Creating the Catalyst for Transformational Change

DHHS Department of Health & Human Services

Kairo Communications LLP
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Racial Equity Contracting Report

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EXECUTIVE SUMMARY

In May 2019, Milwaukee County declared racism a public health crisis. In 2020, Milwaukee County adopted File No. 20-174, which created Chapter 108, "Achieving Racial Equity and Health," of the Milwaukee County Code of General Ordinances. The ordinance established racial equity as a top priority of the Milwaukee County government.

In alignment with Milwaukee County officials, Department of Health and Human Services (DHHS) leadership committed to eliminate institutional racism and achieve racial equity by addressing County policies, practices, and power structures. In the fall of 2020, DHHS hired Kairo Communications LLP, in partnership with Dr. David Pate, to analyze whether racial equity existed in the department's contracting system and to recommend corrective actions, if appropriate. We implemented a multi-method approach including qualitative and quantitative research to collect data from multiple sources to identify policies, practices, and perspectives that affect racial equity. This cross-section of data allowed for the identification of patterns, root causes and added validity to our research. Our evaluation utilized critical race theory and a racial equity lens to guide our analysis of DHHS's systems, policies, and processes.

It was our goal, as researchers, to provide a substantive, objective appraisal of what DHHS must do to transform the department into an environment where racial equity is valued and maintained. Our primary research questions are identified in the Introduction of this report and focus on identifying 1) whether racist practices exist in the DHHS contracting system, 2) indicators of racial equity, 3) biases prevalent in the system, 4) factors that impact equity, and 5) strategies to eliminate racial inequities.

Our premise is that racism is perpetuated through institutional structures, polices, and processes that have operated for decades, even centuries. Some powerbrokers have intentionally maintained this inequitable system. Because racism has been a natural part of American life, other individuals have, at times, played a role in maintaining racism without understanding the ramifications of their actions. As a result, discriminatory systems are seldom fixed by the people who operate them blindly or those who benefit from their existence. For insiders to contribute effectively, they must assess their own biases and the roles they play that reinforce inequity and make adjustments to advance excellence and equity. They must be willing to acknowledge and question unequal policies and practices and subsequently institute remedies through culturally competent stewardship.

The equitable distribution of resources and opportunity is a major goal. Another primary goal is to refashion a system where providers feel valued for their contributions, are held accountable for quality service delivery, and attain outcomes that significantly impact participants and communities. In the end, DHHS must hear the voice of the consumer, the recipient of service, and encourage their contributions to systems change and plan implementation. DHHS must value the opinions of their marginalized constituents regarding service, outcomes, and impact; this must be central to an assessment of achievement of excellence and equity.

To begin this process, we examined four main areas within DHHS: infrastructure, provider organizations, procurement process, and contracting system, which the department's divisions utilize. These divisions: Behavioral Health, Disabilities Services, Youth and Family, Housing Divisions, and the County's Energy Assistance Program, all work to carry out the Department's mission of empowering safe, healthy, and meaningful lives for Milwaukee County residents. Our research did not include the addition of the Division on Aging or the Veterans Services Division.

DHHS's staff of more than 800 ensure the provision of services to more than 80,000 County residents through a system that funds organizations that have a total of more than 20,000 staff. This funding relationship with non-profit and for-profit providers is the primary mechanism for DHHS to award contracts that fall into three major categories: Professional Service Agreement (PSA), Purchase of Services (POS), and Fee for Service Agreement (FFS).

While there is some diversity in racial composition amongst DHHS staff and the provider staff, many of these staff are White; the Milwaukee County residents receiving DHHS services are predominantly Black.[1], Indigenous, People of Color (BIPOC). Thus, a racial mismatch exists between service administrators and providers and the participants they serve. This incongruency between the racial composition of DHHS and provider staff in relationship with County participants in program services reflects a systemic norm in American society regarding service delivery and the power dynamics that exist between Whites and BIPOC.

The goals of DHHS to reduce social determinants of health and achieve racial equity can be realized through a strategic expenditure of contract funds. Our contract analysis confirmed that DHHS has the financial power to be a strong economic engine, fueling County providers and communities. During 2010 – 2019, DHHS awarded $1,212,277,058 in contracts.

Between 2010-2019, across all DHHS Divisions, Fee for Service contracts comprised 9,699, or 93%, of 10,462 contracts. In contrast, the number of Purchase of Service awards constituted only 7%, or 702, of DHHS's total contracts in the last decade. Purchase Service Agreements comprised less than 1% of the contracts awarded. Over the past decade, DHHS has increased the total funding awarded but decreased the number of contract awards. In 2010, the average contract award was $82,316, while in 2019, the average contract award was $250,874, a 205% increase. At the same time, the number of contracts awarded decreased from 1,491 in 2010 to 674 in 2019, a decrease of 817 contracts, or 55%.

During 2010 – 2019, the size of DHHS contracts ranged from $90 to multi-million-dollar awards. An analysis of contract data indicates that many small contracts, under $1,000, are often awarded to individual professionals who provide specialized services and make up a minuscule amount of the total funding. Contracts valued at $10,000 or less comprise 67% of the contracts awarded by DHHS but only makeup 1% of the funding.

[1] The terms "Black" and "African American" are used interchangeably in the report.

DHHS contracts with more than 570 organizations. Given that contracting trends in DHHS have resulted in fewer but larger contracts awarded, it was essential to determine whether DHHS maintains a group of large organizations that serve as the core of its service delivery system, receiving most of the funding. Our analysis confirms that from 2010 – 2019, 30 organizations were awarded a total of $723,024,402 or 60% of the total funds awarded to all DHHS service providers. A breakdown of the core organizations based on the racial composition of the providers' leadership shows that White-led organizations received $484,182,187 or 67% of the funding allocated to core organizations and received 721, or 69%, of the contracts awarded to the core organizations. In comparison, African American organizations received $141,991,292, or 20%, and Latinx-led organizations received $96,850,923, or 13%.

Most providers expressed concerns about the Request for Proposal (RFP) process and expressed difficulty doing business with DHHS. While most White providers rated their administrative capacity as excellent, BIPOC providers rated their capacity as fair. On the other hand, BIPOC providers discussed their ability to connect with BIPOC participants because of their shared life experiences, connection to the community, and cultural knowledge, demonstrating a high level of cultural competency. In contrast, White providers indicated that cultural competency was a goal their organizations were striving to achieve.

The providers expressed repeated concern that access to knowledge about the DHHS process and procedures for grant funds was not readily available. There was an expressed concern that the level of accountability for achieving tangible and practical outcomes was varied amongst staff. In addition, there were concerns on whether the focus was on inputs and outputs instead of outcomes and impacts that could have a significant, long-term effect on addressing the social determinants of health in communities of color.

Interview comments centered on whether staff act as gatekeepers or facilitators in how they communicate opportunities and select providers for contract awards. Providers highlighted the need for accountability regarding the inconsistency of contract award decisions, adherence to policies, and the application of rules and requirements. Several DHHS staff and providers expressed a desire for a real and ongoing discussion on the impact race plays in Milwaukee County. There was a willingness to advance the race equity discussion on the challenges and complexity of race, class, gender, and place.

Our research resulted in the identification of findings in these key areas:

1. DHHS Opportunity for Significant Impact
2. Maintenance of Systems of Power Based on White Privilege
3. Disproportionality in DHHS Contracting System
4. Contracting System Issues as Barriers to BIPOC Providers
5. Lack of Commitment to Cultural Competency
6. Failure to Maximize Contracting with BIPOC Providers
7. Perpetuation of Exclusion through Segregation and Marginalization
8. Potential for a Polarized Environment regarding Issues of Racial Equity and Efficiency

The goal for our research was to conduct a critical but fair analysis of the DHHS contracting system, compare qualitative and quantitative data for congruency, value the voices of all involved in the DHHS system, and develop a quality implementation plan that would guide the work of DHHS in addressing racial equity in its contracting system. The implementation plan contains these four major categories:

1. DHHS will infuse racial equity into all aspects of the department.

2. DHHS will operate a quality, high-functioning contract system.

3. DHHS will strengthen outreach, public engagement, and access to DHHS services for communities of color and improve or change services using racial equity best practices.

4. DHHS will collaborate with communities and institutions to implement upstream solutions in contracting, address social determinants of health, and achieve positive collective impact.

To facilitate the achievement of these goals, we have identified 28 specific recommendations. These five main recommendations illustrate the broad scope of actions necessary to fundamentally change DHHS to position it as an institutional leader that effectively addresses issues of racial equity.

1. Eliminate structural barriers in DHHS by restructuring divisions, increasing diversity hiring to mitigate the historical and negative impact of segregation and other social issues.

2. Increase contract opportunities by improving the RFP and appeal process, refining the provider network and fee for service processes, reviewing the pay rate for providers' front-line staff, and creating strategies to increase opportunities in the informal contracts for BIPOC providers.

3. Support the development of innovative services and ensure quality outcomes, measurement, and accountability.

4. Increase DHHS community presence through culturally competent community engagement and outreach activities.

5. Implement a provider development program to create greater organizational capacity.

Given the commitment of DHHS leadership, we are confident the plan will be used as a catalyst to create transformational – rather than transactional – change. This plan is required to fulfill the commitment reflected in Milwaukee County's declaration of racism as a public health issue and the vision of DHHS, of working collaboratively with diverse stakeholders, together, building healthy communities.

INTRODUCTION

There are many ways in which to describe the social determinants of health in academic, scholarly terms with the use of quality statistics and data. There are also ways to describe social determinants in perhaps a more realistic way that illustrates in simple terms the devastating consequences of racial inequities on Black, Indigenous, People of Color (BIPOC). We have chosen the latter.

For far too long, the playing field has not been level. Discrimination through socially acceptable actions fueled unfair housing and labor practices. Racism, legalized through congressional actions and court decisions, formed the foundation for poor quality education and healthcare. Inequality exposed racial groups to the worse conditions, the poorest of services, the fewest of resources. And then, as if that were not enough, confined them to the poorest land with no transportation and constructed barriers that blocked jobs, investments, and opportunities from coming in. Those in power or who looked like those in power decided, "well, that's how those people want to live," "they have no goals for themselves or their children," "they did this to themselves."

This is what racial inequity looks like.

When finally, it became apparent that ‘those people’ wanted better lives, improved living conditions, a higher quality of life for themselves, their families, and their neighbors, the good folks came rushing in. They brought their good intentions and prepared to rescue those unfortunate people. They did their best with little knowledge about the people they were trying to help. To fill their gap of ignorance, they brought in negative perceptions and stereotypical views and provided care, but they contributed few life-changing, community-building resources. Little changed; few outcomes were produced. And when' those people' asked for the chance to help themselves, to work to rebuild their own communities based on their life experiences, shared knowledge, and innate compassion for each other, that was deemed unacceptable. What could they contribute of value to this predicament? After all, they were a part of the problem.

This is what racial inequity feels like.

This creative narrative can be transitioned into a more formal introduction to the issue. The narrative communicates how racism is embedded in American institutions, power structures, and systems that generate, sustain, and reinforce racial inequity. Inequity manifested in maintaining a dominant White culture that centers power primarily in White values and norms. This normalized social system, often invisible to White people, is built on inherently prejudicial and discriminatory practices, privileging Whites through modes of implicit and explicit bias that influence institutional policies, practices, and everyday operations.

Often ingrained in government contracting policies, processes, and practices, racial inequity can have a devastating effect on residents, providers, staff, and neighborhoods. Entrenched into the fabric of America, racial inequity goes undetected, operating as a natural, normal part of the system. Individual actors, influenced by a culture grounded in inequity, become gatekeepers and purveyors of the status quo and mainstream norms. Policies serve as barriers that prevent the implementation of a contracting system that facilitates the more equitable distribution of funds. Actions to eradicate racism must be purposeful, intentional, and sustainable.

The goal of achieving racial equity is to transform how institutions and systems negatively impact BIPOC. Systemic inequities in procurement practices occur when contracts and purchasing decisions fail to reflect the racial demographics of the community or the participants served, or promote the use of culturally responsive service approaches, or require quality outcomes. Thus, it is imperative to utilize a racial equity lens as a part of research and evaluation. Challenging the long-held principles undergirding a less inclusive procurement process requires heightened esteem for the values, traditions, and practices of diverse communities. The purpose of this study – the evaluation of the Milwaukee County Department of Health and Human Services contracting system from a racial equity perspective- is a critical step in creating more inclusive, equitable practices and aligns with Milwaukee County leadership declaration in May 2019 of racism as a public health crisis.

In 2020, Milwaukee County made a commitment to address the organizational policies, practices, and power structures that maintain White privilege and block opportunities for Black, Indigenous, and other people of color (BIPOC). With the subsequent adoption of the ordinance, Milwaukee County established racial equity as a top priority. DHHS leadership is aligned with the commitment of Milwaukee County leaders to eliminate institutional racism.

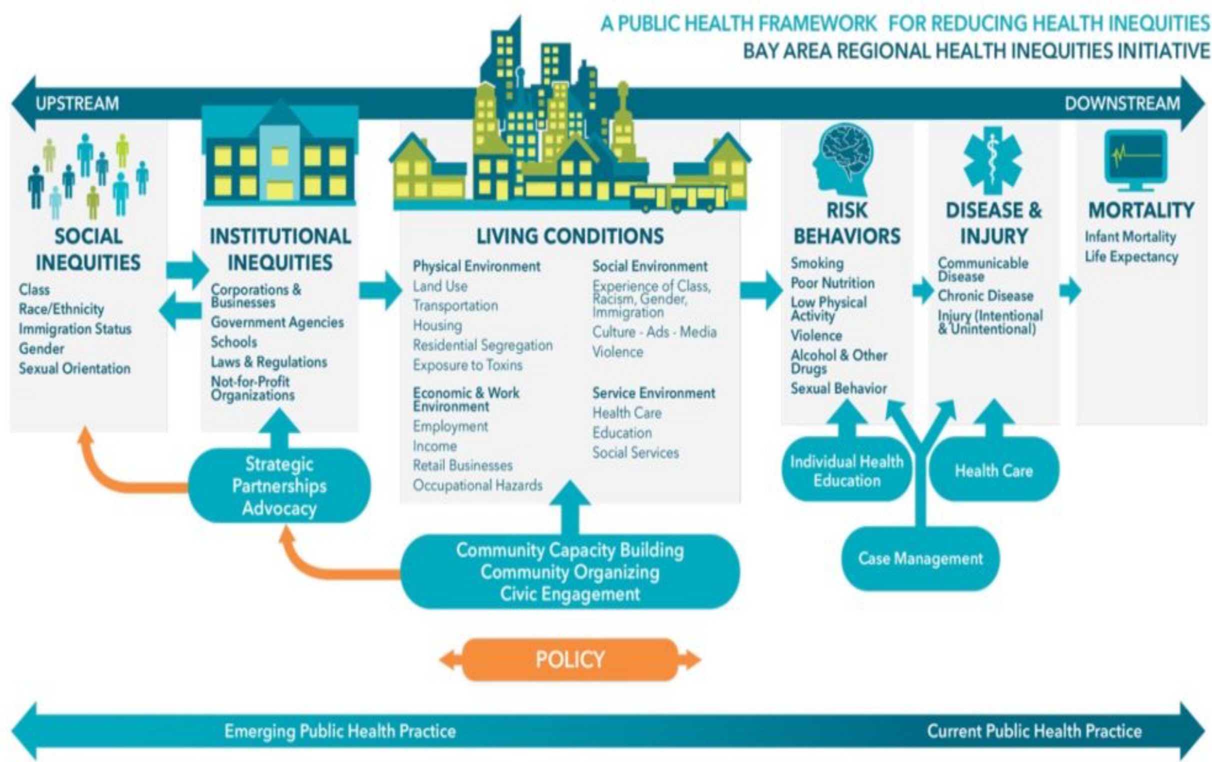
The declaration and subsequent actions are the results of Milwaukee County's history of racial conflict and discriminatory practices. Historian William Trotter, Jr found that racism in Milwaukee County was fueled by the perception held by mainstream society that people of color were an economic, political, and social threat. Based on the fear of racial integration and competition, Milwaukee powerbrokers reacted as most did in urban communities across the nation. In contemporary times, structural barriers established generations ago continue to sustain discriminatory processes, accumulated disadvantages, and practices and policies that perpetuate racially disproportionate access to resources.

Addressing Social Determinants of Health and Racial Inequity

DHHS prioritized the need to reduce racial inequity, improve the social determinants of health, and address environmental conditions in which people are "born, live, learn, work, play, pray, and age". These priorities are interconnected and affect DHHS goal of achieving quality public health outcomes. Similarly, the conceptual framework developed by the Bay Area Regional Health Inequities Initiative (BARHII) connects social inequality and health. DHHS staff utilizes the

BARHII framework which illustrates the connection between downstream factors, upstream factors, and institutional inequity and presents strategies government entities can implement to address issues. The focus of the BARHII framework parallels the Milwaukee County strategic priorities and reflects key elements of the DHHS vision, mission, and values.

Chart 1: BARHII Public Health Framework



The BARHII framework encompasses the SDoH concepts of education, economic stability, neighborhood and built environment, health and health care, social and community context, and social norms and attitudes. To mitigate the effects of SDoH, DHHS must provide services to community residents, improve the living conditions in BIPOC neighborhoods, address social and institutional inequities, and work in strategic partnerships with businesses, non-profit, educational, and other government entities. While we laud DHHS for its commitment to change, we recognize that substantive change is often opposed by traditional power structures threatened by increases in racial equity. Thus, DHHS will be challenged to find common ground to build strong partnerships with entities across the community spectrum to eradicate racial inequity and address disparities in the public health of the county's BIPOC residents.

Operational Framework

Our work examines internal policies, procedures, systems, staffing, and decision-making structures to understand how racial inequities are manifested in DHHS. We interviewed DHHS staff and providers to understand their perspectives and gauge how their views align with the work needed to achieve racial equity. Missing from this report is the consumer's voice; we

advocate for the inclusion of voices of participants during the execution of the Implementation Plan. Our approach does not presume that increased representation by BIPOC in organizations is the magic bullet or that more diverse DHHS staff and contractors will automatically improve outcomes for populations of color living in Milwaukee County. Realistically, systems changes are needed to transform DHHS to meet its racial equity goals.

Our report asserts that POC-led organizations can add value to DHHS's service provision system and that a diversified base of providers is essential to the DHHS's mission. Our report speaks in clear, unapologetic language to discuss issues of race, racism, and equity. Our intent is not to offend, but to enlighten, to avoid sending vague, ambiguous communications. The higher responsibility is to underscore the need for commitment, action, and understanding to eradicate inequity that has been maintained for far too long. So, we use a racial equity lens to take a systemic look at the DHHS contracting system. This lens promotes separating symptoms from causes, assessing root causes using a structural viewpoint, gathering data, and uncovering patterns of inequity. This lens supports the analysis of problems, identifying solutions, and focusing on outcomes and measurements of progress. The lens requires a direct conversation about race and racism to build a foundation for change. As Kendi (2019) states, "The only way to undo racism is to consistently identify and describe it – and then dismantle it."

At the same time, we understand that discussions about racial equity can foster resentment, a sense by some that efficiency will be sacrificed to achieve equity. If this potential conflict is left to fester and not addressed, efforts to increase equity become viewed as undermining efforts to ensure efficiency. Staff and providers become polarized, choosing between equity or efficiency. As advanced by Barry Johnson of Polarity Partnerships, the concept of polarity focuses on the ability of organizations with conflicting goals to achieve both - efficiency and equity - rather than having to choose between either one or the other. An alternate perspective advanced by Arthur Okun, an economist who promoted the equality–efficiency tradeoff concept, argued that equity is not possible when efficiency is the goal. We assert that equity, efficiency, accountability, outcomes, and transparency are all key elements of an excellent contracting system.

While this research examines issues regarding racial equity in contracting, this report is not a disparity study evaluating the degree of disparity in government contracting with minority-owned businesses (MBEs) and is not designed to identify parameters for the creation of a race-based or a race-neutral program. This study evaluates racial equity in government procurement systems that contract primarily with non-profit organizations to deliver social services. The resources provided to MBES could benefit BIPOC non-profits.

