Health Resources and Services Administration
HIV/AIDS Bureau

Dear Title I Colleagues:

Enclosed please find the "*Title I CARE Act Program Fiscal Year 2002 Minority AIDS Initiative (MAI): Frequently Asked Questions and Answer Report*" (*MAI Q&A Report*) dated April 4, 2002, which is being distributed to all grantees funded under Title I of the Comprehensive AIDS Resources Emergency (CARE) Act and Title I planning councils. The report provides guidance on how MAI funds are to be used this fiscal year (FY) in reducing disparities in access and health outcomes among disproportionately impacted communities of color. As such, it supplements the FY 2002 Title I Application Guidance issued August 2001, and replaces *MAI Q&A Reports* issued in prior years.

It will be important to review the entire document carefully before preparing your FY 2002 MAI plan. The report is organized in three sections that address: 1) preparing the FY 2002 plan for the use of MAI funds; 2) documenting MAI-funded activities; and 3) Title I MAI reporting requirements.

Grantees are reminded that FY 2002 MAI plans are due Friday, June 14, 2002 and must include the information specified in Q-4 on pages 4-5. Additionally, I would like to call your attention to several important changes in this year's *MAI Q&A Report.*

1. The purpose of the MAI and intent of the Congress in establishing this initiative, has been updated and expanded in the introduction to reflect the most current language contained in the House Appropriations Committee Report that accompanied this year's appropriation (#107-229, dated October 9, 2001).

2. Similarly, Congressional intent is reflected in the guidance provided regarding selection of organizations and agencies to deliver MAI-funded services. (See page 2 of introduction and the response to Question-13.) In disbursing these funds, HAB strongly encourages grantees to establish objective criteria for selecting contractors to deliver MAI-funded services. The Bureau expects grantees to select MAI-funded providers that:

   - Are located in or near to the targeted community they are intending to serve;

   - Have a documented history of providing service to the targeted community(ies) to be served;

   - Have documented linkages to the targeted populations, so that they can help close the gap in access to service for highly impacted communities of color; and

- Provide services in a manner that is culturally and linguistically appropriate.

3. Guidance regarding the use of MAI funds for capacity development has been revised (see Q-11 on pages 8-10). These changes are consistent with guidance provided in a reauthorization letter to grantees dated February 7, 2002 that addressed Title I capacity development activities generally.

Thank you for your continuing efforts to improve access and health outcomes for persons living with HIV disease in disproportionately impacted minority communities. If you have questions about the *MAI Q&A Report* or how to prepare your FY 2002 MAI plan, please contact your Project Officer.

Sincerely,

Douglas H. Morgan, M. P. A.
Division of Service Systems

Enclosures:

Title I CARE Act Program Fiscal Year 2002 Minority AIDS Initiative (MAI): Frequently Asked Questions and Answer Report"

TITLE I CARE ACT PROGRAM

FY 2002 Minority AIDS Initiative: Frequently Asked Questions and Answers Report

April 3, 2002

Introduction

For fiscal year (FY) 2002, the Congress directed $41,800,000 (6.75 percent) of all funds appropriated under Title I of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act to support the Minority AIDS Initiative[1] (MAI). This represents a 23 percent increase over last year. The purpose of this initiative is to reduce disparities in health outcomes in communities of color disproportionately impacted by the HIV epidemic.

This report had been prepared by the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB), Division of Service Systems (DSS) to provide guidance to Title I grantees on how the MAI funds are to be used in FY 2002. As such, it supplements the *FY 2002 Title I Application Guidance* dated August 2001 and replaces *MAI Q&A Reports* issued in prior years. It is organized in three sections that address: 1) preparing the FY 2002 plan for the use of MAI funds; 2) documenting MAI-funded activities; and 3) Title I MAI reporting requirements.

Title I MAI funds are allocated among the 51 eligible metropolitan areas (EMAs) based on the distribution of minority AIDS cases nationwide, using criteria established by the Congress. As in prior years, the funds are intended to improve access to high quality HIV care services and health outcomes for persons living with HIV disease in communities of color, including African Americans, Latinos, Native Americans, Asian Americans, Native Hawaiians and Pacific Islanders. In directing funds for this purpose, the Congressional Appropriations Committee Report that accompanied this year's appropriation noted the disproportionate impact of HIV disease among communities of color as follows.

