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2018 Asssessment of the Administrative Mechanism
Los Angeles County Eligible Metropolitan Area

Ryan White CARE Act
Based on County Fiscal Years 2014, 2015 and 2016
(Ryan White CARE Act Years 24, 25, 26)

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Under Contract to the Commission on HIV, County of Los Angeles

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EXECUTIVE SUMMARY

The federal Health Resources and Services Administration (HRSA) requires all Part A planning councils (the Commission on HIV is LA County's Ryan White Part A planning council) to conduct annual "Assessments of the Administrative Mechanism" (AAMs). The Los Angeles County Commission on HIV (COH) engaged the services of a consultant to conduct an independent assessment of the Ryan White Part A funded "administrative mechanism" in the Los Angeles County Eligible Metropolitan Area (EMA). The AAM is meant to evaluate the speed and efficiency with which Ryan White Program funding is allocated and disbursed for HIV services in LA County.

In broad terms, the current AAM shows that the overall administrative mechanism that supports the system of Ryan White Care Act-funded service delivery in Los Angeles County is healthy and works well. A number of recommendations were offered by representatives of each component comprising the administrative mechanism as to possible improvements to the system, but **the overarching assessment is that a mature and competent system is in place.**

While the overall assessment included recommendations for improvement, the following positive attributes were noted: 1) the Commission on HIV (which is the Ryan White Planning Council) has highly committed staff that provide excellent support to its members, members are well trained, and their deliberations are thoughtful and result in allocations of resources that are responsive to community needs; 2) the administrative entity (Division of HIV and STD Programs) also is given high marks for competence, dedication and responsiveness to Commission allocations and directives; 3) the provider community has long experience in delivering quality and comprehensive services.

Background

The Los Angeles County Commission on HIV (COH) sought the services of a consultant to conduct an independent assessment of the Ryan White Part A funded administrative mechanism in the Los Angeles County EMA, and a Scope of Work was determined in late 2017. The AAM is intended to determine whether the administrative mechanism procures services according to the planning council's established priorities and allocations; how effectively Ryan White Program funds are disbursed for HIV services, and the efficiency of oversight, monitoring, and other functions. For purposes of this study, the "administrative mechanism" in Los Angeles County comprises the Ryan White Program-related work and responsibilities of the administrative agency (the Division of HIV and STD Programs (DHSP)), the planning council (the Commission on HIV), the grantee (Los Angeles County Department of Public Health), and the Chief Elected Official (CEO), which is the Los Angeles County Board of Supervisors.

The Commission's Operations Committee and Executive Director oversee the completion of the AAM, and supervise the contractor. For this year's AAM, the Operations Committee sought a multilayered assessment that would include input from key informants within all sectors of Los Angeles County's Ryan White Program-funded HIV service delivery system.

Methodology

Because a comprehensive AAM had not been conducted since RWCA Year 17 (2008), it was determined that the current study should elicit **perceptions** in aggregate form from three identified cohorts of key informants, including Commissioners, County programmatic and fiscal staff, and a representative sampling of contracted providers. The identified review period for this AAM was agreed to be FY 2014, 2015 and 2016 (Ryan White Fiscal Years 24, 25, 26).

It was noted early on in the planning process that the Los Angeles EMA is quite "mature" in the sense that, more than 25 years after the creation of the RWCA and the first dedicated HIV funding in the County, the array of RWCA funded service providers has been in place and stable for many years, and contracts for services are typically renewed quite often for existing providers. There have been very few Requests for Proposals (RFPs) issued during the three year period being studied; consequently the determination was made at the outset to focus more on the overall perceptions of the members of three relevant focus areas regarding the planning, procurement and payment process, rather than on quantitative assessments of granular data of the various processes comprising the dissemination of RWCA funds.

The final Scope of Services was approved on November 6, 2017. Three cohorts of interviewees were identified:

- **Focus Area 1: Commission on HIV (COH) Perspectives**
  A total of 24 of the identified members of the Planning, Priorities and Allocations (PP&A) and Executive Committees participated in one-on-one interviews, which were conducted either in person or over the phone.
- **Focus Area 2: Key DHSP/DPH Stakeholder Perspectives**
  There were 12 members of the staffs of the Department of HIV and STD Programs (DHSP), the Department of Public Health (DPH), COH staff, and the Executive Office of the Board (EOB) who were identified at the outset as having the most engagement with the process of contracting for services funded by RWCA. Some of the identified parties offered to include their coworkers, direct reports or associates in the interview sessions; consequently 14 individuals participated.
- **Focus Area 3: Contracted Agency Perspectives**
  A total of 17 provider agencies were surveyed using a semi-structured interview tool that was similar to that used for the other two cohorts. A number of interviewees assembled teams of those in their agency who had direct knowledge of the various aspects of the contracting, monitoring and reimbursement processes.

The full study includes an overview and schematic of the contracting and solicitations process, which is conducted jointly by the entities comprising the administrative mechanism. The report summarizes all relevant comments received from key informants.

Summary of Recommendations *(refer to the full report for rationale and context)*

Focus Area 1: Commission on HIV (COH) Perspectives

- In addition to the Key Informant Interviews (of those most involved in service procurement processes) it is recommended that there be a survey tool to assess the perceptions of efficiency that are held by the entire body.

- Future AAM processes should include tools to elicit perceptions of other components of the "administrative mechanism" as to the efficiency of the COH.

Focus Area 2: Key DHSP/DPH Stakeholder Perspectives

- The next comprehensive assessment of the administrative mechanism (or some other interim administrative review) should include an assessment of the human resources (HR) and finance systems of the County and how they are impacting the ability of DHSP and DPH to efficiently employ appropriate processes to support HIV service delivery. The target timeframe for the next comprehensive AAM is 2022.

- COH should encourage the Executive Office or DPH to explore the impact of the consolidation of Contracts and Grants at the DPH level, as compared to the previous placement of the Contracts and Grants function within DHSP.

- It is recommended that the COH encourage the relevant components of the County to explore compensation for reviewers as many other governmental levels offer. A companion suggestion was made to assemble a "pool" of qualified reviewers (as HRSA does), and this suggestion should be revisited.

- The DPH/DHSP should collaborate with the Internal Services Department (ISD) or undertake its own well-promoted community education sessions to educate service providers who are not current county contractors about the steps, requirements and competencies necessary to do business with the County so as to potentially become qualified HIV service providers.

- Given the reported variability among individual fiscal and programmatic monitors, DHSP should be encouraged to improve the quantity and frequency of its internal training of its contract monitoring staffs.

Focus Area 3: Contracted Agency Perspectives

- COH should explore the possibility of collaborating with DHSP to convene a "best practice summit" where more experienced provider agencies could share information on their systems and processes with less experienced providers.
- If sufficient IT expertise were available or could be secured, a review of the collective data management system used by DHSP would be useful.

General Recommendation

- It is recommended that a task force be convened (by the Executive Office or whatever level deemed appropriate) to do a comprehensive review of all the steps involved in procuring HIV related services to better understand how to create a more streamlined procurement and contracting process.

Procedural Recommendations Regarding Future AAMs

- There seems to be no readily available database or information on the specific dates of each of the steps in the contracting process for each provider. It is recommended that the COH encourage the DHSP to track this information and to make it available for assessments in the future.

- The COH should consider a survey targeting all contracted all providers regarding their assessment of the efficiency of the overall administrative mechanism and in particular the procurement and fiscal/program monitoring procedures. This survey should include both quantitative and qualitative analyses of the local administrative mechanisms for service delivery.

General Observations

As was noted by interviewees at all levels, the system of RWCA-funded client/patient care in Los Angeles County is very mature and a great many of the provider agencies have been both providing services for decades and have developed effective working relationships with DHSP. This high level of provider experience was noted to be a positive in terms of providing quality care (and doing so efficiently), however some observers and participants felt that it has become an inertia-laden "closed system" with little opportunity to bring in new providers who may be closer to emerging communities, geographic areas or specific needs.

Variations on the comment "well, it's the County, you know how that is," were also repeated many times among interviewees in all three focus areas. There is widespread resignation to the fact that Los Angeles County is a large and complicated bureaucracy that does things in its own, very complicated, ways. Those who have been working in this environment for many years have learned to deal with it, even while they wish it could be different. Ironically, the high level of difficulty in working within the system seems to have led to a relatively high level of "satisfaction" with it—that is, once you know the ropes, and find ways to deal with all the hurdles, you can get work done.

Background

The Los Angeles County Commission on HIV (COH) sought the services of a consultant to conduct an independent assessment of the Ryan White Part A funded administrative mechanism in the Los Angeles County Eligible Metropolitan Area (EMA). The Assessment of the Administrative Mechanism (AAM) is meant to evaluate the speed and efficiency with which Ryan White Program funding is allocated and disbursed for HIV services in LA County. The Ryan White Program Part A federal funders require all Part A planning councils (the Commission is LA County's Ryan White Part A planning council) to conduct annual AAMs.

The AAM is intended to determine how well the administrative mechanism procures services according to the planning council's established priorities and allocations; how effectively Ryan White Program funds are disbursed for HIV services; and oversight, monitoring and other functions.

For purposes of this study, in the Los Angeles EMA, the "administrative mechanism" comprises the Ryan White Program-related work and responsibilities of the administrative agency (the Division of HIV and STD Programs (DHSP)), the planning council (the Commission on HIV), the grantee (Los Angeles County Department of Public Health), and the Chief Elected Official (CEO), which is the Los Angeles County Board of Supervisors.

The Commission's Operations Committee and Executive Director oversee the completion of the annual AAM, and supervise the contractor. The Operations Committee sought a multilayered assessment that includes input from key informants from 3 target groups: 1) members of the COH's Planning, Priorities and Allocations and Executive Committees; 2) staff from DHSP and DPH with various levels of involvement in the contracting and procurement process; and 3) providers with Ryan White contracts for Program Years 24, 25, and 26. Providers of varying contract amounts were randomly selected for the interviews. See Appendix 3 for a list of contracted agencies who participated in the interviews. Additional information about the AAM is found in the Appendix.

ADDITIONAL CONSIDERATIONS IN DESIGN OF THE CURRENT AAM

An agreed additional component of the assessment in LA County was to assess how well the COH functions as a planning council. A question that routinely arises in this EMA, like others, is, "how do we differentiate between the AAM and the responsibilities of program and clinical quality management which are done by DHSP?" The answer is that the Grantee (DHSP) exercises complete discretion in the assessment of service delivery (per jointly developed standards) and contract deliverables, while the AAM restricts itself to assessing the functioning of the "overall mechanism" in expending funds that reimburse providers for services.

Because the AAM had not been conducted in the previous three grant years, the current study was designed to elicit **perceptions** in aggregate from three identified cohorts of key informants, including Commissioners, County programmatic staff, and providers. The identified review period referenced in this AAM was agreed to be FY 2014, 2015 and 2016 (Ryan White Fiscal Years 24, 25, 26).

The initial key guiding questions that were developed by the Commission on HIV relating to the AAM were:

1. Did the Grantee disperse Ryan White Part A funds according to the priorities and allocations set by the COH?
2. Was there adequate participation by the community in the planning process?
3. Were service contracts issued in a timely manner and were subcontractors reimbursed in a timely manner?
4. Was the RFP Process fair and effective?
5. Are services funded by the Ryan White Program successfully reaching the community?
6. What specific barriers (i.e., procedural, policies, bureaucratic, and planning) hinder the efficiency of administrative mechanism to rapidly allocate funds to the areas of greatest need within the EMA/TGA [Transitional Grant Areas].

Refer to Appendix 2 for detail of questions for COH, DHSP/DPH staff and contracted providers.

It was noted early on in the planning process that the Los Angeles EMA is quite "mature" in the sense that, 25 years after the creation of the RWCA and the first dedicated HIV funding in the County, the array of RWCA funded service providers has been in place and stable for many years, and contracts for services are typically renewed quite often for existing providers. There have been very few Requests for Proposals (RFPs) issued during the three year period being studied; consequently the determination was made at the outset to focus more on the overall perceptions of the members of three relevant focus areas regarding the procurement and payment process, rather than on quantitative assessments of granular data of the processes comprising the dissemination of RWCA funds.

Process for Securing Services to Conduct AAM

The COH issued its invitation for "informal bids" from individuals or firms interested in conducting the AAM on July 6, 2016, with a deadline date of September 9, 2016. The current contractor submitted a proposal in response to the request for informal bids. A revised full solicitation process was developed in conjunction with the Internal Services Department (ISD), which resulted in issuance of a Request for Bid (RFB-IS-17201149-1), released on March 30, 2017 with a due date of April 17, 2017. A Purchase Order for the services proposed by SST Nonprofit Services was issued on May 17, 2017. The lead researcher of SST Nonprofit Services, Marc W. Haupert, has been involved in four previous AAM processes for Los Angeles County (as well as for other EMAs) and has drawn on his experience in the creation of this report.

After several meetings with the contractor and between the staffs of the COH and DHSP, the final Scope of Work was agreed to by COH staff and DHSP staff on November 6, 2017, and the AAM was initiated shortly thereafter.

