

# Preparing for 2023 ADR Reporting: Updates and Best Practices

AIDS Drug Assistance Program Data Report (ADR)

HRSA HIV/AIDS Bureau

October 25, 2023



Hello everyone. I'm Debbie Isenberg from the DISQ Team. I can see that people are still joining the webcast so we're going to wait a few minutes before we get started. That gives you time to send that last email or grab more water or coffee. I'll be back in about two minutes!

Welcome to today's Webinar-**Preparing for 2023 ADAP Data Report (ADR) Reporting: Updates and Best Practices**. Thank you so much for joining us today!

My name is Debbie Isenberg. I'm a member of the DISQ Team, one of several groups engaged by HAB to provide training and technical assistance to AIDS Drug Assistance Programs, or ADAPs, in completing the ADAP Data Report (ADR).

## Today's Webinar is Presented by:



**Imogen Fua**  
[RyanWhiteDataSupport@wrma.com](mailto:RyanWhiteDataSupport@wrma.com)



**Debbie Isenberg**  
[Data.TA@caiglobal.org](mailto:Data.TA@caiglobal.org)



Today's Webinar is a joint presentation. First, you'll hear from Imogen Fua from RWHAP Data Support, also a group engaged by HAB to provide training and technical assistance. Imogen will focus on 2023 reporting clarifications and reminders and highlight some common reporting requirement challenges. Then I'll jump back in and discuss best practices for reporting high quality data.

Today's webinar is specifically focused on and for ADAPs meaning a program at the state or territorial level that provides medication and/or insurance services. ADAPs are responsible for completing and submitting the ADR annually. This webinar is also focused on reminders and best practices, so we don't review all of the ADR requirements in detail. If you're new, we'll share some resources at the end of the webinar to review to help get you up to speed. Also be sure to sign up for the Spring webinars-the list will be released in the next few weeks.

Throughout the presentation, we will reference some resources that we think are important. To help you keep track of these and make sure you have access to them immediately, my colleague Isia is going to chat out the link to a document right now that includes the locations of all the resources mentioned in today's webinar.

## Disclaimer

Today's webinar is supported by the following organizations and the contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, the Health Resources and Services Administration (HRSA), the U.S. Department of Health and Human Services (HHS), or the U.S. government.

The DISQ Team is comprised of CAI, Abt Associates, and Mission Analytics and is supported by HRSA of HHS as part of a cooperative agreement totaling over \$4 Million.

Ryan White Data Support is comprised of WRMA, CSR, and Mission Analytics and is supported by HRSA of HHS as part of a contract totaling over \$7.2 Million.

Today's webinar is supported by the organizations shown on the slide, and the contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by the Health Resources and Services Administration, the U.S. Department of Health and Human Services, or the U.S. Government.

# Overview

Submission Timeline

ADR Reporting Clarifications and Reminders

Best Practices

Upcoming Webinars & TA Resources

Questions

Thanks, Debbie. Hello everyone. Thank you for joining us today.

This webinar is geared to help you prepare for the 2023 ADR Submission. It is a bit advanced so if you are new to the ADR, there will be webinars next year in Feb and Mar that will have more information for beginners. You can also review similar past webinars on TargetHIV. But please do come back to this webinar for tips on some common challenges that we are seeing most ADAPs are experiencing.

So, we'll begin by reviewing the submission timeline for this year. Then we'll dive right on in. We will focus on the data elements in the Client Report that seem to be challenging and add some clarifications and tips. Then Debbie will come back in and go over best practices. Then she will highlight those upcoming ADR webinars and technical assistance resources available to assist you. And as always, we'll have time at the end of the webinar for questions.

## Poll #1



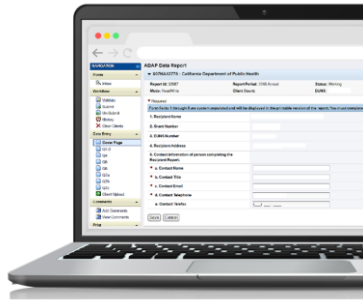
Before we get started, we'd like to learn more about your experience completing and submitting the ADR. Which of the following best describes your ADR experience?

- I've never submitted the ADR before
- I've submitted the ADR once before
- I've submitted the ADR multiple times

# 2023 ADR Instruction Manual

---

AIDS Drug  
Assistance  
Program  
Data Report  
(ADR)



Available soon on the  
[TargetHIV website](#)

For those of you new to the ADR, please do not hesitate to reach out to us for any help. And for those more experienced reporters, I hope this webinar will help clarify some of the challenges you may be experiencing.

