DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date FEB 28 1997

From *for* June Gibbs Brown
Inspector General

Subject Audit of Outreach and Risk Reduction Programs Funded by the New York Eligible Metropolitan Area Under Title I of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CIN: A-02-96-02502)

To Ciro Sumaya, M. D., M. P. H.T.M.
Administrator
Health Resources and Services Administration

Attached is our final report entitled "Audit of Outreach and Risk Reduction Programs Funded by the New York Eligible Metropolitan Area Under Title 1 of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990. " The objective of our audit was to determine whether Title I funds expended by the New York Eligible Metropolitan Area on these programs were for the purpose of delivering or enhancing services for individuals and families with HIV disease.

Officials in your office have concurred with our recommendations, set forth on page 10 of the attached report, and are in process of taking corrective action. We are appreciative for the cooperation given us in this audit.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please call me or have your staff contact Joseph J. Green, Assistant Inspector General for Public Health Service Audits, at (301) 443-3582.

To facilitate identification, please refer to Common Identification Number A-02-96-02502 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF OUTREACH AND RISK REDUCTION PROGRAMS FUNDED BY THE NEW YORK ELIGIBLE METROPOLITAN AREA UNDER TITLE I OF THE RYAN WHITE COMPREHENSIVE AIDS RESOURCES EMERGENCY ACT OF 1990

JUNE GIBBS BROWN
Inspector General

FEBRUARY 1997
A-02-96-02502

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Subject: Audit of Outreach and Risk Reduction Programs Funded by the New York Eligible Metropolitan Area Under Title 1 of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CIN: A-02-96-02502)

To:

Ciro Sumaya, M.D., M.P.H.T.M.
Administrator
Health Resources and Services Administration

This final report discusses our audit of outreach and harm reduction/recovery readiness and risk reduction programs provided by the New York Eligible Metropolitan Area (EMA), under Title I of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CARE Act). The objective of our audit was to determine whether Title I funds expended by EMA on these programs were for the purpose of delivering or enhancing services for individuals and families with HIV disease.

EXECUTIVE SUMMARY

During 1995, EMA awarded 35 contracts totaling $4.7 million, or about 5 percent of the total $93.6 million, grant award received from the Health Resources and Services Administration (HRSA) for Outreach, and Harm Reduction/Recovery Readiness and Risk Reduction programs.

During our on-site review at seven contractors ($1.7 million in Title I contracts), we found that these services were provided predominantly to individuals whose HIV status was unknown at the time the services were provided. The providers classified the individuals to whom the services were provided as either "at risk," "risk unknown," or otherwise not HIV-infected. These programs were targeted to the "at risk" population of the respective provider catchment areas.

In light of the statutory language of Title I of the CARE Act, we believe it is not appropriate to spend Title I funds on programs designed for the "at risk" population instead of programs for individuals with HIV and their families. According to the CARE Act, the primary purpose of Title I grants from HRSA to EMAs is to provide direct financial assistance for the purpose of delivering services for individuals and families with HIV disease.

Three of the contractors ($447,000) provided outreach services such as distributing literature about HIV/AIDS and other sexually transmitted diseases. Two of the three contractors did not maintain documentation that would allow us to determine whether

their clients had HIV disease or were family members of persons with HIV disease. The third contractor reported that, over a 2-month period, 66 clients out of over 3,200 outreach contacts availed themselves of referral services. We reviewed case records of 38 of these 66 clients. Of the 38 clients, 19 received an HIV test. Only one tested positive.

Four of the contractors ($1.3 million) provided harm reduction/recovery readiness and risk reduction services. The program eligibility documentation maintained by these providers varied from contractor to contractor depending on the nature of services provided. For example:

- a substance abuse program had no documentation regarding the individual's HIV status because the program requires anonymity, and

- a entry-level drug program was available to the "at risk" population. Therefore, the provider did not require documentation of HIV disease.

