SAN FRANCISCO HUMAN SERVICES NETWORK

SUMMARY OF NONPROFIT AGENCIES' CONTRACTING ISSUES WITH THE DEPARTMENT OF PUBLIC HEALTH
Presented to the Health Commission on October 17, 2006

We are submitting this memo to formally express our frustration with the Department of Public Health's implementation of the City Nonprofit Contracting Task Force's recommendations and our **concerns about the larger systemic and cultural issues within the Department that hamper the recommendations' full implementation.**

Since June 2006, HSN has conducted outreach through our membership and contractors' associations to enhance the feedback gathered through the Office of Contract Administration's (OCA) nonprofit survey on contract reform. DPH is the department most frequently cited in contractor complaints, particularly CBHS and the AIDS Office. The Task Force's report was issued over three years ago. Today, from the perspective of a significant number of contracting agencies, there are still tremendous problems and a lack of demonstrable progress in many key areas. In some areas, **the process of contracting has actually worsened.** These problems consume far more staff time and funds than necessary, which diverts resources from crucial client services.

Before detailing the problems with DPH, we want to note the significant progress that has occurred in several <u>other</u> Departments. We applaud the Controller's Office for their dedication to both the spirit and letter of the recommendations, particularly their leadership on the development of joint monitoring protocols and procedures that have greatly streamlined that process. In addition, we offer kudos to DCYF, DHS and DAAS for implementing early contract certification, timely payments and efficient electronic systems, and the generally helpful nature of their staff.

<u>Late Contract Certification and Payments</u>
In several ways, DPH's contract processing is worse than it was three years ago when the Task Force report was issued.

- 57% of the nonprofits reported problems with late certification and/or payments for their 05-06 contracts (source: OCA's June survey, includes all Departments). One DPH contractor had to lay off two staff in July, re-hire them in August with added-back money, and subsequently lost one staff due to uncertainty of funding.
- Contractors suffer cash flow crises and accrue interest charges on lines of credit because contract certification and invoice processing is commonly delayed. Several agencies have depleted reserves because of the costs of DPH late payments. One agency was cited during a monitoring visit for a lack of sufficient reserve funds, while their aging receivables from DPH often total more than one million dollars in arrears beyond 60 days.
- DPH has implemented several policies to try to address the problems with late certification: 18-month contracts (replacing the "continuing resolution") and the addition of 12% contingency funds in the original contracts. Some divisions implemented both policies for contracts, some provided a choice, and some made an arbitrary decision on behalf of the contractors without consultation. It would seem that two important principles of streamlining (contractor input and consistency across the Department) were not considered.

- The new 18-month contract with CBHS required little additional contractor staff time. However, 18-month contracts with the AIDS Office and HUH actually double the contract preparation workload of the contractor.
- In an attempt to have more contracts certified on time, DPH staff has been pressuring contractors to agree to "shell" contracts going before the Health Commission for approval, where the dollar amount, units of service and outcomes will be determined later. However, by removing the pressure of getting the document before the Commission, there is then little incentive to speedily complete the process – and full certification and ability to bill are actually delayed rather than accelerated.
- The AIDS Office has almost never certified contracts by the start date of services, and this year's Cost of Doing Business (CODB) increase exacerbated the usual delay. There are always two options: to move the contract expeditiously and modify it later, or to let the whole process languish until the full dollar amount is known. Rarely are contractors asked which option they would prefer – and neither is wholly satisfactory.
- The documents for many 06-07 contracts came out in May for contracts that began in March.
- It is extremely challenging to reconcile DPH full-year contracts with interim agreements at year-end, often requiring amendments or full budget modifications and a re-invoicing of 6 – 12 months' billings, even though the contractors reported expenses have not changed, but only the DPH budget amounts.
- Contracts that do not have to go before the Commission are put on the back burner indefinitely.
- One agency routinely provides a full year of service before one of their DPH contracts is even certified. The program continues only because it is a relatively small contract within a large agency.

Lack of Standardization:

The resolution of concerns or disputes during contract development usually depends on who the program manager is, rather than policy or procedural standards. There should not be different requirements with different program managers or between divisions.

- Inconsistent resolution of disputes: When an individual agency is finally forced to take a contracting problem to Dr. Katz, a solution is quickly reached and DPH staff does implement the needed change. However, the solution is not implemented for other agencies nor are others ever notified of it. In addition, the resolution often applies to the specific contract year only, and the problem reappears the following year.
- Administrative systems are not integrated: Each division has its own data entry system, and they don't "talk" to each other. Substance Abuse, Mental Health and AIDS Offices may have the same contractors and clients, but service providers must enter the same basic information into three databases. Divisions also have separate and distinct monitoring and reporting processes.
- COOL and contract development: DPH award letters informed contractors that COOL is mandatory for contract development for all 06-07 contracts. After complaints from mental health providers, DPH stated that COOL really is not mandatory and agreed that it still has problems. However, DPH failed to disseminate this information to its entire body of contracting agencies, so the provider community is still operating on disparate information regarding an important policy issue. Additional training and technical assistance for contractors and for DPH staff are needed before the system should be mandatory.

