COUNTY OF MILWAUKEE
Inter-Office Communication

DATE: June 25, 2021

TO: Sup. Marcelia Nicholson, Chairwoman, Milwaukee County Board of Supervisors

FROM: Shakita LaGrant McClain, Director, Department of Health and Human Services
Prepared by David Muhammad, Deputy Director, Department of Health and Human Services

SUBJECT: **An informational report from the Director, Department of Health and Human Services, providing an update on the Racial Equity and Contracting Workgroup**

Background:

On April 17, the Milwaukee County Board of Supervisors adopted File No. 20-173 which created Chapter 108, "Achieving Racial Equity and Health," of the Milwaukee County Code of General Ordinances. DHHS is in alignment with this ordinance as DHHS leadership continues to focus on social determinants of health as well as racial and health equity through the work it does internally with its operations and externally, with its participants, contracted provider organizations, system, and community partners. Racial Equity and Contracting is one area identified by DHHS leadership in which there is an opportunity to address structural barriers and advance equitable policy and practice. The primary goal is to assess DHHS's contract procurement strategy and develop additional tactics to address structural barriers to expand the provider network and ensure that its diversity is representative of those served in DHHS.

In early fall of 2020, DHHS convened a short-cycle six-meeting session, Racial Equity in Contracting Workgroup to assess our institutional practices through a racial equity lens. It is our goal to develop DHHS's capacity to improve its work with providers and institutional partners to ensure a consistent process that addresses their needs.

Kairo Communications was hired to perform an external evaluation of the DHHS contracting process, our provider network, demographics, assess institutional readiness, and an environmental scan of services. The evaluation was to culminate in the creation of an implementation plan. The process included 37 key stakeholder interviews, a complete review of relevant contracting documents and policies, data, and literature review. The final report is now complete and ready for public presentation.

Purpose of Committee/Report:

Assist DHHS Leaders to intentionally and critically examine race, ethnicity and health equity when analyzing problems, proposing solutions and measuring success and to evaluate potential

strategies that will expand contracting opportunities for diverse organizations utilizing the Racial Equity tool.

Deliverables:

- Drafting of Workgroup charter, metrics, and timeline
- Apply the GARE Racial Equity Tool to guide the work and evaluate recommendations
- Review and draft recommendations of internal policy and RFP practices
- Oversee the creation of a policy white paper and report regarding diversity in DHHS contracting and the department's overall economic impact on communities of color
- Identify strategies to address structural barriers to ensure a diverse provider network
- Hire external evaluator and create advisory structure for implementation
- Final report and recommendations

Frequency of Meetings: Bi-weekly meetings held for an hour and a half, completed on January 5, 2021

Committee Participants:
Sector & Community Representatives-Arnitta Holliman (Office of Violence Prevention); Darlene Russell (Greater Milwaukee Foundation); Dr. Pat McManus (Black Health Coalition); Mark Fossie (M&S Clinical Services); Elsa Diaz-Bautista (ALAS); Martina Golin-Graves (Mental Health America)

Milwaukee County Representatives-Rashaan Cherry (Wraparound); Jeff Roman (OAAA); Brenda Smith-Jenkins (Contract Services); Kelly Pethke (DYFS); Nzinga Khalid (CARS); Matt Fortman (Director's Office-CFO); Dennis Buesing (Contract Services); Lamont Robinson (CBDP); Antoinette Davis (BHD)

Staff Support: Jessica Peterson, TJ Cobb

External Evaluators: Dr. Debra Blanks (Kairo Communications), Dr. David Pate (UWM)

Tasks Completed:

- Workgroup Charter Drafted (Completed 9/04/20)
- External evaluation contract executed with Dr. Debra Blanks (Kairo Communications) and Dr. David Pate (UWM) as the lead evaluators (Completed 9/9/20)
- Initial Meeting held and policy document review process has begun by workgroup and evaluators (Completed 9/24/20)
- Evaluator led focus groups and stakeholder interviews began in late October.
- Workgroup meetings held 10/13, 10/27, and 11/10, 12/8, 1/5 in addition to document review and stakeholder interviews
- Preliminary Evaluator Report submitted 12/30 presented to Director LaGrant

- Final Draft of Report submitted 3/31
- Internal Review and final proofreading completed 4/30

