2012 ANNUAL RYAN WHITE HIV/AIDS PROGRAM SERVICES REPORT (RSR) INSTRUCTION MANUAL

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WHAT'S NEW

(Last Updated: September 10, 2012)

This manual has been rewritten to improve usability. It combines important information about the RSR from multiple sources including the 2011 RSR Instruction Manual, 2010 RSR Instruction Manual Supplement, and the RSR Data Dictionary and XML Schema Implementation Guide for the Client-Level Data Report (v 2.3, released June 9, 2010). For instance, the descriptions of the client-level data elements have been expanded to include the data element XML variable names. Also, frequently asked question-and-answer sections (FAQs) have been added throughout the document. Look for the Question icon at the beginning of each of these sections.

While much of the material is not new, HAB recommends that you read this manual as if it is new. In particular, you should look for the following changes to HAB's previous RSR guidance.

- **Pages 6 and 55:** Core medical services can only be received by HIV-positive and HIV-indeterminate clients except for HIV-negative clients who are tested under EIS. **NOTE:** HIV-negative clients receiving HIV testing under EIS are reported under HIV Counseling and Testing Services, not EIS.
- **Pages 7, 8, 10, and 21:** EIIHA activities should be reported under any appropriate service category that aligns with the definition of the service category.
- **Pages 6 and 10:** Core medical and support services may **not** be provided anonymously. All providers that deliver core medical or support services are expected to upload client-level data. HIV counseling and testing services, however, may be provided anonymously.
- **Pages 55 and 69:** If any portion of salary for a direct service provider is paid for with Ryan White funds, the expectation is that the provider sees clients who receive Ryan White HIV/AIDS Program (RWHAP) funded services. Therefore, the provider is expected to report client-level data.
- **Pages 58:** Clinical information is no longer required to be reported for HIV-indeterminate clients.
- **Page 53:** Instructions have been added regarding how to report data on clients in high-risk insurance pools (including PCIPs). This will be based on who pays the premium for the insurance.
- Deleted all references to Syringe Service Programs (SSPs). Congress has reinstated the ban on Federal funding for syringe exchange programs as of December 23, 2011. RWHAP funds may no longer be used to support Syringe Services Programs. These services may not be reported in the RSR. Therefore all references to SSPs have been deleted from this Manual. To learn more, read the January 6, 2012, letter "Ban on Federal Funding for Syringe Services Program" available on the HIV/AIDS Bureau (HAB) Web site at **http://hab.hrsa.gov/manageyourgrant/policiesletters.html**.

In addition to the content updates, icons are also featured throughout the text to alert you to particularly important and/or useful information. You will find the following icons in this document:

The Warning icon highlights potential problems you should avoid.

The Note icon highlights information that you should know when completing your RSR.

The Tip icon points out recommendations and suggestions that may make completing the RSR easier.

The Resource icon points out phone numbers, Web sites, and other resources where you can get additional information on the subject or help with a question or problem.

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BACKGROUND

(Last Updated: September 10, 2012)

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 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 the implementation of 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 Ryan White HIV/AIDS Program 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 individuals the 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 with program funds. 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 funds 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 the 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, to limit data collection to only the information that is "reasonably necessary to accomplish the purpose" of the Ryan White HIV/AIDS Program Services Report.

HAB also understands how important the data reported can be to each RWHAP as each assesses their client service needs and establishes practical outcome measures for their 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 RELATIONSHIPS AND REPORTING REQUIREMENTS

(Last Updated: September 10, 2012)

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:

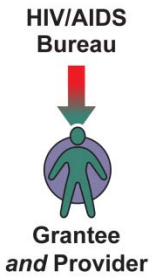
> **Recipients are responsible for managing and monitoring each project, program, subaward, function or activity supported by the award. Recipients shall monitor subawards to ensure that subrecipients have met the audit requirements as set forth in §74.26.**

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.**

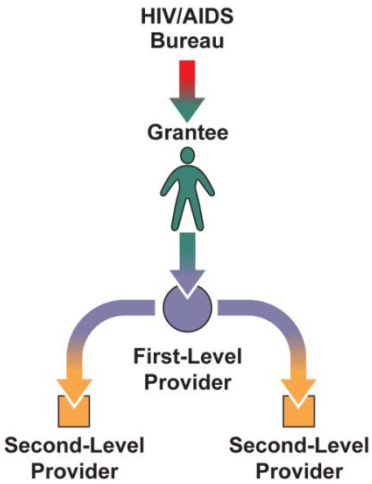
Likewise, HRSA, HHS, and Congress hold HAB responsible for monitoring and reporting the program performance of its grantees and its subgrantees, the RWHAP service providers. HAB has established the following reporting requirements for recipients of RWHAP funds accordingly.

[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.

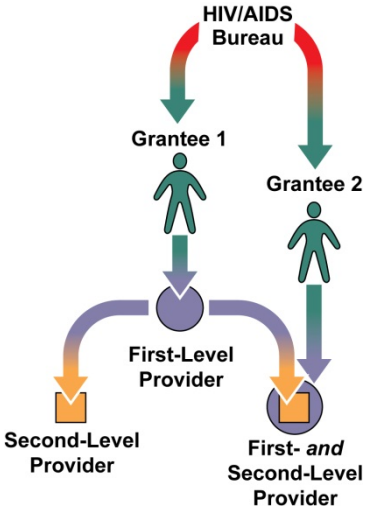


A grantee-provider, a service provider that also is a grantee, must complete a Grantee Report and a Provider Report. A grantee-provider of core medical or support services must also submit a Client Report.

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 and/or support services, upload client-level data. The provider must include client data for ***all*** of its RWHAP contracts.

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., seeing them 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 Ryan White Program 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.

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. You may (1) complete a Provider Report and upload client-level data in the exempted provider's name; (2) report the exempted provider's data with your agency's RSR data; or (3) if the provider is a second-level provider, you may report the exempted provider's data with your RSR, or you may instruct the exempted provider's fiscal intermediary provider (your first-level provider) to report the exempted provider's data with their RSR data.**

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 their grantees agree to the exemption. In other words, exempting a multiply funded provider is an all-or-nothing proposition. If a multiply funded provider is required to submit by any of their grantees, that provider must submit one Provider Report online that includes data for all of the Program Parts under which the provider is funded.

FREQUENTLY ASKED QUESTIONS

about Grantee/Provider Relationships and Reporting Requirements

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?
Remember, the RSR (your annual performance report) is made up of three subreports: the RSR Grantee Report, the RSR Provider Report, and the RSR Client Report (or client-level data). The components you are responsible for depend on the RWHAP funding that you receive and the services that you deliver.

In this case, to complete your RSR you will submit two RSR Grantee Reports, one for your Part C grant and another for your Part D grant. You will also complete one RSR Provider Report that includes data about the Part A, Part C, and Part D–funded services your agency delivered. Finally, you will submit an RSR Client Report that includes one record for each client that received a Part A, Part C, or Part D–funded service visit during the reporting period.

I have several providers that delivered RWHAP-funded services 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 their data. You may complete the provider's RSR Provider Report and upload client-level data into the provider's report or you may report the exempted provider's data with

your agency's RSR data. Alternatively, if the provider is a second-level provider, you may instruct your first-level provider to report the second-level provider's data with their agency's RSR data.

May I ask any other provider to submit an exempted provider's data?
No. If the exempted provider is a first-level provider, HAB expects you to collect and report the exempted provider's data. If the provider is a second-level provider, HAB expects you or your first-level provider to report the exempted provider's data. If you have questions about reporting data for an exempted provider, please contact RWHAP Data Support at 1-888-640-9356.

RYAN WHITE HIV/AIDS PROGRAM SERVICES

(Last Updated: September 10, 2012)

Ryan White HIV/AIDS Program funds are intended to support only the HIV-related needs of clients. All services provided to HIV-positive, HIV-indeterminate, 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 Ryan White HIV/AIDS Program clients who are HIV positive or HIV indeterminate, 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-funded services, keep in mind the following:

1. **Providers that deliver core medical services are required to upload client-level data.**
2. **RWHAP-funded 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 the Ryan White HIV/AIDS Program that provides FDA-approved medications to low-income individuals 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 AIDS Drug Assistance Programs (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-funded services, keep in mind the following:

1. **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.**
2. **Early Intervention Services 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 HIV Counseling and Testing (HC&T) services in the Grantee Report and have their providers check HC&T services in their Provider Reports.**

While HIV counseling and testing (HC&T) activities are an integral part of EIS, HIV-negative individuals 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 individuals 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 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 non-acute 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 a physician's recommendation 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 physician'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 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 infant.

hen reporting RWHAP-funded services, keep in mind the following:

1. **Providers that deliver support services are required to upload client-level data.**
2. **RWHAP-funded support services may not be provided anonymously. *NOTE: This includes outreach services.***
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(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 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 Ryan White HIV/AIDS Program 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 involve 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 individual that 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 individuals 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 the Ryan White HIV/AIDS Program.

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 individuals 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 of Ryan White–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" or "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-funded Outreach services cannot be delivered anonymously. Client-level data must be reported for every individual that 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 are deceased 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) preparation for 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 non-registered 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 Non-medical 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 non-medical) should be reported in the appropriate case management service category—i.e., 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) include 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.

Part C programs are not eligible to provide substance abuse services (residential).

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

The delivery of HIV counseling and testing may include antibody tests, rapid tests, ELISA (Enzyme-Linked Immunosorbent Assay), and Western Blot 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 Early Intervention Services 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.

All HIV counseling and testing activities are reported in the Provider Report as aggregate data. Client-level data are not reported for this service category.

RSR GRANTEE REPORT

(Last Updated: September 10, 2012)

Each grantee of record completes a separate Grantee Report for each RWHAP grant the grantee receive 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 their Part C grant and another for their Part D grant.

General Instructions for Completing the Grantee Report

Step One: Gather your data.

Make sure you have the following resources before you begin your RSR Grantee Report:

- Your username and password for the Electronic Handbooks (EHBs); and
- A list of all your provider contracts that were active at any time during the reporting period. For **each** contract, you will need:
  - The provider's official name and contact information;
  - A contract reference, if applicable;
  - The contract start date and end date;
  - A list of the services you funded in the contract; and
  - The ***total*** amount funded for the contract period.

Step Two: Open the Grantee Report.

(Grantees and Grantee-providers only): 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 via the following:

- "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.
- "Organization" tab, also on the top-left side of the screen. This will take you to a list of all of the organizations with which you are affiliated. Select the "organization folder" link for the organization with an RSR due and find the "Performance Reports" link on the page that comes up.
- "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 on the page that comes up.
- "Items we are tracking for you" section of the EHBs Welcome page. Click the "Task with a deadline" link and locate your annual RSR.
- "My Recently Accessed" section of the EHBs Welcome page. If you have recently worked on the RSR, you will find a link to the report in this list.

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

Find your RSR in your list of deliverables. Click on "Start Report" or "Edit Report." This will bring you into the RSR Web system. You will automatically be under the Provider Report tab in the RSR Inbox.

Once you are in the RSR Web System, go to the "Grantee Report" tab in your inbox and click the envelope icon to access your Grantee Report.

Step Three: Decide if you want to complete the report manually or via an XML upload.

If you want to complete the report manually, follow the instructions listed under **How to Complete the Grantee Report Manually Using the Online Form** on page 17. If you want to complete the report via an XML upload, follow the instructions listed under **How to Complete the Grantee Report by Uploading an XML File** on page 25.

Step Four: Validate and submit your RSR Grantee Report.

Once you are satisfied that 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.

If you need help fixing your errors, contact Data Support at 1-888-640-9356.

Indicate that you have completed data entry for your RSR Grantee Report by clicking "Certify" in the RSR Administration menu (near the upper left-hand corner of the RSR Grantee Report Web pages) and then following the instructions on your screen. 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).

FREQUENTLY ASKED QUESTIONS
about the RSR Grantee Report

I have decided to exempt one of my providers from submitting a Provider Report and client-level data. How do I show that the provider has an exemption on my Grantee Report contracts list?
All providers listed on your contract lists will be required to complete an RSR Provider Report. If a provider has been given an exemption from submitting the RSR Provider Report and client-level data, you may complete the provider's RSR Provider Report and upload client-level data on their behalf via the RSR Web system. Alternatively, you may delete the provider's contract(s) from your contract list. Then you should report the exempted provider's data with your agency's RSR data. If the provider is a second-level provider, instruct the exempted provider's fiscal intermediary provider to report the second-level provider's data with their RSR data.

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.

One of my providers receives both ADAP funds and base funds in a single contract. Do I report the ADAP funds in the total contract amount?
No. In cases like this, the provider must subtract ADAP funds from the total contract amount and report only base funds as the contract amount.

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 their ADAP contractor) on my contract list?
No. Please do not include contracts with the State (or their ADAP contractor) on your contract list. The funding provided by your organization will be reported by the Part B grantee in their ADAP report.

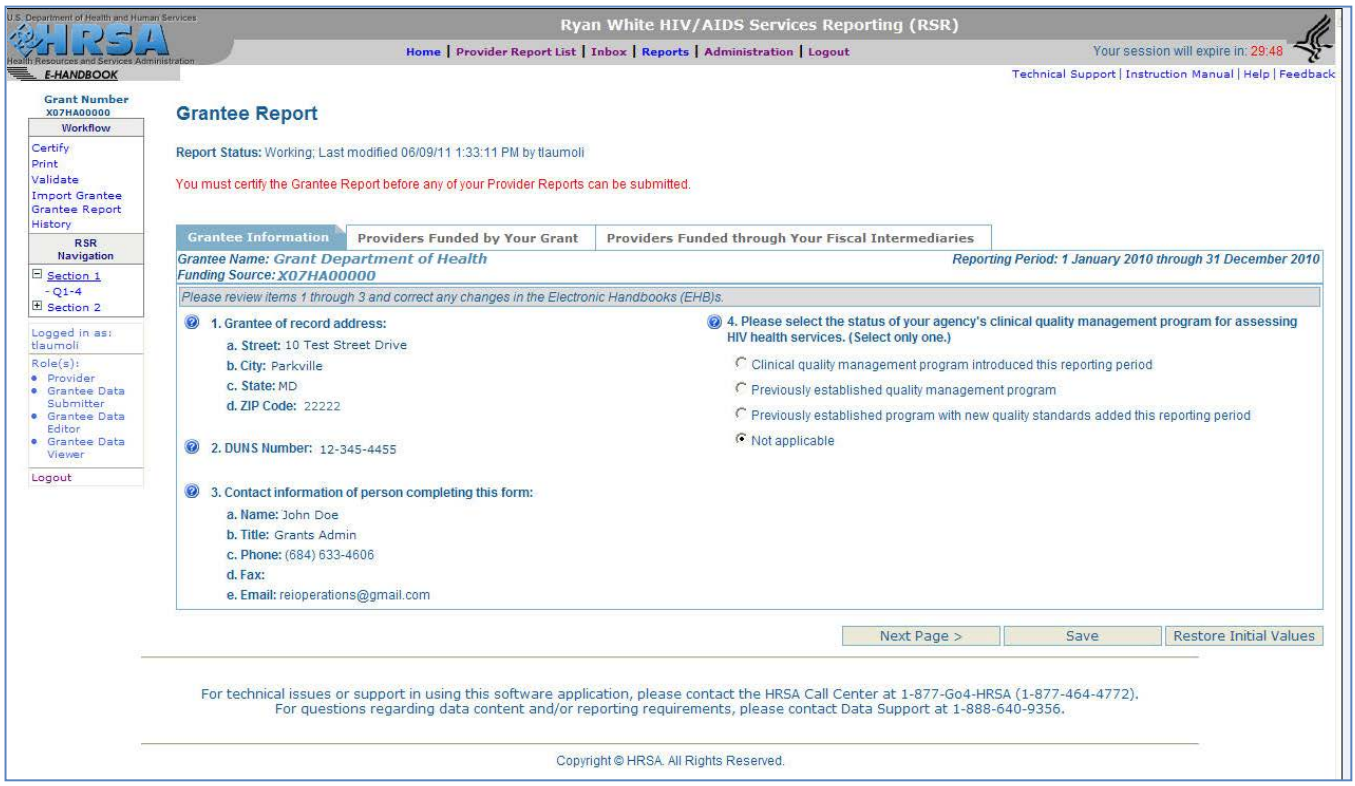
I am a Part A grantee and a Part B fiscal intermediary provider. Do I list provider contracts that are funded exclusively by Part B on my Grantee Report contracts list?
No. Only list the contracts for providers that receive Part A funds on your Grantee Report. The Part B grantee is responsible for entering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

I am a Part C grantee-provider. I also fund two providers. What should I list as the contract amount for the contract I list with my agency?
List the amount you have budgeted to provide services and administer your grant. If you were to add the total amount you award to your providers with the amount of money you use to provide services and administer the grant, that total should match the total amount of your Part C grant for the same contract period. For example, your Part C grant is $80,000. You award $20,000 to one provider and $10,000 to the other provider. You will report $50,000 as the contract amount for your agency.

