Ryan White Part A Program
Central CAREWare Policies & Procedures
Including Central Eligibility and Referrals

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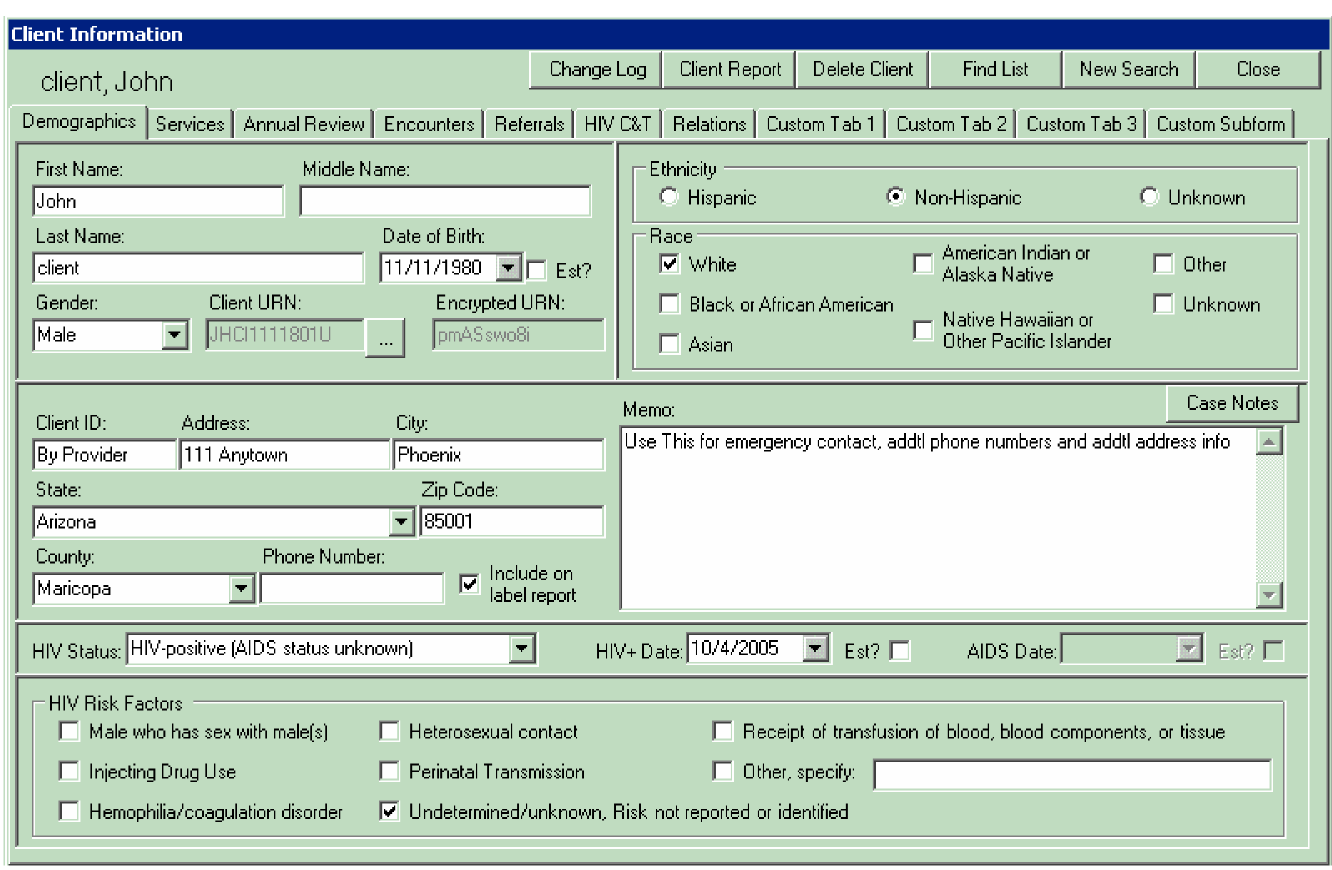
The following information has been outlined to identify for any centralized CAREWare users within the Phoenix EMA the policies and procedures to be used for entering data within the system. It is full understood that the various fields affect the ability for each provider to communicate properly with clients, to have the ability to maintain an unduplicated client database, to produce the HIV/AIDS Program Data (also referred to as CADR) report and to Ryan White grantees. In addition, the data that is entered must comply with standard definitions by either HRSA, state authorities, grantee contracts and policies and procedures. Definitions and information that are available from a HRSA and/or a grantee based policy document will be incorporated into this document.

General Data Entry Policies

1. Capitalization - All fields are to be entered in an upper/lower case format. The first initial of formal names are to be capitalized unless another format is deemed necessary.
2. Unknown/Unreported – Never change known info to unknown/unreported if valid data exists
3. If you see valid data along with unknown data, please remove the unknown data

Client Demographic Tab



Key Fields

The primary fields used to produce an unduplicated client database within CAREWare are: First name, Last Name, Date of Birth and Gender.

Name Fields

The client's formal name is to be entered in the first, middle and last name fields.
Notes:

- Spelling of the name is to follow the legal format
  - Ex, TeKampe (capitalization of other letters)
  - Ex, O'Connor (use the appropriate capitalization and use of characters)
  - Ex, De La Cruz (use appropriate spacing of name as well)
- Seek clarity of names by verifying with an ID or legal documents
- In the prior version of CAREWare the middle initial was the only thing collected
- The critical fields are the first and last name
- Nicknames/aliases are to be placed in the memo field, see memo field instructions

Date of Birth

The client's true date of birth, record it from an id card if needed for verification.
Notes:

- The use of estimated birthdates is not allowed
- If you do not have the birth date you will not be able to enter the client into CAREWare

Gender

The client's self reported gender they identify as.
Notes:

- This is a self reported field
- Unknowns are unacceptable, Must have this information

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25. Gender of clients
Report the actual unduplicated numbers of male,
female, and transgender clients (this item should be
based on the self-report of the client), and the
number of clients for whom gender is unknown or
unreported. Include infants under the age of 2
whose HIV status is indeterminate in the HIVpositive/
indeterminate column. Do not include any
anonymous clients in these counts.
Transgender is an individual who exhibits the
appearance and behavioral characteristics of
the opposite sex and is based on self-report by that individual.

Client URN and Encrypted URN

These are calculated fields and the URN can be modified to accommodate multiple clients with the same URN and the encrypted URN is an encrypted value for the URN.
Notes:
- First and Third Initials of First name
- First and Third Initials of Last name
- Date of Birth
- Gender – 1 = male, 2=female, 3=transgender, 9=unknown/unreported
- Unique character

Ethnicity/Race

Indicate if the client is Hispanic or not and then indicate what race(s) the client identifies themselves as
Notes:
- This is a required field, unknown/unreported is not valid
- This is a self report field
- If a client is marked as Hispanic, you do not need to check a race field
- A client that has an unknown Ethnicity and no Race checked will report as unknown/unreported

2007 Instructions for the Ryan White HIV/AIDS Program Data Report Page 12-13
27. Race/Ethnicity of clients
Report the actual unduplicated number of clients in each racial and ethnic group, based on the selfreport of the client. All individuals who identify themselves with more than one race should be counted in the "More than one race" category. Include infants under the age of 2, whose HIV status is indeterminate, in the HIVpositive/ indeterminate column. Do not include any anonymous clients in these counts.
Data Quality Check The total number of HIV-positive/indeterminate and HIV-affected clients reported in Item 27 must equal the total number of HIV-positive, HIVindeterminate, and HIV-affected clients reported in Item 23.
The following racial category descriptions, defined in October 1997, are required for all Federal reporting, as mandated by the Office of Management and Budget (For more information go to http://www.whitehouse.gov/omb/fedreg/1997standards.html).
White (not Hispanic) is an individual having origins in any of the original peoples of Europe, the Middle East, or North Africa, but not of

Hispanic ethnicity.
Black or African American (not Hispanic) is an individual having origins in any of the black racial groups of Africa, but not of Hispanic ethnicity.
Hispanic or Latino(a) is an individual of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.
Asian is an individual 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.
Native Hawaiian or Other Pacific Islander is an individual having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
American Indian or Alaska Native is an individual having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
Unknown/unreported is an individual who did not self-report either race or ethnicity.

HRSA CAREWare User Manual 7/16/2006

For HRSA CADR reporting purposes, Race/Ethnicity needs to be entered for each client. This is self-selected by clients, and your intake forms should reflect these categories.

Many Hispanic clients self-select Hispanic as their ethnicity and do not specify a race. *CAREWare will no longer consider this as missing data for CADR purposes.* However, if a non-Hispanic client's race is not specified, it *will* be considered missing data for that individual.

Client ID

Not Shared

This is a provider specific field that is used to identify clients between multiple systems. Each agency will determine the use of this field.

Address Fields

Address, City, State, Zip, Include on Label Report

These fields indicate the client's mailing address. The data is to be entered following the USPS guidelines for bulk mail.
Notes:

- If a client has a different eligibility address you will need to record the eligibility address in the memo field, see memo field instructions
- State Field is a drop down list, which is used to build the County Field
- If the client homeless and does not have a mailing address, enter Homeless in the street address line
- Include on Label Report
  - Will allow you from within CAREWare to run the mailing labels report
  - Is not shared

County

This field indicates the county in which their eligibility address is.
Notes:

- If the client's mailing address and eligibility addresses calculate different County's use the county that matches the eligibility address
- This is not a mailing address field, this is an eligibility field

Phone Number

This field will not be used, each provider will have custom fields setup to capture this information.
Notes:

- DO NOT USE
- Move the phone number and additional contact information to the custom fields' setup for your agency.

Memo Field

This field is to be used only for showing a client's aka/aliases and/or eligibility address information
Notes:

- Recording AKA/Aliases/Nicknames
  - Click into the Memo Field and go to the beginning of the field
    - Type AKA:
    - Immediately following AKA: enter the additional names the client goes by
- Recording Eligibility Address Information
  - Click into the Memo Field and go to the area below the AKA info (if applicable, otherwise you would start at the beginning of the field)
    - Type Eligibility Address:
    - On the next line enter the street address
    - On the next line enter the City State Zip
  - If a client is homeless with a mailing address, indicate in the memo field as homeless
- This is the format for this field

- Any additional information will need to be stored in the Case Notes or in custom fields

HIV Status and Diagnosis Dates

This field is to indicate the current HIV Status of a client and the date(s) that the client was originally diagnosed with the either HIV or AIDS
Notes:

- Once a client has been diagnosed as AIDS, they must be reported as AIDS
  - The status may change from HIV to AIDS
  - The status can not change from AIDS back to HIV
- The Date fields will become active depending on the HIV Status that is selected
  - Using an estimated date here is fine
  - Be sure to ask the client for the earliest date they where diagnosed

2007 Instructions for the Ryan White HIV/AIDS Program Data Report Page 14-15
31. HIV/AIDS status
Report the total number of clients by their
HIV/AIDS status at the end of the reporting period.
HIV-positive, not AIDS clients have tested positive
for and been diagnosed with HIV, but have not
advanced to AIDS.
HIV-positive, AIDS status unknown clients have
tested positive for and been diagnosed with
HIV. It is unknown whether or not the client
has advanced to AIDS.
CDC-defined AIDS clients have advanced to and
been diagnosed with CDC-defined AIDS.
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HIV-indeterminate clients are children under age 2,
born to mothers who were HIV-infected, and
whose HIV status is not yet definite.
HIV-negative (affected) clients have tested negative
for HIV and are an affected partner or family
member of an individual who is HIV-positive.
Unknown (affected) indicates the HIV/AIDS status
of the client is unknown and not documented.
NOTE: Once a client has been diagnosed with
AIDS, s/he is always counted in the CDC-defined
AIDS category regardless of disease indicators (i.e.,
CD4 counts).

HIV Risk Factor

This field is to indicate the factor that places the client at risk for disease.
Notes:

- Based upon client's self report
- This is a required field
- Check all that apply

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44. HIV exposure category

Report the number of unduplicated clients in each of the HIV exposure categories.

Clients with more than one reported mode of exposure to HIV are counted in the exposure category listed first in the hierarchy, except for males with a history of both sex with men and injection drug use. They are counted in a separate category.

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.

MSM and IDU cases include men who report sexual contact with men and 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).

