

**LOS ANGELES
ELIGIBLE METROPOLITAN AREA
RYAN WHITE CARE ACT
MANDATED ANNUAL ASSESSMENT
OF THE TITLE I
ADMINISTRATIVE MECHANISM**

**FY 2002 ADMINISTRATIVE
ASSESSMENT FINAL REPORT**

Preface

I. BACKGROUND

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990, along with the CARE Act amendments of 1996 and 2000, are the primary pieces of legislation enacted by the U.S. Congress to meet the emergency health and ancillary needs of those directly affected by HIV disease and AIDS throughout the U.S.

The Federal Department of Health and Human Services, Health Resources and Services Administration (HRSA) is the federal agency responsible for administering the provisions of the CARE Act in states and regions throughout the nation.

Across the country, 51 Eligible Metropolitan Areas (EMAs) with a high incidence of AIDS have been identified by HRSA. Title I of the CARE Act provides funding to these EMAs to implement health planning, contracting, service delivery, monitoring, and evaluation systems for medical health, supportive, and ancillary services.

Each EMA has unique needs and gaps in the services and resources available to those living with HIV and AIDS. In order to plan the local emergency response to the

particular characteristics of the HIV/AIDS epidemic they face, and monitor and evaluate the effects of the distribution of Federal funds and benefits, Congress and HRSA require each funded locality to appoint a board or council representative of affected communities, health service providers, and recipients of HIV/AIDS services.

In the Los Angeles County EMA, covering the geographical area of Los Angeles County, and including some 80-plus municipalities, the planning council is called the Commission on HIV Health Services (CHHS). This body is currently composed of 49 members plus alternates. By the terms of legislation, at least 33% of planning council members must be individuals who are consumers of HIV services who are unaffiliated with Title I-funded or eligible agencies.

In each EMA it is the responsibility of the planning council to plan a comprehensive community-wide service response to HIV and AIDS. These services must take into account particular client characteristics and needs, community characteristics and resources, and sources of information and funding at national, state, and local levels. Planning councils are not advisory, but are authorized to make binding decisions regarding service priorities, budgets, and policies to

implement their local response to the HIV epidemic.

In addition to setting out the responsibilities of HIV/AIDS planning bodies, legislation also provides for each EMA to have in place an administrative mechanism to turn comprehensive care plans into programs, services, and resources that help individuals live with HIV and AIDS.

Heading up this administrative mechanism, and known as the CEO, is the highest elected official of the governmental entity providing the majority of medical services to HIV/AIDS service consumers within the EMA. It is this individual or entity, who is ultimately legally responsible for the implementation, monitoring, evaluation, accounting, and reporting of services for individuals and families living with HIV and AIDS. This position is known as the Chief Elected Official (CEO) and in Los Angeles County the incumbent is the County Board of Supervisors.

In practice, the CEO normally delegates authority for the operation of the administrative mechanism to an organization that can serve as a fiscal and administrative agent. Although from HRSA's perspective the CEO can choose to delegate authority to any organization under its jurisdiction, typically administrative and fiscal duties are delegated to

the public agency providing health services to the greatest number of consumers of HIV services in the EMA. In many EMAs, including Los Angeles, this administrative agency is the department of public health, known in Los Angeles as Department of Health Services (DHS). Within DHS, the actual administering agency, also often referred to as the Grantee, is the Office of AIDS Programs and Policy (OAPP). In day-to-day operations, it is this governmental unit that receives, distributes, and accounts for the EMA's formula and supplemental funds received from HRSA. In turn, the Grantee contracts with health and other service provider agencies (primarily community-based nonprofits and other county government organizations) to provide services consistent with the countywide comprehensive health care plan, on behalf of the planning council.

Somewhat ambiguously, legislation makes the CEO responsible for appointing and training the Planning Council, but also makes the CEO and administering Grantee responsible to the Planning Council to implement its plans and administer service delivery funds. This must be done according to Planning Council service priorities, funding allocation decisions, and other measurable factors, which influence how services are to be delivered to eligible consumers. The Grantee is

also subject to the Planning Council's assessment of its administrative mechanism to rapidly distribute funding to individuals and areas of greatest need, and is subject as well to the Planning Council's evaluation of overall service delivery outcomes.

Further complicating relationships and duties, the Los Angeles EMA Grantee also uses sources of funding for HIV/AIDS services and administrative costs other than Title I funds provided through HRSA. In the case of these other funds, the Commission may often have no legal jurisdiction, even though the expenditure of these other funds affects the use of funds for which the Planning Council remains responsible. Common examples are Federal Department of Housing and Urban Development (HUD) funding for HOPWA (Housing Opportunities for Persons With AIDS) at the federal level, and various Los Angeles County Department of Health Services funds, at the county level.

THE 'ADMINISTRATIVE MECHANISM'

Among many and varied mandates, CARE Act legislation requires the planning council within each EMA to annually assess and report to HRSA on the "...efficiency of the administering agency in rapidly allocating funds to areas of greatest need. The planning council may also, at their

discretion, assess how well services that are funded by the grantee address the planning council's priorities, allocations, and instructions for addressing these priorities" (Ryan White CARE Act Title I Manual, 2002).

In practice, this means that the Commission is required to monitor, evaluate, and report to HRSA regarding 'administrative mechanisms'--policies, procedures, processes, relationships, methods, techniques, tools, and funding types and amounts--designed to rapidly distribute funding to eligible individuals and areas of greatest need. It also needs to be kept in mind that not only must the distribution of funding be rapid and efficient, but that Congress and HRSA also have provided prescriptions regarding *how* funding is to be distributed and what particular outcomes are to be sought.

Examples of primary considerations in the planning and administration of services include, for example, legislative stipulations and ethical themes related to:

- full accessibility to a continuum of care for each eligible individual;
- no disparities in availability or quality of services between eligible individuals or communities of differing demographic groups, characteristics, or situations;

- the manner in which services are provided must take into account their appropriateness and sensitivity to cultural differences;
- the flexibility, speed and responsiveness of services are key to meeting the urgent and emergency nature of the needs of each individual consumer diagnosed and each community approached;
- that services be coordinated with state and regional plans and other providers; and
- that Title I funding be applied only as funding of 'last resort', when other community care options and resources have been exhausted.

Historically, for most EMAs, the 'administrative mechanism' has referred primarily to the administrative duties that have been central to the Grantee service procurement and fiscal agent roles. However, from another perspective, the Title I administrative mechanism is actually a composite of roles and responsibilities shared by several agencies and bodies. In the Los Angeles County EMA those seen as formal "partners" in the execution of the Title I administrative mechanism in this larger sense include the Los Angeles County Board of Supervisors, the Department of Health Services,

and its Office of AIDS Programs and Policy, all of which represent the 'Grantee' administrative function. The community-interest planning function, designed to maintain a balance between HIV/AIDS community needs and administrative mechanism expediency, is served by the County Commission on HIV Health Services. This entity is designed to represent the interests of HIV service consumers, the communities in which they live, and providers of health and other resources available or potentially available in those communities.

It may be noteworthy that the majority of providers of health and support services who actually provide most of the programs and services definitive of the Comprehensive Plan and Continuum of Care are not as a body represented or referred to as formal member of this partnership. Rather, they have a formal and direct influence on the Partnership only to the degree that some individual service provider organization representatives are also members of the HIV Commission.

In any case, it is important to clarify at the outset that the Title I 'administrative mechanism' is a complex system beyond the scope of OAPP alone. By inclusion of some references to and assessment of working relationships between partnering

organizations which share responsibility for meeting the needs of HIV and AIDS service consumers, we hope to identify real opportunities for improvement and make recommendations that in the long term will result in a more appropriate, efficient, timely, and accessible distribution of coordinated HIV/AIDS-related programs and services for Los Angeles County EMA consumers. In effect, we hope that this report and the ones that follow it in years to come will be seen as an integral part of the larger Continuous Quality Improvement system, to which the CEO, Grantee and Planning Council are already firmly committed.

II. CEO AND GRANTEE ADMINISTRATIVE ROLES AND RESPONSIBILITIES

To oversimplify, and yet to set the stage regarding selection of the most appropriate and germane administrative mechanism responsibilities and tasks to assess, it is clear that HRSA believes that CEO and grantee administrative agencies have two quite different yet overlapping primary categories of duties: those related to *program and service administration*, and those related to *service system administration*.

Each one of the major functions or specific duties summarized here is a legitimate candidate for performance assessment, as a key component of a comprehensive, effective, efficient, and appropriate Title I administrative mechanism.

PRIMARY PROGRAM AND SERVICE ADMINISTRATION DUTIES OF THE GRANTEE INCLUDE

- working with the Planning Council to assess consumer and community needs
- working with the Planning Council to assess consumer and community resources
- working with the Planning Council to develop the Comprehensive Plan and Continuum of Care plans
- selecting providers and

contracting for services according to planning council service priorities, funding allocations, and particular factors of service provision specifically aligned with different consumer and community needs

- monitoring contracts and financial expenditures
- reporting service outputs, costs, and consumer health outcomes to the planning council
- processing reimbursements for services
- evaluating services and providers
- working with the planning council to reallocate funding during the contract year
- providing service providers with training and technical assistance
- coordinating with other CARE Act and non-CARE Act programs and services

PRIMARY SYSTEM ADMINISTRATION DUTIES OF THE CEO AND GRANTEE INCLUDE

- establishing the Planning Council
- appointing Planning Council members
- supporting the work of Planning Council members
- establishing, monitoring, and managing intergovernmental agreements (IGAs)

- ensuring services to women, infants, children, and youth (WICY) with HIV disease
- ensuring that CARE Act funds are used to fill gaps and are used only as funding of last resort
- ensuring complete access to care and no disparities in care for all eligible consumers
- ensuring the delivery of quality services and the maintenance of a quality management program
- maintaining outreach and a continuum of care
- implementing grievance procedures
- preparing and submitting Title I applications
- limiting Grantee administrative costs
- limiting contractor administrative costs
- accurately reporting Title I activities, costs, outcomes, and cost/outcome effectiveness to HRSA and others

administrative mechanism.

As it is, however, annual assessments such as this one must be satisfied with a somewhat more limited and less comprehensive scope. While there is currently neither the established standards nor the time and budget for a very far-reaching and very detailed assessment of the type imagined, this report will focus on a few of the most essential roles and responsibilities where recommendations can prove appropriate, constructive, and productive.

Over time, the benchmarks for efficient and effective operations that meet all these legislated responsibilities characteristic of the Title I administrative mechanism will have been established. At that point, it will become possible, at least in theory, to conduct a truly comprehensive assessment of the

**III. ADMINISTRATIVE
MECHANISM
ASSESSMENT ELEMENTS**

Although there are many aspects and components of the overall Title I 'administrative mechanism', all of them support the general goals of appropriate, rapid, and efficient distribution of funding to service providers, consistent with the service priorities and funding allocations annually determined by the Commission.

In practice, this means that the administrative agency (OAPP) must track: dollars available for each category of service; target audiences to whom services are to be provided; factors to be considered in the delivery of services; quantity of units of service to be delivered; and quality standards of service delivery. Then it must screen and select service providers; contract for services; monitor services, contracts, and finances; reimburse providers for the cost of services provided; evaluate services and providers; provide support and technical assistance when needed; and report to the CEO and the sources of funding, among other responsibilities.

