

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

RYAN WHITE EVALUATION SYSTEMS

Title I: Grants to Metropolitan Areas



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Inspector General**

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OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

To examine the evaluation systems used by Title I Ryan White grantees to monitor the compliance, measure the outcomes and measure the overall effectiveness of the programs they fund.

BACKGROUND

In 1990, Congress passed the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act as a comprehensive response to the HIV epidemic and its impact on individuals, families, communities, cities and States. The Ryan White CARE Act was re-authorized in fiscal year (FY) 1996 through FY 2000. Title I of the Act provides emergency relief grants to eligible metropolitan areas (EMAs) disproportionately affected by the epidemic to provide community-based HIV-related health and support services. In FY 1999, 51 EMAs in 21 States, Puerto Rico and the District of Columbia received \$486 million in Title I formula and supplemental funds.

The Ryan White CARE Act will be considered for its second re-authorization in 2000. As Congress debates this re-authorization, questions are certain to be asked about the effectiveness and impact of the programs funded. This inspection examines the capacity of Title I Ryan White grantees to answer those questions.

We conducted an examination of the evaluation mechanisms used by 12 EMAs through an extensive documentation review and on-site interviews. The 12 EMAs visited represent the majority of Ryan White Title I funds and nearly half of HIV/AIDS cases.

FINDINGS

Title I Grantees Have Mechanisms in Place to Adequately Monitor Their Sub-grantees' Activities

The 12 Title I grantees we visited receive frequent program and fiscal reports from their sub-grantees, regularly review their financial audits and conduct routine site visits. A majority of the grantees are tightening fiscal control through unit cost and fee-for-service contracting and tightening programmatic control through EMA-wide databases and the collection of client-level data. Ensuring sub-grantees use Ryan White funds as the payor of last resort is one area where further monitoring mechanisms may be necessary.

Few Grantees Currently Require Outcome Measurement of Their Sub-grantees; Most Are in the Planning Stage of Outcome Measurement

Currently, only 2 of the 12 grantees visited require sub-grantees to measure client outcomes. The other 10 Title I grantees visited are in various stages of preparing to require sub-grantees to collect and report outcome measures in the next few years. The majority of sample Title I grantees have concerns regarding outcome measures and desire more specific guidance from the Health Resources and Services Administration (HRSA) on how to proceed.

The Majority of Title I Grantees Visited Assess the Needs of Sub-populations in HIV/AIDS Care but Do Not Solicit Needs Information from Those Outside of HIV/AIDS Care

In addition to analysis of public health data, information on client needs is often collected through provider and consumer surveys, focus groups and public forums. These mechanisms focus on populations currently in HIV/AIDS care. To detect the needs of those not in HIV/AIDS care, the majority of the Title I grantees visited match the demographics of HIV/AIDS cases to the demographic data of the clients receiving Title I funded services in their eligible metropolitan area (EMA). Matches of epidemiological and utilization data do not provide a complete picture of the needs of persons not in HIV/AIDS care. The matches do not provide information on the barriers individuals face to care or their unique service needs.

RECOMMENDATIONS

The HRSA Should Promote the Development of Metropolitan-wide Data Systems to Further Improve the Program Management Activities of the Sub-grantees

The HRSA should provide grantees with technical assistance on how to develop EMA-wide data systems through which the grantees and sub-grantees can access client-level data. Sub-grantee access to client-level data eliminates inefficient intake duplication and facilitates service coordination. Data systems capacity is a vital ingredient for HIV/AIDS service agencies to improve the efficiency and effectiveness with which they provide their services, track their outcomes and inform their fund sources of their activities and results. There are several potential sources of funds which could be used to assist grantees in building client-level data systems.

The HRSA Should Implement a Multi-year Outcomes Initiative Including Grantee Requirements and Technical Assistance

The HRSA should build upon their efforts to promote grantee outcome measurement by establishing a multi-year implementation plan. Outcome measurement should start on the

sub-grantee level and lead through subsequent steps to grantee analysis of client outcomes across the EMA. Outcome measurement would foster program improvements and greater accountability for expenditures and highlight the value of Ryan White funds.

The HRSA Should Provide Technical Assistance to Improve the Ability of Grantees to Estimate the Needs of Infected Persons Not in HIV/AIDS Care

The HRSA currently requires grantees to estimate unmet need of persons not in HIV/AIDS care by comparing service utilization data to the HIV epidemic in their area. The HRSA should require the grantees to improve their knowledge of unmet need by soliciting information directly from persons not in HIV/AIDS care. The input of infected persons who are not receiving care would add a richness of understanding regarding their needs and the barriers to service they encounter.

Grantee solicitation of the input of persons un-connected to care would assist the grantees in complying with the re-authorized CARE Act's directive to prioritize a portion of funds for emerging populations. Grantee solicitation of this input would also contribute to the Department's efforts to address the greater burden of HIV/AIDS on racial and ethnic minorities.

Several grantees indicated a need for technical assistance on using outreach strategies to solicit information from persons not in HIV/AIDS care. The HRSA could provide the grantees with a technical assistance document detailing how to use outreach strategies with examples of effective strategies for replication. Particular attention should also be paid to reaching persons who receive HIV/AIDS services but may not be receiving primary health care services.

AGENCY COMMENTS

The HRSA provided comments to the draft report. While HRSA concurred with the report's findings and recommendations, they offered suggestions for clarifying the report and making other technical changes. Where appropriate, we changed the report to reflect their comments. The complete text of HRSA's comments can be found in Appendix A.

The HRSA pointed out several ongoing and planned activities in response to the report recommendation to promote the development of metropolitan-wide data systems. We commend their efforts in this area. The HRSA cautioned, however, that they do not have the financial resources to enable grantees to fully develop and implement these systems.

We recommend that HRSA, in partnership with the Department, secure funds to assist in the development of such data systems. The FY 2000 re-authorization of the CARE Act

provides an optimal opportunity to consider funding for infrastructure development vital to ensuring efficient and effective service delivery in the future. The grantees could build upon an initial infusion of funds to streamline their systems, potentially reducing their administrative costs and freeing up funds to maintain their systems over time.

We agree with HRSA that the participation of non-Ryan White public health agencies is necessary to provide additional resources, skills and data to develop client-level data systems which capture the full array of services used by HIV-infected persons. To this end, we recommend that HRSA build upon the HRSA-Health Care Financing Administration (HCFA)- Centers for Disease Control and Prevention (CDC) inter-agency data sharing agreement to promote the development of integrated public health data systems.

The HRSA briefly described a few activities planned or underway in support of our recommendation to implement a multi-year outcomes initiative. We commend HRSA on these activities and plans. Despite their efforts in this area, HRSA expressed a few concerns regarding their ability to carry out this recommendation: 1) data limitations, 2) funding limitations, and 3) confidentiality concerns.

We do not expect the outcomes initiative to lead to rigorous scientific evaluations conducted by every grantee. By examining the client-level impact of the services they fund, the grantees can assess in general terms the effectiveness of these services.

