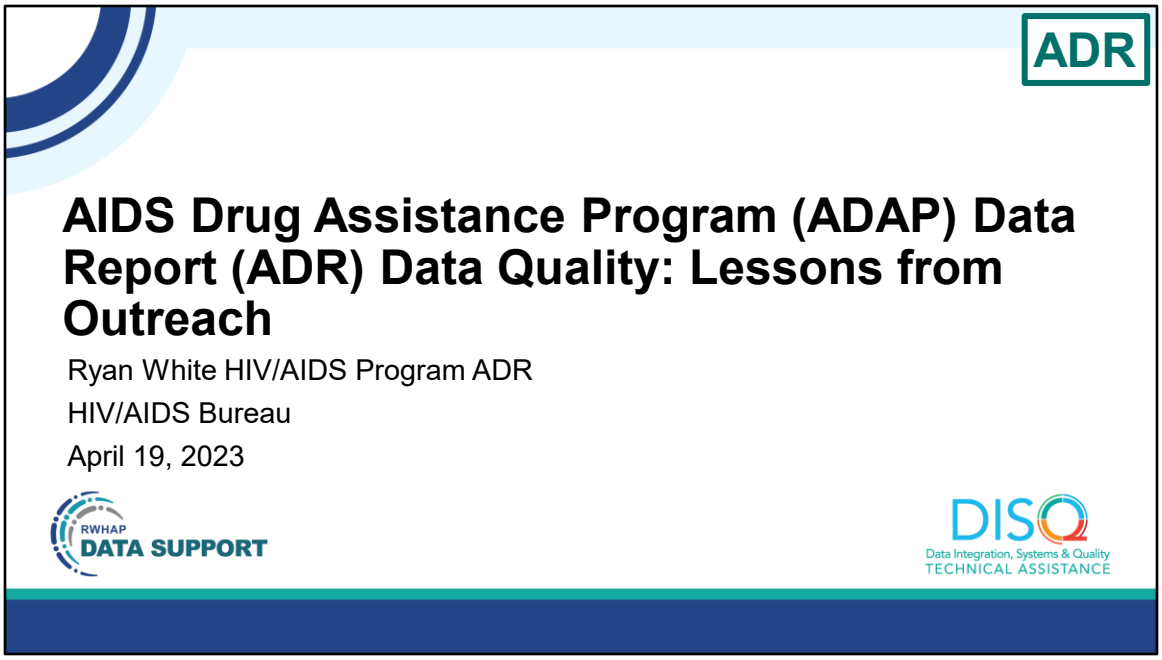


Welcome to today's Webinar. Thank you so much for joining us today!

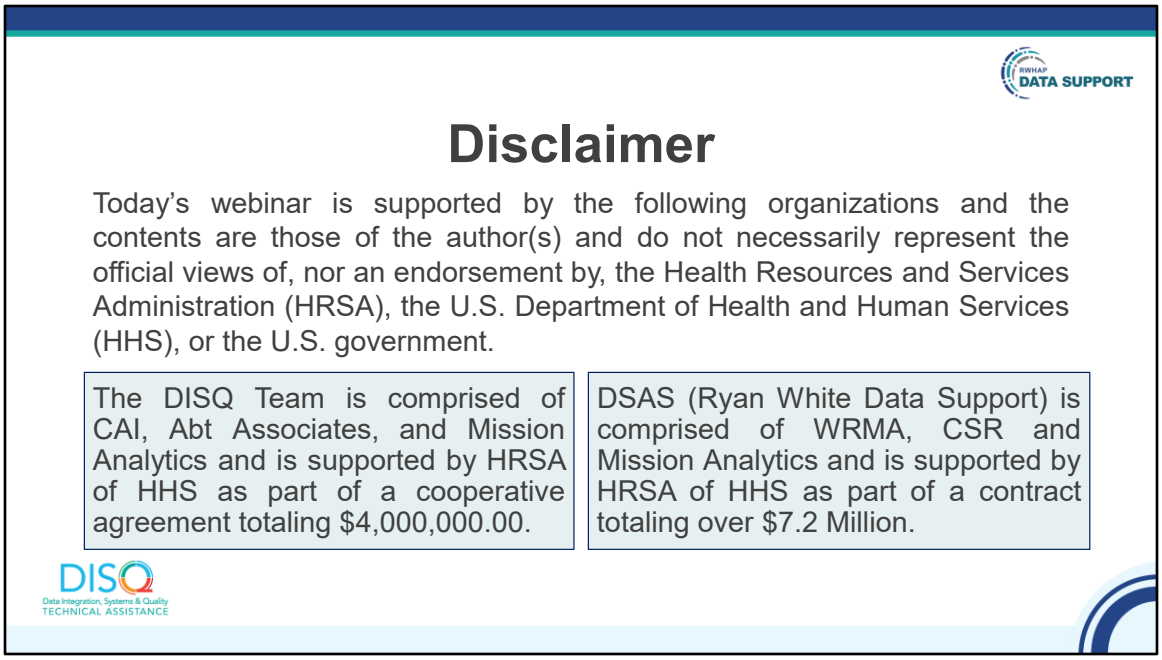
My name is Hunter Robertson. I'm a member of the DISQ Team, one of several groups engaged by HAB to provide training and technical assistance to ADAPs for the ADR.

Today's Webinar is presented by Debbie Isenberg also from the DISQ team. In today's webinar, Debbie will share the findings from this year's ADR outreach activities as well as some approaches that your fellow ADAPs are using to address some data quality issues.

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.

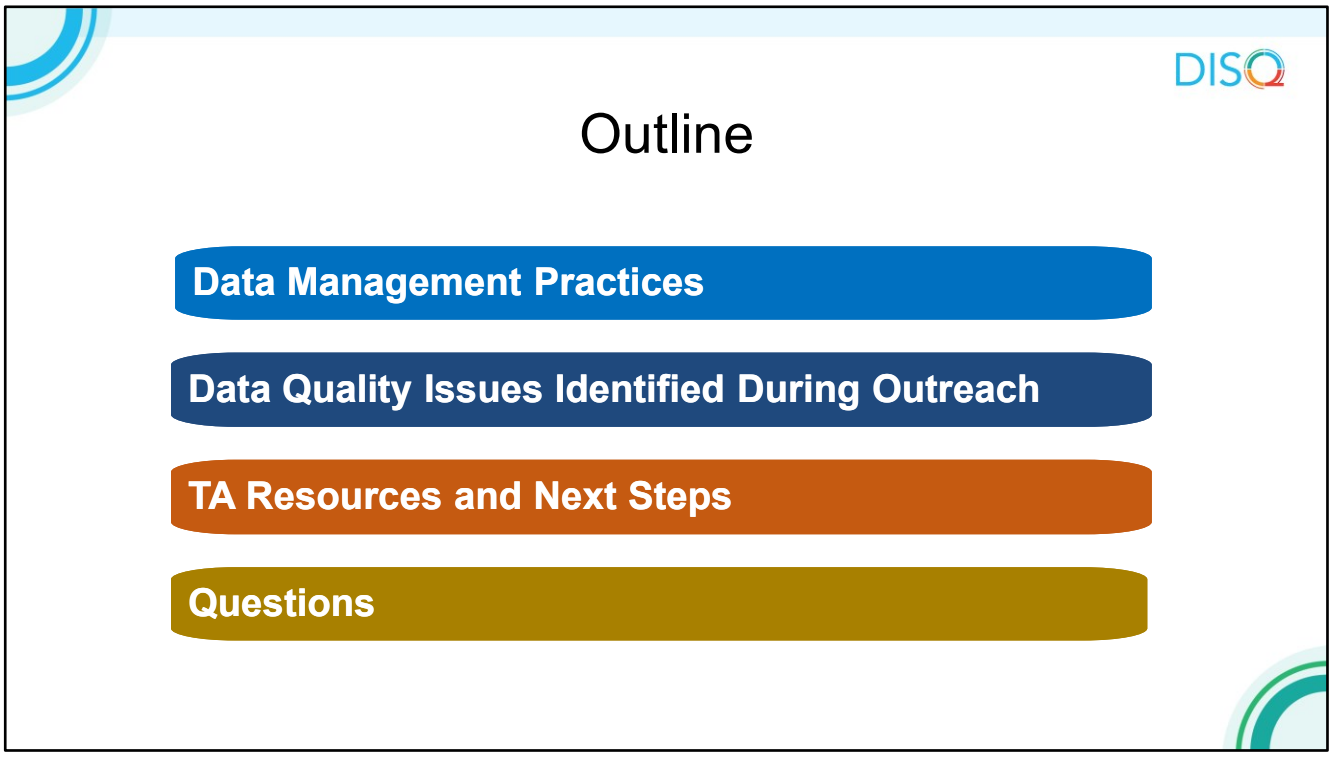
At any time during the presentation, you'll be able to send us questions using the "Q&A" function on the settings bar on the bottom of the screen. All questions will be addressed at the end of the webinar in our live Q&A portion. During that time, you will also be able to ask questions live if you'd like to unmute yourself and chat with us directly.