Final Report Submitted: May 10, 2021

Executive Summary of Report From External Evaluators:

The goal of achieving racial equity is to transform how institutions and systems negatively impact people of color through policies, procedures, and practices. Systemic inequities in procurement practices occur when contracts and purchasing decisions do not reflect the racial demographics of the community. Thus, it is imperative to utilize a racial equity lens as a part of research and evaluation. Challenging the long-held principles undergirding traditional less inclusive procurement processes requires a heightened esteem for the values, traditions, and practices of diverse communities. The purpose of this study—to examine the Milwaukee County Department of Health and Human Services contracting process is a critical step in creating more inclusive, equitable practices.

While our full evaluation report will be completed by the end of the first quarter of 2021, we are pleased to provide you with a summary report with information regarding the foundation on which the evaluation is conducted and some preliminary observations and recommendations. While this information is not comprehensive, it can be used to initiate planning for specific systems improvements and to initiate the reimagining of a contracting system that is fair, inclusive, equitable, and outcomes driven.

It is important to note that this evaluation is not a disparity study, it does not determine the degree of disparity that exist in government contracting with businesses of color and is not designed to identify parameters for the creation of a race neutral program. The goal of this evaluation is to identify opportunities and barriers that affect DHHS' ability to achieve racial equity in contracting, to improve outcomes for families and communities, and to impact the social determinants of health.

Research Objectives

DHHS has an annual budget of approximately $330 million and a staff of over 800. The department's primary mechanism for service delivery is through contracts with non-profit agencies that serve more than 80,000 residents on behalf of the County. The funding for DHHS is derived from State and federal
reimbursement and tax levy. Grants and private funding are applied to varying degrees across divisions.

Our research is conducted based on these assumptions:

- Our research should be viewed as characterizing POC-led organizations as indigent or the County as engaging in benevolent racism—seeking to diversify its contractors as a form of charity. Instead, our report argues that POC-led organizations can add value to DHHS's service provision system and that a diversified base of suppliers, prime and sub-contractors, vendors, and consultants are essential to the DHHS' mission.
- Our work examines internal policies, procedures, systems, staffing and decision-making structures to understanding how racial inequities are manifested in DHHS workplaces, including across management actions.
- Our approach does not presume that diversity is the magic bullet, nor that more diverse DHHS staff and contractors will automatically improve outcomes for populations of color living in Milwaukee County. Instead, we assume that along with changes in representation, systems changes may be required to transform DHHS to meet its racial equity goals which are aligned with the goals of the County Executive and County Board of Milwaukee County.
- Milwaukee County does not operate in a vacuum but is reflective of positive and negative attributes of our society, including the insidious effect of racism on individuals, families, and communities.
- Milwaukee County has made a dynamic pledge to eradicate racism, citing it as a public health crisis. While we laud this action, we also recognize that substantive long-term change is often opposed by traditional power structures threatened by increases in racial equity.

It is our goal, as researchers, to provide a substantive, objective appraisal of the DHHS must do to transform the department into an environment where racial equity is valued and maintained.

Our methods of inquiry include an environmental scan, systems assessment, contract data analysis, and stakeholder interviews. Our research will briefly recount the well documented environmental factors that have historically fostered or stifled the realization of racial equity across Milwaukee County communities and Milwaukee County government.

Our research seeks to answer the following questions:

1. What is the historical landscape of the Milwaukee County Department of Health and Human Services that has promoted or impeded racial equity in its contracting system? Specifically,
    a. How have DHHS policies and processes affected racial equity in its contracting systems?
    b. How have DHHS people and practices influenced racial equity in its contracting system?
    c. Are departmental data, communications, and perspectives congruent with the perspectives of leaders of organizations contracted by DHHS and of community stakeholders?
    d. What impact has racial equity had on DHHS outcome achievements regarding service provision to Milwaukee County residents?
    e. Does a synergy of collective commitment, innovation, and knowledge which is necessary to achieve racial equity exist among DHHS staff?

2. What factors can increase the level of racial equity in DHHS contracting system, promote quality service provision, and ensure fiscal responsibility? Specifically,

    a. What mechanisms have been historically used, intentionally or unintentionally, to suppress achievement of racial equity, participation by providers of color, and utilization of culturally appropriate services?

    b. What are the specific points in the contracting process where opportunities exist to expand racial equity?