Theoretical Framework

Critical Race Theory (CRT) forms the basis of our theoretical framework. CRT emphasizes how race and racism are ingrained into American society through historical policies, practices, and laws that continue to subordinate BIPOC while maintaining White power and entitlement. American systems of governance, law and culture are inherently and historically racially

prejudiced, privileging, upholding the economic, political, and social interests and power of elite Whites.

Critical Race Theory (CRT) deconstructs the power dynamics that position race and racism in institutional structures. CRT provides a counter-narrative to and reframing of stereotypical views designed to marginalize and degrade BIPOC and keep them in their place. It promotes approaches that can alter these power dynamics and move toward equity and representation for marginalized populations. Through a critical race methodology, CRT theorists such as Derrick Bell, Kimberlé Crenshaw, and Richard Delgado have incorporated narratives in their research to validate and document the oppression experienced by BIPOC. White scholars discounted these stories, preferring to produce racial progress narratives, minimizing racism, and diverting attention from Whites' power and privilege. Some White scholars and social workers discounted the provision of social services by BIPOCs who used their understanding of culture, knowledge of ethnic solutions, and compassion for their people. Instead, the White-dominant ideology served as a norming mechanism for social control to regulate BIPOCs to be recipients of services, not the purveyors of solutions and care. It is as Ta-Nehisi Coates explained, for BIPOC in the United States, "The entire narrative of this country argues against the truth of who you are."

Main Research Questions:

We conducted our evaluation based on these research questions.

1. Do structural racial inequities exist in the Milwaukee County Department Health and Human Services contracting system?
2. If racial inequity exists, what key indicators provide evidence of the sustainability and the impact of racial inequity?
3. If racial inequity exists, what role does implicit and explicit bias play in the maintenance and perpetuation of these inequities in the DHHS contracting system?
4. What elements within the DHHS system facilitate or hinder the achievement of racial equity?
5. If racial inequity exists, what specific strategies can DHHS implement to achieve racial equity?

Multi-Methods Research Approach:

We implemented a multi-method approach to gather qualitative and quantitative data to test our research questions and challenge hypotheses developed during data collection. Our methodology included:

1. Historical research regarding the social and economic issues faced by Milwaukee County residents of color.
2. Analysis of DHHS policies, procedures, and reports to examine the DHHS infrastructure, contracting system, and contract management process.
3. Assessment of the Bonfire technology system.
4. Observations of meetings of the DHHS Racial Equity in Contracting Work Group.

5. Conducting interviews with 37 DHHS staff, leaders of organizations, community stakeholders, and advocates.
6. Analysis of contract data for the years of 2010 – 2019.

We used this multi-method approach to collect a baseline of information, obtain information from several different perspectives, identify patterns and root causes, and analyze whether data collected using one method confirmed data collected from other methods. Data incongruency fueled additional research and analysis.

Our interview pool consisted of 37 individuals representing Milwaukee County staff, DHHS staff, and diverse providers representing businesses and non-profits, and community stakeholders. The interview participants were diverse in race, gender, age, length of service at their organizations, and residency within or out of Milwaukee County. We used the interviews to incorporate short narratives from DHHS staff and providers. During the interviews, providers were asked to give ratings and comments about their organizations, the DHHS contracting system, and the department's commitment to racial equity. We present the ratings in an aggregated form.

We used quotes primarily by African American scholars and advocates to enrich our research from a cultural perspective. We present counter-frames to provide a perspective not always incorporated in mainstream research and to elevate the voices of people of color, which are sometimes devalued or ignored. The use of the Critical Race Theory of narratives and counter framing elements supports applying a racial equity lens to analyze systemic issues.

We conducted a content analysis of the interviews to identify the main themes, assess whether the qualitative data collected from the interviews support or counter information collected from documents and contract data, and gauge the congruency between departmental information and individuals navigating the system. We analyzed contract data and constructed tables and figures from the data provided by DHHS. We used the Government Alliance on Race and Equity (GARE) tools and resources, such as *Racial Equity Toolkit: An Opportunity to Operationalize Equity and Racial Equity Action Plans: A How-to Manual.* In the GARE learning community, we learned from the experiences documented in reports from other jurisdictions working to eradicate racial inequity in their communities. We used GARE's *Six-Part Strategic Approach to Institutional Change* to provide a solid foundation for DHHS to implement an action plan for transformative change that impacts county government, the department, providers, and most importantly, Milwaukee County residents.

DHHS INFRASTRUCTURE

The Department of Health and Human Services (DHHS) is a Milwaukee County department charged with providing comprehensive social services. DHHS is a complex system with an infrastructure that includes governance, leadership, financial, organizational structure, staff, and data management systems.

Governance

The Milwaukee County Department of Health and Human Services answers to the Milwaukee County Board of Supervisors as both a policy and budgetary body for all activities in the Disabilities Services, Youth & Family Services, and Housing Divisions. The DHHS Behavioral Health Division reports to the Milwaukee County Mental Health Board (MCMHB). Under the 2013 Wisconsin Act 203, the MCMHB was constituted as a state entity. MCMHB transitioned to a county entity in 2015 with its duties outlined in Wisconsin State Statute 51.42.

Wisconsin State Statute 51.41(10) indicates the MCMHB approves contracts for the BHD and Milwaukee County General Ordinance. Chapter 56 and Chapter 32 require approval from the Milwaukee County Board of Supervisors for professional service contracts and nonprofessional service contracts.

In 2021, the Mental Health Board transitioned to new leadership with BIPOC in crucial leadership roles. It is unique that its leaders and members can be staff of organizations that compete for funding and, as members of the MHB, approve BHD contracts. The BHD Administrator reports to them in some capacity. This power dynamic can positively affect BHD in that practitioners who understand social services are in leadership roles on the MHB. It can also create conflicts of interest.

The Combined Community Services Board holds an advisory role over the Disabilities Services Division. The Aging and Disability Resources Center (ADRC) Governing Board of Milwaukee County advises regarding policy and budget for the DHHS Disabilities Services and the Division on Aging, Aging and Disabilities Resources Center. These Boards also have community advocates who serve as members of the Boards.

The challenge for DHHS leadership is to interact effectively with this diverse array of governance and advisory personnel.

Leadership

The Department of Health and Human Services is led by Director Shakita LaGrant-McClain and Deputy Director David Muhammad, leaders of color, who have committed to racial equity and have initiated a comprehensive racial equity plan. In addition to these leaders, the department has a diverse executive team comprised of division administrators and other key staff who lead the department's efforts to carry out its mission of empowering safe, healthy, and meaningful lives for Milwaukee County residents. Over the last two years, DHHS has implemented several initiatives, including *No Wrong Door* and *Future State* strategies.

The *No Wrong Door* approach is focused on DHHS realizing its vision of "Together, creating healthy communities" and improve health outcomes for Milwaukee County residents by focusing on achieving racial equity to become the healthiest county in Wisconsin. No Wrong Door is an initiative that seeks to center community members who access resources, services, and programs through DHHS and its contracted providers by streamlining the processes people must go through to access care, reducing access points that are harmful, and strengthening partnerships.

As part of the Future State initiative, DHHS will improve Milwaukee County's health outcomes by orchestrating services and care for residents while also working with system partners to address inequities and invest in prevention. DHHS will need to pursue two unique strategies to do so, both of which take advantage of the County government's unique position in the human service ecosystem, as illustrated in the chart below.

Chart 2- DHHS Innovative Strategies

Strategy #1: No Wrong Door/ Integrated Services & Care	**Strategy #2**: Population Health/ System Change
• Focus on families, individuals, and support persons • Orchestrate human care across the age continuum • Get to "yes" on addressing needs, no matter where a participant enters • Address root causes of needs; partner with agencies that address social determinants • Address racial equity within policies and practices, including within contract networks	• Focus on collective health • Lead and catalyze human services systems to address structural racism • Re-direct more DHHS resources to prevention • Influence funders in the allocation of resources • Amplify community voices in DHHS and broader community discussions

In response to the actions taken by DHHS leadership, an African American DDHS staffer said:

> *There is a great effort around our leadership right now to correct wrongs in various initiatives such as NO WRONG DOOR or ONE DOOR INITIATIVES or future state initiatives . . . lots of positive energy around we want to do better and lots of effort at peeling back the layers. For example, the declaration of RACISM IS A PUBLIC HEALTH ISSUE… the momentum is going in the right direction …this contracting process is jacked up, to be honest.*

Another DHHS staffer agreed, saying:

Without hesitation, I would rate the department's leadership and their commitment to racial equity in contracting of services as excellent because---my perception now is that I feel and see positive movement. It is never that it was not happening, but now it is more intentional now, and I see examples of decisions that support it; it is such a desire to give access and opportunity in contracting.

Financials

DHHS Finance staff provided information regarding DHHS revenue, which can be divided into three separate categories: (1) local property tax levy, (2) state & federal grants, (3) and direct patient revenue (primarily Medicaid). The contract type (fee-for-service or purchase-of-service) can be more advantageous depending on the type of funding that is supporting the contract. For example, grant-funded programs are often more compatible with purchase-of-service agreements to ensure that the department does not overspend the grant award. Medicaid-funded programs are more compatible with fee-for-service agreements because there is not an upper limit to how much DHHS can bill Medicaid for in aggregate. This enables DHHS to expand programs like Comprehensive Community Services (CCS) without needing to frequently amend purchase-of-service contract amounts as provider agencies enroll new clients.

From 2010 – 2019, DHHS's budget included expenditures for contracts that totaled more than $1.2 billion. In 2020, the Milwaukee County Department of Health and Human Services had an annual budget of approximately $330 million. As Chart 3 illustrates, DHHS has sufficient funds to support a robust contracting system.

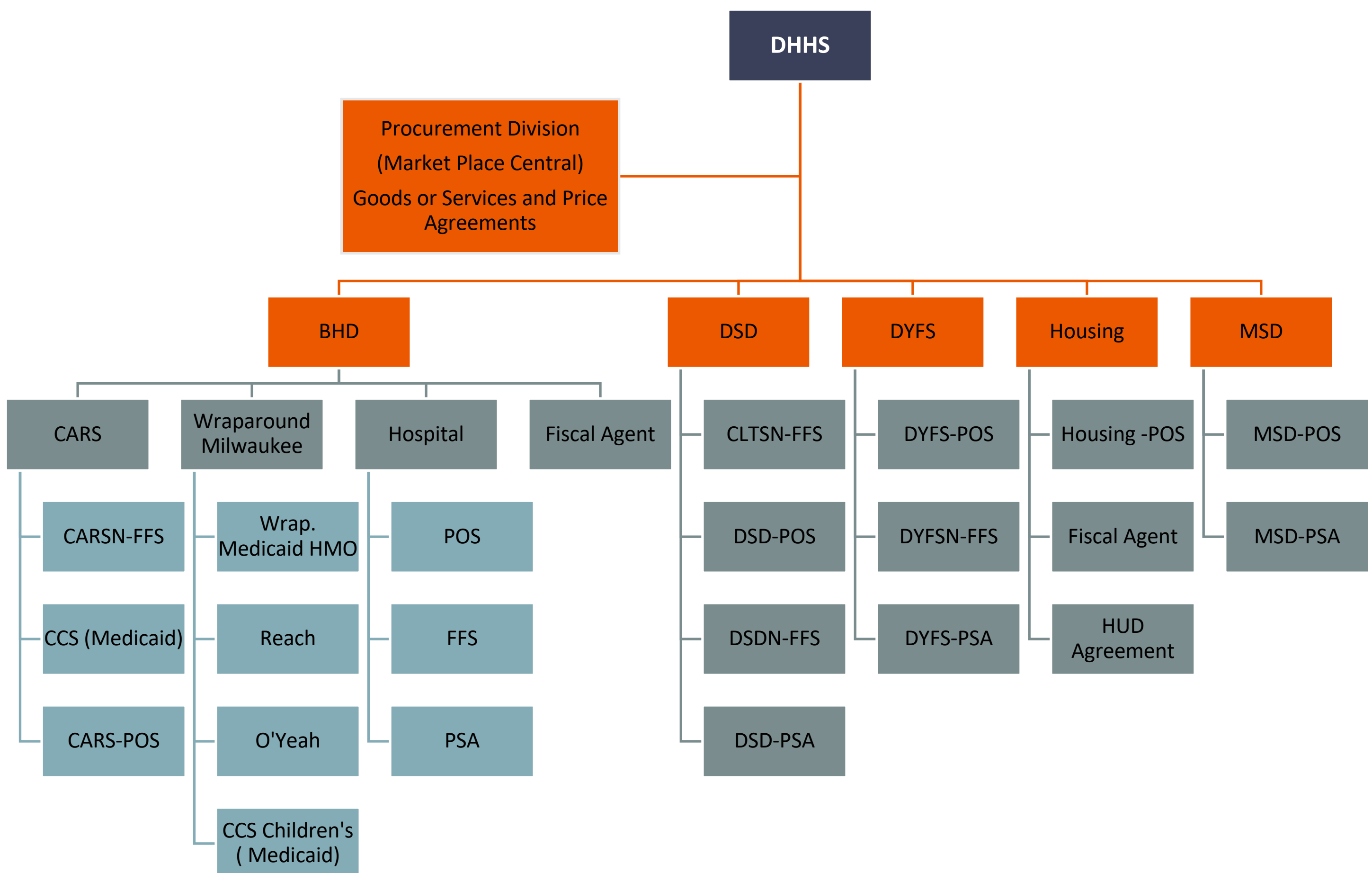
Chart 3: Expenditures of DHHS Divisions	
2020 Funding	**Expenditures**
Management Division (MD)	3,9 27,889
Disabilities Services Division (DSD)	26,695,577
Housing Division (HD)	30,015,595
Division of Youth & Family Services (DYFS)	62,399,317
Behavioral Health Division (BHD)	218,013,732
Total	**341,052,110**

This large-scale budget allows DHHS to be an economic engine in southeastern Wisconsin. How dollars are spent impact the viability of specific neighborhoods and communities. Usually, DHHS's expenditures to procure services do not go directly to residents, but instead, they go to the partner organizations selected to provide services to residents. Thus, DHHS has an opportunity to financially impact communities of color that are often distressed due to historically racist investment practices. Currently, DHHS is not fully maximizing its ability to invest in BIPOC communities. Beyond paying for contracted services for participants, there are opportunities to strengthen BIPOC providers, invest in BIPOC neighborhoods, and support the creation of resources that address and resolve structural issues that perpetuate social determinants of health.

Organizational Structure of DHHS Divisions

Much of the work to fulfill the department's mission and partner with community organizations is done through divisions for whom DHHS is the parent agency. The Behavioral Health Division provides care and treatment for persons with disorders related to alcohol and substance abuse and adults, children, and adolescents with developmental, emotional, and mental health challenges. The Division of Youth & Family Services helps youth involved in the justice system, and community safety, by providing a broad spectrum of programs and services for youth before, during, and after involvement in the justice system. The Disabilities Services Division provides services to ensure the safety and meet the needs of children and adults with disabilities.

Chart 4: DHHS Organizational Chart (Contract Types and Networks)



BHD - Behavioral Health Division, CARS - Community Access to Recovery Services, CARSN-FFS – CARS Fee-for-Services Network, CCS – Comprehensive Community Services (Medicaid)

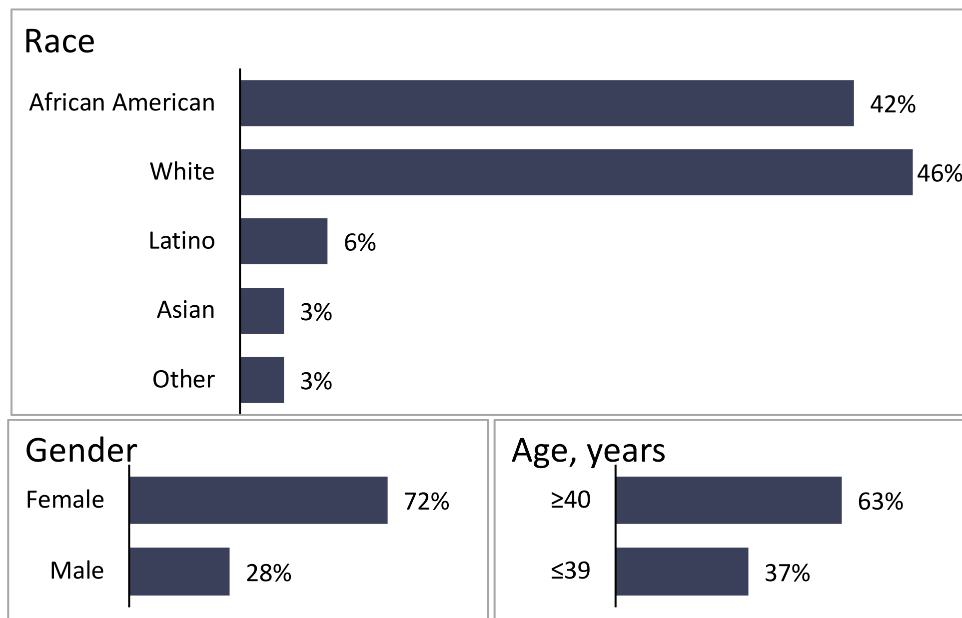
DSD - Disabilities Services Division, DSDN -DSD FFS Network, DYFS- Division of Youth and Family Services, DYFSN – DYFS FFS Network, Housing - Housing Division, MSD - Management Services Division

POS - Purchase of Service, FFS - Fee for Service Agreement, PSA - Professional Service Agreement

CLTSN- Children's Long-term Support Network (Medicaid)

DHHS Staff
The current composition of DHHS staff provided in the chart below reflects a change in demographics that has evolved over the last few years. The influx of more diversity into DHHS leadership, supervisory, and front-line staff have transitioned the staff from a predominantly White, older, female staff to a more racially diverse staff.

Figure 1: DHHS Staff Race, Age, and Gender Profile



While no staff expressed overt opposition to departmental efforts to achieve racial equity, staff views about how to achieve this may vary. Some staff advocate for innovative changes to embrace diverse providers with strong ties to African American and Latinx communities. Other staff support their current, long-term relationships cultivated with organizations considered to be top-tier and middle-tier providers. Without a more cohesive strategy, these different perspectives and approaches could create tension, maintain inconsistencies, foster distrust between staff and providers, and create an "us versus them" environment.

These different perspectives are not surprising. For decades, government and society operated through a White-centered lens where assumptions were made, sometimes based on a White-savior mentality, sometimes based on negative stereotypical views of BIPOCs, and sometimes based on a deficit model regarding BIPOC neighborhoods, assets, and cultures. The racial equity lens used increasingly by government leaders and staff is based on the belief that a racially equitable society is one where a person's race does not predict or determine how resources, opportunities, or burdens are distributed. Thus, this perspective is shaping how leaders address challenges in social service provision. The County's pronouncement of racism as a public health crisis and DHHS's plan to address racial equity in contracting and other facets of its operation is grounded in utilizing a racial equity lens to address social determinants of

health. How DHHS operates its contracting system is a key component of this agenda. Its staff are critical players in achieving this goal.

Thus, it is important to recognize staff efforts to implement innovative changes that address racial inequity. Key DYFS staff advocated for culturally competent services resulting in the Credible Messenger Program, which funds African American providers to work in the African American community. The staff of the providers resemble the youth in the program, have similar life experiences, and a great capacity to develop strong relationships with the youth. This is an example of how the assets of DHHS staff, BIPOC organizations, and community youth are valued and effectively maximized. These types of innovations counter the tendency for government entities to prescribe interventions and services based on White cultural norms. The Credible Messenger Program reflects the flexibility, creativity, and quality in service delivery available when diverse cultural approaches are respected, endorsed, and funded.

The demographic change can impact the power dynamics between government and residents, especially when most participants are African American, as verified in Chart 5. Unlisted groups had less than 1% participants.

Chart 5: Racial Breakdown for Participants			
Division	**African American**	**White**	**Latinx**
DYFS 2018	77%	13%	9%
DSD 2018	68%	28%	0%
Housing 2019	69%	30%	0%
BHD 2018 (ex. Wrap)	49%	33%	7%
Wraparound 2018	64%	14%	14%

This data is informative when one considers that Milwaukee County's population comprises 27% African American, 51% White, 16% Latinx, 5% Asian American and Pacific Islander, and 1% Native American. The disproportionate representation of African Americans in the DHHS social service system is indicative of the long-term effects of racism.