Other Considerations and References

All procurements resulting in contracts are sought for DHSP via the DPH website: http://publichealth.lacounty.gov/dhsp/DoingBusinessWithDHSP.htm

At the outset of this AAM process, the administrative entity noted a number of factors to place the study into context: 1) that only some services are procured by means of "open solicitations;" 2) not all solicitations for services are issued on an annual basis due to reasons of efficiency and the existence of multi-year contracts (as noted further in the following sections); 3) many factors affect the issuance of RFPs, including utilization data, requirements from the federal government and their own RFPs, and feedback from agencies who desire multi-year contracts.

The public has access to RFPs and other procurement tools (current and closed) at the site: http://publichealth.lacounty.gov/cg/index.htm.

STATUS OF PREVIOUS RECOMMENDATIONS RESULTING FROM PRIOR AAM PROCESSES

One of the tasks given to the AAM consultant was to reference five of the recommendations that emanated from previous AAM studies in Los Angeles that were accepted by the Commission for execution and monitoring.

The semi-structured interview tool that was ultimately agreed to by the COH staff and the DHSP staff did not specifically solicit information on the perceptions of the interviewees about these "lingering" recommendations, but some commentary that touched on these topics naturally flowed from the responses to the open-ended questions.

As a reminder and to reiterate the Committee's initial concerns, the following are the previously identified recommendations that the committee determined were still relevant to track:

RELEVANT RECOMMENDATIONS FROM MOST RECENT AAM:

1. Expand ongoing proactive training, technical assistance and encouragement to potential and new service provider organizations, especially in primary target areas, in order to enlarge the pool of competent and appropriate service providers.

2. Explore [a] fast track process for services that warrant urgency or takes advantage of rapid, fast moving scientific advances.

3. Maintain annual review and analysis of contracting and procurement process to identify opportunities for improvement.

4. Conduct annual community-wide orientation targeted to potential new provider agencies for CDC [Centers for Disease Control and Prevention] and HRSA funded services. [The administrative agency should] collaborate with the COH to disseminate information.

5. Assess the current status of the COH with respect to the fulfillment of its legislated roles and responsibilities; appropriate size, overall organization, including committees and leadership structure; staffing needs; budget needs; membership recruitment, retention, and preparation plans; development of additional resources; and strategic relationships with Part A and other community partners.

Readers will find that the current AAM report references to varying degrees all these topics and recommendations highlighted at the outset, although only by means of comments that were volunteered by interviewed commissioners and provider representatives. Those "hold over" items that were referenced in the current process have been considered for inclusion in the Recommendations section of this year's AAM report.

OVERVIEW OF THE CONTRACTING AND SOLICITATIONS PROCESS AT DPH/DHSP

In November of 2016 Dr. Michael Green, Chief of the Planning Section of DHSP made a presentation to the PP&A Committee describing the contracting and solicitations process currently in place at DPH/DHSP. In order to place the process in context, we summarize his presentation here (based on approved minutes[9]):

The process is designed to ensure County programs do not enter into contractual agreements without a full, unbiased review and that community-based organizations (CBOs) receiving contracts meet requirements and are fully accountable to the County.

- The Commission and DHSP coordinate on planning services. DHSP then plans and releases solicitations. Requests for Proposals (RFPs) are the most common while Requests for Statements of Qualifications (RFSQs) are used occasionally. Invitations for Bid (IFBs) are price-based solicitations generally insufficient to reflect the complexity [that] services require.
- It generally takes 12-18 months from solicitation development to contract execution. That does not include time at the Commission and DHSP to develop the service concept and Standards of Care which add at least six months.
- Proposal evaluation is in phases: first, to ensure they meet minimum requirements; second, an external review panel convened by Contracts and Grants (C&G), DPH; third, final funding recommendations; fourth, departmental reviews; fifth, contracts go to the Board for approval. Once approved, contract negotiations occur with the CBOs, then a Board Letter is submitted for contract approval. Once approved, the CBOs sign the contracts and then they can be executed.
- C&G is charged with managing the contracting process and solicitations for DPH overall but, for DHSP, C&G manages solicitation while DHSP manages programmatic content and contracting. In 2015, C&G staff was assigned to DHSP. That increased solicitations from zero in the prior three years with up to six in the last 12-14 months and more in progress.
- C&G's role includes responding to questions on a solicitation and releases an addendum that may clarify or change some solicitation language and answer specific questions. C&G will host a proposer's conference if the solicitation warrants one. Such conferences are not required by the County, but are helpful for complex solicitations.
- Proposers must meet minimum contract requirements as well as appear to be able to sustain services for 90 days without County funds to demonstrate financial stability. Proposers passing those tests go on to further evaluation.

  DHSP is responsible for identifying unbiased, non-conflicted evaluators for review panels. That is difficult, e.g., there were 36 proposals for one RFP. Serving requires significant time for no pay and evaluators must sign a statement of no conflict of interest so local providers are often ineligible. Evaluators have been recruited, e.g., from Las Vegas, San Diego and San Francisco, but often nonlocal people are not invested in participating. DHSP has recommended DPH leadership identify a list similar to a jury pool for a 12-month period. DPH showed interest, but has not acted.

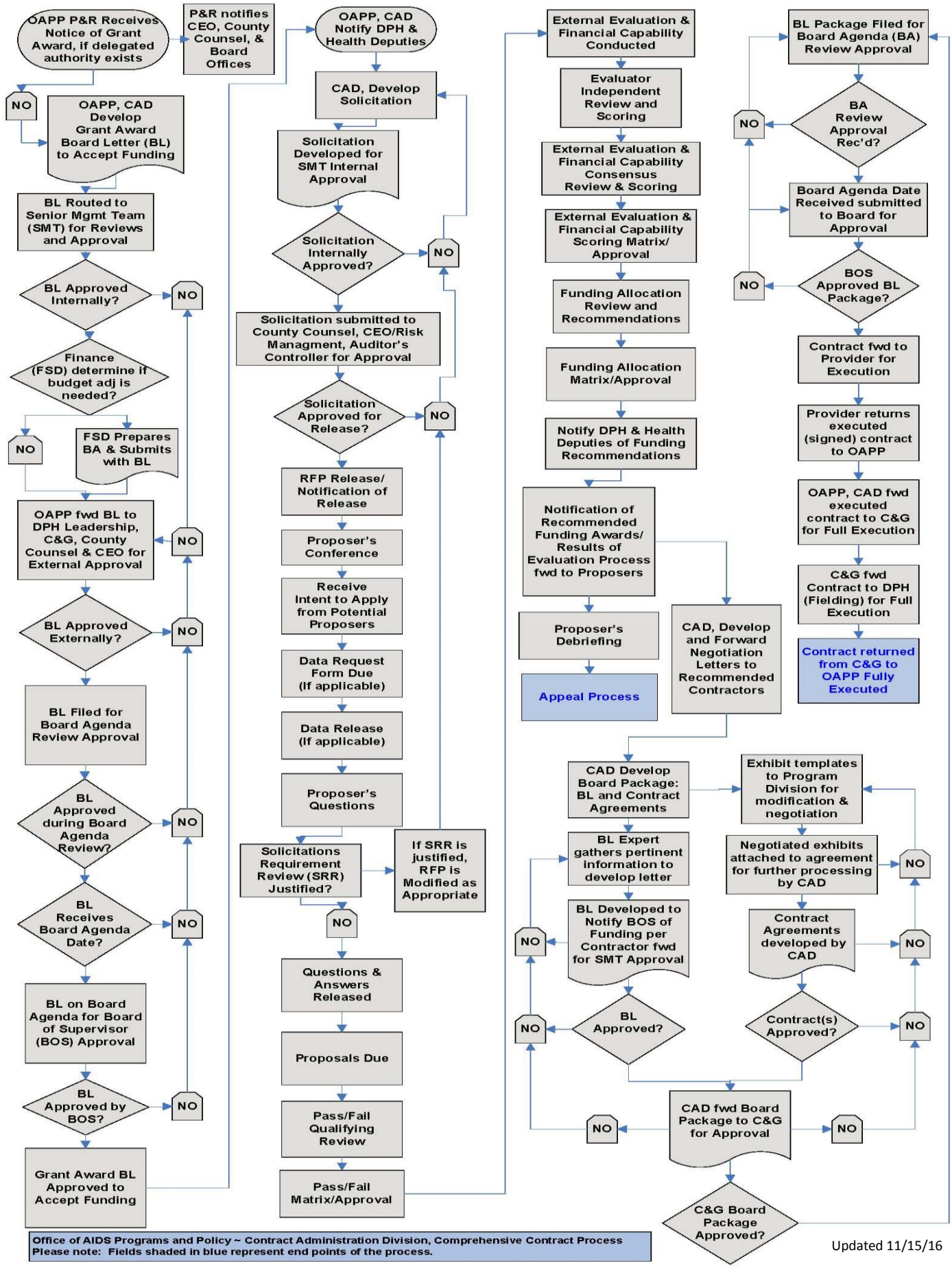
[9] COH Approved Minutes dated 11/15/16

- Contractors are selected and funding recommendations are developed based on evaluation scores as well as funding requirements, geographic distribution of services and targeted populations defined in the solicitation. Proposers may request a debriefing after the recommendations to review their proposals. They may appeal decisions.
- Services are solicited for a variety of reasons, e.g., to meet emerging need, redefine services, replace expiring contracts, [or] utilize new grant funding. DHSP tends not to apply for short-term grants, e.g., 24-36 months, because the time is too short to contract services within the grant term. For longer term grants, DHSP typically begins solicitation at the same time it applies for the grant to facilitate service implementation. Delegated authority allows DHSP to increase or decrease funds for a service by a certain percentage or time, but eventually services will need to be resolicited.
- Prior to applying for funding, DHSP must receive DPH approval by showing: purpose of funding, why it is needed, specifically how it will be used and how services will be implemented in the community.
- Concurrently, DHSP begins work on a Board Letter for approval to receive grant funds which includes: the amount of funds to be received in response to an application submitted on a certain date requesting a certain amount; how funds will be used and a proposed list of contractors. The Board Letter is required even for the annual Ryan White grant. DHSP cannot technically contract any services if the Health Resources Services Administration (HRSA) or another grantor delays its Notice of Grant Award. HRSA often has delayed its Notice of Grant Award from one to six months.
- A sole source solicitation allows DHSP to identify an agency or agencies that it knows can do the work in the way it needs to be performed without putting the contract out to bid. DHSP has to prove to the Board that no other contractors can provide the needed service or that sole source is needed to expedite the work and the identified provider(s) are well-qualified to do the work.
- Generally, the Board does not approve sole source contracting. It did approve DHSP to use sole source for Medical Care Coordination (MCC) expansion after the Commission advocated for it and data supported the beneficial impact of MCC.
- Other solicitation forms theoretically save time, but rarely do so in practice. The RFP process takes the most time, but offers more clarity about what is wanted and proposer submittal requirements are more stringent so results are better.
- Dr. Green said the County's process is determined by the Board, Chief Executive Office and Auditor-Controller. Multiple attempts to persuade the Board to streamline the process were met with opposition but, as noted with MCC, the Board allows adjustments if need is demonstrated.

Dr. Green also provided a schematic of the process (following page), which had been developed several years prior (note that references to OAPP refer to the previous name of DHSP); however Dr. Green indicates that the diagrammed process is still substantially in place at the current time.

Several of the respondents to this year's survey (including Commissioners, DHSP and COH staff and Provider representatives) noted that the overall process has not changed for many years. They noted that despite some attempts to streamline the process (some in concert with overall County administrative changes) the time duration and steps have not changed for a decade or more. Some interviewees (at all levels) noted that the instances where providers (or prospective providers) initiated litigation with the County concerning its procurement processes has resulted in more review steps being added, but they note that when steps are added others are rarely eliminated.

Diagram of steps in procurement process as generated by Chief of Planning at DHSP *(note: references to OAPP are now DHSP)*



Updated 11/15/16

KEY INFORMANT INTERVIEWS OVERVIEW

As a result of negotiations between COH staff and DHSP staff that were undertaken after the determination to conduct a new AAM was made and a contractor had been secured, the Scope of Services was approved on November 6, 2017 (it is included in the attachments).

Three cohorts of interviewees were identified by COH and DHSP staff as relevant for the current AAM. Additional selection factors include:

Focus Area 1: Commission on HIV (COH) Perspectives

- Suggested Key Informants were members of the Planning, Priorities and Allocations and the Executive Committees of COH. In total, approximately one third of the Commissioners interviewed were unaligned consumers.

Focus Area 2: Key DHSP/DPH Stakeholder Perspectives

- Suggested Key Informants were identified members of the staffs of the DHSP, DPH, (later including identified County Executive Office staff and COH staff) who had direct involvement in the procurement, billing and monitoring processes.

Focus Area 3: Contracted Agency Stakeholder Perspectives

- Key Informants were selected by the AAM contractor after receiving information on all contracts executed by DHSP throughout the three year period under study. Representative potential respondents were identified based on an anonymized sampling of representative contracts across the dimensions of: 1) size of contract amount, 2) service type, and 3) type of procurement. If the anonymized sampling methodology generated multiple contacts from the same organization, only one contact from the contracting organization was interviewed. Individual fiscal and administrative contacts were identified by DHSP at each agency, and those contacts thought to be most familiar with the interactions with the administrative agency were interviewed.

Note: the overall timeline was adjusted by mutual agreement throughout the process based on multiple factors including availability of interviewees, the time necessary for the administrative entity to identify appropriate interviewees, the cycles of Commission and committee meetings and the work load of the AAM contractor.

