

**Performance Audit of
Professional Services Contracts:**

**Department of Public Health and
Human Services Agency**

Prepared for the

**Board of Supervisors
of the City and County of San Francisco**

by the

San Francisco Budget and Legislative Analyst

November 8, 2012

TABLE OF CONTENTS

Executive Summary	i
Introduction	1
Profile of Contracts in the Department of Public Health (DPH)	5
Profile of Contracts in the Human Services Agency (HSA).....	10
1. Effectiveness of Program Performance Monitoring at DPH	14
2. Effectiveness of Program Performance Monitoring at HSA	26
3. DPH Sole Source Contracting	37
4. Effectiveness of Corrective Action Process.....	48
5. Use of Contingency Reserves at DPH	60
Response to the Audit and Recommendations from the Department of Public Health and the Human Services Agency	68

BOARD OF SUPERVISORS

BUDGET AND LEGISLATIVE ANALYST

1390 Market Street, Suite 1150, San Francisco, CA 94102 (415) 552-9292
FAX (415) 252-0461

November 8, 2012

Honorable Mark Farrell,
and Members of the Board of Supervisors
City and County of San Francisco
Room 244, City Hall
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689

Dear Supervisor Farrell and Members of the Board of Supervisors:

The Budget and Legislative Analyst is pleased to submit this *Performance Audit of Professional Services Contracts: Department of Public Health and the Human Services Agency*. In response to a motion adopted by the Board of Supervisors on March 6, 2012 (Motion No. M12-031), the Budget and Legislative Analyst conducted this performance audit, pursuant to the Board of Supervisors powers of inquiry as defined in Charter Section 16.114 and in accordance with U.S. Government Accountability Office (GAO) standards, as detailed in the Introduction to the report.

The purpose of the performance audit was to examine the departments' management of professional services contracts, including how each department determines the need for professional services, and measures and reports service levels and changes; policies and procedures for contract performance and performance measurement; and department-wide contracting policies and compliance.

The performance audit contains five findings and 17 recommendations. Nine recommendations are directed to the Director of Public Health, one recommendation is directed to the Health Commission, four recommendations are directed to the Executive Director of the Human Services Agency, two recommendations are directed to both the Department of Public Health and the Human Services Agency, and one recommendation is directed to the Controller.

The Director of Public Health, the Executive Director of the Human Services Agency and the Controller have provided written responses to our performance audit which are attached to this report, beginning on page 68. In total, these departments agree or partially agree with 15 of our 17 recommendations, or 88.2 percent, and disagree or partially disagree with two of our 17 recommendations, or 11.8 percent.

In their written responses, the Director of Public Health and Executive Director of the Human Services Agency disagree with Recommendation 4.1, which states that HSA and

Board of Supervisors
Budget and Legislative Analyst

DPH should clarify internal monitoring and corrective action policies to more accurately reflect the Citywide Nonprofit Corrective Action policy, including (1) developing clear measures and timeframes for when monitoring findings (of nonprofit contractors' performance) should be brought forward for the City's Corrective Action process, and between each stage of the process; and (2) developing standards and guidelines for the amount of technical assistance and financial support provided to nonprofits through the Corrective Action process.

- The Director of Health states that it is more appropriate for the Controller's Office and Joint Fiscal and Compliance Advisory Group to respond to the recommendations, as the Corrective Action Policy is a Citywide policy.
- The Executive Director of HSA states that the Agency prefers to work with underperforming contractors on a case-by-case basis to ensure that neighborhood services can continue to be provided by organizations that understand community concerns.

However, the Budget and Legislative Analyst notes on pages 54 through 56 of the performance audit report that both DPH and the HSA have "not established clear standards and timeframes for support provided to nonprofits throughout the Corrective Action Process...Without specific timeframes between each stage of the Corrective Action Process and standards for how the City should support nonprofits on a corrective action plan, through technical and financial assistance, the City could continue directing resources toward underperforming contractors, at the expense of identifying alternate service providers that could continue providing the same services to underserved populations." Pages 54 and 55 of the audit report provide examples of variations in the type and amount of support provided to DPH and HSA nonprofit contractors. For example, as noted on Pages 54 and 55, pertaining to 12 nonprofit contractors standard correction action plans as of March 2012, "six of the contractors faced 'financial stability' problems and five of the contractors experienced issues with 'financial management practices'. but the DPH never increased such contractors to a higher level of corrective action and the funding for such contractors from the City was never jeopardized. Although the DPH offered technical assistance and additional resources to these contractors, two of the contractors reached such dire fiscal circumstances that the contractors ceased operations, and two other contractors continue to be monitored for ongoing financial management concerns."

While our performance report also recommends in Recommendation 4.1 that the Controller revise the Citywide Corrective Action Policy to strengthen the guidance regarding the amount of time and resources that should be given between the various stages of corrective action, the Budget and Legislative Analyst believes that both the DPH and the HSA should also modify their own policies to provide additional guidance.

The Controller also disagrees with our Recommendation 4.1, which states that the Controller should "Revise the Citywide Corrective Action Policy to add more specificity regarding the amount of time and support that should be given to nonprofits *between*

Honorable Mark Farrell,
and Members of the Board of Supervisors
Performance Audit of Professional Services Contracts: DPH and HSA
November 8, 2012
Page 3 of 3

various stages of the corrective action process (i.e. the time allowed for improvement between the standard corrective action procedure and designation as 'elevated concern')". The Controller's response states that the imposition of a rigid timeline is impractical, given the variability of issues facing organizations and resources available for corrective action.

As stated on page 54 of the performance audit report, the Citywide guidelines "do not specify the amount of time that should be allowed between when a corrective action plan is required and when the City designates the nonprofit as being on 'elevated concern' or 'red flag' status. The Citywide guidelines only state that a nonprofit contract could be designated to an 'elevated concern' status if such contractor has not met the previously prescribed corrective action requirements in a 'timely fashion'. Additionally, in the last action listed for the 'elevated concern' and 'red flag' stages, the City could either remove the status or provide a clear road map as to the steps needed to remove the status, yet there is no timeframe for completion of the additional steps."

The Executive Summary, which follows this transmittal letter, for our *Performance Audit of Professional Services Contracts: Department of Public Health and Human Services Agency*, summarizes the Budget Analyst's five findings and 17 recommendations.

We would like to thank the Director of Health, the HSA Executive Director, the Controller and their staffs for their cooperation during this performance audit.

Respectfully submitted,



Harvey M. Rose
Budget and Legislative Analyst

cc: President Chiu

Supervisor Avalos

Supervisor Campos

Supervisor Chu

Supervisor Cohen

Supervisor Elsbernd

Supervisor Kim

Supervisor Mar

Supervisor Olague

Supervisor Wiener

Clerk of the Board

Jon Givner

Kate Howard

Controller

Director of Public Health

Executive Director, Human Services Agency

Executive Summary

The Board of Supervisors directed the Budget and Legislative Analyst to conduct a performance audit of the Department of Public Health’s (DPH) and Human Services Agency’s (HSA) management of professional services contracts, through a motion (M12-0031) approved on March 6, 2012. The performance audit examined the agencies’ management of professional services contracts, including how each Department determines the need for professional services, and measures and reports service levels and changes; policies and procedures for contract performance and performance measurement; and department-wide contracting policies and compliance. The performance audit was conducted in accordance with Government Auditing Standards, 2011 Revision, issued by the Comptroller General of the United States, U.S. Government Accountability Office.

Introduction

Acquisition of commodities and services is governed by Chapter 21 of the Administrative Code of the City and County of San Francisco. Competitive bids and competitive proposals are solicited through issuance of Invitations to Bid and Requests for Proposals (RFP), and the process is carried out with coordination between departmental staff and the City’s Office of Contract Administration (OCA). Ongoing monitoring of contractor compliance with fiscal, performance, and other requirements is carried out by departmental staff and, for contractors that have contracts with multiple City departments, multi-departmental committees. The Controller’s Office assists in supporting the multi-departmental monitoring efforts (as described in more detail below), and conducts its own reviews of City contracts on a more limited basis.

Scope of Professional Services Contracts at DPH and HSA

According to data provided by DPH and HSA, as of April 2012, there were a total of 370 existing (active) professional services contracts awarded by the DPH having a total value of approximately \$1.43 billion; and there were a total of 363 existing active professional services contracts awarded by the HSA having a total value of approximately \$658 million. These dollar values represent the total value of the full contracts, including all years. As described in the departmental profiles contained in the Introduction section of this report, the terms of these contracts average 4.2 years at DPH and 2.9 years at HSA.

Table 1
DPH & HSA Professional Services Contracts, as of April, 2012

	DPH	HSA
Total Value	\$1,436,317,048	\$658,162,579
Total Number	370	363
Average Value	\$3,881,938	\$1,813,120
Average Term	4.2 years	2.9 years

Sources: Department of Public Health and Human Services Agency

As shown in Table 2, a large majority of professional services contracts awarded by DPH and HSA are awarded to nonprofit organizations. As of April, 2012, 302, or 83 percent of HSA's 363 open professional services contracts were with nonprofit organizations and 62 percent of DPH's 370 open professional services contracts were with nonprofit organizations. The total contract amount awarded to nonprofits by HSA was \$532,606,941, or 69 percent of the total amount awarded to open contracts, as of April 2012. The total contract amount awarded to nonprofits by DPH was \$1,064,276,269, or 74 percent of the total amount awarded to open contracts, as of April 2012.

Table 2
DPH and HSA Non-Profit Contracts, as of April, 2012

		Non-Profit	All Professional Services	Non-Profit as a % of All Professional Services
DPH	Total Value of Contract Awards	\$1,064,276,269	\$1,436,317,048	74%
	Total Number of Contracts	230	370	62%
HSA	Total Value of Contract Awards	\$532,606,941	\$775,675,504	69%
	Total Number of Contracts	302	363	83%

Source: Controller's Office, Department of Public Health, and Human Services Agency

Since nonprofit contractors comprise the majority of DPH and HAS professional services contracts, and the contract performance monitoring and management procedures established by DPH, HSA, and the Controller are directed to nonprofit contractors, audit report pertains largely to nonprofit contractors.

Citywide Fiscal and Compliance Monitoring Efforts

After a series of critical reports by the Civil Grand Jury, the Nonprofit Contracting Taskforce, and other City entities, the City Services Auditor launched the Citywide Nonprofit Monitoring and Capacity Building program in 2005. The program's goals are to streamline and standardize fiscal and compliance monitoring, provide coordinated training on fiscal management and compliance, and to provide capacity building and technical assistance to help contractors address monitoring findings. The program has established a single joint fiscal and compliance monitoring process, using standardized monitoring protocols for certain nonprofit professional service contractors having contracts with more than one City department, in order to minimize duplication of effort and reduce the administrative burden on nonprofit contractors. The program also seeks to increase the use of automation in contract compliance monitoring. In November 2010 the program disseminated a Nonprofit Corrective Action Policy that defined corrective action, City departments' requirements to document and follow up on monitoring findings, and the oversight and reporting responsibilities of the Controller's Office.

Departmental Efforts and Improvements

Both the Department of Public Health and the Human Services Agency played central roles in working with the City Controller to develop the citywide fiscal and compliance monitoring program described above. In addition to the citywide efforts, both DPH and HSA have in recent years undertaken substantial efforts to improve contract monitoring within their departments. DPH, through the establishment of the Community Programs Business Office in FY 2009-10, has reorganized staff and defined new roles and responsibilities to improve accountability and enable more consistent contract monitoring. HSA established a Community Partnerships and Contracting Workgroup in 2009 to consider areas for improvement, and in response, HSA has begun to standardize service objectives across contracts and make other improvements. These efforts are summarized in Sections 1, 2 and 4 of this report.

DPH and HSA should be recognized for their work to improve the tools and systems used to monitor nonprofit contractors. The findings and recommendations contained in this report highlight remaining opportunities to improve the efficiency and effectiveness of professional services contract management.

Effectiveness of DPH's Contractor Performance Monitoring

Despite previously reported findings and recommendations related to weaknesses in the Department of Public Health's contract monitoring policies and practices, and subsequent efforts to improve, DPH continues to have some weaknesses in monitoring contractors' program performance. Although the DPH Community Programs Business Office, which monitors contractors' performance, has recently adopted monitoring tools (checklist, scoring guides, report templates) to standardize the process, DPH has not conducted formal training on program monitoring or provided staff with training materials or manuals on program policies.

Because of frequent changes in DPH program managers' monitoring assignments, many contractors are not monitored by a single consistent manager

Each contract under DPH's Community Programs Division is typically assigned to three program managers and two analysts. The analysts represent the Contracts and Budget sections, and the program managers represent the Contract Development and Technical Assistance (CDTA) section, the Business Office and Contract Compliance (BOCC) section, and the System of Care (SOC).

While a BOCC program manager has primary responsibility for monitoring a specific contractor's performance, program manager assignments are changed frequently so that many contractors are not monitored by a single consistent BOCC program manager. For example, according to a sample of 34 contractors, more than one BOCC program manager monitored a single contractor within a given year:

- In FY 2009-10, 10 of the 28 contractors (36 percent) in the sample were monitored by more than one BOCC program manager;

- In FY 2010-11, 8 of the 28 contractors (29 percent) in the sample were monitored by more than one BOCC program manager;

In addition, although contractors are technically assigned to a specific BOCC program manager, in practice annual monitoring may be performed by another program manager. Because contract monitoring is subject to varying calendar obligations determined by the funding source, monitoring assignments may shift during the year in order to balance workloads for BOCC program staff. Although the monitoring reports do not indicate whether the report writer is the BOCC program manager officially assigned to that contractor, the review of the sample does show how often report writers changed from FY 2009-10 to FY 2010-11: 15 of 31 contractors (48 percent) were reviewed by different BOCC program managers from FY 2009-10 to FY 2010-11.

Given the frequency of these reassignments, the effective transfer of knowledge from one reviewer to another is critical to insure that contractors are sufficiently identified and assessed. However, DPH program managers noted during interviews that there is no official protocol in place for communication when staff assignments shift during a review cycle.

In the absence of guidelines, DPH program managers are inconsistent in interpreting poor performance scores and requiring contractors to correct poor performance

DPH program managers rate contractor performance across the following three categories - program performance, program compliance, and client satisfaction – using a numerical scoring system. In the sample reports, performance has typically been rated on a scale of 1.0 to 4.0. Since FY 2010-11, the Department has revised the templates to detail scores within subcategories on a 100 point scale, that then translate to a score on the 4.0 scale.

It remains unclear, however, why DPH translates these scores to the less detailed 4.0 scale and uses the rating system, since there are no written guidelines for staff to interpret the scores as part of the monitoring process, and interpretation of the scores is inconsistent. DPH has three levels of response to a contractor’s poor performance: recommendations to improve performance without a formal Plan of Action; a Plan of Action to address the poor performance; or a Corrective Action Plan, in which the contractor must correct the poor performance within a reasonable timeframe or risk City funding for the contract. In interviews, program managers stated that a monitoring score of less than three (3.0) often indicates that the program manager should develop a Plan of Action or Corrective Action Plan for the contractor. However, there are no written departmental policies or guidelines that detail how performance scores trigger a Plan of Action or Corrective Action Plan.

Sample contractor monitoring reports clearly show that scores do not consistently trigger a Plan of Action or Corrective Action Plan. For example, one report from FY 2010-11 shows that a contractor scored 67 percent (or a 2.0) in program performance, but was not required to submit a Plan of Action, while another report from the same year shows that a score of 84 percent (or 3.0) for another contractor triggered a Plan of Action. Of 62 sample contractor monitoring reports in which a Plan of Action was required, 32 contractors (51.6 percent) did not score below a 3.0 (or

below 75, if a scale of 100 was used) on any of the three primary measures. In fact, four contractors identified as requiring a Plan of Action had perfect scores across all categories.

The sample program monitoring reports show wide variation in the detail provided by program managers. In fact, the reports show that while DPH has increased its focus on improving the monitoring process over time, the reports themselves provide less information. That format has been replaced with a template that focuses instead on administrative compliance and client chart records. In a similar trend, the actual narrative detail provided by program managers on the monitoring reports has decreased.

Program managers do not receive sufficient training

DPH has not developed formal training or written guidelines for Community Programs Business Office staff responsible for contractors' performance monitoring. Instead, information regarding changes to the monitoring process is discussed at monthly staff meetings as part of regular business. Without such guidelines and training it is more likely that different staff responsible for contractors' performance monitoring will come to different conclusions regarding appropriate response and follow up. The sample of program monitoring reports reviewed for this audit contains substantially inconsistent quality of information. For example, some reports have no program description and some have no recommendations. There is no analysis of why an objective was met or not met, and no explanation why units of service was exceeded or not met.

While the staff responsible for contractors' performance monitoring must retain some measure of flexibility and discretion in assessing contractors and determining responses to findings of performance monitoring, the Community Programs Business Office should develop written guidelines to standardize the use and interpretation of monitoring tools in order to insure fair treatment of all contractors.

DPH also should also supplement training for staff using the contract management system, Contracts Online or COOL, to ensure that staff are entering contract information consistently into COOL and are able to effectively use COOL as a contract management tool.

Effectiveness of HSA's Contractor Performance Monitoring

The Human Services Agency's (HSA) program managers are responsible for monitoring contractors' program performance. However, because HSA does not have agency-wide guidelines or formal for program managers on how to conduct performance monitoring, program managers have discretion in determining how to carry out monitoring and what service and outcome objectives to measure. As a result, HSA contracts may have different service and outcome objectives for similar services, lack specific and quantifiable measures of these objectives, and have a varying number of objectives across contracts, making it difficult to compare services provided by different contractors in similar service areas and ensure high quality of services throughout the City. In 2009 HSA began reviewing service contracts to standardize objectives for similar contracts (clusters), reduce the number of objectives in each contract, and streamline data collection. Due to staffing issues, HSA has only reviewed 141 of HSA's 363 service contracts.

Contractor performance monitoring is not consistent among HSA program managers

Neither HSA program managers nor contractors have consistent understandings of program performance monitoring. For example, contractors are required to submit quarterly and/or annual performance reports to their program managers, but are not provided consistent expectations. One contractor, who regularly submitted reports to two program managers for different contracts, was provided feedback by only one program manager. After 2 ½ years, the program manager that had not provided feedback conducted a site visit, identifying deficiencies in documentation of services. The contractor was subsequently placed on a corrective action plan, after receiving no feedback in the prior 2 ½ years.

The Agency has not provided guidelines for program managers describing the process for determining whether a contractor should receive a site visit or conduct a self-assessment. One program manager stated that she conducted a site visit for all of her contracts, but that her colleagues may conduct a site visit for a sample. Further, in the absence of both written guidelines regarding site visits and lack of central Agency oversight of the program monitoring process, some program managers may not conduct an annual program review at all. For example, one program manager interviewed for this audit reported being employed as a program manager at the Agency for approximately three years before becoming aware of the requirement to conduct an annual site visit or self-assessment.

Formal training for program monitoring is inadequate

The Human Services Agency does not have a formal training curriculum on program performance monitoring for program managers. A handbook with policies and procedures, standards, or guidelines for program monitoring does not exist. Program managers reported they received on the job training for program performance monitoring or had to obtain continuing education on service area regulations and standards through outside trainings, which shaped their procedures and process of performance monitoring.

Communication between program and contract managers is inconsistent

HSA's contracting protocols define the respective responsibilities for contract managers (administering compliance with department, state, federal, and City requirements), and program managers (ensuring conformance to service objectives and program needs). However, communication between program and contract managers is inconsistent. For example, according to HSA contracting protocols, budget revisions must be approved by both the program and contract manager but program and contract managers do not always coordinate on budget details. Agency staff reported that contractors may provide different versions of the budget to one manager or the other, which could result in payments based on incorrect budgets. One program manager recounted an instance in which a significant budget modification was granted for a contractor with the involvement of the contract manager and other Agency staff but without the matter ever being communicated to the program manager.

Contracting protocols state that program staff must provide written monitoring reports to HSA's Office of Contract Management at least once per year, yet contract managers reported varying

access to written reports. One contract manager reported that contractors submit monitoring reports to both the program and contract manager on a quarterly or annual basis, while another contract manager reported that they had never seen a program report submitted by a contractor.

HSA should revise its training, guidelines, standards, forms, and templates, to standardize contractors’ monitoring and reporting procedures. In developing the new contract management system, HSA should also ensure sufficient information for division managers and program directors to oversee contractor performance.

DPH Sole Source Contracting

The San Francisco Administrative Code provides for the award of sole source contracts, without the use of competitive procedures, when commodities or services are available only from a single source and where proprietary software or maintenance of equipment by a particular vendor is required to preserve a warranty. Additionally, Section 21.42 of the Administrative Code authorizes the award of sole source contracts for “professional services contracts for health and behavioral health services and support, where such services are provided by non-profit organizations and a sole source designation is recommended by the San Francisco Department of Public Health.”

Prevalence and Value of DPH’s Sole Source Contracts

As shown in Table 3 below, in FY 2011-2012, an estimated 22 percent of the dollar value of all DPH professional services contracts, or \$318.6 million out of \$1.44 billion contracts awarded, were selected on a sole source basis, without the use of any competitive procedures, not including approximately \$134 million budgeted in FY 2011-12 for the affiliation between DPH and the University of California, San Francisco (UCSF).

Table 3
DPH Sole Source Professional Services Contract Requests
as a Percent of all Professional Services Contracts in FY 2011-12

All Professional Services Contracts	Sole Source Professional Services Contracts	% of Professional Services Contracts that are Sole Source
\$1,436,317,048	\$318,570,240	22%

Source: Controller and DPH

As shown in Table 4 below, excluding contracts for the administration of Healthy San Francisco, sole source contracts were 18 percent of the or 250.8 million of the \$1.4 billion of DPH’s professional services contracts.

Table 4
DPH Sole Source Professional Services Contract Requests
as a Percent of all Professional Services Contracts in FY 2011-12, Excluding Healthy SF

All Professional Services Contracts, Excluding Healthy SF	Sole Source Professional Services Contracts, Excluding Healthy SF	% of Professional Services Contracts that are Sole Source, Excluding Healthy SF
\$1,368,517,048	\$250,770,240	18%

Source: Department of Public Health

DPH Implementation of Sole Source Contracting

Despite a Controller’s report that recommended stronger oversight of sole source contracting at DPH and OCA guidelines that implicitly define the limits of allowable sole source contracting, there are a number of deficiencies in DPH’s sole source contracting practices. These deficiencies weaken the essential intent of the Administrative Code to limit sole source contracting to instances in which a competitive procedure is impractical or unnecessary in order to obtain the highest quality service at the best price.

DPH does not survey availability of contractors as required by the Administrative Code

In addition to giving DPH authority to enter into sole source contracts with nonprofits, Administrative Code Section 21.42 requires that:

Prior to the expiration of an existing contract, the Director of the Department of Public Health survey the availability of providers for the health and behavioral health services and support services required by the Department of Public Health where such services are (1) unique to the Department (2) consistent with its missions and goals and (3) require specialized knowledge, training, personnel, facilities or other resources that are known to be provided by a limited number of non-profit contractors.