Before we start, I'm going to answer one of the most commonly asked questions about the slides. The recording of today's webinar will be available on the TargetHIV website within one week of the webinar; the slides and written question and answer are usually available within two weeks. We will also send an email to everyone registered for this webinar when the recording, slides, and Q&A document are posted.



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.

Now I'd like to turn the webinar over to Debbie.



Thanks Hunter. Today's webinar is specifically focused on and for AIDS Drug Assistance Programs or ADAPS (meaning a program at the state or territorial level that provide medication and/or insurance services). This webinar is also pretty technical, so if you're new to your ADAP, you'll probably want to review the prior webinars as a way to help better understand the information that I'm providing today. Also please feel free to submit any written questions throughout the webinar and we'll address them at the end.

In early 2023, many of you spoke with us to discuss last year's ADAP Data Report (or ADR) submission. As always, we learned a lot about your work and how it is reflected in your data!

Today, I'm going to discuss some of the data management practices that you shared with us including strategies for creating the ADR. Then I'll share some of the data quality issues identified during outreach as well as some strategies suggested by your fellow ADAPs as well as the DISQ team.

Next, I'll review some TA resources and next steps

As always, we'll save time at the end for your questions.

So let's get started.

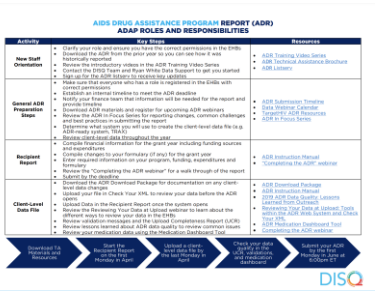
I'd like to start with a poll to get a sense of who's on the webinar today so I'm going to turn things over to Isia. Isia, take it away.

Which of the following best describes your experience in completing the ADR submission?

- ❍ I'm brand new and have never completed the ADR before
- ❍ I've submitted the ADR before but still have questions
- ❍ I've submitted the ADR before and am good to go!
- ❍ I'm not sure how to answer that question

What To Do If You're New

- Download the ADR Roles and Responsibilities document
  - Clarify your role
  - Get EHBs access
  - Download the ADR from the prior year
  - Review the ADR Training Video Series
  - Sign up for the ADR listserv
  - Contact the DISQ Team and Ryan White Data Support to help get you started



For those of you who are new, there are a few initial steps that you can take. You can download the ADR roles and responsibilities document which outlines the key steps that I'm reviewing.

First, clarify what your role is. Will you be working on the Recipient Report? The client-level data? Both?

Second, will you need access to the Electronic Handbooks (or EHBsto complete your role? Well, if you're supposed to enter information into the Recipient Report, upload client-level data or submit the ADR, you'll need EHB access.

If you have EHB access, download the Recipient Report and the Upload Completeness Report from last year. This will help you understand your historical submissions and have a starting point for your work. If you don't have EHB access as part of your role, ask someone who does to download these for you.

Next, review the ADR Training Video series. These are short videos to help orient you to the ADR.

Don't forget to sign up for the ADR listserv. This is how we communicate with you about updates or any issues for the ADR.
Finally, ask for help if you need it. Both the DISQ Team and Ryan White Data Support can help.

ADR Outreach

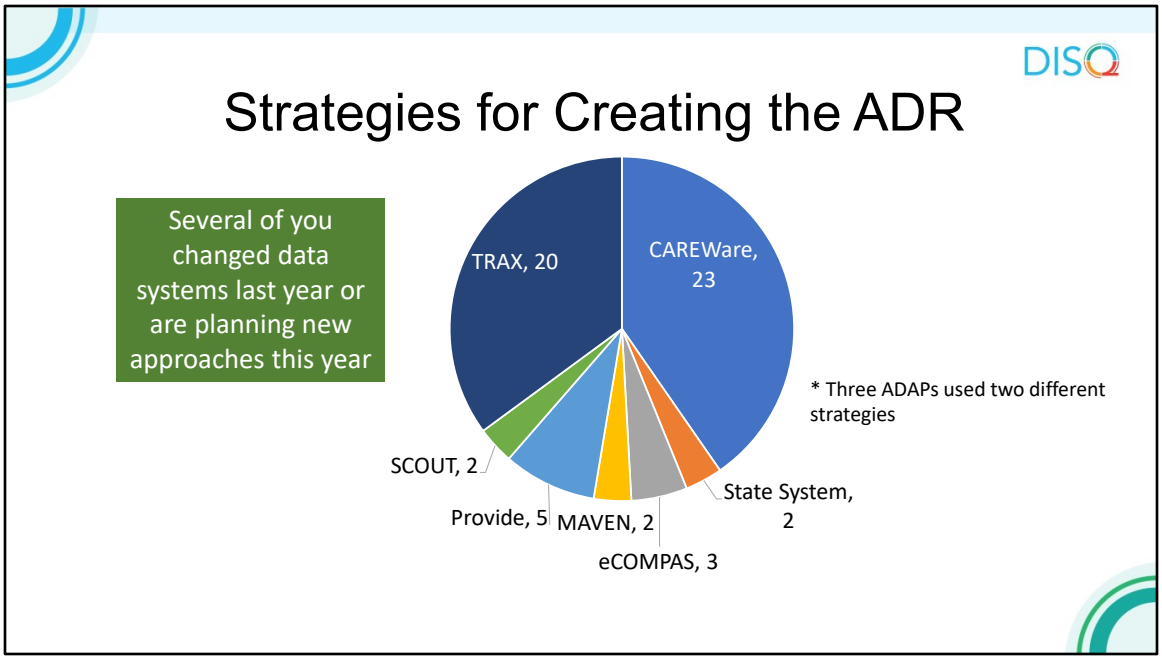
- Reviewed your data in aggregate and at the individual ADAP level
- Created and distributed ADR Summary Reports to all ADAPs
- Talked to 30 ADAPs about:
  - Strategies for creating the ADR
  - Data management practices
  - Data quality issues

Ok, let's jump in to the focus of today's webinar-what we learned from this year's outreach activities.

To learn more about your data quality, we reviewed data that you submitted. We also looked at data trends from previous years' submissions.

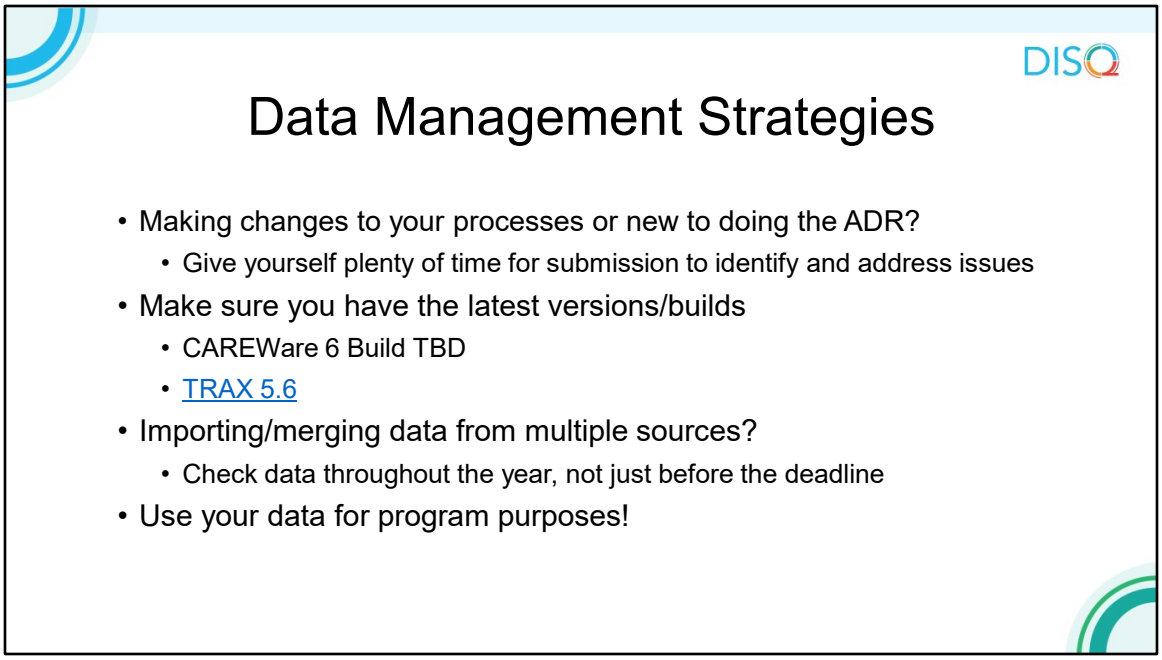
We created state-specific ADR Data Quality Summary Reports and sent them to all of the ADAPS and held calls with 30 ADAPs to go over your 2021 ADR. This helped us learn more about your program, data management practices, and strategies for creating the ADR. We also reviewed your data with you because while we can sometimes spot data quality issues through our own data analysis, we also rely on you to compare the data with your expectations to figure out if there is a data quality issue.