> *"Department statistics show that racial and ethnic minorities represent the highest number of new AIDS cases. While African-Americans and Hispanics are only 12 percent and 13 percent of the U.S. populations respectively, they account for at least 55 percent and 20 percent of all new AIDS cases. In addition, more than 60 percent of people living with AIDS are racial minorities"*[2]

In explaining why this initiative was established four years ago, the Committee Report states:

> *" It was designed to focus special attention on solving a growing public health problem as well as to develop and improve the capacity of minority community based organizations to more effectively serve their communities. This approach was tailored to yield innovative and successful strategies specifically*

[1] Created in FY 1999 as the Congressional Black Caucus Minority AIDS Initiative; now referred to as the Minority AIDS Initiative.
[2] U.S. House of Representatives Appropriations Committee Report 107-229, October 9, 2001, pg. 36. '*Department*' refers to the U.S. Department of Health and Human Services.

targeted to the highest risk and hardest to service populations, which for the past two decades have eluded more traditional HIV/AIDS prevention, treatment, and education efforts. In distributing these funds, the Committee expects HRSA to tailor the portion of the Ryan White programs that are funded under the Minority AIDS Initiative as tightly as possible in order to address the growing health problem and maximize the participation of minority community-based organizations.[3]"

For Title I specifically, the Committee Report further states that MAI funds:

"…are for competitive, supplemental grants to improve HIV-related health outcomes for communities of color and reduce existing health disparities. Funds should be allocated through the established planning council processes of the Title I eligible metropolitan areas."[4]

In disbursing these funds, HRSA/HAB strongly encourages grantees to establish objective criteria for selecting contractors to deliver MAI-funded services. The Bureau expects that the grantee would select MAI-funded providers that:

- Are located in or near to the targeted community they are intending to serve;
- Have a documented history of providing service to the targeted community(ies) to be served;
- Have documented linkages to the targeted populations, so that they can help close the gap in access to service for highly impacted communities of color; and
- Provide services in a manner that is culturally and linguistically appropriate.

These criteria are consistent with the House Report and the Congressional Committee Report accompanying the MAI funding.[5]

While MAI funds represent a modest portion of each individual Title I award, they emphasize Congressional concern that EMAs need to focus attention on ways to expand and improve upon their efforts to: 1) get persons living with HIV disease in communities of color into care at an earlier stage in their illness; 2) assure access to new treatments consistent with established standards of care; and 3) provide related support services that will help individuals and families remain in care.

The over-arching purpose of the MAI is unchanged since its inception: improving access to HIV/AIDS care and eliminating disparities in health outcomes in communities of color. Desirable health outcomes include a reduction in HIV morbidity and opportunistic disease, increased life expectancy, and reductions in HIV transmission. Following Congressional intent, MAI funds must be used to expand or support new initiatives consistent with these goals. As with all Title I funds, priorities for these funds must be established by the Title I planning council, and may NOT be used to supplant funding from other local, state or federal sources or existing programs.

[3] Ibid, pg. 36.
[4] Ibid, p. 37.
[5] Ibid, pp. 36-37.

Section I:
Preparing and Submitting Required FY 2002 Plan

HRSA expects grantees and planning councils to approach planning for the use of MAI funds with a long-term view. That is, planning for MAI-funded activities should be an integral component of ongoing efforts to improve access to care and health outcomes for all communities disproportionately impacted by the epidemic within a given EMA. MAI-funded activities and services must be part of an overall Title I HIV services plan that is based on documented needs; and MAI-funded services must be an integral component of the Title I continuum of care.

Grantees and planning councils are reminded that the Congress amended Section 2602 (b)(4)(1)B of CARE Act 2000 regarding planning council duties. The new provision directs planning councils to consider *"...capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities*" when determining HIV care needs and establishing priorities for the use of Title I funds. To implement this new provision, planning council priority setting and allocation processes should have been revised during FY 2001 to comply with this requirement. For FY 2002, planning councils are expected to take the new requirement into consideration before finalizing this year's program priorities and allocations. For example, to determine if capacity-building activities are needed in relation to specific services or systems-wide program improvements, in order to achieve overall MAI goals of improving access and reducing disparities.

