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COUNCIL OF THE CITY OF PHILADELPHIA
COMMITTEE OF THE WHOLE PUBLIC HEARING

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Room 400 City Hall, Philadelphia, PA
Monday, March 31, 2008, 10:15 a.m.

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Bill 080154 - An ordinance to adopt a Capital Program for six Fiscal Years 1009-20014, inclusive.

Bill 080155 - An ordinance to adopt a Fiscal 2009 Capital Budget.
Bill 080156 - An ordinance adopting the Operating Budget for Fiscal Year 2009

Bill 080173 - A resoolution providing for the approval of a Revised Five-Year Financial Plan for the City of Philadelphia.

Committee Members Present:
Anna C. Verna, Chair
Marian B. Tasco, Co-Chair
Jannie L. Blackwell
Blondell Reynolds Brown
Darrell L. Clarke
Bill Green
William K. Greenlee
Jack Kelly
James F. Kenney

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COUNCIL PRESIDENT VERNA: Good morning, everyone. This is a continued public hearing of the Committee of the Whole regarding Bill No.'s 080154, 080155, 080156, and 080173.

And the first department to testify this morning will be the Health Department.

(Witnesses come forward.)

COUNCIL PRESIDENT VERNA: Good morning.

DR. SCHWARZ: Good morning.

COUNCIL PRESIDENT VERNA: Would you please identify yourself for the record and proceed with your testimony.

DR. SCHWARZ: Good morning, President Verna and members of Council. I'm Donald Schwarz, the Health Commissioner. With me today is Carmen Lemmo, Deputy Commissioner for Financial Administration. Thank you for the opportunity to present the Department of Health Operating Budget request for Fiscal Year 2009.

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The FY '09 budget supports significant efforts by the Department of Public Health to address two of the mayor's six result areas: Healthy and sustainable communities and better customer service and higher-performing government.

The Fiscal Year '09 Department of Health Budget request totals $201,823,211. Of this total, about 122 million is in the General Fund and 80,129,327 is in the Grants Fund. Of the total budget, 26 percent, or 52.5 million, comes from City tax-supported funds. The Fiscal Year '09 General Fund budget represents an increase of $3 million over the Fiscal Year '08 estimated obligations.

The department's Fiscal Year '09 budget will support 1,008 full-time positions: 757 in the General Fund and 251 in the Grants Fund. This represents an increase of ten full-time positions over the

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number of positions in the Fiscal Year '08 adopted budget, an increase of 62 full-time General Fund positions over the Fiscal Year '08 target budget level. The additional positions will serve as an investment in the department that will allow us to enhance the public health services we provide in improved customer service in several areas of the department.

I would like to highlight the program areas that will receive portions of the additional Fiscal Year '09 funding.

The largest portion of the increase will be directed toward the provision of care in our health centers, allowing us to increase staffing in the health center system by 41 people. This additional staff will include a range of medical and technical professionals and support persons who will use this staff to help us move toward our

customer-service goals of shortening the time it takes to schedule an initial clinic appoint and reducing the time it takes to obtain a prescription in the health center pharmacies. Reaching our ultimate goals of shortening the appointment scheduling time to 30 days and filling proscriptions in one day will require significant financial resources.

To further improve delivery of the services at the health centers, we are also working toward instituting an electronic medical records system that will include a state-of-the-art interactive system for patient registration, appointment-scheduling, laboratory testing and reporting, and prescription services at our pharmacies.

Improvements in our Food Safety Program will allow us to make the Philadelphia community safer while improving the service we provide to

the business community we regulate. The additional support in the budget will allow us to hire two additional sanitarians.

This will permit us to increase the frequency of food establishment inspections and shorten the time needed to respond to establishment operators requesting pre-opening, plan reviews, and facility inspections for approval of new licenses. Increasing the inspection frequency will help the department more toward full implementation of the risk-based inspection program for food establishments that we have been developing for nearly two years.

The efficient operation of the Office of the Medical Examiner is critical to both the City departments and agencies that depend on timely reporting and to the families needing the service of that office. I am

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pleased to announce that we have recently hired a new chief medical examiner, who will assume a position vacated nearly two years ago.

With the increased General Fund support, the Office of the Medical Examiner will hire an additional forensic pathologist, two forensic investigators, and a clerical support person. The additional staff will improve our response time to death-scene investigations and expedite the identification of decedents and notification of next of kin.

Lack of staff in this area frequently precludes timely preparation of autopsy reports for homicide cases, which adversely affects the justice system in their ability to bring charges against a criminal suspect. The increase in staffing will help us meet our goal of achieving a 90 percent completion rate

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of homicide autopsy reports within eight weeks.

The department's chronic disease prevention efforts address emerging public health issues related to obesity, diabetes, asthma, and tobacco use. While level funding for tobacco control programs will continue through Fiscal Year '09, a major funding source for chronic disease prevention, the Federal Steps to a Healthier U.S. Grant, will end across the country in September of 2008.

Of the $3 million increase in the department's Fiscal Year '09 General Fund, $300,000, or 10 percent, will be directed to chronic disease prevention efforts, including critical staff and the most effective outreach programs for small community-based organizations that focus on promoting healthy eating, physical activity, and improvements in the local built environment. These programs help

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prevent overweight and obesity, diabetes and asthma in high-risk populations.

A dearth of comprehensive policy and planning strength within the department has increasing negative consequences over the years. To reverse this trend, we are concurrently evaluating the scope of responsibilities for a health planning unit and the credentials of persons who can fill this critical need within the department.

A portion of the Fiscal Year '09 budget increase will allow us to hire two persons that will be dedicated to resource planning, policy development, and effective resource allocation at the executive level.

The department's human resources section, critical to all aspects of filling positions, will also receive funding to support the hiring of two positions to assist the

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department in overcoming the chronic obstacles to filling many vacancies in our civil service professional positions. The new human resources position will allow us to target recruitment networks, particularly for qualified minority candidates. They will also be responsible for heightening our visibility as an employer of choice and promoting additional changes to classification and pay structures needed to reduce the number of vacancies in the department to track and measure the numbers of hires, promotions, and so forth, and shorten the time needed to process internal promotions.

In most of the areas where the Fiscal Year '09 budget increases provide for additional hiring, savings to offset costs will be realized as we improve our capacity to reduce expenditures for overtime, which is used frequently to meet minimum

staffing levels.

In carrying out mission to protect and promote the health of all Philadelphians and provide a safety net for the most vulnerable, the Department of Public Health administers a wide range of essential services for our residents. I believe that the Fiscal Year '09 General Fund budget will allow the department to continue these programs and, with increases in these key operational areas, help us build a more healthy and sustainable Philadelphia community.

Thank you for the opportunity to present testimony today. I will be happy to answer questions at this time.

COUNCIL PRESIDENT VERNA: Thank you very much, Doctor.

I think on the outset, I ought to say that I am very pleased to hear this administration is going to move

forward and finally, finally hire the additional personnel that City Council had approved to your budget for the School District -- or, rather, the district health centers that the prior administration absolutely refused to spend.

With that being said, can you tell us what the waiting period is at this time for clinical appointments?

DR. SCHWARZ: I can. For adult initial visits, it is 55 days; that's down by five days from March of last year at this time.

For return visits, last year, the waiting time was 12 days; it's down now to two days.

COUNCIL PRESIDENT VERNA: I'm sorry? From 12...?

DR. SCHWARZ: From 12 to 2. And I'm happy to provide a table for you that has this information if that would be helpful to you.

For pediatrics, it's down from

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10 days last March to 9 days this March; for initial visits and for returns, down from 6 days last year to three days this year.

For dental visits, we've had difficulty recruiting dentists, as you've heard, so that the initial time for a dental visit has required 24 days from call to visit a year ago and is now up to 34 days, which we're trying very hard to address. We just have been completing interviews for dentists to improve the staffing in our dental practices.

Return visits have been about stable, at about 21 days to get an appointment, versus 20 days this year.

For prenatal care, last year, the initial visit waiting time was 29; it's 20 days this year. Return visits: 13 days last year and 10 days this year.

COUNCIL PRESIDENT VERNA: I know that in the past, we have heard

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consistently that not every district health center had the same waiting period. Some had to wait months for an appointment in some of the centers; and in others, you would wait maybe a month or a month-and-a-half.

Now, you're telling us that the initial clinical appointment will go to 30 days? How's that going to work out if they've been waiting for months in some of the centers?

DR. SCHWARZ: We know that -- the numbers I've given you are averages across the system, so there are health systems that have much longer waits, and there are health centers with shorter waits than that.

We're targeting with the dollars those health centers that have particularly longer waits. For instance Health Center 10 in the Northeast has been known for a long time to have long waits, and we will target with these dollars particularly

Health Center 10 to improve staffing there in order to reduce the waiting time for an appointment.

We've been particularly anxious to improve the facilities there, the staffing there for prenatal care, because, as you may have heard, access to prenatal care for those in the northeastern part of the City has been particularly problematic.

COUNCIL PRESIDENT VERNA: When do you anticipate that we would be able to work with all of the centers to have a 30-day waiting period?

DR. SCHWARZ: That is our goal. We will --

COUNCIL PRESIDENT VERNA: When do you anticipate your goal will be accomplished?

DR. SCHWARZ: I would like to tell you that we could do it by the end of the next fiscal year. I don't know -- the year 2010 fiscal year.

What we have in the budget

currently will not allow us to get to 30 days everywhere. We will approach it; it is the goal to do so.

One of the things that we are working on is looking at both efficiency in the centers and ways to do a better job in terms of particularly no-show appointment schedules.

COUNCIL PRESIDENT VERNA: Can you tell us what is needed to get there this year?

DR. SCHWARZ: An additional $1.1 million.

COUNCIL PRESIDENT VERNA: Thank you.

Commissioner, you state in your testimony that you will be able to fill prescriptions within one day. How are you able to do this and not increase your Class 200 Budget overall? Will you be cutting other services in order to fill prescriptions?

DR. SCHWARZ: Your concern has been my concern over the course of the last two months, since taking office.

What is clear is that we have positions that have been approved in the budget for pharmacists, but we've not been able to fill those positions.

COUNCIL PRESIDENT VERNA: May I ask why?

DR. SCHWARZ: There are a number of reasons. It's -- there's a shortage of pharmacists in general in the Philadelphia area, in ambulatory care. We've made an appeal, for instance, to all of the hospitals in the region to see if we can share employees. And to date, none of the hospitals have been able to come forward with an employee that they can share because, in virtually all cases, everyone is stretched to provide ambulatory hospital services, even at hospitals.

So we're working with the

pharmacy schools, we're making a major effort to recruit, but the issue is that there are few pharmacists who are not -- who are available to come to work.

We've looked at our salary structure, so we've gone back to increased salary for pharmacists to make us more competitive; we will continue to do that.

But recruitment is a serious issue, and one of the things that the H.R. Department and the Health Department is working on now is a more comprehensive strategy for recruitment.

COUNCIL PRESIDENT VERNA: Have you spoken to anyone at the College of Pharmacy?

DR. SCHWARZ: We have.

COUNCIL PRESIDENT VERNA: No success?

DR. SCHWARZ: Well, the -- every college has a graduating class

that ends its schooling in June, so we're hopeful.

COUNCIL PRESIDENT VERNA: Mm-hmm.

DR. SCHWARZ: But we don't have anything to report today.

COUNCIL PRESIDENT VERNA: What is the salary of a pharmacist that works for the Health Department?

DR. SCHWARZ: I will need to get you the precise number.

COUNCIL PRESIDENT VERNA: Thank you.

Commissioner, during the last few budget hearings, we have been told the lead in homes is continuing to be a problem. Can you tell us what, if anything, is being done to address this?

DR. SCHWARZ: I can. There are several issues related to lead in homes. Again, one of them is hiring, so there are vacancies within our current Childhood Lead Prevention

Poisoning Program.

We've targeted those particular ones and are prioritizing the hiring of people in that program. I'm hopeful that this will help.

But in addition, as you may know, federal funding through HUD grants expires this year. We are in the process of reapplying for those monies.

I am concerned that should we not be successful, we will be able to serve less children, and I think that will be a crisis, but we are putting every effort forward to successfully apply for those monies. We've been successful in the past.

And recent site visits have been very positive about our program and the quality of services that we provide, so I'm optimistic that we will able to fund ongoing abatement and cleanup work.

COUNCIL PRESIDENT VERNA: Can

you share with us what the backlog is?
DR. SCHWARZ: I can. There are approximately 260 properties that are waiting for risk assessment and about 70 properties that are waiting for further work after that assessment. There are about 300 homes that still need to be lead-safe.
And we're working hard to reduce that backlog. Part of the issue is staffing. Our current staff does overtime work, but even with that, we need to hire in order to be able to make a dent in that number.
COUNCIL PRESIDENT VERNA: Do you have the monies to hire?
DR. SCHWARZ: We have money in the current budget to hire and we're working to fill those positions. There's been --
COUNCIL PRESIDENT VERNA: There is an existing list, a civil service list, for those positions?
DR. SCHWARZ: There is an

existing list for some of the positions, and we're working on the list for the remainder.

COUNCIL PRESIDENT VERNA: I'll tell you, it seems like this one problem continues to exist no matter how hard we try to address it.

DR. SCHWARZ: I am optimistic that we will make progress in this year.

COUNCIL PRESIDENT VERNA: What is your appropriation for the lead abatement? What is the appropriation that you have in your budget presently, and how many properties would that amount of money be able to address?

DR. SCHWARZ: The appropriation is 8.2 million.

COUNCIL PRESIDENT VERNA: I'm sorry?

DR. SCHWARZ: 8.2 million.

COUNCIL PRESIDENT VERNA: Can you give us a rough estimate as to how much -- or how many homes that that

would be able to address?
DR. SCHWARZ: Six hundred homes.
COUNCIL PRESIDENT VERNA: So that would just address all of those homes that you mentioned earlier.
DR. SCHWARZ: It would.
COUNCIL PRESIDENT VERNA: The figures that you gave us?
DR. SCHWARZ: It would.
COUNCIL PRESIDENT VERNA: Mm-hmm. All right, Doctor, I just have a couple more questions 'cause I know all of my colleagues are eager to be heard.
Doctor, what initiatives will your department be taking to address our high rate of infant morality?
DR. SCHWARZ: We currently are engaged as, you know, in a number of initiatives related to infant morality. The issue about infant morality, per se, is that there is no one activity that can be undertaken to make a

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difference. Infant morality as a measure was developed to measure what happens to women's health, family health, and community health more generally; and as a result, things like poverty, nutrition, and major issues affect the infant morality rate.

Standard teaching is that prenatal care should make a difference to the infant morality rate, and it may to the first piece of infant morality, which is children who are born unhealthy.

One of the things that we're undertaking during this year will be the -- work toward establishing a registry for prenatal care. As you know, we're down to only eight centers in Philadelphia that deliver babies, and prenatal care is available at just those eight centers and one independent practice in the City.

One of the issues that's been identified by the obstetricians in a

working group on obstetrics in the City is that sharing information about prenatal care is very difficult at the moment, so that women from various parts of the City can go anywhere to deliver, and that may mean that a woman arrives at a hospital and there's no information from her prenatal care, which makes a difference to a healthy delivery.

The Health Department can provide, as we do now for immunization, prenatal care to providers by creating a Web-based registry, which is one thing that we're looking into now and hoping to establish over the course of this year. That would allow every delivery site to have accurate and up-to-date prenatal care and information on women, which will go some distance.

In addition, part of infant morality is death in the first year of life, and there are numbers of

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different things that have been identified to make a difference to death in the first year of life.

One of the problems that has been identified and, I believe, Council has had hearings about, is co-sleeping, for instance. We have a new medical examiner who is coming. He is expert in issues around infant death, and one of the things that we've talked about is how we can better target our efforts with DHS and the Health Department and others to the issues of co-sleeping. It's not a problem that's unique to Philadelphia, but I believe that we could come up with unique solutions.

One of the issues with co-sleeping that you've heard about is that many people co-sleep, and co-sleeping deaths are few in number, so I believe that we can better target risk factors for co-sleeping and make them known to people to try to reduce

the number of infants who die from co-sleeping.

And the other is continuing campaigns that are ongoing throughout the City around sudden unexplained infant death, for instance, and sleeping position and so forth.

So doing what public health does well in terms of getting messages out, identifying risk factors, and making sure that people are aware of them, I think, is the most that we will do and the most important work that we'll do in the next year around infant morality.

COUNCIL PRESIDENT VERNA: Thank you. I'll ask one more question and then recognize my colleagues.

Commissioner, please tell us what you think the physical condition of the City's health centers are. I know one in my district that is absolutely horrible.

DR. SCHWARZ: So the PICA Board

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undertook an evaluation of each of the City health-related properties so that I have estimates of the total required capital improvement, and we have estimates of what replacement would cost; it's much more cost-effective for the City to do capital improvement than to replace every one of the health centers.

So we have -- I can tell you by health center what we anticipate the overall cost is and what the total for capital improvement is. And I also have data on the priority-one total costs, which I'm happy to share.

They're in table forms; I can read them to you or I can share them with your office, whichever you would prefer.

COUNCIL PRESIDENT VERNA: If you would send me a copy of whatever you have there --

DR. SCHWARZ: I would be happy to.

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COUNCIL PRESIDENT VERNA: -- I would share it with my colleagues.

For sometime, it's been rumored that the center at Broad and Lombard been may be up for sale. What is the status of that?

DR. SCHWARZ: My understanding at the moment is that there were at the end of the last administration discussions with the -- with a nonprofit organization to purchase that property. I understand that the property was only purchased by the City on the 31st of December. Since that time --

COUNCIL PRESIDENT VERNA: I'm sorry. Repeat that, please.

DR. SCHWARZ: Up until that point, it was owned by a trust, and the trust agreement with the City said that the City had the right of first refusal; the City exercised that right and purchased the property, I believe, on the 31st of December.

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We are currently, as you may know, constantly aware of capital needs in that facility, so we are interested and we're working with Public Property to see if we can identify another site for the current inhabitants of that, which make up many of the programs of the Health Department. And I'm happy to keep you updated on the progress of that work.

COUNCIL PRESIDENT VERNA: I would appreciate it. Thank you.

And I see that we have some of our constituents here -- I'm surprised to see them -- with signs, "Night Hours For Health Clinics."

What are the hours that the health clinics are open?

DR. SCHWARZ: It varies by health center. So for Health Center No. 2, it also varies by day. That health center includes evening hours on Thursdays until 7:30, and it's open on Saturday from 8:00 a.m. until noon.

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At Healthy Center 3, on Mondays, the health center is open until 8 p.m., and there are no weekend hours at this time, but the waiting time for an appointment at Health Center 3 is significantly less than it is at a number of other centers.

Health Center 4 is open until 8 p.m. on Tuesday evenings.

Health Center 5 is open until 8 p.m. on Tuesday evenings.

Health Center 6 is open until 8 p.m. on Wednesday evenings.

Health Center 9 is open until 8 p.m. on Wednesday evenings.

And Health Center 10 is open until 8 p.m. on Wednesday evenings.

The Strawberry Mansion health center is open until 7:30 every other Thursday evening.

COUNCIL PRESIDENT VERNA: So just about every center is open one night a week.

DR. SCHWARZ: They are. One of

the ways that we hope to reduce waiting times is to increase evening hours. As you may imagine, there is some discussion about that because there are many people who, while evening hours may make sense, in dangerous neighborhoods, people may not feel comfortable coming out at night.

So this was a pilot program to make sure how things would go at those centers. In those centers where evening hours are filled, we will first target them for expansion.

COUNCIL PRESIDENT VERNA: Thank you.

And to our constituents that are here, I would just like to make a statement: I just feel very, very encouraged from what the doctor has said today. I think that this is the first time that we're finding that at least we're going to see quite a bit of improvements in the Health Department.

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And, Doctor, I want to thank you. I think -- I don't know you, but I think you're going to do a fantastic job.

DR. SCHWARZ: Thank you for your continuing advocacy.

COUNCIL PRESIDENT VERNA: Thank you.

The Chair recognizes Councilman Greenlee.

COUNCILMAN GREENLEE: Thank you, Madam President.

I want to echo what the Council President just said. You clearly see that the issue at health centers is one of our -- has been a priority at Council for a while, and we're glad to certainly see it's one of your priorities.

As I'm losing my voice, I might need the health center myself.

You mentioned specifically District 10, and I know it's an area we've heard a lot of complaints about.

I don't know if you've gotten into it at this point yet, but what seems the reason why there seems to be more of a backlog there? Is that the worse backlog it seems to be? And is it just pure volume? is there a particular staffing problem there?

DR. SCHWARZ: Health Center 10 is our busiest health center, and it serves the Greater Northeast, and that's an area with rapid population increase. It's an area where the population of those who are uninsured, including those who are undocumented, has increased fairly rapidly, so the need for services is high.

Keeping up with that has been difficult when the budget for the Health Department has generally been reduced year after year and filling positions has been difficult.

So with the increase in budget that we're requesting, Health Center 10 is a high priority for us to target

to expand staffing there, to fill staff positions, to increase hours, to improve prenatal care, and to reduce the waiting time.

COUNCILMAN GREENLEE: Okay, great.

And you mentioned the problem with dentists. Is that a salary issue, or is that why you're having problems with getting dentists, you know?

DR. SCHWARZ: It is a problem. It's a problem paying for them.

COUNCILMAN GREENLEE: Right. What is the -- do you know offhand what a dentist is paid by the --

DR. SCHWARZ: I don't have that.my colleague may.

(Dr. Schwarz consults off the record with some colleagues.)

DR. SCHWARZ: So the range that we have is about $74,000 to about $95,000.

COUNCILMAN GREENLEE: Mm-hmm.

And I guess compared to what other places can pay, that's kind of low, right? Okay.

If I could just jump to the Food Safety Program for a minute, you said that the two additional sanitarians will increase the frequency of food establishment inspections. What is the frequency now? And, again, ideally, what would you like to get?

DR. SCHWARZ: Okay. The change, which I think has been reported to Council in the past, is that we'd like to have a risk-based system.

COUNCILMAN GREENLEE: I'm sorry?

DR. SCHWARZ: A risk-based system.

COUNCILMAN GREENLEE: Okay.

DR. SCHWARZ: So that when we identify an establishment that has particularly difficult practices, we can increase the frequency of routine

inspection, not just coming back to see that they've done what they're supposed to for a given citation.

COUNCILMAN GREENLEE: Mm-hmm.

DR. SCHWARZ: But we actually can come back more frequently to inspect them on a regular basis.

The general practice in restaurant inspection nationally is not risk-based. There's a movement to create a scoring system for risk-based inspection,which we are implementing and will be a leader in the field in doing so. But what we need to do then is have the staffing to go back and inspect some establishments much more.

The official national plan has very frequent inspection, somewhat frequent inspection, and less frequent inspection. Less frequent inspection would be every two years.

We currently, for all establishments, have a standard of one year. We don't feel comfortable

reducing our standard to two years. At the same time, we feel that the highest-risk establishments should have frequent inspections.

So the goal of this budget is to get us to a two-tiered system, where we will have very frequent repeat inspections for those establishments that have high risk, and others will have the standard of a year at minimum.

COUNCILMAN GREENLEE: Is it also complaint-driven if people find problems at --

DR. SCHWARZ: Always, always.

COUNCILMAN GREENLEE: Is that something that you do a lot?

DR. SCHWARZ: We do some.

COUNCILMAN GREENLEE: Mm-hmm, okay. Have you found the problems increasing over time, or are restaurants more careful, are they more observant of the law, less? Is there any kind of a pattern that you see?

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DR. SCHWARZ: I think the answer is, they're getting more observant.

COUNCILMAN GREENLEE: More observant, okay.

DR. SCHWARZ: Our frequency of inspection has become greater.

COUNCILMAN GREENLEE: Mm-hmm.