Within this rather complex process of contract management, it is fair to say that optimization of effectiveness, efficiency, and cost/benefit ratios is derived primarily from the skill exercised

by the administering agency. Specifically, efficiency and effectiveness comes from the skills and methods used to determine the number, nature, range, distribution, scope, focus, and targets of various service contracts that need to be executed in order to achieve comprehensive community HIV health service planning goals, objectives, and outcomes. These service contracts are the causes that produce health outcome effects.

To put it bluntly, administering Title I funding is nearly all about contracting for HIV/AIDS services. It is clear that the process of contracting with providers for HIV services is the centerpiece and focus of the administrative mechanism: it is at once the most critical element in the success or failure of Title I the CARE Act; the activity by which the Grantee's performance is most appropriately judged; and an extremely difficult thing to consistently do well.

This latter fact is true both in a technical sense related to chains of cause and effect that ultimately lead to consumer health outcomes, and also in terms of the political implications of attempting to simultaneously satisfy the needs and wants of multiple stakeholders in multiple communities with finite funding.

Just staying with the technical difficulties for a moment, some of

the variables that have to be continuously identified, tracked, compiled, measured, analyzed, monitored, adjusted, evaluated and reported for the service contracting administrative mechanism to operate as effectively and efficiently as possible include the following:

- numbers and demographic characteristics of eligible HIV service consumers;
- the types, extent, and urgency of their different needs;
- the distribution of services and gaps in services for consumers living in different geographical and political jurisdictions within Los Angeles County;
- the availability of other HIV health resources for each of the health planning regions in which Title I-eligible individuals live;
- the relationships that already exist with and among other Title I and non-Title I community providers;
- the accessibility or inaccessibility of existing services for consumers;
- the appropriateness and levels of cultural competency maintained between service providers, consumers, and potential consumers; and
- coordination with other Title I and non-Title I HIV/AIDS needs and services provided regionally and statewide.

In addition to the *functional* requirements of the administering agency's task, which we have been concentrating on, where effectiveness (measured in terms of consumer outcomes) and efficiency in service procurement are the arbiters of decision making, there are also a variety of *legal* requirements to be complied with. These requirements also create performance expectations and can serve as administrative mechanism assessment criteria. These legal requirements can be at federal, state, county and municipal levels.

For example, while federal regulations allow local government grantees to use their own procurement procedures for issuing contracts, there are still certain federal legislative requirements that govern procurement procedures for administration agencies, including:

- a written code of standards of conduct for employees involved in the award and administration of contracts
- procedures to avoid the purchase of unnecessary and duplicative items
- making awards to responsible contractors
- maintaining records to detail the history of a procurement
- settlement of all contractual and

administrative issues at the EMA level

- developing appeal procedures to handle and resolve disputes
- providing for full and open competition, and
- providing written selection procedures for procurement transactions

Among all these preceding aspects of the administrative mechanism that could be assessed and evaluated, it is necessary to focus on a few that seem most important to do during the current assessment period. Selection of these aspects will naturally be based on historical issues regarding the past effectiveness of the administrative mechanism; strategic issues currently facing the EMA; 2001 comprehensive plan goals, quality management objectives, and the expectations of administrative mechanism partners and consumers; and the current Title I work environment.

The first step to identifying the particular issues to be studied in more detail for FY 2001 year is to see what findings and recommendations came out of the assessment of the FY 2000 year.

IV. FY 2000 ASSESSMENT RECOMMENDATIONS

SUMMARY OF RECOMMENDATIONS

At the conclusion of the FY 2000 service year the Los Angeles EMA undertook its first formal assessment of the Administrative Mechanism. In August of 2001 an assessment report, prepared by the San Diego-based nonprofit consulting firm of Nonprofit Management Solutions, was submitted to the Fiscal Committee of CHHS.

Based on findings from provider agency surveys, key informant interviews, and focus groups, several recommendations were made in the report to improve the efficiency and effectiveness of the Administrative Mechanism in order to improve the delivery of HIV/AIDS services to consumers throughout the Los Angeles County EMA.

Accordingly, the current Service Year 2001 Assessment includes a look at progress achieved by the administrative agency (OAPP) and the planning council (Commission) in addressing the recommendations made the previous year.

In the Service Year 2000 report, nine (9) primary recommendations resulting from assessment of the administrative mechanism were

made for OAPP and Commission consideration. They are summarized as follows:

1) *OAPP* should study ways to expedite *service proposal review and decision making* and *service contract execution*. Studying and revising OAPP staffing patterns and job descriptions was cited as a possibly expeditious way to accomplish this.

2) *OAPP* should improve its attitude and approach with provider agencies in order to *facilitate the mutual flow of information and assistance in a timely and constructive manner*. Recommendations to consider included more frequent and positive communication between OAPP and service provider staff, clarifying mutual expectations, and encouraging OAPP staff to develop a facilitative approach to provider agency staff in order to improve the delivery of services to consumers.

3) *OAPP* should improve its assistance to service provider staff to procure the technical assistance and/or training necessary to help service providers in a number of essential areas, but particularly to *develop and implement quality assurance plans* and *develop systems for monitoring outcome objectives*, two newer requirements of continued CARE Act funding.

4) *OAPP* should develop and manage a single source of accurate and accessible (as appropriate) EMA statistical and other information for its own use and for the use of service providers, other contractors, researchers and evaluators. Recommendations focused on developing an EMA-wide management information system managed by OAPP and including a centralized database to provide essential and reliable information to all authorized users.

5) *The Commission* should broaden its representation, improve its objectivity, and expand available resources to meet the needs of HIV/AIDS service consumers by examining and considering revisions in its own structure and functioning, especially with regard to diminishing the role of service provider agencies sitting on the Commission. It was recommended that the Commission appoint a self-assessment task force or committee to evaluate current policies, procedures and processes and ensure that the Commission not only accurately reflects the needs and interests of the majority of the consumers needing assistance, but also provides new opportunities for community involvement and investment.

6) *The Commission* should consider taking a more active role in the management of its legislated responsibilities, rather than serving

in the capacity of an advisory panel to OAPP initiatives.

Recommendations included implementing a Commission-initiated and managed strategic and annual planning processes, developing or revising volunteer leadership and salaried staff positions descriptions, and developing an adequate management system and the capacity to implement it.

7) *The Commission* should consider meeting its own unique responsibilities by developing its own self-sufficient management and staff infrastructure independent from OAPP. A key recommendation was that the Commission avoids overlapping supervision and accountability concerns by developing its own staffing structure and hiring its own staff, rather than continuing to underwrite the cost of OAPP staff positions.

8) *The Commission*, as the entity responsible for conducting the annual *assessment of the administrative mechanism*, should resist the temptation to have its own staff attempt an objective assessment of its own performance and the performance of OAPP staff. Partly because Commission staff is highly likely to share some responsibility and accountability for key functions with OAPP staff, it was recommended that annual administrative mechanism assessments continue to be done

by a more objective third party,
under the supervision of
Commission and its staff.

9) The last recommendation of the
FY 2000 *Assessment* was to
encourage ongoing and systemic
communication and teamwork
between the Grantee and the
Planning Council. It was
recommended that OAPP and
CHHS work together to create a
formal structure, a venue, and a
process by which representatives
of both groups regularly meet and
discuss impediments to the
administrative mechanism and
identify opportunities to facilitate
its workings.

V. FY 2001 ASSESSMENT GOALS

For this FY 2001 Assessment, the Commission, through the oversight of its Finance Committee, decided to conduct a more focused and detailed evaluation of certain aspects of the administrative mechanism and administrative agency, in order to build on the more comprehensive and general FY 2000 Assessment findings and recommendations.

For example, the current FY 2001 Assessment was designed by the Commission's Finance Committee to focus on six separate aspects or functions of the administrative mechanism performed primarily by its Title I partners (Board of Supervisors, Department of Health Services, and Office of AIDS Programs and Policy) which were considered by CHHS to be key to the efficient operation of Title I administrative mechanisms. These included:

- 1) assessment of the effectiveness and efficiency of *funding disbursement* processes;
- 2) assessment of the effectiveness and efficiency of *procurement of services* processes;
- 3) assessment of the effectiveness and efficiency of the administrative *workflow* that allows activities leading to the rapid disbursement of funding to proceed in an

efficient, appropriate, and timely manner;

4) assessment regarding the degree to which all administrative mechanism partners and vendors set, reinforce and enforce realistic *expectations* regarding the mutual fulfillment of Title I responsibilities for a variety of factors, including determination of needs, priority of services, service budgets, standards of care, satisfaction with services, and cost/outcome effectiveness;

5) assessment of the levels of teamwork, cooperation, productivity, and synergy characterizing the *partnerships* exhibited by the administrative mechanism's three primary institutional partners and the Commission; and

6) assessment of the degree to which a *Continuous Quality Improvement* program is functioning, both in terms of structures and processes that have been set up to support it, and also in terms of the outcomes of those supportive systems to date.

VI. ASSESSMENT METHODS

In order to conduct a comprehensive assessment of these six separate variables and arrive at an objective evaluation of the overall efficiency of a broad administrative mechanism administered by several agencies, several different evaluation and assessment methods were employed:

First, assessment consultants requested and reviewed *documentation* available as evidence of the goals, objectives, standards and states-of-the-art of the six functions already mentioned, as well as other aspects of overall system administration;

Second, consultants prepared, distributed, collected, compiled, analyzed, and summarized a *survey of service providers* primarily to test the efficiency and effectiveness of the *a) service procurement, b) funding disbursement, and c) continuous quality improvement* processes. These are the functions about which service providers have the greatest knowledge and the characteristics of which are likely to have the greatest impact on overall vendor performance and ultimate consumer satisfaction. Thirty-two (32) service provider organizations completed surveys (the complete results are included in the *Appendix* section of the

Report, for an approximate 33% return;

Third, *key informant interviews* were conducted with fifteen (15) representatives of all *Partner* agencies, as well as several service vendor agencies, in order to measure and understand in more detail these three administrative functions already mentioned as key to service provider performance. In addition, key informant interviews and additional review of documentation were also designed to better understand the character and dynamics of the *partnerships, expectations, and workflow* processes and relations. The goal was to identify policies, processes, procedures, methods and tools that either facilitate or hinder the efficiency and effectiveness of the administrative systems that have been put in place to get HIV/AIDS funding to the greatest number of eligible consumers with the most serious and most urgent needs as quickly as possible.

The results of these three methods are summarized in the *Findings* section of this Report. Following the summary of preliminary findings is a listing of initial issues and specific priority recommendations. While not expected to be conclusive in and of itself, it is hoped that it will stimulate further investigation and discussion to focus attention on feasible refinements or changes in the way the administrative

mechanism might operate in the future. Finally, a separate section will address general or overall recommendations at the system administration level.

It will still require focus group discussions and problem-solving meetings following the dissemination of this Administrative Mechanism Assessment final report to gain the full value of suggestions made in response to service provider experiences and key informant insights.

NMS consultants are of the opinion that the best final recommendations regarding strengths, weaknesses, opportunities, and challenges of the current Administrative Mechanism will not be ones made solely by consultants and evaluators independent of the administrative mechanism itself. Rather, we believe that the best recommendations and ones most likely to be implemented will be ones that have been conscientiously processed and formulated by those with the power, authority, and responsibility to see that the administrative mechanism operates as effectively, efficiently, punctually, and appropriately as possible.