Additionally, Section 21.42 states that, “based upon the results of such surveys, the Director of DPH may recommend a sole source designation to the Health Commission.”

DPH has not conducted these surveys. While the Department believed it was in compliance with the survey requirement based on City Attorney advice, no documentation of the advice exists and auditors confirmed with the City Attorney’s Office that the Administrative Code language on surveys was intended to require the Department to periodically consider newly available potential contractors. By failing to implement this section of the Administrative Code, the City may not become aware of the existence of suitable alternatives in the community that could provide similar or higher quality services at similar or more competitive costs.

DPH extends sole source contracts beyond their initial terms

All departments seeking sole source contracts must submit a sole source waiver request to OCA describing the rationale for the sole source contract and receive OCA approval before proceeding with or entering a sole source contract. A review of sole source waiver requests and a recent

supplemental funding request disclosed that DPH extends some sole source contracts beyond the original terms due to the Department's difficulty in issuing RFPs in a timely fashion. On at least three occasions in FY 2011-12, DPH failed to conduct competitive processes for professional services contracts previously awarded on a sole source basis under the condition that they be subject to a competitive award subsequent to the original award.

For example, in 2010, DPH conducted a competitive RFP process for mental health and substance abuse treatment services, and selected Community Awareness and Treatment Services (CATS) as the highest qualified scorer. DPH contracted with CATS for four programs as a result of this competitive RFP process and also continued its existing contract with CATS for three programs on a sole source basis. The term of the original agreement with CATS was from July 1, 2010 through December 31, 2015, but it provided funding for the sole source programs only through December 31, 2011. At the time of Board approval of the CATS contract, DPH management advised that DPH would conduct a competitive bidding process in FY 2010-11 for the three sole source based programs. As of the writing of this report, DPH had not issued an RFP for the three sole source programs as originally reported to the Board of Supervisors. DPH requested and received approval of a supplemental authorization of \$18,952,692 in funding for these programs, again with the caveat that DPH plan and implement an RFP.

DPH lacks guidelines for use of sole source contracting authority

DPH does not have written guidelines for sole source contracting, does not provide adequate rationales for sole source contracting in its sole source waiver requests, and does not report fully on the rationale of its sole source contracting to the Health Commission or Board of Supervisors.

The Office of Contract Administration rules and regulations¹ require departments to justify the need for a sole source acquisition of commodities and services using a Sole Source Waiver request form. DPH fulfills this requirement by submitting a list of sole source contracts annually. However, the list contains only the terms, vendor name, amount and service type. It does not contain any explanation of the reason for the sole source nature of the contract other than reference to the three Administrative Code sections that permit sole source contracting

Since the Administrative Code was amended to include Section 21.42 in 2006, DPH has annually submitted to the Health Commission, for approval by the Health Commission, a list of contracts DPH management recommends be designated as sole source as authorized by Section 21.42. In the six years since adoption of Section 21.42, DPH's memoranda to the Health Commission and the list of contracts recommended as sole source that is attached to the memoranda have not included an explanation of the rationale for the sole source designations beyond reference to Section 21.42 of the Administrative Code itself.

DPH should develop written policies on sole source contracting, conduct the surveys that are required by Administrative Code Section 21.42, and include full rationales for sole source

¹ Rules and Regulations Pertaining to the San Francisco Administrative Code, Chapter 21; Acquisition of Commodities and Services

contracting in its sole source waiver requests. Reporting on sole source contracts to the Health Commission and the Board of Supervisors should include complete justification for why a sole source contract was awarded without the use of a competitive process.

Effectiveness of Corrective Action Process

Standards for determining the triggers for corrective action have not been effectively implemented

In 2011, the Controller’s Office created the Citywide Nonprofit Corrective Action Policy to encourage nonprofit accountability, compliance with government funding requirements and reliable service delivery. The policy established three designated stages for corrective action (standard, elevated concern and red flag), including the corresponding consequences for failure to correct deficiencies. These Citywide standards and designations have not been consistently implemented by DPH or HSA. While DPH has developed examples of findings that could warrant corrective action, neither DPH nor HSA has established clear measures for staff to determine when monitoring findings should be brought forward for formal corrective action.

Standards and timeframes for City support during corrective action have not been established

The Citywide Fiscal and Compliance Monitoring Guidelines do not establish timeframes between each of the three designated stages, nor have DPH and HSA established standards for the amount of time and support a contractor should be granted once the corrective action process has begun.

While the Citywide Nonprofit Corrective Action Policy states that nonprofit contractors in “elevated concern” or “red flag” status are not eligible for new or renewed City funding, no such guidelines exist for nonprofits on standard corrective action. DPH has renewed contracts with nonprofits who have been cited for corrective action, despite documented and ongoing financial problems. Table 5 below contains four examples of nonprofits that have been awarded new or renewed contracts or subcontracts despite repeated corrective action citations.

**Table 5
Nonprofits with Continued Funding from DPH, Despite Corrective Action Status**

Nonprofit	Total Number of Contracts	Total Amount of Contracts
A	6	\$6,623,865
B	2	42,849,811
C	3	2,117,913
D	1 subcontract	547,464
Total	12	\$52,139,053

Source: Department of Public Health

DPH did not assign certain contractors to elevated concern or red flag status although these contractors had significant financial or sustainability concerns. Of 12 contractors on standard

corrective action as of March 2012, three contractors ceased operations and three contractors had continued problems requiring ongoing monitoring. Two of these three contractors with ongoing monitoring received additional funding while on standard corrective action.

In several instances, the DPH has worked with the Controller's Office to provide extensive technical assistance, including paid consultant support, to contractors to help resolve governance and fiscal compliance issues. Two of the three contractors that ceased operations had received technical assistance and additional resources prior to ceasing operations. Without clear direction regarding the level of technical and financial assistance that should be provided to support nonprofits on a corrective action plan, the City could continue directing resources toward underperforming contractors, at the expense of identifying alternate contractors that could provide the same services to underserved populations.

The Board of Supervisors should request that the Controller's Office revise the Citywide Corrective Action Policy to add more specificity regarding the amount of time and support that should be given to nonprofits between various stages of the corrective action process (i.e. the time allowed for improvement between the standard corrective action procedure and designation as "elevated concern"). The Department of Public Health and the Human Services Agency should clarify internal monitoring and corrective action policies to more accurately reflect the Citywide Nonprofit Corrective Action Policy and train monitoring staff regularly to ensure proper implementation of the Citywide Nonprofit Corrective Action Policy.

DPH Contract Contingency Authorization

In FY 2005-06, the Department of Public Health established a policy of providing for a contingency amount on each contract equal to 12 percent of the amount authorized over the life of the contract.² While the DPH's contingency policy facilitates acceptance of new funds and smooth transitions between contractors when needed, DPH has not defined when the contingency should be used, and implementation and reporting weaknesses are evident.

Only a small portion of contingency authorization is used

In FY 2010-11, DPH reported to the Board of Supervisors on seven contracts in which contract expenditures exceeded the original contract budget, requiring the use of the contract contingency. The increase in each of the seven contracts in FY 2010-11 ranged from 0.04 percent to 1.49 percent and averaged 0.5 percent, far below the 12 percent contingency amount authorized. Only one program was allocated more than 1 percent of its original contract budget through the contingency process.

The FY 2010-11 report to the Board of Supervisors includes only the first year of the five-year term for each of the seven contracts. Thus, DPH will likely spend more of the contracts' contingencies in the remaining four years.

² Department of Public Health memorandum to the Health Commission, "Update on Recommendations of the Non-Profit Contracting Task Force", October 6, 2005.

As shown in Table 6 below, the FY 2011-12 report to the Board of Supervisors shows that ten contractors received contingency amount increases over their original contract budgets totaling \$4,116,869,³ or 1.2 percent of total funding over the five-year term of the contracts of \$340,877,388. In addition, two contracts that were consolidated across formerly separate contracts for each vendor provided for another \$1,480,092 in contingency use, or 1.5 percent more than the original contract budgets.

Table 6
Increases in DPH Contracts, FY 2010-11 and FY 2011-12⁴

Contractor	Total Not-to-Exceed Amount (FY 2010-11 through FY 2014-15)	Contract Budget^a	Increase to Date (FY 2010-11 and FY 2011-12)	Total % Increase From Contract Budget
Alternative Family Svcs	\$11,057,200	\$9,863,022	\$100,000	1.0%
Bayview Hunters Point D	27,451,857	24,487,056	676,986	2.8%
CATS	14,854,465	13,250,183	331,893	2.5%
Community Vocational Ent	9,705,509	8,657,314	314,767	3.6%
Conard House	37,192,197	33,175,440	203,957	0.6%
Edgewood Center	29,109,089	25,965,307	157,057	0.6%
IFR	14,219,161	12,683,492	200,182	1.6%
RAMS ^b	34,773,853	31,018,277	490,361	1.6%
UC Regents ^c	74,904,591	66,814,895	343,370	0.5%
Seneca	63,495,327	56,692,257	70,750	0.1%
SF Study Center	11,016,593	9,826,801	503,328	5.1%
Walden House	54,256,545	48,443,344	724,218	1.5%
Total Contract Increases	\$382,036,387	\$340,877,388	\$4,116,869	1.2%
RAMS	\$34,773,853	\$31,018,277	\$916,206	3.0%
UC Regents	74,904,591	66,814,895	563,886	0.8%
Total Contract Consolidation	\$109,678,444	\$97,833,172	\$1,480,092	1.5%

Source: DPH

^aTotal contract not-to-exceed amount less 12% contingency authorization.

^b Does not include \$916,206 transferred for the consolidation of RAMS Adult and Children contracts

^c Does not include \$563,886 transferred for the consolidation of two U.C. Regents contracts

DPH has not defined when contingency should be used or how it should be implemented

The use of the contingency authorization is often for minor contract changes. However, in some instances the contingency authority has been utilized to make much more significant changes, including adding entirely new programs and funding sole source contracts without obtaining Health Commission and Board of Supervisors approval. The contingency policy also appears to conflict with the Health Commission's policy to obtain Commission approval for contract changes exceeding 10 percent.

When contracts are amended, the contingency amount is often increased to 12 percent of the full contract amount, even though some of the term of the contract has expired and significant expenditures have already been incurred. Moreover, the funding authorization of contracts of

³ Excludes funds for continuation of Community Awareness and Treatment Services (CATS) funding, approved by the Board of Supervisors on July 18, 2012.

⁴ Includes increases only. Eight contracts for which funding was are not considered here.

vendors from whom funds were reallocated is not consistently amended downward to reflect the reallocation, allowing some vendors to maintain their original contracted amount as well as their full contingency authorization. These practices have the effect of providing a greater overall increase in DPH contracting authority than is intended by the contingency policy.

Information provided to the Board of Supervisors concerning the use and source of funds for contract increases is inadequate

Finally, the information collected for contract increases funded from contingencies and presented to the Board of Supervisors is inadequate to allow the Board to assess whether the City is meeting its target service levels and to perform its contract oversight function. The report concerning use of the contingency authorization should include the reason for the increase (e.g., to serve additional populations), the specific program to which funds were allocated, a more detailed description of the source of funding (either new or an indication of the contract from which funds were reallocated) and the percent of the contingency used in the prior year and throughout the life of the contract.

Introduction

The Board of Supervisors directed the Budget and Legislative Analyst to conduct a performance audit of the Department of Public Health's (DPH) and Human Services Agency's (HSA) management of professional services contracts, through a motion (M12-0031) approved on March 6, 2012.

Scope

The performance audit examined the agencies' management of professional services contracts, including how each Department determines the need for professional services, and measures and reports service levels and changes; policies and procedures for contract performance and performance measurement; and department-wide contracting policies and compliance.

Methodology

The performance audit was conducted in accordance with Government Auditing Standards, 2011 Revision, issued by the Comptroller General of the United States, U.S. Government Accountability Office. In accordance with these requirements and standard performance audit practices, we performed the following performance audit procedures:

- Conducted interviews with representatives of the Health Commission; and executive, management and other staff in the Department of Public Health and Human Services Agency.
- Interviewed representatives from five non-profit organizations that have professional services contracts with the Department of Public Health and/or the Human Services Agency.
- Reviewed several reports and studies regarding oversight and management of contracts in the City and County of San Francisco, including Civil Grand Jury reports; Nonprofit Contracting Task Force reports; Community-Based Organizations Task Force reports; the City Controller's Sole Source Contracts report; and the HSA Strategic Review and Community Partnerships and Contracting Workgroup report.
- Reviewed Administrative Code provisions, policies, procedures, memoranda, and other guidelines governing the management of professional services contracts Citywide and in the Department of Public Health and Human Services Agency.
- Conducted reviews of (a) 34 DPH professional services contractors, including 323 program monitoring reports for the past three years and fiscal monitoring reports for 30 of the 34 contractors; (b) 17 HSA contractors with a total of 124 contracts, including 890 quarterly and annual program and fiscal monitoring reports; (c) documentation for all contracts in which contingency funds were utilized in FY 2010-11 and FY 2011-12; (d) documentation for 28 DPH sole source contracts in FY11; and (e) other data pertinent to the audit objectives.

- Submitted a draft report, with findings and recommendations, to the Department of Public Health, the Human Services Agency, and the Controller’s Office on September 18, 2012; and conducted exit conferences with department directors and executive on October 2, 2012 (HSA) and October 9, 2012 (DPH).
- Submitted the final draft report, incorporating comments and information provided in the exit conferences, to the Department of Public Health and the Human Services Agency on October 11, 2012.

Overview of City Contracting

Acquisition of commodities and services is governed by Chapter 21 of the Administrative Code of the City and County of San Francisco. This chapter defines the powers of the departments, required contract terms, requirements for competitive solicitation and other elements related to contractor selection. The competitive solicitation requirement is established in Administrative Code Section 21.1, which states: “All City contracts for commodities and/or services shall be procured through competitive solicitation, except as otherwise authorized in this code.” Competitive bids are solicited through issuance of a Request for Proposals (RFP), and the process is carried out with coordination between departmental staff and the City’s Office of Contract Administration (OCA).

Ongoing monitoring of contractor compliance with fiscal, performance, and other requirements is carried out by departmental staff and, for contractors that have contracts with multiple City departments, multi-departmental committees. The City Controller’s Office assists in supporting the multi-departmental monitoring efforts (as described in more detail below), and conducts its own reviews of City contracts on a more limited basis.

Scope of Professional Services Contracts at DPH and HSA

According to data provided by the departments, as of April 2012, total active DPH professional services contracts numbered 370 and amounted to approximately \$1.43 billion; and total active HSA professional services contracts numbered 364 and amounted to approximately \$776 million. These dollar values represent the total value of the full contracts, including all years. As described in the departmental profiles contained in this Introduction, the terms of contracts range in length and, for those active as of April 2012, average 4.2 years at DPH and 2.9 years at HSA.

Determination of Need for Contracts

The audit scope included an examination of how each Department determines the need for professional services contracts. Formal procedures guiding decision-making on whether to

provide services via contract or in-house were not provided by either department¹. Based on interviews with management of both departments, the audit found that DPH and HSA use contracted services based on a number of factors including (a) continuation of departmental history and precedent; (b) perception that community-based organizations may possess greater cultural competency than City departments could provide; (c) limitations on the departments' ability to provide a wide breadth of services at expert levels; and (d) contractors' ability to deliver services in a more efficient manner than the departments could directly within the civil service framework.

In particular, the value of cultural competency was emphasized by departmental staff and managers. Reportedly, community-based organizations exhibit the ability to communicate in client languages; understand client needs based on neighborhood, race, ethnicity, and other socio-economic factors; and convey an overall cultural understanding and acceptance. Cultural competency was raised as a common justification for sole source contracting.

The leadership of HSA also described the importance of separating the Agency's provision of supportive services from the Agency's mandate to enforce laws, particularly those related to child safety. It is a widely held belief that clients are better served and respond better to the Agency when they interface with service providers that are perceived to be neutral third parties, especially when those clients may also interact with HSA on enforcement related matters. In other words, clients may be more likely to access supportive services when they are not provided directly by the entity that they are accustomed to encountering in a punitive context.

Citywide Fiscal and Compliance Monitoring Efforts

This audit is informed by several previously released reports and studies of City contracting. Since 2001, several studies and reports have been issued by City task forces, the Civil Grand Jury, and other groups with recommendations for improving the performance and increasing the efficiency and effectiveness of monitoring of nonprofit professional services contractors. Some of these reports and subsequent efforts are summarized below in order to provide a context for the current monitoring framework.

In 2001 the San Francisco Civil County Grand Jury issued a report on the City's professional services contracting that recommended, among other things, the use of standardized forms and increased automation in professional services contracting. Later in 2001, the San Francisco Civil Grand Jury issued a report on nonprofit contracting that focused on the Human Services Agency, the Department of Public Health and the Mayor's Office of Community Development with findings that the City's decentralized contracting apparatus placed costly and unnecessary administrative burdens on nonprofit organizations. Additionally, the report found that procedures

¹ A draft report of the HSA Community Partnerships Workgroup (Fall 2009) included recommended guiding principles related to the objectives of contractual relationships with community partners and how the use of contractors should complement services provided in-house.

varied widely between City Departments such that contractors with contracts with several City departments were obliged to use disparate reporting and administrative procedures.

In 2002, a Nonprofit Contracting Task Force found that forms, monitoring review practices, data collection and reporting were not standard among and within departments, and that the City needed a clearer and more consistent level of supervision, training and standardization of monitoring practices and clearer timelines and deadlines. The Task Force recommended joint program monitoring visits, coordinated technical assistance, standard monitoring protocols, training of monitoring personnel, and use of risk assessment of programs with the goal of tiered monitoring based on risk.

In 2005, the City Services Auditor launched the Citywide Nonprofit Monitoring and Capacity Building program. The program's goals are to streamline and standardize fiscal and compliance monitoring, provide coordinated training on fiscal management and compliance, and to provide capacity building and technical assistance to help contractors address monitoring findings. The program has established a single joint fiscal and compliance monitoring process, using standardized monitoring protocols for certain nonprofit professional service contractors with contracts with more than one city department in order to minimize duplication of effort and reduce the administrative burden on nonprofit contractors. The program also seeks to increase the use of automation in contract compliance monitoring.

In November 2010 the program disseminated a Nonprofit Corrective Action Policy that defined corrective action, city departments' requirements to document and follow up on monitoring findings, and the oversight and reporting responsibilities of the Controller's Office.

Departmental Efforts and Improvements

Both the Department of Public Health and the Human Services Agency played central roles in working with the City Controller to develop the Citywide fiscal and compliance monitoring program described above. In addition to the Citywide efforts, both DPH and HSA have in recent years undertaken substantial efforts to improve contract monitoring within their departments. DPH, through the establishment of the Community Programs Business Office in FY 09-10, has reorganized staff and defined new roles and responsibilities to improve accountability and enable more consistent contract monitoring. HSA established a Community Partnerships and Contracting Workgroup in 2009 to consider areas for improvement, and in response, the Agency has begun to standardize service objectives across contracts and make other improvements. These efforts are summarized in Sections 1, 2 and 4.

DPH and HSA should be recognized for their work to improve the tools and systems used to monitor nonprofit contractors. The findings and recommendations contained in this report highlight remaining opportunities to improve the efficiency and effectiveness of professional services contract management.

Profile of Professional Services Contracts: DPH

The following information has been summarized from data provided by the Department of Public Health (DPH) in response to a request for a list of all professional services contracts. The analysis below excludes the department's contracts with the University of California, as those contracts are primarily associated with the affiliation agreement with San Francisco General Hospital. As shown in Table I.1, DPH had a total of 370 professional services contracts as of April, 2012, the total value (full term) of which amounted to \$1,436,317,048. On average, the total value of a DPH Professional Services contract was \$3,881,938, and the average term was 4.2 years.

Table I.1
DPH Professional Services Contracts, as of April, 2012

Total Value	\$1,436,317,048
Total Number	370
Average Value	\$3,881,938
Average Term	4.2 years

Source: Department of Public Health

Table I.2 summarizes the number of DPH professional services contracts that exceed certain contract amount thresholds – specifically \$1,000,000, \$10,000,000 and \$20,000,000. As shown, 50 percent of the contracts have a value of \$1 million or less; 42 percent have a value greater than \$1 million and less than \$10 million; 4 percent have a value greater than \$10 million and less than \$20 million; and 4 percent have a value of \$20 million or greater.

Table I.2
DPH Professional Services Contracts by Value, as of April, 2012

Value Range	Number of Contracts	Percent of Total
≤ \$1,000,000	185	50%
\$1,000,001 - \$9,999,999	155	42%
\$10m – \$19,999,999	15	4%
≥ \$20,000,000	15	4%

Source: Department of Public Health

A comparison with the Controller's Office Vendor Data shows the total amount of funding awarded to non-profit contractors through DPH, as well as the total number of those contracts. Note that some of the non-profit contractors have multiple contracts with DPH, so this does not represent a distinct number of non-profit contractors.

Table I.3
DPH Non-Profit Contracts, as of April, 2012

	Non-Profit	All Professional Services	Non-Profit as a % of All Professional Services
Total Value of Contract Awards	\$1,064,276,269	\$1,436,317,048	74%
Total Number of Contracts	230	370	62%

Source: Controller's Office and Department of Public Health

Professional Services Contracts – All Service Categories

Using the service descriptions provided by DPH, the data was then divided into nine (9) general categories of services, including: Consulting Services, Direct Services, Facilities, Financial Services, Food/Nutrition, Housing, IT/Software, Laboratory Services and Transportation. The table below details the total number of contracts, the total contract award amounts, the percentage of contracts and the percentage of total contract award amounts for each service category. The data is presented in descending order of percentage of total contract amount.

Table I.4
DPH Professional Services Contracts by Category, as of April, 2012

Type of Contract	Contract Amounts	% of Total Contract Amount	Number of Contracts	% of Total Contract Count
Direct Services	\$1,120,117,281	76.55%	227	61.35%
Housing	\$94,794,400	6.48%	26	7.03%
IT/Software	\$77,338,451	5.29%	17	4.59%
Financial Services	\$57,556,162	3.93%	12	3.24%
Facilities	\$54,777,369	3.74%	33	8.92%
Consulting Services	\$33,865,349	2.31%	31	8.38%
Transportation	\$14,243,474	0.97%	10	2.70%
Lab/Tech Services	\$5,794,492	0.40%	9	2.43%
Food/Nutrition	\$4,830,070	0.33%	5	1.35%
Grand Total	\$1,436,317,048		370	

Source: Department of Public Health

Table I.4 shows how the direct services contracts compare to the department's total contracts for professional services. The category of services with the greatest number of contracts is Direct

Services, which accounts for 227 of 370 contracts (61 percent). The category of services with highest total contract amount is also Direct Services, which accounts for \$1,120,117,281 of \$1,436,317,048 (77 percent).