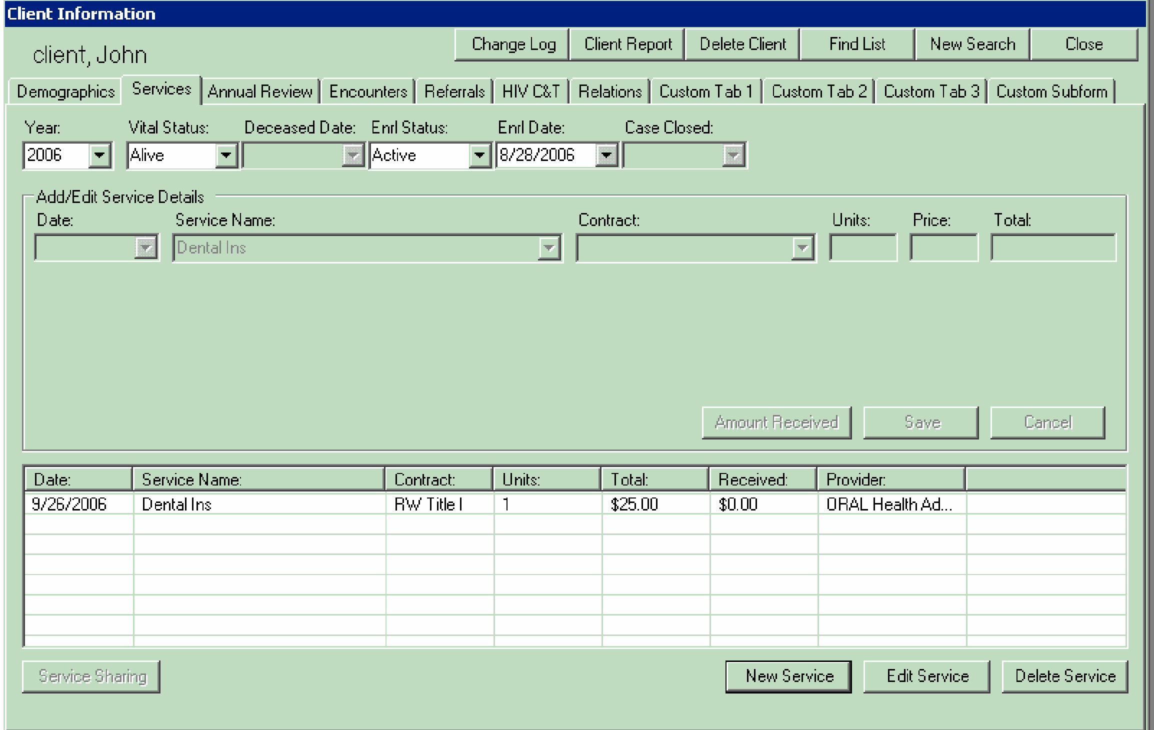
Receipt of transfusion of blood, blood components, or tissue cases include transmission through receipt of infected blood or tissue products given for medical care.

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.

Undetermined/unknown, risk not reported or identified indicates the client's exposure category is unknown or not reported for data collection.

Service Tab



Year

This is drop down list to review either the current year information or prior year information

Vital Status

This field indicates if the client is alive/deceased/unknown
Notes:

- Should be used to indicate alive or deceased
- Unknown should not be used
- Please use this field carefully as the client will show up as deceased on all providers.

Deceased Date

This field indicates the date a client was deceased
Notes:

- Enter the best date you know of the client's death

Enroll Status

Not Shared

This field indicates the client's status within a provider
Notes:

- Choices are
  - Active
  - Inactive/Case Closed
  - Unknown

Enroll Date

Not Shared

This field indicates the date a client was first enrolled with this provider
Notes:

- This should reflect the 1st date a client was seen by this provider
- No services can be entered before this date

Case Closed Date

Not Shared

This field indicates the date a client was closed with this provider
Notes:

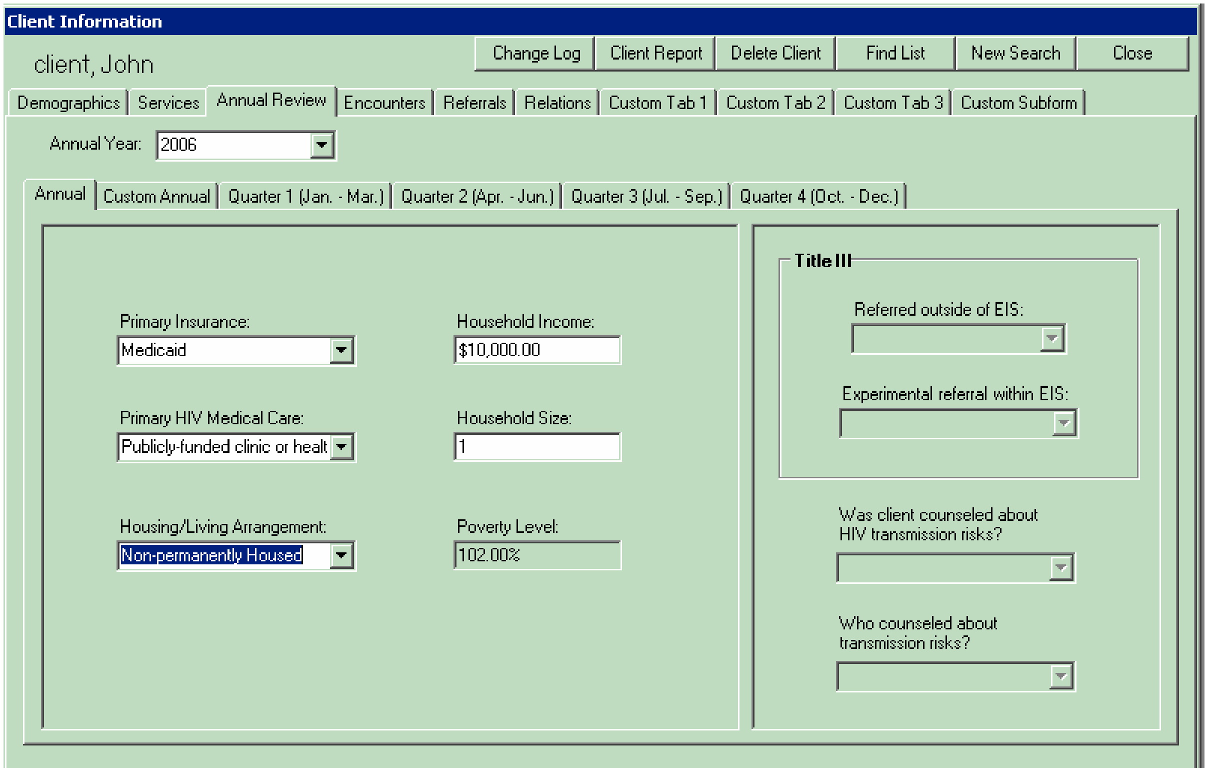
- This will disable you from entering services past the date entered

HRSA CAREWare User Manual 7/16/2006

Services may be entered after a deceased date (for example, when some case management is performed) but not after a case closed date and not before the enrollment date

Annual Tab

In order to view the annual tab you must have at least one service entry posted for the year you want to view.



Primary Source of Medical Insurance

This field is to indicate what the client's primary source is for medical Insurance.
Notes:

- Medical Providers this is based upon Third Party Reimbursements
  - This should be the primary insurance at the end of the reporting period or the most recent data available
  - Other providers, based upon client's self report
- This is a required field

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30. Primary source of medical insurance
Report the number of clients receiving each type of medical insurance **at the end of the reporting period**, or the most recent data available for the reporting period.
Select only one form of insurance for each client.
Report the medical insurance that provides the most reimbursement if a client has more than one source

of insurance at the end of the reporting period. If a client's only means of covering the costs of services is Ryan White HIV/AIDS Program funds, report the client in the "no insurance" category. Include infants under the age of 2 whose HIV status is indeterminate in the HIV-positive/indeterminate column. Do not include any anonymous clients in these counts.

Private includes health insurance plans such as BlueCross/BlueShield, Kaiser Permanente, and Aetna.

Medicare is a health insurance program for people ages 65 years and older, people with disabilities under age 65, 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 people with low incomes.

Other public includes other Federal, State, and/or local government programs providing a broad array of benefits for eligible individuals. Examples include State-funded insurance plans, military health care (TRICARE), State Children's Insurance Program (SCHIP), Indian Health Services, and Veterans Health Administration.

No insurance indicates that the client has no insurance to cover the cost of services (i.e. selfpays).

Other indicates that the client has an insurance type other than those listed above.

Unknown/unreported indicates that the primary source of medical insurance is unknown and not documented.

What plans fall under the HRSA categories:

Medicaid:

All AHCCCS Plans (including any Dept. Of Developmentally Disabled or DDD and any Long Term Care or LTC plan)

Maricopa County Plans: Phoenix Health Plan
Health Choice AZ
Arizona Physicians IPA (APIPA)
Mercy Care Plan
Maricopa Health Plan (MHP)
First Choice
Indian Health Services (IHS)

Pinal County Plans: Community Connection

Mercy Care Plan
Indian Health Services (IHS)

No Insurance: Self-pay; sliding scale programs
Title I

Private: Blue Cross/Blue Shield
HealthSelect
Cigna POS

Primary HIV Medical Care

This field is to indicate what the client's primary method is for Primary HIV Medical Care
Notes:

- Medical Providers this is based what your institution is categorized as
  - Other providers, based upon client's self report
- This is a required field

Choices are:
Publicly-Funded clinic or health department
Private Practice
Hospital Outpatient Center (McDowell Clinic (MIHS), Phoenix Children's Hospital, Phoenix Indian Medical Center, Veterans Administration)
Emergency Room
No primary source of care
Other (Mountain Park)
Unknown

Annual Household Income/Size

These fields are used for poverty level calculations
Notes:

- This field is to be based upon income eligibility documents received at intake and re-certification
- These are required fields

* The Phoenix EMA uses the local standards as defined in the Ryan White Part A Policy and Procedures manual (Section 1.C page 6). This text is left in the document as a reference, but the local definition applies to the CAREWare fields for household income and household size.

Client must provide current (within 90 days) proof of income. Proof of income, with payee's name indicted, includes all of the following types of documentation that apply to client and each member of his/her household (a household consists of the participant, spouse and dependent children less than 18 years of age);

Check stubs listing gross wages/employer's statement listing gross wages,

Self-employment business records,

Income award letters/grant or educational benefits letter,

Social Security award letters, food stamp, G.A., or AFDC award letters, and /or

Other current documentation showing income or source of assistance received (this may include a latest W-2 [tax] form or a submitted Tax Return for the previous tax year).

Text from Page 6 of the Ryan White Part A Policies and Procedures Manual

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28. Annual household income

Report the annual household income category of the client **at the end of the reporting period**, or report the most recent data available within the reporting period. Income is defined in ranges relative to the Federal poverty guidelines. Include infants under the age of 2, whose HIV status is indeterminate, in the HIV-positive/indeterminate column. Do not include any anonymous clients in these counts.
Household includes all people who occupy a house, an apartment, a mobile home, a group of rooms, or a single room. A household consists of a single family, one individual living alone, two or more families living together, or any other group of related or unrelated people who **share** living arrangements.
Household income is the sum of money received in the previous calendar year by all household members, ages 15 years and older, including household members not related to the householder and people living alone.
Families and individuals are classified as below poverty level if their total family income or unrelated individual income was less than the poverty threshold specified for the applicable family size, age of householder, and number of

related children under 18 present. Poverty status is determined for all families (and, by implication, all family members).

For individuals not in families, poverty status is determined by their income in relation to the appropriate poverty threshold. Thus, two unrelated individuals living together may not have the same poverty status. The poverty thresholds are updated each year to reflect changes in the Consumer Price Index. See Poverty Guidelines, Research, and Measurement at http://aspe.hhs.gov/poverty/.

Household income categories:

Equal to or below the Federal poverty level indicates that the client's annual household income is the same as or below the Federal poverty level.

Within 101–200% of the Federal poverty level indicates that the client's income is equal to or no more than double the Federal poverty level.

Within 201–300% of the Federal poverty level indicates that the client's income is double or no more than triple the Federal poverty level.

More than 300% of the Federal poverty level indicates that the client's income is triple or more above the Federal poverty level.

Unknown/unreported indicates that the client's income is unknown or was not reported.