How to Complete the Grantee Report Manually Using the Online Form

To complete your Grantee Report manually, you must use the online form to respond to each item in the Grantee Information section and set up your contract list(s). To complete your contract lists, you will need a list of all your provider contracts that were active at any time during the reporting period. For each contract, you must have the provider's official name and contact information; a contract reference, if applicable; the contract start date and end date; a list of the services you funded in the contract; and the total amount funded for the contract.

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



Grantee Information

1. Grantee of record address (display only) (Figure 1). This item shows the information on the grantee of record stored in the Electronic Handbooks (EHBs). To edit it, you should update your agency information stored there.
2. DUNS number (display only). This item shows the information on the grantee of record stored in the Electronic Handbooks (EHBs). To edit it, you should update your agency information stored there.
3. Contact information of person completing this form (display only). This item shows the information about the user currently logged into the Grantee Report. This information is stored in the EHBs; to edit it, you should update your user profile information stored there.
4. Select the status of your agency's clinical quality management program for assessing HIV health services (select only one):
   - Clinical quality management program introduced 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 provider 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**.

Once you've updated, entered, and/or verified the data on the Grantee Information page, click on "Next Page" to save the data and advance to the next page, "Providers Funded by Your Grant."

Navigation buttons appear at the bottom of each page of the online forms within the RSR Web System. Use the "Next Page" and "Previous Page" buttons to save any edits you have made in one or more fields and navigate through the report. The "Save" button will save your edits without changing the page. Use the "Restore Initial Values" button to undo any edits you have made since last saving the report.

Provider Contract Lists

To complete the RSR Grantee Report, you must certify a list of your service provider contracts that were active during the reporting period. You will need a list of all of your contracts funded during the reporting period to update your contract lists. For the purpose of the RSR, contracts include formal contracts, memoranda of understanding, or other agreements. A service provider contract that was active during the reporting period is a contract under which either of the following happened:

- Services were delivered by the service provider during the reporting period; or
- Any portion of the contract period fell within the reporting period.

All contracts with first-level providers should be listed on the "Providers Funded by Your Grant" contract list. All contracts with second-level providers should be listed on the "Providers Funded Through Your Fiscal Intermediaries" contract list.

Contracts listed in the Grantee Report should match the actual agreements you have in place with your providers. When completing the contract list, grantees should do the following:

- List all contracts active during the reporting period. **NOTE**: If your annual budget period (or contract period) does not align with the calendar year (i.e., the RSR reporting period), you need to list more than one contract with the same provider to cover the entire reporting period. For example, grantee A has a contract with Health & Happiness Clinic to provide services to Ryan White clients. Their contracts are based on their organization's fiscal year (April 1 to March 31). In this case, grantee A will list two contracts with Health & Happiness Clinic on their Grantee Report: the first for April 1, 2011, to March 31, 2012; and the second for April 1, 2012, to March 31, 2013.

Provider Name	Contract Reference	Contract Start Date	Contract End Date	Contact Amount	Services
Health & Happiness Clinic	Contract 1	04/01/2011	3/31/2012	$809,216	Services
Health & Happiness Clinic	Contract 2	04/01/2012	3/31/2013	$812,989	Services

- Enter the actual start date and end date for each contract. Keep in mind that the contract period may begin before and/or extend beyond the reporting dates.
- List a contract with your own agency if you provide Administrative and technical services, Core medical services, Support services, or HIV counseling and testing services. (You are considered a first-level provider to yourself.)
- Select all of the provider's contracted services, even if the provider did not deliver the service during the reporting period. You must select at least one service per contract. Keep in mind, however, that grantees cannot provide fiscal intermediary services to themselves.
- Enter the total award amount for each contract. You should not prorate or annualize the amount reported.

- Only list providers that receive funding through your grant on your contract lists. If your agency is a fiscal intermediary services provider or administrative agent to another grantee, you will not list that grantee's providers on your contract list unless those providers also receive funding from your grant.

  For example, you are a Part A grantee and a Part B fiscal intermediary provider. You are responsible for the oversight of three other Ryan White providers. Healthcare Foundation receives only Part B funding through your agency. University Medical Clinic only receives Part A funding. Regional Hospital Infectious Disease Clinic receives both Part A and Part B funding. When you complete your Part A Grantee Report, you will only list the providers that receive Part A funding, University Medical Clinic and Regional Hospital Infectious Disease Clinic, on your contract list. The Part B grantee is responsible for reporting Healthcare Foundation's contract information in their Grantee Report.

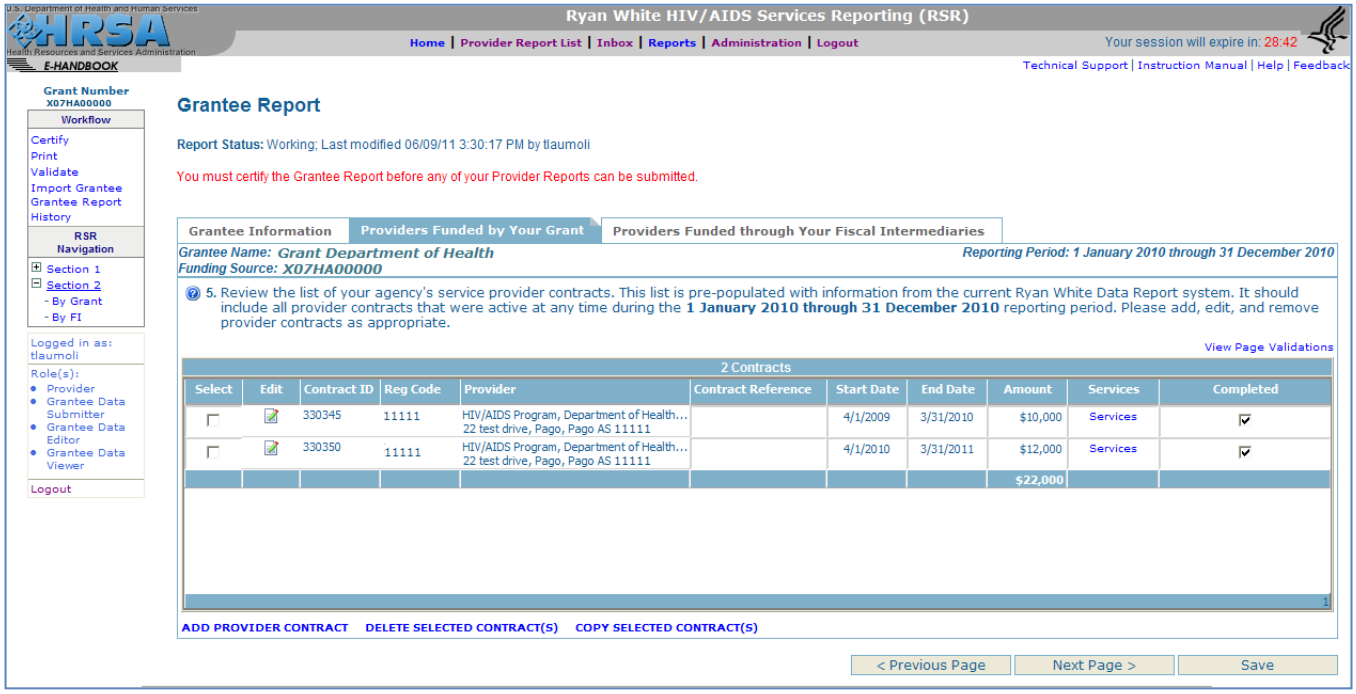
If you need help setting up your contract lists, contact Data Support at 1-888-640-9356 from 9 a.m. to 5 p.m., Monday–Friday ET.

"Providers Funded by Your Grant"

Review the list of service provider contracts. Revise the list as needed so that all of the contracts that were active during the reporting period are shown.

If a contract is missing from the list, add the new provider contract using the ADD PROVIDER CONTRACT link beneath the table on the left side of the screen (Figure 2). This link will open a second window with a search form you can use to locate and select a provider in the RWHAP provider directory.

Figure 2. RSR Grantee Report Online Form: Screenshot of the "Providers Funded by Your Grant" Section



If you cannot find your provider, try expanding your search by using fewer search criteria. For example, only search by State, registration code, Org ID, or a key word in the provider's name. You can remove this search criterion by picking "Select" in the "State" field. If the service provider you have contracted with is not listed in the RSR provider directory, e-mail the provider's name, address, and Federal Employee Identification Number (EIN) to Ryan White Data Support at

RyanWhiteDataSupport.wrma@csrincorporated.com. Data Support will add your provider to the directory and e-mail your provider's registration code to you.

> **If the provider already has a contract on your list but you need to add another, select the box next to the provider's contract in your list and use the COPY SELECTED CONTRACT(s) link. A copy of the selected contract will be added to your list. The provider and the services will be copied; however, you must enter the contract dates and amounts to complete the entry.**

To remove a provider contract, check the box next to the provider's name in your contract list and select the DELETE SELECTED CONTRACT(s) link.

After reviewing and updating your provider contract list, verify the contact information for each of your providers. To edit a provider's address, click on the Edit icon ( ) to open another window.

Next, verify each provider's contract information by reviewing the following information:

- **Contract Reference** (optional): You may want to use this if you have multiple contracts with one of your providers under a single grant. You can assign a contract reference number (or name) for each to make it easier for you and your provider to identify each contract.
- **Contract Start and End Date**: Enter the actual (annual budget period) contract dates. Keep in mind that the contract period may begin before and/or extend beyond the reporting period dates. To edit these fields, place your cursor over the desired field in the table and click your left mouse button. You can then type the contract dates directly in the table OR use the calendar feature to select the desired date.
- **Contract Amount**: Enter the total amount of funding allocated for the selected contract. To edit this field, place your cursor over the field in the table and click your left mouse button. You can then type the contract amount directly in the table.
- **Contract Services**: For each contract, select the services the provider was funded to provide. Select the "Services" link to open a new window (Figure 3) where you can select the services the agency has been contracted to provide under this agreement. The service categories are defined in the section beginning on page 6 of this manual. After saving the information you enter on the Services page, close the window to return to "Providers Funded by Your Grant."

> **Part A and B grantees that fund Early Identification of Individuals with HIV/AIDS (EIIHA) activities should select all of the services their providers need to report based on their EIIHA activities, such as HIV counseling and testing services, outreach, or EIS for Parts A and B. Remember, providers may report their EIIHA activities under any service category for which the definition best describes the service provided.**
>
> **Be sure that your providers know which services they were funded to deliver during the reporting period. They will not be allowed to report visits in service categories that you did not check as funded.**

Figure 3. RSR Grantee Report Online Form: Screenshot of the Ryan White HIV/AIDS Program Services List

Save

Close Window and Return to Contracts Page

Select the services this agency was funded to provide under this agreement. (Check all that apply.)

ADMINISTRATIVE SERVICES

Funded	Service
☐	Planning or evaluation
☐	Administrative or technical support
☑	Fiscal intermediary support
☐	Other fiscal services
☐	Technical assistance
☐	Capacity development
☐	Quality management

CORE MEDICAL SERVICES

Funded	Service ▲
☐	Early intervention services (Parts A and B)
☐	Health Insurance Premium & Cost Sharing Assistance
☐	Home and community-based health services
☐	Home health care
☐	Hospice services
☐	Local AIDS Pharmaceutical Assistance
☐	Medical case management (including treatment adherence)
☐	Medical nutrition therapy
☐	Mental health services
☐	Oral health care
☑	Outpatient/ambulatory medical care
☐	Substance abuse services-outpatient

SUPPORT SERVICES

Funded	Service
☐	Case management (non-medical)
☐	Child care services
☐	Pediatric development assessment/early intervention services
☐	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 for health care/supportive services
☐	Rehabilitation services
☐	Respite care
☐	Substance abuse services-residential
☐	Treatment adherence counseling

HIV COUNSELING AND TESTING SERVICES

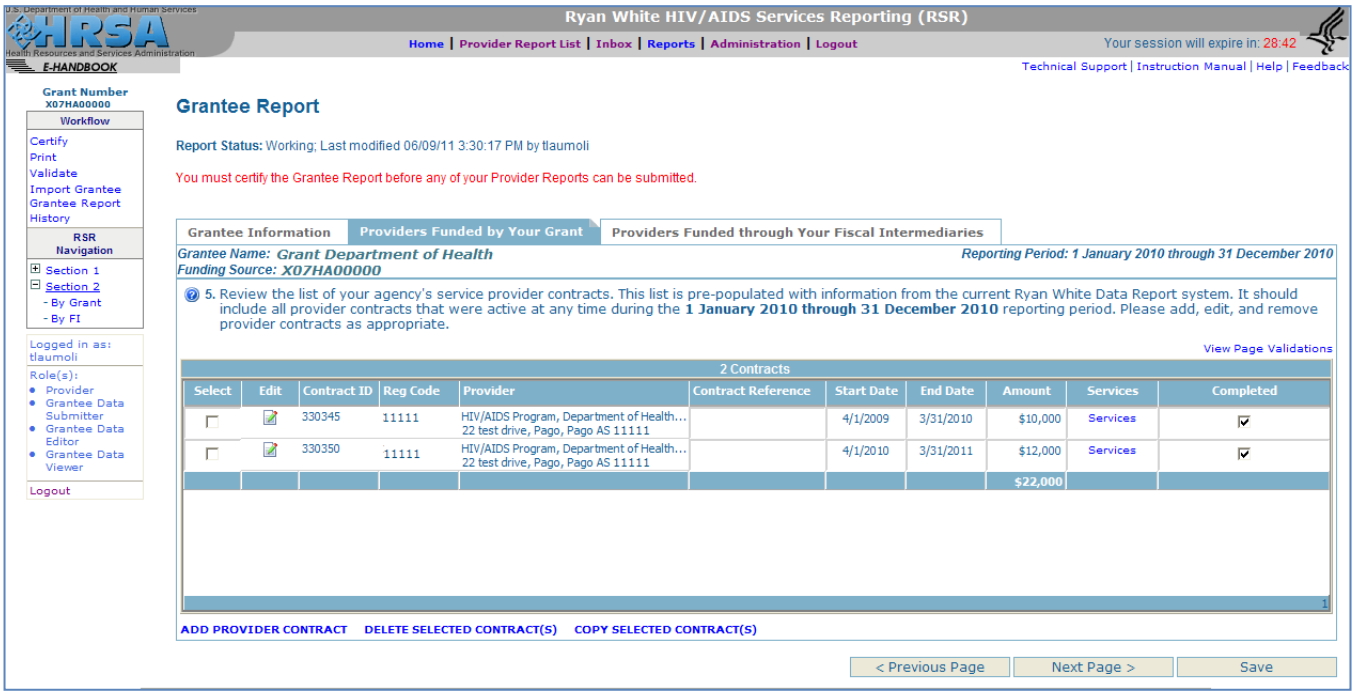
Funded	Service
☐	HIV Counseling and Testing

Save | Restore Initial Values

Close Window and Return to Contracts Page

After reviewing and, if necessary, updating the information for each contract, check the box in the "Completed" column (Figure 4). The use of the "completed" check box is optional. However, if you have a lot of provider contracts, you may find this feature helpful in marking your progress, especially if several work sessions are used to complete your RSR Grantee Report.

