2015 ANNUAL RYAN WHITE HIV/AIDS PROGRAM SERVICES REPORT (RSR) INSTRUCTION MANUAL

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Division of Policy and Data
Health Resources and Services Administration
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WHAT'S NEW

(Last Updated: September 11, 2015)

There are three key changes to the Ryan White HIV/AIDS Program Services Report (RSR) and the RSR Instruction Manual this year:

1) **Eligible Scope Reporting Requirement**

   Starting with the 2015 calendar year data collection period, providers will report data on all clients *eligible* to receive Ryan White HIV/AIDS Program (RWHAP)-funded services, regardless of the actual funding source used to pay for those services.

   Clients who are eligible to receive RWHAP-funded services based on HIV status, income, and other grantee criteria should be reported regardless of insurance status or payer. You no longer need to "filter out" your insured clients for RSR reporting purposes.

2) **The Grantee Contract Management System (GCMS)**

   Starting in December 2015, when grantees open their Grantee Report, a new GCMS will automatically fill in, or populate, most of the items in their report with preexisting information.

   Grantees will also have access to the GCMS from within the RSR system, so if they need to update the information in their Grantee Report, including editing, adding, or deleting contracts, they can do it using the GCMS.

   See the **RSR Grantee Report Section** in this manual (page 17) for more details on using the GCMS to complete the Grantee Report.

3) **Service Delivery Sites**

   Starting with the 2015 calendar year data collection period, providers will report their service delivery sites in the Provider Report. These sites should be the specific locations where clients may access RWHAP services and the contact information clients may use to set appointments. This information will populate the HRSA Data Warehouse service locator feature. You should no longer receive requests to provide site-level contact information manually.

WHAT'S NEW FOR 2016

(Last Updated: September 11, 2015)

Beginning with the 2016 RSR Instruction Manual, some familiar terms in the RSR will change to keep our vocabulary in line with OMB standards. The term "recipient" will replace the term "grantee" (or "grantee of record"), and the term "subrecipient" will replace "subgrantee" (or "subcontractor"). Because service providers may receive grant funds directly, indirectly, or both, through a RWHAP grant, for the purposes of the RSR, the terms "provider-recipient" and "provider-subrecipient" will be used to describe a service provider's reporting responsibilities.

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BACKGROUND

(Last Updated: September 11, 2015)

The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87, October 30, 2009) gives Federal HIV/AIDS programs in the Public Health Service (PHS) Act under Title XXVI the flexibility to respond effectively to the changing epidemic. Its emphasis is on providing life-saving and life-extending services for people living with HIV/AIDS across the country and resources to targeted areas with the greatest need.

All "parts" of the Ryan White HIV/AIDS Program (RWHAP) specify the Health Resources and Services Administration's (HRSA) responsibilities in the administration and allocation of grant funds, evaluation of programs for the population served, and improvement in quality of care. Accurate records of providers receiving RWHAP funding, services provided, and clients served continue to be critical to implementing the legislation and thus are necessary for HRSA to fulfill its responsibilities.

Previously, the HIV/AIDS Bureau (HAB) required all RWHAP-funded grantees and their contracted service providers (or "providers") to report aggregate data annually using the RWHAP Annual Data Report (RDR). However, aggregate data are limited in two ways:

1. Aggregate data lack client identifiers and, by definition, cannot be merged and unduplicated across providers within a given geographic area. As a result, grantees—and ultimately HAB—cannot obtain accurate counts of the number of people RWHAP serves.
2. Aggregate data cannot be analyzed in the detail required to assess quality of care or to sufficiently account for the use of RWHAP funds.

To address these issues, RWHAP grantees and providers began using a new data reporting system in 2009, the Ryan White HIV/AIDS Program Services Report (RSR).

HAB's goal is to have a client-level data reporting system that provides data on the characteristics of the funded grantees, their providers, and the clients served. The data you submit will be used to do the following:

- Monitor the outcomes achieved on behalf of HIV/AIDS clients and their affected families receiving care and treatment through RWHAP grantees and/or providers;
- Address the disproportionate impact of HIV in communities of color by assessing organizational capacity and service utilization in minority communities;
- Monitor the use of RWHAP for appropriately addressing the HIV/AIDS epidemic in the United States;
- Address the needs and concerns of Congress and the Department of Health and Human Services (HHS) concerning the HIV/AIDS epidemic and RWHAP; and
- Monitor progress toward achieving the goals identified in the National HIV/AIDS Strategy.

HAB has taken every measure possible, including the implementation and use of an encrypted Unique Client Identifier (eUCI), to limit data collection to only the information that is "reasonably necessary to accomplish the purpose" of the RSR.

HAB also understands how important the data reported can be to each RWHAP as each assesses its client service needs and establishes practical outcome measures for its programs. HAB considers these data the property of the grantee and will not share the data with other grantees without the permission of the reporting grantee.

GRANTEE/PROVIDER REPORTING REQUIREMENTS

(Last Updated: September 11, 2015)

Federal regulations explicitly state that grantees have a responsibility to monitor their funded providers to ensure they are using their Federal grant program funds in accordance with program requirements.[1]

Title 45 CFR 92.40, monitoring and reporting program performance; monitoring by grantees:

> **Grantees are responsible for managing the day-to-day operations of grant and subgrant supported activities. Grantees must monitor grant and subgrant supported activities to assure compliance with applicable Federal requirements and that performance goals are being achieved. Grantee monitoring must cover each program, function, or activity.**

Title 45 CFR 74.51, monitoring and reporting program performance:

> **Recipients are responsible for managing and monitoring each project, program, subaward, function or activity supported by the award. Recipients shall monitor subawards to ensure that subrecipients have met the audit requirements as set forth in §74.26.**

The Federal regulations go on to affirm that grantees are required to maintain, as set forth in 45 CFR Sec. 74.47:

> **a system for contract administration . . . to ensure contractor conformance with the terms, conditions and specifications of the contract and to ensure adequate and timely follow-up of all purchases. . . . [Grantees] shall evaluate contractor performance and document, as appropriate, whether contractors have met the terms, conditions, and specifications of the contract.**

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

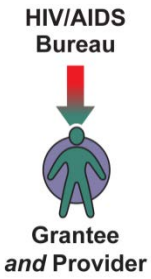
Additional information on a covered entity's use or disclosure of protected health information without the written authorization of the individual to a public health authority can be found in 45 CFR 164.512 at: **http://www.gpo.gov/fdsys/pkg/CFR-2011-title45-vol1/pdf/CFR-2011-title45-vol1-sec164-512.pdf**

[1] The rules and requirements that govern the administration of HHS grants are set forth in the regulations found in Title 45, Code of Federal Regulations (CFR), Part 74—Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education, Hospitals, Other Nonprofit Organizations, and Commercial Organizations; and Part 92—Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local, and Tribal Governments.

GRANTEE AND PROVIDER RELATIONSHIPS

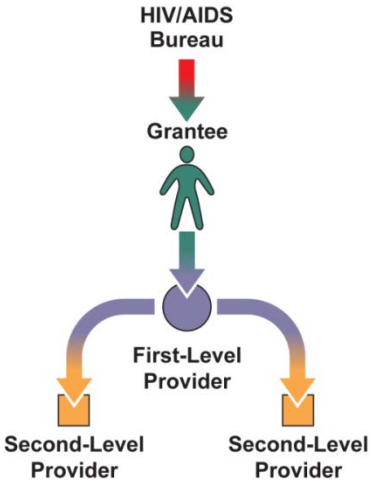
(Last Updated: September 11, 2015)

Grantees and providers work together to quickly and easily submit the RSR. Below are illustrations and definitions of grantee and provider relationships.

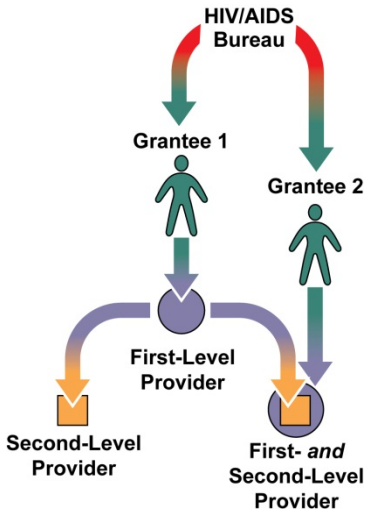


A grantee-provider, which is a service provider that also is a grantee, must complete a Grantee Report and a Provider Report. A grantee-provider of core medical or support services must also upload client-level data.

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



Occasionally, grantees 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 grantee's first-level provider. When the grantee's first-level provider (administrative agent or fiscal intermediary provider) enters into a contract with another provider to use the grantee's funds to deliver services, that provider is considered a second-level provider to the grantee. A second-level provider must complete a Provider Report and, if it provides core medical or support services, upload client-level data.



If a service organization is a multilevel provider (a second-level provider to one grantee and a first-level provider to another grantee), 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*** of its RWHAP contracts.

GRANTEE/PROVIDER EXEMPTIONS

Service organizations may be exempt* from completing their own Provider Report and Client Report at the grantee'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 received less than $10,000 in RWHAP funding during the reporting period;
- 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 grantee; and/or
- They are no longer in business.

*HAB recommends that an exempted provider have the reason and approval for an exemption in writing from its grantee.

Exempting a provider from submitting a Provider Report or Client Report does not exempt the grantee from collecting and submitting data for that provider. If a grantee exempts a provider, the grantee must ensure that the provider's data are reported to HAB. See page 21 for instructions on marking a provider as exempt in the RSR system. You may:

- Complete a Provider Report and upload client-level data in the exempted provider's name (do not select the "Exempt" check box);
- Report the exempted provider's data with your agency's RSR data (all grantees must select the "Exempt" box); or
- If the first-level provider will include the second-level provider's data in its (the first level provider's) Provider Report, the grantee WILL select the "Exempt" checkbox for the second-level provider.

However, not all providers are eligible to receive a reporting exemption:

- Grantee-providers may not be given an exemption.
- Multilevel providers may not be given an exemption.
- A multiply funded provider may be given an exemption only if all of its grantees agree to the exemption.

FREQUENTLY ASKED QUESTIONS

about Grantee/Provider Relationships and Reporting Requirements

I have several providers 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 provider?
If you exempt your provider from submitting an RSR Provider Report and client-level data, HAB expects you to report its data. You may complete the provider's RSR Provider Report and upload client-level data into the provider's report, or you may direct your first-level provider to complete the report on a second-level provider's behalf. If you or your first-level provider will be completing the report, DO NOT indicate that the provider is exempted from reporting. Note: First-level providers cannot access a second-level provider report if the first-level provider is not (1) a grantee AND (2) also funds the provider.