As a result, the *Findings, Priority Issues/Specific Recommendations, and General Recommendations* which will follow are viewed by

Assessment consultants as but an interim step in a process of continuing positive refinement or eventual evolution of the Los Angeles EMA HIV/AIDS services administrative mechanism.

VII. FY 2001 ASSESSMENT FINDINGS

This section represents a summary of findings from a review of documentation, a survey of service providers, and key informant interviews. More details and statistics regarding the questions asked and responses to those questions can be found in the *Appendix*.

This *Findings* section of the Report summarizes research results and provides some qualitative and quantitative measures of challenges and potential opportunities regarding the sustained achievement of an efficient, effective, timely, and appropriate Title I administrative mechanism.

The reader is reminded that this assessment is primarily a report of written survey and key informant interview opinions gathered from others; similar to most research that gathers opinions and individual perspectives, the veracity or reliability of many of the reports and opinions gathered has neither been independently confirmed nor denied, nor, in many cases, can they be. The primary exception to this rule is that independent verification of the length of time historically used to conduct the procurement process was documented from several written sources internal to OAPP and the Commission, in addition to

surveys and interviews.

As mentioned, the assessment of the FY 2001 administrative mechanism focused on six primary indicators of efficiency identified by the Commission. Research findings, in the form of administrative mechanism issues, are listed below under these six performance indicators.

To be presented as a finding, Project staff required that evidence be consistently documented by information gained from at least two of the three sources described earlier:

- documents made available by OAPP staff and/or Commission staff and volunteers at the request of the consultant;
- a survey of contracted service providers; or
- key informant interviews with Commission members, service provider staff, and various Los Angeles County employees at OAPP, DHS, and other departments.

The identification of significant issues and recommendations designed to respond to these issues will be addressed in the two sections of the report immediately following this *Findings* section.

PROCUREMENT

As mentioned earlier, managing

programs and services to meet the needs of persons living with HIV and AIDS is the primary purpose for, and central function of, the Grantee's administration of Title I. Within the service management process, the primary responsibility and, ultimately, the most critical factor related to positive consumer outcomes consists of ensuring that services of the right type, amount, location, quality, accessibility, and cost are procured from the appropriate sources. This process must simultaneously remain consistent with the service priorities and budget allocations established by the Commission in its annual deliberations.

After a review of requested documentation provided primarily by OAPP, the service provider survey and key informant interviews provided more up-to-date and qualitative information regarding each of the six areas that were investigated. Starting with the issue of *Procurement*, here are summaries of the findings that resulted from the provider survey and key informant interviews:

PROVIDER SURVEY

For this Assessment, project consultants sent all known Title I service providers in L.A. County a survey instrument (see *Appendix*) aimed at learning about their experiences with various aspects of the administrative mechanism.

Thirty-two (32) service providers (approximately 33% of all service providers) returned complete surveys. Questions regarding the procurement of services focused on:

- how many years service providers have had contracts with OAPP;
- how many different Title I contracts providers had with OAPP currently;
- how long ago did the provider agency participate in a Request For Proposal (RFP) process with OAPP;
- if the original service contract had been renewed, for how many years has it been renewed;
- how well the RFP process worked, in terms of eight separate variables such as notice, instructions, timeliness, fairness, and other aspects;
- how well the contracting process was carried out, measured in terms of five separate variables (please refer to the survey questionnaire in the *Appendix* for more details);
- how much assistance was provided to service providers in areas such as service implementation, record keeping, reporting, service standards, quality monitoring, and outcome evaluation; and
- whether respondents had any

suggestions to improve the RFP process, contract renewal process, and/or any other aspect of the service procurement process.

In general, survey respondents held contracts with OAPP ranging from 2 to 14 years, with the mean average having had contracts for 9.4 years. Providers tended to have multiple contracts, with a range of 1 to 14 contracts and a mean average of 3 contracts per provider.

When asked how many years had passed since they had last participated in an open and competitive Request For Proposal process to secure a service contract, the range turned out to be from 1 to 13 years, with a mean average of 4.5 years per provider. Finally, when asked how many times their service contract had been renewed since the original contract with OAPP, the range of responses fell between 1 and 12 times, with a mean average of 5.4 times.

Based on these statistics, a general observation can be made that most service providers who responded to the survey have had their contracts for a number of years, have several contracts, have not participated in an open and competitive bidding process for a number of years, and have had their original contracts renewed several times.

In evaluating the service procurement process, one conclusion borne out by the evidence available is that the procurement process is not being utilized as a method to actively recruit new providers who may offer more tailored, more appropriate, more convenient, or less expensive services, as service consumer demographics, geographic distribution, and need for services have changed along with changes within the demographics of HIV.

Rather, it appears that the effect of the current procurement process has been one of stabilization and bureaucratization, as a system that has appeared to focus primarily on the renewal of contracts with existing service provider agencies that have considerable histories of providing services in Los Angeles County.

With regard to the workings of the most recent RFP process that service providers have variously participated in, respondents provided information that may prove useful in fine-tuning the system in the future.

Specifically, 14 respondents said that there was 'sufficient' advance notice to respond appropriately to the notice of RFPs, while 13 felt that notice had been 'barely sufficient' or 'insufficient'. Regarding clear instructions, 18 of

those responding felt that RFP instructions were 'clear enough', while 7 felt that they were 'unclear'. Overwhelmingly, 23 agency representatives remembered the opportunity to attend a bidder's conference for the most recent RFP process participated in, while 1 did not recall an opportunity to attend and 7 organizations weren't sure.

Thirteen (13) agencies remembered the availability of technical assistance to prepare a responsive application, while 18 either said that no assistance was offered or weren't sure whether or not assistance was available. When asked about the timely processing of RFP applications once they were submitted, 8 agencies felt that processing was 'timely', 5 felt that processing was 'adequate', and most of those responding (12) felt that processing was 'slow'. Regarding fairness of the proposal review process, 11 felt that the process was 'fair', 3 felt that it was 'unfair', and 11 weren't sure.

In response to a question regarding agencies' perceptions of the qualifications of proposal reviewers, 6 agencies felt that reviewers were 'qualified', 2 agencies felt that they were 'unqualified' and 15 were 'not sure'. In a closely related question, 6 respondents felt that the application reviewers were 'fair' in their evaluations, 3 responded that reviewers were 'unfair' and 13

answered that they were 'not sure'.

Two questions in the survey asked specifically about the distribution of contract awards. One question asked respondents to answer whether or not contract awards were based on documented assessment of consumers' needs. Of those responding, 5 said that the needs had been 'documented', 4 agencies believed that needs were 'undocumented' and the overwhelming majority of responses, 15 in all, fell into the 'not sure' category.

The other question regarding contract awards resulting from the procurement process was whether or not contract awards were sufficient to meet consumer needs. Respondents who felt that awards were 'sufficient' to the needs numbered 6, those who felt that awards were 'insufficient' numbered 15, and 6 providers said that they were 'not sure'.

Once contracts were awarded during the most recent process, 15 agencies said that orientation and training regarding contract requirements and expectations were provided by OAPP, 9 did not remember an opportunity for orientation or training having been provided, and 6 respondents were not sure.

Regarding a question that had become an issue during the assessment of the 2000-2001

administrative mechanism, 14 respondents reported a 'good' working relationship with their OAPP contracts manager, 8 agencies reported an 'adequate' relationship, and 7 service providers reported either a 'poor' relationship or 'no' relationship.

Overwhelmingly, answers to three separate questions revealed that the administrative agency had made help available to implement service contracts, had provided clear instructions regarding record-keeping requirements, had provided clear instructions regarding reporting requirements, and had provided clear instructions regarding service standards.

To a somewhat lesser extent, but still positive, 17 respondents reported that the Grantee had provided helpful information and/or tools to monitor service quality, while 10 respondents said that such tools had not been provided. Finally, 14 provider organizations reported that helpful information or tools to evaluate service outcomes had been provided and 13 organizations reported that they had not been provided.

In terms of open-ended responses to the question of how the procurement process might be improved, a variety of answers were recorded...

KEY INFORMANT INTERVIEWS

Separate from the service providers' survey, 15 key informant interviews also addressed the effectiveness, efficiency, timeliness, and appropriateness of the service procurement process. In this case, key informants were drawn from the ranks of Commissioners, service provider representatives, OAPP staff, non-OAPP Department of Health Services staff, and County employees outside of DHS (in some cases, individuals represented more than one category of interviewee).

To sum up the nearly unanimous view from key informant interviews regarding the Title I service procurement process, one interviewee said, "HIV is still viewed as an emergency in the eyes of the providers and general public. However, in the eyes of the County's process, it cannot distinguish between funds for emergency and non-emergency."

While a number of different reasons were given for the slowness of the process by which the County is able to process Requests For Proposals (RFPs)--HRSA's preferred method for receiving and comparing bids for services from potential service providers--words like "long", "time-consuming", "cumbersome" and "contentious" were often used to describe the bidding process as it is now used.

One County employee allowed that "the procurement process is by design a nine-month ordeal. This is the reality of the County contracting process." Another interviewee said, "The time between the RFP process and funding announcements don't match the timelines published by OAPP. Oftentimes fixed RFP deadlines are extended. Essentially, it takes one and one-half years to get grants approved."

Some of those interviewed related that a successfully completed RFP process has not taken place over the last two to three years. Various reasons were given for this breakdown, ranging from lack of sufficient staff at OAPP to the lack of timeliness on the part of DHS and other County administrative entities after OAPP has done its work. In addition, some of those interviewed alleged that hold-ups in the process have occurred as individuals and organizations have sometimes attempted to utilize political processes with County Supervisors and others, either to circumvent normal RFP administrative processes or protest their results.

Many of those interviewed recognized the desirability of having regular and more frequent RFP process that could more quickly align services provided with the changing needs of a demographically and geographically unstable population,

as well as with emerging changes in HIV/AIDS care strategies and methods. Some mentioned that it was their hope that the system would be more inclusive and allow more new providers an opportunity to compete with long-term contractors. Others, however, remarked that "after twenty years of service to HIV/AIDS there is a known base of competent providers who typically apply for our funding".

When asked why the RFP process takes as long as it does, interviewees gave a couple of primary reasons. Several of those spoken to said that OAPP has been able to do its work fairly quickly (three to four months), but that from the time their work is done until new contracts or even contract renewals reach a vote by the Board of Supervisors, another four to five months has passed. This extra time is evidently required to allow work to be reviewed by DHS, the County's legal counsel, and budget departments. Others pointed to the amount of time it takes to review and evaluate "upwards of 100 proposals" in response to each RFP, including the time it takes to find unbiased and disinterested volunteer proposal reviewers with expertise in the service area in question.

One result of these difficulties is the policy of attempting to re-bid services only every three to five

years, with annual contract renewals built in to the contracting process. It is felt by many that this system is more efficient and less expensive, producing less work each year and requiring less staff to implement. Some of those interviewed said it is also a way to help save staff time and money for the service providers and potential service providers who have to take time to respond to RFPs. At the same time, also in the name of efficiency, several individuals expressed an interest in going to 'Master Contracts' that would last several years without requiring annual renewal, but said that the Board of Supervisors has not been in favor of such longer-term agreements.

Finally, several of those interviewed related that for more than a year OAPP has requested a rate-review process that would allow some of its primary contracts, such as those for outpatient medical care, to move from a reimbursement-of-cost to an average cost-per-unit basis. While the relationship between making this change in how contracts are paid and instituting a regular and significantly accelerated RFP process is not completely clear, several interviewees were expecting that any new RFP process would probably have to await the results of such a study.