At its core, the intent of the AAM is to explore ways to improve all aspects of the administrative mechanism. While there may be differences in perspectives between the planning council members, recipient and contracted agencies, these insights are all equally valuable and important in ensuring a highly effective local Ryan White-funded system of HIV care and treatment.

Focus Area 1: Commission on HIV (COH) Perspectives

Context

The Ryan White Care Act mandates the formation of a local planning council which decides what Part A services are priorities for funding and how much funding should be provided for each service category, based upon the assessed needs of people living with HIV in the EMA/TGA. The recipient (also known as the Division of HIV and STD Programs in Los Angeles County) is accountable for managing Part A funds and awarding funds to agencies to enable them to provide services that are identified by the planning council as priorities.

The Commission on HIV must ensure that its members identify service needs, prioritize services and make funding recommendations based on data, community perspectives, and a robust, transparent community engagement process. The Commission staff provide administrative oversight, technical support and training for Commissioners so that they acquire the skills and knowledge necessary to perform their duties as local planners.

Process

The members of the Planning, Priorities and Allocations (PP&A) and Executive Committees were selected for Focus Area 1 because they lead the priority setting and resource allocation process for the Commission. Recommendations on service category rankings and allocations are initiated at the PP&A Committee level and then forwarded to the Executive Committee and full body for approval.

The questions for Focus Area 1 were designed to elicit perceptions that will lead to a better understanding of how the Commission staff can improve upon the ways they support the planning council members in making informed decisions, and to identify training and data needed by the PP&A Committee members.

A total of 24 of the identified members of the Planning, Priorities and Allocations and the Executive Committee participated in one-on-one interviews, which were conducted either in person or over the phone (per the preference of the interviewee). COH members were eager to share their insights and provide input regarding the assessment of the county's administrative mechanism for disbursing HIV-related funding.

While the COH is not a forum to discuss how contractors were selected, which agencies submitted an application for funding, or discuss individual agency contracts, the COH members and committee members are responsible for identifying service needs, prioritizing services, and making allocation recommendations related to Ryan White funding.

Summaries of Comments from COH Members Regarding its Planning and Resource Allocation Process (n=24)

Did the Commission assess data or other information on an ongoing basis in order to determine community needs? **100%** responded "YES"	COH respondents unanimously agreed that the Commission did assess a great deal of data on an ongoing basis in order to determine community needs. A few of the respondents indicated that, to them, it is sometimes a lengthy process to secure data from the various offices but ultimately they do receive what is requested.
Was there adequate consumer input in the planning process? **75%** responded "YES"	A significant majority of respondents noted yes, consumer input was adequate in the planning process. Of those who replied in the affirmative, approximately half noted that the Commission itself is comprised of many consumers as well as those who can easily represent the input of various consumer constituencies (by virtue of being involved in consumer caucuses, advocacy organizations, community groups or outreach committees).
Were you adequately notified of planning activities and meetings? **100%** responded "YES"	All respondents indicated that they were adequately notified of planning activities and meetings. Many participants complimented the COH staff for their diligence in notifying members of upcoming meetings and providing relevant background information in advance. This was noted by many as having improved with the arrival of current Commission executive and support staff.
In terms of structure and process, was the Los Angeles County Commission on HIV effective as a planning body? **92%** responded "YES"	Only two Commissioners replied that the Commission is not effective, but both responses were qualified by noting that overall the COH is generally effective but it could be more so. These respondents thought there could be more outreach to engage consumers and newly identified needs should be responded to more quickly. Since there was near-consensus on the affirmative answer to question four, there were only a few comments on areas of

	improvements. A couple of respondents volunteered that there could be more data supplied on which to make decisions. The comment was also made that the COH only has "real power" in the allocations of RWCA funds, and there should be more discussion at the COH table about the other sources of funding from which PLWH/A in the County could benefit.
Were you adequately trained on the structure and process of the Ryan White Planning Council? **96%** responded "YES"	The vast majority of Commissioners interviewed indicated that they were adequately trained in the structure and process of the RWPC. The respondent who indicated "no" noted that it was only because they were newer to the process that they did not yet feel adequately trained.
Were you adequately trained on Standards of Care/Continuum of Care? **66%** responded "YES"	Two thirds of the respondents indicated that they felt that they were adequately trained on Standards of Care and the HIV Continuum of Care. Of those who did not feel adequately trained, most indicated that they were confident that the Standards and Best Practices Committee was continually reviewing and updating standards, and that the Committee's reports at Commission meetings were informative.
Were you adequately trained on the Allocation/Reallocation Process? **90%** responded "YES"	Over 90% of respondents indicated that they were adequately trained in the allocations and reallocations process. Both those who felt that they were adequately trained and those who felt they could use more training noted that the commissioner trainings had increased in the last year and they felt there were many opportunities to become better trained in the allocations and priority setting processes. A few commissioners noted that it is sometimes difficult to follow the complex process undertaken by DHSP in utilizing funds from various "pots" in consideration of the various fiscal years of grants and the concomitant

	restrictions of funding sources. But all expressed confidence that the DHSP does a good job of mixing the various funding streams appropriately in order to meet the allocations decisions of the Commission.
Were you adequately trained on Service Category Prioritization? **92%** responded "YES"	The vast majority of the respondents felt that they received adequate training in prioritization of service categories. Among those who did not feel adequately trained the comment was made that they do trust the Commission's processes and the detailed analysis provided by the Planning, Priorities and Allocations committee. This confidence was reiterated in one way or another by nearly all Commissioners.
Do you believe that the priorities and allocations established by the COH in 2016 were followed by DHSP? **88%** responded "YES"	The large majority of Commissioners responding indicated that the priorities and allocations established by the COH in 2016 were followed by DHSP. The comment was made that the regular financial and allocations reports that are made by DHSP staff to various COH committees and the Commission as a whole were very helpful in understanding how funds were allocated. Similarly, when reallocations were required, the Commissioners felt that there was adequate explanation of why the reallocation was necessary and what the options were for reallocating funds to fully exhaust grant funds and pace expenditures to comply with funders' timing restrictions.

Lastly, Commissioners were asked about the documents and information provided to the Planning, Priorities and Allocations (PP&A) Committee. The question posed was, "in the 2016 planning cycle, what specific DHSP reports do you recall being provided to the PP&A Committee to help inform the priority setting and allocation process? Five types of reports were specifically noted: Fiscal reports, Annual reports to HRSA, Service utilization data, Needs assessment (such as the LACHNA study), and Program updates (such as Linkage and Re-engagement Program update).

As would be expected, those Commissioners who were either appointed to the Committee and/or regular attenders of the PP&A Committee's meetings were more confident of their

answers. Among the subset of respondents who were most familiar with the committee's work, the following comments were noted:

a. **Fiscal reports** – virtually all of the key informants familiar with the committee's work noted that fiscal reports on expenditures were regularly provided to the committee. Two commissioners noted that they would appreciate more timely delivery of fiscal information to the committee.

b. **Annual reports to HRSA** – few of those familiar with the committee's work remembered having been given the annual reports that DHSP provides to HRSA. Responses were nearly evenly split between yes, no and I don't know.

c. **Service utilization data** – virtually all of the key informants familiar with the committee's work noted that regular service utilization reports were provided to the committee.

d. **Needs assessment** (such as Los Angeles Coordinated HIV Needs Assessment LACHNA)) – a significant majority of the respondents noted that needs assessment information such as the LACHNA study were given to the committee, and that presentations on the studies/reports had been made to the overall Commission.

e. **Program updates** (such as Linkage and Re-engagement Program update) – the majority of the informants recalled having been provided program updates such as the one noted. Several Commissioners noted that the frequency of program updates had increased in recent years and they were grateful for that improvement.

Observations on Focus Area 1 (Commissioner Perspectives)

It was a widely shared comment that the vast majority of Commission members were very knowledgeable and felt adequately trained in the various functions within the purview of the COH. It was clear that their requests for aggregate data and specific reports on activities are responded to by COH staff and the DHSP staff assigned to commission work. The commissioners were respectful of the delegated duties of the commission versus the administrative entity, particularly with respect to the responsibility of the administrative entity to have full charge of provider performance monitoring.

Many commissioners noted the improvement in Commission and committee support that came as a result of the new administration at COH, after a period of vacancy in the Executive position and a reorganization of staffing functions. Those who were in place throughout the transition gave the current staff high marks for attentiveness, responsiveness and preparedness.

There is a high level of satisfaction that the Commission receives relevant and appropriate input about the current and changing needs of clients. The source most often stated was that a large proportion of the body comprises PLWHA and they regularly participate in committee deliberations.

The efficiency of the Planning Council component of the administrative mechanism had not previously been assessed in prior AAMs, and based on these interviews the Commission is perceived to be highly effective and efficient. There are a few members who have passionately held alternative views about the way the County dispenses HIV funding, but even these members feel there are mechanisms for giving their input to leadership of the COH and to DHSP staff.

Summary of Suggestions That Informed the Recommendations

The only area that emerged as being of concern resulting from the commissioners was the broad issue (that has been noted many times throughout the existence of the Commission): how to integrate new provider agencies in a timely and relevant way into this mature system of care. While the majority of commissioners did not mention this as a concern, a minority of commissioners were passionate about this challenge. Since an open RFP process for the major categories of service was not undertaken during the period under study (2014-16), there was little opportunity for newer providers (or those not previously within the RWCA system of care) to enter the system.

A similar recommendation was highlighted by the Operations Committee as having emerged from previous AAM processes, which they identified as still relevant: to "expand ongoing proactive training, technical assistance and encouragement to potential and new service provider organizations, especially in primary target areas, in order to enlarge the pool of competent and appropriate service providers." Based on the input received from some commissioners in the current process, it is suggested that this recommendation be reevaluated in the future.

The County overall (primarily driven by ISD, the Internal Services Department) appears to be ramping up its outreach to new potential providers in many areas via its contractors fairs and media outreach, and it was noted that ISD is doing outreach for prospective County vendors in various services. It was recommended that DPH and/or DHSP could piggy-back on those efforts to try to reach newly identified HIV service providers and familiarize them with the contacting process and how to be competitive in an RFP process.

One process recommendation that emerged from this year's AAM process involves the consultant's take on the multiple viewpoints that are necessary to objectively evaluate each cohort identified in the scope of work. It is recommended that in future AAMs, the perspective of other cohorts (i.e., DHSP/DPH/COH staff and Providers) be surveyed as to their opinion on the efficiency of the Commission's operations. As was noted in the above commentary, commissioners give themselves high marks in the dimensions identified, however this summary is absent an objective assessment from other partners.

Focus Area 2 – DHSP and DPH staff

Context

The relationship between the DHSP and the Commission is symbiotic in nature. The planning council cannot do its job without the help of the recipient, and the recipient cannot do its job without the help of the planning council. Once the Commission has approved the service category ranking and allocated funds for services, DHSP takes these recommendations and leads the procurement, contracting and monitoring of subrecipients. The planning council has no jurisdiction over how the recipient uses funds for its own administrative expenses.

Process

For Focus Area 2, key staff from DHSP and DPH were selected based on their extensive knowledge and involvement with the procurement and contracting process. The questions for this cohort were selected to elicit perspectives that would allow better understanding of the steps that must followed to facilitate the development, implementation and monitoring of service contracts. Furthermore, the questions were aimed at understanding the organizational structure, layers of approval and areas of successes and possible improvement within the County contracting process.

There were 15 staff of the Division of HIV and STD Programs (DHSP), the Department of Public Health (DPH), and the Executive Office of the Board (EOB) who were identified by COH Staff at the outset of the AAM as having the most direct involvement with the process of contracting for services funded by RWCA. Some of the identified parties offered to include their coworkers, direct reports or associates in the interview sessions; consequently 17 individuals participated. Nearly all the interviews were conducted face to face.

The first questions focused on staff demographics, to establish their experience level with RWCA funded services and their familiarity with the County's Administrative Mechanism for procuring services, disbursing RWCA funds and monitoring services and finances.

During 2014, what was your position and role in the DHSP?

Respondents described their respective roles within the structure of DHSP, DPH or the Executive Office. All respondents had positions that were directly connected to the various aspects of procurement, contract execution, finance management, provider reimbursement and/or service monitoring.

Did your position or role at DHSP change anytime between 2014 and 2016? If yes, please explain.

There were very few, minor changes in position during the three year study period. It was determined that the changes did not impact their ability to provide their internal view on the

administrative mechanism.

How long have you worked on HRSA Ryan White-funded services/projects?

Respondents' tenure with RWCA funded services and projects ranged from **three to 25 years.** All respondents were in place during the three year period covered by this AAM.

The next set of questions was in regards to the Request for Proposal (RFP) Process. It was noted that during the three year band under study, only one RFP had been issued (for services in a SPA where no applicant had previous applied), however, the RFP process was noted to have been stepped-up after 2016. Most respondents provided perspective from the period under study and subsequent years.

Were the applications received from applicants responsive to the RFP? If not, how were they non-responsive?

The large majority of respondents among this cohort responded that in general, the proposals were responsive to the RFP. A few staffers noted that sometimes proposers do not carefully read the RFP or they might not have the capacity to undertake the project but say they do. However, the small number of references to these occurrences would indicate that the responsiveness of providers is typically quite high with standard RFP solicitation processes.

