProphylaxisID

Required for HIV-positive clients with service visits in the following categories:
Outpatient/ambulatory health services

Description:
PCP prophylaxis is drug treatment to prevent *Pneumocystis jiroveci* pneumonia.

Indicate if clients were prescribed a PCP prophylaxis at any time during the reporting period. **NOTE:** Select "Yes" if the client began or was continuing a prophylactic regimen during the reporting period.

- Yes
- No
- Not medically indicated
- No, client refused

For additional information about PCP prophylaxis, see:

- **https://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html**
- **https://aidsinfo.nih.gov/guidelines**

Client prescribed ART 52

XML Variable Name:
PrescribedArtID

Required for HIV-positive clients with service visits in the following categories:
Outpatient/ambulatory health services

Description:
ART is antiretroviral therapy, the daily use of a combination of HIV medicines to treat HIV.

NOTE: Report "Yes" if the client began or was continuing on ART during the reporting period.

- Yes. This includes clients who were not adherent to the prescribed therapy.
- No, not ready (as determined by clinician)
- No, client refused
- No, intolerance, side effect, toxicity
- No, ART payment assistance unavailable
- No, other reason

For additional information about ART, visit: **https://aidsinfo.nih.gov/guidelines**.

Client has been screened for TB since HIV diagnosis 54

XML Variable Name:
ScreenedTBSinceHivDiagnosisID

Required for HIV-positive clients with service visits in the following categories:
Outpatient/ambulatory health services

Description:
Indicate if the client has been screened for TB since his or her HIV diagnosis.

- No
- Yes
- Not medically indicated
- Unknown

Client was screened for syphilis during this reporting period 55

XML Variable Name:
ScreenedSyphilisID

Required for HIV-positive clients with service visits in the following categories:
Outpatient/ambulatory health services

Description:
Syphilis is a sexually transmitted disease that can be diagnosed by examining material from a chancre (infectious sore) using a dark-field microscope or with a blood test. This element is not required for clients ages 17 years or younger who are not sexually active. Has the client been screened for syphilis during this reporting period?

- Yes
- No
- Not medically indicated

Obtain additional information at **https://aidsinfo.nih.gov/guidelines.**

Client was screened for hepatitis B since HIV diagnosis 57

XML Variable Name:
ScreenedHepatitisBSinceHivDiagnosisID

Required for HIV-positive clients with service visits in the following categories:
Outpatient/ambulatory health services

Description:
Indicate if the client has been screened for hepatitis B since his or her HIV diagnosis.

- No
- Yes
- Not medically indicated
- Unknown

Client has completed the vaccine series for hepatitis B 58

XML Variable Name:
VaccinatedHepatitisBID

Required for HIV-positive clients with service visits in the following categories:
Outpatient/ambulatory health services

Description:
The hepatitis B vaccine series is a sequence of shots that stimulate a person's natural immune system to protect against the hepatitis B virus. Has the client completed the vaccine series for hepatitis B?

- Yes
- No
- Not medically indicated

FREQUENTLY ASKED QUESTIONS ABOUT THIS DATA ELEMENT

How do we report a client whose hepatitis B vaccination is in progress during the reporting period?
If the client is in the process of completing a hepatitis B vaccination series, report "No" for the reporting period. Indicate that the client has completed the series in subsequent reports.

Can we report that the patient has been vaccinated for hepatitis B if the patient has a hepatitis B surface antibody test that is positive/reactive and hepatitis B antigen that is negative/nonreactive? Can an immunity test be a substitute for getting all documented hepatitis B vaccine test dates in the series so I can note that the patient received the series?
No. You may not use a negative hepatitis B surface antigen test (HBsAg) result and a positive hepatitis B surface antigen antibody (anti-HBs) test result in lieu of documentation showing that the patient received the hepatitis B vaccine series to report a "Yes" response to the VaccinatedHepatitisBID data element. A negative HBsAg test and a positive anti-HBs test only indicate that the patient is immune; these tests do not necessarily indicate immunity through the vaccination. A negative HBsAg test result and a positive anti-HBs test result mean that a vaccine is not medically indicated. Remember, this data element is about vaccination, not immunity.