Q-1 **What is the deadline** for submitting a final FY 2002 plan for use of supplemental Title I funds awarded under the Minority AIDS Initiative (MAI), and supporting documentation?

Answer: As stated in the FY 2002 Conditions-of-Award, the required plan and supporting information must be submitted by 5 p.m. EST on Friday, June 14, 2002. (Note: This deadline provides grantees an additional 30 days this year to prepare their MAI plan.)

Q-2 **Where should we send the required plan and supporting information?**

Answer: Title I grantees should mail their EMAs FY 2002 MAI plan to:

Grants Management Officer
HIV/AIDS Bureau
Room 7-89 Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

Please note the contents on the outside of the envelope: Title I FY 2002 MAI Condition-of-award. As a courtesy, please also provide a copy to your Project Officer, but this is not required.

Q-3 **Is it possible to obtain an extension?**

Answer: No. All grantees must submit the plan with supporting information on or before the due date.

Q-4 What information is required under the FY 2002 MAI Conditions-of-Award?

Answer: The plan for the use of FY 2002 MAI funds must be consistent with the priorities established for their use by the planning council, and must include the following information.

1) **A Summary of the plan describing:**

a. The breakout of all MAI funds to be used in FY 2002, including:
- The amount of MAI funds awarded for FY 2002;
- The amount and percentage of FY 2002 funds allocated for grantee administration;
- Any funds from FY 2001 approved by HRSA for carryover into FY 2002; and
- The total amount of MAI funds available for services/activities in FY 2002;

b. The total amount and percentage of MAI funds (2002 plus any carryover) that have been allocated for each service, as well as:
- The racial/ethnic groups to whom the service will be directed;
- The amount of funds budgeted to deliver the service to each racial/ethnic group; and
- Whether the service category is a new or expanded effort with respect to each racial/ethnic group to be served.

Under separate cover, DSS is providing grantees a summary format with instructions to assist them in preparing this summary of the plan.

2) **A detailed report for each planned service to be provided to each racial/ethnic minority community, describing the following information**. (DSS is providing an FY 2002 report format under separate cover with instructions, to assist grantees in preparing these plans.)

a. The specific service to be provided, using HRSA/HAB approved service categories;

b. The racial/ethnic group to whom the service will be directed;

c. The sub-populations of that racial/ethnic group to whom the service will be targeted, e.g. women, adolescents, injection drug users, the homeless, etc;

d. The planned budget to provide that service/activity to a particular racial/ethnic group, including FY 2002 MAI funds and any MAI carryover approved by HRSA for that use;

e. The service unit definition for that service category;

f. The planned, total number of service units to be provided to that racial/ethnic group;

g. The planned number of women, infants, children or youth to be served, and total un-duplicated number of clients from that racial/ethnic group expected to be served; and

h. The definition of outcome measures to be used to assess the impact of that service.

3) **A narrative (4-5 pages) describing the following information**.

a. How the planning council determined priorities for the use of the MAI funds.

b. How MAI funds will be disbursed by the grantee. This includes how priority will be given to community-based organizations that: have a successful track record serving the racial/ethnic group to whom each service is directed; and are situated close to (easily accessible to) the racial/ethnic group to be served.

c. The grantee's timetable for distributing MAI funds.

d. A description of how outcome measures are/will be implemented for each service category receiving MAI funds.

e. How the grantee will monitor activities supported by these funds during FY 2002.

Q-5 To what extent does HRSA expect the planning council to be involved in determining the priorities, allocations and plan for the use of these MAI supplemental funds?

Answer: MAI supplemental funds awarded under Title I of the CARE Act are subject to the same requirements as "regular" Title I formula and supplemental funds. Therefore, the planning council's mandated roles and responsibilities apply to these funds with respect to priority setting, allocating funds and developing a plan for their use. Planning councils should follow established procedures/processes in determining needs, setting priorities and making allocations, with input from impacted communities and PLWH. Planning councils are reminded that in carrying out their duties, CARE Act 2000 requires them to pay particular attention to:

- Individuals with HIV disease who know their status and are not receiving HIV-related services;
- Disparities in access/services among affected sub-populations and historically underserved communities;
- The size and demographics of populations with HIV disease, and the needs of such populations;
- Demonstrated (or probable) cost-effectiveness of proposed strategies and interventions, to the extent that data are reasonably available;
- Priorities of the communities with HIV disease for whom the services are intended;
- Coordination in the provision of services to such individuals with programs for HIV prevention and for the prevention and treatment of substance abuse, including programs that provide comprehensive treatment for such abuse;
- Availability of other governmental and non-governmental resources, including the state Medicaid program and the State Children's Health Insurance Program, to cover health care costs of eligible individuals and families with HIV disease; and

- Capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities. [Section 2602(b)(4) (A)(B)]

Q-6 Is it HRSA's expectation that EMAs will convene planning councils prior to submitting the required documentation for the use of MAI supplemental funds? (Note: FY references updated.)