Content Analysis of Interviews:

Our interview pool consists of 37 individuals representing Milwaukee County staff, DHHS staff, and diverse providers representing businesses and nonprofits, and community stakeholders. The group of individuals being interviewed are diverse in race, gender, age, length of service at their organizations, and residency within or out of Milwaukee County. The Kairo research team values the opportunity to interview a diverse group. We conducted content analysis of the interviews to identify the main themes, to assess whether the interviews support or counter information collected from documents and contract data, and to gauge the level of congruency between departmental information and individuals navigating the system.

We have identified several core themes communicated in the interviews that confirm the absence of racial equity and more specifically the absence of inclusion in the RFP and Fee-For-Service processes.

Major Theme One: An absence of Inclusion

There was repeated concern expressed by the informants that access to knowledge about the DHHS process and procedures for grant funds was not readily available. In addition, there was an expressed concern that only a select group of applicants were "well versed in knowing how to jump through the "hoops" (policy and procedure) to receive DHHS grants. There was concern expressed that staff's efforts at community engagement and education were superficial gestures intended to fulfill federal funding requirements rather than build relationships with communities and providers of color. This maintained a disconnect between DHHS and lesser-known organizations and providers that lacked administrative capacity but possessed quality staff who provided culturally competent services.

Major Theme Two: An absence or inconsistency of Accountability

There was an expressed concern that the level of accountability for achieving tangible and effective outcomes was varied amongst staff and a devaluation of the clients (Black and Brown clients) may account for the low expectations of staff and the culture of the institution. Some comments centered on whether the focus was on inputs and outputs as opposed to outcomes and impacts that could have significant, long-term effect on addressing the social determinants of health in communities of color

Major Theme Three: The need for Fair, Objective, Consistent Processes

Some informants expressed concern about the fairness of the processes including RFP, appeal, payment, and FFS contract award. Informants questioned whether the system was infused with arbitrary and biased decisions made based on the strength of the relationships that existed between DHHS staff and providers rather than on the quality of the providers' work. Comments centered on whether staff act as gatekeepers or facilitators in how they communicate opportunities and select providers for contract awards. Informants

highlighted the need for accountability regarding the inconsistency of contract award decisions, adherence to policies, and the application of rules and requirements.

Major Theme Four: The need for Critical Thinking

Several informants expressed a desire for a real and ongoing discussion on the impact that race plays in Milwaukee County. There was expressed desire to advance the race equity discussion on the challenges and complexity involved when considering race, class, gender, and place. Comments also focused on the need for a greater understanding by staff of how they convey negative perceptions of Black and Brown providers and residents and of how their perceptions, decisions and actions serve as roadblocks for providers of color. In fact, staff's negative assessment of culturally competent approaches to service can impact the quality of services provided to residents.

Major Theme Five: Leadership

Many of the informants talked about the change in DHHS administration as having a positive effect on increasing the opportunity to engage in a "safe" discussion on racial equity and inclusion. It was shared that if change or any movement was going to occur, it was going to happen under the current leadership. At the same time there was recognition that strong leadership alone would not be sufficient to achieve racial equity and inclusion. There was acknowledgement that there needed to be buy-in and commitment from staff at all levels of the organization to achieve this goal.

Major Theme Six: Power Dynamics

Several informants were uncomfortable in speaking up consistently about the issues of racial equity and inclusion. Some informants felt that their words were not taken seriously or were often met with silence. Others expressed concerned about retaliation, not necessarily through overt actions but rather through quiet but effective modes of intimidation as well as labeling them as uncooperative, uninformed, or overly aggressive. These actions of intimidation which discounted or devalued non-traditional perspectives sent a quiet but powerful message that speaking up or out could place one's career, organization, and/or livelihood in jeopardy. As a result, complaints were muffled, appeals were not filed, opportunities were lost while resentment, frustration, and marginalization grew. There is a need for more allies to support the voice of those speaking up for more equity and inclusion, specifically Black and Brown men and women.