Housing/Living Arrangement

This field is to determine the client's homeless status
Notes:

- This field is to be based upon residency eligibility to indicate what type of housing a client resides in as defined below
- This is a required field

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29. Housing arrangement categories
Report the number of clients according to their regular place of residence **at the end of the reporting period**, or most recent data available within the reporting period, using the categories defined below. Include infants, under the age of 2 whose HIV status is indeterminate, in the HIVpositive/ indeterminate column. Do not include any anonymous clients in these counts.
Housing/living arrangements:
Permanently housed includes clients who reside in apartments, houses, foster homes, long-term residences, and boarding homes, as long as they are not time limited.
Non-permanently housed includes clients who are homeless, as well as those living in transient or transitional housing. Homeless includes shelters, vehicles, the streets, or other places not intended as a regular accommodation for living. Transitional housing includes any stable but temporary living arrangement, regardless of whether or not it is part of a formal program.
Institution includes residential, health care, and correctional facilities. Residential facility includes supervised group homes and extended treatment programs for alcohol and other drug abuse or for mental illness. Health care facility includes hospitals, nursing homes and hospices. Correctional facility includes jails, prisons, and correctional halfway houses.
Other includes other housing/living arrangements not listed above.
Unknown/unreported indicates that housing/living arrangements were not reported.

Annual Income Formulas

Due to fluctuations in income and part time employment the following formulas should be used for calculating out annual household income.

Collect income documents for one to three months depending on how much a client's household income fluctuates. A minimum of one month's pay stubs should be attained for all members of the clients household as defined above by the Title I office (based upon a client's tax filing status)

How many pay stubs are needed:

Client is paid:	Number Needed	Number of Pay Periods
Weekly	4	52
Bi-Weekly	2	26
Semi-Monthly	2	24
Monthly	1	12

Formulas:

Note: When calculating income make sure to take into account overtime pay and such. By attaining a months worth of stubs you should be able to see averages.

Weekly Pay

1) Average the 4 pay stubs - Add all the gross pay amounts and divide by 4
2) Average Pay from step 1 X 52 = Annual Household Income

Bi-Weekly Pay

1) Average the 2 pay stubs - Add all the gross pay amounts and divide by 2
2) Average Pay from step 1 X 26 = Annual Household Income

Semi-Monthly Pay

1) Average the 2 pay stubs - Add all the gross pay amounts and divide by 2
2) Average Pay from step 1 X 24 = Annual Household Income

Monthly Pay

1) Monthly pay stub gross pay X 12 = Annual Household Income

NOTE: There are always exceptions to the verification of income, i.e., self employed, seasonal and or commission sales. Seek assistance from other team members for proper calculations. These cases will probably require the collection of three months of documents to average out annual household income.

Centralized Eligibility

CAREWare will be used to manage the eligibility status of a client across all providers. This system does not have the capabilities to pop up messages regarding client status and requires each end user to understand which screens must be reviewed to determine the current client status.

Each defined service has different eligibility requirements in regards to FPL guidelines and various sources for other payers (ensuring that RW Part A is the payer of last resort). This system does not have the capabilities to pop up messages regarding these additional eligibility requirements and requires each end user to understand which screens will assist them in assessing any additional requirements.

Documentation requirements that are not tracked within the CAREWare system are: Release of Information to Maricopa County and Inter-provider, Client Grievance procedures and client rights and responsibilities. These are all documents that must be collected and maintained in a client chart for review and auditing purposes.

Client Eligibility Status Verification

1. Client Status
   a. Providers must review the Central Eligibility tab to determine if a client is eligible for services. This tab will give a snapshot status on overall client status, due dates for documentation required, FPL calculation and other payer sources.
   b. Client Eligibility Status
      i. Eligible - This indicates that the client can receive services.
      ii. Not Eligible – Indicates the client must provide documentation to receive services
      iii. Pending – This indicates the client is in a 30 day period to provide documentation to continue services, the client is still eligible for services
   c. FPL – determines the income level for a client
      i. 1 = 0-100%
      ii. 2 = 101-200%
      iii. 3 = 201-300%
      iv. 4 = 301-400%
      v. 9 = 401- and above or No Annual Income is indicated so can not be calculated
   d. Other Payer – various fields are on this tab indicating if the client has insurance, use these as a guide to determine for the service you are providing that the Ryan White Part A program is the payer of last resort. Each agency will have internal procedures on this as well that must be followed. Some service categories do not have other payer sources.

Provider Data Collection

1. Providers will collect from clients the approved eligibility documents: proof of HIV status, Income Verification, Residency Verification and proof that Ryan White Part A is the payer of last resort.
2. Providers must enter the annual household income and household size on the Annual tab upon receipt of new income documentation. Providers must utilize the approved methodology as defined in the policy to calculate the annual income of a client based on income documents received and number in household. This is a vital calculation because it determines the clients FPL used in each defined service.
3. Providers must enter into the Documentation tab a minimum of the date and type of documentation received. This information is not shared among providers; it is shared with the Ryan White Part A office for verification and monitoring.
4. Providers must fax all eligibility documentation to the Ryan White Part A office for verification.
    a. Initial Intake forms and Release of Information to Ryan White Part A office (new clients)
    b. Ryan White Part A Eligibility form completed by provider and signed by client.
    c. Ryan White Part A Income worksheet
    d. Documentation provided by client

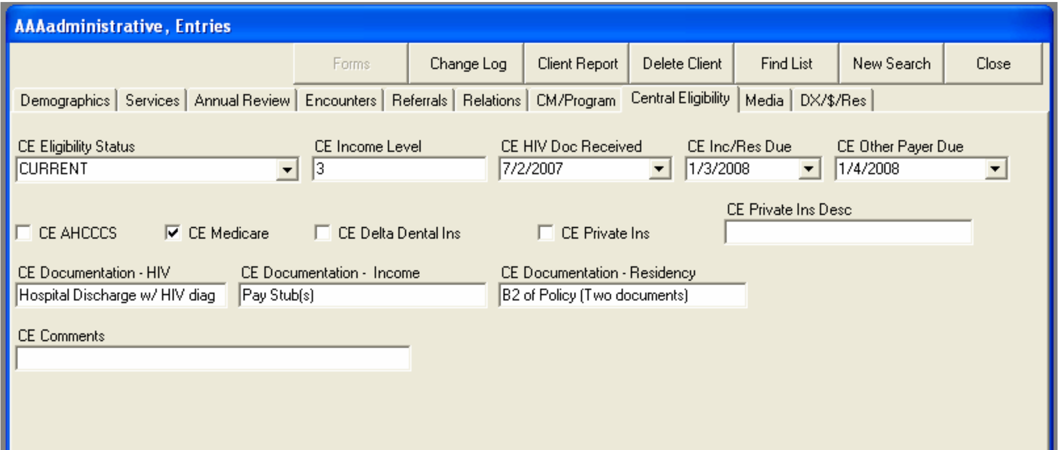
Ryan White Part A Data Verification

1. Part A office staff will verify the information for completeness and that the documentation provided is within the approved guidelines for eligibility.
2. Part A office staff will record in CAREWare under the service tab the verification of documents.
    a. Verification of documents along with type of document and/or identify that documents met which part of the policy (ie, residency)
3. Part A office staff will update the various other payer sources on the Central Eligibility tab.
4. Part A office staff will verify the annual income is entered properly on the Annual Tab.
5. Part A office staff will keep a scanned image of all documents verified in a secured database on the Central CAREWare database server.
6. Part A office will notify the appropriate provider of discrepancies in data entry and unacceptable documents.

Ryan White Part A Status Updates

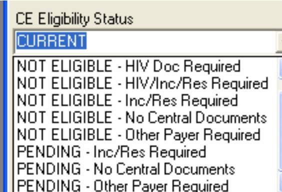
1. CAREWare will be updated based on the above various data collection procedures.
2. The update will occur throughout the business day at a minimum every hour.
3. Part A office staff will record in CAREWare under the service tab the verification of documents.
4. Part A office staff will update the various other payer sources on the Central Eligibility tab.
5. Part A office staff will verify the annual income is entered properly on the Annual Tab.

Central Eligibility Tab



CE Eligibility Status

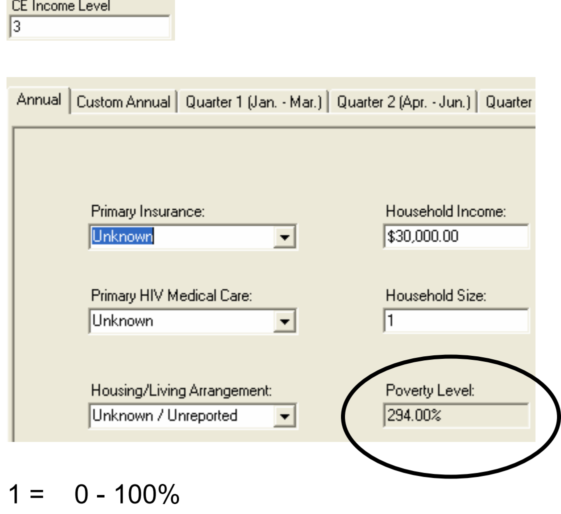
This is a calculated field based upon the verification documents entered under the services tab by the Ryan White Part A office.



- Current – All Eligibility Documents have been received
- Not Eligible – Indicates the client is not eligible for service and which documents are missing
- Pending – Indicates the client is currently within a 30 day grace period, so they are eligible for services but are due to provide documents.
- No Central Documents
    - This status indicates that the AA office has not received/verified the appropriate documents to show a client has been initially enrolled into the system.
    - New Clients
        - They will be given a pending status for 30 days to allow for providers to receive the documents from the client. The client is eligible for services but is currently due to provide documents.

CE Income Level

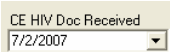
This is a calculated field based upon the current calculation for from the Annual tab. This field is used to determine if the client meets the FPL eligibility limits for a service. Clients with a 9 are not eligible for any Ryan White Part A Services.



1 = 0 - 100%
2 = 101- 200%
3 = 201- 300%
4 = 301- 400%
9 = 401 and above or No Annual Income/Household Size is indicated is so can not be calculated

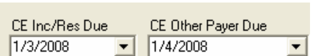
CE HIV Doc Received (Verified)

This is a calculated field based upon the information entered on the services tab from the Ryan White Part A office verifying the required documentation was received.



CE Inc/Res Due and CE Other Payer Due

This is a calculated field based upon the information entered on the services tab from the Ryan White Part A office verifying the required documentation was received. Both of these items are due every 6 months for recertification. The field indicates when recertification of these two items is due.

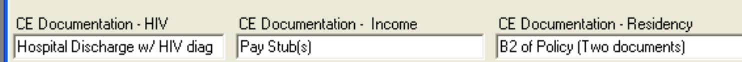


CE Other Payer Sources

These fields are entered by the Ryan White Part A office based upon the latest documentation indicating if the client has other payer sources. The CE Delta Dental Ins field is calculated from the current roster of clients on Delta Dental. Providers should use this field as a indicator of what the client has reported as a guide to assist with internal third party reimbursement policies that meet the requirements of the Modernization Act indicating the Ryan White funds are the payer of last resort.

CE Documentation

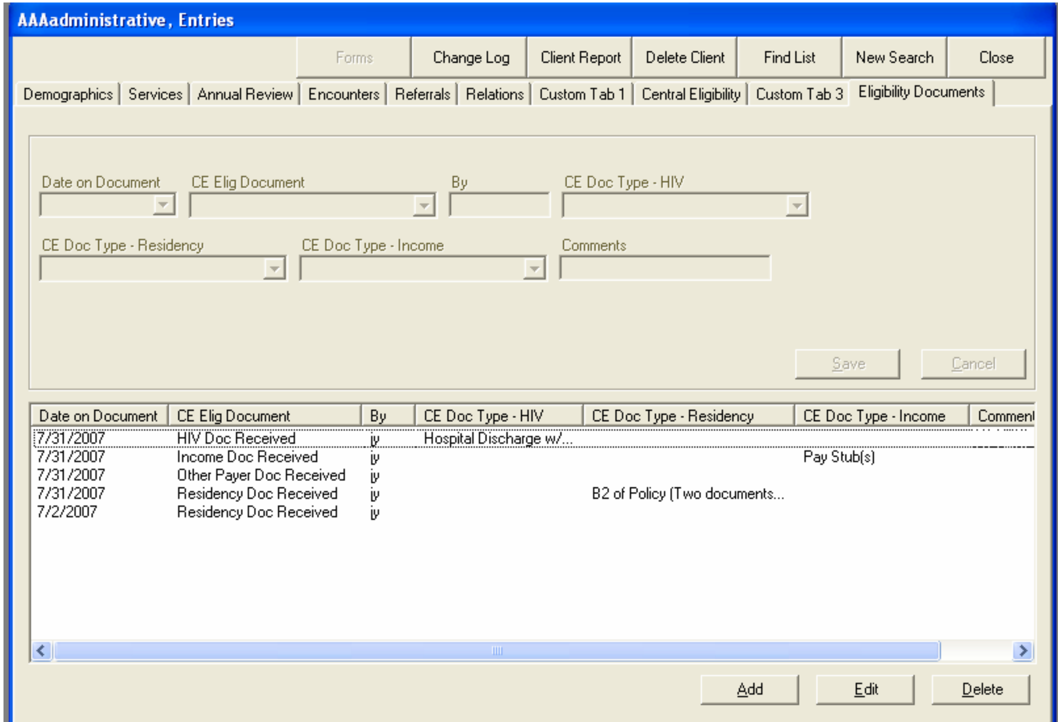
These are calculated fields based upon the information entered on the services tab from the Ryan White Part A office verifying the required documentation was received. The type of document and/or how the documents met the eligibility policy is displayed



CE Comments

This field is updated by the Ryan White Part A office to issue a message regarding the status of a client to the providers. This is an information only field and will be used on an as needed basis.

