September 15, 2006

# Assessing the Success of Title III Planning Grant Recipients

## Final Report

Prepared for

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## EXECUTIVE SUMMARY

The Ryan White CARE Act, enacted by Congress in 1990 and most recently reauthorized in 2000, provides funding to states, eligible metropolitan areas (EMAs), and other public or private nonprofit entities to plan, coordinate, and provide HIV/AIDS treatment, care, and support services to medically underserved individuals and families affected by the disease. The Title III Early Intervention Services (EIS) component of the CARE Act was created in 1990 to fund directly comprehensive primary health care clinics serving individuals and families affected by HIV/AIDS in rural or urban underserved areas and minority communities. Title III includes a Planning Grant program that provides funds to eligible entities to support their efforts to plan for the provision of high quality, comprehensive HIV primary health care services.

Typical Planning Grant activities include but are not limited to

- identifying key stakeholders and engaging and coordinating potential partners in the planning process;
- gathering a formal advisory group to plan for the establishment of services;
- conducting an in-depth review of the nature and extent of the need for HIV primary care services in the community—including a local epidemiological profile, an evaluation of the community's service provider capacity, and a profile of the target population(s);
- defining the components of care and forming essential programmatic linkages with related providers in the community; and
- researching funding sources and applying for operational grants.

The HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration (HRSA) contracted with RTI International (RTI) to assess the success of the Title III Planning Grant program. The purpose of this evaluation was to (1) determine the effectiveness of the Title III Planning Grant program under the CARE Act, (2) identify the primary organizational and community-level determinants of Planning Grant recipient performance, and (3) assess the longer-term impact of the Planning Grants on the expansion and improvement of quality primary health care and supportive services to low-income and uninsured people living with HIV and AIDS.

Of the 136 Planning Grant recipients funded in 2001-2003, slightly less than half (43 %) received EIS grants to establish or expand primary care services after implementation of their Planning Grants. Large organizations such as hospital or university clinics were most successful in receiving subsequent EIS grants after completing their Planning Grants, followed by publicly

funded community health centers and health departments. None of the coordinated care networks, hemophilia centers, or community and mental health centers that had Planning Grants in 2001-2003 received subsequent EIS awards. Surprisingly, a large proportion of Planning Grant recipients were already providing primary care services at the time of application for the Planning Grant, some of which were supported by funds through one of the CARE Act titles.

The findings in this report are based on key informant interviews with representatives from 25 grantee organizations. The goal of the key informant interviews was to obtain in-depth information that would enable cross-case analysis of factors associated with successful grantee outcomes and the impact on the communities they serve. Planning Grant recipients were assigned to one of two categories: those that subsequently applied for and received a new or expansion Title III EIS Grant (Stratum I, eight completed interviews) and those that did not receive a Title III EIS Grant (Stratum II, eight completed interviews), regardless of their EIS application history. A sample of organizations that received Title III EIS Grants without having received prior Planning Grants (Stratum III, nine completed interviews) was used as a comparison group for assessing the impact of the Planning Grant on the subsequent delivery of HIV/AIDS care services.

The most common activities performed under the Planning Grant program were (1) assessing community needs, (2) establishing advisory boards, (3) forming linkages with other community service providers, (4) evaluating existing resource capacity, and (5) investigating alternative funding opportunities. Secondary activities included developing a comprehensive care plan, strengthening technological infrastructure, and training staff and clients. All but one of the 16 Planning Grant recipients interviewed for this study reported that their organizations successfully accomplished their initial objectives and stated that the supplemental funding was critical to their being able to undertake meaningful planning activities in preparation for the delivery of new or expanded services. The one unsuccessful grantee attributed its failure to staff turnover and lack of program leadership.

In most cases, the Planning Grants were used to strengthen or augment existing activities rather than to create completely new capabilities. Most grantees reported that they already had some experience in forming advisory boards and conducting needs assessments prior to the Planning Grant. Planning Grant recipients with continued EIS funding also described having established linkages with other organizations. According to the informants, the Planning Grant helped them strengthen existing collaborations and establish effective referral systems. Providers located in rural communities with few local partners experienced the greatest challenges in forming linkages with other organizations.

In addition to planning activities, several Planning Grant recipients indicated that the program helped them improve their internal organizational capacity and implement key operational changes. Several grantees that subsequently received EIS grants reported that the Planning Grants helped them write effective EIS applications, establish service delivery programs, and identify and respond to unmet needs. A number of these grantees reported specific improvements related to their primary care delivery services, including increased capacity and ability to serve larger patient populations; extended services in evenings, weekends, and on a walk-in basis; bilingual providers and culturally-appropriate services; and the establishment of new services such as dental clinics.

The results of the study also suggest that the Planning Grant program had a positive long-term impact on the delivery of services for those grantees that received subsequent Title III EIS Grants. These grantees appeared to initiate HIV primary care services and implement the activities necessary to deliver HIV/AIDS care faster and with fewer difficulties than those without prior Planning Grants. Title III EIS grantees with prior Planning Grants also reported attaining full staffing more quickly than those without Planning Grants. Further, EIS grantees that had prior Planning Grants reported fewer challenges and time delays in formalizing contracts, memoranda of understanding, and affiliation agreements with partner sites.

The study found that the Planning Grant program had a beneficial impact on those grantees that did not receive subsequent EIS grants as well. At least half of the grantees that did not receive subsequent EIS funding reported providing services similar to those that received such funds. Most of these grantees continued to provide the broad range of HIV primary care services eligible under Title III. At least half of the non-funded Planning Grant recipients continued to maintain established partnerships and advisory boards and provide referrals to established partners. At least three out of the eight interviewed grantees from this group successfully obtained external non-CARE funds to support their HIV service activities. Finally, several recipients reported that the activities they conducted under the Planning Grants made them realize either that the demand for services was already being met by available providers or that efficiencies could be realized if they partnered as a subcontracted provider with another Title III grantee.

RTI recommendations for strengthening the Planning Grant program fall under four categories. First, given the limited amount of resources available under the Planning Grant program, HRSA should consider strengthening the set of internal guidelines that target program funds on the specific types of grantees and activities that offer the greatest potential for ultimately augmenting or improving the delivery of care. Issues related to the targeting of and

eligibility for Planning Grant funds should be developed through internal discussion among Title III program staff, but factors to consider include (1) prior experience in delivering HIV primary care, (2) types of services to be offered, (3) a focus on underserved regions or populations, and (4) types of planning activities to be covered.

Second, the Planning Grant program should be viewed as part of a comprehensive "package" of funding resources that can be used together to build synergies and lead to more effective delivery of care. Given the purpose of the Planning Grant program, it might seem reasonable that program funds would be viewed as a first step in the process of developing care delivery systems, prior to the receipt of funds for the delivery of services under other CARE Act titles. Subsequent receipt of new funds for the delivery of new or expanded services may be made conditional on the successful completion of the selected Planning Grant activities, including needs assessments, advisory boards, and partnering arrangements. A 'sequencing' of funds assumes that additional monies will be available for new or expanded service delivery grants. In fact, HAB should attempt to make explicit in the Planning Grant guidance the link between successful completion of planning and award of service delivery grants. Keeping grantees informed about the likelihood of funding would help manage grantee expectations and the allocation of efforts to develop EIS proposals. If HAB cannot commit to a subsequent funding of service delivery programs (conditional on completion of activities and demonstration of need), then Planning Grant funds should be restricted to current service providers.

Third, HAB may wish to develop more specific guidance and tools that grantees can use to better assess their planning needs, identify their planning objectives, and determine their eligibility for funding under the Planning Grant program. The program guidance might include a list of the types of core planning activities eligible for funding and the steps required for subsequent receipt of a service delivery award, such as the successful completion of a needs assessment with a clear demonstration of unmet need, the creation of an active and effective advisory board with provider and consumer representation, the development of a budget and financial plan identifying external sources of funds, and the establishment of complementary or mentoring relationships with other providers. The program guidance could also offer specific recommendations for implementing each of these activities.

Finally, HAB should consider ways to help disseminate best practices and common challenges under the Planning Grant program. Since many of the awardees are new to the CARE Act and may have no or limited experience in providing primary care services to people with HIV and AIDS, grantees would benefit from increased opportunities for networking with other grantees, especially those successfully delivering Title III EIS Grants. Such opportunities could

be embedded in the national meeting structure or set up as a mentoring program between individual organizations that share similar community and organizational characteristics. Moreover, sharing innovations and successful solutions that address encountered challenges (e.g., obtaining advisory board commitment and participation, establishing dental and oral health services, meeting the needs of multilingual populations, addressing stigma issues) would help to overcome similar barriers faced by others. For the same reason, Planning Grant recipients would also likely benefit from greater technical assistance from HAB program staff. Given that one of the main purposes of the Planning Grant program is to help support the development of qualified HIV health care providers in underserved areas, HAB may need to monitor it more closely and provide more targeted technical assistance than is traditionally given to established programs.

# CHAPTER 1
# BACKGROUND

## 1.1 History and Purpose of Title III and IV Planning Grant Programs

The Ryan White CARE Act (hereafter referred to as the CARE Act), enacted by Congress in 1990 and most recently reauthorized in 2000, provides funding to states, eligible metropolitan areas, and public or private nonprofit entities to plan, coordinate, and provide HIV/AIDS treatment, care, and support services to medically underserved individuals and families affected by HIV/AIDS. The CARE Act is made up of five primary sections, Titles I–IV and Part F, each designating a specific type of grantee, type or range of service(s) or intervention, and/or client population or subpopulation.

The Title III Early Intervention Services (EIS) Program was created in 1990 to fund comprehensive primary health care for individuals living with HIV/AIDS in rural or urban underserved areas and minority communities. Provided services include primary care and clinical interventions through medical, educational, and psychosocial services. The Title IV Women, Infants, Children & Youth Program was implemented in 1988 as the Pediatric AIDS Demonstration Program and expanded under the CARE Act in 1994 to create better links between medical and support services. Title IV is intended to provide primary health care and support services for children, adolescents, women, and families living with or affected by HIV/AIDS.

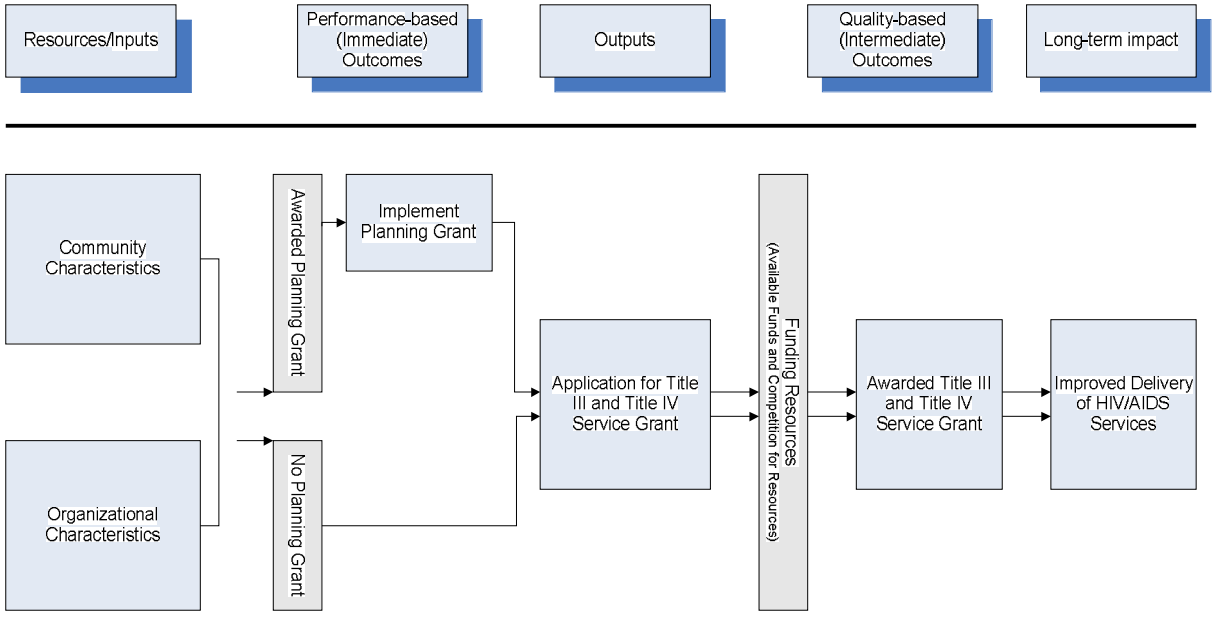
Titles III and IV both offer a supplementary Planning Grant program that provides funds to eligible entities to support their efforts to plan for the provision of high quality, comprehensive HIV primary health care services in underserved rural or urban areas and communities of color. Funded planning activities include (1) identifying stakeholders; (2) gathering a formal advisory group; (3) conducting a formal assessment of the need for HIV primary care services in the community; (4) establishing links with providers in the area; and (5) identifying funding sources. Planning Grant funds are intended for a period of one year and may not be used to support service delivery or patient care directly. The ultimate goal of a Planning Grant is to prepare the grantee to receive an EIS grant. Between 1996 and 2003, the Health Resources and Services Administration (HRSA) awarded more than 350 Planning Grants under this program. Eligible applicants must be public or private nonprofit entities that are or intend to become comprehensive HIV primary care providers. Current Title III and IV Planning Grant recipients are eligible for continued funding if they are proposing to implement an expansion program.

## 1.2 Conceptual Approach

HRSA's HIV/AIDS Bureau (HAB) contracted with RTI International (RTI) to assess the success of the Title III and IV Planning Grant programs. Because there were insufficient Title IV Planning Grant recipients in the evaluation's program years, the evaluation was amended to cover only Title III Planning Grants. The purpose of the overall evaluation is to (1) determine the effectiveness of the Title III Planning Grant programs under the CARE Act, (2) identify the primary organizational and community-level determinants of Planning Grant recipient performance, and (3) assess the longer-term impact of the Planning Grants on the expansion and improvement of quality primary health care and supportive services to low-income and uninsured people living with HIV and AIDS.

The conceptual approach used for evaluating the Title III Planning Grant program is illustrated graphically in Exhibit 1. The first step of the conceptual model is to identify the "resources" or "inputs" into the program. Such inputs are based on the characteristics of the grant, the grantee organization, and the community. They include such factors as the size, type, year, and goal of the grant; the size, structure and experience of the grantee; and the size, location and sociodemographic characteristics of the client community. The model inputs influence the subsequent performance-based (immediate) and quality-based (intermediate) outcomes.

**Exhibit 1. Conceptual Approach**



*Performance-based outcomes* assess grantee success in accomplishing immediate Planning Grant goals. Such outcomes include the ability of grant recipients to engage key stakeholders, form advisory groups, conduct needs assessments, define components of care, and pursue funding sources, in addition to performance on other originally proposed activities. The ultimate performance outcome is the ability of Planning Grant recipients to apply for and obtain service delivery awards.

*Quality-based outcomes* demonstrate the impact that successful accomplishment of Planning Grant goals had on grantees' actual or potential delivery of services to people living with HIV/AIDS. Quality outcome variables include the number of clients receiving HIV care; the number of clients receiving pretest counseling, the number of clients tested, the proportion of clients who returned for results, and the proportion of clients testing positive who entered into regular care; and the average number of outpatient visits. Quality outcomes might also include organizational measures, such as changes in staffing, partnering arrangements with other providers or associations, contracting agreements with subcontracted providers, new or expanded operating procedures and policies, and other factors that lead to improvements in operating efficiency.

As shown in a recent evaluation of the per capita costs of Title III EIS grant recipients, performance-based and quality-based outcomes are likely to be influenced by the characteristics of the grant, the organization, and the community in which they operate[1]. For example, the per capita Title III EIS cost study revealed that larger grant recipients and those affiliated with parent health care provider organizations achieve greater operational efficiencies than smaller, independent community-based organizations. Similarly, Title III EIS grant recipients concentrating on primary medical care and those serving larger proportions of non- minority clients also have higher per capita costs than those focusing on other types of medical care or social services and those treating larger proportions of minority clients. These program, client, and community characteristics are likely to affect the performance and outcomes of the Planning Grant program as well.

### 1.3 Study Objectives and Research Questions

The evaluation had five principal objectives, with a range of research questions related to each objective. Each of these objectives is presented in Exhibit 2 with its associated research questions.

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[1] Gilman, B., Green, J., Brown, P., Aldridge, S., Crespin, D. Understanding Variations in Per Capita Costs among Title III Early Intervention Services (EIS) Grant Recipients. Final Report. Submitted to HRSA HIV/AIDS Bureau April 2006. HRSA contract No. 250-01-008.