Alternatively, you may report the exempted provider's data with your agency's RSR data. In this instance, you WILL select the exempt option in your Grantee Report. See page 21 for instructions on marking a provider as exempt in the RSR system.

What if a provider receiving funding from multiple Program Parts is given an exemption from reporting by one grantee but not another?
Providers must be exempted from reporting by all of their grantees. If your provider has other grantees, you will need to coordinate with the other grantee(s) to ensure that all of you have indicated that the provider is exempted. If one or more of a provider's grantees does not agree to exempt the provider, your provider will still need to complete the RSR Provider Report.

RYAN WHITE HIV/AIDS PROGRAM SERVICES

(Last Updated: September 11, 2015)

RWHAP funds are intended to support only the HIV-related needs of clients. All services provided to HIV-positive, HIV-indeterminate (infants <2 years only), and HIV-affected clients must always promote the medical outcomes of the infected client.

The services are divided into four groups:

- Administrative and technical services;
- Core medical services;
- Support services; and
- HIV counseling and testing services.

Administrative and Technical Services

Planning or evaluation services are the systematic (orderly) collection of information about the characteristics, activities, and outcomes of services or programs to assess the extent to which objectives have been achieved, to identify needed improvements, and/or to make decisions about future programming.

Administrative or technical support services are the provision of quality and responsive support services to an organization. These may include human resources, financial management, and administrative services (e.g., property management, warehousing, printing/publications, libraries, claims, medical supplies, and conference/training facilities).

Fiscal intermediary services are the provision of administrative services to the grantee of record by a pass-through organization. The responsibilities of these organizations may include determining the eligibility of RWHAP recipients, deciding how funds are allocated to recipients, awarding RWHAP funds to recipients, monitoring recipients for compliance with RWHAP-specific requirements, and completing required reports.

Other fiscal services are the receipt or collection of reimbursements on behalf of health care professionals for services rendered or other related fiduciary services pursuant to health care professional contracts.

Technical assistance services identify the need for and the delivery of practical program and technical support to the RWHAP community. These services should help grantees, planning bodies, and communities affected by HIV and AIDS to design, implement, and evaluate RWHAP-supported planning and primary care service-delivery systems.

Capacity development services are services to develop a set of core competencies that in turn help organizations foster effective HIV health care services, including the quality, quantity, and cost-effectiveness of such services. These competencies also sustain the infrastructure and resource base necessary to develop and support these services. Core competencies include management of program finances; effective HIV service delivery, including quality assurance, personnel management, and board development; resource development, including preparation of grant applications to obtain resources and purchase supplies/equipment; service evaluation; and development of cultural competency.

Quality management services comprise systematic processes with identified leadership, accountability, and dedicated resources using data and measurable outcomes to determine progress toward relevant,

evidence-based benchmarks. Quality management programs should focus on linkages, efficiencies, and provider and client expectations in addressing outcome improvement, and they need to adapt to change. The process is continuous and should fit in the framework of other program quality assurance and quality improvement activities, such as the Institute for Healthcare Improvement, the Joint Commission on the Accreditation of Healthcare Organizations, and Medicaid. Data collected as part of this process should be fed back into the quality management process to assure that goals are accomplished and outcomes improved.

Quality management is a continuous process to improve how a health or social service meets or exceeds established professional standards and user expectations. The purpose of a quality management program is to ensure that (1) services adhere to PHS guidelines and established clinical practice; (2) program improvements include supportive services; (3) supportive services are linked to access and adherence to medical care; and (4) demographic, clinical, and utilization data are used to evaluate and address characteristics of the local epidemic. For further information on quality management, please refer to the resources available at **http://hab.hrsa.gov/deliverhivaidscare/qualitycare.html**.

Core Medical Services

Core medical services are specified in the Ryan White HIV/AIDS Treatment Extension Act of 2009. They are a set of essential, direct health care services provided to RWHAP clients who are HIV positive or HIV indeterminate (infants <2 years only), with one exception. HIV-negative clients may receive HIV counseling and testing (HC&T) services under Early Intervention Services for Parts A and B; HC&T data are reported in the Provider Report.

When reporting RWHAP-eligible services, keep in mind the following:

1. **Providers that deliver core medical services are required to upload client-level data.**
2. **RWHAP core medical services may not be provided anonymously.**
3. **Early Identification of Individuals with HIV/AIDS (EIIHA) activities should be reported under the service category with the definition that best describes the service provided.**

Outpatient/ambulatory medical care includes the provision of professional diagnostic and therapeutic services directly to a client by a physician, physician assistant, clinical nurse specialist, nurse practitioner, or other health care professional certified in his or her jurisdiction to prescribe antiretroviral (ARV) therapy in an outpatient setting. These settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not considered outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the PHS's guidelines. Such care must include access to ARV and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination ARV therapies.

Early Intervention Services provided by RWHAP Part C and Part D are reported under outpatient/ambulatory medical care.

AIDS Drug Assistance Program (ADAP) is a State-administered program authorized under Part B of RWHAP that provides FDA-approved medications to low-income people with HIV/AIDS disease who have

limited or no coverage from private insurance, Medicaid, or Medicare. Program funds may also be used to purchase health insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of drug treatments.

Part B grantees and providers should not report ADAP data in the RSR, including services provided with ADAP flexibility funding.

Local AIDS pharmaceutical assistance (APA, not ADAP) includes local pharmacy assistance programs implemented by Part A or Part B grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds or Part B base award funds. These organizations may or may not provide other services (e.g., outpatient/ambulatory medical care or case management) to the clients they serve through a RWHAP contract with their grantee.

Programs are considered APAs if they provide HIV/AIDS medications to clients and meet all of the following criteria:

- Have a client enrollment process;
- Have uniform benefits for all enrolled clients;
- Have a record system for distributed medications; and
- Have a drug distribution system.

Programs are not APAs if they dispense medications in one of the following situations:

- As a result or component of a primary medical visit;
- On an emergency basis (defined as a single occurrence of short duration); or
- By giving vouchers to a client to procure medications.

Local APAs are similar to ADAPs in that they provide medications for the treatment of HIV disease. However, local APAs are not paid for with Part B funds "earmarked" for ADAP.

Oral health care includes diagnostic, preventive, and therapeutic services provided by a dental health care professional licensed to provide health care in the State or jurisdiction, including general dental practitioners, dental specialists, and dental hygienists, as well as licensed and trained dental assistants.

Early intervention services (EIS) for Parts A and B include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, to diagnose the extent of immune deficiency, and to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and provision of therapeutic measures.

When reporting RWHAP eligible services, keep in mind the following:

1. **EIIHA activities should be reported under the service category with the definition that best describes the service provided.**
2. **EIS provided by RWHAP Part C and Part D are reported under outpatient/ambulatory medical care.**
3. **Part A and Part B grantees that fund EIS must also check HC&T services for at least one service provider.**

Although HC&T activities are an integral part of EIS, HIV-negative clients who receive HC&T services under EIS for Parts A and B should be reported only in the RSR Provider Report. This includes data on people with preliminary positive or invalid rapid HIV tests and negative confirmatory HIV tests.

Health insurance premium and cost-sharing assistance, also referred to as Health Insurance Program (HIP), is the provision of financial assistance for eligible individuals living with HIV to maintain continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

Data on health insurance premium and cost sharing assistance funded through ADAP should NOT be reported in the RSR. These data are reported in a separate ADAP data report.

Home health care is the provision of services in the home by licensed health care professionals, such as nurses, and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.

Home and community-based health services includes skilled health services furnished to the individual in the individual's home, based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services.

Inpatient hospital services, nursing homes, and other long-term care facilities are not included as home and community-based health services.

Hospice services are end-of-life care provided to clients in the terminal stage of an illness. They include room, board, nursing care, counseling, physician services, and palliative therapeutics. Services may be provided in a residential setting, including a nonacute care section of a hospital that has been designated and staffed to provide hospice services. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid programs.

Mental health services are psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. They are conducted in a group or individual setting and provided by a mental health professional licensed or authorized within the State to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Mental health services provided to HIV-affected clients should be reported as psychosocial support services.

Medical nutrition therapy, including nutritional supplements, is provided by a licensed, registered dietitian outside of an outpatient/ambulatory medical care visit. The provision of food may be provided pursuant to the recommendation of a health care professional (i.e., physician, physician assistant, clinical nurse specialist, nurse practitioner) and a nutritional plan developed by a licensed, registered dietician. Nutritional counseling services and nutritional supplements not provided by a licensed, registered dietician shall be considered a support service and be reported under psychosocial support services and food bank/home-delivered meals, respectively. Food not provided pursuant to a health care professional's recommendation and a nutritional plan developed by a licensed, registered dietician should also be considered a support service and is reported under food bank/home-delivered meals.

Medical case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services provided by trained professionals, including both medically credentialed and other health care staff. The coordination and follow up of medical treatments are a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of the needs and personal support systems of the client and other key family members. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic reevaluation and adaptation of the plan, at least every 6 months, as necessary over the life of the client. It includes client-specific advocacy and review of utilization of services. This includes all types of case management, including face-to-face meetings, telephone calls, and any other forms of communication.

Substance abuse services (outpatient) are medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting by a physician or under the supervision of a physician, or by other qualified personnel. They include limited support of acupuncture services to HIV-positive clients, provided the client has received a written referral from his or her primary health care provider and the service is provided by certified or licensed practitioners and/or programs, wherever State certification or licensure exists.

Support Services

Support services are a set of services needed to achieve medical outcomes that affect the HIV-related clinical status of a person living with HIV/AIDS. Support services may be provided to HIV-positive and HIV-indeterminate clients (infant <2 years only) as needed. Support services may also be provided to HIV-affected clients. However, the services provided to HIV-affected clients must always support a medical outcome for the HIV-positive client or HIV-indeterminate client (infant <2 years only).

When reporting RWHAP-eligible services, keep in mind the following:

1. **Providers that deliver support services are required to upload client-level data.**
2. **RWHAP support services may not be provided anonymously. NOTE: *This includes outreach services.***
3. **EIIHA activities should be reported under the service category with the definition that best describes the service(s) provided.**

Case management services (non-medical) include advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments.

Child care services are care for the children of clients who are HIV positive while the clients are attending medical or other appointments, or RWHAP-related meetings, groups, or training. These services do not include child care while the client is at work.