We also found that neither HRSA nor EMA had established clear guidelines which would have defined the parameters of eligibility or documentation required to ensure that only eligible individuals or their families received services.

In addition, the methodologies used by EMA and service providers to evaluate the success of outreach and risk reduction efforts were ineffective because they were based primarily on the total number of individuals served rather than the number of HIV-infected individuals served.

We are recommending that HRSA:

- immediately advise EMAs that funds awarded under Title I of the CARE Act may not include outreach programs related to prevention of HIV, rather than the provision of medical and other services to individuals infected with HIV; and that grantees must assure that any outreach programs supported with Title I funds must demonstrate that they have a high probability of identifying persons with HIV infection for purposes of enrolling them in care;

- coordinate with the Office of General Counsel, and others (the Centers for Disease Control and Prevention (CDC), Office of Science and Epidemiology), to establish eligibility and documentation requirements for outreach services that are reasonably calculated to reach HIV-infected individuals; and

- develop procedures for local grantees to use in evaluating the effectiveness of qualified outreach and harm reduction/recovery readiness and risk reduction programs.

In their response to our draft report, HRSA concurred with our recommendations. The entire text of HRSA's comments is contained in the Appendix to this report.

INTRODUCTION

BACKGROUND

On August 18, 1990, Congress passed Public Law 101-381 entitled, "The Ryan White Comprehensive AIDS Resources Emergency Act of 1990" (CARE Act). The CARE Act provides emergency assistance to localities that are disproportionately affected by HIV. The CARE Act is multifaceted, with four titles directing resources to cities, States, and demonstration grants. The purpose of Title I of the CARE Act is to provide resources to cities facing high HIV caseloads for developing and sustaining systems of care that emphasize a continuum of services to reduce inpatient burdens.

The Department of Health and Human Services (HHS), Public Health Service (PHS), HRSA, awards grants to a metropolitan area, designated as an EMA. The assistance under the grant is directed to the chief elected official that administers the public agency providing outpatient and ambulatory services to the greatest number of individuals with AIDS. One of the largest EMAs is New York City (NYC). For 1995 (the 05 year), HRSA awarded NYCEMA $93.6 million.

The New York City Department of Health (NYCDOH) was designated as the local entity responsible for administering Ryan White funds for EMA. As required under the CARE Act, EMA established an HIV Planning Council. Established through the Mayor's executive order, the HIV Planning Council is charged with establishing priorities for the allocation of Title I funds, developing a comprehensive plan for delivery of Title I services, and assessing the efficiency of the administration of Title I funds.

As the grantee, NYCDOH entered into a master contract with Medical Health Research Association of New York City (MHRA), a private not-for-profit organization to administer the Title I program in the five boroughs of New York City. Also, NYCDOH has an intergovernmental agreement with the Westchester County Department of Health (WCDOH) to manage the distribution of Title I funds for the delivery of services in the New York counties of Westchester, Rockland, and Putnam.

OBJECTIVES, SCOPE, AND METHODOLOGY

We conducted our audit in accordance with generally accepted government auditing standards. The objective of our audit was to determine whether Title I funds expended by EMA on outreach, and harm reduction/recovery readiness and risk reduction programs were for the purpose of delivering or enhancing services for individuals and families with HIV disease.

To accomplish our audit objective, we:

- determined whether HRSA provided guidance to EMAs to ensure only individuals with HIV disease and their families received services;
- determined whether NYCEMA had established systems and procedures to ensure only individuals with HIV disease and their families received services;
- determined whether NYCEMA provided CARE Act services contractors with written policy or guidance establishing the parameters of eligibility and documentation required to support outreach and at risk services provided to their clients with HIV disease and their families; and
- consulted with the Inspector General Division of the HHS Office of General Counsel regarding the appropriate use of funds provided under Title I of the CARE Act.

