**Summary of Changes from the Existing RSR Package (0915-0323)**

**Ryan White Services Report**

**Provider Form - General Information**

**Modification**

* **Current questions:** 
  + Within your organization/agency, identify the number of physicians, nurse practitioners, or physician assistants who obtained a Drug Addiction Treatment Act of 2000 waiver to treat opioid use disorder with medication assisted treatment (MAT), [e.g., buprenorphine, naltrexone] specifically approved by the U.S. Food and Drug Administration.
  + How many of the above physicians, nurse practitioners, or physician assistants prescribed MAT (e.g., buprenorphine, naltrexone) for opioid use disorders in the reporting period?
* **Modify to:**
  + How many physicians, nurse practitioners, or physician assistants in your organization prescribed medications for opioid use disorder (MOUD) [e.g., buprenorphine, naltrexone] for opioid use disorders during the reporting period.

**Client Level Variables**

**Add**

* **ID 15 )** MedicalInsuranceID Health Coverage –M**odify to** - HRSA HAB proposes adding Medicare Advantage as a response option to the client's healthcare coverage data element.

**Combine and Modify**

* EthnicityID & RaceID – Proposed modification to race and ethnicity data element per OMB guideline [Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity](https://www.govinfo.gov/content/pkg/FR-2024-03-29/pdf/2024-06469.pdf) announced on March 29, 2024.
  + What is your race and/or ethnicity?

Select all that apply and enter additional details in the space below.

American Indian or Alaska Native

For example enter, Navajo Nation, Blackfeet Tribe Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.

Asian

For example enter, Chinese, Asian Indian, Filipino, Vietnamese, Korean, Japanese, etc.

Black or African American

For Example enter, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.

***Hispanic or Latino***

***For example enter, Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, etc.***

***Middle Eastern or North African***

***For example enter, Lebanese, Iranian, Egyptian, Syrian, Iraqi, Israeli, etc.***

Native Hawaiian or Pacific Islander

For example enter, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese, etc.

White

For example enter, English, German, Irish, Italian, Polish, Scottish, etc.

**TABLE 3**

**Ryan White Services Report (RSR) Variables**

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0906-0039, and the expiration date is 12/31/2024. Public reporting burden for this collection of information is estimated to average 51 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland 20857.

# RSR Client-Level Data – Demographics

| **ID** | **Variable Name** | | **Definition** | | **Required** | | **Occurrence** | **Allowed Values** | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Demographics** | | | | | | | | | |
|  | VitalStatusID | The client’s vital status at the end of the reporting period. | | CM, OA, NMCM, EHE | | 1 per client | | | VitalStatusID**:**   * Active, * Deceased * Unknown |
|  | BirthYear | Client’s year of birth.  This value should be on or before all service date years for the client. | | All (including C&T) | | 1 per client | | | **BirthYear:**  yyyy |
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|  |  |  | |  | |  | | |  |
|  | PovertyLevelPercent | Client’s percent of the Federal poverty level at the end of the reporting period. | | CM, OA, NMCM, EHE | | 1 per client | | | **PovertyLevelPercent:**   * #### |
|  | HousingStatusID | Client’s housing status at the end of the reporting period. | | CM, OA or Housing services, NMCM, EHE | | 1 per client | | | **HousingStatusID:**   * Stable/permanent * Temporary * Unstable |
|  | HivAidsStatusID | Client’s HIV/AIDS status at the end of the reporting period. For HIV affected clients for whom HIV/AIDS status is not known, leave this value blank. | | CM, OA, NMCM, EHE | | 1 per client | | | **HivAidsStatusID:**   * HIV negative * HIV-positive, not AIDS * HIV-positive, AIDS status unknown * CDC-defined AIDS * HIV indeterminate (infants <2 only) |
| 14 | HivRiskFactorID | Client’s HIV/AIDS risk factor. *Report* ***all*** *that apply*. | | CM, OA, NMCM, EHE | | 1-7 per client | | | **HivRiskFactorID:**   * Male to Male Sexual Contact (MSM) * Injection drug use (IDU) * Hemophilia/coagulation disorder * Heterosexual contact * Receipt of blood transfusion, blood components, or tissue * Perinatal transmission * Risk factor not reported or not identified |
| 15 | HealthCoverageID | Client’s medical insurance. *Report* ***all*** *that apply.* | | All core medical services, NMCM, EHE | | 1-8 per client | | | **HealthCoverageID:**   * Private – Employer * Private - Individual * Medicare * Medicare Advantage - Add * Medicaid, CHIP or other public plan * VA, Tricare and other military health care * IHS * No Insurance/ uninsured * Other plan |