**Exhibit 2. Study Objectives and Research Questions**

| Objective | Research Question |
|---|---|
| **Objective 1: Determine whether Planning Grant recipients were successful in meeting the terms of their Planning Grants (immediate outcomes and outputs).** | • How well did grantees meet the proposed Planning Grant goals?<br>• How did activities reported at the end of the grant period compare to those that were originally proposed?<br>• Were grantees successful in establishing formal advisory groups to plan the establishment of services?<br>• Did grantees successfully complete needs assessments for HIV primary care services in the community (including epidemiological profiles), evaluations of the community's existing provider population, and profiles of the target population?<br>• Did grantees form appropriate linkages with other community service providers?<br>• Did grantees investigate other sources of funding? How successful were they in applying for operational funds? |
| **Objective 2: Determine whether organizations that received Planning Grants were successful in receiving Title III service delivery grants (intermediate outcomes).** | • What proportion of 2001–2003 Planning Grant recipients received Title III or IV service grants? How soon after the end of their Planning Grants did they obtain such funds?<br>• Did partnerships with primary care providers change?<br>• Was the number of HIV cases sufficient to sustain the delivery of services?<br>• How many of the Planning Grant recipients that did not receive EIS Grants found other, possibly more suitable, funding sources for delivery of HIV/AIDS services? |
| **Objective 3: Determine if participating in the Planning Grant process led to improved performance among organizations awarded Title III service delivery grants (long-term impact).** | • How many clients received pretest counseling at each site?<br>• How many clients were tested for HIV?<br>• How many clients who tested positive returned for results?<br>• What proportion of clients who received positive test results entered into regular care (defined as at least one outpatient visit per year)?<br>• How many clients met the U.S. Public Health Service (PHS) standard of four outpatient visits per year?<br>• How quickly were the grantees able to achieve full staffing?<br>• How successful and timely were grantees in formalizing contracts, memoranda of understanding, and affiliation agreements with partner sites?<br>• How successfully and quickly did grantees develop operating procedures and policies?<br>• How well were grantees able to meet Title III program expectations and requirements?<br>• Did the grantees involve consumers in developing and/or advising their programs on an ongoing basis?<br>• How many clients did the organizations enroll in HIV care in each year in which they received Title III funds?<br>• Were grant application scores predictive of grantee performance?<br>• Where there other CARE Act-supported services in grantee communities, and was the presence of such services associated with improved grantee performance? |

(continued)

**Exhibit 2. Study Objectives and Research Questions (continued)**

| Objective | Research Question |
|---|---|
| **Objective 4: Identify the organizational characteristics of Planning Grant recipients and assess the impact of these characteristics on grantee performance.** | § To address this objective, we ascertained characteristics such as type of facility, experience in providing HIV care, annual operating budget, and client characteristics, and we compared them to grantee performance measures as determined under Objectives 1 and 3. |
| **Objective 5: Identify the community characteristics of Planning Grant recipients and assess the impact of these characteristics on grantee performance.** | § To address this objective, we ascertained characteristics such community size, location (urban vs. rural), and presence of other Title III or IV programs in the same metropolitan area as they related to grantee performance measures as determined under Objectives 1 and 3. |

## 1.4 Limitations of Study

This evaluation faced several limitations. First, the majority of Planning Grant recipients had simultaneous or prior funding for Capacity Building and or service delivery under Titles I, II, III and IV. Concurrent funding mechanisms make it difficult to attribute outcomes to the Planning Grant program. The second limitation relates to the lag between implementation and evaluation. Most grantees had difficulty recalling the impact of a $50,000 grant that was awarded three to five years ago, as well as other critical information such as their proposed goals. Further, staff turnover and loss of organizational memory limited our ability to assess performance and outcomes. Third, we were unable to obtain complete information on: (1) the number of Planning Grantees that applied for EIS Grants but were not funded and (2) the scores and information about the quality of the EIS Grant applications. This information would have helped us to better understand Planning Grant performance, including success in obtaining EIS grants. Finally, a thorough evaluation of the impact of the Planning Grant program on care delivery exceeds the scope of work funded under this contract. The impact analysis conducted under this contract relies on qualitative responses from interviews with key informants and limited service utilization data provided by participant organizations. A more comprehensive analysis would require a longer post-award period of performance and a comparison group of non-Planning Grant recipients who received a Title III EIS award *for the first time* during the period of evaluation.

## 1.5 Overview of Study Design

To meet the objectives of this evaluation, we engaged in two phases of data collection and analysis. Phase I consisted of reviewing existing data sources. Phase II involved interviewing key informants selected from existing pool of Planning Grant recipients. During Phase I, we identified all Title III EIS Grant recipients that were also awarded Planning Grants between 2001 and 2003 from electronically available data sources at HAB and performed a set of descriptive analyses on these awardees. As part of the Phase II process, we conducted key informant interviews with a subsample of 25 Planning Grant recipients to obtain information on factors relevant to the success of the Planning Grant activities and outcomes. This two-phased strategy allowed us to capture the wide range of factors associated with successful grantee outcomes. Both tasks incorporated an assessment of the immediate and longer-term outcomes, as well as an evaluation of the mitigating effects of grant-, organization-, and community-based characteristics.

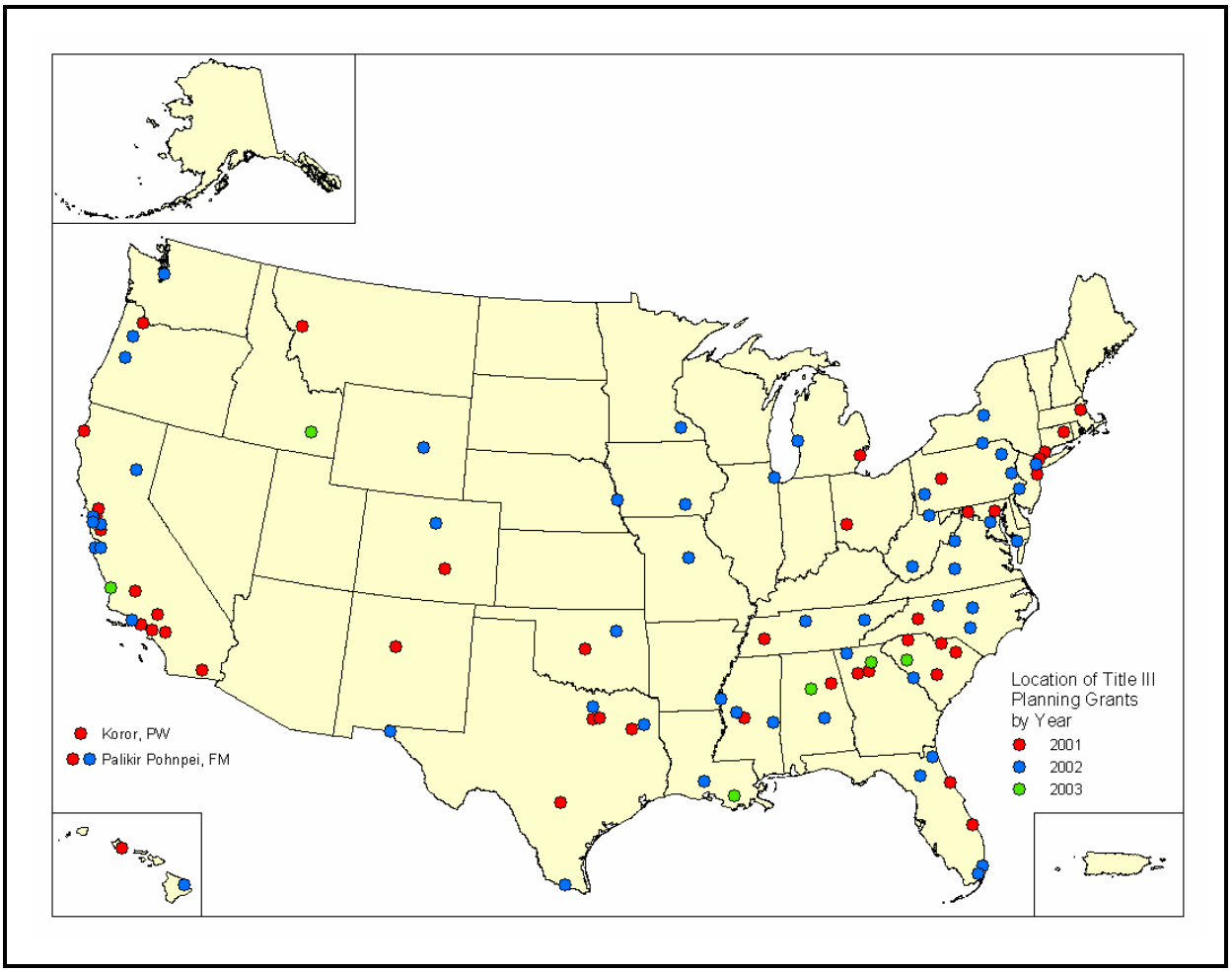
## CHAPTER 2
## PHASE I: GRANTEE PROFILE

This section presents the distribution of Title III Planning Grant recipients by year of award, type of organization, populations served, and graduation to Title III EIS Grants. This report excludes recipients who were actively funded in 2001 but whose funding cycle started in a prior year. Exclusion of these previously-funded grantees allowed us to identify a grantee population that was funded for up to a maximum of one year for a defined amount not exceeding $50,000. Prior to 2001, Planning Grant recipients could have been funded for more than one year. The information presented in this section is taken from an earlier and more comprehensive profile report of Planning Grant recipients prepared and submitted to HRSA under this contract.[2]

Between 2001 and 2003, HAB funded a total of 136 new Title III Planning Grants. The largest numbers of Title III Planning Grants were awarded in 2001 and 2002, with 70 and 60 grants, respectively. Only six new Planning Grant applications were funded in 2003. Most of Title III Planning Grant recipients were located in the Southeastern, Northeastern, and Western Regions of the country (see Exhibit 3). The geographic distribution of subsequent Title III EIS awards reflects the same regional dispersion as the Planning Grant awards. A total of 35 states and 2 U.S. territories (Federated States of Micronesia and Palau) received Title III Planning Grants between 2001 and 2003. The states with the highest numbers of grants were California (N = 20), Texas (N = 10), Florida (N = 9), Pennsylvania (N = 9), and New York (N = 8). Twenty states and two U.S. territories each received three or fewer Title III Planning Grants. Thirty-two states received Title III Planning Grants in 2001, 27 in 2002, and six in 2003. Three states (California, Georgia, and Alabama) received Title III Planning Grants in all three years, and 21 states/territories received Planning Grants in 2001 and 2002 only.

[2] Sorensen, A. and Gilman, B. Assessing the Success of Title III and IV Planning Grant Recipients. Grantee Profiling Report. Submitted to HRSA HIV/AIDS Bureau December 2004.

**Exhibit 3. Geographic Distribution of Title III Planning Grants by Year, 2001–2003**




NOTE: This map includes two United States territories: the Federated States of Micronesia (FM) and Palau (PW). The geographic distribution of the control group grantees (Stratum III) was listed in the Study Protocol report

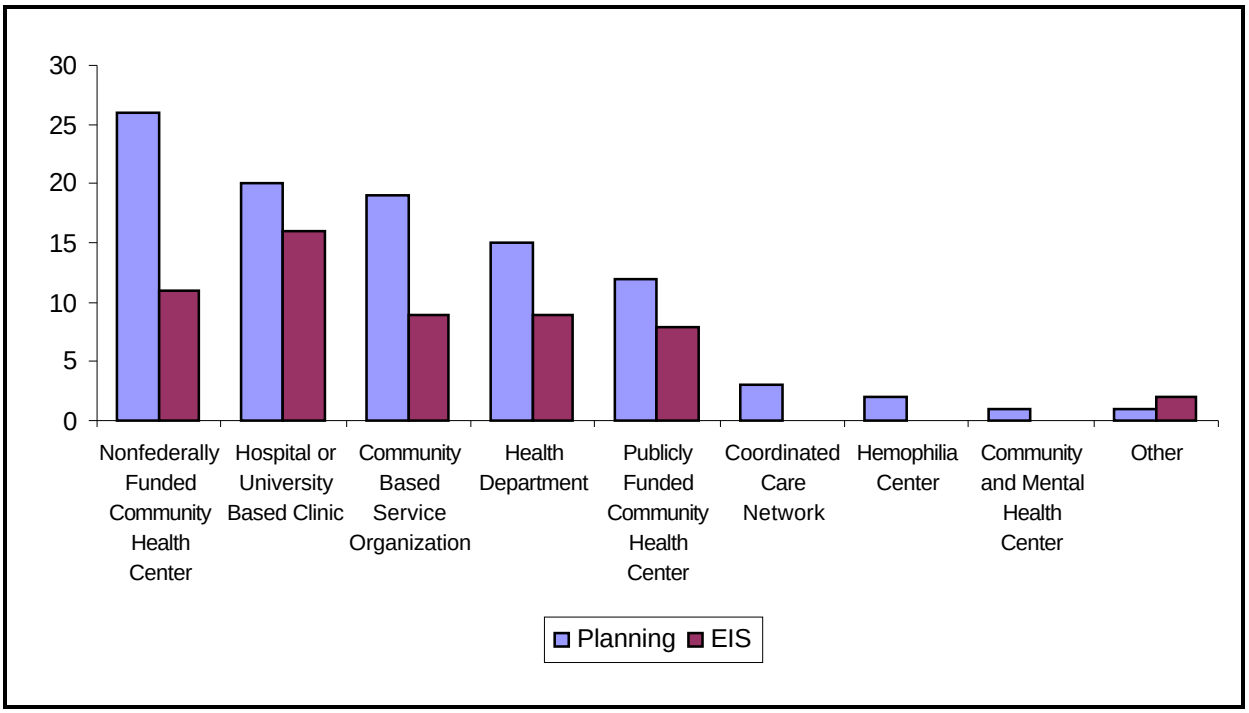
According to the data provided by HAB, 58 of the 2001-2003 Title III Planning Grant recipients (43 percent) also received a Title III EIS Grant award during this period of time. Of these grants, 37 were awarded in 2001 and 21 were awarded in 2002. Based on the information provided to us by HAB in 2005, none of the six Planning Grant recipients in 2003 was awarded a subsequent Title III service delivery grant.

The most common Title III Planning Grant recipients by organization type were non-federally funded community health centers (N = 26), hospital- or university-based clinics (N = 20), community-based service organizations (N = 19), health departments (N = 15), and publicly funded community health centers (N = 12) (see Figure 2-2). This distribution reflects the allocation of Title III EIS grants by type of organization as well. Other funded organizations included coordinated care networks, hemophilia centers, and community and mental health

centers. Although most types of organizations received funding in both 2001 and 2002, only hospital- and university-based clinics, health departments, and publicly funded community health centers received funding in 2003.

As illustrated in Exhibit 4, 16 out of the 26 (80 %) hospital- or university-based clinics that received Planning Grants also received a Title III EIS award. More than half of the publicly funded community health centers (8 out of 12, or 67%) and health departments (9 out of 15, or 60%) were successful in obtaining a service delivery grant. Less than half of the community based service organizations (9 out of 19, or 47 %) and non-federally funded community health centers (11 out of 26, or 42 %) received subsequent EIS funds. None of the coordinated care networks, hemophilia centers, and community and mental health centers received an EIS award.

**Exhibit 4. All Planning Grant Recipients and Planning Grant Recipients that received EIS Grant by Organization Type, 2001–2003**




NOTE: Excludes number of grants with missing data: n = 37 for all Planning Grant recipients and n = 5 for Planning Grant recipients that received EIS

All Title III Planning Grant recipients served either one or a combination of priority populations—rural, underserved, or communities of color. About two-thirds of all Planning Grant recipients served underserved populations or communities of color, while slightly over one-half of all recipients served rural populations. A total of 39 grantees (29 percent) served all three priority populations, 67 (49 percent) served both rural and underserved populations, and 45

(33 percent) served only communities of color. Data on other priority population categories were not available. Populations served by grantees that received subsequent EIS funds were close to identical to those that Planning Grant recipients sought to serve.

# CHAPTER 3
# PHASE II: KEY INFORMANT INTERVIEWS, DESIGN AND METHODS

## 3.1 Sample Strata for Key Informant Interviews

As stated above, 136 organizations received Title III Planning Grants between 2001 and 2003. These organizations were assigned to one of two strata, based on whether or not the Planning Grant recipient subsequently received a Title III EIS Grant. A third stratum included all Title III EIS Grant recipients between 2001 and 2003 that had never received a Planning Grant. This stratum was used as a comparison group for assessing the impact of Planning Grants on the subsequent delivery of HIV/AIDS care services. The three strata employed in this analysis were the following:

Stratum I: Planning Grant recipients that received Title III EIS Grants

Stratum II: Planning Grant recipients that did not receive Title EIS Grants

Stratum III: Title III EIS Grant recipients that had never received Planning or Capacity Building Grants

A representative sample of grantees was then drawn from each of the three strata to be interviewed under Phase II of the study. We recruited key informants for interviews from the pool of grantees in each stratum and conducted a one-hour telephone interview with the grant's project director, coordinator, or an appropriate designee. The total number of grantees and the number of grantees interviewed in each stratum are shown in Exhibit 5.

**Exhibit 5. Number of Total and Sampled Grant Recipients by Strata**

| | **Received Title III EIS Grant** | **Did Not Receive Title III EIS Grant** |
|---|---|---|
| Title III Planning Grant | Stratum I<br>Total: n = 59<br>Key Informant Interviews: n = 8 | Stratum II<br>Total: n = 77<br>Key Informant Interviews: n = 8 |
| No Title III Planning or Capacity Building Grant | Stratum III<br>Total: n = 40<br>Key Informant Interviews: n = 9 | |

## 3.2 Sample Selection Strategy

The purpose of the site selection strategy was to maintain a proportional distribution of the sample within each stratum across selected program and community characteristics considered important for determining the process and quality outcomes. The primary selection criteria used for this phase included:

- Geographic diversity within the United States;
- Frequency of/experience in obtaining Title III Planning Grants by state;
- Urban vs. rural designation of the site;
- Organization type (community health center, health department, hospital- or University-based clinic, other community-based service organization); and
- Year of Planning Grant award.

By selecting the five states with the highest number of grants and the four states with the lowest number of grants, we captured a group of grantees reflecting a range of historic experience in obtaining Title III Planning Grants. As noted above, the states with the highest number of Planning Grants were California, Texas, Florida, Pennsylvania, and New York, and the states with the lowest number were Illinois, Colorado, Tennessee, Missouri, Washington, Montana, and Indiana. Where states with a low number of Planning Grants did not have grantees in each of the three strata, the selection was based on the closest neighboring state with a site in that particular stratum. This site selection strategy also helped ensure that we chose a group of grantees representing different regions of the country with diverse community characteristics.

### 3.3 Data Collection Methods

Phase II included two forms of data collection. First, to ensure the completeness and accuracy of the information provided, prior to the interview we e-mailed or faxed to key informants an advance questionnaire containing a set of closed-ended questions requesting specific demographic or statistical information. The advance questionnaire was not appropriate for the actual telephone interview because it requested quantitative information involving additional investigation, time, and possible multiple respondents. A copy of the advance questionnaire is included in Appendix A.

We then developed a set of interview guides tailored to each stratum. The discussion guides included (1) an introductory letter explaining the purpose of the interview and (2) a request to obtain informed consent and permission to audio record the conversation for quality assurance purposes. Each discussion guide also contained a semi-structured list of open-ended and closed-ended questions organized by topic. The use of interview guides allowed the interviewers to accommodate unique issues pertinent to individual grantees. In addition, “probe” questions were developed to elicit more specific information under the broader questions. To maximize participation rates and minimize the burden on any single informant, telephone interviews with key informants were limited to one hour. Copies of the interview guides for each stratum are provided in Appendices B, C, and D, respectively.