This audit resulted from splitting our initial audit into two distinct segments:

(1) the adequacy of HRSA's eligibility and documentation requirements for harm reduction/recovery readiness and risk reduction programs; and

(2) the adequacy of EMA's efforts to ensure that only eligible individuals and their families are being served under Title I. Because guidelines need to be clarified for harm reduction/recovery readiness and risk reduction programs, these programs were excluded from this second segment. The results of this second segment were included in a report issued to EMA. ("Audit of Eligibility Under Title I of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, New York Eligible Metropolitan Area," CIN: A-02-02517, issued December 12, 1996.)

In our initial audit work, after obtaining an understanding of the types of services provided under the CARE Act, we judgmentally selected service providers for on-site review. Our sample was weighted toward selecting providers with:

- significant contract amounts;
- multiple contracts; and
- a range of Title I services.

Using this criteria, we selected for the first segment of our review, 7 service providers with $1.7 million in Title I contracts out of a total of 35 contracts amounting to $4.7 million that the EMA awarded in 1995 for Outreach, and Harm Reduction/Recovery Readiness and Risk Reduction Programs. For these seven contractors, we examined documentation available to support whether services from outreach and at-risk programs were provided only to individuals with HIV disease and their families.

We conducted our field work at the administrative offices of NYCEMA, MHRA, and WCDOH, and seven outreach and harm reduction/recovery readiness and risk reduction contractors during the period September 1995 through June 1996.

FINDINGS AND RECOMMENDATIONS

Six of the seven EMA contractors reviewed provided services predominantly to individuals whose HIV status was unknown at the time the services were delivered. These services were for activities such as outreach, harm reduction/recovery readiness, and risk reduction. The providers classified the individuals to whom the services were provided as either "at risk," "risk unknown" or otherwise not HIV-infected. We believe it is not appropriate to use Title I funds for programs designed for the "at risk" population because the CARE Act requires Title I funds to be used for the purpose of delivering services for individuals and families with HIV disease.

Criteria

Under Title I of the CARE Act, HRSA is authorized to make grants for emergency relief to certain metropolitan areas which have a high incidence of AIDS cases. The purpose of the Title I grants is contained in section 2604(b)(1) of the Act which states in part that:

> "...The chief elected official shall use amounts...to provide direct financial assistance...for the purpose of delivery or enhancing HIV-related-

(A) outpatient and ambulatory health and support services, including case management and comprehensive treatment services, for individuals and families with HIV disease (Emphasis added); and

(B) inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities."

Subsection (c) establishes limits on expenditures for personnel needs for the care of individuals with HIV disease for certain entities providing inpatient services. Regarding outreach programs, section 2605(a)(5) of the CARE Act stipulates that EMA must provide assurance that:

"(C) a program of outreach will be provided to low-income individuals with HIV disease to inform such individuals of [HIV health care and support] services." (Emphasis added.)

In addition to the statute, the legislative history further indicates that the appropriate uses of Title I funds are for services for individuals with HIV disease and their families. Specifically, the Conference Report (H.R. Rep. No. 652, 101st Cong., 2d Sess. 63) confirms that the primary purpose of the Title I grants is to reduce the burden on hospitals to care for individuals with HIV disease on an inpatient basis by increasing the availability of outpatient care:

> "[i]t is the managers' intention that funds provided under this emergency relief program be used to relieve the overwhelming burden that HIV has imposed on urban health care systems. In particular, this funding is intended to help eligible areas operate programs which enable individuals with HIV disease to receive appropriate care on an outpatient and ambulatory basis."

SERVICES PROVIDED PREDOMINANTLY TO INDIVIDUALS WHOSE HIV STATUS WAS UNKNOWN

Outreach Contractors - 3 Contracts Totaling $447,000.