Although we expect the costs involved to be minimized by emphasizing the use of data resources already available to the providers, many grantees may need additional financial resources to develop an outcomes system. The metropolitan-wide client-level data systems discussed in our first recommendation would develop a sound infrastructure upon which to build the outcome measures initiative. We recommend that HRSA work with the Department to secure funds for these initiatives critical to the future of the Ryan White CARE Act programs.

The HRSA's third area of concern - assuring client confidentiality, can be addressed by using unique identifiers and staff confidentiality agreements.

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INTRODUCTION

PURPOSE

To examine the evaluation systems used by Title I Ryan White grantees to monitor the compliance, measure the outcomes and measure the overall effectiveness of the programs they fund.

BACKGROUND

This study complements our reports, *Ryan White Evaluation Systems, Title II: Grants to States* (OEI-05-98-00393) and *Ryan White Evaluation Systems, AIDS Drug Assistance Program* (OEI-05-98-00390).

The Ryan White CARE Act

In 1990, Congress passed the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act as a response to the HIV epidemic and its impact on individuals, families, communities, cities and States. The Ryan White programs provide health and support services to persons with HIV/AIDS who would otherwise not have access to care. The Ryan White programs constitute slightly over \$1 billion of the \$6.8 billion in HIV/AIDS expenditures in the U.S. Department of Health and Human Services fiscal year (FY) 1998 budget.

The Ryan White CARE Act was re-authorized in FY 1996 through FY 2000. Changes to the Act included a directive to Title I planning councils to consider cost and outcomes in funding allocation decisions to the extent that such data are reasonably available.

The Ryan White CARE Act's four titles and Part F direct resources to various entities and allow grantees maximum flexibility in the use of funds. In FY 1998, nearly 90 percent of the Act's funds were awarded to Title I and Title II grantees.

Title I of the Ryan White CARE Act

Title I provides emergency relief grants to eligible metropolitan areas (EMAs) disproportionately affected by the HIV epidemic. Title I grants are for community-based HIV-related outpatient and ambulatory health and support services, including case management, comprehensive treatment services, prescription drugs, counseling, transportation, meals-on-wheels programs, home care and hospice care.

Grantees are required to establish a planning council that reflects the demographics of the epidemic in the EMA and is representative of the range of individuals involved in HIV care including health and social service providers, government entities, planning agencies, community leaders and other Federal HIV program grantees. The planning council develops a comprehensive plan for delivering HIV services in the EMA, prioritizes the allocation of funds in the EMA, assesses the grantee's fund allocation mechanisms and evaluates the effectiveness of services in meeting identified need.

Metropolitan areas are eligible for Title I formula funding if they have a population of 500,000 or more and have a total of more than 2,000 cases of AIDS reported to the U.S. Center for Disease Control (CDC) for the most recent period of 5 calendar years. In FY 1999, there were 51 EMAs in 21 States, Puerto Rico and the District of Columbia. In FY 1999, EMAs received \$486 million in Title I formula and supplemental funds.

OIG Evaluation Recommendations in 1995

In a June 1995 Office of Inspector General (OIG) report entitled "The Ryan White CARE Act: Local Implementation Issues"(OEI-05-93-00336), the OIG found an absence of program outcome evaluation to measure the CARE Act's impact. Beyond surveys of client satisfaction undertaken by providers at the local level, grantees and planning councils were not assessing the impact of CARE Act funds on their service area.

The OIG recommended that the Health Resources and Services Administration (HRSA) and the Assistant Secretary for Planning and Evaluation (ASPE) fund appropriate studies to assess the overall effectiveness of the Ryan White programs. The OIG also recommended that HRSA ensure grantees evaluate their own programs. The OIG suggested local evaluations include provider compliance reviews, outcome measure studies and overall program effectiveness reviews. The OIG asked HRSA to provide grantees with technical assistance and evaluation instruments that guarantee consistency in data collection and evaluation.

The ASPE did not conduct any evaluations of the Ryan White program with HRSA as recommended in the 1995 OIG report. However, ASPE is currently funding the HIV Costs and Services Utilization Study (HCSUS) with HRSA and the Agency for Health Care Policy and Research (AHCPR). The HCSUS examines who is treated for HIV, the health services HIV patients receive, the costs of the services and means of payment. The ASPE and AHCPR are also sponsoring a related study on the impact of health care financing arrangements on access to and use of new and emerging HIV therapies.

The HIV/AIDS Bureau of HRSA has a national Ryan White evaluation agenda which includes client-level data studies, links with secondary data sets, topic specific evaluations and the aggregate reporting system. The Bureau is focusing on evaluating the following areas: 1) Enrolling under-served, vulnerable populations; 2) Providing clients with care equal to that received by the insured; 3) Providing services that remove barriers to

receiving primary care; 4) Reducing morbidity, including opportunistic infections and perinatal transmission, and maintaining or increasing CD4 levels; 5) Reducing mortality; and 6) Adapting to a changing service and cost environment.

HRSA's Current Evaluation Requirements

The FY 1997 and 1998 Grant Application Guidances asked grantees to specify outcomes for four service categories, including primary medical care. The FY 1999 Guidance asks grantees to describe their processes and results in developing outcomes. Grantees are also instructed to describe the impact of Title I funds. Suggested outcomes to use include: providing access to care whose quality meets or exceeds Public Health Service and other standards, removal of barriers to care, and morbidity reductions.

Title I grantees are required to conduct a needs assessment of HIV-infected populations in their service area and describe its use in funding decisions. The FY 1998 Application Guidance instructed applicants for supplemental funds to estimate unmet need for: persons with HIV by level of illness or transmission category, race/ethnicity, and sex; or enhanced primary care access. Applicants were also instructed to estimate the number of persons with HIV without access to new treatments and/or requisite primary health care.

The FY 1999 Application Guidance asks the grantees for more information on unmet need to be obtained through comparisons of HIV prevalence and service utilization data. The Guidance emphasizes the importance of documenting unmet need and indicates future HRSA plans to work with the EMAs in this endeavor.

HRSA's Technical Assistance on Evaluation

The HRSA has provided technical assistance to Title I grantees on conducting evaluations through a variety of means including: self assessment protocols, meetings to share evaluation strategies, and a series of monograph reports on evaluation and assessment. The most recent report emphasizes the importance of outcome measurement and provides some guidance to grantees on how to approach it. The report does not suggest outcomes to measure or steps to develop outcome measures. More recently HRSA has suggested grantees focus on primary health care outcomes and will soon disseminate a publication focusing on primary health care outcome measures.

Re-authorization in 2000

The Ryan White CARE Act will be considered for its second re-authorization in 2000. As Congress debates this re-authorization, questions are certain to be asked about the effectiveness and impact of the programs funded. This inspection examines the capacity of Title I Ryan White grantees to answer those questions.