Client screened for hepatitis C since HIV diagnosis 60

XML Variable Name:
ScreenedHepatitisCSinceHivDiagnosisID

Required for HIV-positive clients with service visits in the following categories:
Outpatient/ambulatory health services

Description:
Indicate if the client has been screened for hepatitis C since his or her HIV diagnosis.

- No
- Yes
- Not medically indicated
- Unknown

Client was screened for substance use 61

XML Variable Name:
ScreenedSubstanceAbuseID

Required for HIV-positive clients with service visits in the following categories:
Outpatient/ambulatory health services

Description:
Substance use screening is a quick, simple way to identify clients who may need further assessment or treatment for substance use disorders. Screening may include biomarkers (e.g., positive drug screen or liver disease) and client reports of consumption patterns. Substance use screening may be administered by a substance use disorder treatment professional or by a trained health care professional in another medical/clinical discipline. Was the client screened for substance use (alcohol and drugs) during the reporting period?

- No
- Yes
- Not medically indicated

Client received mental health screening 62

XML Variable Name:
ScreenedMentalHealthID

Required for HIV-positive clients with service visits in the following categories:
Outpatient/ambulatory health services

Description:
Mental health screenings include the use of brief structured instruments or commonly used questions to assess potential mental health problems. Screenings are designed to determine whether the client presents signs or symptoms of a mental health problem and if the client should be referred to a mental health professional. Screens are not diagnostic tools and, although typically administered by a mental health professional, may be administered by trained health care professionals in other medical/clinical disciplines. Was a mental health screening conducted for the client during this reporting period?

- No
- Yes
- Not medically indicated

Client received a Pap Smear 63

XML Variable Name:
ReceivedCervicalPapSmearID

Required for HIV-positive clients with service visits in the following categories:
Outpatient/ambulatory health services

Description:
Reported for HIV-positive women only, only report a value for a cervical smear. Do not report a value for an anal test for male or female clients. A Pap smear or screening is a way to examine cells taken from a woman's cervix. It can detect cell changes that may be precancerous as well as small hidden tumors that may lead to cervical cancer. Did the client receive a Pap smear during this reporting period?

- No
- Yes
- Not medically indicated
- Not applicable

Client was pregnant 64

XML Variable Name:
PregnantID

Required for HIV-positive clients with service visits in the following categories:
Outpatient/ambulatory health services

Description:
Reported for HIV-positive women only; do not report a value for male clients unless the client is transgender. Was the client pregnant during the reporting period?

- No
- Yes
- Not applicable

Positive HIV test date 73

XML Variable Name:
HIVPosTestDateID

Required for all clients with a new diagnosis of HIV in the reporting period with service visits in the following categories:
Outpatient/ambulatory health services

Description:
Date of the client's first documented positive HIV test during the reporting period. It can be a positive HIV test from another site as long as it is documented and not a client self-report. May be the client's HIV confirmatory test date.

Positive HIV Test Date:

- MM/DD/YYYY (must be within the reporting period year)

Outpatient/ambulatory health service link date 74

XML Variable Name:
OAMCLinkDateID

Required for all clients with a new diagnosis of HIV in the reporting period with service visits in the following categories:
Outpatient/ambulatory health services

Description:
Date of client's first OAHS medical care visit after positive HIV test. The OAHS visit date must be a visit with a prescribing provider and cannot be a date before that reported in ID 73.

HIV OAHS linkage date:

- MM/DD/YYYY (must be within the reporting period and on the same day or later than positive HIV test date)

FREQUENTLY ASKED QUESTIONS ABOUT THE CLIENT-LEVEL DATA

How does HRSA HAB define a confirmatory test?
Each agency must determine its own guidelines for standard of care that is practiced by its OAHS providers based on HRSA and **CDC guidelines**.

My RWHAP funding covers only salaries. Do I report client-level data?
Yes. HRSA HAB expects that staff whose salary is paid by RWHAP will see clients who meet RWHAP-eligibility requirements. Providers should report all RWHAP-eligible clients who received services that the provider was funded for.

Do I need to report my client-level data by RWHAP Part?
No. HRSA HAB doesn't require you to submit your client-level data by RWHAP Part. Although providers should have an adequate mechanism for tracking clients and services by contract or funding source (RWHAP and non-RWHAP), the intention of the RSR client-level data is to capture all services for all clients served by a provider, regardless of RWHAP Part.