Were there any service gaps because fundable proposals were not received? If so, how were proposals determined to be not fundable? How did DHSP fill the service need?

There was near unanimity on the point that no service gaps resulted from the lack of fundable proposals during the period under study. All respondents noted that the DHSP has the ability to extend contracts of existing providers if no suitable new contractors are identified. One reference was made to a "gap" in a particular SPA for a particular service, but that was rectified by reissuing the RFP for that SPA. One staffer noted that sometimes proposals have been received in response to an RFP that do not comply with the instructions in the document, or the applicants are judged to be not capable of providing the service, utilizing the screening and evaluation protocols in place.

The next section of questions had to do with the contracting and monitoring processes. Those staff not involved in these functions were not asked to respond unless they knew specifically about the topic referenced in the question.

Describe your involvement in the contracting process for 2014, 2015, and 2016?

Of the 14 individuals in this cohort (interviewed one on one or in groups), six provided responses to one or more of the questions in this section. Those who participated were responsible for grants management, finance, contract administration, and management of various relevant sections of the division.

Briefly describe your role in DHSP's contracts and monitoring process beginning with notification to providers of funding awards through the execution of final contracts.

Respondents described their roles and the extent to which they were either directly involved in stewarding the contracts through the process or had an oversight role that gave them detailed familiarity with the process. As mentioned earlier, staff roles ranged from grants management, finance, contract administration, and management of various relevant sections of the division.

How much time does DHSP allow providers to submit grant budgets following their notice of funding award?

It was reported by nearly all the respondents that providers were given 30 days to provide their grant budgets once the notice of funding award was sent to the provider. It was noted that most contractors took the full 30 days to return their budgets.

Upon receipt of the providers' budgets how much time does it take for the DHSP to draft a contract?

Several respondents noted that the budgets needed to undergo finance and programmatic review in order to determine reasonableness of charges and consistency with performance protocols. For some providers the final budgets are consistent with the proposed budget which had already been determined to be appropriate; for others there may be changes in the budget based on the size of the overall award and those changes triggered further fiscal and program review.

Most of the respondents estimated that it generally took 30 to 60 days to finalize the contract once the budget was received from the provider. A majority of respondents indicated that the time was typically closer to the 30 day mark than the 60 day mark. Providers are given 10 days to sign and return finalized contracts.

On average, how long does it take to finalize contracts with providers from the drafting of the contract to approval by Board of Supervisors?

Most respondents to this question noted the multiple factors that affect the timeline of a "ready to execute" contract being fully approved by the BOS. It was noted that staff does not put the contract on the BOS agenda unless they have the contract completely finished. Some noted that it takes three months to get it on the BOS agenda, but if there are not significant numbers of substantial changes that timeline can go faster.

It was noted that in some cases it could take a month to two for a provider to sign and review the contract; sometimes agencies have legal teams that need to review it. It was stated that most of time DPH C&G processes a group of contracts together. Contracts are typically three years with the possibility of one or two year extensions.

It was also noted that typically the Division Director meets with BOS Deputies prior to the presentation of a batch of contracts, which allows BOS staffs to ask questions and it facilitates the execution of contracts. DHSP staff monitor the board dates and know when to have contracts ready for fastest execution. Several of the efficiency enhancement measures that have been learned over the years are in place at DHSP and they continue to look for more. The long tenure of the leadership at DHSP also leads to better relationships with the other components of the County's contracting system.

Does DHSP have internal review and approval processes that impact the time needed to finalize contracts?

It was reported that the Contracts Administration Section plays a significant role at this stage. The Finance section receives the budget from the agency, and asks for relevant documents if they are not supplied. The program area looks at relevant items such as educational level and/or licensure of staff, etc. The contracts area consolidates all the pieces. It was estimated that it probably takes 45-60 days on average to assemble everything. The DHSP has developed systems so that both service assessment and budget assessment are happening simultaneously. Most of the delays have to do with the budget component.

Mention was made of some understandable outliers, for example large institutions such as hospitals or universities that had elaborate processes of their own for executing contracts, which might extend the contract development period.

Describe the overall process for monitoring contracts.

Respondents noted that there are generally three steps in the monitoring cycle: 1) annual program review of all contracts with all providers; 2) then a separate facilities and operations review (licensure, etc.); 3) then fiscal audits. The division's goal is annual monitoring but it may have been 2-3 years between monitoring visits in some cases.

Every month agencies submit monthly reports along with their invoices. They go to finance first, where staff will review the invoice in relation to the budget. A provider will not be paid unless the program report is in. The review of the reports allows staff to determine if the provider is on track to meet the goals of the contract. If they are not, a staff member will follow up if the contractor is behind.

Program staff assemble reports and meet with finance monthly to see how agencies are spending. There is typically an annual monitoring visit, where financial and program monitors go out. In fee-for-service (FFS) contracts monitoring staff randomly choose three months of invoices to see how many clients were seen, and match that with reported numbers.

It was noted that performance of providers varies with each agency, and issues such as staff turnover may have an impact, but typically agencies score 80% and higher. A few might be at 65-70%, but the majority are doing relatively well.

It was reported that the County's Auditor Controller staff and DPH's contract monitoring unit both do audits of providers (typically each staff does half of the contracts); sometimes determined by size; sometimes if they have other county DPH or DHS contracts. An annual audit of contracted agencies is required by the County.

The next set of questions had to do with provider reimbursement processes *(the question was skipped if key informant is not involved in reimbursement process)*

Describe your involvement in the provider reimbursement (billing) process in 2014, 2015, 2016. Describe the reimbursement process from the submission of billing requests to payment disbursement.

The process was described as follows:

- Invoices are submitted to the DHSP Finance office; they are logged in and the secretary checks if all the required information is with the invoice (such as the monthly report); the secretary determines complete/incomplete, then the program manager is told so they can get back to the agency if necessary.
- When the package is complete, it goes to the assigned accounting staff member to process. If it is a cost-based invoice they check the line items. If it is a fee-for-service (FFS) (as for AOM), it goes to the community contracted program area, staff of does an evaluation of the services provided, and then the invoice comes back to finance; the accountant reviews to see that the number of units is correct.
- At that point the invoice is processed; there are three levels of approval for larger amounts and two levels for smaller amounts.
- Payments go through the County's eCAPS system; amounts of $10,000 to $49,999 go through three approvals; over $50,000 requires four levels (the County Auditor Controller sets the mandated levels, which are designed to ensure adequate separation of duties);
- One of the efficiency measures that was promoted to providers during the 2014/2015 period was the opportunity to set up direct deposit for payments, but out of 60 providers, only 25 enrolled in this service. Future AAMs should consider doing a deeper inquiry to understand why not all contractors are enrolled in direct deposit payments.

What is the average time it takes for DHSP staff to process and pay invoices? Please describe any technical assistance you are aware of that is provided to service providers that focused on budget or invoicing during the program year 2016.

Respondents with knowledge of the turnaround time indicated that it takes approximately two weeks to process invoices. There was an acknowledgement that this is a critical function and adequate attention is paid to timeliness.

Please describe any technical assistance that you are aware of that is provided to service providers that focused on budget or invoicing during the program year 2016.

Respondents noted that the Finance team offers technical assistance (TA) and troubleshooting to anyone who needs it, based on request. One of ways TA is offered to invite providers to send their accounting team in and staff walk them through the budget process. It was noted that there are 18 pages of instructions available on the DHSP website and training is made available whenever contracted agencies hire new staff. Training covers budgeting, invoicing and cost reports. Fiscal staff also offers TA over the phone and sometimes they go through the assigned program manager.

If in the course of negotiations providers are having trouble assembling the items needed by DHSP, they may have the agencies come into the office, and both finance and program staff participate and go over any issues the agency may be having. It was also noted that DHSP program managers are talking with contractor program people regularly, and can provide TA during those conversations.

Specific Questions to Patricia Gibson (Chief, Contracts and Grants Division, Department of Public Health):

The Contracts and Grants Division, Department of Public Health is charged with overseeing all RFPs for all programs under DPH of which DHSP is a part DHSP must comply with RFP procedures developed by DPH. The Chief of the Contracts and Grants Division of DPH has been in place since 2014. She has a team of 30 staff in the division: three teams; each team is linked to a department. In 2012 they received five more items (i.e., FTEs) to help DHSP with its solicitations and contracts. With the two FTE additional doing DHSP work (going to board, amendments, change notices, delegated authority), there are seven staff assigned to DHSP. DHSP contracts comprise approximately 25% of the contracts her division handles.

The next question had to do with longevity in the position. She noted her position had not changed over the three years under study.

Describe the DPH RFP process. Is it the same process for all DPH Divisions? Are there additional requirements or unique processes for DHSP RFPs? If so, please describe and why are these additional requirements or unique processes applied to DHSP RFPs?

The DPH RFP process is the same for all DPH Divisions. The only thing unique to DHSP is at the end of the decision making, for the scoring process and ranking. At the end DPH and DHSP staff have a meeting to review results and determine if any unique factors should enter into the scoring. They also build into the RFP process the ability to do a site visit.

Do you think the DPH RFP process effectively and efficiently disperses grant funding into the community? If yes, please provide examples of what works well. If no, please provide examples of improvements needed.

Ms. Gibson, the Division Chief noted that RFPs are a challenge for everybody. The aspect that takes the longest are the evaluation processes. The protest process can also take a good deal of time.

How does DPH select members of the RFP Evaluation Committee?

"Selection depends on the service; for example, right now we [DPH] are evaluating media services. We went out to county departments; we sometimes look internally at staff who have expertise but don't have involvement with direct providers."

Were the applications received responsive to the RFP? If not, how were they non-responsive?

The Division Chief indicated that she did not have specific information to answer this question but generally understood that applications were responsive. The majority of respondents at DPH and DHSP recalled that applications were generally responsive.

Were there any service gaps because fundable proposals were not received? If so, how were proposals determined to be not fundable? How did DHSP fill the service need?

The Division Chief noted that from her position she really couldn't comment. She knew that DHSP can extend the time of existing contracts to cover any potential gap, and does so from time to time. Given that, it is unlikely that there were any funding gaps. This answer matched responses from DHSP participants.

To your knowledge, are there national benchmarks related to contracting and procurement best practices?

The Division Chief noted that she was not aware of national procurement best practice for these types of contracts; her understanding was that one year is the general standard.

What recommendations do you have for improving and/or expediting the County contracting and procurement process?

Comments from all DPH, DHSP and Executive Office respondents are summarized here.

It is the position of several DHSP staff in management levels that they do not have the adequate staffing levels, and this results in lessened ability to undertake the RFP process.

One overarching category of concern and recommendations for improvement had to do with staffing. A variety of similar issues stood out, as mentioned by most interviewees:

- One challenge of the system is that the DHSP staffers that are helping to put together the programmatic elements of the application review are also tasked with on site evaluation of providers, so their time is limited.
- It is acknowledged that DHSP staff have the most specific knowledge of services, while the DPH C&G team has the most knowledge of standard County contracting rules and requirements as they change.
- Another complicating issue noted was that the position salaries ("items") were different between DHSP staff and DPH C&G staff, which led to some turnover as individuals sought the higher scale at DPH. Some turnover among DPH C&G staff was also noted as an issue that impeded efficiency, but it was understood that turnover might be inevitable.
- Turnover in staffing was acknowledged as probably the greatest contributor to lengthening the time to complete the procurement processes; it was noted that the County's process to fill positions takes a very long time while existing staff have to backfill the duties. The comment was made that in order to respond to the wish by some in the community that there be more frequent RFP processes there would need to be more staff, particularly at DHSP.

Two other personnel related concerns are the location of staff and the sometimes overlapping responsibilities of the DHSP contracts staff and the DPH contracts staff.

- It was noted by multiple DHSP respondents that lack of being able to fill positions has been a detriment to efficiency. In the 2015-16 period the DPH developed a new staffing plan that they tested with SAPC and DHSP, where they consolidated contracts staff into a DPH Contracts and Grants area. DPH C&G manages the solicitation process, but DHSP also needs contract and fiscal staff to provide review and oversight of programmatic and financial performance.
- It was noted that SAPC is no longer is part of the consolidated C&G system, but DHSP still retains that structure.
- The DPH C&G staff assigned to DHSP was co-located within DHSP offices which DHSP felt was more efficient, as there was much formal and informal cross-fertilization of information and ideas. The C&G staff is now located elsewhere and regular meetings between the respective staffs are conducted. While DPH feels that there is no significant challenge posed by being located elsewhere, DHSP clearly feels that this configuration is less efficient, with staffs having to drive across town.
- There were also comments about the detail knowledge level of DPH C&G staff given their

being physically removed from the programmatic experts. DHSP leadership indicated that it is problematic not having a say over who is assigned or if they are responsible to DHSP management. Lack of response or inappropriate response can result. There needs to be stability in the teams in order to support increased efficiency.

A suggestion was made that perhaps a future AAM could attempt to look at the finance and HR areas at DPH that might be impacting efficiency of the Administrative Mechanism

It was noted that there are redundancies in the process of fiscal review at DPH C&G and the fiscal review at DHSP; in some cases the same memo needs to be generated to send to DPH finance by both levels. There are also redundancies reported in the preparation of board letters between the two offices.

Another category of recommendations had to do with the type of solicitation for services.