DISBURSEMENT

PROVIDER SURVEY:

The survey of service providers included 20 specific questions regarding the disbursement or reimbursement system used by the Grantee, and also asked one open-ended question to allow respondents to suggest anything that might improve expense reimbursements (please see *Appendix* for answers to open-ended questions).

The first question asked whether contract reimbursement requirements were made clear at contract initiation. By an overwhelming margin (27 to 2), providers reported that requirements had been made clear. A follow-up question asked whether those original requirements, sometimes made close to a decade earlier, had remained the same over the term of the contract with the Grantee. Eighteen (18) respondents said that the requirements had remained the same, while 11 organizations reported that they had changed.

A third question focused on how helpful OAPP had been during FY 2001 in providing a variety of guidelines, policies, procedures, tools and other assistance to providers to help the disbursement or reimbursement process run efficiently and effectively.

Starting with written contract management requirements, 9 respondents said that OAPP had been 'very helpful', 15 said that they had been 'somewhat helpful', and 5 reported that OAPP had been 'unhelpful'. With regard to written service standards, 7 representatives reported that OAPP had been 'very helpful', 17 reported 'somewhat helpful', and 5 reported them to be 'unhelpful'.

Moving to a question about the provision of orientation and/or training regarding permissible service costs, 10 agencies reported OAPP to be 'very helpful', 11 reported 'somewhat helpful', 3 reported them to be 'unhelpful', and 6 respondents reported that no orientation or training regarding service costs was provided. On a similar question related to orientation and training regarding service accounting, 8 respondents said that OAPP had been 'very helpful', 7 organizations reported that they had been 'somewhat helpful', 4 checked the 'unhelpful' category, and 7 respondents reported that no help had been provided to them.

Another question asked if accounting templates or tools of any kind had been provided by the Grantee to assist service providers. With regard to this question, 6 respondents said that OAPP had been 'very helpful', 15 checked the 'somewhat helpful' category, 2 reported OAPP to be 'unhelpful',

and 6 organizations reported receiving no assistance from OAPP in the area of accounting templates or other accounting tools.

Record-keeping technical assistance or training on the part of OAPP was another element of the disbursement or reimbursement process about which service providers were questioned. Nine respondents noted that the Grantee administering agency had been 'very helpful' in this regard, 8 reported that the Grantee had been 'somewhat helpful', 3 checked 'unhelpful', and 7 organizations reported no help from OAPP.

In the area of cost reporting technical assistance or training, 7 respondents felt that the Grantee had been 'very helpful', 8 responded with 'somewhat helpful', 5 reported 'unhelpful', and 8 said that no help had been received. In a similar vein, in response to a question regarding technical assistance or training regarding cost/outcome calculations that are now expected by HRSA to be tracked and reported by EMAs, 5 organizations felt that OAPP had been 'very helpful', 9 said 'somewhat helpful', 4 checked 'unhelpful', and 10 agencies said that no help had been provided to them during 2000-2001.

Under the category of clear OAPP requirements for claiming service-related expenses, the

overwhelming majority of respondents (25 of 30) felt that they were either 'very clear' (6) or 'clear enough' (19). On a related question, 3 respondents believed that OAPP had provided a way to do electronic filing of service expense claim forms, while 20 agencies said that a way to submit claims electronically was not provided to them. Similarly, 3 respondents said that they had filed claims electronically and 22 respondents said that they had not.

Focusing on the reimbursement of claims specifically, 13 respondents reported that OAPP had at one time or another questioned their claims, while 15 respondents reported that their claims had never been questioned. At the same time, with regard to the timeliness with which reimbursements are received from DHS, 7 agencies reported that their claims are 'always' reimbursed within 30 to 45 days, 18 said that they were 'usually' handled within that time frame, 4 agencies reported that they are 'sometimes' processed within the same period, and only 2 respondents reported that their claims were 'rarely' handled within the period identified.

On a related, but different topic, the provider survey attempted to identify the approximate lag time between the first provision of contracted services and the receipt

of the first reimbursement payment, in order to find out more precisely how long providers are expected to 'front' services, or operate without payment from DHS. In practice, the typical range turned out to be from 30 to 90 days, with a mean average of approximately 47 days.

A more specific measure of 'turnaround' time was sought when the survey asked providers the approximate lag time between the submission of the first service reimbursement request and the first reimbursement payment. The 30 to 45-day range of typical responses to this question were significantly less than the previous question, as might be expected, with a mean average lag time of approximately 39 days.

KEY INFORMANT INTERVIEWS:

Based on interviews, the service invoice reimbursement process seems to consistently work quite well, with a turn-around time of ten to fourteen days typical for properly submitted invoices. Part of the responsiveness of the system is seen as a result of OAPP's aggressive monitoring of invoice submissions to the County Auditor/Controller's office, where paperwork is reportedly typically handled in three to five days.

According to interviewees, there are at times still complaints from some provider organizations

regarding reimbursements. However, these situations seem to be in the minority and seem in many cases to stem from slow submission of invoices or submission of invoices that are incorrect in some way. OAPP has made available, and in many cases, has provided technical assistance to contracting agencies, and these efforts appear to have improved the quality of invoices overall.

When invoices are incorrect, OAPP attempts to pay the uncontested amounts and only withholds payment on those areas in question. Nevertheless, it appears that it often becomes the responsibility of the service provider to follow up with OAPP in these situations to identify the specific expenses in question, and may at times take repeated inquiries to determine what changes need to be made so that invoices can be paid in full.

Another issue that emerged is that while OAPP policy is that service provider agencies need to have at least 90 days of cash in reserve to hold them over until reimbursement payments start to arrive, some provider agencies are not able to meet this eligibility requirement. In some cases OAPP has attempted to help some of the smaller agencies by introducing them to local banks in hopes of putting in place lines of credit to help with cash flow issues.

Finances may also be difficult for providers at the end of the year, when OAPP needs to do a final accounting of expenses on contracted services, sometimes delaying final payments until it is determined whether a provider is owed money or owes money for expenses over and beyond contracted amounts.

PARTNERSHIPS

PROVIDER SURVEY:

'Partnership' normally implies a mutual (and often formal) commitment to carry out complementary roles and responsibilities to achieve shared goals and mutually desired outcomes.

In an effort to begin collecting data regarding the effectiveness and efficiency of legislatively-mandated partnerships between the various Grantee representatives and the Planning Council, as well as the more informal partnerships that exist between the Planning Council and service provider agencies which are the instruments of its health care planning and implementation, the 2002 service provider survey identified five preliminary measures of the efficacy of existing partner relations.

First, respondents were asked about the informal partnership

between the Planning Council and service provider agencies; specifically, to what degree does the HIV Commission formally solicit service provider input into processes related to assessing consumer needs, developing continua of care plans, and annually prioritizing services and allocating funding to implement those services. Four respondents reported that the Commission 'always' solicited provider input, 6 said that the Commission 'usually' solicited input, 8 reported that it 'sometimes' solicited, and 2 respondents each said either 'rarely' or 'never'.

Regarding the degree to which the Commission provides, and OAPP accepts, direction concerning 'factors to be considered' in executing service contracts with various providers, 4 providers reported that the Commission 'always' provides guidance, 5 reported that it 'usually' provides guidance, 4 reported that it 'sometimes' provides it 1 said 'rarely', 2 said 'never', and the majority of respondents (15) were 'not sure'. Similarly, 15 respondents were 'not sure' if OAPP regularly accepts direction from the planning council regarding the development and funding of a comprehensive services plan to meet the priority needs of HIV service consumers, while 6 respondents answered that OAPP 'always' accepts direction, 4 answered 'usually', 3 answered

'sometimes', 2 answered 'rarely', and 1 answered 'never'.

When asked if OAPP and the Commission appear to work together with the same mission and strategic goals in mind, 3 respondents answered 'always', 9 answered 'usually', 4 said 'sometimes', 2 said 'rarely' and 12 were not sure. The final question regarding partnerships questioned the perceptions of service provider agencies regarding OAPP staff with responsibility for monitoring service contracts. As to whether or not the relationship with OAPP staff was 'cooperative and productive', 13 agencies said 'always', 10 said 'usually', 4 said 'sometimes', 2 said 'rarely', 1 responded 'never' and only 1 respondent was not sure.

KEY INFORMANT INTERVIEWS:

According to key informants, it is primarily OAPP and the HIV Commission that are actively engaged in a partnership to provide HIV/AIDS services. The other two nominal partners (DHS and the County Board of Supervisors) primarily get involved only when there is a problem or criticism is being leveled at OAPP or the Commission. Mentioned one, "A huge challenge for all of us is the individual provider who tries to bypass the established process and go directly to the Commission or Supervisors to move their issues". Another said, "The 'squeaky wheel syndrome' can get

out of hand and all blown out of proportion when they get the ear of someone in the political structure".

For some, a separate partnership issue was the perceived lack of awareness and involvement of the Board of Supervisors in HIV issues generally, making various approval processes slow and education-intensive, although several individuals felt that this had improved in recent months.

Several blamed internal County fiscal crises as the reason DHS had not hired the requisite staff for OAPP to fully carry out its partnership responsibilities, even in cases where positions were fully funded through federal dollars.

Even within the OAPP/Commission partnership, relations appear to sometimes be strained due to the structures Congress has prescribed and HRSA has had to enforce. For example, though the Commission and OAPP are designed in theory to be equal partners or peers with different roles and responsibilities, according to testimony, in practice an all-volunteer Commission staffed by OAPP employees has historically tended to be subservient to OAPP, with very little influence on OAPP decisions, operations, or accountability. As one interviewee put it, "Keeping roles and responsibilities of all the partners clearly delineated is a challenge. Automatic tension is

built in due to the nature of the reporting structure among the partners".

A near-unanimous suggestion to ease this tension and optimize the performance of the two primary partners was for the Commission to hire its own staff independent of OAPP and DHS. This was most often mentioned in terms of one of two separate possibilities--that the HIV Commission would be set up as an independent Commission under the direct authority of the County Board of Supervisors, with staff supplied to it by the Board, or that as an independent commission it might contract out its staff from a separate nonprofit organization.

Another frequent comment was that the Commission, with its 60-plus members, had over the years become too large and unwieldy a body to function at optimum effectiveness and efficiency, although it was acknowledged that the Commission had worked hard recently to build competency through improved orientation and training opportunities for its members. Several individuals suggested that it needed to reexamine its structure and membership and see if it could be streamlined to some extent.

EXPECTATIONS

PROVIDER SURVEY:

'Expectations' was one of the six areas identified by the Finance

Committee as an area to attend to in assessing the Title I administrative mechanism. Conversations with Finance Committee members and others revealed that at least part of the issue of expectations had to do with concern over mutual lack of knowledge or understanding of a clear division of roles and responsibilities for different administrative and policy functions. The other primary issue identified was a lack of mutual agreement on what constitutes 'reasonable' expectations in the performance of respective roles and responsibilities, related to a lack of mutual appreciation for external constraints on both grantee and the planning council performance in pursuing an optimal administrative mechanism.

While key informant interviews gave a better measure of the status of expectations between the grantee and planning council partners, for the provider survey, an attempt to address different perspectives from service providers regarding the fulfillment of administrative mechanism expectations was made in the form of questions regarding planning process roles and responsibilities.