SCOPE AND METHODOLOGY

In this inspection we examined: the mechanisms Title I grantees use to monitor sub-grantee program and financial compliance, whether and how the grantees measure the outcomes of the programs they fund, and whether and how the grantees measure their effectiveness in meeting the evolving needs of the affected population. This evaluation does not judge the compliance, measure the outcomes or assess the effectiveness of the Title I grantees, but rather judges whether Title I grantees have and appropriately utilize the tools to perform these evaluation functions. We also did not review HRSA's evaluation of the grantees.

For the purposes of this analysis, we define compliance as serving the population, providing the services and spending the resources as agreed to in return for the award of program funds. Outcomes are defined as measures of the benefits clients derived as a result of the program. Finally, we define overall effectiveness as how well the mix of services meets the evolving needs of the population affected by the epidemic.

We conducted an on-site examination of these evaluation mechanisms in 12 EMAs: New York City, Newark, Bergen-Passaic, Baltimore, Washington D.C., Miami, Orlando, Austin, Houston, Chicago, Los Angeles and Sacramento. We selected these EMAs as a purposive sample representative of: comparatively high rates of incidence through intravenous drug use (IDU) transmission, comparatively high rates of infections among minority populations, early and recent EMA designation and regional diversity. In addition, our selected EMAs represent the majority of Ryan White Title I funds and nearly half of the HIV/AIDS cases. These 12 EMAs contain 38 percent of the living AIDS cases reported in 1997 and 51 percent of the Title I funding for FY 1998.

We conducted an extensive documentation review in the 12 EMAs. We examined their FY 1998 Title I grant applications, the contracts of the sample sub-grantees, samples of all program, fiscal, outcome and needs assessment reports, site visit protocols and additional evaluation materials provided by grantees, planning councils and sub-grantees.

We supplemented the documentation review with on-site interviews. In each EMA we interviewed; (1) the Title I grantee, (2) a representative of the Title I planning council, and (3) at least 10 percent of the Title I sub-grantees. The number of sub-grantees visited in each EMA ranged from 3 to 14. In each EMA we interviewed sub-grantees of differing program size, service delivery purpose and location.

All of our data collection was conducted from October through December 1998.

We conducted our review in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

Title I grantees have mechanisms in place to adequately monitor their sub-grantees' activities

Grantees receive regular program and fiscal reports and conduct routine site visits

Ten of the 12 Title I grantees visited require their sub-grantees to submit monthly program and fiscal reports. The other two Title I grantees require quarterly reports. Program reports typically contain units of service provided, number and demographics of clients served and a narrative section on program accomplishments and barriers. Fiscal reports typically contain line item expenditures or detailed billing invoices for unit cost and fee-for-service reimbursement. Most grantees also require fiscal reports to disclose year-to-date expenditures and the unexpended balance. All of the grantees visited report that they review annual fiscal audits from their sub-grantees.

Nine of the 12 sample grantees conduct formal site visits to all of their sub-grantees at least once a year. The Baltimore grantee visits each sub-grantee every 2 years. The Los Angeles and Austin grantees use a risk assessment model to determine which sub-grantees to visit. In all of the sample EMAs, site visits to sub-grantees include review of a sample of client files, financial records and the supporting documentation used for reporting. Many of the grantees also informally monitor sub-grantees through ongoing communication and individualized technical assistance.

Grantees move toward unit cost reimbursement to tighten fiscal accountability

Seven of the 12 grantees we visited reimburse the sub-grantees using a unit cost or fee-for-service method for all or some of their service categories. One additional grantee is planning to use the unit cost method in FY 1999. The other three grantees reimburse their sub-grantees on a line item basis.

The grantees we visited use unit cost reimbursement to tighten their control over costs, to inform their resource allocation, to encourage sub-grantee efficiency and to measure sub-grantee performance. For example, in Newark the sub-grantees propose a unit cost for each service in their grant application. The proposed cost is considered in procurement decisions and is subject to contract negotiations. According to a respondent, this helps the grantee to be an "informed purchaser" of services and has led to lower service costs.

Many grantees use metropolitan-wide databases and client-level data for program management

Nine of the 12 grantees we visited use or are implementing an EMA-wide database, through which all of the sub-grantees enter client level data on a uniform system. In seven of the eligible metropolitan areas, the grantee can access the agency data at any time directly from the system, rather than via down-loads or a contract administrator. In six of the EMAs, the sub-grantees have access to one another's data. An agency can look up a client's identification number and learn what services the client has received elsewhere. This enables the agencies to track clients through the Title I system of care, improving client management and reducing service duplication.

In the EMAs we visited, we noted three implementation concerns regarding unified data systems. A few respondents reported that it has been difficult to include hospitals in the establishment of a common system since hospitals have distinct computer system needs. A second concern expressed by respondents is the data delay caused by a shortage of computer terminals. Many agencies with only one computer terminal linked to the EMA system enter data in weekly or monthly batches. Delays in data entry curtail the benefits of agency to agency client management. A third concern is that where EMA data systems are incompatible with Title II systems or reporting requirements, agencies funded by both Title I and Title II programs may have to collect and report data through dual systems.

Client Management in Newark: The Comprehensive HIV/AIDS Management Program System (CHAMPS):

Newark Title I sub-grantees use CHAMPS to track client care, to manage administrative functions, to report program and fiscal data to the grantee and to aggregate client outcomes. Through the CHAMPS database all sub-grantees and the grantee can access client-level data at any time. Information is entered through a unique client identification number. Sub-grantees can view a client's demographic and health profile and review what services the client has received through other sub-grantees. Multiple fields of information are available for each client, including CD4 & T-cell count, usual source of primary care, and referred services. The planning council uses CHAMPS to facilitate its needs assessment and planning work. For example, the council has used CHAMPS data to review client residency, service location, and the peak months and hours of service utilization to forecast service use.

Grantees try to ensure that Ryan White funds are used as the payor of last resort; Most sub-grantees ensure payor of last resort status

All of the grantees convey HRSA's rules regarding payor of last resort status to the sub-grantees in their contracts and/or policy and procedure manuals. Some grantees require

sub-grantees to report all sources of revenue to verify the use of Ryan White funds as the payor of last resort. In addition, all of the grantees we visited check that sub-grantees are documenting Ryan White eligibility in client files during site visits.

Most of the sub-grantees we visited have mechanisms in place to ensure that they use Ryan White funds as the payor of last resort, such as documenting Medicaid and private insurance coverage in client files and billing accordingly. However, a few of the ancillary service providers we visited appeared unaware of the rules or their responsibility in this area. A few also appeared to be unclear on the services paid for by Medicaid in their State. In addition, sub-grantees have varying capacity to check Medicaid eligibility.