Pediatric developmental assessment and early intervention services are professional early interventions by physicians, developmental psychologists, educators, and others for the psychosocial and intellectual development of infants and children. They involve the assessment of an infant or child's developmental status and needs in relation to the education system, including early assessment of educational intervention services. They include comprehensive assessment, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about

access to Head Start services, appropriate educational settings for HIV-infected clients, and education/assistance to schools also should be reported in this category.

Only Part D programs are eligible to provide pediatric developmental assessment and early intervention services.

Emergency financial assistance is the provision of one-time or short-term payments to agencies or the establishment of voucher programs when other resources are not available to help with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), transportation, and medication. Part A and Part B programs must allocate, track, and report these funds under specific service categories, as described under **2.6 in DSS Program Policy Guidance No. 2 (formerly Policy No. 97-02)**.

It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be the payer of last resort, and for limited amounts, use, and periods of time. Continuous provision of an allowable service to a client should be reported in the applicable service category.

Food bank/home-delivered meals involves the provision of actual food or meals. It does not include finances to purchase food or meals, but may include vouchers to purchase food. The provision of essential household supplies, such as hygiene items and household cleaning supplies, should also be included in this item. The provision of food or nutritional supplements by someone other than a registered dietician should be included in this item as well.

Food vouchers provided as an ongoing service to a client should be reported in this service category. Food vouchers provided on a one-time or intermittent basis should be reported in the emergency financial assistance category.

Health education/risk reduction activities educate clients living with HIV about how HIV is transmitted and how to reduce the risk of transmission. It includes the provision of information about medical and psychosocial support services and counseling to help clients living with HIV improve their health status.

Health education/risk reduction services can only be delivered to individuals who are HIV positive. These services cannot be delivered anonymously. Client-level data must be reported for every person who receives these services.

Housing services are short-term assistance to support emergency, temporary, or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that provides some type of medical or supportive services (such as residential substance abuse or mental health services, residential foster care, or assisted living residential services) and housing that does not provide direct medical or supportive services but is essential for an individual or family to gain or maintain access to and compliance with HIV-related medical care and treatment.

Housing funds cannot be in the form of direct cash payments to recipients for services and cannot be used for mortgage payments. Short-term or emergency assistance is understood as transitional in nature and for the purposes of moving or maintaining an individual or family in a long-term, stable living situation. Therefore, such assistance cannot be permanent and must be accompanied by a strategy to identify, relocate, and/or ensure the individual or family is moved to, or capable of maintaining, a long-term, stable living situation. For more information, see the policy **"The Use of Ryan White HIV/AIDS Program Funds for Housing Referral Services and Short-term or Emergency Housing Needs"** at **http://hab.hrsa.gov/manageyourgrant/policiesletters.html**.

Legal services are services to people with respect to powers of attorney, do-not-resuscitate orders, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under RWHAP.

Legal services to arrange for guardianship or adoption of children after the death of their primary caregiver should be reported as a permanency planning service.

Linguistic services include interpretation (oral) and translation (written) services, provided by qualified people as a component of HIV service delivery between the provider and the client, when such services are necessary to facilitate communication between the provider and client and/or support the delivery ofRWHAP–eligible services.

Medical transportation services are conveyance services provided, directly or through a voucher, to a client to enable him or her to access health care services.

Outreach services are programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status (i.e., case finding) so that they may become aware of, and may be enrolled in, care and treatment services. Outreach services do not include HIV counseling and testing or HIV prevention education. Broad activities such as providing leaflets at a subway stop, a poster at a bus shelter, or tabling at a health fair would not meet the intent of the law. These services should target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort, targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection, conducted at times and in places where there is a high probability of reaching individuals with HIV infection, and designed with quantified program reporting that will accommodate local effectiveness evaluation.

RWHAP outreach services cannot be delivered anonymously. Client-level data must be reported for every person who receives this service.

Permanency planning includes services to help clients/families make decisions about the placement and care of minor children after their parents/caregivers have died or are no longer able to care for them. It includes the provision of social service counseling or legal counsel regarding (1) drafting of wills or delegating powers of attorney and (2) preparing custody options for legal dependents, including standby guardianship, joint custody, or adoption.

Psychosocial support services are support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Nutrition counseling services provided by a nonregistered dietitian are reported in this service category.

Nutritional services and nutritional supplements provided by a licensed, registered dietician are considered a core medical service and should be reported as Medical nutrition therapy. The provision of food and/or nutritional supplements by someone other than a registered dietician should be reported in the Food bank/home-delivered meals service category.

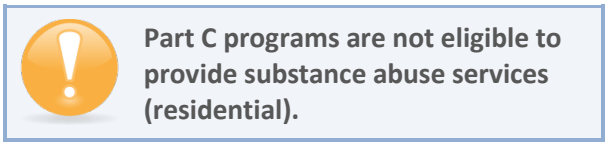
Referral for health care/supportive services is the act of directing a client to a service in person or in writing, by telephone, or through another type of communication. These services are provided outside of an outpatient/ambulatory medical care, medical case management, or nonmedical case management service visit.

Referrals for health care/supportive services provided by outpatient/ambulatory medical care providers should be reported under the outpatient/ambulatory medical care service category. Referrals for health care/supportive services provided by case managers (medical and nonmedical) should be reported in the appropriate case management service category—medical case management or non-medical case management.

Rehabilitation services are provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. These include physical and occupational therapy, speech pathology, and low-vision training.

Respite care is community or home-based non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client living with HIV/AIDS.

Substance abuse services (residential) includes treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term care). They include limited support of acupuncture services to HIV-positive clients, provided the client has received a written referral from his or her primary health care provider and the service is provided by certified or licensed practitioners and/or programs, wherever State certification or licensure exists.



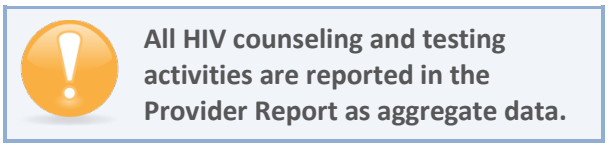
Treatment adherence counseling includes counseling or special programs provided outside of a medical case management or outpatient/ambulatory medical care visit by non-medical personnel to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Treatment adherence counseling provided during an outpatient/ambulatory care service visit should be reported under the outpatient/ambulatory medical care service category. Likewise, treatment adherence counseling provided during a medical case management visit should be reported in the medical case management service category.

HIV Counseling and Testing Services

HIV counseling and testing is the use of an FDA-approved test administered by health professionals to determine and confirm the presence of HIV infection. HIV counseling may include discussions of the benefits of testing, including the medical benefits of diagnosing HIV disease in the early stages and of receiving early intervention primary care; legal provisions relating to confidentiality, including information about any disclosures authorized under applicable law; availability of anonymous counseling and testing; and the significance of the results, including the potential for developing HIV disease.

Counseling and testing do not include tests to measure the extent of the deficiency in the immune system, because these tests are fundamental components of comprehensive outpatient/ambulatory medical care. This service category also excludes mental health counseling/therapy, substance abuse counseling/treatment, and psychosocial support services. These services are reported separately.

HIV counseling and testing are components of EIS for Parts A and B but are reported in the Provider Report in the HIV Counseling and Testing section. They are required components of a Part C program. Part D funds may also be used to support these services.



CHECKING THE CLIENT-LEVEL DATA XML FILE

(Last Updated: September 11, 2015)

The Check Your XML Feature allows providers to confirm the XML file complies with RSR client-level data schema and to review data quality prior to the submission of client-level data. Providers 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 Grantee Report opens.

For detailed instructions on how to access and use the Check Your XML feature, refer to the materials available on the TARGET Center website at https://careacttarget.org/library/check-your-xml-feature-rsr. Instructions on how to import client-level data can be found on page 31 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 GRANTEE REPORT

(Last Updated: September 11, 2015)

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

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

The Grantee Contract Management System

Beginning with the 2015 RSR, all contract information will be stored in a new Grantee Contract Management System (GCMS). The GCMS uses preexisting information from your 2014 RSR and the Consolidated List of Contracts (CLC) to populate your RSR Grantee Report and RSR Provider Report with all the elements necessary to complete the RSR, such as provider relationships and funded services. You will not be required to make any changes to the RSR Grantee Report if the provider and service information is populated from the GCMS is correct. If the data that populate in the Grantee Report are incorrect, however, edit the information in the GCMS, and integrate your changes into your RSR via a new Synchronize option.

Instructions for Completing the Grantee Report

Step One: Open the Grantee Report.

(Grantees and grantee-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. You can find a video as well as slides to assist you with this on the Target Center website: **https://careacttarget.org/library/overview-hrsa-electronic-handbooks-grantees**. Start at slide 26.

- "Grants" tab, also on the top-left side of the screen. This will take you to a list of all of the grants with which you are affiliated. Select the "grants folder" link for the grant with an RSR due and find the "Performance Reports" link under the Submission heading. Find your 2015 RSR Deliverable, and click "Start" or "Edit." Open your Grantee Report using the envelope icon under the Action column.
- "Tasks" tab at the top-left side of the screen. This will take you to a list of your current deliverables. If your RSR is due soon, you'll find it on the list of deliverables. Find your 2015 RSR Deliverable, and click "Start" or "Edit."

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

Select "Search Contracts" in the left navigation menu. Enter the date range for your submission as the search criteria. For example, for the 2015 RSR, enter "1/1/2015" in the Range Start Date field and "12/31/2015" in the Range End Date Field. Information from the contracts shown will be used to populate the Program Information section of your 2015 RSR.

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

Editing Contracts

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 will populate multiple HAB deliverables in the future. 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 Grantee Report. See page 21 for exemption instructions.

Adding Contracts

If your search does not return the desired contract, add the contract:

1. Click the "Add Contract" button below the results table.
2. Search for the organization by registration code, name, or City/State.
3. Locate the provider in the results table, and click "Add" under the action column.

Enter the following information for the contract you are adding to your list:

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 to enter the contract.
4. 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.
5. Is this agency a subcontractor or second-level provider? Select "Yes" or "No." If you select "Yes," select the provider's fiscal intermediary.

Service Information

6. Does this agency provide direct client services? Select "Yes" or "No."
7. 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
8. If applicable, indicate the core medical and essential support services that are funded for this contract by selecting the "Update Services" button. Enter the award amount(s) for each service that the provider was funded to deliver, regardless of whether the provider actually used the funding. To review the service definitions, refer to page 9.

   Once you have entered all the information into the contract, click the "Save" button at the bottom of the page.