DR. SCHWARZ: So it would make sense that more people are attentive to it.

COUNCILMAN GREENLEE: Okay, great. All right, thank you.

Thank you, Madam President.

COUNCIL PRESIDENT VERNA:

You're welcome.

The Chair recognizes Councilwoman Tasco.

COUNCILWOMAN TASCO: Thank you. Good morning and welcome.

DR. SCHWARZ: Good morning.

COUNCILWOMAN TASCO: We're very hopeful that we're going to see some changes in the Health Department.

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I just want to follow up on a couple of questions. Is it possible to contract with dentists who are practicing in the City as opposed to -- do you hire the dentists on staff; is that what you do?

DR. SCHWARZ: We do both, we do both.

COUNCILWOMAN TASCO: And you contract out?

DR. SCHWARZ: We do. Anywhere we can find a dentist who is willing to work with us, we find a way to hire them.

COUNCILWOMAN TASCO: What is the problem with -- in recruiting dentists to participate with the City?

DR. SCHWARZ: Salaries are a huge piece of this. The residency requirement here used to be, but my understanding is that we've gotten a waiver of the residency requirements, which has helped.

But simply finding people who

will work for the amount that we can pay is an issue.

COUNCILWOMAN TASCO: Mm-hmm. And you are looking at maybe changing the salary structure?

DR. SCHWARZ: We've worked with the Civil Service Commission on salary structures and will continue to do so, yes. It's for pharmacists as well and nurses positions.

COUNCILWOMAN TASCO: Let me just ask you a question about the prescription program. Again, you hire pharmacists to work in the health centers?

DR. SCHWARZ: We hire and we contract, both.

COUNCILWOMAN TASCO: And you contract. Is there a possibility, since I do believe City employees have to get their prescriptions filled at Rite Aid, right?

COUNCIL PRESIDENT VERNA: (Inaudible, off-mic.)

COUNCILWOMAN TASCO: Oh, really?

COUNCIL PRESIDENT VERNA: Most of us do go to Rite Aid.

COUNCILWOMAN TASCO: Since the City has these contractual relationships with these pharmacists, is there any way that we could explore working out a relationship with them to fill the prescriptions for our clients, our constituents?

DR. SCHWARZ: I've thought about that. Part of the issue is, if we do that, the issue is that they need to be willing to provide us the same people on a regular basis because our pharmacy system, in terms of the computer and so forth, will be different than their pharmacy system.

And having a rotation of people might sound good, but it won't provide good service within our pharmacies.

So I made an attempt with

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hospitals, 'cause I had the opportunity to challenge them to provide us with help that we would pay for it; we have money to pay.

COUNCILWOMAN TASCO: Mm-hmm.

DR. SCHWARZ: But they're quite short-staffed. I've heard rumors that the chain pharmacies as well have had difficulty with hiring, but I need to explore that.

COUNCILWOMAN TASCO: Mm-hmm. Some time ago when it -- well, let me ask this question: You're not timing this, are you?

How are -- what is the status of our building for individuals who come to the health center and who might have -- might be eligible for Medicaid? And are we doing an effective job of billing for those services that would help with our revenue?

DR. SCHWARZ: So there are two questions. One is, how well are we

identifying potential sources of health insurance for clients?

COUNCILWOMAN TASCO: Mm-hmm.

DR. SCHWARZ: The second is, if we identified that source, how well do we bill; is that right?

COUNCILWOMAN TASCO: Mm-hmm. Well, I guess the question is: Are we billing the State for the services that a client may be eligible for?

DR. SCHWARZ: We are absolutely billing for those services.

COUNCILWOMAN TASCO: Mm-hmm.

DR. SCHWARZ: The bigger issue is identifying folks who are eligible for insurance, which, from a public health point of view, goes beyond just our need to bill. It's better for the individual, if they're eligible for insurance, to have insurance.

COUNCILWOMAN TASCO: Mm-hmm.

DR. SCHWARZ: So we have had benefits counselors. We currently have three vacancies, which we've just

cleared the obstacles and will be filling at three health centers.

COUNCIL PRESIDENT VERNA: Some of our colleagues said they cannot hear. Would you pull the microphone closer? Thank you.

DR. SCHWARZ: I'm sorry.

We have filled vacancies -- or are in the process of filling vacancies at three health centers, where we have had not had benefits counselors. I'm hopeful that by -- certainly by the end of this fiscal year, we will have those positions filled.

But we track carefully the proportion of our clients who are insured and uninsured. We -- the policy in the Health Departments is for those who are uninsured to have a screen done by the provider roughly figuring out if this is someone who has income that wouldn't be eligible -- for instance, for medical

assistance -- and anyone possibly eligible to be referred to benefits counselors.

We are relooking at that process to make sure that we're being efficient and looking to track the portion of clients who actually get referred for benefits-counseling and then the yield on that benefits-counseling.

COUNCILWOMAN TASCO: Mm-hmm.

DR. SCHWARZ: I can say that when we look at the pediatric population, where we believe most children should be eligible, we have a high proportion of children who are not currently insured.

The issue there is the proportion of people in our health centers who are undocumented or the children of those who are undocumented. I believe we have a particularly high proportion, as we should, since otherwise, those

children wouldn't be served, of children who are undocumented, and that means that we will have a higher proportion of children compared to other places who are not insured, but we are working very hard to make sure, in fact, that that is the case.

But when people have insurance we are billing.

COUNCILWOMAN TASCO: Thank you very much.

Let me just ask you another question about the sanitarians. What other areas do they cover? They just don't cover -- inspect restaurants. What other areas do they inspect?

DR. SCHWARZ: The class sanitarian could do a number of different jobs, but in this case, we would be hiring people to do restaurant inspection for the restaurant and food control program.

COUNCILWOMAN TASCO: Mm-hmm. And that's all they would do?

DR. SCHWARZ: That would be it, yes.
COUNCILWOMAN TASCO: Okay. And you have other inspectors (inaudible; off-mic).
DR. SCHWARZ: No, we have inspectors and sanitarians, but they work in other -- the classification is used within environmental health.
COUNCILWOMAN TASCO: Mm-hmm.
DR. SCHWARZ: And there are a number of different things that we do under the auspice of environmental health, so there are sanitarians in a lot of -- in Vector Control, for instance. The rat control program has people who are inspectors and sanitarians.
But the people who we have targeted to hire are for the restaurants control, the food service program, in the Health Department, so that is the work they will do.
COUNCILWOMAN TASCO: When we

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had the hearings some years -- a couple of years back about the -- some of the restaurants in the communities, the Zoning Board was granting a license on variance to restaurants where the ventilation they were installing and proper ventilation; is that something that comes under the Health Department in terms of (in inaudible) but working with the zoning Board so they understand that there could be a health problem in the way they dispose of some of the materials they use in the restaurant, and also how the ventilation has an impact on the community, lack of proper ventilation.

DR. SCHWARZ: Let me ask my colleagues.

COUNCILWOMAN TASCO: Well, listen, you don't have to answer that now, but maybe it's something that you might want to follow through on with so that the Zoning Board may understand that granting those variances without

proper construction of the cooking process is a health hazard.

DR. SCHWARZ: Thank you.

COUNCILWOMAN TASCO: And not that we just don't want the take-out in the neighborhood, but the way they construct the ventilation system causes a lot of problems in the community. And also the disposal of some of the oils. So it's all tied in with the health of the -- of our community.

The other question I want to ask you is: Research shows exercise and sports are helpful in preventing and curing the systems of chronic diseases such as high blood pressure, obesity, and perhaps diabetes. I am glad to see that $300,000 of the '09 General Fund increase will be directed towards these issues.

Are there any plans to partner with the Recreation Department and Fairmount Park to encourage walking, exercises, and sports for

Philadelphians with these diseases?
DR. SCHWARZ: Yes.
COUNCILWOMAN TASCO: (Laughing.) What are you going to do.
DR. SCHWARZ: We currently are part of a coalition that is looking at two things. One is increasing exercise in communities through readily available means, and the other is increasing the availability of fresh fruits and vegetables in community grocery stores.
COUNCILWOMAN TASCO: Mm-hmm.
DR. SCHWARZ: But the first part of it will completely be, and is, a partnership among City agencies but also among non-City agencies, so private and community-based groups.
COUNCILWOMAN TASCO: Now, are you working with the School District to promote healthy life styles for our students?
DR. SCHWARZ: We certainly would like to.

COUNCILWOMAN TASCO: We'll soon be getting a new superintendent, so it might be a collaborative there.

Let's see. Some of my questions -- oh, let me just go back to the closing of the hospitals for OB-GYN services.

You weren't here and I wasn't around, but back in the '70s, when Philadelphia General Hospital was closed, there was -- of course, we had far more hospitals than we have today, but do you know, or does anyone in the Health Department know, whether or not there was an agreement with the local hospitals to provide the services that would have been provided had PGW [sic] not closed?

Is there a formal agreement? And if so, would that agreement cover and require these hospitals to provide those services?

DR. SCHWARZ: I don't know the answer to that. I am happy to look and

see what we can find.
COUNCILWOMAN TASCO: Mm-hmm.
DR. SCHWARZ: Part of the answer to your question will be in the wording of that agreement. My guess would be that it didn't specifically address obstetric services because there wasn't a specific problem with obstetric services at that time, but it's worth looking to see.
COUNCILWOMAN TASCO: Mm-hmm.
DR. SCHWARZ: My guess is that such an agreement -- because I've heard speak of it, but I have not seen it, so I don't want to say there is such an agreement -- may relate to accepting patients who would have gone to PGH, particularly for specialty service.
And if it's written in general terms, we can certainly work with the Law Department, should such an agreement exist, to see what we can do with it.
COUNCILWOMAN TASCO: Why are

these hospitals discontinuing the service?

DR. SCHWARZ: We've spoken with those institutions that continue to provide service. As folks here know, there was a question about one of them in particular, one of the eight remaining hospitals, within the last year-and-a-half. And the Health Department and private partners pulled together a group to work with the obstetric providers to ensure that we stabilize the existing net of eight hospitals.

The general feeling from those providers -- I've met with providers of obstetric services and I've talked to those hospitals. The general feeling is that the cost of malpractice is prohibitive and that reimbursement, particularly from insurance companies, including the State, doesn't cover the cost of malpractice.

COUNCILWOMAN TASCO: Is the malpractice higher for that service?

DR. SCHWARZ: Oh, the malpractice is specialty-based, and within the area of obstetrics and gynecology, it's different for those who are obstetricians versus those who are simply gynecologists.

So yes, the insurance is, in a sense, risk-based. And the insurance premiums for obstetricians have risen precipitously, particularly in the Philadelphia market, because of the high cost of settlements in the Philadelphia area.

And the hospitals say that it means that the -- their ability to break even on obstetric services is limited, and that's a problem.

COUNCILWOMAN TASCO: Is there a higher incidence of claims in that particular area than in other areas?

DR. SCHWARZ: I don't know the specific numbers, but the issue is the

magnitude of the settlements, and the size of the settlements is particularly large in this region.

COUNCILWOMAN TASCO: (Inaudible.) I'll retract that statement. I won't say it, I won't say it.

COUNCIL PRESIDENT VERNA: We didn't hear you.

COUNCILWOMAN TASCO: Okay. I think that's it.

DR. SCHWARZ: Thank you.

COUNCILWOMAN TASCO: Thank you very much.

COUNCIL PRESIDENT VERNA: The Chair recognizes Councilman Jones.

COUNCILMAN JONES: Thank you, Madam Chair.

Commissioner, first, thank you for attending the briefing held by Councilwoman Blondell Reynolds-Brown this morning talking about the CHIP Program and some of the issues related to recruitment of underemployed people

who do not take advantage of CHIP for their children, and your comments were well taken in bringing that issue to light. So thank you for attending that.

Could you give me a brief description of the type of profile of the patient that comes to a public Health Center?

DR. SCHWARZ: I can. So about 59 percent of the patients who come to the health centers are women.

COUNCILMAN JONES: Say that again.

DR. SCHWARZ: About 59 percent are women and 41 percent are men. About 24 percent of the patients are children or adolescents and 76 percent are adults.

Broken down by race and ethnicity, about 65 percent are African-American or black, about 12 percent are white, 11 percent are Latino or Hispanic, 6 percent are

Asian, and 6 percent other.
And I can tell you insurance information.
COUNCILMAN JONES: I would be more interested in their income.
DR. SCHWARZ: I don't know that we know that, but I can certainly find out and get back to you on that.
COUNCILMAN JONES: I think in light of the fact that the City has 24 percent people who live under the poverty guidelines that there would probably be a high percentage of those people that participate in public health centers as poor people.
And I say that to say that I will not burden you with the information again that the 4th Councilmatic District does not have a public health center, but I will ask you today that there are some 19 non-city primary-care centers in operation in the City of Philadelphia's neighborhoods. Where

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are those centers located?

DR. SCHWARZ: Councilman, I appreciate your attention to this, and I want you to know that I've been attentive to this question, and so I have for you a map of your Councilmatic District with the health centers that are not funded by the City but are available through federal funding to those without insurance.

You have two within your district.

COUNCILMAN JONES: Mm-hmm.

DR. SCHWARZ: One is the Spectrum Health Services Center and the other is the Family Practice and Counseling Network.

You also have the distinction of being the only Councilperson who has two medical schools in his district. Neither of those medical schools provide service within your district, though.

COUNCILMAN JONES: Yes.

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DR. SCHWARZ: So I thought I'd bring that to your attention.
COUNCILMAN JONES: Mm-hmm.
(Laughter.)
DR. SCHWARZ: We have also --
COUNCILMAN JONES: He gets it.
DR. SCHWARZ: We have also looked by census block at those folks who come to health centers, and we've tracked, based on census data, the portion of people who, we would anticipate, would be uninsured, so for every census block in the city.
And I can show you one that there is one area within your district that has a high rate of poverty and has folks who are uninsured and not coming for health care.
COUNCILMAN JONES: Where would that be?
DR. SCHWARZ: Those folks live --
COUNCILMAN JONES: Where would that be?

DR. SCHWARZ: I've got it, and I have a map for you to show you precisely.

COUNCILMAN JONES: Mm-hm, okay.

DR. SCHWARZ: Those folks live within twelve blocks of the Spectrum Health Services Center, which has capacity. And I think the issue isn't so much that they don't have access but they may not know about the center.

So we would be happy to help you to work with Spectrum Health to publicize the services that are available to those people with those blocks, and I want to make it available to your office, and I'm happy to do it for every City Councilperson.

COUNCILMAN JONES: I hope that every commissioner in this administration does the good work that you do. When a question is asked, eventually, eventually, there will be an answer. So I appreciate and look

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forward to working with you.

A couple of other questions. You mentioned the problem with prenatal care, high infant-morality rate, some of the issues related to reimbursement, and some of the issues related to the inability to get doctors insured.

Is it time for the City of Philadelphia to revisit a publicly owned hospital? PGW [sic] was in existence; in fact, many Philadelphians were born there, including myself.

And I wondered if we are at a economic point where we need to have a publicly-owned hospital here in Philadelphia?

DR. SCHWARZ: The -- I came from the private sector, the nonprofit private sector, and worked in a hospital for 22 years in Philadelphia and know the state of affairs, I think, a bit both in the City and nationally

around hospitals. The cost of investment in a hospital is extraordinary and the ongoing expense for that is equally extraordinary.

The issue of access to prenatal care is a complex one. There's both the cost side and the revenue side. The revenue issues are ones which principally the State needs to undertake, and we've been in conversation with the State about those. There are a number of things that the State can, do likely in partnership with the City actually, to improve the amount of dollars available to hospitals in the City, particularly those who deliver babies.

But on the expense side, there are a number of expenses that the OB Task -- the Obstetrics Task Force that the Health Department has worked to convene have identified, and we're going through them issue by issue to see if we can help reduce some of the

costs.

The chief cost that we're not going to be able work on in the City is malpractice insurance. However, we do have the ability to, if you will, spread out some of the costs for that under the auspice of the City, which, as you know, has a different liability arrangement than most other providers.

So one of the things we are looking at is whether the City can, under its umbrella in some way help with some of the liability issues and, therefore, assure that those people who need prenatal care can get it by using providers who are a part of the City network. So there are a number of pieces to that.

I'm happy to brief you or anyone else in your staff about those issues, but the Health Department, before I got here, had done excellent work, I think, in trying to form a partnership and identify those issues,

and we'll go forward with that.

COUNCILMAN JONES: Well, I'll accept that answer except for one notion: That the cost of a hospital is probably high; the cost to the citizens of not having a publicly-owned hospital is higher.

When we start talking about issues such as organ failure, kidney failure, it exceeds the death toll of gun violence in the City of Philadelphia, and these are silent killers that are affecting our communities.

And we need as our public health drum major maybe a feasibility study to kind of take that into account and start looking at what's really happening to the public out there that doesn't wind up on the front page of the Daily News because it's just someone's kidney that failed and they died of that mysterious cause.

So I would only caution that we probably don't truly know the cost of not having this facility and might want to engage some people that are a lot smarter than I to look at that. But that's something I'd like you to note.

DR. SCHWARZ: Thank you.

COUNCILMAN JONES: The other issue I have is, in your budget, you have 51 million for ambulatory service. When you say -- could you define that for me?

DR. SCHWARZ: That involves the amount that we spend on the City's district health centers.

COUNCILMAN JONES: So why do you call it "ambulatory service"?

DR. SCHWARZ: It's outpatient. We don't have a hospital, so the general word that people use is "ambulatory" --

COUNCILMAN JONES: So you don't have a hospital? We don't have a

hospital?
DR. SCHWARZ: That would be inpatient as opposed to ambulatory services, sir.
COUNCILMAN JONES: Okay, all right.
DR. SCHWARZ: It's just -- I think it's simply linguistic.
COUNCILMAN JONES: Okay. Have you ever considered telemedicine?
DR. SCHWARZ: I don't know if the City's ambulatory health network has. Part of the issue for that would be whether or not our clients have access to the equipment for telemedicine.
COUNCILMAN JONES: One of the notions that I'd like to put forth again for your consideration is that I believe that the future of publicly-owned facilities such as rec centers will be truly multipurpose centers, where a number of services are provided during different times of the day and

adapting those physical structures to meet the needs of the citizens.

And one such use might be the equipment necessary to do telemedicine, where, if we have a shortage of doctors, we can, through technology, plug people up and into machinery that can do certain types of examinations vis-a-vis telemedicine and something that is low-cost, high-yield by way of access to health care. It may even cut down on the time that it takes for a person to be seen at a public health center, and it might be a worthwhile investment.

Also, I think there are federal grants that might be available to fit out a multipurpose center, and it's something that I think we need to not be (indiscernible) with our health care delivery and be willing to go in different directions on trying to solve, cost-effectively solve, some of the challenges before us.

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Finally, this whole debate about universal health care, every candidate is talking about it in some form or fashion. Has there been any thought to what that means for public health in the City of Philadelphia? And if you could give me your vision of that.

DR. SCHWARZ: There most certainly has been more than discussions so that -- and you may know that this Council helped pass a Charter change that assures that we move toward universal access for people in Philadelphia.

There's a task force that's been working with the Health Department on that, and we're serious about figuring out how to assure that all Philadelphians have access to care.

I think in terms of vision, it's a partnership. So the public sector needs to do some things; I

think the private sector as well needs to do things, and it sounds like you agree with that.

COUNCILMAN JONES: Yes.

DR. SCHWARZ: Identifying how to target those particular services so that our partners within the private sector meet the needs in the City with us so that it's seamless for real people; they can go where they need to go, and we can help facilitate that in an efficient way is a high priority.

One of the things we need to do is make sure people have access; hence, we're investing in the health centers and will continue to invest in the health centers so that people who need have access will have a place to go.

But once they come in, if people have a problem, the next step in this is assuring that they have access, for instance, to specialty care or to diagnostic care. And we're

currently looking at that; we're looking at both the existing City contracts with universities and hospitals that pay for specialty care to see if we can do a better job in managing those dollars and improving access.

We're also looking at pharmacy services that we provide and assuring that people can get prescriptions is in a timely fashion. And one of the big issues there, as I mentioned is hiring so that we have enough pharmacists.

COUNCILMAN JONES: Okay. Commissioner, I just want to encourage you to continue that work. Too often when, finally, the federal government decides to do something about a problem, the only thing that's developed is a cottage industry by the private sector then to take advantage of it, after ignoring it for decades.

So what I would like you to do

is make sure that the City of Philadelphia, the 24 percent of the folk that fall below that poverty guideline, take advantage of any health care at the federal level, that it trickles down truly to them.

Finally, the most expensive thing in the world is being poor; we pay more for everything, you know, whether it's insurance or other commodities, by virtue of the fact that we are poor.

I noted in your testimony that you are looking at the fact that because of high interest rates, because of predatory lending and other monthly obligations, that people are choosing between having utilities on. And I note that you note that, and I'm particularly encouraged by that, looking at that outside of the box as a health hazard.

So I wanted to applaud you on that. I read that and underscored it

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and wanted to say it publicly for the record.

DR. SCHWARZ: Thank you.

COUNCILMAN JONES: Thank you. Thank you Madam Chair.

COUNCIL PRESIDENT VERNA: You're welcome.

The Chair recognizes Councilman Green.

COUNCILMAN GREEN: Thank you, Madam Chair.

Good morning, Mr. Lemmo and Dr. Schwarz. I want to echo those of my colleagues that congratulated you on the appointment that you have and say that the professionalism and expertise that you're bringing to the position gives us hope for the Health Department. So thank you for your willingness to serve the citizens of Philadelphia.

I'm going to follow up on two points raised by the questions on my colleagues that relate to some of

questions I have and then get in my own questions.

In your answer to Councilman Jones, you mentioned that the City's unique malpractice structure compared private industry. One of my questions was going to be:

Do employees, doctors, health professionals, whether they are employed -- in the Health Department, whether they're employees or consultants, do they have sovereign immunity?

DR. SCHWARZ: I can't answer your question directly; I can find the answer for you.

Mostly it's my own lack of knowledge about the specifics of the City's malpractice or liability coverage, and I don't want to misspeak.

COUNCILMAN GREEN: Well, what I would like to suggest is if the City -- if an employee of the Health Department

or a contractor of the Health Department has sovereign immunity for performing medical services -- in other words, the limit are 250 or 500 max on anything that they do, that we look at creating a serious joint-venture partnership with all of the emergency rooms and hospitals delivering children in the City of Philadelphia and perhaps look at opening up some of those that have closed and staffing them with, quote/unquote, City employees, where the doctors can make what they were making in the private sector. We are just the overall employer and, therefore, we severely limit the potential for malpractice.

If we have to lease space in the hospitals or become the operator of the emergency rooms in the City or the operator of the obstetrics wards, or whatever the case is, that we look at taking our sovereign immunity and blanketing the, you know, people

providing services in the City.
And if you could get back to us about the possibility of that.
DR. SCHWARZ: I can tell you I think I now better understand the term and the question.
That is something that we are currently exploring around obstetric services, particularly prenatal-care services.
The question of whether or not there is a protection of a site where we would contract to provide services is one that I think is still open. So, in general, in a malpractice case, all parties are subpoenaed and all parties are named. And if one party has limited liability, the other parties generally are pursued.
COUNCILMAN GREEN: So perhaps we can look at some closed facilities where they used to provide these services or other things where -- maybe not a new hospital, but a hospital

focusing on delivery or emergency services or other things, where we can own the facility; or perhaps we can own the facility and lease departments to lease the non-obstetrics and emergency services departments back to the nonprofits or the hospital on a sale lease-back type situation.

There's ways to take everybody else out of the line of liability and to severely decrease the potential for awards that should make the malpractice insurers, you know, happy.

It's a long-term plan, but it's something that I think we need to look at in the City of Philadelphia, given what's happening to our -- has happened, and is happening, to emergency rooms and obstetric-service provision.