Systems Assessment

Our evaluation includes a critical look at the systems used by DHHS in its operations. To gain an understanding of the DHHS contracting landscape, our research team analyzed contract data for 2010 through 2019. For many years, five divisions have awarded contracts in DHHS; this does not include the recent transition of the Department on Aging into the DHHS structure. Over the last decade 2010 – 2019, DHHS awarded approximately 22,000 contracts totaling more than $1.2 billion dollars. Both the POS contracts using the RFP process and the FFS contracts using provider networks are critical mechanisms for DHHS selecting organizations to provide quality services to Milwaukee County residents. Because of the different degree to which the DHHS divisions utilize these two processes, attention to both processes can reap benefits and increase racial equity in contracting.

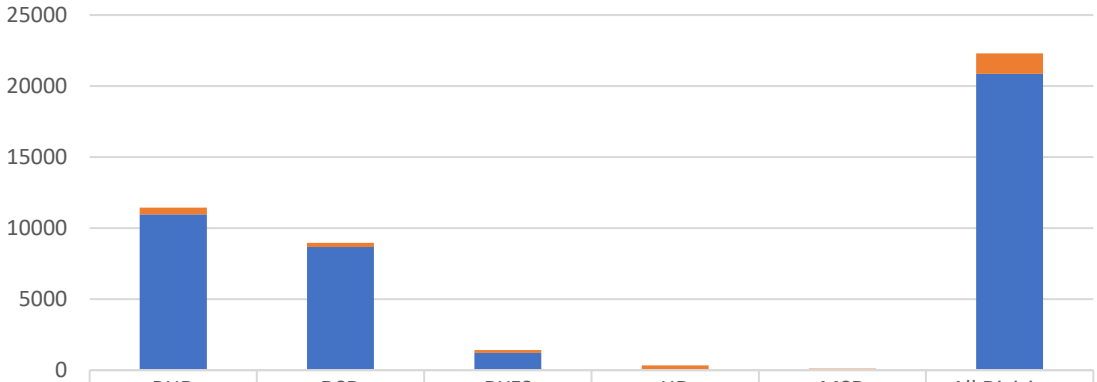
Because Professional Service (PSA) agreements comprise less than 1% of the number of contracts and contract funding from 2010 – 2019, our primary focus is on Purchase of Services (POS) and

Fee for Services (FSS) contracts awarded by the Behavioral Health (BHD), Disabilities Service Division (DSD), Division of Youth and Family Services (DYFS), Housing Division (HD), and the Management Services Division (MSD. Purchases of Services (POS) agreements are awarded through the Request for Proposal (RFP) Process which many prospective providers participate in. This is a public process that requires vendors to submit proposals, at times participate in an interview process with a review panel, and appeal the decision rendered regarding a contract award, when deemed necessary. The proposal is judged based on a set of criteria that will be discussed later in this report.

While the RFP process is a more visible one, the Fee for Service process is the mechanism by which more than 60% of DHHS contract dollars are awarded. Providers apply to be a part of vendor networks, DHHS staff select providers within these networks for contract awards. We are collecting more information about how these networks function and how contract award decisions are made.

From 2010 – 2019, more than 90% or almost 21,000 contracts awarded by DHHS have been Fee for Service. While the volume of contracts is extremely high, the funding for these contracts have totaled about 66% or $800 million of the total contract dollars of$1.2 billion awarded to providers during this period. The other third (34%) or $400 million of the contract dollars have been awarded primarily through Purchase of Service Agreements (PSA). A review of the number of contracts and the funding of those contracts by Divisions is presented in Exhibit 1 and Exhibit 2.

Exhibit 1
Number of Contracts Awarded by Division
POS and FSS (2010 - 2019)



	BHD	DSD	DYFS	HD	MSD	All Divisions
POS	480	311	195	341	108	1435
FSS	10974	8665	1222	0	0	20861

1. The number of Purchase of Service agreements contracted through the RFP process constituted only 7% or 1435 of the total contracts awarded by DHHS in the last decade. The number of Fee for Service contracts awarded through the provider networks constituted 93% or 20,861 of the total 22,296 contracts awarded by DHHS for Purchase of Service and Fee for Service contracts.