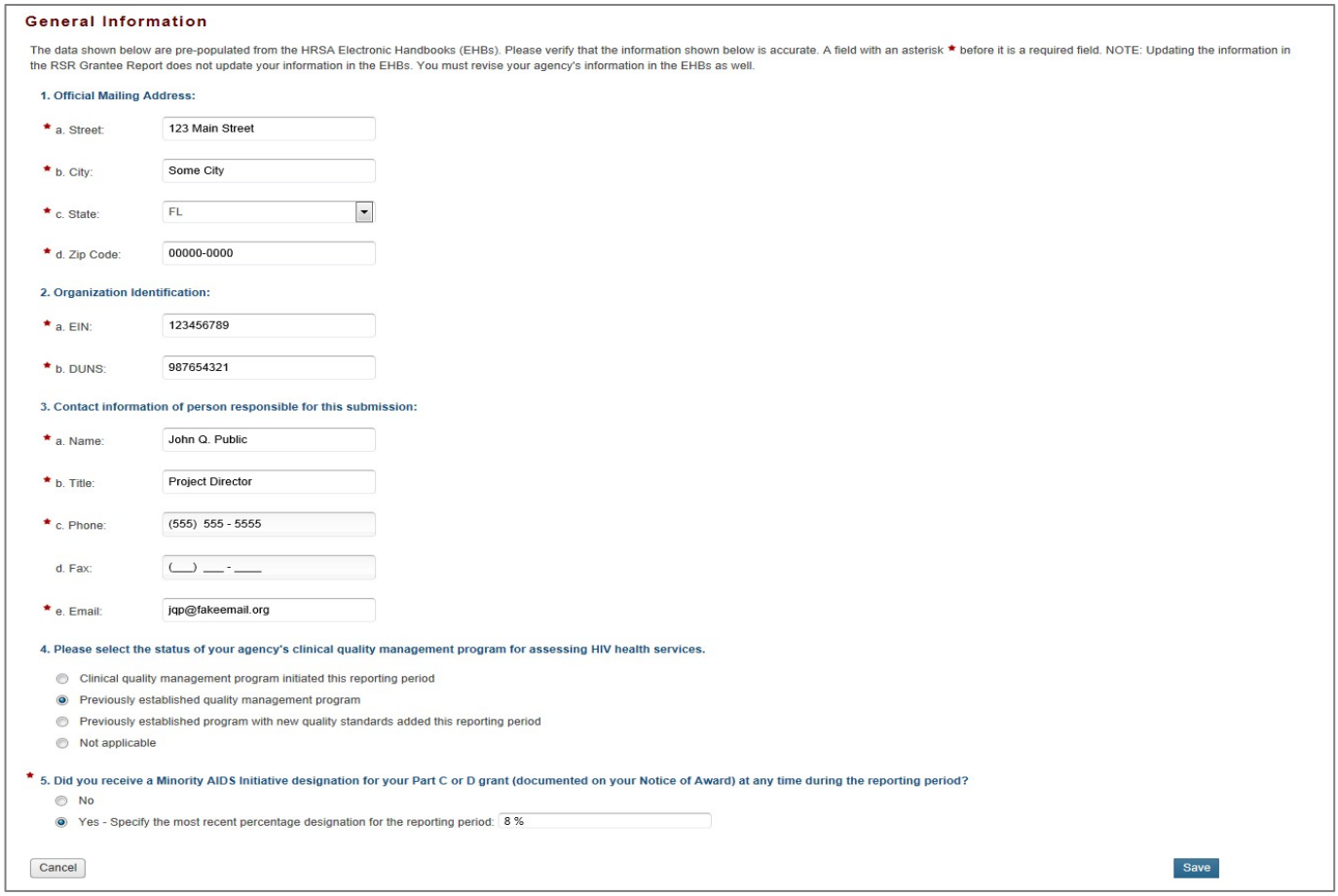
   After you have verified that all contracts listed are correct, you are ready to complete the RSR Grantee Report.

Step Three: Complete your RSR Grantee Report

Under the inbox heading in the left menu, select the "Grantee Report" link. You will be redirected to the RSR Grantee Report Inbox. Open your Grantee Report using the envelope icon under the Action column.

General Information

Figure 1. RSR Grantee Report Online Form: Screenshot of the "General Information" Section



Items 1-3 show the information on the grantee 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 with regards to 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 or support 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 Public Health Service guidelines for the treatment of HIV/AIDS. For further information on quality management, refer to the resources available at **http://hab.hrsa.gov/deliverhivaidscare/qualitycare.html**.

Part C & D Programs Only:

5. 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.

Program Information

Figure 2. RSR Grantee Report Online Form: Screenshot of the "Program Information" Section

	Warning	Reg Code	Provider Name	Exempt
►	⚠	10203	Health and Happiness Clinic	☐ Please Specify:
▼		40506	City State College University Clinic	☐ Please Specify:
Funded Services: Fiscal Intermediary Services, Outpatient/ambulatory medica care, AIDS Pharmaceutical Assistance (Local), Oral health care, Mental health services, Medical case management (including treatment adherence), Child care services, Housing services, Psychosocial support services				
▼		22222	County Health Department	☐ Please Specify:
Funded Services: Outpatient/ambulatory medica care, AIDS Pharmaceutical Assistance (Local), Oral health care, Mental healt services, Medical case managagement (including treatment adherence), Child care services, Housing services, Psychosocial support services				

To complete the RSR Grantee Report, certify a list of your service providers that were active during the reporting period.

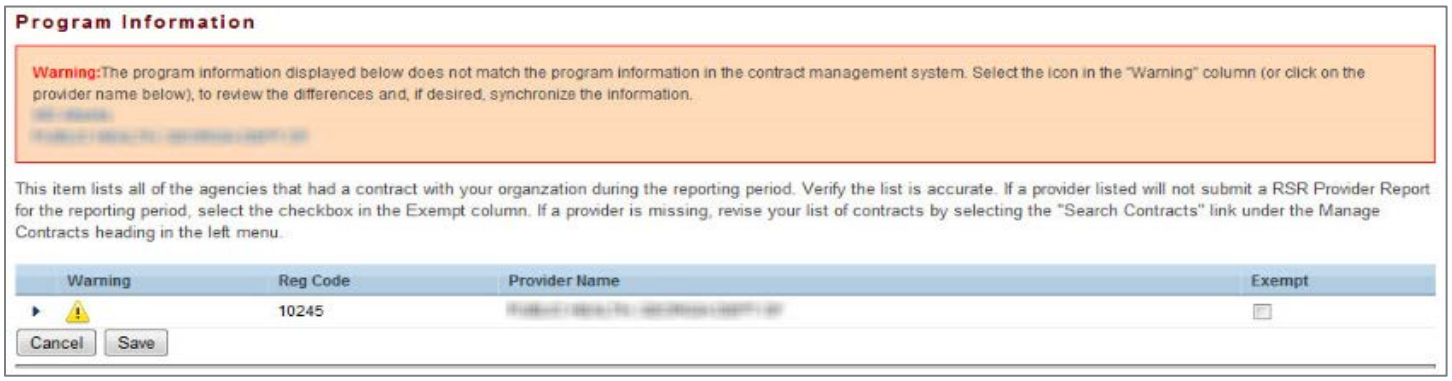
- Select the arrow in the "Expand/Collapse" column to view a prepopulated list of services funded at each provider site. The list should display all of the services that were funded, regardless of whether the provider actually delivered the service.
- If you need to exempt a provider from reporting, check the box in the "Exempt" column on the right of the Program Information page, and enter a brief explanation for the exemption. **Please Note:** If a provider has other grantees in addition to you, all of their grantees must use the "Exempt" check box for the provider to be considered exempt from reporting. If one or more grantee(s) choose not to exempt the provider, then the Provider Report must be completed and should include data for all programs. Refer to page 7 for a list of exemption criteria.
- If all of the information displayed is correct, click "Save" at the bottom of the page, and move on to Step 3 (Validate and Certify your RSR Grantee Report).

Making Changes to the Provider List

If you need to make modifications to your list of service providers displayed in the Program Information section, you can edit the contracts at any time by selecting the "Search Contracts" link in the left menu to return to the GCMS. Once you have completed edits to the contracts in the GCMS, navigate to your Program Information page to review the updated list of your contracts. You will see a Warning message that contains links for each provider with contract edits. An icon under the Warning column will also alert you

that the information in your Grantee Report does not match the information in the GCMS (see following screenshot).

Figure 3. RSR Grantee Report Online Form: Screenshot of the "Program Information" Section with Synchronization Warning



- Click on either the link in the Warning message or the icon in the Warning column to open the synchronization screen.
- Review the list of changes you made to the provider contract(s). To accept the changes and update the data in your Grantee Report, click "Synchronize" at the bottom of the page.

You must synchronize your Grantee Report to incorporate any changes that you made in the GCMS. Once you have synchronized and verified that all of the data in the Grantee Report is correct, you are ready to validate and certify your report.

Step Three: Validate and certify your RSR Grantee Report.

Once your Grantee Report is complete and correct, validate your Grantee Report by selecting the Validate link in the menu on the left. If your Grantee Report triggers a validation error, you must revise your Grantee Report. You cannot certify your Grantee Report with errors.

Indicate that you have completed data entry for your RSR Grantee Report by clicking "Certify" in the menu on the left. Grantees should make an effort to certify their RSR Grantee Reports as soon as possible after the RSR Web System opens. Providers cannot submit their RSR Provider Report and client-level data until their grantee(s) certify their RSR Grantee Report(s).

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

Step Four: (after provider has submitted report)

When your provider(s) have submitted their RSR Provider Report and client-level data, it is your responsibility to review the reports and either accept the report or return it for changes. Navigate to each provider's RSR by using the Provider Report inbox or searching for the provider using the search feature. Review the Provider Report and client-level data and any comments the provider has made, and use the links on the left to either "Submit/Accept" or "Return for Changes."

If you have multiple grants, such as a Part C and Part D grant, accept the report from both grant folders before the Provider Report will advance to "Submitted" status.

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

FREQUENTLY ASKED QUESTIONS
about the RSR Grantee Report

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

We are a Part C and Part D grantee; we are also a Part A provider. We do not have Part C or Part D providers. We use all of our funds to deliver HIV counseling and testing, core medical, and support services. What components of the RSR do I have to complete?
To complete your RSR, submit two RSR Grantee Reports, one for your Part C grant and another for your 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 client that received a service visit during the reporting period.

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

Our organization contributes Part A EMA/TGA funds and/or Part B Base Funds for ADAP. Should I include a contract with the State (or its ADAP contractor) on my contract list?
No. Please do not include contracts with the State (or its ADAP contractor) on your contract list. The funding provided by your organization will be reported by the Part B grantee in its ADAP data report.