May I upload more than one client-level data file?
Yes. If you choose to upload more than one client-level data file to "build" the client report, take the time to (1) make certain your data systems are generating client eUCIs consistently and (2) review the rules that the RSR system follows when it combines information from two or more client-level data files **before** you upload multiple client-level data XML files. To learn more about the RSR system merge rules, see the article *RSR Merge Rules* at **https://targethiv.org/library/rsr-merge-rules**.

What client-level data do I need to report?
Collect the applicable client-level data elements for each client who received services during the reporting period. The data elements reported depend on the service(s) each client receives. To determine the client-level data elements that must be reported for each client, review the chart in **Appendix A. Required Client-Level Data Elements for RWHAP-Eligible Services**.

What if we collect our client information at the first visit in the reporting period rather than at the end?
It is not necessary to collect this information again at the end of the reporting period. Report the latest information on file for each client.

What do we report if a client does not provide all of the data, and there is no option to report the element as unknown?
HRSA HAB encourages you to submit the most complete data possible. If you are unable to collect the data, drop the tag from your data file, and it will be considered a missing value. You may receive a validation message and will need to add comments as necessary. Please refer to page 14 to review data validation reporting requirements.

My agency provides services to HIV-indeterminate infants. We do not perform CD4 or viral load tests on these clients. How do I report this?
Providers are not required to report clinical information (IDs 46–64 and 73–74) for HIV-indeterminate infants (<2 years only).

What if we do not know whether a new client has been screened for TB, hepatitis B, or hepatitis C since his or her HIV diagnosis date? Are we expected to get retrospective data on every client in medical care?

HRSA HAB understands that it may place an unreasonable burden on providers to determine whether certain clients were screened for TB, hepatitis B, or hepatitis C since their diagnosis, and advises providers to screen clients accordingly and report data that can be reasonably obtained.

APPENDIX A. REQUIRED CLIENT-LEVEL DATA ELEMENTS FOR RWHAP SERVICES

(Last Updated: November 29, 2018)

RATIONALE CODES

1) Necessary for identifying new clients
2) 2009 Ryan White Legislation requirement
3) Necessary to assess RWHAP performance as required for HRSA HAB's programmatic measures
4) Necessary to track enrollment or vital status over the course of the reporting period
5) Informs the denominator of other items
6) Used to identify important population subgroups

Table 3. Required Client-Level Data Elements for RWHAP Services

• report the data element Client-Level Data Elements	Outpatient/ambulatory health services	Medical case management	Oral health care	Early intervention services	Home health care	Home and community-based health services	Hospice services	Mental health services	Medical nutrition therapy	Substance use disorder services—outpatient	AIDS pharmaceutical assistance	Health insurance premium and cost-sharing	Nonmedical case management	Child care services	Emergency financial assistance	Food bank/home-delivered meals	Health education/risk reduction	Housing services	Linguistics services	Medical transportation services	Outreach services	Other professional services	Psychosocial support services	Referral health care/support services	Rehabilitation services	Respite care	Substance use disorder services—residential	Rationale
Client Demographics																												
Year of birth	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	2,7
Ethnicity	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	2,4,7
Hispanic subgroup	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	2,4,7
Race	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	4,7
Asian subgroup	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	4,7
NHPI subgroup	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	4,7
Gender	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	2,3,4,7
Sex at birth	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	2,3,4,7
Health insurance	•	•	•	•	•	•	•	•	•	•	•	•	•															2,7
Housing status	•	•											•					•										2,7
Federal poverty level	•	•											•															2,7
HIV/AIDS status	•	•											•															2,4
Client risk factor	•	•											•															7
Vital enrollment status	•	•											•															5,6
HIV diagnosis tear	•	•											•															2,4
Client Clinical Data																												
HIV risk reduce screen/counseling	•																											2,3
First outpatient/ambulatory health service visit	•																											2,3,4
Outpatient ambulatory health service visits and dates	•																											3,4
CD4 counts and dates	•																											3,4
Viral load counts and dates	•																											3,4
Prescribed PCP prophylaxis	•																											3
Prescribed ART	•																											3,4
Screened for TB since diagnosis	•																											3
Screened for syphilis	•																											3
Screened for Hep B since diagnosis	•																											3
Completed Hep B vaccine series	•																											3
Screened for Hep C since diagnosis	•																											3
Screened for substance use	•																											2,3
Screened for mental health	•																											2,3
Pap smear	•																											3,6
Pregnant	•																											2,3,4
Date of first positive HIV test	•																											1,3,4,5,6
Date of OAHS visit after first positive HIV test	•																											1,3,4,5