Answer: It is HRSA's expectation that planning councils will have already established most if not all priorities for the use of these MAI funds during the EMAs overall FY 2002 planning and priority-setting process. However, since the exact amount of the MAI award to each EMA was unknown in October when FY 2002 Title I plans were submitted, planning councils may need to revisit allocation levels or other aspects of their FY 2002 plan, prior to the distribution of MAI supplemental funds. If they have not already done so, planning councils are strongly encouraged to review identified service needs, planned program priorities and allocation levels, paying particular attention as directed by the Congress to the issues listed in the bullets contained in Q-5 above.

Q-7 Our FY 2002 Title I application already provided a set of service/program objectives intended to improve access to HIV/AIDS primary care for disproportionately impacted communities. This included specific sub-populations (e.g., African-American and Latino youth, women and children, PLWH with substance abuse as a co-morbidity, and persons recently released from prison). Our FY 2002 plan reflects careful planning and priority setting based on documented needs with substantial community in-put. Would a plan to simply expand these efforts be consistent with Congressional intent for the use of MAI supplemental funds?

Answer: As stated in the introduction, HRSA recognizes that many EMAs already focus attention on the special and unmet HIV care needs in communities of color that are disproportionately impacted by HIV/AIDS. Nevertheless, disparities in health outcomes underscore the need to look closely at what is being done as well as what is yet needed to achieve improved access to HIV/AIDS care and eliminate disparities in health outcomes in communities of color. It may require, for example:

- HIV service development and/or capacity development initiatives focused on indigenous minority and other non-profit community based providers who already serve highly impacted minority communities, in order to include and link them into the Title I-funded continuum of care;

- Innovative new approaches to services delivery; or

- Possibly new services, e.g. to ensure client understanding of, and compliance with, new treatments; and/or expansion of existing services within communities of color.

Whether an EMA uses MAI funds to initiate, modify or expand services, EMAs are required to assess their impact in terms of specific, measurable health outcomes.

Q-8 Are MAI supplemental funds subject to the same legislatively mandated funding restrictions and requirements as regular (formula and supplemental) Title I funds? In particular, are MAI funds subject to the 5 percent cap on administrative costs at the grantee level, and the aggregate 10 percent administrative cap on funded entities?

Answer: Yes. Funds awarded under the MAI Initiative are subject to the same restrictions and requirements, as they were allocated under Part A of the CARE Act as part of the total Title I award. While this includes the 5 percent cap on administrative costs at the grantee level, HRSA strongly encourages grantees to allocate all of these funds for services/program, particularly in EMAs receiving $50,000 or less in MAI funds. Restrictions and requirements on the use of Title I funds are described in the *FY 2002 Title I Application Guidance*. These include:

1. Prohibiting supplanting/replacing current State or local funds, and maintenance of their level of expenditures for HIV/AIDS services at a level equal to the preceding fiscal year;

2. Prohibiting their use to purchase or improve land/buildings;

3. Prohibiting their use in making payments to recipients of services;

4. Limiting their use with respect to personnel shortages in institutional/in-patient settings;

5. Requiring recipients of these funds (e.g., service providers, contractors) to participate in a community-based continuum of care, as defined on pages 1 and 2 of the Guidance;

6. Restricting the CEO/grantee to a cost cap of using no more than 5 percent of these funds for administrative purposes;

7. For entities to whom these funds are allocated (e.g., contractors, service providers), the 10 percent aggregate administrative cost cap applies;

8. Services provided with these funds that are also available under the State Medicaid Plan, must be provided directly by the grantee and/or enter into an agreement with a Medicaid participating public or private entity, unless the planning council determines a waiver is warranted because the entity does not impose charges or accept payment for the service(s);