Professional Services Contracts – Direct Services

Within the Direct Services service category, the largest number of contracts and the highest total contract award amounts have been awarded to Behavioral Health Services. As shown in Table I.5, the 97 Behavioral Health contracts constitute \$933,244,304 in total contract value, or more than 83 percent of all Direct Services contracts. Of these 97 Behavioral Health Services contracts, 81 are with non-profit contractors representing \$770,727,518 in total contract value.

Table I.5
DPH Direct Services Contracts by Service Type, as of April, 2012

Direct Service Contracts	Contract Amounts	% of Total Contract Amount	Number of Contracts	% of Contracts
Behavioral Health	\$933,244,304	83.32%	97	42.73%
Prevention	\$54,556,267	4.87%	47	20.70%
Education/Workforce	\$24,343,991	2.17%	4	1.76%
Staffing	\$19,245,791	1.72%	20	8.81%
Centers of Excellence	\$18,990,922	1.70%	7	3.08%
Case Management/ Supportive Services	\$16,872,413	1.51%	18	7.93%
HIV	\$16,420,083	1.47%	10	4.41%
Benefits Counseling	\$16,124,307	1.44%	6	2.64%
Primary Care	\$10,693,966	0.95%	7	3.08%
Interpreter Services	\$6,162,440	0.55%	3	1.32%
Legal Services	\$1,129,313	0.10%	1	0.44%
Cash Assistance	\$991,815	0.09%	1	0.44%
Dental Services	\$670,940	0.06%	1	0.44%
Immunization Services	\$347,968	0.03%	4	1.76%
STD	\$322,761	0.03%	1	0.44%
Grand Total	\$1,120,117,281		227	

Source: Department of Public Health

Contractors with Highest Single Contract Amounts and Highest Total Contract Amounts

Table I.6 shows the ten largest individual contracts awarded by DPH for Professional Services. Note that these award amounts are for multi-year contracts, and do not reflect the contract amount for a single year.

Table I.6
DPH 10 Largest Professional Services Contracts, as of April, 2012

Vendor	Service Type	Contract Total
Progress Foundation	Behavioral Health	\$ 92,018,333
Baker Places Inc.	Behavioral Health	\$ 69,445,722
Seneca Center	Behavioral Health	\$ 63,495,327
Asian American Recovery Services Inc.	Behavioral Health	\$ 52,738,076
Crestwood Hope Center	Behavioral Health	\$ 48,787,156
Family Service Agency of San Francisco	Behavioral Health	\$ 45,483,140
Westside Community Mental Health Center	Behavioral Health	\$ 43,683,150
Haight Ashbury Free Clinics-Walden House	Behavioral Health	\$ 42,477,760
Conard House Inc.	Behavioral Health	\$ 37,192,197
Siemens Medical Solutions USA Inc.	IT	\$ 33,820,487

Source: Department of Public Health

Table I.7 shows the ten contractors that have been awarded the largest total Professional Services contract amounts by DPH. This list does not necessarily reflect a single contract award amount, but in some cases, reflects the sum of multiple contracts awarded to a single contractor by DPH.

Table I.7
DPH 10 Largest Professional Services Vendors, as of April, 2012

Vendor	Service Type	Total of Contract(s)
Progress Foundation	Behavioral Health	\$ 92,018,333
Asian American Recovery Services Inc.	Behavioral Health	\$ 83,068,460
Baker Places Inc.	Behavioral Health	\$ 76,464,739
Seneca Center	Behavioral Health	\$ 63,495,327
Westside Community Mental Health Center	Behavioral Health	\$ 58,028,329
Crestwood Hope Center	Behavioral Health	\$ 48,787,156
Richmond Area Multi-Services Inc.	Behavioral Health	\$ 48,651,535
Family Service Agency Of San Francisco	Behavioral Health	\$ 45,483,140
Haight Ashbury Free Clinics-Walden House	Behavioral Health	\$ 42,849,811
Conard House Inc.	Behavioral Health	\$ 37,192,197

Source: Department of Public Health

Profile of Professional Services Contracts: HSA

As of April, 2012, HSA had a total of 364 professional services contracts with a total contract amount of \$775,675,504, or an average of \$2,130,977 per contract. The total number of contracts does not represent individual organizations, as some organizations may have multiple contracts with HSA. The contract terms range from one to ten years,² averaging 2.9 years per contract, and 176 contracts, or 48.4 percent, have a term of three years.

Table I.8
HSA Professional Services Contracts as of April, 2012

Total Value	\$775,675,504
Total Number	364
Average Value	\$2,130,977
Average Term	2.9 years

Source: Human Services Agency

A majority, or 73.1 percent, of the professional services contracts have a total contract amount of less than \$1,000,000. Table I.9 below displays the number HSA professional service contracts by total contract amount.

Table I.9
HSA Professional Services Contracts by Value, as of April 2012

Value Range	Number of Contracts	Percent of Total
< \$1,000,000	266	73.1%
\$1,000,000 - \$9,999,999	88	24.2%
\$10m – \$19,999,999	5	1.4%
≥ \$20m	5	1.4%
Total	364	100%

Source: Human Services Agency

Most of the HSA professional services contracts are with nonprofit organizations. As of April, 2012, 302, or 83.0 percent of the 363 open professional services contracts were with nonprofits. As with the other figures stated in this profile, the total number of contracts does not represent a distinct number of nonprofits due to some having multiple contracts. The total contract amount

² Only one professional services contract has a ten-year term and it is for information technology services.

awarded to the nonprofits was \$532,606,941, or 68.7 percent of the total amount awarded to open contracts, as of April 2012.

Table I.10
HSA Non-profit Professional Services Contracts, as of April, 2012

	Non-Profit	All Professional Services	Non-Profit as a % of All Professional Services
Total Value of Contract Awards	\$532,606,941	\$775,675,504	69%
Total Number of Contracts	302	363	83%

Source: Controller's Office and Human Services Agency

In addition, most of the professional service contracts were awarded on a competitive basis. Only 40, or 11 percent, of the professional services contracts were awarded on a sole source basis. Though the number of sole source contracts represents a small share of the total number of contracts, the total amount awarded to these contracts was \$337,553,229, or 43.5 percent of the \$775,675,504 awarded to contracts as of April, 2012. These figures are summarized in Table I.11 below.

Table I.11
HSA Sole Source Professional Services Contracts, as of April, 2012

	Non-Profit	All Professional Services	Sole Source as a % of All Professional Services
Total Value of Contract Awards	\$337,553,229	\$775,675,504	44%
Total Number of Contracts	41	364	11%

Source: Controller's Office and Human Services Agency

Professional Services Contracts—All Categories

The Human Services Agency divides its professional services contracts into six main service areas. The Department of Aging and Adult Services (DAAS) Division includes professional services contracts for case management, home delivery, and congregate meals for adults age 60 and up, as well as adults age 18-59 with disabilities. These contracts represent the largest share of professional services contracts at HSA, with a total of 153, or 42 percent of the total awarded

contracts, for a total contract award amount of \$278,241,518, or 35.9 percent of the total \$775,675,504 awarded to contracts from HSA. The second largest service area for professional services contracts is Housing, with a total of 103 contracts, or 28.3 percent of the 364 contracts awarded as of April, 2012. Though there are fewer contracts in Housing, the total amount awarded to these contracts was as much as those awarded to DAAS, or \$276,319,163, also approximately 35.6 percent of the total amount awarded to contracts. Table I.12 shows the HSA professional services contracts by service area or type of contract, sorted in descending order of percentage of total contract amount.

Table I.12
HSA Professional Services Contracts by Service Area, as of April 2012

Contract Service Area/Type	Contract Amount	% of Total Contract Amount	Number of contracts	% of Total Contracts
Department of Aging and Adult Services	\$278,241,518	35.9%	153	42.0%
Housing	\$276,319,163	35.6%	103	28.3%
Welfare to Work ¹	\$136,321,466	17.6%	49	13.5%
Family and Children Services	\$39,006,473	5.0%	29	8.0%
Administrative/Miscellaneous/IT	\$37,965,899	4.9%	26	7.1%
Childcare	\$7,820,985	1.0%	4	1.1%
Total	\$775,675,504	100%	364	100%

Source: Human Services Agency

¹ Welfare to Work contracts include childcare subsidies administered by the Children's Council.

As of April, 2012, ten professional services vendors had \$387,651,200 awarded to them over several contracts, representing 50 percent of the total amount awarded to over 364 professional services contracts with HSA. These contracts serve multiple service areas, as shown in Table I.13 below. Tenderloin Housing Clinic Inc. is the largest professional services vendor with eight contracts for housing and the Department of Aging and Adult Services for a total contract award amount of \$139,428,910.

Table I.13
HSA 10 Largest Professional Services Vendors³, as of April, 2012

Vendor	Areas	Total Amount of Contracts
Tenderloin Housing Clinic Inc	DAAS*, Housing	\$ 139,428,910
Children's Council of San Francisco	Welfare to Work	\$ 117,512,925
Episcopal Community Services Of SF Inc	DAAS, Housing, Welfare to Work	\$ 31,468,382
Guardsmark	Admin/Misc/IT	\$ 19,326,260
Seneca Center	Family and Childrens Services	\$ 16,009,600
Catholic Charities CYO	DAAS, Family and Children Services, Housing, Welfare to Work	\$ 15,190,372
Institute Of Aging	DAAS	\$ 14,379,486
Hamilton Family Center	Housing	\$ 13,052,480
St Vincent De Paul Society	Housing, Welfare to Work	\$ 11,338,872
Compass Family Services	Childcare, Housing	\$ 9,943,913
Total		\$ 387,651,200

Source: Human Services Agency

*DAAS: Department of Aging and Adult Services

³ This analysis excludes contracts for the SF In-Home Supportive Services (IHSS) Public Authority, which had two contracts for a total contract award amount of \$187,792,135 and the IHSS Consortium with one contract for \$18,709,074.

1. Effectiveness of Program Performance Monitoring at DPH

- Despite previously reported findings and recommendations related to weaknesses in the Department of Public Health’s contract monitoring policies and practices, and subsequent efforts to improve, some DPH program monitoring weaknesses persist. Although the DPH Community Programs Business Office, which monitors contractors’ performance, has recently adopted monitoring tools (checklist, scoring guides, report templates) to standardize the process, the department has not conducted formal training on program monitoring or provided staff with training materials or manuals on program policies. In addition, the Department’s implementation of its contracts management system (COOL) does not ensure reliable access to contract documents and reports necessary for performance monitoring and quality assurance.
- As a result, program monitoring reports reflect inconsistent policies and procedures, and contractors are held to varying standards for performance monitoring. Under such conditions, it is difficult to assess the quality and consistency of service delivery.
- While the contract compliance staff must retain some measure of flexibility and discretion in assessing contractors and determining responses to findings of performance monitoring, the Business Office should develop written guidelines to standardize the use and interpretation of monitoring tools in order to insure fair treatment of all contractors.
- The Business Office should implement regular and formal training of monitoring staff, and continue to make improvements in its monitoring practices including a more consistently applied performance monitoring methodologies and the development of a contract management system that will insure reliable access to contract documents and reports needed for performance monitoring and quality assurance.

Community Programs Business Office

The Department of Public Health (DPH) created the Community Programs Business Office (“Business Office”) in Fiscal Year (FY) 2009-10 to streamline procedures by consolidating staff responsible for contract development, compliance and monitoring in one organizational unit. The reorganization was an outgrowth of the recommendations in

several studies and reports¹ pertaining to improvements in nonprofit contracting. The ultimate goal of the reorganization is to improve service delivery and client care through more efficient administration. The office had its first full year of operation in FY 2010-11.

In addition to streamlining business processes, the establishment of the Business Office was intended to create an objective and transparent performance monitoring process by placing the program performance monitoring function and staff and the program management staff in separate organizational units, thereby avoiding the potential conflict of interest that can occur when program management is also responsible for monitoring the contractor performance.

Citywide Fiscal and Compliance Monitoring and “DPH Only Monitoring”

As noted in the introduction to this report, the Controller’s Office has implemented a Citywide Fiscal and Compliance and Monitoring process for non-profit contractors that receive funding from more than one City Department. All funders of a given agency or contractor create a team and collaborate in monitoring the contractor’s compliance with the City’s fiscal and governance requirements.

Therefore, DPH contractors receive either a “DPH-only” fiscal and compliance monitoring or a Citywide fiscal and compliance monitoring but not both. Although contractors receive only one fiscal and compliance monitoring by City agencies, they are also subject to program monitoring which may or may not be coordinated with the fiscal and compliance monitoring.

The Community Programs Business Office Compliance Unit conducts “DPH-Only” programmatic and fiscal monitoring of contracts where DPH is the only funder. This monitoring is conducted at least annually and sometimes more frequently depending on the number of contracts with the Department a contractor holds. For example, contractors that receive some combination of city, state, and federal funding receive separate site visits for each funder because the funders’ guidelines and fiscal years differ.

Additionally, some contractors receive General Fund support from different DPH sections (Behavioral Health, HIV Health Services, Housing and Urban Health etc.). Such contractors are monitored separately by each funding source. The Citywide Fiscal and Compliance Monitoring Guidelines suggest that monitoring groups coordinate these visits in order to limit disruption of agencies’ work and DPH management reports that it attempts to do so. Based on sampling and limited interviews conducted during this audit, it appears that monitoring coordination efforts have been focused on cross-program coordination, while fiscal monitoring and program monitoring remain largely uncoordinated.

¹ Nonprofit Contracting Task Force 2003 Report; CBO Task Force “Partnering with Nonprofits in Tough Times, April 2009

Inconsistent Application of DPH Standards and Guidelines

While the department has made significant progress in improving the monitoring process for professional services contracts, there are additional opportunities to refine policies and protocols in order to ensure greater consistency and more effective contract management. The department has developed several policy documents, including the Business Office's Monitoring Matrix, which provide a very basic outline of the monitoring process. In addition, the BOCC has recently developed monitoring checklists, scoring criteria and more standardized report templates for use in FY 2010-11, which have been revised again for FY 2011-12 monitoring. However, interviews with staff members and a review of reports reveals that program managers continue to use different standards in performing assessments and completing reports. As noted above, some degree of variation is necessary due to the different types of services being delivered, as well as the regulations imposed by various funding sources. However, despite efforts by the department to foster standardization of contract monitoring, including the creation of the Business Office, inconsistencies remain.

Continuity of Monitoring Assignments

Each contract under the Community Programs division is typically assigned to three program managers and two analysts. The analysts represent the Contracts and Budget sections, and the program managers represent the Contract Development and Technical Assistance (CDTA) section, the Business Office and Contract Compliance (BOCC) section, and the System of Care (SOC). BOCC program managers maintain primary program monitoring responsibilities.

In response to requests, the Department provided the program monitoring reports for 34 selected contractors. Because DPH established the Business Office and Contract Compliance section in 2009, at which time changes to the program monitoring process were introduced, our analysis focuses on the post-BOCC sample, which includes 31 of the 34 contractors selected². Although some contractors have multiple contracts/programs with the Community Programs division, in order to ensure continuity of monitoring across an agency, one BOCC program manager is responsible for all of the programs/contracts under a single agency. However, according to the data sample, multiple BOCC program managers have monitored single agencies within a given year:

- In FY 2009-10, 10 of the 28 contractors (36%) in the sample were monitored by more than one BOCC Program Manager;
- In FY 2010-11, 8 of the 28 contractors (29%) in the sample were monitored by more than one BOCC Program Manager;

² There are a total of 31 contractors for FY09-11 in the sample, but 28 in each fiscal year.

In addition, although contractors are technically assigned to a specific BOCC program manager, in practice annual monitoring may be performed by another program manager. Because contract monitoring is subject to varying calendar obligations determined by the funding source, monitoring assignments may shift during the year in order to balance workloads for BOCC program staff. Although the reports do not indicate whether the report writer is the BOCC program manager officially assigned to that contractor, the review of the sample does show how often report writers changed from FY 2009-10 to FY 2010-11: 15 of 31 contractors (48%) were reviewed by different BOCC program managers from FY 2009-10 to FY 2010-11.

Given the frequency of these reassignments, the effective transfer of knowledge from one reviewer to another is critical to insure that contractors are sufficiently identified and assessed. However, DPH program managers noted during interviews that there is no official protocol in place for communication when staff assignments shift during a review cycle. There are no guidelines in place to ensure a process for permanently assigned staff to relay relevant contract information to the staff that will be performing the monitoring visit for that year. Conversely, there is no process to ensure that performance monitoring results are communicated back to program staff after a reassignment. Although senior department managers contend that permanently assigned monitors are copied on emails containing monitoring reports and all reports are posted in a shared electronic folder, the lack of formal internal communication exposes the Department to the potential for undetected performance issues. The physical proximity of staff desks and the presence of monitoring on standard biweekly meeting agendas does not sufficiently mitigate this risk. Particularly with inconsistently detailed written monitoring reports and in the absence of formal training (as discussed below), it is important that program monitors have sufficient familiarity with program deliverables and objectives, as well as recent program performance.

Implementation of the Rating System

An analysis of the data also illustrates the subjective nature of determining the severity of issues observed through the monitoring process. While the monitoring report templates vary across division and funding source, the department has successfully standardized certain components of the templates. DPH program managers now rate contractor performance across the following three categories - program performance, program compliance, and client satisfaction – using a numerical scoring system. In the sample reports, performance has typically been rated on a scale of 1.0 to 4.0. Since FY 2010-11, the department has revised the templates to detail scores within subcategories on a 100 point scale, that then translate to a score on the 4.0 scale.

It remains unclear, however, why the Department translates these scores back to the 4.0 scale and why the Department uses the rating system at all, since there are no written guidelines for staff to interpret the scores as part of the decision-making process and there is evidence of inconsistency. Interviews with program managers reveal that a monitoring score of less than three (3.0) often indicates whether a Corrective Action Plan should be developed. However, there are no written departmental policies or guidelines that detail appropriate performance thresholds and the sample reports clearly show that

scores do not consistently either reflect performance or trigger remediation. For example, one report from FY 2010-11 shows that a contractor scored 67% (or a 2.0) in Program Performance, and was not required to submit a Plan of Action while another report from the same year shows that a score of 84% (or 3.0) for another contractor triggered a Plan of Action requirement.

Of the 323 reports in our sample, 62 reports indicated that a Plan of Action was required by the contractor to remedy the deficiency identified. Of these 62 programs, 32 programs (51.6 percent) did not score below a 3.0 (or below 75, if a scale of 100 was used) on any of the three primary measures. In fact, four programs identified as requiring remedial action had perfect scores across all categories. For example, one contractor received perfect scores of 4.0 across all categories, despite the fact that a Plan of Action was required to address substantial data compliance problems. The program manager had identified significant discrepancies between the units of service reported on monthly invoices and the client service data entered into the Department’s health services database. In another instance, a contractor received a perfect 4.0 score, but was required to submit a Plan of Action to address problems with actual service delivery, where client treatment plans had not been updated with appropriate frequency. Again, the purpose of the 4.0 rating scale remains unclear, particularly as it makes less clear the strengths and weaknesses of a contractor’s actual performance.

Performance Rating Calculations

Although it remains unclear how the performance ratings are meant to be used, as a central component of performance monitoring, it is important that they be accurate. Prior to the establishment of the BOCC in FY 2009-10, more than 16 percent of the Community Behavioral Health Services reports in the sample contained errors in calculating performance scores, as shown in Table 1.1. The percentage of errors decreased significantly in FY 2010-11, but some degree of calculation errors remain

Table 1.1
Frequency of Errors in Calculating Performance Scores
by DPH Systems of Care

DPH System of Care	FY 08-09	FY 09-10	FY 10-11	Total
Community Behavioral Health Services	16.2%	9.1%	4.3%	29.5%
HIV Health Services	0.0%	2.7%	0.0%	2.7%
HIV Prevention Services	2.7%	5.4%	0.0%	8.1%
Housing and Urban Health	2.6%	0.0%	0.0%	2.6%
Total	11.2%	6.8%	4.3%	20.7%

Source: DPH Program Monitoring Reports

It should be noted that 65 percent of the reports in the sample were for Community Behavioral Health Services (CBHS) programs.

Most often, the errors were made in the tabulation of the Program Performance category. For example, in FY 2008-09, the CBHS Section used a monitoring report template that rated Program Performance based on the scores for two subcategories: Outcome Objectives and Units of Service Delivered. These measures were taken directly from the Exhibit A of the contract, which details the scope of services. In every instance where calculation errors occurred, the errors overrated performance. For example, one program received a score of 3.5 for Program Performance, where 7 objectives were assessed in the subcategory for Outcome Objectives. However, the program manager used only 6 of those assessments for the rating calculation to show that 5 of the 6 objectives had been “met”. The last objective that was not included was also “unmet”, and if it had been included, it would have lowered the contractor’s overall score.

Clearly, the Department has made progress in reducing the frequency of miscalculations since the BOCC was established in FY 2009-10. However, as the Department moves towards more quantitative and less qualitative reporting, the accuracy of scores becomes increasingly important.

Inconsistent Oversight

Every program monitoring report must be signed by the author, another BOCC staff member (often the BOCC Director of Compliance), and the appropriate System of Care (SOC) program manager. While all reports in the sample reflected all three signatures, the level of actual review remains unclear. Interviews with program managers revealed an inconsistent level of review of and follow-up on monitoring reports. For example, one SOC program manager reports that, due to heavy workload, sometimes that manager only reads reports for programs with scores below 4.0. However, as described above, contractors that earn high or even perfect scores may also exhibit problems that require a plan of action. A reviewer who only scans the numeric scores would not become aware of problems that would only be noted in narrative form. Further, although the Department adapted the monitoring report template in FY 2010-11 to reserve a specific section for SOC program managers’ comments, these have been provided on only one of the 113 sample reports from that year.

Inconsistent Level of Detail in Program Reports

In addition, because the monitoring process is not sufficiently standardized, contractors can be subject to inconsistent assessments. According to DPH contractors, program managers have different approaches to the monitoring process. For example, one contractor, which has had contracts with the Department for decades, referred to some program managers as “negative gatekeepers” and expressed relief that the manager assigned to the organization had not been changed during the reorganization of the Department, noting “it makes it easier on us because different monitors look at different things.” Another contractor interviewed expressed concern that the program manager assigned “was tired of the organization and it showed in the monitoring reports.”

