# CONTRACT REFORM FOCUS GROUP REPORT
## San Francisco Human Services Network
## February 25, 2008

**Background**

HSN conducted six focus groups in November and December 2007 to solicit feedback from nonprofit contractors about the City of San Francisco's progress in implementing contract reform recommendations. Questions focused on the 13 recommendations of the City/Nonprofit Contracting Task Force report of June 2003 and on the 10 agreements between HSN and the Department of Public Health in November 2006.

We conducted conversations with the following groups: the Mental Health Contractors Association, the Substance Abuse Contractors Association, the HIV/AIDS Providers Network, the McKinney Contractors Association, and the Coalition of Agencies Serving the Elderly. We supplemented this feedback with a sixth focus group conducted at an HSN general member meeting, and through outreach to our members for e-mail feedback. Almost 100 people participated in the six focus groups.

**Task Force recommendations**

Consolidate contracts
Document repository
Timely certification
Timely payment
Unnecessary requirements
Electronic processes
Standardized forms
Monitoring (joint monitoring, standard protocols, training, tiered assessments)

**DPH agreements**

Annual contract negotiations
Data disagreements
Training for DPH program staff
Contract changes to be negotiated
Use of COOL, including training
Contractor satisfaction survey
Contractor feedback on policy changes
Streamline cultural competency report
Streamline contract narrative

## General feedback to all city departments

Document repository: Contractors expressed a desire for progress in creating a document repository that is accessible by all departments.

Timely certification: In all departments, when city staff are out sick or on vacation, all progress stops.

Timely payment: The electronic payment process is a major improvement.

Joint fiscal monitoring: Contractors appreciate the Controller's leadership and the progress by departments in implementing joint monitoring. However, some still find it overwhelming and urge the city to do more training with monitors.

Contractors request more clarification regarding the criteria for self-assessment versus site visits, and how those criteria were applied to their agency. Contractors also report that some departments continue to conduct fiscal and compliance monitoring during program site visits.

**Department of Public Health**

Document repository: No contractors reported multiple requests for documents.

Timely certification: Some contracts were certified fairly quickly, and others are still not done. Most feel it has improved. Most experienced delays of 1-2 months, and reported fewer long delays than in past years. But there are still some egregious delays, including contracts still uncertified as of November (mostly CBHS and CARE). Late certification has many implications for contractors, including cash flow problems and additional work to reconcile contracts and invoices. This continues to be an area of concern, and we strongly encourage DPH to begin the contracting process earlier.

Contractors also cite a lack of balance between deadlines given and responded to, rather than a cooperative partnership. Contract and program managers often have unrealistic expectations regarding sufficient time for contractors to respond to requests. Yet they don't hold themselves to the same standards, and contractors sometimes wait months for a response.

HIV/AIDS Office: The contract development process continues to be unnecessarily slow, and certification is never on time. The Office should begin the process earlier.

The AIDS Office also has not adjusted to the current calendar realities. Their process revolves around the March 1 CARE award, while half the funding now comes from general fund dollars budgeted on July 1. Yet program managers don't seem to be aware of what is going on with the Board's process. For example, they didn't know about the cost-of-doing-business (CODB) increase for those that had grants backfilled by the general fund.

18-month contracts: Contractors give mixed reviews of the 18-month contract. They prefer the option because they can continue to bill when certification is delayed, but note that it creates double work in order to redo invoices.

Timely payment: Contractors provide services for months before reimbursements begin. The primary causes of payment delays continue to be late certification and non-receipt of invoice templates in order to bill. Some contractors report that even after signing the contract and receiving the template, the department is not yet ready to receive invoices and does not inform them when they are ready. However, once everything is in place, contractors experience a prompt turnaround on most invoices. The direct deposit system works very well.

Unnecessary requirements: When the funding source moves to general fund, requirements from the previous funding source should not carry over. One example concerns about five additional budget pages in CARE contracts (presumably required by federal regulation, though that is unconfirmed). HUH then adopted these pages when it was first created, and the requirement has hung on as "the way we always do it" for both CARE and general fund contracts. There is no reason to continue this requirement for general fund contracts.