We learned a lot and want to share what we learned with you to help with the upcoming submission.



In terms of strategies to create the client level data file for the ADR, many of you use an ADR-Ready System, such as CAREWare, Provide, eCOMPAS and SCOUT to create your ADR client-level data file; TRAX is another system used where you can take data from various systems, enter the data into multiple .CSV files and TRAX generates the ADR XML file. As you can see from the graphic, the two most commonly used approaches are CAREWare and TRAX.

Several of you changed approaches last year which in some cases impacted your ADR data quality. Some of you are also changing approaches this year.



Through our conversations with you about your data management practices and strategies for creating the ADR, we identified some high-level steps you can take to improve ADR data quality. First, many of your systems or processes are changing or folks are new. If that's the case, build in some extra time this year in creating the ADR to identify and address unforeseen issues.

Make sure you are using the latest version of your system to create the 2022 ADR. For CAREWare, the build hasn't yet been released but should be shortly. For TRAX users, the application should automatically update when you open it to version 5.6. You also want to be sure that you download the updated csv table templates.

In terms of ongoing activities, if you are importing or merging data from multiple sources, do this throughout the year, not just before the deadline. And while today's focus is on the ADR, we encourage to use your data for program purposes such as informing and evaluating program activities.

You've Made Great Progress!

- Fewer ADAPs met criteria for ADR outreach calls
- Multiple ADAPs had or were in the process of implementing changes to improve data quality

Now before we jump in to a review of data quality issues, I want to highlight a few successes. First, based on data quality issues, we had to reach out to a smaller number of ADAPs as compared to last year. In addition, multiple ADAPs commented that they had implemented or were implementing changes to improve their data. Some ADAPs even noted that the 2021 ADR data reflected the most accurate data yet. So I just want to take a moment and congratulate everyone on the progress that you've made.

Data Quality Issues

- Demographic data
- Enrollment and certification data
- Insurance services data
- Medication services data
- Clinical data

Now, let's get into the meat of our conversation with you – specific data quality issues. We have split these issues into the major sections of the ADR Client Report.

Demographic and Enrollment Data

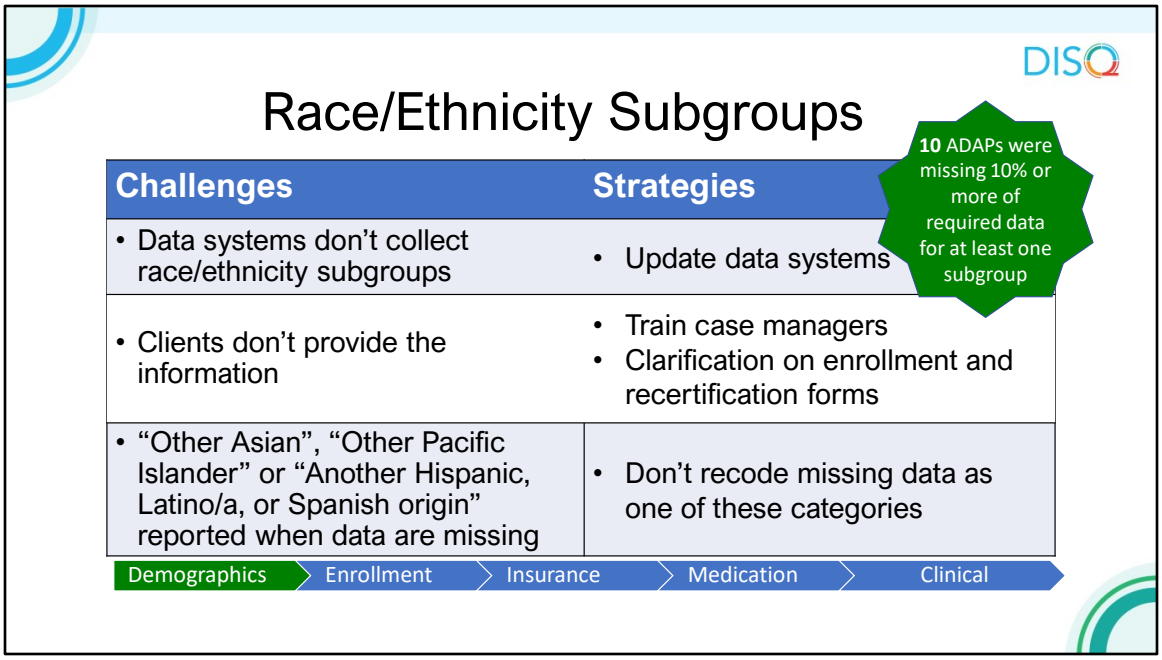
Let’s start with demographic and enrollment data

Known Rates for Demographic Data

Ethnicity	Gender	Birth Year
Race	Sex at Birth	Poverty Level
High Risk Insurance	HIV/AIDS Status	Health Coverage
Hispanic SG	Asian SG	NHPI SG

Demographics | Enrollment | Insurance | Medication | Clinical

Overall demographic data were very complete. Among the 12 demographic data elements , we're going to focus on three today where there were higher rates of missing data : race/ethnicity subgroups



Ten ADAPs reporting at least 10% missing data for at least one of the subgroups, lower than the 17 ADAPs in 2021.

Issues reported included that an ADAP's data system did not collect the data or clients don't report the information. Some ADAPs also reported their missing data as "Other Asian", "Other Pacific Islander" or "Another Hispanic, Latino/a, or Spanish origin" rather than missing data.

So how are your fellow ADAPs addressing these challenges? They are working on any needed system updates as well as providing training to case managers and providing clarification on application forms to help improve data quality.

The DISQ team also wanted to remind ADAPS to leave missing data as missing, rather than recoding it as "Other Asian", "Other Pacific Islander" or "Another Hispanic, Latino/a, or Spanish origin"

Enrollment Status

- Challenges remain in using the enrollment category of 'enrolled, services not received' although it's gotten better

Challenges	Strategies
• Enrolled receiving services reported when client did not receive services	• Run reports to identify clients with incorrect enrollment status • Update enrollment status prior to submitting ADR

Demographics | Enrollment | Insurance | Medication | Clinical

Now let's look at enrollment and recertification data. Data accuracy for the enrollment status of "enrolled, services not received" still remains a challenge for some ADAPs although it looks as if it is getting better (only 5 ADAP didn't use it at all which is better). We've heard that updating this enrollment status can be burdensome in data systems because it has to be done manually and isn't an enrollment status that would be updated as part of recertification since the assumption is that clients are enrolled to get services.

An effective strategy that was shared is to update enrollment status prior to completing the ADR-basically to run a report to identify clients with an incorrect enrollment status once all services for the year have been entered. The enrollment status can then be updated prior to submitting the ADR. For CAREWare users, there is a custom report that can help you identify enrollment statuses that don't match services received. Fixing this is still a manual process (one client at a time) and there is no way to 'batch' the changes. The hope was to change it for this year but that wasn't feasible, so hopefully it will be next year.

One reminder about enrolled, services not received. This enrollment status should be used when a client hasn't received services. This would include if a premium payment or medication claim was paid but then reversed meaning the client never received the service. For more information, check out the ADR Instruction Manual.