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# Client-Level Data – Core Medical Service Visits

| **ID** | | | **Variable Name** | | **Definition** | | **Required** | **Occurrence** | | **Allowed Values** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Core Medical Service Visits** | | | | | | | | | | |
| 16-25\* | ClientReportServiceVisits  ServiceVisit  ServiceID  Visits | | | The number of visits received for each core medical or support service during the reporting period. | | All Core Medical except APA and HIPCSA, all Support Services, EHE | | | 1-number of visits per service per client | **ServiceID:**  Core Medical Services:  ID 16: Outpatient ambulatory health services  ID 18: Oral health care  ID 19: Early intervention services  ID 21: Home health care  ID 22: Home and community-based health services  ID 23: Hospice  ID 24: Mental health services  ID 25: Medical nutrition therapy  ID 26: Medical case Management (including treatment adherence)  ID 27: Substance abuse outpatient care  Support Services:  ID 28: Non-medical case management services  ID 29: Child care services  ID 31: Emergency financial assistance  ID 32: Food bank/home-delivered meals  ID 33: Health education/risk reduction  ID 34: Housing  ID 36: Linguistic services  ID 37: Medical Transportation  ID 38: Outreach services  ID 40: Psychosocial support services  ID 41: Referral for health care/supportive services  ID 42: Rehabilitation services  ID 43: Respite care  ID 44: Substance abuse services (residential)  ID 75: Other Professional Services  EHE Initiative Services:  ID 78: Ending the HIV Epidemic initiative services    **Visits:**  1-365 (must be an integer) |
| 26- 45\* | | ClientReportService-Delivered  ServiceDelivered  ServiceID  DeliveredID | | Indicator of whether a client received certain core medical services. | | APA, HIPCSA | | | 0-1 per service per client | **ServiceID:**  ID 17: AIDS Pharmaceutical Assistance (LPAP, CPAP)  ID 20: Health Insurance Premium and Cost-Sharing Assistance for Low-Income Individuals    **DeliveredID:**  Yes/No - # of services delivered |

\*Element ID#s are listed consecutively according to the RSR Data Dictionary; the 2018 RSR Instruction Manual is pending update.

# Client-Level Data – Clinical Information

| **Client Level Data** | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ID** | **Variable Name** | | **Definition** | | **Required** | **Occurrences** | | **Allowed Values** |
| **Clinical Information** | | | | | | | | |
|  |  |  | |  | | |  |  |
| 47 | FirstAmbulatoryCareDate | Date of client’s first HIV ambulatory health services date at this provider agency.  This value must be on or before the last date of the reporting period. | | OA | | | 0-1 per client | **FirstAmbulatoryCareDate:**  mm/dd/yyyy |
| 48 | ClientReportAmbulatory-  Service  ServiceDate | All the dates of the client’s outpatient ambulatory health services visits in this provider’s HIV care setting with a clinical care provider during this reporting period.  The service dates must be within the reporting period. | | OA | | | 0-number of days in reporting period per client | **ServiceDate:**  mm/dd/yyyy  Must be within the reporting period start and end dates. |
| 49 | ClientReportCd4Test  Count  ServiceDate | Values indicating all CD4 counts and their dates for this client during this report period.  The service dates must be within the reporting period. | | OA | | | 0-number of days in reporting period per client | **Count:**  Integer  **ServiceDate:**  mm/dd/yyyy  Must be within the reporting period start and end dates. |
| 50 | ClientReportViralLoadTest  Count  ServiceDate | All Viral Load counts and their dates for this client during this report period | | OA | | | 1-number of days in reporting period | **Count:**  Integer  Report undetectable values as the lower bound of the test limit. If the lower bound is not available, report 0.  **ServiceDate:**  mm/dd/yyyy  Must be within the reporting period start and end dates. |
| 52 | PrescribedArtID | Value indicating whether the client was prescribed ART at any time during this reporting period. | | OA | | | 1 per client | **PrescribedArtID:**   * Yes * No |
| 11 | HousingStatusDateID | Value indicating date when housing status is collected.  The service date must be within the reporting period. | | OA, CM, NMCM, Housing, or EHE | | | 1 per client | **HousingStatusDateID:**  mm/dd/yyyy  Must be within the reporting period start and end dates. |
| 55 | ScreenedSyphilisID | Has the client been screened for syphilis during this reporting period? | | OA | | | 1-per client | ScreenedSyphilisID   * No * Yes * Not medically indicated |
| 64 | PregnantID | Value indicating whether the client was pregnant during this reporting period. **This should be completed for HIV+ women only.** | | OA  if the client is an HIV+ female | | | 0-1 per client | **PregnantID:**   * No * Yes * Not applicable |