<u>Data Management Systems</u>

While DHHS relies heavily on its management databases to conduct business, several inefficiencies exist in its system. In our efforts to conduct an evaluation, we found issues in the information regarding data for contract award by divisions by year and data collection regarding diversity in provider organizations. Databases that contain contract information need to be reviewed, updated, and cleaned. For example, an organization that does significant business with DHHS is listed Alternative Psychological Consulting regarding many of its DHHS contracts but is also listed as APC for other contracts. These results would be counted separately for contracts, services, and funding as if they were two separate companies if one did not know they were the same. Little effort has been made to condense organizations that have merged, such as Phoenix Care Systems and Bell Therapy, or organizations that are interconnected, such as Milwaukee Center for Independence and subsidiary Whole Health

Clinical Group. While these issues can negatively impact accurate data analysis, they signal a larger issue, a lack of consistency within and across divisions. Not only can this negatively impact the department's efforts to accurately gauge its progress in achieving racial equity, but it can hamper the efficient operation of the DHHS contracting system and the achievement of critical organizational, participant, and community goals. During our evaluation, we found that the issue of inconsistency is evident in other aspects of DHHS operations and fostered the operation of divisions as silos.

To address one of our questions about the data, a department staff responded:

> *There are many different client and case management databases in use across our department. Unfortunately, in some cases, we currently have better demographic information on our community provider agencies and their staff than we do on DHHS clients. Client intake and assessment forms vary in the racial and ethnic demographics that are collected. Within some divisions, information on race, ethnicity, gender, etc., must be submitted in format and content as required by State funders. In some divisions, there is limited information of this type currently being collected. I have recently reviewed intake and assessment forms from one of our divisions and founded that even within a division, the questions and information being gathered on our clients between programs and among the forms varies greatly.*

Unresolved, these issues weaken the department's ability to achieve racial equity. Fortunately, the current DHHS leadership has demonstrated a commitment to excellence and equity, which has generated confidence among some department staff and provider organizations. This will support their efforts to achieve transformational change.

PROVIDER ORGANIZATIONS

Over the last several years, DHHS has gradually transitioned from being a direct provider of social services to County residents to become a purchaser of services that relies on a network of provider organizations for its service delivery. Expenditures for outside contracts make up more than 50 percent of the DHHS and BHD budgets. These contracts are awarded to various provider organizations, such as, non-profit organizations, for-profit businesses, government entities, educational institutions, and healthcare providers, including hospitals and clinics.

Many of these organizations are governed and led by White Board members and executive staff whose decisions impact their ability to achieve racial equity and to deliver quality, culturally relevant services to BIPOC participants. Leadership can demonstrate their commitment to racial equity in their decisions that affect 1) staff diversity, 2) location of facilities, 3) quality of service, 4) staff's ability to connect with participants, 5) cultural competency, and 6) administrative capacity. In our analysis, we sought to understand these critical facets of organizational assessment and decision-making and to identify whether leadership's perspectives regarding these issues are reflected in their efforts to achieve racial equity and serve BIPOC participants.

In 2019, DHHS worked with approximately 570 organizations that range from individuals, such as the 56 volunteer guardian providers whose contracts totaled less than $22,000 to 45 organizations that each received contracts for more than $1 million. Compiled from data provided by 166 organizations that complied with a DHHS request for information, Figure 2 and Figure 3 show the racial composition of some non-profit and for-profit organizations that receive contracts from DHHS. While providers are required to fulfill most DHHS information and reporting requirements, many failed to submit requested data regarding the diversity of their leadership and staff. The 166 organizations that complied with this request for demographic data represent 29% of the 570 organizations contracted by DHHS. In most cases, providers adhere to DHHS requests for information and comply with DHHS requirements. Lack of compliance with a request for diversity information could be interpreted as the hesitancy of providers who were not sufficiently diverse to provide information or the failure of DHHS staff to make this request a requirement or priority. While the reasoning is not known, it does suggest that DHHS leadership must clearly establish expectations regarding the actions providers must take to demonstrate that they are committed to racial equity in their organizations.

Figure 2: Count of Non-Profit and For-Profit Boards of Directors, Owners, Executive Team, by Race/Ethnicity

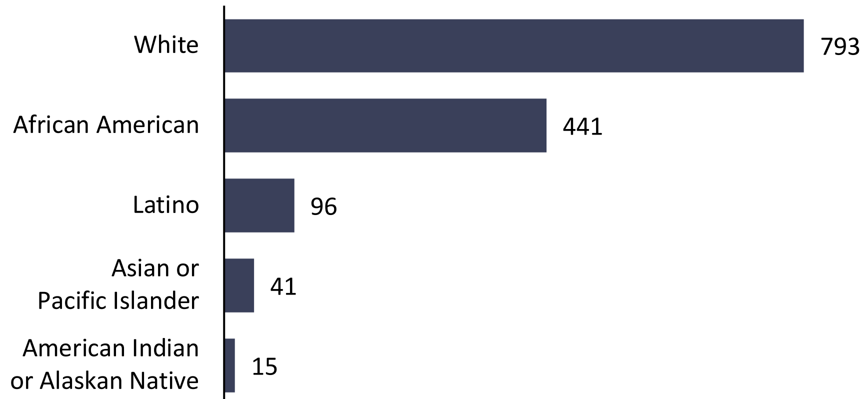
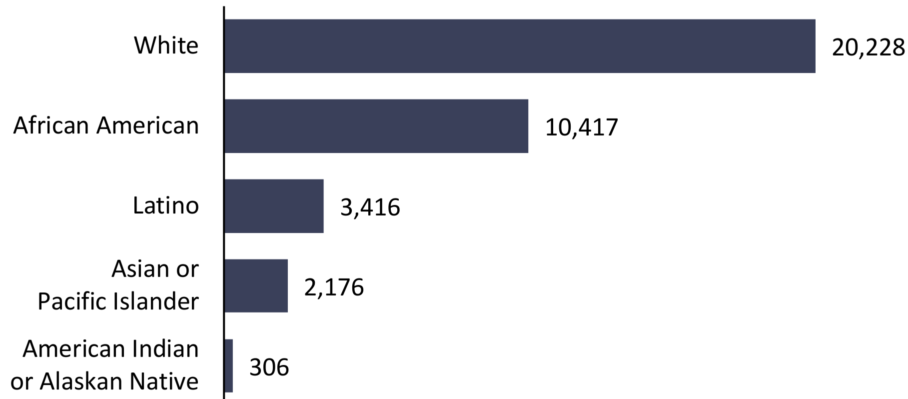


Figure 3: Count of Non-Profit and For-Profit Employees by Race/Ethnicity



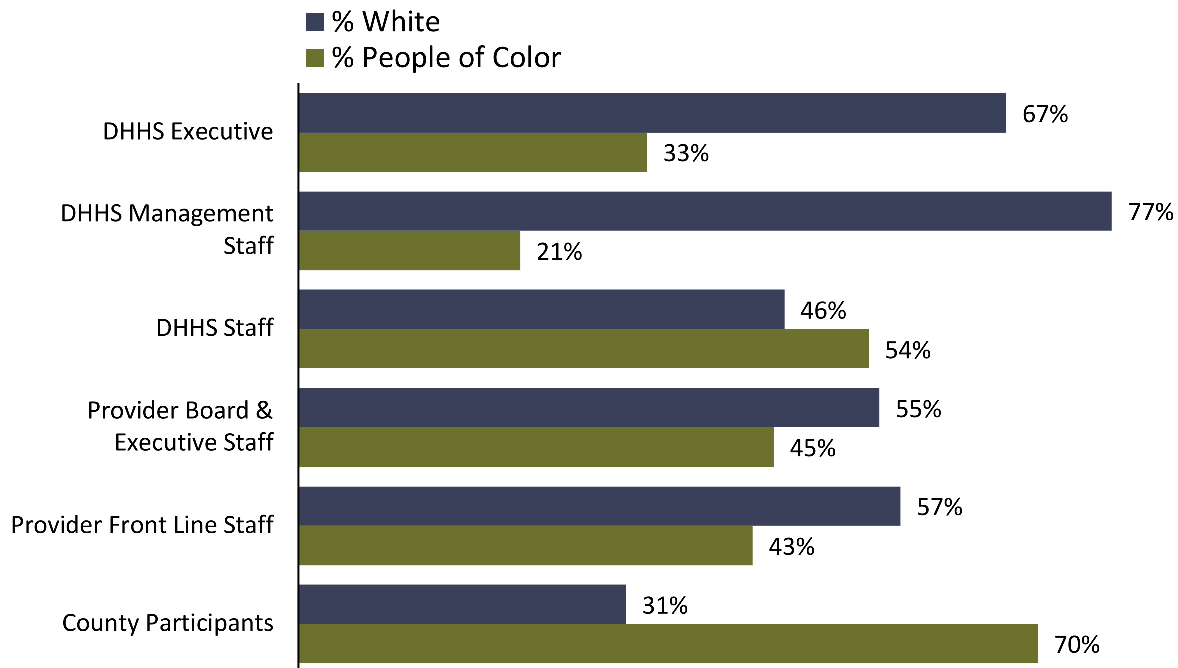
DHHS management is implementing measures that require providers to submit information regarding organizational diversity. In interviews, several individuals indicated compliance and accountability were critical. For example, one recommendation centered on the concept of the creation of an affirmative-action czar who would review plans providers submitted regarding the diversity of their workforce, their affirmative-action efforts, and other contract-related diversity issues. This position could possibly be in Community Business Development Partners (CBDP) under the direction of Lamont Robinson, Director; 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.

In interviews, most White non-profit leaders indicated that they valued diversity and could do better, and it was a goal of theirs to increase the organization's diversity. However, their organizations did not have great racial diversity at the board or executive level. Some leaders indicated that their staff participated in cultural competency training. However, many have not

met the challenge to significantly diversify their organizations at the governance and executive levels.

DHHS's staff of more than 800 ensure the provision of services to more than 80,000 county residents through a system that funds organizations that employ a total of more than 20,000 staff who work on behalf of DHHS to serve County residents. Figure 4 compares the racial composition of DHHS, providers, and participants.

Figure 4: Percent of DHHS Staff, Providers, and Participants by White/Person of Color Identification



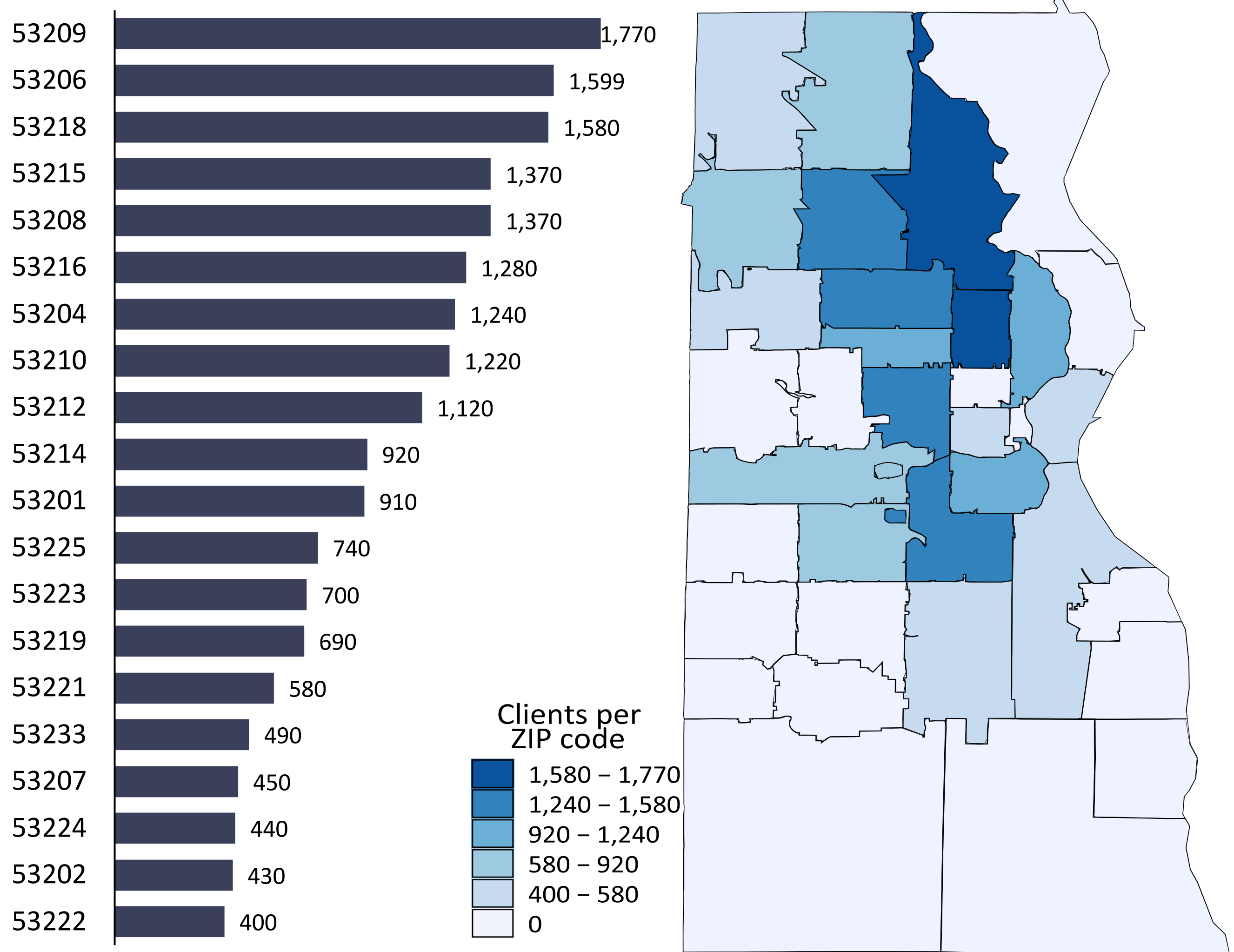
The incongruency between DHHS and provider staff's racial composition in relationship to County participants in program services reflects a norm in American society regarding service delivery and the power dynamics existing between Whites and BIPOC. In their review, DHHS found that its executive and management demographics are comparable to other public sector entities, including Milwaukee Police Department (MPD) and Milwaukee Public Schools (MPS). However benevolent and well-intentioned, these demographics project a picture of White County and provider staff having major decision-making authority regarding services that primarily impact BIPOC. The demographics of DHHS, MPD, and MPS reflect the broader, complex, interrelated criminal justice, educational, and social service systems controlled predominantly by Whites with authority over BIPOCs.

County Participants and Provider Locations

Often the location of service providers is overlooked or dismissed by those in positions of power. Transportation, however, is a vital SDoH factor, as distance often results in increased transportation costs and requiring additional resources such as the time involved in seeking service, which can be an additional burden for low-income residents. Therefore, the accessibility of DHHS and provider facilities sends a strong message to participants. The chart below illustrates where many participants reside.

Knowing the geographic distribution of non-profits in Milwaukee County in relation to participants receiving services and residents living in neighborhoods adversely affected by social determinants of health is a valuable part of a community-building strategy. It provides a tool for identifying where DHHS-funded organizations are located as well as other organizations that could provide services in geographic proximity to specific neighborhoods and their individual needs. It can motivate DHHS to work with lesser known but potentially highly effective BIPOC organizations located in specific zip codes where there are significant participant and community needs. Figure 5 below identifies the zip codes where a concentration of participants resides.

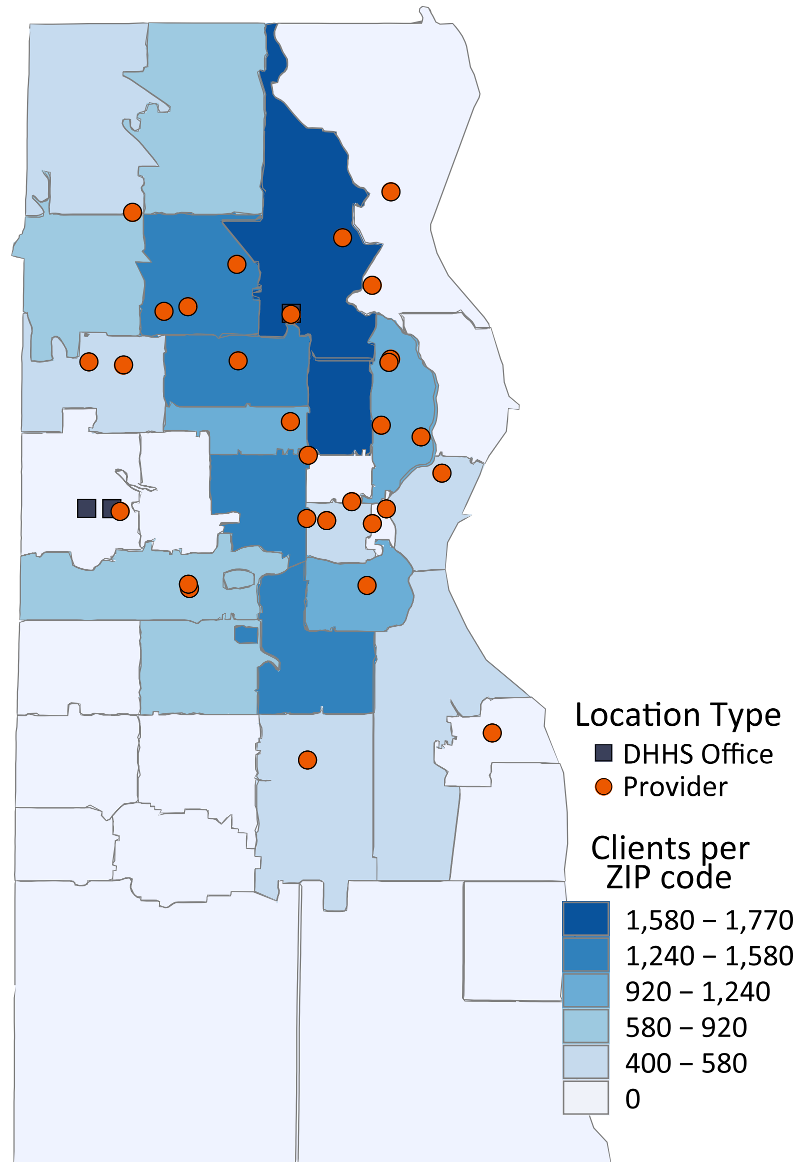
Figure 5: Count of Participants by Zip Code, Milwaukee County



The location of provider offices and DHHS offices in the central city stimulate opportunities for a strong community presence, significant community investments, and strong connections between providers and participants. Conversely, a geographical mismatch amplifies imbalances in the power dynamics between White-led organizations and participants of color. While leaders of White-led organizations may view satellite offices in the central city as sufficient, BIPOC providers are usually headquartered in these neighborhoods, strengthening the trust, commitment, and shared experiences between providers and participants. The fact that many leaders and staff working for BIPOC providers live in these neighborhoods increases their credibility.

In Figure 6, the map below provides information regarding the location of headquarters or main service offices in Milwaukee County by providers who have received large contracts in recent years from DHHS.

Figure 6: Location of 30 Core Provider Organizations and 3 DHHS Locations



This map shows the locations of 30 providers and 3 DHHS facilities. These organizations are currently involved in the DHHS contracting system, receiving large contract awards. Of the 33 provider locations, seven are located outside of the city of Milwaukee. Of the provider locations in the city, many are located outside of the central city where many BIPOC participants reside. To be fair, some of these organizations locate smaller facilities within Milwaukee's central city.

The DHHS facilities raise two concerns: Physical accessibility in the Coggs Building and access to DHHS Divisions located on Watertown Plank Road, on the county's far west side. While participants live throughout the county, data suggests that many participants of color live in segregated neighborhoods in Milwaukee.

