DC Department of Health – HIV/AIDS, Hepatitis, STD, Tuberculosis Administration: Care and Treatment Division Reporting Deliverables Description

The District of Columbia HIV Care and Treatment Division is committed to delivering and continually improving District-wide and Eligible Metropolitan Area-wide HIV care, treatment and supportive services that meet the needs of persons living with HIV. As part of this effort to gather and analyze information about the services delivered, all Ryan White funded providers are required to submit the following financial, programmatic, data, and quality management reports. Should reporting requirements change during the service year or additional reporting become necessary, providers are expected to comply with the changes. Under the terms of the Program Agreement and Human Care Agreement, providers are required to make provisions for a reporting system/s and procedure/s sufficient to ensure that required reporting is timely and accurate. The information provided to HAHSTA are used to fulfill reporting requirements to the Health Resources and Services Administration (HRSA), the Metropolitan Washington Regional Ryan White Planning Council, DC City Council and other stakeholders. It is extremely important that these reports are accurate, complete, and submitted on time.

1. *Client-Level Data Report (Monthly)* – due NLT 10th business day for preceding month

All providers that deliver Ryan White HIV/AIDS Program-funded services must submit client-level data on demographics, insurance and eligibility status, and core medical and support services rendered, as well as HIV clinical information (as applicable). Providers will use this data to generate a HRSA reporting requirement the Ryan White Services Report. Reference the 2017 RSR Instruction Manual for thorough explanation of the RSR reporting requirement. (See CAREWare Data Elements.)

2. *Expense and Reimbursement Report (Monthly)* – due NLT 10th business day for preceding month

Providers will submit an invoice, by service category, for the prior months' expenditures with supporting documentation as evidence of expenditure. Supporting documents must include payroll/fringe and general ledger. Providers must maintain all audit-ready documentation of receipts. Specific instructions for expense and reimbursement may vary by jurisdiction.

Any provider that is a federally-qualified health center (FQHC) or "look alike" will collect and report program income in ways consistent with the regulations and requirements of the FQHC program and the HRSA Monitoring Standards. Providers must maintain records documenting the amount and disposition of any income received as a direct result of income/expenditure and the source of funds. All program income generated by clients with HIV will be returned to benefit the HIV program. HAHSTA is available to provide technical assistance on this topic to maximize the benefit of this provision. (See Invoicing Procedures.)

3. *Progress / Narrative Report (Monthly)* – due NLT 10th business day for preceding month

Providers will submit a brief monthly narrative report. The narrative report must include a work plan status, indicating the extent to which established milestones have been accomplished during the reporting period, and identifying proposed revisions to the work plan to address problem areas. The narrative report will include:

- Program/service implementation progress to date;
- Discussion of any challenges to service delivery, including plans for addressing them;
- A thorough description of any wait list for the service program, including the number of clients on the wait list, the average length of time for clients on the wait list and the longest period of time for any client currently on the wait list;
- Progress toward implementation of any corrective action plan that is open;
- A summary of quality assurance measures conducted on the delivery of services;
- Request for technical assistance, if any;
- (Applicable to grants only) - Any change in personnel supported by the grant in this service program;
- (Applicable to grants only) - A discussion of the reasons for any significant under- or over-

expenditure of funds budgeted relative to expected expenditure to date for any line item in the budget, along with a plan to address the under- or over-expenditure; and

- (Applicable to grants only) - Current contact information for each staff person supported by this agreement, including name, title, mailing address, e-mail address and telephone number.

4. *Quality Improvement Project Report (Quarterly)* – see Reporting Schedule for due dates

In accordance with the HRSA Policy Clarification Notice (PCN #15-02) and FAQ's each organization should engage in clinical quality improvement projects and identify its own process for determining priority quality improvement areas. In addition to the annual submission of the Quality Management Plan, documentation of ongoing projects is due quarterly. Acceptable quality improvement documentation include: Plan-Do-Study-Act, Define-Measure-Analyze-Improve-Control, and Kaizen event. (See Quality Improvement Plan Template.)

5. *Minority AIDS Initiative* – due no later than 30 calendar days from the end of the funding period

The MAI Annual Outcome Measure Report (Attachment Q) should be used to document expenditures for each service delivered to each minority community, specifically the unduplicated number of total clients served; unduplicated number of women, infants, children and youth served; the total number of service units provided; and the total number of clients that achieved each planned outcome. There is also a requirement to submit an Annual Report narrative summarizing MAI program accomplishments, challenges and lessons learned. (See Attachment Q for the required format.)
In order to assess the effectiveness of the MAI Program in achieving goals, funded providers are required to document client-level health outcomes that are consistent with HRSA guidelines. To do this, MAI providers must:

- Document and report client-level health outcomes and the unduplicated numbers of clients receiving each service, broken out by race/ethnicity; and
- Use the pre-selected outcome measures (populated in Attachment Q) for each funded service

6. *Closeout Report (Annually)* – due no later than 30 calendar days from the end of the funding period

The close-out process serves to assess and finalize all activities completed, and derive lessons learned and best practices. The Closeout Report consists of a narrative and service statistics data for the entire length of the program period. All of the components required for the narrative report should be reported on in the year-end closeout.

REPORT SUBMISSION PROCESS

There are two main systems used to report information to HAHSTA. These systems are DC EMA CAREWare (CW) and DC Electronic Grants Managements System (EGMS). Requirements vary based on the funding mechanism. A breakdown of the human care agreement and grant funded service categories are listed below along with the applicable reporting systems. *Note that funded categories may vary by Jurisdiction.

All Providers: funded providers are expected to upload or manually enter client-level data into the DC EMA CAREWare (CW) system. CW users are required to follow the data entry and data elements requirements outlined in the CAREWare User Guide.

Grant-Funded Providers: are to submit the relevant reports to the Enterprise Grants Management System (EGMS) as PDF attachments.

Human Care Agreement-Funded Providers: are to submit the relevant reports to their Contract Administrator.