The interview guides were pilot tested with a professional who had extensive experience in managing Planning and EIS Grant-funded programs. This individual's former and current service organizations were excluded from the study sample. The pretest activities were completed following approval of the key informant interview guides by the HRSA Project Officer. The guides were revised based on the results of the pretest activities and comments from the HRSA Project Officer. The pilot tests were also used as an opportunity for the RTI interviewers to practice administering the questionnaire to respondents in their assigned stratum.

### 3.4 Areas for Discussion with Key Informants

The key informant interviews were designed to provide in-depth information and cross-case analysis of factors associated with successful grantee outcomes, as well as with the impact of the grant on the communities served. The discussion guides were tailored to the characteristics of each of the evaluation strata. However, the substantive issues raised in each set of interview guides were sufficiently similar to allow comparisons across strata. Exhibit 6 provides a list of items that served as a basis for the interview discussion guide and qualitative analysis. The comparison strata associated with each of the topics areas are also shown.

### 3.6 Institutional Review Board Approval

RTI's Institutional Review Board (IRB) reviewed the study to ensure compliance with human subjects' protection requirements and granted approval on April 4, 2005.

### 3.5 Participant Recruitment Process

HRSA informed all 2001–2003 Planning Grant recipients about the study by mailing introductory letters in March 2005. After receiving HRSA's approval for the list of organizations to be interviewed, RTI team members contacted the selected grantees to confirm their willingness to participate in the evaluation and schedule the time for the interview. When an organization's representative declined to participate, we identified another grantee that met the selection criteria described in Section 2.2. The overall response rate for the Phase II data collection task was 76 percent.

### 3.7 Informed Consent and Confidentiality

We obtained consent to participate in key informant interviews by e-mail during the time of recruitment. Additionally, we confirmed consent to participate in the study and obtained permission to audio record the interview at the beginning of each interview. The specific

**Exhibit 6. Topic Areas and Analysis Groups for Key Informant Interviews**

| Topic Areas | Analysis Group(s) |
|---|---|
| Engaging key stakeholders | Strata I and II |
| Establishing a formal advisory group | Strata I and II |
| Completing a needs assessment | Strata I and II |
| Defining components of care and forming linkages with other community service providers | Strata I and II |
| Conducting research on funding sources | Strata I and II |
| Completing other activities as applied for | Strata I and II |
| Intended and actual partnerships | Strata I and II |
| Feasibility of creating a primary care clinic relative to the number of HIV cases in the community | Strata I and II |
| Finding a better-suited organization | Stratum II |
| Number of clients enrolled in HIV care each year in which it received Title III or IV funds | Strata I and III |
| Number of clients who received pretest counseling at the grantee site | Strata I and III |
| Number of clients tested | Strata I and III |
| Number of clients who tested positive and returned for results | Strata I and III |
| Proportion of clients with positive results who entered into regular care | Strata I and III |
| Number of clients who met PHS standard of four outpatient visits per year | Strata I and III |
| Success and timeliness in achieving full staffing | Strata I and III |
| Success and timeliness in formalizing contracts, memoranda of understanding, and affiliation agreements with partner sites | Strata I and III |
| Success and timeliness in developing operating procedures and policies | Strata I and III |
| Ability to meet Title III program expectations and requirements | Strata I and III |
| Consumer involvement | Strata I and III |
| Availability of other CARE Act-supported services in their communities | Stratum I |
| Experience in providing HIV primary care at the time of planning grant application | Strata I and II |
| Annual operating budget | Strata I, II, and III |
| Preexisting Title III or IV program in operation in the same metropolitan area | Strata I, II, and III |

communication concerning the informed consent can be found in the introductory section of each interview guide (Appendices B to D). Topics discussed during the presentation of oral consent information included

- the purpose of this study,
- a statement on how participants were selected,
- participants' rights,
- a statement of confidentiality,
- a statement on data management, and
- a statement on voluntary participation.

Audio tapes and notes including identifiers were accessible only to RTI project members. After the interview, notes were checked for accuracy, formatted electronically, and finalized. The audio tapes will be destroyed upon completion of this report.

### 3.8 Data Management and Analysis

The telephone discussions were transcribed and stored as Microsoft Word files. In addition, key self-reported grantee information was cross-checked with information available from the grantee profile database prepared for HRSA under Phase I of the study. The analyses focused on assessing patterns in outcomes and grantee characteristics from the information gathered during the key informant interviews. RTI analyzed and synthesized qualitative data by identifying common patterns and divergent experiences across grantees in terms of process and outcomes and their associated key determinants. We used an analytic coding structure reflecting the objectives of the study that allowed a comparative analysis of the data across individual grantees. The data were initially managed and coded using the qualitative analysis software, QSR NVivo. A database manager and one of the two other key interviewers double-coded each interview to ensure consistency and accuracy. To increase the accuracy of self-reported data and address the time gap that hindered informants' ability to accurately recall the issues pertaining to the past three to four years, information available in grantee proposals (i.e., proposed Planning Grant goals) was abstracted and compared to the interview data as well. To augment the limitations of the software and to allow further interpretation of results, a researcher performed further inductive analysis by identifying content patterns and themes. To present an accurate and authentic view of respondents, we quote key informants whenever appropriate in this report.

# CHAPTER 4
# SAMPLE CHARACTERISTICS

## 4.1 Interview Participants

RTI completed 25 interviews with key informants and received 20 completed advance questionnaires between July 23 and August 22, 2005. The number of contacts per individual organization required to complete the interview ranged from three to 15. Organizations that did not respond after seven repeated e-mail, telephone, and personal messages were excluded from the sample. Exhibit 7 presents the total number of organizations contacted, the total number of interviews conducted, and the number of advance questionnaires received for each stratum. The recruitment outcomes for each stratum are presented below.

**Exhibit 7. Total Number of Organizations Contacted, Interviews Conducted, and Advance Questionnaires Received**

| | Number of Contacted Organizations | Number of Interviews Conducted | Number of Advance Questionnaires Received | Response Rate |
|---|---|---|---|---|
| Stratum I (Planning and EIS) | 11 | 8 | 8 | 80% |
| Stratum II (Planning and no EIS) | 10 | 8 | 5 | 80% |
| Stratum III (EIS with no prior Planning) | 12 | 9 | 8 | 69% |
| Totals | 33 | 25 | 20 | 76% |

**Stratum I.** RTI contacted 11 organizations, completed eight interviews, and collected eight advance questionnaires for Stratum I sites. The reasons for non-participation are presented below.

- One site indicated that it "turned down" its current EIS Grant and felt that it was not suited to participate in the study. We were unsuccessful in our attempts to learn why the grant was "turned down" and exactly what that term meant.
- One site was randomly selected for participation in both Planning and Capacity Building Grant evaluation studies simultaneously being conducted by RTI. A representative for that organization informed RTI that they would allocate only one hour to both of these studies. Consequently, this grantee was interviewed by Capacity Building evaluation study team.

**Stratum II.** RTI contacted 10 organizations, completed eight interviews, and collected five advance questionnaires for Stratum II sites. Since most of the Stratum II sites were not currently receiving HRSA funds, we anticipated slower recruitment and lower return rates for advance questionnaires. Because they were no longer receiving Planning Grant funds and were

not receiving EIS Grant funds, these sites had less motivation to provide the data requested in the advance questionnaire or to participate in an interview. The reasons for non-participation are presented below.

- One site no longer existed at the time of the interview.
- One site declined to participate because it no longer employed the personnel who were involved with the Planning Grant.

**Stratum III.** RTI contacted 12 organizations, completed nine interviews, and collected eight advance questionnaires for Stratum III sites. The reasons for non-participation are presented below.

- Two sites were disqualified from this stratum because they indicated that they had received a Planning Grant prior to our evaluation period. This information was not indicated in our database because the Planning Grants were awarded before 2001, the earliest year for which data were provided to us by HRSA.
- One site did not respond to five repeated attempts to contact its various staff members by phone and e-mail.

## 4.2 Grantee and Client Characteristics

The grantee and client characteristics of the participating sites are summarized and presented graphically below. The five key characteristics reviewed include (1) geographic distribution of providers; (2) type of communities served; (3) type of provider organization; (4) racial distribution of clients served; and (5) type of services furnished. Most of the information for this section was obtained from grantee records supplied by HRSA.

**Geographic Distribution of Providers.** The organizations participating in Phase II represented a wide range of geographic locations across the continental United States, closely corresponding to the distribution of all 2001–2003 Planning Grant recipients (see Exhibit 8).

**Type of Community Served.** As illustrated in Exhibit 9, the organizations participating in Phase II of the study represented the three main types communities served: rural, underserved, and communities of color. Over two-thirds of the 25 participating sites served communities of color (64 percent), and nearly three-quarters of the participating sites served underserved populations (72 percent of the sample). Organizations serving rural communities were well-represented in the samples for Strata I and II, but not for Stratum III. The available pool of EIS grantees without a Planning or Capacity Building Grant serving rural communities was small.

**Exhibit 8. Geographic Distribution of Participating Sites**

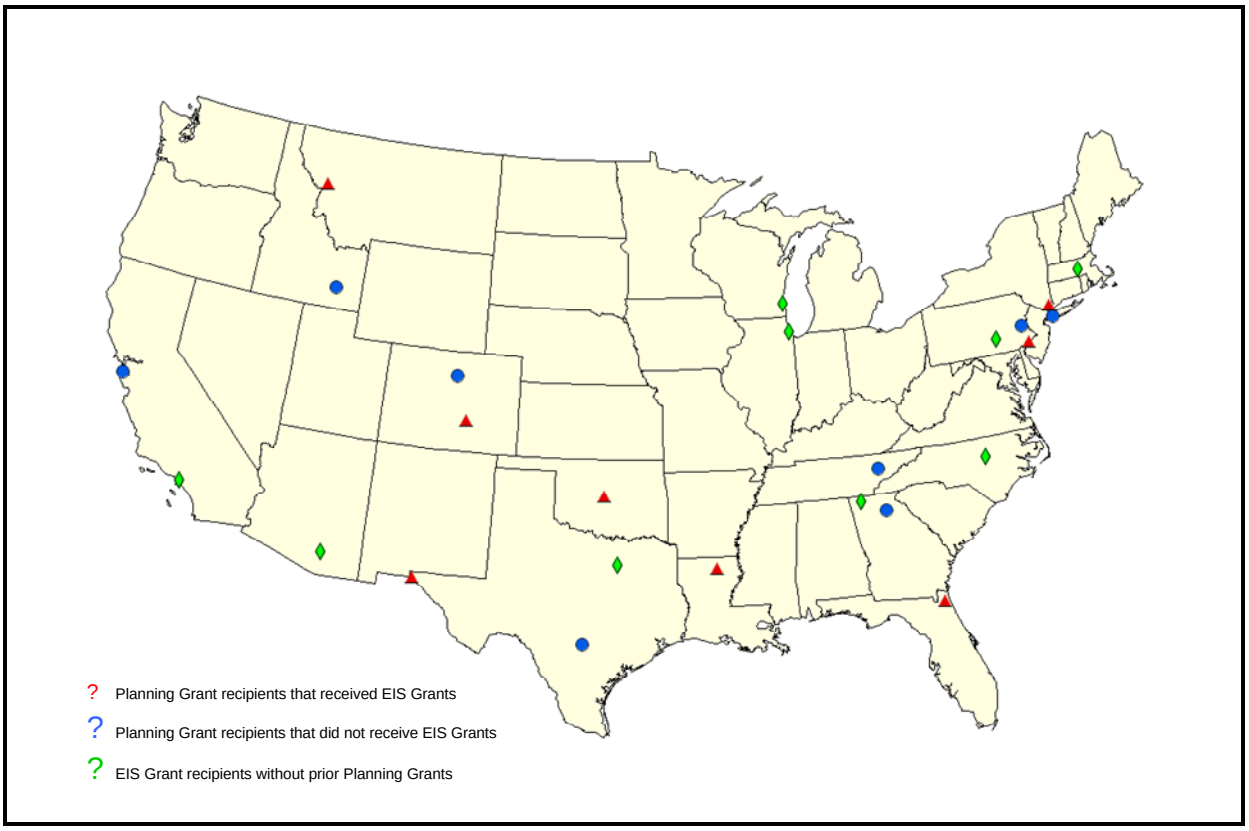
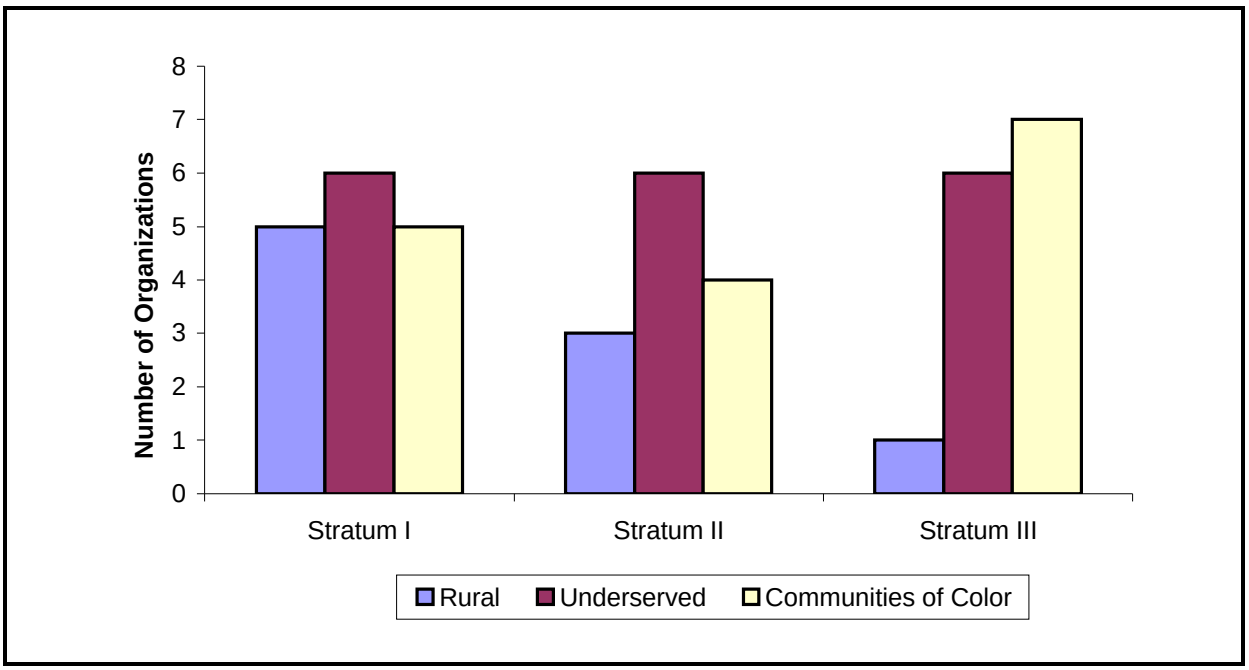
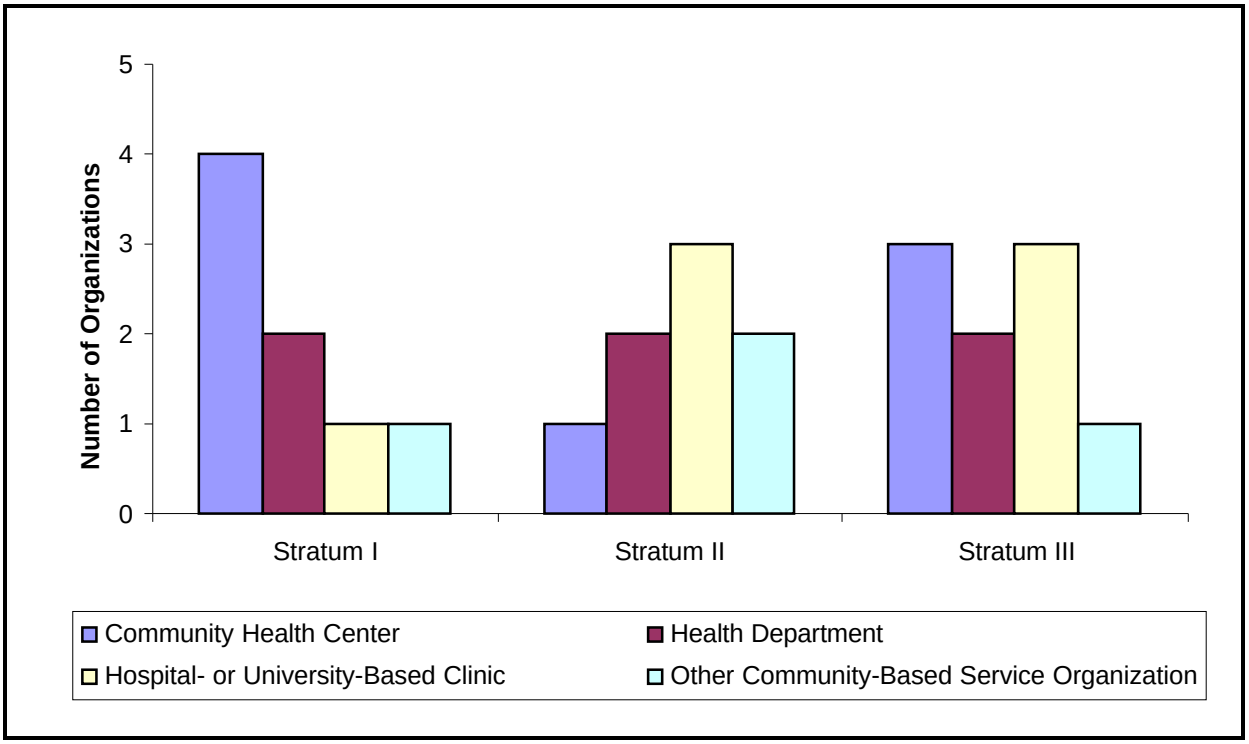



**Exhibit 9. Number of Participating Sites by Type of Community Served**



**Type of Provider Organization.** As illustrated in Exhibit 10, we were also able to obtain a fairly balanced distribution of respondents within each of the three strata based on the type of provider organization. The most common types of organizations receiving Planning Grants are community health centers, health departments, hospital- or university-based clinics, and community-based organizations.