Few grantees currently require outcome measurement of sub-grantees; most are in the planning stage of outcome measurement

Only 2 of the 12 grantees visited require sub-grantees to measure outcomes

The Newark and Sacramento Title I grantees require sub-grantees to measure the outcomes of the services they are contracted to provide. However, sub-grantee interviews in these EMAs indicate that some sub-grantees do not routinely measure outcomes. The Newark and Sacramento grantees are taking steps to increase sub-grantee outcome measurement through greater standardization and increased reporting requirements.

Starting in FY 1998, the Sacramento grantee required sub-grantees to report outcome measures on a quarterly basis. Due to a low level of sub-grantee compliance in the initial 6 months, the grantee developed a standard format for outcome reporting. As of FY 1999, outcome measures are a required component of the sub-grantee quarterly report.

The Newark grantee requires all sub-grantees to outline expected outcomes and their means to measure the outcomes in a logic model in their annual grant proposal. The sub-grantees are required to include the following elements in their logic model: 1) service gaps and consumer needs, 2) activities to address the needs, 3) outcomes defined as short-term consumer benefits, 4) measures to quantify the outcomes, and 5) expected long-term impacts on the system or community. The logic model is subject to contract negotiations.

Sub-grantees are not currently required to report outcome measures to the Newark grantee. However, the grantee requires the sub-grantees to measure the outcomes in their logic model and to conduct an internal evaluation documenting their progress. On site visits the grantee reviews the sub-grantees' internal evaluation reports. Sub-grantee outcome measurement, documentation and achievement is scored and used as criteria in determining annual contract awards to continuing applicants.

The other 10 Title I grantees visited are preparing to require sub-grantees to collect outcome measures in the next few years

The remaining 10 grantees visited reported plans to require sub-grantees to measure client outcomes, however the grantees are at varying levels of planning and implementation. Six of the 10 grantees are currently developing outcome measures, half of them are using a consultant to draft suggested outcomes. The other four grantees are laying the groundwork for outcomes by developing standards of care and data collection mechanisms. Seven of the 10 grantees expect to require some or all providers to report outcomes by FY 2000.

Most of the planning councils in the 12 sample eligible metropolitan areas (EMAs) are involved in the outcome measure efforts underway in their EMA. In six of the EMAs, the councils are involved in the actual determination of the outcome measures. In other EMAs, council involvement includes activities such as establishing broad outcome areas, participating in the development of service standards and reviewing suggested outcomes.

Most of the grantees solicited sub-grantee input in developing outcomes. A few of the grantees cited the United Way's manual on outcome measurement as the primary source of guidance they have relied upon to direct their efforts in this area. The United Way approach emphasizes developing outcomes reflective of an agency's goals and recommends using the data sources readily available to agencies, such as client records, client and staff interviews and mechanical tests and measurements.

Many of the sub-grantees we visited collect client information which could be used to measure program outcomes if aggregated. Sub-grantees often document client progress in a client's chart or case-notes. Most of the sub-grantees we visited do not aggregate the client outcomes and are not able to compare outcomes across client groups, service strategies or over time. Nor do they report outcomes to the grantee or other funders.

Majority of sampled Title I grantees have concerns regarding outcome measures

Most of the Title I grantees we visited expressed concerns regarding outcome measure requirements. The primary area of concern cited is the lack of financial resources and the administrative spending cap. Other concerns include: the burden of additional reporting requirements on sub-grantees; a lack of sub-grantee and planning council expertise in collection, analysis and use of outcome measures; and the difficulty of isolating the influence of Ryan White services on client outcomes. A couple of grantees also expressed a hesitancy to advance outcome measurement efforts in the absence of more specific guidance from HRSA out of concern that local efforts may conflict with future requirements. All of the Title I grantees visited said that they would like more guidance from HRSA on how to proceed with establishing and collecting outcome measures.

The majority of Title I grantees visited assess the needs of sub-populations in HIV/AIDS care but do not solicit needs information from those outside of HIV/AIDS care

The grantees collect information on service and sub-population needs through annual or bi-annual comprehensive needs assessments or targeted assessments of client populations and service categories. All of the grantees use both qualitative and quantitative data sources in their needs assessment work, including public health data, consumer and provider surveys, focus groups, public forums and key informant interviews. Outside of the public health data, information on the needs of infected individuals not receiving HIV/AIDS care is usually not obtained.

The majority of Title I grantees visited match the demographics of HIV cases to demographic data on the clients receiving Title I services to determine unmet need. These data matches do not provide information on the barriers individuals face to care or the unique service needs they may have beyond those implied through co-morbidity data. Furthermore, in the three EMAs visited which do not have unduplicated client counts, the service utilization data most likely count individual clients more than once, inflating the numbers of persons appearing to receive care. Hence, a higher proportion of the HIV/AIDS population is considered receiving care than do in reality.

Only a few of the grantees have gone beyond data matches to obtain information on the needs of persons who are not in HIV/AIDS care. One planning council tried to solicit this information by sending trained peer outreach workers to homeless shelters, without much success. Two other councils were more successful in obtaining information from persons not in HIV/AIDS care, one through street outreach and the State substance abuse program, and the other through focus groups of current and former prison inmates.

Assessing Unmet Need in New York City: The CHAIN Study

Since 1995, the New York City planning council has contracted with the Columbia University School of Public Health to conduct a longitudinal study of persons living with HIV/AIDS (PLWH/A). Through the Community Health Advisory Information Network (CHAIN) study, the planning council collects data on a sample of 700 PLWHA, systematically drawn from over 40 agencies in New York City, including agencies which receive Ryan White funding and those which do not. The sample includes infected persons who are un-connected to care. The CHAIN study collects information on client demographics, risk factors, family and social supports, barriers to care, environmental impacts and client outcomes. Through the CHAIN study, the council has identified unmet needs of persons in and out of care.

RECOMMENDATIONS

The HRSA should promote the development of Metropolitan-wide data systems to further improve the program management activities of the sub-grantees

Building on the client-level data demonstration projects underway,¹ HRSA should provide grantees with technical assistance to facilitate the development of eligible metropolitan area-wide data systems. The sophistication and use of current EMA data systems vary widely by grantee. The HRSA should aid grantee efforts to build or improve unified data systems by disseminating a variety of technical information including information on model systems, effective system development strategies and specific elements to include to maximize benefits. This information should incorporate the lessons learned through the client-level data demonstration projects.

Sub-grantee access to client-level data eliminates inefficient intake duplication and facilitates service coordination by informing providers of a client's existing referrals and services received. Confidentiality concerns can be overcome using staff confidentiality agreements and unique identification numbers, rather than client name, to track clients. Sub-grantees can also use EMA-wide data systems to generate routine program and fiscal reports, reducing the time and resources needed by sub-grantees for reporting.

In addition, sub-grantees can use the systems to track and report outcomes. One concern we heard from several grantees regarding outcome measurement is that they do not want to increase the reporting burden on the sub-grantees. If outcome fields are integrated into the EMA's data systems as they are built, sub-grantees can track, aggregate and report client-level outcome measures through the existing system. Toward this end, HRSA is developing new software for the Annual Administrative Report (AAR) that will include a voluntary module on health-related client-level information.