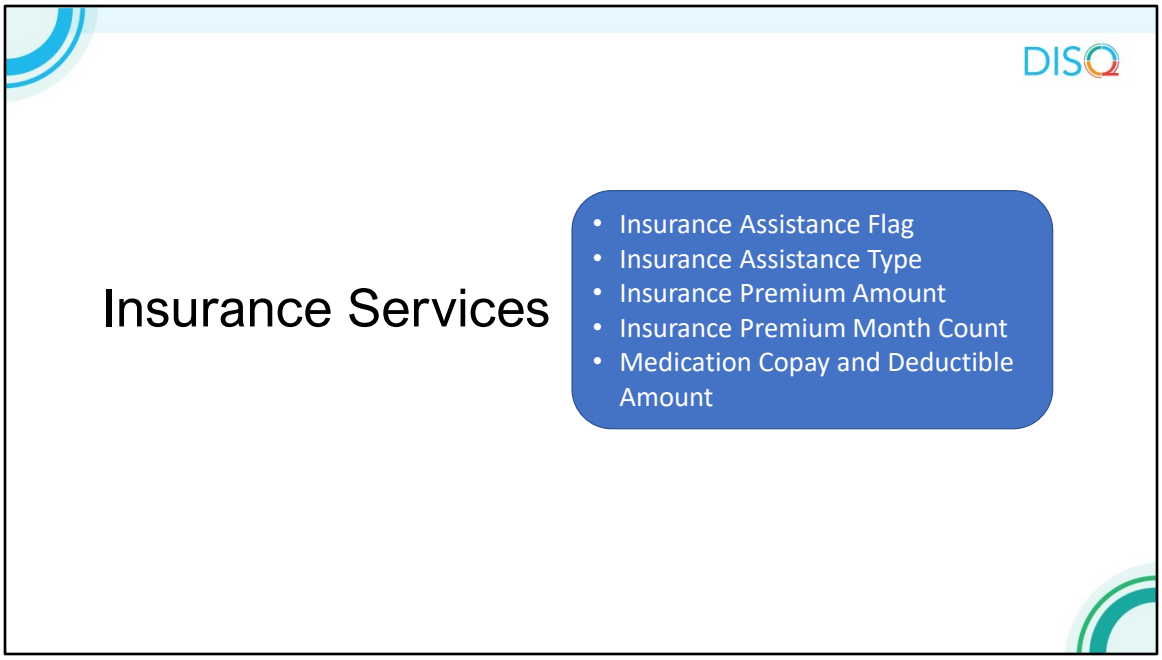
Disenrollment Reason

- Disenrollment reasons of other and unknown used instead of specific categories

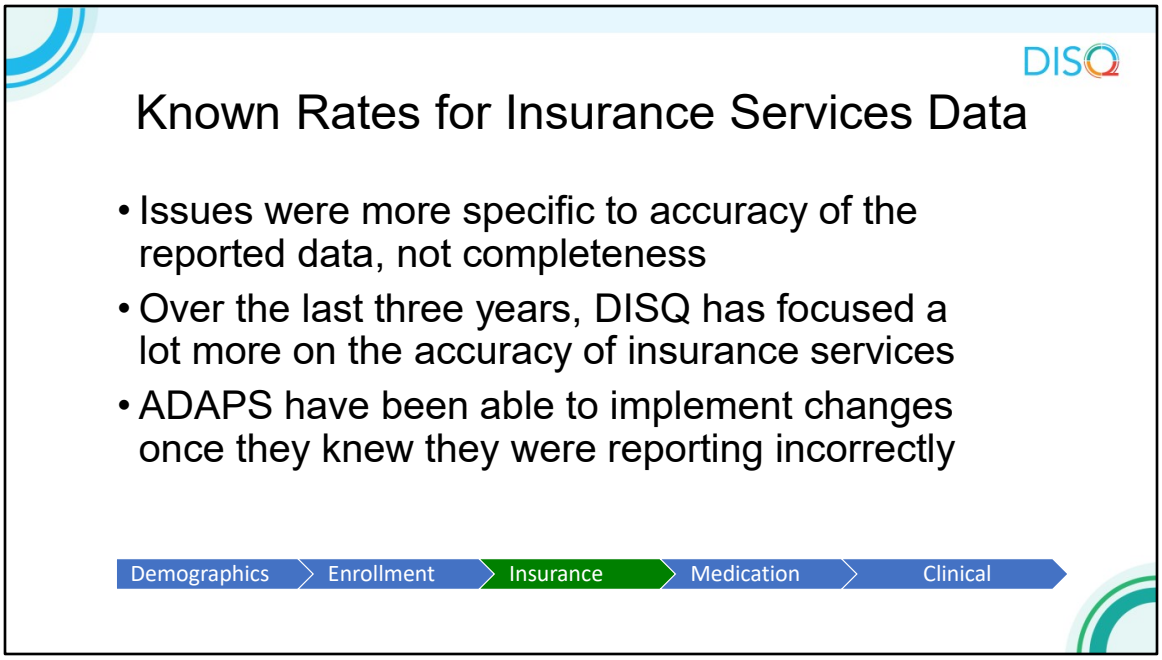
- Program eligibility criteria changed, client no longer eligible
- Client's eligibility changed, client no longer meets eligibility criteria
- Did not recertify
- Did not fill prescription as required by program
- Deceased
- Dropped out, no reason given

Demographics | Enrollment | Insurance | Medication | Clinical

Another issue that we identified is other, unknown or missing disenrollment reason. In the 2021 ADR, the response option Other/Unknown was separated so these were separate categories. 19 ADAPs had more than 10% of disenrollment reasons reported as other, unknown or missing; most were reported as "other". What we've learned in outreach is that often the reasons put in 'other' categories will fit into one of the other ADR options. One effective approach that some ADAPs have used is to create a crosswalk of the common reasons reported and align them with the ADR disenrollment reasons. It's also important to ensure that disenrollment reasons are collected in your data system.



Now let's move to Insurance Services. As a reminder, insurance services includes five data elements-a flag for whether or not the client receives insurance services (yes or no), the insurance type which can include full premiums, partial premiums and medication copays, co-insurance and deductibles, premium amount and month count for any clients who received full or partial premiums and finally the medication copay and deductible amount for medication copays, co-insurance and deductibles.



For insurance services, the data were complete for the majority of ADAPs. The data quality issues identified are more specific to accuracy, not completeness. Over the last three years, the DISQ team has focused a lot more on accurate reporting of insurance services. The great news is that several ADAPS have been able to modify their reporting practices once they realized that there were issues.

Insurance Assistance Type

Challenges	Strategies
• Confusion about definitions	• Review ADR instruction manual • ADR In Focus: Partial Premiums
• Can't differentiate insurance type in claims/premium data	• Review claims data with PBM/vendor • Use internal program names
• Data entered/imported in wrong place in data system	• Talk to system vendor about where to enter/import data

Demographics | Enrollment | Insurance | Medication | Clinical

Let's discuss the accuracy issues more. About 9 ADAPs continue to have difficulty with accurately reporting insurance services. Many of you were able to implement changes to correct your reporting for the 2021 so congrats!

Several challenges were identified as part of outreach. We learned that there is still confusion regarding what is a full premium and what is a partial premium, so we'll be reviewing that again in a moment. Some ADAPs also can't tell from their data how to differentiate between full and partial premiums or medication full pay or copay. In some cases the data are not entered or imported in the right place.

So how are your fellow ADAPs tackling the insurance services issues that we just reviewed?

First, be sure to use the ADR manual to review the definitions, particularly for partial premiums. The DISQ Team also created a resource specifically on partial premiums and it includes more clarification about partial vs full premiums. If you're not sure if you're reporting correctly, the DISQ team can meet with you to learn more about your ADAP and help crosswalk your

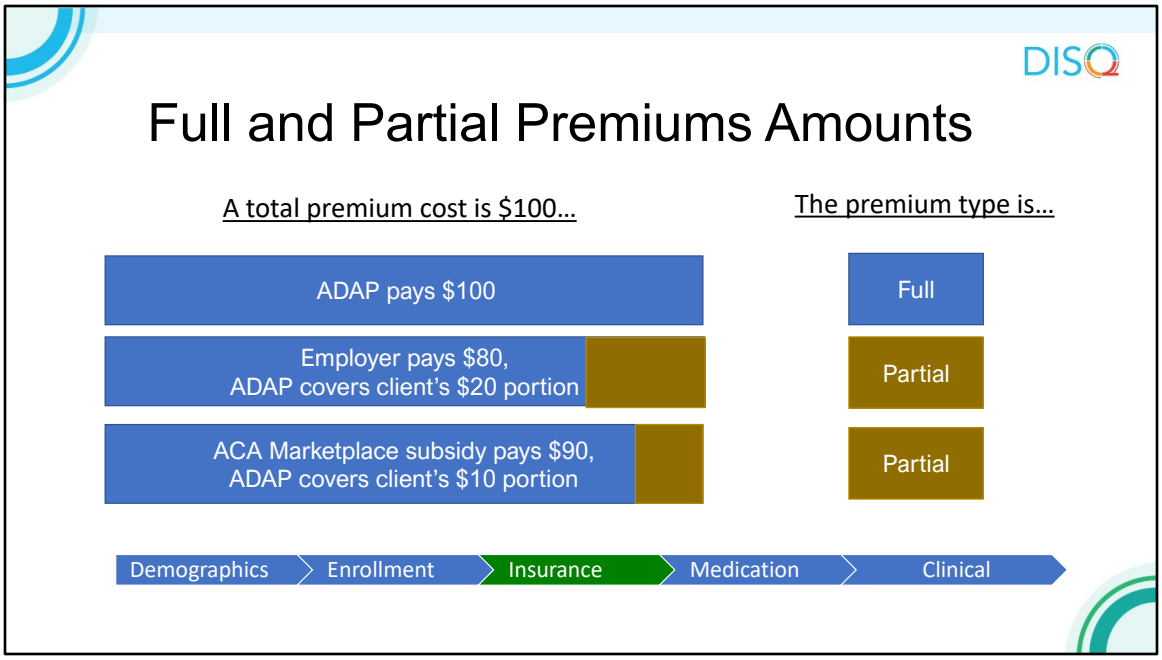
insurance premium assistance activities with full and partial premiums.

