Welcome to today’s webcast: Plans to Streamline Data Collection and Reduce Reporting Burden. Thank you so much for joining us today!

My name is Peggy O’Brien-Strain. I am a member of the DART Team, one of several groups engaged by HAB to provide training and technical assistance to Ryan White grantees during the implementation of the ADR and RSR.

Today’s Webcast is presented by Michael Costa of Abt Associates. Michael will provide an overview of HAB’s current plans to streamline data collection and reduce reporting burden.

At any time during the presentation, you’ll be able to send us questions using the “Question” function on your control panel on the right-hand side of the screen. You’ll also be able to ask questions directly “live” at the end of the presentation. You can do by clicking the “raise hand” button (on your control panel) and my colleague, Titi, will conference you in. You can also click the “telephone” button and you’ll see a dial-in number and code.

We hope you consider asking questions “live,” because we really like hearing voices other than our own.

Now I’ll turn this over to our presenter. Michael?
The goals of the National HIV/AIDS Strategy are to:

1. Reduce New HIV Infections
2. Increase access to Care and Improve Health Outcomes for People Living with HIV/AIDS
3. Reduce HIV-related disparities and Health Inequities
4. Achieve a more coordinated National Response to the HIV epidemic.

To reach the fourth goal, HAB worked with agencies across the Department of Health and Human Services, as well as other parts of the Federal Government, such as HUD and Veterans' Affairs. These agencies identified two important steps to move toward the fourth goal:

**Step 1:** Increase the coordination of HIV programs across the Federal government and between federal agencies and state, territorial, tribal and local governments.

**Step 2:** Develop improved mechanisms to monitor and report on progress toward achieving national goals.

To reach these objectives, HRSA along with other HHS Agencies were tasked with:
- Working together to identify seven common core HIV/AIDS indicators;
- Developing implementation plans to deploy the indicators;
- Streamlining data collection; and
- Reducing reporting burden by 20 – 25 percent.
Seven Common Core Indicators

- HIV Positivity
- Late HIV Diagnosis
- Linkage to HIV Medical Care
- Retention in HIV Medical Care
- Antiretroviral Therapy (ART) among Persons in HIV Medical Care
- Viral Load Suppression among Persons in HIV Medical Care
- Housing Status

The group of which HAB was part, the HIV/AIDS Indicators Implementation Group, met to identify the seven common core indicators started out with approx. 25 measures.

After much discussion, the group identified seven common core indicators:
- HIV Positivity
- Late HIV Diagnosis
- Linkage to HIV medical care
- Retention in HIV medical care
- ART for people with HIV in care
- Suppressed viral load
- Housing status

Not all operating divisions of HHS will be reporting all indicators. For example, HAB will be reporting on 6 of the 7 measures. Ryan White data are unable to report the Late HIV Diagnosis variables. However, HAB is proud to say that three of these measures are based on HAB’s quality work over the past several years and, currently, with the National Quality Forum. These core indicators are:
- Retention in HIV medical care
- ART
- Viral Load

In order to be able to report the Linkage to care, HAB will have to add two data elements.
### Reduce Burden + Streamline Collection

- The HAB plan will:
  - Reduce reported data elements by 37%
  - Reduce reporting frequency by 35%

- **ALL CHANGES ARE EFFECTIVE FOR DATA COLLECTED BEGINNING 2014**

- These changes do not effect 2013 data.

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Based on discussions HAB had with the Office of HIV/AIDS and Infectious Diseases Policy in the office of the secretary, HAB is making changes that will reduce reported data elements by 37%

and will reduce reporting frequency by 35%

**ALL CHANGES ARE EFFECTIVE FOR DATA COLLECTED beginning 2014**

These changes do not effect 2013 data.

As with all other data changes, HAB’s goal is to support grantees in making the transition - not to penalize grantees facing struggles adapting to the changes.
Ryan White Data Reporting Strategy

- ELIMINATE – duplicate and poor quality data
- Integrate – reporting systems
- Reduce – reporting frequency
- Retire – legacy reporting systems
- Implement – HHS data collection standards

These will be achieved by five related processes:

1...HAB will eliminate duplicate and poor quality data
2...HAB will integrate reporting systems
3...HAB will reduce reporting frequency
4...HAB will retire legacy reporting systems
And...
5...HAB will implement HHS data standards.
Data elements that are redundant or that are not used because of poor quality will be eliminated. Examples are listed on the slide.

Results of data validations built into the RSR web system helped HAB identify many of these elements. Technical assistance follow up with grantees and sub‐grantees have also helped HRSA/HAB to identify data elements that service providers cannot report accurately.