2. The Behavioral Health Division (BHD) awarded almost 11,000 (96%) of its contracts through the FFS process

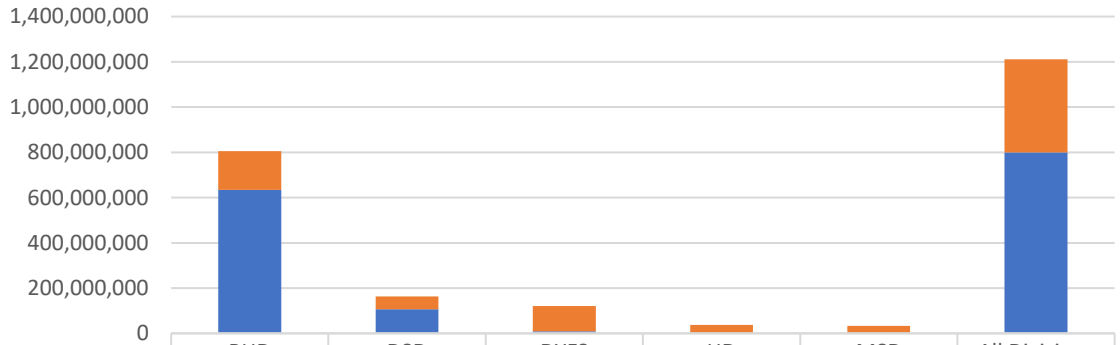
3. The Disabilities Services Division awarded a high volume of its contracts, 8,665 (97%) in the FFS process

4. The Division of Youth and Family Services awards 1,222 (84%) of its contracts through the FFS process.

5. Housing Division (HD) and the Management Services Division (MSD) utilized the RFP process to award most of their contracts, used the PSA process for some contracts but did not use the FFS method.

However, as Exhibit 2 will illustrate, the number of contracts does not reflect the funding dollars allocated through the POS and FSS processes. For example, while the number of contracts awarded through the POS process totals 7% as opposed to the 93% of contracts awarded through the FFS process, the POS contracts comprise 34% (more than $410 million) of the total contract dollars.

Exhibit 2
Contract Funding by Division by Contract Type
POS and FSS (2010 - 2019)



	BHD	DSD	DYFS	HD	MSD	All Divisions
Column1						
POS	171,267,210	57,630,205	111,672,308	37,160,726	33,783,622	411,514,071
FSS	633,855,420	105,998,564	9,553,060	0	0	799,407,044

1. The Behavioral Health Division (BHD) awarded almost 11,000 (96%) of its contracts through the FFS process totaling more than $683 million (80%) of its funding. While BHD only awarded 4% of its contracts through the RFP process, these awards constituted more than $171 million dollars (20%) of its contract funding.

2. The Disabilities Services Division awarded almost $106 million in the FFS process, the Division awarded almost $58 million (35%) of its contract funding through the RFP process.

3. While the Division of Youth and Family Services processes a high percentage or number of contracts (84%) through the FFS process, its awards more than $110 million or (92%) of its total contract funding through the RFP process.

4. The Housing Division awarded most of its contract funds totaling $37,160,726 through Purchase of Service agreements utilizing the RFP process; the Management Services Division awarded most of its contract funds totaling $33,783,622 using the RFP process. While they awarded a few Professional Service Agreements, these divisions did not utilize the Fee for Service process.