You can also review claims or premium payment data and determine if you can use data elements to distinguish full/partial premiums and medication full pay/copay. It may be beneficial to meet with your PBM/pharmacy to discuss what each data element in the claims data means as well as their ability to provide the needed information. The DISQ team can assist you if needed with this-just ask! Some ADAPs also use distinct program names that help differentiate different premium and medication assistance, but we know that this may not be feasible for all ADAPs.

ADAPs who had issues with how data were captured in their data system are working to update their systems. For data entry/import issues, talk to the system vendor if you aren't sure where to enter/import data. Full and partial premiums and medications copays/co-insurance and deductibles are all insurance services. Full pay medications should be entered as medication services.

For CAREWare users, you'll want to ensure that data are entered into the ADAP domain and the correct place. You also need to be sure that you're using the correct subservices for these and there is a CAREWare tip sheet that we developed that can help you with this.

Several ADAPS noted that they have already fixed the issue from last year's ADR or are working on a plan now to fix the data for this year's submission. Other ADAPS just realized this year that they have not been reporting correctly and are working to fix these issues.

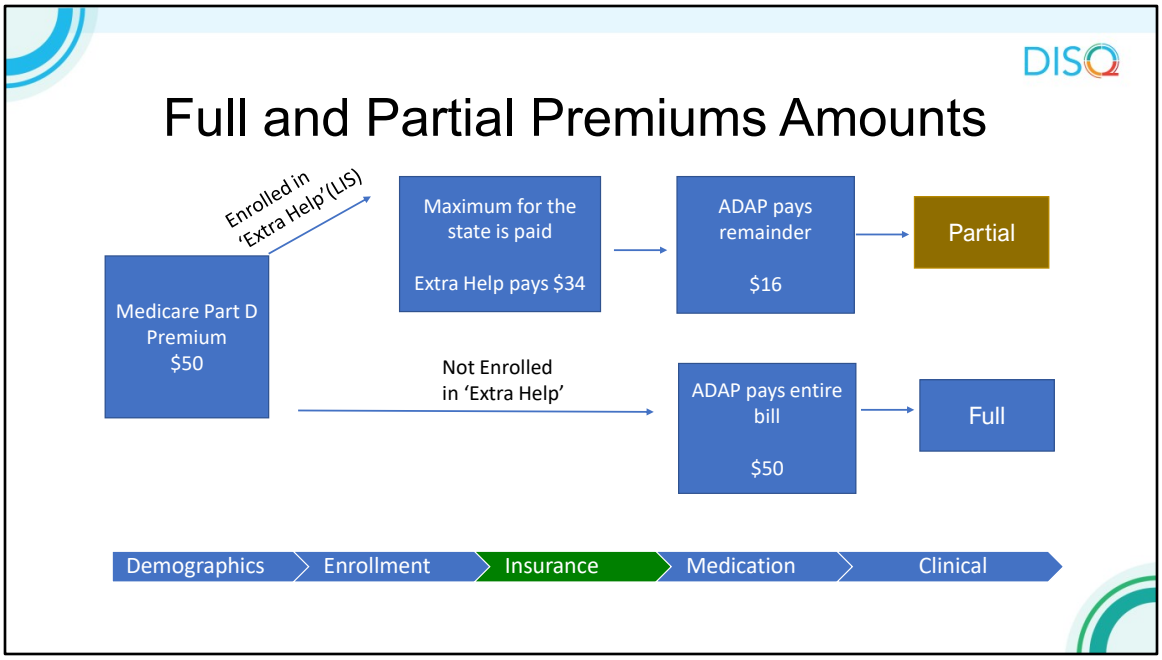


So I mentioned that we were going to discuss definitions more since it is such a common issue. Let's review a few examples of full and partial premiums.

If an ADAP is paying the entire cost of the premium, it is a full premium.

If a client is receiving employer-based assistance and the ADAP is paying the client's portion of the cost, that is a partial premium.

If you obtained insurance for the client through the ACA marketplace and the client received a subsidy and the ADAP pays the non-subsidized portion, that is a partial premium as well. If a client is not receiving a subsidy, then it would be a full premium.



The final example is a little more complicated. This is for Medicare Part D. If a client is getting extra help and has Medicare Part D Low Income Subsidy (LIS), any amount that the ADAP pays is a partial premium. If the client does not have Medicare Part D LIS, the ADAP premium payment is a full premium.

Using the UCR To Identify Inaccurate Data

Insurance Assistance Type* (Item #67)
Denominator: Number of unique clients reported who received insurance services (N=500)

Insurance Assistance Type Received	N	Percentage
Full Premium payment	250	50.0%
Partial Premium payment	0	0.0%
Medication co-pay/deductible including Medicare Part D co-Insurance, co-payment, or donut hole coverage	400	80.0%
Missing/Out of range	0	0.0%

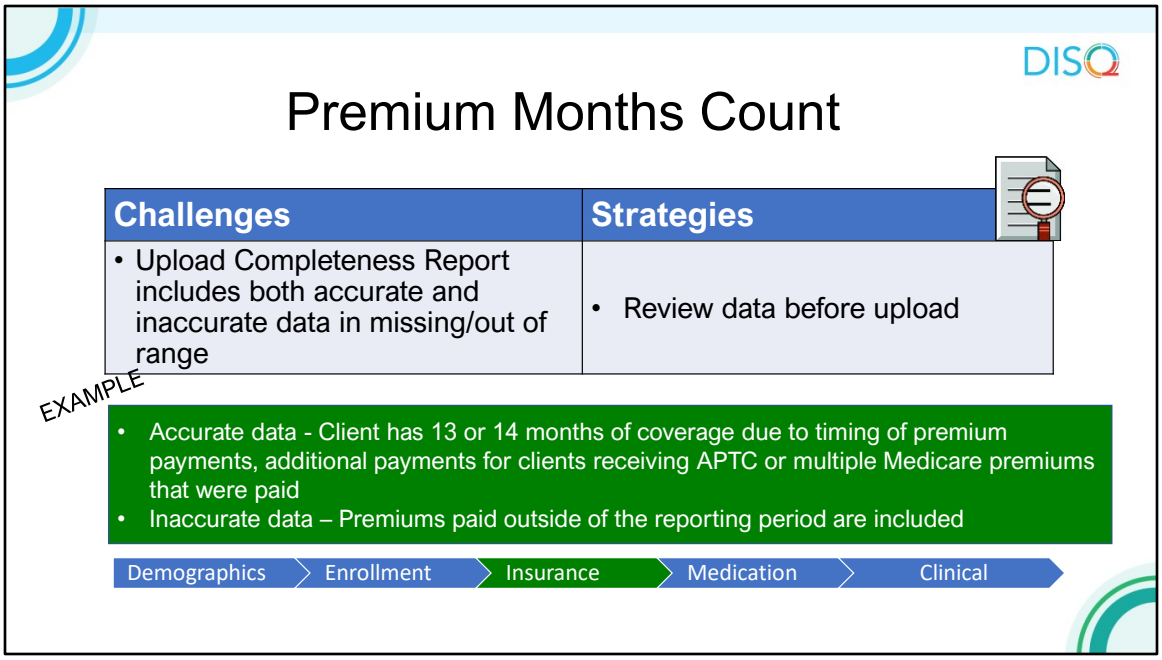
Do these numbers make sense?

As you review your data this year, be sure to check the Upload Completeness Report. Specifically, review the results for insurance assistance type. Make sure that it makes sense based on the insurance services that your ADAP provides. For example, if you know that you pay for ACA marketplace plans for which the client receives a subsidy, only reporting full premiums would be incorrect.

So now it's time for our next poll and I'm going to turn things over to Isia. Isia, take it away.

Based on the definitions just outlined for full and partial premiums, which of the following best describes how accurately you are reporting full and partial premiums?