Is there a problem competing with these federally-funded places like Spectrum? I mean, in terms of people who have insurance or can be

reimbursed with, you know, through these federally-funded operations like Spectrum and then leaving the City of Philadelphia Health Department with the people who are uninsured? Do you have -- is there a problem in the marketplace with respect to that, or is...

DR. SCHWARZ: We collaborate with the other health centers through the Health Federation of Philadelphia. We meet with them frequently. I think we share problems and issues.

There are uninsured people who go to those federally-qualified and federally-funded health centers. The City district health centers are federally-qualified, and so the reimbursement structure is, in many ways, similar.

But I've not heard particular discussion about competition in that way. You're sort of asking about adverse selection.

COUNCILMAN GREEN: I am. In other words, they show up there and then they're found to be uninsured or not reimbursable, and they're told to go see the City Health Department.

DR. SCHWARZ: Yeah. I can certainly look into those issues more specifically. It may be difficult to nail that down, but I hear your point.

COUNCILMAN GREEN: Do you have intake questionnaires when people come in?

DR. SCHWARZ: We generally have questions that are asked routinely, as in any health facility, but I don't know that that question is a part of it. We could certainly ask that question.

COUNCILMAN GREEN: The question, I guess, would be: Were you referred to this facility from another, you know, place?

DR. SCHWARZ: Mm-hmm.

COUNCILMAN GREEN: In terms of

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your testimony, you referenced chronic obstacles to filling many vacancies in our civil service professional positions. I would ask you, what actions can City Council take to change the law with regard to salaries or with regard to more exempt positions, et cetera, that can help you alleviate that problem so that you're, for example, with dentists, maybe not having to negotiate with the Civil Service Commission, but you have the relief you need more quickly and directly from this body.

And if you don't have an answer to that question today, if you could get back to the Chair with what we can do to make your job of getting, you know, health delivery to citizens more efficiently and quickly, I'm sure we would all be very pleased to assist you in that effort.

DR. SCHWARZ: Thank you.

COUNCILMAN GREEN: How many of

the public Health Department's employees are appointed by the Mayor and/or Managing Directors versus employees appointed via Civil Service; do you have any sense?

DR. SCHWARZ: Are you specifically asking about the ambulatory health centers or the whole Health Department?

COUNCILMAN GREEN: The whole Health Departments. Just how many -- in other words, are you using the MDO's office or other places to get exempt employees down into the operations of the Health Department?

DR. SCHWARZ: We think there are about six or seven FTE's. Part of the issue is, it also works the other way so that Health Department personnel also work -- for instance, are deployed to health and opportunity to help share on particular issues, but the number is small.

COUNCILMAN GREEN: Okay. If

you could just get back to the Chair with that information.

DR. SCHWARZ: Mm-hmm.

COUNCILMAN JONES: I note in the administration's Five-Year Plan, it mention that DPH will study the implementation of an electronic medical records system to ensure the efficient delivery of high-quality health care and to enable all departments and agencies to enter pertinent information directly into an electronic system that can then shared by the appropriate providers. The Commissioner will create a task force to review operations and health plan for a new EMR.

DR. SCHWARZ: Mm-hmm.

COUNCILMAN GREEN: I understand that, actually, the last administration did an assessment analysis of this and made recommendations in terms of the implementation of a system, and I'm just wondering if you can talk to us

about where that stands.

DR. SCHWARZ: I can. That implementation suggests that we need somewhere over $2 million in the next fiscal year and about $3 million in the fiscal year after that in order to implement what I would call "a comprehensive electronic medical record" across areas in the Health Department, so not just in the ambulatory health service, but also for prison health.

And we're moving to the next step with that, which is, we're doing a survey of existing capacity, which is what's required ultimately for implementation.

And we're stepping back a bit. Having looked through that plan and having worked in my previous employment a fair amount of electronic medical records, there are different ways to implement electronic records.

There is one that's generally

pushed by the industry that makes electronic records, and there's one that relates to the experience of many providers in the use of electronic records, so thinking about a staged approach, which would allow us to get most of the functionality of a record, an electronic record. It would allow us to share the kind of information we need to share, but it wouldn't provide either the complete expense, nor would it put the burden that is often associated with using electronic medical records on our providers, who are already pretty burdened, to keep up with numbers.

So we're trying to look at a phased-in approach, which will, I think, be both less expensive and more effective in the long run for both prison health and ambulatory services.

COUNCILMAN GREEN: When you say that electronic records burden providers, I don't understand that.

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Any implementation of an electronic medical record system should be purely electronic. Was the proposed system to keep paper records and electronic records?

DR. SCHWARZ: No. The issue is the amount of effort required to do complete electronic documentation of what would be called "the physician or nurse practitioner notes."

So there are a lot of pieces to an electronic record: There's a registration system, a scheduling system, a billing system, a pharmacy system, a laboratory system. There's the documentation of allergies and patient-safety information and the documentation of diagnoses and ordering of tests.

And then on top of that, there's the written text that a physician or nurse practitioner completes on each patient.

COUNCILMAN GREEN: Right.

DR. SCHWARZ: The heavy lifting for the providers in an electronic records system is that which is now currently handwritten documentation, which is actually pretty quick and efficient for most providers on paper, and takes additional time that often is done off-hours, so weekends and evenings in using that kind of record. And also the change in the culture around use of electronic records.

If we have scheduling, billing, laboratory, pharmacy, allergy, patient safety, and so forth information that's available to a provider on every patient, that goes a very long way in allowing that provider to manage that patient's care.

Looking at the text of the last provider's record is very incremental in that. And yet it is the use -- it is the heavy step in provider time in adjusting to an

electronic record.

COUNCILMAN GREEN: I come -- I don't know if you know I come from the software industry; I was CEO of a software company.

And I guess I don't agree because you could take an iPhone and you could literally write the record on it and it could be a part of the file. You could take a -- I can't remember what the new Microsoft computers are called that have -- allow you to write handwritten notes right in them.

There are many PDA's and other devices -- HP makes them, et cetera -- that allow you to simply write on a screen and it's stored as a text, but also, in combination with OCR technology, allows actual searching of that data.

It takes no more time to write on a -- one of those handheld devices than it does to write on a piece of

paper. And then we're eliminating all of the back-office work that is associated with keeping track of that paper, filing that paper, pulling that paper out, et cetera.

DR. SCHWARZ: We're in agreement on that. The issue is the state of affairs in terms of health technology for doing that and doing the rest of the record and what will happen in terms of the change in the health centers if we do it all at once.

The history across the country, I think we might agree, is when that culture you is done in a one-step fashion, what happens is, there's both a certain degree of chaos but there's also a burden placed on providers who have to change every part of their process, not just the documentation part, per se.

And all that I'm saying is that we do it in a two-stage process instead of a one-stage process.

COUNCILMAN GREEN: Okay.
DR. SCHWARZ: So we are going toward the same place, but we're doing it in a way that allows the whole system where we have facility issues, we have hardware issues, we have staffing issues, we have union-position issues, we have a bunch of things that will all -- and paper-management issues that will all be affected simply by creating electronic registration, scheduling, and so forth down the line all at once. And then we do a second-stage implementation of the transfer of medical documentation from the record.
But we're going to the place that I think you're indicating we should go; it's just that instead of doing it in a one-step way, which is what the assessment was focused toward, we're doing it in a two-step process.
COUNCILMAN GREEN: Okay.

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That's great. So you'll have time to re-engineer your work flow processes in connection with going totally paperless prior to the implementation.

DR. SCHWARZ: That is precisely correct.

COUNCILMAN GREEN: And do you have any estimate of the efficiencies that will be gained in Step 1 and Step 2 in terms of savings?

DR. SCHWARZ: The principal efficiency in Step 1 is going to be around billing, particularly pharmacy billing, which currently is a multi-step process because there's no connection between the pharmacy system and the current billing for the health centers; everything is done manually.

And I think we'll see improvements in patient flow with an integrated scheduling registration and so forth system. So those are the principal efficiency.

The efficiency around record

management is one that I've pushed back to have a reassessment, because part of the issue is that we receive a fair amount still of paper-related records.

So subspecialty records, when we send out patients and get them back, are done on paper. And unless we can assure that our vendors, or our subspecialties who we work with, will be able to deliver us an electronic product paper, we're still going to have to maintain a record room and paper records.

So the incremental savings that would ordinarily come from a paperless system we won't get for a period of time because so many of those who surround us still use paper.

COUNCILMAN GREEN: Can we have an open system with an STK, which will allow offices that we communicate with to participate in our paperless system?

DR. SCHWARZ: We most certainly

can if they're prepared to prepare things electronically, or that we invest in scanning, for instance.

COUNCILMAN GREEN: Right. And so I guess my question is, are we looking at whether or not paying for our providers to be paperless or providing them some extra money to -- incentive to do that in Year One will save the system overall, the health care system overall, a lot of money?

I mean, every study I've seen on going truly paperless in the medical records business has tremendous efficiencies associated with that.

DR. SCHWARZ: We're in agreement on that issue.

COUNCILMAN GREEN: Okay.

DR. SCHWARZ: That was not a part of the initial assessment but needs to be.

COUNCILMAN GREEN: And then if you could -- if you do get that

information or if you could figure out that information, let us know.

Also, one of the big problems in going truly paperless, I understand, can be insurance companies, who prefer a slow paper system because it allows them to hold their cash for a longer period of time; you know, 30 days versus instant reimbursement, that sort of thing.

Are you -- have you -- does your system contemplate forcing our insurance providers that the City pays big money to go paperless with us?

DR. SCHWARZ: Most of the insurance providers must have that capability based on now federal and insurance regs, so that's possible.

COUNCILMAN GREEN: Okay.

DR. SCHWARZ: And we should be able to do that.

COUNCILMAN GREEN: Thank you. I have just a few more quick questions.

Is there a coordinated effort

to seek research funding from NIH, CDC, and other sources within the Health Department?

DR. SCHWARZ: There is not at the moment.

COUNCILMAN GREEN: Is that something that you've put in this budget?

DR. SCHWARZ: That is the Planning Office that you see. So my intent is to begin, in the Commissioner's office, with an office that would look at just those issues, how can we better, identify, coordinate, and so forth, applications.

COUNCILMAN GREEN: That's terrific.

Is -- and that would also -- the Planning Office would also coordinate efforts to partner with local research hospitals, medical schools, et cetera, in terms of joint studies?

DR. SCHWARZ: We do a fair

amount of that now.
COUNCILMAN GREEN: Okay.
DR. SCHWARZ: But there's not central coordination.
COUNCILMAN GREEN: Finally, you're department has Budget Detail Section 39, Page 121, $54,760 for lobbying services, the same amount spent as in FY '08, with vendors to be determined.
Is there any reason why this lobbying is not run through the Mayor's Office, which has requested 400,000 in lobbying services in FY '09?
DR. SCHWARZ: This is a tithe to the Managing Director's Office that's paid for across departments, as I understand it, so that the lobbying is actually done centrally, but the cost is dispersed, each department is charged.
COUNCILMAN GREEN: So this is lobbying in addition to the lobbying

budget in the Mayor's Office, because it would not be in the budget twice; is that correct.

DR. SCHWARZ: I don't know the answer to that, but we could certainly ask the Budget Bureau.

COUNCILMAN GREEN: Okay. And it's your understanding that all of the departments include funding for lobbying in their budgets?

DR. SCHWARZ: I don't know that across departments. I can tell that that's the explanation of that line item in the health budget.

COUNCILMAN GREEN: I haven't seen it before, that's all.

With respect to your capital budget, you mentioned the PICA report. Can you tell us --

DR. SCHWARZ: We have an answer to your last question, I think.

(Witness comes forward.)

COUNCILMAN GREEN: Hey, Steve.

Yeah, there's a -- I think the

first two categories are work that need to be performed immediately and then work that should be performed within the first year.

What is the dollar-amount required under the PICA report for Items 1 and 2, and what is the Capital Budget that you've been allocated?

MR. AGOSTINI: Madam President, Councilmember Green, the PICA items ones and twos for the Health Department break into the following category: I think it's approximately 1.6 million for Prior 1 Items, 7.4 million for Priority 2 Items. What we have currently, I think, is about 1.3 million for funding of Priority 1 items in the Capital Budget.

The Capital Planning Office is in the process of assessing those, just as they have done with Police and Fire. We are hoping to sit down with PICA at one point -- at some point in the near future to go over that, but

that's what we have allocated. And our hope is to get the Priority 1's done quickly.

As I understand it right now, the CPO has a fairly high confidence level that the Priority 1's are, indeed, Priority 1 items in terms of life, health safety issues.

For the Police and Fire, part of the process of review has been to assess whether those are, indeed, Priority 1, sort of life-safety issues, and that process is almost complete.

COUNCILMAN GREEN: And Priority 2 also as the recommendation is the first year, so the capital budget for Year 1 for the Health Department, is that 1.3 million?

MR. AGOSTINI: It's 1.3 to deal with the Priority 1's of the 1.6 million and about 7.4 million in Priority 2's, and the --

COUNCILMAN GREEN: I'm sorry.

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That's the PICA report?
MR. AGOSTINI: Yes.
COUNCILMAN GREEN: Is that what's in the -- what's in the Capital Budget for ---
MR. AGOSTINI: 1.3 million.
COUNCILMAN GREEN: For the --
(Indiscernible; parties talking over each other.)
COUNCILMAN GREEN: -- and when PICA recommends 8.6 million for the first year?
MR. AGOSTINI: Councilmember, we've had this sort of running discussion. And I would tell you, having spent a number of hours, probably a half a dozen hours, in the last week or so, in part, because you've prompted me with questions.
I think we need to be very careful about the assessments on the Prior 2's. Not all of them fit into the same category, and I would love to sit with you or any other

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Councilmember to go through in detail with the Capital Planning Office to understand.

In some cases, what you have are visual inspections of situations where someone says, Okay, that light is out. That might be a Priority 2 or a Priority 3; when, in reality, what is out is, you have an electrical system in a building that's over 40 years old that wiring cannot support existing electrical appliances, existing lighting, the kind of load-bearing that, I think, all of us take for granted because we live in fairly updated buildings or in residences.

And when you look at those assessments, we have to sort of keep in mind that a lot of it was visual inspection, they didn't go and tear out walls to go in and see what was behind the wall, that the Priority 1's and 2's are ones that we are trying to

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get on because the sort of criticality of those, and we're trying to fund them.

But, you know, as with everything else here, there are trade-offs and there are priorities. And, sure, if we had the dollars, we would set aside as much as we could for all of these things, but it's a question of balancing and making choices.

COUNCILMAN GREEN: Sure, it is a question of priorities and, you know, we are making choices. Governing is choosing competing ideas for good, and what we're looking at here is the choice between, say, planting trees or the choice between having clean, presentable health, you know, department facilities or great working conditions for police officers.

And my -- I guess what I have been suggesting throughout these hearings is that we may want to look

at infrastructure, which was a major theme during the last year and has been a major theme in this country, is infrastructure investment.

The City has been woefully underfunding infrastructure investment. And the more we continue to do so the more expensive the problem gets in the out-years.

So I am suggesting we probably need to reprioritize to more capital spending funding up front to fix some of these critical issues.

MR. AGOSTINI: We agree that the capital and the infrastructure both for the City, that the owns its own assets, as well as for the City in terms of, you know, streets and -- is something we need to get our hands around, and that's why you've seen a sizeable increase to about $120 million in the Capital Program, that's why you're seeing sizeable increase with respect to maintains. It's why you're

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seeing, I think, a real attempt on our part to try to get a handle on the assessments that were done by PICA.

But it's going to create, you know, some balancing, and we're trying to do -- and I know you're not suggesting this, but we're trying to fund what we can fund within the budget that we have while, at the same time, taking on some other priorities like the trees, which we think are important, like a range of other things.

It's one of the reasons we put 10 million in pay-as-you-go financing for streets, which is not a small number, and will accelerate our ability to get in front of a sizeable backlog.

I appreciate, you know, your intent here and that we're trying to get it. And we'd just like to get across that, you know, we have not sort of left it aside and said, No,

that's not a priority. It is, and we're trying to do it within the resources that we have.

COUNCILMAN GREEN: No, I understand what you're saying, although, you know, to be fair, the increase to $120 million as a one-year investment, it takes, you know, $40 million roughly of the PICA funds that are available for such investments and spends them, and then we drop back down to levels of -- I can't remember exactly -- less than a hundred medicine a year, when the City's own Planning Commission says we need to spend $185 million a year on infrastructure investment every year.

MR. AGOSTINI: And I --

COUNCILMAN GREEN: So, I mean, we could continue this debate forever. I just make the point that I think we've got to make some harder choices and start investing in our infrastructure. That's all.

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No more questions, Madam President. Thank you.

COUNCIL PRESIDENT VERNA: Okay. The Chair is going to recognize Councilmembers who have not been heard as yet, namely: Councilwoman Brown, Councilman Kelly, Councilman Kenney, in that order.

Councilwoman Brown.

COUNCILWOMAN BROWN: Thank you, Madam President.

Good morning, gentlemen.

DR. SCHWARZ: Good morning.

COUNCILWOMAN BROWN: Let me begin first by echoing Councilman Curtis Jones: Thank you for taking the time to stop by this morning and listen and hear from one of our area providers on how we can continue to fill the gaps of children around children's health insurance.

And so let's start there. Just for the record, tell us what you believe the status is and what some of

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the short-term goals are to tighten those gaps, recognizing that there's a ceiling when we know it's not an entitlement.

DR. SCHWARZ: Directly within the Department of Public Health?

COUNCILWOMAN BROWN: Yes.

DR. SCHWARZ: We have, as mentioned, benefits counselors at our health centers. We currently have three positions, which we are filling.

COUNCILWOMAN BROWN: Okay.

DR. SCHWARZ: And those benefits counselors have, as a priority, finding health insurance for anyone who comes into the health centers, but particularly we know that children in general should be eligible for health insurance, unless they are undocumented and not born in this country.

So in those cases, we do everything we can to find ways to make folks eligible if there's a way to do

so. We provide applications, help people fill out applications, submit them.

We do education and outreach with partner agencies within the City, and certainly we advocate for children to receive appropriate health insurance cards and then to know how to access care.

As mentioned earlier, we would be happy to work with your office and others in educating employers about benefits that would be available for dependents, even in places where parents themselves may not receive benefits.

COUNCILWOMAN BROWN: Right.

DR. SCHWARZ: CHIP is something that every child who is eligible should receive.

COUNCILWOMAN BROWN: Okay. And do that in a way, again, where we don't get ourselves in a fix, knowing that the dollars are not limitless, as you

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stated this morning, correct?
DR. SCHWARZ: We know that there are caps on the number of dollars that are available --
COUNCILWOMAN BROWN: Right, caps.
DR. SCHWARZ: -- per fiscal year for CHIP, but we believe that there are dollars in Philadelphia that we need to capture.
COUNCILWOMAN BROWN: That's nice, okay.
DR. SCHWARZ: And we shouldn't go into this, believing that children aren't eligible for health insurance when they are.
COUNCILWOMAN BROWN: Okay. Now, in an earlier hearing -- and I don't remember what department it was -- there was a revelation that the dots are not being connected between the Health Department's CHIP and children whose parents are incarcerated.

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So has any further discussion or thinking been given to making sure we capture those young people as well?

DR. SCHWARZ: I've begun -- it was in, I think, the Capital Budget process where we had the conversation.

COUNCILWOMAN BROWN: Yes, it was, yes.

DR. SCHWARZ: And I've begun the approach to prison health services about this because it's an easy communication that the department has already.

COUNCILWOMAN BROWN: Okay.

DR. SCHWARZ: I think the other area where communication is needed is likely through the court, and I've not yet made that approach, but it's one that is on the list.

COUNCILWOMAN BROWN: On the list, okay. Is there -- okay, we've taken care of that question.

You give some decision on Page 2 of your testimony to preventive

services and the like. Talk to us briefly about preventive services, specifically for children with special needs.

DR. SCHWARZ: There's a children-with-special-needs working group that is convened by the Health Department --

COUNCILWOMAN BROWN: Okay.

DR. SCHWARZ: -- that I think, over time, has been particularly effective in bringing to the table partners who are also concerned about children with special needs. And we will continue to do that going forward. It's an important part of the function of the Health Department.

COUNCILWOMAN BROWN: Okay. And included in prevention are immunization programs. Any status report, any new goals around that function of the Health Department? Is it working, to your satisfaction? Does it need further attention like you've given

some discussion to the lead program and the like?

DR. SCHWARZ: We have. I think it's the nation's premier immunization registry.

COUNCILWOMAN BROWN: Okay.

DR. SCHWARZ: We recently briefed the State on the specifics of our registry. As you may know, the State is looking at creating a statewide immunization registry, and we're pushing for them hard to use our registry rather than other software that they have looked at.

COUNCILWOMAN BROWN: Mm-hmm.

DR. SCHWARZ: We are absolutely willing to share information with the State so that we could have a statewide registry for all children so that a child who comes to Philadelphia, who's been somewhere else and immunized in Philadelphia, we could retrieve their immunization data. Or a family that moves from Philadelphia to the suburbs,

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people in the suburbs would know the child's immunization data. It's incredibly important from a public health point of view --

COUNCILWOMAN BROWN: Sure.

DR. SCHWARZ: -- that we not create barriers to people effectively immunizing children.

I think the newest immunization in the armamentarium is the HPV vaccine.

COUNCILWOMAN BROWN: Yes, yes, yes.

DR. SCHWARZ: And we are both providing it and the vaccine-for-children programs provides access to that for children.

COUNCILWOMAN BROWN: Mm-hmm.

DR. SCHWARZ: And we will continue to do so.

COUNCILWOMAN BROWN: Wow. Okay. Let me thank the administration for assuring what department has the interest in knowing how departments are

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doing with regards contracting with disadvantaged firms, and when I look across departments, including Health, Behavioral Health, and OESS, the Department of Public Health, it's my personal opinion -- I'm pleased with the numbers for minority business entities. I'm struck by the numbers for women business entities both in public health, behavioral health, and OESS.

So the question for me comes, is it lack of access or lack of awareness or lack of women entities out there that have the services that you're looking for?

I don't know the answer to that, so what I'm going to be asking all three departments is to provide to the Chair the types of contracting opportunities that are left, period, so that I can try to figure out why we only see single digits, and I think in one place -- single digits for women

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participating.
DR. SCHWARZ: The one piece that I would point out is that it was done as single counting.
COUNCILWOMAN BROWN: Okay.
DR. SCHWARZ: So that if it's a minority women business --
COUNCILWOMAN BROWN: Okay.
DR. SCHWARZ: -- we didn't double-count as minority and woman.
COUNCILWOMAN BROWN: Got it.
DR. SCHWARZ: So that in the 40 percent, there may well be --
COUNCILWOMAN BROWN: Women, women of color.
DR. SCHWARZ: -- companies that are women-owned or women-controlled businesses.
COUNCILWOMAN BROWN: Mm-hmm.
DR. SCHWARZ: But they appear as minority-business entities.
COUNCILWOMAN BROWN: Okay.
DR. SCHWARZ: So we could break that out and try to give you those

numbers.

I would point out that the Health Department made a special effort to include both for-profits and nonprofit entities here.

COUNCILWOMAN BROWN: Okay.

DR. SCHWARZ: So this includes contracts with not-for-profits, which, in the ASIS system for the City, that information isn't recorded directly; it's only recorded for for-profit entities.

COUNCILWOMAN BROWN: Okay.

DR. SCHWARZ: So we polled our providers and looked at a careful definition of what "minority business enterprise" meant and what "women-owned business enterprise" meant, and so we're particularly happy with the data that we have to share with you, and we'd be happy to present it in another format, if that would help.