- It was acknowledged that the RFP process is the best in terms of obtaining specific types of services delivered in accordance with explicit instruction and program design. However, this procurement method is usually the longest to operationalize.
- It was noted that an "Invitation for Bid" (IFB), which is a more cost-based and proscriptive approach where the applicant submits a budget and the County typically selects the low bid, is a quicker process. It was stated that this device is being used for legal services and language services (although the process to decide on legal services was described as lengthy).
- It was generally agreed that the Fee for Service (FFS) model is the most efficient system to secure services, but the challenge is to determine a fee level for defined services that is considered adequate for varying types of providers throughout the large and diverse geography of LA County.
- Another device noted is a "Request for Statement of Qualifications" (RFSQ), where the first phase is to establish a qualified pool of providers and the second phase is a "mini-solicitation" (typically awarded to the low bid).
- Another possible device would be to retain "Temporary Personnel" (as was used in biomedical solicitation); that also is a quicker process. "[DPH health] Programs are located in various geographical locations throughout the County, and may periodically require temporary personnel services on an as-needed basis to complete certain projects or provide services … The effective and timely delivery of these health services routinely requires tactical planning and launching of initiatives and special projects which often require temporary personnel services on an as needed basis."[10] Theoretically, provider agencies could become "personnel services" providers under contract to the County.
- There have been various attempts to make the system more efficient, and it was noted that multiple offices try to look at the most efficient procurement model for each solicitation. It was noted by several respondents that the system had gotten more efficient over the three years under study.

- One process that was tried by DHSP was an invitation for Concept Papers. It did not seem to be embraced by the provider community.
- Another device that could be used for DPH) is to issue "grants" for the provision of services. Some departments and commissions of the County issue "grants" such as Community Services Block Grants, County Arts Commission Grants, Park and Open Spaces Grants, Supervisor Discretionary Grants and others. It was suggested that perhaps grants could be revisited. A block grant is a large sum of money granted by the national government to a regional government with only general provisions as to the way it is to be spent, in contrast to a categorical grant, which has stricter and specific provisions on the way it is to be spent. Federal funding secured by DHSP for STD and HIV programs are typically categorical grants with specific performance metrics and outcomes measures. This distinction may not have been clear to the respondents.
- DHSP has requested that the CEO's office work with them to explore more efficient processes for procurement and distributing funds to providers. It was noted that sometimes the solicitations processed in the Executive Office (for example COH service procurements) are executed more quickly due to being closer to the ultimate approval levels.
- It was noted that a continuing challenge is to find non-conflicted reviewers of proposals. It was suggested that this situation would probably only improve if there were adequate compensation for those services (including travel expenses), and perhaps an ongoing cohort of reviewers could be assembled (as is done by HRSA for national proposals). Improved technology to enable "virtual face-to-face" reviews could also address the difficulties in assembling and maintaining qualified teams.

One step that was noted as having been implemented and is helpful has been to get the health deputies a draft of the board letter two weeks before their meeting. The Division head goes to all the meetings, which saves time because the deputies are able to get answers to questions on the spot.

Another set of practices that were noted by nearly all respondents have to do with the County's standard protest process. According to interviewees, protests are allowed: first, when the solicitation is released (i.e., regarding matters such as provider requirements, duration of experience of staff, etc.); then when decisions are made, an offer is made to debrief with applicants, and they can ask for proposed contractor solicitation review; they can then see outlines of winning bidders, and can file protest. Then the county independent review process is the last opportunity to protest. It was noted that there were only two protests filed that utilized the full progression of steps.

[10] Language from RFSQ for Temporary Personnel Services currently issued covering 2016-2023

- A further comment received from multiple respondents having to do with protests and their impact on efficiency is that whenever the County is involved in litigation, the settlement usually involves adding layers of bureaucratic review, while other processes are not deleted or shortened. Similarly, when the County Auditor Controller audits DHSP there may be findings that require them to reeducate providers to anticipate budget or contract concerns so that in their own (providers') audits by the County they can avoid negative findings.

It was noted that DHSP continues to try to find ways to make the RFP process more efficient, for example, using templates. There was also mention that ISD (Internal Services Department) was exploring ways to make the procurement process more efficient, including studying standards of a national governmental affairs group

EOB staff made reference to the fact that there used to be meetings scheduled between its staff and COH staff to explore anticipated staffing and other resource needs throughout the year, so that it could be prepared to assist and respond quickly to COH needs or changes. It was recommended that those meetings be reinstituted as an aid to increased efficiency of the procurement process for COH service needs.

A comment from a couple staffers was that now that there is a relatively new BOS and newer support staff there may be an opportunity to take another look at the process for securing HIV services under the RWCA. However the new Board configuration has also meant a great deal of education for BOS staffs to let them know the current standards and practices, and the nuances of both the funder and the provider communities.

Observations related to Focus Area 2: staff members of DHSP, DPH and EOB

There is clearly a division of opinion having to do with the relatively recent model of consolidating the Contracts and Grants operations at DPH, as opposed to its former configuration within the DHSP staffing structure, between leaders of the department and the division. The majority (though not unanimous) opinion of DHSP staff is that they feel the administrative mechanism would be more efficient if the contract staff were back within its ranks. It seems clear that returning to the prior model would be conducive to more interaction between fiscal and program staff, and an additional likely benefit would be that the value of the monitoring to providers could be improved.

There were also many comments having to do with the increasingly complicated requirements for county contracts, often resulting from litigation, and on the phenomenon that when new provisions are added other provisions are rarely eliminated.

Summary of Suggestions That Informed the Recommendations

Because of the varying opinions on the efficacy of the current model of handling contract processing within the DPH Contracts and Grants Division, as compared with the previous model of contract administration entirely within the Division, it was suggested that a study process be inaugurated that looks at the plusses and minuses to overall efficiency that exist in the consolidated model.

It was also noted that the multi-layered county appeals process that is in place for HIV contracts adds significant delays to the process. The study suggested above could look at the necessity for each of the appeals levels.

A variety of staffing suggestions were made having to do with adequate numbers of staff and their respective responsibilities. There was no consensus on where staff is most needed, so a study of the situation is recommended.

Focus Area 3 – Contracted Agency Perspectives

Context

In order for the Commission to better understand the needs of PLWHA who consume Ryan White-funded services in Los Angeles County, they must collaborate with DHSP in conducting needs assessments and understanding the capacity issues and administrative barriers faced by contracted agencies. The questions for the contracted agencies were designed to elicit their perspectives on the efficiency of the County's procurement and contract management processes.

Process

A representative sampling of providers was surveyed for their commentary and observations on the administrative mechanism (as noted on page 28, HRSA suggests that input can be ascertained from providers, as long as only compiled results are shared with the Planning Council).

In order to maintain objectivity and generalizability, providers to be interviewed were selected based on an anonymized list of all the contracts executed in the three year time period under study. The list of contractors were provided by DHSP. The contracts were randomized along the criteria of service category, contract amount, and type of procurement. The list resulting from the randomization was then culled by removing duplicates, so that only one provider representative per agency was interviewed. The final number interviewed resulted from reaching out to all those identified, and interviewing all who were willing and available to participate.

In total, 16 providers were surveyed using a semi-structured interview tool that was similar to that used for the other two cohorts. A number of interviewees assembled teams of those in their agency who had direct knowledge of the various aspects of the contracting, monitoring and reimbursement processes. Following are the questions asked and a list of provider comments.

Describe the level of guidance you get from DHSP in regard to invoicing, budget development, and budget modifications? Probe for responsiveness to questions, clarity of responses, and ease of access to DHSP staff.

The level of guidance is reported to be good, according to 65% of those who responded to the question. Others noted variations with the specific program manager and variations between program and fiscal guidance.

Comments Related to Process and Training:

- Almost every year they had workshops and our controller and accountant attended.
- We are referred to their information site, etc.
- They give strong support and guidance; there is value to the trainings that they mandate contractors to attend.
- They have been responsive. Easy to get hold of monitoring folks, both fiscal and programmatic. Good people there who are responsive. Our program manager is wonderful.
- They have a pretty extensive workbook for us to refer to. Consistent templates across the board. Can prepare for all grants.

Comments Related to Responsiveness:

- No problem with fiscal office – he is great and responsive; we love to work with him; we get good answers now.
- Finance: managers are very responsive and we typically get a response by the next day.
- We had a great contact, but the program person was replaced recently. We have a fiscal contact that is great, but not program staff – we are frustrated by last minute requests.
- Think as far as access, yes, they communicate quickly. Depending on the person it could be like pulling teeth to get to an understanding, for example the breakdown of costs, etc.; we may not always agree on what is on the invoice.
- They give you a manual and you are supposed to derive from that what you are supposed to do. We hear from them only when we have done something "wrong" and they tell us

they are going to disallow an item.

- The staff is quite bureaucratic: it boils down to a drain on programmatic time, they want all the i's dotted and t's crossed.
- Some program managers are easier to work with than others. Over the past few years, we've experienced stricter guidance when we are submitting budgets or modifications; some are more nit-picky; doesn't seem there is uniform guidance we get. For us it becomes very unclear, sometimes we have to follow multiple guidance, based on the program monitor at the time.
- There is not always time spent that is efficient or effective because the contract will start and the TA doesn't come in until several months after the contract starts.
- Sometimes delays in guidance affects cash flow; you can have staff who leaves or is hired and you don't know for sure if they are covered by the grant.
- Budget development and modification are the parts that take a while; we may not hear for three months; you can be at the end of your project and still not have approval; most of the time it is approved but you have to take a risk.
    - Are they responsive? Yes; actually trying to find a way to fix things that are wrong? No.

Comments Related to Clarity/consistency:

- They are pretty instructive on how the process is supposed to work. They give clear guidelines regarding when things are due; what is restricted and unrestricted, etc. Often there is a lot of back and forth to get modifications through. The new budget process is long; often a lot of back and forth; approvals might not happen until the funding period is over.
- They are not great; our senior accountant prepares the budget and deals with them every month; it's not very effective as far as I can see.
- It took nine months to approve a budget modification we submitted in 2016; (it is better now).
- Budget modifications are more challenging than invoicing – that is a huge stress because each monitor responds differently.
- There is no consistency from one program manager to another – what works for one does not work for another.
- Sometimes the clarity depends on the person; program managers sometimes have different criteria than fiscal staff.
- They can be very exact – only what is in the budget is allowed; that can be problematic if they challenge the line items. This phenomenon has been consistent over time, that they are exact on budgets. In our experience, federal budget monitors are more flexible than the County.

General Commentary/observations:

- Regarding processing of invoices, they are pretty good. When I send invoices there is a requirement for paper copy through FedEx, but I would think they should be OK with the electronic copy.
- The templates help with invoicing, but as the project changes, you must absorb the costs for a few months.
- Budget modifications can also sometimes be quick; other times inordinately lengthy and complicated. They are getting better with modifications; they do everything they can on this.

In terms of the process of program monitoring, how clear are you on the expectations prior to the site visit and monitoring? (Very clear, adequately clear, not clear, don't know).

82% of respondents say the expectations are very or adequately clear. Some note differences between fiscal and program monitors, or between one individual monitor and the next.

- The large majority of respondents indicated that they are clear on the expectations prior to the site visit; a few noted that they have been providing services and doing monitoring visits for so long it is a routine. Nearly all noted that monitors provide a list of what they are going to look at and so they know the expectations. Nearly all noted that DHSP sends a letter that verifies what they are looking for in broad strokes; one noted that they don't provide the tools in advance that they are going to use at the time of monitoring. It was noted that while expectations are clear because the provider has a lot of experience, each time there is something new--requirements that they may not know about until that day.
- Other comments included: Very clear; we've been working with them for so long. We have a good working relationship; they provide us with plenty of notice; there are no surprises because the contracts are explicit; they send the scope and forms to complete; their service delivery expectations monthly are very clear and straightforward.
- One provider noted that one negative experience is sometimes when the contracts have rolled over, we haven't received the year-end reports right away and we need to perform without the outcomes report from last year.
- A couple of providers noted that when they have a change in who is doing the monitoring, they can use the same outline but have different interpretations based on program manager.
- A few respondents indicated the monitors should provide more flexibility.
- One provider noted they have two different grants for their clinic; the list is identical for the two programs, so the clinic person has to undergo it twice; they suggested that DHSP

could do them simultaneously, at least for the policies that are the same.

- One provider noted that the program was very rigid and restrictive; but the contractor noted that with the population they serve, you need to be creative sometimes. Monitors were agreeable and gave us helpful ideas, but we couldn't change much.

While it was clear that this line of questioning had to do with DHSP monitoring, no fewer than five respondents volunteered harsh criticism for the audits conducted by the office of the County Auditor-Controller. They highlighted the lack of preparation by the auditors and the extended time spent at agencies. Comments included:

- They didn't even look at our materials prior to latest visit; it was not clear when they were coming and going; they left confidential materials out and visible.
- Auditor controller audits are a nightmare; they over-scrutinize the organization; the level of detail is strenuous; it takes up a lot of staff time--I don't know how smaller nonprofits can do it. We have HRSA auditors and our external audit firm but the county can be even more strenuous. The time spent is extreme and costs the agency a lot in staffing.
- LA County auditors were the ones who were problematic; three weeks is too long – the process lasted from January to the end of March.

Does DHSP regularly provide feedback on your performance? Do you get feedback or technical assistance from DHSP on barriers and challenges reported on progress reports?