For example, one question was asked to get a measure on the degree to which OAPP met planning council expectations in supplying 'epidemiological information regarding the scope,

range, acuity, and tempo of the HIV epidemic'. Responses to this question gave evidence that OAPP is perceived to be meeting most expectations, with 10 respondents saying that OAPP was doing 'well', 9 responding 'satisfactorily', 1 'unsatisfactorily', and 11 'not sure'.

Another question aimed at measuring the status of expectations asked how well the Commission completed or had completed a Comprehensive Assessment of the needs of HIV service consumers. Responses to this question resulted in 5 agencies answering 'well', 10 agencies answering 'satisfactorily', 6 answering 'unsatisfactorily' and 10 'not sure'.

A third question focused on the reasonable expectation that the Commission properly prioritizes consumer needs on an annual basis. For FY 2001, 4 respondents felt that the Commission had met expectations 'well', 13 felt that they had been met 'satisfactorily', 5 thought that they had been met 'unsatisfactorily' and 9 agency representatives were 'not sure'.

The final provider survey question in this category asked how respondents evaluated the Commission's performance in relation to its responsibility to allocate funding to meet the priority needs of the majority of HIV service Consumers. In this case, 4 agencies said that the

Commission had done 'well', 9 said 'satisfactorily', 9 said 'unsatisfactorily' and another 9 were 'not sure'.

KEY INFORMANT INTERVIEWS:

Compared to the previous year's assessment, expectations between Title I partners seem to have improved measurably. While some expectations still go unfulfilled and others still seem unrealistic, overall, there seemed to be a renewed interest in working out differences and making changes as opportunities presented themselves.

One difference that was mentioned in several interviews was OAPP's increased attention to the training and technical assistance needs of service provider staff. Partners at all levels commended the work OAPP Contract Managers and others had done with service providers over the last year to increase communication and clarify expectations so that a sense of teamwork, rather than acrimony, could evolve and flourish.

Emphasis has also been placed on helping contractors understand that the monitoring of contracts is not designed to be punitive, but rather reflects good management practice and an opportunity to head off problems and address emerging issues in positive ways.

Similarly, the HIV Commission had taken it upon itself to revise and

reinvigorate an orientation and training program for new members, and encourage its use as a refresher course for longer-tenured ones. It has seemed by some observers to come to the realization that clearer and more realistic expectations between Title I partners will only come from a clearer understanding of mutual roles and responsibilities for the tasks required by the CARE Act.

A remaining expectation that has not seem to be resolved for many is the speed at which County departments are able to handle Title I business. As one County employee commented, "I understand that there is a sense of urgency in getting HIV money on the streets. However, emergency or not, the County process grinds slowly." Another County staff informant commented, "The County needs a reality check as to what needs to actually occur in order for OAPP to administer funds the way we need to. Their system is antiquated and out of pace with today's needs."

WORKFLOW

PROVIDER SURVEY:

The two primary areas of *workflow* (task and document processing) assessed by the service provider survey were in the areas of *procurement* and *disbursement*, and have already been addressed under those headings. The reader will recall that from a service

provider agency vantage point the procurement process was characterized as having been less than optimal for many years, while the disbursement process seemed to be working quite well, especially in relation to reports from prior assessment periods.

More comprehensive and detailed assessment of task and document processing would require the actual tracking of documents by date and time of completion through the various processing steps in each of these systems, which would necessitate some sort of formal workflow and document tracking audit outside the scope of this FY 2001 assessment.

KEY INFORMANT INTERVIEWS

Conversations with key informants elicited comments related to workflow primarily in three areas: 1) workflow within the HIV Commission; 2) workflow within OAPP; and 3) workflow within the rest of the County government system.

With regard to the Commission, a typical comment received from one interviewee was, "If planning bodies are going to be efficient, they must have paid, professional staff supporting them, given all the expectations placed upon them". The general sense of many of those interviewed was that the Commission's workflow proceeds about as well as can be expected,

given that it is an all-volunteer council currently without the ability to hire its own staff leadership to assist it in setting and carrying out its various functions.

With regard to OAPP, comments expressed wide recognition that workflow processes were slower than they should be and fell short of expectations of those both inside and outside OAPP. Four primary explanations or concerns connected to the inefficiency of workflow arose out of conversations with key informants.

First, several of those interviewed expressed concerns with what could be termed 'micromanagement' within OAPP and the County system generally. As one individual succinctly expressed it, "Inside OAPP the most minor things take review and require scrutiny". Reports from many individuals attributed this management characteristic as a County government response to negative press coverage that had been received as a result of criticism from consumers, service providers, and/or others, resulting in intervention by County Supervisors.

A second concern, and by far the one voiced most often, was real concern about the County's failure to fill key staff positions within OAPP, even when funding was available from federal grants, and the likelihood that staff rolls would

be cut back even further in the months ahead. Some examples of comments that were typical of many interviews include ones like "Filling staff vacancies would help with the workflow and staff burnout issues"; "In-house collaboration has improved greatly, but the great number of unfilled staff positions really hurts this process. Even very key positions are going unfilled for months or years"; "In the fall the County may go through a staff downsizing process to meet the realities of the current budget crisis. This will affect the workflow all across the County"; and "County cutbacks will slow a process that is already unable to keep pace."

A third concern with workflow within OAPP was expressed in terms of the need for a better information management system to expedite work processes related to information transfer. Summing up the issue, one County staff member said, "The lack of a comprehensive database tracking system internally at OAPP has made our workflow inefficient. We are about two years away from seeing this system up and running".

A final concern with OAPP workflow had to do with the perspective with which OAPP and other County departments approached their roles and responsibilities and how they assess the efficiency and effectiveness of their task

management systems. Simply stated by one interviewee, "Everything needs to flow from the needs of the clientele."

Finally, comments about the County work processing system in general--especially related to the 'disjointed' or 'compartmentalized' nature of the workflow (especially between different County departments)--came under criticism from several of those interviewed. As one County employee testified, "No one seems to be handling or monitoring requests between the various entities within the County...for instance, when someone is on vacation or absent from their job, requests simply sit and go without any response." Clearly accountability for work processes and results was a concern for many of those interviewed.

CONTINUOUS QUALITY IMPROVEMENT

PROVIDER SURVEY:

Continuous Quality Improvement (CQI) is a relatively recent focus of CARE Act Title I expectations, administrative policy, funding, and technical assistance from HRSA. Reflecting the importance placed on CQI at the federal level, OAPP has its own Quality Management department or unit. At the time of this assessment several positions in the department were funded but not filled, including the department head position (OAPP reports that this situation has since been

remedied).

The service provider survey included seven specific questions to get a feel for how well the CQI process was working and what results had been achieved for this relatively new function within the administrative mechanism. The first question asked related to the formation of outcome measures for each service category funded by the Commission. Of the 30 agencies responding, 7 said that they believed outcome measures had been developed for all services, 9 believed that they had been developed for at least some services, 1 thought that no outcome measures had been developed, and 13 agencies were not sure if outcome measures existed or not.

Another question aimed at determining whether providers were aware of service standards as part of their responsibility to deliver high quality services that meet Commission and OAPP guidelines. Six of the 29 respondents believed that standards had been developed for all services, 12 believed that they had been developed for at least some of the services, none believed that no standards had been developed, and 11 respondents weren't sure if standards had been developed or not.

As one of the emerging areas of

monitoring and evaluation required by HRSA, the next question asked service providers if cost-per-unit of service guidelines had been developed to assist OAPP in entertaining bids for planned HIV services. Of the 28 agencies responding, 7 felt that some had been developed and the other 21 respondents weren't sure. Similarly, when the question turned to cost/outcome effectiveness measures to evaluate the comparative value of various services delivered, 1 respondent reported that they had been developed for all services, 6 reported that they had been developed for some services, and the remaining 21 were not sure.

Site visits by the OAPP contract monitors are another standard aspect of the CQI program. In response to a question regarding the number of site visits to service provider agencies, 15 reported having been visited more than once during 2001, 11 agencies had reported being visited once, and 3 reported having no visits during the year. In addition to site visits, providers were asked whether or not OAPP had provided any formal report to help improve the provision of services or improve consumer outcomes. Almost identical answers to the previous question were received, with 15 agencies reporting that they had formal feedback from OAPP on more than one occasion, 10 agencies responding that a formal

report had been received at least once, and 4 responding that they had not received a formal report from OAPP.

The final question related to Continuous Quality Improvement was to determine whether or not contract monitors at OAPP had followed up their service improvement recommendations with any observation or other means of determining how service providers were implementing OAPP recommendations. According to the surveys, 11 organizations reported that OAPP had checked on progress repeatedly, 11 organizations reported that OAPP had followed up with them once, 7 reported that OAPP hadn't checked to see if recommendations were implemented, and 1 organization said that it had received no recommendations for improvement.

KEY INFORMANT INTERVIEWS:

From reports received during interviews, all appearances are that OAPP has over the last couple of years taken quite seriously HRSA's nationwide mandate to plan and implement systems of Continuous Quality Improvement within Title I programming.

From the development of organizational strategic plans, to an EMA-wide Comprehensive Care Plan, to a Continuum of Care Plan, to work with the Commission on

the development of service standards, it appears that OAPP has provided significant leadership to the establishment of specific plans and performance benchmarks as one of the requisites to an effective CQI program. Typical of many of the responses received in this regard, "Additional funds have been allocated to help in the monitoring of contracted agencies' programs. Program monitoring was weak at OAPP, but has greatly improved over the past four to five years".

According to interviews, one of the primary ways in which OAPP has worked to improve overall Title I program, service, and administrative management quality is to provide significant capacity building resources to providers. Said one informant, "OAPP has been very aggressive in working with providers to build capacity....Everyone wants to do better. Capacity building money has been very helpful to the providers. This is a two-way street in that by helping providers learn to do their work correctly OAPP is positioned to get its work done faster".

Another enthusiastic supporter of recent developments added, "HRSA is helping OAPP to design outcome measures and to integrate them into the computerized data stream from which CARE Act services are tracked in L.A. County. Twelve new staff have been authorized to

work on outcome measures. I really feel that this will be a positive impact for the providers."

Despite the mostly positive reports from those interviewed, a couple of those interviewed felt that CQI efforts have been hampered by the lack of staff support in key positions, including ongoing vacancies in positions of departmental leadership. One interviewee questioned the productivity of County finance staff responsible for performing utilization reviews and other audits of service providers; "HRSA expects us to audit providers every two to three years, and DHS is not hitting this goal. They are required to do only ten audits per staff per year."

While most of the discussion about Continuous Quality Improvement focused on OAPP's efforts to improve standards of performance in the provision of services by provider agencies, some informants also recognized a substantial, if less obvious, role for the Commission, especially with regard to service planning, formulation of service standards to meet consumer needs, and evaluation of the impact of services and their cost/outcome effectiveness.

Reflecting the need for a larger vision regarding CQI, one interviewee allowed, "Quality improvement must go beyond just

OAPP to the Commission and beyond to the contracted agencies. OAPP is much less autonomous than most people would like to believe. HIV is highly politicized and has been from the beginning of the epidemic. We all must move toward a cooperative approach to partnership on behalf of the clients."

**VIII. PRIORITY ISSUES/
SPECIFIC
RECOMMENDATIONS**

For each of the areas assessed, findings from documentation, provider surveys, and key informant interviews suggest challenges to the operation of the administrative mechanism that detract from its optimum efficiency and effectiveness. They also suggest areas of opportunity, where even small changes could have substantial positive effects. In each area studied, we have attempted to identify any prominent issues and recommend specific actions or approaches that could improve the administrative mechanism, with the benefit to the service consumer as the ultimate goal in mind.