COUNCILWOMAN BROWN: That would be helpful, that would be helpful.

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Talk to me about the relationship between your office and PHMC, Philadelphia Health Management Corporation.

DR. SCHWARZ: Philadelphia Health Management Corporation was founded thirty or more years ago in partnership with the City. The City has had, during that time, significant presence on the board of PHMC.

COUNCILWOMAN BROWN: Mm-hmm.

DR. SCHWARZ: It was formed in order to meet needs that the City, particularly in public health, had but could not be met by the City, either because of particular request-for-proposal issues or hiring delays movement of cash quickly to small enterprises.

COUNCILWOMAN BROWN: Okay.

DR. SCHWARZ: So for community-level agencies, there are often cash-flow issues with dealing with the City.

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COUNCILWOMAN BROWN: I see.
DR. SCHWARZ: PHMC can --
COUNCILWOMAN BROWN: In some instances, they service a fiduciary for smaller health-related nonprofits.
DR. SCHWARZ: Absolutely. Over time, PHMC's capacities have grown, and we continue to partner with them to, in a sense, take major maximal advantage of their capabilities.
COUNCILWOMAN BROWN: Mm-hmm.
DR. SCHWARZ: So that we bring those capabilities to government and can share it with them around those issues. Um...
COUNCILWOMAN BROWN: That's about it?
DR. SCHWARZ: (Nodes head.)
COUNCILWOMAN BROWN: Madam President, point of information: Does PHMC come before us at any point for hearings?
COUNCIL PRESIDENT VERNA: No.
COUNCILWOMAN BROWN: They do

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not, okay.

If I could then burden you, Commissioner, with getting a listing of their board members.

DR. SCHWARZ: Mm-hmm.

COUNCILWOMAN BROWN: I'm not concerned; I'm curious to know if their board looks like Philadelphia. And if we, as a government, are doing business with them, then what is the level of commitment at their level when it comes to people of color, women, and disabled businesses?

DR. SCHWARZ: I'd be happy to get that information for you have.

COUNCILWOMAN BROWN: Okay. There's one other question.

Give us an update, if you would, on the after-school programming; what's happening with the stakeholder meetings and the like?

DR. SCHWARZ: Okay. That is officially DHS.

COUNCILWOMAN BROWN: Okay.

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Then we can wait for DHS, that can wait for DHS. Not a problem.

I think that's it, Madam President. Thank you.

Thank you very much, Commissioner.

DR. SCHWARZ: Thank you, Councilwoman.

COUNCIL PRESIDENT VERNA: The Chair recognizes Councilman Kelly.

COUNCILMAN KELLY: Thank you, Madam President.

Good morning, Commissioner.

DR. SCHWARZ: Good morning.

COUNCILMAN KELLY: As I've been listening to, anyway, and I'm sure that by now that you know how important your office is by the questions of the Council President and many of my colleagues here concerning the health and welfare that many of our citizens who reside in Philadelphia. And I'm quite impressed with the way you responded, incidentally.

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DR. SCHWARZ: Thank you.
COUNCILMAN KELLY: I think you're doing a very, very good job. Sometimes we are not that -- we're shocked when we get direct answers anymore, but you're doing a very effective job.
DR. SCHWARZ: Thank you.
COUNCILMAN KELLY: I just want to say that that's -- your department, of course, has a huge responsibility in doing so, and that's a high priority.
But now I would like to switch the subject a little bit and go into a less prioritized responsibility in your office, and that is animal care.
Now, I know that many cities, of course -- some cities have animal care under their health departments, others don't.
And I would just like to know if you have an opinion of whether this responsibility should be kept under the Health Department's jurisdiction.

Or do you think it would be better if it was just placed somewhere else and it would free up resources and personnel to deal with the more important problems that you have in dealing with improving the health of many of the people in Philadelphia?

DR. SCHWARZ: I appreciate the question.

I don't know entirely the history of how animal care came to be within the Department of Public Health, but certainly the mission for animal control seems to be within the area of public health.

COUNCILMAN KELLY: Mm-hmm.

DR. SCHWARZ: The issue of disease management, for instance, is one; we could look at rabies control as a very tangible example. And I believe that control of rabies is something that falls in general within the general auspice of departments of public health, so I can understand why

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the marriage, if you will, between animal control and the department.

One of the issues, particularly in Philadelphia, that I've been made aware of is that we have a lot of animals. Compared to other cities per capita, we have many more animals than those cities do.

And I think that the department is now focusing a bit on what we can do to think about comprehensively having an animal control program, not just a program to house animals that are captured, but a more comprehensive and, I think, public-health approach to the issue of animal control.

COUNCILMAN KELLY: Well, I'm still waiting for your opinion. Would you think it would be better served if this responsibility was placed somewhere else other than your department, or would you prefer that this remain in your department?

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DR. SCHWARZ: I -- I think I've been on the job a short period of time.
COUNCILMAN KELLY: Okay, but it's something maybe --
(Indiscernible; parties talking over each other.)
DR. SCHWARZ: -- have grown fond of the issues of animal control --
COUNCILMAN KELLY: And I guess it would be unfair of me to ask that question because it's something that you would have to look into.
But I just want to touch upon another subject, and that is, it's my impression that you're going to be sending out contracts on animal care at the end of this year.
DR. SCHWARZ: (Nods head.)
COUNCILMAN KELLY: Now, the current contract, I believe, is going to be extended for six months, but I would like to know who in your department, or if it's you who's going to be responsible for awarding that

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contract.

For instance, what criteria do you use? Is it just monetary? Is it just dollars and cents if we save a half a million dollars that's going to be awarded to a contract? What I would like to emphasize is that you look at the service end of it.

Right now, with PACCA, we've been -- probably we have -- we have actually decreased the killing rate in the City by over 60 percent, and I think our whole goal here is to save animals, not to exterminate them.

You have to look at other -- and it's easy to get to do it cheaply. That's all you have to do, is euthanize every damn animal that comes in your grasp.

This is one of the things that I'm looking at. It's just -- it's one thing to take the contract and save money, but does it -- do the people -- are they going to be providing the

same service? Are they going to be saving as many animals as the current -- the current PACCA people do?

DR. SCHWARZ: I share your concerns and would anticipate that any contract that is let from the department will have a rigorous review of the issues, both around ability to meet the contractual requirements, history in terms of the quality of service, and cost. We'll have to balance those.

And this is, I think, going to be as a transparent a process as we can make it so that people are aware of how the decisions are made.

COUNCILMAN KELLY: Well, I just want to emphasize, and I'm telling you right now, just don't do it with dollars and cents, because right now, if you go back three or four years ago, we were euthanizing, we were killing over 25,000 animals a year. Now, we've reduced that by 60 percent.

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And we've done it through a lot of different ways. We've done it because we have a new board of directors at PACCA, a very dedicated group. We have a new director who's doing a terrific job. We have formed an alliance with probably the best veterinary hospital in the country, and that's the University of Pennsylvania. We have set up an adoption center with PAWS, and we want to have a few more of them.

And with all of this, with the neutering and spaying program that we have in place, and we will have it in place, I think that we're going to increase the amount of animals, the lives of many animals that are destined to be euthanized now.

And I think we're on the right track. We're on the right track to make this the first city in the East Coast to have a no-kill policy. And we can do that despite the fact that

we are underfunded, that they're put probably in a dilapidated building -- I don't know if you've had the opportunity to see it yet --

DR. SCHWARZ: I've been there.

COUNCILMAN KELLY: Yeah. And it wasn't made for that purpose.

And to me, I think it's one of the things that we have to look at, and I hope that I can work with you and the administration and try to work out, I think, a good contract and keep the people that are doing a great job to continue that great job.

DR. SCHWARZ: I appreciate your comments.

COUNCILMAN KELLY: Okay, thank you.

DR. SCHWARZ: Thank you.

COUNCILMAN KELLY: Thank you, Madam President.

COUNCIL PRESIDENT VERNA: You're welcome.

The Chair recognizes

Councilman Kenney.

COUNCILMAN KENNEY: Thank you, Madam President.

Good afternoon. Can we talk a little bit about pharmacy? Can you explain to me how your pharmacy is managed and what some of the issues are that you're faced with other than just costs, which, I know, is a major issue now.

Could you talk just a little bit about how your pharmacy system works?

DR. SCHWARZ: Yes. For those who are patients of the ambulatory health centers, they may receive prescribed medications.

And we've worked hard, as I understand it, to drive down costs. We have a contract, a sort of a collaborative agreement, with one particular drug manufacturer, where we receive pharmaceuticals of high quality at minimal cost.

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People come with prescriptions, prescriptions are dropped off. We make every attempt to fill them as quickly as possible. Emergency prescriptions or more urgent prescriptions are more filled within a reasonably amount of time. And prescriptions that are not urgent may be filled over a two- to three-day period.

COUNCILMAN KENNEY: Are we reimbursed for the prescriptions that we dispense?

DR. SCHWARZ: Yeah. We bill insurance, so we're a full-force pharmacy.

One of the challenges, as I understand it, to the pharmacy has been over time, that our pharmacy system, we have a computerized pharmacy system, it doesn't speak directly to the billing system for the Health Department, so that each prescription that's written generates

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a report, which then has to be key-entered into the billing system in order to generate bills, which is a cumbersome process. One of the things that I'm anxious to do with the electronic medical expansion is to fix that.

COUNCILMAN KENNEY: For those individuals who are uninsured, who gets billed?

DR. SCHWARZ: No one gets billed.

COUNCILMAN KENNEY: Okay. And what is that number? what does that represent in dollars projected for '09?

DR. SCHWARZ: It's approximately $5 million.

COUNCILMAN KENNEY: Okay. And, also, the management of the records, of the pharmacy records, is that done in-house or is that done --

DR. SCHWARZ: It is.

COUNCILMAN KENNEY: It is. Does it make any sense -- and, again,

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you've been here a short period of time, has anyone institutionally in the past years looked at the possibility of going out to privatize that to working with the local or national or regional health-care insurer that may have also back-office operations that handle pharmacy management and recordkeeping?

DR. SCHWARZ: In terms of billing function or the prescription --

COUNCILMAN KENNEY: The prescription purchasing, the billing, the uninsured, all of that.

DR. SCHWARZ: The issue there is that we are, as a federally-qualified health center, we receive discounted rates, and our partnership with the pharmaceutical manufacturer is very much in place because we're a nonprofit, urban, city pharmacy system.

So that the department has apparently looked at this before, and the expense to the City of that partnership, including overhead costs

and things like that, is more than the cost that we currently do per prescription for the services that we currently provide.

COUNCILMAN KENNEY: So that the -- so the partnering with a nonprofit or a for-profit entity is more expensive than what we do now?

DR. SCHWARZ: That's been the experience.

COUNCILMAN KENNEY: How long ago has that been investigated?

DR. SCHWARZ: Two to three years.

COUNCILMAN KENNEY: Okay. How involved is the Health Department in the ongoing 311 Philly Stat project, and could you explain what your interface has been with the Managing Director's Office in this process?

DR. SCHWARZ: The Managing Director's Office has a task force specifically around 3-1-1, and every department participates in Philly Stat.

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So the Health Department actually was only one of two departments that had its first Philly Stat presentation televised, and we have our next presentation sometime -- I think it's in the third week in April, and we will continue to do that.

COUNCILMAN KENNEY: Who attends that Philly Stat meeting from your department?

DR. SCHWARZ: Many of the division directors, particularly those who are concerned -- we have a large department that's very diverse, and the amount of time for Philly Stat is -- has to be limited. So what we are doing is targeting specific areas within the Health Department over the course of the year.

We have what I would call overall -- "overarching goals" for the department, and then we have goals by division. So we will rotate through

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the division so that both the goals of those divisions and the customer-service expectations can be presented to the public.

COUNCILMAN KENNEY: How are the employees and supervisory staff responding to this new advent of --

DR. SCHWARZ: I think people are a little mystified by the process but encouraged by the potential.

COUNCILMAN KENNEY: Okay.

DR. SCHWARZ: And I think the cultural change that is implicit has been embraced pretty well by the department. We've been about customer service for a long time, so this isn't foreign to the department.

COUNCILMAN KENNEY: How often is it proposed that you will meet?

DR. SCHWARZ: Every month.

COUNCILMAN KENNEY: Every month, good, okay.

Thank you.

COUNCIL PRESIDENT VERNA: The

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Chair recognizes Councilman Jones.

COUNCILMAN JONES: Thank you, Madam Chair.

It's my understanding that the Philadelphia Nursing Home contract expires June of '09; is that right?

DR. SCHWARZ: That is correct.

COUNCILMAN JONES: And what thought has been given to the future of the home, and how many patients on average reside there, and what is the current state of capital-project repairs for the nursing home?

DR. SCHWARZ: So the total number of occupants, as of March 27th, was 448, but a number of those occupants are currently hospitalized, so the number of people actually today is 417.

And the second part of the question? I'm sorry.

COUNCILMAN JONES: What is the future of the Philadelphia Nursing Home and its capital repairs that are so

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desperately needed?

DR. SCHWARZ: The capital, actually, investments have been moving forward. I was at the nursing home this week. I went around to look at the particular areas that have b een under consideration for capital investment.

There are three wings of the nursing home, which have yet to be renovated. And I went around to make sure that both the conditions were safe, that the facility was clean, and that inhabitants who are there are not in any way particularly disadvantaged by the need for capital improvement.

But, I have to say, I was very impressed, both with the management of the facility in general, with the cleanliness of the facility in particular, and by the state of residents there, many of whom are young for a nursing home population.

COUNCILMAN JONES: It's my

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understanding that paraplegics that -- are also there along with our seniors, so there's a combined combination of the types of residents there.

DR. SCHWARZ: Absolutely. They aim to -- each unit is organized in the state-of-the-art, I think, fashion, which is by functional limitation. So that however old someone is, the therapy that people receive is consistent with where they're located, and there's been an attempt to match the particular people on a given unit with the therapies that are immediately available to them. So I was impressed by that.

I will say that the boiler at the nursing home is about ten years old, and there's currently discussion with the current contractor about when a boiler should be replaced. It currently functions, but the question is, what's the life expectancy of a boiler? and we're discussing that and

discussing it with capital for the City.

Going forward, we will have a request for proposals put out over the course of the next fiscal year to look at the current contractor and create an open process for other bidders, again, based not only on cost but also, as much as we can, on quality and the capability of a vendor to meet the requirements of the City.

But I will say that at the moment, the City has been quite satisfied with the current vendor.

COUNCILMAN JONES: Thank you.

One last question dealing with the pharmacy. It's my understanding -- how do you deal with the issue of rotation of pharmaceutical products that have reached their expiration date, and has that been a problem in the past?

DR. SCHWARZ: There was a time when we had some expiring

prescriptions; that time is in the past. So currently, there's a rotation policy that's put into effect and inspection that's done so that our pharmaceuticals are handled just like a regular pharmacy would be in terms of sending them back, disposing of them, and so forth.

COUNCILMAN JONES: That is a particular problem that is not just with the public Health Department, but it's also been prevalent dealing with our prison population because of the short-term duration and, you know, people's prescriptions expire or, you know, sit on the shelf.

And we -- I don't know if there is a piggyback purchasing process that happens between your department and the prison system at all, and is that something that could be considered?

DR. SCHWARZ: I've met with the director of prison health services on

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the City side, not the contractor, to think about how we might improve efficiency, efficiency both in the service itself, things like how we purchase pharmacy and so forth, and also in the issue around paying for specialty service, which, you may know, is a substantial issue for the prison.

COUNCILMAN JONES: Thank you, Madam Chair.

COUNCIL PRESIDENT VERNA: You're welcome.

The Chair recognizes Councilwoman Brown.

COUNCILWOMAN BROWN: Thank you, Madam President.

There was one remaining question that I couldn't find amongst these papers.

It's somewhat sensitive, but Madam President and Mr. McPherson alerted me that -- of a pending transfer ordinance from City Council to the Health Department that will be

considered at the end of this FY budget process specifically for the Children's Report Card. And the reason for the transfer, I completely understand and I'm okay with.

If you're not able to answer the question at this time, I am curious to know, is or will the administration remain committed to the creation of the Children's Report Card, which has been a valuable public-policy information tool for those of us in government going forward. The transfer $267,000 transfer was for the creation of the Children's Report Card.

DR. SCHWARZ: It's again, I think, DHS but let me answer the question --

COUNCILWOMAN BROWN: Okay.

DR. SCHWARZ: 'Cause later, I will be sitting here --

COUNCILWOMAN BROWN: Even though those dollars are coming to

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health?
(Indiscernible; parties talking over each other.)
DR. SCHWARZ: I think they're going to DHS.
COUNCILWOMAN BROWN: Okay. Well, then let's reserve it for --
DR. SCHWARZ: I can answer the question --
COUNCILWOMAN BROWN: Okay.
DR. SCHWARZ: -- which is, I feel badly not too, which is -- certainly, it's an important document, and we've heard Council's both appreciation for the document and the utility of the document.
COUNCILWOMAN BROWN: Yes, okay, all right. So I'll leave it there for now. Thank you.
Thank you, Madam President.
COUNCIL PRESIDENT VERNA: You're welcome.
Doctor, I want to thank you for your candor. I think we, too, got

much more from your testimony than I can tell you.

At the request of the stenographer, I think we're going to take a break.

Supposing we recess until 1:30. We'll recess until 1:30, at which time we will then hear from -- we can hear from the Office of Supportive Housing and then Behavioral Health and the Department of Human Services.

DR. SCHWARZ: Thank you.

COUNCIL PRESIDENT VERNA: Thank you.

(Recess taken at 12:39 p.m.)

(Proceedings resume at 2:12 p.m.)

COUNCIL PRESIDENT VERNA: The 82 is now back in session.

The next department we will hear from will be Behavioral Health.

(Witness comes forward.)

COUNCIL PRESIDENT VERNA: Hello.

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DR. EVANS: Hello.

COUNCIL PRESIDENT VERNA: All right. Please identify yourself for the record and proceed with your testimony.

DR. EVANS: Good morning, President Verna and members of Council. My name is Dr. Arthur C. Evans, Director, and I'm here to present testimony on the Department of Behavioral Health and Mental Retardation Services' FY '09 budget.

The FY '09 department budget requests $1.4 billion, 14.3 million in the General Fund, 549.7 million in the Grants Revenue Fund, and 883.8 million in the Health Choices Behavioral Health Fund.

The Department of Behavioral Health and Mental Retardation Services' FY '08 [sic] budget will support 297 positions, 33 in the General Fund, 264 in the -- 264 in -- 264 in the Grants Revenue Fund. Of

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the 1.4 billion, 352 million, or 24.4 percent, is in the Mental Retardation Services, and 1.1 billion, or 75 percent, in the Behavioral Health Services.

The mission of the department is to support people in an environment of recovery focused on prevention, wellness, self-determination, and the realization of personal goals, leading to improved quality of life.

We work with consumers and clients, families and providers to ensure that services are accessible, effective, appropriate, and of high quality.

The Behavioral Health component of the department coordinates the City's behavioral health treatment services for approximately 100,000 adults and children annually. Mental Retardation Services is a component of the department responsible for the

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development, coordination, and monitoring of services for approximately 12,000 children and adults with mental retardation.

In FY '09, the department will continue its efforts to address behavioral health and mental retardation needs of Philadelphia citizens. Key activities supporting these activities include enhancement of consumer- and community-based recovery and resiliency supports, including the hiring of certified peer specialists, engagement of the faith community, and the transformation of traditional facility-based treatment premises.

Secondly, sustaining supports to vulnerable underserved populations, including the recent expansion of services to the homeless, the Southeast Asian community, the LGBT community, and individuals leaving prison.

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Thirdly, enhancement of services to individuals with mental retardation, including the department of -- including the development of new supports for individuals on the waiting list and affording individuals and families an array of in-home vocational and employment supports.

And, lastly, promoting accountability through the development of performance expectations and performance-based contracting.

The department is committed to supporting the core service and customer-service standards that have been articulated by the administration. Examples of the DBH MRS efforts include the following:

First, during FY '09, the department will serve approximately 7800 consumers in inpatient psychiatric settings at a cost of $86 million per year. Approximately 14 percent return within 30 days

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post-discharge. This indicates insufficient treatment follow-up or insufficient home supports or premature discharge or subsequent crises.

Effective linkages and interventions at the community level should provide a shift in dollars from inpatient to outpatient, as the consumer moves towards recovery. Initially, the goal is to reduce recidivism to the national Medicaid standard of 10 percent.

Secondly, during FY '09, the department will provide school-based behavioral health services to 3,000 children in over 50 schools. This intervention is designed to improve attendance and afford children the appropriate balance between meeting behavioral health needs while, at the same time, maintaining the child in his or her own school. The long-term goal of this intervention is to minimize the

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use of out-of-home placement for children.

Third, the department provides for the continued support of the transition of individuals with substance-use disorders from prison to appropriate community treatment. During FY '09, we expect that 2500 non-violent individuals will be afforded early release or diversion by virtue of their commitment to enter substance-abuse treatment services in the community.

The long-term goal of this effort is to assure that individuals will become active community members, thus reducing the recidivism rate back to the prison, which so many individuals face.

Fourthly, the department will -- the department supports the administration's goal of healthy communities through the provision of early-intervention services to children

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0 to 3 who are experiencing developmental delays. The department expects the number of children to be served by this program to exceed 12,000 in FY '09. Research has shown that the of services at an early age impacts positively on children as a move into the educational system.

In addition to supporting the core service initiatives of the administration, the department has also established initial customer-service standards, which will be refined and measured in the upcoming year. Examples of these standards include:

Number one, requests for behavioral health rehabilitation services will be responded to within 48 hours. This requirement will be measured by assuring the appropriate review and response of all BHR requests within 48 hours. Failure to respond in the mandated time will result in the service being authorized as requested

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by family or behavioral health practitioner.

A second example is, providers will be paid in a timely manner. Providers under contact with the department through the Healthy Choices program will be paid within 45 days of submission of claims. The standard will be measured electronically from the date of provider submission. Failure to meet the standard will result in the payment at a rate of 10 percent per annum for all payments beyond 45 days.

And, again, these are examples.

The department has continued its efforts of the past few years to increase the number of minority providers. Currently, over 25 percent of the department's contracts are with community-based minority organizations.

Thank you for the opportunity to provide this overview. I look

forward to working with City Council in the upcoming year.

COUNCIL PRESIDENT VERNA: Thank you very much, Dr. Evans, and may I say welcome.

DR. EVANS: Thank you.

COUNCIL PRESIDENT VERNA: Doctor, you mention on Page 3 of your testimony that failure to pay a provider within 45 days will result in the payment of interest at the rate of 10 percent. Is the penalty for late payments germane to your department only, or is it going to be a citywide practice?

DR. EVANS: I'm sorry. Or a citywide...?

COUNCIL PRESIDENT VERNA: A citywide practice.

DR. EVANS: That is a practice for our department only at this point.

COUNCIL PRESIDENT VERNA: Is that a State-mandated --

DR. EVANS: Yes. That is for

the Health Choices Program through CBH that is administered by CBH. So as a part of our contractual standards -- I'm sorry, as a part of our contract with the State of Pennsylvania, we are required to pay providers if we exceed that time period and we've not paid a claim.

COUNCIL PRESIDENT VERNA: Also, Doctor, on Pages 40 to 43 of your detail, you're requesting $397,095 for the Bucks County Council on Alcoholism and Drug Dependence. Can you explain what services they provide?

DR. EVANS: Those services are by an organization called "Pro Act." And they actually have a local chapter within Philadelphia. They've been very instrumental in a lot of the work working with the Philadelphia recovery community.

One of the most recent things that they've done is to operate a recovery center in Philadelphia. And,

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essentially, this is a place where individuals can go to receive information about substance-abuse treatment. They run groups there.