Program monitors often monitor things that are not in the contract. Contractors should be evaluated based on what they sign a contract to do. If there are other evaluation criteria, contractors need to know ahead of time.

HIV/AIDS: The replacement of some CARE funds with general fund dollars has led to much more work. Contractors have one multi-year contract, but have to do three separate budget exhibits and invoices (CARE, general fund, and general fund restoration). In contrast, DAAS

tracks these funding streams internally. This cumbersome process needs joint problem solving and perhaps the establishment of a citywide best practice.

Monitoring (joint monitoring, standard protocols, training, tiered assessments): Contractors say most (75%) but not all monitors know the program and know what they're doing.

Many contractors feel that they are monitored and held accountable for things that were never requested before, and that there is no appeal process. Resolution of problems is episode-specific, and does not become a generalized solution or policy.

Outcome objectives are evaluated based on data from the first 6 months of the year, and that data goes in a report to the Health Commission. However, some contractors regularly experience higher data at other times. For example, variable data results when nonprofits expand their programs with interns for part of the year. The data should be annualized to reflect the last 12 months, or the period since the last monitoring. Contractors question what would be the most meaningful data for the Health Commission and how to pro-rate it in order to best show whether the contractor performed.

Some contractors noted that they did not receive feedback on their monitoring reports in a timely way, and had no opportunity to address issues before their contract went back to the Health Commission.

A few contractors report that they still receive multiple site visits, and want to see more joint program monitoring.

HIV/AIDS: Contractors feel that monitors often miss the core of what they do and focus on little things that may not even be relevant to the contract. They then get a lower score even if they over-achieved and did their best job. Contractors are very concerned about this because the monitoring report is a public document, and they feel the problem is getting worse. There are supposed to be standards, but evaluation and scoring are also subjective based on who is doing the monitoring; for some monitors, it's black and white, and with others, it's all grey.

Contractors also feel the process is very rote. It's about completing the file and checking the boxes.

Annual contract negotiations: Much of the feedback on the first year of annual contract negotiations was positive. The negotiation is an important venue that provides an opportunity to discuss things you see coming up. However, contractors have several suggestions for next year.

The most frequent comment is that decision-makers need to be present. Contractors expressed appreciation about having a conversation with several DPH staff. But it is not really a negotiation if decision-making takes place through passing messages up and down the chain of command. Some felt that their meeting was more about what the department wanted to tell them than about hearing from the contractor.

Negotiations should begin earlier and be more substantive. Contractors also wonder about how to negotiate around longterm issues that go beyond the contract's 12-month framework, and strategize together to resolve them.

Contractors also are concerned about whether and how information will be captured and travel in a meaningful way that leads to follow-through. At minimum, minutes should be written immediately after the meeting to memorialize agreements.

Finally, contractors should not have to fill out a form to get a negotiation. In addition, AIDS Office contractors said they did not receive the form.

Data disagreements: Data disagreements have been resolved, but discrepancies are frequent, and it's labor-intensive.

Use of COOL, including training: Contractors feel COOL is great in concept but was rolled out without appropriate DPH staff and contractor training. Some lack the confidence to upload their own documents, but when they email it in, their contract managers don't upload it to COOL.

Streamline cultural competency report: Contractors received timely information about the streamlining, and appreciate the new format.

Streamline contract narrative: Positive feedback for getting rid of the budget narrative and standardizing objectives in CBHS. Exhibit B is better, but some contractors felt that the changes were not adequately communicated in the instructions.

RFPs: Positive feedback on the specificity of DPH RFPs (as compared to HSA's, which are often vague). But response deadlines are tight, and then contractors are left hanging for months waiting for a response.

Relationship with contract and program managers: Most have a good or great relationship. For example, one contractor said that these people care about the clients and the kind of job we're doing, and are pretty reasonable; we have shared values, even if we don't always agree on the specifics. However, contractors also feel that program managers used to be like coaches to help them provide better services, and now, they are just paper-pushers. Substance abuse contractors gave special praise to one program manager who they feel really fights for their programs. A few contractors reported that their contract or program managers are not helpful.