Eligibility Documentation Tab



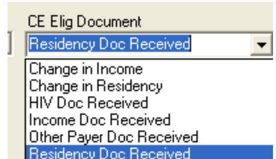
This tab indicates for each provider what documents where received along with how the document meets the requirements. There may be other uses for this tab as defined by an individual provider needs. This tab may be named differently by each provider. The information entered in this tab is only visible to the provider that entered the information and the Ryan White Part A office.

Date on Document

This is the date the document(s) where received by the provider.

CE Eligibility Document

This field is entered by the provider receiving the document.



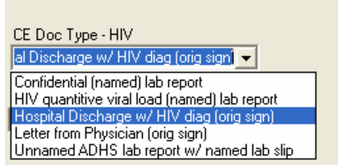
- Change in Income – Client Reported Change of Eligibility
- Change in Residency – Client Reported Change of Eligibility
- HIV Doc Received – Provider received HIV documentation that meets the requirements
- Income Doc Received – Provider received Income documentation that meets the requirements

- Other Payer Doc Received – Provider received Other Payer documentation that meets the requirements
- Residency Doc Received – Provider received Residency documentation that meets the requirements

NOTE: When a client notifies you of an address or income status change, you must record the item as the change and also record that you received new documentation. When a client reports a change to income and/or residency the eligibility status will be changed to pending for 30 days to allow the client time to provide the proper documentation.

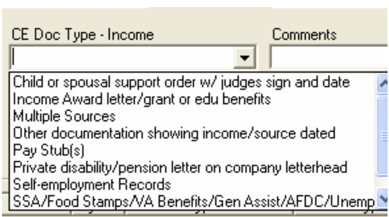
CE Doc Type - HIV

This field is entered by the provider receiving the document.



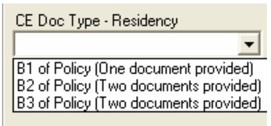
CE Doc Type - Income

This field is entered by the provider receiving the document and indicates what type of income documentation has been received that meets the requirements.



CE Doc Type - Residency

This field is entered by the provider receiving the document and indicates under what option 1,2,3 does the residency documentation received meet.



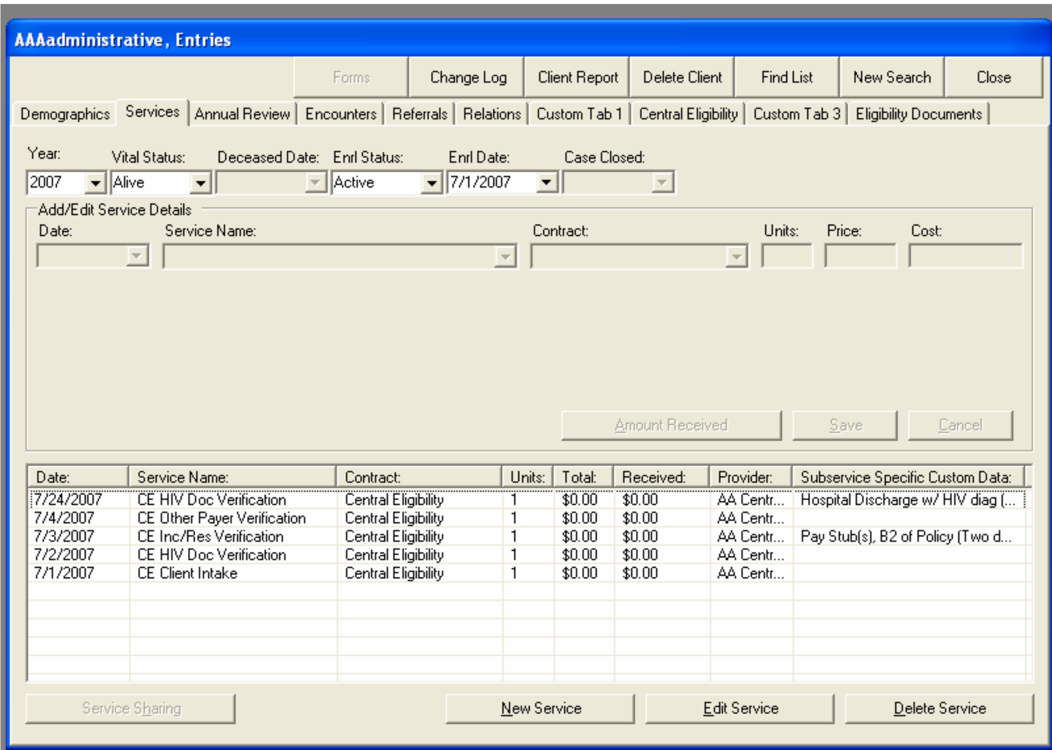
By and Comments

These fields are used to indicate which employee at the provider verified that the documents meet the requirements and any additional comments.

Additional Fields

Other fields may be added in this screen for internal provider purposes.

Eligibility Services Entered Tab



This tab will show all verifications completed by the Ryan White Part A office. These will be seen by all providers.

NOTE: The eligibility status update on the Central Eligibility tab is dependent upon the activities posted under services.

Referrals

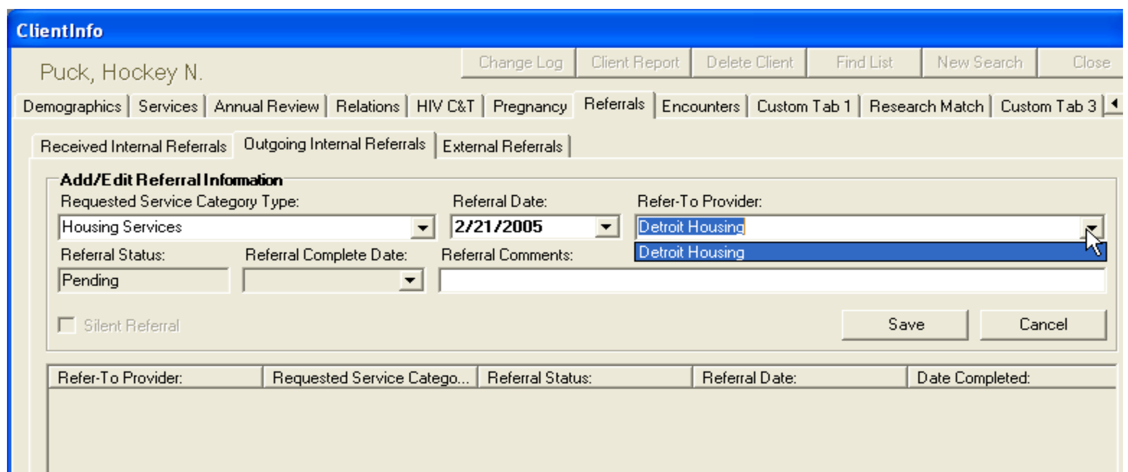
There are two types of referrals in CAREWare 4.0/4.1: **Internal** referrals are made between providers who are connected to a central database on a real-time network (for instance, a primary care provider and a housing agency both receiving funds from a Title I grantee). **External** referrals are made to providers who are not part of the real-time database network managed by the grantee. External referrals are the only type available to standalone users.

ⓘ Important difference between *Service* and *Referral*

A *service* is any service for which a provider pays **any** part. If you refer a client to a dermatologist, for instance, and you pay the copay for that visit out of your contract funds, that is a *service;* enter it in the Service tab. If you refer the client and pay no part of the cost of the visit, it is a *referral;* enter it in the Referral tab.

Making Internal Referrals on a realtime network of providers

To make a referral to another provider on your network, go to the Referrals tab and then click the 'Outgoing Internal Referrals' subtab:

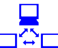


- Select a service category, then enter the referral date. Only those providers within the network who provide services in the category you selected will be displayed on the Refer-To Provider pulldown menu.

- Referral Status and Referral Complete Date will be shaded out; the status defaults to "Pending." This setting will be changed by the receiving agency if and when the

client follows through on the referral.

- When the internal referral service has been received and entered by the referred-to provider, this specific referral will automatically get set to 'Completed' and will be removed from the pending list.



About "Silent" Referrals

A "silent" referral allows you to make a referral with a higher degree of confidentiality. With a normal, internal referral, the receiving provider gets a system message when they logon informing them that a client has been referred (see screenshot on top of page 4). With a silent referral, the referred-to provider does not know the client has been referred until that client makes contact with that provider.

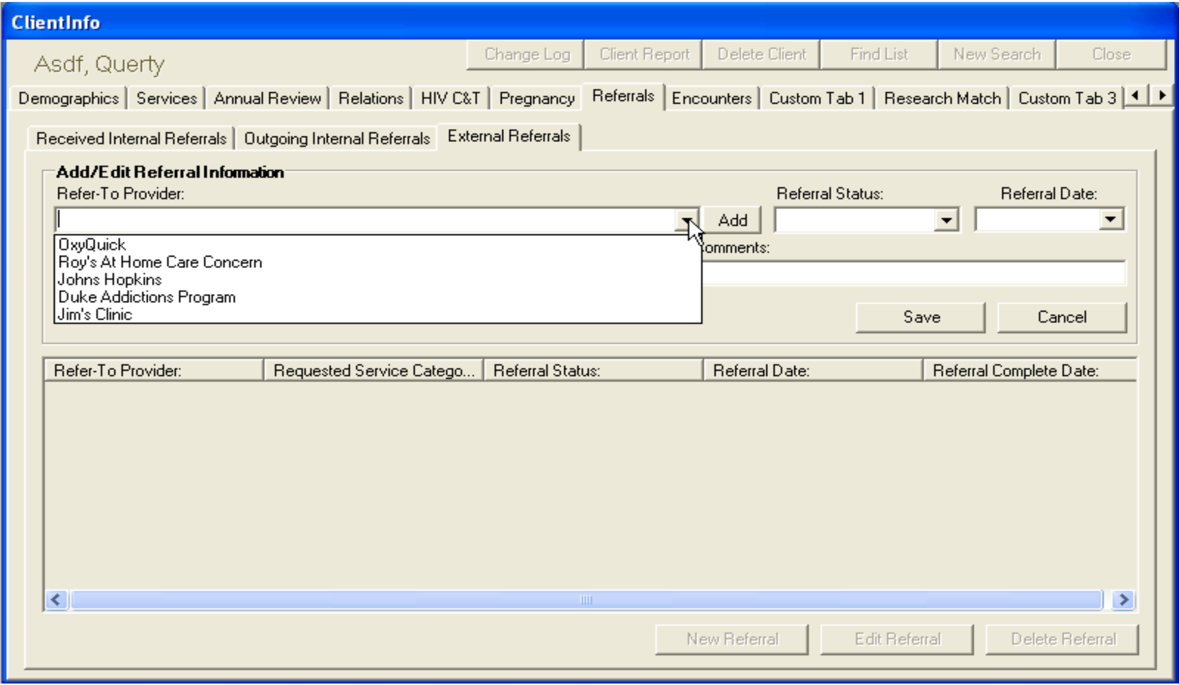
For silent referrals, the referred-to agency will have to enter the client as a new client, at which time they will get the "possible duplicate client" menu (page **Error! Bookmark not defined.**), after which they will be notified onscreen that this client has been referred from another provider on the network.