I do want to bring everyone's attention to the 2023 ADR Instruction Manual, that should be available on the TargetHIV website by the beginning of next year. The ADR Instruction Manual is an essential resource to use while completing your ADR and provides more information on what we will be reviewing in today.

# ADR Timeline

Date	Client XML File Reporting Period: 1/1/2023 – 12/31/2023	Recipient Report Reporting Period: 4/1/2023 – 3/31/2024
To be determined	2023 ADR Check Your XML and Data Quality Feature opens	--
Monday, April 1, 2024	ADR Web System opens for 2023 data submission	ADR Web System opens for 2023 data submission
Monday, April 22, 2024	Target upload date for all 2023 ADR client-level data files	--
Monday, June 3, 2024	ADRs must be in "Submitted" status by 6:00 PM ET	ADRs must be in "Submitted" status by 6:00 PM ET

[2023 ADR Submission Timeline](#)

This is ADR Submission timeline. Beginning with the Check your XML tool opening date, please keep a look out for an update of when this will open, which could be either January or February. CHECK YOUR XML IS A GREAT TOOL THAT LETS YOU CHECK AND REVIEW YOUR DATA QUALITY BEFORE THE ADR OPENS. Monday, April 1st, 2024, the ADR Web system will officially open, so all ADAPs can begin working on the Recipient Report and uploading the client-level data. Monday, April 22nd, 2024, is the target upload date for all client-level data files. We recommend uploading by this date so that you have enough time to review and update any data before the final ADR submission deadline, which is on Monday, June 3th, 2024, at 6:00 pm Eastern time. By this date, all ADRs must be In "Submitted" status.

## 2023 ADR Changes

---

- There are no changes to reporting requirements!
- There will be updates in both the Upload Completeness Report and the Validations
  - Anticipated release date is January 2024

For this year's submission, there are no changes to the data elements or reporting requirements.

There will be updates in the Upload Completeness Report and the validations that are both important tools that you can access in the ADR system to help you quality check your data. The Upload Completeness Report allows you to check your data to make sure it accurately reflects your program; while validations check to make sure your data are complete and correct against the ADR system requirements. And these updates are anticipated come out in January.





## Reporting Clarifications, and Reminders

Okay, so let's move right on along. Now in the next few slides, as I said I'm going to highlight a few reporting clarifications and reminders that tend to be common reporting challenges to ADAPs.

## Health Coverage

- ‘Other Plan’ should not be used for insurance plans for which the ADAP pays the premium
- Report the payer for health coverage, regardless of what the health coverage is (e.g. limited Medicaid plans)
- Check to see if your ADAP has added Medicare Part C as an option for applications/recertifications

10

The first thing I want to go over is health insurance coverage. We found that there is some confusion, particularly with how to report certain ones. So we will go over some.

There are a few things to consider:

- 1) We’ve noticed that ADAPs are reporting clients in “Other Plan.” As we asked more about this, we identified that in some cases “Other Plan” is being used to report clients receiving insurance for which the ADAP is paying the premium. So just because ADAP is paying, doesn’t mean it goes in “Other Plan”. Those clients should be reported as Private Insurance-Individual or Private Insurance-Employer depending upon the type of premium being paid.
- 2) There is also some confusion about what to report if the client has health coverage that is limited coverage -- like limited Medicaid plans. You want to report the health coverage, regardless of what the plan covers. So for limited Medicaid plan, report Medicaid.
- 3) Finally, Medicare Part C was added as a health coverage option for the 2021 ADR. We’ve noticed that some ADAPs are not reporting any clients with Medicare Part C Coverage, so we just wanted to remind everyone to be sure that those options are included in your application and recertification forms and they should be reported in your ADR.

## Poll #2



Which of the following options would be reported as Other Plan for Health Coverage?

- ADAP paying the subsidized premium of a marketplace plan
- ADAP paying the employee portion of an employer sponsored plan
- A Medicaid plan that has limited coverage
- A company that self-insures and pays the medical expenses of the employees
- Medicare Advantage Plans
- None of the above

## Poll 2 Answers Explained

Scenarios	Health Coverage
ADAP is paying the subsidized premium of a marketplace plan	Private-Individual
ADAP is paying the employee portion of an employer sponsored plan	Private-Employer
Client has a Medicaid plan that has limited coverage	Medicaid, Children's Health Insurance Program (CHIP), or other public plan
Client works for company that self-insures and pays the medical expenses of the employees	Other Plan
Medicare Advantage Plans	Medicare Part C

This first scenario is when ADAP is paying the subsidized premium of a marketplace plan. This would be Private Individual, not Other Plan. A Marketplace plan is private insurance. Just because it is paid by ADAP, does not make it Other Plan.