Figure 4. RSR Grantee Report Online Form: Screenshot of the "Providers Funded by Your Grant" Section



Once you have entered all of your first-level provider contracts, click on "Next Page" to save the data and advance to the final page, which is the "Providers Funded Through Your Fiscal Intermediaries" contract list.

"Providers Funded Through Your Fiscal Intermediaries"

This contract list is only completed by grantees that use the services of an administrative agent or fiscal intermediary provider. Please be sure to collect the required contract data for your second-level providers from your Fiscal intermediary or administrative agent before you begin.

When applicable, a list of fiscal intermediary services contracts is shown in the box under the instructions for Item 6. If you fund fiscal intermediary providers and a contract is missing, you must revise your list of contracts on the "Providers Funded Through Your Grant" contract list. When you select a fiscal intermediary services contract in the list box, a list of second-level provider contracts—contracts indirectly funded by your grant through the selected FI contract—will be displayed in the table below the list box.

If a second-level provider's contract is missing from the list, add the new provider contract using the ADD PROVIDER CONTRACT link beneath the table on the left side of the screen (Figure 5). This link will open a second window with a search form you can use to locate and select a provider in the RWHAP provider directory.

If you cannot find your second-level provider in the RWHAP provider directory, try expanding your search by using fewer search criteria. For example, only search by State, registration code, Org ID, or a key word in the provider's name. You can remove this search criterion by picking "Select" in the "State" field. If the service provider you have contracted with is not listed in the RSR provider directory, e-mail the provider's

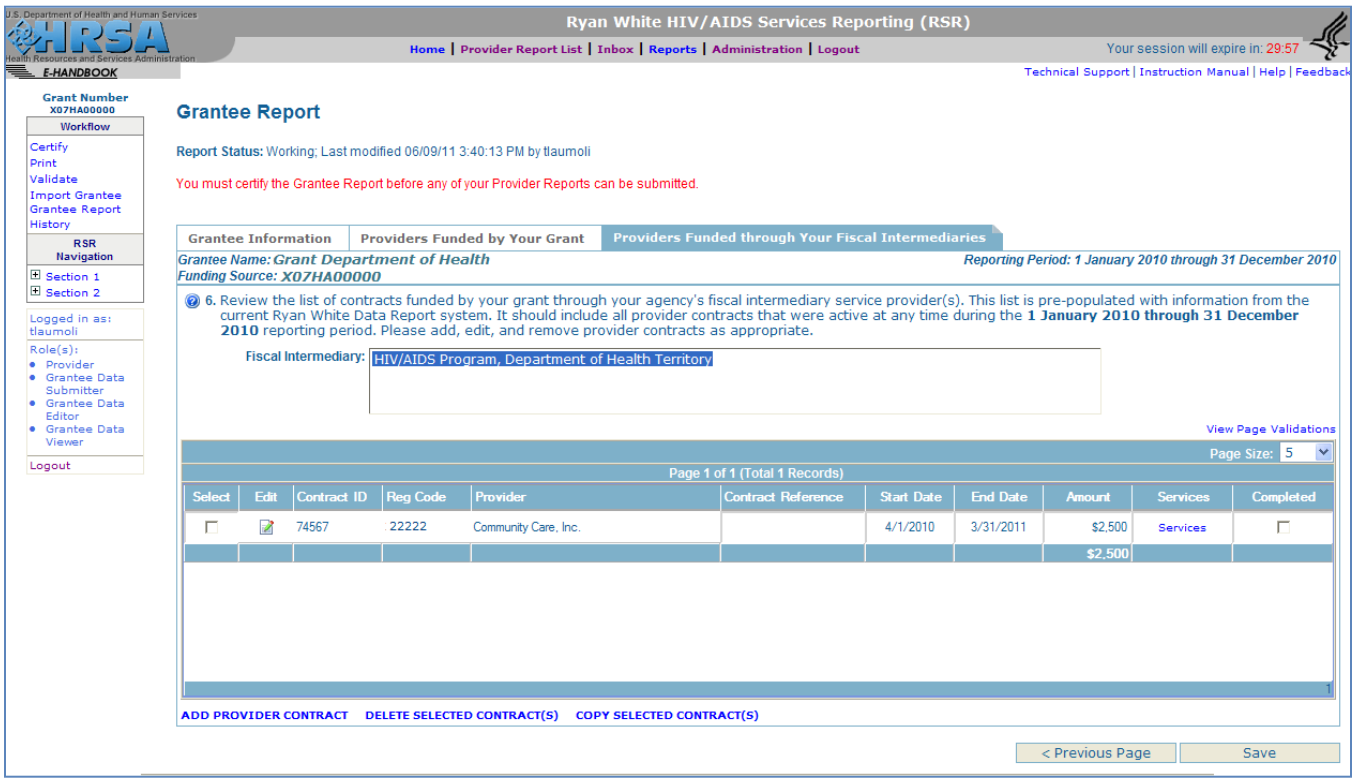
name and address to Ryan White Data Support at **RyanWhiteDataSupport.wrma@csrincorporated.com.** Data Support will add your provider to the directory and e-mail your provider's registration code to you.

> **If your second-level provider already has a contract on your list but you need to add another, select the box next to the provider's contract in your list and use the COPY SELECTED CONTRACT(s) link. A copy of the selected contracts will be added to your list. The provider and the services will be copied; however, you must enter the contract dates and amounts to complete the entry.**

To remove a second-level provider contract, check the box next to the provider's name in your contract list and select the DELETE SELECTED CONTRACT(s) link.

After reviewing and updating your list of second-level provider contracts, verify the contact information for your providers. To edit a provider's address, click on the Edit icon to open another browser window.

Figure 5. RSR Grantee Report Online Form: Screenshot of the "Providers Funded Through Your Fiscal Intermediaries" Section



Next, verify the contract information for your second-level providers by reviewing the data in the following fields.

- **Contract Reference** (optional): You may want to use this if you have multiple contracts with one of your providers under a single grant. You can assign a contract reference number (or name) for each to make it easier for you and your provider to identify a particular contract.
- **Contract Start and End Date**: Enter the actual (annual budget period) contract dates. Keep in mind that the contract budget period may begin before and/or extend beyond the reporting period dates. To edit these fields, place your cursor over the desired field in the table and click your left mouse button. You can then type the contract dates directly in the table OR use the calendar feature to select the desired date.

- **Contract Amount**: Enter the total amount of funding allocated for the selected contract. To edit this field, place your cursor over the field in the table and click your left mouse button. You can then type the contract amount directly in the table.

> **Be careful when you enter your contract amounts. The amount used and distributed by your fiscal intermediary provider cannot exceed the amount you awarded to them. For example, Part B grantee State of Euphoria uses Big County as a fiscal intermediary provider. It gives Big County $1.02 million: $20,000 to administer the Part B funds and $1 million to distribute to providers in Big County's region. Big County awards $250,000 each to 5 providers in their service area. If you report this information, it will trigger a validation error! You cannot report that Big County awarded $1.25 million ($250,000 × 5) when you only gave this provider $1.02 million.**

- **Contract Services**: For each contract, grantees are required to specify the services the provider is funded to deliver. Select the "Services" link to open a new window (Figure 3) where you can select the services the agency has been contracted to provide under this agreement. (The service categories are defined in the **Ryan White HIV/AIDS Program Services** section on page 6 of this manual.) After saving the information you enter on the Services page, close the window to return to the "Providers Funded Through Your Fiscal Intermediaries" page.

After reviewing and updating (if necessary) all information for each contract, check the box in the "Completed" column (Figure 4). The use of the "completed" check box is optional. However, if you have a lot of provider contracts, you may find this feature helpful in marking your progress, especially if several work sessions are used to complete your RSR Grantee Report.

Click on "Save" to save the data in the Grantee Report and go on to your next Fiscal Intermediary services contract.

How to Complete the Grantee Report by Uploading an XML File

Grantees have the option of importing an XML Grantee Report file into the RSR Web System as an alternative to manually entering the data in the report. To upload the Grantee Report XML File, click on "Import Grantee" in the RSR Workflow menu (near the upper left-hand corner of the page) to open another window, then follow the on-screen instructions.

After you upload your Grantee Report XML file, be sure to review the data in the RSR Web System for accuracy, paying special attention to the data reported in your contract list(s).

If there are errors in the report, you may correct the errors manually using the online form. Alternatively, you may upload a revised Grantee Report XML file. However, after the initial Grantee Report XML file upload, all subsequent file uploads will overwrite the existing data in the RSR Web System.

RSR SERVICE PROVIDER REPORT

(Last Updated: September 10, 2012)

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 their RWHAP contracts. Providers may key in their data manually using the online form or may upload an XML file of the Provider Report into the RSR Web System.

All agencies that provide RWHAP-funded services must complete one Provider Report online on the RSR Web-based System. Multiply funded providers will include information from all Program Parts under which the agency is funded in one Provider Report.

HAB expects all service providers to complete their own Provider Reports. Grantees may not complete a provider's report unless the provider is exempted from completing the Provider Report. A full explanation of exempting providers can be found in the section **Grantee/Provider Relationships and Reporting Requirements** on page 2.

General Instructions for Completing the Provider Report

Step One: Gather your data.

Make sure you have the following resources before you begin your RSR Provider Report:

- Your system username and password.
- A list of all your RWHAP contracts that were active at any time during the reporting period. For each contract, you will need:
  - Your grantee's official name;
  - Your contract references, if applicable;
  - The contract start date and end date;
  - A list of the services you provided under the contract; and
  - The ***total*** amount funded for the contract period.
- If your organization provides Oral health care services with RWHAP Part A, Part B, Part C, or Part D funds, ***not*** Dental Reimbursement Program (DRP) or Community-Based Dental Partnership Program (CBDPP) funds, you must know the total amount spent providing those services during the reporting period (January 1 to December 31).
- If your organization uses Ryan White HIV/AIDS Program funds to provide HIV Counseling and Testing Services, you will need to the following information to complete the HIV Counseling and Testing section:
  - The total number of individuals that your agency tested for HIV during the reporting period regardless of funds used to provide the service.
  - The number of individuals who tested NEGATIVE for HIV during the reporting period.
  - The number of individuals who tested NEGATIVE and received posttest counseling.
  - The number of individuals who tested POSITIVE for HIV during the reporting period.

  - The number of individuals who tested POSITIVE and received posttest counseling.
  - The number of individuals who tested POSITIVE and were referred to HIV medical care.
- Your client-level data XML file, if applicable.

Step Two: Open the Provider Report.

Grantee-providers: If you are a grantee-provider, you must access the RSR Web system via the Electronic Handbooks (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:

- "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.
- "Organization" tab, also on the top-left side of the screen. This will take you to a list of all of the organizations with which you are affiliated. Select the "organization folder" link for the organization with an RSR due and find the "Performance Reports" link on the page that comes up.
- "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 on the page that comes up.
- "Items we are tracking for you" section of the EHBs Welcome page. Click the "Task with a deadline" link and locate your annual RSR.
- "My Recently Accessed" section of the EHBs Welcome page. If you have recently worked on the RSR, you will find a link to the report in this list.

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

Find your RSR report in your list of deliverables. Click on "Start Report" or "Edit Report." This will bring you into the RSR Web system. You will automatically be under the Provider Report tab in the RSR Inbox.

Use the envelope icon to open the Provider Report that you want to work on.

Providers: To access the RSR system, go to **https://performance.hrsa.gov/hab/RegLoginApp/Admin/Login.aspx**. Enter your username and password, and click "login." 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 re-register in the system. If you are a new RSR system user, then you will need to get 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, contact the HRSA Contact Center at 1-877-464-4772.

Step Three: Decide if you want to complete the report manually or via an XML upload.

If you want to complete the report manually, follow the instructions listed under **How to Complete the Provider Report Manually using the Online Form** beginning on page 30. If you want to complete the report

via an XML upload, follow the instructions listed under **How to Complete the Provider Report via XML File Upload** beginning on page 39.

Step Four: 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 the **Importing the Client-level Data XML File** on page 68.

Agencies that do not provide RWHAP-funded core medical or support services directly to RWHAP clients WILL NOT submit client-level data (go to Step Five).

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

Validate your Service Provider Report by clicking "validate" under the RSR Administration heading from the menu on the left.

When you validate your Provider Report, the data reported in your Client Report are also validated.

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 Provider Report may be fixed manually using the online form. 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, you should 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 you need to upload a new client-level data file to fix an error, be sure to check the "Clear clients" box when you upload your revised data to clear all of your old data. If you do not, your new data will be merged with your old data. Remember, when you select the clear clients check box in the RSR system, you are only clearing the client-level data that you uploaded before. If someone else also uploaded data into your RSR Provider Report, their data will remain in the report. To clear **all** of the client-level data in your Provider Report, contact the HRSA Contact Center at 1-877-464-4772.

If your validation report contains warnings, you can submit your Provider Report. However, you should first try to fix all the warnings. Keep in mind that some warnings should not be corrected. For example, if your grantee funded a service that you did not provide (e.g., none of your clients needed the service) please insert a comment explaining the service was available but not used during the reporting period. To submit your Service Provider Report with warnings, you must write a comment for all of the warnings that cannot or should not be fixed by clicking the "Add Warning Comments" link at the top of the validation report window. You must enter a response for every "group" of warning comments and select the "Add Comments" button at the bottom center of the validation comments Web page to save your comments.

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.

You should carefully review all of your data validation warnings and alerts because, in general, RSR validation alerts will progress to warnings and warnings will progress to errors in future reporting periods. A limited number of alerts and warnings, however, will always be an alert or warning. If you have questions about a specific data validation check, contact Data Support at 1-888-640-9356.

Step Six: Submit your data.

When you are satisfied that your report is complete, submit the Provider and Client Reports by clicking on "Submit" in the RSR Administration menu and following the instructions on your screen.

Depending on the grantees that fund your agency, 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, accept, and submit 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 or the HRSA Contact Center at 1-877-464-4772.

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.

Our organization is very large, receives funding from multiple Ryan White Program Parts, and provides services through several different departments. Each department acts as an independent entity and keeps separate client records. Combining the data into a single Provider and Client Report would be burdensome. Are there any alternatives to submitting a single Provider Report?
A single agency (or organization) that wishes to submit more than one Provider Report must first obtain permission from HAB and, if applicable, their grantee. HAB will allow a single agency to submit as if it is more than one provider if the agency can provide evidence of a sufficient degree of independence between the programs they administer. For example:

- The programs have their own staffs (medical and administrative) as well as their own management/organizational structures.
- The programs have established their own operating procedures.
- The programs have separate facilities (e.g., they do not share office and/or clinic space).
- The programs have their own operating budgets.
- The programs do not share supplies or other resources.
- The programs have completely separate systems (i.e., IT networks, EMR, accounting, etc.).

HAB will consider these and other factors, such as reporting burden, when determining if a single agency will be permitted to submit multiple Provider Reports. Grantees are encouraged to contact Data Support to discuss the possibility of reporting as more than one service provider.

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.

What about providers that 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? Are they required to submit a Provider Report and client data?
If a provider meets the exemption requirements outlined the section **Grantee/Provider Relationships and Reporting Requirements** on page 3, the grantee may exempt a provider from reporting their own

data. However, the grantee then assumes the responsibility of reporting the exempted provider's data. In this situation, you may (1) complete a Provider Report and upload client-level data in the exempted provider's name; (2) report the exempted provider's data with your agency's RSR data; or (3) if the provider is a second-level provider, you may instruct the exempted provider's fiscal intermediary provider to report the exempted provider's data with their RSR data.