GLOSSARY

Active client: A person who was a client when the reporting period ended and is expected to continue in the program during the next reporting period.

Affected client: A family member or partner of a person living with HIV who receives at least one RWHAP support service during the reporting period.

AIDS: Acquired Immune Deficiency Syndrome. A disease caused by the human immunodeficiency virus (HIV).

ART: Antiretroviral therapy. An aggressive anti-HIV treatment including a combination of three or more drugs with activity against HIV that is designed to reduce viral load to undetectable levels.

ARV: Antiretroviral. A drug that interferes with the ability of a retrovirus, such as HIV, to make more copies of itself.

CDC: Centers for Disease Control and Prevention. The U.S. Department of Health and Human Services agency that administers HIV-prevention programs, including the HIV Prevention Community Planning Process, among others. CDC is responsible for monitoring and reporting infectious diseases, administers HIV surveillance grants, and publishes epidemiologic reports such as the HIV Surveillance Report.

Client: See PLWH client, affected client, active client, or indeterminate client.

Clinical care provider: A physician, physician assistant, clinical nurse specialist, nurse practitioner, or other health care professional who is certified in his or her jurisdiction to prescribe ARV therapy.

Combination therapy: Two or more drugs or treatments used together to achieve optimum results against HIV/AIDS. For more information on treatment guidelines, visit **https://www.aidsinfo.nih.gov/guidelines**.

Confidential information: Information, such as name, gender, age, and HIV status, that is collected on the client and the unauthorized disclosure of which could cause the client unwelcome exposure, or discrimination.

Consortium/HIV care consortium: An association of one or more public, and one or more nonprofit private, health care, and support providers; people with HIV groups; and community-based organizations operating within areas determined by the State to be most affected by HIV disease. The consortium agrees to use RWHAP Part B grant assistance to plan, develop, and deliver (directly or through agreement with others) comprehensive outpatient health and support services for people with HIV. Agencies constituting the consortium are required to have a record of service to populations and subpopulations with HIV.

Continuum of care: An approach that helps communities plan for and provide a full range of emergency and long-term service resources to address the various needs of people living with HIV.

Contract: An agreement between two or more parties, especially one that is written and enforceable by law.[4] For the purposes of the RSR, contracts include formal contracts, memoranda of understanding, or other agreements.

Core medical services: A set of essential, direct health care services provided to people with HIV and specified in the Ryan White HIV/AIDS Treatment Extension Act.

Division of Policy and Data: The division within HRSA HAB that serves as HAB's principal source of program data collection and evaluation and the focal point for coordination of program performance

[4] Contract. (n.d.). *The American Heritage® Dictionary of the English Language,* Fourth Edition. Accessed November 28, 2018, at Dictionary.com website: **https://dictionary.reference.com/browse/contract**.

activities, policy analysis, and development of policy guidance. The division of policy and data coordinates all technical assistance activities for HAB in collaboration with each HRSA HAB division.

Eligible scope: A method of data collection based on a client's ability to receive federally funded RWHAP services using established recipient criteria.

EMA/TGA: Eligible Metropolitan Area/Transitional Grant Area**.** The geographic area eligible to receive RWHAP Part A funds. The boundaries of the EMA/TGA are defined by the Census Bureau. Eligibility is determined by AIDS cases reported to the CDC. Some EMA/TGAs include just one city, and others are composed of several cities and/or counties. Some EMA/TGAs extend across more than one State.

Exposure category: See risk factor.

Family-centered: A model in which systems of care under RWHAP Part D are designed to address the needs of people living with HIV and affected family members as a unit by providing or arranging for a full range of services. The family structures may range from the traditional, biological family unit to nontraditional family units with partners, significant others, and unrelated caregivers.