An analysis of the program monitoring reports in the sample shows wide variation in the detail provided by program managers. In fact, the reports show that while DPH has

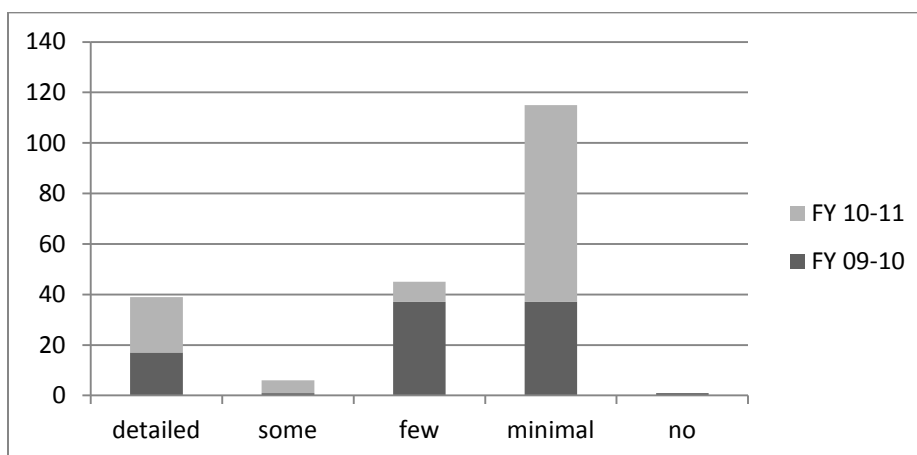
increased its focus on improving the monitoring process over time, the reports themselves provide less information. That format has been replaced with a template that focuses instead on administrative compliance and client chart records.

In a similar trend, the actual narrative detail provided by program managers on the monitoring reports has decreased. To characterize the level of detail provided by program managers in the report, the following categories were used:

- No Detail: reports were signed and appropriate boxes checked, but no additional narrative regarding performance was provided
- Minimal Detail: program manager included up to two sentences of narrative in the body of the report.
- Few Details: program manager provided more than two sentences of narrative detail in one section of the report.
- Some Details: program manager provided more than two sentences of narrative detail in more than two sections of the report.
- Detailed: program manager wrote multiple paragraphs of narrative detail to support findings.
- Highly Detailed: program manager wrote multiple pages of narrative detail to support findings.

The chart below shows how levels of detail have changed over time for DPH program monitoring reports, with a specific focus on those reports that were completed following the creation of the BOCC

Chart 1.1
Level of Detail in DPH Program Monitoring Reports



Source: DPH Program Monitoring Reports

While the Department has clearly adapted the monitoring template and process towards more quantitative and less qualitative information, there remains a lack of clarity in how the scores are used. Since program monitoring reports offer more limited information, performance scores are sometimes inaccurately calculated, and monitoring staff assignments regularly shift, the Department is limited in its ability to ensure proper oversight and detect program deficiencies.

Inadequate Training in Program Monitoring

DPH has not developed formal training or written guidelines for Community Programs Compliance managers who conduct performance monitoring. Instead, information regarding changes to the monitoring process is discussed at monthly staff meetings as part of regular business.

Without such guidelines and training it is more likely that different compliance monitors will come to different conclusions regarding appropriate response and follow up. As described throughout this section, the sample of program monitoring reports reviewed for this audit contains substantially inconsistent quality of information. For example, some reports have no program description and some have no recommendations. There is no analysis of why an objective was met or not met, and no explanation why units of service was exceeded or not met.

Training deficiencies were noted by the San Francisco Community Based Organization Task Force convened in 2009 to make recommendations on how the City and its nonprofit partners could be strategic in their business relationships³. In a report to the Health Commission⁴, Department management noted numerous training opportunities available to contractors and staff offered by the Business Office of Contract Compliance and the Controller's Office. However, training was either limited to fiscal and compliance matters or was focused on specialized areas such as chart/billing documentation training and cultural competence training.

While the contract compliance staff must retain some measure of flexibility and discretion in assessing contractors and determining responses to findings of performance monitoring, written guidelines for program monitoring are required in order to assure fair treatment of all contractors. Particularly given the recent reorganization described above and the introduction of new monitoring tools, management should provide program monitoring staff with regular, formal training on broadly applicable best practices, use of monitoring templates and other monitoring practices. While the Business Office is fortunate to include many veteran DPH staff (with an average DPH tenure of more than 23 years, according to the Department), training remains critical, especially in the context of changing tools, techniques, and systems that have been so prevalent in recent years.

³ Strengthening The Partnership: Recommendations for the City and CBOS: December 2010 (page 5); Partnering with Nonprofits in Tough Times; Recommendations from the San Francisco Community Based Organizations Task Force (Page 21)

⁴ Memorandum from DPH Director Barbara Garcia to the Health Commission: October 31, 2011

Contracts Management System Incompletely Implemented

The Department of Public Health launched the Contracts Online (COOL) database in 2004, after procuring the system through a competitive Request for Proposal process. The new system was intended to create a centralized, electronic document repository to facilitate document sharing and processing between the various internal staff that manage contracts.

The COOL system has since been expanded to allow access to contractors who can upload information, including invoices, to the system in order to expedite processing. In addition, the City, through the Controller's Office, procured the database to share it with all City Departments participating in the Citywide Joint Fiscal Monitoring Process.

Contracts Database

One of the two features of the system is a contracts database, which allows DPH Contracts staff to track basic information on all contracts, including: contractor name, contractor address, contract term, contract amount, and services to be delivered.

Initial conversations with IT and Contracts staff indicated that a listing of DPH contracts, including term periods and total amounts, could be easily generated by querying COOL. However, a request for this information was submitted on April 6, 2012 and as of the submission of this report, has yet to be received in its entirety. Three of four parts of the information were received by June 20, 2012, and the Department states that another system, CMS, was used to generate this information. Although the Department has not explained the explicit challenges faced in producing this information, the database function has clearly lost some of its efficacy – whether due to insufficient management or outdated functionality.

Contract Document Repository

Despite the innovation of the system at the time of its launch, and its later expansion to share monitoring reports citywide, DPH program managers cite multiple frustrations with document management function of COOL. In fact, most described the variety of ways in which they circumvent the system in order to complete their regular work – including physically traveling to other DPH sites to photocopy hard files. Program managers described in detail the time spent searching through folders in COOL to locate contract documents and previous program monitoring reports – often to no avail. The inefficiencies created by this breakdown in the system impair the staff's ability to receive and share important contract information. From interviews with DPH staff at all levels, it is clear that the system no longer functions as intended.

File Naming Conventions

Staff members point to three key problems with COOL: file naming conventions, file locations, and general uploading protocols. Staff described the problem with inconsistent file naming conventions in detail, and a review of the data sample provides a useful

perspective on the challenges. Table 1.2 below shows the various formats used to name the reports that were submitted for the audit sample.

Table 1.2
File Naming Conventions Used in the Sample Reports

Audit Sample File Name Conventions
Contractor_Program_FY_”MRS&Findings”
Organization Program “MR” FY
FY Funding Source Organization Program
FY Organization Program “Monitoring”
Organization Program “Monitoring”_FY
Organization_Program “Monitoring”_FY
Organization “Signed Monitoring” FY
Year_DPH Section_Contractor_Program
Contractor_Program_FY_”MRS&Findings”
DPH Section_Contractor_Program_FY_”MRS”
FY_Section_Organization_Program
“MR”FY_Section_Organization_Program
OrganizationProgram_FY_”MRS&Findings”

Source: DPH Program Monitoring Reports

The sample reports showcase 13 different naming conventions for 323 records. Program managers report that actual contract documents, including the original certified contract and all subsequent modifications, can be difficult to identify based on the various ways in which documents are named. Here again program managers say that they will often make a copy of the hard record, which they then keep in their own contract files. Assuming that documents are filed in the proper location, such inconsistencies might be less problematic for the user. But program staff report that files are often not saved to the appropriate folder in COOL. Each contract has “Archived” and “Current” folders, and often documents are located in the wrong one.

COOL Training

While Contracts Office staff point to training resources that can be found in COOL, many program managers remain unaware that these tools exist. Similarly, some staff reported that the only actual training session for COOL contract management practices was held in conjunction with the system’s launch in 2004, even though management notes that the Contracts Office has conducted multiple group training sessions since COOL’s roll-out. These inconsistencies underscore the need for new training for all staff. Additional training resources should be provided, particularly given the reorganization of the Community Programs division, and the heightened focus on contract management

practices. COOL was designed to make contract management more efficient. It seems likely that developing standards and ensuring proper training would be sufficient to bring the system to a greater level of efficacy.

Conclusions

Despite significant efforts and improvements in recent years, DPH's contract monitoring review practices, data collection and reporting could be improved. In addition, DPH needs a clearer and more consistent level of supervision and adequate training for qualified monitors. While the Department's BOCC has begun to remedy these deficiencies, and Department management has noted that program performance monitoring is evolving, several opportunities for short-term improvement exist. The BOCC should implement regular and formal training of monitoring staff, and continue to make improvements in its monitoring practices including consistently applied performance monitoring methodologies, and development of a contract management system that will insure reliable access to contract documents and reports needed for performance monitoring and quality assurance.

Recommendations

The Department of Public Health should:

- 1.1 Enhance program monitoring policies and protocols to provide step-by-step details for staff regarding the entire process by:
 - (a) Defining the purpose and meaning of the numeric scoring system, and establishing clear thresholds for action based on numeric scores.
 - (b) Ensuring continuity in the monitoring process such that program managers are familiar with a program's history and status.
 - (c) Establishing a formal internal review process to identify any errors in the program monitoring reports and include the review process in BOCC staff training.
- 1.2 Create clear training materials and resources to ensure that existing and revised processes are adequately communicated to staff by:
 - (a) Developing resource materials that can be readily accessed by staff.
 - (b) Hosting annual COOL training opportunities for staff to refresh knowledge and learn about new features or policies.

- (c) Implement periodic quality assurance measures and conduct staff trainings at least annually to ensure that policies are being implemented.
- 1.3 Ensure that the functionality of COOL continues to improve the performance and efficiency of the Contract Management and Monitoring functions of the Department by:
- (a) Developing standards for naming conventions and file locations.
 - (b) Creating training opportunities for staff and require participation.
 - (c) Establish a COOL/Documents Management Committee, with representation from all sections and staff levels, to ensure the improvement of functionality, identification of future problems, and the opportunity for further system enhancements.

Costs and Benefits

Enhancing the program monitoring process and protocols will allow the Department to demonstrate the efficiency and cost-effectiveness of service delivery provided through professional services contracts. This will provide the Board of Supervisors and the Health Commission with improved opportunities for oversight and information regarding programs that are operated by contractors. In addition, expanding training opportunities for staff – both for program monitoring and document management through COOL – will eliminate inconsistencies and create valuable efficiencies for staff to complete assignments.

Although all will require additional time, these recommendations can be implemented using existing department resources.

2. Effectiveness of Program Performance Monitoring at HSA

- **The Human Services Agency's (HSA) program managers are responsible for monitoring service contractors' performance. Because HSA does not have agency-wide guidelines for program managers on how to conduct performance monitoring, program managers have discretion in determining what service and outcome objectives to measure. As a result, HSA contracts may have different service and outcome objectives for similar services, lack specific and quantifiable measures of these objectives, and have a varying number of objectives across contracts, making it difficult to compare services provided by different contractors in similar service areas and ensure high quality of services throughout the city. In 2009 HSA began reviewing service contracts to standardize objectives for similar contracts (clusters), reduce the number of objectives in each contract, and streamline data collection. Due to staffing issues, HSA has only reviewed 141 of HSA's 363 service contracts (38.8 percent).**
- **Neither program managers nor contractors have consistent understandings of program performance monitoring. Contractors are required to submit quarterly and/or annual performance reports to their program managers, but are not provided consistent expectations. One contractor, who regularly submitted reports to two program managers for different contracts, was provided feedback by only one program manager. After 2 ½ years, the program manager that had not provided feedback conducted a site visit, identifying deficiencies in documentation of services. The contractor was subsequently placed on a corrective action plan, after receiving no feedback in the prior 2 ½ years.**
- **In contrast to HSA fiscal monitoring, which includes high level periodic summary reports available for management review, HSA program monitoring does not produce such tools for high level review of program performance. In the absence of such tools or procedures, division managers and program directors are hindered in their ability to efficiently ensure that program managers are adequately overseeing contractor performance.**
- **HSA should revise its guidelines, standards, forms, and templates, to standardize contractors' monitoring and reporting procedures. In developing the new contract management system, HSA should also ensure sufficient information for division managers and program directors to oversee contractor performance.**

Program Manager and Contract Manager Division of Labor

Each contract with the Human Services Agency (HSA) is assigned a program manager and a contract manager. The program manager is primarily responsible for monitoring and assessing the program performance of contractors to ensure compliance with the scope of services in their agreement(s) with HSA, and State and Federal regulations. Program managers typically specialize by programmatic area as reflected by the Agency's primary service divisions. The contract manager conducts the administrative monitoring for the contract, including fiscal monitoring of invoices and compliance with citywide fiscal and contract compliance standards. This section focuses primarily on the effectiveness of program monitoring at HSA, which the audit team found to be generally less comprehensive and consistent than HSA's fiscal monitoring.

Lack of Agency-Wide Guidelines for Program Monitoring

The Human Services Agency does not have agency-wide guidelines for program managers on how to conduct performance monitoring. This results in program managers having substantial discretion on several key issues in monitoring, including determining (a) what service and outcome objectives to measure and (b) whether to conduct site visits or have contractors complete self-assessments.

Service and Outcome Objectives

HSA has already identified agency-wide weaknesses on how program managers set service and outcome objectives for contractors. In response to the HSA strategic review conducted in 2008¹, HSA established a Community Partnerships and Contracting Workgroup consisting of Agency staff and contractors in 2009 to consider issues related to contracting within the Agency. The Workgroup observed inconsistencies in the quality of service and outcome objectives within HSA agreements, including lack of specific and quantifiable measures of service delivery or program achievement, and a varying number of objectives across contracts, with one having as many as 29 objectives. The Workgroup subsequently recommended that "planning staff work with program staff to devise the most efficient and useful performance measures."² Such inconsistencies made it difficult to compare services provided by different contractors in similar service areas and ensure high quality of services throughout the city.

In response to the Workgroup's recommendations, the Agency's Policy and Planning Division, in coordination with program managers, reviewed 141 of HSA's 363 service contracts (38.8 percent) to standardize objectives for similar contracts (clusters), reduce the number of objectives in each contract to two to four, and streamline data collection³. Of the contracts reviewed, 114 or 80.9 percent were housing and homeless contracts, which HSA reported targeting first because of the stronger quality of objectives and outcomes in these contracts than compared to those in contracts for the other divisions.

¹ "San Francisco Human Services Agency Strategic Review," November 1, 2008.

² "SF HSA Community Partnerships and Contracting Workgroup Draft Report," Fall 2009.

³ "Contract Cluster Reviews: Service and Outcome Objectives Overview," created for HSA program staff.

HSA has not reviewed the remaining 222 service contracts because, according to Agency management, the contract cluster review project has been temporarily suspended and will likely continue once the Agency hires an additional staff person to oversee the completion of the review and ongoing management of contracting quality assurance projects.

Cost per Service Unit Analysis

The absence of standardized service and outcome objectives can result in varied costs of services among contracts. HSA analyzed family supportive housing contracts to develop its proposed Fiscal Year (FY) 2011-12 budget, and found that the cost per unit of service among contractors ranged from approximately \$8,500 to \$500 per unit in FY 2009-10. Taking into consideration various factors such as the age of the programs and types of services provided, HSA was able to reduce contract budgets based on a formula that included the median cost per unit for all family supportive housing contracts. The proposed contract savings ranged from \$326 to \$71,284 for FY 2011-12.

During the course of this audit, Agency managers stated their intention to continue efforts to further develop this type of analysis. For example, HSA is assessing the costs associated with finding housing for current and former foster care youth ages 18 through 24 using data from its Transitional Housing Placement (THP) Plus contracts. HSA management anticipates that this analysis will be completed before February 2013.

Site Visits versus Self-Assessments

Although program assessment forms, created to assist program managers in program monitoring, state that the assessment could be completed by a program manager based on a site visit or a self-assessment completed by the contractor, the form does not list the criteria used to determine which type of assessment should occur for program monitoring. Additionally, the Agency has not provided guidelines for program managers describing the process for determining whether a contractor should receive a site visit or conduct a self-assessment. One program manager stated that she conducted a site visit for all of her contracts, but that her colleagues may conduct a site visit for a sample. Further, in the absence of both written guidelines regarding site visits and lack of central Agency oversight of the program monitoring process (discussed below), some program managers may not conduct an annual program review at all. For example, one program manager interviewed for this audit reported being employed as a program manager at the Agency for approximately three years before becoming aware of the requirement to conduct an annual site visit or self-assessment.

In contrast, Human Services Agency contract managers responsible for fiscal monitoring and compliance with citywide contract policies utilize a standard risk assessment form to determine whether the fiscal and compliance monitoring requires a site visit or self-assessment. The risk assessment form contains six criteria, in which affirmative responses to the first four criteria automatically result in a site visit. The criteria for the

risk assessment are the same as those listed in the Citywide Fiscal and Compliance Monitoring Guidelines and include whether the contractor:⁴

- Has not, within the last two years, received a site visit-based monitoring;
- Provides services that must receive annual physical site visits (i.e. due to program type or funding source);
- Has shown areas of “significant concern” in previous monitoring reports, and corrective action(s) were not implemented within one year;
- Has consistently been delinquent in submitting required fiscal reports, or lacked required documentation;
- Has “material weaknesses, noncompliance or reportable conditions” in its most recent audited financial statements; and/or,
- Has experienced other significant events related to services provided (i.e. changes in program discretion or mission, key staff, funding, etc.)

Because HSA does not have agency-wide guidelines for performance monitoring, contractors with more than one contract with HSA may report to several different program managers with inconsistent monitoring procedures. One non-profit contractor that provides permanent housing and supportive services for adults had been submitting quarterly reports for two of its programs to its respective program managers. One program manager provided feedback to the contractor noting that the reports were received and sufficient, whereas the other program manager provided no feedback. After over two and half years into the contract, the nonresponsive program manager notified the contractor that it was due for a comprehensive program monitoring site visit. As a result of the site visit, the program manager identified deficiencies in the documentation of services and outcome objectives, which the contractor had previously reported in the quarterly reports as having met. The contractor was subsequently placed on a corrective action plan. According to the contractor, it would have been helpful if the nonresponsive program manager had: (a) communicated expectations regarding quarterly monitoring reports; (b) requested back up documentation for objectives stated in the quarterly monitoring reports; and/or (c) conducted a site visit earlier in the contract period.

The Agency should create guidelines or a risk assessment similar to that used by contract managers for determining whether a site visit or self-assessment is required for monitoring program performance. These guidelines should be used to ensure that significant time does not pass before a contractor receives a site visit for program performance monitoring and issues of concern from previous monitoring reports are addressed in a timely manner. Additionally, all staff should be made aware of and trained on these guidelines.

⁴ “FY 2010-11 Joint Fiscal & Compliance Monitoring Nonprofit Contractor Risk Assessment,” created for citywide use.

Inconsistent Program Monitoring Reports and Templates

HSA requires contractors to submit quarterly and/or annual reports to their program managers on how they meet their service and outcome objectives. Program managers are required to prepare an annual assessment report of the contractor's program performance. These reports are not standard or consistent among contractors and program managers, based on our review of a sample of program monitoring reports over the past three fiscal years, and as described below. By contrast, we found that HSA's fiscal monitoring reports prepared by contract managers, which utilize the Citywide Fiscal and Compliance Monitoring Guidelines and forms, are more consistent.

Contractors' Quarterly and Annual Reports

While most contractors are required to submit quarterly reports and/or an annual report to HSA describing how the contractor is, or is not, meeting the service and outcome objectives stated in their agreement's scope of services, the requirement, including the frequency of the reports, is not consistent across all contractors. HSA may also request changes to reporting frequency during the term of the contract.

For example, one contractor that provides meals and nutrition to elderly communities is required to submit monthly client data and an annual report regarding the service and outcome objectives of the program, according to the scope of services. However, the program manager and contractor reported that the contractor is now required to submit quarterly reports to the Agency, though no amendment reflecting this change could be found in the scope of services.

Also, some contractors submit three quarterly reports and an annual report that includes data from the last quarter, while others submit four quarterly reports and a separate annual report. In contrast, one program manager stated that her contractors are not required to submit an annual report because the information would be duplicative of the quarterly reports.

Contractors also submit reports in various formats. These formats range from long narratives to a hybrid of brief statistics with some narrative, to the completion of a standard form or checklist. The variations may exist among multiple contractors within the same area of service (i.e. housing, aging and adult services, welfare to work, etc.), or even when one contractor has multiple contracts for various services or sites (i.e. housing sites, community centers, etc.).

Standardizing the frequency and format of contractors' reports could streamline the reporting process and facilitate analysis and comparison of contractor performance. Because some contractors may be submitting the same program monitoring reports to multiple funding agencies, HSA managers should work with contractors to develop standardized reports and procedures that also accommodate various funding requirements.

Human Services Agency Program Managers' Monitoring Reports

Utilizing the same standards for assessment of program performance, particularly for contractors providing similar services, ensures that clients receive (a) the services stated in the contractors' scope of services and (b) quality services when compared to the same or similar services provided to other clients throughout the city. The Agency has created a standard program assessment form for program monitoring which includes sections reviewing:

- Program units of service;
- Quality of the program, based on reviews of program files or records, client satisfaction surveys, and other specific standards; and,
- Program outcomes, based on service and outcome objectives stated in the agreement.

However, the standard program assessment forms have been reformatted by some program managers to fit the needs of their programs and contracts. For example, the forms may or may not include numeric scoring as a way to assess the level of compliance with each standard. Further, some program assessment forms include additional required standards based on State or Federal regulations in a particular program area, such as adult services and nutrition.

Additionally, program managers do not consistently use the standard program assessment forms to measure program performance. For example, a contractor with 14 separate contracts with HSA, totaling \$15,190,372 in funds as of April 2012, has ten separate program managers for its housing, family and children services, aging and adult services, and welfare to work contracts. The three program managers responsible for the contractor's housing contracts used three distinct formats for providing feedback to the contractor, which included: (a) completion of a standard program assessment form; (b) a letter with bold subheadings that matched some of the standards used in the standard program assessment form; and (c) a letter with general comments and subheadings that do not match the standards used in the standard program assessment form.

The Agency should review all program assessment forms, including those that have been reformatted by program managers, and revise the program assessment forms and ensure standardization, at least across similar types of services provided by contractors. Further, the Agency should develop methods for ensuring that program managers utilize the standard program assessment forms, such as through periodic supervisory reviews.

Management Oversight of Contractor Performance

In contrast to HSA fiscal monitoring, which includes high level periodic summary reports available for management review, HSA program monitoring does not produce such tools for high level review of program performance. According to Agency staff, each program manager is responsible for tracking each contractor's submission of timely quarterly and annual reports for program monitoring. While quarterly and annual program monitoring reports are stored in an agency-wide server, HSA division managers and program

directors cannot quickly and consistently access these reports, and, in the absence of high level program performance summary reports, they cannot quickly identify which contractors may be delinquent in their submissions. Especially given the inconsistency observed in program monitoring practices among the program managers, summary reporting tools and procedures should be developed for division managers and program directors to oversee contractor performance. Department management states that the program monitoring module within the new contract management system, Contracts Administration, Reporting, and Billing Online (CARBON), will provide the capability to produce such reports. As HSA launches this new module, management should ensure that, at a minimum, a report is developed to track which contractors do and do not submit program reports, and identify any contractors with possible performance concerns.