Silent referrals are more confidential than ordinary internal referrals. If the client never follows up on the referral, the other agency will never know that this individual is HIV-positive or in need of their services.

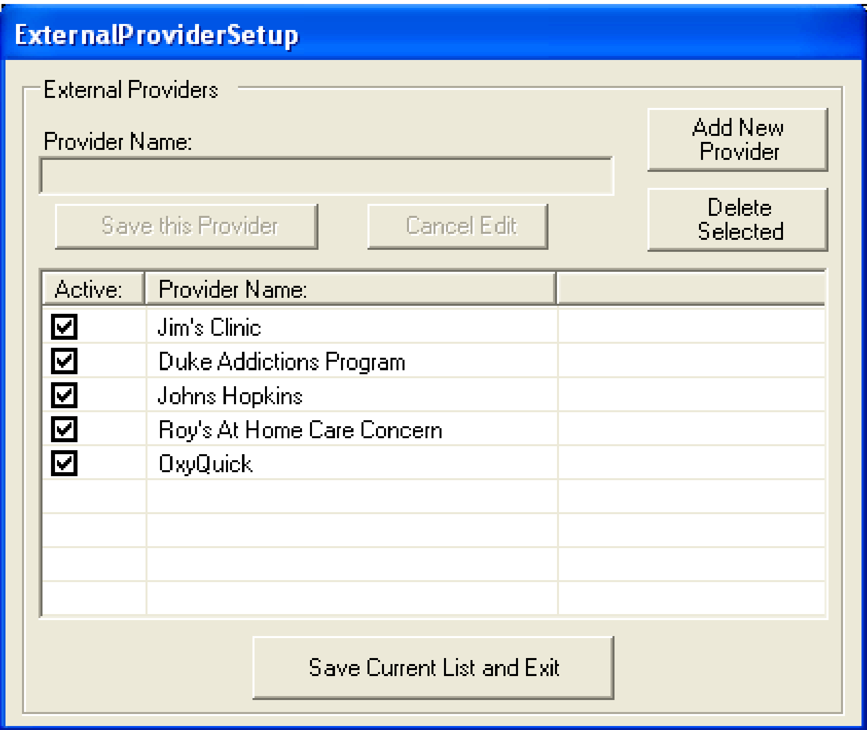
To make a silent referral, check the box under the Referral Status field. You may also edit outgoing referrals that have not been completed, and alter their silent/non-silent status.

External Referrals

To make an external referral, go to the Referrals tab/External Referrals subtab. Whereas an internal referral begins with the service type and then "narrows down" the number of internal providers to whom you can refer a client for that type of service, the External Referrals is completely flexible. The Refer-To Provider pulldown will show you all external providers to whom your agency has previously made referrals:


ClientInfo
Asdf, Querty
Change Log
Client Report
Delete Client
Find List
New Search
Close
Demographics
Services
Annual Review
Relations
HIV C&T
Pregnancy
Referrals
Encounters
Custom Tab 1
Research Match
Custom Tab 3
Received Internal Referrals
Outgoing Internal Referrals
External Referrals
Add/Edit Referral Information
Refer-To Provider:
Add
Referral Status:
Referral Date:
OxyQuick
Roy's At Home Care Concern
Johns Hopkins
Duke Addictions Program
Jim's Clinic
Save
Cancel
Refer-To Provider:
Requested Service Catego...
Referral Status:
Referral Date:
Referral Complete Date:
New Referral
Edit Referral
Delete Referral

If the agency to whom you are referring the client is not on the list, push the **Add** button:



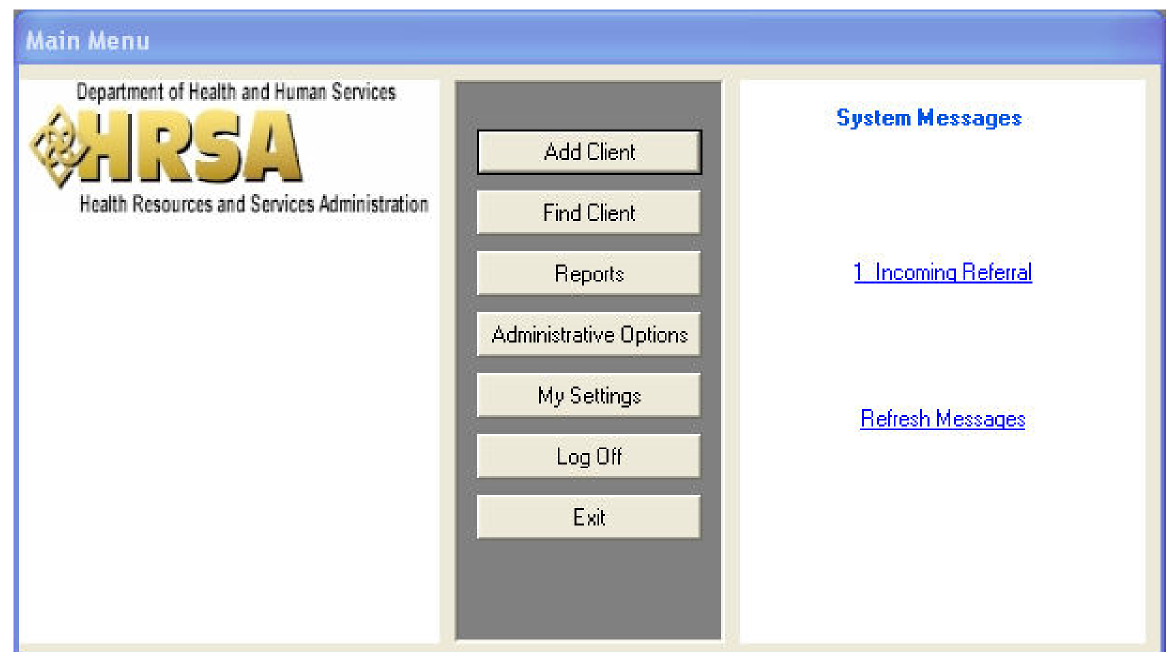
Select **Add New Provider** and enter the provider name, then select **Save this Provider.**

You cannot remove providers from the list to whom referrals have already been made, but you can remove them from the pulldown menu by unchecking the "Active" box next to their name.

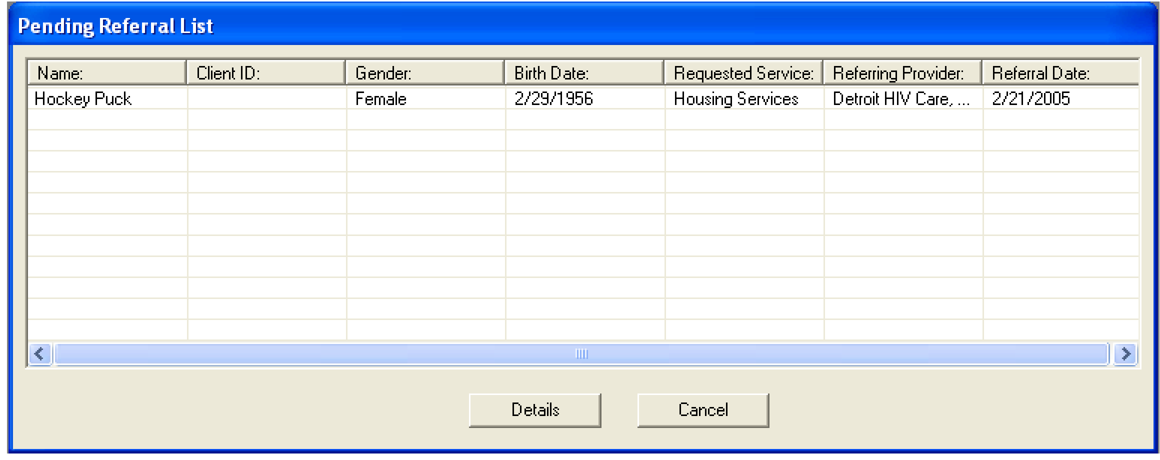
- New referrals should be marked "Pending." When the referral's status changes, you can return to this subtab, edit the status, and add the date the referral was rejected, completed or lost to follow-up.

Handling an incoming (non-silent) referral

Providers within a network will know when a client has been referred by another provider when they see a system message on the right-hand side of the main menu screen.



Click on the link to the incoming referral, select a referral and press **Details**, or double click the line item:



Name:	Client ID:	Gender:	Birth Date:	Requested Service:	Referring Provider:	Referral Date:
Hockey Puck		Female	2/29/1956	Housing Services	Detroit HIV Care, ...	2/21/2005

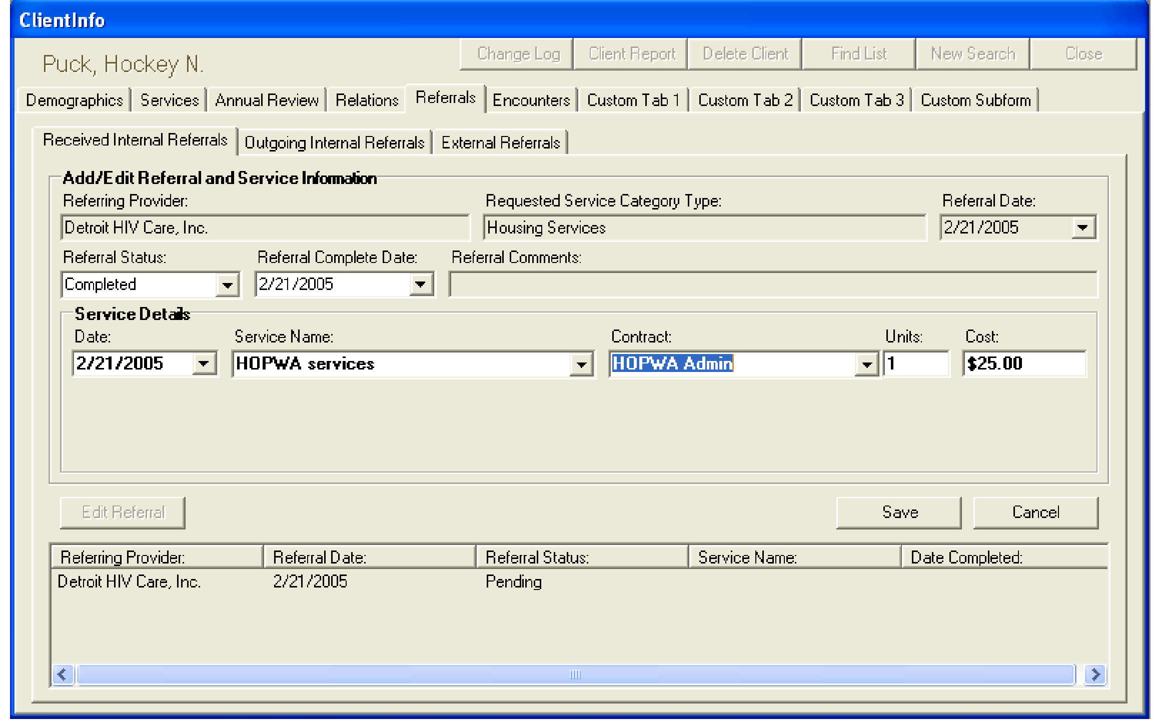
NOTE: Clicking “refresh messages” will refresh the system messages on the main menu. If you have one referral, and act on it, and refresh messages, that incoming referral message will disappear.

If the client is already a client of both providers, when you open the referral you will be taken directly to the Referrals tab/Received Internal Referrals subtab.

Handling an incoming (non-silent) referral (cont'd)

If the client is not yet a client of the agency receiving the referral, that agency will see the "Possible Duplicate Client" message (see page **Error! Bookmark not defined.**). This will prompt them to link their agency to this client's record.

Select any referral at the bottom of the screen, double-click it or press **Edit Referral**:



You can enter a service record directly on this screen (it will show up under the Services tab when you're done).

