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**OFFICE OF
INSPECTOR GENERAL**

RYAN WHITE EVALUATION SYSTEMS

Title II: Grants to the States



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EXECUTIVE SUMMARY

PURPOSE

To examine the evaluation systems used by Title II 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 II of the Act provides grants to States to improve the quality, availability and organization of health care and support services for individuals and families with HIV disease. In FY 1999, the States received \$710 million in Title II funds. Most grantees disburse a portion of these funds to service providers through regional fiscal agents called lead agencies and planning bodies called consortia.

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 II Ryan White grantees to answer those questions.

Through an extensive documentation review and on-site interviews, we examined the evaluation mechanisms used in 8 States, 12 consortia/lead agencies and 5 consortia responsible for planning only. The eight States visited represent 61 percent of FY 1998 Ryan White Title II funds and 68 percent of reported AIDS cases in FY 1997.

FINDINGS

In Most Sampled States, Program and Fiscal Compliance of Service Providers Is Monitored Through Fiscal Intermediaries; Intermediaries Have Monitoring Mechanisms in Place

In the eight States we visited, seven of the grantees use regionally based lead agencies to serve as fiscal agents for the service providers. In six of the States, the lead agencies have primary responsibility for monitoring the program and fiscal compliance of the service providers. The lead agencies receive regular program and fiscal reports from the providers and conduct frequent site visits to providers. Likewise, the grantees receive

regular program and fiscal reports from the lead agencies and conduct periodic site visits to them. Most of the grantees and lead agencies have mechanisms in place to ensure that Ryan White funds are used only for eligible clients and as the payor of last resort.

Few Grantees or Lead Agencies Currently Require Outcome Measurement of Their Service Providers; Most Are in the Early Stages of Discussion Regarding Outcome Measures

Currently, only 1 of the 8 State grantees and 1 of the 12 lead agencies we visited, require client outcomes to be measured. The majority of grantees and lead agencies are in the early stages of planning for outcome measurement. Concerns regarding outcomes measures and a desire for technical assistance from the Health Resources and Services Administration (HRSA) were expressed by over half of the grantees and lead agencies.

Grantees Rely on Consortia to Assess Needs; Most Consortia Routinely Assess the Needs of Clients but Not of Persons Outside of HIV/AIDS Care

All of the State grantees we visited rely on regional consortia to assess the needs of persons with HIV/AIDS and require them to do so on a routine basis. Slightly over half of the grantees require the consortia to submit the needs assessment results as part of the consortium's annual application for funds.

Most of the consortia or local planning bodies use both qualitative and quantitative data sources in their needs assessment work, including public health data, consumer and provider surveys, focus groups and public forums. Outside of the public health data, information on the needs of infected individuals not receiving HIV/AIDS care is typically not obtained. Of the 17 planning bodies we interviewed, only 3 reported that they have successfully solicited needs information from persons with HIV/AIDS not in care.

RECOMMENDATIONS

The HRSA Should Implement a Multi-year Outcomes Initiative

The HRSA should build upon their efforts to promote outcome measurement by establishing a multi-year implementation plan. Outcome measurement should start on the provider level and lead through subsequent steps to consortia-wide analysis of client outcomes by the responsible fiscal agent. Outcome measurement would foster program improvements and greater accountability for expenditures and promote the achievements of the Ryan White programs.

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

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 and consortia to improve their knowledge of unmet need by soliciting information directly from persons not in HIV/AIDS care.

Grantee solicitation of the input of persons unconnected to HIV/AIDS 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 respondents 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 and consortia with a technical assistance document detailing effective outreach strategies. 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

While HRSA concurred with the findings and recommendations in our draft report, they offered suggestions for clarifying the report. Where appropriate, we changed the report to reflect their comments. The HRSA's complete comments can be found in Appendix B.

The HRSA briefly described a few activities 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 data limitations, funding limitations, and 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. We recommend that HRSA work with the Department to secure funds for these initiatives. 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 HRSA's third area of concern - assuring client confidentiality, can be addressed by using unique identifiers and staff confidentiality agreements.