PROCUREMENT

ISSUES:

No one interviewed during the assessment denied that the service bidding and other elements of the procurement process are slower than desired, often cumbersome, and often out of the control of those who staff the primary Title I administering agency, Office of AIDS Program and Policy.

The main differences in responses between individuals related to the causes of the problems, who is responsible for them, and whether the problems should be solved or merely accepted as part of the

environment of County government.

By County employees' admission, County Request For Proposal processes and timelines do not meet the needs of an 'emergency' service function that intends to consistently assess needs, plan care, and prioritize services and allocate funding on an annual basis, as is built into Title I legislation.

Given that the Ryan White CARE Act Title I funding year begins March 1 and ends February 28 (except for leap years) Title I Planning Councils typically attempt to complete their Comprehensive Needs Assessment and Comprehensive Service Plan processes in late Spring and early Summer, so that they can prioritize services and allocate budgets for the next fiscal year in time for those priorities and allocations to be included in the annual Supplemental Funding Applications to HRSA. These applications are normally due to HRSA in September or October, for awards announced in December or January.

In order for service provider agencies to have the staff, facilities, equipment, supplies, and other elements of service provision to be in place for the following March 1 initiation of Title I services, notice of impending contracts should be given as soon

as they are known. Actual contracts for services need to be executed with the Grantee administering agency by early February of each year at the very latest, and preferably some time before that so that service providers can recruit, hire, and train new staff or make solid commitments to current staff for the following program year.

In effect, because HRSA only provides Title I funding awards on an annual basis, each year the Grantee has a viable opportunity to accomplish the service procurement (contracting) process some time between the HIV Commission completing its priority setting, funding allocation, and service provision instructions in mid to late summer (typically July or August) and the time that the final awards from HRSA are known (January of the following year at the latest). This allows an approximately five- to six-month 'window of opportunity' in which a responsive Grantee must process whatever number of service contracts are up for bidding or re-bidding, depending on how much change in proposed consumers, services, or allocated budgets has taken place.

It is logical to assume that since service needs, audiences, geographic regions, demographics, medical and pharmaceutical (and other) health advances, and community resources available for

individuals living with HIV and AIDS are changing continually, the ability to maintain a quick, flexible, simple, effective, and efficient contracting process would be paramount for a service contracting agency. At minimum, one would expect that a Title I Grantee agency would be able to process, on an annual basis if needed, new or revised contracts that respond to changes in services resulting from the annual service priority setting and funding allocation processes that are mandated under Title I. The capacity and capability to do this appears to be a necessary feature of any effective and efficient Title I administrative system, even if some or all contracts remained substantially the same for two or three years (or longer) and needed only very minor annual reviews and revisions.

In fact, established and documented County policies, procedures, and timetables prescribe a ten- to eleven-month period to process Title I Requests For Proposals. Since the HIV Commission is required by law to annually re-establish service priorities and instruct the Grantee on ways in which it wants service delivery to change and annually allocate funding based on specific epidemiological and other information, the RFP process cannot even begin until the Commission has had several months to do its work. This means

that the current RFP process, as prescribed, does not allow enough time each year for an RFP process to take place.

Individuals interviewed took one of two main approaches to dealing with this inescapable conclusion. One group, currently the most influential, have concluded that it is not essential to have an RFP process to select contractors, and give a variety of reasons why opening bidding competition either annually or periodically most often produces no appreciable benefit to administrators, service providers, or consumers. Contrarily, they tend to emphasize the cost and the stress produced by trying to implement such a process in what they consider seriously understaffed administrative and provider organizations.

Rather, they argue, annual renewal of contracts with known and proven providers is often the most efficient way that services can be provided. Sometimes they also mention sole-source contracting, purchase orders, and sub-contracts as other expedient means to have services delivered that are equally legitimate to open and competitive bidding utilizing an RFP process.

In fact, during the 2002-2003 period in which this Administrative Mechanism Assessment project was being implemented, the purchase orders for various consulting firms working on

separate projects required the seven-month period between March 1 to the middle of November, 2002 to execute, leaving only December, January, and February to legitimately carry out work which in some cases had been planned for a five- to six-months period. Thus, it turns out that in several recent cases that occurred during the assessment process, at least for purchase orders, and possibly for other methods of implementing contracts, these alternate methods turned out to be no more expedient or efficient than the RFP process they were meant to improve upon.

In contrast, those interviewed who were concerned about the lack of an effective and efficient RFP process to let Title I contracts, point to not only issues of fairness and appropriateness in a relatively 'closed' contracting system where some contracts have been renewed for twelve and fourteen years without going to bid. Some also expressed concern, from a purely business point of view, as to the actual and potentially growing ineffectiveness, inefficiency, and expense of services being provided by agencies that may have grown out of touch with their clients, their communities, service methods and protocols, and whose cost-per-unit of service or cost/outcome effectiveness may have dropped substantially over time in relation to services that could be provided

by others.

Special criticism was leveled by some for the practice of offering small contracts to small or young agencies through larger, more established providers. To their way of thinking this practice not only circumvents open bidding, but also has the potential to reduce the amount of funding spent on services as administrative time and costs must be borne at both the primary contractor agency and the subcontracting agency levels.

A variety of reasons were given for the lack of urgency in the County procurement process. Among them were:

- ✓ the need for multiple levels of approval from different County departments;
- ✓ being continuously subjected to the County's political process;
- ✓ understaffing within OAPP and DHS;
- ✓ assertions that it is done intentionally by the County to stretch procurement process timelines as a way to avoid having to spend money in any given year, thus reducing the potential for cost overruns.

Not only did interviewers discover a general feeling of powerlessness

to improve the system, but also feelings of frustration were common at all levels. Whatever the causes attributed, it became clear that it has been and continues to be very difficult for those with the responsibility of planning and funding services to find a particular entity or person who will take responsibility for or can be held accountable for delays and 'hang-ups' in procuring services. The 'county system' is always ultimately responsible.

SPECIFIC RECOMMENDATIONS

On study and reflection, it seems fairly clear that a primarily federally-funded program focused on providing flexible and appropriate services to meet the urgent, life-threatening, and changing needs of individuals and families affected by HIV and AIDS is incompatible with the standard Los Angeles County procurement process. The County procurement system is not designed to consistently handle sustained and growing life-threatening consumer needs flexibly and urgently, and it doesn't.

The question that remains is whether those responsible for guarding the interests of HIV/AIDS consumers and complying with federal funding guidelines find the discrepancies serious enough to make changes in how County service procurement is done, or,

alternatively, whether the goals of the CARE Act's Title I program and the policies and procedures enacted to facilitate it are, as a matter of policy, going to be compromised instead.

If the EMA chooses to improve the efficiency of the administrative mechanism in keeping with the spirit of CARE Act legislation, improve the speed of contracting, and foster a more open, competitive, and presumably economically advantageous (to the County) process, it seems that the only ways to accomplish this will be to either 'fast track' HIV/AIDS services procurement within the County system, or move service procurement out of the normal County channels into some other arena.

When asked how else an RFP process or a streamlined version of the typical County service procurement process could be implemented, several of those interviewed discussed possible options in relation to a recent Commission staffing proposal already in front of County administrators and elected officials. This proposal was put forth during 2002 as a way of providing the Planning Council its own staff, instead of using OAPP staff to carry out its legislated responsibilities and improve its accountability. It was also seen as a way to continue to clarify the division of responsibilities between the

Planning Council and the Grantee, and lessen confusion and potential conflicts of interest that sometime exist when OAPP employees are asked to carry out Planning Council directives.

Pointing to perceived precedent set by other County Commissions administered out of the Office of the Clerk of the County Board of Supervisors, one suggestion was to move not only some Planning Council staffing functions under the umbrella of a County Commission, but to also see if it might be possible to move at least part of the Grantee service bidding and contracting functions from Department of Health Services and OAPP to another entity. The idea expressed was to achieve a simplified and accelerated contracting process internal to staff at the office of the County Supervisors, as opposed to encountering the delays that have come operating through normal County procurement channels.

For example, such a change might allow service priorities and allocation budgets normally developed by the Planning Council by June or July to be relayed directly to a suitable entity. From there, the Commission can propose the service plan for immediate Board endorsement, and immediate assignment to a County entity in June or July for rebidding or simple contract renewal, depending on the service.

With an RFP process or contract renewals begun in mid to late summer, months of time that would normally be needed for OAPP, DHS, and other County budget and purchasing personnel to get approvals and process contract requests back and forth could be dispensed with. In this way, it might be possible to have Board endorsement for contract bidding and preparation in late summer and final approval for finished contracts in late fall, rather than trying to get Board approval for service contracts in January, February, or March, when service delivery activities need to be underway, as now happens.

In principal, such a change might allow County administrators at Department of Health Services and OAPP to focus their attention on implementing, monitoring, assisting, and evaluating the services once contracted, rather than have RFP preparation, bid processing, and contract preparation a part of their Grantee responsibilities.

Even if such an approach proved feasible only in part, or unfeasible for reasons unclear to some of those interviewed, the current procurement process could still benefit from the review and application, as appropriate, of several potential new policies and procedures. In fact, during the period in which this assessment

was conducted the Commission made the commitment to attempt to accelerate its priority-setting and funding-allocation processes to March rather than its usual June/July schedule, in order to allow OAPP, DHS, and other County departments more time to process contracts. That decision raises its own problems, in that service priorities and funding allocations are best made when a comprehensive needs assessment has been conducted, and a comprehensive service plan prepared, neither of which can be accomplished in the first month of a Title I fiscal year.

The following suggestions are offered for further discussion and consideration by all Title I partners:

1) commit to a 'staggered' RFP process, so that annually an appropriate portion of all services (perhaps 1/4 or 1/5) are opened to bid and so that all services are open to rebidding on a regular and planned basis. This would help the EMA maintain pace with changes in consumer demographics, therapies, and provider capacity and service pricing;

2) more aggressively seek RFP applications from service providers already working with targeted consumer populations, especially in chronically underserved and underrepresented communities, where needs are greatest now or

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growth in urgent needs is most likely;

3) investigate ways to expand ongoing proactive training, technical assistance, and encouragement to potential service provider organizations, especially in primary target areas, in order to enlarge the pool of competent and appropriate service providers;

4) avoid 'sole source' contracts as an alternative to an open bidding process, except in cases of true emergency or when providers have unique skills or capacities truly not available elsewhere;

5) create policies and procedures regarding the practice of having larger or more general service providers issue sub-contracts to smaller or more specialized contractors, in order to improve program management and accountability and reduce redundant administrative costs;

6) assess and document the number and types of staff reasonably needed to carry out an effective, efficient, and timely RFP process for an appropriate portion of all HIV/AIDS services per year and staff accordingly;

7) assess and document the number and types of staff needed to reasonably carry out an effective, efficient, and timely contract renewal process for the majority of HIV/AIDS services not

being rebid each year and staff accordingly;

8) distribute duties of various agency and departmental staff within and/or without the L.A. County government structure, as necessary, in order to produce annually an open, fair, and timely RFP process;

9) propose to the Board of Supervisors an RFP and service bidding 'fast track' process for HIV/AIDS services outside the standard County system, so that the contracts that result from each year's RFP process can be acted upon by the Board within two months' time, rather than the current four to five month time span;

10) absent an RFP and service bidding 'fast track', investigate setting a policy that strictly enforces new contract deadlines to facilitate the ability of service providers to accommodate the unique and urgent needs of HIV/AIDS service consumers;

11) institute an adequate data management system that would allow authorized Commission, OAPP, DHS, and other appropriate County staff to schedule, track, and report on service contracting progress or problems as individual contracts make their way through County approval processes; and

12) identify a single person or entity responsible for timely County service contracting and give it the authority necessary to empower and support processes that produce desired service procurement results.