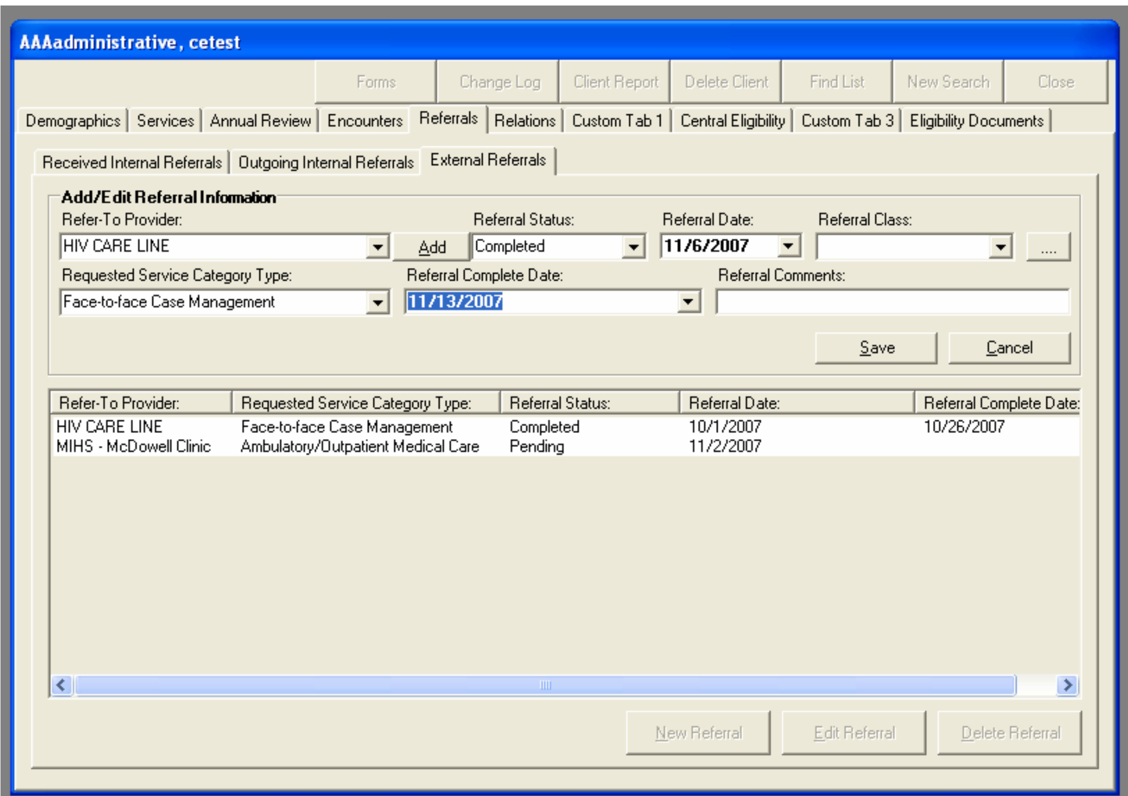
Entering a service automatically changes the Referral Status to "Completed" and the Referral Complete Date to the date of the service. Or, you can mark the referral status "Completed" with a completion date without entering any service.

HIV Care Line Referrals to Case Management

HIV Care Line will refer clients via direct transfer to several of the Case Management Agencies. In addition, new clients may come directly into service to a non-case management provider. Either way, clients are being referred through the HIV Care Line.

These will be different because the HIV Care Line will not be entering the referrals into our system.

To track these services you will go to the External Referral tab:



Create a New Referral

Refer-to Provider: HIV CARE Line
Referral Status: Completed, because the client has contacted you
Referral Date: Get from the client when they called in, ie, a week ago etc… Enter the best date you can determine from the client's statement
Referral Class: Do not use
Requested Service Category Type: Select from the list Case Management
Referral Complete Date: Enter the date you completed the initial intake/assessment with the client.
Referral Comments: For your own notes

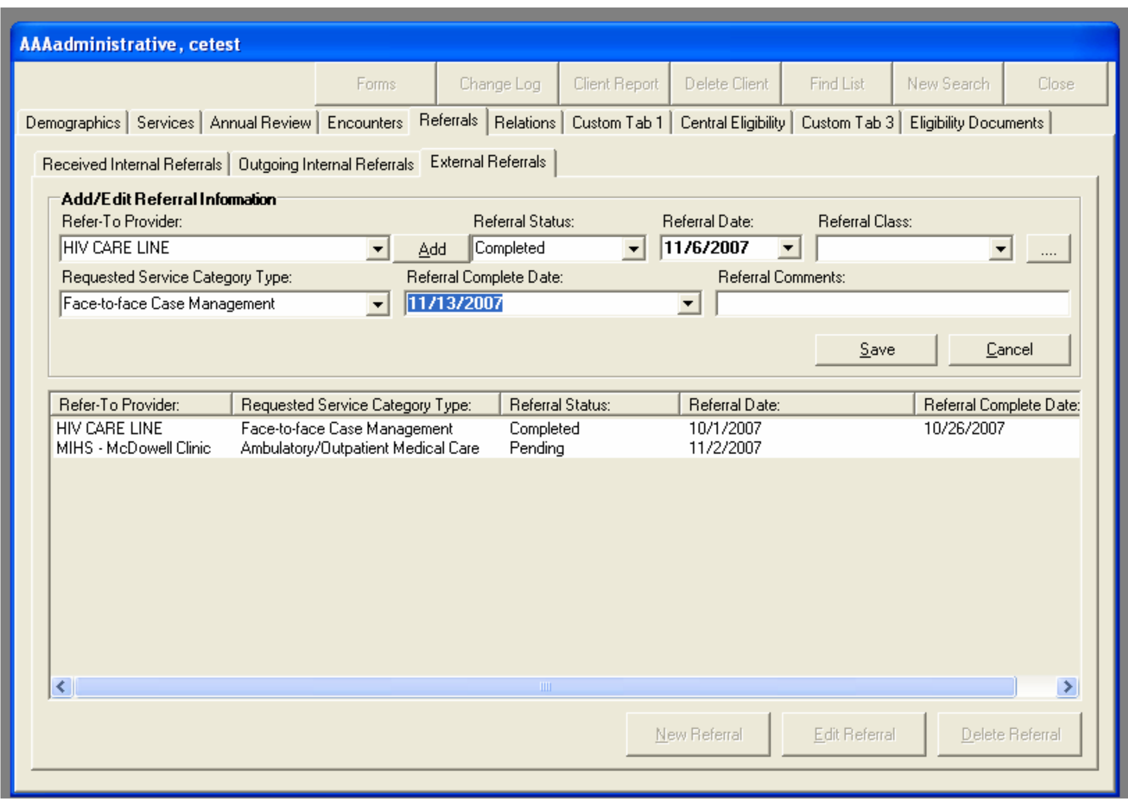
Click SAVE

Primary Medical Care Referrals

HIV Care Line will refer clients via direct transfer to several of the Case Management Agencies. In addition, new clients may come directly into service to a non-case management provider. Either way, clients are being referred through the HIV Care Line.

These will be different because the HIV Care Line will not be entering the referrals into our system.

To track these services you will go to the External Referral tab:



Create a New Referral

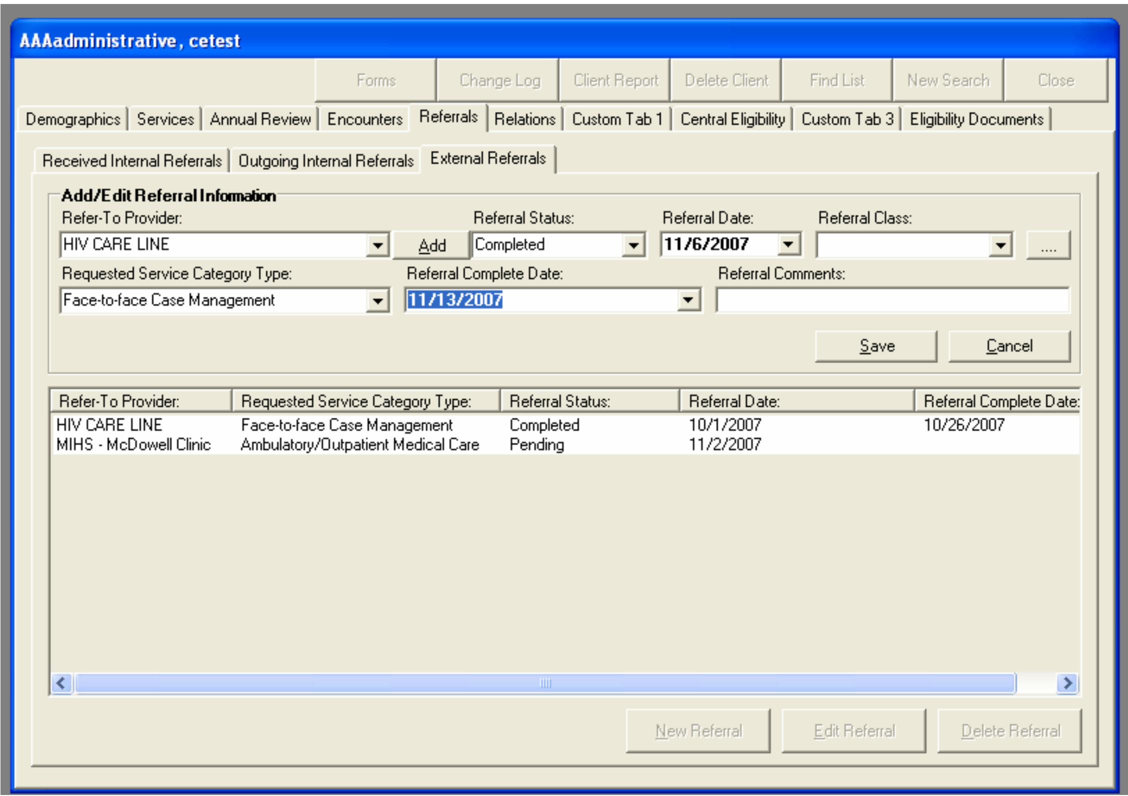
Refer-to Provider: HIV CARE Line
Referral Status: Pending, until you find out the client was seen by the PMC
Referral Date: Get from the client when they called in, ie, a week ago etc… Enter the best date you can determine from the client's statement
Referral Class: Do not use
Requested Service Category Type: Select from the list Ambulatory/Outpatient Medical Care
Referral Complete Date: Enter the date you completed the initial intake/assessment with the client.

Referral Comments: For your own notes

Click SAVE

Recording the referral was complete

To track these services you will go to the External Referral tab:



Select the referral row for the PMC referral
Click the button – Edit Referral

Change the Referral Status – Completed
Enter the Referral Complete Date – Enter the date the client had their first appointment
Referral Comments: You can enter your own notes, ie who confirmed the client was seen

Click SAVE

Additional Outside Referrals

Some clients will be brought in through other sources. These will be tracked using the following external providers. Just like the HIV Care Line the referring source will not be entering the referrals into our system, so you will have to setup the completed referral.

Referrals from a Counseling & Testing Facility

Refer-to Provider: Counseling & Testing
Referral Status: Pending, until you find out the client was seen
Referral Date: Get from the client/facility when the client was diagnosed, ie, a week ago etc… The best date to use is not the actual date of the testing, but the date the final Western Blot results where received
Referral Class: Do not use
Requested Service Category Type: Select from the list Ambulatory/Outpatient Medical Care or Face to Face Case Management based on the service the client seeks.
Referral Complete Date: Enter the date you completed the initial intake/assessment with the client.
Referral Comments: For your own notes
Click SAVE

Referrals from a Self Report of a client via – PCP/ER

Refer-to Provider: Self Report by Client – PCP/ER
Referral Status: Pending, until you find out the client was seen
Referral Date: Get from the client/facility when the client was diagnosed, ie, a week ago etc… The best date to use is not the actual date of the testing, but the date the final Western Blot results where received
Referral Class: Do not use
Requested Service Category Type: Select from the list Ambulatory/Outpatient Medical Care or Face to Face Case Management based on the service the client seeks.
Referral Complete Date: Enter the date you completed the initial intake/assessment with the client.
Referral Comments: For your own notes
Click SAVE

Finalizing the Referral

Select the appropriate referral row for the Case Mgmt/PMC referral
Click the button – Edit Referral
Change the Referral Status – Completed
Enter the Referral Complete Date – Enter the date the client had their first appointment or initial intake (Case Mgmt)
Referral Comments: You can enter your own notes, ie who confirmed the client was seen

Click SAVE

GLOSSARY OF RYAN WHITE HIV/AIDS PROGRAM DATA REPORT TERMS

Active client continuing in program
An individual who was a client when the period started and continued in the program.
Active client new to the program
A client whose first point of contact with the program occurred during this reporting period.
ADAP *AIDS Drug Assistance Program*—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 disease who have limited or no coverage from private insurance, Medicaid, or Medicare.
ADAP Flexibility Policy
HIV/AIDS Bureau's (HAB) Policy Notice 00-02 provides grantees greater flexibility in the use of ADAP funds and permits expenditures of ADAP funds for services that improve access to medications, increase adherence to medication regimens, and help clients monitor their progress in taking HIV-related medications.
NOTE: Grantees ***must*** request in writing to use ADAP dollars for services other than medications.
Administrative or technical support
The provision of qualitative and responsive "support services" to an organization. Services may include human resources, financial management and administrative services (e.g., property management, warehousing, printing/publications, libraries, claims, medical supplies, and conference/training facilities).
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.
Agency reporting for multiple fee-forservice provider
An agency that reports data for more than one fee-for-service provider.
Aggregate data Combined data, composed of multiple elements, often from multiple sources. For example,
combining demographic data about clients from all primary care providers in a service area generates aggregate data about client characteristics.
AIDS *Acquired immune deficiency syndrome*—A disease caused by the human immunodeficiency virus.
American Indian or Alaska Native
An individual having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
Anonymous client No identifying information is collected from the client.
APA *AIDS Pharmaceutical Assistance*—A local pharmacy assistance program implemented by a Part
A EMA/TGA, a Part B State, or a Part C or D agency. The Part B grantee consortium or Part A planning council contracts with one or more organizations to provide HIV/AIDS medications to

clients. These organizations may or may not provide other services (e.g., primary care, case management) to the clients that they serve through a Ryan White (or other funding sources) contract with their grantee. (See **ADAP** and **Local/Consortium Drug Reimbursement Program**)

ARV *Antiretroviral*—A substance that fights against a retrovirus, such as HIV. (See **retrovirus**)

Asian An individual 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.