The second scenario is when ADAP is paying the employee portion of an employer sponsored plan. This is Private- Employer, not Other Plan. It's private insurance that the employer sponsored even if ADAP paid the employee portion. Again, just because it is paid by ADAP, does not make it Other Plan.

A Medicaid plan that has limited coverage – This falls under Medicaid, not Other Plan. Even though it's limited, it's still considered Medicaid.

A company that self-insures and pays the medical expenses of the employees – This is the ADR manual definition of Other Plan. It's not a common scenario and this scenario doesn't fit into the other categories, so it should be reported as Other Plan.

Medicare Advantage Plans – is considered Medicare Part C. It's just another name that is used sometimes for Medicare Part C. So it also should not be reported as Other Plan.

## Application Received and Approved Dates

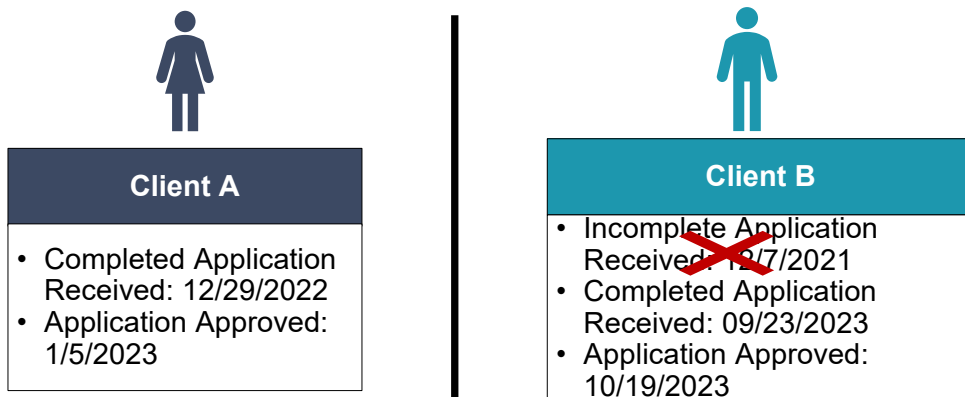
- Only reported for new clients in the reporting period
- ID 15 - Application Received Date is the first date that your ADAP received a completed application
  - Date can be prior to the reporting period
- ID 16 - Application Approved Date is the date that the first completed application was approved
  - Date must be in the reporting period

Next, let's tackle the ADAP application questions - Application Received and Application Approved Dates. So first of all, these dates are only reported for new clients. Application Received date is the first date that your ADAP received a completed application and it also can be prior to the reporting period, while Application Approved Date is the date that you approved the first completed application and must be in the reporting period.

The common reporting issue we notice is that for Application Received Date, ADAPs report dates as old as up to two years ago, which may reflect that a client submitted a partially completed application.

So, let's quickly run through an example of this to further explain.

## Application Received and Approved Dates Example



To better understand issues with application received dates prior to the reporting period, let's look at two new clients.

Starting off with Client A who submitted a completed application to your ADAP on December 29, 2022, and then the application was approved January 5, 2023. In this situation, December 29, 2022, would be reported as the application received date and January 5, 2023, would be reported as the application approved date.

Now let's take a look at client B. Client B submitted a partially complete application on December 7, 2021, which is about two years ago, but was never completed. Now, a month ago, on September 23, 2023, the same client, client B, submitted a completed application. And this one was approved on October 19, 2023. In this case, September 23, 2023, would be reported as the application received date and October 19, 2023, would be reported as the application approved date. Also, I want to point out that the incomplete application received date December 7, 2021, should not be reported in the ADR.

# Disenrollment Reason

- Disenrollment reason
  - 'Other' is being used often
  - Map to existing categories if possible

ADAP Reason	ADR Reason
Client moved out of state	Client's eligibility changed, client no longer meets eligibility criteria
Client's income increased above ADAP requirements	Client's eligibility changed, client no longer meets eligibility criteria

The DISQ Team can help you develop a crosswalk-just ask!

Next, we also noticed that Other is used fairly often for disenrollment reason. Again, it's fine to use "Other" if the existing categories don't fit. But its important to first map "Other" to existing categories if possible. For example, if a client moved out of state or the client's income increased above your ADAP's requirements, those can actually both be mapped to the option, "Client's eligibility changed, client no longer meets eligibility criteria." So please see if the disenrollment reason can be mapped to existing categories first.

The DISQ Team can help you develop a crosswalk if you need some help getting started on this, so get it in touch if we can be of assistance.

## Type of Health Insurance Assistance Received

- A **full premium payment** is when ADAP pays 100 percent of the premium.
- A **partial premium payment** is when the RWHAP ADAP pays a portion of the premium (i.e., less than 100 percent).