Contractor training and meetings: Contractors appreciate that trainings and meetings are generally noticed well ahead of time, with input into the best date and time.

Cultural competency is an unfunded mandate. It's expensive to bring in trainers, and departments should help programs fund trainings and awareness. Contractors feel they need more support and training on what DPH wants.

Communication issues: DPH divisions still do not work together when it comes to integration of administration. HIV/AIDS is especially fragmented, and is structured such that nobody has the authority to make decisions.

Very strong praise for Barbara Garcia's accessibility and willingness to meet regularly and work together to discuss and resolve mutual concerns.

Substance abuse contractors feel the system is working well because of Jim Stillwell's open-door policy. You can email him, and he will respond.

## Human Services Agency (DHS and DAAS)

Department/contractor relationship: HSA contractors have concerns about the department/contractor relationship. Recent issues arose with the Homeless Employment Collaborative, including analysis and outcome standardization without contractor input, and changing the scope of services mid-year without negotiation. Other issues relate to high-level decisions imposed on contractors without negotiation, and difficulty in getting a meeting with the decision-makers. For example, Integrated Service Network contractors were told about changing the scope of services from place-based to roving teams; contractors had several meetings with program staff that had no authority, and couldn't get a meeting with decision-makers until they sent a letter to everybody.

Communication between contractors and decision-makers: Typically, HSA staff that facilitate meetings with contractors are not the decision-makers, and are there only to tell contractors to implement new requirements.

Nonprofits would like to see a closer collaboration with decision-makers. Contractors feel that they used to be part of the decision-making and community process within HSA, but now, HSA just decides and announces it at a meeting. This leads to reactive responses rather than a true partnership. A proactive problem-solving approach that recognizes nonprofit expertise would be healthier. The final decision may still be unpopular, but at least it would be reached through a mutual process.

Other communication issues: HSA has a clear division between the roles of the contract and program sides. They do not communicate with each other, leading to contradictory information and directives. This applies not only to program and contract managers, but at higher levels within HSA. Contractors feel that both sides should negotiate contracts together.

Contractors have expended funds because they were not aware of policy changes (for example, the policy that bottled water and water coolers for clients are no longer reimbursable). Departments should issue memos, and should not penalize contractors when changes are not communicated.

Contractors also report problems due to poor communication and planning between entities, leading to delays and redundancy. Examples include delays while waiting for HSA and HUD to communicate, and duplicative work due to conflicting information on whether to use HSA or DCYF budget forms.

Document repository: DHS contractors reported few problems, though one had to send their insurance documents in three times to four different places, rather than submitting only once.

DAAS contractors say that DAAS is not using COOL, and contract managers still ask them to send documents for every contract.

Timely certification: Generally positive feedback on general fund contracts. Praise for HSA beginning the process early. Most contracts are certified with minimal delay.

Some problems with non-general fund contracts. Some contractors reported issues and delays with their McKinney funding, including lack of notification, communication problems about who to talk to on the program side, a new person that couldn't explain new provisions,

outcome objectives increased without HUD requiring it, slow response to questions, and changes to the contract without discussion.

DAAS contractors reported that contracts are certified on time, and that the department really tries to certify contracts by the start date.

Timely payment: Contractors praised the new electronic payment process. One DAAS contractor called it "the best thing they ever did." Payment used to take 1.5 months; now it takes days.

Unnecessary requirements: Contractors reported possible unnecessary requirements including new program requirements and separate budgets for each funding source.

The level of budget detail differs with different contracts. Some can't be changed by even minor amounts without a budget modification. Is this level of detail required by the funding source?

DAAS contractors with meal programs feel their contracts are micromanaged and subject to excessive bureaucracy, including multiple forms to back up fees-for-service, on-line OOA reporting, unnecessary reporting of the number of meals/day/site, and showing that every signature is authentic. Reservation and signature requirements are a barrier for seniors and those with mental illness. Requirements were imposed without discussion, and take time away from providing services.

DAAS contractors also say the department is asking for less paperwork in some programs, but has not confirmed these things are no longer needed, so they continue tracking data out of fear. (E.g. counting inventory at the beginning and end of every month for nutrition programs). Contractors also question whether some data requests are federally mandated (e.g. tracking the number of hours of staff activities at senior centers; some OOA intake data).