9. These funds must be used as the payer of last resort;

10. If an EMA or entity receiving these funds charges for services, it must do so on the basis of a sliding scale fee as specified by the CARE Act;

11. The requirement regarding allocation of an aggregate, proportionate amount of Title I funds for services to infants, children and women, includes the MAI supplemental funds;

12. HRSA requirements with respect to unobligated funds; and

13. Funds must be used consistent with current and any future program DSS/HAB policies.

Q-9 Should EMAs that cover multiple jurisdictions distribute MAI funds proportionally among the jurisdictions based on the percentage of living HIV/AIDS cases among disproportionately impacted communities of color within each jurisdiction; or, should MAI funds be targeted to particular jurisdiction(s) that have the greatest disparities among communities of color?

Answer: The purpose of MAI funds is to improve access to services for racial/ethnic minorities that are disproportionately impacted by the HIV/AIDS epidemic within each EMA. The Congressional Report accompanying this year's appropriation states that: "*These funds are for activities that are designed to address the trends of the HIV/AIDS epidemic in communities of color based on the most recent estimated living AIDS cases, HIV infections and AIDS mortality among ethnic and racial minorities as reported by the Centers for Disease Control and Prevention*[6]." For Title I MAI activities specifically, the Committee Report further states that these funds *"…are for competitive, supplemental grants to improve HIV-related health outcomes for communities of color and reduce existing health disparities. Funds should be allocated through the established planning council processes of the Title I eligible metropolitan areas.*[7]*"*

To the extent that there may be more unmet critical service needs in certain jurisdictions or geographic areas than in other jurisdictions/areas, planning councils should prioritize and allocate MAI supplemental funds in a targeted manner to reach disproportionately impacted communities of color. HRSA strongly encourages EMAs to focus efforts as much as possible on identified high need communities of color. (Note: This answer was revised to incorporate language from this year's House Appropriations Committee Report.)

Q-10 Has HRSA established service priorities for the use of MAI funds?

Answer: No, because the CARE Act mandates that local planning councils are responsible for establishing priorities for the use of all Title I funds—which includes MAI funds. However, pursuant to the Congress directing a portion of Title I funds for the MAI Initiative, these funds must be: a) prioritized for services targeting disproportionately impacted communities of color, and b) designed to improve access to care and reduce health outcomes disparities among people of color living with HIV/AIDS. Plans for the use of MAI funds that DO NOT meet these mandated requirements, will not be approved.

HRSA will continue to closely monitor implementation of the MAI Initiative and assess the need for future direction and technical assistance. In doing so, HRSA will work collaboratively with grantees, other CARE Act and HRSA programs, the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Agency (SAMHSA), the Office of Minority Health (OMH), and representatives of national organizations and people living with HIV/AIDS.

Q-11 Can capacity development activities be supported using MAI supplemental funds? (Note: this was previously Q-12. The answer below was revised this year to reflect the: (1) House Appropriations Committee Report language, and (2) content of HAB/DSS reauthorization letter dated February 7, 2002 that addressed Title I capacity development activities.)

Answer: Yes. The MAI Initiative is aimed at encouraging EMAs to fund easily accessible and culturally and linguistically competent community-based care services that will lead to improved health outcomes. The Committee Report that accompanied the FY 2002 Title I appropriation states that:

[6] Ibid, p. 36.
[7] Ibid, p. 37.

"These funds are expected to improve and develop the capacity of these organizations to deliver HIV-related treatment and supportive services within communities of color, that are both culturally and linguistically appropriate to individuals living with HIV/AIDS."[8]

As discussed in Q-5, CARE Act 2000 mandates that planning councils to pay particular attention to the "*capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities*[9]*"* in carrying out their duties related to determining needs and establishing priorities for the use of Title I funds. (This includes determining needs related to persons who know their HIV status and are not in care, and disparities in access and services among affected subpopulations and historically underserved communities.) Moreover, it should also be pointed out that since 1992, HRSA has approved the use of Title I funds on a limited basis for service-oriented capacity development activities that are not in and of themselves a specific service, nor administrative in nature.