Further indication of the limited availability of program performance information is that not all program monitoring reports are available on the server. HSA was not able to provide auditors all quarterly and annual reports for three fiscal years. Table 2.1 below provides a summary of reports that were unavailable for the sample of contracts for each of the last three fiscal years.

**Table 2.1
Number of Contracts Without Quarterly and Annual Reports Provided**

	FY 09-10		FY 10-11		FY 11-12	
Total Sample	71		107		123	
	No Reports	Partial Reports*	No Reports	Partial Reports*	No Reports	Partial Reports*
Number of Contracts	23	16	27	33	20	33
Percent of Total Sample	32.4%	22.5%	25.2%	30.8%	16.3%	26.8%

Source: HSA Program Monitoring Reports

*“Partial reports” indicates that less than three quarterly reports and/or an annual report was not provided.

As part of fiscal and compliance monitoring, the Office of Contract Monitoring prepares an annual risk assessment for each contract that identifies whether:

1. The contract requires an annual site visit;
2. Corrective actions were taken within one year;
3. Required fiscal reports and documentation were submitted;
4. The most recent audited financial statements contained reportable or noncompliant conditions; and
5. The contractor experienced significant events, such as staff turnover or resignation of a director.

The Office of Contract Monitoring records “yes”, “no”, “new contract”, or “n/a” without further explanation. If the contractor received corrective action, no additional information regarding the corrective action is provided, such as (a) when the contractor was placed on corrective action, (b) details of the corrective action plan, and (c) the severity of the corrective action status (i.e. the contractor has repeatedly failed to submit requested documents, the corrective action plan is not acceptable, or the corrective action plan was not implemented).

Further, in the risk assessment for FY 2011-12, eight organizations were identified as having areas of significant concern and/or had not taken prescribed corrective action(s) within the previous year. However, only two of the organizations were included in the list of contractors on corrective action in FY 2011-12, provided by HSA. According to HSA management, if the Agency is not planning to renew funding for the organization, managers will not place them on corrective action. Five of the eight organizations had contracts through 2013 or 2014 and were not part of the list of organizations that lost HSA funding in FY 2011-12 due to merging of contracts or declaring bankruptcy. Therefore, these five should have been placed on corrective action. Given such discrepancies, managers may not be able to easily identify low-performing contractors on a real time basis.

HSA is currently developing program reporting and monitoring modules in its new contract management system, CARBON, which should provide division and other managers better access to contractor performance information. The program reporting module is intended to allow contractors to input high level performance data on service and outcome objectives on a monthly or quarterly basis through the online system, replacing the requirement to produce and email quarterly or annual program reports. Additionally, Agency staff will be able to run high level reports showing which contractors had not submitted data by set deadlines, as well as additional high level analysis of the service and outcome data submitted across service areas or the entire Agency. According to HSA management, with the implementation of CARBON, contractors will be required to be current with program reporting prior to receiving payments. Implementation of the program reporting module is expected to be completed in October, 2012.

The program monitoring module is still in development and is expected to be implemented after the program reporting module is operational. This module is intended to collect data and produce high level reports based on the findings from program managers’ site visits or the contractors’ self-assessments of program performance. The Agency should consider ensuring that the program monitoring module has capabilities of reporting key program monitoring findings, required actions, and timelines from the program monitoring reports.

Communication between Program and Contract Managers

HSA's contracting protocols state that “programs and OCM (Office of Contract Management) can and should work together professionally and cooperatively in developing and managing contracts”. The contracting protocols define the respective responsibilities for contract managers (administering compliance with department, state, federal, and City requirements), and program managers (ensuring conformance to service objectives and program needs).

However, communication between program and contract managers is inconsistent. For example, according to HSA contracting protocols, budget revisions must be approved by both the program and contract manager but program and contract managers do not always coordinate on budget details. Agency staff reported that contractors may provide different versions of the budget to one manager or the other, which could result in payments based on incorrect budgets. One program manager recounted an instance in which a significant budget modification was granted for a contractor with the involvement of the contract manager and other Agency staff but without the matter ever being communicated to the program manager. Since the program manager was never consulted during the process, the program manager’s perspective about the advantages and disadvantages of the decision were never considered.

Contracting protocols state that program staff must provide written monitoring reports to OCM at least once per year, yet contract managers reported varying access to written reports. One contract manager reported that contractors submit monitoring reports to both the program and contract manager on a quarterly or annual basis, while another contract manager reported that they had never seen a program report submitted by a contractor, though they should have access to them through the Agency server. The same contract manager noted that she contacts program managers for their input when it is time to review the contract for renewal. As a result, the contract manager may not be aware of any program performance issues until well into the contract term.

Contract managers’ consistent access to and review of program performance data and program monitoring findings could help the Agency identify and begin to address performance issues well before a contract is being considered for renewal, allowing the Agency sufficient time to consider alternatives, such as identifying a new contractor, to ensure that adequate services are provided to communities. Agency staff have reported that there are opportunities to discuss program issues through monthly meetings with service area liaisons (contract managers), and informal phone calls and emails, but these opportunities may not be utilized by all program managers when there are program performance issues.

The implementation of the CARBON contract management system, particularly the program reporting and monitoring modules, could improve contract managers’ ability to work with program managers when performance issues surface because all managers will have access to the same budgets and program performance reports.

Inadequate Formal Training on Program Monitoring

The Human Services Agency does not have a formal training curriculum on program performance monitoring for program managers. A handbook with policies and procedures, standards, or guidelines for program monitoring does not exist. Program managers reported they received on the job training for program performance monitoring or had to obtain continuing education on service area regulations and standards through outside trainings, which shaped their procedures and process of performance monitoring.

Contract managers similarly reported receiving most of their training for fiscal and compliance monitoring through reviewing other contracts, forms, and receiving guidance from supervisors. However, contract managers utilize the Citywide Fiscal and Compliance Monitoring Guidelines for a majority of their work. Additionally, contract managers are able to attend the City Controller's annual fiscal and compliance monitoring training.

To complement the development of standard forms, templates, and guidelines, the Agency should develop a formal training curriculum, including a handbook. Human Services Agency management reported recognizing the need for such tools and is proposing to create a new position, in which one of the main responsibilities would be to develop the handbook and training curriculum for program and contract managers.

Conclusions

The Human Services Agency lacks agency-wide guidelines, standards, forms and templates for consistent program performance monitoring, and as a result, monitoring contractor's performance is inconsistent among program managers. Also, monitoring of contractor performance ends with the program manager. HSA does not have standard procedures for division and other managers to oversee contractor performance. HSA should revise its guidelines, standards, forms, and templates, to standardize contractors' monitoring and reporting procedures. Also, HSA does not have a formal training curriculum or handbook for program performance monitoring, but should develop such tools and train staff after developing central guidelines, standards, forms and templates.

Recommendations

The Human Services Agency should:

- 2.1 Revise program performance monitoring policies and procedures to include standard procedures by service area (or cluster) for:
 - (a) Quarterly and annual reports submitted by contractors, including frequency and format; and for program managers to provide feedback to contractors; and

- (b) Annual assessments conducted by program managers, including criteria for conducting site visits or requiring self-assessment by contractors, and standardized reporting formats.
- 2.2 Complete the review of all contract service and outcome objectives to standardize objectives for similar contracts (clusters), reduce the number of objectives in each contract to two to four, and streamline data collection.
- 2.3 Develop a handbook and formal training curriculum for program and contract managers that include revised policies and procedures, guidelines, and standard forms for program performance, fiscal, and compliance monitoring. All existing and new program and contract managers should receive the handbook and participate in the training.
- 2.4 Develop program reporting and monitoring modules for the CARBON contract management system that includes:
 - (a) The collection of simple and consistent service and outcome objective data that is comparable across contractors that provide similar services.
 - (b) Central tracking and reporting of contractors that do not submit program data in a timely manner.
 - (c) Central tracking and reporting of contracts with program, fiscal, and/or compliance monitoring findings, required corrective action(s), timelines, and the status of corrective action(s).

Costs and Benefits

Implementation of these recommendations will require additional staff time. However, streamlined data collection, centralized tracking of key program performance issues, and consistent use of standard forms and performance monitoring procedures could subsequently lead to reducing staff time currently expended on program performance monitoring. Additionally, financial compensation for underperforming contractors could be reduced and/or redirected to other contractors for similar or new services.

3. DPH Sole Source Contracting

- **The San Francisco Administrative Code allows sole source contracts when commodities or services are available only from a single source and where proprietary software or maintenance of equipment by a particular vendor is required to preserve a warranty. Additionally, Section 21.42 of the Administrative Code authorizes “professional services contracts for health and behavioral health services and support, where such services are provided by non-profit organizations and a sole source designation is recommended by the San Francisco Department of Public Health.”**
- **An estimated 22 percent of the dollar value of all DPH professional services contracts are selected on a sole source basis, not including approximately \$134 million budgeted in FY 2011-12 for the affiliation between DPH and UCSF. Excluding contracts for the administration of Healthy San Francisco, sole source contracts are 18 percent of the dollar value of DPH’s professional services contracts.**
- **On at least three occasions in FY 2011-12, DPH has failed to conduct competitive bid processes for contracts previously awarded on a sole source basis under the condition that they be bid competitively subsequent to the original award, and DPH has not surveyed the availability of providers of goods and services previously obtained through sole source contracts as required by the Administrative Code.**
- **DPH does not have written guidelines for sole source contracting, does not provide adequate rationales for sole source contracting in its sole source waiver requests, and does not report fully on the rationale of its sole source contracting to the Health Commission or Board of Supervisors.**
- **DPH should develop written policies on sole source contracting, conduct the surveys that are required by Administrative Code Section 21.42, and include full rationales for sole source contracting in its sole source waiver requests. Reporting on sole source contracts to the Health Commission and the Board of Supervisors should be improved to include complete justification for why a competitive process was not used.**

Appropriate Uses of Sole Source Contracting

The City’s competitive bid process is intended to promote fairness, competition, and transparency in the interaction between the City and vendors who wish to provide goods or services to City departments, and to ensure that the City receives the highest quality in goods and services at the lowest price. The competitive bid process requirement is established in Administrative Code Section 21.1, which states: “All City contracts for

commodities and/or services shall be procured through competitive solicitation, except as otherwise authorized in this code.” Competitive bids are solicited through issuance of a Request for Proposals (RFP), and the process is carried out with coordination between departmental staff and the City’s Office of Contract Administration (OCA). Entities that respond to an RFP are ranked on their responsiveness to the RFP and contracts are generally awarded to the highest scoring bidder.

Sole source contracting is an alternative selection process in which a contract is awarded to a contractor without fulfilling the requirements of the competitive process. The Administrative Code limits the instances in which sole source contracts are appropriate as follows.

- Section 21.30 allows sole source contracts with vendors who have proprietary rights to software and hardware and for associated maintenance agreements.
- Section 21.5(b) states that procurement of commodities or services available only from a sole source shall be made in accordance with Purchaser’s regulations.

In other words, award of a sole source contract may be appropriate when there is only one supplier of a particular good or service or in other limited circumstances such as emergencies or when a competitive bid would jeopardize the continued delivery of essential goods or services. The Director of Public Health confirmed that it is her understanding that sole source contracts should only be used as short-term solutions in cases where an urgent need necessitates more expeditious action than is possible via the competitive bid process.

All departments seeking sole source contracts must submit a sole source waiver request to OCA describing the rationale for the sole source contract and receive OCA approval before proceeding with or entering a sole source contract. Additionally, departments seeking sole source contracts other than those funded by state or federal grants must secure a waiver of compliance with Administrative Code sections 12B (Equal Benefits) and 14B (Local Business Enterprise) from the Human Rights Commission.

Specific Code Section Authorizing DPH Sole Source Contracts

Prior to 2006, in accordance with established Health Commission policy, DPH submitted contracts to the Health Commission annually as new contracts, which were less than \$10 million in value and thus not subject to approval by the Board of Supervisors. In the Fall of 2006, the City Attorney advised DPH that (1) contracts originate from the date of the RFP; (2) annual renewals of contracts are contract modifications, rather than new contracts; (3) contracts that were competitively bid must be executed within one year of RFP issuance and that, with limited exceptions, contracts need to be rebid at the end of their initial terms. As a result of these findings, DPH re-bid the majority of its contracts.

In 2006, as a result of this City Attorney advice, the Board of Supervisors amended the City’s Administrative Code by adding Section 21.42 to allow DPH to award sole source

designations to professional services contracts for health, behavioral health and support services provided by non-profit organizations until DPH could re-advertise such RFPs.

Prevalence and Value of DPH's Sole Source Contracts

Auditors estimated the value of the department's sole source professional services contracts at \$318 million, or 22 percent of the total value of all of the department's professional services contracts as shown in Table 3.1 below. Auditors reached this estimation by comparing the total value of sole source professional service contracts as presented in the Department's FY 2011-12 Public Health Sole Source Report to the Board of Supervisors to the total value of all DPH professional service contracts in FY 2011-12. However, the department's reporting on the number and value of its sole source contracting is deficient in two ways that make estimating the proportion of its professional services contracting -- either dollar value or simply the proportion of all contracts that are sole source -- inexact.

First, the Department's annual sole source reports to the Board of Supervisors are compilations of *requests for* sole source contracting authority not a list of sole source contracts entered into during the fiscal year as required by Administrative Code Section 67.24(e). Final contract amounts may vary from the amounts shown on the request report. Second, the department's sole source reports have included a mix of (1) individual contracts and the amount of those contracts and (2) *programs* that the department intended to award on a sole source basis that are part of a larger contract that includes other services that may have been awarded competitively. The reports do not distinguish which line items are individual contracts and which are programs (and program amounts)

Therefore, although auditors were able to estimate the percentage of the total dollar value of professional service contracts that was sole source (with the constraints described above), auditors were not able to determine what proportion of all of the department's professional services contracts are sole source¹.

¹ After completion of the audit, the Public Health Department revised the information in its Sole Source Report for FY 2011-2012, and now estimates final approved sole source contracts represented between 11% and 15% of all professional services contracts in FY 2011-2012. However, auditors received this information after completion of the audit and were not able to review and confirm these estimates.

Table 3.1
DPH Sole Source Professional Services Contract Requests
as a Percent of all Professional Services Contracts in FY 2012

All Professional Services Contracts	Sole Source Professional Services Contracts	% of Professional Services Contracts that are Sole Source
\$1,436,317,048	\$318,570,240	22%

Source: Controller and DPH

The figures shown in Table 3.1 do not include approximately \$134 million budgeted in FY 2011-12 for the affiliation between DPH and the University of California San Francisco (UCSF).

Healthy San Francisco

The figures in Table 3.1 include contracts with the San Francisco Community Health Authority (SFCHA) for the administration of the City's Healthy San Francisco (Healthy SF) health care plan for uninsured City residents. The value of these contracts totaled \$67,800,000 over a contract term of three years from July 2011 through June 2014.

The Healthy San Francisco Program provides health care to uninsured adult residents of San Francisco through a network of nonprofit and for profit health care clinics and DPH-operated clinics. Sole source agreements with SFCHA to provide third party administrator services and provider payment services for the Healthy San Francisco program constituted DPH's largest sole source arrangement in FY 2011-12.

SFCHA is a nonprofit created by the Board of Supervisors in 2005 to increase access to health care for low and moderate-income residents and to provide third-party administration of various City public health insurance programs. Since 2008, DPH has entered into two separate sole source agreements with SFCHA whereby SFCHA provides provider payment services and third party administrator services for Healthy San Francisco. In the most recent renewal of the contract to provide payment services, Department management informed the Board of Supervisors that a competitive bid process would be inefficient because the SFCHA had already been awarded a sole source contract to serve as the third party administrator for the Healthy San Francisco Program. Management has not indicated whether it intends to open either contract to a competitive process. These contracts are DPH's largest sole source arrangements in FY 2011-12.

As shown in Table 3.2, when the Healthy San Francisco contracts are excluded, sole source contracts constitute 18 percent of all professional services contracts.

Table 3.2
DPH Sole Source Professional Services Contract Requests
as a Percent of all Professional Services Contracts in FY 2012
Excluding Healthy SF

All Professional Services Contracts, Excluding Healthy SF	Sole Source Professional Services Contracts, Excluding Healthy SF	% of Professional Services Contracts that are Sole Source, Excluding Healthy SF
\$1,368,517,048	\$250,770,240	18%

Source: Department of Public Health

DPH Implementation of Sole Source Contracting

Despite a Controller's report that recommended stronger oversight of sole source contracting at DPH and OCA guidelines that implicitly define the limits of legitimate sole source contracting, there are a number of deficiencies in DPH's sole source contracting practices. These deficiencies weaken the essential intent of the Administrative Code to limit sole source contracting to instances in which competitive bidding is impractical or unnecessary in order to obtain the highest quality service at the best price.

Controller's Report on Sole Source Contracts

In its April 2003 study² of sole source contracting in San Francisco conducted in response to an April 2002 Civil Grand Jury recommendation, the Controller's Office found that DPH had contracts with some organizations for more than 10 years without conducting competitive solicitations or obtaining sole source waivers from the City's Human Rights Commission. The Controller's study noted that "These practices bring into question whether the City is receiving the best quality services at reasonable cost." The report recommended that competitive solicitation processes be put in place as soon as feasible for these contracts.

The Controller's report also recommended that the City's Sunshine Ordinance be enhanced to require reports from all departments annually on all existing (not just new) sole source contracts and that the Clerk of the Board of Supervisors report on compliance with this requirement.

Although DPH has not developed internal written guidelines on the use of sole source contracting apart from those issued by the Office of Contract Administration, DPH management states that the Department has in practice begun to limit sole source contracts to 18 months. Additionally, as noted above, the department rebid the majority

² City and County of San Francisco; Office of the Controller; Sole Source Contracts: The City Needs Better Information on and Improved Management of Its Sole Source Contracts

of its contracts in 2006 in response to the City Attorney's advice on its contracting practices.

DPH does not survey availability of contractors as required by the Administrative Code

In addition to giving DPH authority to enter into sole source contracts with nonprofits, Administrative Code Section 21.42 requires that:

Prior to the expiration of an existing contract, the Director of the Department of Public Health survey the availability of providers for the health and behavioral health services and support services required by the Department of Public Health where such services are (1) unique to the Department (2) consistent with its missions and goals and (3) require specialized knowledge, training, personnel, facilities or other resources that are known to be provide by a limited number of non-profit contractors.

Additionally, Section 21.42 states that, "based upon the results of such surveys, the Director of DPH may recommend a sole source designation to the Health Commission."

The audit process confirmed that DPH has not conducted these surveys. While the Department believed it was in compliance with the survey requirement based on City Attorney advice, no documentation of the advice exists and auditors confirmed with the City Attorney's Office that the Administrative Code language on surveys was intended to require the department to periodically consider newly available potential contractors. By failing to implement this section of the Administrative Code, DPH weakens the City's efforts to ensure it receives high quality services at the best price. In the absence of a systematic survey process, the City may not become aware of the existence of suitable alternatives in the community that could provide similar or higher quality services at similar or more competitive costs.

DPH and HSA's recent experience with one problematic sole source contractor that ultimately dissolved and was replaced illustrates the risk of implementing sole source contracting in this manner. Tenderloin Health, a provider that until early 2012 provided services through a combination of sole source and competitively bid contracts at both DPH and HSA, struggled with documented fiscal and compliance issues as far back as 2006. When the organization finally failed and dissolved, multiple alternative service providers sought to secure the contract and the services were transferred to multiple new providers. The availability of alternative providers in this instance suggests that sole source contracting may not have been warranted.

Extension of sole source contracts beyond their initial terms

A review of sole source waiver requests and a recent supplemental funding request indicate that DPH extends some sole source contracts beyond the original terms due to the Department's difficulty in issuing RFPs in a timely fashion. For example, in 2010, DPH conducted a competitive RFP process for mental health and substance abuse treatment services for men and women, and selected Community Awareness and

Treatment Services (CATS) as the highest qualified scorer. DPH contracted with CATS for four programs as a result of this competitive RFP process. DPH also continued its existing contract with CATS for the following three programs on a sole source basis, in accordance with Administrative Code Section 21.42: (a) Mobile Assistance Patrol; (b) San Francisco Homeless Outreach Team (SF HOT); and (c) San Francisco Medical Respite and Sobering Center. The term of the original agreement with CATS was from July 1, 2010 through December 31, 2015 for an amount not to exceed \$12,464,714. The \$12,464,714 budget for the original agreement provided funding for the sole source programs through December 31, 2011 but did not include funding for the period from January 1, 2012 through December 31, 2015 for these sole source programs.

At the time of Board approval of the CATS contract, DPH management advised that DPH would conduct a competitive bidding process in FY 2010-11 for the three sole source based programs. As of the writing of this report, DPH had not issued an RFP for the three sole source programs as originally reported to the Board of Supervisors. DPH requested and received approval of a supplemental authorization of \$18,952,692 in funding for these programs, again with the caveat that DPH plan and implement an RFP.

At the time of the supplemental request, DPH management reported that DPH had not implemented a competitive bidding process for the three program services previously awarded sole source contracts because DPH was conducting “reconfiguration and redesign of the program in order to maximize efficiencies” and that “coordination of services to homeless clients took longer than anticipated”. DPH management also indicated that DPH plans to create a pilot program to confirm the functionality of the new program design before implementing a new RFP process. Subsequently, DPH management has reported that they have devised a pilot program for the services in question and are planning to pilot it before issuing an RFP for the services, which is expected by June 2014.

In a review of 28 sole source waiver requests of the total 383 sole source programs and contracts³ that were reported on DPH’s 2011 and 2012 sole source reports, auditors found six other instances in which the terms of sole source contracts were extended (with OCA approval) and/ or the amounts of contracts increased either because of delays in issuing RFPs or because an initial RFP failed to attract qualified bids as shown in Table 3.3 below.

³ As noted on page 3-3, the Departments annual sole source reports to the Board of Supervisors include a combination of individual sole source contracts and programs awarded on a sole source basis that were part of a multi-program contract.

Table 3.3
Sample of Delayed DPH RFPs

Vendor	Date of Original Sole Source Waiver Request	Date(s) of Sole Source Waiver Request (s)	Length of Extension(s) of Contract Terms	\$ Increase in Contract
Asian American Recovery Services	6-25-10	4-19-11 9-12-11	Six months Six months	\$2,165,688 \$3,018,344
Boys and Girls Club	2-15-11	7-28-11	12 months	\$50,000
Bayview Hunters Point Health Environmental Resource Center	6-29-11	6-29-11	Unspecified ⁴	Not indicated ⁵
Catholic Charities	4-23-10	4-23-10 10-5-11	Unspecified Six months	Not indicated ⁶
Golden Bear Associates	N/A	12-7-09	12 months	Not indicated ⁷
Jewish Family and Children's Services	4-23-10	9-20-11 3-7-12	Six months Six months	\$176,000 \$205,000

Source: Department of Public Health

In three of the above instances, contracted services were included in a multi-services solicitation, RFP 23-2009. However, according to DPH, the RFP yielded no qualified proposal for the service category. In each instance DPH's Office of Contracts Management and Compliance indicated that the RFP would be reviewed, amended, and re-solicited in early FY 2011-12, but that in the meanwhile the current contract needed to be extended to allow the current contractor to continue to deliver essential services. In two of these instances, a new RFP process has been held and new contracts awarded to the current contract holders..