We reviewed three outreach contractors and found that program eligibility was established to provide services to the "at risk" population rather than to only HIV-infected individuals and their families. The type of outreach services provided included community outreach services, street outreach (street corners, shopping centers, and parks), and school presentations. The outreach methods used included distributing literature about HIV/AIDS and other sexually transmitted diseases, information and

referral to other services, i.e., HIV testing centers, tuberculosis testing, drug treatment programs, housing, social services, legal services, and food services.

Our review of documentation maintained by these contractors to support the eligibility of individuals contacted consisted solely of the number of persons seen that were provided some form of the aforementioned services. No specific case records or client identifiers were maintained. We were able to reconcile the number of contacts reported to supporting documentation at two sites, while, at the third site, the documentation for the number of individuals receiving services differed considerably from the number reported.

We found that the type of eligibility documentation maintained was minimal. At two sites, the documentation consisted of contractor-developed forms that recorded the responses of the individuals to a battery of behavioral questions. The forms attempted to determine the individual's risk factor, i.e., injectable drug user, partner of injectable drug user, men sex/with men, women sex/with women and HIV status: HIV+, HIV-, and Risk Unknown. These forms also indicated the number of clients referred for other services. Based upon our review of these forms, we were able to determine that the preponderance of CARE Act services provided were to individuals classified as "at risk" of being infected with the HIV disease rather than to individuals with HIV disease and their families. At the other contractor, we were provided a spiral notebook that recorded the number of clients seen by race and age. For the month reviewed, 4,075 individuals were provided outreach services. There was no information as to how many of the 4,075 were classified as HIV positive, "at risk," or risk unknown, nor was there specific data as to the number of referrals made for other services.

One provider reported that for 1 month 3,218 outreach contacts were made. In addition, the contractor reported that 11 clients availed themselves of referral services provided by this contractor. Because of the small number of referrals, we also sampled from the prior month's 55 referrals. Thus, for this 2-month period, a total of 66 case records were created for individuals that came in for AIDS testing, tuberculous testing, and testing for various sexually transmitted diseases. Of this number, we judgmentally sampled 38 cases for review. Of the 38 case records reviewed, 19 individuals received an HIV test of which only one tested positive.

We were informed by the outreach program managers that outreach programs did not require documentation to support the HIV status of the individual who received services. Rather, the purpose of the program was to inform people about HIV/AIDS and to refer them to the appropriate care settings. Since our tests showed that the majority of services reported were provided to non-HIV-infected individuals, it is our opinion that this position may not be consistent with the intent of Title I of the CARE Act, which is to provide emergency services to HIV-infected individuals and their families.

Harm Reduction/Recovery Readiness and Risk Reduction Contractors - 6 Contracts- $1.3 million

Our review of four contractors disclosed that they also developed programs to serve both the HIV and the "at risk" population. As contrasted to the outreach program, the degree of HIV eligibility documentation varied from contractor to contractor depending on the nature of services provided as illustrated below:

-- A substance abuse program had no documentation regarding the individual's HIV status since the concept of the program centers on anonymity or minimal intake information. As a result, individuals "at risk" were provided service, some for extended periods, without documentation as to their HIV status.

-- An entry-level drug program was available to the "at risk" population defined as individuals with prior drug use and with a history of encounters with the correctional system. Therefore, the provider did not require documentation of HIV. Our review of cases reported in 1 month showed that the preponderance of services were provided to individuals classified as "at-risk."

-- A contractor with "at risk" substance abuse, and drop-in programs stressed anonymity. Documentation supporting HIV status, although not required, was present for only 44 percent of the cases we reviewed for 1 month.

A methadone maintenance program had documentation supporting HIV status consisting primarily of laboratory reports.

Of the four contractors reviewed, only this contractor had adequate eligibility documentation supporting services rendered. This was due to the fact that it offered a continuum of care which included treatment of medical problems in conjunction with the individual's drug problem.

Overall, we determined that for 3 of the 4 contractors reviewed involving 5 contracts for $1.2 million, services were provided predominantly to individuals categorized by the contractors as either "at risk", or "risk unknown" rather than to HIV-infected individuals and their families as required by Title I of the CARE Act.