We acknowledge that DHHS staff and providers consider a multitude of factors when selecting locations for service delivery and administrative offices. The location of facilities is just one of many factors that contribute to racial equity. However, segregation, a persistent factor throughout Milwaukee County, serves as a structural barrier that limits access to services and perpetuates racism, White privilege, and disinvestment. This historical, pervasive segregation requires aggressive action to eradicate its existence and to remedy its long-term effects. Thus, our argument about the location of facilities is threefold: 1) Organizations that receive funding to provide services to BIPOC participants should invest in BIPOC communities. One way of doing this is through the location of facilities in these neighborhoods; 2) Organizations that are located in BIPOC communities are likely to be connected to these neighborhoods and residents, understand the values and assets of the neighborhoods, and hire staff from these neighborhoods. For these reasons, strong efforts should be undertaken to fund these organizations; and 3) many BIPOC residents live in segregated neighborhoods where they face disparities in housing, employment, food security, healthcare, and other critical areas. Organizations that DHHS funds must be charged to implement services and initiatives that reduce the impact of segregation and racial disparities.

To some degree, DHHS is powered by White Board members and executive leadership that often live in Waukesha County and other areas outside of Milwaukee County. Leaders of these organizations do not demonstrate a valuing of diversity but acknowledge a significant lack of diversity at the governance and leadership levels and express the need and intent to do better. Still, the fact that the lack of diversity remains an unresolved issue undergirds a system that maintains White privilege, values White-centric approaches to service, and promotes inequitable power dynamics. This imbalance in power is entrenched in the DHHS contracting system, maintaining it as one where primarily White providers are funded to deliver services to BIPOC. This can perpetuate a savior complex rooted in charity and paternalism, the idea of benevolent, well-intentioned Whites saving poor black folks from poverty and, at times, from themselves. This sense of White superiority can rob BIPOC participants of their pride, foster a sense of powerlessness, and maintain the stereotypical view of Blacks being dependent on government and the charity of Whites. "Charity is no substitute for justice," proclaims Professor Michael Eric Dyson (2006). "If we never challenge a social order that allows some to accumulate wealth – even if they decide to help the less fortunate – while others are short-changed, then even acts of kindness end up supporting unjust arrangements. We must never ignore the injustices that make charity necessary or the inequalities that make it possible."

Perceptions of Provider Organizations

What is the perception of leaders of provider organizations as they navigate through a critical government system of social service provision that interfaces with the criminal justice, educational, and healthcare systems? During interviews, leaders of provider organizations were asked to discuss their perceptions of their own organizations. They rated these four attributes of their organizations:

1. The quality of their organization’s services
2. Their staff’s ability to connect with program participants
3. Their organization’s cultural competency
4. Their organization’s administrative capacity

Leaders rated their organizations using a scale from 1 to 5, with one being poor (★) and five being excellent (★★★★★). Provider leaders tended to view their organization's service quality and staff connections with program participants as excellent. However, views about administrative capacity and cultural competency were divided, to a great extent, along racial lines.

Providers, regardless of race, talked proudly about their organizations and the services they provide to Milwaukee County residents. When asked about the quality of their organizations' services, they rated their organizations as excellent, as Chart 6 illustrates.

Chart 6: Quality of Service	
BIPOC Providers	★★★★★
White Providers	★★★★★

While most White providers enthusiastically rated the quality of services as excellent, BIPOC providers were measured in their assessment. Although the organization had a long history of providing quality, culturally appropriate services in the African American community, the African American provider said, “I don’t believe in giving us an Excellent in this category cause there’s always room to improve and shift based on the needs of the young people, and we have that ability to adapt and change.” A Latinx provider indicated that “We give really good service; we’re striving for excellence, and that’s a process.” Another Latinx provider said, “We’re always adjusting, constantly asking, ‘What do you need – how can we serve you better?’”

An African American provider indicated that “I don’t live in Mequon, I don’t drive a Mercedes Benz, I am not taking a vacation, and every penny I have goes back into the organization. I work as hard as I can to make this an excellent business providing excellent services.”

Chart 7: Staff’s Ability to Connect with Program Participants	
BIPOC Providers	★★★★★
White Providers	★★★★★

When asked about their staff’s ability to connect with program participants, most providers rated their organization’s staff as excellent. An African American provider said, “We have a connectedness to the community – there’s roots here, and the ability to now make a collective impact. We’re here for the long haul. People know our hearts and our commitment, and that connectedness sets us up to be effective.” An African American provider explained the

organization's ability to connect to program participants, saying, "We're not bound by a 9 to 5 schedule. We are in the community. It's good to see people who look like you who are not afraid to share their struggles and their resiliency in a manner that motivates youth to think that maybe 'I can be okay."

Chart 8: Cultural Competency	
BIPOC Providers	★★★★★
White Providers	★★★

As shown in Chart 8, as interviewers, we assessed the cultural competency of providers based on their discussion of cultural competency issues, the actions they identified to achieve cultural competency, and the racial composition of their Board, executive team, and staff. An African American provider said, "Our cultural competency level is excellent because we were designed that way, and we continue to learn about other cultures." A White provider indicated that "We have put a laser focus on cultural competency this year. We have a strong diversity value; we have a diversity team and a Director of Diversity in the Human Resources department, and we are using a national cultural competency training program." An African American male who worked in a White-led organization said that "I went through the YWCA Unlearning Racism program and then pushed for every staff in our organization to participate in the program. Some people thought they knew a lot and realized they didn't know much at all. Since then, we have been doing very good in this area."

Most White providers indicated that their organizations needed to do more to increase the diversity of the Boards, executive team, and front-line staff and to increase the organization's cultural competency.

Chart 9: Administrative Capacity	
BIPOC Providers	★★
White Providers	★★★★★

Often, the reason cited for the inability of organizations led by leaders of color to obtain contracts is their lack of sufficient administrative capacity. Many BIPOC providers acknowledge the need to improve their administrative capacity and express a willingness to do so. The reasons they give include limited staffing, limited funding, and leadership needing to perform too many responsibilities. This lack of administrative capacity fuels a vicious cycle – the lack of significant administrative capacity limits the ability of some BIPOC organizations to obtain contracts, which limits their ability to earn revenue to support an increase in their administrative capacity.

The leaders identified their organizational strength as their ability to deliver quality culturally competent services and their strong commitment to improving their communities. A Latinx

provider indicated that “If you’re talking about the ability to write grants and obtain funding through grant proposals, I would have to rate us a 2+.” An African American provider indicated that “We have accounting systems and human resources systems and are in a position to help others. We wish we had had that support when we first started.” Another Latinx provider indicated that “We’re small but mighty; we all wear a lot of hats.”

At times, some individuals involved in the contracting system use the issue of administrative capacity to justify the government's historically poor track record of contracting to BIPOC organizations. A White community stakeholder suggested that the lack of racial equity in the system could be associated with the limited administrative capacity of BIPOC organizations. We assert that many reasons impact whether BIPOC organizations receive contracts. Strong administrative capacity does not guarantee quality service provision. However, the lack of administrative capacity impacts a provider's ability to write a quality contract proposal, provide sound fiscal management, maintain records, submit reports, and perform other key administrative responsibilities.

The DHHS Racial Equity and Contracting Work Group discussed possible approaches to resolve administrative capacity issues of provider organizations. The Work Group's suggestions focused on County staff providing some technical assistance in this area. We would argue against this. Bias and subjectivity are elements that hinder racial equity in contracting spheres. The provision of technical assistance to enhance an organization's administrative capacity can 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 non-profits and other provider organizations.

Our analysis demonstrates how critical organizational decisions reflect the degree to which leaders understand how their actions impact their ability to deliver culturally appropriate services to BIPOC participants and to achieve racial equity. In a society that has been inequitable for far too long, organizational leaders must be intentional, self-critical, and knowledgeable to effectively address these issues.

DHHS PROCUREMENT PROCEDURES

A major goal of government contracting is the expenditure of taxpayer funds in an efficient, cost-effective manner to secure services that benefit citizens. Like most large government entities, Milwaukee County has a variety of processes that staff can utilize to purchase services based on the level of complexity, value, risk, and transaction volume associated with the purchasing needs of departments and divisions. These processes range from 1) low-cost purchases, such as purchasing cards and time and material contracts; 2) competitive sourcing, such as informal proposals, formal sealed bids, and requests for proposal (RFP); and 3) exceptions to competitive sourcing, such as emergency situations, non-competitive sole source, and fee for service provider network. The DHHS procurement and contracting system has many levels of discretionary decision-making where staff can affect the equity of the process. We analyzed the following processes to determine how discretionary decision-making could impact racial equity in the DHHS procurement and contracting system.

1. Contracts Under $100,000
2. Request for Proposal (RFP) process
3. Provider Networks
4. Contract Extensions/Amendments

Contracts Under $100,000

Often decisions to award contracts to provider organizations require several levels of approval based on the contract amount. Most contracts greater than $100,000 require approval from the Division Administrator, Director of DHHS, Risk Manager, Corporation Counsel, Office of County Comptroller, Community Business Development Program, and Milwaukee County Executive. The Mental Health Board also approves contracts for the Behavioral Health Division, and the County Board of Supervisors approves contracts for the other DHHS Divisions.

DHHS can award contracts lower than $100,000 through an informal process that provides DHHS management with the opportunity to award contracts to providers without engaging in a strenuous proposal process. This flexibility can increase racial equity and can allow BIPOC providers an entryway into DHHS contracting, demonstrate quality performance, deliver quality services, achieve quality outcomes, and build professional relationships with DHHS staff and county participants. This is not to say that there are no requirements involved. The process can still require submitting a proposal, meeting insurance requirements, and assuming other contractual obligations.

Consideration of how to utilize a percentage of small, under $100,000 contracts to increase diversity and promote providers who use innovative, culturally appropriate strategies could be valuable. This could support their development of a track record with DHHS, broaden the scope of strategies employed by service providers, and expand the pool of quality providers. Ultimately, policies and processes are enacted and controlled by the practices of individuals with decision-making authority and control. This makes DHHS's commitment to infusing racial

equity into their decisions and processes critical. We acknowledge department training aimed at reducing implicit and explicit bias. We encourage the continuation of this training and an emphasis on ensuring that the right people are in the right positions in the department to make important discretionary decisions.

Request for Proposal (RFP) Process

Many opportunities to compete for contracts through the DHHS competitive sourcing process often require a provider to submit a proposal in response to a Request for Proposal for Purchase of Services or some Fee for Service contracts. The Request for Proposal (RFP) process enables prospective providers to participate in a competitive process that requires the submission of proposals. A review panel then scores the proposals based on a set of criteria discussed below. Sometimes providers participate in an interview process with a review panel. An appeal process facilitates the opportunity for providers to appeal a contract award decision. The appeal is evaluated, and a decision is made to change or maintain the original award decision.

The RFP process is used for contracts that exceed $100,000 on an annual basis, the need for the service is anticipated four to six months in advance, there are federal mandates requiring an RFP process (e.g., 2 CFR 200), or there is a need for a new service to be provided that had not been offered previously. In March 2017, DHHS began using Bonfire, an online portal, for issuing RFP's, accepting proposals, and scoring/evaluating the RFP’s. It is a highly efficient system that provides providers with the required documents and allows them to submit the final submissions electronically. The integrity of the process is maintained with the use of Bonfire as it creates electronic signatures and submission dates/times. Bonfire also allows vendors to receive timely updates and provides reviewers with access to the information they need to score proposals.

During the fall of 2020, the DHHS Racial Equity Work Group met to discuss several issues regarding the department’s procurement and contracting system. The Work Group paid significant attention to the RFP process and identified some key areas where process changes could improve the process. As a part of our evaluation of the system, we observed Work Group meetings, reviewed Work Group meeting materials and reports. We also gathered information about the RFP process during our interviews with DHHS staff and provider organizations.

The main areas of concern identified by the Work Group and/or in interviews were:

1. Development of RFP – Staff who develop an RFP can design it to cater to the strengths of specific organizations. Staff can control the focus of the RFP and encourage or dissuade the use of innovative, culturally appropriate methods of service delivery.
2. Notification of RFP – Currently, DHHS uses mainstream processes to inform organizations of new RFP opportunities. Notification to existing providers, use of

mainstream media, and use of Bonfire ensure that organizations familiar with the DHHS notification process will learn of these opportunities. However, this does notify organizations that are not connected, but have an interest in and, perhaps, a quality effective organization whose services could benefit DHHS participants.

3. Completion of Proposal – Many providers identified the use of the Bonfire system as a quality method to complete and submit proposals. At the same time, they criticized the system as containing redundant information, which made the submission process confusing, frustrating, and difficult.
4. Scoring of RFP – Work Group members were extremely concerned about two aspects of the RFP scoring process: the composition of the review panel and the application of the scoring rubric.
5. Appeal of RFP Decision – Some interviewers expressed concern that the appeal process was not timely and was arbitrary.

First, we will discuss the input of the Work Group regarding the Scoring of Proposals, specifically the selecting of scoring panels and the use of the scoring rubric.

The Work Group discussion centered on the number of panelists serving on review panels and the lack of diversity. Panels were not often diverse, and a few DHHS managers and staff identified panelists. The Work Group recommended, and DHHS agreed to increase representation on panels from 3 to 5 panelists, with DHHS staff only able to serve as 2 of the members of a panel. DHHS started compensating external reviewers of the RFP's at a rate of $100 per proposal submitted up to a maximum of $500 per RFP. In addition, demographic data was added as part of the information requested and documented as part the RFP submissions. These improvements support a fair process. Engaging diverse, knowledgeable community residents as external reviewers adds value and credibility to the process. We would suggest the development of a pool of potential panelists to ensure that review panels meet specific criteria, including diverse representation, subject matter expertise, and knowledge of the community. 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 goal.
The Work Group also discussed 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.

Chart 10: 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 on an organization's 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 reflects 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 defines 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.

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. Previous experience providing culturally competent services 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 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.

The recommendations of the DHHS Work Group and our assessments align with the views expressed by the DHHS staff and leaders of provider organizations we interviewed. The RFP process drew significant criticism from many interviewees. When specifically asked to rate the DHHS RFP process on a scale from 1 to five, with one being very difficult (★) and five being very easy (★★★★★), providers generally gave the rating of 2 for difficult (★★) as shown below.

Chart 11: Request for Proposal Process	
BIPOC Providers	★★
White Providers	★★

A significant theme that emerged was the need for a fair, objective, consistent RFP process. Organizational leaders repeatedly conveyed their concern about the inconsistencies, redundancy, and unnecessary requirements in the DHHS contracting system. The RFP scoring process also received considerable criticism, including concerns about cultural competency scoring and the lack of diversity on the RFP scoring panels.

While the Bonfire platform is recognized as an effective mechanism for digitally processing proposal submissions online, most of the RFP process was deemed cumbersome by the providers we interviewed that submitted RFPs.

A DHHS staff commented:

> I have gotten feedback from providers, from reviewers, it's [the contracting process] is confusing...it's confusing and not a friendly tool to use, it has gotten better in the last few years. However, I just got a call from a provider who said that they did not apply because the process seemed intimidating to them (they said: all these forms and all these papers, I don't want to complete this, and a lot of times, it is small agencies that are not applying and then some of the requirements they cannot meet. (for example, the insurance requirement) . . . people see that requirement . . . and that's discouraging.

A long-term provider stated that:

> I just wish there were more communication, timeliness of the execution of the contracts, RFPS addendum need to be reviewed, and they are not so clear and prep time for the proposal needs to be better communicated. How would a minority agency be able to participate and . . . we need a grant writer, and we are a large agency.

While a DHHS staff stated that:

> I do not think it [the contracting process] is equitable at all... well actually, I think it is actually equitable if everyone was on the same playing field and had the same access to information, but because that is not the case … I think the process is not appropriate in terms of providing equity…the way the award process is set up, you have to be a part of a group already that is knowledgeable about the process…such as how to respond, how to draft the language, how to … there is a group of folks who are already in the know and …so it does not provide equity at all.

A White provider indicated that DHHS “could streamline the process by 25%.” A DHHS staff member stated that he did not feel there was much redundancy in the RFP process but was willing to make changes if warranted to reduce redundancy and inconsistency.

As one provider said: “I don’t know how a small organization can write a proposal for Milwaukee County and maintain all that needs to be maintained for contracting.”

Another provider said, "I would say that if DHHS is trying to increase racial equity in contracting …they are intentionally or unintentionally operating a system that is making that more difficult to impossible… for example, requiring programs to name staff for positions in the contract … small organizations may not have a staff to name, so that disqualifies/eliminates their opportunities."

A significant theme that emerged in our interviews was an absence of inclusion in the RFP process and throughout the contracting system. There was repeated concern expressed that access to knowledge about the DHHS process and procedures for grant funds was not readily available. A benefit of White privilege is being included in the conversation, being told how to play the game, and then being awarded for playing the game. For instance, regarding the requirement that providers indicate in their proposals the name of staff who would work in the program, providers stated they usually do not hire the staff until they receive the contract. A White provider indicated that when they are writing a proposal, they "plug in a fake name in the proposal – but those people might not work in those programs. They don't hire staff before they have a contract – because that's not sustainable. You get points for doing that (plugging in the name)."

Some organizations, specifically BIPOC providers, did not know that was permissible. Not only would BIPOC providers not know that the practice is acceptable to DHHS staff, but some would be hesitant to do this for fear that they would be accused of doing something unethical and possibly disqualified from participating in the contracting system.

Another White provider indicated that they “get points in a proposal for what you said you are going to do . . . I can put down what I think they want to hear – not what we will actually do . . . [until later or not].”

As a DHHS staff explained, “We see the same group of folks that go after the dollars who are well versed on how to jump through the hoops. But there may be folks that are more needed,

can connect better with the population we serve, but they don't have the access, and they can't get the contract."

An interview can be, but is not required, as part of the RFP process. Providers who participated in an interview indicated that the process is not always structured and lacked DHHS guidance regarding presentation format or scoring criteria. Thus, providers expressed concern that the ambiguity of the interview process could be used by DHHS staff to select the provider they preferred regardless of the quality of their interview. A DSD staff indicated implementation of a structured framework and a scoring process in their interviews. The ambiguity of the interview process is an example of the inconsistency in the RFP process and how decisions can appear to be arbitrary, fueling provider concern about objectivity and fairness.

The appeal process was also criticized by providers as being arbitrary, without clear explanations of appeal decisions, and without DHHS resolving appeals in a timely manner. A provider expressed concern about the appeal process but said, "we can't afford to fight. You have to have the "willingness not to get your checks on time, snubbed out of information. You can't really put your hands on it, but you know you are being treated differently."

Provider Network

DHHS operates several fee-for-service provider networks that include numerous providers in each network. These networks are designed to deliver services in a flexible and cost-effective manner. Because there are multiple service providers in the network for most services, families have a great deal of choice in selecting a service provider.

BHD operates several networks. The Community Access to Recovery Services (CARS) network provides non-inpatient programs and services and community-based programs and services for adults. The Wraparound Program network provides non-inpatient programs and services and community-based programs and services for children and adolescents. BHD identifies the services they want to expand their network capacity in and releases an Expression of Interest (EOI) at the start of the open enrollment period on July 1 through July 30. EOI is a standard BHD business process used to solicit proposals from community agencies, organizations, and interested parties interested in joining a network.

Entry into some provider networks is limited. The Open Enrollment period starts July 1 and ends July 30. Providers can also register their agency to receive notices about future service and program opportunities within networks. DHHS staff can use but are not required to use the RFP process to select providers for contract awards in the provider network.

In our attempt to learn more about the provider network system, what we found is a process that can perpetuate racial inequity in the following ways:

1. An annual time frame of one summer month (July) when providers can apply to be included in a network.

2. An open enrollment period that may not be communicated effectively to BIPOC and other small organizations not as familiar with the DHHS network process.
3. Contract awards that can be renewed for several years without competition.
4. Networks that may not seek additional providers on an annual basis.
5. Networks that may consist of numerous providers with no guarantee that all will receive contracts.
6. Networks where incumbent providers may have their contracts renewed for several years regardless of their performance.

Having a network of providers offers continuity of service and the opportunity for DHHS staff to form strong relationships with a group of providers. While there may be more than 100 organizations in a provider network, many organizations may not be awarded. Once a provider in the network is awarded a contract, it is unusual for the provider to lose the contract. Thus, the providers can form long-term, significant funding relationships with a DHHS division staff and, over time, become an organization a Division prefers to fund.