Capacity development activities were recently defined by HAB/DSS in a letter to grantees dated February 7, 2002 as follows:

> *"DSS defines capacity development as activities that increase core competencies that substantially contribute to an organization's ability to deliver effective HIV/AIDS primary medical care and health-related support services. Capacity development should increase access to the HIV/AIDS service system and reduce disparities in care among underserved PLWH in the EMA. In accomplishing this goal, EMAs must ensure the quantity, quality and cost effectiveness of primary medical care, and the ability of an organization receiving capacity development funding to sustain the resource base necessary to support these specific competencies. Core competencies among Title I service providers for which capacity development activities may be appropriate include:*
>
> - *Conducting effective HIV/AIDS clinical service delivery;*
> - *Management of program finances*
> - *Developing and implementing quality assurance and continuous quality improvement programs;*
> - *Managing personnel*
> - *Developing governing boards;*
> - *Purchasing medical supplies and equipment;*
> - *Improving service provider ability to administer subcontracts for services;*
> - *Conducting service evaluations; and*
> - *Developing culturally appropriate services.*

Other examples of capacity development activities that may be appropriate for MAI-funded providers:

- Training to improve staff expertise with respect to client HIV care and treatment needs;
- Help with planning and/or service delivery design improvements; and
- Activities to improve a provider's capacity to document, manage, use and report information tracking client demographics, service utilization and/or client-level health outcomes.

[8] Ibid, p. 37.
[9] Section 2602(b)(4)(B)(vi)

Grantees are reminded that all Title I funded capacity development activities should be targeted to service providers that are located in or near the community(ies) to be served with a history of serving the community(ies) where the planning council has identified access or service disparities. Additionally, capacity development activities must contribute to meeting specific service needs identified by the planning council, based on a needs assessment process that analyzed access and service disparities among populations highly impacted by HIV disease, especially those who know they are HIV positive but are not receiving appropriate treatment. Please refer to the letter referenced above for specific guidance on minimum requirements for determining the need for capacity development within an EMA.

As in prior years, MAI funds allocated for capacity development must be clearly linked to a specific service(s) and/or a clearly defined systems-wide initiative, with clear, measurable and time-specific objectives that can be linked to improved client health outcomes. **Planning council and grantee are reminded that the implementation plan for the use of MAI funds will be carefully reviewed and must be approved by HRSA. Proposed capacity development activities must at a minimum be:**

1) Consistent with HRSA grants and program policies (e.g., MAI funds may not be used for health care system infrastructure development and capital improvements or major equipment purchases);

2) Established by the planning council based on documented need(s); and

3) Accompanied by an implementation plan that meets HRSA's guidelines.

Q-12 May MAI funds be used to support quality management activities? (Previously Q-13)

Answer: No. Title I funds awarded under the MAI Initiative are not intended for such activities.

Q-13 Must MAI funds be awarded to minority community based organizations? (Note: Previously Q-14, the answer has been revised this year.)

Answer: The intent of Congress is to expand access to HIV/AIDS care services and reduce disparities in health outcomes among disproportionately impacted communities. Although there is no requirement that funds be awarded to minority community-based organizations, in order to maximize accessibility of services and improve client retention in care it is HRSA's expectation that in evaluating organizations or agencies seeking MAI funding, grantees will select providers that:

- Are located in or near to the targeted community they are intending to serve;
- Have a documented history of providing service to the targeted community(ies) to be served;
- Have documented linkages to the targeted populations, so that they can help close the gap in access to service for highly impacted communities of color; and
- Provide services in a manner that is culturally and linguistically appropriate.[10]

Grantees are also encouraged to review the "*National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care*"[11] report published in December 2000, which may be

[10] Ibid, pp. 36-37.

accessed online at http://www.omhrc.gov/CLAS/frclas2.htm.) The report includes definitions of terms such as "culture" and "cultural and linguistic competence," as well as standards to assist federal agencies and their grantees in assuring that health care services are delivered in a manner that is culturally and linguistically appropriate.

Q-14 Should a community-based provider have a history of delivering services to each targeted community of color, if more than one racial/ethnic group is to receive a particular service? (Previously Q-15; the answer was revised to be consistent with Q-13 above.)

Answer: Yes. However, if the grantee determines that there is no existing community-based provider with a successful track record of delivering services to a particular population or sub-population within a community of color, it may be appropriate to fund a capacity-development initiative designed to expand the capability of one or more existing providers to meet the special needs of the targeted population(s).