**Exhibit 10. Number of Participating Sites by Type of Provider Organization**




**Racial Distribution of Clients Served.** Organizations participating in this study served clients of various racial backgrounds and mirror the major racial and ethnic groups served by Title III EIS organizations generally. The client racial distribution of Phase II participants is presented in Exhibit 11. The proportion of clients served may not add up to 100% due to errors in self-reported data. For confidentiality reasons, the names of the respondent organizations are not included in this report.

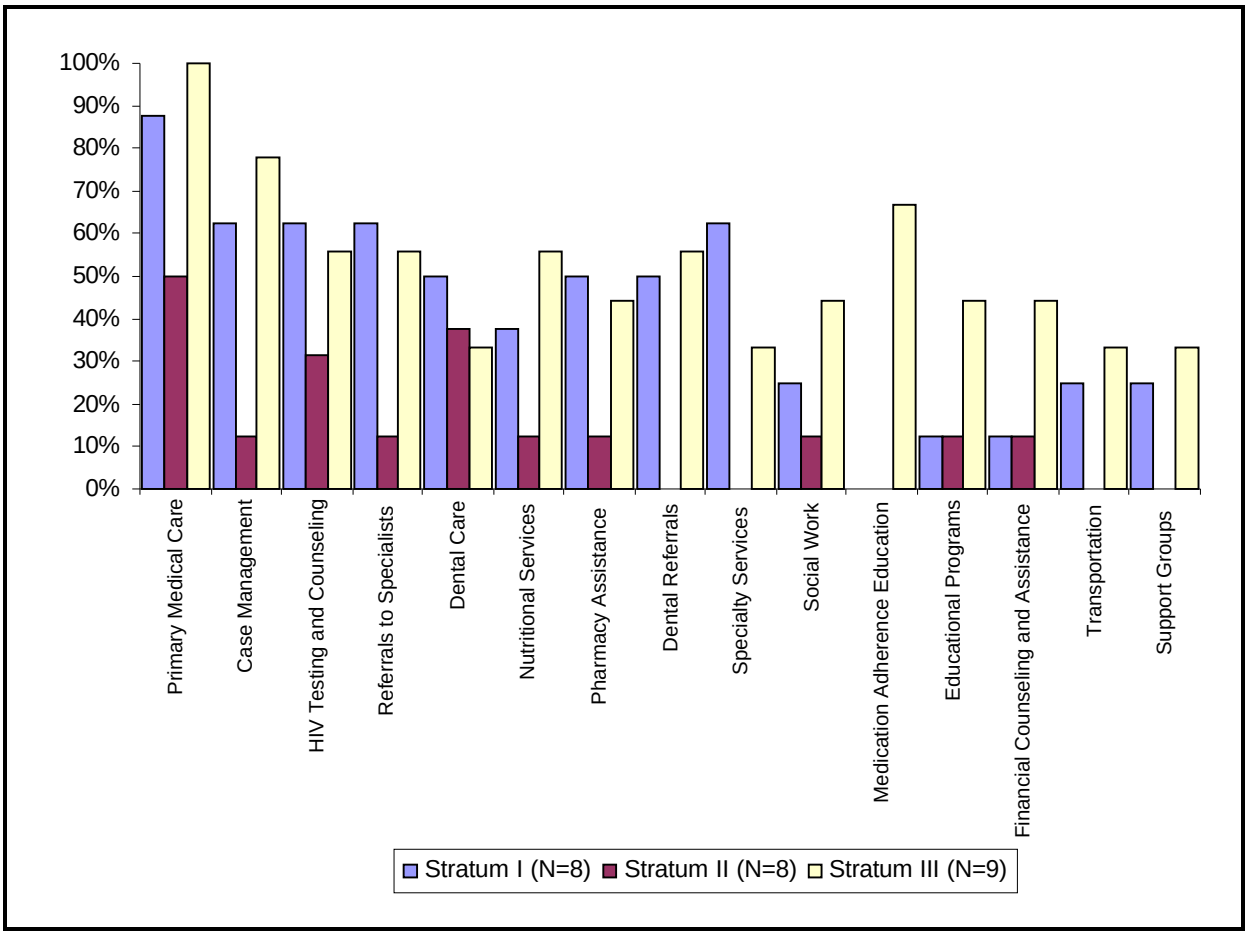
**Exhibit 11. Distribution of Clients by Type of Race**

| Grantee by Stratum | Caucasian | African American | Hispanic | Asian | Other | Unknown |
|---|---|---|---|---|---|---|
| ***Stratum I*** | | | | | | |
| Grantee A | 10% | 2% | 85% | 0% | 1% | 2% |
| Grantee B | 10 | 90 | 0 | 0 | 0 | 0 |
| Grantee C | 63 | 21 | 6 | 0 | 6 | 4 |
| Grantee D | 17 | 23 | 53 | 2 | 0 | 5 |
| Grantee E | 8 | 76 | 7 | 6 | 0 | 3 |
| Grantee F | 30 | 70 | 0 | 0 | 0 | 0 |
| ***Stratum II*** | | | | | | |
| Grantee A | 0% | 0% | 0% | 98% | 0% | 2% |
| Grantee B | 15 | 6 | 59 | 10 | 0 | 10 |
| Grantee C | 0 | 14 | 61 | 0 | 1 | 24 |
| Grantee D | 80 | 13 | 7 | 0 | 0 | 0 |
| Grantee E | 85 | 0 | 10 | 0 | 5 | 0 |
| ***Stratum III*** | | | | | | |
| Grantee A | 52% | 45% | 7% | 0% | 0% | 0% |
| Grantee B | 16 | 73 | 7 | 0 | 4 | 0 |
| Grantee C | 0 | 50 | 50 | 0 | 0 | 0 |
| Grantee D | 87 | 13 | 3 | 0 | 0 | 0 |
| Grantee E | 21 | 63 | 15 | 1 | 0 | 0 |
| Grantee F | 59 | 14 | 26 | 0 | 1 | 0 |
| Grantee G | 58 | 11 | 19 | 1 | 1 | 10 |
| Grantee H | 15 | 20 | 60 | 0 | 5 | 0 |

SOURCE: Advance Questionnaire; data were not provided by two Stratum I, three Stratum II, and one Stratum III organizations. Total percentages do not always add up to 100% because of errors in self-reported data.

**Type of Services Provided.** Organizations participating in Phase II interviews provided a wide variety of services (see Exhibit 12). The most commonly provided services by Strata I and III organizations were primary care, case management, HIV testing and counseling, referrals to specialists, and dental care. Other services included nutritional services, pharmacy assistance, dental referrals, specialty services, social work, medication adherence education, educational programs, financial counseling, transportation, support groups, on-site laboratories, and translation services. Although most of the services were provided by EIS Grant recipients (Strata I and III), Figure 4-4 also illustrates the range and magnitude of services provided by Planning Grant recipients that did not receive EIS Grants (Stratum II). The most commonly provided services by Stratum II organizations were primary medical care, dental care, and HIV testing and counseling. None of the interviewed Stratum II organizations reported providing medication adherence counseling, transportation services, or support groups.

**Exhibit 12. Type of Services Provided**



# CHAPTER 5
# SUMMARY OF FINDINGS

In this chapter, we provide a summary of the major findings from the key informant interviews and the advance questionnaires. The chapter is divided into three major sections. Section 5.1 discusses issues related to the implementation of the Planning Grants. Hence, the findings are based on sites from Strata I and II only. Issues addressed in Section 5.1 include: (1) experiences completing the Planning Grant application; (2) identifying the goals and objectives of the Planning Grant; (3) success in achieving Planning Grant objectives; (4) impact of Planning Grants on organizational capacity; and (5) experiences in applying for Title III EIS Grants. Section 5.2 discusses issues related to the operational performance and delivery of care among providers subsequently funded under the Title III EIS program. The findings presented in Section 5.2 are thus based on sites from Strata I and III only. Issues addressed in Section 5.2 include: (1) the impact of Planning Grants on operational performance among service providers and (2) the impact of Planning Grants on delivery of services. Specific challenges reported by Planning Grant recipients in both the application and implementation phases of the program are discussed in Section 5.3.

## 5.1 Implementation of Planning Grants (Strata I and II)

This section describes and assesses the immediate performance-based outcomes and program outputs of the Planning Grant program, as revealed during the interviews with key informants. It describes Planning Grant recipients' experiences (immediate outcomes) relative to accomplishing grant objectives such as forming advisory boards and partnerships, engaging and sustaining stakeholders, conducting needs assessments, and forming linkages with community service providers. It also discusses their experiences (program outputs) in obtaining subsequent Title III EIS Grant funding. In addition, this section discusses the challenges experienced by Planning Grant recipients in carrying out these activities. Wherever appropriate, we identify differences in performance between organizations that received Title III EIS Grants (Stratum I) and those that did not (Stratum II).

### *5.1.1 Experiences Completing the Planning Grant Application*

***Involvement of Leaders and Champions in Application Process.*** The motivation to apply for Planning Grant funding among most organizations (13 of the 16) was internally driven. The effort was often spearheaded by one individual or champion within the organization. These individuals were either in charge of HIV services in larger organizations or key decision makers, such as the Executive Director, in smaller organizations. Interestingly, a sizeable number of

Stratum II organizations reported significant staff turnover in recent years, including the loss of key personnel responsible for facilitating the Planning Grant implementation process. If the Planning Grant was spearheaded by a single individual, the loss of such a key employee may have negatively affected the ability of these organizations to obtain EIS Grant funding to support the delivery of services.

Few organizations identified external influences that contributed to their decisions to apply for Planning Grant funding. Three respondents indicated that they were prompted by other organizations to apply. One grantee was approached by its local Title II consortium administrator, whereas the other two organizations received encouragement from their state medical director and the HRSA staff that were assisting them on another grant. Once a decision was made to apply, the actual planning and proposal writing usually fell to an individual or small team within the organization. At least two grantees had collaborated with outside organizations to collect data necessary for measuring local need, as required for the proposal. Other strategies used to prepare the proposal included collecting grant applications written by other organizations and hosting meetings with other service providers in the community to gauge their levels of interest.

Respondents from both Strata I and II indicated having prior proposal-writing experience and the internal capacity to prepare the proposal. In one case, a university-based applicant had a team of four individuals whose job it was to identify and apply for external funding. Three of the organizations that applied for Planning Grants had hired external consultant grant writers to assist with the Planning Grant proposal process. However, most of the sites that used external consultants also indicated that those efforts were not successful because the consultants lacked knowledge about the programs and site-specific issues. Similarly, five sites that collaborated with other organizations shared some of the writing with staff from those organizations that were not applying. An organization's size did not appear to be related to its ability to prepare a successful Planning Grant proposal.

***Building Partnerships.*** Most of the sites interviewed under Strata I and II (13 of 16) reported that they had collaborated or partnered in the Planning Grant application process, usually establishing relationships with at least one community-based organization providing HIV primary care services. Other partnerships included collaborations with community hospitals, health departments, and community and ethnic social support groups. One Stratum I urban health department met monthly for more than eight months as part of a group that was formed from the agencies in the city that had already received grants under Titles I and II. Before pursuing the Planning Grant proposal, this collaborative reviewed its grants to see how Title III could

complement its existing work. This approach enabled the group to identify partners quickly and to collaborate in its proposal activities. Additionally, it enhanced this organization's success in completing its subsequent Planning Grant activities.

Most sites also reported communicating with organizations that were providing services in their area under Titles I, II, and IV. Three organizations, all in urban settings, mentioned the presence of other Title III care providers. However, one interviewee representing a hospital-based organization suggested that obtaining funding can be a very competitive process in urban areas in which many well-organized groups are already addressing HIV. This competitive atmosphere was viewed as a disincentive for partnering with other care providers. In contrast, representatives from three rural sites (two from Stratum I and one from Stratum II) stated that they were not involved in any partnerships at the time at which they applied for Planning Grants. Respondents representing two rural communities indicated that there were no other CARE Act-funded activities in their areas.

### *5.1.2 Goals of the Planning Grant Program*

The ultimate goal of the Planning Grant program was to support the introduction of care delivery systems or to help expand the provision of existing services. Most Planning Grant recipients (six of eight in Stratum I and seven of eight in Stratum II) indicated that their organizations already had experience in providing HIV primary care services at the time of their application for Planning Grant funding. Additionally, three Stratum I organizations had previously been awarded Title III EIS Grants, some dating back to the early 1990s. Most Planning Grant recipients reported that they either had CARE Act funding under Titles I, II, or IV at the time of application or had collaborated closely with organizations that had such funding. Further, several Planning Grant recipients had prior or concurrent Title III supplemental Capacity Building Grants as well.

As summarized in Exhibit 13, over half of the interviewed Planning Grant recipients (nine of 16) indicated that their organizations were seeking Planning Grant funding to provide comprehensive HIV primary care services *for the first time*. Four of these organizations were from Stratum I, and five were from Stratum II. Most (six of nine) of the organizations that were proposing new HIV/AIDS primary care services were located in rural communities. In fact, among the nine organizations implementing new services, six (four from Stratum I and two from Stratum II) sought to start providing services in geographic areas in which no other services were available at the time of the application. For the nine sites planning to provide HIV primary care services for the first time, the Planning Grants were a critical step in planning and preparing for

**Exhibit 13. Goals of Planning Grant**

| Planning Grant Goals | Stratum I | Stratum II | Total |
|---|---|---|---|
| **Offering New HIV/AIDS Services** | 4 | 5 | 9 |
| **Expanding HIV/AIDS Services** | 4 | 3 | 7 |
| **Total** | 8 | 8 | 16 |

the provision of comprehensive services. Using their Planning Grants, these organizations reported that they intended to conduct a range of planning activities, both to develop information required for an EIS Grant and to secure partners necessary for expanding services in their communities.

The remaining seven of the 16 Planning Grant recipients interviewed (four from Stratum I and three from Stratum II) reported that they were already providing comprehensive HIV services and intended to use their Planning Grants to expand their services. Surprisingly, four of the seven sites seeking to expand services were from Stratum I and had already obtained EIS Grants. They were hoping to use the Planning Grants to expand the services provided under their existing EIS Grants. Further, nearly all (six of seven) of the organizations seeking to expand services planned to expand them into new patient populations. For example, two applicants, both in urban areas, wanted to expand services to serve specific ethnic groups that they believed were underserved or disproportionately affected by HIV. Another organization wanted to use the Planning Grant to better target services to patients in a nearby neighborhood in which treatment adherence was seen as being low. Those proposing to expand primary care services to new geographic and patient populations were located mainly in urban areas (five of seven).

### *5.1.3 Objectives of the Planning Grant Program*

The immediate objectives of the Planning Grant recipients that we interviewed are summarized in Exhibit 14. Most of the objectives that organizations chose matched the set of program objectives identified by HRSA in the Planning Grant guidance. The most common of these were establishing formal advisory groups, conducting needs assessments, and forming linkages with other community service providers. However, several organizations developed their own unique sets of objectives. Those included developing continuum or comprehensive care plans, educating or training providers and/or clients, improving access to care, and providing culturally appropriate services. Each of the grantee activities related to each of the five more common Planning Grant guidance objectives is discussed in greater detail below.

**Exhibit 14. Objectives of Planning Grant Recipients**

| Planning Grant Objectives | Stratum I | Stratum II | Total |
|---|---|---|---|
| | N = 8 | N = 8 | N = 16 |
| **Primary Objectives** | | | |
| Conduct in-depth needs assessment | 6 | 7 | 13 |
| Establish formal advisory group | 4 | 7 | 11 |
| Form linkages with other community service providers | 4 | 4 | 8 |
| Evaluate existing provider population | 1 | 2 | 3 |
| Investigate other sources of funding | 2 | 1 | 3 |
| **Secondary Objectives** | | | |
| Develop continuum or comprehensive care plan | 5 | 5 | 10 |
| Educate/train providers and/or clients | 2 | 3 | 5 |
| Improve access to care | 3 | 1 | 4 |
| Provide culturally appropriate services | 0 | 4 | 4 |
| Develop fiscal management information systems | 3 | 0 | 3 |
| Create awareness of HIV care needs | 1 | 2 | 3 |
| Develop clinical and case management information systems | 2 | 0 | 2 |

***Establishing Advisory Boards.*** Most Planning Grant recipients indicated that their organizations established formal advisory boards to plan for the delivery of services. Advisory boards included health care professionals, planners, and consumers. One grantee used an advisory board that was a part of the university's existing internal medicine committee structure. Only one Stratum II organization did not establish an advisory board, as proposed under its Planning Grant application. Many organizations already had functioning advisory boards that were transitioned into the Planning Grant process. In other cases, representatives from external organizations, usually with some HIV service delivery focus, served as advisory board members during the Planning Grant period. At least one organization used an existing organizational board to provide guidance until a board could be established in the community in which it sought to expand services. As one respondent noted, this arrangement offered a continuity of leadership in the grant process, stating, *"Once we received the funding, they [the initial planning committee] had become so involved. They wanted to continue to work with us to ensure that the work they put into this would continue to go on. The consumers on the board wanted to make sure that the barriers that they had spoken about would at least [be] addressed and corrected whenever possible."*

Three advisory boards formed by Stratum II grantees continued to exist informally in the absence of further EIS funding. According to one grantee, their advisory board "w*as very*

*successful and helpful in developing a culturally appropriate model to address HIV primary care and early intervention services. The expertise of the group is critical to addressing questions we want answered. For example, the women's health director provides lots of input in prenatal HIV testing*." Another Stratum II grantee representing a rural area indicated that, "*The hearts of the committee are those at the clinic or HIV patients. We meet relatively informally and discuss patient care issues*." An additional grantee indicated that the advisory board established as a result of the Planning Grant activities would be able to resume functioning as soon as they received new funding. Several respondents noted that the sustainability of their advisory boards was an important goal of their Planning Grant.