Reporting on sole source contracting to the Health Commission and Board of Supervisors and its sole source justifications are perfunctory

The Office of Contract Administration rules and regulations⁸ require departments to justify the need for a sole source acquisition of commodities and services using a Sole Source Waiver request form. OCA rules and regulations specify that in requesting a sole source waiver, departments must explain:

⁴ According to a DPH Office of Contracts Management and Compliance memo to OCA, services provided by the vendor were included in a 2009 RFP that yielded no qualified proposal for the service category. The RFP was to be "reviewed, amended, and re-solicited in early fiscal year 2012"

⁵ The contract amount indicated in the most recent sole source waiver request is \$949,760

⁶ The contract amount for the original term of 7-1-10 to 12-31-11 was \$1,329,552

⁷ The contract amount indicated in the most recent sole source waiver request is \$118,020

⁸ Rules and Regulations Pertaining to the San Francisco Administrative Code, Chapter 21; Acquisition of Commodities and Services

- Why a particular product or service uniquely meets the City’s needs
- Why only one vendor or contractor can provide the products or services
- What steps were taken to verify that goods or services are not available from other sources
- What efforts were made to obtain the best possible price
- Why the price is considered fair and reasonable

Additionally, Section 67.24(e) of the Administrative Code states “At the end of each fiscal year, each City department shall provide to the Board of Supervisors a list of all sole source contracts entered into during the past fiscal year.” DPH fulfills this requirement by submitting a list of sole source contracts annually. However, the list contains only the terms, vendor name, amount and service type. It does not contain any explanation of the reason for the sole source nature of the contract other than reference to the three Administrative Code sections that permit sole source contracting: 21.5(b), 21.30 and 21.42.

Additionally, there are no internal DPH written policies and procedures or guidelines governing use of sole source contracting that could be referenced to elucidate the Department’s sole source contracting practices. The absence of some sort of internal policy documentation or guidelines on sole source contracting combined with the limited information in the annual sole source list provided to the Board of Supervisors limits Board (and public) understanding of the rationale for sole source contracting and limits Board oversight of Department’s sole source contracting practices.

Since the Administrative Code was amended to include Section 21.42 in 2006, DPH has annually submitted to the Health Commission for its approval a list of contracts DPH management recommends be designated as sole source as authorized by Section 21.42. The request to the Health Commission includes an explanation of the authority granted under Administrative Code Section 21.42 and an explanation of the past contracting practices that led to the adoption of the code section. However, in the six years since adoption of Section 21.42, DPH’s memoranda to the Health Commission and the list of contracts recommended as sole source that is attached to the memoranda have not included an explanation of the rationale for the sole source designations beyond reference to Section 21.42 of the Administrative Code itself.

Similarly, in its sole source waiver requests submitted to the Office of Contract Administration, DPH’s Office of Contract Compliance does not include a rationale for the sole source designation other than reference to the authority granted in Administrative Code Section 21.42, and the Health Commission’s designation of a particular contract as sole source in accordance with Section 21.42. In the 28 sole source waiver requests reviewed in this audit, the list of sole source designated contracts that DPH has submitted to the Health Commission for approval is included as an attachment.

The Office of Contract Administration, in approving the sole source waiver requests, typically references Section 21.42 and the list of sole source designated contracts

submitted by DPH as the basis of its determination. Of the 28 sole source waiver requests reviewed during this audit, in only three out of the four sole source justifications based on Administrative Code Section 21.5(b) did the Department or OCA address OCA criteria for sole source contracting. In these cases the criterion was that only one vendor was available. In the remaining 24 sole source waiver requests none of the criteria for sole source contracting contained in the OCA guidelines was addressed.

By not providing substantive justification for sole source contracting in accordance with OCA guidelines, DPH limits the quality of possible oversight of the contracting process. As a result, OCA and the Board of Supervisors are hindered in their ability to determine whether the Department has made a good faith effort to find other possible vendors and obtain the highest quality service at the best price despite using a sole source contract.

Conclusions

DPH's lack of internal written guidelines on sole source contracting (especially given the broad authorization to award sole source contracts that Administrative Code Section 21.42 grants); the Department's failure to survey periodically the availability of providers of health, behavioral health and support services; and delays in implementing Requests for Proposals are all potential impediments to competition on the basis of price and quality that a full and open competitive RFP process is meant to insure. Additionally, the limited nature of the Department's annual report to the Board of Supervisors on its use of sole source contracting (shows requests, not actual sole contracts) hinders a complete accounting of the extent of the Department's use of sole source contracting, and limits oversight and public scrutiny of DPH contracting practices.

While at times there may be only a small number of viable vendors for some services and client populations, in these instances DPH only rarely explains why services are available from only one contractor in its sole source waiver requests, instead simply citing its Administrative Code authority. Additionally, DPH has not surveyed potential vendors either to establish a public record of the limited pool of viable contractors for certain services and client populations or to inform contractors who have entered a service field since the last RFP issuance or contract award of the potential to contract with the Department.

These weaknesses limit the ability of the Board of Supervisors and the Health Commission to oversee and assess the services that result from sole source contracting and ensure compliance with relevant Administrative Code requirements that set limits on sole source contracting.

Recommendations

The Director of Public Health should instruct DPH's Office of Contract Compliance to:

- 3.1 Develop written policies and procedures for the use of sole source contracts to be approved by the Health Commission. These policies and procedures should specify the necessary justifications for use of sole source contracts in accordance with OCA rules and regulations.
- 3.2 Expand the current annual reporting to the Board of Supervisors and Health Commission on use of sole source contracting to (a) include justifications for sole source contracts and (b) distinguish between sole source contracts and programs awarded on a sole source basis within multi-program contracts.

The Director of Public Health should direct appropriate System of Care staffs to:

- 3.3 Conduct the surveys that are required by Administrative Code Section 21.42 and report the results to the Health Commission by the start of FY 2013-14.

Costs and Benefits

Conducting the surveys noted above will bring the Department into full compliance with Administrative Code Section 21.42. Expansion of reporting on sole source contracting will improve Board of Supervisors and Health Commission oversight of professional services contracting at DPH. Developing written policies and procedures that align more closely with Office of Contract Administration rules and regulations combined with the surveys mentioned above will ensure that sole source contracting is limited to only those instances in which a competitive bid process is not feasible or unnecessary in order to insure the Department receives the highest quality service at the best price.

An annual survey of potential service providers, and the work involved in the proposed expanded reporting and development of written policies and procedures may require additional staff time in the Office of Contract Compliance and among the Systems of Care.

4. Effectiveness of Corrective Action Process

- In 2011, the Controller’s Office created the Citywide Nonprofit Corrective Action Policy to encourage nonprofit accountability, compliance with government funding requirements and reliable service delivery. The policy established three designated stages for corrective action (standard, elevated concern and red flag), including the corresponding consequences for failure to correct deficiencies.
- These Citywide standards and designations have not been consistently implemented by the departments. While DPH has developed examples of findings that could warrant Corrective Action, neither DPH nor HSA have created clear measures for staff to determine when monitoring findings should be brought forward for formal Corrective Action. In addition, the amount of time and the level of support provided to nonprofits throughout the Corrective Action process have not been standardized at DPH or HSA.
- These inconsistencies in enforcing the City’s policy have resulted in wide discrepancies in the standards to which contractors are held. Without proper implementation of the City’s standards and clear direction regarding the level of technical and financial assistance that should be provided to support nonprofits on a corrective action plan, the City could continue directing resources toward underperforming agencies, at the expense of identifying alternate service providers that could provide the same services to underserved populations.
- The Controller’s Office should revise the Citywide Corrective Action Policy to add more specificity regarding the amount of time and support that should be given to nonprofits *between* various stages of the corrective action process (i.e. the time allowed for improvement between the standard corrective action procedure and designation as “elevated concern”). The Department of Public Health and the Human Services Agency should clarify internal monitoring and corrective action policies to more accurately reflect the Citywide Nonprofit Corrective Action Policy and train monitoring staff regularly to ensure proper implementation of the Citywide Nonprofit Corrective Action Policy.

Citywide Nonprofit Corrective Action Policy

In 2011, the City initiated a Citywide Nonprofit Corrective Action Policy to encourage nonprofit accountability, compliance with government funding requirements and reliable service delivery. The policy outlines how the City should respond when a nonprofit fails to comply with performance or monitoring standards stated in the scope of work included in the nonprofit's agreement with the City. Noncompliance includes failure to submit requested documentation within a required timeframe. Further, the policy requires nonprofits to work to correct deficiencies in compliance. Since a majority of the contracts held by the Department of Public Health (DPH) and the Human Services Agency (HSA) are with nonprofit organizations, this section focuses on those agencies.

Designations for Corrective Action

The Citywide Nonprofit Corrective Action Policy includes three designations for stages of corrective action and subsequent consequences associated with each designation.

Standard Monitoring and Corrective Action Process

When a City department conducts a monitoring assessment and identifies noncompliance with fiscal, compliance, or programmatic standards discussed previously in this report, the department must document these findings and any need for corrective action in writing to the nonprofit. The nonprofit then has one month to respond to the City with a corrective action plan, including a timeline for full implementation of the plan.

If the City department is satisfied with the corrective action plan, then that department should notify the nonprofit in writing that the nonprofit is in compliance with the agreement, so long as the corrective action plan is implemented. The policy states that the City department must take responsibility for any needed monitoring of the implementation of the corrective action plan.

Elevated Concern Status

The "elevated concern" status is designated when the nonprofit has not: (a) responded to the City's request for corrective action; (b) provided a corrective action plan that is acceptable to the City; or (c) complied with the implementation of the corrective action plan. If a nonprofit is on elevated concern status for program-related reasons, then they will be less competitive for new grants or contracts through the Request for Proposal process.

Red Flag Status

A nonprofit could be placed on "red flag" status if it is a "critical service provider" at "imminent risk" of being unable to perform services in accordance with their agreement, or unable or unwilling to engage in required corrective action. The Citywide Nonprofit Corrective Action Policy defines a critical service provider as the only, or one of the only, nonprofits that provide a critical service/level of services in the City, has a critical

and unique cultural competency, and/or has important licenses or facilities that are otherwise difficult to attain.

Examples of issues that can lead to “red flag” status include:

- Inadequate cash flow;
- Consistently and significantly inaccurate and/or late invoicing;
- Low units of services below needed outcome measurements; and,
- Governance and management problems.

If a nonprofit is either in “elevated concern” or “red flag” status due to fiscal or City compliance reasons, they are not eligible for new or renewed City funding.

Standards for Determining the Triggers for Corrective Action Have Not Been Effectively Implemented

The Citywide Nonprofit Corrective Action Policy clearly states that all City departments should have written procedures regarding nonprofit corrective action that are consistent with the Citywide guidelines, including: documented response and follow up to monitoring findings, an updated list of nonprofit contractors on “elevated concern” or “red flag” status, and a clear process for following up with nonprofits who have been cited. Despite these requirements, implementation on the department level remains inconsistent.

Practices at the Department of Public Health

DPH has played a central role in the development of the Citywide Nonprofit Monitoring and Compliance Program and the Corrective Action guidelines. In addition to the Department’s major reorganization to create the Community Programs Business Office, the Department has demonstrated a strong commitment to managing contracts effectively to ensure cost-effectiveness and quality service delivery. In practice, however, the policies are not consistently implemented.

Levels of Response to Performance Findings

When a contractor performance issue has been identified, the Department follows three levels of response: a recommendation without a required Plan of Action, a recommendation with a required Plan of Action, or a Corrective Action Plan. Although this process is not outlined in a formal policy document, it is generally accepted as practice by program monitoring staff. Recommendations appear to be made informally, though some are noted in the body of program monitoring reports. Plans of Action require a written response from the contractor that must be approved by the Department. Program monitoring reports typically include a checkbox indicating whether a Plan of Action is required, which the Department has standardized in the report templates for FY 2011-12. The highest level of response is Corrective Action, in which the Department

requires the contractor to take specific actions to remedy deficiencies. Although these general steps are commonly recognized by department staff, and the Department has provided some examples of findings that may warrant corrective action, there is insufficient guidance regarding implementation. This is demonstrated by the inconsistent content of the monitoring reports and examples of actual contractor experiences, described throughout this section.

The Performance Rating Threshold

As discussed in Section 1 of this report, the performance rating system used by DPH shows that staff do not apply the standards systematically. DPH program managers typically rate contractor performance on a scale of 1.0 to 4.0 across the following three categories: program performance, program compliance, and client satisfaction. There are no written departmental guidelines that detail how these scores should be interpreted by either staff or contractors. Although report analysis and staff interviews reveal that a monitoring score of less than three (3.0) sometimes triggers an advanced level of response (i.e. Plan of Action or Corrective Action Plan), there is little consistency in the relationship between performance scores and remediation activities.

The Department has taken steps to make the monitoring process less qualitative and more quantitative (through the scoring system) in order to promote standardization. However, it remains unclear what findings trigger lower scores and what scores trigger plans of action. In the absence of a consistently applied guideline, the Department cannot be sure that contractors are receiving equal oversight and support, which may increase the Department's risk of encountering exacerbated performance problems with some contractors during the life of the contract. Although the BOCC Director reviews every monitoring report in order to identify when Plans of Action are required, this does not sufficiently mitigate the risk of subjectivity.

Practices at the Human Services Agency

In contrast to the Department of Public Health, the standard program assessment forms at the Human Services Agency do not always contain numeric scoring. Therefore, HSA is unable to use scoring to create standards for determining when corrective action is needed. Although numeric scoring may not be necessary for all contracts, there is no clarity on what types of comments or feedback recorded in the program assessment forms require corrective action. In the absence of standard guidelines and standards, program managers at the Human Services Agency could decide how and when to follow up on potential program performance issues, which could vary across the Department. HSA program managers reported assessing such instances on a case by case basis and employing their best judgment to decide how to respond. For example, if a contractor submits a quarterly report and the units of service do not appear to be at a level on target to meet annual outcome objectives, in accordance with its agreement with the Human Services Agency, the program manager has the discretion to decide whether and how to follow up with the contractor. Additionally, the program manager can determine if the reason(s) behind the contractor's low numbers, such as vacancy rates in staffing, warrant an immediate formal corrective action plan or if the program manager should allow for

more time prior to bringing up the potential performance issue to a Human Services Agency contract manager. As a result of this heavy dependence on the program managers' discretion, the Agency cannot guarantee that contractors are receiving equal performance monitoring and assistance, which, as stated above in the case of DPH, may increase the Agency's risk of encountering significant performance problems with some contractors during the life of the contract.

Standards and Terminology Established by the City Have Not Been Adopted

The Citywide Fiscal and Compliance Monitoring Guidelines direct departments to categorize deficient contractors using standard terminology developed by the Controller's Office. Specifically, as noted above, the guidelines establish three phases of Corrective Action: standard, elevated concern status, and red flag status. These distinctions are important because each carries corresponding consequences for failure to respond sufficiently.

Citywide Quarterly Reports on Red Flag and Elevated Concern Status

In its role as the coordinator of this process, the Controller's Office releases quarterly reports on elevated concern and red flag designations. As stated in the Controller's Office first Quarterly Report on Elevated Concern and Red Flag designations from May 2012, the corrective action policy "ensures that the City as a funder acts appropriately when a non-profit is failing to meet criteria, and that the non-profit works to correct deficiencies...Nonprofit organizations designated with either elevated concern or red flag status due to fiscal or compliance reasons are not eligible for new or renewed City funding." This establishes an important mechanism by which the City can ensure quality service delivery and sound fiscal investment.

Practices at the Department of Public Health

DPH maintains a report titled "Community Programs Business Office Schedule of Corrective Action Plan Issues" that records the contractors on corrective action, the issues for which they are on corrective action, and the status/resolution of these issues. Of the 12 contractors listed on the March 2012 DPH report, three have ceased operations and three have ongoing issues that continue to be monitored by the Department. The table below shows the status of DPH corrective action.

Table 4.1
Status of DPH Corrective Action Plans (CAP) as of March 2012

	CAP Closed	CAP Ongoing	Total
Program Closed	3	n/a	3
Program Received Additional Funds from DPH	3	2	5
Program Receiving Technical Assistance	3	1	4
Total	9	3	12

Source: DPH March 2012 Schedule of Corrective Action Plan Issues

From a review of the Corrective Action Plan reports provided by the Department, and through conversations with contractors, it is clear that the Department often invests time and resources to help contractors resolve the issues identified. In several instances, the Department has worked with the Controller's Office to provide extensive technical assistance to contractors. Increased support, at times in the form of paid consultants, has been offered to contractors to help resolve governance and fiscal compliance issues.

Notably, however, none of the contractors listed on this schedule have ever been placed on either elevated concern or red flag status. While the designations were not introduced by the Controller's Office until March 2011, five of the contractors on the March 2012 Schedule had ongoing CAP issues at the time that included financial management and sustainability concerns. Although City policy requires that contractors respond in writing to corrective action findings with a plan for remediation within 30 days of receipt of the monitoring findings, DPH develops these corrective action plans for contractors, and establishes timelines for resolution. A review of the Corrective Action Plan reports, however, shows that these timelines range widely and there are no consequences for failure to meet the deadline. For example, as the table above shows, 5 of the 12 contractors in corrective action have received additional funding. In some cases, this funding increase clearly took place while the corrective action issue was ongoing. In one example, the Department even continued to fund a contractor that had demonstrated severely deficient fiscal policies, including incurring a significant debt to the Department, over several years. Despite the fact that six of the contractors faced "Financial Stability" problems and five of the contractors experienced issues with "Financial Management Practices", the Department never raised them to a higher level of corrective action and their funding from the City was never jeopardized. Although the Department offered technical assistance and additional resources, two of those contractors reached such dire fiscal circumstances that they ceased operations, and two of them continue to be monitored for ongoing financial management concerns. An additional contractor ceased operations for reasons other than fiscal difficulty and an additional contractor continued to be monitored for ongoing non-fiscal difficulty.

Practices at the Human Services Agency

Similarly, HSA has not adopted the City terminology for this process. HSA does not maintain an active list of agencies in Corrective Action and there were no references to “elevated concern” or “red flag” status in the monitoring reports sampled for this audit. However, one organization that provided housing and supportive services demonstrated issues that met the guidelines for being designated with a “red flag” status in FY 2010-11, including: (a) inadequate cash flow; (b) an inability to produce basic financial documents; and (c) management turnover resulting in governance and management problems. Despite these characteristics, this organization was not deemed to be on “elevated concern” or “red flag” status in FY 2010-11. In the absence a consistent application of the City’s established stages of corrective action, cross-departmental monitors will find it difficult to fairly and consistently compare contractor performance.

Standards and Timeframes for City Support during Corrective Action have not been Established

The Citywide Fiscal and Compliance Monitoring Guidelines do not provide clear timeframes between each designation for the severity and stage of corrective action needed. Despite the absence of clear citywide guidelines, the Department of Public Health and Human Services Agency have not established clear standards for the amount of time and support a contractor should be granted once the Corrective Action Process has begun.

Citywide Guidelines

Within each stage of the Corrective Action Process—standard monitoring and corrective action, “elevated concern” status, and “red flag” status—there are timeframes for action included in the Citywide Fiscal and Compliance Monitoring Guidelines. For example, a nonprofit has 10 business days to one month to submit a satisfactory corrective action plan in the standard monitoring and correction action stage.

However, the Guidelines do not specify the amount of time that should be allowed *between* when a corrective action plan is required and when the City designates the nonprofit as being on “elevated concern” or “red flag” status. The Guidelines only state that a nonprofit could be designated in “elevated concern” if it has not met the requirements, stated earlier in this section of the report, in a “timely fashion.” Additionally, in the last action listed for the “elevated concern” and “red flag” stages, the City could either remove the status or provide a clear road map as to the steps needed to remove the status, yet there is no timeframe for completion of the additional steps.

Department Standards and Guidelines

The Department of Public Health and Human Services Agency have similarly not established clear standards and timeframes for support provided to nonprofits throughout the Corrective Action Process. For example, a nonprofit that has a contract with the

Human Services Agency is currently implementing a corrective action plan due to programmatic issues. According to the monitoring assessment reports, the nonprofit had not been sufficiently documenting services provided and outcome objectives in accordance with its agreement for a period of almost three years. The program manager stated that she is currently meeting, with the nonprofit on a monthly basis and will continue to do so for a period of six months. After the six month period, another audit will be conducted to determine if the corrective action plan has been implemented.

In contrast to the above example, another nonprofit that had a contract with the Human Services Agency had been on a corrective action plan during three fiscal years, from FY 2009-10 through FY 2011-12, before finally declaring in January of 2012 that it would dissolve. According to Human Services Agency management, additional resources provided to the nonprofit while on corrective action include: (a) advances in payments to meet cash flow issues; (b) additional capital contributions; and (c) staff time and support in the form of meeting with the nonprofit's staff and Board of Directors for technical assistance. This nonprofit also had contracts with the Department of Public Health, had been on a corrective action plan with the Department of Public Health before the contracts with the Human Services Agency began, and had additional technical assistance and financial support from the Department of Public Health. In fact, at the time that this contractor entered into a contract with HSA, it had not successfully completed its second Corrective Action plan with DPH.

This contractor's last DPH Corrective Action Plan report provides useful insight into the Department's approach to corrective action. Referencing issues dating back to January 2008, the report details widespread financial and ongoing financial instability. Not only did the organization have severe cash flow problems, but it had incurred various debts, including one to the City that remains unpaid. Despite the fact that its deficiencies were never resolved, DPH did not place the organization on elevated concern or red flag status. New contracts were issued – both by DPH and other City departments – and funding was never suspended, despite the obvious risks.

By contrast, another nonprofit organization with contracts at both DPH and HSA examined during the audit was able to successfully emerge from a period of struggle with fiscal and compliance issues after receiving technical assistance from City staff and a consultant retained by the City. With focused support over a period of at least two years, the contractor moved off of corrective action status by making several substantial governance changes, including revision and enforcement of the organization's by-laws, changes in the composition of the board of directors, and changes in executive management. In an audit interview, the director of this organization stated that the substantial level of technical assistance and other support it received allowed it to survive and become an effective organization, but that not all contractors receive this level of support. While this contractor provides an example of the City successfully implementing technical support, scarcity of resources dictates that this level of support is not feasible for all contractors. Given limited resources available for technical assistance and related support, it is critical that departments establish and implement clear standards for the provision of such resources and for timeframes within which contractors should be expected to address compliance findings.