Approximately half of the respondents (47%) rated this item as positive. While there were great variations, most of the respondents who ranked this item as unsatisfactory noted that feedback came only once per year and by means of providing POCA requirements.

The half who had positive responses provided commentary such as:

- They are clear and timely.
- Yes, especially if we are having problems meeting our initial goals; they will give ideas on how to increase the census, find different clientele, sometimes may recommend partners; generally do little check-ins periodically; we have had our program for decades so we are familiar with what has to be done; with newer services we have more frequent conversations.
- If we ask for help, they will provide it to us. We have to be proactive. We have had DHSP staff ask questions about some of our reports, but we only get help if we ask.
- Sometimes we can't fix the challenge but they provide the assistance they can.
- We do get feedback throughout the year; when we have challenges and they have

been made aware, the supervisors of the program will provide assistance.

- I wouldn't call it feedback, but if there are issues or concerns, if the staff is needed they are responsive. It is usually at the time of the cost reports or at the time of an audit.
- Yes. It varies from program to program, but overall it's very good to excellent with a few exceptions.
- Yes, they are good with feedback.
- Yes. They provide feedback on whether you are performing or not; but no guidance is given on how to improve.

Among the more critical comments were:

- The only shortcoming might be on certain interventions they are sun-setting; like comprehensive risk assessment; we needed training but it was not offered; the training was not frequently enough.
- No, they don't regularly give feedback; it only comes with the annual visit, we have either fully complied or a POCA is required. In between when we change staff, they are pretty helpful with that.
- No, not throughout the year. The only time is at the time of annual program review. Also if we request guidance they usually have to elevate the question so it's not usually a direct or timely response. Typically when they have a roll out of new programs they don't give full instruction on how to roll them out. There is a big learning curve on how to implement the changes; they aren't responsive; it takes them a while. That tends to be a frustration; we are expressing challenges and suggesting possible modifications. There is not room for negotiation. Would like to see more of a partnership. Other funders are more flexible; DHSP is the most challenging.
- We are left to our own devices on how to fix whatever is noted; we have other RWCA funding so we know how it works elsewhere. We do not always get guidance; they will refer to the contract but not much specific guidance; it only happens at site reviews; we don't get feedback during the year; they have never asked otherwise.

With regards to the development of your DHSP contract, how would you describe the level of technical assistance and support provided by your assigned Program Manager and Fiscal Representative?

The large majority (82%) of respondents gave positive marks to DHSP on providing technical assistance and support to develop their contract.

Among the positive comments were:

- Seems like they go over it pretty well before it gets to administration; have never known them to not give clarification.
- Pretty good (it's the county so things do take a while); they are getting better on that, with more documentation. In the past it may have been just in an email but now it is provided in a document; sometime it takes a while, we may not have the final budget modification approved until almost the last day before submitting the cost report. But it is getting better over time.
- Has gotten better; several years back when the effective date of the contract would be March but we didn't get a contract until August. It has gotten better, especially now that the contract is good for two years; also, amendments before had lots of paperwork and now the amendments are more of a solid system; not as difficult now.
- DHSP is good; our last program manager was very good and responsive; any time we wanted to reach out and get clarification he would be available; and if he didn't know the answer, he would find out.
- OK because we have been doing it so long; our folks and theirs are OK with it.

Among the more critical comments were:

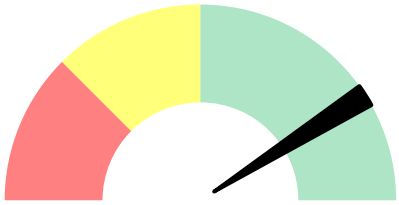
- Sometimes they have some problems and many times we have to send in our billing but the contract is not signed and we can't get paid for months. At the beginning of the contract year there is a lag; same with budget modification, they take a long time. They take too long for modifications. Even on a monthly basis, they take a long time to pay the contracts; they don't pay in 30 days, maybe 60-90.
- They ask for very specific documentation but we are always looking in a crystal ball to try to figure out what they will require. They are a little too aggressive at the point of trying to develop a contract; there needs to be clarification about the rigor of backup documentation needed versus what is expected at the time of the cost report. To ask for specific documentation for every small purchase we feel is an overreach.
- Our program monitors are very approachable; one problem is that they don't stay on the audits that long; you get to know one and they move on. Seems to be a thing at DHSP, you have to learn a new person and what they want. We would like more flexibility in terms of how funds are allocated within roles in the clinic. The rule is that we have to submit a formal request, do the hiring, and get it approved. We have to wait for DHSP to do the review of our change request. It takes about four weeks to approve; then we have to wait for the training. Casewatch trainings are scheduled as needed, but it takes another step.
- Program side was good; fiscal was not (delays, etc.).
- There was no TA for the contract development; we review and ask for changes if we need to.

How well written are the RFPs, and do you feel they provide clear direction? Please reference which RFP or service category you are referring to. What was your role in developing the application for the specific RFP? In what ways was DHSP unclear? What recommendations do you have that could improve that specific RFP?

Among interviewees, 93% indicated the direction was clear; there was some variability in response as to how clear they were; several respondents noted that there were no large RFP processes undertaken during the period studied, and/or there were no RFPs issued to which they responded during the period in question.

- RFPs are good to very good, not excellent. There is some ambiguity – across the board (but some are more challenging); think the response time is shorter than is doable (sometimes they are not considerate of holidays or people's vacations); regarding technical support they are reluctant to give direct answers (I guess they want to feel they are impartial and give the same information to everyone); those supplements are helpful; ongoing Q&As are very helpful. It's always better to have the contracting at DHSP as opposed to DPH. DHSP is close to the Commission and it gets lost in DPH.
- RFPs over time have been very detailed; when they have needed to, they have made changes to certain administrative items.
- [Bidders] definitely need more guidance and clarity in the proposal process; there are occasions when what the RFP says is different than what's said to bidders.
- I think the RFP process could be streamlined a bit; I think a lot of the documents are quite dense; sometimes they duplicate across areas in the RFP (but we understand this might be a county thing, as sometimes the sections go to different areas). They are clear and straightforward—not unreasonable.
- They provide clear direction, they will have a conference to talk through what the requirements of the funding are; they are familiar with our program, that helps a lot; they help us with going through the dollars and goals and outcomes; they get together with us.
- I work with our director of grants who has no complaints about DHSP – we have been with them so long we have a good grasp of what's required

Do you feel the County's process of awarding contracts for services is fair? If not, in what ways do you feel they are not fair?



In total, 81% of interviewed providers say the process is fair and/or it follows HRSA guidance and funder requirements.

Additional commentary was received that provided nuance to the assessment of fairness:

- Don't think anything the County does is transparent—selection or awarding; but they do follow the Commission's direction.
- I guess they could be fairer; by and large, they are relatively consistent and want to focus on populations at highest risk. But there are populations that are given the shorter end of the stick. Women at risk aren't particularly highlighted, or Native Americans; they are just as impacted as other communities. It has become more fair, for example the process in which we have shifted from cost reimbursement to Fee For Service (FFS); but it has impacted service delivery. The 10% admin cap is a problem. Once they made rent purely an administrative cost; then they changed and allowed rent as a program expense.
- We had a grant we did but we were not awarded; of three reviewers, two said we met the goals but the other one didn't; they didn't explain how the scoring was so different between reviewers, and they didn't disclose the reviewers.
- Maybe for them it is fair since they follow the State (whenever I complain they always say it is the State that is responsible). For SAMHSA, you can use your federal indirect rate, but for Ryan White it is 10% for indirect and often less.
- No, the process has never been fair. We know who the big players are and who is getting funded. Just give people a chance. It seems like SPA 3 has never been very important.
- What I think could be called unfair is that the contract was reduced by so much that it was not possible to reach the numbers we were supposed to reach. For example our mental health contract was reduced by so much we could not hire staff. Although it was reduced we still had to see the same number of clients. In the FFS rates, even though we have exceeded what was expected, we ask for increased funding but we might get just a set percentage of the increase – they are not proportionate across all the costs.
- The process is fair, but it can be improved upon by bringing on additional new organizations and those that have solid performance history should be better acknowledged and understood. They should avoid favoritism—I have seen instances of favoritism with certain partners.

What are the most effective practices employed by your agency to ensure that Ryan White funds are spent efficiently?

Providers related a variety of effectiveness enhancements that they utilized in their agencies:

- Our accounting department just converted recently to new accounting system—we can code down to a pencil or personnel line item. Our accounting department has grown and matured with new CPAs, controller, etc. we are more on top of budget; we are very by the book. Ongoing investment in improving and increasing efficiency.
- We run a great program and DHSP is major funding for our program; since it is so important we pay particular attention to billings, etc. Related to the fiscal part I make recommendations and my bosses respond. I go to training if it is helpful. DHSP trainings have been helpful in the past, like the Casewatch update training.
- We track through our fund accounting system; can pretty quickly ascertain if we are attributing proper costs to each program; our staff monitors how well the spending is going and if we are on track.
- We do have financial software to track by grant; can attach an activity code to all expenditures. Timekeeping system for payroll is able to process by grant number, so we are able to report out the county financials in the grant year that can be traced. I think DHSP does a pretty good job; it works well for all.
- DHSP has helped us developed some of the process and flow to screen clients to see if they qualify. We make sure we are spending the dollars appropriately. We do internal audits to ensure we are following our own procedures
- Our director looks at all the grants and tries to integrate all the services together; we are "anti-silos," and are big on "lean" processing and open communications. He is always looking at break even and how to employ all necessary software to determine that. A continuing problem for us is client no-shows; we employ "robo-calls," texts, reminders, humans calling—whatever we can do.
- We are very efficient; 99.9% of the time we have to use funds from our general fund to help subsidize the cost of Ryan White care.
- We do have Casewatch so we make sure that all clients have verification of their HIV, and that clients are linked to medical care; we do well in that area. We have systems for reliable reporting; making sure we are updating how we are spending, and what modifications are needed; we have experienced a quick turnaround when we need to.
- As far as patient care goes, we have patient databases computerized to track things like immunizations; the [DHSP provided] systems for monitoring taxi vouchers and transportation are awesome. We track attendance automatically in order to bill at the end of the month.
- We have ongoing quality management; fiscal management internally; good management; our auditor comes in on a regular basis; the system ensures we are in compliance. We are part of a larger system so we have resources to ensure fiscal responsibility and fiscal management.
- Our methods here are used not only with DHSP, but there are four audits per year; regular chart audits; financial; lab; administrative.

General Provider Comments

Providers were also given the opportunity to provide any additional observations or suggestions regarding the effectiveness of the administrative mechanism and any topics or issues that impact it.

Following is a summary of their comments:

- I guess from an efficiency standpoint I would cite the potential conflict of interest now that DHSP is directly operating services. That could be a potential challenge. Now service providers have to compete with the County, so the system is not as competitive. They started their own case management and patient navigators, for example.
- Hope DHSP can help us to get the funds faster, and answers when we need them. Now it is a one way street – you must provide information on time or they will withhold payments, no exceptions. It should be both ways: we will pay on time when you send in your invoice. They might put you in the "black book" and they will reference that in the future that you were late.
- A couple specific concerns are:
    - Eligibility requirements – right now the requirement is every six months to screen to see if patients are still eligible. For more severe patients, we would like to do that annually rather than six months. They might be lost to follow up past six months, and we might get dinged for that.
    - Reports - now when we send in monthly invoice we have to send a narrative, but some of this is repetitive, could we submit quarterly for MCC narratives?
    - Can we get credit for work done if they are not yet fully Casewatch eligible--maybe give us 60 days that we can report the eligibility? Or if they would honor our hard copy it would help.
    - Casewatch technical support - for those that are now completing formal training, could it be more available, can we get technical support during business hours? The training is at the end, but we try to get find training we need as we go along. If they can upgrade Casewatch from DOS it would help – it is a difficult system to work with.
- The Casewatch system is definitely a dinosaur system; need a centralized eligibility system; we should cut down barriers for clients and agencies. There are redundant systems across providers. Sometimes we are working with low staff and it is hard to enter the eligibility information for clients each time. Maybe Casewatch is meant to be that centralized system but it is not used that way.
- It is no secret and maybe it comes from HRSA, there is an influx of requirements on the clients; initially the eligibility was annual and now every six months; paperwork required for clients is complicated (it's probably from HRSA). Requirements for RSR reports should be clearer; when you ask, you get the run around, with comments like, "access the correct website."
- In my oversight role, I have to sign off on the invoices; it's the most convoluted system I've ever seen; only county people can understand it

- I think they should get into the 20th century much less the 21st century. It is probably a system developed in the 60s or 70s in terms of finance; with turnover at the county I doubt that it's ever going to be reformed. We should be together and not as adversaries. If they want to approach this as a collaboration they should get their folks to meet with ours. It's typical government—two leviathans (DHSP and DPH) that combine their requirements; it makes it difficult on the fiscal side.