| **Client Level Data** | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ID** | **Variable Name** | | **Definition** | **Required** | | **Occurrences** | | **Allowed Values** |
| **New Variables** | | | | | | | | |
| **Demographics** | | | | | | | | |
| 68 | HispanicSubgroupID | If EthnicityID = Hispanic/Latino(a), Client’s Hispanic Sub-group (choose all that apply) | | | All (included C&T) | | 0-4 per client | * Mexican, Mexican American, Chicano/a * Puerto Rican * Cuban * Another Hispanic, Latino/a or Spanish origin |
| 69 | AsianSubgroupID | If RaceID = Asian, Client’s Asian subgroup. (choose all that apply) | | | All (included C&T) | | 0-7 per client | * Asian Indian * Chinese * Filipino * Japanese * Korean * Vietnamese * Other Asian |
| 70 | NHPISubgroupID | If RaceID=Native Hawaiian/Pacific Islander, Client’s Native Hawaiian/Pacific Islander subgroup.(choose all that apply) | | | All (included C&T) | | 0-4 per client | * Native Hawaiian * Guamanian or Chamorro * Samoan * Other Pacific Islander |
| 72 | HIVDiagnosisYear | Year of client’s HIV diagnosis, if known. To be completed for a new client when the response is **not** “HIV-negative” or HIV indeterminate” in 12.  This value must be on or before the last date of the reporting period. | | | CM, OA, NMCM, EHE  For a new client, if the response is **not** “HIV-negative” or HIV indeterminate” in 12. | | 1 per client | HIVDiagnosisYear:  yyyy  Must be less than or equal to the reporting period year. |
|  |  |  | | |  | |  |  |
| 71 | SexAtBirth ID | The biological sex assigned to the client at birth | | | All (included C&T) | | 1 per client | 1 = Male  2 = Female |
| **HIV Counseling and Testing** | | | | | | | | |
| 73 | HIVPosTestDateID | Date of client’s confidential confirmatory HIV test with a positive result within the reporting period. | | | OA (for clients with new HIV diagnosis in the reporting period) | | 0-1 per client | HIVPosTestDateID:  mm/dd/yyyy  Must be within the reporting period. |
| 74 | OAHSLinkDateID | Date of client’s first OAHS medical care visit after positive HIV test.  Date must be the same day or after the date of client’s confidential confirmatory HIV test with a positive result. | | | OA (for clients with new HIV diagnosis in the reporting period) | | 0-1 per client | OAHSLinkDateID:  mm/dd/yyyy  Must be within the reporting period and on the same day or later than HIV positive test date. |
| 76 | NewClient | Indicate whether the client is new to the service provider. Only required for EHE initiative funded providers. | | | All Core Medical, all Support Services, EHE | | 0-1 per client | * Yes * No |
| 77 | Received Service Previous Year | Indicate whether the client received one service in the previous year. Only required for EHE initiative funded providers. | | | OA, CM, NMCM, EHE | | 0-1 per client | * Yes * No |