DISBURSEMENT:

ISSUES:

Overall, consistent with findings from FY 2000, disbursement of funds to reimburse expenses allowed under existing contracts is considered by nearly all sources to be exceptionally quick and efficient. Most often, vendors report that properly completed invoices result in payments within ten days to two weeks. This is the case even though several County government departments are required to provide approval for each reimbursement check issued.

Despite the speed of reimbursements, it is important to note that a common complaint of service providers is that some unspecified expenses on invoices are disallowed and County payments often don't match service provider invoices.

At the same time, some vendors assert that normally no details of which expenses were allowed and which were not allowed are

forthcoming from the County without repetitive and time-consuming follow-up calls and correspondence. It appears that policies or criteria for determining legitimate expenses under contracts are not made clear enough in advance for many service provider agency personnel.

SPECIFIC RECOMMENDATIONS:

The following suggestions are made primarily to help service provider staff get the training and assistance needed to consistently file accurate and timely expense and reimbursement documentation and minimize time spent on tracking incomplete payments. It is hoped that OAPP and/or DHS staff will consider providing service provider staff additional assistance in the following ways:

- 1) orient and train provider staff, on a semi-annual or even quarterly basis, regarding concepts, methods, and requirements concerning allowable expenses and the preparation of conforming invoices;
- 2) expect OAPP and DHS staff to proactively supply details of partial payments to provider staff for correction and resubmittal as quickly as possible;
- 3) develop electronic formats and templates to standardize invoices and reduce the incidence of faulty or incomplete information.

PARTNERSHIPS

ISSUES:

Until FY 2002 and participation in the first formal EMA-wide strategic planning process, the information available from all sources gives little evidence of Title I partners' mutual agreement on the mission, goals, objectives, respective duties, or performance standards that should apply between agencies and organizations sharing responsibility for meeting the emergency needs of HIV/AIDS service consumers.

Whether speaking of the Commission, OAPP, DHS, or the County Board of Supervisors (as the 'Partners' are commonly defined), each potential partner appears, in the recent past, to have tended to act independently and in isolation, often in ways uncomplimentary to achieving the most efficient or efficacious administrative mechanism possible. Again, in many ways the service procurement and contracting processes appear to be the most pervasive example of an inability to work as a team to expedite processes or use innovative methods that will consistently result in the most positive outcomes for consumers.

Despite these past, and to some extent lingering, issues, the Title I partnership appears to have grown

appreciably stronger over the past year to eighteen months. On the part of the Commission, significant effort has gone into becoming more accountable for legislated responsibilities, including needs assessments, comprehensive planning, strategic planning, standard setting, developing an independent staff function, and revising and providing new orientation and training experiences for Commission members.

Similarly, OAPP has expended considerable time, effort, and money on strategic planning, developing a Continuum of Care concept and plan, implementing standards developed by the Commission, monitoring and evaluating services more regularly and carefully, reporting to the Commission more comprehensively and more often, and providing technical assistance, training, and counsel to service providers to help them deliver services to consumers as effectively and efficiently as possible.

Areas of concern that still remain include an apparent unwillingness for the County to staff essential functions, even when federal and/or County funds are available; the perceived unwieldy nature of a 48-plus member Planning Council; continuing (and to some degree, structural) vagueness in prescribed Grantee and Planning Council roles and responsibilities and leadership

for various Title I functions; and the perceived absence of the primacy of measurable consumer benefit (as opposed to administrative expediency, for example) as the principle by which the legitimacy of all planning and administrative decisions are to be tested.

A separate *Partnership* issue, at least for some HIV/AIDS service providers, is their perception of exclusion from meaningful roles in information gathering and decision making processes that might better capitalize on *all* Partner competencies and assets. To some agency representatives, it is the service provider agencies and organizations that have the most knowledge and experience regarding the identification and satisfaction of consumer needs and selection of the most effective and efficient service options. Therefore, service priority setting, funding, and contracting processes, among others, are seen by some as ones that could benefit substantially from increased provider participation.

SPECIFIC RECOMMENDATIONS:

Some specific recommendations are being made here in support of continuing efforts to settle partnership issues that are perceived by some as reducing optimum levels of teamwork. As such, these recommendations may be considered structural in nature and may be considered rather

long-term and less urgent than some others made in other sections of this report. The following suggestions are aimed at promoting a more complete and mature partnership between the Grantee and Planning Council in order to continue to encourage an environment of participation, innovation, and mutual commitment:

- 1) prepare a Grantee staffing utilization and need report to identify the functions being filled satisfactorily by existing staff; essential Grantee functions that remain understaffed; the availability of CARE Act and other funding to meet essential staff needs that are unfilled; and plans to provide adequate staff to meet legislated roles and responsibilities over the next three to five years (or at least for the span of the current strategic plan)
- 2) prepare an updated report assessing the current status of the Commission 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 Title I and other community partners;

- 3) plan and implement a comprehensive staff development and training program operating on a continuous basis to help all Title I Partners, including service providers, work in concert to accomplish EMA goals and meet legislated responsibilities; and
- 4) arrange for more effective information-sharing forums and venues to facilitate the exchange of essential information between Title I partners and service providers, especially with regard to comprehensive EMA-wide documentation, such as that related to needs assessments, strategic plans, comprehensive care plans, service utilization and cost statistics, service evaluations, and consumer outcome data.

EXPECTATIONS

ISSUES:

The importance of including the topic of Title I administrative mechanism *Expectations* as one for assessment seems to reflect the historical view that some Partners to the administrative mechanism designed to implement the CARE Act have either a) failed to live up to expectations others have held for them or b) may have labored under unrealistic expectations set by others.

For example, Title I legislation places very high expectations on an all-volunteer Planning Council.

Among its duties are those related to conducting community needs assessments, comprehensive services planning, service prioritization and budgeting, standards monitoring and service evaluation, and a host of other quite complex and integrated functions. Yet the Commission has for many years been expected to accomplish all these tasks without its own staff accountable solely to it.

Similarly, the Planning Council, service provider agencies, and members of the public have over the years come to expect OAPP to annually oversee an effective, efficient, open, and fair and timely service bidding process, utilizing RFPs, even though a good part of the County service procurement process is outside the control of OAPP.

One difficulty with these expectations is that when they have not been met over a number of years they become, and have the potential to remain, a continual source of frustration and disillusionment among and between partners. Possibly more significant is that over time they may also represent a large opportunity cost by reducing trust, slowing partnership momentum, and effectively shutting off chances for increased cohesion, integration, teamwork, and synergy on a variety of issues and opportunities.

In fact, despite evidence that there have been many opportunities for historically unmet expectations to stall progress, it appears from written documentation, service provider surveys, and key informant interviews, that much progress has been made fostering teamwork, especially over the last twelve to eighteen months.

Examples include OAPP's explicit support for a new Commission staffing arrangement that will allow the Commission to have and supervise its own staff separate from potential conflict of interest as OAPP employees; increased emphasis on combined and integrated strategic planning and comprehensive service planning that meets both Planning Council and Grantee responsibilities; OAPP's and CHHS's combined efforts to create, apply, monitor, enforce, document, and report progress regarding service standards and measures of cost/outcome effectiveness; OAPP's provision of training and technical assistance to provider agencies to meet financial, quality standard, and reporting guidelines; CHHS capacity-building assessments, role and responsibility analyses, organization development planning, technical assistance to meet legislated responsibilities, and training programs for its committees and members; and some reorganization of functions and staffing within OAPP to interface better with CHHS

members and service provider staff.

Expectations that from surveys and interviews appear still to remain either unfulfilled or unrealistic at times include:

- those that assume that the long-term interests and needs of the majority of clients and consumers will always take priority over either the exceptional needs of individual consumers, or established and sometimes inappropriate administrative policies and procedures designed for different situations or applications;
- ones related to OAPP serving in a primarily facilitative and supportive role, rather than a monitoring and enforcement role, relative to service provider agencies;
- the Commission's ability to be perceived as an 'emergency-response community service planning' partner with a role equal in importance, status and authority to the 'implementation' or 'oversight' roles performed primarily by OAPP and DHS;
- OAPP's and DHS's expectations that either their own staff, Commissioners, or provider representatives will fully understand their Title I roles and responsibilities without

regular and continuous compulsory orientation, training, and development programs; and

- OAPP's expectation that consumers and provider representatives will utilize only existing internal communication channels, rather than public political forums, to air concerns or iron out differences in policies, procedures, or operational preferences.

A fundamental distinction regarding *expectations* that would likely benefit from more consideration and more discussion on the part of all Partners (and potential partners) is the difference between what may be considered 'realistic' expectations in the present--and what might ultimately be considered 'reasonable' expectations when all Partners are operating at fuller capacity and with a common goal in mind.

What is 'realistic' may be limited only by current organization capacities and intentions or lack thereof, while what is 'reasonable' may be a matter of conscientiously understanding and diligently preparing for legislated or assumed roles and responsibilities to the highest standard one can imagine and can fund. This approach may reduce frustration with current perceived shortfalls and hold out hope that teamwork can, over the long run, result in reasonable

expectations being mutually satisfied.

SPECIFIC RECOMMENDATIONS:

Similar to resource development efforts by nonprofit organizations, issues related to maintaining and improving relations and teamwork between partners are ones that have no end point and will need to be continually and regularly readdressed in both formal and informal ways.

Specific recommendations that may assist the EMA in fostering increased mutual understanding and fulfillment of mutual expectations may include:

1) establish a formal CHHS mechanism, representing all Title I partners and service providers, to meet regularly to resolve issues and exploit opportunities regarding mutual expectations and divisions of labor to achieve EMA goals and objectives; and

2) formally document, as part of the Title I vision, mission, and values, the priority of HIV/AIDS service consumer health and quality of life outcomes as the primary measures by which the success of HIV care system administration will be evaluated.

WORKFLOW

Because of historical perceived blockages and barriers within the L.A. County government portion of

the EMA administrative mechanism, one of the Commission's requests for the 2002 Assessment was to try to identify some of the ways in which authorizations and approvals-- especially regarding financial expenditures--could be expedited. As a result, this assessment was designed to elicit comments regarding the actual flow of work through OAPP, DHS, and other County government departments upon whose formal approval the release of Federal funds to accomplish the rapid and comprehensive implementation of programs and services for HIV/AIDS consumers relies.

Because there is no centralized work flow data base or document tracking system for Partners' use, determining the direction, speed, and results of document processing is a time-consuming manual endeavor that was only undertaken in a few areas of the administrative mechanism in order to try to verify reports of specific problems. As already discussed, flaws in the service contract procurement system were the most commonly reported example of areas in which workflow and document processing could be improved.

A separate effort, more similar to a financial audit, would be needed to track documents through various departmental processes to provide a more robust and accurate assessment of actual

administrative system utilization. Due to the need for complete access to records and cooperation with employees, it is recommended that if such an audit is desired, the County should assign its own staff to conduct such a confidential internal review.