TABLE OF CONTENTS

EXECUTIVE SUMMARY	1
INTRODUCTION	5
FINDINGS	
Fiscal Intermediaries Perform Monitoring	9
Few Require Outcomes	11
Adequately Assessing Client Needs, Not Those Outside of Care	14
RECOMMENDATIONS	16
AGENCY COMMENTS	20
APPENDICES	
A: Title II Administrative Structure by State	21
B: Agency Comments	24
C: Related Office of Inspector General Reports	32

INTRODUCTION

PURPOSE

To examine the evaluation systems used by Title II 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 entitled, *Ryan White Evaluation Systems, Title I: Grants to Metropolitan Areas* (OEI-05-98-00392) and *Ryan White Evaluation Systems, AIDS Drug Assistance Programs* (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 II grantees to prioritize a portion of their funds for emerging populations.

The Health Resources and Services Administration (HRSA) directs Ryan White resources to various local entities through the Act's four titles and Part F and allows 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 II of the Ryan White CARE Act

Title II provides grants to States to improve the quality, availability and organization of health care and support services for individuals and families with HIV disease. Grants are awarded to States in accordance with the number of living AIDS cases in the State or territory and the estimated number of living AIDS cases outside of Title I funded eligible metropolitan areas. In addition to the base award, States receive earmarked funds for the

AIDS Drug Assistance Programs (ADAPs) through which States provide medications to low-income individuals with HIV disease with no or limited insurance coverage.

Outside of the earmarked funds, States can use Title II funds to support home and community based health and support services, continuation of health insurance coverage, pharmaceutical treatments through the ADAP, HIV care consortia, and direct health and support services. This inspection focuses on evaluation mechanisms within the consortia program, as this program receives the largest share of Title II non-ADAP funds.

Consortia are community-based regional planning entities established by Title II grantees. The consortia plan and prioritize Title II funds in their area, promote coordination of services and serve as a community forum. Representatives of local public and non-profit health and support service providers serve as consortium members. Incorporated consortium may serve as the local fiscal agent for Title II funds. In other cases, consortium designate a member agency to be the “lead agency,” responsible for grants administration and provider monitoring of Title II funds in the region. In some areas, the lead agency is the same agency that is responsible for the administration of Title I funds. (See Appendix A for a description of the consortia/lead agency structure in visited States)

OIG Evaluation Recommendations in 1995

In a June 1995 Office of Inspector General (OIG) report, “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 consortia were not assessing the impact of CARE Act funds on their service area.

The OIG recommended that the Health Resources and Services Administration 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 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 Office of Science and Epidemiology, within 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 office is focusing on evaluating the following areas: 1) Enrolling under-served 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

In recent years, HRSA's Grant Application Guidances have placed a growing emphasis on the ability of grantees to document and quantify the impact of the services they fund. The FY 1999 application guidance asks grantees to begin developing outcome measures in relation to four program principles: responding to the needs of the underserved and hard-to-serve, assuring access to emerging therapies, adapting to changes in the health care market, and documenting client-level outcomes. Suggested client-level outcomes include: decreased viral load, declines in perinatal transmission of HIV, and morbidity and mortality reductions. In the absence of defined outcome measures, the grantee is asked to describe activities they will undertake to measure impact in these areas.

The FY 1999 Application Guidance instructs applicants to estimate unmet need for those in care and those not currently in the system of care in terms of their demographics, geographic variation across the State and their unmet need. Applicants are also instructed to provide quantitative data on co-morbidities, poverty status and insurance status of the State's living HIV/AIDS cases.

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 States in this endeavor.

HRSA's Technical Assistance on Evaluation

The HRSA has provided technical assistance to Title II 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 II Ryan White grantees to answer those questions.

SCOPE AND METHODOLOGY

In this inspection, we examined the mechanisms Title II grantees use to monitor sub-grantee program and fiscal compliance, measure the outcomes of the programs they fund and assess 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 II grantees, but rather judges whether the grantees have and appropriately utilize the tools to perform these evaluation functions. We 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 derive 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 eight States: New York, New Jersey, Maryland, Florida, Illinois, Texas, California and the District of Columbia. We selected these States as a purposive sample representative of comparatively high rates of incidence through intravenous drug use transmission, comparatively high rates of infections among minority populations, and regional diversity. In addition, our selected States contain 68 percent of the living AIDS cases reported in 1997 and 61 percent of the Title II funding for FY 1998.

We conducted an extensive review of documentation provided by the grantees, consortia and providers. We examined States' FY 1998 Title II grant applications, service provider contracts, samples of all program, fiscal, outcome and needs assessment reports, site visit protocols and additional evaluation materials.