Contributing to this condition was the fact that neither HRSA nor EMA had established clear guidelines defining the parameters of eligibility for beneficiaries of outreach, and harm reduction/recovery readiness and risk reduction programs, or the documentation

required to ensure that only eligible HIV-infected individuals or their families received services.

Specifically, we were informed by EMA that they are unaware of any specific guidance provided by HRSA in establishing policy for service providers regarding documentation of eligibility for outreach and "at risk" programs. It had always been understood that as an EMA, they were bound by the general eligibility requirements of the CARE Act.

Regarding its own eligibility and documentation standards, EMA stated that it has not directly issued specific policy regarding the required documentation of HIV status at the provider level. Although no formal eligibility policies and procedures were issued to contractors, EMA informed us that eligibility is limited to HIV-infected, or in specific instances, affected individuals and their families. Therefore, eligibility documentation was left to the discretion of the provider. Since these programs relied heavily on client anonymity, client eligibility for services and related documentation to support HIV infection were not critical factors in the program's design. This was clearly evident in our review which showed that providers maintained minimal evidence to support that services were rendered solely to individuals with HIV and their families.

Finally, we found it difficult to evaluate the effectiveness of EMA's outreach and at risk programs. We noted that, although EMA and the service providers established policies to monitor and evaluate the relative success of their outreach, and harm reduction/recovery readiness and risk reduction efforts, these methodologies were ineffective as they were based primarily upon the total number of individuals contacted and provided services rather than the number of HIV-infected individuals or family members identified as receiving services.

Therefore, although statistics showing the number of individuals contacted would seemingly indicate that programs were achieving their overall program objectives, the majority of individuals receiving services were, in fact, not HIV-infected. Since the program was designed to service the "at risk" population, the actual number of HIV-infected individuals and the specific type services provided might not always be quantifiable or even identifiable. However, without this information, it would be virtually impossible for program managers to judge the effectiveness of the programs in reaching the intended HIV-infected population.

We recommend that HRSA:

- immediately advise EMAs that funds awarded under Title I of the CARE Act may not include outreach programs related to prevention of HIV, rather than the provision of medical and other services to individuals infected with HIV; and that grantees must assure that any outreach programs supported with Title I funds

must demonstrate that they have a high probability of identifying persons with HIV infection for purposes of enrolling them in care;

- coordinate with the Office of General Counsel, and others (CDC, Office of Science and Epidemiology), to establish eligibility and documentation requirements for outreach services that are reasonably calculated to reach HIV-infected individuals; and

- develop procedures for local grantees to use in evaluating the effectiveness of qualified outreach and harm reduction/recovery readiness and risk reduction programs.

The HRSA's Comments

In their response to our draft report, HRSA concurred with our recommendations. The HRSA stated that they will provide initial policy guidance for Title I and Title II grantees regarding the use of CARE Act funds for outreach before the end of the second quarter of Fiscal Year (FY) 1997. In addition, HRSA is utilizing its Policy Review Board to develop documentation requirements in consultation with other stakeholders in FY 1997. Finally, regarding the evaluation of the effectiveness of qualified outreach programs, HRSA replied that it is working to address this issue, and in FY 1997, it will implement a process to establish a protocol for local use.

The entire text of HRSA's comments is contained in the Appendix to this report.

Appendix

APPENDIX

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Health Resources and
Services Administration
Rockville MD 20857

FEB 3 1997

TO: Inspector General, DHHS

FROM: Acting Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report, "Audit of Outreach and Risk Reduction Programs Funded by the New York City Eligible Metropolitan Area (NYEMA) Under Title I of The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990." (CODE A-02-96-02502)

Attached is HRSA's response to a memorandum dated December 30, 1996, from Joe Green, Assistant Inspector General for Public Health Service Audit Division, requesting revised comments on revised recommendations in the subject draft report.