Do second-level providers have to submit Provider Reports?
Yes, both first- and second-level providers need to complete Provider Reports. First-level providers will see the name of their grantee in their contracts list (Item 8 of the Provider Report). 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.

What if a provider receiving funding from multiple Program Parts is given an exemption from reporting by one grantee but not another?
A provider cannot be given an exemption without the consent of all of their grantees. It is an "all-or-nothing" activity. If the provider is required to submit an RSR by any of their grantees, then the service provider must submit data for ***all*** of the RWHAP Parts under which the provider is funded.

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 they do not need to submit their data until HAB's recommended submission deadline. I really need my provider to submit their 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. Remember, Part C and Part D providers typically have more data to prepare, and HAB expects them to submit all of their data at one time.

Should providers report everyone they tested for HIV during the reporting period, regardless of where the test occurred or which funds are used to pay for the test kits?
Yes. If the provider uses RWHAP funding to conduct HIV counseling and testing activities, then the provider must report data for all of their HIV counseling and testing activities. It does not matter where the test occurred (e.g., a mobile testing unit) or what funds were used to pay for the test kits (e.g., CDC funds). The provider must report everyone they tested during the reporting period in their Provider Report.

We use our RWHAP grant to fund only the salaries of the individuals who provide HIV counseling and testing services. The test kits are funded through another program. Do I still complete the HIV counseling and testing section?
Yes, you must complete the HIV counseling and testing section.

How to Complete the Provider Report Manually Using the Online Form

To complete the form manually, respond to each item as applicable using the online form.

Provider Information

1. **Provider Address** (display only) (Figure 6). Check your address for accuracy. If the data are correct, go to the next item. If the data are incorrect, update your agency profile in the RSR system. If you are a

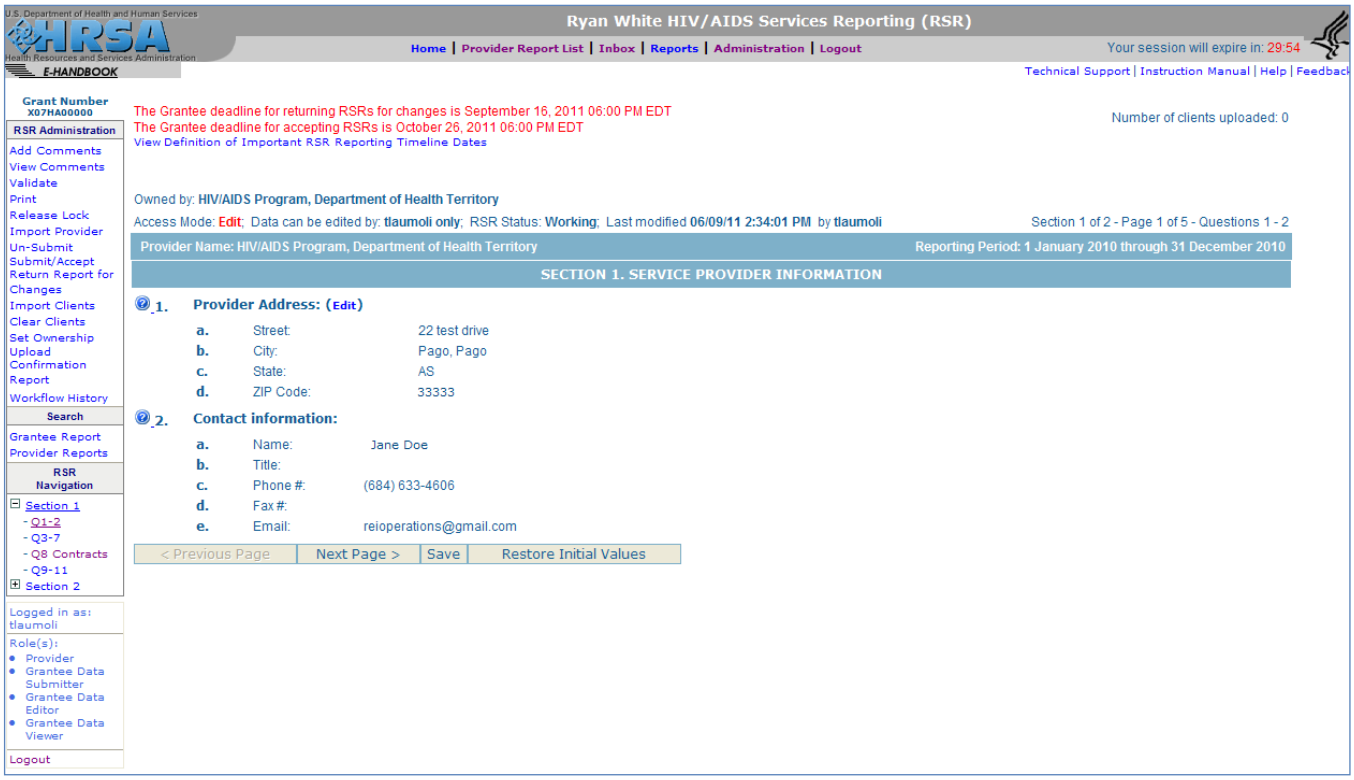
grantee-provider, update your agency profile in both the EHBs and the RSR Web System. You may update the profile at any time during the year.

2. **Contact information of person completing this form** (display only). Check the data for accuracy. If the data are correct, go to Item 3, Provider Type. To edit this item, update your user profile in the RSR system. If you are a grantee-provider, update your user profile in both the EHBs and RSR system. The contact information for RSR system and EHBs users may be updated at any time during the year.

   The contact information in Item 2 will change until the Provider Report is submitted. Initially, it will show the name of the person with data entry rights. For reports in "Review" or "Submitted" status, this item will show the name of the last person to save changes to the report.

> ***Grantees:*** **Your providers must complete or revise and then submit the report to "Review" status if you want your provider's contact information to appear in this item.**

Figure 6. RSR Provider Report Online Form: Screenshot of Provider Information Section (Questions 1–2)



3. **Provider Type** (select only one): Select the provider type that best describes your agency (Figure 7).
   - 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 (CBO) includes non-hospital-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).
- PLWHA coalition includes organizations of People Living with HIV/AIDS (PLWHA) 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.

4. **Did your organization receive funding under Section 330 of the Public Health Service Act (PHSA)** (funds Community Health Centers, Migrant Health Centers, and Healthcare for the Homeless)? Section 330 of the 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 (yes, no, unknown) if you received such funding during the reporting period.

5. **Ownership Status**

   a. Type of ownership (select only one): Select the category that best describes your agency's ownership status:
      - 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.

   b. For private, nonprofit organizations only: Is your organization faith based? If you selected "private, nonprofit," indicate if your agency received funding as a faith-based organization (i.e., one operated by a religiously affiliated entity, such as a Catholic hospital).

Figure 7. RSR Provider Report Online Form: Screenshot of Provider Information Section (Questions 3–7)

U.S. Department of Health and Human Services
HRSA Health Resources and Services Administration
E-HANDBOOK

Ryan White HIV/AIDS Services Reporting (RSR)

Home | Provider Report List | Inbox | Reports | Administration | Logout

Your session will expire in: 17:28

Technical Support | Instruction Manual | Help | Feedback

Grant Number X07HA00000

RSR Administration
Add Comments
View Comments
Validate
Print
Release Lock
Import Provider
Un-Submit
Submit/Accept
Return Report for Changes
Import Clients
Clear Clients
Set Ownership
Upload Confirmation Report
Workflow History

Search
Grantee Report
Provider Reports

RSR Navigation
Section 1
- Q1-2
- Q3-7
- Q8 Contracts
- Q9-11
Section 2

Logged in as: tlaumoli
Role(s):
- Provider
- Grantee Data Submitter
- Grantee Data Editor
- Grantee Data Viewer

Logout

The Grantee deadline for returning RSRs for changes is September 16, 2011 06:00 PM EDT
The Grantee deadline for accepting RSRs is October 26, 2011 06:00 PM EDT
View Definition of Important RSR Reporting Timeline Dates

Number of clients uploaded: 0

Owned by: HIV/AIDS Program, Department of Health Territory
Access Mode: Edit; Data can be edited by: tlaumoli only; RSR Status: Working; Last modified 06/09/11 2:34:01 PM by tlaumoli

Section 1 of 2 - Page 2 of 5 - Questions 3 - 7

Provider Name: HIV/AIDS Program, Department of Health Territory
Reporting Period: 1 January 2010 through 31 December 2010

SECTION 1. SERVICE PROVIDER INFORMATION (Continued)

3. **Provider type:**
- (•) Hospital or university-based clinic
- ( ) Publicly funded community health center *(go to Item 4)*
- ( ) Publicly funded community mental health center
- ( ) Other community-based service organization (CBO)
- ( ) Health Department
- ( ) Substance abuse treatment center
- ( ) Solo/group private medical practice
- ( ) Agency reporting for multiple fee-for-service providers
- ( ) PLWHA coalition
- ( ) VA facility
- ( ) Other provider type (Specify: [ ])

4. **During this reporting period, did your organization receive funding under Section 330 of the Public Health Service Act (funds community Health Centers, Migrant Health Centers, and Health Care for the Homeless)?** (Clear my answer)
- ( ) Yes ( ) No ( ) Unknown

5. **Ownership status:**

a. Type of ownership:
- (•) Public/local
- ( ) Public/state
- ( ) Public/federal
- ( ) Private, nonprofit *(go to Item 5b)*
- ( ) Private, for-profit
- ( ) Unincorporated
- ( ) Other (Specify: [ ])

b. For private, nonprofit organizations only: is your organization faith-based? (Clear my answer)
- ( ) Yes ( ) No

6. **During this reporting period, did your organization receive Minority AIDS Initiative (MAI) funds?**
- ( ) Yes (•) No ( ) Unknown

7. **Enter the amount of Part A, B, C, or D funds that were expended on oral health care during this reporting period** *(rounded to the nearest dollar):*
$ [ ]

< Previous Page | Next Page > | Save | Restore Initial Values

6. **During this reporting period, did your organization receive Minority AIDS Initiative (MAI) funds?** Indicate (yes, no, unknown) whether your organization received MAI funds during the given period.

7. **Enter the amount of RWHAP Part A, B, C, or D funds expended on oral health care during the reporting period.** Do not include Dental Reimbursement Program (DRP) or Community-Based Dental Partnership Program (CBDPP) funds.

8. **Please indicate if your organization expended Ryan White HIV/AIDS Program funds to provide services under each of the contracts listed** (Figure 8).

Figure 8. RSR Provider Report Online Form: Screenshot of the Provider Information Section (Question 8)

U.S. Department of Health and Human Services
HRSA Health Resources and Services Administration
E-HANDBOOK

Ryan White HIV/AIDS Services Reporting (RSR)

Home | Provider Report List | Inbox | Reports | Administration | Logout

Your session will expire in: 29:58

Technical Support | Instruction Manual | Help | Feedbac

Grant Number X07HA00000

RSR Administration
Add Comments
View Comments
Validate
Print
Release Lock
Import Provider
Un-Submit
Submit/Accept
Return Report for Changes
Import Clients
Clear Clients
Set Ownership
Upload Confirmation Report
Workflow History

Search
Grantee Report
Provider Reports

RSR Navigation
Section 1
- Q1-2
- Q3-7
- Q8 Contracts
- Q9-11
Section 2

Logged in as: tlaumoli
Role(s):
- Provider
- Grantee Data Submitter
- Grantee Data Editor
- Grantee Data Viewer

Logout

The Grantee deadline for returning RSRs for changes is September 16, 2011 06:00 PM EDT
The Grantee deadline for accepting RSRs is October 26, 2011 06:00 PM EDT
View Definition of Important RSR Reporting Timeline Dates

Number of clients uploaded: 0

Owned by: HIV/AIDS Program, Department of Health Territory
Access Mode: Edit; Data can be edited by: tlaumoli only; RSR Status: Working; Last modified 06/09/11 2:55:12 PM by tlaumoli

Section 1 of 2 - Page 3 of 5 - Question 8

Provider Name: HIV/AIDS Program, Department of Health Territory
Reporting Period: 1 January 2010 through 31 December 2010

SECTION 1. SERVICE PROVIDER INFORMATION (Continued)

8. Please indicate if your organization expended Ryan White HIV/AIDS Program funds to provide services funded by the grantees listed below by selecting the "Services" link for each contract.

Contract ID	Grantee Name	Funding Source	Grant Number	Contract Reference	Start Date	End Date	Services	Amount Funded
330345	HIV/AIDS Program, Department of Health	Part B	X07HA00000		04/01/2009	03/31/2010	Services (2)	$ 10,000
330350	HIV/AIDS Program, Department of Health	Part B	X07HA00000		04/01/2010	03/31/2011	Services (3)	$ 12,000
							Total Funded:	$22,000

To view the crosswalk of services Funded, Delivered and Uploaded grouped by Contract, click here .
To view the crosswalk of services Funded, Delivered and Uploaded grouped by Service, click here .

*: Fiscal Intermediary service has been selected.

NOTE: If your agency indicates that it only provides administrative and technical services under all contracts, *STOP HERE* . You are not required to complete the remainder of this report. You are *NOT* required to submit client data records.

< Previous Page | Next Page > | Save | Restore Initial Values

Grantee/Contract Information

The list of grantees/contracts is prepopulated with information already provided by your grantees in their Grantee Reports. If a contract is missing from this list, ask your grantee to add the missing contract to their Grantee Report. Likewise, if a contract is listed that you do not have, contact the grantee shown and ask them to delete the contract from their Grantee Report.

If you require assistance contacting a grantee to ask about making changes to their Grantee Report, contact Data Support at 1-888-640-9356 from 9 a.m. to 5 p.m., Monday–Friday ET.

Contract Reference

A contract reference is an optional data field in your grantee's Grantee Report. A contract reference will only appear if your grantee designates a contract reference number or name. Frequently, grantees use this field to help you identify the contract you have with their agency as you complete your Provider Report.

Services

For each of the contracts listed in Item 8, click on the "Services" link to open a new window to indicate the services your agency delivered with RWHAP funds during the reporting period. The window shows all RWHAP services in each of the four categories Administrative and Technical, Core Medical, Support, and HIV Counseling & Testing (see Figure 9 for an example).

Figure 9. RSR Provider Report Online Form: Screenshot of the Ryan White HIV/AIDS Program Services List

Save

Close Window and Return to Contracts Page

Select the services this agency delivererd under this agreement. (Check all that apply.)

ADMINISTRATIVE SERVICES

Funded	Delivered	Service
☐	☐	Planning or evaluation
☐	☐	Administrative or technical support
☐	☐	Fiscal intermediary support
☐	☐	Other fiscal services
☐	☐	Technical assistance
☐	☐	Capacity development
☐	☐	Quality management

CORE MEDICAL SERVICES

Funded	Delivered	Service
☑	☑	Outpatient/ambulatory medical care
☐	☐	Local AIDS Pharmaceutical Assistance
☐	☐	Oral health care
☐	☐	Early intervention services (Parts A and B)
☐	☐	Health Insurance Premium & Cost Sharing Assistance
☐	☐	Home health care
☐	☐	Home and community-based health services
☐	☐	Hospice services
☐	☐	Mental health services
☐	☐	Medical nutrition therapy
☐	☐	Medical case management (including treatment adherence)
☐	☐	Substance abuse services-outpatient

SUPPORT SERVICES

Funded	Delivered	Service
☐	☐	Case management (non-medical)
☐	☐	Child care services
☐	☐	Pediatric development assessment/early intervention services
☐	☐	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 for health care/supportive services
☐	☐	Rehabilitation services
☐	☐	Respite care
☐	☐	Substance abuse services-residential
☐	☐	Treatment adherence counseling

HIV COUNSELING AND TESTING SERVICES

Funded	Delivered	Service
☐	☐	HIV Counseling and Testing

Save | Restore Initial Values

Close Window and Return to Contracts Page

Review the services funded by your grantee. The box next to the service in the "Funded" column will be checked if your agency may provide the indicated service with RWHAP funds. If a service you were contracted to provide is missing from the list, contact your grantee. Ask your grantee to revise your contract in their RSR Grantee Report. Services that were not funded by your grantee cannot be delivered by your agency. Client-level data should not be reported for services that you aren't funded to provide.