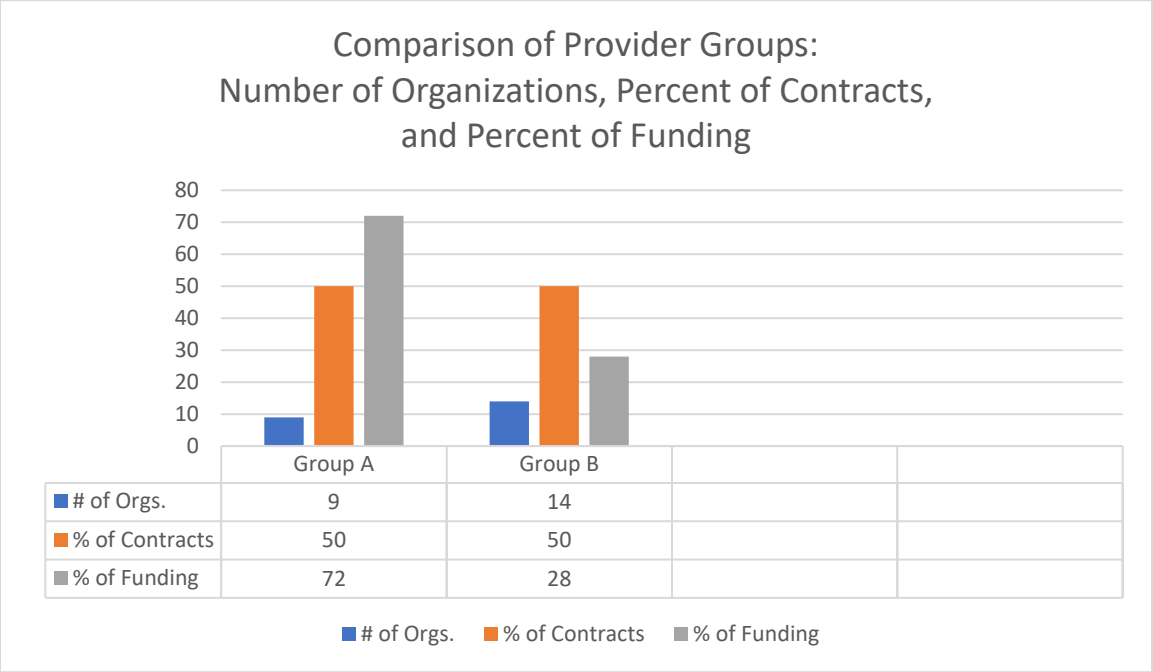
While the number of RFPs used by BHD and DSD to award contracts is significantly smaller than the other divisions, the value of their contracts constitutes more than 50% of the total funding allocated through the RFP process over the last decade. Because of the high number of contracts and/or the dollar value the Divisions award through the RFP process, all the Divisions and the organizations they fund will be impacted by changes to the process. Because of the high volume in contracts and funding awarded by BHD and DSD through the Fee for Service process, the efficiency and fairness of this process is also paramount to achieving racial equity in DHHS contracting.

Ramifications of Selection Decisions

Government financing of nonprofit organizations for service delivery is a standard practice in government procurement and contracting. Several studies explored what factors affect government's source selection, or framed, differently, what type of nonprofits are preferred by funding agencies. We are reviewing a body of literature that has examined the various organizational and environmental factors that influence nonprofits' receipt of government funding.

In our preliminary analysis of the contract data for 2010 we work to determine if there are patterns that reflect the potential for bias. One of the patterns identified is one in which there seems to be specific providers that consistently receive grant awards. In our initial review we identified two groups of providers that receive contracts from DHHS. One of the hypotheses that our research team is testing is whether some of the organizations in the provider network from which service providers are selected for Fee for Service contracts are treated as preferred providers. We seek to answer the question: Does DHHS utilize a core group of organizations, perhaps preferred organizations, that receive a significant number of contracts and funding compared to other organizations contracted by DHHS to provide services. Our initial review identified two groups. Group A consists primarily of large organizations, primarily but not exclusively white led organizations. Group B consists of most organizations that receive contract awards with DHHS.

An illustration of this idea is illustrated below by providing data from a DHHS division's funding of 23 organizations to provide services in one contract type. As the chart indicates while the two groups received the same number of contracts, Group A which consisted of fewer organizations received more than twice the amount of funding of Group B.



Admittedly, this hypothesis requires further testing and generates a series of questions, including:

1. Does DHHS maintain a group of large organizations that serve as the core of the DHHS service delivery system?
2. Does a pattern of contracting with a core group of organizations reflect preferential treatment, a biased selection process, or the ability of some organizations to successfully navigate and compete in the system more efficiently than others?
3. Is there a perception among contractors that there is an imbalance regarding the ability of contractors to successfully compete in the DHHS contracting process? If so, what do they identify as the reason for this imbalance?
4. What incentive and resources do small contractors have to meet DHHS insurance requirements or build administrative capacity if a perception exists in the provider community that DHHS favors a group of preferred providers? In addition, do the small contracts they receive cover insurance and other administrative costs?
5. How does the maintenance of a core group of providers or the perception of this impact DHHS' ability to ensure racial equity in contracting and quality service delivery?

DHHS Racial Equity Work Group and the RFP Process

The DHHS Racial Equity Work Group paid significant attention to the RFP process and identified some key areas where process change could potentially result in a fairer process. While we concur with many of the ideas suggested in the Work Group meetings, we believe that further evaluation of the RFP process is warranted, and we plan to do so in our evaluation.