Q-15 Can any MAI dollars be used on the evaluation of improved health outcomes? (Previously Q-17)

Answer: MAI funding is aimed at encouraging EMAs to support services and activities that will lead to improved health outcomes. To the extent that the planning council determines it is important to evaluate MAI funded activities to assess their effectiveness in achieving improved health outcomes, this is allowable. **However, HRSA strongly encourages EMAs to utilize other Title I funds for this purpose rather than to allocate any of the MAI supplemental funds for this purpose**. **Grantees are reminded that CARE Act 2000 allows grantees to allocate up to five percent of Title I funds for quality management purposes.** (Please refer to the *FY 2002 Title I Application Guidance* regarding the use Title I funds for quality management, evaluation or other program support purposes.)

Q-16 What expectations does HRSA have regarding coordination between providers funded under the MAI Initiative and other CARE Act funded providers, including Titles II, III, IV, and SPNS? (Previously Q-18)

Answer: HRSA has the same expectations for providers funded under the MAI Initiative as for providers who receive other Title I funds, whether MAI funded services/activities are new or an expansion of existing efforts. HRSA believes that effective coordination across CARE Act providers is essential in order to maximize resources, improve access to care, and avoid duplication of effort.

[11] Prepared by the DHHS Office of the Secretary, Office of Public Health and Science, Office of Minority Health and published in the Federal Register December 22, 2000 (Volume 65, Number 247, pages 80865-80879.

Section II:
Documenting Proposed Activities/Services

Q-17. If EMAs provide justification for allocating MAI supplemental funds to more than one community, is it HRSA's expectation that they then monitor health outcomes for each community served (e.g., Latinos, African Americans and Asian Americans)? (Previously Q-19)

Answer: Yes. Grantees must monitor and report outcomes separately for each population receiving a given service funded wholly or in part with Title I MAI supplemental funds. Please refer to the FY 2002 Title I MAI reporting guidelines and instructions provided by HAB/DSS in a separate report.

Q-18 Should the outcome measures selected for MAI-funded services differ from those used by the grantee for the same service(s) addressing the needs of other populations? Are process measures okay in lieu of outcome measures? (Previously Q-20)

Answer: Outcome measures for services funded under the MAI Initiative will often be the same as those used to document improved health outcomes for other populations receiving the same service. **Grantees must be able to establish baseline data or measurements in order to track/document improvements in health status due to MAI funds, and must utilize outcome measures in order to assess the impact of MAI funds on the target population**. Process measures are not permitted as a substitute for outcome measures. However, they may be used to provide additional information on how provider staff, services or client characteristics, for example, might influence health outcomes.

Q-19 What is HRSA's guidance for outcome measures to assess impacts of MAI funded services? (Previously Q-21; revised to reflect most recent technical assistance resources.)

Answer: HRSA has and will continue to provide technical assistance on the development of outcomes and outcome indicators (measures) directly to grantees requesting assistance. HAB has published three *Outcomes Evaluation Technical Assistance Guides: Getting Started* (1999), *Case Management Outcomes* (2001) and *"Primary Medical Care Outcomes* (2001). HAB distributed them to all CARE Act grantees and trained a cadre of consultants in their use. Copies may be accessed from the HRSA/HAB website at: http://hab.hrsa.gov/tools/outcomeguides.htm. Also, the Office of Science and Evaluation (OSE), HAB has published *"A Practical Guide to Evaluation and Evaluation Terms for Ryan White CARE Act Grantees* (1999) and *An Approach to Evaluating HARRT Utilization Outcomes in CARE Act Funded Clinics "*(2000) as part of their HIV/AIDS Evaluation Monograph Series. These resources may be ordered from the HRSA Information Center, either on-line at www.hrsa.gov/instructions.cfm or by calling toll-free at: 888-ASK HRSA (275-4772).

EMAs are reminded that the HIV/AIDS outcomes for MAI funded initiatives should be consistent with the core program evaluation questions identified by HRSA for CARE Act programs. That is, to the extent the program is:

- Enrolling underserved and vulnerable populations in clinical care;
- Providing care that meets the current standards of care;
- Providing services that remove barriers to care; and
- Reducing morbidity and mortality.