I am a Part A grantee and a Part B fiscal intermediary provider. Do I list provider contracts that are funded exclusively by Part B on my Grantee Report contracts list?
No. Only list the contracts for providers that receive Part A funds on your Grantee Report. The Part B grantee is responsible for entering its second-level provider contracts.

The services listed for one of my provider's contracts 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 provider, make updates as necessary, and synchronize your report. As a reminder, verify contracts BEFORE starting the Grantee Report to avoid the need to synchronize the data.

I have already certified my Grantee 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 Grantee 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, re-validate, and re-certify your report. Please contact Data Support at 1-888-640-9356 or ryanwhitedatasupport@wrma.com for assistance with requesting a decertification.

RSR SERVICE PROVIDER REPORT

(Last Updated: September 11, 2015)

The Service Provider Report (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 online on the RSR Web System. Multiply funded providers will include information from all Program 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 Grantee/Provider Reporting Requirements on page 5.

Instructions for Completing the Provider Report

Step One: Open the Provider Report.

Grantee-providers: If you are a grantee-provider, you must access the RSR Web system via the EHBs. To access the RSR system, log 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:

- "Grants" tab on the top-left side of the screen. This will take you to a list of all of the grants with which you are affiliated. Select the "grants folder" link for the grant with an RSR due and find the "Performance Reports" link under the Submission heading. Find your 2015 RSR Deliverable and click "Start" or "Edit." Click "Provider Report" on the left hand navigation menu. Open your Provider Report using the envelope icon under the Action column.
- "Tasks" tab on the top-left side of the screen. This will take you to a list of your current deliverables. If your RSR is due soon, you'll find it on the list of deliverables. Find your 2015 RSR Deliverable and click "Start" or "Edit." Click "Provider Report" on the left hand navigation menu. Open your Provider Report using the envelope icon under the Action column.

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

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

To get your registration code, contact your grantee or Data Support at 1-888-640-9356. If you need help logging into or registering to use the RSR system, call the HRSA Contact Center at 1-877-464-4772.

Step Two: Complete the Provider Report

General Information

The information below is in the General Information section of the Provider Report.

Confirm the following information. This information is populated from your organization's profile. Use the "Update" link to modify as needed.

Organization Details:

- Mailing Address
- Tax ID/EIN
- DUNS

Provider Profile Information

Provider 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 abuse treatment programs, sexually transmitted diseases (STD) 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 abuse treatment programs, case management agencies; and mental health care providers.
- **Health department** includes State or local health departments.
- **Substance abuse treatment center** is an agency that focuses on the delivery of substance abuse 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/AIDS (PLWHA)** 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 (PHSA) 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. Local health departments are examples of local publicly owned organizations.
- **Public/State** is an organization funded by a State government entity and operated by State government employees. A State health department is an example of a State publicly owned organization.
- **Public/Federal** is an organization funded by the Federal Government and operated by Federal Government employees. A VA hospital is an example of a Federal publicly owned organization.
- **Private, nonprofit** is an organization owned and operated by a private, not-for-profit entity, such as a nonprofit health clinic.
- **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

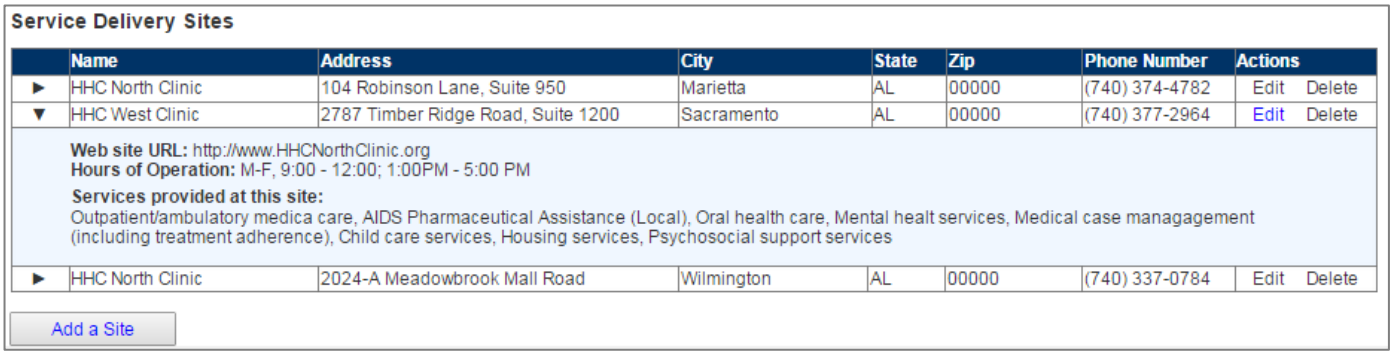
Categories that best describes the agency's racial/ethnic characteristics. Select all that apply:

- Agency in which racial/ethnic minority group members make up more than 50% of the agency's board members.
- Agency in which more than 50% 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% 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.

The fourth and fifth responses are mutually exclusive. Providers may report the first, second, and/or third response, the fourth response, OR the fifth response.

Service Delivery Sites: If the provider delivers client services, at least one service delivery site should be listed. 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 4. RSR Provider Report Online Form: Screenshot of the "Service Delivery Sites"



Service Delivery Sites

	Name	Address	City	State	Zip	Phone Number	Actions
▶	HHC North Clinic	104 Robinson Lane, Suite 950	Marietta	AL	00000	(740) 374-4782	Edit Delete
▼	HHC West Clinic	2787 Timber Ridge Road, Suite 1200	Sacramento	AL	00000	(740) 377-2964	Edit Delete
	Web site URL: http://www.HHCNorthClinic.org **Hours of Operation:** M-F, 9:00 - 12:00; 1:00PM - 5:00 PM **Services provided at this site:** Outpatient/ambulatory medica care, AIDS Pharmaceutical Assistance (Local), Oral health care, Mental healt services, Medical case managagement (including treatment adherence), Child care services, Housing services, Psychosocial support services						
▶	HHC North Clinic	2024-A Meadowbrook Mall Road	Wilmington	AL	00000	(740) 337-0784	Edit Delete

Add a Site

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 have entered 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.** You may 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 in HIV/AIDS care), simply 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 health services** (select only one):

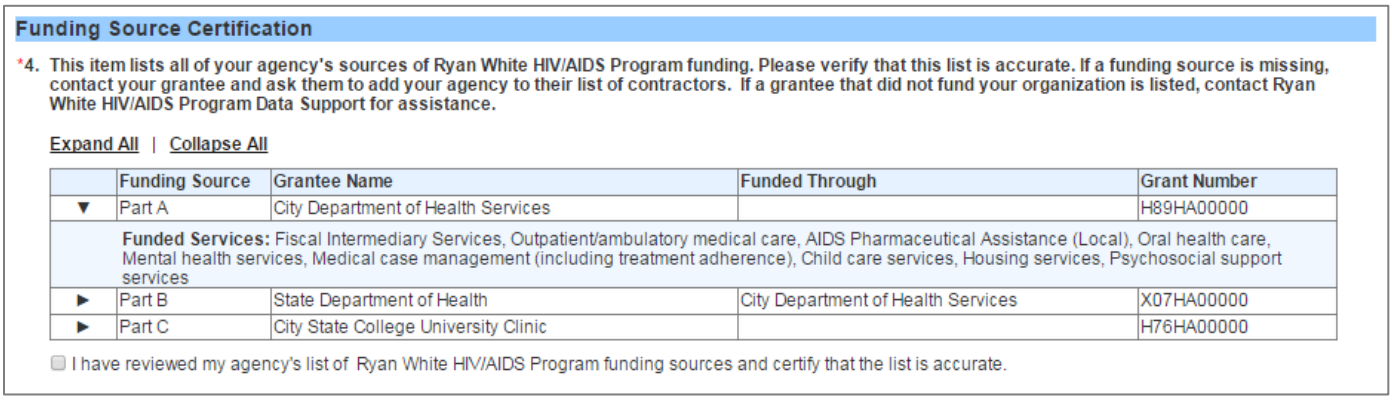
- Clinical quality management program initiated this reporting period;
- Previously established clinical quality management program;
- Previously established program with new quality standards added this reporting period; or
- Not applicable.

Every RWHAP is required to use such a program to assess the extent to which HIV health services that medical providers and/or medical case managers provide patients are consistent with the most recent PHS guidelines for the treatment of HIV/AIDS. For further information on quality management, please refer to the resources available at **http://hab.hrsa.gov/deliverhivaidscare/qualitycare.html**. 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 of your agency's sources of RWHAP funding. Verify that this list is accurate by checking the box under the funding source table. If a funding source is missing, contact your grantee and ask it to add your agency to its list of contractors. If a grantee that did not fund your organization is listed, contact RHAP Data Support for assistance.

Figure 5. RSR Provider Report Online Form: Screenshot of the "Funding Source Certification"



Funding Source Certification

*4. This item lists all of your agency's sources of Ryan White HIV/AIDS Program funding. Please verify that this list is accurate. If a funding source is missing, contact your grantee and ask them to add your agency to their list of contractors. If a grantee that did not fund your organization is listed, contact Ryan White HIV/AIDS Program Data Support for assistance.

Expand All | Collapse All

	Funding Source	Grantee Name	Funded Through	Grant Number
▼	Part A	City Department of Health Services		H89HA00000
	Funded Services: Fiscal Intermediary Services, Outpatient/ambulatory medical care, AIDS Pharmaceutical Assistance (Local), Oral health care, Mental health services, Medical case management (including treatment adherence), Child care services, Housing services, Psychosocial support services			
►	Part B	State Department of Health	City Department of Health Services	X07HA00000
►	Part C	City State College University Clinic		H76HA00000

☐ I have reviewed my agency's list of Ryan White HIV/AIDS Program funding sources and certify that the list is accurate.

Service Information

5) Review the services funded by your grantee(s). This is populated from the services indicated as funded by your grantee(s) in its Grantee Report(s). **Select the services that were delivered by your agency during the reporting period regardless of funding source.** Please note: If a service category is missing, please contact the appropriate grantee.

HC&T Information

If your agency used Ryan White Program funding to provide HC&T services during the given reporting period, you must complete this section. Report ALL individuals who received the service at your agency during the reporting period, regardless of funding source. You will still complete this section if Ryan White funds are only used for staff salaries.

If you provide HC&T services as part of your EIIHA activities or under EIS for Parts A and B service category, report your HC&T data in this section.

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

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

8) **Of those tested**, **number that tested NEGATIVE**: The number that tested NEGATIVE for HIV during the reporting period.