[ADR In Focus: Partial Premiums](#)

One more reminder on reporting health insurance ASSISTANCE SERVICES.

We are still seeing some ADAPs reporting premium payments incorrectly.

Remember a full premium payment is when ADAPs pays 100% of the premium for purchasing a client's health insurance.

A partial premium is when the ADAP pays for a portion of the premium.

NOW YOU'LL NOTICE I SAID PREMIUM and premium is underlined on the slide. So when you get the bill and the ADAP pays the entire bill, you need to check whether you are paying the full premium or a subsidized premium payment. Once you've verified whether ADAP paid for a full premium or a partial premium payment, that's what you report – full premium payment for 100 percent of the premium and partial payment for a subsidized premium.

Linked on this slide is DISQ's ADR in Focus document that further explains partial premiums. So let's do another poll and again see if I've clarified things.





Your ADAP pays premiums for clients. Which of the following would be reported as partial premiums?

- Client has marketplace plan and gets a subsidy
- Client has marketplace plan and does not get a subsidy
- Client has Medicare Part D
- Client had Medicare Part D Low Income Subsidy (LIS)
- Client has an employer-sponsored plan
- None of the above

## Poll 3 Answers Explained

Scenarios	Full or Partial Premium?
Client has marketplace plan and gets a subsidy	Partial Premium because the premium is subsidized
Client has marketplace plan and does not get a subsidy	Full Premium
Client has Medicare Part D	Full Premium
Client has Medicare Part D Low Income Subsidy (LIS)	Partial Premium because the premium is subsidized
Client has an employer-sponsored plan	Partial Premium because ADAP is paying the employee portion of the employer sponsored plan

18

So the main take-away here is that it isn't about whether ADAP paid the entire bill. You have to know the type of plan the client has.

So for example, the first example is that client has a marketplace plan and gets a subsidy. You would report this as a partial premium because the payment ADAP paid is subsidized.

The second example is that the client does not get a subsidy so that's a full premium payment.

Medicare Part D is also a full premium because there is no subsidy.

But for Medicare Part D Low Income Subsidy, that payment is subsidized so it would be partial payment.

Lastly, if the client has an employer-sponsored plan, it would also be partial payment because the employer paid a portion of it.

## Medication Payments – Where To Report?

- Medication Services
  - ADAP paid for medications in full
- Medication copay/co-insurance/deductible
  - ADAP paid the medication copay/co-insurance/deductible
- Challenges in distinguishing full pay medication vs medication copay/co-insurance/deductible in a single claims data
  - Request two files from your Pharmacy Benefit Manager (PBM) if possible

Another common challenge we have noticed is in reporting medication payments, specifically distinguishing between full pay medication and medication copays/coinsurance and deductibles. Full payment of medications is reported under the Medication Services which means ADAP paid for that medication in full. But when the ADAP pays for a copay or deductible for medication, it goes under health insurance ASSISTANCE services since the health insurance is the main service that paid for that medication.

This can be even more difficult for ADAPs to determine if the claim file they receive from their Pharmacy Benefit Manager(PBM), for example, doesn't distinguish these costs. So a suggestion is to ask your PBM to provide you with two files that distinguish these two different types of costs – medications paid in full or medication copay/coinsurance and deductibles.

## Medication Reimbursements

When a payer (e.g., Medicaid, private insurance) pays the ADAP back for a service



ADAP application approved, and Medicaid application submitted

Client receives medication from ADAP, and claim submitted



Medicaid application approved



ADAP bills Medicaid program for dispensed medication



ADAP received Medicaid reimbursement

The next common reporting challenge that I want to go over requires some background so I wanted to take a moment to go over two terms before moving one. First let's review the term, reimbursements. Reimbursements occur when a payer pays the ADAP back for a service.

Here is a common example on this slide. First, the client's ADAP application is approved and it is also determined that they should apply for Medicaid. The client is enrolled in the ADAP's full pay medication program and receives their medication. A month after being enrolled in the ADAP, the client is approved for Medicaid. Medicaid will not only pay for the client's medications moving forward but can also be billed for the medications already provided to the client. This is known as Medicaid back billing. The ADAP bills Medicaid for past medications paid and gets reimbursed.

## Medication Reversals

When a cost is paid by ADAP and later refunded



Pharmacy dispenses medication (prepared for client pick up)



Claim submitted for dispensed medication



Client does not pick up medication



Claim for dispensed medication reversed

The next term I want to go over is reversals. Reversals occur when a cost is paid by an ADAP that is later refunded. A common example is that a medication is dispensed but the client doesn't pick it up or the premium is paid by the client disenrolled before the effective period.