We supplemented the documentation review with on-site interviews from October through December 1998. In each State we interviewed: the Title II grantee, the Title II consortia/lead agency in up to three different regions, and at least 10 percent of the Title II providers. The number of providers interviewed ranged from 4 to 15. They were chosen to represent various program sizes, service delivery purposes and locations.

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

FINDINGS

In most sampled States, program and fiscal compliance of service providers is monitored through fiscal intermediaries; intermediaries have monitoring mechanisms in place

In the eight States we visited, seven of the grantees use regionally based lead agencies to serve as fiscal agents for the service providers. The grantees monitor the lead agencies and the lead agencies monitor the providers. The lead agencies determine funding awards in accordance with a service plan developed by the regional consortium or planning body. In six of the States, the lead agencies have primary responsibility for monitoring the program and fiscal compliance of the service providers. In two of these six States, the grantees keep abreast of individual provider performance by reviewing the reports providers submit to the lead agency or by accompanying the lead agency on site visits. In the other four States, the grantees leave all provider monitoring responsibilities to the lead agencies.

Grantees receive regular program and fiscal reports from lead agencies and most conduct periodic site visits to lead agencies

All of the grantees we visited receive monthly or quarterly program and fiscal reports from the lead agencies. Program reports typically contain compiled program data, such as the units of service provided and the number and demographics of clients served, as well as a narrative section on program accomplishments and barriers. Fiscal reports are typically expense vouchers or invoices of line item costs.

Most of the grantees we visited reimburse the lead agencies based on a line item budget. A couple of the grantees reimburse lead agencies on a fee-for-service or unit cost basis. Some grantees advance the lead agencies a portion of their funds to facilitate the flow of the grant making process. All but one of the grantees requires the lead agencies to have an independent audit performed. The majority of grantees require the audits to be submitted for review on an annual basis.

Most of the grantees conduct formal site visits to the lead agencies at least once every 2 years. Two of the grantees have not routinely visited lead agencies but plan to conduct routine visits in the future. One of these grantees plans to visit lead agencies once every 3 years.

Lead agencies receive regular program and fiscal reports from providers and conduct frequent site visits to providers

All of the lead agencies we visited receive monthly or quarterly program and fiscal reports from their service providers. The program and fiscal reports contain similar information to that which the lead agencies report to the grantees. While most of the grantees reimburse lead agencies based on a line item budget, the majority of lead agencies reimburse providers on a fee-for-service or unit cost basis or have plans to do so. Nearly all of the lead agencies require and review annual audits of the providers.

The majority of sampled lead agencies conduct formal site visits to service providers at least once a year and as often as quarterly. Site visits typically include a review of a sample of client files, financial records and other support documentation used for reporting. Most of the lead agencies also informally monitor providers through ongoing communication and individualized technical assistance.

Most grantees and lead agencies have mechanisms to ensure that Ryan White funds are used only for eligible clients and as the payor of last resort

All of the grantees and lead agencies have mechanisms in place to ensure that providers verify client eligibility for Ryan White services. Six of the eight grantees and most of the lead agencies also have mechanisms to ensure that providers use Ryan White funding as the payor of last resort. The grantees and lead agencies include eligibility and payor requirements in written policy and procedural manuals and check relevant documentation on site visits. A few lead agencies do not routinely verify provider use of Ryan White funds as the payor of last resort. These lead agencies indicated awareness of the need to devote more attention to this area in the future.

Most of the service providers 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 of the services paid for by Medicaid in their State. In addition, service providers have varying capacity to check Medicaid eligibility.

Few Grantees or Lead Agencies Currently Require Outcome Measurement of Their Service Providers; Most Are in the Early Stages of Discussion Regarding Outcome Measures

Currently, Only One of the Eight State Grantees and One of the Twelve Lead Agencies We Visited, Require Client Outcomes to Be Measured

The New York grantee currently requires outcome measures for three service categories, primary care, dentistry and case management. Primary care and dentistry are measured according to professional clinical guidelines and expected clinical health outcomes. An independent peer review organization monitors providers' performance on a set of core indicators such as CD4 count and gynecological health. These are tracked by a common software package that aggregates individual level clinical data entered to manage patient care. The grantee is also piloting outcomes in case management in the following areas: optimal health, financial/entitlements, independent living, adult education/employment, family stability, mental health, substance abuse and client empowerment.