- COOL as a document repository: While the COOL system is generally appreciated, there are still some inconsistencies with contractors' COOL files, including the posting of expired contracts, essential information not posted, and incorrectly filed documents.

Unnecessary Contract Requirements:

Contractors feel that DPH exerts a higher level of control over the process of service delivery than necessary. As examples, they cite contract requirements with an unnecessarily high level of specificity in staff training, daily program schedules (which should be fluid throughout the year in response to client needs rather than static) and in design of client satisfaction surveys. Most contractors do not feel they can challenge DPH on unnecessary requirements.

- Performance Measures: While all contractors agree with the Health Commission's desire to see more client **outcome** measures in the contract, the DPH response was to develop these in isolation from both the contractors and the consumer community. In a large number of contracts, the outcome measures bear little or no relationship to the actual needs of the clients being served. Additionally, the number of "process objectives" controlled by DPH is staggering in comparison to other City/County departments.
- Document submission: Contractors should have to submit documents (legal, insurance, corporate, etc.) only once. The document repository is still not fully in place, and AIDS Office contractors are still asked repeatedly for documents that they submitted to COOL. Likewise, every division insists upon its own copies of Board membership rosters, annual audits, etc.
- The annual cultural competency report is extensive and overly burdensome. It currently covers all program activities, all partnerships, all collaborations, and many things unrelated to the actual cultural competency of service provision. The report should be shortened to only relevant areas. A brief annual update for agencies with long records of strong compliance should be enough.

Monitoring:

- Monitoring criteria and goals are often developed by DPH staff without contractor input.
- DPH has subsequently added monitoring criteria not included in original contracts; data was therefore not collected, and the agencies had to negotiate not to be penalized.
- Monitors sometimes lack knowledge of the systems they are monitoring, which makes it difficult to prepare and, in some cases, explain procedures.

Contract Consolidation:

Half of the surveyed nonprofits believe they have contracts that should be consolidated. These include contracts within Departments (even when the funding comes from separate sources), and between different Departments when contracts fund the same program with similar goals and outcomes, particularly between DPH and DHS.

- One organization with several DPH-CBHS mental health contracts stated that their separate contracts are an impediment to their efforts because they force the agency to work with clients as if they only have one diagnosis while most clients are dually or multiply diagnosed. The current efforts at integration do not take into account the differing state requirements, and the (previously cited) different clinical and fiscal data bases.
- A few organizations reported that they have been forced to consolidate inappropriate contracts. Consolidation should not occur when the nonprofit opposes it.

Systemic/Cultural Problems within DPH:

The above problems are deeply rooted within the bureaucratic culture at DPH. While the City depends on the nonprofit sector to deliver what are often basic, last-resort, safety-net services, the providers are not regarded as partners by many within the DPH staff. When the original Task Force embarked on the contract streamlining process, we underestimated the power of this culture to resist change.

- Changes made to fulfill the Task Force recommendations have often superficially addressed the symptoms while perpetuating the problems. They are often made in a reactionary mode without consulting contractors, who may have proposed better options, or at least pointed out some of the complications in advance.
- Contractors feel that program monitors should be both fiscally and programmatically knowledgeable, and willing to provide resources and technical assistance. Regular DPH staff training is needed to provide hands-on technical assistance for contractors at their sites.
- Many providers' experience is that DPH staff see their role as policing, especially in the AIDS Office. Contractors spoke of program managers inappropriately threatening contractors with consequences, and holding up contracts over small things like sentence structure.
- Poor communication between DPH staff and contractors, and also within DPH between contract and program staff often causes delays in contract certification and wastes contractors' time. For example, mandatory meetings often come with short notice. Some meeting notices do not provide an agenda or indicate appropriate level staff to attend. One Executive Director went to a mandatory Directors' meeting, which was a four-hour training for finance staff. Communications at meetings are often unprofessional and patronizing.
- DPH senior management directives are commonly ignored by middle managers and line staff. Staff make isolated, independent decisions about contracts without consulting contractors, visiting the program site, or speaking with staff or clients. Staff seem unwilling to seek additional information when contractors confront them about changes that the Department has agreed to implement.

HEALTH COMMISSION ACTION NEEDED:

We are requesting that the Health Commission:

- Formally and specifically address these problems by adopting policies, procedures and practices to hold departmental staff accountable for correcting the issues, utilizing contractor input and seeking best practices from other departments for possible replication.

- Review organizational structures within each division and across divisions for standardization and the most effective use of human resources.

- Develop performance measures for each division in the areas cited; and provide for regular reports to the Commission at public meetings until these issues are resolved.

Thank you for providing us with this opportunity to present our views before these issues go before the Board of Supervisors at their November 13 hearing. We look forward to working with the Commission to dramatically improve the contracting process. We are hopeful that such changes can be implemented, since other Departments have made significant improvements.

Timely and efficient contracting processes will allow nonprofits to devote more staff time and resources to providing vital health and human services for vulnerable San Franciscans, the goal we all share.