Let's walk through another example. A client is enrolled in the ADAP's full pay medication program. The pharmacy prepares a client's medication for pickup. The pharmacy submits a claim for the dispensed medication assuming that it will be picked up. However, after a week the client doesn't pick up the medication. Since the client never received the medication, the ADAP doesn't have to pay for the medication and the claim is reversed.

## Reporting Medication Services in the ADR

- Only submit ADR services with cost >\$0
  - If a service is reimbursed, submit the service but not the reimbursement
  - Services for which the cost was reversed should not be reported
- If cost is >\$0 but <.50, round UP to \$1.00
- Medication services
  - Costs should be before any rebates and should not include dispensing fees

Now that we've gone over reimbursements and reversals, let's go over what they have to do with reporting medication services in the ADR. First, ADAPs should only report medication services for which there is a cost to the ADAP. So, if a service was reimbursed, the original cost of the service should be reported but not the reimbursement. You do not need to go back and delete the service.

However, if the cost for the service was reversed, ADAPs should not report the service at all since it was never received. That means that the ADAP needs to reconcile their data before entering/importing the services.

We've also noticed that ADAPS are submitting services with \$0 cost and when asked, we learned that this may be medications that cost less than \$1.00 but less than 0.50. In those cases, be sure to round up to \$1.00.

Also, just a reminder that medication costs should be reported before rebates and should not include dispensing fees.

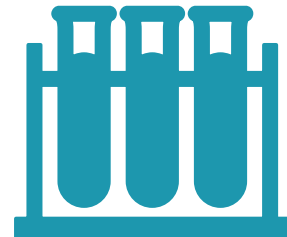
## Viral Load Count

Report value (between 0-500,000,000 copies/mL) of all viral load tests administered to the client during this reporting period. Test results should be reported as the number of copies per milliliter of blood plasma.

**Do not report in log scale. Convert to copies/ml.**

*Example:*

*1.3 log result = 20 copies/mL*



The final reminder we have has to do with viral loads. For viral load counts, you should report these counts as copies per milliliter and not the log scale. Some test results will only give you the log scale, some give you both.

If you are only given the log scale, you will need to convert it to copies per milliliter. For example, if you have a log result of 1.3, that should be converted and reported as 20 copies per milliliter.

IF YOU NEED HELP IN DOING THIS, PLEASE REACH OUT TO THE DISQ TEAM.



## Best Practices in Submitting High Quality Data

Now I will pass the presentation to Debbie to review best practices for the ADR.



## Best Practices

---

- Gather your tools
- Document your ADR process
- Review data through the year
- Establish data sharing with HIV surveillance

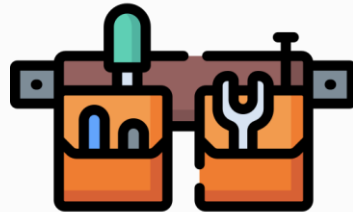
Documenting your ADR process is really important, particularly developing a programmatic crosswalk between your local ADAP activities and the ADR reporting requirements.

Next reviewing your data throughout the year and not just before the ADR submission.

And last but definitely not least, establishing data sharing with your HIV surveillance program. I'm going to review each of these in a little more detail.

## Gather Your Tools!

- TargetHIV has an [ADR home page](#)!
- Download the most recent version of the [ADR Instruction Manual](#)
- Review the [ADR validations](#) for any changes



Ok let's start with gathering your tools. There are a lot of resources on TargetHIV. If you're not familiar with TargetHIV, it's the one stop shop for resources for RWHAP recipients and providers on a range of topics including data and reporting. There is actually a page specific to the ADR that is great to bookmark.

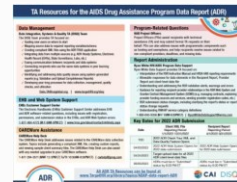
I also want to highlight specific resources that we recommend. The first one is a resource that Imogen already highlighted – the ADR Instruction Manual. It's updated each year to reflect any reporting requirement changes as well as clarification on existing requirements. We base the clarifications on questions that we receive from you as well as by reviewing the data that you submit.

You'll also always want to check the ADR validations. These are the validation messages that are programmed into the ADR web system to help support the submission of high quality data. Changes can include the addition of new validations, the removal of existing validations (most common if there is a reporting change) and the escalation of a validation (for example from an alert to a warning). These are not yet updated, but should be available early next year. We'll talk more about the validations and how to address them in our webinars next Spring.