We recognize that DHHS leadership is motivated to continue making systems improvements. Five areas that have been identified in the DHHS Racial Equity Workgroup and commented on by some interviewees where improvements could increase racial equity are:

1. Review Panels

Much discussion has centered on the number of panelists serving on review panels and suggestions have been made regarding increasing representation on panels from 3 to 5, to increase the panels' diversity, including race, age, gender, and expertise. From the input we have received, it appears that panels often are not diverse, and panelists are identified by a few DHHS managers and staff. We would suggest the development of a pool of potential panelists to ensure that review panels meet specific criteria including diverse representation, subject knowledge, etc. More than the creation of a list of panelists, the actual training of and utilization of diverse panelists on RFP panels resulting in fair, objective scoring of proposals is the ultimate goal.

2. Scoring Rubric

Much discussion has taken place in the Work Group regarding the scoring rubric used by DHHS in the scoring of RFPs. Several Work Group members identified the need for an increase in points for cultural diversity and a decrease in points for experience or even the elimination of points for experience.

DHHS RFP Scoring Rubric	
Criteria	**Scoring**
Administrative Ability	12
Budget Justification	13
Cultural Diversity and Cultural Competence	9
Previous Experience	18
Outcomes and Quality Assurance	13
Service Plan and Delivery	23
Staffing Plan	12
Total Score	**100**

While our research supports an increase in points regarding diversity, we would caution against decreasing points for experience. We suggest that DHHS consider dividing Cultural Diversity and Cultural Competency into two separate scoring criteria. Cultural Diversity focuses primarily on the representation of racial and cultural minorities in board and staff relative to the representation of racial and cultural minorities in the projected target population. Thus, the racial composition of an organization's board, leadership team, and front-line staff is important and reflect organizational diversity. The Cultural Competency score could focus on a provider's methods for developing and maintaining cultural competency among staff, using culturally competent approaches in service delivery and client

interactions, and an assessment of a provider's history of performance in this area. We suggest the following:

A) DHHS define this criterion so that there is a common definition and understanding of how DHHS views cultural competency and the department's expectations for providers in this area.
B) Greater weight be given to an organization's history of cultural competency as well as its existing approach and tools for ensuring cultural competency.
C) DHHS require proposers to submit their plan for ensuring cultural competency in providing services for a specific contract.

A recommendation made by Attorney Emery Harlan centered on the concept of the creation of an affirmative action czar whose focus would be on reviewing the plans providers submitted regarding the diversity of their workforce, their affirmative action efforts, and other contract related diversity issues. This position could possibly be located in Community Business Development Partners (CBDP) under the direction of Lamont Robinson, Director and staff would assess an organization's efforts and results in specific diversity and workforce areas, identify potential corrective actions, support the organization's efforts to improve and hold the organization accountable. If DHHS is interested in this concept, staff could pursue further development of the concept or Kairo could work with Attorney Harlan to identify the specifics and include greater details in our final report.

3. Experience Criteria

Based on our preliminary review, the experience criteria should be kept in the scoring rubric and not eliminated. Experience is sometimes equated with a sense of quality in service delivery and while experience and quality are not synonymous, there is value in having providers possess experience. Just as previous experience in providing cultural competency to residents is valued so is previous experience providing specific services.

While a track record of experience can be difficult for small organizations to establish, there are informal and non-traditional ways for organizations to gain experience providing services. The question for us, as researchers, is not whether experience is needed, but what type of experience equips an organization to provide specific quality services to a specific group for a specific type of service. We highly encourage DHHS to engage members of diverse communities in a conversation about what experience in service provision means in their communities and to develop a framework for scoring experience that is more culturally competent. For example, some communities of color view mutual aid, mentoring, family care, volunteerism, and other cultural modes of service as a means of gaining experience in service provision.

4. Insurance Requirements

This is an area that serves as a barrier for many small organizations. Information provided by the Milwaukee County Risk Manager in a DHHS Work Group meeting suggests that in some cases, opportunities may exist to revise the insurance requirements on some projects. We would highly recommend that Risk Management work with DHHS leadership to explore this option to identify when the opportunity might exist to lower the insurance requirements or to institute an innovative process that provides the necessary insurance to hold the County harmless without placing an overwhelming burden on small organizations that precludes from participation.