The Sacramento County Department of Health and Human Services, the lead agency for Title II funds in the Sacramento area, requires providers to report outcome measures on a quarterly basis. Since reporting compliance was low in the initial 6 months, the lead agency is developing a standard format for outcome reporting. Outcome measures are a required component of the provider quarterly reports as of FY 1999.

The rest of the grantees and lead agencies rely on process measures to measure the success of service providers. These measures, along with annual goals, are usually outlined in the scope of work section of a provider's contract. The process measures typically consist of the number of clients served and the number of service units delivered in the contract year. Some contracts require that the measures be broken down by sub-population, with a special emphasis on women and children.

A few providers currently report outcomes; many others have client outcomes in case files

A few providers in several localities have developed aggregate outcomes to measure the impact of the services they provide. These providers have taken the initiative due to the requirements of other funding sources or their own desire for greater program accountability. Though they are not required to, these agencies typically submit their outcome information to their lead agencies as part of their quarterly or annual progress reports.

The outcome measures developed by the Mount Carmel Guild in Mercer County New Jersey provide an example of the type of outcome measures some providers are using. The

Mount Carmel Guild provides nutritional counseling, nutritional food packages and personal care packages for HIV infected clients. They have a set of outcome measures that are tracked for each client and aggregated to evaluate overall program performance. The measures include weight loss, weight gain, weight stabilization, cholesterol level, albumin level and routine vitamin intake. The nutritionist routinely tracks progress on these outcomes by client and aggregates them annually through a random audit of 50 client charts. The organization has plans underway to refine this process by analyzing outcomes across sub-populations.

Many other providers we visited collect client information which could be used to measure program outcomes if aggregated. For example, case managers often establish client goals at intake and document progress towards these goals in a client's case file. Physicians also typically record clinical progress in patient charts. In these situations, a client's progress or the progress of the caseload in general may be discussed at organizational meetings, but agencies 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 lead agency or grantee.

The Majority of Grantees and Lead Agencies We Visited Are in the Early Stages of Planning for Outcome Measurement

Most State grantees are in various stages of planning for outcome measures. Two State grantees are discussing the development of outcome measures in the near future. Both are planning on developing a core set of outcomes at the State level with provider input. One has begun by introducing the concept of outcome measurement to its providers to solicit their feedback. The other grantee is setting up a task force to focus on outcome measures. This task force is soliciting information from other Ryan White programs and is searching for a consultant to help them devise a strategy to develop outcome measures in a participatory manner. They are also considering contracting a local university to define the measures once they are selected.

Other State grantees, while not yet engaged in outcomes discussions, are laying the groundwork for future outcome measurement. A few are developing standards of care. It is their belief that this standardization of service provision is necessary in order to hold providers accountable to a common set of outcome measures. Several grantees are working to improve their databases which will facilitate the collection of outcome measures. The improvements include projects such as developing the capacity to collect client-level data and devising standard data definitions to assure accurate and reliable reporting.

Half of the lead agencies are also engaged in the development of outcome measures. Half of these agencies indicated that they are actively engaged in putting outcome measures in place by the FY 1999 grant cycle. The other half are in the very early stages of discussion surrounding the implementation of outcome measurement.

Agencies actively pursuing outcome measures are doing so by formulating a core set of outcome measures. One agency has, based on the United Way model¹, met with all of the providers to assess the data they are collecting and their capacity to aggregate outcome measures with minimal additional burden. This information will be used to create a set of outcomes for each service category. Another lead agency, already receiving voluntary outcome measures from its providers, has compiled a list of all of the outcome measures reported and is in the process of selecting a core set of measures. Another agency has hired a consultant to develop a set of quality indicators in consultation with staff and providers. This agency plans to recommend a set of outcome measures and require that providers incorporate a minimum of three outcome measures per service category.

Other lead agencies are aware of the management and accountability benefits of utilizing outcome measures, but are still “figuring out their approach.” While they indicate plans to have outcomes in place by FY 2000, they have no specific plans underway.