Provider networks are an important part of the contracting systems. For example, in the BHD 2019 Grants Management Manual, the following was listed:

- Access Points – IMPACT, Justice Points, M&S Clinical Services, United Community Center, Wisconsin Community Services
- Case Management – St. Charles, LaCausa, Wisconsin Community Services, Justice Point
- Recover Support Coordination – St. Charles, LaCausa, Wisconsin Community Services, Justice Point

We are not debating whether service provider networks are efficient service delivery systems; we recognize that many large and small and BIPOC organizations provide quality services in a timely and cost-effective manner. We are suggesting that the current operation of DHHS provider networks should be further assessed to determine if it is a fair, objective, and racially equitable process. Provider network policies, processes, and practices can be evaluated by DHHS staff and other stakeholders to ascertain how the networks can be improved and expand opportunities to increase racial equity while achieving efficiency and quality services.

In interviews, many providers, regardless of race, expressed concerns about the reporting requirements, the responsibility to record their time while delivering services, sometimes in 6-minute increments, the duplication of data entry, and the reimbursement rates for many services delivery. Many complimented the use of a billing system that processed payments promptly.

Contract Amendments/Extensions

Legitimate procurement processes can circumvent the use of BIPOC providers. The use of contract amendments and extensions can affect providers' ability to obtain a contract award.

Even when DHHS staff make what appear to be good business decisions, they can negatively affect departmental efforts to achieve racial equity. The introduction of Contract Performance Measures in 2017 increased the normal contract cycle from 3 years to 4 years. DHHS staff use the extra year to evaluate/analyze, modify, or replace contract performance measures. In certain situations, the provider may ask for a longer contract cycle for certain reasons. Services contracted through FFS networks can be extended.

There is likely no explicit bias is in play, no intent to avoid contracting with BIPOCs. However, the reality is that when a provider participates in a competitive process and is not awarded the contract, it may be four years before the opportunity occurs again.

There is nothing illegal or non-compliant with the execution of this contract extension. Still, the reality is that these processes unintentionally circumvent the use of BIPOC providers with the use of contract extensions. This illustrates the difficulty of creating a contracting system that is racially equitable. DHHS staff seek to make quality business decisions that make the system efficient and cost-effective. Contract extensions reward the work of some providers while making it even more difficult for other providers, sometimes BIPOC providers, to participate in the contracting system.

Another credible process is the practice of adding services to a contract through a contract amendment. If additional services are within the same program group, the amendment does not have to receive approval from the County Board or Mental Health Board if the increased services do not cost more than $99,000. Program groups are generally defined at the Federal or State level, such as Comprehensive Community Services (CCS), Targeted Case Management (TCM), and the Birth to 3 programs. The addition of new programs to a contract is generally RFP'd. However, in a Fee For Service Network, such as the Substance Abuse Residential Services network open to all interested applicants, BHD can discontinue RFPing the program. It is important for DHHS to ensure that staff are making decisions to amend and/or extend contracts for the right reasons.

Many of those interviewed rated their experience doing business with DHHS as difficult, as the chart below illustrates.

Chart 12: Ease of Doing Business with DHHS	
BIPOC Providers	★★
White Providers	★★

Providers, regardless of race, expressed concerns regarding the difficulty they experienced in doing business with DHHS. For most non-profit leaders, the contracting system was challenging to navigate. One Latinx provider said, "the process is so cumbersome," and "the reports are cumbersome, and the phone calls have my heart beating so fast, and the person on the other side is comforting." However, serious process inefficiencies make doing business with DHHS

difficult. Deficient DHHS processes increase racial equity, adversely affecting BIPOC providers who are at times undercapitalized, underutilized, and undervalued.

Another provider of color explained the challenge of participating in a system that lacks transparency.

> *I do not think that there was anything malicious, but I do question what they were looking for. We had an established program . . . but if you are providing service delivery that is exceptional and suddenly you learn that the RFP was awarded for reasons beyond…that is just how the scoring came out... it definitely hurts, the consumers were hurt by this, the staff are impacted by that…but it does not give us the apparatus to fully understand the rationale so we can improve our own processes…it is like you are given a report card which says sorry you did not get it.*

A White provider explained that:

> *One of the biggest criticisms that I would have and one of the biggest thoughts that I have with this whole process about equity for providers is really around contracting, and I would draw the line between being a larger organization and a smaller organization. I do not know how a smaller organization could write the Milwaukee County Proposal, which is very cumbersome, or maintain all of the stuff that needs to happen for contracts. We have departments that do that; we have specific personnel that do those things. If I am a Mom and Pop organization trying to get into this business, trying to be a provider in my neighborhood and doing services with Milwaukee County that has got to be daunting on so many levels . . . that is just drawing the distinction between having capacity and not having capacity, and we think that we [large organizations] have capacity and [so I do not know how small organizations do it and we (large organizations) are overwhelmed]*

Providers indicated several other reasons why working with DHHS is difficult. For instance, many providers work with at least two DHHS divisions. These divisions operate in silos with different requirements. One may require tuberculosis tests; another may not. As one provider said, the "County has a system that makes achieving racial equity very difficult. Each division has a pre-approval process for their division, but they are different processes and processes are changed each year."

The County must approve the staff that providers hire to work on County contracts. This means that while the provider can select staff, they cannot hire staff until the DHHS approves. This process can take weeks, during which the prospective staff may gain employment elsewhere. As one provider said, “You almost need a full-time position for approval for hiring. A policy can be different for each division.”

The County requires new staff to go through a training process before they can begin doing the work that they were hired by the provider to do. This means the provider is paying staff before they can start work that can be billed to the County.

A White provider recalled a conversation with "the County about the rates for behavioral health technicians, some who were making $10 an hour… and we want to talk about the cost of living, racial equity, and access because most of those staff are African Americans and they are trying to make it work on 10 bucks an hour, and we are competing with Target and Menards who are paying 16 bucks an hour."

Providers that participate in a network can be awarded fee-for-service contracts that provide DHHS with an efficient way to measure provider performance and a payment system that provides a quick, easy method for providers to receive payments. Processes some DHHS staff considered effective and efficient were processes that many providers felt increased the difficulty of doing business with the department.

Part of the challenge with the provider networks and other aspects of DHHS operations is the discretionary way communication is provided. For example, a DHHS staff indicated that there is some flexibility in some networks that would permit a provider to suggest a service that could be implemented. However, the staff indicated that "most providers don't know they can talk to us about ideas." This example illustrates that many providers are not aware of appropriate, sometimes informal communication channels and that some DHHS staff fail to communicate with providers that do not have significant business relationships with the department. Contrary to this, a White provider whose organization has had large DHHS contracts for many years indicated that when she has a question or concern, "I just pick up the phone and call my contact at DHHS." This access is not something many BIPOC providers have.

A repeated area of concern expressed in the interviews centered on the insurance requirements as a barrier to participating in the contractual process. An African American provider said, "It is hard [for a smaller agency] to take this $5,000 or $10,000 contract when I have a million-dollar insurance requirement… or there is no liability here, so why I have to have a million-dollar insurance policy… the juice is not worth the squeeze."

In a DHHS Work Group meeting, the Milwaukee County Risk Manager indicated that opportunities may exist to revise the insurance requirements on some projects in some cases. We recommend that Risk Management work with DHHS leadership to explore options to reduce insurance requirements on contracts, when feasible, or institute an innovative process that provides insurance to hold the County harmless without placing an overwhelming burden on small organizations, preventing their participation.

Providers also made the following comments:

- "Expectations have become too onerous. Instead of saying, you're responsible for your staff, and the County wants immunizations, health care data, license data."
- "Report service required by the 6-minute increment. The labor that goes into that, it's sad cause it takes away from service delivery and our staff providing quality services."
- “Billing has become so complicated and cumbersome.”
- “Decide not to provide not to do programs because we can’t make it work financially.”
- “Don’t know how a small organization can write the County proposal or maintain all that needs to be maintained for contracting.”

The three major themes that emerged from interviews regarding DHHS procurement processes are:

Three themes regarding the lack of racial equity in DHHS processes

The Need for Fair, Objective, and Consistent Processes

Some providers expressed concern about the fairness of the contracting system, including RFP, appeal, payment, and FFS contract award. Providers questioned whether the system was infused with arbitrary and biased decisions based on the strength of the relationships 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. Some DHHS staff and providers highlighted the need for fair, objective, and consistent contract award decisions, adherence to policies, and the application of rules and requirements. There is a need to hold DHHS staff accountable for execution of their responsibilities in a racially equitable manner.

The Absence or Inconsistency of Accountability

A key theme was the absence or inconsistency of accountability. Providers interviewed expressed concerns that some providers receive preferential treatment even when their contract performance is poor. There was an expressed concern that the level of accountability for achieving quality outcomes varied amongst staff and that some staff's devaluation of clients (Black and Brown clients) may account for the low expectations of DHHS 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 a significant, long-term effect on addressing the social determinants of health in communities of color.

From a DHHS staff perspective, there are concerns about provider accountability. In speaking of the larger agencies, a DHHS staff member indicated that "We tend to have more struggles with these agencies …some of them are so big that they have the infrastructure in place, and they can outcompete a lot of the smaller agencies for contracts, but we have been intentional in making space for the smaller agencies to turnaround a proposal in a week…"

Some DHHS staff discussed their experiences working with organizations that receive a large share of the division's contracts. One staff explained that some large organizations seem to feel privileged, entitled, and empowered. One staff expressed concern about a large organization and indicated the concerns were valid based on "the content of complaints, quality of interactions, serious incidents, and their resistance to complying with division's request or requirements. Rather than working with DHHS staff to try to figure things out, the leadership of the organization, as part of their regular process, would go up the chain of command because they have a difficult time being held accountable."

Another DHHS staff indicated that the

> *Staff do not necessarily like or think it is a great idea to always work with these large agencies to deliver services because it is not always the quality there . . . and I am looking for quality and impact in the community, and sometimes the agencies are not able to produce that, but they still get contracts and so . . . [I know this is being recorded, so I will stop there] … Well, I will say it is a political environment, and so it's politics …it is politics and not the quality of services…that is why contract management has gone to performance measures. So, if you are not performing or you are not meeting those measures, then you do not get the full contract, and I think that is a fair way of doing . . . but to take a critical look at these agencies . . . for example, you said that you were going to serve 700 people and you only serve 200 people . . . what's going on is the question?*

The Absence of Inclusion of BIPOC Providers

Government entities often fund White-led organizations with strong administrative capacity but, in some instances, possess little knowledge or competency regarding the culture and assets of diverse program participants. This practice values administrative capacity but undervalues diverse providers from communities of color who practice deeply held cultural

traditions of helping mutual aid and benevolence. The lack of diversity in this approach is rationalized by focusing on perceived or actual challenges some organizations of color face regarding capacity, capital, or lack of experience working in government contracting systems. However, these decisions can have negative outcomes for customers of color, lead to lower service access, and perpetuate systemic inequities.

In the past, government services reflected mainstream norms and traditions and the expectation that BIPOC would adapt and conform to White-culture and norms. Racial equity requires that service approaches reflect the culture, traditions, and norms of the diverse populations represented in the community. There are several positive byproducts of increasing utilization of BIPOC providers in DHHS procurement and contracting. One, not often discussed, is the importance of community institutions that reflect the values, traditions, and representation of the specific individuals being served and their communities. This practice of patronizing, supporting, and funding White nonprofits, businesses, and institutions is unapologetically and naturally a part of predominantly White communities. Edward Blythe stated the importance, saying, "Every race has a soul, and the soul of that race finds expression in its institutions, and to kill those institutions is to kill the soul… No people can profit or be helped under institutions which are not the outcome of their own character."

While we do not argue for the provision of DHHS services exclusively by provider organizations that represent specific BIPOC communities, we do assert that the inclusion of these organizations as important actors in the DHHS system is a critical, often ignored asset in addressing social determinants of health. This is especially true in a community like Milwaukee that has a track record of racism, an issue Milwaukee County leadership is committed to resolving. Thus, a remedy to past and current inequity is the inclusion of BIPOC organizations and support of their efforts to gain the resources needed to compete on a level playing field. This is done, in part, by ensuring fair, objective processes to guarantee the equitable application of discretionary decision-making. DHHS will achieve racial equity by implementing transformational change and holding staff accountable for achieving the goal.

President Lyndon B. Johnson stated, “You do not take a person who, for years, has been hobbled by chains and liberate him, bring him up to the starting line of a race and then say, ’you are free to compete with all the others,’ and still justly believe that you have been completely fair. We seek not just legal equity but human ability, not just equality as a right and a theory but equality as a fact and equality as a result.”

President Johnson's statement reiterates that government actions to address racial equity must be intentional, specific, and results oriented. The next section will highlight how racial inequity influences the DHHS contracting system.

DHHS CONTRACTING SYSTEM

The previous section discussed the procurement process, highlighting how contracts are awarded through low costs purchasing, competitive sourcing, and non-competitive sourcing. This section focuses on the results of the procurement process and analyses the contracts awarded over the decades of 2010 – 2019.

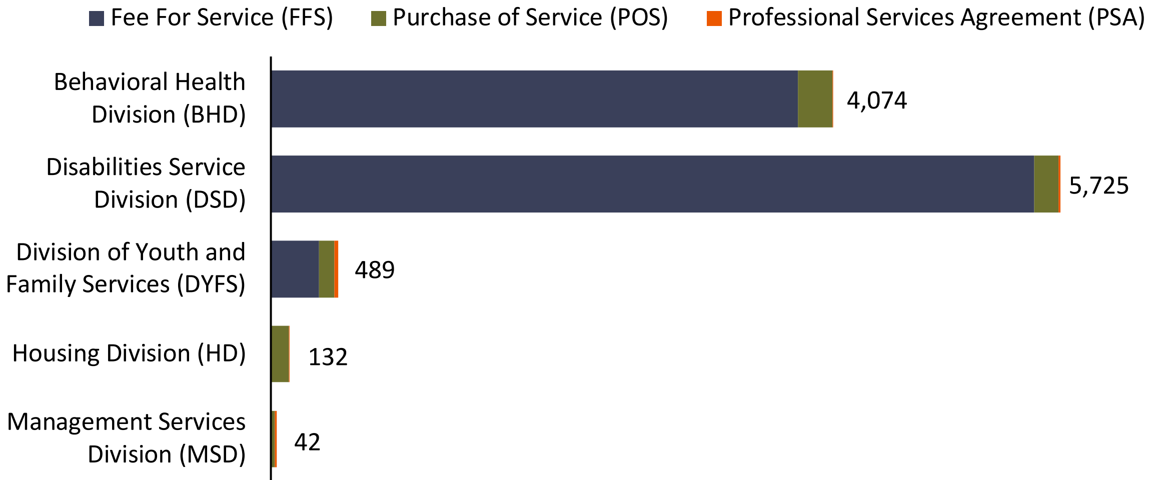
It is through this racial lens we analyzed the DHHS contracting system. To gain an understanding of the DHHS contracting landscape, our research team analyzed contract data for 2010 through 2019, during which DHHS awarded 10,462 contracts totaling $1,212,277,058. During this time, contracts were awarded in five DHHS divisions: Behavioral Health Division (BHD), Disabilities Service Division (DSD), Division of Youth and Family Services (DYFS), Housing Division (HD), and Management Division (MD). This does not include the recent transition of the Division on Aging or the Veterans Services Division, which officially became divisions of DHHS in January 2021.

The department's primary mechanism for service provision is the funding of non-profit agencies with contracts that fall into three major categories: Professional Service Agreement (PSA), Purchase of Services (POS), and Fee for Service Agreement (FFS). A brief description of these types of contracts is provided below.

1. A Professional Services Agreement (PSA) is a type of agreement to contract with a consultant for professional services over a specific period.
2. A Purchase of Service (POS) is a contract between the County DHHS and a private service provider, organization, or municipality to obtain direct health and human services.
3. A Fee for Service Agreement (FFS) is an agreement and method of business payment requiring specialized skills, knowledge, and resources in the application of technical or scientific expertise of service providers to provide services and be paid for each service they provide.

A review of the number of contracts and the funding amounts of those contracts by various DHHS Divisions are presented in Figure 7 and Figure 8.

Figure 7: Number of Contracts Awarded by Division, by Type (2010-2019)

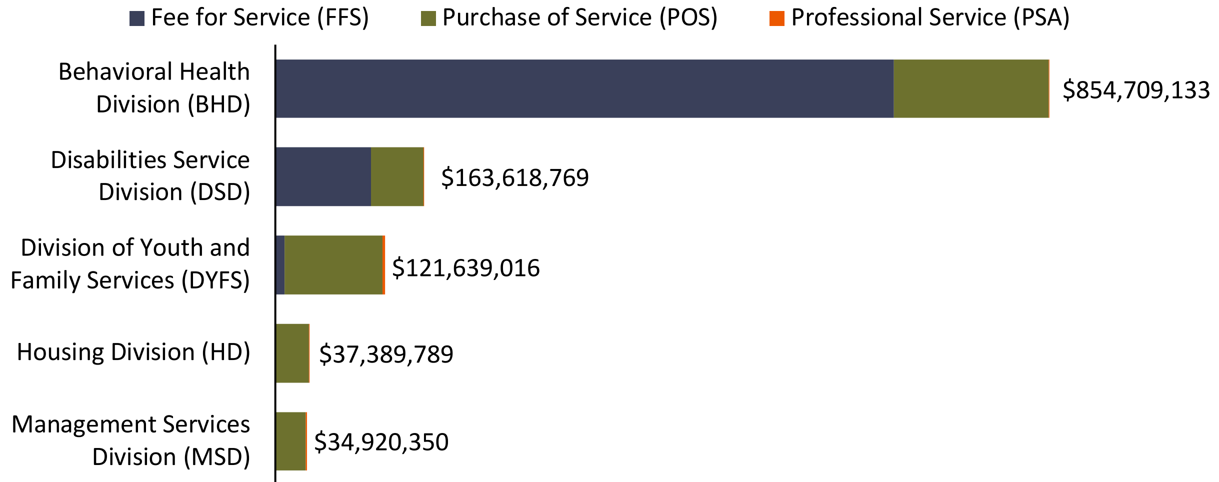


Note: The number at end of each stacked bar shows the total number of contracts awarded by Division.

In Figure 7, the number of Fee for Service contract awards constituted 93% or 9,699 of the total 10,462 contracts. The Behavioral Health Division (BHD) awarded almost 3,820 (94%) of its contracts as a Fee for Service Agreements. The Disabilities Services Division awarded a high volume of its contracts, 5,531 (97%) as FFS agreements. The Division of Youth and Family Services awarded 348 (71%) of its contracts as FFS agreements. The number of Purchase of Service awards constituted only 702 or 7% of DHHS's total contracts in the last decade. Housing Division (HD) and the Management Services Division (MSD) awarded PSA and POS contracts but did not award FFS contracts.

Figure 7 showed that the number of contracts awarded through the POS process totaled 7% as opposed to the 93% of contracts awarded through the FFS process. However, as Figure 8 illustrates, the POS contracts comprise 34%, almost $408 million, of the total contract dollars, and the FFS contracts total 66%, or $799 million. During 2010 – 2019, the PSA, POS, and FFS contracts totaled $1,212,277,078.

Figure 8: Contract Funding by Division, by Type (2010-2019)



Note: The number at the end of each stacked bar shows the total value of Contracts awarded by each Division.