9) **Number who tested NEGATIVE and received post-test counseling**: Of the number indicated in Item 8, the number who received HIV post-test counseling.

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

11) **The number who tested POSITIVE and received post-test counseling**: Of the number specified in Item 10 indicate how many received HIV-post-test counseling immediately following the test or returned for counseling at a later date.

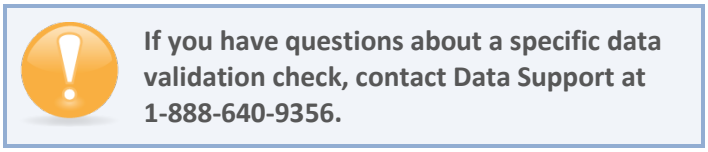
12) **Of those who tested POSITIVE**, **number referred to HIV medical care**: Of the total number who tested positive for HIV, indicate how many were referred to HIV medical care.

Step Three: Upload your client-level data (if applicable).

If you provide core medical or support services, you must upload a client-level data file to complete your Provider Report. The Client 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 31.

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

Validate your Service Provider Report by clicking "validate" on the left navigation panel.



If your validation report contains errors, resolve all of them by revising the data as required. Remember, you cannot submit your Service Provider Report with errors. Errors in the client-level data must be fixed in your local data collection systems. Once you find and fix the client data in your local system, generate and upload a new client-level data file into the Provider Report. When you have finished updating your data, validate your report again.

If your validation report contains warnings, you can submit your Provider Report. However, you should first try to fix all the warnings. To submit your Provider Report with warnings, write a comment for all of the warnings that cannot or should not be fixed by clicking the "Add Comments" link under the action column in your validation report. Client-level data file contains personal health information (PHI). PHI includes, but is not limited to, client names, addresses, DOB, SSN, dates of service, and unique record numbers (URNs) generated for your organization's client-level data XML file. To ensure client confidentiality, never share PHI. 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 **http://www.hhs.gov/ocr/privacy** for additional information about client confidentiality and privacy.

There are also a series of data checks in the RSR Web system that return alerts. Data alerts are informative and intended to help you identify potential issues in your data collection and reporting processes. You do not need to fix or write comments about a data alert before submitting the RSR.

To upload a new client-level data file to fix a validation issue, first delete the old files by using the "clear clients" link from the left navigation panel and selecting the files you wish to delete. If you do not, your new data will be merged with your old data. Contact Data Support for assistance in clearing your client records.

Step Five: Submit your data.

When you are satisfied that your report is complete, submit the Provider Report and client-level data by clicking on "Submit" in the left navigation menu 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 grantees 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.

The option to complete the Provider Report via an XML upload is no longer available.

FREQUENTLY ASKED QUESTIONS
about the RSR Provider Report

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

Are providers with whom we do not have formal contracts 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 receive Ryan White funding.

Do providers need to submit a Provider Report and client-level data if they do not serve many clients, submit only vouchers, only serve clients on a fee-for-service basis, or receive a small amount of funding from my grant?
All providers listed on your contract lists will be required to complete an RSR Provider Report unless all of the provider's grantees have marked it as exempted by checking the box in its Grantee Report. Please refer to page 21 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 grantee and the name of their fiscal intermediary provider, 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 grantee told my provider that it does not need to submit its data until HAB's recommended submission deadline. I really need my provider to submit its data early. What do I do?
Contact your provider's other grantee(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 grantees will enforce will help ensure a smooth submission process. If your provider is also a grantee, be sure to negotiate an early submission deadline that is agreeable to both of you.

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, you will need to contact your grantee to add the service(s) on its Grantee Report. If you did not receive RWHAP funds to deliver the service, you should not mark it in your Provider Report.

RSR CLIENT-LEVEL DATA

(Last Updated: 9/11/15)

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 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 can be found in the section Grantee/Provider Reporting Requirements on page 5.

Importing the Client-level Data XML File

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 menu on the left. Then, follow the on-screen instructions.

Please be sure to upload the data in the RSR Provider Report by using the "Import Client-Level Data" link in the left navigation menu. If using the Check Your XML feature, the data will not be transferred to the RSR Provider Report.

Each file uploaded into the RSR system goes through a schema validation check. This check is automatically performed by the RSR system when a file is uploaded. If the file is noncompliant, the user's file will be rejected by the RSR system and a complete list of error messages will be displayed. Users can download the list as a text file and use it to fix the client-level data in their source system.

To generate an XML file, providers need to extract the client-level data from their systems into the proper XML format before the data can be submitted to HAB. Several software applications for managing and monitoring HIV clinical and supportive care are able to 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 can be found on the TARGET Center Web site at https://careacttarget.org/content/vendor-status-and-contact-information-0. No special action will be required to generate the XML file. However, if your organization uses a custom-built data collection system, you have two options:

1. Write a program that extracts the data from it, and insert it into an XML file that conforms to the rules of the RSR XML schema. The schema can be obtained from HAB at https://careacttarget.org/library/xml-file-all-things-xml.
2. Use TRAX to create your client-level data XML file. TRAX was created to help grantees and providers that do not use CAREWare, a Provider Data Import (PDI), or other RSR-ready vendor system to create their client-level Data XML file.

Providers should generate and review a client-level data upload confirmation report before they submit their data. The upload confirmation report is an aggregate report that can be used to verify that the counts and totals reported in your client report match data stored in your source system(s)—that is, the correct number of clients and services are being reported. To run this report, select the "Upload Confirmation Report" link from the left hand navigation menu in the RSR web system.

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

Client-Level Data Elements

The client report should contain one record for each client who was eligible to receive RWHAP core medical services or support services during the reporting period. The data elements reported per client are determined by the specific RWHAP services that your agency is funded to provide. See the chart in **Appendix A. Required Client-level Data Elements for RWHAP Services** on page 57 to determine the client-level data elements that will be reported for a client. The 2015 client-level data elements and response options have not changed from the 2014 RSR.

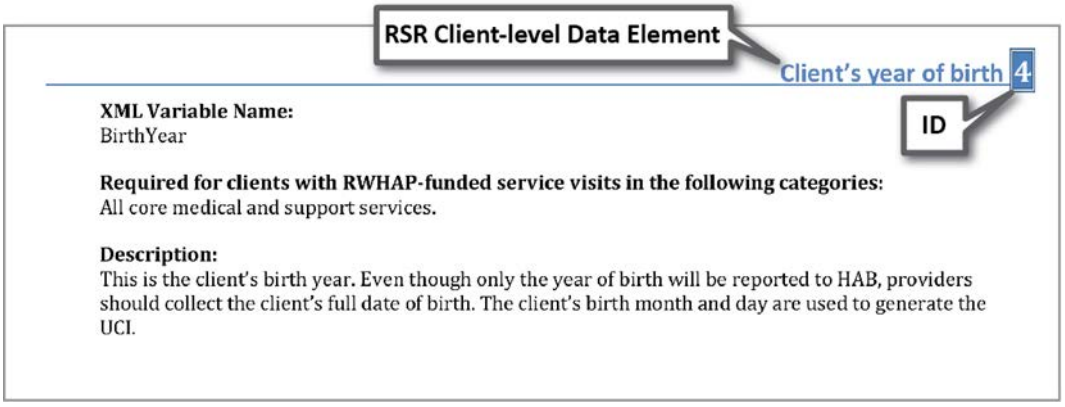
Up to 64 data elements may be reported for each client. The data elements include the following:

- The client's encrypted Unique Client Identifier (eUCI);
- The client's demographic information;
- The core medical and support services the client received; and
- The client's clinical information if he or she received outpatient/ambulatory medical care services.

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://careacttarget.org/library/xml-file-all-things-xml** .

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. It is the method by which the data are labeled 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 service they received. You are required to report the data element for clients who meet your eligibility criteria.

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 grantees and providers ask the most about the data element.

System Variables

Deleted RSR 2015 SV2

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 eUCI is used for reporting Ryan White client data. Using eUCIs allows HAB to de-duplicate the clients and obtain a more accurate count of the clients RWHAP serves .

Note: Client-level data file 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, never share PHI. You must 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 **http://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 TARGET Center website at https://careacttarget.org/library/encrypted-unique-client-identifier-euci-application-and-user-guide.

Guidelines for Collecting and Recording Client Names

Grantees should develop business rules/operating procedures outlining the method by which client names should be 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.

Grantees should instruct providers and staff 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, you should do everything possible to obtain those data elements. It is required for each client. This effort will improve not only the quality of data linking but also case management and patient care.

Deleted RSR 2015 **SV5**

Demographic Data

Up to 16 demographic data elements may be reported for each client. You can 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 57.

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 medical care services
- Medical case management
- Nonmedical case management

Description:
This is the client's vital enrollment status at the end of the reporting period. These are the response categories for this data element:
- *Active*—The client will be continuing in the program.
- *Referred or Discharged*—The client was referred to another program for services and will not continue to receive services at this agency. Also select this category if the client was discharged from a program because he or she became self-sufficient and was no longer eligible to receive RWHAP–funded services, the client voluntarily leaves your program, or the client refuses to participate.
- *Removed*—The client was removed from treatment due to violation of rules.
- *Incarcerated*—The client will not be continuing in the agency's 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 has moved out of the agency's service area and will not continue to receive RWHAP services at the agency's location.
- *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.

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 did not and/or will not continue in your agency's program, choose the category that explains why the client is no longer active.

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 HAB, providers should collect the client's full date of birth. The client's birth month and day are used to generate the UCI. The value should be on or before all service date years 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. For more information, go to:
http://www.whitehouse.gov/omb/fedreg/1997standards.html.

HAB is required to use the OMB reporting standard for race and ethnicity. However, service provider agencies 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 should 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 individual'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/ or Spanish origin*—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 or Spanish origin*—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 or Spanish origin," 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 Other 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*— An individual whose gender identity is not congruent with his or her biological gender, regardless of the status of surgical and hormonal gender reassignment processes. Sometimes the term is used as an umbrella term encompassing transsexuals, transvestites, cross-dressers, and others. The term transgender refers to a continuum of gender expressions, identities, and roles, which expand the current dominant cultural values of what it means to be male or female.
- *Unknown*— Indicates the client's gender category is unknown or was not reported.

Client's self-reported transgender status 8

XML Variable Name:
TransgenderID

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

Description:
If the client is reported as "transgender" in ID 7, report:

- Male to Female
- Female to Male
- Unknown

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 medical care 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% of the Federal poverty level
- 100–138% of the Federal poverty level
- 139–200% of the Federal poverty level
- 201–250% of the Federal poverty level
- 251–400% of the Federal poverty level
- 401–500% of the Federal poverty level
- More than 500% 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 2015 HHS Poverty Guidelines, go to **http://aspe.hhs.gov/poverty/index.shtml**.