More than Half of the Grantees and Lead Agencies Expressed Concerns Regarding Outcomes Measures

Grantees and lead agencies share a variety of concerns regarding the development of outcome measures. Several respondents noted that the administrative cap limits the amount of money available to track outcomes. Additional grant funds that can be set aside for outcome measurement would be in direct competition with direct service funds. There are also capacity concerns. A number of grantees and lead agencies are concerned that they do not possess the technical expertise to develop outcome measures that would appropriately reflect the diversity of service delivery and which could be attributed solely to the infusion of Ryan White funds. Respondents also questioned the ability of planning bodies to properly understand and utilize outcome measures. Providers voiced similar concerns regarding outcome measures. In particular, they felt that they did not have the resources or skills to properly develop or monitor client outcomes.

Respondents also questioned whether the State and local levels are the appropriate place to develop and conduct outcome measurement. Many respondents feel that outcome measures should be uniform across Ryan White Titles, the State and the country in order to reduce the reporting burden and to allow for meaningful comparisons between programs. Some also feel that Ryan White outcome measures should relate to the outcomes measures of other Federal agencies that support HIV services, such as the Department of Housing and Urban Development, and the Public Health Service goals for the year 2000. In addition, several respondents suggested that tracking outcomes at the national level would be more cost-effective. Respondents indicated that with uniform measures HRSA could take advantage of sampling methodologies to reduce the amount of

¹ The United Way approach emphasizes developing outcomes reflective of an agency’s goals and recommends using data sources readily available to agencies such as client records and responses to routinely administered standardized tests and measurements.

labor involved. The HRSA could also tap into the capacity and resources that already exist in the medical research field.

Majority of grantees desire technical assistance from HRSA on outcome measurement

Grantees requested that HRSA clearly delineate and communicate the direction they are headed with regards to outcome measures. Grantees asked for a definition of what is meant by outcome measures and what outcome measures are appropriate for specific service categories.

Several grantees also want HRSA to offer guidance on how to design an inclusive process of developing outcomes, how to measure service outcomes and how to build organizational capacity to interpret and analyze outcomes. They want answers to questions such as: How do you create indicators that provide the information you are after? How do you track outcome measures over time? How do you get the necessary information from the client or their provider? What about confidentiality issues? The respondents suggested that the answers to these questions could be provided through workshops, dissemination of best practices and national conferences, designed to promote information exchange among the grantees.

Grantees rely on consortia to assess needs; most consortia routinely assess the needs of clients but not of persons outside of HIV/AIDS care

All of the State grantees we visited rely on regional consortia to assess the needs of persons with HIV/AIDS and require them to conduct periodic assessments. Slightly over half of the grantees we visited require the consortia to submit needs assessment results as part of the consortium's annual application for funds. A couple of grantees supplement the local needs assessments with limited Statewide assessments of specific issues or sub-populations. None of the grantees currently conduct comprehensive assessments of the needs of the HIV/AIDS population in their State. However, in compliance with Federal law, all of the State grantees review local needs assessments to identify Statewide needs as part of the Statewide Coordinated Statement of Need (SCSN) process.² Building on the momentum of the SCSN process, two of the grantees are planning to conduct a Statewide needs assessment in FY 1999.

² The 1996 CARE Act legislation requires all Ryan White grantees to participate in a Statewide Coordinated Statement of Need (SCSN) process to collaborate in identifying and addressing HIV care issues. The SCSN is to be based on existing information from local needs assessments. Starting in FY 1998 Title II grantees are required to submit a copy of the SCSN with their grant applications and update the SCSN every three years, at a minimum.

Most grantees do not specify what to include in the needs assessment

Most of the grantees we visited do not specify what the consortia must include in their needs assessment or provide a standard tool for conducting the needs assessment. A few of the grantees provide some guidance to the consortia on how to conduct the needs assessment and on the types of information they are expected to collect. For example, the Florida grantee specifies what types of entities and population groups the consortium should consult with in the assessment. Lead agencies in Florida are also directed to include an epidemiological profile, a demographic survey, focus groups, a resource inventory and a profile of provider capacity. Two of the State grantees are in the process of developing a standard needs assessment tool for use by their consortium.

Most consortia do not assess the needs of infected persons not in HIV/AIDS care

We interviewed 17 planning bodies responsible for conducting local Title II needs assessments, including 5 “HIV/AIDS care networks” in New York and several Title I planning councils who assess needs for both Title I and Title II services. Most of the consortia or planning bodies use both qualitative and quantitative data sources in their needs assessment work, including public health data, consumer and provider surveys, focus groups and public forums.