While the Citywide Nonprofit Corrective Action Policy states that nonprofit contractors in “elevated concern” or “red flag” status are not eligible for new or renewed City funding, no such guidelines exist for nonprofits on the Standard Corrective Action Process. The lack of guidelines for continued funding, combined with no standard timeframe for the Standard Corrective Action Process have resulted in the Department of Public Health renewing contracts with nonprofits who have been cited for corrective action, despite documented and ongoing financial problems. Table 4.2 below contains four examples of nonprofits that have been awarded new or renewed contracts or subcontracts despite repeated corrective action citations.

Table 4.2
Nonprofits with Continued Funding from DPH, Despite Corrective Action Status

Nonprofit	Total Number of Contracts	Total Amount of Contracts
A	6	\$6,623,865
B	2	\$42,849,811
C	3	\$2,117,913
D	1 subcontract	\$547,464
Total	12	\$52,139,053

Source: Department of Public Health

Although senior department officials maintain that funding limitations should only impact contractors on elevated concern or red flag status, it is clear from the review of the Corrective Action Plan reports that the necessary safeguards are not in place. Certainly, contractors should be afforded an opportunity to remediate issues, but limits and policies must be established to protect resources and service delivery. .

Without specific timeframes between each stage of the Corrective Action Process and standards for how the City should support nonprofits on a corrective action plan, through technical and financial assistance, the City could continue directing resources toward underperforming agencies, at the expense of identifying alternate service providers that could continue providing the same services to underserved populations.

Funding Diversification Guideline

One Citywide monitoring guideline that has in some cases been challenging for departments to enforce is the guideline that nonprofit contractors secure at least 15 percent of their annual organizational budgets from sources other than the City. The standard was recommended by the Community Based Organization Task Force¹ to support the sustainability of nonprofit contractors by encouraging diversified funding. FY 2010-11 was the first full fiscal year in which this monitoring guideline was implemented.

¹ Partnering with Nonprofits in Tough Times, April 2009

Despite this monitoring standard, the extent of the city’s nonprofit contractors’ reliance on the City for funding and the sustainability of nonprofit contractors in the absence of city funding are unclear. The Controller’s Office reported that nine contractors (including six with DPH contracts and one with an HSA contract) out of 125 contractors in the Citywide Fiscal and Compliance Monitoring pool in FY 2011-12 did not meet the standard in FY 2011-12. DPH management reports that of the five contractors that were the subject of DPH-only monitoring in FY 2011-12, one contractor did not meet the 15 percent standard in FY 2011-12. HSA management reports that of the 25 contractors that were the subject of HSA-only monitoring in FY 2011-12, one contractor did not meet the standard. These figures are summarized below in Table 4.3.

Table 4.3
Non-profit Contractor Compliance with
15% Funding Diversification Guideline FY 2011-12

	Citywide Monitoring	DPH-Only Monitoring	HSA-Only Monitoring
Non-compliant with 15% Guideline	9	1	1
Total Reviewed	125	5	25

Source: Controller’s Office, Department of Public Health, Human Services Agency

The demonstrated ability of the vast majority of contractors to successfully meet the funding guideline suggests that it is an appropriate threshold. However, since there are no real consequences for failure to comply with the 15 percent standard and because not every contractor receives an annual fiscal monitoring to determine whether it is in compliance, the standard does not serve either to measure accurately the extent of contractor reliance on City funding or to encourage diversified funding.

HSA and DPH should develop strategies to support contractors in their efforts to come into compliance with the funding diversification guideline. In FY 2011-12, DPH began such efforts by engaging a pro bono consultant to conduct a workshop for agencies on how to develop successful fundraising strategies. Providing these types of resources and support to contractors, combined with program manager’s ongoing monitoring and follow-up on this guideline, should communicate the importance of this measure.

In addition, the departments and the City Controller should seek more detailed information about contractors’ compliance with the guideline. Even for those contractors who meet the standard, fiscal monitoring reports do not describe the amount in excess of 15 percent of the agencies total funding that non-City sources constitute. Information about the degree of funding diversification would allow City agencies to better understand contractors’ level of dependence on City resources.

Conclusions

The Citywide Nonprofit Corrective Action Policy that was launched in 2011 provides an important tool for City departments to standardize the process for ensuring that nonprofit contractors providing professional services maintain certain levels of performance. The guidelines are intended to ensure quality service delivery and to establish clear guidelines for the identification and resolution of fiscal and programmatic deficiencies.

The Department of Public Health and the Human Services Agency have not fully adopted these standards as part of their program monitoring process, and as such, program reports show a wide range of enforcement standards. To ensure that performance weaknesses can be quickly identified and resolved, DPH and HSA should update all internal policies to reflect the City's designations and policies, and both departments should provide sufficient training and resource materials to program staff so to standardize the implementation of the process.

Recommendations

The City Controller should:

- 4.1 Revise the Citywide Corrective Action Policy to add more specificity regarding the amount of time and support that should be given to nonprofits *between* various stages of the corrective action process (i.e. the time allowed for improvement between the standard corrective action procedure and designation as "elevated concern").

The Department of Public Health and Human Services Agency should:

- 4.2 Clarify internal monitoring and corrective action policies to more accurately reflect the Citywide Nonprofit Corrective Action Policy by:
 - (a) Developing clear measures and timeframes for when monitoring findings should be brought forward for the City's Corrective Action Process, and between each stage of the process.
 - (b) Developing standards and guidelines for the amount of technical and financial support the Department should provide to nonprofits throughout the Corrective Action Process.
 - (c) Developing guidelines to monitor and ensure that 15 percent of each nonprofit contractor's annual budget is derived from non-City sources, and further develop strategies to support contractors in their efforts to comply.
- 4.3 Train monitoring staff regularly to ensure proper implementation of the Citywide Nonprofit Corrective Action Policy.

Costs and Benefits

Implementation of these recommendations should be accomplished using existing resources. Establishing timeframes between each stage of the Corrective Action Process and creating standards and guidelines for City support throughout the process would help improve the City's ability to encourage nonprofit accountability, compliance with government funding requirements and reliable service delivery. Specifically, such timeframes and standards could help divert additional funds and resources from going to underperforming agencies and redirect resources to providing effective technical assistance or the identification of an alternate service provider in order to ensure continuity of services to underserved populations.

5. DPH Contract Contingency Authorization

- While the Department of Public Health's policy of setting a contingency on each contract is generally sound business practice, allowing for rapid acceptance of new funds and smooth transitions between vendors when needed, the department has not defined when the contingency should be used and implementation and reporting weaknesses are evident.
- The use of the contingency authorization is often for quite minor contract changes. However, in some instances the contingency authority has been utilized to make much more significant changes, including adding entirely new programs and funding sole source contracts without obtaining Health Commission and Board of Supervisors approval. The contingency policy also appears to conflict with the Health Commission's policy to obtain Commission approval for contract changes exceeding 10 percent.
- When contracts are amended, the contingency amount is often increased to 12 percent of the full contract amount, even though some of the term of the contract has expired and significant expenditures have already been incurred. Moreover, the funding authorization of contracts of vendors from whom funds were reallocated is not consistently amended, allowing some vendors to maintain their original contracted amount as well as their full contingency authorization. These practices provide DPH with more flexibility than is needed to achieve the goals of the policy.
- Finally, the information collected and presented to the Board of Supervisors is inadequate to allow the Board to assess whether the City is meeting its target service levels and to perform its contract oversight function. The report concerning use of the contingency authorization should include the reason for the increase (e.g., to serve additional populations), the specific program to which funds were allocated, a more detailed description of the source of funding (either new or an indication of the contract from which funds were reallocated) and the percent of the contingency used in the prior year and throughout the life of the contract.

Establishment of DPH's Contingency Policy

In 2002, the City's Non-Profit Contracting Task Force recommended that departments implement policies and procedures to streamline internal contract processes. In FY 2005-06, as part of its response to the Task Force's findings, the Department of Public Health (DPH) established a policy of setting a contingency on each contract equal to 12 percent of the amount authorized over the life of the contract.¹

The purpose of the 12 percent contingency is not well defined. In the October 20, 2005 Non-Profit Contracting Task Force progress report to the Board of Supervisors, the Task Force reported that adding a contingency to the contract budget allows DPH the flexibility to anticipate funding changes that are tied to the funding cycle without having to seek authorization for a formal contract amendment from the Health Commission or Board of Supervisors, easing contracting and preventing interruption in client services. DPH subsequently indicated to the Board of Supervisors that the contingency policy provides the department with flexibility to modify professional service contracts due to changes in available funding from various sources and if a service provider is unable to meet service levels, resulting in the need to transfer services to another provider. DPH does not have a written policy on including contingencies in contract budgets or guidelines on the use of contingencies to modify contracts.

Funds are not appropriated for the contingency. Instead, the contingency increases the maximum expenditure authority over the life of the contract that allows funds to be added to the contract should they become available. DPH initiates the increase to the contractors, sometimes through sole source contracts and sometimes through competitive Requests for Proposals (RFP). Since the majority of the Department's contracts are based on payment per unit of service, additional funds generally translate directly into more service being provided by a given contractor and are not used to cover cost overruns for the previously agreed-upon level of service.²

During a Budget and Finance Committee meeting in October, 2008, the Budget and Finance Committee requested that DPH report to the Board of Supervisors on the use of contingencies in DPH service-based contracts. However, in a subsequent hearing, department management advised that DPH has not tracked the increased amounts of such contracts or the number of times that all or a portion of the 12 percent contingency has been used. In May, 2010, the Board of Supervisors adopted Resolution 563-10, requiring that DPH summarize mid-contract increases within the "not to exceed" amount represented by the contingency. DPH provided the first of these summaries to the Board

¹ Department of Public Health memorandum to the Health Commission, "Update on Recommendations of the Non-Profit Contracting Task Force", October 6, 2005.

² Some DPH contracts provide for reimbursement on other than a per unit basis. For example, information technology contractors may be paid for programming changes. DPH reports that amendments made under the contingency umbrella for one IT contract in FY 2011-12 provided for software revisions allowed DPH to receive new funding under Federal American Reinvestment and Recovery Act regulations.

of Supervisors in June, 2011.³ A summary for FY 2011-12 was submitted to the Board of Supervisors on July 26, 2012 and revised on August 28, 2012.⁴

Only a Small Portion of Contingency Authorization is Used

In FY 2010-11, there were seven instances when contract budgets were increased to an amount above the original contract budget but within the not-to-exceed amount allowed by the contingency. The memorandum issued by DPH to the Board of Supervisors indicated that contract increases in that year totaled \$338,326. Information initially provided as part of this audit also indicated that contract increases totaled \$338,326, but on further examination, DPH amended that figure to \$1,044,144.

As seen in Table 5.1 below, the increase in the seven contracts in FY 2010-11 ranged from 0.04 percent to 1.49 percent and averaged 0.5 percent, far below the 12 percent contingency. Only one program was allocated more than 1 percent of its original contract budget through the contingency process. Moreover, only 0.5 percent of the approximately \$200 million in estimated annual value of behavioural health contracts were utilized from the contingency authorization.

Table 5.1
Increases in DPH Contracts, FY 2010-11

Contractor	Total Not to Exceed Amount (FY 2010-15)	Contingency	Contract Budget	Contingency %	2010-11 Increase from Contract Budget	% Change From Contract Budget
Edgewood	\$29,109,089	\$3,118,831	\$25,990,258	12.0%	\$95,505	0.37%
Hyde Street	\$17,162,200	\$1,838,808	\$15,323,392	12.0%	\$6,000	0.04%
IFR	\$14,219,161	\$1,523,482	\$12,695,679	12.0%	\$31,320	0.25%
RAMS Adult	\$18,710,169	\$1,873,806	\$16,836,363	11.1%	\$85,144*	0.27%
RAMS Children	\$16,063,684	\$1,721,109	\$14,342,575	12.0%	**	**
Seneca	\$63,495,327	\$6,803,070	\$56,692,257	12.0%	\$70,750	0.12%
SF Study Center	\$11,016,593	\$1,180,349	\$9,836,244	12.0%	\$31,207	0.32%
Walden House	\$54,256,545	\$5,813,201	\$48,443,344	12.0%	\$724,218 ⁵	1.49%
TOTAL			\$200,160,112		\$1,044,144	0.52%

* Includes RAMS Children ** Included in RAMS Adult contract.

Source: Department of Public Health, "Explanation for DPH FY10-11 Contingency Increases", submitted to the Budget and Legislative Analyst (August 6, 2012).

³ Department of Public Health report to the Board of Supervisors: "Increases in Contracts During Fiscal Year 2010-11", July 14, 2011.

⁴ Department of Public Health report to the Board of Supervisors: "Increases in Increases in Contracts during Fiscal Year 2011-12 – Revised", August 28, 2012.

⁵ The original memorandum to the Board of Supervisors indicated that this contract was increased by \$18,400 during FY 2010-11, the increase from the final award letter, not the total increase during the year.

The FY 2010-11 report to the Board of Supervisors includes only the first year of each of these five year contracts; thus, more contingency authority can be expected to be utilized in the remaining four years. For FY 2011-12, DPH submitted an initial and an amended report, making several corrections. The amended submission to the Board of Supervisors for FY 2011-12 indicates that greater use was made of the contingency authority in that fiscal year than in the first year and that the purposes for use of the contingency were more varied. The amended report shows that ten contractors received increases totaling \$4,116,869 from new funding allocations,⁶ for a cumulative percentage increase of 1.2 percent over the two years. In addition, two contracts that were consolidated across formerly separate contracts for each vendor provided for another \$1,480,092 in contingency use, or 0.4 percent over the allocated contract amount.

Table 5.2
Increases in DPH Contracts, Cumulative Through FY 2011-12⁷

Contractor	Total Not to Exceed Amount (FY 2010-15)	Contract Budget*	Increase to Date (FY 2010-11 and FY 2011-12)	Total % Increase From Contract Budget
NEW AND REALLOCATED FUNDING ALLOCATIONS				
Alternative Family Services	\$11,057,200	\$9,863,022	\$100,000	1.0%
Bayview Hunters Point Fndn.	\$27,451,857	\$24,487,056	\$676,986	2.8%
CATS	\$14,854,465	\$13,250,183	\$331,893	2.5%
Community Vocational Entrprs.	\$9,705,509	\$8,657,314	\$314,767	3.6%
Conard House	\$37,192,197	\$33,175,440	\$203,957	0.6%
Edgewood Center	\$29,109,089	\$25,965,307	\$157,057	0.6%
IFR	\$14,219,161	\$12,683,492	\$200,182	1.6%
RAMS**	\$34,773,853	\$31,018,277	\$490,361	1.6%
UC Regents***	\$74,904,591	\$66,814,895	\$343,370	0.5%
Seneca	\$63,495,327	\$56,692,257	\$70,750	0.1%
SF Study Center	\$11,016,593	\$9,826,801	\$503,328	5.1%
Walden House	\$54,256,545	\$48,443,344	\$724,218	1.5%
SUBTOTAL	\$382,036,387	\$340,877,388	\$4,116,869	1.2%
CONTRACT CONSOLIDATIONS				
RAMS	\$34,773,853	\$31,018,277	\$916,206	3.0%
UC Regents	\$74,904,591	\$66,814,895	\$563,886	0.8%
SUBTOTAL	\$109,678,444	\$97,833,172	\$1,480,092	1.5%

* Total contract less contingency authorization.

** The \$916,206 in funds transferred to effectuate the consolidation of the RAMS Adult and RAMS Children contract are included in the contract consolidation subsection of the table..

***The \$563,886 in changes to the contract with the U.C. Regents which resulted from consolidation of two contracts are included in the contract consolidation subsection of the table..

Source: Department of Public Health data presented to Budget and Legislative Analyst's Office.

⁶ Excludes funds for continuation of CATS funding, approved by the Board of Supervisors on July 18, 2012..

⁷ Includes increases only. Eight contracts for which funding was reduced and included in the report from DPH to the Board of Supervisors are not considered here.

Were this amount for new or reallocated funding projected forward across the five years of these contracts, the percentage increase over the full contract period would be 3 percent, far less than the 12 percent authorized under the policy. In only one instance, that of the San Francisco Study Center contract, would the entire 12% authorization be required were the current rate of increases to continue over the five year contract period (discussed further below). The instances in which the contingency were used to consolidate contracts are most likely one-time events that will not be repeated and, in any event, represented percentage increases far below the 12 percent allowed in the policy. Thus, it appears very unlikely that the full contingency authorization will be utilized over the term of these contracts for the purpose for which it was established.

The contingency policy may be providing DPH with more flexibility than is needed to fulfill the stated purposes of the policy. Department management indicates that the 12 percent figure was selected as it was greater than the 10 percent contract increase which, under a 1997 policy adopted by the Health Commission,⁸ requires Health Commission approval. Thus, the contingency policy appears to conflict with the direction to acquire Commission approval for contract changes exceeding 10 percent. Because DPH's expected use of contingency authorization is less than 10 percent over the term of the contracts, setting the contingency amount at 10 percent of the contract budget, rather than 12 percent, is sufficient to meet the department's requirements and consistent with Health Commission policy for contract increases.

Significant Policy Changes Have Been Made Using the Contingency

While DPH has reported to the Board of Supervisors that the contingency authorization is most generally used to allocate new or reallocated funds to already existing programs, DPH has not articulated allowable uses of the contingency.. While the use of the contingency authorization in FY 2010-11 and FY 2011-12 was often for quite minor contract changes, in some instances, DPH has used contingency authorization to increase contract expenditures for programs that are more significant in size and scope and would benefit from Health Commission review or which were awarded as sole source rather than competitively bid..

For example, the FY 2011-12 increase for the San Francisco Study Center included \$200,000 in new Mental Health Services Act (MHSA) innovation funding to implement new short-term projects. This increase represents not simply an expansion of ongoing services to more individuals but a change in service model. The broad outlines of the additional MHSA funding were considered by the Health Commission, and the Board of Supervisors during the annual budget review process. Consistent with its usual practice, the Health Commission did not review specifics of how those funds were allocated to the particular contractor. However, given that this contract was for an entirely new program and amended the terms as well as the amount of the contract, the use of contingency for this purpose inhibits the use of contracts as tools in policy-making. At a minimum, the Commission should be informed immediately following allocation of funding for new programs or services using the contingency authorization, including which contractor

⁸ Health Commission resolution approving Policy on Contract Modifications, October 1, 1997.

received the funding and whether that contractor was selected through competitive bid or a sole source. DPH also used contingency authorization to fund three sole source programs under its contract with Community Awareness and Treatment Services, Inc. (CATS), which DPH had indicated to the Board of Supervisors would be competitively bid. While these sole-sourced programs were ultimately approved by the Board of Supervisors in July, 2012, DPH funded the sole source contracts using the contingency authorization in the contract with CATS from 2010 to 2012.

Contingencies Generally Remain at 12 Percent when a Contract is Amended Mid-Term and Expenditures Have Already Been Incurred

When contracts are amended, the contingency amount is often increased to 12 percent of the full contract amount, even though some of the term of the contract has expired and significant expenditures have already been incurred. The Board of Supervisors has accepted recent Budget and Legislative Analyst recommendations to reduce the contingency amount to a percentage of only the remaining contract funds. For example, a recently recommended amendment to a contract between the City and Asian American Recovery Services retained the contingency percentage at 11.4 percent of the total increased contract amount, even though three of the contract's seven years had already elapsed. By instead calculating the contingency on the remaining four years of the agreement, the contingency was reduced by \$5,388,999.

The Level of Contingencies is Inconsistent

The treatment of contingencies is inconsistent. In some instances the contingency amount is set at less than 12 percent of the total contract. In the example above, the contract with Asian American Recovery Services utilized an 11.4 percent, instead of 12 percent, contingency. Similarly, the amended RAMS Adult contract for FY 2010-15 included an 11 percent contingency (see Table 5.1 above). The first amendment to the FY 2010-15 contract between DPH and BAART set the contingency amount at only 2.8 percent, rather than 12 percent, increasing the total agreement by 3 years to \$9,990,000, or \$10,000 less than the \$10,000,000 contract level that requires Board of Supervisors' approval. The reasons for these differences in the contingency percentage were not explained by DPH.

Some Vendors from which Funds are Reallocated Were Allowed to Retain Their Full Contingency Authorization

Department management indicates that the contracts of vendors from whom funds were reduced because the agency is not delivering promised units of service are not always amended either in terms of dollars or expected deliverables and their annual budget may or may not be amended. This allows the vendors from whom funds were reallocated to maintain their original contracted amount as well as the contingency authorization. The cumulative effect is an increase to DPH's total spending authority. Department management further reports that DPH does not as regular practice track information on an ongoing basis about the vendors from whom the funds were reallocated. DPH is able to

provide this information only after significant effort on behalf of department management.

Information Provided to the Board of Supervisors Concerning the Use and Source of Funds for Increased Contracts is Inadequate

Written explanations in the reports to the Board of Supervisors⁹ covering FY 2010-11 focused only on the source of funds, e.g., "reallocation of general fund", "grant funds", "work order funds", "MHSA funding". There is no documentation in the memo of the reason for the increase (e.g., to serve an additional xx clients of a given type. e.g., children or seniors), the proportion of the contingency used in the prior year and throughout the life of the contract and, in the case of reallocated funds, the contract from which funds were reallocated. In addition, increases in Medicare funding as well as reallocations from one contractor to another are both described as "reallocated general fund", reducing the Board of Supervisors' ability to understand the source of funds. On request, DPH was able to provide the type of detail discussed above.

Enhancing the information regularly collected and reported will allow DPH, the Health Commission and the Board of Supervisors to assess whether the City is meeting its target service levels and to perform its contract oversight function.

Conclusions

The Department's policy of setting a contingency on each contract is sound business practice, allowing for rapid acceptance of available funds and providing a mechanism for insuring that client services are not interrupted when a vendor cannot perform services and funds need to be reallocated. However, much less than the 12 percent authorization is likely to be used. Other departmental practices provide DPH with more flexibility than is needed to achieve the goals of the policy and can result in significant policy changes being made without Health Commission or Board of Supervisors approval. Finally, the information collected and presented to the Board of Supervisors is inadequate to allow the Board to assess whether the City is meeting its target service levels and to perform its contract oversight function.

Recommendations

The Health Commission should:

- 5.1 Consider limiting the standard contingency to 10 percent of each contract's budgeted allocation, consistent with the Commission's policy of requiring Commission approval of contract increases of more than 10 percent.

⁹ Ibid.