But it is a -- an organization of peers. They -- and the recovery center in particular, it is an enormous resource because many individuals in our city are reluctant to walk into a formal treatment program. They're much more likely to walk into a community-based organization that is a part of the community.

And those are the kind of things that Pro Act does for us.

COUNCIL PRESIDENT VERNA: I was rather puzzled when I saw Bucks County Council on Alcoholism, and I thought to myself, You mean to tell me we cannot find --

DR. EVANS: Yeah. Well --

COUNCIL PRESIDENT VERNA: -- an agency here in Philadelphia that can do

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the same thing?
DR. EVANS: Well, they are based here in -- they have a Philadelphia presence. They have an office, I think, on Arch Street or Race Street, that part of the City.
Part of the -- there's been a national movement around organizing people who are in recovery, and most states have statewide organizations. The Philadelphia vicinity has Pro Act.
And, again, they have a local presence, but they are a regional-type organization.
COUNCIL PRESIDENT VERNA: Do they live there, at this facility? Do the clients live at this facility?
DR. EVANS: No, people don't live there. This is --
COUNCIL PRESIDENT VERNA: Is this -- explain what it is, please, 'cause I'm not familiar with this at all.
DR. EVANS: Okay. As I

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mentioned, the -- there is a national movement to organize people and essentially put a face on recovery. There are chapters or organizations literally across the country.

Philadelphia -- or Pennsylvania has several. The one in this geographic area, the five-county area, is Pro Act. And they have chapters within each of the five -- the local five counties.

What they do is enormously important to the City. They do put a face on recovery, they organize various activities to promote the idea of people getting into recovery. I mentioned the recovery center that they operate for us. And so they are very important in terms of getting the word out about people accessing recovery services.

And, again, they have a very local presence. They're very invested in this community. They organize a

walk here in the community. And, as I mentioned, they operate the recovery center that I mentioned.

COUNCIL PRESIDENT VERNA: Would you have any indication at all as to how many clients they see during the year?

DR. EVANS: Well, they don't really see clients; they're not a treatment provider.

COUNCIL PRESIDENT VERNA: So if this -- we're paying almost $400,000? For what?

DR. EVANS: They provide, as I mentioned, information to individuals. They help us -- they train people for something called "pier specialists"; it's a certification that the State of Pennsylvania has created for individuals who are in recovery to work within the field. They provide some of that training and they provide a variety of other kinds of educational activities.

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COUNCIL PRESIDENT VERNA: Doctor, I would appreciate it if you would provide me written information on this, please.

DR. EVANS: I'd be happy to.

COUNCIL PRESIDENT VERNA: And precisely what the responsibilities is of this Bucks County Council on Alcoholism and Drugs.

DR. EVANS: I would be happy to.

COUNCIL PRESIDENT VERNA: Thank you.

DR. EVANS: Okay.

COUNCIL PRESIDENT VERNA: Also, on Page -- on the same page, you're requesting $500,000 for Safe and Sound for Department of Social Service Cares. Can you explain what services Safe and Sound provides?

DR. EVANS: President Verna, you probably know that last year, or the year before last year, we had a blue-ribbon commission that looked at

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children's behavioral health. And out of that commission we developed something called "The Philadelphia Compact."

The compact was -- is essentially a group of City agencies, provider agencies, community people that are -- that come together around promoting and implementing the recommendations of the blue-ribbon commission.

What we have are a couple of staff that work with us to implement those recommendations. And the -- the request that you see there is for the implementation of those recommendations.

COUNCIL PRESIDENT VERNA: Doctor, can you explain how CBH funding can be used for capital-improvement projects?

DR. EVANS: Well, we have a -- at -- if the department, which is capitated for the Medicaid population

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has a surplus, we are able -- part of that surplus has to go into our reserves, but anything over and above the reserve amount allows us -- we're allowed to reinvest those dollars back into the system. In fact, we're required to reinvest those dollars back into the system.

The State puts several stipulations on that reinvestment. One is that it has to be primarily targeted to the Medicaid population; secondly, it has to be behavioral health in nature; thirdly, it has to be something is that can either be sustained within the Healthy Choices program so that we use those dollars as seed money, or they have to be one-time costs.

And so one of the things that the contract with the State allows us to do is to make investments into small capital investments into providers who are providing those

kinds of services.

COUNCIL PRESIDENT VERNA: What do you consider small?

DR. EVANS: Well, in this case, we gave providers up to $15,000 to do a variety of small capital projects; for example, it could have been a health and safety issue. Some providers needed to upgrade their health and -- to come into compliance with health and safety regulations. Some chose to use that money to fix up their waiting rooms, for example.

We also had a match to providers who wanted to match the amount. They could get up to $50,000. And, again, those were primarily residential providers. These were individuals who are providing services to people with serious mental illness or serious addictive problems and who are running residential facilities. Those providers were able to get up to $50,000 if they wanted to match that

money with what we were giving them.
COUNCIL PRESIDENT VERNA: I see here that, actually, the appropriation for that service is a million dollars.
DR. EVANS: I think it was 1.4 million, I believe.
COUNCIL PRESIDENT VERNA: It's a million dollars.
DR. EVANS: Okay.
COUNCIL PRESIDENT VERNA: Just to the one group.
DR. EVANS: Oh, for CCTC.
COUNCIL PRESIDENT VERNA: Child ren's Crisis Treatment Center, a million dollars.
DR. EVANS: Right. We have not -- we have not made that -- we have not given that -- those dollars. And at this point, we're not sure that we will.
This is a provider who was able to get a match from one of their board members who was willing to match what the department was able to put

in. This is a provider who provides services to children and is in a building that is really not adequate at this point to adequately serve those. And we were presented with an opportunity to match funding from one of their major donors.

COUNCIL PRESIDENT VERNA: Doctor, are you saying, then, that that million dollars should not be appearing in the budget?

DR. EVANS: I'm saying that at the time that the budget was prepared, that was -- that money was there for that particular provider. There have been some changes that may make that more difficult, and so we're not clear at this point whether or not that will go through.

COUNCIL PRESIDENT VERNA: Are there any other changes --

DR. EVANS: That is the only one.

COUNCIL PRESIDENT VERNA: --

that are going to be made or suggested since the preparation of the budget was made?

DR. EVANS: No, that is -- that's the only one.

COUNCIL PRESIDENT VERNA: Okay. I have several other questions, but I see that we have Councilmembers waiting.

Councilman Jones.

COUNCILMAN JONES: Good afternoon, Commissioner.

DR. EVANS: Good afternoon, sir.

COUNCILMAN JONES: Thank you, Madam Chair.

DR. EVANS: Good afternoon.

COUNCILMAN JONES: Can you describe for me the evolution which split the Health Department from your department and how that occurred?

DR. EVANS: That predated me. I'll tell you what I know about that split.

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The department has historically operated two components within the Health Department; one of those components was called "The Coordinating Office of Drug and Alcohol Programs" and the other was "The Office of Mental Health, Mental Retardation."

The department -- or the City, ten years ago, also created something called "Community Behavioral Health," which is essentially a Medicaid managed-care company, a 501(c)3 company that manages the behavioral health benefit for individuals on Medicaid.

Over the years, historically, what the City has done is to try to combine those behavioral-health entities and operate them as one system. And, in fact, Philadelphia is one of the few places in the country where all of the behavioral health dollars are managed by a single

entity. If you go into most communities, most states, Medicaid is managed by a Medicaid agency. City or state grant dollars or block grant dollars will be managed by a different agency.

The problem with that is that the individuals who may be on Medicaid today may be unentitled tomorrow. And what happens is that their care becomes fragmented. You're not able to follow those people from a clinical standpoint well because they are being paid for through different funding streams that have different criterial for admission to treatment.

And as a result, I think the people in Philadelphia have had the foresight to say that you really have to manage all of the public-sector dollars in one entity, and so there was an emphasis or a push to combine those into one administrative entity, and that's when the department was

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formed, my position was created, and I was fortunate enough to be able to come here and to manage the department as its first director.

COUNCILMAN JONES: In that I see in your testimony that you subcontract out to 251 different providers --

DR. EVANS: Mm-hmm.

COUNCILMAN JONES: -- can you describe some of the services generally.?

DR. EVANS: Well, those would be everything from hospitals, like Temple Hospital and other hospitals, to residential providers who provide services for people who are addicted, or it could be residential providers who are providing psychiatric services for children. It would be outpatient providers who are providing outpatient psychiatric or substance-abuse treatment. It would be people who are providing case-management services,

people who are providing prevention services.

It's really a whole range of services that the City provides to the department.

COUNCILMAN JONES: How do you evaluate service delivery with so many providers?

DR. EVANS: Yeah, it's a good question. We evaluate that through multiple means.

One of the things -- and you heard in my testimony that what we look at is the recidivism rate, so we will look at the numbers of people who are going into inpatient care and how many of those return back to care within a certain period of time. Obviously, we want that number to be as small as possible, as an example.

So we look at key indicators that tell us whether or not the service that we're paying for is a -- is being effective.

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Furthermore, the department, through the Philly Stat process and also through an initiative at the state level to move to more of a pay-for-performance system, is looking at other measures to refine how we look at individual providers

COUNCILMAN JONES: Could you elaborate on that a bit? When you say you're rethinking how you evaluate, from what to what?

DR. EVANS: I wouldn't say that we're rethinking; I think what we're saying is that we want to refine how we look at providers and to create incentives for provider performance.

Heretofore, while we've looked at those aggregate numbers, we've looked at them really in total and we've looked at how do we make system changes that tell us whether or not the system is working appropriately.

We want to move to a system that looks at individual providers and

says, This provider's performing well versus this provider who is not performing well. For the provider who is performing well, we want to provide some --

COUNCILMAN JONES: Comparing apples to apples, apples to apples?

DR. EVANS: I think it's providing -- comparing apples to apples, but it's also making sure that we reinforce the behavior that we want from our provider system.

Again, for example, one of the numbers that we look at, as I mentioned, was recidivism.

COUNCILMAN JONES: Recividism.

DR. EVANS: And if you look in our system, or any other system, most systems, there's like an 80/20 -- there's an 80/20 rule.

Eighty percent of the resources are being used by twenty percent of the people, which means that if we can do a better job of

working with those 20 percent, we can save substantial resources that can be reinvested into the system.

And so, last year, one of the system changes that we made was to introduce substance-abuse case management, because heretofore, we did not pay for case management, those kinds of case-management services for individuals who were receiving substance-abuse treatment.

What that allows us to do, then, is to target those individuals who are the recidivists, to make sure that they step down through the continuum of care.

COUNCILMAN JONES: Is that what you meant when you said that the chronically homeless that you have substance-abuse problems, you're looking at how you (indiscernible) recidivism?

DR. EVANS: Well, in part. One of things that we did this year was, as

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you look at the homeless population, what you find is that -- well, the first issue is that they're homeless, and that's the issue that you have to get at, but a number of those individuals also have behavioral-health problems.

And what we found was that even though, I think, the City has historically has done a good job of doing outreach and connecting with those individuals, a lot of those individuals, when they were connected, did not do well in traditional addictions programs.

And so what we've done now is to take existing capacity and convert it to specialize with working with homeless individuals. In particular, what we have done is to lengthen the length of stay in those services, so that individuals who are going into those services have a real shot at initiating recovery before we step

them down to a lower level of care.
COUNCILMAN JONES: You mentioned recidivism, and the national Medicaid standard is 10 percent. I think we are this year 17 percent?
DR. EVANS: It varies for children and adults. We are doing better with children than we are with adults. And while we want to get to the national standard, we actually want to do better than the national standard. I think we can do better than the national standard.
COUNCILMAN JONES: How? How do we - what's the amount of dollars?
DR. EVANS: Well, through -- I think if you look at people who recidivate, one of the biggest predictors of whether or not someone is going to end up back into an acute level of care is the extent to which there is good planning from a hospital -- the hospital level of care to the next level of care. There are things

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that we can do to improve that with our hospitals.

The case management that I talked about is another way that we can make sure that we have people working with people prior to them leaving a hospital level of care and essentially hand-holding to make sure that they get to the next level of care.

Thirdly, we are improving the -- the quality of our outpatient services across the board by emphasizing evidence-behaved practices. There's a big disconnect from what we know from a scientific basis works in treatment versus what we see practice on a wide scale. That's true in health care in general.

And so we're working with, for example, Dr. Aaron Beck who is internationally known and is "the Father of Cognitive Therapy" and working with him to increase the

amount of our service system that's using that particular -- that particular technique, which we know is much more effective, which will engage people better and improve our outcomes.

So we're really coming at this from a multi-facetted standpoint. All of those things are going on. There are other things that are going on, and we fully anticipate that, in the aggregate, that those things will have a huge impact on our recidivism rate.

COUNCILMAN JONES: We went, as a municipality, from a municipally-owned care facility to subcontracting. We closed that over a period of time and then outsourced some of this to private providers; is that correct?

DR. EVANS: I'm not clear on what you're saying. What municipal facility?

COUNCILMAN JONES: Well, didn't we own psychiatric centers?

DR. EVANS: No. There was a State-owned facility.
COUNCILMAN JONES: But we didn't own it.
DR. EVANS: No. That was State-owned.
COUNCILMAN JONES: And so the one on Roosevelt Boulevard, that is owned by whom?
DR. EVANS: Byberry.
COUNCILMAN JONES: Byberry?
DR. EVANS: Yes. That's the State --
COUNCILMAN JONES: And that's State still?
DR. EVANS: That was a State psychiatric hospital, State-run.
COUNCILMAN JONES: And who owns it now?
DR. EVANS: It's no longer open. I think the State still owns that property.
COUNCILMAN JONES: All right. There's a facility on Roosevelt

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Boulevard that provides psychiatric care --

DR. EVANS: Are you talking about Friends Hospital?

COUNCILMAN JONES: I want to say it's at Pratt and the Boulevard.

DR. EVANS: That's Friends, yeah, that's Friends.

COUNCILMAN JONES: Okay. And you subcontract with them?

DR. EVANS: They are one of our providers. They provide --

COUNCILMAN JONES: They're one of the 251 providers?

DR. EVANS: They're one of the 251 providers.

COUNCILMAN JONES: And that's the old Byberry facility?

DR. EVANS: No.

COUNCILMAN JONES: No?

DR. EVANS: Byberry's in a different location.

COUNCILMAN JONES: It's further north.

DR. EVANS: Yes.
COUNCILMAN JONES: Further up.
(Addressing Councilman Greenlee.) Well, you're at-large, Councilman Greenlee; I expect you to know those kinds of things.
(Laughter.)
COUNCILMAN JONES: I'm in the 4th Councilmatic District.
So based on performances, you're saying -- is it more cost-effective to do it the way we're doing it, by subcontracting, outsourcing. Or is it too mammoth a thing -- I guess what I'm saying --
DR. EVANS: Mm-hmm, I understand.
COUNCILMAN JONES: You go through -- you deal with services in schools.
DR. EVANS: Mm-hmm.
COUNCILMAN JONES: You deal with services in prisons. You deal with catchment conduct situations with

people off of the street.

DR. EVANS: Mm-hmm.

COUNCILMAN JONES: So I'm trying to put my arms around how we evaluate, whether it's better to subtract or to provide -- I guess it's the same question I asked the Health Commissioner about owning our own facilities versus subcontracting.

DR. EVANS: Right. Well, you know, it's -- a lot of those decisions were made before I ever came to Philadelphia. We have essentially a contracted system, and the department is primarily a payor.

I think that -- a personal preference, I think that that's a much better system in our case. I think it's different at the State level; the State has certain responsibilities; for example, the forensic population. And the State has to, in my opinion, run some facilities. Some states contract all of those services out.

But I think, for us, it is a good system. It allows us to be more flexible and nimble than we could be if we were trying to run all of those services ourselves and some of those services, it would be impractical. It would be impractical for us, for example, to run, you know, acute services.

COUNCIL PRESIDENT VERNA: Excuse me, Councilman. I see that we have the Budget Director here and Dr. Schwarz. And, apparently, I asked a question, and they would like to clarify exactly what all of Page 43 means. If you don't mind.

COUNCILMAN JONES: No, I don't mind.

COUNCIL PRESIDENT VERNA: And I don't want to keep him waiting.

COUNCILMAN JONES: No, Madam President.

COUNCILWOMAN TASCO: Point of order, Madam President, but we went

through changes of the system to create the Office of Behavioral Health back in the '90s, when Mayor Rendell was here, to sort of streamline the system.

And maybe Mike can give us a little overview. I can't remember all of the details, but we can tell you it's better 'cause Council was involved in the creation of this (inaudible).

COUNCILMAN JONES: Thank you, Councilwoman.

COUNCILWOMAN TASCO: (Inaudible.)

MR. COVONE: Michael Covone, Deputy Director with the Department of Behavioral Health.

Councilwoman is testing my memory, but actually, one of the reasons for the creation of the entire system under one department is, as Dr. Evans said, really goes back to what existed prior to 1997.

And, I guess, for lack of a

better explanation, that Behavioral Health, when it was contracted by the State to private for-profit entities were really taking the profit and not delivering the service.

And the City's decision at that point in time in the creation of Community Behavioral Health and blending of the department was really to, number one, have an entity that, first and foremost mission, was to provide the services, not deny 'em and not to build stockholders' equity, for lack of a better term. And I think that's the fairly short and quick version of that.

It came with a lot of risk, it came with a lot of anxiety, but I think it's been relatively successful in meeting those goals over the last ten years.

COUNCILWOMAN TASCO: Thank you.

COUNCIL PRESIDENT VERNA: I would ask Dr. Schwarz to approach the

table. I believe you want to clarify much of what's on Page 43? I see there are a number of curfews; I don't know what that means.

MR. AGOSTINI: Madam President, thank you. Steve Agostini, Budget Director.

The Health Commissioner and I were talking about this, and what became clear -- and we apologize for the confusion about this. What became clear is that the page you're referencing, the 2008 dollars that are allocated there represent what was actually allocated for 2008.

What we have for 2009 represents more of a placeholder, and it's a placeholder that tries to capture the following dollars. One, that the decisions at the State level haven't been made as to the actual dollars that are made available. We may end with up best less may, we may end up with more.

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In trying to sort of allocate in appropriately, what Behavioral Health did was sort of set dollars aside to, in essence, sort of reflect what had been spent in prior years, but that may change as our allocation from the State changes.

It functions as a placeholder. It's not the best way to approach that, and we apologize for the confusion, but as we get more information and we have a better sense from the State, what we would like to do is bring that back to you and the Council to provide that information and provide that detail so that you have a more accurate snapshot of what that is.

COUNCIL PRESIDENT VERNA: I'm just checking to see if and where these curfew centers are; and if, in fact, they were in existence in 2007 and 2008.

DR. EVANS: The curfew, what

that is not the curfew centers, per se; it's the Behavioral Health supports for the curfew centers. And it was --

COUNCIL PRESIDENT VERNA: Wait a minute, you lost me. Let's go back. What did you say? What is a curfew center?

DR. EVANS: The curfew centers are the curfew centers that are around the City. They are part of the administration's public safety campaign.

The Police Commissioner is strongly supportive of them and the Department of Behavioral Health has been an integral part of them by providing Behavioral Health supports.

COUNCIL PRESIDENT VERNA: Doctor?

DR. SCHWARZ: I agree with Dr. Evans. Essentially, we bring young people who are caught or found out after curfew to a center. And rather than just warehousing them, there are

services. This represents the services for those young people. The expense for the curfew centers themselves, the facility itself is in DHS budget, in the Safe and Sound part of the budget.

So there are two budget items here for curfew centers.

COUNCIL PRESIDENT VERNA: But this isn't Safe and Sound. Are those curfew centers? I doubt that any of my colleagues know where they're located in this budget. I don't know that many of my colleagues would know where these curfew centers are on Page 43 of the budget. Could we possibly have a list of them, where they're located?

DR. EVANS: Yes, we can give you that but -- yes.

COUNCIL PRESIDENT VERNA: There aren't that many. If you have it before you, why don't you just give it to us for the record.

DR. EVANS: Yes, I can, sure.

For the record, The Lighthouse

at 141 West Sommerset Street.
There's another at 42 -- I'm sorry, 4620 Briscom Street.
Another at 4300 Germantown Avenue.
Ray of Hope at 6640 Wyncote Avenue.
1319 North 52nd Street.
1601 Hellerman Street.
6517 Chester Avenue.
2551 North 22nd Street.
2029 South Eighth Street.
2700 North 17th Street.
And 1920 South 20th Street.
COUNCIL PRESIDENT VERNA: So to the Budget Director, I ask: Page 43 is something that we should not even be discussing at this point because --
MR. AGOSTINI: Madam President --
COUNCIL PRESIDENT VERNA: -- we don't know what the State is doing, for one thing. And when would we know and how would we address this issue?

MR. AGOSTINI: Madam President, that's a very fair question. We should come back to you when we have a better sense of the actual allocation from the State. And then with our preliminary attempt to sort of allocate those dollars so that what you have before you is more accurately reflective of what we would do moving forward.

I don't know the timeframe. I would defer to Dr. Evans or Dr. Schwarz on the timeframe.

They're telling me by mid-May.

COUNCIL PRESIDENT VERNA: Thank you. All right.

Councilman Jones?

Doctor, thank you very much.

COUNCILMAN JONES: Thank you Madam President.

Two quick questions. One, what percentage of the prison population requires mental-health services? And to what degree are they included in the general population?

DR. EVANS: I don't know what the exact percentage would be; I'd have to talk to the Prisons Commissioner.

The prison has a separate facility for individuals who have the most serious mental health needs, and they are sequestered. The other individuals who might have less severe forms -- less severe mental health problems are integrated into the general population.

COUNCILMAN JONES: To what degree -- and this is my final question. How do you take people that are maybe institutionalized and recidivise them into communities, and how are families and relatives involved in that process?

DR. EVANS: That's a really good question. That is, I think, at the heart of the work that we're doing in the City in terms of trying to transform our system.

Historically, behavioral

health systems tended to be very institutionally-based. We created treatment, we discharge people back to the community, and we assume that people are going to sustain their recovery going back to the community.

We're putting much more emphasis on the kinds of supports that I talked about earlier. The recovery center doing more family work in particular with children, making sure that we're not only doing the family work prior to children leaving residential treatment, but also making sure that there are community-based supports in the community that allow -- that sustain the children in terms of the progress that they've made in residential treatment.

So it's a large emphasis on that. And we're doing that across populations, whether it's children, adults, addiction or mental health.

COUNCILMAN JONES: Are any of

those court-mandated involvements?
DR. EVANS: Some of them are. There is a percentage of people that we work with who are forensically involved, and we're work with the courts with those populations.
COUNCILMAN JONES: Thank you, Madam President.
(Councilwoman Tasco takes over as chair of the committee.)
COUNCILWOMAN TASCO: I'm going to take advantage of serving as the Chair to ask my questions.
DR. EVANS: Okay.
COUNCILWOMAN TASCO: If I can find them here.
On Page 40, a $56 million increase is identified for mental health and mental retardation services. What services does this increase represent?
MR. COVONE: This would basically -- the primary dollars that we would anticipate expansion for would

be on the MR side. The State has undertaken a major waiting list initiative over the course of the last couple of years so that individuals who have been living at home have had the opportunity to move into either day services or, in some cases, community residential services.

What we generally try and build with the budget is enough appropriation to accommodate the potential for the waiting list initiative.

The balance of those increases would be an anticipation of if the Governor's budget ends up with a cost of living or some other targeted initiatives there.

COUNCILWOMAN TASCO: On Page 7 of your PowerPoint presentation, you show a 20 percent MBEC participation. What steps are being made to increase that participation?

DR. EVANS: Well, we've been

very aggressive at bringing in minority providers into our network. Over the past three years, we've brought in a number of new providers. We've increased the revenue of minority providers by 29 million over the last three to four years.