Outside of the public health data, information on the needs of infected individuals not receiving HIV care is usually not obtained. Of the 17 planning bodies interviewed, only 3 reported that they have successfully solicited needs information from persons with HIV/AIDS who are not in care. A few others indicated that they may have obtained needs information from infected persons not in care through public forums, but these forums were not targeted to this population. Two of the other needs assessment bodies tried to solicit information from persons not in HIV/AIDS care through advertising in local newspapers and through substance abuse facilities, but were reportedly unsuccessful.

The three consortia successful in obtaining the input of persons not in HIV/AIDS care used peers and street outreach to solicit input. Two of the consortia trained persons living with HIV to survey infected persons in non-HIV/AIDS provider locations such as shelters and community groups. One care network in New York conducted focus groups in shooting galleries and crack houses to solicit information on needs from persons outside of the HIV/AIDS care system.

RECOMMENDATIONS

The HRSA should implement a multi-year outcomes initiative

The HRSA should build upon their efforts to promote outcome measurement by establishing a multi-year implementation plan. Outcome measurement should start on the provider level and lead through subsequent steps to consortia-wide analysis of client outcomes by the responsible lead agency.³ Outcome measurement would foster program improvements and greater accountability for expenditures and promote the achievements of the Ryan White program.

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 the grantees to direct the lead agencies of the Title II consortia to develop three additional outcomes for each service category. The HRSA's core outcomes could be used for both Title II and Title I grantees and should be aligned with the performance goals outlined in HRSA's annual performance plan. The HRSA should urge Title II lead agencies to work with co-located Title I grantees and planning bodies in establishing the consortia-level outcome measures, so as to avoid imposing a greater measurement burden on providers funded under both Titles.
- ▶ In stage two, HRSA could require the grantees to direct the lead agencies of the consortia to collect the established outcome measures from the providers on a quarterly basis. The HRSA should also urge the grantees and the lead agencies to require providers to report outcome measures as client-level data. These agencies will need client-level outcome data in order to analyze client outcomes across the region in stage three.
- ▶ In stage three, HRSA could require the grantees to direct the lead agencies of the consortia to analyze the reported outcome measures across services and report consortia-wide outcomes to HRSA via the grantees on an annual basis.

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

³ In States where grantees, rather than regional consortia, have direct oversight over providers, the responsibility of developing, collecting and analyzing outcomes would fall to the State.

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. The HIV/AIDS 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.

In recent years, HRSA's application guidance to Title II 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 stated that they would like more specificity from HRSA on what outcomes they are expected to measure and on HRSA's implementation plans.

Stronger leadership from HRSA on outcome measurement would help coordinate efforts that remain fragmented at various levels of the Title II program. Further, outlining a multi-year initiative would provide grantees and the lead agencies with the necessary perspective to strategically plan for the future. As HIV/AIDS has evolved from an emergency epidemic to a chronic disease in a tight health care market, it is critical that the agencies serving infected individuals build the capacity to provide care efficiently and effectively through the productive use of outcome and impact studies.

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 States to address this area in the future. The HRSA should build on this effort by requiring the grantees and consortia to solicit needs information from persons not in HIV/AIDS care and by providing technical assistance on how to do this. In turn, the grantees should provide the consortia and other Title II planning bodies with guidance on needs assessment expectations and on methods to obtain the required information.

Currently, grantees are required to use public health data to estimate unmet need in their applications to HRSA. This data 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 HIV/AIDS 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 grantees 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 grantees to recognize the complexity and disproportionate costs which may be involved in serving persons 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 care. The materials suggest avenues for soliciting this information, such as substance abuse clinics and homeless shelters. Outside of suggesting that consortia provide incentives like food vouchers or use the media to solicit participation, the materials do not describe specific outreach strategies. As these ideas are discussed only generally, we suggest HRSA provide more detailed information on steps to solicit needs information. Several consortia representatives indicated that they would like more guidance on how to reach infected persons not in care.

The HRSA could provide the grantees and the consortia with a technical assistance document devoted to soliciting needs information from people living with HIV/AIDS 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, Centers for Disease Control and Prevention 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 B.

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.

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. We recommend that HRSA work with the Department to secure funds for these initiatives. 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 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.

Structure of Title II Programs

CALIFORNIA

The California Department of Public Health is the Title II grantee agency. Funds are dispersed through 37 regionally-based consortium. Each consortium has a lead agency which is responsible for the fiscal and administrative functions of the Title II consortia program in their region. The State monitors the lead agencies and requires them to monitor the programmatic and fiscal compliance of the service providers they fund.