## Gather Your Tools!

- Be sure that you have the most recent build/version for your [ADR-ready system](#) or [TRAX](#)
- [Register](#) for webinars!
- [Sign up for the DISQ listserv](#)
- Request TA

To learn more about all ADR TA Resources, check out the [ADR TA Brochure](#)



You'll also want to be sure that you have the right version of the system that you use to create your ADR client-level data file. If you're using an ADR-ready system, we update the status on TargetHIV, but be sure to check to see that you have the right version. For CAREWare users, the minimum build for the ADR is also usually announced on the CAREWare listserv. TRAX updates automatically once you open it. There aren't usually changes to the csv files unless there is a reporting change, so you should be able to use the ones from last year.

Be sure to register for the ADR webinars. I'll talk more about future webinars later in the presentation. The webinars are also recorded, so if you miss one you can always watch the recording.

The DISQ listserv (choose the ADR option) is another resource to sign up for. You'll receive important updates regarding the ADR submission but don't worry, there aren't a lot of emails.

## Document ADR Process

---

- Document programmatic crosswalk
  - Common reason for incorrect reporting is that ADAPs don't translate their local program to the ADR



Now if you've ever joined a TA webinar or received TA from us, you've heard us talk about documenting the process. So what do we actually mean?

Well, first and foremost, you need to be sure that your ADAP can speak Ryan White. What do I mean by that? For many ADAPs, what they call their programs locally is different than the terms used in the ADR.

## Document ADR Process

Program Name	Description	Vendor	Federal Report (ADR/RSR)	Federal Report Service Category
ADAP	Full pay medications for underinsured and uninsured clients	PBM	ADR	Medication Services
HIP	Marketplace insurance premiums	ABCD agency	ADR	Insurance Services-Full premiums or partial premiums
HIP	Medication copays for clients on insurance program	PBM	ADR	Insurance Services-Medication Copays, co-insurance and deductibles
HIP	Office visit copays for clients on insurance program	ABCD agency	RSR	Health insurance premium and cost sharing assistance

Let's walk through a quick example. Here's a state ADAP (I'm using the federal term here). They have two programs: one is called ADAP which is just for full pay medications and one is called their Health Insurance Program (or HIP). This program includes insurance premium assistance for private health insurance plans as well as medication and office visit copays (funded by Part B not ADAP) for clients for whom they are paying their full or partial insurance premium. For each program, the vendor or agency is listed so they know the data source, in what federal report it must be reported and the associated service category. You can see that for this state, they would actually report activities in both the ADR and the RSR.

By developing a crosswalk, it not only facilitates accurate data reporting, but also helps staff understand federal terms as compared to state terms. In addition, it can highlight potential data quality issues. For example, in this state when a client moved from ADAP to HIP, the staff would update their enrollment status to disenrolled and then enter a new application received and approved date to reflect enrollment in the insurance program. This also meant that the client was reported as 'new'. While the state may consider this two programs, HAB considers it one program so the client shouldn't be disenrolled and then enrolled for the purposes of the ADR. Before this crosswalk was completed, the state has no idea they were reporting incorrectly.

# Document ADR Process

- Highlight key deadlines (Not just HAB deadlines, but yours)
- Outline roles and responsibilities
  - Programmatic, fiscal and data/IT staff all have a role
  - [ADR Roles and Responsibilities](#)
- Outline data sources
  - Meet with PBMs/IBMs/agencies as needed to discuss requirements
  - Map source data to ADR-ready systems/TRAX using [ADR crosswalk](#)

The image shows a document titled "AIDS DRUG ASSISTANCE PROGRAM REPORT (ADR) ADR ROLES AND RESPONSIBILITIES". It contains a table with three main columns: "Role", "Responsibilities", and "Contact Information". The roles listed include Program Manager, Technical Support, and Data Support. The responsibilities are detailed for each role, and contact information is provided for each. At the bottom of the document, there is a flowchart showing the ADR process steps: "Request ADR", "Review ADR", "Submit ADR", "Review ADR", and "Final ADR". The DISQ logo is visible in the bottom right corner.

You'll also want to highlight key program deadlines. HAB lists the federal deadlines but when will you start working on the ADR? When will you request data from your PBM, IBM or HIV surveillance? When will the team working on the ADR meet? When will you review data?

It's also important to know who's doing what. Programmatic, fiscal and data/IT staff all have a role in completing the ADR. We have a resource called ADR Roles and Responsibilities that can be useful to outline roles and responsibilities for key ADR activities.

Finally, outline data sources. In the previous slide, I listed the vendor from which the ADAP receives their data. It's important to ensure that the vendor is both collecting the needed data and provides it in a format and within a timeline that supports the ADR submission. Finally, the data sources you use will need to be mapped to the system that you use for the ADR. You can use the ADR data crosswalk to document this.