And one of the ways we do it is to use targeted investments to -- particularly for providers who want to work in high-risk areas or with specialized populations.

So, for example, we've had providers who are doing special outreach to the Southeast Asian community or providers who are working in some of the most challenged communities within the City. And so what we've done is to provide seed money for those providers to start services in those areas that are underserved.

COUNCILWOMAN TASCO: Are the services pretty much spread around

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across the City, or are you -- is there a -- an unintended effort to -- not effort. Unintended, I guess, impact on neighborhoods? Maybe two or three neighborhoods rather than providing services across the City? Did you look at that?

DR. EVANS: It depends on what the services are. I think if you looked at all of the services, you would see that they're pretty much spread out across the City. We tend to concentrate in those areas where we have a high percentage of Medicaid or unentitled individuals, because those are the individuals who are receiving those services, particularly outpatient services, but the distribution tends to be pretty even.

There are some areas of the City that have more of the residential, particularly the small two- to three-person residential facilities than others, and that has

more to do more with the type of housing that are in those areas than anything else.

COUNCILWOMAN TASCO: Sometimes you will get a provider who will go into a neighborhood, purchase a large home, and then proceed to convert the home into a facility.

Are you mindful of that project, contracting with that person to see if they first converted legally and then went before the Zoning Board?

DR. EVANS: Right, yeah. What we --

COUNCILWOMAN TASCO: 'Cause we get a few complaints about that, particular in the East Oak Lane area.

DR. EVANS: Yeah. We do would with our providers around that. Sometimes providers are ahead of us, and they will do those things unilaterally.

The providers who have been around for a while know that our

expectation is that there will be outreach to the Councilperson in particular and that there will be community work in general if that's needed. There are a couple of providers now that are working with members of Council and community groups in trying to work that out.

And so, for the most part, I think that we do a pretty good job of closing that loop and making sure that the appropriate people in the community know, but there are times when providers may move ahead of us and we are, you know, brought in on the back end of those.

COUNCILWOMAN TASCO: What do you do about it?

DR. EVANS: Well, when we know about it, then we -- you know, our protocol is, you have to involve the Councilperson, and sometimes you have to -- and many times, you have to also involve community groups.

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COUNCILWOMAN TASCO: Are there any more questions for Dr. Evans?
(No further questions.)
COUNCILWOMAN TASCO: Thank you.
DR. EVANS: Thank you.
MR. McPHERSON: The next department is the Department of Human Services.
(Witnesses come forward.)
COUNCILWOMAN TASCO: Before you go, and since you're going to remain at the table, I just need to ask you a question.
I think we've had this discussion before, and I -- you don't have to answer it, but just know that it has -- the issue has come before us a number of times about people who live in a community and the person may have a mental health problem and they're causing a lot of problems and distress to their neighbors.
But because of the law, it's difficult to do anything about it. We

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may call, and they may get 302ed, but they become a constant concern of the neighbors 'cause they feel helpless; they can't do anything, they're not members of the family.

And so, you know, you've done the blueprint, but I think that's an area that you all might want to look at to see if there are -- there may be legislation that needs to be introduced.

I have one constituent who's just constantly -- I mean, just constantly causing my neighbors a problem, and it's very difficult to deal with that.

So that's an issue I'm going to ask you about.

DR. EVANS: Yeah. If those situations come up, please let us know. And I know your office and other offices let us know.

I think, you know, there is a threshold, a legal threshold, that has

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to be met before a person can be involuntarily committed.

Short of that, what we try to do is engage people and try to get them into and connected with some kind of treatment, but sometimes that is a process; it's not the kind of thing that happens automatically.

And so, to the degree that you have those kind of issues, let us know and we'll work with you.

There's a case now that I'm aware of where we're working with a Councilperson that's kind of in a similar situation. And because of my sort of dual role now, the family is -- both DHS involved and Behavioral Health involved, and we're bringing together staff and providers from both systems tow work with that family.

So I think we have a lot of options, and I would just say don't give up if those kind of situations present themselves.

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COUNCILWOMAN TASCO: Well, there's one guy who's running for president. He was on Channel 6.

(Laughter.)

DR. EVANS: Is he getting support?

COUNCILWOMAN TASCO: I looked up, and there he was.

DR. EVANS: Okay. Well, we'll work with him.

COUNCILWOMAN TASCO: Thank you.

(Witnesses come forward.)

COUNCILWOMAN TASCO: You may proceed.

DR. EVANS: It works (referring to microphone).

Good afternoon. I am Dr. Arthur C. Evans, Jr., Acting Commissioner for the Department of Human Services. Today I will present to you the department's FY '09 operating budget request and report on how DHS is addressing the core areas outlined in the City's Five-Year Plan.

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DHS's FY '09 General Fund Budget request is $616.3 million, which represents a carry-forward budget allocation, with no significant budget increase over the current year's level.

The allegation of this request by class is:

Class 100, 98 million.

Professional services, 148 million.

Professional services for the care of individuals, 367 million.

Materials and supplies, 1.6 million.

And equipment 1.8 million.

The allocation by division is:

Administration and management, 15.5 million.

Contract and administration -- contract administration and program evaluation, 3.2 million.

Juvenile justice services, 126.7 million.

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Children and youth, 360 million.

And community-based prevention, 110 million.

Over the last year, DHS has undertaken a major reform effort. This effort is a multifaceted strategy, which is changing the entire culture of the department as well as the way it addresses service delivery, accountability, communications, and infrastructure.

As part of this effort, the department has developed a new mission and core values statement that serves as a foundation for its policy and practice.

It states that DHS's mission is to provide and promote safety and permanency for children and youth at risk of abuse, neglect, and delinquency. Our goal is to strength and preserve families while empowering them to make choices that lead to

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safety, stability, and well-being.

We partner with communities, providers, advocates and each other to develop and deliver preventative and culturally-appropriate services that are consistent with the needs of Philadelphia's diverse communities. This mission is well aligned with the core areas outlined in the City's Five-Year Plan.

In terms of public safety, the core area of public safety is at the heart of DHS's mission and its reform effort. One of the department's major accomplishments in this area has been the completion of face-to-face visits with every child in the Children and Youth Division who is either in placement or receiving in-home services to ensure their safety and well-being.

We have also adopted standardized evidence-based tools to improve the way we assess the safety

of children in our care, and are currently in the process of training staff to use those tools.

Additionally, in line with the City's plan to improve emergency response time, DHS has taken several steps to improve its own response to potential emergencies. The department now ensures that children five and under for whom a report of abuse or neglect has been made are visited within two hours of the time a report is accepted for investigation.

In addition, a rapid-service response initiative is also in place to provide services during the investigation period to children with reports of abuse or neglect.

DHS is also striving to eliminate preventable deaths of children due to fire or co-sleeping. We've teamed up with the Fire Department to provide working smoke alarms and education to families

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involved with DHS. We've also partnered with the Health Department and the Maternity Care Coalition to raise awareness of the dangers of unsafe sleeping and provide cribs to families.

The department is also improving public safety by aggressively working to reduce juvenile crime. Through the Adolescent Violence Reduction Partnership, outreach is conducted in community settings to youth at high risk of delinquency or violence. Program participants receive regular and intensive supervision and are linked to a continuum of supports.

In addition, the police, under Commissioner Ramsey, are using the curfew centers more to reduce the number of young people on the streets during the hours when crime is most prevalent.

Finally, we are making strides

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in reducing recidivism among those who are involved in the juvenile justice system. The Philadelphia Reintegration Initiative provides young offenders with the necessary supports and resources to help them make a process transition into their community and to avoid first time contact with the criminal justice system.

Education is another key component of our mission. DHS is actively involved in the effort to ensure our city's youth consistently attend and graduate if school. The department's truancy prevention programs provide case management and support to address the underlying factors that lead to truancy for youth involved in the City's regional truancy court process.

To help youth who have already dropped out of school complete their education and prepare for employment,

the department supports specialized community-based programs called "E3 Centers," which provide intensive career preparation, educational support, life-skills training, subsidized employment opportunities, and job-placement support particularly for youth who have been involved JJS.

All of the youth in placement receive instruction and mentoring to help develop the life skills they need to live independently through a variety of programs at the Achieving Independence Center.

In the coming year, the department will also collaborate on an education and physical-health support center to provide consultation and technical assistance regarding the education and health-related services that DHS-involved children and families needs.

Healthy and sustainable communities are also central to our

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mission. DHS funds a comprehensive network of community-based prevention services that help at-risk families address the underlying problems that often lead to abuse and neglect in an effort to reduce their involvement with formal child protective services.

In addition, our Teen Placement Diversion Program has been effective in helping families address issues that might otherwise result in the placement of an older youth. For children already in the department's care, DHS has been extremely successful in attaining permanent homes in a timely manner through initiatives such as performance-based contracting as well as a pioneering Achieving Reunification Center, which provides a host of services under a single roof to help parents with children in placement reunite with their families.

In situations where

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reunification with a child's family of origin is not an option, we employ innovative measures to find loving adoptive families such as the Heart Gallery, Wednesday's Child, Philly Kids Connection, and Faith and Families in permanent legal custodianship.

DHS is also better meeting the physical and mental health needs of children in our care. Nurses are onsite to assist social workers on cases involving medically-fragile children, and Behavioral Health staff provide consultation to the social workers for children with behavioral health issues.

In the past year, DHS has also diligently strived to improve the quality of our services as well as way we communicate with families. We have established the Commissioner's Action Response Office to address concerns and complaints, and have contracted

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with the Consumer Satisfaction Team, incorporated, which conducts consumer satisfaction interviews with youth in group homes.

In addition, DHS is working hard to communicate more effectively with its clients, stakeholders, and the general public. Widely distributed newsletters and reform updates as well as a regularly updated website provide information about our reform efforts and other important issues. We also continue to hold town meetings in locations throughout the City to provide information about the reform, answer questions, and address concerns.

Moreover we meet regularly with the Community Oversight Board that was established by the Mayor, the Child Welfare Advisory Board, and other stakeholders.

We are also taking steps to ensure that clients receive highest-

quality services. We have implemented enhanced standards for targeted providers, and we are holding them accountable. Every week, contract administration and program evaluation staff call a random sample of families to validate that our providers are visiting regularly and providing the services and supports families need.

Furthermore, the department is undertaking several efficiencies to reduce cost and adhere to its budget, including reducing overtime while ensuring effective delivery of client services and thoroughly examining ways to reduce paperwork requirements so social workers can devote more of their time to direct client care.

Additionally, as noted, the department is making numerous service improvements through its reform effort. DHS is fervently dedicated to becoming the best child welfare agency in the country. In doing so, I

believe this agency will significantly advance the goals outlined in the City's Five-Year Plan.

Thank you for this opportunity to present on behalf of the Department of Human Services. I will be happy to answer any questions that you may have.

COUNCIL PRESIDENT VERNA: Thank you, Doctor.

Dr. Evans, is DHS's proposed FY '09 budget consistent with the proposed State budget?

DR. EVANS: It is consistent with what we have been told our allocation will be from the State for FY '09.

COUNCIL PRESIDENT VERNA: Can you tell us, when will you be vacating the current Juvenile Justice Center?

DR. EVANS: We are planning to move out this summer. We don't have a date certain on that yet, but we are anticipating that we'll be out by this

summer.

COUNCIL PRESIDENT VERNA: And can you tell us when you expect the new center to be completed?

DR. EVANS: The final center?

COUNCIL PRESIDENT VERNA: (Nods head.)

DR. EVANS: I believe that is 2010.

UNIDENTIFIED SPEAKER: Summer.

COUNCIL PRESIDENT VERNA: The summer of --

DR. EVANS: The summer of 2010.

COUNCILMAN JONES: Point of information, Madam President.

COUNCIL PRESIDENT VERNA: Yes. The Chair recognizes Councilman Jones.

COUNCILMAN JONES: When is the interim temporary not-to-exceed-three-years-and-a-day center going to be completed?

DR. EVANS: As I mentioned, we anticipate moving in the summer, probably the late summer.

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COUNCILMAN JONES: And out in three years or --

DR. EVANS: And we'll be out in time for the new center.

COUNCIL PRESIDENT VERNA: In 2010.

DR. EVANS: In 2010.

COUNCILMAN JONES: Thank you.

COUNCIL PRESIDENT VERNA: Dr. Evans, on Page 45-5 of your detail, it reflects a $4 million reduction in prevention programs. Will you explain this reduction, please.

DR. SCHWARZ: This represents a transfer of $4 million within DHS from Safe and Sound programming to other programming in Children and Youth.

COUNCIL PRESIDENT VERNA: Any particular programs, or can you tell us for the record?

DR. SCHWARZ: There are both programs that currently are pass-through programs and programs which were divided in the last administration

between Safe and Sound and DHS prevention programs.

So this represents rationalization, if you will, of those programs, so moving dollars back so that we have a rational expenditure within DHS for programming as opposed to pass-through's.

COUNCIL PRESIDENT VERNA: Dr. Evans, on Page 46-76, would you please explain for the record why you're requesting over $46,000 for Fund for Philadelphia? And also for the record, can you tell us what Fund for Philadelphia does?

DR. EVANS: The $46,000 is for family-preservation programs.

COUNCIL PRESIDENT VERNA: I'm sorry?

DR. EVANS: The $46,000 is for family-preservation programs. Those are families where we're trying to keep the family together.

COUNCIL PRESIDENT VERNA:

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Please explain for the record precisely what the fund -- what is the Fund of Philadelphia and what does it do?

DR. EVANS: The fund, as I understand -- and I discovered the fund probably halfway into my tenure -- is a mechanism that the department has used historically to fund a variety of activities: In particular, what we just talked about, the family preservation, but also things like the facility rental. The department does not have adequate space in our building at 1515, and so we rent a considerable amount of space from Temple University.

Communication. You probably are aware of a public relations or a public education campaign that we recently did on safe sleeping. Those activities are funded out of the Fund for Philadelphia.

COUNCIL PRESIDENT VERNA: All right. On Page 46-76, you're requesting a little more than $46,000.

Again, on Page 46-82, you're requesting over $879,000 for Fund for Philadelphia. Can you please explain?

DR. EVANS: In the $879,000 portion of that, that would be our public outreach efforts.

As I mentioned, in -- I didn't mention the numbers in my testimony, but in Philadelphia, for example, we have between 40 and 50 children who die each year as a result of unsafe sleeping conditions. Back in October, we started a public education campaign to educate the community about that. That comes out of our communications budget, which is operated out of the fund.

In addition, the facility rental that I talked about, there are some Web-based activities that are also a part of that.

COUNCIL PRESIDENT VERNA: Dr. Evans, let me ask you, does Fund for Philadelphia actually follow

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bidding requirements?
DR. EVANS: I don't believe that the way the fund operates today is consistent with the new contracting requirements. And, in fact, when I discovered the fund, one of the things that we did was a review of the fund.
We looked at what was in the fund and we made the decision that those things that needed to fall in line with those contracting requirements would be procured that way in the next fiscal year, starting July 1.
COUNCIL PRESIDENT VERNA: I'm sorry, they would...?
DR. EVANS: They would be procured that way, beginning July 1 of this year.
COUNCIL PRESIDENT VERNA: And how long are these contracts for, just a year?
DR. EVANS: I'm sorry?
COUNCIL PRESIDENT VERNA: If a

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contract is signed, how long is the contract for?

DR. EVANS: A contract is for one year.

COUNCIL PRESIDENT VERNA: Is it for a year, is it for three years?

DR. EVANS: A contract is for one year.

COUNCIL PRESIDENT VERNA: One year.

DR. EVANS: We can't contract beyond one year.

COUNCIL PRESIDENT VERNA: You can't contract beyond one year?

DR. EVANS: That's correct.

COUNCIL PRESIDENT VERNA: Why is that?

DR. EVANS: Without an amendment.

COUNCIL PRESIDENT VERNA: Without...?

DR. EVANS: I'm sorry?

COUNCIL PRESIDENT VERNA: Without what?

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DR. EVANS: Without Council approval or an amendment.

COUNCIL PRESIDENT VERNA: So are we just doing it for a year so Council doesn't have to approve?

DR. EVANS: I'm not following your question. I'm sorry. What contract --

COUNCIL PRESIDENT VERNA: Are we just doing one-year contracts so that they don't have to come to City Council to approve the contract for more than one year?

DR. EVANS: No.

COUNCIL PRESIDENT VERNA: Well, why are they doing just a one-year contract?

DR. EVANS: I'm not sure I'm following the question. When you say "they," who are you referring to? Are you talking about the Fund for Philadelphia?

COUNCIL PRESIDENT VERNA: Okay. Dr. Evans, on Page 46 -- we'll come

back to the bidding process.
On Page 46-122, you're requesting more than $109,000 for the 1st Judicial District for the REAPP Program. What does REAPP stand for?
DR. EVANS: I'm sorry, what page were you on?
COUNCIL PRESIDENT VERNA: Page 46-121.
DR. EVANS: I'll have my Director of Prevention talk about the program.
COUNCIL PRESIDENT VERNA: Sure.
(Witness comes forward.)
COUNCIL PRESIDENT VERNA: Good afternoon.
MS. WALKER: Good afternoon.
COUNCIL PRESIDENT VERNA: Please identify yourself for the record.
MS. WALKER: Ellen Walker, Divisional Director for Community-Based Prevention Services.
We apologize for the acronyms,

but REAP, which stands for reasonable efforts at assessment and planning, is a program facilitated by the First Judicial Court system for children that are brought to that system for incorrigible (indiscernible), et cetera.

COUNCIL PRESIDENT VERNA: Can you tell us how these funds are budgeted for in the courts?

MS. WALKER: They are budgeted in collaboration with Judge Dougherty. This year, they were budgeted in line with the utilization by program. Some programs were reduced.

Next year, we are looking at whether to continue the current structure or whether we do want to RFP it out.

COUNCIL PRESIDENT VERNA: Can you give us an example of the program, what it does, please.

MS. WALKER: Case-management services to the older youth that -- for

example, a mother feels their child is incorrigible, they're not appropriate for child welfare services, they want to bring 'em to court to evoke what actions the court can bring to the table, so to speak.

And the court, as a diversion method, uses the REAPP programs to provide intensive case-management services to those older youths while the case is opening or pending opening with the family courts.

COUNCIL PRESIDENT VERNA: Thank you.

MS. WALKER: You're welcome.

COUNCIL PRESIDENT VERNA: The Chair recognizes Councilwoman Tasco.

COUNCILWOMAN TASCO: You know, Dr. Evans, we want a little update on Safe and Sound. Would you give us an update? I'll repeat my question.

DR. EVANS: Sure.

COUNCILWOMAN TASCO: 'Cause there are some, you know, providers

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that are still concerned about their funding and what's going to happen in '09, so if you could give us a little update, I would appreciate that.

DR. EVANS: Dr. Schwarz would like to give that update.

DR. SCHWARZ: As we discussed at the time of the hearings here in City Council, we have been throughout the last month working with Safe and Sound on their budget revisions for the current fiscal year.

COUNCILWOMAN TASCO: Mm-hmm.

DR. SCHWARZ: We, I believe, have come up with a final agreement.

In addition, we've been meeting, as you directed, with providers on a weekly basis to assure that providers have agreements in place, that they're clear on their allocation and that they're clear on the expectations for them in terms of serving children between now and the end of this fiscal year.

We have told providers that the summer program, particularly the after-school summer program and Beacons, will receive word from the administration through Safe and Sound this week about our intentions. We're in the final stages of that discussion.

COUNCILWOMAN TASCO: Mm-hmm.

DR. SCHWARZ: The chief set of issues is that we want to both assure that the program is in keeping with the Mayor's agenda and that we don't leave children without something to do in the summer.

And we are trying to figure out the balance between existing providers and existing areas of the City and the nine high-crime areas that the Mayor has targeted.

COUNCILWOMAN TASCO: Mm-hmm.

DR. SCHWARZ: So that is the current discussion.

We also are developing a

timeline for looking at each of the programs that's within the Safe and Sound Program for opening rebidding, as we promised Council we would over the course of the spring. We hope to have those requests for proposals out within the next 60 days certainly and back by the beginning of June so that by the --

COUNCILWOMAN TASCO: This is to operate the program?

DR. SCHWARZ: Operate the program beginning in Fiscal Year '09.

COUNCILWOMAN TASCO: Okay, mm-hmm, okay.

I'm still on, right? Thank you.

Over the past several years, Council has heard from DHS providers that they have not received consistent cost-of-living increases or rate adjustments to compensate them for additional contractual and regulatory requirements such as obtaining FBI

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clearances for staff and foster parents and increased home visits.

This year, some services did receive a 2 percent increase, but this did not cover the skyrocketing expenses like gas, health insurance, and utilities.

Some programs such as diversion case-management and counseling and educational services have not received increases since their inception.

As a result of chronic underfunding, providers cannot offer competitive salaries to attract and retain staff. Will a COLA be given to the providers in 2009?

DR. EVANS: Well, right now, Councilperson, our tentative allocation from the State does not include a COLA for providers. I have been consistently an advocate for not only COLAs for providers but paying providers a fair and adequate rate.

And, in fact, we put that into our needs-based budget request consistently since I've been at the department.

We will continue to advocate with the State around that issue. I know that the statewide provider organization is lobbying hard for that. We would be very supportive of that.

The problem for us right now is that we get our allocation from the State. At this point, our allocation does not include that. But we feel -- and I feel personally very strongly -- that we should make sure that providers are paid an adequate rate.

What happens when they are not paid an adequate rate is that we get poor quality of services, they have high turnover, and ultimately, the people that we're trying to serve aren't served adequately.

COUNCILWOMAN TASCO: Okay, thank you.

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As DHS moves ahead with reform efforts, how does it plan to adequately fund client services delivered through the private sector?

DR. EVANS: I'm sorry. I didn't quite understand the question.

COUNCILWOMAN TASCO: (Referring to aide.) Let me ask him; he wrote this question.

(Laughter.)

COUNCILWOMAN TASCO: Again, let me -- while he's trying to figure that out for me, would you talk to me about your minority participation? It seems that you have 17 percent. Tell me how you plan to increase it.

And also let me know if there are enough providers in the broader community that maybe contracted before in the past, haven't contracted in a while, maybe they went out of business or maybe they did something else. And are they coming back, or just what is going on with that?

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DR. EVANS: Well, I think there are a few answers to that question. The first is that the department has to put an emphasis on what is often called "cultural competency," the degree to which a provider understands the community that they're serving, has members of the communities that their serving, hopefully are a part of the community that they're serving.

I think increasingly what we are trying to do, at least certainly under my tenure and I'm sure in my predecessor's tenure, is to write into RFPs that as a requirement, that that's not an add-on but that's really central to how service delivery happens.

And so by doing that, we increase the odds that we will have in the pool of people that are selected providers from the minority community.

Secondly, I think -- and this is an area that we frankly have not

worked on in the last year primarily because our attention has been diverted on the reforms, but I think we have to do a better job of providing technical assistance to providers.

My experience, both in Behavioral Health and in Child Welfare, is that often you will have providers that are very good at engaging the community, can be very good at service delivery, but may not have the administrative infrastructure, may not have the administrative systems to really run a business in a way that -- that's needed.

And I think that by providing more support around those kinds of technical administrative capacities, I think we're going to do a much better job of making sure that we have a broad and diverse group of providers.

I can talk more about it if

you'd like. I think it's an important issue, but I think it's not something that happens simply because you want it to happen; I think you have to make an effort, you have to be willing to put resources into it.

I think that the department overall has done a good job. I mean, one of the difficulties in the private and nonprofit world is that, how do you define "a minority provider"? Is it where they're located? is it who the CEO is? if the CEO changes, does that mean it's no longer a minority provider? is it the board of directors?