For example, many service providers noted an inability to report reliable data on clients’ date of death. Providers indicated that a client’s death is often not a result of HIV disease but other non‐HIV causes and providers are less likely to be notified of deaths not related to a medical condition.
A major reduction in reporting burden will come from eliminating duplicate reports. Each year, grantees note their providers contracts, amounts, and services covered in the RSR. (It’s called Service Provider Contracts, and its information identifies providers who must report client level data.)

Part A and Part B grantees also must submit a Consolidated List of Contractors 90 days after the start of the budget period. Program staff uses this information as they monitor the grant.

The data in these two reports is very similar. HAB will revise the RSR grantee report so that it will provide the information needed for both reports. This will allow a single report to provide both information for program monitoring and a basis for RSR client level data.

It seems that this will also eliminate a part of the Allocations and Expenditures (A&E) report for grantees. The integration of these two reports will also be used to generate the Allocations half of the A&E report. (However, you will all continue to submit the Expenditure portion of the A&E report.)
HAB is also reducing the frequency of reporting.

The ADR will reporting will become annual, rather then semi-annual.

Beginning with the 2013 data, the next report will include data for the full calendar year and will be due April 28, 2014.
As I have already discussed, HAB will eliminate the consolidated list of contractors. This is important for the Part A and Part B grantees.

The ADAP Quarterly report will also be retired. HAB plans the final AQR to cover the period ending March 31, 2014. This data report will be due in July 2014.

HAB is also working on a long term change that will provide for MAI reporting based on the RSR and ADR. This will retire the separate MAI reports. Although the major burden of these reports are on Part A grantees, we know that many Part C and Part D grantees are also Part A providers. HAB does not expect to begin work on the MAI report until these current changes are rolled out.
Some data elements will need to change in order to confirm to the HHS data standards.

These standards are:

- Required under the Affordable Care Act
- Consistent with Meaningful Use standards
- Consistent with HHS Civil Rights requirements

The URL listed on the slide provides a link to the full language regarding these standards.

http://aspe.hhs.gov/datacncl/standards/ACA/4302/index.shtml#IV
Federal Poverty Level

- Change to Affordable Care Act groupings:
  - <100% of Federal Poverty Level
  - 100% - 138% Federal Poverty Level
  - 139% - 200% Federal Poverty Level
  - 201% - 250% Federal Poverty Level
  - 251% - 400 Federal Poverty Level
  - 401% - 500% Federal Poverty Level
  - >500% Federal Poverty Level

The FPL categories will now align with the ACA groupings.
Align Coverage Categories

Private – Employer
Private - Individual
Medicare
Medicaid, CHIP or other public plan
VA, IHS, Tricare and other military health care
Other plan
No Insurance/ uninsured

As will coverage categories...

Note: These insurance categories are still under review, so consider this list tentative.
The race and ethnicity categories are being expanded. The ethnicity categories now have 4 Hispanic/Latino Subgroups and race has expanded Asian and Native Hawaiian/Pacific Islander sub groups,
“Sex at birth” will be added to (but not replace) the current gender variables.

In addition, primary language at home and daily functioning activities will be collected. Similar to the insurance categories, Language are still under development.
So to summarize...

HAB is:

- Implementing 6 of the Core Indicators  (HAB will have to add data elements for this)
- Eliminating duplicate data reporting
- Retiring ineffective data elements
- Decreasing Reporting Frequency
- Aligning Demographics across HHS.
These are numerous trainings and resource materials coming your way to make sure you’re a fully informed and supported through these data changes.

### Technical Assistance

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Our regular cadre of support team will be here throughout the process...and as always, there is no wrong door.

Thanks. Over to you, Peggy.
Thank you Michael. Before we take your questions, we’d like your feedback on this webcast presentation. On your screen you will see two poll questions appear. Please take a moment to respond to each poll by clicking on the appropriate box. We will pause for a moment to give you time to do this.

Thank you for your assistance. As a reminder, one final evaluation question will appear on your screen as you exit this webcast, to help us understand what other information you would have liked included. We appreciate your feedback very much, and use this information to plan future webcasts. Thank you!

We will now take questions. As a reminder, you can send us questions using the “Question” function on your control panel on the right hand side of the screen. You can also ask questions directly “live.” You can do this by clicking the raise hand button (on your control panel). If you are using a headset with a microphone, my colleague, Titi, will conference you in; or, you can click the telephone button and you will see a dial in number and code. We hope you consider asking questions “live”, we really like hearing voices other than our own.

We do want to get all of your questions answered, and we do not usually run over an hour. If you have submitted your question in the question box and we cannot respond to your question today, we will contact you to follow up. We often need to explore your question in order to give you the most appropriate answer.

[As you exit this webcast, please complete the evaluation question that appears on your screen. This will help us understand what other information you would have liked included. We appreciate your feedback very much, and use this information to plan future webcasts. Thank you for joining us today!}