- ❍ Our reporting aligns with the definitions so I'm good
- ❍ Based on the definitions, I need to make changes
- ❍ I'm not sure if we're following the definitions



Now let's talk about premium months coverage. The reporting requirement is that any insurance premiums paid during the reporting period should be reported, regardless of the time frame that the premium covers. For most ADAPs, that means that most of their clients receiving insurance premium services will have a maximum of 12 months of coverage. However, there are some situations that can contribute to more than 12 months.

There are situations where an ADAP may report a client with 13 or 14 months of coverage reported because they had two premium payments because of the timing of when payments are made. In addition, an ADAP may also have a client who received an Advance Premium Tax Credit (or APTC) and they end up owing more for insurance premiums once they file their taxes, so the ADAP needs to make an additional insurance payment in the year. An ADAP also may be paying more than one Medicare Premium in the same month. These are examples of accurate data. Inaccurate data would be if premiums paid outside of the reporting period are reported or there were data entry issues.

be paying more than one Medicare Premium in the same month. These are examples of accurate data. Inaccurate data would be if premiums paid outside of the reporting period are reported or there were data entry issues.

Premium Months Count

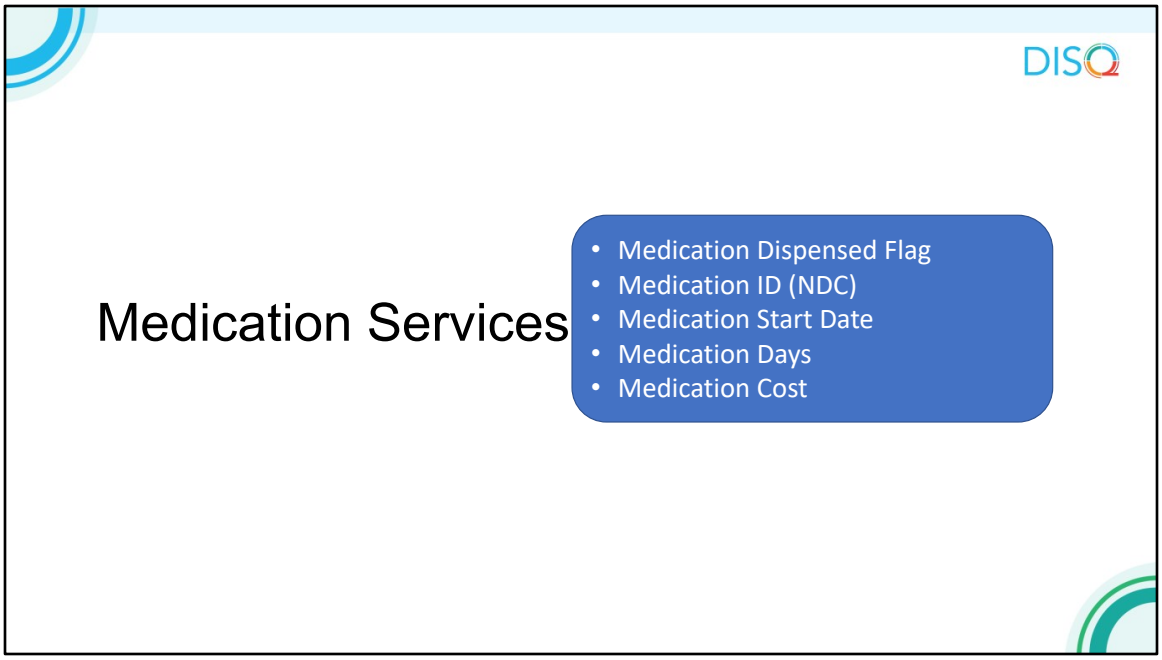
Insurance Premium Number of Months of Coverage (Item #22)

Denominator: Number of unique clients reported with full or partial premium payment insurance assistance received (N = 400)

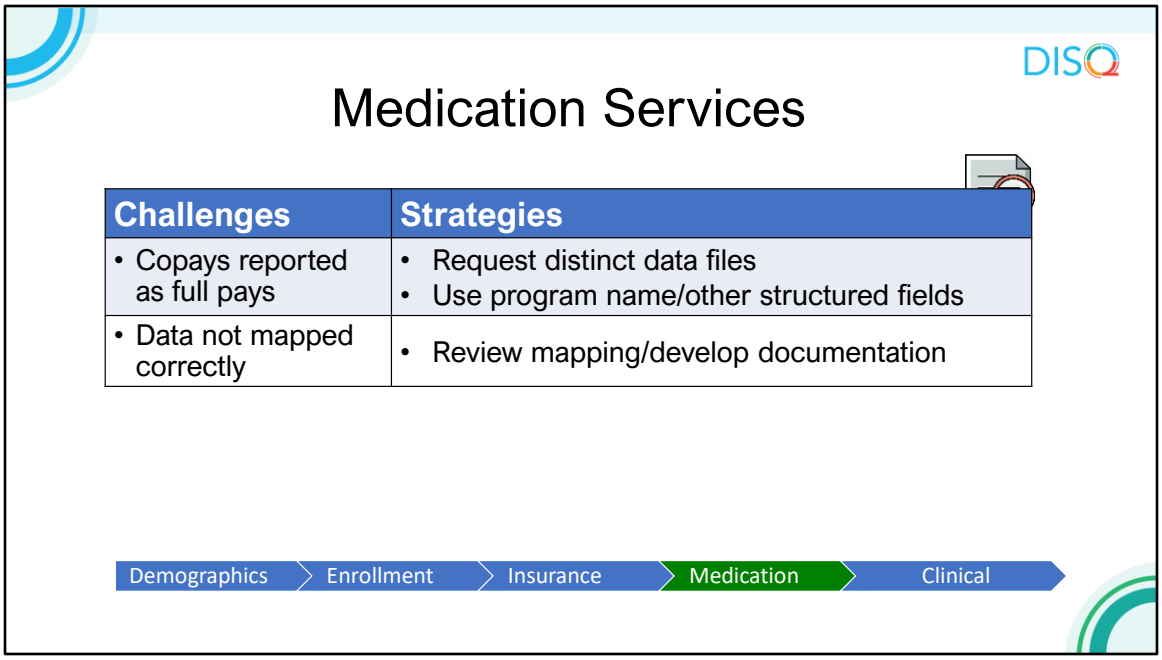
Insurance Premium Number of Months of Coverage	N	Percentage
0 month	0	0.0%
1 - 3 months	20	5.0%
4 - 6 months	100	25.0%
7 - 9 months	60	15.0%
10 - 12 months	200	50.0%
13 -15 months	10	2.5%
Missing/Out of range	10	2.5%

Demographics | Enrollment | Insurance | Medication | Clinical

Another row has been added to the table for premiums 13-15 months. This should help with your data review. You may still have premium months missing or out or range. We recommend reviewing data in your data system before upload as it is often easier to determine this when your data are still in your data system. For CAREWare users, there is a custom report that can help you review the data.



Now let's move on to Medication Services. There are five data elements for medication services-a flag for whether or not the client receives medication services. In addition for each dispensed medication, the National Drug Code (NDC), start date and cost need to be reported. Medication days supply was also added back to the ADR after being removed in 2021.



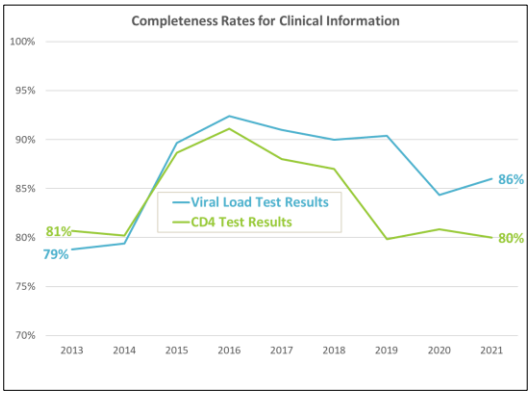
While data completeness is high for medication data, data accuracy issues were noted for 3 ADAPs. This is a large improvement from last year. Specific issues include:

- Copays reported as full pay medications
- Data not mapped correctly

So how to tackle these issues?

If you're having trouble distinguishing between full pay and copay medications, see if your pharmacy/PBM can separate the data before they give it to you. If they can't, see if you can use the ADAP program name or other structured fields in the data to help distinguish. If your data aren't being mapped correctly, be sure to review and update your mapping and enhance your documentation. The DISQ Team can help with this, so just let us know.