What we did on the Behavioral Health side a couple of years ago to try to get a handle on that was, we actually surveyed our providers and asked them, you know, tell us the racial, ethnic composition of your board of directors, tell us the CEO, who it is that you serve primarily.

And even with all of that information, it was kind of difficult to, you know, where do you draw the line in terms of defining?

In the private world, it's a lot easier; it's my ownership, and you don't have the same kind of ownership in private nonprofits.

That being said, though, there are some providers who historically have been considered minority providers, and those are the ones that we try to reach out to.

COUNCILWOMAN TASCO: Okay. Do you feel that the children are now in the last, say, year or so, the children are -- our children are safe under the care of DHS or safer (inaudible) --

DR. EVANS: I would say that children are absolutely safer today than they were a year ago in the department, and that's, I think, due to a lot of hard work of a lot of different individuals. And I can give

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you a number of examples.

One of the recommendations from the Mayor's expert panel, national panel, was that we respond to reports of abuse or neglect within two hours. We call that our "expedited response," and so now, if you call into the department and the child is 0 to 5 years of age, and we accept that as a report, we're out there within two hours. The last data that I looked at showed that we were meeting that standard over 90 percent of the time.

We are -- we have much better oversight of our contractors. I mentioned in my testimony that we do random calling. You may recall one of the really horrific cases that was publicized prior to my coming to the department. It was very clear that a provider was supposed to be visiting a child, had not seen the child. Because we didn't have systems in

place, the department missed it.

We now randomly call families to find out whether or not a provider has shown up. It's been very helpful in both verifying that the service has been delivered, but we've also found other issues that we've been able to intervene on.

We're working much closer with the Behavioral Health System to share information. What happens sometimes is that information about a provider might be discovered in Behavioral Health System, but we have not been very good at making sure that the DHS knew about it or vice-versa.

We're now sending joint teams out across the country to residential providers and making sure that we are sharing that kind of information.

There are at least a dozen examples of things that we're doing today that we weren't doing a year ago that have a direct bearing on the

safety of children in the system, and we're just beginning.

I think one of the major changes that we're making is changing and moving to an evidenced-based way of assessing safety, which is -- probably will have the biggest impact on the department's ability to keep kids safe.

Prior to now, when an assessment was done on a child, it was not standardized. It was -- clearly, people had some guidelines, but you may do it a little different than the way that I did it.

We are eliminating that kind of variability by moving toward a more evidence-based tool and being very clear about what are the things people ought to be looking at and basing their decision on.

By -- in two weeks, we will be moving to a structured decision-making process in the hotline, something

called "guided decision-making." Again, standardizing how those calls are received, what information is asked for on the phone, and then how that information is analyzed, and then a disposition made. That will be starting in two weeks. We are training all of the hotline staff on that practice.

So, again, I can easily talk about at least a dozen things that we've implemented just really over the last ten months, and there are another does practices, changes that we'll be making that we think will significantly improve the safety of children.

COUNCILWOMAN TASCO: Thank you. Well, we enjoy having Dr. Evans over there. We want to have him back at CBH (inaudible; off-mic).

DR. SCHWARZ: We've been working on it.

(Laughter.)

COUNCILWOMAN TASCO: Okay. Thank you very much.

COUNCIL PRESIDENT VERNA: The Chair recognizes Councilman Jones.

COUNCILMAN JONES: It was fascinating to hear your testimony on how you're making improvements on information systems.

I had a brief question to ask. How does that information -- how will that information be used in 3-1-1? And to what degree do you share information with other relevant departments; meaning, does the guidance counselor at the school know about the health -- the mental-health problem of the student, and is there unified treatment of that individual when we run into problems?

DR. EVANS: Very good question. I think really at the heart of a lot of reforms that we're making is, how do we share information. And I think your question alludes to the fact that a lot

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of the children -- probably the majority of the children that we work with also touch other systems, whether it's Behavioral Health System, educational system, a lot of those systems. And often, the work with that family is not coordinated information, is not shared. And often, I think too often, systems work at odds with each other.

So there are a couple of things we're doing. One of them is creating something called "an educational support center." We've gotten approval or agreement with the School District of Philadelphia to station -- to outsource a person that will be in the department and will be a resource to our staff. Because a number of the children in the child welfare system have very significant educational needs, which cannot be adequately -- excuse me, adequately be addressed by people who are not

educational professionals. And so that's one concrete way that we're doing that.

I know that the City is looking at how to incorporate on a wider scale something that had been called "DSS Cares" and is now called "Philly Cares," and I know Dr. Schwarz is working very hard on that issue, which allows us to pull information from various databases from Behavioral Health, from Child Welfare, from other systems, and essentially create a dashboard where you can see all of the systems that a child is -- or a family is involved in.

That will be a huge improvement. Of course, that has to be done with the proper -- the proper releases, but that will be a huge improvement, because right now, you could have someone in the child welfare system who is also maybe in the shelter system or maybe in the

Behavioral Health System, and that information is not known.

And so those are concrete things that are underway that will greatly improve that ability to coordinate care for individuals that we serve.

COUNCILMAN JONES: Data, when processed, becomes useful information. And I'm wondering, are there bells and whistles that you guys look for when you notice a problem, whether it is abuse, whether it is neglect by way of nutrition?

I mean, what are the bells and whistles, signals that can be incorporated into this data-gathering to give a social worker a heads-up that they need to make a visit?

DR. EVANS: Again, I think that's a good question. I don't think we at this point -- well, there are some things that will be built into the new data system that will greatly

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enhance a social worker's ability to stay on top of the case, but I think that there are even more opportunities.

For example, when we did a study of the parents of -- the parents who had essentially killed their children, and we looked at those parents, over half hour of those parents had also had a history of being abused or neglected themselves.

So that tells us that if we're working with a family where the parent had been in the child welfare system, that is a high-risk case just by definition.

And so what we've done in the interim is to send out an alert to our staff, sort of educating people that this is a high-risk factor, this information that went out to all of our social workers.

I think what you're suggesting -- I think what you're suggesting is that we ought to also

look at opportunities to create a flag within our system so that as we're taking history, that information goes in, that that becomes a flag for the social worker.

And I think that kind of -- using technology makes a lot of sense and, I think, is the next iteration of this.

COUNCILMAN JONES: I know you have all kinds of legal issues by way of confidentiality. I know that you have to respect the client-patient privilege, I understand all of that.

But if we can prevent a death by these bells and whistles being in place, I'm willing to lose a little bit of that confidentiality to save a life, and I'm encouraging you and your departments to look at those things so that we can -- now, there are no absolutes. One bell, one whistle doesn't equal one train wreck always.

DR. EVANS: Right.

COUNCILMAN JONES: But if we can prevent it a percentage of the time, I think that will be good.

Now, my understand part of that question is: How does the 3-1-1 system integrate with what you're doing?

DR. EVANS: Well, Dr. Schwarz might want to talk more about that.

My understanding of the 3-1-1 system, as it is evolving, is that it's really an information and a referral system. We would either provide staff there locally or we would be connected to 3-1-1 electronically for those cases where someone called in needed information and it really was a DHS issue.

We have the infrastructure within DHS to handle those calls. I think the issue is, how do we then connect that infrastructure to the broader 3-1-1 infrastructure? And that's the kind of thing that I know

people are looking at right now.
COUNCILMAN JONES: Just thank you. And the reason why with ask so many questions is not just to get on your nerves, but it is --
DR. EVANS: I think they're good questions.
COUNCILMAN JONES: Here's why: When we go out in the public, in town meetings, town hall meetings, we are you; meaning, they see the City as one entity. They don't know this department from that department.
So in many cases, we have to be your ombudsman, your translator, your ambassador, if you would. So the more we know, the better we are able to address at least the questions that we get from the public.
So I thank you, Dr. Evans.
DR. EVANS: Thank you.
COUNCIL PRESIDENT VERNA: The Chair recognizes Councilman Green.
COUNCILMAN GREEN: Thank you,

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Madam Chair.

Good afternoon, Dr. Evans.

DR. EVANS: Good afternoon.

COUNCILMAN GREEN: You mentioned a new data system, and I walked in late, so I apologize if you mentioned DHS Cares before I got in here.

But can you describe what you mean by "new data system versus? the DHS Cares?

DR. EVANS: Two different things. And I'll let Dr. Schwarz talk about the DSS Cares or Philly Cares, as we're calling it now.

The department has right now a legacy system called "FACTS," which is a sort of an old, awkward system. It really requires a lot for our social workers to use that.

We are updating that system to what we're calling "FACTS II," which is more of a Windows-based system, more a point-and-click kind of

interface and an interface that allows us to do more of the kind of programming that I was just talking to Councilperson Jones about.

So we are very close to being able to launch that. We have identified all of the business practices, we have done the programming, and we are going to be launching that within the next month or two.

COUNCILMAN GREEN: When you say you identified the business practices, did you look at current business practices and program around those?

DR. EVANS: Well, it's a combination of looking at what we were currently doing, but then also looking at opportunities moving forward, because what we didn't want to do is just simply take outdated practices and then automate them; we really wanted to capitalize on the technology. And so we really tried to look forward and do

that.

I'll give you an example. One of the reasons that the system isn't up now -- I mentioned a little while ago that we are moving to something called "guided decision-making," which is a structured way of taking information in and making decisions.

And so, three months ago, I was asked whether or not I would delay the implementation of the new system so that we could program that into the system.

Now, my view was that it was a great opportunity. We've changed the practice for the social workers at the front end. If we can automate that and delay the implementation by three months, it made a lot of sense. And that's the kind of thing that we tried to take advantage of groups.

COUNCILMAN GREEN: So earlier, Dr. Schwarz and I were having a conversation about EMR and an effort to

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go paperless within the medical practice in the Department of Health.

So what extent does FACTS II move us towards the elimination of paper to the extent legal and practicable within your department?

DR. EVANS: Another good question.

There are two parallel processes that are going on in the department. FAX II predated me coming to the department, and people have been working on that, I think, probably two or three years. And so that was pretty close to being ready to be launched not long after I came into the department.

As I mentioned, we delayed the implementation. So that process has been going on.

When I came to the department and looked at the efficiencies, or inefficiencies, one of the things that was very clear to me was that we spend

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a lot of time -- our social workers spend a lot of time filling out paper, and they literally have boxes and boxes of paper.

And my view is that there's no way that can be useful. A person can't digest that information and still do all of the work that they need to do.

And so, we brought in national consultants to come in, look at all of the paperwork we were doing, our processes, and make recommendations. And of 269 forms that were being used by our child protection -- as I said, 269 forms that were being used in some way by our staff, we have a recommendation to eliminate 103 of those.

And so, we will be eliminating -- drastically eliminating some forms, consolidating some other forms, and then that work will then feed into this new system.

So we sort of have these parallel processes going on just because of historical issues, but those will merge.

COUNCILMAN GREEN: Are you leaving those forms as paper forms or the --

DR. EVANS: Well, for now, we are. My view is that we need to get the efficiencies and realize the efficiencies quickly.

And so what we will do is eliminate some forms, continue the other forms in some kind of paper fashion, but as I mentioned, the goal would be to try to get as many of those forms into an electronic format so that people aren't filling out the same name and numbers over and over again.

And so we're going to get, I think, some huge efficiencies just by eliminating those forms, but ultimately, I would like to see the

department move to a more electronic format.

COUNCILMAN GREEN: Yeah. If your intake system is electronic and you put all of the information in at the front end, then even if you need to print out a form. Nobody has to reenter the data as long as there's an account number for that client. The forms can be automatically populated; and if they can be automatically populated, they can also be automatically transmitted electronically --

DR. EVANS: The --

COUNCILMAN GREEN: -- even if there are other agencies that require forms.

So there's really no need at all, once you have all of the data in the system, to be filling out a form.

DR. EVANS: Right.

COUNCILMAN GREEN: Would you agree with that?

DR. EVANS: I absolutely agree with that. And the people -- the IT people within the department, I think, have done a wonderful, wonderful job of getting those kinds of efficiencies.

My only point is that if you look at the totality of everything that a social worker has to do, not everything will be -- you'll be able to do that with the first iteration of this. There will be a lot of that kind of efficiency in the first iteration, but I think we still have some room to go in terms of making it completely electronic.

COUNCILMAN GREEN: Okay. I would -- Terry Phyllis and MOIS have done a great job in going paperless. They do have OCR-scanning technology available, for example, in the pension system and the Pension Board.

So I just -- they say it is cut -- and this is without having totally electronic forms. This is

just the first time a paper form comes into the system, it's scanned, which has OCR capability, and then it becomes a part of the file or permanent record electronically.

DR. EVANS: Mm-hmm.

COUNCILMAN GREEN: They say that has cut down their processing time by 50 percent per case because all of the data is available even on a screen in front of somebody, rather than having paper files going back and forth, and then future information, once it's there, is done electronically.

So I would ask you to talk to them about -- or bring them into the process if they have not been in the process.

DR. EVANS: Sure.

COUNCILMAN GREEN: So how is FACTS II different from DHS Cares and Philly Cares? And why are we having two separate systems -- actually, let

me ask that question a second back, something you said.

Many of the agencies and nonprofits and other people that do business with DHS, one of the biggest complaints that I have from them is that -- the people that I've spoken to is that when they send information into you, or data or a bill or whatever it is, that they do it by fax generally or they have to send it in; they can't remit it electronically.

They all have said that they would pay to go electronic on their end if you would go electronic, because it would save them so much time and money.

But one of the biggest complaints is that they're asked for the same information three or four or five times from DHS. What are you doing to try to eliminate that, you know, burden on the people who are having to spend their money on that

instead of the provision of the services that you're contracting them for?

DR. EVANS: It is burdensome and I think that -- I'm very sensitive to that, having been a provider myself.

I'll tell you what we did on the Behavioral Health side. Two years ago, we made a requirement that all information coming into the department had to be electronic. And there were some providers that we helped to get there because some of them couldn't do that.

If I were going to stay in the department, one of the things I would do -- this will be an issue for the next commissioner -- is that I would require that providers move to a completely electronic system. To me, it doesn't make sense in this day and age to have a paper system.

There's Web-based technology, where people can just sign onto a Web

site, enter the information. They've entered it once; we don't have to reenter the information into our systems. There are a lot of advantages and efficiencies that can be realized by moving to a completely electronic system.

I probably won't be in the department long enough to effectuate that, but that would be one of my strong recommendations to my successor.

COUNCILMAN GREEN: Thank you.

Just for the record, do you know how much time a social worker spends on paperwork versus the provision of delivery of services?

DR. EVANS: We didn't do a time study; that was one of the questions I asked the consultant who looked at the paperwork. We didn't do a time study, so we don't know that.

What I can tell you is that I think it is much, much too much of

their time is spent in just completing forms. And literally, it is not unusual to have a box of forms for an individual case.

And that's not a good use of anyone's time because that information is never really used. And so, we want to eliminate that.

COUNCILMAN GREEN: Also, I think I noticed -- or someone told me that DHS spends $700,000 a year on SEPTA tokens?

DR. EVANS: I don't know what the number is, but I wouldn't be surprised. Yeah, Transpasses and tokens.

COUNCILMAN GREEN: And that's for people to get to and from -- that's for people to get to and from sites, not to and from work.

DR. EVANS: I think that is for our staff.

COUNCILMAN GREEN: Yes. And although I'm a big proponent of public

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transportation and I think it's terrific for people to use, in terms of the time of the social worker and the time they have to get to and from places, and when you take a look at the entire DHS fleet in terms of what's available to social workers, I would ask you to please -- I'd ask you to please take a look at Philly Car Share and see if participating in the car-sharing service and eliminating your fleet for people who don't need a car in the evening might actually increase the ability for people to get to and from locations quickly.

I know Philly Car Share or Zip Car or someone else would be very interested in providing the vehicles to you for the week and then having them available to citizens for the weekend.

The more that we use them and citizens use them, the more we're going to get cars off our streets in

the City of Philadelphia and replace the second car with a Philly Car Share car or a Zip Car or whatever.

So I think it might provide efficiencies for your department in terms of time, getting to and from cases and also, you know, be good for the City and the environment, et cetera.

DR. EVANS: Yeah, okay. Yes, sir, we will look at that.

COUNCILMAN GREEN: Okay. Back to my previous question, which was FACTS II, DHS Cares. Why are we having more than one system where people have to input data?

DR. EVANS: Well, I think Dr. Schwarz is chomping at the bit here, so let me give you at least the DHS part of that.

The way DSS Cares was conceptualized was that you have different departments and systems that have their own database, for

legitimate reasons. For example, within CBH, we have to pay claims, and so we have to have a specific database to pay those claims. Within DHS, we have to have a different kind of system, so we're collecting different information.

And so when the concept of DSS Cares, Philly Cares now, was created, you know, I think that the initial -- again, this predated me coming to Philadelphia, but my understanding was that what people tried to do is to take all of that information, put it into one single system, and combine it, and that didn't work well for a lot of reasons.

And so the idea was to leave the databases intact. And, really, what you want to know are some key indicators and -- or key variables in each database. So pull those into a common interface and then be able to look at, Here's a history from

Behavioral Health, here's a history from Child Welfare, here's a history from Homeless Services, which essentially gives you a dashboard of information for each system.

And so, the reason that there are those separations is historically that's why each -- that would be why.

COUNCILMAN GREEN: Right. Philly Cares was programmed using existing work processes in each department and did not look for efficiencies in its implementation. In other words, people had to do their regular department computer programming or paper forms and take the additional step of then putting the information in what we're calling "Philly Cares" right now.

DR. EVANS: Right.

COUNCILMAN GREEN: And that created --

DR. EVANS: Double work.

COUNCILMAN GREEN: Rather than

re-engineering work-flow processes so the information is entered once and the data can then go into automatically a Philly Cares system, we've done that.

Also, I understand, part of the problem is that it was programmed in a way that everybody -- that you had to have permission from through each permission to share the information among the departments because of privacy and privilege concerns, et cetera; when, if the system, when it was originally architectured, had allowed all of the data to go into a system but only allowed those departments that had permission to look at it, then we'd be collecting all of this data over the years while we try to get permission. And then, when finally you get someone's signature, it would all be available.

So I'd ask you to look -- work with MOIS or work with somebody to try

to either scrap that system and just find a way to integrate the databases and then go seek permission based on that, or change the system so that we can have all the information going into these databases so that when you get permission, the whole history is available.

DR. EVANS: Right.

COUNCILMAN GREEN: And it's already been input 'cause it's been in each system's computer. That would create far more efficiencies than requiring an additional step in a social worker or other person's process.

So I just wonder if you could talk about that and whether or not that's a part of the plan.

DR. EVANS: Dr. Schwarz is working on that.

DR. SCHWARZ: Part of the issue is that Philly Cares was not designed with a front end, so it wasn't designed

as a primary input system; it was designed as the back end, taking the information from a series of systems and putting it into a warehouse, which is both searchable and able to then push information back out to each individual system.

The reason that that's needed is that we don't have a unique identifier in the City of Philadelphia for every client. So that if you think about it, the information that's collected in any one system, because I think it grew from legislative mandates, that information is different across systems.

And when someone enters the DHS system, while their name may be John Jones yesterday, they may be George Jones today, for any one reason. Even birth dates are not always accurate. Social Security numbers aren't collected by every system.

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So the expenditure and the heavy lifting, if you will, for DHS Cares, as I understand it, was for the technology to identify clients based on the likelihood that two records are -- relate to the same person, since we don't have a unique identifier, and that's the advantage that it provides to the system.

The problem was that all of that information was only searchable through a web portal that didn't interface back into primary systems.

So that if a social work in DHS put information in, it was then uploaded to DHS Cares, combined with everything else, so if there's a matching record from the justice system, the mental health system, or wherever else, things would be combined, and then sent back to being a separate portal.

What we're currently doing is working with the people who designed

the FACTS II system so that in a way that's seamless, a social worker will put information into FACTS II and then get a little notification that there may be other information in City systems about an individual, can then be prompted to get the individual's consent, and then have that information available within the same application that the Department of Human Services work is using rather than have them access several systems at a time.

Where we're currently thinking at the moment is that the front-end investments that exist, we won't shut them down but, rather, we'll use this behind the scenes to communicate across systems since the expense apparently for trying to move all of these systems to single identifiers is enormous.

COUNCILMAN GREEN: It's enormous to do it with past records.

Can we try to do it going forward?

DR. SCHWARZ: You've anticipated my great interest. We are already exploring for several of the departments in health and opportunity. If there's a way to do that, the carrot, if you will, is that several systems have identification cards; like, for instance, libraries, schools recreation, centers. And the technology for reading those cards has had a major investment, for instance, by the libraries.

We can take that technology and share it with other departments, which we should do, so that we minimize the cost to the City for trying to figure this out. And at the same time, when we do that, we could invest in a single number that all of those people who use that card begin with, and then spread that to other systems.

But we're going to have to do

some major work to, as you can imagine, map every individual to that unique identifier and spread that out, which won't happen overnight, but I think it's an important contribution of this administration to the City going forward.

COUNCILMAN GREEN: Great. I probably misdescribed Philly Cares. What I'd heard from many providers was that it created an additional step, and you're saying that's not the case.

DR. SCHWARZ: The additional step has been because no one interfaced that that information back into the primary input systems so that there were parallel systems that one had to access.

COUNCILMAN GREEN: Okay.

DR. SCHWARZ: What we're doing for relatively minor costs compared to the architectural expense is, we're building a Web-based interface back into the primary system, so that no

worker will have to try to access a separate system. And the information in Philly Cares will be available to them in the front-end system that they're already using.

COUNCILMAN GREEN: Is there any thought or effort to integrate these -- this information or these systems into a platform or a system similar to the one New York City has, which identifies, then, based on all of the information in these kind of programs, what federal, state, et cetera, funds or benefits are available to these people that are not currently being taken advantage of by them so that we can, as the City, make sure we get as much of that to our residents as possible.

DR. SCHWARZ: I think it's a great idea, and it's something in a needs to happen.

The design of Philly Cares as of two months ago wasn't geared toward

allowing that to happen, but it certainly can be in the future.

And the question then becomes, whose responsibility is it and how do we make it the responsibility of the appropriate people who interact with clients for case management and so forth to assure that they have accessed each of those entitlements?

COUNCILMAN GREEN: Okay. If you're pursuing that or looking at that, if you could provide the Chair with that information or my office.

DR. SCHWARZ: We're not yet pursuing that piece of it.

COUNCILMAN GREEN: Okay.

DR. SCHWARZ: There's a lot of work to do at the moment just to get the system to be useful to workers without having to go into a separate system, but I'm happy to work on it over the course of this year and get back to you next year.

COUNCILMAN GREEN: Great.

One finally question for you, Dr. Schwarz, and that is -- I'll give the Budget Director some warning 'cause he distracted me before when he got up.

Are you satisfied with the capital expenditures in the Department of Health? Is 1.3 million enough for this year, or would your druthers be more?

DR. SCHWARZ: We would need to spend that money, and part of the issue is how quickly we can spend money to do things that are needed. And what we can find, as we do those things, may be done more efficiently. So I think every responsible manager would say we should work toward efficiency.

And I believe the capital expenditure that has been allocated, while it won't fix all of the capital needs, I think for this year, it will take us some distance. And I believe that the administration is working

hard to figure out how to meet the large capital needs for all of the --

COUNCILMAN GREEN: And if you look at the six-year capital plan, is that satisfactory?

DR. SCHWARZ: I believe so.

COUNCILMAN GREEN: Okay. I think you're the first department head to say that.

Let's see. I have a couple of questions about the ongoing work of the Community Oversight Board. What is the timeframe for the COB to complete its verification activities outlined in the January of 2008 report?

DR. EVANS: I believe it's the end of the year for the next report out.