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

Calculating a Client's Income Percentage of the Federal Poverty Measure

To determine a client's income percentage of the Federal poverty measure using HHS Federal poverty guidelines (FPG), follow these five easy steps:

1. Count the client's family size. Family size is the number of family members who live together. An individual living alone (or with only nonrelatives) counts as a family of one.
2. Add up the family income. Family income is the sum of income of all family members who live together. It includes pretax money (or "cash") income (earnings; unemployment compensation; Social Security; public assistance; veteran payments; survivor benefits; pension or retirement income; interest; dividends; rents; royalties; income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources). It excludes noncash benefits (e.g., food stamps, housing subsidies) and capital gains (or losses).
3. Look up the FPG for the family size, year, and geographic location. The FPG are dollar amounts that vary according to family size and are used to determine poverty status. HHS issues them each year in the Federal Register. There are separate guidelines for the contiguous 48 States, Alaska, and Hawaii.
4. Calculate the family income as a percent of the family FPG:

   family income / guideline × 100 = % family FPG

5. Use the percent of the family FPG to report the client percent of the Federal poverty measure for ID 9 of your RSR Client Report.

All family members have the same poverty status; thus, all family members have the same income percentage of the Federal poverty measure.

Client's housing status 10

XML Variable Name:
HousingStatusID

Required for clients with service visits in the following categories:

- Outpatient/ambulatory medical care 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. NOTE: Unstable housing is associated with poorer viral load suppression everywhere in the country. It is important for grantees/providers to be continually aware of clients' housing status and make every attempt to connect unstably and temporarily housed clients with all available resources. 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 (TBRA) or Facility-Based Housing Assistance, but not including the Short-Term Rent, Mortgage and Utility (STRMU) 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 (SHP), and the Moderate Rehabilitation Program for SRO Dwellings (SRO Mod Rehab).
- 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 Ryan White Program housing subsidy.
- Temporary placement in an institution (e.g., hospital, psychiatric hospital or other psychiatric facility, substance abuse treatment facility, or detoxification center).
- Hotel or motel paid for without emergency shelter voucher.

Unstable Housing Arrangements include the following:

- Emergency shelter, a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings, 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 (APR), 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 medical care services
- Medical case management
- Nonmedical case management

Description:
This data element is the client's HIV/AIDS status at the end of the reporting period. For HIV-affected clients for whom HIV/AIDS status is not known, 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 infected with HIV/AIDS.

- *HIV-positive, not AIDS*—Client has been diagnosed with HIV but has not been diagnosed with AIDS.
- *HIV-positive, AIDS status unknown*—Client has been diagnosed with HIV. It is not known whether the client has been diagnosed with AIDS.
- *CDC-defined AIDS*—Client is an HIV-infected individual who meets the CDC AIDS case definition for an adult or child. **NOTE:** Once a client has been diagnosed with 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 whose HIV status is not yet determined but was born to an HIV-infected mother.

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?
HAB uses the current CDC surveillance case definition for Acquired Immunodeficiency Syndrome for national reporting. For additional information, see:

- **http://www.cdc.gov/mmwr/preview/mmwrhtml/00018871.htm**
- **http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4813a2.htm**
- **http://www.cdc.gov/mmwr/preview/mmwrhtml/00032890.htm**

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 medical care
- 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 this data element

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

Client's risk factor for HIV infection 14

XML Variable Name:
HivRiskFactorID

Required for clients with service visits in the following categories:

- Outpatient/ambulatory medical care services
- Medical case management
- Nonmedical case management

Description:
This data element is the client's initial risk factor for HIV infection. You may report all of the response categories that apply.

- Men who have sex with men (MSM) 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 user (IDU) cases include clients who report use of drugs intravenously or through skin-popping.
- 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 with, or at increased risk for, HIV infection (e.g., an injection drug user).
- Receipt of transfusion of blood, blood components, or tissue cases include transmission 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. This category also refers to HIV-affected clients who do not have a risk factor.

Client's Medical insurance 15

XML Variable Name:
MedicalInsuranceID

Required for clients with service visits in the following categories:

- All core medical services.
- Nonmedical case management.

Description:
Report all sources of health insurance 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 and older, some disabled people ages 64 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. 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 a client who has private insurance, but Ryan White funds are used to pay their copay and/or deductible?
If the client has private insurance, select the corresponding response option AND select "No Insurance." 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.

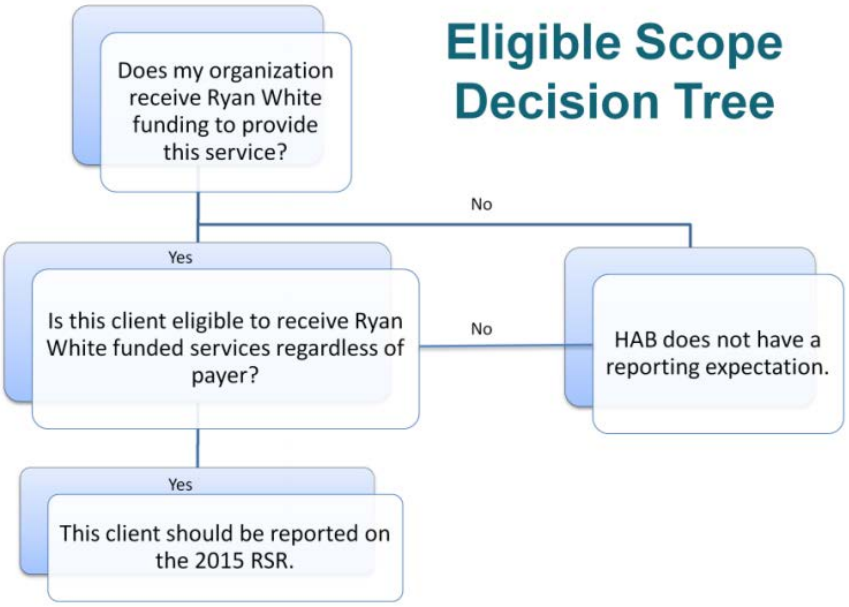
How should a provider report a client who is covered by COBRA?

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 a client's service visits delivered when the client was eligible to receive RWHAP-funded services. Report clients who did not actually receive RWHAP-funded services if they meet your agency's eligibility requirements. 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 flow chart below:



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

- Aaron receives OAMC services, 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 grantee level. Contact your grantee 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 2015.

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 OAMC client moves in and out of eligibility and the agency is RWHAP funded for OAMC services, report the services (ID 16) within the period of eligibility AND the clinical data elements (including OAMC visit dates ID 48) from the ENTIRE year.

Core Medical Service Visits Delivered 16, 18–19, 21–27

XML Variable Name:
ClientReportServiceVisits

- Service Visit
- ServiceID (See table below.)
- 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 the table below.

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 5 services, the provider will only report 1 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 4 services, the provider will report only 3 service visits for that day: 1 mental health service visit, 1 medical case management service visit, and 1 outpatient/ambulatory medical care visit.

Core medical services (IDs 16-27) 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 Part A and B should only be reported in the HIV Counseling and Testing section of the provider report.

The definitions for the **RWHAP Core Medical Services** can be found in the **Ryan White HIV/AIDS Program Services** chapter on page 9.

ELEMENT ID	Service Category	ServiceID
16	Outpatient ambulatory medical care	Service ID 8
18	Oral health care	Service ID 10
19	Early intervention (Parts A and B)	Service ID 11
21	Home health care	Service ID 13
22	Home and community-based health	Service ID 14
23	Hospice	Service ID 15
24	Mental health	Service ID 16
25	Medical nutrition therapy	Service ID 17
26	Medical case management (including treatment adherence)	Service ID 18
27	Substance abuse outpatient	Service ID 19

Core Medical and Support Services Delivered 17, 20, 28–45

XML Variable Name:
ClientReportServiceDelivered

- Service Delivered
- ServiceID (See table below.)
- 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 Core Medical Services** can be found in the **Ryan White HIV/AIDS Program Services** chapter on page 10. The definitions for the **RWHAP Support Services** can be found in the **Ryan White HIV/AIDS Program Services** chapter on page 13.

ELEMENT ID	Service Category	ServiceID
17	Local AIDS Pharmaceutical Assistance (Local APA)	Service ID 9
20	Health Insurance Program (HIP)	Service ID 12
28	Case management (non-medical)	Service ID 20
29	Child care	Service ID 21
30	Pediatric developmental assessment/early intervention	Service ID 22
31	Emergency financial assistance	Service ID 23

ELEMENT ID	Service Category	ServiceID
32	Food bank/home-delivered meals	Service ID 24
33	Health education/risk reduction	Service ID 25
34	Housing	Service ID 26
35	Legal	Service ID 27
36	Linguistic	Service ID 28
37	Medical transportation	Service ID 29
38	Outreach	Service ID 30
39	Permanency planning	Service ID 31
40	Psychosocial support	Service ID 32
41	Referral for health care/supportive	Service ID 33
42	Rehabilitation	Service ID 34
43	Respite care	Service ID 35
44	Substance abuse–residential	Service ID 36
45	Treatment adherence counseling	Service ID 37

Clinical Information

The final group of data elements collected in the client-level data XML file are the clinical information data elements. Clinical information is required to be reported by all providers who received RWHAP funding to provide outpatient/ambulatory health services.

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 HAB measure to what extent the program is meeting patient care requirements nationally, as set forth in the 2009 RWHAP legislation and HAB's HIV/AIDS Core Clinical Performance Measures for Adults & Adolescents. The reporting period for RSR purposes is the period of time for which data are submitted to HAB (e.g., January 1–December 31). This should not be confused with clinical performance measurement periods. Though you are required to report the applicable data elements with each report submission, you should not perform a clinical activity more frequently than required to meet the generally accepted standards of medical care for HIV-positive patients.

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 medical care 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 infection or reinfection, followed by counseling of patients about ways to reduce their risk.

Date client's first HIV outpatient/ambulatory care visit 47

XML Variable Name:
FirstAmbulatoryCareDate

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

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

- The visit should meet the RWHAP definition of an outpatient/ambulatory medical care 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, please 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 medical care visit does not change in subsequent reports.

Dates of the client's outpatient ambulatory care visits 48

XML Variable Name:
ClientReportAmbulatory
- Service
- ServiceDate

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

Description:
Report all dates (MM/DD/YYYY) of the client's outpatient/ambulatory care 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 (ARV) therapy. The number of outpatient ambulatory care 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 medical care 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 medical care 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 medical care 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, you should report the lower bound of the test limit. If the lower bound is not available, report 0.