The comments from the providers listed above underscore the importance of regular, ongoing communication and training between DHSP and their contracted providers regarding HRSA and Los Angeles County contract requirements. A monthly newsletter sent to all contracted agencies that provides clarifications on documentation, contractual and fiscal requirements may help address the statements noted above. A sound practice to consider is to use the "Word on the Street" section of the Public Health Accreditation Board's (PHAB) monthly newsletters as a model for regular communications. "Word on the Street" publishes questions and concerns received by PHAB from health departments and provides answers so that all stakeholders receive consistent, regular guidance on a variety of programmatic, fiscal and accreditation requirements (http://myemail.constantcontact.com/PHAB-E-Newsletter--March-April-2018.html?soid=1102084465533&aid=dUy79gPhv7o)

Observations and Recommendations

General Observations

As was noted by interviewees at all levels, the system of RWCA-funded client/patient care in Los Angeles County is very mature and a great many of the provider agencies have been both providing services for decades and have developed effective working relationships with DHSP. This high level of provider experience was noted to be a positive in terms of providing quality care (and doing so efficiently), however some observers and participants indicate it has become an inertia-laden "closed system" with little opportunity to bring in new providers who may be closer to emerging communities, geographic areas or specific needs. As would be expected, most of the large providers who have been operating with contracts that renew from year to year have a higher opinion of the system than those who are smaller or newer to the field. It was of interest though, that some of the larger institutional providers indicated frustration with the many levels of bureaucracy in the Ryan White system (exacerbated by the low level of allowed administrative costs), to the point that some indicated they do not seek RWCA funds and rely on other funding.

Variations on the comment "well, it's the County, you know how that is," were also repeated many times among interviewees in all three focus areas. There is widespread resignation to the fact that Los Angeles County is a large and complicated bureaucracy that does things in its own, very complicated, ways. Those who have been working in this environment for many years have learned to deal with it, even while they wish it could be different.

Ironically, the high level of difficulty in working within the system seems to have led to a relatively high level of "satisfaction" with it—that is, once you know the ropes, and find ways to deal with all the hurdles, you can get work done. With all the effort that has been expended in figuring out how to deal with the current system, there is little appetite for changing it in any radical way.

Summary of Recommendations

Regarding the Commission (Focus Area 1)

While there was high satisfaction with the effectiveness and efficiency of the COH as a whole among those who are most regularly involved, the next level of assessment that would contribute to a complete picture would be a survey of the entire membership. In addition to the Key Informant Interviews (of those most involved in service procurement processes) **it is recommended that there be a survey tool to assess the perceptions of efficiency that are held by the entire body.**

A second recommendation is that **future AAM processes should include tools to elicit perceptions of other components of the "administrative mechanism" as to the efficiency of the COH.** While it is helpful to compile the collective perception of some of the most involved members of the COH regarding the body's efficiency, it would be a more robust assessment to include the perceptions of other partners in the administrative mechanism, such as DPH/DHSP staff and Providers.

Regarding DHSP and DPH (Focus Area 2)

The next assessment of the administrative mechanism (or some other interim administrative review) should include an assessment of the HR and Finance systems of the County and how they are impacting the ability of DHSP and DPH to efficiently employ appropriate processes to support HIV service delivery. It was not within the scope of the current AAM to look into these systems, but they emerged often as impediments to efficiency. Of course, any time there is a changeover in staffing it impacts operations, but a lengthy process for filling vacancies can unduly exacerbate the efficiency of processes in a tightly interdependent system. The salary levels and "items" in the Department and Division should also be assessed so that salaries are competitive and consistent, and variances do not encourage movement between staffs that might lead to critical vacancies. The lack of adequate numbers of items in both the EOB and the DHSP were noted by informants, so staffing levels should also be explored.

Several interviewees noted the difficulty of finding unaligned, impartial, competent reviewers for the RFP process. **It is recommended that the COH encourage the relevant components of the County to explore compensation for reviewers as many other governmental levels offer**. **A companion suggestion was made to assemble a "pool" of qualified reviewers (as HRSA does), and this suggestion should be revisited.**

Another recommendation was carried over from previous AAM processes, and was reiterated by sufficient numbers of KII subjects in the current study to reinforce its continuing relevance. **The DHP/DHSP should collaborate with ISD or undertake its own well-promoted community education sessions to educate providers who are not current county contractors about the steps, requirements and competencies necessary to do business with the County so as to**

potentially become HIV service delivery providers. Special outreach should be made to providers with competency in minority communities and in the HIV "hot spots" identified in the county's HIV epidemiology reports.

Given the reported variability among individual fiscal and programmatic monitors, DHSP should be encouraged to **improve the quantity and frequency of its internal training of its contract monitoring staffs.** While most staff members received high marks for their competency, there was sufficient commentary about variability among staff in their interactions with providers to warrant a review by DHSP senior staff.

Regarding Providers (Focus Area 3)

There is clearly a great deal of variability among providers in terms of their own internal processes that ensure efficient delivery of funded services. A recommendation for COH to consider would be to **participate with DHSP to convene a "best practice summit" where more experienced provider agencies could share information on their systems and processes with less experienced providers**. Various incentives could be explored such as compensation for staff time, or prizes for "best new practice," or other incentives that might be funded by COH or private funders.

Casewatch is used to track and report on various aspects of HIV care and treatment service delivery and is also used to generate invoices for various programs and services (DHSP Program Guidance 2015.02: Use and Access to Casewatch). Contracted agencies must use Casewatch according to the guidelines specified by DHSP. Since Casewatch is used to generate invoices, some contracted agencies expressed opinions regarding how the data management system affects operational efficiency at their agencies.

It is clear that there were many critical opinions about the "Casewatch" data system regarding its efficacy and interoperability with other agency administrative and data systems. It was noted by more than one provider that they have staff who enter the same data in two systems that don't or can't talk to each other. It was described as "DOS-based" and a "dinosaur" system. Clearly, there could be improvements to provider efficiency if the current mandated data system were improved or another system implemented. If sufficient IT expertise were available or could be secured, **a review of the collective data management system used by DHSP would be useful**. Particular dimensions of the functionality of such a system that should be explored would be its use to avoid multiple eligibility processes across providers, and its ability to generate data so that monitoring of contract performance by providers could be partially automated and thereby both agency and DHSP staff would need less time on site.

General Recommendations

It is recommended that a task force be convened (by the Executive Office or whatever level deemed appropriate) to do a **comprehensive review of all the steps involved in procuring HIV related services**. Given that it is reported by multiple sources that the overall timeline from

identifying a need to getting reimbursable services on the street is around 24 months, and that timeline has not changed for over a decade, it is clear that this complicated and sometimes redundant system could be "tested" for efficiencies.

It was noted by various informants that ISD is exploring its procurement processes and looking for improved efficiencies. During the course of undertaking the current AAM (March of 2018), Dr. Jeffrey Gunzenhauser, Interim Health Officer at Los Angeles County Department of Public Health, made a presentation to COH members and noted that the department is moving on a fiscal and administrative function reorganization that could have an impact on HIV related service contracting. **It appears timely to intensively study the procurement process for RWCA funded services as a part of the preparation for this reorganization**. Presumably future AAM processes could contribute to this effort and/or provide additional contextual information during its implementation.

Procedural Recommendations Regarding Future AAMs

A procedural recommendation (that had been made in previous AAMs) reemerged in the process of conducting the current AAM. There seems to be no readily available database or information on the specific dates of each of the steps in the contracting process for each provider. In three previous AAMs, the administrative agency provided a spreadsheet indicating the timeline of each step in each provider's contracting process, and so an assessment of the range and variety of timelines across providers could be done. However, this information was not made available for this current assessment. **It is recommended that the COH encourage the DHSP to track this information and to make it available for assessments in the future.** This is one of HRSA's recommended practices, and it would augment future AAMs.

Another procedural component that is very useful to quantitative analysis (and has been done in prior AAMs) is to conduct a survey of providers regarding their assessment of the efficiency of the overall administrative mechanism and in particular the procurement and fiscal/program monitoring procedures. **COH should include a survey of all providers as component in the design of future AAM exercises**. Incentives could be used to ensure high response rates, and the representativeness of the body of respondents could be analyzed as part of the process, and adjusted if needed.

Next Steps

Once the AAM report is adopted by the full COH body, the Operations Committee will prioritize the recommendations and develop an action plan for implementation in the next three years. During 2019-2022, the COH and DHSP will focus on implementing recommendations from this AAM that will yield the greatest impact while also considering feasibility and overall administrative capacity. Under the leadership of the Operations Committee, the COH will review the scope and progress of the comprehensive AAM in 2022.

Appendices

1. List of Abbreviations
2. Copy of Final AAM Scope of Work
3. List of Participants
4. Background on the EMA Requirements in the context of the federal Ryan White CARE Act

Appendix 1: List of Abbreviations

The following abbreviations and acronyms are used in this report.

AAM	Assessment of the Administrative Mechanism
AOM	Ambulatory and Outpatient Medical (type of funded service)
CBO	Community-Based Organizations
CEO	Chief Elected Official (related to this study, the LA County Board of Supervisors)
COH	Commission on HIV
CQM	Clinical Quality Management
DHSP	Division of HIV and STD Programs
DPH	Department of Public Health
eCAPS	electronic Countywide Accounting and Purchasing System
EFA	Emergency Financial Assistance
EFT	Electronic Funds Transfer
EMA	Eligible Metropolitan Area
FFS	Fee-for-service (type of contract)
FTE	Full-time equivalent (refers to staff positions)
HRSA	Health Resources and Services Administration
IFB	Invitation for Bid
ISD	Internal Services Department of Los Angeles County
KII	Key Informant Interview
LAC	Los Angeles County
LACHNA	Los Angeles Coordinated HIV Needs Assessment, 2016
MCC	Medical Care Coordination (a funded service)
NOA	Notice of Award
OAPP	Office of AIDS Programs and Policies, former name of DHSP
PC	Planning Council
PLWH/A	People Living With HIV/AIDS
PP&A	Planning, Priorities and Allocations Committee of COH
PO	Purchase Order
POCA	Plan of Corrective Action
PSRA	Priority Setting and Resource Allocation
RFP	Request for Proposals
RSR	Ryan White HIV/AIDS Program Services Report
RWCA	Ryan White CARE Act
RWPC	Ryan White Planning Council
SAPC	Substance Abuse Prevention and Control Division of DPH
SPA	Service Planning Area - (eight in LAC, originally defined by the Children's Planning Council) used by a number of County departments [Public Health, Health Services and Mental Health] to plan and manage service delivery across the County)
TA	Technical Assistance

Appendix 2: Copy of Final Scope of Work for Assessment of Administrative Mechanism (AAM)

Scope of Work for SST Nonprofit Services (Updated 11.6.17/FINAL)

Purpose of AAM:

The core tenet of the Ryan White legislation with regard to the AAM is: *The Ryan White HIV/AIDS Program mandates that the EMA/TGA Planning Council must assess the efficiency of the administrative mechanism to* ***rapidly allocate funds*** *to the areas of greatest need within the EMA/TGA*. The end goal is to ensure the EMA's Ryan White funds are being spent efficiently.

The planning council is responsible for evaluating how well the grantee gets funds to providers. This means reviewing how quickly contracts with service providers are executed and how long The grantee takes to pay these providers. It also means reviewing whether the funds are used
to support services that align with the planning council's priorities.

The review period for this AAM: FY 2014, 2015 and 2016 (Fiscal Years 24, 25, 26)

Focus Area 1: Commission on HIV (COH) Perspectives
Method: Key Informant Interviews
Suggested Key Informants: Planning, Priorities and Allocations (See Attachment A)
Timeframe: Conduct interviews November-December 2017

Regarding Planning:

1. Did the Commission assess data or other information assessed on an ongoing basis in order to determine community needs? (Yes, No, I don't know)
2. Was there adequate consumer input in the planning process? (Yes, No, I don't know)
3. Were you adequately notified of planning activities and meetings? (Yes, No, I don't know)
4. In terms of structure and process, was the Los Angeles County Commission on HIV effective as a planning body? (Yes, No, I don't know)

3a. If not, in what areas can it be improved?

4. I feel I was adequately trained in the following:
    a. The structure and process of the Ryan White Planning Council (Yes, No, I don't know)
    b. Standards of Care/Continuum of Care (Yes, No, I don't know)
    c. Allocation/Reallocation Process (Yes, No, I don't know)
    d. Service Category Prioritization (Yes, No, I don't know)

5. Do you believe that the priorities and allocations established by the COH in 2016 were followed by DHSP? (Yes, No, I don't know)

6. In the 2016 planning cycle, what specific DHSP reports do you recall being provided to PP&A Committee to help inform the priority setting and allocation process? Probe for:

a. Fiscal reports

b. Annual reports to HRSA

c. Service utilization data

d. Needs assessment (LACHNA)

e. Program updates (such as Linkage and Re-engagement Program update)

Focus Area 2: Key DHSP/DPH Stakeholder Perspectives

Method: Key Informant Interviews

Suggested Key Informants: Michael Green, Ph.D., Pamela Ogata, Paulina Zamudio, Terina Keresoma, and David Young (to be confirmed by DHSP)

Timeframe: Conduct interviews January-February 2018 (to be confirmed by DHSP)

Staff Demographics

1a. During 2014, what was your position and role in the DHSP?

1b. Did your position or role at DHSP change anytime between 2014 and 2016? If yes, please explain.

2. How long have you worked on HRSA Ryan White-funded services/projects?

Regarding the Request for Proposal (RFP) Process

3. Were the applications received from applicants responsive to the RFP? If not, how were they non-responsive?

4. Were there any service gaps because fundable proposals were not received? If so, how were proposals determined to be not fundable? How did DHSP fill the service need?