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Black or African American (not Hispanic)
An individual having origins in any of the black racial groups of Africa, but not of Hispanic ethnicity.

Capacity development
A set of core competencies that contribute to an organization's ability to develop 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 of supplies/equipment; service evaluation; and cultural competency development.

Case management services (medical)
(See **medical case management services**)

Case management services (nonmedical)
Includes the provision of 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, as medical case management does..

CD4 cell count The number of T-helper lymphocytes per cubic millimeter of blood. The CD4 count is a good
predictor of immunity. As CD4 cell count declines, the risk of developing opportunistic infections increases. The normal range for CD4 cell counts is 500 to 1,500 per cubic millimeter of blood. CD4 counts should be rechecked at least every 6 to 12 months if CD4 counts are greater than 500/mm^3. If the count is lower, testing every 3 months is advised. A CD4 count of 200 or less indicates AIDS.

CD4 or CD4+ cells Also known as "helper" T-cells, these cells are responsible for coordinating much of the
immune response. HIV's preferred targets are cells that have a docking molecule called "cluster designation 4" (CD4) on their surfaces. Cells with this molecule are known as CD4-positive (CD4+) cells. Destruction of CD4+ lymphocytes is the major cause of the immunodeficiency observed in AIDS, and decreasing CD4 levels appear to be the best indicator for developing opportunistic infections.

CDC *Centers for Disease Control and Prevention*—The DHHS agency that administers HIV/AIDS
prevention programs, including the HIV Prevention Community Planning process, among other programs. The CDC is responsible for monitoring and reporting infectious diseases, administers AIDS surveillance grants, and publishes epidemiologic reports such as the HIV/AIDS

Surveillance Report.
CEO *Chief Elected Official*—The official recipient of Part A Ryan White HIV/AIDS Program funds
within the EMA/TGA, usually a city mayor, county executive, or chair of the county board of supervisors. The CEO is ultimately responsible for administering all aspects of the Ryan White HIV/AIDS Program in the EMA/TGA and ensuring that all legal requirements are met. In EMAs/TGAs with more than one political jurisdiction, the recipient of Part A Ryan White HIV/AIDS Program funds is the CEO of the city or urban county that administers the public health agency that provides outpatient and ambulatory services to the greatest number of people with AIDS in the EMA/TGA.
Child care services The provision of care for the children of clients who are HIV-positive while the clients are
attending medical or other appointments or attending Ryan White HIV/AIDS Program-related meetings, groups, or training. This does not include child care while the client is at work.
Client (See **infected client** or **affected client**)
Co-morbidity A disease or condition, such as mental illness or substance abuse, co-existing with HIV disease.
Combination therapy Two or more drugs or treatments used together to achieve optimum results against HIV
infection and/or AIDS. For more information on treatment guidelines, visit
http://www.aidsinfo.nih.gov/guidelines.
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Confidential Information such as name, gender, age, etc., that is collected on the client, and the client is
reassured that no identifying information will be shared or passed on to anyone.
Consortium/HIV Care
Consortium
An association of one or more public, and one or more nonprofit private, health care, and support service 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 comprising the consortium are required to have a record of service to populations and sub-populations with HIV.
Continuum of care An approach that helps communities plan for, and provide, a full range of emergency and longterm
service resources to address the various needs of PLWHA.
DCBP *Division of Community-Based Programs*—The division within HRSA's HIV/AIDS Bureau that
is responsible for administering Part C, Part D, and the HIV/AIDS Dental Reimbursement Program.
Dispensing of
pharmaceuticals
The provision of prescription drugs to prolong life or prevent deterioration of health.
DSP *Division of Science and Policy*—The division within HRSA's HIV/AIDS Bureau which serves
as the principal source of program data collection and evaluation, the development of innovative models of HIV care, and the focal point for coordination of program performance activities and development of policy guidance.
DSS *Division of Service Systems*—The division within HRSA's HIV/AIDS Bureau that is responsible

for administering Part A and Part B including the AIDS Drug Assistance Program (ADAP).
DTTA *Division of Training and Technical Assistance*—The division within HRSA's HIV/AIDS Bureau that is responsible for administering the AIDS Education and Training Centers (AETC) Program and technical assistance and training activities of the HIV/AIDS Bureau.
Dual therapy The use of two antiretroviral drugs at one time to reduce the amount of detectable HIV.
Early intervention (See **HIV/EIS**—*HIV/Early Intervention Services/Primary Care)*
EIS for Parts A and B *Early intervention services for Parts A and B* include counseling individuals with respect to
HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, tests 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 providing therapeutic measures.
Eligibility criteria The standards set by a State ADAP, usually through an advisory committee, to determine who
receives access to ADAP services. Financial eligibility is usually determined as a percentage of the Federal Poverty Level (FPL), such as 200% FPL. Medical eligibility is most often a positive HIV diagnosis. Eligibility criteria vary among ADAPs.
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 eligible metropolitan area/transitional grant area are defined by the Census Bureau. Eligibility is determined by AIDS cases reported to the CDC. Some EMAs include just one city and others are composed of several cities and/or counties. Some EMAs extend across more than one State.
Emergency financial assistance
The provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available. Part A and Part B programs must be allocated and tracked, and report these funds under specific service categories as described under 2.6 in DSS Program Policy Guidance No. 2 (formally Policy No. 97-02).
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Epidemic A disease that occurs clearly in excess of normal expectation and spreads rapidly through a
demographic segment of the human population. Epidemic diseases can be spread from person to person or from a contaminated source such as food or water.
Exposure category (See **risk factor**)
Faith-based organization
An organization that is owned and operated by a religiously affiliated entity, such as a Catholic hospital.
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.
Family members Includes children, partners, biological parents, adoptive parents, foster parents, grandparents,
other caregivers, and siblings (who may or may not be living with HIV).

Fiscal intermediary services
Reimbursements received or collected on behalf of health care professionals for services rendered or other related fiduciary services pursuant to health care professional contracts.
Food bank/homedelivered meals
The provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. Includes vouchers to purchase food.
FTE *Full-time equivalent*—A standard measurement of full-time staff (either paid or volunteer), which is based on a 35 to 40 hour work week. It is calculated by taking the sum of all hours worked by staff and dividing by 35 to 40, depending on how your organization defines full-time employment. For example, 2 staff members who work 20 hours each per week represent 1 FTE, assuming full-time employment is defined as 40 hours per week.
Grantee of record The official Ryan White HIV/AIDS Program grantee that receives Federal funding directly from
the Federal government (HRSA). A grantee may also 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 (DHHS) that is responsible for administering the Ryan White HIV/AIDS Program. Within HAB, the Division of Service Systems administers Part A, Part B, and the AIDS Drug Assistance Program (ADAP); the Division of Community-Based Programs administers Part C, Part D, and the HIV/AIDS Dental Reimbursement Program; and the Division of Training and Technical Assistance administers the AIDS Education and Training Centers (AETC) Program. The Bureau's Division of Science and Policy administers the SPNS Program, HIV/AIDS evaluation studies, and the Ryan White HIV/AIDS Program Data Report.
Health education/risk reduction
The provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information about medical and psychosocial support services and counseling, to help clients with HIV improve their health status.
Health insurance premium & cost sharing assistance
The provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.
Hemophilia/ coagulation disorder
Individuals with delayed clotting of the blood.
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Heterosexual contact Individuals who report specific heterosexual contact with an individual with, or at increased risk
for, HIV infection (e.g., an injection drug user).
High-risk insurance pool
A State health insurance program that provides coverage for individuals who are denied

coverage due to a pre-existing 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 maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

Hispanic or Latino/a An individual of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish
culture or origin, regardless of race.

HIV counseling and testing

The delivery of HIV counseling to an individual. Counseling includes pretest and posttest counseling activities (e.g., offering the individual the HIV antibody test, as appropriate; services discussing the benefits of testing, including the medical benefits of diagnosing HIV disease in the early stages and of receiving early intervention primary care; reviewing the provisions of laws relating to confidentiality, including information regarding any disclosures that may be authorized under applicable law, and information regarding the availability of anonymous counseling and testing; and discussing the significance of the results, including the potential for developing HIV disease). Testing refers to antibody tests administered by health professionals to ascertain and confirm the presence of HIV infection (includes ELISA and Western Blot). Counseling and testing ***does not*** include tests to measure the extent of the deficiency in the immune system because these tests are fundamental components of comprehensive primary care. This service category also excludes mental health counseling/therapy, substance abuse counseling/treatment, and psychosocial support services. These services are listed separately.

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

HIV/AIDS status The outcome of the client's HIV test result, which includes (1) HIV-positive not AIDS—client
has tested positive for and been diagnosed with HIV, but has not advanced to AIDS; (2) HIVpositive
AIDS status unknown—client has tested positive for and been diagnosed with HIV, but it is unknown whether or not the client has advanced to AIDS; (3) CDC-defined AIDS—client has advanced to and been diagnosed with CDC-defined AIDS; (4) HIV-negative (affected)—client is HIV-negative and is an affected individual of an HIV-positive partner or family member; and (5) unknown—HIV/AIDS status of the client is unknown and not documented.

HIV/EIS *HIV/Early Intervention Services/Primary Care*—A program that encompasses the care supported by the Part C legislation and is made available by the grantee organization and its subcontractors. Subcontractors render care to clients referred to them by the grantee organization, and are reimbursed for their services, or otherwise have a remunerative relationship with the grantee for the referred service.

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 hospitals services, nursing home and other long term care facilities are **NOT** included.

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

Hospice services Includes room, board, nursing care, counseling, physician services, and palliative therapeutics
provided to clients in the terminal stages of illness in a residential setting, including a non-acutecare
section of a hospital that has been designated and staffed to provide hospice services for terminal clients.

Hospital or university-based clinic
Includes outpatient/ambulatory care/outpatient medical care departments or clinics, emergency rooms, rehabilitation facilities (physical, occupational, speech), hospice programs, substance abuse treatment programs, STD clinics, AIDS clinics, and inpatient case management service programs.

Household All people who occupy a house, an apartment, a mobile home, a group of rooms, or a single
room. A household consists of a single family, one individual living alone, two or more families living together, or any other group of unrelated people who share living arrangements.

Household income The sum of money received in the previous calendar year by all household members 15 years
old and over, including household members not related to the householder, people living alone, and others in non-family households.

Housing services The provision of 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 does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.

HRSA *Health Resources and Services Administration*—The U.S. Department of Health and Human
Services (DHHS) agency 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, provide primary health care to medically underserved people, serve women and children through State programs, and train a health workforce that is both diverse and motivated to work in underserved communities. HRSA is also responsible for administering the Ryan White HIV/AIDS Program.

IDU *Injection drug user*—Individuals who report use of drugs intravenously or through skinpopping.