Identify each funded service your agency provided with RWHAP funds under the selected contract during the reporting period by checking the box in the "Delivered" column. If you did not deliver a service you were funded to provide to any clients during the reporting period, don't check the box for that service. Click the "Save" button at the top or bottom of the screen to save your changes. Then close the window using the link "Close Window and Return to Contracts Page."

After reviewing and updating the information for each contract, click the "Save" button at the bottom of the contracts page to save the edited data and continue with the final three items in the Provider Information section (Figure 10) of the Provider Report.

If your agency only provides administrative and technical services, STOP HERE. You are not required to complete the remainder of this report. You are NOT required to submit client-level data. However, if you provide other services, you must go on to Item 9.

9. **Which of the following categories describes your agency?** 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, specifically "Other traditional provider that has historically served racial/ethnic clients but does not meet any of the criteria above" and "Other type of agency or facility," are mutually exclusive. Providers may report the first, second, and/or third response, the fourth response, OR the fifth response.

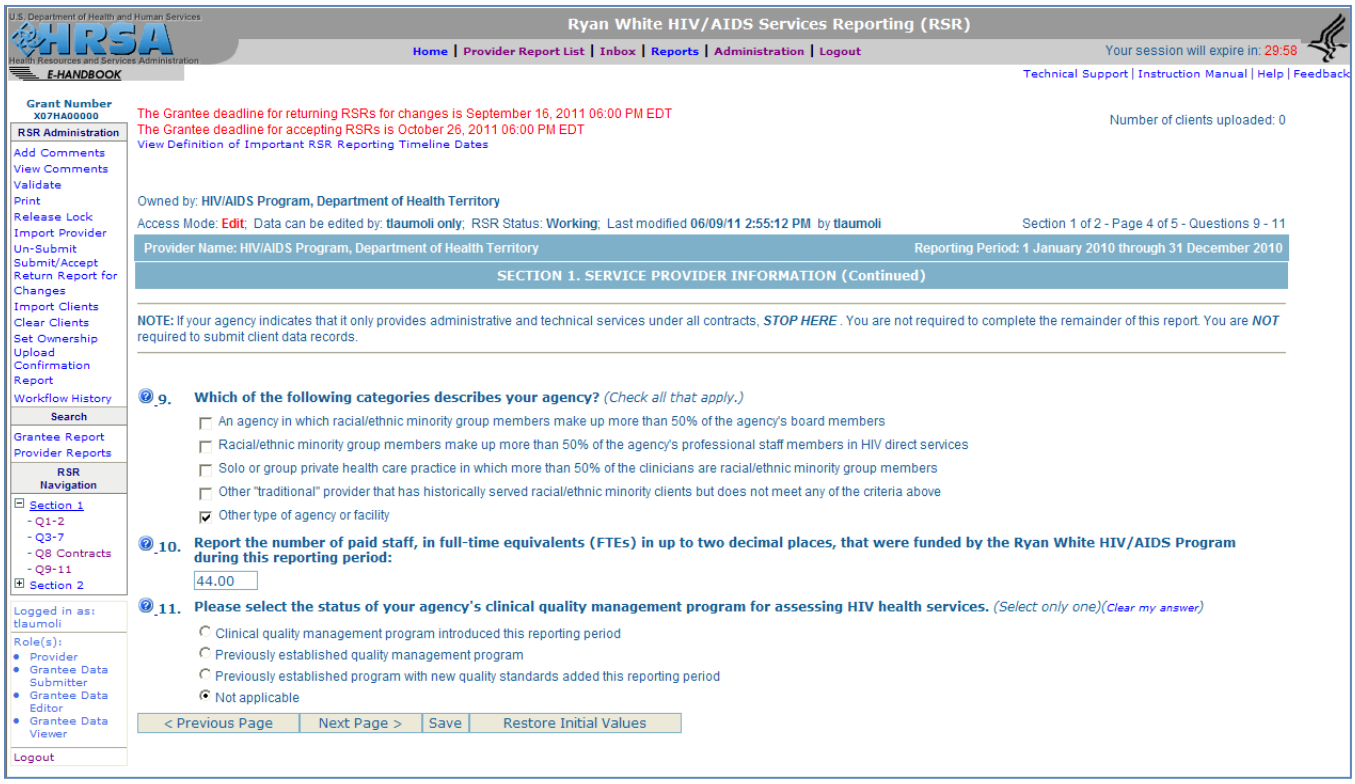
10. **Report the number of paid staff, in full-time equivalents (FTEs), funded by the Ryan White HIV/AIDS Program during the given reporting period.** You may enter up to two decimal places. Enter a zero if there are no paid staff.

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 their Service Provider Report.

Figure 10. RSR Provider Report Online Form: Screenshot of the Provider Information Section (Questions 9–11)



11. **Select the status of your agency's clinical quality management program for assessing HIV health services** (select only one):
    - Clinical quality management program introduced 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 Public Health Service 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), click on "Next Page" to save the data and advance to the last page in the Service Provider Report, "HIV Counseling and Testing" (Figure 11).

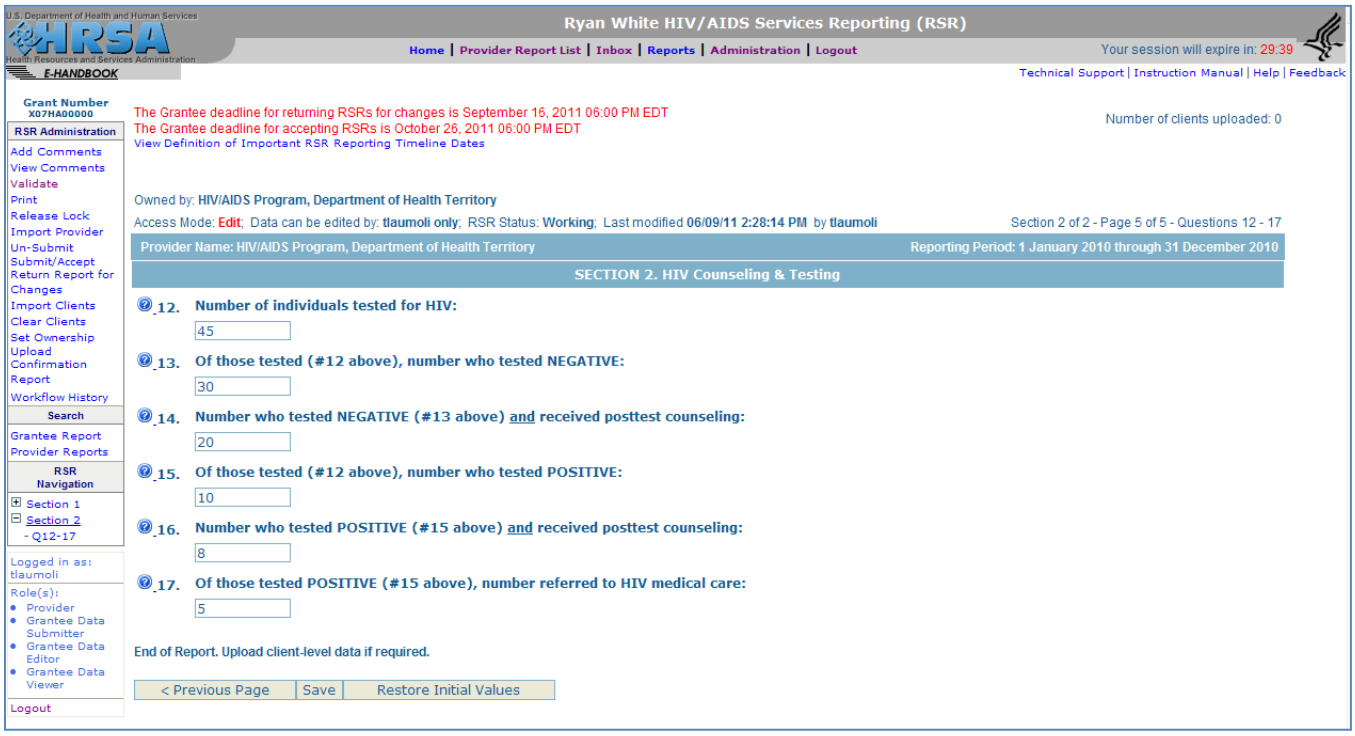
HIV Counseling and Testing

If your agency used Ryan White Program funding to provide HIV counseling and testing (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. Keep in mind that, because Ryan White funding may be used to test individuals anonymously, those you report in this section may include people who are not counted or reported as Ryan White Program clients in any of your other data reporting items.

> **If you provide HIV counseling and testing (HC&T) services as part of your EIIHA activities or under Early Intervention for Parts A and B service category, report your HC&T data in this section. Do not upload client-level data for clients who received only HC&T services.**

12. **Number of individuals tested for HIV**: Indicate the number of people tested using an FDA-approved test during the reporting period.
13. **Of those tested** (Item 12), **number that tested NEGATIVE**: The number that tested NEGATIVE for HIV during the reporting period.
14. **Number who tested NEGATIVE** (Item 13) **and received posttest counseling**: Of the number indicated in Item 13, the number who received HIV posttest counseling.

Figure 11. RSR Provider Report Online Form: Screenshot of the HIV Counseling and Testing Section



15. **Of those tested** (Item 12), **number that tested POSITIVE**: Of the total number tested, indicate how many tested positive for HIV during the reporting period.
16. **The number who tested POSITIVE** (Item 15) **and received posttest counseling**: Of the number specified in Item 15, indicate how many received HIV-posttest counseling immediately following the test or returned for counseling at a later date.
17. **Of those who tested POSITIVE** (Item 15), **number referred to HIV medical care**: Of the total number who tested positive for HIV, indicate how many were referred to HIV medical care.

How to Complete the Provider Report by uploading an XML File

Agencies required to submit a Provider Report have the option of importing an XML Provider Report file into the RSR Web System as an alternative to manually entering the data in the report. To upload the Provider Report XML File, click on "Import Provider" in the RSR Administration menu (near the upper left-hand corner of the pages) to open another window, then follow the on-screen instructions.

After you complete your RSR Provider Report and upload your client-level data, be sure to review the Provider Report data in the RSR Web System for accuracy after the upload is complete, paying special attention to the data reported for Item 8, the item where you report all of the services that you delivered during the reporting period under each of your RWHAP contracts. When the RSR Web System receives an XML file that either does not use the contract reference field or the contract reference field does not match the contract reference entered by the grantee, the system will associate service data based on a set of predetermined rules:

- If a service reported as delivered in the uploaded XML matches a service authorized under one (and only one) contract in the RSR Web System, the system will associate the service with that contract.
- If a service reported as delivered in the uploaded XML matches a service authorized under more than one contract in the RSR Web System, the system will associate the service with all contracts under which it is authorized.
- If the service reported as delivered does not match ANY service funded by the provider's grantee(s) under ANY contract, the provider will receive a data validation error. To resolve this error, you will need to either (1) modify the services reported as delivered in your Provider Report, and/or (2) contact your grantee to ask him or her to revise your contract in their Grantee Report.

If there are errors in the report, you may correct the errors manually. Alternatively, you may upload a revised XML Provider Report File. However, after the initial Provider Report XML file upload, all subsequent file uploads will overwrite the existing Provider Report data in the RSR Web System.

RSR CLIENT REPORT (OR CLIENT-LEVEL DATA)

(Last Updated: September 10, 2012)

A Client Report must be submitted for all providers that used RWHAP funds to provide core medical or support services directly to clients during the reporting period. HAB's expectation is that providers submit the Client Report unless the provider has been exempted.

Submitting Client-level Data to HAB

The Client Report (client-level data set) must be uploaded in the required XML format. To learn how to upload the client-level data XML file, see the section **Importing the Client-level Data XML File** on page 68. XML (eXtensible Markup Language) is 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.

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 **http://www.careacttarget.org/category/topics/ryan-white-services-report-rsr** under the topic "Software Systems." 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 **http://hab.hrsa.gov/manageyourgrant/clientleveldata.html**.
2. Use T-REX to create your client-level data XML file. "T-REX" (Tool for RSR Export) was created to help grantees and providers that do not use CAREWare, a Provider Data Import (PDI), or other RSR-ready vendor system create their Client-level Data XML file.

Technical support is available to grantees whose providers have custom systems through the HAB Web site.

Client-level Data Elements

The client report should contain one record ("row" of data in a database) for each client who received a RWHAP-funded core medical service or support service during the reporting period. The data elements reported per client are determined by the specific RWHAP-funded service(s) the client received at your agency. See the chart in **Appendix A, Required Client-level Data Elements for RWHAP Services** on page 71 to determine the client-level data elements that will be reported for a client based on the RWHAP-funded service(s) he or she received. Appendix A includes a chart with the services listed in the column heading and the client-level data elements listed in the row heading. If a dot appears at the intersection of a service and data element, that data element is required to be reported for the recipient of that service.

Up to 66 data elements may be reported for each client. The data elements include the following:

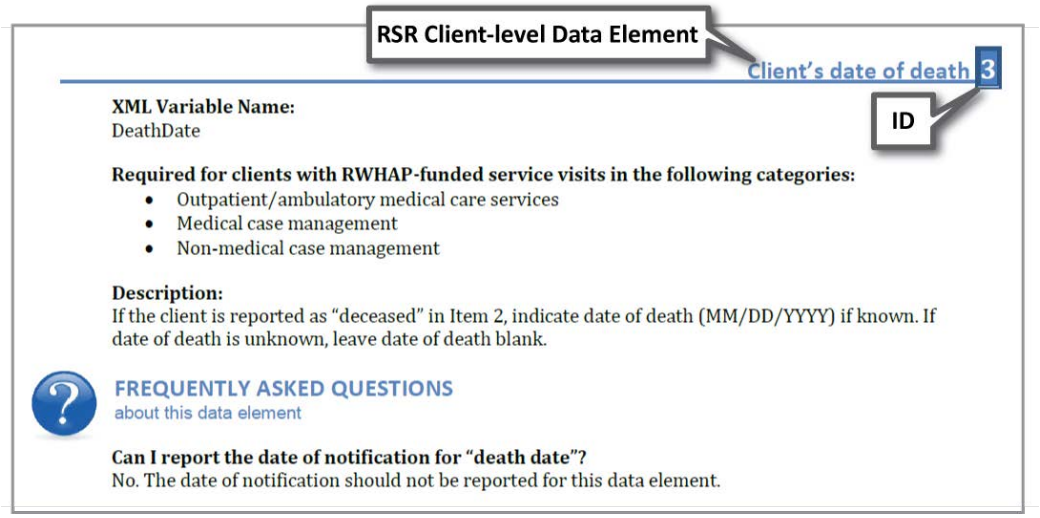
- The client's encrypted Unique Client Identifier (eUCI);

- The client's demographic information;
- The RWHAP-funded core medical and support services the client received; and
- The client's clinical information if he or she received a RWHAP-funded Outpatient/ambulatory medical service.

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

ID: Each data element has been assigned a value for convenient referencing between this document and the RSR Data Dictionary available at **http://hab.hrsa.gov/manageyourgrant/clientleveldata.html**. The data element ID is frequently referred to as an "Item" in this document (i.e., Item 1).

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 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 RWHAP-funded service visits in the following categories: The data elements that must be reported for your clients are based on the type of service the client received. You are only required to report the data element for recipients of the indicated RWHAP-funded service.

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

Reporting period SV1

XML Variable Name:
ReportPeriodID

Description:
The reporting period for the RSR is January 1 through December 31. This data element is no longer required and should not be included in the client-level data XML file.