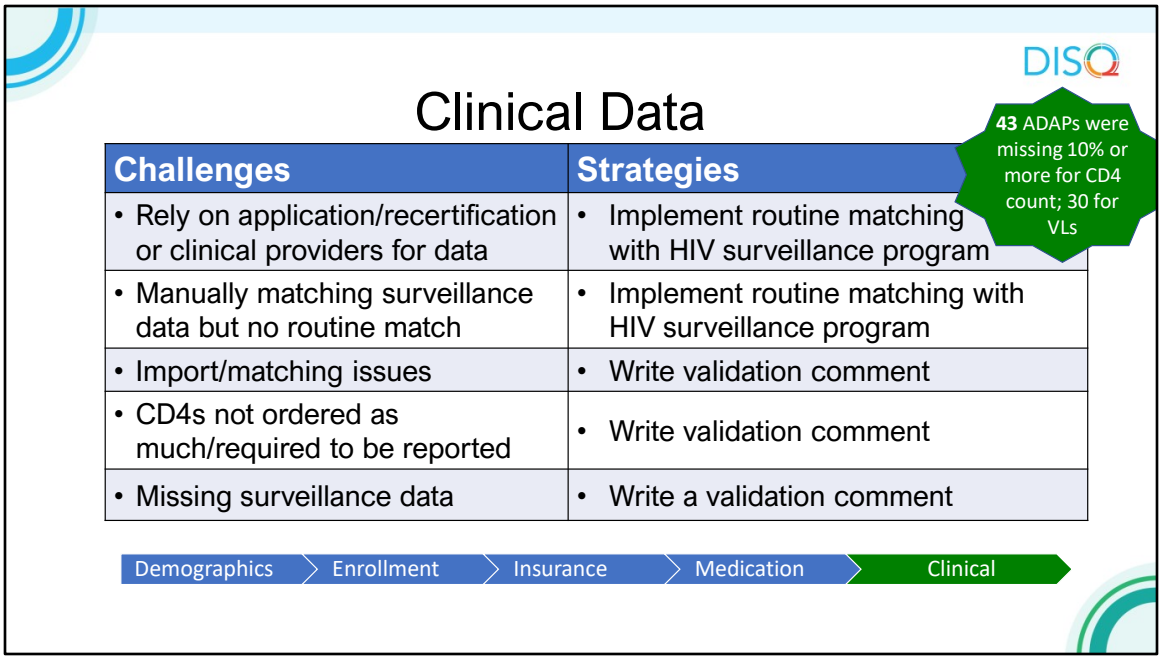
Clinical Data



Demographics | Enrollment | Insurance | Medication | Clinical

So now let's switch to clinical completeness. Here's completeness data over time. For the 2020 ADR, COVID deployments and short term changes in enrollment had a large impact on both CD4 and VL completeness rates. ADAPs also reported that CD4s were being ordered less than viral loads. In 2021, the reporting requirement changed where ADAPs has to report all CD4 and all Viral Load for all clients. While completeness improved from 2020 for VL, it didn't return to 2019 levels. Overall ADAPs that shared data with their HIV surveillance programs faired much better with the reporting changes.

Let's look at some of the challenges and strategies in more detail.

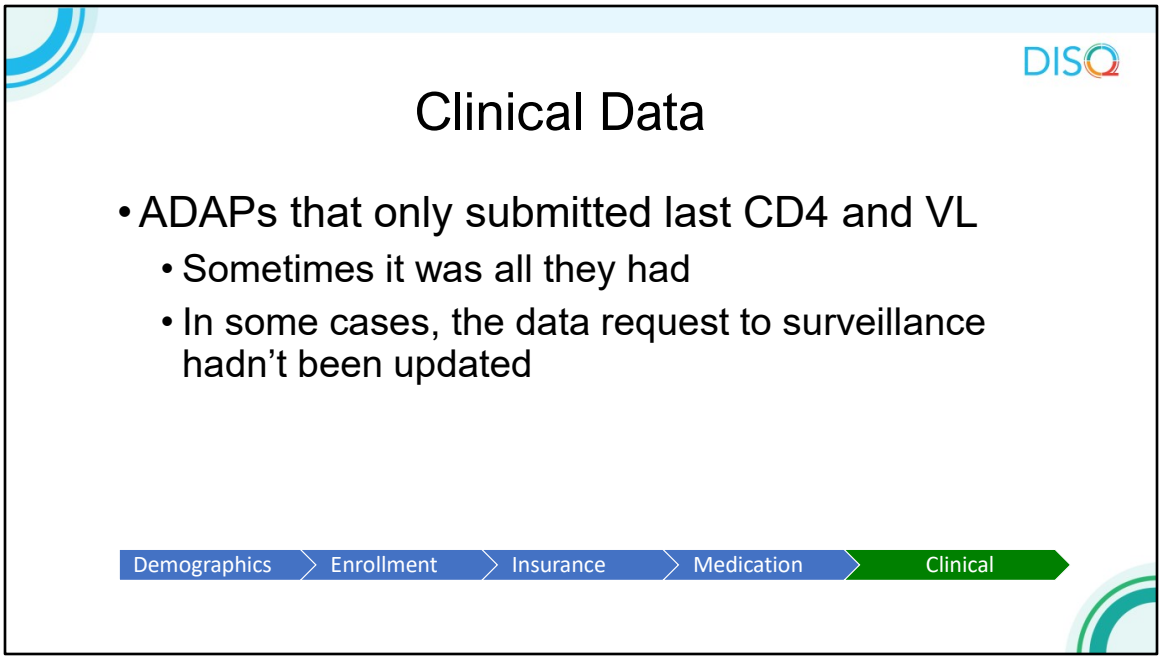


More than ¾ of all ADAPS had 10% or more missing data for CD4 count, while 30 had 10% or more missing data for viral loads. This was about the same as last year (41 and 29)

Several ADAPS are relying on applications for lab information and don't always get updated data for recertifications. This challenge was amplified by the new lab reporting requirement and was also impacted as ADAPs revised their recertification practices in respond to PCN 21-02. Several ADAPS are also manually matching surveillance data to a list right before the submission but are not routinely matching surveillance data.

Several ADAPs also reported importing or matching issues. For last CD4 date and count, some ADAPs noted that clinicians are not ordering the lab test as much as compared to viral loads or that the data are not required to be submitted on applications.

Finally, some ADAPs were matching but there was actually missing surveillance data. So how to tackle this? If you're not yet matching and sharing data with your HIV surveillance program or you're doing it manually but there isn't a routine match, implement it. Matching and sharing data with your HIV surveillance program (and vice versa) is encouraged by both HRSA HAB and CDC. If you need help getting started, contact the DISQ team. For those ADAPs with import or matching issues, fewer CD4s ordered or missing surveillance data, you would just write validation comments for this.



We also identified another issue among a small number of ADAPs. While CD4 and VL were reported, only one lab per client was reported. While in some cases this was the only data the ADAP, in others the ADAP identified that they hadn't updated their data request or code to include all CD4s and all VLs.

Before we move on to reviewing next steps for the current submission, let's do our final poll.

Now let's go to our final poll.

Which of the following best describes your understanding of your ADAP's data quality issues?

❍ We have known data quality issues we are fixing and don't need help
❍ We have known data quality issues we are trying to fix and need help
❍ We don't have any data quality issues
❍ I don't know if we have any data quality issues and would like TA

That's about it for outreach. Now let's turn to the 2022 ADR submission.

Tools Available for Data Review

- ADR-Ready Systems may have tools available
  - CAREWare has the Viewer and Validation Report
- TRAX users can use CHEX
- Upload data in EHBs and review the Upload Completeness Report
  - Focusing just on the validation report limits your data review

So we want to ensure that you know there are lots of tools (and technical assistance) to help you submit high quality data. Let's review some of the tools.

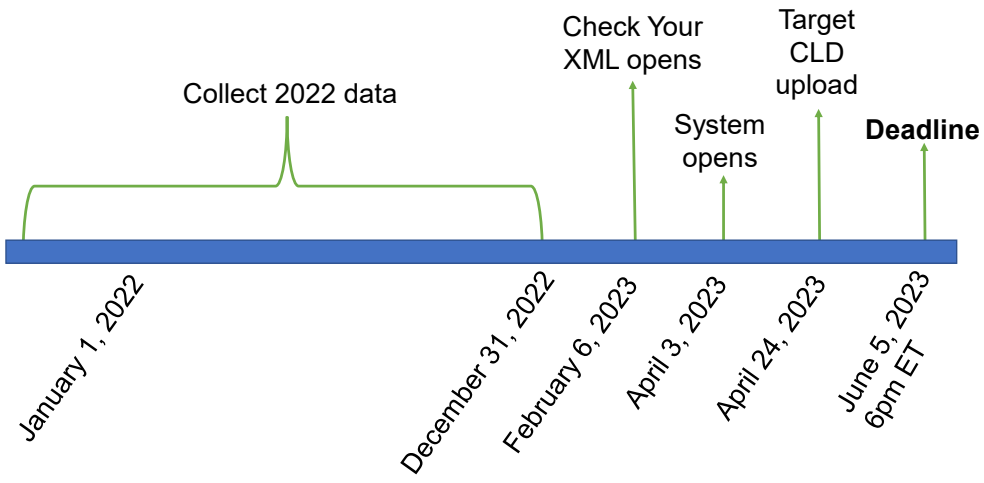
Many ADR systems have tools built into the system. For example CAREWare has both the Viewer and the Validation Reports. If you aren't sure what your data system has, check with your system vendor.