Contract & Monitoring Process (skip questions not relevant to staff)

5. Describe your involvement in the contracting process for 2014, 2015, and 2016?

a. Briefly describe your role in DHSP's contracts and monitoring process beginning with notification to providers of funding awards through the execution of final contracts.

b. How much time does DHSP allow providers to submit grant budgets following their notice of funding award?

c. Upon receipt of the providers' budgets how much time does it take for the DHSP to draft a contract?

d. On average, how long does it take to finalize contracts with providers from the drafting of the contract to approval by Board of Supervisors?

e. Does DHSP have internal review and approval processes that impact the time needed to finalize contracts?

6. Describe the overall process for monitoring contracts.

Provider Reimbursement Process (Skip if key informant is not involved in reimbursement process)

7. Describe your involvement in the provider reimbursement (billing) process in 2014, 2015,

2016?
8. Describe the reimbursement process from the submission of billing requests to payment disbursement.
9. What is the average time it takes for DHSP staff to process and pay invoices?
10. Please describe any technical assistance you are aware of that is provided to service providers that focused budget or invoicing during the program year 2016.

Specific Questions to Patty Gibson (Department of Public Health, Chief, Contracts and Grants Division):

Staff Demographics

1a. During Fiscal Year 24, what was your position and role in the DHSP contracts/procurement process?
1b. During Fiscal Year 25, what was your position and role in the DHSP contracts/procurement process?
1c. During Fiscal Year 26, what was your position and role in the DHSP contracts/procurement process?

Regarding the Request for Proposal (RFP) Process

5. Describe the DPH RFP process? Is it the same process for all DPH Divisions? Are there additional requirements or unique processes for DHSP RFPs? If so, please describe and why are these additional requirements or unique processes applied to DHSP RFPs?
6. Do you think the DPH RFP process effectively and efficiently disperses grant funding into the community? If yes, please provide examples of what works well. If no, please provide examples of improvements needed.
7. How does DPH select members of the RFP Evaluation Committee?
8. Were the applications received responsive to the RFP? If not, how were they non-responsive?
9. Were there any service gaps because fundable proposals were not received? If so, how were proposals determined to be not fundable? How did DHSP fill the service need?
10. To your knowledge, are there national benchmarks related to contracting and procurement best practices?
11. What recommendations do you have for improving the County contracting and procurement process? What recommendations do you have for expediting the County contracting and procurement process?

Focus Area 3: Contracted Agency Perspectives

Method: Key Informant Interviews
Suggested Key Informants: TBD after contractor information is received from DHSP
Timeframe: Conduct interviews February-March 2018 (could be moved earlier, once information about contractors is received from DHSP)

1. Describe the level of guidance you get from DHSP in regard to invoicing, budget development, and budget modifications? Probe for responsiveness to questions, clarity of responses, and ease of access to DHSP staff.
2. In terms of the process of program monitoring, how clear are you on the expectations prior

to the site visit and monitoring? (Very clear, adequately clear, not clear, don't know). Does DHSP regularly provide feedback on your performance? Do you get feedback or technical assistance from DHSP on barriers and challenges reported on progress reports?

3. With regards to the development of your DHSP contract, how would you describe the level of technical assistance and support provided by your assigned Program Manager and Fiscal Representative?
4. How well written are the RFPs, and do you feel they provide clear direction? Please reference which RFP or service category you are referring to. What was your role in developing the application for the specific RFP? In what ways was DHSP unclear? What recommendations do you have that could improve that specific RFP?
5. Do you feel the County's process of awarding contracts for services is fair? If not, in what ways do you feel they are not fair?
6. What are the most effective practices employed by your agency to ensure that Ryan White funds are spent efficiently?

Project Milestones	**Milestone Target Date**
Secure DHSP agreement on SOW. Prioritize agreement on Focus Area 1 (COH Perspectives)	November 13 for Focus Area 1 November 24 for Areas 2 and 3
Secure from DHSP a list of funded (use unique ID number instead of agency name) agencies for all Ryan White service categories for PY 24, 25, 26 (information will be used for anonymized extraction).	January 20, 2018
Conduct key informant interviews for focus area 1 (COH PP&A Members)	November 24-December 31, 2018
Conduct key informant interviews for focus area 2 (Key DHSP/DPH stakeholders)	January-February 2018
Conduct key informant interviews for focus area 3 (Contracted agency perspectives)	February-March 2018
Secure from DHSP random sampling of at least 20 agencies from PY 24, 25, 26 of invoices	February 9, 2018
Conduct analysis of key informant interviews and processed invoices.	April 2018
Present draft report with recommendations to Operations and Executive Committees, DHSP	April 26, 2018
Revise and finalize AAM report and recommendations	May 2018
Present final AAM report and recommendations to Operations	May 24, 2018
Present final AAM report with recommendations to full COH	June 14, 2018
COH Co-Chairs present findings to Health Deputies, BOS, DPH	June 25-July 31, 2018
Operations Committee and COH staff track implementation of	August, ongoing

Appendix 3: List of Participants

The consultant wishes to thank the following for their time, candor and cooperation in the development of this report.

Commission Members

Al Ballesteros	Aaron Fox	Derek Murray
Traci Bivens-Davis	Grissel Granados	Frankie Palacios
Jason Brown*	Joseph Green*	Raphael Pena*
Joseph Cadden	Bradley Land*	Ricky Rosales
Raquel Cataldo	Eric Paul Leue	LaShonda Spencer
Deborah Owens Collins	Abad Lopez*	Kevin Stalter*
Kevin Donnelly*	Miguel Martinez	Yolanda Sumpter*
Susan Forrest	Anthony Mills	Russell Ybarra*

*Indicates unaffiliated consumer members of Commission

County Staff

Karen Buehler	DPH C&G	Dawn McClendon	COH
Monique Collins	DHSP	Pamela Ogata	DHSP
Carolyn Echols-Watson	COH	Angel Ortega	EOB
Patricia Gibson	DPH C&G	Mario Perez	DHSP
Michael Green	DHSP	Sarine Sarkssian	EOB
Nanette Herrera	EOB	Dave Young	DHSP
Terina Keresoma	DHSP	Paulina Zamudio	DHSP
Ric Macaisa	EOB		

Providers

- Jack Bernstein, Cri-Help,Inc.
- Silvia Cadena, Tarzana Treatment Center
- Jury Candelario, Special Services for Groups
- Charity Chandler, AIDS Healthcare Foundation
- Lee Huey, Valley Community Healthcare
- Sharon McNealy, St. Mary Medical Center
- Carroll McNeely, Watts Healthcare Corporation
- Matthew McPeck, Children's Hospital Los Angeles
- Non Nguyen, Ira Grant, Annie Santos, Yair Katz, Miller Children's Hospital Long Beach
- Brendan O'Connell, Bienestar Human Services, Inc.
- Melissa Nuestro, USC Ostrow School of Dentistry
- Kathy Paik, Project New Hope
- Cheryl Peterson, Natalie Sanchez, AltaMed Health Services Corporation
- Tim Pusateri, Kari Pacheco, Los Angeles LGBT Center
- Nick Rocca, Van Nuys Adult Health Center
- Maritza Toma, Foothill AIDS Project

Appendix 4: Background on the EMA Requirements in the context of the federal Ryan White CARE Act

The mandate for an Assessment of the Part A Administrative Mechanism was initially set forth in the Ryan White CARE Act, as amended, and has been incorporated into the Ryan White HIV/AIDS Treatment Modernization Act (RWTMA) of 2006 and the Ryan White HIV/AIDS Treatment Extension Act (RWTEA) of 2009. This requirement was summarized in the HRSA Ryan White HIV/AIDS Program Part A Manual:

> "Assessment of the Administrative Mechanism and Effectiveness of Services Section 2602(b)(4)(E) of the PHS Act requires planning councils to 'assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area, and at the discretion of the planning council, assess the effectiveness, either directly or through contractual arrangements, of the services offered in meeting the identified needs.' Planning councils are required to complete the assessment annually."

HRSA Guidance Regarding Respective the Grantee and Planning Council

The HRSA manual for RWCA Part A areas includes specific references to responsibilities of the respective partners in the AAM process:

> *"Planning Council Expectations of the CEO or Grantee*
> Support of the evaluation of the EMA/TGA's administrative mechanism to ensure that funds are allocated in a timely manner, providers are reimbursed efficiently, and contracts are monitored properly."[2]
>
> "The planning council also evaluates how efficiently providers are selected and paid and how well their contracts are monitored (assessment of the efficiency of the administrative mechanism)."[3]
>
> "Assessment of the Administrative Mechanism
> The planning council assesses the efficiency of the administrative mechanism, which involves how rapidly funds are allocated. This is the only situation in which the planning council considers issues related to procurement and contract management, which are the grantee's sole responsibility. The purpose is to assure that funds are being contracted for quickly and through an open process, and that providers are being paid in a timely manner. The planning council should not be involved in how the administrative agency monitors providers, nor should the names or situations of individual providers be included in the assessment.
>
> "Generally, assessments are based on time-framed observations of procurement, expenditure, and reimbursement processes. For example, the assessment could identify the percent of funds obligated within a certain time period (e.g., 90 days) from the date of grant award and the percent of providers that are reimbursed within a specified number of days following submission of a monthly invoice. Reimbursement processes

can be tracked from date of service delivery through invoicing to payment, with documentation [on] delayed payments and, where feasible, any adverse impact on clients or providers. This information is usually obtained from the grantee in aggregate form. Sometimes the planning council will arrange to obtain information directly from providers. In such situations, it is important that someone other than a planning council member receives and aggregates the information so the planning council receives only the combined data.

"In assessing the administrative mechanism, communication between the grantee and planning council is essential so that information sharing is timely and efficient. The assessment is conducted annually. Prior to the beginning of the procurement process, the planning council and grantee should agree on the process, documentation, responsibilities for data gathering and data sharing, deliverables, review and response process, and timeline. This information should be written in a memorandum of understanding which is then approved by both parties.

"The grantee must communicate back to the planning council the results of its procurement process. The planning council may then assess the consistency of the contracted service dollars with its stated service priorities and allocations. If the council finds that the existing mechanism is not working effectively, it is responsible for making formal recommendations for improvement and change, and the grantee is responsible for responding in writing, indicating how it will address these recommendations."[4]

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[2] From HRSA Manual, Pg. 89
[3] From HRSA Manual, Pg. 94

Obligations per the executed MOU in Los Angeles County

An MOU was executed by DHSP and the COH in 2017 that makes reference to the AAM.

An excerpt appears below:

> "2. Assessment of the Administrative Mechanism (AAM)[5]: Assess the efficiency of the administrative mechanism, of service effectiveness, outcome evaluation, cost effectiveness, rapid disbursement of funds, compliance with Commission priorities and allocations, and other factors to ensure the effective and efficient operation of the local EMA. The AAM includes the evaluation of how rapidly funds are allocated. The purpose is to ensure that funds are being contracted appropriately and timely in an open process, and that the contracted providers are being paid in a timely manner. The assessment is required to be done every 3 to 5 years[6], or as needed. The Commission and DHSP may establish a written memorandum of understanding outlining a process and timeline for sharing data necessary to evaluate the administrative mechanism. If the Commission finds that the existing mechanism is not working effectively, it is responsible for making formal recommendations for improvement and change. The assessment of the administrative mechanism is not an evaluation of DHSP or individual service providers. Monitoring and evaluation of individual service providers is a DHSP responsibility. The Commission should not be involved in how DHSP monitors providers."
>
> "C. Information to be provided by DHSP to the Commission[7]
> Information requested as needed by the Commission to meet its responsibility for assessing the efficiency of the Administrative Mechanism. The content and format for this information will be mutually agreed upon each year, but will typically include information from DHSP on the procurement and grants award process; statistics (such as number of applications received, number of awards made, and number of new providers funded), and reimbursement procedures and timelines."[8]

[4] From HRSA Manual, Pg. 102-3

[5] Pages 2-3 of the MOU

[6] Note, while the MOU references 3-5 years, HRSA guidance requires annual AAMs

[7] Pages 6-7 of the MOU

[8] Source: Memorandum of Understanding (MOU) Between the Los Angeles County Division of HIV and STD Programs (DHSP; Ryan White Part A Recipient) and the Commission on HIV (COH) - Final Draft V4 4/7/17 Reviewed By A. Ross and Executive Office

The table below summarizes the roles and duties of the Ryan White HIV/AIDS Program grantee (DHSP in Los Angeles County) and the Planning Council (Commission on HIV).

ROLE/DUTY	**RESPONSIBILITY**		
	CEO (Board of Supervisors in LAC)	**RECIPIENT (DHSP in LAC)**	**PLANNING COUNCIL (Commission on HIV in LAC)**
Establishment of Planning Council/Planning Body	✓		
Appointment of Planning Council/Planning Body Members	✓		
Needs Assessment		✓	✓
Integrated Comprehensive Planning		✓	✓
Priority Setting			✓
Resource Allocations			✓
Directives			✓
Procurement of Services		✓	
Contract Monitoring		✓	
Coordination of Services		✓	✓
Evaluation of Services: Performance, Outcomes and Cost Effectiveness		✓	Optional
Development of Service Standards		✓	✓
Clinical Quality Management		✓	Contributes but not responsible
Assessment of the Efficiency of the Administrative Mechanism			✓
Planning Council Operations and Support		✓	✓