The Director of Public Health should:

- 5.2 Develop a written policy for the application of contingencies to professional services contracts that (a) requires consistent application of the contingency percentage adopted by the Health Commission; (b) defines the allowable use of contingencies as the allocation of new funds or reallocation of funds from existing providers; (c) calculates the contingency percentage on the balance of the contract when contract amendments are executed; and (d) reduces the contract amount of low-performing providers from whom contract funds have been reallocated to other providers.
- 5.3 Require a report to the Commission immediately following allocation of funding for new programs or services using the contingency authorization, detailing to which contractor the funding was directed and whether that contractor was selected through competitive bid or a sole source.
- 5.4 Revise the annual report to the Board of Supervisors concerning use of the contingency authorization to include the reason for the increase (e.g., to serve an additional xx clients of a given type. e.g., children or seniors), the proportion of the contingency used in the prior year and throughout the life of the contract and, in the case of reallocated funds, the contract from which funds were reallocated.

Costs and Benefits

Strengthening controls on contract contingencies will insure that the Health Commission and Board of Supervisors, as appropriate, approve expenditure increases that are financially significant or which allow for new programs or services to be implemented; limit department use of the contingency authorization to enter into sole source contracts without prior approval; improve coordination of performance monitoring and contracting and allow the Board to assess whether the City is meeting its target service levels and to perform its contract oversight function. The enhanced oversight will occur while allowing DPH the ongoing flexibility needed to achieve the goals of the policy and cost little to implement.

Human Services Agency and Department of Public Health Written Responses to
the Performance Audit Report and Recommendations

City and County of San Francisco



Edwin M. Lee, Mayor

Human Services Agency

Department of Human Services
Department of Aging and Adult Services

Trent Rhorer, Executive Director

October 25, 2012

Harvey M. Rose
Harvey M. Rose Associates, LLC
1390 Market Street, #1025
San Francisco, CA 94102

Dear Mr. Rose,

Thank you for the opportunity to respond to your performance audit of professional services contracts dated October 11, 2012. Two sections of this performance audit deal with contracts under the jurisdiction of the Human Services Agency (HSA). One section deals with performance monitoring and the other section deals with the corrective action process. The Human Services Agency response addresses these two sections separately.

Performance Monitoring

Your report acknowledges the central role played by the Human Services Agency working the City Controller in the development of Citywide fiscal and compliance monitoring program for contracts. Your report also states that HSA "should be recognized for their work to improve the tools and systems used to monitor nonprofit contractors." We appreciate this recognition of our efforts. We also acknowledge that improvements can be made in our contract monitoring, particularly in the area of program monitoring. We are continuing our effort to revise the service objectives of our contracts in order to make these objectives more consistent and more measurable. We are also installing a new contract management system which includes performance measures as part of the invoicing process. We project that all of our contracts will be entered into this new contract management system by the end of the current calendar year. We will also be completing a handbook and training program for all of our staff the monitor contracts. The training program will include policies and procedures, guidelines and standard forms for program, fiscal and compliance monitoring. We project that all contract monitors will have completed this new training by the end of the current fiscal year.

Corrective Action Process

The City's Nonprofit Corrective Action Policy is intended to encourage nonprofit accountability and compliance with government fund requirements as well as reliable service delivery. Your report faults the Human Services Agency for not maintaining a list of agencies in corrective action and for not establishing clear standards and timeframes for dealing with contractors in corrective action.

The Human Services Agency believes that corrective action should be handled on a case-by-case basis. Of the 367 contracts administered by HSA, less than ten contracts are in corrective action at any given time. Reasons for corrective action vary from contract to contract but generally include concerns about financial stability and/or the delivery of services specified in the contract. When problems are identified, HSA attempts to provide technical support including, in some cases, the provision of a fiscal agent if the problems identified concern financial stability. In cases where identified problems concern the delivery of

services, HSA works with contractors to clarify expectations and to implement measurable objectives. Only after making such efforts does HSA seek to replace an under-performing contractor and, in some cases, alternative service providers are not available.

SUMMARY

The Human Services Agency appreciates this opportunity to respond to the Budget Analyst's performance audit of professional services contracts. We are in general agreement with your findings and recommendations regarding performance monitoring of contracts and believe that the implementation of our new contract management system will address your recommendations. We are not in agreement, however, with applying "one-size-fits-all" standards to under-performing contractors. Instead, we attempt to work with the very small number of contractors that we have in corrective action to address their specific performance issues, be they financial stability or service delivery. We believe that this approach is a better way to ensure that community-based organizations can continue to provide the service needs that have been identified in San Francisco's neighborhoods. As you requested, I have attached our detailed responses to your specific recommendations.

Sincerely,

A handwritten signature in black ink, appearing to read 'Trent Rhorer', followed by a long horizontal line extending to the right.

Trent Rhorer
Executive Director

Attachment



San Francisco Department of Public Health
Barbara A. Garcia, MPA
Director of Health

City and County of San
Francisco
Edwin M. Lee
Mayor

October 29, 2012

Severin Campbell
San Francisco Board of Supervisors
Budget and Legislative Analyst's Office

Re: Professional Services Contracts Audit

The Department of Public Health (DPH) appreciates the efforts of the Budget and Legislative Analyst's effort in conducting the Professional Services Contracts Audit. We have reviewed and agree with some, but not all, of the analysis and recommendations of the report.

As DPH has approximately \$1.4 billion of multi-year professional services contracts at a given time, most of which are with nonprofit providers providing critical services for the community, we recognize that this audit was no easy task. While DPH and Budget and Legislative Analyst staff made significant efforts to clarify issues in report, we believe that there are some areas of the report that does not accurately characterize our performance monitoring process nor does it fully recognize the very significant improvements the department has made in that area. Over the last several years we have achieved the following accomplishments:

- Development of the Corrective Action Process: The Department developed its Corrective Action Process three years before a citywide policy was adopted. The Department has effectively utilized the Corrective Action Process to implement a Community Programs-wide approach to addressing contractors with serious issues. The Department effectively utilizes its sources of information (e.g., fiscal and program monitoring results, whistleblower, client or staff complaints, audited financial reports, billing invoices) to foster early problem recognition and to deal with those problems in a highly structured and detailed manner. It is noted that the Budget Analyst Report raised no issues regarding the content of these Corrective Action Plans – including the level of detail, timelines, Department follow up, and corrective action strategies. The Department has been able to guide contractors to compliance and stability, and when necessary, to defund contractors and seamlessly transition clients, while helping them to close operations.

-
- Development of the Community Programs Business Office: Prior to the formation of the Community Programs Business Office and Contracts Compliance (BOCC) in August, 2009, Community Programs sections relied on self reporting by contractors to develop monitoring reports and to rate contractors' performance. The BOCC eliminated the self reporting process. In its place, virtually all monitoring consists of site visits at which contractors are required to provide source data, not just summary reports, to document compliance with various rules and regulations. Additionally, the BOCC standardized the Monitoring Report template review categories across Community Programs, improved the format of the report template to ensure all measured objectives and their scores were detailed in the report, developed a Monitoring Report Checklist to ensure that criteria for successfully achieving a measure was clearly outlined, and a corresponding Scoring Sheet to identify the score for each measure, based on the level of compliance that was met. Additionally, the BOCC staff are trained at the onset of each of the Department's three annual monitoring review cycles on how to use each of the forms, thereby ensuring that all agencies are uniformly assessed to the same standards for each measure.
 - Implementation of Declarations of Compliance: In FY 2010-11, the BOCC implemented Community Programs-wide distribution of its Declaration of Compliance, a standard list of compliance requirements such as posting employee grievance procedures and developing an emergency plan. We require each contractor at the program level to attest to conformance. The BOCC staff then reviews contractors' compliance with the Declaration's during on-site monitoring visits. This pre-notice process has resulted in an increase in the level of compliance among agencies.

We are very proud of the substantial improvements DPH has made in its contracting process over the past several years. We continue to strive to improve our contract processing and monitoring and look forward to making additional improvements. Some of the suggestions made in your report will help us continue to formalize and document systems we already have in place. We will bring the Budget Analyst's recommendations on standardizing and formalizing our contracting policies to the Health Commission for their consideration. In addition to the recommendations outlined in this report, we are open to any other suggestions you may have for improvement.

Attached are DPH's complete responses to the Budget and Legislative Analyst recommendations directed to our department.

Respectfully,



Barbara A. Garcia
Director of Health

Professional Services Contracts Audit

Recommendation Priority Ranking

Based on the management audit findings, the Budget Analyst has made 17 recommendations which are ranked based on priority for implementation. The definitions of priority are as follows:

- Priority 1: Priority 1 recommendations should be implemented immediately.
- Priority 2: Priority 2 recommendations should be completed, have achieved significant progress, or have a schedule for completion prior to April 30, 2013.
- Priority 3: Priority 3 recommendations are longer term and should be completed, have achieved significant progress, or have a schedule for completion prior to October 31, 2012.

Professional Services Contracts Audit

	Recommendation	Priority	Department Response (Agree/ Disagree)	Department Implementation Status/ Comments
	The Department of Public Health should:			
1.1	<p>Enhance program monitoring policies and protocols to provide step-by-step details for staff regarding the entire process by:</p> <p>(a) Defining the purpose and meaning of the numeric scoring system, and establishing clear thresholds for action based on numeric scores.</p> <p>(b) Ensuring continuity in the monitoring process such that program managers are familiar with a program’s history and status.</p> <p>(c) Establishing a formal internal review process to identify any errors in the program monitoring reports and include the review process in BOCC staff training.</p>	2	Partially Agree	<p>DPH has made significant changes in the last several years which address the specific Budget Analyst recommendations in this section, but are not reflected in their report.</p> <p>In FY 10-11, DPH defined the scoring system in the scoring worksheets for all DPH sections and train staff on the use of these worksheets. DPH provided these worksheets to the Budget Analyst and offered to meet to explain how the reports are used and how the reports relate to each other, as well as to attend a site visit where the forms are used. The Budget Analyst declined this invitation.</p> <p>In addition, we have recently implemented a new scoring database that will eliminate any calculation errors in future program monitoring reports.</p> <p>DPH has several mechanisms to ensure continuity of the monitoring process and the integrity of the review process including:</p>

Professional Services Contracts Audit

	Recommendation	Priority	Department Response (Agree/ Disagree)	Department Implementation Status/ Comments
				<ul style="list-style-type: none"> • Regular meetings including: <ol style="list-style-type: none"> 1. Formal training meetings at the start of every monitoring cycle 2. Semi-weekly meetings for all BOCC staff with a standard agenda component to discuss monitoring results information and agency specific issues, and regular and ongoing training 3. Monthly Community Programs Contract Oversight Committee meetings • Contract Compliance Staff Assignment Policies which require: <ol style="list-style-type: none"> 1. Contract review assignments are only made prior to the start of a contract cycle. Assignments do not change mid-cycle. 2. BOCC Staff do not lack historical knowledge. All staff members are have access to copies of the agency’s certified contract, prior year monitoring report, which would identify issues, copies of any required Plans of Action submitted by an agency, and its acceptance status. 3. Permanently assigned staff always manage or co-manage Corrective Action Plan. <p>We agree to continue these activities. We continuously strive to improve our process and are open to additional recommendations to improve areas we haven’t already addressed</p>

Professional Services Contracts Audit

	Recommendation	Priority	Department Response (Agree/ Disagree)	Department Implementation Status/ Comments
1.2	<p>Create clear training materials and resources to ensure that existing and revised processes are adequately communicated to staff by:</p> <ul style="list-style-type: none"> (a) Developing resource materials that can be readily accessed by staff. (b) Hosting annual COOL training opportunities for staff to refresh knowledge and learn about new features or policies. (c) Implement periodic quality assurance measures and conduct staff trainings at least annually to ensure that policies are being implemented. 	2	Partially Agree	<p>DPH is already complying with recommendations a and c because it already has existing processes to ensure that staff are properly trained and that staff has access to the applicable materials, some which has been described in section 1.1. DPH will continue the work it is currently doing in this area.</p> <p>Furthermore, the Department already provides training at the beginning of each of its three program monitoring review cycles instructing BOCC Compliance Managers on</p> <ul style="list-style-type: none"> (a) the monitoring review Report Template content that contains all items which will be reviewed for compliance with DPH requirements, including State and Federal funding requirements, (b) Site Visit Checklist which provides the criteria, in checklist form, which must be present for an agency to meet each requirement included in the Report Template (c) Scoring Worksheet that provides instructions for determining a score for each item, depending on how much of an item is achieved, and (d) Related documentation, as needed, including additional training is provided for the more technical knowledge required for BOCC staff to conduct chart reviews.

Professional Services Contracts Audit

	Recommendation	Priority	Department Response (Agree/ Disagree)	Department Implementation Status/ Comments
				<p>The Department disagrees with assertion that the training provided to staff during staff meetings does not constitute formal training, even if it is designated as the sole purpose of the meeting. The training materials are the documents themselves, along with supporting policies as needed, and shadowing by senior members during actual site visits provides additional feedback and guided training to BOCC Compliance Managers working in a programmatic area that is new to him or her.</p> <p>DPH concurs with recommendation b. Please see section 1.3.</p>

Professional Services Contracts Audit

	Recommendation	Priority	Department Response (Agree/ Disagree)	Department Implementation Status/ Comments
1.3	<p>Ensure that the functionality of COOL continues to improve the performance and efficiency of the Contract Management and Monitoring functions of the department by:</p> <p>(a) Developing standards for naming conventions and file locations.</p> <p>(b) Creating training opportunities for staff and require participation.</p> <p>(c) Establish a COOL/Documents Management Committee, with representation from all sections and staff levels, to ensure the improvement of functionality, identification of future problems, and the opportunity for further system enhancements.</p>	3	Agree	<p>DPH concurs with these recommendations, and will formalize and enhance its existing procedures and training accordingly. The DPH Contracts Office will develop standards, a training schedule (including annual trainings as described in recommendation 1.2b), and a COOL documents management committee by April 30, 2013.</p>

Professional Services Contracts Audit

	Recommendation	Priority	Department Response (Agree/Disagree)	Department Implementation Status/Comments
	The Human Services Agency should:			
2.1	<p>Revise program performance monitoring policies and procedures to include standard procedures by service area (or cluster) for:</p> <p>(a) Quarterly and annual reports submitted by contractors, including frequency and format; and for program managers to provide feedback to contractors; and</p> <p>(b) Annual assessments conducted by program managers, including criteria for conducting site visits or requiring self-assessment by contractors, and standardized reporting formats.</p>	2	Agree	<p>(a) Monthly reporting of service objectives will be included in our new contract management system, as will quarterly and annual reporting of performance outcomes.</p> <p>(b) Annual assessments are already required. See also response to recommendation 2.3.</p>
2.2	Complete the review of all contract service and outcome objectives to standardize objectives for similar contracts (clusters), reduce the number of objectives in each contract to two to four, and streamline data collection.	3	Agree	Implementation is ongoing.

Professional Services Contracts Audit

	Recommendation	Priority	Department Response (Agree/ Disagree)	Department Implementation Status/ Comments
2.3	Develop a handbook and formal training curriculum for program and contract managers that include revised policies and procedures, guidelines, and standard forms for program performance, fiscal, and compliance monitoring. All existing and new program and contract managers should receive the handbook and participate in the training.	1	Agree	Handbook and training projected to be completed by the end of FY12-13 or early FY 13-14.
2.4	<p>Develop program reporting and monitoring modules for the CARBON contract management system that includes:</p> <ul style="list-style-type: none"> (a) The collection of simple and consistent service and outcome objective data that is comparable across contractors that provide similar services. (b) Central tracking and reporting of contractors that do not submit program data in a timely manner. (c) Central tracking and reporting of contracts with program, fiscal, and/or compliance monitoring findings, required corrective action(s), timelines, and the status of corrective action(s). 	2	Partially Agree	<p>Agree as to the collection of simple and consistent service and outcome objective data.</p> <p>Given the small number of contractors in corrective action, we prefer to work with under-performing contractors on a case-by-case basis to ensure that neighborhood services can continue to be provided by community-based organizations with ties to and understanding of specific neighborhood concerns.</p>

Professional Services Contracts Audit

	Recommendation	Priority	Department Response (Agree/ Disagree)	Department Implementation Status/ Comments
	The Director of Public Health should instruct DPH's Office of Contract Compliance to:			
3.1	Develop written policies and procedures for the use of sole source contracts to be approved by the Health Commission. These policies and procedures should specify the necessary justifications for use of sole source contracts in accordance with OCA rules and regulations.	1	Agree	The department will work with the Health Commission to develop written policies and procedures for their consideration and approval prior to April 30, 2013.
3.2	Expand the current annual reporting to the Board of Supervisors and Health Commission on use of sole source contracting to (a) include justifications for sole source contracts and (b) distinguish between sole source contracts and programs awarded on a sole source basis within multi-program contracts.	1	Agree	These enhanced reporting requirements will be included in the FY 12-13 sole source contracting report.

Professional Services Contracts Audit

	Recommendation	Priority	Department Response (Agree/ Disagree)	Department Implementation Status/ Comments
	The Director of Public Health should direct appropriate System of Care staffs to:			
3.3	Conduct the surveys that are required by Administrative Code Section 21.42 and report the results to the Health Commission by the start of FY 2013-14.	2	Partially Agree	City Attorney has advised DPH that it is in compliance with the Administrative Code Section 21.42, as they believe that the administrative code allows for informal surveys conducted by those who specialize in overseeing the type of services or program in issue. As DPH program managers have strong connections to the community, they will be familiar with any additional contractors in the community that may arise, and therefore informal surveys are more applicable to DPH. In addition, DPH does regular Requests for Proposals which are publically posted and disseminated widely. DPH agrees to continue these activities.
	The Controller should:			
4.1	Revise the Citywide Corrective Action Policy to add more specificity regarding the amount of time and support that should be given to nonprofits <i>between</i> various stages of the corrective action process (i.e. the	2	Disagree	The number of variables involved in a corrective action procedure makes it impractical to set a rigid timeline for improvement. The combination and

Professional Services Contracts Audit

	Recommendation	Priority	Department Response (Agree/ Disagree)	Department Implementation Status/ Comments
	time allowed for improvement between the standard corrective action procedure and designation as “elevated concern”).			severity of findings affect the amount of time an organization will need to implement improvements. In addition, the capacity of an organization to make change varies based on overall size of the organization, ability of personnel, and availability of City staff for training, coaching or other technical capacity building.
	The Department of Public Health and Human Services Agency should:			
4.2	<p>Clarify internal monitoring and corrective action polices to more accurately reflect the Citywide Nonprofit Corrective Action Policy by:</p> <p>(a) Developing clear measures and timeframes for when monitoring findings should be brought forward for the City’s Corrective Action Process, and between each stage of the process.</p> <p>(b) Developing standards and guidelines for the amount of technical and financial support the department should provide to nonprofits throughout the Corrective Action Process.</p>	2	HSA: Partially Disagree DPH: N/A	<p>HSA: (a) and (b) Given the small number of contractors in corrective action, we prefer to work with under-performing contractors on a case-by-case basis to ensure that neighborhood services can continue to be provided by community-based organizations with ties to and understanding of specific neighborhood concerns.</p> <p>(c) HSA is already enforcing the City’s funding diversification guideline. The 15% standard is monitored for during the fiscal and compliance monitoring</p>

Professional Services Contracts Audit

	Recommendation	Priority	Department Response (Agree/ Disagree)	Department Implementation Status/ Comments
	<p>(c) Developing guidelines to monitor and ensure that 15 percent of each nonprofit contractor’s annual budget is derived from non-City sources, and further develop strategies to support contractors in their efforts to comply.</p>			<p>site visits. If the contractor does not meet this threshold, it becomes a documented finding and the Agency makes a recommendation that the contractor increase its funding diversity.</p> <p>DPH: DPH believes it is more appropriate for the Controller’s Office and Joint Fiscal and Compliance Advisory Group respond to these recommendations, as this is a Citywide policy, and not unique to DPH.</p> <p>Regarding the recommendation 4.2a, DPH does not believe that standards and timeframes would be useful, as each agency is already provided with a timeline for compliance with each corrective action identified. The established timeframe and amount of technical support is tailored to the capacity of the agency, and monitored closely by DPH. Each agency is different, and achieving compliance varies by agency and issue. We believe this flexibility is critical to increasing the likelihood of an agency</p>

Professional Services Contracts Audit

	Recommendation	Priority	Department Response (Agree/ Disagree)	Department Implementation Status/ Comments
				successfully addressing issues in its corrective action plan.
4.3	Train monitoring staff regularly to ensure proper implementation of the Citywide Nonprofit Corrective Action Policy.	1	HSA: Agree DPH: Partially Agree	HSA: Training projected to be completed by the end of FY12-13. DPH: DPH staff is already properly implementing the Citywide policy. DPH will continue to remind staff of the Citywide policy and of DPH's internal process for determining when contractors will be placed in formal corrective action.
	The Health Commission should:			
5.1	Consider limiting the standard contingency to 10 percent of each contract's budgeted allocation, consistent with the Commission's policy of requiring Commission approval of contract increases of more than 10 percent.	2	Agree	DPH will work with the health commission to review its contingency standard with the Commission policy on contract increases and formalize its policy by April 30, 2013.
	The Director of Public Health should:			
5.2	Develop a written policy for the application of contingencies to professional services contracts that (a) requires consistent application of the contingency	2	Agree	DPH will work with the Health Commission to develop adopt a formal written policy for the application of contingencies to professional services

Professional Services Contracts Audit

	Recommendation	Priority	Department Response (Agree/ Disagree)	Department Implementation Status/ Comments
	percentage adopted by the Health Commission; (b) defines the allowable use of contingencies as the allocation of new funds or reallocation of funds from existing providers; (c) calculates the contingency percentage on the balance of the contract when contract amendments are executed; and (d) reduces the contract amount of low-performing providers from whom contract funds have been reallocated to other providers.			contracts for their consideration by April 30, 2013.
5.3	Require a report to the Commission immediately following allocation of funding for new programs or services using the contingency authorization, detailing to which contractor the funding was directed and whether that contractor was selected through competitive bid or a sole source.	2	Partially Agree	DPH will work with the Health Commission to review its contingency and contracting policies and make any modifications they deem necessary by April 30, 2013.. Much of this information is currently being provided to the Health Commission. The Health Commission approves all contracts with a value of \$50,000 or more. As part of their approval process, we provide information on whether the contractor was selected through competitive bid or a sole source. At the monthly Health Commission contracts review, it also reviews and approves any and all modifications of 10% and over.
5.4	Revise the annual report to the Board of Supervisors	2	Partially Agree	DPH will include in its contingency report the reason for the increase, the

Professional Services Contracts Audit

	Recommendation	Priority	Department Response (Agree/ Disagree)	Department Implementation Status/ Comments
	concerning use of the contingency authorization to include the reason for the increase (e.g., to serve an additional xx clients of a given type. e.g., children or seniors), the proportion of the contingency used in the prior year and throughout the life of the contract and, in the case of reallocated funds, the contract from which funds were reallocated.			proportion of contingency used in the prior year and throughout the life of the contract and indicate whether or not the funding source is new or reallocated from an existing source. We do not believe that it is relevant to identify the contracting agency by name when funding is reallocated from that agency, except as described in recommendation 5.2 d. Contract projections fluctuate over the course of the year and sources for a contingency may vary.