Fee-for-service: The method of billing for health services whereby a physician or other health service provider charges the payer (whether it be the patient or his or her health insurance plan) separately for each patient encounter or service rendered.

GCMS: The Grantee Contract Management System. An electronic data system that RWHAP recipients use to manage their subrecipient contracts.

HAB: HIV/AIDS Bureau. The HHS bureau within HRSA that is responsible for administering RWHAP. Within HRSA HAB, the Division of Metropolitan HIV/AIDS Programs administers RWHAP Part A; the Division of State HIV/AIDS Programs administers RWHAP Part B and the AIDS Drug Assistance Program (ADAP); the Division of Community HIV/AIDS Programs administers RWHAP Part C, D, the F Dental Reimbursement Program, and the RWHAP Part F Community-Based Dental Partnership Program; and the Office of Training and Capacity Development administers the RWHAP Part F AIDS Education and Training Centers Program and the RWHAP Part F Special Projects of National Significance Program. HSB's Division of Policy and Data administers HIV evaluation studies, the Ryan White HIV/AIDS Program Services Report, the ADAP Data Report, the Dental Services Report, the Allocation and Expenditure Reports, HIV Quality Measures Module, and the AIDS Education and Training Centers Reports.

High-risk insurance pool: A State health insurance program that provides coverage for people who are denied coverage due to a preexisting condition or who have health conditions that would normally prevent them from purchasing coverage in the private market.

HIP: Health insurance premium and cost-sharing assistance for low-income individuals. A program that provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. The service provision consists of either/or both of the following: paying health insurance premiums to provide comprehensive HIV outpatient/ambulatory health services and pharmacy benefits that offer a full range of HIV medications for eligible clients, and paying cost-sharing on behalf of the client.

HIV disease: Any signs, symptoms, or other adverse health effects due to the human immunodeficiency virus.

HOPWA: Housing opportunities for persons with AIDS. A program administered by the U.S. Department of Housing and Urban Development (HUD) that provides funding to support housing for people living with HIV and their families.

HRSA: Health Resources and Services Administration. A Federal public health agency that is part of HHS responsible for directing national health programs that improve the nation's health by assuring equitable access to comprehensive, quality health care for all. HRSA works to improve and extend life for people

living with HIV, provides primary health care to medically underserved people, serves women and children through State programs, and trains a health workforce that is both diverse and motivated to work in underserved communities. HRSA administers RWHAP.

Indeterminate client: A child ages 2 years or younger with an HIV status that is not yet determined but was born to an HIV-infected mother.

Inpatient setting: This includes hospitals, emergency rooms and departments, and residential facilities where clients typically receive food and lodging as well as treatments.

Institution: This includes residential, health care, and correctional facilities. Residential facilities include supervised group homes and extended treatment programs for alcohol and other drug misuse or for mental illness. Health care facilities include hospitals, nursing homes, and hospices. Correctional facilities include jails, prisons, and correctional halfway houses.

Laboratory services: Services provided by a licensed clinical laboratory responsible for analyzing client specimens to inform the diagnosis, treatment, and evaluation of health factors for people living with HIV.

MAI: Minority AIDS Initiative. A national initiative that provides special resources to reduce the spread of HIV and improve health outcomes for people living with HIV within communities of color. This initiative was enacted to address the disproportionate impact of the disease in such communities.

Not medically indicated: A determination made by a clinical care provider that a service, procedure, or treatment is not medically necessary. Medically necessary health care services are procedures used by a prudent medical care provider to diagnosis or treat an illness, injury, or disease or its symptoms in a manner that is (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for a patient's illness, injury, or disease; and (3) not primarily for the convenience of the patient or treating clinical care provider.

OI: Opportunistic infection. An infection or cancer that occurs in people with weak immune systems due to HIV, cancer, or immunosuppressive drugs such as corticosteroids or chemotherapy. Kaposi's sarcoma, *Pneumocystis jiroveci* pneumonia, toxoplasmosis, and cytomegalovirus are all examples of such infections.