***Conducting Needs Assessments.*** Conducting needs assessments was the second most common objective among Planning Grant recipients. The results of the needs assessments were used to determine if a need for HIV/AIDS primary care services existed in their communities and, if so, to identify where those services were most required. Six Stratum I and seven Stratum II organizations proposed conducting needs assessments as part of their Planning Grant activities. Stratum II organizations were more likely than Stratum I organizations to rely on existing data available from the state, the health department, and the Centers for Disease Control and Prevention (CDC) to assess the need for HIV/AIDS primary care services in their communities. Two of the organizations from Stratum I did not conduct needs assessments under their Planning Grants because this information was already available to them through existing Title III EIS or Capacity Building Grant activities.

Among those grantees that conducted needs assessments, most described this activity as successful and helpful for their organizations. Identifying gaps in services appeared to be the primary outcome of these assessments. In one case, a site identified a need to extend the services they offered to the evenings and reported that over half of their patients were now seen during that time. In another case, the results of the needs assessment led to a decision not to apply for a subsequent EIS Grant because the organization did not find a sufficient demand for HIV primary care services in its community.

Similar to the advisory boards, organizations often had elements of needs assessments, if not complete ones, available to them at the start of their Planning Grants. Most groups reported that getting epidemiological data was not difficult and said that state health departments, the CDC, or local agencies were able to provide them with current information. Only one organization from Stratum II reported using Planning Grant funds to develop previously unavailable epidemiological data for its community. In fact, by conducting needs assessments,

two organizations were able to identify critical limitations in the reporting systems used by local officials in their communities which led to the underreporting of HIV-positive individuals.

Several organizations included formal efforts to identify providers in their communities as part of their needs assessments. In most cases, surveying providers was not difficult, particularly in rural communities, where usually only a few providers offered HIV services. As one respondent described, "*We surveyed public and private agencies that provided HIV services and looked at their ability to serve this population culturally. I don't think we learned much since we knew there was not much out there*." In urban areas, organizations were more likely to survey providers to identify the need for ancillary services for their primary care clients, such as dental clinics or drug and alcohol counseling services. Organizations that conducted physician or consumer surveys reported low response rates, particularly among providers.

***Forming Linkages with Related Community Providers.*** The sites we interviewed used the planning process either to strengthen existing links with known partners or to form links with new partners. Organizations that were already providing primary care services, particularly those with EIS Grants, reported having few difficulties in forming linkages. In these cases, the recipient used the Planning Grant to renew or strengthen existing collaborations. As one organization described, *"I don't think we established new linkages, but [we] increased the activity of existing linkages."* In contrast, sites in rural areas with few available partners had the most trouble forming linkages with other organizations. Among these organizations, the lack of service delivery partners caused many organizations to seek support from non-HIV primary care service delivery groups such as churches and community support groups. Many of the sites that faced few partnering opportunities were from Stratum II.

Across both strata, organizations were generally able to expand their networks of partnerships as part of the Planning Grant process. The new partnerships tended to relate to the specific needs that were identified in the Planning Grant application process. Organizations often engaged in partnerships with other organizations or physicians in their communities that could provide specialized services, such as infectious disease expertise or drug and alcohol counseling.

***Seeking External Funding Sources.*** Three Stratum II organizations used their Planning Grants to secure other small grants for service delivery. Two Stratum I organizations indicated that they were able to supplement funding for EIS activities by coordinating better with Title I and Title II activities in their communities.

***Strengthening Technical Infrastructure.*** Most organizations engaged in the primary set of activities under the Planning Grant program guidance (i.e., establishing formal advisory boards, conducting needs assessments, and developing linkages with other organizations). However, four Stratum I organizations proposed Planning Grant activities relating to the development of financial and information technology, activities that coincide with the main focus of the alternative supplemental Title III Capacity Building Grant program. These four grantees also intended to expand their EIS Grant services into new communities and populations. When asked whether they could have expanded without Planning Grant funds, most Stratum I organizations indicated that they would have eventually expanded their services without the support provided by the Planning Grant, but it would have been much harder and taken them longer to accomplish their goals.

### *5.1.4 Success Meeting Planning Grant Objectives*

All but one of the 16 key informants in Strata I and II indicated that their organizations had accomplished what they had initially set out to do with their Planning Grants. Some organizations reported minor revisions to particular tasks, but their overall objectives remained the same throughout the process. For example, one group reported, "*We kept to our main objectives. The only real changes involved changing the number of desired meetings due to being unable to coordinate people's schedules.*" Even among those sites that did not receive EIS Grants, there was a feeling that the tasks they had outlined in their Planning Grants proposals were in fact accomplished. As one of the organizations indicated, "*We learned that planning is planning—it is not initiation of a service. It is evaluating if something will work."*

The Stratum II community-based service organization that did not meet its Planning Grant objectives was serving a homeless population in a rural area. This grantee attributed its inability to accomplish its Planning Grant objectives to staff turnover, lack of experience in preparing a successful grant application, and lack of program leadership. Despite a concurrent Title II grant and experience in delivering HIV primary care, this organization did not establish a planning or consumer advisory committee and was unsuccessful in forming partnerships with other providers. This organization submitted an application for an EIS grant that was not funded.

### *5.1.5 Impact of Planning Grant on Organizational Capacity*

Most Planning Grant recipients stated that the grant had a positive impact on their internal capacity to expand and deliver quality care. Stratum I organizations reported that the Planning Grants helped them write effective EIS proposals and establish their programs more quickly than if they had not received such grants. As one interviewee indicated, "*The impact is*

*huge. We would not have been successful with the EIS Grant without the Planning Grant. There is still much to be done. The Planning Grant brought about a common understanding of the challenges of providing HIV care*." A number of grantees also emphasized that the Planning Grants helped them to identify the unmet needs of clients and services and to strengthen their ability to meet those needs. Additionally, many grantees also indicated that the Planning Grants had improved the quality and efficiency of care. Surprisingly, this opinion was most commonly expressed among Stratum II grantees. As one Stratum II grantee stated, "*We are able to be more efficient with our care. We are doing more with less money*."

Stratum II organizations reported that the Planning Grants provided valuable information and strengthened their ability to undertake activities and to lobby for needed resources. One respondent stated, "*It had an impact on medical providers because it focused them on the trends in the AIDS epidemic and on the fact that this population was increasingly at risk and not receiving culturally appropriate services. It raised awareness of the needs of the target population*." Stratum II organizations also emphasized the significance of established linkages and collaborations with other organizations. One respondent noted, "*Through our Planning Grant, we have shown our community partners our interest in providing HIV primary care to patients. We have established links and referral systems with major providers and better systems to provide prevention at the center. We work very closely with our partners in order to reach out to our immigrant community*."

Several Stratum II grantees also recognized that improved linkages and collaborations had a positive impact on their communities. As one respondent explained, "*It was one of the things that brought a community together—we know each other now. We have a blooming relationship with our colleagues along the border. The Planning Grant was the start of the developing relationship*." Finally, both Strata I and II grantees reported that the Planning Grants had a beneficial impact on patients by helping providers increase their capacity to conduct outreach and provide services.

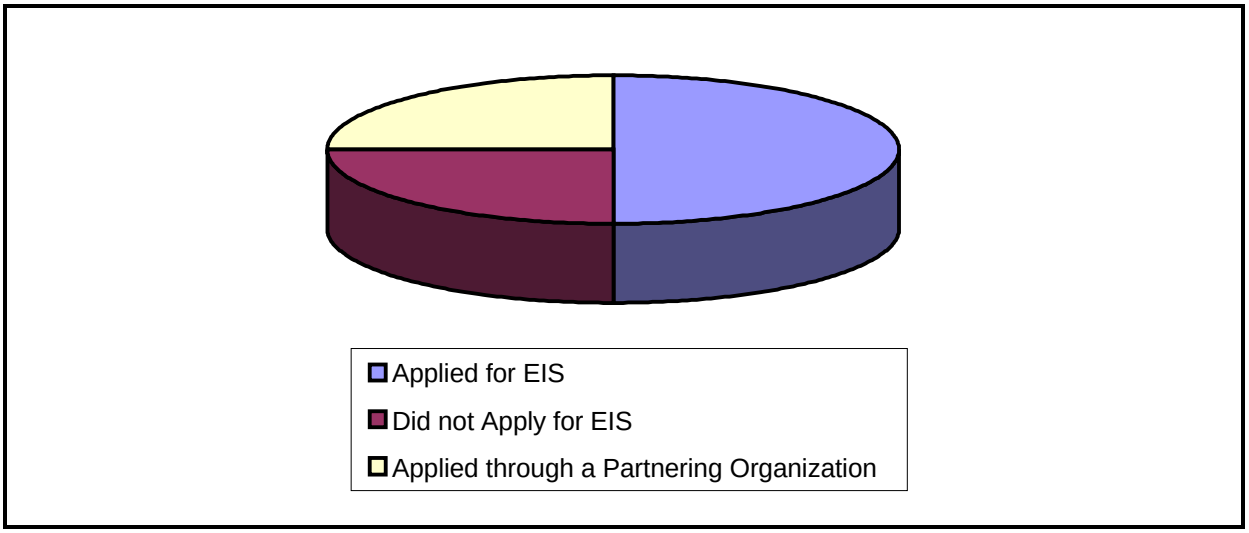
While the impact of Planning Grants on care delivery is analyzed in greater detail under the Strata I and III comparison in Section 5.2, several comments were voiced during this phase of the evaluation as well. Four Stratum I and three Stratum II grantees stated that the Planning Grants had a positive impact on their ability to deliver care. Specifically, Strata I and II organizations cited the following ways in which the Planning Grants had transformed their delivery of care:

- improving access to care by offering primary care services at the community health center five days a week, serving people on a walk-in basis, and doubling the number of patients served within the first year;
- adding a site for rapid testing and achieving the goals for patients testing positive receiving primary care;
- expanding to an evening clinic which is now financially supported by the city;
- extending evening hours, offering Saturday clinics, and hiring female physicians;
- providing a dental residency program for patients (based on unmet needs for dental care identified as result of a needs assessment);
- establishing links and referral systems with major providers and better systems to provide prevention at the center; and
- hiring bilingual providers to provide culturally appropriate services.

### *5.1.6 Experience in Seeking Title III EIS Grant Funding (Stratum II)*

Most (six out of eight) of the Planning Grant recipients in Stratum II (i.e., those who did not receive subsequent EIS Grants) applied for new or expanded Title III EIS Grants either directly as the prime grantee or indirectly as a subcontracted provider with another organization. As illustrated in Exhibit 15, half of the eight Stratum II grantees applied for but did not receive subsequent EIS Grant funding. Two of the Stratum II grantees applied for EIS Grant funding indirectly through a partner organization, one of which received an EIS Grant. The remaining two sites in Strata II did not apply for EIS Grants.

**Exhibit 15. Planning Grant Recipients that Did Not Receive EIS Grant (Stratum II N=8)**



The six organizations that applied for but did not receive EIS Grants offered several reasons for their rejected application status. One Planning Grant recipient stated that the poor quality of their application led to its rejection by HRSA. According to this respondent, "*The grant was not written well. The Board didn't have a chance to look at it. It needed a second set of eyes, and there were a lot of mistakes in it. It should have been proofed by someone else.*" However, this respondent also stated that the organization would be better able to submit a competitive application in the future because they had hired a new Executive Director with experience in grant writing.

A second Planning Grant recipient stated that their organization's application was rejected because the community did not meet the threshold for population size and because the application did not effectively demonstrate sufficient need. According to the informant, "*We had to demonstrate that our Title I funding was not sufficient. We knew that our Title I funds were not sufficient, but we could not convince the funding agency."* This grantee also indicated that part of the challenge in demonstrating need was the nature of the population and community it served, which was comprised primarily of transient migrants. Although no longer with the organization, this respondent indicated that the next time the organization applied for an EIS Grant, it would develop a better understanding of the needs of the local population, involve professional grant writers, and obtain greater buy-in from other organizations.

A third organization believed that it did not receive an EIS Grant because of insufficient Federal funds. As the respondent expressed, "*There was no funding available at the time, but we really need a Title III grant. Applying for the grant is our next step once more EIS Grant applications are being accepted. Early intervention is needed, and we are trying to take care of the HIV-positive population without Title III funds.*" The fourth organization argued that it was not awarded an EIS Grant because of its close proximity to two hospitals that were already receiving Title III EIS funds. The interviewee acknowledged that, "*Knowing that we were competing with the other hospitals, I would look to collaborate with them at the beginning, instead of waiting another two years before deciding to collaborate with them.*"

The two Planning Grant organizations that did not apply for EIS Grants provided different explanations for their decisions. One respondent indicated that the organization had originally applied for a Title III EIS Grant but had been awarded a Planning Grant instead. After completing the Planning Grant, the organization considered becoming a service provider but decided it was in a better position to furnish services as a partnering clinic rather than as a sole provider. The representative of this organization also indicated that HRSA discouraged it from applying because it was already funded under Title II. However, this view is inconsistent with

the experience of other Planning Grant recipients who stated that, although they received Title II funds, they were also awarded Title III EIS Grants. The other organization that did not apply for EIS funds stated that it came to realize that the existing HIV providers were already meeting the demand for HIV primary care services in its community. The respondent explained, "*We did not want to duplicate our services. After receiving the [Planning] Grant, we were able to maintain relationships with providers by referring HIV-positive patients to them*."

As stated earlier, two sites did not apply for EIS Grants directly but, rather, chose to seek EIS funds indirectly as subcontracted service providers to other grantees. One of the two organizations reported that it did not apply for Title III EIS funds because it was already a subcontracted site for outreach services for an established family practice center that was supported by an EIS Grant. The interviewee stated that, "*They [the contracting organization] encouraged us to set ourselves up as our own EIS site because we are growing. We would be happy if we were our own site. It's a cooperative relationship. We will set ourselves [up] as an EIS site when EIS money becomes available. They [HRSA] are currently not releasing proposals for new sites*." The other organization decided to apply for EIS funds through a partnering organization because of internal staff turnover, the dissolution of the statewide Title II consortium, and internal leadership problems. However, the partnering organization that applied for EIS Grant money was not funded, and the key informant explained that the application was rejected because of these internal and external issues.

In summary, despite their failure to obtain Title III EIS funding, all but one of the Stratum II grantees said that there remained a strong need to increase HIV primary care services in their communities. A few of the views expressed concerning the need for additional local services follow:

> *"A large unmet need still exists. We have a larger capacity now, but there is still more to be done. We have 35 new patients in this year alone. Of those, eight or ten are newly diagnosed. The need continues."*
>
> *"We had an increase in care for 200 patients this year, and providers are not caring for HIV-positive patients due to costs. It's a late epidemic in our area because HIV appeared late in minority populations, especially among women."*
>
> *"We continue to grow. In another 12 months, we will easily be at 60 patients. Some towns are increasing in population, and because patients are spreading the word, we see a shift of patients increasing at our clinic. We need to increase the*

*clinic's days and hours, and work out a lot of details, but a lot of that planning has been put on hold until we receive our own EIS funds."*

## 5.2 Impact of Planning Grant on Delivery of EIS-funded Services (Strata I and III)

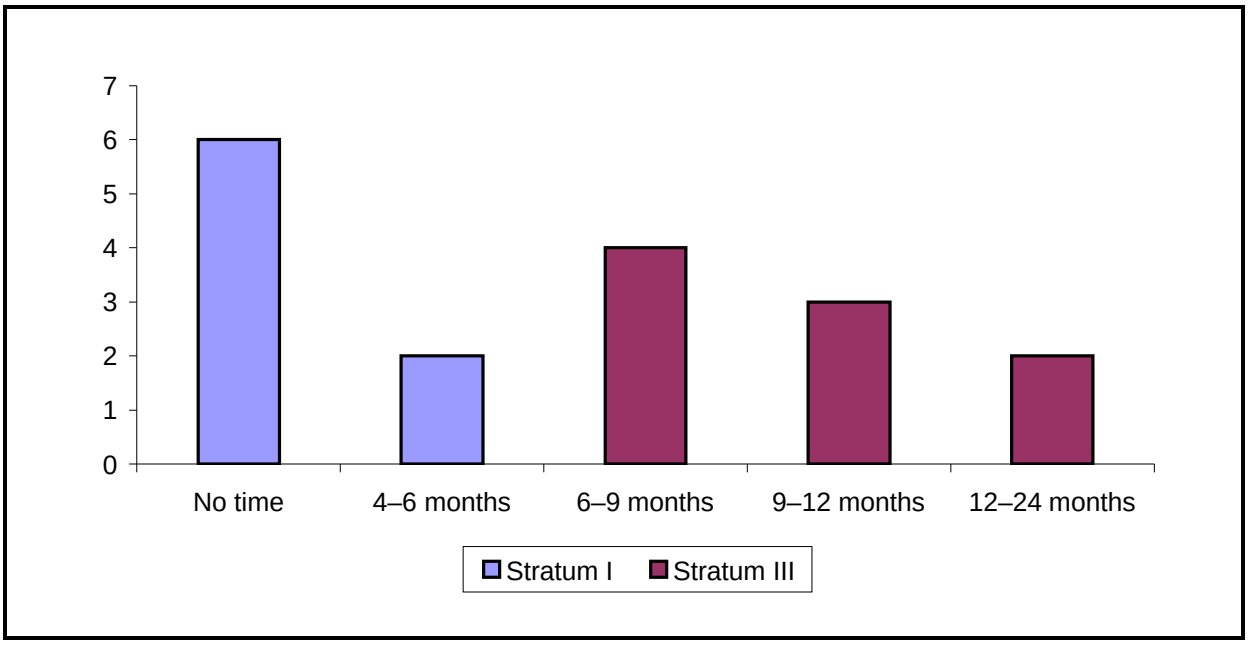
To assess the long-term impact of the Planning Grant program on the delivery of services, we compared Stratum I grantees (i.e., Planning Grant recipients that subsequently received Title III EIS Grants) with Stratum III grantees (i.e., Title III EIS Grant recipients that had never received Planning Grants). We compared the experiences of the two strata with respect to both operational performance and delivery of services. The operational performance of EIS Grant recipients was evaluated along several dimensions, including achieving full staffing, formalizing agreements with partners, developing operating policies and procedures, and involving consumers in their programs. To understand the effects of the Planning Grant on the delivery of services, we assessed the number of clients who received HIV counseling and testing, the number of tested clients who returned for their results, the proportion of HIV-positive clients who entered into regular care, and the number of HIV-positive clients who met the U.S. Public Health Service (PHS) standard of four outpatient visits per year. The impacts of the Planning Grant program on operational performance and service delivery are discussed separately below.