RSR system's unique provider identification number SV2

XML Variable Name:
ProviderID

Description:
This number is automatically generated by the RSR system when the provider is first listed in the RSR Web System. For providers that were entered in the system, the provider IDs in the system will not change because they are prepopulated by the RSR Web System.

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 RWHAP-funded service visits in the following categories:
All core medical and support services.

Description:
One benefit to HAB of having client-level data reporting is the ability to de-duplicate the clients to obtain a more accurate count of the clients served by the Ryan White HIV/AIDS Program. To protect client information, an encrypted Unique Client Identifier (eUCI) is used for reporting Ryan White client data.

The Unique Client Identifier (UCI) is a unique 11-character alphanumeric code that is the same for the client across all provider settings. The UCI is derived from the first and third characters of a client's first and last name, his or her date of birth (MM/DD/YY), and a code for gender (1=male, 2=female, 3=transgender, 9=unknown). SHA-1, a one-way hashing algorithm that meets the highest privacy and security standards, is used to encrypt the client's UCI resulting in a 40-character alphanumeric code, the encrypted Unique Client Identifier.

It is possible that different clients have identical 40-digit eUCIs. Therefore, grantees/providers must add a 41st character at the end of the eUCI to distinguish these clients. If only one client within a data system has a given UCI, the suffix should be "U" for unique. If more than one client has the same UCI, the final character of the first client's eUCI needs to be "A," the final character of the second client's eUCI needs to be "B," and so on. The suffix prevents multiple clients from having the same eUCI.

The UCI is encrypted with SHA-1 at the provider site BEFORE the data are submitted to HAB. SHA-1 is a trap door algorithm, meaning that the original UCI is unrecoverable from the eUCI. The resulting alphanumeric code, the eUCI, is used to distinguish one Ryan White client from all others in a region.

To learn more about the eUCI including rules on how to construct the UCI before encryption, view the resources available on the TARGET Center Web site at http://www.careacttarget.org/category/topics/ryan-white-services-report-rsr.

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 (i.e., for Hispanic clients living in Puerto Rico, record both surnames in the appropriate order).
- Avoid using nicknames (i.e., 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 UCI?
If you are missing data elements required for the eUCI, you should do everything possible to obtain those data elements. This effort will improve not only the quality of data linking, but also case management and patient care.

Demographic Data

Up to 15 demographic data elements may be reported for each client. The demographic data elements reported for each client are determined by the service(s) the client received. 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 71.

Date of client's first service visit at this provider's agency or organization 1

XML Variable Name:
FirstServiceDate

Required for clients with RWHAP-funded service visits in the following categories:

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

Description:
The date of first service visit is the date the client first received a service at your agency, regardless of the reason. It may or may not be the client's first HIV-related visit or RWHAP-funded visit. The date of first visit with a provider cannot change in future reports.

You are not expected to go to extremes 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.

FREQUENTLY ASKED QUESTIONS
about this data element

If a client has been out of care for several years, do we enter their re-enrollment date as the date of first service visit?
No. Report the date of the client's first service visit at the provider's agency or organization. The RSR currently does not account for the re-enrollment of clients that have been out of care for long periods of time, although agencies may want to enter re-enrollment dates in their own data collection systems. HAB does not expect providers to go to unreasonable lengths to locate the client's initial enrollment date in their files.

Will a client that receives services at several provider agencies have multiple first service visit dates?
Yes. Each provider will report the date that the client first enrolled in services at their site. The reason for the visit does not matter. The visit may or may not be the date the client received his or her first Ryan White–funded service. The visit may or may not be for a HIV-related service. The visit might not be for medical service—i.e., it could be a case management visit.

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

XML Variable Name:
EnrollmentStatusID

Required for clients with RWHAP-funded service visits in the following categories:
- Outpatient/ambulatory medical care services
- Medical case management
- Non-medical case management

Description:
This is the client's 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 no longer needed Ryan White Program–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*.
- *Unknown*—The client has been "lost to care."

FREQUENTLY ASKED QUESTIONS
about this data element

What are the guidelines for determining if a client is lost to care?
Each agency must determine their own guidelines for classifying a client as "lost to care" or "discharged."

Where do we report a client who is lost to care and whose vital status is unknown?
Clients who are lost to care should be reported as "Unknown."

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 date of death 3

XML Variable Name:
DeathDate

Required for clients with RWHAP-funded service visits in the following categories:
- Outpatient/ambulatory medical care services
- Medical case management
- Non-medical case management

Description:
If the client is reported as "deceased" in Item 2, indicate date of death (MM/DD/YYYY) if known. If date of death is unknown, leave date of death blank.

FREQUENTLY ASKED QUESTIONS
about this data element

Can I report the date of notification for "death date"?
No. The date of notification should not be reported for this data element.

Client's year of birth 4

XML Variable Name:
BirthYear

Required for clients with RWHAP-funded 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.

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." 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 RWHAP-funded service visits in the following categories:
All core medical and support services.

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

- *Hispanic or Latino*—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."
- *Not Hispanic or Latino*—A person who does not identify his or her ethnicity as "Hispanic or Latino."
- *Unknown*—Indicates the client's ethnicity is unknown or was not reported.

Client's self-reported race 6

XML Variable Name:
RaceID

Required for clients with RWHAP-funded 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. The unknown option may only be selected if no other options are selected.

- *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.
- *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.
- *White*—A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- *Unknown*—A person's racial category is unknown or was not reported.

Client's current self-reported gender 7

XML Variable Name:
GenderID

Required for clients with RWHAP-funded 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.

- *Male*—An individual with strong and persistent identification with the male sex.
- *Female*—An individual with strong and persistent identification with the female sex.
- *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 RWHAP-funded service visits in the following categories:
All core medical and support services.

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

- Male to Female
- Female to Male
- Unknown

Client's annual household income category 9

XML Variable Name:
PovertyLevelID

Required for clients with RWHAP-funded service visits in the following categories:

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

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

- Equal to or below the Federal poverty measure
- 101–200% of the Federal poverty measure
- 201–300% of the Federal poverty measure
- More than 300% of the Federal poverty measure
- Unknown

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 the HHS). For more information on poverty measures and to see the 2012 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 the U.S. Department of Health and Human Services Federal poverty guidelines (FPG), follow these five easy steps:

- Count the client's family size. Family size is the number of family members who live together. An individual living alone (or with only non-relatives) counts as a family of one.

- Add up the family income. Family income is the sum of income of all family members who live together. It includes pre-tax 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 non-cash benefits (e.g., food stamps, housing subsidies) and capital gains (or losses).
- 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.
- Calculate the family income as a percent of the family FPG:

family income / guideline × 100 = % family FPG

- Use the percent of the family FPG to report the client percent of the Federal poverty measure for Item 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 RWHAP-funded service visits in the following categories:

- Outpatient/ambulatory medical care services
- Medical case management
- Non-medical case management
- Housing services

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

- Stable Permanent Housing
- Temporary Housing
- Unstable Housing
- Unknown

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.

Unknown:

- The client's housing status is unknown or was not reported.

These definitions are based on:

- Housing Opportunities for Persons With AIDS (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 geographic unit code 11

XML Variable Name:
GeographicUnitCode

Required for clients with RWHAP-funded service visits in the following categories:

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

Description:
This data element is the geographic unit code of the client's residence at the end of the reporting period. The geographic unit code is the initial three digits of a U.S. Postal Service ZIP Code. For example, "200" is the geographic unit code for a client living in an area represented by the five-digit ZIP Code "20001."

The privacy of RWHAP clients is of the utmost importance to HAB. To ensure that client information is protected, HAB has chosen to collect only the initial three digits of a U.S. Postal Service ZIP Code. Should a client record report one of the low-population geographic unit codes outlined in the latest release of the HIPAA Privacy Rule, the RSR system will automatically replace the reported geographic unit code with "000."

The HIPPA Privacy Rule, as defined in 45CFR164.514(b)(2), requires the removal of all geographic subdivisions smaller than a State, including street address, city, county, precinct, ZIP Code, and their equivalent geocodes, except for (1) the initial three digits of a ZIP Code if the geographic unit formed by combining all ZIP Codes with the same initial three digits contains more than 20,000 people; and (2) the provision that the initial three digits of a ZIP Code for all geographic units containing 20,000 or fewer people is changed to 000.

The Final Modification of the HIPAA Privacy Rule, which used 2010 Census data, identifies 18 restricted ZIP Codes: 036, 059, 102, 202, 203, 204, 205, 369, 556, 692, 753, 772, 821, 823, 878, 879, 884, and 893.

If the client's housing is "Unstable," enter the geographic unit code of the place he or she considers his or her residence or "home base." Home base for a person who is homeless or has an unstable living arrangement is the place where that person returns regularly and currently intends to remain, including an emergency shelter or a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings, such as a vehicle, abandoned building, bus/train/subway station/airport, or anywhere outside. It also can be a place the person returns to regularly where he or she can receive messages and be contacted.

Client's HIV/AIDS status 12

XML Variable Name:
HivAidsStatusID

Required for clients with RWHAP-funded service visits in the following categories:

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

Description:
This data element is the client's HIV/AIDS status at the end of the reporting period. 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 RWHAP-funded 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. For additional information, see:
  http://www.cdc.gov/hiv/topics/surveillance/resources/guidelines/index.htm
- *HIV-indeterminate* (infants 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 client is confirmed HIV negative, he or she must be reclassified as an HIV-affected client.

- *Unknown*—A client who is not an infant and whose HIV/AIDS status is unknown or was not reported.

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/ncphi/disss/nndss/casedef/aids1993.htm
- http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4813a2.htm
- http://www.cdc.gov/mmwr/preview/mmwrhtml/00032890.htm

How are HIV-exposed infants who received medical care services categorized for the RSR?
HIV-exposed infants who received medical care services should be reported as HIV indeterminate unless the infant's status is confirmed during the reporting period. If the infant's status is confirmed during the reporting period, then the child should be reported in the appropriate category, HIV positive or HIV negative.

Client's AIDS diagnosis year 13

XML Variable Name:
AidsDiagnosisYear

Required for clients with RWHAP-funded service visits in the following categories:

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

Description:
If the response to Item 12 is "CDC-defined AIDS," indicate the year (YYYY) of the client's AIDS diagnosis, if known. If year of AIDS diagnosis is unknown, leave year of AIDS diagnosis blank.

Client's risk factor for HIV infection 14

XML Variable Name:
HivRiskFactorID

Required for clients with RWHAP-funded service visits in the following categories:

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

Description:
This data element is the client's 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.
- Other indicates the client's exposure category is known, but not listed above.
- Unknown indicates the client's exposure category is unknown or was not reported.

FREQUENTLY ASKED QUESTIONS
about this data element

What if a client has more than one risk factor for HIV?
Select all risk factors that apply.

What if a client does not have a risk factor? Several of my HIV-affected clients receive RWHAP-funded services, but they do not have an HIV risk factor. How do I respond to this data element for these clients?
Until further notice, if your RWHAP client does not report a HIV risk factor, report the client's risk factor as "Unknown".

Client's source(s) health insurance 15

XML Variable Name:
MedicalInsuranceID

Required for clients with RWHAP-funded service visits in the following categories:
- All core medical services
- Non-medical case management

Description:
Report all sources of health insurance the client had for any part of the reporting period. If the insurance that the client had was unknown for the entire reporting period, report "Unknown" (select one or more).

High-risk insurance pool clients should be reported based on who pays the premium for the insurance, e.g. if the client pays, select "Private" or if the State or Federal government pays, select "Other public." (**NOTE**: If RWHAP funds are used to pay the premium for the high-risk insurance pool, report "No insurance.")

- Private means health insurance plans such as BlueCross/BlueShield, Kaiser Permanente, and Aetna.
- Medicare is a health insurance program for people 65 years of age and older, some disabled people under 65 years of age, and people with end-stage renal disease (permanent kidney failure treated with dialysis or a transplant).
- Medicaid is a jointly funded, Federal–State health insurance program for certain low-income and needy people.
- Other public means other Federal, State, and/or local government programs providing a broad set of benefits for eligible individuals. Examples include State-funded insurance plans, military health care (TRICARE), State Children's Health Insurance Program (SCHIP), Indian Health Service, and Veterans Health Administration.

- No insurance means the client did not have insurance to cover the cost of services at any time during the reporting period, the client self pays, or services are covered by RWHAP funds.
- Other insurance means client has an insurance type other than those listed above.
- Unknown means the primary source of medical insurance is unknown and not documented.

If the "Unknown" option is reported, no additional options may be reported. Providers may report the "Private," "Medicare," "Medicaid," "Other public," and/or the "No insurance" option. Or, providers may report only the "Unknown" option.

FREQUENTLY ASKED QUESTIONS
about this data element

Where should high-risk insurance pool clients (including PCIPs) be reported?
High-risk insurance pool clients should be reported based on who pays the premium for the insurance. For example, if the client pays the premiums for their insurance, select "private." If the Federal or State government pays, select "other public." If the RWHAP pays, select "no insurance."

Ryan White HIV/AIDS Program Funded Service Data

The next set of data elements collect information about the service visits the client received that were paid for, at least partially, with RWHAP funds. For example, Elizabeth has insurance coverage through the State's high-risk insurance pool. Elizabeth comes in to see her nurse case manager. During her case management visit, her nurse case manager performs Elizabeth's semiannual needs assessment and provides treatment adherence counseling. The State's high-risk insurance pool pays for her semiannual needs assessment; however, it does not cover treatment adherence counseling. Therefore, the provider uses RWHAP funds to cover Elizabeth's treatment adherence counseling service. In this case, the provider will report the medical case management service visit as a RWHAP-funded visit, because RWHAP funds were used to cover a portion of the service visit.

Keep the following guidance in mind as you prepare your client-level data XML file for submission:

- You should only report the RWHAP-funded core medical and support services that your clients received during the reporting period in this section. Definitions for these services can be found in the section **Ryan White HIV/AIDS Program Services** on page 6.
- HAB does not want providers to include data on clients that did not receive at least one Ryan White–funded service **visit** during the reporting period. Every client reported in your client-level data XML file should have at least one RWHAP-funded core medical or support service visit. Core medical services (Items 16–27) should be reported only for HIV-positive and HIV-indeterminate clients. HIV-negative clients who receive HIV counseling and testing services as part of Early Intervention Services for Part A and B are reported in your Provider Report in the HIV Counseling and Testing section.
- If a client received a core medical or support service that was not paid for with RWHAP funds, do not report that service for the client in this section (Items 16–45). This includes services visits where the negotiated compensation rate does not cover the full cost of the service (for example, if you agreed to take $30 for a $100 service, you can't "bill" the RWHAP $70). The RWHAP is the "payer of last resort" and should not be "balance billed" for services provided to clients that are paid for by other third-party payers.
- HAB expects that staff whose salary is paid by the RWHAP will see clients whose services are not otherwise reimbursed and meet the eligibility requirements of the RWHAP. Providers should not report services that are paid for entirely by another third-party payer ***and*** should not balance bill the RWHAP. However, if a client receives ***any*** RWHAP-funded service that is not otherwise

reimbursed, you should report client-level data. The client data that you will report for that client is determined by the RWHAP-funded service(s) he or she receives at your agency. Keep in mind that the RSR is not a cost-accounting process.

- Providers may report core medical or support services visits funded through multiple sources—including Ryan White funds and other funds—if (1) you cannot use your data systems to distinguish whether or not the client visits were paid with funds other than RWHAP funds, ***and*** (2) the service visit is typically paid for with RWHAP funds.
- Service visits initially paid for with RWHAP funds that are retroactively funded by a third-party payer should be reported as RWHAP-funded service visits.

Core Medical Services 16–27

XML Variable Name:
ClientReportServiceVisits

- QuarterID (1–4)
- ServiceID (See table below)
- Visits (Number of visits the client received in the service category indicated.)

Each client's record only needs to include data on the RWHAP-funded services that he or she received during the reporting period.

Required for clients with RWHAP-funded service visits in the following categories:
Recipients of Core Medical Services, as listed in the table below.