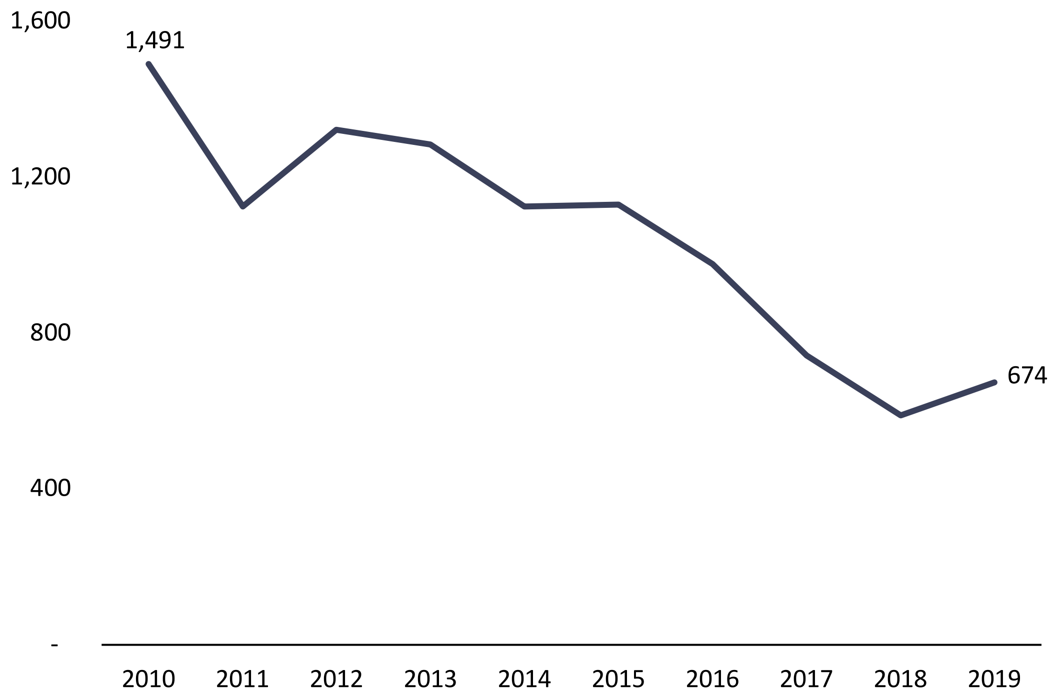
DHHS awarded Fee for Service contracts totaling almost $800 million to providers during 2010 – 2019. The Behavioral Health Division (BHD) awarded nearly 3,820 (96%) of its contracts as FFS, totaling more than $683 million (80%) of its funding. The Disabilities Services Division awarded almost $106 million in FFS contracts. The Division of Youth and Family Services awarded a high percentage (84%) of FFS contracts.

DHHS awarded Purchase of Services contracts totaling more than $400 million during 2010 – 2019. While BHD only awarded 4% of its contracts as POS, these awards constituted more than $171 million (20%) of its contract funding. DYFS awarded more than $110 million or (92%) of its total funding in POS contracts. DSD awarded almost $58 million (35%) of its funding in POS contracts. The Housing Division awarded most of its funds totaling $37,160,726 through Purchase of Service contracts. The Management Services Division awarded most of its funds, totaling $33,783,622, through POS contracts. While the number of POS contracts awarded by BHD and DSD is significantly smaller than the other divisions, the value of their contracts constituted more than 50% of the total POS contracts awarded by DHHS.

Typically, contractors receive the full payment of their Professional Service Agreements and Purchase of Service Agreements unless an unforeseen issue arises that requires DHHS to end a contract before all funds have been paid to a provider. Conversely, payments for fee for service contracts are not guaranteed and are paid based on an organization providing specific services and being reimbursed for those services. Small organizations may not be able to manage FFS contracts because they need to earn the total amount of the contract to remain fiscally sound. Their ability to do this may be based on the volume of referrals received and other factors they may not control. While these issues may negatively affect larger organizations, they are often better positioned fiscally to navigate this challenge than smaller organizations.

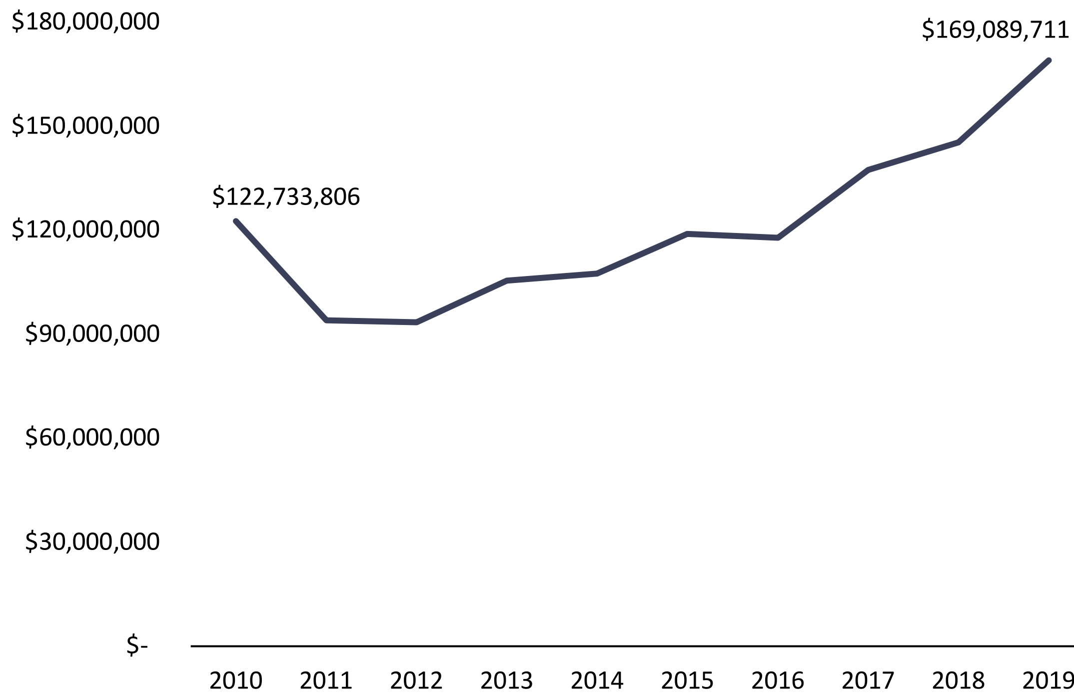
Figures 9 and 10 below illustrate the decrease in contract awards and the increase in contract funding from 2010 – 2019. Over the years, DHHS has increased the total funding awarded but decreased the number of contract awards. In 2010, DHHS contract funds totaled $122,733,806 and increased in 2019 to $169,089,711. In 2010, the average contract award was $82,316, while in 2019, the average contract award was $250,874, a 205% increase. At the same time, the number of contracts awarded decreased from 1,491 in 2010 to 674 in 2019, a decrease of 817 contracts or 55%. This suggests that the contract award process has become more competitive with limited contract opportunities while the financial benefits reaped from receiving a contract have significantly increased. This has implications for DHHS achieving racial equity because of the disparity in BIPOC providers being able to effectively navigate the DHHS contracting system compared to White-led organizations. The factors that create this disparity are discussed later.

Figure 9: Number of DHHS Contracts Awarded by Year (2010-2019)



The volume of contracts dropped from 1,491 contracts in 2010 to 674 contracts in 2019, a 55% decrease in the number of contracts awarded, resulting in fewer contract opportunities.

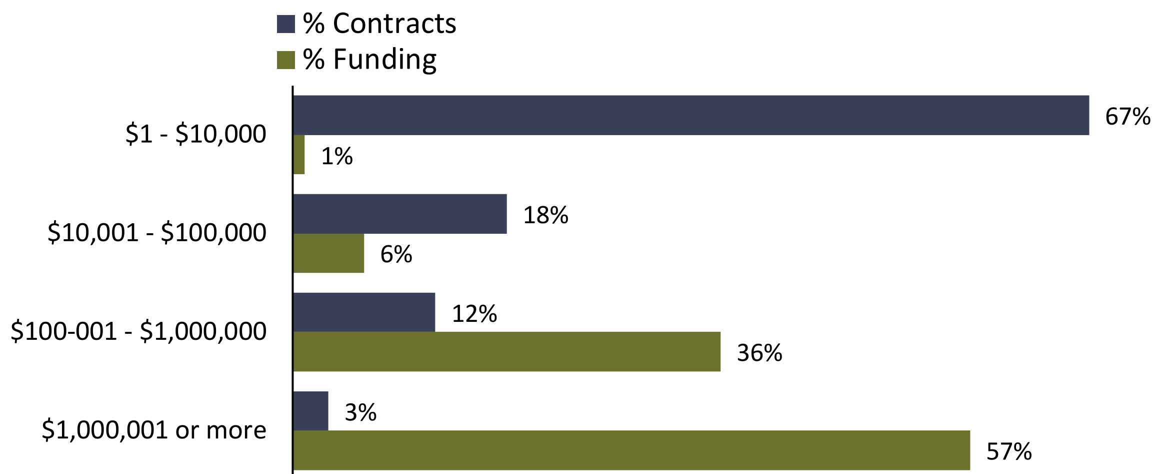
Figure 10: Total Value of DHHS Contracts Awarded by Year (2010-2019)



Four Levels of Contracting

Figure 11 below shows that many contracts, under $1,000, are awarded to organizations that provide specialized services. These contracts valued at $10,000 or less comprise 67% of the contracts awarded by DHHS but only 1% of the funding. Contracts valued at $100,000 or less comprise 85% of the contracts, but only 7% of the contract funding. These contracts are often awarded through processes that allow for discretionary decision-making by individual staff.

Figure 11: Percentage of Contracts and Contract Funding Based on Contract Size (2010 - 2019)



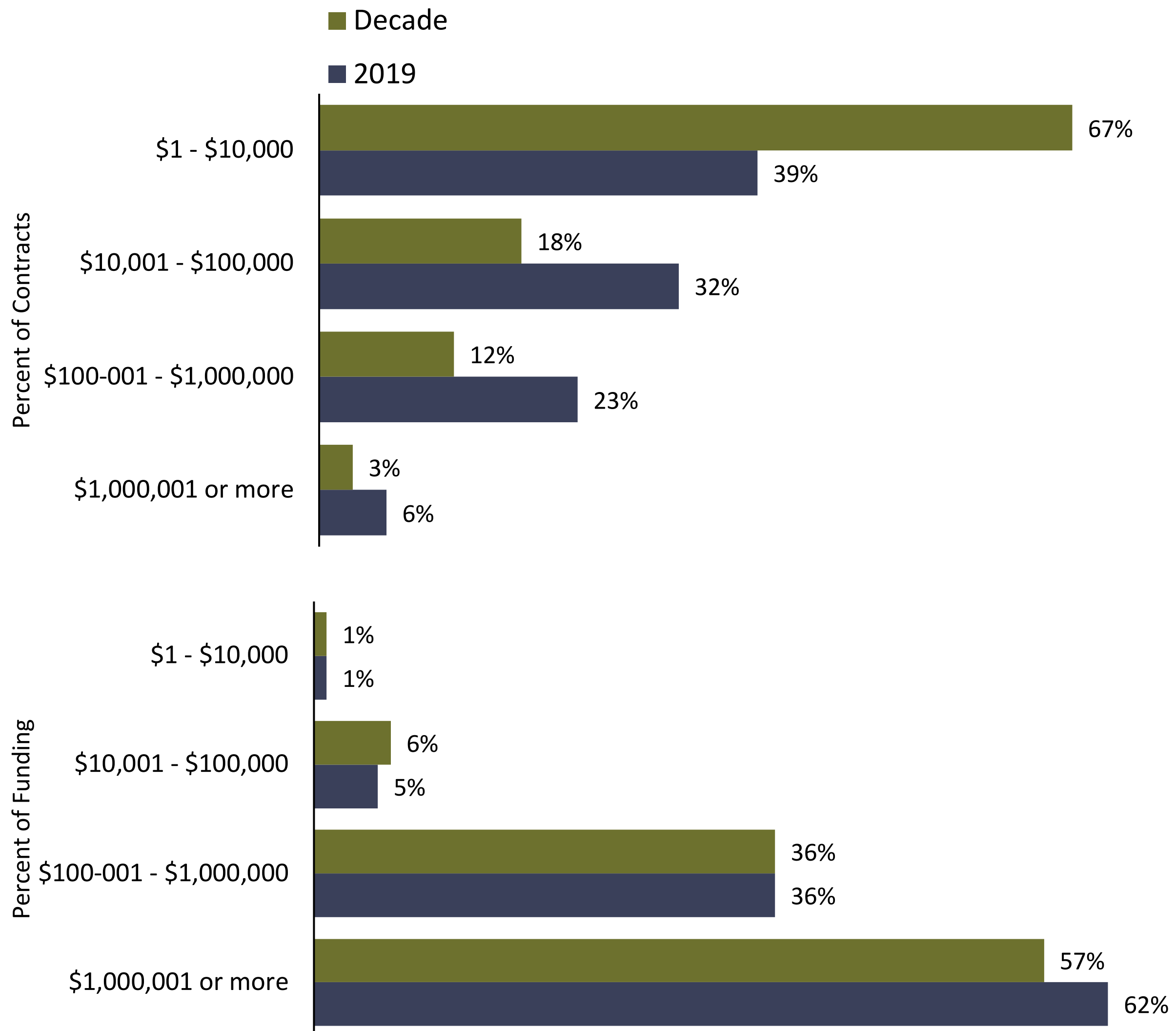
Presented below is the breakdown of the number of contracts and funding. Chart 13 compares the contract totals during the decade compared to 2019.

Chart 13: Comparison of Number of Contracts and Funding (Decade of 2010-2019) vs. 2019					
Contract Size	**Decade**			**2019**	
	Number of Contracts	**Contract Funding**		**Number of Contracts**	**Funding**
$1 - $10,000	7020	11,396,520		266	546,168
$10,001 - $100,000	1876	73,110,111		218	8,713,245
$100,001 - $1,000,000	1244	439,821,437		154	53,420,258
$1,000,001 and greater	322	687,348,990		44	106,410,040
Total	10,462	1,212,277,058		682	169,089,711

The data in Figure 12 indicates that the number of contracts awarded for $100,000 or less during the decade was 85% of the total number of contracts and 7% of total contract funding. In comparison, the number of contracts awarded in 2019 awarded for contracts of $100,000 or less was 71% of the total number of contracts and 5% of the contract funding. Conversely, larger contracts totaled $1,127,170,427 or 93% of the total funding during the decade and 159,830,298 or 94% of the toral funding in 2019.

The percent of contracts valued at $100,000 or lower was 42% compared to the decade percent of 62%. This shows that contracting trends have evolved into fewer but larger contracts. Larger contracts can benefit organizations in that they provide greater resources for service delivery, staffing, and administrative support. At the same time, there is more competition for these contracts.

Figure 12: Comparison of Percent of Contracts and funding for Four Contract Levels (Decade v. 2019)



In Figure 12, in comparison, a larger percentage of the 2019 contracts were awarded for contracts higher than $100,000 than for the decade. In comparison, a higher percent of funding for contracts over $1,000,000 was awarded in 2019 than for the decade. This confirms a shift to a contracting and funding strategy that emphasizes fewer contracts and larger contract dollars. A racially inequitable system adversely affects small organizations of color that may provide quality services and employ culturally competent staff. However, inadequate administrative capacity to compete for larger contracts or the lack professional relationships with DHHS staff stifle their ability to foster effective communication, establish a track record, and facilitate conflict resolution. In a racially equitable environment, these issues are resolved.

Core Organizations

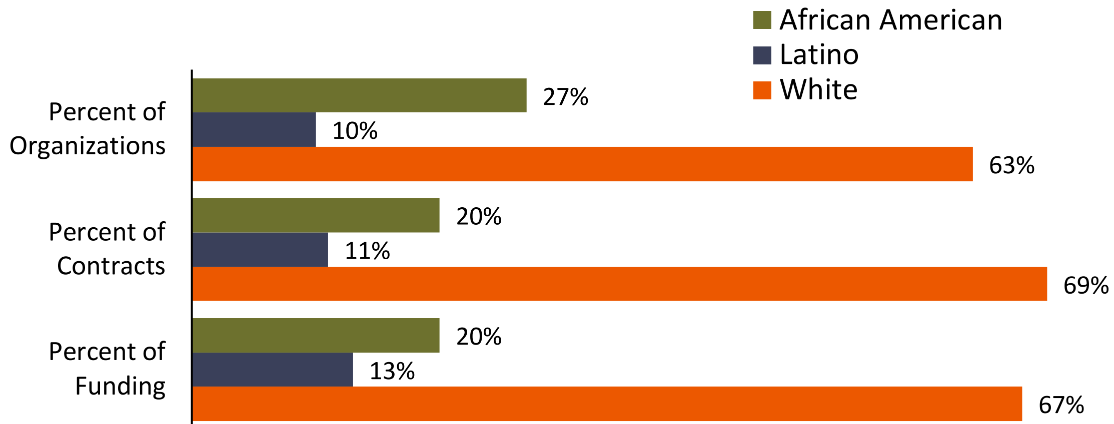
Given DHHS contracting trends resulting in fewer but larger contracts, it is important to determine whether DHHS maintains a group of large organizations that serve as the core of its service delivery system.

Our analysis confirms that from 2010 – 2019, thirty organizations were awarded a total of $723,024,402 or 60% of the total $1,212,277,058 awarded to all DHHS service providers. These core organizations were awarded 1,047 or 10% of the total contract awards. Chart 14 presents data about the 30 core organizations based on race.

Chart 14: Demographics of Core Organizations: Contracts and Funding						
Leadership	**Number of Providers**	**% of Providers**	**Number of Contracts**	**Percent of No of Contracts**	**Percent of Contract Funds**	**Contract Values**
African American	8	27%	210	20%	20%	$141,991,292
Latinx	3	10%	116	11%	13%	96.850,923
White	19	63%	721	69%	67%	484,182,187
TOTALS	**30**	**100%**	**1047**	**100%**	**100%**	**$723,024,402**

Chart 14 summarizes the data regarding core organizations. A breakdown of the core organizations based on the providers' racial composition shows that White-led organizations received $484,182,187 or 67% of the funding allocated to core organization and received 721 or 69% of the contracts awarded to the core organizations. In comparison, African American organizations received $141,991,292 or 20%, and Latinx-led organizations received awards of 96,850,923 or 13%. Figure 13 illustrates the comparison of core organizations, contracts, and funding percentages by race.

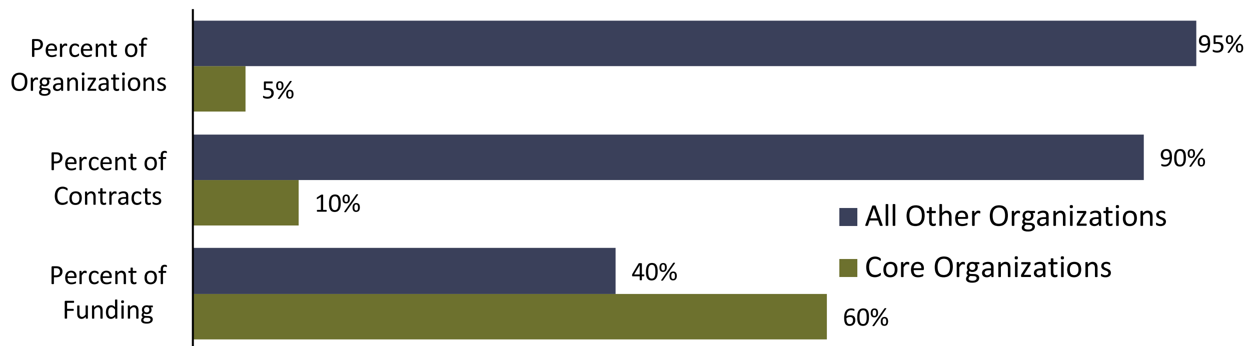
Figure 13: Racial Demographics of Core Organizations: Percent of Organizations, Contracts, and Funding



Note: The demographics for this figure were calculated from raw data for all PSA, POS, and FFS contracts awarded by DHHS from 2010 – 2019. Figures included the main providers, subsidiaries, and mergers. The total contract funding received by individual organizations ranged from about $9 million to approximately $95 million over the decade. There were no AAPI or Native organizations that received contracts at this funding level.

For 2010 – 2019, Figure 14 indicates that 30 core organizations represent 5% of the total number of providers who were awarded contracts. Based on DHHS records, 570 organizations were awarded contracts. When comparing the number of contracts awarded to the core organization, they received 1,047 contracts or 10% of the contracts and $723,024,402 or 60% of the total contract awards.

Figure 14: Comparison of Core Organizations to other Contracted Organizations (2010 -2019



Having a core group of providers offers continuity of service and the opportunity for DHHS staff to form strong relationships with a small group of providers. While there may be over 100 organizations in a provider network, many organizations may not be awarded. Several DHHS confirmed that once a provider is awarded a contract in the network, it is unusual for the provider to lose the contract. Thus, the providers can form long-term, significant funding relationships with DHHS division staff and, over time, become an organization a division prefers

to fund. Conversely, this relationship can foster a sense of entitlement where the provider's leadership feels indispensable, exerts political pressure to influence DHHS staff, and resists attempts to hold their organization accountable for the service quality, contract performance, reporting, and outcomes.