### *5.2.1 Impact of Planning Grant on Operational Performance*

***Achieving Full Staffing.*** There were significant differences between Strata I and III sites in achieving full administrative and clinical staffing after receiving EIS Grant awards. As illustrated in Exhibit 16, six out of the eight Stratum I organizations reported that they had staff in place at the time of their EIS application and thus took no time to achieve full staffing. Two other organizations reported that it took four to six months to achieve full staffing. In contrast, all Stratum III grantees reported significant challenges in achieving full staffing. Seven of the nine organizations in Stratum III indicated that it took six to twelve months to achieve full staffing, while the remaining two reported that it took close to two years. Two of the Stratum III organizations felt that they were not sufficiently staffed at the time of this study. Reported challenges associated with achieving full staffing among Stratum III grantees included

- newly hired administrative staff who had no prior experience with the service communities faced difficulties in networking with primary care providers,
- difficulties in establishing dental services,
- an inability to find bilingual providers, and
- a shortage of social workers and care providers who were willing to work with HIV-infected patients.

**Exhibit 16. Months Required to Achieve Full Staffing after Receiving EIS Award**




One grantee explained that the difficulties they experienced recruiting clinical staff were especially relevant in the southern region of the country. The interviewee offered, "*There is a shortage of clinicians in general, particularly a geographic mal-distribution… that is exacerbated by the notion that there are a sufficient number of clinicians to take care of this [HIV/AIDS] growing population in the South."* One Stratum III grantee recognized that a Planning Grant would have helped them to achieve full staffing more quickly. This comparison group interviewee acknowledged that "*Should we have received the Planning Grant, I think we could have had this place fully operational in three to six months maximum. If we had really been proactive, we could have planned all this out and established the network much quicker.*"

Another participant located in the central region of the United States indicated that dental services were the biggest challenge. This respondent stated, "*We wanted to see if we could actually hire a dentist or at least pay a part-time dentist to see our patients, and that didn't work out. With the dental crisis we have in the state, to get an appointment takes six months. So realizing that patients were not going to get quick dental services, we had to establish new relationships with other organizations.*"

***Formalizing Agreements with Partners.*** EIS providers that had prior Planning Grants (Stratum I) were reportedly more successful in formalizing agreements with partners than those without Planning Grants (Stratum III). According to the interviews, EIS Grant recipients that had prior Planning Grants experienced a smoother process in formalizing contracts, establishing

memoranda of understanding, and obtaining affiliation agreements with partner sites. Most of the Stratum I respondents reported that such systems and agreements were already in place at the time of EIS application. One respondent stated, "*It was fine, because 80 percent of the service delivery for dental, hospital, and pharmacy, we were already providing directly or through contracts*." Others reported that they also had such relationships in place from previous CARE Act funding (mostly under Titles I, II, and IV). A common challenge in formalizing provider agreements cited by Stratum I grantees was establishing salary caps under the EIS Grant. One respondent reported that they were able to overcome this challenge by allowing doctors to see the grant budget and then working together to reach a compromise about staff salaries.

EIS Grant recipients without prior Planning Grants reported a different experience in formalizing agreements with partners. Those who were, in fact, able to establish agreements did so by finding and using templates from other initiatives, projects, or organizations. One respondent reported that she had used a template from her prior employer. As the informant acknowledged, "*I tried not to reinvent the wheel. We had subcontracted with several organizations in the past, so I tried not to reduplicate. I pulled out their contracts and saw what I could copy.*" Those who tried to develop new provider agreements reported a range of difficulties and delays similar to the difficulties experienced in achieving full staffing levels. It took close to a year or longer to set up such contracts for at least four grantees. As one interviewee expressed, "*It was a little bit of a red tape for a large organization (a university-based clinic), but we got it done. First year we carried over $40,000 because we didn't get staff hired right away*." Another grantee similarly noted that, "*It took forever. The county didn't want to help with mental health services; we couldn't get [provider name omitted] system to sign the contract for dental services in a timely fashion; all the contracts took forever … they are all done now, but it took about two years*."

***Developing Operational Policies and Procedures.*** Stratum I and III grantees reported no differences in their experiences in developing new operating policies and procedures. Most Stratum I and III grantees indicated that they were able to make necessary modifications within the first year of their EIS Grants. The majority of Stratum I and III grantees reported that they were able to modify and adopt policies and procedures that already existed. As one respondent stated, "*Seventy-eighty percent of the policies and procedures were in place. Over the next 18 months we developed, implemented, tested, tweaked, and cemented the procedures for meeting the needs of the EIS population*." Some grantees felt that most of the operating policies and procedures were already in place as a result of providing primary care services prior to receiving EIS funding. One informant claimed, "*It was easy for us because we have been providing HIV*

*services for so long. By the time we wrote the grant we were already 10 years into providing HIV services, so many of the things were already in place*."

***Involving Consumers.*** Both Strata I and III grantees reported successfully integrating consumers in developing and/or advising their programs, an objective actively promoted by HRSA. The most common vehicles for obtaining community involvement were patient advisory boards, community councils, and committees. Consumer advisory boards were involved to various degrees, with some organizations convening them as often as twice a month, while others held as few as two meetings in total. Other activities used to encourage the involvement of consumers included

- conducting patient satisfaction surveys,
- incorporating patient advocates in clinics, and
- sponsoring consumer education forums and social activities.

Some of the challenges reported by respondents associated with obtaining consumer involvement were integrating clients who spoke different languages, addressing issues of HIV stigmatization, ensuring client representation and continuous involvement from migrant communities, and putting client recommendations into practice. Because of the stigmatization of HIV, grantees from rural parts of the country had a difficult time obtaining the involvement of HIV-infected consumers, rather than just friends and family members of those who are infected. As one respondent noted, "*Being in a rural area, it's much harder to get consumer involvement than in, say, a more metropolitan area. And that's because of stigma. These people do not want people knowing. … Because of stigma, it is very difficult to find a consumer who is willing to be 'out' about their status. To serve on the board, at this point, we have affected, not infected, members like family who serve on the board*."

One of the grantees felt that obtaining and providing information to HRSA on the HIV status of their planning volunteers was especially troublesome. As this respondent commented, "*HRSA wants it [this information] in a very specific way. For example, 50 percent of our board has to be patients. It has to utilize our services, so our board of directors is representative of our consumers. And that wasn't good enough because HRSA asks if any of them are positive, and we would say, 'We don't know, it's not like we're asking them to disclose that information*'."

Another significant challenge cited by several respondents was integrating into the planning process consumers who spoke different languages. One organization was able to overcome this challenge by creating two separate councils, one for each linguistic group in their

community. As the respondent observed, "*It was difficult to have [both] English- and Spanish-speaking members in the meetings, with the constant interpretation. There was no flow at all, very frustrating … We decided to separate the English-speaking and the Spanish-speaking [consumer representatives], and it has made a big difference*."

Despite these challenges, informants from most of the organizations interviewed for this study felt that consumer input to their activities was extremely valuable. By involving consumers, grantees improved their services in a variety of ways. For example, one grantee was able to reduce the fears of stigmatization among patients by changing the location of the waiting area from the front of the prevention manager's office to a more private area.

### *5.2.2 Impact of Planning Grant on Delivery of HIV Services*

To determine whether Planning Grants led to improvements in delivering services to people living with HIV and AIDS, we collected data on the number of clients who received HIV testing and counseling, the proportion of tested clients who returned for results, the proportion of those receiving positive results who entered into regular care, and the proportion of HIV positive clients who met the U.S. Public Health Service (PHS) standard of four outpatient visits per year. However, it should be emphasized that assessing the impact of Planning Grants on service delivery is an extremely difficult task. First, as discussed earlier, grantees had difficulty providing and reporting complete outcome data. Five organizations did not return their advance questionnaires, and those that did return the questionnaires were not able to provide all the requested information. Second, we have concerns about the accuracy and consistency of these self-reported data. Several questionnaires failed simple validity checks, such as the proportions of clients by race not adding up to 100. Similarly, some respondents summed outcomes over the entire 3-year period that was requested, while others provided the information for a 1-year period only. Third, assessing the impact on care delivery requires a longer post-Planning Grant period of performance than was possible under this study. Fourth, our comparison group of non-Planning Grant recipients may have been providing EIS services for long periods of time, making it difficult to compare their experiences with those newly funded after the completion of the Planning Grant. Finally, reports from several Planning Grant recipients included HIV primary care provided under other sources of funding. Despite these limitations, the data collected for this study revealed some information on the impact of Planning Grants on service delivery.

The number of clients enrolled in HIV care during the most recent year for which organizations had available data ranged from 130 to 1,587, with no differences between the two

strata. (The results of the advance questionnaire upon which this analysis is based are presented in Appendix E.) Most organizations that reported data indicated that from 70 to 100 percent of their patients had at least four outpatient visits per year. Only two Stratum III organizations reported that 55 percent or less of their patients met the PHS standard. Interestingly, all Stratum III organizations that responded to the advance questionnaire provided this information, whereas three Stratum I organizations did not. This reporting difference may be due to the fact that Stratum I grantees had shorter periods of EIS-funding and therefore less experience in collecting and reporting client utilization data. Most organizations indicated that they were providing HIV testing and counseling services on site. The number of clients tested ranged from 235 to over 600. All respondents indicated that the majority of patients who tested positive were subsequently entered into regular primary care.

While this information is insufficient to draw firm conclusions about the impact of Planning Grants on service delivery, the results illustrate that those EIS grantees that participated in the Planning Grant program performed at least as well as EIS Grant recipients in the provision of care.

### 5.3 Challenges in Implementing Planning Grants (Strata I and II)

In general, grantees were supportive of the Planning Grant program and stated that it made a positive impact on their infrastructure and communities. However, as with any activity, grantees identified a few common challenges in implementing their Planning Grants. The challenges reported by the Planning Grant informants were associated with the grants' adequacy to support the proposed activities and the grantees' ability to coordinate services with other providers, obtain participation from physicians and consumers, understand HRSA's expectations, and obtain consistent technical assistance from HRSA. Each of the challenges discussed in this section was reported by two or more grantees.

***Obtaining Advisory Board Commitment.*** Three grantees indicated having problems scheduling and obtaining commitment from their advisory board members. One organization reported overcoming this barrier by holding individual meetings and sharing the notes with the larger group later. Another group was able to increase its advisory board's attendance by providing mileage reimbursement for board members residing outside its county.

***Planning Grant Adequacy for Proposed Activities.*** Several grantees reported that the 1-year Planning Grant cycle was too short to implement their proposed activities and achieve their stated objectives. When asked how the Planning Grant process could be improved, two grantees stated that 2-year or multiyear awards would better allow them to complete all of the proposed

activities. In contrast, another grantee strongly argued that there should be no need to extend the Planning Grants for longer than one year. Interestingly, this grantee represented a rural community-based organization that had no prior experience in delivering HIV primary care. In addition, one informant stated that the money provided through the grant was insufficient to cover the expenses related to planning for the delivery of services in its geographic area.

***Partnerships and Coordination of Care.*** Several grantees reported experiencing problems in creating partnerships and coordinating care. These challenges seemed to be related to the areas in which they were located. One respondent from a site located in a major metropolitan area felt that there was strong competition for EIS funding. According to the respondent, other organizations in that community were already in the process of providing HIV primary care. In this grantee's view, it had to prepare stronger grants and be more aggressive in securing partnerships with organizations in the community to compete with existing providers of HIV-related services. On the other hand, grantees from rural areas reported having trouble getting other service providers in their communities to collaborate for the purpose of providing integrated primary care services. As one grantee described, the organization identified a particular type of primary care service that was needed in the area but had difficulty gaining buy-in from other providers for the service.

***Challenges Related to HRSA.*** Experience with HRSA staff varied among Planning Grant recipients in both strata. While most respondents said that their relationship with HAB improved their ability to plan for and provide care and cited excellent relationships with their project officers, a few grantees expressed a lack of satisfaction with the technical assistance provided by the Agency. One respondent expressed frustration over having had to work with three different project officers within a one-year period.

Additionally, two Stratum II organizations expressed disappointment at not being selected for EIS Grants. As one organization shared, "*The uncertainty of whether you will get implementation makes the planning process feel unsatisfying. If there was a more direct link between planning and implementation, the process would be more satisfying. People feel like they just wasted 2 years because there was no funding attached to the implementation process.*" Another group suggested that more support for grant writing at the end of the Planning Grant period would have been constructive and would have increased their chances of winning an EIS Grant.

Respondents from two organizations that had already been awarded EIS Grants expressed frustration over the potential for abuse of the Planning Grant program by organizations that never

intend to apply for EIS Grant funding. These respondents suggested that HRSA should develop clearer expectations in the Planning Grant guidance that grantees should complete EIS Grant proposals at the end of the funding cycle.

Finally, several grantees noted that they had had difficulty in meeting HRSA's reporting requirements under CARE Act titles. The majority of the study respondents indicated that, in addition to their Title III awards, they also received service delivery grants under Titles I, II, or IV. As one Stratum III respondent offered, "*The most difficult challenge for reporting was to meet the administrative separation of what was Title I and Title III as far as reporting is concerned. My issue is that the reporting requirements seem to be different from one Title to the other. The idea of having to separate these patients by Title is not how practice occurs. Patients go into more than one Title. Some may be Title I for some things and Title III for others. For example, insurance status may change, and that might cause them going into a different Title. Part of the issue is that for years, the Titles did not talk to each other.*"

# CHAPTER 6
# CONCLUSIONS

The primary purpose of the Planning Grant program is to support the introduction or expansion of quality care delivery systems for people living with HIV or AIDS. The results of this qualitative evaluation indicate that the Planning Grant recipients interviewed for this study successfully achieved most of their intermediate objectives and that the program ultimately helped strengthen the delivery of quality care in several important ways:

- Most grantees successfully implemented the immediate objectives of their Planning Grants, most notably, conducting needs assessments, creating advisory boards with client participation, establishing partnering arrangements, evaluating existing provider capacity, and identifying additional sources of funding.
- Most grantees successfully realized the longer term goals of their Planning Grants. Stratum I organizations described their longer term goals in terms of service expansion through EIS grants. Importantly, Stratum II organizations also expressed satisfaction with the information they had obtained and the plans that they were able to develop through the Planning Grant process. However, in these cases, the Planning Grant led to a realization either that the current need for care was adequately covered by the existing service providers in the community or that the organization was better suited to participate in service delivery through a subcontracting arrangement with another grantee.
- Almost half of all Planning Grant recipients successfully received Title III EIS grants directly as prime grantees, while several others received EIS funds indirectly through subcontracting agreements with other grantees.
- Planning Grant recipients that received EIS funding reported greater success in obtaining full staffing, formalizing contracts with providers, establishing memoranda of understanding, and obtaining affiliation agreements with partner sites than EIS providers that had not implemented a Planning Grant.

## 6.1 Performance of Planning Grant Activities

Most Planning Grant recipients successfully completed their proposed activities. Planning Grant recipients reported success in forming advisory boards and conducting needs assessments. Two areas in which differences in performance were particularly evident between Strata I and II were: (1) forming linkages with other organizations and (2) engaging in consumer and provider evaluation activities. Organizations with continuing EIS funding (Stratum I) exhibited both stronger linkages with other organizations and more focused activities in their planning processes. The success of Stratum I grant recipients in achieving their Planning Grant objectives relative to the Stratum II sample is likely due in part to their prior experience in providing services, particularly when that experience was with Title III EIS funds.

A large proportion of Planning Grant recipients were in the process of delivering primary care services at the time of their applications. A large number of organizations in Stratum I indicated that they would have expanded their services even if they had not received new or continuation EIS Grants. However, these grantees also indicated that expanding services would have been more difficult and taken longer to accomplish without the Planning Grant support. Prior experience with EIS Grants seemingly gave these organizations an advantage in their ability to meet performance requirements, which possibly led to an increased likelihood of their obtaining both Planning and subsequent EIS Grants. One important program-related issue that this study did not address was whether Planning Grant funds are best used to support planning for the expansion of ongoing EIS-funded programs or rather to help new organizations start EIS-funded services, and whether the expectations for performance should be the same for both types of organizations.

In general, participants in the Planning Grant program indicated that the program helped them achieve their organization objectives, including in some cases learning that the community did not need additional HIV primary care services. Although some respondents that did not receive Title III EIS Grants expressed disappointment that their Planning Grants had not led to additional funding, most respondents felt that the supplemental funding contributed to the collection of information that was useful for further planning for care delivery services in their organizations and communities. The continuation of advisory boards among Planning Grantees that did not receive subsequent EIS awards represented an additional benefit of the program.

### 6.2 Impact of the Planning Grant on Operational Performance and Delivery of Care

EIS Grant recipients that received Planning Grants (Stratum I) appeared to meet the Title III EIS Grant requirements and to implement the activities necessary to deliver quality HIV care faster and with fewer difficulties than EIS grant recipients that had never received Planning Grants (Stratum III). Most of the Planning Grant recipients that received EIS Grants were fully staffed at the time of receiving their EIS funding. Those that were not fully staffed experienced no or significantly shorter delays in achieving full staffing and reported fewer other challenges than EIS-funded providers without prior Planning Grants.

Strata I and III grantee experiences in other operational areas (e.g., formalizing contracts with providers, establishing memoranda of understanding, and obtaining affiliation agreements with partner sites) differed as well. Organizations that did not have Planning Grants prior to receiving their EIS awards reported significant challenges and time delays in establishing such procedures. Difficulties in setting up contracts, memoranda of understanding, and affiliation

agreements may have been driven in part by problems in achieving full staffing. However, these challenges may have been minimized by the presence of focused planning efforts in prior years through the Planning Grant mechanism. In contrast, there were no observed differences in the development of operating policies and procedures between grantees that were delivering primary care services with or without prior Planning Grants. Similarly, with varying degrees of involvement and success, most EIS Grant recipients in both strata successfully integrated consumers into their programs.