The development of client-level data systems requires a substantial financial investment. Based on the client-level data demonstration projects, HRSA estimates that it costs between \$100,000 and \$500,000 in start-up costs for each grantee to build a client level data system and between \$50,000 and \$335,000/year for each grantee to maintain the

¹ Under the client level data demonstration project, four EMAs and three States have been collecting and analyzing client-level data since 1994. Collected data includes client characteristics, health indicators and services received. The HRSA plans to expand the client level data set in 1999.

system. Currently, grantees are restricted in the amount of funds they can invest in infrastructure by an administrative cap and by competing demands to fund services.

Recognizing the current limitations on funds available for data collection and evaluation in the Ryan White CARE Act, HRSA should work in partnership with the Department to secure funds to facilitate the development of needed infrastructure in the CARE Act program.

There are several potential sources of funds which could be used, either alone or in combination, to assist grantees in building client-level data systems including: 1) the one percent set-aside of program funds reserved for evaluation of programs authorized under the Public Health Service Act; 2) an appropriation specifically designated for data system development, similar to the funding allocated for such development within the child support enforcement program; and 3) a designation of funds for evaluation of the Ryan White programs included in the CARE Act's FY' 2000 re-authorization, carved outside of the administrative spending cap.

Grantees could build on an initial infusion of funds, received through one or more of the above means, to streamline their tracking and reporting systems, potentially reducing their administrative costs over the long term. A reduction in administrative costs achieved through more efficient tracking and reporting processes could free up funds to support the improved data collection systems in the future.

As HIV/AIDS has moved from an emergency epidemic to a chronic epidemic, it is critical for service providers to move from a crisis mode of operations to more long-term capacity building. Data systems are a vital ingredient for HIV/AIDS service agencies to improve the efficiency and effectiveness with which they provide their services, track their outcomes and inform their funding sources of their activities and results. Promoting the development of these systems is one practical step the administration can take in its initiative to strengthen the capacity of small, community-based organizations to serve the emerging HIV/AIDS population. Agencies with the most skill in serving the needs of disenfranchised populations often lack the resources for necessary infrastructure.

In their data systems promotion and technical assistance efforts, the HRSA should urge Title I grantees to work with the other grantees in their State to develop a shared system so as to reduce multiple system requirements on sub-grantees receiving funding through more than one Ryan White Title. Recent HRSA efforts to develop a cross-Title AAR should facilitate the development of shared data systems.

In addition, HRSA should encourage the CARE Act grantees to reach out to other public health programs serving persons with HIV/AIDS in their State to share services data. The 1998 inter-agency agreement between HRSA, HCFA and CDC to promote the development of integrated public health information systems and the inter-departmental activities supporting this agreement are intended to foster such collaborations.

The HRSA should implement a multi-year outcomes initiative including grantee requirements and technical assistance

The HRSA should build upon their efforts to promote grantee outcome measurement by establishing a multi-year implementation plan. Outcome measurement should start on the sub-grantee level and lead through subsequent steps to grantee analysis of client outcomes across the EMA. Outcome measurement would foster program improvements and greater accountability for expenditures and highlight the value of Ryan White funds.

Here is one option of how HRSA could proceed:

- ▶ In stage one, HRSA could develop one or more core outcomes for each service category and require Title I grantees to develop three additional outcomes for each service category in collaboration with Title II Consortia where they are co-located. The core outcomes HRSA requires the grantees to measure should be aligned with HRSA's performance goals outlined in their annual performance plan.
- ▶ In stage two, HRSA could require grantees to collect the established outcome measures from the providers on a quarterly basis. Outcome measures should eventually be reported as client-level data in preparation for stage three.
- ▶ In stage three, HRSA could require the grantees to analyze the reported outcome measures across services and report EMA-wide outcomes to HRSA annually.

In establishing the core outcomes, HRSA should place a greater emphasis on primary health care outcomes since the ultimate goal of the Ryan White CARE Act is improved health status. However, at least one core outcome should be developed for each support service category. The outcomes for the support services should reflect the contribution the support services make to improved health status such as facilitating access to primary care or creating conditions conducive to following and benefitting from a structured health care regimen. Measuring these incremental outcomes would provide valuable information on the contribution of these services to health outcomes. This information could be used for accountability and program improvement purposes. Confidentiality concerns can be overcome using staff confidentiality agreements and unique identification numbers, rather than client name, to track clients.

The outcome measurement initiative can serve as a means for HRSA to further promote continuous quality improvement (CQI) efforts. Through CQI, information on the effectiveness and quality of program delivery is fed back to program managers on a continuous basis, serving as a tool for managers to improve program delivery. While quality assurance and process indicators are used to gauge the quality of services delivered, outcome measures can be used to gauge service effectiveness. Service providers could use outcome measures along with quality of care indicators to improve their performance through program alterations and further self-evaluation under CQI. As the Ryan White CARE Act faces its second decade of providing care to persons

infected with HIV/AIDS, it is time to ensure that the grantees have the capacity to evaluate the outcomes of the services they deliver. Outcome evaluation as a CQI tool is vital to strengthening the effectiveness of the services delivered and the efficiency of the funds expended to provide the services. This basic need for appropriate funding should be addressed in the re-authorization of the CARE Act in FY 2000.

The HRSA should provide the grantees with technical assistance to implement the core outcome measures and to develop and implement their own additional outcome measures within a CQI framework. The technical assistance could emphasize soliciting provider input in the development of the additional outcomes, using the United Way approach.

The United Way approach to outcome measurement emphasizes using outcome measures for program improvement purposes. To this end, the United Way emphasizes soliciting provider input in the development of outcome measures to make sure that outcome measures reflect program goals. The United Way also stresses the importance of considering the data resources already available to the providers when developing outcome measures so as not to impose too much additional administrative or cost burden.

The United Way's approach recognizes the limited capacity of health and human service providers to engage in rigorous outcome evaluation. Hence, the United Way model emphasizes contribution rather than attribution. Using outcome measures, providers can determine if clients achieve an expected result after receiving their service intervention. While the provider is not able to scientifically prove that the result is due solely to their intervention, they can see whether their service is contributing to positive outcomes on a regular basis.

The HRSA should urge Title I grantees to work with co-located Title II consortia in establishing the outcome measures sub-grantees will be required to measure, so as to avoid imposing a greater measurement burden on sub-grantees funded under both Titles. The HRSA should also urge the grantees to require sub-grantees to report outcome measures as client-level and aggregate data. Grantees will need client-level outcome data in order to analyze client outcomes across the EMA. The HRSA should urge the grantees to consider this need in the creation or redesign of unified data systems.

In recent years, HRSA's application guidance to Title I grantees has stressed the importance of documenting outcomes and has asked grantees to include outcome data in their applications. All of our respondents have received the message from HRSA that outcome measures are important and that HRSA expects them to move ahead in this area. However, respondents in the 12 EMAs we visited stated that they would like more specificity from HRSA on what outcomes they are expected to measure and on HRSA's implementation plans.