In Eligible Metropolitan Areas, the lead agency is typically the same as the Title I grantee. For example, the Los Angeles County Department of Health Services receives Title I funds and also acts as the fiscal intermediary for the Title II consortium funds. In these situations, a planning council that has merged with the local consortia is responsible for advising the lead agency regarding needs and service priorities. In non-EMA areas, the lead agencies are counseled by a regional consortia as to the service priorities of that area.

THE DISTRICT OF COLUMBIA

The District of Columbia Department of Health is the Title II grantee. The Department of Health has designated the DC CARE Consortium to be responsible for conducting needs assessments, planning service delivery, promoting service coordination and monitoring the program and fiscal activities of the service providers. The Department of Health maintains some oversight over provider-level activities by reviewing individual provider reports submitted to the consortium and by accompanying the consortium on some provider site visits.

FLORIDA

The Florida Department of Health is the Title II grantee agency. The Department of Health has established 14 regionally based consortia to provide a continuum of care for HIV infected persons throughout the State. The consortia plan and prioritize Title II funds in their area, promote coordination of services and serve as a community forum.

Each consortium has a lead agency which is responsible for the fiscal and administrative functions for the Title II consortia program in their region. In some consortia areas, the Department of Health serves as the lead agency for the consortium. In other areas, the

Structure of Title II Programs

local consortia designate a lead agency. All of the lead agencies in the State act as the fiscal conduit and data coordinator for the service providers in their area.

ILLINOIS

The Illinois Department of Public Health HIV/AIDS Section administers the Title II program in Illinois. The Department relies on 11 lead agencies to disperse the funds regionally and to monitor service providers. The State monitors the lead agencies. Regional consortium plan and prioritize Title II funds in their area and promote coordination of services.

MARYLAND

The Maryland Department of Health and Mental Hygiene AIDS Administration is the Title II grantee agency. There are now five lead agencies that disperse the Title II funds regionally in accordance with a consortia developed service priority and allocation plan. The State has oversight over the lead agency's funding decisions. The State also retains control over monitoring the service providers. Both the lead agencies and service providers are required to submit their routine program and fiscal reports to the State Title II staff.

NEW YORK

The New York State Department of Health is the designated Title II grantee. The AIDS Institute of the Department of Health operates the Title II program. The AIDS Institute contracts with 17 Consortia, 16 of which are regionally based and one which is a Statewide consortium for special populations. The consortia, otherwise known as "HIV care networks" are responsible for conducting local needs assessments, identifying local service priorities and developing service delivery plans. The AIDS Institute determines funding allocations and awards contracts directly to service providers, in accordance with the networks' service delivery plans. The Institute maintains fiscal and administrative oversight of the service providers funded through the Title II program, rather than use regionally based lead agencies.

Structure of Title II Programs

NEW JERSEY

The New Jersey Department of Health and Senior Services is the Title II grantee. The Department allocates its Title II consortia funds to 10 consortia, 9 of which are regionally based and one of which is a Statewide network of hospital sites serving HIV-infected women and children. New Jersey is in the process of phasing out the six regional consortia which are located in Title I EMAs. The New Jersey consortia are responsible for planning and coordination activities. Each consortium designates a lead agency to handle fiscal and administrative responsibilities for the region. Although monitoring responsibilities primarily fall to the lead agencies, the State grantee maintains some oversight over the activities of local service providers. The lead agencies determine contract awards but provider contracts are subject to the review of the grantee. The grantee also conducts annual site visits to all service providers.

TEXAS

The Texas Department of Health is the Title II grantee agency. They allocate funds to 26 regionally-based lead agencies which are either a local health department or a community organization. The State monitors the lead agencies and relies on the lead agencies to monitor the programmatic and fiscal compliance of the service providers they fund. Funding decisions made at the local level are directed by regional consortia.

The Title II structure in Austin differs from the rest of Texas. In Austin, the Austin/Travis County Health and Human Services Department is the lead agency for the Title I funds and Title II consortium funds. The local planning council performs the priority setting and allocation for both Title I and Title II funds to all 10 counties.

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.

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

Page 2

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

Page 3

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.

Agency Comments

Page 4

- 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

Page 5

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 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.

Agency Comments

Page 6

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.

Agency Comments

Page 7

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)