The revised OIG recommendations to HRSA were the result of a meeting between the OIG and the Division of HIV Services (DHS), Bureau of Health Resources and Development, and the Office of General Counsel, to discuss HRSA's comments to the original recommendations in the subject draft report. We appreciate the OIG conducting this review and understand that the revised OIG recommendations and HRSA's comments to them will be included in the final report.

Questions may be referred to Paul Clark on 443-5255.

Thomas G. Morford

Attachment

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA) COMMENTS ON THE OIG DRAFT REPORT, "AUDIT OF OUTREACH AND RISK REDUCTION PROGRAMS FUNDED BY THE NEW YORK CITY ELIGIBLE METROPOLITAN AREA (NYEMA) UNDER TITLE I OF THE RYAN WHITE COMPREHENSIVE AIDS RESOURCES EMERGENCY (CARE) ACT OF 1990."
(CODE A-02-96-02502)

OIG RECOMMENDATION:

That HRSA immediately advise EMAs that funds awarded under Title I of the CARE Act may not include outreach programs related to prevention of HIV, rather than the provision of medical and other services to individuals infected with HIV; and that grantees must assure that any outreach programs supported with Title I funds must demonstrate that they have a high probability of identifying persons with HIV infection for purposes of enrolling them in care.

HRSA RESPONSE:

We concur. This recommendation supports the legislative intent of Title I as a HIV care program that provides medical and other services to individuals infected with HIV and appropriately excludes primary prevention activities.

Under Title I, Section 2605 specifies that, "...To be eligible to receive a grant under Section 2601, an eligible area shall ... submit ... an application ... including assurances adequate to ensure-- ... (5) to the maximum extent practicable, that-- ... a program of outreach will be provided to low-income individuals with HIV disease to inform such individuals of such services...." Consistent with the statutory language and aided by 5 years program experience, the Bureau has determined that it is both prudent and necessary to carry out outreach activities which engage people not known to have HIV infection, but who have a high probability of being seropositive, in hopes of entering and retaining them in a system of community-based HIV care. Title I EMAs may identify local priorities that result in service provision where documentation of HIV status is not able to be provided, at least initially, or may, in fact, be counterproductive to the goal of increasing access to the system of care for those with HIV infection.

HRSA further supports the notion of accountability for such outreach programs and agree that the grantee should assure that CARE Act funds used for outreach activities achieve the intended outcome.

The DHS will provide initial policy guidance to Title I and II grantees regarding the use of CARE Act funds for outreach before the end of the second quarter of Fiscal Year FY 1997.

OIG RECOMMENDATION:

That HRSA coordinate with the Office of the General Counsel, and others (CDC, Office of Science and Epidemiology), to establish eligibility and documentation requirements for outreach services that are reasonably calculated to reach HIV infected individuals.

HRSA RESPONSE:

We concur. HRSA is establishing eligibility and documentation requirements for outreach services to ensure that CARE Act resources are used as intended. Procedurally, the DHS is moving forward, utilizing its Policy Review Board to develop such policies in consultation with other stakeholders in FY 1997.

OIG RECOMMENDATION:

That HRSA develop procedures for local grantees to use in evaluating the effectiveness of qualified outreach and harm reduction/recovery readiness and risk reduction programs.

HRSA RESPONSE:

We concur. HRSA supports evaluation efforts by Title I grantees focused on the effectiveness of all services at the local level including outreach, and can develop procedures for local use and provide technical assistance to facilitate the implementation of quality evaluations. Evaluation activities are not required, however, and must be prioritized at the local level by the Title I HIV Health Services Planning Council as per legislative requirements of Title I.

The DHS is working with the Office of Science and Epidemiology, BHRD, to address this issue, which has been added to the FY 1997 evaluation plan. In FY 1997, DHS will implement a process to establish a protocol for local use, including identification of and consultation with a small group of grantees and providers of outreach services.