COUNCILMAN GREEN: Okay. And I think in the COB report, Page 15 and 16, it said that completing this recommendation -- and its impediments to completing COB's recommendation of

monthly face-to-face contact between DHS and children receiving services, completing this recommendation requires resolution of a number of issues that limit the availability of social workers for home visit, a substantial number, 90 vacancies in case-carrying social work positions, which have required the reallocation of uncovered cases, result in high caseloads, et cetera, delays in (indiscernible) process that needs to be resolved.

What -- I guess I have two questions. Number one, what, if anything, can City Council do to help move the hiring progress along? If you have recommendations, you don't have to have them today, please provide them to the Chair.

And then, what progress have you made in fillings these vacant positions?

DR. EVANS: We've done a couple of things. Just to give you -- sort of

put that issue in context. The paperwork consultation that we just had was an example of that.

We also -- Judge Dougherty, Kevin Dougherty, and I spent a day in Pittsburgh recently to look at efficiencies that can be gained through the court process. Judge Dougherty and I meet every month. We look at the amount of time our social workers are spending in court, we track that, and have been pushing those numbers down.

In addition to that, and the issue that you specifically asked about, was the number of vacancies. We currently are at 56; we've been able to get the number down.

The civil service system can be very onerous. A year ago -- well, not a year ago. Six months ago, I asked our H.R. director to look at how long it took us to get someone in the door with a full caseload from the

time they showed up to the time that they would have a full caseload. That process takes eleven to fourteen months, which is much too long.

And so based on that, we approached Central Personnel and have gotten an agreement to streamline our process of bringing people on.

For example, one of the things that created a large delay in the process was the whole testing process. And so, what we've done is to move the testing process to be a part of the training process.

If we have a cohort, for example, of new graduates from one of our local colleges, we want to bring those individuals in, begin them in the training process quicker, and then use that process to ferret out those who can move forward. That process alone will save us several months in terms of getting people in.

So those are the kinds of

efficiencies that we've tried to -- that we're implementing. As I said, we've cut the vacancy rate in half. We think by making the changes I talked about, by the end of the year, we can be pretty close to having all of the department's vacancies filled.

COUNCILMAN GREEN: Great. If you do have recommendations, I'd be more than happy to help. Thank you very much.

DR. EVANS: Sure, sure.

COUNCIL PRESIDENT VERNA: The Chair recognizes Councilwoman Brown.

COUNCILWOMAN BROWN: Thank you Madam President.

Good afternoon. Earlier today, you mentioned after-school program period. Where are we with the after-school program?

DR. EVANS: Okay. I think, actually, Dr. Schwarz wants to answer that one, so I'm going to defer to him.

COUNCILWOMAN BROWN: Okay.

DR. SCHWARZ: The current situation is that we have, as mentioned, I think, assured that there is a contract in place or a letter in place with every provider, that those numbers and reductions and budgetary requirements have been met.

COUNCILWOMAN BROWN: Okay.

DR. SCHWARZ: And through weekly meetings with providers, I think that you would find that the providers feel that at least they're clear in terms of information.

COUNCILWOMAN BROWN: And expectations.

DR. SCHWARZ: And expectations.

COUNCILWOMAN BROWN: And those meetings continue?

DR. SCHWARZ: They do, every week. We have one on Wednesday of the week.

COUNCILWOMAN BROWN: Okay, all right.

The second question was the --

I think you answered that about the report card.

DR. SCHWARZ: Yes.

COUNCILWOMAN BROWN: Okay. Earlier -- late last year, Councilwoman Tasco and I convened a hearing that was in response to the report prior -- to the report around the evaluation of systemic operations at DHS, and one of the revelations or discoveries was the either inadequate or unavailability of regular professional training opportunities for social workers.

Can you give us an update on where you were you are with that recommendation?

DR. EVANS: Sure. We are making a considerable investment in staff training in the department. And, in fact, our staff might be complaining that we're getting too much training right now. We're asking them to go through a training on a new evidence-based safety tool, which is

several days' long.

I also mentioned the guided decision-making training that we are simultaneously having staff go through.

In addition to that and to other trainings that are available to staff, one of the things that we have implemented is leadership development training. It's our view that -- and my view in particular that if DHS is going to not only initiate the level of change that we're looking at but sustain that change, we have to have people in the organization who are not just good managers but who are good leaders.

And so we've graduated two cohorts of those individuals. Those individuals that are going through that get a 360 assessment, they go through other kinds of assessments, they get some didactic training, as well as coaching after the training.

COUNCILWOMAN BROWN: Okay, good.

DR. EVANS: And so, you know, your goal is -- and we've made this available to all of our supervisory and management staff across the organization.

COUNCILWOMAN BROWN: Okay.

DR. EVANS: And our goal is to have all of our staff, our supervisory and up staff, go through some kind of leadership training.

COUNCILWOMAN BROWN: Just my editorial comment as a former social worker: There's never too much training, especially if the expectations are going to rise.

DR. EVANS: Well, I feel the same way. I think they feel that they have a lot of work to do as well, but we are -- I think people do understand the importance of it.

COUNCILWOMAN BROWN: Indeed. Let me underscore the observation made

by my colleague Councilman Bill Green around efficiencies with regards to the transportation of social workers.

Philly Car Share is becoming more recognizable and respected with regards to the efficiencies that it brings, so I would underscore his recommendation to look into that and see how that might aid the department in efficiencies with the transportation of social workers.

DR. EVANS: I think it's a wonderful idea. I hadn't thought of it. Great idea.

COUNCILWOMAN BROWN: That's it for me for today.

DR. EVANS: Thank you.

COUNCILWOMAN BROWN: Thank you, gentlemen.

DR. EVANS: Okay, thank you.

COUNCIL PRESIDENT VERNA: Thank you very much.

Are there any other questions from members of the committee?

(No further questions.)
COUNCIL PRESIDENT VERNA: Thank you.
DR. EVANS: Council President Verna, this will probably be the last time that I come to you as DHS Commissioner, so I just wanted to thank you and members of Council for your support of me personally and for the department. We've gone through a very difficult time.
I will be going back to Behavioral Health full-time, but I wanted you all to know that we appreciate the support. I'm very confident and very proud of the work that people have done in the department.
And I think it was Councilman Green that asked me, What can you do to -- a more pointed question but I think more generally for people in the department to know that you continue to support the work that they do.

It's very important. And any way that you can share that with them, I think, will mean a lot to them.

So thank you and I appreciate it.

COUNCIL PRESIDENT VERNA: Well, we thank you and we wish you well.

DR. EVANS: Okay, thank you.

MR. McPHERSON: The Office of Supportive Housing.

(Witnesses come forward.)

COUNCIL PRESIDENT VERNA: Good afternoon. Please identify yourself for the record and proceed with your testimony.

MS. MINTZ: Good afternoon. My name is Dainette Mintz. I'm the Director of the Office of Supportive Housing.

COUNCIL PRESIDENT VERNA: Welcome. And thank you for your patience. I know you've been waiting to testify.

MS. MINTZ: Thank you.

Good afternoon, Council President Verna and distinguished members. My name is Dainette Mintz and I am the Acting Deputy Managing Director for Special Needs Housing and Acting Director of the Office of Supportive Housing, OSH. The function of OSH is to plan for and assist individuals and families in moving toward independent living and self-sufficiency.

I am pleased to offer this testimony outlining the OSH budget request for Fiscal Year 2009 totaling $97,989,500, as well the challenges and opportunities that lie ahead for Philadelphians experiencing homelessness and the agencies, offices, and departments dedicated to serving them.

In Fiscal Year 2009, OSH will promote and healthy and sustainable communities and continue to strategize on efforts to address increasing

demand. By focusing on preventing from households from entering emergency housing and measuring the percent of households discharged to appropriate housing, OSH will focus on returning households to housing located in the community. By mandating appropriate placement and measuring success, DHS will enhance its management of the provision of service and resource allocation.

The Housing Retention Program will again target specific neighborhoods that have high rates of foreclosures and evictions, with provider partners assigned to specific geographical areas. In Fiscal Year 2009, this program is expected to again serve over 300 households who would otherwise need to enter the emergency-housing system.

In addition, OSH will incorporate new customer-service standards into to daily operation. By

setting the customer-service standard of communicating the expected wait for an intake interview, OSH will promote efficiency and service delivery and provide effective means to respond to consumer complaints and provide redress when required.

Also, in Fiscal Year 2009, OSH will continue the implementation of Philadelphia's Ten-Year Plan to end homelessness. The major work areas of the Ten-Year Plan are:

Prevent and treat into homeless.

Address chronic homelessness and visible street consumers by providing appropriate housing and treatment opportunities.

Increase the number of affordable permanent housing units.

Revise program and facility operations standards.

And address the above, using best-practice models.

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In keeping with the key principal of fostering healthy and sustainable communities, the Ridge Avenue Center, Philadelphia's main intake and emergency-housing site for single men experiencing homelessness will be phased out over time and reconfigured into smaller, more specialized facilities with community resident resource centers and a community advisory board as part of the model.

This new initiative will promote community collaboration, improved customer service, and foster healthy and vibrant communities. By providing specialized and appropriate placements, the number of visible individuals experiencing chronic street homelessness will decrease, and the public safety and the safety of homeless residents will increase.

As presented to Council, the OSH Fiscal Year 2009 budget request,

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totaling $97,989,500, represents a reduction of 2 percent in General Funds. Of the $40,210,085 General Fund appropriation, the funding breakdown is as follows:

6,601,227 is Class 100.

33,201,779 is Class 200.

236,174 is Class 300.

135,855 is Class 400.

And 35,050 is Class 500.

The OSH Fiscal Year 2009 budget also represents a continuation of focused coordination between City agencies, offices, and departments to provide specialized and appropriate placement opportunities and maximize grants revenues to create appropriate permanent-housing opportunities for individuals and families experiencing homelessness.

By continuing strategic prevention efforts to close the front door to homelessness and prioritizing the creation of additional permanent

housing to open the back door out of homelessness, OSH will be a key strategic partner in ensuring the health and sustainability of Philadelphia's neighborhoods, increasing public safety, and providing consumer-service standards, practices, and accountability.

Our community is capable of developing and delivering lasting solutions to the experience of homelessness, an issue that we all have a significant stake in. We must refuse to allow past successes to be sufficient and recent setbacks to recur.

In Fiscal Year 2009, OSH will implement the described strategic initiatives and accountability measures to ensure quality services for all residents, including those residents living with the least.

I appreciate the opportunity to testify before you today. I would

be happy to answer any questions you may have.

Thank you.

COUNCIL PRESIDENT VERNA: Thank you very much.

Miss Mintz, you state in your testimony that OSH will incorporate new customer-service standards into daily operation. By setting the customer-service standard of communicating, the expected wait for an intake interview, OSH will promote efficiency and service delivery and provide effective means to respond to customer complaints -- or I'm sorry, consumer complaints and provide redress when required.

How long can a wait for an interview be?

MS. MINTZ: It can vary. We're currently in the process of doing a time study, but one of the standards that we want to be able to identify is what is a reasonable period of time

someone should expect to wait when they come into our intake centers and are called and an interview is actually taken to identify what their issues are and how quickly we can then expedite the process for placing them.

And our expectation is that we will be able to identify within all of our facilities what anyone coming in can expect, so that they would then be able to know when we have addressed the wait time that we've identified as the standard.

COUNCIL PRESIDENT VERNA: All right. Miss Mintz, how can telling someone how long they have to wait for an interview improve efficiency?

MS. MINTZ: Because we have had the history of some clients coming in and sitting in our intake centers for a period of time that we believe is excessive. The sooner we do the interview, the sooner we're able to move forward in making the placement.

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So what we're actually proposing here is to increase our response to folks coming into our centers, identifying them coming in, and being able to undertake their interview in a much more expedient manner.

COUNCIL PRESIDENT VERNA: Can you tell us why your General Fund budget is being cut by more than $945,000?

MS. MINTZ: The budget reduction is to address efficiencies within our budget. We are proposing, for example, to address and eliminate funding for organizations in which we had previously been providing General Funds, but we would secured alternative federal funds.

We are also proposing to eliminate funding to a consultant that we had on board to assist us in being able to develop stronger internal processes. So we're proposing to

eliminate those things.

We also had an opportunity to look at how we could increase efficiencies in the relocation of our intake staff from our previous location to our new location and our relocation staff, and we have some efficiencies in the operation costs there.

So those were the variety of things that make up that total reduction.

COUNCIL PRESIDENT VERNA: Thank you very much.

The Chair recognizes Councilman Jones.

COUNCILMAN JONES: Thank you, Madam President.

Director Mintz, Deputy Director (inaudible), my first day on the job, I was sworn in, we had a wonderful reception over in the inauguration room. I came here, I had a great big party, a wonderful event,

and I went into my office, and I got my first constituent-service request, which was a homeless a couple of couple who had some issues related to mental health, and I'll say that.

We made a call to your office, and this was after hours; it was actually probably around 7 o'clock in the afternoon. Within a hour of that call, you had a team over that dealt with it. And I was a very new Councilperson scared to death, and I was under -- I'm a little superstitious. I figured the first constituent-service request I better solve for a positive resolution.

And I just wanted to thank the both of you for being so attentive.

MS. MINTZ: Thank you.

COUNCILMAN JONES: And making sure that those people who were facing sleeping under a bridge did not. They not only got a place to stay; they were also dealt with on other issues, and it

was a whole list of treatment for them.
MS. MINTZ: Thank you.
COUNCILMAN JONES: So I want to thank you for that on the record and publicly.
MS. MINTZ: Thank you.
COUNCILMAN JONES: The second thing I want to ask is, you're experiencing budget cuts?
MS. MINTZ: Mm-hmm.
COUNCILMAN JONES: To $600,000 worth, is it my understanding?
MS. MINTZ: Beyond.
COUNCILMAN JONES: So is homelessness going away? Are there less homeless that you can afford a budget cut?
MS. MINTZ: There aren't less homelessness, but one of things that we do recognize is that there is always the opportunity for us to be more efficient in how we're using our resources.
So while we still are

challenged by the number of homeless folks that we have to serve, we utilize that opportunity to look at how we could be more efficient in how we allocate our funding.

COUNCILMAN JONES: Now, just so you know, for the last 20 years, I sat on that of the table.

MS. MINTZ: Yes, I'm aware of that.

COUNCILMAN JONES: So I know what that kind of means. So quantitatively, what has been the number of homeless people that you've serviced over the last four years? And up down, increased, decrease?

MS. MINTZ: There certainly has been an increase in homelessness and in the visible street population in the last two-and-a-half years.

COUNCILMAN JONES: Okay.

MS. MINTZ: That increase has been at a high in the summer of 2007 of 661 persons on the street. Many of

them are persons who have behavioral-health issues and who tend not to come into the existing emergency-housing system, either because of their mental health and their disability and their unwillingness to come in because those facilities do have standards of behavior, and/or because their disabilities preclude them from making a determination that they want to come in and address their issues.

We have been assisting for the last three years approximately over, I would say, 3,000 placements on any given night in our shelter.

COUNCILMAN JONES: Say that again?

MS. MINTZ: Over 3,000 placements on any given night in our existing system. That oftentimes is due to us, again, being able to place folks at any time of the day and night.

And we also recognize that we do have turnover in the system. So

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while, on any given time, we're serving about 3,000 or a little less, we oftentimes are serving the same individuals repeatedly over the course of the fiscal year.

COUNCILMAN JONES: I already know it is not your desire to do so, so you do not have to answer this defensively. Just, in fact, do you ever have to turn people away for lack of beds?

MS. MINTZ: Yes, we do.

COUNCILMAN JONES: So you do not need less money; you need more. I'll say it for you for the record.

Second -- and don't even answer that; you don't have to answer that. Don't get yourself in trouble.

But if you are turning people away, you need more beds, more money, more support. And I'll say that for you.

The second thing is, with the increase of the housing sub prime

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lending and subsequent sheriff's sales, are you seeing more people who, because of the loss of a primary residence, are needing homes?

MS. MINTZ: We are. And we are in a very fortunate position of being able to address that through our homeless prevention program. We have a program that is our housing retention program. It's the program I made reference to in my testimony that's trying to prevent folks from coming into our system.

We have earmarked in this current fiscal year really trying to address folks who have foreclosures, and so we have four -- I'm sorry, five organizations that we subcontract with, who have designated geographical areas that they serve, who are actually working with folks who come in who have foreclosures or are facing eviction due to delinquent rent or utilities.

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COUNCILMAN JONES: And what kind of services do you provide them monetarily?

MS. MINTZ: Monetary assistance. We will pay to bring their rent current. We will provide delinquent payment for utilities. We also provide funding to help them cover past-due outstanding mortgage payments.

COUNCILMAN JONES: And for my conservative Republican friends, the math rationale of this is that it is cheaper to keep them in their current housing situation --

MS. MINTZ: Absolutely.

COUNCILMAN JONES: -- than to put them in the system. And it comes out --

MS. MINTZ: Absolutely. And in addition to the realization that we don't have the capacity to house them if they were to come into our system, but in many cases, one of our primary mandates is to try to prevent folks

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from ever experiencing the homeless system by having to come in.

And so the prevention program has been wonderful in avoiding the system for over 300 persons in this fiscal year.

COUNCILMAN JONES: You currently subcontract the housing overnight stays through several vendors.

MS. MINTZ: Yes.

COUNCILMAN JONES: Can you tell us who they are.

MS. MINTZ: Sure. We subcontract with 58 individual contracts. Many of at home are private, nonprofit organizations who primarily are housing providers for emergency housing, transitional, and permanent housing. It would include: Project H.O.M.E.; Resources for Human Development; 1260 Housing Development Corporation; Self, Incorporated; Travelers Aid Society, just to name a

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few but it's a variety.
COUNCILMAN JONES: How do -- do you determine your vendors geographically or by the amount of space in zoning that is allowed to --
MS. MINTZ: No. In many cases, these are providers who have had contracts predating my appointment. We -- on a annual basis, we issue either a request for proposal in order to identify any new providers, and we will issue a request for information from the existing providers. And then every two years, we do an open RFP for all providers to be able to respond to so that we can have the opportunity to evaluate, once again, their service provision, their performance, and make determinations of either to continue to contract with them or to make changes.
That's complicated by the fact that we certainly have providers who own their own facilities. And so for us to make a decision not to contract

with someone means we have to have a alternative to house those families or individuals.

COUNCILMAN JONES: I understand many of those contracts are coming up soon?

MS. MINTZ: Yes. We contract on the annual fiscal year basis. So we're currently in the process of reviewing all of the responses to our RFPs and our RFI's.

COUNCILMAN JONES: I would say that the vast majority of your facilities, I think, are beyond my own personal expectations. Some of them need to be looked at. And as you stated for the record, they predate you.

MS. MINTZ: Yes.

COUNCILMAN JONES: And I understand the challenge to take someone out of the contracting process that provides beds you have to put people in or you're going to be faced

with turning more homeless people away, so I understand all of those challenges.

But we have to work with you to provide decent places for people to live and stay, because at the end of the day, all of us are only a few paychecks away from being homeless, so there but by the grace of God stands I.

And in some of those circumstance, I think we can do better. And I'm going to -- I want to -- as a Councilperson on the Housing and Homelessness Committee, I want to work closely with you. I believe in what you're doing.

MS. MINTZ: Thank you.

COUNCILMAN JONES: I know it is a difficult job, I know you are up for it, so I'm offering our assistance in that committee to be a part of the solution to the problems and not just pointing the fingers.

So whatever we can do to help you out -- and you do need to have that $600,000 restored to your budget, and I see the Budget Director there making notes, that if we are turning people away, how can we cut your program. And I don't think that that should happen.

Thank you.

Thank you, Madam President.

COUNCIL PRESIDENT VERNA: You're welcome.

The Chair recognizes Councilwoman Brown.

COUNCILWOMAN BROWN: Thank you, Madam President.

Good afternoon, ladies.

MS. MINTZ: Good afternoon.

COUNCILWOMAN BROWN: Just a couple of questions. On any given night, how many children are in the homeless shelters on average? Knowing that it fluctuates.

MS. MINTZ: Over 900.

COUNCILWOMAN BROWN: Over 900, okay. Well, you know, the good news is that that number has lowered in the years that I've been in City Council, so that's good news.

You acknowledged in Councilman Curtis Jones question that on occasion, regretfully, you do have to turn individuals away.

MS. MINTZ: Yes.

COUNCILWOMAN BROWN: Does that include children?

MS. MINTZ: It may include a family. Typically what we will do if we are at full capacity is, we will ask the family if they have any inability to make their own arrangements for that night.

COUNCILWOMAN BROWN: Mm-hmm.

MS. MINTZ: If they indicate that they do, we ask them to identify who that is. It's typically a family member.

We verify, by making contact

on the phone, that the family member will allow that person to stay with them that night, or for whatever period of time they indicate that they can.

COUNCILWOMAN BROWN: Mm-hmm.

MS. MINTZ: We will then place the family on a wait list so that when we have an opening in our capacity, we will contact them to determine if they still desire to be placed.

COUNCILWOMAN BROWN: I see.

MS. MINTZ: That has also allowed us to be able to assess whether or not the family truly did not have any other alternatives than coming into emergency housing. Oftentimes, we will have very young heads of family show up because they've had a falling-out. It's not anything that can't be repaired.

COUNCILWOMAN BROWN: Sure.

MS. MINTZ: And so we have found, interestingly, that for many of

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the families who have had to make their own arrangements, less than a third have actually come back to being placed.

COUNCILWOMAN BROWN: Okay. Gee whiz. A couple more questions before my closing comment.

CHIP. We've given a lot of conversation with the leadership of the Health Department.

MS. MINTZ: Mm-hmm.

COUNCILWOMAN BROWN: Taking some special attention with children of parents who are incarcerated.

MS. MINTZ: Mm-hmm.

COUNCILWOMAN BROWN: And the same applies would apply here, children who are in homeless shelters.

MS. MINTZ: Mm-hmm.

COUNCILWOMAN BROWN: So is there a connection of the dots with health and the children you have to make sure that there's health coverage for the time that they're within your

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care?
MS. MINTZ: We are in partnership with the Health Department. I think that that is a new area for us to explore with them, and we would certainly follow up with them on that.
COUNCILWOMAN BROWN: Okay. Just to make -- to the extent in learning today that CHIP is not an entitlement --
MS. MINTZ: Mm-hmm.
COUNCILWOMAN BROWN: -- but we would certainly want to max out all available dollars for our city's children.
MS. MINTZ: Oh, absolutely, absolutely.
COUNCILWOMAN BROWN: And, finally, I will simply say thank you for the partnership that my office has enjoyed with OESS every single year when we do our holiday piece of trying to keep children warm.
MS. MINTZ: Thank you. Yes.

COUNCILWOMAN BROWN: And you should know that the nonprofit Operation Warm, which is in the business of giving out coats internationally now wants to work with us and, therefore, with you.

MS. MINTZ: Yes. And they've made contact.

COUNCILWOMAN BROWN: So that we can bump up how we take care of those children for winter '09. So anticipate follow up from our office.

MS. MINTZ: Absolutely.

COUNCILWOMAN BROWN: Thank you for your good work.

MS. MINTZ: Thank you.

COUNCILWOMAN BROWN: Thank you, Madam President.

COUNCIL PRESIDENT VERNA: You're welcome.

Are there any other questions?

(No further questions.)

COUNCIL PRESIDENT VERNA: Seeing none, thank you very much.

MS. MINTZ: Thank you.
COUNCIL PRESIDENT VERNA: This committee will stand in recess until tomorrow, Tuesday, April 1, at 10 a.m.
Thank you all very much.
(Proceedings end at 4:44 p.m.)
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C E R T I F I C A T E

I HEREBY CERTIFY that the proceedings of the City of Philadelphia Council Committee of the Whole are contained fully and accurately in the stenographic notes taken by me on Monday, March 31, 2008, and that this is a true and correct statement of same.

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JOSEPHINE CARDILLO
Registered Professional Reporter

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