Description:
Report the number of RWHAP-funded core medical service visits the client received. 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. All of these services were paid for with RWHAP funds. In this situation, even though the client received 5 RWHAP-funded 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. All of the services John received were RWHAP-funded. Even though John received 4 RWHAP-funded services, the provider will report only 3 RWHAP service visits for that day: 1 RWHAP-funded Mental health service **visit**, 1 RWHAP-funded Medical case management service **visit**, and 1 RWHAP-funded Outpatient/ambulatory medical care **visit**.

Core medical services (Items 16–27) should be reported only for HIV-positive and HIV-indeterminate clients. HIV-negative clients who receive HIV counseling and testing services as part of Early Intervention Services for Part A and B should only be reported in your Provider Report in the HIV Counseling and Testing section.

The definitions for the **RWHAP Core Medical Services** can be found in the **Ryan White HIV/AIDS Program Services** chapter on page 7.

ID	Data Element	ServiceID
16	Number of RWHAP-funded **Outpatient ambulatory medical care** service visits the client received during each quarter of the reporting period	Service ID 8
18	Number of RWHAP-funded **Oral health care** service visits the client received during each quarter of the reporting period	Service ID 10
19	Number of RWHAP-funded **Early intervention (Parts A and B)** service visits the client received during each quarter of the reporting period	Service ID 11
21	Number of RWHAP-funded **Home health care** service visits the client received during each quarter of the reporting period	Service ID 13
22	Number of RWHAP-funded **Home and community-based health** service visits the client received during each quarter of the reporting period	Service ID 14
23	Number of RWHAP-funded **Hospice** service visits the client received during each quarter of the reporting period	Service ID 15
24	Number of RWHAP-funded **Mental health** service visits the client received during each quarter of the reporting period	Service ID 16
25	Number of RWHAP-funded **Medical nutrition therapy** service visits the client received during each quarter of the reporting period	Service ID 17
26	Number of RWHAP-funded **Medical case management (including treatment adherence)** service visits the client received during each quarter of the reporting period	Service ID 18
27	Number of RWHAP-funded **Substance abuse outpatient** service visits the client received during each quarter of the reporting period	Service ID 19

XML Variable Name:
ClientReportServiceVisits

- QuarterID (1–4)
- ServiceID (See table below)
- Delivered (1—Yes, 2—No, or 3—Unknown)

Each client's record only needs to include data on the RWHAP-funded services that he or she received during the reporting period.

Description:
Report whether or not the client received these RWHAP–funded support services during each quarter of 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 7.

ID	Data Element	ServiceID
17	Quarters in which the client received a RWHAP-funded ***Local AIDS Pharmaceutical Assistance (Local APA)*** service visit	Service ID 9
20	Quarters in which the client received a RWHAP-funded ***Health Insurance Program (HIP)*** service visit	Service ID 12

FREQUENTLY ASKED QUESTIONS
about this data element

My agency provides free long-distance clinical consultation services to physicians treating HIV/AIDS in their local populations. Our agency develops an individualized treatment plan

for each client and regularly monitors each client's progress. Our agency uses a portion of our RWHAP grant to fund the salaries for the clinicians providing this service. Should we report these services as Outpatient/ambulatory medical care?
No. HAB has determined that long-distance clinical consultation services do not meet the definition of Outpatient/ambulatory medical care services (OAMC), because the services are not provided directly to the HIV-infected client. Instead, please report your long-distance clinical consultation services as Medical case management services.

My client's medical service visits are paid for by another third-party payer such as Medicaid or private insurance, but his or her lab services are covered by RWHAP. How do I report these visits?
Lab-only visits are not reported in the RSR.

A medical service visit includes all associated lab work, regardless of when the lab work is performed. Because lab services are part of the medical visit, if RWHAP funds are used to pay for the lab service, the medical visit is reported as a RWHAP-funded visit. Remember, if any part of a client's medical visit is funded by the RWHAP, the entire visit may be reported as a RWHAP-funded visit. It does not matter if the lab service takes place before, after, or on the same day as the medical visit; you may report the medical visit as a RWHAP-funded visit.

Support Services 28–45

XML Variable Name:
ClientReportServiceVisits

- QuarterID (1–4)
- ServiceID (See table below)
- Delivered (1—Yes, 2—No, or 3—Unknown)

Each client's record only needs to include data on the RWHAP-funded services that he or she received during the reporting period.

Required for clients with RWHAP-funded service visits in the following categories:
Recipients of Support Services, as listed in the table below.

Description:
Report whether or not the client received these Ryan White–funded support services during each quarter of the reporting period. The definitions for the **RWHAP Support Services** can be found in the **Ryan White HIV/AIDS Program Services** chapter on page 10.

ID	Data Element	ServiceID
28	Quarters in which the client received a RWHAP-funded **Case management (non-medical)** service visit	Service ID 20
29	Quarters in which the client received a RWHAP-funded **Child care** service visit	Service ID 21
30	Quarters in which the client received a RWHAP-funded **Pediatric developmental assessment/early intervention** service visit	Service ID 22
31	Quarters in which the client received a RWHAP-funded **Emergency financial assistance** service visit	Service ID 23
32	Quarters in which the client received a RWHAP-funded **Food bank/home-delivered meals** service visit	Service ID 24

ID	Data Element	ServiceID
33	Quarters in which the client received a RWHAP-funded **Health education/risk reduction** service visit	Service ID 25
34	Quarters in which the client received a RWHAP-funded **Housing** service visit	Service ID 26
35	Quarters in which the client received a RWHAP-funded **Legal** service visit	Service ID 27
36	Quarters in which the client received a RWHAP-funded **Linguistic** service visit	Service ID 28
37	Quarters in which the client received a RWHAP-funded **Medical transportation** service visit	Service ID 29
38	Quarters in which the client received a RWHAP-funded **Outreach** service visit	Service ID 30
39	Quarters in which the client received a RWHAP-funded **Permanency planning** service visit	Service ID 31
40	Quarters in which the client received a RWHAP-funded **Psychosocial support** service visit	Service ID 32
41	Quarters in which the client received a RWHAP-funded **Referral for health care/supportive service** visit	Service ID 33
42	Quarters in which the client received a RWHAP-funded **Rehabilitation** service visit	Service ID 34
43	Quarters in which the client received a RWHAP-funded **Respite care** service visit	Service ID 35
44	Quarters in which the client received a RWHAP-funded **Substance abuse–residential** service visit	Service ID 36
45	Quarters in which the client received a RWHAP-funded **Treatment adherence counseling** service visit	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 only required for HIV-positive clients who receive a RWHAP-funded outpatient/ambulatory medical care visit. Clinical information is *not* required to be reported for HIV-indeterminate clients.

These providers will report all of the clinical information (Items 46–66) for each of their HIV-positive clients who received RWHAP-funded outpatient/ambulatory medical care services (as reported in Item 16), regardless of who paid for or delivered those clinical services. For example, an HIV-positive client receives two outpatient/ambulatory medical service visits, one paid for in part with RWHAP funds. Only one visit is reported in Item 16. However, all of the client's clinical information is reported in Items 46–66. This provider will report all of the client's clinical activity in Items 46–66, including two outpatient/ambulatory care visits in Item 48.

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.

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 Ryan White HIV/AIDS program legislation and HAB's HIV/AIDS Core Clinical Performance Measures for Adults & Adolescents.

Client received HIV risk-reduction screening/counseling 46

XML Variable Name:
RiskScreeningProvidedID

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

Description:
Indicate (yes/no/unknown) 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 RWHAP-funded 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 item, 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.
- This date may or may not be same date reported in Item 1, date of client's first service visit with this provider.
- 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 RWHAP-funded 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 item should be equal to or greater than the number of visits reported in Item 16. **NOTE**: The visits should meet the RWHAP definition of an outpatient/ambulatory medical care visit.

Client's CD4 counts and test dates 49

XML Variable Name:
ClientReportCd4Test

- Count
- ServiceDate

Required for HIV-positive clients with RWHAP-funded 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.

FREQUENTLY ASKED QUESTIONS
about this data element

My agency provides services to HIV-indeterminate infants. We do not perform CD4 tests on these clients. How do I report this?
Providers are not required to report clinical information (Items 46–66) for HIV-indeterminate infants.

Client's viral load counts and test dates 50

XML Variable Name:
ClientReportViralLoadTest

- Count
- ServiceDate

Required for HIV-positive clients with RWHAP-funded 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 add the "IsDetectible" attribute to the Count element and set the value to "0" which represents a value of "false".

FREQUENTLY ASKED QUESTIONS
about this data element

My agency provides services to HIV-indeterminate infants. We do not perform viral load counts on these clients. How to I report this information?
Providers are not required to report clinical information (Items 46–66) for HIV-indeterminate infants.

Client prescribed PCP prophylaxis 51

XML Variable Name:
PrescribedPcpProphylaxisID

Required for HIV-positive clients with RWHAP-funded 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 persons 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
- Unknown

For additional information about PCP prophylaxis, see:
http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html
http://aidsinfo.nih.gov/guidelines

Client prescribed HAART 52

XML Variable Name:
PrescribedHaartID

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

Description:
HAART is highly active 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 HAART during the reporting period.

- Yes
- No, not medically indicated
- No, not ready (as determined by clinician)
- No, client refused
- No, intolerance, side effect, toxicity
- No, HAART payment assistance unavailable
- No, other reason
- Unknown

For additional information about HAART, visit: **http://aidsinfo.nih.gov/guidelines**.

FREQUENTLY ASKED QUESTIONS
about this data element

How do we report clients who are non-adherent with ARV therapy?
Providers are only required to report whether a client was prescribed treatment, not whether the client adhered to the prescribed therapy.

How do we report clients who are on HAART but were not prescribed HAART during the reporting period?
"Prescribed HAART" means they were on the treatment regimen—not that they were written a prescription during the reporting period. If the client started HAART during a previous reporting period, report the client in the "Yes" category.

Client was screened for TB during this reporting period 53

XML Variable Name:
ScreenedTBID

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

Description:
Tuberculosis screening is the use of physical examinations and tests (such as PPD skin tests, blood tests, X-rays, and sputum tests) to determine latent or active infection by *mycobacterium tuberculosis* (*M. tuberculosis*) bacteria. Indicate if the client was screened for tuberculosis (TB) during the reporting period.

- Yes
- No
- Not medically indicated
- Unknown

For additional information about tuberculosis, 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 RWHAP-funded service visits in the following categories:
Outpatient/ambulatory medical care services

Description:
If the response to Item 53 is "no," "not medically indicated," or "unknown," indicate if the client has been screened for TB since his or her HIV diagnosis.

- Yes
- No
- Not medically indicated
- Unknown

FREQUENTLY ASKED QUESTIONS
about this data element

What if we do not know whether a new client has been screened for TB 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 since their diagnosis and advises providers to report whatever data may be reasonably obtained. **NOTE:** HAB expects you to screen your client if you do not know whether or not your client has been screened for TB since his or her HIV diagnosis.

Client was screened for syphilis during this reporting period 55

XML Variable Name:
ScreenedSyphilisID

Required for HIV-positive clients with RWHAP-funded 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. Has the client been screened for syphilis during this reporting period?

- Yes
- No
- Not medically indicated
- Unknown

Additional information may be obtained at http://aidsinfo.nih.gov/guidelines.

Client was screened for hepatitis B during this reporting period 56

XML Variable Name:
ScreenedHepatitisBID

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

Description:
Hepatitis B is a serious infection caused by the hepatitis B virus (HBV). If it goes undiagnosed and untreated, it can cause permanent liver damage. A screening blood test can determine a diagnosis. Has the client been screened for hepatitis B during this reporting period?

- Yes
- No
- Not medically indicated
- Unknown

For additional information, please see: **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 RWHAP-funded service visits in the following categories:
Outpatient/ambulatory medical care services

Description:
If the response to Item 56 is "no," "not medically indicated," or "unknown," indicate if the client has been screened for hepatitis B since his or her HIV diagnosis.

- Yes
- No
- Not medically indicated
- Unknown

FREQUENTLY ASKED QUESTIONS
about this data element

What if we do not know whether a new client has been screened for hepatitis B 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 hepatitis B since their diagnosis and advises providers to report whatever data may be reasonably obtained. **NOTE:** HAB expects you to screen your client if you do not know whether or not your client has been screened for hepatitis B since his or her HIV diagnosis.

Client has completed the vaccine series for hepatitis B 58

XML Variable Name:
VaccinatedHepatitisBID

Required for HIV-positive clients with RWHAP-funded 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
- Unknown

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 test (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 during this reporting period 59

XML Variable Name:
ScreenedHepatitisCID

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

Description:
Hepatitis C screening is the use of physical examinations and tests—such as anti-HCV tests, HCV RIBA tests, HCV-RNA tests, and viral load or quantitative HCV tests—to detect the presence of the HCV virus and/or antibodies indicating exposure to the virus. Has the client been screened for hepatitis C during this reporting period?

- Yes
- No
- Not medically indicated
- Unknown

Client screened for hepatitis C since HIV diagnosis 60

XML Variable Name:
ScreenedHepatitisCSinceHivDiagnosisID

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

Description:
If the response to Item 59 is "no," "not medically indicated," or "unknown," indicate if the client has been screened for hepatitis C since his or her HIV diagnosis.

- Yes
- No
- Not medically indicated
- Unknown

FREQUENTLY ASKED QUESTIONS
about this data element

What if we do not know whether a new client has been screened for 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 hepatitis C since their diagnosis and advises providers to report whatever data may be reasonably obtained. **NOTE:** HAB expects you to screen your client if you do not know whether or not your client has been screened for hepatitis C since his or her HIV diagnosis.

Client was screened for substance use 61

XML Variable Name:
ScreenedSubstanceAbuseID

Required for HIV-positive clients with RWHAP-funded 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. Was the client screened for substance use (alcohol and drugs) during the reporting period?

- Yes
- No
- Not medically indicated
- Unknown

Client received mental health screening 62

XML Variable Name:
ScreenedMentalHealthID

Required for HIV-positive clients with RWHAP-funded 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?

- Yes
- No
- Not medically indicated
- Unknown

Client received a Pap smear 63

XML Variable Name:
ReceivedCervicalPapSmearID

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

Description:
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?

- Yes
- No
- Not medically indicated
- Not applicable
- Unknown

Client was pregnant 64

XML Variable Name:
PregnantID

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

Description:
Was the client pregnant during the reporting period?

- Yes
- No
- Not applicable
- Unknown

Trimester client entered prenatal care 65

XML Variable Name:
PrenatalCareID

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

Description:
If the response to Item 64 is "yes," indicate when the client entered prenatal care. Women whose pregnancies did not result in a live birth should be reported in the "Not applicable" category.

- First trimester
- Second trimester
- Third trimester
- At time of delivery
- Not applicable
- Unknown

Client prescribed ARV to prevent Mother-to-Child transmission of HIV 66

XML Variable Name:
PrescribedArvMedicationID

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

Description:
For HIV-positive women only: If the response to Item 64 is "yes," indicate if the client was prescribed antiretroviral therapy to prevent maternal-to-child transmission (vertical) of HIV. Women whose pregnancies did not result in a live birth should be reported in the "Not applicable" category.

- Yes
- No
- Not applicable
- Unknown

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 Clients" link in the RSR Administration menu (near the upper left-hand corner of the Provider Report Web pages). This will open another window. Then, follow the on-screen instructions.

Each file uploaded into the RSR system goes through an initial round of data validation. These validations are initial checks that are automatically performed by the RSR system when you upload your file. If your file does not pass the initial checks, it will be rejected by the RSR system and you will receive an error message stating the "file upload unsuccessful." Most providers that use an RSR-ready vendor system to generate their client-level data XML file will not have problems with the initial checks. However, if you do have trouble with the initial validation checks, be sure to make note of the error message and contact your vendor's help desk or the HRSA Contact Center at 1-877-464-4772 for assistance.