OMB: Office of Management and Budget. The office within the executive branch of the Federal Government that prepares the president's annual budget, develops the Federal Government's fiscal program, oversees administration of the budget, and reviews government regulations.

Outpatient setting: A hospital, clinic, medical office, pass-through organization, or other place where clients receive health care services but do not stay overnight.

Part A: The Part of RWHAP that provides direct financial assistance to designated EMAs/TGAs who have been the most severely affected by the HIV epidemic. The purpose of these funds is to deliver or enhance HIV-related core medical and support services to people living with HIV.

Part B: The Part of RWHAP that authorizes the distribution of Federal funds to States and territories to improve the quality, availability, and delivery of core medical and support services for people living with HIV. RWHAP emphasizes that such care and support is part of a coordinated continuum of care designed to improve medical outcomes.

Part B ADAP: AIDS Drug Assistance Program. The Part of RWHAP that authorizes the distribution of Federal funds to States and territories to provide FDA-approved medications to low-income people living with HIV who have limited or no health coverage from private insurance, Medicaid, or Medicare. Congress designates a portion of the RWHAP Part B appropriation for the ADAP base.

Part C: The Part of RWHAP that provides funding to local community-based organizations to support outpatient ambulatory health services and support services for people living with HIV through Early Intervention Services (EIS) program grants.

Part D: The Part of RWHAP that supports coordinated family-centered outpatient care for women, infants, children, and youth with HIV.

PHSA: Public Health Service Act.

PLWH: People living with HIV.

PLWH client: A person who is HIV positive and eligible to receive at least one RWHAP service during the reporting period.

PLWH coalition: Organizations of people living with HIV that provide support services to individuals and families infected with and/or affected by HIV.

Primary health care service: Any preventive, diagnostic, or therapeutic health service received on an outpatient basis by a client living with HIV. Examples include medical, subspecialty care, dental, nutrition, mental health, or substance use disorder treatment services; medical case management; pharmacy services; radiology, laboratory, and other tests used for diagnosis and treatment planning; and counseling and testing.

Provider (or service provider): The agency that provides direct services to clients (and their families) or the recipient. A provider may receive funds as a recipient (such as under RWHAP Parts C and D) or through a contractual relationship with a recipient funded directly by RWHAP. Also see subrecipient.

Recipient of record (or recipient): An organization receiving financial assistance directly from an HHS-awarding agency to carry out a project or program. A recipient also may be a recipient-provider if it provides direct services in addition to administering its grant. Replaces the term "grantee of record."

Recipient-provider: An organization that receives RWHAP funds directly from HRSA HAB and provides direct client services. Replaces the term "grantee-provider."

Reporting period: A 12-month period, January 1 through December 31, of the calendar year.

Risk factor or risk behavior/exposure category: See also "transmission category." Behavior or other factor that places a person at risk for HIV. This includes such factors as male-to-male sexual contact and injection drug use.

RSR: Ryan White HIV/AIDS Program Services Report.

RWHAP-funded service: A service paid for with Ryan White HIV/AIDS Program funds.

Ryan White HIV/AIDS Treatment Extension Act of 2009: The Federal legislation created to address the health care and service needs of people living with HIV and their families in the United States and its territories.

SPNS: Special Projects of National Significance. A health services demonstration, research, and evaluation program funded under Part F of RWHAP. SPNS projects are awarded competitively.

Subrecipient: The legal entity that receives RWHAP funds from a recipient and is accountable to the recipient for the use of the funds provided. Subrecipients may provide direct client services or administrative services directly to a recipient. Replaces the term "provider (or service provider)."

Support services: A set of services needed to achieve medical outcomes that affect the HIV-related clinical status of a person living with HIV.

Transmission category: The term for summarizing the multiple risk factors that a person may have had by selecting the one most likely to have resulted in HIV transmission. Transmission categories include male-to-male sexual contact, heterosexual contact, injection drug use, and male-to-male sexual contact and injection drug use.

UCI: Unique Client Identifier. A unique alphanumeric code that distinguishes one RWHAP client from all others and is the same for the client across all provider settings.

XML: eXtensible Markup Language. A standard, simple, and widely adopted method of formatting text and data so that it can be exchanged across the different computer platforms, languages, and applications.

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