Likewise, in response to a July 1998 survey sent out by HRSA's technical assistance contractor, 81 percent of the 37 responding EMAs indicated that "clear written guidance

from the HIV/AIDS Bureau on outcome evaluation expectations or requirements” would be among the “most useful” types of technical assistance they could receive. Seventy-eight percent of the responding EMAs indicated that “lists of suggested outcome indicators for other (non-primary care) service categories” would be among the most useful assistance.

The HRSA should provide technical assistance to improve the ability of grantees to estimate the needs of infected persons not in HIV/AIDS care

In the FY 1999 Application Guidance, HRSA emphasizes the importance of obtaining information on unmet need, acknowledges the difficulty of obtaining this information and pledges to work with EMAs to address this area in the future. The HRSA should build on this effort by requiring the grantees to solicit needs information from persons not in HIV/AIDS care and by providing the grantees with technical assistance on how to do this.

The public health data grantees are currently required to use to estimate unmet need provides useful information on the needs of infected persons. However, the input of persons outside of the care system would add a richness of understanding regarding their needs and the barriers to service they encounter.

Grantee solicitation of the input of persons un-connected to care would assist the grantees in complying with the re-authorized CARE Act’s directive to prioritize a portion of funds for emerging populations. Grantee solicitation of this input would also contribute to the Department’s efforts to address the greater burden of HIV/AIDS on racial and ethnic minorities.

In their attempt to fulfill the CARE Act’s requirement to prioritize funds for emerging populations, HRSA should urge the planning councils to strive to reach persons unconnected to HIV/AIDS care, in addition to efforts to reach persons who demographically reflect the emerging populations. The HRSA should urge the councils to recognize the complexity and disproportionate costs which may be involved in serving persons previously unconnected to HIV/AIDS care. Persons infected by HIV/AIDS are increasingly individuals who are traditionally not connected to the health care system for reasons such as poverty and historic mistrust of institutional health care. A focused outreach and planning strategy is required to address their needs.

The HRSA’s technical assistance materials on conducting needs assessments urge grantees to solicit information from persons not in HIV/AIDS care. Although the materials suggest avenues for soliciting this information, they do not include any information on how to use these means. Several grantees indicated that they would like more guidance on how to proceed in this area.

The HRSA could provide the grantees with a technical assistance document devoted to soliciting needs information from PLWH/A who are not in HIV/AIDS care, providing steps for conducting outreach and examples of effective strategies. The HRSA could highlight outreach strategies which have been used by other Ryan White grantees, CDC HIV prevention community planning groups and service providers in other arenas. Particular attention should also be paid to reaching persons who receive HIV/AIDS services but may not be receiving primary health care services.

AGENCY COMMENTS

The HRSA provided comments to the draft report. While HRSA concurred with the report's findings and recommendations, they offered suggestions for clarifying the report and making other technical changes. Where appropriate, we changed the report to reflect their comments. The complete text of HRSA's comments can be found in Appendix A.

The HRSA pointed out several ongoing and planned activities in response to the report recommendation to promote the development of metropolitan-wide data systems. We commend their efforts to assist the grantees in the development of these data systems. The revisions to the Annual Administrative Report (AAR) to allow for cross-Title reporting and the addition of the voluntary module on health-related client-level information in the AAR software will provide the grantees with added flexibility to track client-level information across CARE Act Titles. We also commend HRSA on their plans to host a FY 1999 meeting of grantees with expertise in client-level reporting to launch a peer-based technical assistance effort.

In response to our recommendation that HRSA provide technical assistance and financial resources to support the development of EMA-wide data systems, HRSA cautioned that it would "be unreasonable to expect technical assistance and financial resources from HRSA's HIV/AIDS Bureau to be sufficient to fully develop and implement those systems in an appropriate manner." The HRSA has made a great start in the provision of technical assistance through building expertise via the seven client-level data demonstration sites and the planned FY 1999 meeting to launch the peer-based technical assistance effort. These endeavors will facilitate an exchange of information on model systems and lessons learned, providing a knowledge base to support local system development efforts. We urge HRSA to continue down this path.

We do not expect HRSA to provide all of the financial resources necessary to fully develop and implement metropolitan-wide data systems. We recommend that HRSA, in partnership with the Department, secure funds to assist in the development of such data systems. The FY 2000 re-authorization of the CARE Act provides an optimal opportunity to consider funding for infrastructure development vital to ensuring efficient and effective service delivery in the future. The grantees could build upon an initial infusion of funds to streamline their systems, potentially reducing their administrative costs and freeing up funds to maintain their systems over time.

Furthermore, we agree with HRSA that the participation of non-Ryan White public health agencies is necessary to provide additional administrative resources, skills and data to develop client-level data systems which capture the full array of services used by HIV-infected persons. To this end, we recommend that HRSA build upon the HRSA-HCFA-CDC inter-agency data sharing agreement to promote the development of integrated

public health data systems by encouraging Ryan White CARE Act grantees to work with the other public health programs in their State serving persons with HIV/AIDS.

The HRSA briefly described a few activities planned or underway in support of our recommendation to implement a multi-year outcomes initiative. We commend HRSA on these activities and plans. Despite their efforts in this area, HRSA expressed a few concerns regarding their ability to carry out this recommendation: 1) limitations on accessibility and compatibility of data sets, 2) restrictions on administrative costs impacting a Grantee's ability to use complex data sets for outcome studies, and 3) confidentiality concerns.

These limitations are to be expected in a large endeavor but are not insurmountable. For this reason we recommend an outcomes approach designed with feasibility as a cornerstone. We do not expect the outcomes initiative to lead to rigorous scientific evaluations conducted by every grantee. The HRSA is funding such projects on a limited basis where the capacity exists. It is not feasible, nor is it necessary, for every grantee to participate in this work. What is feasible and necessary for every grantee to undertake is an assessment of the effectiveness of the services they fund. By examining the contributions made by the services to client outcomes, the grantees can assess, in general terms, the effectiveness of these services. We highlight the United Way approach which emphasizes contribution, rather than attribution, for this reason. The United Way approach is designed for service providers, like those in the Ryan White program, who face data and cost limitations.

Although we expect the costs involved to be minimized by emphasizing the use of data resources already available to the providers, many grantees may need additional financial resources to develop an outcomes system, depending upon the size of their grant and competing demands on limited administrative funds. The metropolitan-wide client-level data systems discussed in our first recommendation, would develop a sound infrastructure upon which to build the outcome measures initiative. We recommend that HRSA work with the Department to secure funds for these initiatives critical to the future of the Ryan White CARE Act programs.

The HRSA's third area of concern - assuring client confidentiality, can be addressed by using unique identifiers and staff confidentiality agreements. Grantees collecting client-level information have used these measures successfully to address confidentiality concerns.