SPECIFIC RECOMMENDATIONS:

1) OAPP and/or DHS should implement a centralized document data base and tracking system to locate documents, determine their status, expedite their processing, and report on progress; and

2) The Commission should make workflow analysis and efficiency enhancement priorities for a subsequent assessment of the administrative mechanism and/or work with the Grantee to procure technical assistance to accomplish an internal or independent workflow audit, and make system adjustments as needed.

CONTINUOUS QUALITY IMPROVEMENT

ISSUES:

From documents, provider surveys, and key informant interviews it appears that significant gains have been made over the last several years in this function, even despite vacancies in key staff positions responsible for this effort within OAPP.

In fact, quality management has been perhaps the best example of

a Commission/OAPP team effort to assemble a planning, monitoring, management, and reporting system that meets program needs and funding requirements simultaneously.

Among innovations adopted within the last couple of years are increased attention to comprehensive consumer needs assessment; development of a comprehensive continuum of services to meet the different needs of several demographically different consumer groups in different communities; the creation of service standards for many (if not all) services; incorporation of service delivery 'factors to be considered' in the guidance given by the Commission to OAPP along with service priorities and funding allocations; inclusion of many of service standards into service contracts as they are renewed; and capacity-building training made available through OAPP. This training has been designed to assist service providers in interpreting standards, establishing uniform methods and procedures to achieve standards, and collecting data necessary to report on progress.

Within a system of successfully emerging CQI administration, the issues that seem to be growing in importance and may be ripe for focused attention in the near future appear to be in the areas of:

- need for increased sophistication and scope in methods of quality standards development, and data collection, analysis, and evaluation;
- need for increased standardization and use of technology to establish a quality analysis data base and the means to define, monitor, quantify, and report on service quality issues;
- the need for more in-depth and continuous training and technical assistance to County staff and service providers in service assessment and evaluation policies, procedures, practices, and tools; and
- increased emphasis on the utilization of quality assessment, financial, and other statistical data to inform and anchor planning processes focused primarily on consumer outcomes rather than service outputs.

SPECIFIC RECOMMENDATIONS:

Suggestions for the further development and maturation of an integrated, EMA-wide system of Continuous Quality Improvement in which both the Planning Council and Grantee have significant and complementary leadership roles and responsibilities include the following:

- 1) complete the drafting and subsequent refinement of service standards for all Title I services, and insure that they are incorporated in realistic ways into service contracts;
- 2) standardize ranges of unit-of-service costs and determine acceptable cost/outcome measures for each service and for the continuum of care as a whole;
- 3) continue to provide regular and increasingly sophisticated training and technical assistance to service provider and Title I administrative partner staff in areas of service assessment and evaluation policies, procedures, practices, and tools, including automated electronic applications;
- 4) develop and implement a Quality Management database and management system and make it available to service providers to assist with Quality Management monitoring, evaluation, and reporting;
- 5) utilize targeted annual Administrative Mechanism assessments as integral components of the EMA-wide QM function;
- 6) the Commission should undertake periodic evaluations of total quality and impact of Title I planning and service delivery and utilize the results to update the EMA's Comprehensive Care Plan, service priority setting, funding allocations, and achievement of the HRSA goal of 100% access and 0% disparity in care to eligible consumers; and
- 7) County funding should be available to support OAPP in full staffing of the Quality Management function as needed to adequately meet EMA goals and objectives, HRSA-mandated roles and responsibilities, and opportunities for increased funding; and
- 8) all Title I partners, including service providers, should continue to make Quality Management a priority in order to maintain accountability for system outputs and consumer outcomes, comply with funding requirements, improve competitiveness with future funding applications, and implement cost-effective practices to continually lower costs and improve overall cost/outcome effectiveness.

**IX. GENERAL
RECOMMENDATIONS**

A) Efficiency:

'Efficiency' is a relative term that allows one to compare systems and processes that arrive at the same outcomes with variability in time required, resources expended, and directness of cause and effect, among other possible variables.

Systems and processes that are complex, representative, open, fair, and accurate often take more time, effort, and care than systems and processes that are not. Additionally, organization processes with political elements and built-in checks and balances are often not efficient ones.

While Title I of the CARE Act requires planning councils to assess and document the relative efficiency of administrative mechanisms designed to rapidly distribute funding (in the form of appropriate services) to areas of the community in greatest need, compliance with a variety of legal and ethical requirements often prevents development and implementation of executive systems of the greatest efficiency.

Nevertheless, there are a variety of areas where improvements could be made if improving the efficiency of the administrative mechanism were of the highest priority.

While several suggestions have already been made in this regard, especially with respect to administrative processes related to the procurement of services, a general suggestion would be to for the planning council and grantee to make efficiency a higher priority in the evaluation of the administrative mechanism.

Implementing this general recommendation can be done in many ways, but setting up systems to formally measure, monitor, and report cost/productivity and cost/outcome effectiveness of services and administrative systems on a regular basis would be a starting point.

Once productivity and outcome measures are in place, the goal of improved efficiency, evidenced by improved cost/output and cost/outcome ratios, could be accomplished through a number of activities already suggested.

These could include a variety of ongoing performance enhancement activities, such as work processing audits, organization structure analyses, staffing productivity assessments, and efforts to automate work flow with improved computer and communications technologies.

As a first stage of implementing the goal of improving the efficiency of administrative systems, perhaps a simple focus on implementing

new measures to reduce its costs, without effecting productivity or consumer outcomes, would be worth monitoring, documenting, and reporting, either periodically during the year, and/or as a major feature of the next annual assessment of the administrative mechanism.

B) Effectiveness:

Effectiveness' relates to the ability to produce measurable results or outcomes over and above the simple completion of processes and activities. In the case of HIV/AIDS services, it relates specifically to the health and quality-of-life outcomes created for consumers through the implementation of services and the execution of administrative steps necessary to deliver those services.

A necessary precursor to the process of improving administrative mechanism *efficiency* by comparing the cost/output and cost/outcome effectiveness of different ways of selecting, producing, delivering, and evaluating services, is to determine the particular consumer outcomes desired in the first place and the criteria by which achievement of those outcomes will be determined.

At some point in the future it would a positive development for the EMA to focus on monitoring, documenting, and reporting

targeted consumer health and quality-of-life outcomes as barometers of the effectiveness of service priority setting, service funding, service contracting, and service delivery.

This step in the evolution of the administrative mechanism will require a variety of new policies, procedures, and methods. Starting with new definitions of services and service standards expressed in terms of measurable consumer outcomes, methods and systems of monitoring, measuring, documenting, and funding processes and procedures will need to become focused on effects, rather than activities.

While HRSA has for a number of years tried to channel EMA standard setting and evaluation efforts in the direction of focusing on planning, delivering, and evaluating HIV/AIDS services based on measurable consumer health and other quality-of-life outcomes, progress in this area has been slow. In this regard, it appears that the Los Angeles County EMA is no worse off (and might well be better) than most EMAs nationwide; nevertheless, the opportunity remains for it to be one of the first EMAs to develop standard setting, contract enforcement, evaluation, and funding systems based on the achievement of measurable consumer outcomes, rather than service provider activity.

C) Relationships:

One of the potentially most promising developments that has been discussed for a number of years (and is in process as this report is being written), likely to have a substantial positive impact on the relative efficiency of the administrative mechanism, is the imminent change in staffing systems designed to execute the responsibilities borne by the planning council under Title I of the CARE Act.

Partly because Title I legislation has never provided for the establishment of planning councils as independent legal entities, EMAs nationwide have struggled with ways to develop strong planning councils with the authority and human resource capabilities to carry out their legislated roles and responsibilities.

By leaving the grantee administering agency role and funds in the hands of governmental agencies (and primarily departments of public health), federal legislation and commonly accepted interpretation of administrative policies have caused significant confusion regarding sources, funding, and supervision of staff available to planning councils.

Often with interests and predispositions somewhat different from those of the planning council

volunteers they are obligated to serve, government grantee staff are often required to provide leadership to processes involving advising, counseling, monitoring, and evaluating their own work and the work of their grantee employer.

As a result, planning councils have often had a difficult time balancing their need for personnel, on one hand, with the responsibility to carry out legislatively prescribed roles and responsibilities not identical to, and some times in conflict with, the interests of and administrative expediciencies available to grantee staff, on the other hand.

Without an effective way to hire and supervise their own staff, planning councils nationwide have by and large been forced to accept the services of department of public health employees over which they have no direct legal authority. Effectively, this has meant that day-to-day planning council activities and operations have remained under the direction of the grantee administering agencies, even though legislation calls for a clear separation of roles and responsibilities in many areas.

Besides confusion over issues such as staff supervision and accountability, the setting of work priorities for staff to planning councils has been a constant source of frustration and

controversy in many EMAs.

It is clear to almost all staff and planning council volunteers involved that maintaining a separation in grantee and planning council responsibilities also requires a separation in staff positions and supervisory systems.

For the Los Angeles County EMA, the sooner this transition to independent staffing of grantee and planning council roles takes place, the sooner potential conflict of interest issues will dissipate, task priorities will be clarified, and staff accountability can be efficiently monitored and enforced.

D) Leadership and Accountability:

During this assessment of the administrative mechanism, it is clear that new, wider-ranging, and more comprehensive levels of strategic leadership have been achieved within the Los Angeles County EMA over the last several years.

From new strategic planning initiatives, to more comprehensive and robust service planning processes, to implementation of new quality management systems and policies, it appears that both the grantee and planning council have become more proactive and assertive partners on behalf of HIV/AIDS service consumers and

the communities in which they live.

Nevertheless, one of the recurring issues encountered during this assessment and the previous one is a sense of continuing frustration on the part of many Title I partners, service providers, and consumers concerning lack of system accountability and unclear locus of authority.

Most easily noticed in the areas of service procurement process management, implementation of computer-assisted information technology, and compartmentalization of staff functions and responsibilities among several county departments and divisions, the grantee administrative mechanism still appears at times to suffer from a lack of continuity and focus.

A typical criticism from interviews done as part of this assessment is the sense that there is no single entity or individual to whom one can point as the source of authority or accountability for Title I activities and results, or the lack of them.

Certainly, it would not be fair to attribute this perceived lack of clear leadership solely to County administrators and staff responsible for implementing Title I legislation. Title I legislation itself, and the morass of administrative systems, relationships, and entities created by it, have tended to dilute

authority and leadership for the operation of a comprehensive emergency response to the HIV/AIDS pandemic.

Nevertheless, when systems don't function as planned, when tasks are delayed, or when outcomes are not delivered, some single entity must eventually accept responsibility for the problems encountered and for the solutions developed to counteract them.

In the few specific cases when administrative systems appeared upon investigation to be flawed, the experience of this assessment was that individuals and departments tended to lay blame on others—whether it be the 'County system' or 'political process' or whatever.

Leadership is more than taking credit when things go right; it also means taking credit when things go wrong. Leadership requires a constant and conscientious effort to make sure that everything possible is done to insure smooth operation of processes that produce optimal, and even extraordinary results. When failures occur, they represent opportunities to learn, experiment, and improve. Some one entity or individual must fill this leadership role and take on these leadership responsibilities for any administrative system to truly work.

With all the positive changes encountered since the last assessment, and new developments achieved during the course of this one, that kind of leadership promises to be a characteristic of the next evolution of the Los Angeles County EMA Title I administrative mechanism.

San Diego, California
August, 2003