The Planning Grant program appeared to have a positive impact on the delivery of services for those grantees that received subsequent Title III EIS Grants (Stratum I), as well as for those that provided services but did not receive EIS awards (Stratum II). Organizations that received Planning Grants provided a broad range of services to patients with HIV and AIDS in the subsequent two- to four-year period after completing the grants. Grantees that participated in the Planning Grant process delivered services at least as well as the Stratum III comparison group of EIS Grant recipients with no prior Planning Grants. Perhaps the most interesting and unanticipated finding is that at least half of Stratum II grantees also provided HIV primary care services, although they were not supported by Title III EIS grants. Those that chose not to provide services reported that the Planning Grant process helped them develop a better understanding of both the demand for care and the capacity of existing services in their local communities. The Planning Grants also helped them establish successful linkages with other care providers.

# CHAPTER 7
# RECOMMENDATIONS

Based on the findings from key informant interviews with Planning Grant recipients, we believe that the Planning Grant program is an important component in the array of resources that HRSA makes available to local communities to help them plan for and implement quality care for low-income and disadvantaged people living with HIV and AIDS. As we have reported in this study, many recipients have used the Planning Grants to conduct critical activities that have led to the development of new or expanded HIV primary care services. In a few cases, activities conducted under the Planning Grants led recipients to realize either that the demand for services was already being fulfilled by available resources or that resources would be better used by partnering with other grantees in the care system.

However, our discussions with a representative sample of Planning Grant recipients reveal several areas in which the program might more effectively achieve both its intermediate objectives relating to planning and its longer-term goals of improving the delivery of quality care. Our recommendations for improving the Planning Grant program are divided into three broad areas: (1) targeting of and eligibility for Planning Grant funds; (2) coordination of Planning Grants with other CARE Act funds; and (3) Planning Grant guidance and technical assistance from HRSA. The recommendations under each of these three areas are summarized separately below.

## 7.1 Targeting of and Eligibility for Planning Grant Funds

Our evaluation has shown that Planning Grants have been used by a wide variety of providers to conduct a wide range of activities. In some cases, recipients had experience in delivering primary care services, including Title III EIS-funded services, and were exploring opportunities to offer a new set of services or to expand into a new area or population group. In other cases, recipients had no prior experience in delivery primary care services and were exploring opportunities to enter into the HIV care delivery system for the first time. Several Planning Grant recipients also had previous or concurrent experience in delivering primary care under Titles I, II or IV. We found similar variation in the types of activities being conducted under the Planning Grant program. While most recipients conducted the core set of services identified in the program guidance (i.e., assessing local needs, creating advisory groups, and establishing linkages with other providers), others undertook activities that are important but less germane to the planning process, such as developing fiscal, clinical and case management

information systems—activities that might more appropriately be conducted under Capacity Building Grants.

Given the limited amount of resources available under the Planning Grant program, HRSA should consider strengthening the set of internal guidelines that target program funds more specifically on the types of grantees and activities that offer the greatest potential for ultimately augmenting or improving the delivery of care. HRSA might consider developing a priority list of the types of grantees and services eligible for funding under the Planning Grant program. Issues related to the targeting of and eligibility for Planning Grant funds should be developed through internal discussions among Title III program staff. Factors to consider include the following:

- **Prior experience delivering HIV primary care**. As a way of expanding the number of CARE Act providers in underserved areas or populations, HAB might choose to target funding on entities with no prior experience in delivering HIV primary care. Alternatively, HAB might choose to target funds to existing CARE Act providers only if they are seeking to expand the types of primary care services offered or the geographic regions served.
- **Types of services offered.** HAB might want to restrict Planning Grant funds to those entities that seek to provide or expand a core set of health care services that have been shown to be effective as prevention and maintenance interventions, such as primary or specialty medical care; case management; identification (outreach), retention, and adherence programs; and substance abuse or mental health.
- **Focusing on underserved regions or populations.** HAB might consider targeting Planning Grant funds on areas of the country known for having a lack of qualified and experienced providers of care for HIV and AIDS. Potential candidates include states and rural areas in the southeastern region of the country. HAB might also consider directing Planning Grant funds to providers seeking to offer new services or expand existing services into disenfranchised subpopulations such as minorities, the non-permanently housed, the previously incarcerated, immigrants, substance abusers, and those with mental health or other medical comorbidities such as hepatitis C.
- **Types of activities covered.** HAB might consider more clearly defining the types of activities eligible for coverage under the Planning Grant program. Clearly, eligible activities should be critical to planning for the delivery of quality services. While needs assessments, collection of epidemiological data, advisory boards, consumer participation, partnering arrangements, and budgeting are all important components of planning, other activities such as staff training and the development of technological infrastructure may be more appropriately funded under other grant mechanisms such as the Title III Capacity Building Grant program. HAB might consider restricting the list of eligible activities to those that are the most important for planning purposes and make sure that these activities are clearly explained in the program guidance and articulated in the grant applications. HAB might also want to

monitor the activities during the period of performance more closely to ensure that grant recipients adhere to the eligible services.

## 7.2 Sequencing of Planning Grant with Other CARE Act Funds

As stated in the companion Capacity Building Grant program evaluation report,[3] the Planning Grant program should be viewed as part of a comprehensive "package" of funding resources that can be used together to build synergies and lead to more effective delivery of care. These other sources of funds include the Title III Capacity Building Grant program, designed to help providers improve their internal capacity to deliver care, and the Title III EIS program, designed to fund a core set of primary care services. But they also include funds that may be indirectly allocated through eligible metropolitan areas (Title I funds) and states (Title II funds), as well as funds received directly or indirectly through Title IV for service delivery targeted toward infected or affected women and children. Given the purpose of the Planning Grant program, it might seem reasonable that program funds would be viewed as the first step in the process of developing care delivery systems, prior to the receipt of funds for the delivery of services under other titles. Subsequent receipt of new funds for the delivery of new or expanded services may be made conditional on the successful completion of the selected Planning Grant activities, including needs assessment, advisory boards, and partnering arrangements. Applicants who have not completed these planning tasks would not be eligible for subsequent funding for service delivery or capacity building under the CARE Act.

A 'sequencing' of funds assumes that additional monies will be available for new or expanded service delivery grants either through new awards under Titles III and IV or through an internal reallocation of funds under Titles I and II. Planning Grants should be awarded to new entities only if there are sufficient funds under Titles III or IV to increase the total number of grantees or if states and/or EMAs agree to reallocate their subcontracted dollars to these entities after they have completed their Planning Grants. Without a commitment to provide service delivery grants to new entities that complete their Planning Grants (either directly from HAB or indirectly from states and EMAs), then program funds should be restricted to current CARE Act providers. In fact, HAB should attempt to make explicit in the Planning Grant guidance the link between the successful completion of planning and the award of service delivery grants. Several grantees felt that they did not receive EIS grants due to a lack of Federal funding. Keeping grantees informed about the likelihood of funding as the information becomes available would help manage grantee expectations and the allocation of efforts to develop EIS proposals. If HAB

[3] Aldridge, S., Mitchell, N., Harris, S., Squire, S., Swinson, T., Brown, P., Green, J., and Gilman, B. Factors Contributing to the Success of Title III Capacity Building Grants. Draft Final Report to be submitted to HRSA HIV/AIDS Bureau May 2006.

cannot commit to a subsequent funding of service delivery programs (conditional on completion of activities and demonstration of need), then Planning Grant funds should be restricted to current service providers.

### 7.3 Planning Grant Guidance and Technical Assistance for HRSA

As stated earlier, HAB may wish to develop more specific guidance and tools that grantees can use to better assess their planning needs, identify their planning objectives, and determine their eligibility for funding under the Planning Grant program. The program guidance might include a list of the types of core planning activities eligible for funding and the steps required for subsequent receipt of a service delivery award, such as the successful completion of a needs assessment with a clear demonstration of unmet need, the creation of an active and effective advisory board with provider and consumer representation, the development of a budget and financial plan identifying external sources of funds, and the establishment of complementary or mentoring relationships with other providers. The program guidance could also specify the guidelines and recommendations for implementing each of these activities. Program details might include

- representation on the advisory board and definition of the term 'consumer;'
- strategies for obtaining consumer input;
- the role of the advisory board and the frequency of advisory board meetings;
- types of acceptable linkages with other providers;
- requirements for demonstrating unmet needs, including target populations and services; and
- budget and financial plan templates.

Finally, HAB should consider ways to help disseminate best practices and common challenges under the Planning Grant program. Since many of the awardees are new to the CARE Act and may have limited or no experience in providing primary care services to people with HIV and AIDS, grantees would likely benefit from increased opportunities for networking with other grantees, especially those successfully delivering Title III EIS Grants. Such opportunities could be embedded in the national meeting structure or set up as a mentoring program involving organizations that share similar community and organizational characteristics. Moreover, sharing innovations and successful solutions that address encountered challenges (e.g., obtaining the commitment and participation of advisory boards, establishing dental and oral health services, meeting the needs of multilingual populations, and addressing issues of stigmatization) would help to overcome similar barriers faced by others. For the same reason, Planning Grant recipients

would also benefit from greater technical assistance from HAB program staff. Given that one of the main purposes of the Planning Grant program is to help support the development of qualified HIV health care providers in underserved areas, HAB may need to monitor grantees more closely and provide more targeted technical assistance than is traditionally given to established programs.

# APPENDIX A:
# ADVANCE QUESTIONNAIRE

**ADVANCE QUESTIONNAIRE**

Thank you for agreeing to participate in an interview for the HRSA study "Assessing the Success of Title III Planning Grant Recipients." We are looking forward to speaking with you on _____.

Before our scheduled interview, it would be helpful if you could review the following questions. Please return your responses to these questions before our scheduled interview. If that is not convenient, we will be happy to collect the information from you as part of our phone discussion.

1. What is your organization type?
   - Publicly Funded Community Health Center
   - Community Based Service Organization
   - Health Department
   - Hospital or University Based Clinic
   - Non-Federally Funded Community Health Center
   - Other _____

2. What types of services do you provide?

3. How many full time equivalent employees are employed in your organization?

4. Do you have volunteers? If so, how many?

5. In how many locations do you have offices?

6. What proportion of your funding comes from private or federal grants?

7. What is your annual operating budget?

8. What types of populations do you serve? (Please provide general proportion.)
   - Race/ethnicity
   - Gender
   - Insurance status
   - Location [rural/urban]
   - HIV risk factors

9. What is the overall ethnic/racial composition of the care providers (medical doctors, nurses, social workers) in your organization?

10. How many clients were enrolled in HIV services or care for the past 3 years (or the past 3 years for which you have data available)?

11. How many clients met the U.S. Public Health Service (PHS) standard of four outpatient visits per year for the past 3 years (or the past 3 years for which you have data available)?

12. Does your clinic provide testing and counseling services?

    If "yes,"

    a. How many clients received pretest counseling during the past year (or the last year that you have data available)?

b. How many clients were tested for HIV during the past year (or the last year for which you have data available)?

13. How many clients who tested positive returned for results during the past 3 years (or the last 3 years for which you have data available)?

14. What proportion of clients who received positive test results entered into regular care (defined as at least one outpatient visit per year) during the last 3 years (or the last 3 years for which you have data available)?

Please return this form to asorensen@rti.org or fax to 919-541-7384,

**Attn: Asta Sorensen**

# APPENDIX B:
# TELEPHONE INTERVIEW GUIDE
# TITLE III PLANNING GRANT—STRATUM I:
# PLANNING GRANT RECIPIENTS THAT RECEIVED EIS GRANTS

**INTRODUCTION**

Thank you for taking the time to talk with me today. We appreciate your interest and willingness to discuss your Title III Planning and Service Delivery Grant with us.

As you may have been informed, the HRSA HIV/AIDS Bureau is interested in gaining a better understanding of the Planning program impact on the performance of Planning Grant recipients. The objectives of this study are

- To understand grantee experience with CARE Act Planning Grant program;
- To assess the Planning Grant's impact on the delivery of services; and
- To identify the effects of organizational and community characteristics on grantee performance and delivery of services.

RTI is assisting HRSA with this activity by conducting a series of telephone interviews with current and past planning program grantees. We expect this interview to last about one hour. Your participation today is completely voluntary. You may decline to answer any question, and you can refuse to participate further at any point during this discussion. Your decision to participate will not have any impact on your relationship with HRSA or your current or future CARE Act funding.

With your permission, we will audiotape the conversation to assist us with our note-keeping. You may make off-the-record remarks if you wish; these will not be recorded. The tape recording will be destroyed after the study is complete. This conversation will be kept confidential. It is possible you might be contacted at a later date if issues are raised in other discussions that need clarification.

RTI will write a summary report of the findings from all the discussions. Your name and the name of your organization will not appear in any reports from this study, and no comments made during this conversation will be attributed to you or your organization. If any information is distributed beyond HRSA, no names of individuals or grantees will be included.

Your organization was selected for this study from organizations that received the Title III EIS Grant after participating in the Planning program in 2001 and 2002. Of those organizations, you were further selected based on sample requirements in terms of geographic location and the type of organization. We are asking you these questions in your capacity as a Project Director or Project Director's designee.

Do you have any questions before we start? With your permission, we'd like to get started.

## INTERVIEW QUESTIONS

First, let's talk about some characteristics of your organization and community.

**1. Organizational and Community Characteristics**

a. Tell me a little about your organization.

*Probes: size, history, and services.*

b. What is your role in your organization?

c. How have you been involved with CARE Act Planning and Service Delivery Grants*?*

*Probes: writing, managing, monitoring, evaluating?*

d. Did your organization have experience in providing HIV primary care at the time of your Planning Grant application, _____ (PROVIDE GRANT APPLICATION YEAR)?

(1) If so, how long you had been providing those services?

**2. Leadership**

a. In applying for Title III Planning Grant, was there a specific person who championed the idea of obtaining CARE Act funds?

*Probe: What was this person's role in your organization?*

b. What support or resources did you have in writing a proposal for the Planning Grant?

*Probe: Did you use any grant writing support or other professional services in preparing your proposal?*

**3. Partnerships**

a. Did you partner with any other organizations BEFORE or during the process of applying for the Planning Grant?

*Probe: What type of organizations?*

b. What new partnerships did you form AFTER receiving the Planning Grant?

c. Were there other organizations providing CARE Act-supported services in your community at the time of your application to the Planning Grant program (not just Title III)?

*Probes: What were they?*

*What relationships did you have with them, if any?*

d. Were there other groups providing HIV/AIDS care services in your community?

*Probes: What were they?*

*What types of relationships did you have with them, if any?*

e. **[If YES to c. or d.]** In what ways did these partners contribute to your Planning Grant performance?

The next set of questions pertains to your experiences with the Planning Grant.

*[For questions **c-h**, check and ask only those questions that apply based on prior review of grant application or if it is listed in answering question **4a**. If this information is not available, ask all the questions in this section.]*

**4. Meeting the Terms of Planning Grants**

a. What goals were proposed by your organization under the Planning Grant?

b. How did the activities you reported at the end of the grant period compare to those that you originally proposed?

*Probes: Were they the same?*

*How did they change?*

*What led to these changes in activities?*

c. Did your organization establish a formal advisory group or work with an existing group in planning the initiation of new services?

*Probes: Was it successful?*

*Was it sustained after the Planning Grant was complete?*

*What challenges did you encounter in establishing the advisory group?*

d. Did your organization complete an in-depth needs assessment and epidemiological profile for HIV primary care services in the community besides the one you did for the proposal? (If yes,) Tell me about that.

*Probes: Was it successful?*

*What were the outcomes?*

*What were the challenges to doing the needs assessment/epi profile?*

e. Did your organization complete an evaluation of your community's existing provider population?

*Probes: Was this helpful to your organization? Tell me more.*

*Were there any challenges in this? If so, what were they?*

*Was there anything that helped you to achieve this? Please describe.*

f. Did your organization complete a profile of the target population? What did you learn as a result of this process?

*Probes: What challenges were there in creating a profile?*

*Was there anything in particular that helped you in creating the profile? Please describe.*

g. Did your organization form linkages with other community service providers to apply for the Planning Grant? If so, what types of linkages and providers?

*Probes: What challenges did you encounter in working with other providers?*

*Was there anything that helped you in creating linkages? Please describe.*

*Did your partnerships with community service providers change when the grant ended? Please explain.*

h. Did your organization investigate other sources of funding? How successful were you in receiving additional funds for operations?

*Probe: Did the Planning Grant help you in obtaining additional funds? How?*

i. Did your organization perform any other activities with the Planning Grant funds that I didn't ask about?

*Probe: If so, can you tell me about them?*

How did this contribute to the functioning of your organization(s)?

j. What challenges did you experience in completing the Planning Grant Program? What were they and how did you address them?

k. Did you accomplish what you thought you would with the Planning Grant program? *Why/Why not?*

l. Overall, how would you describe the impact of the Planning Grant on your organization and on your community?

m. What things did receiving a Planning Grant enable you to do that you would not have been able to do otherwise?

n. What recommendations do you have for improving the Planning Grant Program?

Next, we would like to learn about your organization's success in obtaining **a Service Delivery Grant**.

**5. Success in Obtaining Service Delivery Grants**

a. Based on the information we have from HRSA, we'd like to confirm that your organization applied for and received a Title III Service Delivery Grant approximately **X** months after completing your Planning Grant. Is this information correct?

b. How did the EIS Grant fit into the overall vision of your organization?

c. How strong was the need for delivery of services in your community at that time?

d. What support or resources did you have in writing a proposal for the Service Delivery Grant?

*Probe: Did you use any grant writing support or other professional services in preparing your proposal?*

**6. Service Delivery Grantee Performance**

a. How significant was Service Delivery Grant in improving the services provided by your organization?

b. How quickly was your organization able to achieve full staffing after you received the EIS award?

*Probes: Were there any challenges to achieving full staffing? If so, what were they?*

§ Was there anything that helped you to achieve full staffing? Please describe.

c. What was your organization's experience in formalizing contracts, memoranda of understanding, and affiliation agreements with partner sites that might have been required?