We commend HRSA's efforts to address our recommendation to improve the ability of grantees to estimate the needs of infected persons not in HIV/AIDS care. We urge HRSA to disseminate technical assistance information to grantees in this area as soon as possible, as the population of infected persons outside of care continues to grow.

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Health Resources and
Services Administration
Rockville MD 20857

JUL 16 1999

TO: Inspector General

FROM: Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Four Draft Reports,
"Ryan White Evaluation Systems: 1) The AIDS Drug
Assistance Program (OEI-05-98-00390); 2) Title I:
Grants to Metropolitan Areas (OEI-05-98-00392);
3) Title II: Grants to States (OEI-05-98-00393)"; and
"The Ryan White Spousal Notification Requirement
(OEI-05-98-00391)"

Attached, in response to your May 26 request, are HRSA's
comments to the subject draft reports.

Staff questions may be referred to Jeanellen Kallevang on
(301) 443-5181.

A handwritten signature in black ink, appearing to read "T. G. Morford".

Thomas G. Morford

Attachment

Agency Comments

Health Resources and Services Administration Comments on the Office of Inspector General (OIG) Four Draft Reports: “Ryan White Evaluation Systems: 1) The AIDS Drug Assistance Program (OEI-05-98-00390); 2) Title I: Grants to Metropolitan Areas (OEI-05-98-00392); 3) Title II: Grants to States (OEI-05-98-00393)” and “The Ryan White CARE Act : Implementation of the Spousal Notification Requirement (OEI-05-98-00391)”

RYAN WHITE EVALUATION SYSTEMS: THE AIDS DRUG ASSISTANCE PROGRAM

OIG RECOMMENDATION

To initiate outcome measurement, HRSA should require ADAPs to compare utilization data to recommended clinical guidelines.

HRSA COMMENTS

We do not concur with the recommendation as written. Even if HRSA had statutory authority to require ADAPs to compare their utilization data to NIH/PHS guidelines, the data available to ADAPs would be insufficient to extrapolate client health outcomes. However, we do agree with the objective of equitable access to treatments for all persons with HIV-infection.

AIDS Drug Assistance Program (ADAP) data alone would not be adequate to perform the comparison. As acknowledged in the report, many ADAP clients receive medications from other sources, including Medicaid, other Ryan White local pharmacy assistance programs, and private insurance. In fact, some clients switch between systems in a single reporting period. In addition, most ADAP programs are administratively distinct from clinical care sites. Therefore, the available data could give an incomplete drug therapy history, and therefore distort the results of the comparison, and may not be linked to client-level medical files. Meaningful comparisons can only be accomplished with longitudinal client-level data sets which include all payers (Ryan White, Medicaid, private insurance, HICP, etc.) and all HIV related health information regarding the stage of disease and types of clinical diagnoses of the individual client. These requirements are beyond the data management and administrative capacity of current ADAP grantees.

HRSA does, however, maintain an ADAP formulary database in order to monitor national formulary trends. HRSA also works continually with ADAPs on formulary development in order to ensure that, to every extent possible, the appropriate drugs are included on the formulary.

Agency Comments

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OIG RECOMMENDATION

The HRSA should encourage collaborative efforts among Ryan White Titles to monitor client adherence to drug regimens.

HRSA COMMENTS

We concur with this recommendation. HRSA has sponsored a number of technical assistance activities focused on this issue and encourages collaborative efforts among Ryan White Titles to monitor client adherence to drug regimens. Additionally, under the Special Projects of National Significance Program, FY 1999 funds will be used to support "Projects to Evaluate the Effectiveness of Existing Programs to Promote Adherence to Anti-Retroviral Therapies".

OIG RECOMMENDATION

The HRSA should instruct ADAPs to collaborate with Title I and Title II needs assessment efforts to assure that they explicitly evaluate medication therapy needs.

HRSA COMMENTS

We do not concur with this recommendation, although we agree that there should be collaboration. First, it is important to note that ADAP advisory boards and needs assessment activities are not required by statute. Furthermore, ADAPs may not be the most appropriate entities to take the lead in coordinating needs assessment efforts. As noted in the OIG report, ADAP Advisory Boards are typically comprised of individuals who first and foremost provide the clinical expertise necessary to make formulary decisions. We believe that those ADAP Advisory Boards whose members are already coordinating needs assessment efforts with Title I and II will provide additional insight in future Title I applications regarding this matter.

At present, all Title I Planning Councils have a Title II representative on the board. HRSA, through the Title II application guidance, has instructed the Title II programs to collaborate with ADAPs on needs assessment. HRSA will expand this initiative to include the Title I application guidance, so that both Titles coordinate with the ADAPs on this important issue.

Agency Comments

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TECHNICAL COMMENTS

Please note an incorrect reference in the draft report on page 6, paragraph 2, under Ryan White CARE Act Evaluation Requirements. This paragraph should be re-written with proper citation of the 10% administrative cap and 10% planning/evaluation cap as follows:

"The Ryan White CARE Act includes caps on the amounts of funds Title II grantees, including ADAPs, can spend on administrative and planning/evaluation functions. Grantees cannot exceed 10% administrative cap and 10% planning/evaluation cap, the combined total of which cannot exceed 15% allowed under the Title II program, inclusive of ADAP. Grantees can pay for needs assessments, program evaluation and service delivery assessments out of their planning/evaluation caps."

RYAN WHITE EVALUATION SYSTEMS: TITLE I: GRANTS TO METROPOLITAN AREAS

OIG RECOMMENDATION

The HRSA should promote the development of metropolitan-wide data systems to further improve the program management activities of the sub-grantees.

HRSA COMMENTS

We concur with the recommendation in concept and agree with the objective. However, we must note the following activities being conducted by HRSA and the limitations on HRSA's ability to comply with the OIG's recommended action plan.

Activities (ongoing or planned) related to this recommendation:

- Current data requirements are being revised in the form of a cross-Title Annual Administrative Report (AAR). This effort will involve substantial external feedback that likely will generate interest in the possibilities of client-level data.
- New software for the existing AAR is being developed that will include a voluntary module on health-related client-level information.
- Expertise in using data for program planning and management is being developed via 7 client-level demonstration sites.

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- HRSA is analyzing responses to a data collection/MIS query of CARE Act grantees and is identifying a number of grantees that have initiated their own client-level reporting systems to analyze health service utilization and program outcomes. There is a plan to host a late FY 1999 meeting of grantees with such experience in an effort to launch a more proactive, peer-based technical assistance effort.