## Routinely Review Data

---

- Many ADAPs wait to review their data until it is in their ADR-ready system or TRAX
- Reviewing data throughout the year makes it easier to identify and correct issues
  - It's fine to use your local system to do this but it may not catch all data quality issues

Ok on to data review. What we most commonly see is that ADAPs wait to review their data until it is in their ADR ready system or TRAX. The challenge is that if you have a data quality issue, it can be difficult to resolve it in April or May.

The DISQ Team recommends reviewing data throughout the year to both identify and correct any data quality issues. Now we understand that based on how many of you operate your ADAP, it may not be feasible to combine all of your data multiple times a year. Let's look at the earlier example I shared. Let's say the ADAP has a full pay medication program that they call ADAP and then an insurance program they call HIP. The ADAP may be able to review data for each program (ADAP and HIP) but not across programs for the ADR until closer to the submission. The ADAP may also review data by data source - enrollment data, claims data, premium data and clinical data to see if it 'looks right'. That is still helpful, but that means you have to know what to look for regarding incorrect data.

## Routinely Review Data

---

- Check Your XML is always available, but any updates to the validations or Upload Completeness Report are not implemented until closer to the reporting
- For CAREWare users, you can use the Viewer and Validation report
  - [ADR Validation Report](#)
  - [ADR Viewer](#)

That's why we suggest using the structure of the ADR to check your data. Putting your data into the ADR structure provides additional context and can highlight data quality issues that may not have been evident from the individual review. We suggest at a minimum to try to do a mid-year review using the ADR structure. That may mean combining files for TRAX and making sure that all of the data have been entered/imported into CAREWare or another system you use.

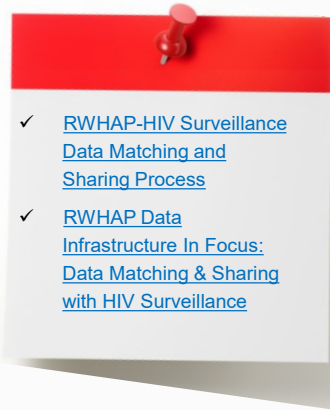
Check Your XML is always available. What changes each year are any schema, validation or Upload Completeness Report updates. We announce once those are implemented, but you can still use the system. Quick reminder-if the data system that you use to create the client-level data XML has been updated with the new schema, you won't be able to use Check Your XML until it is updated with the new schema.

Finally, for CAREWare users, the Viewer and Validation Reports are built into CAREWare and are great resources. I've included links here that provide more information about the reports.



## Establish Data Sharing

- All CD4 and all Viral Load data are required for all clients
- Can be challenging for ADAPs that rely on applications for lab data
- Your HIV surveillance program collects these data for ALL people with HIV in your jurisdiction



Finally let's talk about data sharing. All CD4 and VL data have to be reported for all clients regardless of whether or not they receive services. This continues to be challenging for some ADAPs, particularly those who rely on application and recertification processes to get labs. With changes to processes as a result of PCN 21-02, it may get even more difficult to get labs.

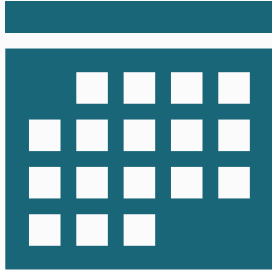
The solution? Working with your HIV surveillance program to share data in both directions. HIV surveillance gets labs for all people with HIV, including ADAP clients. This is actually something encouraged by not only HAB, but also CDC. We know that this takes time and resources and we're happy to help you with technical assistance.



So on to the final poll before we go through TA resources.

Based on today's webinar, which of the following statements best fits your needs for technical assistance?

- I'm good to go but thanks for the offer
- I'll need to check but I'll reach out if needed
- I definitely need help so please contact me
- I'm new to the ADR, please help!



## Upcoming Webinars and TA Resources

Now let's end the presentation by reviewing upcoming ADR webinars and TA resources.

## Upcoming ADR Webinars

---

- December 13<sup>th</sup> from 2-3pm ET
  - [Strategies for ADR Data Integration](#)
- Spring ADR webinar schedule is in the process of being finalized
  - [DISQ ADR listserv](#)
  - [Data Webinar Calendar](#)

First, just a reminder that today is just the beginning! We have an upcoming webinar in December focused on strategies for ADR Data Integration. Most ADAPs have multiple data sources they use for the ADR and we're going to discuss approaches to make combining those data sources easier! We'll also have several more webinars in the Spring of 2024. They usually start in early March. We'll send out a notification once the updated schedule is posted on TargetHIV, so be sure that you've subscribed to the DISQ ADR listserv. You can also check the data webinar calendar on TargetHIV in a few weeks. We should have the schedule out by then.