*Probes: Were there any challenges to this? If so, what were they?*

§ Were you able to set up contracts, memoranda of understanding, and affiliation agreements in a timely fashion?

§ Was there anything that helped your organization to achieve these? Please describe.

d. How quickly was your organization able to develop new operating procedures and policies based on your EIS proposal?

e. How successful would you say your organization was in implementing the Service Delivery Grant activities? Why?

*Probe: What challenges did you encounter?*

f. Were there areas of performance where your organization found it hard to meet Title III program expectations and requirements? What areas and why?

g. Did your organization involve patient representatives in programs on an ongoing basis?

*Probes: How did they contribute to your programs?*

§ Did you find them helpful?

h. Is there anything else that you think affected the performance of your organization in the Title III program that I didn't ask about?

**7. Advance questions**

**Advance questions received:**

Thank you for sending your response to some of our questions in advance. *Please clarify if some of the responses are not complete.*

**Advance questions NOT received:**

Prior to this interview, we have sent you a list of questions. I would now like to go over these questions [use the advance sheet].

8. **Additional comments** Do you have any additional comments or suggestions regarding the Planning Grant Program or this assessment?

   Well, that's all the questions I have. Thank you for your time.

9. **Site visit contacts**

   *We are planning to conduct case studies with two Planning Grantee organizations. These would involve a one day site visit and staff interviews with others who were involved in the Planning Grant process. Would your organization be interested in participating in a case study?*

   *We will be contacting you later for scheduling a site visit if your site is selected for a case study. Are you the appropriate person for me to contact?*

   *We really appreciate your time and your insights. Thank you.*

   *[If they express a desire to talk to someone at HRSA, can offer project officer's number; don't offer without their requesting]*

# APPENDIX C:
# TELEPHONE INTERVIEW GUIDE
# TITLE III PLANNING GRANT—STRATUM II:
# PLANNING GRANT RECIPIENTS THAT DID NOT RECEIVE EIS GRANTS

**INTRODUCTION**

Thank you for taking the time to talk with me today. We appreciate your interest and willingness to discuss your Title III Planning Grant with us.

As we have informed you earlier, the HRSA HIV/AIDS Bureau is interested in gaining a better understanding of the Planning program impact on the performance of Planning Grant recipients. The objectives of this study are

- To understand grantee experience with CARE Act Planning Grant program;
- To assess the Planning Grant impact to delivery of services; and
- To identify the effects of organizational and community characteristics on grantee performance and delivery of services.

RTI is assisting HRSA with this activity by conducting a series of telephone interviews with current and past planning program grantees. We expect this interview to last about one hour. Your participation today is completely voluntary. You may decline to answer any question and you can refuse to participate further at any point during this discussion. Your decision to participate will not have any impact on your relationship with HRSA or your CARE Act current or future funding.

With your permission, we will audiotape the conversation to assist us with our note-keeping. You may make off-the-record remarks if you wish; these will not be recorded. The tape recording will be destroyed after the study is complete. This conversation will be kept confidential. It is possible you might be contacted at a later date if issues are raised in other discussions that need clarification.

RTI will write a summary report of the findings from all the discussions. Your name and the name of your organization will not appear in any reports from this study, and no comments made during this conversation will be attributed to you or your organization. If any information is distributed beyond HRSA, no names of individuals or grantees will be included.

Your organization was selected for this study from organizations that received the Planning program grant in 2001 and 2002. Of those organizations, you were further selected based on sample requirements in terms of geographic location and the type of organization. We are asking you these questions in your capacity as a Project Director or Project Director's designee.

Do you have any questions before we start? With your permission, we'd like to get started.

**INTERVIEW QUESTIONS**

First, let's talk about some characteristics of your organization and community.

**1. Organizational and Community Characteristics**

a. Tell me a little about your organization.

*Probes: Size, history, and services.*

b. What is your role in your organization?

c. How have you been involved with CARE Act Planning Grant*?*

*Probe: Writing, managing, monitoring, evaluating?*

d. Did your organization have experience in providing HIV primary care at the time of your Planning Grant application, _____ (PROVIDE GRANT APPLICATION YEAR)?

(1) If so, how long you had been providing those services?

**2. Leadership**

a. In applying for Title III Planning Grant, was there a specific person who championed the idea of obtaining CARE Act funds?

*Probe: What was this person's role in your organization?*

b. What support or resources did you have in writing a proposal for the Planning Grant?

*Probe: Did you use any grant writing support or other professional services in preparing your proposal?*

**3. Partnerships**

a. Did you partner with any other organizations BEFORE or during the process of applying for the Planning Grant?

*Probe: What type of organizations?*

b. What new partnerships did you form AFTER receiving the Planning Grant?

c. Were there other organizations providing CARE Act-supported services in your community at the time of your application to the Planning Grant program (not just Title III)?

*Probes: What were they? What relationships did you have with them, if any?*

d. Were there other groups providing HIV/AIDS care services in your community?

*Probes: What were they? What types of relationships did you have with them, if any?*

e. **[If YES to c. or d.]** In what ways did these partners contribute to your Planning Grant performance?

The next set of questions pertains to your experiences with the Planning Grant.

*[For questions **c-h**, check and ask only those questions that apply based on prior review of grant application or if it is listed in answering question **4a**. If this information is not available, ask all the questions in this section.]*

**4. Meeting the Terms of Planning Grants**

a. What goals were proposed by your organization under the Planning Grant?

b. How did the activities you reported at the end of the grant period compare to those that you originally proposed?

*Probes: Were they the same?*
*How did they change?*
*What led to these changes in activities?*

c. Did your organization establish a formal advisory group or work with an existing group in planning the initiation of new services?

*Probes: Was it successful?*
*Was it sustained after the Planning Grant was complete?*
*What challenges did you encounter in establishing the advisory group?*

d. Did your organization complete an in-depth needs assessment and epidemiological profile for HIV primary care services in the community besides the one you did for the proposal? (If yes,) Tell me about that.

*Probes: Was it successful?*
*What were the outcomes?*

*What were the challenges to doing the needs assessment/epi profile?*

e. Did your organization complete an evaluation of your community's existing provider population?

*Probes: Was this helpful to your organization? Tell me more.*
*Were there any challenges in this? If so, what were they?*

*Was there anything that helped you to achieve this? Please describe.*

f. Did your organization complete a profile of the target population? What did you learn as a result of this process?

*Probes: What challenges were there in creating a profile?*
*Was there anything in particular that helped you in creating the profile? Please describe.*

g. Did your organization form linkages with other community service providers to apply for the Planning Grant? If so, what types of linkages and providers?

*Probes: What challenges did you encounter in working with other providers?*
*Was there anything that helped you in creating linkages? Please describe.*

Did your partnerships with community service providers change when the grant ended? Please explain.

h. Did your organization investigate other sources of funding? How successful were you in receiving additional funds for operations?

*Probe: Did the Planning Grant help you in obtaining additional funds? How?*

i. Did your organization perform any other activities with the Planning Grant funds that I didn't ask about?

*Probe: If so, can you tell me about them?*

(1) How did this contribute to the functioning of your organization(s)?

j. What challenges did you experience in completing the Planning Grant Program? What were they and how did you address them?

k. Did you accomplish what you thought you would with the Planning Grant program? *Why/Why not?*

l. Overall, how would you describe the impact of the Planning Grant on your organization and on your community?

m. What things did receiving a Planning Grant enable you to do that you would not have been able to do otherwise?

n. What recommendations do you have for improving the Planning Grant Program?

Next, we would like to learn more about your organizational experience after completing the Planning Grant.

**5. Success in Obtaining Service Delivery Grants**

a. Based on the information we have from HRSA, we'd like to confirm that your organization applied for and received a Title III Service Delivery Grant approximately **X** months after completing your Planning Grant. Is this information correct?

b. How did the EIS Grant fit into the overall vision of your organization?

c. How strong was the need for delivery of services in your community at that time?

d. What support or resources did you have in writing a proposal for the Service Delivery Grant?

*Probe: Did you use any grant writing support or other professional services in preparing your proposal?*

**6. Service Delivery Grantee Performance**

a. How significant was Service Delivery Grant in improving the services provided by your organization?

b. How quickly was your organization able to achieve full staffing after you received the EIS award?

*Probes:* *Were there any challenges to achieving full staffing? If so, what were they?*
*Was there anything that helped you to achieve full staffing? Please describe.*

c. What was your organization's experience in formalizing contracts, memoranda of understanding, and affiliation agreements with partner sites that might have been required?

*Probes:* *Were there any challenges to this? If so, what were they?*
*Were you able to set up contracts, memoranda of understanding, and affiliation agreements in a timely fashion?*
*Was there anything that helped your organization to achieve these? Please describe.*

d. How quickly was your organization able to develop new operating procedures and policies based on your EIS proposal?

e. How successful would you say your organization was in implementing the Service Delivery Grant activities? Why?

*Probe:* *What challenges did you encounter?*

f. Were there areas of performance where your organization found it hard to meet Title III program expectations and requirements? What areas and why?

g. Did your organization involve patient representatives in programs on an ongoing basis?

*Probes:* *How did they contribute to your programs?*
*Did you find them helpful?*

h. Is there anything else that you think affected the performance of your organization in the Title III program that I didn't ask about?

**7. Advance Questions**

**Advance questions received:**

Thank you for sending your response to some of our questions in advance. *Please clarify if some of the responses are not complete.*

**Advance questions NOT received:**

Prior to this interview, we have sent you a list of questions. I would now like to go over these questions [use the advance sheet].

**8. Additional Comments.** Do you have any additional comments or suggestions regarding the Planning Grant Program or this assessment?

Well, that's all the questions I have. Thank you for your time.

**9. Site Visit Contacts**

*We are planning to conduct case studies with two Planning Grantee organizations. These would involve a one day site visit and staff interviews with others who were involved in the Planning Grant process. Would your organization be interested in participating in a case study?*

*We will be contacting you later for scheduling a site visit if your site is selected for a case study. Are you the appropriate person for me to contact?*

*We really appreciate your time and your insights. Thank you.*

*[If they express a desire to talk to someone at HRSA, can offer project officer's number; don't offer without their requesting]*

# APPENDIX D:
# TELEPHONE INTERVIEW GUIDE
# TITLE III PLANNING GRANT—STRATUM III:
# EIS GRANT RECIPIENTS WITHOUT PRIOR PLANNING GRANT

**INTRODUCTION**

Thank you for taking the time to talk with me today. We appreciate your interest and willingness to discuss the CARE Act Title III Service Delivery Grant with us.

As we have informed you earlier, the HRSA HIV/AIDS Bureau is interested in gaining a better understanding of the Planning program impact on the performance of Planning Grant recipients. The objectives of this study are

- To understand grantee experience with CARE Act Planning Grant program;
- To assess the Planning Grant impact to delivery of services; and
- To identify the effects of organizational and community characteristics on grantee performance and delivery of services.

We understand that your organization did not receive the Planning Grant prior to receiving the EIS Grant. We are asking about your EIS Grant experience for comparative purposes in order to assess Planning Grant recipient effectiveness in delivery of services. RTI is assisting HRSA with this activity by conducting a series of telephone interviews with current and past planning program grantees. We expect this interview to last about one hour. Your participation today is completely voluntary. You may decline to answer any question and you can refuse to participate further at any point during this discussion. Your decision to participate will not have any impact on your relationship with HRSA or your current or future CARE Act funding.

With your permission, we will audiotape the conversation to assist us with our note-keeping. You may make off-the-record remarks if you wish; these will not be recorded. The tape recording will be destroyed after the study is complete. This conversation will be kept confidential. It is possible you might be contacted at a later date if issues are raised in other discussions that need clarification.

RTI will write a summary report of the findings from all the discussions. Your name and the name of your organization will not appear in any reports from this study, and no comments made during this conversation will be attributed to you or your organization. If any information is distributed beyond HRSA, no names of individuals or grantees will be included.

Your organization was selected for this study from organizations that received the Title III EIS Grant without participating in the Planning program in 2001 and 2002. Of those organizations, you were further selected based on sample requirements in terms of geographic

location and the type of organization. We are asking you these questions in your capacity as a Project Director or Project Director's designee.

Do you have any questions before we start? With your permission, we'd like to get started.

**INTERVIEW QUESTIONS**

First, let's talk about some characteristics of your organization and community.

1. **Organizational and Community Characteristics**
   a. Tell me a little about your organization.
   b. What is your role in your organization?
   c. What is your role in the organization's Title III Service Delivery Grant*?*

      *Probe: writing, managing, monitoring, evaluating?*
   d. Did your organization have experience in providing HIV primary care at the time of your EIS Grant application, _____ (PROVIDE GRANT APPLICATION YEAR)?

      (1) If so, for how long you have been providing those services?
2. **Leadership**
   a. Was there a specific person that championed the idea of obtaining CARE Act funds?

      *Probe: What was this person's role in your organization?*
   b. How did the EIS Grant fit into the overall vision of your organization?
   c. What support or resources did you have in writing a proposal for the EIS Grant?

      *Probe: Did you use any grant writing support or other professional services in preparing your proposal?*
3. **Partnerships**
   a. Did you partner with any other organizations before you applied for the EIS Grant? If so, what type of organizations?
   b. Were there other CARE Act-supported services in your community at the time of your application to the EIS Grant program?
   c. Were there other groups providing HIV/AIDS care services in your community at the time of your application to the EIS Grant program?

Now we would like to talk more about your participation in the Title III Service Grant Program.

**4. Success in Obtaining Service Delivery Grants**

a. Did your organization ever apply for a Title III Planning Grant?

(1) If *No*, why not?

(2) If *Yes*, did you receive one?

– If *received*, what year was that?

– If *did Not Receive*, what did you learn from applying?

b. How strong was the need for delivery of services in your community at that time?

**5. Service Delivery Grantee Performance**

a. How significant was Service Delivery Grant to the services provided by your organization?

b. How quickly was your organization able to achieve full staffing after you received the EIS award?

*Probes: Were there any challenges to achieving full staffing? If so, what were they?*

*Was there anything that helped you to achieve full staffing? Please describe.*

c. What was your organization's experience in formalizing contracts, memoranda of understanding, and affiliation agreements with partner sites?

*Probes: Were there any challenges to this? If so, what were they?*

*Were you able to set up these procedures in a timely fashion?*

*Was there anything that helped your organization to achieve these? Please describe.*

d. How quickly was your organization able to develop new operating procedures and policies based on your EIS proposal?

e. How successful would you say your organization was in implementing the Service Delivery Grant activities? Why?

*Probe: What challenges did you encounter?*

f. Were there areas of performance where your organization found it hard to meet Title III program expectations and requirements? What areas and why?

g. Did your organization involve patient representatives in programs on an ongoing basis?

*Probes: How did they contribute to your programs?*

*Did you find them helpful?*

h. Is there anything else that you think affected the performance of your organization in the Title III program that I didn't ask about?

**6. Advance Questions**

**Advance questions received:**

Thank you for sending your response to some of our questions in advance. *Please clarify if some of the responses are not complete.*

**Advance questions NOT received:**

Prior to this interview, we have sent you a list of questions. I would now like to go over these questions [use the advance sheet].

*Well, that's all the questions I have. Do you have any questions for me?*

*We really appreciate your time and your insights. Thank you.*

*[If they express a desire to talk to someone at HRSA, can offer project officer's number; don't offer without their requesting]*

# APPENDIX E:
# PERFORMANCE ACTIVITIES IN DELIVERY OF SERVICES

## Performance Activities in Delivery of Services

| Stratum | Organization Type | Number of Clients enrolled in HIV services or care (1) | Proportion of Clients Enrolled in the Outpatient Services (1) | Sites Providing Testing and Counseling Services | Number of Clients that Received pre-test Counseling (1) | Number of Clients Tested (1) | Proportion of HIV-positive Clients that Returned for Results (1) | Proportion of HIV-positive Clients that Entered into Regular Care |
|---|---|---|---|---|---|---|---|---|
| S1 | Publicly Funded Community Health Center | 130 | 85% | Yes | 1055 | 1055 | | |
| S1 | Health Department | 882 | N/A | Yes | 100% | 3918 | | |
| S1 | Community-Based Service Organization | 331 | 76% | Yes | 466 | 466 | 4 | 100% |
| S1 | Publicly Funded Community Health Center | 122 | 79% | Yes | 6291 | 6291 | 100% | 100% |
| S1 | Publicly Funded Community Health Center | 908 | 72% | Yes | 1781 | 1780 | 87% | 80% |
| S1 | Hospital or University Based Clinic | 875 | N/A | No | | 1375 | 100% | 100% |
| S1 | Health Department | 1062 | 100% | Yes | 3845 | 3017 | 99% | 99% |
| S1 | Community-Based Service Organization | N/A | N/A | Yes | | | | |
| S2 | Health Department | 563 | 89% | Yes | 3976 | 3985 | 20 | 100% |
| S2 | Community-Based Service Organization | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| S2 | Health Department | 150 | 100% | Yes | 2640 | 2640 | 56% | 80% |
| S2 | Hospital or University Based Clinic | 55 | 55% | No | | | | |
| S2 | Publicly Funded Community Health Center | 1573 | 32% | Yes | 1036 | 1066 | | |
| S2 | Hospital or University Based Clinic | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| S2 | Community-Based Service Organization | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| S2 | Hospital or University Based Clinic | 1587 | 76% | Testing Only | | 214 | 38 | 79% |
| S3 | Hospital or University Based Clinic | 350 | 70% | No | | | | |
| S3 | Publicly Funded Community Health Center | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| S3 | Health Department | 150 | 80% | Yes | 1487 | 1487 | 15 | 100% |
| S3 | Publicly Funded Community Health Center | 137 | 70% | Yes | 2704 | 2704 | 5 | 90% |
| S3 | Hospital or University Based Clinic | 637 | 38% | No | | | | |
| S3 | Health Department | 405 | 96% | No | | | | |
| S3 | Hospital or University Based Clinic | 475 | 91% | Yes | 240 | 235 | 100% | 100% |
| S3 | Community-Based Service Organization | 846 | 55% | Yes | 308 | 308 | 96% | |
| S3 | Publicly Funded Community Health Center | 178 | 82% | Yes | 1512 | 1331 | 98.50% | 98.50% |