Current limitations:

- Grantees reported problems with inaccessible and/or incompatible data bases and reporting delays. In response to these findings, the OIG recommends additional technical assistance and financial resources from HRSA's HIV/AIDS Bureau to develop and implement these systems among Ryan White grantees. It would be unreasonable to expect technical assistance and financial resources from HRSA's HIV/AIDS Bureau to be sufficient to fully develop and implement those systems in an appropriate manner. Developing outcomes solely on Ryan White resources and data will limit the types of information necessary to do meaningful outcomes assessment. In addition, client-level data often includes various data sets at sub-grantee levels that may be incompatible. Thus, access to diverse and compatible data sets, along with the administrative resources and skills necessary in managing these data sets, may need to include the participation of public health agencies beyond the Ryan White CARE Act programs, as well as across the various Titles. A commitment may be necessary at a local and State health level (beyond agencies and providers funded by Ryan White) to standardize, link, and share public health data related to providing the full array of services used by HIV infected persons across multiple agencies.
- One-percent set-aside evaluation funds that HRSA receives are severely limited and there is no specific designation of funds in the CARE Act, at HRSA or grantee levels, for data collection and evaluation. HRSA cannot put the entire responsibility for eligible metropolitan areas (EMA)-wide data systems on the Ryan White grant recipients. This activity would be considered administrative in nature. There are specific limitations within the CARE Act that restrict the use of funds to a 5% administrative cap, with other funds supporting various categories of direct services.
- Given current funding and staffing limitations, HRSA is open to discussions with the OIG on other potential sources of funds available to assist grantees in building client-level data systems that were alluded to in the report.

OIG RECOMMENDATION

The HRSA should implement a Multi-year outcomes initiative including grantee requirements and technical assistance.

Agency Comments

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HRSA COMMENTS

We concur with this recommendation. However, we must note the following activities being conducted by HRSA and the limitations on HRSA's ability to comply with the OIG's recommended action plan.

Activities (ongoing or planned) related to this recommendation:

- HRSA, in partnership with constituency groups, will be developing a strategy for development and implementation of just such an outcomes initiative. The initiative recommended in this document (i.e., core outcomes and the United Way approach) will be included in the various models for discussion.
- An effort is underway to develop a guidance manual on program outcomes and outcomes measurement, with a focus on primary medical care. Additionally, using one-percent evaluation funds, HRSA is ready to release a Request for Quotation for "An Evaluation of Outcomes among PLWH Receiving Services from Ryan White Care Act-Funded Programs", open to current CARE Act-funded grantees and including non-medical care services.
- HRSA has supported the use of HIV-specific continuous quality improvement program (HIVQUAL) activities at numerous Ryan White funded community health center sites (Title III sites). Several sites are recipients of Titles I and II funds. We plan to continue to support such program activities among our grantees.

Current limitations:

- Many of the same limitations, as identified above, relate to the development and implementation of a provider-based client-level data set and CQI practices. Limitations on accessibility and compatibility of data sets and restrictions on the use of Ryan White funds for administrative costs (including quality assurance activities) impact a Grantees' ability to optimize access and use of complex data sets for outcome studies
- To the extent that client information is shared among and between Ryan White service provider groups, issues of confidentiality and privacy are an important consideration.

OIG RECOMMENDATION

The HRSA should provide technical assistance to improve the ability of grantees to estimate the needs of infected persons not in HIV/AIDS care.

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HRSA COMMENTS

We concur with this recommendation. HRSA will work collaboratively with CDC in its effort to better estimate and document HIV infection. Additionally, using one-percent evaluation funds, HRSA is ready to release a Request for Quotation for “Population- and Data-Based Assessment of Unmet HIV Service Needs”, open to current CARE Act-funded grantees. This effort is expected to produce both usable data for jurisdictions that are funded and a methodological approach that can be documented and replicated in other areas.

TECHNICAL COMMENTS

On page 6, paragraph 2, the eligibility requirements for formula grants were modified during the 1996 reauthorization. Therefore, please revise the 1st sentence to read as follows: “Metropolitan areas are eligible for Title I formula funding if they have a population of 500,000 or more and have a total of more than 2,000 cases of AIDS reported to the CDC for the most recent period of 5 calendar years.”

RYAN WHITE EVALUATION SYSTEMS: TITLE II: GRANTS TO STATES

OIG RECOMMENDATION

The HRSA should implement a Multi-year outcomes initiative.

HRSA COMMENTS

We concur with this recommendation. HRSA, in partnership with constituency groups, will be developing a strategy for development and implementation of just such an initiative. Please refer to our response on pages 3 and 4 of these comments regarding Ryan White Evaluation Systems, Title I (OEI-05-98-00392) for additional comments related to accessibility/incompatibility of data systems.

An effort is underway to develop a guidance manual on program outcomes and outcomes measurement, with a focus on primary medical care. Additionally, using one-percent evaluation funds, HRSA is ready to release a Request for Quotation for “An Evaluation of Outcomes among PLWH Receiving Services from Ryan White Care Act -Funded Programs”, open to current CARE Act-funded grantees.

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OIG RECOMMENDATION

The HRSA should provide technical assistance to improve the ability of grantees and consortia to estimate the needs of infected persons not in HIV/AIDS care.

HRSA COMMENTS

We concur with this recommendation. HRSA will work collaboratively with CDC in its effort to better estimate and document HIV infection. Additionally, using one-percent evaluation funds, HRSA is ready to release a Request for Quotation for "Population- and Data-Based Assessment of Unmet HIV Service Needs", open to current CARE Act-funded grantees. This effort is expected to produce both usable data for jurisdictions that are funded and a methodological approach that can be documented and replicated in other areas.

TECHNICAL COMMENTS

Under HRSA's current evaluation requirements on page 7, the second paragraph, the first sentence is not accurate. There is no legislative mandate for Title II to use needs assessment data to allocate Title II funds. Therefore, we recommend the 1st sentence be deleted.

Related Office of Inspector General Reports

The Ryan White CARE Act: Local Implementation Issues (OEI-05-93-00336)

The Ryan White CARE Act: Examples of Local Coordination (OEI-05-93-00335)

The Ryan White CARE Act: Special Projects of National Significance (OEI-05-93-00332)

The Ryan White CARE Act: Technical Report of 1992 Expenditures (OEI-05-93-00334)

The Ryan White CARE Act: Funding Formulas (OEI-05-93-00330)

Medicaid Managed Care and HIV/AIDS (OEI-05-97-00210)

Audit of State AIDS Drug Assistance Programs' Use of Drug Price Discounts (A-01-97-01501)

Review of Maximizing Drug Discounts Under the Missouri Ryan White Program
(A-01-97-00926)

Audit of the Ryan White Comprehensive AIDS Resource Emergency Act of 1990, Title II,
Administered by the Health Resources and Services Administration (A-01-97-01500)

Audit of Eligibility Under Title I of the Ryan White Comprehensive AIDS Resource Emergency
Act of 1990, New York Metropolitan Area (A-02-95-02517)

Audit of the Ryan White Comprehensive AIDS Resource Emergency Act of 1990, Title II,
Administered by the State of Connecticut (A-01-96-01501)

Audit of the Ryan White Comprehensive AIDS Resource Emergency Act of 1990 in the Boston
Metropolitan Area for Fiscal Year 1994 (A-01-95-01504)