Inactive client A client whose status is inactive (as defined by your agency), which includes many possible
reasons (e.g., client moved or is lost to follow-up).

Indeterminate client A child under the age of 2 whose HIV status is not yet determined, but was born to an HIVinfected
mother.

Infected client An individual who is HIV-positive who receives at least one Ryan White HIV/AIDS Programeligible

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 facility includes
supervised group homes and extended treatment programs for alcohol and other drug abuse or for mental illness. Health care facility includes hospitals, nursing homes and hospices. Correctional facility includes jails, prisons, and correctional halfway houses.
Legal services The provision of 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. It does **not** include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.
Linguistics services The provision of interpretation and translation services.
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Local county or State
health department
Publicly funded health department administered by a local, county, or State government.
LTBI Latent Treatment of Mycobacterium tuberculosis infection (LTBI) prevents the development of
active disease and has been an essential component of tuberculosis (TB) control in the United States for several decades.
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.
Medicaid A jointly funded, Federal-State health insurance program for certain low-income and needy
people.
Medical case
management
services (including
treatment adherence)
A range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is 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 client's and other key family members' needs and personal support systems. 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 re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.
Medical nutrition
therapy
Provided by a licensed registered dietitian outside of a primary care visit and includes the

provision of nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.

Medical transportation services
Conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

Medicare 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).

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

Monotherapy The use of only one antiretroviral drug to reduce the amount of detectable HIV.

More than one race An individual who identifies with more than one racial category.

Mother with/at risk for HIV infection (perinatal transmission)
Transmission of disease from mother to child during pregnancy.

MSM *Men who have sex with men*—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).

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Native Hawaiian or Other Pacific Islander
An individual having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

New clients Individuals who received services from a provider for the first time ever during this reporting
period. Individuals who returned for care after an extended absence are not considered to be new unless past records of their care are not available.

Non-permanent Includes individuals who are homeless, as well as transient or in transitional housing. Homeless
includes shelters, vehicles, the streets, or other places not intended as a regular accommodation for sleeping. Transitional housing includes any stable but temporary living arrangement, regardless of whether or not it is part of a formal program.

OI *Opportunistic infection*—An infection or cancer that occurs in individuals with weak immune systems due to AIDS, cancer, or immunosuppressive drugs such as corticosteroids or chemotherapy. Kaposi's Sarcoma (KS), pneumocystis pneumonia (PCP), toxoplasmosis, and cytomegalovirus are all examples of opportunistic infections.

OMB *Office of Management and Budget*—The office within the executive branch of the Federal Government, which prepares the President's annual budget, develops the Federal Government's fiscal program, oversees administration of the budget, and reviews Government regulations.

Oral health care Includes diagnostic, preventive, and therapeutic services provided by general dental
practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care

providers.

Other communitybased service organization

Includes non-hospital-based organizations, AIDS service and volunteer organizations, private non-profit 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.

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

Outpatient/ ambulatory medical care

Includes the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not 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 Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. **NOTE: Early Intervention Services provided by Ryan White Part C and Part D Programs should be included here under *Outpatient/ambulatory medical care*.**

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Outreach services 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. These services may 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; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

Outside the EIS program

A referral made to a provider that (1) is not part of the grantee organization; (2) does not have a contractual relationship with the grantee; and (3) does not receive reimbursement from the Part C grantee or its parent organization.

Part A The part of the Ryan White HIV/AIDS Program that provides direct financial assistance to designated EMAs/TGAs that have been the most severely affected by the HIV epidemic. The purpose of these funds is to deliver or enhance HIV-related: (1) outpatient and ambulatory health and support services, including case management and comprehensive treatment services for individuals and families with HIV disease; and (2) inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, when medically appropriate, from inpatient facilities.

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 organization of health care and support services for individuals with HIV disease and their families. The Ryan White HIV/AIDS Program emphasizes that such care and support is part of a continuum of care in which all the needs of individuals with HIV disease and their families are coordinated. The funds are distributed among States and Territories based, in part, on the number of AIDS cases in each State (or Territory) as a proportion of the number of AIDS cases reported in the entire United States.
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 HIV/AIDS clients. This support includes a continuum of comprehensive primary health care, referrals for specialty care, counseling and testing, outreach, case management, and eligibility assistance.
Part D The part of the Ryan White HIV/AIDS Program that supports coordinated services for women,
infants, children, and youth with HIV disease and their affected 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 them in care.
Partner Notification A service provided by a clinician in your program to notify the partner of a client of possible
exposure to HIV. (Check State and local laws for specific requirements.) It is not the number of individuals who tested positive for HIV antibodies and offered partners' names for notification, nor is it the number of individuals who came to your program because of a referral by a partner notification service.
Pediatric developmental assessment and early intervention services
The provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. These services involve the assessment of an infant's or a child's developmental status and needs in relation to the involvement with the education system, including early assessment of educational intervention services. It includes comprehensive assessment of infants and children, 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-affected clients, and education/assistance to schools should also be reported in this category.
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Permanency planning
The provision of services to help clients/families make decisions about the placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.
Permanent housing Includes apartments, houses, foster homes, long-term residences, and boarding homes, as long
as they are not time limited.
PHSA *Public Health Service Act.*
Planning or evaluation
The systematic collection of information about the characteristics, activities, and outcomes of

services or programs to assess the extent to which objectives have been achieved, needed improvements have been identified, and/or decisions about future programming have been made.

PLWHA coalition *People living with HIV/AIDS 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.

Private health insurance
Health insurance plans such as Blue Cross/Shield, Kaiser Permanente, Aetna, etc.

Private, for-profit ownership
The organization is owned and operated by a private entity, even though the organization may receive government funding. A privately owned hospital is an example of a private, for-profit organization.

Private, nonprofit (not faith-based)
The organization is owned and operated by a private, not-for-profit, non-religious-based entity, such as a non-profit health clinic.

Prophylaxis Treatment to prevent the onset of a particular disease (primary prophylaxis) or recurrence of
symptoms in an existing infection that has been brought under control (secondary prophylaxis).

Provider agency/ service provider
The agency that provides direct services to clients (and their families) and is funded by the Ryan White HIV/AIDS Program. Services may be funded through one or more Federal Ryan White HIV/AIDS Program grants, or through subcontract(s) with official Ryan White HIV/AIDS Program grantees. A provider may also be a grantee such as in Parts C and D.

Psychosocial support services
The provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.

Public/Federal ownership
The organization is funded and operated by the Federal Government. An example is a Federal agency.

Public/local ownership
The organization is funded and operated by a local government entity. An example is a city health department.

Public/State ownership
The organization is funded and operated by a State government entity. An example is a State

health department.

Publicly funded community health center

Includes community health centers, migrant health centers, rural health centers, and homeless health care centers.

Publicly funded community mental health center

A community-based agency, funded by local, state, or Federal funds, that provides mental health services to low income people.

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Quality management A systematic process with identified leadership, accountability, and dedicated resources that
uses data and measurable outcomes to determine progress toward relevant, evidence-based benchmarks. Quality management programs should also focus on linkages, efficiencies, and provider and client expectations in addressing outcome improvement and be adaptive to change. The process is continuous and should fit within the framework of other program quality assurance and quality improvement activities, such as JCAHO 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 improved outcomes are realized.

Referral for health care/supportive services

The act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made within the non-medical case management system by professional case managers, informally through support staff, or as part of an outreach program.

Referrals for health services

The act of directing a client who is HIV-positive to a health service not available within an EIS program. For the purposes of Part C data reporting, the process of making a referral is independent of the health service provided, and does not require evidence that the client actually received the service for which he or she was referred. However, if the service that the client is being referred for is paid for by the EIS program, then the cost of providing referral services should be reported. Part C funds can be used to pay for the costs associated with making the referral, as well as to pay for the services for which the client was referred. The referrals reported by Part C programs should be referrals for health services provided outside of the EIS program. Case management and other referrals for social or support services should not be reported in the *Referrals* section, nor should they be factored into the cost of providing referral services. Examples of health services for which clients may be referred outside of the EIS program include primary health care or specialty health services, any diagnostic health services such as radiology, lab tests, mental health evaluations, biopsies, and so forth.

Rehabilitation services

Services 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. Services include physical and occupational therapy, speech pathology, and low-vision training.

Reporting period A calendar year, January 1 through December 31 of the reporting year. The reporting period
may be shorter than a year if a provider agency did not receive Ryan White HIV/AIDS Program funding for an entire calendar year.

Reporting scope Scope 01 is the reporting scope for providers reporting ELIGIBLE services. Under the
ELIGIBLE reporting scope, clients receiving any service eligible for Ryan White Parts A, B, C, and D funding are included in the report even if the service was not paid for with Ryan White Parts A, B, C, and D funds. This reporting scope is preferred by HRSA.
Code 02 is the reporting scope for providers reporting FUNDED clients. Under the FUNDED scope, only clients receiving services paid for exclusively with Ryan White A, B, C, and D funds are included in the report. Typically, this is a subset of the eligible reporting scope. Providers using the funded-only reporting scope must have an adequate mechanism for tracking clients and services by funding stream and have secured prior approval from their grantee in consultation with HRSA.
Respite care The provision of community or home-based, non-medical assistance designed to relieve
the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS.
Retrovirus A type of virus that, when not infecting a cell, stores its genetic information on a single-stranded
RNA molecule instead of the more usual double-stranded DNA. HIV is an example of a retrovirus. After a retrovirus penetrates a cell, it constructs a DNA version of its genes using a special enzyme, reverse transcriptase. This DNA then becomes part of the cell's genetic material.
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**Risk factor or risk
behavior/exposure
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, injection drug use, and commercial sex work.
**Ryan White HIV/AIDS
Program**
The Ryan White HIV/AIDS Treatment Modernization Act of 2006—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 newly enacted law changes how Ryan White funds can be used, with an emphasis on providing life-saving and lifeextending
services for people living with HIV/AIDS.
Section 330 of 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.
Self-pay A client pays out of pocket for the majority of his or her health care costs.
**Solo/group private
medical practice**
Includes all health and health-related private non-profit practitioners and practice groups.
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.
STI *Sexually transmitted infection*—Infections spread by the transfer of organisms from person to person during sexual contact.
**Substance abuse
services-residential**
The provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term).

Substance abuse services–outpatient
The provision of 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, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

Substance abuse treatment center
An agency that focuses on the delivery of substance abuse treatment services.

Target population A population to be reached through some action or intervention; may refer to groups with
specific demographic or geographic characteristics.

Taxpayer ID # The unique nine-digit number issued to an organization or agency by the Internal Revenue
Service for use in connection with filing requirements. This may be the same as your Employer Identification Number (EIN).

TB skin test (PPD Mantoux)
The abbreviation for purified protein derivative (PPD), a substance used in intradermal testing for tuberculosis.

Technical assistance or TA
The identification of need for and delivery of practical program and technical support to the Ryan White HIV/AIDS Program community. TA should assist grantees, planning bodies, and affected communities in designing, implementing, and evaluating Ryan White HIV/AIDS Program supported planning and primary care service delivery systems.

Total client-months A calculation obtained by adding together the number of months that a premium, deductible, or
co-pay was made for each unduplicated client. (e.g., If an agency pays the premiums for Client A's insurance for 12 months and Client B's insurance for 8 months, the total client-months equals 20 months.)

Transgender An individual who exhibits the appearance and behavioral characteristics of the opposite sex.

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, etc.

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Treatment adherence counseling
Provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting.

Unduplicated client count
An accounting of clients in which a single individual is counted only once. For providers with multiple sites, a client is only counted once, even if he or she receives services at more than one of the providers' sites.

URN *Unique record number—A* nine-digit encrypted record number following HRSA's URN specifications that distinguishes the client from all other clients and that is the same for the client across all provider settings. The URN is constructed using the first letter of the first name, the third letter of the first name (if blank use middle initial, if no middle initial use '9'), first

letter of the last name, third letter of the last name (if blank, use '9'), month of birth, day of birth, and gender code. This string is then encrypted using a HRSA-supplied algorithm that can be incorporated into the provider's data collection system.

VA facility Any facility funded through the Veterans Administration.

Viral load test A test that measures the quantity of HIV RNA in the blood. Results are expressed as the number of copies per milliliter of blood plasma. This test is employed as a predictor of disease progression.

White (not Hispanic) An individual having origins in any of the original peoples of Europe, the Middle East, or North Africa, but not of Hispanic ethnicity.