5. Administrative Capacity and the Provision of Technical Assistance

In its initial assessment DHHS found that many smaller agencies face challenges with administrative capacity. Our preliminary findings support this. Some discussion in the DHHS Work Group has centered on the issue of administrative capacity; our research would confirm that having adequate administrative capacity can be a challenge for small organizations. Work Group suggestions have centered on County staff providing some technical assistance in this area. We would argue against this. If bias and subjectivity are elements that hinder racial equity in contracting spheres, providing technical assistance to enhance an organization's administrative capacity could also be affected by bias and subjectivity. Organizations that are already firmly entrenched in the network and have established positive professional relationships with Division managers and staff could receive preferential treatment that could further enhance their ability to win contract awards.

Rather we would suggest an external organization, such as, a chamber of commerce or other appropriate entity expands its reach to provide technical support to nonprofits. Another alternative to consider would be working with different County department, such as the CBDP, to provide technical assistance to organizations connected to DHHS. CBDP has experience working with for profit businesses that could bring value to working with nonprofit organizations.

Conclusion

As previously stated, our evaluation uses a racial equity lens methodology; we do not foster the idea of achieving race neutral environment which in the past has been used as code for a discounting of the culture, values, and even existence of people of color. Rather we support actions that promote antiracist policies, practices, and decisions. In the recent publication, "How to be an antiracist," Prof. Kendi defines "An antiracist policy is any measure that produces or sustains racial equity between racial groups. By policy we mean written and unwritten laws rules, procedures, processes, regulations, and guidelines that govern people. There is no such thing as a nonracist or race-neutral policy. Every policy in every institution in every community in every nation is producing or sustaining either racial inequity or equity between racial groups." (Kendi, pg. 13-14)

Government, at most levels, have well documented racist legislation and policies that have produced or sustained racial inequity. In fact, as the history of our nation and our community have demonstrated, racism itself is institutional, structural, and systemic.

Based on our preliminary assessment, practices exist in the operation at DHHS that maintain the status quo and support a racialized system of capitalism. Without major changes in current practices and policies, it is likely that the groups that DHHS leadership states they want to involve in the contracting process will not be a part of the process. It is our goal to further identify and define the specific policies and practices, provide evidence of inequity, and recommend methods to resolve these issues to level the playing field for all providers in the DHHS contracting system. We would recommend that DHHS leadership include a goal for Managers that reflects their efforts and achievements in implementing change and increasing the department's achievement of racial equity in contracting.

Milwaukee County has embraced the GARE concept and tools for improving its contracting processes. Our

research team will utilize GARE tools in our analysis and recommendations to identify how DHHS can achieve contracting equity. This will maximize DHHS' ability to invest in the health and wellbeing of Milwaukee County residents, to provide opportunities to a diverse network of providers, and to eradicate racism as a public health issue.

Finally, the Kairo Communications' research team appreciates our positive and cooperative working relationship with DHHS staff. Our commitment is to provide a thorough, fact-based, quality report that facilitates implementation of critical actions to achieve racial equity

Next Steps:

- Present findings and final report to Chairwoman, and Board (July 2021)
- Convene Provider and Community Stakeholder meeting to present results and disseminate final report (June 2021)
- Formulate Implementation Team and timeline for implementation (August 2021)
- Quarterly report of progress of Action/Implementation Team

Recommendation

This report is informational, and no action is required.

Shakita LaGrant-McClain

Shakita LaGrant McClain, Director
Department of Health and Human Services

Attachment (1)

cc: County Executive David Crowley
Sup. Jason Haas, Chair, Finance Committee
Sup. Felesia Martin, Chair, Health Equity, Human Needs, & Strategic Planning Committee
Mary Jo Meyers, Chief of Staff, County Executive's Office
Aaron Hertzberg, DAS Director
Kelly Bablitch, Chief of Staff, Milwaukee County Board of Supervisors
Steve Cady, Research Director, Comptroller's Office
Pam Matthews, Fiscal & Management Analyst, DAS
Lottie Maxwell-Mitchell, Research & Policy Analyst, Comptroller's Office