TRAX Users can use CHEX which is available in the download package.

Finally, upload your data in EHBs and review the Upload Completeness Report. Using just the Validation Report does not review your data in the same way.

The DISQ Team is happy to review your data with you-just ask

2022 ADR Submission Timeline



That's one of the reasons we encourage that you start early, particularly this year. Let's review the timeline so you know when everything is due. You spent calendar year 2022 collecting data for the ADR.

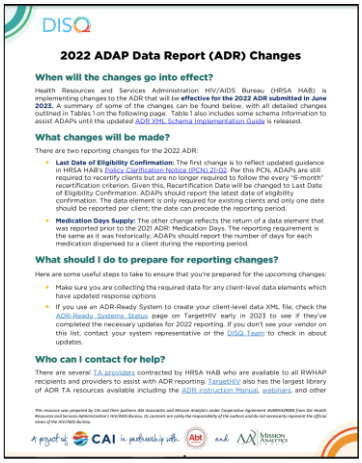
On February 6, 2023, the Check Your XML and Data Quality feature for the ADR opened. This feature allows you to test your client-level data XML file for schema compliance and run reports on the quality of your data. We hosted a webinar on March 1st walking you through tools in the ADR web system and the Check your XML feature. If you missed the webinar, there is a recording available on the TargetHIV website.

The main ADR Web System, accessible through the EHBs, opened on April 3 so you can start working on your Recipient Report and uploading your client-level data file to the main system.

By April 24, we'd like to see an initial client-level data file uploaded to the main system if at all possible. This will give you plenty of time to check and correct your data as needed before the final submission. And, you'll avoid pesky calls from TA providers and your project officer as the deadline approaches – which is June 5, 2023

TA Materials

- TargetHIV website ADR reporting resources
- 2022 ADR Reporting Changes
- 2022 ADR Instruction Manual
- ADR Validations
- ADR In-Focus Series
- ADR Download Package



DISQ

2022 ADAP Data Report (ADR) Changes

When will the changes go into effect?

Health Resources and Services Administration HIV/AIDS Bureau (HRSA HAB) is implementing changes to the ADR that will be **effective for the 2022 ADR submitted in June 2023.** A summary of some of the changes can be found below, with all detailed changes outlined in Tables 1 on the following page. Table 1 also includes some schema information to assist ADAPs until the updated ADR XML Schema Implementation Guide is released.

What changes will be made?

There are two reporting changes for the 2022 ADR:

- **Last Date of Eligibility Confirmation:** The first change is to reflect updated guidance in HRSA HAB's Policy Clarification Notice (PCN) 21-02. Per this PCN, ADAPs are still required to recertify clients but are no longer required to follow the every "6-month" recertification criterion. Given this, Recertification Date will be changed to Last Date of Eligibility Confirmation. ADAPs should report the latest date of eligibility confirmation. The data element is only required for existing clients and only one date should be reported per client; the date can precede the reporting period.
- **Medication Days Supply:** The other change reflects the return of a data element that was reported prior to the 2021 ADR: Medication Days. The reporting requirement is the same as it was historically; ADAPs should report the number of days for each medication dispensed to a client during the reporting period.

What should I do to prepare for reporting changes?

Here are some useful steps to take to ensure that you're prepared for the upcoming changes:

- Make sure you are collecting the required data for any client-level data elements which have updated response options
- If you use an ADR-Ready System to create your client-level data XML file, check the ADR-Ready Systems Status page on TargetHIV early in 2023 to see if they've completed the necessary updates for 2022 reporting. If you don't see your vendor on this list, contact your system representative or the DISQ Team to check in about updates.

Who can I contact for help?

There are several TA providers contracted by HRSA HAB who are available to all RWHAP recipients and providers to assist with ADR reporting. TargetHIV also has the largest library of ADR TA resources available including the ADR Instruction Manual, webinars, and other

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A project of CAI in partnership with Abt and Mission Analytics

There are also a lot of TA materials on TargetHIV. You can find this list on the handout that Isia chatted out at the beginning of the webinar. TargetHIV actually has a section just for the ADR! It includes the instruction manual as well as validations. The ADR in Focus services covers several different topics, including the 2022 ADR changes and a resource on ways to identify Partial Premiums.

The ADR download package includes the schema which can be useful if this is your first time reporting the ADR and you are not using an ADR-ready system.

TA Materials

Date	Title
October 26, 2022	Preparing for 2022 ADR Reporting: Updates and Best Practices
March 1, 2023	Reviewing Your Data at Upload: Tools in the ADR Web System and the Check Your XML Feature
April 5, 2023	Completing the ADR: Recipient Report & Client Level Data Upload
April 12, 2023	ADR TRAX

Finally don't forget the webinars that we conducted this year. They are all available on the TargetHIV website.

TA Resources

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

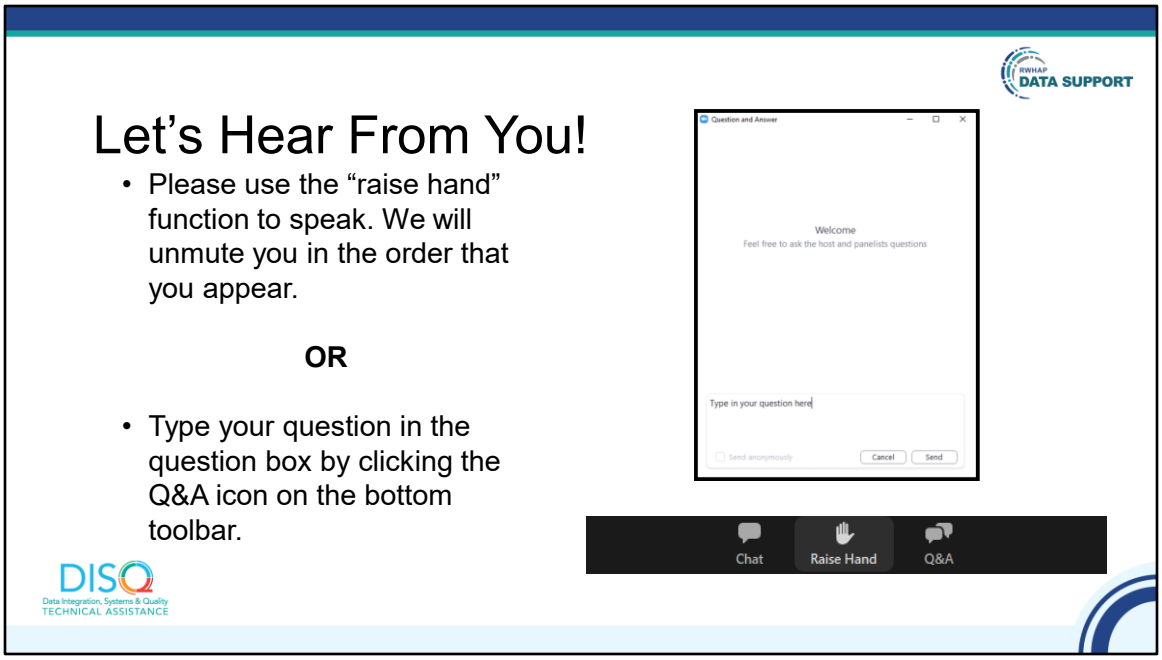
So I know that was a lot and several of you might be feeling overwhelmed. There are several resources available to help you. The DISQ Team addresses questions for those needing significant assistance to meet data reporting requirements. DISQ also deals with data quality issues, as well as providing TA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

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.

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

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. Most importantly, there is no wrong door for TA – if we can't assist you we're happy to refer you to someone who can!
Thank you all for joining us today to learn more about preparing for ADR submission. Now I will pass things off to Ruchi for the Q&A portion of the webinar.

Finally, to connect with and find out more about HRSA, check out HRSA.gov.



And now to your questions – but first, I would like to remind you 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 webinar. We really appreciate your feedback, and use this information to plan future webinars. My 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 "Q&A" button on your control panel on the bottom of your screen. You can also ask questions directly "live." You can do this by clicking the "raise hand" button, which is also on your control panel. If you raise your hand, we'll be able to allow you to unmute and ask your question. 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 via email to follow up. Sometimes we need to do some follow-up before providing you with a final answer, so stay tuned for the written Q&A as well for answers to all of your questions.