## Annual ADR Outreach

---

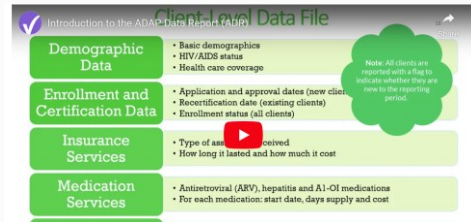
- Each ADAP receives a State Data Quality Summary Report
- Calls are scheduled to review data quality issues
- Technical assistance and resources are provided



Most of you know that we conduct outreach each year to help you look at your data more closely. This year we did some summer outreach if there was a data workflow issue about which we wanted to be sure the ADAP was aware. We will also be doing additional outreach later this year. We'll send out a state summary report that provides aggregate ADR data. We schedule calls with ADAPs to review the report and identify potential data quality issues. We also provide TA to help address any issues that we identified as well as provide available ADR resources. If you want to start TA earlier or you're new and need more assistance learning about the ADR, you can reach out and we'll be happy to work with you.

# Resources

- For new folks – [ADR Training Video Series](#)
  - Introduction to the ADR
  - Creating the ADR Client-Level Data File
  - Tips for ADR Data Quality



We've actually shared a lot of TA resources during this webinar. I want to highlight resources for anyone new ADR Training Video Series-There are three short videos. These include: Introduction to the ADR, Creating the ADR Client-Level Data File and Tips for ADR Data Quality. It's a great place to get started and then plan to sign up for the Spring ADR webinar series once it is released. Please also feel free to reach out to the DISQ Team and we can help orient you to the ADR.

## TA Resources

- The DISQ Team
  - [Data.TA@caiglobal.org](mailto:Data.TA@caiglobal.org)
  - [Sign up for the DISQ listserv](#)
  - [Submit a DISQ TA request](#)
- EHBs Customer Support Center:
  - 877-464-4772
  - [Submit an EHBs TA Request](#)
- Ryan White HIV/AIDS Program Data Support
  - [RyanWhiteDataSupport@wrma.com](mailto:RyanWhiteDataSupport@wrma.com)
  - 888-640-9356
- CAREWare Help Desk:
  - [cwhelp@jprog.com](mailto:cwhelp@jprog.com)
  - 877-294-3571
  - [Join the CAREWare listserv](#)

So I know that was a lot and several of you might be feeling overwhelmed. There are several resources available to help you. (click) The DISQ Team addresses questions for those needing significant assistance to meet data reporting requirements. DISQ also deals with data quality issues, as well as providing TA on TRAX and support in creating documentation.

(click) Data Support addresses ADR-related content and submission questions. Topics include: Interpretation of the Instruction Manual and HAB's reporting requirements; Allowable responses to data elements; Policy questions related to the data reporting requirements; and Data-related validation questions.

(click) The EHBs Customer Support Center addresses software-related questions. Topics include: Electronic Handbook (EHB) navigation, registration, access and permissions and Performance Report submission statuses.

(click) Finally, the CAREWare help desk is your best resource for any TA requests related to CAREWare. We encourage you to register for the listserv to join the conversation with other CAREWare users across the country.



## Connect with HRSA

---

To learn more about our agency,  
visit

[www.HRSA.gov](http://www.HRSA.gov)



Sign up for the HRSA eNews

FOLLOW US:    

Finally, to connect with and find out more about HRSA, check out [HRSA.gov](http://HRSA.gov).

So now let's turn to the Q & A portion of the webinar.

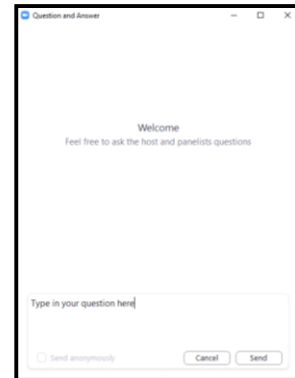
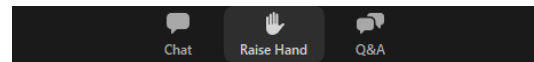


## Let's Hear From You!

- Please use the “raise hand” function to speak. We will unmute you in the order that you appear.

**OR**

- Type your question in the question box by clicking the Q&A icon on the bottom toolbar.

Before we start the Q & A, just a quick reminder that a brief evaluation will appear on your screen as you exit, to help us understand how we did and what other information you would have liked included on this webcast. We appreciate your feedback very much, and use this information to plan future webcasts. My DISQ colleague Isia is going to put a link out in the chat feature if you would prefer to access the evaluation right now. We'll also send a final reminder via email shortly after the webinar

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, Isia 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” because 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.