Given these factors, it is understandable that some view the system as one where a core group of organizations receives preferential treatment, which, in turn, prevents other organizations – especially organizations of color – from fully participating in the DHHS contracting system.

The analysis of the contracts awarded from 2010 – 2019 indicate the following:

1. Many contracts, specifically those under $100,000, are awarded in a non-competitive process where staff can make discretionary contract award decisions.
2. A small percentage (5%) of providers receive a large percentage of the DHHS contracts.
3. The number of contracts awarded by DHHS has decreased over the last decade while the funding has significantly increased, creating a highly competitive environment for providers.
4. While the high use of Fee for Service Agreements may increase the department's ability to manage its financial resources effectively, it can adversely affect the ability of small non-profits of color to function in the system.
5. While long-term relationships between DHHS staff and provider organizations are a natural part of business, there is the possibility that a preference for maintaining these relationships could result in biased treatment of these primarily White-led organizations.

The DHHS Contracting System: The Means To An End

This evaluation of the DHHS procurement processes and the contracting system is fueled by DHHS leadership's intent to do more than purchase services and partner with provider organizations. The intent is to have a major impact on the lives of participants, on the quality of life in Milwaukee County communities, and to decrease social determinants of health that adversely impact residents and the environment.

A DHHS management staff indicated the department's agenda is to make a huge shift from a heavy focus on outputs, the number of surveys taken, and the number of participants served. Rather DHHS is modifying performance measures to transition to a focus on achieving meaningful, long-range outcomes, incorporating culturally responsive care, and establishing a new set of contract deliverables for serving participants. The department will link this transition to population health issues to resolve social determinants of health.

However. a review of the DHHS 2020 Annual Report focuses on activities and outputs rather than outcomes. Divisions generated high-quality outputs. In the Disabilities Services Division, enrollment in the Children's Long-Term Support Waiver program increased by 200 children, and the Disability Resource Center hit a record of 209 individuals enrolled in publicly funded Long-Term Care.

DYFS achieved an approximately 57% reduction in the daily census of youth in the Detention Center, which is the fewest Milwaukee County youth committed to youth corrections in its history and a 76% reduction in the average daily population since January of 2016.

The Milwaukee County Housing Division prevented more than 1,700 evictions, with 81 percent being African American households. By implementing additional efficiencies, the Housing Division increased the number of leaseholders in Section 8 to 1,925 households, the most households served in the program over the past ten years.

Wisconsin Home Energy Assistance Program (WHEAP) served 62,028 customers, distributing over $4 million in regular benefits. 10,774 WHEAP customers received crisis benefits in addition to the regular benefits, which stabilized their utilities and prevented disconnection.

In 2020 BHD focused on racial equity in their efforts to address SDOH through access to programs and supports: 1) Analysis and expansion of the racial, geographic, and linguistic demographics of the provider network, 2) Participation in Racial Equity Ambassadors, and 3) the creation of collaboratively developed racial equity and inclusivity training. The effectiveness of implementing these activities, the level of staff bias, and the ability to maintain momentum are critical factors that impact whether these actions will result in systems changes that eliminate racial inequity.

The challenge for the department is to transform from a heavy focus on activities and outputs to outcomes. This could maximize the power of contracting with provider organizations, increase racial equity in the contracting system, and improve the lives of Milwaukee County residents by eliminating racism as a critical public health issue.

KEY PERCEPTIONS REGARDING RACIAL EQUITY

In previous sections, we have included feedback of DHHS staff and providers regarding the procurement and contracting processes. Their comments highlight concerns regarding 1) The need for fair, objective, and consistent processes. 2) The absence of inclusion of BIPOC providers, and 3) The absence or inconsistency of accountability.

The perspectives that staff and providers communicated in the interviews confirm the need for but the absence of racial equity in the DHHS contracting system. Four themes are discussed below.

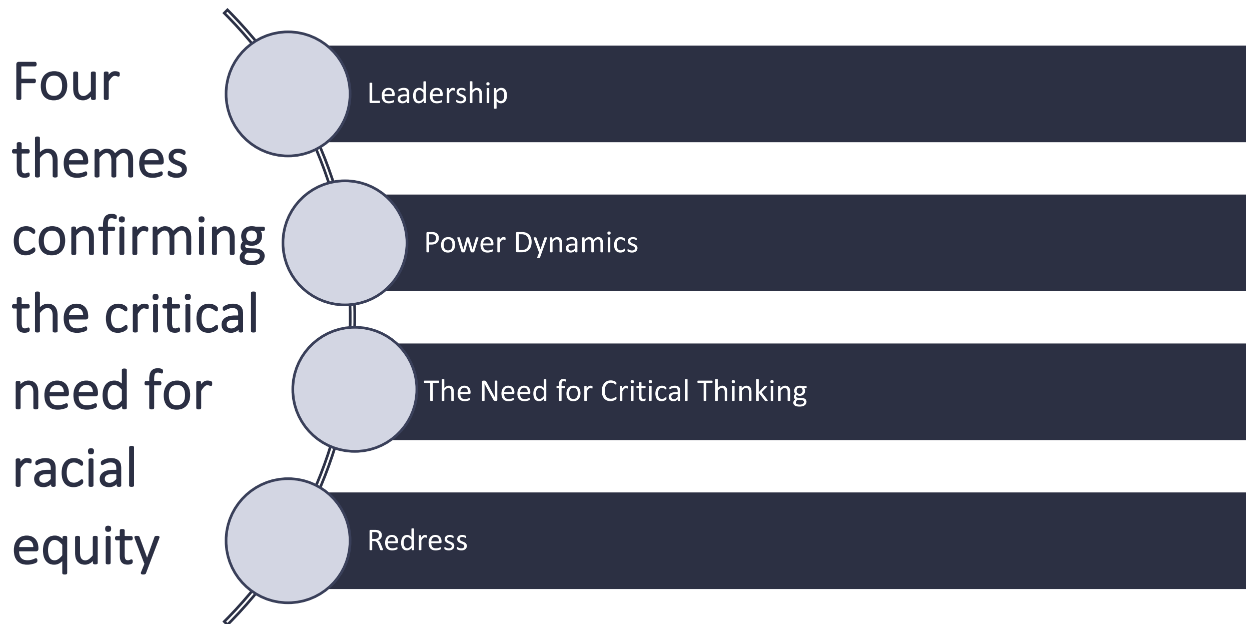


Chart 15: The Commitment of DHHS Leadership to Racial Equity	
BIPOC Providers	★★★★★
White Providers	★★★★★

Many of the interviewed individuals 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 positive change or movement were going to occur, it would 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 were various comments on the current and past leadership in DHHS, specifically as it related to the topic of securing racial equity in the contracting process. Many of the responses from all levels confirmed that evaluating racial equity in contracting was a proactive process because the contracting process seemed to need revision.

Chart 16: Importance of Racial Equity in DHHS Contracting	
BIPOC Providers	★★★★★
White Providers	★★★★

Regarding the importance of racial equity in the DHHS contracting system, almost every provider indicated that racial equity was very important. However, one White provider did not completely embrace the need for racial equity, rating its importance as "nice but not necessary." This individual said, "I guess nice but not necessary, but it depends how that happens …I think it is important … I am trying to figure out whether it is a minority agency or not … how does a new player become a player/a provider if they have not done something before, if the[contract] weighting is on previous experience."

This comment illustrates the challenge of changing the norms, biases, and use of power that are ingrained into American society. The comment also raises the issue of whether the government has a responsibility to right the wrongs of its own creation, to deconstruct patterns of oppression that structural racism has perpetuated for centuries. Rather than use a deficit model, implementation of an asset model benefits efforts to transform systems, practices, and people. The deficit model has been used to view BIPOC as having deficiencies, in being broken, and in need of being fixed while rewarding Whites for their benevolence. The asset model focuses on the strengths, celebrates the past successes, and emphasizes the positive attributes of BIPOCs and their communities.

When one reviews the feedback from providers, it is easy to assume that most providers welcome racial equity. Before this can be assumed, there are a few factors to consider that may cast a different light on the issue. While all providers indicated that they provided excellent, quality services and employed staff who exhibited excellent ability to connect with participants, some, specifically, White providers indicated that they were not as diverse in governance, executive and management leadership, and, at times, lacked sufficient diversity in front line staff. These realities seem to conflict with an organization's ability to achieve racial equity and could promote a belief that demographic change and diverse representation is not needed to effectively serve BIPOC participants. If so, this would reinforce old perspectives and the continuation of a White-centered, racially inequitable system.

Further, evidence of concern, is the fact that as some executives of provider organizations indicated, many front-line staff cannot support their families on the pay they receive for the direct services they provide to participants and are often forced to work two jobs to make ends meet. The fact that many White led providers tend to locate their main headquarters outside of the central city where many BIPOC live coupled with the fact that many Board members and executives live in more affluent suburbs and counties can foster the question about how then does leadership gain sufficient knowledge, understanding, and respect for residents who do not look like them, do not have the same culture, or life experiences. The question that persists is

not about the quality of services and ability of staff to connect in most situations. The specific question is regarding the quality of services and ability of staff to connect to BIPOC participants when a provider organization lacks adequate BIPOC representation in governance and leadership roles, is not culturally competent, and has little connection with a diverse population that is different from them in many social, cultural, and economic dimensions.

The Power Dynamic

Several individuals were uncomfortable speaking up consistently about issues of racial equity and inclusion. Some BIPOC department staff and providers felt that their words were not taken seriously or were often met with silence. Others expressed concern 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 perspectives outside the norms for White behavior – sent a subtle but powerful message that speaking up or out could place one's career, organization, or livelihood in jeopardy.

One person expressed their discomfort at a recent meeting. 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 voices of those speaking up for more equity and inclusion, explicitly supporting the voices of Black and Brown men and women.

In addition to the deficiencies in the contracting system, BIPOC providers identify another critical factor that impacts their ability to navigate the system and effectively compete - entrenched insider networks. One African American provider termed it the "good ole boys' network." Other providers acknowledged there was what some call "The Family" – White providers and government staff who have developed friendly professional relationships. This cohesive group of insiders may belong to the same social networks, have interacted for years, and respect each other. This should be harmless but, in one of the most segregated counties in the nation, BIPOC providers often feel excluded from "the club" and "the Family" and believe their ability is diminished because of such exclusion.

The issues of being Black, Indigenous, or other persons of color and "knowing your place" in a White dominant society that determines who is worthy of opportunity and assigns value based on race, influences the way BIPOC participate in the DHHS contracting system. Understanding how different racial lenses shape perspectives and expectations can help understand why some aspects of these systems have become so entrenched.

Most White nonprofit leaders praised BHD for being cooperative; nonprofit leaders of color held a different view of BHD. One nonprofit leader of color talked about the fact that she had thought she had a good relationship with BHD staff, but when she spoke out and expressed concerns, she learned a lesson. As one leader of color indicated their awareness of these subtle modes of exclusion, "A force (unspoken) is if you make too much noise, you pay a price."

While White nonprofit leaders and a black leader criticized DYFS as difficult to work with, a division staff member suggested that some providers have a sense of entitlement and privilege and want to dictate the way things will operate.

In discussing the ease or difficulty in working with DHHS, a leader of color indicated that "It depends on which contract administrator you work with."

While White nonprofit leaders may feel entitled, many leaders of color feel powerless. A White leader who does significant business with the County said, "Whenever I have a concern, I just call up DHHS staff." This was not something BIPOC providers generally did. For example, a provider of color indicated that "If I say something, I'm gonna get punished for that. Don't push so hard; you'll lose the contract. Feel like you are targeted, under the microscope." Another provider of color said, "I regret not appealing a contract, but I was scared."

An African American provider indicated they felt that connections were important, saying that "for the County and the City, you have to be connected to get a contract. Some organizations get funding even if they don't deliver outcomes and even if clients complain."

Another African American provider indicated that "Some people say, 'I ain't bidding on the contract cause they gonna give it to whomever they want.'"

One nonprofit leader indicated that the "Interview process provides DHHS with a way to move away from the scoring process to award contracts to favored organization."

The Need for Critical Thinking

There was discussion about DHHS needed to be more intentional, to consider new innovative ideas and to use a different lens to understand different perspectives. 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.

Another issue that reinforces the need for critical thinking is the idea that large organizations that receive government contracts deliver quality services and those BIPOC organizations that struggle to receive contracts deliver poor quality services. A DHHS staff shared how "a small minority owned organization received a $10,000 contract and served more people than any of

the other providers even the larger organization that had received a $200,000 contract to provide the same services."

There was concern expressed that the DHHS staff's efforts at community engagement and education were superficial gestures intended to fulfill federal funding requirements rather than build relationships with communities and BIPOC providers. The concern was expressed that community engagement needed to be more than "handing out stuff, giving away tickets and focus more on less glamourous but more substantive things."

Redress

The theme of redress – ways to correct unfair situations – was met with mixed results. Several interviewees discussed remedies to increase equity in contracting by race and gender. However, there were mixed feelings on whether this solution would have public or political support. One of the interviewees eloquently stated a rationale for redress:

> *When you look at the strengths and challenges of Milwaukee County, which list us at the top of a list we do not want to be a part, such as the most segregated, highest incarceration, health equity issues, challenges of school achievement . . . One of the ways that those statistics improve, government . . . DHHS… engages and includes people of all types of diversity in order to serve the community. And it has to be intentional --- real and perceived systemic issues makes it harder for organizations that are new, or perhaps minority or women-led or veteran-led, to break into a relationship with the government --- the size and scope of Milwaukee County . . . Systemic realities might make it harder so, for example, a larger organization like ours might have to provide less so that others (smaller agencies) can provide more services . . .*

In conclusion, many of the interviewees were eager to support improvements in the contracting process, have ongoing discussions about racial equity in contracting, and want to move to a better space of inclusion with all providers.

RESEARCH FINDINGS

Our research resulted in the identification of these key findings.

1. **DHHS Opportunity for Significant Impact**

DHHS is a part of a county government that has acknowledged racism as a public health issue. While the department can be credited for its current efforts to reduce racial equity, it must also recognize its role in perpetuating systemic and social inequities.

The prevalence of social determinants of health remains high in Milwaukee County communities of color, reflecting long-term, systemic racism. DHHS must clearly define its role as a leader in resolving these issues and working across public health, juvenile justice, criminal justice, and other systems that impact the SDoH. While many challenges exist, DHHS can significantly impact its internal operations, DHHS staff, provider organizations, and most importantly, County residents, participants, and communities.

2. **Maintenance of Systems of Power Based on White Privilege**

Even though DHHS has BIPOC leadership, a system of power exists which advantages Whites within the procurement and contracting system, as evidenced by the demographics of DHHS staff and provider staff. As previously discussed, both groups have a preponderance of Whites in leadership roles on management teams, supervisory roles, and boards. Some of the staff/providers live in adjacent counties, which may distance them from the urgency of the issues impacting Milwaukee County residents, specifically BIPOC residents. This is not meant to be offensive, but the use of a racial equity lens promotes discussing realities in terms of race and ethnicity. Historically, nationally, and locally, a system of power that advantages White people with authority to solve issues that primarily affect BIPOC has been implemented, validated, and maintained as a natural part of the institutional and societal practice. This imbalance of power is a root cause of the sustainability of racial inequity.

3. **Disproportionality in DHHS Contracting System**

African Americans are disproportionately represented as participants in the social service, juvenile justice, and criminal justice systems. BIPOC providers are underutilized in the DHHS contracting system.

Chart 17: Population Percentages for County, DHHS, and Core Providers			
	County Population	**DHHS Participants**	**DHHS Core Providers**
African American	27%	65%	27%
Latinx	16%	6%	10%
White	51%	24%	63%

This results in a system that does not rely heavily on BIPOC providers as central or valuable in the provision of support and service to BIPOC participants. This undermines ethnic traditions of self-help, collectivism, interdependence, unity, and community service, fundamental values of BIPOC communities. The concepts of "I am my brother's keeper" and "giving back to the community" are valued responsibilities in BIPOC communities. DHHS does not demonstrate respect for these community values.

4. Contracting System Issues as Barriers to BIPOC Providers

Based on observations, interviews, archival, and descriptive data, past systemic organizational changes have not proven to be an approach that has generated significant gains in the utilization of BIPOC providers or the reduction of social determinants of health. There are many issues ingrained in the DHHS contracting system that makes racial equity difficult to attain at this time. Some of those issues include:

a. Reliance on a small group of core organizations reflects a service delivery landscape dominated primarily by White providers and fosters a power dynamic that is counter to achieving racial equity.
b. The use of fewer contracts with larger monetary awards has made DHHS a highly competitive environment but not an inclusive, equitable one.
c. Providers have not been held accountable for achieving substantive outcomes; outputs are acceptable as performance measures.
d. DHHS has made a minimal investment in cultivating a more diverse provider base. Without intentional effort and a quality strategy, the current system will be maintained and serve as a barrier to achieving racial equity.
e. Contract opportunities are not clearly communicated to BIPOC providers or communities. Heavy reliance on mainstream media, digital communications, and DHHS staff's professional relationships and networks are not designed to effectively inform BIPOC providers about contract opportunities.
f. The Request for Proposal process is cumbersome and flawed by inconsistencies. Improvements could be made in the RFP application, in the diversity of panels, and in the scoring rubric. Some of these changes are being made in response to the work of the DHHS Work Group.
g. Provider Networks have short application timeframes, one month in the summer, which is not conducive to soliciting greater BIPOC provider participation unless concerted efforts are undertaken to inform these providers of potential opportunities and requirements. Also, the process of making participant referrals has the potential for bias toward some vendors and preferential treatment of others.
h. Fee for service reporting and data collection requirements and lack of guaranteed funding present challenges for many BIPOC providers

i. DHHS has not demonstrated maximization of diverse staff and their connection to the community. More innovative, culturally responsive services, like the DYFS Credible Messenger Program, should be an integral part of DHHS services.

j. Reliance on participant surveys and the evaluation of providers based on their achievement of outputs is not a quality strategy for ensuring participation satisfaction or long-term impact on the lives of participants or in their communities.

5. Lack of Commitment to Cultural Competency

Discussions in the DHHS Work Group and in interviews confirm that the application of cultural competency criteria in scoring provider's proposals in the Request for Proposal process has been ineffective. The Work Group has taken actions to resolve this in the RFP process. However, in other competitive and non-competitive contracting processes, scoring or assessing a provider's cultural competency may not be a priority.

In the interviews, it was apparent that while White providers had good intentions, many had not achieved a high level of diversity or cultural competency in their organization, on their Board of Directors or their executive management teams. In fact, DHHS commitment must be more than just holding organizations accountable for training staff, but also in developing effective communication and skills that build trust between individuals from diverse backgrounds and creating organizational systems and policies that support culturally appropriate practices to meet the needs of diverse participants.

While DHHS identifies cultural competency as one of the primary variables for consideration in grading contracts, they have not been diligent in holding providers accountable for effectively addressing and resolving these issues. In fact, less than 30% of the providers submitted information requested by DHHS regarding the diversity of their Boards, management staff, and front-line staff. Thus, the DHHS promotion of cultural competency has not achieved its intended results.

6. Failure to Maximize Contracting with BIPOC Providers

We learned from the interviews about DHHS's lack of attention to eliminating barriers for BIPOC providers. For instance, the lack of administrative capacity and the high cost of insurance are routinely identified as barriers for BIPOC providers. However, DHHS has done little to address these issues and has failed to clearly communicate their intent to reduce these issues as barriers to participation in the contracting system. To some degree, it appears that some DHHS staff are comfortable in perpetuating the deficit model when assessing BIPOC providers. This provides DHHS with a rationale for the low participation of BIPOC providers but does not address systemic issues of racial inequity.

Increased utilization of providers of color that represent BIPOC communities must be viewed as a value and a priority. BIPOC providers bring a sense of inclusivity to participants as opposed to their feeling like outsiders. They connect with participants through shared experiences,

understanding of community needs, and a valuing of culture and community. They provide a respite from racism, the ability to build trust and respect quickly, and the potential for investing social and economic capital into the neighborhoods they serve.

Government's identification of minority-owned and women-owned businesses in government procurement and construction opportunities has proven useful for the growth of many BIPOC businesses. This same attention has not been given to the growth and development of BIPOC nonprofit providers in the provision of government services.