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)—i.e., the correct number of clients and services are being reported. To run this report, select the "Upload Confirmation Report" link in the RSR Administration menu on the left hand side of the Provider Report Web pages. The CLD Upload Confirmation Report will open in a separate window.

FREQUENTLY ASKED QUESTIONS
about the Client Report

My RWHAP funding covers only salaries. Do I report client-level data?
HAB expects that staff whose salary is paid by the RWHAP will see clients whose services are not otherwise reimbursed and meet the eligibility requirements of the RWHAP. Providers should not report services that are paid for entirely by another third-party payer **and** should not balance bill the RWHAP (for example, if you agreed to take $30 for a $100 service, you can't bill the RWHAP $70). However, if a client receives **any** RWHAP-funded service that is not otherwise reimbursed, you should report client-level data. The client data that you will report for that client are determined by the RWHAP-funded service(s) he or she receives at your agency. Keep in mind the RSR is not a cost accounting process.

I provide Ryan White–funded outpatient/ambulatory medical care. When I report the clinical information data elements (Items 46–66) for my outpatient/ambulatory medical care clients, do I report only Ryan White–funded outpatient/ambulatory medical care services?
No, report all of the available clinical information data elements (Items 45–66) for each of your HIV-positive clients who received a RWHAP-funded outpatient/ambulatory medical care service at your agency, regardless of who paid for or delivered those clinical services.

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. While 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 Report is to capture all RWHAP-funded services for all clients served by a provider, regardless of RWHAP Part.

May I upload more than one client-level data file?
Yes. However, providers should avoid uploading multiple XML files generated from different data systems. And, 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. The RSR system may not work as you expect, and you may be surprised by what you get. To learn more about the RSR system merge rules, see the article *Rules for Merging* at **http://www.careacttarget.org/category/topics/ryan-white-services-report-rsr**. To learn more about the eUCI, including rules on how to construct the UCI before encryption, view the *Using the Encrypted Unique Client Identifier (eUCI) Application* also available on the TARGET Center Web site.

Do I have to collect and report every data item (element) in the Client Report?
No. The client-level data elements reported for each client depends on the type of service(s) the client received. To determine the client-level data elements that must be reported for each client, review the Required Client-level Data Elements for RWHAP Eligible Services matrix in the RSR Instruction Manual, available at **http://hab.hrsa.gov/manage/cld.htm**.

Our agency provides support services and non-medical case management. If a client receives only support services, what demographic information am I required to report?
The client data that you will report for that client are determined by the RWHAP-funded service(s) he or she receives at your agency. See the chart in **Appendix A, Required Client-level Data Elements for RWHAP Services** on page 71 to determine the client-level data elements that will be reported for a client based on the RWHAP-funded service(s) he or she received.

How is a service visit different from a "unit of service" or a subservice?
The difference between a "unit of service" and a service visit depends on how agencies are reimbursed. In some cases, a visit may consist of several units of service (e.g., an oral health visit may include multiple units of service—a dental exam, a cleaning, a filling, X-rays, and a fluoride treatment). Ultimately, it is up to the grantee to define a service visit. Remember, for each day, only one service visit per category may be reported for the RSR—even if the client receives more than one unit of service in a particular category on a single day.

Why doesn't HAB request the number of service visits for the support services section of the Client Report?
HAB recognizes that reporting support service data would place too much of a burden on providers.

What client-level data do I need to report?
You must collect the applicable client-level data elements for each client who received services funded by the Ryan White HIV/AIDS Program 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 chart in **Appendix A, Required Client-level Data Elements for RWHAP Eligible Services**.

Do I report the services my client receives from my agency only, or do I report all Ryan White–funded services that are part of my client's care plan?
When reporting the Core Services (Items 16–27) and/or the Support Services (Items 28–45), you are only responsible for reporting the services that the client received at your agency and that were funded by the Ryan White HIV/AIDS Program. Outpatient/ambulatory medical care providers. However, they should report all of the available clinical information data elements (Items 46–66) for each of their HIV-positive clients who received RWHAP-funded outpatient/ambulatory medical care services at their agency, regardless of who paid for or delivered those clinical services.

What happens if a client receives services at two or more agencies and data, such as demographic information or housing status, are reported differently by each agency?
It is possible that client information may change or may be entered incorrectly. When HAB does encounter conflicting data, it will use a set of pre-established rules to determine which data are likely to be most accurate.

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, although changes should be documented. Report the latest information on file for each client.

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

(Last Updated: September 10, 2012)

Client-level Data Elements	Outpatient/ambulatory medical care	Medical case management	Oral health care	Early intervention services (A and B)	Home health care	Home and comm-based hlth serv	Hospice services	Mental health services	Medical nutrition therapy	Substance abuse services--outpatient	AIDS Pharmaceutical Assistance (local)	Health Insurance Program (HIP)	Case management (non-medical)	Child care services	Ped develop assess/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
Race	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	4,7
Gender	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	2,3,4,7
Transgender subgroup	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	2,3,4,7
Health insurance	•	•	•	•	•	•	•	•	•	•	•	•	•																		2,7
Housing status	•	•											•						•												2,7
3 Digit ZIP code	•	•											•																		8,9
Federal poverty level	•	•											•																		2,7
Date of first service visit	•	•											•																		2,3,4,7
HIV/AIDS status	•	•											•																		2,4
Year of AIDS diagnosis	•	•											•																		2,4
Client risk factor	•	•											•																		7
Vital enrollment status	•	•											•																		5,6
Date of death	•	•											•																		5,6

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

Required Client-level Data Elements for RWHAP Services (continued)

Client-level Data Elements	Outpatient/ambulatory medical care	Medical case management	Oral health care	Early intervention services (A and B)	Home health care	Home and comm-based hlth serv	Hospice services	Mental health services	Medical nutrition therapy	Substance abuse services--outpatient	AIDS Pharmaceutical Assistance (local)	Health Insurance Program (HIP)	Case management (non-medical)	Child care services	Ped develop assess/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
Core Services																															
Outpatient/ambulatory health services	●																														2,3,4,10
Medical case management		●																													2,10
Oral health care			●																												2,10
Early intervention services (Parts A and B)				●																											2,10
Home health care					●																										2,10
Home and comm-based hlth services						●																									2,10
Hospice services							●																								2,10
Mental health services								●																							2,10
Medical nutrition therapy									●																						2,10
Substance abuse outpatient care										●																					2,10
Local AIDS Pharm Assistance											●																				2,10
Health Insurance Program (HIP)												●																			2,10
Support Services																															
Case management (non-medical)													●																		2,10
Child care														●																	2,10
Ped developmental assessment/ EIS															●																2,10
Emergency financial assistance																●															2,10
Food bank																	●														2,10
Health education/risk education																		●													2,10
Housing services																			●												2,10
Legal services																				●											2,10
Linguistic services																					●										2,10
Transportation services																						●									2,10
Outreach services																							●								2,10
Permanency planning																								●							2,10
Psychosocial support																									●						2,10
Referral hlth care/supp services																										●					2,10
Rehabilitation services																											●				2,10
Respite care																												●			2,10
Subst abuse services— residential																													●		2,10
Treatment adherence counseling																														●	2,10

Required Client-level Data Elements for RWHAP Services (continued)

Client-level Data Elements	Outpatient/ambulatory medical care	Medical case management	Oral health care	Early intervention services (A and B)	Home health care	Home and comm-based hlth serv	Hospice services	Mental health services	Medical nutrition therapy	Substance abuse services-outpatient	AIDS Pharmaceutical Assistance (local)	Health Insurance Program (HIP)	Case management (non-medical)	Child care services	Ped develop assess/early interv serv	Emergency financial assistance	Food bank/home-delivered meals	Health education/risk reduction	Housing services	Legal services	Linguistic 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
Clinical Information																															
HIV risk reduc screen/counseling	•																														2,3
First outpatient /ambulatory care visit	•																														2,3,4
Outpatient ambulatory care visits	•																														3,4
CD4 counts and dates	•																														3,4
Viral Load counts and dates	•																														3,4
Prescribed PCP prophylaxis	•																														3
Prescribed HAART	•																														3,4
Screened for TB	•																														3
Screened for TB since diagnosis	•																														3
Screened for syphilis	•																														3
Screened for Hepatitis B	•																														3
Screened for Hep B since diagnosis	•																														3
Completed Hep B vaccine series	•																														3
Screened for Hep C	•																														3
Screened for Hep C since diagnosis	•																														3
Screened for substance use	•																														2,3
Screened for mental health	•																														2,3
Pap smear	•																														3, 6
Pregnant	•																														2,3,4
Entry into prenatal Ccre	•																														2,3
ARV therapy for pregnant women	•																														3

• report this data element

APPENDIX B. FREQUENTLY ASKED QUESTIONS

Reporting Requirements

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? 4

My provider is multiply funded. Does it have to submit multiple RSR Provider Reports? 4

Do providers receiving funding from multiple Program Parts complete multiple Provider Reports? 29

Do second-level providers have to submit Provider Reports? 30

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 they do not need to submit their data until HAB's recommended submission deadline. I really need my provider to submit their data early. What do I do? 30

HIV Counseling and Testing

Should providers report everyone they tested for HIV during the reporting period, regardless of where the test occurred or which funds are used to pay for the test kits? 30

We use our RWHAP grant to fund only the salaries of the individuals who provide HIV counseling and testing services. The test kits are funded through another program. Do I still complete the HIV counseling and testing section? 30

AIDS Drug Assistance Program

One of my providers receives funds to provide ADAP services only. Will this provider submit an RSR? 16

One of my providers receives both ADAP funds and base funds in a single contract. Do I report the ADAP funds in the total contract amount? 17

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 their ADAP contractor) on my contract list? 17

Grantee Report Contract Lists

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? 17

I am a Part C grantee-provider. I also fund two providers. What should I list as the contract amount for the contract I list with my agency? 17

Our organization is very large, receives funding from multiple Ryan White Program Parts, and provides services through several different departments. Each department acts as an independent entity and keeps separate client records. Combining the data into a single Provider and Client Report would be burdensome. Are there any alternatives to submitting a single Provider Report? 29

Are providers with whom we do not have formal contracts required to submit data? 29

Reporting Exemptions

I have several providers that delivered RWHAP-funded services 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? 4

May I ask any other provider to submit an exempted provider's data? 5

I have decided to exempt one of my providers from submitting a Provider Report and client-level data. How do I show that the provider has an exemption on my Grantee Report contracts list? 16

What about providers that 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? Are they required to submit a Provider Report and client data? 29

What if a provider receiving funding from multiple Program Parts is given an exemption from reporting by one grantee but not another? 30

Reporting Ryan White HIV/AIDS Program Services

How is a service visit different from a "unit of service" or a subservice? 70

Do I report the services my client receives from my agency only, or do I report all Ryan White–funded services that are part of my client's care plan? 70

My agency provides free long-distance clinical consultation services to physicians treating HIV/AIDS in their local populations. Our agency develops an individualized treatment plan for each client and regularly monitors each client's progress. Our agency uses a portion of our RWHAP grant to fund the salaries for the clinicians providing this service. Should we report these services as Outpatient/ambulatory medical care? 56

My client's medical service visits are paid for by another third-party payer such as Medicaid or private insurance, but his or her lab services are covered by RWHAP. How do I report these visits? 57

Why doesn't HAB request the number of service visits for the support services section of the Client Report? 70

Client-Level Data Elements: General

My RWHAP funding covers only salaries. Do I report client-level data? 69

Do I need to report my client-level data by RWHAP Part? 69

May I upload more than one client-level data file? 69

What client-level data do I need to report? 70

Do I have to collect and report every data item (element) in the Client Report? 69

What happens if a client receives services at two or more agencies and data, such as demographic information or housing status, are reported differently by each agency? 70

What if we collect our client information at the first visit in the reporting period, rather than at the end? 70

Will a client that receives services at several provider agencies have multiple first service visit dates? 44

Client-Level Data Elements: Demographic Information

Our agency provides support services and non-medical case management. If a client receives only support services, what demographic information am I required to report? 69

What if I am missing data elements that compose the UCI? 43

If a client has been out of care for several years, do we enter their re-enrollment date as the date of first service visit? 44

What are the guidelines for determining if a client is lost to care? 45

Where do we report a client who is lost to care and whose vital status is unknown? 45

How are HIV-exposed infants who received medical care services categorized for the RSR? 52

What if a client has more than one risk factor for HIV? 53

What if a client does not have a risk factor? Several of my HIV-affected clients receive RWHAP-funded services, but they do not have an HIV risk factor. How do I respond to this data element for these clients? 53

Where should high-risk insurance pool clients (including PCIPs) be reported? 54

Client-level Data Elements: Clinical Information

I provide Ryan White–funded outpatient/ambulatory medical care. When I report the clinical information data elements (Items 46–66) for my outpatient/ambulatory medical care clients, do I report only Ryan White–funded outpatient/ambulatory medical care services? 69

Can I report the date of notification for “death date”? 45

What is the operational definition of AIDS? 52

My agency provides services to HIV-indeterminate infants. We do not perform CD4 tests on these clients. How do I report this? 60

My agency provides services to HIV-indeterminate infants. We do not perform viral load counts on these clients. How to I report this information? 61

How do we report clients who are non-adherent with ARV therapy? 62

How do we report clients who are on HAART but were not prescribed HAART during the reporting period? 62

What if we do not know whether a new client has been screened for TB since his or her HIV diagnosis date? Are we expected to get retrospective data on every client in medical care? 63

What if we do not know whether a new client has been screened for hepatitis B since his or her HIV diagnosis date? Are we expected to get retrospective data on every client in medical care? 64

How do we report a client whose hepatitis B vaccination is in progress during the reporting period? 65

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? 65

What if we do not know whether a new client has been screened for hepatitis C since his or her HIV diagnosis date? Are we expected to get retrospective data on every client in medical care? 66

GLOSSARY

Active client: An individual 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 Ryan White HIV/AIDS Program support service during the reporting period.

AIDS: Acquired immune deficiency syndrome. A disease caused by the human immunodeficiency virus.

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 whose unauthorized disclosure 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 individuals 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 (PLWHA).

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 persons 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 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.

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[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.

EMA/TGA. Eligible Metropolitan Area/Transitional Grant Area**.** The geographic area eligible to receive Part A Ryan White HIV/AIDS Program 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 Ryan White 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.

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 Ryan White HIV/AIDS Program services. **http://www.whitehouse.gov/omb/mgmt-gpra/index-gpra**

Grantee of record (or grantee): The official Ryan White HIV/AIDS Program 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.

HAART: Highly active 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.

HAB: HIV/AIDS Bureau. The Bureau within the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) that is responsible for administering the Ryan White HIV/AIDS Program. Within HAB, the Division of Metropolitan HIV/AIDS Programs administers Part A; the Division of State HIV/AIDS Programs administers Part B and the AIDS Drug Assistance Program (ADAP); the Division of Community HIV/AIDS Programs administers Part C, Part D, and 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 individuals 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 individuals 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 the Ryan White HIV/AIDS Program.

Indeterminate client: A child under the age of 2 whose HIV status is not yet determined but who was born to an HIV-infected mother.

Infected client: An individual who is HIV positive and receives at least one Ryan White HIV/AIDS Program–funded 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 individuals 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 Ryan White HIV/AIDS Program, 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 the Ryan White HIV/AIDS Program that provides direct financial assistance to designated EMAs that 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 the Ryan White HIV/AIDS Program 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 individuals living with HIV/AIDS and their affected partners and family members. The Ryan White HIV/AIDS Program emphasizes that such care and support is part of a coordinated continuum of care designed to improve medical outcomes.

Part C: The part of the Ryan White HIV/AIDS Program 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 the Ryan White HIV/AIDS Program 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 Ryan White HIV/AIDS Program.

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 an individual 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 (PLWHA) disease and their families in the United States and its territories. The law has changed how Ryan White 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 the Ryan White HIV/AIDS Program. 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 Ryan White 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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