For the purpose of evaluating CARE Act programs, outcomes are defined as benefits or other results positive or negative) for clients that may occur during or after program participation. Outcomes can be classified as initial, intermediate, and longer-term based on how soon they occur after program participation begins.

Outcome indicators are observable, measurable data sets – such as changes in CD_4 counts or non-injury related emergency room visits over time – that are used to track a program's success in reaching desired outcomes. For specific examples, please see the *Outcomes Evaluation Technical Assistance Guides* referenced on the previous page. To receive technical assistance in this area, please contact your Project Officer.

Q-21 Does HRSA expect grantees to track outcome indicators for other, non-MAI funded services that the target population accesses under Title I? (Previously Q-22)

Answer: HRSA has emphasized the importance of documenting the impact of ALL Title I funds since the CARE Act was reauthorized in 1996, starting with the FY *1997 Title I Application Guidance* and continuing since then. For example, HRSA directed EMAs in the *FY 1998 Guidance* to describe their plan and process(es) for developing and implementing outcome measures, beginning at a minimum with outpatient primary medical care. A year later, grantees were required to identify at least two additional service categories for which outcome measures had been or would be developed and implemented during FY 1999. Since then, HRSA has continued to work with grantees and evaluation experts to provide technical assistance.

While EMAs are not expected to be able to document and report client level outcomes for each and every Title I service, they are expected to:

a) have established outcome measures for primary medical care and two additional services at a minimum, including those serving communities of color;

b) have implemented their plans for documenting and reporting client level outcomes for all Title I MAI-funded services, as FY 2000; and

c) be well on the way to implementing a plan to document and report outcomes for other key services funded under Title I, as part of their overall assessment of the impact of Title I funding in the EMA.

Section III:

Reporting to HRSA on MAI Activities

As in the past, grantees must report the EMA's accomplishments with regard to overall program efforts to improve access to care and health outcomes for disproportionately impacted communities, as well as to report the specific impact(s) of MAI-funded services/activities. This information must be submitted as part of the mid-year progress report due October 1, 2002 and the year-end annual report, due June 1, 2003; and these reports must document expenditures, service utilization, clients served and outcomes for each MAI-funded service targeting each racial/ethnic group.

Q-21 Can providers receiving MAI funds track and report the number of clients they serve on a proportionate basis, if the funded service also is supported with other local, state or CARE Act funds, e.g., on the CARE Act Data Report (CADR) that is submitted to HRSA? That is, if MAI funds account for 20% of total funding used to provide medical care by a provider, can we assume that 20% of the patients receiving those services for that year, accessed the service as a result of those MAI funds; and will HRSA accept that approach as adequate in documenting the quantitative impact of MAI funding with respect to services utilization? [Previously Q-23; revised to reflect new CADR instead of Annual Administrative Report (AAR).]

Answer: In general, HRSA's CADR is a provider-based report, although some grantees have implemented client-level reporting. Therefore, the CADR cannot adequately track clients served as a result of MAI funding, if the service has multiple funding sources.

As in the past, grantees must be able to identify specific objectives, the health outcomes to be achieved, and number and demographics of persons of color projected to be served during FY 2002 (please refer to the MAI Report Format). If the EMA decides to fund an existing contractor to provide new or expanded services to one or more communities of color, it may do so. However, the contractor must be able to demonstrate sufficient reporting capabilities for tracking, documenting and reporting required client and outcomes information that is needed to assess the impact of MAI funds on the target population(s). HRSA will provide a *FY 2002 MAI Report Format* with instructions as in prior years in April 2002, for grantees to use reporting MAI-related expenditure, client and outcomes data as part of their Program Progress Reports.

Q-22 Must the grantee also report on MAI funds with respect to other information submitted to HRSA required in other Conditions-of-Award, (e.g., with respect to final allocations, contractor budgets, progress reports, etc.)? (Previously Q-24)

Answer: Yes. These funds are subject to all conditions and their respective due dates as stated on the FY 2002 COA. These conditions are attached to facilitate easy reference to them.

Q-23 Are there any other conditions-of-award that apply to these MAI supplemental funds?

Answer: Yes, Condition F applies specifically to MAI supplemental funds. In addition, Condition C.3 regarding the submission of a revised FY 2002 Title I Implementation Plan directs that this report include MAI funds, which must be clearly identified. (Previously Q-25)