7. Perpetuation of Exclusion through Segregation and Marginalization

Milwaukee County has a history of segregation. DHHS must act intentionally when considering the location of facilities, effective communication strategies, and investment of funds to promote and value communities that are often viewed as only recipients of services and excluded from full participation in the opportunities of the County and society. Further, the DHHS's community engagement strategy employed in BIPOC communities has been called a "window dressing approach" that consists of free giveaways and superficial community events. DHHS must commit to substantive community engagement to increase understanding of key issues and foster a connection to BIPOC communities. The department should utilize staff, resident, and community expertise in designing service concepts, measuring effectiveness, and achieving outcomes. To achieve this, DHHS must be willing to share power with rather than maintain power over BIPOC communities.

8. Potential for a Polarized Environment regarding the Issues of Equity and Efficiency

In the interviews, BIPOC providers discussed their commitment to provide quality services, maintain positive staff-participant relationships, and continuously improve their organizations. BIPOC staff at DHHS valued the innovation that BIPOC providers demonstrated in their service delivery to participants. Some White providers expressed empathy for BIPOC organizations because they lacked administrative capacity. This deficiency was the main characteristic White providers identified about BIPOC providers. A polarized environment could arise if key stakeholders do not accept that racial equity and efficiency can both be achieved by DHHS. Staff and providers who have benefitted from the status quo could view the systems changes as detrimental to them rather than creating a win-win environment.

THE RACIAL EQUITY IMPLEMENTATION PLAN

The most pervasive health inequities stem from structural racism and historically discriminatory policies that limit Individual control over the circumstances that contribute to their socioeconomic status. Thus, DHHS must address social determinants of health (SDoH) through inclusive policy solutions. As a guiding principle for corrective policy-making that is fair and just, SDoH requires input from the very community members affected by systemic racial bias and insight from service providers who continually interact with these residents.

Our plan was developed to address the issues identified through our analysis of qualitative and quantitative data. To ground our work, we used the Government Alliance on Race and Equity (GARE) racial equity framework, which has guided the work of many communities throughout the country and provides the opportunities to participate in a learning community, share ideas, gain insights, and gauge progress. Initially, we were guided by the GARE Racial Equity Plan Process as identified below.

The Racial Equity Plan Process

This report showcases the results of our preparation, research and operational assessment, research findings, and plan development. The report was written to assess whether racial inequity exists in the DHHS contracting system, document specific issues, and compare data with perspectives of the diverse actors in the system. The plan presented in this report has been developed as a fluid document in which input from DHHS staff, leaders of provider organizations, Milwaukee County residents, and community partners can impact the plan design and implementation. This review and input process ensures that the plan can obtain buy-in, ownership, collaboration, and the support necessary for plan implementation to achieve quality outcomes that impact Milwaukee County.

In 2014, the Center for Social Inclusion and the Government Alliance on Race and Equity assessed national best practices in government that advance racial equity. These best practices suggest government entities successfully address inequity when employees and institutions normalize racial equity as a key value, operationalize equity via new policies and practices, and organize internally and with other institutions and stakeholder communities. So, across the country, best practices focus on these three goals: normalize, operationalize, and organize, as defined below.

- **Normalize**
  Establish racial equity as a key value by developing a shared understanding of central concepts across the entire jurisdiction and create a sense of urgency to make changes.

- **Organize**
  Build staff and organizational capacity, skills, and competencies through training. Simultaneously build infrastructure to support the work (e.g., internal teams focused on organizational change; external partnerships with other institutions and communities).
- **Operationalize**
  Put theory into action by developing a Racial Equity Action Plan and implementing new tools for decision making, measurement, and accountability (e.g., the Racial Equity Tool).

The following six strategies are part of the GARE theory of change and crucial for meeting equity goals. The chart below connects DHHS equity goals with the overarching goals to normalize, operationalize, and organize using the six proven strategies.

<table>
<tr><th colspan="3">Milwaukee County Department of Health and Human Services
Racial Equity Goals & Strategies</th></tr>
<tr><th>Equity Goals</th><th colspan="2">Overall Strategies</th></tr>
<tr><td rowspan="2">Equity Goal #1: Normalize
Infuse a norm of racial equity into all aspects of the DHHS</td><td>1</td><td>Use a racial equity framework: DHHS must articulate racial equity goals, identifies implicit and explicit biases, and disrupts individual, institutional, and structural racism.</td></tr>
<tr><td>2</td><td>Build organizational capacity: DHSS commits to the breadth and depth of institutional transformation to create lasting change. While the leadership of elected and key officials is critical, an infrastructure that creates racial equity experts in DHHS is essential.</td></tr>
<tr><td rowspan="2">Equity Goal #2: Operationalize
Manage a high functioning, equitable contracting system

Maintain racial equity in community engagement and outreach</td><td>3</td><td>Implement a racial equity lens: Past actions have created racial inequities; current practices sustain them. Implement strategies to change policies, programs, and practices that perpetuate inequities. New policies and programs must be constructed with a racial equity tool.</td></tr>
<tr><td>4</td><td>Be data-driven: Accurate measurement gauges the effectiveness of plan implementation: to measure the success of specific programmatic and policy changes and to develop baselines, set goals, and evaluate progress towards goals.</td></tr>
<tr><td>Equity Goal #3: Organize
Collaborate with communities in partnerships to address social determinants of health</td><td>5</td><td>Partner with other institutions and communities: While local and regional governments' racial equity work is necessary, it is not sufficient alone. DHHS must partner with residents, communities, and local institutions to achieve meaningful racial equity results.</td></tr>
</table>

		6	**Operate with urgency and accountability:** Urgency, public commitment, and accountability are essential to achieve timely outcomes. A climate of accountability requires clearly articulated plans with specific recommendations and identification of responsibilities.

The Plan

As a result of the research and analysis conducted in our evaluation of DHHS contract provision systems, we have developed the following action plan. This plan identifies more than 20 major areas of focus, recommendations, and actions. These recommendations form the basis for developing timelines, establishing accountability, identifying performance indicators, and promoting a racial equity lens to reimagine all aspects of the DHHS contracting system. The use of small workgroups within or across DHHS divisions can result in several groups working on different aspects of a plan simultaneously and reflect the urgency needed to move the plan forward promptly.

GOAL 1: INFUSE RACIAL EQUITY INTO ALL ASPECTS OF DHHS		
DHHS Structural Barriers		
Major Focus	**Recommendations**	**Key Actions**
Ownership of and support for the plan	Gain buy-in from County leadership, governance authority, Division's advisory committees, staff, providers, and community leaders.	DHHS Leadership, Kairo Communications make presentations and engage in discussions with leadership, staff, and community groups.
Racial Equity Education	Connect education with plan implementation to help staff actively employ racial equity ideas and values in their transformational work.	Work with the Milwaukee County Office of African American Affairs; utilize GARE and other resources (e.g., Racial Equity Tool).
Division Restructuring	Eliminate siloed divisions with different contract requirements, technology, and processes.	DHHS Leadership
Workforce Diversification	Proactively increase diverse staff hiring and promotion to reflect the population of Milwaukee County and, specifically, recipients of DHHS services.	Participation of DHHS Leadership, Management, Milwaukee County Human Resources Department.
Segregation and Disinvestment	Mitigate the adverse effect of disinvestment. Address the historical and current impact	Identify opportunities for DHHS and providers to locate facilities in communities of

	of segregation in communities of color. Identify opportunities to invest resources into these neighborhoods proactively.	color; increase utilization of providers located in communities of color.
Information Management	Improve data management; assess data capacity and identify data that support plan implementation.	Utilize meaningful data to track outcomes and foster quality decision-making.
Outcomes, Measurement, and Accountability		
Major Focus	**Recommendations**	**Key Actions**
Key Racial Equity Indicators	Develop key indicators for semi-annual measurement of progress in achieving racial equity in contracting.	Work with DHHS quality assurance and data management staff to implement a tracking system.
Staff Performance Evaluations	Include specific racial equity goals in performance evaluations of staff and leadership.	Work with County Human Resources Department. Gain DHHS staff buy-in.
Service Outcomes	Increase transparency in reporting service outcomes rather than outputs.	Communicate progress in annual reports; use other forums to report outcomes (e.g., culturally appropriate community meetings).
GOAL 2: OPERATE A HIGH FUNCTIONING, EQUITABLE CONTRACTING SYSTEM		
DHHS Contracting System		
Major Focus	**Recommendations**	**Key Actions**
Contract Opportunities	Utilize culturally appropriate approaches to inform providers of color of contracting opportunities.	Create and implement a strategy to inform providers of and communities of color of contract opportunities. Publish RFP postings in ethnic newspapers, not just with mainstream media. List FAQs.
RFP Process Improvements	Reduce redundancy and bias in RFP application processes.	Incorporate recommendations of Racial Equity Work Group; engage County Procurement Director; use diverse short-term provider workgroup.

Appeal Process Improvements	Incorporate best practices for the appeals process in a fair and timely manner; ensure consistency and transparency.	Collaborate with Milwaukee County Purchasing Department. Utilize an inter-divisional work team.
Contract Management	Review and revise, when appropriate, contract requirements regarding DHHS approval of provider hiring decisions, immunizations, quality assurance, etc.	Utilize diverse short-term provider workgroups. Work with Milwaukee County Risk Manager and Human Resources Department, when appropriate. Identify federal requirements related to these issues.
Compensation of Providers' Front-line Staff	Review DHHS policies and rules that affect providers' compensation of front-line staff to ensure support for family-supporting wages.	Small workgroup of providers to outline their concerns for consideration by DHHS leadership.
Provider Network	Review provider network practices, including annual application period, continuity of long-time network providers, and provider evaluation process to increase racial equity.	Small workgroup of key DHHS staff.
Fee for Service Practices	Assess Fee for Service practices regarding case referrals; proposal process to decrease the financial burden on providers.	Utilize diverse short-term provider workgroups.
Informal Contracts	Implement innovative strategies to utilize informal contracts ($100,000 or less) to develop opportunities for diverse providers.	A Small workgroup of key DHHS Division staff, DHHS leadership, County Procurement Director, and Legal Counsel.
Appeal Process Practices	Increase transparency, clarity, communication, and DHHS adherence to timelines and rules.	Small workgroup of DHHS staff. Work with Milwaukee County Procurement Director.
Innovative Services & Delivery		
Major Focus	**Recommendations**	**Key Actions**
Service Delivery Innovation	Create innovative, culturally competent services based on	Replicate the concept of Credible Messenger Program.

	traditions, culture, and values of communities of color. Initiate a pilot program to test and learn.	Utilize a workgroup of staff, providers, participants, and community stakeholders.
Business Support Services		
Major Focus	**Recommendations**	**Key Actions**
Business Support Services	Evaluate the feasibility of Milwaukee County providing business support services (e.g., loan program) to nonprofit providers similar to those offered for minority-owned businesses (MBEs).	Collaborate with County Community Business Development Partners (CBDP). Also, assess other compliance support available from CBDP regarding workforce diversity.

While Goals 1 and 2 focus on the DHHS infrastructure and contracting systems, Goal 3 focuses on strengthening relationships between DHHS and Milwaukee County communities of color.

GOAL 3: MAINTAIN RACIAL EQUITY IN COMMUNITY ENGAGEMENT AND OUTREACH		
Community Engagement		
Major Focus	**Recommendations**	**Actions**
DHHS Community Presence	Increase DHHS community presence in diverse communities.	Support initiatives that create opportunities for investments in communities of color; provide small grants that engage residents and providers in group work that impacts social determinants of health. Ensure community representation includes Asian American and Native American communities.
Community Engagement	Increase DHHS community presence through outreach activities that connect with the needs and cultures of diverse communities.	Engage community representatives to identify culturally competent community engagement and outreach efforts.
Community Outreach	Implement culturally relevant outreach strategies. Use culturally relevant media outlets and platforms (e.g., ethnic newspapers, radio, social media accounts)	Create a small workgroup of communication experts representing diverse communities to educate DHHS staff about outreach in communities of color.

Community Access to Information	Ensure residents can access information about the department and its services promptly.	Create a user-friendly, online tool/presence to provide information about DHHS, Divisions, and services.

Goal 4 focuses on maximizing the collective impact that can be realized through quality community partnerships and collaborations. This goal addresses short-term issues but is focused on resolving long-term, systemic, and upstream challenges.

GOAL 4: COLLABORATE WITH COMMUNITY PARTNERS TO ADDRESS SOCIAL DETERMINANTS OF HEALTH		
Community Collaborations		
Major Focus	**Recommendations**	**Actions**
Social Development of Health Determinants	Create a strategy to address social determinants of health more effectively.	Convene key community stakeholders and institutions to develop a public health approach to create solutions to racial inequity.
Community Experts and Resources	Expand DHHS staff knowledge of the assets and resources in communities of color.	Develop community resource guides to identify assets and resources; engage with experts in communities to inform DHHS decisions, participate in review panels, and partner on key initiatives. Identify the vast yet latent talents and resources respected and valued in communities of color yet underutilized in mainstream society.
Provider Development	Implement a coordinated provider development program to support existing providers. Support pilot programs to test and learn.	Create initiative to provide organizational assessments, improve administrative capacity, service delivery, and cultural competency. Conduct asset mapping of diverse communities' provider capacity.
Development of a Workforce Pipeline	Create an equity-oriented mechanism to serve as a pipeline for meeting existing and future workforce needs and to increase	Implement a workforce development program to increase the knowledge and skill of people of color to increase diversity in nontraditional human service occupations. Collaborate

	employment and leadership opportunities for people of color.	with healthcare and educational institutions to increase the available talent pool for staff and leadership roles.

Working with DHHS leadership and an Implementation Team, Kairo Communications would appreciate the opportunity to serve as a project manager to facilitate plan implementation. Effective implementation can dismantle structural barriers that impede racial equity and strengthen the community's ability to address social determinants of health.

These recommendations provide the foundation for reimagining and transforming DHHS. Staff buy-in is essential; provider and community buy-in is critical as well. Implementation of key parts of a plan can be supported by involving the following:

1. Milwaukee County staff including Lamont Robinson, Director of Community Business Development Partner; Jeff Roman, Director of Office of African American Affairs; Megan Rogers, Director of Risk Management; and Patrick Lee, Procurement Director.
2. Several leaders of organizations that participate in the contracting system can add valuable expertise, specifically regarding the Request for Proposal processes, the Fee for Service contracts, and in addressing barriers to doing business with DHHS. This collaboration can strengthen DHHS-provider relationships. An effective method to gain their expertise in a short timeframe would be through small workgroups. Input regarding the issues identified in their interviews would increase the efficiency of implementing meaningful and lasting change. Including providers who were not interviewed can add value as well.
3. Engagement with residents, participants, and advocates can be valuable regarding specific issues that impact participants and communities.
4. Leaders of community organizations can play an integral role in implementing the recommendations identified in Goal #4: Collaborate with community partners to address social determinants of health to understand the excellent and abundant assets and resources in communities of color throughout Milwaukee County.

It is critical that DHHS staff are an integral part of plan implementation, setting realistic timelines and meaningful performance measures, upholding accountability, and supporting positive racial equity outcomes.

CONCLUSION: A CALL To ACTION

While the evaluation is complete and the report is finalized, much of this work has just begun. Working to transform a department takes courage, the willingness to be vulnerable and open to criticism, the drive to seek excellence, and the audacity to take bold and innovative actions. It could be easier in some ways to maintain the status quo and keep the bias buried deep in the contracting system. After all, the system has benefited some while marginalizing "the others," those groups often devalued by mainstream, White society. The unlevel playing field has been constructed and supported by policies, practices, and those in power for so long that many believe the field is level. This is systemic racism – invisible to those who benefit most. Discussions about bias and racism, calls for fairness and justice, have too often been discounted or ignored. After all, the American government is based on the maintenance of power dynamics that support and validate White power structures and the myth of White supremacy.

The Kairo Communications team is grateful to DHHS leadership for their commitment to ensuring that their department, which so many people depend upon for services and support, functions at a highly efficient level for all. That is what racial equity is all about! We thank County and DHHS staff and providers who provided us with their openness about issues, who demonstrated their commitment to providing quality services to Milwaukee County residents, and whose life and professional experiences often provided them with the motivation to do good work. But racial equity is a new topic of discussion for many, one that generates fear and hesitation and sometimes creates resentment and resistance to change. Conversations about race without placing blame while focusing on creating positive, long denied, and transformative change are still difficult discussions. Cultivating a team of staff, providers, and community members who step beyond their skepticism and apprehension to do the heavy lifting of righting the wrongs of history to achieve racial equality is a daunting task.

As the Center for Assessment and Policy Development states, "Racial equity is the condition that would be achieved if one's racial identity no longer predicted, in a statistical sense, how one fares. When we use the term, we are thinking about racial equity as one part of racial justice, and thus we also include work to address root causes of inequities, not just their manifestation. This includes the elimination of policies, practices, attitudes and cultural messages that reinforce differential outcomes by race or fail to eliminate them."

Racial equity is the goal of this report. Not to change the dynamics so that a different group is privileged or receives preferential treatment because of their race or ethnicity. Racial equity means that the injustices and barriers ingrained into White dominant culture, and the biases held by individuals, are precluded from marginalizing and penalizing individuals based on race. Racial equity results in equitable distribution of resources and opportunities. The playing field does not level off after a few months of equal treatment. This is long-term work; there is much that needs doing. In a blog post on Medium, Richard Leong wrote that "Driving equity and justice isn't about tinkering with systems that just ended up being imbalanced, it's about dismantling oppressive systems that are working exactly as they were designed."

Our evaluation of DHHS contract provisioning systems identified many issues. This is a good thing! It is better to find and change structural barriers than hide them or ignore them once they are known. Identifying these critical issues provides opportunities to create significant, positive, transformational, and sustainable change. We identified long-standing concerns embedded in policies and practices supported intentionally or not by staff working to follow the rules and work within an institutionalized, racist system.

But we know that commitment, good intentions, and great ideas are only part of the elements necessary for ensuring change. Action, urgency, and accountability are also required. To that end, we have provided a series of recommendations and specific actions that, if implemented and sustained with intention and integrity, generate solutions to strengthen partnerships and cultivate an environment where racial equity is valued and accepted as a natural part of Milwaukee County culture. This is not a report or plan to be put on a shelf but rather a document that should be used to balance power, right wrongs, and bring about healing and justice for all citizens of Milwaukee County.

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2020 DHHS Contract Tracker
2020 RFP – RFI Schedule
Accessibility
Additional Disclosures and Certifications
Appeals
Appeal Letters
Audit services division Fraud Hotline
BHD Contract Appeal Policy Procedure
BHD Open Enrollment Process2020 RFP Notifications
Center for Assessment and Policy Development.
Certified Audit or Financial Statement
Certification Statement – Debarment and Suspension
Civil Rights Compliance Review 2010
Community Support Program Award Letter

Contract Data 2010 – 2019
Contracted Agency Site Information/ Update Form
Department of Health and Human Services Documents:
Detox Award Letter
DHHS Acronym List
DHHS Contracting Information
DHHS Contract Overview
DHHS Organization Charts
DHHS Demographics: Race-Ethnicity by Division & Programs
DHHS Demographics. Race-Ethnicity
Emergency Management Plan
Employee Hours- Related Organization Disclosure
Equal Opportunity Policy
Excerpts Taken from BHD Purchasing & Procurement Policy
Experience Assessment for Agency Leadership
Experience Assessment for Agency
Intent to Award Contract Letter – Peer Run Respite Program
Intent to Award Contract Letter – Compliance Consultant
Intent to Award Contract Letter - Notice of Incomplete Submission of Proposal
Licenses and Certificates
Linked Budget Forms
Major Process Changes Last Five Years
Minority Majority Report
Non-receipt of Annual Evaluation Reports
Notice of Contract Award
Office of Consumer Peer Specialist Award Letter
Performance-Based Data: BHD, DSD, DYFS, and HD
Program Evaluations
Program Logic Model
Program Mission Statement
Program Narrative
Promotion of Cultural Competence
Proposal Summary Sheet
Provider Proposal Site Information
RFP Master Spreadsheet
RFP Notifications
RFP Tracker
Shelter Consensus Meeting
Staffing Plan
Staffing Requirements
Technical RFP Scoring Training