Client prescribed PCP prophylaxis 51

XML Variable Name:
PrescribedPcpProphylaxisID

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

Description:
PCP prophylaxis is drug treatment to prevent *Pneumocystis jiroveci* pneumonia. It is a major cause of mortality among people with HIV infection, yet it is almost entirely preventable and treatable. People with CD4 T-cell counts under 200 cells/mm^3 are at greatest risk of developing PCP.

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:
http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html
http://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 medical care services

Description:
ART is antiretroviral therapy, an aggressive anti-HIV treatment including a combination of three or more drugs with activity against HIV whose purpose is to reduce viral load to undetectable levels. **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: **http://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 medical care 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 medical care services

Description:
Syphilis is a sexually transmitted disease (STD) 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 or younger who are not sexually active. Has the client been screened for syphilis during this reporting period?

- Yes
- No
- Not medically indicated

Additional information may be obtained at **http://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 medical care 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 medical care services

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

- Yes
- Not medically indicated
- No

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. You will indicate that the client has completed the series in subsequent reports.

Can we report that the client has been vaccinated for hepatitis B if the client has a hepatitis B surface antibody test that is positive/reactive and hepatitis B antigen that is negative/non-reactive? Can an immunity tests be a substitute for getting all documented hepatitis B vaccine test dates in the series to 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 client received the hepatitis B vaccine series to report a "yes" response to the VaccinatedHepatitisBID data element. A negative hepatitis B surface antigen test (HBsAg) and a positive hepatitis B surface antibody test (anti-HBs) only indicate that the client is immune; they do not necessarily indicate immunity through the vaccination. 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 medical care 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 medical care 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 abuse 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 medical care 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 medical care services

Description:
Reported for HIV-positive women only, do not report a value for male 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 pre-cancerous as well as hidden, small 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 medical care services

Description:
Reported for HIV-positive women only, do not report a value for male clients. 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 medical care 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.)

OAMC 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 medical care services

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

HIV OAMC 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 HAB define a confirmatory test?
Each agency must determine its own guidelines for standard of care that is practiced by its OAMC provider based on CDC guidelines.

My RWHAP funding covers only salaries. Do I report client-level data?
Yes. 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. 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 *Rules for Merging* at **https://careacttarget.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, ensure changes are documented. 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?
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 22 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?
HAB understands that it may place an unreasonable burden on providers to determine whether certain clients were screened for TB, Hep B, or Hep C since their diagnosis and advises providers to report whatever data may be reasonably obtained. HAB expects you to screen your client if you do not know whether or not your client has been screened since his or her HIV diagnosis.

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

(Last Updated: September 11, 2015)

RATIONAL CODES

1) Necessary for identifying new clients
2) 2009 Ryan White Legislation requirement
3) Necessary to assess RWHAP performance as required for GPRA
4) Necessary to assess RWHAP performance as required for HAB's programmatic measures
5) Necessary to track enrollment or vital status over the course of the reporting period
6) Informs the denominator of other items
7) Used to identify important population subgroups
8) Used to measure and assess the extent of out-of-service area utilization
9) Used to determine areas of eligibility
10) Accountability, use of funds

Client-level Data Elements	Outpatient/ambulatory medical care	Medical case management	Oral healthcare	Early intervention services (A and B)	Home health care	Home and comm-based hlth serv	Hospice services	Medical nutrition therapy	Mental health services	Substance abuse services-outpatient	AIDS Pharmaceutical Assistance (local)	Health Insurance Program (HIP)	Case management (non-medical)	Child care services	Ped develop assss/early interv serv	Emergency financial assistance	Food bank/home-delivered meals	Health education/risk reduction	Housing services	Legal services	Linguistics services	Medical transportation services	Outreach services	Permanency planning	Psychosocial support services	Referral hlth care/support services	Rehabilitation services	Respite care	Substance abuse services-residential	Treatment adherence counseling	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
Transgender subgroup	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	2,3,4,7
Sex at Birth	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	2,3,4,7
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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 an infected client 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.

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/AIDS prevention programs, including the HIV Prevention Community Planning process, among others. The CDC is responsible for monitoring and reporting infectious diseases, administers HIV surveillance grants, and publishes epidemiologic reports such as the HIV/AIDS Surveillance Report.

Client: See infected 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 **http://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, discrimination, and/or abuse.

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/AIDS, and community-based organizations operating within areas determined by the State to be most affected by HIV disease. The consortium agrees to use 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 disease. Agencies constituting the consortium are required to have a record of service to populations and subpopulations with HIV/AIDS.

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/AIDS.

Contract: An agreement between two or more parties, especially one that is written and enforceable by law.[2] For the purposes of the Ryan White Services Report, 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/AIDS and specified in the Ryan White HIV/AIDS Treatment Extension Act.

Division of Policy and Data: The Division within HRSA's HIV/AIDS Bureau that serves as the Bureau's principal source of program data collection and evaluation and the focal point for coordination of program

[2] Contract. (n.d.). *The American Heritage® Dictionary of the English Language,* Fourth Edition. Accessed December 12, 2008, at Dictionary.com Web site: http://dictionary.reference.com/browse/contract.

performance activities, policy analysis, and development of policy guidance. The Division coordinates all technical assistance activities for the Bureau in collaboration with each HAB Division.

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

EMA/TGA: Eligible Metropolitan Area/Transitional Grant Area**.** The geographic area eligible to receive Part A RWHAP 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 PLWHA 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 grantees use to manage their provider contracts.

GPRA: The Government Performance and Results Act. Enacted in 1993, the law requires Federal agencies to establish standards measuring their performance and effectiveness. HRSA has set both long-term and annual measures to assess the performance of RWHAP services. **http://www.whitehouse.gov/omb/mgmt-gpra/index-gpra**

Grantee of record (or grantee): The official RWHAP grantee that receives Federal funding directly from the Federal government (HRSA). A grantee also may be a provider if it provides direct services in addition to administering its grant.

HAB: HIV/AIDS Bureau. The Bureau within HRSA of the U.S. Department of Health and Human Services (HHS) that is responsible for administering RWHAP. Within HAB, the Division of Metropolitan HIV/AIDS Programs (DMHAP) administers Part A; the Division of State HIV/AIDS Programs (DSHAP) administers Part B and the AIDS Drug Assistance Program (ADAP); the Division of Community HIV/AIDS Programs (DCHAP) administers Part C, Part D, the HIV/AIDS Dental Reimbursement Program (DRP), and the Community-Based Dental Partnership Program (CBDPP); and the Division of Training and Capacity Development administers the AIDS Education and Training Centers (AETC) Program and the Special Projects of National Significance (SPNS) Program. The Bureau's Division of Policy and Data administers HIV/AIDS evaluation studies, the Ryan White HIV/AIDS Program Services Report (RSR), the ADAP Quarterly Report (AQR), the ADAP Data Report (ADR), and the Allocation and Expenditure (A&E) Report.

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 program. A program of financial assistance for eligible people living with HIV to enable them to maintain continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

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 PLWHA and their families.

HRSA: Health Resources and Services Administration. A Federal public health agency of the U.S. Department of Health and Human Services that is 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/AIDS, 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 or younger with an HIV status that is not yet determined but was born to an HIV-infected mother.

Infected client: A person who is HIV positive and receives at least one RWHAP service during the reporting period.

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 abuse or for mental illness. Health care facilities include hospitals, nursing homes, and hospices. Correctional facilities include jails, prisons, and correctional halfway houses.

MAI: Minority AIDS Initiative. A national HHS initiative that provides special resources to reduce the spread of HIV/AIDS and improve health outcomes for people living with HIV disease within communities of color. This initiative was enacted to address the disproportionate impact of the disease in such communities. It was formerly referred to as the Congressional Black Caucus Initiative because of that body's leadership in its development.

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; or (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 (KS), *Pneumocystis carinii* pneumonia (PCP), 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, or other place where clients receive health care services but do not stay overnight.

PART: Program Assessment Rating Tool. A diagnostic tool used to assess the performance and management of Federal programs. For the RWHAP, annual goals and outcome measures include, for example, improving access to health care by increasing the proportion of people living with HIV who receive medical care and treatment; and improving health outcomes by expanding health care to underserved, vulnerable, and special needs populations.
http://www.whitehouse.gov/omb/expectmore/part.html

Part A: The part of RWHAP that provides direct financial assistance to designated EMAs 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/AIDS and their affected partners and family members.

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/AIDS and their affected partners and family members. RWHAP emphasizes that such care and support is part of a coordinated continuum of care designed to improve medical outcomes.

Part C: The part of RWHAP that provides support for early intervention services, including preventive, diagnostic, and therapeutic services for people living with HIV/AIDS and their affected partners and family members. This support includes a comprehensive continuum of outpatient HIV primary care services including: HIV counseling, testing, and referral; medical evaluation and clinical care; other primary care services; and referrals to other health services.

Part D: The part of RWHAP that supports coordinated family-centered outpatient care for women, infants, children, and youth with HIV/AIDS and their affected partners and family members. The Adolescent Initiative is a separate grant under the Part D program that is aimed at identifying adolescents who are HIV positive and enrolling and retaining them in care.

PHSA: Public Health Service Act.

PLWHA: People living with HIV/AIDS.

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

Primary health care service: Any preventive, diagnostic, or therapeutic health service received on an outpatient basis by a client who is HIV positive. Examples include medical, subspecialty care, dental, nutrition, mental health, or substance abuse treatment, medical case management, and 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 grantee. A provider may receive funds as a grantee (such as under Parts C and D) or through a contractual relationship with a grantee funded directly by HRSA's RWHAP.

Recipient: An organization receiving financial assistance directly from an HHS awarding agency to carry out a project or program. For the purposes of the Ryan White Services Report, a recipient is the grantee of record. See also "Grantee of record."

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 disease. For HIV/AIDS, 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/AIDS disease and their families in the United States and its territories. The law has changed how RWHAP funds can be used, with an emphasis on providing life-saving and life-extending services for people living with HIV/AIDS.

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.

Subgrantee: The legal entity to which a subaward is made and which is accountable to the grantee for the use of the funds provided. For the purposes of the Ryan White Services Report, a subgrantee is the service provider (contractor or subrecipient). See also "Provider/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/AIDS.

Transmission category: A grouping of disease exposure and infection routes. In relation to HIV disease, exposure groupings include injection drug use, men who have sex with men, heterosexual contact, perinatal transmission, and so forth.

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 all of the different computer platforms, languages, and applications.

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