The taxi voucher program leads to unnecessary requirements because it operates under both DPH and HSA. Contractors have to do two reports, and get confused over which program expenses fit under. They should be consolidated by work order.

For case management under DAAS, there is a communication gap about whether a full assessment is required. Short and long-term case managers are doing a 2-hour assessment for everybody. At a meeting, DAAS said this isn't necessary for all clients, but the form says it is.

Standardized forms: Contractors would like HSA to explore ways to streamline the budget narrative and other contract documents.

Monitoring (joint monitoring, standard protocols, training, tiered assessments): The joint monitoring process is useful and shows recognition of the need to reduce duplication. But it can be overwhelming. More training for monitors is needed, and it needs to be well controlled.

DAAS contractors feel that monitoring still needs more consolidation. They report multiple visits for fiscal, program and administrative monitoring, on top of OOA monitoring. They also note very different and inconsistent experiences with different fiscal monitors. For example, some want few documents, and some want all of them.

Contract negotiations: DAAS contractors say there are no negotiations, except in a few cases where contractors pushed for discussion. Even when responding to RFPs, contractors often don't get what they propose. The department won't cover the whole cost, tells contractors their rent is

too high, or tells them how to spend the money. The experience varies with different program managers.

RFPs: RFPs are not specific enough. Response deadlines are too tight, then contractors wait for months to hear back. Contractors also ask HSA to spread out RFPs so they are not happening all at once just before the holidays.

Relationships with contract and program managers: Relationships with most contract and program managers are positive, helpful and friendly. Over the years, there has been good follow-through with program and contract managers. But some DAAS contractors said their communication with their program analyst is not good, that they get different answers from different people, or that the program analyst feels they can't or won't advocate for them. Contractors want their program analysts to be more helpful with problems, rather than just passing on information and managing the contract.

Contractor training and meetings: DAAS contractors say most meetings are not mandatory, and DAAS does a good job of providing advance notice. They say that trainings have been useful (e.g. case management and waiver application training). They have asked for RFP technical support training, but this has not happened. They note that MOCD has done trainings through Compass Point and/or given training vouchers, and would like to see DAAS do this.

Cultural competency: HSA's fiscal monitoring includes a piece about cultural competency, which is an unfunded mandate. Contractors want more support and training by departments, including funding for trainings and awareness.

Data collection: Some contractors have been locked out of the Homeless Management Information System due to technical problems. But at the same time, contractors must report on the monitoring form as to whether they are up to date and in compliance. Developing a system that allows them to upload their data will be good, but right now, the system doesn't work.

Cost-of-doing-business increases: DAAS blended federal, state and local funding and provided the 3.45% CODB increase on everything. They were the only department to recognize the impact of flat funding on all services, regardless of the funding source.

**Mayor's Office (MOCD, MOCJ, MOEWD, MOH)**

Document repository: MOEWD does not seem to be aware of the document repository in COOL or of the streamlining process. For example, MOEWD requested that contractors submit copies of two years of Workforce Investment Act fund audits that are accessible on-line.

Timely certification: At MOCD, the process is good. There are good managers in place, and they are incredibly responsive. But contractors report that this year has been the slowest ever for MOH funding.

Unnecessary requirements: Contractors appreciate MOCD eliminating the requirement for Board signatures on invoices.

MOCD recently began requiring payroll records and verification of payment of payroll taxes with submission of invoices.

MOCJ's monthly invoicing protocols require copies of all invoices as documentation for every penny of expense. This requirement is unique and burdensome.

Electronic processes: As with COOL, $7c^2$ is great in concept but was rolled out without appropriate training. The department doesn't always know the answers to questions, and small bugs take up a lot of time. But the second year with $7c^2$ at MOCD is markedly better. Contractors appreciate the lessons learned and changes made.

Monitoring (joint monitoring, standard protocols, training, tiered assessments): One contractor received a joint monitoring, then six months later, MOCD wanted everything again, including standard documents that should be in the document repository.